Health Law Section Initial Report on the Medicaid Program and the Role of the Office of the Medicaid Inspector General group of the Health

New York State Bar Association

Health Law Section

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March 13, 2024

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Dated: March 13, 2024

Background

The medical assistance program ("Medicaid") is a critical New York State safety net program that provides essential health care services to more than 7.5 million New Yorkers who might otherwise be unable to afford care. Providers that serve Medicaid beneficiaries are subject to a complex framework of onerous operational, service delivery, and compliance requirements. These requirements are set forth in a patchwork of federal and state statutes and regulations and a vast, dispersed collection of agency materials published by state and federal agencies in the form of manuals, policies, directives, and other informal and formal statements of agency policy.

The Office of the Medicaid Inspector General ("OMIG") was established in 2006 as an independent office within the New York State Department of Health ("DOH"), the single state agency charged with administering the Medicaid program in New York. OMIG was initially created through executive order, and then subsequently enacted as legislation. (N.Y. Pub. Health Law § 30), in response to a series of critical New York Times articles in 2005 highlighting extensive fraud and lack of oversight for New York's Medicaid program. OMIG's stated mission is to enhance and protect the integrity of the Medicaid program by preventing and detecting fraudulent, abusive and wasteful practices within the Medicaid program, through program integrity initiatives such as audits of Medicaid providers ("Audits").

Provider Outcry and the Need for Reform

Unfortunately, over the years since its inception, OMIG has increasingly adopted Audit practices that are unnecessarily punitive and threaten the financial viability of safety net providers that serve Medicaid beneficiaries. In addition to creating an existential threat for these providers, OMIG's Audit practices result in the loss funds providers could have reinvested in new programs or better services. This persistent financial stress makes cost of living raises for staff perpetually out of reach, thereby contributes to a persistent staffing crisis among Medicaid providers.

As discussed in this memorandum, OMIG has adopted Audit practices that result in providers having to return the entire reimbursement amount received for services they rendered, despite having undisputedly provided the service in question and despite there being no evidence of fraudulent or abusive practices, and there being no concerns raised about the quality, necessity, or appropriateness of the underlying services for which a provider was reimbursed.

These Audits often base recoupment entirely on highly technical grounds and clerical/ministerial errors that have no bearing on quality or appropriateness of care. To do so, OMIG uses aggressive auditing and extrapolation methodologies that result in larger

recoupments than audits conducted in accordance with standards promulgated by the federal Centers for Medicaid and Medicare Services ("CMS"), greatly and unfairly magnifying the financial impact of OMIG Audits on providers.

These Audits and other practices of OMIG, which are discussed in more detail in this Memorandum, force Medicaid providers to expend significant resources responding to and defending against such Audits, to protect their entitlement to payment for quality services that were medically necessary, reasonable and appropriate. And, in other instances, providers simply pay back funds to OMIG upon receipt of a request, out of fear and not understanding their rights. In either event, providers are foregoing or are otherwise utilizing already scarce resources and diverting resources away from the provision of care, which puts good Medicaid providers that have not engaged in fraud, waste or abuse in financial peril. These safety net providers already face significant financial and operational challenges due to rising labor and operational costs, low rates of Medicaid reimbursement, increasing levels of uncompensated care and other factors that jeopardize their continued ability to provide health care to Medicaid recipients and historically underserved populations.

Reform Efforts

Medicaid providers have repeatedly raised concerns about OMIG practices that have imposed undue financial hardships that threaten the state's health care safety net and penalize reputable, quality service providers in the state. Providers and their counsel have consistently reported over-reaching and other abuses of process that impair their mission as health care providers in the Medicaid program.

These concerns have repeatedly been the focus of legislative action. The New York State Legislature has previously convened hearings and made findings supporting provider concerns, requesting OMIG to alter its practices. Such concerns and widely reported abuses have fueled legislative reform efforts that have received unopposed, 100% support from the Legislature, only to be vetoed by the executive. In 2011, the Legislature passed Senate Bill S3184-A. In its memorandum, the bill stated that the original OMIG enabling legislation, which had the aims to address the fraud and waste in the Medicaid system, was missing key provisions to ensure "fairness and procedural clarity for all the parties involved, including the personnel of the OMIG." (S.3184-A (Little) (passed by Senate June 20, 2011)). Unfortunately, the 2011 reform bill was vetoed by then Governor Cuomo. While Governor Cuomo recognized that there were legitimate concerns regarding OMIG's practices, he stated that the bill was too far reaching, and while vetoing the bill, directed OMIG to review its practices and convene a workgroup of provider associations.

