Quarterly Report of the Bureau of Medicaid Fraud and Abuse Covering the Expanded Period April 1 - October 15, 1977

STATE OF NEW YORK
Hugh L. Carey, Governor

DEPARTMENT OF SOCIAL SERVICES
Carmen Shang, Acting Commissioner

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I. Introduction

This report is prepared for the Legislature, in accordance with its request, for the purpose of providing information on the progress and results of the DSS Bureau of Medicaid Fraud and Abuse. It covers activities undertaken through October 15, 1977.

Medicaid is a health care financing program, designed to remove the economic barriers to obtaining care for welfare recipients and the medically needy. In New York, the Department of Social Services has been designated as the "single state agency" responsible for the administration of the Medical Assistance Program. Several functions, however, such as rate-setting and quality assurance continue to reside with the Department of Health pursuant to statutory schemes. Policies are thus jointly determined by these two agencies. In New York, the major share of Medicaid expenditures are funded 50% by the Federal Government, 25% by the State, and 25% by the local districts.

Federal law provides 50% federal funding for state fraud and abuse efforts conducted by the single state agency. Prior to April 1, 1977, the State Department of Health was responsible for New York State's fraud and abuse program under the State Medical Handbook, Item 35, and Title 18, NYCRR, Part 515.

Background

In his February 17, 1977 special message to the Legislature on the State of the Health, Governor Carey announced his intention to form a single unit responsible for combating Medicaid fraud and abuse in ambulatory care. The Bureau of Medicaid Fraud and Abuse was created within the Department of Social Services, Office of Audit and Quality Control, to assume this responsibility. An agreement was reached transferring authority to the State Department of Social Services from the State Department of Health.

The Bureau of Medicaid Fraud and Abuse operates out of the Central and Regional Offices of Audit and Quality Control. Direct operating responsibility has been assumed in New York City. Administration and coordination with local contract and non-contract counties is achieved through technical staff in each Audit and Quality Control region.

The Bureau of Medicaid Fraud and Abuse has been staffed to meet the overall goals of deterring unacceptable practices by providers in the Medical Assistance Program and thus improve the general quality of care provided under Medicaid. While not a prosecutorial agency, the Bureau is charged with the responsibility of detecting and investigating aberrant medical practices. These investigations, via trained professional staff, lead to either administrative action or civil or criminal preparatory legal action. In civil cases, the Bureau, through its legal staff, prepares cases to be presented by the Attorney General of the State. In criminal

cases, the legal staff works with local district attorneys or U.S. attorneys to secure indictments and convictions.

Central Office Staff of the Bureau of Medicaid Fraud and Abuse sets the policies and tone of the Statewide effort. The management and technical staff works closely with regional offices and the New York City operations to assure a coordinated approach to deterring fraud and abuse. Detection systems are developed in the Central Office. Liaison with the DSS/Division of Medical Assistance provides regional staff with Medicaid policy interpretations and will improve regulations. Technical expertise is available to local districts for specific projects and to communicate the latest techniques used in deterring fraud and abuse in the Medicaid Program.

II. Organization and Staffing

On July 1, 1977 the Bureau of Medicaid Fraud and Abuse began its formation. Within a very short period of time, less than four months, a highly competent staff was recruited. Of the total budgeted staff of 353, the Bureau has 301 staff positions in the three regional offices. Two hundred sixty nine (269) of these positions have been filled, with the remaining 32 positions open due only to the inability of getting Civil Service classification and compensation approvals. The remaining 52 positions are delegated to other departments that provide direct support in Medicaid Fraud and Abuse efforts.

The Bureau of Medicaid Fraud and Abuse concentrated on recruiting professionals from the following categories:

Investigators -Recruited from state and local police departments, prosecutorial agencies, and special investigation units. All personnel have experience in investigative work and many of the investigators meet the requirements for actively working with minority groups in the inner cities.

Investigative Auditors -We have been extremely fortunate to have attracted for these positions experienced personnel from such public and private agencies as: the Internal Revenue Service, the Federal Bureau of Investigation, Bureau of Alcohol, Tobacco and Fire Arms of the Treasury Department and the private sector such as bank auditors and insurance company investigators.

Attorneys -Experienced lawyers have joined the Bureau of Medicaid Fraud and Abuse from local district attorney offices. These individuals have backgrounds in the prosecution of fraud cases and in some instances Medicaid fraud.

Medical Assistance Specialists-The Bureau of Medicaid Fraud and Abuse has concentrated its efforts to engage Medical Assistance personnel from varied medical institutions including clinics, hospitals, public health agencies, etc.

Professional Medical Staff -In cooperation with the Department of Health, doctors and nurses from many specialities have been employed to assist in medical evaluation. Reputable specialists and experts in every sub-speciality will be contracted with on a per diem basis to participate in the determination of quality of care issues that will impact on the fraud and abuse effort.

EDP (Electronic Data Processing) - Past experience in working with sophisticated EDP systems techniques was taken into consideration in choosing management staff. This provides user input into the systems planning of the Bureau while utilizing management skills from industry and the public sector.

The New York City operations have been staffed with 207 individuals with operational skills as listed above. This staff has been structured into two units - the Medicaid Billing Review Unit and the Medicaid Fraud Special Investigations Unit.

The Medicaid Billing Review Unit utilizes the EDP programs developed by the Bureau of Medicaid Fraud and Abuse to evaluate abusive billing practices. Provider payments are reviewed for fiscal abuses as well as quality of care. Interviews are scheduled with providers that show billings beyond the norms of their peer groups. Billing reviews may include both medical and fiscal evaluation of charts included in valid statistical samples which are selected by our contract statistical expert. These reviews are exploratory and, if indicated, disallowances are made and restitution sought. In addition, Medical Specialists of this unit will perform, in conjunction with the Department of Health medical staff, quality of care reviews concerning unacceptable practices by providers.

The Medicaid Billing Review Unit is also responsible for auditing clinics. Teams of auditors are in the field reviewing billing procedures and payment audits which are based on computer systems designed to specifically highlight possible abuse in clinics. Initial computer output for the past $4\frac{1}{2}$ years of payments in New York City indicate possible billing irregularities of approximately $20,000,000.

