New York State Office of the State Comptroller
Thomas P. DiNapoli

Division of State Government Accountability

Accuracy of Reported Cost Savings

Office of the Medicaid Inspector General

Report 2013-S-29 July 2014

Executive Summary

Purpose

To assess the accuracy of the Office of the Medicaid Inspector General's reported cost savings for calendar years 2008 through 2012. This audit covers the period January 1, 2008 through December 31, 2012.

Background

The Office of the Medicaid Inspector General's (OMIG) mission is to enhance the integrity of the New York State Medicaid program by preventing and detecting fraudulent, abusive and wasteful practices, and to recover improperly expended Medicaid funds while promoting a high quality of patient care. OMIG conducts and supervises prevention, detection, audit and investigation efforts, and coordinates activities with various State agencies as well as Federal and local law enforcement agencies. These activities result in reported cost savings to the Medicaid program. There are no industry standards or guidelines for calculating cost savings values, so OMIG calculates cost savings as estimates based on historical and current Medicaid claims data. For calendar years 2008 through 2012, OMIG reported cost savings totaling $10.1 billion for 35 initiatives.

Key Findings

- Although our audit showed the majority of the reported cost savings we examined were reasonable and adequately supported, we also estimate OMIG overstated savings from 27 of 35 activities examined by at least $1.2 billion as a result of flaws and/or inconsistencies in the methodologies used to estimate savings. OMIG officials indicate they have taken corrective action on the methodologies for many of these 27 activities.
- A lack of communication among the managers responsible for the various activities contributed to these problems.

Key Recommendations

- Perform a full review of cost savings activities to identify and correct inconsistencies and inaccuracies in methodologies.
- Routinely take steps to identify changes in the Medicaid program that impact cost savings activities and update cost savings methodologies when needed to ensure consistency among all cost savings methodologies.
- Improve communication among managers responsible for cost savings calculations and use their collective input to help routinely identify inconsistencies and refine methodologies.

Other Related Audit/Report of Interest

Office of the Medicaid Inspector General: Quality of Internal Control Certification (2012-S-46)

State of New York
Office of the State Comptroller

Division of State Government Accountability

July 11, 2014

Mr. James C. Cox
Medicaid Inspector General
Office of the Medicaid Inspector General
800 North Pearl Street
Albany, NY 12204

Dear Mr. Cox:

The Office of the State Comptroller is committed to helping State agencies, public authorities and local government agencies manage government resources efficiently and effectively and, by so doing, providing accountability for tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit entitled *Accuracy of Reported Cost Savings.* This audit was performed according to the State Comptroller's authority under Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Office of the State Comptroller
Division of State Government Accountability

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Background

The Office of the Medicaid Inspector General (OMIG) was established in 2006 as an independent entity within the Department of Health to improve and preserve the integrity of the Medicaid program. OMIG's mission is to enhance the integrity of the New York State Medicaid program by preventing and detecting fraudulent, abusive and wasteful practices, and to recover improperly expended Medicaid funds while promoting a high quality of patient care. In carrying out its mission, OMIG conducts and supervises prevention, detection, audit and investigation efforts, and coordinates activities with various State agencies as well as Federal and local law enforcement agencies. These program integrity activities result in reported cost savings to the Medicaid program. Each year OMIG reports to the Governor, other State officials and the public its activities from the previous year to prevent and detect Medicaid fraud, abuse and waste. For the five calendar years 2008 through 2012, OMIG reported cost savings for 35 initiatives totaling $10.1 billion.

OMIG calculates cost savings using a variety of cost savings methodologies depending on the nature of the activity. These include:

- Estimating the amount saved when claims are denied (e.g., improper billing or when third party insurance should have been billed);
- Comparing the costs of a service before and after a cost savings control is implemented;
- Estimating cost savings for a given time period, such as one year, based on average monthly claims values; and
- Using the Department of Health's Medicaid claims processing and payment system (eMedNY) edits to identify and prevent payment of fraudulent, wasteful or abusive claims.

There are no industry guidelines or standards for calculating cost savings values and, therefore, OMIG calculates cost savings as estimates based on historical and current Medicaid claims data. These estimates should reflect accurate calculations to the greatest extent possible, and OMIG performs reviews of the various methodologies to help ensure this.

During the course of our audit period, the Medicaid program began implementing Care Management for All, a Medicaid Redesign Team initiative to transition as many populations and services as possible from the Fee-for-Service payment system to Managed Care, which impacted the way certain cost savings were calculated.

