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ANALYSIS  
OF  
NEW YORK'S  
PROFIT-MAKING LONG-TERM CARE FACILITIES

TO

HUGH L. CAREY, GOVERNOR

ROBERT ABRAMS, ATTORNEY GENERAL

THE LEGISLATURE OF THE STATE OF NEW YORK

THE PEOPLE OF THE STATE OF NEW YORK

FROM

CHARLES J. HYNES

DEPUTY ATTORNEY GENERAL

FOR NURSING HOMES,

HEALTH & SOCIAL SERVICES

DECEMBER 1, 1978

## PREFACE

This report is the result of an in-depth audit of the profit-making long-term care facilities operating in New York State. The investigation was conducted by this office under Section 63 (8) of the Executive Law.

It summarizes the activity of our office in this area. It is based on an audit and investigation of these homes for the period 1969 - 1975.

These audit findings of profit-making long-term care facilities total \$63,136,249\* in overstated expense claims. These claims have cost the State \$42,600,000 in Medicaid overpayments.

As of August 1978, we became the Medicaid Fraud Control Unit for New York State. This expanded jurisdiction will necessitate a reorganization of the operations and staff of this office to meet the needs of our new responsibilities. We will continue to monitor both profit and non-profit nursing homes, investigate charges of patient abuse as well as pursue our adult home inquiry. However, hospitals and ambulatory care providers (doctors, Medicaid Mills, clinics, laboratories, pharmacies) will be the primary focus of our activities. A majority of our staff will be phased into these investigations.

\*This figure is exclusive of any audit findings of these facilities made by the New York State Department of Health.

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## HISTORICAL BACKGROUND

At the end of 1974, New York State was in the midst of one of the largest scandals in its history. An aggressive media exposed to public view what the State Government for years had been unable or unwilling to see: the Medicaid-supported nursing home industry had become the home of too many ruthless profiteers whose activities have unfairly maligned the many honest nursing home operators in the state. Helpless, sick and elderly patients were being treated in a manner that belonged in the pages of a Dickens novel, not in the real life of 20th century New York State.

In the first major act of his new administration, Governor Hugh L. Carey decisively ended the years of Government neglect and indifference that had permitted the corrupt misuse of taxpayers' dollars. With the active cooperation of Attorney General Louis J. Lefkowitz, on January 10, 1975, he directed the formation of the Office of the Special Prosecutor for Nursing Homes, Health and Social Services. In addition, he created a Moreland Commission and appointed a distinguished lawyer, Morris B. Abram, as its chairman. The Governor's mandate was simple: root out the corruption in nursing homes. An aroused

legislature provided the funds the Governor requested, and this office began an immediate investigation into nursing home conditions. That investigation gave initial priority to the profit-making nursing homes where scandals were exposed. But non-profit facilities are also under the scrutiny of this office and are investigated where appropriate.

The Special Prosecutor's investigation had two basic tasks. First, a large number of apparently corrupt practices had already been identified. It was necessary to answer the following questions:

Could these crimes actually be proven and just punishments imposed?

Could the complex financial manipulations uncovered by the media be untangled and their elements documented and detailed in a way that would stand up in a court of law?

Second, an inquiry had to be conducted in order to determine how far these fraudulent practices had penetrated into the industry. The publicly notorious individuals owned but a small portion of the more than 300 proprietary nursing homes. These homes in 1975 were receiving over half a billion dollars a year in Medicaid funds. Prior to 1975, despite the repeated pleas of the Department of Health, the Bureau of the Budget had allocated only enough

funding to support a staff of 16 State auditors to scrutinize the use of that money. For all intents and purposes, it had been open season on the public purse.

By the end of 1975, this office was pursuing over 40 investigations. The results conclusively established that the misuse of public funds had spread far beyond a few highly publicized individuals. Every facility investigated in that first year had obtained Medicaid overpayments.

What would it take to clean up the industry? And what could be done to prevent a recurrence of such abuses?

This office set forth its answers to those questions in its First Annual Report to Governor Carey at the beginning of 1976. Only an investigation commensurate with the size of the problem would provide the public with a meaningful guarantee that fraud would be ended. Since the problem apparently encompassed the entire profit-making nursing home industry, it was our belief that the entire industry's past conduct should be reviewed for evidence of fraud. This would involve an audit of all cost claims submitted by industry participants between 1969 and 1975, with whatever backup investigation was required. Such a review, at its conclusion, it was hoped would leave a nursing home industry

where there would be no successful past frauds and no reimbursement rates inflated by overstatement of past costs, to compromise the State's revitalized regulation of health care. It would also leave the State with a cadre of investigative personnel who, trained in industry practice and familiar with the usages of fraud, could successfully conduct an ongoing fraud prevention program.

To the people of this State, this proposal meant even more. New York State would be given an opportunity to meaningfully address the problems of rising health care costs. The ramifications of these findings would be far reaching in determining the actual costs of health care.

This proposal also promised considerable relief to New York's long suffering taxpayers. Millions of tax dollars lost in Medicaid overpayments would be identified for public recovery. From the results of our first year of investigation, this Office projected that it would identify Medicaid overcharges approaching \$70 million.

Governor Carey enthusiastically approved this proposed inquiry. In January, 1976, he submitted a request to the State Legislature for a funding increase

to provide the necessary legal, audit and investigative staff for this office. On April 12, 1976, the Legislature, acting with consistent responsibility, approved Governor Carey's request in special enabling legislation.\*

That legislation ensured maximum possible coordination of this office's investigation with the Department of Health. On May 12, 1976, we began the task of recruiting the additional 146 staff positions provided by the Legislature. As rapidly as staff became available, they were funneled into investigative work.

Today the investigation of the past financial dealings of New York's profit-making long-term care facilities is nearing completion. Investigation of 85 facilities must be completed, a substantial number of criminal indictments remain to be carried through the court system and many civil recovery actions remain to be completed.

The following report details what has been accomplished so far, how the original goal of the investigation has been met, and what the implications of this massive investigation are for the future.

\*Chapter 118 of the Laws of 1976.

## SCOPE

In April of 1976, when this office was formally directed to investigate the past financial dealings of all profit-making nursing homes, the industry consisted of 312 facilities containing a total of 38,131 patient beds. This office used those figures in developing its projections in the First Annual Report as well as its proposal for the staffing of this investigation.

But as we gained experience in 1976, it gradually became apparent that an investigation of nursing homes had to include the other component of the long term care industry, Health Related Facilities (HRFs).\*

Many operators of profit-making nursing homes also operated health related facilities. Those situations included 76 combined facilities, containing a nursing home

\* There are two types of long term facilities: nursing homes which offer round-the-clock nursing care, and HRFs which offer nursing assistance as needed on a regular periodic basis. Legally, the two types of facilities are described as residential health care facilities [See N.Y. Public Health Law Sec. 2801 (3) (McKinney 1977)].

It should also be noted that the term profit-making nursing home or facility is identical with the phrase proprietary nursing home or proprietary facility.

and an HRF in a single operation. Investigation also revealed that, out of 17 freestanding HRFs, 15 were financially connected to nursing home operators. The result was that out of a total of 93 profit-making HRFs, only the owners of two of these facilities were not involved with nursing homes as well.

