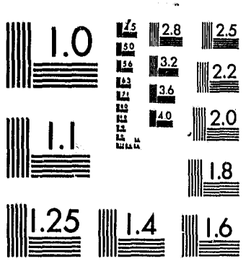

REPORT TO THE LEGISLATURE
ON
COORDINATED WORK PLANS OF STATE AGENCIES INVOLVED IN FRAUD AND ABUSE INVESTIGATIONS

June 21, 1977

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A. Background

This report has been prepared as a response to a Legislative mandate to outline the steps being taken by various State agencies to avoid duplication of investigative resources and maximize the application of those resources to the most appropriate targets. The report encompasses the activities of the following State activities as they relate to the Medicaid/Social Services spectrum:

a. Department of Education
b. Department of Health
c. Department of Mental Hygiene
d. Department of Social Services
e. Division for Youth
f. Office of Drug Abuse Services
g. Office of the Welfare Inspector General
h. Office of the Special State Prosecutor for Health and Social Services.

In order to be responsive to this Legislative request, the Department of Social Services organized a meeting of involved agencies/offices, assembled the group on May 20, and reviewed the subject areas with each agency. Potential conflicts in various program areas were discussed and resolved, and agreement was reached on development of expenditure, recovery, and planning data for use in this report.

Legislative concern for duplication of agency activities in Medicaid and welfare is well founded in that the programs are extremely varied and complex and responsibility for various programmatic and regulatory functions is fragmented. Despite this situation, we have found that actual duplication of major activities is at the present time limited and not seriously disruptive of fraud and abuse activities.

It is the conclusion of the various agencies that the work plans discussed in detail in this report demonstrate minimal overlap.

Although it is clear that each agency/office is doing its utmost to minimize duplication of efforts in fraud and abuse, DSS, as the agency charged under this year's legislation for monitoring fraud and abuse activity, plans to take several steps to provide for an on-going forum for interaction with concerned agency representatives.

- DSS will reconstitute the Medicaid Fraud and Abuse Task Force. This entity will serve as a means for direct exchange of agency plans and problems and will serve as a viable conduit for exchange of information on areas of mutual concern.
- DSS is proposing to establish a Centralized Data Exchange which will mandate reporting of selected status information relative to fraud and abuse investigations from inception through penalty/recovery. This will insure that both local and State investigatory/prosecutory authorities can avoid duplicative investigations of the same providers while at the same time the exchange will serve as a vehicle for measuring progress on a Statewide basis of actions taken against fraud and abuse.

B. Legislative Authority of the Agencies

The powers and responsibilities of the various Agencies and Offices involved in fraud and abuse vary significantly depending on mission. The Legislative authority of each is as follows:

1. Department of Social Services

The Commissioner of Social Services is empowered by the Social Services Law (Section 17, 20 and 34) to exercise general supervision over the work of all local welfare authorities and conduct any inquiry pertinent or material to the discharge of the duties imposed on him by law and subpoena any witnesses, records, etc. pertinent to such an investigation.

Section 145-b gives the Department a right to treble damages to redress fraud and abuse in the Medicaid program.

Section 364 invests the Department with the responsibility for maintaining standards for non-institutional medical assistance and for assuring that the quality of medical care and services is in the best interest of the recipients.

2. Department of Health

Article 28 of the Public Health Law charges the Commissioner of Health with the responsibility of audits of Hospitals, Nursing Homes, Health Related facilities and clinics for the purpose of establishing rates of reimbursement.

Section 12 of the Public Health Law prescribes civil penalties for violation of the State Commissioner of Health's orders, regulations or the Public Health Law.

Section 12a of the Public Health Law authorizes the Commissioner of Health to conduct formal hearings, issue subpoenas.

Section 16 of the Public Health Law provides summary power to the State Commissioner of Health to abate dangers to the public health and safety.

Section 364 of the Social Services Law establishes the responsibility of the State Department of Health to review and audit the quality and availability of MAP medical care and services.

Section 364a of the Social Services Law provides that the State Department of Social Services will enter into a cooperative agreement with SDH for the administration and supervision of MAP medical care and services.

Social Services Regulation Part 515 outlines due process related to administrative penalty and hearing procedures for providers suspected or accused of unacceptable practices in the Medicaid program; designates the State Commissioner of Health as the authority responsible for the conduct of such administrative actions and hearings.

State Medical Handbook, Item 35 provides the MAP operational guide for the above administrative actions and hearings.

Section 230 of the Public Health Law creates a Board of Professional Medical Conduct within the State Department of Health with authority to investigate, hear, and refer cases of alleged unprofessional physician conduct.

3. Special Prosecutor for Health and Social Services

The Special Prosecutor is empowered to investigate residential health care facilities under the provisions of subdivisions 3 and 8 of Section 63 of the Executive Law of the State of New York.

The Special Prosecutor is also responsible under the same provisions for investigations into the activities of Proprietary Homes for Adults (PPHA's).

4. Office of the Welfare Inspector General

The OWIG operates under provisions of sections 46-50 of the Executive Law which empowers it to:

- receive complaints of alleged abuses and suspected frauds of the Welfare System, and
- investigate the operations of Social Services and of local social services districts in order to insure the proper expenditure of Welfare funds and to identify violations of the Welfare System, the failure to prosecute Welfare frauds, the failure to enforce

the State's laws regarding the employment of welfare recipients in available employment, and the failure of local officials and employees to comply with State law, rules and regulations regarding Welfare administration in New York State.

5. Department of Education

Pursuant to the Education Law, the State Board of Regents, through the Education Department and the Commissioner of Education, is responsible for supervising admission to and the practice of professions in New York State (§§ 6501 and 6502). The role of the Board and the Department includes establishment of required qualifications, promulgation of regulations, conduct of necessary investigations, and assessment and prosecution of professional misconduct (§§ 6507, 6509, 6510, 6511, 6512, 6513, 6514, and 6515).

The professions so regulated by the Board of Regents and Education Department include: (1) Medicine (§§ 6520-27); (2) Physical Therapy (§§ 6530-36); (3) Physicians Associates and Specialists' Assistants (§§ 6530-36); (4) Chiropractic (§§ 6550-56); (5) Dentistry and Dental Hygiene (§§ 6600-6611); (6) Pharmacy (§§ 6800-6828); (7) Nursing (§§ 6900-6908); (8) Podiatry (§§ 7000-7006); (9) Optometry (§§ 7100-7106); (10) Ophthalmic Dispensing (§§ 7120-7126); (11) Psychology (§§ 7600-7605); and (12) Social Work (§§ 7700-7705).

Since the Department of Education has focused its limited resources (four staff assigned to Medicaid) on licensing infractions (fee splitting, improper or no license, percentage leasing, etc.) which in no way conflict with the activities of other agencies and since that agency is a member of the Governor's Strike Force on Medicaid Mills, we have included reference to DOE efforts only in the expenditure schedules.

6. Division for Youth
Office of Drug Abuse Services
Department of Mental Hygiene

The above agencies were also represented on the Task force; however, it was clear from the outset that although they have certain program responsibilities they have no statutory authority to investigate fraud and abuse nor resources to accomplish it. As such the balance of this report will be restricted to those agencies with such statutory responsibilities.

C. Medicaid Vendors

As indicated in Section E of this report, there are a number of reviews or investigations under way or planned by the various Offices and Departments for the 1977-78 fiscal year covering all vendor areas. For ease of presentation, we will discuss each provider area separately as well as delineate the problems associated with each area. Exhibit II delineates the basic responsibility of operating Departments as well as the provisions of cooperative agreements between the Departments.

