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Medicare Thieves

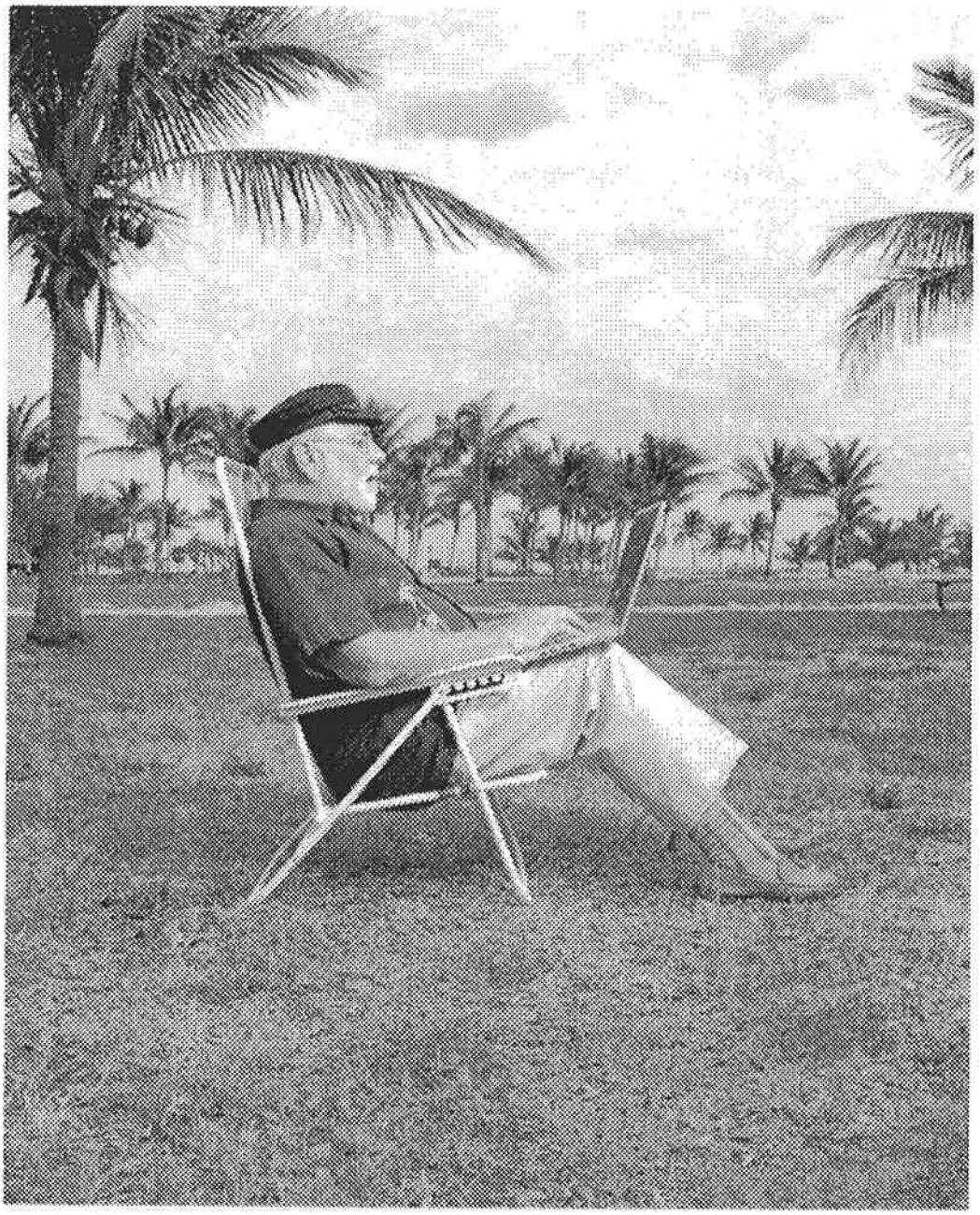
Stealing from the government-run health care system is much easier—and potentially more lucrative—than dealing drugs.

Peter Suderman from the October 2011 issue

If the polls are to be believed, most American seniors love Medicare. It's easy to understand why: When seniors are sick, they get care, and the bills get paid. When a senior citizen walks into a storefront health clinic and seeks treatment—a prescription drug, say, or some sort of physical therapy—the service is performed and the patient walks away feeling better, if only because he knows that whatever the bill might be, the taxpayers will pay for it.

