94th Congress
2d Session

COMMITTEE PRINT

FRAUD AND ABUSE AMONG PRACTITIONERS PARTICIPATING IN THE MEDICAID PROGRAM

A STAFF REPORT

PREPARED FOR THE

SUBCOMMITTEE ON LONG-TERM CARE

OF THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

AUGUST 1976

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE
75-902 O WASHINGTON : 1976

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402 - Price $2.65

SPECIAL COMMITTEE ON AGING

FRANK CHURCH, Idaho, *Chairman*

HARRISON A. WILLIAMS, JR., New Jersey
JENNINGS RANDOLPH, West Virginia
EDMUND S. MUSKIE, Maine
FRANK E. MOSS, Utah
EDWARD M. KENNEDY, Massachusetts
WALTER F. MONDALE, Minnesota
VANCE HARTKE, Indiana
CLAIBORNE PELL, Rhode Island
THOMAS F. EAGLETON, Missouri
JOHN V. TUNNEY, California
LAWTON CHILES, Florida
DICK CLARK, Iowa
JOHN A. DURKIN, New Hampshire

HIRAM L. FONG, Hawaii
CLIFFORD P. HANSEN, Wyoming
EDWARD W. BROOKE, Massachusetts
CHARLES H. PERCY, Illinois
ROBERT T. STAFFORD, Vermont
J. GLENN BEALL, JR., Maryland
PETE V. DOMENICI, New Mexico
BILL BROCK, Tennessee
DEWEY F. BARTLETT, Oklahoma

WILLIAM E. ORIOL, *Staff Director*
DAVID A. AFFELDT, *Chief Counsel*
VAL J. HALAMANDARIS, *Associate Counsel*
JOHN GUY MILLER, *Minority Staff Director*
PATRICIA G. ORIOL, *Chief Clerk*

SUBCOMMITTEE ON LONG-TERM CARE

FRANK E. MOSS, Utah, *Chairman*

HARRISON A. WILLIAMS, JR., New Jersey
FRANK CHURCH, Idaho
EDMUND S. MUSKIE, Maine
EDWARD M. KENNEDY, Massachusetts
CLAIBORNE PELL, Rhode Island
THOMAS F. EAGLETON, Missouri
JOHN V. TUNNEY, California
WALTER F. MONDALE, Minnesota
LAWTON CHILES, Florida
DICK CLARK, Iowa

CHARLES H. PERCY, Illinois
HIRAM L. FONG, Hawaii
EDWARD W. BROOKE, Massachusetts
J. GLENN BEALL, JR., Maryland
PETE V. DOMENICI, New Mexico
BILL BROCK, Tennessee
DEWEY F. BARTLETT, Oklahoma

LETTER OF TRANSMITTAL

AUGUST 30, 1976.

Hon. FRANK E. MOSS,
Chairman, Subcommittee on Long-Term Care, Senate Committee on Aging, Washington, D.C.

DEAR MR. CHAIRMAN: In accordance with your instructions, the committee staff and temporary investigators have completed an examination into fraud and abuse among practitioners participating in the Medicaid program. This report is primarily a look at the growing phenomenon of "Medicaid mills"—small, for-profit welfare clinics which proliferate the ghettos of our cities.

The good work apparent in this report could not have been possible without the help and support of so many people. Most of all, Mr. Chairman, we appreciate your personal involvement in the investigation. You have provided an important dimension of concern and conviction that today's wrongs must be overcome. William E. Oriol, staff director, Committee on Aging, provided guidance and direction. Patricia G. Oriol played a most important role, posing as a Medicaid beneficiary in addition to her duties as the committee's chief clerk. Temporary investigators William J. Halamandaris, David L. Holton, Catherine Hawes, and Thomas G. Cline deserve much credit, as do volunteers Suzanne Kaufman, Debbie Galant, and Theodore U. Murphy. Summer interns Arcola Perry and Stephanie Fidel also played a significant part in this effort.

We would also like to express our appreciation to a great many others who have aided our work, including: George Wilson, assistant U.S. attorney, southern district of New York; Elliot Gray, Commissioner, Internal Revenue Service Region II, and his assistant, Tony Carpiniello; Gerald Turetsky, Regional Manager, General Services Administration; Charles J. Hynes, special prosecutor for nursing homes; Stanley Lupkin, Commission of Investigations, City of New York; John C. Fine, former assistant district attorney, County of New York; and Bill Cabin in the office of New York's Secretary of State, who aided in the preparation of this report.

I would like to add a special word of commendation for Privates James A. Roberts Jr., and Darrell R. McDew of the U.S. Capitol Police Force who performed their role as "Medicaid shoppers" in admirable fashion. Their assistance was invaluable. We are grateful to Chief James C. Powell and Senate Sergeant at Arms Nordy F. Hoffmann, for allowing them to be temporarily assigned to our committee.

Publication of this report in time for the August 31 hearing was possible only because of round-the-clock efforts by Printing Assistant Eugene Cummings and other representatives of the Government Printing Office.

We believe this report is important because it presents to the Congress first-hand evidence of the massive fraud and abuse in the Medicaid program. We believe this report is significant in that it will result in legislation to improve the quality of health care for all Americans.

With best wishes,

Sincerely,

VAL J. HALAMANDARIS, *Associate Counsel,*
Senate Committee on Aging.

CONTENTS

APPENDIXES

FRAUD AND ABUSE AMONG PRACTITIONERS PARTICIPATING IN THE MEDICAID PROGRAM

INTRODUCTION

In 1965, President Lyndon Johnson told the Congress, "Our first concern must be to assure that the advance of medical knowledge leaves no one behind. We can—and we must—strive now to assure the availability of and accessibility to the best health care for all Americans regardless of age, geography, or economic status."

In response to the President's call, the Congress enacted the Medicare program, a federally financed program of medical insurance coverage for all Americans over 65. At the same time, Congress enacted Medicaid, which consolidated the medical assistance program originally established by the Kerr-Mills Act of 1960. The enactment of the Medicaid program:

(*a*) Required States to cover all persons eligible for cash assistance.

(*b*) Increased the rate of Federal financial participation in the costs of medical care.

(*c*) Permitted States to include the medically needy under 65 in their medical assistance plans.

(*d*) Required that all participating States include in their plans inpatient and outpatient hospital services, other laboratory and X-ray services, skilled nursing home services, and physician services. Many other services were permitted at the option of the States.

The Medicaid program has now been in existence for over 10 years. In those 10 years it has served many people, without a doubt bringing medical care to the poor, disadvantaged, and elderly.

The Medicaid program has expanded rapidly, from a $1.5 billion program in fiscal year 1966 to a $15 billion program this year (1976)—a tenfold increase in just 10 years. There are an estimated 28 million Americans who are eligible for the Medicaid program.

The ever-increasing cost of administering to their needs has been the source of much concern to policymakers. More than 20 States have cut back on their Medicaid programs in the past 2 years.

To add to these already significant worries concerning the escalating price of this program is the new and mounting evidence that the program is not only inefficient, but riddled with fraud and abuse.

In the past, this subcommittee has examined the allegations of fraud and abuse as they relate to the nursing home field, which accounts for almost 40 percent of the Medicaid program. Some 27 hearings have been devoted to this subject since July of 1969. Details of the subcommittee's findings have been outlined in a continuing 12-volume report which has been released in increments since November of 1974.

This subcommittee has also examined abuses in the supplementary security income program, the recent trend to discharge thousands of individuals from State mental hospitals and place them in old hotels or other unsuitable, unsupervised facilities. It has also examined the growing fraud and abuse among some of the agencies providing home health services under Medicaid.

In February, this subcommittee released a report dealing with "Fraud and Abuse Among Clinical Laboratories," charging that $1 out of every $5 spent for laboratory services under the Medicare and Medicaid programs is fraudulent.

Most recently, the subcommittee is working on a report entitled, "Fraud and Abuse Among Physicians Participating in the Medicare Program." This report indicates that a small number of physicians abuse the Medicare program (only 4 percent of the 250,000 who participate), but the amount of fraud is significant—estimated at about $300 million a year. A preview of this forthcoming report was given by the chairman of this subcommittee in his July 28, 1976, appearance before the Senate Committee on Finance.

The report which follows attempts to document the degree of fraud and abuse perpetrated by practitioners in the Medicaid program. Our investigation focused on five States which receive more than 50 to 55 percent of Medicaid funds: California, New Jersey, Michigan, Illinois, and New York.

New York was singled out for in-depth analysis for several reasons: (a) it has the largest Medicaid program in the Nation, spending an average of $180 per inhabitant while the national average is $66 per inhabitant; (b) New York accounts for almost 25 percent of total Medicaid outlays despite the fact that New York has less than 9 percent of the country's population; (c) the New York program historically has been charged with being of the worst managed in the Nation; and (d) because of the apparent relationship between the mismanagement of the program and New York's current fiscal crisis.

In the course of this investigation, the following steps were taken in an effort to ascertain as accurately as possible the size and dimensions of the problem and to determine what remedial steps are necessary. Senate investigators attempted to test the system from three perspectives: government, provider, and patient.

Specifically, the investigation involved the following:

(1) Examining in detail more than 100 major reports produced by Federal, State, or local agencies detailing fraud, waste, or inefficiency in the Medicaid program with particular emphasis on New York.

(2) Reviewing records in the New York City Department of Health, in the office of the U.S. attorney for the southern district of New York, and the District Attorney's Office for New York County, as well as in the offices of Michigan's Post Payment Surveillance Unit—the so-called Fraud Squad.

(3) Manually evaluating the medical vendor statement—a computer printout—compiled from payment records of the New York City Department of Social Services.

(4) Interviewing 20 public officials and sending written interrogatories to 30 additional public officials with present or past responsibility for the operation of the Medicaid program in New York.

(5) Interviewing more than 60 physicians who work in or own "Medicaid mills" (50 were Illinois physicians interviewed in January in connection with our report on clinical laboratory fraud).

(6) Sending questionnaires to the 250 physicians in New York who were paid from $75,000 to $785,000 by the Medicaid program last year.

(7) *Posing as Medicaid beneficiaries and entering more than 100 so-called Medicaid mills, committee staff presented themselves for treatment some 200 times. More than 120 of these visits were in New York City. The remainder were in California, New Jersey and Michigan.*

(8) Announcing establishment of a corporation for the ostensible purposes of buying and operating health care facilities. Accompanied by cooperating physicians, investigators answered advertisements in the New York Times, noting Medicaid mills for sale in Manhattan, Brooklyn, Queens, and the Bronx. This technique, along with our interviews of the 50 physicians in Illinois, gave us direct information as to the financial operation of numerous Medicaid mills.

(9) Monitoring the operation of a storefront medical clinic established last December by Chicago's Better Government Association.

Part 1 of this report provides the necessary statistical base. Part 2 outlines the active phases of this investigation in all its dimensions. Part 3 is an evaluation of past studies, reports, and records, addressed particularly to the New York Medicaid program. Part 4 explores the interrelationship between mismanagement of the Medicaid program and New York City's current fiscal crisis. Part 5 of this report addresses the question of responsibility for the serious and protracted abuses apparent in the Medicaid program. Part 6 is a summary which also states our conclusions. Part 7 contains our recommendations. Appendix 1 carries the names and addresses of all physicians making more than $100,000 from the Medicaid program in 1974, in addition to New York figures for 1975.

After this intensive investigation, the committee staff concludes—as it did in the report relating to fraud and abuse among clinical laboratories—that fraud and abuse in the Medicaid program is massive. Our in-depth analysis in New York State indicates that the size and dimensions of the problem in that State are astonishing.

Amazing as it seems, the committee staff learned that most of the problems in the New York program have been known for 10 years or more. Federal, State, and local officials are and have been apprised of the nature of the problem for a number of years as evidenced by the mountain of reports going back to 1966. Clearly, these shortcomings and the names of specific providers who are defrauding the program (and the methods used by these providers) are and have been known to both policymakers and law enforcement agencies. Despite alternate alarms sounded by generations of office holders and despite an equal number of press releases indicating progress toward estab-

lishing accountability, the fraud and the abuse continue in blatant fashion. This situation can no longer be tolerated, particularly in view of New York City's fiscal crisis and the commitment of taxpayers' dollars in the form of loans insuring the city's solvency.

The operation of the Medicaid program in Michigan (and to a lesser extent, in California and New Jersey) provides an effective contrast to the past administration of programs in New York and Illinois.* In these States, some abuses still exist, but blatant wholesale thefts are not as evident, reflecting what appears to be a serious effort to root out fraud and abuse.

*For further discussion of the administration of the Medicaid program in Illinois, see parts 2–4 "Medicare and Medicaid Frauds," hearings by the Subcommittee on Long-Term Care. Also, "Fraud and Abuse Among Clinical Laboratories," a report by the Subcommittee on Long-Term Care, February 19, 1976. It should be added that much recent progress has been made in Illinois due to the efforts of Mr. James Trainor, director, Illinois Department of Public Aid.

Part 1

THE NUMBERS

Last year Americans spent an average of $547 each—or $2,188 per family—for health care. This is 3 times as much as was spent for health in 1965 ($39 billion) and 10 times the amount spent in 1960 ($12 billion). Measured in terms of the gross national product, the cost of health care has increased from 4.6 percent in 1950 to 8.3 percent today—fully one-twelfth of the GNP at the end of 1975.

The rapid growth in spending is associated with a sharp increase in governmental participation. In 1965, public funds made up only 26 percent of all health expenditures; today, public funds make up 42 percent of the total.

As noted above, the Medicaid program has contributed significantly, increasing from $1.5 billion spent in fiscal year 1966 to a $15 billion program today.

In 1973, 23.5 million people received medical assistance under Medicaid; in 1975, there were an estimated 28.6 million Medicaid eligibles. Using 1975 estimates, 5.1 million Medicaid eligibles were aged, 200,000 were blind, 2.4 million were disabled, 12.9 million were children under 21, and 7.9 million were adults in the aid to families with dependent children.

According to the special analysis of the budget of the U.S. Government from which these figures were taken, the average benefit per Medicaid recipient was $215, with average payments of $467 being paid to the aged, $521 to the blind and disabled, $99 to children under 21, and $142 to adults in AFDC families.

Table 1 below lists Medicaid patients by eligibility and percent of Medicaid funds going to each category. As noted, in calendar 1975, the aged constituted 23.5 percent of Medicaid eligibles and received 38.7 percent of Medicaid funds. As table 2 indicates, the percent of Medicaid funds may actually be much higher, perhaps approaching 50 percent of Medicaid funds.

TABLE 1

	Percent of medicaid eligibles by category [1]	Percent of medicaid funds received by category [1]
Age 65 or over	23.5	38.7
Blindness	.5	.6
Permanent and totally disabled	13.7	
Membership in family with dependent children under 21	56.0	30.3
Other title XIX recipients	6.9	6.1
Total	100.0	100.0

[1] Due to rounding figures do not total 100.

TABLE 2

[In calendar 1975, the States and Federal Government spent $14,000,000,000 for medicaid. A breakdown of these expenditures by category and by percent of such services received by the elderly follows below]

[Dollar amounts in millions]

	Paid	Going to elderly (percent)	Going to aged
Hospitals	$4,200	26	$1,092
Physicians	1,400	23	322
Nursing homes:			
Skilled	2,700	82	2,214
Intermediate	2,500	72	1,800
Drugs	901	41	369
Dental care	371	[1] 25	93
Lab and X-ray	118	[1] 25	30
Home health	112	[1] 25	28
Outpatient clinics	850	[1] 25	212
Other/eye care and glasses	848	[1] 25	211
Total	14,000	46	6,371

[1] Estimated.

A. MEDICAID PAYMENTS BY TYPE OF SERVICE

Seventy cents of every Medicaid dollar was spent for inpatient services in 1973. Although fewer than one in six Medicaid recipients received general hospital inpatient services, payments for such services constituted the largest share of the Medicaid dollar: 31 percent. The various long-term care inpatient services (mental hospital, skilled nursing, and intermediate care facility) comprised 39 percent of payments. Persons receiving such services represented at most 6.2 percent of Medicaid recipients. Physicians' services and prescribed drugs represented 11 and 7 percent of the payments, respectively. Table 3 provides details.

TABLE 3.—*Distribution of medicaid dollars by type of service (fiscal year 1973)*

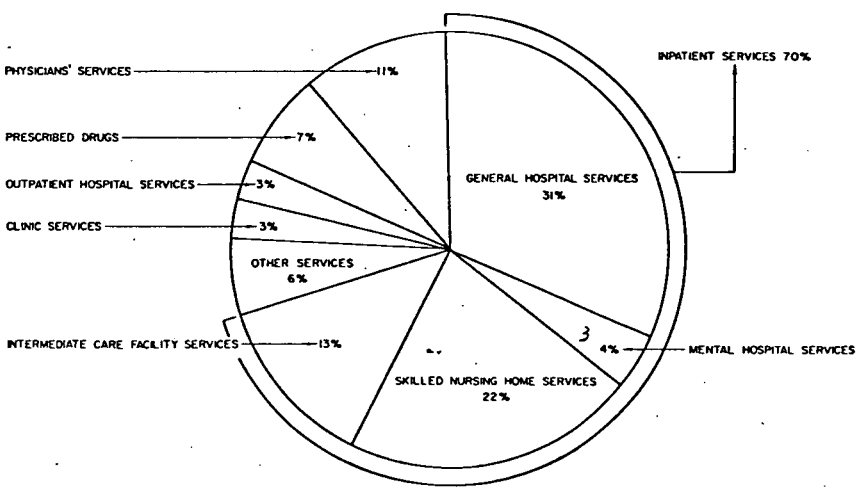
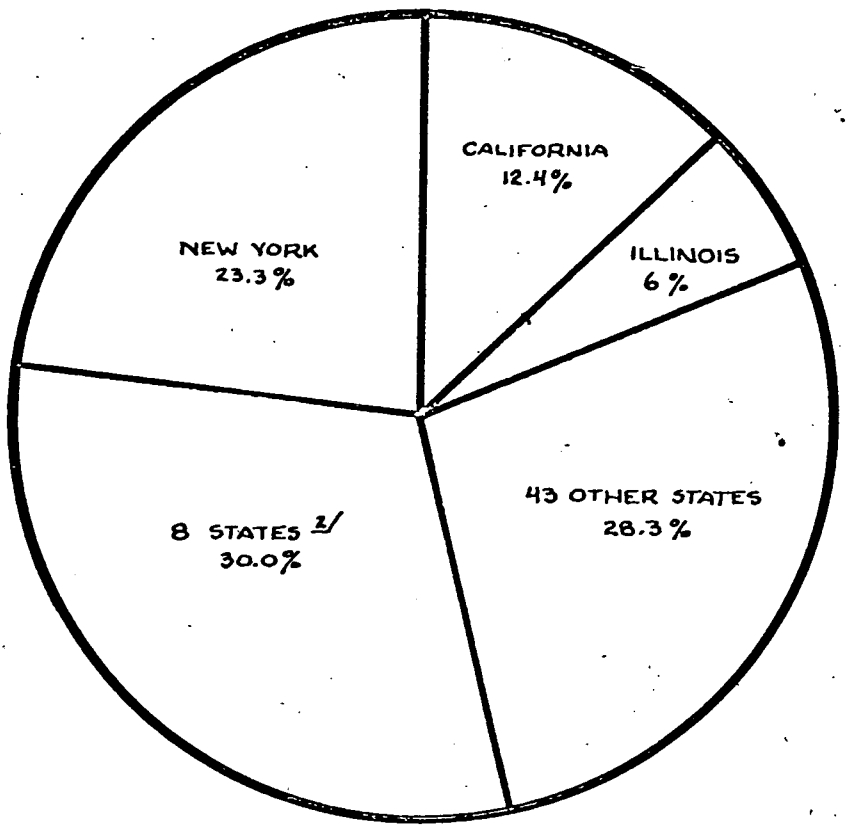


Table 4 indicates the concentration of Medicaid payments in the 10 largest States. Last year some $14 billion in Medicaid funds were paid out in calendar year 1975. The 10 largest States are as follows:

New York	$3, 252, 328, 327	Massachusetts	$577, 115, 417
California	1, 483, 990, 363	Texas	519, 912, 780
Pennsylvania	768, 224, 615	Ohio	413, 276, 480
Illinois	753, 418, 270	Wisconsin	402, 039, 501
Michigan	677, 077, 811	New Jersey	401, 726, 751

TABLE 4.—*Proportion of total U.S. medicaid payments by selected States, calendar year 1975*

(Total expenditures,[1] calendar year 1975, were $14 billion)



[1] Includes expenditures for payments made directly to medical vendors and for monthly premiums or per capita payments into agency pooled funds, to the Social Security Administration (for aged persons), or to health insuring agencies. Includes all such expenditures made under federally aided assistance programs and under general assistance programs financed from State-local funds.

[2] Michigan, Pennsylvania, Massachusetts, Texas, New Jersey, Ohio, Wisconsin, and Minnesota.

Source: SRS, NCSS, medical assistance financed under title XIX of the Social Security Act, December 1974, NCSS Report B–1, p. 40.

B. MEDICAID IN NEW YORK

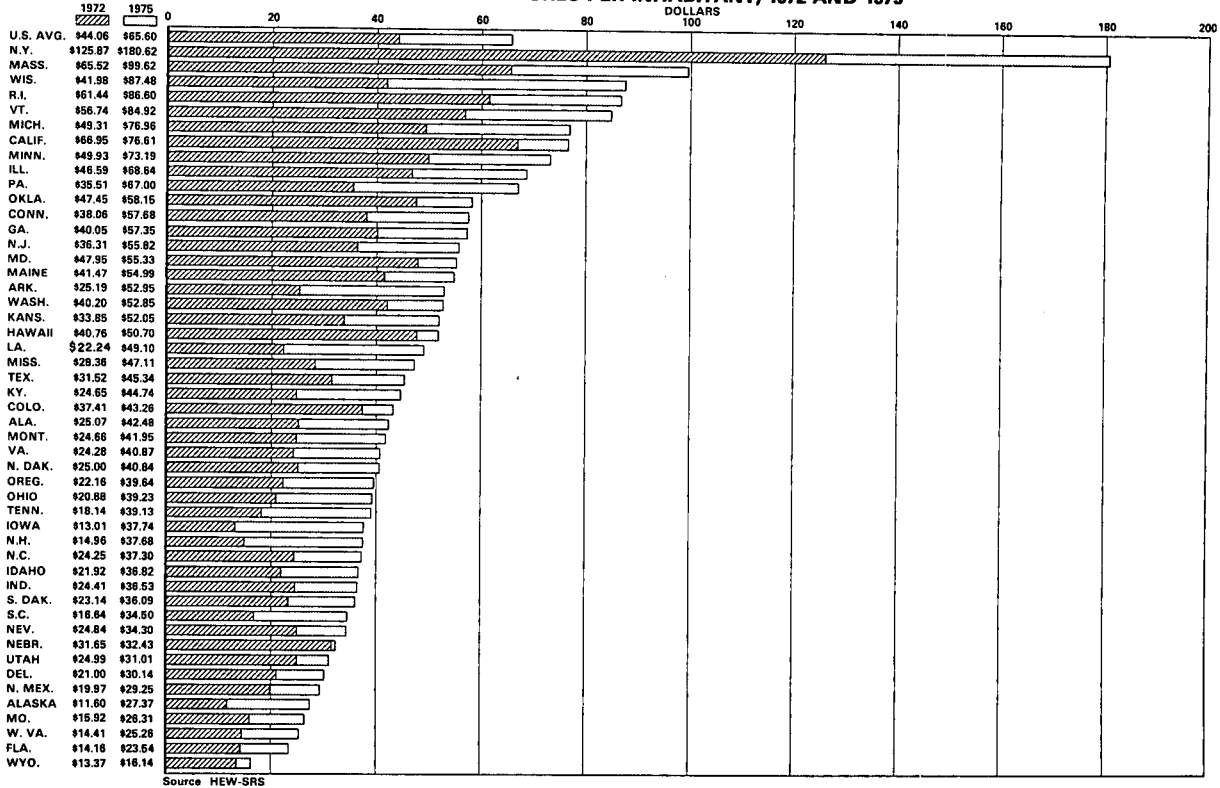
Medicaid expenditures in New York State are now at $3.2 billion a year. This figure represents 23 percent of all Medicaid expenditures annually by all States and territories of the United States. The cost of Medicaid in New York is paid for by the Federal (50 percent—$1.60 billion), State (25 percent—$800 million), and local governments (25 percent—$800 million). New York is only 1 of 5 States where the State and localities equally split the non-Federal contribution share and only 1 of 14 States where the localities make some contribution. In 36 States the cost of Medicaid is split 50–50 between the Federal and State Governments.

Approximately 2.1 million persons are enrolled in the Medicaid program in New York State. There are basically three types of enrollment in New York as in most other States. All individuals qualifying for welfare (public assistance) in New York are automatically eligible for medical assistance (Medicaid). All recipients of the Federal supplementary security income (SSI) (the uniform Federal welfare payments to the poor averages $157 a month) are automatically eligible. In addition, States may elect, as New York has, to make Medicaid available to those with incomes too high to allow them to qualify for welfare. Individuals who apply for Medicaid in local welfare offices qualify, providing their incomes are no more than 133 percent higher than New York's limit for welfare eligibility. *In total, Medicaid accounts for over one-half of New York's $6 billion yearly total for welfare.* Table 5 indicates the relative position of New York compared to the rest of the States in terms of Medicaid outlays per inhabitant. New York leads all States with $180.62 in Medicaid funds spent per inhabitant. No other State is over $100. Wyoming is last with outlays of $16.14 per inhabitant on the average.

75-902 O - 76 - 2

TABLE 5

MEDICAID EXPENDITURES PER INHABITANT, 1972 AND 1975

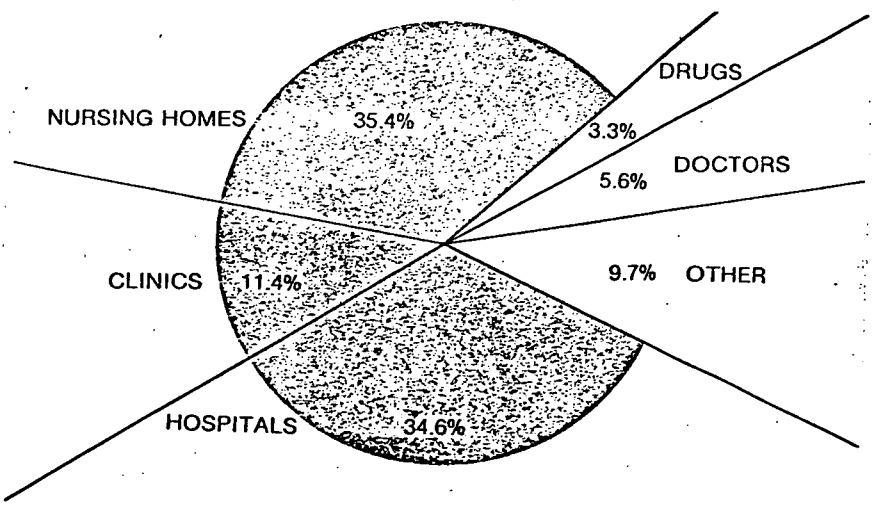


Source HEW-SRS

The cost of Medicaid and the number of recipients in New York State have increased enormously since the program's inception in 1966. In the 10 fiscal years of the program's existence, these costs have risen by approximately 800 percent and the number of recipients by approximately 900 percent to the current level of $3.2 billion in costs for 2.1 million recipients.

As table 6 indicates, payments are made to various kinds of providers. Approximately 70 percent of the payments ($1.9 billion) go to institutions providing inpatient care (hospitals, nursing homes, public home infirmaries, and intermediate care facilities) and 30 percent ($800 million) for outpatient care (clinic care, prescribed drugs, dental and physician services, and other medical services such as physical therapy and medical devices). Twenty-three percent of all the moneys ($620 million) went to physicians, dentists, pharmacists, and clinics. The bulk of the payments (84 percent—$2.7 billion) are made by the 58 local social service districts throughout the State. Supervision over these providers for compliance with Federal and State requirements is done by the local health departments and State Department of Health. The remaining 16 percent ($500 million) is paid directly by the State Department of Social Services to the State Department of Mental Hygiene. These moneys are monitored by the respective agencies.

TABLE 6.—Where the Medicaid dollar goes in New York



C. NEW YORK PHYSICIANS RECEIVING OVER $100,000 FROM MEDICARE OR MEDICAID

There are about 378,000 physicians in the United States at the present time. New York claims almost 10 percent of this number—or about 35,000 doctors. Nearly two-thirds of all doctors (250,000), participate in the Medicare and Medicaid programs.

In 1974, of those 250,000, some 365 physicians received $100,000 or more from the Medicaid program; 55 were in New York. In 1975, 79 doctors received over $100,000 from Medicaid in New York.

Also in 1974, there were 247 doctors who received over $100,000 from the Medicare program; 82 of this number were in New York.

Precise data as to the number of physicians in New York State participating in the Medicaid program are not available. New York City figures extracted manually from the medical vendor statement printout given to the committee staff provide the following totals for New York City, which accounts for 68 percent of all New York Medicaid expenditures and for 61 percent of Medicaid recipients:

PRACTITIONERS PARTICIPATING IN MEDICAID, NEW YORK CITY

Physicians	9,326
Dentists	1,974
Podiatrists	661
Optometrists	410
Chiropractors	229

Part 2

PRACTITIONER ABUSE OF THE MEDICAID PROGRAM

In the investigation of Medicare and Medicaid, committee staff quickly learned that there were many differences between the types of practitioner fraud and abuse perpetrated against the two programs. Medicare frauds were, for the most part, isolated individual acts, one man, acting alone, generally billing for services not rendered. In Medicaid, most abuses involve a conspiracy of several practitioners and the introduction of assembly-line methods to defraud the Government. Medicaid fraud includes everything from billing for services not rendered to "writing paper"—the wholesale manufacture of phony bills.

Our first exposure to such practices came in the course of an investigation relating to fraud and abuse among clinical laboratories. We monitored the work of Chicago's Better Government Association (BGA) which established a storefront medical clinic on Morris Avenue in Chicago. Representatives of more than 12 laboratories entered the clinic and all but 2 offered investigators kickbacks of from 25 to 55 percent of Medicaid billings provided they could secure all the clinic's laboratory business.

Armed with the information that laboratories gave kickbacks (and with the approximate amounts), the committee staff, aided by the BGA, constructed a profile on each of the laboratories, identifying the names of every physician who used them. These names were cross-indexed with the names of doctors with incomes over $100,000. Some 50 doctors were selected.

To our surprise, the addresses where we found the doctors practicing were, without exceptions, little storefront clinics not much more elaborate than the one established on Morris Avenue.

In New York, we had much the same experience. We began with a list of physicians who have repeatedly been charged with fraud and abuse. This list was derived from newspaper clippings and other public sources. To these names, we added the names of a number of New York's high providers (making over $75,000 a year from Medicaid). In tracking the addresses of these physicians, we once more found ourselves involved with "Medicaid mills."

A. MEDICAID MILLS: BACKGROUND AND DEFINITION

"Medicaid mill" is a term new to the health care field. "Mills" are unregulated and unlicensed. Legally, they fall into a crack between a clinic—which, by definition, presents a single bill for all services offered—and individual practitioners.

A "Medicaid mill" is generally a hole-in-the-wall located in a dilapidated part of town. A few have large plate windows, but most are solid brick without windows or with windows boarded. Some waiting rooms, however, were attractively and even cheerfully furnished, complete with wood janeling, television sets, and bright plastic chairs. This was in stark contrast, however, to many of the "treatment" rooms immediately beyond. Almost all carry an extensive multilingual list of services—everything from internists to chiropractors, podiatrists, allergists, and psychiatrists. They are easy to find on the street. Most are designed for visibility. Many carry pennants and banners. Most have door-to-curb canopies. Some advertise their presence with arrows painted on neighboring buildings and the words "centro medico" or "medical center" written above or below.

Most mills are single-story facilities, not infrequently the ground floor of former residential buildings. Others are fitted into commercial real estate too run down to be suited for its original purpose. A very few have been specially designed for use as medical facilities. Inside, they tend to be cramped: a small waiting room, a dozen or more chairs, and a number of very small servicing cubicles. Typically, the room in which the patient sees the physician is 5 feet by 10 feet or less. Usually, the facility is minimally equipped. Some do not have the most basic supplies and equipment. thermometers, stethoscopes, soap dispensers, etc.

The doctors found in mills are also characteristic. They tend to be foreign medical graduates. They tend to be young. They tend to work "welfare medicine" exclusively and to have no private practice.

Many Medicaid mills employ "hawkers" who round up customers for treatment. Several mill administrators have admitted to Senate investigators that they bribe social workers at hospitals or discharge planners at State mental hospitals to send them business. A number cater to the drug traffic; and many others make deals with unions or other private pension plans to provide health services for their members.

The best thing that can be said for such facilities is that they are located in the ghettos—the areas of greatest need. However, the appearance of medical care is an illusion which soon evaporates. One resident of the inner city told us: "We never go to these places when we are really sick; we go to hospital emergency rooms. If it is something like a hurt finger, then you might go."

It appears clear that these facilities would not survive without Medicaid. Repeatedly in our investigation, the staff learned of now-prosperous participants in the Medicaid program who could never find a practice before the proliferation of Medicaid mills. For example, three New York chiropractors who ultimately formed a partnership which gave them the ownership of a half dozen facilities and an income of $500,000 a year each had been unable to find work in their professions until the enactment of Medicaid. Significantly, the practitioners were licensed to practice a dozen years before the enactment of the Medicaid program, but until that time two of the men were working as taxi drivers and the third was working as a butcher.

No one could tell the staff exactly how many doctors and other providers practice in Medicaid mills. Compared to the total number of doctors in the Nation (378,000), they are probably few. The only meaningful statistics obtained related to the city of New York. As noted above, there are some 9,000 doctors who work in that city's Medicaid program.

Clearly, a few physicians take most of the money paid out under New York's Medicaid program. According to our analysis of computer billings, some 7 percent of the doctors practicing in New York City's Medicaid program earned 50 percent of the total paid to all doctors by the program. In Michigan, 3 percent of the doctors in that program earned 25 percent of Medicaid funds paid to physicians.

In our investigation, we learned that many doctors in New York were "ice skating," that is, working 1 day a week or half a day a week in various clinics all over the city of New York. Occasionally, investigators recognized a practitioner whom they had seen before and had to hope the doctor would not remember having previously "treated" them.

Another factor which is readily apparent is that the doctors who are in Medicaid mills generally concentrate on welfare medicine. This can be seen by the top-heavy nature of a graph of Medicaid billings in New York City. The top 471 physicians in that city earned an average of $80,000 each in 1974. The average income of the remaining physicians participating in the program was $7,127—a difference of 1,254 percent. These figures again come from our analysis of computer printouts for calendar year 1974.

Medicaid Income Concentrated in the Hands of a Few Providers

In our analysis of computer printouts from New York we learned that the concentration of Medicaid funds in the hands of a few applied not only to physicians. Typically, a Medicaid mill will list every medical discipline and have one or more practitioners providing health services. The presence of a variety of caregivers serves as a magnet to attract clients.

Since most patients ask to see a doctor, the general practitioner is said to be the key to the operation of a profitable Medicaid mill. After "seeing a patient," (the expression is fairly exact as most visits last only 3 to 5 minutes), a general practitioner will often "refer" (with varying degrees of compulsion) patients to another practitioner.

Sometimes the patient is *told*, "Wouldn't you like to see the dentist now?" In other cases, "You should really have your feet looked at," or "We have a man here who can take care of this while you are waiting for the doctor."

These "referrals," when divorced from medical necessity, are a form of overutilization, if not outright fraud, of the Medicaid program. It is these referrals that explain why a few practitioners in every discipline make most of the money in the program. They revolve around the Medicaid mill. The following totals are derived from our analysis of New York's medical vendor statement:

Optometrist.—5 percent of the optometrists earned 21 percent of the total paid in 1974; 22 optometrists earned an average of $67,612.63 each while the average for the remaining providers (95 percent) was $13,913.

Podiatrist.—5 percent of the podiatrists participating in the Medicaid program in New York were paid 20 percent of the total expended to their category, averaging $46,537 each, while the remaining 95 percent averaged $10,748.

Dentist.—2.5 percent of the dentists receive 26 percent of the total, with 50 of these earning an average of $145,803, while the remainder received an average of $10,807.

Pharmacies.—2 percent of the pharmacies earned 12 percent of the total.

FACTORING FIRMS

A factoring firm is essentially a billing agency. "Factors" have long provided needed services in the business world. They can provide a broad range of services including preparation of invoices, collection of accounts receivable, payment of accounts payable and a variety of other basic bookkeeping and accounting services. The relationship between factoring companies and Medicaid mills is more direct.

In the Medicaid context, factors primarily act as collection agents for the practitioners. Factoring firms flourish where Medicaid payment is slow. Illinois and New York are the primary locations for factoring firms. These two States comprise about 31 percent of total Medicaid billings and the rate of payment has been historically very slow in each State (at least 3–6 months). In comparison, no factoring firms of any consequence can be found in Michigan where 87 percent of all claims are paid within 15 days and 97 percent are paid within 30 days.

In our analysis of computer printouts from New York, we learned the higher the volume of Medicaid payments, the greater the likelihood a practitioner would resort to factoring. For example, we learned from our analysis of one major factor in New York City, that practitioners who used its services were paid approximately twice as much per year ($36,511) as the average Medicaid practitioners in New York City.

An average physician cannot afford to absorb the overhead accumulated by waiting 3 to 6 months for payment. Therefore, physicians with large outstanding accounts receivable from Medicare or Medicaid transfer their accounts to a factor who in turn advances them case payment immediately. The charge for their service varies from 12 to 24 percent of the face value of the practitioners invoices. When computed in terms of actual interest (interest = rate × time × principal) the rate is more than 48 percent a year.

In many cases the factoring charge is really an additional unnecessary overhead charge incurred by Medicaid practitioners. For instance, in New York City, the high volume Medicaid practitioners are invariably associated with Medicaid mills. As will be detailed later in this report, there are many other nonessential payments by Medicaid practitioners to nonmedical entrepreneurs, such as: "rentals" based on gross billings, "finders fees," "franchising fees" to mill owners, and service charges.

Dr. Emil Lentchner, DDS, executive director the 11 District Dental Society (Queens County, New York), wrote to the committee that:

> Factoring for collection of Medicaid claims is improper and should be regulated. It is clear that if Medicaid is effectively administered (which is not the case) to provide

prompt payment of claims, "factoring" would not be significantly indulged in. The clear effect of "factoring" is to lower the net reimbursement to the health provider—suggesting that the health service could have been provided for an amount less the "factoring" percentage. The net result is to "lower" the quality of care provided to accommodate the decrease in reimbursement.

One notorious example of the operation of factors is the Rugby Funding Ltd. case* in New York City. Rugby was organized in 1967 with the sole purpose of servicing Medicaid practitioners. By the end of 1969 the firm was doing an annual business of $12 million per year servicing 400 Medicaid practitioners. The primary service Rugby provided its customers was prompt payment on their accounts receivable.

Rugby was able to effectuate prompt payment by legally negotiating special prepayment agreements with local Medicaid authorities. In New York City, Rugby had an agreement whereby the city assured them a minimum payment of $450,000 every 2 weeks. Rugby was the New York subsidiary of a parent company Professional Health Services Inc., which had subsidiaries similar to Rugby operating throughout New York State. In addition, the company employed politically influential lawyers to facilitate their operations. One was John Phelan who they employed in 1969 to talk to city authorities about processing Rugby's claims quickly at a time when the city had a suit pending in State court against Rugby. Phelan at the time was an aide to the State Senate Majority Leader, Earl Brydges. Another example is the employment of Robert Marinelli of Buffalo as an attorney for the company's western New York subsidiary. Marinelli's law partner was State Senator William B. Adams. Adams was chairman of the State Senate Social Services Committee and the sponsor of legislation passed in 1969 which amended the State social services law so as to, in effect, fully legalize factoring agreements in the Medicaid field. Senator Adams was indicted in 1970 for alleged periury and obstruction of justice in relation to the Rugby investigation. The charges were ultimately dismissed.

Not only has the factoring business siphoned off large, and apparently unnecessary, amounts of Medicaid moneys, but the firms themselves have been fraught with corruption and have contributed to Medicaid fraud and abuse.

For example in 1969 a Federal indictment was handed down charging Rugby with the following:

—Siphoning off $823,000 in income from the City Department of Social Services into a bank account whose existence was kept a secret from stockholders and from the public.

—Advancing more than $750,000 to itself from its own escrow account and telling stockholders the money was a liability.

—Conspiring to defraud the Federal Government in the administration of the Medicaid program.

* See further, New York Times editions of October 29, 1969, May 5 and 6, 1970, and January 25, 1972.

In testimony before the 1969 Manhattan grand jury (New York County), Mr. Henry Rosner, deputy commissioner of finance for the New York City Department of Social Services, stated the city had paid Rugby at least $330,000 in Medicaid claims which were unsubstantiated by billings. Mr. Rosner further testified that Rugby may have submitted forged billings.

There also is often overlapping ownership between Medicaid mills and factoring companies. For example, in 1969 Rugby was the majority stockholder of the 125th Street Medical Center. Committee staff have visited this center and found that it is still in operation. No data was available as to current ownership. In another current case, two dentist brothers (Alan and Howard Cohen) own Narco Freedom, Inc. (Bronx, N.Y.)—the fourth largest Medicaid-billing methadone clinic in the city. The Cohen brothers are also the two sole stockholders in Lirode Services, Inc., which is the factor for Narco Freedom, Inc. The committee staff found similar cases of overlapping ownership in Illinois.

The committee staff believes that such overlapping ownership arrangements further accentuate the profitmaking motive in the operation of Medicaid mills, increasing the propensity for fraud and abuse, and decreasing the quality of care rendered to Medicaid clients.

Another abuse related to the existence of factors is the increased possibility of illegal collusion between welfare department employees and factors to increase the volume of payments and speed of payment to the factors. In Illinois, the Better Government Association (BGA) has found indications that factors friendly with welfare department employees receive more prompt payment than other persons submitting Medicaid claims. In 1970, six New York City welfare department employees and six officers of Rugby Funding were indicted for allegedly participating in a scheme in which more than $2 million in Medicaid moneys were "stolen" from the city through collections on fictitious bills. The city employees were charged with taking bribes.

Many of these factors, in Illinois, for instance, have been loan sharks in the past. The BGA testified, in earlier committee hearings, that organized crime is muscling into the factoring business. BGA stated the take in Illinois is thought to be about $10 million per year. Moreover, the physician's bills are often increased by factors. In 3,569 cases studied by the BGA, some 1,711 bills (nearly 50 percent) have been raised to larger amounts by the factors.

The real tragedy of this situation is that the money Congress has appropriated for health care is diverted into the hands of middlemen. The average citizen would ask, "Is this practice legal?" The answer is yes and no. The Congress, in 1972, outlawed the practice. However, factoring firms have evaded the attempts at forcing them out of the Medicare and Medicaid business by having practitioners give them a "power of attorney." In essence, the execution of power of attorney affords the factor an opportunity to change or otherwise tamper with practitioners' bills prior to or after payment because the practitioner has delegated to them all legal rights associated with those billings. However, health departments still hold the practitioner, not the factor, legally liable for the treatment he renders and for any false billing. Legal action against factors must be initiated in a separate proceeding.

From the physician's point of view things can get even worse since the factoring company rarely gives him any accounting. He does not know how much the factor has submitted in his name or how much Medicaid has paid him through the factor. All he has is the factoring firms' check for a certain amount. Since factoring firms advance practitioners moneys, the practitioners are never really quite sure where they are vis-a-vis the welfare department in payment. Factoring firms often tell them that "we advanced you $10 but the State only paid us $8, therefore you owe us $2."

"THE KEY IS VOLUME"

As one dentist and mill owner told us, "The key is volume. You have to have referrals and return visits. You have to get them to come back and bring their friends. And you have to help each other." By "help each other," he meant that once a patient comes in the door, he must be passed around.

As the dentist put it, the way the system is structured the trick is to see as many patients as possible as quickly as possible. Visits must be brief. Accordingly, it is uneconomical to give good care. It takes too much time. A doctor interested in making money will spend less and less time with patients. As we learned, some doctors, in fact, see no patients at all. One physician arrived for work at his Brooklyn clinic each morning, got some coffee, the newspaper, and retired to his office for the day. He saw no patients, merely reading the paper and writing invoices from patients' file folders.

MOST COMMON ABUSES IN MEDICAID MILLS

The abuses most frequent in Medicaid mills are ping-ponging, ganging, upgrading, steering, and billing for services not rendered.

—"Ping-ponging" is the expression given to the most common mill abuse, the referral of patients from one practitioner to another within the facility, even though medically there is no need. Generally, patients, come to see a GP or the internists—internists are particularly prized by mill owners. They command the highest fees for services, attract the most patients, and give the most referrals. Once the patient has seen the internist, reasons can be found for sending him or her to other providers in the facility.

—"Ganging" refers to the practice of billing for multiple service to members of the same family on the same day. It generally occurs when one member of a family is accompanied in his visit to see the doctor by other members of the family—most commonly a mother and her children. The abuse occurs when the physician or other provider takes advantages of their presence and treats them without a specific complaint, or bills as though he has treated them.

—"Upgrading" is the practice of billing for a service more extensive than that actually provided. A physician may treat a suspected cold, for example, and bill for treating acute bronchitis and laryngitis.

—"Steering" is the direction of a patient to a particular pharmacy by a physician or anyone else in the medical center. It is a violation of the patient's freedom of choice.

—"Billing for services not rendered" consists either of adding services not performed onto an invoice carrying legitimate billings or submitting a totally fraudulent billing for a patient the doctor has never seen and/or an ailment he has not treated.

Other abuses include:

—Billing for work performed by others or by unlicensed practitioners;
—Making multiple copies of Medicaid cards, apparently for multiple billing;
—Soliciting, offering, or receiving kickbacks;
—Billing twice (or more) for the same service;
—Billing both Medicare and Medicaid for the same service.

In our investigation we found many variations on these basic themes. We also learned of specific fraud and abuse relating to other Medicaid providers. For example, one common fraud associated with pharmacies who invariably are affiliated with Medicaid mills is called "shorting."

"Shorting" refers to the pharmaceutical practice of issuing a short count—of taking a prescription for a set number or quantity of medication and delivering something less. Generic substitution is charging Medicaid for brand-name drugs while supplying less expensive generics.

"Upgrading of claims" is a charge that is often leveled at podiatrists; that is, they charge for performing extensive foot surgery when, in reality, they clip toenails or perform no services at all.

Optometrists often were found to prescribe glasses that were unnecessary. Sometimes the precriptions in the lenses were so far from the patient's needs that he or she was forced to return again for an adjustment which, of course, was reimbursed by Medicaid. In other instances, optometrists tell welfare clients that "for a few bucks under the table" they can supply the more fashionable wire rim or plastic frames rather than one of the limited choices (two frames) sanctioned by New York Medicaid.

Medicaid Mills and the Entrepreneur

If all of the preceding were not complicated enough, there is yet another layer to the tangled web described as a Medicaid mill. In many of the interviews we conducted in Chicago in conjunction with our investigation of laboratory kickbacks, we were surprised that numerous physicians listed as making over $100,000 from Medicaid did not actually receive this amount. We were more surprised to learn that most of the money (and kickbacks) went to businessmen who owned the building or who held the lease to the Medicaid clinic. In many instances we encountered foreign-trained physicians. Almost to a man they told us they worked essentially on commission. They were allowed to keep approximately 20 to 40 percent of the amount of money they generated from Medicaid. They told us that they were under continuous pressure to order more tests, to see more patients, and to spend less and less time with them.

The pressure, they reported, came from the entrepreneurs, holding the real estate or the building lease, mill owners or administrators. In our investigation in the other four States—New York, Michigan,

California, and New Jersey—we found these financial arrangements were national patterns.

As is noted later, this arrangement raises numerous legal, moral, and ethical questions. Even at the outset however, the committee staff had grave reservations that the Congress intended 60 to 80 percent of Medicaid moneys to be spent for rent, to be relegated as profit for a businessman rather than as a legitimate fee for the services rendered by practitioners.

B. "SHOPPING"*

In order to test the prevalence of the practices described above, the committee staff determined to "shop" Medicaid mills in several States. "Shopping" is a standard investigative practice used by Medicaid fraud units. It consists of obtaining a valid Medicaid card and placing the investigator in the role of a Medicaid recipient seeking treatment.

Valid Medicaid cards were obtained from four States. In New York, cards were obtained with the assistance of the U.S. attorney, southern district of New York. An agreement was made that the bills sent in by practitioners following our visits would be referred to the U.S. attorney's office so that criminal cases could be brought where appropriate. A similar arrangement was made in New Jersey with the Special Commission on Investigation and in Michigan with that State's Post-payment Surveillance Unit. In California, our intermediary was the Joint Legislative Audit Committee.

The efforts of this agency to obtain California Medicaid (called Medi-Cal in California) cards for us were rebuffed by the director of the State Department of Health who argued that "Too many investigators would discourage providers of medical care from accepting Medi-Cal patients." Subsequently, cards were arranged from another source.

To play the role of Medicaid shoppers, the committee staff recruited two officers from the U.S. Capitol Police Force. With the permission of Captain James Powell and Sergeant at Arms Nordy Hoffmann, Privates James A. Roberts, Jr., and Darrell R. McDew were transferred temporarily to the committee.

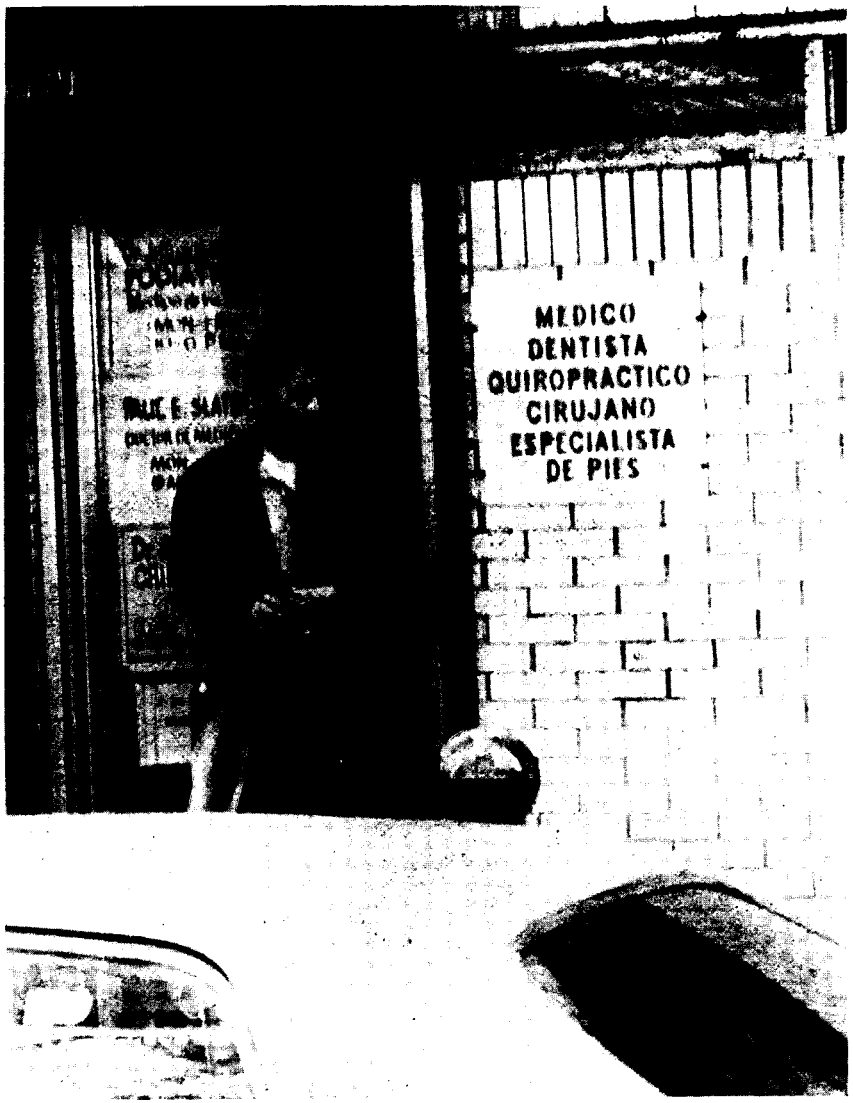
On May 7, the officers were examined by Dr. Freeman Carey, attending physicians, U.S. Capitol, and certified as being in excellent health *with no medical infirmities of any kind.*

As the investigation progressed, other members of the staff, all in good health (see following photographs), were called upon to assist in the shopping. This development was precipitated when we learned that the New York City Health Department has no female shoppers. Since more than half of the city's recipients are female, the inclusion of female shoppers was the only way to achieve a fair test of the system.

---

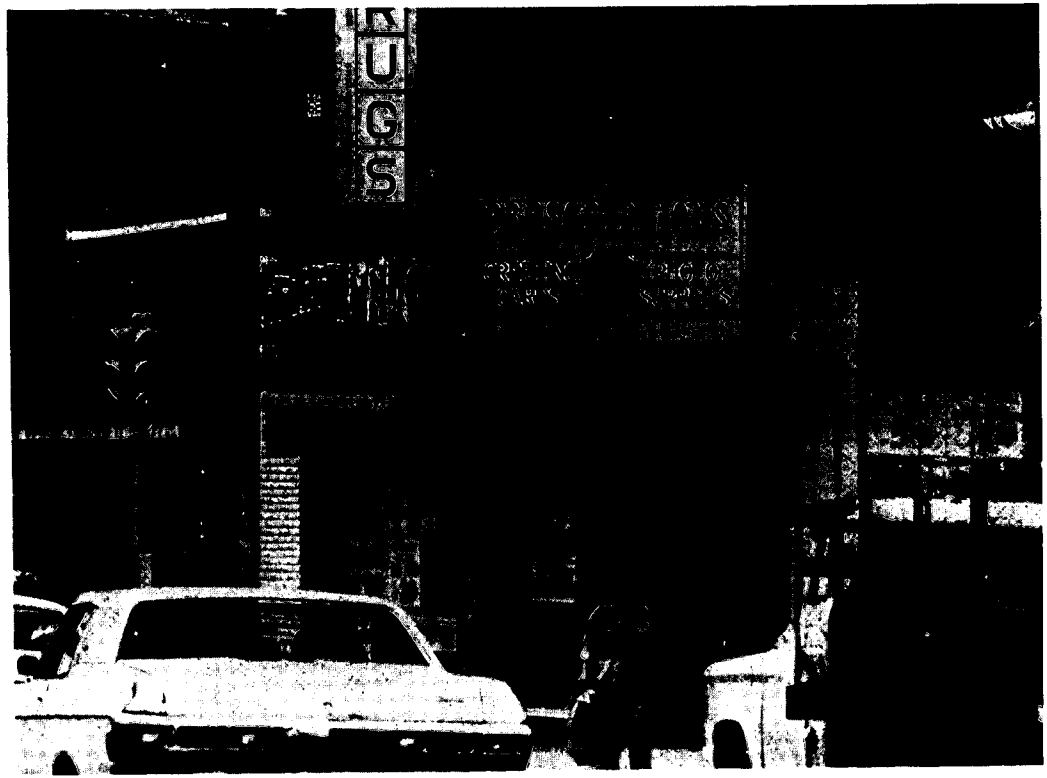
* Statements concerning individuals or clinics are to be presented under oath by Senate investigators at hearings planned for August 30 and 31, 1976. Named parties have been notified and will have an opportunity to appear or they may reply in writing.

Private James Roberts, U.S. Capitol Police, assigned to and working as an investigator with the Senate Committee on Aging, poses as a Medicaid patient seeking service in Medicaid mills in Paterson, N.J.



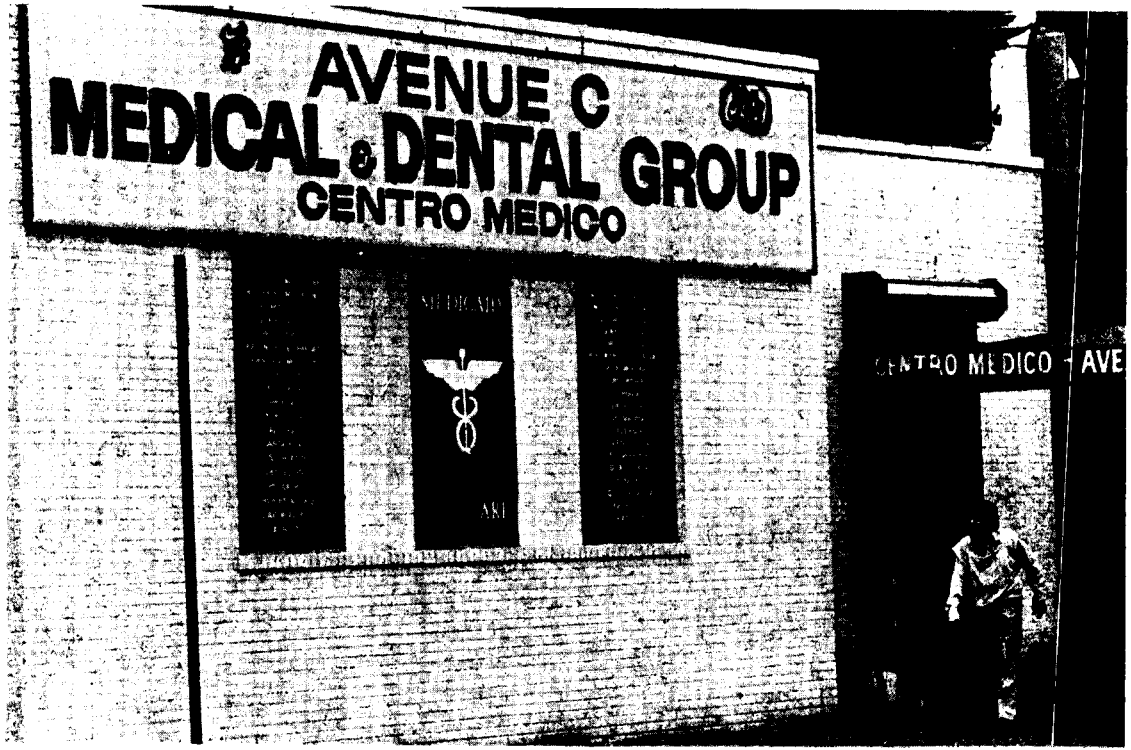
Private Darrell McDew poses as a Medicaid patient on Avenue B on the Lower East Side of New York City.

Patricia G. Oriol, chief clerk of the Senate Committee on Aging, poses as a Medicaid beneficiary in Los Angeles, Calif.



Catherine Hawes, investigator, Senate Committee on Aging, poses as a Medicaid beneficiary on the street in Newark, N.J.

75-902 O - 76 - 3



Val J. Halamandaris, associate counsel, Senate Committee on Aging, poses as a Medicaid patient on the Lower East Side of Manhattan, New York City.

The Procedure

Senate investigators were given explicit instructions prior to their entering Medicaid clinics. Each was told to present a general complaint and preferably to use the following language: "I think I have a cold." In some cases, symptoms were changed in order to "shop" specific providers and specialties. Shoppers were under orders not to seek referral or to suggest the need for medical treatment in any other way.

The only other instruction they were given was that, for purposes of their own health, they should refuse injections and X-rays whenever possible and to limit the amount of blood they allowed to be taken from them.

The shopping activity was monitored by committee staff positioned in a surveillance vehicle borrowed from the Internal Revenue Service. Security was maintained on the street by employing shoppers in teams and using the "buddy system." Following each visit, the shoppers were immediately debriefed and the recordings were sent to Washington for transcription. These transcriptions have subsequently been reduced to affidavit form. They have been presented to law enforcement authorities and are the source of the following statements.

Treatment

In the 3 months of our shopping activity in four States (New York, California, Michigan, and New Jersey), our investigators (perfectly healthy) were told the following:

(1) Private Roberts entered Gouveneur Medical Center in the lower East Side of Manhattan, New York City, complaining of burning and discharge in his urinary tract. He was given a general physical and a tuberculosis (TB) test, told he had a heart murmur and given an electrocardiogram (EKG). A second shopper, Investigator William Halamandaris, entered the same clinic several minutes later complaining of a possible head cold. His "head cold" was diagnosed as "sinusitus," he was given a general physical, an EKG, a TB test, told he had a severe heart murmur and that he probably had rheumatic fever as a child. In addition the doctor ordered a series of X-rays of the patient's sinuses and chest, and referred him to the heart specialist—*all in the space of 3 minutes.*

Third shopper, Patricia G. Oriol, chief clerk of the Senate Committee on Aging, entered this same clinic a month later complaining of a possible cold. She too was told she had a severe heart murmur and high blood pressure and told to return for further tests.

All three shoppers were given a large amount of medication and specifically instructed to have the prescriptions filled "at the pharmacy next door." (It is a violation of New York State law and Federal regulations to refer a patient to a specific pharmacy.)

(2) At the Avenue C Medical Center, Darrell McDew, complaining of slight dizziness, received a general physical and was referred to the chiropractor and optometrist. He was given an EKG, scheduled for laboratory work, and offered a vitamin B_{12} shot. As a result of his visit to the optometrist, Private McDew, who has 20/20 vision, received a set of eyeglasses (*one of three pairs he received while shopping*

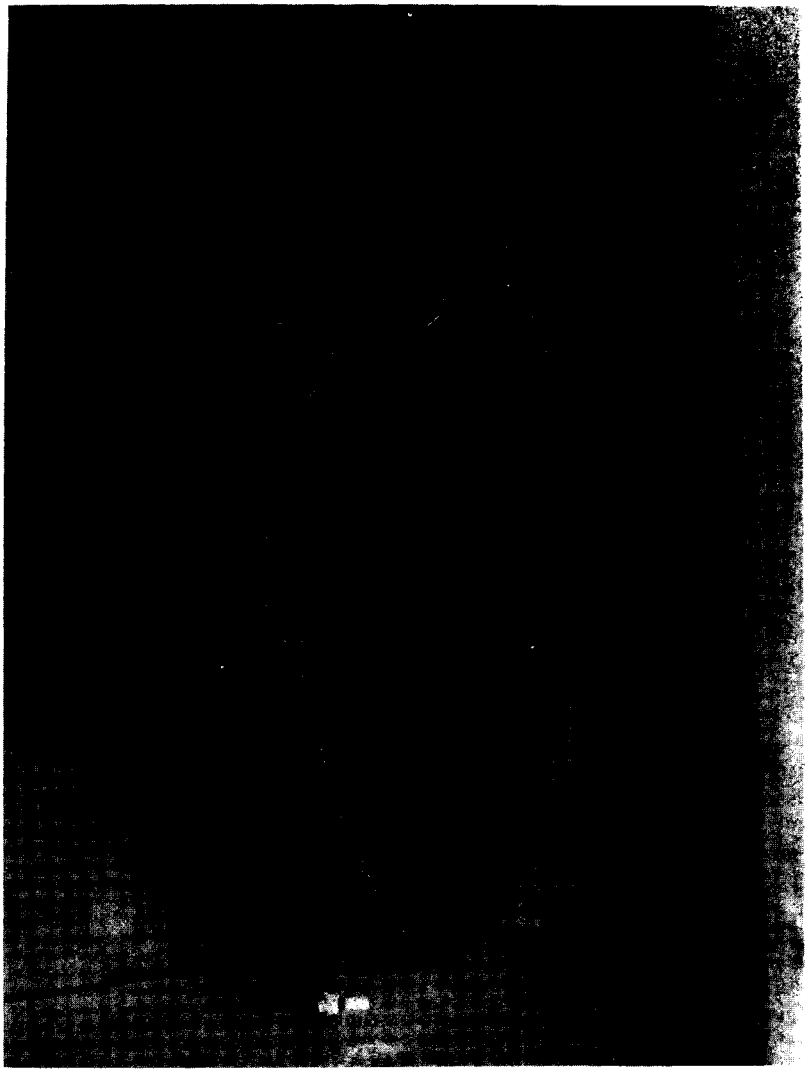
Medicaid mills). Private Roberts, entering the same clinic, again complaining of a urinary problem, received a general physical, and was referred to the chiropractor, optometrist, and dentist. Private Roberts also received a set of eyeglasses and was scheduled to return for extensive blood tests. Roberts was told to fill his prescriptions at the adjoining pharmacy.

(3) At the Riis-Wald Medical Center, one block away from the Avenue C Clinic on the Lower East Side, Private McDew was given a general physical, referred to the chiropractor and the podiatrist. The podiatrist informed Private McDew that he had hammer toe, and flat feet (for which the podiatrist placed "arches"—actually they were small pieces of felt—see photo—in his tennis shoes). He was also told his feet sweat. Subsequently, the same shopper met the same podiatrist (again on referral as a result of a "ping-pong") in a second clinic in Uptown Harlem. The podiatrist, after putting face and name together, checked his notebook and informed our investigator: "Remember what you had before? Well, you've got it again." He placed another set of "arch supports"—this time in the investigator's oxfords. In addition to arch supports, Private McDew received skull and chest X-rays (more than 10) and was ordered to return "next week" for additional tests. When Private Roberts entered the Riis-Wald clinic, he received a general physical and was referred to the chiropractor who ordered a full set of X-rays. He was also referred to the podiatrist, but had to refuse treatment because his toes had been painted the previous day by another podiatrist.

(4) At the East Harlem Medical Center, Private McDew asked to see a podiatrist. He was sent, instead, to the general practitioner and owner. The doctor listened to his chest and referred him to the chiropractor. He saw the podiatrist only after he had seen all other practitioners in the facility. Despite the nature of his complaint, "The bottom of my feet hurt," blood and urine samples were taken and his chest and feet were X-rayed. The podiatrist prescribed ankle braces which Private McDew was told to obtain "down the street" from a particular supplier. He was specifically referred to the East 116th Street Pharmacy to fill three pharmaceutical prescriptions which included two antibiotics. Private Roberts entered this same clinic complaining of tiredness, and received a general physical. He was referred to the podiatrist and given a future appointment to see the psychiatrist. Blood and urine samples were taken. His feet and chest were X-rayed and he was given two prescriptions which he was told to fill at the adjoining pharmacy.

(5) On May 20 at the Family Health Professionals Office on Second Avenue, Uptown New York City, Private Roberts saw a general practitioner, was referred to a dentist, and a podiatrist who diagnosed a bunion on his *left* foot. On the following day, May 21, at the Urban Medical Group, a clinic located on Third Avenue, Private Roberts, complaining of a cold, had a general physical, was referred to the optometrist, and a podiatrist who examined his feet and also diagnosed a bunion, *this time on his right foot.* Roberts has no bunions on either foot.

(6) Entering the 164th Street Medical Clinic on Morris Avenue in the Bronx, Private Roberts, complaining of a cold, received an



allergy test (before seeing the doctor), then a general physical and a hearing test, chest X-rays, and an EKG. He was also scheduled for an ear, nose, and throat examination at a later date. Private McDew, complaining of a headache, also received an allergy test, a general physical, an EKG and a number of X-rays.

(7) At the 80 Delancy Medical Center, Pat Oriol, complaining of a cold, was given a general physical, a TB test, a number of X-rays, and an EKG. Blood and urine samples were taken and she was referred to the pharmacy in the building.

(8) At the 14th Street Medical Center, located at 209 East 14th Street, Senate investigators sought treatment on six different occasions. On every occasion they were turned away with statements such as, "The doctor just left," or "He is not seeing any more patients today," or "If you want medical treatment, go to the city clinic." Observation of the clinic over a protracted period indicated that it was a haven for addicts and did a lively traffic in drugs. Committee staff were successful in taking movie films of several of these transactions. Two months after shoppers visited this clinic, it was closed by the New York City Department of Health. In closing the clinic, Dr. Martin Paris, executive medical director of Medicaid, said: "Physicians involved were effectively utilizing their medical degrees to act as legal pushers. The drugs were used as bait to insure them a steady flow of Medicaid patients."

(9) The Grand Street Medical Center in Brooklyn was visited by Pat Oriol, complaining of a cold. She was given a general physical and received four prescriptions. She was scheduled to return for two blood tests, an SMA 6, a complete blood count (CBC), an EKG, and an electroencephalogram (EEG). She was directed to the adjoining pharmacy to fill prescriptions for valium, ornade, vitamin C, and tyzine.

(10) At the Peoples Medical Center in Brooklyn, Catherine Hawes complained of a cold. She saw a general practitioner and received a complete physical exam. She was then referred to a gynecologist, pediatrician, and podiatrist. The podiatrist scraped the bottom of her feet with a knife, trimmed her toenails, and took two X-rays. Miss Hawes said her feet bled for a week. She also received four prescriptions, including nose drops, Cepacol mouthwash, E-mycin, and valium.

(11) Entering the Berman Medical Center in Detroit, investigator William Halamandaris complained of a sore arm. He was diagnosed as being depressed and nervous, told he had tennis elbow and given prescriptions for elavil (an "upper"), valium (a tranquilizer or "downer"), an antibiotic, and vitamins. The shopper had to refuse a "shot to make him feel better" three specific times.

(12) At the Omega Clinic, also in Detroit, shopper Pat Oriol received a prescription for Ornade Spansules and a vitamin supplement, which she took to the Kingsmart Drug Store to be filled. The druggist there informed her that he had only one of the two prescriptions on the form, which he provided, and then proceeded to fill out a second prescription for the second compound (Therabee), signing the doctor's name at the bottom and telling our shopper she could "take it anywhere" to be filled. (Copies of the two prescriptions are reproduced below.)

PHARMACEUTICAL SERVICES, INC.
Phone 921-5254-55
9016 Van Dyke - Detroit, Michigan 48213
Serving Nursing Homes and Hospitals

Name Carol Johnston Date 6/24/76
Address 12414 Lenox Age

① Ornade Spansules
#30 Caps
Sig: 1 B.I.D.
L.A.B.

② Therabee
#30
Sig: 1 Daily c meal
A.T. Miller MD

Authorization is given to dispense by non-proprietary name per approved formulary unless checked here ☐ Non-Rep ☐ Refill Times

Prescription

Name Carol Johnston Date
Address Age

℞

Therabee
#30
1 daily c meals

Non-Rep. ☐
Refill Times
DEA NO.
MA ID #

Dr. Miller
Address

(13) In New Jersey at the Washington Park Medical Center, Dr. Sonoski examined Mrs. Oriol for a "running nose." Dr. Sonoski gave her a general physical, appointments to see the gynecologist and podiatrist, scheduled her for a full set of tests, and offered her an injection, which was refused. When invoices for that visit were collected by the New Jersey Special Commission of Investigation, we found the Medicaid program had not only been billed for the shot Mrs. Oriol had specifically refused, but for a TB test and a blood test as well. The 3-minute physical she had received was billed at $30. A second shopper, Pvt. James Roberts, entering the same facility, received the same general treatment. Again the program was billed for a shot, a TB test, and a blood test, all of which had not been received. He too received a $30, 3-minute physical.

(14) In California at the Inter-Med Clinic, in Los Angeles, shopper Catherine Hawes received what she called "the most thorough examination she had while visiting Medicaid clinics." The physician spent approximately 15 minutes with her taking a medical history and performing a general physical. The nurse, however, who took blood pressure, temperature, height, and weight, ordered a urine sample which she tested as well (using the labstick method) and pronounced normal—*even though the sample was a soap-and-cleanser combination Miss Hawes had concocted in the rest room*, thus employing a stratagem similar to one already improvised by Senator Moss.

(15) At the Kandel Medical Center in Los Angeles, Mrs. Oriol, again complaining of a possible cold, received an examination which consisted of looking into her ears and throat, and listening to her heart with a stethescope placed on her collarbone. The doctor ordered a blood test, urine sample, chest X-rays, and three prescriptions. A technician performed the urine and blood analysis in the facility and informed her that she had a kidney and bladder infection and added: "We'll have to do more work on you."

(16) Associate Counsel Val J. Halamandaris entered the Concourse Medical Group, located at 1398 Grand Concourse, Bronx, N.Y. He spent less than 5 minutes with a general practitioner. He observed a patient obtaining a prescription for elavil without ever seeing a physician. He observed that the Medicaid cards of patients were routinely Xeroxed several times. In the open file for one patient, given an elavil prescription without seeing the doctor, were no less than eight Xerox copies of his Medicaid card. Although Counsel Halamandaris left the facility without seeing any other practitioners, the billings which have been returned for the visit claimed treatment by a podiatrist and one other practitioner.

THE BILLINGS

The above examples are merely illustrative of the more than 200 visits made by committee staff. Other visits were equally dramatic. However, even when a visit was less "eventful" or dramatic, the billings submitted invariably included either inaccurate diagnoses, charging for services not rendered, or both. Accordingly, this investigation will not be complete until all the bills are retrieved and law enforcement officials have the opportunity to compare them against the sworn affidavits we have prepared. This includes the bills presented by pharmacists.

Even at this early date, a number of billings have been returned which indicate charges for many services we did not receive and for visits that did not take place. The billings also indicate positive diagnoses used as justification for providing additional tests. The six Senate investigators have been diagnosed as having:

Tylomia (calcium on the feet),
Severe urinary tract infection,
Inner ear infection,
Low back syndrome,
Sesplanus plantafecetis,
Lower back pain,
Flat feet,
Insomnia,
Tension headache,
Headache and tension,
Symptomatic pronation (deformed foot),
Virus,
Hayfever,
Larangytis,
Bronchitis,
Right toe infection,
Chest pains (hyper-spasms),
Cystitus,
Displacement of lateral sensoral,
Bilateral hyvalgus,
Palix valgus (overlapping toes),
Sinutitis maxillary,
Acute otis media,
Conjuntivitis,
Allegic rhynitus,
Acute hypertension,
Asthma,
Anxiety, and
In-grown toenail (billed as a surgical procedure at a cost of $17).

The preliminary billings already indicate that one podiatrist billed for treating three Senate investigators without seeing any of the three.

Concerns About Quality of Care

For all the emphasis on fraud and abuse, the most important single point is the quality of care provided under the Medicaid program. From our detailed investigations, we have concluded that the concept of "Medicaid mills" is incompatible with quality health care. Time and time again, we saw patients with very real and obvious medical problems going untreated. Time and time again we saw serious medical problems ignored or undertreated while essentially minor complaints were overtreated. At one point we saw a mother bring a child with a severely cut foot into a shared health care facility in New York only to be turned away and told that the clinic would not provide the required service.

We saw known and obvious addicts being given valium, elavail, and methadone without prescriptions (in fact, without even seeing a doctor).

We saw X-rays being given (to us) without plates in the machine. We had numerous X-rays given without changing plates. We had chest and feet X-rayed with dental X-ray equipment.

On one occasion, Officer Roberts was given a foot X-ray using a dental X-ray machine. A piece of film was placed on the floor and Roberts was asked to place his foot on the film while the attendant turned on the machine. The entire procedure took place in the middle of a hallway without benefit of lead shields or other protections for the patients, attendants, and others.

We have been given EKGs when the tapes were not marked and dated.

We had allergy tests that were not read.

We had TB tests where the area was not circled (as it is in standard medical practice); nor were we told what reaction to look for or what to do in case of a reaction.

We had EKG's taken with electrodes placed over our stockings.

In almost every instance where a stethoscope was used, it was placed over our clothing.

We have seen disposable needles retained and reused.

We have seen clinics with one thermometer.

In all the time we spent in Medicaid mills we never had anything approaching an adequate medical history taken.

We never spent more than 5 minutes with any particular practitioner.

Testimony Concerning Inadequate Care

In addition, physicians we have interviewed* or those who cooperated with us in our investigation have provided a number of examples of the inadequate care received by patients in Medicaid mills. These include:

—Undiagnosed scurvy (deficiency of vitamin C),
—Undiagnosed acromegalia,
—Undiagnosed diabetes,
—Undiagnosed tachycardia, severe,
—Undiagnosed tuberculosis,
—Undiagnosed syphilis and gonorrhea,
—Undiagnosed cellulitis,
—Undiagnosed rheumatoid arthritis,
—Undiagnosed malnutrition,
—Undiagnosed heart disease,
—Undiagnosed carcinoma (cancer).

The following are five more-detailed examples of the kinds of shortcomings found in many Medicaid mills:

(1) One physician told us of a patient who had a tracheotomy 12 years ago and has had recurring pain in his face ever since. He had been coming to one particular Medicaid mill seeking relief from that recurring pain for more than 3 years. The doctor said that on examining the exterior wound she found that it had healed and gave no indication of the source of pain. In examining the man further, she asked him to open his mouth, and thereupon discovered a tumor the size of an egg. She said that it was literally choking the man. The tumor was so large as to have been obvious to anyone who had looked. The patient said that this was the first time in his clinic experience that anyone had bothered to look in his mouth.

(2) A Harlem physician reinforced what we learned in Illinois about the dismal quality of laboratory work performed for Medicaid patients. As an example, he told us that every serology that he had seen performed by one particular laboratory had a positive reading. He said every one of these serologies that he checked with the public health department came back negative. He also provided an example of one

*See page 46 for additional information on interview technique.

patient who, if the hematocrit readings were to be believed, would have had to have been hemorrhaging to death on one day and getting whole blood transfusions the next.

(3) A girl who had been treated at one New York clinic for over a year came in to see a physician who had been working with us at one point in our investigation. All the girl could tell the doctor was that she had lost 105 pounds in the last year. The doctor verified the weight loss and determined that the patient either had primary pituitary failure or primary adrenal failure. She had all the physical signs including tachacardia, low blood pressure, and anorixia. The doctor told us that the patient will either die or go blind from these ailments, but she has been treated instead for nonexistent diabetes.

(4) A physician in uptown Manhattan told us a patient came in with pain radiating from his abdomen, pin-hole pupils, and posterial hypertension. The doctor ran a VDRL test, learning that the man had syphilis. When confronted, the patient indicated he knew this to be the case; he had been treated before for the disease. However the only treatment he had been receiving for syphilis in the New York Medicaid mill he utilized was rendered by a chiropractor.

(5) Another patient entered a Medicaid mill in Harlem complaining of chest pains. He was referred to one of the physicians cooperating with us in our investigation instead of his usual practitioner. Upon reading the patient's electrocardiogram, taken several months previously, the physician learned that the 35-year-old patient had suffered cardiac infarction (a heart attack) some time in the past. The doctor who normally treated this man either did not discern this fact or did not tell the patient. At any rate, there was no evidence in the chart, or from talking to the patient, that he was treated for this condition.

Shortcomings: Other Providers

We learned of similar shortcomings with respect to the quality of medical treatment offered by other providers as well as physicians. For example, we discovered:

—Pharmacists who dispense outdated drugs.
—Dentists who insert fillings that fall out, bridges that crumble, and dentures that don't fit.
—Optometrists who dispense inaccurate or worthless prescriptions.
—Chiropractors who X-ray the entire body even though they are only authorized to X-ray the lower back.
—On one occasion we witnessed an optometrist measure everyone in the waiting room for a pair of glasses including a 6 month old baby and a man returning to his seat.

Senator Frank E. Moss Poses as a Medicaid Patient

The efforts of the staff to brief Senator Frank E. Moss of the foregoing events produced several questions and quizzical looks if not outright disbelief. The Senator decided to come to New York "to see things for himself."

A valid Medicaid card was arranged in the Senator's name through the U.S. attorney's office with the cooperation of the department of

social services. The address indicated on his card [p. 36] is the street address for the Statler Hilton in New York City where the Senator and staff were staying.

On June 7, Senator Moss put on "the worst looking clothes I could find" and appeared in the office of the U.S. attorney, southern district of New York. The photograph [p. 37] shows Senator Moss signing his Medicaid card.

Later that morning the Senator entered the East Harlem Medical Center, 145 East 116th Street, accompanied by Patricia G. Oriol, who posed as his "girlfriend." He presented himself for treatment, saying he thought he might have a cold. He was given a brief cursory examination by Dr. Clyde Weisbart, owner and administrator.

The physician asked Senator Moss if he had a fever and the Senator replied he did not. The physician then took a brief medical history, asking the Senator if he had diabetes, high blood pressure, or any allergies, and if he had ever been in a hospital. He asked the Senator if he had an arthritic condition. Despite the fact that the Senator said he did not, Dr. Weisbart decided to send him to the chiropractor, saying, "What I am going to do is to send you up to see Dr. Cohen. He is our chiropractor. You might have some muscle spasm."

The doctor added, "You do have a red throat."

The physician continued, "I don't think you have a meningital problem. It might feel tight, it might be just a muscle spasm, but he can work on it. He is pretty good at what he does. He'll relax you, and probably give you some medication."

He continued, "You aren't allergic to anything, are you? I am going to get a blood test, urine test, and a chest X-ray."

Senator Moss was directed up the stairs to see Dr. Cohen.

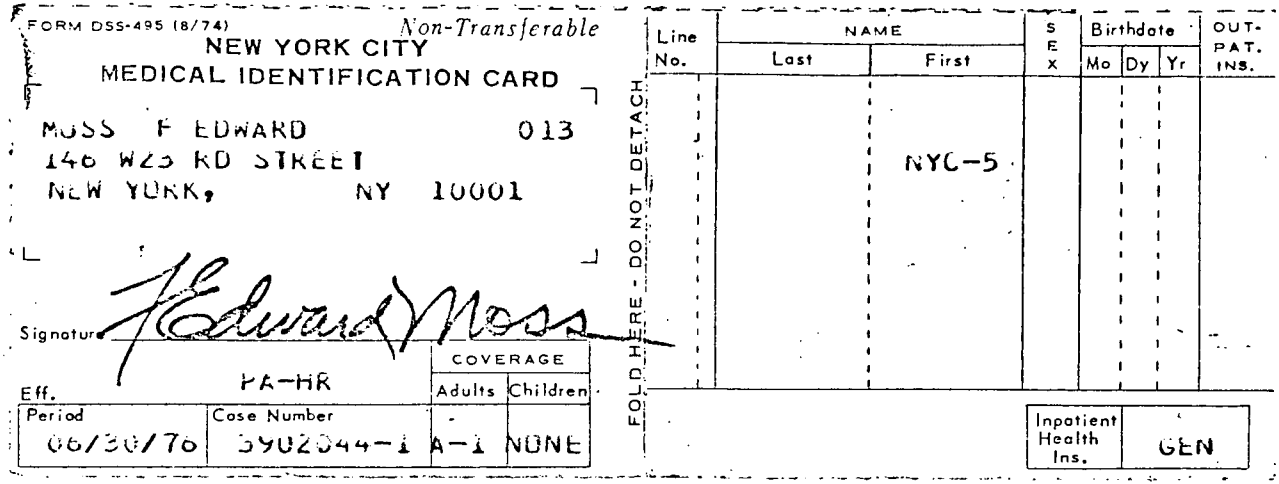
Dr. Cohen asked the Senator if he had a history of arthritis. Senator Moss responded, "Not that I know of. I have no way of knowing that I have. No one ever told me I have."

The doctor then proceeded to twist the Senator's neck, asking, "There, doesn't that feel better?"

The chiropractor stressed that the relief was only temporary and that he needed to get at the underlying causes for any permanent relief. "I'll have to give you a little bit of treatment before I can honestly tell you what is wrong and what I can do. It might be necessary to look at a picture to find out the underlying problems. There could have been a problem a couple of years ago, or it could be a symptom of another condition."

The chiropractor invited the Senator to come back for treatment the next day. "Come straight here tomorrow; 11 or 11:30 is good," reminded Dr. Cohen. "What we will do now is send you downstairs to get a picture of your cervical spine."

The Senator submitted himself to extensive X-rays and blood tests. He gave a urine sample, and was given a return appointment. He was directed to the "pharmacy next door" to have the prescriptions filled which he had been given by Dr. Weisbart.