In view of this widespread connection, it would have been naive and inefficient not to investigate an operator's health related facilities at the same time as his nursing home activities were under scrutiny. Many of the operator's financial transactions could not be unraveled until they were allocated between these two operations. Moreover, it soon became apparent that the similarities in operation and reimbursement, along with a similar lack of enforcement, had induced the same fraudulent practices in HRFs as in nursing homes.

Thus, the investigation of proprietary nursing homes became an investigation of all proprietary long-term health care facilities. The 93 proprietary HRFs containing 11,610 patient beds were a very substantial increase in investigative work load.

The inclusion of closed long-term care facilities in this investigation accounts for the other substantial increase in the scope of this project.

Between January 1, 1974 and January 1, 1976, 75 long-term care facilities closed in New York State.\* While these facilities were no longer receiving Medicaid reimbursement, immediate investigation would enable the State to assert its rights by whatever fraud prosecution was appropriate, and by identifying and recovering whatever public monies they had wrongfully received. A number of closed facilities had been investigated in 1975 and proved to be some of the worst Medicaid offenders. It was, therefore, decided to immediately review all investigative materials available on closed homes to determine if a full investigation was justified. Of the 75 facilities closed during the 1974 to 1976 period, investigations were ultimately undertaken of 25 facilities. In addition, 17 investigations of facilities closed before 1974 were undertaken on the basis of complaints and other investigative information.

\*The health care industry is, of course, a changing one with facilities opening and closing on a regular basis. For facilities closing after January 1, 1976, the policy of the office was to routinely investigate them, on a priority basis, since the possibility of such facilities being in receipt of Medicaid overpayments was substantial. Facilities opening after January 1, 1976, presented a

Overall, the investigation was originally meant to encompass the past affairs of 312 profit-making nursing homes. In its final scope, it expanded to encompass the following 371 profit-making long term care facilities.

236	Freestanding nursing homes
76	Combinations of a nursing home and a health related facility tied into a single operation
17	Freestanding open health related facilities
42	Long term care facilities no longer operating
—	
371	Total

From this total, 28 facilities were considered to be unnecessary or inappropriate for investigation. In many instances these facilities had received either no Medicaid payments or Medicaid payments in such small amounts that without any clear suspicion of criminality, there was no reason to undertake the effort. Ultimately, this project included 343 profit-making long-term care facilities.

different problem. They had a limited cost history and had not participated in the historical period of industry-wide abuse this investigation was seeking to clean up. These facilities were not included in this report, but, of course, are part of our ongoing investigation.

Overall, since 1976, 81 profit-making long-term care facilities have closed and 37 facilities have opened.

This investigation reviewed the reimbursement claims submitted by each long-term care facility for the period 1969-1975. To understand why this period was selected, it is necessary to understand the functioning of the reimbursement system.

New York's reimbursement system is what is called a prospective system. That is, costs incurred in one year are projected forward to set the reimbursement rate two years later.

An example of how the 1978 rates were set will illustrate how the reimbursement system works. Each nursing home submitted in the first quarter of 1977 a cost report containing its claimed expenses for the year 1976. According to State Law,\* sometime during 1977 that cost report must be audited by the Department of Health. Following the Department's audit, the adjusted costs are then used to calculate the 1978 rate. Essentially, the 1976 costs are multiplied by an inflation factor, to adjust the 1976 costs for the price increase between 1976 and 1978. A factor for profit percentage on equity is then added on.\*\* The total figure is then divided by the total of 1976 patients days in the facility. That produces a rate per day, per patient for the 1978 daily rate that the State will pay for each patient day in the facility.

\* New York Public Health Law, Section 2803 (1) (b) [McKinney 1977].

\*\* Historically, the profit percentage on equity has ranged from 8.5% to 11%.

A number of specific features of the reimbursement system such as adjustments for specific expenses, like labor settlements, have been excluded from this simplified discussion, but they do not change the essential fact about the reimbursement system: the reimbursement for any particular year is based on the expenses reported in the year two years prior to reimbursement.

From an investigative viewpoint, this means that to investigate the money received in 1976, you have to review the expenses claimed in 1974. It, also, means that if a false submission is made in early 1977 on the cost report for 1976, that submission in itself does not constitute a larceny. The larceny will not be completed until the State makes a Medicaid payment in reliance on those figures, over a year later in 1978.

\* Thus, this investigation began in 1976 and was concerned with the past conduct of the industry. The 1976 payments were based on 1974 costs. The applicable Statute of Limitations bans prosecution for larceny and other related felonies after five years, so any payment received prior to 1971 was protected by the Statute of Limitations. The 1971 payments were based on 1969 costs.

This defined the period of investigative concern as the financial transactions for the years 1969 to 1974.

As this inquiry extended into 1977, 1975 cost claims were also brought under scrutiny in a number of instances.

Out of the 343 profit-making facilities within the scope of this investigation, we have now completed fact-finding reports in 258 instances.

To date\*, 109 operators and employees at 91 different facilities have been indicted for Medicaid fraud and related crimes. The cases against 81 of these defendants at 68 such facilities are now completed, with a record of 72 convictions, 2 acquittals and 7 dismissals.\*\*

Of the remaining 85 facilities where fact-finding must be completed, 56 investigations are currently in progress, including nine that have already resulted in indictments, largely for illegal kickbacks to vendors. Of these 56, the audit work is done in 33 cases. What remains is purely investigative, to determine whether willful fraud was involved. In the remaining 23 cases, the audit element of the investigation, also, must be completed. In most of the latter cases, unusual litigation delays in obtaining books and records have prolonged these investigations. Twenty-nine investigations

\*As of December 1, 1978.

\*\*Overall, this office, as of December 1, 1978, has indicted 147 individuals. And out of 109 completed cases, we have 94 convictions, 8 dismissals and 7 acquittals.

remain to be initiated. These are, in a majority of instances, lower priority cases.

The results of this investigation are startling. Our audit findings have identified \$63,136,249 in cost overstatements by proprietary nursing home owners which document the fact that fraud is a hidden factor in the State's health care costs.

## AUDIT FINDINGS

### A. THE AMOUNT OF OVERPAYMENTS

The \$63,136,249 in overstatements includes \$54,599,008 in findings in the 258 cases where fact-finding has been completed and \$8,537,241 of findings in the 33 cases where fact-finding is continuing, but audit work is completed.

There are 52 remaining facilities in which the audit work remains to be completed. There will be additional audit findings in those facilities. However, it would not be possible to do anything more than roughly estimate their value at this time. For that reason, this report does not include any amount of findings for those facilities. Thus, the total \$63 million in cost disallowances should be regarded as a minimum figure.

What is the value of these findings to the State in terms of actual Medicaid payments?

At the end of 1975, in the Special Prosecutor's First Annual Report to Governor Carey, this office estimated an investigation of all profit-making nursing homes would produce savings to Medicaid of approximately \$70 million. That estimate compares to the actual results of the investigation as follows:

First, the \$63+ million in overstated expense claims has cost the State \$42,600,000 in Medicaid overpayments.

This money should be available for recovery by the State.

In fact, part of it has already been recovered.

Second, the overstated expense claims have inflated the cost ceilings used by the State in the years covered by this investigation. Recalculating those ceilings would save the State a substantial sum. A precise calculation was beyond the scope of this investigation, but the total potential savings on the basis of initial calculations could approach \$10 million for the years we audited.