Doctors generally don't love Medicare as much as seniors, mostly because the program's reimbursement rates to health care providers are somewhat lower than the rates paid by private insurers. But doctors do love one thing about socialized health care for the elderly: its certainty. Seniors seek medical assistance, doctors respond with whatever treatment they deem necessary, and Washington picks up the tab. The providers must pass through a few cursory procedural requirements and complete some paperwork, but for the most part the government doesn't ask questions; it just sends money. What's not to like?

For taxpayers, this arrangement leaves much to be desired. What if the treatment wasn't necessary or the patient didn't want it, but the provider billed the government for it anyway? What if the storefront clinic didn't exist at all?



This is exactly what's happening all across the country, as schemers, career criminals, and unscrupulous providers take advantage of the government's lax controls over Medicare payments. Taxpayers are lining the pockets of health care criminals.

No one knows for sure exactly how much fraud exists in the Medicare system, but most experts agree that it costs billions of dollars each year. Between 2007 and early 2011, the federal government reports having won convictions against 990 individuals in fraud cases totaling $2.3 billion. In 2010, it recovered an additional $4 billion through

collection of non-criminal penalties on health providers who improperly billed the government. But that's just a fraction of the total problem.

According to a 2011 report from the Government Accountability Office, Medicare makes an estimated $48 billion in "improper payments" each year, an estimate that's almost certainly lower than the actual amount since it doesn't include bad payments within the prescription drug program. Some of that money, perhaps a lot of it, is fraud, but experts differ on exactly how much. On the very low end, the National Health Care Anti-Fraud Association has estimated that about 3 percent of all U.S. health care spending is fraud. Assuming fraud is distributed equally across payment systems, that would mean Medicare's share is roughly $15 billion a year. But almost all analysts believe fraud is much more common in Medicare than in it is in payments by private insurers. Toward the high end, Sen. Tom Coburn (R-Okla.) once suggested the number could be as much as $80 billion a year. In March, the executive director of the National Health Care Fraud Association told members of Congress that total health care fraud losses likely range from $75 billion to $250 billion each year.

With $36 trillion in unfunded liabilities just over the horizon, and with Medicare's own actuaries projecting insolvency by 2024, Medicare is a fiscal nightmare. It's the single biggest driver of the long-term federal debt, and just about everyone in Washington is looking for ways to cut back on health spending without trimming legitimate services. Last year the program paid out slightly more than $500 billion in reimbursements to doctors and other providers. Paring it back by $48 billion a year—or even half that amount—by attacking criminal behavior would be a major accomplishment and could go a long way toward reducing the program's unsustainable fiscal burden.

Every politician with a pulse talks a big game about eliminating Medicare "waste, fraud, and abuse," yet nothing much seems to get done. The bigger the government's role in paying for Americans' health care, the easier it becomes to divert that revenue stream into the bank accounts of criminals.

Florida: The Medicare Fraud State?

Fred E. Dweck was 74 when he was arrested in December 2009. Dweck, a top surgeon at two Broward County hospitals, was the director of Courtesy Medical Group, a health care business in Miami that, among other things, sent patients to home health clinics via referral. In the four years before his arrest, according to multiple news accounts, Dweck had bilked Medicare out of $24 million and falsely billed the government for an additional $15 million that was never paid. Dweck's gimmick, like the payment system he was manipulating, was simple: He gave the go-ahead to official orders for prescription drugs, staff-assisted insulin injections, in-home visits by nurses, and an assortment of other treatments for an estimated 1,279 different patients, none of whom actually needed treatment. With the help of five nurses who faked bundles of official patient records and payment forms, Dweck raked in cash on the taxpayer tab. Less than a year after his arrest, he pleaded guilty.

Dweck's case is not unusual, especially in the region of South Florida he called home. Thanks to a larger-than-average senior population, which provides a larger-than-average potential pool of Medicare dollars from which to steal, the region is widely considered the epicenter of Medicare fraud. In 2009 the state's rehabilitation facilities billed Medicare $310 million, roughly 140 times what similar facilities billed in New York, another state with a large senior population. The state's mental health clinics charged $421 million, according to a *Miami Herald* investigation. That's roughly four times the amount by Texas, another major fraud center that boasts a substantially larger overall population and a comparable number of Medicare enrollees.

