Amendment in the Nature of a Substitute to the Committee Report Entitled "Billions of Federal Tax Dollars Wasted Annually by New York's Medicaid Program"

Offered by Chairman Darrell Issa

Strike all and insert the following:

U.S. House of Representatives

Committee on Oversight and Government Reform

Billions of Federal Tax Dollars Wasted Annually by New York's Medicaid Program

COMMITTEE REPORT
U.S. HOUSE OF REPRESENTATIVES
113TH CONGRESS
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
FEBRUARY 5, 2013
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[1] For more information about Personal Care Services in New York and Dr. Feldman's testimony before the Committee, *see* the Committee Staff Report entitled *Uncovering Waste, Fraud, and Abuse in the Medicaid Program*, U.S. House Committee on Oversight & Gov't Reform (April 25, 2012) [hereinafter COMMITTEE STAFF REPORT].

Executive Summary

New York's spending on Medicaid ($54 billion in 2012 alone)[2] is typically the highest of any State in the country by a considerable amount. In fiscal year 2010, New York's $2,700 per capita Medicaid spending exceeded per capita Medicaid spending in the rest of the country by more than $1,500. According to two witnesses at Congressional hearings during the last Congress, much of New York's Medicaid spending on long-term care services and supports goes to relatively affluent individuals. According to several other sources, much of New York's spending is misspent from poor program oversight at both the State and federal level. In fact, during the beginning of his term, Governor Andrew Cuomo called New York's Medicaid program "bloated" and argued that it "must be reformed to help [New York] [S]tate begin to make ends meet." This report discusses several problems of waste, fraud, and abuse within New York's Medicaid program that have been uncovered or highlighted by this Committee, discusses recent developments affecting the integrity of the State's program, and offers several recommendations aimed at protecting billions in tax dollars from being misspent each year by New York's Medicaid program.

In a September 2011 hearing, the Subcommittee on Health Care, District of Columbia, Census and the National Archives heard testimony from an administrator of Medicaid Services in New York City. She stated that it is commonplace for affluent State residents to "artificially impoverish" themselves in order to qualify for Medicaid and have taxpayers pick up the cost of their long-term care services and supports. In April 2012, the Subcommittee held a hearing and received testimony from a doctor in charge of Medicaid eligibility determinations in New York City about how New York's Medicaid Personal Care Services (PCS) program was beset by inappropriate and fraudulent spending on the magnitude of many hundreds of millions of dollars per year. He testified that despite recent progress, a large amount of inappropriate and fraudulent spending remains.

In a September 2012 hearing, the Subcommittee learned that New York benefited from a complicated payment methodology initially approved more than two decades ago and re-approved dozens of times by the Centers for Medicaid and Medicaid Services (CMS) since. This methodology has resulted in *daily* payment rates exceeding $5,000 for each institutional resident of New York's developmental centers, which are well in excess of the allowable rates under federal law. Since these are public institutions, the State receives a large windfall from these excessive rates. The Committee estimates that the federal share of total payments going to the State through these facilities was $15 billion in excess of what is allowable under federal law over the past two decades. Although the State has acknowledged that these rates are nearly five times greater than the actual cost of providing services, New York officials have not been fully cooperative with the federal government's efforts to reduce these rates to an appropriate and lawful amount. The excessive rates remain in place three years after CMS began asking the State for information about the developmental center payment rates.

[2] Nina Bernstein, *Cuomo's Medicaid Changes Are at Washington's Mercy*, NEW YORK TIMES, October 23, 2012, (*quoting* Paul J. Castellani, who formerly directed upstate operations for the state, and teaches at the Rockefeller College of Public Affairs and Policy at the State University at Albany. Prof. Castellani is the author of *From Snake Pits to Cash Cows*, which was published in 2005 and details the continued operation of developmental centers in the state and its implications on Medicaid policymaking.).

The Committee has also uncovered excessive salaries being paid to executives of nonprofit institutions that are nearly completely financed by Medicaid. A simple analysis conducted by the Committee found that at least 15 of these executives received yearly compensation exceeding $500,000 and at least 100 others received yearly compensation exceeding $200,000.

The Committee has learned that several key factors contribute to the large size of New York's Medicaid program. First, the Committee has learned of a long-standing "if it moves, Medicaid it" governing philosophy. The State has used this philosophy to take advantage of the federal reimbursement of state Medicaid expenditures. Second, many powerful special interest groups in New York benefit from the State's large Medicaid expenditures and lobby strongly against changes that would reform the State's program. Third, significant corruption and cronyism in the State has likely impeded meaningful Medicaid budgeting and oversight reforms. For instance, two former State Senate majority leaders have recently been convicted of schemes related to Medicaid or health care fraud. Fourth, there have been several reports that the State is not seriously investigating and prosecuting Medicaid waste, fraud, and abuse. According to a recent report, the Office of Medicaid Inspector General (OMIG), the agency charged with cracking down on waste and fraud in New York's program, has failed to be effective since Governor Cuomo replaced James Sheehan with James Cox as Inspector General:

> New audits are rare, investigations are stalled and productivity [at OMIG] is meager. Current and former employees are complaining privately and publicly about the Office of Medicaid Inspector General, calling it a highly politicized, dysfunctional, mismanaged and ineffective agency where many of the 500 or so employees have little to do.[3]

The problems highlighted by the Committee in this report certainly do not represent a comprehensive audit of New York's Medicaid program. For instance, in addition to the Committee's findings, the Office of the Inspector General (OIG) at the Department of Health and Human Services (HHS) has uncovered ten instances over the past decade in which the State has improperly claimed at least $50 million in federal Medicaid dollars. Moreover, in the past four years, the federal government has successfully sued New York for unlawful Medicaid expenditures twice, recovering more than $600 million. In totality, the large number of failures within New York's Medicaid program proves that a full, independent audit of the State's entire program is certainly warranted and long overdue.

Governor Cuomo's administration has been proactive in addressing some of the problems discussed in the report. For example, early last year, Governor Cuomo issued an executive order which limits executive compensation at Medicaid-financed institutions to less than $199,000. Moreover, it appears the State has had some initial success with reducing waste, fraud, and abuse within New York City's PCS Medicaid program. However, it is clear that much more reform is needed. Neither New York taxpayers, nor federal taxpayers who finance over half of New York's Medicaid spending, can afford to continue to support the billions of dollars misspent annually by New York's Medicaid program.

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[3] James M. Odato, *Fraud agency called adrift: Office of Medicaid Inspector General is ineffective and mismanaged, critics say*, TIMES UNION, November 19, 2012, *available at* http://www.timesunion.com/local/article/Fraud-agency-called-adrift-4047131.php

While national Medicaid reform will require compromise and cannot happen overnight, our Committee recommends six specific actions that should be taken immediately to reduce Medicaid waste, fraud, and abuse in New York's program and save both federal and New York State taxpayers billions of dollars each year:

- Excessive federal payments to New York for its State-operated developmental centers must end immediately, and an appropriate portion of previous overpayments must be recovered.
- The Department of Health and Human Services must ensure that the baseline from which New York is calculating its savings from recently submitted waivers does not include the excessive overpayments received by the State through the development centers. HHS must also have both auditors and budget experts verify the State's estimates for the impact of these waivers.
- New York's Personal Care Services Program must only enroll individuals who meet the eligibility thresholds required by law.
- New York must aggressively pursue estate recovery against affluent New Yorkers who artificially impoverish themselves or invoke spousal refusal to qualify for Medicaid.
- New York's legislature must enact into law Governor Cuomo's executive order that limits compensation of executives at organizations that receive nearly all their money through Medicaid to amounts below $199,000. New York must also aggressively monitor and enforce these limits.
- A complete, independent audit of New York's Medicaid program must be conducted including an investigation into the accusations that the New York Office of Medicaid Inspector General has become politicized, dysfunctional, and complacent.

I. Introduction

In June 2011, nearly 53 million Americans were enrolled in Medicaid, a joint federal-state program that finances health and long-term care services for a diverse group of individuals.[4] While federal law currently mandates certain minimum coverage standards for state Medicaid programs, states can – and very often do – expand eligibility criteria and benefits beyond mandated thresholds. Adjusted for inflation, Medicaid spending has increased over 250 percent since 1990,[5] and government experts estimate that Medicaid cost American taxpayers $459 billion in 2012.[6] To put the size of the program in context, annual Medicaid spending now exceeds Wal-Mart's worldwide annual revenue and is more than 50 percent larger than Greece's entire economy.[7] The federal government reimburses state Medicaid spending, typically equal to half of Medicaid expenditures in states with the highest per capita income, and about 75 percent in states with the lowest per capita income.[8] In aggregate, the federal government reimburses about 60 percent of state Medicaid spending.[9]

This uncapped federal reimbursement makes the program particularly susceptible to waste, fraud and abuse. As explained in an April 2012 Republican staff report:

> The policy of an open-ended federal reimbursement of state Medicaid spending significantly reduces the incentives for states to act as wise stewards of federal tax dollars. For example, in order to return $1,000 in fraudulent Medicaid funding for state purposes, a state with a 60% federal Medicaid reimbursement rate would have to identify and recover $2,500 of waste, fraud, and abuse in its program. Since 60% of the total recovery would have to be returned to the U.S. Treasury, the state would have to refund $1,500 of the $2,500 it recovered. Moreover, due to the open-ended federal Medicaid reimbursement, many states view Medicaid as an economic growth engine and therefore lack much interest in where the money is going. States would also have to increase resources to uncover the waste, fraud, and abuse. For these reasons, the federal Medicaid reimbursement demonstrates one of the core reasons the Medicaid program suffers from rampant waste, fraud, and abuse.[10]

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[4] Kaiser Commission on Medicaid Facts, *Medicaid Enrollment: June 2011 Data Snapshot*, (June 2012), *available at* http://www.kff.org/medicaid/upload/8050-05.pdf.

[5] In 1990, national expenditures on Medicaid equaled $73.7 billion. (*See* National Health Expenditures, Levels and Annual Change, Table 3, Center for Medicaid and CHIP Services, *available at* http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/tables.pdf.) Adjusted for inflation, this would equal about $129.5in 2012 dollars since the average annual consumer price index was 130.7 in 1990 and 229.594 in 2012. (*See* Consumer Price Index, Bureau of Labor Statistics, U.S. Dept. of Labor, *available at* ftp://ftp.bls.gov/pub/special.requests/cpi/cpiai.txt.)

[6] Sean P. Keehan et al., *National Health Expenditure Projections: Modest Annual Growth Until Coverage Expands and Economic Growth Accelerates*, HEALTH AFFAIRS, July 2012, vol. 31 no. 7 1600-12.

[7] According to the World Bank, Greece's Gross Domestic Product was slightly under $290 billion in 2011. *See* Data, Greece, The World Bank, *available at* http://data.worldbank.org/country/greece

[8] Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy, Aged, Blind or Disable Persons for FY 2012, 75 Fed. Reg. 69082, 69083 (Nov. 9, 2010), *available at* http://aspe.hhs.gov/health/fmap12.shtml.

[9] The American Recovery and Reinvestment Act raised the average reimbursement rate for the U.S. states to nearly 70 percent for fiscal years 2009 through 2011. Between fiscal year 2008 and fiscal year 2009, the average state FMAP increased from 59.7% to 70.0%. Kaiser Family Foundation State Health Facts, *Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier*, (accessed Jan. 24, 2013) *available at* http://www.statehealthfacts.org/comparetable.jsp?ind=184&cat=4

[10] *See* COMMITTEE STAFF REPORT, *supra* note 1.

Each dollar misspent on Medicaid is one less dollar for the country to use for better health care for the poor, education, infrastructure, national defense, deficit reduction, or any other priority.

