



April 3, 2026

Mehmet Oz, MD, MBA
Administrator, Centers for Medicare & Medicaid Services

Dear Honorable Mehmet Oz, M.D., MBA:

We are in receipt of your March 3, 2026, letter containing the Centers for Medicare & Medicaid Services' ("CMS's") extensive request for information regarding New York's ("the State's") Medicaid program integrity. As demonstrated by the State's detailed responses herein, New York has been steadfast in its commitment to safeguarding the Medicaid program while ensuring that eligible individuals have meaningful access to necessary and high-quality health and medical services. Historically, CMS has been the State's partner in those efforts.

In recent years, the State has continued to strengthen eligibility and coverage for its most vulnerable populations, expand access to behavioral health services, and emphasize fiscal discipline and long-term sustainability in administering the Medicaid program. The State's commitment to access is matched by rigorous stewardship of public funds, as reflected in its program integrity structure and outcomes. New York takes seriously its responsibility to ensure Medicaid program integrity and to combat fraud, waste, and abuse ("FWA"). The stakes are high, as New York's Medicaid program serves more than 6.7 million residents—including over 2 million children—and the State recognizes the importance of strong enforcement tools to protect against FWA when delivering comprehensive coverage to such a large and varied population. The State is proud of its track record detecting, preventing, and recovering fraudulent and improper Medicaid payments.

The State is continuing to evaluate and consider the suggestions included in the document that CMS recently provided, *Home and Community-Based Services (HCBS) in Medicaid: Fraud Waste and Abuse (FWA) Best Practices*. As demonstrated in this response, the State continues to work hard to eliminate FWA from HCBS, including through the use of Electronic Visit Verification ("EVV"). As discussed fully in the response to Request 31, *infra*, EVV is now required for all services requiring in-home visits by providers (Personal Care Services ("PCS"), Home Health Care Services ("HHCS"), and HCBS, which includes the Children's Waiver, Nursing Home Transition and Diversion ("NHTD"), Traumatic Brain Injury ("TBI"), and Office for People With Developmental Disabilities ("OPWDD"). Furthermore, both the New York State Department of Health ("DOH") and Office of the Medicaid Inspector General ("OMIG") use EVV data to identify discrepancies as possible instances of FWA. The State has also made enhancements to its provider enrollment procedures to cut down on FWA, discussed in more detail in the responses to Requests 14–21, *infra*.



Nevertheless, your letter mischaracterizes in significant respects the State’s efforts to eliminate FWA, relying, in many instances, on misleading information. For example, your letter vastly overstates the expansion of New York’s utilization of PCS, claiming inaccurately that nearly 75% of Medicaid beneficiaries received PCS in 2025, when in truth only about 6% received PCS.¹ Overall, your letter conflates growth in the Medicaid program with fraud. That fundamental mischaracterization distorts CMS’s assessment and obscures the core point: New York’s Medicaid program advances longstanding federal objectives while maintaining rigorous, results-driven controls to identify, investigate, and prevent FWA.

The State utilizes multiple, complementary methods and leverages multiple technologies to meet federal standards and combat FWA, starting with the systemic framework of the Medicaid program. For example, the Consumer Directed Personal Assistance Program (“CDPAP”) allows eligible Medicaid recipients to choose and hire their own personal caregiver. To mitigate potential FWA within CDPAP, the State substantially reformed the program, which used to rely on over 600 fiscal intermediaries, making New York a far outlier among the states, and resulted in creating heightened risk for FWA. Instead, the State selected a single Statewide Fiscal Intermediary (“SFI”), Public Partnerships LLC (“PPL”), for the entire program in 2025. Moving to an SFI enhances DOH’s ability to monitor compliance and detect potential fraud.

As described further below, multiple State agencies partner to combat FWA in Medicaid through a robust compliance program involving numerous controls, policies, and practices. These layered safeguards—front-end screening, ongoing monitoring, and coordinated enforcement—have produced substantial, documented results. Over the past five years, New York State Medicaid has realized more than \$15 billion in cost savings and recoveries. The program’s success is unassailable: CMS’s most recent measurement found New York’s Medicaid improper payment rate—although itself not necessarily a measure of fraud or abuse—at 1.43%; this is well below the national estimated federal Medicaid improper payment rate of 5.09%.² In short, the State’s approach deters, detects, and remedies FWA while maintaining and increasing access to necessary services.

New York’s Coordinated, Multi-Agency Oversight Protects Medicaid Funds and Ensures Accountability

The three key agencies for combating FWA in the State’s Medicaid program are DOH, OMIG, and the Medicaid Fraud Control Unit (“MFCU”) of the New York Attorney General’s Office—the largest unit within that office. The State’s Medicaid program is administered by DOH. OMIG is an independent oversight agency that promotes program integrity, thereby ensuring that

¹ This measure of PCS includes Consumer Directed Personal Assistance Program (“CDPAP”).

² OMIG, 2024 *Annual Report* at 11.



necessary resources are preserved to sustain critical health services.³ OMIG is responsible for the detection, investigation, and prevention of FWA within the Medicaid program. To fulfill this mission, OMIG executes audits, conducts investigations, and imposes administrative enforcement to prevent and detect FWA, recover overpayments, and ensure provider compliance.⁴ MFCU is responsible for investigating and prosecuting alleged violations of state law related to fraud connected to the Medicaid program. When warranted, MFCU may also make statutory or programmatic recommendations to DOH and OMIG related to Medicaid program integrity.

The partnership between these three agencies is effective. Between 2021 and 2024, OMIG finalized over 3,600 audits and completed over 9,100 investigations.⁵ These efforts resulted in over \$15 billion in cost savings and recoveries during that same period, with recovery figures increasing each year by at least \$200 million.⁶ In 2024 alone, OMIG completed 2,530 audits and investigations, generating more than \$4.5 billion in cost savings and recoveries for taxpayers.⁷

OMIG works closely with other state and federal agencies, law enforcement, third-party contractors, Managed Care Organizations (“MCOs”), and MFCU to expand the reach of New York’s FWA prevention and detection efforts.⁸ In fact, based on data from the Department of Health and Human Services Office of Inspector General (“HHS-OIG”), New York has one of the largest MFCUs in the United States in terms of both staffing levels and total recoveries.⁹ The partnerships between DOH, OMIG, and MFCU root out FWA across the Medicaid program, protecting beneficiaries and safeguarding taxpayer dollars.

New York’s Layered Controls Prevent, Detect, and Remedy FWA Across the Program

New York’s comprehensive Medicaid compliance program is replete with internal controls, which begin at the provider enrollment phase and continue throughout the duration of a provider’s partnership with the State.¹⁰ DOH, in close coordination with OMIG, implements this compliance program focused on prevention, monitoring, and, when necessary, enforcement.

³ OMIG, 2024 Annual Report at 5–7.

⁴ *Id.*

⁵ OMIG, 2021 Annual Report at 9; OMIG, 2022 Annual Report at 9, OMIG, 2023 Annual Report at 11; OMIG, 2024 Annual Report at 29, 40.

⁶ OMIG, 2021 Annual Report at 9; OMIG, 2022 Annual Report at 9, OMIG, 2023 Annual Report at 11; OMIG, 2024 Annual Report at 4.

⁷ OMIG, 2024 Annual Report at 4.

⁸ OMIG, 2024 Annual Report at 5–7, 42–49, 67.

⁹ HHS-OIG, *Medicaid Fraud Control Units Annual Report: Fiscal Year 2025*, 6 (Mar. 2026), <https://oig.hhs.gov/documents/evaluation/11553/OEI-09-26-00140.pdf>.

¹⁰ See 18 N.Y.C.R.R. §§ 504, 515, 517–519.



Prevention: rigorous eligibility and enrollment screening stops improper claims before they start.

New York implements numerous controls to prevent FWA by verifying that applicants for benefits and applicants for provider enrollment meet eligibility criteria. These initiatives continue throughout the applicant’s interactions with the Medicaid program, including through revalidation and verifications to confirm continued enrollment.

DOH conducts intensive enrollment screening—through written requests, background review, and verification of qualifications—to prevent FWA before it starts.¹¹ These screenings enforce the comprehensive regulations and requirements to prevent systemic vulnerabilities, particularly in high-risk service areas, from taking hold. For example, DOH has tightened eligibility requirements for PCS to ensure funds go to enrollees with verified high-needs.¹² Additionally, to ensure they exhibit the competencies required to perform services in the Medicaid program, individuals who serve as Personal Care Aides (“PCAs”) or Personal Assistants (“PAs”) must undergo required screening and training provided by a combination of DOH, Licensed Home Care Services Agencies (“LHCSA”), and the Medicaid enrollees themselves, depending on the particular program, before care begins.¹³

Data sharing and cross-agency screening further strengthen enrollment review to ensure efficient signal sharing between agencies and external partners. Collaboration between DOH and OMIG enabled OMIG to initiate 757 provider enrollment application reviews in 2024.¹⁴ DOH also collaborates on enrollment with its transportation broker, Medical Answering Services (“MAS”), from which new transportation providers are required to receive a letter of support prior to enrollment. This collaboration has led to a significant decrease in new enrollment applications from transportation providers, cutting out FWA at the top of the funnel.¹⁵

¹¹ See EMedNY, *Information for All Providers General Policy*, 16 (Dec. 30, 2022), https://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information_for_All_Providers-General_Policy.pdf.

¹² 18 N.Y.C.R.R. §§ 505.14(a)(3)(iv), 505.28(b)(15).

¹³ DOH, *Guide to Operating a Personal Care Aide Training Program*, 2 (May 2022) https://www.health.ny.gov/professionals/home_care/guide_to_operate_pcatp/docs/guide.pdf; 18 N.Y.C.R.R. § 505.28(h)(1)(i).

¹⁴ See OMIG, *2024 Annual Report* at 55.

¹⁵ *Id.*



Monitoring: enforceable MCO contract duties, mandatory reporting and referrals, and technology-enabled audits identify outliers and drive recoveries.

Once providers are enrolled, the State utilizes a multilayered approach to monitor and identify FWA across the program. Through numerous frameworks and initiatives, New York is able to efficiently and effectively monitor MCOs, providers, and enrollees.

DOH continues to prevent FWA after enrollment by initiating discretionary revalidation requests, when concerns arise regarding accuracy of enrollment files or program integrity.¹⁶ Enrollees also undergo an annual process to confirm ongoing eligibility.¹⁷ Additionally, to ensure continued compliance with Medicaid program requirements, OMIG employs clinical reviews and Credential Verification Reviews (“CVR”) that verify provider compliance and training.¹⁸

New York’s Medicaid program integrity framework is anchored in clear, enforceable contractual obligations that require MCOs to partner with the State in preventing, detecting, and reporting FWA.¹⁹ Those obligations are enforced by streamlined self-disclosure mechanisms administered by OMIG, which enable MCOs and providers to promptly disclose overpayments and support timely remediation.²⁰ These mechanisms have generated thousands of MCO referrals, expanding the State’s enforcement reach and reinforcing accountability across core stakeholders.²¹

The strength of this collaboration continues to grow every year as New York develops new enforcement processes and ways to interface with MCOs. In 2025, OMIG received 1,936 referrals from MCOs, an increase of nearly 500 referrals compared to 2021.²² DOH and OMIG also assume a hands-on role in ensuring MCOs are addressing FWA in the State’s Medicaid program. DOH submits Managed Care Program Annual Reports (“MCPAR”) to CMS pursuant to 42 C.F.R. § 438.66(e), and OMIG conducts “Program Integrity Reviews” pursuant to New

¹⁶ eMedNY, Revalidation, <https://www.emedny.org/info/ProviderEnrollment/revalidation/index.aspx>.

¹⁷ DOH, *Managed Long Term Care (MLTC) Policy 22-01: New York Independent Assessor for Personal Care Services (PCS) and Consumer Directed Personal Assistance Services (CDPAS)* (Apr. 27, 2022), https://www.health.state.ny.us/health_care/medicaid/redesign/mrt90/mltc_policy/docs/2022-04-27_mltc_22-01.pdf.

¹⁸ OMIG, *2024 Annual Report* at 44–45.

¹⁹ See DOH, *Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract*, §§ 18, 23 (Mar. 1, 2024), https://www.health.ny.gov/health_care/managed_care/providers/docs/mmc_fhp_hiv-snp_harp_model_contract.pdf.

²⁰ OMIG, *Self-Disclosure*, <https://omig.ny.gov/provider-resources/self-disclosure>.

²¹ See response to Request 3, *infra*.

²² See response to Request 3, *infra*.



York Social Services Law § 364-j (36) and 18 N.Y.C.R.R. § 517, to ensure MCOs are compliant with program integrity requirements.²³

Moreover, OMIG works closely with third-party contractors to identify the most at-risk areas with respect to FWA and initiate audits and recovery projects accordingly. These efforts have generated billions of dollars in cost savings and avoidances and show the depth of the State's commitment to preventing, detecting, and extinguishing FWA.²⁴ For example, work by OMIG's contractors from 2021 through 2025 resulted in nearly \$2 billion in recoveries alone.²⁵ OMIG engages contractors to detect and collect overpayments, report suspected fraud, and then implement actions that will prevent future improper payments. Overall, OMIG's work with its contractors helps to increase recoveries and cost savings.²⁶

Further, OMIG and DOH monitor for FWA directly. OMIG conducts regular reviews of providers' compliance programs to ensure adherence to regulatory and contractual requirements, with meaningful consequences including financial penalties and termination of enrollment for providers that fail to meet those standards.²⁷ In parallel, OMIG conducts ongoing compliance program reviews to assess the effectiveness of program integrity initiatives across the managed care landscape.²⁸ The State's sustained investment in oversight—OMIG's annual budget alone has totaled more than 50 million dollars since 2021—is complemented by comprehensive guidance and training for both staff and providers, reflecting New York's enduring commitment to equipping all participants with the tools to administer a high-integrity Medicaid program.²⁹

As part of this monitoring, DOH and OMIG continue to expand and modernize their enforcement toolkit, leveraging advanced data analytics and technology-driven insights to focus resources where risk is greatest.³⁰ This includes recent development of sophisticated data extraction and artificial intelligence tools that allow the State to use data patterns to identify FWA risks.³¹ DOH uses data monitoring of provider utilization to identify providers for further investigation and referral to OMIG for audit and enforcement. OMIG also uses advanced data analytics techniques to identify outlier providers, prevent improper use of Medicaid funds, and

²³ See response to Request 7, *infra*.

²⁴ OMIG, *2021 Annual Report* at 19–20; OMIG, *2022 Annual Report* at 17–19; OMIG, *2023 Annual Report* at 28–31; OMIG, *2024 Annual Report* at 59–61; see also responses to Requests 1, 5, *infra*.

²⁵ See response to Request 5, *infra*.

²⁶ See response to Request 1, *infra*.

²⁷ OMIG, *Compliance*, <https://omig.ny.gov/compliance/compliance>; OMIG, *Compliance Program Guidance* (Jan. 2023), <https://omig.ny.gov/media/80796>.

²⁸ See OMIG, *Compliance Program Guidance*, 6–7 (Jan. 2023), <https://omig.ny.gov/media/80796/download?attachment>.

²⁹ See OMIG, *Provider Resources*, <https://omig.ny.gov/information-resources/provider-resources>.

³⁰ See OMIG, *2024 Annual Report* at 27.

³¹ See response to Request 25, *infra*.



recover any improperly paid funds.³² After providers are identified for further investigation and enforcement, DOH and OMIG employ corrective measures—including sanctions, fines, licensing consequences, overpayment recovery, and referrals to MFCU for potential criminal investigation.³³

Enforcement: swift administrative action and coordinated referrals ensure consequences for wrongdoing.

New York’s legal and regulatory controls enable decisive action against noncompliant providers, including suspension or termination where warranted. DOH may terminate providers for, among other reasons, inaccurate enrollment information, or failure to report changes in ownership or control. OMIG investigates providers and takes action against providers who engage in unlawful or unacceptable practices—such as false claims or care furnished in excess of patients’ needs.³⁴ DOH and OMIG also have other enforcement tools at their disposal, to ensure that appropriate action is taken against providers who fail to comply with Medicaid program requirements. OMIG’s partnership with MFCU is a central enforcement channel: OMIG makes hundreds of referrals each year when credible allegations arise or utilization reviews reveal aberrant patterns, ensuring that suspected fraud is promptly investigated and, where appropriate, prosecuted.³⁵ MFCU’s prosecutions have recovered millions of dollars from fraudsters and reinforced deterrence across the program.³⁶

Cross-agency collaboration and data sharing help track and ensure timely enforcement against non-compliant providers. For example, OMIG participates in the Healthcare Fraud Prevention Partnership (“HFPP”), a CMS initiative to share current research and data which, in turn, helps the State refer findings for audit or investigation.³⁷ In addition, OMIG’s “Data Request Form” is used as a standardized tool that facilitates data sharing among the agency’s various departments for ad hoc data requests for research purposes.³⁸ New York also maintains lists of enrolled and excluded providers on the public DOH and OMIG websites, proactively screens for affiliate relationships among providers, and requires provider disclosure of these relationships according

³² OMIG, 2024 Annual Report at 27.

³³ See response to Request 36, *infra*, for details on the State’s correctional actions.

³⁴ See 18 N.Y.C.R.R. § 504.7.

³⁵ OMIG, 2021 Annual Report at 5–6, 32; OMIG, 2022 Annual Report at 5–6, 36; OMIG, 2023 Annual Report at 49–50; OMIG, 2024 Annual Report at 7, 43, 48.

³⁶ MFCU, Attorney General James Secures More Than \$13 Million in Sweeping Takedown of Transportation Companies for Defrauding Medicaid, <https://ag.ny.gov/press-release/2025/attorney-general-james-secures-more-13-million-sweeping-takedown-transportation>.

³⁷ See response to Request 6, *infra*.

³⁸ See response to Request 25, *infra*.



to pre-defined criteria.³⁹ Moreover, the State utilizes comprehensive data monitoring tools that leverage existing data, such as EVV submissions, to combat FWA in some of the services most vulnerable to it.⁴⁰

* * *

DOH and OMIG, on behalf of the State, respectfully submit the following responses to CMS's specific requests. *See* Appendix – Responses to CMS's Requests. Together, these responses demonstrate the scope, rigor, and effectiveness of New York's Medicaid program integrity framework and the State's sustained commitment to preventing, detecting, and addressing FWA. They also reflect the depth of coordination among state agencies and the strength of New York's ongoing partnership with the federal government in safeguarding program integrity. Finally, the responses underscore the State's data-driven, multi-layered approach to oversight and continuous improvement across all facets of the Medicaid program.

In addition to these responses, New York is providing documentary materials requested in requests 10-14 and 31. These materials and the Responses to CMS's Requests contain proprietary information from New York and have been redacted to exclude personal identifiable information. The initial production of these documents is enclosed herein and the remaining materials will be provided next week. New York requests that the materials receive confidential treatment pursuant to the Freedom of Information Act, 5 U.S.C. § 552, and applicable regulations, including 42 C.F.R. § 401. Further, New York requests that CMS provide timely notice before permitting disclosure of the data or information enclosed or any part or copies thereof.

Best regards,

Amir Bassiri

New York State Medicaid Director

Frank Walsh

Acting Medicaid Inspector General

³⁹ See EMedNY, *Information for All Providers General Policy* at 26, https://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information_for_All_Providers-General_Policy.pdf; 18 N.Y.C.R.R. § 502.4.

⁴⁰ See DOH responses to Requests 25, 31, 33, *infra*.

Appendix – Responses to CMS’s Requests

Fraud, Waste, Abuse and Improper Payments — Program Level Oversight

1. How many full-time equivalent staff are employed by DOH whose primary job duty is related to fraud, waste, and abuse? Beyond full time staff, what contractors has DOH procured to address fraud, waste, and abuse? Please describe the scope of work, timeframe, total dollars for these contracts, and outcomes or results from these contracts.

OMIG serves as a central enforcement authority for New York’s Medicaid program integrity efforts. OMIG—whose primary responsibilities include prevention, identification, and remediation of FWA in the Medicaid program—completes thousands of audits and investigations every year leading to billions in annual cost savings and recoveries for New York.⁴¹ New York is one of only three states to have created an Office of Medicaid Inspector General dedicated solely to identification, prevention, and remediation of FWA in the Medicaid program. OMIG’s statewide, multidisciplinary workforce consists of more than 480 staff as of March 2026—including auditors, investigators, nurses, pharmacists, data analysts, compliance specialists, program administrators, and legal and technical staff—and reflects the State’s substantial and sustained efforts in robust oversight to protect against FWA.⁴² These staff are assigned to six divisions or departments, with the Audit and Investigations Divisions having the largest headcount devoted to combatting FWA.

Although OMIG bears primary responsibility for program integrity efforts, it closely partners with DOH’s Office of Health Insurance Programs including the Division of Health Plan Contracting and Oversight, Division of Finance and Rate Setting, Division of Program Development and Management, and the Division of Data Services and Analytics focused on program integrity initiatives, as well as MFCU, who prosecute instances of criminal fraud within the New York Medicaid Program. Together, these entities coordinate and execute sophisticated initiatives to root out FWA in New York’s Medicaid program.

In addition, OMIG strategically engages contractors who leverage FWA detection, prevention, and recovery capabilities. Partnerships with third-party contractors augment OMIG’s broader oversight framework. The following three contractors have provided services and additional resources to OMIG in furtherance of its FWA efforts: Health Management Systems (“HMS”), Performant Recovery, Inc. d/b/a Performant Healthcare Solutions (“Performant”), and the University of Massachusetts Chan Medical School (“UMass”).⁴³

⁴¹ OMIG, 2024 Annual Report at 4; OMIG, 2023 Annual Report at 4; OMIG, 2022 Annual Report at 3; OMIG, 2021 Annual Report at 3.

⁴² OMIG, 2024 Annual Report at 9.

⁴³ OMIG, 2024 Annual Report at 28, 58–61.

Third-party liability contractor HMS identifies third-party insurance coverage and redirects improperly billed claims away from Medicaid and to responsible third-party payors.⁴⁴ This ensures Medicaid is the payor of last resort. HMS' current contract term is April 7, 2025 through April 6, 2028. OMIG measures HMS's services by comparing their performance against contractual requirements and established benchmarks, reviewing recoveries brought in for the State, reviewing provider feedback, and reviewing their quality of work. Results can be monitored by using monthly status reports, process documents, contractor evaluations, and having weekly/monthly meetings throughout the duration of the contract. Through these efforts, New York recovered more than \$909 million between 2021 and 2025 and avoided more than \$7.8 billion in inappropriate Medicaid payments through pre-payment verification services from 2021 to 2023 alone.⁴⁵ The total dollars for this contract from 2021 through January 2026 is \$173,094,184.24.

OMIG also fulfills federal obligations by working with a Recovery Audit Contractor ("RAC")⁴⁶ that uses sophisticated data mining techniques to identify improper payments and recover overpayments.⁴⁷ The RAC's mission is to coordinate efforts with the State to reduce improper payments through efficient detection and collection of overpayments, to report suspected fraudulent and/or criminal activities, and to implement actions that will prevent future improper payments.⁴⁸ Performant is OMIG's current RAC, with a contract term of January 30, 2025 through January 29, 2028. HMS was the former RAC from April 7, 2016 through April 6, 2025. The RAC's services are monitored and evaluated in the same manner as the third-party liability contractors. Program integrity efforts performed under the RAC contracts generated nearly \$998 million in recoveries between 2021 and 2025. The total dollars for this contract from 2021 through 2025 is \$86,399,153.

OMIG also contracts with UMass to perform a Medicare Home Health Appeals Initiative through the "Home Health Care Medicare Maximization" program.⁴⁹ Under this program, providers are directed to "demand bill" Medicare for HHCS rendered to dual eligible Medicare/Medicaid beneficiaries that have previously been paid by Medicaid.⁵⁰ UMass pursues coverage for Medicare payment denials via the federal Medicare appeals process.⁵¹ Provider audits are initiated in instances where providers fail to comply with demand billing requirements or fail to reimburse New York Medicaid as directed after Medicare has remitted payment.⁵²

⁴⁴ OMIG, *2021 Annual Report* at 19–20; OMIG, *2022 Annual Report* at 17; OMIG, *2023 Annual Report* at 28–29; OMIG, *2024 Annual Report* at 58–59.

⁴⁵ OMIG, *2021 Annual Report* at 19–20; OMIG, *2022 Annual Report* at 17; OMIG, *2023 Annual Report* at 28–29; OMIG, *2024 Annual Report* at 59.

⁴⁶ See 42 C.F.R. § 455.502.

⁴⁷ OMIG, *2021 Annual Report* at 20; OMIG, *2022 Annual Report* at 18; OMIG, *2023 Annual Report* at 31; OMIG, *2024 Annual Report* at 58.

⁴⁸ OMIG, *2024 Annual Report* at 58.

⁴⁹ OMIG, *2022 Annual Report* at 19; OMIG, *2023 Annual Report* at 46; OMIG, *2024 Annual Report* at 61.

⁵⁰ OMIG, *2024 Annual Report* at 61.

⁵¹ *Id.*

⁵² *Id.*

Outcomes and results are measured by reviewing the recoveries the contractor brings in for the State and are also guided by discussions with the contractor on specific projects. This contract term is from July 1, 2022 through June 30, 2027. The total dollars for this contract from 2021 through March 2026 is \$19,996,524. So far, between 2021 and 2025, this targeted initiative has generated nearly \$20 million in recoveries.

2. Does DOH establish targets for managed care plan fraud recoveries, and if so, on what basis are these targets determined and what targets has DOH established for plan recoveries?

