July 19, 2005
Pataki Orders Broad Overhaul of Agencies That Watch Medicaid
NY Times
By CLIFFORD J. LEVY and MICHAEL LUO

Gov. George E. Pataki today ordered a broad overhaul of the state agencies that protect Medicaid from fraud and abuse, creating an independent inspector general's office and bringing in a former federal prosecutor to help reorganize the policing of the program, which is New York State's largest expense.

The inspector general is expected to take over some authority to find fraud from the State Department of Health, which currently administers the overall program but has fared poorly in detecting Medicaid fraud compared to its counterparts in other states.

Mr. Pataki said he was appointing Paul Shechtman, a former federal prosecutor who led the governor's criminal justice initiatives early in his tenure, to develop new strategies for combating Medicaid fraud and reorganizing the state agencies. The governor did not announce his choice for the Medicaid inspector general position.

The actions, which the governor's aides said he intends to carry out through an executive order, would reorganize the program in a significant way, removing some of the responsibilities for enforcement of the program from the agency that writes Medicaid checks. Medicaid, a 40-year-old program that provides health care to 4.2 million low-income New Yorkers, has grown sharply over the last decade, to $44.5 billion, even as the state has repeatedly scaled back the security force intended to safeguard the spending.

The governor's order followed articles in The New York Times today and Monday that detailed how billions of dollars in Medicaid spending were being siphoned from the program through fraud, waste and profiteering.

The Times reported that New York appears to have stumbled in its efforts to prevent health care providers from abusing Medicaid. The State Department of Health, which bears primary responsibility for detecting fraud in the program, referred just 37 cases of suspected fraud to the state attorney general's office in the 2004 fiscal year, far fewer than its counterparts in any other large state.

Recoveries of money from fraud and abuse inquiries by the department have fallen 70 percent since 2000, according to federal statistics.

The state's poor performance is caused in part by a sharp drop in the number of people in the state government dedicated to rooting out fraud and abuse, according to former senior state officials.

It has not just been the department that has lagged. The Medicaid Fraud Control Unit in the state attorney general's office, which prosecuted fraud, has fallen behind its counterparts in other large states as well.

Analyzing Medicaid billing records obtained from the state under the Freedom of Information law, The Times found numerous instances of spikes in claims, a telltale sign of fraud, that were never scrutinized by the state.

The Medicaid billings for a Brooklyn dentist, Dr. Dolly Rosen, rose to $4 million in 2003 from zero in 2001. She claimed to have performed as many as 991 procedures a day in 2003.

After the Times questioned the state about her extraordinary billings, Dr. Rosen and two associates were indicted on charges of stealing more than $1 million from the program.

While the governor plans to use an executive order to create an inspector general, the Republican-controlled State Senate in May approved legislation that created a similar office. At the time, Mr. Pataki opposed the measure, as did the Democratic majority in the State Assembly, which has long allied itself with large health care lobbies and unions. Assemblyman Richard N. Gottfried, a Manhattan Democrat who is chairman of the Health Committee, said he did not believe that the system needed to be changed.

July 19, 2005
As Medicaid Balloons, Watchdog Force Shrinks
NY Times
By MICHAEL LUO and CLIFFORD J. LEVY

New York's Medicaid program pays more than a million claims a day, feeding a $44.5 billion river of checks to radiologists and ambulance drivers, brain surgeons and orderlies, medical centers and corner pharmacies. Many who get those checks pocket more money than they deserve, and millions of taxpayer dollars are believed to be lost every day to theft and waste.

Yet the state, charged with protecting those dollars, has done little to stop them from draining away.

A yearlong New York Times investigation found only a thin, overburdened security force standing between this enormous program and the unending attempts to steal from it. Even as spending by New York Medicaid has more than tripled since the late 1980's, the number of fraud investigators who guard its cash register has fallen by half, and several of their leaders have quit or retired in disillusionment.

Of the 400 million claims that Medicaid paid last year, Health Department regulators uncovered just 37 cases of suspected fraud, far fewer than their counterparts in any other large state, even though New York's Medicaid budget is by far the largest in the nation. Many experts say that it is likely that at least 10 percent and probably more of New York Medicaid dollars are stolen or wasted.