Audit Findings and Recommendations

Our audit showed that the majority of the reported cost savings we examined for the five-year period 2008 through 2012 represent reasonable estimates calculated using methodologies that were consistently applied, based on valid assumptions and supported by appropriate documentation. However, we also determined that OMIG's estimates overstate the savings attributable to many of its individual activities. These overstatements total at least $1.2 billion (see Table 1) and resulted from flaws and/or inconsistencies that we identified in the methodologies used for 27 of 35 cost savings activities we reviewed. A lack of communication among the managers handling the cost savings activities also contributed to these problems.

Table 1- Breakdown of Overstated Cost Savings by Category (*in millions*)

Category of Overstatement	Number of Activities	Reported Savings	Savings Tested[1]	Overstated Savings
Inaccurate and Inflated Calculations	6	$ 1,736	$ 1,133	$ 940
Inaccurate Discount Ratios	19	848	848	99
Inflated Pre-payment Insurance Verification	2	5,247	2,366	144
Total	**27**	**$ 7,831**	**$ 4,347**	**$ 1,183**

[1] *Our audit did not test all reported savings from several activities due to a lack of documentation and other limiting factors as detailed throughout the report.*

OMIG officials indicate that they have already taken steps to correct many of the inaccuracies we identified. In addition, several problems are no longer applicable due to the shift from Fee-for-Service to a Managed Care payment methodology. OMIG disagrees with several of our findings and recommendations, citing a lack of any authoritative cost savings guidelines or standards to follow and stating that its savings are only estimates based on the best information available at the time. Also, OMIG officials indicate that they identified an additional $1.5 billion in savings after reviewing and amending their methodologies in response to our audit findings.

Inaccurate and Inflated Cost Savings Calculations

One way OMIG calculates cost savings is to measure changes in a Medicaid provider's claim behavior after OMIG takes some remedial action to prevent improper or fraudulent claims submissions. Remedial action could include things like requiring providers to swipe a recipient's Medicaid identification card at the time of service to ensure the patient is present, notifying providers that their billing behavior is irregular, or simply excluding providers from the Medicaid

program. Cost savings result when the providers then reduce or cease their Medicaid billings after the action. OMIG considers these reductions in Medicaid billings to be cost savings due to the action.

Between 2008 and 2012, OMIG reported cost savings of $3.7 billion for 12 activities based on these types of changes. We determined that OMIG likely overstated cost savings for 6 of the 12 activities by nearly $940 million. These overstatements were the result of using inconsistent methodologies, not considering the fact some providers had re-enrolled in the Medicaid program, and including savings stemming from a Department of Health regulation that had been in effect for many years.

Inconsistent Application of Methodologies

We determined that OMIG likely overstated cost savings by about $743 million for three activities for which different, and less accurate, methodologies were used to determine cost savings. The three activities include:

High-Ordering Physicians

OMIG identified and sent letters to about 100 physicians who had the highest value of ordered services in various categories, including pharmacy claims, lab services, and eye care. The letters informed the providers that they had ordered services that were among the highest in total cost compared with other physicians. OMIG then monitored these physicians' ordering trends after the letter and compared their ordering with the average cost of ordered services prior to the letter. Any decreases in the value of ordered services were considered cost savings. As a result of the decrease in expenses originating from these physicians, OMIG attributed $422.5 million in cost savings to this action.

OMIG started claiming cost savings from this activity in 2010. However, as of October 2011, with the transition from Fee-for-Service to Managed Care, any cost savings related to services such as pharmacy claims were no longer attributable to this remedial action and instead stemmed from the change in care management. This resulted in overstated cost savings of about $317 million. OMIG discontinued reporting cost savings for this activity as of July 2013 but still included these savings in its 2012 annual report produced in October 2013.

Pharmacy Claims - Credits for Voided Prescriptions

During our audit period, OMIG sent letters to 1,000 of the approximately 5,000 pharmacies in the State that their credits for voided claims (adjustments for prescriptions that were never picked up) were well below the statewide average. This could be an indication that drugs actually returned to stock were still being billed to Medicaid. However, after these letters were sent, OMIG captured any increase in voided claim credits by any pharmacy in calculating the $270.9 million cost savings reported for this activity during our audit period.

We concluded OMIG's methodology was flawed because it measured the increase in voided

claim credits for all pharmacies statewide, not just the 20 percent of pharmacies considered to be the highest risk and targeted in the action. It inappropriately assumed that all pharmacies, including those that already have average or above-average credit amounts, pose an equal risk of underreporting credits. In contrast, for the High Ordering Physicians activity discussed earlier, OMIG based its estimates only on the subset of physicians it identified and targeted as high risk. We concluded that this inconsistency was due primarily to a lack of communication among the managers directly responsible for accumulating cost savings information across the various activities. In this case, one person simply did not know that another was doing something similar, but in a different way.

