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Good morning Chairman Carper, Ranking Member Brown, and distinguished members of the Committee. My name is Douglas Wilson and I serve as the Inspector General for the Texas Health and Human Services Commission. I appreciate the opportunity to be with you today to offer testimony from the Texas perspective regarding program integrity challenges, opportunities and successes.

Over the past year since I assumed the position of Inspector General, Texas has reformed and reenergized its Medicaid program integrity efforts. Our Medicaid program has a budget of $19.6 billion annually and my office has about 615 employees. Although completed case investigations are a long way from recouped dollars (and in fact the two are only marginally related), our reinvigorated Office of Inspector General has significantly increased the number of case investigations in the last fiscal year, and we are on track to increase the identification of potentially recoupable dollars by more than eighteen times. However, much like high pressure water through a leaky hose, the efforts we have made have identified some holes in the system requiring attention.

State-CMS Coordination and Cooperation

Although some bemoan the inflexibility of federal agencies that has not been our experience with CMS. Our relationships primarily are with the Medicaid Integrity Group, where we have experienced significant and meaningful cooperation at all levels. In particular, we have regular, positive and useful contact with Robb Miller, Director of the Division of Field Operations, Lyn Killman, the Deputy Director, and Angela Brice-Smith, Director of the Medicaid Integrity Group. They have repeatedly sought to assist and encourage us in our innovative efforts, and we view them as active, cooperative team members. Our joint challenge is to work through policies and regulations that were designed to create certainty in process but which actually have hampered our efforts.

A specific example of the assistance CMS recently provided to Texas in the area of program integrity is an innovative, but common sense effort we have launched to reduce fraud involving durable medical equipment. Our experience tells us DME vendors are more likely than other providers to overbill the Medicaid program. As difficult as it may be to believe, one relatively easy method to steal from Medicaid is to obtain a Medicare and Medicaid provider number and simply start billing for DME – no supplies delivered. Our solution to this problem is to sweep all the DME vendors in the State of Texas – nearly 6,000 of them – with onsite visits. Simply physically visiting each vendor to identify which of them do not have a physical location, or have a location that is inadequate for the volume they bill, will likely reduce the number of DME vendors (and concomitantly, the fraud exposure those vendors create) by a third or more. Yet the Affordable Care Act requires each of these vendors receive two visits – once immediately before

re-enrollment, once after re-enrollment – and Texas is not yet ready to begin the re-enrollment process. Obviously, traveling to and conducting site visits on all of these vendors will take tens of thousands of hours and will be a significant cost to the Office of Inspector General. So we called CMS, starting with Robb Miller. We explained what we wanted and he engaged Lyn Killman. Together they cleared obstacles for us and facilitated an arrangement that permits Texas to pilot this type of statewide fraud sweep while still permitting us a year's grace period to count the fraud site visits as re-enrollment site visits under the Affordable Care Act. Although it may sound simple, this type of cooperation is exactly what we need to combat fraud jointly. CMS will provide us with up to date Medicare site visit data, thereby reducing the overall number of vendors interviews we must conduct. In return, Texas will comply with the Medicare site visit requirements, including photographing or making a video record of the site visits. We will then provide the results of our visits to CMS for use in the Medicare program, thus eliminating the needs for Medicare's contractor to repeat our efforts.

In addition, no comment on CMS assistance to the states would be complete without a reference to the Medicaid Integrity Institute in South Carolina. Texas has taken advantage of the support the Medicaid Integrity Group has provided to the Medicaid Integrity Institute and we regularly send the maximum number of students to the Medicaid Integrity Institute's training programs. My office's senior executive management takes advantage of every opportunity the Institute provides to meet with executive management from other states, and we have found nothing to compare to that experience for the knowledge, ideas and innovation that occurs simply by putting like-positioned people together to talk about ideas and experiences.