The Billing Review Unit has separate subunits in the field auditing and reviewing possible billing abuses in pharmacies, laboratories, and transportation companies. In addition, dentists and specialists are regularly audited in the New York City office of the Bureau.

The Medicaid Fraud Special Investigations Unit consists of investigators, investigative auditors, computer evaluation specialists and specialized legal staff. The work of this unit is separate and distinct from the Billing Review Unit and includes preparation of criminal cases for prosecution of fraud. All of the latest techniques in the pursuit of white-collar crime are utilized by this Special Investigations Unit. Cases are packaged for prosecution by local district attorneys or the U.S. Attorney, and the unit is available to prosecutors for completion of Medicaid fraud case preparation.

In the three Regional Offices, DSS Bureau of Medicaid Fraud

and Abuse staff mirrors the technical specialties employed in the New York City operation. Each office staff includes investigators, investigative auditors, medical technical personnel, attorneys, management specialists and EDP technical specialists. These staff work with local contract and non-contract counties in the detection and pursuit of abusive and fraudulent provider practices.

Regional office staff act on a consulting basis with local fraud and abuse personnel, and initiate fraud and abuse activities when deemed necessary or requested.

The Bureau of Medicaid Fraud and Abuse has also employed professional collectors on the Central Office staff to insure the recoupment of restitution by abusive providers. These collectors come from both private industry and the public sector, and are experienced in the recovery of funds through direct contact and civil action.

Coordination with Other Units

The Bureau of Medicaid Fraud and Abuse interacts extensively with other units within the Department of Social Services as well as with other State agencies and departments. Within DSS, a very close working relationship exists with the Medical Assistance Division. It is envisioned that these two units will work together to clarify provider regulations, and set policies aimed at improving the quality of care for recipients. Among its many functions, the Medical Assitance Division assists the Bureau in developing EDP programs for the detection of fraud and abuse, and acts as principal liaison with the Department of Health and the medical community to insure maximum cooperation and communication of the primary objective of the Bureau - improving quality of care to Medicaid recipients.

The Bureau has also worked extensively with staff of the Department's Medicaid Management Information System. The Bureau has cooperated with MMIS during the provider enrollment process in order to prevent unwanted medical providers from enrolling in the MMIS program. In addition, the Bureau, in conjunction with staff from the Department's EDP office, has developed a sophisticated fraud and abuse detection system. During the MMIS implementation period, this system will combine payments made through the MMIS system with those still being made by the New York City Department of Social Services.

This combining process will insure that during the entire MMIS phase-in period, overall fraud and abuse detection will continue. Once MMIS is operational the fraud and abuse computer system will become an integral part of the State system, either as prepayment edits or as part of the Surveillance and Utilization Review Subsystem.

Hearings

Pursuant to Department Regulations, when it has been determined that a provider is engaging in an unacceptable practice and administrative action is warranted (such as disqualification from the Medical Assistance Program), the provider is accorded the right to a hearing to contest such determination.

The hearings are conducted by Department Hearing Officers of the Bureau of Administrative Procedures. A new section of that Bureau has been established solely to handle hearings in this area. In the past, the administrative process was protracted (hearings running in some cases over the course of a full year) because of lengthy adjournments of hearings and a lack of an established procedure to handle hearings quickly and uniformly. By using Department hearing staff, rather than contract per diem hearing officers, and by establishing formalized hearing practices and procedures, it is expected that the hearings generated will be handled more expeditiously thereby achieving time disqualification, suspension or censure of a provider when the evidence so warrants.

In addition, DSS Bureau of Medicaid Fraud and Abuse has established liaisons with the Office of the Special Prosecutor and the Office of the Welfare Inspector General.

III. Administration and Operating Procedures

The Bureau of Medicaid Fraud and Abuse has been structured to provide numerous autonomous working units. This allows for maximum productivity and flexibility. Various units cover the entire field of ambulatory care services simultaneously. This allows the total impact of the Bureau's activities to be felt on a continuous basis throughout the Medical Assistance Program. It also permits the fraud and abuse effort to be expanded to special projects that may arise, without disturbing the entire work flow. Moreover, by shifting parts of units, emphasis can be placed on specific groups of providers who might, from time to time, require a greater effort.

The expertise of the staff adds to this flexible structure. Investigators and auditors can be shifted on an "as required" basis to cases needing additional manpower. Billing Review staff can combine with Special Investigations staff to give an added dimension to certain cases. Staff medical and legal personnel are available to all units, as well as local county efforts.

Work flow follows a predetermined pattern to maximize manpower efficiencies. Allegations and complaints referred from outside sources are first entered into a case tracking system, as are EDP generated cases. From this initial point forward, all cases are tracked through to final disposition. The case tracking system is reported statewide and updated with every change of status for each case.

Every case requires a complete profile at the outset. EDP is geared to furnish basic information as well as various intersect programs upon request. Data analysis is first made in the Central Office and, if necessary, additional computer output is requested. All EDP information relating to an allegation, or an internally generated inquiry, is then forwarded to the region for further analysis. The case is then referred to the proper unit where either a full investigation is initiated, or an appointment is made with the provider to review his billing practices.

When administrative action is warranted; preset statewide procedures are followed. Uniform statewide "provider letters" are used. Since the Bureau recognizes and respects the rights of the provider, these letters not only serve as a notification of the intended action (i.e. censure, suspension, or disqualification) but also inform the provider of his right to a formal hearing before an impartial hearing officer.

Throughout the entire process, the case is followed on the case tracking system. This system allows the activities of the Bureau to be monitored both centrally and regionally by caseload, manpower utilization, efficiency and time requirements. This insures fast disposition of cases. Moreover, the Bureau is able to provide status reports on any and all cases in progress.