We recalculated the savings using only those pharmacies targeted for action and, as a result, we estimate savings were overstated by nearly $229 million. OMIG stopped reporting cost savings for this activity in October 2011, primarily due to Medicaid's transition to Managed Care.

Card Swipe/Post-and-Clear Program

This pre-payment control requires certain providers to swipe Medicaid recipients' identification cards to ensure the patient is present either at the point of service or when services are ordered, or a combination of both. Expenses that decrease as a result of this remedial action are considered cost savings.

This cost savings calculation included providers whose claim amounts decreased, but excluded providers whose claim amounts increased after this action. In contrast, when using this methodology in other applications, OMIG offsets increases and decreases to calculate the net overall savings. For calendar years 2011 and 2012, we estimate cost savings were likely overstated by nearly $198 million by excluding providers whose claim amounts increased. Our estimate does not include calendar years 2008 through 2010 because supporting documentation for these years was not available. However, since the methodology was the same from 2008 to 2012, we believe the amounts reported between 2008 and 2010 were also likely overstated.

OMIG officials told us that excluding providers with increased billings is appropriate because the control is by provider, and not by volume of claims. However, an external review in August 2008 also noted that OMIG should consider increases in billings from baseline amounts to reflect a more accurate annual cost savings figure. OMIG officials stated they will no longer report cost savings for this activity as of January 2014.

Inflated Prescription Drug Cost Savings

In January 2002, a Department of Health remedial action required physicians to request prior authorization before prescribing and dispensing a human growth hormone marketed as Serostim. OMIG reported a total of $196.4 million in cost savings between 2008 and 2011 based on the effects of the new policy. The reported cost savings were based on the difference between the average monthly amount paid for Serostim before and after the new policy took effect. By 2008, this policy had been in effect for six full years. We therefore question whether OMIG should be claiming recurring savings so many years after the administrative action was taken. In fact,

OMIG's own internal review of the methodology completed in December 2009 found the Health Department's policy had been effective at reducing the drug's cost to the Medicaid program and recommended management discontinue reporting cost savings for this activity. Even so, OMIG continued to report an additional $91.8 million in cost savings for 2010 and 2011.

No Adjustment for Re-Enrolled Providers

Between 2008 and 2012, OMIG reported cost savings totaling $132.1 million for two activities that resulted in providers being excluded or terminated from Medicaid. However, we determined OMIG likely overstated a portion of these cost savings because it did not adjust its calculations to reflect providers who subsequently re-enrolled. We did not estimate the extent to which savings estimates were inflated as a result of this problem, largely because the percentage of cost savings associated with re-enrolled providers can fluctuate widely from year to year (e.g., 31 percent in 2012 vs. 5 percent in 2013). However, OMIG estimates that it overstated the $71.4 million in reported cost savings for the three years ended December 31, 2010 by about $1 million because it counted savings from providers who were subsequently reinstated. As a result of an internal review that identified this deficiency, officials had already adjusted their methodology starting with the 2012 savings calculations.

Inaccurate Discount Ratios Applied to Denied Claims

According to the Public Health Law, Medicaid is the payer of last resort. Therefore, providers must bill recipients' third party insurance before submitting claims to Medicaid. From 2008 to 2012, OMIG reported cost savings of $1.1 billion for 21 activities that build edits into the eMedNY computer system to automatically identify and deny improper claims. OMIG estimates the cost savings resulting from denied claims by reducing the full claim amount by a discount factor, since Medicaid typically does not pay the full claim amount for health care services even when they are approved. The discount factor represents the percentage of the bill that Medicaid would have paid had the claim not been denied, and is based on comparing actual paid amounts to total billed amounts.

We determined that the cost savings for 19 of the 21 edit-based activities were likely overstated by an estimated $99 million because the discount factors used improperly included the amounts normally paid by third party insurance instead of only the lower amounts Medicaid would have paid. We note that an April 2013 internal review identified that the amounts used to calculate savings were too high, and that management adjusted the methodology accordingly for more accurate savings.

Inflated Pre-Payment Insurance Verification Savings

Some Medicaid patients have third party insurance policies that are identified and verified through data matches between Medicaid recipient files and commercial, Medicare, military, and other available third party insurance files. These matches allow OMIG to reject claims until recipients' third party insurance has been utilized. OMIG uses both the value of these denied claims and the amounts paid by third party insurance on legitimate claims as part of its cost saving calculation.

Between 2008 and 2012, OMIG reported a total of $5.2 billion in cost savings as a result of its pre-payment insurance verification efforts. We were unable to review detailed claims data to verify the amounts originally reported from 2008 to 2010 due in part to the lack of documentation and other limitations within the Medicaid Data Warehouse. However, we estimated that the savings were likely overstated by about $144 million for calendar years 2011 and 2012 due to over-counting of denied claims (see Table 2).