Another concern is that some politicians and policymakers view Medicaid not as the welfare assistance program it is intended to be, but as a program to stimulate the economy and create jobs. Governor Jan Brewer's recent statements illustrate this problem. According to Governor Brewer, "[w]ith this [Medicaid] expansion, Arizona can leverage nearly $8 billion in federal funds over four years, save or protect thousands of quality jobs and protect our critical rural and safety-net hospitals."[11] The press statement announcing Arizona's decision to expand Medicaid says the federal money "will be an economic boon."[12] While it is certainly true that spending this additional money will have benefits, there are costs involved as well. The opportunity cost is the value of the best alternative use of that spending, whether that is on education or infrastructure, or whether it is better to lower taxes and leave the spending decisions to entities in the private sector. When policymakers, like Governor Brewer, are in a position to consider only the benefits of additional Medicaid spending, poor decisions are more likely to be made.

While misuse of Medicaid funds is a problem nationwide, New York State's long-standing attitude of "[i]f it moves, Medicaid it"[13] has resulted in the State inappropriately spending tens of billions of federal tax dollars over the past few decades. Although the Committee's oversight efforts during the last Congress focused on problems in the Medicaid program across the country, time and time again, the Committee discovered that the worst abuses of the program consistently occurred in New York.

II. Examples of Problems in New York's Medicaid Program

New York's spending on Medicaid is the highest in the country by a considerable amount. Table 1 shows Medicaid per capita spending in fiscal year (FY) 2010 on the program's three main spending categories – acute care, long-term care, and disproportionate share hospitals (DSH)[14] – for California, New York, Pennsylvania, and the rest of the country. The numbers in parenthesis show how many dollars New York spends per capita on Medicaid spending for every dollar spent per capita in each of the other three regions. As Table 1 shows, New York's per capita Medicaid spending is nearly double that of Pennsylvania and more than double that of California and the rest of the country. Appendix A contains a table that shows the *federal share* of state Medicaid spending for FY 2010 on a per capita basis for all 50 states. Federal taxpayers contributed $1,657 toward New York's Medicaid program per State resident in FY 2010, an amount nearly 20 percent greater than that of Vermont, the State with the second highest per capita federal Medicaid contribution, and more than 60 percent greater than the median per capita federal Medicaid contribution.

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[11] Office of the Arizona Governor, *Governor Jan Brewer Joined by Arizona Health Care, Business Leaders who Rally behind Medicaid Expansion*, January 16, 2013, *available at* http://azgovernor.gov/dms/upload/PR_011613_Medicaid.pdf.
[12] *Id.*
[13] *See supra* note 2
[14] DSH spending is intended to benefit hospitals that treat a large number of uninsured patients and patients with Medicaid. *See* Congressional Research Service, *Medicaid Disproportionate Share Hospital Payments*, December 18, 2012, *available at* http://www.fas.org/sgp/crs/misc/R42865.pdf.

Table 1 – Per Capita Medicaid Spending (Fiscal Year 2010), by Service

Geographic Area	Acute Care	Long-term Care	DSH	Total
New York	$1,404	$1,122	$161	$2,687
California	$728 (1.93)	$343 (3.28)	$58 (2.78)	$1,129 (2.38)
Pennsylvania	$873 (1.61)	$536 (2.09)	$66 (2.42)	$1,476 (1.82)
Rest of USA*	$764 (1.84)	$339 (3.31)	$48 (3.36)	$1,151 (2.34)

* The rest of the USA represents national figures for the U.S. states plus the District of Columbia minus California, New York, and Pennsylvania.
Source: Data is from the Kaiser Family Foundation.

Table 2 shows how much certain states spend on Medicaid divided by the number of individuals in the State who have income below the poverty line. The numbers in parentheses show how many dollars New York spends on Medicaid for every dollar spent by the three other regions divided by the number of people in poverty. Although a significant amount of Medicaid spending is for individuals above the poverty line, Table 2 provides perspective about State Medicaid spending relative to the number of individuals at or below the poverty line. Table 2 shows that New York's Medicaid expenditures exceed $18,000 for each person in poverty, well over double the corresponding figure for both California and the rest of the country, and 62 percent more than the corresponding figure for Pennsylvania. The disparity is especially pronounced for spending on long-term care services, on which New York spends more than three times what California and the rest of the country spends.

Table 2 – Medicaid Spending Per Person in Poverty (FY 2010), by Service

Geographic Area	Acute Care	Long-term Care	DSH	Total
New York	$9,653	$7,716	$1,105	$18,473
California	$4,701 (2.05)	$2,213 (3.49)	$373 (2.96)	$7,287 (2.54)
Pennsylvania	$6,737 (1.43)	$4,137 (1.87)	$512 (2.16)	$11,386 (1.62)
Rest of USA	$5,098 (1.89)	$2,259 (3.42)	$319 (3.47)	$7,676 (2.40)

* The rest of the USA represents national figures for the U.S. states plus the District of Columbia minus California, New York, and Pennsylvania.
Source: Data is from the Kaiser Family Foundation.

Table 3 offers another comparison that demonstrates how New York spends significantly more through Medicaid, and particularly on elderly and disabled enrollees, compared to other states.

Table 3 – Medicaid Spending Per Enrollee (FY 2009)

Geographic Area	Aged	Disabled	Adults	Children	Overall
New York	$22,494	$29,881	$4,277	$2,505	$8,960
California	$10,528 (2.14)	$16,269 (1.84)	$1,073 (3.99)	$1,567 (1.60)	$3,527 (2.54)
Pennsylvania	$21,268 (1.06)	$12,883 (2.32)	$3,692 (1.16)	$2,748 (0.91)	$7,397 (1.21)
USA	$13,149 (1.71)	$15,840 (1.89)	$2,900 (1.47)	$2,305 (1.09)	$5,527 (1.62)

* The USA represents national figures for the U.S. states plus the District of Columbia.
Source: Data is from the Kaiser Family Foundation.

State, federal, and private entities have all found that much of New York's Medicaid spending is wasteful. During the administration of Governor George E. Pataki, James Mehmet, a former chief Medicaid investigator in New York City, estimated that at least ten percent of New York's Medicaid spending is lost on fraudulent claims, while another 20 percent to 30 percent is misspent on unnecessary services.[15] In 2005, the *New York Times* blasted New York's Medicaid program for "misspending billions of dollars annually because of fraud, waste, and profiteering" after a year-long investigation into the State's program.[16] The most troubling aspect of the *Times* reporting was that State oversight authorities failed to detect egregious examples of fraud in the Medicaid program, such as a dentist who billed Medicaid for 991 procedures in a single day and a Buffalo school district that rubber-stamped 4,434 special education students – nearly 60 percent of the district's special education population – onto the Medicaid rolls in a single day.[17] These problems went undetected by the State since *The Times* investigation revealed that New York had virtually no oversight of its Medicaid program at the time.[18]

Wasteful spending was also documented more recently, with the Office of the Inspector General (OIG) for the U.S. Department of Health & Human Services (HHS) finding ten specific instances in which New York State received improper federal Medicaid payments in excess of $50 million over the past decade, with six of these instances exceeding $170 million.[19] Each of these OIG reports pointed out substantial problems in New York's Medicaid program, but rather than using the reports as impetus to reform its Medicaid program, New York State, under both Republican and Democratic governors, disagreed with the OIG's findings in all ten reports.[20]

The following examples highlight a sampling of waste, fraud, abuse, and mismanagement in New York State's Medicaid program that have been highlighted or uncovered by the Committee:

[15] Clifford J. Levy and Michael Luo, *New York Medicaid Fraud May Reach Into Billions*, NEW YORK TIMES (July 18, 2005).
[16] *Id.*
[17] *Id.*
[18] *Id.*
[19] Office of the Inspector General at the Department of Health and Human Services, Schedule of Federal Produced Audits and Monetary Recommendations 01/01/2001-04/30/2012.
[20] *Id.*

1. Misspending in New York's long-term care Medicaid program[21]

Misspending within New York State's Medicaid long-term care program was rampant in its Personal Care Services (PCS) program. The PCS program, which costs up to $150,000 per enrollee per year, is designed to provide qualifying Medicaid beneficiaries services such as cleaning, shopping, grooming and basic aid.[22] In 2009, Dr. Gabriel Feldman, a local medical director (LMD) employed by the New York County Health Services Review Organization, filed a federal lawsuit against the City of New York under the False Claims Act alleging fraud and abuse within the PCS program.[23] The United States Attorney for the Southern District of New York joined Dr. Feldman's lawsuit, alleging that "the City improperly authorized and reauthorized 24-hour care for a substantial percentage of the thousands of Medicaid beneficiaries enrolled in the PCS program" by disregarding the requirements for enrollment.[24] According to Timothy Wyant, the expert hired by the U.S. Attorney's Office to calculate the measure of fraud, the total damages caused by the City's conduct ranges from $990 million to $2.581 billion using conservative assumptions.[25] The City of New York eventually settled this lawsuit with the federal government for $70 million.[26]

2. Overpayments to New York Developmental Centers

In September 2012, the Committee released a majority staff report showing that New York State has received an estimated $15 billion windfall over the past two decades from large federal Medicaid over-payments received by certain State-operated institutions that treat and house patients with developmental disabilities.[27] (This estimate calculates the difference between what Medicaid paid and the Committee's estimate of what Medicare would have paid for these patients, which is the legal allowable limit. The calculation is explained in Appendix C). The Committee majority staff report was motivated by a May 2012 OIG report[28] that found developmental centers in the State received nearly $1.7 billion in Medicaid payments *beyond* the facilities' reported costs in State fiscal year (SFY) 2009 alone.[29]

Although these facilities housed roughly 1,700 patients in 2009, total Medicaid payments to New York's developmental centers were nearly equal to total payments made for all 372,522 enrollees in Kansas' Medicaid program in that same year.[30] In FY 2011, these State-operated

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[21] For more information about Personal Care Services in New York and Dr. Feldman's testimony before the Committee, *see* COMMITTEE STAFF REPORT *supra* note 1.
[22] Daniel R. Levinson, HHS OIG REVIEW OF PERSONAL SERVICES CLAIMS MADE BY PROVIDERS IN NEW YORK (A-02-07-01054), OFFICE OF THE INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (June 3, 2009) *available at* http://www.oig.hhs.gov/oas/reports/region2/20701054.pdf.
[23] First Amended Complaint-In-Intervention of Plaintiff-Intervenor United States of America, United States of America *ex. rel.* Dr. Gabriel Feldman v. The City of New York, 09 Civ. 8381 (JSR) (S.D.N.Y. 2011).
[24] *Id*.
[25] First Amended Complaint-in-Intervention, Expert Report of Timothy Wyant, Ph.D, *supra* note 20 at 4.
[26] Anemona Hartocollis, *City to Pay $70 Million in Medicaid Suit*, N.Y. TIMES, Oct. 31, 2011.
[27] Staff Report, *The Federal Government's Failure to Prevent and End Medicaid Overpayments*, U.S. House Committee on Oversight & Gov't Reform (September 20, 2012).
[28] MEDICAID RATES FOR NY STATE-OPERATED DEVELOPMENTAL CENTERS MAY BE EXCESSIVE (A-02-11-01029), OFFICE OF THE INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (2012), *available at* http://oig.hhs.gov/oas/reports/region2/21101029.pdf [hereinafter OIG REPORT].
[29] According to the OIG REPORT, New York claimed Medicaid reimbursement totaling $2,266,625,233 in SFY 2009 and the state's actual costs for the developmental centers that year totaled $577,684,725. *See id*.
[30] Kaiser Family Foundation, *Total Medicaid Enrollment, FY 2009*, available at: http://www.statehealthfacts.org/comparemaptable.jsp?cat=4&ind=198. Kaiser Family Foundation, *Distribution of Medicaid*

developmental centers in New York charged the Medicaid program $5,118 per patient per day, or the equivalent of $1.9 million per year, for a *single* patient.[31] One former New York State official dubbed developmental center residents "cash cows" because of the excessive payments received by the State on behalf of the residents.[32]