1. Hospitals

As indicated in the following table, the problems associated with hospitals (proprietary, voluntary, public) fall into several unique areas thereby limiting the potential for overlap in monitoring and enforcement activities.

TABLE I

	Issue Area	Program Responsibility	Problem Area	Audit/Investigative Coverage
1.	Rates/ costs	DOH	-Intentionally inefficient/ unreasonable or padded costs -kickbacks by suppliers -failure to account for revenues.	-Blue Cross/Blue Shield audits all hospitals -DSS/DOH presently have 12 cooperative audits planned or under way to test the accuracy of the Blue Cross/Blue Shield system, isolate rate-inflating factors, identify billing deficiencies and identify inefficient or unreasonable costs, etc. -Special Prosecutor plans to investigate a number of institutions over the next two years, utilizing HEW funds to develop a model investigation. -OWIG plans to review the DOH Shared Audit Program, test selected expense categories at specific hospitals and investigate specific complaints. -OWIG also plans a review of DMH operated facilities and programs including psychiatric hospitals.

TABLE I (cont.)

	Issue Area	Program Responsibility	Problem Area	Audit/Investigative Coverage
2.	Correct bills	DSS	Intentional or unintentional inflation of bills	-DSS/DOH will jointly consider the billing aspects in the 12 reviews cited above. DSS further plans to use the computer data generated for fraud and abuse purposes to isolate duplicate payments as well as other unusual billing patterns.
3.	Insurance offsets	DSS	Coverage not used or when it is, it is not reflected as a reduction to the bill because either hospital or client retains it	-DSS plans to access the files of major insurers and make an automated match with payment files of local districts starting with New York City with follow-up investigations at each hospital. -DSS identifies third party losses on a continuing basis as part of its Medicaid Quality Control and Medicaid operational audits. -OWIG plans a test of third party losses in New York City and Monroe County similar to the DSS Quality Control approach.
4.	Eligibility	DSS	Extensive client misrepresentation or misuse of I.D. cards	-present coverage limited to Quality Control checks with referrals to locals -major DSS client fraud detection system planned as an adjunct to automated fraud/abuse payment system, however, specific investigations will remain with local authorities.

As the above table depicts, the Departments of Health and Social Services and the Special Prosecutor all have major investigative thrusts under way or consideration in the hospital sector. In the areas of potential overlap, however, agreements have already been reached which will maximize interaction while at the same time negate the possibility of duplication of effort.

Health and Social Services entered an agreement on November 23, 1976, whereby investigations of a selected number of hospitals will take place on a joint basis using pooled resources from both Departments. These reviews will cover the Medicaid cost concerns of both Departments in the areas of rate-setting and revenues including third party insurers.

DSS has requested a special grant from the Department of Health, Education and Welfare which could impact significantly on the amount of resources applied to hospital-related fraud. DSS will propose as part of a broad proposal on control of fraud and abuse, an investigation of a minimum of 12 hospitals to isolate occasions of fraud and abuse. Such reviews would be performed jointly with the Department of Health and would extend somewhat the scope of activity in hospitals presently covered for planning purposes as well as the number and type of facilities.

The Special Prosecutor has been requested by DHEW to submit a proposal for a demonstration program in investigation of hospital-related fraud. Agreement is to be reached between the Commissioner of Social Services and the Special Prosecutor about conducting such investigative activity including provisions that to whatever extent possible the hospitals selected for DSS/DOH purposes and for Special Prosecutor investigations will be coordinated in advance. The Special Prosecutor will receive selective types of fraud referrals from DSS/DOH in accordance with agreements that will be committed to writing in the immediate future and which will, of course, be available to the Legislature.

2. Nursing Homes/Health Related Facilities

Problems as well as investigative responsibilities in the nursing home sector (voluntary, public, proprietary) are well defined because of the relative interest that this industry has engendered in the past two years. The following table depicts the problem as well as efforts planned to investigate those situations.

TABLE II

	Issue Area	Program Responsibility	Problem Area	Audit/Investigative Coverage
1.	Rates/ costs	DOH	-inefficient/ unreasonable/ fraudulent costs result in increased Medicaid rates -kickbacks by suppliers have same effect	-Voluntaries and Publics are to be reviewed by DOH while Special Prosecutor focuses on Proprietaries. Any fraud surfaced by DOH is to be referred to Special Prosecutor. The Special Prosecutor will conduct a certain number of survey investigations into voluntary and public facilities. -OWIG plans to review two Public homes which should not conflict with DOH plans and schedules.
2.	Billings	DSS	-Limited overbilling primarily in connection with discharges	-Extensive reviews in the past have indicated that only minimal tests are required focusing primarily on local district records. As with hospitals, DSS plans extensive computer audit using fraud and abuse data base
3.	Insurance	DSS	-Failure to submit revenues from third party payors	-DSS plans extensive reviews, however, most of the effort involves records of insurance companies versus local district files with minimal nursing home interface. Any irregularities will be referred to Special Prosecutor for investigation.
4.	Patient funds	DSS	-Misuse	-DSS and DOH have decided to include coverage of this area in DOH audit programs -Extensive past reviews by DSS have indicated numerous abuses that necessitate a review in every home and this can best be accomplished by DOH. This transfer is endorsed by the Special Prosecutor.
5.	Eligibility	DSS	-Client misrepresentation is limited in the nursing home area	-Individual fraud is investigated by locals -State DSS tests client misrepresentation via Quality Control with referrals of specific violations to locals.

As the above table indicates, State Health and the Special Prosecutor have the major interface in the nursing home arena with a relatively minor

amount of effort planned by OWIG. A cooperative agreement is in effect between Health and the Special Prosecutor which limits the types of homes to be covered by each thus precluding duplication. DOH will concentrate its efforts during this fiscal year on voluntary and public homes leaving the proprietary sector to the scrutiny of the Special Prosecutor.

3. Ambulatory Care Providers/Purveyors

a. Clinics

As with other major cost areas, clinic responsibilities must be segregated into appropriate subject areas under the aegis of the major Departments.

TABLE III

	Issue Area	Program Responsibility	Problem Area	Audit/Investigative Coverage
1.	Rates	DOH	-Inflated/ inefficient or unreasonable costs including "dumping" of inpatient costs on the clinic base -Failure to acknowledge revenues	-DOH has plans for a review of approximately 60 clinics this fiscal year. In addition, the joint DSS/DOH audits of hospitals apply to hospital based clinics as well as inpatient care. Any indications of fraud will be referred to DSS per agreement. -OWIG has plans to review a selected number of comprehensive health and family planning clinics, however, the reviews will be limited to determining whether restricted grant income was applied in computing Medicaid clinic rates.
2.	Billings/ utilization (medical abuse)	DSS	-Duplicate or exaggerated billings -Misuse or abuse by client and provider alike -Inappropriate or inadequate care	-Using computerized fraud and abuse payment data, DSS will be reviewing all New York City clinics together with 12 major Upstate clinics. Where feasible, such reviews will be coordinated with DOH audit staff. Under the single fraud/abuse structure, DOH medical expertise will be assigned to work with DSS on all fraud/abuse matters

TABLE III (cont.)

	Issue Area	Program Responsibility	Problem Area	Audit/Investigative Coverage
3.	Insurance	DSS	-Third party payments not pursued or retained by client or provider	-DSS aforementioned plans for hospitals will be applied to clinics as well.
	Eligibility	DSS	-Misrepresentation by client of resources/income -False identification	-Quality Control process is used to test this area with follow-up by locals on any client-related fraud. -DSS will identify abusive clients via computerized files and client interrogations. Local DSS will be responsible for follow-up and prosecution as well as restriction of services. -OWIG plans an investigation of misuse or misrepresentation of ID cards.

