U.S. SENATE COMMITTEE ON
Finance
SENATOR CHUCK GRASSLEY, OF IOWA - CHAIRMAN
http://finance.senate.gov

For Immediate Release
Tuesday, August 23, 2005

Grassley asks for information about incomplete federal inquiries into abuse of Medicaid program

WASHINGTON — Sen. Chuck Grassley has asked the Attorney General and the Secretary of Health and Human Services for information about why inquiries by their departments into inappropriate Medicaid claims for school-based services were stopped in 2002, as reported this summer by the New York Times.

Grassley is Chairman of the Senate Committee on Finance, which is responsible for Medicaid legislation and oversight. In June he conducted two days of hearings about Medicaid fraud, waste and abuse. The budget resolution adopted by Congress this year directs the Finance Committee to reduce expenditures on Medicaid and other programs by $10 billion over the next five years.

The text of Grassley's letters to Attorney General Alberto Gonzales and Secretary Michael Leavitt follows here.

August 23, 2005

The Honorable Alberto Gonzales
Attorney General
United States Department of Justice
950 Pennsylvania Avenue, N.W.
Washington, DC 20535

Dear Attorney General Gonzales:

The U.S. Senate Committee on Finance (Committee) has jurisdiction over the Medicare and Medicaid programs, and, accordingly, a responsibility to the more than 80 million Americans who receive health care coverage under these programs. As Chairman of the Committee, and as a senior member of the United States Senate, it is my Constitutional duty to ensure that Federal monies, including Medicare trust funds, are spent in an appropriate manner, free of fraud, waste, or abuse.

Recently, the Committee held two days of hearings focused on fraud, waste and abuse in the Medicaid program. During the hearings, the Committee heard testimony from the Office of Inspector General (OIG), Department of Health and Human Services and the Government

Accountability Office (GAO) regarding state projects to maximize Federal Medicaid reimbursements. According to both the OIG and the GAO, these projects are questionable and may threaten the long-term integrity and stability of the Medicaid program.

In particular, both the OIG and the GAO testified regarding school-based services associated with state projects. Under the Individuals with Disabilities Education Act, schools are allowed to claim reimbursement from Medicaid for services provided to students. School-based services, ranging from speech therapy to transportation service, are intended to help students, however, three audits conducted by the OIG paint a different picture. The OIG reports found that nearly $620 million in Federal matching funds were inappropriately spent by the State of New York and New York City on school-based services between 1993 and 2001. These losses represent a significant portion of Federal Medicaid dollars that were intended to provide meaningful and potentially life-saving care to the Nation's most vulnerable populations.

It has come to my attention that the Civil Division of the Department of Justice (Department) began an inquiry into this matter back in April of 2002. Specifically, this inquiry requested information from both the State of New York and New York City regarding Federal reimbursement for school based Medicaid services dating back to 1993. While this review requested information, it is unclear whether the Department received any documents in response to its request. Further, I question why the Department decided to suspend its inquiry into this matter in July of 2002, as reported in a recent article in The New York Times. These unanswered questions raise concerns that enforcement of Medicaid fraud, waste, and abuse by Department may not be as high a priority as it should be.

Accordingly, I request that you provide a detailed briefing to address the following questions:

(1) Did the Department suspend its civil inquiry into questionable spending in the state of New York and New York City back in 2002?

(2) If so, what is the current status of any Department inquiry into school-based service reimbursement by Medicaid in both the state of New York and New York City?

(3) If the Department's inquiry is closed, what was the basis for closing it?

(4) How many open investigations into school based Medicaid reimbursement in any jurisdiction remain open at this time? In responding, provide the jurisdiction in question, the estimated loss to Medicaid, and a current status of the inquiry.

Thank you in advance for your attention to this matter.

Sincerely,
Charles E. Grassley
Chairman

August 23, 2005

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

Dear Secretary Leavitt:

The U.S. Senate Committee on Finance (Committee) has jurisdiction over the Medicare and Medicaid programs, and, accordingly, a responsibility to the more than 80 million Americans who receive health care coverage under these programs. As Chairman of the Committee, and as a senior member of the United States Senate, it is my Constitutional duty to ensure that Federal monies, including Medicare trust funds, are spent in an appropriate manner, free of fraud, waste, or abuse.