More than ten years later, OMIG was still engaging in these detrimental practices and, in fact, OMIG audits that were fraught with the same concerns that had been raised previously had increased exponentially. In response, the Legislature again unanimously passed an OMIG reform bill, Assembly Bill A788-A, in 2022. Like the 2011 bill, the 2022 bill was vetoed, this time by Governor Kathy Hochul. Governor Hochul reasoned that the bill as written restricted

OMIG's ability to recover overpayments, which she viewed as required by federal law. Like Governor Cuomo did in 2011, Governor Hochul directed OMIG to review its practices in collaboration with the provider community.

Unfortunately, OMIG's response to the direction of both Governor Cuomo and Governor Hochul has resulted in little practical change. The lack of voluntary redress on the part of OMIG makes clear that legislative action is needed. Presently, S05329 (the "Current Bill"), a legislative reform bill that is intended to address many of the abuses and devastating consequences of OMIG's activities discussed in this Memorandum, is currently being considered by the Legislature.

In 2023, the New York State Bar Association ("NYSBA") Health Law Section convened a Joint Committee Task Force ("Task Force") to study OMIG processes, procedures and activities relating to OMIG's Medicaid program integrity efforts; to study and evaluate the legislative, regulatory and licensing structures governing OMIG and its activities; to provide input and submit recommendations on those efforts; and to develop resources to assist in educating lawyers on how to represent clients effectively, knowledgeably and ethically in these areas. The work of the Task Force, which includes attorneys who represent both Medicaid providers and Medicaid Managed Care plans, is ongoing.

SUMMARY OF OMIG PRACTICES THAT ARE REDRESSED BY THE CURRENT BILL

1. Issues and concerns related to OMIG Audit practices.

One of OMIG's primary initiatives is to conduct Audits of payments received by Medicaid providers. These Audits are typically not focused on verifying service delivery, the quality or appropriateness of such services, or the benefits to the Medicaid beneficiaries who receive such services. Rather, these Audits focus on a provider's technical compliance with a myriad of applicable laws, DOH and other agency regulations, and Medicaid program guidance, manuals and administrative directives that other health oversight agencies and contractors enforcing other program and compliance requirements generally allow to be redressed through corrective action plans, rather than punitive recoupment or extrapolation. Auditing activities focus on ministerial, paperwork technicalities such as a missing or incomplete date on a signature, timeliness of paperwork completion, and completeness of employee files. These Audits are not initiated in response to complaints from patients, concerns about the quality of care, or suspicion or allegations of fraudulent or improper conduct. Rather, providers are seemingly randomly selected for Audit, without consideration of the medical need for the services rendered.

Despite the ministerial focus of these Audits, the consequences to providers are devastating. Providers subject to Audit face recoupment for 100% 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, ultimately decreasing the capacity of such providers to hire and retain sufficient staff which imperils access to health care services for Medicaid recipients and other underserved populations. It also compounds the problem by increasing the likelihood that increasingly overworked providers will commit similar errors in future documentation.

CMS has long recognized that such disallowances are inappropriate and has adopted clear guardrails for its personnel and its contracted auditors to generally prohibit them. For example, while current OMIG audit protocols for Diagnostic and Treatment Centers and other services require OMIG audit staff to disallow a claim for outpatient clinical services if the medical record was not signed, the Medicare Program Integrity Manual requires CMS auditors and CMS contractors to accept unsigned documentation in the exact same circumstances if the rendering provider attests in response to the audit that the medical record entry accurately reflects the service he or she furnished on the date in question. (Compare OMIG Audit Protocol for Diagnostic and Treatment Center Services, Revised 03/14/18 at 2 ["The claim will be disallowed when the entry in the medical record was not signed and dated by the person making the entry"] to Medicare Program Integrity Manual, Chapter 3, Section 3.3.2.4.(A) ["If the signature is missing from any other medical documentation (other than an order), MACs, UPICs, SMRC, and CERT shall accept a signature attestation from the author of the medical record entry"] [emphasis in original]). Compounding the negative impacts on Medicaid providers, OMIG's Audit policies and processes seriously compromise providers' ability to adequately and thoroughly defend against an OMIG Audit. For example:

a. It can take OMIG many years to complete its audit and issue a draft audit report. During this time, providers' records can inadvertently be misfiled, lost or moved to storage, and institutional knowledge about practices and policies can be lost, compromising the provider's ability to locate allegedly missing records, identify secondary sources of information, and ultimately provide testimony from relevant personnel. The delay in completing audits is also detrimental to providers' financial health, the unknown liability compromising a provider's ability to get favorable lending and business terms.

b. Despite the fact that OMIG can take many years to conduct an audit, the provider is required to respond to any and all issues, and to provide all documentation, within a period of only thirty (30) days. Upon request, OMIG may grant a brief extension of this time, but this is discretionary, and individual practices vary. In a detailed audit with numerous issues or documentation that is not easily accessible (particularly where many years have lapsed since the audit was initiated), this may impose an undue burden on the provider.

c. In some cases, OMIG conducts desk audits using available claims and other databases alone to formulate findings. In such cases, the provider does not learn they are being audited until they receive a draft audit report. While desk audits are potentially appropriate in some cases, OMIG has been inappropriately using these desk audits where a full analysis

of the claim and the provider's entitlement to payment requires a review of the provider's record, effectively shifting the cost and burden of conducting the audits onto providers.

d. Many errors identified by OMIG are correctible and/or can be adequately addressed through secondary or alternative documentation. Notwithstanding this, OMIG does not allow for correction and often refuses to consider secondary evidence even where such evidence adequately verifies the timeliness and appropriateness of service delivery and adherence to program requirements.

e. Under OMIG regulations, OMIG is not required to produce its audit file until the prehearing conference, which occurs after the provider has requested an administrative appeal of the final audit report (18 NYCRR § 519.14). Thus, the provider has no right to review information in the audit file at the time of, or for the purpose of, responding to the draft audit report. And, even after the provider gives notice of the appeal, OMIG can delay providing the audit file until the prehearing conference, which may take place as late as seven (7) days before the hearing date. As a result, the provider may not have access to information it needs to fully respond to the draft audit report, to decide whether and on what grounds to challenge a final audit report, or to adequately prepare for a hearing.

f. Under 18 NYCRR § 517.6(a), OMIG may issue a final audit report after receiving the provider's objections to the draft audit report or any time after the expiration of forty (40) days after mailing of the draft audit report without objections having been received. Under 18 NYCRR § 517.3(h), OMIG may also terminate an audit at any time in the audit process and in such cases, OMIG must notify the provider in writing of the termination. If OMIG terminates the audit, it is precluded from recommencing an audit of the items that were the subject of the terminated audit. In some cases, however, OMIG simply refuses to act, neither issuing a final audit report nor officially terminating the audit. As a result, open audits can languish for years after the provider has responded to the draft audit report without any clarity as to OMIG's intent as to the continuation or termination of the audit. In these cases, the provider has no certainty as to the status of the audit, must continue to report the audit as a potential liability on its financial reports, and in business and financial transactions, and must prepare for the potential of significant recoupment (e.g. through reserves). This is fundamentally unfair to providers.

Exacerbating the already outsized consequences of recouping 100% of the provider's payment for paperwork errors, OMIG uses a sampling and extrapolation methodology to apply the "error" rate found in a small sample of claims (typically a sample of 100 claims) to the entire universe of claims (often several hundred thousand claims) and recoup what OMIG estimates to be the amount of the total overpayment for all claims submitted by the provider during the period in question. OMIG's sampling and extrapolation approach is untethered to accepted scientific and statistical practices, CMS standards, and logic. For example:

a. Despite being the auditor and not the regulating agency, OMIG impermissibly determines what issues or errors are sufficiently material to be appropriate for extrapolation. Appropriateness for extrapolation should be based upon sound policy considerations as to

the real significance or impact of any such error on recipient care, such that only substantive errors that can lead to an undesirable service outcome are extrapolated.