Table 2 - Breakdown of Pre-Payment Insurance Verification Activities (*in millions*)

Verification Activity	Reported Cost Savings	Savings Tested	Overstated Savings
Medicare	$ 776	$ 108	$ 2
Commercial Insurance	4,471	2,258	142
Total	**$ 5,247**	**$ 2,366**	**$ 144**

It is likely that savings reported for 2008 through 2010 were similarly overstated, since the same methodology applied in 2011 and 2012 was also used during this earlier period.

Double Counting Savings on Denied Claims

We identified two scenarios under which the savings from denied claims are overstated. In both scenarios, a provider incorrectly submits claims to Medicaid when it should have billed third party insurance instead, and Medicaid denies the claim. Under the first scenario, if the provider submits a new claim for the exact same service without utilizing third party insurance, it will be denied again for the same reason. OMIG, in calculating its cost savings for this activity, then counts the savings from both the initial and the duplicate denials, when actually the value of only one service was saved.

In the second scenario, the provider submits a new claim for the same service after first utilizing third party insurance. Medicaid will then pay its portion of the claim. When OMIG calculates cost savings, it includes the value of the initial denied claim as well as amounts subsequently paid by third party insurance. This again results in OMIG counting savings on the same service twice. In contrast, we found that for other cost savings activities OMIG excludes from its calculations duplicate denied claims and claims that are initially denied but later paid.

Between 2008 and 2012, OMIG reported savings on claims that it had already accounted for under these scenarios, resulting in likely overstatements of about $144 million in cost savings for 2011 and 2012. OMIG officials agreed and indicated a complete review of this activity was needed.

Possible Double Counting of Third Party Insurance Savings

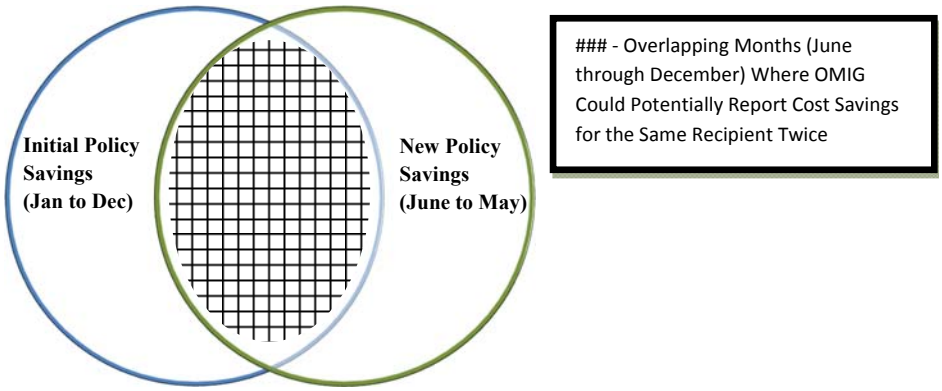
Insurance information for Medicaid recipients is subject to frequent change, such as when patients gain third party insurance, lose third party insurance, or change to a new third party insurance

provider. In fact, a January 2013 U.S. Department of Health and Human Services report states that Medicaid recipients with commercial third party insurance are likely to have fluctuations in coverage. Policy change information is verified and updated in the eMedNY claims processing system. New third party insurance additions in the eMedNY system are considered cost savings events, and thus are included in cost savings calculations. However, OMIG's methodology did not make adjustments for Medicaid recipients who experienced multiple changes in their third party insurance status (e.g., gain and/or loss of coverage). Thus, the cost savings methodology is likely to overstate savings during some months.

Although we could not quantify an amount due to the wide variations in costs and terms for which third party insurance may be in effect, the following scenario illustrates the potential for overstated cost savings resulting from fluctuations in third party insurance:

A recipient is identified with third party insurance in January, and thus, OMIG calculates and reports cost savings over the 12-month period January through December. Over the next 6 months, the same recipient obtains new employment and changes insurance providers or changes insurance policies. The eMedNY system is then updated with a termination of the initial policy along with an addition for the new policy in June. OMIG, having already reported cost savings from January through December, again reports cost savings for the same recipient for the 12-month period June through May of the following year for the new policy. In this case, OMIG would have overstated cost savings by reporting duplicate savings during the 7-month period of June through December (see Figure 1 below).