Recently, the Committee held two days of hearings focused on fraud, waste and abuse in the Medicaid program. During the hearings, the Committee heard testimony from the Office of Inspector General (OIG), Department of Health and Human Services and the Government Accountability Office (GAO) regarding state projects to maximize Federal Medicaid reimbursements. According to both the OIG and the GAO, these projects are questionable and may threaten the long-term integrity and stability of the Medicaid program.

In particular, both the OIG and the GAO testified regarding school-based services associated with state projects. Under the Individuals with Disabilities Education Act, schools are allowed to claim reimbursement from Medicaid for services provided to students. School-based services, ranging from speech therapy to transportation service, are intended to help students, however, three audits conducted by the OIG paint a different picture. The OIG reports found that nearly $620 million in Federal matching funds were inappropriately spent by the State of New York and New York City on school-based services between 1993 and 2001. These losses represent a significant portion of Federal Medicaid dollars that were intended to provide meaningful and potentially life-saving care to the Nation's most vulnerable populations.

It has come to my attention that the DOJ began an inquiry into this matter back in January of 2002. Specifically, this inquiry requested information from both the State of New York and New York City regarding Federal reimbursement for school based Medicaid services dating back to 1993. For reasons which remain unknown, this investigation by DOJ was suspended back in 2002, according to reports that appeared in The New York Times last month. In this same article, the author stated that an investigation on the part of the Department of Health and Human Services (Department) was also put on hold for a reason that has not been made public.

Accordingly, I request that you provide a briefing to address the following concerns:

(1) Did the Department agree to forgo the collection of any restitution from school districts that were found to have utilized school based services to increase their Federal share of Medicaid funds?

(2) If so, what is the current status of any Department inquiry into school-based service reimbursement by Medicaid in both the state of New York and New York City?

(3) Has the Department initiated a review of school based services to determine if other states have used these services as a means to facilitate a higher share of Federal Medicaid dollars?

(4) Does the Department plan on revising the regulatory guidance for states to follow regarding school based Medicaid services?

Thank you in advance for your attention to this matter.

Sincerely,
Charles E. Grassley
Chairman

The New York Times
July 18, 2005 Monday
Late Edition - Final
SECTION: Section A; Column 5; Metropolitan Desk; Pg. 1
LENGTH: 5510 words
HEADLINE: New York Medicaid Fraud May Reach Into Billions
SERIES: PROGRAM DISORDER: Exploiting a Safety Net
BYLINE: By CLIFFORD J. LEVY and MICHAEL LUO
BODY:

It was created 40 years ago to provide health care for the poorest New Yorkers, offering a lifeline to those who could not afford to have a baby or a heart attack. But in the decades since, New York State's Medicaid program has also become a $44.5 billion target for the unscrupulous and the opportunistic.

It has drawn dentists like Dr. Dolly Rosen, who within 12 months somehow built the state's biggest Medicaid dental practice out of a Brooklyn storefront, where she claimed to have performed as many as 991 procedures a day in 2003. After The New York Times discovered her extraordinary billings through a computer analysis and questioned the state about them, Dr. Rosen and two associates were indicted on charges of stealing more than $1 million from the program.

It has drawn van services, intended as medical transportation for patients who cannot walk unaided, that regularly picked up scores of people who walked quite easily when a reporter was watching nearby. In cooperation with medical offices that order these services, the ambulettes typically cost the taxpayers more than $50 a round trip, adding up to $200 million a year. In some cases, the rides that the state paid for may never have taken place.

School officials around the state have enrolled tens of thousands of low-income students in speech therapy without the required evaluation, garnering more than $1 billion in questionable Medicaid payments for their districts. One Buffalo school official sent 4,434 students into speech therapy in a single day without talking to them or reviewing their records, according to federal investigators.

Nursing home operators have received substantial salaries and profits from Medicaid

payments, while keeping staffing levels below the national average. One operator took in $1.5 million in salary and profit in the same year he was fined for neglecting the home's residents.

