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July 20, 2005

VIA FAX AND OVERNIGHT MAIL

Hon. Joseph Bruno
Temporary President and Majority Leader
New York State Senate
State Capitol, Room 330
Albany, New York 12247

Hon. Sheldon Silver
Speaker
New York State Assembly
State Capitol, Room 349
Albany, New York 12248

Dear Senator Bruno and Speaker Silver:

I am writing to request that both the Senate and the Assembly return to session as soon as possible to enact two bills that I have proposed to enhance the State's ability to discover, prevent and prosecute Medicaid fraud. In addition, I urge you to support my efforts to convince the federal government to remove unnecessary regulatory restrictions on our ability to uncover such frauds.

As you know, in recent days the *New York Times* has reported on significant waste and abuse of the State's Medicaid program. For the past several years, I have proposed two bills that would improve our ability to learn about such frauds, prosecute those who have engaged in such wrongdoing, and to recover defrauded funds on behalf of the State. Neither of these bills have passed the Legislature.

The first bill is the proposed False Claims Act [S.3895(Farley)/A.8107(Weinstein)], which I have submitted to the Legislature every year since 2001, and which is modeled on the



very successful federal False Claims Act. This legislation increases the civil penalties and other monetary relief that can be obtained against those who defraud the State and its local governments, and provides a financial incentive for individuals to report such frauds. Numerous other states – including California, Florida, Illinois and Virginia – have adopted legislation modeled after the federal law, and just last month the New York City Council adopted its own municipal false claims act. The legislation is supported by a broad coalition, including the New York State Association of Counties, the New York Insurance Association and the National Insurance Crime Bureau.

The second bill is the proposed Health Care Fraud Act [A.7594(Lentol)], which establishes new crimes related specifically to health care fraud, including: (1) prohibiting schemes to defraud Medicaid or other health plans; and (2) penalizing those who make false statements or use fraudulent documents relating to the provision of health care. The Penal Law currently is not designed to adequately address sophisticated patterns of criminal health care fraud, and do not impose appropriate penalties against those who engage in such crimes. The proposed Health Care Fraud Act – which I first proposed shortly after taking office in 1999 – is modeled on laws that have been adopted in numerous other states, and would give New York prosecutors the same ability to address health care fraud as exists elsewhere.

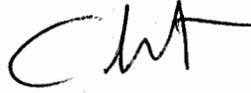
Enactment of these two bills will help protect the public by: (1) encouraging the public to disclose information about Medicaid and other frauds; (2) facilitating the prosecution of those who engage in such frauds; (3) increasing financial recoveries from those who have defrauded the government, thereby protecting taxpayer dollars; and (4) deterring such fraudulent activity in the future.

I strongly urge that the Senate and Assembly both hold sessions as soon as possible to pass these two important measures. MFCU recovers millions of dollars every year on behalf of the State's taxpayers, including \$65.7 million in 2004, which is 700% more than the \$9.1 million recovered in 1999. Enactment of these bills will greatly assist our efforts to recover additional funds in the future.

Finally, last month I wrote to the Secretary of the Department of Health and Human Services (HHS), asking that HHS amend its existing regulation that prohibits MFCU from using computers to analyze Medicaid claims data to expose patterns of fraud. (A copy of this letter is attached.) The *New York Times* reporters – unfettered by the ban – were able to perform simple analyses on a laptop computer to identify providers engaged in criminal wrongdoing. The federal regulation forbids MFCU from using this obvious tool. This regulation is a major impediment to MFCU's ability to uncover significant waste, abuse and fraud, and should be eliminated. I request that you write to Secretary Leavitt, and express your strong support for this change.

Thank you for your attention to these urgent matters, and please feel free to call me if you have any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'E. Spitzer', with a large, sweeping initial 'E' and a stylized 'S'.

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June 10, 2005

Mr. Michael O. Leavitt
Secretary of Health and Human Services
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Leavitt:

I write to urge the Department of Health and Human Services to amend 42 C.F.R. 1007.19(e) to eliminate the rule that prohibits State Medicaid Fraud Control Units (MFCUs) from engaging in basic anti-fraud detection efforts that are readily available to Units, like New York's, that have direct computer access to Medicaid claims data. Simply stated, the federal rule prohibiting state Units from "mining" this computerized claims data to expose patterns of fraud is an unnecessary obstacle to effective state law enforcement. While advancing no legitimate governmental interest, it compromises the ability of State MFCUs to identify and prosecute fraud and recover Medicaid overpayments.