In 1991, Elin Howe, the then-Commissioner of the New York State Office of Mental Retardation and Developmental Disabilities, and New York Governor Mario Cuomo called for the closure of New York State developmental centers by 2000.[33] According to Howe, "[i]ndependent fiscal analyses of closure demonstrate that it is the most cost-effective course to take."[34] Former New York State Senator Nicholas A. Spano, then-Chairman of the Committee on Mental Hygiene, concurred, recommending that "all developmental centers in the State of New York be permanently closed by the year 2000."[35] However, Governor Pataki scrapped the plan to close the developmental centers by 2000, in large part because the centers generated so much revenue for the state.[36]

The payment rates ratcheted up so high because of a formula New York first negotiated with the Centers for Medicare and Medicaid Services (CMS) more than two decades ago. The payment rate formula includes a factor that allows the developmental centers to maintain nearly two-thirds of the payment for a patient <u>even after</u> the patient leaves the facility.[37] However, the Committee has learned that the individuals transitioning out of the developmental centers into much more affordable community settings still qualify for Medicaid. The OIG confirmed with Committee staff that taxpayers, therefore, are paying twice for individuals who leave the developmental centers. Moreover, the excessive developmental center payment rates also violate the law, specifically Medicaid upper payment limits (UPL).[38]

CMS shares a large share of the blame for permitting the overpayments to rise. According to the OIG:

> CMS did not adequately consider the impact of State plan amendments on the developmental centers' Medicaid daily rate. Specifically, CMS approved more than 35 State Plan Amendments related to the . . . rates, including some that pertained only to developmental centers. CMS reviewed the proposed amendments and, in some cases, asked the State for additional information to

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Payments by Enrollment Group, FY 2009, available at http://www.statehealthfacts.org/comparemaptable.jsp?typ=4&ind=858&cat=4&sub=47.

[31] *See* OIG REPORT, *supra* note 28.

[32] Mary Beth Pfeiffer, *State won't release Wassaic resident data*, POUGHKEEPSIE JOURNAL, Oct. 29, 2010, *available at* http://www.poughkeepsiejournal.com/article/20101029/NEWS01/106070006/State-won-t-release-Wassaic-resident-data.

[33] Mary Beth Pfeiffer, *At $4,556 A Day, N.Y. Disabled Care No. 1 in Nation*, POUGHKEEPSIE JOURNAL, June 20, 2010.

[34] *Id.*

[35] *Id.*

[36] *See* supra note 2.

[37] *See* OIG REPORT *supra* note 28.

[38] "[T]he Upper Payment Limit is the maximum a given State Medicaid program may pay a type of provider in the aggregate, Statewide in Medicaid fee-for-service. State Medicaid programs cannot claim Federal matching dollars for provider payments in excess of the applicable UPL. . . . To create an upper bound to Medicaid spending on fee-for-service hospital rates, Congress imposed an Upper Payment Limit based on what Medicare would have paid facilities for the same services." (*See* Kip Piper, *Medicaid Upper Payment Limits: Understanding Federal Limits on Medicaid Fee-for-Service Reimbursement of Hospitals and Nursing Homes*, The Piper Report, April 25, 2012.)

> address concerns CMS had about the rate-setting methodology. However, CMS's efforts did not prevent the rate from increasing to its current level.[39]

At a 2012 Committee hearing on these overpayments, CMS agreed that the payment rates were "excessive and unacceptable" and committed to reducing the payment rates to "about one-fifth of its current level."[40] While CMS's admission was a positive sign, it only occurred after the media and the Committee shed light on decades of excessive federal overpayments and argued strongly that these rates should be immediately corrected.[41]

3. Abuses of Medicaid Eligibility Rules in New York

While Medicaid is commonly referred to as a program for the poor, middle-class and upper-class individuals often qualify for Medicaid long-term care benefits.[42] This is not a problem specific to New York as David Armor and Sonia Sousa of George Mason University have found that nearly 80 percent of the non-disabled elderly population on Medicaid is above the poverty line, and about half of this population is over 200 percent of the poverty line.[43]

A growing legal industry, dubbed "Medicaid estate planning," helps Medicaid applicants and their children shelter savings and future inheritances by creatively arranging applicants' finances to meet Medicaid eligibility rules. Medicaid estate planning has been prevalent in New York State for some time, as Ned Regan, the former State comptroller in New York, explained in a 1996 article in *City Journal*:

> At an unknown cost, middle- and even upper-income families often take advantage of these Medicaid services to avoid the major costs of caring for their elders. To qualify for Medicaid, middle-income people often feign poverty by placing money in a trust, by transferring assets to children or a spouse, and by preserving in their own name only assets not counted in eligibility tests – houses and cars. These middle-class Medicaid recipients are yet another addition to Medicaid's powerful political base.[44]

During a hearing on September 21, 2011, the Committee's Subcommittee on Health Care, District of Columbia, Census, and National Archives examined abuses of Medicaid eligibility rules.[45] Janice Eulau, assistant administrator of the Medicaid Services Division at the Suffolk County Department of Social Services, testified about the ease with which relatively wealthy New York residents can protect their assets by enrolling in Medicaid and how roughly

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[39] *See* OIG Report, *supra* note 28.
[40] *Examining the Administration's Failure to Prevent and End Medicaid Overpayments*: *Hearing Before the H. Comm. on Oversight & Gov't Reform*, 112th Cong. (2012) (testimony of Penny Thompson, Deputy Director, Center for Medicaid and CHIP Services).
[41] *See* COMMITTEE STAFF REPORT, *supra* note 1.
[42] *See* e.g., Stephen A. Moses, *Medi-Cal Long-Term Care: Safety Net or Hammock?*, PACIFIC RESEARCH INSTITUTE, January 2011, *available at* http://www.centerltc.com/pubs/Medi-Cal_LTC--Safety_Net_or_Hammock.pdf.
[43] David J. Armor and Sonia Sousa, *Restoring a True Safety Net*, NATIONAL AFFAIRS, Fall 2012, *available at* http://www.nationalaffairs.com/publications/detail/restoring-a-true-safety-net.
[44] Ned Regan, *Medicaid's Fatal Attraction*, CITY JOURNAL, Winter 1996, *available at* http://www.city-journal.org/html/6_1_medicaids_fatal.html.
[45] *Examining Abuses of Medicaid Eligibility Rules*: *Hearing Before the H. Comm. on Oversight & Gov't Reform*, 112th Cong. (2011).

60 percent of Medicaid applicants in Suffolk County engage in estate planning to gain program eligibility:

> As a long-time employee of the local Medicaid office, I have had the opportunity to witness the diversion of applicants' significant resources in order to obtain Medicaid coverage. It is not at all unusual to encounter individuals and couples with resources [beyond exempt resources] exceeding $500,000, some with over $1 million. There is no attempt to hide that this money exists; there is no need. There are various legal means to prevent those funds from being used to pay for the applicant's nursing home care. Wealthy applicants for Medicaid's nursing home coverage consider that benefit to be their right, regardless of their ability to pay themselves.… [I]ndividuals with resources above and beyond the level prescribed by law should not be allowed to fund their children's inheritance while the taxpayers fund their nursing home care. I strongly believe that this is not a partisan issue. I also believe in the merits of the Medicaid program, but feel just as deeply that these issues regarding resource diversion need to be addressed.[46]

Eulau also testified about a technique called "spousal refusal," a provision of the Medicare Catastrophic Coverage Act of 1988 that is being misused in New York.[47] Under spousal refusal, a couple shifts assets from a sick or disabled spouse to a healthy spouse in order to "artificially impoverish" the sick or disabled spouse and qualify him or her for Medicaid. The healthy spouse then invokes spousal refusal and declines to provide financial support for the spouse who is on Medicaid.[48] Moreover, under spousal refusal, income earned by the healthy spouse is exempt from being considered available to the impoverished spouse.

According to the *New York Times*, "[w]hile many state and local governments do not openly acknowledge the spousal refusal option, New York City actually provides a form letter for it."[49] In 2009, more than 1,200 people in New York City invoked spousal refusal, a significant increase from prior years.[50] The *Times* article also indicated that the City reviewed spousal refusal applications to recover money, but only $3.7 million was recovered in 2009, or less than $3,000 on average for each individual invoking spousal refusal.[51] Eulau testified that most married people in Long Island, New York, who apply for Medicaid use spousal refusal, and she confirmed to Committee staff that the use of this technique has grown over time.[52]

4. Excessive Salaries Paid to Executives of Medicaid-funded Organizations

The Committee has found that federal taxpayers have subsidized lavish lifestyles for many executives in organizations that receive almost all of their funding through Medicaid. The Committee's oversight work in this area was informed by an August 2011 *New York Times*

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[46] *Examining Abuses of Medicaid Eligibility Rules*: *Hearing Before the H. Comm. on Oversight & Gov't Reform*, 112th Cong. (2011) (testimony of Janice Eulau, Assistant Administrator for Medicaid, Suffolk County, New York Department of Social Services).
[47] *Id*.
[48] Allan Rubin and Harold Rubin, *Spousal Refusal to Pay for Nursing Home Costs*, THERUBINS.COM (Feb. 7, 2009) *available at* http://www.therubins.com/legal/refusal.htm.
[49] Anemona Hartocollis, *Full Wallets, but Using Health Program for Poor*, NEW YORK TIMES, December 10, 2010, *available at* http://www.nytimes.com/2010/12/12/nyregion/12medicaid.html?pagewanted=all.
[50] *Id.*
[51] *Id.*
[52] *See* supra note 46.

article that exposed how top executives at the Young Adult Institute (YAI) – a nonprofit that runs group homes for the developmentally disabled – used Medicaid funds to lease luxury cars, to pay tuition bills and living expenses for their children, and to reward themselves with generous compensation packages.[53] In fact, four executives at the YAI (Phillip Levy, Joel Levy, Tom Dern, and Stephen Freeman) each received compensation in excess of $1 million in 2008, with money derived almost entirely from Medicaid.[54]

While YAI may be the worst offender, high executive salaries funded with tax revenue is a common occurrence within several Medicaid-financed nonprofit organizations in New York State. A study conducted by the Committee found that, of the top executives at New York nonprofits financed primarily by Medicaid, at least 15 of them receive yearly compensation exceeding $500,000 and more than 100 other executives receive yearly compensation exceeding $200,000 per year.[55] The Committee's study was not a comprehensive or exhaustive search of compensation packages received by top employees at Medicaid-funded organizations, but rather a simple search of publicly available IRS 990 Forms.