In addition to the existing sophisticated EDP systems developed by the Bureau of Medicaid Fraud and Abuse, work continues in the development of new programs for the detection of aberrant medical practices. Currently, a test is underway in the Albany area of a simple detection program that may be easily adapted by local counties not requiring the highly complex programs developed for New York City. This program, known as "Amoeba", will be evaluated for effectiveness and ease of implementation. Should it meet the requirements set forth in the test, it will be used in every county with the computer capacity required for its utilization. This packaged program can provide an interim detection system until such time that the most sophisticated EDP systems can be implemented statewide.

The Bureau does not stop with either of these two computer programs. A constant evaluation of EDP needs and potential improvements are in progress. New areas of possible abuse are considered, investigated, and test programs written. Tapes of provider billings to other agencies are being sought and evaluated for possible Bureau use in expanding our detection capabilities.

As each unit expands its operations, procedures are outlined and tested before being put into effect throughout the Bureau. Evaluation of procedures are monitored by management. EDP information is constantly audited. Continuous training of all personnel is required to maintain the effectiveness of the entire Fraud and Abuse staff.

IV. Achievements to Date

Although the Bureau of Medicaid Fraud and Abuse has been in operation for only four months, it is noteworthy to review the achievements to date.

- EDP information on all New York City ambulatory care providers has been obtained for the past 4½ years. This involves 160,000,000 claims sorted and programmed.
- 112 investigations initiated by New York City Department of Health have been completed.
- 61 convictions have been handed down on cases worked on by the Bureau of Medicaid Fraud and Abuse.
- 39 indictments pending adjudication have been handed down on cases worked on by the Bureau of Medicaid Fraud and Abuse.
- $6,305,000 in restitution has been generated by the Bureau of Medicaid Fraud and Abuse.
- 1,945 bills for restitution have been mailed to providers who have duplicate billed or overutilized first visit codes for a 2½ year period. As a result of this effort, preliminary indications are that there is a considerable reduction of physician claims.
- Administrative action (censure, suspension, or disqualification) has been taken against 131 providers who abused the Medicaid Program.
- 70 hearings are in the process of being scheduled.
- 163 clinic audits are underway.
- Meetings have been held by Central Office staff with all 57 local districts within the State.

V. Anticipated Future Developments

Based on the information generated thus far, it is clear that the Bureau of Medicaid Fraud and Abuse can anticipate rewarding results from current and planned efforts. These results will be measureable both in recoupment of overpayments and more importantly in the reduction of overall expenditures in the Medical Assistance Program due to the Bureau's deterrent effect.

Our EDP information indicates that probable recoupments of overpayments and restitution for the current fiscal year will total about $20,000,000. Investigations underway should result in 27 indictments, 73 disqualifications or suspensions and 167 civil actions.

The future holds the possibility of furthering our efforts by matching Medicaid and Medicare payments, which may double the amount of money involved in billing abuses. The pursuit of interstate activities by providers seems to be another potential area of fraud and abuse. It must also be recognized that new provider payments are made daily, many of which are filed with disregard to program objectives and the taxpayer's money.

This program's total budget for fiscal year 1977/78 as approved by the legislature is $5,116,000. After four months of start-up operations, the Bureau of Medicaid Fraud and Abuse has just scratched the surface. Yet $6,305,000 in restitutions has already been generated by the Bureau. This is 123% of the Bureau's entire current fiscal year's budget.

VI.

APPENDICES

Appendix	Chart No.	Title
A		Organizational Charts
	1	Department of Social Services
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	a	Central Office
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B	4	GANTT Chart of Actual and Projected Tasks
C	5	Actual and Projected Restitution

