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Office of the Medicaid Inspector General

Joint Legislative Budget Testimony

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Good afternoon Chairwoman Krueger, Chairwoman Weinstein, distinguished members of the Senate Finance and Assembly Ways and Means Committees, and Health Committee Chairs Senator Rivera 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 is recognized nationally for its efforts to protect the integrity of New York's Medicaid program. The agency's Medicaid recoveries and cost savings in calendar year 2018 – preliminary figures for which are estimated at more than $2.4 billion – result from our comprehensive investigative and auditing practices, extensive compliance initiatives and provider/stakeholder engagement efforts, as well as our effective partnerships with law enforcement and various agencies at the local, state and federal level.

OMIG saw an increase in recoveries in 2018. Preliminary numbers indicate recoveries - including audits, third-party liability, and investigations - total more than $529 million, an increase of more than $27 million over 2017.

In addition to our focus on recoveries, OMIG continues to emphasize measures that prevent – up front - inappropriate and unnecessary costs to the Medicaid program. These proactive efforts represent a significant, cost-effective component of the agency's approach to program integrity. Preliminary 2018 data show a savings of more than $1.9 billion.

OMIG's auditors, data analysts, and investigators play a critical role in collaborative law-enforcement actions targeting multi-million-dollar fraud schemes, drug diversion cases, and eligibility fraud.

For example, OMIG's participation in the 2018 National Healthcare Fraud Takedown, led by the federal Medicare Fraud Strike Force, helped uncover more than $163 million in alleged fraud schemes in the greater NYC metropolitan area.

Thirteen individuals - including five doctors, a chiropractor, three licensed physical and occupational therapists and two pharmacy owners - were charged in June of last year in federal court in Brooklyn and Central Islip for their alleged participation in multiple schemes that fraudulently billed the Medicare and Medicaid programs more than $163 million.

Also, in 2018, OMIG's inspections of a Brooklyn-based pharmacy and the agency's referral to federal authorities, including the U.S. Drug Enforcement Agency and the New York City Office of the Special Narcotics Prosecutor, helped lead to the arrest of a Brooklyn pharmacist accused of diverting thousands of oxycodone pills, a dangerous, highly addictive opioid, to the black market.

This case reflects the tragic reality of the prescription opioid abuse epidemic that continues to ravage communities across the country.

OMIG, as part of New York State's multifaceted response to this health care crisis, continues to work closely with law enforcement, health care providers, managed care plans, and other stakeholders across the state. For example, the agency's Recipient Restriction Program (RRP) increased its activity in 2018. The RRP plays a key role in preventing the filling of duplicate prescriptions through doctor or pharmacy shopping by restricting patients suspected of overuse or abuse to a single designated health care provider and pharmacy.

Preliminary 2018 data show 1,705 of the 2,003 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 $89 million in costs to the Medicaid program were avoided and, quite likely, many lives were saved.

OMIG is actively involved in recipient investigative and enforcement efforts throughout the state focused on eligibility fraud and drug diversion. In addition to its participation in the state's Opioid Task Force, OMIG is active at the county level. For example, in 2018, OMIG investigative and pharmacy staff took part in the Franklin County Opiate Forum, a day-long learning session that brought together state and local government officials and nonprofit professionals to share information, data and strategies to address the opioid epidemic. OMIG's presentation included information about the issue of local Medicaid recipients having prescriptions filled at pharmacies at faraway locations - such as New York City – as well as the agency's efforts to identify and track utilization trends of opioids and gabapentin in Franklin and other counties across the state.

Also, in 2018, OMIG launched a new project with its Unified Program Integrity Contractor (SGS) to assist in identifying and investigating providers and recipients whose prescribing or utilization patterns are outside normal parameters.

OMIG's 2018 preliminary enforcement activity statistics show strong results. OMIG opened more than 2,700 investigations, completed over 2,400 investigations, and referred close to 900 cases to law enforcement and other federal, state and local agencies, including the NYS Attorney General's Medicaid Fraud Control Unit and the New York City Human Resources Administration. In addition, preliminary 2018 data show OMIG issued more than 750 Medicaid exclusions. Once excluded, a provider is prohibited from participating in New York's Medicaid program or any other state's program.

