

Statement of

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before

COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS
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AND INTERNATIONAL SECURITY

on

Eliminating Waste and Fraud in Medicare and Medicaid

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Office of the Medicaid Inspector General

Committee Chair Senator Carper, Ranking Member Senator McCain, and all committee members present, I appreciate the opportunity to appear today to talk about the New York Office of the Medicaid Inspector General, known as OMIG, and our approach to the issue of Medicare and Medicaid fraud, abuse, and waste.

OMIG is New York's Medicaid program integrity agency. We have 600 employees working on audits, investigations, data mining and analysis, and program exclusion, in the Nation's largest Medicaid program (over \$46 billion per year). We work in partnership with the New York Department of Health which administers New York's Medicaid program, and the New York Medicaid Fraud Control Unit. I have been the Inspector General for two years, after spending 27 years in the Department of Justice, working primarily on health care fraud. During that time, I handled or supervised over 500 Medicare, Medicaid, and OPM fraud matters.

Today I want to talk about the approach New York is taking to Medicaid program integrity. 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 over \$550 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 Medicaid oversight.

Although we have been successful in identifying significant recoveries, New York's long-term program integrity goal is to prevent and to detect improper payments. In

working toward that goal, we have reviewed the approaches of other program and oversight agencies, the work of Congress in oversight, the scholarly literature, the reports and results of government contractors and think tanks, and the analysis of trade, professional, and advocacy groups as well as New York's (and my) own experience.

Based on our review, opportunities exist for significant improvements which will reduce program costs, reduce collateral costs to providers, and improve outcomes.

The public health care system suffers significant losses from improper payments to large organizations where individual responsibility can be difficult to assign:

- The laboratory company which bills the program for an unreliable test whose results cause patients to get unnecessary surgery;
- The pharmaceutical company which fails to disclose that its product causes weight gain and diabetes in significant numbers of patients;
- The pharmacies which provide "home-delivered" prescriptions to patients who died weeks or months before;
- The nursing homes that bill the Medicaid program for the cost of the administrator's Lexus or Mercedes on the theory that they are occasionally used for patient transport;
- The managed care plans and hospitals that bill Medicaid for prenatal services for males;
- The mental health services facility that bills Medicaid for "patient management" to take a patient shopping at the Dollar store;

- 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.

At best, investigations of improper payments, when they involve large organizations and the potential for intentional conduct, have followed a predictable course. They are investigated for many years, eventually resulting in a criminal declination or an indictment which will have a very limited effect on the provider (a defunct subsidiary or a non-program misdemeanor), payment of large amounts of money in a civil settlement, and a corporate integrity agreement to address future conduct. By the time the settlement occurs, the individuals who were in charge at the time have moved on, and the business models have changed. The government issues a press release stating “Providers that attempt to defraud federal insurance programs will be held accountable to the full extent of the law.” The defendant issues a press release announcing “This settlement resolves a five-year old government investigation, and puts it behind us.” The stock goes up. I know this because I have worked on many of these cases.

We think there is a better way to address these issues. We need to move from a system which encourages some providers to look for excuses to a system which requires and supports having an effective and appropriate billing and compliance systems in place.

Too often, law enforcement and oversight agencies describe the task of enforcement as “combating” rather than preventing fraud and waste. This focus means that agencies describe their goals “to conduct” investigation and “facilitating enforcement” (from the program goals section 2007 Health Care Fraud Abuse Control Program). We need to move to a system which makes program integrity a major goal of oversight, investigative, and prosecutive efforts.

- 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, 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.

- 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; “expected severity of sanctions does not predict compliance” (Braithwaite: 2005). CMS historically has advised individual providers of their ranking in use of specific codes of concern. 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.

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