Figure 1 – Overlapping Cost Savings Reporting Periods



Inconsistent Calculation Methods for Third Party Insurance

OMIG reported the average cost savings realized each month from new third party insurance events. Its methodology factors in policy values for commercial insurance and Medicare, as well as the number of new insurance events. Based on our comparison of the monthly calculations for 2011 and 2012, we determined that the cost savings methodology was not applied consistently over time, possibly inflating the cost savings reported in 2012 by $6.3 million. For example, when questioned why the policy values used in the savings calculations were re-calculated more

frequently in 2011 and why the percentage increases were so high in a short period of time, officials could not provide complete explanations or documentation to support changes to the methodology.

As a result of our findings, OMIG developed a new approach to calculate Pre-Payment Insurance Verification Cost Avoidance, which corrects for the deficiencies that we found in the original calculations. Officials also indicated that, in developing this new approach, they identified other areas where they believe the original calculations were too conservative and may have understated actual savings. In addition, officials stated they are assembling a work group of staff from across functional lines to review all cost savings on a quarterly basis, and to routinely identify and assess fluctuations in the savings reported.

Recommendations

1. Perform a full review of cost savings activities to identify and correct inconsistencies and inaccuracies in methodologies.

2. Routinely take steps to identify changes in the Medicaid program that impact cost savings activities and update cost savings methodologies when needed to ensure consistency among all cost savings methodologies.

3. Improve communication among managers responsible for cost savings calculations and use their collective input to help routinely identify inconsistencies and refine methodologies.

Audit Scope and Methodology

Our audit assessed the accuracy of OMIG's cost savings as reported in its annual reports for calendar years 2008 through 2012. Our audit scope included the period January 1, 2008 through December 31, 2012.

To accomplish our audit objectives, we interviewed OMIG officials responsible for cost savings activities. We reviewed relevant State and Federal laws and regulations and relevant OMIG records. We also reviewed the controls over the cost savings data to ensure its reliability. In addition, we reviewed the methodologies employed for 35 activities reporting cost savings between 2008 and 2012. Our review determined whether the methodologies focused on actions taken by OMIG and resulted in reasonable and consistent calculation of savings to the Medicaid program. We tested $4.3 billion of $7.8 billion in savings reported for 27 activities. We did not test the remaining $3.5 billion for various reasons, including uncertainties caused by fluctuations in certain key factors affecting individual methodologies and, in a few cases, lack of available supporting documentation.

We also reviewed documentation supporting the 2011 calculations for 10 activities that reported $50 million or more in savings on the 2011 annual report to determine if the calculations were accurate and consistent with amounts reported in OMIG's annual reports. We used actual

Medicaid claims data, provided directly by OMIG or obtained from the Medicaid Data Warehouse, to verify calculations and to recalculate cost savings for certain activities that were questionable. We also tested the reliability of OMIG's computer systems.

We conducted our performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. In addition, the Comptroller appoints members to certain boards, commissions and public authorities, some of whom have minority voting rights. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these functions do not affect our ability to conduct independent audits of program performance.

Authority

This audit was performed pursuant to the State Comptroller's authority under Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

Reporting Requirements

A draft copy of this report was provided to Office of the Medicaid Inspector General officials for their review and comment. Their comments were considered in preparing this final report and are attached in their entirety to the end of this report. Our rejoinders to certain OMIG comments are included as State Comptroller's Comments.

Within 90 days after final release of this report, as required by Section 170 of the Executive Law, the Medicaid Inspector General shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons why.

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Vision

A team of accountability experts respected for providing information that decision makers value.

Mission

To improve government operations by conducting independent audits, reviews and evaluations of New York State and New York City taxpayer financed programs.

Agency Comments

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ANDREW M. CUOMO
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MEDICAID INSPECTOR GENERAL

May 30, 2014

Mr. John Buyce, Audit Director
Office of the New York State Comptroller
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110 State Street – 11th Floor
Albany, New York 12236-0001

Dear Mr. Buyce:

Enclosed are the Office of the Medicaid Inspector General's (OMIG's) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2013-S-29 entitled, "Accuracy of Reported Cost Savings." OMIG appreciates this opportunity to respond to the Draft Audit Report issued by OSC and the on-going dialogue between our two agencies.

OMIG believes it is vital for readers to have a clear understanding of this audit. While we are pleased that OSC's draft audit report recognized that OMIG saved tax payers billions of dollars, we disagree with many of the findings in this report. Accordingly, OMIG has identified areas for which further explanation is warranted, and if necessary, a request that OSC amend its findings. Those main areas are summarized as follows:

First, it is important to note OMIG properly utilized established agency policies and procedures for its cost savings initiatives. It is well-established that there are no laws, regulations, technically developed standards or norms, or defined business practices regulating cost savings methodologies. In such cases, Government Auditing Standards explicitly allow the use of policies and procedures established by the audited entity (OMIG).

