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KICKBACKS AMONG MEDICAID PROVIDERS

A REPORT

OF THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

JUNE 30 (legislative day, MAY 18), 1977.—Ordered to be printed

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PREFACE

Over the past seven years the Senate Committee on Aging has helped bring the facts about Medicare and Medicaid fraud to the American public and to the Congress. Through its investigations and its hearings the Committee has proved conclusively that there are serious questions about the government's health care programs which are designed to meet the needs of the poor and elderly.

This report is a summary of the evidence which the Committee has collected related to that most common and least prosecuted kind of Medicaid fraud called "kickbacks" or "rebates". Kickbacks describe the practice whereby pharmacists or other providers are forced to pay a certain percentage of the fees they receive from Medicaid back to others for the privilege of providing such services to patients.

The variations of Medicaid kickbacks are described in this report with the hope of informing Federal and State prosecutors as well as agency directors and the general public. It is hoped that more vigorous prosecutions and widespread understanding will result.

With best wishes.

Sincerely.

FRANK CHURCH,
Chairman.

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Mr. CHURCH, from the Special Committee on Aging, submitted the following

REPORT

INTRODUCTION

In 1965, the Congress embarked on a bold new direction in enacting the medicaid program, which consolidated medical assistance programs in an effort to bring quality health care to the poor, the disadvantaged, and the elderly. From 1966 through 1976, the program expanded tenfold, from $1.5 billion to $15.5 billion at the end of fiscal 1976.[1] An estimated 28 million Americans are eligible for the program.

Undoubtedly the program has been a major benefit to the needy who otherwise would be deprived of any medical services. However, in recent years there has been increasing concern about the escalating cost of the program. More than half of the States have made major cutbacks in their medicaid programs in the last 2 years.

To add to these significant worries, there is new and mounting evidence that the program is not only inefficient but riddled with fraud and abuse.

In the past 8 years, the Senate Committee on Aging has conducted more than 50 hearings related to one or more aspects of the medicaid program. A 12-volume report entitled, "Nursing Home Care in the United States: Failure in Public Policy," is underway. In February 1976, the committee issued a report entitled, "Fraud and Abuse Among Clinical Laboratories," which charged that $1 out of every $5 spent for laboratory services under medicare and medicaid is fraudulent. In August of 1976, the subcommittee released its much publicized report on medicaid mills entitled, "Fraud and Abuse Among Practitioners Participating in the Medicaid Program."

These reports have attempted to provide generic examples of the most frequent abuses of the system and to provide some recommendations for the benefit of legislative committees.

[1] Cost estimates for fiscal 1977 are about $18 billion.

This report deals with what must be the most commonly occurring scheme to defraud the medicaid program. The word "kickbacks" connotes a practice that has been found to some degree in every aspect of the medicaid system. Such rebates have the effect of increasing the cost of the medicaid program. They undermine the quality of services which are offered since operators become more concerned with rebates than with care. As this report indicates, the most frequent setting for such questionable transactions is the nursing home. However, increasing evidence points to hospitals, medical practitioners, clinical laboratories, and other suppliers.

This report summarizes the evidence collected by the Senate Committee on Aging. It concludes that kickbacks are rampant and that a 1972 law enacted by the Congress to make them illegal is not being enforced. It is a plea for aggressive action to root out fraud and abuse, as promised by the new Carter administration.

Part 1

THE NUMBERS

In 1975, Americans spent an average of $547 each—or $2,188 per family—for health care. This is 3 times as much as was spent for health in 1965 ($39 billion) and 10 times the amount spent in 1960 ($12 billion). Measured in terms of gross national product, the cost of health has increased from 4.6 percent in 1950 to 8.3 percent at the end of 1975, fully one-twelfth of the GNP.

The rapid growth in spending is associated with sharp increases in government participation. In 1965, public funds made up only 26 percent of all health expenditures; today public funds make up 42 percent of the total.

Medicaid is a Federal grant-in-aid program in which the Federal Government provides 50 to 78 percent of the cost of providing health services to the aged, blind, and disabled. The amount of Federal match is determined by a State's per capita income. As a precondition of participating in the medicaid program, the States must agree to provide at least the following services: hospital care, physicians' services, nursing home care, home health care, and laboratory and X-ray services. Other services, such as eye care or dental care, may also be offered by the States and qualify for Federal matching.

In fiscal year 1975, medicaid paid $15.5 billion for health services. Some 37 percent of the money, or over $5 billion, went to pay for nursing home care; 31 percent ($4.9 billion) was paid to hospitals; physicians' services received 10 percent of all medicaid funds, or about $1.5 billion. The next largest category was prescription drugs at a little over $1 billion; dental services were funded at nearly $500 million.

The States of New York (23.3 percent), California (12.4 percent), and Illinois (6 percent) accounted for more than 40 percent of all medicaid funds.

The U.S. average for per capita medicaid payments was $66.60 in 1975. New York was high with an average of $180.62 per inhabitant and Wyoming was low with $16.14 per inhabitant.

In calendar year 1975, the 10 States receiving the most medicaid money were as follows:

New York	$3, 252, 328, 327
California	1, 483, 990, 363
Pennsylvania	768, 224, 615
Illinois	753, 418, 270
Michigan	677, 077, 811
Massachusetts	577, 115, 417
Texas	519, 912, 780
Ohio	413, 276, 480
Wisconsin	402, 039, 501
New Jersey	401, 726, 751

THE GROWTH OF NURSING HOMES

From 1960 to 1976, the number of older Americans in the United States increased 23 percent—from 17 million to more than 21 million. At the same time, the number of nursing homes increased 140 percent, the number of beds by 302 percent, and total expenditures for nursing home care by more than 2,000 percent. Details follow:

	1960	1976	Percent increase
Homes	9,582	23,000	140
Beds	331,000	1,327,358	302
Patients	290,000	1,000,000	245
Employees	100,000	650,000	550
Amount (millions)	$500	$10,500	2,000

As noted above, 37 percent of all medicaid moneys, or about $5.7 billion, went toward the payment of nursing home care to some 15,569 nursing homes participating in the program. These facilities represent about 750,000 beds. Clearly, medicaid pays the lion's share of the estimated $10.5 billion in yearly nursing home revenues.

Part 2

THE LAW

In 1972, the Congress enacted an amendment to make the offer, receipt, or solicitation of a kickback illegal—a misdemeanor punishable by a year in jail, a $10,000 fine, or both. At the same time, the Congress enacted an amendment (now section 162(c)(3)) which mandates that no deductions shall be allowed for any kickbacks, rebates, or bribes paid under medicare and medicaid. Unfortunately, there has only been one case prosecuted under the kickback statute since its enactment in 1972 and the Internal Revenue Service has been anything but aggressive in its enforcement of the new Code provisions.

The pertinent statutory language follows.

TITLE 42, UNITED STATES CODE, SECTION 1395nn

1395nn. Offenses and penalties

(a) Whoever—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under this subchapter,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to any such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $10,000 or imprisoned for not more than 1 year, or both.

(b) Whoever furnishes items or services to an individual for which payment is or may be made under this subchapter and who solicits, offers, or receives any—

(1) kickback or bribe in connection with the furnishing of such items or services or the making or receipt of such payment, or

(2) rebate of any fee or charge for referring any such individual to another person for the furnishing of such items or services,

shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $10,000 or imprisoned for not more than 1 year, or both.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, or home health agency (as those terms are defined in 1495x of this tile), shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $2,000 or imprisoned for not more than 6 months, or both.