b. Providers face devastating financial consequences through the use of extrapolation even where errors are infrequent. OMIG's use of extrapolation even in the face of infrequent errors is inconsistent with the approach taken by CMS with respect to the Medicare program, which requires an error rate of at least fifty (50%) percent before extrapolation is applied. The goal of an effective anti-fraud, waste and abuse program should not be based upon "gotchas" for ministerial and technical violations that are automatically extrapolated based on audit sample findings, depriving providers of the resources needed to combat and protect against actual fraud, waste and abuse. Rather, an effective anti-fraud, waste and abuse program should focus on ensuring quality and medically necessary services are rendered, and appropriately billed and documented in the clinical record.

c. Providers are not able to replicate and test OMIG's sampling and extrapolation methodology to verify the accuracy and integrity of OMIG's methodology. OMIG should be required to use a random number generator program which is free to all users, such as RAT-STATS offered by the HHS US OIG, and to provide all information necessary for a provider to replicate and test OMIG's methodology.

d. OMIG seeks to defend and recoup the "point estimate," a statistically calculated estimate of the error in the total population of claims audited based on the sample information, even where the sample is not adequately powered and precision levels are not sufficient to provide reasonable assurance of the accuracy and reliability of the point estimate as a measure of the true overpayment. OMIG should only be permitted to seek the point estimate where probability sampling is conducted in accordance with the Medicare Program Integrity Manual (MPIM) and adequate precision is obtained. Absent such methods and metrics, recoupment of the point estimate is not scientifically justified and OMIG's recoupment should be limited only to the sample overpayment or, at most, the lower confidence limit (an alternative, conservative estimate of the true overpayment that is not dependent on the precision of the sampling and extrapolation process).

Providers that disagree with OMIG's findings in an Audit often face a Hobson's choice -- (1) accept OMIG's audit findings as set out in its final audit report even though the provider disagrees with OMIG's application of applicable rules in exchange for the benefit of repaying at the statistically calculated lower confidence limit or (2) exercise its due process right to challenge erroneous findings but face recoupment at the higher "point estimate" calculation (which, as noted above, is often not even statistically valid given the poor statistical precision of such estimate). A few years back, OMIG quietly abandoned its long-standing practice of only defending the point estimate if a provider both requested and actually proceeded with a hearing challenging OMIG's findings. Prior to this time, although OMIG had indicated it would defend the point estimate once the provider requested a hearing, its practice was to allow settlement discussions to take place prior to the actual commencement of the hearing (and even at times during the hearing itself) and to adjust (subtract) any removed findings from the lower confidence limit. Now, once the provider requests a hearing, OMIG calculates any adjustments from the point estimate. In practice, what this can

mean is that OMIG counsel can agree a finding is flawed or incorrect but the removal of the finding will still result in a higher overpayment than if the provider did not request a hearing at all and had, instead, accepted the erroneous findings and repaid at the lower confidence limit. The practice is economically coercive and imposes a burden on providers in response to the exercise of their due process rights.

2. Problems with the Administrative Hearing Process

Medicaid providers that do proceed with an administrative hearing to challenge OMIG's final determination, as reflected in a final audit report, continue to face financial hardships as a result of hearing policies and procedures that are unnecessarily punitive and put the safety net of the Medicaid program in jeopardy. For example:

a. During the pendency of the hearing process, which can take many months, OMIG routinely begins recouping the contested overpayment from the provider via a payment withhold (i.e. an offset against current payments). OMIG's standard practice is to withhold a draconian fifty percent (50%) of a provider's payments during the pendency of the hearing. For providers already crippled with financial pressures from labor shortages, inadequate Medicaid rates, and escalating inflation costs, and especially those who service primarily or exclusively the Medicaid population, a fifty (50%) reduction in their Medicaid payments places their continued operations, and the beneficiaries they serve, in jeopardy.

b. A provider's only remedy is to request a financial hardship determination from OMIG, but the process, as it has been revised by OMIG, is an onerous and cumbersome process that requires the disclosure of financial information about a broad range of affiliated entities and individuals with a tenuous relationship to the provider, many of whom are not Medicaid providers and are not even within the scope of persons from whom the provider's overpayment could theoretically be collected. The demand for this level of disclosure is an overreach by OMIG and creates a virtually impossible barrier to the hardship process.

c. If a provider ultimately succeeds in the administrative hearing and finds that OMIG has recouped more than the final amount it owes, OMIG pays no interest on the excess it has collected, effectively requiring the provider to make an interest-free loan to OMIG throughout the hearing process, which can take many months and, in some cases, even years. Conversely, a provider is generally required to pay interest to OMIG from the time a final audit report is issued until payment in full is made, at the rate of prime plus two (2%) percent. While OMIG has the authority to waive interest, it traditionally has refused to do so.