FORM DSS-495 (8/74) *Non-Transferable*

NEW YORK CITY
MEDICAL IDENTIFICATION CARD

MOSS F EDWARD 013
146 W23 RD STREET
NEW YORK, NY 10001

Signature Edward Moss

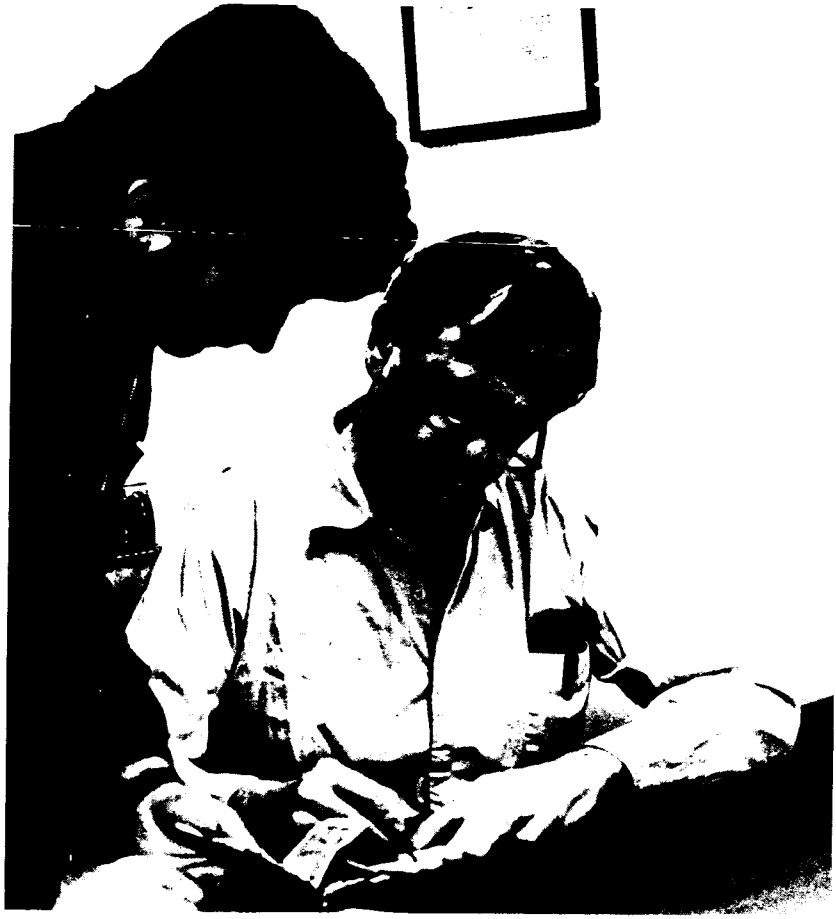
Eff. Period	Case Number	COVERAGE Adults	Children
06/30/76	5902044-1	A-1	NONE

PA-HR

FOLD HERE - DO NOT DETACH

Line No.	NAME Last	First	SEX	Birthdate Mo	Dy	Yr	OUT-PAT. INS.
		NYC-5					

Inpatient Health Ins.	GEN



Senator Frank E. Moss signs his Medicaid card in the office of the United States Attorney, Southern District of New York. Investigator Bill Halamandaris looks on.

Senator Moss and Pat Oriol are shown in front of the 116th Street pharmacy after having these prescriptions filled [see p. 38]. The medicine received included erythrocyns, darocet, and phenergen.

Dr. Weisbart and his brother-in-law, Dr. Sampson, collectively billed Medicaid for more than $300,000 for personal services. In addition, the pharmacy is one of the high volume providers, showing billings of about $100,000 a year. As indicated above, Senate investigators had "shopped" this facility a number of times previously. On each occasion the pattern was consistent: a brief general examination, several prescriptions, extensive blood, lab and X-ray work, and a number of referrals.

Senator Moss examines medications he has received from the 116th Street pharmacy after treatment in the East Harlem Medical Center. The Senator posed as a Medicaid beneficiary accompanied by his "girlfriend" Patricia G. Oriol, chief clerk of the Senate Committee on Aging.

MOSS VISITS THE 164TH STREET CLINIC

The 164th Street Clinic on Morris Avenue in the Bronx is a new facility administered by Dr. Enrique Davis, who billed Medicaid for more than $100,000 last year. Senate investigators had "shopped" this facility more than a month before and in each case the shopper was greeted with an allergy test, literally as they walked in the door (*before seeing a physician*). Again the pattern was consistent, a brief examination, extensive blood and lab work, and a number of referrals. In the interim, between the initial visits to the 164th Street Clinic and the entry made by Senator Moss on June 7, the Clinic obtained the services of one more provider, a psychiatrist who changed the texture of the facility from one dealing primarily in overutilization (high volume and unnecessary tests) to one catering to the needs of the addict community.

Inside the facility, again accompanied by his "girlfriend," Pat Oriol, Senator Moss found many of the same conditions. A number of tests were ordered. He was asked to give blood and urine, and was scheduled to come back for further testing and treatment with the suggestion that referral to other practitioners might be necessary. He was given several prescriptions for his nonexistent cold, and was instructed to have them filled at the adjacent pharmacy.

Page 40 carries a photograph of Senator Moss and Patricia G. Oriol in front of this clinic. Pvt. Darrell R. McDew is visible under the sign saying "prescriptions."

MOSS VISITS 209 EAST 14TH STREET

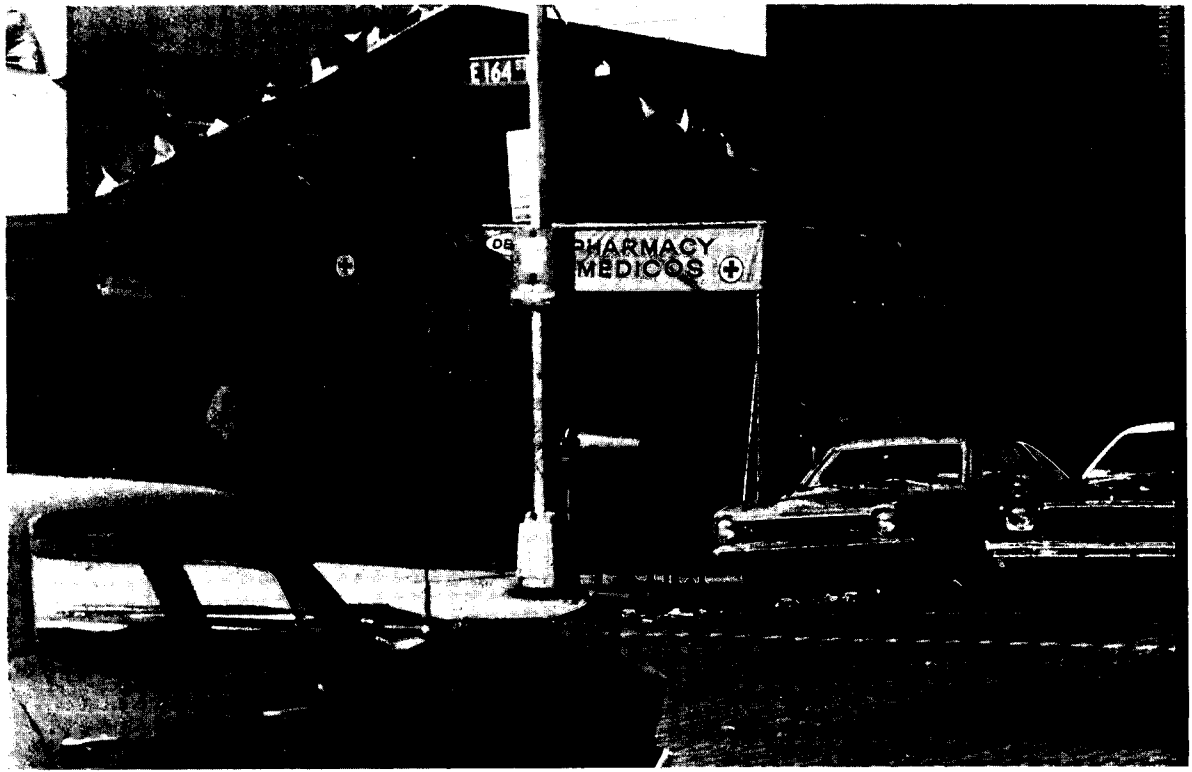
Senator Moss also visited the clinic located at 209 East 14th Street. It is called the 14th Street Medical Center. Investigators presented themselves for treatment at this place 6 previous times and were turned away. The clinic was a haven for addicts. Senate investigators were successful in filming the lively traffic in drugs that took place in front of the facility.

Senator Moss did not obtain treatment at the 14th Street Medical Center, but did enter the adjacent pharmacy. In the pharmacy located in the basement, Senator Moss found himself in a room the size of a bathroom and partitioned with bulletproof glass between the pharmacists and the receiving area. A number of apparent addicts were milling about.

Behind the plexiglas stood the pharmacist filling prescriptions, seemingly at random. A number of bottles in front of him were all filled with the same white pill compound in seemingly assembly line fashion. The pharmacist asked Senator Moss what he wanted. He said he was looking around.

Two months later the health department closed the facility at the 14th Street Medical Center for catering to the needs of addicts, saying doctors were using their medical licenses to act essentially as "legal pushers." Significantly, the facility was actually closed because of violation of the city health code: unclean and unsanitary conditions.

Page 41 shows Senator Moss in front of this clinic.



Senator Moss and Pat Oriol posing as Medicaid patients in front of the 164th Street Medical Center in the Bronx, New York. Pvt. Darrell McDew is under the "prescriptions" sign, far left.

Senator Frank E. Moss, posing as a Medicaid patient, visits the Medical Center at 209 East 14th Street on the lower East Side of Manhattan.

Two days later Senator Moss returned to Washington somewhat tired. Asked how he was he answered: "Fine for someone who is so sick." He displayed bruises in his arms caused by inept blood drawing [see photo below]. "You have to experience it to believe it," he said. *Note: 3 weeks prior, Senator Moss had been given his annual physical and declared in excellent health with no medical problems.*

Senator Frank E. Moss on the "morning after." (Discoloring resulted from inept blood drawing.)

Medicaid Mills: A Box Score

Medicaid mills are a growing phenomenon. They are the home of Medicaid's high providers, the doctors and dentists who individually billed the program for more than $100,000 last year.

The concentration of Medicaid funds is nothing short of phenomenal. In New York, the 7 percent of all doctors participating in the Medicaid program received fully 50 percent of the funds going to physicians' services. Almost all of these practitioners work in Medicaid mills. Nor is this strictly a New York happening. A similar pattern was revealed in the staff's investigation in Illinois, California, and New Jersey. In Michigan, 3 percent of the Medicaid doctors working out of Medicaid mills earned fully 25 percent of Michigan's total payments for physicians' services.

Since Medicaid mills are essentially unlicensed and unregulated, no one knows how many of such facilities there are in the United States. Estimates in New York City alone vary from 350 to as many as 1,000 or more. From observations in five States, it is evident such facilities are highly profitable. In Chicago, Senator Pete V. Domenici observed that their rate of expansion was such that they were pushing out of their wake another highly profitable enterprise: pornographic book stores. The observation was made after passing a Medicaid clinic which, until recently, had been such a magazine store.

The committee staff believes that the Congress must be informed that Medicaid mills across the Nation may rake in as much as 75 percent of all the money paid to physicians, dentists, chiropractors, podiatrists, pediatricians, clinical laboratories, as well as receiving possibly half of the money paid for Medicaid prescription drugs (the remaining amount for drugs is paid to nursing home patients).

The foregoing assumption is already a fact in the city and State of New York. It appears to be the fact also in the four other States we studied in detail.

If the committee staff's analysis is correct then, based on 1975 Medicaid payments, Medicaid mills may receive 75 percent of the $3 billion paid to doctors, dentists, labs, and pharmacies by Medicaid.

This means that Medicaid mills may be receiving $2,225 million a year from Medicaid.

In the course of this investigation, we visited some 250 Medicaid mills either as patients, interviewing physicians, or posing as businessmen pretending to buy clinics. By this process we gained unique insights about the operation of such facilities. Insights were further strengthened by looking over the shoulder of BGA investigators who set up a storefront clinic themselves for purposes of testing the system last December.

Senate investigators offered themselves for treatment more than 200 times. Some 120 of these clinic visits (as patients) took place in New York City's Harlem, Bedford Styvesant, Bronx, Queens, and lower East Side. The remaining visits took place in California, New Jersey, and Michigan.

Senate investigators were not successful in obtaining treatment in every instance. In the beginning, the Medicaid cards investigators were furnished with were from the series New York City routinely uses in its "shopping" efforts. Some clinics showed an obvious recognition of the names on our cards and turned investigators away.

In all, investigators saw about 85 practitioners. Perfectly healthy staff members collected literally bushels full of prescriptions. *Despite the fact that investigators were instructed to refuse X-rays*, more than 100 were received. Investigators received numerous other questionable tests in view of their feigned ailment, usually a cold. These included 18 electrocardiograms, 8 tuberculosis tests, 4 allergy tests, hearing tests, glaucoma tests, and three electroencephalogram tests. Investigators were asked to give, and did give, a tremendous number of blood samples, and literally gallons of urine. They were told repeatedly (no less than 11 times) to return for full-scale testing. They received seven pairs of glasses without ever asking to see an optometrist. The eyeglasses were not only unnecessary, they were totally useless, the refractions on the seven glasses were bizarre, with no consistency at all. Investigators were repeatedly "ping-ponged" to neurologists, gynecologists, internists, psychologists, psychiatrists, heart specialists, podiatrists, dentists, chiropractors, opticians, ophthalmologists, occulists and pediatricians. In some clinics, investigators had to run out of the clinics in order to end the protracted medical merry-go-round.

It is to be emphasized that these practices occurred in all four of the States "shopped" by the committee staff. One significant fact: In all the 4 months of this investigation, only one physician told an investigator, "Get out of here, there is nothing wrong with you."

If further generalizations are possible, most clinic visits, whether in Watts or Bedford Styvesant, were brief. In most cases, physicians ordered several tests. In at least 70 percent of the cases, overutilization was present. In about 25 percent of the cases, Senate investigators classified the excessive testing and ping-ponging as an obvious, intentional attempt at defrauding the Medicaid program. In more than 90 percent of the clinic visits, staff members classified the quality of care as inadequate. Factors in this determination are the normal procedures an average physician would take with a patient with a possible cold. All too often, temperature was not taken, blood pressure was not taken, practitioners did not examine the patients' ears or eyes or did so only in cursory fashion (example: shining a flashlight at a patient's throat from 5 feet away, without using a tongue depresser). One explanation for these lapses is that care takes time. It was the opinion of investigators that the practitioners they saw were under pressure to see as many patients as possible; the pressure being applied by owners holding percentage leases and expecting a high return on their investments.

In short, the care provided in more than 90 percent of the cases was inadequate. This is obviously a fraud on the American taxpayers who are under the impression that their tax dollars are buying useful health care for the poor aged and disabled. As noted, the appearance of medical care is far from reality. Moreover, there is obvious overutilization instigated by practitioners on unsuspecting patients who acquiesce in the suggestions given them by men in white coats that they need to see the chiropractor or the like. Overutilization may make up a full 25 percent of the billings submitted to Medicaid from these Medicaid mills. Direct fraud or billing for services not rendered also exists in about 15 to 20 percent of the billings submitted to Medicaid on behalf of the visits of staff members. Full details will not be apparent until all billings are identified and retrieved for processing against the affidavits completed under oath by the committee staff. In addition to these pernicious practices, Medicaid mills are layered with complex financial

leasing arrangements which exploit the foreign trained physicians or the young doctor out of medical school in order to line the pockets of businessmen who essentially provide no services to patients. Criss-crossing this complex medical maze are abundant layers of kickbacks, rebates, and "cuts off the top." The overwhelming impression investigators are left with is that the Medicaid mills are rotten onions. Layer after layer has been peeled away to reveal still more decay. A small core is all that is left in testimony to Congress' noble intent to make health care available to all without regard to ability to pay.

C. OPENING A MEDICAID MILL: INTERVIEWING PHYSICIANS IN ILLINOIS

As noted earlier, this investigation into fraud and abuse among practitioners participating in the Medicaid program commenced in September of 1975. It began when a physician contacted the staff, telling us that he had been approached by a clinical laboratory and offered a rebate of 30 percent if he would send them all of his laboratory business. At our request, he consented to call the lab salesman back. On October 14, 1975, the lab representative repeated the offer with a Senate investigator present in the closet.

At the close of the meeting the representative indicated the lab firm had similar kickback arrangements with clinics all over Chicago. An analysis of billings paid to this laboratory gave us the names of the physicians who employed their services. We then had a reasonable expectation that they received the same arrangement for a 30 percent kickback.

Confronted with this evidence, Senate investigators sought to find the answer to an essential question: How common was the practice? An extensive discussion among the staff led to the conclusion that the best way to test the extent of such practices would be to simulate the actions that would be taken by an independent physician beginning a practice specializing in public aid patients. For this purpose, it was decided that a storefront clinic would be opened in an appropriate area. Only from the perspective of the practitioner at street level could the committee gain information on the mechanics of the highly questionable operations. And only through understanding the mechanics of the operation could effective corrective legislation be proposed.

A decision was made to go ahead with this plan in conjunction with the Better Government Association of Chicago, Ill., a nonprofit, nonpartisan civic organization which has cooperated with the Committee on Aging for more than 6 years. Subsequently, due to considerations of time and money, the BGA assumed primary responsibility for setting up and operating the storefront clinic with committee staff present only as observers. (See photo, page 47.)

Over the next 3 weeks, business representatives from more than 12 laboratories, doing more than 65 percent of the Medicaid business in Illinois, visited the storefront clinic. All but two offered some form of inducement or kickback. The offers ranged from an "education program" for physicians in billing procedures to maximize returns from public aid to cash rebates of more than 50 percent of gross payments received from the Illinois Department of Public Aid.

Armed with this information, we constructed a "profile" on each lab to identify the doctors who used them. We cross-indexed the names of physicians making over $100,000 from Medicaid, selecting 50 physicians in 50 Medicaid clinics for interview. These interviews gave us our first hard look at Medicaid mills.

In the great majority of cases, physicians confirmed the existence of the arrangements. Under questioning they provided specifics concerning the amount of rebates and the method of payment. In addition, a number volunteered that they had similar arrangements with other vendors such as pharmacies and medical supply companies.

We encountered two typical financial arrangements in Illinois Medicaid mills. In the first instance the physician himself was the owner of the clinic, either owning or renting the building. In this case he subleased to other practitioners for as much as 80 percent of the money these doctors were paid from Medicaid for treating patients. In the vast majority of cases, however, the physicians we saw indicated that they were not the owners. They were employed essentially on commission, keeping perhaps 20 to 40 percent of the money they received from Medicaid. The entrepreneur or businessman, generally not a medical practitioner, kept the remaining 60 or 80 percent of the money.

Following are examples from each situation:

(i) Dr. H. M. William Winstanley told investigators that he received some $100,000 from Medicaid for his medical center last year. He paid a rent of $1,000 a month for a small suite. In turn, he "rented" the suite to several practitioners. He received rental of $1,000 a month from a pharmacist. (Actually the amount fluctuated with the volume of billings the doctor submitted, but $1,000 was about average he told investigators.) The dentist, he claimed, paid him about $800 a month, depending on billings.

The optician added another $400 a month. In return for sending his laboratory business to United Medical Laboratory, he was paid $950 a month which he viewed as a rental fee for a 7-by-10-foot room in his clinic. In addition, he was paid $130 a month for an employee to draw blood and perform related services in this room.

(ii) A second physician, Dr. Julio Lara-Valle told investigators that the State's third largest laboratory in terms of public aid business paid him $1,000 a month (more or less depending on volume) for the use of a closet-sized room in a suite that cost him $300 a month to rent. Under questioning from Senators Frank E. Moss and Pete V. Domenici on their February 6, 1976, visit, the physician added he was paid another $1,000 rental by the operator of the pharmacy connected to his facility.

(iii) Our visit to Dr. Jose Jaime Hilao produced a surprise. He stated that he was paid a salary depending on his Medicaid earnings. He indicated that we should see the clinic owner, Mr. Robert C. Parro, who owned the Robert C. Taylor Medical Center where Doctor Hilao worked as well as the Professional Medical Group, a facility in another part of Chicago, in which Dr. Hilao's wife worked. When interviewed by Senate investigators and later by Senator Moss, Parro stated that he had received more than $300,000 each year in Medicaid funds from the Department of Public Aid. He confirmed the usual financial arrangement with the physicians and he stated that his pres-

Photo by George Quinn, Chicago Tribune

The storefront clinic at 1520 West Morse Street, Chicago, Ill.

ent "rebate" arrangement from the clinical laboratory amounted to 50 percent of the total his clinic charged Medicaid for lab services on behalf of Medicaid beneficiaries. Mr. Parro expressed concern that some people might consider this entire fee-splitting arrangement illegal or unethical, inasmuch as he, a layman, was sharing in the revenue earned by Medicaid practitioners.

These interviews, and others like them, convinced us of the need for a detailed examination of the financial and operational aspect of Medicaid mills.

D. THE EXECUTIVE LEVEL

Our insight into the financial and operational aspects of Medicaid mills comes, essentially, from three sources: (a) Reviewing cases in the office of the U.S. Attorney, southern district of New York, reflecting what has been described as the single most extensive Medicaid fraud investigation (begun in 1973 and involving over 100 practitioners associated with 8 Medicaid mills owned by 3 individuals and literally millions of dollars in fraud); (b) interviewing physicians who have worked or who are still working in Medicaid mills; (c) posing as businessmen attempting to buy into the executive level of mill ownership.

1. Medicaid Mills: A Look at the Inside Operation

The following paragraphs detail some of the practices defined by the Assistant U.S. Attorney, George Wilson, in the celebrated Medicaid fraud investigation. The names have been withheld by his request.

For a period of 3 years, 8 clinics controlled by Dr. I and Dr. S, two chiropractors, billed the New York City Medicaid program in the amount of $2,222,000. The two principals received a flat 25 percent of this amount as rent from practitioners in their clinics plus 50 percent of a net after factoring plus a kickback of 5 percent from the factor, and a 30-percent kickback from the clinical laboratory.

The following is a rough application of these figures to the total moneys for which the clinic billed:

	Amount to principals
i. The factoring firm takes 12 percent $2,222,000 as his fee, or $266,640. Of this amount ($266,640), 5 percent is paid back to the principals as a kickback	$10,332
ii. 25 percent of gross is claimed by principals as rent	555,000
iii. Subtracting $266,640 and $555,000 from the $2,222,000 leaves $1,400,360, which is divided 50–50 between the owners and the practitioners who work in the clinics	700,120
iv. The total so far equals	1,265,452
v. To this amount is added a 30-percent kickback (eight clinics averaged about $800 a month in kickbacks over 3 years) for a total of	217,400
Grand total	1,482,852

In short, the two principals made about $1.5 million from their Medicaid mills over this period.

These figures reflect the general pattern of rental arrangements and kickback fees. There are some rather special arrangements. In 1970, an agreement was entered into between the two principals and Dr. Y, an elderly cardiologist. The terms of the contract were that Dr. Y would work for a weekly salary of $120 and that all the Medicaid income earned would revert to the employers. His function was to sign fraudulent invoices. He was driven from clinic to clinic and seated at a desk with a pile of patient records and blank invoices. He rarely saw patients, spending all of his time writing. The U.S. Attorney estimated that 98 percent of his billings were fraudulent.

To make matters worse, a few months after the contract was entered into a joint savings account was opened by Dr. Y and another physician who worked in the clinic, Dr. B. The establishment of a joint account was for the purpose of "laundering" Dr. Y's Medicaid receipts for eventual disbursement among the owners. Subsequently, to further facilitate this disbursement of funds, a similar arrangement was made between Dr. Y and one of the secretaries employed at one of the clinics.

An interesting note is that when this case was unraveled by authorities, Dr. Y was found to have received only about $10,000 out of a total of $50,000 or more represented by checks made out to his order by the factoring firm. (It is to be recalled that factors pay cash for accounts, keeping their 12 percent or more and then collecting from local welfare departments.)

The secretary mentioned above became so adept at preparing bills that she soon did little else. She began to invent invoices and forge the doctors' names. First she wrote only a few fraudulent billings. But when she learned that her fraud went undetected, she wrote increasingly more illegitimate invoices. She has admitted writing so many phony invoices that at times she developed writer's cramp, or wrote with her left hand, and subcontracted to her roommate. Sometimes, she confessed they both stayed up half the night "writing paper".

Among the other fraudulent practices discovered in these clinics were:

A doctor who billed invoices at a clinic where he never worked;

A gynecologist who billed for a pap smear at a time when the treatment table was pressed up against the wall;

A doctor who went to his office two and three times a week, picked up charts of patients and began writing billings at random. Apparently, this was a fairly common practice for this practitioner who was frequently observed sitting, drinking coffee, and writing bills;

An X-ray technician who was told to use exposed film because "no one will know the difference";

An internist who studied the racing forms in the morning and wrote invoices in the afternoon (while never seeing patients); and

A pediatrician who administered an antibiotic shot to a neighbor's dog and billed Medicaid for the service.

An internist specializing in geriatrics (characterized as the most flagrant abuser of the group) was observed by a number of witnesses sitting in the office of the clinic manager and "just signing his name through a whole pile of blank invoices." This physician had an extensive Medicare practice in addition to his Medicaid and private

earnings. He has been charged with an abuse known as "gang visits", that is, walking through a nursing home and charging each patient for a visit and examination. He averaged 60 patients an hour in this fashion; one patient every minute. Under examination by the U.S. attorney's office, he was asked if he took blood samples. He stated that he did not. Asked if he took the pulse of patients, he said he did not. In fact, his entire examination consisted of examining the feet of patients, as he walked down the hall, to see if they were swollen. The doctor made similar "gang visits" in four other New York nursing homes.

RATIONALIZATIONS

The physicians involved attributed their conduct to the atmosphere of the "mill" in which they worked. Frequently, they said they were approached by the owners and told that their bills were low. Reportedly, they were told: "Get your billings up." The owners (principals) rationalized their conduct, saying they were compensating for disallowances and a too low fee schedule. They admitted they were spurred on by the knowledge that the worse that can happen would be nonpayment of their claims or a fine. They cited as examples, numerous flagrant offenders who had been fined amounts up to $10,000 or more but still allowed to continue in the program.

The only fear expressed by this group of criminals was of the factoring company, who they said had used its knowledge of the phony billing practices as a lever to lower the kickback paid to 2 percent, then down to 1¼ percent, and finally to zero.

2. What It Is Like To Work in a "Medicaid Mill"

In the course of the more recent investigation by committee staff, some 60 physicians who work or have worked in Medicaid mills have been interviewed. Questionnaires were sent out to 250 physicians making more than $75,000 a year from the Medicaid program in New York. In addition, committee staff met and discussed the problem at length with the Illinois State Medical Society and with the Illinois Physicians Union, both of whom were most helpful and supportive of the committee's efforts.

In the course of these interviews committee staff asked questions ranging from "How does one apply to become a Medicaid physician?" to "What is the quality of care that is offered?". With respect to the application process, no better illustration can be found than the following article, entitled "Medicaid and Me: Condition Normal," by B. P. Reiter, M.D., which appeared in the July 21, 1975, *New York* magazine.

APPLYING FOR A JOB: DR. B. P. REITER

> Once I finished medical school, I figured I would go out and get rich. Not super-rich, but rich enough to move out of my 1-room apartment. I also wanted to buy a new motorcycle, and perhaps pay off a few of the constellation of loans I had collected in medical school.
>
> I could do none of these things. It turned out I had an M.D., but I had no license. You need at least a year of internship in

order to get a license to practice medicine. I went and did an internship. A lot of interesting things happened; but I survived. And I got my license.

Well, I thought, now I'm going to go out and get rich.

"What are you talking about?" my friends said. "You have to specialize."

"I don't want to specialize," I said, "I want to get a job."

"You can't get a good job unless you specialize in something."

I specialized in something. Three years later I had my M.D., my license, and my specialty. I'm not going to talk to anybody this time. I thought. I'm just going to go out and get rich. I planned to open an X-ray office.

I called the X-ray equipment company and said hello, I'm a young radiologist and I'd like to open an office. The X-ray equipment company said no problem, they could set me up, on a modest scale of course, for about $220,000. Oh, I said.

I didn't have $220,000. If I'd had $220,000, I wouldn't have opened an office. I would have closed the office and retired.

Well, I figured, maybe I can find a job in the New York *Times*. What with the doctor shortage and everything, there ought to be a job someplace for a radiologist.

There was a whole string of ads in the Sunday *Times*. "Medicaid Clinics! Serve the community! No overhead, no investment, high volume. All types of doctors needed. Should speak a little English."

I speak a little English, I said to myself. I called up one of the clinics.

"I'm a radiologist," I said, "and I was wondering . . ."

"Come in," they said. "Come in and see us!" I drove to Brooklyn the next day and found the place. It was hard to miss—there was a gigantic, multilingual sign out front advertising medical care, dental care, chiropractic care, any kind of care you wanted. Everything but topless waitresses. Right next door, a similar, slightly smaller sign identified a conveniently located pharmacy. Also gladly accepting Medicaid.

I went inside. There was a small waiting room, with a very big guard standing in the corner. I walked up to the little glass window.

"Hello," I said, "I have an appointment here."

"What?" the woman on the other side said through an intercom thing.

"I have an appointment. I am a doctor."

The piece of plate glass between us was about 3 inches thick, and she couldn't hear anything. It was like a check-cashing place on the Bowery. "What?" she said again.

"I said I'm a doctor," I yelled. "I've got an appointment!"

The guard came over and shook his stick at me. "Sit down and be quiet," he said to me, "or you won't get your methadone."

"I don't want any methadone," I said. "I'm a doctor and I have an appointment about a job here."

"Sit down and be quiet," the guard said, looking nasty. He was twice as big as I was and I sat down.

I looked around the little waiting room. This was a high-volume operation all right, no question. I had to take a seat way in the back, but there was another great big sign up front, with an illuminated, moving message. It was certainly big enough and bright enough not to be missed, even from the cheap seats.

"V.D. Tests," it announced in several languages. "Pregnancy Tests. Pap Tests, Road Tests. Learners Permits. Auto Insurance, Life Insurance. Personal Loans—Low Rates."

"What am I doing in this place?" I said to myself. Two gentlemen dressed up in long white coats appeared from behind the armored window and came hurrying over to me.

"Are you the doctor who called up yesterday?" the smaller one said. "The radiologist?"

"Yeah, I'm the radiologist."

"Wonderful, wonderful," he said. "This is my partner. Come with us, doctor."

We went inside. The guard did not frisk me; but looked like he wanted to.

The three of us sat down in a plasterboard office that had padlocks on everything.

"Would you like a cigar, doctor?" the little one said.

"No, thank you," I said. "I'd like a job. I finished my residency last June, and I'm pretty well trained in general radiology, isotopes, and angiography."

"That's very nice," he said. "We take 70 percent."

"Pardon me?"

"You give us 70 percent of your billing."

"I don't understand," I said.

"Let's say you become our radiologist," the little one said with a kindly look on his face. "We handle everything for you. We take care of all the equipment, we buy the film, we pay the technician. All you have to do is read the film."

"I see. Well, who supervises the technician's work?"

"Oh, we do," the big one said. "We watch him very closely."

"Yes," the little one said, "you don't have to worry about anything. All you have to do is read the films and give us 70 percent of your billing."

"Seventy percent? You're kidding."

"This is a wonderful opportunity for a young doctor like you," the little one said enthusiastically. "Do you know how much that equipment costs?"

I knew. "Well, I'm not sure," I said. "I mean, that doesn't leave very much for me."

"Look at it this way. This is a very high-volume clinic. Let's say you have $1,000 worth of billing. That's $300 a week for you, right there. By the way, have you ever done any Medicaid work before?"

"No. This is my first job."

"Well, there's one more thing," the big one interjected. "We like to get paid right away."

"Yes," the little one said, "that's true. We have a lot of overhead."

"What do you mean?" I asked, innocently.

"It works like this. Let's say there's $1,000 worth of billing for one week. You come in and read the films, you pick up all the invoices, and you give us a check for $700. For our overhead."

"You mean I have to pay you to work here?"

They both chuckled. "No, no, doctor," the big one said. "You're looking at it the wrong way. You send the invoices to Medicaid, and they pay you the $1,000. And you've got $300, free and clear."

"How long does that take?"

"Oh," the little one said casually, "not more than 4 months."

"Wow," I said. "You mean, every week I give you $700, and 4 months later I get it back from Medicaid?"

"Well, more or less. You know, we have to meet our overhead here."

"I'm sorry," I said, getting up. "I don't have any money. That's why I was looking for a job."

"Sit down, sit down," they both said, still extremely genial. "No problem, doctor. We'll take care of everything, don't worry. We factor."

"Oh," I said. "What's that?"

"We'll help you out. We have a company that loans money to young doctors. You know, just until the bureaucrats at Medicaid get around to sending out your checks. That 4 months can be a long time."

I was learning. "How much?" I said.

"Just 10 percent. We try to help our doctors along."

"You're joking," I said. "That's 30 percent a year. How much do I keep? Eleven dollars?"

The two of them chuckled again. "You'll do very well," the big one said, "don't worry. It just takes a while for a young fellow like you to get started."

"You mean," I summed up, "you loan me money at 30 percent a year, and I lend the same money back to you for nothing? That's crazy."

"You're looking at it the wrong way, doctor," the little one said.

"I don't think I can afford to work here," I said.

They changed the subject. "Say, would you mind looking at a case for us? Our last radiologist got discouraged and left. This patient's been waiting weeks for his results."

I love to look at films. I examined their case for them, holding the films up to the window and squinting at them. It was an oral cholecystogram.

"Where are the rest of the films?" I asked. "This is a very incomplete study."

"Well," the little one said, "things have been kind of slow. The technician tries to save us a little money sometimes—the film is expensive. We've got a lot of overhead, you know."

"Yeah," I said, "you must have some electric bill for all those signs out there."

I inspected the films again, and made a learned discussion about adenomyomatosis and cholesterolosis. The little one looked at me absolutely blankly.

"What?" he said.

I figured maybe he was a psychiatrist or something, and he had been away from clinical medicine for a while. "What's your specialty, doctor?" I asked politely.

He thrust his hands into the pockets of his white coat and leaned back in his swivel chair. "Oh, I'm not a doctor," he said.

"Well, who are you?" I asked.

"I'm the executive administrator," he said. My partner is the doctor."

I turned to the bigger one. "What was your feeling about this case?" I inquired.

"Me?" he said. "I'm a chiropractor. We have a different concept of disease, you know."

"Oh boy," I said.

A family with a large number of children wandered into the office. "Excuse me," the mother said, "is this where we find out about the apartment that's for rent?"

"No, no," the chiropractor said, hustling them out, "that's down in the basement. Go back downstairs."

He came back in looking annoyed. "I don't know how they got past the guard," he said.

"Oh yes, there's one more thing." the executive administrator said, "You don't bill for any chest films."

"Don't you take chest X-rays here?"

"Oh sure," he said, "you'll have plenty of chests to read. But the pediatricians and internists like to bill for them."

"And I read them?"

"Well, yes," the executive administrator said. "The other doctors like to bill for them, but sometimes they miss things on the films."

"I bet."

"Yeah, well, you sort of check up on them, so they don't get sued. It's a service I like to provide for our doctors."

"That's very nice of you." I said.

"One more thing, doctor," the chiropractor said. "Some of the patients don't have Medicaid or Medicare, so you read those films for free."

"You mean like for indigent patients?" I said. "Sure, that's okay."

The chiropractor looked at me oddly. "We have no indigent patients," he said, "I mean for private patients."

"I don't understand. Why don't you bill the private patients?"

"Oh, we bill the private patients." the chiropractor said. "You don't bill them. It's sort of a service you provide for us."

"I still don't understand," I said. "Why do you get paid if I read the films?"

"Well," the chiropractor said, "with cash changing hands and everything, it's just easier. Ask around, all the Medicaid clinics work that way."

"Yeah," I said, "I bet they do."

It was the executive administrator's turn. "There just one more thing," he said, holding up an invoice. "See where it says 'diagnosis'? Never put down 'normal,' no matter what."

"But suppose that the films are normal?" I said. "Don't you ever get any normals?"

"Oh yeah," he said, "all of them are normal, just about."

"Well, what am I supposed to put down?" I asked.

"It doesn't matter what you put down," he said, "as long as you don't put down 'normal.' "

"You mean you want me to make things up? I can't do that."

"No, no, of course not," the executive administrator said, beginning to look impatient. "Just use the referring doctor's diagnosis."

"This is getting kind of tricky," I said, "Is this legal?"

"Would we break the law?" the executive administrator said. "Let's go downstairs, and we'll show you."

We all went back downstairs. The chiropractor had to go and reprimand a patient who was kicking the soda machine. The executive administrator led me to a tiny examining cubicle with (the name is changed) "R. Jacobson, Doctor of Chiropractic" on the door.

"This is Dr. Jacobson," he said. "Dr. Jacobson, this is the new radiologist. He needs some help in learning how to fill out the invoices."

Dr. Jacobson was crowded into the little room with a young, hulking, very healthy-looking patient. There were a couple of viewboxes on the wall, and this chiropractor was looking at some cervical spine films. Upside down. He stood up.

"Glad to meet you," he said. "The invoices are a snap to fill out." He gestured at the X-rays. "This young man, for instance, is suffering from a cervical radiculopathy."

"A what?" I said.

"A cervical radiculopathy. Look at the films."

I went over, and as casually as I could, turned the films right side up. "Where?" I said. "I don't see anything."

"Right there," the chiropractor said, pointing. "Look at those spurs."

"Those little osteophytes? Everybody has them. That's practically normal."

The chiropractor gave me a very hostile look, and motioned me out into the corridor. He closed the door on the patient.

"What's the matter with you?" he said. "Do you want the patient to hear you?"

"But there's nothing wrong with him on those films," I said. "Besides, if he's got neurological symptoms you've got to look at the neural foramina. You can't even see those on the lateral films. Where are the oblique films?"

"All you M.D.'s think you're so smart," the chiropractor said, retreating back into the examining cubicle. "You guys give me a pain in the ass." He slammed the door.

The executive administrator took me by the arm. "We don't take that many obliques here," he said. "We find we don't really need them. Don't worry, you'll catch on. Where are you parked?"

"Right out front."

"Come on, I'll walk you out to you car," he said expansively.

"Is the interview over?"

"Sure, sure," he said, lighting up a large cigar. "All these details are simple. Don't worry about them. You know, we're opening a new place in Queens next month. You might be interested in doing some work for us out there too. We're going to have a real empire. You're pretty lucky—you can get in on the ground floor."

We walked out into the street. "Oh, that's too bad," he said, looking at my ancient Volkswagen. "You've got M.D. plates on your car."

"What's wrong with that?" I said.

"Well, nothing. Just keep changing your schedule. You know, don't show up at the same time every day. Otherwise you might get jumped."

"Me?" I said. "Why would anybody want to rip me off? I don't have any money."

The executive administrator looked tolerant and amused. "The methadone. They'll think you've got the methadone. See you Monday."

3. "Getting the Job"

As the above example illustrates, the most important factor in getting a job in a Medicaid mill is a fondness for money. Qualification, training, and education are almost never discussed. Physicians repeatedly told investigators that the first two questions (and sometimes the only two questions asked) of a prospective job applicant are: Do you have a Medicaid number?; and, Have you got anything against making money?

The doctor in the foregoing example had the good sense to walk away. Others with fewer options, particularly foreign trained medical practitioners, have not been as fortunate. In a May 11, 1976, interview with the committee staff, one physician recounted his experiences:

> What the clinic administrator asked me first was, "how much do you want to make?" I said, "I don't know. I am new to this country. What is possible?" He said, "You can make as much as you want."
>
> I said, "What do you mean you can make as much as you want? What's the average? How does it work? How much do you get for seeing a patient?"

He said, "Well, you know, each patient you see averages $12, or something like that, and then if you order a lot of cardiograms you make more. If you order a lot of X-rays you make more. You make as much as you want to make."

I said, "Well, how am I going to get paid?" He said, "There are several ways. You can either wait for Medicaid to process your invoices and get paid in about 6 months, and then there is prepayment, where they pay 75 percent of your bills in 10 days and the 25 percent they drag out forever, or you can factor. You get your money right away but it costs you 12 percent interest."

So I said, "Fine, I'll factor." After several months I figured it out, and it wasn't 12 percent I was paying the factor but 48 percent. The time turnaround (for the factor's money) was 3 months. So, I thought, hey, I got to get out of this factor business. And I went down to the factor, which is Health Factors (determined to have billed nearly $25 million to New York's Medicaid program in 1974 by analysis of computer printouts). I said, "How much do I owe?"

He (the factor) told me $8,000 had accumulated. I said, "Give me all my invoices and I will give you the money." He said, "Fine, come back in 2 weeks." I went back in 2 weeks and he had a whole pile of invoices for me, and he said, "Here they are, let me have my money."

I said, "Let me add them up." He said, "Here, they are all added up." I said, "Let me look at them." I went through each one. They were 6-month-old and 10-month-old invoices. So I said, "These must have been paid." The factor said, "Well, there will have to be a reconciliation, come back in 2 weeks."

In 2 weeks when I came back it was $4,500. So I gave him a check for this amount and got the invoices and Medicaid paid me about $3,500 for them. I lost $1000, and that was OK. Then I got my income tax thing (an earnings summary) from Medicaid and they said I had made "X" amount of dollars, but I actually made $5,000 less.

You see I had no way of knowing what was billed under my name. I signed the invoices in blank. They were prepared up front. Lennie or whoever fills out the charts and sends in the billing form (to the factor) and you never see it again.

When the check comes in, it comes to the administrator, who gives me half, and that's the factor's check anyway. I never see the Medicaid check. I found out later that the factor and the administrator were very close. The factor owned the building and the administrator leased it from the factor. There are other things I could tell you but I really don't want to get into that.

The way this thing works, you're on the hook. They have your power of attorney, so you are liable for whatever they submit, and nobody worries too much about getting caught. The only thing you can get caught for is overbilling. There

was one guy that showed me the ropes. He was billing Medicaid for as much as he could because he was moving to California. What he did was to bill $12,000 a month, or $20,000, or whatever. I really don't know. But I know everybody he saw got everything possible (tests), and he had been doing this for several months. He had been factoring so the factor kept paying. Then he left and Medicaid stopped payment and the factor was left holding the bag. He was a young guy—in his early 30's. He died right after that. They said he had a heart attack.

All I know is that a lot of checks I never signed got cashed but I never got paid. Somebody would just endorse my name and the bank would cash the check. Someone would sign my name on an invoice and send it in. And I can't say anything, because if there is anything wrong on any of the invoices, the only one who is going to get screwed is me. It's in my name.

My impression is that you have to be a real pig to get into trouble. There was a radiologist who was billing for one-quarter of a million, or half of a million, out of his home. He got into a lot of trouble for doing that but there is no real control of the program. If I could live with myself I could do it very easily.

Every day, when I see a patient, I have to write down what I saw him for. I either write down 902b and I get paid $15, or 902e and I get $25, or 9004 and I get paid $7.50. Right now I write down that 9004, and I have no problems sleeping. But from the department of health's standpoint, you wouldn't be worried about them picking it (fraud) up. They never have and there is a lot of money going through those mills.

In places I worked, the administrator made a quarter of a million profit. I was seeing eight patients an hour (the doctor speaking is an internist) and they were pushing me to see twice that many.

4. How To Get Away With It

From what committee staff have been able to gather, it is common practice for clinic administrators or cheating physicians to "school" new doctors in the techniques of fraud. The best evidence of this practice is an investigative tape recording made by law enforcement officials in New York in 1975. It records a conversation between Dr. L, a gynecologist, and Dr. B, a pediatrician.

Dr. L.: You see the trick is never to put down or to charge for a patient you didn't see. When I billed for a SED (sedementation) rate or a CBC (complete blood count), or whatever, I always drew blood. Where the blood went I did not know.

Dr. B.: One of the most common things is to bill each patient as if it was his first visit, to get the higher rate. Suppose they hit you with that one?

Dr. L.: My attorney says, "I don't remember—I don't even remember what I put down for 95 percent of my patients."

He also says, "You're close to the statute of limitations, so stall. They are going to run out of time unless you give them the nails they need to drive into your coffin."

Dr. B.: Suppose they bring in one of their house doctors to examine your bills?

Dr. L.: I don't know what you did in your practice. You don't know what I did in mine. So what can the expert tell them? He'll say, "He is a good doctor so far as I know." The nurse, is she going to argue? She wasn't even in the room with you when you saw the patient. So you come down to the patient. He is going to say, "What, I only saw the doctor 10 times in 3 years." You see there are only three parties—doctor, nurse, and patient. The doctor is easy to wrap up, the nurse doesn't know, and the patient isn't going to remember.

If the patient walks in here and I bill him [sic] for a vaginal smear, what is he going to say? How is he going to describe what I did and didn't do? How is he going to know how long it should take or what the procedures are?

If they ask you did you ever put down for a patient you didn't see, you say, "I don't recall." If they ask you would you do that, you say, "No, that is dishonest. I wouldn't even think about it." "Did you do these procedures?" You say, "I wouldn't even think about it." "Is this your signature?" You say, "Yes, but that's not my writing. The girl did the work. I should read it more carefully, she must have made a mistake."

Dr. B.: I see.

Dr. L.: I am trying to tell you doubts. You create doubts. Who can disprove it? The nurse? Do you think she can remember any better than you? The nurse is out. The doctor is out. I am not going to cast mud on anyone. The patient, that's where it's at, that's the one they are interviewing. Patients from 3 to 4 years ago. And you know the type of intellect patients have to begin with. This is why I never put down for a CBC, or a SED rate, or whatever, if I don't draw blood. They remember if you give an injection. I don't like going through the routine of doing it but it must be done.

Dr. B.: Yeah.

Dr. L.: There is no way to prove a thing. Even if they show you the worst piece of paper you ever wrote, there is no way to prove a thing. You never put through for a patient you didn't see. The patient might have been on vacation or in the hospital. That's the only way that they can hang you. I'm not that stupid. It is stupid to write bills on patients you didn't see, on dates you weren't in your office. Other things (kinds of fraud) are all right. But if you put down anything strange, you'd better set a date or a note explaining it. Those are the things they look for.

In sum, as one Illinois practitioner put it, one patient can generate revenue for a medical facility in excess of $250 for a single visit. The process he described is as follows:

The patient comes in with a complaint. He or she wants to see the doctor. They receive them, process their papers, and they do see the doctor. The doctor evaluates and makes a diagnosis. In any event, he writes prescriptions and drug orders, laboratory orders, X-ray orders, and the patient returns to the waiting room. While they wait, they are asked if they want to see the dentist, the eye doctor, the foot doctor, the chiropractor, or any of the other health providing services that are in this particular unit. They make the trip from one to another like a roundrobin or a merry-go-round. The patient is really unaware that he is being manipulated. It is a simple matter, and then there are ways of increasing the laboratory work. The doctor may order a urinalysis or a blood chemistry. If you are not familiar with medical terminology or the way that laboratory sheets are set up, it is a system of boxes and "X's." So a doctor checks two, and the firm or the administrator or whoever checks six. You have increased the amount of laboratory work six times. Where a urinalysis and a blood chemistry test will run roughly $20, if you check the additional boxes on this list, you'll run it up to $150.

The more volume the more money is what it amounts to. The mother may be the prime patient, but she'll be asked, when has the youngster had his last shots, or has he seen the doctor lately, or the dentist, and usually, since its free, it's, "Sure, take Suzy in, or Johnny, or whomever."

5. Buying a Medicaid Mill: The Executive Level

To further test the profitability of Medicaid mills and to gain more insight into their financial arrangements, the committee staff decided to pose as businessmen interested in buying Medicaid mills. Mills change hands frequently; there is a lively market in such facilities. In fact, the Medicaid mill has been described as the fastest growing industry in New York. This traffic in Medicaid mills is commonly indicated by advertisements in the classified sections of metropolitan newspapers.

In order to provide appropriate cover, a corporation was established and common business cards were printed. The company's name was listed in the real names of Senate investigators. An answering service was established to respond to calls. With this slight cover, a number of inquiries were initiated and a wealth of information provided.

Investigators answered advertisements in the *New York Times*, and then, with the assistance of our accompanying physician, introduced as an apparent business partner, pretended to be interested in buying into the Medicaid mill business.

IN THE SHADOW OF YANKEE STADIUM

On Monday, May 17, 1976, a telephone call was placed in answer to the following advertisement from the *New York Times*: "Medical Center for sale. Great location, West Bronx. Call. . . .

An appointment was made to meet with the owners on the following day. We were told to look for a man wearing a brown leisure suit standing outside a mill on East 161st; he identified himself on the telephone as Mr. P, a C.P.A., and a partner in a firm located in White

Plains, N.Y. On the 18th, Associate Counsel Val J. Halamandaris and a cooperating physician met a man so-clad who identified himself as Mr. P.

He explained that he didn't want buyers trooping in and alarming the mill's practitioners who hadn't been notified of the pending sale. After waiting on the street corner for some time, Mr. P invited investigators into a small, narrow, one-story facility. The building was approximately 20 feet wide and 125 feet long.

Walking through the front door, investigators found a bare waiting room about 14 feet square which boasted only a few chairs, a television set, and a reception desk. Separated from the waiting room by a wall was a pharmacy which also had entry from 161st Street. The pharmacy looked to be about 6 feet by 20 feet deep.

Investigators were invited into the working area. Passing the two small public lavatories, Mr. P explained the large amounts of water which was apparent, buckling the carpet, by saying the toilet had overflowed. Noting the stains of past floods, investigators asked him if this was a recurrent problem. He replied, "What can you do? The pipes are old and these people come in—they don't know any better; they throw all kinds of things into the toilet."

The first impression of the work area was a long, narrow hall running the length of the building separating the examining rooms. These rooms were about 8 feet square. In stepping toward the back of the building, the investigators saw signs which indicated dentistry, an office of some sort, podiatry, and X-ray on the left; with pediatrics, two or three medical examining rooms and a storage area on the right. In the very back of the building there was a 6 by 9 foot room which contained a Eureka 15 X-ray machine and a small alcove with film and a cheap DSP processor (developer). No lead insulation was apparent in the X-ray room.

Toward the middle of the building there was a second X-ray, a dental machine, which was stored in the middle of a hallway leading toward a side exit. Again, there was no evidence of lead shields or other protections against the possible damage which may be caused by X-rays. In the small office occupied by the podiatrist was a third X-ray unit.

During the time of this staff visit, the dentist, Dr. Q, was occupied showing the financial records to another prospective buyer. He was asked out into the hall momentarily to meet investigators, spoke to them briefly, and suggested that Mr. P take the investigators to a nearby cafe for coffee, saying he would join us as soon as possible.

At the nearby restaurant, Mr. P unraveled the financial details of the clinic's operation, indicating that it was a most profitable venture and that it could become even more so with the right kind of people who would like to work at it. Dr. Q soon joined the party. Dr. Q announced that he was prominent in the New York health providers association. He added that they had a third partner.

In the course of the discussion, Mr. P made several allusions to the profitability of the mill, showing investigators the log book indicating an average of 100 patient visits a day. He lauded the excellent location of the clinic, in the shadow of the renovated Yankee Stadium and right on a subway stop. He added that his internist made $100,000 a year. He described leasing arrangements totaling $3,200 a month. These included $1,000 a month paid by the pharmacy, $1,200 by the internist, $500 by the optician, and $500 by the podiatrist. Asked if these amounts

varied with the volume of Medicaid business, they answered in the affirmative. They added that since they owned their own X-ray equipment they would receive 75 percent of the radiology billings. Dr. Q added: "You can also get a percentage from the clinical laboratories. I don't even want to talk about it. But they all pay a little something. If you shop around, you can do pretty well for yourself.* "

Later, Mr. P stated that, "One thing good, if you buy this place, is that no one can open up within 20 blocks of you."

Dr. Q also indicated that the clinic had the help of friends, including one social worker who sends in patients to the clinic. He added that the practice was strictly legal and that the health department knew and sanctioned the idea. Asked if he paid the social worker anything, he said, "No, but I give her the use of my car, things like that."

Asked why they were selling, Dr. Q indicated that he was spending too much time administrating and that he only wanted to take care of patients. Mr. P said he wanted to spend more time with his family. He also made oblique references to another Medicaid mill they had an interest in which had burned down and some suggestion of heavy debt.

When asked to further sketch liabilities, they indicated a 9½-year lease paying $1,750 a month in rent to a firm located on Long Island, N.Y. With utilities, they had total monthly outlays of $1,900. Mr. P. also indicated something about paying $8,000 a month in short-term renovation loans. It was not clear whether they meant the current facility, the one that burned, or something else.

Pressed for details, they said: "Just come in the office and you can see the books for yourselves," adding that another time would be better since both had commitments. Mr. P was going to little league practice. Investigators stated an interest in bringing "our accountant" to go over the figures and the mill principals agreed.

Mr. P stated that they wanted $60,000 cash and that "whatever deal we would like could be arranged." Dr. Q indicated he would be willing to "sell out his dental practice" or to continue, *providing he would receive 50 percent of his billings*. He offered to serve as a consultant or to work in any other way.

The conversation ended with a discussion of how to, in Dr. Q's words, "optimize" patients. He asked our cooperating doctor for his specialty. His face lit up when the helpful physician stated he was an internist. "Everything depends on having a good GP," said Dr. Q. "I have one now who isn't worth a damn. She is satisfied with her lousy $75 or $100 grand a year. I don't get any referral from her. You have got to make maximum use of the patients who come in your clinic. We're doing $3,000 worth of X-rays a week now; we should be doing $9,000. You've got to work at it. You've got to push. That is the only way to succeed in this business. With the right kind of people you can do very well for yourselves." Mr. P excused himself, saying he had other appointments and would be glad to show the committee staff the books.

Before leaving, Mr. P reassured investigators as to the profitability of the venture, saying: "If I were you guys, I would get in on this. It's a great deal, especially for a young doctor just getting into practice. If things go bad, you can always sell out," he reassured, "or take out a lot of fire insurance. A lot of mills in this area have been burned

*Quoted excerpts are based upon notes made immediately after the conversation.

out, including one owned by the pharmacist across the street," added Dr. Q.

The interview was terminated at this point; Mr. P raced to his car, reaching for a business card, which he gave to investigators saying, "Let us hear from you."

THE FATHER OF THE STOREFRONT CLINIC

On May 19, another advertisement from the *New York Times* was answered by committee investigators who immediately recognized the name of the man who answered the telephone as an extremely high-volume provider with a protracted history of fraud and abuse of the Medicaid program in New York. A tentative appointment was established for the following afternoon.

Because of the detailed file on this provider, the U.S. attorney's office was notified. After a short discussion, that office provided Senate investigators with a recording device.

The following statements are taken from a recording made of the subsequent meeting. In the course of the conversation, the subject of the interview made a number of statements and specific allegations involving fraud, bribery of city officials, union racketeering, arson, and the involvement of organized crime figures in the ownership of Medicaid mills. These matters are now under investigation by the U.S. attorney's office. For that reason, the names of all parties concerned are withheld:

> Essentially, I'm the dentist here. This is my practice. I have been in the area since 1964. I have been in Medicaid approximately 17 years. I was in Medicaid from the very inception. I was across the street in my own medical center which burned down, and I had everything, you know, long-term medicine, the whole works. And I was one of the pioneers; I had one of the first storefront operations in 1966 with—we had eight dental chairs and I had about six full-time dentists, two part-time dentists, and other providers. Then we had a fire, and the whole place burned down. You know, the insurance just barely covered enough, and this place was available.
>
> * * * * * * *
>
> I have since opened up in Florida. I have a group of clinics. I have one in South Miami Beach. My brother is running it. We just opened up in Winston Towers, north of Hollywood.
>
> * * * * * * *
>
> An internist is the key to the whole thing. An internist—its unlimited with an internist. I can sit down with you if you are really interested and show you how an internist can make so much money it is ridiculous.
>
> * * * * * * *
>
> I am telling you this is a safe investment. They have been saying its [Medicaid] folding every year since I can remember and I have been in Medicaid since the beginning—since

Rockefeller signed the bill in 1966. Every 6 months they were saying: "It's out, it's out!" There is always a crisis. And I went right in and opened up a store. At the beginning—people thought I was crazy at the beginning. In my first year . . . up until I practiced under Medicaid I never made $100,000 . . . I made over $200,000. I can show you my income tax returns for 1966 and 1967. I am prepared to show you that.

* * * * * * *

In dentistry a man should do $300 a day; if you don't you're in bad shape. You give him [a hired dentist] $100, and you take $200. You pay him a salary and that is it, or you can pay him 35 percent, 45 percent, 50 percent, depending on what you want to do. If you manage the place properly, you should give the guy—it should be a 60–40 split. You get 60 percent, he gets 40 percent. Some people get 35 percent.

Asked if this amount (35 percent) would include income from X-rays, the subject responded, "He doesn't get anything. Nothing. He's a puppet. He is just there. He is a worker and you're the boss."

Asked about chiropractors, the subject responded that he gives them the same arrangement—a 60–40 split.

What does it cost to run this place? It costs $950 for this place and $200 for the drugstore. Together you are talking $1,150 every month. I tell you what you should get in rent. After about 3 months, you should get a minimum of about $1,500 from the chiropractor, and $1,500 from the podiatrist. The pharmacist is on an escalating lease. It is at $800 at the present, but it escalates in $200 increments. And then you've got your dentist and MD's and the rest. You've got your rent free, you've got everything. I can't talk really freely with you, you know. I don't know who you are. I just can't tell you everything about what I know, you know. . . . It is good to have a 38-caliber pistol around; it doesn't hurt. These are some really rough times. Let's not kid ourselves.

* * * * * * *

You can make a nice buck with insurance if you feel like going that route. People have done it, don't laugh. You've got to insure for a couple of hundred thousand dollars and that is it. Then if it burns you collect your money and you're out.

* * * * * * *

It is a good business to be in, I'll tell you. Whether you buy mine or not, it is definitely much better than investing in something like Wall Street.

* * * * * * *

One of my places in Florida is for sale, too. It is a beautiful spot. It's super. The volume down there is seasonal, you understand, but it is beautiful. Only down there we don't call it Medicaid, its Medicare. There is no dental medicine down there. It's radiology and very heavy on the EKG's. Everybody's into internal medicine and cardiology. My

brother is the internist there and we can make you a whole package deal.

Asked if he has flat rental arrangement or percentage arrangements in Florida, he replied,

Percentage, 55–45 all across the board. The owner gets the 55.

* * * * * * *

Any kind of deal can be done here. Anything. The deal here is what you want it to be, but you've got to have doctors. That is the whole thing. Now, if I was an intern, I would go to the medical societies and I would join everything in sight. You've got to know a lot of medical doctors. You've got to really be able to get to them. It is like a stock exchange. You've got to have new doctors on the line all the time.

* * * * * * *

You really want to do a job? Then you go down to the hospital, say your name is Malcolm X or whatever you want to call yourself, walk into an office there and ask to speak to someone in personnel. Tell them "I would like to see some patients as soon as possible. I would like to do more union work." You should talk to one of the girls, and the secretaries, and say, "Look Hon, spread the word around." You've got to hustle. You know? There is no other way. You go talk to Mr. ——— [a union leader] and he puts you on a panel.

Asked if the union leader is going to want some money, the subject responded "Yes." Asked "How much is he going to want?" the subject answered:

I am not at liberty to tell that but he is going to want something. You'll have to make your own connections.

There are lots of kickbacks you can do in dentistry and medicine. I mean, I know guys that have got sweet things going with their suppliers. And they pay list price and get a nice cash rebate on it every month. I mean, I can tell you a million ways to make a buck in this kind of field.

Asked for a couple more examples, the subject said:

I can't, I don't want to go to jail. Maybe you have a tape recorder on you.

Medicine is a business like any other business. It is a very big business. I was approached by a guy about 3 years ago who wanted to get into the Medicaid business. And I had a very nice deal for him. Unfortunately, at that time, there was a big war going around between Columbo and Gallo and the guy disappeared from the face of the earth. He just vanished. He was a beautiful guy, too.

I can teach you the business very good. You've got to be a doctor and a businessman. Then you'll do very well. I gave it a little more than 5 years of my life and that was it. I did very well. Every dollar, I made. I didn't inherit a thing. I live very well. It's all from Medicaid. Okay? A place in Darien, a place in Vermont. All from Medicaid.

E. FEE SPLITTING AND PERCENTAGE LEASES—COMMON PRACTICES IN MEDICAID MILLS

The committee found in its investigations that fee-splitting and percentage lease arrangements were common practices in New York, New Jersey, Illinois, California and Michigan and that they go hand-in-hand with Medicaid mills. In fact, the percentage lease is at the heart of the array of economic incentives which encourage the formation of Medicaid mills.

As noted earlier in this report, such practices present serious moral, legal, and ethical questions and have been debated for years by State and Federal elected and appointed officials and professional legal and medical societies.

The percentage lease undeniably increases providers' propensity to commit abusive practices. These leasing agreements which give the landlord a percentage of the provider's gross income in return for office space, equipment, and various administrative services. The Association of Health Care Facilities, Inc. (hereinafter referred to as "the association"), a New York City group representing owners of about 123 Medicaid mills in the city, estimates that the average percentage lease is anywhere from 30 percent to 40 percent of the provider's gross fees for most medical disciplines. The association also estimates that in the field of radiology a radiologist generally pays anywhere from 60 percent to 75 percent of his gross to the owner of the building. The reason for the higher rate for radiologists, the association claims, is the higher cost of X-ray equipment provided by the landlord. In recent court testimony, Mr. Cyril Sack, president of the Mermaid Medical Building Realty Corp., said he had based his 35 percent lease on information from an AMA journal article which said the overhead cost of a private physician's office was 35 percent. Mr. Sacks' corporation owns a building in Brooklyn leasing to 14 medical professionals on percentage leases.

In New York City, most of the percentage lease arrangements are in what are known as "Medicaid mills," "Medicaid clinics," or "shared health facilities". These are buildings owned by an individual or individuals, usually in a partnership or corporation arrangement, who lease office space, equipment, shared waiting rooms, laboratory services, custodial and office help, and often administrative services to a group of doctors. Each doctor usually has a separate lease which in most cases is an oral, not written lease. Such facilities began to flourish in the city in 1971 and are always located "in the areas where the medical indigents are located," according to the association. The primary, if not exclusive, source of income for these facilities is Medicaid. It is estimated that there are currently 451 such facilities in the city and that at least 66 percent to 75 percent of all individual Medicaid providers in the city are located in these facilities.

In some cases the owners of these facilities own more than one facility. The owners sometimes are providers themselves on the facility premises or at another location. In other cases the owners are also owners of pharmacies or laboratories located on or near the facility and often are used as the exclusive lab and pharmacy service by all providers in the facilities. Dr. Morton Kurtz, secretary-treasurer of

the Queens County Medical Society, estimates that at least 15 percent of the owners of such facilities are physicians.

The percentage of gross fees lease arrangement has been ruled unethical conduct for physicians by the American Medical Association (AMA). Opinion No. 23 of the AMA's judicial council states:

> An arrangement by virtue of which a physician leases office space for a percentage of gross income is not acceptable; it is violative of ethical principles. The practice indirectly results in fee splitting and tends to exploit the practice of medicine. If the size of a doctor's practice increases and imposes additional demands on the facilities of the building, these facts may be considered when the time comes to renegotiate the rental value of the leased premises, and a new fixed rental, taking these items into account, might be agreed upon.

The AMA has defined "fee-splitting" in the judicial council's opinion No. 16:

> By the term secret splitting of fees is meant the sharing by two or more men in a fee which has been given by the patient supposedly as the reimbursement for the service of one man alone. By secrecy is meant that the division of the fee is done without the knowledge of the patient or some representative of the family. It includes those cases in which the term assistant is used as a subterfuge to obtain a part of the fee which otherwise could not be rightfully claimed.

The AMA also has ruled as unethical the acceptance of rebates on prescriptions and appliances, the ownership of clinics or laboratories by joint stock companies composed in part or in whole by physicians, and the percentage lease renting of pharmacy space for a pharmacy owned by a physician or physicians.

These ethical standards are not necessarily legally binding, but they are the standards of the national professional society of the Nation's physicians. However, members of the AMA do agree by virtue of membership to abide by the AMA's "principles of medical ethics" and the judicial council's rulings as standards by which they "may determine the propriety" of their conduct "with patients, with colleagues, with members of allied professions, and with the public." They have no effect whatsoever on other medical professions and, in fact, the American Dental Society has no such rulings on fee-splitting.

Enforcement of the AMA's rulings and principles regarding fee-splitting is the responsibility of local societies. The judicial council's opinion No. 20 states:

> Fee splitting is to be condemned wherever it may be found, and component societies and constituent associations must purge their membership of any who willfully refuse to desist from such practice, the continuance of which can only bring dishonor and reproach on the medical profession.

The State of New York Medical Society does not explicitly prohibit fee-splitting in its "Principles of Professional Conduct" (hereinafter referred to as "principles"). The State society's principles do prohibit physicians from having financial interests in an optical dispensing

facility or pharmacy unless prior approval is obtained from the local county medical society (chapter I, section 5, "principles"). The "principles" also state it is unethical for a physician to "engage in barter or trade in the appliances, devices or remedies prescribed for patients" and further states:

> He should receive his remuneration for professional services rendered only in the amount of his fee specifically announced to his patient at the time the service is rendered or in the form of a subsequent statement, *and he should not accept additional compensation, secretly or openly, directly or indirectly, from any other source.*

The enforcement of these "principles" is basically with the local county societies.

Dr. Mortin Kurtz, secretary-treasurer of the Queens County Medical Society, in recent court testimony said his society views the percentage of gross fee leasing arrangement as unethical. However, his local society apparently has not taken any action against doctors involved in such leases despite knowledge and evidence of such participation.

In New York, the practice of fee-splitting vis-a-vis percentage leases appears to be governed by a 1971 opinion by the State Department of Education. In 1970, and again in 1971, Mr. August J. Bardo, Jr., then director of the department's division of professional conduct stated that:

> It would not be illegal, on the other hand, for a physician, dentist, podiatrist and chiropractor to conduct their separate and independent practices on the same premises, and pay the landlord a fair percentage of their gross income for the rent and shared services.

The Bardo opinion did not specify what was "fair percentage" and did not clarify whether the facilities operating in New York City could be defined as having "separate and independent practices" in view of existing evidence as to their operations.

The Bardo opinion went on to say:

> However, such rental may not be based upon net income. It would be the substance and not the form of the arrangement that would determine its legality, any interference or control by the landlord over the practice of the profession would be illegal.

Evidence presented to date indicates that the percentage leases in the facilities in question are not based on net income. However, in court testimony the association and individual facility owners have admitted that the leases are generally oral and often the landlord also operates a pharmacy or lab utilized by the professionals in his facility. There has been no ruling as to whether such "oral leases" and/or ownership of labors or pharmacies serving the facility per se or in individual cases constitute "interference or control by the landlord over the practice of the profession."

The State and local county medical societies as well as the State department of education, health, social services, and law all appear to

abide by the Bardo opinion and until last month had not taken any action against such "gross" income percentage lease arrangements despite the unanswered questions in the Bardo opinion.

On June 7, 1976, the committee sent a detailed letter to Mr. Robert Stone, counsel to the New York State Department of Education, questioning the policy set forth in the Bardo opinion (see appendix 2). By a letter of July 6, 1976, Mr. Stone advised the committee that effective August 31, 1976, the commissioner of education and board of regents had amended the commissioner's regulations so as to rescind the Bardo opinion. The amended regulations prohibit the use of either gross or net income as a basis for leasing arrangements for space and other services between landlords and any licensee in the 13 health professions in the State of New York (see appendix 2). They also state that any health professional who has a *financial interest* in a percentage leasing facility is subject to unprofessional conduct charges. Any professional violating the new regulation is subject to disciplinary action by Education.

The committee staff believes this change in policy is long overdue and that it may provide the first major legal inroad against Medicaid mill operations, if properly communicated to and implemented by the appropriate State and local agencies.

In June 1975, the New York City Department of Health attempted to attack the percentage lease problem and to generally gain regulatory control over the "shared health facilities." Such facilities currently are not subject to regulation by the State or city since they are not included in the definition of "clinics" in the public health law (see article 28, section 600.7). The only regulation is over the individual professionals at the facilities in their capacity as Medicaid providers.

The city attempted to regulate these facilities by amending its local medical plan with item 230 by requiring registration of all such facilities with the city and a variety of prohibited practices and administrative requirements, including a prohibition on percentage leases of any type, a requirement that all leases be in writing, and access of the city to all records of the providers.

The Association of Health Care Facilities, Inc., successfully received a temporary and then permanent restraining order prohibiting implementation of item 230. The case is now being appealed by the city.

In the opinion, the judge stated the paying of a sum equal to a percentage of the physician's gross income "is neither illegal nor unethical" and that such practice "has long been recognized as legal, proper and ethical in many professions and businesses." However, the opinion made no reference to the AMA judicial council's rulings or the limits of the Bardo opinion. Furthermore, in the transcript of the case, argued in July 1975, the judge specifically stated that he was not concerned with the AMA's opinion on percentage leasing.

The judge did say that the plaintiff association and its members who designate themselves as "health care facilities" "would be well advised to change their names and their signs on their buildings." He did not pass upon the right of the city "to seek an injunction restraining the use of the words 'health care facilities' or 'medical clinics' by those not conducting such facilities or clinics."

Case Examples: Mermaid, Parsons, and Medical Facilities, Inc.

The item 230 court case revealed three case examples of typical facility operations of two coplaintiffs with the association (Parsons Group, Inc., and Mermaid Medical Building Realty Corp.) and the operation of the association's president (Medical Facilities, Inc.)

MERMAID

Mermaid owns a building at 3108 Mermaid Avenue (Brooklyn, N.Y.) which is called "Community Medical Clinic." At various times since its opening in June 1974, there have been between 10–14 medical professionals leasing space and services in the building. As of July 1975 there was a surgeon, chiropractor, dentist, podiatrist, phychiatrist, neurologist, dermatologist, radiologist, pediatrician, dentist, and pharmacist. Initially all held individual oral leases on a fixed rental basis, but 6 months after the "clinic" opened they were changed to oral leases based on an average of 25 to 35 percent of the individual practitioner's gross income. In return, Mermaid supplies each practitioner with a private office, shared use of waiting rooms, laboratory, custodial help, central maintenance of records by a Mermaid employee, and a "clinic" administrator paid by Mermaid. An estimated 600–800 patients come to "clinic" each week and 85 to 90 percent of all the providers' income at the clinic is from Medicaid. The building owners state that they exercise no control over the individual practices of the medical professionals.

The building is owned by Mr. Cyril Sack, president, and Mr. George Greene, secretary-treasurer, who are the only officers and sole shareholders of Mermaid Medical Building Realty Corp. Mr. Sack states that he is at the "clinic" from 9 a.m. to 6 p.m. daily and receives no salary from the Realty Corp. He gave no information as to Realty Corp.'s annual income or his or Mr. Greene's gross or net share of said income. Mr. Sack said his capital for the realty venture was derived from personal savings.

Mr. Sack said his income is derived from ownership of four pharmacies. Mr. Sack is not a registered pharmacist, according to the court papers, and did not divulge his income as an owner of the four pharmacies. However, data provided to the committee staff by the State department of education indicates that Mr. Sack was a licensed pharmacist in New York State until 1975, at which time the State board of regents revoked his license for unprofessional conduct. He admitted that three of the four pharmacies are located in Medicaid clinics (in Bronx and Brooklyn) and one is an independent retail store.

One of the pharmacies is located in the "clinic" on Mermaid Avenue. It is owned by the "3108 Mermaid Drug and Surgical Corp.," whose officers are Mr. Sack and a Mr. Franklin Sack. Neither man is a registered pharmacist and they employ pharmacists at the Mermaid and other pharmacies. Mr. Cyril Sack stated he receives a salary of $400 per week (approximately $21,000 per year) from the Mermaid pharmacy. This is exclusive of any salaries he draws from the other pharmacies, his income as an owner of the Mermaid and the other three pharmacies, and his income as president of the Mermaid Realty Corp.

Mr. Sack provided no information on these potential or actual income sources and did not indicate whether he had a property interest in the other two "clinics" where two of his other pharmacies are located.

Mr. Sack said the Mermaid pharmacy "fills most of the prescriptions written by the doctors in the building and pays the realty corporation a rental of 20 percent of its gross income."

Mr. Sack said the providers in the clinic use the Clarendon Laboratory, but did not indicate where the lab was located, or if he (Sack) had any direct or indirect financial relationship with the laboratory.

PARSONS GROUP, INC.

Parsons Group, Inc. (hereinafter referred to as "the group"), is the primary lessee of a building at 88–01 Parsons Boulevard in Jamaica, Queens. The "group," which began operation in 1972, in turn sublets individual private office space to about 30 physicians. There are currently 21 offices in the building for the 30 physicians. One office is a dental office operated in partnership by three dentists who employ a fourth dentist. All physicians are Medicaid providers. The sign on the outside of the building does not list any specific names of physicians.

Each sublessee has an oral lease with each physician at an average rental of 40 percent of the physician's gross income. According to Mr. Thomas Panebianco, an attorney and president of both "the group" and the 8801 Parsons Corp. (which owns the property), said that the lowest percentage lease is 35 percent and the highest was 60 percent charged to a radiologist. Mr. Panebianco maintains a law office five to six blocks away from the building (146–08 Hillside Avenue) and the individual providers' Medicaid payment checks are mailed by the city to either the 88–01 Parsons Boulevard address or Mr. Panebianco's law office address. Mr. Panebianco did not state whether he operated as a "factor" for the providers—factors usually receive a 12 to 15 percent commission on the providers' Medicaid income—or provide any data on his financial remuneration from "the group" or the realty operation. He also gave no information on other officers, partners, stockholders or other beneficiaries involved in "the group" or realty operation.

In return for their rental the providers receive individual office space, shared waiting room facilities, custodial staff and administrative support services from "the group." There are administrative offices on the premises and a clinic administrator employed by "the group." Among other duties the administrator places ads in newspapers to lease space and selects the lab to be used by all of the providers in the building. The lab used is Biostat Laboratories. No further data was provided regarding the laboratory's relation to "the group," the realty corporation, any of the providers, or Mr. Panebianco.

There is a "3653 Broadway Pharmacal" located at the 88–01 Parsons Boulevard address. While the phone number for "the group" is different than for the pharmacy, the receptionist for both phone numbers answers, "Good afternoon, Parsons." No further information is available regarding the pharmacy, although it appears to be the pharmacy used by most, if not all, providers at 88–01 Parsons Boulevard.

MEDICAL FACILITIES, INC. AND THE ASSOCIATION OF HEALTH CARE FACILITIES, INC.

The founder of the association was Mr. Owen McCormack who originally incorporated the association in October 1974 as a not-for-profit corporation. In court testimony in July 1975, Mr. McCormack said the association was originally formed to deal with a union (Local 143) which was trying to organize at Mr. McCormack's facility (Medical Facilities, Inc. in Bronx) and several others. Mr. McCormack estimates the association currently has 70 members who owned among them approximately 123 facilities.

Mr. McCormack was a public relations and public affairs representative before opening Medical Facilities, Inc. (MF) in 1969. Medical Facilities is located at 481 East Tremont Street, Bronx, N.Y. Mr. McCormack serves as president and treasurer and Mr. John Faux is secretary.

Medical Facilities leases space to physicians under oral leases based on 40 percent of the provider's gross income. A radiologist pays on a 60 percent basis. Mr. McCormack said all leases were originally written, but in 1971 they were changed to the oral form and he simultaneously instituted a central recordkeeping system. He gave no further details as to the providers at or operation of Medical Facilities.

Mr. McCormack also said he owns and operates a pharmacy and has a residence at the same address as Medical Facilities.

DENTAL EQUITIES, INC.

One classic case of the entrepreneurial aspect of "Medicaid mills" involves two dentist brothers, Alan and Howard Cohen, who set up a corporation called Dental Equities, Inc., in 1968. The corporation's aim was to find buildings in ghetto areas which could be converted into dental practices so as to take advantage of the high concentration of Medicaid recipients in such areas.

On July 12, 1968, Dr. Alan Cohen sent out a letter to some dentists in an apparent promotion campaign for Dental Equities. It read, in part:

> Your earning potential since the advent of Medicaid has been dramatically increased. We can help you realize that potential. Success and financial security are more readily available than you might think.
>
> We will furnish you with your own fully equipped modern dental office. No capital investment is required. We would like to meet with you to discuss our "unique arrangement."

At the heart of the "unique arrangement" was a lease rider which bound client dentists to hand over a percentage of their gross to Dental Equities on a scale ranging from 20 percent of the first $200,000 and ran to an additional 10 percent on income over $300,000 a year.

The Cohen rider also included one way for the dental client to escape from its terms: "In the event the existing Medicaid program is terminated, or if the program terminates treatment of dental patients for general dentistry in private offices, the tenant may cancel and terminate this lease."

Initially, response was excellent. Dental Equities filled about a dozen properties . . . providing space and equipment. The Cohen rider also

commanded that the tenant dentists surrender full access to their books so Dental Equities could insure it was not being shortchanged.

In late 1968 or early 1969, an investigation was begun by the State department of education to determine if the graduated scale lease arrangement constituted fee splitting. On August 6, 1969, the counsel for the State education department, which regulates such matters, ruled that the lease had not run afoul of the law and Dental Equities was permitted to continue in business. As previously noted, the American Medical Association has formally held the percentage lease practice to be unethical for physicians. "If this isn't fee splitting, it's fee splitting's cousin," said an AMA spokesman. But as a Dentist Cohen is not subject to AMA sanction and dental professional groups have adopted ethical standards less rigorous than the AMA's.

Also the AMA's ethical standards on fee-splitting, as noted earlier, are basically not recognized or implemented by professional societies or State agencies in New York. As of August 1974 Dental Equities still owned three such properties.

The Cohen brothers are also involved in ownership of a Medicaid-dependent methadone clinic, dental practice, and factoring company all in Bronx. These are discussed in greater detail in the section of this report on "Methadone Maintenance."

F. METHADONE MAINTENANCE

Another major area of Medicaid fraud and abuse is methadone clinics. These clinics have some unique characteristics, but also share all the problems of fraud, abuse, and excessive third-party intervention which the committee has uncovered in Medicaid mills.

An estimated $30 million in Medicaid moneys a year is spent on methadone maintenance in New York City for approximately 33,000 clients in privately operated clinics. Of these moneys, approximately $18 million goes to "non-profit centers" (i.e., city clinics and hospitals) servicing 22,000 patients and the remaining $12 million goes to private clinics servicing approximately 11,000 patients. The private clinic share constitutes about 55 percent of all persons in all methadone clinics in New York City and almost 45 percent of *all* expenditures and 40 percent of all MA expenditures for such operations. The Medicaid payments for private clinics go directly to individual MA providers since they operate the clinics and bill Medicaid under their name.

Methadone clinics in New York State are subject to requirements issued by two Federal agencies (National Institute for Drug Abuse and the Drug Enforcement Administration), three State agencies (Office of Drug Abuse Services, Department of Health, and Department of Social Services), and three local agencies (Health, Social Services, and in New York City, the Addiction Services Agency).

Methadone clinics are reimbursed either on a "fee for service" basis or a Medicaid rate established on overall program costs. In the latter case, the program must meet all establishment standards of the Public Health Council (art. 28, Public Health Law) and their reimbursement rate is set by the Health Department's Bureau of Health Economics in the same manner rates are set for nursing homes. There are between 15–20 "fee for service" clinics in New York City. All are

75-902 O - 76 - 6

privately operated and receive reimbursement at the rate of $4 per patient visit. A $6 average per patient visit rate applies to private clinics outside the New York City area.

A total of approximately 116 non-proprietary clinics in New York City receive the article 28 rates which range from $8–$20 per patient visit. Approximately 39 are operated by the City itself, 8 under direct State operation (Office of Drug Abuse Services (ODAS)), and 69 are "public-non-profit." Of the 69 "public-non-profit", most are operated by hospitals with another 9 operated by the Addiction Research and Treatment Corporation (ARTC) and one by Narco Freedom, Inc.—a "not-for-profit" corporation located at 2780 Third Avenue, Bronx.

The Mary Scranton Clinic

In fact, the highest billing Medicaid physician in the nation is Dr. William Triebel who received $857,000 from Medicaid in 1974 for operating his Mary Scranton Clinic in New York City. Dr. Triebel's billings for the clinic's main office at 205 Second Avenue alone were $451,156. The Mary Scranton Foundation, Inc., a "not-for-profit" entity, is the parent organization and also operates clinics at 2 other New York City locations—400 East 77th and 2 West 116th Street. The total Medicaid billings for the three Scranton clinics in 1974 was approximately $857,000, and is now estimated by committee staff to be at least $1 million a year.

The Scranton operation began in 1970 and was founded by Dr. Triebel, a Manhattan psychiatrist, who named the operation after his mother's maiden name. Triebel and his wife are 2 of the Foundation's 5 trustees and two of the three trustees who derive income from the clinics. Triebel also maintains a separate private psychiatric practice while remaining a trustee of the Foundation and director of the Second Avenue clinic. Despite numerous audits and other investigations, finding violations of State and Federal regulations at Dr. Triebel's clinic, he has yet to be penalized in any way by ODAS, Medicaid, or any law enforcement authority. The committee staff notes with irony that on August 20, 1976 the State Health Department announced that Dr. Triebel made restitution of $320 for double-billings detected by the department. The $320 is equivalent to .4% of Dr. Triebel's 1974 Medicaid income of $857,000.

In 1974, there were seven other operators of private methadone clinics whose Medicaid billings were over $100,000—ranging from $131,000–$282,000. According to HEW statistics, these eight methadone clinic operators alone represent 15% of the 55 New York State physicians who received $100,000 or more from Medicaid in 1975.

The Narco Freedom Case

In the case of *Narco Freedom*, the Public Health Council did not approve the program for article 28 establishment until 1974. The program had a record of serious deficiencies based on prior ODAS reviews; its first Medical Director, Dr. Evaldas Deckys, was convicted for illegal sale of dangerous and narcotic drugs while on the facility premises; the succeeding Medical Director, Dr. Roger Tarter, was convicted on charges of writing false prescriptions for methadone and demoral and using the demoral for himself—ultimately resulting in an improper injection and the amputation of two fingers on his

right hand. Dr. Tarter ultimately received a suspension of his doctor's license by the State Education Department, but the suspension was itself suspended to a three-year probation period. Dr. Tarter is still the Medical Director for Narco Freedom which received the fourth largest amount of Medicaid funds for all methadone clinics in the city ($571,459 in Fiscal Year 1975), and is the director of a Federally-funded "drug-free" clinic at Coney Island Hospital.

Narco Freedom received its initial article 28 reimbursement rate in 1975 at approximately $9 per patient visit. Prior to 1975, Narco received the $4 rate on "fee for service" basis. In auditing the facility's submission the State Health Department disallowed nearly 50% of all claimed reimbursable items before arriving at the $9 rate. The health department's audit also found that approximately 62% of all the facility's expenditures ($402,800 of 647,500) went to "salaries and wages."

Nearly 14% of the overall expenditures and 23% of all "salaries and wages" expenditures went for the salaries of three officers of the corporation which runs the facility:

1. *Dr. Roger Tarter* (president of corporation) received $25,000 as "medical director" on a part-time basis (15 hours/week) while simultaneously holding a position as "full time" director of a "drug-free" program at Coney Island Hospital;

2. *Dr. Alan Cohen* (executive vice president) received $35,000 as "program administrator". In 1973 Dr. Cohen was the 30th highest billing dentist in the City's Medicaid program. He received $141,270.51 in 1973 with his dental office being in the same building, listed as a different address, as Narco Freedom (487 Willis Avenue).

3. *Dr. Howard Cohen* (vice president) received $30,000 as "program coordinator". Dr. Cohen is also a dentist, the brother of Dr. Alan Cohen, and also was a high biller as a Medicaid dentist in partnership with his brother through 1972.

