

**Testimony of Kimberly A. O'Connor, New York State Medicaid Inspector General**  
**March 28, 2006**  
**Subcommittee on Federal Financial Management, Government Information and**  
**International Security**  
**Senate Homeland Security and Governmental Affairs Committee**

Mr. Chairman, Committee members, thank you for the opportunity to present this written testimony concerning the recent changes made by Governor Pataki to New York's Medicaid program. My name is Kimberly A. O'Connor and I am the New York State Medicaid Inspector General.

Last July, Governor Pataki appointed an outside expert to conduct a comprehensive review of New York State's Medicaid system and recommend fundamental, long-term structural changes and reforms to improve efforts to control fraud, waste and abuse. In August, Governor Pataki, by Executive Order, appointed me to the newly created position of New York State Medicaid Inspector General. My charge was to coordinate Medicaid fraud, waste and abuse control activities of all State executive branch agencies and to recommend legislative, policy and structural changes needed to strengthen the integrity of the Medicaid program. Accordingly, I worked in conjunction with the outside expert and we conducted an extensive review of New York's Medicaid system and examined the systems of other states. We also had the input of the Rockefeller Institute, private sector insurers and consultants, provider groups, medical professionals and information technology analysts.

Together we concluded that at that time, New York's Medicaid fraud, waste and abuse control activities conducted by the Department of Health's Office of Medicaid Management and various state regulatory agencies, while having been successful at recouping, withholding or avoiding \$9.3 billion of overpayments since 1999, suffered from fragmentation among the various state agencies and offices charged with Medicaid fraud-fighting responsibilities. Additionally, we found that the system had an insufficient focus on specific auditing and fraud prevention goals and needed greater coordination and communication among the State agencies engaging in fraud, waste and control activities.

We made several key recommendations to Governor Pataki, the central component of which was the expansion of the Office of the Medicaid Inspector General from an advisory role to actually undertake and be responsible for the New York State Department of Health's duties as the single state agency for the administration of the Medicaid program in New York State with respect to the prevention and detection of fraud, waste and abuse.

In so doing, we sought to establish an independent fraud-fighting entity within the Department of Health that would build on our State's accomplishments in preventing Medicaid fraud, waste and abuse by prioritizing and focusing fraud, waste and abuse control activities; creating a single point of leadership of and responsibility for such activities; building and maintaining an

integrated system of communication among all involved agencies with fraud, waste and abuse control responsibilities; and maximizing the use of all available state resources for such activities.

New York's anti-fraud programs were concentrated principally in the Department of Health, which also oversees the Medicaid program itself. That creates an obvious inevitable conflict, as the pressure to pay providers wars with efforts to ensure that monies are not misspent. Increasingly, other states are also separating the funding of Medicaid services and recipient eligibility determinations from the policing of service providers. Such a separation will guarantee that the mission of the Office of the Medicaid Inspector General is free from conflict and that its energies (and resources) do not get diverted.

We concluded that New York should devote additional resources to Medicaid fraud, waste and abuse prevention and detection. In recent years, there had been a commendable investment of funds in the development of computer technology, which is essential to an effective anti-fraud program. We have the capacity to "data mine" and thereby to identify "outliers" -- practitioners whose billings seem out of the ordinary. Data mining, however, is only the first stage of an effective program as auditors, investigators, and medical professionals are needed to determine whether an outlier is committing fraud or whether legitimate factors explain the billings. We believed that some resources could be used more efficiently (e.g., that sample sizes for initial provider audits could be reduced), but firmly believe that additional auditing staff would far more than pay for itself in additional recoveries of misspent Medicaid funds. Due to the "aging out" of New York's state workforce, a large number of retirements have occurred. New York is now filling existing vacancies within its Medicaid integrity program and will also aggressively recruit for 81 new state positions as well that have been proposed in the Governor's Executive Budget.

Also, in response to our recommendations, New York is currently in the process of increasing the number of medical professionals that are available to assist auditors and investigators to determine if Medicaid billings are proper. As noted above, sophisticated data mining is only the first step in curtailing fraud, waste and abuse. An auditor often cannot determine whether a doctor is improperly billing unless she can review the case with an experienced medical practitioner in the same field. Efforts are underway to develop a peer review program with New York's extensive state university system. At the same time, the civil service pay scale for state nurses and other medical professionals involved in anti-fraud efforts should be reevaluated. The expertise of a good medical professional is invaluable to an anti-fraud program, and the State is losing good staff because of lower pay.

The State is planning on devoting resources to a State-Federal task force to be located in New York City that will be dedicated to investigating and prosecuting criminal groups that engage in extensive health fraud. Although Medicaid fraud knows no geographic limits, there is no doubt that large-dollar frauds are heavily concentrated in New York City and often perpetrated by organized groups. We have spoken at length with federal law enforcement authorities in New York City -- to the FBI and senior federal prosecutors -- and they are eager to join forces with the State in creating a task force that would focus on health care fraud. Adding their resources and targeting large-scale schemes can only strengthen our anti-fraud efforts.

Another state-federal initiative recently commenced by New York and CMS is the Medi-Medi program. When fully operational, New York will be able to look at Medicaid and Medicare claims simultaneously and identify inappropriate billing patterns that are not clearly evident when claims from either program are viewed independently.