In January 2009, the Department of Health and Human Services (HHS), which oversees Medicare and its administrators at the Centers for Medicare & Medicaid Services (CMS), started a regularly updated Web page devoted to nothing but news stories about fraud in Florida. Several times a month, a new story appears with shocking numbers: $200 million in claims for unnecessary mental health services, $24 million for a scheme built around AIDS injections, $61 million in real money paid to a man running a network of fake health clinics, another $21 million in fraudulent payments to a health company senior vice president who administered considerably less care to HIV-positive patients than he claimed. The fraudsters used their ill-gotten gains to live the good life, buying horses, Mercedes, and Ferraris. One bought $500,000 worth of jewelry. Meanwhile, an already overburdened program continues to bleed taxpayer dollars.

For years, Florida's league of health care fraudsters operated with minimal federal interference. They forged medical records, bought and sold patient ID numbers, billed for treatments not provided, and ran criminal enterprises out of fake storefronts. In 2006 investigators from the HHS inspector general's office made unannounced visits to 1,581 Medicare suppliers in South Florida and found that more than one-third didn't even maintain a business office at the address listed on Medicare's payment files.

In 2007 the federal government set up its first ever "Medicare strike force" in Miami, assigned to target high-dollar fraud cases. As the news reports compiled by HHS show, there were plenty to be found. According to Alex Acosta, the former U.S. attorney for the Southern District of Florida, the newly created Medicare team charged more than 700 individuals with more than $2 billion in fraud between its inception and the middle of 2009.

Members of the task force have argued that the Medicare fraud industry has supplanted the illegal drug trade in Miami. In congressional testimony, Acosta noted signs that "Medicare fraud is rapidly eclipsing the drug trade as Florida's most profitable and efficient criminal enterprise." It has even trickled down to the folks who might otherwise have been involved in simple, petty crime. "They've figured out that rather than stealing $100,000 or $200,000, they can steal $100 million," Justice Department fraud prosecutor Kirk Ogrosky told *60 Minutes* in 2009. "We have seen cases in the last six, eight months that involve a couple of guys that if they weren't stealing from Medicare might be stealing your car." Medicare fraud also has spread to organized crime. In January 2011, *Politico* reported the bust of an Armenian mob ring charged with perpetrating $163 million in Medicare fraud. Among the items seized from the New

Jersey group was a bundle of weapons, including multiple guns and a Bat'leth, a two-handed, double-bladed long sword modeled after the weapons used by Klingons on *Star Trek*. For criminals smart enough to work the basics of the payment system, the choice between drugs and Medicare is easy: Medicare is safer, potentially more lucrative, and much, much easier.

Easy Money

Just how easy is Medicare fraud? According to Aghaegbuna Odelugo, who swindled Medicare out of nearly $10 million between 2005 and 2008, it's "very easy"—arguably no more difficult than doing summer temp work at a call center. Earlier this year, Odelugo told Congress in written testimony that the "primary skill required to do it successfully is knowledge of basic data entry on a computer." The only other important element "is the presence of so-called 'marketers' who recruit patients and often falsify patient data and prescription data. With these two essential ingredients, one possesses a recipe for fraud and abuse. The oven in which this recipe is prepared is the Medicare system. This system has a number of weaknesses which are easily exploitable." Odelugo then described how con artists manipulate the system's billing codes, physician identification system, and prescription drug reimbursement program.

Medicare's billing system is based on a hodgepodge of bureaucratic codes, one for each medical device or procedure. But the coding system is imprecise and contains significant overlap: Two nearly identical devices—say, a wheelchair and a variation on the same product with a slightly different safety strap—might be assigned two different codes. If one code is kicked back as ineligible for reimbursement, the scammer can easily submit the same claim under a different code for an essentially identical device. The same technique can be used to submit multiple claims for the same item, double-billing the government for the same service or product. Medicare's billing system has long allowed providers to submit and resubmit claims with virtually no serious checks on their validity or patterns of misuse.

According to Odelugo, the process of billing for forged prescriptions is similarly easy. "A person engaging in this fraud will typically purchase a forged prescription from a marketer for a price determined by the amount the person anticipates earning," he explained. "Usually this would be an amount of 15% to 20% of the anticipated profit." The forger then submits the claim electronically, and Medicare responds as it is designed to: with a prompt payment.

Security surrounding the system is astonishingly lax. The "unique physician identification numbers" (UPINs) that doctors use to submit their claims are openly available to anyone on the Internet. Odelugo claimed to be able to hunt them down in just a few minutes on the Web. "As this statement is being written," his testimony reports, "I have looked up the UPIN's of several doctors simply to illustrate...how easily accessible this critical information is." New Medicare provider numbers, meanwhile, have been easy to obtain by just about anyone, even those with criminal records.