APPENDIX A

ORGANIZATIONAL CHARTS

NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES

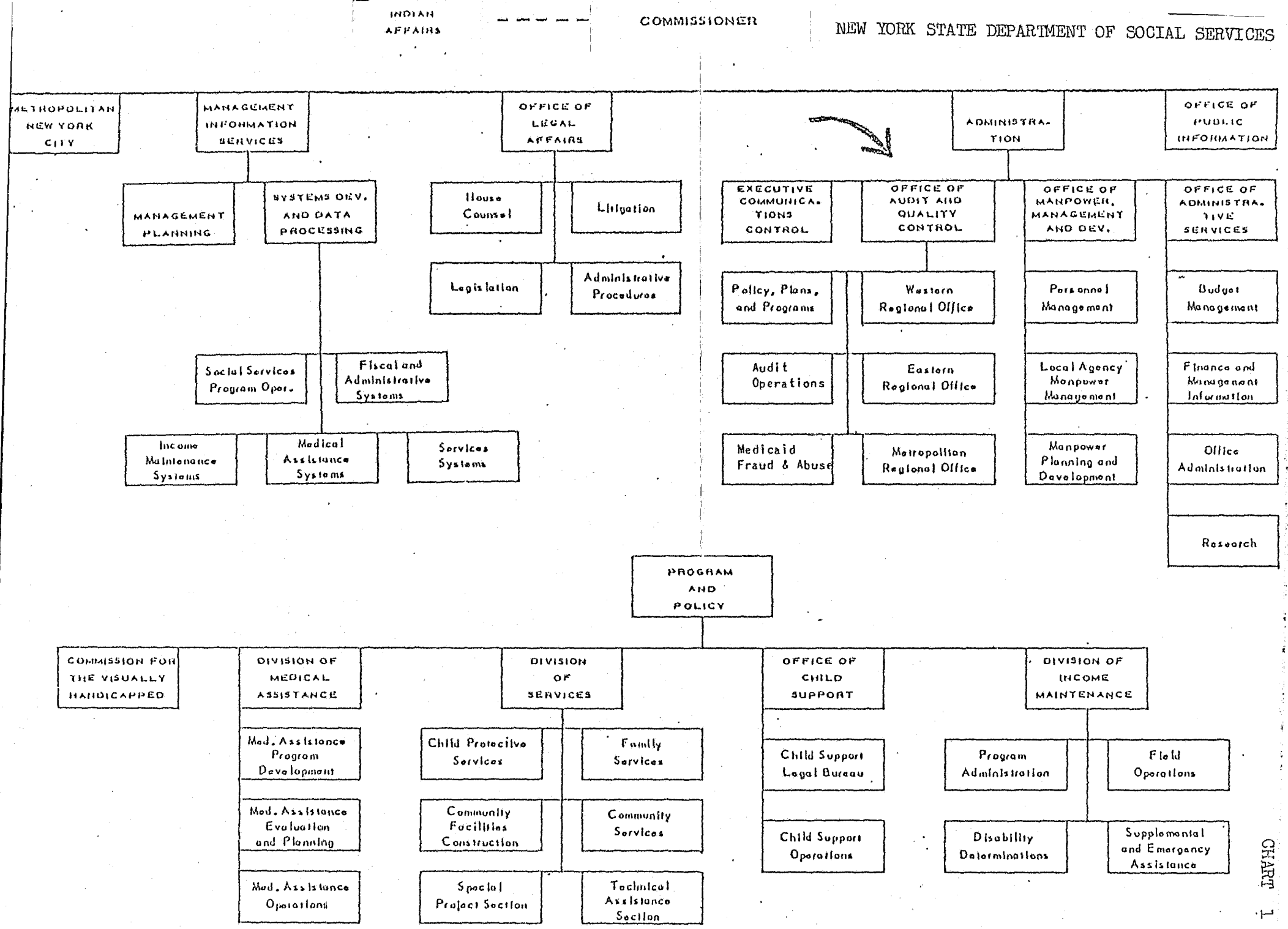