Second, OMIG asserts that although it was unnecessary for OSC to retroactively adjust cost savings estimates, OMIG has since tabulated revised estimates based on OSC's recommendations and the additional adjustments that OMIG feels should be noted in the Final

* Comment 1

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* See State Comptroller's Comments on page 21.

Report. These calculations resulted in the identification of a $794 million understatement of reported cost savings, making the total cost savings to the New York State Medicaid program $10.9 billion rather than the $10.1 billion originally reported by OMIG for the entire audit period.

Third, although OSC reviewed a modification to OMIG's Pre-Payment Insurance Verification – Commercial and Medicare (PPIV) methodology, it did not account for or report the resulting $1.5 billion under-reported cost savings. OMIG requests that the Final Report be amended to include this information.

* Comment 2

Finally, OMIG respectfully notes that the majority of OSC's findings were actually adjustments that OMIG had identified through internal reviews prior to OSC's audit, and that OMIG has already implemented those findings prospectively.

With OMIG's comments properly considered, we believe that OSC's expansive review affirms the accuracy of OMIG's performance metrics and reinforces OMIG's position as the most effective State Medicaid Program Integrity agency in the nation.

If there are matters in this response that you or your staff would like to discuss, you can contact me at (518) 473-3782.

Sincerely,

James C. Cox

James C. Cox
Medicaid Inspector General

Enclosure

2

The following are the Office of the Medicaid Inspector General's (OMIG's) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2013-S-29 entitled, "Accuracy of Reported Cost Savings."

1. Misapplication of Audit Criteria

OMIG disagrees with OSC's contention, in the Executive Summary on page 1, that the methodologies OMIG utilized to estimate cost savings had flaws and/or inconsistencies that resulted in overstated savings. It is well-established that there are no laws, regulations, technically developed standards or norms, or defined business practices regulating cost savings methodologies. Rather, pursuant to Government Auditing Standards, published by the Comptroller General of the United States, the use of policies and procedures established by the audited entity (OMIG) are, clearly and explicitly, allowed. Specifically, Government Auditing Standards, Chapter 6 Field Work Standards for Performance Audits, Section 6.37, require that auditors identify criteria represented by laws, regulations, standards or specific requirements and benchmarks against which performance is compared or evaluated. In addition, Appendix I, Information to Accompany Chapter 6, Section A6.02 provides examples of criteria which include, among others, purpose or goals prescribed by law or regulation or set by officials of the audited entity, policies and procedures established by officials of the audited entity, technically developed standards or norms, expert opinions, defined business practices, and performance of other entities used as defined benchmarks. Indeed, OSC itself acknowledges, on page 4 in the Background section, that *"...there are no standardized industry guidelines for calculating cost savings..."*.

* Comment 3

OMIG asserts that it was following acceptable standards when it established its own methodologies for identifying cost savings activities. As presented to OSC on many occasions, while there can be similarities between project methodologies, each can contain a unique algorithm which is justified based on the differing controls and circumstances relative to each. Determining the most appropriate algorithm is subjective and requires some amount of latitude. When cost savings are valued, there is almost never a single "right" or "best" way. OSC appears to make the assumption that, where their opinion on a given algorithm is different from OMIG's, that they are correct.

2. Omission of a Revised Methodology with Improved Cost Savings

OSC did not report OMIG's modification to its Pre-Payment Insurance Verification – Commercial and Medicare (PPIV) methodology. This modification resulted in a $1.5 billion understatement of OMIG's reported savings - more than offsetting all of OSC's findings. This makes the total cost savings to the Medicaid program $10.9 billion rather than the $10.1 billion reported for the audit period.

* Comment 2

Although we have asserted that it is not necessary to adjust cost savings estimates retroactively, we have tabulated revised estimates below based on OSC's recommendations and the additional adjustments that OMIG feels should be noted in the Final Report. These calculations result in a $794 million understatement of previously reported cost savings.

OMIG Reported Cost Savings for the Audit Period	$10,087,387,982
Total Adjustments[1]	$794,552,249
Total Cost Savings to NYS Medicaid	**$10,881,940,231**

Furthermore, OMIG staff, as a result of the OSC audit, started an internal review of the current methodology to determine if improvements were needed. As a result of this review, the new PPIV methodology was provided to OSC as part of OMIG's response to the OSC preliminary report. OSC performed a detailed review of the algorithm - in fact - the final version of the algorithm which was implemented included recommendations made by OSC.

Throughout OSC's draft report, OSC auditors adopted OMIG's own adjustments and created findings by retroactively applying overstatements; however, this $1.5 billion adjustment which resulted in an understatement of savings was omitted.