Under 18 N.Y.C.R.R. § 521-2.4, every MCO is required to audit, investigate or review at least one percent (1%) of the aggregate Medicaid claims it pays to its providers and subcontractors, based on the total prior year's claims paid by the managed care plan.⁵³ Further, Special Investigation Units ("SIUs") for Managed Long Term Care ("MLTC") partial capitation plans are required to audit and investigate at least five percent (5%) of Medicaid claims each calendar year.⁵⁴

Otherwise, consistent with federal regulation, DOH does not rely on set recovery targets as a measure of program integrity effectiveness.⁵⁵ Instead, New York takes a rigorous, compliance-focused approach that prioritizes detection through robust controls, mandatory reporting, and corrective action. MCOs are required to promptly refer any potential FWA to OMIG and any potential fraud to MFCU.⁵⁶ DOH enforces this requirement through contractual obligations imposed in the Medicaid Model Contracts.⁵⁷ This approach is consistent with CMS guidance and underscores New York's close alignment with federal expectations by prioritizing detection, reporting, and corrective action over recovery targets.⁵⁸

Model Contract provisions mandate that MCOs maintain written policies and procedures consistent with applicable federal and state requirements, maintain a formal compliance program, designate responsible compliance leadership, train staff, conduct routine monitoring and auditing, and implement internal controls to prevent and detect FWA.⁵⁹

MCOs must also provide regular Program Integrity Reporting to DOH and OMIG and must maintain service verification processes using statistically valid sampling to confirm that billed

⁵³ 18 N.Y.C.R.R. § 521-2.4(c)(2).

⁵⁴ *Id.*; DOH, *Managed Long Term Care Partial Capitation Contract*, 54, https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/2023/docs/part_cap_model.pdf.

⁵⁵ See 42 C.F.R. § 438.608.

⁵⁶ See 42 C.F.R. § 438.608(a)(7).

⁵⁷ See DOH, *Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract*, § 18 (Mar. 1, 2024), https://www.health.ny.gov/health_care/managed_care/providers/docs/mmc_fhp_hiv-snp_harp_model_contract.pdf (hereinafter "*Medicaid Model Contract*").

⁵⁸ CMS, *Medicaid and CHIP Managed Care Program Integrity Toolkit*, <https://www.cms.gov/files/document/managed-care-compliance.pdf>, (last updated Nov. 1, 2023).

⁵⁹ See DOH, *Medicaid Model Contract* at §§ 18, 23.

services were actually delivered.⁶⁰ At the direction of either DOH or OMIG, MCOs must withhold payments when either entity has determined that a provider is the subject of a pending investigation of a credible allegation of fraud.⁶¹ To enforce compliance, New York both incentivizes and penalizes conduct: MCOs may share in up to ten percent of recovered FWA overpayments, while failures to report recoveries expose MCOs to liquidated damages.⁶²

New York regulations impose stringent requirements on MCOs with enrolled populations of at least 1,000 individuals.⁶³ Those MCOs must file a Fraud Prevention Program with OMIG and maintain a dedicated SIU responsible for detecting, investigating, and preventing FWA.⁶⁴ These SIUs are responsible for identifying and investigating FWA and reporting such matters to OMIG and MFCU.⁶⁵ The regulation is designed to ensure proactive and systematic FWA prevention and enforcement within the Medicaid managed care system. SIUs participate in quarterly meetings with OMIG to discuss investigations and identified areas for review.⁶⁶ OMIG also conducts periodic reviews of MCOs' compliance with program integrity sections of the Model Contract, which includes an assessment of adherence to contractual standards for preventing FWA.⁶⁷

3. Does DOH receive cases referred to the state by managed care plans, and, if so, how many cases were referred to the state by plans, by year, over the past 5 years? What were the resolutions of those cases?

MCOs must report confirmed or suspected FWA to OMIG within seven business days of identification. Upon receipt of a referral, a cross-departmental group of OMIG staff reviews the referral and, within thirty days, notifies the MCO of whether the case has been accepted by OMIG or the MCO can pursue enforcement activity itself. OMIG's data team extracts a predefined dataset from the MCO referrals to assist the multi-divisional OMIG triage group in their decision-making. Each analyst, upon receipt of an MCO referral, follows a routine process to complete the request.

Referrals are assessed individually. The assessment in part considers if the MCO was granted clearance by OMIG to audit/investigate (Contract Section 19.9). If OMIG grants clearance for the MCO to audit/investigate, the MCO is still required to report "potential fraud, waste, or abuse" (Contract Section 18.5) resulting from their audits/investigations. Not all reports allege fraud. The determination to accept the referral or return it to the MCO for action also considers

⁶⁰ See *id.* at §§ 18.5(a)(viii), 23.6.

⁶¹ See *id.* at § 23.7.

⁶² See *id.* at §§ 23.8, 23.9.

⁶³ See 18 N.Y.C.R.R. § 521-2.

⁶⁴ *Id.* at § 521-2.4.

⁶⁵ *Id.*

⁶⁶ OMIG, 2022 *Annual Report* at 34; OMIG, 2023 *Annual Report* at 51; OMIG, 2024 *Annual Report* at 7, 48.

⁶⁷ See OMIG, *Medicaid Managed Care Program Integrity Reviews*, <https://omig.ny.gov/audit/medicaid-managed-care-program-integrity-reviews>; N.Y. Soc. Serv. Law § 364-j(36).

the overall impact to the Medicaid program (e.g. conduct; amount of overpayment; participation in other plans), and any corrective action the MCO may have already taken or plans to take, and whether the allegation may warrant a sanction that only OMIG could impose.

Over the years, MCOs' FWA referrals to OMIG have produced meaningful outcomes. Since 2021, several thousand subjects were opened as a result of MCO referrals. A "subject" is an individual or entity relating to the referral. A single referral can lead to opening multiple subjects. This includes 1,420 subjects in 2021, 1,538 subjects in 2022, 1,466 subjects in 2023, 1,605 subjects in 2024, and 1,936 subjects in 2025. Resolutions of subjects referred by MCOs are illustrated below.

Resolutions of Subjects Referred by MCOs in 2021	
<i>Resolution</i>	<i>Number of Subjects</i>
Returned to plan for continued action	370
Closed on initial review	696
Referred to OMIG divisions, MFCU, or other agency	147
Education letter issued	4
Medicaid benefits closed	2
Still open or closed with no action	201

Resolutions of Subjects Referred by MCOs in 2022	
<i>Resolution</i>	<i>Number of Subjects</i>
Returned to plan for continued action	520
Closed on initial review	769
Referred to OMIG divisions, MFCU, or other agency	74
Education letter issued	4
Still open or closed with no action	171

Resolutions of Subjects Referred by MCOs in 2023	
<i>Resolution</i>	<i>Number of Subject</i>
Returned to plan for continued action	503
Closed on initial review	741

Resolutions of Subjects Referred by MCOs in 2023	
Referred to OMIG divisions, MFCU, or other agency	55
Education letter issued	9
Medicaid benefits closed	1
Notice of Proposed Agency Action issued	3
Notice of Agency Action Report issued	2
Still open or closed with no action	152

Resolutions of Subjects Referred by MCOs in 2024	
<i>Resolution</i>	<i>Number of Subjects</i>
Returned to plan for continued action	585
Closed on initial review	871
Referred to OMIG divisions, MFCU, or other agency	21
Education letter issued	3
Notice of Proposed Agency Action issued	1
Still open or closed with no action	124

Resolutions of Subjects Referred by MCOs in 2025	
<i>Resolution</i>	<i>Number of Subjects (Preliminary)</i>
Returned to plan for continued action	552
Closed on initial review	1,087
Referred to OMIG divisions, MFCU, or other agency	61
Still open or closed with no action	236

MCOs can also refer potential fraud directly to MFCU within ten business days of identification.⁶⁸ All referrals by MCOs to OMIG or MFCU must be reported to DOH, and any overpayments are returned to DOH.

⁶⁸ See DOH, *Medicaid Model Contract* at § 23.11.

4. Does DOH refer cases to the state’s Medicaid Fraud Control Unit (MFCU) and Office of the Medicaid Inspector General (OMIG), and if so, how many cases were referred to the MFCU and OMIG by the state, by year, for the past 5 years? What were the resolutions of those cases?

DOH refers cases to MFCU and OMIG as policy staff learn of credible allegations of FWA, or when reviews of utilization demonstrate unusual patterns.⁶⁹ The transportation policy unit also uses fraud referral trends to build new system requirements and policy parameters. DOH has made referrals across other areas such as PCS, CDPAP, Applied Behavior Analysis (“ABA”), and Children’s 1915(c) waiver services. Referrals are investigated by OMIG and may be further referred to MFCU.⁷⁰ MFCU is responsible for prosecuting those engaged in fraudulent Medicaid schemes, and it is a cornerstone of the State’s comprehensive strategy to detect, investigate, and deter FWA.⁷¹ Each year, OMIG refers hundreds of cases of suspected fraud to MFCU for a full investigation and possible prosecution pursuant to federal and state law, as outlined in a Memorandum of Understanding (“MOU”) between the entities.⁷² Information is communicated on a referral form, which was developed in light of CMS guidance. Referrals are made from OMIG to MFCU by designated liaisons.

Since 2021, OMIG has opened several hundred new subjects for investigation as a result of DOH referrals. This includes 207 referrals in 2021, 276 referrals in 2022, 141 referrals in 2023, 197 referrals in 2024, and 89 referrals in 2025. The resolutions of cases referred to OMIG by DOH are illustrated below.

Resolutions of Subjects Referred by DOH to OMIG in 2021	
<i>Resolution</i>	<i>Number of Subjects</i>
Referred to other OMIG divisions, including Audits or Investigations; MFCU; and/or other agencies	68
Educations letters issued	19
Notice of Proposed Agency Action issued	1
Notice of Agency Action Reports issued	1
Pre-payment reviews requested	101
Still open or closed with no action	17

⁶⁹ See response to Request 22, *infra*.

⁷⁰ OMIG, 2024 Annual Report at 53.

⁷¹ See MFCU, Medicaid Fraud Control Unit, <https://ag.ny.gov/about/about-office/criminal-justice-division>.

⁷² 42 C.F.R. §455.14; N.Y. Pub. Health Law § 32; OMIG, 2021 Annual Report at 31; OMIG, 2022 Annual Report at 31; OMIG, 2023 Annual Report at 47; OMIG, 2024 Annual Report at 4.

Resolutions of Subjects Referred by DOH to OMIG in 2022	
<i>Resolution</i>	<i>Number of Subjects</i>
Referred to other OMIG divisions, including Audits or Investigations; MFCU; and/or other agencies	37
Education letters issued	18
Pre-payment reviews requested	128
Still open or closed with no action	93

Resolutions of Subjects Referred by DOH to OMIG in 2023	
<i>Resolution</i>	<i>Number of Subjects</i>
Referred to other OMIG divisions, including Audits or Investigations; MFCU; and/or other agencies	46
Education letters issued	13
Pre-payment reviews requested	46
Still open or closed with no action	36

Resolutions of Subjects Referred by DOH to OMIG in 2024	
<i>Resolution</i>	<i>Number of Subjects</i>
Referred to other OMIG divisions, including Audits or Investigations; MFCU; and/or other agencies	28
Education letters issued	22
Pre-payment reviews requested	58
Still open or closed with no action	89

Resolutions of Subjects Referred by DOH to OMIG in 2025	
<i>Resolution</i>	<i>Number of Subjects</i>
Referred to other OMIG divisions, including Audits or Investigations; MFCU; and/or other agencies	14
Education letters issued	9
Pre-payment reviews requested	24

Resolutions of Subjects Referred by DOH to OMIG in 2025	
Still open or closed with no action	42

This coordinated enforcement illustrates the scope, rigor, and consistency of New York’s efforts to protect against FWA, which have proved a tremendous success. For example, earlier this year, MFCU secured a conviction and sentence against the owner of a transportation company who stole over \$1 million from New York’s Medicaid Program through fraudulent billing and kickback schemes.⁷³ In 2025, MFCU procured another victory against sixteen transportation companies who were engaged in fraudulent billing practices, recovering more than \$13 million.⁷⁴ And in 2024, MFCU successfully prosecuted the former owner of several New York pharmacies that stole over \$11.5 million through a Medicaid fraud scheme.⁷⁵ These examples are illustrative of MFCU’s efforts furthering the State’s FWA-prevention goals but are in no way exceptional. MFCU continues to demonstrate a sustained commitment to protecting the Medicaid program and ensuring that bad actors are identified, prosecuted, and removed.

OMIG maintains a Bureau of Self-Disclosure (“BSD”) to encourage providers to disclose overpayments.⁷⁶ The BSD specifically supports providers in fulfilling their obligations to investigate and report potential FWA through mechanisms of self-review, compliance programs, and internal controls.⁷⁷ BSD’s efforts are proving successful. In 2024 alone, OMIG processed 635 self-disclosures, a 32% increase from the previous year.⁷⁸ Further, from January 1, 2021 to present, BSD has received 49 self-disclosure submissions from providers who reported that they identified Medicaid overpayments based on guidance and advisement from DOH.

In that same timeframe, BSD made 394 referrals or requests for clearance to OMIG’s Division of Medicaid Investigations and/or MFCU. A request for clearance occurs where OMIG receives a self-disclosure from a provider for whom MFCU already has an open investigation. Thus, OMIG requests clearance to proceed with processing the self-disclosure so as not to interfere with MFCU’s ongoing investigation. BSD is not typically provided the outcome or resolution of those cases.

⁷³ N.Y. Att’y Gen., *Attorney General James Announces Conviction and Sentencing of Suffolk County Transportation Company Owner for Stealing Over \$1 Million from Medicaid*, (Jan. 14, 2026), <https://ag.ny.gov/press-release/2026/attorney-general-james-announces-conviction-and-sentencing-suffolk-county>.

⁷⁴ N.Y. Att’y Gen., *Attorney General James Secures More Than \$13 Million in Sweeping Takedown of Transportation Companies for Defrauding Medicaid*, (June 30, 2025), <https://ag.ny.gov/press-release/2025/attorney-general-james-secures-more-13-million-sweeping-takedown-transportation>.

⁷⁵ N.Y. Att’y Gen., *Attorney General James Announces Sentencing of Former Owner of Over 20 New York City Pharmacies for Running \$11 Million Medicaid Fraud Targeting Vulnerable HIV Patients*, (Nov. 20, 2024), <https://ag.ny.gov/press-release/2024/attorney-general-james-announces-sentencing-former-owner-over-20-new-york-city>.

⁷⁶ OMIG, *Self-Disclosure*, <https://omig.ny.gov/provider-resources/self-disclosure>.

⁷⁷ OMIG, *Self-Disclosure*, <https://omig.ny.gov/provider-resources/self-disclosure>.

⁷⁸ OMIG, *2024 Annual Report*, at 4.

5. What are the primary areas where FWA has been identified and expenditures recovered in the past 5 years? Please specify the amount of expenditures recovered in each area.

The primary areas where FWA has been identified in the past five years include Home Health Services, Managed Care, Behavioral Health, and Transportation.

OMIG has also made substantial recoveries outside of these areas. For example, since 2021, the top five categories of service or provider types with opened investigations are Pharmacy, Physician Services, Transportation, Vendor Personal Care Services, and CDPAP. In addition, the below charts illustrate the areas where OMIG audits have identified the largest overpayments from 2021 through 2025, OMIG's top ten projects by recoveries for 2021 through 2025, and the Recoveries by OMIG Contractors for 2021 through 2025. These recoveries—totaling over \$3.84 billion—demonstrate New York's commitment to accurately identifying FWA in the Medicaid program and ensuring appropriate remediation.

Audits Identifying Largest Overpayments 2021-2025		
<i>Area</i>	<i>Audits Finalized</i>	<i>Identified Overpayments</i>
Managed Care – Retro Disenrollments	1,223	\$238,238,188
Managed Care – Death Match	180	\$137,356,058
Managed Care – Enhanced NH Rate Code Review	57	\$127,013,064
Managed Care – Prison Match	189	\$104,316,207
Managed Care – Multiple CIN	134	\$84,600,076
Skilled Nursing Facility – Property	167	\$76,666,836
Managed Care – Family Plan Chargeback/MCO	67	\$71,517,559
Managed Care – MLTC Eligibility	26	\$47,375,959
Transportation Taxi/Livery	29	\$28,862,093
Managed Care – PARIS Match	94	\$22,375,159
	Total Finalized: 2,166	Total Identified Overpayments: \$938.32 million

Top Ten Projects by Recoveries Total 2021-2025	
<i>Project</i>	<i>Recoveries</i>
Managed Care – Retro Disenrollments	\$242,726,819
Managed Care – Death Match	\$137,397,250
Managed Care – Enhanced NH Rate Code Review	\$125,986,412
Managed Care – Prison Match	\$103,963,070
Managed Care – Multiple CIN	\$84,501,559
Skilled Nursing Facility – Property	\$75,947,389
Managed Care – Family Plan Chargeback/MCO	\$71,517,559
Managed Care – MLTC Eligibility	\$47,435,935
Managed Care – PARIS Match	\$22,380,773
Certified Home Health Agency (“CHHA”)	\$19,077,243
	Total Recovered: \$930.93 million

Recoveries by OMIG Contractors by Scope and by Identified Overpayments and Recoveries 2021-2025	
<i>Scope</i>	<i>Recoveries</i>
Third-Party Liability	\$909,926,527
Recovery Audit Contractor	\$997,944,975
Home Health Care Medicaid Maximization	\$19,983,517
	Total Recovered: \$1,927 billion

6. Does DOH have internal controls, in addition to those required by CMS, to identify and recover potential FWA expenditures? If so, what are those controls?

New York has numerous internal controls to identify and recover potential FWA in the Medicaid program including but not limited to those previously discussed in the responses to Requests 2 and 3. DOH recognizes that strong internal controls are necessary to enhance integrity of operations and ensure that resources are effectively protected and managed. New York’s

Internal Control Act requires state agencies to establish and maintain internal controls.⁷⁹ Therefore, DOH undergoes Risk Management and Internal Control Reporting each year as required by the New York Governmental Accountability, Audit, and Internal Control Act and the Division of Budget Reporting Manual Item B-0350 (“DOB B-350”). This annual process includes training and an entire survey of each functional area within DOH. Accordingly, every DOH office completes an Annual Risk Management Report administered by DOH’s Risk Management Unit.

The review process identifies internal control weaknesses and provides, monitors, and assesses corrective action. The annual reports go through several layers of review, eventually landing with the Commissioner of Health who reviews the report and signs a certification assessing compliance with the Internal Control Act and DOB B-350. These processes ensure that DOH has strong internal control systems incorporated into its daily activities, including those devoted to FWA prevention, identification, and remediation.

7. Does DOH evaluate and monitor whether managed care plans have any internal controls to identify FWA and recover associated overpayments? If so, please explain.

As discussed, DOH’s Model Contracts require MCOs to implement and maintain procedures to detect and prevent FWA.⁸⁰ DOH regularly reviews MCO compliance with these contractual requirements in surveys and audits of MCOs.⁸¹ DOH also routinely evaluates and monitors whether MCOs have internal controls to identify and recover fraud in accordance with 42 C.F.R. 438.H. The MCPAR reinforces DOH’s oversight of MCO program integrity efforts.⁸² As part of this process, DOH evaluates each MCO’s responses to assess the scope and effectiveness of its program integrity activities. This evaluation includes a review of the volume of program integrity investigations opened and closed during the reporting period and plan-reported overpayments, all in accordance with 42 C.F.R. 438.B.⁸³

OMIG also conducts periodic Program Integrity Reviews to assess compliance with program integrity sections of the Model Contract.⁸⁴ Specifically, OMIG assesses whether MCOs are

⁷⁹ N.Y. Exec. Law § 951.

⁸⁰ See response to Request 2, *supra*.

⁸¹ See DOH, *Managed Care Reports*, (rev. Mar. 2026), https://www.health.ny.gov/health_care/managed_care/reports/.

⁸² DOH, *Managed Care Program Annual Reports*, (rev. Mar. 2026), https://www.health.ny.gov/health_care/managed_care/reports/; e.g., DOH, *Managed Care Program Annual Report (MCPAR) for New York: Managed Long Term Care Partial Cap (MLTC)*, https://www.health.ny.gov/health_care/managed_care/reports/mcp/2024-25/mltcp.pdf.

⁸³ See CMS, *CMCS Informational Bulletin*, (June 28, 2021), <https://www.medicare.gov/federal-policy-guidance/downloads/cib06282021.pdf>; e.g., DOH, *Managed Care Program Annual Report (MCPAR) for New York: HIV Special Needs Plan (HIV SNP)*, https://www.health.ny.gov/health_care/managed_care/reports/mcp/2024-25/hiv.pdf; DOH, *Managed Care Program Annual Report (MCPAR) for New York: Managed Long Term Care Partial Cap (MLTC)*, https://www.health.ny.gov/health_care/managed_care/reports/mcp/2024-25/mltcp.pdf.

⁸⁴ OMIG, *Managed Care Program Integrity Reviews*, <https://omig.ny.gov/audit/medicaid-managed-care-program-integrity-reviews>; see also N.Y. Soc. Serv. Law. § 364-j(36).

submitting timely and complete FWA reports to OMIG, fully implementing all FWA prevention measures implemented by New York and otherwise complying with applicable New York regulations and statutes.⁸⁵ In conducting these reviews, OMIG also assesses whether MCOs are:

- Identifying payments to excluded participating and non-participating providers who are not enrolled in the State's Medicaid program and thus ineligible to bill Medicaid;
- Conducting required federal and state database checks of their employees and participating and non-participating providers, at the frequency required by regulation and any governing contracts;
- Developing and maintaining a FWA public awareness program, FWA prevention plan, and making information available to their providers on their website regarding how to report, return, and explain overpayments;
- Implementing a service verification process that evaluates the delivery of billed services; and
- Establishing a full-time SIU to identify risk and detect and investigate cases of potential FWA, and that the SIU meets staffing requirements provided in 18 N.Y.C.R.R. § 521.⁸⁶

8. Does DOH validate encounter data from managed care plans to ensure it accurately reflects services delivered, pursuant to 42 CFR 438.818?

As required by 42 C.F.R. §§ 438.602 and 438.818, the State contracts with a third-party independent auditor to conduct an audit of the accuracy, truthfulness, and completeness of the encounter data submitted by MCOs.⁸⁷ The report is posted on DOH's website.⁸⁸

DOH requires MCOs to regularly prepare and submit encounter data.⁸⁹ MCOs must submit annual notarized attestations that the encounter data is accurate and complete.⁹⁰ Penalties in the form of reduced Medicaid capitated premiums are assessed for MCOs' untimely or inaccurate

⁸⁵ OMIG, *Medicaid Managed Care Program Integrity Reviews Matrix of Contract Obligations and Performance Standards*, <https://omig.ny.gov/media/99111/download?attachment>; OMIG, *Medicaid Managed Longterm Care Program Integrity Reviews Matrix of Contract Obligations and Performance Standards*, <https://omig.ny.gov/media/93016/download?attachment>.

⁸⁶ OMIG, *Medicaid Managed Care Program Integrity Reviews Matrix of Contract Obligations and Performance Standards*, <https://omig.ny.gov/media/99111/download?attachment>.

⁸⁷ 42 C.F.R. §§ 438.602(e), 438.602(g), 438.818.

⁸⁸ E.g., DOH, *Audit of Managed Care Organization (MCO) Encounter Data Submissions for Calendar Year 2023*, (Apr. 23, 2025), https://www.health.ny.gov/health_care/managed_care/reports/docs/cy2023_encounter_data_audit.pdf.

⁸⁹ DOH, *Medicaid Model Contract* at § 18.5(a)(vi).

⁹⁰ *Id.*

submission of encounter data.⁹¹ OMIG has authority to audit misstated encounter data.⁹² OMIG routinely exercises that audit authority to recover overpayments.⁹³

9. How many payment suspensions did DOH implement due to credible allegations of fraud over the last 5 years, pursuant to 42 CFR 455.23?

Payment suspensions represent only one mechanism of FWA remediation. In addition to payment suspensions, DOH refers many other cases to OMIG and MFCU that result in FWA enforcement actions.⁹⁴ Because New York's robust oversight and monitoring infrastructure succeeds in preventing FWA, payment suspensions are rarely a required remedy. From January 1, 2021 through March 11, 2026, OMIG implemented twenty-four (24) payment suspensions against Medicaid providers due to credible allegations of fraud pursuant to 42 C.F.R. § 455.22 and 18 N.Y.C.R.R. § 518.7.

In accordance with 42 C.F.R. § 455.23, New York annually reports information regarding payment suspensions to the Secretary of the Department of Health and Human Services.⁹⁵ The reporting requirements include the following: the nature of suspected fraud, the basis for the suspension, and the outcome of the suspension, where applicable.⁹⁶ New York submits these reports annually via the CMS Payment Suspension Website Portal for the requested Federal Fiscal Year.

10. Please provide all guidance, policies, or training materials related to state staff responsibilities for fraud detection, prevention, and reporting.

All DOH employees are trained to understand that New York law creates an affirmative duty for state officers and employees of covered agencies to report to the state inspector general "any information concerning corruption, fraud, criminal activity, conflicts of interest, or abuse by another state officer or employee relating to his or her office or employment."⁹⁷ DOH also trains its employees on internal control responsibilities, including annual Risk Management and Internal Control Reporting which, as mentioned in the response to Request 6 ensure that DOH has strong internal controls including methods to prevent, identify, and remedy FWA.