CHART 1

SEPTEMBER - 1976

GENERAL ORGANIZATION CHART

OFFICE OF AUDIT AND QUALITY CONTROL

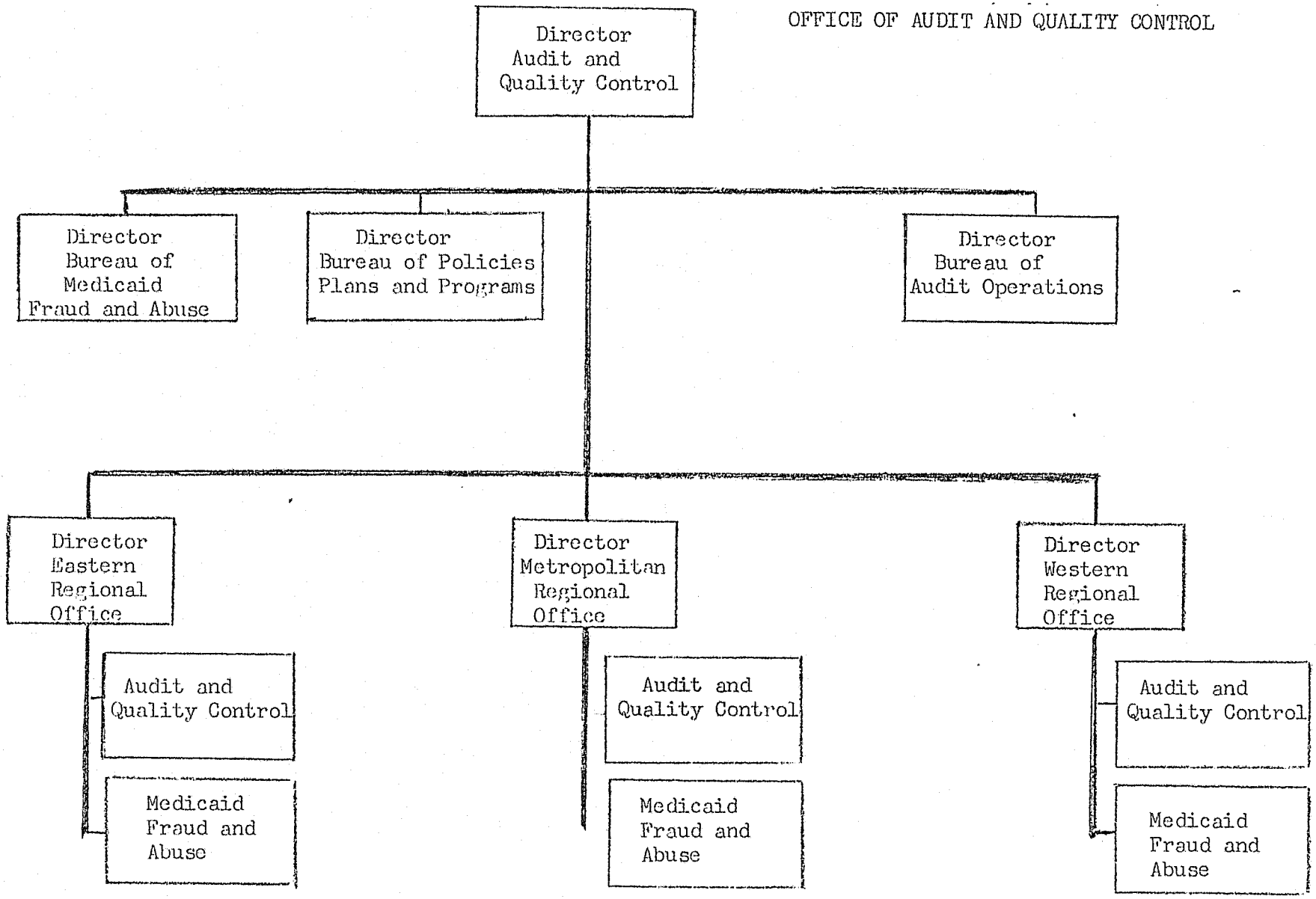


CHART 2