3. Issues Noted by OSC Were Already Addressed by OMIG

OMIG had already commenced internal reviews of their cost savings initiatives several years before OSC began its audit. Since 2009, OMIG had proactively modified 24 of the 27, or 88%, of the cost savings initiatives reviewed. As a result, OMIG had already discovered and addressed the overwhelming majority of OSC's findings listed in the draft report.

* Comment 4

As stated in interviews with OSC's staff, and in OMIG's response to the Preliminary Reports, modifications to cost savings methodologies are not applied retroactively. In April 2013, OMIG prospectively adjusted all the discount ratios associated with the edit-based cost savings initiatives. OSC did not reflect OMIG's adjustments in its draft report.

* Comment 5

4. Additional Comments on the OSC Report

Lack of documentation for cost savings initiative – OSC incorrectly states, on page 9 in the Inflated Pre-Payment Insurance Verification section, that its auditors were unable to review the amounts reported for PPIV from 2008 – 2010 due in part to the lack of documentation. On

* Comment 6

[1] This amount includes all OSC findings, as well as OMIG's adjustments to Pharmacy Prior Authorization (Serostim) for 2008 and 2009; Pharmacy Claims – Credits for Prescriptions for 2010 and 2011; and under-reported PPIV amounts for the entire audit period.

August 21, 2013, OSC Auditors interviewed and met with the OMIG employees responsible for calculating these cost avoidance figures and reviewed all of the requested backup documentation and calculations related to this initiative. In addition, OMIG sent numerous emails to OSC with supporting documentation for the time period January 2007 through December 2012.

Furthermore, OMIG does not understand the origin of the comment, made on page 9 in the Inflated Pre-Payment Insurance Verification section, regarding Data Warehouse limitations. OSC made no reference to OMIG of Data Warehouse limitations prior to this issued Draft Report.

Additional PPIV savings – OSC states, on page 10 in the Inconsistent Calculation Methods for Third Party Insurance section, that OMIG incorrectly applied its PPIV methodology in 2012. This is incorrect. OMIG incorrectly applied the PPIV methodology in 2011. Had OMIG correctly utilized its PPIV methodology in 2011, as it was for 2012, it would have resulted in an under-reporting of cost savings figures for 2011 in excess of $54 million, not an over-reporting of cost savings for 2012 exceeding $6 million.

* Comment 7

Underestimation of the Sentinel Effect and Lack of Communication - OSC erroneously concluded that OMIG's methodology for the Pharmacy Claims – Credits for Voided Prescriptions initiative was flawed because OMIG did not send letters to all impacted pharmacies.

OMIG disagrees that its methodology was flawed. OMIG notified 1,000, or 20%, of the approximately 5,000 pharmacies in the State that their credits for voided claims (adjustments for prescriptions never picked up) were well below the statewide average. In the January/February 2010 edition of New York City (NYC) Pharmacists Society newsletter, the Chairman's Report contained an article regarding the letters sent by OMIG. This association is an affiliate of the larger, statewide Pharmacists Society of the State of New York. The society's decision to publish an article on OMIG's notification letter alerted all of the affiliate's members that their credits for voided claims were potentially at issue. Sentinel effect is defined as: *the tendency for human performance to improve when participants are aware that their behavior is being evaluated.* The fact that an article was published by an affiliate of the Pharmacists Society of the State of New York supports OMIG's theory that more than just those who received the letters were aware their behavior was being evaluated.

* Comment 8

Moreover, OSC incorrectly assumed that a lack of communication among managers, as referenced on page 7 in the Pharmacy Claims - Credits for Voided Prescriptions section, led to this initiative being inconsistently calculated compared to High Ordering Physicians initiative. There was no lack of communication. The methodologies used were for two different projects that seemed similar but were intentionally calculated differently due to differing controls and circumstances relative to each project.

Misrepresentation of the Percentage Application for Providers Re-enrolled in the Medicaid program - OMIG calculates cost savings on providers who have been excluded from the

Medicaid program either due to internal investigations or external actions taken by other agencies, such as the United States Department of Health and Human Services, the New York State Department of Education, or the Department of Health's Office of Professional Medical Conduct.

OSC has proposed a finding because OMIG did not re-adjust its calculations when a provider was reinstated into the Medicaid program. OSC is not interpreting the percentages correctly. The referenced percentages are not cost savings, but the actual percentage of providers from each year's exclusions which were subsequently re-enrolled. These fluctuations are natural and fully accounted for in the OMIG methodology.