In dozens of interviews, prosecutors, lawmakers and former regulators said the program paid for almost everything and scrutinized almost nothing, in large part because its primary mission has been to ensure that there are enough health care providers in the system to address the needs of the poor. It often appears that the Health Department is barely even looking: There are more than 140,000 hospitals, nursing homes, doctors and other health care providers in the system, but the department visited just 95 in the 2004 fiscal year to audit their billings.

Analyzing Medicaid data obtained under the state's Freedom of Information Law, The New York Times identified scores of instances in which the claims of health care providers jumped markedly in a single year. These spikes are a classic indication of possible improper billing, yet few of those providers had even part of their billings audited by the department, state records show.

New York's Medicaid program, once the pride of the Great Society era, has become a system "that almost begs people to steal," said Michael A. Zegarelli, a senior New York Medicaid regulator until 2003 and a past president of the national association of Medicaid oversight officials.

Meanwhile, other states, including California and Texas, have increased their antifraud efforts and discovered what seems a simple truth: The effort to seek out theft and unnecessary spending can more than pay for itself, just as a parking violations bureau brings in revenue. Workers assigned to Medicaid fraud prosecution units around the nation help bring in an average of $200,000 each in recoveries, according to federal statistics.

Twenty-five years ago, New York was in the vanguard of fraud prevention. But over the decades it has failed to maintain the investment in employees necessary to close the door on thievery and abuse. Repeated delays stretched the replacement of a 1970's-era computer system that could barely detect fraud into a seven-year ordeal, allowing billions to slip by with little scrutiny.

As dozens of former employees describe it, the state's antifraud effort has been plagued by the same gridlock that has stifled innovation in Albany for years: bureaucratic infighting, allegiance to campaign contributors from the health care field, reliance on public indifference.

In an interview, Dennis P. Whalen, executive deputy commissioner of the Health Department, said combating fraud remained a major goal. He denied that the department had been lax in policing Medicaid and excluding providers who had cheated the program, saying that new computer systems have improved the state's detection efforts.

But State Senator Kemp Hannon, a Nassau County Republican who is chairman of the Senate Health Committee, called The Times's findings deeply troubling, and said they showed that the Medicaid fraud detection system was broken. Mr. Hannon said the Health Department, run by a fellow Republican, Gov. George E. Pataki, was failing to oversee the system.

"This is a red flag for them," Mr. Hannon said. "I have not seen anything that would indicate that there has been any sort of focus at all from the department."

New York's failures have come at a high price, according to advocates for the program's recipients.

"There is all this money that is being drained away and not being spent on care for the poor people who need it," said Elisabeth Benjamin, who spent eight years as a lawyer at the Legal Aid Society specializing in Medicaid. "It's analogous to the $5,000 toilet seat in the military."

Investigation Staff Is Cut

More than a dozen years ago, in the heyday of the unit charged with fighting Medicaid fraud and abuse in New York City, dozens of state employees would troop out to locations throughout the city for a regular ritual. With reporters in tow, they would serve papers on scores of shady doctors operating low-quality, high-volume clinics known as "Medicaid mills," said James Mehmet, who retired from the State Health Department in 2001. Mr. Mehmet was the unit's chief of investigators in New York City.

Most days, more than a dozen investigators went undercover as patients to see how they were treated by a doctor or a pharmacist, and then how their visit was billed. In the office, they worked alongside auditors and lawyers, as well as nurses, dentists and doctors - a full medical review staff.

But the energy and ambition of the office have dissipated along with the staff, Mr. Mehmet said. By the time he retired, he said, the 15 lawyers in the office had been reduced to one. The medical review staff was gone. And with the Medicaid budget growing rapidly, it was not the fraud that had diminished, he said, but the will to pursue it.

"The volume of work was so much different," Mr. Mehmet said, recalling earlier days. "The caliber of work was so much different. There was much more emphasis on going after people that were committing fraud and abuse."

Mr. Mehmet and other frustrated former regulators say the drop in the New York City office mirrors the statewide decline in staffing over the last decade, at a time when thieves have

become more sophisticated.

In the late 1980's, more than 200 people in the New York Medicaid bureaucracy were devoted to fighting fraud and abuse, said Philip J. Natcharian, who directed those efforts until 1990. Now only 50 people, including clerical staff, have that job, along with a few dozen outside contractors, said Mr. Zegarelli, who worked at the Health Department's headquarters in Albany until his retirement. He said that was far too few to be effective, an assessment echoed by four other former senior department officials.