INTERNAL REVENUE CODE

Section 162(c)(3)

(3) Kickbacks, rebates, and bribes under medicare and medicaid. No deduction shall be allowed under subsection (a) for any kickback, rebate, or bribe made by any provider of services, supplier, physician, or other person who furnishes items or services for which payment is or may be made under the Social Security Act, or in whole or in part out of Federal funds under a State plan approved under such act, if such kickback, rebate, or bribe is made in connection with the furnishing of such items or services or the making or receipt of such payments. For purposes of this paragraph, a kickback includes a payment in consideration of the referral of a client or customer.

Part 3

THE EVIDENCE

The Senate Committee on Aging and particularly its Subcommittee on Long-Term Care, chaired by Senator Frank E. Moss, have documented in detail the extent of nursing home pharmacy kickbacks. A report was released on this subject in January 1975 entitled, "Drugs in Nursing Homes: Misuse, High Costs, and Kickbacks." Later hearings disclosed that kickbacks were also common practice between other vendors who served nursing homes. Kickbacks were also documented from clinical laboratories to medicaid mills and nursing homes.

In November 17, 1976, hearings, Senator Frank Church, chairman of the Senate Committee on Aging, announced his intention to continue the efforts toward exposing and correcting fraud and abuse in the medicare and medicaid programs, which Senator Moss had initiated. In that hearing, Senator Church and the committee heard testimony that the practice of kickbacks was frequently the norm, the way business was done in the medicaid program. Of serious concern was testimony implicating some welfare hospitals, which historically have not been identified with such practices.[1]

CALIFORNIA

In 1968, the Senate Committee on Aging received a report by the attorney general of the State of California which charged that it was common practice in the State for nursing home operators to require pharmacists to pay back a certain percentage of the price of nursing home prescriptions for the privilege of providing such services. The amount of kickback ranged from 25 to 40 percent of the total price of the prescription drugs delivered to the nursing homes.[2]

In 1970 and 1971, spokesmen for the American Pharmaceutical Association informed the Subcommittee on Long-Term Care and its staff that kickbacks were widespread and continuing, particularly in California. A decision was made to look into the question in some detail.

In cooperation with the American Pharmaceutical Association, the subcommittee fashioned a questionnaire which was sent to every pharmacist in the State of California and to 200 more throughout the Nation. In the questionnaire, the word "kickback" was defined as:

> . . . The practice whereby pharmacists are forced to pay a certain percentage of the price of nursing home prescription drugs back to the nursing home operator for the privilege of providing those services.

[1] Evidence relates primarily to ghetto hospitals which specialize in welfare patients.

[2] Report by the Medi-Cal program by the California Department of Justice; Charles A. O'Brien, chief deputy attorney general; reprinted in hearings by the Committee on Aging, "Cost and Delivery of Services to Older Americans," part 3, Los Angeles, Calif., Oct. 16, 1968.

The questionnaire was sent blind—that is, no one needed to identiy himself although many pharmacists took advantage of the opportunity to air their grievances. Some signed their names and some did not.

In all, the questionnaire was sent to 4,400 pharmacists; 40 percent, or 1,792, were returned to the committee.[3]

Of the 1,792 responses received, 326, or 18 percent, stated that they had never attempted to serve a nursing home.

Another 18 percent, 328, indicated that they had attempted to deal with nursing homes but were not approached for a kickback and did not believe the practice was widespread.

Some 383 pharmacists, or 21 percent, indicated they had tried to serve a nursing home, had not been approached for a kickback, but had a positive belief that they were widespread.

The remaining 755, or 42 percent, of the pharmacists indicated that they served nursing homes and that they had been approached for a kickback. Of these, 353 indicated that kickbacks were increasing, 51 indicated they were decreasing, and 251 felt that they were about the same.

In other words, 63 percent of all pharmacists responding indicated an actual experience or a positive belief that kickbacks were widespread.

Pharmacists projected $10,363,000 in lost accounts from refusing to go along with kickbacks in 1971.

The average kickback was 25 percent, although some were larger. Postmarks identifying the State of Illinois, among those outside California, indicated generally higher kickbacks, but few as high as 50 percent.

But the pharmacists from all parts of the country did not limit their response to answering the questionnaire. Many provided the committee with written comments and with actual names of pharmacists and nursing home operators. In some cases, they made incredible admissions relating to their participation in forced profit sharing, allegedly to secure and maintain a nursing home account.

These admissions were made despite the fact that these practices are in violation of California law.

A few pharmacists accepted primary or joint responsibility for kickbacks. The following comments are typical: "The ethical pharmacists are not usually approached for a percentage kickback; most are prearranged by both sides." "In order to testify I would have to name the most important members of our association. Sorry, I'm too small now." "Not being a member of our profession, I would not expect you to know how we operate. It is not the nursing home that instigates the kickback but the hungry-for-business members of our group. They are the ones who offer the nursing home the deal."

Most of the replies the committee received are on the other side of the ledger. They charged that nursing home operators, driven by inadequate medicaid reimbursement rates, were resorting to any and all methods to pick up a few extra dollars. For their part, the pharmacists recognized little difference between discounts, collection fees, and rebates. A few were willing to accept, as legitimate, discounts of 10

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[3] See "Drugs in Nursing Homes: Misuse, High Costs, and Kickbacks", report by the Senate Committee on Aging, Subcommittee on Long-Term Care, January 1975.

percent or less given for quantity purchasing, or to have nursing home accounts paid within 30 days. But these discounts were recognized only if voluntarily given and if such discounts could be given without inflating the costs of drugs to private paying patients or to medicare and medicaid. From the pharmacist's point of view, a voluntary discount rarely happens. One pharmacist wrote: "I'm afraid to testify. My biggest account is a nursing home. If I lost this business, who will sustain me?"

Another said, "I own part of a nursing home and do not get any prescriptions from them, as I wouldn't kick back to them."

Still another commented: "In one pharmacy we served about 12 nursing homes. We were required to pay 25 percent to the operator of several of the homes and lost the business of three of them when we attempted to cut the kickback to 20 percent. The volume loss was in the vicinity of $5,000 a year."

One pharmacist noted: "Your effort is too late. Now many homes are owned by corporations that also own pharmacies and medical supply houses. No kickbacks as such are needed; they make it all in the pharmacy."

More typically, a pharmacist wrote:

> GENTLEMEN: This kickback in nursing homes is an absolutely rotten practice. And it is demanded by, I would estimate, at least 95 percent of homes in southern California. Certainly, all large chain type operations demand it. These kickback demands are not only limited to drug services: all suppliers to nursing homes are required to participate—milk suppliers, laundry, food suppliers. Even the individual services of physical therapists fall under the demands of these ————. And that is the best description of most of these operators. I have attended their meetings, have known them socially, and have participated in their kickback demands. Their sole concern is for the "buck." Nothing else matters. And lowest on the list is the pathetic patient in these convalescent homes and hospitals. They are treated as a piece of living meat—a commodity.

Another stated:

> I am now required to give 30 percent to one home—have not agreed to it yet—feel I will lose the account if I refuse. Another home—Baptist home—stated that their pharmacy (an independent) always donated enough money to the home to cover the drugs purchased. Another home—Jewish home—stated that 15 to 20 percent was not enough—claimed they were getting more in kickbacks.

A Massachusetts man wrote:

> Why is it that a drugstore, say in Chelsea . . . is able to go all the way (20 miles) through traffic, et cetera, and servic. a nursing home in Newton, Mass., West Roxbury, Mass., et cetera.
>
> Why? Because he is a nice fellow? . . . Hell no. . . . Kickbacks are so prevalent that you would be amazed at the discounts given in cash under the table . . . tax free. . . .

> The only way I am able to beat competition on nursing home prescription service without giving a 20 percent kickback . . . is by (1) delivering papers to patients, (2) show movies every week to patients, (3) inservice movies, (4) take urine samples to the hospital lab.
>
> In my estimate (based on factual information) approximately 99 percent give kickbacks.

