

# Medicare, Medicaid fraud a billion-dollar art form in the US

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## In Brief

MEDICARE AND MEDICAID FRAUD COSTS BILLIONS OF DOLLARS each year in the US. Investigators have shown that fraud is found in all segments of the health care system. Even though the Canadian system has stricter regulations and tighter controls, can regulators here afford to be complacent about believing that such abuse would not happen here? One province has established an antifraud unit to monitor its health insurance scheme; it already has 1 prosecution under its belt.

## En bref

LES FRAUDES CONTRE L'ASSURANCE MALADIE ET L'ASSURANCE SERVICES MÉDICAUX coûtent des milliards de dollars par année aux États-Unis. Des enquêteurs ont démontré que la fraude sévit dans tous les secteurs du système de soins de santé et que les cas varient du sublime au ridicule. Même si le système de soins de santé du Canada est réglementé et contrôlé plus rigoureusement, les organismes de réglementation peuvent-ils se permettre de céder à la complaisance en croyant que de tels abus ne se produiront pas ici? Une province a adopté une attitude défensive proactive et établi un service anti-fraude pour surveiller son régime d'assurance maladie. Le service a déjà intenté sa première poursuite.

**W**hen an Ontario court sentenced a Toronto-area chiropractor to 90 days in jail last year for billing the Ontario Health Insurance Plan (OHIP) for \$65 000 worth of services he had never provided, health ministry regulators hoped they had sent a clear signal about the risks taken by those who loot the public trough.

That the chiropractor was being allowed to serve his time on weekends certainly muted the message, but it was better than no message at all. It was the first case prosecuted from beginning to end by OHIP's antifraud unit, and even though prosecutors didn't get the restitution they had asked for, they got a chance to show their teeth.

Margaret Buffington, head of the investigations unit, takes some satisfaction from that, even though she admits that provincial efforts to fight medicare fraud are in their infancy. "But it is a start," she said confidently.

To judge how much effort this will take, Canadian investigators might be wise to look south of the border. There, health care fraud has become so blatant that President Bill Clinton has asked for almost \$600 million to fund Medicare and Medicaid antifraud initiatives across the US. The primary targets are high-growth areas: home-health agencies, nursing homes and medical-equipment suppliers.

The budget request was based on a successful fraud-fighting demonstration program in 5 states, which cost only \$4 million (all American figures are in US dollars) but which netted more than \$42 million in restitution, fines and penalties, and resulted in some jail sentences. The program was called Operation Restore Trust.

Antifraud statutes have been strengthened and legislators have passed several bills. One prohibits physicians from referring Medicare or Medicaid patients to "entities" in which they have a financial interest. With the enormous amounts of money at stake, however, it's unlikely profiteers will fade away without a fight.

Medicare, the federal program covering 38 million elderly and disabled Americans, paid out almost 700 million claims worth \$192 billion in 1994. Legislators



## Features

## Chroniques

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**Legislators say that  
Medicare fraud  
in the US costs  
\$50 million per day.**

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say \$50 million of that is being skimmed off fraudulently every day.

Medicaid, the program covering the destitute, is also riddled with problems. It serves 39 million people and the bill exceeds \$141 billion annually.

Investigators have found fraud in all segments of the health care system, from physicians and hospitals to nursing-home operators, providers of patient transportation and laboratory and clinic operators.

Probes by federal and state agencies have uncovered a large array of misdeeds: the government was billed for services that were never provided, orders for goods and services were forged, and services that were not medically necessary or even useful were provided. There were also overcharging and improper referrals, and even payoffs for providing the names of new health maintenance organization (HMO) enrollees (see sidebar).

**W**hy are Medicare and Medicaid such easy marks? Government watchdogs such as the General Accounting Office say they are ripe for abuse because they are fragmented, poorly supervised and awash in public money. Much of that money is within reach of practitioners and entrepreneurs who have little accountability and can order goods and services as they see fit; their clients, on the other hand, have no incentive to care

about costs, all of which are paid by a distant third party.

My friend Carmine, a gentle but streetwise 80-year-old cancer outpatient who requires frequent treatment in community clinics and doctors' offices, only has to call a Medicare-approved van service to be transported to his facility of need. For that he pays a \$3 fee (plus tip) and the van service bills Medicare for the remainder.

Carmine thinks this is so wonderful he uses it to go to the bank, grocery store, or even to the airport (a \$25 trip) when he is going to visit his family in New Jersey. For him the \$3 user fee is a pretty good deal, and the van driver doesn't care whether he heads for the radiation clinic or the airport. And Medicare will pay.

**D**r. Robert MacMillan, president of Insurance Claims Management Systems, provides claims management and managed-care services for Canadian and other foreign health insurance firms that cover travellers in North America. From his Florida office he deals with many American hospitals, doctors, labs, managers and suppliers across the American health care system.

MacMillan, a past president of the Ontario Medical Association and former executive director of OHIP, says health care fraud in Canada pales in comparison to that south of the border. He says Canada's disciplinary colleges have demanded a higher level of accountability and have stricter

## Fraud cases range from the sublime to the ridiculous

American investigators didn't have to look far to find examples of Medicare and Medicaid fraud.

Consider the van service that, over 16 months, billed Medicare \$62 000 for ambulance trips to transport one beneficiary 240 times. Nobody noticed.

Medicare was also charged rates as high as \$600 per hour for physical and speech therapy services rendered by therapists earning \$20 an hour. Elderly residents of a nursing home were occasionally invited to coffee meetings to greet newcomers. When one of the resident's sons examined billing statements for his mother, he found that the nursing home had been billing Medicare for group-therapy sessions for everyone attending the coffee klatches. Nobody but the son noticed.