III. New York's Medicaid Program Harms Many Patients

Unfortunately, the interests of individuals who profit from New York's Medicaid program often diverge from the interests of those the program purports to serve. Throughout 2011 and 2012, the *New York Times* ran a series titled 'Abused and Used' about how the large expenditures New York's Medicaid program makes toward treatment of the developmentally disabled do not necessarily translate into quality care received by these individuals.[56] For example, despite the large payments received by the State for the residents of developmental centers, the *Times* reported that patient care is often substandard:

> [T]he institutions are hardly a model: Those who run them have tolerated physical and psychological abuse, knowingly hired unqualified workers, ignored complaints by whistle-blowers and failed to credibly investigate cases of abuse and neglect, according to a review by The New York Times of thousands of State records and court documents, along with interviews of current and former employees. Since 2005, seven of the institutions have failed inspections by the State Health Department, which oversees the safety and living conditions of the residents.[57]

According to the *New York Times*, New York State has consistently failed to take complaints from employees of the developmental centers or family members of residents seriously.[58] Employees who report problems have experienced retaliation by other employees, and the length of time it takes to settle complaints disincentivizes employees from filing

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[53] Russ Beuttner, *Reaping Millions in Nonprofit Care for Disabled*, NEW YORK TIMES, August 2, 2011, *available at* http://www.nytimes.com/2011/08/02/nyregion/for-executives-at-group-homes-generous-pay-and-little-oversight.html?pagewanted=all.
[54] *This information obtained from publicly available 990 forms.*
[55] *See* Appendix B for Committee's data on salaries for executives at nonprofits funded by Medicaid in New York State
[56] *See Abused and Used*, NEW YORK TIMES, *available at* http://www.nytimes.com/interactive/nyregion/abused-and-used-series-page.html.
[57] Danny Hakim, *A Disabled Boy's Death, and a System in Disarray*, NEW YORK TIMES, June 5, 2011, *available at* http://www.nytimes.com/2011/06/06/nyregion/boys-death-highlights-crisis-in-homes-for-disabled.html?pagewanted=all&_r=0.
[58] *Id.*

complaints in the first place.[59] Many residents have suffered significant verbal, emotional, and physical abuse at the developmental centers.[60] Several residents at New York's developmental centers, and at numerous Medicaid-financed group homes across the state, have died directly because of employee incompetence or negligence, and in some cases even from manslaughter at the hands of their caretakers.[61]

A large part of the problem of poor resident care appears to be the difficulty of firing incompetent or neglectful employees:

> Since 2007, the state has tried to fire employees of a dozen local facilities for the developmentally disabled 20 times. It has failed 18 times. Quite simply, it's nearly impossible to get fired from state-run facilities that care for people with autism, Down syndrome and other mental disabilities, according to a *Poughkeepsie Journal* review of 1,900 pages of disciplinary documents involving 98 group homes and six institutions statewide. Just 2 percent of cases resulted in termination, with workers keeping jobs even in cases of serious alleged abuse and neglect.[62]

The *Poughkeepsie Journal* found that workers who left disabled people alone in a running vehicle or outside in the rain kept their jobs. Additionally, workers who stole State property, brought drug paraphernalia to work, or harassed disabled residents almost always kept their jobs.[63] An article in the *New York Times* suggests that the Civil Service Employees Association is partially to blame for this problem.[64] According to the *New York Times*, "the union's approach – contesting just about every charge leveled at a worker – has contributed to a system in which firings of even the most abusive employees are rare."[65] Office of People with Developmental Disabilities (OPWDD) spokesman Herm Hill said OPWDD's hands were often tied in cases against abusive workers because of the disciplinary and arbitration rules involving the workers' union.[66] The union's representation of repeat offenders made it possible for employees like Mitchell T. Lovett to rack up ten offenses – including twice punching residents in the face – before losing his job.[67]

There is also evidence that many individuals are inappropriately housed in the State's developmental centers. For example, according to a survey conducted by *The Poughkeepsie Journal*, New York locks up significantly more people with lifelong brain disorders, such as Down syndrome, compared to other states.[68] New York was sued in 2008 on charges that

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[59] *Id.*
[60] *See supra* note 56.
[61] *Id.*
[62] Mary Beth Pfeiffer, *Caregivers of Mentally Disabled Keep Jobs, even in cases of abuse, neglect*, POUGHKEEPSIE JOURNAL, Sept. 17, 2011, *available at* http://www.poughkeepsiejournal.com/article/20110918/PROMO/109180384/Journal-investigation-Caregivers-mentally-disabled-keep-jobs-even-cases-abuse-neglect.
[63] *Id*.
[64] Danny Hakim, *At State-Run Homes, Abuse and Impunity*, NEW YORK TIMES, March 12, 2011, *available at* http://www.nytimes.com/2011/03/13/nyregion/13homes.html?pagewanted=all.
[65] *Id*.
[66] *Id*.
[67] *Id*.
[68] Mary Beth Pfeiffer, *New York a leader in confining mentally disabled*, POUGHKEEPSIE JOURNAL, Sept. 7, 2010, *available at* http://www.poughkeepsiejournal.com/article/20100908/NEWS01/9080323/New-York-leader-confining-mentally-disabled.

residents had languished for years at State-operated developmental centers located in Wassaic and Schenectady.[69]

IV. New York Has a History of Enabling Medicaid Waste, Fraud, and Abuse

Many special interest groups serve as a roadblock to reforming Medicaid and eliminating waste, fraud, abuse, and mismanagement within the program. Although reducing Medicaid waste, fraud, and abuse in New York would benefit the nation, as valuable resources misspent on Medicaid could be used to provide better health care for the poor or for other purposes, these powerful special interest groups lobby strongly against Medicaid reform. Moreover, New York State officials have often taken actions that have actually enabled the waste, fraud, and abuse that permeates the State's Medicaid program.

Corruption and Cronyism of New York State officials

The corruption of several prominent New York State politicians has likely contributed to a culture in the State that enables Medicaid waste, fraud, and abuse to be so commonplace. In the last decade, at least half a dozen elected state representatives, including two State Senate Majority leaders, have been convicted of theft, bribery, or honest services fraud,[70] related to health care:

- On May 14, 2012, former New York State Senate Majority Leader Pedro Espada was convicted in federal court on four counts of theft for stealing over $500,000 from Soundview, the nonprofit health care network he founded in the Bronx which received federal funding in excess of $1 million per year.[71] Federal Medicaid money that was intended to be used for health care for the city's poorest residents instead paid for private family parties, school tuition, luxury car payments and $100,000 in lobster, sushi and other meals.[72] Additionally, Espada packed the Soundview board and staff with members of his own family and close personal friends.[73]

- In May of 2012, former New York Senate Majority Leader Joseph Bruno was charged with two counts of fraud for accepting $440,000 from a businessman who managed the assets of a health and welfare fund and sought the then-Senator's influence in legislative matters.[74]

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[69] Mary Beth Pfeiffer, *'Confidential' Paper: Quality of Care for Developmentally Disabled would Fall without Overpayments*, POUGHKEEPSIE JOURNAL, Sept. 5, 2010, *available at* http://www.poughkeepsiejournal.com/article/20100905/NEWS/9050379/-Confidential-paper-Quality-care-developmentally-disabled-would-fall-without-overpayments.

[70] Honest services fraud is federal crime defined in *Skilling v. United States* as "fraudulent schemes to deprive another of honest services through bribes or kickbacks supplied by a third party who has not been deceived." (Skilling v. United States 130 S. Ct. 2896, (2010).)

[71] Espada is expected to face a retrial on four other counts of theft, fraud and conspiracy on which the jury failed to agree after his six-week trial. *See* Mosi Secret, *Ex-State Senator Guilty of Theft from Nonprofit*, NEW YORK TIMES, May 14, 2012, *available at* http://www.nytimes.com/2012/05/15/nyregion/ex-senator-espada-guilty-of-embezzling-from-soundview-health-network.html?pagewanted=all.

[72] *Id*.

[73] Julia Marsh and Dan Mangan, *Pedro's board stiffs were his puppets*, NEW YORK POST, March 21, 2012, *available at* http://www.nypost.com/p/news/local/bronx/pedro_board_stiffs_EjyOnu7lWNZZyXtXqtzpBM.

[74] Joseph L. Bruno, *Times Topics*, NEW YORK TIMES (updated May 4, 2012) *available at* http://topics.nytimes.com/top/reference/timestopics/people/b/joseph_l_bruno/index.html?inline=nyt-per ("The indictment, unsealed in Federal District Court in Albany, came nearly six months after a federal appeals court vacated Mr. Bruno's previous

- Former New York State Senator Carl Kruger was sentenced to seven years in prison after pleading guilty to two counts of conspiracy to commit honest services fraud[75] and two counts of conspiracy to commit bribery.[76] Mr. Kruger accepted bribes from two hospital executives, a prominent lobbyist and a healthcare consultant in exchange for taking official action on behalf of those parties, including sponsoring and supporting legislation, favorably directing State grants, and writing to State officials in his capacity as State legislator.[77]

- In 2005, former New York State Senator Guy Velella pled guilty to one count of bribery and was sentenced to one year in prison for the felony conviction.[78] He was charged with a 25-count indictment alleging the solicitation of $250,000 in bribes for steering public works contracts to those who paid the bribes.[79] During the 1990s, his law firm was given hundreds of thousands of dollars in legal work by large insurance companies while he headed the State Senate Committee that oversaw legislation affecting them.[80]

- In 2004, New York State Assemblyman Anthony Seminerio pled guilty to a single fraud count for influence peddling and was sentenced to six years in prison.[81] Seminerio admitted to promoting the interests of Jamaica Hospital Medical Center, from which he received over $300,000 for obtaining State financing and lobbying legislators on behalf of the hospital's efforts to take over other hospitals.[82]

- New York State Assemblyman William Boyland, Jr. was indicted in 2011 for conspiring to accept $175,000 in bribes in exchange for influence peddling on behalf of MediSys Health Network, a health care organization that runs hospitals in the state.[83]

Outright corruption and favoritism has occurred in New York as well. For example, Kenneth Bruno, son of former New York State Senate Majority Leader Joseph Bruno, was hired as a lobbyist for the New York Ambulette Coalition on the same day that the State Legislature eliminated $4.4 million in Medicaid transportation funding that would have gone to the Coalition's members.[84] Within ten days, the funding was restored "at the insistence of the

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conviction because of a ruling in a separate case by the United States Supreme Court that undermined the government's legal claims against Mr. Bruno, a Republican from Rensselaer County. But the appeals court said Mr. Bruno could be retried on different charges.")

[75] *See supra* note 70.

[76] Benjamin Weiser, *Former State Senator Is Sentenced to 7 Years in Vast Bribery Case*, NEW YORK TIMES, April 26, 2012, *available at* http://www.nytimes.com/2012/04/27/nyregion/carl-kruger-sentenced-to-seven-years-in-corruption-case.html.

[77] *Id*.

[78] Liz Krueger, *Former Senator Guy Velella: Convicted Felon, $80,000-A-Year Public Pensioner*, GOTHAM GAZETTE, October 25, 2004, *available at* http://www.gothamgazette.com/article/fea/20041025/202/1156.

[79] *Id*.

[80] Clifford J. Levy and Christopher Drew, *In Albany, Ally of Insurers Profits From Them*, NEW YORK TIMES, February 4, 2011, *available at* http://www.nytimes.com/2001/02/04/nyregion/in-albany-ally-of-insurers-profits-from-them.html.

[81] David M. Halbfinger and William Rashbaum, *Ex-Assemblyman From Queens Dies In Federal Prison*, NEW YORK TIMES, January 7, 2011, *available at* http://query.nytimes.com/gst/fullpage.html?res=9D02EFD7143AF934A35752C0A9679D8B63.

[82] *Id*.

[83] Bill Hammond, *William Boyland is the poster child for the culture of corruption in Albany*, NEW YORK DAILY NEWS, November 8, 2011, *available at* http://www.nydailynews.com/opinion/william-boyland-poster-child-culture-corruption-albany-article-1.974029.

[84] Fredric U. Dicker, *It Pays (4.4 million) to Hire Bruno's Son*, NEW YORK POST, April 25, 2005, *available at* http://www.nypost.com/p/news/item_Usy1VfKTPyNavkRCN2mb4K.