As the above table would indicate, State DSS and DOH because of the joint nature of the ambulatory care fraud and abuse agreement will be conducting a well-coordinated effort in the clinic area with no likelihood of duplication. Coverage will be extensive in both New York City and the Upstate area.

b. Pharmacies, Practitioners, and Other Purveyors

Ambulatory care providers/purveyors present a complex problem in terms of fraud and abuse control because of the significant number of providers in this area and the variety of methods that can be used to bilk or abuse the client and system alike. A list of the extensive abuses compiled by DSS for the ambulatory care area is included as Exhibit V. Although the methodology differs according to provider area, the result is essentially the same; an inflated or fabricated billing or inappropriate/inadequate care. The following table depicts the coverage in this area.

TABLE IV

Issue Area	Primary Responsibility	Extent of Audit/Investigative Coverage
All aspects of fraud, abuse and unacceptable practices relating to Medicaid services	DSS with Medical expertise provided by DOH	-Using automated data, DSS has identified 5,300 potential fraud/abuse cases cutting across all providers or purveyors (Medicaid mills, labs, clinics, pharmacies, dentists, doctors, podiatrists, chiropractors, etc.). DOH will participate fully in accordance with a cooperative agreement between the two Departments. Any evidence of professional misconduct or licensing infractions will be referred to Health or Education in accordance with existing working arrangements between the two Departments. -OWIG has plans for reviews in several ambulatory provider areas including: 1. billings by three Manhattan pharmacies, 2. claims from speech and physical therapists, 3. double billings by hospital-based physicians, and 4. transportation costs in selected counties.

Although there is some degree of overlap between the DSS/OWIG efforts, agreements will be reached between the two agencies to preclude a duplication of efforts.

D. Plans for Investigations in Specific Subject Areas - Non-Medicaid

In analyzing the specific areas of responsibility for each Department/Office, it becomes immediately evident that Medicaid related tartets offer the greatest potential for overlap and as such most of the focus of this report is on plans in that subject area. In Non-Medicaid functions the fraud and abuse concerns are limited to the following:

- client fraud or abuse in the cash and other assistance forms
- local personnel fraud
- selected non-Medicaid vendors (Proprietary Homes for Adults - PPHA's, Homemaker/Housekeeping, Day Care, Foster Care, etc.).

1. Client Fraud or Abuse (Non-Medicaid)

At present there is only one State entity directly involved in the investigation of client fraud/abuse. The Office of the Welfare Inspector General receives and acts upon specific allegations in concert with local prosecutory interests. The majority of the investigations are conducted locally by Social Services districts and local district attorneys as part of their ongoing fraud operations.

State DSS, although not charged with specific operating responsibility in this area, does uncover specific instances of fraud as part of its ongoing quality control reviews (600 fraud cases annually) and operational audits. It is the policy of this Department however to refer all such cases to local officials for investigation and disposition.

Also, pursuant to Title IV-D of the State Social Security Act, State DSS has responsibility for location of deserting parents and for arranging to secure support from such parents in behalf of their dependent children.

E. Employee Fraud

It is the responsibility of the local districts to investigate employee fraud. Although State DSS does test the controls over employee fraud, the number of instances involving some form of State investigation (five cases detected by State DSS in 1976-77 in three counties and New York City) are sporadic and do not occasion a separate plan and segregation of resources. In contrast, local prosecutory authorities investigate hundreds of cases of employee fraud annually.

3. Non-Medicaid "Vendor" Fraud and Abuse

Potential vendor targets in Non-Medicaid areas are limited in terms of both numbers and occasion of fraud and abuse. For the purposes of this report, the following targets were considered:

- Proprietary homes for adults (PPHA's)
- Day Care
- Homemaker-Housekeeping
- Landlords, furnace repairs, etc.

a. Proprietary Homes for Adults

If Legislative action is taken to transfer PPHA's from the Board of Social Welfare to DSS, both State DSS and the Special Prosecutor's Office will be reviewing certain aspects of PPHA management. DSS is preparing plans for an initial program and fiscal review of all PPHA's to insure that clients are receiving the level and type of services required. Under the present system of flat monthly charges (primarily Supplemental Security Income) for PPHA residents, there are relatively few opportunities for fraud against the assistance programs; however, there is widespread abuse of residents as well as potential tax fraud. Such frauds are currently under investigation by the Special Prosecutor. If responsibility is transferred to DSS, it may be desirable for the

Special Prosecutor and DSS to develop a memorandum of understanding detailing the targets to be covered by each in exercising their responsibilities.

b. Day Care

At present DSS is the only State activity with resources applied to Day Care fraud activities. A total of six staff will continue to be assigned to a major investigation being conducted on the awarding of "direct leases" involving 177 day care centers in New York City coupled with a limited number of other alleged improprieties. Estimates of fiscal recoveries in this area would be premature.

c. Homemaker - Housekeeping

OWIG has plans for a review in a suburban New York County. State DSS which has in prior years conducted extensive reviews of Homemaker -Housekeeping as well as the Home Attendant program in New York City has no specific plans in the Homemaker - Housekeeping area for the present fiscal year but does anticipate another review of Home Attendant services.

d. Landlords, Furnace Repairs, Etc.

The Office of the Welfare Inspector General acts upon complaints in this area. As with other public assistance offenses, the majority of these sporadic cases are investigated by local Social Services districts in cooperation with local prosecutors. OWIG has one such investigation under way in Monroe County.

e. Foster Care

The Department of Social Services is conducting extensive audits and reviews on all aspects of Foster Care operations. OWIG is planning audits of agencies in New York City.

E. Cash Recovery versus Expenditure Analysis for selected Fraud and Abuse Efforts

	May Year Expenditures by Agency					
Subject Area	DSS [1]	DOH	Spec. Pr.	OWIG	Educ.	Others [2]
Medicaid						
1. Hospitals	20	↑		↑	↑	
2. Nursing Homes	6	226	356	18	4	NA
3. Clinics	30	↓		↓	↓	
4. Other ambulatory care	333					
[5] Total Man Years	389	226	356	18	4	
[4] $ Expenditures	5.2 m.		6.2 m.	.285 m.	Licensing only .10	
Anticipated Recoveries [3] (in Millions)	40 m.	20 m.	4.0 m. [7]	N/A	N/A-6/	
Other Audit/Investigative Activities						
Client Fraud				59		
Client Eligibility	135			↑		
Foster Care	40			22		
Misc. Studies	40			↓		
PPHA's	9		51			
Day Care	11					
Fraud Operations in Local Districts	6					
Reimbursement Claims	103					
Title IV-D-	11					
Operational Reviews	48					
	403		51	81		
$ Expenditures	6.0		.750	1.14 m.		
Anticipated Recoveries	$76 m.		N/A	N/A		

1/ Includes DOH Medical Support

2/ Mental Hygiene, Division for Youth, and ODAS have no audit/investigative responsibilities in Fraud/Abuse areas

3/ Gross share (Federal, State, Local). OWIG presently has no means of estimating

3/ the amount of cash recoveries since the recovery activity is performed by local agencies, State DOH, etc. They do anticipate that their findings in all review areas will be in the $30-40 million range. There are, of course, other potential cost savings associated with the work of each agency which cannot be reflected as a recovery but are recognized as cost avoidance.

4/ Expenditure levels for 1978-79 are expected to remain relatively the same for all agencies with the exception of Health and DSS. Health plans to add 7 staff for rebuttals of appeals to audit. DSS's proposed fraud and abuse expenditures will increase from the present nine-month appropriation level to a full twelve-month funding.