The former officials said reducing the fraud force made little sense to them, given the huge increase in Medicaid spending in recent years, which has brought the program to more than 40 percent of the state budget.

"How do you not increase the staff to monitor the largest expenditure in New York State?" said Mark J. Ives, who directed the state's fraud and abuse efforts until he retired in 1998.

One likely result of the staffing decline is that since 2000, the amount of money the Health Department has recovered from fraud investigations has fallen by 70 percent, according to data compiled by federal regulators.

At the same time, the state has virtually stopped excluding doctors from Medicaid for violating its rules, excluding only eight out of the 43,000 doctors enrolled in the program last year, a Times analysis shows.

"I think the department's reached the point of Smokey the Bear with a shovel," Mr. Zegarelli said. "They're just running around putting out fires."

The former regulators said they did not believe there had been a deliberate decision in Albany to loosen enforcement. Instead, they described a gradual move away from regulation as Albany focused on expanding and plugging holes in the program.

"They want recipients to get medical care," said Michael P. Sofarelli, who retired as a Medicaid prosecutor in the attorney general's office in 2003 after handling some of the state's biggest Medicaid fraud cases. "Investigating is a small part of the job."

The Health Department reports to Governor Pataki, and in recent years, his budget aides have actually reduced goals for recouping money from Medicaid providers for improper billing.

The decline of fraud control in New York contrasts sharply with the situation in other states. In 1998, California, which had several high-profile Medicaid fraud cases in the 1990's, added about 400 employees to an existing staff of about 40 charged with rooting out abuse. The number of fraud cases referred to prosecutors has since doubled.

Officials in Illinois and Ohio, where the Medicaid budgets are roughly a quarter the size of New York's, visited more than three times as many health care providers in the 2004 fiscal year to audit their billings.

Mr. Whalen, the executive deputy commissioner of the Health Department, said it frequently stopped Medicaid payments it considered questionable. He acknowledged that the staffing for fraud prevention had dropped, but described the change as insignificant, saying the state employed roughly 400 workers whose jobs involve fighting Medicaid fraud and abuse, supplemented by 200 outside contractors.

"The number, in terms of a pure number, has declined, but I would say that it has not been a huge decline," he said.

"Every agency, I am sure, would love to have more staff, and we are no different," he said.

"But we are also realistic about the state's fiscal situation."

But former senior department officials said most of the workers cited by Mr. Whalen are not actually investigating fraud. They are accountants, nurses, computer analysts, clerks and others doing administrative jobs, making sure basic regulations are followed, leaving only about 50 state employees dedicated to fraud work.

Mr. Whalen and his aides said new computers and software were helping the department shift its focus from reviewing Medicaid claims already paid to preventing questionable claims from being paid in the first place.

But state statistics show that the department rejected a much smaller percentage of claims in the 2004 fiscal year than its counterparts in California, Florida or Pennsylvania.

Asked to list cases that they developed that led to arrests and prosecutions, Health Department officials could point to only a handful in the last two years.

The result of the cuts is evident in case after case that the state simply missed. The billings of a Queens pharmacist, Newton Igbinaduwa, rose to more than $1.4 million in 2002 from $78,000 in 1998, according to billing records analyzed by The Times. But the department never referred the case to the state attorney general's office.

It was only when prosecutors in the attorney general's office got a tip through another case that they found out about Mr. Igbinaduwa, who pleaded guilty last year to grand larceny after billing for drugs he never dispensed.

Prosecution Unit Shrinks

The Health Department is only half of the dwindling security force posted outside Medicaid's gate. The responsibility for prosecuting Medicaid fraud lies with the state attorney general, Eliot Spitzer, who runs the Medicaid Fraud Control Unit. And in the attorney general's office, too, Medicaid abuse has had a reduced priority for more than 15 years, with far fewer prosecutors than it had in the days when Medicaid was a much leaner program.

Though New York has the largest Medicaid fraud prosecution staff in the country, several other states have fraud offices that are larger in proportion to the size of their Medicaid budgets, and they recover a larger percentage from fraud prosecutions. As a percentage of the overall Medicaid budget, New York's 301 employees won less than half as much as those in Texas, Florida and New Jersey, according to statistics compiled by the federal government for its 2003 fiscal year.

