Statement of

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Containment System

On

Waste and Abuse in Government

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Good afternoon, Chairman Gowdy, Ranking Member Davis, and other distinguished Members of the Subcommittee thank you for the invitation to speak before this committee. I am David Botsko, Inspector General of the Arizona Health Care Cost Containment System (AHCCCS) the state Medicaid Agency.

AHCCCS was established in October 1982 as a managed care agency and is a leader in controlling medical costs within the Medicaid program. The AHCCCS budget is $10 billion which serve the 1.3 million beneficiaries. We are currently contracted with 19 health plans to serve the state Medicaid population.

The AHCCCS Office of Inspector General (OIG) was created in November 2009 to more accurately reflect the overall scope and enhanced mission relating to fraud and program mismanagement. Prior to formation of the OIG, the AHCCCS Office of Program Integrity accomplished the fraud and abuse investigations for the Administration. The organizational goal of the OIG is to protect and serve the Medicaid public interest by increasing awareness and improving the detection, investigation, civil and criminal prosecution and prevention of health care fraud in the state of Arizona. As of February 28, 2011 the OIG has recognized a total savings and cost avoidance of approximately $31 million during the current state fiscal year. During the same period there have been nine criminal convictions and 11 additional individuals are pending prosecution.

I am thankful for the opportunity to discuss the problems faced by the state Medicaid program in fulfilling the responsibilities entrusted to us by the American public. While a

small percentage of health care providers and consumers engage in fraudulent activities the impact can inflict serious consequences on expenditures. The state agencies are in the forefront in the fight against fraud. The AHCCCS OIG cooperates with state and federal law enforcement, regulatory agencies and state and federal prosecutors to detect prevent and prosecute Medicaid fraud. My testimony will focus on three elements that impact the success or failure of Medicaid investigations and some recommend solutions.

I. Effectiveness of pre-screening Medicaid applicants and providers

The Office of Inspector General utilizes a unique dedicated team of investigators to screen Medicaid applications that meet our criteria that may indicate the presence of fraud. The applications are referred to the OIG Fraud Prevention Unit (FPU) which strives to conduct the initial investigation with 24 hours of receipt. During the state fiscal year 2010 the unit received almost 8,200 referrals for investigation and conducted approximately 8,000 investigations. The investigations resulted in 1500 individuals being denied benefits. The estimated cost avoidance savings for these ineligible participants was $15.23 million. During this time frame the FPU operated with eight full time investigators and saved an average of $1.9 million per investigator per year, in program dollars. Again, these investigations were based upon referrals with established fraud indicators. Beginning in July 2010 the FPU inaugurated an outreach program to train and educate our eligibility entities and we increased their staffing by one full time employee. This effort has resulted in an increase in the percentage of cases investigated and a corresponding number of individuals were found ineligible and denied services. As of March 2011 we have already surpassed last year's savings and have realized a cost

avoidance of $15.6 million. There are approximately 73 offices that determine eligibility for Medicaid programs in Arizona and we currently receive fraud referrals from 27 of them. We are unable to expand this program to more offices without the requisite staff to conduct the additional investigations.

When the Office of Inspector General was formed the provider registration functions were subsequently transferred to the OIG. The transfer of the provider registration function has proven to be beneficial in screening providers who may have criminal convictions or misconduct charges. Utilizing the resources and investigative capabilities of the entire OIG to examine facility ownership and relationships between provider entities has been extremely beneficial and cost effective.

II. Return on investment

The OIG also has two units for investigating member and provider compliance issues. The average cost per investigator for the Member and Provider Compliance Unit's was approximately $58,000 per year per investigator during the last state fiscal year. During that period the Office of Inspector General had an average staffing of 34 investigators and supervisors. Excluding the Fraud Prevention Unit, the Member and Provider Compliance Investigative Units opened 450 investigations and closed 300 cases. During the state fiscal year 2010 these two units realized a total cost avoidance and recovery of $13 million with an average recovery per investigator of $500,000 or approximately a 9:1 return on investment. We are utilizing an analytical tool produced by a company named EDI Watch to discover suspicious payment patterns and apply this information to other

providers within the system. This tool generates additional information and potential cases that also require more state matching funds for investigations.