Magnifying the financial risk of the hearing process, providers that challenge an OMIG audit determination are subject to procedural and evidentiary rules that are stacked against them:

a. Pursuant to 18 NYCRR § 519.18(a), upon submission of objections to the draft audit report or notice of proposed agency action, a provider may not raise a matter not already considered by OMIG. Many times, even where the provider raised an issue or objection or provided documentation to OMIG during the audit process, clearly putting OMIG on notice

of the provider's position, OMIG will seek to preclude the evidence at the hearing if the provider did not specifically raise the issue in the response to the draft audit report. This is a trap for the unwary and unfair to the provider.

b. Under 18 NYCRR § 519.18(d), the appellant has the burden of showing that OMIG's determination was incorrect and all claims submitted and denied were due and payable under the program, or that all costs claimed were allowable. The appellant also has the burden of proving any mitigating factors affecting the severity of any sanction imposed. Placing the burden of proof on the provider is unfair, because the provider may not be aware of the complex rules of the Medicaid system, especially concerning payment and documentation issues. Further, in some cases (particularly desk audits that are based entirely on agency claims and other databases), there is little to no interaction with the auditors prior to the issuance of the draft audit report and it is not until the hearing that the reasoning of the auditors is made apparent. Because of these evidentiary limitations, providers are limited in their ability to address explanations and positions taken by OMIG.

c. Too often, it becomes clear during an administrative hearing that OMIG auditors have misapplied, misunderstood or erroneously applied Medicaid requirements that are driving the findings. A provider's ability to submit a post-hearing brief to outline the correct applicable law and how the facts apply is critical to a provider's ability to clearly explain to the administrative law judge why the findings are erroneous. However, appellant providers do not have a right to file a post-hearing brief and, as such, the ability to make these submissions is at the discretion of the individual administrative law judge. If the administrative law judge does allow a post-hearing brief, the provider does not have the right to respond to any new issues OMIG may raise or positions it may take in its post-hearing briefing, even though as discussed in (a) above, the provider has no right to raise new matters with OMIG. Not only is this one-sided, but it unfairly surprises the provider.

The above process turns due process on its head, reflecting OMIG's presumption that the overpayment is correct and imposing collection and interest on a provider before the provider's due process remedies have been exhausted.

3. Risks Associated with the Financial Hardship Application Process

As discussed above, OMIG may institute a payment withhold to begin recouping an alleged overpayment as early as twenty (20) days after OMIG issues a final audit report. There is no limit on the percentage of payments that OMIG can withhold, and generally withholds are imposed equal to fifty percent (50%) of a provider's Medicaid payments, absent a financial hardship determination, which as discussed is an intrusive and inappropriate application process deterring providers from making use of the hardship process and forcing them to instead operate under intense financial strain that does not benefit the provider, the population it serves, or the Medicaid program as a whole.

Further, the standards used by OMIG in evaluating provider hardship applications are unclear. Hardship applications are reviewed internally, rather than by a certified public accountant, and it

is unclear whether any metrics are used in making these determinations or if such metrics are applied uniformly, raising questions about the integrity of OMIG's decisions with respect to these applications. Indeed, at least one provider has applied for a hardship application only to find that their withholding percentage was increased, raising serious questions about the quality and nature of the process. Furthermore, there is no internal review or appeal mechanism by which these determinations can be reviewed by anyone at the OMIG.

CONCLUSION

The Task Force recommends that the Health Law Section adopt a resolution supporting the Current Bill, which is intended to address some of the concerns raised by Medicaid providers and their counsel regarding current OMIG practices. Legislative reform is a necessary, urgent and preliminary step to addressing the negative impact of OMIG's practices on Medicaid providers and the beneficiaries that they serve, and to preserve New York's safety net.