Senate," according to a senior State official.[85] Bruno reportedly called his father's top aides personally to ask them to restore the funds.[86] Leaders throughout New York State voiced their disapproval about Bruno's lobbying deal. Conservative Party Leader Michael Long said the deal "shows the system is broken," and Rachel Leon, executive director of Common Cause, called the action by Bruno's son, Kenneth, "an instant symbol of what's wrong in Albany."[87]

Problems with State Oversight of the Medicaid Program

The problem of waste, fraud, abuse, and mismanagement within New York's Medicaid program is long-standing with blame properly divided among Republicans and Democrats. Several whistleblowers within the New York State health care system have brought to light serious failures indicating that State bureaucracy has historically enabled Medicaid waste, fraud and abuse. Paul F. Stavis, counsel to three different New York State health agencies during his 28-year career, alleged that "anti-fraud efforts in New York have not been taken seriously by the state's executive agencies."[88] In an April 2011 article in *Newsday,* Stavis cited multiple examples of Medicaid-related fiscal abuse[89] and how both the State's Department of Health (DOH) and the State's Office of the Medicaid Inspector General (OMIG) looked the other way when faced with evidence of Medicaid fraud.[90]

According to Stavis, New York State continued to pay providers who were suspected of abusing the Medicaid system. For instance, the DOH gave a $1 million grant to Pedro Espada's nonprofit, Soundview, even after seeing evidence of ongoing fraud.[91] In fact, Stavis brought evidence of Espada's illegal activities to the attention of the DOH in 2005 and OMIG in 2007, years before the former State Senate Majority leader was convicted of Medicaid fraud. No action was taken by either State office.[92] The illegal payments continued until 2011, when the federal government ordered the payments stopped and commenced criminal proceedings against Espada.[93]

Stavis is not the only person to accuse the bureaucracy of enabling Medicaid waste, fraud, and abuse. Earlier, this report highlighted the suit Dr. Gabriel Feldman successfully brought against the City of New York in 2011.[94] As a medical director, Feldman determined

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[85] *Id*.
[86] *Id*.
[87] Fredric U. Dicker, *Pol Son Burned - Right & Left Agree: Bruno Kin's Deal Is Wrong*, NEW YORK POST, April 26, 2005, *available at* http://www.nypost.com/p/news/item_IwRwuubUpAd1M23lYXtDCK.
[88] Paul Stavis, *NY too weak on Medicaid fraud*, NEWSDAY, April 1, 2011, *available at* http://www.newsday.com/opinion/oped/stavis-ny-too-weak-on-medicaid-fraud-1.2795786.
[89] *See id*. Stavis states that New York State law contains a loophole that prevents the State from prosecuting certain types of Medicaid fraud, which then necessitates the federal government's intervention when such misappropriation crimes are committed. Stavis characterized the inability of New York state to prosecute and the resulting need for federal involvement as an "embarrassment." Although Stavis drafted legislation to close the loophole during his tenure as counsel for the State, Stavis writes that the New York state legislature refused to pass this legislation.
[90] *Id*. In addition to outright fraudulent activities, New York State is also inundated with numerous cases of fiscal abuse regarding Medicaid. In an outstanding example of fiscal abuse, Stavis cites instances where providers diverted Medicaid funds to make "donations" to charities in foreign countries, give nearly $2 million per year to a house of worship, fund religious schools, and pay excessively high salaries to executives at nonprofit corporations.
[91] Jacob Gershman, *State Ignored Call to Probe Espada Clinics*, WALL STREET JOURNAL, December 17, 2010, available at Reference needed .
[92] *Id*.
[93] Stavis, *supra* note 88.
[94] *Is Government Adequately Protecting Taxpayers from Medicaid Fraud*?: *Hearing Before the H. Comm. on Oversight & Gov't Reform*, 112th Cong. (2012) (testimony of Gabriel Feldman, Local Medical Director, New York Personal Care Services Program).

which individuals met the qualifications for Medicaid-funded home health care services. Despite firm criteria outlining program eligibility, Feldman encountered "tremendous pressure" from advocacy groups, politicians, and family members of clients to approve service requests for individuals who did not meet the qualifications.[95] When he refused to grant such requests, Feldman found that his decisions were "knowingly, intentionally and routinely being overridden without legal basis"[96] in order "to admit as many clients as possible who apply for the PCS Program regardless of his or her condition, fitness or qualification for the program."[97] In testimony before the Committee, Feldman stated that "a pervasive culture of non-accountability and non-compliance to PCS State regulations made it simply far too easy for local social service offices in New York City to spend billions in taxpayer money without regard to common sense oversight, regulations of the State, or patient safety concerns."[98]

During the Committee's hearing, Feldman used the term "Medicaid industrial complex"[99] to refer "to the New York State Government, the healthcare providers and the unions essentially operating as one unified entity and making any enforcement and recovery actions largely unsuccessful."[100] Feldman further explained that "the current system of quality assurance, oversight, and rate setting was completely dysfunctional" and "there are insufficient resources and staff in the Inspector General's Office and in New York City's Human Resource Administration, devoted to enforcing fiscal discipline and fraud oversight in the system."[101] Like Stavis, Feldman also indicts the DOH for having "utterly failed in their oversight functions."[102]

V. Improvements and Additional Concerns in Last Two Years

During his first month as New York's Governor, Andrew Cuomo called for Medicaid reform, stating, "New York's bloated Medicaid program, which spends at a rate more than twice the national average, must be reformed to help our state begin to make ends meet."[103] The administration of Governor Cuomo had taken positive steps to alleviate some of the problems discussed in Section II of this report. To his credit, Governor Cuomo has also proposed various additional Medicaid reforms, such as capping medical malpractice awards and beginning to transfer the state's Medicaid population from fee-for-service to Medicaid managed care.[104] These efforts have been dubbed by the *New York Post* as "a break with past efforts" because of the support he obtained from the Service Employees International Union and the hospital association.[105] However, despite the "bloated" Medicaid program when Governor Cuomo took office, New York's annual Medicaid spending has increased $4 billion since he was elected only

[95] *Id*.
[96] First Amended Complaint-In-Intervention of Plaintiff-Intervenor United States of America, United States of America *ex. rel.* Dr. Gabriel Feldman v. The City of New York, 09 Civ. 8381 (JSR) (S.D.N.Y. 2011).
[97] *Id*.
[98] *See supra* note 94.
[99] *Id*.
[100] Letter from Gabriel Feldman to H. Comm. on Oversight & Gov't Reform, Response to Questions for the Record, (May 10, 2012) (on file with Committee).
[101] *Id.*
[102] *Id.*
[103] Governor Andrew M. Cuomo, Press Release, *Governor Cuomo Issues Executive Order Creating Medicaid Redesign Team* (January 5, 2011) *available at* http://www.governor.ny.gov/press/01052011medicaid.
[104] Brendan Scott and Fredric U. Dicker, *Gov and health bigs forge Medicaid deal*, NEW YORK POST, (February 25, 2011) available at: http://www.nypost.com/p/news/local/gov_and_health_bigs_forge_medicaid_OvOOAOL1jgjCBmplovDuCK
[105] *Id.*

two years ago. According to Dr. Feldman, "[w]hile Governor Cuomo has taken bold steps to redesign Medicaid in New York State, the Medicaid industrial complex is thriving, especially in New York City."[106]

According to Dr. Feldman, there have been some additional measures "taken by New York City and New York State to ensure proper compliance with federal and state regulations" for the Personal Care Service (PCS) Program.[107] Feldman has indicated that average service hours to clients have dropped drastically because of the new attention being paid to regulatory requirements, case files are being checked and re-checked to ensure greater accountability, and eligibility assessments for the program have become more standardized with less being left to the discretion of the individual conducting the evaluation.[108] In the first year of the Cuomo administration, the State also started a phase-out of fee-for-service home care, an action which may ensure greater integrity in the PCS Program. This effort began in New York City, where the State converted the City's fee-for-service PCS program to the State's Medicaid Managed Long Term Care program.[109]

On January 18, 2012, Governor Cuomo issued an executive order to address the problem of outrageous executive compensation packages at Medicaid-financed organization.[110] The order recognized that "New York has an ongoing obligation to ensure that taxpayers' dollars are used properly, efficiently and effectively to improve the lives of New Yorkers and our communities," and that "in certain instances providers of services that receive State funds or State-authorized payments have used such funds to pay for excessive administrative costs and outsized compensation for their senior executives."[111] The Governor's order directed that payments to "providers of services that receive reimbursements directly or indirectly" from State agencies "shall not be provided for compensation paid or given to any executive by such provider in an amount greater than $199,000."[112] The Governor's order also stated: "A provider's failure to comply with such regulations established by the applicable State agency shall, in the commissioner's sole discretion, form the basis for termination or non-renewal of the agency's contract with or continued support of the provider."[113]

To Governor Cuomo's credit, he proposed eliminating spousal refusal in New York in his first budget.[114] However, the powerful interest groups, especially the elder law bar, lobbied strongly to prevent the change. The interest groups' opposition proved successful, and New York was not able to end the abuse of spousal refusal.[115] In his 2013-2014 budget proposal, Governor Cuomo has again proposed changes that would reduce the ability of individuals in

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[106] *See supra* note 94.
[107] *See supra* note 100.
[108] *Id.*
[109] New York 2013-2014 Executive Budget, *NY Rising*, (January 22, 2013), available at: http://publications.budget.ny.gov/eBudget1314/fy1314littlebook/BriefingBook.pdf.
[110] Governor Andrew M. Cuomo, State of New York, Executive Order 38, (Jan. 18, 2012), available at: www.governor.ny.gov/executiveorder/38.
[111] *Id.*
[112] *Id.*
[113] *Id.*
[114] Carl Campanile, *Andy to end 'rich' home-care ruse*, NY POST, (March 7, 2011), available at: http://www.nypost.com/p/news/local/andy_to_end_rich_home_care_ruse_UO5gsIz0Fcat1zrZ1XwXdP.
[115] Sanford Altman, *Better With Age: NY seniors win as Legislature drops* provision, (April 10, 2012, available at: http://www.recordonline.com/apps/pbcs.dll/article?AID=/20120410/BIZ/204100328.

New York to abuse the spousal refusal technique by passing private costs onto taxpayers.[116] Unfortunately, the Committee has not found evidence that the State has attempted to make Medicaid estate planning more difficult.

Although the State has taken positive steps to reduce problems in its Medicaid program, New York did not quickly or adequately cooperate with the federal government on the need to reduce the excessive developmental center payment rates to a reasonable level. CMS first inquired about the excessive payment rates in 2010 and the rates have only grown more excessive since.[117] When asked by the Committee for information relating to this abusive use of federal taxpayer dollars, an aide to New York Governor Andrew Cuomo responded, "[w]e aren't sure responding to the Committee's request at this time when we are working through these issues serves the best interests of the State."[118]

In a November 2012 briefing, CMS staff informed Committee majority staff that New York had decided not to cooperate with CMS on reducing the payment rates to a reasonable rate of about one-fifth the current rate and that the matter was likely to go into litigation.[119] Between mid-November and the present, New York and CMS have entered negotiations about reducing the developmental center payment rate through the Medicaid State plan amendment process.[120] According to the *Wall Street Journal*, "New York has agreed to give up about $800 million in payments to the developmental centers."[121] However, the details have not been worked out yet and the State continues to receive an inappropriate and unlawful windfall through excessive payment rates.