Perhaps the biggest problem with Medicare's billing system, however, is its pattern of excessive reimbursement rates, particularly for the category known as "durable medical equipment," which encompasses medical devices, such as wheelchairs and oxygen tents, that assist patients living at home. These devices tend to be fairly inexpensive on the open market, but Medicare pays highly inflated rates for them. According to Odelugo, the reimbursements are "beyond exorbitant"—as much as 10 times the normal cost for knee braces, for example. "For anyone engaging in fraud," he testified, "these numbers are too good to be true. It defies logic to believe that a system like Medicare can reimburse at these rates and not attract a great deal of fraud." Nor were Medicare administrators unaware of the problem: In 2004, the Government Accountability Office published a report noting a failure to control rising spending on power wheelchairs, much of it due to fraud and abuse.

To assess how easy it is to defraud Medicare on medical devices, the Government Accountability Office in 2008 had agents set up fake names and bank accounts, then apply for permission to bill the system. At first Medicare rejected their application. But the GAO agents persisted. After the initial stamp of disapproval, GAO investigators produced quickly forged documents indicating business arrangements with other medical suppliers who didn't actually exist. For contact information, the forged documents listed an unmanned telephone line inside GAO's official headquarters. Medicare officials called the number and left a brief message asking for more information about the supplier contracts. One of the GAO agents returned the call and left what the agency describes as "a vague message in return pretending to be the wholesaler." That proved to be enough.

Even though the GAO scammers had no medical clients—or even records suggesting client interest—Medicare eventually approved the payment application. Using "simple methods of deception," the ensuing GAO report explained, "we obtained Medicare billing privileges and billing numbers...even though we had absolutely no means of supplying prospective clients with durable medical equipment." It really is that easy.

Fixing Fraud

If fraud is so easy, why hasn't the federal government instituted reforms? One reason is that the system is almost incomprehensibly large: This year Medicare is paying, on average, 4.4 million claims to 1.5 million providers every *day*. Truly fixing such an enormous system would require a wholesale overhaul.

Another reason: For all its flaws, there are considerable benefits to the system's current administrative ease of use, at least for the providers and patients who rely on it most. A system in which fraud is tougher to pull off is also one in which it is more difficult for legitimate providers to get paid. And the harder it is to get paid, the fewer doctors will want to participate in the system at all. The number of Medicare providers is already falling, and it is becoming harder for the rapidly growing senior population to find doctors.

One of the biggest reasons doctors are dropping out is that Medicare pays considerably less for medical services than private insurers. The payment system's instability has made the situation even worse: Thanks to a poorly designed payment formula introduced in the 1990s, doctors face major potential reimbursement cuts every year or so, even though the cuts are almost never implemented. If doctors are going to work for Medicare's lower rates, they expect at least to be paid promptly and without hassle. Adding layers of anti-fraud procedures on top of the current process would annoy the providers that the system relies on to provide seniors with care.

Criminal enforcement in the form of the strike forces in Miami and elsewhere has helped bring attention to the problem. But the potential gains from such efforts are small relative to the likely size of the problem: Unearthing a few billion a year in fraud is impressive only until you remember that the abuse involved may total $60 billion or more. And even those victories come at a price: For the 2011 fiscal year, HHS budgeted a total of $1.7 billion for anti-fraud activities, a $250 million increase from the prior year.

Ending 'Pay-and-Chase'

So is there a viable solution? In March, Rep. Cliff Stearns (R-Fla.) held a congressional hearing on the matter. In addition to Odelugo's testimony, he heard from insurance industry representatives, Medicare administrators, the Office of the Inspector General, and the executive director of the National Health Care Fraud Administration. Each recommended a series of small fixes designed to ensure "program integrity," the bureaucratic catchphrase of choice for finding ways to stop crooks from stealing taxpayer money. Many of the witnesses recommended increased communication between law enforcement, health care officials, and medical professionals. The specific solutions were mostly small and technical.

A CMS official, for example, highlighted the system's recently implemented efforts to enhance oversight of the screening process for new applicants. But it's hard to trust a bureaucracy so slow that it took more than three years to implement those changes following the GAO report that inspired them. As the director of the National Health Care Fraud Administration later pointed out, Medicare thieves "have proven themselves to be creative, nimble, and aggressive." For the most part they've managed to stay ahead of both administrative fixes and law enforcement. "These people do nothing but recruit patients, get patient lists, find doctors, look on the Internet, find different scams," Florida FBI agent Brian Waterman told CBS News in 2009. "There are entire groups and entire organizations of people that are dedicated to nothing but committing fraud, finding a better way to steal from Medicare."