5/ All man-year estimates include distribution of clerical support, administration, etc.

6/ Department of Education has only 4 staff involved in the licensing activities of individual providers, nurses, etc. Their activity does not conflict with efforts in other Agencies in that the focus is on licensing infractions resulting from professional misconduct in the following areas:

1. Improper or no licenses; failure to conspiciously display either NYS license or current registration for address. (Possible illegal practice.)
2. Improper practice of a profession under an assumed name.
3. Percentage leasing.
4. Fee splitting.
5. Inappropriate signs, inappropriate advertising.
6. Suspected cases of arson.
7. Other unprofessional conduct involving gross negligence.

7/ Includes only criminal institution. Does not include audit findings referred for administrative recovery of overpayment.

EXHIBIT I

MEDICAID PROGRAM FUNCTIONS -- FEBRUARY 1977

FUNCTION	CURRENTLY PERFORMED BY	STATUTORY LIMITATIONS	EXHIBIT II COOPERATIVE AGREEMENT PROVISION	MEMO OF UNDERSTANDING
PROGRAM MANAGEMENT				
State Plan	DSS		I.A.	
Federal Relations	DSS		I.A, I.B	
Financial Mgmt. (Federal $)	DSS	Title XIX requires the designation of a single State agency to be accountable for the performance of all functions.	X	
Financial Mgmt. (State $)	DSS/DOH/DMH/ODAS			
Audits	DSS/DOH		IX	Exhibit III
MMIS	DSS		None	
Reporting	DSS/DOH/LDSS		VII	
Delegation, Monitoring & Enforcement	DSS		IX.A	
Research & Program Evaluation	DSS/DOH/DMH/ODAS etc.		None	
ELIGIBILITY				
Standards & Policies	DSS	Title XIX requires that the eligibility function be vested in the IV-A Agency (i.e. DSS)	II	
Determination	LDSS DSS for DMH & ODAS		II	
Fair Hearings	DSS Conducts DOH Supports		VIII.A VIII.B	
PROVIDER RELATIONS				
Licensure (Individuals)	DOE	Authority Granted to Education by EL	None	
Certification (Institutions)	DOH	Authority Granted to Health by PHL Art. 28	IV.C.1	
Provider Agreements	DSS for SNF's & ICF's LDSS for some others		IV.C.2	

FUNCTION	CURRENTLY PERFORMED BY	STATUTORY LIMITATIONS	COOPERATIVE AGREEMENT PROVISION
PROVIDER RELATIONS (cont'd)			
SNH Compliance Enforcement	DOH		III.B
SNF Administrators	DOH		IV.A.4
Consultative Services	DOH		IV.D.1
HEALTH CARE STANDARDS			
State Medical Handbook	DOH		III.A
Non-Institutional Standards	DOH develops DSS promulgates		IV.A.1 IV.A.2
Institutional Standards	DOH DMH & ODAS for their facilities	By federal law, institutional standards must be established by the State Health Agency.	IV.A.3
Local Medical Plans	DSS/DOH		V.A-V.D
Administration & Supervision of Medical Care and Services	DOH		V.E
REIMBURSEMENT			
Rates	DOH DMH/ODAS for their facilities. DSS for FC Medical per diem.	PHL Art. 28	VI.
Prices (drugs)	DSS/DOH for non-legend		None
Fees	ICHE/LDSS		None
Claims Processing	LDSS DSS for DMH & ODAS		None

FUNCTION	CURRENTLY PERFORMED BY	STATUTORY LIMITATIONS	COOPERATIVE AGREEMENT PROVISION
PROFESSIONAL REVIEWS			
Life Safety Surveys	DOH	Performed by DOH for Title XVIII	None
PMR	DOH		IV.B.2
IPR	DOH		IV.B.2
On-Site Monitoring	DOH		None
Utilization Control			
- Utilization Review	DOH, PSRO, LMD	Title XI of the Social Security Act Grants broad authority to PSRO's	IV.B.1
- Local Medical Director	DOH		V.F, G
- Quality & Availability Reviews	DOH		IV.B.1
- Prior Authorization	LMD		None

EXHIBIT II

COOPERATIVE AGREEMENT
BY AND BETWEEN

The State Department of Social Services hereinafter referred to as "Social Services" and the State Department of Health, hereinafter referred to as "Health", on behalf of itself and those local health districts with which Health may contract in accordance with Section 364-a of the Social Services Law.

WITNESSETH:

WHEREAS, on July 30, 1965, the "Social Security Amendments of 1965" were enacted into law as Public Law 89-97, which among its provisions included the enactment of Title XIX making additional funds available to the states for medical assistance provided to eligible individuals; and

WHEREAS, such Title XIX makes provision for the submission of a "State plan" by a "single State agency"; and

WHEREAS, such Title XIX makes provision permitting a state agency other than the "single State agency" to be designated to establish and maintain standards for institutions in which recipients of medical assistance may receive care or services, and certain functions and services may be performed under such title for the single State agency by other state or local agencies; and

WHEREAS, on November 10, 1965 Governor Rockefeller, issued an Executive Order designating Social Services as the "single State agency" responsible for preparing and supervising the administration of the "State plan"; and

WHEREAS, by such Executive Order the State Department of Health was assigned the responsibility of "establishing, maintaining and certifying" to Social Services standards for all institutional and non-institutional care and services under the "State plan"; and

WHEREAS, by such Executive Order Social Services and Health are directed to enter into cooperative arrangements with each other; and

WHEREAS, Health is the State agency which licenses health institutions and agencies, the primary health service agency, and the agency designated to determine whether providers under Title XVIII of the Social Security Act meet the standards for participation in such program; and

WHEREAS, Chapter 256 of the Laws of 1966, adding a new Title 11 to Article 5 of the Social Services Law, to promote the State's goal of making available to everyone uniform high quality medical care, makes provision for a program of Medical Assistance for Needy Persons, hereinafter referred to as "Medical Assistance" and designates Social Services as the "single State agency" having overall responsibility for the medical assistance program under Title XIX of the Social Security Act and Title 11 of Article 5 of the Social Services Law; and

WHEREAS, Social Services as such single State agency is responsible for the submission of the "State plan" for Medical Assistance to the Federal Department of Health, Education and Welfare, and is required to take such steps, not inconsistent with law, as may be necessary to assure approval of such plan by the Federal Department of Health, Education and Welfare; and

WHEREAS, such plan has been developed and submitted to the Federal Department of Health, Education and Welfare and has been approved; and

WHEREAS, such Chapter 256 of the Laws of 1966 mandates that Social Services is to enter into a cooperative agreement with Health, whereby the latter is "to administer and supervise the medical care and health services" available to eligible applicants or recipients of Medical Assistance, either directly or by contract with certain local health districts; and

WHEREAS, Chapter 257 of the Laws of 1966 amended such Chapter 256 and required that all functions for the "administration and supervision of medical care and services" available under Medical Assistance, are to be performed by Health, "to the extent permitted by applicable Federal law and to the extent Federal reimbursement for such care and services is not impaired"; and

WHEREAS, on January 2, 1968, the "Social Security Act Amendments of 1967" was enacted into law as Public Law 90-248 and on October 30, 1972, the "Social Security Act Amendments of 1972" was enacted into law as Public Law 92-603 which amend Title XIX of the Social Security Act and impose additional responsibilities and functions upon Social Services and upon Health in fulfilling their respective roles in Medical Assistance; and