Third, many overstated expense claims have a prospective, as well as an historical, impact on the Medicaid reimbursement a facility receives. The precise impact is impossible to calculate because it will depend on what specific guidelines are used for property reimbursement. This office has projected a possible saving of \$33 million. This saving is the result of our audit adjustments to property and mortgage interest based on the current system of reimbursement.

This significant dollar value assigned to projected savings is due primarily to the compounding effect of interest over a predetermined number of years. For example, if the value of a building and the mortgage thereon is determined to be overstated by \$100,000 and that \$100,000 is financed over 30 years at 10%, the result would be a projected overstatement of \$315,929 (over 20 years -- would result \$231,607; over 25 years -- would result \$272,613).

Each of these three items is discussed in detail below.

1. Reimbursement is not on a dollar-for-dollar basis. The direct impact of the disallowance of expense claims on Medicaid payments will vary from facility to facility, depending on the operation of the reimbursement formula. Consequently, this office calculated the reimbursement impact of each facility's findings.

The audit findings were put through the reimbursement formula, to determine the Medicaid payments a facility received by virtue of its overstated cost claims.

There are basically four separate components that make up the Medicaid reimbursement formula. The formula, in a simplified form, can be expressed as follows:

$$\frac{\text{Operating Expense} + \text{Property Costs}}{\text{Patient Days}} + (\text{Equity} \times \text{Profit \%}) = \text{Medicaid payment per patient per patient day}$$

Operating expenses are those expenses used in the everyday care of the patients, e.g., food, maintenance, nursing care, etc.

Property costs include depreciation, insurance on property and interest expense on allowable financing.

Equity is the excess of an owner's investment in the facility over the debts owed by that facility.

Profit % is the rate of return an owner is allowed on that investment.

As these factors vary in relation to each other, the reimbursement impact of the findings will vary, from facility to facility and from year to year.

The \$63+ million in findings was distributed as follows among the various reimbursement categories.

<u>Reimbursement Component</u>	<u>% of Total Disallowances</u>
Operating Expense Disallowances	43.59
Equity Disallowances	33.55
Property Disallowances	22.71
Patient Days	.15
TOTAL	100.00

These various disallowances were plugged into the reimbursement formulas for each home investigated. They yielded \$42,600,000 in Medicaid overpayments that the State had made in reliance on the inflated cost claims of providers.

2. During the period covered by this investigation, the overstated expense claims inflated the costs ceilings used by the State. If the ceilings were now appropriately adjusted, it would add a substantial sum to the \$42.6 million

in excess Medicaid costs paid out by the State to profit-making long-term care facilities during the course of this investigation.

To prevent abuse of Medicaid's reimbursement system, the State sets ceilings on allowable cost claims. Various operating cost categories have particular ceilings. The Department of Health calculates the ceilings by establishing peer groups of similar homes, by size and by geographic area. Then, for each peer group, it takes the average of the cost submissions of the homes in the group, and sets, for that group, 110% of the average cost as the peer group ceiling. Before calculating a facility's reimbursement rate, the Department reduces any costs above the applicable ceiling down to the ceiling figure.

The weakness in this process is that the ceilings are established on the basis of unaudited costs. The Department simply uses the initial cost submissions of the various facilities. It does not adjust the ceilings to reflect the results of auditing the various homes. Consequently, the ceilings do not reflect actual costs. They reflect cost claims.

In its investigations, this office has established by audit the actual costs of operating long-term care facilities in the years 1969-1975. Using 1973 figures, this office made a limited experiment of recalculating the ceilings for three peer groups to see what the change

would be from the Health Department's figures.\* The reduction in the peer group averages was 1% for one group 3% for the other two. These reductions affected 12 out of the 30 homes in the three peer groups tested, reducing the reimbursement of those 12 homes by an average of \$8,500 per home annually.

With such a small sample, any attempt to project out to obtain an industry figure must be made with great caution. But, if the experience of these three peer groups was typical of the industry as a whole, then the use of unaudited expense claims cost the State an estimated \$1.5 million during each of the years covered by this investigation. While this result cannot be claimed with any certainty, it does indicate that the Department of Health should conduct a much more comprehensive review of past ceilings, as well as change the procedures for setting these ceilings in the future.

Since the Department is now charged with auditing each facility every year,\*\*this office recommends that the Department implement a new administrative policy of setting the ceilings on the basis of actual audited costs.

\*The three peer groups tested were Buffalo 51-99 bed homes (8 homes), Long Island 100-199 bed homes (17 homes), and Rochester 100-199 bed homes (5 homes), all for the year 1973.

\*\*N.Y. Public Health Law, Sec. 2803(b) (McKinney 1977).

Such a policy is imperative if the Department is ever to move towards the important goal of determining the actual cost of quality health care in nursing homes and other health facilities. As long as the cost analyses of the Department are based on the unverified cost claims of the providers, health planning in this State will have a built-in inflation factor. The purpose of the ceilings is to restrain inefficient or fraudulent providers. If these ceilings are not set on the basis of the actual costs providers incur, then the very providers these ceilings seek to restrain remain at liberty to undermine them.

It seems today that quality health care and the economical use of public resources are in conflict. We will never know if this conflict is real or imagined until we remove from the administration of health care all elements, such as the use of unaudited costs in setting health care ceilings, that unnecessarily and inaccurately destroy the health care picture.

3. Certain costs, once established, remain in the rate base year after year. These costs are those related to the property or equity components of reimbursement. Thus, for example, reimbursement is based in certain ownership situations on the certified cost of constructing the facility. If that cost is inflated at the time of constructing the facility, and the overstatement is undetected,

then the property reimbursement will be inflated year after year as a matter of course. Whereas, if an investigation succeeds in reducing construction costs, that savings will be realized year after year into the future during the useful life of the building.

That, in fact, is what has happened. This investigation audited and disallowed numerous cost claims that not only inflated past Medicaid payments, but future ones as well.

The value of the future savings involved cannot be estimated with certainty. The reimbursement formula for real property has been changed twice over the last two years from cost plus to fair rental to modified fair rental. Each time the formula changes, it changes the impact of the audit findings on future Medicaid expenditures. At best, what can be calculated at this time is a potential savings of \$33 million.

B. GETTING THE MONEY RETURNED

Identifying the cost to the State for overpayments to Medicaid providers has been one problem. Returning the cash to the coffers of the State has been a far more difficult one.

Through the spring of 1977, the responsibility of obtaining the actual repayment was outside the jurisdiction of this office. In certain criminal cases, we were able to obtain restitution of the stolen money specified in the indictment as part of a negotiated plea.

In all other instances, this office referred its audit findings to the Department of Health. Under this procedure, the Department was, then, to use those audit findings in its administrative processes to establish the correct reimbursement rate and transmit those adjusted rates to various County Social Service Departments. As the payment agents for Medicaid, these departments had the responsibility for recovering Medicaid overpayments.

However, the administrative process was so vague and ill-defined that it turned out to be practically interminable. And, this was only the first hurdle to be overcome. Beyond the administrative process loomed the prospect of lengthy court challenges to the Department's administrative conclusions. Assuming the State could prevail there, the local counties would still have to act, each on its own, to recover its particular portions of

the overpayment made to a facility. All these delays cost a facility operator absolutely nothing. Any objection, no matter how frivolous, to the State's findings could be argued on both the administrative and the court level.