In addition, OMIG conducts extensive guidance, training, and policies related to the agency's responsibilities to enhance the Medicaid program through fraud prevention and reporting.

⁹¹ N.Y. Soc. Serv. Law § 364-j(32).

⁹² DOH, *Medicaid Model Contract* § 19.6, https://www.health.ny.gov/health_care/managed_care/providers/docs/mmc_fhp_hiv-snp_harp_model_contract.pdf.

⁹³ E.g., OMIG, *Audit of Encounter Data for Reported Payments Improperly Made for Managed Care Recipients in the Restricted Recipient Program for Dates of Service January 1, 2019 to December 31, 2023*, <https://omig.ny.gov/media/93666/download>.

⁹⁴ See response to Request 3, 4, *supra*.

⁹⁵ 42 C.F.R. § 455.23(g)(3).

⁹⁶ *Id.* at § 455.23(g)(3)(i).

⁹⁷ N.Y. Exec. Law § 55(1).

Training regarding the overall mission of the agency and its core functions is provided when an employee onboards and continues during the employee's tenure with the agency. Staff also receive division-specific training tailored to specific program integrity activities, as appropriate. Additionally, OMIG promotes opportunities for employees to attend training conferences with external partner agencies at the state and federal level. These opportunities allow staff to engage with federal experts from CMS and Office of Inspector General for the HHS-OIG on how to address FWA trends. This ongoing and comprehensive training and guidance illustrates OMIG's commitment to ensuring that staff are well-prepared and equipped to root out FWA in New York's Medicaid program.

New York's Office of Mental Health ("OMH") also has a Medicaid Compliance Committee the purpose of which is to oversee OMH's Medicaid Compliance Program. OMH's policy manual outlines expectations for employees to timely report any FWA allegations and provides guidance on the system for promptly responding to Medicaid Compliance issues.

11. Please provide all guidance, policies, or training materials related to FWA that have been shared with New York State Medicaid providers.

New York equips providers with comprehensive guidance, policies, and training materials relating to FWA.

Providers are directed to OMIG's publicly accessible website, which contains a wealth of information specifically for providers regarding preventing, identifying, and reporting FWA.⁹⁸ This guidance includes compliance education and recordings, guidance on self-disclosure, and information about OMIG audit processes and areas of focus.⁹⁹ OMIG also regularly presents on FWA prevention to providers and similarly makes its presentations available on its website.¹⁰⁰ During stakeholder engagement, outreach, and education sessions, OMIG informs providers that the goal of compliance programs under 18 N.Y.C.R.R. § 521-1 is to ensure providers successfully prevent, identify, and mitigate FWA in the State's Medicaid program.

OMIG also provides guidance materials directly to providers regarding provider obligations to assist with FWA efforts. For example, OMIG distributes written guidance on providers' duties to submit a monthly Provider Investigative Report to OMIG and DOH and on MCOs' duties to notify OMIG of its intent to open an investigation on a provider.

DOH is likewise committed to ensuring providers have access to necessary information to safeguard program integrity. DOH has a website dedicated to health plans, providers, and professionals that contains information to ensure New York Medicaid providers can successfully

⁹⁸ OMIG, *Provider Resources*, <https://omig.ny.gov/information-resources/provider-resources>.

⁹⁹ *Id.*

¹⁰⁰ OMIG, *2024 Annual Report* at 17, 20; OMIG, *Webinars*, <https://omig.ny.gov/information-resources/webinars>.

and appropriately administer their programs.¹⁰¹ Information regarding audit processes is also made available to providers on DOH's website.¹⁰² Further, DOH maintains Medicaid Update, a monthly publication produced with input from OMIG that notifies providers of changes in the Medicaid program.¹⁰³ For example, a 2023 Medicaid Update informed providers of OMIG's guidance regarding 2022 regulatory changes affecting Medicaid provider compliance programs, FWA prevention programs, and self-disclosure and overpayment reporting.¹⁰⁴ Most recently, in June 2025 and January 2026, OMIG published articles advising providers of upcoming compliance program reviews and reminding them of their obligations to self-disclose overpayments.¹⁰⁵

In addition, DOH provides several comprehensive, easily accessible provider manuals to guide providers throughout their participation in Medicaid.¹⁰⁶ In addition to provider-specific manuals, DOH shares general policies that notify providers of their duties to maintain FWA compliance programs and advise on recovery of overpayments and withholding of payments.¹⁰⁷

DOH also hosts monthly Managed Care Policy and Planning meetings, which serve as a forum for DOH to relay program updates and guidance. OMIG assists DOH in preparing for these meetings by providing information falling within its areas of expertise for DOH to present to providers.

Moreover, New York regulation makes clear to providers that any form of FWA is considered an unacceptable practice within the Medicaid program.¹⁰⁸ State regulation outlines unacceptable Medicaid practices, including false claims and statements, receiving bribes or kickbacks, and furnishing excessive services.¹⁰⁹ The regulations also clearly explain duties of Medicaid providers, including keeping proper records, submitting accurate claims, and permitting audits.¹¹⁰

¹⁰¹ DOH, *Health, Plans, Providers, and Professionals*,

https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/hlth_plans_prov_prof.htm.

¹⁰² See, e.g., DOH, *Post-Payment Audit Home*, https://health.ny.gov/health_care/medicaid/redesign/ehr/audit/.

¹⁰³ DOH, *Medicaid Update*, https://health.ny.gov/health_care/medicaid/program/update/main.htm.

¹⁰⁴ DOH, *Medicaid Update*, (Feb. 2023),

https://www.health.ny.gov/health_care/medicaid/program/update/2023/docs/mu_no5_feb23.pdf.

¹⁰⁵ DOH, *Medicaid Update*, 7 (June 2025),

https://www.health.ny.gov/health_care/medicaid/program/update/2025/docs/mu_no06_jun25_pr.pdf; DOH, *Medicaid Update*, 5 (Jan. 2026),

https://www.health.ny.gov/health_care/medicaid/program/update/2026/docs/mu_no01_jan26_pr.pdf.

¹⁰⁶ EMedNY, *Provider Manuals*, <https://www.emedny.org/providermanuals/>.

¹⁰⁷ EMedNY, *New York State Medicaid Program Information for All Providers General Policy*, 20, 30 (Dec. 30, 2022) https://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information_for_All_Providers-General_Policy.pdf.

¹⁰⁸ 18 N.Y.C.R.R. § 515.2.

¹⁰⁹ *Id.*

¹¹⁰ *Id.* at § 504.3.

12. Please provide all reports from Quality Improvement Organizations (QIOs), External Quality Review Organizations (EQROs), or other independent review bodies from the past 5 years that identify or describe overpayments, instances of upcoding, or fraud.

New York engages numerous independent review bodies to conduct quality assurance reviews to detect and ameliorate any instances of FWA occurring in the state Medicaid program.

By way of example, per federal regulation, New York receives an annual External Quality Review Annual Technical Report.¹¹¹ These reviews analyze the quality, timeliness, and access to healthcare services that MCOs furnish to Medicaid and Child Health Plus enrollees.¹¹² The Quality Reviews evaluate validation of performance improvement projects and performance measures, review compliance with Medicaid and Children's Health Insurance Program standards, validate network adequacy, and administration of quality of care surveys.¹¹³

Under a contract with DOH, New York State Technology Enterprise Program ("NYSTEC") conducts quality assurance activities related to 1915c Children's Waiver.¹¹⁴

Moreover, OMIG's External Audit Unit coordinates and manages audits of the Medicaid program conducted by outside audit and oversight agencies, such as the Office of the State Comptroller, Health and Human Services-Office of Inspector General, and CMS.¹¹⁵

13. Please provide all records or logs documenting allegations of FWA referred to the state from providers, managed care organizations, or other stakeholders over the past 5 years, including how these cases were investigated and resolved.

Between 2021 and 2025, OMIG opened several thousand subjects as a result of allegations received from various sources including federal, state, and local law enforcement and government agencies, MCOs, MLTC, providers, Medicaid recipients, and through a dedicated hotline and website that enable the public to report allegations of fraud.¹¹⁶ This includes 3,692 subjects in 2021; 3,865 subjects in 2022; 3,667 subjects in 2023; 3,668 subjects in 2024; and 4,693 subjects in 2025. FWA referrals received by OMIG are all opened and reviewed by the

¹¹¹ DOH, *2023 External Quality Review Annual Technical Report*, (Apr. 2025), https://www.health.ny.gov/statistics/health_care/managed_care/plans/reports/docs/2023_mlrc_atr_report.pdf; DOH, *2022 External Quality Review Annual Technical Report*, (Apr. 2024) https://www.health.ny.gov/statistics/health_care/managed_care/plans/reports/docs/2022_eqr_annual_technical_report.pdf; DOH, *2021 External Quality Review Annual Technical Report*, (Apr. 2023) https://www.health.ny.gov/statistics/health_care/managed_care/plans/reports/docs/2021_eqr_annual_technical_report.pdf.

¹¹² DOH, *External Quality Review Annual Technical Report*, https://www.health.ny.gov/statistics/health_care/managed_care/plans/reports/, (last updated Apr. 2025).

¹¹³ *Id.*

¹¹⁴ DOH, *Application for 1915(c) HCBS Waiver: NY.4125.R06.02*, 22 (Feb. 28, 2024), https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/1915c_cms_wdml.pdf.

¹¹⁵ OMIG, *2021 Annual Report* at 45; OMIG, *2022 Annual Report* at 52; OMIG, *2023 Annual Report* at 71; OMIG, *2024 Annual Report* at 67.

¹¹⁶ OMIG, *2024 Annual Report* at 42; OMIG, *File an Allegation*, <https://omig.ny.gov/medicaid-fraud/file-allegation>.

Division of Medicaid Investigations and may be referred to the Division of Medicaid Audit (“DMA”) when appropriate. OMIG reviews referrals and may conduct audits, pursue investigations, perform pre-payment reviews, or provide guidance regarding applicable Medicaid rules and regulations to educate providers and warn of the consequences for noncompliance.¹¹⁷ If appropriate, OMIG will refer the matter to MFCU for potential criminal investigation, or to other state agencies as warranted.¹¹⁸ The matter may also be referred back to the MCO for further action.¹¹⁹ A summary of the resolutions of all FWA referrals by OMIG for the past five years is outlined below.

Resolutions of Subjects Opened in 2021	
<i>Resolution</i>	<i>Number of Subjects</i>
Returned to MCO for further action	370
Closed on initial review	1,011
Referred to other OMIG divisions, MFCU, or other state agencies	941
Education letters issued	148
Medicaid recipient ineligibility communicated to DOH	236
Pre-payment review requested	359
Notice of Proposed Agency Action issued	4
Notice of Agency Action issued	3
Still open or closed with no action	620

Resolutions of Subjects Opened in 2022	
<i>Resolution</i>	<i>Number of Subjects</i>
Returned to MCO for further action	520
Closed on initial review	1,131
Referred to other OMIG divisions, MFCU, or other state agency	902

¹¹⁷ See response to Request 3, 4, *supra*.

¹¹⁸ See response to Request 4, *supra*.

¹¹⁹ See response to Request 3, *supra*.

Resolutions of Subjects Opened in 2022	
Education letters issued	47
Medicaid recipient ineligibility communicated to DOH	364
Pre-payment reviews requested	204
Notice of Proposed Agency Action issued	11
Notice of Agency Actions issued	3
Still open or closed with no action	683

Resolutions of Subjects Opened in 2023	
<i>Resolution</i>	<i>Number of Subjects</i>
Returned to MCO for further action	503
Closed on initial review	1,067
Referred to other OMIG divisions, MFCU, or other state agencies	589
Education letters issued	70
Medicaid recipient ineligibility communicated to DOH	88
Pre-payment review requested	110
Notice of Proposed Agency Action	10
Notice of Agency Action issued	8
Still open or closed with no action	1,222

Resolutions of Subjects Opened in 2024	
<i>Resolution</i>	<i>Number of Subjects</i>
Returned to MCO for further action	585
Closed on initial review	1,092
Referred to other OMIG divisions, MFCU, and other state agencies	364

Resolutions of Subjects Opened in 2024	
Education letters issued	146
Medicaid recipient ineligibility communicated to DOH	5
Pre-payment reviews requested	117
Notice of Proposed Agency Actions issued	1
Still open or closed with no action	1,358

Resolutions of Subjects Opened in 2025	
<i>Resolution</i>	<i>Number of Subjects</i>
Returned to MCO for further action	552
Closed on initial review	1,344
Referred to other OMIG divisions, MFCU, or other state agencies	381
Education letters issued	128
Medicaid recipient ineligibility communicated to DOH	30
Pre-payment review requested	107
Notice of Proposed Agency Action issued	1
Still open or closed with no action	2,150

Provider Screening, Enrollment, and Revalidation

14. Please provide a list of all currently enrolled New York State Medicaid providers, regardless of investigation status.

A list of enrolled providers in the New York State Medicaid program is published by DOH at the Health Data NY Website: https://health.data.ny.gov/Health/Medicaid-Enrolled-Provider-Listing/ke5t-qx5t/about_data.¹²⁰

¹²⁰ DOH, *Medicaid Enrolled Provider Listing*, (last updated March 30, 2026).

15. What criteria does DOH use to determine the risk level (limited, moderate, high) that applies to New York State Medicaid providers pursuant to 42 CFR 455.450?

DOH follows the criteria set forth in 42 C.F.R. § 455.450, as well as in Sections 1.3D, 1.3E, 1.5.3., and 1.5.4 of the Medicaid Provider Enrollment Compendium (“MPEC”).¹²¹ For example, according to federal regulations, prospective home health agencies and newly enrolling suppliers of durable medical equipment (“DME”), prosthetics, orthotics, and supplies are categorized as high risk, while ambulance service suppliers are moderate risk.¹²² Limited or moderate risk providers are adjusted to high risk in various circumstances, including but not limited to when a payment to a provider is suspended based on a credible FWA allegation, or when the provider has been excluded and then reinstated by HHS-OIG or another state’s Medicaid Program.¹²³

New York retains discretionary authority to determine whether certain providers are high risk. DOH can raise the risk level of a provider or provider type or can do so at the request of OMIG. As the MPEC notes with respect to Medicaid-only providers, New York’s state Medicaid agency is “uniquely qualified to understand issues involved with balancing beneficiaries’ access to medical assistance and ensuring the fiscal integrity of the State Medicaid Program” and possesses “discretion to make its own risk level determinations.”¹²⁴

16. Does DOH conduct off-cycle revalidations pursuant to 42 CFR 455.414, and if so, in what circumstances and what is the scope of such revalidations?

In addition to the required revalidation of enrollment of all providers at least every five years pursuant to federal regulation,¹²⁵ DOH performs off-cycle revalidations when concerns arise that an enrollment file may not be accurate or that there may be program integrity issues with an individual on a provider’s file.¹²⁶ A provider’s enrollment will be terminated in instances where revalidation is not successful.¹²⁷

¹²¹ 42 C.F.R. § 455.450; CMS, *Medicaid Provider Enrollment Compendium (MPEC)*, <https://www.medicaid.gov/medicaid/program-integrity/downloads/mpec.pdf>, (last updated Nov. 17, 2025).

¹²² CMS, *Medicaid Provider Enrollment Compendium (MPEC)* at 21–22, <https://www.medicaid.gov/medicaid/program-integrity/downloads/mpec.pdf>, (last updated Nov. 17, 2025).

¹²³ *Id.* at 22–23.

¹²⁴ *Id.* at 23.

¹²⁵ 42 C.F.R. § 455.414.

¹²⁶ eMedNY, *Revalidation*, <https://www.emedny.org/info/ProviderEnrollment/revalidation/index.aspx>, (last updated Aug. 2024) (“Revalidation dates that are published on the Medicaid Enrolled Provider Listing and those appearing on provider files are estimated dates that may be subject to change based on factors such as a timing lag, updates made to an enrollment file, and the State’s ability to extend the date for certain providers.”).

¹²⁷ eMedNY, *Frequently Asked Questions (FAQs) for Revalidation*, <https://www.emedny.org/info/ProviderEnrollment/revalidation/FAQs.aspx?qid=R12>.

17. Does DOH allow for exceptions that prevent provider termination, such as for sole community providers or rural providers, and if so, what are these exceptions?

DOH possesses discretion, granted by New York regulations, to terminate providers.¹²⁸ DOH terminates providers to enforce compliance with program requirements, while making limited exceptions depending on the reason for the proposed termination and the impact the termination would have on access to care.

18. How many providers have been suspended and/or terminated, including through off-cycle revalidation, in the past 5 years?

Revalidations and terminations of providers are conducted by DOH, and are discussed in detail in Response 19. DOH regularly terminates providers, including about 65,000 in the past five years. The overwhelming majority of providers were terminated because they failed to reply to a revalidation notice, or because their license to practice medicine had expired and they failed to provide a current one.

OMIG does not use the terms “suspended” in its program integrity actions related to the investigation, audit, or review of providers. However, OMIG issues “exclusions,” which are the functional equivalent of suspensions from participation in the Medicaid program once enrolled.¹²⁹

OMIG may issue sanctions, including exclusion from the Medicaid program upon determining that a provider engaged in “unacceptable practices” pursuant to authorities in 18 N.Y.C.R.R. §§ 515.2–515.3, described in the response to Request 19. Under certain circumstances, OMIG can impose “immediate sanctions” or “mandatory exclusions” pursuant to authorities in § 515.7 and § 515.8 respectively. Excluded providers cannot participate in the Medicaid program unless they are reinstated.¹³⁰ In addition, the provider’s name will be included on a list of excluded providers.

OMIG publishes a publicly available list of excluded providers on the OMIG website, including their date of exclusion, at: <https://omig.ny.gov/medicaid-fraud/medicaid-exclusions>.¹³¹

¹²⁸ 18 N.Y.C.R.R. § 504.7.

¹²⁹ In relevant part, New York Public Health Law provides that OMIG has the authority “to pursue civil and administrative enforcement actions against any individual or entity that engages in fraud, abuse, or illegal or improper acts or *unacceptable practices* perpetrated within the medical assistance program, including but not limited to... (c) imposition of administrative *sanctions* and penalties in accordance with state and federal laws and regulations; (d) *exclusion* of providers, vendors and contractors from participation in the program.” N.Y. Pub. Health Law § 32(6) (emphasis added).

¹³⁰ 18 N.Y.C.R.R. §§ 515.2–515.3, 515.7, 515.8.

¹³¹ OMIG, *Medicaid Exclusions*, <https://omig.ny.gov/medicaid-fraud/medicaid-exclusions>.

The table below outlines the number of exclusions of both enrolled and unenrolled¹³² persons imposed by OMIG.

Applicable Regulation	2021	2022	2023	2024	2025	2026 Jan-March	Total
18 N.Y.C.R.R. § 504.1(d)(1) ¹³³	88	87	28	58	45	7	313
18 N.Y.C.R.R. § 515.2	1	2	NA	1	7	1	12
18 N.Y.C.R.R. § 515.7(b)	84	46	35	84	53	13	315
18 N.Y.C.R.R. § 515.7(c)	111	143	80	70	48	11	463
18 N.Y.C.R.R. § 515.7(d)	NA	NA	2	NA	NA	NA	2
18 N.Y.C.R.R. § 515.7(e)	77	122	111	168	244	29	751
18 N.Y.C.R.R. § 515.8	95	162	139	216	132	26	770
Totals	456	562	395	597	529	87	2,626

19. In what circumstances does DOH suspend or terminate a New York State Medicaid provider’s enrollment beyond federal reasons outlined in 42 CFR 455.416?

The authority provided by 18 N.Y.C.R.R. § 504.7 enables OMIG and DOH to suspend or terminate a provider’s enrollment, respectively. As explained in the response to Request 18, OMIG interprets the term “suspend” to mean “exclude,” which OMIG has the authority to do pursuant to the sanctions authorities in 18 N.Y.C.R.R. § 515. DOH is responsible for terminations of providers.¹³⁴

¹³² The term “person” includes “natural persons, corporations, partnerships, associations, clinics, groups and other entities.” 18 N.Y.C.R.R. § 504.1(d)(17). Given the broad definition of “person” under the Medicaid regulations, OMIG’s sanction authorities also extend to persons not enrolled as a provider.

¹³³ “Whenever the department sanctions a person, it may also sanction any affiliate of that person.” 18 N.Y.C.R.R. § 515.3. An “affiliate” is defined in 18 N.Y.C.R.R. § 504.1(d)(1).

¹³⁴ 18 N.Y.C.R.R. § 504.7.

In order to safeguard the quality of care that New Yorkers receive within the State’s Medicaid Program, DOH and OMIG are empowered to suspend or terminate providers for reasons that go beyond those encompassed in federal regulation. 18 N.Y.C.R.R. § 504.7(b) allows for a provider’s participation in the program to be “terminated, suspended or restricted for a reasonable period of time” if the provider has engaged in an “unacceptable practice,” which includes soliciting or receiving bribes or kickbacks, offering premiums or inducements to a client in return for a client’s patronage of the provider, making an agreement to defraud the program by obtaining payment of false claims, furnishing medical care in excess of a patient’s needs, failing to meet professional standards for the provision of healthcare, unlawful discrimination, solicitation of patients, denial of services based on inability to pay, and conversion of medical payments for purposes other than the use intended by the Medicaid program.¹³⁵ OMIG is primarily responsible for investigating allegations of “unacceptable practices” and excluding providers following the issuance of a “final determination” to the provider. OMIG’s findings can be challenged if the providers choose to request a hearing before an administrative law judge.¹³⁶ If the hearing decision is adverse to the provider, they are entitled to appeal through a special proceeding under Article 78 of the New York Civil Practice Law and Rules in New York Supreme Court.¹³⁷

18 N.Y.C.R.R. § 504.7(d)–(h) also provide additional bases beyond 42 C.F.R. § 455.416 for DOH to terminate a provider. DOH has the authority to implement these terminations.

- Section 504.7(d) provides for automatic termination when a provider’s license to practice medicine or provide medical care, services, or supplies is revoked.¹³⁸
- Section 504.7(e) provides for automatic termination when a provider fails to maintain up-to-date statements disclosing its owners and controlling interest holders.¹³⁹
- Section 504.7(f) provides that a provider “may be terminated,” when “the ownership or control of the provider has substantially changed since acceptance of its enrollment application.”¹⁴⁰
- Section 504.7(g) provides that a provider “will be terminated” when the provider furnishes incorrect or incomplete information in their application and correct and complete information would have resulted in denial of their application.¹⁴¹
- Section 504.7(h) provides that a provider “will be terminated” when the provider fails to

¹³⁵ See 18 N.Y.C.R.R. §§ 504.7(b), 512.2.

¹³⁶ *Id.* at § 515.

¹³⁷ N.Y. C.P.L.R. art. 78.

¹³⁸ 18 N.Y.C.R.R. § 504.7(d).

¹³⁹ *Id.* at § 504.7(e).

¹⁴⁰ *Id.* at § 504.7(f).

¹⁴¹ *Id.* at § 504.7(g).

pay imposed penalties in full.¹⁴²

Furthermore, as discussed in New York’s response to Request 22, certain providers must maintain a compliance program with the required components set forth by New York law.¹⁴³ Failing to do so may result in termination of enrollment and exclusion from the Medicaid Program.¹⁴⁴

20. Does DOH identify and monitor related entities, common ownership, or shared management across multiple enrolled providers, and if so, how?

DOH defines “[a]ffiliated persons” as “those individuals having an overt, covert or conspiratorial relationship with another such that either of them may directly or indirectly control the other or such that they are under a common control.”¹⁴⁵ Some examples of affiliated persons are persons with an ownership or controlling interest in a provider, agents and managing employees of a provider, providers who share common managing employees, and subcontractors with whom the provider has more than \$25,000 in annual business transactions.¹⁴⁶

DOH identifies and monitors information on ownership and control by requiring providers to disclose those with an ownership or control interest in their practice.¹⁴⁷ Failure to keep these disclosures up to date may result in termination of the provider’s ability to participate in Medicaid.¹⁴⁸

New York is updating its provider enrollment portal to collect disclosures of affiliation information, which will assist in complying with the federal “Disclosure of affiliations” requirement set forth in 42 C.F.R. § 455.107. These updates are scheduled for release at the end of June 2026.

Provider enrollment staff carefully monitor a repository of allegations against New York Medicaid providers in order to terminate affiliated providers as soon as possible, when appropriate. Staff cross-reference multiple enrollment files, including the CMS Medicare enrollment portal Provider Enrollment, Chain, & Ownership System (PECOS), to ensure that related entities are added to the repository of allegations in a timely manner. If the owners listed when a provider enrolls in Medicare differ from the owners listed when a provider enrolls in New York’s Medicaid program, the provider will be flagged and further investigated.

¹⁴² *Id.* at § 504.7(h).

¹⁴³ N.Y. Soc. Serv. Law § 363-d; 18 N.Y.C.R.R. § 521-1.1.

¹⁴⁴ OMIG, *Compliance Program Guidance*, 6 (Jan. 2023), <https://omig.ny.gov/media/80796/download?attachment>.

¹⁴⁵ See 18 N.Y.C.R.R. § 504.1.

¹⁴⁶ See eMedNY, *Information for All Providers General Policy*, 25–26 (Dec. 30, 2022), https://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information_for_All_Providers-General_Policy.pdf.

¹⁴⁷ See 18 N.Y.C.R.R. § 502.4.

¹⁴⁸ See *id.* at §§ 504.7(e), 504.7(f).