WHEREAS, Health and Social Services have been cooperating in carrying out the directives of the Governor and the Legislature, in implementing the new Federal requirements, including those contained in PL 92-603, and in defining the respective functions and responsibilities of Social Services and Health; and

WHEREAS, it is necessary to amend the existing cooperative agreement and contract between Social Services and Health to reflect the changed responsibilities and functions and to remain in compliance with Federal requirements; and

WHEREAS, Social Services has responsibility pursuant to the Social Services Law and, as the single State agency pursuant to the Federal Social Security Act, to take whatever steps necessary to detect and investigate Medicaid fraud and abuse, and to prevent the payment of false or invalid claims because of unacceptable claiming practices; and

WHEREAS, the Governor of the State of New York, in his 1977 Annual State of the Health Message to the Legislature, indicated that in order to avoid unnecessary duplication, fragmentation and inefficient use of staff and fiscal resources the Medicaid fraud and abuse control function should be centralized in Social Services; and

WHEREAS, Health and Social Services entered into a Memorandum of Understanding on September 29, 1976 which sought to clarify Departmental relationships in combating and abating Medicaid fraud and abuse, which memorandum is hereby understood to be no longer in effect;

NOW, THEREFORE, in order to carry out the directions of the Governor and the Legislature, implement the new Federal requirements and to define the respective functions and responsibilities of "Social Services" and "Health" to assure a uniform high quality of medical care throughout the State for eligible persons, the parties hereto terminate the Cooperative Agreement heretofore entered into by them on August 30, 1966, effective October 31, 1966, as amended by agreements dated December 30, 1971 and January 17, 1972, effective January 1, 1972, and do terminate the contract by and between the parties relative to skilled nursing homes dated January 27, 1972, effective January 1, 1972, and do terminate the Cooperative Agreement dated July 1, 1974, and have agreed as follows:

I. FEDERAL RELATIONS

A. Social Services shall be responsible for submitting amendments of the "State plan" to the Federal Department of Health, Education and Welfare (hereinafter, "HEW") and for the conduct of negotiations relating thereto with such Federal agency.

B. This agreement and all materials implementing the same shall be submitted to HEW by Social Services.

II. MEDICAL ASSISTANCE ELIGIBILITY

A. Social Services has the responsibility for establishing or revising the standards, policies and procedures for determining the eligibility of persons for Medical Assistance, and for requiring adherence thereto by the social services districts of the State.

III. STATE MEDICAL HANDBOOK

A. With the cooperation and advice of Social Services, Health has the responsibility for developing standards of medical care and health services to be provided under Medical Assistance, which standards, collectively, shall be known as the State Medical Handbook, and which shall govern the contents of local medical plans.

B. Health has the responsibility for requiring adherence by providers of medical care and health services to the regulations promulgated by Social Services reflecting the standards of medical care and health services included in the State Medical Handbook developed by Health.

IV. MEDICAL STANDARDS AND FACILITY CERTIFICATION

A. Health Standards

1. Health shall establish, maintain and certify to Social Services standards for non-institutional medical care and health services.
2. Social Services shall approve and promulgate in the form of regulations the standards for non-institutional medical care and health services certified by Health.
3. Health shall be responsible for establishing and maintaining in accordance with standards established by the regulations of the Secretary of Health, Education and Welfare, health standards for private or public institutions and agencies in which recipients of Medical Assistance may receive care or service, and for certifying to Social Services that these institutions meet the applicable standards.

4. Health shall continue to provide for the examination licensure and registration of nursing home administrators in accordance with the provisions of the Public Health Law and applicable Federal requirements.

B. Utilization Review and Periodic Medical Review

1. Subject to consultation and periodic review and evaluation by Social Services, Health shall establish, maintain, and implement a plan for continuing review of the utilization, appropriateness, availability and quality of care and services furnished to recipients of Medical Assistance under the State plan and shall certify such plan and its implementation to Social Services.
2. Health shall develop a plan and provide for periodic medical review and medical inspections in skilled nursing homes and shall make periodic reports of the findings together with any recommendations to Social Services in accordance with Section 1902(a) (26) of the Social Security Act and 45 CFR 250.23. Health and Social Services shall fulfill their respective functions and responsibilities in medical review and inspection in accordance with all other applicable Federal requirements.

C. Certification

1. Health shall provide Social Services with a listing of the institutions and agencies to which an operating certificate pursuant to Article 28 of the Public Health Law has been issued, and shall notify Social Services concerning any additions or deletions from such listing, as soon as they occur. For Title XIX purposes, Social Services or Health, as the case may be, shall notify the other of skilled nursing facilities certified by the Secretary of Health, Education and Welfare under Title XVIII, any change in such certification, and the period of such certification.

2. Social Services shall provide for agreements with providers of services under the State plan, in accordance with applicable Federal requirements.

3. Health shall report on and inform Social Services of the appropriateness of the additional care and services in any proposed contract of Social Services pursuant to the authority of Section 1902(a)(23) of the Social Security Act for care and services in addition to those offered under the State plan.

D. Consultative Services

1. Health shall provide consultative services as described in Section 1902(a)(24) of the Social Security Act, and 45 CFR 250.41. Such consultative services shall be provided as indicated and will be directed toward assisting hospitals, nursing homes, health related facilities, home health agencies, clinics and laboratories to qualify for payments under the Social Security Act, to establish and maintain such fiscal records as may be necessary for the proper and efficient administration of the Social Security Act, and to provide information needed to determine payments due for care and services furnished to individuals under said Act.

V. LOCAL MEDICAL PLANS

A. Social Services shall continue to require by regulation that each social services district provides medical care and health services, under Medical Assistance, in accordance with a local medical plan approved as conforming to State requirements.

B. Social Services shall require that the local medical plans be submitted by the social services districts to Social Services and by it to Health for review.

C. Health shall review local medical plans and when found to be in conformity with State requirements, certify them to Social Services for approval.

D. Social Services shall approve medical plans meeting requirements certified to it by Health, but shall disapprove any plan which does not meet such requirements.

E. Health shall be responsible for providing, either directly or through contracts with local health districts, "administration and supervision of the medical care and health services" available under Medical Assistance, in accordance with the regulations promulgated by Social Services.

F. Health shall be responsible for the functions assigned to the medical director by Section 365-b of the Social Services Law; i.e., providing guidance or direction for the development and maintenance of the local medical plan, and for supervising the medical care and health services aspects of the Medical Assistance program. Health shall discharge this responsibility for the social services districts either directly through the employment of medical directors for this purpose or through contracts with local health districts.

G. Any contract which Health may enter into with a local health district shall conform with applicable provisions of State and Federal law, the terms of this agreement and shall require adherence thereto, and to such regulations promulgated by Social Services as are included in the standards, policies and procedures developed by Health and constituting the State Medical Handbook.

VI. RATES

A. Health shall provide Social Services with a list showing rates of payment established for each institution under Section 2807 of the Public Health Law. Such list shall specify participation in Title XIX for each institution so certified.

VII. REPORTS, FORMS AND PROCEDURES

A. Through cooperative efforts, Social Services and Health shall develop mutually satisfactory forms and procedures for carrying out their respective responsibilities under Title 11 of Article 5 of the Social Services Law, and this agreement. Such forms and procedures shall include those necessary for claiming State and Federal reimbursement.

B. Social Services shall require such reports as are or may be necessary to comply with Federal requirements and Health shall do whatever may be necessary to be done on its part to assure that such requirements may be met.

C. Health shall be responsible for requiring and obtaining such reports relating to the quality and availability of medical care and health services as may be necessary, and Health shall make provisions for making copies thereof available to Social Services.