BUREAU OF MEDICAID FRAUD AND ABUSE

CENTRAL OFFICE

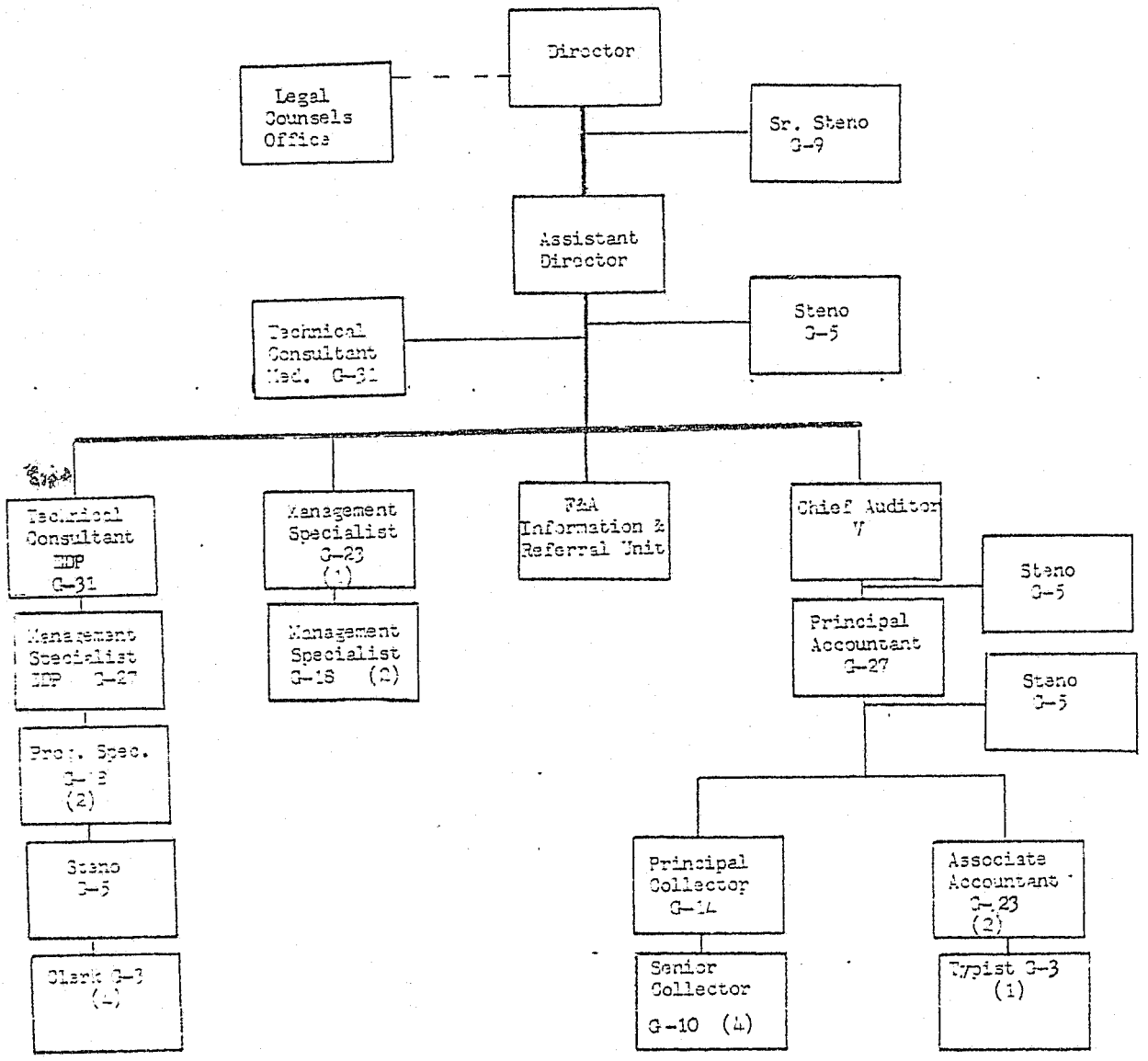
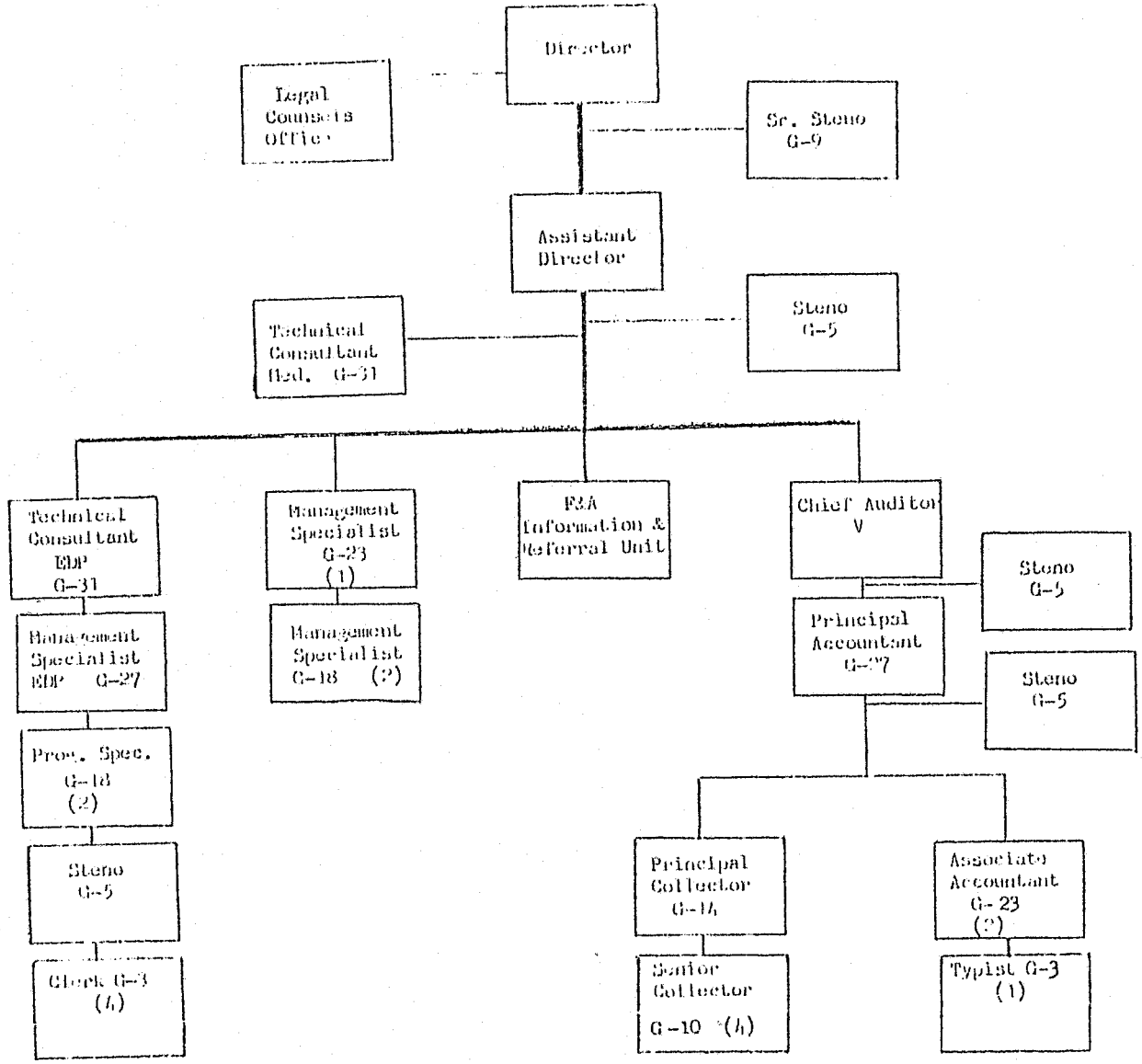