Moreover, a troubling report recently emerged that suggests that the State's Office of Medicaid Inspector General has become complacent, dysfunctional, and politicized.[122] In November 2012, several New York State employees came forward alleging dysfunction in the bureaucracy tasked with New York State Medicaid program integrity. According to an article in the *Times-Union*, New York's OMIG, the agency tasked with "preventing and detecting fraudulent, abusive, and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds,"[123] suffers from misdirection and its investigations lack a sense of urgency, according to multiple long-term OMIG employees.[124]

The *Times-Union* article suggests that problems began at OMIG when James Sheehan, who took an aggressive approach to combating problems in the state's Medicaid program and was largely credited with recouping $1.5 billion in Medicaid overpayments in a four-year

[116] 2013-2014 New York State Executive Budget Health and Mental Hygiene Article VII Legislation Memorandum in Support, available at: http://publications.budget.ny.gov/eBudget1314/fy1314artVIIbills/HMH_ArticleVII_MS.pdf.
[117] Letter from Sue Kelly, Associate Regional Administrator, Division of Medicaid and Children's Health, CMS to Donna Frescatore, Deputy Commissioner, NY State Department of Health, (July 13, 2010) (on file with Committee).
[118] Email from Alexander Cochran, Special Counsel to the Governor, to Committee on Oversight and Government Reform staff, September 4, 2012.
[119] Briefing between CMS staff and majority Committee staff, (November 20, 2012).
[120] Laura Nahmias, *Budget Hole Seen After Loss of Aid*, WALL STREET JOURNAL, January 24, 2013.
[121] *Id.*
[122] *See supra* note 3.
[123] Office of the New York State Medicaid Inspector General, Mission Statement, *available at* http://www.omig.ny.gov/data/content/blogcategory/20/192/
[124] *See supra* note 3.

period,[125] was replaced with James Cox as OMIG Director by Governor Cuomo. Sheehan was appointed as Inspector General of OMIG in 2007 by Governor Spitzer in response to the outcry generated from the *New York Times* 2005 series about the rampant waste, fraud, abuse, and mismanagement within the state's Medicaid program and the corresponding lack of oversight.[126] Sheehan believes that he was removed as the Inspector General of OMIG because he represented a challenge to a powerful Medicaid industry in New York that is a large employment engine.[127] According to Sheehan, "Medicaid is to New York what corn is to Iowa. It's a heavy lift."[128]

According to the *Times-Union*, Sheehan's replacement has not hired employees with the necessary knowledge and experience to investigate Medicaid waste, fraud, and abuse and to protect taxpayer dollars from being misspent through the program.[129] According to a former employee with a 32-year history at the agency, employees have nothing to do: "[f]or a year, we aren't doing anything …. I know for a fact that people aren't working."[130] Former employees also report that OMIG has recently backed off audits and investigations of organizations suspected of Medicaid fraud and abuse for politically-motivated reasons.[131]

The *New York Times* has reported that audits released by the State show that Cox's findings of overpayments have fallen steeply over time.[132] According to the *New York Times*, New York was on target to *avoid* (which is much more difficult to quantify accurately than recoveries) $1.1 billion last year.[133] However, the *Times* also pointed out that most of the important audit responsible for the avoided cost were started under Sheehan.[134] Another indication of reduced State oversight is a *New York Post* report that the State Office of the Welfare Inspector General has dramatically reduced its staff devoted to investigating fraud in welfare programs over the past decade.[135]

V. Recommendations

Satirist P.J. O'Rourke has remarked, "[b]eyond a certain point complexity is fraud … when someone creates a system in which you can't tell whether or not you're being fooled, you're being fooled."[136] New York's State Medicaid Plan, like almost all State Medicaid plans, consists of thousands of pages of dense rules and reimbursement methodologies that no one completely understands. According to Paul Stavis, who served as counsel to three different New York State health agencies during his 28-year health care career,[137] New York has made its

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[125] Nina Bernstein, *Under Pressure, New York Moves to Soften Tough Medicaid Audits*, NEW YORK TIMES, March 18, 2012, *available at* http://www.nytimes.com/2012/03/19/nyregion/new-medicaid-inspector-general-supports-less-adversarial-audits.html?pagewanted=all.
[126] *See supra* note 15.
[127] *See supra* note 122.
[128] *Id.*
[129] *See supra* note 3.
[130] *Id.*
[131] *Id.*
[132] *See supra* note 125.
[133] *Id.*
[134] *Id.*
[135] Erik Kriss, *State's welfare-fraud force is a farce*, NEW YORK POST, November 21, 2011 available at. *http://www.nypost.com/p/news/local/state_welfare_fraud_force_is_farce_hZvwh2SQKLHm1T3Mi0E7UJ.*
[136] P.J. O'Rourke, *How to Stuff a Wild Enron*, ATLANTIC MONTHLY, April 2002, *available at* http://www.theatlantic.com/past/docs/issues/2002/04/orourke.htm.
[137] The complaints Mr. Stavis brought against New York's Medicaid program are discussed in Section III of this Report.

Medicaid program "so utterly complicated that nobody completely understands it. It allows New York to pull the wool over the feds' eyes."[138]

The federal government, particularly CMS, has been culpable in New York's virtually unchecked Medicaid growth. No example illustrates the failure of the federal government to protect taxpayer dollars from New York's Medicaid industrial complex better than CMS's approval of 35 modifications related to the excessive developmental center payment rate over the past 25 years. These modifications have collectively caused the State to receive around $15 billion beyond both a reasonable amount and an amount allowed by federal law for just one, relatively small, part of the State's Medicaid program.

As discussed in the previous section, Governor Cuomo has taken steps to correct some of the problems with the State's Medicaid program. Moving forward, Governor Cuomo has proposed limiting future growth in Medicaid spending to four percent each year, and the State has submitted several applications for waivers from CMS that relate to the financing of its Medicaid program.[139] Those reforms include instituting a "global cap" on Medicaid spending and the expansion of "health homes." [140] New York State projects that their newly-implemented Medicaid reforms will save the federal government $17 billion over five years.[141] However, the Medicaid Redesign Team (MRT) Waiver Amendment asks CMS to allow New York to keep $10 billion of those proposed federal savings. It is imperative that the State does not use the MRT waiver and other waivers to capture savings that should rightfully accrue to federal taxpayers from the necessary trimming that New York must make to its excessive Medicaid spending.

Before considering the merits of these waivers, the federal government needs to take three actions. First, CMS must follow through on its commitment to the Committee and cap reimbursements to the State's developmental centers to a rate of one-fifth of their current levels. Second, the Department of Health and Human Services (HHS) must ensure that the baseline from which New York is calculating its savings from recently submitted waivers, including the MRT waiver, do not include the excessive overpayments received by the State through the development centers. HHS must also have both auditors and budget experts verify the state's estimates for the impact of these waivers. Third, a complete, independent audit of New York's Medicaid program must be conducted including an investigation into the accusations that the New York Office of Medicaid Inspector General has become politicized, dysfunctional, and complacent. Federal taxpayers, as well as New York State taxpayers, have a right to know how their tax dollars are actually being spent by New York's Medicaid program and whether or not

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[138] Mary Beth Pfeiffer, *Feds Launch Audit of Medicaid Payments to N.Y. Institutions*, POUGHKEEPSIE JOURNAL, May 14, 2011.

[139] *See* ACHIEVING THE TRIPLE AIM, NEW YORK STATE MEDICAID REDESIGN TEAM WAIVER AMENDMENT, NEW YORK STATE DEPARTMENT OF HEALTH, http://www.health.ny.gov/health_care/medicaid/redesign/docs/2012-08-06_waiver_amendment_request.pdf*;see also It's Going to be a 1915 b/c Waiver*, NEW YORK STATE OFFICE FOR PERSONS WITH DEVELOPMENTAL DISABILITIES, PEOPLE FIRST WAIVER (June 6, 2012) *available at* http://www.opwdd.ny.gov/opwdd_services_supports/people_first_waiver/1915_b_c_waiver ("During discussions with CMS in May, OPWDD determined that a combination of a 1915 b and 1915 c waiver will provide the flexibility needed to redesign the delivery system to provide person-centered, need-focused supports and services as outlined under the People First Waiver. Therefore, OPWDD will pursue a combination of these two types of waivers rather than an 1115 Research and Demonstration Waiver.").

[140] New York's "global cap" is the first-in-the-nation statutory cap on state Medicaid spending. It is linked to the 10-year rolling average for medical price inflation.

[141] Governor Andrew M. Cuomo, Press Release, *Governor Cuomo Announces that New York Submits Federal Waiver to Invest $10 Billion in Medicaid Redesign Team Savings to Transform the State's Health Care System* (August 6, 2012) *available at* http://www.governor.ny.gov/press/08062012-federal-waiver-health-care.

New York's Office of Medicaid Inspector General is capable and willing to protect taxpayer dollars within the program.

In addition to these three steps, the Committee's review indicates three other specific steps that can be taken to begin reforming New York's bloated program:

- New York's Personal Care Services Program must only enroll individuals who meet the eligibility thresholds required by law.
- New York must aggressively pursue estate recovery against affluent New Yorkers who artificially impoverish themselves or invoke spousal refusal to qualify for Medicaid.
- New York's legislature must enact into law Governor Cuomo's executive order that limits compensation of executives at organizations that receive nearly all their money through Medicaid to amounts below $199,000. New York must also aggressively monitor and enforce these limits.

While significantly more reform is needed to right size New York's Medicaid program and reduce waste, fraud and abuse within the program, these steps would fix some of the major problems that currently exist and would shed light on where the $54 billion that New York is spending on Medicaid is going.

VI. Conclusion

In 2003, the Government Accountability Office (GAO) added Medicaid to its list of high-risk programs.[142] This report highlighted significant waste, fraud, abuse, and mismanagement in New York State's Medicaid program, and the previous section outlined six specific steps that CMS and New York can take to protect taxpayer dollars from being misspent through New York's Medicaid program. Many of the recommendations discussed in the report, such as limiting Medicaid eligibility to individuals who meet the program's criteria, limiting executive compensation at organizations that receive the vast majority of their money through Medicaid, and strong State estate recovery programs should be implemented across the country.

It is also important to note how poorly CMS has historically performed in protecting federal tax dollars from being misspent through Medicaid. CMS has been hampered by poor data quality, but the agency has also failed to prioritize program integrity and to competently pursue and eliminate waste, fraud, abuse, and mismanagement within State programs. A Committee majority staff report from April 2012 detailed several examples of how CMS has failed to protect taxpayer dollars spent through the Medicaid program.[143] Moreover, as GAO has widely reported, states have resorted to creative techniques such as provider taxes and large supplemental payments to draw down additional federal dollars into their states through the Medicaid program without net State contributions.[144] These techniques undermine the nature of joint federal-state financial responsibility for the Medicaid program by significantly increasing

[142] *See Medicaid Waste, Fraud and Abuse, Threatening the Healthcare Safety Net: Hearing Before the Senate Comm. on Finance*, 109th Cong. (2005) (written statement of Kathryn G. Allen, Health Care Director, Government Accountability Office), *available at* http://www.gao.gov/new.items/d05836t.pdf.
[143] See supra note 1.
[144] U.S. GOV'T ACCOUNTABILITY OFFICE (GAO): CMS NEEDS MORE INFORMATION ON THE BILLIONS OF DOLLARS SPENT ON SUPPLEMENTAL PAYMENTS (2008), *available at* http://www.gao.gov/new.items/d08614.pdf.

the federal share of Medicaid expenditures and further undermining State incentives to run efficient Medicaid programs.

The national debt of the United States now exceeds $16.4 trillion, with more than $6 trillion added to the national debt in just the last four years. Congress faces critical and difficult choices about how to put the federal budget on a sustainable path. The ideas in this report, which should receive bipartisan support and be implemented across the country, would alleviate some of the most egregious problems in the program and would begin to put the Medicaid program on a sustainable path.

Appendix A: Per Capita Federal Medicaid Dollars, by State (FY2010)

State	Federal Spending	State	Federal Spending
New York	$1,655	Alabama	$769
Vermont	$1,398	Texas	$764
New Mexico	$1,341	Oregon	$761
Maine	$1,295	Maryland	$754
Louisiana	$1,248	Iowa	$742
Mississippi	$1,184	Illinois	$739
Rhode Island	$1,170	Montana	$737
West Virginia	$1,143	New Jersey	$716
Arizona	$1,111	North Dakota	$713
Massachusetts	$1,107	Hawaii	$705
Arkansas	$1,095	Idaho	$695
Alaska	$1,056	California	$695
Kentucky	$1,033	Indiana	$690
Tennessee	$1,010	South Dakota	$680
Missouri	$1,008	Washington	$659
Connecticut	$990	Nebraska	$650
Pennsylvania	$972	Florida	$624
Ohio	$972	New Hampshire	$623
South Carolina	$888	Georgia	$601
Delaware	$885	Kansas	$594
Minnesota	$880	Wyoming	$586
Michigan	$865	Utah	$499
North Carolina	$855	Virginia	$496
Oklahoma	$841	Colorado	$494
Wisconsin	$809	Nevada	$357

Medicaid expenditures by State as well as FMAP rates are from the Kaiser Family Foundation's State health care facts.[145] Population figures were obtained from the Census Bureau.