Medicaid has even drawn several criminal rings that duped the program into paying for an expensive muscle-building drug intended for AIDS patients that was then diverted to bodybuilders, at a cost of tens of millions. A single doctor in Brooklyn prescribed $11.5 million worth of the drug, the vast majority of it after the state said it had tightened rules for covering the drug.

New York's Medicaid program, once a beacon of the Great Society era, has become so huge, so complex and so lightly policed that it is easily exploited. Though the program is a vital resource for 4.2 million poor people who rely on it for their health care, a yearlong investigation by The Times found that the program has been misspending billions of dollars annually because of fraud, waste and profiteering. A computer analysis of several million records obtained under the state Freedom of Information Law revealed numerous indications of fraud and abuse that the state had never looked into.

'It's like a honey pot," said John M. Meekins, a former senior Medicaid fraud prosecutor in Albany who said he grew increasingly disillusioned before he retired in 2003. "It truly is. That is what they use it for."

State health officials denied in interviews that Medicaid was easily cheated, saying that they were doing an excellent job of overseeing the program.

"This continues to be an area where we think that we have made substantial progress," said Dennis P. Whalen, executive deputy commissioner of the State Health Department. "But by no means are we sitting back and resting on the accomplishments that we have made."

Nonetheless, after being informed of The Times's findings, the Republican majority in the State Senate began a push recently to overhaul the system intended to protect Medicaid, which has been sharply reduced even as Gov. George E. Pataki and lawmakers have nearly doubled the program's budget over the last decade. The Democratic majority in the Assembly has remained on the sidelines. So has Mr. Pataki.

New York's Medicaid program is by far the most expensive and most generous in the nation. It spends far more -- now $44.5 billion annually -- than that of any other state, even California, whose Medicaid program covers about 55 percent more people. New York's Medicaid budget is larger than most states' entire budgets, and it spends nearly twice the national average -- roughly $10,600, more than any other state -- on each of its 4.2 million recipients, one in every five New Yorkers.

That generosity was born of good intentions when Gov. Nelson A. Rockefeller signed the program into law in 1966, following the state's tradition of creating big antipoverty programs. But Medicaid has become far more than the child of that altruism, having morphed into an economic engine that fuels one of the state's biggest industries, leaving fraud and unnecessary spending to grow in its wake.

There are no precise estimates for the cost to the state's program. Officials who have

spent their careers chasing unscrupulous doctors and other providers in New York Medicaid say the losses to taxpayers here are probably higher than typical estimates of overall health care fraud. The Government Accountability Office in Washington and others have estimated that 10 percent of all health care spending nationally is lost to "fraud and abuse."

James Mehmet, who retired in 2001 as chief state investigator of Medicaid fraud and abuse in New York City, said he and his colleagues believed that at least 10 percent of state Medicaid dollars were spent on fraudulent claims, while 20 or 30 percent more were siphoned off by what they termed abuse, meaning unnecessary spending that might not be criminal. "So we're talking about 40 percent of all claims are questionable," Mr. Mehmet said -- an amount that would approach $18 billion a year.

Despite the debate, and the enormous sums at stake, Albany has never formally studied how much of the huge government investment in Medicaid is lost to criminal activity and abuse.

For their part, federal auditors have made New York a leading target for inspection as Washington has begun to crack down on Medicaid spending abuses. The federal government shares the cost of Medicaid with the states. In New York, it pays half the bill; Albany splits the rest of the cost with its counties and New York City.

The lax regulation of the program did not come about by chance. Doctors, hospitals, health care unions and drug companies have long resisted attempts to increase the policing of Medicaid. The pharmaceutical industry, which has spent millions of dollars annually on political contributions and lobbying in Albany, has defeated several attempts to limit the drugs covered by Medicaid; other states have saved hundreds of millions of dollars annually with such restrictions.

Earlier this year, after the Legislature agreed to impose such a limit and steer patients to generic drugs, the industry won a major loophole that allowed any doctor to substitute a higher-priced brand name with a simple phone call to the state.