As you know, rapidly rising Medicaid costs have created fiscal burdens that state and local governments across the country are hard pressed to meet. New York's Medicaid program, the largest by far of any state in the nation, has grown from a program costing \$4 billion in 1979 to one costing more than \$44 billion in 2004. Governor Pataki has observed that, if left unchecked, Medicaid costs could consume more than half of the State budget in six years. Local counties, which in New York are required to pay a significant portion of these costs, are facing significant fiscal hardships as a direct consequence of spiraling Medicaid costs.

Bringing these costs under control is, of course, a major objective of government at every level. The federal rule prohibiting State MFCUs from analyzing information from available computerized data is irrational, and should be eliminated.

Pursuant to federal law, State MFCUs are integral parts of the battle against Medicaid fraud. These federally funded units are required to conduct Statewide programs to investigate and prosecute fraud committed by Medicaid providers as well as fraud in the administration of the Medicaid program. 42 U.S.C. 1396(b)(q). The New York MFCU, which is located within



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my office, is a national leader in the fight against providers who defraud the Program and in the recovery of Medicaid assets that have been lost to fraud.

Notwithstanding our success, I am convinced that we can do more, and that the elimination of the prohibition on data mining would greatly assist in that effort. Current federal regulations prohibit State MFCUs from engaging in what, in other areas, is a standard investigative technique. They prohibit the use of federal funding for:

Efforts to identify situations in which a question of fraud may exist, including the screening of claims, analysis of patterns of practice, or routine verification with recipients of whether services billed by providers were actually received. 42 C.F.R 1007.19(e)(2).

On its face, it is mystifying that the same rules that created the state entity (the MFCU) that investigates and prosecutes fraud also prohibited it from identifying situations in which fraud may exist. I can think of no other similar instance where law enforcement is asked to fight crime with one hand tied behind its back.

I have been told that this prohibition may have been intended to avoid having the federal government pay the States twice for the same governmental activity. The federal rules split anti-fraud responsibilities between State MFCUs and the state agencies which administer the Medicaid programs (in New York, the Department of Health). The rules provide that State Medicaid agencies like the Department of Health (DOH), which also receive federal funding, have the responsibility to review utilization data for patterns of fraudulent conduct or other program abuse. Pursuant to the regulation quoted above, MFCUs are prohibited from duplicating this work. Instead, Medicaid agencies are required to refer suspected fraud cases to the MFCUs which, in turn, are responsible for investigating and, where appropriate, prosecuting that fraud.

While avoiding redundant payments is a worthwhile governmental objective, this data mining prohibition is a classic example of being "penny wise and pound foolish."

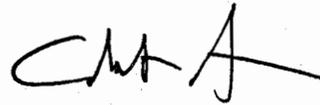
For all their other talents, health professionals at DOH are not professional prosecutors and law enforcement investigators. In contrast, MFCU prosecutors and forensic auditors have special expertise in the complexities of health care fraud and patterns. It makes no sense to preclude these experts from aggressively combing the data for patterns of fraud. In New York, claims data exists in electronic form that is already available to MFCU attorneys, investigators and auditors on their office desktops. Given the scope of the problem of Medicaid fraud and the complexities of modern health care fraud, it is foolish and frustrating indeed that a federal reimbursement rule prevents these individuals from fully using the tools that are sitting on their desks. No real governmental interest can be served by such an arrangement.

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Given the dollars at stake, it is incomprehensible that the federal government has a rule that prevents State MFCUs from using every available resource. I am not suggesting that claims utilization review be removed from State Medicaid agencies. Rather, I urge that federal rules be amended to permit New York's MFCU to fully apply its talents to do more of what we do well – exposing fraud and prosecuting those who commit it. Removing a restriction on data review will allow this.

I look forward to hearing your response to this proposal and to discussing the matter with you and your staff.

Sincerely,

A handwritten signature in black ink, appearing to read 'E. Spitzer', with a long horizontal flourish extending to the right.

Eliot Spitzer

cc: William Comiskey, Deputy Attorney General
New York Medicaid Fraud Control Unit