An Illinois pharmacist wrote:

> It amazes me that Government on the one hand can shout to the rooftops about the high cost of drugs—and on the other hand—piddle and piddle around about discounts, kickbacks, rebates, and such.
>
> Remember this—in any rebate situation, the rebate is added to the drug bill.
>
> It is the patient that pays.
>
> Any cost involved in a drug distribution system, any cost in accounting, or any other cost in handling patients' medications—should be reflected or included in the daily room rate.
>
> Any person giving or receiving any discount, kickback, or rebate whatsoever should have his license revoked. This includes prepaid vacation trips and such.

A Florida letter read:

> Kickbacks to nursing homes and extended care facilities have been prevalent in the Tampa Bay area as long as I have been in the drug business—1958.
>
> The practice increased sharply with the introduction of medicare and medicaid.
>
> I believe very strongly that medicare placed a big club in the hands of nursing homes by allowing the nursing home to bill for pharmaceutical services and pharmaceutical consulting fees, and not allowing the pharmacy nor the pharmacist to effect their own billing, as do other professionals in the medical field. This practice has increased the cost of medications tremendously to nursing home clientele, no matter who pays the bill.
>
> I believe the practice of kickbacks to be present in 95 percent of homes in St. Petersburg, Fla.

Pharmacists wrote that kickbacks can be cash, that is, 25 percent of total prescription charges or a flat $5,000 a year. They can be in the form of long-term credit arrangements or, in some cases, unpaid bills to pharmacists. They can be in the form of rental of space in the nursing home—$1,000 a month for a closet, for example—or they can be in the form of a pharmacy bill to an individual patient in the nursing home where the home keeps 25 percent of the total bill as a collection fee.

With some pharmacists, the kickback is supplying the drugs, vitamins, and supplies at no charge, or merchandise offered to employees at no charge, or personal cosmetics and pharmacy needs of nursing home personnel delivered to the nursing home and charged to the home.

Other pharmacists pay the salary of certain nursing home employees who are ostensibly working for the pharmacy. Still others noted that outright gifts of large quantities of green stamps, new cars, color televisions, boats, desks, and prepaid vacations to Hawaii or Europe are made. Some are required to advertise in the home's brochure at 10 times normal prices.

Some nursing homes have opened their own pharmacy and offer shares in the corporation to other nursing homes if they agree to use this new pharmacy.

Examples of each of these abuses are provided below; *they are quoted from replies the subcommittee received to its questionnaire:*

CASH

> Another means of kickback is accomplished by just sending over to the owners—physician-owners love this one—20 to 25 percent of the previous month's gross or a present fee in cold cash every month. Just put eight $50 bills or whatever in an envelope and hand deliver it to him or them.

CREDIT

> One such method to which I have been personally subjected in at least a couple of instances involved very strong pressure to grant excessive credit in amounts never allowed anyone else. In each case, the operator folded, leaving me stuck with an uncollectible bill of $1,000 to $2,000 each time.
>
> You might not consider this to be a kickback. I do, for its origins, cause, and effect were precisely the same as in the more formal instances you might have in mind.

RENTING SPACE

> Both places wanted me to rent a complete room in ECF, plus supplying their own personal needs. This, at that time, was about $' ,000 to $1,200 per month with an estimated percent to volume of about 20 to 25 percent. The pharmacy who had the contract was renting a linen closet for $700 per month for storage. The home owner also wanted me to explore with him the setting up of a company to supply these homes—he had two, and one in the planning stage—since if the supply costs were higher they would do better since they were on a cost-plus percentage with the health agencies.

FURNISHING SUPPLIES

> I was requested to supply the nursing home with such things as mineral oil, aspirin, gauze pads, tape, et cetera, free of charge. These were things that the nursing home was being paid to supply in the daily rates set by the State.
>
> I was also requested to mail out prescriptions for drugs that were not used, but instead I was asked to supply things that the nursing home was supposed to supply. These were to be charged to welfare, but instead sent to the patient a posey belt restraint.

HIRING EMPLOYEES OSTENSIBLY WORKING FOR THE PHARMACY

Kickback demands are in various forms, not necessarily cash rebates. Two examples are: The supplying of certain drugs, vitamins, and supplies at no charge to the ECF. Paying the monthly salary of a full-time employee whose sole duty is to tell the pharmacy whether the patient is a Medi-Cal, medicare, or private patient in the ECF, thus ostensibly working as an employee of the pharmacy, but in reality working for the ECF.

GIFTS OF TRADING STAMPS

Kickbacks in this area are more subtle. For example, green stamps, advertising in facilities, promotional brochures at 10 times the normal prices.

GIFTS OF COLOR TELEVISIONS AND BOATS

I have no real proof of kickbacks on a specific situation as far as cash is concerned—however, I do know that on Christmas of one year, color TV's were delivered and paid for by one of the stores—also, the following year a boat was given—also, massive amounts of trading stamps are sent to the facility.

PREPAID VACATIONS

In this area the kickback is in the form of personal gratitude such as prepaid trips to Hawaii, Japan, a new desk, free use of a ski cabin, beach house, or other valuable usage.

ADVERTISING

Because of my refusal to buy advertising space in their monthly nursing home newsletter, a three-page affair, priced at $124 per month—my rebate computed at 10 percent of medical charges and 15 percent of private patient charges—I was dropped as the pharmacy to provide services. Whether I buy advertising space or slip them the money in cash under the table, it is still graft and I certainly hope you are able to stem this horrible practice. I wrestled with my conscience as to whether I should suffer the $15,000 a year loss or whether I should make up the difference on charges for my new prescription for the private patients that would be reimbursed under extended medicare funds. You would be absolutely amazed at the amount of Government money being sopped up by these extra billings.

AUTOMOBILE LEASING

Another approach is that of auto leasing for the home's administrator—maybe given him as a fringe benefit of his job by the owners. All kinds of things can be worked out by the

leasing company whereby it is almost completely tax deductible. Most pharmacies have delivery cars, usually small and compact cars with low monthly leasing fees. Now, a new Mark III leases for $225 per month and a VW delivery car for $50 monthly. The leasing agency writes up any kind of lease it wishes; it can lease the Mark III to the rest home owners for $75 per month and charge the pharmacy $200 a month for the VW. Everybody is happy, IRS cares not because somebody is going to write off the car as expense anyway, no cash has been lifted from the pharmacy so no books have to be juggled, and you get the business.

PURCHASING SHARES OF STOCK IN THE FACILITY

Owners of nursing homes in our area have joined forces and opened pharmacies which only service nursing homes. They then offer interest in their pharmacy to other nursing home operators if they will use the pharmacy.

One nursing home approached drugstores in our area as to the amount of kickback they would give to get the drug business. It was given to one drugstore. This went on for some time. Then the manager, a circuit judge, asked the drugstore supplying drugs to the nursing home to buy stock in said nursing home for the business. This he wouldn't do and business was taken away and given to a drugstore that did. The amount of stock asked to buy in the corporation was $5,000.

Many pharmacists wrote of their serious concern about the conflict of interest presented where the ownership of the pharmacy and the nursing home overlap. One side of the argument is the ability to manipulate prescriptions to bill the Government and the other related to the ability to cover up mistakes:

> Another reason I have never pursued nursing home accounts is because they are always having drug problems as most of them are operating without pharmaceutical assistance and often request drugs to cover up some they have borrowed from another patient. They have a number of reasons for requesting drugs early and an investigation will show that many laws are being violated daily and I don't intend to practice in this manner.