Narco Freedom also paid an additional 3% of its overall expenses ($22,300 of $647,500) for "professional consulting fees", "advertising and public relations", and "accounting and legal". Included in these fees were payments to the other four board members of Narco Freedom (Melvin Rubin, Secretary-Treasurer, as accountant to the program and Jerome Gordon, Jerome Disson and Francisco Lugarina as consultants). Mr. Disson also operated two high-billing Medicaid pharmacies in the Bronx.

Narco Freedom's billing is handled by Lirode Service, Inc., a factoring company. The only two stockholders in Lirode are Alan and Howard Cohen and Lirode's four directors include the two Cohen brothers and two other members of their family.

Dr. Alan Cohen also still controls Dental Equities, Inc. which was established in 1968 to lease property and equipment to dentists in ghetto areas who wanted to open a Medicaid-oriented practice. The Dental Equities leases gave the company a percentage of the dentists' gross fees on a scale ranging from 20% of the first $200,000 up. Dental Equities had eight such leases at its height and still had three leases in effect as of late 1974. (see section E of this part.)

The Cohen brothers also own the 487 Willis Avenue property where their dental office is located. They also lease space in that building to A&S Dental Labs and to Dr. Jamshid Sheik—both recipients of Medicaid funds.

G. FRAUD AND ABUSE BY MEDICAID PRACTITIONERS OTHER THAN THOSE WORKING IN MEDICAID MILLS

While fraud seems to be particularly abundant in Medicaid mills, there is also a significant amount of fraud and abuse among other individual practitioners participating in the program. Below are examples taken from files of Federal and State agencies.

1. Chiropractors

In 1972, a Brooklyn chiropractor billed for 12 visits in less than 1 month for a patient who denied ever seeing the physician. Another Brooklyn chiropractor was indicted earlier this year and charged with submitting billings for treating people who were dead, for men in prison, for people who have been homebound for more than 5 years, and for children under the age of 5 he had never seen.

A Detroit chiropractor, not allowed to dispense medicine or give injections under Michigan law, was charged last year with nine counts of practicing internal medicine without a license.

In 1975, a New York chiropractor was indicted for entering false dates and false statements on Medicaid invoices, both for patients he had not seen and for patients he had seen only once. Those patients he did see were billed for many more treatments—up to 15 times as many as were actually administered. The chiropractor confessed that at least 50 percent of his invoices were fraudulent.

In 1974, two chiropractors who billed the New York City Medicaid program in excess of $300,000 were charged with fraudulently billing Medicaid for patients never seen, billing for more than 100 Medicaid patients a day, billing Medicaid for patients seen by other doctors, and billing for two or three visits by the same patient in a single day.

2. Dentists

In 1969, a New York dentist was indicted on 471 counts which included submitting invoices for services never received, soliciting signatures on invoices before the work was performed, forging patients' signatures on invoices, billing repeatedly for the same service including several sets of false teeth for the same patient, and billing for the work performed by another dentist. The litany also included: Broken or ill-fitting bridgework, filling and extracting the same tooth, and billing twice for the same extractions. Ultimately, the dentist received a 90-day jail sentence of which he served 70 days. He was reinstated in the Medicaid program.

Another New York dentist recently developed a technique for getting around New York's requirement of prior approval for major dental work. Before he was discovered by authorities, he was drilling holes in perfect teeth and X-raying the teeth with the newly created cavities. The X-rays were kept to justify the fillings which the dentist then installed in the once-healthy teeth.

Earlier this year a Maryland dentist was charged with 74 counts of filing Medicaid payments under false pretenses. In one instance, he claimed he had extracted 38 teeth from one patient. The average adult has only 32 teeth. He had been billing the Medicaid program for more than $200,000 a year.

In Illinois last year, a professor of dentistry was asked to evaluate the billings submitted to the Illinois Department of Public Aid by a high-volume Medicaid dentist. This is what the professor concluded:

> Obvious fraud on the part of the recipient was discovered in approximately 20 percent of all DPA forms. The IDPA was billed in excess of $6,000 for professional services which were possibly not rendered, double and triple billing, and very questionable dental treatment.
> Specific acts of fraud are listed:
> (1) Extraction of a tooth on a Monday. On Tuesday the State was billed $40 for the placement of two plastic fillings on the tooth that was extracted.
> (2) Form No. 134 would indicate a filling on tooth No. 7. A second, third, and a fourth form No. 134 on different dates would indicate the same filling on the same tooth. This violation was the most common.
> (3) Five permanent fillings would be placed on a tooth on a given date. Within 1 to 2 days a stainless steel crown was inserted on that specific tooth. Total cost: $130.
> (4) In a 1-week period 43 fillings were inserted on one patient for a total billing to the State in excess of $900. The type of filling material utilized on specific teeth is extremely questionable.
> (5) Treatment of the six anterior or front teeth, maxillary and mandibular. It would be extremely easy for the dentist, without difficulty, to insert up to 60 fillings in 12 teeth with total billing to the State of $1,200. From a professional viewpoint, the involved dentist, without doubt, inserted fillings into specific areas of the anterior teeth that were not indicated. An anterior tooth needing five fillings is an extremely rare occurrence. An isolated case, yes, but not literally hundreds of patients. If, in fact, these were his professional findings, I suggest he write a scientific paper and publish it in a dental journal. It would make dental history!

3. Physicians

A New York physician last year was charged with spending less than 3 hours a day in his office and yet billing the program for more than $150,000—a rate approaching one patient every 2 minutes.

A Michigan doctor in 1975 was charged with billing for work not performed by an unlicensed practitioner, including diagnosis and prescribing treatment.

A New York psychiatrist who ran a methadone clinic which was described as a "factory" was charged with distributing methadone indiscriminately to anyone possessing either a Medicaid card or cash.

Another New York psychiatrist was charged with "upgrading" his counseling sessions, billing the program for an hour's counseling when the sessions had, in fact, lasted some 15 minutes.

A third psychiatrist billed, at a rate higher than that allowed by the program, for an inordinate number of single visits and as many as 19 patient-hours a day.

Three psychiatrists in Nassau County, N.Y., last year billed for more than $100,000 in fraudulent treatment, including 500 patients

they never treated, a number of others they had never seen, and for treating a woman who was dead.

A Michigan physician was charged with "family ganging," billing for excessive services, billing for as many as 140 home visits a day, and billing separately for as many as 8 or 10 recipients at a given address.

A New York physician in 1975 billed for as many as 150 Medicaid patients a day (in addition to another 150 private patients he treated each day), upgrading second and subsequent visits and billing for as many as 97 percent of his services at a higher rate.

In 1975, a New York physician, who has consistently been among the highest billers in the city, billing for more than $100,000 for each of the last 4 years, was charged for billing up to 80 methadone detoxification cases, even though department of health guidelines limit the number that can adequately be treated to 25.

A Michigan doctor, in 1974, was charged with overbilling more than $800,000 over a 2-year period, including services not performed and EKG's, X-rays and lab work not documented in the patients' records.

A Washington State physician was charged in 1975 with steering patients to a particular pharmacy, indicating it was the only place in town the patient could get a particular medication.

A second Washington physician was charged with issuing duplicate narcotics prescriptions to patients last year.

A Michigan physician was charged with billing for work performed by unlicensed physician assistants and medical assistants. The more than 80 unlicensed providers he hired billed Medicaid $5 million in fiscal year 1973–74.

4. Podiatrists

A Port Washington, N.Y., podiatrist billed for seeing 50 or more patients a day, more than 15 beyond the established quality care line, billing for 60 toe jackets in one day (an average practitioner does about 4), X-raying two-thirds of new patients (the guidelines are about 40 percent). In addition, the department of health determined that 90 percent of the castings performed were unnecessary.

A New York City podiatrist in 1974 was charged with billing the city for hundreds of shoe molds, prescribed, but not delivered, excessive use of injections and X-rays, and double billing Medicaid for patient treatment.

A Manhattan podiatrist was charged with billing Medicaid for toe slings, for seeing patients at a rate exceeding many times the average podiatrist's practice, excessive padding and strapping, and employing mass-made appliances but billing for custom-made.

In 1975, a Brooklyn podiatrist was charged with consistently examining all members of a family despite the fact that only one member had sought treatment. He was also charged with requiring patients to return when the diagnosis did not warrant it.

5. Optometrists and Opticians

On July 14 of this year, the *Chicago Tribune* reported the fraudulent practices of optometrists and opticians participating in the Illinois Medicaid program. Among the findings of the *Tribune* investigation are:

The State Department of Public Aid paid for 26 pairs of glasses for one young Medicaid patient within the space of 6 months.

The Illinois Department of Public Aid is so inefficient in monitoring its payouts that five optometrists and two optical companies were able to collect $1,235.40 during a 7-month period for 55 visits to eye care specialists by a seven-member public aid family. The family says it never received the services or the glasses.

In one instance, an optometrist was paid $20 for an eye examination he said he had performed on a west side welfare recipient who had died 1 month before. In another case, an optician was paid $29.50 for a pair of glasses issued to a nursing home resident who had died 21 days before.

The Public Aid Department paid eye care vendors for services to persons who had gone off the welfare rolls, or whose addresses were checked out by reporters to vacant lots and even the Chicago River, or who were unknown to apartment building landlords.

Names of hundreds of welfare recipients who told the *Tribune* they never had been to an eye doctor in their lives were sent to Springfield on the blue paper billing forms for payment.

The practice of filling out the blue forms with names of untreated relief clients was so widespread that the investigators came to refer to the whole fraudulent operation as the "Blue Paper fraud."

When a resident of the Robert Taylor Homes went to a nearby optical center to have her glasses prescription filled, the optician issued her three pairs, telling her she should always have extra pairs for emergencies.

A Harvey mother and her nine children were given three sets of glasses, each within a year's time, because the mother said, "The glasses kept falling off our faces."

Hundreds of relief clients who actually sought and obtained glasses complained to investigators that the glasses were cheap, kept breaking, and in some instances were nothing more than "window glass."

The investigators found the 871 individuals who claimed they never had received the services for which optometrists and optical firms were paid were named on bills submitted by the following practitioners during the period between January 1, 1975 and April 30, 1976:

R. B. Optical Co. owned by Romero Bernales, with 32 individuals who claimed no knowledge of its billed services; his wife, Lolita Bernales, 26 individuals; Jerome Brotman, 67 individuals; Norman Brotman, his brother, 56 individuals; Crown Optical Co., 19 individuals; George W. Davis, 36; Samuel A. Dorsey, 113; Bruce Fogel, 74; Ford Optical, 18; Fullerton Optical, 81; Neilan Jacobs, 38; Orillaza Optical, 209; Harold Seldin, 37; Henry Sikora, 42; and Suico Optical, 23.

These persons and firms collected a total of $1,223,768 from the Public Aid Department in 1975, and through April 1976,

have received another $559,387 in payments, some of which, of course, may be legitimate.

6. Pharmacies

A Brooklyn pharmacist was indicted last year and charged with selling amphetamines and barbiturates without a prescription. He was charging $0.75 to $1.50 a pill.

A second pharmacy was charged with forging prescriptions; 20 of 160 prescriptions checked by investigators were forged. Another 58 were upgraded from over-the-counter drugs to more expensive compounds.

This year, three Manhattan pharmacists were charged with issuing psychotropic drugs with overlapping prescription periods, substituting generic drugs, and double billing Medicaid.

In 1974, a pharmacy in Twin Falls, Wash., was charged with falsification of billings and billing Medicaid for drugs the Veterans' Administration provided free of charge.

A pharmacy in Yakima, Wash., earlier this year was charged with double billing, false billing, and other illegal acts.

A pharmacy in Ellensburg, Wash. was charged with dispensing drugs to recipients without a prescription from a physician.

H. SUMMARY: AN IN-DEPTH LOOK AT AN ONGOING MEDICAID MILL

In our examination of Medicaid mills, we have determined that such facilities are uncommonly profitable. On average, a practitioner will pay from 30 to 40 percent of his income as rent; he will lose 12 percent of his income to the factor and, in most cases, be asked to divide the remaining net 50–50 with a mill owner. The State of New York's records (particularly even more to the point, the records of the City of New York) are such that it is difficult to be precise. *But it is clear that at least half of the amount paid to doctors and other practitioners working in mills does not go for the provision of services but, rather, is bled off in factoring charges, kickbacks, rent, and "finders fees." From the point of view of the Congress and the taxpayer, the expenditure of money in this fashion is clearly wasted. In addition to these "wasted" sums must be added the fraud and abuse which, it is now apparent, riddles the program. All in all, it is apparent that less than one-third of the millions flowing through Medicaid mills goes for the purpose for which it was intended: the provision of health services for the poor and elderly.*

Equally apparent, is the fact that the quality of medical care rendered in the great majority of these establishments is minimal.

The following in-depth analysis of one Medicaid mill is provided to summarize findings previously discussed separately.

The facility is located at 80 Delancy Street on the lower East Side of New York and is called the 80 Delancy Medical Center. This center has billed the Medicaid program for more than $1 million each year since 1972. It's medical facilities are on the second floor of a six-story building and consists of a small pharmacy and a number of small examining rooms where as many as 20 practitioners have been employed at the same time. A photograph of the facility is shown on page 81.

HOUR SERVI
CORNER
DELANCEY & ORCHARD

The history of abuse at 80 Delancy is extensive, involving the pharmacy, individual providers, and the facility itself, which has been consistently singled out by the City Health Department for specific violations of the health code.

As an example of the difficulties encountered with this facility, the following excerpts are taken from a report prepared by the health department after a detailed audit (visit) by a team composed of a doctor, a dentist, a registered nurse, and a health department investigator. The report is dated July 17, 1973. Their findings were as follows:

(1) *Sanitary inspection.*—In general, there is good lighting and ventilation. However, the following health code violations are in evidence and require immediate correction:

(a) Indequate handwashing facilities.

(b) No handwashing done between patients.

(c) Some littered floors and bathrooms.

(d) Exposed rheostat wiring in podiatry room.

(e) Encrusted handwash sink in lavatory adjacent to waiting room.

(f) No soap or single-service towels in lavatories.

(g) Uncovered waste receptacles.

(2) *Dental audit.*—The dental facilities are pleasant, large, and airy. The offices are fully equipped and well staffed. The only problems are:

(a) There is no appointment book. An appointment book should be maintained for the provision of adequate followup care and the reduction of patient waiting time.

(b) Pre-op X-rays, diagnosed and charted by staff dentists, are not examined by Dr. Alan Rosen prior to treatment. Given the fact that all of the billing is being done in Dr. Rosen's name and he is thus responsible for the quality of the work being performed, it is strongly suggested that he be at least doing random checks of these X-rays.

(3) *Physician's audit:*

(a) The radiologist, Dr. Max Rakofsky, has some films that defy interpretation. Since most of his films are of good quality, it is difficult to understand this dichotomy. Nondiagnostic X-rays may be harmful to patients. Nondiagnostic X-rays are not reimbursable by Medicaid.

(b) On May 1, 1973, Dr. Sholom Shakin was audited by Dr. Howard Katz. Although his records were found to be basically good, it was noted that SMA–12's, CBC's, and urinalyses were being ordered indiscriminately. Also, while it may be sound and reasonable practice to order chest X-rays on all new patients, according to our guidelines EKG's on patients under 40 years of age should not routinely be performed unless warranted specifically by diagnoses. There was a further problem in that followup visits were billed for on a first-visit basis in Dr. Shakin's name. The administrator, Dr. Kolman Brown, indicated that this was a secretarial error and that he would rectify the situation. Such errors must not reoccur in the future.

(4) *Managerial report:*

(a) Inadequate privacy in the allergist's (Dr. John McGovern) examining room. Patients were congregated outside of the examining room, which was clearly open to view. Within the room, one patient with her blouse off was being examined while two RN's were administering injections to the patients streaming through. This is inhuman stockyard treatment. A patient must receive adequate privacy during any examination and/or treatment.

(b) Referrals should be recorded in the day book.

(c) There are no patient profiles in the pharmacy for individual patients or families. As of May 1, 1973, a patient profile was made mandatory at all pharmacies in or adjacent to medical centers. A pharmacy investigator will make a site-visit in the immediate future to check on the implementation of this requirement.

A PULITZER PRIZE WINNING SERIES IN THE NEW YORK DAILY NEWS

The facilities and practitioners at 80 Delancy were discussed in detail in Reporter William Sherman's Medicaid probe series for the *New York Daily News*. In January of 1973, Sherman posed as a Medicaid beneficiary and sought treatment in many Medicaid mills, including 80 Delancy Street.

In the fifth of his 12-part series, Mr. Sherman described the Del-Med Pharmacy, stating:

> The pharmacy in the Delancy Medical Building is only a counter in the second-floor hallway. And behind that, a room with some shelves and a small working area for mixing prescriptions. But last year, out of that small one-man operation at 80 Delancy Street, came $95,000 worth of Medicaid billings. The business was generated from a large group of doctors, dentists, podiatrists, and other specialists who rent space on that floor and cater exclusively to Medicaid clients.
>
> In all, that center, which features a color television and a hot coffee machine in the waiting room, will generate more than $1 million in Medicaid billings this year.

Sherman went on to say:

> An investigation [of the Del-Med Pharmacy at 80 Delancy] showed that prescriptions were brought to the pharmacy by attendants of the medical center. A sample survey of 15 patients showed eight discrepancies, including bills for twice the amount of the medicine actually dispensed. The investigation also revealed that generic drugs are being substituted for brand name drugs and billed for under the more expensive brand names.
>
> The owner of the Del-Med Pharmacy told the *Daily News* that he paid $13,200 in rent a year for that closet-sized space located in the hallway.

In his sixth report, dated January 31, 1973, Mr. Sherman told of visiting the podiatrist at the 80 Delancy Medical Building. Mr. Sherman said he found that bills and X-rays came first, before he even took off his socks and shoes. Mr. Sherman described the process as follows:

At the Delancy Medical Building, 80 Delancy Street, the patient was ushered into a small room on the second floor where a young receptionist took his Medicaid card, began filling out an invoice, and then said, "We are going to X-ray your feet."

"But I want to see the podiatrist," insisted the patient.

"He's busy; go into that room for X-rays," she ordered.

"You haven't asked me what is wrong yet; nobody has even seen my feet," he argued.

"It doesn't matter," she said, "the city requires that we X-ray everybody's feet before we see them." The patient refused and a health department podiatrist said later that it is absolutely ridiculous to X-ray someone's feet before you examine them. More important, it is unhealthy to expose someone to radiation unnecessarily.

When the *News* reporter refused the X-rays, the receptionist, Maggie Rivera, brought in podiatrist Neal Blatt who said he was sitting in for someone else. Blatt examined the patient's feet, noted a slight rash on the left foot, sprayed the foot, rubbed some ointment on, bandaged the foot heavily, and wrote out two prescriptions.

The treatment took 5 minutes. Such examinations usually cost the city $5.25, according to the standard Medicaid fee schedule. Including the bandaging and the prescription, the bill would total about $15.

The man Blatt was sitting in for was Jay Rosenberg, and health department records show that he earned $69,611 in Medicaid funds for 1971. During the first 6 months of 1972, he billed for $43,986, an increase over his previous year's earning rate. That figure made him the highest billing podiatrist out of 702 practicing in the city last year.

A health department investigation of Rosenberg's practice showed that on many occasions he was seeing more than 50 patients a day. Department podiatrist Benjamin Watkins maintains that 35 patients per day is the maximum a foot doctor can see to insure quality care.

Rosenberg, records show, also billed for 60 toe jackets during 1 day's practice. Toe jackets cost the city $11.20 each. They are made from a plaster cast of a toe, consist of moleskin, and fit over the toe like a miniature sock. The average podiatrist, Watkins said, rarely makes more than four toe jackets a day. The jacket is used, in rare cases, to prevent severe friction or to protect an arthritic or deformed joint.

Some of Rosenberg's patients, the investigation revealed, complained that their toe jackets collapsed in a few weeks. The department found that Rosenberg was using polyfoam for the jackets instead of moleskin.

Rosenberg agreed to make a restitution of $6,000 to the city and a short suspension from the Medicaid program was imposed.

RELATIONSHIPS

The Medicaid mill is owned by a corporation, Del-Med Service Co., Dr. Coleman Brown, 805-215th Street, Bayside, New York, president.

He has owned the facility since 1969, having bought out one Edward Cohen of Lawrence, Long Island. The building, according to available records, is owned by Institutional Management, 130 West 42nd Street in New York. Institutional Management also leases to Cohen Optical, which is located on the ground floor of the Delancy Medical Building. Cohen Optical is owned by Mr. Robert Cohen and his brother, in partnership. They also own Health Factors according to listings in the reverse telephone directory and information provided by several physicians who have dealt with Health Factors. Health Factors has been listed at 16 Delancy street, 111 Delancy Street and 421 East 6th Street. The practitioners at 80 Delancy Street, who utilized a factoring firm (according to city health records), all used Health Factors.

Leasing Arrangement: Where the Money Goes

No one knows for sure how much money is generated at 80 Delancy Street. In an attempt to estimate the amount of money billed Medicaid out of the 80 Delancy Street medical center, committee staff aggregated the income of those individual practitioners identifiable as billing out of the center. With the information and a health department summary, indicating the percentage each of those practitioners paid as rent, an attempt was made to calculate the total earnings of the mill. Again, it should be emphasized that these are estimates. The tangled condition of New York City's records does not permit any better calculations.

After unravelling the disorganized medical vendor printouts provided to us by New York City officials, staff identified eleven of the individuals who bill out of 80 Delancy Street. The practitioners received the following sums in calendar 1974:

Stanley David Blatt	$11,879
Max Rakofsky	342,641
Lewis A. Lando	63,974
S. Gupta	39,505
John Lorenz	21,621
Ellen Rosen	144,102
Marvin Baumol	33,694
Nourolleh Chadi	3,281
Richard M. Bauer	25,328
Coleman Brown	119,431
The Del-Med Pharmacy	100,224
Total	905,680

Six other practitioners who, according to health department records, billed out of 80 Delancy Street could not be found in the jumble of computer printouts.

In addition to Medicaid patients, stated to be some 350 a week, practitioners drew from more than 280 private paying patients *per week* as well.

According to the health department's records, every practitioner in the facility was on a percentage lease. Dr. Nasser, a psychiatrist, paid the least, some 25 percent of his gross earnings. Most practitioners paid 40 percent. Dr. Rakofsky, the radiologist who billed for more than $300,000 in 1974, was paid $400 a month by the owner for reading X-rays.

Based on available figures, total earnings for the facility were estimated in excess of $2 million. Applying the stated lease percentages against that figure reveals a minimum income to the owners of $800,000. In this figure we make no attempt to calculate possible rebates from a variety of vendors, including clinical laboratories, factors, and pharmacies. We deal solely with what the mill owners call "rent."

The Track Record Continues

Health department records indicate that this facility continues to violate certain aspects of the City's health code. In October of 1975, investigators marked the mill for close scrutiny because of a developing pattern of upgrading return visits to first visits. First visits are reimbursed at the higher rate. The files also indicate that EKG's were commonly taken but not interpreted, a reference similar to the statement in the 1973 audit, described above, referring to X-rays "without diagnostic purpose."

Shopping at 80 Delancy

Senate investigators shopped at 80 Delancy three times. Private James Roberts entered the facility twice, the first time on May 11, 1976. He was treated by a Dr. Rod for a head cold complaint, given a general physical, and referred to the Del-Med Pharmacy with three prescriptions. The entire process took 3½ minutes. At Cohen Optical, located in the same building, when Pvt. Roberts asked to have his eyes examined, he was referred to 80 Delancy. At the Portnow Surgical Supply, located across the Street from 80 Delancy, when Pvt. Roberts complained of a back pain, he was again referred to 80 Delancy for a prescription. The second time Pvt. Roberts entered the mill was on June 5, when he again complained of a cold. He was treated by Dr. Gupta, given a number of X-rays, asked for blood and urine samples and referred to the Del-Med Pharmacy with four prescriptions. The bill submitted by Dr. Gupta for that visit, totaling 4 minutes work, indicated Roberts had an asthmatic condition and totaled $30.

The second shopper to enter this clinic was Mrs. Pat Oriol (who also entered on June 5) complaining of a cold. She saw Dr. Gupta a few minutes after Pvt. Roberts. She was given a general physical, a TB test, X-rays, asked for blood and urine samples, and given an EKG. She was given two prescriptions but not referred to the pharmacy. The bill submitted by Dr. Gupta for the 3 minutes she spent with Mrs. Oriol totaled $46 including diagnoses of an upper respiratory infection, and chest hyper-spasms.

Both shoppers indicated that they were X-rayed in a hallway closet adjacent to the bathroom, and within a few feet of the reception room. Mrs. Oriol had the humiliating experience of being examined with the door open and stated that at one point a handyman came in and picked up the garbage while she was disrobed. She further stated that she was asked to wait for her turn to be X-rayed in the general waiting area while dressed only in a thin, paper hospital gown. While she was waiting, she observed an unidentified optician measuring nearly everyone in the waiting room for glasses. She stated that he stopped people as they walked by and, at one point, *even measured a 6-month-old baby for glasses.*

Part 3

THE CHRONOLOGY: TEN YEARS OF REPORTS

The operation of the Medicaid program in New York State has been the subject of more than 100 major reports in the last 10 years. Moreover, there is a great deal of similarity in the problems identified and in the solutions suggested over the past 10 years. Even a cursory view of these reports indicates that they have been largely ignored and that the problems have been exacerbated over the years. Only very recently have there been any signs of improvements. The most positive developments in this area in the past 10 years are the appointment of Mr. Charles J. Hynes, the special prosecutor for nursing homes, the establishment of the Moreland Act Commission for the same purpose, and the commitment of funds for the long-overdue Medicaid Management Information System (MMIS). All three of these developments can be credited to the administration of Governor Hugh Carey. Excerpts from the major reports relating to the administration of Medicaid (exclusive of nursing home reports) follow below.

(A) "Report on the Audit of Medical Assistance Program Administered by the State of New York," May 1, 1966, to June 30, 1968: The August 1969 report prepared by the HEW Audit Agency said in part:

> Our review disclosed weaknesses in the administration of the medical assistance program indicating a need for prompt action to strengthen the administrative procedures and internal controls to reasonably assure that the program objectives are being accomplished.
>
> —The affidavit or declaration system for establishing Medicaid eligibility is used but "to date, the validation process has not provided management with useful and precise data on the actual and potential rate of ineligibility under the declaration system.
>
> —The percentage of sample cases closed because of ineligibility was more than *18 percent* and should have alerted management that problems existed in their determination process.
>
> —*The New York City Department of Social Services has not satisfactorily implemented procedures to identify and proceed against recipients who obtained medical assistance on the basis of fraud and misrepresentation. The city took no effective followup action to proceed against the recipients involved.* One of the primary reasons for inaction was the inability of the New York City Department of Social Services computer to provide data identifying the cost and other details of services rendered to such recipients.
>
> —From the inception of the Medicaid program in May 1966 to the present (April 1969), the New York City Depart-

ment of Social Services has not properly utilized its computer capability to enable management to effectively monitor program expenditures. Patient and vendor profiles, which would provide ready access to information on past services rendered a recipient and/or payments made to a vendor, have not been established. Moreover, controls have not been established to detect duplicate payments made.

(B) Medicare and Medicaid hearings before the Committee on Finance of the U.S. Senate, July 1 and 2, 1969, represented the first detailed look at fraud and abuse in government health care programs. At page 68 of the hearing record, then Under Secretary of Health, Education, and Welfare, John Veneman reinforced the need for patient profiles:

> Senator, I might point out that one of the big weaknesses we have now in the entire program is that in many of the States, they do not even have a patient profile by name or even a doctor's history provider profile.

At page 34 the report also states:

> There is substantial evidence that many physicians are engaging in the practice known as "gang visits" to nursing home and hospital patients. Under this practice a physicians may see as many as 30, 40 and 50 patients in a day in the same facility—regardless of whether the visit is medically necessary or whether any service is actually furnished. The physician in many cases charges his full fee for each patient, billing Medicare for as much as $300 or $400 for one sweep through a nursing home.
>
> There is evidence that physicians are now billing separately for services which were previously routinely included in a charge for an office visit or a surgical fee. For example, routine laboratory tests which were part of the office visit charge are now billed in addition to the fee for the visit. In some cases a surgeon now charges separately for preoperative and postoperative visits, services which used to be part of his surgical fee. This kind of price increase does not show up in the consumer price index figures set out in an earlier chart.
>
> Conflict of interest situations occur with apparent widespread physician investment in nursing homes and proprietary hospitals. The physicians in these situations have an economic incentive to order as many services as possible and to extend the duration of stay for those of his patients whom he places in a medical facility in which he has an investment. It appears that many general practitioners are providing services—such as psychiatric counseling, injections, and laboratory work—to an extent unrelated to medical needs and solely for the purpose of maximizing their Medicare billings.

(C) "Medicare and Medicaid, Problems, Issues, and Alternatives," report of the staff to the Committee on Finance, U.S. Senate, February 9, 1970, charged widespread fraud and abuse in Medicare and Medicaid, with costs mounting beyond control. The appendix of the report carries a "Summary of Medicaid State Audits by the HEW

Audit Agency." The covering letter signed by John J. Mallen, Deputy Director of the Audit Agency, states:

> The report shows the existence of widespread administrative problems which require prompt action by both the States and SRS if program objectives are to be achieved efficiently and economically. Problem areas of most concern centered on: (1) duplicate payments, excessive rates and fees, and other types of erroneous charges which would not have occurred if adequate management control had been established over claims submitted; (2) the lack of systematic reviews of utilization of service; and (3) the need for improved procedures in determining eligibility and operating quality control programs. With respect to New York, the report notes "serious weakness in management controls."

(D) Medicare and Medicaid hearings before the Subcommittee on Medicare-Medicaid, Committee on Finance, U.S. Senate, July 2, 1970, includes testimony by Lowell E. Bellin, first deputy commissioner, Department of Health, New York, N.Y. On that date, Dr. Bellin provided the outline of a newly instituted program called a Medicaid watchdog system. Physicians making more than $5,000 a year from Medicaid were marked for monitoring or investigation. The figure, Bellin stated, was the equivalent of a doctor seeing 40 Medicaid patients a day (not counting private-paying and Medicare customers).

He noted several areas of abuse in the program, including the obtaining of duplicate professional services from separate practitioners, e.g., more than one pair of glasses from different optometrists. He said:

> Without the means to identify such patients, it is impossible to be precise about the magnitude of such abuse. Within 1 year we expect to have the computer capability ot identify all Medicaid services provided to any individual patient [patient profiles].
>
> [I]n comparison to the abuse emanating from providers of care, we estimate the dollar cost of patient abuse to be relatively negligible.

On June 16 of these same hearings, Dr. William S. Apple, executive director of the American Pharmaceutical Association, testified that kickbacks were common practice between pharmacists and nursing home administrators. The average kickback he said, was 15 to 20 percent. Asked if it was a widespread national practice, Dr. Apple responded:

> Well, Senator Ribicoff, with regard to the nursing home situation, it is the worst we have experienced in the history of our profession. It has been virtually a gun to the head of the pharmacist—you will not get in the door without a kickback.

In the September 21 hearing in this series, Meade Whitaker, tax legislative counsel of the Treasury Department, told the committee that one doctor out of every three who received substantial income from treating patients under Medicare and Medicaid appeared to be cheating on his income tax. Some 4,000 of 11,000 doctors examined by

the Internal Revenue Service underrepresented their payments from the program by a sufficiently large margin to justify detailed audits of their tax returns. Audits of 3,000 of the 4,000 were complete at the time of Mr. Whitaker's appearance and he noted that about "half of these show deficiencies."

(E) Supreme court of the county of New York, "Report of the Fourth November 1969 Grand Jury," January 1972. Perhaps the most significant document in this section is the 1972 report of a Manhattan grand jury filed after a 2-year review of the administration of Medicaid in New York City. The grand jury received testimony from 47 witnesses including Medicaid patients; Medicaid providers; administrators from the city's health and social services departments; Federal, State, and city auditors; and investigators and accountants from the New York County District Attorney's office. In all, they took 1,500 pages of testimony and received 403 exhibits and documents in evidence.

The grand jury found the program was administered "in an incredibly chaotic manner" and concluded that "corrective legislative, executive, and administrative action in the public interest" was required.

In releasing the report, State Supreme Court Justice Jacob Grument keyed on the testimony of a former high-ranking official in the city's Medicaid program who testified that of more than $2 billion "nearly 50 percent of the money spent on Medicaid went down the drain" due to improper practices during the period May 1966 to December 1969.

The committee staff interviewed Judge Grument in April 1976. The judge indicated he remembered the grand jury report very well. Asked if he thought the grand jury's evidence justified this conclusion, he answered, "Yes, or I wouldn't have said what I did."

More specifically, the grand jury said:

> It is evident that improper and corrupt practices disclosed by this investigation were, in large measure, caused by the fact that these essential services were rendered in a completely disorganized, if not chaotic, manner.

The abuses included:

—Payments for services not rendered, often procured by forging patient signatures or having patients sign Medicaid forms *prior to* treatment, such as dental work and physical therapy to the elderly.

—Payments for unauthorized or unnecessary services, such as tooth extractions, X-rays, a bridge, and referral visits to other medical specialists in a Medicaid group (this practice is commonly known as "ping-ponging").

—Payments for defective pharmaceutical devices, such as vaporizers and corrective footwear.

—Payments for *brand name* drugs when *generic name* (i.e., less expensive) drugs were provided.

—Payment for Medicaid clients who were actually ineligible for Medicaid.

The grand jury also observed major administrative failures responsible for these abuses and for other losses in Medicaid moneys:

—Failure to have patient and provider profiles to detect abusive providers, even though the Federal Government ordered the city to do so.

—Failure to have a system to detect duplicate, triplicate, or multiple payments to providers.

—Failure to adequately control blank checks.

—Failure to promptly pay providers resulting in the advent of third-party "factoring" companies which charged providers 12 to 15 percent commission charge of their total billings. This increases the providers' propensity to inflate Medicaid claims.

—Failure to read State action on Federal and State reports since 1969 criticizing administrative deficiencies.

—Failure to file timely claims for State, Federal, and third-party insurer reimbursement resulting in the "loss of millions of dollars."

—Failure to adequately screen Medicaid applicants for eligibility.

—Failure to adequately maintain records for detection and prosecution of frauds and abuses; many records were found missing or out of order and in "shoeboxes" in a warehouse.

—Failure to alter the inefficient delegation of payment responsibility to social services and program monitoring to health.

Other relevant comments from the grand jury included:

> The city comptroller's office cited one case where the city's Department of Social Services had lost $500,000 in Federal Medicare reimbursement because the claim was not timely. The reason for the loss was that the notification slips "used for reimbursements were hidden in several shoeboxes and were, therefore, never processed."
>
> The comptroller's office received half of the money, but the other one-quarter million could not be recovered because, according to one auditor, "The records did not lend themselves to discover what had happened to these cases or whether the city had, in fact, claimed against the State for reimbursement."
>
> Invoices that had been submitted by Medicaid providers and allegedly paid by the city were found by the New York County District Attorney's investigators to be strewn about in a warehouse, torn and mutilated, with no semblance of an attempt to file them. Huge stacks of invoices were piled on desks, in cartons, and scattered about the room in an apparently disorganized manner. The grand jury found that many of the records sought had been either lost or destroyed.
>
> Two of the city's top Medicaid administrators were interviewed in April 1971 by the grand jury. They were presented with findings from an August 20, 1969, HEW report, a February 1971 city comptroller's audit, and three State comptroller's audits (September 1970, November 1970, and April 1971), all of which documented criticisms of the administration of Medicaid in New York City. According to the grand jury, one witness testified "that he was totally unaware of the existence of these reports . . ." The other "expressed total ignorance of the existence of the reports."

Distribution of the Grand Jury Presentment

The committee staff attempted to learn who had received copies of the original grand jury presentment which, it should be remembered, is a summary report and not the original grand jury minutes. With the cooperation of the district attorney for New York County, Robert Morgenthau, the committee staff appeared before the State supreme court, county of New York, and received permission to review and copy the entire grand jury records. By checking records in the district attorney's mail room, it was determined that copies of the grand jury presentment were sent to the following individuals: Hon. John L. Mitchell, Attorney General of the United States; Hon. Nelson Rockefeller, Governor, State of New York; Hon. John A. Lindsay, Mayor, city of New York; Hon. Abraham D. Beame, then comptroller, city of New York; Human Resources Administrator Jule Sugarman; Mary C. McLaughlin, commissioner of health, New York City; Michael Whiteman, esq., counsel to the Governor; and Hon. Perry Duryea, minority leader, State assembly.

All letters and replies are reprinted in appendix 2 of this report. Analysis of the replies received indicates that there was little done by public officials even in the face of so massive an indictment of the city's operation of the Medicaid program.

Analysis of the Replies

Perry Duryea, minority leader of the State assembly, could point only to creation of the office of welfare inspector general (OWIG) as the legislative action taken in response to the report. However, the committee staff observes that the legislature created OWIG in 1971 and by the time the grand jury report was issued OWIG had been in operation for 6 months. In fact, the Governor's counsel, Michael Whiteman, sent a copy of the report to OWIG (see Mr. Whiteman's comments below and in appendix 2).

Commissioner Mary C. McLaughlin said she did not remember reading the report, and added that all Medicaid cases were sent to her first deputy, Dr. Lowell Bellin, the present commissioner of health in New York City. Ms. McLaughlin referred her letter to Dr. Bellin, and Senator Moss also wrote, but neither brought any response.

The former U.S. Attorney General, John Mitchell, responded that he did not remember personally reviewing the document, and referred the committee to the Department of Justice records section to see where the report was sent.

Hugh Morrow, answered on behalf of the Vice President, the Honorable Nelson A. Rockefeller, saying files were being researched, but nothing further was received beyond this June 24 interim reply. However, Michael Whiteman, then counsel to Governor Rockefeller, reported that Governor Rockefeller directed copies of the grand jury presentment to George Berlinger, the State welfare inspector general, and Stuart Scott, chairman of the Temporary commission to Study the Governmental Operations of the State of New York. Copies were also sent to Dr. Andrew C. Fleck, first deputy commissioner of health, and to Barry L. Van Lare, executive deputy commissioner of social services. As noted later, Mr. Berlinger released his report in January of 1974, but the Scott commission report is silent on the grand jury report.

New York's Mayor Abraham Beame answered:

> At that time I met with Jule Sugarman, then administrator of the human resources administration, to determine what actions were being taken to correct Medicaid abuses. I suggested that high priority be given to developing a computer system to automatically generate client profiles. Mr. Sugarman agreed, and this system is now partially operational.

Jule Sugarman, now chief administrative officer of the city of Atlanta, wrote: "There were a series of . . . reforms carried out, not primarily due to the grand jury report, but due to the fact that I had ordered a number of other investigations which showed what had to be done."

John V. Lindsay, former mayor of New York City, stated that his administration had conceived the idea for implementing a sophisticated computer system to identify abuse. He noted that Governor Carey had just signed a law authorizing a Medicaid management information system (funded primarily with Federal funds). He stressed that implementation had been delayed because of New York's fiscal crisis.

Impact of Grand Jury Report

It is obvious that the grand jury presentment did not prompt any legislative or agency changes regarding fraud and abuse. The Moreland commission noted that there has not been any "augmentation of statutory or regulatory authority" and only "minor increases in inspection and enforcement staff" during the 10-year history of the Medicaid program in the department of health (DOH).

The DOH's State medical handbook (SMH) item 35 on "Unacceptable Practices and Fraud" was promulgated in its three-page format of general guidelines in July 1971 and no changes were made until the October 1975 revision. SMH item 34 on "Medical Review and Evaluation of Program Operation" was issued in January 1972 and prompted primarily by new HEW requirements. The New York State housing and urban renewal program was not initiated until 1974 and its development began prior to the issuance of the grand jury reports.

New ethics and legislation affecting legislators involved with health care facilities was not introduced until 1975 and it was not passed. The Medicaid reimbursement role-setting and audit procedures for institutions remained the same until 1975 when minor changes in procedure were introduced and new staff was added. New requirements on the financial statements submitted by health care facilities were not legislated until 1975 and were a result of efforts by the Moreland Act Commission and special prosecutor's office.

The social services law, rates and regulations regarding Medicaid payment to vendors have remained unchanged since 1966. There were changes in eligibility determination procedures in 1973, but they were a direct result of increased pressure from HEW to reduce eligibility rates upon penalty of disallowance of reimbursement claims. The creation of the department of social services (DSS) Office of Audit and Quality Control again was attributed to HEW regulations regarding eligibility.

(F) "Summary of Audit Reports Issued by the State Comptroller's Office Concerning the New York City Department of Social Services

for the 3 Years Ended December 31, 1970," by the Office of State Comptroller, Division of Audits and Accounts, Report No. NY–NYC–1–72, provides a summation of the findings and conclusions contained in 37 such audit reports issued before the 1971 legislative changes. The report's major observations include:

> Our reports clearly indicate that there is a need for more effective management by the city DSS and for closer supervision by the State DSS. Many of the audit reports show that tighter administration would have resulted in operational economies, additional Federal funding, and reduced potential excessive or fraudulent payments.

1. *Coverage:* In New York (1970), all public assistance recipients and approximately 300,000 other city residents are considered medically needy. The New York City DSS is the largest service agency of its kind in the world. The 1970 caseload of more than a million persons is more than twice the 1965 caseload. It had previously taken 17 years to double the 1948 caseload of a quarter-million welfare recipients.

2. *Eligibility:* The "declaration" method was faulted in that case workers rely on statements made by recipients with some 10 percent selected and investigated using conventional methods. "Our audit showed that the results of the 10 percent sample were being improperly analyzed and that potentially, a significantly larger number of ineligible applicants were being approved than that reported."

3. *Administrative practices:* "Our review of this area indicated a general lack of control in the recordkeeping practices of both the city social services department of medical payments unit and the health department's group involved in the invoice audit function. . . . Even though a provider may have been found to be overcharging as a result of the review and deductions were taken from current invoices, the medical payments unit did not have the capability of easily retrieving prior invoices to charge back similarly excessive amounts."

These poor recordkeeping practices were said to have resulted in the overclaiming of State aid for Medicaid nursing home buildings by almost $2 million in 1970.

1973

(G) Pulitzer prize winning series in the *New York Daily News:* In January of 1973, a *New York Daily News* undercover reporter, William Sherman, documented the same types of provider abuses cited in the grand jury report in visits to 32 Medicaid providers. This effort won Mr. Sherman the Pulitzer Prize but, unfortunately, resulted in little apparent change in the administration.

Sherman said in part:

> Medicaid has become an unmanageable monster in New York City, consuming billions of dollars while failing to keep its promise of an effective system of responsible health care for the poor.
>
> Playing an expensive version of "Beat the Clock," some Medicaid psychiatrists routinely dismiss patients after a 10-minute chat, then bill the city for a full hour's psychiatric examination.

> Podiatrists have socked the city for $35 million in the last 7 years. The taxpayers are footing the bill for expensive and often unnecessary care, according to the city's department of health.
>
> The *News* investigation also showed how doctors and other professionals are almost entirely immune from criminal prosecution for abuses of the Medicaid program.

Sherman closed his study by claiming the Medicaid monster could be tamed by computer technology, including patient and provider profiles, and competitive bidding by laboratories for contracts to process Medicaid patients' blood tests and other examinations.

(H) Electronic Data Systems, Federal, "Proposal to New York State Department of Social Services," May 1, 1973: The report identified New York City as the key to the problem of welfare administration in New York State. It was particularly critical of the city's human resources administration (HRA), noting that it ". . . has the capability to make tremendous presentations on the plans for improvement," but, "management plans tend to evaporate at the operating level." It observed that little has changed at HRA, save ". . . an increase in operating costs and a refinement of planned improvements," and predicted that, "no major improvements will occur in the next term."

It recommended a phased-in central control of eligibility as a solution. No action was taken.

(I) "Audit of New York State, New York City, and Public Authorities for the 2 Years Ended March 31, 1972," Office of the State Comptroller, State of New York, Division of Audits and Accounts: The audit said in part:

> Our audits showed numerous instances where (1) excessive or fraudulent public assistance expenditures were made, (2) excessive charges were made against the State, (3) additional Federal funds could be attained, and (4) reductions in cost could be achieved through greater efficiency.
>
> We concluded that the city's quality control procedures were such that the city had no basis for determining the true degree of ineligibility in the New York City Department of Social Services caseload, that the degree of ineligibility was far greater than that reported by the New York City DSS; and that the cost of maintaining ineligible cases on the roles was running about $60 million a year.
>
> We concluded that the degree of ineligibility in the ADC caseload was at least 10 percent, and when all categories of public assistance are considered, the cost of ineligibles was more than $90 million a year.

With respect to the productivity of quality control staff:

> There was a lack of control of case reviewers' activities. . . . We observed, for instance, lengthy discussions of personal business during the work period, other nonwork activities and extended lunch hours. We also observed that timecards of persons leaving the office early were punched by other employees at the end of the day.

With respect to Medicaid:

> Our records in this area also indicated a general lack of control in the recordkeeping practices of both the city social services department and the medical payments unit. . . . The medical payments unit does not have the capability of easily retrieving prior invoices to charge back similarly excessive amounts.
>
> Computations made by New York City's DSS for determining allowances to public assistance recipients have shown extremely high rates of error. Analyses over a period of time have indicated that approximately one-third of the computations are erroneous, resulting in a net overpayment of more than $25 million a year.

(J) International Business Machines Corp., "Management and Information Study for Public Assistance and Medical Assistance," May 1, 1973, concluded that the administration of the medical assistance and public assistance programs required, ". . . massive resources and advanced technology that cannot be provided effectively on a local basis."

The report recommended that, ". . . the State administer and operate the welfare system directly." No action followed.

(K) "Report on the Audit of Administrative Costs, Title 19, Medical Assistance Program, State of New York, May 1, 1966, to June 30, 1972," Department of HEW Audit Agency, released December 4, 1973. Highlights include:

> From the inception of the State's Medicaid program in 1966, we noted that limited coverage has been given by NYSDSS to reviews of local agency claims for State and Federal reimbursement.
>
> During the period May 1966 to June 1972, upstate (New York) local agency MA claims for both administrative and vendor care costs totaled about $2.19 billion. However, during this 6-year period only 12 administrative cost audits and 74 medical vendor audits were completed covering the 63 upstate districts.
>
> In addition, we noted that audits were never made of administrative costs in 24 districts and of medical vendors in 8 districts.
>
> The audits that were made accounted for only about 2 percent of total MA claims submitted by the upstate districts during this period.
>
> In addition to the infrequency of medical audits, we noted that the audits that were made were limited in scope and were not designed to provide an overall comprehensive assessment of the accuracy and propriety of claims submitted.
>
> For example, the Onondaga County medical audit, completed in September 1969, disclosed significant financial weaknesses in the test month examined. Fiscal exceptions totaling over $80,500 were found involving duplicate payments to providers, overcharges for lenses and eyeglass frames, and other incorrect payments. Further, the audit report stated that the failure of the county to maintain computer profiles caused

overpayments, duplicate payments, and loss of reimbursement of undetermined thousands of dollars. Notwithstanding these deficiencies, we saw no evidence that the audit scope was expanded to include other transactions within the audit period.

1974

(L) "An Administrative Study of the Enforcement of Medicaid Compliance Procedures in the City of New York," Office of the Welfare Inspector General, January 24, 1974: *In January 1974, the State welfare inspector general's office found that the city's health and social services departments had not taken any action on the 1972 grand jury report, and still found:*

—No patient profiles, despite the 1969 Federal order and a State statutory requirement for patient profiles (section 541.1, social services law).

—Little, if any, discipline of providers alleged to have committed abuses.

—Maintenance of records manually in the same warehouse with no new storage or retrieval mechanism.

—No regular system or trained staff to conduct regular audits of the programs major providers.

—Continued duplication of effort and buck-passing between the city's health department, social services department, department of education, city's corporation counsel, and State agencies.

Like the 1972 grand jury report before it, the 1974 OWIG followup study found a continuation of the practice whereby the city was annually expending close to $1 billion on Medicaid payments without adequate control over records and invoice audits. This is despite the fact that the New York City Department of Health's Medicaid program alone has a $2.4 million annual administrative budget. In the grand jury testimony, the chief of the practices division of the city corporation counsel stated that because of a diffusion of responsibility in the administration of the Medicaid program and the inability to retrieve and procure needed records, the city could not adequately defend itself against lawsuits by vendors. He cited one case where a dentist who received $1,312,752 from Medicaid in 1968 and 1969 submitted an additional claim for $358,000 for those 2 years. The dentist claimed he had submitted the bills, but was never paid. *The city had to pay the additional claim because the department of social services could not locate the dentist's original bills.*

(M) "A Study of the Eligibility Determination Process for Medicaid-Only Applicants and Recipients in New York City," April 8, 1974, Office of the State Welfare Inspector General: *The office of the welfare inspector general concluded that nearly 50 percent of the persons receiving Medicaid only in New York City were totally or otherwise ineligible for such benefits, and that the loss to the city each year from total ineligibles alone is more than $28 million.*

In a random sampling of 126 cases, the OWIG determined 22 percent were totally ineligible, and 49 percent were either ineligible or their eligibility status were highly questionable.

The city's bureau of medical assistance which administers Medicaid was said to keep ineffective client records, fail to follow normal and State-mandated procedures, and does not endeavor to obtain reasonable verification from clients and collateral sources."

In 99 percent of the ineligible cases, OWIG found there were one or more instances of agency error and/or client fraud. Fraud was found in 22 percent of the sample cases, totally concealed or under-reported assets in 29 percent of the cases, and the absence of key items required for verification of eligibility in 44 percent.

Key among the seven recommendations made by the report is "That New York State DSS immediately enforce a State law which has existed for 8 years requiring the city to establish a patient profile." Vendor profiles were also recommended.

In sum, the study found "that the city's bureau of medical assistance keeps ineffective client records, fails to follow normal procedures, does not endeavor to obtain reasonable verification from clients and collateral sources, and basically fails to meet State-mandated procedure pertaining to the acceptance and subsequent maintenance of persons on Medicaid." As a result, OWIG found that large numbers of persons who are either actually totally ineligible of whose eligibility is highly questionable are being accepted and maintained on Medicaid.

(N) "Audit of New York City Agencies, Office of the State Comptroller, New York City, Period Ending March 31, 1974": A 1971 amendment to article 3 of the general municipal law authorized the New York State Comptroller to audit New York City in addition to all other municipalities. In approving the amendment, Governor Rockefeller stated: "Now, more than ever before, the State must meet its responsibility to insure that municipalities deliver the services funded with State and Federal aid."

Audits for the period ending March 31, 1974, conducted by the office of the State comptroller under article 3, as amended, concluded that the rate of ineligibility and overpayment in the city's public assistance program has been extremely high.

In addition, the Audit of the State comptroller stated the following:

> Our audits of the public assistance programs showed numerous instances of: (1) payments to ineligible persons and other overpayment errors, (2) excessive or fraudulent public assistance expenditures, (3) inadequate financial controls, (4) unclaimed and overclaimed Federal and State aid, (5) inadequate controls over medical assistance payments, (6) unproductive work habits and inefficient operations at income maintenance centers, and (7) inadequate implementation of mandated changes and management improvement systems. We concluded that the public assistance programs have not been administered efficiently or effectively.

A review of the total caseload indicated the city had made incorrect budget computations in about 19 percent of the sample. The audit concluded, as a result, that overpayments had been made in the amount of $23 million.

In addition, the audit faulted the productivity of the city's OC staff.

Our audit indicated that a major contributing factor was the low productivity level of the staff. We found an almost complete lack of on-the-job supervision and no managerial controls over employee performance. An HEW official told us that a case reviewer should complete 15 cases a month, but the city reviewers were averaging only six a month at the time of our audit. We observed lengthy discussions of personal business during the work period, other nonwork activities, and extended lunch hours. We also observed that the time cards of persons leaving the office early were punched by other employees at the end of the day.

In an audit of medical assistance cases, the New York City comptroller estimated "that payments for ineligible non-PA Medicaid cases amounted to $21.5 million during fiscal 1972. Payments to ineligible medically needy only cases amounted to $9.2 million."

Corrective action programs, including face-to-face recertification, error accountability, and photo identification, though previously recommended, had not been implemented.

(O) "Annual Report 1974, Office of the Welfare Inspector General":

Two 1974 OWIG studies of public assistance eligibility upstate reconfirmed that the problem was not confined to New York City alone.

In a reply to an OWIG July 1973 study, which had estimated an overall ineligibility rate of 31 percent, the Albany Department of Social Services claimed that only 11 percent of cases studied during a single week were ineligible. In a February review of the data used by Albany County DSS in its study, OWIG concluded that the actual ineligibility rate to be derived from their study should have totaled 25 to 26 percent, which compared favorably to OWIG's earlier 31 percent estimate.

In an OWIG review of a random sampling of Niagara County public assistance cases, nearly a third of them were found to contain fraud or agency error. The Niagara County commissioner of social services took exception to the findings, but further OWIG investigation reaffirmed its original conclusions.

In a study of Medicaid eligibility, OWIG sampled cases at the Queens Income Maintenance Center in Long Island City, and found that 12 percent of these cases were ineligible, with an annual loss of $37,500,000 when projected to the city's current caseload.

The study also uncovered an 86 percent agency error factor by the New York City DSS which contributed to a total projected annual loss to the city of more than $150 million as result of public assistance and Medicaid ineligibility and overpayments. The errors involved New York City DSS's failure to properly budget cases, to locate legally responsible relatives, to perform case recertifications, to evaluate employability of clients, to apply income tax refunds to reduce public assistance need levels. [OWIG notes in response that

New York City DSS stated they had closed ineligible cases and requested recoupment, but added that in the city's November 1974 report on Medicaid-only face-to-face recertification, approximately 60 percent of the cases had failed to report, 20 percent were carried over, and only 15 percent were found to be clearly eligible for benefits.]

Upstate, the New York State DSS "responded to a longstanding OWIG recommendation by mandating statewide face-to-face recertification of all Medicaid clients effective November 1973. OWIG analyzed the initial upstate results and found that only 54 percent of those interviewed were clearly eligible and had received correct payments. These results confirmed earlier OWIG estimates that Medicaid client ineligibility ranges from 20 to 30 percent statewide."

In 1974, OWIG investigated the Albany County Department of Social Services' failure to review Medicaid case closings for possible fraud or ineligibility, resulting in needless waste of State and county funds. In a sampling of closed cases, OWIG found a 33 percent preclosing ineligibility rate, a 37 percent fraud rate and a 46 percent agency error rate. The inspector general said that the Albany County DSS did not review or investigate for possible fraud any of the 93 cases closed in May 1974.

1975

(P) "The Administration of Medicaid in New York State, Interim Study Report No. 6," New York State Temporary Commission to Revise the Social Services Law, February 1975: The report made the following criticisms of the administration of Medicaid in New York State:

(a) Lack of a central authority for administering the program.

(b) Existence of conflicting goals and objectives because of division of responsibility between New York State DOH and New York State DSS.

(c) The absence of a centralized computer-based system.

(d) The absence of a monitoring or control system to maintain a continuous check on recipient ineligibility levels.

(e) Absence of effective utilization review procedures to prevent overutilization.

(f) The presence of complex Federal and State eligibility, resulting in administrative problems at the local level.

(g) The existence of inefficient and costly hospital operations.

(h) The existence of a reimbursement system that encourages higher medical costs.

(i) Declining participation by individual providers in the Medicaid program.

The report concluded by underscoring a recommendation previously made for legislative action essentially calling for a separate medical assistance administration to be set up within the executive department to be charged with the administration of the entire Medicaid program in New York State. The recommendation has not been implemented.

(Q) "Report on the Hempstead Medical Services Shared Professional Facility," Office of the Welfare Inspector General, April 25,

1975: The report raised "grave questions about the quality of medical care offered" in this facility. The report stated that unlicensed personnel were performing allergy tests and giving X-rays. The report noted that "Patients were being ping-ponged from one doctor to another, submitted to a battery of tests before ever seeing a doctor, and provided, apparently, with excessive prescriptions for drugs." The facility was operated by a nonprofessional whose ". . . practices included the solicitation of patients with offers of free transportation and fee reductions through requiring the doctors to absorb the Medicare $60 deductible."

As a result of the OWIG report, the facility is currently being investigated by a number of agencies. The operators of the facility have tentatively agreed to a proposed consent judgment which would divest them of all interest in the facility. The corporation involved in the operating of the facility would be dissolved. All illegal activities practiced by the defendants would be discontinued, and damages of $2,000 would be paid by each of the defendants.

(R) "New York City has a $18 million Medicaid Goof," Dan Thomasson and Carl West, Scripps-Howard staff, the Rocky Mountain News, May 10, 1975: The syndicated report indicated a "computer error" was responsible for erroneously billing the Federal Government $18 million for unauthorized Medicaid payments. The News quoted one HEW official as saying: "Someone really goofed." Other Health, Education, and Welfare officials were said to believe "the New York case is the largest single bureaucratic bungle in Medicaid's 10-year history."

(S) Report of the Moreland Commission on Nursing Homes and Residential Facilities, November 1975: In the first of a seven-part report on the care, financing, planning, and politics of the nursing home industry, Commission Chairman Morris Abram stated that the function of regulators is to see that the hands reaching for government funds perform. "From 1966 to 1974," he added, "the regulators in New York flunked the test."

Among their conclusions were the following:

> The State health department has failed dramatically to use its powers to enforce standards of acceptable patient care in nursing homes and in health related facilities.
>
> Responsibility for firm action and leadership in enforcing standards of care was massively evaded in classic instances of bureaucratic buck-passing.
>
> The detailed provisions of the State hospital code regarding nursing homes and residential facilities and the variety of Medicare and Medicaid regulations present, in many respects, an array of empty boxes. The task of developing meaningful, explicit, and enforceable standards of care remains to be accomplished.

(T) "Report on Audit of Income Tax Information Returns Related to Medicaid and Medicare Providers in New York City, Title XIX," HEW audit, December 10, 1975: Under section 6041 of the IRS code, payments of fees to doctors and other health care providers must be reported annually in returns of information to the IRS. In its audit, HEW "ascertained that for calendar year 1974 the forms reported

by New York City DSS to IRS totalled $496.8 million of a total reportable $738.8 million."

New York City DSS understated:

—Physician income by $19 million.
—Dentist and osteopaths income by $6 million.
—Other provider income by $217 million (includes podiatrists, optometrists, chiropractors, physical therapists, opticians, pharmacists, medical supply vendors, nursing homes, and hospitals).

The audit concludes with the statement that these conditions were detailed and discussed in meetings with the assistant director, informations systems and services, New York City Human Resources Administration, a year ago (in 1974), notes that no corrective action has been taken to this point, and asks to be advised of any anticipated corrective action.

(U) "New York State Medicaid Program, Provider Surveillance Activities, Organization, Systems, and Procedures," Department of Health, Education, and Welfare, Social Rehabilitation Service, Region II, December 16, 1975: The report, based on a survey of local Medicaid programs in five social service districts—New York City, Westchester, Nassau, Suffolk, and Saratoga—comprising 75 percent of the State's Medicaid population and 80 percent of the State's Medicaid expenditures, concluded the State's fraud and abuse monitoring program under Medicaid continued to be ineffective.

The study found the following:

(a) While New York has one of the most comprehensive and costly Medicaid programs in the country, management systems at the State and local level have not been designed or sufficiently modified since the start of the program 9 years ago, to effectively and efficiently control overutilization and provider abuse.

(b) Whatever long-range changes occur in the New York State Medicaid program, there is an immediate need to strengthen the management structure, to provide adequate data system capability, to assign additional managerial and operational staff, and to expand legal resources for monitoring utilization and controlling against abuse and fraud.

(c) The New York State Department of Social Services, the State agency accountable for overall program administration, has not effectively supervised or monitored provider surveillance operations. Technical assistance to local social service districts is limited, and there is no viable program information or data exchange system between the State department of social services and either local programs or the State department of health (bureau of medicaid).

(d) The New York State Department of Health, which holds delegated responsibility for provider surveillance activities throughout the State, has carried out only a minimal amount of management initiative in the review of ambulatory services. The primary emphasis, however, has been on the development of a statewide utilization review program for hospitals.

(e) Because of the lack of State level supervision, there is no comprehensive management information available to measure the effectiveness from a cost/benefit and program perspective of surveillance activities within New York State.

(f) Local social services offices visited during the project were found to have only a limited capability to perform postpayment

reviews. New York City does not have patient profiles or adequate staff while Nassau, Suffolk, and Westchester Counties do not have patient or provider profiles that could identify patient over-utilization or provider practices that exceed established norms.

1976

(V) "New York State Department of Social Services Report to the Legislature," recommendations of the Temporary State Commission to Revise the Social Services Law, January 1976: After noting that the Medicaid program since its inception in New York has grown by approximately 600 percent, the commission stated there were a number of legitimate contributing factors (coverage, range of service, and health care costs), then added:

> Yet it is clear, too, that part of the high cost of health in New York is due to poor management, inefficiency, over-utilization of the more expensive forms of care, and deliberate fraud and abuse by providers and clients alike. *Alone among all the States, New York has sought to operate its Medicaid program without a system of centralized management controls and centralized processing of payments.* The ultimate truth of the situation is that New York, with clearly the most expensive Medicaid program in the country and probably one of the best in terms of the quality of care provided to the poor, has consistently failed to maintain an acceptable level of administrative performance. This situation has never been defensible, but given the current condition of the State's economy, its continuation would be worse than indefensible. It would be a form of fiscal suicide.

The report urged the implementation of an MMIS system, and pointed out that it would:

—Provide savings from (a) more careful editing of claims, (b) surveillance and utilization review, and (c) management reports generated to assist in fiscal planning and control;

—Provide the capability to recover losses in nursing homes and hospitals estimated in excess of $90 million annually;

—Permit "the analysis of data for followup audits and review of fraud and abuse, particularly in areas related to some obvious weaknesses of the present system;"

—Furnish the "data base that is needed to collate bills from providers operating in the medicaid mills."

The report estimated that unsupported billings from these providers alone (i.e., those operating in mills) may amount to as much as $50 million per year.

In addition, the report added, MMIS would:

> (a) Assist efforts to curb provider fraud and abuse through production of "exception" reports that identify providers appearing to provide (1) more services than necessary, and (2) services inappropriate to diagnosis;
>
> (b) Assist with curbing client abuse through the production of client profiles of care received.

On July 26, 1976, Governor Carey signed a bill funding the development of the recommended MMIS system.

(W) "Control Procedures," Office of the Welfare Inspector General, March 8, 1976: The report concludes that "Most social services districts in the State had little or no control procedures for detecting fraud or program abuse in disbursing hundreds of millions of dollars annually to Medicaid providers."

Twenty-four of the State's 57 counties reported having providers under close audit surveillance. These providers accounted for 1.7 percent of the billings for all 57 counties. The remaining 33 counties had no providers under close audit surveillance according to their responses.

The audit stated:

> (1) For the most part procedures forwarded dealt exclusively with the processing of billings by vendors for compliance with local and State regulations governing allowable fees, completeness of forms, correctness of code, mathematical accuracy, and payment.
>
> (2) Procedures ranged from comprehensive in a very few counties to minimal in the majority of counties.
>
> (3) As a rule, processing procedures were handled by personnel at the clerical level with very little, if any, senior supervisory control indicated.
>
> (4) In most instances, there were no detailed control procedures during the processing stage which would serve to flag instances of potential fraud, unusual or suspicious billing patterns, overutilization of program services, consistently high billers, and so forth. It must be assumed, therefore, that to the extent that monitoring for these situations is taking place at all, clerical personnel bear a major part of the responsibility for such determinations.

The State medical handbook requires the counties to develop locally Medicaid claims procedures for reporting, monitoring, and processing of vendor claims and yet on the basis of the data OWIG accumulated, it appeared "no comprehensive data retrieval system exists in any county in the State to assist in monitoring the large sums involved . . . despite hard evidence of fraud and abuses within the various State health delivery programs."

(X) "State Medicaid Chief Resigns in Protest," Peter Kihss, the *New York Times*, March 24, 1976: Quoting a memorandum to her staff, the *New York Times* reported that Mrs. Beverlee Myers, who had been a deputy commissioner of the State Department of Social Services and in charge of the Medicaid program in New York since November 1973, resigned because the program was "mismanaged" and contained "basic flaws." She said the program suffered from fragmented responsibilities, adversary relations and inadequate supervision.

(Y) "Ineligibility in the New York City Medicaid Program," Office of the State comptroller, June 1, 1976: The report's findings were as follows:

—Annual costs for Medicaid ineligibles might have run between $19 and $40 million in 1974.

—More than one-half of the city's nonwelfare Medicaid cases failed to show up for their annual recertification interview.

—Deficiencies in State regulations and human resources administration procedural standards contributed to abuses and ineligibility.

(Z) "States Put Scalpel to Medicaid in Budget-Cutting Operations," John Taft, *Health Report*, May 1, 1976: The article addresses the current trend toward reduction of service and participation in Medicaid brought on in large measure by the skyrocketing costs fueled by waste, fraud, and abuse. It said in part:

> It is unbelievable in this day and age that States with some of the largest Medicaid programs have no computerized management system.

"The split nature of program administration between States' welfare and health agencies—has meant," said Former Deputy Commissioner of Social Services in New York, Beverlee Myers, "that, in fact, no one agency can be held accountable" and led "to the current inability of States to manage Medicaid."

HEW Secretary David Mathews is quoted as estimating the annual losses through fraud and abuse in the medicaid program at $750 million.

(AA) "Field Test Report, Development of Medicaid Provider Abuse Detection Program," Department of HEW, SRS, MSA, Touche, Ross & Co., March 17, 1976: Among the findings include the following:

—Computer-prepared provider service profiles and recipient utilization profiles are necessary to sample claims and detect certain types of physician and pharmacy abuse, namely duplicate claims, gang visits, itemized billing for all inclusive billings, prescription splitting, and prescription shorting. If profiles are not available, it is questionable whether a review is feasible.

—Total potential abuse in the program estimated at 15.7 percent as follows: Services billed but not rendered, 47 percent; services provided by nonphysician, 36 percent; duplicate payments, 8 percent; first visit for routine, 7 percent; other, 2 percent.

—Total potential pharmacy abuse in the program was estimated at 13.4 percent as follows: Claim submitted but drug not dispensed, 72 percent; exceeding usual and customary, 9 percent; duplicate payment, 8 percent; generic for brand, 5 percent; other, 6 percent.

—The subjective nature and labor intensiveness of one-on-one reviews of providers make it infeasible for broad based routine reviews and should be reserved for situations where a medical review is the basis for possible suspension or license revocation.

—Since profiles are essential for reviewing medical necessity and were available in only one State, Touche, Ross & Co. was unable to determine program waste due to overservicing. However, the present state of provider fraud and abuse appears to be sufficiently unsophisticated that substantial amounts of abuse were found even without the detection of overservicing.

The company recommended:

(1) Studies on a national basis to determine the total rate of Medicaid frauds and potential abuses.

(2) Guides detailing potential provider abuses to improve the effectiveness of prevention and detection.

(3) A systematic review of individual providers to determine if they are complying with program requirements and whether further investigation and administrative or criminal action should be undertaken.

75-902 O - 76 - 8

To date, none of these recommendations have been implemented.

(BB) "Audit Report on Controls over Medicaid Identification Cards New York City Human Resources Administration," Office of the State Comptroller, Audit Report No. NYC 30–76: "We found that controls and security over such cards was nonexistent. As a result, the State's Medicaid program was exposed to many potential fraudulent abuses." (Example: imprinting could be simulated with an ordinary typewriter.)

More than 10 million blank cards are shipped annually by the city. (The city reprints cards monthly.) Accountability for these cards is said to be "poor." Further, any misappropriation while en route from the State's printing contractor could not be detected readily. There is no regular control procedure even on a spot basis. Thus, a difference of 56,345 cards between the quantity shipped by State social services and the quantity reported by HRA in January 1974 was undetected and unreported (until this audit in 1976).

In addition, cards could also be misappropriated without detection:

(1) While en route from the warehouse to HRA's computer center;

(2) From the computer inventory room;

(3) From the computer center's stockroom;

(4) From the incinerator pit where obsolete cards await destruction;

(5) While being processed at the mailing contractor;

(6) While en route to the post office.

> In 1974, approximately 695,000 of the Medicaid identification cards mailed to clients—10 percent of those issued—were returned by the postal service as undeliverable . . . . HRA procedures did not prevent the monthly reissue of identification cards to persons whose previous cards had been returned. Our tests indicated instances where monthly reissue of an ID card to the same deceased person continued over a period of 6 to 9 months. This resulted from (1) the destruction of incorrectly addressed cards without determining the causes for the incorrect addresses, and (2) the lack of timely case closings for deceased persons.
>
> We estimate that the cost of the unnecessary reissues during 1974 amounted to approximately $229,000.

Previous control recommendations in October 1974, including Medicaid ID card reconciliation, "were not implemented as of February 1975." The reconciliation had not been carried out at the time of this audit (January 1976).

The Catalogue of Losses

These same reports can be summarized to graphically indicate the tremendous amount of dollars lost to the city and State of New York because of fraud, abuse, waste, and mismanagement in the Medicaid and public assistance programs. (The two programs are tied together in New York because qualification for welfare also makes one eligible for Medicaid.)

The reports above indicate from 20 to 30 percent of Medicaid recipients in New York State are ineligible for the benefits they receive.

Projected on an annual basis, this means an annual loss of $45 to $60 million. Figures for New York City, according to the various reports mentioned above, are from 33 to 50 percent—at a cost of $16 to $25 million.

Based on HEW's national estimates of fraud and abuse (8 percent), there would be $256 million in fraud and abuse in the New York Medicaid program. Most experts and the reports above concur in the suggestion that New York's figures for fraud and abuse would be higher than the national average. Estimates of loss through fraud run to 20 percent of the entire program. The staff projects a more conservative figure of 12 percent, or annual losses of about $384 million. Within the city, the range of fraud is from 10 to 15 percent, which means $180 million to $270 million lost.

Total losses to the State of New York combining ineligibility and possible fraud are at about $444 million a year. Adding the same two figures for New York City yields losses of $295 million a year.

Part 4

NEW YORK'S FISCAL CRISIS AND MEDICAID

A. OVERVIEW

Throughout 1975, national headlines focused on the fiscal problems of New York City and New York State. The problems surfaced initially with a near-default in January 1975 by the State's Urban Development Corp. (UDC), a public benefit corporation created to finance construction projects throughout the State. Shortly thereafter the city of New York announced it was on the verge of bankruptcy. For nearly a year, the State and city created special panels, arranged intricate financing schemes with pension funds, banks, and State agencies, and ultimately sought and secured a massive and unprecedented Federal loan (a maximum of $2.3 billion a year through June 30, 1978) to save New York City. As of the date of loan authorization, April 1976, the State was still involved in efforts to save four State agencies from default on bond obligations, to save seven other major cities from default, and to reestablish the State's credibility in the money market. To this date, the success of these efforts is still precarious.

In order to insure the flow of Federal funds, to create a balanced budget by June 30, 1978, and to avoid any future fiscal crisis, the city and State have initiated a number of control mechanisms. The Emergency Financial Control Board (EFCB) was created in the spring of 1976 by the State legislature, in effect, to oversee the fiscal operations of the city. Its primary role is to insure: (1) that the city makes timely repayment of the Federal loans extended by Congress; (2) that the city makes sufficient budgetary adjustments in the next 2 years so as to prove to the Secretary of the Treasury that there is a "reasonable prospect of repayment"—if the Secretary does not find such "reasonable prospect," he may delay or discontinue authorization of the seasonal loans approved by Congress; and (3) that the city draw up and implement a financial recovery plan to bring its budget into balance by June 30, 1978. The State legislation creating the EFCB mandated such a plan and the Federal loan authorization passed in 1976 terminates June 30, 1978. To date, the city has made timely repayments on all Federal loans issued pursuant to the constitutional authorization.

Another mechanism to control city expenditures is the Office of the Special Deputy Comptroller for New York City Affairs. This position was created within the State Department of Audit and Control shortly after the congressional authorization of Federal loans. His primary role is to review the financial recovery plans submitted by the city and submit his findings to the EFCB. Since April 1976, the city has submitted its initial financial recovery plan and numerous revisions to the EFCB. The Special deputy comptroller has criticized

each such submission for overestimating revenues and underestimating expenditures with the effect of underestimating the net deficit. In each critique the deputy comptroller also has noted areas where the city has failed to plan or implement necessary cost-saving procedures. Invariably, welfare and Medicaid administration is cited.

As of the printing of this report, the city is developing another fiscal recovery plan revision. It is not unreasonable to anticipate, in these circumstances, that there will be a continued flow of such revisions, comptroller's critiques, and EFCB reviews at least until June 30, 1978.

The city itself has increased the staffing of its budget bureau and comptroller's office in order to prepare and, theoretically, implement the recovery plans. They have also added a host of special advisory panels and task forces to focus on fiscal problems.

The following part of this section of the report will deal in greater detail with the relation between the city's fiscal recovery and Medicaid.

B. FISCAL CRISIS AND WELFARE AND MEDICAID PROGRAMS

Amidst the fiscal crisis there were renewed calls from the State and local level for Federal takeover of the costs of welfare. Emphasis was placed on the inordinate and rising costs of welfare, particularly Medicaid, and the need for increased Federal intervention and tighter controls on fraud, abuse, and administrative mismanagement in the Medicaid program. These utterances were not new. They reflect a recurrent problem recognized in New York State's Medicaid system since its inception in 1966: The continual rising costs of the Medicaid program and attendant fiscal burdens on the State and its localities caused by inadequate administrative controls for detecting and reducing fraud and abuse in the Medicaid program.

The rising cost of Medicaid in New York State is well documented. Between 1966, when Medicaid was established, and 1974, the total cost of Medicaid in New York State rose 900 percent to a staggering $2.1 billion ($3.2 billion as of 1976). During the same period the average number of monthly recipients rose 470 percent to a monthly average of 1,083,451. The bulk of the statewide costs (68 percent) and recipients (61 percent) are in New York City. And in New York City alone, Medicaid costs have increased by 125 percent over the last 6 fiscal years.

Medicaid costs are allocated between the Federal (50 percent), State (25 percent), and locality (25 percent) in New York State as they are in only four other States. The impact of the rising caseload and costs on localities, as well as the State, has been significant. In New York City, an average of 23 percent of the annual budget goes for welfare costs, nearly half of which is for Medicaid. In 1975 the city's share of all Medicaid costs alone was approximately $450 million—approximately 56 percent of the total city share of $800 million for all welfare programs in the city. The city has consistently argued that the continuously rising burden of welfare recipients and clients has placed inordinate demands on its declining tax base.

For instance, it is estimated that as of 1976 welfare costs comprised the largest bite on the city's tax dollar with 24 percent of all city tax levy funds going for welfare.

The pressure of welfare, and particularly rising Medicaid costs in the State's other 57 counties, has been similar. Recent estimates are that between 40 to 60 percent of these county budgetary expenditures are for welfare. For instance, in Suffolk County it is estimated that 13 cents of every dollar spent by government in the county is for welfare and that 40 percent of the county's budget is paid in welfare costs.

And there has been a clear history that these skyrocketing costs have placed a strain on the resources of the counties.

The fiscal "crisis" of New York also was not unique to the situation in the State's major cities. At least seven other major cities in the State have been designated as on the brink of a "fiscal" crisis: Yonkers, Rochester, Buffalo, Albany, Utica, Syracuse, and Binghamton. In each case, the cities cited are at the center of the State's largest urban counties and are primary consumers of welfare and Medicaid expenditures. Yonkers also has a State-legislated EFCB.

In 1966, Franklin County, which had the lowest per capita income of any county in the State, had 80 percent of its population eligible for Medicaid. As a result, its original $840,000 county share for Medicaid had to be supplemented by an additional $500,000 appropriation. The added moneys were garnered by imposition of a new 2-percent sales tax. Also in that first year of Medicaid in New York State, Suffolk County required an additional $4 million and Westchester County an additional $2.5 million to cover their local shares.

The irony of these facts is that in 1965 all official estimates projected that the Medicaid program would not draw increasing funds from the Federal Government, would allow the State's share to remain the same, and would *decrease* the costs to localities. However, the liberal "need standard" established by the State as an eligibility standard resulted in cost increases at all three governmental levels as did the legislature's decision to add a host of "optional" services under Medicaid coverage. State and county budget estimates were totally undermined and the increased Medicaid costs resulted in increased real estate taxes in every county and new sales taxes in 28 counties.

These pressures on localities continue. In 1975 the State and its Medicaid recipients were threatened with a near revolt by the counties. In August 1975 the Orange County legislature refused to authorize $1.5 million in borrowing to cover the county's share of a $5.5 million deficit in its Medicaid and AFDC programs. Only after the State initiated court proceedings against the county in September did the legislators reverse their position. Orange County's lead was followed by similar moves in Sullivan, Oneida, Ulster, and Dutchess Counties. The counties did not want to borrow money to cover Medicaid and other welfare budget deficits because such borrowing results in excessive interest costs (estimated at 10 to 12 percent annually) which invariably can only be paid for by increasing property and sales taxes.

To emphasize the significance of the problem, the county officers Association projected that most, if not all, of the State's counties would exhaust welfare funds before the end of 1975. They estimated that the State's thirteen major urban and suburban counties would face welfare deficits of $70 to $80 million above the $800 million already budgeted for welfare. Additionally, many counties face the problem of having no additional ability to raise revenues because of the State

constitution's limit on the amount of revenues that can be raised from real estate levies. For example, Orange County is currently taxing at 98.8 percent of its constitutional limit and Schenectady County is within 94 percent of its limit. Sales taxes are another alternative, but counties are only empowered to add up to an additional 3 percent sales tax on top of the State rate of 4 percent.

The protests of localities have been vocal throughout the State. In April 1976, the town supervisor of Woodstock, N.Y. claimed he would not pay his town's share of reimbursement of Ulster County until the county stopped abuses in the welfare program. He claimed that within 1 year the cost of welfare to the town jumped from $3,000 a month to $70,000—well over a 2,000 percent increase.

Sarah Curtis, commissioner of the Steuben County Department of Social Services and president of the western New York region, Social Service Commissioner's Association, has stated: "The Medicaid bill is breaking us. The Federal and State governments lack a sensitivity to local welfare problems."

The situation culminated in meetings of officials from all New York State counties in September and October 1975. The threat of an all-out revolt and court fight by the counties was avoided by the State Social Service Commissioner's promise to cover the deficits for this year by advancing to various counties their State and Federal aid shares. *This action only delays the immediate cash shortage problem for 1 year as the State and its counties mount an intensive lobbying effort for federalization of welfare.* The committee staff observes that such advance payments have been one of the traditional financial "gimmicks" used by the city and State to avoid strict cost containment and balanced budgets. Such arrangements allowed the city to continue what, in fact, was deficit spending for many years and contributed to creating the current fiscal crisis.

Fiscal Recovery and Medicaid

1. STATE CREATED ROADBLOCKS TO AUSTERITY

The State has asserted that New York City alone bears one-third of the national effort in welfare at the local level while comprising only 4 percent of the national population. Similarly, the committee staff found, as noted earlier in this report, that New York State accounts for nearly 25 percent of all Medicaid expenditures nationwide while representing only 9 percent of the Nation's population.

Felix Rohatyn, chairman of the Municipal Assistance Corp. and one of the three members of the city's emergency financial control board, has said: "Unless there is a Federal assumption of welfare and Medicaid costs, the city within its borders is not a viable economic entity." Mr. Rohatyn has been joined by Governor Carey, Mayor Beame, the State County Officers Association, and the county executive of the major counties surrounding New York (Suffolk, Nassau, and Westchester) in urging federalization of all welfare costs. In the summer of 1976, a similar policy position was adopted by the National Governor's Conference and the nonprofit Committee for Economic Development. It is currently being advocated in Congress as well. A bill (H.R. 9552) has been introduced which would grant an additional annual $1.2 billion to the State, with between $375 million and $750

million earmarked for the city, depending on whether the State permits the city to forego its full 25 percent share of the funding.

However, much of New York's welfare burden on localities is created because of the State's own reimbursement requirements and the poor administration by the localities, as discussed in parts 3 and 5 of the report. For instance, since the inception of Medicaid in New York State, State law has required a 50–50 split between the State and localities of the non-federally-funded share (i.e., 25 percent State, 25 percent city, 50 percent Federal). This was part of the State's plan as submitted to and accepted by HEW. However, New York is only one of five States which split the non-Federal share on a 50–50 basis. The others (Iowa, Kansas, Minnesota, and North Carolina) all have small Medicaid programs (0.63 percent to 0.79 percent of all national expenditures for Medicaid, as opposed to New York's 20.57 percent share in 1974). In fact, there are only 14 States which require any local contribution whatsoever. Five, as cited above, require a 50–50 cost-sharing while the other nine range from 1 percent (Illinois) to 40 percent (Indiana). The 36 other States all have the State government fully responsible for the non-Federal share. One source summarized the situation by saying: "In all but five States, local governments are required to pay for none or a miniscule portion of welfare."

This situation is not new. In 1970, 20 States required either no local contribution or less than 1 percent local contribution and only 9 required local contributions in excess of 15 percent.

In testimony before the Senate Banking, Housing and Urban Affairs Committee on April 1, 1976, Secretary of the Treasury William Simon commented on this allocation of Medicaid and welfare costs among the governmental levels and labeled it the "root" of the State's fiscal problem. He added, however, "that New York State is hardly in a financial position to change this formula now." He also opposed the federalization of welfare as a solution to New York or any other municipality's fiscal problems. He urged, in the alternative, an extension of revenue sharing and passage of President Ford's $10 billion health services grants legislation (as a replacement for Medicaid).

The staff observes that in view of the past abysmal record of the States in administering Medicaid, the release of more millions in block health grants to the States without cost control requirements would be an unparalleled disaster in terms of fiscal integrity.

Federal law requires a minimum Federal contribution of 50 percent and a maximum of 83 percent for medical assistance expenditures in a State's approved Medicaid program. The Federal share is based on a variable-grant, Federal-State matching formula which pays the most to the State with the lowest per capita income.

As regards the States' own share of funding, until July 1, 1970, each State had to pay at least 40 percent of the non-Federal share from State money with the remainder being allowed to come from local funds. By July 1, 1970, all of the non-Federal share had to be provided by the State Government or through an approved tax-equalization formula with the same effect. All these provisions encouraged State rather than local responsibility and that has been the national trend. *New York State's pattern is atypical.*

Another reason for the heavy cost of Medicaid built into the New York system is that New York has added by legislative mandate, a large number of additional services to Medicaid coverage. Federal

law (42 USC 1397) mandates only five "basic" health services for Medicaid coverage—physician care, hospitalization, nursing home care, laboratory and X-ray services, and outpatient clinic services. The amount of service is mandated by Federal law but left to State determination within the areas of coverage (i.e., number of days in nursing home or hospital). The law also permits the States to add additional services at their own discretion.

At its own discretion, New York has added all the additional nonmandatory services for which Federal matching funds are available: medical or remedial care furnished by other practioners licensed under State law (e.g., chiropractors, podiatrists, etc.), home health care, private duty nursing care, clinic services, physical therapy, prescribed drugs, dentures, prosthetic devices and eyeglasses, other diagnostic, screening, preventive, and rehabilitative services, inpatient hospital and nursing home services for persons aged 65 or older in a TB or mental institution, and adult dental care.

Until recently, the State also had a basically liberal policy as to the extent of coverage permissible within the five mandated coverage categories. This policy again was by legislative mandate. However, in 1976 the State legislature, is direct response to the city and State's fiscal problems, legislated new limits on: Medicaid-covered hospital length of stay, provisions of deferrable surgery, and eligibility for skilled nursing services (see chapter 76, New York State Laws of 1976 and part 85, Rules and Regulations, New York State Department of Health).

Another factor which automatically increases the costs of Medicaid in New York is the State's addition of the "medically indigent" category. Federal law requires only that all public assistance and SSI clients automatically become Medicaid eligibles. The law also permits each State to add a "medically indigent" category to be defined by each State (often referred to as "MA-only"). New York is one of the few States which has the "MA-only" category and is generally considered the most liberal in terms of eligibility standards. Approximately 25 percent of all MA recipients in New York State and about 10 percent in New York City are in the MA-only category.