[145] Kaiser Family Foundation, *Total Medicaid Spending, FY 2010* (January 3, 2012), *available at* http://www.statehealthfacts.org/comparemaptable.jsp?ind=177&cat=4.

Appendix B: Executive Salaries at Non-Profits Financed Mostly by Medicaid[146]

Organization	Position	2008 Total Compensation	2008 Average County Income	2011 Total Compensation	2010 Average County Income
Young Adult Institute	President	$2,106,905	$118,293	$868,761	$111,386
	C.E.O.	$1,991,753	$118,293	Retired	$111,386
	Co-C.O.O.	$1,070,614	$118,293	$497,233	$111,386
	Co-C.O.O.	$1,191,809	$118,293	$534,276	$111,386
Maryhaven Center of Hope	C.E.O.	$923,878	$52,085	$643,484	$49,994
	Exec. V.P.	$778,990	$52,085	$1,003,980	$49,994
	C.F.O	$344,459	$52,085	$429,328	$49,994
	V.P Finance	$231,698	$52,085	$244,565	$49,994
The Center for Discovery	C.E.O.	$939,280	$35,130	$649,977	$35,764
	Former C.F.O	$480,832	$35,130	N/A	$35,764
	C.F.O	$254,595	$35,130	$238,293	$35,764
	Medical Director	$271,902	$35,130	$269,030	$35,764
	Chief of Program	$262,393	$35,130	$257,200	$35,764
	Chief of Admission	$226,224	$35,130	$228,140	$35,764
	Chief of Health Services	$248,725	$35,130	$223,398	$35,764
	Chief of Development and Fundraising	N/A	$35,130	$223,658	$35,764
NYSARC (NY Chapter)	Exec. Director	$538,104	$118,293	$644,157	$111,386
	Director Info Tech.	$211,853	$118,293	$260,784	$111,386
	Education Director	$201,311	$118,293	$268,612	$111,386
	C.F.O.	$297,000	$118,293	$268,867	$111,386
	Assoc. Exec. Director	$369,195	$118,293	$149,061	$111,386
	Assoc. Exec. Director	$327,896	$118,293	$422,456	$111,386
	Budget Director	$300,300	$118,293	$371,766	$111,386
	Chief Compliance Officer	$263,995	$118,293	$372,667	$111,386
	SR Policy Advisor	$243,661	$118,293	$666,444	$111,386
	Director of Employee Higher	$211,853	$118,293	$351,703	$111,386
A.C.L.D	Exec. Dir.	$525,704	$68,918	$552,761	$65,615
	CFAO	$302,883	$68,918	$333,466	$65,615
	Asst. Exec. Dir.	$178,026	$68,918	$196,673	$65,615
	Asst. Exec. Dir.	$186,836	$68,918	$201,530	$65,615
	Medical Dir.	$329,119	$68,918	$322,012	$65,615
	Asst. Medical Dir.	$234,325	$68,918	$220,778	$65,615

[146] This chart is not a comprehensive or exhaustive search of compensation packages received by Medicaid managers, but is rather compiled from a simple search of publicly available IRS forms 990.

Organization	Position	2008 Total Compensation	2008 Average County Income	2011 Total Compensation	2010 Average County Income
NYSARC (Montgomery Co. Chapter)	C.O.O.	$168,034	$31,524	$182,842	$31,887
	C.F.O.	$109,542	$31,524	$156,315	$31,887
HeartShare Human Services of New York	President and C.E.O	$454,975	$36,555	$507,852	$37,527
	Executive Vice President, Finance	$286,794	$36,555	$285,181	$37,527
	Executive Director	$217,484	$36,555	$230,350	$37,527
Jawonio Inc.	C.E.O (Now Deceased)	$545,783	$77,741	$278,049	$73,159
	Current C.E.O, Assistant Executive Director (2008-2010)	$161,202	$77,741	$223,194	$73,159
Head Injury Association Inc.	C.E.O	$250,349	$52,085	$370,996	$49,994
Albert Einstein School of Medicine	President of Yeshiva University	$857,047	$29,133	$879,921	$30,551
	Vice President for University Life	$374,876	$29,133	$349,989	$30,551
	Vice President of Administrative Services	$273,997	$29,133	$263,715	$30,551
	Vice President of Finance and C.F.O	$255,061	$29,133	(Left for a different position)	$30,551
LifeSpire Inc.	Unspecified	$401,140	$118,293	$409,614	$111,386
	Unspecified	$214,039	$118,293	$222,119	$111,386
Human Care Services for Families & Children Inc.	Executive Director	$162,883	$36,555	$214,087	$37,527
Upstate Cerebral Palsy Inc.	Psychiatrist	$204,660	$33,716	(Left for a different position)	$34,560
	President/C.E.O	$213,429	$33,716	$232,975	$34,560
Developmental Disabilities Institute, Inc.	Executive Director	$266,960	$52,085	(Left for different position)	$49,994
	Associate Executive Director	$186,116	$52,085	$260,155	$49,994
Ohel Childrens Home and Family Services	C.E.O	$292,449	$36,555	$344,563	$37,527
	C.F.O	$206,750	$36,555	$216,632	$37,527
	C.O.O	$226,292	$36,555	$249,495	$37,527
	C.O.O	$223,722	$36,555	$237,202	$37,527
	Chief Development Officer	$275,904	$36,555	$285,981	$37,527

Organization	Position	2008 Total Compensation	2008 Average County Income	2011 Total Compensation	2010 Average County Income
Research Foundation of State University of New York	Director	$231,812	$45,129	$246,877	$45,764
	Treasurer	$221,164	$45,129	$278,387	$45,764
	Senior Vice President	$327,415	$45,129	$293,976	$45,764
	Principal Investigator	$432,001	$45,129	(Left for a different position)	$45,764
	Project Administrative Officer	$598,482	$45,129	$726,728	$45,764
	Project Staff Associate	$340,261	$45,129	$363,622	$45,764
	Senior Research Scientist	$306,241	$45,129	(Left for a different position)	$45,764
	Principal Investigator	$317,405	$45,129	$294,734	$45,764
	Project Administrative Officer	$304,415	$45,129	(Left for a different position)	$45,764
	General Counsel and Secretary	N/A	$45,129	$325,152	$45,764
Epilepsy Foundation of Long Island	Executive Director	$170,736	$68,918	$255,925	$65,615
Center for Disability Services Inc.	President/C.E.O	$247,394	$45,129	$274,818	$45,764
	Medical Director	N/A	$45,129	$227,235	$45,764
Block Institute Inc.	Executive Director/C.E.O	$201,586	$36,555	$225,114	$37,527
Life's Worc Inc.	Executive Director	$331,217	$68,918	$328,471	$65,615
Federation Employment and Guidance Services	C.E.O	$533,323	$118,293	$477,925	$111,386
	Executive Vice President	$421,275	$118,293	$362,538	$111,386
	C.O.O	$460,158	$118,293	$303,781	$111,386
	C.F.O	N/A	$118,293	$285,964	$111,386
	General Counsel	$222,935	$118,293	$261,919	$111,386
	Chief Development Officer	N/A	$118,293	$241,723	$111,386
	Sr. Vice President of Home Care and DD	$271,870	$118,293	$229,651	$111,386
	Sr. Vice President Behavioral Health	$256,144	$118,293	$222,031	$111,386
	Sr. Vice President Residential Housing Services	$204,587	$118,293	$211,523	$111,386
	Sr. Vice President Work Services	$260,302	$118,293	$196,416	$111,386
	Sr. Vice President-EMP, TRNG, EDUC & Youth	$206,998	$118,293	$163,046	$111,386
Springbrook NY Inc.	Executive Director	$205,937	$31,266	$217,706	$31,700

Organization	Position	2008 Total Compensation	2008 Average County Income	2011 Total Compensation	2010 Average County Income
Staten Island Mental Health Society Inc.	Unspecified	$547,585	$47,908	$498,311	$47,444
	Unspecified	$190,249	$47,908	$209,342	$47,444
	Unspecified	$233,740	$47,908	$208,732	$47,444
	Unspecified	$209,513	$47,908	$223,753	$47,444
Westchester Institute for Human Development	President/C.E.O	$202,173	$77,741	$242,422	$73,159
Interfaith Medical Center	Vice Chair, Secretary	$378,525	$36,555	$316,408	$37,527
Adults and Children with Learning and Development Disabilities Inc.	Executive Director	$418,865	$68,918	$395,859	$65,615
	C.F.A.O	$257,445	$68,918	$283,731	$65,615
	Medical Director	$302,814	$68,918	$286,645	$65,615
	Assistant Medical Director	$211,912	$68,918	$190,957	$65,615
People Inc.	President/C.E.O	$196,261	$38,437	$451,476	$39,369
Family Residences and Essential Enterprises Inc (FREE)	C.E.O	$255,429	$68,918	$308,731	$65,615
	C.F.O	$166,000	$68,918	$229,808	$65,615
	Chief Compliance Office	$176,471	$68,918	$201,081	$65,615
Occupations Inc.	President/C.E.O	$266,561	$38,304	$274,068	$38,399
	Executive Vice President and C.O.O	$236,823	$38,304	$242,333	$38,399
	Vice President of Industrial Operations	$115,497	$38,304	$262,511	$38,399
	Psychiatrist	$238,242	$38,304	$281,823	$38,399
	Medical Director	$203,923	$38,304	$194,815	$38,399
Premier Healthcare Inc.	Medical Director	$248,846	$118,293	$259,882	$111,386
	Chief of Psychiatry	$211,641	$118,293	$263,172	$111,386
Kelberman Center Inc.	Treasurer/Secretary	$258,704	$33,716	$276,326	$34,560
Catholic Charities Neighborhood Services Inc.	C.E.O	$252,659	$36,555	$279,948	$37,527
HASC Center Inc.	Executive Director	$171,121	$36,555	$221,294	$37,527
	Clinical Director	$209,767	$36,555	$236,198	$37,527

Organization	Position	2008 Total Compensation	2008 Average County Income	2011 Total Compensation	2010 Average County Income
Westchester School for Special Children	Executive Director	$271,430	$77,741	$135,848	$73,159
Institute for Community Living, Inc.	C.E.O	$752,330	$118,293	$2,876,700	$111,386
	C.F.O	$244,434	$118,293	$218,537	$111,386
	C.O.O	$266,752	$118,293	$229,956	$111,386
	Senior Executive Vice President	$222,110	$118,293	$183,053	$111,386
	Medical Director	$349,293	$118,293	$305,338	$111,386
	A.C.F.O	$202,156	$118,293	$121,211	$111,386
Community Services for the Developmentally Disabled	President & C.E.O	$166,137	$38,437	$205,108	$39,369
Independence Residencies Inc.	Executive Director	$182,845	$118,293	$218,008	$111,386
Hamaspik of Rockland County	Executive Director	$201,602	$53,826	$222,681	$52,030

Appendix C: Committee's Methodology for Calculating Medicaid Overpayments

On July 19, 2012, the (Committee) sent a letter to Dr. Nirav Shah, Commissioner of the New York State Department of Health, asking for detailed information regarding overpayments received by New York State-operated developmental centers. Despite initial assurances from State officials that New York would respond to the Committee's request for information, the State decided not to comply. Because the State refused to comply with its request, the Committee compiled as much available information as possible from reliable sources in order to estimate the amount of overpayments received by New York State's developmental centers since 1990.

