Statement of

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Before

SPECIAL COMMITTEE ON AGING

on

Catch Me If You Can:
STOP Medicare and Medicaid Fraud
From Hurting Seniors and Taxpayers

May 6, 2009

Ranking Member Martinez and all Committee Members present,

On behalf of New York's Medicaid Inspector General James G. Sheehan, and the New York State Office of the Medicaid Inspector General, known as OMIG, I thank you for the opportunity to describe our efforts at preventing and detecting Medicaid fraud, waste and abuse.

The New York State Office of the Medicaid Inspector General (OMIG) was created to coordinate and improve the state's process of combating Medicaid fraud, waste and abuse. We do this by collaborating with our fellow state and federal partners and with providers, their representatives, consultants and counsel, to prevent or detect fraud, waste and abuse in the Medicaid Program. While we do not have prosecutorial authority, when we find possible criminal intent, we assist federal, state and local law enforcement agencies to ensure that criminal activities relating to Medicaid answer to the full extent of the law.

We pursue our mission in the framework of our Governor's commitment to ensuring a "patient-centered" approach to health care. We carefully consider the effect each enforcement action has on the quality and availability of medical care, services and supplies in the community and always base our actions on the best interest of both the Medicaid program and Medicaid enrollees.

Measured by fraud and abuse recoveries reported to CMS, New York was the most successful state in the nation in Medicaid program integrity over the past year, identifying recoveries of more than $551 million. This success results from the commitment of state elected officials and state agencies and the support of federal agencies. It is also the result of congressional, media and legislative attention in 2005 and 2006 to the significant failures of New York's Medicaid oversight. While recovering overpayments is a necessary part of our efforts, and although we have been successful in identifying significant recoveries, New York's long-term program integrity goal is to prevent or

minimize improper payments. This is a daunting task given the $46 billion spent on Medicaid covering 60,000 providers and over 4 million enrollees.

Even at the time of enacting our enabling legislation, the New York Legislature fully appreciated that a "pay and chase" approach is neither effective nor efficient and that New York State Medicaid Providers have a responsibility and are in a prime position to identify instances of non-compliance and to correct billing and payment mistakes. With this in mind, our State Legislature, on a bi-partisan effort, passed §363-d of the Social Services Law that mandates that providers of Medicaid care services or supplies adopt an effective compliance program. As a former in-house Compliance Officer for a comprehensive healthcare system, I have seen first-hand what works, and what doesn't in terms of provider efforts to adopt and implement systems and tools to assure program integrity.

In developing our compliance guidance documents, in addition to addressing the typical billing and coding issues, we have placed additional accountability on Board members, senior executives and font-line staff related to governance and oversight of ethical business conduct and the expectation that all providers will provide access to high quality care.

We also support and use the administrative tools related to provider enrollment review, payment suspension, pre-payment review, audit, sanction, and individual and entity exclusion when improper payments are discovered. All too often, these remedies are deferred pending the outcome of the extended criminal investigation-this means that we keep providers in the program who are most likely to be collecting improper payments and continue to pay those providers. In New York, we have significantly expanded the use of pre-payment reviews, payment suspensions and individual and entity exclusions.

Recognizing that we will never eliminate all overpayments, we have and continue to develop ways to integrate technology into our audit and investigatory practices. Individuals throughout the OMIG use data mining as a resource during the course of day-

to-day activities. Every OMIG auditor, investigator, clinical staff (including physicians, dentists, pharmacists and nurses) and data analyst has unlimited and immediate access to our "data-warehouse", our claims data system that holds $200 billion in claims data covering claims submitted by 60,000 providers for services for over 5 million Medicaid enrollees over the past 5 years.