Rosemary and Robert Stevens, in their recent book "Welfare Medicine in America," have asserted that the New York Medicaid program has always been the most liberal in the Nation based on its maintenance of the MA-only category, liberal eligibility standards, provision of virtually every "optional" service, and relatively loose limitations on the scope of permissible coverage within the five mandated Federal coverage categories. The Stevenses document this policy as a deliberate political and governmental policy of the Rockefeller administration, including the Governor's dealings with the legislature to insure these provisions.

These built-in factors and the administrative deficiencies in New York (see parts 3 and 5 of this report) account largely for the high comparative costs of welfare in New York. A New York State Senate task force, for example, observed recently "that the New York Medicaid average of $188.26 per month recipient is nearly triple that of Mississippi." The same report noted "The average monthly welfare payment in New York State comes to $104.80, as against $14.40 in Mississippi."

Ironically, since early 1975 Governors and legislatures in more than 20 States have introduced a wide variety of cost-containment mesures in an effort to curb the Mediciad crisis (i.e., reduced reimbursements, tighter eligibility requirements, reduction of "optional" coverages and reduction of scope of benefits in the five "mandated" categories). Governor Hugh L. Carey attempted to impose some similar controls in 1976, but was rebuffed by the legislature on most of the proposals.

Parenthetically, a similar problem exists in the public assistance area. New York adds the home relief (HR) category to its public assistance outlays. The HR program is not part of the Social Security Act and receives no Federal reimbursement. The cost is 50 percent State and 50 percent Federal. The existence of the HR category in New York, plus the State's 50-50 split with the localities on the non-Federal portion of all other PA costs, places a heavy burden on New York State localities compared to other States' localities. For instance, in 1974, New York City bore 30.4 percent of the cost of all the PA expenditures in the city, and in Erie County the locality paid 29.6 percent of all the costs. These compare to significantly smaller costs borne by other major cities due to the less extensive PA coverage and greater State assumption of costs.

The following chart illustrates this point for PA and is parallel to the Medicaid situation, particularly since most Medicaid recipients are PA clients.

1974 PUBLIC ASSISTANCE EXPENDITURES BY SOURCE IN 7 MAJOR CITIES

[Dollars per capita]

City	Total		City share		County share		State share		Federal share	
	Dollars	Percent	Dollars	Percent	Dollars	Percent	Dollars	Percent	Dollars	Percent
New York	$158.94	100	$48.34	30.4	----------		$48.76	30.7	$61.84	38.9
Chicago	170.83	100	4.89	2.9	----------		94.04	55.0	71.90	42.1
Los Angeles	90.51	100	----------		$24.85	27.4	27.93	30.9	37.73	41.7
Philadelphia	169.45	100	----------		----------		99.66	58.8	69.79	41.2
Detroit	222.40	100	----------		9.49	4.3	126.54	56.9	86.37	38.8
Houston	15.93	100	----------		0.63	4.0	4.59	28.8	10.71	67.2
Baltimore	102.73	100	1.23	1.2	----------		57.40	55.9	44.10	42.9

New York also did not take either the option of delayed entry or nonentry in the Medicaid program. Either option would have reduced costs to the State, but would have severely limited the availability of health care services to low-income citizens. Title XIX allowed payment for State medical expenses under the old categorical assistance programs (OAA, AFDC, AB, APTD, and Kerr-Mills) until December 31, 1969. After that date there was no Federal reimbursement unless a State had an approved title XIX plan. Three States did not enter the Medicaid program in 1966, but remained on the old programs until the 1969 deadline—Arkansas, Alabama, and Mississippi. Alaska did not enter the Medicaid program until 1972, claiming the potential costs would be unbearable since virtually all Eskimos would be eligible. Arizona has not participated in Medicaid, using the same logic of "unbearable" costs due to the eligibility of virtually all Indians.

2. FAILURE TO ALLOCATE MONEY FOR MEDICAID ENFORCEMENT

A constant irony in the "New York City fiscal crisis" is that there have been no significant increases in staff for the Medicaid enforcement program while the city has simultaneously failed to drop well-recognized superfluous programs and has granted significant pay increases in other areas. This is despite widely-recognized existence of fraud and abuse in the costly Medicaid program (see part 3 of this report) and the City Health Department's assertion that even with its current limited staff it generates a 10 to 1 cost-benefit ratio.

Compounding the irony is the continuance of many unnecessary high-paying jobs in many city agencies at the same time that staff increases are denied in Medicaid. A recent study by a State Senate task force observed:

> We question whether life-saving services such as the fire department can be cut further, but certain departments such as public events, board of water supply, taxi and limousine commission, and city records should be abolished before essential services are further deteriorated.
>
> There are numerous other functions of city government that duplicate Federal and State services, such as the board of examiners, city register, and ports and terminals. And while the functions of such departments as city planning, housing and development, highway planning are necessary, they are presently being funded in far too costly a fashion, considering all other demands. [*The committee staff believes health care to the poor and elderly is also an essential service.*]

A recent report by the special State deputy comptroller assigned to oversee New York City's fiscal crisis charged that the city was maintaining a $77 million annual planning and design payroll although prospects for new city construction before 1980 were "extremely doubtful." The report particularly noted that while the City Parks Department capital budget had been cut by 80 percent ($30 million to $6 million), there was only a 10 percent cut in the 160-man capital projects planning staff (15 staff cut) which utilizes the capital budget funds.

Another recent example of questionable allocation of money, particularly vis-a-vis the lack of Medicaid enforcement staff and other enforcement resources, was the granting of nearly $128,000 in annual salary increases to professionals in the city's bureau of the budget. The mayor's office said such salary increases were unusual in view of the city's freeze on pay increases, but they were necessary to maintain the budget staff which has acquired increased duties due to the fiscal crisis. This is despite the addition of the staff of MAC, EFCB, and nearly a 50-man special staff in the State comptroller's office, in addition to the city's budget and comptroller's office, assigned to deal with the city's fiscal matters.

Based on the estimates of the city health commissioner, if the $128,000 in salary increase allocated to budget staff were allocated to the Medicaid enforcement staff there would be a minimum return of $128 million or a net return of 900 percent in profit on investment.

Even with the admitted need and cost-benefit justification for an

expanded Medicaid enforcement program in New York City, the city health department's Medicaid program currently has an annual administrative budget of approximately $2.4 million.

3. UNDERESTIMATING MEDICAID COST—IMPACT ON FISCAL RECOVERY

New York City's loan from the Federal Government was based on the city's 3-year financial recovery plan. As cited earlier in this section, that plan has been the subject of much criticism, most of which alleges the plan overestimates savings and underestimates costs.

One of the areas of constant criticism has been welfare and Medicaid costs.

The original financial recovery plan projected no increased costs for welfare or Medicaid over the next 3 years. However, data from the city's bureau of the budget and the citizen's budget commission shows that there has been an annual average increase of 25 percent in Medicaid costs in New York City over the last 5 years. Mr. Richard Morris, an economist and president of the Public Affairs Research Organization, says that based on these figures it is reasonable to conservatively expect a rise of 30 percent in Medicaid costs over the next 2 fiscal years. *Mr. Morris calculates this means an estimated total of $540 million in additional Medicaid costs in New York City which are not anticipated in the financial recovery plan—$135 million of which would be paid for directly by the city.* Mr. Morris has also noted that the fiscal recovery plan does not balance the projected savings from firing various numbers of municipal employees and cutting service programs (i.e. day care) against the projected increased welfare and Medicaid costs incurred by the displacement of these workers and persons dependent on service programs.

The ultimate irony in this respect is that the Senate Committee on Banking, Housing and Urban Affairs, headed by Senator William Proxmire, has stated that the biggest threat to New York's financial recovery is the State and city's "gloomy economic outlook." In its May 1976 report, Senator Proxmire's committee noted the following factors mitigating against economic recovery:

> . . . an unemployment rate of 12.2 percent, the loss of 141,000 private sector jobs in the last year alone, *the increase in welfare costs* [emphasis added], the loss of construction jobs due to cuts in the capital budget, and the undeniable fact that New York City is lagging behind the rest of the country in terms of the economic recovery.

Senator Proxmire's committee report also noted that the city's fiscal recovery plan contained many "risk" areas in terms of projected savings—including welfare and Medicaid.

Not only does the city's plan not project any Medicaid or welfare costs increase, it simultaneously predicts $60 million worth of savings in welfare and Medicaid and a "more or less steady caseload over the next 2 years." The savings are projected despite no additional city allocations for welfare or Medicaid enforcement, no prospects for an improved city or statewide computerized monitoring system for at least 3 years, decreases in the number of health and welfare department employees due to layoffs, and the city's freeze on hiring and current evidence of the continuing failure of the city to curb client and

provider abuse in the welfare and Medicaid programs as documented in parts 2, 3, and 5 of this report.

The city has at least partially recognized some of the deficiencies in its revised revenue and expense estimates submitted in February 1976—6 months after the initial plan was adopted. The revised estimates projected an additional deficit of $525 million in the original plan due to "lagging economy and continued inflation, amendments to Federal and State law, and other unforeseen changes." Among the $525 million increased deficit was a projected $82 million deficit due to "increased welfare, health, and energy costs." These figures also do not factor in possible increased costs of any new labor contracts with hospital workers or the possibility that projected Medicaid costs decreases may not be effectuated if proposed hospital closings and health manpower layoffs are not implemented.

Reports of various State bodies overseeing the city's fiscal recovery in recent months have observed the city's failure to accurately calculate the impact of welfare and Medicaid costs on the possibility of fiscal recovery. The following are some major observations contained in these reports:

(1) In May 1976, the special deputy comptroller, in commenting on the city's proposed 1977 $12.5 billion expense budget, described as "unattainable" plans to reduce Medicaid and public assistance spending by $15.7 million.

(2) In June 1976, the EFCB said the city must "slash" $150 million from its 1976–77 budget because the city was not moving fast enough "to end mismanagement" and too many city agencies were still doing "business as usual."

In this respect the EFCB report singled out the city's Health and Social Services Department for "conducting business as usual." The report noted "waste in Medicaid and welfare—notably the failure to crack down on welfare ineligibles." The report also noted that the municipal hospital system, a major recipient of Medicaid money, was "lagging in their cuts."

(3) Also in June 1976, the Municipal Assistance Corp. (MAC) identified several "areas of risk" in the city's proposed 1976–77 budget accounting for between $250 and $300 million in possible additional costs. Approximately $160 million of these "risks" were either directly or indirectly attributable to Medicaid, "planned cuts in Medicaid, public assistance, addiction services, day care, and hospitals."

The EFCB report referred to above was prepared by Mr. Stephen Berger, EFCB's Executive Director. The committee staff notes that prior to assuming the EFCB position, Mr. Berger served as the State's commissioner of social services during Governor Carey's first year of office. In fact, in a January 1976 report to the State legislature, then Commissioner Berger stressed that the State "*has consistently failed to maintain an acceptable level of administrative performance*" in the Medicaid program. He said further:

> *This situation has never been defensible, but given the current of the State's economy, it continuation would be worse than indefensible. It would be a form of fiscal suicide.*

Mr. Berger estimated that once the proposed computerized welfare management system (WMS) is operational, an estimated $48 million

in cost savings/reductions would be realized in New York City alone due to decreased Medicaid eligibility. *This would mean a reduced expenditure of $12 million a year from the city treasury.*

In addition, Mr. Berger estimated that once the proposed computerized Medicaid management information system (MMIS) is operational, a conservative estimate of $74 million (second year of operation) to $163 million (by the fourth year of operation) would be achieved in cost savings/reductions in New York City alone due to decreased administrative errors and fraud and abuse related to Medicaid provider payments. *This would mean a reduced expenditure of $19 to $40 million a year from the city treasury, conservatively estimated.*

This would mean an annual savings to the city itself of between $31 to $53 million a year from computerization alone. As the committee staff has noted elsewhere in this report (parts 2 and 5.C), both the city and State have continually failed to institute any overall WMS or MMIS systems, or interim computer provider surveillance programs despite the fact that:

(1) New York has the most expensive Medicaid program in the country with a consistent record of a "failure to maintain an acceptable level of administrative performance"—resulting in extensive ineligibility and provider fraud and abuse.

(2) At least since 1973, the Federal Government has made extensive financial aid available for the development, phasing in, and operation of MMIS in the States. Under Public Law 92–603, Federal financial participation was made available at the rate of 90 percent for the development, 50 percent for phase in, and 75 percent for the operation once it meets Federal requirements.

(3) Approximately 15 States, including California, Michigan, Ohio, New Jersey, and North Carolina, already have fully operational MMIS operations. In several cases the full MMIS, or key providers surveillance components thereof, were operational in 1 year.

(4) Both the State and city have for some time had extensive computer facilities at their disposal.

Committee staff notes that in 1976 the State legislature finally approved allocation of the State's share of moneys necessary to trigger Federal participation in financing the development of an MMIS. However, the State has projected that it will be at least 3 years before the MMIS is operational (1980) and that no cost savings/reductions will be realized until the second year of operation.

The committee staff, therefore, makes the following observations:

(1) The projected savings from computerization cannot be reliably counted as part of any fiscal recovery plan until after 1980.

(2) The State and city should proceed to implement the basic computer programs for "provider and patient profiles" which, given current computer capabilities, can be implemented in approximately 3 months. As discussed in part 5 of this report, HEW Region II Audit Agency developed a prototype of this run using city tapes in less than 2 months.

The committee staff also believes that a reasonable increase in investigative staff in the New York City Health Department's Medicaid program, with the readily available provider and patient profiles and other accessible computer surveillance tools, would make a significant impact on MA provider fraud and abuse.

Conclusions

The city's "fiscal crisis" and the need for Federal assistance were predicated on the revelation of a $1 billion budget deficit in early 1975. The committee staff concludes from the data before us that if the city had taken reasonable and prudent steps repeatedly suggested over the last 10 years, against fraud and abuse found in the Medicaid system, that the fiscal crisis could have largely been avoided.

The current evaluations of the city's financial recovery plan and the operation of the city's health and social services' agencies, cited in parts 3 and 4 of this report, still indicate the same pattern of administrative laxity which has resulted in this $1 billion loss.

There is ample evidence to indicate that one of the primary causes, if not the primary cause, of the city's and State's fiscal crises has been its mismanagement of the Medicaid program. The committee conservatively estimates that $444 million annually is lost in New York State, of which $295 million annually is lost in New York City due to ineligible Medicaid recipients and individual Medicaid provider fraud and abuse.

These calculations are deliberately conservative. Based on these estimates, the city's share of funds lost to Medicaid practitioner fraud and abuse and recipient ineligibility is $74 million a year (i.e., the 25 percent non-Federal share of the $295 million in annual losses). This means that in the 10 years of the Medicaid program, the city has unnecessarily paid out $740 million for its share of Medicaid costs.

The application of other less conservative figures indicates that in the last 10 years New York City has incurred an unnecessary debt of $1 billion due to fraud and abuse by all categories of Medicaid providers and Medicaid recipient ineligibility—a sum equal to the budget deficit which brought New York City to the brink of bankruptcy.

Part 5

JURISDICTION AND RESPONSIBILITY

"I am somewhat embarrassed that your staff has produced in 2 months something which neither the city nor the State has been able to produce in over 7 years."

—Dr. Martin Paris, deputy executive medical director for Medicaid, New York City Health Department; letter to Mr. Bernard Luger, Director, HEW Region II Audit Agency, on the audit agency's development of provider and patient profiles (December 16,1975).

"The ultimate truth of the situation is that *New York, with clearly the most expensive Medicaid program in the country and probably one of the best in terms of the quality of care provided to the poor, has consistently failed to maintain an acceptable level of administrative performance.* This situation has never been defensible but, given the current condition of the State's economy, its continuation would be worse than indefensible. It would be a form of fiscal suicide."

—Mr. Stephen Berger, commissioner, New York State Department of Social Services, to the New York State Legislature, (January 1976). Mr. Berger is currently executive director of the State's Emergency Financial Control Board for New York City.

Previous protions of this report have detailed the significant amounts of fraud, waste, and inefficiency in the Medicaid program—particularly in New York. The immediately preceding part points out that proper management of this program over the years would have wiped out New York City's present financial deficit, making Federal loans and guarantees to the city unnecessary. Part 5 of this report raises the question: Who is responsible for the present tangled state of the program?

Part 5 begins with a detailed outline of the responsibilities of the various agencies in State and local government. The committee wrote to each of these public officials, asking pointed questions about their efforts to control fraud, abuse, waste, and mismanagement. Their replies are capsuled in sections A and B below. The full text of their letters can be found in appendix 2. Section C is a general critique of governmental responsibility in New York. Section D assesses the responsibility of professional medical societies. Section E assesses the respon-

sibility of the Federal government, particularly the Department of Health, Education, and Welfare.

A. STATE GOVERNMENT

The responsibility for the administration of the New York Medicaid program is fractured within several agencies. This relationship, in large part, explains the historic maladministration of Medicaid in New York State. The powers and duties of the various State agencies follow.

1. Overview

Title XIX of the Social Security Act was enacted into law July 30, 1965 (Public Law 89–97—see 42 U.S.C. 1581, et seq.). On November 10, 1965, New York Governor Nelson Rockefeller issued an executive order designating the State department of social welfare (now State department of social services) as the "single State agency" required to submit the State's plan under title XIX.

New York State joined the Medicaid program with passage of enabling legislation on April 30, 1966. The legislation placed overall administration for the program under the then department of social welfare (now department of social services) as the "single State agency" required under title XIX. The legislation, however, required the department to contract with the State department of health with respect "to administer and supervise the medical care and health services" available to eligible applicants or recipients of medical assistance, either directly or by contract with certain local health districts. (Chapters 256 and 267, Laws of 1965, adding title 11 to article 5 of the Social Services Law—see specifically section 364(a), a Social Service Law.)

The basic division of labor between health and social services was set forth in an interdepartmental contract between the two departments dated August 30, 1966. The agreement became effective October 31, 1966, as section 364 of the Social Services Law. (Chapter 256, Laws of 1966.) Under the terms of the agreement, the State and local social service departments have two primary obligations, among the seven specified by statute:

(1) All client eligibility determination and recertification; and
(2) Payment of all claims.

The State and local health departments' two primary obligations, among the six specified by statute, are:

(1) Setting standards (including fee schedules) for proper medical care and health services through the State medical handbook and *local medical plans;*

(2) Supervising providers to insure compliance with Federal and State standards, including quality and availability of services and adherence to all rules and regulations contained in the State handbook, State laws, and State compilation of codes, rules, and regulations.

The State and local health departments are thus responsible for surveillance over all institutional (i.e., nursing homes, hospitals, and other health care facilities) and noninstitutional (doctors, dentists, and other individual medical professionals) providers under the Medicaid program.

The bifurcation of responsibility for the Medicaid program has been a constant source of criticism of the New York program.

This is because both the social services and health departments have audit and review responsibilities—health under item 35 and the interdepartmental contract; social services as part of their responsibility for paying claims and claiming reimbursement from the State and Federal Governments. Yet the practical manual and computer controls over Medicaid providers rarely dovetail into an effective monitoring system. Each agency historically has blamed the other for failures in the program and, to date, the State has failed to alter its "State plan" so as to consolidate all Medicaid monitoring functions in one agency.

An additional problem has been that licensure of all medical professionals rests with the State department of education. Until recently, the health department had virtually no input on discipline of such professionals and now only over physicians. This has added a third party to the maze of agencies involved in the discipline and surveillance of professional conduct by individual Medicaid providers. The department of health has full licensure control over hospitals, nursing homes, and other institutional providers. However, "Medicaid mills," discussed earlier in this report, are not regulated by any of these agencies.

A further complication is added when legal action is sought against providers. Such actions must be initiated by the State attorney general on behalf of health, social services, or education authorities, local county attorneys, district attorneys, or Federal authorities.

The State estimates that the total annual administrative costs incurred by all State agencies involved in administering the $3.2 billion New York Medicaid program is $43.6 million (Social Services—$7.5 million; Health—$14 million; Mental Hygiene—$22.1 million—Mental Hygiene receives $500 million in Medicaid moneys to administer from Social Services).

2. Department of Social Services

a. ORGANIZATION

The State department of social services has approximately 2,300 employees and annually administers funds valued at approximately $6 billion. There are three regional offices. These offices and three central office units, combined with 58 local social service districts, are the organizational resources available for implementing social services' obligations under the Medicaid program.

The three central office units are:

(1) Within DSS, responsibility for the medical assistance program is lodged in the *division of medical assistance*, which has a total staff of 83 and is headed by a deputy commissioner. The division includes two small units involved in planning, program development, and the monitoring of Federal actions.

The division's main operations, however, are centered in the *bureau of medical assistance operations*. The bureau:

—Monitors local eligibility determinations in the "MA-only" category (that is, Medicaid recipients who are not public assistance or SSI recipients);

—Provides liaison with the departments of health and mental hygiene;
—Provides staff for the New York State Hospital Utilization Review program—located in health;
—Processes applications for Medicaid for DMH and office of drug abuse services (ODAS) inpatients;
—Provides supervision and technical assistance to operators of skilled nursing facilities (SNF) and health-related facilities (HRF);
—Operates a "placement exchange" designed to expedite transfer of patients from SNF's and HRF's to lower cost types of adult care facilities.

In addition, review of expenditures of Medical moneys, eligibility determinations, and systems problems may be conducted by DSS's office of adudit and quality control.

(2) *The office of audit and quality control (AQC)* was not established until 1973. Its aim is to give State DSS the capacity for monitoring and improving the efficiency of local welfare operations and particularly to reduce ineligibility and overpayment rates among public assistance recipients to the tolerance levels established by HEW. Under Public Law 92-603, HEW set tolerance levels for States and deadlines for their implementation. AQC has been spending most of its time and manpower in this area. There are 557 staff members assigned to AQC: 39 in its central office (Albany) and 518 in its three field offices—Albany (68), Rochester (96), and New York City (354).

AQC's operational emphasis was described in a January 1975 report to the Governor as follows:

> Until now the office has concentrated its efforts on improving income maintenance efforts. Its mandate, however, covers Medicaid and social services as well, and it is now beginning to involve itself in review of those programs as well.

Nevertheless, the department's 1974 annual report showed the results of several AQC audits of medical assistance which revealed frauds abuse in the Medicaid program's utilization by hospitals, nursing homes, and medical practitioners.

(3) *The Office of Management Planning and Data Processing* has been working with New York City to develop the city's proposed automated payment system for Medicaid vendors and has projected future plans to develop a statewide automated Medicaid payment system, automated eligibility determination for "MA-only" cases, and a central automated statewide client registry.

Activities of the New York State Department of Social Services Office of Audit and Quality Control in the Medicaid program based on its 1974 annual report:

Audits of Medical Assistance

Hospitals.—An audit of the New York City Health and Hospitals Corp., whose hospitals receive more than a third of all Medicaid payments for hospital care in the State, revealed large-scale wrongful charges to Medicaid for patients who had other health insurance available to them.

Preliminary reviews of municipal and voluntary hospital outpatient departments disclosed excessive Medicaid claims through duplicate billings. Errors included Medicaid billings for more than the actual number of outpatient visits and claims for both Medicare and Medicaid for the same treatment.

Recommended corrective actions include a uniform hospital record system, sample audits by the city department of social services, and an electronic data processing program to sort out duplicate claims.

Nursing homes.—Reviews of eligibility and billing and claiming procedures in 46 nursing home audits across the State indicated:

—Nursing homes were failing to bill Medicare first and claim Medicaid reimbursement only for services not paid by Medicare.

—Extended care facilities were not billing Medicare for certain periods of care that Medicare will pay in situations related to hospitalization.

—Nursing homes kept inadequate records and made incorrect charges against patients' incidental funds.

An estimated $25 million in additional Federal funds can be collected with corrected eligibility, billing, and claiming procedures.

Audit of medical practitioners.—The department completed groundwork for an audit of payments to medical practitioners to establish the validity of their claims for Medicaid and to identify related problems.

A related survey is underway to help determine appropriate department policy toward group practice operations such as the store front facilities common in New York City.

Improved eligibility controls.—During 1974 the department cooperated with the Federal Department of Health, Education, and Welfare in a pilot project to test methods of improving controls over eligibility for Medicaid and correct payments to MA providers.

In addition, the "on-site" deployment of quality control auditors in local districts to monitor eligibility determinations for public assistance was extended on a selected basis to monitor eligibilty for MA-only. The auditors help correct weaknesses in local eligibility determination procedures and contribute to the improvement of local staff performance.

The "on-site" MA-only audits were conducted in New York City and Nassau and Suffolk Counties. They are scheduled to be implemented statewide.

Other medicaid audits.—In 20 districts the department audited local agency compliance with State guidelines for the child health assurance program, the State's version of the Federal early and periodic screening, diagnosis, and treatment program to safeguard the health of Medicaid-eligible children.

Audits reviewed other facets of the Medicaid program, including the operation of hospital inpatient utilization review, public institutions and public home infirmaries, the visiting nurse program in New York City, the purchase of hearing aids under Medicaid, Medicaid fraud, the per diem rates for private child caring institutions, and hospital claims.

b. POWERS AND DUTIES

The State department of social services has the responsibility to conduct investigations and audits of any payment made through the

local agency, any person involved in the operation of agency programs, and of the programs themselves (sections 20 and 34, Social Services Law). Although the heads of county and city social service districts are appointed by the local entities, the State DSS commissioner may present charges to the local appointing officer where he believes there has been a failure to properly perform duties as required by statute, rule, or regulation (section 34, Social Services Law). *The committee has found no record of such "charges" ever having been presented.* The general supervisory power of the department includes the ability to grant or withhold reimbursement and issue rules and regulations regarding administration of programs and internal administration (section 20, Social Services Law).

These general powers of the commissioner and department of social services, and the specific responsibilities regarding the Medicaid program, have resulted in a variety of rules and regulations governing the recipients of Medicaid, providers, and local administration. These are set forth in volume 18 of the Official Compilation of Codes, Rules, and Regulations of the State of New York (18 NYCRR).

These rules cover procedures for the submission to and payment of bills by local welfare departments (part 302), eligibility and audit reviews (part 326), requirements applicable to fraud cases (part 348), requirements for public assistance eligibility (parts 349 and 360), and detailed requirements on accounting records, controls, and reimbursement procedures (parts 585 and 605). As regards medical care, there are detailed rules and regulations promulgated covering program administration, policies, and standards governing provision of medical and dental care, fees and reimbursement, and procedures and forms (parts 500–541). These sections include the professional requirements for any person authorized to render Medicaid services, fee schedules, and authorization procedures as required under sections 363–369 of the Social Services Law and incorporates relevant portions of Federal and State health department requirements (i.e., from State medical handbook) in these areas.

The basic responsibilities of the State DSS and local social service districts regarding Medicaid provider unacceptable practices and fraud appears in item 35 of the State medical handbook. This was originally promulgated on July 15, 1971, and revised October 1, 1975. The revision was sent to all State DSS district offices and local social service commissioners by the State DSS under transmittal No. 75–MHR–31 on November 24, 1975.

Item 35.1 deals with unacceptable practices by Medicaid providers. The local social service district is supposed to be represented at the initiation by the local health director of any proceeding against a provider. This is because if legal proceedings are required to make restitution of moneys as ordered by the local health director, the local social services agency must initiate such action. The local social services agency also may have to produce copies of vouchers and payment records for the administrative action by the local health director or, if appealed, by the regional director or a court. Also, the local health director cannot suspend or disqualify a provider from Medicaid without written approval from the local social services commissioner. If this is done, then the action applies to said provider's ability to operate as a Medicaid provider anywhere in the State. In such cases, the

local social services agency must so notify State DSS so it can, in turn, notify all other local social service districts. The same holds true if the provider is reinstated.

As regards fraud by Medicaid providers, two sections of the State Social Service Law deal directly with penalties for fraudulent activities. Section 145–b, Social Service Law (effective Sept. 1, 1975), *authorized the imposition of treble damages against any person, firm, or corporation that fraudulently obtains or attempts to obtain public funds for services or supplies under the medical assistance program.* In addition, where a provider or supplier of services must repay funds received under the medical assistance program, *repayment shall bear the maximum rate of interest from the date the payment was originally made to such provider.* Section 145–b also states that these penalties are "in addition to any other remedy provided by law."

Section 366–b,* Social Services Law (effective Sept. 1, 1970), states fraud exists when a person "knowingly makes a false statement or representation," or "by deliberate concealment of any material fact, or by impersonation or other fraudulent device obtains or attempts to obtain or aids or abets any person to obtain medical assistance to which he is not entitled," or when "any person who, with intent to defraud, presents for allowance or payment any false or fraudulent claim for furnishing services or merchandise, or knowingly submits false information for the purpose of obtaining greater compensation than that to which he is legally entitled for furnishing services or merchandise, or knowingly submits false information for the purpose of obtaining authorization for furnishing services or merchandise under medical assistance."

Item 35.2 of the State medical handbook ("Fraud by Medicaid Providers") essentially makes the local social services district responsible only for identification and referral of alleged frauds to law-enforcement agencies. More specifically, item 35.2 requires:

> *In the Medicaid program, responsibility for investigating and taking action against a provider for alleged fraudulent activities is a responsibility of local, State, and Federal law-enforcement agencies, not of health or social services program personnel.*
>
> Social services officials shall, however, remain responsible for identification and referral to law-enforcement agencies of cases of suspected fraud, and providing, along with local professional directors, *assistance to those agencies in the conduct of their investigations.* To the extent of their powers under statute and regulations, social services officials shall assure, by contract or otherwise, that each district attorney or other law-enforcement official to whom such a referral is made will decide whether or not to prosecute and advise the social services official of that decision and the reasons therefor within a speci-

* Section 366-b makes such acts class A misdemeanors, "unless such act constitutes a violation of a provision of the penal law of the State of New York, in which case he shall be punished in accordance with the penalties fixed by such law." A class A misdemeanor is punishable by a maximum prison term of 1 year, a maximum fine of $1,000 or double the profit from the crime, or fine plus imprisonment. The court also his discretion to give an unconditional discharge, conditional discharge (1 year), probation (3 years), or probation plus fine. (See Sentence Charts III and IV, pp. 13–14, Penal Law, State of New York.)

fied time, report monthly on the status of each such case then pending, and within a specified period of time after final disposition, advise the social services official thereof. The local social services commissioner will inform the local professional director regularly regarding the status of such referrals and will report monthly on the BM–2 reports and D–87 reports.

However, the Social Services Law does empower the State DSS and the local welfare agencies to investigate alleged fraud (sections 20.3, 34.3, 61, 65, 74, and 76.) Also, investigation may be necessary in social services' claims-processing routine. Those activities defined as "unacceptable practices" (item 35.1, State medical handbook) may involve fraud and their investigation and administrative action thereon is a requirement placed on social services and health districts.

The State department of social services is responsible for insuring that local social services administrations enforce items 35.1 and 35.2, the "fraud" provisions of the Social Services Law, and the recordkeeping, claims processing, and accounting requirements (18 NY CRR). (See sections 20 and 34, Social Services Law.)

The local social services district must prepare appropriate reports to the State DSS regarding cases of suspected fraud by Medicaid providers. The data for these reports comes from the local social services own actions (under item 35.2) and those of the local health director (under item 35.1). This data is forwarded quarterly to State DSS which compiles statewide quarterly reports which must be submitted to HEW as form SRS NCCS 119.2, "Medical Provider Schedule on Allegation of Suspected Fraud Under Title XIX." State DSS has outlined these requirements to the localities in Administrative Letter 74 ADM–63.

There are various rules and regulations requiring administrative controls over the recordkeeping and claims procedure by the local welfare district in addition to the statutory responsibility to discharge his duties. (See sections 363–a, 368–a, 368–b, Social Services Law.)

Section 540.1 (18 NYCRR) requires that "appropriate authorization" must be obtained before vendor payments for medical care and other items of medical assistance may be made. *Prior authorizations are required from the local medical director and social services official in the specific situations, by speciality, specified in sections 505–509 (18 NYCRR) and in item 34 of the State Medical Handbook.* Otherwise, a vendor is entitled to reimbursement as long as the patient's MA identification number is currently valid and the claims forms are otherwise submitted in proper form (section 540 et seq., 18 NYCRR). Fee schedules are set by the State Department of Health and appear in the State Medical Handbook and 18 NYCRR 522–539.

Bills submitted by vendors to local social services districts for medical care, services, and supplies must have each piece of data thereon as required in section 540.7 ("Requirements for Billing") of 18 NYCRR. This includes a certification by the vendor attesting to the truth of his claims, that he has adequate supporting records and will provide them to local and State social services officials, and that he understands "that he may be prosecuted under applicable Federal and State laws for any false claims, statements, or documents, or concealment of a material fact."

Section 540.8 of 18 NYCRR ("Verification, payment, and recording of medical bills") requires the local social services district to receive bills from vendors, classify them on the basis of State and local charge status, and verify said bills as against any "prior" or other authorizations issued and as against the fees and rates promulgated for payment. Verification includes:

> (1) Verification of bills against authorization and against the schedule of fees and rates includes: verification of mathematical accuracy of billing; conformity with all billing requirements (properly signed, etc.); verification of technical or professional qualifications where such may affect the fee to be allowed; verification of mileage rates and total charges; etc. (Verification of such scope may necessitate provisions for internal agency examination of billings by clerical personnel, in part, and by professional personnel, in part.)

The rules further provide for the recording of the specific amounts paid on the appropriate client's case card and for periodic reconciling of this figure as against "control entries in the general accounts. *In addition, the public welfare official may require additional records to be kept for administrative purposes.*" (18 NYCRR 540.8 (d) and (e).)

Section 540.9 ("Filing of authorizations, bills, and related documents") requires further specific maintenance of records:

> 540.9 Filing of authorizations, bills, and related documents. (a) *General.* (1) Notifications and authorizations for medical services (either the originals, if available, or copies thereof) shall be maintained on file in the public welfare agency in such a manner as to facilitate audit. If the notification and authorization constitute separate documents, each notification and the authorization relative to it shall be filed together.
>
> (2) Paid bills for medical services shall be maintained on file by the public welfare agency in a manner to facilitate audit and shall be filed in voucher number sequence, or in sequence as listed on the payment rolls.

Section 540.10, which deals with "Claims for State Aid," also specifies the necessary maintenance of records, including:

> (3) Where claims and rolls for State aid purposes must be supported by vouchers or statements of services paid for medical care, the public welfare agency must ensure, in its operating procedures, that sufficient copies of the appropriate documents are developed to meet both its internal needs and the roll and claim requirements.

Section 540.11 deals with "Internal Administrative Safeguards Over Medical Care Expenditures" and gives wide discretion to the local social services district. Section 540.11 has one general provision, "The local public welfare official shall establish internal practices that will safeguard the proper expenditure of funds for medical care." Section 541.1 deals with "Procedures for Patient's Medical Records" and similarly gives wide discretion to the locality. Section

541.1 has one general provision, "The agency shall maintain adequate records for each patient to show diagnosis and medical services provided under the medical care program."

Some typical "practices" and "records" utilized in other States in terms of the areas covered by sections 540.11 and 541.1 are: patient profiles, provider profiles, high provider profiles, repeat offender profiles, profiles of frequency of initial and followup visits, "prior" authorizations, medication prescriptions, and other services. These tools are used to set priorities on selecting providers and clients for on-site audits, close-audit surveillance, random audit, investigation, and utilization review, vis-a-vis, practices such as those specified in items 34, 35.1, and 35.2 of the State medical handbook.

Parts 585 and 586 of 18 NYCRR, which deal with "accounting records," place additional requirements on the local social services officials. For example, section 585.1(b) requires:

> (b) DSS–519 (formerly MA–21) is a basic record of a social services district which brings together, in one place, all the financial data and medical information pertaining to medical services for each individual in receipt of medical assistance. Local social services districts are required to post a complete record of all medical services provided to an individual. The DSS–519 may be maintained by either the accounting division or the medical division of a local social services district, but not both. In addition, payment and service data, eligibility status, effective dates, title XVIII status and buy-in status, and private medical insurance coverage must be recorded. These records shall be maintained currently in the local districts and shall be filed in such a manner as to be readily accessible for audit by State and Federal authorities. A file of cards shall be maintained for active and for closed cases.

The other provisions deal with "monetary controls," "claims control" (for reconciliation and auditing for reimbursement purposes), and "case count control."

Before paying any Medicaid reimbursement claims by local social services districts, section 368–a of the Social Services Law requires that the State DSS:

> Before approving such expenditures for reimbursement, the department shall give due consideration to the results of the reviews and audits conducted by the department of health pursuant to subdivision 2 of section 364.

Section 364.2 specifies the department of health's obligations under the Medicaid cooperative agreement. Under section 368, all local districts are to submit to State DSS quarterly estimates "of its anticipated expenditures for medical assistance to needy persons and administrative expenses."

Despite these rules and regulations, the statutes and SMH items 34 and 35, a number of studies over the last 10 years indicate that the State DSS and local social services districts have not developed effective procedures and controls on claims, maintenance of records, and detection and investigation of fraudulent and abusive practices. These studies are reviewed in detail in part 3 of this report.

An illustration of these facts and studies is contained in a 1976 report by the New York State Welfare Inspector General.

In a survey completed in October 1975 on Medicaid claims procedures in the State's 57 county social services districts outside New York City, the State Welfare Inspector General found:

> —As a rule, processing procedures were handled by personnel at the clerical level with very little, if any, senior supervisory control indicated.
>
> —In most instances, there were no detailed control procedures during the processing stage which would serve to flag instances of potential fraud, unusual or suspicious billing patterns, overutilization of program services, consistently high billers. . . .
>
> —No comprehensive data retrieval system exists in any county in the State (including New York City) to assist in monitoring the large sums involved, the huge number of people served, and the huge number of vendors involved, despite hard evidence of fraud and abuses within the various State health delivery programs.

In essence, the report found that the procedures required under social services rules and regulations and SMH Item 34 "do not seem to exist in any but a few of our counties." This also hinders implementation of the "prior approval" and "required review" process by health officials under item 34 SMH. Similar findings were made in a December 1975 HEW Region II report dealing with provider surveillance activities in New York State (see part 3 of this report).

[*The lack of such procedures, controls, and records also may account for the fact that from January 1972–March 1975 New York State reported no referrals of fraud cases to law-enforcement agencies. This is based on an HEW survey for the years 1972–74 and New York State's "quarterly fraud reports" (NCSS form 119.2) which HEW regulations have required since June 1974. HEW ranks New York among 21 States being "inactive in fraud and abuse detection and investigations."*]

C. SOCIAL SERVICES' "COOPERATIVE AGREEMENTS" WITH MENTAL HYGIENE (DMH) AND THE OFFICE OF DRUG ABUSE SERVICES (ODAS)

DSS has "cooperative programs" with DMH and ODAS. Section 364 of the Social Services Law makes the State department of mental hygiene (DMH) and office of drug abuse services (ODAS) responsible "for establishing and maintaining standards for medical care and services received in institutions operated by it or subject to its jurisdiction" (sections 364.3 and 364.3–a, Social Services Law). The delivery of proper medical care and services is also subject to review by the board of visitors of each DMH facility as part of such board's nonpartisan oversight functions (section 7.19, Mental Hygiene Law).

As cited in that portion of this section dealing with the State Health Department, SMH item 34 requires program review and evaluation of various types of care and services paid for by Medicaid at State mental hygiene institutions. This is the responsibility of local health districts and State DOH. State DSS is responsible for processing applications for Medicaid for DMH and ODAS inpatients and for

monitoring the use of Medicaid funds by DMH. State DSS has been lax in monitoring these funds and, according to DSS outgoing Deputy Commissioner for Medical Assistance Beverlee Myers, DSS has been "*giving mental hygiene $500 million (a year) in a brown paper bag and walking away.*" Mrs. Myers was deputy commissioner from November 1973–April 1976 and prior to that was with HEW.

State DMH is responsible for the proper expenditure of Medicaid moneys allocated to it by DSS by supervision through its central and regional offices, and through its individual facilities. DMH also is responsible for directing many of its dischargees to local social services offices in order to obtain public assistance and Medicaid. *As noted earlier, State social services estimates that mental hygiene spends $22.1 million annually to administer its $500 million in Medicaid funds.*

ODAS is responsible in the same manner for persons receiving Medicaid moneys who reside in their facilities, and for similar direction of its dischargees to local social services district upon discharge. ODAS is also responsible for supervision of the general operation of all public and private methadone maintenance clinics in the State. Local health districts and State DOH are responsible for supervising the quality of care and proper use of any Medicaid moneys allocated to the clinics as part of their responsibility for all MA vendors. Approximately $50 million annually in Medicaid moneys go to methadone clinics in New York City each year and many of the Medicaid provider abuses cited in reports and the media involve providers operating methadone clinics (see part 2 of this report).

The quality of care and utilization of funds at State DMH facilities has been the subject of ongoing criticism by the media, State comptroller, and other sources for at least the last 10 years.

ODAS was severely criticized for its poor administrative operations in a 1976 investigation by the New York State Commission of Investigation. The investigation ultimately resulted in the resignation of the agency head and, combined with the fiscal crisis, in large budget cuts in the ODAS budget.

ODAS is housed within the DMH (section 81.07, Mental Hygiene Law). It was previously called drug abuse control commission (DACC).

It has been estimated that ODAS spends approximately $28 million a year in Medicaid moneys alone for the 14 ODAS-run treatment facilities in the State. The SIC's chief accountant has observed that this amount is well below the actual amount ODAS could and should be claiming from Medicaid. The accountant, Mr. Albert Sohn, observed "some facilities apply for as few as 25 percent of their residents for Medicaid reimbursement and others apply for, perhaps, 80 to 85 percent of their residents for Medicaid reimbursement." ODAS could not account for this disparity in Medicaid applications.

Medicaid reimbursement does not go directly to ODAS. Medicaid moneys received for services rendered by ODAS are immediately transmitted to the New York State Facilities Development Corp. (FDC). The FDC uses these funds to offset construction costs of various mental hygiene facilities and has played a part in the financing of ODAS's major construction projects. Since the FDC is responsible for the development of all mental hygiene facilities, only a portion of

the Medicaid money generated by ODAS actually goes back to offset the expenses of the agency.

Recent Federal legislation and rules enacted thereunder (see Public Law 92–223; 85 Statutes at Large 810; also 38 Federal Register 5974 and 39 Federal Register 2220) require that ODAS's residential treatment centers be subject to inspection by the State health department as intermediate care facilities, just as nursing homes are. Although some health department and ODAS officials have pointed out that many of the criteria applied to nursing homes need not be applied to facilities housing young, active patients, failure by ODAS to conform to the published rules could have resulted in a potential loss of $21 million to the State of New York during the present fiscal year. This would have occurred if the residential treatment facilities operated by ODAS failed to receive certification from the State health department and lost Medicaid reimbursement.

A recent New York State DOH review found the ODAS facilities were not meeting the new Federal requirements.

ODAS is also responsible for supervision of all private and public methadone and drug treatment facilities in the State. The methadone clinics receive substantial sums of Medicaid moneys (estimated at $30 million a year in New York City alone) and other moneys (estimated at a total of $67 million in New York City alone) and have been the subject of much evidence of fraud, abuse, and poor quality of care (see part 2 of this report).

d. RESPONSE TO THE COMMITTEE

The committee's review of the State department of social services' performance of its administrative and supervisory responsibilities prompted a June 7, 1976 letter from the committee to New York State DSS Commissioner Philip Toia. The letter requested answers to 32 specific questions regarding detected shortcomings in the agency's implementation of the Medicaid program. As of this printing, nearly 3 months after the committee wrote Commissioner Toia, there has been no reply. A copy of the committee's letter appears in appendix 2, item 4, of this report.

However, the committee staff notes that in a January 1976 report to the State legislature, Commissioner Toia's predecessor, Stephen Berger, stated:

> The ultimate truth of the situation is that New York with clearly the most expensive Medicaid program in the country and probably one of the best in terms of the quality of care provided to the poor, *has consistently failed to maintain an acceptable level of administrative performance. This situation has never been defensible, but given the current condition of the State's economy, its continuation would be worse than indefensible. It would be a form of fiscal suicide.*

Mr. Berger is now executive director of the emergency financial control board, the body created by the legislature to oversee New York City's fiscal recovery.

The committee did not address a specific inquiry to the New York State Department of Mental Hygiene or to the office of Drug Abuse

Services (ODAS). However, the State comptroller's reply confirms the allegations of the Region II HEW report (December 1975) and the former New York State DSS deputy commissioner for Medicaid (Beverlee Myers) that the $500 million per year in Medicaid moneys allocated to New York State DMH and the moneys to ODAS are virtually a giveaway without any effective pre- or post-audit review. The comptroller admitted to the committee (see appendix 2) that DMH's own internal audit program for *all* aspects of fiscal operation of its over 60 facilities—of which Medicaid is only one aspect—has been 4 professionals at most over the MA program's 10-year life. In 1976, according to the comptroller, the DMH internal audit program "is being expanded to 13 professionals." *However, State social services estimates that DMH spends $22.1 million a year for Medicaid administration.*

The comptroller also advised the committee that "budget limitations preclude audits of State institutions and facilities [by his own staff], including those which use Medicaid moneys, more frequently than on a 3- to 4-year cycle." This includes audits of monetary expenditures of Medicaid moneys (i.e., verification of cost reports) as well as utilization and quality of care to Medicaid-subsidized patients at State facilities (i.e., approximately 60 DMH facilities and 10 ODAS facilities statewide).

The committee also asked the comptroller why in view of these circumstances the DMH and ODAS facilities might not more productively be placed under the Medicaid auditing program for health care facilities operated by the department of health. The comptroller made no reply.

3. Department of Health

> It must be conceded that until the recent past . . . provider fraud and abuse was known to exist but received less than adequate attention.
>
> —Dr. Frank Cicero, NYS Department of Health, August 9, 1976.

a. ORGANIZATION

The State department of health has approximately 6,000 employees and annually administers funds valued at approximately $250 million. It has six regional and seven district offices. These offices and two central office divisions, combined with local health districts, are the organizational resources for implementing health's obligations under the Medicaid program.

The two central office divisions are both in the preventive services and medical care organizational unit of New York State DOH. This unit is headed by a deputy commissioner with overall responsibility for hospital planning, surveillance of hospitals and other medical facilities, health economics and cost control, and the supervision of preventive health services.

The two divisions are:

(1) *The Division of Health Economics* performs the crucial function of determining rates and fee schedules for payment of medical care under Blue Cross and Medicare.

The division is divided into three bureaus: Health care reimbursement, economic analysis, and provider audit. These bureaus perform research and analysis and determine Medicaid and Blue Cross rate schedules for payment for hospital and related services and certify to the director of the budget and the superintendent of insurance that such schedules are reasonably related to the cost of providing service. This division also performs the staff work for a system of hospital cost accounting and cost finding, setting specific standards for the determination of hospital rates, and providing for consideration of innovative alternatives to the present method of health care delivery.

The division of health economics also analyzes the fiscal implications of proposals for construction and program changes and in this capacity, as well as other matters, performs staff work for the public health council and the State hospital review and planning council.

A 1975 State task force report to the Governor observed:

> The Governor's health program associate pointed out that the work of the division of health economics may not be sufficiently interfaced with that of the division of medical care services and evaluation in the research and development section. A closer relationship between those who are determining rates and those who are evaluating quality and attempting to maximize efficiency in the Medicaid program is clearly necessary.

(2) *The Division of Medical Care Services and Evaluation* plays a major role in the Medicaid program. It has a unit concerned with the quality and extent of dental services available through Medicaid.

The Bureau of Medicaid sets standards, guidelines, and procedures for assuring the quality and availability of care. It works with the division of health economics to develop fee schedules for providers and has primary responsibility for reviewing participation of providers and availability of care. It also carries out liaison with other State agencies, central offices of the department of health and regional and local health offices, identifies and assists regional offices and local districts with administrative problems (especially in developing data systems), reviews proposed changes in medical plans, and evaluates, supervises, and manages medical assistance contract with local health units.

Of course, the commissioner's office, counsel's office, and data processing staff are collateral resources available in the central office.

As noted earlier, the State Social Services Department estimates that State Health expends $14 million annually to administer its Medicaid responsibilities.

b. POWERS AND DUTIES

As previously noted, the legislated cooperative agreement between the State departments of health and social services gives the State health department. through its local health districts, the responsibility for setting standards for proper medical care, including rate schedules, and supervising providers to insure that such standards, as specified by Federal and State statutes, rules, and regulations, are properly enforced (sections 364 and 364–a, Social Services Law).

As with the commissioner of social services, the commissioner of the State department of health is a gubernatorial appointee whose appointment is subject to confirmation by the State Senate (section 204, Public Health Law; section 11, Social Services Law). Such commissioners are subject to removal from office at the pleasure of the Governor (section 33–a, Public Officers Law) and are empowered by statute to organize their departments and appoint staff in accordance with required approvals and procedures of the State department of civil service and division of the budget.

The State health commissioner has broad powers and duties, including exercise of "general supervision over the work of all local boards of health and health offices" (section 206.1(b), Public Health Law; note: except prior to 1971 the city of New York was excluded from this provision). This parallels the State social services commissioner's general supervisory power over all local welfare authorities (section 34.3(d) Social Services Law).

The commissioner of health, as with social services, has broad rulemaking power (Section 11, Public Health Law), and the department's rules and regulations appear in three volumes (10 (A), (B), and (C) NYCRR). These rules and regulations contain, among other things, the State hospital code and the State sanitary code.

The commissioner also has power to issue subpenas, compel attendance of witnesses and testimony, hold hearings, and issue penalties, as prescribed by law, after a hearing (section 206.4, Public Health Law). Penalties may not exceed $1,000 for "every such violation or failure." *Such powers extend to all providers of Medicaid services.* Providers, as any other citizen of the State, are also subject to any additional criminal penalties for specific violations of the State's penal laws and any Federal statutes. The law also provides for the assessment of a civil penalty of not more than $1,000 per violation for any violation of the health laws or regulations, authorizes the commissioner to recover such penalties by bringing a court action, and authorizes the attorney general, upon a request and evidence from the commissioner, to seek injunctive relief for such violations (section 12, Public Health Law).

He also has the power to set fees for home health care services (sec. 206.7) in addition to the fixing of Medicaid reimbursement rates for Medicaid providers (sec. 364, Social Services Law; article 28, Public Health Law). He also is empowered to create State regional and district health areas to facilitate implementation of his agency's powers and duties (section 240–243, Public Health Law).

The health commissioner also is impowered to regulate the manufacture, sale, and distribution of narcotic drugs, including the issuance of appropriate licenses and approvals, under article 33 of the Public Health Law (see also 10 NYCRR, pt. 80).

Since 1970, the licensure of nursing home administrators and the supervision of their activities has been done by an 11-man board appointed by the commissioner of health (article 28–D, Public Health Law). The commissioner is empowered to suspend, revoke, or issue fines against such licenses, after a proper hearing, upon proof of specific violations as set forth in section 2897. Any administrative disciplinary action of a State or local agency may be appealed in the courts of the State by initiation of an action under article 78 of the

Civil Practice Laws and Rules (CPLR). In such cases, a person whose license or operating certificate has been suspended or revoked (i.e., nursing home, hospital, health care facility, nursing home administrator) or whose ability to participate in a program has been suspended or revoked (i.e., Medicaid) can obtain a stay of such action pending court resolution of his article 78 proceeding (article 78, CPLR).

Nursing homes, home health agencies, hospitals, and other residential health care facilities are granted operating certificates by the State department of health after a review of their plans for construction and justification of need for such facilities under articles 28–28–B of the Public Health Law. The approval process for establishment requires approval by the State department of health after review and approval by the public health council and hospital review and planning council (article 28, Public Health Law; Public Health Council; see section 220–229, Public Health Law; Hospital Review and Planning Council; see section 2904, Public Health Law.) The commissioner has the power, subject to hearing procedures, to revoke, suspend, or limit any medical care facility's operating certificate (section 2806, Public Health Law). Prior to 1973, any such action in New York City could only be initiated by the city's health services administration.

In addition, any nursing home or other health care facility which wants reimbursement under Medicaid or Medicare must be approved for a provider agreement by the State department of social services. Signing of such an agreement subjects the home to Federal regulations under title XIX in addition to State laws and regulations on the establishment and operation of such facilities. The State department of social services, as the single State agency, is charged with carrying out the annual inspection of such facilities for compliance with the terms of title XIX requirements, including the Federal life safety code. Under the terms of State legislation (sections 364 and 364–a, Social Services Law), these inspections are contracted over to the State department of health.

The department of health is also responsible, through its regional and district offices, for enforcing the requirements of the State sanitary code and the State hospital code. The State hospital code (10(C) NYCRR, pts. 700–782) details exclusive requirements for medical facility construction, hospital, nursing home, health related facility, treatment and diagnostic center, and home health agency operations. Local health departments are also charged with insuring that facilities comply with State, as well as local, codes (article 3, titles 3 and 4, Public Health Law).

The reimbursement rates for Medicaid for all medical care facilities in the State are computed, reviewed, and enforced by the State Department of health (sections 364 and 364-a, Social Services Law). The basis for computation of rates and requirements for submission of data and records by providers appear in 10 NYCRR, Part 86 and in sections 2805-a, 2807-a, and 2808 of the Public Health Law. The actual rates must be approved by the director of the division of the budget.

The rates to all other providers of Medicaid services are established by the State department of health and published in the State medical handbook (and in parts 500–541 of 18 NYCRR, Social Services). In order to qualify to be a Medicaid provider the medical practitioner

need only prove he is properly licensed to practice his profession in the manner required by the State education law (see 18 NYCRR, parts 500–541; State Education Law, title VIII).

As with Medicaid providers which are medical care facilities, the individual providers are subject to State and Federal criminal statutes and to the administrative action of the State and local departments of health. The State department of health and the local health districts are charged with enforcing compliance by Medicaid providers with all Federal and State laws, rules, and regulations pertinent to title XIX (sections 364 and 364-a, Social Services Law).

The principal tools for implementing this responsibility are items 34 and 35 of the State medical handbook which are distributed to all relevant State DSS and DOH offices and all local social service and health district directors.

Item 35.1 ("Unacceptable Practices") originally was issued July 15, 1971 (5 years after Medicaid was in operation in New York State) *and was revised October 1, 1975. The basic aim and policies of item 35.1 are:*

> A. *Introduction:* This section is concerned with problems of unacceptable practices by a provider which have been identified as the result of reviews by or reports to a local professional director. Other problems concerned with provider participation may be identified in the course of other local agency activities such as claims review or bill payment and may be handled in accordance with procedures established by the local social services commissioner. Local professional directors are expected to provide all requested and appropriate assistance to a local social services commissioner in his review, establishment, and resolution of problems with providers of health care and services.
>
> B. *Basic Policies:* 1. Local professional directors must be alert to problems involving unacceptable practices by providers of service. They should assist in the establishment of procedures designed to reveal the existence of unacceptable practices and supervise the proper implementation of such procedures.
>
> 2. Unacceptable practices by providers may include, but are not limited to, provision of care or poor and unacceptable quality; flagrant and continuing disregard of established policies, standards, fees, and procedures; provision of excessive, unnecessary, professionally unacceptable, unproven, or experimental care.

Item 35 further makes the local professional health director responsible for investigating and acting on any alleged unacceptable practices. He is also authorized to resolve any improper or questionable practice "by inquiry to or discussion with the provider" and to reach mutually agreed upon corrective action. An elaborate procedure is set out for notifying the provider of the allegations, recording such notice and response on monthly report forms (BM–2 and D–87, copies of all notices go to local health and social services district offices, regional DOH offices, and State DSS and DOH offices), and for the conduction of the "discussion" proceedings, and for taking corrective action.

75-902 O - 76 - 10

The local director is to dispose of the case by dropping the charge, reprimand, ordering restitution or payment adjustments, requiring prior approvals on all or specific services in the future, subject the provider to more complete post-audit review, or ordering suspension or disqualification from the Medicaid program. (This applies to prohibition activity by the provider in any local health and social services district in the State.) These actions may be initiated upon mutual agreement of the provider and local director or unilaterally by the local director. Item 35 specifies that a representative of the local DSS office "should be" present at the initial provider discussion in case Social Services must seek restitution of moneys through legal proceedings or in case of ultimate suspension or disqualification which requires *written approval* of the local Social Services commissioner. The only exception is where, under section 16 of the Public Health Law, there is deemed to be "a potential threat to public health or safety." In such cases the local professional health director may initiate suspension or disqualification *with* written approval of the regional DOH director (with notice of the action to the local DSS commissioner).

Notification of administrative action must be sent to the affected provider. The provider may appeal the decision by asking a hearing before the appropriate regional health director. The regional director may appoint a hearing officer or board for such cases, the provider may have legal counsel, witnesses, right to cross-examine and subpena evidence. The regional office, after the hearing, issues a decision affirming, modifying, reversing the local decision, or referring it back to the local director "for further investigation, review and action." All parties to the proceeding are to be notified of the decision as are the local social services and health directors, central offices of the State DSS and DOH, and other interested "State and Federal agencies."

This latter communication of all item 35 actions is done by forwarding the monthly BM–2 and D–87 reports to the State DOH Medicaid Utilization Review Operations Unit. This unit is to maintain a statewide monthly summary report, share it with State DSS, and forward it "as appropriate" routinely to "other interested State and Federal agencies," including: State DOH bureau of professional medical conduct; State attorney general; DMH; DOE; department of insurance; worker's compensation board; welfare inspector general; Region II, HEW; other States' Medicaid programs (where appropriate); insurance carriers PSRO's and State support center for PSRO's; State and local professional associations.

Responsibility for supervising and coordinating item 35 activities is assigned to the various regional offices of State DOH and statewide supervision and coordination to State DOH's Medicaid and utilization review operations unit. Detailed records of all item 35.1 actions, including documentation, must be maintained by the local professional health director.

The provider ultimately can appeal any regional office hearing decision in a court of competent jurisdiction under article 78 of the State's Civil Practice Law and Rules (CPLR).

Item 35.2 deals with "Fraud by Medicaid Providers." It places the local social services commissioner with the basic responsibility for determining whether a case of alleged fraud merits referral to the appropriate local, State, or Federal law-enforcement agency.

The only obligations of the local health director as regards alleged fraud are:

(1) Instances resulting from a utilization review activity, claims review, administrative hearing, referral from an outside source, complaint, or based on other source of information where evidence of possible provider fraud is recognized by a local professional director shall be promptly reported, in writing; to the local social services commissioner.

(2) Recording all such referrals on the monthly DOH report form and forwarding said report to the appropriate regional office accompanied by "copies of pertinent agency records or files which provide information concerning the nature of the problem, agency review, findings of the review and action taken."

Under sections 364 and 364–a of the Social Services Law, the department of health has the responsibility for evaluating the quality and the availability of medical care and supplies provided to all medical assistance recipients. This "medical review and evaluation of program operation" is detailed in item 34 of the State medical handbook (SMH).

The responsibility for implementation rests with the local health department director (i.e., *local professional director*) and with the State health department's regional offices and the central review unit in the DOH bureau of Medicaid. Item 34 states that local directors are to carry out these evaluations "within the limits of the local agency capabilities to collect and make available the necessary medical data for such purpose, the availability of supportive staff and other pertinent resources." Regional offices are to "carry out regular reviews and evaluations." Item 34.1 allows the *local medical and dental directors* within the local health department to utilize "professional consultants in other disciplines (pharmacy, podiatry, etc.) . . . on a regular or ad hoc basis" and to use "advisory committees." (Item 34.1, item 34.2 E.3, item 38 SMH.)

Item 34.2–B specifies 19 separate types of medical care and supplies provided by inpatient and outpatient Medicaid providers. In each area there is a specification as to what, if any, "*prior approvals*" and "required reviews" must be undertaken by the local and regional offices. These include skilled nursing facilities, health related facilities, and State mental hygiene institutions, as added effective July 1, 1973, under section 207 and 237–A of the Social Security Act and supplementary Federal instructions. *In these three inpatient institutional areas, reviews must be made of:*

(1) Certifications by a physician of each patient's need for care upon admission to or, if later, upon application for medical assistance;

(2) Recertification by a physician of need for continued care at least every 60 days;

(3) A plan of care for each patient established and periodically evaluated by a physician;

(4) Establishment and operation of utilization review committees for the facility.

"*Required reviews*" *of providers rendering outpatient services* usually involve review of cases where a specific type of care is rendered in excess of a specific dollar figure in a specific period of time. For

example, on "X-rays" there is a required review of "care in excess of $50 to an individual in a month"; on laboratories, there is a required review of "care in excess of $50 to an individual in a month." There are also "required reviews" of providers rendering in excess of a specified dollar amount in a specified time period. For example, review of "characteristics of care" rendered by a physician or dentist paid in excess of $2,000 in a month; by a podiatrist in excess of $1,000 a month; by a retail optical establishment in excess of $2,000 a month. "All chiropractic treatment plans" must be reviewed.

Most "prior approval" requirements are in the areas of "eye care services," "podiatrist," "dentist," "private duty nursing," "private health home aide," "rehabilitation therapies," "prosthetic appliance," "transportation for medical care," "drug and sickroom supplies," and "out-of-State" care.

Item 34.2 C and D set forth "suggested other reviews" and "special studies," including "evaluation of performance by a provider or group of providers."

All these "prior approvals" and "required reviews" are carried out by the local health districts and State DOH regional and central offices. However, the health officials are dependent on the forms, records, and procedures maintained on patients and providers by the local social services districts and State DSS. In a reciprocal sense, the local social services districts and State DSS are dependent on the local and State Health entities for important data on providers committing fraud, abuse, and unacceptable practices under SMH, item 35.

As a 1975 report by a New York State gubernatorial task force has observed, "Each local (social service) district has the responsibility for receiving, processing, and payment of Medicaid claims. The department of health is thus totally dependent on these 58 separate local agencies (under the general supervision of a different State department) which vary in quality for information on the characteristics of the enrollee, services provided, program utilization, etc." The report notes that, as a result, the only area in which Health's "medical review and evaluation of program operation" has had "any success" is in the inpatient hospital care area. Inpatient hospital care, in terms of SMH, item 34, review, is conducted under Health's central office's "New York State Hospital Utilization Review program" (NYSHUR). However, NYSHUR took "4 years of pilot development" and was not operational until December 1, 1973. One of the alleged reasons for NYSHUR's "success" is that it "really circumvents DSS with forms filled out by the physicians at the time of discharge that are simply forwarded to the department of health by each local social services agency."

In general, as has been extensively documented, each agency blames the other and the fragmented division of responsibility for Medicaid between the two agencies for any problems. "DSS feels health gives it inadequate information and health feels that DSS gives it inadequate information for effective administration and cost control."

C. RESPONSE TO THE COMMITTEE

In response to a committee inquiry (see appendix 2) the health department admitted their "shared responsibility (with social serv-

ices) for the Medicaid program has limited its ability to effect necessary reforms." They indicated that the deficiencies and necessary reforms were basically the same as those cited in the 1969 Manhattan grand jury report. Health said the report "contains many accurate observations and justifiable criticism of program administration." However, they said these "did not represent a major revelation in terms of new information or understanding of the issues in the New York City program."

The health department said the "shared responsibility" system of Medicaid administration was originally created by the legislature and that "*successive legislatures and administrations have reexamined this legislation and decided to maintain it substantially in the original form.*" The department's second deputy commissioner, Dr. Frank Cicero, stated "*The State department of health does not have the authority to make such decisions—they are the proper province of the State's political decisionmakers.*" Dr. Cicero similarly said New York's decisions to provide the full range of optional services under Medicaid, to continue the "MA-only" category, and to allocate 25 percent of costs each to the State and localities "*are expressions of legislative and executive preference and intent.*" The committee staff observes that the State's Moreland Act Commission on Nursing Homes similarly blamed "legislative and executive preference and intent" for continual denials of budget requests for increased auditors for health despite innumerable cost-effective justifications.

The department also advised the committee staff that it had helped New York City develop, along with social services, the proposed item 230 amendment to regulate Medicaid mills. The amendment was enjoined by State courts. Health also "backed amendments to the public health, education, and Social Services Law designed to provide the legal basis for effective regulation of Medicaid mills." The department advised the committee staff that the proposed legislation would have defined Medicaid mills so as to make them subject to health's jurisdiction over health care facilities and prohibited the characteristic "percentage lease arrangement." The proposals were rejected by the legislature, but the department plans to redraft the bills and resubmit them in the 1977 legislative session so as to place the "mills" under the operation controls of the State's Public Health Law.

Dr. Cicero said that "A department-sponsored budget proposal for 'Medicaid mill' audit investigative staff was turned down during the last legislative session." He further said that "As mandated by the legislature, the newly allocated audit and investigative staff" which was given to the department "will be primarily concerned with institutional providers," *not individual practitioners.* However, he stated that "At this department's insistence, the New York City Department of Health has re-allocated staff to provide increased surveillance of Medicaid mills and other noninstitutional providers."

The department did concede to the committee staff that not all the problems with the State's Medicaid program were the result of "legislative and executive preference and intent." Deputy Commissioner Cicero noted several administrative shortcomings at health:

(1) While he asserted the agency has "an effective centralized unit" for Medicaid fraud and abuse investigation, he said, "*it must*

be conceded that until the recent past . . . provider fraud and abuse was known to exist but received less than adequate attention."

(2) Data exchange on undesirable providers between localities "has long been in existence" by required periodic reports to the State health department. However, Dr. Cicero said "*little use was made of the information thus obtained and the cooperation among state agencies was negligible.*"

The committee staff observes that Dr. Cicero's statement confirms observations in this report and in HEW reports issued as late as 1975 as to the ineffective implementation of items 34 and 35 of the State medical handbook. Dr. Cicero advised the committee that a "concerted effort" is underway by health and a special task force on fraud and abuse, headed by the Governor's health advisor, to remedy the situation.

Dr. Cicero asserted that item 35, defining unacceptable practices and appropriate corrective measures, was first issued in 1968, 3 years before there was any "Federal guidance in this important program area." He also asserted that item 34, defining standards and procedures for review and evaluation of services provided (i.e., utilization review), was first issued in 1967. He further cited item 22 of the handbook, issued in 1966, which "establishes basic policies for program administration and identified numerous services requiring prior approval."

The committee staff acknowledges Dr. Cicero's comments on items 22, 34 and 35, but still believes there is overwhelming evidence that health did not have adequate procedures for Medicaid fraud and abuse monitoring in place at the inception of the program in 1966. Further, the procedures, once promulgated, have never been effectively implemented. Evidence of this is that both items 34 and 35 were not promulgated until 1 and 2 years, respectively, after Medicaid was in operation. Item 22, except for its prior approval provisions, contained only general language on "program administration" and nothing specific on utilization review and unacceptable practice procedures. Furthermore, the original item 34 (1967) and item 35 (1968) both were general in language and effective specific procedures were not transmitted to regional offices until the 1971 revision of item 35 and 1972 revision of item 34.

Also, Dr. Cicero has admitted in the same letter that known fraud and abuse received "less than adequate attention," that "little use" was made of such information, and cooperation between State agencies was "negligible." The committee staff notes that the procedures outlined in items 34 and 35 require cooperation between social service and health at the local and State levels. The existence of "negligible" cooperation means that these basic antifraud programs have been rendered, in effect, a nullity. Further evidence of this situation is the December 1975 HEW Region II analysis of the poor administration of items 34 and 35 (see part 3 of this report).

The committee staff agrees with the health department's observations that HEW was remiss in not providing any guidelines on Medicaid fraud and abuse monitoring until 1971—5 years after the program's inception and that there is a need for more Federal leadership in the fraud and abuse area, particularly relating to "mills" and noninstitutional providers. The committee staff has noted elsewhere in this report (see parts 3 and 4) HEW's failure to advise State's as to definitions of "unacceptable practices," "fraud" and "abuse," and its failure to

promptly promulgate sanctions against providers and recipients engaging in such activities.

The Medicare program, through its fiscal intermediaries, mails each recipient of Medicare services an "Explanation of Medicare Benefits" form (EOMB). The EOMB shows the recipient a record of all medical services (by practitioner's name, date, type, and cost of service) rendered to him during a given month. Medicare program officials in region II advised the committee staff that the EOMB's are their major source of detecting provider fraud and abuse and that they had suggested that NYS Medicaid officials adopt an equivalent approach at least twice in the last 3 years.

The committee staff asked the health department why they had not adopted the EOMB form or some equivalent thereof. Health said that they had reviewed the EOMB forms with social services staff but had found "little evidence of effectiveness as a control measure." However they advised the committee staff that "now that MMIS has been approved by the New York State legislature, the forms and their mailing can be accomplished at a low enough cost to approach a reasonable cost-benefit basis. The two departments will collaborate in reappraisal and planning for this purpose." *The committee observes that such an EOMB-type system is required by Federal regulations before the Federal Government will pay its 75 percent share of costs for operation of any MMIS. (See Public Law 92-603).*

The committee staff observes that New York State officials have indicated that the MMIS program will not be operational at least until 1980 so that any use of the EOMB approach *does not* appear imminent. The fact that use of the EOMB approach depends on computer capability further reinforces the negative impact of the State's failure to implement a statewide Medicaid MMIS and payments system. Approval of MMIS moneys, which are matched by HEW, did not come until 1976 despite numerous studies demonstrating the cost-effective justification of MMIS and the fact that New York State has the largest Medicaid program in the Nation.

As regards possible use of private companies as "third-party payers" (another parallel to the Medicare system), health has recommended that social services pilot test such a concept in the drug claim processing and drug utilization control program in New York City. However, health advised the committee staff that they "temporarily withdrew" that proposal at social services' request "because of the sensitive nature of the State MMIS negotiations." There was no further elaboration on this point.

Health advised the committee staff that they believed they had undertaken several positive actions regarding monitoring of Medicaid providers:

(1) The initiation of an inpatient hospital utilization review (UR) program in 1971 and a cost containment statute, both prior to promulgation of Federal UR regulations. Health also contends that their UR regulations "exceed the scope of Federal UR regulations." The committee staff observes that the Governor's task force reviewing health in 1975 indicated in its report that the hospital UR program was not implemented until 1973 and that no positive results were forthcoming until 1975.

(2) "Strict limitations on MA-covered hospital length of stay, provision of deferrable surgery and eligibility for skilled nursing

services have recently been enacted and implemented." (Ch. 76, New York State laws of 1976; part 85, health commissioner's rules.)

(3) "The Department has long sought to improve the City Department of Health's ambulatory care controls, and these efforts have in many instances been successful."

The committee staff observes that these actions do not deal primarily with control of noninstitutional provider fraud and abuse and further emphasize health's historic preoccupation with institutional providers.

d. ENFORCEMENT FAILURES BY NEW YORK STATE DEPARTMENTS OF HEALTH AND SOCIAL SERVICES

There is no centralized program in New York State for insuring compliance with Medicaid requirements by providers. The basic responsibilities for auditing, investigating, and taking administrative or other legal action against providers is split between DSS and DOH. *As regards institutional providers:* in the department of health, licensure of institutional providers rests with two councils (public health council and hospital review and planning council), ratesetting and auditing is with two units (bureaus of provider audit and health care reimbursement), review of "quality of care" is with another unit (bureau of chronic diseases and geriatrics), and legal advice is with another unit (counsel's office). Add to this the separate operation of the special prosecutor's office in the department of law, licensure of nursing home administrators by a separate board in health, and discipline for nonprofessional conduct with two boards (one in health and one in education). Then institutional providers are handled by a separate unit in health (bureau of Medicaid) and all payments are handled by central DSS and the 58 local social services districts.

The bureau of health care reimbursement of the division of health economics is responsible for operational and management audits for the State's nearly 600 nursing homes, 230 health related facilities, 365 hospitals, 300 clinics, 120 home health agencies, and 6 health maintenance organizations. Medicaid expenditures in 1975 to the nursing homes and health related facilities alone is estimated at $1.25 billion. The bureau is also responsible for the financial management of two special State-sponsored construction programs (articles 28–A and 28–B, Public Health Law) for nursing homes and hospitals and for the outpatient deficit financing program. The bureau and division are also responsible for developing and administering the Medicaid reimbursement rates for these institutions—which the commissioner must certify to the division of the budget—and for providing support staff to the two councils which license such facilities. Field audits of facilities are conducted by the division's bureau of provider audit. *This bureau was not established until 1971—5 years after the Medicaid program had been in operation.*

The bureau of health care reimbursement's basic function is to set rates based on forms showing nursing home expenditures for the prior year. These costs are used to establish cost ceilings, by item, and cost items which are allowable for reimbursement purposes. Throughout its history, the bureau has used the costs as reported by the operators, and not any outside objective parameters, to establish cost ceilings. The

forms submitted annually have been generally subjected only to a "desk audit" (i.e., no collateral verification beyond the form submitted by the provider). Prior to the creation of the bureau of provider audit in 1971, only 17 field audits were done for the 5 years. Most were done between 1968 and 1971 by one auditor. His results found that for every day he devoted to field audits he returned $2,200 to the State in detected Medicaid overpayments.

From 1968 to 1973 the department consistently requested more auditor positions in its budget request to the Governor. Those requests were consistently rejected by the State division of the budget and the Governor's office. This continued even though field audit results showed a $15 to $1 return rate in terms of overcharges detected to cost of audit, despite constant Federal, State, and local agency reports of fraud and abuse, and despite the 1972 Manhattan grand jury report—which focused in large part on nursing home and hospital abuses of Medicaid.

The only reimbursement auditing staff the bureau of provider audit obtained between 1971 and 1974 were 14 positions created by reorganization and reclassification within the department. (From 1970 to 1974 there were 23 other auditors in the bureau who were assigned, by budget service of funding, solely to audits of the article 28–A and 28–B construction programs.) In fiscal 1974–75, nine new positions were added and, under a new Governor, in fiscal 1975–76 a total of 36 new auditors were added as well as the creation of a special prosecutor's office in the department of law to remedy the years of neglect in investigating and auditing nursing homes. The special prosecutor's office, created in January 1975, was fully staffed with 36 attorneys, 47 special investigators, 64 special auditor-investigators, and 60 support and supervisory staff by June 1975.

In the current fiscal year the department has received 120 new positions "for auditing residential health care facilities" and the special prosecutor's office is seeking increased funding for an equal number of positions for its staff. *However, a request for a "permanent audit and fraud unit" funded at $2.2 million has been denied to date by the 1976 legislature—even though 75 percent of the moneys are federally reimbursable.*

Most studies agree that the major reason for health's ineffectiveness in the investigation and auditing of institutional and Medicaid providers has been inadequate staffing. *The result has been a total of approximately 28 field audits a year since 1971 for the over 1,600 facilities annually receiving Medicaid funds.*

As the State's Moreland Act Commission on Nursing Homes recently noted:

> The record suggests continuing shortsightedness on the part of the division of the budget. The department estimated that the average return for payment of the auditor's salary was 15 times that salary in Medicaid savings. The Federal Government reimburses the State for 75 percent of the costs incurred in conducting Medicaid audits. Medicaid overpayments would be shared—50 percent from Federal funds, and 25 percent each in State and local funds.
>
> The department estimates that a total of $9.848,145 in Medicaid savings was realizable as a result of the field audits performed by the bureau as of August 1975, or an average of $71,885 per audit.

In addition to the lack of auditors per se, there also have been qualitative problems in the bureau of provider audit. The bureau's auditors are not trained as "investigative auditors" and usually do a straight accounting audit of books based on standardized procedures. The bureau did not have any formalized and regular system for data exchange with other private third-party insurers, Medicare, or other States. The bureau did not have a rational system for setting priorities on which homes to audit, given its limited auditing staff. For instance, one State agency found that the Towers Nursing Home, which was the 10th highest MA billing private nursing home in New York City had never been field audited in its 9 years on the Medicaid program. The special prosecutor's office has found over $1 million in MA overcharges by the Towers' operator.

The responsibility for conducting the annual surveys of facilities for compliance with Medicaid/Medicare requirements is with the bureau of chronic diseases and geriatrics of the State health department. The bureau, through regional offices, sent out survey teams once a year to review conditions in order to determine if renewal of the Medicaid and Medicare provider agreements was merited. Prior to January 1975, facilities were given advance notice of all such surveys. Prior to 1973, the licensure and inspection of proprietary nursing homes in New York City was left, by statute, with the city. Otherwise licensure of non-New York City nursing homes and other health care facilities has been the responsibility of the State through its public health council and hospital review and planning council. The staff work of these councils is done by the New York State DOH.

A recent study has found that "prior to 1975, the department had not limited or suspended an operating certificate, had not recommended revocation of a Medicare or Medicaid provider agreement, had not moved to revoke or suspend a nursing home administrator's license, and had not referred cases to the attorney general in any instance in which operating deficiencies were the sole or leading cause of such action." This contrasted with a flurry of disciplinary actions during the first 6 months of 1975: preparation of over 60 cases for fines; revocation proceedings initiated against three operators for inadequate care; referral of 10 cases to the New York State Department of Law; and initiation of investigations to determine if license revocation was merited against 12 different nursing home administrators. As the study observed, this shift occurred "with no augmentation of statutory or regulatory authority, and with minor increases in inspection and enforcement staff." All this after the Medicaid program had been in operation for 10 years, expending 70 to 80 percent of all Medicaid moneys per year to institutional providers in New York State (as of 1976, an estimated $2.5 billion).

There was not even a basic policy to correct operating deficiencies by fine, suspension, or revocation—let alone enforce such disciplinary action until late 1973. Prior to that time (for the first 7 years of Medicaid) the general policy was a colleagueal "policy of persuasion and consultation."

In April 1973, the move toward a more punitive approach was triggered by a central office directive from New York State DOH's second deputy commissioner, Dr. Robert Whalen (now commissioner) to a deputy commissioner (Dr. Donald Dickson) and associate commis-

sioner (Dr. Frank Cicero) to develop standards and procedures for a fine-oriented system. The result of this effort from 1973–75 was:

—"No documented standards issued by any central unit of the department as to what would constitute an operating deficiency significant enough to be subject to fines."

—A total of only five recommendations from the regional offices as to "cases suitable for imposition of fines." Four regional offices—Albany, New York City, Rochester, and White Plains—"made no response" in that 2-year period. This is despite the documented cases of poor quality care presented in the New York City Department of Investigations reports of 1960 and 1962 and the results of the 1972 grand jury inquiry in Manhattan.

There was no attempt to factor the operational quality of a nursing home (as detected by the bureau of chronic diseases and geriatrics) into the setting of Medicaid reimbursement rates (as set by the division of health economics' bureau of health care reimbursement) until 1970. A special State task force on nursing homes in 1972 attributed this, in part, to the resistance of the division of health economics to being communicative. The division was characterized as "remaining almost totally isolated and apart from the communication system as it exists today." From 1970 to 1975, lists of homes with significant operating deficiencies were forwarded to the central office. The central office, however, never developed an objective or structured system for defining a "significant operating deficiency" for purposes of developing an "incentive" reimbursement system for nursing homes.

Neither the division of health economics (and its constituent bureaus) nor the bureau of chronic diseases and geriatrics have their own legal staffs. They rely on counsel's office of the department of health—an office directly accountable to the commissioner of health. Counsel's office is involved in all enforcement efforts—preparing and conducting hearings, researching and rendering opinions, drafting regulations and proposed legislation, preparing cases for referral to the attorney general, Federal and/or local law enforcement agencies, and providing legal advice on an ongoing basis to agency staff as regards the powers and duties of the agency.

The Moreland Act Commission cited at least four specific instances where counsel's office failed in its responsibilities. Among the instances was one where the director of the Albany regional office "testified that her conversations with lawyers in the office of counsel persuaded her that the procedures necessary to impose a fine were too cumbersome to be of use."

The commission concluded that there were four major failures by the counsel's office:

—Failure of the office of counsel to propound legal standards and guidelines necessary to effective regulation.

—Failure of the office of counsel to encourage the development and use of enforcement techniques.

—Failure of the office of counsel to make legal assistance more readily available for purposes of enforcement.

—Inability of the office of counsel effectively to implement existing enforcement policies.

This same counsel's office is also responsible for advice and legal action, vis-a-vis, the health department's bureau of medicaid which is

responsible for monitoring the noninstitutional providers of Medicaid services.

In 1975, counsel's office did designate nine of its attorneys as a special enforcement unit focusing on health care facilities.

HEW reports that New York State has reported no referrals of alleged Medicaid provider fraud by local agencies to law enforcement officials since HEW gathered such data by survey (1972–74) and required reports (1974–present). There already is evidence that at least two such referrals were made. Thus, the report of no referrals seems more a lack of effective data gathering and reporting by New York State than a lack of making any referrals. *In fact, New York State DSS does not have a centralized list of the highest billings by provider, or any provider profile, and relies solely on the locals to maintain such data. The locals generally do not maintain such profiles.*

The major reason for this situation has been the lack of one centralized enforcement unit for individual Medicaid provider fraud and abuse. Detection of such activities is split between DSS and DOH with DOH bearing the basic responsibility for initiating administrative action against providers. These procedures and responsibilities are set forth in SMH item 35 which has been discussed in detail earlier in this report.

However, item 35 was not even promulgated until July 15, 1971—5 years after the Medicaid program began and after $2 billion had been doled out to individual Medicaid providers. A similar situation existed in the New York City DOH where one State study found "that New York City DOH had no central organized investigations unit until early 1971" and did not have any formal written investigative procedures until late 1974. Meanwhile, between 1966 and 1971 the city paid out a total of $500 million to noninstitutional providers without any centralized compliance control. Another recent State study indicates that this situation is typical of the other 57 districts throughout the State.

Furthermore, the original 1971 version of item 35 was only three pages and did not establish specific actions and procedures for detecting, investigating, and taking administrative action against providers' alleged unacceptable or fraudulent practices. The October 1975 revision of item 35 contains detailed procedures, including reporting requirements, which are 17 pages in total. These procedures were in part prompted by HEW requirements promulgated in late 1973 (see CFR section 250.80, part 250, ch. II, title 45). Prior to that date, HEW "relied primarily on the States" for Medicaid enforcement.

Therefore New York State in effect had no formal centralized procedures for detecting, investigating, and taking administrative action on alleged unacceptable Medicaid practices and fraud until 1975—a decade after Medicaid began in New York State.

Even now with these procedures there are still staff problems. New York City DOH indicates its compliance unit is severely understaffed, its existing staff is inadequately trained, and there are insufficient attorneys, investigators, and auditors. This again seems to be typical statewide. The local health districts and regional health offices responsible for monitoring health care (items 34 and 35 SMH) are staffed primarily by medical professionals who review utilization. There are few, if any, investigators, auditors, or attorneys. Limited auditing staff

is available at the local social services district, but this staff does not have the basic tools to detect and refer alleged patterns of fraud and abuse for administrative action by health.

Health's central office, bureau of Medicaid, is similarly staffed without auditing, investigatory, or legal personnel. The emphasis is on medical professionals reviewing utilization patterns. Some cognizance of this problem was noted in the report of the fiscal committees of the State legislature concerning moneys allocated for fiscal year 1976–77 to the "Health Facilities Review, Development, and Management" units. These are the units previously discussed as responsible for inspection, licensure, audits, and rate setting for *institutional* providers.

The fiscal committees stated:

> One hundred and twenty new positions intended for auditing residential health care facilities are also approved. However, the fiscal committees expect the commissioner of health to use both new and existing staff to selectively audit other health practitioners, particularly individuals making excessive profits from Medicaid and those practicing in Medicaid mills.

However, the same committees denied funding of a centralized permanent audit and fraud unit in DOH's central office to oversee Medicaid providers.

There are no discernible changes in the staffing and activities of DSS's Medicaid program. In fact, the legislature seems to be focusing all Medicaid enforcement on the departments of health and law. In the fiscal committee reports, a savings of $3 million was projected from the New York State HUR program of on-site review of inpatient hospital stays of Medicaid patients. This is despite the relative newness and untested efficacy of the New York State HUR program. The fiscal committees also cut $6.6 million from DSS's statewide Medicaid program "to reflect increased audit activities by the health and law departments."

