



**Office of the
Medicaid Inspector
General**

Joint Legislative Budget Testimony

**Testimony of Dennis Rosen
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Office of the Medicaid Inspector General**

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Good morning Chairwoman Young, Chairwoman Weinstein, distinguished members of the Senate Finance and Assembly Ways and Means Committees, and Health Committee Chairs Senator Hannon and Assemblyman Gottfried. I appreciate this opportunity to share with you the activities and initiatives of the Office of the Medicaid Inspector General (OMIG).

OMIG's approach to protecting the integrity of New York's Medicaid program is a recognized national model. The agency's comprehensive investigative and auditing efforts, extensive partnerships with law enforcement agencies, and wide range of compliance initiatives and provider education efforts are projected to result in more than \$2.4 billion in Medicaid recoveries and cost savings in calendar year 2017.

OMIG's recoveries were significantly higher in 2017. Preliminary numbers indicate 2,133 audits were initiated (an increase of more than 400 over 2016) and 2,050 were finalized (an increase of more than 340 over 2016). Recoveries for 2017 - including audits, third-party liability, and investigations - total more than \$485 million, which represents an increase of more than \$67 million over 2016.

As I've indicated in previous testimony, in addition to recoveries, OMIG has been refining measures that prevent - up front - inappropriate and unnecessary costs to the Medicaid program. These proactive efforts are far more cost effective than relying solely on a "pay-and-chase" approach to Medicaid program integrity. OMIG's cost-avoidance efforts continue to deliver impactful results for the Medicaid program, as preliminary 2017 data show a savings of more than \$1.9 billion.

OMIG works independently as well as in close partnership with local, state, and federal law enforcement; various government agencies at all levels; provider organizations and associations; and managed care plan special investigation units. OMIG's teams of auditors, investigators, data analysts, and licensed health care professionals provide vital support and resources in collaborative law-enforcement actions, which include takedowns of multi-million-dollar fraud schemes, criminal "pill mill" operations and drug diversion cases, as well as enrollment fraud prosecutions.

For example, OMIG played a critical role in a multi-agency takedown of a massive \$146 million Medicaid and Medicare fraud and money-laundering scheme that had been operating out of Brooklyn. This criminal operation involved an extensive, sophisticated network of physicians, clinic managers, recruiters and others who are alleged to have conspired to fraudulently bill Medicare and Medicaid for thousands of unnecessary medical tests and services. In December of 2017, the Brooklyn District Attorney's Office announced an 878-count indictment naming 34 defendants - 14 corporations and 20 individuals, including four doctors (one of whom is an NYPD surgeon). Key elements of OMIG's support in this case included real-time, language-translation assistance during wiretapped phone conversations, as well as the use of data analytics to help identify fraudulent billing practices.

In a separate high-profile case in July of 2017, ten individuals - including three doctors, a chiropractor, three licensed physical therapists, an occupational therapist, and two medical company owners - were charged for their alleged participation in multiple schemes that fraudulently billed the Medicare and Medicaid programs more than \$125 million. These schemes, which took place in multiple New York City boroughs, included money laundering, falsifying millions of Medicaid claims for services that were not medically necessary or not rendered, and paying illegal bribes and kickbacks to patients to receive medically unnecessary services and diagnostic tests.

As we all know, the prescription opioid abuse epidemic is a horrific national crisis. In fact, the CDC estimates *nearly half* of all opioid overdose deaths involve a prescription opioid.

As part of New York State's multifaceted response to this crisis, OMIG is working on many fronts. For example, in 2017 we saw robust activity in the agency's Recipient Restriction Program (RRP). This

program serves to prevent duplicate prescription fills through doctor or pharmacy shopping by restricting patients suspected of overuse or abuse to a single designated health care provider and pharmacy.

Preliminary 2017 data show 1,886 of the 2,221 Medicaid recipients reviewed were recommended for restriction to the appropriate Medicaid managed care plan, county agency, or NY State of Health. As a result, more than \$77 million in cost savings to the Medicaid program was realized and, quite likely, many lives were saved.