Several pharmacists believe that inadequate nursing home rates encourage nursing home operators to make a profit elsewhere. Many also felt that reimbursement formulas for welfare medications are too low, stating that the necessity to pay kickbacks leads pharmacists to many shortcuts. As an illustration, one pharmacist noted that a prescription might cost $4.50 plus a fee of $2.30. This was the most welfare would allow as a fee. Thus, the total price of the prescription would be $6.80, and with a 25-percent kickback of $1.70, only 60 cents would be left over for profit, salary, rent, et cetera.

Accordingly, some of the pharmacists admitted:

(1) Billing welfare for nonexistent prescriptions.

(2) Supplying outdated drugs or drugs of questionable value.

(3) Supplying stolen drugs which they have purchased or supplying discarded drugs—those belonging to dead or discharged patients.

(4) Supplying drug samples which they have received free of charge.

(5) Supplying generic drugs and charging the State for brand name drugs.

(6) Dispensing less than the prescribed amount and billing for the full amount.

(7) Raising the amount prescribed by the doctor (kiting) and billing for the same.

(8) Billing for refills not dispensed.

(9) Receiving payment from a patient and submitting invoice for payment.

(10) Using a particular line of drugs because the manufacturer has a price list where every item is listed at a higher price than is actually charged. By using such products, the pharmacist can charge the State more and make a higher profit.

The practices above are highly questionable and, in most cases, clearly illegal. There are many reasons for the prevalence of these practices but the primary cause is the reimbursement system for nursing home drugs.

How does this system work? Obviously, there are many variations among the 50 States, but in general the practice works as follows:

The pharmacist presents a bill (often unitemized) for the prescriptions to the nursing home; the nursing home then bills each individual patient, collecting from those who pay for their own drugs and sending the balance to the State welfare department or to medicare for payment. Neither the welfare department nor the medicare intermediaries examine the billings very carefully. Most are paid automatically. Upon receiving payment from these third-party payers, the nursing home then reimburses the pharmacist, often keeping a prearranged percentage for handling, et cetera.

This policy of allowing the nursing home to act as the middleman between the pharmacy which supplies the drugs and the source of payment, private patient, medicare, or medicaid, creates an inviting atmosphere for abuse. The shortcomings of this questionable policy are obvious:

(1) Medicare, medicaid, and the private patient have no idea what they are paying for. The bill does not come from the pharmacist, but from the nursing home, and it is often unitemized. Close scrutiny of a bill is extremely difficult, if not impossible.

(2) Cozy relationships between pharmacies and nursing homes are encouraged whereby both parties can benefit at the expense of the private patient and the public. With the taxpayers paying $2 out of every $3 that goes into nursing homes, the implications of a nursing home owning its own pharmacy are all the more serious.

(3) In the end, pharmacies and nursing homes find it easy to cover up mistakes and increase their profits.

In order to obtain the nursing home operator's view of this question, Senator Moss directed that a questionnaire be sent to every administrator/owner in the State of California. About 2,050 questionnaires were sent out—619, or 30 percent, were returned.

Of the 619 returns, only 20 nursing home operators indicated having an interest in a pharmacy; 60 percent (373) indicated that their nursing homes were served by more than one pharmacy; 78 percent (484) nursing home providers stated that they had never offered or accepted a kickback; 67 percent (415) indicated they did not believe kickbacks were widespread.

For the most part, nursing home owners were much less free with their additional written comments. The comments that were received related to the definition of the word "kickback" and to what are felt to be inadequate nursing home reimbursement rates.

Nursing home operators went to great pains to emphasize a difference between unearned kickbacks or other considerations and earned service discounts. They pointed out that in many cases nursing homes bill all the patients in their homes and that they collect the money from their individual private paying patients. This saves the pharmacist the cost of billing and collecting from nursing home patients individually. It also allows the pharmacist to receive a lump-sum payment which is paid by the nursing home on behalf of its patients.

If the pharmacy were troubled to collect from individual patients, presumably it would have to wait longer for its payment. In the case of medicare and medicaid, pharmacies often have to wait for months for final payment. The nursing homes feel they create a cash flow for the pharmacist and that they guarantee payment from individual private paying patients. For this service and because of the large quantities of drugs purchased, many nursing home operators believe that they are entitled to a cut or discount.

The following comments are typical: "Everyone gets their cost except the nursing homes so they must accept discounts from the pharmacy." "Kickbacks are wrong in any field; however, I do not feel a discount for buying volume merchandise and providing bookkeeping services for billing are wrong. Discounts are part of the American scene." "The common misconception is that a pharmacist should receive retail prices for, let's say, 400 prescriptions delivered to the nursing home and which the nursing home collects for the pharmacy, guaranteeing payment. An arrangement involving a fee for nursing home services should be recognized as legitimate. Some pharmacists want full retail for a wholesale account and don't care who pays. Nursing homes in most cases bargain for better prices and pass at least part of the savings on in terms of reduced costs, or as discounts taken, et cetera, to their patients, private and medicare."

Clearly, the results of the two questionnaires indicate two differing points of view. On the one hand, pharmacists indicate they are forced to pay a kickback as a precondition of obtaining a nursing home account; on the other hand, nursing homes claim they are legitimate discounts justified by their quantity buying or because of billing services performed for the pharmacist. The line between kickbacks and discounts is perhaps difficult to draw. However, there are several factors which should be considered:

—Is the arrangement between the parties disclosed?
—Is the discount voluntarily given or is it mandatory?
—Is the discount a prerequisite of doing business with the nursing home?
—Is the amount, or percentage, of the discount nominal or excessive?

The committee staff next decided to discuss the alleged problems directly with the industry. Officers and members of the American Nursing Home Association met with Senator Moss and the subcommittee staff and pledged their best efforts toward preventing kickbacks. They offered to define the relationship between the nursing home and the pharmacist, and to distinguish kickbacks from earned discounts. The association, in fact, appointed a blue ribbon panel, promising the subcommittee a full report addressed to these objectives. Their efforts resulted in a 2½-page list of suggested principles in which the term "kickback" is not even mentioned. The essence of this document is one line: "The financial arrangement between the pharmacist and the nursing home should be fully disclosed."

By contrast, spokesmen for the National Council on Health Care Services (NCHCS) gave the problem far greater attention in 1973. A press release from NCHCS says in part, "Nursing home kickbacks or rebates pose a serious threat in the relationship with the pharmacy profession and in the optimum delivery of health care."

The executive vice president of NCHCS offered some definitions:

> *Rebate.*—Where a home takes back a dollar percentage of all drugs delivered. Certainly illegal for medicare drugs when only reasonable costs are paid for, a bit unsavory when applied to medicaid drugs, and hardly conscionable when an unreported profit is made on private patient drugs.
>
> *Kickback.*—Similar to rebate, only more so, usually with an under-the-table connotation.
>
> *Discount.*—If unearned, then in the same category as rebates and kickbacks.
>
> *Earned discount.*—When a nursing home is rendering a service for the pharmacist which he would normally be required to perform, such as billing and collections, where the nursing home, like Bankamericard and similar bank credit cards, guarantees payments to the pharmacist for all drugs ordered; and where the pharmacist gives a nursing home a service or volume discount, as most suppliers do for other goods and services, the National Council of Health Care Services believes that a discount can and should be offered by the pharmacist in return for services rendered.
>
> On the other hand, if a nursing home demands a reduction in charges from the pharmacist without offering any compensatory advantages to the pharmacist, an unwarranted situation is occurring and should not be countenanced.

H.R. 1: KICKBACKS MADE ILLEGAL

As noted above, there was no specific prohibition against kickbacks until November of 1972 when Public Law 92–603, section 242, became law (otherwise known as 42 U.S.C. 1395nn). The law made kickbacks a misdemeanor punishable by 1 year in jail, a $10,000 fine, or both.

KICKBACKS CONTINUE

In early 1974, the committee sent its same questionnaire to 100 pharmacists who had responded in 1972. The overwhelming response from

those who had previously stated kickbacks were widespread was that the practice was continuing unabated.