In line with New York State's ongoing transition from traditional fee-for-service Medicaid to a managed care system, OMIG continues to develop and implement new measures and mechanisms to address fraud, waste, and abuse.

For example, in 2018 OMIG initiated the Provider Investigative Report (PIR). Under the terms of the Medicaid Managed Care Model Contract, managed care organizations (MCOs) are now required to submit a PIR to OMIG and DOH quarterly. The Report provides OMIG and DOH with valuable information, including but not limited to provider investigative activities performed by MCOs as well as copies of MCO settlement agreements with network providers. This information is critical for two reasons: first, substantial MCO recoveries of overpayments may impact capitation rate-setting, and, secondly, once OMIG is informed of inappropriate provider behavior, it can investigate whether the provider is engaging in such behavior in other MCO networks in which it participates.

OMIG's managed care efforts also include performing various match-based audits and utilizing data mining and analyses to identity potential reviews. These audits result in the recovery of inappropriate premium payments and identification of actions to address systemic and/or programmatic concerns. For 2018, preliminary data show these efforts resulted in 456 finalized audits with more than $105 million in identified overpayments.

OMIG's Managed Care Investigation Unit continues its collaborative work with MCOs and their special investigation units to address network provider fraud. Further, in 2018, OMIG established MCO liaisons; an agency investigator is now assigned to each managed care plan in the state. This effort serves to greatly enhance and streamline communication channels, information sharing, reviews and reporting practices.

Also last year, OMIG completed visits with every mainstream MCO in the state to discuss program integrity efforts. These two-day, onsite meetings proved mutually beneficial. OMIG gained key insights into MCOs' various business processes and procedures. At the same time, MCOs emerged from these sessions much better informed of OMIG's program integrity responsibilities, approaches, and interest in working collaboratively.

To provide OMIG with additional tools to address program integrity issues, the Executive Budget includes authorization to enable OMIG to ensure managed care plans are held accountable for submitting intentionally inaccurate encounter data to DOH. The proposal would also ensure, for the purposes of OMIG activities, any payment made by the State to an MCO or MLTC shall be deemed a payment by Medicaid and would support recoveries of overpayments from network providers. This addresses a longstanding misconception that once monies are paid by the State to a managed care plan, any payments made by the Plan to downstream providers or subcontractors are no longer "Medicaid payments" and therefore not subject to oversight or recovery.

OMIG's budget proposal also seeks to hold managed care plans accountable for the program integrity obligations outlined in their contract with the State by conducting program integrity reviews of all Plans. OMIG's proposal would also require home care service workers to obtain a free National Provider Identifier (NPI) to be used on Medicaid claims. This would enhance the State's ability to confirm an individual aide's services related to submitted Medicaid claims, and to also ascertain whether an aide has been cited for quality of care issues. Thus, an NPI would provide greater transparency and accountability which, in turn, will enhance the quality of care for a vulnerable population of Medicaid beneficiaries.

Finally, reflecting its commitment to comprehensive outreach and education, OMIG produced informational webinars and guidance materials and delivered dozens of presentations to, and attended on-site meetings with, associations, provider groups and other stakeholders across the state on such topics as compliance, audit processes and protocols, and Medicaid fraud awareness.

In the compliance area alone, there were more than 100,000 visits to the compliance section of OMIG's website in 2018 and hundreds of calls and emails to the OMIG Compliance Bureau. Additionally, OMIG maintains an email listserv with more than 5,100 subscribers. Finally, OMIG currently posts 40 audit protocols on its website, of which seven were revised last year and two new ones were added – one for the Consumer Directed Personal Assistance Program, and one for OASAS Opioid Treatment Programs.

OMIG's comprehensive oversight and enforcement activities, coupled with these outreach and education efforts, serve to increase program integrity and provider accountability, contribute to improved quality of care, and save taxpayers' dollars. Going forward, my office's commitment to its mission and to helping maintain and sustain the state's high-quality health care delivery system is unwavering.

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