D. Social Services shall develop, in cooperation with Health, a system of reports required to be made periodically by local social services departments to satisfy the requirements of either or both such State departments. Such reports shall be made to Social Services which shall make provision for making copies thereof available to Health.

VIII. APPEALS AND FAIR HEARINGS

A. Social Services shall make provision for appeals to be made by dissatisfied applicants for, or recipients of Medical Assistance; to determine such appeals without hearing when no hearing is requested;

when hearings are requested to hold fair hearings on such appeals; to issue appropriate decisions thereon; and to take such steps as may be necessary to enforce its determinations and decisions.

B. Health, consistent with its responsibility under Chapters 256 and 257 of the Laws of 1966 and under this agreement shall participate, as advisors and expert witnesses in appeals and fair hearings when the appeals relate to the necessity for, the quality or quantity of medical care, health services or supplies or the local method or procedure for supplying the same.

IX. MONITORING AND ENFORCEMENT

A. Social Services shall establish and implement such policies and procedures that will monitor and evaluate the effectiveness and efficiency of the activities performed under this agreement, appropriate to its responsibilities under the State plan and in accordance with applicable State and Federal Laws and Regulations.

B. Social Services shall assume full responsibility and shall have full authority for the detection, investigation, deterrence and prosecution of fraud and abuse and for the detection, investigation, deterrence and prosecution of unacceptable claiming and medical practices by providers of Medical care, services and supplies, in the ambulatory care setting, to the extent such functions have not been delegated by law or by action of the Governor to an agency other than Health, as more particularly described below. Provided however that the functions exercised by the Commissioner of Health pursuant to Section 230 of the Public Health Law, and the State Hospital Code and State Sanitary Code shall not be affected by this provision.

1. Administrative Proceedings

Social Services shall be responsible and have authority for determining on behalf of the State and any social services district the amount of any restitution or civil penalty due from a provider because of fraud or abuse or an unacceptable practice, and any other civil penalty including the suspension, disqualification or limitation of such providers participation in the Medicaid program and the Commissioner of Social Services or his designee shall be delegated to perform any and all of the functions, and shall have the authority heretofore vested in the Commissioner of Health for all matters described in 18 NYCRR Part 515; and

2. Civil Restitution

Social Services shall be responsible and have authority for the preparation of cases for litigation to achieve civil restitution for such sums of money that were obtained by a provider or other vendor as the result of fraud, abuse, or unacceptable practice in the Medicaid program.

3. Criminal Prosecution

Social Services shall be responsible and shall have the authority for the preparation of cases involving fraud, abuse or unacceptable practice in the Medicaid program for referral to an appropriate prosecuting agency or agencies.

C. In order to carry out the aforedescribed functions Health and Social Services shall undertake the following activities:

1. Health shall develop and certify to Social Services standards for acceptable medical practices and a delineation of unacceptable medical practices appropriate for application to the Medicaid program, and shall provide such appropriate technical assistance as may be necessary in order to effectively apply such standards to providers under the Medicaid program; and
2. Health shall, subject to the amount of funds provided to it for such efforts, continue to provide appropriate licensed professional staff to assist Social Services in the performance of its fraud and abuse control activities described in this agreement. Such staff shall be located in the Regional Offices of Health. Health shall ensure that its local professional directors continue to provide at least the present level of necessary expert services that are requested of Social Services. Such services will be performed under the direction of Social Services.
3. Health shall forward to Social Services any information in its possession indicating that a provider or group of providers may have been or may be engaged in a practice constituting fraud or abuse or an unacceptable practice, except where prohibited by statute.
4. Social Services shall notify Health of any information it may possess indicating that a provider has engaged in any activity that may constitute professional misconduct, for which Health has review responsibilities pursuant to the Public Health Law.
5. Social Services shall maintain information and records relating to its activities under this agreement and shall make such information and records available to Health upon request, in a manner consistent with any requirements of safeguarding confidentiality that may be

6. Social Services shall provide Health with such reports prepared in such form as agreed upon by the parties.

7. Social Services and Health shall each designate a person or persons to serve as coordinator to facilitate the terms of Paragraph IX of this agreement. Social Services and Health shall agree upon the compensation for the person or persons designated by Health as coordinator.

X. FEDERAL ADVANCES

A. Social Services will periodically obtain, on behalf of Health, and in conformity with applicable Federal Regulations and practice, advances against Federal funds provided for the conduct of the functions and activities herein prescribed and authorized. Such funds may be received by the State Comptroller and, upon allocation in accordance with applicable provisions of law, shall become available to Health in anticipation of Federal reimbursement to which Social Services may become entitled as a result of reasonable and necessary costs incurred by Health in performing the functions authorized by this Agreement.

B.1. Health will submit estimates of anticipated costs and entitlement to Federal reimbursement as a result thereof for such periods, at such time and in such manner, as may be requested by Social Services. Such costs shall be limited to costs allocable to the functions and activities herein provided in accordance with records maintained or submitted to Social Services including the names of employees, salaries paid, hours of performance and specification of such activities, provided, however, that where Health utilizes services or materials in the execution of this Agreement for purposes which include purposes other than those authorized by this Agreement, the cost of those services or materials shall be pro-rated in proportion to the relationship

which the salaries and wages to functions performed pursuant to this Agreement in the organizational unit using such services and materials has to the total salaries and wages of such organizational unit. Indirect costs in accordance with the applicable proposal of Health, if any, then on file and approved by the Department of Health, Education and Welfare, shall be applied in accordance with the principles applicable in such approved proposal.

2. At such intervals as Social Services may require, Health will submit a report of its actual expenses in executing the functions and activities herein authorized. Social Services will determine whether such expenditures were necessary for the performance of the functions authorized by this Agreement and will compare such expenditures, and Health's entitlement to Federal funds as a result thereof, to the advances received from Federal funds on behalf of Health for the period. If Social Services' examination of such expenses determines that any such expenditure was not necessary to the purposes of this Agreement, Social Services shall so inform Health of tentative exceptions. Health thereupon will be given a reasonable length of time, of not less than thirty (30) days to justify such expenditures. If Social Services thereafter finds that such expenses are not necessary to the performance of such purposes, Health's entitlement to Federal reimbursement shall be reduced by an amount so determined and subsequent Federal advances adjusted, by increase or reduction, to compensate for such expense and for any difference between entitlements reported by Health for the prior period and the advance for that period.

XI. MISCELLANEOUS

A. Social Services and Health shall observe and require the observance of the applicable requirements relating to confidentiality of records and

information, and each agrees not to allow examination of records or to disclose information, except as may be necessary for the purpose of obtaining medical care and health services or the proper discharge of responsibilities relating thereto, and except as provided by applicable State and Federal Laws and Regulations.

B. Social Services and Health shall observe and require the observance of the requirements of Section VI of the Civil Rights Act of 1964.

C. Personnel of Social Services and Health performing functions under this Agreement shall be subject to the New York State Merit System.

XII. TERMS OF AGREEMENT

A. This Agreement shall be effective only to the extent that it is found by the appropriate Federal agency to be permitted by applicable Federal law, and to the extent that Federal aid is not impaired thereby.

B. Either party may terminate this Agreement on 30 days advance notice in writing to the other party. If terminated, any funds paid to Health under the provisions of this Agreement which have not been expended or encumbered in accordance with the provisions of this Agreement prior to the date as of which the Agreement was terminated and any property purchased with funds paid to Health under the provisions of this Agreement, shall be accounted for in accordance with standards established by Social Services governing disposition of such property and funds.