Data Access

The Texas experience is that more data is better. Whether the data comes from Medicaid, Medicare, SNAP, WIC, TANF, Craig's List, county property lists, banking records, arrest records, employment records or nearly any other source you can imagine, all of this data can help to identify patterns of behavior and billing which lead to identifying intentional or inadvertent overbilling and the accompanying overpayment. Although I will discuss pattern recognition more later, the single largest source of non-Medicaid data and cooperation is Medicare. Unfortunately, our interaction with Medicare is limited to the unsuccessful Medi-Medi program. In Texas, as in most places, Medi-Medi is unsuccessful because of its focus on specific cases, invariably Medicare, rather than upon the *purpose* of the program, which is enhanced cooperation between the two federally-supported health insurances. Thus, we receive few referrals and the ones we do receive are limited to small, dual-eligible overpayments. What we want and need is usable access to the Medicare claims and payment data. We know providers who defraud one program are overwhelmingly likely to defraud the other, or the Children's Health Insurance Program. Yet while we all know that, we still encounter federal institutional opposition to sharing Medicare data with us. The reality is that additional data would enable us to see and identify overpayments in a far broader context – overpayments which might otherwise fly below the radar and escape our notice.

Pattern Recognition Technology

Many argue that data analytics and approaches among the states and federal government on Medicaid expenditures should be standardized to facilitate the transfer and analysis of data. Yet

the old adage is that if you have seen one state's Medicaid program, you have seen one state's Medicaid program. Because each state assigns different levels of effort and funding to priorities within the Medicaid program, a universal approach to data analysis would likely prove counterproductive. Even if it were possible to run the same analytics on every state or territory's program, the results quickly would grow stagnant. Ranchers and farmers know the value of hybrid vigor – cross breeding different strains of livestock or crops – to enhance the strength and viability of the animal or plant. A similar concept applies in investigations. Too many people running the same queries or investigations stifle creativity, innovation and adaptability. We would end up with every investigator in the country aware of and investigating the same schemes, while those bent on stealing money from the Medicaid program would stay up late plotting ways to avoid detection. In our judgment, CMS should encourage each state to use whatever method of data analysis is effective for that state. To some degree, trial and error will help reveal the most effective methods of approaching large quantities of data and extracting useful information from it. Yet the more programs that are looking at data and trends from more perspectives, the greater the probability that schemes and patterns will become visible to everyone sooner.

In Texas, we have identified pattern recognition technology that traverses gigantic quantities of data in remarkably short times to identify patterns and connections between seemingly unrelated events and individuals. Thus, data queries that might normally take hours or even days to run can be completed in minutes, seconds or even sub-seconds, and a physical graph of the results can be displayed on a desktop computer for an investigator to see. Recognizing that fraud is fundamentally a behavior rather than simply an act, we can begin to compile databases of

Medicaid transactional history, other social service program history and additional data from widespread other resources to track relationships between people and specific acts in time. In this way, we can see how events, times, locations and actions are related to each other. Importantly, we can begin to understand not only the actions individuals commit, but also the behavioral indicators and relationships that are suggestive of fraud The end result will be a remarkable abbreviation of the time it currently takes us to see aberrant billings or expenditures. Although much is said about pre-payment review of claims, the reality is that investigators still must know trends and patterns to know whether a creeping upward expenditure line is an aberration or expectation, and whether physicians referring to certain pharmacies or therapy clinics are doing so for professional or fraudulent reasons.

This technology is not without cost, and states need federal assistance in obtaining it. Yet equally as important is access to federally-maintained data, such as that in the Medicare databases. There are organized groups of people in the United States today who are, this very moment, conspiring to defraud the government and our taxpayers. Until the states and the federal government reach the point where there is no "our data" and "your data," we will continue to play catch me if you can with criminals who skip from state to state and scheme to scheme as easily as other people change socks.

Federal – State Recoupment Cooperation

Currently, interdiction and recoupment efforts are a two-edged sword. States identify potential overpayments and, after the proper due process steps are observed, CMS is entitled to 50% of the

identified overpayment. States have 60 days to repay the overpayment to CMS in non-fraud cases, one year to do so in cases where the state has established fraud.

Unfortunately, this process builds in disincentives to the states to be active in identifying and publicizing anti-fraud, anti-overpayment activities. In Texas we currently have a number of large cases where the potential overpayment could easily involve tens of millions of dollars. Historically, our options for cases where we identify a potential overpayment of that size are limited. Providers with large overpayments generally go out of business or bankrupt, either of which relieves them (and consequently the state) of the burden of repaying any portion of the overpayment they obtained.

