

**Chairman:** Rep. Carter.

**Rep. Carter:** Oh, thank you, Mr.. Chairman. On page 35, you've identified some initiatives with regard to fraud and waste. This is such an important issue especially as we stretch our budget in our demographics and our growth and population all change. I just have a quick question about – under each of the investigation process[es?] in the initiative program, the numbers have just increased so drastically, from 12 cases to 108. More than half a billion dollars became recovered through this initiative program. And I just want to find out in a little bit more detail how you were successful with it.

**Dr. Janek:** Sure. And if my questions are insufficiently vague, I'll be happy to ask Jack Stick to come up. But basically, it's this: you've got a couple of areas, orthodontia and others, where sort of a national phenomenon was uncovered, if you will, that a lot of kids in the Medicaid system were getting braces without necessarily needing them.

Now there are strict criteria: there's actually a numerical grade that the orthodontists use to determine where a kid is in terms of the tooth placement and [...] projections and that sort of thing. And everyone is supposed to meet that numerical requirement. It has been our determination that a lot of those providers could not substantiate their documentation, that that was where that kid was. And therefore couldn't substantiate that the kid needs braces.

And so right now the focus is on where did this fall through? Where did the agency fail, where did the providers fail, what guidance did we get from the federal government? How was it that suddenly we had this explosion of dollars that was spent in orthodontia care and as yet there didn't seem to be any suitable guardrails to keep it from just going out of hand. [2:15]

**Rep. Carter:** May I interrupt for just a sec? Are you looking at when you are talking about the target case investigation, or are you looking at the overpayments? Because in particular, it seems like over 1 fiscal year, you were from identifying overpayment at 28 million to over 500 million. And so I don't know if the dentistry is reflecting that \$500 million dollars of overpayment, or that some other area. But I am familiar with the dentistry. I think that's positive. [2:42]

**Dr. Janek:** Sure. If you will allow me, Mr. Chairman, I'm going to ask Jack Stick, our director of enforcement in the OIG to help out.

**Rep. Carter:** Hi, Representative Stick.

**Stick:** Good afternoon, Mr. Chairman and the members of the Committee. My name is Jack Stick. I'm the deputy inspector general in charge of enforcement actions at Health and Human Services. Let me see if I can try to explain what was going on.

In fiscal year 2011, we completed about 12 cases during that entire fiscal year valued at about \$28 million. When we value a case, we look at the overpayment amount we've been able to establish either potentially or finally. That year, it was \$28 million. In fiscal year 2012, we had a new

approach to handling cases. So we imposed time limits, we restructured how we would look at a case, when we would look at a case and we prioritized cases. So while we had cases that were as many as 10 years old, we were handling them kind of *in seriatum*. So whichever case got there first, if it was valued at \$100,000, we would handle that one before a \$15 million case. We changed all of that up. And in the process of doing that, significantly increased both the number of investigations we were able to complete as well as the dollar value of those cases.

So of the \$531 million that we identified in state fiscal year 2012, about 300 million of those are attributable to orthodontia. There's another hundred million attributable to hearing aids, 50 million or so in therapy, and so on. So I think what the committee can expect is to see that in subsequent years, we'll continue to see an increase in the number of cases that we complete annually as well as the dollar value of those cases until we've worked through that backlog and until we've kind of reached the point where the program is a little bit cleaner than it is right now. Thank you. [4:48]

**Chairman:** Representative Giddings.

**Rep. Giddings:** Yes. I can't – I don't know what to call Jack. What is your official title here?

**Stick:** Jack is fine.

**Rep. Giddings:** I don't want to take up this committee's time with this, but there is an issue here involving fraud that I have personally tried to work on for a couple of people and got no place.