In order to further document this practice, the committee asked for testimony from the California Pharmaceutical Association. Mr. Charles D. Brown, president of that association, appeared before the committee on November 13, 1975. Mr. Brown was reminded of his 1972 response to the committee's questionnaire in which he stated that pharmaceutical rebates were running rampant in California. Senator Charles Percy asked him whether this were still the case. Mr. Brown responded: "Yes; it is; especially in the metropolitan areas." [4]

He estimated that 40 percent of all pharmacists participated in rebate schemes, again noting concentration in the urban areas. He said that he personally had lost five accounts because he refused to go along with kickback requests. The dollar volume of those lost accounts, he estimated, was $200,000.

He described several new kickback techniques. The first involved the home charging the pharmacy a fee, purportedly to store drugs in the facility—the only storage involved may be the prescription bottles for the patients. He said that many operators were demanding service from pharmacies which offered a unit-dose concept in terms of reducing medication errors, but he objected to operators insisting pharmacists install such systems in order to obtain the nursing home account. This was particularly true, said Brown, when the unit-dose systems turned out to be owned by a medical supply firm and, in turn, owned by a major nursing home chain which was the parent company of the home he had asked to serve.

He added that the new regulations which require nursing homes to employ consultant pharmacists has been exploited by nursing home owners to the point of being a kind of kickback:

> There is nothing in the State law which requires a facility to reimburse the pharmacist for those services. Therefore, pharmacists are using this as a tool to obtain accounts and nursing facilities are saying, "If you want to retain the account, you will not ask for this amount, but you will perform the service." [5]

Brown stated that private paying patients and medicare were absorbing the average 25-percent kickback that is required to obtain a nursing home account. "[T]he unethical provider makes money and the ethical provider loses business." He added that the intervening Federal statute, 42 U.S.C. 1396, enacted by the Congress in 1972, has had no effect on the kickback problem. He stated that if a few providers were prosecuted, "the practice would diminish considerably." "We feel that mandatory penalties along with complete restitution should be required," he said. [6]

In early 1976, the committee received a number of serious allegations from a former nursing home operator licensed in the State of California. He asked that his name be withheld, fearing possible reprisals and the safety of his family. He alleges pyramiding of nursing

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[4] "Medicare and Medicaid Frauds," hearings by the Subcommittee on Long-Term Care, Senate Committee on Aging, Washington, D.C., Nov. 13, 1976, p. 265.
[5] Ibid., p. 263.
[6] Ibid., p. 264.

home ownership. He said he had partial control of four nursing homes, yet never invested any of his personal capital. He alleges declaring only 30 percent of his annual salary for income tax purposes. He states he had the free use of leased cars and credit cards. He admits paying physicians and hospitals $50 for each patient referral.

When asked about the current levels of rebates or kickbacks in California, the former nursing home administrator and owner said the following were average rates paid to nursing homes:

(1) Pharmacies pay 25 percent.

(2) Physical and occupational therapists 50 to 60 percent.

(3) Food supplies, he said, were competitive except that some owners were supplied food for their personal use.

(4) Laundry—he alleges that no rebates are paid as the industry is controlled by organized crime.

(5) Undertakers pay 20 percent.

(6) Cemetery lot sales, including tombstones, may bring operators a 20-percent rebate.

(7) Contractors pay 10 percent of the gross construction price of a new nursing home.

State and Federal authorities are investigating these allegations, which are considered highly credible.

The committee staff has also documented numerous examples of kickbacks between clinical laboratories and medicaid practitioners in California. California and Federal authorities have been apprised of these findings. California Gov. Edmund G. Brown, Jr., and Secretary of Health and Welfare Mario Obledo, recently announced a major initiative to crack down on fraud and abuse in the State of California.[7]

FLORIDA

Following publication of the report, "Drugs in Nursing Homes: Misuse, High Costs, and Kickbacks," published by the Subcommittee on Long-Term Care, the Secretary of the Florida Department of Health appointed a committee to investigate and determine if the general allegations made in the Moss report about drug kickbacks from pharmacists to nursing homes is a practice in Florida and, if so, to what extent.

Under the direction of Jack H. Jones, coordinator of pharmaceutical services, the committee sent a questionnaire to every pharmacist in the State of Florida. Some 30 percent of the 863 questionnaires were returned.

Twenty-five percent of the responding pharmacists said they had been approached for a kickback, as compared to 42 percent who told the Senate they were approached in California.[8]

Some 90 percent of the pharmacists in Florida indicated their belief that kickbacks were widespread between pharmacists and nursing homes, as compared with 63 percent of California pharmacists who thought so.

About 50 percent of Florida pharmacists said that it was necessary to give a kickback in order to obtain a nursing home account and

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[7] "Medicare and Medicaid Frauds," hearings by the Senate Committee on Aging and the House Ways and Means Committee, part 9, Mar. 9, 1977.

[8] *Final report of the Department of Health and Rehabilitative Services Nursing Home Pharmaceutical Services Study Committee* and cover letter to Senator Frank E. Moss conveyed to the Senate Committee on Aging on Feb. 16, 1976.

about this same number said they had lost accounts because of their refusal to go along with requested rebates.

Only one-quarter of Florida pharmacists reported that kickbacks were increasing; about 60 percent said the level was about the same; and the remainder thought that kickbacks were on the decline.

In a similar survey of Florida nursing home operators, over 90 percent reported they had neither been approached for a kickback nor had solicited such payments. As noted in the Senate survey, 78 percent of all nursing home operators in California answered similarly.

The committee concluded its report as follows:

> One general conclusion which encompasses the entire scope of charge to the committee was reached by unanimous consent of the members. That conclusion is that a definite problem exists in the State of Florida with respect to rebate and kickback arrangements between vendors and nursing homes and that some remedial action, whether legislative, administrative, or both, is necessary.[9]

More specific conclusions offered by the Florida committee include:

> Present laws and administrative rules are either not stringent enough or are not being enforced to a degree that serves as a deterrent to nursing homes and vendors against engaging in unethical financial arrangements.
>
> Excessive discounts, rebates, and kickback situations exist in Florida to the financial detriment of the nursing home patient and the taxpayer.
>
> Both the vendor and the nursing home must share the blame equally when a financial arrangement contrary to public policy is entered into.
>
> It is in the best interest of all concerned—the patient, the nursing home, the vendor, the relatives or guardians of the patient, the taxpayer, and the Government—to provide strong sanctions against unethical financial arrangements. A chain is only as strong as its weakest link, and it is the opinion of the committee that no nursing home or vendor whose primary concern is excessive profits will be able to concentrate on patient services to the degree that will guarantee an acceptable level of quality.

The committee added that both pharmacists and nursing home operators must share the blame for kickbacks.

They declared:

> The only discount a nursing home is entitled to is that discount in return for reciprocal services provided to the vendor.

In short, the Florida committee stated that "it does not believe a party to such contracts should be able to receive something for nothing." Any inequity in arrangements between vendors and nursing homes should be investigated through a cross audit, that is an audit of the books and financial records of both parties. It also recommended that "all contracts between vendors and nursing homes be on file with

[9] Ibid., p. 44.

the department and open to public inspection and that all financial arrangements including discounts be described in detail." [10]

WISCONSIN

In July of 1975, an investigation by the Milwaukee Sentinel revealed a pattern of illegal kickbacks between pharmacies and nursing homes in that State. Specifically, the Sentinel reported:

> One pharmacist had been paying a nursing home $3,000 to $4,000 a year for the privilege of selling drugs to the home's medicaid and private patients. The exact amount, he said, was based on a bed count formula.
>
> Another pharmacist estimated that he had paid more than $25,000 to a nursing home in kickbacks from the sale of drugs to its medicaid and private patients.
>
> A Catholic nursing home dropped the pharmacist servicing its patients after he refused to kick back a portion of his profit on each medicaid prescription.[11]

Partly as a result of these disclosures, a Federal grand jury investigation was opened under the direction of William Mulligan, U.S. attorney, Eastern District of Wisconsin. Aiding in the investigation is Lt. Gov. Martin J. Schreiber, who has had an active interest in nursing home problems for several years.