Upon discovering the lack of actual cash recovery from its investigative work this office proposed remedial legislation to Governor Carey. In early 1977, three proposals were recommended to the Legislature to improve the recovery process. They included a streamlined administrative procedure; sanctions for frivolous use of the court process; and an automatic collection mechanism once the amount owed was resolved. These proposals passed the Assembly, but failed in the State Senate.\*

Fortunately, at this point, Attorney General Louis J. Lefkowitz intervened. He offered to delegate to this office the power to institute civil suits to directly recover by immediate court action the Medicaid overpayments identified by this investigation. The Department of Health supported this proposal and Governor Carey accepted it. He moved immediately to obtain a Supplemental Budget appropriation to provide the necessary staff. His request was granted by the Legislature in the summer

\*See Appendix A for specific legislative proposals.

of 1977 and in September of that year a special Civil Recovery Unit began operation in this office.

With the starting of a civil recovery program in this office, the recovery process has become organized as follows:

In any criminal case where complete restitution is not obtained, or in any civil case where the provider has received \$25,000 or more in Medicaid overpayments, this office will bypass the Department of Health's administrative process and initiate a civil suit to recover the overpayments. In any such instance, the office adds any audit findings uncovered by the Department of Health to its own findings in the amount claimed in the suit for maximum cost effectiveness.

In any civil case where the value of the audit findings is under \$25,000, the audit report is turned over to the Department of Health for recovery through its administrative process, as the amount in question would not justify the expense of a lawsuit.

Illustration I\* summarizes the recovery process. As this illustration shows, there are 230 facilities in which investigations, including any criminal proceedings have been completed. In these cases, recapture proceedings are now in progress.

\*See Appendix B

This illustration also specifies the current status of the remaining 113 facilities and the amount of Medicaid overpayments these facilities have received. Audit work is completed in 61 facilities, but the cases cannot yet proceed to the recapture stage. In 28 instances, a criminal case is still under way. In the 33 other cases, while the audit work has been completed, investigative work remains to determine whether or not the overpayments identified were procured by criminal fraud.

Finally, Illustration I shows that there are 52 facilities where audit findings are not yet available. In 23 of these cases, investigations are currently in progress and audit work is actively proceeding. In the remaining 29 facilities, audit and investigative work has yet to be initiated due to prolonged litigation. (Discussion of that litigation is discussed in another section of this report.)

As previously discussed, the \$63+ million in audit findings has cost the state \$42,600,000 in Medicaid overpayments. Of this amount, \$31.2 million was paid to the 230 facilities where proceedings to recapture that money has begun. The remaining \$11.4 million was paid to the 61 facilities where criminal or investigative work is still in progress. Thus, recapture proceedings cannot be initiated at this time.

Illustration II\* summarizes the recapture proceedings for the \$31.2 million. As this illustration shows, this office is responsible for the collection of \$28.5 million of the \$31.2 million available for recapture. The balance, \$2.7 million, has been forwarded to the Department of Health for collection by that Agency.

This illustration also shows that out of \$28.5 million available for collection by this office, \$6.2 million has already been obtained and/or pledged through restitution and \$1 million has been recovered civilly. The balance of \$21.3 million is still to be recaptured by our Civil Recovery Division.

Overall, then, out of 230 facilities, this office has obtained complete payment in ten instances through the vehicle of restitution. In the case of 114 facilities, this office will seek recovery through civil suit of the funds owed, including 23 instances where partial restitution has already been made. Finally, 106 facilities will be referred to the Department of Health for administrative recovery.

Of the 114 facilities scheduled for civil suit, 41 facilities have been brought into court to date. Of these, 35 are outstanding totalling \$12,853,718. Settlements have been obtained in 16 facilities totalling \$987,950. Out of

\*See Appendix C.

the 106 facilities, 56 have been referred to date to the Department of Health. No recovery has yet taken place.

The total amount of repayment settlements is:

Criminal Restitution	\$6,258,113
Civil Recovery	<u>987,950</u>
Total	\$7,246,063

Of this amount, \$4,361,550 is already paid, \$2,884,513 is scheduled for repayment.

And in cooperation with the New York State Tax Department, liens of over \$4 million have been assessed against providers. Twelve have been indicted on tax charges -- six have been convicted. There have been no dismissals or acquittals.

It should be noted that as restitution is paid, it is deposited in a special account in the Controller's Office, the OSP resitutuion Fund. The understanding, when that account was set up in 1975, was that the monies would be distributed from that account to the various federal, state and local governments entitled to them. However, that has not happened. Three years later there has been no distribution. The delay has earned the state \$400,000 in interest, but has had no other benefit. Apparently, this delay has been caused by the inability to determine how to divide the 25% local share among the various counties. It seems that the appropriate records cannot be assembled to determine for how many patient days each county has paid.\*

\*We have been notified by the Department of Social Services, as of December 20, 1978, that a plan has been devised to distribute the recovered funds.

## SPECIAL ASPECTS OF THE INVESTIGATION

### A. The Team Approach to Investigative Auditing

The tremendous work volume this investigation faced required the development of a new technique of investigative management. This new technique -- the team concept -- was the essential ingredient in the success of this office.

Traditionally, prosecutors' offices are organized around a legal staff. This makes them responsive in nature, to complaints from citizens or referrals from governmental agencies. Whenever any special investigative work is needed, they are dependent on other separate governmental agencies to provide specialized investigative personnel, particularly auditors, to carry out the work. This office could not handle its investigative volume within this framework.

As a result, the team concept was devised -- attorneys, auditors, and investigators working together in one agency. This team concept also accelerated the progress of the various investigations. We were not dependent on two or three different organizations harmonizing their

skills. The only priority of all the professionals was the responsibility for carrying the investigation to a successful conclusion.

This unique mix of attorneys, investigators, and auditors provided the office with the ability to go beyond cost statements. To crosscheck the accuracy of the claims made by the provider, we went directly to the vendors involved.

If no more than usual audit techniques had been used, fraudulent practices would have remained concealed. Many expenses in the cost reimbursement statements would have been accepted as reasonable and properly classified. Field checking identified concealed vendor kickbacks, phony billings, undisclosed related companies, inflated rental agreements among related parties, and transferral expenses from one facility to another facility with a higher rate.

Such fraud audits are far more productive in terms of prosecution than are standard business practice audits. Their objective, fraud detection and prosecution, demands particular fraud audit programs and procedures. Normal auditing practice is not primarily oriented to identifying fraud. A fraudulent item disguised by proper entry and false documentation might escape question.

Our office utilizes its experience base to identify cost statements that, however valid on the surface, may be fraudulent. An item, though seemingly legitimate, may reveal some characteristic that suggests a surreptitious manipulation. Investigative clues are identified from experience and analyzed. These techniques are responsible for the accomplishments of this office and it will continue to function as the basis of our investigative work in the future.

Other management innovations in this office supported and enhanced the team concept. Targeting and the collection of investigative information from other agencies was centralized. Investigative findings were constantly analyzed. Information on new approaches was disseminated to all field personnel by a central audit analysis staff.

