

**Testimony Presented by  
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**Joint Legislative Budget Testimony  
New York State Office of the Medicaid Inspector General**

**Hearing Room B  
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11:30 a.m.**

Committee Chairs Kruger, Farrell, Duane and Gottfried, and all committee members present, I want to thank you for the opportunity to discuss Governor Paterson's budget and goals for the Office of the Medicaid Inspector General (OMIG) this year.

As Governor Paterson said in the State of the State, "This is a winter of reckoning" for the government and people of New York. This message is especially important when we look at our State's Medicaid program. New York's Medicaid program is the nation's largest with anticipated expenditures of over \$50 billion in the next fiscal year. New Yorkers must trust that we as a State are doing everything possible to assure that Medicaid dollars are well-spent, and that the providers who receive those dollars are appropriately accountable. The Governor has called upon OMIG to continue and increase our efforts to assure the integrity of the Medicaid program, and the Governor's budget provides the resources necessary to achieve that goal. The Executive budget proposes a series of actions that would improve the coordination and administration of public benefits, and prevent and uncover public benefits fraud, including increased civil penalties for first-time and repeat offenders who commit Medicaid fraud; shared services between the OMIG and the Office of the Welfare Inspector General (OWIG) to provide greater efficiency and strengthen collaborative efforts to detect and control public benefits fraud; and the ability to match individuals and providers who are disqualified from the Medicaid program and thus prohibited from billing for Medicaid services to the records of the Department of Taxation and Finance and the Workers Compensation Board to ensure that Medicaid is not billed. In addition, the Budget also proposes additional measures to ensure the integrity of public benefits programs such as closing loopholes that allow for the transfer of assets; implementing an asset verification system to identify resources not captured today; and collaboration between the OWIG and the Department of Labor (DOL) to target those who illegally shift the cost of employees' medical care to Medicaid by paying people under the table to lower their own insurance costs and/or enable employees who receive public benefits to earn income in excess of established eligibility levels.

Assuring the good stewardship of the over \$50 billion in Medicaid expenditures is the mission of OMIG. The agency's statutory authority directs it to preserve 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. The state's efforts to prevent and detect fraud, waste and abuse have taken us from a national symbol of Medicaid fraud, waste and abuse in 2005 to the nation's leader in recovery dollars and program integrity today.

While much more remains to be done, the State's progress to date reflects three things: first, Legislative and Executive leadership in creating an effective fraud control program; second, improvements undertaken by the provider community; and third, good work on the part of all the entities responsible for program oversight and enforcement. In addition to OMIG, these include the Department of Health-responsible for program design and regulation of other state agencies involved in oversight; the Attorney General's Medicaid Fraud Control Unit (MFCU)-responsible for criminal prosecutions; the county social services agencies-handling the primary responsibility for enrollment integrity; the Office of State Comptroller-providing information and policy recommendations for decision makers;

and various government contractors. We are on FBI led task forces in NYC, Albany, Rochester and Buffalo. We are also on the DOJ led Strike Force in Brooklyn. In addition, we are on a DEA task force in Albany. In each case, we are members with federal law enforcement agencies, as well as other state and local agencies and private insurers. At the county level, we have a network of counties including the City of New York doing work through the county demonstration project to perform audits and/or investigations of Medicaid providers in selected ambulatory care areas.

These improvements stand in stark contrast with where we were five years ago. In July of 2005, a series of articles in the New York Times painted a painful picture of New York State's Medicaid program. "Medicaid has . . . morphed into an economic engine that fuels one of the state's biggest industries, leaving fraud and unnecessary spending to grow in its wake." "The lax regulation of the program did not come about by chance. Doctors, hospitals, health care unions and drug companies have long resisted attempts to increase the policing of Medicaid." These articles and later reviews by the Federal Center for Medicare and Medicaid Services, Federal Office of the Inspector General, and State Senate Finance Committee addressed the reduction in state staff responsible for audit and investigations, and the approach of audit reviews as "provider education" rather than recovery of improper payments.

Within a year after the New York Times series, the legislature created the independent Office of the Medicaid Inspector General.

As the state's first Senate confirmed Medicaid Inspector General, I came to a new agency tasked with overseeing the largest Medicaid program of any State, and a recovery commitment, Federal State Health Reform Partnership (FSHRP), requiring that New York alone exceed the total 2006 national Medicaid fraud and abuse recovery.

New York has met its FSHRP obligations to the federal government. We have improved the controls on the Medicaid system to keep bad providers out. We have met aggressive budget targets for recoveries and avoided costs set by the Governor and the Legislature (which, as shown in chart 1, have gone from \$300 million in 2006 to \$1.2 billion in this year's budget).

As part of our budget message, I want to give you a progress report on where the Office of the Medicaid Inspector General is today and where we are going. I hope we will leave you with an understanding of how the Governor's commitment, and the Legislature's commitment to rooting out fraud, waste and abuse in the Medicaid system has resulted in lower costs and greater accountability.

The 2010-11 Executive Budget includes a total of \$88 million, including \$50 million in federal funds for the OMIG. We are projecting that OMIG will have a workforce of 659 by the end of SFY 09-10 and anticipate filling another 69 positions in SFY 10-11 to reach our funded target of 728.