* Comment 9

OSC Recommendations

a. *Perform a full review of cost savings activities to identify and correct inconsistencies and inaccuracies in methodologies.*

OMIG had already undertaken a full review of its cost savings activities well before the OSC audit commenced. OSC acknowledges OMIG's actions on page 4 in the Background section of this Draft Audit Report: *"These [cost savings] estimates should reflect accurate calculations to the greatest extent possible, and OMIG performs reviews of the various methodologies to help ensure this."* OMIG has also created a Cost Savings Workgroup to ensure continued improvements to its processes.

b. *Routinely take steps to identify changes in the Medicaid program that impact cost savings activities and update cost savings methodologies when needed to ensure consistency among all cost savings methodologies.*

OMIG had already undertaken a full review of its cost savings activities. OMIG's Cost Savings Workgroup will continue to review proactively the agency's cost savings initiatives.

* Comment 10

c. *Improve communication among managers responsible for cost savings calculations and use their collective input to help routinely identify inconsistencies and refine methodologies.*

As stated earlier, there was no lack of communication. Moreover, the Cost Savings Workgroup reviews methodologies, and facilitates communication among all managers responsible for developing and implementing cost savings initiatives.

Summary

With OMIG's comments properly considered, we believe that OSC's expansive review affirms the accuracy of OMIG's performance metrics and reinforces OMIG's position as the most effective State Medicaid Program Integrity agency in the nation.

OMIG remains committed to its core mission to enhance the integrity of the New York State Medicaid program by preventing and detecting fraudulent, abusive, and wasteful practices

within the Medicaid program and recovering improperly expended Medicaid funds while promoting a high quality of patient care. Based on these points, OMIG believes that the cost savings estimates reported by the agency were, and continue to be, conservative and likely understate the larger program integrity benefit to the State Medicaid program.

7

State Comptroller's Comments

1. We estimated the dollar impact of the flaws and inconsistencies we identified in OMIG's methodologies. We did not adjust cost savings or recommend that OMIG do so.
2. OMIG made revisions to its PPIV methodology in response to our preliminary findings, which we note addressed two of our recommendations. We raised questions about the changes with OMIG, and OMIG made additional revisions to the methodology, which were completed subsequent to the completion of our audit fieldwork. Consequently, we did not audit OMIG's final estimate of $1.5 billion in additional savings, and therefore we cannot attest to its accuracy. We amended the report to include OMIG officials' comments that they identified $1.5 billion in additional savings by revising their PPIV methodology.
3. We believe our findings clearly show that some methodologies had flaws and/or inconsistencies that reduced the accuracy of OMIG's cost savings. In fact, OMIG revised many of the methodologies during the audit period, including some changes it made during our audit fieldwork.
4. OMIG states it proactively modified 24 of the 27 activities we found issues with. Our report acknowledges that OMIG modified 21 activities prior to our audit. The remaining six activities were adjusted either as a result of the change to Managed Care or as a result of our audit. For example, PPIV, its largest cost savings activity (over 50 percent of total cost savings reported for 2008 through 2012) was last reviewed by a CPA firm in 2007 and not reviewed again by OMIG until our audit.
5. OMIG's assertion is incorrect. In fact, we cite the adjustments OMIG made in each respective section throughout the report.
6. OMIG provided us with calculations for the savings for each year. However, they did not provide support for the policy values used in their calculations for the years 2008 through 2010. Additionally, the detailed claims data we needed to independently verify OMIG's calculations for 2008 through 2010 was no longer available in the data warehouse. Therefore, we did not estimate cost savings for those years.
7. We did not report that 2012 was incorrectly applied. We state that there was an inconsistency between how savings were calculated in 2011 (when the policy values changed twice) and in 2012 when the policy values changed again. OMIG officials could not provide an explanation as to why this occurred. This number was not included in the overall overstatement of cost savings, but was meant to illustrate the inconsistencies in calculations between the two years.
8. We disagree. We compared the methodology used for the Pharmacy Claims for Voided Prescriptions activity with the methodology used for the High Ordering Physicians activity because both took action on the portion of the population considered the greatest risk for improper claims. Despite the similarity, OMIG calculated cost savings differently.
9. We believe OMIG is incorrect in its statement on the referenced percentages. The savings are not a function of the percentage of providers that become re-enrolled, but of the portion of cost savings attributable to the re-enrolled providers. For example, if 20 of 100 providers (20 percent) are re-enrolled, but these providers account for 40 percent of the total savings, the adjustment percentage should be 40 percent. Additionally, we state that we did not estimate the extent to which savings estimates were inflated for this

activity because the percentage of cost savings associated with re-enrolled providers can fluctuate widely from year to year.

10. We applaud OMIG's efforts to create a Cost Savings Workgroup.