OMIG assists DOH in identifying and monitoring related entities, common ownership, or shared management of providers. OMIG uses its own internal database, the Fraud Activity Comprehensive Tracking System (FACTS), to monitor entities.¹⁴⁹ It also uses the state database eMedNY as well as federal databases such as CMS Data Exchange System (DEX) and PECOS. OMIG also communicates directly with providers, as well as hospital associations, to ensure a compliance program review encompasses all relevant, related and affiliated providers. In 2024, OMIG established an Advanced Analytics Unit (“AAU”), which has expanded and improved OMIG’s ability to detect undisclosed provider relationships.¹⁵⁰

21. What tools are used to detect improper provider screening, enrollment, and revalidation, across locations?

Throughout the life cycle of a provider’s participation in New York’s Medicaid program, DOH and OMIG employ internal controls, in addition to those outlined in the response to Request 6, to ensure that providers are appropriately monitored. Improper screening is prevented through a variety of tools used by DOH with support from OMIG. DOH uses background checks, fingerprinting, requests for information, third-party screening vendors, quality assurance review of applications, and review by its transportation broker to screen new applicants.

Upon receipt of an application for enrollment or re-enrollment, DOH will conduct an investigation within 90 days to verify or supplement application information.¹⁵¹ DOH may request further information from an applicant, including by performing criminal history background checks and fingerprinting. If the applicant cannot be fully evaluated within ninety days, DOH may extend the time for acting on the application for up to 120 days from receipt of the application.¹⁵² Providers are also screened through third party vendors upon application, and monthly once enrolled.

DOH uses a checklist when it has finished reviewing an application to ensure applicants were screened appropriately and that the requirements for enrollment or revalidation were met. The checklist requires staff to initial each required screening step, and it is reviewed by a quality assurance team with expertise in detecting enrollment application errors that can cause risks.

In addition, since March 1, 2024, new transportation providers have been required to receive a letter of support from MAS, the transportation broker that DOH contracts with, to enroll in the

¹⁴⁹ DOH, *State Medicaid HIT Plan (SMHP) Update*, https://www.health.ny.gov/health_care/medicaid/redesign/ehr/repository/hit_plan_update.htm.

¹⁵⁰ OMIG, *2026 Work Plan*, <https://omig.ny.gov/new-york-state-office-medicare-inspector-general-2026-work-plan>; see response to Request 25, *supra*.

¹⁵¹ See eMedNY, *Information for All Providers General Policy*, 16 (Dec. 30, 2022), https://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information_for_All_Providers-General_Policy.pdf.

¹⁵² *Id.*

New York Medicaid Program.¹⁵³ This has led to a significant decrease in new enrollment applications from transportation providers.¹⁵⁴

OMIG supports DOH by performing additional layers of review, for certain provider types: transportation providers, independent pharmacies, DME suppliers, dental groups, laboratories, physical therapists, and physical therapy groups.¹⁵⁵ OMIG's review process includes assessing whether applicants have prior exclusions, charges of healthcare fraud, or licensing issues. OMIG also identifies the exclusion status of applicants, including any person with an ownership or control interest in the provider, and any person who is an agent or managing employee of the provider, through checks of federal databases. Further, OMIG verifies the validity of the licensure of applicants and reviews enforcement actions taken with respect to their licensure. OMIG also conducts site visits during its review process, or relies on approved site visits completed by CMS or its contractors.¹⁵⁶

New York also has tools in place to prevent improper revalidation, including requests for information and documentation. When an application for revalidation is incomplete or there are discrepancies in information, missing documentation and/or corrections are requested. If the provider does not respond or does not respond with acceptable information, they are terminated for failure to revalidate.¹⁵⁷ Additionally, once providers are enrolled in the New York Medicaid Program, OMIG conducts interviews and field assistance, performs data analysis on claims, analyzes allegations received, reviews medical records, and audits various providers.¹⁵⁸ OMIG also employs clinical reviews, and CVR that verify staff credentials and training to ensure ongoing compliance with Medicaid program requirements.¹⁵⁹ When a provider has been excluded and subsequently requests reinstatement and removal from the exclusion list, OMIG reviews such requests, and when appropriate, issues denial letters.¹⁶⁰

Program Integrity Infrastructure and Accountability

22. Are program integrity responsibilities divided among DOH, MFCU, other state agencies, managed care plans, contractors, or providers, and if so, how?

DOH, MFCU, and OMIG are mutually responsible for program integrity. Their responsibilities are delineated in both enabling legislation and in Memoranda of Understanding (MOUs), the

¹⁵³ MAS, *Become a Transportation Provider*, <https://wp2.medanswering.com/transportation-providers/become-a-provider/>; OMIG, 2024 *Annual Report* at 55.

¹⁵⁴ OMIG, 2024 *Annual Report* at 55.

¹⁵⁵ *Id.*

¹⁵⁶ OMIG performs these visits for the following moderate and high-risk provider types: DME suppliers, freestanding laboratories, physical therapy groups, and portable x-ray providers.

¹⁵⁷ See eMedNY, *Revalidation*, <https://www.emedny.org/info/ProviderEnrollment/revalidation/index.aspx> (last updated Aug. 2024).

¹⁵⁸ OMIG, 2024 *Annual Report* at 44.

¹⁵⁹ *Id.*

¹⁶⁰ OMIG, 2026 *Work Plan*, <https://omig.ny.gov/new-york-state-office-medicare-inspector-general-2026-work-plan>.

most recent of which took effect as of October 23, 2025 (“October 2025 MOU”). These agencies coordinate to effectively detect, prevent, investigate, refer, sanction, and prosecute FWA in the New York Medicaid Program. Given the diverse and substantial services that the New York Medicaid program provides to its residents in need of health and medical care, partnerships with other state agencies, managed care plans, contractors, and providers are also vital to preventing FWA. Both DOH and OMIG may enter MOUs with state and local entities in furtherance of program integrity initiatives.

DOH as the single state agency has overall responsibility to establish policies to enhance and promote program integrity activities. Pursuant to New York Public Health Law § 31(1), OMIG is responsible for: (1) the prevention, detection and investigation of fraud and abuse within the Medicaid program; (2) referral of appropriate cases for criminal prosecution; and (3) the recovery of improperly expended Medicaid funds.¹⁶¹ MFCU investigates and prosecutes violations of all applicable state laws pertaining to any and all aspects of fraud in connection with the Medicaid program.

The October 2025 MOU contains various provisions designating the responsibilities of OMIG and MFCU with respect to referring investigations of credible allegations of fraud. MFCU initiates pending investigations upon receipt of referred fraud allegations from OMIG, and OMIG initiates payment suspension for subjects of pending investigations.¹⁶² OMIG also investigates allegations of overpayments referred to it by MFCU and initiates administrative action and recovery in cases when MFCU does not pursue civil recovery.

When alleged fraud is referred by OMIG, MFCU has 30 days to advise OMIG whether any part of the allegation is being accepted or referred back to OMIG for potential administrative action. OMIG can designate certain investigations as “high priority,” in which case MFCU will evaluate whether to accept an allegation for investigation or prosecution within 15 days. As discussed in the response to Request 4, DOH also refers credible allegations of FWA to OMIG and MFCU.

Both New York Social Services Law § 364-j(39) and 18 N.Y.C.R.R. §§ 521-2.1–521-2.4 provide for the oversight of MCOs.¹⁶³ Under these provisions, as well as provisions in contracts between the MCO and DOH, MCOs must:

- Detect and prevent FWA through their compliance programs¹⁶⁴
- Audit, investigate, or review cases of fraud, waste or abuse specific to their participation in the Medicaid program¹⁶⁵

¹⁶¹ N.Y. Pub. Health Law § 31(1).

¹⁶² See 18 N.Y.C.R.R. § 518.7.

¹⁶³ N.Y. Soc. Serv. Law § 364-j(39); 18 N.Y.C.R.R. §§ 521-2.1–521-2.4.

¹⁶⁴ 18 N.Y.C.R.R. § 521-2.4(a).

¹⁶⁵ *Id.* at § 521-2.4(c).

- Report cases of FWA to OMIG, and fraud to MFCU¹⁶⁶
- Immediately refer reasonably suspected criminal activity to both OMIG and MFCU¹⁶⁷
- Have policies and procedures for their providers to timely report, return, and explain overpayments to the MCO, and for the MCO to report such recoveries to OMIG and DOH¹⁶⁸
- Pursuant to N.Y. Social Services Law § 363-d, certain providers are required to adopt and implement a compliance program. This is a condition of payment from the Medicaid program. OMH and OPWDD licensed providers must also maintain a compliance program.¹⁶⁹

In addition, and as discussed in the response to Request 2, MCOs with an enrolled population of 1,000 or more persons must establish an SIU that meets rigorous regulatory requirements with the goal of eliminating FWA within MCOs.¹⁷⁰ OMIG coordinates activities with SIUs, which strengthens program integrity and increases the number of referrals to OMIG.

23. What metrics does DOH use to assess the effectiveness of its program integrity initiatives over time? How are these metrics publicly displayed?

OMIG employs numerous metrics to assess the effectiveness of its program integrity efforts, many of which are featured in its Annual Reports.¹⁷¹ Beginning in 2006, OMIG has published a comprehensive Annual Report summarizing the agency's efforts to detect, prevent, and combat Medicaid FWA across New York State's Medicaid Program.¹⁷² The Annual Reports also include narrative information about audits, investigations, and administrative actions initiated and completed by OMIG, as well as other operational statistics that demonstrate OMIG's program integrity efforts.¹⁷³ These statistics include the amount of self-disclosure reports OMIG receives, the number of audits initiated and finalized annually, the number of exclusions issued, and the amount of overpayments recovered.¹⁷⁴ The Annual Reports also outline data and statistics that demonstrate OMIG's statewide reach, including self-disclosures, referrals, and recoveries by region.¹⁷⁵

¹⁶⁶ *Id.* at § 521-2.4(d).

¹⁶⁷ *Id.* at § 521-2.4(e).

¹⁶⁸ *Id.* at § 521-2.4(f).

¹⁶⁹ N.Y. Soc. Serv. Law § 363-d.

¹⁷⁰ *See id.* at § 364-j(39)(b); 18 N.Y.C.R.R. § 521-2.3.

¹⁷¹ OMIG, *Annual Reports*, <https://omig.ny.gov/information-resources/annual-reports>.

¹⁷² *See* OMIG, *2006 Annual Report*, <https://omig.ny.gov/media/15756/download?attachment>.

¹⁷³ *See* OMIG, *Annual Reports*, <https://omig.ny.gov/information-resources/annual-reports>.

¹⁷⁴ *Id.*

¹⁷⁵ *See generally, id.*

Additionally, OMIG measures the effectiveness of its program integrity initiatives by analyzing cost savings. OMIG tracks cost savings on a monthly basis by measuring estimates of Medicaid dollars that were prevented from being improperly paid to providers as a result of OMIG’s program integrity controls. This metric is distinct from OMIG recoveries data, which OMIG uses to track the recovery of Medicaid dollars improperly paid out to providers. Several metrics contribute to OMIG’s estimated cost savings, including abbreviated self-disclosure claim voids or adjustments; pre-payment review for medical, dental, or transportation services; OMIG provider enrollment denials cost savings;¹⁷⁶ excluded provider cost savings; and restricted recipient cost savings. OMIG uses data from denied claims, paid claims, and providers to calculate cost savings on a monthly basis. OMIG reports cost savings results to the New York State Division of Budget¹⁷⁷ and includes these results in the Annual Reports.¹⁷⁸

24. Are trends in error rates, recoveries, and enforcement outcomes evaluated and reported to the public, and if so, how?

OMIG publishes a significant amount of data regarding its integrity work, including information, broken down by region, on the number of audits initiated, the total amount of overpayments discovered, audit recoveries made, and penalties issued.¹⁷⁹ For example, across regions, between 2021-2024, OMIG recovered \$955,894,654 in overpayments identified through audits.¹⁸⁰ In addition, OMIG discloses the number of self-disclosures and referrals made by providers by region, highlighting the collaboration between the State and providers to root out FWA. For instance, between 2021 and 2024, MCOs referred over 4,000 cases to OMIG alone.¹⁸¹ The table below captures just some of the totals and trends reported by OMIG across its program integrity work, including recoveries and cost savings, collaboration with MCOs and MFCUs, and enforcement efforts (audits, investigations, hearings, and sanctions).

Reported Program Integrity Data, 2021-2024 (OMIG)¹⁸²					
Metric	2021	2022	2023	2024	Total (2021-2024)
Recoveries + Cost Savings¹⁸³	\$3.2B	\$3.4B	\$4.0B	\$4.5B	\$15.1B

¹⁷⁶ See response to Request 21, *supra*, for details on screening process for provider enrollment.

¹⁷⁷ N.Y. State Division of the Budget, *NYS Enacted Budget Financial Plan Fiscal Year 2025*, 23 (May 2024) <https://www.budget.ny.gov/pubs/archive/fy25/en/fy25fp-en.pdf>.

¹⁷⁸ See OMIG, *Annual Reports*, <https://omig.ny.gov/information-resources/annual-reports>.

¹⁷⁹ See generally, OMIG, *Annual Reports*, <https://omig.ny.gov/information-resources/annual-reports>.

¹⁸⁰ OMIG, *2021 Annual Report* at 48; OMIG, *2022 Annual Report* at 59; OMIG, *2023 Annual Report* at 77; OMIG, *2024 Annual Report* at 75.

¹⁸¹ OMIG, *2021 Annual Report* at 34; OMIG, *2022 Annual Report* at 33–34; OMIG, *2023 Annual Report* at 50–51; OMIG, *2024 Annual Report* at 42.

¹⁸² Reported program integrity data for 2025 will be made available later this year.

¹⁸³ OMIG, *2021 Annual Report* at 3; OMIG, *2022 Annual Report* at 3; OMIG, *2023 Annual Report* at 4, 11; OMIG, *2024 Annual Report* at 4.

Reported Program Integrity Data, 2021-2024 (OMIG)¹⁸²					
Referrals from MCOs¹⁸⁴	900	1,003	1,101	1,169	4,173
Referrals to MFCU¹⁸⁵	202	199	241	454	1,096
Finalized Audits¹⁸⁶	943	1,123	891	702	3,659
Completed Investigations¹⁸⁷	2,930	2,385	2,022	1,828	9,165
Hearings Resolved¹⁸⁸	64	56	44	21	185
Exclusions Issued¹⁸⁹	457	562	395	597	2,011
Self-Disclosures Finalized¹⁹⁰	246	301	480	635	1,662

25. How, including by what metrics, does DOH measure potential FWA risks, and use that information to prioritize prevention, detection, and remediation activity and staffing?

OMIG’s advanced data and technology tools enable it to spot potential FWA risks, which in turn enables OMIG to prioritize prevention, detection, and remediation efforts. OMIG created a dedicated data and analytics unit, the Advanced Analytics Unit (“AAU”), in 2024 to focus on new opportunities to expand or improve efforts to spot FWA by analyzing data patterns.¹⁹¹ AAU assesses claims data from the Medicaid Data Warehouse (“MDW”)—where all Medicaid claims are entered—to identify improper payments and create detailed data sets that investigators use to target problem areas, provide audit sampling claim packages that auditors use to apply audit protocols to claim documentation, or to provide target reports for investigators.¹⁹² The AAU applies data visualization, complex statistical modeling, and machine learning across agency projects to detect FWA in the Medicaid system.¹⁹³

For instance, AAU’s data extracts allow execution of system match audits, which identify recovery issues within MDW.¹⁹⁴ This process spots duplicate encounter and fee-for-service

¹⁸⁴ OMIG, 2021 Annual Report at 34; OMIG, 2022 Annual Report at 36; OMIG, 2023 Annual Report at 51; OMIG, 2024 Annual Report at 42.

¹⁸⁵ OMIG, 2021 Annual Report at 9; OMIG, 2022 Annual Report at 34; OMIG, 2023 Annual Report at 50; OMIG, 2024 Annual Report at 4.

¹⁸⁶ OMIG, 2021 Annual Report at 23; OMIG, 2022 Annual Report at 21; OMIG, 2023 Annual Report at 34; OMIG, 2024 Annual Report at 29.

¹⁸⁷ OMIG, 2021 Annual Report at 9; OMIG, 2022 Annual Report at 9; OMIG, 2023 Annual Report at 55; OMIG, 2024 Annual Report at 40.

¹⁸⁸ OMIG, 2021 Annual Report at 44; OMIG, 2022 Annual Report at 50; OMIG, 2023 Annual Report at 67; OMIG, 2024 Annual Report at 4.

¹⁸⁹ OMIG, 2021 Annual Report at 52; OMIG, 2022 Annual Report at 62; OMIG, 2023 Annual Report at 82; OMIG, 2024 Annual Report at 40.

¹⁹⁰ OMIG, 2021 Annual Report at 49; OMIG, 2022 Annual Report at 14; OMIG, 2023 Annual Report at 24; OMIG, 2024 Annual Report at 24.

¹⁹¹ OMIG, 2024 Annual Report at 27.

¹⁹² See *id.* at 26

¹⁹³ *Id.* at 27

¹⁹⁴ *Id.* at 26.

payments, identifies fee-for-service pharmacy claims submitted by excluded pharmacists and the total Medicaid payments made, and targets likely overpayments for Certified Home Health Agency fee-for-service episodic payment system claims. Further, data extracts allow capitation-based audit packages, which identify capitation claims paid to MCOs for potential recovery. This includes, for example, identifying capitation claims paid after an individual's date of death according to New York vital statistics files and other resources. Additionally, investigation-support reports produced by data extracts help identify new targets for investigation. For example, these processes can identify transportation claims that do not have a corresponding medical visit.

In 2025, AAU also implemented a system crosswalk table tool that analyzes metrics related to the data OMIG uses. This will improve OMIG's reports on research efforts, as well as its ability to devote resources to Medicaid programs with high investigation volumes, and those that have historically received less attention. Additionally, AAU monitors and reports on instances of high-cost limited distribution drugs, high-dollar national drug code claims, excessive mileage and tolls, restricted recipient utilization, "impossible days" where providers claimed more hours than possible to perform in a day, and excessive DME units for adults.

To further help identify risk areas for investigation, OMIG's Bureau of Business Intelligence ("BBI") processes between 2,000 and 3,000 Data Request Forms each year, which seek data-based responses to questions regarding providers, recipients, and known or suspected FWA schemes. To strengthen efforts to prevent and remediate FWA, OMIG uses an abbreviated self-disclosure process for claims that were voided or adjusted to repay Medicaid, and employs pre-payment verification systems.¹⁹⁵

BBI further collaborates with HFPP,¹⁹⁶ demonstrating OMIG's and HFPP's mutual interest in identifying and reducing FWA across the healthcare sector. The HFPP liaison for OMIG regularly monitors and reviews the data and information HFPP receives from its members for any relevance to New York Medicaid recipients or providers, retrieves and curates any supporting evidence of the allegations, and refers the information to the appropriate OMIG bureau. Relevant trends and information relayed by HFPP are used by OMIG to open new audits or investigations.

OMIG also participates in the Interstate Data Analytics Initiative, which is a multi-state collaboration to develop innovative analytic methods, tools, and systems to detect suspected fraudulent behavior. This partnership focuses on analyzing both effective and ineffective fraud

¹⁹⁵ OMIG, *Abbreviated Self-Disclosure Process*, <https://omig.ny.gov/abbreviated-self-disclosure-process>; OMIG, *2024 Annual Report* at 46.

¹⁹⁶ HFPP is a public/private partnership between federal and state agencies, law enforcement, private health insurance plans, employer organizations, and healthcare anti-fraud associations focused on identifying FWA trends and methods to combat FWA.

detection efforts, which helps OMIG prioritize initiatives that will accurately and reliably detect suspected fraudulent behavior.

OMIG is also working to leverage artificial intelligence and machine learning capabilities to improve its efficiency related to data analysis, while maintaining its strict data privacy and security standards. And OMIG is developing Tableau dashboards to monitor utilization, outliers, relationships, ownership, and control. Using and developing cutting-edge technology demonstrates OMIG's commitment to proactive oversight, efficient identification of potential FWA, and responsible stewardship of Medicaid funds.

Targeted Oversight Questions to Address High-Risk Billing Patterns and Systemic Vulnerabilities in New York State Medicaid

26. Does DOH undertake any fraud investigation or oversight specifically related to the below list of five high-risk services, and if so, what activities has the state undertaken?

DOH and OMIG employ multiple internal oversight mechanisms to identify and address FWA before a referral for investigation is ever necessary. As discussed in more detail in response to Request 30, DOH and OMIG utilize data analytics and dashboards to monitor real-time data week-to-week.¹⁹⁷ DOH also partners with third-party contractors to monitor providers in Non-Emergency Medical Transportation ("NEMT") and CDPAP, receiving regular reports on utilization and other key metrics. The State refers CMS to its responses to Requests 6, 25, 28, 30, 32, 33, 34, and 35 for further information on its internal controls dedicated to detecting FWA.

When DOH identifies a concern, it refers those suspicions or allegations of fraud to OMIG for investigation.¹⁹⁸ OMIG has undertaken fraud investigations and oversight of these five service areas, as discussed herein. OMIG has been successful in investigating and identifying fraud, and recovering fraudulently gained funds in these service areas. Overall, from 2021 through 2025, OMIG's investigation unit opened more than 3,900 subjects in these service areas, leading to 548 referrals, 896 pre-payment review requests, and 320 education letters issued. In that same period, OMIG's audit division initiated and finalized over 500 audits in these areas, identifying over \$98 million in overpayments.

In November 2024, CMS issued its findings for the Payment Error Rate Measurement Review for the New York Medicaid Program for the 2024 review year.¹⁹⁹ Not only did CMS determine that the New York Medicaid estimated federal improper payment rate fell well below the national combined rate,²⁰⁰ the medical review component's random sample of Medicaid claims

¹⁹⁷ See response to Request 30, *infra*.

¹⁹⁸ See response to Request 4, *supra*.

¹⁹⁹ CMS, 2024 Payment Error Rate Measurement (PERM) Program Medicaid Improper Payment Rates, <https://www.cms.gov/files/document/2024-perm-medicaid-improper-payment-rates.pdf> (last updated Nov. 2024).

²⁰⁰ OMIG, 2024 Annual Report at 11.

showed very few New York claims in error, even in these high-risk areas. And of those claims that were found in error, nearly all were already under investigation by the MFCU.

As discussed in response to Requests 2 and 7, MCOs also conduct mandatory program integrity functions, including oversight of the five service areas identified by CMS. The specific integrity activities vary by type of MCO and service area. Generally, these activities include auditing and investigating providers, educating providers on relevant regulations and requirements, and receiving self-disclosures from providers.²⁰¹ Additional details of the State's efforts for each service area discussed in CMS's letter are described further below.

Adult Day Care Services

New York Medicaid provides for both Social Adult Day Care ("SADC") and Adult Day Health Care ("ADHC"). SADC is a benefit available in the Managed Long-Term Care benefit package and plays a role in addressing the social, functional, and nutritional needs of older adults. These programs support participants who wish to remain in their communities by providing structured daytime services and supervision, while also offering essential respite and support for family caregivers. This variety of long-term care services for functionally impaired individuals may be delivered in congregate, community, or home settings.²⁰² SADC is designed to improve social determinants of health, provide respite and support to caregivers, reduce loneliness and social isolation, and help working caregivers balance employment and caregiving responsibilities.²⁰³ Similarly, ADHC provides a variety of long-term care services that are medically supervised, including nursing, transportation, physical therapy, medical social services, rehabilitation, leisure activities, and socialization, among others.²⁰⁴

In 2015, New York State implemented a revised SADC certification process that requires SADCs contracted with MLTC plans to receive certification through OMIG. Additionally, DOH established comprehensive tracking of all SADCs contracted with MLTC plans beginning in 2021, as discussed in the State's response to Request 30. In 2025, DOH reviewed 418 SADCs for HCBS compliance, requiring remediation where needed. Additionally, between 2021 and 2025, OMIG investigated 387 subjects associated with 324 cases related to SADC. Of these cases, it referred over 100 SADC cases to MFCU for law enforcement action.

²⁰¹ See responses to Request 2, 7, *supra*.

²⁰² NYSOFA, *Social Adult Day Services (SADS): Program Description*, <https://aging.ny.gov/social-adult-day-services-sads>.

²⁰³ NYSOFA, *Social Adult Day Services (SADS): Program Description*, <https://aging.ny.gov/social-adult-day-services-sads>.

²⁰⁴ DOH, *Adult Day Health Care*, https://www.health.ny.gov/health_care/medicaid/program/longterm/addc.htm.

Personal Care Services, including those Covered by 1905, 1915, and 1115

In New York, CDPAP and PCS are both Medicaid services that provide home care for individuals who need assistance.²⁰⁵ Both programs are designed to assist patients with maintaining independence and remaining in their homes, but the types of services provided and who can provide those services are different between the two programs.²⁰⁶

As explained in greater detail in response to Request 48, PCS are provided by licensed and professionally supervised PCAs through licensed home care services agencies.²⁰⁷ By contrast, CDPAP empowers the consumer to hire, train, and manage their own PA to perform various care tasks, subject to some limitations.²⁰⁸

Investigation and oversight of these programs are conducted on a number of levels. OMIG performs post-payment audits of both PCS providers²⁰⁹ as well as the SFI who manages the administration of PA wages and benefits.²¹⁰ As mentioned in the introduction to this letter, New York recently shifted from a network of over 600 fiscal intermediaries in CDPAP to a single FI, significantly lowering administrative costs to the program and enhancing DOH oversight capabilities. DOH routinely interacts with local districts and MCOs, participating in monthly meetings and responding to questions. DOH conducts reviews of local district activities for the services when they are provided in fee-for-service Medicaid. DOH maintains a tracker for the monitoring of local district compliance with desk reviews and follow-up on corrective action plans.