It is imperative that those engaged in anti-fraud efforts share information more effectively. Throughout our review, we have been surprised by how poorly information is shared by those involved in preventing health care fraud, waste and abuse. In New York, a significant portion of our Medicaid program is now administered by managed care organizations, and each is obliged to have an investigative unit to ferret out fraud. Private insurance companies have similar units. Everyone in “the business” knows that a provider who is defrauding one program is likely to be defrauding others, yet there is little communication among programs. I have made it a high priority to remedy this deficiency.

While most Medicaid providers (and recipients) are entirely honest, the program has grown so large that even a small percentage of fraud, waste and abuse represents a large diversion of taxpayers’ monies. New York can and will do better.

As a result of our review and recommendations, Governor Pataki expanded the functions of the Office of the Medicaid Inspector General by issuing a superseding Executive Order on February 2, 2006. We are now seeking legislative adoption of the Office of the Medicaid Inspector General in statute as a part of the Governor’s Executive Budget proposal and are hopeful that this proposal will become law on or before April 1 of this year.

The proposed statute provides that the head of the Office of the Medicaid Inspector General is the Medicaid Inspector General of the State of New York who shall be appointed by the Governor and confirmed by the Senate, and shall report directly to the Governor’s Office. To maximize the independence of the office, the Governor has proposed a five year term for the Medicaid Inspector General.

Existing state personnel from various state executive branch agencies, including the Department of Health, the Office of Mental Retardation and Developmental Disabilities, the Office of Mental Health, and the Office of Alcohol and Substance Abuse Services, that engage in the detection and prevention of Medicaid fraud, waste and abuse, will be transferred to the OMIG. Pursuant to the February 2, 2006 Executive Order, this process was already started by transferring the appropriate personnel from the Department of Health, Office of Medicaid Management to the Office of the Medicaid Inspector General.

The functions of the OMIG include:

- conducting and supervising activities to prevent, detect and investigate Medicaid fraud, waste and abuse and, to the greatest extent possible, coordinating such activities amongst the Offices of Mental Health, Mental Retardation and Developmental Disabilities, Alcoholism and Substance Abuse Services, Temporary Disability Assistance, and Children and Family Services; the Department of

Education; the fiscal agent employed to operate the Medicaid management information system; the State Attorney General for Medicaid Fraud Control; and the State Comptroller;

- pursuing civil and administrative enforcement actions against those who engage in fraud, waste, abuse or other illegal or inappropriate acts perpetrated within the Medicaid program, including providers, contractors, agents, recipients, individuals or other entities involved directly or indirectly with the provision of Medicaid care, services and supplies;
- keeping the Governor and the heads of agencies with responsibility for the administration of the Medicaid program apprised of efforts to prevent, detect, investigate, and prosecute fraud, waste and abuse within the Medicaid system;
- making information and evidence relating to potential criminal acts which he or she may obtain in carrying out his or her duties available to appropriate law enforcement officials and consulting with the New York State Deputy Attorney General for Medicaid Fraud Control, federal prosecutors, and local district attorneys to coordinate criminal investigations and prosecutions;
- recommending and implementing policies relating to the prevention and detection of fraud, waste and abuse;
- monitoring the implementation of any recommendations made by the Office of the Medicaid Inspector General to agencies or other entities with responsibility for administration of the Medicaid program;
- receiving and investigating complaints of alleged failures of state and local officials to prevent, detect and prosecute fraud, waste, and abuse; and
- performing any other functions that are necessary or appropriate to fulfill the duties and responsibilities of the office.

The OMIG also has broad subpoena powers, both duces tecum and ad testificandum, and has the authority to:

- subpoena and enforce the attendance of witnesses;
- administer oaths or affirmations and examine witnesses under oath;
- require the production of any books and records deemed relevant or material to any investigation, examination or review;
- examine and copy or remove documents or records of any kind prepared, maintained or held by any agency the patients or clients of which are served by the Medicaid program, or which is otherwise responsible for the control of Medicaid fraud, waste and abuse; and
- perform any other functions that are necessary or appropriate to fulfill the duties and responsibilities of office.

The Executive Order also requires the cooperation of all relevant state and local agency officials and employees.

Projected figures for state fiscal year 2005-2006 for fraud waste and abuse initiative include: 300 provider exclusions and terminations, 90 referrals to the Attorney General's Medicaid Fraud Control Unit, 1200 undercover shops/onsite inspections, and at least \$89 million in audit recoveries.

Statistics for the fourth quarter of 2005 include audit recoveries of approximately \$25 million and there were 20 referrals to the Attorney General's Medicaid Fraud Control Unit.

Based upon the reform initiatives that have already been put into place, the Governor's Executive Budget proposal has doubled our audit target for state fiscal year 2006-2007 from the previous year.

I hope that the preceding information has been helpful to the Committee and I appreciate being given the opportunity to submit this written testimony.

I look forward to providing this Committee with information regarding the progress and accomplishments that New York has made with respect to the OMIG and the fight against Medicaid fraud, waste and abuse as we move this critical mission forward.

Thank you.