Governor Pataki would not be interviewed about Medicaid for this article, and his aides referred questions to the State Department of Health, which is part of his administration. The health commissioner, Dr. Antonia C. Novello, also declined to be interviewed.

In defending the department's performance, Mr. Whalen, the executive deputy commissioner, said it had saved $9.3 billion in recent years through investigations of providers, a new computer system and other measures.

Asked repeatedly to provide an in-depth explanation of their claim of major savings or for any state records or other documentation to back up the figures, department officials would not supply any.

The Times investigation drew upon interviews with scores of current and former officials and health-care providers, including several former investigators who say they left the state disillusioned about its commitment to fighting fraud. A review of thousands of pages of state, federal and local records turned up repeated examples of cost savings and waste reduction used by the federal government and other states, but not by New York.

The investigation found audits on Medicaid spending that were brushed aside, and reports on waste that appear to have been shelved. There have been multiple warnings from watchdog agencies in New York and in Washington that indicate that the program is becoming increasingly porous. Prosecutors said state regulators had all but lost interest in bringing Medicaid thieves to justice, preferring instead to focus on recouping money through a few civil cases that have little deterrent value.

The Dentist

On the streets of Downtown Brooklyn, the young men would regularly fan out to drum up business for Fulton Gentle Family Dentistry.

"Got a Medicaid card?" one of the men shouted one day last November. "Come in and get your free CD player right now!"

But inside the office at 575 Fulton Street, Dr. Dolly Rosen seemed to make money whether or not the barkers did their job. She simply invented the dental work she did, according to state prosecutors alerted by The Times, and then billed it to Medicaid. And the breadth of her deception was enormous, the prosecutors said.

In 2003, less than two years after joining Medicaid, Dr. Rosen and an associate reaped $5.4 million, more than the amounts garnered by 98 percent of providers of all types in the entire New York program, according to the analysis of Medicaid billings.

Dr. Rosen claimed to be doing thousands of procedures every month, far more than any group of dentists could possibly perform, according to the analysis and interviews with dental experts.

In September 2003, she charged Medicaid roughly $725,000 for 9,500 individual dental procedures, many of them expensive and complicated, such as filling cavities that had rotted away much of the tooth. On a single day that month, she billed for 991 procedures, or more than 100 an hour in a typical workday.

In criminal complaints, an investigator said that more than 80 percent of the procedures for which the dental office billed were not performed, were unnecessary or were improper.

Dr. Rosen, who is 48 and lives in Manhattan, was licensed in 1995 and joined the Medicaid program in 2002. Since then, she has billed taxpayers more than $7 million.

She and her lawyer, Jeffrey A. Granat, would not comment.

The allegations of fraud in this case involved dentistry, but in the world of New York Medicaid, this kind of scheme is not unusual in any specialty, although it rarely occurs on such a scale. Many doctors, clinics, pharmacists and other providers routinely exaggerate their billings, investigators say, often claiming to do more work than they really performed, or substituting an expensive procedure for a minor one. Others invent visits that never occurred.

"This is an age-old problem in New York," said Professor Malcolm Sparrow of Harvard,

who has written extensively on health care fraud.

Albany stood by as Dr. Rosen's Medicaid billings went from zero in 2001 to $4 million in 2003, according to the analysis of her billing records.

Her 2003 billings were by far the highest of the 50,000 dentists or doctors in New York Medicaid -- $1 million more than those of the next highest, the records show.

Dr. Rosen had an associate in the Brooklyn office, Dr. Alex Silman, who sent his own bills to Medicaid. His billings showed a similar spike, rising to $1.4 million in 2003 from $115,000 in 2002, records show.

The Department of Health and the state attorney general's office blamed each other for failing to stop Dr. Rosen and Dr. Silman. The department said it had alerted the office that it should investigate possible improprieties with their practices. The office said the department had botched its inquiry.

Last fall, The Times brought its findings on Dr. Rosen and Dr. Silman to the attention of the Medicaid Fraud Control Unit, which is in the state attorney general's office. On March 24, prosecutors in the unit had Dr. Rosen and Dr. Silman arrested.