Rep. Stearns thinks the root of the problem lies in the easy-to-manipulate design of Medicare's payment system. "Medicare is a fee-for-service program," he tells me. "You perform a service and you get paid." More payments mean more services and more fraud. It also creates opportunities for criminals. "It's a pay-and-chase model," Stearns says. "They pay out the money—and they go after it later, but they're not checking on where it goes." According to data released by Medicare, less than 3 percent of claims are reviewed before they are paid.

It's very different with private insurers, according to James Capretta, a senior fellow at the Ethics and Public Policy Center who served as associate director at the Office of Management and Budget from 2001 to 2004. "Do we think that there's the same level of improper payment occurring on the private side?" he asks. "The answer is no. And the reason is that they have a revenue motive."

Medicare is not the only organization in the world that processes millions of payments across the country every single day: Credit card companies and private insurers do much the same thing, and their rates of fraud and improper payment are considerably lower. "The credit card industry has over $2 trillion in transactions per year and is nearly the size of the health care sector," Sen. Scott Brown (R-Mass.) said at another health care fraud hearing in March. "Yet credit card fraud is a fraction of one percent, and I'm shocked that the government can't do it better."

Stearns thinks it can. "Every credit card company in America does predictive computer modeling for credit card fraud," he says. "None of that computer predicting modeling has been done for Medicare." The trick is to create complex algorithms that crunch historical data on Medicare ID numbers and reimbursement requests, then match them with procedures. If the government builds up a big enough database of providers, procedures, and transactions, and cross-indexes those with related factors, it may be able to determine with some degree of accuracy which payments are bunk.

Republicans such as Stearns may have an ally in their quest to make the payment system more rigorous: the White House. During a health fraud prevention convention in Boston at the end of 2010, Secretary of Health and Human Services Kathleen Sebelius and Attorney General Eric Holder announced that the Obama administration planned to implement a predictive modeling pilot program. In June a CMS press release said Medicare payments would be run through a risk-prediction model beginning July 1, giving the federal government its first ever real-time review of payments. The press release touted predictive modeling as a "revolutionary new way to detect fraud and abuse." If the results are good, the system will expand to Medicaid in 2015.

Will it work? It's too early to tell for sure. But in general, health care pilot programs run by federal bureaucrats have been notoriously unsuccessful. Nor have previous fraud fighting efforts had much effect: In July, the GAO released yet another report calling out inadequate anti-fraud efforts in Medicare and its sister program, Medicaid. By Cato Health Policy Director Michael Cannon's count, it was GAO's 159th such report.

The Cost of Fighting Fraud

There are costs to fraud-fighting programs as well. One anti-fraud plan first sponsored by House Republicans is projected to cost about $930 million during the next decade. In itself, given the size of the problem, that's a pittance. But the direct cost isn't necessarily the biggest barrier for fraud fighters. "There would be some political problems with going after fraud," says James Capretta, because "providers like to get prompt, no-questions-asked payment." As a result, any such reform effort could provoke a revolt

among the doctors, which would almost certainly be followed by a revolt among seniors when they are unable to find physicians to treat them.

Medicare's pervasive waste belies the argument that it's more efficient than private providers; in 2010, the system made improper payments equal to nearly four times the total amount of all U.S. health insurer profits. But predictive modeling is only a small part of private-sector success; insurers also engage in extensive underwriting and human case-by-case review. Many doctors don't look kindly on such bureaucratic intrusions. The Association of American Physicians & Surgeons, for example, has issued reports warning of the "negative impact" and "adverse side effects" of anti-fraud efforts, claiming they "have made it more difficult for patients to get care from the most honest and qualified physicians." The real price of stepping up fraud prevention, they caution, may be paid by seniors who lose access to medical services. That's a price few politicians are willing to pay.

Weeding out fraud is an arduous, time-intensive process. And Medicare's administrators, who are beholden to politicians who are in turn beholden to patient and provider constituents, may not have the stomach for it. It's the classic political problem of diffuse costs and concentrated benefits. The cohorts that stand to benefit most from an inefficient system are also those with the loudest and most influential voices on the issue. It's no accident that Medicare has evolved the way it has.

No politician ever claims to *like* waste, fraud, and abuse. But powerful constituencies are invested in rejecting any meaningful change to a system that just so happens to enable such massive criminality. By guaranteeing speedy payments for the medical care of almost 50 million people, the government seems to be guaranteeing profits for health care crooks.

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