III. Impact of unfunded mandates

I can not over emphasize the importance of having strong program integrity initiatives that deter entities that attempt to defraud the Medicaid program. The AHCCCS Office of Inspector General has developed fraud and awareness educational programs that are presented on the AHCCCS Website. The successful outreach program has dramatically increased the amount of fraud referrals received by the OIG. The OIG currently has a backlog of 600 fraud referrals which have not been assigned due to the lack of available resources. Other issues impact our resources such as countless staff hours working with Recovery Audit Contractors (RAC) and Medicaid Integrity Contractors (MIC) which have historically had little positive impact while draining resources. The recently imposed affordable care act rules mandate additional screening requirements, additional accountability for receiving mandated application fees, payment suspensions, and compliance plans for providers and suppliers has had and will have impacts on the Provider Registration Unit, such as:

- System changes that impact several major operating systems

  Addition of reading new databases

  Tracking mechanisms

  A Mechanism to record, track and report fees collected

- Additional requirements that are outside the scope of existing processes: such as site visits, fingerprint verification, application fees, etc.

- Processing procedures that require modification to all provider types. There are currently 56,000 providers registered in the State of Arizona.
- Staffing: Resources needed to plan, implement and maintain changes

The additional requirements placed on existing resources create a strain on an already overburdened workforce. Backlogs are expected to increase as well as staff attrition. With existing budget constraints the agency is restricted from providing any type of added incentive to compensate for the additional workload.

IV. Conclusion

I have spent my entire career enforcing laws and protecting citizens. Prior to my work in Medicaid, I was a special agent with the U. S. Defense Department OIG and the U. S. State Department for 22 years conducting criminal investigations. The ongoing efforts at the federal and state level to reduce fraud and waste in health care programs are critically important. We are confident that we can continue to improve our oversight by focusing responsibilities and resources on those who are best equipped and most informed, the states. Furthermore, we are implementing a number of measures that will enhance our enforcement and administrative actions in the prevention of fraudulent and improper payments. This shift involves many different activities which we are carrying out with the new EDI Watch anti-fraud tool recently acquired by the AHCCCS Administration. We are utilizing analytical tools to search across all contracted health plans to discover suspicious payment patterns and apply this information to other providers within the system. The OIG also utilizes a sophisticated data base named CLEAR to identify

individuals who may be attempting to defraud the Medicaid system. Eliminating the problem of fraud and overpayments within the Medicaid system requires a long-term, sustainable approach. The duplication of audit efforts at the federal level requires an unnecessary amount of staff time to educate and assimilate them into a position to produce results. Additional experience has proven that the state OIG or Program Integrity Unit is in a better position to conduct the audit due to expertise and experience with the rules and contract requirements which impact the entities undergoing the audit. Each state plan is a little different and each contain nuances' that make them singular in methodology and practices. Attempting to write federal rules and guidelines for Medicaid by placing the words "and Medicaid" after the Medicare rules does not always work.

Changes and new authorities that may improve the effectiveness of the Medicaid anti-fraud activities are:

- Provide funding to permit the state to focus our limited resources on conducting effective audits at the local level.
- The state Medicaid Fraud Control Units are funded with 75% federal matching dollars. Fund the state Medicaid OIG's and Program Integrity Unit's with the same funding.
- 42 CFR 455.14 requires the Medicaid agency to conduct a preliminary investigation and when fraud is suspected refer the allegation to the Medicaid Fraud Control Unit (MFCU). In some states the Medicaid OIG or Program Integrity Unit may be equipped to conduct a full investigation and subsequently refer the case to the MFCU for prosecution, avoiding duplication of effort and

save valuable time and money. A minor change to the law by striking the words "of a preliminary investigation" to "of an investigation" would allow states with the appropriate capabilities to become a more effective partner with the MFCU.

- Add language to the existing legislation that would permit Medicaid OIG's and Program Integrity Units to issue subpoenas for records in support of Medicaid investigations. Currently some states have this authority others do not. Additionally, if the subpoena's are federally mandated it would assist the states in obtaining information across state lines.

To summarize: Each state program is unique. In Arizona we rely significantly on managed care. We work collaboratively with our managed care partners but as the state we play a critical role in investigating and pursuing fraud. The states are the best source to conduct provider audits due to program familiarity. The recommendation to increase federal matching dollars should not require additional federal expenditures if duplicative federal initiatives were streamlined and focused on state efforts. Unfunded mandates are a burden that detract from the fraud detection and recovery mission of the state agencies. Based on my many years of experience I firmly believe that the state Medicaid OIG's and Program Integrity Units are the best line of defense against fraud and we have the results to prove it..

Thank you, I would be happy to answer any question you may have.