According to the Sentinel's survey, nursing home-pharmacy kickbacks are a significant problem in Wisconsin. W. Allen Daniel, executive director of the Wisconsin Pharmaceutical Association, acknowledged that kickback schemes exist. Speaking for his association, he said: "We are adamantly opposed, and condemn both the nursing home administrator who would demand such improper considerations from the pharmacist and the pharmacist who would accept the contract." According to Sentinel sources, the average kickback in Wisconsin ranges from "token amounts up to 30 percent of sales." [12]

ILLINOIS

In 1971, Senator Moss received a letter from an Illinois certified public accountant imploring the Senate to do something about the kickback problem. He said that the following was true with respect to a chain of nursing homes with whose books he was familiar:

> (1) The pharmacies which supply these nursing homes have agreed to a kickback to the home which averages out between 25 and 30 percent on all prescription drugs delivered to the home.
>
> (2) A 50-percent across-the-board kickback is given by the pharmacies on all welfare prescriptions—prescriptions paid for, in part, by a third party.

The existence of some kickbacks was quickly confirmed by a questionnaire to 100 Illinois pharmacists and by an HEW audit agency report. The audit agency noted that the Illinois reimbursement formula for drugs could lead to high profits, which could be used to pay kick-

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[10] Ibid., quotations in this paragraph found on pages 45 and 46 of the report.
[11] "Druggist Kickbacks Bared," Milwaukee Sentinel, July 7, 1975, p. A1, by Gene Cunningham and Dan Patrinos.
[12] Ibid., p. A1.

backs. Illinois paid pharmacists their average wholesale cost, plus a profit of 30 percent, plus a constant factor of $1.35 per prescription.

One result from this letter was the full-scale study of practices in the State of California reported above. As noted above, the same questionnaire was sent to 100 pharmacists in the State of Illinois; 58 percent of those who replied indicated they had been approached for a kickback or believed that they were widespread.

The U.S. General Accounting Office also found evidence of nursing home pharmacy kickbacks in its April 23, 1975, audit of the State of Illinois entitled, "Improvements Needed in the Medicaid Program Management, Including Investigations of Suspected Fraud and Abuse," prepared at the request of the Senate Finance Committee. GAO, in part, verified findings by the Bureau of Health Insurance. Specifically, there were no prescriptions for 17 of 363 claims which a pharmacy had submitted to medicaid for payment. Moreover, a pharmacy paid $4,500 a month to a management company for services performed at four nursing homes. The management company was owned by the spouses of the owners of the nursing homes. BHI officials were told that the services performed were reviews of patients' charts to determine the accuracy of medications ordered or dispensed.

"However," reports GAO, "BHI region V officials believe that the payment may have been in the form of a kickback for the privilege of obtaining the nursing home's drug business."

On February 5, 1976, U.S. Attorney Sam Skinner, Northern District of Illinois, returned an indictment against eight defendants and owners of the above nursing homes. The indictment charged a conspiracy to defraud the Government under the terms of title 42, United States Code, section 1396. These were the first indictments under the 1972 law enacted by the Congress to try to stem kickbacks. The indictment charged that the Ideal Drug Co. paid a kickback equal to $5 per month for each patient at the Evergreen Nursing Home whose drugs could be and were paid for by medicaid.

Allegedly, Ideal Drug obtained the money from its cash receipts without recording that amount as part of income to or as a disbursement of the company. It was further agreed that the kickbacks from Ideal Drug were to be paid to Multicare Management Co. for distribution by Multicare Management Co. to various individuals who, either personally or through their spouses, held an ownership interest in Evergreen Gardens Nursing Home. The indictments also specify that it was part of the conspiracy that the true nature of the kickbacks paid through Multicare be concealed by Ideal Drug from the Government by labeling the kickbacks as fees for consulting services, although no consulting services were provided by Multicare Management to Ideal Drug. It was also part of the conspiracy that the kickbacks not appear on the books of the Evergreen Nursing Home.

As a final postscript, the indictment charges that defendants made an entry in the books of the Evergreen Gardens Nursing Home indicating that Multicare owed Evergreen $4,500, after the defendants became aware of an investigation by the Bureau of Health Insurance.

Testifying before the Senate Committee on Aging on November 17, 1976, Mr. Skinner reported that his office had obtained a conviction against the named defendants who among themselves controlled almost 25 percent of the nursing homes in the State of Illinois. In addi-

tion to incarceration for about 90 days each, the operators were fined some $900,000 by the court. Mr. Skinner questioned the fiscal integrity of the medicaid program, calling it the biggest ripoff in history.[13] Although he obtained the first convictions under the 1972 law, Skinner argued that the penalties for offering, receiving, or soliciting kickbacks in the medicare or medicaid program be strengthened to felonies. His recommendation, also concurred in by Assistant U.S. Attorney George Wilson, Southern District of New York, has been integrated into H.R. 3, the antifraud and abuse bill introduced by Congressmen Dan Rostenkowski and Paul Rogers in the House of Representatives and by Senator Herman Talmadge in the Senate.

CLINICAL LABORATORY KICKBACKS

In September of 1976, the committee staff documented one example of kickbacks between clinical laboratories and a physician who had a large-volume medicaid business. Knowing that the practice was clearly illegal, committee investigators set out to find an answer to an essential question: how common was the practice? An extensive discussion among the staff of the Committee on Aging led to the conclusion that the best way to test the extent of such practices would be to simulate the actions that would be taken by an independent physician beginning a practice specializing in public aid (welfare) patients. To this purpose, it was decided that a storefront clinic would be opened in an appropriate area. Only from the perspective of the practitioner, at street level, could the committee gain information on the mechanics of these highly questionable operations. And only through understanding the mechanics of the operation could effective corrective legislation be proposed.

A decision was made to go ahead with this plan in conjunction with the Better Government Association (BGA) of Chicago, Ill., a nonprofit, nonpartisan civic organization which has cooperated with the Committee on Aging for more than 6 years in a number of areas of investigation. Subsequently, due to considerations of time and money, the BGA assumed primary responsibility for setting up and operating the storefront clinic with committee staff present only as observers. Two Illinois physicians cooperated with investigators to the extent of allowing their names to be used.

A small storefront was rented at 1520 West Morse in the Rogers Park area of Chicago. This neighborhood has the highest proportion of aged in any area in Chicago . . . and possibly one of the highest in the Nation. A sign announcing the opening of the clinic was placed in the window. A number was listed with the statement: "Professional inquiries invited." Mr. Douglas Longhini, a BGA investigator, posed as a business representative of the two doctors. Working with the BGA personnel was Producer Barry Lando and other individuals from the CBS television program "60 Minutes," who modified the storefront clinic. They installed special lighting and a one-way mirror, hoping to film those who entered the clinic offering kickbacks to the disguised BGA investigators.

Over the next 3 weeks, business representatives from more than 12 laboratories doing more than 65 percent of the medicaid business in

[13] "Medicare and Medicaid Frauds," hearing by the Senate Committee on Aging, part 7, Nov. 17, 1976.

the State of Illinois visited the storefront clinic. All but two offered some form of inducement or kickback. The offers ranged from an educational program for physicians in billing procedures to maximize return from public aid, to cash rebates of more than 50 percent of gross payments received from the Illinois Department of Public Aid.

