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MEDICARE UNMASKED

Sprawling Medicare Struggles to Fight Fraud

BY JOHN CARREYROU AND CHRISTOPHER S. STEWART

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John and David Mkhitarian found a soft spot in Medicare's defenses against fraud: Inspectors aren't required to visit medical providers deemed to present a lower risk of fraud and abuse.

So the cousins used exchange students to create some 70 bogus laboratories, clinics and physician practices, then enrolled the companies in the program with the stolen identities of doctors, prosecutors assert. Medicare paid out $3.3 million over about two years.

Both Mkhitarians pleaded guilty to health-care fraud conspiracy. David was sentenced in September to seven months in prison, and John will be sentenced in February.

Their case illustrates a vulnerability in the nearly $600 billion taxpayer-funded program: Vetting of new providers often is inadequate. An inspection of the Mkhitarians' companies might have stopped the scheme before it started.

Shortcomings in Medicare's efforts to stop fraud, abuse and waste have come into focus since April, when the Centers for Medicare and Medicaid Services, the agency that runs the program, made public medical-provider billing records for the first time since 1979. The disclosure followed a legal effort by The Wall Street Journal.

CMS must strike a delicate balance: reducing fraud and abuse as much as possible without restricting access to medical care for the 50 million people who depend on the program. "Preventing fraud, abuse and waste are priorities" and "hold equal importance with creating and maintaining transparent and viable patient-doctor relationships," CMS said in a written statement.

Fixing some of the system's most pervasive problems — such as doctors billing for lots of procedures that may not be medically necessary — would require Medicare to change how it pays providers, some former Medicare officials said. That, in turn, would necessitate an act of Congress, they said.

"Unless you change the rules of the game in terms of how

Medicare pays, you'll never fix it," said Gail Wilensky, who ran Medicare in the early 1990s. Congress is "not going to voluntarily make major changes in a program that is as popular as Medicare," she said.

Two improvements could be made without congressional involvement: tighter screening of medical providers when they enroll in the program, and more rigorous enforcement to kick out bad actors.

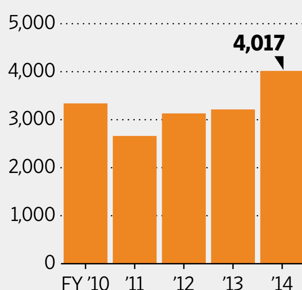
CMS said it has implemented stricter measures to vet new enrollees in recent years. And this month, the Obama administration strengthened CMS's authority to revoke billing privileges of doctors and other providers with a suspicious pattern of billing.

Current and former law-enforcement officials estimate that fraud accounts for as much as 10% of Medicare's yearly spending, or about $58 billion in fiscal 2013. Federal anti-fraud efforts clawed back $2.86 billion in Medicare funds that year.

CMS hasn't publicly set a specific monetary goal for fraud reduction. In government programs, as in business, attempting to eradicate all fraud is considered close to impossible — and perhaps not even cost-effective, given how expensive it can be.

Booted

Number of medical providers excluded from Medicare by the Office of Inspector General of the Health and Human Services Department



Source: Health department's Office of Inspector General

The Wall Street Journal

One problem is that CMS doesn't have the resources to deal with the sheer volume of providers flooding the system. Every month, some 45,000 new providers, from doctors and physical therapists to nursing homes and ambulance operators, apply to enroll in Medicare.

CMS has tightened some screening requirements since 2011, hiring new contractors that specialize in site visits. The agency also has begun looking for bad actors by checking the fingerprints of, among others, providers of home-health care and durable medical equipment like wheelchairs, two categories with a history of fraud.

In some fraud hot spots around the country, CMS has imposed moratoria on the enrollment of new home-health agencies and ambulance operators. And it now requires suppliers of prosthetics and orthotics to submit $50,000 "surety" bonds before they can start billing Medicare.

The most stringent vetting is limited to provider categories deemed to carry the highest risk of fraud and abuse. Visiting every new provider would be impractical, former Medicare officials say.

"If the cops stop and hassle every single motorist, two

things happen: traffic congestion, and you get political blowback," said Ted Doolittle, a former deputy director of CMS's antifraud unit.

Yet simple improvements to the screening process would make it easier to spot fake medical providers.

"Even to get a driver's license, you need to take a driver's education course and pass a test," said Ryan Stumphauzer, former head of the Medicare Fraud Strike Force in Miami. "Why not perform this type of common-sense screening before handing out Medicare billing privileges? Ask basic questions: Does the applicant have education, training or experience in health care? Are they versed in basic Medicare rules and regulations?"

Some legislators say that once bad providers are in the program, CMS and its contractors aren't quick enough to kick them out.

Sen. Orrin Hatch, a Utah Republican, is expected in January to become chairman of the Senate Finance Committee, the committee that oversees Medicare. He said much more needs to be done "to weed out the bad actors."

Sen. Hatch and Tom Coburn, an Oklahoma Republican, in September 2011 sent CMS a list of 34 individuals who still had their Medicare-billing privileges despite being convicted of, or pleading guilty to, felonies such as health-care fraud, tax evasion and lewd and lascivious behavior.

CMS responded with a variety of reasons why they might still be enrolled, including that some of the felonies were "not excludable offenses."

Calling the response unacceptable, the senators criticized the agency for not taking immediate action. And they raised a 35th name: Conrad Murray, Michael Jackson's personal physician.

Dr. Murray remained "a legitimate Medicare provider," they noted, even though California had suspended his medical license and a jury had recently convicted him of involuntary manslaughter for providing the pop star with the sedative that caused his death.

Dr. Murray wasn't excluded from Medicare and Medicaid by the health department's Office of Inspector General until June 2012, although data show no billing by him that year. He was released from custody last year after serving two years of a four-year sentence. His lawyer, Valerie Wass, said "it's going to be very difficult for him to get a medical license again in this country because of his conviction."

A complicating factor is that CMS and the inspector general — two separate agencies within the health depart-

ment — have separate rules about when they can act against medical providers.

Of the 34 felons on Sens. Hatch and Coburn's original list, 15 eventually were excluded from Medicare and Medicaid by the inspector general, but some of the exclusions didn't take effect until two to three years after a conviction or guilty plea. Another 16 are no longer listed as program participants on Medicare's website. Three remain Medicare providers.

CMS declined to comment on the individuals, citing the federal Privacy Act. A spokesman for the inspector general said the exclusion process takes time because providers have extensive appeal rights. He said the inspector general excluded 4,017 providers in the 2014 fiscal year, up from 3,214 the proceeding year.

When CMS does act to curb questionable billing, recouping the money can be difficult. Providers prevailed at least in part in 62% of the nearly 600,000 Medicare appeals decided by administrative-law judges since 2005, according to a Journal analysis of data published by the health department's Office of Medicare Hearings and Appeals. The government won just 26% of the time, and 12% of cases were dismissed.

Christopher Weaver contributed to this article.