Some of these individuals operate within our audit or investigative units, while others are dedicated to targeting, provider analysis, support of targeting tools, creation of data match algorithms and the provision of pre-audit analysis & audit samples, but everyone involved with data mining collaborates with program units to get new ideas and fresh perspective from the field

We utilize several tools – one that presents ease-of-use through a graphical user interface, yet allows the user to make complex queries and effortlessly drill down into increasing levels of detail. Another specializes in resolving entity relationships (e.g. link analysis) from disparate data sources. Examples of recent findings include:

- Managed care fees paid to managed care companies after a Medicaid recipient has been admitted to an assisted living center or nursing home
- Multiple client identification numbers used for the same recipient
- The pharmacies which provide "home-delivered" prescriptions to patients who died weeks or months before;
- The managed care plans and hospitals that bill Medicaid for prenatal services for males;
- The transportation company that bills Medicaid for patients who are dead, or hospitalized, or in a nursing home, or incarcerated at the time the outpatient services were allegedly rendered:
- The providers who credit a refund when an agency review identifies an overpayment, and then rebill the State for the same services six months later.

Through data mining, and technology we are able to identify issues that enable our investigators to dig deeper into a situation and determine whether we have found an isolated incident or a trend that indicates potential fraud, waste or abuse.

We need to move to a system which makes program integrity a major goal of oversight, investigative, and prosecutive efforts through the following principles:

- First, require and support effective corporate compliance programs and professional compliance officers. New York requires by law that larger providers have an effective compliance program, with eight elements. The Medicare program suggests model compliance programs. We want health care providers to identify and resolve issues themselves; the best already do.

- Second, hold senior executives and board members accountable for failing to have systems to prevent improper billing. Corporate and non-profit law requires boards to have systems in place "reasonably likely to detect and prevent" violations of law. The Office of Inspector General (HHS) has done a great job of articulating its expectations for board members of hospitals and nursing homes. We need to assure that the focus of program integrity efforts is on systems control failures by management and the board as well as wrongful intent.

- Third, elevate, support and use the administrative tools of payment suspension, prepayment review, audit, sanction, and individual and entity exclusion when improper payments are discovered. All too often, these remedies are deferred pending the outcome of the extended criminal investigation-this means that we keep providers in the program who are most likely to be collecting improper payments and continue to pay those providers. In New York, we have significantly expanded the use of pre-payment reviews, payment suspensions and individual and entity exclusions.

- Fourth, recognize that the most effective deterrence requires regulator communication to and persuasion of those whose behavior we are trying to influence. Most health care providers are risk-averse and the literature has shown frequent and predictable interventions for providers are more effective than occasional severe sanctions.

- Fifth, develop and communicate consistent measures of effectiveness of program integrity which capture cost reduction and avoidance as well as recoveries, and minimize costs imposed by reviews and investigations. Measuring program integrity by recoveries alone, or by prosecutions alone, or by the cost of auditors divided by their recoveries does not give a clear picture of what is expected or of what is being accomplished.

- Sixth, recognize incentives which cut against effective program integrity. CMS currently requires states to repay the federal share of identified Medicaid recoveries as soon as they are identified (Section 1903 (d)(2)(A) of the Social Security Act, 42 U.S.C. 1396b (d)(2)(A). This discourages states from investing in program integrity efforts against program providers who are in financial difficulty and will be unable to repay identified overpayments. Let the state and federal governments face the same risk of non-payment from providers who have obtained improper payments, or provide an enhanced percentage to states for identified overpayments.

Conclusion

We are finding fraud, waste and abuse in New York's Medicaid program, and we are also intensifying our efforts to stop these problems. We expect providers to review themselves and correct incidents of non-compliance. Our recently released self-disclosure protocols and annual work plan are posted on our Web site to inform providers of areas of focus. We are recovering improper payments, but our ultimate goal is to prevent those payments from being made in the first place. Toward that end, we are committed to educating the provider community on ways to incorporate compliance and integrity into their day-to-day activities.

Our efforts have contributed significantly to the integrity of Medicaid in New York and beyond. We believe that the time for other states to take on these issues is long overdue, and hope that our ideas will be replicated in other states as we seek--as a nation--to improve the quality of health care for all citizens.

On behalf of OMIG and New York, I want to thank you for the opportunity to present this testimony today.