Mr. Spitzer's office said New York used a more conservative method of calculating recoveries than other states, but even using that method, New York still fails to make the nation's top 15 states in the amount recovered as a percentage of the overall Medicaid budget, going back as far as 1999.

Mr. Spitzer's zeal in fighting corporate abuses has not been matched by his efforts in fighting Medicaid fraud, former employees say.

"I didn't think there was that much focus at the main office," said John M. Meekins, who retired in 2003 as the director of the Albany regional office of the Medicaid Fraud Control Unit. Referring to Mr. Spitzer, he added: "I'm not faulting the man. His focus was on Wall Street."

Mr. Spitzer said his office had made strides, especially in investigating the abuse of nursing home residents. The fraud unit's prosecutors have made a philosophical shift, he said, cutting back on the number of inquiries to concentrate on what they consider cases with bigger impact, which could lead to industrywide changes.

"The strategies that we have pursued have made sense and have been successful," Mr. Spitzer said.

However, the attorney general's office has had few such breakthroughs. None have shaken the health care industry in the manner of his successes on Wall Street and in the insurance industry, or the inquiries into nursing homes conducted by his predecessors in the 1970's.

The relatively low profile given to antifraud efforts dates to before Mr. Spitzer's term in office. The size of the fraud control unit dropped by more than 40 percent between 1979 and the early 1990's. Even after Mr. Spitzer became attorney general in 1999, the size of the fraud unit remained about 300 workers, the same as in the early 1990's. Back then, though, Medicaid cost about $14 billion a year, and its cost has since more than tripled.

The state could have a much larger prosecution force with a relatively small investment, because the federal government has made a standing offer to pay three-fourths of the cost, and New York's current allotment is well under the maximum. If the state spent an additional $24 million on its fraud prosecution unit, the unit's current budget of $45.7 million would more than triple to $148 million, mostly from the federal match.

Mr. Spitzer said state budget officials had repeatedly demanded hiring freezes for his office.

"The possibility of increasing simply has not been presented by the Department of Budget," he said, emphasizing that he believed that hiring more staff members made sense.

Last year, Mr. Spitzer said, the fraud unit recovered a record amount in overpayments: $62.5 million, up from $40 million in 2003. But the higher figure includes $30.8 million that was New York's share of a major nationwide settlement with two pharmaceutical companies over drug pricing. That case was spearheaded by federal prosecutors, not New York officials.

Behind the Scenes, Turf Battles

The Health Department and the attorney general's office must contend not only with growing fraud and depleted resources but also with another opposing force: each other. Over the years, they have accused each other of foot-dragging, incompetence, or resistance to change. Their mutual animosity and suspicion have come at the expense of the battle against fraud.

By law, it is the Health Department, not the attorney general's office, that is primarily responsible for identifying fraud. But the department's principal task is to keep the huge flow of payments moving swiftly, and at this point, with its shrunken enforcement bureau, the department sends very few cases to prosecutors.

Former officials of both departments say their different missions have left them clashing instead of cooperating.

Former prosecutors complained that Medicaid regulators often crippled their criminal cases by suing those they suspected of overbilling in civil court, hoping to get some money back to the system before the attorney general filed criminal charges. In those cases, prosecutors said, the state would often settle a case quickly for only a fraction of the amount overbilled.

Mr. Spitzer, a Democratic candidate for governor, said his prosecutors could not depend on the Health Department.

"They are just not a useful resource for us in the sense of providing us with ideas, places to look, referrals," he said.

Asked about Mr. Spitzer's criticism, a department spokesman, William C. Van Slyke, said,

"We believe that his political ambitions are the motivation for his comments, as opposed to the facts."

Former Health Department officials said that when they turned over evidence of fraud to the attorney general's office, the prosecutors often took months or even years to piece together a case, all while the fraudulent activity continued to siphon money from the system. Medicaid officials said they preferred a civil case to stop the fraud immediately.

"They were malingerers," said Mr. Ives, former director of the department's fraud section. "They would take forever and ever to process a case."

Mr. Van Slyke said 70 percent of the cases the department referred to the attorney general's office since 2000 were still open. The office responded that many of those cases were fully investigated but just not technically closed.