In addition to Mr. Longhini, Mrs. Geralyn Delaney, a BGA secretary, was present during each of the interviews and recorded the conversations that took place in shorthand.[14] At times, BGA Investigator Patrick Riordan was present. Bill Recktenwald and David Holton, temporary investigators for the Senate Committee on Aging, were present on several occasions, posing as maintenance men. As an example of what transpired in these visits, the following exchange between Mr. William Footlick, owner of Division Medical Laboratory, said to be the largest lab in terms of public aid business in the State of Illinois, and Douglas Longhini, is reprinted below as taken from Mrs. Delaney's sworn statement:

> (Mr. Longhini asked what arrangements were made.)
>
> Mr. FOOTLICK. "A percentage of the volume of business in dealing with public aid."
>
> Mr. Longhini asked Mr. Footlick how many square feet the lab would need to draw the blood.
>
> Mr. FOOTLICK. "A blood drawer, chair, and cabinet."
>
> Mr. Longhini stated the clinic's rent is $450 a month. If the clinic's business is brisk in the beginning the clinic could get that $450 back in rent.
>
> Mr. FOOTLICK. "Oh, sure, $5,000 to $6,000 a month."
>
> Mr. Longhini asked whether the clinic would get $5,000 to $6,000 a month for rent.
>
> Mr. FOOTLICK. "Sure . . . volume of people."
>
> Mr. Longhini asked if the clinic would sign a lease.
>
> Mr. FOOTLICK. "Sure . . . wouldn't be able to refer to rent until we look at volume. We would have to renegotiate the lease."
>
> Mr. Riordan asked whether the clinic's rent would change four times a year.
>
> Mr. FOOTLICK. "I don't think it would be fair to do once or twice and get good idea of volume."
>
> Mr. Riordan asked whether Mr. Footlick's firm provides a technician to draw the blood.
>
> Mr. FOOTLICK. "Depends on volume."
>
> Mr. Longhini asked Mr. Footlick if the clinic gets a rebate off of the volume.
>
> Mr. FOOTLICK. "A rose is a rose. I look at it as a rental."
>
> Mr. Longhini asked whether the clinic was safe from the FBI.
>
> Mr. FOOTLICK. "FBI frowns upon an incentive for the doctor to draw in a lot of . . . on kickback system . . . I justify it would cost more to bring these patients to the lab than if I were to do the work here."

[14] Particular care was taken to make sure that no Federal or State laws were broken in this effort. Illinois has a statute which prohibits electronic recording of conversations unless all parties consent to it. Accordingly, the best alternative available was stenographic recording. The CBS cameras did not record sound unless all parties consented.

All in all, the offers received by BGA personnel ranged from a small discount offered to private patients to the full package offered by Mr. C.'s firm, including: 20 to 30 percent of gross billings which would be paid in the form of rent, said to be as much as $5,000 to $6,000 a month, plus salary for a clinical secretary or a nurse, plus equipment and supplies, plus X-ray and technician's services, plus electrical plumbing services for the clinic.

Typical of the kickback offers was that of Mr. Nemie LaPena, representative of a northside clinical laboratory. In the first 6 months of fiscal year 1976, his firm was paid $550,802.64 for laboratory services by the Illinois Department of Public Aid (medicaid), making it among the highest paid labs in Illinois for that period.

In a meeting with BGA Investigators Douglas Longhini and Geralyn Delaney on December 23, Mr. LaPena said:

> You'll make lots of money, I guarantee that... you'll get a rebate of 45 percent of your gross public aid billings. I'll deliver a check to you every Tuesday; and if your billings go over $1,000 per week, then the percentage goes up to 50 percent.

During this conversation, subcommittee investigators were also present and overheard the offer.

INTERVIEWS WITH PHYSICIANS

From information gathered at the storefront, a profile was constructed of each laboratory. Billings presented to the State for medical testing on public aid patients were pulled and examined. The physicians using the services of labs identified were selected for interview. On January 7, 1976, interviews were made.

Four teams of investigators, comprised of one BGA and one Senate staff member, conducted more than 24 interviews on that day. Physicians were asked: (1) Whether they did business with a particular lab as indicated by bills paid by the Illinois Department of Public Aid; (2) whether they had an arrangement with that lab; (3) the details of any such arrangement; and (4) to examine particular bills submitted on their behalf by medical testing laboratories and paid by the Illinois Department of Public Aid.

In the great majority of cases, physicians confirmed the existence of arrangements. They provided specifics concerning the amount of rebates and the method of payment. The primary exceptions to the above were cases where the physician was an employee of another physician, or a third party, or otherwise on salary from the medical clinic.

In one such example of the latter, the investigators interviewed Dr. Jose Jaime Hilao, of the Robert Taylor Medical Center, Chicago, Ill. Dr. Hilao indicated that he was on salary and that he knew nothing of any rebate arrangements. He referred the committee staff to Mr. Robert C. Parro, president, Robert Taylor Medical Center. Dr. Hilao volunteered that Mr. Parro also owned the Professional Medical Center in Chicago.

Mr. Parro told Val J. Halamandaris, associate counsel, Senate Committee on Aging, and BGA Investigator James Huenink that he—actually the two clinics—received some $300,000 the previous year in medicaid funds from the Department of Public Aid. He added that

one of his clinics had been using the services of the North Side Medical Laboratory in Chicago and that the Parke-Dewatt Laboratory provided service to the second of his centers. Now both medical centers are using the Parke-Dewatt Laboratory.

Mr. Parro stated that his present arrangement amounted to 50 percent of the amount his clinic charged medicaid lab services on behalf of medicaid beneficiaries.

He added that he was troubled by this arrangement in that some might think it illegal. He described it as a gray area and stated that the law should be clarified. He added that his decision to give all of his business to this particular laboratory was not motivated by the desire to make greater profit. He volunteered that the North Side Medical Laboratory, which he had been using in one of his clinics, had offered him a kickback of 55 percent of total public aid billings which he turned down because he was dissatisfied with the services of this particular laboratory.[15]

Halamandaris and Huenink also interviewed Mr. Roy Oliver, administrator, 47th Street Medical Center in Chicago. Mr. Oliver indicated that this medical clinic received some $250,000 from the Department of Public Aid last year. The clinical lab services were provided by a laboratory which provided a rebate of 30 percent of total volume—approximately $900 a month. The rebate was received, disguised as a rental fee for a 5- by 7-foot room in the clinic. In addition, the lab paid $325 a month, some $160 each, to two clinic employees.

In the other situation most frequently found, the physician is the owner of the clinic. Dr. H. M. William Winstanley, King Drive Medical Center, told investigators Halamandaris and Huenink that he received some $100,000 from medicaid for his medical center last year. He paid a rent of $1,050 a month. He receives rental of $1,000 a month from a pharmacy subleasing space in this building; a dentist pays him about $800 a month and an optician about $400 per month. He sends his lab business to the United Medical Laboratory. They pay him a constant $950 a month which he views as a rental fee for a 7- by 10-foot room in his clinic. In addition, he is paid $130 per month for an employee to draw blood and perform related services in this room. (These specifics should not be interpreted as making any judgments as to the quality of medical services offered by Dr. Winstanley. It is assumed he is providing needed and valuable service to his community.)

Other arrangements which other physicians admitted included: Acceptance of salary for staff supplies and equipment, the use of double pricelists, rental arrangements based on volume, and discounts for private paying patients. Discounts for private paying patients enable a physician to have tests such as a urinalysis done for him free or at a sizable discount. The doctor can then turn around and bill private patients $3 to $5. With respect to rental agreements based on volume, Dr. Julio Lara-Valle told investigators that the third largest laboratory in terms of public aid business, D. J. Medical Laboratory, paid him $1,000 a month for the use of a closet-sized room in a suite that cost him $300 a month to rent.