C. This Agreement may be amended from time to time, but no such agreement shall be effective unless signed by the Commissioners of Health and Social Services, and shall be effective only to the extent set forth in paragraphs A. and B. above.

Dated at
Albany, New York
5/19/77

NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES

BY _____
Philip L. Toia
Commissioner

Dated at
Albany, New York
5/23/77

NEW YORK STATE DEPARTMENT OF HEALTH

BY _____
Robert P. Whalen, M.D.
Commissioner

EXHIBIT III

STATE OF NEW YORK

DEPARTMENT OF HEALTH

DEPARTMENT OF SOCIAL SERVICES

MEMORANDUM OF PROVISIONAL UNDERSTANDING

Section I - SIGNATORIES AND PURPOSES

This memorandum of provisional understanding is entered into between the Commissioner of Health and the Commissioner of Social Services. Its purpose is to set forth the mutual responsibilities of the signatories in the conduct of a joint audit effort through a common audit plan in order to maximize the impact of the respective Departments' limited personnel resources through the avoidance of duplicative effort.

The audit of hospitals and their financial records by the Commissioner of Health is in discharge of his duties under Article 28 of the Public Health Law, including those specified in Section 2803 of that Article, and is carried out for the purposes set out therein. The audit of hospitals and their financial records by the Commissioner of Social Services is in discharge of his duties under Section 365 of the Social Services Law.

Nothing in this memorandum of understanding is intended to relieve either party of the duty to make whatever effort is necessary to fully carry out their respective responsibilities.

Section II - JOINT AUDIT PLAN

The Commissioners agree to a joint effort in the conduct of these hospital audits. To accomplish the objectives of this agreement, a "joint audit plan" shall be prepared by the cooperative participation of involved staff of the two Departments.

The plan shall be developed in such a manner and shall provide for all such audit activities as will assure that the responsibilities of both Departments will be adequately fulfilled. Specifically, the plan will give full consideration to the respective responsibilities:

- of the Commissioner of Health, in the establishment of reimbursement rates, the inclusion of ambulatory care deficits under Section 2807.4 of the Public Health Law, and the provision of health services at reasonable cost to the citizens of the State; and
- of the Commissioner of Social Services, to assure the proper and efficient administration of the Medical Assistance to Needy Persons Program in the State as provided under Title 11 of the New York State Social Services Law and, particularly, to assure that payments for hospital services provided under that Program were made in accordance with and reimbursement properly claimed under the provisions of Federal and State Statutes and Regulations concerning billing, payment and reimbursement.

Section III - IMPLEMENTATION

This joint audit effort shall be started during the month of October, 1976 with the audit of two hospitals in the New York City area, one to begin in October and the second to begin after completion of the first.

The hospitals selected for these initial audits will be of the following natures:

(A) One hospital which has not been audited by Blue Cross.

(B) One hospital which is/or has been audited by Blue Cross.

It is anticipated that the audit designated as "A" above will require a staff of auditors and supervisor for approximately 300 total staff days, while "B" above will require a staff of auditors for approximately 500 total staff days. The audit teams will consist of equal numbers of staff from each of the Departments. Supervision of the joint audit team will be provided through the assignment of supervisors by each of the departments to supervise the activities of their respective staffs. Day-to-Day, on-site coordination of audit actions will be accomplished through continual liaison and consultation between the lead supervisors from each department. It is also agreed that overall coordinative and directional responsibility for the planning and execution of the joint audits provided for in this memorandum shall be mutually agreeable to the designees of the Commissioner of Health and the Commissioner of Social Services.

Section IV - USE OF AUDIT FINDINGS

Combined audit reports will be prepared through the cooperative participation of staff of the two departments. These reports will be the instrument for conveying the audit findings to the respective parties to this agreement. This agreement, however, shall not preclude either Department to issue supplementary reports as in their discretion are necessary to fulfill their individual responsibilities.

Section V - DURATION OF PROVISIONAL UNDERSTANDING

This agreement shall remain in effect through the completion of the audits selected as outlined in Section III of this agreement. The results of this joint audit will be reviewed periodically while the audits are in progress and again at the time they are completed. The parties may at any time supplant this agreement with a permanent agreement.

Section VI - REPRESENTATIVES

The Commissioner of Health designates Frederick J. Parker, Director of the Bureau of Audit and Investigation, and the Commissioner of Social Services designates James A. Durkin, Director of the Office of Audit and Quality Control to act on their respective behalfs to implement this agreement and its provisions.

Section VII - EFFECTIVE DATE

This agreement shall be effective immediately upon approval by the Director of the Division of the Budget.

Approved _____ Date 11/10/76
Commissioner of Health

Approved _____ Date 11/23/76
Commissioner of Social Services

Approved _____ Date _____
Director of Division of Budget

EXHIBIT IV

STATE OF NEW YORK

DEPARTMENT OF HEALTH

DEPARTMENT OF LAW

OFFICE OF DEPUTY ATTORNEY GENERAL

PROSECUTOR FOR HEALTH AND SOCIAL SERVICES

MEMORANDUM OF UNDERSTANDING

SECTION I: Signatories and Purposes

This memorandum of understanding is entered into between the Commissioner of Health and the Deputy Attorney General acting as Special Prosecutor for Health and Social Services, pursuant to the provisions of Chapter 118 of the Laws of 1976, amending Chapter 50 of the Laws of Nineteen Hundred and Seventy Six. Its purpose is to set forth the mutual responsibilities of the signatories for common staff and a common audit effort and audit plan.

The audit of nursing homes and their financial records by the Commissioner is in discharge of his duties under Article 28 of the Public Health Law, including those specified in Section 2803 of that Article, and is carried out for the purposes set out therein. The audit of nursing homes and their financial records by the Deputy Attorney General is in discharge of his duty to investigate fraud in the use of public funds by the nursing home industry, pursuant to the direction of Attorney General Louis Lefkowitz in his appointment letters to Charles J. Hynes, Deputy Attorney General, dated January 10, 1975 and February 10, 1975, under the authority of subdivisions three and eight of Section 63 of the Executive Law, respectively.

Nothing in this memorandum of understanding is intended to relieve either party of the duty to make whatever effort is necessary to fully carry out their respective responsibilities.

SECTION II: Independence of the Deputy Attorney General

Both parties acknowledge that the funds appropriated by the above statute are solely for the use of the Deputy Attorney General in his investigation of the nursing home industry and are appropriated to him through the Department of Health, to be administered by him in accordance with the provisions of subdivisions three and eight of Section 63 of the Executive Law under whose authority he is acting.

The Commissioner further acknowledges that the appointment of a Deputy Attorney General as a Special Prosecutor was for the express purpose of providing a completely independent investigation of the nursing home industry and nothing contained in this agreement is meant to in any way impinge on the Deputy Attorney General's independence in conducting the investigation.

SECTION III: Common Audit Plan and Common Training

The Commissioner and the Deputy Attorney General shall coordinate their audits of nursing homes in a common audit effort. They shall provide for coordinated scheduling of all audits and whatever other measures are necessary.

Both parties acknowledge the importance of proceeding as expeditiously as possible to obtain recovery by the State of Medicaid overpayments. Both parties also acknowledge the importance of utilizing to the fullest extent possible the forensic audit capabilities of the Deputy Attorney General's audit staff. The parties shall therefore provide for the participation of the Deputy Attorney General's auditors in the exit conferences and other Health Department administrative proceedings for which their findings are the basis; for the management of such proceedings in the most expeditious manner possible; and, for the management of the audit work of the parties in a manner that minimizes the use of the audit staff of the Deputy Attorney General in situations that do not present the significant possibility of fraudulent practices.