Two people contacted us regarding these power chairs. They said they didn't want them, they never accepted them. And we know who sold them to them. And so I called this agency. I called the AG, I called the feds. And finally, my office sent the information on the name of the company and whatever to the federal agency. I think it was the Office of the Inspector General. And that must've been 90 days, 120 days, maybe even 6 months ago, and I never heard anything more. And it was an absolute abuse, an absolute fraud for people to be offered these. And the way they found out is one of these people since the power chair back – clearly didn't need it. But did need the kind of wheelchair that you get behind and push, and couldn't get the kind of wheelchair that you get behind and push because the records indicated that they had had this \$5,000 power chair which they never got. And I happened to go over to this particular area, and there were all kinds of people in that neighborhood running up and down the street no less in power chairs. So that's one that personally upsets me.

**Stick:** Representative, I'll follow up with your office on that one. I'm not aware of that case in particular, but I am aware that there is an extant and growing problem in the area that you've described. I can tell you that if I get a phone call from a representative's office, we will respond to it within 24 hours. Representative Crownover spoke with me about a week and a half ago about a case in her district and we were able to address it in about 24 hours I think fairly successfully. So I will follow-up with you on this. [7:22]

**Rep. Giddings:** And I don't think I got your office. I'm not sure. And generally, I don't pick up the phone and go to Dr. Janek. I try to solve the problem down there if I can. And so I was okay when I

was saying you need to talk to the federal Office of the Inspector General. I was fine with that. I sent in all the information I had, I just never heard anything from it. I'll be happy to get with you because I don't want it to take up your time on this issue. [7:52]

**Dr. Janek:** Let me add if I may: frequently in the instance of the power chairs, those are Medicare expenditures. There's a low chance that Medicaid could be doing it. Nonetheless, if some evidence of money being wasted is brought to our attention, then our job is to make sure that it gets to the feds and not say, "well, it's a Medicare thing, we can help you," and so we'll try to be better at this. I can tell the committee that I do know you can go on eBay and buy supplies that we pay for. You can go and find the glucose strips that diabetics use. And I'm told that you can buy diapers. You can buy a lot of things that we are paying for and the question is how are they getting diverted to that market. And this is part of what we are asking Jack and his folks to accomplish over there.

**Chairman:** Representative Crownover.

**Rep. Crownover:** Yes. I do want to thank you and compliment your organization. They were very timely, very on top of everything. And it's an ongoing situation that we will be working on together. I know that President Obama himself said that he admitted or he recognized that there were hundreds of billions – not millions – billions of dollars of Medicaid and Medicare fraud. And I think we have an absolute responsibility to address this. So I would like to ask you and give you the opportunity. Do you have the tools that you need? Is there something that we should do to help empower you?

**Stick:** Representative, we have submitted a list of exceptional items and then of course we'll be working through the work group to discuss ongoing needs. The short answer is we spend billions of dollars in Texas. We have in the last probably year or so, significantly addressed and restructured how we're approaching our cases. We've worked closely with CMS. They've been extraordinarily supportive of the efforts that we've made in Texas. We've increased our activity in dollars identified by about 1,800%. We increased our cases completed by about 800%. CMS has funded a complete revision of our analytics – initial analytics – in case management system for us almost at a 90/10 split. So in those areas, I think we are successful.

Looking beyond that, we need to integrate how we look at cases so that were not looking at just Medicaid and just SNAP, TANIF and WIC. Currently we silo those. We need to look at them on an integrated basis and that will require additional analytics. We need to risk score our cases better. That will require additional analytics. And as you'll see in our exceptional items, we've requested additional money for investigators.

We've tripled the number of investigators assigned to Medicaid provider integrity. I think we are probably half at least of what we need in that area to work through the backlog that we've got and then maintain a level that I think the legislature expects of us. We will always do the best that we can with the resources that we have available. If the legislature determined that it was appropriate to give us additional resources, we could put them to pretty good use. [11:43]

**Rep. Crownover:** Thank you. And my comment would be, this may be one of those cases where it's not good money to save if you're not addressing this huge pot of fraud and abuse.

**Stick:** Along those lines, I can give you one other little snippet of information. In June of 2011, the return on investment per investigator was about \$120,000. Last year, it was close to 17 million.

**Rep. Crownover:** Wait. Say that again.

**Stick:** In June of 2011, the ROI per investigator assigned to Medicaid provider integrity was right at about \$120,000. Today, it's right at about 17 million.