CHART 3 a

BUREAU OF MEDICAID [illegible]

CENTRAL OFFICE



METROPOLITAN REGIONAL OFFICE

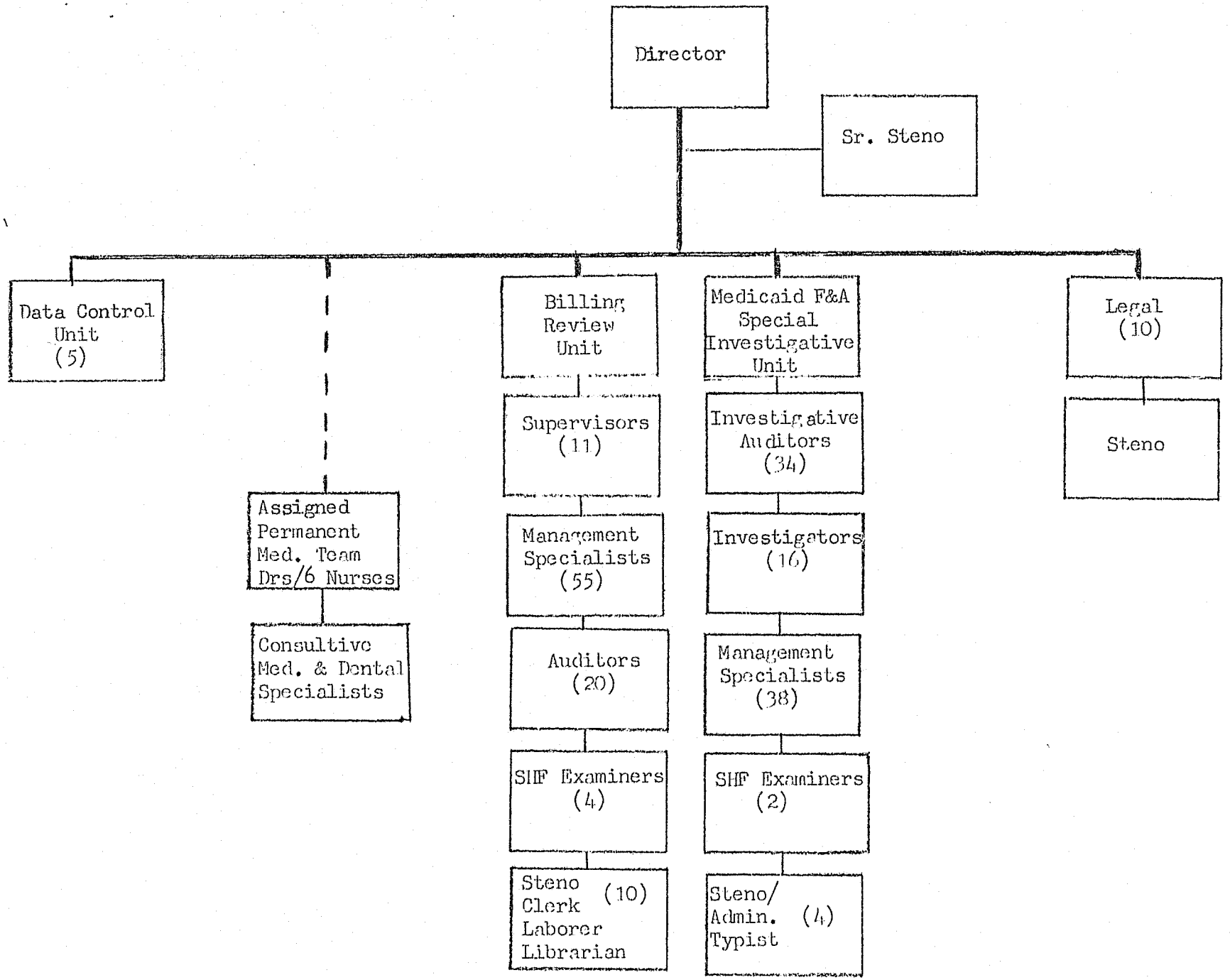
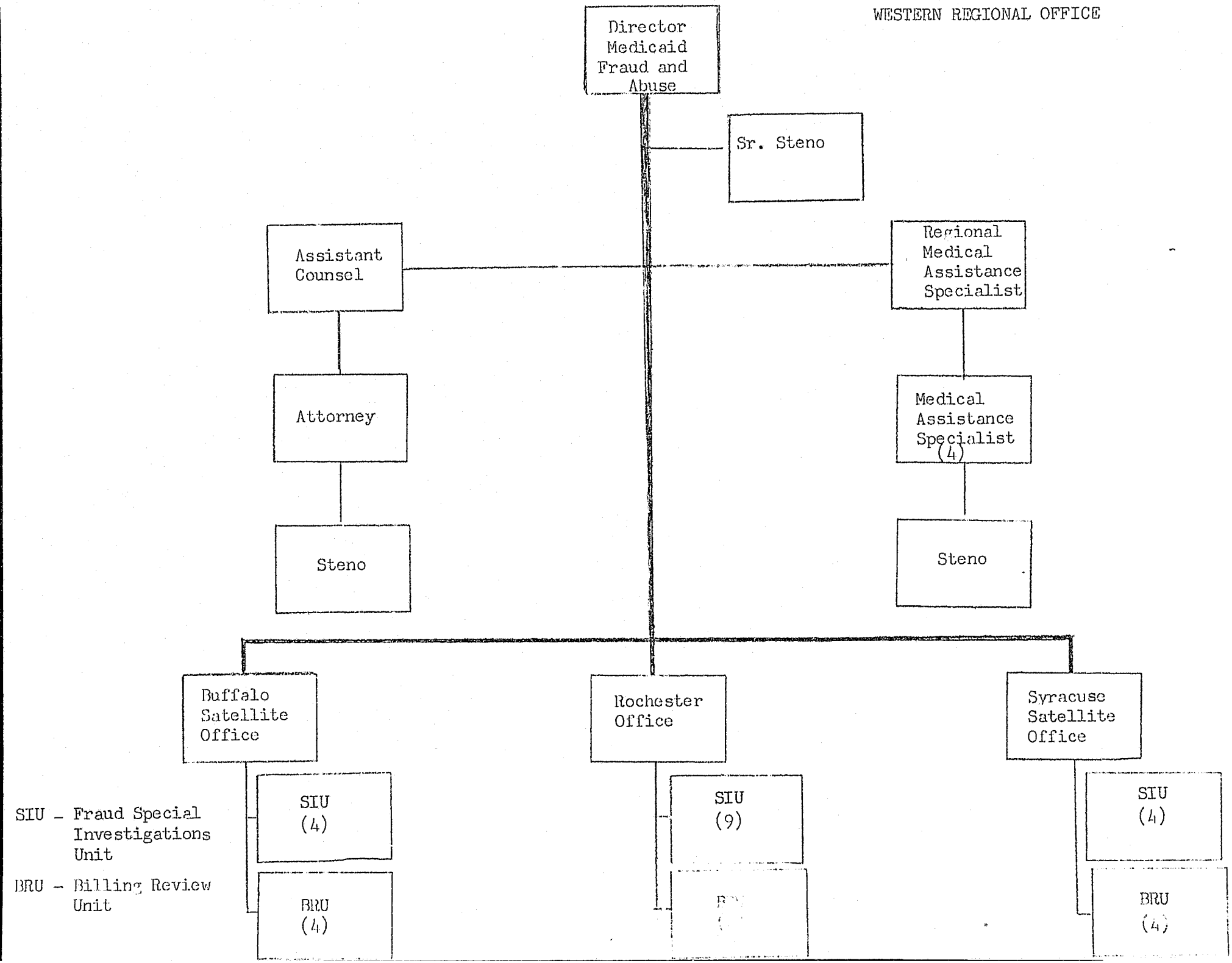