Dr. Barry Feldman, a podiatrist and middleman for a medical-equipment company, was convicted of soliciting Medicare referrals and then giving each patient a lymphedema pump, regardless of need. Medicare paid the \$4800 bill that came with each pump.

One psychiatrist billed Medicare for an average of 26 sessions, 45–50 minutes each, per day. They had not been provided.

Then there were Robert and Margie Mills, owners of

ABC Home Health Care (America's largest privately held home health-services company), who charged Medicare \$84 341 for gourmet popcorn for parties and "conferences," \$27 930 for ABC umbrellas, and over \$1 million for liquor, lease payments for their son's BMW, maid services and utility fees for their personal ocean-front condo. In all, ABC was charged with submitting \$14 million in improper billings. At the end of 1994, ABC's revenues from Medicare totalled almost \$616 million for the year and accounted for 95% of the company's business. Robert Mills was subsequently convicted of Medicare fraud, mail fraud, money laundering, conspiracy and witness tampering; his wife was found guilty of making false statements.

Even mainstream hospitals have been targeted by federal investigators. Investigators say that more than 4600 hospitals have illegally billed Medicare separately for outpatient services that should have been covered by inpatient reimbursements. That's double billing, and the government says it intends to recover at least \$125 million from the errant hospitals under a settlement plan that cuts their penalties in return for cooperation.



rules at their disposal. "In Canada I can't phone up my favourite ambulance service, because they are government run. And if I want to get a patient into a nursing home there are coordination services that decide which home.

"Physicians in Canada generally are not led into temptation situations as easily as they are in the United States. Even the acceptance of gifts from drug companies is highly scrutinized."

**I**n the US, gift giving is an art form. Consider the "research grant" program in which physicians are given substantial payments for minimal record-keeping tasks.

Physicians administer the drug manufacturer's product to patients and make brief notes, sometimes a single word, about treatment outcomes. Upon completion of a limited number of such "studies," they are paid by the manufacturer. There is also a campaign in which physicians are given credit toward airline frequent-flier miles each time they complete a questionnaire for a new patient placed on a drug company's product.

Still, the major problems involve Medicare and Medicaid fraud. Testifying before a congressional committee last year, Sarah Jaggar, director of health financing and policy issues for the Department of Health and Human Services, charged that "Medicare is overwhelmed in its efforts to keep pace with, much less stay ahead of, those bent on cheating the system."

She roasted the Health Care Financing Administration (HCFA), which runs Medicare. It has "weak fraud and abuse controls to detect questionable billing practices," and even extraordinarily high volumes of services to individual patients or by individual providers have failed to trigger claims reviews. "[These] factors," said Jaggar, "converge to create a particularly rich environment for profiteers."

Even companies with no address other than a post office box can qualify to bill — "shell" companies with no employees have in fact billed Medicare for large sums for providing "rehabilitation therapy."

- A physician formerly licensed in Florida was sentenced to 26 months in jail and ordered to make restitution of \$441 000 for submitting false Medicare claims for durable medical equipment and vascular testing at nursing homes. He was also forbidden to have anything to do with any medically related concern during 3 years of supervised release following his jail sentence.
- Frank Aiello, who owned a northern California nursing home known as Lincoln Care Center, was charged with engaging in a conspiracy to submit more than 7000 false nursing home claims for which Medicare paid almost \$4 million. Last year, he received an 11-year jail sentence.
- A grand jury in Columbus, Ohio, charged an osteopathic physician with receiving \$134 000 in illegal kick-

backs over 4 years from a home-infusion company. The indictment alleges that the physician received the services of a registered nurse for his office at no cost to him, as well as a free computer and fax machine.

- In Maryland, HMO "recruiters" allegedly paid state officials for lists of prospective Medicaid beneficiaries they would then attempt to "recruit." The going rate was 50 cents a name. And in Memphis, the number of homeless people "enrolled" in the city's Medicaid programs exceeded the city's total homeless population.

**I**ronically, as incidents of fraud have been increasing, federal budget and deficit cutters have been slashing the programs and devices that could help limit it.

More than 90% of Medicare spending is for payments to providers, says Jaggar, yet claims processing and activities to prevent inappropriate payments account for only 1% of total spending; less than 0.25% goes toward checking for erroneous or necessary payments. (Medicare pays 86 cents for a gauze pad that costs another federal agency 4 cents, and \$186 for a home blood-testing device that is widely available for less than \$50.)

Jaggar adds that Medicare pays more claims with less scrutiny today than at any other time over the past 5 years. Physicians, supply companies or diagnostic laboratories have about 3 chances in 1000 of having Medicare audit their billing practices in a given year.

Jaggar emphasizes that 92% of Medicare providers bill appropriately, but the others could receive more than \$3 billion in unwarranted payments over the next 5 years. Stung by criticism of its impotence in fighting fraud, HCFA and the Los Alamos National Laboratory have begun to develop computer programs to analyse Medicare data and define ways to detect unusual claims patterns.

In Ontario, OHIP's Buffington notes that before the birth of her investigations unit, Medicare fraud was assigned mostly to municipal or provincial police forces, and few cases were prosecuted. The Conservative government turned up the heat a notch and the focus shifted from the police to health ministry regulators; the initial results, even if only modest weekend prison sentences, are encouraging.

In the US, Health and Human Services Inspector General June Gibbs Brown says that "a new focus on fraud and abuse, and new cooperative approaches, can help us better protect federal Medicare and Medicaid dollars."

She, better than anyone, knows that help is needed. "I've never seen anything like the problem we have in health care," she told a group of lawyers last year.

She may have been referring to a supplier of adhesive tape who, over 15 months, billed Medicare for an average of 268 rolls of tape per beneficiary enrolled in 1 health plan.

Medicare paid the bills.?