Behavioral Health Services

Several types of Behavioral Health Services are available under New York Medicaid. Many types of Behavioral Health Services are available under Medicaid Managed Care, though some services are available only through fee-for-service Medicaid, such as Certified Community Behavioral Health Clinics (“CCBHC”) and residential treatment services.²¹¹

As discussed previously, the State disagrees with CMS’s contention that the magnitude of utilization of behavioral health psychotherapy codes warrants additional scrutiny. This growth in

²⁰⁵ DOH, *Consumer Directed Personal Assistance Program (CDPAP)*, https://www.health.ny.gov/health_care/medicaid/program/longterm/cdpap, (last updated Feb. 2026).

²⁰⁶ DOH, *Consumer Directed Personal Assistance Program (CDPAP)*, https://www.health.ny.gov/health_care/medicaid/program/longterm/cdpap, (last updated Feb. 2026).

²⁰⁷ 18 N.Y.C.R.R. § 505.14.

²⁰⁸ *Id.* at § 505.28.

²⁰⁹ OMIG, *Audit Protocol – Consumer Directed Personal Assistance Program*, (Dec. 9, 2020), <https://omig.ny.gov/media/59921>; OMIG, *Audit Protocol – Personal Care Aides*, (Dec. 5, 2018), <https://omig.ny.gov/media/54161>.

²¹⁰ OMIG, *Audit Protocol – Consumer Directed Personal Assistance Program*, (Dec. 9, 2020), <https://omig.ny.gov/media/59921>.

²¹¹ OMH, *New York State Medicaid Managed Care Behavioral Health Billing and Coding Manual* (Oct. 2025), <https://omh.ny.gov/omhweb/bho/harp-mainstream-billing-manual.pdf>.

utilization is expected: over the past five years, CMS has implemented a series of policy and payment initiatives which deliberately expanded access to mental health and substance use disorder services across Medicaid, Medicare and CHIP.²¹² A central component of these efforts has been the expansion of the CCBHC model.²¹³ CMS has supported states in implementing and expanding CCBHCs, which are required to provide a comprehensive range of behavioral health services, including psychotherapy, using a prospective payment system designed to support sustainable, high-quality care.²¹⁴ In fact, New York was one of the original states awarded a grant for the CCBHC demonstration initiative in 2017 and subsequently received expansion awards throughout the demonstration. By expanding the demonstration to additional states and sustaining the program through approved Medicaid state plans, CMS has helped increase the availability of community-based behavioral health services.²¹⁵ CMS has also broadened the behavioral health workforce and modernized coverage policies to improve access to care including increased access to the 988 Suicide & Crisis Lifeline,²¹⁶ expanding telehealth coverage for BH services,²¹⁷ and establishing Medicare coverage for intensive outpatient behavioral health programs as examples.²¹⁸ Nevertheless, both OMH and OMIG conduct oversight activities related to Behavioral Health Services. OMH conducts routine oversight activities as the licensing authority for most mental health providers.²¹⁹ In this role, OMH assesses compliance with regulatory and Medicaid program requirements, including service documentation, treatment planning, and utilization review.²²⁰ OMH also utilizes enhanced provider monitoring processes to address identified compliance or fiscal concerns and refers suspected FWA to OMIG or MFCU, as appropriate.

Additionally, Behavioral Health Services are subject to utilization and reimbursement system controls, including psychotherapy service thresholds in fee-for-service Medicaid, and utilization review conducted by Medicaid managed care plans, which includes review of coding

²¹² CMS, *CMS Behavioral Health Strategy*, (May 2022), <https://www.cms.gov/files/document/cms-behavioral-health-strategy.pdf>; CMS, *Mental Health and Substance Use Disorder Action Plan: Overview* (July 2023),

<https://www.medicaid.gov/medicaid/benefits/downloads/cmcs-mntl-helth-substnce-disrdr-actn-plan-overview.pdf>.

²¹³ SAMHSA, *Section 223: Certified Community Behavioral Health Clinics*, <https://www.samhsa.gov/communities/certified-community-behavioral-health-clinics/section-223> (last updated Mar.23, 2026).

²¹⁴ *Id.*

²¹⁵ Press Release, CMS, *Biden-Harris Administration Expands Access to Mental Health and Substance Use Services with Addition of 10 New States to CCBHC Medicaid Demonstration Program*, (June 4, 2024),

<https://www.cms.gov/newsroom/press-releases/biden-harris-administration-expands-access-mental-health-and-substance-use-services-addition-10-new>.

²¹⁶ CMS, *988 Suicide & Crisis Lifeline*, <https://www.cms.gov/digital-service/988>, (last updated Apr. 30, 2025).

²¹⁷ CMS, *CMS Behavioral Health Strategy*, (May 2022), <https://www.cms.gov/files/document/cms-behavioral-health-strategy.pdf>.

²¹⁸ CHCS, *New Changes to Intensive Outpatient Program Coverage* (July 2024), <https://www.chcs.org/resource/new-changes-to-intensive-outpatient-program-coverage>.

²¹⁹ N.Y. Mental Hygiene Law §§ 31.02, 31.04, 31.07; 14 N.Y.C.R.R. §§ 551, 553.

²²⁰ See e.g., 14 N.Y.C.R.R. §§ 599.6, 599.10, 599.11 (regulatory requirements for outpatient mental health treatment and rehabilitation services).

practices.²²¹ The State also utilizes data tools to identify patterns for further review, as explained in DOH’s response to Request 33.²²²

The volume of psychotherapy services has logically increased in the State due to growing community need, particularly since New York was the first epicenter of the COVID 19 pandemic in the U.S. and caused significant challenges for youth, increased loneliness, and social isolation.²²³ Additionally, psychotherapy is the most common intervention in mental health both in the private and public sectors. It is often the first line or “front door” for mental health interventions and in highest demand for individuals and families seeking support for mental health crises. Psychotherapy can be provided for a short period of time (several sessions) to longer periods based on individual needs and severity of symptoms. Still, psychotherapy must be medically necessary based on identified mental health conditions, and it is provided only by licensed individuals or as part of a multi-disciplinary team supervised by licensed professionals.

Separately, OMIG performs post-payment audits of an array of behavioral health service programs, including programs overseen by OMH, New York’s Office of Addiction Services and Supports (“OASAS”), and OPWDD.²²⁴ From 2021 to 2025, OMIG finalized 352 audits related to behavioral health services with \$33.3 million in identified overpayments.

As noted on OMIG’s website, the agency is actively developing audit protocols and, upon completion, will begin audits of additional behavioral health programs, including Children's HCBS, Children's Family and Treatment and Support Services (“CFTSS”), and ABA.²²⁵ However, the agency already reviews and investigates all allegations received pertaining to these areas to ensure that there is continued oversight within these programs.

Non-Emergency Medical Transportation

The New York State Medicaid Transportation program ensures Medicaid members can get to and from their medical appointments at no cost to them.²²⁶ The program includes, among other things, NEMT for pre-scheduled trips to primary care appointments and the dentist.²²⁷ The

²²¹ OMH, *14 N.Y.C.R.R. Part 599: Mental Health Outpatient Treatment and Rehabilitative Services—Medicaid Billing and Fiscal Guidance*, (Nov. 2023), https://omh.ny.gov/omhweb/clinic_restructuring/docs/mhotrs_billing_and_fiscal_guidance.pdf.

²²² See response to Request 33, *infra*.

²²³ Sana Malik et al., *Young Adults at the National Epicenter of the COVID-19 Outbreak: Understanding the Impact and Future Challenges of Social Distancing on Mental Health Outcomes*, 21 Int’l J. Env’t Rsch. & Pub. Health art. 33 (2024), <https://doi.org/10.3390/ijerph21010033>; Abosede Akinkuowo et al., *Loneliness, Emotional Support, and the Mental Health of Young Adults and Their Parents in New York During the COVID-19 Pandemic*, 24 BMC Psychiatry art. 305 (2024), <https://doi.org/10.1186/s12888-024-06305-x>.

²²⁴ OMIG, *Audit Protocols*, <https://omig.ny.gov/audit/audit-protocols>, (last updated Apr. 2026).

²²⁵ OMIG, *New York State Office of the Medicaid Inspector General 2026 Work Plan*, <https://omig.ny.gov/new-york-state-office-medicare-inspector-general-2026-work-plan>.

²²⁶ DOH, *Medicaid Transportation Overview*, https://www.health.ny.gov/health_care/medicaid/members/medtrans_overview.htm, (last updated Feb. 2026).

²²⁷ *Id.*

program does not provide rides to non-medical locations, such as pharmacies, gyms, schools, or grocery stores.²²⁸

Consistent with federal and state regulations,²²⁹ DOH contracts with MAS, a transportation broker, to administer NEMT.²³⁰ MAS schedules trips, manages contact centers, conducts utilization reviews, and performs other administrative functions for the program.²³¹ MAS contracts directly with transportation providers to develop an adequate network, ensure compliance with transportation network driver and vehicle requirements, and negotiate fee-for-service transportation provider reimbursement.²³²

Several programmatic safeguards are in place to prevent, detect, and address FWA in NEMT services. First, MAS carries out program integrity functions. Among these responsibilities, MAS is obligated to receive, investigate, and resolve complaints from Medicaid enrollees, medical providers, and transportation vendors.²³³ It also refers identified potential abuse to DOH and performs quality assurance surveys.²³⁴

Second, NEMT services generally require prior authorization from MAS before transportation expenses are incurred.²³⁵ In most cases, approval must be obtained prior to each trip (or round-trip) taken by the Medicaid enrollee, though a standing order prior approval may be granted in certain circumstances for an extended period of time.²³⁶

Third, DOH requires all transportation providers to comply with Global Positioning System (“GPS”) requirements for all trips.²³⁷ Since April 3, 2023, transportation providers must submit trips starting points, endpoints, and all GPS coordinates along the trip to MAS.²³⁸ DOH

²²⁸ *Id.*

²²⁹ 42 CFR § 440.170(a) (providing for the establishment of NEMT brokerage program); 18 N.Y.C.R.R. § 505.10.

²³⁰ DOH, *Medicaid Transportation Overview*,

https://www.health.ny.gov/health_care/medicaid/members/medtrans_overview.htm, (last updated Feb. 2026). MAS assumed Medicaid Transportation Broker responsibilities for all counties except Nassau and Suffolk on August 1, 2023; those counties transitioned to MAS on December 1, 2023. DOH, *Medicaid Transportation Policy Manual*, 13 (Aug. 25, 2023)

https://www.emedny.org/providermanuals/transportation/pdfs/transportation_manual_policy_section.pdf.

²³¹ DOH, *Medicaid Transportation Overview*,

https://www.health.ny.gov/health_care/medicaid/members/medtrans_overview.htm, (last updated Feb. 2026).

²³² DOH, *Medicaid Transportation Policy Manual*, 13 (Aug. 25, 2023),

https://www.emedny.org/providermanuals/transportation/pdfs/transportation_manual_policy_section.pdf.

²³³ *Id.* at 14.

²³⁴ *Id.*

²³⁵ *Id.*

²³⁶ *Id.* at 13.

²³⁷ DOH, *Upcoming GPS Compliance Requirements for NYS Medicaid Non-Emergency Medical Transportation (NEMT) Providers*, (Feb. 3, 2023), <https://wp2.medanswering.com/wp-content/uploads/2024/05/NYS-GPS-Requirement.pdf>; DOH, *Medicaid Transportation Policy Manual*, 24 (Aug. 25, 2023)

https://www.emedny.org/providermanuals/transportation/pdfs/transportation_manual_policy_section.pdf.

²³⁸ *Id.*

implemented this requirement specifically to increase program integrity and assist in the reduction of FWA, among other goals.²³⁹

Fourth, DOH works with OMIG by referring potential fraud for further investigation, as discussed in response to Request 4. Because transportation has been one of the fastest-growing Medicaid service categories from both a provider enrollment and cost perspective,²⁴⁰ OMIG has identified this area for enhanced oversight.²⁴¹ OMIG routinely conducts CVRs, pre-payment reviews and post-payment audits of NEMT providers covering ambulette, livery, and taxi services.²⁴² Between 2021 and 2025, OMIG completed a total of 1931 NEMT provider investigations, referring 293 providers to MFCU. OMIG also finalized 40 NEMT provider audits that identified \$29.3 million in overpayment.

Additionally, DOH and OMIG play a critical role in identifying FWA in cases that have ultimately led to convictions and restitution. Several recent investigations and convictions out of the MFCU have explicitly expressed gratitude to both DOH and OMIG for their assistance and cooperation in high dollar investigations. For example, DOH and OMIG played a significant role in the January 2026 conviction of and restitution paid by a transportation company owner for stealing more than \$1 million from New York Medicaid, which was highlighted in a DOJ press release announcing the conviction.²⁴³ DOH and OMIG routinely play a significant role in prosecuting Medicaid-related FWA.²⁴⁴

²³⁹ *Id.*

²⁴⁰ OMIG, *2021 Annual Report* at 37.

²⁴¹ OMIG, *2021 Annual Report* at 38.

²⁴² See OMIG, *Audit Protocol – Transportation (Ambulette)*, (rev. June 18, 2025), <https://omig.ny.gov/media/92261>; OMIG, *Audit Protocol – Taxi and Livery*, (rev. June 18, 2025), <https://omig.ny.gov/media/92266>.

²⁴³ N.Y. Att’y Gen., *Conviction and Sentencing of Suffolk County Transportation Company Owner for Stealing Over \$1 Million from Medicaid*, (Jan. 14, 2026), <https://ag.ny.gov/press-release/2026/attorney-general-james-announces-conviction-and-sentencing-suffolk-county> (announcing conviction and 4.5-year prison sentence of owner of Jim Jim Rentals, Inc., and restitution of approximately \$1.5 million for fraudulent Medicaid transportation claims).

²⁴⁴ See, e.g., N.Y. Att’y Gen., *Medical Transportation Industry on Notice, Announces New Actions to Stop Ongoing Fraud* (Jan. 8, 2025), <https://ag.ny.gov/press-release/2025/attorney-general-james-puts-medical-transportation-industry-notice-announces-new> (issuing cease-and-desist notices to fifty-four transportation companies, announcing settlements totaling approximately \$847,000, and warning of potential criminal and civil penalties for continued Medicaid overbilling, with acknowledgment of cooperation from DOH, OMIG, and MAS); N.Y. Att’y Gen., *Sweeping Takedown of Transportation Companies for Defrauding Medicaid*, (June 30, 2025), <https://ag.ny.gov/press-release/2025/attorney-general-james-secures-more-13-million-sweeping-takedown-transportation> (reporting settlements with sixteen transportation companies totaling approximately \$13 million, new lawsuits against seven companies, and criminal convictions of two individuals and their companies); N.Y. Att’y Gen., *Convictions and Sentences of Five Taxi Company Owners in Orange and Rensselaer Counties for Stealing Millions from Medicaid*, (Dec. 5, 2024), <https://ag.ny.gov/press-release/2024/attorney-general-james-announces-convictions-and-sentences-five-taxi-company> (announcing convictions and sentences for theft of approximately \$8.85 million by five individuals and seven medical transportation companies through Medicaid fraud schemes); N.Y. Att’y Gen., *Convictions of Orange County Transportation Company Owners for Stealing More Than \$2.1 Million from Medicaid*, (Oct. 22, 2024), <https://ag.ny.gov/press-release/2024/attorney-general-james-announces-convictions-orange-county-transportation> (announcing guilty pleas by the owners of DYD Universe Inc. for theft of more than \$2.1 million from the Medicaid program).

Home Health Services

Licensed Home Care Services Agencies (“LHCSA”) and Long Term Home Health Care Programs (“LTHHCP”) provide part-time, intermittent, skilled services that are of a preventative, therapeutic, rehabilitative, health guidance and/or supportive nature to persons at home.²⁴⁵

These types of services may include: nursing services, home health aide services, medical supplies, physical or occupational therapy, speech pathology, nutritional services, and medical social services.²⁴⁶

Home Health Aides are certified individuals who have completed an approved home health training program.²⁴⁷ These aides assist patients with health-care tasks, assistance with personal hygiene, housekeeping, and other supportive tasks in their home.²⁴⁸ The services are supervised by a registered professional nurse or therapist, ordered by a licensed physician or authorized practitioner, and included in a plan of care.²⁴⁹

OMIG performs post-payment audits of LHCSAs and Long Term Home Health Care providers.²⁵⁰ OMIG also performs post-payment audits of NHTD services providers and TBI services providers, both of which provide Home Health Aide services and are covered under a 1915c waiver.²⁵¹

Additionally, to ensure that NYS Medicaid remains the payor of last resort, OMIG contracts with UMass to perform a Medicare Home Health Appeals Initiative.²⁵² Under this initiative, providers are directed to demand bill Medicare for HHCS rendered to dual eligible Medicare/Medicaid beneficiaries that have previously been paid by Medicaid, demonstrating New York’s vigilant commitment to ensuring that costs are properly attributed.²⁵³ UMass pursues coverage for Medicare payment denials via the federal Medicare appeals process.²⁵⁴ Provider audits are initiated in instances where providers fail to comply with demand billing requirements or fail to reimburse NYS Medicaid as directed, after Medicare has remitted payment.²⁵⁵

²⁴⁵ DOH, *Certified Home Health Agencies (CHHAs)*, https://profiles.health.ny.gov/home_care/pages/chha.

²⁴⁶ *Id.*

²⁴⁷ DOH, *Home Care Services*, https://profiles.health.ny.gov/home_care/services.

²⁴⁸ *Id.*

²⁴⁹ *Id.*

²⁵⁰ OMIG, *Audit Protocol – Certified Home Health Agency (CHHA)*, (rev. June 26, 2018), <https://omig.ny.gov/media/53991>; OMIG, *Audit Protocol – Health Home*, (May 31, 2023), <https://omig.ny.gov/media/83136>.

²⁵¹ OMIG, *Audit Protocol – Nursing Home Transition and Diversion Waiver (NHTD)*, (rev. Dec. 17, 2025), <https://omig.ny.gov/media/97676>; OMIG, *Audit Protocol – Traumatic Brain Injury*, (rev. Mar. 9, 2018), <https://omig.ny.gov/media/59981>.

²⁵² OMIG, *2023 Annual Report* at 46.

²⁵³ *Id.*

²⁵⁴ *Id.*

²⁵⁵ *Id.*

27. What steps is DOH taking to investigate the overlap between top providers of the high-risk service categories identified above, to ensure there are no improper kickback or steering arrangements?

New York respectfully refers CMS to its responses to Requests 16, 19, 20, 21, 25, and 26 for information on how DOH and OMIG monitor providers of these services.

28. How frequently does the state conduct post-payment reviews or audits for the five high-risk service categories identified above?

New York respectfully refers CMS to its response to Request 26. In addition, New York provides the following in response:

OMIG routinely conducts post-payment audits of four of the five service areas identified by CMS in Request 26.²⁵⁶ Since January 1, 2021, OMIG initiated over 600 audits and finalized over 500 audits of providers offering services in these areas.

A full list of all the areas and services that OMIG audits, as well as the specific audit protocols used for each area, is available on OMIG’s website.²⁵⁷ OMIG has specific protocols for NEMT services,²⁵⁸ PCS²⁵⁹ and CDPAP,²⁶⁰ Home Health Care,²⁶¹ and various behavioral health services.

The State also has significant controls in place to monitor SADC providers. SADC providers are required to complete online certification. In addition, the State employs consistent oversight of SADC providers via their contracts with Managed Long Term Care Plans. In September 2025 DOH updated the Managed Long Term Care Policy providing guidance and instructions to MLTCs to improve oversight of their contracted SADCs. The MLTCs must require SADCs to obtain an organizational National Provider Identifier (“NPI”) via the National Plan and Provider Enumeration System, and the MLTCs must report the validated NPIs to DOH on their quarterly Provider Network Data System (“PNDS”) report. These controls are in addition to other existing requirements for SADC providers, as noted on the certification site and in the DOH guidance, and will serve to enhance OMIG’s program integrity efforts in this area. OMIG’s oversight

²⁵⁶ See OMIG, *Audit Protocol – Ambulette*, (rev. June 18, 2025), <https://omig.ny.gov/media/92261>; OMIG, *Audit Protocol – Taxi and Livery*, (rev. June 18, 2025), <https://omig.ny.gov/media/92266>; OMIG, *Audit Protocol – Personal Care Aides (PCA)*, (Dec. 5, 2018), <https://omig.ny.gov/media/54161>; OMIG, *Audit Protocol – Consumer Directed Personal Assistance Program*, (Dec. 9, 2020), <https://omig.ny.gov/media/59921>; OMIG, *Audit Protocol – Certified Home Health Agency (CHHA)*, (June 26, 2018), <https://omig.ny.gov/media/53991>.

²⁵⁷ See OMIG, *Audit Protocols*, <https://omig.ny.gov/audit/audit-protocols>, (last updated Apr. 2026).

²⁵⁸ OMIG *Audit Protocol – Ambulette*, (rev. June 18, 2025), <https://omig.ny.gov/media/92261>; OMIG, *Audit Protocol – Taxi and Livery*, (rev. June 18, 2025), <https://omig.ny.gov/media/92261>.

²⁵⁹ OMIG, *Audit Protocol – Personal Care Aides*, (Dec. 5, 2018), <https://omig.ny.gov/media/54161>.

²⁶⁰ OMIG, *Audit Protocol – Consumer Directed Personal Assistance Program*, (Dec. 9, 2020), <https://omig.ny.gov/media/59921>.

²⁶¹ OMIG, *Audit Protocol – Certified Home Health Agency (CHHA)*, (June 26, 2018), <https://omig.ny.gov/media/53991>.

activities have resulted in law enforcement actions,²⁶² including through collaboration with federal law enforcement, as well as exclusions from the Medicaid program.

In addition, OMIG has plans to commence audit activities of additional programs that fall within the five service areas on which CMS is focused.²⁶³ OMIG is actively developing audit protocols for the following areas:

1. Applied Behavior Analysis
2. Certified Community Behavioral Health Clinics
3. Children's HCBS Waiver Services
4. Children and Family Treatment and Support Services
5. Adult Day Health Care²⁶⁴

Finally, MCOs also conduct post-payment reviews and audits, as discussed in response to Request 2.²⁶⁵ This information is reported to OMIG through Provider Investigative Reports, which reflect activities that result in a recovery.

29. What are DOH's total annual overpayment recoveries for the past 5 years, and what proportion relates to each high-risk service category identified in this letter?

OMIG reports the total amount of money it recovers across multiple activity areas each year in its annual report.²⁶⁶ These activity areas include Managed Care, Third-Party Liability, RAC, Provider, Self-Disclosure, and others.²⁶⁷

From 2021 to 2025, OMIG recovered \$3.924 billion. Since 2021, it has recovered the following amounts across all Medicaid services:

Year	Total Recoveries
2021	\$713,722,810 ²⁶⁸
2022	\$819,094,818 ²⁶⁹
2023	\$872,047,552 ²⁷⁰
2024	\$752,398,131 ²⁷¹
2025	\$767,182,500*

²⁶² U.S. Att'y's Office, Eastern District of New York, *Two Doctors, Two Licensed Physical Therapists, a Pharmacist, and Four Pharmacy Owners and Operators Among Those Charged in Brooklyn as Part of National Health Care Fraud Takedown*, (Sept. 30, 2020), <https://www.justice.gov/usao-edny/pr/two-doctors-two-licensed-physical-therapists-pharmacist-and-four-pharmacy-owners-and-operators-among-those-charged-in-brooklyn-as-part-of-national-health-care-fraud-takedown>.

²⁶³ OMIG, *Audit Protocols*, <https://omig.ny.gov/audit/audit-protocols> (last updated Apr. 2026).

²⁶⁴ *Id.*

²⁶⁵ See 18 N.Y.C.R.R. § 521-2.4(c)(2); DOH, *Medicaid Model Contract*, https://www.health.ny.gov/health_care/managed_care/providers/docs/mmc_fhp_hiv-snp_harp_model_contract.pdf.

²⁶⁶ OMIG, *2021 Annual Report* at 53.

²⁶⁷ *Id.*

²⁶⁸ *Id.*

²⁶⁹ OMIG, *2022 Annual Report* at 63.

²⁷⁰ OMIG, *2023 Annual Report* at 8.

²⁷¹ OMIG, *2024 Annual Report* at 79.

Please note that the (*) indicates the 2025 data is preliminary and subject to change until final publication of the 2025 Annual Report in October 2026.

OMIG recovered \$1.23 billion in total overpayments related to audits and investigations specifically between 2021 and 2025. The table below reflects the amount recovered from audits and investigations in the five service areas identified by CMS, as well as proportion of total recoveries, from 2021 to 2025 by service area:

Service Area	Total Recoveries (2021-2025)	Proportion of Total Recoveries
Personal Care	\$21,180,514	1.72%
Behavioral Health	\$47,778,125	3.87%
NEMT	\$16,193,622	1.31%
Home Health Aide	\$28,578,365	2.32%
Social Adult Day Care	\$44,910	0.00%

30. What data analytics tools or dashboards are currently deployed to flag coding intensity and utilization anomalies across the five high-risk service categories identified above?

DOH and OMIG both utilize data analytics and/or dashboards to oversee the five identified service areas.

DOH

DOH has established dashboards that it utilizes to routinely monitor and identify anomalies for further review in the five programmatic areas of focus, among others. This includes dashboards reviewed for NEMT, Long Term Care, Children's HCBS utilization, and Behavioral Health services.