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[15] On Feb. 6, 1976, Mr. Parro repeated these statements to investigators accompanied by Senator Moss.

Senators Frank E. Moss and Pete V. Domenici also interviewed Dr. Lara-Valle. He told them that the D. J. Medical Laboratory was now closed down and that its operator, Mr. Espino, "has flown the coop." Dr. Lara-Valle confirmed that he now has the identical rental arrangement with another laboratory.

The committee report on this investigation concluded that a few laboratories control all the medicaid business in Illinois and four other States: New York, California, New Jersey, and Pennsylvania. Kickbacks are widespread among such labs.

It added:

> In fact, it appears that it may be necessary to give a kickback in order to secure the business of physicians or clinics who specialize in the treatment of welfare patients.

The average kickback to physicians or medical center owners in Illinois was 30 percent of the monthly total the lab received for performing tests for medicaid patients. Kickbacks took several forms, including cash, furnishing supplies, business machines, care or other gratuities, as well as paying part of a physician's payroll expenses. Most commonly it involved the supposed rental of a small space in a medical clinic.

The report concludes that it is apparent that the law passed by the Congress in 1972 prohibiting kickbacks and mandating a $10,000 fine and 1 year in jail upon conviction is not being enforced.

To date, U.S. Attorney Sam Skinner has obtained indictments against six of the laboratories that offered investigators rebates at the Morse Avenue storefront clinic.

UTAH

The Bureau of Health Insurance documented, and the U.S. attorney in Salt Lake City, Utah, is currently prosecuting, two nursing home owners whose alleged kickback scheme appears to be identical to that used by the Illinois operators above. The nursing home owners appear to have funneled kickbacks to them from a pharmacy through a medical supply firm and a consulting firm, both owned by the nursing home owners. The allegation is that what are disguised as payments from the pharmacy to the supply and consulting firm are really kickbacks to the nursing home operators since these consulting and supply firms provided few if any services for the pharmacy.

NEW YORK

The Subcommittee on Long-Term Care conducted a major investigation of nursing homes in New York State in January of 1975. Over 60 subpenas were issued to nursing home operators, vendors, insurance companies, and banks. Among the recurrent problems which the subcommittee encountered was evidence of kickbacks not only between nursing homes and pharmacists, but between nursing homes and other vendors, such as those supplying linen, produce, an milk.

After its February 17, 1975, hearing, the subcommittee decided to turn over these books and records, together with analyses by GAO auditors, to Charles J. Hynes, appointed special prosecutor for nursing

homes by Governor Hugh Carey. Since that time, Mr. Hynes has obtained over 100 indictments and more than 27 convictions.

Testifying at the committee's November 17, 1976, hearing, Mr. Hynes described an elaborate 18-month investigation into nursing home kickbacks. A cooperating nursing home owner wore a microphone and recording device while negotiating contracts for his nursing home with over 30 suppliers in New York City. The recording equipment captured elaborate kickback offers from cash to prepaid vacation trips. Mr. Hynes indicated that others wore recording equipment to help his office and that more than 50 conversations were recorded.

On the basis of these recordings, Mr. Hynes had announced 26 indictments on November 16, and 16 more on March 11, 1977. He stated he expected many more indictments to follow. When asked how prevalent the kickback problem was in New York, he indicated that it was widespread and that perhaps half of the 125 nursing homes in New York City were involved in kickback schemes.

"Our indication is that the same kinds of abuses are found in all provider services in medicaid," said Mr. Hynes. "Kickbacks were paid to nursing homes by linen, laundry, milk, produce vendors as well as by contract cleaning firms and medical supply houses." [16]

In answer to a specific question from Senator Church, Mr. Hynes said he had direct evidence of kickbacks to hospitals. Some of the suppliers who admitted kickbacks to nursing homes also had admitted similar arrangements with welfare hospitals, he responded.

In the course of its investigation of medicaid mills and related abuses in New York, the committee staff documented kickbacks were a common practice between clinical laboratories and medicaid mills in New York. Both Assistant U.S. Attorney George Wilson, Southern District of New York, and New York County District Attorney Robert Morgenthau have obtained several indictments against laboratories in the past 6 months.

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[16] New York Times, Nov. 16, 1976, p. A1.

Part 4

SUMMARY AND CONCLUSIONS

After 8 years of investigation and more than 50 hearings, the Senate Committee on Aging has received significant and convincing evidence that kickbacks are widespread in medicaid. As one provider wrote, "Kickbacks are a way of life in medicaid; there is a little larceny in us all."

After the committee's indepth investigations in the States of New York, California, Wisconsin, Florida, Illinois, and other States, there can no longer be any doubt about this pervasive practice which picks the taxpayer's pocket.

The evidence is overwhelming that many pharmacists are required to pay kickbacks to nursing home operators as a precondition of obtaining a nursing home's business. Pharmacists also must pay rebates to practitioners or other owners of medicaid mills, the small "shared health care facilities" which checker the ghettos of our major cities. Moreover, there is increasing evidence that these same payments are being made to some hospitals which specialize in welfare patients.

It is evident that kickbacks are frequently required from clinical laboratories if they hope to obtain the business of both medicaid mills and nursing homes. Committee investigators are convinced that laboratories are barred from obtaining a medicaid account unless they pay kickbacks. This fact in part accounts for the consolidation of laboratory business. In New York, 16 laboratories controlled 70 percent of the State's medicaid business. In New Jersey, a dozen labs controlled more than 60 percent of the funds. In Illinois, 12 laboratories controlled 65 percent of the State's medicaid business.

Based on the intensive investigation conducted by Charles J. Hynes, special prosecutor for nursing homes in New York State, as well as testimony received by the committee, it is apparent that kickbacks to nursing homes from vendors and suppliers such as purveyors of meat, linen and laundry services, produce, groceries, medical supplies, and contract cleaning services also make under-the-table payments to nursing homes with regularity. While the evidence still is unfolding in New York, it is evident that these same vendors and suppliers also pay kickbacks to some hospitals.

What is just as certain as the conclusive evidence that kickbacks are widespread in medicaid is the fact that few cases of this nature are ever prosecuted. Only one case has ever resulted in a successful conviction under the specific 1972 law Congress enacted. Medicare officials disclosed that only 18 kickback cases were referred for prosecution in the medicare program since 1969. Medicaid officials had no accurate count to offer but indicated the number of kickback cases reported to HEW by the States would be negligible. In the 12 months, July 1974 through June 1975, only one case of kickbacks among medicaid providers had been reported to HEW by the States.

When asked why so few prosecutions resulted, U.S. attorneys and States' attorneys told the committee staff that kickbacks were among the most complicated and difficult to prove. Moreover, the penalty provided under the 1972 law is a misdemeanor. Prosecutors indicated they found it hard to justify the expenditure of man-hours on misdemeanor violations.

Part 5

RECOMMENDATIONS

(1) H.R. 3 (S. 143) should be enacted. Of particular importance is the provision which makes offering, soliciting, or receiving kickbacks a felony, instead of the present misdemeanor, in both medicare and medicaid.

(2) The Department of Justice should intensify its efforts to identify medicare and medicaid fraud and to recover Federal funds inappropriately paid out under these programs.

(3) The Internal Revenue Service should begin a systematic analysis of the tax returns of high-volume medicare and medicaid providers.

(4) The Congress should provide 100 percent Federal funding to the States for a 3-year period to help them hire investigators and auditors. After the 3-year period, the States should be allowed to keep 75 percent or perhaps even 100 percent, of any funds they recover which have been fraudulently paid to providers.

(5) All Federal and State authorities should make an aggressive effort to eliminate kickbacks which apparently are the normal way of doing business in the medicaid program.

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