**Dr. Janek:** And I don't think that's in terms of funds recouped, but rather funds identified as overpaid.

**Rep. Crownover:** Great. Thank you. Stay tuned.

**Chairman:** OK, members, this especially for the new ones: if you want to be recognized Oscar, you just push your button. So push your button And then – we have a light board up here that flashes. So would you push your button, Oscar.

**Rep. Longoria:** Rep. Stick, I have a question. How much has actually been recovered?

**Stick:** We calculate recovery based on actual dollars in the door plus the identified dollars that are subject or liable to recovery. So based on that, the recovery for state fiscal year 2012 is about 996 ½ million dollars. The cost avoidance, which would be the money that we never spent because of some OIG action is about 197 million dollars. I can get you the exact number of dollars that came in the door, but it's important to note that – and this was a frustrating thing for me to understand fully – we may litigate or we may investigate a case this year and not see dollars for years, or the dollars may trickle in for 10 years. So it's a little bit difficult to get a hold of an accurate measurement on the success of an investigation based on whether dollars have come in because the dollars from today may be based on 2005 actions. But having said that, we can get you the exact number of dollars in the door. [14:31]

**Rep. Longoria:** All right, thank you.

**Chairperson:** Thank you. [Garbled].

**Rep. Munoz Jr.:** Thank you. I just have a couple of questions, but first of all when you mentioned earlier that you value a case, how do you determine that?

**Stick:** Representative, what we'll do is we will investigate a case. We will establish an overpayment amount. The way we establish an overpayment amount if there is any, is, depending on the nature of the case, we'll hire an expert witness or an expert consultant to look at the reviews. So a board-certified ENT would get a board-certified ENT reviewing the records. They look at the records and they calculate whether there are mistakes, whether there are overpayments and if so, what they are. And then we divide those into 2 different categories. There are the recoupable overpayments and then the non-recoupable overpayments. So if you make an

error, and it's kind of a no harm, no foul error, we don't recoup on that. We'll notify you that you that you've made a mistake, but we don't recoup on it.

In the recoupable errors, there are 2 different categories of those. There are the errors that are 100% recoupable and the ones that are partially recoupable. So if you're a physician and you bill at a level 4 office visit which might cost \$150 but it should have been an office visit level 2 which is maybe \$100, we recoup the delta between those two, so it would be a \$50 recoupment.

We identify the total number of errors, the total types of errors and then we extrapolate to the total dollars amount or dollars billed in the period that we've established as the recoupment period.

**Rep. Munoz Jr.:** I guess by the extrapolation of what you're saying is for example, if you identify like 3% or you know, 5%, right, out of 100, then you would multiply that by the whole – like, for example, if you find that two or three visits, right, that should have been done at level 2, and you found a percentage that was overpaid, then how do you extrapolate that versus their whole – the whole patient mix that they have?

**Stick:** Sure, that's a good question. What we do is take a statistically valid random sampling. And the size of the statistically valid random sampling depends in large part on the size of the practice. So a practice with 100,000 patients would have a larger sample that we draw than one with a smaller sample. So everything that we do is statistically valid. So we make sure that when we identify samples, that it is possible for us to extrapolate. So we don't want any cases that anybody has already touched, that anybody has already recouped on. The feds, sometimes another division of OIG will occasionally recoup as well. So we try to eliminate all those. If we don't eliminate those, it ruins the investigation. So we're pretty careful about that.

Then what we do is we break it down. We striate it into the types of cases that were looking at, and it's based on the codes that the provider would bill. So we will take a sampling that the formulas tell us are statistically valid and reliable. And then we conduct the investigation based on those. So we will have pulled those files that represent a statistically valid sampling of what that doctor has done over a 5-year period. We go back actually 4 years and 10 months. And that way, when we arrive at an overpayment percentage amount, we can extrapolate that to the total amount of dollars billed and have statistical confidence that the amount of money that we've identified is correct.