For NEMT, DOH monitors utilization through a Tableau data visualization tool that department staff use to identify changes in trip volume, miles per trip, number of utilizers, and overall spend. This tool has been in use since 2021, and the data is updated weekly to reflect the newest claims data. The dashboard includes the different views and filtering options to assist in reviewing the data.

DOH also works closely with MAS, the New York Medicaid Transportation Broker, to identify potential FWA within NEMT services. MAS has proprietary software and training tools that have controls built in to assist with ensuring that transportation requests are authorized in accordance with policy guidelines and contractual obligations. These controls cover:

- Eligibility checks – to determine if the enrollee is eligible for the service.
- Medical Reason – the system has controls in place to prohibit requests for non-covered services from being authorized.

- Address validation – the system has controls in place to prohibit requests to locations that do not offer the service requested from being authorized.
- Medical necessity – MAS has controls in place to prohibit a request from being authorized for a mode of transportation that is not pre-approved by a medical provider.

Additionally, MAS provides a monthly report covering several metrics that are reviewed by DOH and MAS staff to flag any unexpected utilization trends. The reports cover the following metrics:

- Call Center Answering Time
- Total Call Hold Time
- Trip Verifications
- Complaint Resolution
- Transportation Provider Network On-Time Trip Performance
- Hospital Discharge
- Declined Trips
- Form 2015 (Appropriate Mode of Transport)
- Trips by Mode and Transportation Provider
- Trip Cancellation Report - Custom Payments
- Public Transit Utilization

MAS also provides a Network Transportation Providers Performance Report to DOH every six months, which is used to monitor the overall performance and capacity of MAS's network and can be used as a benchmark to measure performance over time.

For CDPAP monitoring, DOH contracts with the SFI, PPL, that provides regular reporting of activities. These reports provide insight the DOH did not have prior to the implementation of the SFI including the number of PAs serving consumers within the program, PA compliance with required trainings and health assessments, number of authorized hours, consumer utilization of authorized hours and information regarding the detailed nature of services provided, such as outlier analyses. The reports also detail contract metrics including call center and customer performance metrics, complaint resolution and payroll metrics. DOH monitors this reported information daily, weekly, and monthly, and DOH meets with the SFI regularly to discuss operational activities including emerging data patterns and identified areas for further exploration.

DOH also monitors Long Term Care utilization through a Tableau data visualization tool that permits DOH staff to identify changes in the amount of claims, members, spending, and other metrics year-over-year. The tool has been in use since before 2021 and provides information on several levels, allowing DOH to assess overall utilization, per utilizer per month utilization, and

different geographic views by county, as well as filter for enrollment and new utilizer metrics. Many Long Term Care services are covered by this tool, including Adult Day Care, CDPAP, and Personal Care, among others.

For the Children's Waiver, DOH monitors utilization trends by service, provider and managed care plan. Providers billing a high volume of services in comparison to other providers, or on a per-member basis are prioritized for program reviews. DOH maintains a dashboard to monitor claims data as it becomes available. This dashboard includes views to ascertain total costs, number of claims, number of enrollees, costs per member per month and can be sorted by a variety of variables including target population, age group, member characteristics, managed care plan and provider.

OMIG

OMIG leverages numerous algorithms to flag various utilization anomalies. Across the five service categories, the algorithms analyze likely overpayments for Certified Home Health Agency fee-for-service claims; home health encounters occurring simultaneously with a fee-for-service inpatient stay; excessive toll claims; transportation claims that occur while the Medicaid member is in an inpatient stay; and transportation claims that do not have a corresponding medical visit. The algorithms used to detect utilization anomalies are run using MDW data maintained by DOH, as requested for audit purposes. OMIG is currently exploring the feasibility of providing these reports to OMIG program staff regularly with Tableau dashboards. OMIG prepares guidance documents outlining the parameters for these algorithms and reports.

31. What documentation can the state provide as evidence that Electronic Visit Verification has been implemented and is being used in compliance with the 21st Century Cures Act?

The 21st Century Cures Act, a bipartisan federal statute aimed broadly at medical and health improvements, was signed into law on December 13, 2016.²⁷² The Cures Act impacts biomedical and clinical research, medical device and drug development, mental health and substance use policy, Medicaid program integrity, and health information technology and data access.²⁷³ In furtherance of Medicaid program integrity, the Cures Act introduced the EVV requirement as a payment integrity and service verification mechanism.²⁷⁴ The Cures Act required all states to implement EVV for all Medicaid-funded PCS and HHCS that require an in-home visit by a provider:²⁷⁵ PCS, HHCS, and HCBS, which includes Children's Waiver,

²⁷² 21st Century Cures Act, Pub. L. No. 114-255, 130 Stat. 1039 (2016); DOH, *EVV Program Guidelines and Requirements*, at 4 (Apr. 14, 2022)

https://www.health.ny.gov/health_care/medicaid/redesign/evv/repository/docs/evv_prog_guidelines.pdf.

²⁷³ 21st Century Cures Act, Pub. L. No. 114-255, 130 Stat. 1039 (2016).

²⁷⁴ 21st Century Cures Act, Pub. L. No. 114-255, § 12006, 130 Stat. 1039, 1275–78 (2016).

²⁷⁵ DOH, *EVV Program Guidelines and Requirements*, at 4 (Apr. 14, 2022),

https://www.health.ny.gov/health_care/medicaid/redesign/evv/repository/docs/evv_prog_guidelines.pdf.

NHTD, TBI, and OPWDD (“EVV Providers”).²⁷⁶ Under the Cures Act, EVV systems are required to capture the following information: service type, individual receiving the service, date of service, location of service delivery, individual providing the services, and beginning and end times of the service.²⁷⁷

In line with the implementation deadlines under the Cures Act, New York began requiring EVV for PCS providers in 2021 and for HHCS providers in 2023.²⁷⁸ New York’s agencies work with EVV Providers to ensure their compliance with EVV requirements and identify any barriers to implementation.²⁷⁹ DOH offers extensive compliance resources.²⁸⁰ DOH’s EVV page for providers makes clear that compliance is not optional: “All EVV services are required to have complete EVV data in order to be considered a verified visit. If NYSDOH detects steady non-compliance over time, NYSDOH reserves the right to conduct a compliance review.”²⁸¹ Compliance for EVV Providers includes regular submission of an annual EVV attestation,²⁸² submission of complete and accurate EVV data to the State’s EVV Data Aggregator,²⁸³ and/or cooperation with agency oversight.

Additionally, DOH and OMIG take numerous steps to ensure EVV compliance. For example, providers are required to file an annual attestation to acknowledge EVV compliance.²⁸⁴ If a provider fails to submit a complete and accurate attestation, the provider is referred to OMIG for review.²⁸⁵ DOH and OMIG also use EVV data to identify service discrepancies. Specifically, EVV Providers are required to submit EVV data to the New York State EVV Data Aggregator,

²⁷⁶ DOH, *NY Medicaid Electronic Visit Verification Program (EVV)*, at 2.2, https://www.health.ny.gov/health_care/medicaid/redesign/evv/, (last updated Nov. 2023).

²⁷⁷ DOH, *NY Medicaid Electronic Visit Verification Program (EVV)*, at 2.3, https://www.health.ny.gov/health_care/medicaid/redesign/evv/, (last updated Nov. 2023).

²⁷⁸ DOH, *Electronic Visit Verification Frequently Asked Questions*, https://www.health.ny.gov/health_care/medicaid/redesign/evv/faqs.htm, (last updated Sept. 2024); *EVV Program Guidelines and Requirements*, at 5.

²⁷⁹ DOH, *NY Medicaid Electronic Visit Verification Program Guidelines and Requirements*, (Apr. 14, 2022), https://www.health.ny.gov/health_care/medicaid/redesign/evv/repository/docs/evv_prog_guidelines.pdf; see DOH, *NY Medicaid Electronic Visit Verification Provider and Fiscal Intermediary Info.*, https://www.health.ny.gov/health_care/medicaid/redesign/evv/provider/index.htm, (last updated Sept. 2023).

²⁸⁰ See DOH, *NY Medicaid Electronic Visit Verification Provider and Fiscal Intermediary Info.*, https://www.health.ny.gov/health_care/medicaid/redesign/evv/provider/index.htm, (last updated Sept. 2023).

²⁸¹ DOH, *EVV Frequently Asked Questions*, at 2.1, https://www.health.ny.gov/health_care/medicaid/redesign/evv/faqs.htm, (last updated Sept. 2024).

²⁸² DOH, *Compliance Information*, https://www.health.ny.gov/health_care/medicaid/redesign/evv/compliance/index.htm, (last updated Sept. 2023).

²⁸³ DOH, *NY Medicaid Electronic Visit Verification Program Guidelines and Requirements*, at 9–10 (Apr. 14, 2022), https://www.health.ny.gov/health_care/medicaid/redesign/evv/repository/docs/evv_prog_guidelines.pdf

²⁸⁴ DOH, *EVV Attestation Form Instructions*, https://www.health.ny.gov/health_care/medicaid/redesign/evv/repository/docs/attestation_instructions.pdf; DOH, *NY Medicaid Electronic Visit Verification Program Guidelines and Requirements*, at 13 (Apr. 14, 2022), 24–25, https://www.health.ny.gov/health_care/medicaid/redesign/evv/repository/docs/evv_prog_guidelines.pdf; DOH, *eMedNY, Electronic Visit Verification (EVV)*, <https://www.emedny.org/evv/>.

²⁸⁵ DOH, *NY Medicaid Electronic Visit Verification Program Guidelines and Requirements*, at 7 (Apr. 14, 2022), https://www.health.ny.gov/health_care/medicaid/redesign/evv/repository/docs/evv_prog_guidelines.pdf.

where it is analyzed for reporting and audit purposes.²⁸⁶ OMIG reviews EVV data submitted to the Data Aggregator and identifies discrepancies, such as lack of EVV data and/or EVV data not matching paid claims, and issues provider letters in response.²⁸⁷

DOH is working to improve the efficacy of provider submissions to the Data Aggregator by drafting additional regulations to ensure that EVV data is submitted on a real-time basis after the service is rendered and before the claim is paid. Once the regulations are promulgated, a proposed system edit will take effect that matches claims to EVV data and pends incomplete claims. In addition, New York's transition to an SFI for CDPAP significantly increased oversight, accountability, and transparency for CDPAP services. For example, PPL now leverages EVV data and geolocation validation to prevent improper billing for care.

32. What processes are in place to monitor high-volume providers of personal care, home health, adult day care program, NEMT, and behavioral health services?

New York respectfully refers CMS to its response to Requests 26, 30, and 33. In addition, the State provides this information:

OMIG's audit and investigation teams regularly request utilization reports for various Medicaid services, which can be used to identify the high-volume providers for the five high-risk services. Further, these teams utilize the algorithms detailed in response to Request 30 to identify high-volume providers. Additionally, data obtained for NEMT providers with high-mileage or excessive tolls, which are expected to become an area of focus for OMIG, are reported to the investigations team monthly to identify targets for investigation. While a significant number of transportation audits have been completed and are currently in process, OMIG plans to more narrowly focus on providers with high and unexpected claim amounts for tolls and mileage.²⁸⁸

In addition to regular investigations of high-volume providers across these five high-risk areas, OMIG regularly conducts post-payment audits, which include audits of high-volume providers across these five high risk areas, as discussed in response to Request 26. Each initiated audit project is based on Medicaid claims and encounter data, including any notable changes in the total amount billed, number of recipients per provider, and average length of treatment, during the six-year review period. This is done both at the program and individual provider level. Providers may be selected for post payment audit based on their high billings or outlier billing patterns, audit history such as prior audits with significant findings, few or no previous audits or self-disclosures.

²⁸⁶ DOH, *NY Medicaid Electronic Visit Verification Program Guidelines and Requirements*, at 9–10 (Apr. 14, 2022), https://www.health.ny.gov/health_care/medicaid/redesign/evv/repository/docs/evv_prog_guidelines.pdf.

²⁸⁷ OMIG, *2023 Annual Report* at 12.

²⁸⁸ See OMIG, *Audit Protocol – Ambulette*, <https://omig.ny.gov/media/92261>.

(last updated June 18, 2025); OMIG, *Audit Protocol – Taxi and Livery*, <https://omig.ny.gov/media/92266> (last updated June 18, 2025).

33. How does New York State Medicaid identify and investigate outlier providers with unusually high claim volumes or concentrations of payments in narrow service categories?

DOH program staff regularly review data on billing trends and regular reporting from MAS and PPL to identify providers with unusually high claim volumes, which are then reported to OMIG for investigation. Based on its data monitoring, DOH will request explanations from outlier providers. For instance, if DOH identifies a NEMT provider with unusually high claim volume, DOH coordinates with MAS to review trips for the year and request explanations for the increased volume.²⁸⁹ Where claim volumes are unexpected and unexplained, DOH refers to OMIG.

Monitoring high claim volume has resulted in, for example, successful identification of impossible mileage for driver toll-claims as outliers for investigation and audit.²⁹⁰ A similar process of monitoring high claim volumes is in place for SADC and has yielded numerous referrals.

For mental health services, OMH utilizes various tools to identify patterns for further review. For example, OMH analyzes data from the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES)²⁹¹—a web-based platform that contains comprehensive data on Medicaid claims, data and documents from providers, and other state health administrative data—to identify aberrant service utilization patterns.²⁹² OMH also uses licensing oversight processes, such as utilization review and enhanced provider monitoring, to flag potential outlier providers as they go through the licensing process.²⁹³ When atypical patterns are identified, the State conducts further programmatic review and coordinates with managed care plans or program staff, as appropriate, to prepare a plan of correction and provide technical assistance.²⁹⁴ Where concerns suggest potential FWA, OMH works with OMIG to promote Medicaid program integrity through investigation and oversight.²⁹⁵

Not only does OMIG investigate reports that the other agencies flag, it also applies its own data analytics to DOH databases, including MDW, to identify and review providers with unusually high claim volumes and aberrant billing patterns.²⁹⁶ OMIG currently uses a statewide surveillance and utilization review subsystem called Java Surveillance Utilization Review

²⁸⁹ See DOH, *Medicaid Transportation Policy Manual* at 14, https://www.emedny.org/providermanuals/transportation/pdfs/transportation_manual_policy_section.pdf; responses to Requests 26, 30, *supra*, for more information on the responsibilities of the Transportation Broker.

²⁹⁰ OMIG, *2022 Annual Report* at 37–38.

²⁹¹ OMH, *About PSYCKES*, https://omh.ny.gov/omhweb/psyckes_medicaid/about/.

²⁹² *Id.*

²⁹³ See, e.g., 14 N.Y.C.R.R. §§ 588.12, 595.13(b); see also response to Request 26, *supra*.

²⁹⁴ See, e.g., 14 N.Y.C.R.R. § 588.12.

²⁹⁵ OMH, *Medicaid Fraud and Abuse Notification*, <https://omh.ny.gov/omhweb/guidance/mfa/medicaidfraudabuse.html>.

²⁹⁶ See OMIG, *2021 Annual Report* at 5, 18; OMIG, *2022 Annual Report* at 5, 17; OMIG, *2023 Annual Report* at 8, 27; OMIG, *2024 Annual Report* at 7; see also response to Request 25, *supra*.

System (“J-SURS”), as provided by federal regulations,²⁹⁷ to analyze data and flag outliers based on the number and types of claims submitted by providers.²⁹⁸ Additionally, OMIG conducts System Match and Recovery Audits to identify potentially inappropriate provider claiming patterns.²⁹⁹ These patterns are identified through data analysis of paid claim data sets and further analyzed according to claim type, billing service category, and other service factors such as geography.³⁰⁰ This analytical approach allows OMIG to conduct a comprehensive audit across many providers at once.³⁰¹ In 2023, OMIG finalized 77 audits identifying overpayments of more than \$5.4 million and recovered more than \$5.7 million in this audit area.³⁰²

34. What controls exist to detect upcoding or overuse in behavioral health or personal care services, especially for services with time-bound delivery codes (e.g., 90832, 90834, and T1019)?

There are numerous controls in place that monitor, audit, and prevent upcoding in behavioral health or PCS. First, behavioral health services provided in Medicaid Managed Care plans are rigorously monitored and audited. Medicaid Managed Care plans are permitted to conduct concurrent review for psychotherapy services provided in OMH licensed clinics in excess of 30 visits per year.

OMIG also performs post payment audits of mental health clinics, substance abuse clinics, and OPWDD Article 16 clinics, which include the review of brief (90832) and extended (90834) psychotherapy services to ensure service duration requirements for billed services were adhered to.³⁰³ To do so, OMIG reviews service documentation for a random sample of claims to verify that the minimum duration required was met for the procedure code billed and was documented in accordance with all applicable regulations.³⁰⁴ Where services are determined to be short of the required minimum duration, the amount of the overbilling is disallowed and extrapolated across the universe of claims in the audit.³⁰⁵ OMIG has performed audits of these providers since January 2021 and continues to do so.

Second, OMH has implemented utilization thresholds for psychotherapy services in Medicaid fee-for-service. Under this threshold, payments are reduced by 50% for any visit in excess of

²⁹⁷ 42 C.F.R. § 456.3.

²⁹⁸ OMIG, *2024 Annual Report* at 47; CMS, *Surveillance and Utilization Review Subsystem Snapshot*, (Sep. 2016), <https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/medicaid-integrity-education/downloads/ebulletins-surs.pdf>.

²⁹⁹ OMIG, *2023 Annual Report* at 44.

³⁰⁰ *Id.*

³⁰¹ *Id.*

³⁰² *Id.*

³⁰³ OMIG, *Audit Protocol – OMH Mental Health Outpatient Treatment and Rehabilitative Services* <https://omig.ny.gov/media/90881/download>, (last updated Mar. 6, 2025).

³⁰⁴ See, e.g., OMIG, *Audit – Behavioral Health Servs. North, Inc.*, Audit No. 20-6137 (Oct. 13, 2022), <https://omig.ny.gov/media/79511/download>.

³⁰⁵ See, e.g., OMIG, *Audit – Behavioral Health Servs. North, Inc.*, Audit No. 20-6137 (Oct. 13, 2022), <https://omig.ny.gov/media/79511/download>.

fifty visits per year for anyone under twenty-one years of age. For those twenty-one and older, a 25% reduction applies for visits thirty-one through fifty and a 50% reduction for all visits in excess of fifty. Some exceptions apply, such as for crisis intervention services, complex care management, or services provided as part of an Intensive Outpatient Program.³⁰⁶ Payments are further reduced by 50% for any visit in excess of 50, subject to the same exceptions.³⁰⁷

Third, for CDPAP and PCS, upcoding or overuse dynamics are eliminated by the structure of the program. Payment is available only for PCS or CDPAP services that have received prior authorization by the Local Department of Social Services (“LDSS”) or managed care plan.³⁰⁸ Authorizations for services are determined in advance: each individual receiving PCS or CDPAP has prior authorization for a set amount of service hours. These services must be provided in accordance with the member’s authorization and person centered plan of care, as well as the provider’s contractual agreement with the LDSS or managed care plan or the SFI’s contractual agreement with the DOH.³⁰⁹

Additionally, as discussed in response to Request 26, OMIG performs post-payment audits of PCS providers as well as CDPAP providers, which include the T1019 procedure code. OMIG reviews these services to ensure that time billed matches the service that was provided and that the services are documented in accordance with the relevant rules and regulations.³¹⁰

35. How does DOH use predictive models or algorithms to detect patterns of FWA in community-based services?

As described in the response to Request 25, DOH and OMIG use predictive models, algorithms, and other advanced data analytics tools to detect patterns of FWA across provider types. Community-based services include MLTCs, which provide services to recipients to keep them in their communities, rather than institutionalized. OMIG employs several algorithms across MDW data to identify several indicators of FWA in MLTCs. For example, OMIG uses an algorithm to identify potentially wasteful MLTC capitation payments for recipients without sufficient encounter records to correspond to those payments. Another OMIG algorithm identifies

³⁰⁶ OMH, *14 N.Y.C.R.R. Part 599 Mental Health Outpatient Treatment and Rehabilitative Services: Medicaid Billing and Fiscal Guidance*, 10–11 (Nov. 2023), https://omh.ny.gov/omhweb/clinic_restructuring/docs/mhotrs_billing_and_fiscal_guidance.pdf.

³⁰⁷ *Id.*

³⁰⁸ DOH, *Consumer Directed Personal Assistance Program Provider Manual* (Dec. 22, 2011), https://www.emedny.org/ProviderManuals/CDPAP/PDFS/CDPAP_Policy_Manual.pdf; DOH, *Personal Care Services Program Provider Manual* (2021), <https://www.emedny.org/ProviderManuals/PersonalCare/PDFS/PersonalCareManual-Policy.pdf>.

³⁰⁹ DOH, *Consumer Directed Personal Assistance Program Provider Manual* (Dec. 22, 2011), https://www.emedny.org/ProviderManuals/CDPAP/PDFS/CDPAP_Policy_Manual.pdf; DOH, *Personal Care Services Program Provider Manual* (2021), <https://www.emedny.org/ProviderManuals/PersonalCare/PDFS/PersonalCareManual-Policy.pdf>.

³¹⁰ OMIG, *Audit Protocol – Consumer Directed Personal Assistance Program* (Dec. 9, 2020), <https://omig.ny.gov/media/59921>; OMIG, *Audit Protocol – Personal Care Aides* (Dec. 5, 2018), <https://omig.ny.gov/media/54161>.

wasteful MLTC claims by identifying any fee-for-services claims billed directly to the state that should have been covered under the MLTC capitation rate.

36. What corrective actions are applied when documentation deficiencies or improper billing are identified?

OMH, DOH, and OMIG collaborate to identify and act on documentation deficiencies and improper billing.

DOH and OMH promulgate regulations, issue billing and program guidance, and oversee the standards of care for licensed clinics and other licensed programs.³¹¹ There are numerous requirements in these areas to ensure that submitted documentation supports both the service and claim and that medical necessity is documented.³¹² OMH reviews behavioral health provider practices for due diligence and compliance with documentation requirements and, when OMH identifies deficiencies, it provides notice to the provider.³¹³ Providers must submit and implement a plan of correction, with technical assistance from OMH, if necessary.³¹⁴ If the provider fails to prepare an acceptable plan of correction within a reasonable time, fails to accept technical assistance from OMH, or fails to implement an approved plan of correction, the provider will be deemed in violation of the regulations.³¹⁵ Noncompliant providers may be subject to revocation, suspension, limits to their operating certificate, or fines, and providers seeking reimbursement in excess of reimbursement standards will be identified for DOH to recover any overpaid funds.³¹⁶ In cases with suspected FWA, OMH cooperates with OMIG for investigation and enforcement.³¹⁷

Like OMH, DOH requires providers to maintain records sufficient to verify the services provided and refers suspected FWA cases to OMIG for investigation and enforcement.³¹⁸

OMIG receives referrals from DOH and OMH and conducts audits, reviews, and investigations. When an OMIG investigation identifies documentation discrepancies and improper billing practices, OMIG may issue findings, disallow claims, and seek repayment of Medicaid funds.³¹⁹ And when OMIG takes formal administrative enforcement action (via a Notice of Agency Action), it may impose a sanction, censure, or exclusion, in addition to recovering any overpayment resulting from the documentation deficiencies or improper billings identified.³²⁰

³¹¹ See 14 N.Y.C.R.R. §§ 587, 593, 599.

³¹² See, e.g., 14 N.Y.C.R.R. §§ 587.22(a), 593.8(b).

³¹³ 14 N.Y.C.R.R. §§ 587.22, 593.8.

³¹⁴ 14 N.Y.C.R.R. § 593.8(d).

³¹⁵ 14 N.Y.C.R.R. § 593.8(e).

³¹⁶ 14 N.Y.C.R.R. § 593.8(f).

³¹⁷ OMH, *Medicaid Fraud and Abuse Notification*, <https://omh.ny.gov/omhweb/guidance/mfa/medicaidfraudabuse.html>.

³¹⁸ DOH, *eMedNY, Information for All Providers: General Policy* at 22, https://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information_for_All_Providers-General_Policy.pdf.

³¹⁹ OMIG, *2024 Annual Report* at 30; OMIG, *2023 Annual Report* at 34; OMIG, *2022 Annual Report* at 4.

³²⁰ OMIG, *2024 Annual Report* at 41; OMIG, *2023 Annual Report* at 21–22, 52.

Corrective actions include suspension or withholding of payments; administrative sanctions (e.g., exclusion from the Medicaid Program and monitoring and review of all payments to be rendered); and fiscal sanctions (e.g., restitution, reductions in payment, denial of payments).³²¹

OMIG also works to mitigate the recurrence of deficiencies once they are identified. OMIG includes a self-disclosure reminder statement in all final determinations (Final Audit Reports and Notices of Agency Action).³²² The statement reminds providers of their obligation under both federal and state law and regulations to exercise reasonable diligence to identify overpayments outside the scope of OMIG’s audit, review, or investigation period for issues similar to those identified in the final determination.³²³ Providers can easily access the Abbreviated and Full Self-Disclosure Statement Forms to report overpayments.³²⁴ The Full Self-Disclosure form requires a provider to explain the actions taken to ensure that the error that caused the overpayment and necessitated self-disclosure does not reoccur.³²⁵ This section of the form is required and is reviewed to determine adequacy as part of project processing.³²⁶ By requiring providers to explain the errors that led to corrective action, OMIG encourages provider accountability in the audit process.

37. How does the state coordinate with law enforcement to address systemic vulnerabilities and pursue recovery of improper payments? What are the recent results of such coordination?