These *projected* savings of nearly $10 million were designed to restore proposed cuts in Medicaid optional services which the State has been covering since 1966. Cuts will be made in adult dental care, podiatory, physical and occupational therapy, speech therapy, audiology, psychology, radiology, and X-ray services. The projected savings are also being relied on to allow maintenance of clinic rates at their current level as opposed to a 10-percent reduction which had been proposed in the initial budget submission for the executive budget.

4. Department of Education

a. organization, powers, and duties

Prior to 1975, the State departments of health and social services could not take any action to remove the professional license of a medical professional in the Medicaid program. Their only recourse, primarily through local health districts, (item 35.1, State medical handbook), was to limit or disqualify such persons from the Medicaid program and refer their findings to the State department of education for possible action against the individual's professional license.

Such referrals to education, which licenses medical professionals in New York State, had to follow a lengthy procedure (section 6509–6515, Education Law). Such referrals went to the education department's division of professional misconduct which reviewed and investigated the case and recommended any disciplinary action. The findings were reviewed by the committee on professional conduct for the particular profession. If the Department and committee are in agreement, the attorney general was requested to prepare charges. The attorney general decided whether to prepare charges and, if so, the charges were prepared and a hearing was scheduled.

The hearing was presented by the attorney general, or his designee, to a panel of five or more members of the committee on professional conduct for the particular profession. The licensee was entitled to counsel and the right to subpena witnesses, evidence, and cross-examine. The panel made findings of fact, a determination as to whether the licensee is guilty on each charge, and if there was a determination that the licensee is guilty, then a recommendation was made as to penalties. A determination of guilty required a four-fifths vote of the panel.

The hearing transcript, results, and recommendations of the panel were forwarded to the licensee and the board of regents. A review committee appointed by the board (three members, one of whom must be a regent) reviewed the transcript, results, and recommendations. The licensee was entitled to request to appear or be required to appear at the review committee meeting (with counsel).

The review committee transmitted a written copy of its review to the board of regents which made a decision on the case based on a majority vote. If the board disagreed with a hearing panel's determination of not guilty, it remanded the matter to the panel for a new hearing. If the panel still found the licensee not guilty, the decision was final.

If the board found the licensee guilty, the licensee was entitled to appeal to the courts under article 78, Civil Practice Laws and Regulations.

Effective September 1, 1975, a board of professional medical conduct was created in the department of health to replace the jurisdiction of education over medical professionals up to the point of a final decision by the board of regents (section 230, Public Health Law). The procedures remain essentially the same as under the education law except the board and the committees on professional conduct use their own counsel and not the attorney general. One committee receives and prepares the charges, another committee conducts the hearing, and the committee forwards its transcript, findings, and recommendations to the commissioner of health. The commissioner makes his findings and recommendations as to the committee's report and forwards it to the board of regents, with a copy to the licensee. The board retains final decisionmaking power (procedures specified in the education law). An article 78 proceeding is still available to the licensee.

New York State DOE's Division of Professional Conduct indicates that in the 10-year history of the State's Medicaid program there has not been a license revocation for any medical profession based on alleged or proven Medicaid fraud of abuse. The division also has

indicated that it maintains no central index file with the names of referrals from local health departments or regional DOH offices.

In a 1974 study by a State agency, a discrepancy was found between the number of cases New York City DOH said it referred to New York State DOE and the number New York State DOE said it had received from New York City DOH. The city claimed it had sent 82 cases to DOE between January 1969–January 1974. The DOE said it received only 20 direct referrals from New York City DOH. Each agency blamed the other's poor recordkeeping for the discrepancies in data.

In their 1974 accounting of the 20 cases, DOE indicated there were no referrals involving physicians, 1 involving a dentist, 1 involving a chiropractor, and 18 involving pharmacists. As of January 1974 the 20 cases were disposed of as follows:

10—An average penalty of $350 per case assessed by the State Board of Pharmacy (SBOP).
1—A 90-day suspension by the SBOP.
6—Administrative verbal warning by the SBOP.
1—Pending review by attorney general.
2—Dentist and chiropractor cases under investigation.

b. FEE-SPLITTING, PERCENTAGE LEASING POLICY

In addition to its administrative record on monitoring professional conduct, education has been a major force in allowing the practice of percentage leasing to flourish, particularly in New York City. Percentage leasing is one of the major economic incentives to operate Medicaid mills. It involves a group of medical practitioners renting space and related facilities (often administrative and clerical staff, lab services, etc.) from a common landlord in a common building. Each practitioner signs a separate lease with the landlord with his rental based on a percentage of his monthly Medicaid income. The average percentage lease is now estimated to be 35 percent. The American Medical Association (AMA) and the New York State Dental Society have both condemned this practice as fee-splitting and, therefore, as unethical conduct for their members. The committee staff has detailed case examples of fee-splitting and percentage leasing in part 2 of this report.

In New York, the practice of fee-splitting vis-a-vis percentage leases appears to be governed by a 1971 opinion by the State Department of Education (hereinafter referred to as the Bardo opinion). In 1970, and again in 1971, Mr. August J. Bardo, Jr., then director of education's division of professional conduct, stated that:

> It would not be illegal, on the other hand, for a physician, dentist, podiatrist, and chiropractor to conduct their separate and independent practices on the same premises, and pay the landlord a fair percentage of their gross income for the rent and shared services.

The Bardo opinion did not specify what was "fair percentage" and did not clarify whether the facilities operating in New York City could be defined as having "separate and independent practices" in view of existing evidence as to their operations.

The Bardo opinion went on to say:

> However, such rental may not be based upon net income. It would be the substance and not the form of the arrangement that would determine its legality, any interference or control by the landlord over the practice of the profession would be illegal.

Evidence analyzed in part 2 of this report indicates that the percentage leases in New York City Medicaid mills are based on gross, not net, income. However, in court testimony in 1975 members of the Association of Health Care Facilities, Inc. (hereinafter referred to as the "association") and individual facility owners admitted that such leases are generally oral and often the landlord also operates a pharmacy, lab, or "factoring" company utilized by the professionals in his facility. Education has never ruled as to whether such "oral leases" or ownership of labs, factors, or pharmacies serving the facility *per-se*, or in individual cases, constitute "interference or control by the landlord over the practice of the profession." Education similarly has not ruled as to whether provision of centralized record maintenance and clerical and administrative personnel by the landlord constitutes such "interference."

The AMA has condemned any percentage leasing arrangement as unethical. The committee staff wrote to various medical and dental societies in New York State regarding this practice. The State dental society, the Queens County Dental Society, and New York County Medical Society all replied that they condemned as unethical any percentage lease agreement (see appendix 2). They also said they supported the State and city health departments' attempts to regulate these and other practices of Medicaid mills in New York City by amended item 230 to the local medical plan. The committee staff also wrote the State attorney general's office on this matter. The attorney general also said he supported item 230 and that as regards the Bardo opinion, "When we found out about it, we informed Mr. Bardo and counsel for the education department that the percentage lease arrangement could lead to abuses." The attorney general took no further action.

Despite these sentiments, the Bardo opinion has stood for nearly 7 years as policy. As discussed in part 2 of this report, the association obtained a court restraining order blocking implementation of item 230 and one of its major supporting arguments was the Bardo opinion (see part 2 of this report and *Association* v. *Bellin*, N.Y. Sup. Ct., Kings County, N.Y. Law Journal, March 19, 1976).

Given this situation, the committee wrote a detailed letter on June 7, 1976 to Mr. Robert Stone, counsel for the State education department, questioning the Bardo policy (see appendix 2). *By a letter of July 6, 1976, Mr. Stone advised the committee that effective August 31, 1976, the departments rules were amended so as to rescind the Bardo opinion.*

The amended regulations prohibit the use of either gross or net income as a basis for leasing arrangements for space and other services between landlords and any licensee in the 13 health professions in the State of New York. They also state that any health professional with a *financial interest* in a percentage leasing facility is subject to unprofessional conduct charges. Any professional violating the new regulation is subject to disciplinary action by education (see appendix 2).

The committee staff believes this change in policy is long overdue and

that it may provide the first major legal inroad against Medicaid mill operations, if properly communicated to and implemented by the appropriate State and local agencies.

C. RESPONSE TO THE COMMITTEE

The department of education's response to the committee's inquiry (see appendix 2) confirms the administrative inadequacies of that agency in disciplining medical professionals in general and particularly as related to Medicaid fraud and abuse.

The committee requested that education's office of professional conduct supply it with "A list, by type of licensee, of the total number of cases of alleged misconduct referred to your office for the period of January 1, 1966–January 1, 1976 . . . and the disposition of the cases." Education replied, "We do not maintain lists of all complaints by type of case and ultimate disposition . . . We expect to implement an information retrieval system on January 1, 1977 which will enable records of all future cases to be retained on such a list."

The committee requested a list of all complaints received from January 1, 1966–January 1, 1976 and the disposition of each such case where the charge was one of Medicaid fraud or abuse. Education said their lack of a master list of all complaints received and "present staffing" limitations made it "impossible . . . to go through the thousands of cases processed by this office during this period and break them down into the categories requested." However, education did provide the committee with a list of "Medicaid fraud or abuse cases that were readily available." They cautioned that the list was incomplete for two reasons:

(1) "Since we were not able to go through all the cases opened during this period, some Medicaid cases may have been missed."

(2) *Education does not consider* cases involving overbilling or where settlements were reached by Medicaid authorities and providers for restitution to Medicaid by deductions from future billings as automatic cases of unprofessional conduct.

The committee observes that it is highly questionable not to review the facts of overbilling cases and negotiated restitution cases for consideration as cases of unprofessional conduct.

The list submitted to the committee by education, with all the aforementioned caveats, shows that during the 10-year period of the Medicaid program education received only 53 cases of unprofessional conducts by medical professionals, excluding pharmacies and pharmacists, based on Medicaid fraud or abuse (i.e., an average of only 5.3 cases per year). Of the 53 cases, the dispositions were as follows:

—43 percent (23 cases) allegations unsubstantiated,
—28 percent (15 cases) still pending,
—15 percent (8 cases) "warning" or "reprimand,"
—10 percent (5 cases) formal discipline (conviction, revocation, or temporary suspension, and
—4 percent (2 cases) subject deceased.

The committee feels that the above data further confirms previously cited data on education's ineffective information gathering and investigatory techniques, lenient disciplinary actions and ineffective coordination with relevant Federal, State, and local agencies, particularly in the Medicaid and Medicare field. For example, in response to a committee inquiry, the New York City Department of Health's

Medicaid Unit, indicated that between January 1, 1972, and June 1, 1976, alone they suspended or disqualified 120 providers from the Medicaid program, referred 66 cases for criminal action, and referred 35 cases to education. The committee staff notes that this confirms that discrepancies in data between education and local agencies and their lack of effective cooperation as cited in detail in other studies in part 3 of this report.

The committee staff also submitted to education a list of 48 cases where either the New York City Department of Health or the Region II Bureau of Health Care Insurance (Medicare) files indicated the provider had been subjected to either administrative or court-imposed penalties due to Medicaid or Medicare fraud or abuse. *Education indicated they had opened cases on only 42 percent (20 of 48) of the practitioners. As to the remaining 58 percent (28 cases), education replied they have "No record of the other 28 names on the list. Of the 20 cases, 65 percent (13 of 20) of the cases are still pending and half of the pending cases have been pending since 1974 or earlier.* Among the pending cases the committee staff observes that there is a charge of alleged "insurance fraud" pending against Fred Fisher, DDS since September 1974. Dr. Fisher's case is detailed in part 2 of this report as having allegedly defrauded Medicaid of nearly $1 million dollars over a 5-year period. The sentencing judge in the *Fisher* case said that the city's lack of adequate records limited his ability to order any significant restitution or jail sentence. Dr. Fisher has not received any disciplinary action from State education and has not been banned from the Medicaid program.

Education also indicated to the committee that since 1966 there have been a steady decrease in the size of its staff from a high of 51 in 1966 to 36 in 1976. The total staff for this 10-year period has averaged 45 with only half of the total being investigating staff. Education did not have personnel budget data available for 1966–74, but the 1975 and 1976 budgets averaged $429,000. The committee staff observes that education's office of professional conduct, until September 1, 1975, had statutory responsibility for monitoring the professional conduct of licensed medical professionals in 12 different professions as well as 10 other nonmedical professions (i.e., accountants, engineers, social workers, teachers, etc.).

The State board of pharmacy, which is also part of the education department, responded to the committee's inquiry indicating that it has had an average staff of approximately 30 persons since 1965, with about two-thirds of these being professional staff, and a personnel budget of nearly $370,000. The committee staff observes that the entire office of professional medical conduct has only about 13 percent more moneys and 50 percent more total staff than the pharmacy board while it is responsible for a total of 22 different professions as compared to pharmacy's one. *The committee staff believes the discrepancy in manpower and budgetary allocation should be corrected for more equitable and cost-effective results.*

The board of pharmacy advised the committee that between 1969 and 1976 it had the following results in disciplinary actions:

(1) An average of 167 cases annually where monetary penalties were imposed averaging $59,600 per year. Both the number of such cases and penalties imposed have increased steadily since 1972.

(2) A total of 117 cases between 1970 and 1975 where pharmacies or pharmacists were given formal discipline by the board (i.e., revocation, suspension, resignation, dismissal, censure).

(3) *Only 6 of the 117 cases (5 percent) of formal discipline between 1970 and 1975 involved Medicaid fraud or abuse, and all 6 were in 1975.*

The committee staff observes that past data cited in various State, Federal, and local reports (see part 3 of this report) and the staff's own prior studies and investigative work (see part 2 of this report) indicate that the pharmacy board's activities in this are well below what should be expected.

The pharmacy board's limited activities regarding Medicaid fraud and abuse were heightened by the fact that the Brooklyn district attorney's office recently announced the arrest of 16 druggists on alleged charges of substituting generic for brand-name drugs in filling Medicaid prescriptions. The district attorney estimated that Medicaid is defrauded of $1.68 million a year alone by such activities.

The committee staff believes the board of pharmacy suffers from the same types of problems already discussed in terms of education's office of professional conduct, particularly in view of pharmacy's relatively high staffing level vis-a-vis the health and education departments' offices of professional conduct.

The State board of professional medical conduct was established within the department of health effective September 1, 1975 (Ch. 109, Laws of 1975, NYS). The board does not supersede the department of education's role regarding professional conduct of medical professionals, but merely shifts the initial investigation of complaints from education to the board. As the board's executive secretary observed in his response to a committee inquiry (see appendix 2), the board of regents (education) review process is still operational and no action can be taken against a professional's license until the regents make a final determination.

The professional conduct board's response to the committee indicates that its creation may not streamline the disciplinary process but may in fact add to the already cumbersome and lengthy process administered by education. For instance, the board's response revealed these facts:

(1) *The board has only limited funding and staff.* The initial budget was only about $28,500 per month or about $342,000 prorated for the first year of operation. This budget supports a staff of eight medical conduct investigators, two secretaries, and one person serving both as executive secretary to the board and as director of the health department's office of professional medical conduct. The scope of the board and office's jurisdiction is to receive and investigate any complaints of professional misconduct regarding physicians and physicians' assistants in New York State.

(2) All other medical professionals licensed in New York State are still subject to the cumbersome professional conduct procedures or the department of education.

(3) The board to date has "had little to do with Medicaid fraud and abuse," and cannot initiate any action against a physician for Medicaid abuse/fraud until health's own Medicaid unit has completed its investigation and the administrative and court hearing

procedures have been exhausted. The board states that "there is a separate Medicaid fraud abuse program that investigates abuses of this nature ... It is only after the completion of their investigation, in general, that this information is forwarded to our office for further action."

The board also indicated that they would not be able to do anything "with Medicaid fraud or abuses unless there was accompanying evidence of unprofessional conduct or misconduct." The board did not indicate when it would consider a substantiated case of Medicaid fraud or abuse synonymous with unprofessional conduct or misconduct.

5. Board of Social Welfare

The State board of social welfare is responsible for licensing, inspecting, and otherwise supervising all private and public agencies and facilities in the State which provide care for children and domiciliary care for adults (sections 730–759, Executive Law). There are currently approximately 600 child-caring institutions and agencies with 15,000 children; 600 domiciliary care facilities with 31,000 persons; 1,100 family-type homes (2- to 4-person capacity each) with 3,400 persons.

The facilities subject to the board's jurisdiction are for ambulatory patients and medical care generally is not rendered on the premises. However, these facilities do provide room and board, allow residents to store and use medication and medical equipment on the premises, and allow periodic visits by nurses and various medical practitioners. The board has detailed requirements regarding physical plant and the conduct of the operators of the facilities (see 18 NYCRR parts 1–226). The board can issue orders to such facilities, based on investigations, to correct inadequacies in the care and well-being of residents, including medical care, and is empowered to revoke operating certificates.

Most of the residents of such facilities, particularly the DCF's, are on public assistance, supplemental security income (SSI), and/or eligible for Medicaid and Medicare. Recent data shows that about 66.6 percent of all DCF residents are on SSI and another 20 percent, primarily State mental hospital dischargees and other local social services district referrals, are on public assistance or Medicaid. While the SSI recipients are automatically eligible for Medicaid, very few are actually enrolled in the program because of the time and energy necessary to go through a separate Medicaid and SSI eligibility determination.

As such, the institutions are subject not only to supervision by the board but by the State and local departments of health. They can be audited and inspected as regards the provision of care and utilization of funds allocated to such residents.

6. Division of the Budget

The State division of the budget is responsible to review the use of funds and operation of programs in all State departments. The division is specifically charged with, among other responsibilities, assisting the Governor "in his duties respecting the investigation, supervision, and coordination of the expenditures and other fiscal operations" of the various civil departments (section 180, Executive Law). As such,

it has a series of examining units each of which is responsible for one of more areas which receive moneys for the State budget. The same examining unit is in charge of the departments of health and social services while other units are responsible for DMH and ODAS. The division of the budget also has a program analysis and review (PAR) unit which conducts analyses of program operations in agencies usually geared to recommendations for cost-effective management and delivery of services. The budget division, along with the State department of civil service, also procedurally must authorize expenditures for various staff positions and other fiscal allocations before they can take effect.

This authority is important because the budget division, by aiding the Governor in the preparation of his budget for submission to the legislature and its actual implementation, often determines if and when a unit is created, staffed, and funded. In the department of health, for instance, this has affected the ability to get a unit staffed with sufficient numbers of attorneys, investigators, and auditors to monitor all Medicaid vendors and particularly to review the establishment of health care facilities, set reimbursement rates, and monitor reimbursement claims for possible fraud and abuse. For example, until 1975, the Governor and budget director consistently refused DOH requests for additional auditing and investigatory staff despite data indicating that State DOH auditors saved the State nearly $15 in Medicaid funds for every $1 expended for their salaries. In the department of social services, for instance, budget's role is, in part, accountable for the failure to create an office of audit and quality control until 1973. The office monitors the operations of local welfare operations particularly as regards ineligibility and overpayments to public assistance clients.

Under article 28 of the Public Health Law, the budget director actually promulgates the rate schedules (including fee schedules for individual providers) for Medicaid payments to providers. The commissioner of health is responsible for developing the rates and certifying to Budget that said rates are reasonably related to the production of service (section 2807, Public Health Law; Sections 364 and 364–a, Social Services Law).

A recent State study has observed:

> The traditional structure of the health industry in New York State and in the Nation, as a whole, permits the dominance of the medical profession and the insurance industry which contribute to spiralling costs. The health department, in setting rate schedules for Medicaid and Blue Cross, is required to certify to the division of the budget and department of insurance that they are reasonably related to the cost of the efficient production of services. Fundamental questions concerning the relative cost of physician services and the availability of physician services are not addressed by the department in setting rates.

After release of the committee's March 19, 1976 hearings and release of the staff's supporting paper No. 7, the special State prosecutor for health and social services was given authorization (by SBSW and DSS) to investigate fraud and abuse in homes for adults subject to SBSW jurisdiction.

7. Department of Law

a. Organization, powers, and duties

The attorney general, an elected official, and the department of law, which he heads, is charged with prosecuting and defending all actions and proceedings in which the State is interested and has "charge and control of all the legal business of the departments and bureaus of the State" (article V, section 1, Constitution; art. V, sections 63, 63–c, Executive Law). While each State agency has its own counsel and legal department, all court actions initiated by or against the State cannot proceed except as under the aegis of the attorney general's office. Therefore, any recommended civil or criminal action by the Departments of Health or Social Services regarding Medicaid, for example, must be handled through the attorney general's office in terms of State action. Local, county, town, and city attorneys, district attorneys, and U.S. attorneys may initiate cases involving Medicaid fraud in terms of their particular jurisdictions.

The attorney general also is authorized, upon the request of the Governor, comptroller, or head of any department, authority, division, or agency of the State to "investigate the alleged commission of any indictable offense or offenses in violation of the law which the officer making the request is especially required to execute or in relation to any matters connected with such department, and to prosecute. . . " any persons involved in such offenses (section 63.3, Executive Law). He is also authorized to appoint any additional deputies, officers, and other persons he deems necessary to "inquire into matters concerning the public peace, public safety and public justice" when he deems that the public interest requires such action and upon the direction and approval of the Governor (section 63.8, Executive Law).

Based on these authorities, on January 10, 1975, Mr. Charles J. Hynes was appointed a deputy attorney general and designated as special State prosecutor for health and social services. His inquiry into the operation of nursing homes and vendors to said industry was preceded by nearly 6 months of extensive media publicity, several reports by the welfare inspector general and the Temporary State Commission on Living Costs and the Economy, a special report by Secretary of State-designate Mario M. Cuomo, and ultimately requests for an inquiry under section 63.3 of the executive law by the State commissioners of health and social services.

In April 1976, a similar request was made by the State Board or Social Welfare for Mr. Hynes' office to expand his inquiry into the operation of domiciliary care facilities.

Simultaneous with the creation of the special prosecutor's office, the Governor established a "Moreland Act Commission" to inquire into the operation of nursing homes and residential care facilities in the State. Under section 6 of the executive law, the Governor can create such commissions "to examine and investigate the management and affairs of any department, board, bureau, or commission of the State." Such commissions have the power to subpena and examine witnesses under oath and to require the production of "any books or papers deemed relevant or material." The Governor also specifically requested this Moreland Act Commission to make recommendations on legislative and administrative changes.

Approximately 30 percent of all the Medicaid expenditures in New York State ($960 million) go to nursing homes and intermediate care facilities and most, if not all, persons in residential care facilities are Medicaid and/or Medicare recipients.

Prior to the special prosecutors office creation, the attorney general initiated few, if any, actions against nursing homes or other health care facilities. There still is little, if any, activity by the attorney general against individual MA providers.

No statistics are available on the number of nursing home, other institutional provider, or noninstitutional Medicaid provider cases referred to the attorney general. However, the State's Moreland Act Commission found the attorney general's office severely lacking in initiating inquiries in the nursing home area despite widespread knowledge of alleged fraud and abuse.

To quote the commission's 1976 report:

> The question of the attorney general's vigor in investigating abuses in nursing homes boils down to the following: If Lefkowitz had as little basis for concern about nursing homes as he stated to the commission ("isolated complaints"), then it is unclear why he would have specifically requested Ingraham to grant him section 63(3) authority in the first place, especially since his office was already well aware of and using its powers under section 63(12). If he was in earnest about launching an investigation with specific authority to bring criminal charges as is permitted under section 63(3), and if he really sought to develop evidence which would have compelled Ingraham to change his position and grant him section 63(3) authority, then his relegating the task to a small and untrained group of summer interns was a distinctly unpromising way to achieve the intended result.
>
> In short, not until December 1974, and then only in response to media pressure, did Lefkowitz renew his request to Ingraham and receive his authorization and that of Social Services Commissioner Lavine to proceed under section 63 (3). Shortly thereafter, his participation was rendered superfluous by the appointment of both a Moreland Act Commission and a special prosecutor.

The results of the special prosecutor's office detecting Medicaid overcharges and obtaining criminal indictments and convictions in its first year of operation indicate there was ample basis and power in the attorney general's office for such action prior to 1975. Most of the special prosecutor's actions involve activities by nursing home operators between 1971 and 1974. The special prosecutor is a special deputy attorney general and his jurisdiction and powers are those derived from the attorney general's jurisdicion and powers.

The Moreland Act Commission also revised questions as to the propriety of the attorney general forwarding recommendations to the Governor's office for favorable action on applications for establishment of nursing homes by voluntary, "nonprofit" groups.

In the area of investigation and/or prosecution of individual MA providers, the attorney general did receive a copy of the 1972 Manhattan grand jury report. Despite the prosecution of at least two pro-

viders by the Manhattan district attorney based on evidence from that grand jury, the attorney general never initiated any State action against either provider or any others. Nor did he initiate any request to DSS or DOH to initiate a special State inquiry pursuant to his powers under State law.

b. RESPONSE TO THE COMMITTEE

In response to a committee inquiry (see appendix 2) the State attorney general's (AG) office indicated that it had received only 19 cases of alleged illegalities by medical professionals in the State's Medicaid program during its first 8 years (i.e., 1966–74). The AG indicated that in 63 percent of the cases (12 of 19) the result was either a suspension or revocation, but in five of the cases the practitioner was placed on probation in lieu of suspension or revocation.

The AG said the reason for so few actions given the size of the Medicaid program was that legal jurisdiction for criminal prosecution and recoupment of moneys rests with local law enforcement and Government agencies. He also noted that the State department of health has authorization to seek restitution and suspension of providers on its own; the State education department may discipline professionals short of court action; and the State welfare inspector general is empowered to investigate welfare frauds.

The AG has taken the position that he will not initiate his own criminal action in a Medicaid case unless he receives a referral from a locality or a specific request from a State agency to initiate criminal prosecution pursuant to section 63.3 of the State's executive law. Because of this philosophy the AG admits he never had a special unit to deal exclusively with Medicaid and welfare fraud, and has never made an attempt to coordinate the legal staff and activities of the State agencies involved in the Medicaid area (health, mental hygiene, social services, and education). All 19 cases referred to the attorney general were handled by staff in two separate bureaus. It was not until a letter was received in late 1974 from the State department of health and social services and the issuance of an executive order by the Governor that a special prosecutor's office was created within the AG's office to handle solely Medicaid cases. However, as of this printing, the special prosecutor's jurisdiction is limited to institutional Medicaid providers (i.e., nursing homes, hospitals, and other health care facilities).

The AG's contention that a specific letter from a State agency is a prerequisite to any action was sharply criticized by the State's Moreland Act Commission on Nursing Homes. . . . The commission said the AG had been lax in initiating action in the Medicaid area despite repeated evidence from various grand juries, reports, and State agencies of criminal activities by Medicaid providers. The commission noted that the AG had in fact received numerous requests from the State health department, but that health officials said they received either no response or mere procrastination.

The commission also notes the irony that while the AG was waiting for the section 63.3 statutory request on specific cases, many of which were widely publicized in the media, the attorney general himself was writing formal requests to the Governor's office recommend-

ing favorable action on applications for health care facilities operated by persons who had been finance and vote raisers for the State Republican Party.

Further evidence of the laxity of the AG's office is its response to the committee's June 7, 1976 letter admitting its failure to take any action on cases reported in the 1969 Manhattan grand jury report. That report, according to State Comptroller Arthur Levitt, was based in large part on audit reports and testimony submitted by State auditors. Individual cases of alleged fraud and other wrongdoing were contained in the report. The AG requested a copy of the report upon its issuance in January 1972, but did not initiate any case based on that report. The AG also admitted that he has never initiated a Medicaid case based on any of the 42 Medicaid audits issued by the State comptroller between 1967 and 1976.

The AG also indicates that he has taken a passive attitude in sponsoring corrective legislation and insuring that legal departments with health, social services, and education are proper. For instance, in his response to the committee, the AG says the responsibility for legislation rests with responsible State agencies and he "may be asked to comment on it." The AG indicates he has not taken an initiative on amending the public health law to cover Medicaid mills and has not even filed an amicus curare brief in support of the New York City Health Department's proposed Medicaid mill regulation (i.e., item 230 local health plan)—despite the fact that he "agrees with its provisions."

While the AG says he believes that the practice of percentage-of-gross-income leases "lends itself to fee splitting," he did not void the department of education's 1971 legal opinion permitting such leases. Instead the AG said, "When we found out about it, we informed Mr. Bardo and counsel for Education that the percentage lease arrangement could lead to abuses." However, the AG has neither initiated a court challenge nor sponsored legislation as a means of curtailing the operation of Medicaid mills and the existence of percentage leases.

8. Department of Audit and Control

a. organization, powers, and duties

The comptroller, an elected official, and the State department of audit and control, which he supervises, is responsible ultimately for "the payment of any money of the State, or of any money under its control, or the refund of any money paid to the State" (article V, section 1, State Constitution). He has broad powers to investigate and audit payments by any State department or other entities receiving State moneys and the administration of the programs using said moneys (sections 40–44, Executive Law; Section 8, State Finance Law). As such, the Department of Audit and Control must certify payment of vouchers paid by the State. This includes payments by the State, for reimbursement purposes, to localities operating under the Medicaid program; payments to staff of State agencies administering such programs; payments by State and local agencies using State funds to private or public entities; review of claims for reimbursement, by State and local entities using State funds, from the State and Federal Governments.

The comptroller is authorized to withhold or disallow payments on

reimbursement claims where he finds noncompliance with rules, regulations, or laws applicable to the specific program.

The comptroller has done numerous audits on the Medicaid program in New York State, particularly in New York City. (See part 3 of this report)

b. RESPONSE TO THE COMMITTEE

In response to a committee inquiry (see appendix 2), the comptroller's office claimed it does not have specific legislative authority or guidelines to deny all or partial reimbursement "as a penalty for lack of an adequate administrative system." Further the comptroller asserts that such action "could impair provision of necessary medical services to needy persons genuinely entitled to them." The comptroller says he does "deny requested reimbursement to local governments for any items we identify which reflect violations of statutes or regulations" and "in some cases" withhold monthly estimates of similar items "until shown that the illegal practices have been discontinued." However, the committee notes with irony that when it asked the comptroller how he can allow New York State DSS to pay Medicaid moneys when it has no centralized Medicaid payments system, provider profile, patient profile, or uniform reporting requirements enforced on localities, the response was that "Our authority to disapprove vouchers submitted through New York State DSS for reimbursement of local governments does not include authority to disapprove such vouchers on the basis of our appraisal of that department's administration or of the statutes under which it operates." The committee notes that the comptroller, by his own admission, does have power to disallow payments "which reflect violations of statutes or regulations." New York State DSS's statutes and regulations require specific accounting data and procedures, provider information, and verifying documents before payment may be authorized, and the comptroller and other auditing sources have noted New York State DSS's continued authorization of payments even when these requirements are not met. The specific statutes and regulations are set forth in the section of this report dealing with New York State DSS's responsibilities.

The committee notes that the comptroller has the power to restrict or deny payment of State moneys any time he does not have adequate verification of claimed expenditures. *In fact only 3 weeks before the comptroller replied to the committee his office issued an audit criticizing New York City for paying between $19 and $40 million annually to Medicaid ineligibles due to inadequate administrative procedures and supervision. In that report, the comptroller recommended that the State withhold reimbursement until the city "complies fully to reduce excess Medicaid costs." The committee staff finds such language in direct contradiction to the comptroller's assertion to the committee that he lacks the power to deny or withhold reimbursement "as a penalty for lack of an adequate administrative system."* (See appendix 2)

The comptroller also has criticized various basic parts of New York City's Medicaid program for not having a system of verifiable claims. For example, the comptroller has detailed "inadequate transaction documentation" in Medicaid nursing homes (1971), duplicate Medicaid payments to New York City Health and Hospital Corp. (1975),

failure to reconcile claims to central appropriations records at New York City DSS (1974), and Medicaid payments made without prior use of third-party insurance coverage (1971), among others in 42 audit reports issued between 1967 and 1976. The comptroller also recognized in 1969 that a substantial portion, if not all, Medicaid payments being made by New York City could not be substantiated by appropriate provider invoices. Auditors from the comptroller's office gave testimony to the 1969 Manhattan grand jury to this effect. The comptroller also observed that the same situation still exists in 1976 with the lack of a centralized statewide MMIS system and New York City's maintenance of the different payment systems.

Despite these facts, the comptroller still asserts that "neither the constitution nor the statutes of the State vest me with power to require State agencies or local government to revise their administrative procedures or punish them for failure to do so. The committee notes that the New York State constitution (article V, section I) and various State statutes (sections 4044, executive law; section 8, State finance law) give the comptroller clear authority to control the payment of any State moneys (or moneys under State control), to investigate and audit any payments so made, and to withhold or disallow payments where he finds noncompliance with rules, regulations or laws. The comptroller's own audits indicate such noncompliance as does a recent HEW report and welfare inspector general's report on the voucher and claim records maintained by local social service agencies.

The comptroller has not actively endeavored, in the committee's view, to pressure State and local agencies to alter administrative practices which have been found responsible for improper payments upon threat of delayed or denied reimbursement. One reason may be the already heavy financial burden on localities in the State to finance Medicaid and the fear that vigorous monitoring and control of State reimbursement might result in Federal reimbursement denials with a serious threat to the fiscal existence of many localities. The comptroller's approach appears to be one of maximizing revenues to the State and its localities which in Medicaid means insuring Federal matching 50 percent reimbursement for equivalent State and local outlays. To highlight local errors would jeopardize the Federal moneys. The State's attitude may be the same as the provider who relies on the ongoing flow of Federal moneys to pay his costs, even if said costs are incurred by fraud and error.

The comptroller also admits that his followup on audit reports is limited. Of the 42 audits performed between 1967 and 1976, only one reported "followup" audit. As the comptroller says in his reply to the committee, "further action, action to correct managerial or programmatic shortcomings disclosed by the audit reports, is the responsibility of the officials who receive the reports." *The committee observes that as the State's chief fiscal watchdog the comptroller has the power and duty not only to detect shortcomings but to insure that the agency at fault corrects those shortcomings by the necessary administrative, budgetary and, if necessary, legislative changes.* Other parts of the comptroller's response to the committee, as cited herein, indicate that he does not take this approach.

The committee notes that the failure of the comptroller to apply effective followup audits and restrict payments made without proper

documentation is further accentuated by New York City's current "fiscal crisis." The comptroller's own Special Deputy Comptroller for New York City Affairs has repeatedly observed the continued loss of millions of dollars annually due to administrative failures in the city's Medicaid program. All of these failures are ones which have been noted in a variety of comptroller's and other reports over the last 10 years. The same special deputy comptroller also has criticized the city's fiscal recovery plan several times for underestimating projected deficits due to ineffective administration in Medicaid.

The comptroller advised the committee that each county's social service operation is audited "regularly" by his office "as part of our periodic audits of each county." There was no indication what was meant by "regularly." In addition the comptroller said his office has performed 42 audits of various aspects of the Medicaid program between 1967 and 1976, 52 percent of which (22 of 42) have dealt with the New York City operation. *The committee notes that this is an average of only four audits per year by the State's chief fiscal watchdog for a program in which the State and its localities pay nearly $1.6 billion per year (50 percent of the total $3.2 billion annual cost).* The remainder have dealt with program aspects of the New York States DSS and New York DOH Medicaid programs and use of Medicaid moneys within the department of mental hygiene (DMH).

The comptroller admitted that both his own audit program for DMH's and DMH's internal audit program for nearly $500 million in MA moneys used annually by the agency were limited. He said the reason was that "Budget limitations preclude audits of State institutions and facilities, including those which use Medicaid moneys, more frequently than on a 3- to 4-year cycle." He said that "this year" DMH's internal auditing staff is being expanded "from 4 to 13 professionals," but did not indicate how these "professionals" would spend their time vis-a-vis Medicaid.

The comptroller said his office has no procedures for auditing Medicaid-reimbursed psychiatric services at private profitmaking hospitals because such hospitals "seldom provide more than a modicum of care to needy persons eligible for Medicaid." As to psychiatric services at voluntary hospitals, the comptroller said his office relies on the city comptroller to do such audits and "we avoid duplication of effort and monitor performance of the city auditors." A December 1975 HEW Region II review of the State's Medicaid program for DMH Medicaid expenditures and for Medicaid-subsidized psychiatric services at private and voluntary hospitals were severely deficient.

The committee asked what the comptroller did regarding is auditing responsibilities in response to the 1969 Manhattan grand jury report since records indicate a copy was sent to his office. The comptroller merely said the report "did not address itself to performance of the comptroller's office." However, he claimed "testimony by members of my staff and our audit reports . . . formed the foundation of the grand jury report." A committee review of the grand jury report indicates that examples were cited from State audits and some State auditors did testify, but that such material was merely used to buttress the testimony of city personnel, recipient witnesses, and providers brought before the grand jury. The comptroller also did not indicate why he had not requested the convening of such a grand jury or

asked the State attorney general to convene such a grand jury if his own staff and reports documented such a persistent pattern of fraud, abuse and maladministration.

The comptroller did admit the report, which he received in 1972, was a "factor in leading" his office to undertake an audit of the Medicaid peer review program in New York City. The audit was just completed in 1976—4 years later—and marks the first audit by the comptroller of any aspect of the State's utilization review program. Health, the Governor's office, and HEW had indicated that health did not have an operational hospital utilization review program until at least 1971—4 years after Medicaid was effective. HEW and the Governor's office both indicate the program did not have any real impact until 1974. The comptroller indicated that it was basically his policy to let health utilize its own monitoring programs to audit Medicaid and the list of 10 years of audits on Medicaid indicates that only 3 of the 42 audits were of State Health's administration of Medicaid—and all three of them were done in 1975 and 1976. *The Committee observes that this confirms the State comptroller's basic policy of abdicating a supervisory audit responsibility over the Medicaid program administered by the State departments of social services, health, and mental hygiene.* This is despite the comptroller's admission and knowledge that all three agencies have been plagued with maladministration, provider fraud, and inadequate staff for years causing large monetary losses to the State, Federal, and local governments.

On this very point the comptroller further admitted to the committee that there still was no uniform statewide Medicaid information and payments system even though this failure was cited in various reports, including the 1969 grand jury report. The comptroller said he believed the 1976 legislation signed by the Governor to provide State funding for such a system would remedy the problem of having 58 disparate local systems. He did not mention that all State officials contacted said that such a system would not be operational at least until 1980.

The comptroller also displayed a similar passive attitude to the committee in terms of his role in recommending and sponsoring corrective legislation. Despite the fact that the comptroller serves as the State's fiscal watchdog, the comptroller said suggested corrective leigslation, rules and regulations are left to the individual agencies. He said, "Were we to draft legislation relating to all areas we audit, we would be undertaking responsibilities charged to all other State agencies and would be forced to subordinate performance of our primary responsibilities."

The committee asked the comptroller why he had not supported, on a cost-benefit basis, the various requests of the State health department for more auditors from 1966 to 1975, particularly in view of his own audit findings of severe maladministration and monetary losses in the Medicaid program. The comptroller advised the committee that he "has no role in developing, reviewing or approving budget requests of other agencies" stating that such responsibilities are "lodged in the Governor, his division of the budget, and the legislature." The comptroller indicated, "We have difficulty in obtaining authorization for the number of auditors for our own department which we believe to be warranted on a cost-benefit basis."

In terms of primary responsibilities (i.e., auditing), however, the comptroller indicated no effort in the 10 years of the Medicaid program on the part of his agency to coordinate its own auditing resources with those of the individual State agencies so as to maximize the admittedly limited auditing staff available. This parallels the attorney general's failure to effectively coordinate the legal staffs of the relevant State agencies with his own personnel. The State's Moreland Act Commission on Nursing Homes noted the essentially independent operations of the State agency legal staffs and the AG's office, despite the demonstrated need for coordination between such staffs. The merit of such a coordinated approach, the committee observes, is demonstrated by the cost-effective results of the coordination of legal, auditing, and investigatory personnel of the State department of health and the office of special prosecutor for nursing homes since the latter's inception in 1975.

The committee observes another irony in the comptroller's response. Every major State, Federal, and local agency involved in New York State's Medicaid program over the last 10 years admits that the bifurcation of responsibility between health and social services at the State and local levels is counterproductive, inefficient, costly, and the major underlying administrative problem in the State's Medicaid program. This observation has been made at various times by the State comptroller's office and was a major observation of the 1969 Manhattan grand jury report which, the comptroller asserts, was based primarily on his agency's audits and staff testimony.

The committee asked the comptroller why he has not urged specific legislative amendment of the cooperative agreement between health and social services (section 364–a, Social Services Law) so as to create a "truly streamlined single State agency" for Medicaid. The comptroller's response ironically was "That purpose is more debatable and its achievement more complex than might appear or than could be effected by amendment of that section." The comptroller went on to say that his office does not involve itself in drafting or sponsoring legislation unless it pertains "to matters directly affecting its own powers and duties."

9. Office of Welfare Inspector General

a. organization, powers, and duties

The office of welfare inspector general (WIG), created in 1971, was within the executive department until 1975 when the legislature transferred it to the department of audit and control (chapter 219, Laws of 1975—now sections 46–50, Executive Law). The office has subpena power, but not enforcement powers. It is authorized to receive and investigate complaints regarding alleged frauds and abuses of the welfare system; alleged failures to prosecute such frauds, including Medicaid; alleged failures of local officials and employees to comply with State laws and regulations regarding welfare administration; to initiate its own investigations in all the aforementioned areas; and additionally in "the operations of the State social services department and local social services districts in order to insure proper expenditure of welfare funds" (section 48, Executive Law).

The office, as with the department of audit and control and di-

vision of the budget, has the power to subpena witnesses, administer oaths, take testimony, and compel the production of any books, papers, records, and documents as may be relevant to any inquiry or investigation authorized by statute.

From a budget perspective, the State now allocates the nearly $1.8 million OWIG budget to the State department of social services (NYCDSS). New York City DSS then contracts with OWIG so that OWIG may perform its statutory duties. The reason for this arrangement is that it may enable the State to receive approximately 50 percent reimbursement on OWIG budgeted funds on the basis of OWIG being a fraud and abuse unit. However, OWIG has jurisdiction only in the noninstitutional area of Medicaid (MA) and all of public assistance (PA), a significant portion of their work is analysis of "systems" problems as opposed to fraud and abuse investigation of PA and MA cases. Thus they overlap and often duplicate existing New York State DSS and local agency units. Furthermore New York State DSS has no control over OWIG's activities. OWIG operates as an independent unit within the department of audit and control and the welfare inspector general himself is appointed by the State comptroller.

The committee did not address a specific inquiry to the office of the welfare inspector general (OWIG), but did ask the State comptroller several questions regarding OWIG. By statutory amendment in 1975 the OWIG office was transferred from the executive department to the department of audit and control (i.e., comptroller's office).

The committee asked the comptroller three questions regarding WIG (see appendix 2):

(1) Do you believe it makes sense to spend $1.5 million a year on the office of welfare inspector general when that office has no enforcement power?

(2) Isn't it duplicative of work your agency and health and social services in Medicaid auditing?

(3) Might not the money be better spent for a centralized Medicaid fraud and abuse unit?

The committee observes that all State agencies contacted confirmed the committee's finding that no such statewide centralized Medicaid fraud and abuse control unit exists.

The comptroller's response is that WIG's function "is to investigate primarily for instances of fraud, *and not* to audit social service programs or directly enforce compliance with the law." In this respect the WIG "refers cases to the county district attorney for criminal prosecution and he makes available to our auditors information indicative of maladministration." The comptroller stated his staff "does not have that type of investigative power" and that, "In my opinion, there is effective coordination, not duplication, of effort."

The committee observes that the comptroller's response was to justify WIG's existence on the basis of being a fraud investigation arm of the comptroller's office. However, this does not address the basic question of the agency's redundancy. The bulk of WIG manpower is a staff of investigators who investigate complaints of fraud and abuse by individual public assistance recipients and, where merited, refers cases to local district attorneys. This function is a clear duplication of the work of similar staffs in the local social service agencies. Both the

current Governor and his first social service commissioner recognized this fact and sponsored legislation in 1975 which would have transferred WIG staff to the New York City DSS. The legislature defeated this proposal.

Also, prior to the creation of the special prosecutor's office in 1975, the WIG had a unit of nearly 20 persons (auditors and investigators) assigned to Medicaid audit-investigations. This function clearly overlapped that of the State health, social services, and comptroller's departments and upon creation of the special prosecutor's office WIG's jurisdiction over institutional Medicaid providers was terminated, but it retained the staff previously allocated to that function. That staff now focuses on noninstitutional providers and has only referred one case to any law enforcement agency in its 2-year existence. The staff, contrary to the comptroller's assertion, does include auditors.

The $1.5 million annual budget of WIG is questionable, secondly, because of the lopsided allocation of budget moneys to executive staff. WIG allocates more than 10 percent of its total budget to five executive staff members alone who each earn more than $30,000 per year.

The committee staff believes the WIG has long since served its initial function of calling public and governmental attention to the deficiencies of State and local agencies in the welfare field. *In view of the lack of a centralized statewide Medicaid fraud and abuse unit, the committee staff believes the $1.5 million annually expended on WIG would be more effectively utilized by creating a State unit for surveillance of noninstitutional Medicaid providers in the New York State DSS.* Investigation of such individual practitioners requires primarily investigative, not auditing, staff such as that currently employed at WIG.

The current creation of such fraud and abuse units within regional HEW offices and at the HEW central office, as well as New York State's poor record in meeting Federal reporting requirements on fraud and abuse activities (see parts 1 and 3 of this report) further supports this recommendation.

B. THE LOCAL GOVERNMENTS

1. Social Services Districts

"New York is the only State in the Nation which has delegated the primary operational role in the Medicaid program to its localities." This assessment was made in a January 1975 report on the Medicaid program in the State department of social services by a task force established by Governor-elect Hugh L. Carey.

As previously noted, New York is only one of five States where the State and localities pay an equal share of the non-Federal Medicaid contributions (and only 1 of 14 States where localities make any contribution). As a result, the day-to-day operational responsibility for Medicaid eligibility determinations and payments rests with 58 separate social services districts (i.e., public welfare districts).

Fifty-seven of the local districts are county operations with the remaining district being New York City. New York City's program, for all five component counties, is administered by the New York City Department of Social Services (NYCDSS). New York City DSS is part of the city's Human Resources Administration (HRA) which

was one of several "super-agencies" created by former Mayor John Lindsay in an effort to centralize and improve the cost-efficiency of city administration. HRA is responsible for administering a variety of public welfare programs (public and medical assistance, day care, youth services, child care, employment programs, and community development programs receiving federal moneys). The bulk of HRA's staff and budget is allocated to New York City DSS.

The other 57 local social services districts administer their programs through a local public welfare or social services department.

As noted earlier, the State social services department estimates that the 58 local social service districts expend $77 million annually for administrative costs in the Medicaid program.

Under section 116 of the Social Service Law, the local social services commissioner is appointed by the local elective body (usually county board of supervisors) and in some cases, depending on local legislation, by the chief elective official of the county. He is a noncompetitive employee under civil service and has a 5-year term. He can be removed only by the authority which appoints him, upon its own initiative, or upon presentation of charges by the State commissioner of social services to said authority. In the latter case a hearing must be held by the appointing authority. The same removel procedures apply to any deputy or other employee of a local DSS (section 34, Social Services Law). All such removals are subject to appeal in the courts under article 78, CPLR.

Section 17 of the Social Services Law authorizes the State DSS commissioner to establish "minimum" qualifications for local DSS commissioners and employees. None have been established for local DSS commissioners. Localities set their own requirements for employees unless there are special State or Federal requirements for a specific position.

The county board of supervisors authorize the number and types of personnel to be employed by the local DSS and the county DSS commissioner makes the appointments (section 66). The commissioner and deputy commissioner must be bonded before taking office. In New York City, the city council (local legislative body) allocates the funds to hire staff, and staff is appointed by the city commissioner (section 77).

Section 365–b authorizes the local social services commissioner to hire a physician, on a full- or part-time basis, to serve as medical director to direct the locality's Medicaid program. All such medical directors must meet qualifications established by the State public health council. The medical director must develop a local medical plan which must be submitted to, reviewed, certified, and approved by New York DSS and New York State DOH (section 365–b, Social Services Law).

The creation and responsibilities of the local districts is set forth in article 3 of the Social Services Law. Section 62.1 of article 3 specifically makes the local district "responsible for the assistance and care of any person who resides or is found in its territory and who is in need of public assistance and care which he is unable to provide for himself." (See also sections 56 and 65.) More specifically, sections 365 and 365–a (Social Services Law) makes the local districts responsible for administering Medicaid in terms of eligibility determination

and payments. The requirements for eligibility determinations appear in sections 366–369.

The locality is also charged with implementing all State and Federal requirements regarding eligibility, payments, and quality of care, and to implement SMH items 34 and 35 as previously discussed in this report.

The State DSS must promulgate policies, procedures, rules, and regulations for the Medicaid program and advise the localities of their applicability (secs. 17, 20, 34, and 364, Social Services Law). These include rules and regulations covering eligibility determination, payments, reimbursement, records maintenance, and accounting procedures which are required by statute (sections 364–369, Social Services Law; see part 5.A of this report). State DSS advises localities of these requirements, as well as Federal and State DOH requirements, through a series of administrative letters, transmittals, and various State manuals. The local commissioner is responsible for implementing all such requirements by issuance of appropriate materials and through his supervisory responsibilities (sections 62, 64, 65, 76, and 77, Social Services Law).

The State is also responsible, through the commissioner and his employees, to "exercise general supervision over the work of all local welfare authorities" and "enforce" the State Social Services Law and the regulations of the department "within the State and in the local governmental units" (sections 34.3 and 20). The State is also empowered to withhold or deny any part or the total local claim for reimbursement for failure to comply with applicable rules, regulations, or laws (section 20.3). *The State DSS has often threatened but rarely, if ever, actually withheld reimbursement.*

All Medicaid payments to providers are made by the locality which then files reimbursement claims with the State and Federal Governments (sections 153–a, 153–b, 368–a, and 368–b). State (section 20.3) and Federal regulations permit the disallowance of any claims made improperly or which were made without complying with applicable rules, regulations, and laws.

Before paying any Medicaid reimbursement claims by local social services districts, section 368–a requires that the State DSS:

> Before approving such expenditures for reimbursement, the department shall give due consideration to the results of the *reviews and audits* conducted by the department of health pursuant to subdivision 2 of section 364.

Section 364.2 specifies the department of health's obligations under the Medicaid cooperative agreement.

Sections 86–a and 90–a authorize the local legislative bodies to levy taxes to pay for the localities' share of Medicaid (and public assistance). Section 92 authorizes the localities to make deficiency appropriations, where necessary, for unanticipated costs in the Medicaid program. Upon approval of the State comptroller, the State DSS can advance localities payments on future claims to meet immediate cash shortages (see part 5.A of this report).

Medicaid payments are made upon authorization of the county treasurer or finance commissioner, who also serves as treasurer of the local DSS (section 83), upon certification as to validity of claims by

the local commissioner. The same procedure applies in New York City where the finance administrator performs this function (section 86–a). In all cases, the accounts and payments of the local DSS are subject to audit by the locality's finance officer (in New York City, the office of the city comptroller).

The local commissioner must annually submit estimates of revenues and expenditures anticipated for the ensuing fiscal year to the local legislative body in the manner prescribed by law (sections 89 and 91). Additionally:

> Each public welfare district shall submit to the department quarterly estimates of its anticipated expenditures for medical assistance for needy persons and administrative expenses not less than thirty days before the first day of each of the quarters beginning on the first day of the months of July, October, January, and April, in such form and together with such other information as the department may require (section 368).

Thus, local legislative bodies, local welfare departments, and the State DSS are supposed to have data sufficiently in advance of budget submission time so as to make proper estimates, requests, and program adjustments.

2. Local Health Districts and Regional Health Offices

The department of health implements its responsibilities under the Medicaid contract with DSS at the local level either through: (1) Direct administration by a State-employed medical and dental director and staffs operating within the DOH's regional offices or (2) subcontracts with full-time county or city health departments. Only 30 percent of the State's 62 counties (19 of 62) administer the health monitoring responsibilities on the subcontract basis. Five of the nineteen are the five counties which comprise New York City and all five counties' responsibilities are handled by the Bureau of the New York City Health Department. These 19 counties account for approximately 77 percent of the State's annual Medicaid expenditures ($2.1 billion), exclusive of moneys allocated directly to DMH. The remaining 43 counties' Medicaid "health monitoring" programs are administered directly by the State Health Department, through their regional offices, and account for the remaining 23 percent ($600 million) of the State's non-DMH Medicaid expenditures.

The 19 counties which have subcontracts are: New York City (5 counties), Nassau, Suffolk, Rockland, Ulster, Dutchess, Rensselaer, Columbia, Clinton, Broome, Tioga, Onondaga, Erie, Chemung, and Niagara.

The operation of local health districts is otherwise similar to the arrangement of local social services districts. They are appointed by and responsible to the local appointing authority and, as regards Medicaid particularly, subject to the general supervision of the State Department of Health in terms of implementing State and Federal laws, rules, and regulations (article 3. Public Health Law; art. 2, section 206, Public Health Law.). Until 1971, the City of New York's local board of health and Health offices were *excluded* from the "general supervision" power of the State Department of Health.

In the Medicaid area costs for implementing the State and local health districts obligations (sections 264 and 364–a, Social Services Law) are reimbursable under section 368–a of the Social Services Law. The specific obligations of the State DOH and the local health districts under Medicaid as discussed earlier in section VA.

Two major examples of local failure are the hospital and methadone maintenance program operations under New York City DOH. The city's expenditures for health and hospitals currently run to approximately $1.2 billion a year. Of this amount nearly $140 million constitutes the city's outlays for its Medicaid share of inpatient hospital care. The total estimated cost to all three levels of government for Medicaid-supported hospital inpatient care in New York City is $600 to $800 per year.

A number of studies by private groups and various governmental agenices have criticized the general operation of the city's hospital care program, particularly the 19 municipal hospitals operated under the aegis of the city's Health and Hospitals Corporation. The criticisms have focused primarily on the inefficiencies of the hospital system in New York City and the estimated resultant losses of at least $100 million a year.

As regards Medicaid, the primary criticisms have been that the hospitals often double bill Medicaid and Medicare for the same services; that Medicaid-subsidized patients remain under hospital care well beyond the time necessary for such care (instead of proper release to outpatient or nursing home care—both of which are less costly); that patients often receive unnecessary and costly surgery and other care; that private health insurance coverage is not properly utilized prior to charging Medicaid; that eligibility for Medicaid done by hospital staff includes little, if any, collateral verification. For example, in 1974 a New York State DSS study found that failure to properly screen Medicaid patients for placement from hospitals to alternate care facilities resulted in an annual loss of $7.2 million in Medicaid moneys. A State comptroller's audit made similar findings in 1971.

In most instances the criticisms applicable to inpatient hospital care also have been made regarding outpatient hospital and clinic care. These primarily involve duplicate billings and failure to properly utilize other health insurance coverage. Criticisms focus not only on the failure of the hospitals to properly control application of Medicaid coverage but on the failure of the city's social services department to properly process and audit payment claims and the city's health department to properly review utilization.

One belated effort the State has made in tightening cost controls on Medicaid moneys in hospitals has been the initiation in 1974 of the New York State Hospital Utilization Review program (HUR). The program was 4 years in development and is currently being applied only in New York City under the auspices of the State's DOH's Bureau of Medicaid.

The State describes the program as follows:

> Basically, the present New York State HUR program is a sensitive statistical record abstract screening program for Medicaid inpatients. Experience-generated norms are developed and updated for such variables as age, sex, and diag-

nostic mix. The utilization review system establishes an "expected length of stay" for each combination of patient attributes.

When a patient enters a hospital, an admission certification by a physician must be completed for each Medicaid patient. Recertifications for extension of hospital care must be completed by the 12th day, the 18th day, and every 30 days thereafter. An additional certification is necessary for Medicaid patients who are ready for discharge but who must continue to be hospitalized pending arrangements for some other form of care.

Upon discharge of a Medicaid patient, the physician is required to complete a standard discharge abstract consisting of 15 basic items. This discharge form is sent to the local social services department which forwards it to the Department of Health.

Unusual patterns of practice in hospitals serving Medicaid patients are determined by comparing the average and expected stay among all providers. Criteria can then be established to select hospitals and physicians whose average difference from the expected length of patient stay is excessive.

In order to change the patterns of behavior of the hospital and of the individual physician, the New York State HUR program has a number of options. First, merely informing the hospital of the findings may be sufficient.

Second, the department may impose some financial penalty on the hospital; although more symbolic than real, this financial penalty is usually considered harsh by the hospitals.

Third, the field staff of the department may visit the physicians who are most involved.

As a last resort, the department of health may have the department of social services withhold payment.

"The department hopes that the very existence of New York State HUR will act as a deterrent since doctors will be less inclined to be lax about the hospitalization of Medicaid patients when they are aware of the monitoring system."

The New York State HUR program has been handling inpatient utilization review pending the implementation of the federally mandated PSRO program in the State. To date, New York State HUR has not reported any firm fiscal savings data.

Methadone maintenance

An estimated $30 million in Medicaid moneys a year are spent on methadone maintenance in New York City for approximately 33,000 clients in privately operated clinics. Of these moneys, approximately $18 million goes to "nonprofit centers" (i.e., city clinics and hospitals) servicing 22,000 patients and the remaining $12 million goes to private clinics servicing approximately 11,000 patients. The private clinic share constitutes about 55 percent of all persons in all methadone clinics in New York City and almost 45 percent of *all* expenditures and 40 percent of all MA expenditures for such operations. The Medicaid payments for private clinics go directly to individuals MA

providers since they operate the clinics and bill Medicaid under their name. The fee schedules for methadone reimbursement are part of the MA fee schedule set by New York State DOH. The clinics are subject to supervision by New York State DSS and DOH, ODAS, local social services and health districts and the Federal Government. Fraud and abuse in these programs has been well documented. (See part 2 of the report.)

In fact, the highest billing Medicaid physician in the Nation is Dr. William Triebel who received $451,156 from Medicaid in 1974 for operating his Mary Scranton Clinic in New York City. Dr. Triebel's billings were for the clinic's main office at 205 Second Avenue. The Mary Scranton Foundation, Inc., a "not-for-profit" entity, is the parent organization and also operates clinics at two other New York City locations—400 East 77th and 2 West 116 Street. The total Medicaid billings for the three Scranton clinics in 1974 was approximately $857,000.

The Scranton operation began in 1970 and was founded by Dr. Triebel, a Manhattan psychiatrist, who named the operation after his mother. Triebel and his wife are two of the foundation's five trustees and two of the three trustees who derive income from the clinics. Triebel also maintains a separate private psychiatric practice while remaining a trustee of the foundation and director of the Second Avenue clinic. Despite numerous ODAS audits and other investigations, finding violations of State and Federal regulations at Dr. Triebel's clinic, he has yet to be penalized in any way by ODAS, Medicaid, or any law enforcement authority.

In 1974, there were seven other operators of private methadone clinics whose Medicaid billings were over $100,000—ranging from $131,000 to $282,000. The State rates are $4 per visit per patient and this is scheduled to go to $6 in 1977.

C. GENERAL CRITIQUE OF GOVERNMENTAL RESPONSIBILITY IN NEW YORK

1. Introduction

The committee staff already has detailed in parts 2 and 3 of this report the long history of fraud, abuse, and maladministration in the New York City and State Medicaid program. The preceding sections of this part have detailed the failures of the responsible Federal, State, and local agencies to carry out their legal responsibilities. The remainder of this part reviews the general nature of government's failure to respond to Medicaid problems in New York despite 10 years of repeated warnings from private and public sources.

The committee staff compiled its data based on 8 months of investigation and research of the New York problem between January and August 1976. The staff's study included approximately 2 months of on-site review of records of the New York City Health Department's Medicaid program and on-site investigation of conditions in New York City Medicaid mills (see part 2 of this report). Coincidentally during the peak of the committee staff's activities and discussions with the city health department's Medicaid program, that agency made two major public releases. One was before a State assembly subcommittee

on July 22, 1976, claiming that a fraud rate of at least 20 percent existed in the city's 350 unregulated Medicaid mills. A second was an August 11, 1976, release of a "preliminary audit" claiming that as much as $18 million in Medicaid overpayments may have gone to private nonprofit clinics in 1975. The $18 million represents 12.8 percent of the nearly $140 million paid to such clinics in 1975. The preliminary audit covered a sample of free-standing dental and medical clinics as well as clinics located at a sample of 12 voluntary hospitals.

In addition, on August 20, 1976, the Brooklyn district attorney's office arrested 16 pharmacists on misdemeanor charges involving fraud by the substitution of generic-name for brand-name prescription drugs. The Brooklyn district attorney said a year-long investigation by his office revealed Medicaid was "bilked $1.68 million a year in this fashion."

On the same day, the State health department released a list of 33 doctors, clinics, and other health care providers disqualified or suspended from the Medicaid program for a variety of alleged abuses. The department also released the names of 23 other providers whom they had "censored for alleged improper billing and ordered them to make restitutions amounting to $817,165."

2. Critique

a. COMPUTERIZATION

The only significant effort by the State to control Medicaid expenditures has been the recent passage of legislation which freezes rates and limits some services to Medicaid clients, particularly at hospitals and nursing homes. These restrictions place increased power over reimbursement rates with the State budget director and health commissioner, but do not deal with the problem of fraud and abuse by Medicaid vendors. In fact, the head of State department of social services' Medicaid program resigned in March 1976 protesting the new legislation and the general mismanagement of Medicaid in the State. HEW also has raised objectives to several provisions of the new legislation as being in violation of Federal requirements. In addition to criticizing the legislation, she noted that even if the legislature finally approves funds for a computerized Medicaid management and information system, it would take 3 to 4 years to become fully operational. (That legislation was signed by the Governor in July 1976—Ch. 638 and 639, NYS Laws of 1976.) The city department of health's Medicaid program director claims the city's system is at least 2 years away from being fully operational. The New York State approach is ironical and questionable in several respects. Both the city and State have commissioned numerous consultants and spent enormous amounts of money for computerization and management feasibility studies over the last 9 years. Yet there is no effective computer system in place for antifraud purposes despite the fact other States—particularly Michigan and California—have already implemented significant cost-saving Medicaid antifraud systems with computer support in much less time than the New York projections.

The lack of patient and provider profiles, a "high provider" printout, adequate computer and manual storage and retrieval of Medicaid records, and other administrative deficiencies have persisted to

the present day despite the volumes of actual reports, numerous costly private consultant studies and the city's assertions of improved management efforts. In the fall of 1971, then-Mayor John Lindsay established a management team in the city's human resources administration (HRA) to overhaul the Medicaid and welfare systems. The "team" was headed by a Harvard MBA and composed of "young turks" with business and engineering degrees. From 1971 to 1974, the city spent at least $10 million annually in salaries alone for the "team." Yet in early 1973, HRA's deputy director in charge of Medicaid echoed the observations of earlier years by saying "The present system doesn't make any damn sense." And as of April 1976 the head of the health department's Medicaid program claims a computerized system is still at least 2 years away from implementation.

However, in the last 18 months the U.S. attorney's office in New York has obtained 20 guilty pleas (with waiver of indictment) and five indictments on criminal charges of Medicaid fraud. The indictments were obtained by use of data gathered from computer tapes obtained from New York City which were reprogramed by HEW and run through U.S. Army computers in New Jersey.

HEW's regional audit agency has used New York City's own data to develop preliminary provider profiles within a 2-month period and estimates the city could establish its own profiles within 3 to 6 months. In fact, the current acting executive director of the city health department's Medicaid program, Dr. Martin Paris, told HEW Region II Audit Agency Director Bernard Luger, in a December 16, 1975 letter:

> *I am somewhat embarrassed that your staff has produced in 2 months something which neither the city nor the State has been able to produce in over 7 years.*

In 1973 the State welfare department awarded three $40,000 contracts to computer firms to produce an automated computerized model of the welfare Medicaid payment systems. Additionally, a separate $125,000 consultant contract was awarded, without competitive bidding, to Electronic Data Systems Co. to help prepare a statewide registry of the State's welfare and Medicaid clients. Three years later neither system exists and the State predicts conservatively that such systems will not be operational for at least another 3 years (i.e., 1980). The legislature did not allocate its portion of the necessary moneys until the end of the 1976 legislative session. In 1973 the projected cost of a contract for the computerized payments system alone was $30 million.

The New York situation exists despite the existence of fully operational statewide computerized systems in every other industrial State, all developed in less time than New York projections. In New Jersey, the computerized central registry and payment systems were developed in 1 year and are operated on contract by private companies. A similar system on contract to a private company was implemented in only 1 years' time by North Carolina.

The lack of an effective computerized Medicaid control system in New York City and State is all the more frustrating, in the committee's view, because significant Federal financing of MMIS has existed since at least 1973 (Public Law 92–703). Federal financial participation in

the cost of Medicaid currently equals approximately 50 percent of costs. To provide an incentive for States to undertake development of mechanized Medicaid claims processing systems, Federal law provides for 90 percent Federal financial participation in the cost of developing such systems, 50 percent toward phasing in of such operations and 75 percent toward the cost of the operation of such systems, after the system is operational and is in conformance with Federal requirements.

The State has estimated that the total costs of its MMIS system will be:

(1) $8.57 million for development (90 percent Federally financed); and

(2) $38.4 million a year operating costs once fully operational (75 percent federally financed).

Best estimates by the State are that an MMIS system will not be fully operational *at least* for 3 years (1980). The States' projected annual savings from MMIS in the first year of full operation are $180 to $288 million. "roughly half of which will accrue to the State and its localities." The committee staff already has estimated that if such projections are actualized there would be an annual savings of $19 to $40 million to New York City by conservative estimate (see further part 4 of this report).

b. ENFORCEMENT

The current status of the city's medicaid enforcement program was summarized by city Health Commissioner Lowell Bellin in his February 13, 1976, testimony before the Subcommittee on Oversight and Investigation of the House Interstate and Foreign Commerce Committee. Mr. Bellin said that at present up to *40 provider discussions* are scheduled *each* month by the New York City DOH. These procedures are currently returning approximately $2 million annually to the program for the payment of services that cannot be justified. *An average of* one provider is *permanently disqualified* from the Medicaid program *each month.* In addition, an average of *two providers each month are referred to the city's department of investigation or a district attorney's office* for further investigation leading to possible criminal prosecution for fraud. However, Commissioner Bellin's own staff was unable to produce records supporting his assertions in May 1976.

Commissioner Bellin also stated his investigative staff has found "that from 60 to 75 percent of individuals in skilled nursing facilities in New York City do not require skilled nursing care." However, he did not indicate what corrective action, if any, had been initiated.

He stated that in 1974 city expenditures for *facility-based ambulatory and long-term care services exceeded $600 million*" and that this was over three times the cost of individual practioners expenditures. He said in this area alone "conservative estimates of potential savings can be expected at the level of $50 to $100 million or greater." Such projections indicate at least a 17 percent loss rate in institutional facilities due to fraud and abuse.

The commissioner estimated in data submitted to a congressional committee in February 1976 that his agency had a 10:1 cost-benefit ratio in 1974 and 13:1 ratio in 1975 (i.e., savings: staff costs).

The same "poor internal administration" and "sloppy recordkeeping", cited in the 1969 Manhattan grand jury report (see part 3 of this report) has made and continues to make the city unable to bring civil and criminal lawsuits against providers and hinders internal administrative discipline of providers (i.e., fines, suspensions, revocations). In 1974 Mr. Stuart Laurence, head of the city health department's Medicaid investigations unit, said "No information or data for files is available for before October 1970." Mr. Laurence said the reason was that the city had no centralized investigations unit until 1971. *Thus, from 1966 to 1971 the city paid a total of nearly $158 million annually to approximately 16,000 individual Medicaid providers without any centralized compliance control unit.*

Laurence's comments and the grand jury data contrasts sharply with the 1968 assertions of then-Medicaid Program Director Lowell Bellin's assertion that he had the most extensive antiabuse program in the country "including 134 professionals, 60 paraprofessionals, and 143 clerks—a larger staff, one should note, than the Medical Services Administration had, at that time, in Washington." Mr. Bellin is currently commissioner of the city's health department. Mr. David Lurie, head of the social service department's division of medical payments (DMP), said that prior to 1971 "investigations were much less structured and informal. Investigations were not a major concern and what was done was handled by the professional auditors." Laurence further noted that his investigations unit was poorly staffed and inadequately trained. The grand jury had found similar deficiencies at all levels of the city's Medicaid staff. At its peak in 1973, Laurence said he had one attorney (himself) and four investigator positions to screen complaints, investigate, and hold hearings on a program involving approximately 16,000 individual vendors receiving $158 million a year from Medicaid. Interviews with the current head of the city health department's Medicaid program indicate the quantity and quality of the investigate staff remains essentially the same as of 1976.

The problems in enforcing compliance at the local and State level follow a frustrating and costly sequence. The government lacks the necessary trained auditors, investigators, and attorneys and proper computer and manual controls to detect fraud and abuse. If and when fraud and abuse is detected the records are usually inadequate to sustain a charge. Even where a charge can be sustained the provider remains as a Medicaid provider until his legal remedies in the courts are exhausted. Where the government has a basis for an administrative disciplinary action, the penalty is usually a verbal or written reprimand, temporary suspension, insignificant restrictions on types of claims which will be honored, referrals to law enforcement and licensing officials, and minor fines. In the small percentage of cases where fines are levied restitution is made by deductions from future billings by the provider. This tends to encourage padding of future Medicaid claims to recoup the cost of such fiscal penalties. Where cases are referred to other agencies for legal action or action against the provider's professional license, cases are usually dropped because the records are not sufficient to meet the legal standards for evidence. For instance in the New York City Health Department between 1970 and 1974 there was no regular on-site audit of investigation

procedure for any Medicaid providers on a random basis or even for the highest billing providers in the twelve individual provider categories. The department relied on complaints from outside sources and potential abuses detected internally as its major monitoring mechanism. Of the 1,321 complaints received on this basis, the Department investigated only 50 percent.

In a different 5-year period the city health department was able to substantiate 736 cases of fraud and abuse. In 45 percent of these 331 cases there was no fiscal penalty and in every one of the remaining cases the fiscal penalty was reduced below the amount alleged by the city and, always recouped by deductions from future billings. Twenty-seven of the cases were referred to the city corporation counsel's office and 16 to the State department of education. In no case could the corporation counsel sustain a court case. The department of education did not revoke any licenses, issued one 90-day suspension, and disposed of the remaining cases by an "administrative verbal warning" or small coverage fine of $350/referral.

In what is recognized as one of the health department's most intensive investigations, a team conducted an investigation for over 1 year of alleged overutiiization and improper care by dentists and optometrists. The cases of 1,300 Medicaid clients receiving dental care and 500 clients receiving optometric services were reviewed. The department could not sustain cases against 24 percent of the 271 optometrists (i.e., 63 cases), permanently suspended only 1 percent of the optometrists (3 cases), and levied "fiscal adjustments" against only 31 percent (86 cases). The remaining 44 percent of the cases involved reprimands and temporary suspensions. In the investigations of the dentists, no irregularities were found in 82 percent of the cases.

State and Federal reports indicate the same abuses still exist with the same frequency in 1975 and 1976 as in 1969 despite all the reports, despite city health's development of elaborate "standards enforcement protocols and sanctions" in 1974, and despite an annual administrative budget of $2.4 million. For instance, there are the following examples of city health's disciplinary actions on detected cases of unacceptable practice:

(1) A medical doctor who, in 1971 and 1972, received *over* $400,000 from Medicaid, was double-billing, and billing MA for 80 methadone detoxification cases a day when New York State DH guidelines specify that only 25 such cases can be adequately treated by a doctor each day, (i.e., billing for too many patients a day for quality care). His patient records also showed inadequate physical examinations and irregularities in the immunization of children. *The department of health merely reprimanded him.*

(2) A doctor who billed MA for nearly $15,000 total in 1971 and 1972 prescribed unnecessary medication and consistently directed patients to a specific pharmacy, thereby denying patients "freedom of choice" in choosing a pharmacy. *The department of health again found only a reprimand was necessary.*

(3) A psychiatrist who billed MA for nearly $30,000 total in 1971 and 1972 was distributing methadone indiscriminately over the counter to anyone possessing cash or a Medicaid card. He was also double-billing and billing Medicaid for 1-hour visits with

patients when, in fact, he was only seeing them for 15 minutes. The department of health found it only necessary to reprimand him and ask restitution of $2,500.

(4) A pharmacy, which billed MA for a total of nearly $300,000 in 1971 and 1972, was shortchanging on prescriptions to clients while billing MA the full cost, billing clients for more expensive brand name drugs while giving them the cheaper generic drugs, and improperly labeling and packaging prescriptions. In this case New York City DOH investigators visited 49 clients and found 21 shortages and 14 substitutions. The pharmacy signed a stipulation agreeing to $50,000 restitution "without admitting guilt." *However, the restitution was made from "future billings" over nearly 1 year's time, and amounted to only about 17 percent of the total 1971–72 billings. No referral was made to the State board of pharmacy*, and the pharmacy is still actively participating in the MA program.

(5) A doctor, who billed MA for a total of over $210,000 in the 1971–72 period, was found to be spending only a few hours each day on a 3-day week, allowing his assistant to bill under his name (i.e., a violation of MA regulations), and billing patients he did not treat. After an informal hearing in January 1973 he was temporarily suspended from the MA program. New York City DH records do not indicate the length of the suspension, but as of August 1973 he was still actively participating in the MA program. Also, New York City DOH found New York City DH had insufficient records so that "it appears that a case of criminal fraud cannot be made. . . ."

(6) A pharmacist, who billed MA for a total of nearly $85,000 in 1971 and 1972, was found to be double-billing, billing for drugs never dispensed, and collaborating with a medical group to refer patients solely to his pharmacy and thereby denying patients "freedom of choice" in selecting a pharmacy. *He agreed to make restitution of $2,500 (i.e., only 3 percent of the 2-year's billings) as of January 1973, but New York City DH records do not indicate whether any of the money was paid. There was no referral to the State board of pharmacy and he is still actively participating in the MA program.*

(7) A doctor, who billed MA for a total of over $140,000 in 1971 and 1972, was found to be prescribing unnecessary medication for clients and referring patients to a specific pharmacy, thereby denying "freedom of choice." New York City DH files indicate that, *as of May 25, 1972, an investigation was to be initiated. However, there is nothing further in the file* to indicate if the investigation was held and, if so, its results. *The doctor is still actively participating in the MA program.*

In our interviews with New York City officials, we found the city cannot tell with any assurance how many authorized providers it has in the Medicaid program at any particular time. Mr. Jay Abberman, director of the division of investigation and enforcement, stated he thought there were some 36,000 providers, but he wasn't sure: "We have a professional registry that has everybody listed and printout books; but a compilation? I don't know." Dr. Robert Gentry, former director of New York City health and Medicaid program, told com-

mittee investigators there was a city provider list, "But it is largely a compendium of everyone who has ever applied for the program and few deletions." Attempts at updating it, he said, had resulted in the wrong people being added and the wrong people being deleted. He stated it may be as much as "50 percent in error." In effect, then, the city cannot tell whether any particular physician qualifies for the program.

As a test, committee staff searched for a particular provider, a podiatrist named Wilner. We employed the "provider list" Dr. Gentry referred to, the city health's medical vender statement (a quarterly profile current through the second quarter of 1975), and the tax runs furnished by the department of social services (ranking every physician paid by dollar amount of income reported to IRS for calendar 1975). We found three Wilners on the "provider list," all of them doctors in general practice. We found two additional Wilners on the tax runs, but not the two previously found, and not the podiatrist. On the third list we found two Wilners, one a dentist and one a doctor, one from each of the other sources; but still no podiatrist. The only evidence we could find of the provider's existence was an invoice submitted for payment indicating he had treated our people on three separate occasions apparently in two separate facilities.

Committee staff found the city cannot determine how many times any physician prescribed any particular service. Lacking accurate provider and patient profiles, they can't even determine how many patients a particular physician saw for any particular period. Nor can they tell how many recipients they have qualifying for service, or how many times any particular recipient avails himself of health services. Demonstration profiles provided for the city by HEW (and prepared in less than 2 months) indicated one family received 1,025 services for three members whom some 27 physicians reported seeing in a period of a month. In addition, preliminary findings indicated nearly $2 million in duplicate payments to MD's alone. Mr. Abberman told our investigators: "Until we get this patient profile, we're not going to be able to catch these people. But that isn't our function. It's social services' function. They've been working on it for a couple of years. They've been working on it as long as I've been here." When asked specifically about the payment spot auditing and profiles, Mr. David Laurie of social services told committee investigators, "We don't get involved in any of that. Our only function is to pay bills. There are a lot of things we'd like to do, but the first question is: 'Does this hold up the payments?' "

Lacking built-in parameters and spot audits of the computer capacity, the city relies on desk audits. Cases are initiated by individuals within the bureau of health care surveying one particular invoice out of the more than 2,000 batches of invoices arriving daily and deciding something looks wrong. Health has one investigator, a male, to shop all the Medicaid mills. They cannot force mills to file ownership information. To identify mills, they had to physically take to the streets and count heads.

There is no interjurisdictional cooperation between service areas or programs regarding mutual offenders, although BHI does forward a quarterly list of those suspended from the Medicare program. There is no "central offenders list" of perpetual offenders, those suspended and readmitted or barred from the program. On this point, Mr. Abberman

said: "Their files will indicate how many times they've been in here before."

They know what a random sample service questionnaire is but have never employed it. Miss Rosmary Russo, chief investigator of the investigation and enforcement unit, stated: "We'd love to do it but we don't have the manpower. At the present time, we respond mostly to complaints."

The record-keeping capacity of the city does not seem to have changed significantly from that so sharply criticized by the 1969 grand jury. We were told by Miss Russo and others that it was difficult to obtain enough information to justify a restitution order. "It's very difficult to get sufficient information," she said. "Just trying to get the invoices to prepare it is a chore. When you go to trial on a doctor you need more than one billing. We have to go through as many as possible and see how far back the pattern has been present. And its difficult. You can't have a hearing without it. It's very difficult getting the paper. If the paper is more than 3 months old, if it's been processed, it's going to be out at our warehouse (Ryerson photo warehouse). We've given up trying to get social services to go out to the warehouse to get them. A representative of the Manhattan district attorney, found out at the warehouse searching through the invoices, stated much the same thing, complaining, "In the end, we're lucky if we find 50 percent of them."

Miss Russo described the process as follows: "Invoices are batched by transmittal, all invoices, 90 percent of the invoices, are still being processed under the old system. What you have to do to pull the doctor's invoices is to pull his vendor statement (kept at DSS on 34th Street in Manhattan), go to the vendor statement and pull out every single transmittal number and pay cycle date to get the transmittals that his papers are in, go out to Ryerson (Brooklyn), sort through the boxes for the transmittals his papers are in, pull out his paper from the transmittals and bring them back here. There's no way to just go to a file and say, "Let's see how much Doctor X was paid. There's no cross references at all. There's no cross-filing system for the invoices. If his vendor statement happens to be missing, then it's almost impossible to find [the doctor's invoices]."

In short, the city does not know which doctors are in their program, where they are, how much they earn (let alone how much they keep and how much is passed on to entrepreneurs), how many times they perform, or bill as if they have performed a particular procedure in any particular period. They cannot even tell with complete assurance how much money they are spending. In 1974 they underreported program payments to IRS by more than $300 million.

In effect the city is without fraud control. The odds are if a doctor submits two bills he will be paid for both. There is no reconciliation of services to recipient. The only way New York City Medicaid can catch a duplicate billing, the most blatent of abuses, is if the same provider submits a bill for treating the same patient on the same day in exactly the same manner for the same diagnosis in the same payment cycle. If any of those half dozen variables is changed, the bill will be paid. Xerox copies of that same bill submitted for payment in subsequent payment cycles can and have been paid.

It is, in sum, a bureaucratic rats' nest of conflicting jurisdictions, buckpassing, and structured inefficiency. The division of investigation and enforcement with a limited staff manages to recapture $18 for every $1 expended, a remarkable effort under the circumstances; but it is inescapable a great deal, literally millions, slips through the cracks.

Another irony is that neither the State, city, nor other localities have increased the number of auditors and investigators assigned to investigate Medicaid vendor abuse despite the overwhelming success of a similar approach to nursing homes. In January 1975, the State created a special State prosecutor for nursing homes. Armed with a staff of 147 attorneys, auditors, and investigators, the special prosecutor has, in its first year: (1) obtained statewide 12 felony indictments involving over $3.4 million on Medicaid fraud and larceny; (2) obtained guilty pleas and agreements to return over $2 million in Medicaid moneys obtained by fraud from the two major nursing home operators in the New York City metropolitan area—Eugene Hollander and Bernard Bergman; (3) found overcharges totaling nearly $12 million in an in-depth audit of 40 of the State's nearly 400 proprietary nursing homes; (4) projected total overcharges to the State at $70 million for 1969–73; (5) found $2,500 in Medicaid overcharges for each man-day of auditing. In early 1975 the Governor also added 25 auditors to the department of health's staff of 34 auditors.

In 1976 the Governor and legislature also added 168 new positions for "health facility survey teams" and 120 more auditors to the department of health. The legislature undertook extensive debate before adding a team of over 130 auditors and attorneys to the special prosecutor's office for an audit and fraud unit. The unit would work for 1 year with the special prosecutor and then become a permanent unit in the department of health; 75 percent of the $2.3 million required for this unit is federally reimbursable.

In addition, the antifraud approach of the special prosecutor's office has been so effective as to encourage expansion of his jurisdiction into the area of proprietary homes for the aged. After substantial documentation by an interagency task force and hearings by the Senate Subcommittee on Long-Term Care, the State board of social welfare requested in April that the special prosecutor extend his efforts to the homes for the aged.

And there has still been no action in terms of more auditors, investigators, and basic computer tools for an antifraud program directed at individual Medicaid providers.

Another result of the city's poor administration of Medicaid has been the growth of "factoring" and its attendant abuses. "Factoring" is discussed in detail in part 2 of this report. The committee staff observes additionally that factoring, and its attendant propensity to accelerate fraud and abuse, is a direct result of the city department of social services' failure to implement the intent, if not the specific language, of regulations.

Section 540.6 of the State DSS' rules and regulations (18 NYCRR) require Medicaid vendors "to submit bills as soon as practicable after rendering services and furnishing supplies and within sufficient time to enable the district to make payment to the vendor within the time limitation prescribed by section 302.1." Section 302.1

reiterates the obligation of vendors to submit bills "promptly" and also states the social services district shall "arrange to pay such bills promptly." Section 302.1, however, then says the district shall "process payments so that in no event shall more than 12 months elapse between the month of the latest services or supplies furnished with respect to an individual and the month of payment for the particular services or supplies." It is apparent that the operational guide for local districts has been the 12-month criteria as compared to the basic responsibility to "pay such bills promptly."

As early as 1969 professional medical societies in the New York City area claimed that the number of professionals willing to accept Medicaid clients was diminishing steadily due to the extensive claims processing delays. In many cases practitioners in the program began resorting to the use of factoring companies to obtain quicker claims processing. The 1969 Manhattan grand jury report noted that such companies charged providers 12–15 percent of their gross billings increasing the tendency of providers to overcharge, double-bill, and commit other fraudulent practices to recoup the amount paid to the providers. The result was a tendency to give financial interests greater priority over adequate care to Medicaid clients.

Even where "factoring" is not a reason for falsifying claims, any typical provider fraud or abuse of Medicaid generally benefits the provider to the detriment of the Medicaid client. Such practices as "over-utilization", "ping-ponging", "kiting", and "shorting" all are counter to the welfare of the patient.

C. REIMBURSEMENT

Another major area of criticism of administrative operations has been the failure to make proper and timely claims for reimbursement. In some cases the city and State lose valuable Federal funds because they do not file claims on time or meet program standards necessary for reimbursement. In other cases Federal audits reveal Federal moneys that were improperly claimed and reimbursed—often resulting in refunds of the Federal moneys.