**Rep. Munoz Jr.:** OK. And have there ever been situations where that extrapolation – even though it's just a percentage of the cases that are in part of mix – but I would just think, has there ever been a chance where that maybe has not been necessarily correct? Because if you figure out let's say, maybe 5 out of 100 that may have been overbilled, but then you are going to use it percentage-wise over their whole – over the amount of cases that they have – I guess you're putting more in the mix than were necessarily identified to begin with, right?

**Stick:** Sure. I understand your question. Let me answer it this way. First, directly, no. I'm not aware of a situation where we have had a statistically invalid sample that surprised us. We've had occasions where we have subsequently learned that one or 2 of the cases that we were looking at

have been recouped previously. And that would of course invalidate the sample. You can't just have pull one case out even among the thousands that we would look at.

That's the other thing I wanted to point out. We're not looking at 5 cases out of a medical practice. We take a pretty big sample. So we're looking at 80 -85 cases often. And each one of those cases has multiple detail lines in it. So multiple things that happened with that patient. So we're often looking at thousands and thousands of claims that are filed. So I don't want anyone to walk away with the misunderstanding that were only looking at a couple of cases here and there and then sending a bill for a large amount of money.

The third thing I want to point out is even after we identify a potential overpayment amount, the provider has multiple opportunities to work with us to explain where our expert may be wrong, where the expert may be right but the provider may be right, or just to negotiate the case altogether.

**Rep. Munoz Jr.:** Do you think there is anything that the legislature could do to allow for further due process for individuals?

**Stick:** Well, I think what I can do is explain to you what the due process opportunities are, and then you can draw your conclusions from there about whether there's more that you are interested in. Certainly, we don't have the position on whether there should be more or less. When we identify an overpayment, well, actually even before that, if we decided there's evidence – credible evidence – of fraud, we're required by the Affordable Care Act to place that provider on a payment hold.

We notify the provider. We also notify each elected official representing that provider The provider has an opportunity to request an informal conference with us and also has an opportunity at that time to request a formal hearing at the State Office of Administrative Hearings.

When we afford a provider the opportunity to talk with us informally, it's an opportunity to bring up anything they want. Anything at all. So anything from “look, I haven't had a chance to review all the material that you sent me. This is killing my business. Here's proof that it's killing my business. Can you relax this while we work this out?” And we've had a lot of those conversations. To “actually, I have had a chance to look at your material, and I think that you're wrong on these five areas. I think you're right on these three areas.” So the informal process is the first opportunity really for them to sit down and work through with us either a resolution of the case or a reduction of the credible allegation of fraud hold.

Secondarily, there's an opportunity to meet with us again when we identify a potential overpayment. So they have an opportunity to come in for an informal conference to discuss that. And when I say they have an opportunity, I want you to understand we've never denied an informal conference. Anybody who asks for an informal conference gets it, and they get as many as they want. And then they also have an opportunity after that informal conference if they're not satisfied to appeal the case to the HHSC appeals division.

**Rep. Munoz Jr.:** And how long does that process normally take?

**Stick:** It's really driven by the provider. The provider has in obligation to make the request. We don't make the request for them. Once they make the request, it sort of preserves their ongoing right to have a either a SOHA hearing or an administrative appeals hearing, depending on the status of the case. But when it gets docketed, it historically has been up to the provider I can tell you that although we have a couple of cases set later this year – I want to say April or May – we've only actually had one provider take a case to an administrative hearing. And we've got roughly – in December, we had about 91 providers on payment hold. I think it's a little bit more now.

**Rep. Munoz Jr.:** OK. And I guess – just my final question, but when the recoupment is made and the money is recouped, I guess on behalf of the state, does the state then have to return the percentage back to the federal government at that point or is it collected –

**Stick:** Yes. Yes.

**Rep. Munoz Jr.:** OK.

**Dr. Janek:** If I may, Mr. Chairman, just to go to what Representative Longoria and Representative Muñoz were asking. All of these things where we have to do statistical sampling and look-backs and that sort of thing get really complicated when you're talking about look-backs of 2, 3, 5 years, which is the period of time when providers are requested, required to keep records by contract. And so in the future, you'll hear some more testimony. Next week, we'd like to do a couple of things that we think are better. First is, be a little more proactive and identify mispayments in the early stages. Not go back to a provider and say, "Gosh, we want to see your records from four years ago. And we're going to take statistical samples. We'd like to identify if providers are making an innocent mistake. We'd like to correct it early, when it's a thousand dollar mistake, not a seventy thousand dollar mistake.