OMIG and DOH coordinate closely with state and federal law enforcement agencies to anticipate potential vulnerabilities in the Medicaid system and pursue recovery of wrongfully gained funds.³²⁷ OMIG makes hundreds of referrals to MFCU and other law enforcement agencies every year.³²⁸ OMIG frequently provides other law enforcement agencies with its valuable investigative services and subject matter expertise in medical billing and fraud.³²⁹ In 2024 alone, OMIG worked with the following law enforcement organizations: District Attorneys’ offices, Sherriff’s office, NYS Department of Financial Services (“DFS”), and the Federal Bureau of Investigation (“FBI”).³³⁰ DOH and OMIG also provide regular assistance as subject matter

³²¹DOH, *eMedNY, Information for All Providers: General Policy*, https://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information_for_All_Providers-General_Policy.pdf at 26–27.

³²² See generally OMIG, *Final Audit Reports*, <https://omig.ny.gov/audit/final-audit-reports> (final audit reports contain self-disclosure reminder statement). See, e.g., OMIG, *Final Audit Report 2025Z01-134S* at 10, <https://omig.ny.gov/media/99241/download>; OMIG, *Final Audit Report 2025Z01-120M* at 10, <https://omig.ny.gov/media/99101/download>; OMIG, *Final Audit Report 22-7113* at 4, <https://omig.ny.gov/media/98791/download>.

³²³ See OMIG, *Self-Disclosure Guidance* (July 2025), <https://omig.ny.gov/self-disclosure-guidance>.

³²⁴ OMIG, *Self-Disclosure*, <https://omig.ny.gov/provider-resources/self-disclosure>.

³²⁵ OMIG, *Self-Disclosure Full Statement*, <https://omig.ny.gov/media/80816/download?attachment>.

³²⁶ OMIG, *Self-Disclosure Guidance* (July 2025), <https://omig.ny.gov/self-disclosure-guidance>.

³²⁷ OMIG, *2024 Annual Report* at 50.

³²⁸ OMIG, *2021 Annual Report* at 5–6, 32; OMIG, *2022 Annual Report* at 5–6, 36; OMIG, *2023 Annual Report* at 49–50; OMIG, *2024 Annual Report* at 7, 43, 48.

³²⁹ OMIG, *2024 Annual Report* at 48.

³³⁰ *Id.*

experts to various local, state, and federal agencies, including the United States Attorneys' Offices in each of New York's four districts. These close partnerships have resulted in several successful joint investigations—for example: a 2021 transportation investigation involving MFCU, DHS, and HHS-OIG that led to restitution of \$971,268;³³¹ a fraud investigation of a dermatologist submitting claims for a non-covered cosmetic procedure resulting in a guilty plea and \$239,771 in restitution; exposure of a housing scheme resulting in more than \$4 million in restitution; and a joint investigation with Washington County Sheriff's Office led to the arrest and prosecution of a Medicaid recipient fraudulently using transportation services.³³² New York has also focused on addressing FWA in CDPAP services, and, before the transition to a single fiscal intermediary, the State Attorney General collaborated with federal law enforcement on a number of cases, including one in the Eastern District of New York that secured a settlement agreement for more than \$17 million in wage violations by two CDPAP agencies.³³³

New York's MFCU has a proven track record of impactful healthcare fraud investigations and recoveries. According to the HHS-OIG's own analysis, New York's MFCU is among the leading MFCUs in the country in the amount it recovers through enforcement efforts. The 2026 Annual Report on MFCUs, released in March by the HHS-OIG, observed that total civil recoveries substantially increased from \$407 million in FY 2024 to \$706 million in FY 2025.³³⁴ Significantly, New York's MFCU was among the four state MFCUs that accounted for half of the total civil recoveries in FY 2025.³³⁵ New York's MFCU was also among the three state MFCUs that reported 54% of all nonglobal civil recoveries (\$272 million).³³⁶

38. For personal care services, how does DOH ensure that individuals meet the needs criteria and level of care for the different authorities?

For individuals seeking Community Based Long Term Services and Supports ("CBLTSS"), which includes both CDPAP and PCS, DOH contracts with an outside agency to conduct an independent, initial assessment and a clinical appointment to assess an individual's service needs.³³⁷ Effective May 2022, DOH contracts with Maximus Health Services, Inc. to serve as

³³¹ OMIG, *2021 Annual Report* at 38–39.

³³² OMIG, *2022 Annual Report* at 39–40, 45–46.

³³³ N.Y. Att'y Gen., *Attorney General James and U.S. Attorney Peace Secure Over \$17 Million From Home Health Agencies for Cheating Workers and Defrauding Medicaid in Landmark Wage Parity Agreement* (Sept. 30, 2024), <https://ag.ny.gov/press-release/2024/attorney-general-james-and-us-attorney-peace-secure-over-17-million-home-health>.

³³⁴ HHS-OIG, *Medical Fraud Control Units Annual Report: Fiscal Year 2025*, 6 (Mar. 2026), <https://oig.hhs.gov/reports/all/2026/medicaid-fraud-control-units-annual-report-fiscal-year-2025>.

³³⁵ *Id.*

³³⁶ *Id.* at 7.

³³⁷ 18 N.Y.C.R.R. §§ 505.28, 505.14; DOH, *Managed Long Term Care (MLTC) Overview*, https://www.health.ny.gov/health_care/managed_care/mltc/mltc_overview.htm.

the New York Independent Assessor (“NYIA”) to conduct all initial assessments for adults.³³⁸ Assessments for children are conducted by the LDSS or managed care plan.³³⁹

The assessment process includes a Community Health Assessment (“CHA”) conducted by a nurse with at least two years of recent experience in home health care and an independent medical exam conducted by the clinician or Independent Practitioner Panel under the NYIA.³⁴⁰ For high needs cases—where the proposed plan of care includes services for more than 12 hours per day on average—an Independent Review Panel evaluation must ensure that the proposed Plan of Care is appropriate and reasonable to maintain the individual’s safety in their home.³⁴¹

The CHA assesses eligibility for CBLTSS based on several factors. These include the functions and tasks required by the individual, the individual’s perception of their circumstances and preferences, and consideration of potential contribution of informal supports, such as family members or friends, to the individual’s care.³⁴² Additionally, the CHA evaluates whether the individual satisfies the minimum needs requirement to qualify for managed long-term care services, which includes CBLTSS.³⁴³ Effective September 1, 2025, a heightened minimum needs requirement must be met by demonstrating that the individual (1) requires at least supervision with more than one activity of daily living if the individual has been diagnosed with dementia or Alzheimer’s, or (2) requires at least limited assistance with physical maneuvering with more than two activities of daily living (“ADL”).³⁴⁴ Individuals who qualified for CDPAP or PCS under the prior, less stringent standard remain qualified, and the new standard will not apply to these individuals in future reassessments.³⁴⁵

The independent medical exam is conducted by a licensed physician employed or contracted by an entity designated by DOH to provide independent practitioner services.³⁴⁶ This medical professional examines the individual’s medical condition and regimens as well as the individual’s need for assistance with PCS, home health aide services, and skilled nursing tasks.³⁴⁷ In addition to the physical exam, the medical professional reviews the CHA, may review additional medical records, and can consult with the individual’s providers if determined

³³⁸ DOH, *Managed Long Term Care (MLTC) Overview*, https://www.health.ny.gov/health_care/managed_care/mltc/mltc_overview.htm.

³³⁹ DOH, *Administrative Directive Transmittal 22 OHIP/ADM-01: New York Independent Assessor for Personal Care (PCS) and Consumer Directed Personal Assistance Services (CDPAS)*, 4, 13 (Apr. 20, 2022), https://www.health.ny.gov/health_care/medicaid/publications/docs/adm/22adm01.pdf.

³⁴⁰ DOH, *Managed Long Term Care (MLTC) Overview*, https://www.health.ny.gov/health_care/managed_care/mltc/mltc_overview.htm.

³⁴¹ 18 N.Y.C.R.R. §§ 505.28(d)(3)(vi), 505.14(b)(2)(iii)(f); DOH, *Managed Long Term Care (MLTC) Overview*, https://www.health.ny.gov/health_care/managed_care/mltc/mltc_overview.htm.

³⁴² 18 N.Y.C.R.R. §§ 505.28(d), 505.14(b).

³⁴³ *Id.*

³⁴⁴ 18 N.Y.C.R.R. § 505.14(a)(3)(iv); 18 N.Y.C.R.R. § 505.28(b)(15).

³⁴⁵ DOH, *Medicaid Redesign Team (MRT) #90: Managed Long Term Care Policy* (rev. June 30, 2025), https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policy/2025/25-04.htm.

³⁴⁶ 18 N.Y.C.R.R. §§ 505.28(d), 505.14(b).

³⁴⁷ *Id.*

necessary.³⁴⁸ The independent medical exam results in a signed Practitioner Order that describes the individual's medical condition.³⁴⁹

After the NYIA Program assessment is complete, the LDSS and/or the Medicaid MCO must review it. These entities assess the CHA and Practitioner's Order to determine whether CDPAP or PCS can be provided according to the program rules, that the services are medically necessary, and whether the services can reasonably maintain the individual's health and safety in their home.³⁵⁰ Prior to authorizing CDPAP or PCS, LDSS and MCOs must review other available services and support to determine appropriateness and cost-effectiveness; determine frequency of nursing supervision; determine the individual's preferences and social and cultural considerations for the receipt of care; and develop the plan of care, including the amount, duration and frequency of services.³⁵¹

Finally, all individuals receiving PCS and CDPAP services must undergo routine annual reassessments to continue authorizing the services. In addition, certain non-routine reassessments are necessary when an individual returns from institutionalization, when there has been a significant change in condition, or at the individual's request.³⁵² The LDSS or managed-care plan conducts the reassessments.³⁵³

39. How does DOH use its Electronic Visit Verification (EVV) data to identify suspected FWA for agency and individual Personal Care Aides (PCAs)?

New York respectfully refers CMS to its response to Request 31.

40. What safeguards and thresholds does DOH have in its personal care services, such as location when clocking in on EVV, manual entry of services as opposed to using EVV, radius in miles of where PCA clocked in from where they deliver services, etc.?

New York respectfully refers CMS to its response to Request 31. New York additionally provides the following in response:

LDSS, managed care plans, and providers are required to develop methods of checking on individuals in receipt of PCS and CDPAP to ensure their plans of care meet the needs and

³⁴⁸ *Id.*

³⁴⁹ *Id.*

³⁵⁰ 18 N.Y.C.R.R. §§ 505.28(d), 505.14(b); DOH, *New York Independent Assessor Program (NYIAP)*, https://www.health.ny.gov/health_care/medicaid/redesign/nyiap/ldss-mmco.htm (last updated July 2023).

³⁵¹ *Id.*

³⁵² DOH, *Managed Long Term Care (MLTC) Policy 22-01: New York Independent Assessor for Personal Care Services (PCS) and Consumer Directed Personal Assistance Services (CDPAS)* (Apr. 27, 2022), https://www.health.state.ny.us/health_care/medicaid/redesign/mrt90/mltc_policy/docs/2022-04-27_mltc_22-01.pdf.

³⁵³ DOH, *Administrative Directive Transmittal 22 OHIP/ADM-01: New York Independent Assessor for Personal Care (PCS) and Consumer Directed Personal Assistance Services (CDPAS)* (Apr. 20, 2022), https://www.health.ny.gov/health_care/medicaid/publications/docs/adm/22adm01.pdf.

support the health and safety of the individuals.³⁵⁴ The agency authorizing the services is responsible to address any questions of the individual not complying with policy or where the safety or health is not maintained.³⁵⁵

With respect to EVV usage and monitoring, New York adopted the EVV Choice Model, allowing providers to select and self-fund their EVV system of choice.³⁵⁶ Regardless, all EVV systems are required to capture certain data elements as discussed in response to Request 31.³⁵⁷

PCS and CDPAP can be administered in the community.³⁵⁸ Accordingly, PCAs and PAs need not be within a specific radius of their patient's home when clocking in. The EVV system does allow for manual entry, meaning in these instances the EVV data is not reported electronically at the time-of-service delivery but later entered administratively. Each of these edited entries require either agency management approval or CDPAP consumer approval prior to adjustment and submission to the NYS Data Aggregator.

To further monitor PCS manual entries, OMIG can check provider compliance and take action at its discretion. LDSS and managed care plans can also monitor for compliance rates. Further, required nursing supervision ensures PCAs are safely and appropriately caring for consumers, as detailed in response to Request 50.

In CDPAP specifically, the SFI notifies consumers immediately if one or more of their PAs is non-compliant with EVV requirements. The SFI will notify LDSS for the managed care plan when PAs are regularly out of compliance. In the event of a review or audit, providers and/or the SFI must have the ability to show the original and the edited data sets for comparison, along with the documented reason for the manual adjustment. Pending regulation further enhances these protections by, once promulgated, requiring providers and the SFI to identify manual entries prior to submission to the NYS Data Aggregator.

Data validation and analysis is performed when EVV data is submitted to the New York State EVV Data Aggregator.³⁵⁹ The EVV applicability logic, detailed in response to Request 31, provides safeguards against bad or irrelevant data submissions.

41. How does DOH use EVV data to monitor self-directed care and paid family caregivers?

New York respectfully refers CMS to its response to Request 31.

³⁵⁴ 18 N.Y.C.R.R. §§ 505.14, 505.28.

³⁵⁵ *Id.*

³⁵⁶ DOH, *New York State Medicaid Electronic Visit Verification (EVV) Technical User Guide* (Nov. 2021), https://www.emedny.org/evv/EVV_Technical_User_Guide.pdf.

³⁵⁷ *Id.*

³⁵⁸ DOH, *New York Medicaid Electronic Visit Verification (EVV) Program*, https://www.health.ny.gov/health_care/medicaid/redesign/evv/.

³⁵⁹ See response to Request 31, *supra*, for details on the EVV Data Aggregator.

42. For 1905 personal care services, how does DOH monitor for fraud and how does DOH monitor for waste?

New York respectfully refers CMS to its response to Requests 26, 30, 32, 33, and 34 for details on how DOH monitors so-called high-risk Medicaid programs, including PCS.

OMIG leverages algorithms and Medicaid data to identify suspected PCS—or CDPAP—related FWA, including algorithms to identify excessive hours or overlap of paid claims at both the aide and agency level.³⁶⁰ Additionally, OMIG applies algorithms using DOH’s MDW data to identify potentially wasteful MLTC capitation payments or fee-for-service claims billed directly to the state that should have been covered under the MLTC capitation rate. Moreover, OMIG also determines when a member billed for PCS or CDPAP simultaneously with an inpatient stay.

43. How many individuals in the DOH 1915k program utilize personal care services and how does DOH monitor for fraud?

New York implemented the Community First Choice Option created by Section 1915(k) of the Social Security Act.³⁶¹ Individuals can access these services through an MCO or through fee-for-service Medicaid. In 2024, approximately 437,659 individuals accessed CFCO services through Managed Care and another 13,238 individuals through fee-for-service Medicaid.

New York respectfully refers CMS to its response to Requests 26, 30, 32, 33, 34, and 42 for details on how DOH monitors high-risk Medicaid programs, including CDPAP.

44. For self-directed care and paid family caregivers, what internal controls does DOH have to mitigate or address FWA?

DOH has extensive internal controls, described more fully in Responses 6 and 21, to mitigate and address risk of FWA in the Medicaid program. DOH also addresses FWA for self-directed care and paid family caregivers specifically through a variety of regulations and protections. These regulations provide built-in controls to prevent and address FWA. First, DOH does not permit a designated representative, the person delegated with authority to instruct and supervise the consumer’s care,³⁶² to serve as a CDPAP PA, an employee of the SFI, or its subcontractors.³⁶³ This restriction ensures that the designated representative does not have any conflicting interests in their role, thereby reducing an underlying cause of FWA.³⁶⁴

³⁶⁰ See response to Request 34, 35, *supra*.

³⁶¹ 42 U.S.C. § 1396n(k); 18 N.Y.C.R.R. § 505.28.

³⁶² A “designated representative means an adult to whom a self-directing consumer has delegated authority to instruct, supervise and direct the consumer directed personal assistant and to perform the consumer's responsibilities With respect to a non self-directing consumer, a designated representative means the consumer's parent, legal guardian or, subject to the social services district's approval, a responsible adult surrogate who is willing and able to perform such responsibilities on the consumer's behalf.” 18 N.Y.C.R.R. § 505.28(b)(7).

³⁶³ See 18 N.Y.C.R.R. § 505.28(b)(7).

³⁶⁴ See *id*.

Second, the assessment and authorization process provides another level of built-in controls against FWA. To receive services, beneficiaries must obtain an independent medical assessment.³⁶⁵ The LDSS or MCO then reviews the assessment and authorizes services based on it and the plan of care. Service authorizations thus inherently limit the number of care hours received by consumers, and guard against overuse of services, by prescribing only the clinically appropriate volume of hours as dictated by the assessment and set forth in the plan of care.³⁶⁶

Third, consumers and designated representatives must also review and sign Consumer Directed Personal Assistance Program Agreements, which require them to understand their responsibilities and attest to prudent self-directed care by agreeing to recruit, hire, train, supervise, and schedule a sufficient number of qualified individuals.³⁶⁷ Fourth, the SFI, which processes all wages and withholdings for PAs, provides oversight of hours worked and billed by CDPAP PAs.³⁶⁸ This contributes to rapid detection of and response to FWA, as the SFI monitors time worked by CDPAP PAs, including family members,³⁶⁹ and communicates any issues requiring action to MCOs and LDSSs.³⁷⁰

OMIG also collaborates with local agencies, including OMH and OPWDD, to develop and execute audit protocols specific to CDPAP and PCS.³⁷¹ These protocols are publicly available for providers and help prevent FWA by informing providers of their obligations.³⁷² OMIG also conducts joint post-payment audits with OPWDD to review claims for self-directed services, including fiscal intermediary services, HCBS services, and support brokerage services.

45. How many FWA allegations have been identified for personal care services by agency, individual independent provider, self, and family caregiver in the past 5 years? What are the resolutions of those allegations?

Between 2021 and 2025, OMIG received 1,643 subjects open in PCS, covering CDPAP, Home Health Aides, and PCAs. The chart below details the number of allegations by source:

³⁶⁵ See response to Request 38, *supra*, for a description of the assessment process for Personal Care Services.

³⁶⁶ See 18 N.Y.C.R.R. § 505.28(e)(1)(iii).

³⁶⁷ DOH, *CDPAP Member/DR/MCO Agreement*, https://www.health.ny.gov/health_care/medicaid/redesign/2021-12-10_cdpap_mco_agrmnt.htm, (last updated Sept. 2021).

³⁶⁸ DOH, *Consumer Directed Personal Assistance Program (CDPAP)*, https://www.health.ny.gov/health_care/medicaid/program/longterm/cdpap/, (last updated Feb. 2026).

³⁶⁹ See 18 N.Y.C.R.R. § 505.28(j)(1); DOH, *Consumer Directed Personal Assistance Program Statewide Fiscal Intermediary Policy for Medicaid Managed Care Plans*, (Feb. 26, 2025), https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/2025/docs/cdpap_sfi_policy_for_mmcp.pdf.

³⁷⁰ See DOH, *Consumer Directed Personal Assistance Program Statewide Fiscal Intermediary Policy for Medicaid Managed Care Plans*, (Feb. 26, 2025), https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/2025/docs/cdpap_sfi_policy_for_mmcp.pdf; DOH, *Administrative Directive, Consumer Directed Personal Assistance Plan (CDPAP) Statewide Fiscal Intermediary*, (Feb. 21, 2025), https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/2025/docs/25_ohip_adm-01.pdf.

³⁷¹ OMIG, *Audit Protocols*, <https://omig.ny.gov/audit/audit-protocols>, (last updated Apr. 2026).

³⁷² *Id.*

Allegation Source	Total Allegations
Anonymous	319
Enrolled Recipient	24
Federal Bureau of Investigation	1
General Public (Non-Enrolled)	263
U.S. Department of Health and Human Services	11
Local District Social Services	26
Local Law Enforcement	1
Managed Care Plans	425
Managed Long Term Care Plans-MLTC	413
NYS Department of Health	8
NYS Office of the Attorney General	9
NYS Office of the Inspector General	3
OMIG Audit	21
OMIG Division of Compliance and Self-Disclosure	3
OMIG Division of Medicaid Investigations	12
Provider	104
Grand Total	1, 643

Resolutions of these allegations varied. Just over 40% of these allegations (720) were closed on initial review. Another sixty cases were returned to the MCO for further action, and 113 cases were referred to other OMIG divisions, MFCU, or another state agency. In forty-one cases, an education letter was issued. Three Notices of Proposed Agency Actions were issued, and two Notice of Agency Actions were issued. The remainder (704) are either still open or closed with no action.

Subjects are closed with no action when the allegation is not substantiated. Allegations include various levels of information, often depending on the allegation's source. Reports from MCOs, for example, often include significant information which enables an investigation while allegations from the public, particularly those from anonymous complainants, often do not include enough information to investigate or may include an allegation that is not related to a Medicaid program requirement. Additionally, the reports which are returned to MCOs for their action are reflected as closed on initial review.

There is no typical timeline for an allegation to be closed or referred. There are many variables which impact the timeline including but not limited to the complexity of the investigation and volume of work versus resources available.

46. Given that NY Medicaid has one of the highest rates of spending on personal care services per capita among all states, can you measure how high-need the beneficiaries are in terms of activities of daily living (ADL) and instrumental activities of daily living (IADL), and what evidence does DOH have that these services are preventing institutionalization?

Long-term care, including PCS and CDPAP, measures a beneficiary's individual needs by assessing whether help is required with basic activities, referred to as ADL, and more complicated activities, called Instrumental Activities of Daily Living ("IADL").³⁷³ Recognized ADLs include bathing, dressing, eating, transferring, toileting, and continence.³⁷⁴ There are several more IADLs, including housekeeping, laundry, meal planning and preparation, using a telephone, managing finances, shopping, and errands.³⁷⁵ The completion of ADLs and IADLs may be accomplished independently or require some or total assistance from others.

ADL and IADL scores are assessed as part of the eligibility determination process for both of these programs. Higher scores indicate a higher level of need. As explained in response to Request 38, all new enrollees receiving CDPAP or PCS must meet a heightened minimum needs standard.³⁷⁶ These individuals must either be diagnosed with dementia or Alzheimer's and require at least supervision with more than one activity of daily living or, for everyone else, require at least limited assistance with physical maneuvering with more than two ADL.³⁷⁷ The graphs in Figure 1 and Figure 2 show the distribution of needs across individuals receiving PCS or CDPAP from 2021 through 2025.

³⁷³ 18 N.Y.C.R.R. § 505.14.

³⁷⁴ *Id.*

³⁷⁵ *Id.*

³⁷⁶ *Id.* at §§ 505.14(a)(3)(iv), 505.28(b)(15).

³⁷⁷ *Id.* at §§ 505.14(a)(3)(iv), 505.28(b)(15).