Here are some typical examples:

—The 1972 grand jury report heard testimony from representatives of the city comptroller's office that reimbursement of $2 million was lost by the city because of late filing of claims by the New York City DSS. Another case revealed a $250,000 loss of reimbursable money under Medicare due to late filing of claims.

—A 1976 audit by HEW's Regional Audit Agency found that New York City DSS had improperly over claimed more than $1.6 million in Federal Medicaid moneys for administrative costs in the operation of four dental clinics by New York City DH.

—A 1975 review of the State's ODAS program found the State could lose approximately $21 million a year in possible Medicaid reimbursement moneys because of the failure of ODAS facilities to comply with new Federal requirements.

—A 1976 audit by the HEW Regional office charged the Erie County Department of Social Services with improperly overclaiming various amounts of Federal reimbursement for Medicaid services between May 1, 1966–June 30, 1973, including: $1.6 million in Fed-

eral moneys for a 4-year period for medical services rendered to home relief (50 percent State, 50 percent locally funded—no Federal funding) recipients which were charged to the federally reimbursable ADC category; overstatement of outpatient service expenditures resulting in excess Federal reimbursement claims of over $50,000/year; improper overclaim of $33,647 in Federal funds and nearly $17,000 in State funds for services rendered by nurses' aides and unlicensed practical nurses over a 3-year period.

—In 1975 a study by the HEW Regional Office found that due to a computer program error the New York City DSS had underreported to IRS by $242 million the total amount it had paid in 1974 to doctors and other care providers.

—A 1973 audit by the State comptroller found that improper reconciliation procedures by New York City DSS for a 2-month period resulted in a duplication of Federal and State reimbursement claims valued at approximately $3.4 million.

—A 1973 State comptroller's audit found that the New York City DSS and New York City Department of Mental Health and Mental Retardation Services overstated their reimbursement claims for outpatient psychiatric care by $6.2 million for the period of January 1970–September 1971.

d. ELIGIBILITY

One of the major reasons for the expansion of the Medicaid population and cost over the past 10 years was the ultra-liberal welfare philosophy of Mayor John Lindsay for all but the last year of his two terms as Mayor. When Lindsay took office in 1966 there were approximately 500,000 persons receiving public assistance in New York City and Medicaid had just been enacted. The mayor and his welfare commissioners advocated a laissez-faire attitude toward welfare eligibility. Their espoused goal was to allow the city's welfare rolls to swell enormously and thereby force the Federal Government to legislate a guaranteed annual income.

As a result, a simple declarative system was used for public assistance and Medicaid. An applicant need only fill out a three- or four-page application, attest to its veracity, and he was quickly accepted as eligible with little, if any, collateral verification or direct documentation of financial status required. Recertification was done once a year by mailing a one-page questionnaire to the recipient who merely answered "Yes" or "No" to four or five questions, attested to the veracity of his answers, and remained on welfare. Little, if any collateral verification and field visits were done, especially with the addition of a series of prowelfare clients' rights decisions by the U.S. Supreme Court.

By 1970, the city's public assistance rolls had doubled to nearly 1 million recipients, all of whom were receiving Medicaid. An additional 400,000 were on Medicaid only. The doubling of the welfare caseload in the first term of the Lindsay administration was equal to the total increase in the city's welfare caseload for the preceding 20 years. The cost of welfare was consistently taking the largest share of the city's budget expenses at 23 percent a year.

75-902 O - 76 - 13

It was not until 1973 that the mayor realized his strategy to precipitate a guaranteed annual income had failed. He did an abrupt about-face and revamped the city's welfare system by hiring a team of "management experts" at $10 million a year to take over the welfare program from "social-work" oriented types. However it was too late.

By 1973 the city's public assistance client ineligibility rate was estimated at between 25 and 30 percent at an annual cost of nearly $600 million. The lower estimates came from the city, the higher estimates from the State. Even now, some State official still claim the PA ineligibility rate is 20 percent with an annual loss of $800 million. The Medicaid only client ineligibility rate has been estimated at 15 to 20 percent for an additional loss of nearly $30 million per year.

The management team, combined with an almost simultaneous effort at the State level, developed a new 12-page PA application form (10-page for MA-only) and instituted a twice-a-year, face-to-face recertification requirement. They also took major steps in the development of computerized controls over welfare and Medicaid eligibility and provider fraud and abuse. However the new forms and recertification requirements have decreased the PA ineligibility rate by only a few percentage points, the PA fraud control program has not worked, and the computerized controls are still 2 to 4 years away from implementation at best (see part 2 of this report).

The city's processing system for PA/MA and MA-only applicants has been continuously criticized for not properly determining eligibility. City and State officials have estimated that between 10 to 20 percent of the persons receiving MA-only in New York City are either partially or totally ineligible—at an estimated annual loss of $28 million. The estimates of the ineligible rate among public assistance clients, who automatically receive Medicaid, has ranged from 17.5 percent on a statewide basis to an average of 20 percent in New York City alone. In an audit released in June 1976, the State comptroller estimated that in New York City in 1974 alone between $19 and $40 million was paid to Medicaid ineligibles. The comptroller also noted that recovery of frauds is also limited because the New York City Department of Social Services does not maintain records showing services provided to each Medicaid client "contrary to regulations."

New York State DSS requires collateral verification of only every 20th Medicaid-only applicant (see New York State DSS' Medicaid booklet).

In an effort to reduce the ineligibility rates the State DSS implemented a new 12-page PA application form and 10-page MA application form in 1973. They also began verifying documentation collaterally by field investigations and required a semiannual face-to-face (as opposed to mail) recertification. Medicaid cards previously issued only twice a year were to be issued on a monthly basis. The rationale for this was to insure proper eligibility, but the cards are still issued by mail. All these efforts were aimed at criticisms that ineligible persons were receiving benefits or that overpayments were being made due to concealment of assets and income sources; failure to reveal private health insurance coverage; failure of local districts to properly apply private insurance coverage before issuing Medicaid payments; fraudulent acquisition and use of Medicaid identification

cards (which show only name, address, case number and category of assistance, have no picture or fingerprints and are not laminated) and various other administrative and client errors.

Despite these efforts, the ineligibility estimates still remain in the same range and the time required for processing applicants has increased.

For instance, a 1974 pilot study for New York City DSS by Datatron, a private firm, found that the city's Medicaid program paid out nearly $3.2 million in 1972 to clients who had, but did not use, their private health insurance coverage in paying for visits to municipal and voluntary hospitals. The study involved only those MA clients covered by *one* of the many private health insurance plans, namely health insurance plan (HIP). A similar situation exists in the failure to utilize Medicare benefits before using Medicaid. A recent GAO study noted that substantial overpayments are being made in the Medicaid program in part due to lack of a common audit agreement and effective data exchange between Medicare and Medicaid.

A New York State DSS Medicaid eligibility audit of "MA-only" cases in New York City for the period of July 1-December 31, 1972, found a 31.5 percent ineligibility rate among the cases sampled. When New York City began its face-to-face recertification of MA-only recipients in December 1973, the first 2 months' activity showed that an eligibility recertification could be made in only 30 percent of the scheduled cases. In approximately 16 percent of those cases, the clients were found completely ineligible.

After not reviewing Medicaid eligibility in New York State at all from 1972 to 1975, HEW's Regional Office conducted its first quality control (QC) eligibility review of MA-only cases in New York State in July 1975. The review was not based on a complete sample of cases because the State's quality control team, which conducts the review subject to HEW's subsequent review, was not fully staffed. According to Mr. Louis Katz, Chief of the Special Initiatives Unit of HEW's Region II Office, "The sample is too small now to make an accurate dollar estimate but it gives us some rough parameters."

The results of that QC review show an estimated *22 percent of the MA-only recipients were ineligible for MA benefits.* Of these, 17.4 percent were totally ineligible. *The sample includes MA recipients in institutional and noninstitutional settings, but all payments reviewed were made to individual MA providers. HEW projects that the dollar cost* of these ineligibles for the 3-month period covered by the review (July 1, 1975 to September 30, 1975) *was $11.2 million. Projected on an annual basis this comes* to approximately *$44.8 million in dollar losses due to client ineligibility in MA-only cases.* It is noted that MA-only is some 25 percent of all MA recipients in New York State with the remaining 75 percent being on Medicaid by virtue of their welfare status.

Mr. Katz again stressed that *such figures were not too reliable due to the very limited sample size, but he added, "I believe the 22 percent is an underestimate. As we get more staff and larger samples I expect the rates will be higher."* The review was done by New York State DSS and completed in January 1976. A review for the October 1, 1975 to April 1, 1976 period is now in progress. Mr. Katz expects this review will have the full 875-case sample. The New York State DSS unit

doing the review is a 24-man unit for MA-only QC eligibility review located in New York State DSS's Offices of Audit and Quality Control. Mr. Katz stated ther are averaging four cases per man per month. This compares to the 15 case/man month average for the AFDC QC review which has more manpower and a higher priority due to the stress on meeting Federal tolerance limits. Mr. Katz estimated that each man in the New York State DSS unit gets paid about $15,000 a year. To date, his unit's subsample review of the New York State DSS data shows no discrepancies in findings.

The review shows that the bulk of the *institutional* MA recipients found ineligible were ineligible due to agency errors (70.4 percent). The remaining 29.6 percent were due to recipient errors. A total of 13 percent of all errors were attributed to "willful misrepresentation of facts by recipients."

The review shows that the bulk of the *noninstitutional* MA recipients found ineligible were ineligible due to recipient errors (78.8 percent). The remaining 21.2 percent were due to agency errors. A total of 64.5 percent of all errors were attributed to "willful misrepresentation of facts by recipient."

The recipients in the noninstitutional setting are usually processed by local DSS centers. Mr. Katz agreed that the high rate of recipient error and "willful misrepresentation" among this category reflected the lack of effective collateral verification techniques in the States.

The recipients in institutional settings are usually aged persons in SNF's and ICF's. They are usually processed upon entry to a hospital or SNF or when placed in such facilities by a local DSS center. Mr. Katz agreed that the preponderance of agency errors in this category indicated the inadequancy of personnel processing applications in these facilities (usually persons employed by the hospital, SNF or ICF—not the local DSS) and failure of local DSS's to properly review such applications. He parenthetically observed that he believed most elderly persons receiving MA were properly eligible and that the "willful misrepresentations" and recipient errors were primarily by the nonelderly.

The major types of agency error were:

(1) Improper arithmetic computation;

(2) Failure to act on reported information (such as assets, other medical insurance, and other income sources);

(3) Failure to apply proper policy.

The major types of recipient error were:

(1) Failure to report changed circumstances (new income, death of client, added benefits);

(2) Failure to give correct data (concealed assets and other resources);

(3) Failure to give complete data.

Mr. Katz said that a 1973 GAO study showed the MA-only ineligibility rate nationwide was 20 percent. The current AFDC ineligibility rate in New York State based on 1975 QC reviews, is about 11 percent, statewide and 13 percent in New York City, which exceeds Federal limits and threatens the State with losses of an estimated $32 million in reimbursement.

According to Mr. Katz it was difficult to draw a sample for QC and any other review purposes in New York State. He said the State does

not have a "central payroll" with DSS showing all providers and all recipients (i.e., provider and recipient profiles) and there is no centralized payment system. "I really sympathize with the guys at QC (New York City DSS). There are 58 localities and each submits its records in different ways—some send them a tape (computer tape), some send cards, and others send manual lists." He said that this makes it very difficult to pull a sample. In New York State it takes 30 to 35 days after the end of each month to draw a sample. He compared this to New Jersey where there is a centralized payment system and payroll (on contract to Blue Cross and Prudential) on computer and the sample can be pulled in 5 days after the end of a given month.

Mr. Katz agreed that the lack of a statewide centralized payment system and "payroll" also necessarily make it difficult to monitor provider and recipient fraud and abuse and to conduct an effective utilization review program. He noted that New York City, the largest locality recipient-wise and expenditure-wise for MA in New York State, also lacked such tools. He observed, "In New York City alone they have three different payment systems. There is a manual system for nursing homes; one computerized payment system for proprietary hospitals; and yet another separate computerized payment for facilities of the Health and Hospitals Corp. and all other noninstitutional providers."

Mr. Katz said that "Two years ago the State (New York State DSS) brought in Stu Patterson to develop an MA and PA information system. Patterson had done so in Michigan. But even now they (New York State DSS) have to get the legislature to give it the money and even then they must still meet Federal MMIS standards to get Federal funds. Even if the legislature allocates the money, a system on-line is at least 2 years away."

He said the city was having its own problems with its existing computers and did not believe they were making any efforts toward developing a medicaid provider or patient profile. "After all when it takes your data processing people 34 days after receipt of all paperwork to close out a case, you've got problems," Katz said, referring to a recent audit finding by the State comptroller.

Mr. Katz said he believed the State and city approach was wrong in that they were trying to develop a computerized MA payment and profile system within the existing State bureaucracy. "They'll ultimately have to use the State's computers at the State campus which means they'll have problems with getting computer time." He noted the State would be better off hiring a company on a contract basis. "Any company which does payroll work can do this type of thing." He observed that in New Jersey the centralized payment system and profiles are done on a contract basis with Blue Cross and Prudential. He said it took them "1 year at most" to have the system on line. He also noted that "New Jersey has one of the cleanest systems," and added that their ineligibility rate was about half New York's for the same period. New Jersey has the 9th largest MA program in the country.

Eligibility verification is also hindered by listed data exchange with third party insurers. Local social service districts can get data from the Social Security Administration on SSA and SSI benefits, but they have no tie in to unions, Medicare, BC/BS, HIP, and other third-party insurers. The importance of this is that it deprives local DSS of

the ability to cross-check coverage of recipients. Where such coverage exists, it often should be applied before MA is used. The State comptroller and New York State DSS QC have found this to be a significant cause of ineligibility and overpayments. Similarly, a 1974 GAO audit found there was a major problem in the failure of effective data exchange between Medicaid and Medicare (B–164031(4), August 16, 1974). Furthermore, New York State did not require data exchange on providers with abuse/fraud records between its own 58 localities until 1974.

Another problem related to eligibility is the State's lack of a centralized Medicaid fraud and abuse unit. According to HEW, New York State DSS planned such a unit in 1975, but it will not be undertaken due to city and State fiscal crisis. (See January 19, 1917 none from William Toby to Keith Weikel, Commissioner, Medical Services Administration, re: "Progress Report on Medicaid Fraud Investigation in New York City.") Mr. Katz said HEW had never placed a priority on such units in States or is HEW regional offices and that only now are such units being set up in HEW regional offices.

Historically, HEW has not been concerned with Medicaid eligibility. Mr. Katz said, "Medicaid eligibility was a sleeper until last year. It was always a nonpriority item with SRS. Then the nursing home and provider scandals broke it open in SRS."

As regards eligibility in general, there has been very little emphasis on quality control review. The first real emphasis came in 1972 with new HEW regulations which set tolerance levels by State upon penalty of withholding reimbursement if certain tolerance levels were not met. Since 1972, New York State DSS and regional HEW have focused primarily on PA eligibility in view of the concern for possible reimbursement penalties if New York State did not meet tolerance levels. Also, AFDC (the major PA program) was the highest dollar outlay program until recently when it was surpassed by MA.

With regard to Medicaid eligibility specifically, between 1966 and 1972 the MA eligibility review was done for PA/MA and MA-only cases as well. Data for these years "is not good" and since the bulk of the cases were PA/MA it was impossible to sort out the cost in the MA area. For instance, a person found ineligible for PA might have been eligible for MA since there are different income levels for eligibility. Also, they could not compute the actual MA moneys paid on behalf of an ineligible PA/MA case because their sample was based on individual cases and not on claims paid.

From 1972 to 1975, HEW stopped QC review of MA eligibility nationwide. The reason was the 1972 emphasis on PA (AFDC) ineligibility tolerance levels and Federal penalties if States exceeded these tolerance levels. No similar tolerance level and penalty provision was established for MA in 1972 and none has been set to date. States were allowed to do MA QC reviews at their option, but between 1972 and 1975, "Most didn't . . . they were just as glad not to have to do it." In region II, Puerto Rico was the only State to carry out QC in the MA area between 1972 and 1975. New York State did nothing.

In 1975, HEW reinstituted a QC review of MA-only cases. The review program was based on standards developed by Touche-Ross and Co. The program deals only with MA-only cases and PA/MA

cases are not reviewed to determine what persons ineligible for PA (or overpaid for PA) are ineligible for MA benefits they received. The bulk of the persons receiving MA in New York State are PA/MA (about 75 percent). The MA aspect of PA/MA cases is not reviewed at all. However, Mr. Katz observed 10 States have not picked up on MA-only QC reviews yet.

In New York State, the sample standard is 875 cases for a 6-month period. The QC team reviews all claims paid to the 875 cases during the 6-month review period. The reviews are done on a yearly basis.

e. QUALITY OF CARE

Both the process for applying for "Medicaid-only" (MA-only) and for public assistance continually giving MA coverage) are lengthy, with approval taking on the average of 2 to 3 months. About 75 percent of all MA recipients statewide are public assistance (PA/MA) recipients and the other 25 percent are "MA-only." In New York City, approximately 90 percent are PA/MA and only 10 percent "MA-only."

The processing problems are even more acute for elderly, disabled, and blind persons. As of January 1, 1974, all such persons seeking public assistance were transferred from the previously locally administered disable, aged, and blind (DAB) public assistance programs to the federally administered and federally funded supplemental security income program (SSI). However, while SSI applicants are automatically eligible for Medicaid, they must apply separately for SSI (at Federal social security offices) and for Medicaid (at local DSS offices).

Since the local welfare agencies cannot process these applications until notification is received from the Social Security Administration of the applicant's SSI status, there are frequently long delays before medical benefits actually become available. According to New York State DSS, for most of 1974 the length of time taken to produce Medicaid cards for SSI recipients "ran as high as 4 or 5 months." By January 1975, MUSDSS claimed the time was reduced to "an average of 6 to 8 weeks."

In addition, SSI clients must return to their local centers *each month* for recertification and issuance of new cards. This whole process can involve considerable hardship for the elderly and infirm. These delays often create situations where qualified and ready persons do not get the necessary medical care due to a maze of redtape in the processing of applications for Medicaid coverage and Medicaid claims by providers. There are these recent case examples noted by reputable voluntary groups dealing with the elderly in New York:

> The Visiting Nurse Service of New York is assisting a 54-year old woman immobilized by a disease of the nervous system. "She can't move a pinky. She's helpless, said Visiting Nurse official Magda Bondy.
>
> Her husband earns $900 a month as a factory foreman and is snowed under by medical bills. The couple own a house in Queens which, though it is fully mortgaged, complicates the possibility of receiving Medicaid. Their daughter, 16, is hav-

ing difficulty coping with the emotional situation in a house centered on her crippled mother. The husband, frustrated by mounting bills and problems in finding some one to care for his wife, has vowed to quit his job and go on welfare.

The visiting nurse service's Mrs. Magda Bondy told of a 65-year-old diabetic whose leg was amputated during a 2-year illness. He visits the clinic once a week but should go more often. Doctors are trying to save his other leg. Confined to a wheelchair and struggling to live on $280 a month social security, he breaks many appointments because he cannot afford a taxi fare.

Medicaid has established a reputation for its slowness in processing paperwork. Many persons have to impoverish themselves in order to qualify for Medicaid. They are often in a no-man's land where they have insufficient income to pay exorbitant medical costs (but too much income often in nonliquid assets) to qualify for Medicaid. The process of such intentional and necessary impoverishment often results in a torturous situation for senior citizens. Mrs. Gertrude Elowitz, who directs the older persons service for the Community Service Society of New York, explained the situation as follows:

> The first month the Medicaid patient has to spend the money on medical bills to prove how much they cost. Some patients can't get any other assistance so they don't eat very well that month. Maybe Mount Sinai Hospital can wait 3 months but someone who spent the money the previous month out of a $250 social security check can't.

Another commentator recently observed yet another burden placed on the elderly by Medicaid:

> Medicaid's slow billing pace has led many private doctors to reject patients under the program. The new Medical reimbursement rate also is a factor). Since there are few individual physicians who accept them, the patients are forced to go to hospital clinics, which are often inconveniently located and, again, involve hours of waiting.

These burdens continue for the needy elderly while the Medicaid program continues to accept hundreds of thousands of ineligible persons each year.

On the other hand, many local officials claim that SSI allows persons into their program with little collateral verification creating large numbers of ineligibles who are automatically placed on Medicaid due to Federal requirements. Allen J. Eisenberg, Tioga County Social Services Commissioner, related one example which occurred in December 1975.

> "A women came in a few months ago applying for Medicaid. Under the law, she didn't qualify because she had insurance policies amounting to much more than the $1,500 limit.
>
> "A few months later she was back—this time as a recipient of the SSI program. We were required to give her Medicaid benefits," he said.

"It's a Federal fiasco, a boondoggle. The social security people determine whether a person's eligible, but they don't do a thorough job. Then automatically, the person qualifies for Medicaid and we get stuck with the bill," Eisenberg continued.

The Monroe County Deputy Director of Medicaid has stated:

"Since the onset of the SSI program, local departments of social services have experienced ongoing difficulties in administration of the program, not only as it relates to medical assistance (Medicaid), but in its relationship to providing sustenance needs for individuals.

"During the period of our relationship with SSI . . . we have realized . . . that the SDX list is neither accurate nor timely in providing information that would allow effective and efficient administration of the local Medicaid program."

The deputy director of Monroe County further pointed out that "while our original thought . . . was that the Federal takeover would require less work on the part of the department in fulfilling Medicaid responsibilities, we have found that a full unit staff, six people and one supervisor, is necessary to cope with the problems and difficulties related to acceptance of the SDX as the only means for eligibility verification. In comparison to activities of workers in AABD (aid to aged, blind, and dependent) prior to SSI, this unit currently performs three times the workload that had been required under the AABD program."

The SDX list is a list of SSI recipients provided to local welfare agencies by the Social Security Administration.

The Federal Government has admitted that there may be as much as a 25 percent margin of error in determining SSI caseloads and that SSI alone has issued an estimated $500 million in overpayments to its recipients. Most of this has been attributed to administrative problems and not to client fraud or error.

Some more specific examples of questionable quality care rendered by Medicaid provides: As early in the program as December 1967 the city department of social services found one physician billing Medicaid for examinations to all members of every family he visited, sick or not, for a total of 65 house calls per day.

In 1969, the dental team from the city health department found "Some 1,300 patients were examined after work had been done by private dentists about whom the department had some questions. Nine percent of those examined showed poor quality dental work and a further 9 percent showed a descrepancy between work performed and work claimed. More alarming were the results with a group of 500 patients who had received optometric services. Some 72.2 percent had received satisfactory care, and 17.2 percent unsatisfactory care; by September 1969, of the full-scale investigation of providers undertaken, 207 had been sustained in full and 64 had not."

In August 1971, Councilman Carter Burden charged that Medicaid patients receiving treatment in New York City "storefront" clinics were receiving shoddy treatment, and the commissioner of the New

York City Department of Health estimated that 5 to 10 percent of the care given to Medicaid patients was unacceptable.

In July 1974, the New York City Department of Health barred 30 practitioners from the Medicaid program for providing poor care and engaging in unjustified and even dangerous medical practices.

Once again similar examples of overutilization, unnecessary treatment, and poor quality care were recited throughout the 1972 grand jury report.

Another area where quality of care under Medicaid has suffered due to administrative laxity has been in the early and periodic screening, diagnosis, and treatment program (EPSDT). The program was mandated in 1967 by the Federal Government and by regulations published in November 1971. The EPSOT program was aimed at more effective screening of children under the age of 21 for mental and physical defects in order to provide more appropriate care and to decrease overutilization and other improper utilization of Medicaid-funded services for children.

New York did not implement the EPSDT program until March 1972. An HEW Regional Audit agency report issued in 1975 to New York State DSS showed that statewide implementation of the program had reached only 3 percent of all eligible children during the program's first 20 months of operation (March 1972–December 1973).

D. PROFESSIONAL SOCIETIES

1. Organization, Powers, and Duties

The American Medical Association (AMA) provides its members with guidelines to ethical professional conduct in its "Principles of Professional Conduct" and issues opinions interpreting these "principles" through its judicial council. Enforcement of these "principles" and "opinions" is within the jurisdiction of State societies which in turn defer jurisdiction to local societies. In general local societies have the power to expel, suspend, and censure their members, but only the regulating State agency can act per se to revoke or suspend a physician's license or impose monetary penalties. The same basic professional conduct hierarchy exists at the national, State, and local levels in dentistry and the remaining 11 health professions licensed by the education department in New York State.

Section II of this report deals with the national and New York State medical and dental societies' positions on specific issues: fee-splitting, percentage-leasing, and regulation of Medicaid mills. Part of this section dealing with the department of education's responsibilities also discusses these issues. In addition, the committee staff wrote to the New York State medical and dental societies and the local medical and dental societies in New York City to ascertain their positions on percentage leasing, and Medicaid mills, the relationship with State and local regulatory agencies, and their own disciplinary actions.

As of this printing, the committee staff had not received replies from the following: Medical Society of New York State, Bronx County Medical Society, Kings County Medical Society, Queens County Medical Society, Richmond County Medical Society, and the Second District Dental Society (i.e., Kings and Richmond Counties).

Summaries of the four professional society responses received by the committee staff appear below. The responses appear in full in appendix 2.

2. Responses to the Committee

a. New York State Dental Society

In response to a committee inquiry (see appendix 2), the Dental Society of New York State says it has "relatively good" liaison with State enforcement agencies. The society itself relies on local district societies to monitor professional activity, does not exercise any disciplinary action itself, and keeps no centralized data on the localities' activities. Locals are able to expel, suspend, and censure members.

The society basically endorses the idea that percentage lease arrangements are unethical and that Medicaid mills should be regulated by the city and State. The society further stated that it considers the current 35 percent of gross profits lease arrangement not only unethical in concept but an "unreasonable rate." This is despite the fact that mill operators say the rate is based on the average overhead costs medical professionals usually pay for such services.

They have endorsed the New York City Health Department's attempt to regulate mills under item 230. They further state that a situation where the landlord provides not only office, waiting room space and equipment, but also all custodial, clerical, secretarial and administrative services (i.e, centralized record maintenance and selection of laboratory) as one which "certainly endangers the independence and control of a professional practice." As previously noted, the committee has found such arrangements to be typical of mills in New York and elsewhere.

However, the society finds it ethical (1) for a dentist to utilize a factoring company to collect Medicaid claims regardless of the commission charged by such a company, and (2) for a dentist to have a financial interest in a company or partnership which leases space, provides "factoring" or other services to other medical professionals. The AMA finds the latter practice unethical and so states in its code of conduct.

b. First District Dental Society

The first district covers New York County (Manhattan). The first district advised the committee staff that it has an agreement with New York City Medicaid whereby their peer review committee "will render an opinion as to the quality of dental treatment, when requested by the city Medicaid administration."

The society's position on specific issues is:

(1) *Support of health, item 230 amendment to regulate Medicaid mills.* They said they helped formulate the amendment and "feel the enforcement of item 230 is dependent upon *the prohibition of percentage of gross rental agreements.*"

(2) *Oppose the basic concept of "factoring" in all phases.*

(3) Consider the practice whereby the landlord provides a practitioner with multiple types of services "as one which endangers the independence of a member of our society in the control and operation of this professional practice."

c. ELEVENTH DISTRICT DENTAL SOCIETY

The Eleventh District encompasses Queens County, N.Y. The society advised the committee of its position as follows:

(1) Support legislative or regulative action "to correct abusive practices currently engaged in by "shared health facilities." They support item 230 and urge that parallel State and Federal action should be initiated in this area.

(2) Oppose lease of office space based on a percentage of income and urge such practices be made illegal and unethical.

(3) Believe "factoring" for collection of Medicaid claims "is improper and should be regulated."

As to "factoring", Dr. Emil Lentchner, the society's executive director, advised the committee staff:

> It is clear that if Medicaid is effectively administered (which is not the case) to provide prompt payment of claims, "factoring" would not be significantly indulged in. The clear effect of "factoring" is to lower the net reimbursement to the health provider—suggesting that the health service could have been provided for an amount less the factoring percentage. The net result is to lower the quality of care provided to accommodate the decrease in reimbursements.

Dr. Lentchner claims that Medicaid in New York State is "at a very low ebb" and says the current division of labor between health and social services "creates confusion, duplication and dichotomy." He suggests the use of fiscal intermediaries as an alternative administrative approach.

Dr. Lentchner asserts that the current "bureaucratic maladministration" of Medicaid and setting of maximum allowable fee schedules for dental care at 1966 rates creates a situation whereby dentists "cannot conscientiously participate to any significant degree in the program." He says the result is a "deplorable condition wherein 95 percent of dental Medicaid services are provided by less than 5 percent of licensed dentists in the "City of New York," and most of these dentists operate from Medicaid mills.

d. MEDICAL SOCIETY OF THE COUNTY OF NEW YORK

The society advised the committee staff of its positions as follows:

(1) Urge the board of regents to declare as unprofessional conduct participation by any licensed health professional "in any percentage letting office space agreement."

(2) Support item 230 and participated in its preparation as part of the Interprofessional Society Advisory Committee to Medicaid of the New York City Department of Health.

(3) "On general principles of medical ethics, factoring would be frowned upon but it is not specifically forbidden." The society is aware the sue of "factors" has increased due to long delays in payment of Medicaid bills, but feels percentage leasing is a more pressing problem.

The society advised the committee that its board of censors has authority to investigate complaints against its members and make any referrals it deems appropriate to the New York State Board of Pro-

fessional Medical Conduct. About 90 percent of the complaints are lodged by patients against physicians and the remaining 10 percent involve one physician complaining about another physician or physician requests for ethical opinions.

Between 1972 and 1976 the board of censors considered approximately 400 cases. During 1974–75 charges were preferred against three physicians and four cases were referred to the department of education. In 1975–76, three cases were referred to the department of education, three to health, and one to the attorney general. They did not report on the nature or current status of these cases.

The society also has peer review activities carried out by various subcommittees. These have no disciplinary powers, but are solely limited to "factfinding and education." Between 1972 and 1976 a total of 110 cases were submitted to the Medicare-Medicaid surgical and medical subcommittees by the Medicare fiscal intermediary and New York City Health Department's Medicaid program. The society said, that where appropriate, referrals were made to their own board of censors, health, or education. The society did not provide the committee staff with any further statistical breakdown of these cases or referrals.

In the 1966–76 period the society expelled ten physicians from its membership, but "none of these cases were primarily related to abuse of Medicare or Medicaid." During 1976 the society's board of censors referred 14 complaints and their investigative reports to the professional conduct offices either in health or education. The society stated that:

> In one of these cases, our investigative committee concluded that the physician was guilty of overutilization and consequent overcharging of Medicaid, presentation of false bills with inaccurate diagnoses; unnecessary injections of vitamin B–12 and prednisolone, both given indiscriminately, and the prednisolone frequently contraindicated by the patient's condition, poor quality and substandard medical care.

The society advised the committee staff that they "are conducting investigations in three cases which involve physicians who have received prior direction by our Medicare-Medicaid subcommittee to cease their patterns of practice, which in that committee's estimation, amounted to abuse of Medicare or Medicaid." The society expects their board of censors to try those cases in the fall of 1976 and thereafter to make appropriate internal action or referral to State agencies.

E. FEDERAL RESPONSIBILITY

Federal responsibility for mismanagement, fraud, and abuse in the Medicaid program has been of continuing concern to several committees of the Congress. The Subcommittee on Long-Term Care has been critical of the enforcement of nursing home standards by the Department of Health, Education, and Welfare and has chided the Department's failure to head off fraud and abuse among clinical laboratories. The oversight subcommittee of the House Interstate and Foreign Commerce Committee chaired by Representative John Moss of California has been critical of the department's failure to withhold funds from those States which have not established effective utilization review procedures. Senator Herman Talmadge has expressed his con-

cerns in the form of legislation, S. 3205, to create a central fraud and abuse unit and streamline the department's ability to prevent and prosecute fraud. Senator Sam Nunn, as chairman of the oversight subcommittee of the Senate Government Operations Committee, has also revealed his misgivings about the administration of some aspects of the Medicaid program. Finally, Representative L. H. Fountain and his Subcommittee on Intergovernmental and Human Resources of the House Government Operations Committee has studied this matter in detail.

Not surprisingly, the findings of all of these groups are similar. There is much need for improvement in the management of the Medicaid program. A few States, notably Michigan, New Jersey, and California, appear to be doing an excellent job. But most States are not. The Department of Health, Education, and Welfare has been either unwilling or unable to require them to meet their responsibilities under the Medicaid law, which places responsibility for policing fraud and abuse squarely on the shoulders of the States.

Federal Standards

Section 250:80 of the Code of Federal regulations sets forth the Federal requirements that States must meet with respect to fraud and abuse, if they are to continue in the Medicaid program. These seven standards require:

(1) There must be methods and criteria for identifying possible fraud cases and there must be appropriate referral procedures to law enforcement authorities.

(2) There must be procedures to assure that fraud investigations do not infringe on the legal rights of those being investigated.

(3) The State Medicaid agency must designate positions with responsibility for referring suspected fraud cases to the proper authorities.

(4) The State Medicaid agency must establish a fraud reporting system that will protect the identity of providers. These reports are to be made available to SRS.

(5) Provider claim forms must contain a certification, as set fourth in section 250.80(5)(A) of the Code of Federal Regulations, which asserts to the truth, accuracy and completeness of the claim.

(6) A State agency must provide verification of services to a sample of patients, or to all patients if 75 percent matching is requested.

(7) A State agency must establish procedures to inform providers and recipients of the specific Federal penalties for fraudulent acts and for fraudulent reporting.

In addition to these regulations the States are bound by section 1902(a)(4) of the Social Security Act which provides the original legal basis for the establishment of fraud procedures in State Medicaid programs. According to this section a State medical assistance plan must "provide . . . such methods of administration . . . as are found by the Secretary to be necessary for the proper and efficient operation of the plan . . ."

Public Law 92–603 made a number of key additions to the fraud provisions of title XIX, as follows:

(1) The Secretary was given authority to terminate title XIX payments to providers who had been determined guilty of abuses in the Medicare program.

(2) A new Section, 1909, was added to title XIX which provided specific penalties for fraudulent acts and reporting under Medicaid and Medicare.

Assistance to the States

Through various provisions in the Medicaid law, the Congress has sought to assist the States in their enforcement of standards preventing or identifying fraud and abuse.

The Medicaid program, by definition, aids the States, since it pays for from 50 to 83 percent of the State's costs in bringing medical services to the medically indigent. In New York, the Federal government pays 50 percent of the costs, which includes the cost of administering the program.

In addition, the Federal government pays 100 percent of the cost of State inspections of nursing homes participating in the Medicare and Medicaid programs. It pays 50 percent of the cost of making State audits. Beginning in 1972, Federal financial participation was available at the rate of 90 percent for development, and 75 percent for the operation of automated data systems known as MMIS systems.

Performance by the States

Despite these advantages, most States still do not have effective fraud and abuse programs leading to the U.S. General Accounting Office (GAO), Congressional committees, and others to continue their criticism of the Department of Health, Education, and Welfare.

The GAO Report: April 1975

One of the most important reports on this subject was produced by GAO and released on April 14, 1975, in response to a request from Senator Herman Talmadge, chairman, Subcommittee on Health of the Senate Committee on Finance. The report notes that since Medicaid is a State administered program, the Social and Rehabilitation Services (SRS: the agency within HEW which has responsibility for Medicaid) has taken the position that States have primary responsibility for detecting and prosecuting fraud and abuse.

However, as GAO was very quick to point out, HEW (through SRS) has its own responsibility for administration at the Federal level. GAO said:

> HEW can withhold funds or, under certain conditions, assess lesser monetary penalties if States do not comply with Federal requirements.

GAO added:

> Between October 1, 1969, and September 30, 1974, HEW regions reported 2,300 instances in which States did not comply

with Federal Medicaid requirements. However, HEW has not imposed monetary penalties against any State.

Twenty States have never referred a suspected Medicaid fraud case to State or Federal law enforcement agencies for prosecution.

Improved coordination of State Medicaid fraud and abuse investigations with Medicare is needed. A combined Medicare-Medicaid investigative unit should improve HEW's ability to investigate fraud and abuse under both programs.

GAO stated that improvements were needed in the Federal management of Medicaid, pointing out that SRS has attempted to monitor the Medicaid program in the following ways:

—Testing State operations to determine whether programs are operating in accordance with Federal requirements;
—Requiring States to submit financial and statistical reports which can be analyzed to assess program effectiveness; and
—Conducting investigations and audits and hiring consultants to identify problems that need correction.

However, GAO found that SRS had not:

—Given sufficient attention to reviewing States' Medicaid operations;
—Obtained or analyzed needed data to provide indicators of the effectiveness of State Medicaid programs; or
—Given adequate consideration to recommendations made by consultants and the HEW audit agency for correcting program deficiencies.

GAO ended with a long list of recommendations urging the Secretary of HEW to direct the SRS administrator to insure that all States comply with Federal requirements for investigating suspected Medicaid fraud and abuse cases, including assessing financial penalties against those States which do not take adequate steps to meet Medicaid requirements. GAO also called upon the Secretary to insure that States implement the MMIS program rapidly and that such systems provide the necessary capability needed to perform utilization reviews.

The Fountain Report

Representative L. H. Fountain and the staff of his Intergovernmental and Human Resources Subcommittee, House Government Operations Committee, conducted lengthy hearings in April, May, and June 1975, to assess the capability of the Department of Health, Education, and Welfare to not only monitor State performance but to aid directly in ferreting out fraud and abuse.

The findings of the Fountain subcommittee were released in a January 1976 report entitled, "Department of Health, Education, and Welfare (Prevention of Fraud and Program Abuse)," 10th report of the Committee on Government Operations, House of Representatives. The report reached the following conclusions:

1. The Department of Health, Education, and Welfare currently is responsible for about 300 separate programs involving expenditures in excess of $118 billion annually—more

than one-third of the entire Federal budget. Because of the magnitude and complexity of its activities, aggravated in many instances by lack of direct control over expenditures, HEW's operations present an unparalleled danger of enormous loss through fraud and program abuse.

2. HEW officials responsible for prevention and detection of fraud and abuse have little reliable information concerning the extent of losses from such activities.

There is no central source of data concerning fraud and abuse nor, evidently, has any meaningful attempt been made to evaluate the overall extent of the fraud and abuse problem. Statistics which are available are often incomplete and unreliable.

HEW officials were unable to provide such basic information as an accurate count of the number of HEW programs until more than five months after the information was initially requested. During this period, at least four different figures on the number of HEW programs were supplied to Congressional committees, ranging from a low of 250 to as many as 320.

Without adequate information, neither HEW officials nor Congress can accurately measure either the need for or the effectiveness of action to prevent and detect fraud and program abuse, nor can priorities for use of available resources be determined on a rational basis.

3. Fraud and abuse in HEW programs are undoubtedly responsible for the loss of many millions of dollars each year. The committee has not attempted to name a specific figure at this time because HEW officials could not provide information on which a reliable estimate of such losses could be based.

4. HEW units charged with responsibility for prevention and detection of fraud and program abuse are not organized in a coherent pattern designed to meet the overall needs of the Department.

There is no central unit with the overall authority, responsibility and resources necessary to insure effective action against fraud and abuse. Under its charter, the Office of Investigations and Security has departmentwide responsibility for leadership, policy direction, planning, coordination and management of investigations. However, its authority over operations of the Social Security Administration has been effectively nullified as the result of agreement made by non-OIS officials; moreover, OIS could not possibly carry out its assigned responsibilities with the hopelessly inadequate resources it now has.

Fraud and abuse units other than OIS and the audit agencies are scattered throughout HEW in a haphazard, fragmented and often confusing pattern. Some major programs have no fraud and abuse unit, while other units exist mostly on paper. Some units have no personnel in field offices; in other instances, field personnel are not subject to the direction and control of the unit's headquarters. Personnel of most units

75-902 O - 76 - 14

work exclusively and continuously on a single program, and are not available to help correct more serious problems elsewhere.

5. Personnel of most HEW fraud and abuse units lack independence and are subject to potential conflicts of interest because they report to officials who are directly responsible for managing the programs the unit is investigating. Under these circumstances, employees may be inhibited in making an honest and thorough report that could embarrass their superiors.

The independence of the Office of Investigations is restricted in another way. Under current arrangements, OIS may not initiate any investigation without specific approval of the Secretary or Under Secretary. In addition to the obvious restriction on the independence of OIS, this procedure creates an unnecessary burden for the Secretary or Under Secretary and places them in the undesirable position of having to decide personally whether or not suspected irregularities are to be investigated. Any safeguards necessary to insure that inappropriate investigations are not conducted should be imposed through carefully adopted procedures and guidelines, rather than individual decisions by the Secretary or Under Secretary.

6. Under current organizational arrangements, there is little assurance that the Secretary will be kept informed of serious fraud and abuse problems, or that action necessary to correct such problems will be taken. The OIS charter does not provide for guaranteed access to the Secretary or Under Secretary. Most other fraud and abuse units report to program officials, usually at a relatively low level. Since those receiving reports of fraud and abuse problems are likely to be responsible for the programs involved, there may be little incentive for such officials either to call problems to the attention of the Secretary or to initiate prompt and aggressive corrective action which could result in public laundering of their own dirty linen.

7. Resources devoted by HEW to prevention and detection of fraud and program abuse are ridiculously inadequate. Although HEW has more than 129,000 full-time employees, the Office of Investigations and Security has had only ten investigators.

At least partially because of its fragmented organizational structure, HEW has failed to make effective use of the resources it has. As a result, OIS has a ten-year backlog of uninvestigated cases; at the same time, the 11 investigators in the SSA Investigations Branch have been so underutilized that the unit has no significant backlog and has left 8 investigative positions unfilled.

Although the total number of persons reported assigned to fraud and abuse units is about 300, more than 180 of them work exclusively on the Medicare program, and most of the remainder are assigned to other programs of the Social Security Administration, Individuals working in OIS and the

SSA Investigations Branch are qualified investigators, but personnel assigned to other units may have no substantial investigative training or experience.

8. There are serious deficiencies in the procedures used by HEW for the prevention and detection of fraud and program abuse. Until recently, HEW had not advised employees of the Department that they had an obligation to call information indicating possible fraud or abuse to the attention of appropriate officials. Moreover, there is no departmentwide policy for or centralized supervision of the referral of possible fraud cases for prosecution.

The subcommittee's investigation disclosed instances in which it took as long as five years or more for HEW to take corrective action after deficiencies in its regulations became known. Part of the blame can be attributed to cumbersome procedures for changing regulations; however, some delays were so lengthy as to indicate the almost total lack of any sense of urgency.

REPORT BY THE SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE, SELECT COMMITTEE ON AGING, HOUSE OF REPRESENTATIVES, JANUARY 1976

In its report, "New Perspectives for Health Care for Older Americans," the House Subcommittee on Health and Long-Term Care addressed the question of the number of nursing home audits conducted by the States and the Department of Health, Education, and Welfare. Condemning the "dearth of audits," the Subcommittee pointed out that 20 States had never audited a single Medicaid-eligible long-term care facility since 1967. (See exhibit I below). At that time (January 1975) the HEW audit agency had conducted only some 200 audits since the beginning of the Medicaid program in 1967.

EXHIBIT I

Number of Medicaid facilities audited by State organizations [1]

Alabama	55	Kansas	36
Alaska	0	Kentucky	94
Arizona	(2)	Louisiana	206
Arkansas	0	Maine	75
California	0	Maryland	543
Colorado	1	Massachusetts	600
Connecticut	0	Michigan	1370
Delaware	24	Minnesota	51
District of Columbia	0	Mississippi	0
Florida	0	Missouri	350
Georgia	0	Montana	1
Hawaii	NA	Nebraska	0
Idaho	3	Nevada	16
Illinois	398	New Hampshire	25
Indiana	0	New Jersey	316
Iowa	0	New Mexico	36

See footnotes at end of article.

EXHIBIT I—Continued

Number of medicaid facilities audited by State organizations [1]—Con.

New York	222	South Dakota	0
North Carolina	87	Tennessee	60
North Dakota	0	Texas	375
Ohio	4	Utah	0
Oklahoma	0	Vermont	0
Oregon	57	Virginia	170
Pennsylvania	319	Washington	0
Puerto Rico	0	West Virginia	0
Rhode Island	27	Wisconsin	487
South Carolina	38	Wyoming	0

[1] Since enactment of Medicaid
[2] Does not participate in the medicaid program.
NA—Information not available.

These facts came to this subcommittee's attention during its own hearings, held in New York City on January 21, 1975. Testimony was provided that comparatively few nursing home audits were undertaken in New York and elsewhere. However, the subcommittee soon learned that even fewer audits were made in other areas.

For example, from 1971 through December 1974, New York audited 125 of its 400 for-profit nursing homes. It recouped $8.611,300 in fraudulent or questionable payments. During this same time period New York was able to audit only:

6 of its 300 nonprofit nursing homes;
2 of its 300 health clinics;
2 of its 120 home health agencies; and
1 of its 150 health related facilities

Dr. Frederick Parker, director of the Bureau of Provider Audit of the New York State Department of Health explained that priority was placed on for-profit nursing homes because of shortages in staff.

The committee wrote the director of the HEW audit agency, asking how many audits were undertaken with respect to all aspects of the Medicaid program. The agency responded that 264 audits were completed in the past 5 years relating to the Medicaid program. Some 12 areas of concern are evaluated in various audits. An audit usually includes more than one area but no audit includes all 12. Accordingly while 264 audits were issued, 740 areas were audited.

Analysis of these 740 areas indicates that 136 or *18 percent* of the total deal with questions of administration or costs; 249 or *34 percent* deal with nursing homes, including problems associated with patients' accounts; 93 or *13 percent* deal with eligibility for Medicaid; 181 or *25 percent* relate to various problems associated with Medicaid providers. Some 41 areas or *5 percent* of the total relate to pharmacies; 16 additional cases (2 percent) relate to other subjects. *The remaining 24 areas (3 percent) relate to hospitals which receive more than one third of all Medicaid funds. This suggests a slight imbalance and a need to examine hospitals more closely.*

The following chart was provided to the subcommittee by Albert J. Benz, Assistant Director of the Health, Education, and Welfare Audit Agency.

	Total reports issued	Eligibility	Administrative functions and costs	Hospitals	Pharmacies	Nursing homes: Certification	Nursing homes: Level of care	Nursing homes: Costs	Patient accounts and admissions	EPSDT	Provider claims: TPL	Provider claims: Duplicate claims	Provider claims: Other	Total areas audited
Total	264	93	136	24	41	61	70	82	36	14	39	41	103	740
Region I	42	13	17	1	6	8	10	15	9	5	4	5	12	105
Connecticut	6	2	4			1	2	3	3		1	1	1	18
Maine	5	2	3		1	1	1	2	1	1			2	14
Massachusetts	16	3	4	1	2	2	2	5	1	1	3	2	4	30
New Hampshire	7	2	3			2	2	2	1	1		2	2	17
Rhode Island	5	3	2		2	1	2	2	2	1			2	17
Vermont	3	1	1		1	1	1	1	1	1			1	9
Region II	41	8	20	5	1	4	3	2		2	3	6	28	82
New Jersey	3	1	1				1			1			1	5
New York	35	5	16	3	1	4	2	2		1	2	6	25	67
Puerto Rico	3	2	3	2							1		2	10
Virgin Islands	0													
Region III	39	6	12		1	6	10	17	8		2	3	5	70
Delaware	3		1			1			1				1	4
District of Columbia	5	2	1			1	1	3	2		1	1	1	13
Maryland	8	1	3		1		2	2	2				1	12
Pennsylvania	12	3	4			4	3	7	1		1	1	1	25
Virginia	5		1				2	2	1					6
West Virginia	6		2				2	3	1			1	1	10
Region IV	27	13	16		5	9	9	9	4	3	9	2	6	85
Alabama	5	2	4		1	1	1			1			1	11
Florida	6	2	3		1	1	2	1		1	1			12
Georgia	2	1	2		1	1	2	2	2					11
Kentucky	4	3	2			1	1	1			3		2	13
Mississippi	3	1	2				2	1			1		1	8
North Carolina	4		2			1				1	2	2	2	10
South Carolina	1	2			2	2	1	2	2		2			13
Tennessee	2	2	1			2		2						7
Region V	31	10	19	6	6	10	10	9	2		2	5	12	91
Illinois	14	2	5	6	2	3	5	4	2			4	3	36
Indiana	4	1	3		1	1		1			1		3	11

	Total reports issued	Eligibility	Administrative functions and costs	Hospitals	Pharmacies	Nursing homes: Certification	Nursing homes: Level of care	Nursing homes: Costs	Patient accounts and admissions	EPSDT	Provider claims: TPL	Provider claims: Duplicate claims	Provider claims: Other	Total areas audited
Michigan	2	2	2			1	1	1				1	1	9
Minnesota	4	2	4		1	2	2	1			1		1	14
Ohio	3		3		2	1	1	1					3	11
Wisconsin	4	3	2			2	1	1					1	10
Region VI	13	8	7	1	2	5	3	6	2		1	4	6	45
Arkansas	3	1	2			1		2				1	1	8
Louisiana	1	1	1	1		1		1				1	1	7
New Mexico	3	1	2		1	1	1	1	2			1	2	12
Oklahoma	4	3	1		1	1		1				1	2	10
Texas	2	2	1			1	2	1			1			8
Region VII	17	8	6	2	7	3	10	8	3	3	3	2	9	64
Iowa	2	1	2		2	1								6
Kansas	4		2		2		3	2					2	11
Missouri	5	1	1	1	2		2	2	1	2		1	2	15
Nebraska	6	6	1	1	1	2	5	4	2	1	3	1	5	32
Region VIII	17	11	14	3	4	2	5	6	5		4	5	7	66
Colorado	8	6	8	1	2	1	1	1	1		1	3	2	27
Montana	1	1	1					1			1		1	5
North Dakota	2	2	1	1	1		1					1	1	8
South Dakota	1		1				1	1	1		1		1	6
Utah	4	2	3	1	1		2	2	2		1	1	2	17
Wyoming	1					1		1	1					3
Region IX	17	11	14	3	5	6	7	3			8	6	12	75
American Samoa	0													
Arizona	0													
California	13	8	10	1	3	6	5	2			7	6	9	57
Guam														
Hawaii	3	2	3	2	2		2	1					2	14
Nevada	1	1	1								1		1	4
Trust Territory	0													
Region X	20	5	11	3	4	8	3	7	3	1	3	3	6	57
Alaska	1		1											1
Idaho	4	3	3			2	1	4					2	15
Oregon	8	1	5	1	2	3	2	2	2	1	1	1	2	23
Washington	7	1	2	2	2	3		1	1		2	2	2	18

Pending Medicaid Fraud Cases: Most Recent Statistics

The committee staff attempted to obtain the most recent statistics available with respect to pending fraud cases referred to the Department of Health, Education, and Welfare's Social and Rehabilitation Service. The most recent statistics we received were for the quarter ending December 31, 1975. The staff evaluated these fraud reports covering four quarters, or an entire year. The following table sets forth the staff's findings. We found that some 2,062 cases might be pending in any one quarter. Some 93 percent of these cases will have been reported by 5 States: California, Michigan, Massachusetts, Pennsylvania, and Ohio. An average of 12 States have no cases pending at the end of each quarter and an average of 22 States reported no new cases each quarter.

PENDING MEDICAID FRAUD CASES REPORTED QUARTERLY TO HEW BY THE STATES

	Quarter—					
	Dec. 31, 1974 to Mar. 31, 1975	Mar. 31 to June 30, 1975	June 30 to Sept. 30, 1975	Sept. 30 to Dec. 31, 1975	Average cases by State	Percent of pending cases
Total cases, United States	1,881	2,291	2,279	1,800		
Average cases pending per quarter	2,062					
Cases by State:						
Massachusetts	115	125	147	150	134	6.5
Pennsylvania	130	137	148	168	146	7.0
Illinois	26	28	27	26	27	
Florida	1	1	1	1	1	
Michigan	297	318	350	360	331	16.0
Ohio	232	539	591	611	493	24.0
Texas	21	31	19	18	22	
California	951	897	790	640	820	40.0
New York	0	4	2	2	2	.1

As the above statistics taken from HEW's quarterly fraud summaries indicates, 5 States: California, Michigan, Pennsylvania, Massachusetts, and Ohio, make up 93 percent of the fraud cases reported to HEW in any given quarter.
12 States averaged no cases pending each quarter and 22 States on the average reported no new cases each quarter.
Also indicated from these most recent statistics available, New York which pays out 23 percent of all medicaid funds spent in the United States reported only 0.1 percent (1/10 of 1 percent) of the average fraud cases last year; by contrast, California, which represents 13 percent of total medicaid funds, reported 40 percent of the medicaid fraud cases.

California leads all States reporting 40 percent of the total, Ohio and Michigan follow with 24 and 16 percent of the total.

It is more than ironical that the State of New York pays out 23 percent of all the Medicaid funds in the nation and yet reported (on the average) only .1 percent (one-tenth of 1 percent) of the cases received by HEW. By contrast, California which pays out 13 percent of all Medicaid funds reported 40 percent of the pending fraud cases.

Even though there may have been some recent progress in New York to even the balance, this one fact is the most damning evidence possible concerning the historical maladministration of the Medicaid program in New York City and State.

It should be added, parentheticallv, that the States with high fraud figures all have an operational MMIS system. New York has made the commitment, and mav soon reverse a pattern of neglect, helplessness, or indifference which has marked its past administration of the Medicaid program.

HEW's Reaction

HEW's reaction to its congressional critics was that the agency had wanted to do more in the area of audits and investigations but has been hampered for lack of funds. Congress in turn reacted by funding 108 new positions in the medical services administration, in what is called the new Medicaid Fraud and Abuse Unit. At the same time, Secretary David Mathews added his commitment to the new 74-member office of investigations. John J. Walsh was named the director of this unit.

According to HEW's press releases, it is contemplated that the two agencies will work together closely.

Teams of Federal auditors and investigators will work also with State investigators. They will function as "strike forces" moving from State to State to help the State's personnel identify kinds and causes of abuse, to assist in the development of better management systems and to aid in investigations in prosecutions.

It may seem that by this reorganization, HEW has at last taken on some of the direct responsibility for eradicating fraud and abuse in the program. Unfortunately this is not so. HEW continues to stress that the States have the major responsibility. This is part of the thinking behind the "strike force" idea. Whatever Federal help there is, will be essentially by invitation, and will be short term.

Critics have suggested the need for a more permanent and more aggressive effort rather than what Chairman Moss called a "transitory foot patrol". There are serious questions as to whether there is enough manpower to complete even the limited objectives, which HEW officials have set for themselves. A closer look at the office of investigations reveals that only 56 of the 74 staff members are professionals. This averages out to 5 people in each of the 10 HEW regional offices. Since HEW admits that some $750 million a year is taken from Medicaid, the task facing these employees is monumental.

As a consequence, Representative Fountain and Senators Talmadge and Moss continue to push for a centralized fraud and abuse unit in HEW and the creation of the inspector general, who would have wide powers and the requisite manpower to proceed against providers who abuse or defraud the program. These members of Congress believe that it is essential that such a unit be established at once. The need is evident now but would become many times more so with the enactment of one or another national health insurance proposals pending on the congressional horizon.

Part 6

SUMMARY AND STAFF CONCLUSIONS

OVERVIEW

The committee staff and temporary investigators have set forth in this report the results of an intensive 8 month investigation in New York, New Jersey, Michigan, Illinois and California—five States which account for a total of over 55 percent of the Nation's $15 billion annual Medicaid expenditures. The investigation involved some 200 first-hand visits to more than 100 "Medicaid mills" (most in New York City): interviewing of more than 60 physicians who work or own Medicaid mills; a review of more than 100 major reports on New York's Medicaid system covering the past 10 years; and interviews with 20 government officials in New York, and sending written interrogations to 30 additional officials, as well as assessing independent evidence in other States and sending questionnaires to New York City's 250 top billing Medicaid physicians.

Based on the findings of this investigation, committee staff and investigators conclude that rampant fraud and abuse exists among practitioners participating in the Medicaid program and that such fraud and abuse is matched by an equivalent degree of error and maladministration by government agencies. The scope and degree of these problems is most acute in New York and is commensurate with its having the largest Medicaid program of any State in the Nation—$3.2 billion and 23 percent of the national expenditures annually.

It appears to the staff that the current manner in which Medicaid is administered discourages reputable medical professionals from participating in the program. The result is the dominance of the Medicaid program by a small number of practitioners who, in league with a handful of real estate operators and other businessmen, often with substantial political influence, have substituted entrepreneurial expediency for Congress' original aim of using Medicaid to deliver adequate health care to the needy at a reasonable cost.

Practitioner Fraud and Abuse

In the New York City Medicaid program, the overwhelming bulk of Medicaid moneys goes to a handful of participating practitioners (known as "high providers").

For example, over 95 percent of all the dental Medicaid services are rendered by less than 5 percent of the city's licensed dentists; 2.5 percent received 21 percent of all dental Medicaid moneys in 1974. Based on the city's most current data on this topic (1974), the Committee staff found:

—Seven percent of the participating physicians receive 50 percent of all Medicaid payments to physicians. The top 5 percent receive

an average of $80,000 per year from Medicaid, whereas the remainder receive an average of only $7.127 per year. (In Michigan, 3 percent of the physicians receive 25 percent of all Medicaid physician payments.)

—Five percent of the participating optometrists receive 21 percent of all Medicaid payments to optometrists, for an average Medicaid income of $67,612 per year. The remainder receive an average of only $13,913 per year.

—Five percent of the participating podiatrists receive 20 percent of all Medicaid payments to podiatrists for an average Medicaid income of $46,537 per year. The remainder receive an average of only $10,748 per year.

—Two percent of the pharmacies receive 12 percent of all Medicaid pharmacy payments.

Many of these practitioners found it financially impossible to practice prior to the advent of Medicaid and the bulk of the "high providers" restrict their practice to "Medicaid" or "welfare" medicine. Committee staff found three chiropractors in New York City who were making $500,000 a year each from ownership of a half dozen "Medicaid mill" facilities. All three were licensed to practice at least 12 years before the enactment of Medicaid, but up until the time Medicaid was legislated, none practiced as a chiropractor—two were taxi drivers and one was a butcher.

Most Medicaid practitioners at the outset have little, if any, working capital and often hold foreign medical degrees. As a result the average private Medicaid practitioner in an urban area works in a "Medicaid mill." The "mill" is a small office divided into cubicles manned by various types of medical practitioners. The committee staff believes the "Medicaid mill" at the hub is comprised of Medicaid practitioners, real estate operators, and other third parties who are subordinating Medicaid's care motive into the profit motive. "Mills" are usually owned by real estate operators who have sufficient capital to purchase the land, office space, and equipment necessary to operate a medical practice. "Mills" as such are not regulated at any government level due to lack of legislative or administrative authority. The result is that the Medicaid practitioner, even many "high providers", pay large percentages of their Medicaid income to landlords and other third parties. Virtually every high volume Medicaid practitioner in New York and in most urban areas, operates from one or more "mills". The average Medicaid practitioner pays between 30 to 50 percent of his gross Medicaid income as a rental. While most national and state professional medical and dental societies find this practice unethical, it is considered legal in most States and is not prohibited by Federal regulations. *The committee staff concludes that the "mill" operator in effect is charging the practitioner a "franchise fee" vis-a-vis the percentage lease.* In some "mills," the practitioner's total Medicaid income is turned over to the "mill" operator and the practitioner receives a commission based on dollar volume (an average of 20 to 40 percent to the practitioner and 60 to 80 percent to the "mill" operator).

As a result, the "mills" spawn a host of frauds and abuses designed to increase dollar volume and decrease the quantity and quality of health care. The committee staff found the average "mill" visit lasted

3 minutes and that their billings reflected at least one or more of the classic abuses cited in over 100 major reports over the last 10 years: "ping-ponging," billing for services never rendered, unnecessary treatment, and excess charges.

"Mill" operators also virtually demand "kickbacks" from pharmacies, clinical laboratories, and other suppliers in exchange for the exclusive right to the mill's business. As cited in the subcommittee's "Staff Report on Fraud and Abuse Among Clinical Laboratories" (February 1976) evidence in Illinois, New York, and New Jersey, indicates that by conservative estimates a minimum of 20 percent of the $213 million in annual Medicare and Medicaid payments for clinical laboratories is either fraudulent or unnecessary and caused by the kickback requirement. The need to pay mill operators a kickback of between 25 to 55 percent makes it necessary for lab operators to have physicians order unnecessary tests and charge for tests which were never made.

A similar situation exists with pharmacists and pharmacies. The committee staff found that practically every one of the 100 mills visited dealt exclusively with one pharmacy in return for an average kickback of 25 percent. An earlier staff report found a similar 25 percent kickback scheme between pharmacies and nursing homes. In order to recoup the moneys paid for kickbacks, pharmacists resort to a number of frauds and abuses—shorting the prescription, substitution of cheaper generic name drugs for brand name drugs, forging physician signatures on prescriptions, and issuing drugs without prescriptions to addicts. *The committee staff finds that this granting of an "exclusive franchise" to pharmacies by practitioners unnecessarily inflates Medicaid costs and violates the "freedom of choice" provision of Federal Medicaid regulations.*

In some cases the Medicaid practitioner has become so wealthy from Medicaid that he often becomes a "mill" operator instead of, or in addition to, a practicing medical professional. In New York, the staff found these examples: three chiropractors in partnership owning six mills and earning $500,000 each a year; two dentist brothers who owned a company, which at its height, owned or leased out twelve "Medicaid dental offices" in ghetto areas, and who currently own the city's fourth largest methadone clinic, a "factoring" company, and their own private Medicaid practice; a dentist who operates four "mills" (one in New York and three in Florida) earning in excess of $500,000 per year; and a psychiatrist in New York who operates a Methadone clinic and receives more money from Medicaid than any single practitioner in the Nation—approximately $1 million a year.

When all factors are considered including kickbacks (from laboratories, pharmacies, X-ray firms and other vendor-suppliers), factoring charges, billing fees, and "finders" fees, it is obvious that about 70 percent of the income flowing into Medicaid mills is siphoned off by businessmen and real estate speculators.

There are no firm figures on the number of Medicaid mills in the Nation and as to the amount of money going into them. However, using 1975 figures, the committee staff estimates that about $2.2 billion a year flows through Medicaid mills. This figure is roughly 75 percent of the total funds paid to doctors, dentists, X-ray and laboratory firms and pharmacies participating in Medicaid. As noted several times in

this report the big Medicaid money is concentrated in Medicaid mills. This concentration is shown by the fact that 7 percent of Medicaid physicians in New York City (most of whom practice in Medicaid mills) received 50 percent of all Medicaid funds for physicians' services.

Applying the 70 percent figure to the roughly $2.2 billion in Medicaid funds yields a total of about $1.5 billion which is pocketed by entrepreneurs who essentially provide no services.

After considering legitimate expenses for which a businessman is entitled to recover on their investment, overhead and expenses, plus a small profit, the amount of the unnecessary unessential, wasteful government expenditures remains more than $1 billion a year.

Of the amounts unnecessarily paid ($1 billion), the committee staff estimates that $220 million (10 percent of all payments made to Medicaid mill practitioners or pharmacists) is outright fraud. Another $550 million of the $2.2 billion total (25 percent of all payments to Medicaid mill practitioners) consists of overutilization. Incentives under the present system encourage the ordering of repeated and unneeded tests and the provision of unwanted and unnecessary services.

Quite apart from the questions of possible fraud, abuse, and overutilization is the basic question: What is the quality of health care that the government and taxpayers are getting for their money? To this question, the committee staff answers with one word, "REPREHENSIBLE".

The Congress must intervene and prevent the further growth of this blight on the American conscience; the resurrection of two track medicine with one standard of quality for the rich and one for the poor.

Government Administration

STATE LEGISLATURE

The New York State Legislature must bear the major responsibility for the continuing problems of the State's Medicaid program. *It was the legislature which mandated the requirement that localities pay 25 percent of the non-Federal share of Medicaid.* This policy which has pushed many localities to the limits of their statutory tax authorization powers as welfare and Medicaid comprise the largest single expenditure item in most of the State's 62 counties. The 25 percent cost to localities exists only in 5 States, and in 36 the State pays the full non-Federal share.

It was the legislature which created, and has maintained, the division of administrative and supervisory responsibility between Social Service and Health Departments at the State and local level despite the call for one consolidated agency by every State, Federal, local, and private expert in the field. The 58 local social service districts are responsible for payment of bills and certain fraud and abuse surveillance functions. There are 6 regional health offices and 18 county health districts (under contract to Health for MA functions—see part 5, A of this report) which bear the primary responsibility for fraud and abuse surveillance, including utilization review programs for quality of care.

State health supervises the regional and county health offices; State social services supervises the local social service districts. Neither

agency can fulfill its job without the cooperation of the other and the State health department's second deputy commissioner has aptly summarized the sentiments of numerous other sources by saying "the cooperation between the state agencies was negligible." Health needs invoices, cancelled checks, and patient and provider profiles from social services in order to ascertain if providers are meeting Federal and State requirements. Social services needs health's data on provider abuses in order to properly issue payments.

It was the legislature which created a system of 58 separate local social service commissioners and a similar number of local health commissioners who are appointed by and accountable to the local governing body even though their responsibilities all involve Federal and State statutes and regulations.

The local commissioners each run their own fiefdom and rarely can the State achieve any uniform system of accounting, record maintenance, or data retrieval. This has been a major problem in implementing any manual or computer data base on providers and patients—a key element in fraud abuse and detection.

It was the legislature which failed for 10 years to appropriate the moneys necessary to develop and implement a statewide Medicaid Management Information System (MMIS) and welfare payments systems despite the repeated clamorings of State, local, and Federal authorities and the availability of Federal financing of MMIS since 1973. The legislature did not appropriate the State share of MMIS development moneys until 1976. Federal financial participation for MMIS (90 percent development and 75 percent for operation) has been available since 1973 and the State itself has repeatedly estimated that the MMIS would save the fiscally troubled State $180 to $288 million per year.

It was the legislature which passed the legislation supported by the Rockefeller administration which has been characterized as the most liberal Medicaid eligibility and scope of coverage legislation in the Nation. This includes: addition of 15 "optional" types of medical services to Medicaid beyond the five federally mandated categories; virtually no limits, until July 1976, on the scope of coverage within each of the five mandated categories; addition of the "optional" Medicaid-only (MA-only) category for persons other than the mandated categories of persons eligible for Medicaid; establishing the most liberal "MA-only" eligibility income level in the Nation.

It was the legislature which in 1976 defeated a proposed amendment to the State's Public Health, Education, and Social Services Law which would have placed "Medicaid mills" under State and local regulation. The "mills" remain unregulated despite conservative estimates they account for an estimated $1 billion a year in fraud and abuse, over utilization, or unnecessary expenditures.

As one high-ranking State official advised the committee, all the aforementioned statutory restrictions "are expressions of legislative and executive preference and intent. . . . They are the proper province of the State's political decisionmakers."

The committee also notes that it was the executive branch, under Governor Nelson Rockefeller, and the legislature which refused health department requests for more staff for audits of Medicaid payments to nursing homes and hospitals for five successive years despite a

proven dollar return of $13 for every $1 expended. That refusal aided in perpetuating an annual loss of at least $14 million due to fraud and abuse by nursing home providers of Medicaid services.

STATE AND LOCAL AGENCIES HEALTH AND SOCIAL SERVICES

Although the legislature and executive must bear a significant responsibility for creating statutory provisions antithetical to fiscal integrity in the Medicaid program, the responsible State and local agencies have an abysmal record of administrative performance which cannot be excused merely by blaming statutory constraints.

The State health and social services agencies have continually agreed that one single State agency is a necessary prerequisite for effective Medicaid administration. However, each agency also has continually asserted that it alone should be the single State agency. *In every one of the 100 major reports reviewed by the staff where both health and State officials commented (including grand jury presentments), each blamed the other for lack of cooperation and coordination within the present system.* The result, as summarized by one State official, is that cooperation between the State agencies has been "negligible." The same philosophy and result has trickled down to the local level where local social service and health agencies pass the back of inefficiency to each other, to their respective State supervisory agencies, and the Federal government.

State and local agencies have failed to comply with a variety of Federal and State regulations:

1. *New York City, the largest locality (68 percent of all Statewide Medicaid expenditures), has neither a Medicaid provider nor a patient profile as required by State regulation.* Most of the remaining 57 localities also lack such profiles and there are no such profiles maintained by social services on a Statewide basis. HEW's Region II audit agency has developed initial patient and provider profiles for New York City in 2 months. The city Medicaid director's response was that he was "somewhat embarrassed" because neither the city nor the State had been able to produce such profiles "in over 7 years."

2. *The State has failed to comply with prompt and accurate submission of its fraud activity reports to HEW, as required by Federal regulation.* Social services must submit these reports, but claims it has lagged due to lack of uniformity in the submission of reports by the 58 localities. During 1975 New York State has .1 percent of all reported fraud cases nationwide while accounting for 23 percent of all Medicaid expenditures. This contrasts to California with 40 percent of all reported fraud cases and 13 percent of national Medicaid expenditures.

3. *The localities and the State have not effectively implemented the State's procedures on monitoring unacceptable provider practices and review of quality of care (items 34 and 35, State Medical Handbook).* The State health Department advised the committee staff that "provider fraud and abuse was known to exist but has received less than adequate attention" from its enforcement unit. Items 34 and 35 were not even issued until between 2 to 5 years *after* the State's Medicaid program was in operation.

HEW has cited New York as one of 45 States which do not have active antifraud programs.

4. *Neither New York City nor New York State even attempted to obtain statutory amendments or changes in administrative regulations to regulate "Medicaid mills" and prohibit percentage leasing until 1976, despite widespread knowledge that they are at the heart of Medicaid practitioner fraud and abuse.*

5. *The approximately 60 State-operated mental hygiene facilities and 10 drug rehabilitation facilities are not audited at all by social services or health even though they receive $500 million a year in Medicaid moneys.* One former high-ranking HEW and State official said "Social service has been giving mental hygiene $500 million (a year) in a paper bag and walking away."

Mental hygiene has virtually no internal audit program, having a staff of only four professionals—the staff is supposed to expand to thirteen in 1976. The State comptroller only audits these facilities on a "3-to-4-year cycle . . . due to budget limitations."

6. *New York City Health Department's Medicaid program has never had the proper quantity and quality of staff required for an effective enforcement program.* During the Medicaid program's first 5 years (1966–1971) the department paid out over $500 million without having a centralized enforcement unit.

The enforcement unit charged with the surveillance of a program with 36,000 practitioners servicing 1.5 million recipients at an annual cost of $600 million is composed of 3 attorneys, 2 field investigators (one shopper and a bodyguard) and a handful of desk auditors and support staff. There has never been more than one full-time attorney handling disciplinary actions—a situation which has created a severe backlog of cases and which is prime for corruption and injustice.

The committee staff believes the city health department's Medicaid enforcement unit requires a generic overhaul. A reasonable increase in staff is necessary, but this must be done by the hiring of attorneys and investigators who have appropriate training and experience. The committee staff recommends a staff of the calibre of the special State prosecutor for health and social services.

7. *New York City and other localities do not maintain the necessary records to properly verify provider payment claims in advance, to properly conduct utilization review, and to properly sustain administrative disciplinary actions and legal prosecutions.* The failure to maintain such records is a violation of State and Federal regulations. *The committee staff believes that this situation accounts for the city's historic record of few and lenient disciplinary actions (warnings, reprimands, and minor fines) and few, if any, successful criminal prosecutions of practitioners—only one successful conviction between 1966 and 1974.*

The committee staff notes that New York City's records are still maintained manually in virtually the same chaotic manner and in the very same warehouse which was sharply criticized in the 1969 Manhattan Grand Jury Report (see photo, p. 216.) There are virtually no records for the 5 years prior to 1971 and no use of microfilm or microfiche—two standard data storage and retrieval mechanisms.

8. *New York City and other localities do not pay providers "promptly", as suggested in State regulations.*

The delay in claims processing and payment has been the primary cause for the growth of "factors"—companies established to expedite

payment of bills to providers. At one time (1970) one factoring company in New York had 400 Medicaid practitioner accounts and an annual income of $12 million. "Factors" usually charge providers at a rate of 12 to 24 percent of the face value of their accounts receivable (or the equivalent of a 48 percent annual interest rate). The growth of "factors" and attendant costs is another incentive for providers to resort to fraud and abuse as a means to recoup the added overhead cost of a factor. In some cases the relationship is very direct with the same persons owning a factoring company and one or more "Medicaid mills." "Factors" circumvent existing State and Federal prohibitions by use of "power of attorney."

EDUCATION

The Department of Education's Office of Professional Conduct is responsible for licensing and monitoring the professional conduct of twelve different types of health professionals in New York State. The Committee staff found, by their own investigation as well as numerous prior studies, that education has done a wholly inadequate job, as evidenced by:

1. *Assigning an investigative staff of only 22 persons to the Office of Professional Conduct for monitoring of 12 health professions and ten nonhealth professions licensed by education.* In 1975, jurisdiction over monitoring physicians was transferred by the legislature, to a similar office in Health and is similarly understaffed.

2. *Not maintaining a list, by type of licensee, of all the cases of alleged misconduct and their disposition.* Education could not meet a committee staff request for such a list and, more particularly, for a complete list of cases involving Medicaid fraud and abuse. They have promised to have such an information retrieval system by January 1977.

3. *Receiving only 53 cases in the entire State of alleged professional misconduct between 1966–1976, while in New York City alone between 1972–1976 the Health Department suspended or disqualified 120 practitioners from Medicaid and referred 66 for criminal action.*

4. *Taking extremely lenient disciplinary action. Of the 53 cases, education took formal disciplinary action only in 10 percent of the cases (5 cases).*

In order to verify the historic record of inefficiency in the Office of Professional Conduct, the committee staff sent the office a list of 48 cases of Medicaid/Medicare fraud or abuse where either the NYC Health Department or Region II, Bureau of Health Care Insurance (Medicare), files indicated the provider had been subjected to either administrative or court-imposed penalties. *Education indicated that they had opened cases on only 42 percent (20 of 48) of the practitioners and "had no record of the other 28 names on the list." Of the 20 cases opened, 65 percent (13 of 20) are still pending and half have been pending since 1974 or earlier.*

Committee staff also found that since 1971, education had a formal policy approving percentage leases based on a percentage of a practitioner gross Medicaid income. The same policy permitted practitioners to have a financial interest in a percentage leasing facility. The percentage lease is the core economic incentive to the Medicaid mill industry.

On June 7, 1976, Senator Frank Moss wrote the Department of Education, the State medical and dental societies, and various local medical and dental societies suggesting that the department's policy was contributing to the proliferation "Medicaid mills," fraud and abuse. All the professional societies who responded to Senator Moss endorsed his position and simultaneously wrote letters to education. *By a letter of July 6, 1976, the education department advised Senator Moss that effective August 31, 1976, the department's rules were amended so as to rescind the policy and to define both practices as "unprofessional conduct."*

The committee staff believes this change in policy is long overdue and that it may provide the first major legal inroad against Medicaid mill operators, if properly communicated to and implemented by the appropriate State and local agencies.

LAW

The committee staff found that the State's attorney general and comptroller have taken a passive role in the monitoring of the Medicaid program to the detriment of the public interest.

The attorney general, the State's chief law enforcement officer, has taken the position that Medicaid prosecutions are the responsibility of local law enforcement agencies and State and local regulatory agencies. He claimed that he has no jurisdiction unless he receives a specific request from a State agency to initiate a criminal investigation or prosecution. *The committee staff finds that the attorney general's explanation is merely an excuse for avoiding jurisdiction and that there is ample precedent for the attorney general requesting the formal request letter authorizing his assumption of jurisdiction.*

The attorney general's failure to take such action is inexcusable in view of the 1969 Manhattan grand jury report and widespread publicity of Medicaid fraud and abuse. He had the legal power and obligation to immediately impanel a grand jury himself based on the 1969 report alone. The State's Special Prosecutor's Office for Health and Social Services was created in 1975 upon the Governor's request for a formal authorizing letter from the health department. The special prosecutor is housed within the attorney general's office and now has jurisdiction over institutional Medicaid providers (from health) and over proprietary homes for adults (from the State Board of Social Welfare). There is no reason why the attorney general could not have obtained the same authorization between 1966–1975.

The attorney general also has not taken an active role in coordinating legal staffs of health, social services, and education, to effectively deal with Medicaid problems. He let education's policy on percentage leasing stand for 5 years, and when he "found out about it" he "informed" education he thought it would contribute to fraud and abuse.

Both the attorney general and the comptroller advised committee staff that they did not initiate or support legislation or administrative regulations unless it deals directly with their respective department's "own powers and duties". *The committee staff believes this is an untenable position, particularly in the Medicaid field where many of the major impediments to curbing fraud and abuse have been inadequate statutory provisions and administrative regulations.*

AUDIT AND CONTROL

The committee staff believes the comptroller, the State's chief fiscal officer, has not sufficiently carried out his obligation to restrict and deny payments to the various localities and practitioners in the State while he has known they lack the necessary accounting records and verification documents required by law for authorization of Medicaid payments.

The comptroller has not actively endeavored to pressure State and local agencies to alter administrative practices which have been found responsible for improper payments upon threat of delayed or denied reimbursement. One reason may be the already heavy financial burden on localities in the State to finance Medicaid and the fear that vigorous monitoring and control of State reimbursement might result in Federal reimbursement denials with a serious threat to the fiscal existence of many localities.

The comptroller's approach appears to be one of maximizing revenues to the State and its localities which in Medicaid means ensuring Federal matching 50 percent reimbursement for equivalent State and local outlays. To highlight local errors would jeopardize the Federal moneys. The State's attitude may be the same as the provider who relies on the ongoing flood of Federal moneys to pay his costs, even if said costs are incurred by fraud, abuse, or error.

The committee staff suggested to the comptroller that given the massive amount of evidence of payments having been made to numerous specific practitioners without supportive verification documents, the comptroller should use his authority to force localities to withhold future payments to all such practitioners until the necessary missing documents were submitted and incomplete records clarified. Any locality failing to comply would be subject to reimbursement denial on the billings of the practitioners in question.

The comptroller asserted that he lacks the power to deny or withhold reimbursement "as a penalty for lack of an adequate administrative system." The committee staff reviewed 42 audits on Medicaid conducted by the comptroller between 1967–1976 and the provisions of the State constitution, executive law, finance law, social services law and rules and regulations for social services. Based on this review the committee staff concluded *the comptroller has the legal power and obligation to deny payment any time there is not adequate supportive verification of claimed expenditures.* Such inadequacies are in violation of State statute and social service regulations and constitute the "lack of an adequate administrative system."

In fact, in early July 1976, only three weeks prior to advising committee staff that he lacked such authority, the comptroller released an audit in which he recommended that the State Department of Social Services withhold reimbursements from New York City until the city "complies fully to reduce excess Medicaid costs," incurred due to payments to ineligible Medicaid clients.

The comptroller also admits that his followup on audit reports is limited. Of the 42 audits performed between 1967 and 1976 only one reported "followup" audit. As the comptroller says in his reply to the committee, "further action, action to correct managerial or programmatic shortcomings disclosed by the audit reports, is the responsibility of the officials who receive the reports." *The staff observes that*

as the State's chief fiscal watchdog the comptroller has the power and duty not only to detect shortcomings but to ensure that the agency at fault corrects those shortcomings by the necessary administrative, budgetary and, if necessary, legislative changes.

The committee notes that the failure of the comptroller to apply effective followup audits and restrict payments made without proper documentation is further accentuated by New York City's current "fiscal crisis." The comptroller's own special deputy comptroller for New York City affairs had repeatedly observed the continued loss of millions of dollars annually due to administrative failures in the city's Medicaid program. All of these failures are ones which have been noted in a variety of comptroller's and other reports over the last 10 years.

WELFARE INSPECTOR GENERAL

The committee has sponsored legislation to create a Welfare Inspector General at the Federal level. (S. 3205.)

However, New York State's Welfare Inspector General's (OWIG) functions do not parallel the committee's conception of an effective inspector general.

The New York OWIG office allocates most of its manpower and moneys to a high-paid executive staff which does systems analyses and to investigative staff whose primary purpose is to investigate complaints of fraud and abuse by individual public assistance clients and, where merited, refer cases to local district attorneys. As such, it clearly duplicates the work of similar staffs in local and State health and social service agencies. *The OWIG has no enforcement powers and expends little, if any, activity in Medicaid.*

The committee staff believes the New York OWIG is redundant and has long since served its initial function of calling public and governmental attention to the deficiencies of State and local agencies in the Medicaid and welfare field. *In view of the lack of centralized statewide Medicaid fraud unit, the committee staff believes the $1.5 million annually expended on OWIG would be more effectively utilized by creating a State unit for surveillance of noninstitutional Medicaid providers in the State department of social services.*

FEDERAL RESPONSIBILITY

The committee staff joins the U.S. General Accounting Office, Senator Herman Talmadge, and Representative L. H. Fountain and the House Government Operations Committee in their conclusion that HEW's efforts to eliminate fraud and abuse have been inadequate.

The creation of the 108-member Medicaid fraud unit and the expansion of the Office of Investigations are certainly welcome steps for which Secretary David Mathews should be credited. However, the staff believes that these actions fall short of the mark.

The massive nature of the fraud and abuse in Medicaid requires aggressive and continuous pressure against law breakers rather than the kind of "episodic" pressure applied by Federal "strike forces" which aids the States and then move on.

It is apparent that New York continues to be in violation of the provisions of section 280:40 of the Federal regulations with respect to precautions against fraud and abuse. Throughout 1975, New York

accounted for an average of one-tenth of 1 percent of all the pending Medicaid fraud cases submitted to the Department of Health, Education, and Welfare. This is totally inexcusable when the State receives 23 percent of all Medicaid funds. California, a State with roughly equally population, and receiving 13 percent of all Medicaid funds in the Nation, reported an average of 40 percent of all Medicaid fraud cases.

The committee staff believes that the central fraud and abuse unit and the provisions with respect to establishing the Office of Inspector General in the Department of Health, Education, and Welfare to coordinate the attack against fraud and abuse should be enacted immediately.

Fiscal Crisis

The city's "fiscal crisis" and need for Federal assistance was predicated on the revelation of a $1 billion budget deficit in early 1975. *The committee staff concludes from the data it has reviewed that if the city had taken reasonable steps against Medicaid system fraud and abuse, as suggested repeatedly over the last 10 years, the fiscal crisis could have been avoided.*

The committee staff observers that the current evaluations of the city's financial recovery plan and the operation of the city's health and social services, agencies, as cited in this section and sorts 3 and 4 of this report, still indicate the same pattern of administrative laxity which has resulted in this $1 billion loss.

There is ample evidence to indicate that one of the primary causes, if not the primary cause, of the State and city's fiscal crisis has been its mismanagement of the Medicaid program. The committee conservatively estimates that $444 million annually is lost in New York State due to ineligible Medicaid recipients and all categories of Medicaid provider fraud and abuse. This amount includes $295 million annually lost in New York City.

The committee staff has calculated that based on these conservative estimates alone, the city's share of moneys lost (because of Medicaid fraud, abuse, waste and inefficiency) is $74 million a year. This $74 million represents the city's 25 percent share of the Medicaid losses. The State, which also contributes 25 percent, lost $74 million. The remainder of the loss ($147 million) was incurred by the Federal Government which pays 50 percent of the Medicaid bill.

As noted, conservative estimates have been applied. One benchmark is HEW's estimate that fraud and abuse may constitute 8 percent of the entire program. However, most experts will agree that the degree of fraud and abuse in the Medicaid program in New York, particularly New York City, is a great deal higher than the national average. This has certainly been our experience. *Consequently, the application of slightly higher estimates supports the conclusion that Medicaid losses in New York City over the past 10 years probably equal the $1 billion deficit which brought New York City to the brink of bankruptcy.*

Part 7

RECOMMENDATIONS

TO THE CONGRESS

(1) The fraud and abuse provisions of S. 3205, including establishing the Office of Inspector General in the Department of Health, Education, and Welfare, should be enacted immediately.

