Office of the
Medicaid Inspector
General

Joint Legislative Budget Testimony

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Good morning Chairwoman Young, Chairman Farrell, 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 efforts to protect the integrity of New York's Medicaid program continue to serve as a national model. Our investigative work, partnerships with state and federal law enforcement agencies, innovative auditing techniques, and OMIG's extensive compliance initiatives and provider education efforts are projected to result in more than $2.3 billion in cash recoveries and cost savings in 2016.

A core function of OMIG is identifying and recovering Medicaid overpayments. Preliminary numbers indicate 1,724 audits were initiated and 1,707 were finalized in 2016. Cash recoveries for 2016 - including audits, third-party liability, and investigations - total more than $418 million, representing an increase of more than $79 million over 2015.

In addition to pursuing cash recoveries, OMIG's cost-avoidance efforts prevent, *up front*, improper Medicaid costs and billings. Proactively eliminating improper payments in the first place is far more cost-effective than later identifying and chasing after dollars that have been paid out inappropriately. According to preliminary data, OMIG's cost-avoidance initiatives for 2016 saved nearly $1.9 billion.

OMIG works both independently and in collaboration with partners at all levels, including local, state and federal law enforcement, provider organizations, and managed care plan special investigation units. As a result, OMIG often plays a critical role in collaborative law-enforcement actions that result in the takedown of major fraud schemes, enrollment fraud arrests, and drug diversion cases.

For example, OMIG pharmacists and investigators worked with the Attorney General's Medicaid Fraud Control Unit to obtain the conviction and sentencing in 2016 of Long Island-based pharmacists, Ira Gross and Glenn Schabel, for their roles in a massive, black-market HIV prescription drug ring. The scheme involved the sale of more than $274 million of diverted, medically worthless medications from wholesalers in multiple states to Medicaid recipients in New York State. The pair were sentenced to lengthy prison terms and ordered to pay back more than $30 million to the Medicaid program.

As part of the fight against opioid abuse, OMIG has been very involved in drug diversion cases. For example, in 2016, OMIG investigators provided critical evidence that helped lead to the conviction of Brooklyn pharmacist Kian Gohari for illegally distributing more than 25,000 medically unnecessary oxycodone pills between 2012 and 2015. Gohari's accomplices bought prescriptions for oxycodone and other high-price medications from patients, filled them, and then sold them on the black market throughout the NYC metropolitan area. He was convicted in federal court in November of conspiracy to distribute narcotics and conspiracy to commit healthcare fraud. He faces up to 30 years in prison.

Prescription opioid abuse is a recognized national health care crisis, and New York is not immune. A key tool in OMIG's arsenal to address this epidemic is its Recipient Restriction Program (RRP), which prevents duplicate prescription fills through doctor or pharmacy shopping by restricting patients suspected of overuse or abuse to a single designated provider, pharmacy, or both.

Preliminary 2016 data show 1,961 of the 2,331 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 $58 million in cost savings to the Medicaid program was realized.

Also, OMIG is a member of the Federal Healthcare Fraud Prevention Partnership. Working with the Centers for Medicare and Medicaid Services, the Department of Justice, the FBI, and national health insurance companies, OMIG helped identify practices and strategies to address opioid abuse in

general, and opioid prescription abuse in particular. On January 19th of this year, the Partnership released a white paper entitled *Healthcare Payer Strategies to Reduce the Harms of Opioids*, which arose out of this collaboration. It describes best practices to address the dangers of opioids while ensuring access to necessary therapies and reducing fraud, waste, and abuse.

Overall, OMIG's 2016 preliminary enforcement activity statistics are robust. OMIG opened 3,493 investigations, completed 4,418, and referred 1,079 cases to law enforcement and other agencies. Referrals include 155 to the NYS Attorney General's Medicaid Fraud Control Unit and 924 to the New York City Human Resources Administration and other federal, state and local agencies. In addition, preliminary 2016 data show OMIG issued 929 Medicaid exclusions.

OMIG's Managed Care Investigation Unit meets regularly with, and receives complaints from, managed care organizations (MCOs) relating to network provider fraud, and works with their special investigation units to develop comprehensive investigative plans. Preliminary data for 2016 show that referrals from MCOs to OMIG totaled 518, up from 344 referrals in 2015.

OMIG has also worked closely with the State Department of Health in developing amendments to the Managed Care Model Contract to enhance program integrity. These include: the creation of a clearance process to ensure that OMIG and MCOs are not duplicating audit and investigative efforts; the submission by each MCO of a quarterly report showing all Medicaid overpayments it has identified or recovered; a provision enabling OMIG to obtain MCO assistance in recovering overpayments made to network providers identified by the State; and allowing an MCO to share in recoveries made as a result of a referral to OMIG. The Model Contract is currently under federal review.

Lastly, OMIG continues to emphasize provider outreach and education, particularly in the area of compliance. Through a comprehensive array of webinars, guidance materials, self-assessment tools, protocols, and presentations, OMIG's oversight activities and educational efforts increase provider accountability, contribute to improved quality of care, and save taxpayers' dollars. In 2016, OMIG issued 15 compliance-related guidance materials and conducted more than a dozen educational presentations and webinars. The compliance section of the OMIG website is among the site's most active areas, with close to 40,000 visits to compliance webinars, over 30,000 visits to compliance publications, and more than 40,000 visits to compliance resources and FAQs. Many of our webinars are accredited for legal, accounting or compliance continuing-education credits. In 2016, 439 participants received credits; up from 428 in 2015.

With the transformational changes occurring in the Medicaid program, OMIG's commitment to protecting the integrity of the program and ensuring a cost-effective, sustainable healthcare delivery system remains unwavering.

Thank you. I am happy to address any questions you may have.