The Office of the Inspector General (OIG) at the Department of Health and Human Services (HHS) supplied the Committee with a significant amount of information on these overpayments. Chiefly, OIG provided the actual payments received by New York developmental centers for State fiscal year (SFY) 2007 ($1.828 billion), SFY 2008 ($2.107 billion), and SFY 2009 ($2.267 billion) as well as the daily Medicaid payment rate per patient for New York's developmental centers over the entire period. Using the actual payments received by New York's developmental centers and OIG's calculations for reimbursable expenses, OIG estimated Medicaid overpaid the State developmental centers by $1.41 billion in SFY 2009, $1.359 billion in SFY 2008, and $1.063 billion in SFY 2007. The Committee requested that OIG estimate the developmental center overpayments over the past two decades using the same methodology it employed for its 2007-2009 estimates; however, OIG lacked the necessary information (the same information the State of New York has refused to provide the Committee) in order to perform the calculations.

It is important to note that OIG's calculation of overpayments relies upon the State's reported costs, and the State's reported costs were not verified or audited by either OIG or CMS. There is a complex formula with many supplementary and substantial add-ons that convert a prior year's reported costs into a current year's reimbursable costs. For example, New York's total reported costs for SFY 2008 were $581 million. After adding the various supplementary factors, OIG calculated the reimbursable cost for SFY 2009 was $858 million, about 48 percent higher than New York's reported costs for the previous year.

Therefore, there is reason to believe that the reimbursable costs calculated by OIG are significantly higher than are necessary to serve the State's developmental center population. According to the OIG report, the total reimbursement cost per patient was $1,532 per day for SFY 2009. Since OIG reported that the average rate received by similar, privately-operated Intermediate Care Facilities (ICFs) was $444 in SFY 2009, a $1,532 rate appears very high. Since OIG's report calculates overpayments by subtracting these inflated "reimbursable costs" from the payments received by State-operated developmental centers, the overpayments calculated by OIG for SFY 2007, SFY 2008, and SFY 2009 are likely substantially too low.

To avoid the shortcomings involved with OIG's somewhat nebulous "reimbursable costs," the Committee calculated the developmental center overpayments as the amount received by New York State-operated developmental centers in excess of the Medicaid Upper Payment Limit (UPL). According to federal Medicaid law, the UPL is the maximum a given State Medicaid program can pay to Medicaid providers in the aggregate. To satisfy UPL requirements, Medicaid payments must not exceed what the Medicare program would pay for the

same services. The Committee therefore estimated the Medicaid UPL using the most expensive Medicare payment category (see Footnote ii in the Table). Since the Committee's estimates used Medicare rates for the most costly patients in skilled nursing facilities (SNFs) and not all of the developmental center patients would fall into this category, the Committee's Medicaid UPL is almost certainly too high. Therefore, since the Committee is estimating the overpayments in excess of Medicaid UPL amounts and the Committee assumed the highest possible Medicare reimbursement rates, the Committee's estimates of the overpayments received by New York developmental centers are probably too low.

Medicare's reimbursement rates also vary by geographic location and the State of New York has 14 geographic areas. The Committee calculated a weighted average of Medicare reimbursements using the geographic breakdown of the State's developmental centers in 2010. (This was the only year the Committee found an accounting of each developmental center's payment). Using developmental center population from that year, the Committee assigned Medicare payment regions the following weights: 37.19% to New York City, 21.10% to Binghamton, 15.81% to Rural New York State, 10.73% to Poughkeepsie, 8.75% to Rochester, 3.25% to Albany, and 3.18% to Buffalo. The Medicaid UPL estimates shown in the Table below for SFY 1999 through SFY 2011 were estimated using weighted average calculations. The Medicare payment information was easily obtainable only for the years after 1998. The average price change from 1999 to 2005 in Medicare's reimbursement rate for the most expensive patients in SNF was $12. Therefore, for purposes of the Committee's estimates, the Medicare UPL was increased $12 each year from SFY 1991 to SFY 1998.

In order to calculate the estimated payments received by New York developmental centers, the Committee multiplied daily Medicaid payment rates per patient by the estimated number of patients residing in developmental centers at one point during the SFY. OIG provided the daily Medicaid payment rates and the Committee relied on reports issued by New York's Office for People with Developmental Disabilities (OPWDD) and its predecessor agency, the Office of Mental Retardation and Developmental Disabilities (OMRDD), to estimate patient numbers.[147] The fifth column in the Table shows the Committee's estimate of the amount Medicaid paid New York state-operated developmental centers beyond the Medicaid UPL (the amount Medicare would have otherwise paid). The second to last column is the present value of each year's estimated overpayment calculated using the consumer price index. Summing the overpayments from 1991 to 2011 yields a net estimated overpayment of nearly $28.8 billion beyond what was allowed by the Medicaid UPL. Finally, the last column shows the federal share of the overpayments since the federal government reimburses at least half of New York's Medicaid expenditures. The total federal overpayment (in present value terms) between 1991 and 2011 was approximately $15 billion.

[147] OMRDD reports from 1999 to 2006 contained annual counts of the total residents in the State's developmental centers and OIG provided the actual reimbursements received by the State-operated developmental centers for 2007 through 2009. The sources for 1991, 1994, 2010, and 2011 are contained in the footnotes below the Table showing the estimated overpayments by year. For the remainder of the years (1992, 1993, 1995, 1996, 1997, and 1998), the Committee used a linear interpolation to estimate the number of developmental center residents.

Table: Estimated Medicaid Overpayment to New York State-Operated Developmental Centers

State Fiscal Year	Estimated Dev. Center Patients	Daily Dev. Center Pay Rate[i]	Estimated Medicaid UPL[ii]	Over-payment	Overpayment Present Value (2011 $)[iii]	Federal Share of Overpayment[iv]
1991	6,350[v]	$389	$319	$162.2M[vi]	$267.9M	$134.0M
1992	5,437	$442	$331	$220.3M	$353.2M	$176.6M
1993	4,524	$552	$343	$345.1M	$537.2M	$268.6M
1994	3,611[vii]	$654	$355	$394.1M	$598.1M	$299.1M
1995	3,294	$936	$367	$684.2M	$1,009.9M	$504.9M
1996	2,978	$1,093	$379	$776.0M	$1,112.6M	$556.3M
1997	2,661	$1,310	$391	$892.7M	$1,251.1M	$625.5M
1998	2,345	$1,522	$403	$957.6M	$1,321.5M	$660.8M
1999	2,028[viii]	$1,729	$415	$972.6M	$1,313.2M	$656.6M
2000	2,020[ix]	$1,930	$426	$1,108.9M	$1,448.5M	$724.3M
2001	1,711[x]	$2,165	$435	$1,080.4M	$1,372.3M	$686.1M
2002	1,692[xi]	$2,434	$474	$1,210.4M	$1,513.7M	$756.8M
2003	1,599[xii]	$2,723	$457	$1,322.5M	$1,617.1M	$808.6M
2004	1,610[xiii]	$2,934	$483	$1,440.3M	$1,715.1M	$882.9M
2005	1,696[xiv]	$3,063	$490	$1,592.8M	$1,834.5M	$944.4M
2006	1,700[xv]	$3,284	$594	$1,669.1M	$1,862.4M	$931.2M
2007	X[xvi]	$3,715	$613	$1,526.3M	$1,655.9M	$827.9M
2008	X[xvii]	$3,736	$658	$1,736.1M	$1,813.8M	$906.9M
2009	X[xviii]	$4,116	$645	$1,911.4M	$2,004.1M	$1,090.0M
2010	1,417[xix]	$4,556	$645	$2,022.8M	$2,086.6M	$1,277.9M
2011	1,313[xx]	$5,118	$751	$2,092.9M	$2,092.9M	$1,274.3M
Total					**$28,781.6M**	**$14,993.8M**

[i] Development Center payment rates were according to the Office of Inspector General (OIG), Department of Health and Human Services.

[ii] The Committee estimated the Medicaid UPL using the Medicare case-mix group with the highest reimbursement rate. For FY 2006 to FY 2011, this group was the Rehabilitation Plus Extensive Services (RUX) group. Beneficiaries classified under RUX generally have complex needs and require more assistance with activities of daily living, a greater amount of physical therapy, occupational therapy, and/or speech-language pathology services, and more complex clinical care. For FY 1999 to FY 2005, the group with the highest reimbursement group was RUC from the Rehabilitation case-mix group. Medicare's reimbursement rates also vary by geographic location and the State of New York has 14 geographic areas. The Committee calculated a weighted average of the Medicare reimbursement using the geographic breakdown of the developmental centers in 2010. The following weights were assigned: New York City 37.19%, Binghamton 21.10%, Rural New York State 15.81%, Poughkeepsie 10.73%, Rochester 8.75%, Albany 3.25%, Buffalo 3.18%. Therefore the estimates in this category from FY 1999 to FY 2011 were estimated using weighted average calculations. We used the average historical price change from 1999 to 2005 of $12 to estimate that Medicaid UPL increased $12 each year from FY 1991 to FY 1998.

[iii] This column adjusts the overpayment column for 2011 values using the Consumer Price Index.

[iv] This calculation uses the state's Federal Medicaid Assistance Percentage (FMAP). Generally, New York's FMAP is 50%. In fiscal years 2004, 2005, 2009, 2010, and 2011, the federal government increased the FMAP so the federal share of the state's Medicaid expenditures in those years is higher. New York's FMAP in SFY 2004 and SFY 2005 was 51.48%. In SFY 2009, New York's FMAP was 54.39%. In SFY 2010, New York's FMAP was 61.24%. In SFY 2011, New York's FMAP was 60.89%.

[v] Paul J. Castellani, *From Snake Pits to Cash Cows: Politics and Public Institutions in New York*, State University of New York, 2005, page 249.

[vi] All of the figures in the table are in the millions. This particular figure is $162.2 million.

[vii] *Castellani, supra* note v, at259.

[viii] The 1998-99 Budget for the New York State Office of Mental Retardation and Developmental Disabilities

[ix] A Summary of the 1999-2000 Executive Budget Recommendation

[x] 2000-01 Executive Budget Recommendation for the New York State Office of Mental Retardation and Developmental Disabilities (OMRDD)

[xi] 2001-02 Fiscal Year Executive Budget Recommendations for OMRDD

[xii] 2002-03 Fiscal Year Executive Budget Recommendations for OMRDD

[xiii] 2003-04 Fiscal Year Executive Budget Recommendations for OMRDD

[xiv] 2004-05 Fiscal Year Executive Budget Recommendations for OMRDD

[xv] 2005-06 Fiscal Year Executive Budget Recommendations for OMRDD

[xvi] According to information provided by the OIG to the Committee, Medicaid made payments of $1,827,939,932 for State developmental centers in SFY 2007. Therefore, the Committee did not have to know the number of developmental center residents this year.

[xvii] According to information provided by the OIG to the Committee, Medicaid made payments of $2,107,245,318 for State developmental centers in SFY 2007. Therefore, the Committee did not have to know the number of developmental center residents this year.

[xviii] According to information provided by the OIG to the Committee, Medicaid made payments of $2,266,625,233 for State developmental centers in SFY 2007. Therefore, the Committee did not have to know the number of developmental center residents this year.

[xix] Mary Beth Pfeiffer, *At $4,556 A Day, N.Y. Disabled Care No. 1 in Nation*, POUGHKEEPSIE JOURNAL, June 20, 2010.

[xx] OPWDD Statewide Comprehensive Plan: 2011-2015