(2) Legislation should be enacted barring fee splitting and rental based on a percent of gross (or net) income between practitioners working in shared health facilities.

(3) Legislation to bar factoring in Medicare or Medicaid should be enacted.

TO THE DEPARTMENT OF JUSTICE

Efforts should be intensified to review and process Medicare and Medicaid fraud cases as soon as possible. This will involve the greater commitment of time, money, and resources; in short, giving cases some sense of priority.

TO THE INTERNAL REVENUE SERVICE

The Service should intensify its audits of hospitals, nursing homes, and of practitioners receiving $100,000 a year or more from Medicare or Medicaid.

TO THE TREASURY DEPARTMENT

The Treasury should scrutinize present Federal loans extended to the city of New York carefully. The Treasury should suggest that Medicaid reform is synonymous with fiscal reform.

TO THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

(1) The Department should enforce existing regulations with respect to fraud and abuse and withhold funds from those States which are not in compliance with these standards.

(2) The Department should intensify not only its efforts to assist the States in identifying fraud but should proceed to direct Federal efforts as well.

(3) The Program Integrity Unit, in the Bureau of Health Insurance, should be expanded.

(4) The Department should place all possible priority on helping New York establish an effective MMIS system.

(5) The Department should fund the pilot project to test competitive bidding of clinical laboratory services in the State of New York.

NEW YORK STATE

LEGISLATURE

(1) That the existing office of special prosecutor for health and social services be made a permanent, ongoing office by legislation. The legislation should give the special prosecutor all the current powers he has as a deputy attorney general and legislatively expand his jurisdiction to include any government agency, individual, or institution receiving moneys under titles I, XIV, XVIII, XIX, or XX of the Social Security Act. The legislation should mandate full cooperation of all State agencies and authorize access to any necessary computer resources and records, including those of the State department of taxation and finance.

(2) That the legislature pass the proposed amendment to article 28 of the Public Health Law (and accompanying amendments to the education and social services laws) so as to place "Medicaid mills" under the same regulatory requirements as are currently applied to nursing homes, hospitals, clinics, and other health care facilities.

(3) That the legislature abolish the existing office of welfare inspector general and use the moneys and investigative personnel to fund a special unit in the State Department of Social Services to investigate Medicaid practitioner fraud and abuse.

(4) That the legislature enact legislation prohibiting medical professionals from entering into percentage leasing arrangements and prohibiting financial participation by medical professionals in any percentage leasing facilities. The recently amended regulations of the department of education on percentage leasing should be used as guidance in drafting the legislation.

(5) That the legislature review, with the department of health, the necessity of having such "optional" Medicaid financed medical services as podiatry and chiropody at all, or at their current levels.

(6) That the legislature review, with the department of health and division of the budget, the current Medicaid fee schedules and make appropriate adjustments to correct any existing inequities, particularly in dentistry.

(7) That the legislature review, with the departments of health and social services, the existing Medicaid-only income eligibility level and the nature of Medicaid financed health care services actually being used by the MA-only population. This review should be done on a cost-benefit basis, accounting for both the governments and the clients perspective, and recommend whether the MA-only category should be continued in New York and, if so, what "need" level should be used for eligibility.

(8) That the legislature amend the public health and education laws so as to streamline the current cumbersome and lengthy procedure for cases of alleged unprofessional conduct by medical professionals.

(9) That the legislature mandate data exchange on medical providers between the State departments of education, health, and social services, and between localities.

(10) That the legislature amend the public health and social services laws so as to make local commissioners appointees of the appropriate State agencies with specific minimum professional qualifications, to be developed by the respective State agencies and appropriate professional societies.

(11) *That health be made the single State agency responsible for Medicaid providers.* Section 364–a of the social services law should be revised to assign to social services the responsibility for Medicaid eligibility determination and all other aspects of responsibility for Medicaid clients. Health would be assigned all responsibility for claims processing and payments (now DSS functions) and the monitoring of provider fraud, abuse, and utilization review. Appropriate statutory changes should be made, approval obtained from HEW, and Civil Service should help expedite transfer of the persons involved in the payments process from the DSS to the health payrolls, at State and local levels, without any detriment to their job status.

AGENCIES

(1) That the departments of education, social services, and health, and the local agencies they "supervise," make a coordinated effort to implement education's new regulations prohibiting participation by medical professionals in percentage leasing arrangements or facilities.

(2) That the department of social services enforce its existing regulations requiring uniform accounting, record maintenance, and reporting procedures by localities, upon penalty of denying or withholding reimbursement.

(3) That the department of audit and control enforce the existing requirement of denying or withholding reimbursement to any local or State agency which does not have the supporting documentation necessary to verify Medicaid provider payment claims.

(4) That the State comptroller and attorney general take a more active role in safeguarding the public interest by overseeing the audit, cost control, and legal practices of all State agencies involved in the Medicaid and Medicare programs. That the city comptroller and corporation counsel take similar action as regards city agencies.

(5) That the State attorney general, U.S. Department of Justice, and HEW Counsel's office join the New York city corporation counsel, at least in an *amicus* capacity, in a concerted effort to reverse the court decision which has stayed implementation of the amendment to item 230 of the city's local medical plan.

(6) That New York City, and all other localities, be required to meet the existing requirements for patient and provider profiles and to do so by January 1, 1977. These profiles should be developed, as much as possible, in a uniform format so as to facilitate an integrated statewide profile system. The full resources of HEW and any other Federal or State agency with necessary computer resources should be made available. Any locality failing to meet the deadline should be subject to withholding of Federal and State reimbursement.

(7) That as soon as the patient and provider profiles are developed the localities should implement the use of a "monthly notice of services

rendered" to each Medicaid recipient. This notice should parallel the one currently in use by Medicare. Proposals for implementing such a system should be ready by January 1, 1977.

(8) That there be a generic overhaul of the office of professional conduct, both in education and health, with particular emphasis on increasing the quantity and quality of staff and implementing a data and record maintenance system which provides adequate storage and timely retrieval of information. This overhaul should be ready for presentation in the forthcoming budget proposals to the Governor and legislature.

(9) That there be a generic overhaul of the New York City Health Department's Medicaid program with an emphasis on increasing staff size and requiring a quality legal and investigatory staff similar to that of the State special prosecutor's office. This staff overhaul should be accompanied by new procedures for the commencement and conduct of disciplinary proceedings in the program which will result in effective discipline and in cases which will withstand court challenge. This overhaul proposal should have a firm, but reasonable, implementation date, and should be ready for presentation to, and be given priority by, the mayor's office and the emergency financial control board this fall.

(10) That there be a generic overhaul of the New York City Department of Social Services' Division of Medical Payments with an emphasis on decreasing the number of clerical staff and establishing either a microfilm, microfiche, or equivalent nonmanual data storage and retrieval system. This overhaul proposal should have a firm, but reasonable, schedule for implementation, and should be ready for presentation to, and be given priority by, the mayor's office and emergency financial control board this fall.

(11) That the State immediately initiate an intensive audit of the use of Medicaid moneys at State-operated mental hygiene and drug rehabilitation facilities. The Governor should take an active role in making available from existing State agencies the manpower necessary to accomplish this task, and should establish a schedule of deadlines for the completion of the facility audits. An ongoing annual audit requirement for these facilities must be mandated.

(12) That the New York City Department of Health mount an immediate and intensive investigation of fraud and abuse at "Medicaid" pharmacies with a focus on the "exclusive franchise" arrangements with Medicaid mills. These arrangements violate Federal "freedom of choice" regulations for the Medicaid program. If necessary, the mayor should facilitate the temporary assignment of personnel from other city agencies (and appropriate district attorney offices) to accomplish this task.

(13) That New York City adopt a pilot program of competitive bidding on clinical laboratory services for Medicaid providers. This pilot program would give a cost-benefit analysis of lab costs and provide guidance for any necessary legislative or administrative corrective action, including the possible adoption of a mandatory competitive bidding requirement. In an earlier report, the committee suggested that HEW fund such a pilot program, but HEW has not done so. HEW should fund a New York pilot program.

(14) That the health and social service departments effectively implement items 34 and 35 of the State medical handbook and meet the

Federal requirements for filing timely and accurate fraud activity reports. Any locality which does not cooperate should be subjected to denial or withholding of appropriate Medicaid moneys as provided by law. HEW should take similar action against the State if they continue not to meet these requirements (The State has failed to meet the Federal requirements since their initiation in 1973).

(15) That the Governor immediately initiate an investigation of the ownership interests and collateral entrepreneurs in "Medicaid mills" vis-a-vis financial interests, political influence, and unnecessary costs to the city. The investigative report should be presented to the Emergency financial control board, with recommendations for corrective action, by March 1977.

APPENDIXES

Appendix 1

LIST OF PHYSICIANS IN INDIVIDUAL PRACTICE WHO RECEIVED MORE THAN $100,000 FROM MEDICAID DURING CALENDAR YEAR 1974

(Source: Department of Health, Education, and Welfare, Social and Rehabilitation Service) [1]

Name and address	Amount paid by Medicaid	
	1974	1975
ALABAMA		
Carl E. Robinson, 1702 6th Ave., North, Bessemer 35020	$273,848.00	
ALASKA—None.		
ARIZONA—None.		
ARKANSAS—None.		
CALIFORNIA		
C. Dotson, Jr., 3756 Santa Rosalia Dr., Los Angeles 90008	348,387.35	
Morris Adkins, 5510 Duarte St., Los Angeles 90008	285,659.30	
Tucker S. Edward, 1635 E. 103d St., Los Angeles 90002	254,692.42	
Sumner Bohee, 5911 South Avalon Blvd., Los Angeles 90003	237,933.17	
Edward Holden, 8475 West Vanness Ave., Inglewood	220,204.81	
Emilio Marquez, 4055 Whittier Blvd., Los Angeles	210,401.77	
Joel Smietana, 1336 Whittier Blvd., Montebello	114,169.52	
Mayor De Lilly, 1336 West Whittier Blvd., Montebello	114,506.61	
Myron Nathan, Century Park, East 1402, Los Angeles	113,039.00	
Howard Ragland, East Vernon Ave., Los Angeles	112,816.39	
Nicholas Braemer, 3400 Lomita Blvd., STE 204, Torrence	110,495.82	
Edward C. Lampley, 9925 East 14th St., STE 1, Oakland	110,442.15	
Peter Niciforos, 11502 South Vermont Ave., Los Angeles	185,666.79	
H. B. Van Maren, 4025 Webster St., Oakland	222,612.22	
M. Hakhmimi, 1161 Logan St., Los Angeles	194,333.96	
Robert S. Haglund, 10723 Ramona Blvd., STE B, El Monte	171,475.85	
Joanne Ewing, 1581 W. Adams Blvd., Los Angeles	150,840.17	
Lloyd T. Hunter, Jr., 3750 Santa Rosalie Dr., Los Angeles	148,970.43	
Daniel Solomon, 12095 West Washington, Los Angeles	161,947.70	
Ribton Wade, 791 Orchard Ave., Coachella	140,795.32	
Willie Brown, 302 Fresno St., STE 105, Fresno	139,806.53	
Lee Lawrence, Jr., McArthur Blvd., Oakland	138,650.08	
Gilbert Landis, 267 East Slayson Ave., Huntington Park	136,027.52	
Milton Woods, 12006 South Avalon, Los Angeles	136,010.08	
Clarence Littlejohn, Santa Rosalia Dr., Los Angeles	134,130.09	
Chester Barnes, 1625 East 4th St., Los Angeles	132,215.21	
Julian Mittledorf, 650 South Hobson Way, STE 104, Oxnard	129,819.91	
Jerry Fox, 234 Baker St., Bakersfield	129,413.27	
Noli Zosa, 8337 Telegraph Rd., STE 123, Pico Rivera	128,054.05	
Fred Parrott, 575 East Hardy St., STE 224, Inglewood	126,351.77	
Noel Smith, 302 Fresno St., STE 106, Fresno	125,028.28	
Howard Daniel, 9953 McArthur Blvd., Oakland	125,097.47	
Leonard Harris, 113 Santa Barbara Plaza, Los Angeles	122,735.12	
Arnold Peterson, 625 East Century Blvd., STE 3, Lynwood	120,425.77	

[1] This list was requested by the news media and HEW/SRS was required to make it available under the terms of the Freedom of Information Act. As HEW's accompanying press release states: "The fact that these physicians received the stated amounts should not be construed as any evidence of wrongdoing, nor do the amounts listed necessarily represent "earnings" or "profits."

Name and address	Amount paid by Medicaid 1974	1975
Leon Banks, 1828 South Western Ave., Los Angeles	119,991.58	
I. Plank, 6425 Whittier Blvd., Los Angeles	119,979.58	
John Duff, 1617 Broadway, Vallejo	119,637.12	
Ronald A. Pitts, 1818 South Western Ave., STE 201, Los Angeles	117,237.86	
James Jackson, 5709 Market St., Oakland	117,008.52	
Frank Shear, Glendale Blvd., Los Angeles	110,232.55	
Henry Heins, Jr., 3756 Santa Rosalia Dr., Los Angeles	109,232.94	
Leland Fillerup, 771 Bushmann Rd., Paradise	108,946.60	
William Waters, 1650 Valencia St., San Francisco	107,421.50	
Benjamin Vines, 265 West Bonita Ave., Claremont	106,352.17	
Alfred L. Wical, 2717 East Glenoaks Blvd., Glendale	106,176.40	
Thurml Banks, 1532 Ocean Ave., San Francisco	105,483.47	
Lawrence McAlpine, 315 Cooper Rd., Oxnard	105,030.91	
John Thanos, 3760 Cooper Rd., Oxnard	105,030.91	
Joel Kowan, 4477 Whittier Blvd., Los Angeles	103,557.40	
Wilmer Buller, 2145 Niles St., Bakersfield	102,098.03	
Emil Martinez, 1150 North Havienda Blvd., La Puente	102,098.33	
Harold Watkins, 1635 East 103d St., Los Angeles	101,908.18	
Lester Nichols, 1220 East Ave., South Palmdale	101,286.56	
Mira Harrow, East Firestone Blvd., Los Angeles	101,095.41	
Marvin Goodwin, 9201 Sunset Blvd., Los Angeles	101,058.06	
Michael Abramson, 1650 Valencia St., San Francisco	101,055.25	
Accie Mitchell, 7301 South Western Ave., Los Angeles	100,521.25	
Sylvan Gross, 2700 East 14th St., Oakland	100,356.85	
Francisco Alvarez, 341 Paulin Ave., Calexicj	100,662.34	
COLORADO—None.		
CONNECTICUT—None.		
DELAWARE—None.		
DISTRICT OF COLUMBIA		
Eugean C. Vanhorn, 4650 Livingston Rd., SE., Washington, D.C	128,484.00	
Gideon M. Kioko, 665 E St., SW., Washington, D.C. 20024	114,494.00	
Fay B. Graves, 747 Alabama Ave., SE., Washington, D.C. 20032	286,668.00	
D. J. Sewell, 820 Quincy St., SW., Washington, D.C. 20011	109,337.00	
C. C. Edwards, 4256 East Capitol St., Washington, D.C. 20019	309,468.00	
Robert J. Sherman, 1835 I St., NW., Washington, D.C. 20006	101,486.00	
Robert T. Greenfield, 665 E. St., SW., Washington, D.C. 20024	145,572.00	
FLORIDA		
Dr. Rufus Thane, Milton	125,000.00	
Dr. Donald McClandaan, St. Petersburg	108,000.00	
Dr. Fred Pacheco, Miami	107,000.00	
Dr. Louis Gaeta, Miami	101,198.00	
GEORGIA		
Richard L. Hanberry, 657 Hemlock St., Macon 31201	152,517.00	
W. V. Gillikin, P.O. Box 68, Twin City 30471	144,144.00	
Armand Glassman, 1120 15th St., Augusta 30902	118,137.00	
Harry J. Portman, 118 East 34th St., Savannah 31401	116,207.00	
Hans A. Keuls, 723 East Forsyth St., Americus 31709	115,063.00	
Walter Carl Gordon, Jr., 401–A South Madison St., Albany 31701	103,139.00	
James S. Snow, P.O. Box 746, Darien 31305	100,103.00	
HAWAII		
Robert D. Edwards, P.O. Box 20C, Waianae	100,000.00	
IDAHO—None.		
ILLINOIS		
Arnold Bickham, 850 West 103d, Chicago	792,266.00	
Keith Knapp, 2957 South Wallace, Chicago	288,966.00	
Rodolfo Casaglang, 143 Broadway, Melrose Park	285,515.00	
Zeliha Bilsel, 4601 State St., East St. Louis	268,090.00	
Lepoida Jurado, 6032 South Halsted, Chicago	248,570.00	
Bilan Ghorbani, Skokie	242,768.00	
Dorothy Cooney, 2600 South Michigan, Chicago	226,014.00	
Regalado Florendo, 1321 West 87th, Chicago	219,037.00	
Jose A. Berrios, 6854 North Dowagia, Chicago	211,539.00	
Aaron Cahan, 4010 West Madison, Chicago	210,372.00	
Henry Pimentel, 6032 South Halstead, Chicago	191,399.00	
James Bransfield, Cabrini Hospital, Park Ridge	181,902.00	
William W. Adams, 4601 State St., East St. Louis	172,417.00	
Kenneth Weiss, 460 South Northwestern Hwy., Park Ridge	172,209.00	
Arturo Delreal, 1430 IL Astor, Chicago	166,204.00	
Diosdado Momongan, 1325 South Racine, Chicago	166,197.00	
Raul J. Lamas, Melrose Park	165,987.00	
R. Kanokvechayant, 18 West 022 Standish Lane, Villa Park	159,430.00	

Name and address	Amount paid by Medicaid 1974	1975
Ruix Charles, East St. Louis	159, 344. 00	
Richard Caleel, 1371 East 53d, Chicago	158, 951. 00	
Samuel Ezenwa, 3120 South State, East St. Louis	156, 906. 00	
William Cataldi, 3358 West 26th St., Chicago	156, 810. 00	
K. Vellody, Chicago	156, 461. 00	
Mary T. Sylora, 11654 South Longwood, Chicago	152, 529. 00	
Andres Botuyan, 804 North Central, Chicago	150, 003. 00	
Charles Sassoon, 5159 South Damen, Chicago	150, 003. 00	
Durand Leonard, Chicago	149, 576. 00	
Nathanial Cualoping, 1314 West Garlied Blvd., Chicago	149, 263. 00	
Jong H. Bek, 4800 Chicago Beach Dr., Chicago	145, 496. 00	
Renato Tanquillut, 1321 West 87th St., Chicago	145, 447. 00	
Usha Acharya, Morton Grove	145, 128. 00	
Gerald Kaplan, 700 North Michigan, Chicago	143, 237. 00	
Nader Bozorgi, 17 West Grand, Chicago	141, 758. 00	
R. M. Balas, 539 West North, Chicago	141, 165. 00	
Arnold H. Kaplan, 104 South Michigan, Chicago	141, 130. 00	
Procopis Yanong, Northbrook	140, 457. 00	
Nunilo Rubio, 3758 West Chicago Ave., Chicago	140, 330. 00	
Jose Rodriguez, 3724 West Chicago, Chicago	138, 382. 00	
Penchala Sompalli, 2720 West 15th, Chicago	137, 422. 00	
Percy Conrad May, Jr., 3857 West Washington, Chicago	136, 169. 00	
Arthur Savitt, 2218 South Michigan, Chicago	135, 595. 00	
Romeo Colino, 2777 Greenwood, Northbrook	135, 577. 00	
Ignacio Rodriguez, 1366 North Milwaukee, Chicago	134, 496. 00	
Erlindo Evaristo, 1133 West Lawrence, Chicago	134, 151. 00	
Luis A. Ortiz, 2945 North Sheridan, Chicago	133, 635. 00	
Edilberto, Nepomunceno, 4845 South Ellis, Chicago	133, 476. 00	
Edward, Charlip, 3604 West 16th, Chicago	133. 056. 00	
Swie Liang Tan, 1558 West 79th, Chicago	132, 370. 00	
Reyes Luis Perez, 566 Stratford, Chicago	131, 792. 00	
Robert Gloss, 15643 Lincoln, Harvey	131, 688. 00	
Manuel Triana, 1462 North Milwaukee, Chicago	131, 108. 00	
Lawrence Gluckman, 2407 West Warren, Chicago	129, 837. 00	
Neal A. Sperg, 2857 West Washington, Chicago	130, 306. 00	
Jose Calub, 2555 The Strand, Northbrook	129, 723. 00	
Alan P. Mintz, 580 Roger William, Highland Park	129, 026. 00	
Vladimir Skut, 6130 North Sheridan, Chicago	126, 313. 00	
Julian Q. Amado, Jr., 2332 Castillian, Northbrook	125. 285. 00	
Marlo Correa, 847 West Belmont, Chicago	124. 526. 00	
Ramon Cabrera, 2654 Kingston, Northbrook	123. 793. 00	
Clyde Henry, 515 East 47th St., or 3900 South State, Chicago	121, 144. 00	
T. R. Howard, 850 West 103rd, Chicago	121, 002. 00	
Victor Wong, 916 West Belmont, Chicago	120, 695. 00	
Chun Tong Chen, P.O. Box 2584, Chicago	120, 209. 00	
George P. Rowell, 9143 Bennett, Chicago	120, 044. 00	
Stuart Chesky, 153 West Lake, Bloomingdale	119, 977. 00	
Z. Esmail, 749 East 47th, Chicago	119, 080. 00	
E. M. Martin, 1522 West Chicago Ave., Chicago	117, 220. 00	
Alfredo Ramirez, 1200 Sunset, Winnetka	116, 948. 00	
Supachai Pongched, P.O. Box 2584, Chicago	116, 717. 00	
Leon H. Reed, 4625 Lindell, St. Louis	116, 532. 00	
Francis E. Bihss, 4601 State, East St. Louis	115, 485. 00	
Beri A. Gueyikian, P.O. Box 48023 and 48061, Niles	115, 073. 00	
Jacinto Lam, 480 Central, Northfield	114, 880. 00	
Shoh-Kai Tan, 1525 East 53d, Chicago	114. 294. 00	
Ippu Fukuda, 317 Willow Crest, Villa Park	113, 958. 00	
Wesley Tabayonyong, 1301 West 22d, Brook	113, 779. 00	
Canaan Yunez, 916 West Belmont, Chicago	113, 617. 00	
Yilmaz Bilsel, 4061 State St., East St. Louis	112, 565. 00	
Renato Alcaraz, 738 West 79th, Chicago	111, 831. 00	
Robert R. Roth, Zion Benton Hospital, Zion	111, 628. 00	
Hector Tobon, 1557 North Milwaukee, Chicago	111, 251. 00	
Frank Boon, 1301 North Ashland, Chicago	110, 988. 00	
Bahram Sadeghieh, 2909 Av. Loire, Oak Brook	110, 462. 00	
Isadore Gun, 2748 West North, Chicago	110, 287. 00	
John W. Jackson, 1509 Bond, East St. Louis	110, 072. 00	
Earley Butler, Jr., 4135 South Cregier, Chicago	110, 032. 00	
Rafaela M. Ulrich, 6135 North Drake, Chicago	109, 092. 00	
Gloria B. Jackson, 13220 South Ellis, Cnicago	108, 656. 00	
Francisco Fernandez, 3800 Waverly, East St. Louis	108, 547. 00	
Marcos Soriano, 1950 Milwaukee, Chicago	108, 294. 00	
Fritz R. Michel, 122 West 95th, Chicago	108, 012. 00	
Anthony F. Yipp, 122 North York, suite 107, Elmhurst	107, 433. 00	
Alan Cadkin, 480 Central, Northfield	107, 342. 00	
Robert Bloomgarden, 1105 North Clark, Chicago	107, 262. 00	
Morten B. Andelman, 4751 Touhy Ave., Lincolnwood	106, 242. 00	
Alfonso Del Granado, 1301 West 22d, Oak Brook	105, 835. 00	
Leo G. Pepa, P.O. Box 17519, Chicago	105, 826. 00	
Irene Panayotou, 4940 North Lincoln, Chicago	104, 414. 00	
Zbigniew Dziedziech, 335 East 51st, Chicago	104, 376. 00	
Nadhum Shashoua, 3712 West Roosevelt Rd., Chicago	102, 999. 00	
Juvenal Argaiz, 4420 West Lunt, Lincolnwood	102, 907. 00	
Myriam Wilson, 101 West 111th, Chicago	101, 702. 00	

Name and address	Amount paid by Medicaid 1974	1975
Morton Miller, 3857 West Washington Blvd., Chicago	101,584.00	
Carlos Zalduendo, 5520 West Touhy Ave., P.O. 794, Skokie	101,534.00	
Harold Katzen, 1525 East 53d, Chicago	101,470.00	
Cornelio Ang, 904 West Belmont, Chicago	100,856.00	
Samy W. Ghali, 8447 South Racine, Chicago	100,579.00	
Rodolfo D. Bernal, 4708 West Addison, Chicago	100,428.00	
INDIANA		
David Chube, 1649 Broadway, Gary	210,195.00	$255,358.00
Ben F. Grant, X Assoc. I, 1706 Broadway, Gary	101,599.00	
Theodore Espy, Gary		108,821.00
IOWA—None.		
KANSAS—None.		
KENTUCKY—None.		
LOUISIANA		
Forest M. Terral	159,950.00	
Charles Fontenot	127,511.00	
Odell Dean	126,511.00	
John Coats	121,010.00	
Albert Shiu	116,842.00	
James Moorman	113,669.00	
Ernest Cherrie	113,015.00	
MAINE—None.		
MARYLAND—None.		
MASSACHUSETTS		
Kabrosky, 2595 Main St., Springfield	105,252.00	
Walther Tayber	104,000.00	
MICHIGAN		
H. Parameswarappa, Westminister Medical Clinic P.D., 19431 Van Dyke, Detroit 48234	214,597.72	
Sanford Polansky, 89 West Main St., Benton Harbor 49022	166,876.49	
Aldrich M. Brooks, 17376 West Land Dr., Southfield 48075	121,945.94	
J. Peter Johnson, Wm. Beaumont Hospital Royal Oaks, 3601 West 13 Mile Rd., Royal Oaks 48072	121,442.51	
James P. Kitsos, Neighborhood Medical Clinic, 6303 Mack, Detroit 48207	115,244.12	
Edith J. Lee, 150 Massachusetts, Highland Park	100,154.00	
James Swad, 3558 Conner St., Detroit 48215	267,381.92	
Clarence B. Williams, McClelland Street Clinic, 302 East McClelland St., Flint 48505	229,090.92	
Marvin Goldberg, 16070 Sherfield, Southfield 48076	214,480.60	
Bernard S. Arden, Arden Clinic P.C., 3434 Michigan Ave., Detroit 48216	160,160.25	
Louis Amalfitano, Suite 404, 13700 Woodward, Highland Park 48203	121,985.24	
Allan M. Ebert, Beecher Clinic P.C., G-6061 North Saginaw St., Mt. Morris 48458	112,065.66	
John W. Thompson, 11751 Grand River, Detroit 48204	111,057.43	
Ralph G. Sachs, 701 Medical Arts Bldg., 13700 Woodward, Highland Park 48203	109,599.43	
Dudley W. Goefz, 14200 Puritan, Detroit 48277	104,002.30	
MINNESOTA—None.		
MISSISSIPPI		
Robert C. Tibbs II, Hospital Dr., Cleveland 38732	175,172,00	
J. E. Warrington, Shelby Clinic, Shelby 38774	167,946.00	
John G. Downer, 110 Tchula St., Lexington 39095	133,274.00	
Travis Q. Richardson, 181 West Park Ave., Drew 38737	133,274.00	
Julius L. Levy, 270 Yazoo Ave., Clarksdale 38614	126,584.00	
A. E. Wood, Jr., P.O. Box 549, Belzoni 39038	123,238.00	
Leroy Howell, Hospital Dr., Starkville 39759	114,880.00	
J. Ed Hill, 301 East Ave., North, Hollandale 38748	106,559.00	
MISSOURI—None.		
MONTANA—None.		
NEBRASKA—None.		
NEVADA—None.		
NEW HAMPSHIRE—None.		
NEW JERSEY		
E. Garcia, 321 30th, Union City	135,791.00	
B. B. Kaplan, 1815 Kennedy Blvd., Jersey City	116,971.00	
V. H. Kaji, suite C 304 Medical Arts Bldg., 433 Belevue Ave., Trenton	121,886.00	

Name and address	Amount paid by Medicaid 1974	1975
B. Greenspan, 85 Presidential Blvd., Paterson	109,540.00	
J. Rodriguez, 91 Main St., Paterson	117,319.00	
S. Cocoziello, 661 14th Ave., Paterson	140,181.00	
N. A. Shinefeld, 765 Broadway, Paterson	157,464.00	
R.A. Zevin, 50 Ball St., Irvington	122,847.00	
E.D. Brodsky, 2829 Atlantic Ave., Atlantic City	186,863.00	
J. Goldstein, 506 Broadway, Campden	150,160.00	
M. S. Schulman, 309 Marlton Ave., Campden	106,124.00	
E. A. Capriola, 195 Central Ave., Newark	247,302.00	
F. Sesin, 225 60th St., West New York	115,911.00	
NEW MEXICO		
Daniel M. Enneking (now deceased)	111,807.00	
NORTH CAROLINA—None.		
NEW YORK		
William Triebel, 2 West 116th St., New York 10021	451,156.00	785,114.08
Eugene Silbermann, 1650 Madison Ave. New York, 11029	200,195.00	604,045.60
Mora Arnoldo, 1230 Park Ave., New York 10028	258,850.00	560,409.06
Arthur Zaks, 136–80 Roosevelt Ave., Flushing 11354	246,078.00	499,546.80
Norman Dinhofer, 255 Eastern Pkyw., Brooklyn 11238	210,456.00	404,402.32
Eugene Schupak, 29–14 Northern Blvd., Long Island City 11101	373,223.00	364,867.13
Allan Hausknecht, 301 West 37th St., New York 10018	281,824.00	350,911.40
Jaime Titievsky, 255 Third Ave., New York 10010	209,872.00	305,101.60
Sylvan L. Sacolick, 150 East 69th St., New York 10021	200,879.00	305,594.00
Hans Wehrweim, 1011 Lexington Ave., New York 10021	212,742.00	291,260.72
Joseph G. Falk, 25 Lenox Ave., New York	158,624.00	290,088.55
Oscar Burgos, 520 East 72nd St., New York 10021	136,213.00	255,492.47
Robert Soberman, 376 East Gun Hill Rd., Bronx 10467	191,068.00	246,090.59
Melvin Moore, 7815 Bay Pkwy., Brooklyn 11214	118,955.00	224,984.82
Ronald Brady, 41 21 27th St., Long Island City	102,946.60	215,712.60
Conrado Cuadras, 2 West 87th St., New York	116,402.00	208,338.16
Marendra Kumar Khurana, 1569 Metropolitan Ave., Bronx 10462		183,648.22
Elias Oweis, 34 Fletcher Ave., Valley Stream 11580	103,343.00	173,588.43
Mohamad Keshavarz-Arshadi, 422 Clifton Ave., Staten Island 10305		173,149.42
Sidney Hendler, 1880 Ocean Ave., Brooklyn 11230	108,254.00	162,755.63
Ernest Melton, 1880 Ocean Ave., Brooklyn 11230		156,322.16
Jose Rivero, 1882 Grand Concourse, Bronx 10457		154,504.95
Leon Nichols, Jr., 720 Pelham Rd., New Rochelle 10804		153,876.90
Norman Marine, 250 East 87th St.–16A, New York 10028		153,334.73
Sol Feigman, 178 2d Ave., New York 10003	173,908.00	152,742.30
San Subias, 39–11 104th St., Corona 11368		151,651.09
Romeo Samonte, 32 Gilbert Ave., Paramus 07652	132,833.00	149,736.41
Ilene Coopersmith, 5103 Surf Ave., Brooklyn 11224		142,750.95
Massimo Degiarde, 226 Lafayette St., New York, 10012		142,040.94
Frantz Gibbs, 61–15 98th St.—3D, Rego Park 11374		141,281.32
David Gordon, 29 North Dr., Great Neck 11021		139,291.34
Leonor Samano, 11035 Saultell Ave., New York 11368		137,481.71
Alan Kay, 301 East 69th St., New York 10021	146,372.00	136,230.67
Clyde H. Weissbart, 145 East 116th St., New York 11029	105,154.00	136,225.25
Uthai Malakorn, 2 Tufts Court, Paramus, N.J. 07652	137,901.00	136,188.51
Philip H. Friedman, 1430 East 22d St., Brooklyn 11210	165,885.00	134,544.99
Barry Rudin, 630 3d Ave., 5th floor, New York 10017	138,119.00	133,096.89
Juanito Pung, 61 Manorhaven Blvd., Port Washington 11050		132,296.61
Joseph Giummo, 370 9th St., Brooklyn 11215		132,274.45
Arie Liebeskind, 1450 Broadway, 6th floor, New York 10018	117,768.00	132,207.40
Gary Lazachek, 14 Grove St., New York 10014		131,955.70
Alma Tosca Blitz, 63 Avenue A, New York 10009		131,946.56
Parviz Naysan, 14 Pine Dr., Great Neck 11021	112,082.00	131,812.05
Jason Robert, 410 Central Park West, New York 10025		131,792.45
Jae Kyung Kim, 48 Ardell Rd., Bronxville 10708		131,551.44
Petar Jovanovic, 4465 Douglas Ave., Bronx 10471		127,329.49
Thomas Jorge, 70–12 Harrow St., Forest Hills 11375		126,746.50
Dudley Leibowitz, 1465 Myrtle Ave., Brooklyn 11221		126,679.21
Paul Slater, 562 East 9th St., Brooklyn 11218		124,155.57
Sharod Regay, 907 St. Marks Ave., Brooklyn 11213	127,905.00	123,953.97
Tesse Stark, 736 Kelly St., Bronx 10455		123,662.47
Metarda F. Slominska, 4455 Douglas Ave., Bronx 11271	101,539.00	122,315.10
Paul Fuchs, 7–15 162d St., Whitestone 11357		121,381.83
Allan Kaiser, 1740 Ocean Ave., Brooklyn 11230		120,647.57
Mukund Nody, 516 Pennsylvania Ave., Brooklyn 11207		120,141.85
Philip C. Suriano, 2157 Tomlinson Ave., Bronx 10461		119,828.20
Hugo Bejar, 493 East 138th St., Bronx 10954		119,458.70
Samarn Sarabanchong, 639 Albany Ave., apartment 5J, Brooklyn 11203		119,011.69
Donald Labrecque, 336 East Shore Dr., Massap 11758		118,125.70
Jiunn-Bor Hwang, 3990 Bronx Blvd., 6J, Bronx 10466		117,814.94
Ashfaq Ahmed, 168–11 Gothic Dr., Jamaica 11432		117,751.18
Richard Dankner, 75–55 189th St., Flushing 11366		116,248.77
R. Herszkowicz, 200 Winston Dr., 2812 Cliffside Park, N.J. 07010		115,728.76
Mahmood Karimi, 89–26 205th St., Hollis 11423		115,187.75
Gerald Levinson, 2917 Mott Ave., Far Rockaway 11691	104 799.00	115,082.43

Name and address	Amount paid by Medicaid 1974	1975
Aspet Haruthunian, 27 Kenwood Dr., New Rochelle 10804		114,925.12
Quirino Dizon, 881 Prospect Ave., Bronx 10459		114,759.88
Siegfried Mayer, 1882 Grand Concourse, New York 10457		113,360.84
Arthur Weinberg, 999 Central Ave., Woodmere 11598		112,227.81
Herbert Berger, 740 East 6th St., New York 10009		111,354.88
Edwin A. Mathias, 79 West 125th St., New York 10027		111,125.39
Diosdado Dipasupil, 1450 Broadway, 6th floor, New York 10018	120,697.00	111,103.33
Marius Costin, 101-10 70th Ave., Forest Hills 11375		110,781.98
Doreen S. Polak Liebeskind, 2621 Palisade Ave., Bronx 10463		110,360.74
Mauricio Videgain, 94-11 59th Ave., Elmhurst 11373	103,330.00	110,240.33
Jan Kosmowski, 100 Pennsylvania, Brooklyn 11207		110,125.86
Cheng Wang, 27 Oliver St., New York 10038		109,945.18
Kumar K. Mecherimadom, 29 Chestnut Rd., Manhasset 10030		109,939.53
Dilip Mukhiyar, 85 Hampton Oval, New Rochelle 10805		109,894.98
Harold Rosenberg, 46 Hampton Rd., Scarsdale 10583		108,939.30
Stuart Sheinbrot, 40 Clinton St., Brooklyn 11201		108,317.57
Neville Anthony, 855 Pepperidge Rd., Westbury 11590		108,312.48
Juana Toporovsky, 2 Vista Lane, Scarsdale 10583		108,291.33
Eduardo Zlolaover, 100 Olive Lane, Manhasset 11040		107,726.18
Antonio Bambina, 796A Drew St., Brooklyn 11208		106,939.30
Hae Ja Yoon, 159 Rockaway Ave., Garden City, 11530		106,902.86
Iraj Bassaly, 115-25 Metropolitan Ave., Kew Garden 11418		106,584.12
Emma Florez, 1572 East 174th St., Bronx 10472		106,234.94
Yumei Fan, 162-39 13th Ave., Whitestone 11357		106,126.25
Suryaprakasa D. Rao, 141-14 56th Ave., Flushing 11355		104,821.55
Dennis May, 361 Broadway, Brooklyn 11211		103,820.39
Gilbert Handal, 1203 Albemarle Rd., Brooklyn 11218		103,640.77
Aftab A. Siddiqui, 1 Liberty St., J1, Little Ferry, N.J. 07643		103,494.90
Romula Orgue, 46 Lincoln Rd., Scarsdale 10583		103,085.43
Francisc Delara, 1525 Pitkin Ave., Brooklyn 11212		102,783.62
Habibolf Ghatan, 8533 Avenue B, Brooklyn 11236		102,649.80
Henry Schechter, 3777 Independence Ave., Bronx 10463		102,643.15
Baldo Bertocchi, 442 Bay Ridge Pkwy., Brooklyn 11209	182,735.00	102,575.72
Ezra Cohen, 2307 Avenue M, Brooklyn 11210		102,472.42
Augusto G. Lizarazo, P.O. Box 465 Flushing Station, Flushing 11352		102,292.01
Salim Sadka, 50-41 Oceania St., Bayside 11364		101,748.31
S. Shafi Ahmad Bezar, 61-15 97th St., Apartment 1K, Flushing 11374		101,380.93
Victoria Toma, 560 Melrose Ave., Bronx 10455		101,119.15
Ebrahim Abtahian, 86-15 Ava Place, Apartment 3H, Jamaica 11432		100,699.99
Douglas Sinensky, 12 Sycamore Rd., Scarsdale 10583		100,640.63
Enrique Davis, 25 Frederick Place, Mount Vernon 10552		100,320.11
Roberto Rivera, 78-17 21st Ave., Jackson Heights 11370		100,067.65
Hamid Alizadeh, 116A Lee Ave., Brooklyn 11211		100,061.05
OHIO		
Louis E. Hammond, 11201 Shaker Blvd., Cleveland 44104	111,311.00	
Octubre Reyes, Mount Sinai Hospital Emergency, 1800 East 105th, Cleveland 44106	112,007.00	
Caridad C. Agdinaday, 13944 Euclid Ave., East Cleveland 44112	246,640.00	
Lolita Rodriguez Agra, Cedar Medical Clinic, 7818 Cedar Rd., Cleveland 44103	111,952.00	
Bertold J. Pembaur, 430 Rockdale, Cincinnati 45229	133,689.00	
David Wallace, 13944 Euclid Ave., East Cleveland	127,890.00	
OKLAHOMA		
Holt C. Sanders, 909 East 36th Street, north Tulsa 74106	100,261.00	
OREGON—None.		
PENNSYLVANIA		
Edgar Escobar, P.O. Box 5091, Philadelphia		148,639.00
Martin T. Garfinkle, D.O., 55th St. and Greenway, Philadelphia	156,345.00	263,744.00
Robert Kaplan, D.O., 1601 West Columbia Ave., Philadelphia		130,878.00
Morris J. Kniazer, 201 Radburn St., Philadelphia		102,138.00
Morris J. Kniazer (other addresses), 6900 Rising Sun Ave., Philadelphia, and R.D. No 1, Hildebidle Road, Collegeville		
John C. Kalata, 404 East 8th St., Erie	126,894.00	
Jerry London, 4600 Cottman Ave., Philadelphia 19135	126,103.00	
Natan Blinn, 1345 Susquehanna Ave., Philadelphia 19122	114,355.00	
Jack Silver, Croydon 19020	100,682.00	
PUERTO RICO—None.		
RHODE ISLAND—None.		
SOUTH CAROLINA		
H. B. Rutherford, Jr	155,045.00	
SOUTH DAKOTA—None.		
TENNESSEE—None.		

Name and address	Amount paid by Medicaid 1974	1975
TEXAS		
Damaso A. Oliva, P.O. Box 13176, San Antonio	215,185.00	
J. B. Coleman, 5445 Almeda, Houston	169,121.00	
E. J. Mason, 2516 Forest Ave, Dallas	152,446.00	
M. L. Coleman, 1711 North Garrett, Dallas	151,003.00	
Garcia-Romey, 112 Cotillion, San Antonio	147,447.00	
Pierre G. Craig, 1429 Forest, Dallas	142,974.00	
N. H. Wolff, 6601 Laura Koppe, Houston	139,650.00	
Carlos F. Rocha, 1110 El Paso St., San Antonio	138,704.00	
Alfred R. Louis, 8109 Cullen Blvd., No. E, Houston	135,948.00	
Francis J. Rodriguez, 311 Camden, San Antonio	134,202.00	
Hugo E. Muzza, 4006 Nogalitos, San Antonio	131,174.00	
Jose J. Gamboa, 6315 South Zarzarmora, No. A, San Antonio	127,701.00	
Alvin Thaggard, Jr., 120 Medical Professional Bldg., San Antonio	119,180.00	
Frank W. Thompson, 307 Dallas North Shopping Center, Dallas	118,348.00	
Enrique Velez, 934 Patricia, San Antonio	118,268.00	
James C. Watson, 8803 Scott, Houston	115,156.00	
Eduardo, 730 North Main, No. 52, San Antonio	114,345.00	
Antonio Cavazos, 343 West Houston, No. 312, San Antonio	112,840.00	
Christi L. Saller, 4407 Yoakum, Houston	111,716.00	
Antonio Garcia, 2000 Crawford, No. 11, Houston	110,620.00	
Richard L. Garcia, 311 Camden, San Antonio	106,546.00	
Eugene W. Dorsey, 2524 Forest, Dallas	108,019.00	
J. Hadnott, 710 Augusta, San Antonio	106,546.00	
R. L. Hilliard, 710 Augusta, San Antonio	106,417.00	
Hector X. Samaniego, 1723 Buena Vista, San Antonio	104,122.00	
Marcel Molina, 8830 Long Point, Houston	102,656.00	
Guillermo Marcos, 102 Congress St., San Antonio	102,101.00	
Herbert J. Robinson, 2201 Main, Dallas	101,971.00	
UTAH—None.		
VERMONT—None.		
VIRGINIA		
Theodore Keats, University of Virginia Hospital, Charlottsville	122,675.00	
Dr. Ben Steingold, Norfolk	100,447.00	
WASHINGTON		
Jerry Williams, 7411 27th West St., Takoma	102,058.00	
WEST VIRGINIA—None.		
WISCONSIN		
Milton F. Gutglass, 1218 West Kilbourn, Suite 404, Milwaukee	102,353.00	
William E. Finlayson, 2411 West Capitol Dr., Milwaukee	153,157.00	
Chris Christopher, 950 North 35th St., Milwaukee	287,843.00	275,000.00
WYOMING—None.		

Appendix 2

LETTERS TO PRESENT AND PAST NEW YORK PUBLIC OFFICIALS, FROM SENATOR FRANK E. MOSS, CHAIRMAN OF THE SUBCOMMITTEE ON LONG-TERM CARE, AND REPLIES RECEIVED

ITEM 1. LETTER TO ARTHUR LEVITT, COMPTROLLER, STATE OF NEW YORK, AND REPLIES

JUNE 17, 1976.

DEAR MR. LEVITT: Our committee is currently reviewing the operation of the Medicaid program in several States including New York. We are particularly concerned about the program's status in New York because your State represents a large portion of total Medicaid expenditures in the Nation. Additionally, we are concerned because a number of studies and reports have come to our attention documenting program deficiencies continuing over the past 10 years.

We realize that some of the very best reports in this respect are audits you have conducted on various phases of the Medicaid program. However, in view of the protracted nature of the problems and violations of specific laws and regulations:

(1) Why have you not specifically withheld reimbursement from localities which fail to maintain proper administrative controls as required under State statutes? For instance, failure to have "patient" and "provider" profiles and to have an adequate record maintenance and retrieval system so as to be able to verify the delivery of services and to take disciplinary action against providers who abuse the system.

(2) Why haven't you urged specific legislative amendments to section 364–a of the Social Services Law so as to create the truly streamlined single State agency your audit and others have shown is necessary to properly administer Medicaid?

(3) Why have you conducted so few audits (i.e., once every 3–4 years/facility) of Medicaid monies utilized by the State's Department of Mental Hygiene and office of Drug Abuse Services, particularly the Medicaid per diem rate (i.e., verification of cost reports)?

(4) Why are there no procedures for auditing fiscal operators at private psychiatric hospitals? Shouldn't you seek corrective legislation.

(5) Why doesn't Mental Hygiene have its own internal audit program or, in the alternative, why aren't its facilities processed under the Medicaid auditing program for health care facilities operated by the Department of Health?

(6) While we realize the bulk of the State's Medicaid monies recipients are in New York City, why have you conducted so few Medicaid audits in the other local social service districts?

(7) Do you believe it makes sense to spend $1.5 million a year on the office of Welfare Inspector General when that office has no enforcement power? Isn't it duplicative of the work of your agency and Health, and Social Services in Medicaid auditing? Might not the money be better spent for a centralized Medicaid fraud and abuse control unit?

(8) How can you continue to reimburse New York City when it currently maintains three different Medicaid payments systems and persists in having the same basic administrative deficiencies as noted over the last 7 years by your agency?

(9) When was the last time you audited the Medicaid supervisory program of the Department of Health's regional and district offices?

(10) What suggestions do you have for improving the operation of the Medicaid program? Have you considered contracting out the State's Medicaid payment and monitoring responsibilities to a private firm?

(11) As Comptroller, why didn't you back on a cost-benefit basis the various requests of the State Health Department for more auditors from 1966–1975? Why did it take the "nursing home crisis" of 1974 to get such action? We have been able to find no record of your urging the Budget Division, Governor's office or Legislature to take such action?

(12) How can you allow the State Department of Social Services to pay Medicaid monies when it has no centralized Medical payments system, provider profile, patient profile, or uniform reporting requirements enforced on localities?

(13) What did your agency do regarding its responsibilities under the Medicaid program. Particularly as it relates to individual providers, upon receipt in 1972 a copy of the "Report of the Fourth November 1969 Grand Jury on the Administration of Medicaid in the City of New York" (Copy as same and letter of transmittal to Mr. Arthur Gordon attached).

We would appreciate the courtesy of your specific responses to these questions at your earliest possible convenience.

With best wishes,

Sincerely,

FRANK E. MOSS,
Chairman, Subcommittee on Long-Term Care.

[Replies]

JUNE 28, 1976.

DEAR SENATOR MOSS: This is in response to your letter of June 17 asking 13 questions about administration of the Medicaid program in New York State.

Before answering the individual questions, I ask your indulgence for a few general observations. Many of the questions appear to assume that I have the authority and responsibility, not only to audit State and local government operations, but also to obtain correction of any legislative or administrative deficiencies disclosed by the audits. That is a fundamental misconception of my role in the State government.

That role, while very broad, is nonetheless limited. With respect to most programs, including Medicaid, it includes both pre-audit approval (or disapproval) of individual vouchers and post-audit review

of program operations. It is the latter to which your inquiries relate. As developed in this State and by the General Accounting Office, post-audits not only determine whether State payments are being made in violation of statutes or regulations, but also, and often more significantly, provide the Executive and the Legislature with an independent appraisal of the effectiveness with which programs are being conducted. Accordingly, my audit reports always contain findings and recommendations and are transmitted to the Governor, legislative leaders, and appropriate agency and municipal officials. It is important to bear in mind that further action, action to correct managerial or programmatic shortcomings disclosed by the audit reports, is the responsibility of the officials who receive the reports. Except with respect to payments which are made in violation of law and thus warrant specific disallowance or adjustment, neither the Constitution nor the statutes of the State vest me with power to require state agencies or local governments to revise their administrative procedures or to punish them for failure to do so.

Nonetheless, while an audit program is but one part of Medicaid or any other governmental operation, I am proud of what we have accomplished. The second paragraph of your letter acknowledges the quality of our reports on Medicaid. The quantity is also significant. In view of the large amounts of money flowing into Medicaid and public assistance operations, we have for many years programmed the maximum audit resources possible into these areas. Enclosed is a partial list of forty-two reports dealing with Medicaid problems; it does not include the many county audits which report on operations of social service districts outside New York City.

Responses to your specific questions, numbered to correspond to them, follow:

(1) We do deny requested reimbursement to local governments for any items we identify which reflect violations of statutes or regulations. In some cases we are also able to estimate the monthly amount of similar items and withhold such amount from monthly reimbursement payments shown that the illegal practices have been discontinued. To deny all reimbursement or an arbitrary part of it as a penalty for lack of an adequate administrative system, however, would be questionable in the absence of specific legislative authority or guidelines and could impair provision of necessary medical services to needy persons genuinely entitled to them.

(2) There are two aspects to proposals for a "truly streamlined" single State agency to properly administer Medicaid. First, there is need for a statewide information and payments system to supersede the separate and uncoordinated systems operated by the fifty-eight social service districts. Secondly, there is a case for combining the Medicaid responsibilities of the Department of Social Services (for determination of eligibility and payment) with those of the Department of Health (for setting rates to be paid to providers). A bill to accomplish the first purpose (A. 12234) has been pending in the Legislature and has the Governor's support; a copy is enclosed. The second purpose is evidently what you had in mind in proposing amendments to Section 364–a of the Social Services Law. That purpose is more debatable and its achievement more complex than might appear or than could be effected by amendment of that section. In sponsoring

legislation this Department generally confines itself to matters directly affecting its own powers and duties. Were we to draft legislation relating to all areas we audit, we would be undertaking responsibilities charged to all other State agencies and would be forced to subordinate performance of our own primary responsibilities.

(3) Budget limitations preclude audits of State institutions and facilities, including those which use Medicaid moneys, more frequently than on a three-to-four-year cycle. The Division of the Budget in the Governor's Office has responsibility for reviewing the per diem Medicaid rate at such institutions and facilities.

(4) We assume your question relates to psychiatric services, mostly in clinics, at non-profit (voluntary) hospitals and not at profit-making (proprietary) psychiatric hospitals. By their nature, the latter seldom provide more than a modicum of care to needy persons eligible for Medicaid. With respect to the former, the services in question are rendered mostly in New York City where they are audited by resident auditors of the City Comptroller. We avoid duplication of effort and monitor performance of the City auditors. We do not know what you mean by "fiscal operators" or what corrective legislation you believe is needed.

(5) The Department of Mental Hygiene does have its own internal audit program. This year its auditing staff is being expanded from four to thirteen professionals.

(6) Social service districts (counties) outside New York City are audited regularly as part of our periodic audits of each county. Each report on a county audit has a section devoted to social services. Separate special reports, explaining disallowances of Medicaid reimbursement and identifying the recipients of improper payments, are furnished to officials legally entitled to such information.

(7) The Welfare Inspector General's function is to investigate, primarily for instances of fraud, and not to audit social service programs or directly enforce compliance with the law. Our own audit staff does not have that type of investigative power, and expansion of its authority to include such power would dilute the audit function. The Welfare Inspector General refers cases to the county district attorneys for criminal prosecution, and he makes available to our auditors information indicative of maladministration. In turn, he receives our audit reports and has access to internal audits by the Social Services and Health Departments. In my opinion, there is effective coordination, not duplication, of effort. I understand that Congress is considering the creation of a Federal counterpart to the Welfare Inspector General.

(8) New York City uses one system to pay providers who process their billings by computer and another for those providers, mostly nursing homes, which lack that capability. It also has a system of advances necessitated by delayed processing of bills by hospitals and clinics. The City combines its payments in seeking reimbursement from the State. As to denial of such reimbursement, please refer to the response to item (1) above.

(9) The Department of Health has a number of programs to monitor and supervise different aspects of Medical administration. Our practice is to audit each of these programs in the way we believe will most effectively disclose its strengths and weaknesses. For example,

we audit its Utilization Review Program as part of our audits of individual public hospitals. A report has just been issued on its Medicaid Peer Review Program for evaluating the nature and quality of service by providers in New York City.

(10) Our audit reports over an extended period of time have contained many recommendations for coordinating Medicaid records and payments as well as for other administrative improvements. The Governor's Office has several times considered contracting out responsibilities for maintaining information on eligible individuals and paying providers. My understanding is that such contracting, while being tested in North Carolina, has not yet been proved a successful approach. Please refer also to the bill mentioned in item (2) above.

(11) This Department has no role in developing, reviewing or approving budget requests by other agencies. Those functions are lodged in the Governor, his Division of the Budget and the Legislature. We have difficulty in obtaining authorization for the number of auditors for our own Department which we believe to be warranted on a cost-benefit basis.

(12) Our authority to disapprove vouchers submitted through the Department of Social Services for reimbursement of local governments does not include authority to disapprove such vouchers on the basis of our appraisal of that Department's administration or of the statutes under which it operates. Please refer to item 1) above.

(13) The 1969 grand jury report did not address itself to performance of the Comptroller's duties. A copy of the report was transmitted to Mr. Arthur Gordon of my staff, at Mr. Gordon's request, for possible assistance in our audit work. Indeed, testimony by members of my staff and our audit reports on New York City's administration of Medicaid formed the foundation of the grand jury report. Material in the report was a factor in leading us to undertake the recently completed audit of the Medicaid Peer Review Program which is referred to in item 9) above and which covers individual providers among a host of other matters.

As you can tell from the foregoing, I believe a number of your questions proceed from erroneous factual assumptions, as well as misconceiving the function of my office in the New York State government. I feel compelled to add that I feel the generally critical tone of the questions to be totally unjustified. If you believe it would advance understanding of the important problems with which your Subcommittee is wrestling, I would be glad to make members of my staff available for informal discussion with your staff.

Sincerely,

ARTHUR LEVITT, *Comptroller.*

JULY 8, 1976.

DEAR SENATOR MOSS: This letter supplements my letter of June 28 in reply to your letter of June 17 asking questions about the administration of the Medicaid program in New York State.

In further reference to question 2 in your letter, the State Legislature has now passed two bills. One, A–12234/S–10526, provides for the State Department of Social Services to establish a statewide centralized medical assistance information and payments system. The other,

A–12233/S–10525, provides for the Department to establish a centralized welfare management system for information on eligibility under the State's public assistance programs.

The Governor has indicated he intends to sign both bills.

Sincerely,

ARTHUR LEVITT, *Comptroller.*

ITEM 2. LETTER TO LOUIS LEFKOWITZ, ATTORNEY GENERAL, STATE OF NEW YORK, AND REPLY

JUNE 17, 1976.

DEAR ATTORNEY GENERAL LEFKOWITZ: Our Committee is currently reviewing the operation of the Medicaid program in several States including New York. We are particularly concerned about the program's status in New York because your State represents such a large portion of the total Medicaid expenditures in the Nation. We are also concerned because a number of studies and reports have come to our attention indicating program deficiencies continuing unchecked over the past 10 years.

We need to assess the current situation with some precision. We would appreciate your assistance in this matter. You could be of great help by responding to the following questions at your earliest possible convenience:

1. What did your agency do regarding its responsibilities under the Medicaid program as a result of the "Report of the Fourth November 1969 Grand Jury on the Administration of Medicaid in the City of New York." (Copy enclosed.)

2. Why were there virtually no prosecutions of institutional Medicaid providers by your office between 1966–1974 given the numerous verified cases of fraud and abuse; including the audits of such providers by the State Department of Health?

3. Why were there virtually no prosecutions of individual noninstitutional Medicaid providers by your office from the program's inception to date?

4. What is your agency's position of the legality of proposed item 230 to the New York City Local Medical Plan (shared health facilities—so-called "Medicaid Mills")?

5. What is your agency's position as to whether Part 600 of 10(C) NYCRR makes so-called "Medicaid Mills" subject to its provisions?

6. Why haven't you sponsored or recommended legislation which would place such "mills" under State regulations?

7. On an annual basis, please advise us as to how many staff you have exclusively devoted to the Medicaid area from 1966 to present, *exclusive of the nursing home area* from 1957 to present. Please provide the number and type of staff and total budgetary allocation.

8. Have you ever had a separate unit dealing with the Health and Social Services area, particularly Medicaid, prior to the creation of the Special Prosecutor's office?

9. Do you currently have a unit which deals solely with cases of noninstitutional Medicaid provider abuse? If so, please explain its size, budget and operation. If not, please explain how such cases are handled.

10. Please forward our Committee a list of all cases referred to you involving alleged illegalities by medical professionals in the New York State Medicaid program from 1966–1974. Include in each case the name of the provider, the source of the referral, date received, the charge or complaint and ultimate disposition of case.

11. What is your agency's opinion of the practice whereby medical professionals rent space and other services from a landlord on a lease requiring a percentage of their gross income (usually 30–40%) as rent, particularly vis-a-vis the Department of Education position (see attached)?

12. Were you ever consulted prior to the issuance of the 1971 Bardo letter? If so, please explain.

May I have your early response to this request?

With best wishes,

Sincerely,

FRANK E. MOSS, *Chairman,*
Subcommittee on Long-Term Care.

[Reply]

JULY 8, 1976.

DEAR SENATOR MOSS: This is in further response to your letter of June 17, 1976.

The report, a copy of which was attached to your letter, was issued at the end of December, 1971. Since this office had no jurisdiction in respect to the subject of the report, the Grand Jury did not direct that a copy of the report be forwarded to this office, but to other State officials and agencies. Nevertheless, the Attorney General requested that a copy be furnished to him and on January 7, 1972 received such a copy.

In New York State, any criminal jurisdiction rested with the District Attorney of each county in the State, and recoupment of monies paid was handled by the county or municipal locality, i.e. in New York City by the Corporation Counsel. The Attorney General may exercise criminal jurisdiction in this area when authorized by a departmental request pursuant to N.Y. Executive Law, § 63, Subd.3. A request was made in late 1974 by both the New York State Commissions of Health and Social Services and pursuant to such request a Grand Jury was impaneled and Special Prosecutor Charles J. Hynes was appointed.

The statutory responsibility of this office is limited otherwise to the enforcement of disciplinary action against licensed professionals such as physicians, dentists, chiropractors and pharmacists as a result of hearings before appropriate disciplinary boards under the aegis of the N.Y. State Board of Regents. (Education Law, § 6509) (By recent law, disciplining of doctors is under the aegis of the State Department of Health).

Additionally under item 35.1 of the State Medical Handbook issued by the N.Y. State Department of Health, that agency is authorized to take its own action against Medicaid providers for restitution and suspension from the Medicaid program.

Apart from that, in this State there is an office entitled Welfare Inspector General. The scope of duties and responsibilities of such office requires him to investigate Medicaid frauds. The Welfare In-

spector General did forward one matter involving the Hempstead Medical Center to this office and the Special Prosecutions Bureau of this office in 1975 enjoined the individuals and firms concerned from doing business in this State.

The Education Bureau of this office immediately, in January 1972, communicated with Felix Infausto, Counsel to the New York State Department of Social Services, requesting information relative to the prosecution of members of the various professions who had filed fraudulent Medicaid claims. He agreed to issue directives to each local office to furnish us with the names of the violators who were licensed professionals and those whose cases had been referred to local district attorneys for criminal prosecution.

Requests were also made directly to the Deputy Commissioner of the New York State Health Department for cases of Medicaid fraud and such cases and its evidence were to be sent to the Division of Professional Conduct of the New York State Education Department for referral to this office for investigation.

Additionally, specific requests were made directly to the Division of Professional Conduct to obtain evidence from all sources as to Medicaid fraud for referral to us for disciplinary prosecution.

As a result, every case that has been presented to the Bureau of this nature has been prosecuted by the Bureau in disciplinary proceedings in the fields of Medicine, Dentistry, Pharmacy, Optometry, Chiropractic and Public Accountancy. These have resulted in the revocation or suspension of the professional Medicaid providers' licenses. Additionally, the Bureau still has some pending cases.

It should be noted that there were many cases never referred to this office, the city or local authority merely obtaining restitutions of monies from the offenders and in some instances merely removing them from Medicaid participation.

The above appears to respond to questions 1 through 3 listed in your letter.

With respect to item 230 of the New York City Local Medical Plan (Question #4), we agree with its provisions. However, a recent lower court decision held that its regulation with respect to "percentage leases" was not enforceable (Association v. Bellin, N.Y. Sup. Ct. Kings County, N.Y.L.J. Mar. 19, 1976). We have been informed that this decision is being appealed by the Corporation Counsel.

Jurisdiction with regard to Part 600 of 10(c) NYCRR lies with the N.Y. State Dept. of Health (Question #5) and in any court proceeding we would appear to sustain any position of that Department.

The recommendation of any legislation (Question #6) is the responsibility of the Departments of Social Services and Health and the State Welfare Inspector General. When such legislation is proposed, this office may be asked to comment on it either before enactment or when before the Governor.

We have no segregation of staff in this office devoted to the Medicaid area (Questions 7, 8, 9). The staff of the various bureaus handle the defense of any actions by Medicaid providers. The Special Prosecutions Bureau here would handle any affirmative litigation and, as we have stated, the Education Bureau handles disciplinary proceedings

against professionals including Medicaid providers. No separate budgetary statistics are available as to the segregated activity of the bureaus in dealing with Medicaid providers other than the staff of such bureaus who handled not only these matters but others.

Attached is the list requested in Question 10.

We have been of the view that the practice lends itself to fee splitting (Question 11).

We were never consulted prior to the 1971 Bardo letter (Question 12). When we found out about it, we informed Mr. Bardo and counsel for the Education Department that the percentage lease arrangement could lead to abuses. We are informed that there is now pending before the Board of Regents a proposed regulation which would make entering into such a percentage arrangement unprofessional conduct on the part of the licensed professional.

Best wishes.

Sincerely,

JOSEPH L. FRISTACHI,
Executive Assistant Attorney General.

Name of provider	Source of referral	Date received	Charge	Ultimate disposition
Richard Kones, M.D.	New York State Education Department	December 1974	Fraudulent billing	Suspension 6 mo.
Francisco Pratofiorito, M.D.	Department of social services, Suffolk County.	February 1974	do	Awaiting decision from New York State Board of Medicine
Stanley Groman, M.D.	New York State Department of Health	December 1973	do	Revocation, stayed and placed on probation for 2 yr.
Luis Mizray, M.D.	Article in press	January 1975	do	Revocation, stayed and placed on probation for 3 yr.
Ralph Kornblatt, O.D.	Police Department, Suffolk County	July 1972	do	Suspended for 6 mo., stayed and placed on probation.
William Gliwa, Chiropractor	New York City Department of Social Services.	April 1972	do	Suspension for 6 mo., and 18-mo. probation.
Samuel Fargnoli, D.D.S.	Department of social services, Broome County.	April 1969	do	Suspension for 2 yr.
William Goldman, D.D.S.	New York City Department of Social Services.	March 197x		Hearing scheduled for June 11, 1976. Dr. Goldman recently was released from prison where he was confined for approximately 3 yr.
Henry Goldstein, D.D.S.	do	July 1973		Suspended for 6 mo.
Frederic Fisher, D.D.S.	New York County District Attorneys Office	December 1973		Disciplinary hearing commenced when Dr. Fisher was released from prison during course of the hearings. A member of the panel of the New York State Board for Dentistry died and hearings are to commence anew.
Chester Redhead, D.D.S.	Complaint from member of the public directly to Attorney General's office.	February 1971	Fraudulent billing	Censure and reprimand by New York State Dental Board.
Albert Bzura, P.A.	Press article	September 1972	Fraudulent billing by his company on medicaid claims of physicians who sold his company the claims.	License revoked.
Leonard Spector, pharmacist	New York City social services	December 1974	Fraudulent billing shortages and substituting of drugs.	Suspended for 6 mo.
Bernard Siegel, pharmacist	Suffolk County Police Department	June 1972	Fraudulent billing in altering prescriptions to increase amounts to increase fees.	License suspended for 1 yr.
Mastic Beach Pharmacy	do	do	do	License suspended for 1 yr, stayed and probation.
David Blake, pharmacist	New York City Department of Social Services.	April 1970	Fraudulent billing, shortages	License suspended for 90 days.
Leo Mariano, pharmacist	New York State Board of Pharmacy	February 1976	do	Case pending.
Benjamin Calodny, pharmacist	do	do	do	Do.
Joseph Brounstein, pharmacist	New York City Board of Health	May 1972	Fraudulent billing	License suspended for 3 mo.

ITEM 3. LETTER TO ROBERT WHALEN, COMMISSIONER OF HEALTH, STATE OF NEW YORK, AND REPLY

JUNE 17, 1976.

DEAR DR. WHALEN: Our Committee is reviewing the operation of the Medicaid program in several States including New York. We are particularly concerned about the program's status in New York because your State represents a large proportion of the total Medicaid expenditures in the Nation. Additionally, we are concerned because of the number of studies and reports which have come to our attention documenting deficiencies continuing over the last ten years.

We are well aware of the progress which has been made in the nursing home field in the past 17 months, thanks to your aggressive leadership, however, severe problems seem to persist in other aspects of the Medicaid program. We need to assess the situation with some precision. We would appreciate your assistance by responding to the following questions at your earliest possible convenience:

(1) What did your agency do regarding its responsibilities under the Medicaid program, particularly as regards individual providers, upon receipt in 1972 of a copy of the "Report of the Fourth November 1969 Grand Jury on the Administration of Medicaid in the City of New York"? (Copy enclosed, as well as a letter of transmittal to Mary C. McLaughlin.)

(2) What is your agency's position on the proposed Item 230 to the local Medical plan for the City of New York (i.e., shared health facilities)?

(3) Why have you not altered your cooperative agreement (Section 364–a, Social Services Law) so as to place all responsibilities for the State's Medicaid program truly under one State agency?

(4) Why does your State continue to require a 25 percent local share in Medicaid costs when in 45 of the 50 States participating in Medicaid, the localities make little or no contribution?

(5) Does your State continue to provide the full range of optional service beyond the five Federally-mandated categories of coverage under Medicaid? If so, to what extent?

(6) Is it true that your State continues to provide coverage almost without limitations within each of the Federally-mandated categories of Medicaid coverage?

(7) Do you believe it is desirable and necessary to continue the "MA-only" category even though it is not required by Federal law in order to participate in the Medicaid program?

(8) Why don't you have a centralized Fraud and Abuse unit in your agency specializing in the investigation of individual Medicaid providers?

(9) Why did it take five years (July 1971) before Item 35 of the State Medical Handbook (SMH) was issued ("Unacceptable Practices by Providers")? Why was it written in such general terms? Why did it take four years to revise?

(10) Why didn't the Department have a requirement and a system for data exchange between your localities on providers alleged or proven to have committed fraud or abuse until November 1975 (i.e., under new Item 35 SMH)?

(11) Why doesn't the Department utilize a notice to beneficiary form similar to the "Explanation of Medicare Benefits" form

(EOMB) used by Medicare? I understand that your agency has reviewed the use of such a form several times over the past three years.

(12) What alternative plans have you considered for making Medicaid more efficient? What do you think of contracting the Medicaid payment and/or surveillance functions to a third party private company? What are your views of the potential of the Health Insurance Plan (HIP)?

(13) Does your agency plan to use any of the new auditing and investigative staff allocated under the 1976–77 fiscal year budget for monitoring of noninstitutional Medicaid providers (i.e., individual practitioners)?

(14) Does your agency believe Part 600 of your agency's current rules and regulations (10(c) NYCRR 600) legally places so-called "shared health facilities" under the licensure requirements for health care facilities?

(15) Do you plan to amend Part 600 or to introduce legislation requiring licensure of so-called "shared health facilities" under Article 28 of the Public Health Law?

(16) Why did it take six years (January 1972) to issue Item 34 of the State Medical Handbook (SMH)?

(17) Why did it take seven years (December 1973) to implement an inpatient hospital care utilization review program?

(18) Why do you have such limited staff (particularly legal resources) in your regional and district offices to implement the requirements of Items 34 and 35 of the State Medical Handbook?

With best wishes,

Sincerely,

FRANK E. MOSS,
Chairman, Subcommittee on Long-Term Care.

[Reply]

AUGUST 9, 1976.

DEAR SENATOR MOSS: In Commissioner Whalen's vacation absence, I am responding to your June 17, 1976 letter and your August 2, 1976 reminder. The response delay arose not from oversight, but because we wanted to assure fully effective consideration of each point you raised. We are pleased with the opportunity to contribute to the Committee's review of Medicaid program operations.

The questions posed fall into several areas of inquiry; to facilitate discussion, I have arranged my responses in accordance with these inquiries.

Your staff has done an excellent job of this, indicating their awareness of many of the tough issues involving New York State Medicaid. I will do my best to respond to all your questions, but since many of the issues you raise result from well known problems in the Medicaid eligibility, claim payment and reporting processes, I am pleased to note that you have directed similar questions to the New York State Department of Social Services.

Although the "Report of the Fourth November 1969 Grand Jury . . ." contains many accurate observations and justifiable criticisms of program administration, it did not represent a major revelation in terms of new information or understanding of the issues in the New York City program. The sheer size of the recipient population and the

large number of providers contributed to intractable problems in determination of eligibility, payment of claims, generation of reports and control of quality and expenditures. Many of the cited deficiencies were (and are) associated with the difficulties that New York State has experienced in its efforts to develop a mechanized control system approaching or equivalent to the model provided by the Federal MMIS. The State Department of Health's shared responsibility for the Medicaid program has limited its ability to effect necessary reforms. Nevertheless, this Department has long sought to improve the City Department of Health's ambulatory care controls, and these efforts have in many instances been successful. Needed controls have been proposed by the City and approved by the State Department of Health. At present a wide ranging review and revision of the New York City ambulatory care program is underway. (Question 1.)

Allocation of state and local shares in funding of the M.A. Program, provision of optional services and continuance of the "M.A. only" category are expressions of legislative and executive preference and intent. The State Department of Health does not have the authority to make such decisions—they are the proper province of the State's political decision makers. With specific reference to Question 5, New York State continues to provide a full range of optional services (see Commerce Clearing House State Chart). (Questions 4, 5, and 7). An appreciation of the respective interests and capabilities of the State Health and Social Services Departments led the State legislature to require the cooperative agreement between the two State agencies in order to ensure the proper control of the medical aspects of the Medicaid program. Successive Legislatures and Administrators have re-examined this legislation and decided to maintain it substantially in the original form. (Question 3)

Strict limitations on MA-covered hospital length of stay, provision of deferrable surgery and eligibility for skilled nursing services have recently been enacted and implemented (Chapter 76 New York State Laws of 1976 and Part 85 of the Commissioner's Rule and Regulations attached). Unlimited coverage within federally mandated categories has never been available; prior approval and/or post-audit review of all services has been an integral part of the New York State program since its inception. (Program limits are discussed further in succeeding sections of this letter. Also see Item 34, State Medical Handbook, attached.) (Question 6)

Item 230 of the New York City Local Medical Plan was developed with the approval and assistance of the State Departments of Health and Social Services. Unfortunately, this much needed regulation was enjoined by State court actions shortly after its introduction, and subsequently, nullified by final court decision. Health Department backed amendments of the Public Health, Education and Social Services Law designed to provide the legal basis for effective regulation of Medicaid mills by defining Medicaid mills and prohibiting the characteristic percentage lease arrangement were rejected by the recently-adjourned legislature. Under present statutes Part 600 of the Commissioner's Rules and Regulations does not apply to most Medicaid Mills. Redrafted bills to define Medical Mills and to place them under the operational controls of the Public Health Law, Article 28 will be re-

submitted to the next session of the state legislators. (Questions 2, 14 and 15.)

The Health Department has an effective centralized unit (in the Division of Medical Standards) to direct statewide the investigation, examination, reporting and referral of individual and other providers determined to be in violation of program regulations or accused of unethical and illegal practices. It must be conceded that until the recent past the primary concern of the responsible legislative and administrative authorities was provision of a comprehensive health care system for the State's indigent and medically indigent populations; provider fraud and abuse was known to exist, but received less-than-adequate attention. Although the basic mechanism for data exchange on undesirable providers between localities has long been in existence (required, periodic reports to the State Department of Health) little use was made of the information thus obtained, and the cooperation among state agencies was negligible. Concerted effort within the Department and by a State Task Force on Fraud and Abuse headed by the Governor's Health Advisor, Doctor Cahill, have begun to remedy this situation. It should be noted that Federal guidance in this important program area was non-existent before 1971, the year HEW first issued guidelines on fraud and abuse; the New York State Department of Health had already taken the initiative and had defined unacceptable practices and appropriate corrective measures in 1968 in Item 35 of the *State Medical Handbook*. (Questions 8, 9 and 10.)

Legal resources are available to our field offices from the Department's Central Enforcement Unit. All field offices have personnel trained and experienced in the necessary investigative and administrative procedures. As mandated by the Legislature, the newly allocated audit and investigative staff will be primarily concerned with institutional providers. A Department-sponsored budget proposal for "Medicaid Mill" audit investigative staff was turned down during the last legislative session. At this Department's insistence, the New York City Department of Health has reallocated staff to provide increased surveillance of Medicaid Mills and other non-institutional providers.

One of the problems we face in attempting to deal with Medicaid Mills is the lack of established standards and guidelines from DHEW defining unacceptable practice or abuse in the Medicaid program and establishing provision for sanctions for unacceptable practices by providers and recipients. This problem is particularly serious in non-institutional care and I would urge you to consider the need for some Federal leadership in this area. For additional information on the State Provider Fraud and Abuse Program, please consult the attached program manual. (Questions 8, 9, 13 and 18.)

The Department has, with the Department of Social Services, reviewed EOMB forms and their use. Little evidence of effectiveness as a control measure was found. However, now that MMIS has been approved by the New York State Legislature, the forms and their mailing can be accomplished at low enough cost to approach a reasonable cost-benefit basis. The two Departments will collaborate in reappraisal and planning for this purpose. We also are aware of the advantages of, and have recently prepared studies on, the potential benefits of

employing third-party payors as fiscal intermediaries. Nevertheless, considering the reports of HAS problem in North Carolina and difficulties between fiscal intermediaries in other states (e.g., California), we do not view the use of private companies as a panacea. However, we do believe such approaches should be thoroughly tested and appraised before they are discarded. We have proposed to the State Department of Social Services a pilot test of drug claim processing and drug utilization control in New York City, but temporarily withdrew our proposal at their request because of the sensitive nature of the State MMIS negotiations. (Questions 11 and 12.)

This Department supports the basic concept of the health maintenance organization, and is currently engaged in negotiations with the New York City HIP to design a workable capitation-based health care program. Past experience in New York State and elsewhere indicates that HMOs are subject to various control and marketing problems which clearly indicate that this type of service is not a cure-all to medical care delivery. (Question 12.)

State Medical Handbook Item 34 was first issued in 1967. It called for review and evaluation of services provided in the program and outlined various types of review requirements. For your information we have attached a copy of the original Item 34. In this and other instances the transmittal date on the most recent revision was unfortunately interpreted as the date of initial issuance. (Question 16.)

Item 35 issued in 1968 established the penalties for unacceptable practices in the program and established the initial reporting requirements for actions taken by field offices. A copy of the original Item 35 and a copy of the 1969 revision is attached. It should also be noted that Item 22 of the *State Medical Handbook*, in effect since 1966, establishes basic policies for program administration and identified numerous services requiring prior approval.

Inpatient hospital utilization review was initiated in 1971 based on a pilot program which began during 1970 in our Buffalo region. New York State's hospital utilization review and cost containment statutes, however, ante-date and exceed the scope of Federal UR regulations. Since 1963, the Commissioner of Health has had the power to conduct audits of medical care provided in any medical facility within the State (Public Health Law, Section 206(j)); responsibility for promulgation of hospital rates was assigned to the Commissioner of Health in 1968 by Section 2807 of the Public Health Law. Comprehensive regulation of hospital admissions, utilization review and discharge requests, applicable to all patients, are mandated by the State Hospital Code. (Question 17.)

I trust that my discussion has given you some additional insight of the New York State Medicaid Program. If you desire further information or clarification of any of the above, please do not hesitate to call on me.

Sincerely yours,

FRANK T. CICERO, M.D.,
Second Deputy Commissioner.

ITEM 4. JUNE 17, 1976, LETTER TO PHILIP TOIA, COMMISSIONER, NEW YORK DEPARTMENT OF SOCIAL SERVICES

NO REPLY HAS BEEN RECEIVED AS OF THE TIME OF THIS PRINTING, MORE THAN 2 MONTHS LATER

JUNE 17, 1976.

DEAR MR. TOIA: Out Committee is currently reviewing the operation of the Medicaid program in several States including New York. We are particularly concerned about the program's status in New York because your State represents a large portion of the total Medicaid expenditures in the Nation. Additionally, we are concerned because a number of studies and reports which have come to our attention documenting deficiencies continuing over the last ten years.

We are well aware of the progress that has been made on the nursing home front in the past 17 months, however, serious problems seem to persist in other aspects of the program. We would appreciate your assistance in responding to the following questions at your earliest possible convenience:

(1) What did your agency do regarding its responsibilities under the Medicaid program, particularly as regards individual providers, upon receipt in 1972 from the Governor's office of a copy of the "Report of the Fourth November 1969 Grand Jury on the Administration of Medicaid in the City of New York"? (Copy enclosed, along with a letter of transmittal to Jules M. Sugarman.)

(2) What is your agency's position on proposed Item 230 to the Local Medical Plan for the City of New York (i.e., "shared health facilities")?

(3) Why have you not altered your cooperative agreement (Section 364–a, Social Services Law) so as to place all responsibilities for the State's Medicaid program truly under one State agency?

(4) Why does your State continue to require a 25 percent local share of Medicaid costs when in 45 of the 50 States participating in Medicaid the localities make little or no contribution?

(5) Does your State continue to provide the full range of optional services, beyond the five Federally-mandated categories of coverage, under Medicaid?

(6) Is it true that your State continues to provide coverage almost without any limitations within each of the five federally-mandated categories of coverage even though Federal law permits you to limit such coverage?

(7) Do you believe it is desirable to continue to maintain the "MA-only" category which is not required by Federal law in order to be in the Medicaid program?

(8) Why don't you have a centralized Medicaid Fraud and Abuse unit in your agency specializing in investigation of individual Medicaid providers?

(9) Why did it take five years (July 1971) before Item 35 of the State Medical Handbook (SMH) was issued ("Unacceptable Practices by Providers")? Why was it so general? Why did it take four years to revise?

(10) Why didn't you have a requirement and system for data exchange between your localities on providers alleged or proven to have

committed fraud/abuse until November 1975 (i.e., under new Item 35 SMH)?

(11) Why don't you utilize a notice to beneficiary form similar to the "Explanation of Medicare Benefits" form (EOMB) used by Medicare? Your agency has reviewed the use of said form several times over the past three years.

(12) What alternative plans have you considered for making the Medicaid program in your State more efficient? What is your view of the benefits of contracting out the Medicaid payment and/or surveillance functions to a third party private company? What do you think about the possible benefits to be derived from the Health Insurance Plan (HIO)?

(13) Why doesn't your agency centrally maintain, and require maintenance by local DSS in a uniform format, a listing of all "factors" used to collect Medicaid payments as well as the names and addresses and amounts paid to all providers using a given factor?

(14) Why doesn't your agency centrally maintain, and require maintenance by local DSS in a uniform format, a listing of all "shared health facilities" (i.e., so-called Medicaid Mills) and the providers at said facilities?

(15) Why doesn't your agency centrally maintain, and require maintenance by local DSS in a uniform format, a "provider profile," "high provider" profile, and a "patient profile" especially in view of recommendations to this effect for the last seven years and Sections 540.11, 541.1, and 585.1(b) of your own rules and regulations?

(16) Why has your State made such little use of the 75 percent Federal reimbursement available for MMIS?

(17) Why did it take your State five years (January 1, 1971) before imposing the "20 percent of all ambulatory fees/spend down" requirement on MA-only recipients?

(18) Why haven't you developed a centralized computerized registry of Medicaid patients (i.e., patient profile) and providers and Medicaid payments systems in view of the large amounts of moneys you have expended on feasibility studies?

(19) Why do you allow New York City's Department of Social Services to maintain three different payment systems (one for nursing homes; one for private hospitals; one for non-institutional providers and the Health and Hospitals Corporation), especially given Parts 540, 585, and 586 of your own regulations (18 NYCRR)?

(20) Why do you allow the local social service districts to submit records to you in no uniform format, especially given Parts 540, 585, and 586 of your own regulations (18 NYCRR)? Some submit data on a computer tape, some send cards, and some send manual lists.

(21) Why don't you have any specific qualification requirements for local social service commissioners in view of Section 17 of the Social Services Law?

(22) Why has your agency been delinquent in submitting its SRS NCCS 119.2 reports ("Medical Provider Schedule on Allegation of Suspected Fraud Under Title XIX")?

(23) Why don't you have a data exchange system with your neighboring States (New Jersey, Pennsylvania, Connecticut and Massachusetts) regarding providers alleged to or proven to have committed Medicaid fraud/abuse?

(24) Why don't you have any uniform requirement as to the way in which localities maintain their records of claims paid? For example, New York City still maintains its records in a manual storage system in a warehouse. Why don't you require a microfilm, microfiche or some other comparable storage and retrieval system in view of past criticisms regarding insufficient or incomplete records as reasons for dismissing civil, criminal, or administrative disciplinary action?

(25) Why don't you audit more closely the moneys you dispense to the State Department of Mental Hygiene and the State Office of Drug Abuse Services in view of the continuing allegations of misuse?

(26) Why do you allow New York City to conduct collateral verification on only every twentieth case applying to become a Medicaid recipient? Can you certify the City is conducting such verifications even at this (1/20) frequency?

(27) Why haven't you developed effective mechanisms to meet the Federal Fraud requirements contained in Sections 250.80(a)(6) and (7) of the Code of Federal Regulations (CFR)?

(28) Why was your Office of Audit and Quality Control not created until 1973 given the results of a variety of studies showing high ineligibility rates or virtually non-existent auditing and quality control procedures over Medicaid providers?

(29) Why has your Office of Audit and Quality Control devoted such a relatively low priority to Medicaid?

(30) Why haven't you specifically required various specific administrative reforms at the local level by regulation upon penalty of withholding reimbursement (i.e., "provider" and "patient" profiles in a uniform format, effective methods of record maintenance and retrieval)?

(31) How many cases of suspected Medicaid fraud has your Department referred to which State agencies in the last four years? How many of such cases have you also brought to the attention of the (1) Bureau of Health Insurance (Medicare) and (2) other Federal agencies?

(32) In addition, would you supply the Committee with (a) your most current list of factoring companies complete with their business addresses and the name of the persons responsible; (b) a list of providers by factoring firm for 1975; (c) a list of the dollar amount paid factoring firms by DSS for each provider for this same year (substitute 1974 if necessary); (d) a list of total payments to factors last year or 1974.

I look forward to your early response.

With best wishes,

Sincerely,

FRANK E. MOSS,
Chairman, Subcommittee on Long-Term Care.

ITEM 5. LETTERS TO ROBERT ASHER, DIRECTOR, AND ROBERT STONE, COUNSEL, NEW YORK STATE DEPARTMENT OF EDUCATION, AND REPLIES

JUNE 17, 1976.