Whatever the cause of the tensions, the department refers far fewer cases to prosecutors than its counterparts in other large states. Texas referred nearly seven times as many cases to its Medicaid prosecutors as New York did in the last fiscal year. California referred nearly four times as many, and Ohio more than three times as many.

Resisting Reform

In the fight against fraud, New York's inadequate arsenal is not an accident. In Albany, reformers have repeatedly been outspent and outmaneuvered by the health care industry.

Several large states, including California, Florida and Illinois, have laws that encourage whistleblowers to come forward with information about fraud schemes, offering them a portion of any money recovered. There is a similar federal law to fight fraud in Medicare, the program for the elderly and disabled.

But when Mr. Spitzer has had this type of bill, called a false claims act, introduced in New York, it has died. The bill was denounced by the Healthcare Association of New York State, which represents hospitals, nursing homes and other providers, as well as the State Medical Society, which represents doctors. The groups, which spend millions annually on lobbying and campaign contributions, predicted that the bill would lead to an epidemic of frivolous allegations.

"New York State's health care provider community has faced unprecedented, overzealous investigations by regulators and law enforcement officials," the association said in a memo.

Daniel Sisto, president of the association, said that its members believed that federal officials had used inappropriate tactics to crack down on fraud, and that they had fought the whistleblower law out of fear that the state would follow suit. He said the group's members faced a raft of different requirements from Medicaid, Medicare and numerous private insurance companies, and as a result made billing mistakes that were wrongly criminalized.

"What concerns me from our past experiences is that there is overzealousness in the interpretations of any overpayments as fraud and abuse," Mr. Sisto said.

In May, the Republican-controlled State Senate approved legislation, sponsored by Senator Dean G. Skelos of Nassau County, that would create an independent Medicaid inspector general. The measure would take away some of the responsibility for combating fraud from the Health Department and the attorney general's office and give it to the new agency and to local prosecutors.

Mr. Pataki and Mr. Spitzer opposed the measure, as did the Democratic majority in the State Assembly, which has long allied itself with large health care lobbies and unions. Assemblyman Richard N. Gottfried, a Manhattan Democrat who is chairman of the Health

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Who's Minding NY's Medicaid?

EDITORIAL
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New York's Medicaid program has always had a reputation as the Cadillac of state health care programs. The 4.2 million people in the state's program have access to some of the best and most complete medical coverage in the country. The very fact that it's so generous makes it particularly critical that the public is assured that money is not being wasted. Unfortunately, the opposite seems to be true. As revealed by a year's investigation by Clifford J. Levy and Michael Luo of The Times, New York's $44.5 billion Medicaid program has become a honey pot for unscrupulous practitioners.

As one former prosecutor said, the pursuit of Medicaid fraud by Gov. George Pataki and Attorney General Eliot Spitzer is now so lax that New York State's Medicaid program "almost begs people to steal."

Better management of Medicaid and expanded enforcement should pay for itself - especially since there are federal funds available if New York steps up its pursuit of those ripping off the state. Yet the number of investigators has been cut so badly that, with 400 million claims paid last year in the state, Health Department regulators uncovered only 37 cases of suspected fraud.

Albany's politicians are scrambling to blame one another for this scandal, and whipping up plans for reform. But Governor Pataki, who is now nursing presidential ambitions, is going to have to explain this one to the voters he's been courting in Iowa. Mr. Spitzer, who is running for governor, now has a big question mark on his rÃ©sumÃ© as a reformer. The Legislature deserves its share of the blame as well. The State Senate, dominated by Republicans, has failed to beef up the attorney general's enforcement budget and the Assembly, controlled by Democrats, has rebuffed the Senate's ideas for Medicaid oversight.

What all state officials share is the ability to cower like Harry Potter's Dobby before the lobbyists from health unions, nursing homes, hospitals and big pharmaceutical companies. It's time for them to stop catering to this powerful shadow government. New York was once in the forefront in investigating Medicaid fraud, with charges against "Medicaid mills" a routine item on the docket. Now the state spends the most money but ranks way down the list for the number of on-site audits or cases referred for prosecution.

Every dollar stolen from Medicaid is a dollar taken from a single mother with a feverish child or an elderly person who needs a steady doctor. This is a scandal and a disgrace for the government of New York State and those who run it.