B. The Difficulties in Obtaining Financial Records

The most frustrating aspect of this investigation was the difficulties encountered in obtaining the financial records necessary for proper investigative work. The requests for such records met bitter and unremitting resistance.

Barring unusual circumstances, this office will normally open an investigation by requesting a Medicaid provider to cooperate with the investigation and make his books and records available on a voluntary basis. If the provider refuses, a subpoena will be issued.

Compliance with these subpoenas has been regularly resisted in the courts. Though this office has been almost uniformly successful in sustaining the validity of such subpoenas, the resulting motions, arguments and appeals have seriously delayed investigative work. Indeed, in some instances, this office had sustained subpoenas after extensive litigation, only to be informed that the critical books and records were lost, destroyed and even stolen.

The history of a single subpoena in April, 1975, for the books and records of one of New York's largest nursing homes graphically illustrates the problem. This particular nursing home owner's attempts to avoid compliance with that subpoena embroiled this office in seemingly

interminable litigation beginning with the New York County Supreme Court and on through the Appellate Division, the Court of Appeals, and ending in the U.S. Supreme Court. However, after exhausting all legal remedies available to him, this operator claimed, for the first time, that he did not have a significant portion of the subpoenaed books and records. We then commenced a contempt proceeding. After a hearing, the owner was held in contempt. However after, more than three years and many court orders later, all the books and records of this home still have not been produced.

This office has been completely sustained in over 95 percent of the nearly 400 subpoenas litigated in the course of this investigation. Yet, use of legal procedures available to defendants has routinely delayed the start of various investigations by three to six months. Delays of over a year have been regularly encountered as defendants create further delay by frivolously resorting to the Appellate process.

There is a strong need for reform. Two problems in particular should be addressed.

Under New York law, it is possible to bring a series of motions to quash the same subpoena. If the first motion is denied, a second motion raising a different ground is then made. Since it takes approximately one to two months for each such motion to be decided, the opportunity to obtain unjustifiable delay in compliance with the subpoena by this method is clear. A statute is required which would prevent making more than one motion to quash a subpoena, unless for good cause the court grants leave to raise a new ground not available at the time of the first motion.

The appellate process has also been misused by appeals from a denial of a motion to quash a subpoena for books and records without regard to the merits of the appeal. Under New York practice, an appeal to the Appellate Division may take six months and an appeal to the Court of Appeals may take another four months. Since it is possible to obtain a stay of enforcement of the subpoena during this time, the motivation to bring such appeals is obvious. This is particularly true in the case of Grand Jury subpoenas for books and records since the Grand Jurors may not be able to sit for the year required to obtain compliance with the subpoena.

State law should be changed regarding permission to appeal to the Appellate Division. The Appellate Division should require that permission to appeal be granted before an appeal may be taken to that court. Specifically, this would apply to a case involving the denial of a motion to quash a subpoena for books and records (or the granting of an order compelling compliance with such a subpoena). This is precisely the way the legislature dealt with the problem of frivolous appeals from denials of motions to vacate judgements of conviction or to set aside sentences.\* If an appeal is meritorious, leave to appeal will be granted. If it is frivolous, unnecessary delay will be curtailed.

\*See CPL §460.15.

### C. Typical Schemes

The following are specific examples of ways in which providers fraudulently manipulated the Medicaid system for profit. This list is not meant to be exhaustive. Rather, the intent is to graphically show how vulnerable the vast complexity of Medicaid is to fraudulent manipulations.

#### SCHEME 1

A method of generating cash for nursing home builders and operators is to arrange a lease agreement for equipment from related parties for which they are billed at inflated prices. They then take these invoices to a bank and/or a leasing company to obtain the financing. They find it easy to arrange for leases because they create what appears to be an excellent financial picture.

Equipment with a cost of \$200,000 is presented to the bank as costing \$300,000. The bank then "buys" the equipment and leases it back to the builder/operator, paying him \$300,000. Medicaid then pays, over the term of the lease, the \$300,000 plus the financing cost. To

further complicate matters, oftentimes the builder/operator soon thereafter consummates sales of the facility to a predetermined third party who takes over the lease and makes the payment. The process of selling the facility completes the concealment of the substituted price for the equipment.

#### SCHEME 2

Checks were drawn payable to various professional consultants and doctors whose endorsements were forged by the owners of the nursing home. These checks were then endorsed by the owner(s) and either cashed or deposited in the owner's personal checking accounts or in the home's checking account. In fact, no services had been performed by these professional people and no monies were due them. The home was reimbursed by New York State for the phony costs.

#### SCHEME 3

A no-show owner/operator was listed on the HE-2P\* as working full time when, in fact, he did no work at the home. His salary was charged on the HE-2P and reimbursed.

\*HE-2P is a financial report form filed with the Department of Health.

SCHEME 4

An operator, whose nursing home did not have prescription drugs included in its rate, purchased prescription drugs and included the cost with medicine cabinet drugs. The operator billed private pay patients for the prescription drugs but concealed this revenue on the financial report in room and board income. On the page in the financial report which asks the question, "Are the costs of any prescription drugs included in the statement of expenditures?", the operator replied, "No." The operator was then reimbursed for prescription drugs which were applicable to private patients.

SCHEME 5

A vendor doing business with a nursing home kicked back money to the owner of the facility in the form of a check to the nursing home. What is unique about this scheme is the manner in which the nursing home recorded this receipt on its books.

During the course of a routine vendor audit, a check payable to the nursing home in excess of \$23,000 was disclosed. In an attempt to trace the check to the nursing home's cash receipts book, no entry could be found of a cash

receipt from the vendor in question on that date or any other date. However, on or about the same date, a loan made by the owner to the nursing home in the amount of \$25,000 was recorded. An examination of the details of that deposit, obtained from the bank, revealed that the loan was made up of two items, a check from the vendor in question in the amount of \$23,272 and cash making up the difference. Since loans from owners are treated as equity for reimbursement, this manipulation resulted in excess payment to the home.

#### SCHEME 6

The owner of a grocery store located in Manhattan gave a Suffolk County nursing home operator blank invoices. The operator would fill the invoices out for whatever amounts desired and have a check drawn payable to the grocery store. He would then take the check to the grocery store and have it cashed. In some instances, the operator would take the checks directly to his personal bank where he was well known and cash the checks with only a rubber stamp endorsement of the grocery store's name. The endorsement did not say "for deposit only". The store was a corporation, and the check should not have been cashed. However, because he was well known at the bank, the check was cashed with no other endorsements or identifying numbers.

When an investigator interviewed the grocery story owner, he stated that he did not make deliveries, and that the operator of the facility came in and made the purchases himself.

The inherent implausibility of a nursing home operator traveling 45 miles in the Metropolitan area, to make grocery purchases in small quantities led to the uncovering of this scheme.

#### SCHEME 7

A partner in a nursing home acquired a Condominium in Florida for her personal use and charged it to Medicaid. To aid in the furnishing and decoration, she procured the services of a local interior decorator. The decorator and the partner visited a New York City branch of a multi-branch furniture dealer and ordered various items for delivery by the Miami branch.

The decorator accompanied the partner to the Miami Condominium and supervised the decoration and installation of the furniture in the apartment.