OMIG has used a four step approach to meeting its statutory and budget obligations:

First, we have conducted an examination of every major component of Medicaid expenditures to determine the amount paid in that area, the audit and investigative activity committed to it, and the risks of fraud and abuse. This includes use of significant new data mining techniques and technologies. As a result of this effort, OMIG has expanded its efforts to look more closely at the fast growing areas of managed care, home health care, and personal care.

Second, we conducted together with CMS an examination of the Medicaid program through a random sample to determine the extent of improper payments of claims based upon the patient records submitted by providers. For 2008, our review showed that improper payments of claims were less than 1.5 percent of Medicaid expenditures. There is no question that this is a significant amount of money, but it is substantially better than the performance of the Medicare and Medicaid programs of most other states, and reflects our audit efforts, the improvements by DOH to its payment and edit systems, and providers' compliance efforts.

Third, State law now requires that every provider billing over \$500,000 have an effective compliance program, including auditing of its billings and disclosure of overpayments. In 2009, we received over 85 disclosures by New York providers.

The overpayment disclosures reflect a significant provider commitment to the compliance process, and have educated OMIG about potential weaknesses in billing and claims to look for in other providers. Where a provider has an effective compliance program, including reliable auditing of areas OMIG would audit, we want to refocus our audit activity toward other providers who have not demonstrated an effective program, and reduce the burdens on the compliant providers.

Fourth, OMIG has begun a series of initiatives designed to address significant gaps between the requirements of law, proper medical and billing practices, and the practices of some providers. These initiatives involve significant data analysis, and focus on encouraging entities to change their practices, identifying system weaknesses, and identifying providers who are "frequent flyers" (that is providers who keep appearing in our data mining and audit efforts) for more intense audit and investigative attention.

One example of our new initiatives is our deceased patients project, which began with an open letter to providers that we would be targeting claims for patients at the time the service was allegedly performed. We selected the month of October 2009, and identified 290 claims for services to patients who were, according to our records, deceased. On December 1, we sent letters to each provider, asking for information within 15 days about who provided the service, who billed the service, and whether the patient was actually deceased.

We have learned a great deal from this project. A number of providers responded, identifying errors they had made (wrong service date, billing for a dead twin instead of a live one, billing from a roster of scheduled patients instead of upon performance of the

service). Over 150 providers claimed that the patients were still alive at the time of the service. We are currently obtaining death certificates from DOH's Vital Statistics Office to confirm the date of death. Two months after the letters went out, 14 providers had not responded at all, despite a certified mail receipt and follow-up phone calls, including some I made myself.

Some responses were instructive. In one pharmacy, the patient's prescription was picked up two days after her death by a family member. In another, the patient's physician requested delivery of the patient's prescription to his office after she died. One dead patient's Medicaid number visited three different dentists in a week. A family accepted delivery on a new bed paid for by Medicaid after the patient's passing. One provider explained that the person responsible for the improper transportation billing had "returned to Miami." A major teaching hospital received the body of a deceased Medicaid patient to harvest organs for transplant, but billed Medicaid as though they were treating the live patient.

The Medicaid program is one of the most reliable payers of claims submitted to it, despite the fact that the law says it should be the payer of last resort. So, we have spent time specializing some of our work to make sure that private insurers, the federal government, or the appropriate insurer liable for those payments, is the one to pay first. That's because we believe, as the Governor and you do, that taxpayers should never foot the bill when someone else is really responsible. Through this work we have been able to meet each year's audit plan goals. New York leads the country in this work.

The OMIG is an agency that prides itself on openness and transparency. We have a seventy-page work plan that is published annually and is available on our website. We do more than 60 public speaking events a year and we are training our staff to make sure that we walk every provider through what the audit process is going to look like, as much as possible. Through these measures, we try to ensure that the audit process is understandable and approachable. We have also begun a survey of auditees to measure our auditor's performance.

All of this work has been done with your support. In order to continue and build upon these results we will need your help again.

Our audit target for 2010-11 has increased by \$300 million to an overall state fiscal year target of approximately \$1.2 billion. We have been asked if that number is achievable. Based on past experience we believe that it is, but we will need the resources that the Governor has requested more this year than any year before.

All of this does not take into account our need to achieve our federal targets under the FSHRP agreement. Under FSHRP, we will be required to start our work on the last year of FSHRP in October 2010, with a recovery target of \$644 million as demonstrated by chart 2. This goal is something that no state has ever achieved.

In line with this, I recently testified at a Senate hearing where I and my staff listened to concerns raised by provider groups about OMIG audits and their effects on provider operations. As I stated before, OMIG practices a commitment to continuous improvement, so we take those matters to heart. We have put controls in place that can cancel an audit when we find low levels of non-compliance (1 percent rule). We work closely with our agency partners and providers to listen, learn and broaden our staff's understanding of the Medicaid system, past practices, and emerging trends to help maintain the stability of the Medicaid system. I have lead an effort in the agency to assess, absorb, review and take action where appropriate. A few weeks back we took all of our senior staff off-line to discuss what was said at the hearing and plan for the year ahead. The result has been a renewed commitment to core values, and an improved focus on our mission. In the coming months, providers and recipients will see some of the fruits of those labors.

I thank you for your continued support and for the opportunity to speak here today.