DEAR DR. ASHER: Our Committee is reviewing the operation of the Medicaid program in New York State and we would appreciate you providing us with the following information:

1. A list, by type of licensee, of the total number of cases of alleged misconduct referred to your office for the period of January 1, 1966–January 1, 1976. The list should indicate the disposition of the cases in terms of the following categories: allegations not substantiated, reprimand, fine, temporary suspension, revocation, case pending. Where the basis of action has been a charge of Medicaid fraud or abuse, please so indicate.

2. For the same time period as cited in point 1 above, please advise us as to your total number and type of staff and budget allocation for that portion of your office assigned to the professional conduct of members of the medical profession. Please present this data on an annual basis for each of the ten years requested.

3. Please advise our Committee as to whether your office has initiated any investigations since 1972 on any of the forty-eight medical professionals whose names appear on the attached two lists. If you have not, please indicate so by answering "None". If you have, please give a summary of the case, including date and nature of allegations, findings, and date and nature of disposition.

We would appreciate your earliest possible response.

With best wishes,

Sincerely,

FRANK E. MOSS,
Chairman, Subcommittee on Long-Term Care.

[Enclosures]

Attachment I:

1. Dr. Norman Katz (New York, N.Y.).
2. Dr. Stanio Bistreff (New York, N.Y.).
3. Dr. Samuel Carlyle Trattler (Bronx, N.Y.).
4. Dr. Richard Kones (New York, N.Y.).
5. Dr. Harold Tara (New York, N.Y.).
6. Dr. Marvin Roberts (Brooklyn, N.Y.).
7. Dr. Irving Jacobson (Bronx, N.Y.).
8. Dr. Gary Korenman (New York, N.Y.).
9. Dr. Abraham Ostad (Brooklyn, N.Y.).
10. Dr. Paul Goldberg (Brooklvn, N.Y.).
11. Dr. Seymour Wanderman (New York, N.Y.).
12. Dr. Lawrence Harris (New York, N.Y.).
13. Dr. Harold Rubin (Buffalo, N.Y.).
14. Dr. Albert Brinz (Scarsdale, N.Y.).
15. Dr. Eugenia Iutcovish (Roslyn, N.Y.).
16. Dr. Gabriel Laurv (Roslyn, N.Y.).
17. Dr. Seymour Feldman (Beacon, N.Y.).
18. Dr. Barbara Rosen (Cedarhurst, N.Y.).
19. Dr. Lee Zinman (Dobbs Ferry, N.Y.).
20. Dr. J. Lee Carrel (Tonawanda, N.Y.).

Attachment II:

1. Dr. Arthur P. Solomon (Great Neck), physician.
2. Dr. Morty Kazdin (Baldwin, N.Y.), chiropractor.
3. Dr. Christine Duffy (Cedarhurst, L.I.), psychiatrist.
4. Dr. Roger Tarter, physician.
5. Dr. Evaldas Deckys, physician.

6. Dr. Fred Fisher (New York, N.Y.), dentist.
7. Dr. William Goldman (New York, N.Y.), dentist.
8. Dr. Ralph Berger (New York, N.Y.), dentist.
9. Dr. Les Blaine (Brooklyn, N.Y.), optometrist.
10. Dr. Ralph Boxer (New York, N.Y.), dentist.
11. Howard Siegal (New York, N.Y.), pharmacist.
12. Dr. Allen Feinberg (New York, N.Y.), podiatrist.
13. Dr. S. David Geller (Queens, N.Y.), podiatrist.
14. Dr. Arthur Goldberg (Bronx, N.Y.), chiropractor.
15. Dr. Rafig Jan (New York, N.Y.), psychiatrist.
16. Dr. Samuel Kramer (Queens, N.Y.), psychiatrist.
17. Dr. Emanuel Lampidis (Brooklyn, N.Y.), physician.
18. Kenneth Levy (New York, N.Y.), pharmacist.
19. Dr. Michael Mansdorf (Brooklyn, N.Y.), chiropractor.
20. Dr. Max Packer (Queens, N.Y.), psychiatrist.
21. Dr. Alfred Pecora (New York, N.Y.), chiropractor.
22. David Reifman (Brooklyn, N.Y.), pharmacist.
23. Dr. Jay Rosenberg (New York, N.Y.), podiatrist.
24. Dr. Gerald Strauss (Brooklyn, N.Y.), chiropractor.
25. Dr. David Boschowitz (Brooklyn, NY.), chiropractor.
26. Dr. Leslie Unger (Brooklyn, N.Y.), podiatrist.
27. Dr. Alan Cohen (Bronx, N.Y.), dentist.
28. Dr. Howard Cohen (Bronx, N.Y.), dentist.

JUNE 17, 1976.

DEAR MR. STONE: Our Committee is currently evaluating the Medicaid program in New York and in several other States. You would be of great assistance to us in this effort if you will answer the following questions at your earliest possible convenience:

1. Why don't the rules and regulations of your agency prohibit the paying by a physician, or any other medical professional licensed by your agency, of a percentage of their gross income for rent and/or shared services in a building in view of Opinion #23 of the American Medical Association's Judicial Council?

2. Has your agency altered its position on the issues discussed in Mr. August Bardo, Jr. November 4, 1971 letter (see attached)?

3. As regards Mr. Bardo's letter:

a) What is your rationale for holding percentage of gross income leasing agreements legal while holding percentage of net income leasing agreements illegal?

b) Do you have any definition, or guidelines, rules, or regulations, for determining what is a "fair percentage of their gross income"? If not, why not?

c) Do you consider the current average of 35% of gross income charged to many physicians in New York City and 60–75% charged to radiologists as a "fair percentage"?

d) Do you consider a situation where the landlord provides all custodial, secretarial, clerical, and administrative services, including centralized record maintenance, and selection of laboratory to be used by medical practitioners in his building as being the type of "interference or control by the landlord over the practice of the profession" which would be illegal?

f) Do you have any procedure, rule, or regulation requiring your licenses to register or clear such leases with your agency or any other agency? It not, why not?

4. Would you furnish the Committee with a list of names representing the number of licenses which the Department has revoked (for all medical providers by category) during the period January 1972 through January of 1976 and, more specifically, the number of these revocations which were related to Medicare or Medicaid fraud or abuse?

We would appreciate your early response to this request for information.

With best wishes,

Sincerely,

FRANK E. MOSS,
Chairman, Subcommittee on Long-Term Care.

[Reply]

JULY 28, 1976.

DEAR SENATOR MOSS: The information contained herein is being submitted to you in response to your letter of June 17, 1976 to me and paragraph 4 of your letter of June 17, 1976 to Robert D. Stone, Counsel to the New York State Department of Education. The delay in responding to your letter of June 17, 1976 was occasioned by the fact that our records are not collected and maintained in the form, nor with the information you requested. Therefore, scarce staff resources had to be devoted to the gathering of this information in addition to their other duties.

The information furnished is not complete in all cases. Where this is the case, the reason why we have not provided all of the information requested is indicated.

In regard to paragraph 1, we do not maintain lists of all complaints by type of case and ultimate disposition. Such lists are maintained only for cases which are ultimately decided by the Board of Regents. We expect to implement an information retrieval system on January 1, 1977 which will enable records of all future cases to be retained on such a list. I am furnishing the information that we were able to compile as attachments to this letter. Attachment I is a breakdown by profession by year of the cases opened and closed from April 1, 1970 to March 31, 1975; Attachment II is a copy of the Annual Report by profession for the year ending March 31, 1970; Attachment III is the Annual Report by profession for the year ending March 31, 1969; Attachment IV is the summary of cases opened and closed during the year ending March 31, 1976. Reports for the years before 1968 are not available.

It would have been impossible under present staffing to go through the thousands of cases processed by this office during this period and break them down into the categories requested. However, the Medicaid, fraud or abuse cases that were readily discernible were gone through and divided into the requested categories. The summary sheet for these cases is included as Attachment V. It should be noted that the Division did not open cases in the Medicaid or Medicare area when no unprofessional conduct was alleged or was apparent from the facts.

Therefore, cases where overbilling was alleged or where settlements were reached by Medicaid authorities by which the provider accepted, as full payment, only a percentage of his total billings, were not automatically opened. Since we were not able to go through all the cases opened during this period, some Medicaid cases may have been missed.

In regard to paragraph 2, Attachment VI indicates the Personnel Budget and staff assigned to the Division during the period January 1, 1966 to April 30, 1976. The personnel expenditures for payment of employees are not available for most of that period.

In regard to paragraph 3, since 1972, we have opened cases on 20 of the practitioners included on the attached list. The name, profession, date of opening, type of case and disposition are appended in Attachment VII.

In regard to paragraph 4 of your letter of June 17, 1976 to Robert D. Stone, Attachment VIII contains the information requested on all cases considered by the Board of Regents during this period.

It should be noted that this Division does not investigate complaints concerning pharmacists on pharmacies. The investigation of such complaints is supervised by Dr. Albert Sica, Secretary to the Board of Pharmacy. I shared your letter with Dr. Sica, and he will respond to your letter under separate cover. However, since cases which reach the Board of Regents are processed by this office, the list given in Attachment VII includes such cases.

I hope that the above information will be sufficient to meet your needs.

Very truly yours,

ROBERT S. ASHER, *Director.*

[Attachments]

ATTACHMENT V.—*Total number of cases involving Medicaid fraud or "abuse":*

Resolution of case:	*Number*
Allegations not substantiated	23
Reprimand	1
Temporary suspension	3
Revocation	1
Case pending	15
Warning-violation discovered	7
Subject deceased	2
Conviction-illegal practice	1

Profession	Total cases	Coded disposition
Medicine	11	A1, C1, E6, F1, G2.
Physiotherapy	1	E1.
Dentistry	19	A7, B1, C1, D1, E2, F6, H1.
Optometry	8	A8.
Ophthalmic dispensing	2	A2.
Chiropractic	6	C1, E5.
Podiatry	6	A5, E1.
Total	53	

Code: A, allegations not substantiated; B, reprimand; C, temporary suspension; D, revocation; E, case pending; F warning—violation discovered; G, subject deceased; H, conviction—illegal practice.

ATTACHMENT VI.—STAFF ASSIGNED AND PERSONNEL BUDGET 1966–76

	Personnel budget	Total staff	Investigative staff
Year:			
1976 (April)	442,000	36	19
1975	417,000	37	21
1974	(1)	26	13
1973	(1)	29	15
1972	(1)	31	17
1971	(1)	37	19
1970	(1)	52	27
1969	(1)	50	25
1968	(1)	49	25
1967	(1)	49	25
1966	(1)	51	27

[1] Not available.

Note: 1971–76 indicates actual number of employees on hand; 1965–70 indicates employees assigned to the Division

ATTACHMENT VII

Name	Profession	Opening date	Type of case	Disposition
Norman Katz	Doctor of medicine	Aug. 15, 1973	Improper narcotic prescription, medicaid fraud.	Pending.
Richard Kones	do	June 16, 1972	Medicaid fraud	2-yr suspension, stay 1½ yr.
Harold P. Rubin	Podiatrist	Nov. 5, 1973	do	Pending.
Albert J. Brinz	Doctor of medicine	Aug. 1, 1974	do	Do.
Eugenia Iutcovich	do	Jan. 7, 1976	do	Do.
Gabriel Laury	do	do	do	Do.
Barbara Rosen	Psychologist	Apr. 25, 1975	do	Do.
Lee Zinman	Podiatrist	Mar. 24, 1976	do	Do.
Mort Kazdin	Chiropractor	Feb. 23, 1976	do	Do.
Christine Duffy	Psychologist	Mar. 18, 1975	do	Do.
Roger P. Tarter	Doctor of medicine	Oct. 12, 1972	Narcotic abuse	Cleared Apr. 12, 1976, Reg.-RSP.
Evaldas Deckay	do	Apr. 2, 1973	do	Revocation.
Fred Fisher	Doctor of dental surgery.	Sept. 16, 1974	Insurance fraud	Pending.
Ralph Berger	do	Apr. 12, 1973	Irregulation in medicaid billing and practice.	Cleared June 24, 1974, insufficient evidence.
Leslie Blaine	Optometrist	Mar. 13, 1972	Charged with unprofessional conduct by medicaid.	Cleared Sept. 25, 1975, no violation, no evidence.
Allen Fernberg	Podiatrist	Mar. 8, 1972	By medicaid—misrepresentation of diagnosis.	No evidence.
Rafig Jan	Doctor of medicine	July 13, 1972	Unprofessional conduct by medicaid.	Pending.
Gerald Strauss	Chiropractor	June 20, 1974	Medicaid fraud	Do.
David Boschavitz	do	do	do	Do.
Emanuel Lampidis	Doctor of medicine	Sept. 20, 1972	Selling narcotics	Suspension.

Note: No record of other 28 names on list.

JULY 28, 1976.

DEAR SENATOR MOSS: Robert Asher, Director of the Division of Professional Conduct, has shared your letter of June 17, 1976 with me. The Office of the State Board of Pharmacy is responsible for the investigation of complaints against pharmacies and pharmacists as well as the routine inspection of pharmacies, manufacturers and wholesalers.

I have attached a table containing discipline case data for the past several years and a table with personnel information.

Of the pharmacists listed in Attachment II of your letter, one, David Riefman, is the subject of a pending case. There are no actions pending against the other two individuals.

I trust this information is sufficient. If not, please invite your staff to contact me. We will provide whatever additional data we can within existing time and resource limitations.

Sincerely,

ALBERT J. SICA, Ph. D.,
Executive Secretary.

[Enclosures]

BOARD OF PHARMACY

DISCIPLINE (LICENSE OR REGISTRATION) CASES

[Figures in parentheses represent cases involving medicaid fraud or abuse]

	Revocation	Suspension	Censure and reprimand	Resigned	Dismissed	Tota
1970 (10 mo):						
Pharmacist	7	1	1			9
Pharmacy	2					2
1971: Pharmacist	2	2		1		5
1972:						
Pharmacist	6	4	2			12
Pharmacy	1					1
1973:						
Pharmacist	2	3				5
Pharmacy	2					2
1974:						
Pharmacist	3	19	3	1		26
Pharmacy	2	14	1	1	1	19
1975:						
Pharmacist	6	(3) 16	2	(1) 3		(4) 27
Pharmacy	1	(2) 5			1	(2) 7
Manufacturer/wholesaler	1	1				2

DISCIPLINE (MONEY PENALTY) CASES

	Number of cases	Penalties imposed
June 1, 1969 to May 31, 1970	114	$29,925
June 1, 1970 to May 31, 1971	109	34,400
June 1, 1971 to May 31, 1972	88	36,100
June 1, 1972 to May 31, 1973	175	57,500
April 1, 1973 to Mar. 31, 1974	173	61,500
April 1, 1974 to Mar. 31, 1975	203	93,550
April 1, 1975 to Mar. 31, 1976	300	104,500

OFFICE OF THE STATE BOARD OF PHARMACY PERSONNEL 1965–75

	Professional Staff	Clerical Staff	Total
1975	17	10	27
1974	17	10	27
1973	17	10	27
1972	17	10	27
1971	18	10	28
1970	19	11	30
1969	19	11	30
1968	19	11	30
1967	19	11	30
1966	19	11	30
1965	19	11	30

Note: The approximate budget for full-time personnel in this office from Apr. 1, 1975 to Mar. 31, 1976, was $370,000.

JULY 6, 1976.

DEAR SENATOR MOSS: Thank you for your letter of June 17 concerning your Committee's current evaluation of the Medicaid program in New York and in several other states.

I have delayed in responding to your questions concerning the use of a percentage of gross income of physicians and other health professionals in connection with arrangements for providing space and other services, because of proposed amendments of the regulations of the New York State Commissioner of Education, which have now been adopted.

Attached is a copy of a series of amendments to the Regulations of the Commissioner which were approved by the New York State Board of Regents at its meeting of July 1, 1976, effective August 31, 1976. You will note that the new regulations prohibit the use of gross income as a basis for such arrangements with licensees in thirteen health professions in New York State.

With respect to the information requested in the item numbered 4 in your letter, I am referring a copy of your letter to Dr. T. Edward Hollander, our Deputy Commissioner for Higher and Professional Education. Although the statistical data you request will take some time to compile, I am certain that you will hear from Dr. Hollander as soon as that information can be pulled together.

Sincerely,

ROBERT D. STONE.

[Attachments]

JULY 1, 1976.

REGULATIONS PERTAINING TO PERCENTAGE RENTALS

TO THE COMMISSIONER OF EDUCATION:

Amendments to Sections 60.1, 60.8, 60.10, 61.5, 65.1, 66.1, 72.2, 73.2, and 74.1 and new sections 60.11, 64.7, 75.5 and 76.7 of the Regulations of the Commissioner have been prepared and are herewith submitted for consideration by the Regents at the June meeting.

The amendments define as unprofessional conduct in medicine, physician's assistants, specialist's assistants, physical therapy, acupuncture, dentistry, nursing, podiatry, optometry, psychology, chiropractic, social work, speech pathology and audiology, and occupational therapy, respectively, entering into arrangements whereby leasing of space, facilities, equipment, or certain services is based upon a percentage of the income or receipts of the practitioner.

RECOMMENDATION: I recommend that subdivision (d) of Section 60.1 of the Regulations of the Commissioner be amended by the addition of a new paragraph (12), that Section 60.8 be amended by the addition of a new subdivision (e), that subdivision (j) of Section 60.10 be amended by the addition of a new paragraph (11), that a new Section 60.11 be added, that subdivision (b) of Section 61.5 be amended by the addition of a new paragraph (4), that a new Section 64.7 be added, that subdivision (c) of Section 65.1 be amended by the addition of a new paragraph (3), that subdivision (a) of Section 66.1 be amended by the addition of a new paragraph (11), that subdivision (a) of Section 72.2 be amended by the addition of a new paragraph (7), that Section 73.2 be amended by the addition of a new subdivision (i), that Section 74.1 be amended by the addition of a new

subdivision (h), that a new Section 75.5 be added, and that a new Section 76.7 be added in accordance with the attached drafts, and that the Regents take the following action:

VOTED: That subdivision (d) of Section 60.1 of the Regulations of the Commissioner be amended by the addition of a new paragraph (12), that Section 60.8 be amended by the addition of a new subdivision (e), that subdivision (j) of Section 60.10 be amended by the addition of a new paragraph (11), that a new Section 60.11 be added, that subdivision (b) of Section 61.5 be amended by the addition of a new paragraph (4), that a new Section 64.7 be added, that subdivision (c) of Section 65.1 be amended by the addition of a new paragraph (3), that subdivision (a) of Section 66.1 be amended by the addition of a new paragraph (11), that subdivision (a) of Section 72.2 be amended by the addition of a new paragraph (7), that Section 73.2 be amended by the addition of a new subdivision (i), that Section 74.1 be amended by the addition of a new subdivision (h), that a new Section 75.5 be added and that a new Section 76.7 be added in accordance with the attached drafts, as submitted, effective August 31, 1976.

Respectfully submitted.

T. Edward Hollander.

Approved by Commissioner for submission to Board of Regents, June 30, 1976.

Approved, Counsel and Deputy Commissioner for Legal Affairs, June 30, 1976.

July 1, 1976.

To: Temporary President of the Senate, Speaker of the Assembly.
From: Robert D. Stone.
Subject: Proposed amendments to the Regulations of the Commissioner of Education.

This notification is submitted in accordance with the provisions of Chapter 275 of the Laws of 1971.

The Commissioner of Education proposes to amend Sections 60.1, 60.8, 60.10, 61.5, 65.1, 66.1, 72.2, 73.2, and 74.1, and to add Sections 60.11, 64.7, 75.5 and 76.7 of the Regulations of the Commissioner of Education, effective August 31, 1976. The purpose of the proposed amendments and additions is to define as unprofessional conduct the participation in a percentage leasing arrangement by practitioners of the following professions: medicine, physician's assistants, specialist's assistants, acupuncture, physical therapy, dentistry, nursing, podiatry, optometry, psychology, chiropractic, social work, speech pathology and audiology, and occupational therapy. A percentage leasing arrangement is defined as one whereby the professional receives office space, facilities, equipment or personnel services in return for a percentage of his or her income or gross receipts.

Statutory Authority: Sections 207 and 6509 of the Education Law.

Opportunity for submission of data, views or arguments. Communications concerning the proposed action may be submitted to T. Edward Hollander, Deputy Commissioner for Higher and Professional Education, State Education Department, 99 Washington Avenue, Albany, New York 12230.

Text for proposed action: Attached.

Fiscal Statement: There are no fiscal consequences to the proposed amendments.

AMENDMENTS TO THE REGULATIONS OF THE COMMISSIONER OF EDUCATION

PURSUANT TO SECTIONS 207 AND 6509 OF THE EDUCATION LAW

1. Subdivision (d) of Section 60.1 of the Regulations of the Commissioner of Education is amended by the addition of a new paragraph (12), effective August 31, 1976, to read as follows:

(12) Except as otherwise provided by law with respect to a facility licensed pursuant to Article 28 of the New York State Public Health Law or Article 13 of the New York State Mental Hygiene Law, entering into an arrangement or agreement with any person or other entity in the State of New York whereby the amount received by such person in payment for furnishing space, facilities, equipment, or personnel services used by a physician in his or her practice constitutes a percentage of or is otherwise dependent upon the income or receipts of the physician from such practice.

2. Section 60.8 of the Regulations of the Commissioner of Education is amended by the addition of a new subdivision (e), effective August 31. 1976, to read as follows:

(e) Unprofessional conduct by a physician's assistant or specialist's assistant. Unprofessional conduct by a physician's assistant or specialist's assistant shall include but shall not be limited to the following: Except as otherwise provided by law with respect to a facility licensed pursuant to Article 28 of the New York State Public Health Law or Article 13 of the New York State Mental Hygiene Law, entering into an arrangement or agreement with any person or other entity in the State of New York whereby the amount received by such person in payment for furnishing space, facilities, equipment, or personnel services used by a physician's assistant or specialist's assistant in his or her practice constitutes a percentage of or is otherwise dependent upon the income or receipts of the physician's assistant or specialist's assistant from such practice.

3. Subdivision (j) of Section 60.10 of the Regulations of the Commissioner of Education is amended by the addition of a new paragraph (11), effective August 31, 1976, to read as follows:

(11) Except as otherwise provided by law with respect to a facility licensed pursuant to Article 28 of the New York State Public Health Law or Article 13 of the New York State Mental Hygiene Law, entering into an arrangement or agreement with any person or other entity in the State of New York whereby the amount received by such person in payment for furnishing space, facilities, equipment, or personnel services used by an acupuncturist in his or her practice constitutes a percentage of or is otherwise dependent upon the income or receipts of the acupuncturist from such practice.

4. Section 60.11 of the Regulations of the Commissioner of Education is added, effective August 31, 1976, to read as follows:

60.11. Unprofessional conduct in the practice of physical therapy. Unprofessional conduct in the practice of physical therapy shall include but shall not be limited to the following: Except as otherwise provided by law with respect to a facility licensed pursuant to Article 28 of the New York State Public Health Law or Article 13 of the New York State Mental Hygiene Law, entering into an arrangement or agreement with any person or other entity in the State of New York whereby the amount received by such person in payment for furnishing

space, facilities, equipment, or personnel services used by a physical therapist in his or her practice constitutes a percentage of or is otherwise dependent upon the income or receipts of the physical therapist from such practice.

5. Subdivision (b) of Section 61.5 of the Regulations of the Commissioner of Education is amended by the addition of a new paragraph (4), effective August 31, 1976, to read as follows:

(4) Except as otherwise provided by law with respect to a facility licensed pursuant to Article 28 of the New York State Public Health Law or Article 13 of the New York State Mental Hygiene Law, entering into an arrangement or agreement with any person or other entity in the State of New York whereby the amount received by such person in payment for furnishing space, facilities, equipment, or personnel services used by a dentist in his or her practice constitutes a percentage of or is otherwise dependent upon the income or receipts of the dentist from such practice.

6. Section 64.7 of the Regulations of the Commissioner of Education is added, effective August 31, 1976, to read as follows:

64.7 Unprofessional conduct in the practice of nursing. Unprofessional conduct in the practice of nursing shall include but shall not be limited to the following:

Entering into an arrangement or agreement with any person or other entity in the State of New York whereby the amount received by such person in payment for furnishing space, facilities, equipment, or personnel services used by a registered professional nurse or licensed practical nurse in his or her practice constitutes a percentage of or is otherwise dependent upon the income or receipts of the registered professional nurse or licensed practical nurse from such practice.

7. Subdivision (c) of Section 65.1 of the Regulations of the Commissioner of Education is amended by the addition of a new paragraph (3), effective August 31, 1976, to read as follows:

(3) Except as otherwise provided by law with respect to a facility licensed pursuant to Article 28 of the New York State Public Health Law or Article 13 of the New York State Mental Hygiene Law, entering into an arrangement or agreement with any person or other entity in the State of New York whereby the amount received by such person in payment for furnishing space, facilities, equipment, or personnel services used by a podiatrist in his or her practice constitutes a percentage of or is otherwise dependent upon the income or receipts of the podiatrist from such practice.

8. Subdivision (a) of Section 66.1 of the Regulations of the Commissioner of Education is amended by the addition of a new paragraph (11), effective August 31, 1976, to read as follows:

(11) Entering into an arrangement or agreement with any person or other entity in the State of New York whereby the amount received by such person in payment for furnishing space, facilities, equipment, or personnel services used by an optometrist in his or her practice constitutes a percentage of or is otherwise dependent upon the income or receipts of the optometrist from such practice.

9. Subdivision (a) of Section 72.2 of the Regulations of the Commissioner of Education is amended by the addition of a new paragraph (7), effective August 31, 1976, to read as follows:

(7) Except as otherwise provided by law with respect to a facility licensed pursuant to Article 28 of the New York State Mental Hygiene Law, enters into an arrangement or agreement with any person or other entity in the State of New York whereby the amount received by such person in payment for furnishing space, facilities, equipment, or personnel services used by a psychologist in his or her practice constitutes a percentage of or is otherwise dependent upon the income or receipts of the psychologist from such practice.

10. Section 73.2 of the Regulations of the Commissioner of Education is amended by the addition of a new subdivision (i), effective August 31, 1976, to read as follows:

(i) Entering into an arrangement or agreement with any person or other entity in the State of New York whereby the amount received by such person in payment for furnishing space, facilities, equipment, or personnel services used by a chiropractor in his or her practice constitutes a percentage of or is otherwise dependent upon the income or receipts of the chiropractor from such practice.

11. Section 74.1 of the Regulations of the Commissioner of Education is amended by the addition of a new subdivision (h), effective August 31, 1976, to read as follows:

(h) Except as otherwise provided by law with respect to a facility licensed pursuant to Article 28 of the New York State Public Health Law or Article 13 of the New York State Mental Hygiene Law, entering into an arrangement or agreement with any person or other entity in the State of New York whereby the amount received by such person in payment for furnishing space, facilities, equipment, or personnel services used by a certified social worker in his or her practice constitutes a percentage of or is otherwise dependent upon the income or receipts of the certified social worker from such practice.

12. Section 75.5 of the Regulations of the Commissioner of Education is added, effective August 31, 1976, to read as follows:

75.5. Unprofessional conduct in the practice of speech pathology or audiology. Unprofessional conduct in the practice of speech pathology or audiology shall include but shall not be limited to the following:

Entering into an arrangement or agreement with any person or other entity in the State of New York whereby the amount received by such person in payment for furnishing space, facilities, equipment, or personnel services used by a speech pathologist or audiologist in his or her practice constitutes a percentage of or is otherwise dependent upon the income or receipts of the speech pathologist or audiologist from such practice.

13. Section 76.7 of the Regulations of the Commissioner of Education is added, effective August 31, 1976, to read as follows:

76.7 Unprofessional conduct in the practice of occupational therapy. Unprofessional conduct in the practice of occupational therapy shall include but shall not be limited to the following:

Except as otherwise provided by law with respect to a facility licensed pursuant to Article 28 of the New York State Public Health Law or Article 13 of the New York State Mental Hygiene Law, entering into an arrangement or agreement with any person or other entity in the State of New York whereby the amount received by such person in payment for furnishing space, facilities, equipment, or

personnel services used by an occupational therapist in his or her practice constitutes a percentage of or is otherwise dependent upon the income or receipts of the occupational therapist from such practice.

JULY 26, 1976.

DEAR SENATOR MOSS: This is in response to a copy of a letter sent to Mr. Robert Asher, Director of the Office of Professional Conduct in the New York State Department of Education.

The New York State Legislature established a State Board for Professional Medical Conduct within the New York State Department of Health effective September 1, 1975. As specified by Law, the jurisdiction of this Board is only concerned with physicians and physician's assistants and not with the other health related professionals. Further, this was a new program within the Health Department and the first several months were spent staffing both the central and regional offices throughout the State of New York. Nevertheless, complaints that were received were investigated as rapidly as possible and these mainly concerned misconduct and unprofessional conduct as defined in the Law.

During the short existence of our program in 1975 we had little to do with Medicaid fraud unless there was accompanying evidence of unprofessional conduct or misconduct. Within the Health Department there is a separate Medicaid Fraud Abuse program that investigates abuses of this nature and also has provisions for an administrative hearing process. It is only after the completion of their investigation in general, that this information is forwarded to our office for further action.

In looking over the attachments accompanying your letter, several of the physicians listed are under investigation by this office but the Law prevents us from disclosing any information until the Board of Regents has made a final determination in the matter.

In respect to staffing prior to January 1, 1976 there were eight medical conduct investigators, two secretaries and one person who has a dual role: Executive Secretary to the State Board for Professional Medical Conduct and Director of the Office of Professional Medical Conduct. The initial budget covering the period September 1, 1975 to March 31, 1976 was approximately $200,000.

I hope this information will be helpful to you and if there are any other specific questions that I am at liberty to disclose to you, I would only be happy to do so upon request.

Sincerely,

THADDEUS J. MURAWSKI, M.D.,
Director, Office of Professional Medical Conduct.

ITEM 6. LETTERS TO DR. RALPH WEIL, PRESIDENT, SECOND DISTRICT DENTAL SOCIETY; DR. SEYMOUR NASH, EXECUTIVE DIRECTOR, NEW YORK STATE DENTAL SOCIETY; AND DR. EMIL LENTCHNER, EXECUTIVE DIRECTOR, QUEENS COUNTY DENTAL SOCIETY, AND REPLIES

JUNE 17, 1976

DEAR DR. WEIL: Our Committee is reviewing the operation of the Medicaid program in New York State and would appreciate your cooperation in answering the following questions:

(1) Does your Society consider the situation where a dentist pays a rental for office space and related services based on a percentage of either his gross income or net income as unethical?

(2) What disciplinary actions are within the powers of your Society? How many cases have been referred to you for investigation in the past four years by source of referral?

(3) Has your Society taken any disciplinary action against any dentist during the period from January 1966–January 1976? If so, please provide a summary of each case. Specifically, (1) how many licenses have been revoked and (2) how many of them were related primarily to Medicare/Medicaid abuses?

(4) What type of liaison do you maintain with State and local health departments and law enforcement agencies regarding referral of and action on cases of alleged professional misconduct?

(5) Does your Society consider it unethical for a dentist to have a financial interest in any company or partnership which leases space, provides "factoring" or other services to other medical professionals?

(6) What is your Society's position on the proposed Item 230 amendment to the New York City Local Medical Plan governing the Medicaid program (i.e., regarding shared health facilities)?

(7) Does your Society consider it proper for a dentist to utilize a "factoring" company to collect his Medicaid claims regardless of the commission charged by such a company?

(8) Based on your experience, what are the five major complaints dentists have regarding the Medicaid program and what are the five major types of dentist abuses of the Medicaid program?

(9) Does your Society consider the current average of 35 percent of gross income charged as rental to many medical practitioners in Medicaid-based "shared health facilities" in New York City as reasonable or ethical?

(10) Do you consider the following type of situation as one which endangers the independence of a member of your Society in the control and operation of his professional practice: where the landlord provides not only office, waiting room space, and equipment, but also all custodial, clerical, secretarial and administrative services including centralized record maintenance and selection of laboratory to be used by practitioners in the building.

With best wishes,

Sincerely,

FRANK E. MOSS, *Chairman,*
Subcommittee on Long-Term Care.

[Reply]

JULY 29, 1976.

DEAR SENATOR MOSS: As president of the Medical Society of the County of New York, I am pleased to respond to your questionnaire of June 17, 1976. I hope that our answers to these questions will be of help to your subcommittee.

The New York County Medical Society is unalterably opposed to percentage letting agreements. Our opposition is based on long-standing principles of medical ethics. The *Judicial Council Opinions and Reports* of the American Medical Association, Section 7, Paragraph 23, states:

"An arrangement by virtue of which a physician leases office space for a percentage of gross income is not acceptable; it is violative of ethical principles. The practice indirectly results in fee splitting and tends to exploit the practice of medicine. If the size of a doctor's practice increases and imposes additional demands on the facilities of the building, these facts may be considered when the time comes to renegotiate the rental value of the leased premises, and a new fixed rental, taking these items into account, might be agreed upon."

I recently led a delegation of health care providers who testified before the Board of Regents of the New York State Department of Education. We requested the Regents to adopt as a definition of unprofessional conduct the participation of licensed professionals in any percentage letting office space agreement.

At their June 1976 meeting, the Board of Regents unanimously amended their regulations to state:

> (12) Except as otherwise provided by law with respect to a facility licensed pursuant to Article 28 of the New York State Public Health Law or Article 13 of the New York State Mental Hygiene Law, entering into an arrangement or agreement with any person or other entity in the State of New York whereby the amount received by such person in payment for furnishing space, facilities, equipment, or personnel services used by a physician in his or her practice constitutes a percentage of or is otherwise dependent upon the income or receipts of the physician from such practice.

Identical language was also made applicable to all of the licensed professions providing health services in New York State. We feel that this regulation is an essential first step in a cooperative effort between State authorities and the medical professions to formulate effective rules for the delivery of Medicaid services.

Disciplinary power of the Medical Society of the County of New York is limited to reprimand, admonition, censure and expulsion. These powers and the procedures for their exercise are defined in Chapter VIII of the By-Laws of the Medical Society of the County of New York, copy of which is appended to this report. Disciplinary procedures within the Medical Society are subject to the requirements of due process and judicial review.

Your committee should note that the Board of Censors (Ethics Committee) or a Trial Commitee of our Society have authority according to the By-Laws to transmit to the New York State Board for Professional Medical Conduct the results of a disciplinary proceeding, or any information obtained in the course of an investigation or hearing concerning a member of the Society with, or without a recommendation, as they deem appropriate.

It is important to note that in New York State, the county medical society's disciplinary authority is strictly limited to members and may be avoided by any doctor by the simple device of resignation or failure to pay dues. (In this State, membership in the county medical society is voluntary.)

During the period, 1972–1976, the Board of Censors considered approximately 400 cases.

During 1974–1975, charges were preferred against 3 physicians, and 4 cases were referred to the New York State Education Department.

In 1975–1976, 3 cases were referred to the New York State Division of Professional Conduct; 3 to the Office of Professional Medical Conduct of the New York State Department of Health and one case to the office of the Attorney General of the State of New York.

Over 90% of the cases investigated by our society are patient complaints against physicians. About 10% involve complaints of one physician about another, or requests by physicians for ethical opinions relating to advertising, media appearances or the conduct, or sale, of their practice.

Beginning in August 1975, our disciplinary committees have received complaints from the New York State Board of Professional Medical Conduct relating to our members. It has been our practice to conduct the initial investigation and report our findings to the State Board for further action, if such action is deemed appropriate.

Peer Review, the all-inclusive term for medical-review efforts, is carried out by subcommittees which function in the following areas:

1) Medical Audit—a retrospective examination of the clinical application of medical knowledge, advancing the level of medical care.

2) Claims Review—peer review and adjudication of claims questions referred for peer review by any party with a valid interest in the case.

3) Utilization Review—the evaluation of the efficient use of professional medical care services, procedures and facilities.

While the Board of Censors is the Society's only disciplinary body, our Peer Review activities are carried out by specialized subcommittees, which function in the areas as described in the foregoing paragraph. These subcommittees, it should be noted, do not have disciplinary powers, but may make recommendations. The scope of their activity is limited to fact-finding and education. These are the subcommittees of peer review: (a) Grievance; (b) Medicare-Medicaid Medical; (c) Medicare-Medicaid Surgical; (d) Medical Insurance Review.

During the period 1972–76, the Grievance Subcommittee considered a total of 800 complaints from the lay public. The Subcommittees on Medicare-Medicaid Medical and Surgical, a total of 110, submitted by the fiscal intermediary for this area, and the New York City Medicaid Department. Those cases which in the judgment of these committees violated either medical ethics or the law were referred either to our Board of Censors (in the case of ethical violations) or directly to the Office of Professional Medical Conduct of the New York State Department of Health (in the case of legal violations), for further investigation.

During the ten-year period, 1966–1976, ten physicians were expelled from membership in this society. None of these cases were primarily related to abuse of Medicare or Medicaid. Because our Society does not have statutory authority to take any action which would lead to revocation or suspension of a doctor's license to practice medicine, it has been our practice to refer serious matters directly to the State agency with the authority to do so. At present, it is the New York State Department of Health's Office of Professional Medical Conduct. In the past it was the New York State Department of Education.

Within the past year, our Board of Censors has referred 14 complaints, along with the reports of our investigative bodies, to the Office of Professional Medical Conduct, or its predecessor the Division of Professional Conduct, for official action. In one of these cases, our

investigative committee concluded that the physician was guilty of over-utilization and consequent over-charging of Medicaid; presentation of false bills with inaccurate diagnoses; unnecessary injections of Vitamin B–12 and Prednisolone, both given indiscriminately, and the Prednisolone frequently contraindicated by the patient's condition; poor quality and substandard medical care.

We are currently conducting investigations in three cases which involve physicians who have received prior direction by our Medicare-Medicaid Subcommittee to cease their patterns of practice, which in that committee's estimation, amounted to abuse of Medicare or Medicaid. We expect these cases to be tried before our Board of Censors in the Fall of this year. If the charges against these physicians are sustained, disciplinary action, which could include expulsion from membership in the society, will be taken.

As you can see by the foregoing, the Medical Society of the County of New York maintains a close working relationship with all state and local agencies and law enforcement agencies regarding referral of, and action on, cases of alleged professional misconduct.

The Principles of Professional Conduct of the Medical Society of the State of New York (our Canon of Ethics) provides in Chapter I, Section 5, that "An ethical doctor of medicine . . . limits the sources of his professional income to professional services rendered the patient.

"He should receive his remuneration for professional services rendered only in the amount of his fee specifically announced to his patient at the time the service is rendered or in the form of a subsequent statement, and he should not accept additional compensation, secretly or openly, directly or indirectly, from any other source, except as provided in Article VI, Section 3, of Chapter III."

The new regulation of the Board of Regents states that a physician who has a financial interest in a percentage letting facility is committing an act which can constitute unprofessional conduct.

The Medical Society of the County of New York, in cooperation with the other four county medical societies in New York City, participated in the development of an amendment to the New York City Local Medical Plan governing the Medicaid program regarding shared health facilities (Item 230). Representatives of the Society testified many times in support of Item 230 and have, through our representation on the Interprofessional Society Advisory Committee to the Medical Assistance Program (Medicaid) of the Department of Health of the City of New York, been instrumental in the implementation of this legislation. Hopefully, the action we have taken regarding the problem of percentage letting will serve to overcome the injunctions against Item 230.

The question of factoring has not been addressed by our medical society nor, as far as I know, by the American Medical Association or the Medical Society of the State of New York. On general principles of medical ethics, factoring would be frowned upon, but it is not specifically forbidden. We are aware of the fact that factoring is becoming more common in the medical profession because of the long delay in payment of bills, especially for services provided to Medicaid recipients. Quite frankly, as far as medical ethics are concerned, there have been many more pressing problems for us to address, including the problem of percentage letting.

The major complaints of physicians regarding the Medicaid program are: substandard payment schedules; excessive delays in reimbursement (necessitating the use of factoring agencies); excessive paperwork and difficulties encountered in competing with Medicaid Mills. In addition, our members have the same complaints as the medical consumer, i.e., the present Medicaid mechanism has fostered overutilization, inappropriate consultations, substandard medical care, and indiscriminate drug prescription.

I would consider the hypothetical problem you pose in question 10 of your letter of June 17, 1976, to be suspect, but one which would have to be determined on an ad hoc basis. The key question, of course, is control by the physician of all professionals providing medical services to patients. On its face, the situation you outline is exactly that which would be encountered by a physician practicing in a hospital setting. To me, one thing I would want to know is, who is responsible? The question is not so much whether or not the "doctor's independence" is preserved, but, rather, whether or not the doctor is directly accountable to the patient for any abuse, negligence, or nonfeasance, which constitutes part of that patient's total care.

Sincerely yours,

JOHN A. FINKBEINER, M.D., *President.*

[Enclosure]

Attached letter to:

Dr. J. Richard Burns, General Counsel, Medical Society of the State of New York, 420 Lakeville Road, Lake Success, N.Y. 11040.

Dr. Nathan Greenstein, President, Bronx County Medical Society, 2455 Sedgwick Avenue, Bronx, N.Y. 10468.

Dr. Marvin Markowitz, President, Kings County Medical Society, 1313 Bedford Avenue, Brooklyn, N.Y. 11216.

Dr. William Hewlett, President, Queens County Medical Society, 112–25 Queens Boulevard, Forest Hills, N.Y. 11375.

Dr. Ivan L. Bennett, President, New York County Medical Society, 40 West 57th Street, New York, N.Y. 10019.

Dr. Gerald Evans, President, Richmond County Medical Society, 101 Third Street, Staten Island, N.Y. 10306.

JUNE 17, 1976.

DEAR DR. BURNS: Our Committee is reviewing the operation of the Medicaid program in New York State and would appreciate your cooperation in answering the following questions:

(1) Does your Society consider the situation where a physician pays a rental for office space and related services based on a percentage of either his gross income or net income as unethical?

(2) What disciplinary actions are within the powers of your Society? How many cases have been referred to you for investigation in the past four years by source of referral?

(3) Has your Society taken any disciplinary action against any physician during the period from January 1966-January 1976? If so, please provide a summary of each case. Specifically, (1) how many licenses have been revoked and (2) how many of them were related primarily to Medicare/Medicaid abuses?

(4) What type of liaison do you maintain with State and local health departments and law enforcement agencies regarding referral of and action on cases of alleged professional misconduct?

(5) Does your Society consider it unethical for a physician to have a financial interest in any company or partnership which leases space, provides "factoring" or other services to other medical professionals?

(6) What is your Society's position on the proposed Item 230 amendment to the New York City Local Medical Plan governing the Medicaid program (i.e., regarding share health facilities)?

(7) Does your Society consider it proper for a physician to utilize a "factoring" company to collect his Medicaid claims regardless of the commission charged by such a company?

(8) Based on your experience, what are the five major complaints physicians have regarding the Medicaid program and what are the five major types of physician abuses of the Medicaid program?

(9) Does your Society consider the current average of 35 percent of gross income charged as rental to many medical practitioners in Medicaid-based "shared health facilities" in New York City as reasonable or ethical?

(10) Do you consider the following type of situation as one which endangers the independence of a member of your Society in the control and operation of his professional practice: where the landlord provides not only office, waiting room space, and equipment, but also all custodial, clerical, secretarial and administrative services including centralized record maintenance and selection of laboratory to be used by practitioners in the building.

With best wishes,

Sincerely,

FRANK E. MOSS,
Chairman, Subcommittee on Long-Term Care.

[Reply]

AUGUST 10, 1976.

DEAR SENATOR MOSS: I thank you for your letter of August 2d with copy of your letter to The Dental Society of the State of New York, dated June 17, 1976. The copy was most opportune since our files did not contain the original letter. This accounts for our failure to reply.

After considerable thought, it seems best to reply to your complex questions in number order.

1. Yes.

2. The only disciplinary actions open to branches of this Society are expulsion, suspension and censure. No cases are referred to the DSS NY. Action is taken at the local district level. This Central Office has no statistics on such activity.

3. Revocation of licensure is only within the power of the State of New York, which originally granted such license. It is suggested that you contact the Office of Professional Conduct, New York State Education Department, 261 Madison Avenue, New York, New York 10016, for such information.

4. Liaison with state enforcement agencies is relatively good. We are in contact with both the Health Department and the Education Department.

5. No, if the dentist does not use his degree to promote the activities of the company or partnership.

6. It agrees with the plan.

7. Yes.

8. Complaints are: very low fees; extreme bureaucratic redtape; slowness in processing claim forms; patient abuse of the professional relationship, i.e. broken appointments, etc. Abuses are: overutilization; medicaid mill ping-ponging; poor quality treatment; fraud.

9. It considers 35% unreasonable. It has no opinion that a business relationship should be considered unethical.

10. It certainly endangers the independence and control of a professional practice.

Sincerely,

SEYMOUR L. NASH, D.D.S.,
Executive Director.

JULY 29, 1976.

DEAR SENATOR MOSS: This is in reply to your letter requesting information from the First District Dental Society of New York concerning the operation of the Medicaid program in the state.

The First District is opposed to leasing on a percentage basis of income in "shared health facilities". I have been informed that according to a recent State Education Department's official release, entering into percentage leases now constitutes unprofessional conduct in New York State. The Society is not opposed to cases of similar nature where the procedure is through an organized hospital plan.

The Society is opposed to the basic concept of "factoring" in all phases.

With regard to Item #230 Amendment to the New York City Local Medical Plan, the First District was one of the sponsors of the measure, helped to formulate it and worked very hard to get it approved. We feel that enforcement of Item #230 is dependent upon the prohibition of percentage of gross rental arrangements.

The Society has an agreement with New York City Medicaid where our Peer Review Committee will render an opinion as to quality of dental treatment, when requested by the City Medicaid Administrators. I understand the State Medicaid is opposed to using external peer review.

Disciplinary actions that are within the powers of the Society concern matters of professional ethics. Matters of violation of the State Dental Practices Act and matters of professional conduct are under the jurisdiction of the State Department of Education.

Major complaints that dentists have regarding the Medicaid program are concerned with preauthorization, alternate methods of treatment, delay in reimbursement and arbitrary administrative procedures. I have no information on major type of dentist abuses. It would seem that the Medicaid Administration itself would be a better source of information on this point.

And lastly, the case you cite where the landlord provides multiple types of services is considered a situation as one which endangers the independence of a member of our Society in the control and operation of his professional practice.

Respectfully yours,

RAYMOND H. FRIESZ, D.D.S.,
Executive Director.

JUNE 28, 1976.

DEAR SENATOR MOSS: With reference to your request for the opinions of the Eleventh District Dental Society (Queens County, N.Y.) as to the operation of the Medicaid program in New York State, I respectfully submit the following:

1. Letter dated March 3, 1976, directed to the Regents of the University of the State of New York recommending legislative or regulative action to correct abusive practices currently engaged in by "shared health facilities."

2. Letter dated February 23, 1976, to the Regents, from the Medical Society of the County of New York in opposition to lease of office space for a percentage of income, proposing that a regulation be established to declare gross rental arrangements as illegal as well as unethical. The Eleventh District Dental Society is in full agreement that such regulations are necessary to safeguard the quality of health care including dental care provided under the Medicaid program.

3. Letter dated March 15, 1976, from Regents of the University of the State of New York to Dr. Hollander, Deputy Commissioner, and Robert D. Stone, Esq., Counsel and Deputy Commissioner of the New York State Education Department suggesting that the problem of "Medicaid Mills" is pressing and scheduling a meeting of appropriate officials to discuss remedial action. The proceedings of this conference are available from Emlyn I. Griffith, Chairman, Regents Committee on Professional Discipline, University of the State of New York, State Education Department, 225 N. Washington Street, Rome, New York 13440. Generally the recommendations of this conference were to support legislative action to prohibit "percentage leasing" in shared health facilities which provide health care services reimbursable thru the Medicaid program.

Presently there is before the legislature of the State of New York, a bill which would adequately regulate shared health facilities and prohibit percentage leasing. The Eleventh District Dental Society firmly supports this legislation. Should the legislature pass this bill, there is indication that a constitutional challenge may be instituted. We would hope that any such appeal would be unsuccessful and that appropriate regulation by the state laws be established to correct obvious abuses in the Medicaid system by entrepreneurs whose operation in many instances is inimical to the best interests of the public.

Item 230 amendment to the New York City Local Medical Plan governing the Medicaid program intended to prohibit percentage leasings, will be frustrated should state and possible federal action not be advanced to accomplish this same result.

The Eleventh District Dental Society believes further that "factoring" for collection of Medicaid claims is improper and should be regulated. It is clear that if Medicaid is effectively administered (which is not the case) to provide prompt payment of claims, "factoring" would not be significantly indulged in. The clear effect of "factoring" is to lower the net reimbursement to the health provider—suggesting that the health service could have been provided for an amount less the "factoring" percentage. The net result is to lower the quality of care provided to accommodate to the decrease in reimbursement.

I should additionally comment that the Medicaid program in New York State, which held so great a promise for the medically needy,

is at a very low ebb indeed. There is an immense backlog of need for dental care, for the medically indigent in New York State—a need which is poorly met, and in a totally inefficient and ineffective manner. Division of administration authority between the Departments of Health and of Social Services creates confusion, duplication and dichotomy. As a consequence of bureaucratic mal-administration and impossibly inadequate fee reimbursement set at 1966 levels, 95% of dentists in New York State find that they cannot conscientiously participate to any significant degree in the program. As a result of unrealistic fiscal policy and mismanagement, the Medicaid program in New York City has degenerated to the point where there is a burgeoning movement to the establishment of "shared health facilities" or "medicaid bills"—indeed a sad commentary on so bright a promise for the delivery of health care to the poor.

I believe that an environment no longer exists in New York State in which Medicaid can hope to achieve the objective for which it was originally conceived. I recommend that an amendment to the Medicaid legislation be sought which will formulate a basic program for the medically indigent entirely at federal expense and that it be made available uniformly throughout the United States and be supplemented at the discretion of states by means of matching subsidies.

The dental profession, having experienced 10 years of the unfortunate failures of Medicaid, urges that administration of the program be transferred to fiscal intermediaries, under the supervision and regulation of government, rather than presently ineffective management by dual governmental agencies.

We have repeatedly stated our objections to and continue to oppose practices by individual or group providers which utilize dubious and ill-conceived practices for their own self aggrandizement rather than the provision of quality health care for the public.

It may be of some help to briefly review the reasons for the accelerated growth of group practices and shared health facilities for the delivery of health care under the Medicaid program. Maximum allowable fee schedules for reimbursement to providers of dental care in the medicaid program for New York State were promulgated in 1966, revised downward by 20% in 1969, and raised as of April 1, 1974 by 25%; so that the present maximum allowable dental fee schedule equates with 1966, ten years ago. I am sure you realize the steep escalation in the cost of living and consumer price indexes in the years since 1966. Added to the inadequacy of reimbursement, excessive paper work and long delays in payment of claims results in the reluctance of most health providers to participate in medicaid practice. Altogether the short sighted financial and administrative policies have produced the deplorable condition wherein 95% of dental medicaid services are provided by less than 5% of licensed dentists in the City of New York. Medicaid is so encumbered administratively and at such substandard reimbursement levels as to make it virtually impossible for a dentist to perform the services and yet maintain his professional responsibilities to his patients.

It is no wonder then that some entrepreneurs, utilizing the concept of shared health facilities and assembly line delivery centers, have entered the vacuum created by government failure to effectively reform the medicaid program. It is no wonder that of the miniscule percentage

of the dentists now participating to any degree in Medicaid, there is an even smaller percentage which finds it opportune to rely upon high volume practices to economically survive in the delivery of health care under the medicaid program.

It is not unexpected, though certainly lamentable, that such practices have subjected needy persons to unreasonable segregation and indignity in obtaining health care services.

The resolution of the problem is to so order the medicaid program so that indigent recipients would find it conveniently possible to be treated by their freely chosen family dentist, in the same manner and with the same dignity of person as the remainder of the population. Objectionable practices should be prohibited by regulatory fiat or by legislation directed specifically to their elimination.

I hope that the foregoing may be of assistance to your review of the operation of the Medicaid program in New York State. I urge that amendments to federal medicaid legislation will be directed to provide the medically indigent with access to health care of a quality equivalent to other sectors of our population.

Sincerely,

EMIL LENTCHNER, D.D.S.,
Executive Director.

MARCH 3, 1976.

DEAR SIR: The Eleventh District Dental Society and we, personally and as a result of a long time contact with administration of Dental Medicaid in the City and State of New York, have the most vital concern over the lack of any reasonable regulation of the abusive practices currently engaged in by shared health facilities. The enclosed letter addressed to you by Dr. Bennett on behalf of the Medical Society of the County of New York, explicitly details the problems and suggest that the Board of Regents rule on the percentage of gross rental arrangements as illegal and/or unprofessional.

We endorse the suggestion that the Board of Regents go on record in declaring that current arrangements in which percentage of gross receipts in utilized for rentals does in fact represent fee splitting, with all that connotes to the detriment of the delivery of high quality health care to the citizens of this city and state.

We urge your immediate consideration of appropriate action in this matter.

Sincerely,

PAUL S. KAUFMAN, D.D.S.,
President.
EMIL LENTCHNER, D.D.S.,
Executive Director.

FEBRUARY 23, 1976.

DEAR SIR: In November of 1975, members of the Interprofessional Societies Advisory Committee for Medicaid, New York City Department of Health, Bureau of Health Care Services met with your committee to discuss regulation of medical services in shared health facilities, sometimes referred to as Medicaid Mills.

This letter and the attached materials support our request at that meeting, that you rule percentage of gross rental agreements between licensed health providers and entrepreneurs to be illegal.

The Interprofessional Societies Advisory Committee for Medicaid (Exhibit A) is composed of official delegates of professional associations, municipal health services, and social services agencies. The Committee has met regularly since the enactment of the Medicaid laws to address problems of the system's health service delivery.

A common practice of shared health facilities is for the holding corporation to provide office space, equipment, x-ray and laboratory services, nursing personnel, and bookkeeping and clerical services for practitioner lessees in return for a varying percentage of their gross Medicaid billings.

A typical example of such arrangements is documented in the Post Trial Memorandum of Corporation Counsel (Exhibit B, pp. 4–8). Practitioners working in these facilities have oral agreements with the management to pay up to 70% of gross income (Exhibit B, p. 8). Such arrangements work to the detriment of patients since the non-professional landlord entrepreneur retains the authority over organizational structure and staffing of the facility. The physician and other independent health care providers are present on a part-time basis and have no authority over the support staff. Since all patients come to the practitioners through the direction of the management, it is common practice for a patient to be referred to a number of practitioners within the facility in order to increase Medicaid billings. A routine practice is for the entrepreneur to pressure the physician to see as many patients as possible in order to increase the facilities gross Medicaid billing. This practice sacrifices quality medical care for the increased income of the entrepreneur.

In addressing this problem, the Advisory Committee for Medicaid set two goals: First, to insure that health care will continue to be provided to citizens through the mechanism of controlled shared health facilities which provide a uniform level of health care. Second, to create legislation which sets minimum standards and requires registration and control of such facilities. The result of this effort was Item 230 of the local medical plan for the New York City Social Services District (Exhibit C). Enforcement of Item 230 hinges on the prohibition of percentage of gross rental arrangements (Exhibit C, p. 6, at § 230.5).

Item 230 has been challenged by the owners of shared health facilities. *Association of Health Care Facilities Incorporated v. Lowell E. Bellin, et al.*, was argued in the Supreme Court of Kings County in July. No decision has been announced. The plaintiffs' argument relied heavily on a series of opinion letters from Mr. Stone, your Counsel and Deputy Commissioner for Legal Affairs, which state that percentage of gross rental arrangements are not illegal. (Exhibit D and Exhibit B at 11–13.) Although the members of the Interprofessional Advisory Committee, as well as the Comitia Minora (Board of Directors) of The Medical Society of the County of New York, The New York States Dental Association, and The New York State Podiatry Association agree with the interpretation expressed in the enclosed Defendant Post Trial Memorandum (Exhibit B, at 12), that such reliance is not justified by a close reading of Mr. Stone's opinion letters, the lack of a clear rule by the Board of Regents does leave the question open.

It is our understanding that local regulations must give way to state law. Mr. Stone's opinion letters have the force of law if there is no official rule of regulation by the Board of Regents on this subject. We therefore urge the Board to clarify their position on this question by an official rule. We also urge the Board to rule that such arrangements are illegal. We believe that local regulations such as Item 230, are carefully designed to correct many of the abuses in the Medicaid system. Their effect should not be frustrated by the Board of Regents' silence on this important question.

The position of the medical profession is that the percentage of gross rental arrangements are unethical. The American Medical Association's *Judicial Council Opinions and Reports* states, (§ 7, PP. 23):

> An arrangement by virtue of which a physician leases office space for a percentage of income is not acceptable; it is violative of ethical principles. The practice indirectly results in fee-splitting and tends to exploit the practice of medicine. If the size of a doctor's practice increases and imposes additional demands on the facilities of the building, these facts may be considered when the time comes to renegotiate the rental value of the lease premises and a new fixed rental, taking these items into account, might be agreed upon.

Until recently, professional societies have been unable to take action against members who participated in percentage of gross rental arrangements. First, because uniform registration of shared health facility practitioners was not required. Second, it has been virtually impossible to get documented evidence of lease arrangements. Third, because an attack on this limited ground could easily be construed as a condemnation by the professions against shared health facilities themselves which we believe do perform a valuable and necessary service in underprivileged areas. However, the New York County Medical Society has maintained a consistent position of advising its members that such arrangements are unethical (Exhibit E). In recent months, our position has been strengthened by our designation as the official utilization review body for Medicaid. The New York County Medical Society has taken positive action in letting our members know their responsibilities. We have also instituted a program of thorough investigation when complaints reach us regarding abuses in Medicaid facilities.

The New York City Department of Health, Bureau of Health Care Services, has agreed to supply us with a roster of physicians participating in shared health facilities.

A declaration by the Board of Regents that percentage of gross rental arrangements are illegal as well as unethical is an important first step toward the regulation of shared health facilities in New York City. We believe that Item 230 represents one of the few times that the professions and the city administration have been in full agreement on a remedy for problems of health care delivery. We know that the goal of your committee is to do everything possible to safeguard the quality of health care for our citizens. We need your support on this question.

The Medical Society of the County of New York urges the Board to recognize that the current arrangements involving percentage of gross rental as discussed does represent fee-splitting with all its hazards.

Sincerely yours,

IVAN L. BENNETT, Jr., M.D., *President.*

APRIL 2, 1976.

From: Emlyn I. Griffith, Chairman, Regents Committee on Professional Discipline

To:

Dr. Henry I. Fineberg, Executive Vice-President, Medical Society of the State of New York

Dr. Seymour L. Nash, Executive Director, The Dental Society of the State of New York

Mr. Sal Rubino, Executive Secretary, Pharmaceutical Society of the State of New York

Mr. Gilbert Hollander, Executive Director, Podiatry Society of the State of New York

Miss Florence Pressman, Administrative Director, New York State Optometric Association

Mr. Howard Davis, Executive Secretary, New York State Chiropractic Association

Mr. Murray Doody, Executive Secretary and Counsel, Society of Dispensing Opticians, Inc.

Dr. Julia L. Freitag, Assistant Commissioner for Health Manpower, Department of Health

Dr. Thaddeus Murawski, Director, Office of Professional Medical Conduct, Department of Health

Dr. Ivan L. Bennett, Jr., President, Medical Society of the County of New York

Dr. T. Edward Hollander, Deputy Commissioner State Education Department

Mr. Robert D. Stone, Deputy Commissioner and Counsel, State Education Department

Dr. E. E. Leuallen, Associate Commissioner State Education Department

Mr. Robert S. Asher, Director Division of Professional Conduct State Education Department

Dr. Jackson W. Riddle, Executive Secretary State Board for Medicine

Dr. Donald F. Wallace, Executive Secretary State Board for Dentistry

Dr. Albert J. Sica. Executive Secretary State Board of Pharmacy

Mr. Kenneth T. Stringer, Executive Secretary State Board for Podiatry, State Board for Optometry and State Board for Opthalmic Dispensing

Mr. Philip R. Johnston, Executive Secretary State Board for Chiropractic

Re: Shared health facilities and percentage rentals

Last week Chancellor Theodore M. Black and my colleagues on the State Board of Regents approved final plans for the upcoming con-

ference on shared health facilities ("Medicaid mills") and the adverse professional and fiscal effects of percentage rentals.

I will convene the conference promptly at 9:30 a.m., Tuesday morning, April 27, in the Regents Room, State Education Building, Washington Avenue, Albany, New York, and devote one and one-half hours to off-the-record discussions of the first four items on the agenda outlined below. The next hour will be devoted to on-the-record discussion of item 5 ("recommendations for corrective action") and be open to the news media. For the convenience of participants from New York City, I will strive for adjournment at 12:00 noon.

The professions will be represented by the societies and associations listed above and by the executive secretaries of their state boards. State and municipal agencies will be represented by the departments and bureaus listed above and by key officials of the State Education and Health Departments.

Attendance will be limited by the size of the Regents Room, which can accommodate 18 principals, 24 observers and 6–8 media representatives. Persons planning to attend from the Albany area should contact E. E. Leuallen, Associate Commissioner, State Education Department, Albany, New York 12224, (518–474–3862). Persons planning to attend from the metropolitan area should contact Gary Gatza, Board of Censors Medical Society of the County of New York, 40 West 57th Street, New York, 10019, (212–582–5858).

Subject to minor modification, the agenda will be as follows:

1. Identification and explanation of problems, including harmful effects on the public.
2. Comments by Counsel Robert D. Stone on current Regents Rules and Commissioner's Regulations.
3. Comments by representatives of affected professional societies and state boards on current codes of ethics and professional conduct.
4. Consideration of possible revisions in Regents Rules, Commissioner's Regulations and codes of conduct.
5. Recommendations for corrective action by the Regents, affected professions and governmental agencies.

Our Committee on Professional Discipline will consider all recommendations immediately after the conference on April 27, and the entire Board of Regents has been alerted to the possibility of appropriate action during our April 27–29 meetings. Therefore, I have requested Mr. Stone and Dr. Leuallen to submit drafts of possible changes in Regents Rules and Commissioner's Regulations which would address our mutual concerns. Similarly, I am encouraging the various professional groups to present drafts of possible changes in their codes of ethics and conduct which would complement action by the Regents. The basic problems involve all of us, and solutions must be developed in concert.

If you have questions about the substance of the conference on April 27, do not hesitate to call me. If you have questions about procedure or if you wish to have materials distributed in advance, pleace call either Dr. Leuallen or Mr. Gatza as indicated above.

EMLYN I. GRIFFITH,
Chairman, Regents Committee on Professional Discipline.

MARCH 15, 1976.

Re: Shared health facilities ("Medicaid Mills") in New York City

DEAR TED and BOB: You will recall that representatives of the Medical Society of the County of New York and other health-related professions in the metropolitan area met with the Regents Committee on Professional Discipline in New York City on November 19, 1976. The discussion on the above subject was informative and productive.

Recently, representatives of the same professional groups requested another session with our Committee; and I have tentatively set the meeting for 9:30 a.m., Tuesday, April 27, 1976, at the Regents Room, State Education Building in Albany.

In addition to our Committee members, I would expect that Messrs. Hollander and Stone be present, along with Dr. Leuallen and executive secretaries of the State boards for Medicine, Podiatry and Dentistry. I also suggest that Dr. Leuallen invite the executive secretary of the State Board for Professional Medical Conduct in the State Health Department.

The problem of "Medicaid mills" is pressing, and I believe that the Regents and State Education Department should assume a leadership role and strengthen our bonds with the affected professional groups.

Logistics for the meeting can be arranged by William Carr, Secretary of the Board of Regents, and Mr. Gary Gatza, Staff Investigator of the Medical Society of the County of New York.

Cordially yours,

EMLYN I. GRIFFITH, *Regent.*

ITEM 7. LETTER TO JULE SUGARMAN, CHIEF ADMINISTRATIVE OFFICER, CITY OF ATLANTA, GA., AND REPLY

JUNE 17, 1976.

DEAR MR. SUGARMAN: My Subcommittee on Long-Term Care of the Senate Committee on Aging is evaluating the administration of the Medicaid program in two States, California and New York.

In connection with our New York investigation, we are tracing the possible results and effects of the Fourth November 1969 Grand Jury's protracted study of Medicaid abuses in New York City. The files of the New York County District Attorney indicate that you received a copy of the Grand Jury's report during your term as Commissioner of Social Services in New York. (I enclose copies of the letter of transmittal signed by Assistant District Attorney John C. Fine, and a copy of the Grand Jury presentment which is the subject of that letter).

Would you be so kind to tell me if you personally reviewed this report and what actions you took with respect to its recommendations? If you did not review the report, can you tell me if any action was taken with respect to it in your office and by whom it was taken?

I would appreciate your early reply to this request.

With best wishes,

Sincerely,

FRANK E. MOSS.

Chairman, Subcommittee on Long-Term Care.

[Reply]

JULY 13, 1976.

DEAR SENATOR MOSS: I am pleased to respond to your letter of June 17, 1976. Unfortunately, I am considerably handicapped in doing so because none of the records of our experience with the Grand Jury report are available to me here in Atlanta. Therefore, I will have to rely basically on my memory of the events surrounding that Grand Jury report.

I think the first point to note is that the Grand Jury report was provided to the Human Resources Administration only after it had been leaked to the press and some two (2) years after the report of the Grand Jury was actually made. Our first knowledge of the report came when the press asked us about it. We were forced to react without the benefit of having the report in hand. In fact we experienced considerable difficulties, even after the newspaper account, in getting the courts and the District Attorney to release a copy of the report. Once the report was obtained, we found that very little of it was sufficiently detailed for us to be able to investigate specific misdeeds. Many of the general practices which were criticized were by that time known to me (I had arrived in the Human Resources Administration in July 1970) and a broad scale and vigorous campaign of reform was already underway. Similarly, a number of developments had taken place in the City's Health Department, most particularly the installation of a Quality Control Program under which City dentists and physicians were double checking the quality of dental work and medical care on a sample basis and confirming that it had actually been provided and had been appropriately done. The computer payment system and medical records were in very bad condition when I arrived in the City, despite numerous consultant reports aimed at improving the situation. We did succeed in making a number of major improvements over the next two years, but were considerably delayed by conflicts between the state and city governments as to exactly how we should proceed. At the time I left New York in 1974, the matter was not fully resolved and an effective medicaid computer system operation was not fully operational.

There were a whole series of other reforms carried out, not primarily due to the Grand Jury report, but to the fact that I had ordered a number of other investigations which showed what had to be done.

The Medicaid system, like most parts of the Welfare system, is an administrative impossibility in my judgment. I do believe that marginal improvements can be made under the present law, but do not expect that the integrity of the system and the quality of service can ever reach acceptable levels without substantial changes in law.

Sincerely,

JULE M. SUGARMAN.

ITEM 8. LETTER TO MICHAEL WHITEMAN, ESQ., FORMER COUNSEL TO FORMER GOVERNOR NELSON ROCKEFELLER, AND REPLY

JUNE 17, 1976.

DEAR MR. WHITEMAN: My Subcommittee on Long-Term Care of the Senate Committee on Aging is evaluating the administration of the Medicaid program in two States, California and New York.

In connection with our New York investigation, we are tracing the possible results and effects of the Fourth of November 1969 Grand Jury's protracted study of Medicaid abuses in New York City. The files of the New York County District Attorney indicate that you received a copy of the Grand Jury's report during your term as Counsel to the Governor. (I enclose a copy of the Grand Jury presentment which is the subject of this letter).

Would you be so kind to tell me if you personally reviewed this report and what actions you took with respect to its recommendations? If you did not review the report, can you tell me if any action was taken with respect to it in your office and by whom it was taken?

I would appreciate your early reply to this request.

With best wishes,

Sincerely,

FRANK E. MOSS, *Chairman,*
Subcommittee on Long-Term Care.

[Reply]

JULY 8, 1976.

DEAR SENATOR MOSS: I write in response to your inquiry of June 17 concerning the Report of the Fourth of November 1969 Grand Jury of New York County on the administration of Medicaid in the City of New York.

The subject matter of the Grand Jury's report was central to the investigative responsibilities and concerns of both the State Welfare Inspector General and the Temporary State Commission to Study the Governmental Operations of the City of New York.

Accordingly, at the direction of then Governor Rockefeller, I referred copies of the Grand Jury's report to George Berlinger, State Welfare Inspector General, and Stuart N. Scott, Chairman of the Temporary State Commission to Study the Governmental Operations of the City of New York for their attention. Copies were also furnished to Dr. Andrew C. Fleck, First Deputy Commissioner of Health, and Barry L. Van Lare, Executive Deputy Commissioner of Social Services with the request that they make the aid of their respective departments available to Messrs. Berlinger and Scott in their respective investigations. I enclose copies of my letters for your convenient reference.

If I can be of any further assistance, please do not hesitate to call upon me.

Sincerely,

MICHAEL WHITEMAN.

ITEM 9. LETTER TO VICE PRESIDENT NELSON ROCKEFELLER; INTERIM RESPONSE RECEIVED AS OF TIME OF PRINTING

JUNE 17, 1976.

DEAR MR. VICE PRESIDENT: My Subcommittee on Long-Term Care is evaluating the administration of the Medicaid program in two States, New York and California.

In connection with our investigation in New York we are tracing the results of the Fourth of November 1969 Grand Jury's protracted study of Medicaid abuse in New York City. The files of the New York

County District Attorney indicate that during your term as Governor of New York, you received at least two copies of the Grand Jury's report. I enclose copies of the letters from the District Attorney's records and a copy of the Grand Jury presentment which is the subject of the letters.

Can you tell me if you personally reviewed this report and what actions you took with respect to recommendations in the Grand Jury report? If you did not review the report, do you have any recollection of any actions taken by anyone in the Governor's office with respect to it?

I would appreciate your early reply to this request.

With best wishes,

Sincerely,

FRANK E. MOSS, *Chairman,*
Subcommittee on Long-Term Care.

[Reply]

JUNE 24, 1976.

DEAR SENATOR MOSS: The Vice President has received your inquiry on the Fourth of November 1969 Grand Jury study of Medicaid abuses in New York City.

The files in New York are being researched for the information you request and you may anticipate an early reply.

With best wishes,

Sincerely,

HUGH MORROW,
Assistant to the Vice President.

ITEM 10. LETTER TO JOHN C. MITCHELL, FORMER ATTORNEY GENERAL OF THE UNITED STATES*

JUNE 17, 1976.

DEAR MR. MITCHELL: My Subcommittee on Long-Term Care of the Senate Committee on Aging is evaluating the administration of the Medicaid program in two States, California and New York.

In connection with our New York investigation, we are tracing the possible results and effects of the Fourth of November 1969 Grand Jury's protracted study of Medicaid abuses in New York City. The files of the New York County District Attorney indicate that you received a copy of the Grand Jury's report during your term as Attorney General. (I enclose copies of the letter of transmittal signed by Assistant District Attorney John C. Fine, and a copy of the General Jury presentment which is the subject of that letter).

Would you be so kind to tell me if you personally reviewed this report and what action you took with respect to its recommendations. If you did not review the report, can you tell me if any action was taken with respect to it in your office and by whom it was taken.

I would appreciate your early reply to this request.

With best wishes,

Sincerely,

FRANK E. MOSS, *Chairman,*
Subcommittee on Long-Term Care.

*Mr. Mitchell's interim reply indicated that the information requested could be obtained from the Department of Justice, to which a request was then sent.

ITEM 11. LETTER TO PERRY DURYEA, MINORITY LEADER, NEW YORK STATE ASSEMBLY, AND REPLY

JUNE 17, 1976.

DEAR SENATOR DURYEA: My Subcommittee on Long-Term Care of the Senate Committee on Aging is evaluating the administration of the Medicaid program in two States, California and New York.

In connection with our New York investigation, we are tracing the possible results and effects of the Fourth of November 1969 Grand Jury's protracted study of Medicaid abuses in New York City. The files of the New York County District Attorney indicate that you received a copy of the Grand Jury's report during your term as Speaker of the Assembly. (I enclose copies of the letter of transmittal signed by Assistant District Attorney John C. Fine, and a copy of the Grand Jury presentment which is the subject of that letter).

Would you be so kind to tell me if you personally reviewed this report and what actions you took with respect to its recommendations. If you did not review the report, can you tell me if any action was taken with respect to it in your office and by whom it was taken.

I would appreciate your early reply to this request.

With best wishes,

Sincerely,

FRANK E. MOSS, *Chairman,*
Subcommittee on Long-Term Care.

[Reply]

JULY 23, 1976.

DEAR SENATOR MOSS: I am in receipt of your letter of June 17, 1976 with regard to the Grand Jury presentment on the administration of the Medicaid Program in New York. There is no question that there are many abuses of Medicaid.

Following the release of the report of the Grand Jury investigation, the New York State Legislature created the Office of Welfare Inspector General as a separate division within State government. This Office conducted a thorough investigation into the City of New York and was most successful in its findings and recommendations. However, New York State's Chief Executive, newly elected in 1974, tried to abolish this position. The people, aware of the work and the accomplishments of the Welfare Inspector General, resisted. The Governor's reaction was to keep this Office, but to relegate the Inspector General as an employee in the Office of the Comptroller. Nevertheless, you may wish to contact that Office for an account of its findings.

I trust this information will be of help to you and thank you for contacting me.

Sincerely,

PERRY B. DURYEA.

ITEM 12. LETTER TO JOHN V. LINDSAY, FORMER MAYOR, CITY OF NEW YORK, AND REPLY

JUNE 17, 1976.

DEAR MR. LINDSAY: My Subcommittee on Long-Term Care of the Senate Committee on Aging is evaluating the administration of the Medicaid program in two States, California and New York.

In connection with our New York investigation, we are tracing the possible results and effects of the Fourth November 1969 Grand Jury's protracted study of Medicaid abuses in New York City. The files of the New York County District Attorney indicate that you received a copy of the Grand Jury's report during your term as Mayor of New York City. (I enclose copies of the letter of transmittal signed by Assistant District Attorney John C. Fine, and a copy of the Grand Jury presentment which is the subject of that letter).

Would you be so kind to tell me if you personally reviewed this report and what actions you took with respect to its recommendations? If you did not review the report, can you tell me if any action was taken with respect to it in your office and by whom it was taken?

I would appreciate your early reply to this request.

With best wishes,

Sincerely,

FRANK E. MOSS, Chairman,
Subcommittee on Long-Term Care.

[Reply]

AUGUST 10, 1976.

DEAR SENATOR MOSS: I have your letter of June 17 pertaining to your Subcommittee on Long-Term Care of the Senate Committee on Aging. Please forgive my delay in responding, but since my retirement from government I have been out of the city more than seventy per cent of the time almost the last three years, mainly involving a great deal of foreign business travel; I also wanted very much to give myself a reasonable amount of time to search my memory concerning the questions you have raised.

I have no personal recollection of the Grand Jury study, a copy of which your letter indicates was sent to my office. Naturally, since transmittal of the report apparently took place nearly four years ago, it may be difficult to discover with certainty its fate. However, review and improvement of the City's Medicaid program was a constant priority of my Administration, and I am confident that, upon receipt, the report would have been forwarded to the appropriate City department and carefully studied.

Indeed, as a result of concerns I had which parallel some of those voiced in the Grand Jury report, we took a number of significant steps in New York City to deal effectively with possible abuse in the Medicaid program. As an example, we conceived a massive, new automated system to collect, analyze and evaluate data on our medicaid and other public assistance programs. That effort, monitored by our Human Resources Administration, called for detailed financial analysis of service providers and careful monitoring of client eligibility.

The effectiveness of that system's approach was recognized in an independent study commissioned by the state government and has been further confirmed by recent legislation which I understand was enacted by our State legislature and, I believe, signed into law by the Governor, providing for a Medicaid Management Information System to be funded primarily with federal funds. Since full implementation of the system we conceived has been delayed because of the City's recent fiscal crisis, I hope that you will personally support the providing of federal funds to help us complete the task we had started during my Administration.

Yet another example of our dealing with the concerns voiced in the Grand Jury report was an audit program, supervised by our Health Services Administration, which monitored services rendered, appropriateness of treatment ordered, and actual delivery of services for which Medicaid reimbursement was sought:

Upon my retiring from the Office of Mayor almost three years ago, all of my files and records of every kind were turned over to the Archives of the City of New York and to the Library at Yale University for permanent keep, indexing and micro-filming. I have no papers of any kind in my personal possession nor any staff able to perform research. And my own personal staff at City Hall is pretty much scattered around, overly busy in professional lives of their own or in Federal or State governments around the country. It may well have been, although again I have no personal recollection of this being the case, that if a copy of the report was indeed received by the Mayor's Office, it was routed to the Human Resources Administrator, Jule Sugarman, now Deputy Mayor of the City of Atlanta, or the Health Services Administrator, Gordon Chase, now teaching at Harvard University. It may be that a sensible next step would be for your staff to contact either of these two gentlemen.

I would be happy to be of further assistance to you should that be desired. I hope that this information has been of some help to you.

Sincerely,

JOHN V. LINDSAY.

ITEM 13. LETTER TO HON. ABRAHAM BEAME, MAYOR, CITY OF NEW YORK, AND REPLY

JUNE 17, 1976.

DEAR MAYOR BEAME: My Subcommittee on Long-Term Care of the Senate Committee on Aging is evaluating the administration of the Medicaid program in two States, California and New York.

In connection with our New York investigation, we are tracing the possible results and effects of the fourth November 1969 grand jury's protracted study of Medicaid abuses in New York City. The files of the New York County district attorney indicate that you received a copy of the grand jury's report during your term as comptroller. (I enclose copies of the letter of transmittal signed by Assistant District Attorney John C. Fine, and a copy of the grand jury presentment which is the subject of that letter).

Would you be so kind to tell me if you personally reviewed this report and what actions you took with respect to its recommendations?

If you did not review the report, can you tell me if any action was taken with respect to it in your office and by whom it was taken?

I would appreciate your early reply to this request.

With best wishes,

Sincerely,

FRANK E. MOSS, *Chairman,*
Subcommittee on Long-Term Care.

[Reply]

JULY 26, 1976.

DEAR SENATOR MOSS: I have reviewed actions taken on receipt of the fourth November 1969 grand jury study of Medicaid abuses in New York City. At that time, early 1972, I met with Jule Sugarman, then Administrator of the Human Resources Administration (HRA) to determine what actions were being taken to correct Medicaid abuses. I suggested that high priority be given to developing a computer system to automatically generate client profiles. Mr. Sugarman agreed, and this system is now partially operational.

I am still concerned about the administration of the Medicaid program. In May of this year, I issued an executive order establishing a Medicaid Task Force and designating J. Henry Smith, the current HRA Administrator, as citywide Medicaid coordinator. Mr. Smith's role is to oversee administration of the program and to coordinate the cost reduction measures which are a part of the City's financial plan.

I must say that reducing costs in the Medicaid program can be quite difficult for local government. For example, some time ago the City tried to institute a program to reduce the cost of laboratory services provided to Medicaid recipients. Responding to allegations that costs were inflated due to kickbacks and other abuses, competitive bidding was to be substituted for the existing fee-for-service system. Bids were taken last year and a 50 percent reduction in costs was projected. This program has not yet been instituted. The fee-for-service laboratories instituted a lawsuit. They were joined by H.E.W. who claimed that the City's action would interfere with recipients' freedom of choice. The court stopped the program and asked that an experiment be designed for one borough. The design of that experiment is still waiting for approval from the State of New York and H.E.W. Undaunted, we are pressing ahead with other cost reduction measures.

Sincerely,

ABRAHAM D. BEAME, *Mayor.*

ITEM 14. LETTER TO MARY C. MCLAUGHLIN, COMMISSIONER, SUFFOLK COUNTY, N.Y., DEPARTMENT OF HEALTH SERVICES, AND REPLY

JUNE 17, 1976.

DEAR DR. MCLAUGHLIN: My Subcommittee on Long-Term Care of the Senate Committee on Aging is evaluating the administration of the Medicaid program in two States, California and New York.

In connection with our New York investigation, we are tracing the possible results and effects of the Fourth November 1969 Grand Jury's protracted study of Medicaid abuses in New York City. The files of the

New York County District Attorney indicate that you received a copy of the Grand Jury's report during your term as Commissioner of Health. (I enclose copies of the letter of transmittal signed by Assistant District Attorney John C. Fine, and a copy of the Grand Jury presentment which is the subject of that letter.)

Would you be so kind to tell me if you personally reviewed this report and what actions you took with respect to its recommendations? If you did not review the report, can you tell me if any action was taken with respect to it in your office and by whom it was taken?

I would appreciate your early reply to this request.

With best wishes,

Sincerely,

FRANK E. MOSS,
Chairman, Subcommittee on Long-Term Care.

[Reply]

JULY 1, 1976.

DEAR SENATOR MOSS: In response to your letter of June 17 re the Grand Jury's study of Medicaid abuses in New York City in 1969, I attempted to locate through the mail log in New York City where this report might have been sent. I do not remember reading it, although it is certainly possible that I did. We were very active at that time in uncovering the Medicaid abuses; in fact, in reading through some of the report, many of the cases seemed to be the ones our Department gave a great deal of publicity to. However, it was noted that all Medicaid materials were sent to my First Deputy, who was Dr. Lowell Bellin, the present Commissioner of Health of New York City. Before he became Deputy Commissioner, he was in charge of the Medicaid program, and it was through his efforts that many abuse cases were brought to court.

I spoke with Dr. Bellin on the phone, and he would be most happy to discuss the entire operation with you. I have taken the liberty of sending him a copy of your letter and the Grand Jury report.

Very sincerely yours,

MARY C. MCLAUGHLIN, M.D., M.P.H.,
Commissioner of Health Services.

ITEM 15. LETTERS TO ROBERT MORGENTHAU, DISTRICT ATTORNEY, COUNTY OF NEW YORK

NO REPLY RECEIVED AS OF THIS PRINTING

JUNE 17, 1976.

DEAR MR. MORGENTHAU: As you know, our Committee is currently reviewing the operation of the Medicaid program in several States including New York. New York is of special concern since it receives about 20 percent of all Medicaid funds and because of its history of program abuse and maladministration.

We are grateful for all the help and assistance you and your office has extended to our staff and would further appreciate your cooperation in supplying answers to the following questions at your earliest possible convenience:

(1) On an annual basis, how many staff members have you devoted exclusively to the investigating and prosecuting Medicaid fraud over the past 3 years? How many are attorneys? Investigators? Clerks?

(2) What percent of your Fraud Division's time is spent on the investigation or prosecution of Medicaid (Vendor as opposed to recipient) fraud in 1976 and each year previous back to 1972.

(3) What is the total budget allotment for the District Attorney's Office for the County of New York? How much did you allocate to your Fraud Division this year?

(4) Would you please forward to the Committee a list of all cases referred to you involving alleged illegalities by Medicaid professionals participating in the New York State Medicaid program from 1972 through 1976. Please include the name of each provided (or an initial if a case is pending and sensitive), the source of each referral, the date received in your office, the charge or complaint, and the ultimate disposition of each case.

May we have your early response?

With best wishes,

Sincerely,

FRANK E. MOSS, *Chairman,*
Subcommittee on Long-Term Care.

AUGUST 2, 1976.

DEAR MR. MORGENTHAU: More than a month and a half ago I wrote to you asking for some detailed information relating to your involvement with or responsibilities for the Medicaid program in New York. I chose this avenue instead of public hearings in the hope that I would receive reasoned and specific responses to the complex questions which I asked.

To date, I have not heard from you. While I assume this is just an oversight or that your answer is still being prepared, I wanted to reinforce the importance of your answers to my questions. Once again, I ask for the courtesy of a response at your earliest possible opportunity.

For your convenience, I enclose a copy of my original letter to you.

With best wishes,

Sincerely,

FRANK E. MOSS, *Chairman,*
Subcommittee on Long-Term Care.

○