In Texas, we are currently in the midst of investigating a relatively small number of orthodontists who collectively have overbilled the State in the neighborhood of hundreds of millions of dollars over the past five years. Although the pattern recognition software I mentioned earlier would have identified the creeping upward trends and identified this problem much earlier, we are confronted with a situation now where a few providers are providing care to an enormous number of Medicaid recipients. One provider alone has roughly $27 million in orthodontic overpayments in addition to general dentistry overpayments that may far exceed that amount. The easiest thing for a provider in that situation to do is close, leaving the state scrambling to identify substitute providers for the patients affected. For larger providers, the number of affected children easily reaches the tens of thousands. Although Texas could absorb that type of disruption once or twice, perhaps even three or four times, we simply do not have enough

professionals to care for all the children who would be affected if their orthodontist went out of business.

Thus, we are confronted with two dilemmas. First, we have providers overbilling the Medicaid program. At the same time, we need their services to complete the treatment they began or, in some cases, simply provide care in areas where there are no other providers. Second, we have little ability and few tools to recoup money from those individuals. Recognizing that over-billers rarely save their ill-gotten gains in liquid accounts, we see provides buying jets, expensive cars and building enormous houses. If we pursue them for repayment, we find few easily collectible assets. Worse, we can only pursue them once we have established a definite overpayment amount – which means the clock starts running for the state to repay CMS one half of the identified overpayment. In the case of my state, our program integrity efforts could perversely cost the state hundreds of millions of dollars in identified overpayment money CMS is obligated to claw back.

However, given enough time and flexibility it is possible for us to recoup some lost money. Long term repayment arrangements and litigation to pursue assets are two readily identifiable methods for recovering money the program paid improperly. Yet neither option is possible under current rules and strictures, leading to a Hobson's choice: we can either finally and formally identify an overpayment amount, and enter into a relatively short repayment arrangement (thereby triggering state repayment obligations to CMS), or we can put the provider out of business (thereby eliminating the specter of CMS withholding millions of dollars from the State's Medicaid payments). In the first case we either significantly restrict the total amount of

recovery available to that which the provider can repay within 60 days (or one year for fraud cases), or the state shoulders the burden of paying the CMS portion up front and recouping from the provider as time goes by. In the second case, the provider often escapes with no liability whatsoever.

When the federal government pursues a provider for an overpayment, it rarely, if ever, seeks settlement approval from the State. The converse is not true. Perhaps there was a time when this was appropriate, when the federal government took a greater portion of any recovery. Today, the State and the federal government share the recoupment amount equally. If we had the authority to negotiate cases directly with providers to establish long-term payment plans, or had the flexibility to pursue assets in court for as long as that took and could repay 50% of the recovery – whatever it was – upon actual recovery, it is my belief we would unquestionably see our recovery rates and absolute dollars skyrocket.

Summary

Half of the equation in Medicaid fraud, waste and abuse detection and prevention is investigative and audit driven: getting the right technology and human resources to identify the behavior and actions that pose a risk to the program. The other half is what we do with that information once we get it.

We believe there is a solid foundation for the CMS-state relationship, but also that the environment in which that relationship exists needs to change to improve. An attitude of cooperation and assistance is already evident but needs to extend further, to data access and

resource development. We need financial assistance to obtain the best technology to identify and combat waste, fraud and abuse. Recognizing that states are equal participants in recoveries, states should have the ability – or at least CMS should have the authority to delegate it – to enter into settlement agreements designed to maximize recoveries for the state and federal governments, without fear those agreements will result in significant costs to the state's general revenue.

It is of paramount importance to both the Medicare and Medicaid programs that program integrity efforts lead to dollars being saved, not recouped, to client services being provided, not falsified and to fraudsters and inappropriate payments being stopped early, not years later.

I appreciate the efforts of CMS, and in particular am grateful for the efforts this subcommittee has made and continues to make. The Texas OIG looks forward to partnering with CMS and other federal, state, and local agencies involved in the fight to rid our programs of fraud, waste and abuse.