Governor Adds Muscle to Curb Medicaid Fraud
NY Times
July 20, 2005
By CLIFFORD J. LEVY and MICHAEL LUO

Gov. George E. Pataki yesterday ordered a broad overhaul of the state agencies that protect Medicaid from fraud and abuse, creating an independent inspector general's office and bringing in a former federal prosecutor to help reorganize the policing of the program, which is New York State's largest expense.

attorney general's office, which prosecutes fraud, has fallen behind its counterparts in other large states as well, according to federal statistics.

According to the governor's announcement, the inspector general will have subpoena power and is supposed to coordinate and consolidate antifraud efforts between the Department of Health and other agencies that have some role in the program, including the Office of Mental Health and the State Education Department.

It has not been determined whether the current fraud detection staff at the Department of Health will move to the new agency, or instead be overseen jointly by the health commissioner and the inspector general.

Administration officials said the current system was governed by a patchwork of formal and informal agreements between state and federal agencies that was probably outmoded and that Mr. Shechtman would be asked to evaluate and streamline it.

Mr. Pataki also announced that he was asking doctors and other staff members at SUNY medical centers around New York to help the state develop better antifraud initiatives.

Using a laptop computer, reporters for The Times analyzed millions of Medicaid billing records and found numerous instances of spikes in claims, a telltale sign of fraud, that were never scrutinized by the state. The billings of a Brooklyn dentist, Dr. Dolly Rosen, rose to $4 million in 2003 from zero in 2001. Dr. Rosen, who was paid by Medicaid for as many as 991 procedures a day in 2003, was indicted on charges of stealing more than $1 million from the program after The Times questioned the state about her billings.

Addressing precisely this kind of technological shortcoming, Mr. Pataki said the inspector general would work with the State Office for Technology to find better ways to analyze Medicaid billings.

The announcement by Mr. Pataki, a Republican, was met with approval by legislative leaders, as well as by the state attorney general, Eliot Spitzer, a Democrat who is running for governor.

The governor did not announce his choice for Medicaid inspector general.

In an interview, Mr. Shechtman said he had just begun to examine the problems in the system, but he suspected that additional money and legislation would probably be needed.

"It sounds to me like at the moment, we have made it too easy for people who are embarking on fraud," said Mr. Shechtman, who is a private lawyer. "And that can't be good government."

While the governor plans to use an executive order to create an inspector general, the Republican-controlled Senate approved legislation in May that created a somewhat similar office. At the time, Mr. Pataki did not announce support for the measure, and it was opposed by the Democratic majority in the Assembly, which has long allied itself with large health care lobbies and unions.

At a news conference at City Hall in Manhattan yesterday, John E. Sweeney, a Republican congressman from upstate New York, and State Senator Dean G. Skelos, a Nassau County Republican, called on the federal government to audit how New York is spending its share of federal money on antifraud efforts.

"This abuse is reprehensible and has to stop," Mr. Sweeney said, adding that he believed the current system to be broken.

"It's obviously not working," he said. "Something else needs to happen."

The Assembly speaker, Sheldon Silver, a Democrat, said in a telephone interview that he would support more money for fraud detection. "It's clear that something is necessary," Mr. Silver said, adding that he was not ready to settle upon an exact figure.

James Mehmet, who retired in 2001 as the chief of investigators for the Health Department's fraud and abuse office in New York City, applauded the administration's proposal. The pooling of resources in an inspector general's office was a significant step, he said, along with the independence of the unit from the health department.

"It takes the politics out of it," he said. "It's removing the investigative function from the agency that is concerned about providing the services."

Several states, including Florida, Illinois and Texas, have set up similar kinds of inspector general offices.

Brian Flood, an inspector general for health programs in Texas, said the creation of the office led to a 23 percent jump in recoveries from fraud inquiries between the 2003 and 2004 fiscal years, even though more money was not budgeted for antifraud efforts.

"The Health Department, its mission is to deliver services," Mr. Flood said. "Whereas, an I.G.'s mission is to question the delivery of services. Those aren't diametrically opposed, but pretty close. One is, 'How fast can I get the French fries out the window.' The other is, 'Does the guy need the fries at all?' "

Michael Cooper contributed reporting from Albanyfor this article.