While reviewing the nursing home's cancelled checks, it was noted that a number of checks had been cleared through

a Miami, Florida bank. The cancelled checks had on their backs an identifying number below the endorsement.

An interview with an employee of the New York furniture branch disclosed that the numbers and the preceding letter indicated delivery by the Miami furniture branch.

Subsequent interviews and correspondence resulted in the cooperation of an Office Manager of the Miami furniture branch who provided this office with sales invoices, delivery sheets and correspondence outlining the delivery and billing procedure.

#### SCHEME 8

An insurance company had issued checks to a nursing home to refund premium overpayments.

When the nursing home's broker brought the checks, the operator asked if he could cash them for him. The broker indicated that it was possible to cash the checks but that it would take time to accumulate the cash.

The broker was able to convert the checks into cash and then cash was delivered to the operator. The receipt of this money was not recorded in the books and

records of the nursing home and, therefore, the home received excess reimbursement.

This arrangement was disclosed after the cancelled refund checks were obtained from the insurance company. The checks were hand endorsed by the operator and second endorsed by the broker. When confronted with the cancelled checks during a personal interview, the broker outlined the above scheme.

#### SCHEME 9

The pharmacy billings were made up of three parts, private prescriptions, ancillary items and bulk items. The portion of the billings representing the bulk items were considerably inflated.

The arrangement started by inflating the regular monthly bill to cover the purchase of liquor for a Christmas party. From that time on the owners of the facility continually requested personal items, even things such as TV sets, refrigerators, air conditioners, etc., that the pharmacist had to go out and purchase.

In those instances where the pharmacist had to make retail purchases, he would double or triple the amount and add it to the bulk billings. Each month the bills were inflated by \$1,400 for these personal items.

Partner A eventually became a little greedier and requested cash payments, so the pharmacist inflated the bill by an additional \$600, paying \$400 to partner A and keeping \$200 for himself. At this point the bulk billing was up to \$3,500/month.

\$1,500	- legitimate billings
1,400	- personal items
400	- cash payments to partner A
200	- cash payments to the pharmacist
<u>\$3,500</u>	- Total bulk items

Partner A again went to the pharmacist in need of a greater cash flow. To handle this request the pharmacist added 20 percent to the monthly billing - ( $\$3500 \times 20\% = \$700$ ). The \$700 was given in total to partner A, making the total bulk billing \$4,200.

At this point the two partners, A & B together, approached the pharmacist for additional cash payments. The pharmacist replied by adding an additional 20 percent to the monthly billing - ( $\$4200 \times 20\% = \$840$ ). The total monthly billing is now up to \$5,020.

Once more the two partners approached the pharmacist for additional cash, this time he replied by giving them 25 percent of the private patient prescription fees, approximately \$400 per month. This portion came from his profits.

It should be noted that partner B did not know about partner A's side deals.

#### SCHEME 10

In this particular scheme, the operator of the nursing home set up a friend in the medical supplies business.

The medical supply company was used to submit a large number of fictitious invoices to the nursing homes' operator. It should be noted that the medical supply company did make actual sales and deliveries to the homes as well.

In order to generate the needed cash from the fictitious bills submitted to the homes, the medical supply company in turn asked two of his vendors to submit fictitious bills to the medical supply company. These bills were paid and the checks were cashed by the two vendors.

The big advantage to using the two vendors was that the books and records of the medical supply company reflected nothing unusual. That is, the gross profit margin looked normal. The checks paid to the company by the homes were always deposited and no unusual amount of cash was being taken out of the business.

In addition to the scheme mentioned above, the owner of the medical supply company went out and recruited four other vendors to do business with the homes owned by the operator. For obtaining exclusive rights to sell their particular product line to the homes, the vendors were required to pay kickbacks ranging from five to ten percent of their total business to the owner of the medical supply company. He pooled the cash from these four vendors and then passed it along once a month to the operator of the nursing homes. In addition to the kickbacks, the owner of the supply company was paid a commission ranging from \$250 to \$400 a week by each of the four vendors. He received this money as his compensation for controlling the details and keeping track of the kickbacks to be paid.

#### SCHEME 11

In December 1971, the nursing home recorded an

expense for additional salaries of \$42,000. Actual salary checks were issued in January of 1972 and were cashed by personnel who in turn issued checks in like amounts payable to the operator. The operator then issued interest bearing notes totalling \$42,000 to those employees.

The 1971 financial data submitted by the nursing home recorded these loans as deposits in transit with offset to equity. This had the effect of increasing the equity on which the operator of the facility received a profit as "a return on equity".

The transactions were, in fact, loans payable to unrelated parties and not additional equity.

#### SCHEME 12

During a four year period, the wife of one of the partners of a facility was a patient at the facility although she was not listed on the nursing home records as a patient. Private nurses were retained to assist this woman. They were not listed on the payroll, but were paid as subcontractors. So disguised, payments to these nurses were included in financial data submitted by the facility under the caption Professio. Care of Patients and were subsequently included in the Medicaid rate paid the facility.

### SCHEME 13

Oftentimes, nursing homes record purchases of various items whose related costs are included in financial data which the home is required to submit in order to calculate a reimbursement rate. Many items, including services, supplies and other expenses, which are in fact, utilized in the operation of a related facility in other states are included as used in New York State.

The home is reimbursed by the State of New York on reported costs. Its financial support of a related facility inflated the amount of expenditures to be used in the calculation of the home's reimbursement rate. In contrast, the out of state facility is reimbursed on a flat rate, irrespective of actual cost, creating a major incentive to hide costs in New York.

### SCHEME 14

A nursing home, in its annual financial data, submitted to New York State to serve as a basis for reimbursement, included an expense figure of \$10,000 for alleged Medical Supplies. This amount was taken into consideration in arriving at the reimbursement rate for this home.

During the course of an audit of this home, it was determined that this figure represented charges for prescription drugs.

The nursing home was receiving \$.70 per patient day for prescription drugs as part of its reimbursement rate, and, therefore, any amounts listed under the caption "Prescription Drugs" in its cost submission would have been automatically eliminated by Department of Health rate reimbursement. The misclassification of this item allowed the nursing home to receive excess reimbursement.

#### SCHEME 15

When a new facility begins operation, there is no financial history from which to calculate a reimbursement rate. In most cases, the State determined a rate based on average costs of homes of similar size and location plus a few costs for which the home submits an estimate or budget. Comparison of these budgeted costs to actual costs in most cases showed that the budgeted costs were much higher and, therefore, the homes received excess reimbursement. There were also some cases where the entire rate was determined on budgeted costs with the same results.

SCHEME 16

Over a five year period, the individual earnings records as well as cash disbursement journals of one facility indicated that the payroll checks of the owner/operators were not subject to any deductions for F.I.C.A. taxes for Social Security. Federal law mandates a 50 percent allocation of contributions by both the employer and employee. Examination of the employers quarterly returns for such taxes and annual W-2 forms disclosed a deduction for these taxes for the owner/operator whose contributions were, in fact, paid by the facility. The net effect of this manipulation was to provide additional income to the owner/operator, which was never reported as such in financial data required to be disclosed by the facility.