Figure 1

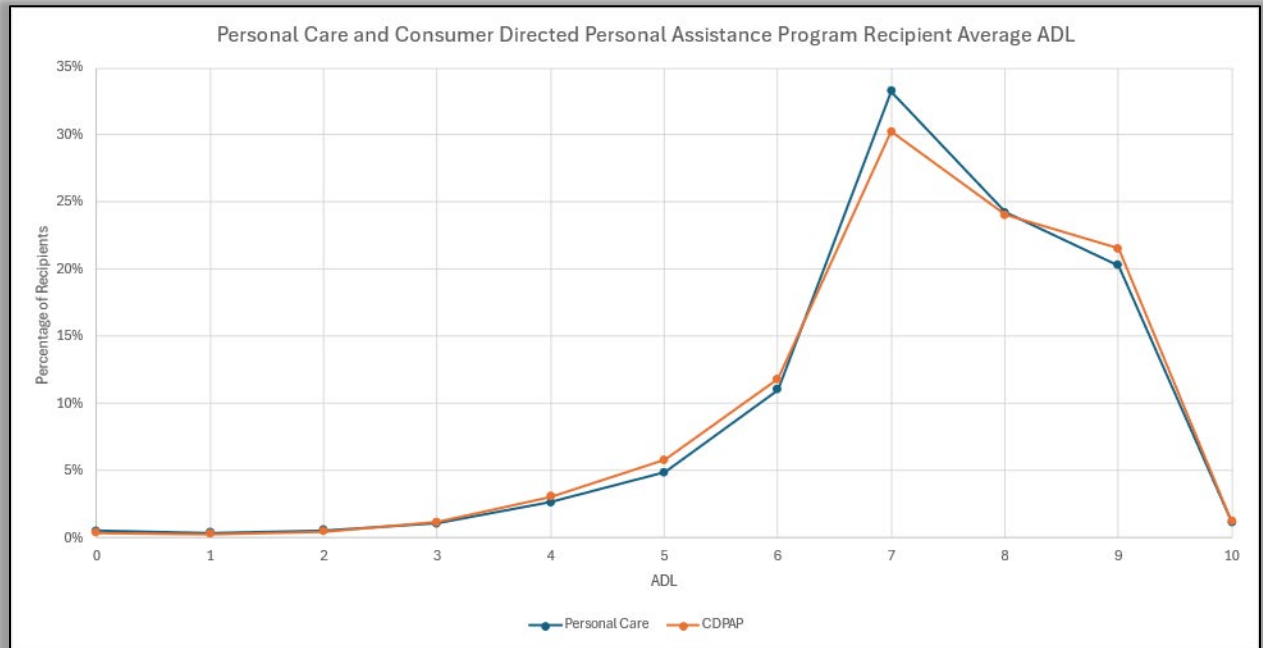
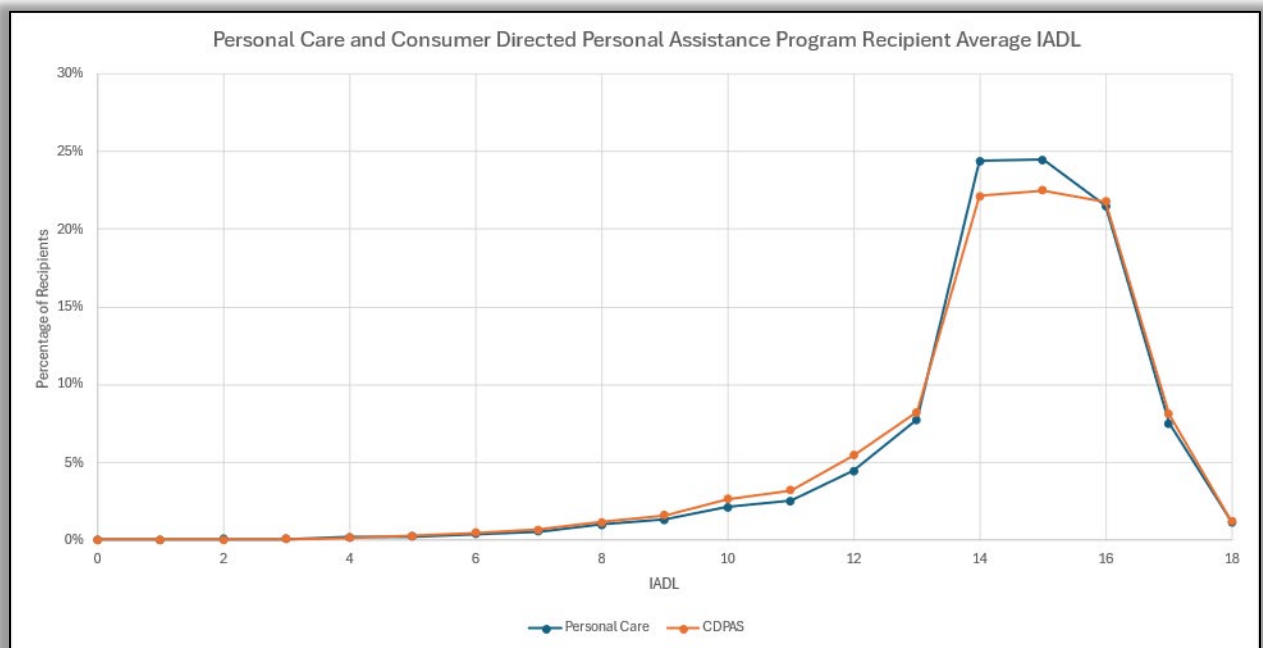


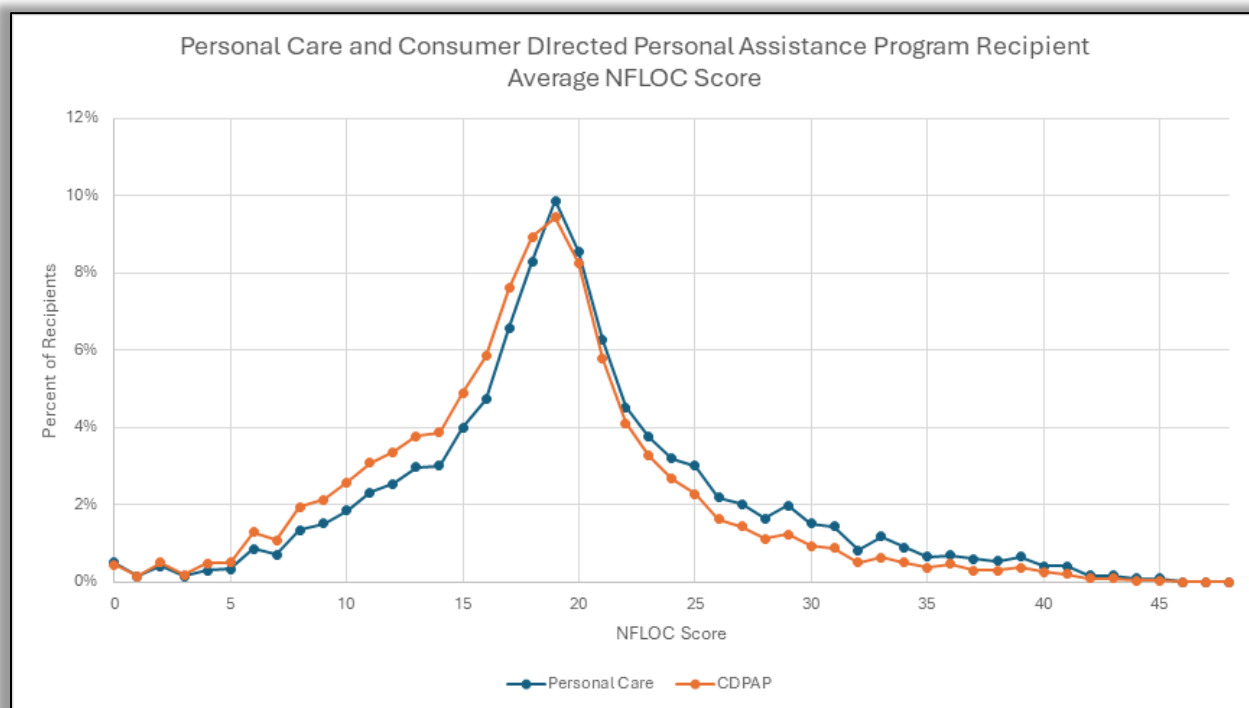
Figure 2



Another measurement of an individual's care needs is the Nursing Facility Level of Care ("NFLOC") score. Points are allocated to the different levels of functioning with the number of points increasing as the functional deficits increase. Any score above 5 indicates the individual

is eligible to receive nursing home services. Figure 3, below, shows average NFLOC scores among those receiving PCS and CDPAP.

Figure 3



Studies have shown that HCBS prevent institutionalization and keep individuals in the community. A 2023 study of older adults diagnosed with dementia found the implementation of MLTC in the home lowered the odds of nursing home use by 8% annually between 2013 and 2019.³⁷⁸ Further, an interim report evaluating New York’s MLTC program noted that a substantial majority, between 66% and 85%, of the individuals transitioned from institutions into the community remained successfully in the community.³⁷⁹

Additionally, home and community-based personal care services are more cost-effective for the average member when compared to the average amount spent on an individual living in a nursing home, as the chart below details:

³⁷⁸ Jordan Harrison, et al., *Changes in Nursing Home Use Following Medicaid-Supported Expanded Access to Home- and Community-Based Services for Older Adults with Dementia*, 6 JAMA Network Open (2023), <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2807111>.

³⁷⁹ DOH, *New York Medicaid Section 1115 Demonstration Independent Evaluation*, xiii (Aug. 3, 2021), https://www.health.ny.gov/health_care/medicaid/redesign/mrt2/ext_request/docs/2021-08-03_1115_demo_eval.pdf.

Fiscal Year	Personal Care Services – Average Spent Per Capita	Nursing Home – Average Spent Per Capita
2025	\$32,951.41	\$56,082.47
2024	\$41,539.74	\$56,209.29
2023	\$37,498.68	\$51,941.88
2022	\$38,841.75	\$48,172.44

47. How many CDPAP recipients have qualified at each level of need — 1IADL, 2IADL, 1 ADL, 2 ADL, etc.

As of 2025, there were more than 209,000 consumers authorized for the CDPAP program who had registered for the new SFI, PPL.³⁸⁰

Internal data shows that between 65% and 70% of PCS and CDPAP recipients have an average of 14 to 16 IADLs. Between 75% and 80% of recipients need support with an average of 7 to 9 ADLs. Please refer to the charts below for more detailed trend reporting.

	2021		2022		2023		2024		2025		5-Year Average	
	PC	CDPAS	PC	CDPAS	PC	CDPAS	PC	CDPAS	PC	CDPAS	PC	CDPAS
IADL Average	<u>14.43</u>	<u>14.45</u>	<u>14.34</u>	<u>14.24</u>	<u>14.25</u>	<u>14.07</u>	<u>14.24</u>	<u>14.06</u>	<u>14.42</u>	<u>14.51</u>	<u>14.34</u>	<u>14.25</u>
ADL Average	<u>7.29</u>	<u>7.34</u>	<u>7.26</u>	<u>7.26</u>	<u>7.20</u>	<u>7.17</u>	<u>7.22</u>	<u>7.17</u>	<u>7.34</u>	<u>7.44</u>	<u>7.27</u>	<u>7.27</u>
NFLOC Average	<u>19.88</u>	<u>18.23</u>	<u>19.82</u>	<u>17.86</u>	<u>19.96</u>	<u>17.90</u>	<u>20.08</u>	<u>18.08</u>	<u>19.90</u>	<u>19.08</u>	<u>19.93</u>	<u>18.26</u>

48. What training do personal care attendants have to undergo? What screening do they have to undertake (i.e., fingerprints, interviews of associates)?

There are two types of home care aides under the New York State Medicaid Program: PCAs and PAs. PCAs provide PCS under professional supervision and require specific certification while PAs—who provide services through CDPAP—do not possess formal certification.³⁸¹ Instead, PAs are trained by the consumer.

³⁸⁰ DOH, *CDPAP Update: State Department of Health Provides Data on Number of Consumers and Personal Assistants Registered With Statewide Fiscal Intermediary Ahead of June 6 Deadline* (May 19, 2025), https://www.health.state.ny.us/press/releases/2025/2025-05-19_cdpap_update.htm.

³⁸¹ See 10 N.Y.C.R.R. § 700.2(b)(14) (defining personal care aide); 18 N.Y.C.R.R. § 505.28(b)(4) (defining consumer directed personal assistant).

Personal Care Aides

To provide PCS in New York State as a PCA, an individual must meet certain screening requirements and successfully complete a state-approved Personal Care Aide Training Program (“PCATP”).³⁸²

From the outset, PCATPs must develop and employ procedures to screen trainees. Since June 27, 2012, training programs have been required to verify and document each trainee’s identity at the outset of training by examining and recording information from an approved list of photo identifications.³⁸³ Trainees who fail to provide appropriate documentation cannot participate in the training program.³⁸⁴ Additionally, within ten business days of the commencement of a training program, the PCATP is required to submit the names and dates of birth for all trainees to the New York State Home Care Registry (“HCR”), established by New York Public Health Law Section 3613.³⁸⁵ The HCR was implemented on September 25, 2009 as part of an ongoing effort to ensure the individuals working for home care agencies and providing home care services are properly trained and suitable to provide those services.³⁸⁶ Both training programs and home care agencies must submit the required information on trainees and aides to the HCR, including information on successful completion of training programs within ten business days of the end of a training program.³⁸⁷

Additionally PCATPs are required to assess all trainees for, at minimum: (1) maturity and emotional and mental stability; (2) experience in personal care or homemaking; (3) ability to read and write, understand and carry out directions and instructions, record messages, and keep simple records; (4) sympathetic attitudes toward providing services to patients at home who have a medical condition; and (5) good health.³⁸⁸ DOH recommends a minimum age of 18 for trainees, but this is not required.³⁸⁹ PCATPs may also impose additional criteria for admission so long as the policy explicitly demarcates between regulatory and agency requirements.³⁹⁰

PCATPs must be approved by either DOH or the New York State Education Department.³⁹¹ The content of the PCATP must use DOH’s Home Care Curriculum, which contains twelve discrete

³⁸² DOH, *Guide to Operating a Personal Care Aide Training Program*, 2 (May 2022), https://www.health.ny.gov/professionals/home_care/guide_to_operate_pcatp/docs/guide.pdf

³⁸³ 10 N.Y.C.R.R. § 403.4(a).

³⁸⁴ *Id.*

³⁸⁵ *Id.* at § 403.4; N.Y. Pub. Health Law § 3613.

³⁸⁶ DOH, *Home Care Registry (HCR) Public Application: Frequently Asked Questions*, https://www.health.ny.gov/professionals/home_care/registry/frequently_asked_questions.htm, (last updated Dec. 2014).

³⁸⁷ 10 N.Y.C.R.R. § 403.4.

³⁸⁸ DOH, *Guide to Operating a Personal Care Aide Training Program*, 4 (May 2022), https://www.health.ny.gov/professionals/home_care/guide_to_operate_pcatp/docs/guide.pdf.

³⁸⁹ *Id.*

³⁹⁰ *Id.*

³⁹¹ *Id.* at 3; 18 N.Y.C.R.R. § 505.14(e).

content areas or modules and covers interpersonal skills, nutrition and meal preparation, safety and injury prevention, and personal care tasks.³⁹² The program must consist of at least forty hours of training and be provided by or under the direction of a Nurse Instructor who is a registered professional nurse with at least two years of nursing experience, including one year of nursing experience in the provision of HHCS.³⁹³ Nurse Instructors require approval by DOH and are included in the HCR instructor database.³⁹⁴ PCATPs are required to evaluate trainees through written and/or oral examinations to demonstrate knowledge of classroom training and through observation and demonstration of the required skills.³⁹⁵ Trainees must achieve at least 80% accuracy to ensure mastery of subject material.³⁹⁶ Upon successful completion, trainees are awarded certificates through the HCR; PCA certificates do not lapse and they do not expire.³⁹⁷

The basic training requirement may be waived by DOH for qualified individuals with related training or experience who can demonstrate competence in an ACD program.³⁹⁸ Instead of the standardized classroom and skills training, the ACD program tests competency by assessing attitude, knowledge base, and specific skills performance.³⁹⁹ The specific minimum standards that must be satisfied, as well as the required documentation of related training or experience that an individual must provide to qualify for this type of program is outlined in the guidance document *Alternative Competency Demonstration for the Personal Care Aid*, available on the Health Commerce System.⁴⁰⁰

Even after PCAs have successfully completed an approved training program and received certification to provide services, they must continue to receive in-service training for at least three hours semi-annually to develop specialized skills or review and build upon skills or knowledge included in basic training.⁴⁰¹ Further, PCAs may receive on-the-job training, as needed, to learn specific skills or techniques for a particular client.⁴⁰² A supervising professional

³⁹² DOH, *Home Care Curriculum*, at 15–61 (Jan. 2007), https://www.health.ny.gov/professionals/home_care/curriculum/docs/home_care_curriculum.pdf.

³⁹³ DOH, *Guide to Operating a Personal Care Aide Training Program*, 3, 5 (May 2022), https://www.health.ny.gov/professionals/home_care/guide_to_operate_pcatp/docs/guide.pdf.

³⁹⁴ *Id.* at 6.

³⁹⁵ DOH, *Guide to Operating a Personal Care Aide Training Program*, 7 (May 2022), https://www.health.ny.gov/professionals/home_care/guide_to_operate_pcatp/docs/guide.pdf; see 18 N.Y.C.R.R. § 505.14(e)(2)(i)(e).

³⁹⁶ DOH, *Guide to Operating a Personal Care Aide Training Program*, 7 (May 2022), https://www.health.ny.gov/professionals/home_care/guide_to_operate_pcatp/docs/guide.pdf.

³⁹⁷ *Id.* at 8.

³⁹⁸ 18 N.Y.C.R.R. § 505.14(e)(4).

³⁹⁹ DOH, *Guide to Operating a Personal Care Aide Training Program*, 8 (May 2022), https://www.health.ny.gov/professionals/home_care/guide_to_operate_pcatp/docs/guide.pdf.

⁴⁰⁰ *Id.* at 7.

⁴⁰¹ 18 N.Y.C.R.R. § 505.14(e)(2)(ii).

⁴⁰² 18 N.Y.C.R.R. § 505.14(e)(2)(iii).

registered nurse is responsible for evaluating each PCA's ability to function competently and safely as well as providing or arranging necessary on-the-job training.⁴⁰³

Beyond providing services to trainees, training programs must conduct quality assurance and monitoring of their program.⁴⁰⁴ DOH's *Guide to the Operation of a Personal Care Aid Training Program* requires programs to implement policies and procedures describing their quality management program and the annual evaluation of the program.⁴⁰⁵ The guide also explains that quality assurance programs must include data collection, analysis and evaluation of the data collected, as well as strategies and actions to improve performance, when needed.⁴⁰⁶ Focusing on monitoring and evaluating the effectiveness of the overall operation, quality assurance programs should incorporate systems to ensure compliance with the requirements set forth by DOH guidelines, evaluate educational outcomes, and develop and implement strategies to improve the program itself.⁴⁰⁷

Separate from training programs, PCAs are also screened by the home health agencies that employ them. PCAs who engage in face-to-face contact with residents or patients are screened by agencies in three ways.⁴⁰⁸ First, agencies must verify an applicant successfully completed the required training, primarily through the applicant's profile on the HCR; anyone not listed in the HCR cannot be considered for employment.⁴⁰⁹ Second, agencies must verify an applicant's employment history from previous employers, if applicable, and recommendations from other persons unrelated to the applicant if there is no employment history prior to patient contact.⁴¹⁰ Third, New York statute requires a criminal history record check for any unlicensed person providing face-to-face care or supervision.⁴¹¹

Personal Assistants

Under CDPAP, the consumer is empowered to function as the employer by recruiting, hiring, and training their own PAs.⁴¹² PPL, the SFI, supports consumers by providing certain administrative

⁴⁰³ *Id.*

⁴⁰⁴ DOH, *Guide to Operating a Personal Care Aide Training Program*, 10–11 (May 2022), https://www.health.ny.gov/professionals/home_care/guide_to_operate_pcatp/docs/guide.pdf.

⁴⁰⁵ *Id.*

⁴⁰⁶ *Id.* at 10.

⁴⁰⁷ *Id.*

⁴⁰⁸ DOH, *Dear Administrator Letter (DAL) 22-07: Aide Training and Certificate Verification* (Apr. 11, 2022), <https://leadingagency.org/leadingagency/assets/File/DHCBS%20DAL%2022-07%20-%20Aide%20training%20and%20cert%20verification.pdf>; 10 N.Y.C.R.R. § 766.11(f)-(g); N.Y. Pub. Health Law § 2899-a; N.Y. Exec. Law § 845-b.

⁴⁰⁹ DOH, *Dear Administrator Letter (DAL) 22-07: Aide Training and Certificate Verification* (Apr. 11, 2022), <https://leadingagency.org/leadingagency/assets/File/DHCBS%20DAL%2022-07%20-%20Aide%20training%20and%20cert%20verification.pdf>.

⁴¹⁰ 10 N.Y.C.R.R. § 766.11(f)-(g).

⁴¹¹ N.Y. Pub. Health Law § 2899-a; N.Y. Exec. Law § 845-b.

⁴¹² 18 N.Y.C.R.R. § 505.28(h).

services such as PA payroll and provides both required and optional trainings to PAs.⁴¹³ As of April 2026, the following trainings were either required or optional:

Required Trainings	Optional Trainings
• HIPAA • Fraud, Waste, and Abuse • Sexual Harassment • EVV – Time4Care • Emergency Preparedness Planning	• HIV – NYS • Infection Control and Prevention • Tuberculosis • Elder Abuse • Corporate Compliance • Cultural Competency

PAs must also complete annual health assessments with PPL to be eligible to provide services to a consumer.⁴¹⁴

49. What is the average number of hours a personal care attendant provides in a week, what is the maximum number of hours a personal care attendant provides, and how many personal care attendants are providing the maximum number of hours?

As explained in DOH’s response to Request 48, New York Medicaid provides for two types of personal care attendants: PCAs and PAs.

PCAs are employed by a licensed home care service agency, and the agency assigns PCAs to provide the required services according to the client’s authorization.⁴¹⁵ New York does not have a formal rule establishing a maximum number of hours that a PCA may work as this is dependent upon the member’s authorization and person-centered plan of care. Licensed home care service agencies manage the number of hours worked by each PCA they employ.⁴¹⁶

Similarly, New York does not have a specified maximum number of hours that a PA may work as this is dependent upon the member’s authorization and person-centered plan of care. According to reports from the SFI, the weekly average number of hours reported by PAs is between twenty-seven and thirty hours per worker. The very small number of PAs who have tried to report 168 hours per week—or twenty-four hours for all seven days of the week—have been referred to OMIG for investigation.

⁴¹³ DOH, *Consumer Directed Personal Assistance Program (CDPAP)*, https://www.health.ny.gov/health_care/medicaid/program/longterm/cdpap/ (last updated Feb. 2026); PPL First, *New York CDPAP: Frequently Asked Questions*, <https://pplfirst.com/new-york-cdpap-frequently-asked-questions/>.

⁴¹⁴ PPL First, *New York CDPAP: Frequently Asked Questions*, <https://pplfirst.com/new-york-cdpap-frequently-asked-questions/>.

⁴¹⁵ 18 N.Y.C.R.R. § 505.14(d)(3); DOH, *Personal Care Services Program*, https://www.health.ny.gov/health_care/medicaid/program/longterm/pcs.htm.

⁴¹⁶ 18 N.Y.C.R.R. § 505.14(d)(3).

50. What organization credentials and oversees personal care attendants in NY Medicaid?

DOH respectfully refers CMS to its response to Request 48. In addition, DOH provides the following information in response:

PCAs providing services under New York Medicaid must be registered with the HCR and receive valid certification through an approved training program.⁴¹⁷ PCAs are subject to ongoing administrative and nursing supervision.⁴¹⁸ Administrative supervision ensures personal care services are provided at the appropriate level, amount, frequency, and duration in accordance with a member's authorization and plan of care.⁴¹⁹ This type of supervision is provided by the agency employing the PCA.⁴²⁰ Nursing supervision ensures a patient's needs are appropriately met and the PCA is competently and safely performing the functions and tasks specified in the patient's plan of care.⁴²¹ Nursing supervision must be provided by a registered professional nurse, who is employed by an agency and has at least two years of recent home health care experience or a combination of education and experience with at least one year in home health care.⁴²²

Under CDPAP, the consumer is responsible for training, supervising, and scheduling each PA; terminating the PA's employment; and assuring that each PA competently and safely performs the personal care services, home health aide services and skilled nursing tasks that are included in the consumer's plan of care.⁴²³ The consumer is also responsible for attesting to the accuracy of the hours reported by their PAs, ensuring their PAs adhere to the EVV requirements, and ensuring that their PAs' required documents are submitted to the SFI, including annual worker health assessments and required employment documents.⁴²⁴

⁴¹⁷ See response to Request 48, *supra*.

⁴¹⁸ 18 N.Y.C.R.R. § 505.14(f).

⁴¹⁹ 18 N.Y.C.R.R. § 505.14(f)(2).

⁴²⁰ 18 N.Y.C.R.R. § 505.14(f)(2)(i).

⁴²¹ 18 N.Y.C.R.R. § 505.14(f)(3).

⁴²² *Id.*

⁴²³ 18 N.Y.C.R.R. § 505.28(h)(1)(i).

⁴²⁴ DOH, *Consumer Directed Personal Assistance Program Agreement Between the Consumer/Designated Representative and the Local Department of Social Services*, 2 (May 2025), https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/2025/docs/25_ohip_adm-01_att1.pdf.

Acronyms Appendix

Acronym	Definitions
AAU	Advanced Analytics Unit
ABA	Applied Behavior Analysis
ADHC	Adult Day Health Care
ADL	Activities of Daily Living
BBi	Bureau of Business Intelligence
BSD	Bureau of Self-Disclosure
CBLTSS	Community Based Long Term Services and Supports
CDPAP	Consumer Directed Personal Assistance Program
CFTSS	Children’s Family and Treatment and Support Services
CHA	Community Health Assessment
CHHA	Certified Home Health Agencies
CMS	Centers for Medicare & Medicaid Services
CVR	Credential Verification Reviews
DFS	Department of Financial Services
DME	Durable Medical Equipment
DOH	New York State Department of Health
EVV	Electronic Visit Verification
FBI	Federal Bureau of Investigation
FWA	Fraud, Waste, and Abuse
GPS	Global Positioning System
HCBS	Home and Community-Based Services
HCR	Home Care Registry
HFPP	Healthcare Fraud Prevention Partnership
HHCS	Home Health Care Services
HHS-OIG	Department of Health and Human Services Office of Inspector General
HMS	Health Management Systems
IADL	Instrumental Activities of Daily Living
LDSS	Local Department of Social Services
LTHHCP	Long Term Home Health Care Programs
MAS	Medical Answering Services
MCO(s)	Managed Care Organizations
MCPAR	Managed Care Program Annual Report
MDW	Medicaid Data Warehouse
MFCU	Medicaid Fraud Control Unit
MLTC	Managed Long Term Care
MOU	Memoranda of Understanding
MPEC	Medicaid Provider Enrollment Compendium
NEMT	Non-Emergency Medical Transportation
NFLOC	Nursing Facility Level of Care
NHTD	Nursing Home Transition and Diversion
NYIA	New York Independent Assessor
NYSTEC	New York State Technology Enterprise Program

Acronym	Definitions
OASAS	Office of Addiction Services and Supports
OMH	Office of Mental Health
OMIG	Office of the Medicaid Inspector General
OPWDD	Office for People With Developmental Disabilities
PA	Personal Assistants
PCA	Personal Care Aides
PCATP	Personal Care Aide Training Program
PCS	Personal Care Services
PPL	Public Partnership LLC
RAC	Recovery Audit Contractors
SADC	Social Adult Day Care
SFI	Statewide Fiscal Intermediary
SIU(s)	Special Investigation Units
TBI	Traumatic Brain Injury
The State	New York