This month, the two were indicted on charges of first-degree grand larceny, each accused of stealing more than $1 million from the program. Another associate, David Ibragimov, who handled billing for the office, was also indicted. All three have pleaded not guilty.

The Times found Dr. Rosen's extraordinary billings using a laptop computer and commonly available software after spending a few hours studying New York Medicaid billings. And she was only one of scores of medical providers who turned up in the search with similar spikes in revenues, including three Brooklyn pharmacies, a Manhattan doctor and a Queens medical supply company. None had even been audited by the state.

The AIDS Drug

The woman said her name was Pamela Borden, but it was not. She told the doctor that she had AIDS and had been losing weight rapidly, but she did not have AIDS and was overweight. Yet when she walked out of Dr. Mikhail Makhlin's Brooklyn office in February 2002, she was clutching a prescription for a very expensive synthetic growth hormone intended to treat wasting syndrome, a side effect of AIDS.

The cost of the drug, entirely borne by taxpayers, was $6,400 a month.

The woman's real intention for the synthetic hormone, Serostim, had nothing to do with AIDS. Serostim is highly sought in a thriving black market among bodybuilders, who use it like a steroid to bulk up.

And Dr. Makhlin wrote far more prescriptions for Serostim than any other Medicaid doctor in the state, more than even prominent AIDS specialists with large practices. From 2000 to 2003, Dr. Makhlin prescribed 12 percent of all the Serostim purchased by New York

Medicaid, costing the program $11.5 million, according to the Times analysis of Medicaid billings.

Medical records and interviews with state officials suggest that the woman's visit was part of an elaborate series of scams involving Serostim that stole tens of millions of dollars from New York Medicaid, long after other states realized what was going on. In 2000, New York Medicaid paid $7 million for Serostim, but the following year, after the schemes took off, the state spent $50 million on the drug.

The money was spent despite national publicity that had led other states to realize that Serostim was being abused, and to begin reining in their spending on the drug. Florida, for example, put restrictions on Medicaid payments for Serostim in 1997. The same year, federal officials broke up a Medicaid fraud ring that recruited people from Washington Square Park and paid them $20 to $50 to get Serostim illegally.

At the Health Department, Mr. Whalen and his aides described the department's handling of the drug as a success. They said they had detected the increase in Serostim prescriptions and required doctors to get special approval to prescribe the drug after January 2002. But billing records show that Dr. Makhlin wrote 80 percent of his Serostim prescriptions after the restrictions were adopted.

Serostim was approved in the mid-1990's to treat wasting syndrome, a side effect of AIDS. It is injected under the skin and causes a significant increase in lean body mass and weight.

The drug's manufacturer, Serono Laboratories, is the subject of an extensive federal criminal investigation into whether its executives paid kickbacks to doctors to prescribe Serostim. The company said it was cooperating with the inquiry.

Federal authorities would not say whether Dr. Makhlin had been questioned in the federal inquiry. What is clear is that Dr. Makhlin played a pivotal role in the epidemic of Serostim abuse on the East Coast. Even now, he retains his Medicaid privileges and medical license, and has not been a subject of a state criminal inquiry.

Dr. Makhlin, who was educated in Russia and arrived in New York in 1989, maintains that he was unwittingly duped by a parade of patients he tried to help, and that he received no benefit for prescribing a drug he considered necessary. But he and his lawyer, Nathan Dembin, will not explain how he ended up prescribing far more Serostim under Medicaid than any other doctor in the state. Thirty of his patients each received more than $100,000 worth of the drug.

The State Department of Health did not try to discipline Dr. Makhlin until late 2003, seeking to suspend him from the program for five years and fine him $164,000. But Dr. Makhlin has successfully fought the penalties, and retains his Medicaid privileges while an administrative law judge in the department weighs his case.

"I did not intentionally or knowingly violate any Medicaid regulations," Dr. Makhlin said in court papers. "I was simply exercising my best medical, professional judgment."

It was not until 2004 that the amount of Serostim purchased by New York Medicaid returned to where it was before the spike.

The true identity of the woman who received the prescriptions from him in February 2002 will probably never be known. The real Pamela Borden was found in Brooklyn and said her Medicaid card had been stolen in late 2001. She said no one from the state had contacted her about Dr. Makhlin.