## ADDITIONAL ACCOUNTING MANIPULATIONS

The following are some other accounting manipulations that nursing home operators have used:

Misrecording of an expense by use of a journal entry;

Recording of an expense twice, once into purchase journal and a second time into cash disbursement journal;

Over-accruals and failure to reverse previous accruals;

Expensing of capital items;

Improper characterization of withdrawals of equity causing cash shortage at the nursing home. As a result, the nursing home would borrow money upon which Medicaid would pay the interest;

Refinancing of nursing home property and channelling of the proceeds for other business activities while Medicaid paid the interest;

Loss of records;

Non-disclosure of related companies doing business with the nursing home;

Avoiding ceilings set by the Department of Health by:

- (a) False classification of administrative salaries,
- (b) Reclassification of "Other Administrative", "Dietary" and "Housekeeping" costs,
- (c) Non-disclosure of relatives working at the nursing home.

## CONCLUSIONS

This report documents the results of the most exhaustive investigation of the proprietary nursing home industry ever undertaken in this or perhaps any other state. The results are at once shocking and encouraging -- shocking in that they reveal that New York's profit-making nursing home operators submitted over \$63 million worth of inflated claims for Medicaid reimbursement between 1969 and 1975 and shocking in that they reveal that nearly one-quarter of these homes have been involved in Medicaid fraud and related crimes; encouraging in that New York has led the nation in initiating a successful program of identification and recovery of these lost monies and has now, for the first time since the advent of Medicaid over ten years ago, the opportunity to administer its proprietary nursing home industry on a relatively fraud-free basis.

These results should not, however, be overestimated. Much remains to be done. Initially, of course, the long road toward the recapture of these lost taxpayer dollars still lies ahead. But more importantly, this report -- and the investigation upon which it was predicated -- have dealt exclusively with the past financial dealings of but one aspect of New York's mammoth health care industry -- namely, profit-making long-term care facilities.

These findings suggest that fraud in New York State was a pervasive element of the nursing home industry. But until now, there has been little hope for a permanent solution to these problems. Only a few states like New York have been able to make progress in combatting such fraud without any federal support.

Today, however, there is at last reason for optimism. What we have accomplished is New York has provided a basis for a new national policy that can potentially provide for the containment and elimination of fraud in health care services. This policy is embodied in Section 17 of the Medicare - Medicaid Fraud and Abuse Bill of 1977, whose provisions give each state the opportunity to establish a program of long-term control of fraud in health care by setting up a Medicaid Fraud Control Unit. It was the success of New York, particularly in this investigation, that provided the example and incentive for this new program that will finally control Medicaid fraud.

As Congress said of this office at the time the bill was enacted:

"The Committee was particularly impressed with the organization and operation of the New York Special Prosecutor's Office, and believes it constitutes a model for anti-fraud efforts in other states."\*

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\* Medicare-Medicaid Antifraud and Abuse Amendments Report by the Committee of Interstate and Foreign Commerce (to accompany H.R.-3) House Report No. 95-393 Part II, July 12, 1977, p. 80.

The federal anti-fraud program established by Section 17 has three key elements. First, it sets out a specific design for a program to control Medicaid fraud. The design is based on the organization of this office and the investigative techniques we pioneered. Second, it requires this kind of investigative presence throughout the Medicaid system. Third, it provides states with the necessary federal financial support -- 90 per cent federal reimbursement, for a three-year period, of state costs in establishing such units -- to make the anti-fraud program a viable reality.

On August 3, 1978, this office was certified as the Medicaid Fraud Control Unit for New York State. As a result, we can now undertake a much-needed investigation into the provision and financing of ambulatory care delivery services -- that is, doctors, dentists, psychiatrists, Medicaid mills, clinical laboratories, pharmacies and the like -- throughout the state. We will, of course, continue to pursue intensive inquiries into voluntary and public nursing homes, adult homes, and hospitals, and investigate charges of patient abuse throughout the industry.

When the results of these investigations are in, this office will be able to determine with some certainty the extent, if any, to which fraud and abuse has inflated this state's health care costs during the last decade. Then, New York will be in a position to plan intelligently for the needs of its health care system based on true costs.

Regardless of the work that remains to be done, however, one thing is certain: New York can never again afford to relax its guard in the supervision of its proprietary nursing home industry; it cannot afford, either morally or financially, a return to the status quo as it existed before 1975. Governmental expenditures for nursing homes alone consume approximately one-third of this nation's and this state's annual Medicaid budget. An industry of this magnitude and complexity requires continuous monitoring. It cannot be dealt with on a stop-gap basis every five or ten years. Therefore, this office intends, as part of its mandate as the state's Medicaid Fraud Control Unit, to maintain a constant vigil in this area in order that our poor and our elderly -- and indeed, all taxpayers -- receive that to which they are entitled and to assure that the scandal of the 1960s and the scandal of the 1970s does not ever become the scandal of the 1980s.

Today, most of the profiteers have been driven out of the long-term care industry. What remains are the honest and decent providers who have had to continue to furnish good quality health care to our indigent elderly throughout the nursing home scandals. And, these operators did just that without complaining. Unfortunately, the nursing home scandals tarred these honest operators along with the crooks. These providers deserve recognition for their honesty and the humane care they have continued to give our State's elderly throughout this difficult period. They are the people who ought to be rewarded by Government with sensible regulations and efficient administration. And that is precisely the goal that this Office, the Department of Health, a number of providers and numerous community and institution-alized care advocates sought in reshaping the State Hospital Code. Today, we share a common interest: Superior Care of our confined elderly.

## APPENDICES

## APPENDIX A

# STATE OF NEW YORK

7879-A

Cal. No. 1470

1977-1978 Regular Sessions

## IN ASSEMBLY

March 29, 1977

Introduced by M. of A. NINE—Introduced at the Request of the Governor—  
read once and referred to the Committee on Social Services—reported from  
said committee with amendments, ordered reprinted as amended and placed  
on the order of second reading

### AN ACT to amend the social services law, in relation to review of final administrative determinations

*The People of the State of New York, represented in Senate and Assembly, do enact as follows:*

- 1   Section 1. The social services law is hereby amended by adding thereto a new section, to be section three hundred sixty-nine-a, to read as follows:
  - 3   § 369-a. Review of final administrative determination of overpayment. A final administrative determination by a department or agency administering a program of medical assistance to needy persons that a provider of medical assistance to needy persons has been overpaid from public funds for the care of patients may be challenged by commencing a proceeding pursuant to article seventy-eight of the civil practice law and rules. Such proceeding may be commenced only after all administrative remedies have been exhausted and must be commenced within sixty days after the provider has been served with a copy of the final administrative determination and a computation of the amount of money which the facility has assertedly been overpaid in the manner provided by the civil practice law and rules for service of a summons.
  - 14   Before commencing a proceeding under article seventy-eight, the provider must file an undertaking with the court that if the final administrative determination is upheld or the proceeding dismissed, the provider shall pay the amount of the asserted overpayment plus any penalty or interest, at the rate authorized by law for such an overpayment, computed from the date of the final administrative determination, and all costs and charges which may accrue against him in prosecution of the proceeding, including the costs of all appeals.
  - 21   The commencement of an article seventy-eight proceeding pursuant to this section within the time authorized and with the required undertaking or deposit shall stay the imposition of any lien, or any levy or restraint, to collect such overpayment.
- 24   § 2. This act shall take effect immediately.

EXPLANATION—Matter in italics is new; matter in brackets [ ] is old law to be omitted.