Nothing in the preceding paragraph is meant to place any requirement on the Deputy Attorney General to make available his auditors for the Health Department's administrative proceedings when, in the Deputy Attorney General's opinion, such action would be inconsistent with their participation in a criminal prosecution based on the same findings.

In the coming year, the Commissioner shall first audit the fiscal 1975 financial records of proprietary nursing homes audited by the Deputy Attorney General, and of voluntary and public nursing homes.

Both parties, to the extent practicable, shall audit simultaneously all nursing homes linked together by common ownership interests, or linked in common ownership interest to hospitals or health related facilities.

The Commissioner shall, as soon as his auditors identify potential criminal fraud in a nursing home or health facility they are auditing, immediately consult with the Deputy Attorney General on the future scope and management of the audit.

The Deputy Attorney General shall furnish to the Commissioner in a timely manner, subject to the applicable restrictions on the use of subpoenaed material, all information developed by his investigation bearing on the Commissioner's discharge of his duties in administering the Medicaid reimbursement system.

The Commissioner shall include in the program and practices of his audit staff procedures developed by the Deputy Attorney General for identifying fraudulent practices and claims.

The Deputy Attorney General shall report his audit findings in formats suitable for the use of the Commissioner in his administrative proceedings.

The Commissioner shall provide training in reimbursement auditing procedures and methods to the audit staff of the Deputy Attorney General.

The Deputy Attorney General shall provide training to the audit staff of the Commissioner in forensic auditing and the detection of fraud.

If the Deputy Attorney General completes an audit of the financial records of fiscal year 1975 or 1976 of a nursing home or other residential health facility, such an audit may, in the interests of avoiding duplication, be used by the Department of Health for the purpose of discharging its financial audit obligation under Section 2803 of the Public Health Law.

In accordance with the laws governing the investigations of the Deputy Attorney General, the records for audits conducted by the Deputy Attorney General shall be obtained by subpoena or consent only.

SECTION IV: Use of the Deputy Attorney General's Findings

Both parties acknowledge that nothing in this agreement is to be read as in any way altering the constitutional and statutory rights of any party subject to audit and/or investigation by either the Commissioner or the Deputy Attorney General.

Both parties acknowledge and recognize that the Deputy Attorney General obtains the financial records and other materials for use in his investigations by consent of the party or through the use of subpoena powers. There are legal restrictions on the use of information so obtained. The Deputy Attorney General shall be solely responsible for determining what uses, if any, of his audit and other findings are legally consistent with these restrictions. Both parties acknowledge and recognize that these restrictions, particularly those on the use of material obtained by Grand Jury subpoena, may require separate audits by each party of the same facility in order to discharge their respective legal obligations.

SECTION V: Representatives

The Commissioner designates the Assistant Commissioner for Health Care Cost Control as his representative to the Deputy Attorney General and authorizes him to act on his behalf to implement this agreement and its provisions, and to carry out the mandate of the above statute.

The Deputy Attorney General designates his Chief of Auditing as his representative to the Commissioner and authorizes him to act on his behalf to implement this agreement and its provisions, and to carry out the mandate of the above statute.

SECTION VI: Effective Date

This agreement shall be effective immediately upon approval by the Director of the Division of the Budget. This agreement shall remain in force until April 1, 1977.

Nothing contained above shall restrict the parties from taking such other common action as will from time to time appear to be desirable.

Dated:

Commissioner of Health

Deputy Attorney General
Prosecutor for Health and Social Services

APPROVED:

Director, Division of the Budget

EXHIBIT V

FRAUD and/or ABUSE PRACTICES

General (Encountered in all provider and vendor groups)

Billing Conditions

Billing for:

- The full amount allowed under Medicaid when Medicare has also paid.
- 100% of secondary procedure done at the same time as a primary procedure.
- Dead patients.
- Non-existent patients.
- Ineligible patients.
- All members of a family when only one was seen.
- Duplicate billing.
- First visit fee for subsequent visits.
- Speciality codes for non-speciality treatments.
- Non-work days
- Goods and services in addition to those that were provided.

Unacceptable Practice Conditions

Providing:

- Poor or questionable services
- Too many services to a patient based on his or her sex, age or condition.
- Unnecessary treatment of additional family members (family ganging)
- Unnecessary goods or services (e.g. recalling clients for unnecessary visits)

Conspiracy Conditions

- Unnecessary referrals of clients to other practitioners (ping-ponging).
- Providers and vendors exchanging Medicaid ID #'s for clients seen.
- Kick-back schemes.

Administrative Infractions

Maintaining poor or no record to support goods and services provided.

Fraud and Abuse Practices Peculiar to Particular Provider or Vendor Groups.

Physicians

1. Ordering unnecessary lab work and/or referring all work to a particular lab for a kick-back.
2. Steering all patients to a particular pharmacy for a kick-back.
3. Gang visiting in SNF's, HRF's, PPHA's and Welfare hotels.
4. Allowing I.D. # to be used by a medical facility (e.g. clinics and Hospitals) for billing purposes in order to duplicate bill for services.

Medical Facilities With More Than One Provider Number (e.g. hospitals or SNF-HRF)

1. Billing for the same case number for the same date of service for each provider number.

Clinics

a) Duplicates between institutions for same patient and same day of service.

b) Charges for successive (one after another) days services for any patient within same clinic or different clinics.

c) Continually recalling the same patients for additional visits.

In-patient Services (Hospitals)

a) Based upon available beds, excess of billed patients to bed available.

b) Duplicate and triplicate billing for physician and other services supplied by the hospital. This is done by billing for session payments (physician services only) and by using the physician's or other provider's ID # to send in a separate bill for that service.

c) Using MA patient's ID # to resupply hospital pharmacy.

Out-patient Hospital Emergency Room

a) Successive visits by one client or members of family at same hospital emergency room (using the ER for routine medical care).

Laboratories

a) Billing for individual tests when all encompassing panel test was performed.

b) Billing to both panel test and individual tests which are encompassed in panel test.

c) Billing for tests not immediately preceded by physician, clinic, emergency room, or other medical vendors charge.

d) Billing for more tests than the lab could possible perform.

Dental

a) More than 3 visits by any family member in any one given year for general (non-extractions, orthodontist or similar type work) work procedures.

Eye Care Services

a) Billing for two or more pairs of glasses for same patient in same year.

Pharmacies

a) Duplicates without including authorized refills.

b) High billings for certain restrictive drugs to be given to you by MA Division.

c) Billings for nursing home patients for items normally covered under nursing home rate (information to be furnished by MA Division).

d) Billing for contradictive drugs.

Transportation

a) Billings for services when no other medical services billed (doctor, clinic, etc).

b) Multiple vendor bills for same client on same day.

Prosthetic Appliances

a) Charge for more than one prosthesis for same client.

Methadone Maintenance

a) Keeping clients enrolled in program when not needed.

b) Not reducing a client's daily visits by allowing take home doses.

c) Failing to check if clients are enrolled at another clinic.

d) Not providing general medical care to clients.

Podiatrist

1. Dealing in kick-back schemes with shoe stores where the podiatrist is paid a percentage of all sales made to MA clients he refers to the store.

2. Billing for ganging routine foot care, such as nail clipping for all patients in a nursing home.

Client Abuses

1. Enrolling in multiple methadone programs.

2. Going from physician to physician seeking unnecessary medical care.

3. Using MA card to purchase unnecessary goods and services.

4. Collecting from insurance companies for claims paid by Medicaid.

5. Loaning MA card to non-family members.

6. Selling MA cards.

END