Secondly, is that we want to work with the providers to shorten the period of time. We don't want this hanging over their head. For a provider who's done something wrong, we don't want them in the program any longer than is necessary. For a provider who has done nothing wrong, we don't to have this lingering in their office, and just sort of a cloud hanging over them for, you know, 2, 3 and 4 years. We want to shorten that length of time, get this down to a reasonably period of time, where we can put in investigators, determine whether there was fraud and then get out an make a determination. So we'll be working with the committee on some of these initiatives.

**Chairman:** Any other questions? Representative Longoria.

**Rep. Longoria:** Yes, chairman. Representative Stick, Commissioner. What information do you guys get in order to show up to a provider, in order to conduct one of these investigations on overpayment or fraud?

**Stick:** So historically, we got leads from any number of sources. We got leads from our electronic Medicaid fraud abuse detection system, which looked primarily at outliers or did targeted queries of the data. So how many men got hysterectomies? That would be an automatic problem. You know, those kind of queries.

We got providers who would call and give us information or confidential leads on other providers. Recipients. Pretty much anyplace that you can think of. We found that that was not a particularly effective method of approaching cases. It didn't give us a comprehensive look at what was going on in the Medicaid program. So that if there were a provider that somebody dropped a dime on, we would know what that provider was doing, but we couldn't see whether providers in others communities were doing it as well. There was no comprehensive or holistic approach. So we – this was what I was talking about earlier – where we asked CMS to help fund a comprehensive look at – or enable us to buy the equipment and technology that will allow us to have a comprehensive look at the program and see what was going on. It's really a 4-phase process with graph pattern analysis as the 1st phase, an enterprise case management system as the second phase. A data analytics or risk-type scoring as the third phase and then a fourth, as of yet undefined phase. But we assume there's going to be stuff that we haven't figured out that we will in the next 12 to 18 months.

So the answer to your question is historically, it's been kind of a mish-mash of ways that we would get information prospectively. And by prospectively, I mean within the next few weeks, we'll be much more dependent on technology.

**Rep. Longoria:** All right, thank you.

**Chairman:** Any additional questions to the Commissioner?

**Rep. Charles Perry:** I want to clarify: if we don't recoup, but if we do determine fraud, we still have to write that check to the feds. Is that a good statement? We don't actually get the money back from the provider. We still owe the fed for the FMAT part. Is that correct?

**Stick:** Yes, unless the provider goes out of business.

**Rep. Perry:** OK. I mean, realistically, the law is we've got to pay it. We may not be able to collect it, but we still owe f amount that we determine to be fraud.

**Stick:** I'm sorry, Representative, I didn't mean to interrupt.

**Rep. Perry:** No.

**Stick:** You know, historically, we've not run into that situation because we were [...] 28 million dollars. Today, we've had significant and expensive discussions with CMS about that. We're continuing to talk with elected officials on Capitol Hill about that very issue because essentially there is a built in disincentive for states to be effective. Texas right now is the national leader in identifying waste, fraud and abuse. And consequently, we're taking the lead on this because we have the most to lose. The answer is we've not yet had CMS say we're going to claw back any money, partially because we've got this bolus of cases that are working through the system and we haven't reached a critical point yet.



But secondarily, the providers who are large – we had one provider in the 48 million dollar – 50 million dollar range – they’re in bankruptcy court. So when they’re in bankruptcy court, it wipes the obligation out altogether. Or if they go out of business, even if they don’t declare bankruptcy it wipes the obligation that we have.

**Rep. Perry:** I want to say this. I’ve worked with you guys over the interim. You’re doing a great job and we’re moving in the right direction. And again, whatever we can do from a legislative perspective, let us know.

**Stick:** Thank you.

**Rep. Perry:** Thank you.

**Chairman:** Any other questions for the Commissioner?