NEW YORK STATE SENATOR

William Larkin

Senate Passes Plan To Fight Medicaid Fraud

WILLIAM J. LARKIN JR. June 21, 2006

Senator Bill Larkin (R-C, Cornwall-on-Hudson) announced the New York State Senate today passed the toughest, most comprehensive plan to combat Medicaid fraud in the United States. The legislation (S.8450) represents the agreement between the State Senate and Assembly and would fight fraud and abuse at every step of the process, from billing and pre-payment review to investigation, civil recovery and criminal prosecution of Medicaid thieves.

"Every New Yorker is affected by Medicaid fraud," said Senator Larkin. "The people who are cheating the system are driving up your property taxes, state taxes and federal taxes. They cost the state and local governments billions of dollars each year. The worst effect of this crime is that it hurts those who need the program the most, namely, children, the elderly, and the disabled. This plan will give law enforcement the tools they need to catch and prosecute these unconscionable individuals."

The Federal Department of Health and Human Services Centers for Medicare and Medicaid Services released a report last month following a comprehensive review of New York's anti-Medicaid fraud program. The report concluded that "New York's overall commitment to program integrity has lagged behind the growth of its program. As the largest single Medicaid program in the nation, New York's antifraud efforts over the last several years have

not been proportionate to its vulnerability. In the final analysis, the Centers for Medicare and Medicaid Services believes that New York must do more to meet its program integrity obligations."

The report also pointed out that "the single most empirical measure of program integrity, actual audit collections, has dropped both in overall collections and the average value of each audit." The federal report recommended that enforcement should be the primary goal of the program.

The Senate anti-Medicaid fraud bill would address these recommendations by:

> Creating a new, independent Office of Medicaid Inspector General by consolidating responsibilities and staff from six agencies into the new Office and empowering the Medicaid Inspector General with the ability to detect, investigate and recovery improper Medicaid payments;

> Providing county governments with new incentives and access to information to become active partners in the fight against Medicaid fraud;

> Enhancing the capacity of the Department of Health and Office of Medicaid Inspector General to fight fraud with new, state-of-the-art technology;

> Establishing new protocols and procedures to ensure the effective sharing of information and evidence regarding Medicaid fraud between the Office of Medicaid Inspector General, the Attorney General's Medicaid Fraud Control Unit, county governments and district attorneys;

> Requiring health care institutions to implement corporate compliance programs and allowing providers to request advisory opinions to ensure proper billing practices and

> Creating new Health Care Fraud offenses to aid in the criminal prosecution of Medicaid fraud.

The federal General Accounting Office estimates that 10 percent of Medicaid expenses are diverted through fraud, an amount equal to billions of dollars spent by New York on the program.

The comprehensive Senate Medicaid fraud plan was developed after statewide public hearings held by the Senate Medicaid Reform Task Force. At the hearings, the task force received input and suggestions from people in the health care industry and the law enforcement community on what could be done to strengthen the state's efforts to detect and prevent Medicaid fraud.

The Senate Medicaid Reform Task Force, created by Senator Bruno in 2003, recommended several important measures that have become law, including the State cap on local Medicaid expenses and the State takeover of the local share of the Family Health Plus program, that have saved local property taxpayers billions of dollars.

The bill was sent to the Assembly.

Provisions of the comprehensive Medicaid fraud legislation include the following:
> Office of Medicaid Inspector General

The legislation consolidates the Administration's Medicaid program integrity responsibilities and over 600 staff from each of the six involved Executive-level state agencies into a new Office of Medicaid Inspector General within the Department of Health. While the Office must remain within the Department of Health to receive federal matching funds and maintain access to the necessary claims information, its operations will be completely independent. The Inspector General will be required to meet stringent qualifications and serve at the pleasure of the Governor. To help focus the Office's efforts and promote the necessary organizational culture, the legislation requires all Office staff to be co-located, except for regional office personnel.

The Office will focus on three main functions: compliance, investigation and recoupment/sanctions. To this end, it will review all Medicaid expenditures and investigate those identified as suspected fraud or abuse. It will have the power to withhold payment until the claim is determined to be appropriate (up to 30 days under federal law), impose administrative sanctions and pursue civil recoveries and third-party recoveries, i.e., coordination of benefits with health insurers. The Office may also bring civil recovery actions.

For those fraudulent claims determined to be criminal, the Office will serve as the investigative entity for provider fraud cases prosecuted by the Attorney General's Medicaid Fraud Control Unit ("MFCU") and local district attorneys. Along with the state Welfare Inspector General, district attorneys also prosecute recipient fraud.

> Improved Technology

The Senate bill authorizes and directs the Department of Health to contract with vendors for upgraded information technology necessary to detect Medicaid fraud, conduct utilization

review and coordinate third-party benefits (health plans). Improved technology would improve accountability in Medicaid expenditures throughout the process and coordinate benefits with health plans to ensure Medicaid is the payor of last resort..

> New Medicaid Fraud Offenses and Penalties

The Senate bill creates new Health Care Fraud offenses to facilitate the criminal prosecution of Medicaid fraud.

> Local share for certain Medicaid recoveries

The bill would enable local social services districts (i.e., counties and the City of New York) to receive up to 15 percent of the gross amount collected from a fraud investigation if the district participates in the identification, investigation or development of a Medicaid fraud case. A local social services district could also receive up to 15 percent of the gross amount collected for participating in criminal fraud cases referred to the Attorney General.

> Health Insurance Fraud Report

The Senate bill requires the State Insurance Department to annually submit a report detailing its investigation of health insurance fraud cases submitted by health plans. Currently, SID is investigating 2.9 percent of all such cases—far below levels for other types of suspected insurance fraud.

> Corporate Compliance Program

As a prerequisite for Medicaid eligibility, the Senate bill requires larger Medicaid providers to implement Sarbanes-Oxley style corporate compliance and internal controls programs designed to prevent improper and inaccurate billings and fraud. The Senate bill also creates an Advisory Opinion process to encourage proper billing.

The legislation builds on Senate Medicaid fraud initiatives that were included in the 2006-07 State budget including:

> A $500,000 budget appropriation for the New York Prosecutors Training Institute (NYPTI) to conduct an educational program relating to Medicaid fraud for local district attorneys and to prepare form materials and perform research.

> The establishment of a local Medicaid fraud demonstration project in Chemung County, which is developing a fraud detection system that uses the latest technology to review inappropriate utilization of services.