Additionally, OMIG works closely with county officials across the state, as well as with all levels of law enforcement partners to help identify drug diversion schemes, recover Medicaid dollars, and hold wrongdoers fully accountable for their criminal conduct. OMIG investigators recently participated in an investigation with Sullivan County officials and federal prosecutors that resulted in felony criminal charges being filed in November against a physician and his assistant for their alleged roles in a \$2 million opioid-diversion scheme that included thousands of medically unnecessary prescriptions for oxycodone and fentanyl patches over an approximate three-year period.

OMIG is actively involved in similar investigative and enforcement efforts throughout the state.

OMIG's 2017 preliminary enforcement activity statistics show strong results. OMIG opened 3,224 investigations, completed 3,186 investigations, and referred 898 cases to law enforcement and other agencies. Referrals include 276 to the NYS Attorney General's Medicaid Fraud Control Unit, 144 to the New York City Human Resources Administration, and 478 to other federal, state and local agencies. In addition, preliminary 2017 data show OMIG issued 935 Medicaid exclusions. Once excluded, a provider is prohibited from participating in New York's Medicaid program or any other state's program.

As New York continues to transition from traditional fee-for-service Medicaid to a managed care system, and alternative payment arrangements are introduced - such as Value Based Payments - OMIG has developed and implemented new mechanisms to address fraud, waste, and abuse.

Currently, OMIG's Managed Care Investigation Unit continues to work closely with managed care organizations (MCOs) to address network provider fraud, and collaborates with their special investigation units to develop comprehensive investigative plans.

With respect to managed care, OMIG's ongoing efforts include but are not limited to performing various match-based audits and utilizing data mining and analysis to identify potential reviews. These audits result in the recovery of inappropriate premium payments and identification of actions to address systemic and/or programmatic concerns. For 2017, preliminary data show these efforts resulted in 543 finalized audits with more than \$131 million in identified overpayments.

Additionally, OMIG has been conducting onsite visits with MCOs across the state to discuss program integrity-related processes and procedures. Further, as part of the agency's managed care efforts, OMIG's Value Based Payment (VBP) Project Team works closely with other state agencies to identify potential program integrity risk areas and effective measures to mitigate those risks as part of VBP implementation.

To expand upon these efforts and provide OMIG with all of the tools necessary to provide flexibility to address program integrity issues as they arise, the Executive Budget includes authorization to enable OMIG to fine providers and MCOs that fail to comply with the requirements of the Medicaid program. In the case of an MCO, fines could also be imposed for failure to comply with its contract with the State. The proposals also would require MCOs to refer all instances involving potential fraud, waste, or abuse to OMIG, in conformance with federal law.

Additionally, OMIG's budget proposals seek to address MCO recovery of overpayments paid to network providers by an MCO. Specifically, the proposals explicitly acknowledge that payments made by the Medicaid program to an MCO, and from an MCO to any subcontractors or providers, are public funds. This clarifies a misconception that once monies are paid by the State to an MCO, those monies are no longer "public funds" and therefore not subject to oversight or recovery. This provision would provide a mechanism for OMIG to continue to recover inappropriate payments from network providers, and, if unsuccessful in those efforts, OMIG could require the MCO to recover the amount from its network provider.

Finally, OMIG continues to emphasize provider outreach and education. Throughout 2017, the agency produced and presented a wide array of informational webinars, presentations, guidance materials, and stakeholder engagements focused on compliance, audit processes and protocols, and Medicaid fraud awareness. For example, there were more than 90,000 visits to the Compliance section of OMIG's website in 2017. Additionally, OMIG participated in 23 stakeholder outreach engagements, which consisted of presentations, conferences, and on-site meetings with providers and numerous associations.

Combined with OMIG's comprehensive oversight and enforcement activities, these outreach and education efforts serve to increase provider accountability, contribute to improved quality of care, and save taxpayers' dollars.

Going forward, as the health care landscape and the Medicaid program continue to evolve and change, OMIG will continue to aggressively protect the integrity of the program, which is a key component in maintaining and sustaining the state's high-quality health care delivery system.

Thank you. I'd be pleased to address any questions you may have.