The Ambulettes

With an immense public transit system and fleets of taxis and car services, New York is one of the nation's easiest cities to get around in, even for the old and the sick. But instead of reimbursing patients for a $2 bus ride to their doctor's office, or a $10 fare for a car service, Medicaid typically pays $25 or $31 each way for these rides, and it adds up.

New York Medicaid paid far more than any other state to get patients to hospitals and doctor's appointments: $316 million in 2003. The state accounts for about 15 percent of all the nonemergency Medicaid transportation spending in the country, according to a 2001 report by the Community Transportation Association of America, and spends more than the next three states -- California, New Jersey and Florida -- combined.

The largest chunk of the $316 million spent on transportation went to some 450 ambulette services, about a fifth of which are clustered in Brooklyn.

And much of that spending appears to be entirely unnecessary.

That was clear on a recent afternoon in southern Brooklyn, when an elderly woman strolled out of a doctor's office and clambered into the front seat of a van owned by M.J. Trans Corporation, a medical transport company that billed Medicaid for more than $2 million last year. After a 25-minute ride across the borough, she got out in front of her apartment, again without help, and walked inside.

The van is called an ambulette, and Medicaid is supposed to pay for it only when a patient cannot walk without help or requires a wheelchair. In fact, the state refers to the service as an "invalid coach." But on three days spent following M.J. vans over several months, a Times reporter found that almost all of the company's passengers walked easily, without assistance. The pattern was repeated as recently as last month.

Many doctors, therapists and clinics regularly order ambulette transportation for their patients when cheaper alternatives should have been used instead, according to a 2003 audit of Medicaid transportation expenses in New York City by the state comptroller, Alan G. Hevesi.

The state has known about abuses in the ambulette industry for years, and about the neighborhoods where kickbacks and other questionable activity takes place. In the early 1990's, regulators discovered that a quarter of the entire state's transportation billings were coming from Brighton Beach, Brooklyn, where a few companies had cornered the market with an elaborate set of kickback arrangements, according to a 1996 report on waste in the industry by the New York City public advocate's office. The report, along with others on the industry, suggested that many

ambulette services billed Medicaid for rides that were never delivered.

But even though these schemes date back years, government records show that the state has spent almost no time looking into the ambulette industry. Prosecutors and outside auditors say that fraud, including the kind in which van services pay kickbacks to medical offices that order rides, remains rampant.

Only five ambulette providers who billed Medicaid in the 2004 state fiscal year had even a portion of their billings audited by state officials, according to state records.

Mr. Whalen, the senior state health official, maintained that the industry was properly regulated, adding that in an effort to detect fraud, the department had begun requiring providers to supply more information on their operations. "Transportation and ambulettes are on our radar screen as an active area of inquiry," he said.

One of the ambulette companies that has never been audited is M.J. Trans, though it had more billings per vehicle than almost any other of its size in the state. Its Medicaid billings jumped to more than $2 million annually in 2004 and 2003 from $700,000 in 2001.

Yuri Levitas, a manager at the ambulette company, said none of its billings were illegal or improper.

"We do only legal business," he said.

In fact, an analysis of its Medicaid billings raises questions about whether the company is abusing the system, or possibly allowing individual patients and doctors to do so. The records indicate that the company has business relationships with medical practices in southern Brooklyn that often bill Medicaid for what seem an inordinate number of trips.

A doctor at a pair of clinics that specialize in pain relief and massage therapy often ordered more than 90 trips a day, as did a colleague of his.

At another doctor's office, Medicaid was billed 153 times by M.J. for transporting a single passenger in 2003, or essentially two or three times a week for an entire year. Another recipient went 152 times. Still others made the trip in M.J. vans more than 130 times.
M.J. Trans said most of those rides were ordered by the office for recipients receiving physical therapy there.

"They order, and we go," Mr. Levitas said, adding that he was not responsible for ensuring that the rides were necessary.

Several physical therapists expressed skepticism that anyone would need so much therapy.

