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Office of the Medicaid Inspector General

Joint Legislative Budget Testimony

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Good morning Chairwoman Young, Chairman Farrell, distinguished members of the Senate Finance and Assembly Ways and Means Committees, and Health Committee Chairs Senator Hannon and Assemblyman Gottfried. I am Dennis Rosen, Medicaid Inspector General, and I appreciate this opportunity to discuss the activities and initiatives of the Office of the Medicaid Inspector General (OMIG) as they relate to the 2016-17 Executive Budget.

OMIG is nationally recognized for its commitment to protecting the integrity of New York State's Medicaid program. It has done so through its investigative work and partnerships with other law enforcement agencies, innovative auditing techniques, and proactive outreach and compliance initiatives - all of which have resulted in billions of dollars in cash recoveries and cost savings. As such, OMIG plays a vital role in ensuring that Medicaid recipients throughout the State have access to New York's high-quality, cost-effective healthcare delivery system.

OMIG pursues recoveries where overpayments have been made. Even more important, in my view, are OMIG's efforts to, *up front*, prevent improper costs and billings in the Medicaid program. As we all know, it is far more cost effective to prevent improper payments in the first place, as opposed to chasing dollars *after* they have been paid out.

OMIG's cost-avoidance initiatives for 2015 delivered savings of more than $1.4 billion through September. These results are on track to exceed 2014's cost-avoidance results of $1.8 billion. Each of OMIG's cost-avoidance initiatives has its own comprehensive methodology for accurately calculating Medicaid program dollars that are saved. For example, OMIG uses pre-payment program edits that we build into the Medicaid billing system that deny improper provider claims. Another area of cost savings is, where OMIG has had an intervention with a provider, OMIG will subsequently compare billing patterns prior to the intervention with those after to determine the cost savings attributable to the modifications in the provider's operations that were a result of our involvement.

In addition to cost-avoidance, identifying and recovering dollars that have actually been paid because of fraud, waste or abuse in the Medicaid program is a core OMIG function. OMIG's 2015 preliminary audit results through September show more than 1,700 audits initiated and

over 725 audits finalized. Cash recoveries for this nine-month period, including audits, third-party liability, and investigations total approximately $250 million.

Moreover, holding accountable those who intentionally defraud the system is priority number one. To this end, OMIG works independently and in collaboration with partners at all levels, including local, state and federal law enforcement, provider organizations, and health plan special investigation units (SIUs). These collaborative efforts have become more effective as the healthcare delivery system continues its shift from a predominantly fee-for-service model to a managed care approach.

One example of this is OMIG's Managed Care Investigation Unit. The Unit investigates complaints received from managed care organizations (MCOs) relating to network provider fraud, and works with their SIUs to develop comprehensive investigative plans. OMIG conducts quarterly statewide meetings with all of the SIUs, at which it shares recent case referrals from SIUs to identify suspicious trends across plans, coordinate next steps, and provide additional information to enhance program integrity and drive results. OMIG has created a database, that is accessible to OMIG investigators, consisting of contact information for SIU staff in all managed care plans. Preliminary data for 2015 show that, as a result of OMIG's work with the SIUs, referrals from MCOs to OMIG totaled 344, up from 273 referrals in 2014.

Also, as part of its managed care focus, OMIG continues to generate results through its reviews of managed long-term care plans (MLTCs). These MLTC audits focus on enrollee eligibility for long-term care, and whether the plans are meeting the service needs of enrollees based on their plans of care. OMIG has engaged 26 MLTC plans for audit, and has reviewed enrollment eligibility criteria and related care plans for more than 4,900 enrollees.

In addition, OMIG, in concert with the Department of Health and the Office for the Aging, developed and implemented last year New York State's first-ever certification process for social adult day care providers (SADCs). This will play an important role in the State's oversight of managed long-term care organizations and their relationships with SADCs.

Additionally, OMIG has played a critical role in many collaborative law enforcement actions that have resulted in the takedown of major fraud schemes, enrollment fraud arrests, and drug diversion cases. One example of these joint-enforcement actions resulted in the indictment of 23 defendants who were involved in a $7 million Medicaid fraud scheme in Brooklyn. Last March, OMIG, along with the Brooklyn District Attorney, the United States Health and Human Services Office of the Inspector General, and the New York City Human Resources Administration, announced charges against nine physicians and 14 other individuals pursuant to a 199-count indictment. The defendants lured homeless people, and individuals from low-income areas, to medical clinics where they received unnecessary tests in exchange for free shoes. OMIG provided Russian-speaking staff, data collection and analysis, and intelligence gathering in the course of the investigation.

OMIG has also been very involved in drug diversion cases. For example, OMIG assisted the Suffolk County District Attorney's Office investigation of Ingrid Gordon-Patterson, a nurse practitioner based in Suffolk County. In a one-year period, she wrote more than 1,200 prescriptions of Oxycodone for patients who had no medical need for this highly addictive drug. OMIG's assistance included surveillance, data-mining services, and reviewing documentation from MCOs. On June 29, Gordon-Patterson was convicted on five counts, which included Criminal Sale of a Controlled Substance. On August 25, she was sentenced to nine to 19 years in prison.

Thus far our 2015 statistics regarding enforcement activity are robust. Preliminary numbers through September indicate that OMIG opened more than 2,700 investigations, completed more than 2,900, and referred 926 cases to law enforcement and other agencies. In addition, during the same nine-month period, OMIG excluded 844 providers from the Medicaid program, which exceeds the 822 provider exclusions for all of 2014.

OMIG also places great emphasis on provider outreach and education, particularly focusing on providers having proactive compliance programs that will prevent or, when necessary, detect and address abusive practices. We offer compliance webinars, guidance materials, self-assessment tools, presentations, and a dedicated compliance email address and phone

number. OMIG's oversight activities and educational efforts increase provider accountability and contribute to improved quality of care.

In 2015, OMIG issued more than 30 compliance-related guidance materials and conducted over 20 educational presentations and webinars. The compliance section of the OMIG website had 36,000 visits to compliance webinars, 25,000 visits to compliance publications and 40,000 visits to compliance resources and FAQs. Many of our webinars are accredited for legal, accounting or compliance continuing-education credits. In 2016, 206 participants have already received credits, largely because last November OMIG created and posted on its website a nine-part series on New York's mandatory compliance program obligation, as well as a webinar detailing the 2015 Compliance Program Certification Process.

We at OMIG appreciate this opportunity to speak with you about our Medicaid program integrity activities. We believe that our provider education and outreach programs, our investigative efforts, and our success in identifying cost savings and recovering inappropriate Medicaid payments, play a vital role in preventing and detecting Medicaid fraud and abuse while promoting the delivery of high-quality care to millions of New Yorkers.

Thank you. I am happy to address any questions you may have.