CHART 3 b

WESTERN REGIONAL OFFICE

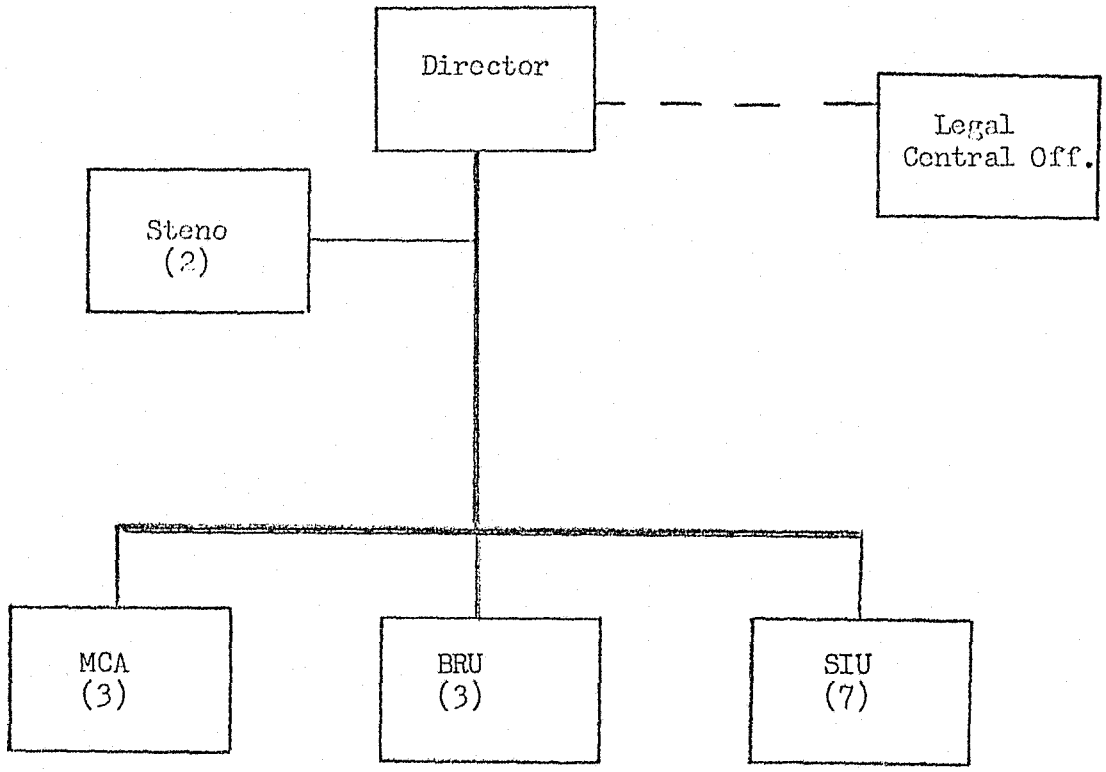


SIU – Fraud Special Investigations Unit

BRU – Billing Review Unit

CHART 3 c

EASTERN REGIONAL OFFICE



MCA - Medical Care Administrator

SIU - Fraud Special Investigations Unit

BRU - Billing and Review Unit

CHART 3 d

APPENDIX B

GANTT CHART OF ACTUAL AND PROJECTED TASKS

GANTT CHART OF ACTUAL AND PROJECTED TASKS — CHART 4

TASK	APRIL	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MARCH
. Organization and Staffing	x	-	-	-	-	-	-	-	-O			
. MMIS Consultation				O	N	G	O	I	N	G	A	C T I V I T Y
. Provider Billing Review				O	N	G	O	I	N	G	A	C T I V I T Y
.1 1st Provider Mail-out for Duplicate Payment and Excessive Use of First Visit Codes (Physicians only)	x	-	-	-	-	-	-	-	-O			
.2 2nd Provider Billing												
Physicians							x	-	-	-	-	-
Osteopaths									x	-	-	-
Dentist										x	-	-
Podiatrist										x	-	-
Optometrist										x	-	-
Optomic Dispensor										x	-	-
Physical Therapist											x	-
Speech Therapist											x	-
Chiropractor											x	-
Occupational Therapist											x	-
Visiting Nurse Serv												x -
Home Health Service												x -
Clinics - Municipal Hospitals	x	-	-	-	-	-	-	O		x	-	-
Clinics - Voluntary Hospitals							x	-	-	-	-	-
Pharmacy									x	-	-	-
Laboratories									x	-	-	-
Appliance Vendors												x -
Administrative Directive - Preparation and Presentation to Counties				x	-	-	-	-O				
Development of Computerized Tracking System					x	-	-	-	-	-	O	
Installation and testing of AMDOBA Computer System on Albany Co. Payment Data	x	-	-	-	-	-	-	-	O			

GANTT CHART OF ACTUAL AND PROJECTED TASKS — CHART 4

TASK	APRIL	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MARCH
• Expansion of Fraud and Abuse EDP System to Upstate Counties				x - - - - -								
• Fraud Investigations				N G O I N G A C T I V I T Y								

Legend

x = started
O = completed

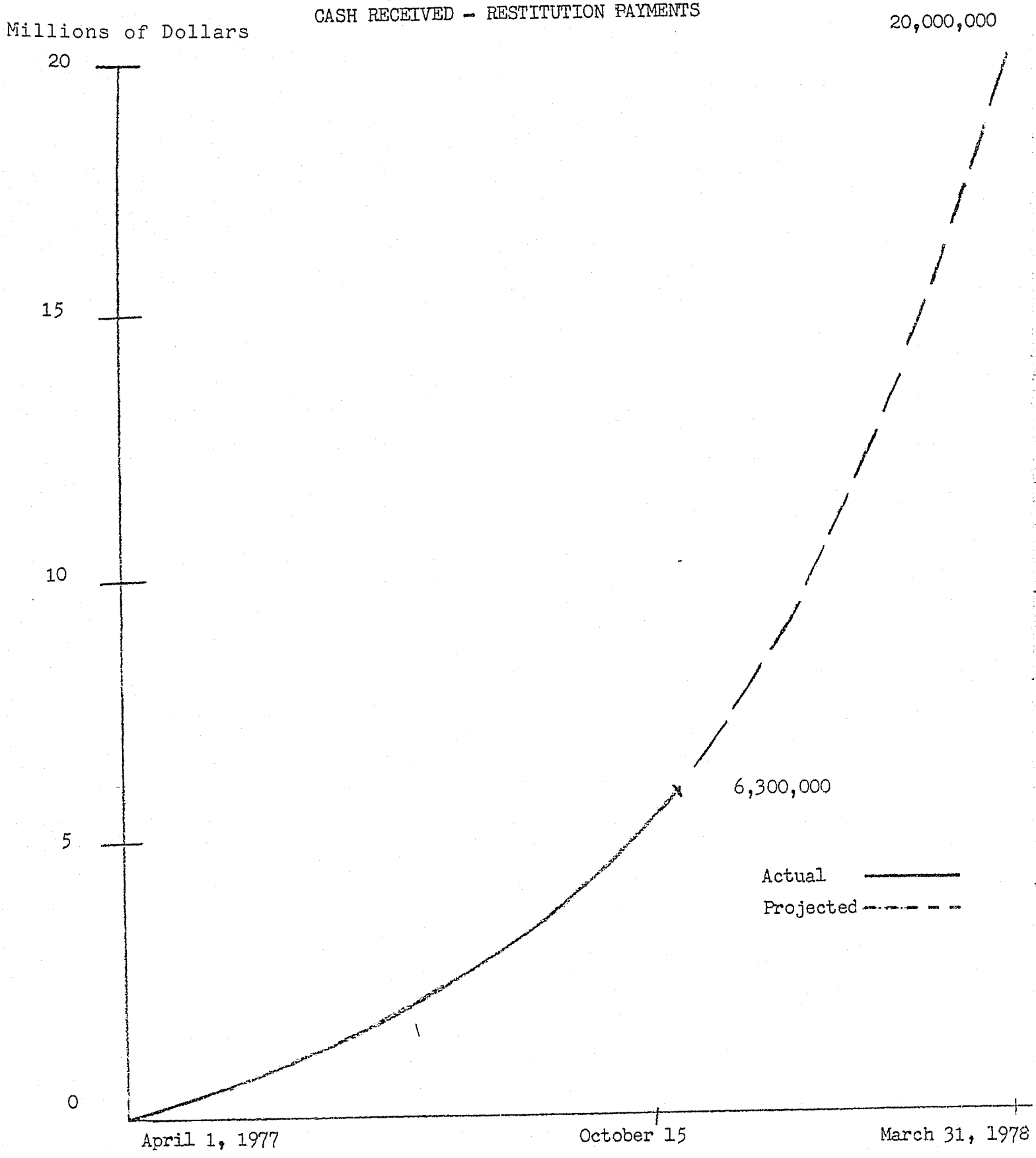
APPENDIX C

ACTUAL AND PROJECTED RESTITUTION

CHART 5

ACTUAL AND PROJECTED

MEDICAID FRAUD & ABUSE
CASH RECEIVED - RESTITUTION PAYMENTS



FISCAL YEAR 1977 - 1978

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