"There is always the difficult or complicated case here and there that requires extensive and intensive therapy, but as a general rule, 153 visits would seem excessive," said Gabriel E. Yankowitz, a physical therapist for more than two decades and an official with the New York Physical Therapy Association.

But Gail Bednik, the manager of the office, at 280 Quentin Road in Gravesend, that is in the records as having ordered the 153 rides, said there was nothing surprising about the patients who took scores of ambulettes annually at taxpayer expense.

"It's old people," Ms. Bednik said. "They want to come every day because they're bored at home."

The School Districts

In just a few hours on a single day in September 2000, a senior official in the Buffalo school system wielded a rubber signature stamp and cost millions of dollars in questionable Medicaid payments for children.

Her name was Sheryl Carswell, and at the time she was Buffalo's director of special education. Moving her rubber stamp with assembly-line speed that day, she put 4,434 special-education students on the Medicaid rolls by recommending that they receive speech therapy, according to a federal audit. That represented nearly 60 percent of the district's special-education population, roughly twice the national average of special-education students who require speech therapy.

Yet she had not evaluated more than a few of those 4,434 students, according to the audit, issued by the inspector general of the federal Department of Health and Human Services, nor had she reviewed their case files.

Ms. Carswell was not stealing the money for herself or maliciously abusing the system. Instead, she was doing business in a way that has become increasingly common in Buffalo, New York City and around the state, collecting millions of Medicaid dollars for her school district by putting students into health and speech programs, often without any apparent effort to see if the students really needed them.

All told, the schools in New York State misspent $1.2 billion in Medicaid payments on speech services from 1993 to 2001, federal audits concluded.

In an interview, Ms. Carswell said she was simply following longstanding school procedures. "I just filled out the paper," she said. "Nobody bothered me about it."

Since 1990, schools in New York have been able to bill Medicaid for speech, hearing, and other school health services, and the state has become the most aggressive in the nation at taking advantage of this benefit. Around the state, school districts short on cash discovered in Medicaid a new revenue source. As a result, in recent years, school health services have become an $800 million annual expense, rising to the point that New York accounts for 44 percent of this type of Medicaid spending nationally, according to federal statistics.

Licensed speech professionals quickly realized what was happening, and many have complained that schools are cutting corners and using the funds to pay for services that have nothing to do with helping poor children speak or hear better. "We have been seeing a lot of very suspicious billing practices in New York," said James G. Potter, director of government relations and public policy at the American Speech-Language-Hearing Association, which has 118,000

members. "At times, folks in the schools have been just plain making it up out there when it comes to billing."

This spending was routinely approved by the state, but the federal government was not as credulous. The questionable spending touched off two audits in 2002 by the inspector general, and a civil inquiry by the federal Department of Justice.

In an audit released last month, the inspector general revealed that in New York City schools, 86 percent of the Medicaid claims that were paid from 1993 to 2001 lacked any explanation for why the services had been ordered or violated other program rules. In Buffalo and other upstate schools, the auditors concluded that the figure was 56 percent for the same period, according to a report released last year.

The audits should not have come as a shock. In the mid 1990's, a private consultant told New York City school officials that their record-keeping was in such disarray that 51 percent of attendance forms for speech students could not be found. Yet school officials did not change their practices, according to the subsequent audit.

When the upstate school districts found out about the audits in 2002, some tried to cover their tracks, the inspector general found. Digging through their filing cabinets, they backdated records to justify Medicaid spending for services performed as many as eight years earlier.

Now, after the audits, federal officials say Washington is likely to begin demanding its money back, and so this misuse of Medicaid money could haunt either the districts that spent it, or the state, or both. Many districts are worried that the repayment could devastate their education budgets.

School officials, including those in New York City, have sharply disputed the audits, and called for them to be withdrawn.

The Justice Department suspended its civil inquiry after complaints from Senator Charles E. Schumer, Democrat of New York, and other politicians, and federal health officials have agreed, for now, not to seek restitution from school districts. But the state itself could still be liable, and could then in turn penalize the districts.

Pataki administration officials say Washington has never been clear about what kind of school services it will pay for and how children should be referred to these programs, accusing Washington of changing the rules.