## APPENDIX A

# STATE OF NEW YORK

9292-B

Cal. No. 71

## IN ASSEMBLY

(Prefiled)

January 4, 1978

Introduced by M. of A. EVE, PROUD, NINE—read once and referred to the Committee on Social Services—reported from committee, advanced to a third reading, amended and ordered reprinted, retaining its place on the order of third reading—again amended on third reading, ordered reprinted, retaining its place on the order of third reading

### **AN ACT to amend the social services law, in relation to liens upon property of overpaid medical providers**

*The People of the State of New York, represented in Senate and Assembly, do enact as follows:*

- 1      Section 1. The social services law is hereby amended by adding a new section  
2 three hundred sixty-nine-b, to read as follows:
  - 3      **§ 369-b. Liens.** *1. If any provider of medical assistance for needy persons has  
4 been overpaid public funds as determined by a final administrative determination,  
5 including the opportunity for a fair hearing in accordance with applicable  
6 department regulations, for the care of patients and neglects or refuses to repay the  
7 same within sixty days after notification of the final administrative determination  
8 without having commenced a proceeding to challenge such determination of  
9 overpayment, the amount (including any interest or penalty together with any costs  
10 that may accrue in addition thereto) shall be a lien in favor of the state of New York  
11 upon all property and rights to property, whether real or personal, belonging to such  
12 provider. The commissioner or his delegate shall file a written notice of this lien with  
13 the clerk of the appropriate county. When written notice is filed, the commissioner  
14 shall, in the name of the people of the state of New York, be deemed to have obtained  
15 judgment against the provider in the amount of the lien.*
  - 16      *2. The notification required to invoke the provisions of this section shall be made  
17 in writing and served with any determination on which it is based upon the provider  
18 in the same manner as provided by the civil practice law and rules for service of a  
19 summons. Such notification shall inform the provider that failure to commence an  
20 appropriate judicial proceeding to challenge the final administrative determination,  
21 or to make restitution within sixty days of such notification shall result in the  
22 provisions of this section being implemented.*

**EXPLANATION—Matter in italics is new; matter in brackets [ ] is old law to be omitted.**

1       *3. If any monies are obtained in satisfaction of a lien for such an overpayment of*  
2       *public funds, the state shall reimburse the federal government and any local*  
3       *governmental entity which contributed such funds to such overpayment for its*  
4       *contributory share.*

5       § 2. This act shall take effect immediately.

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## APPENDIX B

### ILLUSTRATION I

#### LONG TERM CARE FACILITIES UNDER INVESTIGATION

FACILITIES WITH AUDIT COMPONENT OF INVESTIGATIONS COMPLETED	291
Facilities in Overpayment Recovery Process	230
Facilities not ready for Overpayment Recovery	61
Criminal Cases in Progress	28
DUE TO	
Investigative Work Remaining	33
 FACILITIES WITH AUDIT FINDINGS UNAVAILABLE	52
Investigations in Progress	23
DUE TO	
Facilities Awaiting Investigation	29
 TOTAL PROFIT-MAKING FACILITIES UNDER INVESTIGATION	343

APPENDIX C

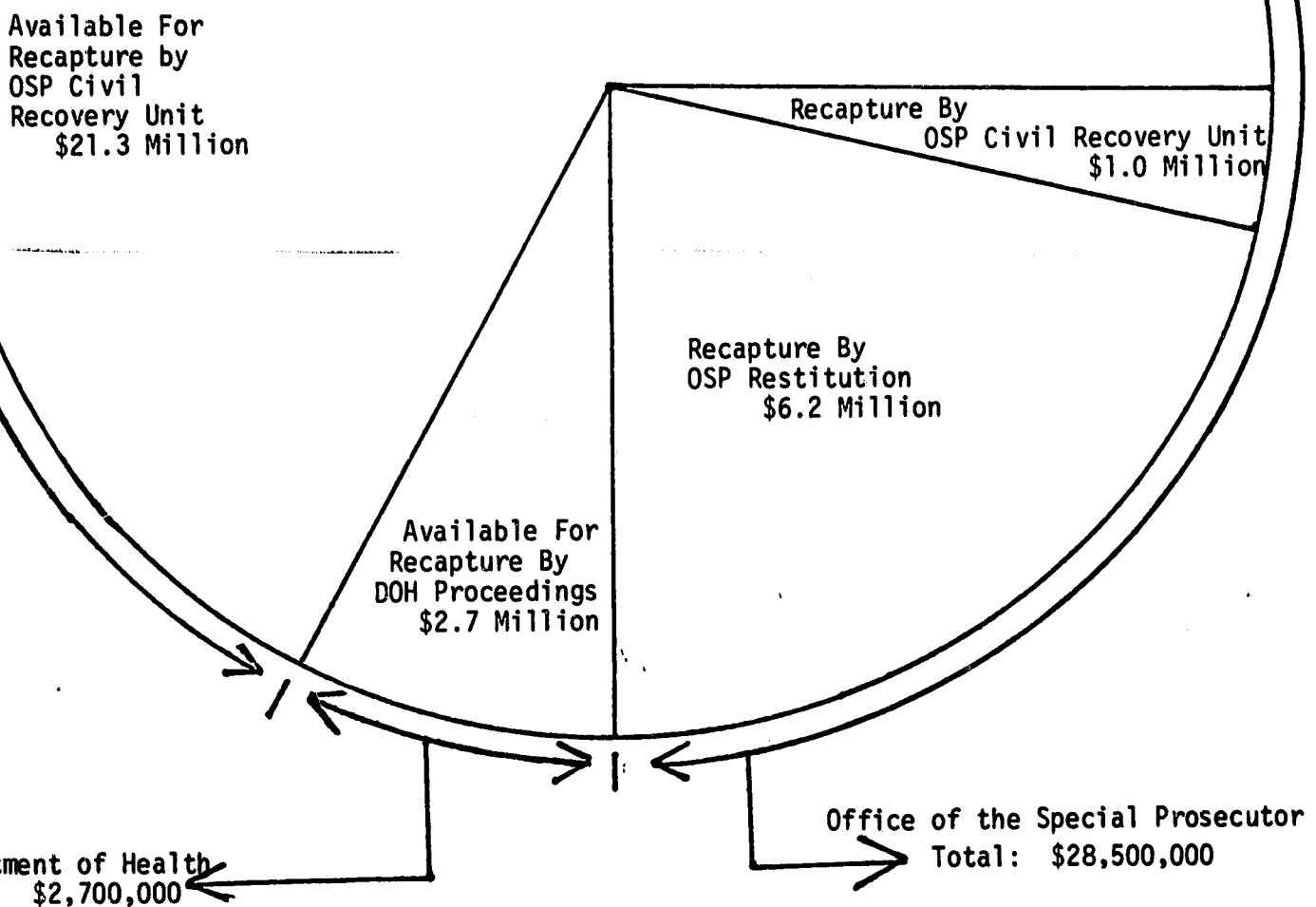
## ILLUSTRATION II

## **CHART OF RECOVERABLE MEDICAID FUNDS**

BY: New York State Office of the Special Prosecutor  
New York State Department of Health

\$28.5 Million  
2.7 Million

**TOTAL \$31.2 Million**



**END**