"There is no question that school districts actually provided health services to poor, disabled children," wrote Kathryn Kuhmerker, a deputy health commissioner, in her response to the upstate audit.

The state, however, did not meet its responsibility to make sure the money was properly spent, the federal audit found. The State Health Department reviewed the books of the Buffalo district only once from 1993 to 2001, and told the district its records were "well organized."

The Executives

Among the biggest beneficiaries of the Medicaid program have been executives of the state's nursing homes and clinics, many of whom earn substantial salaries and profits from the program.

According to records obtained from the Health Department under the Freedom of Information Law, 70 executives of nursing homes and clinics personally made more than $500,000 in 2002, the last year for which figures are available. Twenty-five executives made more than $1 million.

For the nursing home executives, that money was earned in salaries and profits, most of which came directly from the daily fee that Medicaid pays for caring for each low-income patient, usually in the range of $200. Salaries are earned by employees of the homes, and profit is earned by owners, although owners are often executive directors or chief executives of the homes, allowing them to benefit in both ways.

Consider three homes in the Bronx. The operator of the Laconia Nursing Home, which receives 90 percent of its revenues from Medicaid, earned $3 million in salary and profit. At the Grand Manor Nursing Home, also 90 percent financed by Medicaid, the operator and three family members earned a total of $2.4 million in salaries and profit. The owner and operator of the Morris Park home, 75 percent financed by Medicaid, took in $1.5 million in salary and profit.

Advocates for nursing home residents acknowledge that the homes' operators and executives are entitled to make decent profits and salaries. But the advocates insist that it is unseemly for the profits and salaries to reach such high levels, given what the advocates contend is the industry's longstanding record of poor care. They point out that at New York nursing homes, the staffing levels are lower than the national average, a crucial indicator. All three of the Bronx homes have staffing levels lower than the national average, according to federal statistics.

"It's unconscionable to give yourself high salaries and not give some more money to hire people so some of these quality problems can be dealt with," said Cynthia Rudder, executive director of the Long Term Care Community Coalition, an advocacy group for nursing home residents.

Trade groups representing nursing homes counter that most homes in the state are actually in financial distress because Medicaid does not pay enough.

Many hospital executives in New York also receive high salaries, but hospitals earn significant revenues from sources other than government social programs, including H.M.O.'s and private insurance. The 550 public, private and nonprofit nursing homes around the state, by contrast, earn more than two-thirds of their revenues from Medicaid, taking in roughly $6 billion last year from the program, according to state records. Many clinics receive most of their revenues from Medicaid as well.

Morris Berkowitz, operator of the Morris Park home, said he deserved his profits because he worked long hours and provided excellent care.

"Do you know how much I have invested in this place?" he said. "A lot of money. And I am constantly investing in this place."

Earlier this year, after residents repeatedly wandered from Morris Park, federal and state officials accused the home of grievously poor supervision, and it was fined $86,000.

Mr. Berkowitz said the home had done nothing wrong. "It was a political thing, and we got caught up in it," he said. "People with power, they abuse their power."

Martin Liebman, operator of Grand Manor, said it was misleading to focus on salaries and profits.

"This is a family-owned business," said Mr. Liebman, an officer of the state trade group of private nursing homes. "I'm third generation in the business. We have taken care of thousands of residents and given quality care for many, many years."

Barry Braunstein, operator of the Laconia home, did not respond to three calls seeking comment.

Besides their high salaries, some executives profiting from Medicaid were also taking part in another tradition: cheating the program.

In 2002, the two owners of the AllCity Family Healthcare clinics in Brooklyn collected a total of $1.4 million in salaries, according to state records. Last year, the company was forced to return $6 million to the state, and one of its owners, Rossia Pokh, pleaded guilty to grand larceny in a case brought by the attorney general.

At the AllCity clinics, it turns out, thousands upon thousands of the Medicaid claims were fraudulent.

Medicaid in New York

This is the first of a series of articles that will examine the security, the effectiveness and the cost of New York's Medicaid program, the largest of its kind in the nation and the state's biggest expense.

Tomorrow: How the state's protections against fraud have grown increasingly frail.