HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1257 Medicaid Fraud
SPONSOR(S): Bilirakis
TIED BILLS: None. **IDEN./SIM. BILLS:** CS/SB 1064 (s), HB 1811 (s)

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Services (Sub)	8 Y, 0 N	Garner	Collins
2) Health Care			
3) Public Safety & Crime Prevention			
4) Public Safety Appropriations (Sub)			
5) Appropriations			

SUMMARY ANALYSIS

Medicaid fraud and abuse have been a high profile problem in recent years. Dollars are drained off through fraud which should be used to benefit those people the Medicaid program was designed to benefit. Fraud can be perpetrated by Medicaid providers, non-Medicaid providers, clinics, pharmacists, drug companies, Medicaid recipients, and industrious entrepreneurs.

The level of fraud, abuse and error in the Medicaid program has been estimated from between 5% and 20% of all Medicaid payments. In 2002, the Agency for Health Care Administration completed a scientific study and found that 6.25% of its sampled claims were paid in error. This study was unable to separate this into a percentage of fraud versus abuse versus simple error, and in fact, may have not captured the effect of fraud because of its illicit nature.

To address these concerns, the Legislature has enacted a number of laws to prevent, deter, detect, and recover funds lost to fraud, abuse and error, including fines and other penalties, as well as criminal prosecution.

HB 1257 expands the ability of the Office of the Attorney General to investigate and prosecute cases involving Medicaid provider and recipient fraud, especially as it relates to prescription drugs. The impetus for the bill is the report of the Seventeenth Statewide Grand Jury report issued in December 2003. The Grand Jury report found widespread prescription drug diversion and adulteration by both Medicaid providers and recipients.

The bill increases penalties related to Medicaid fraud to the extent of allowing the Attorney General to use racketeering charges against perpetrators of Medicaid Fraud. One of the most significant aspects of the bill is that non-Medicaid providers are prohibited from writing prescriptions for Medicaid recipients, except for cases of bona fide emergencies. The bill also requires the Agency for Health Care Administration to enroll Medicaid recipients in “lock-in” programs, especially in pharmacies.

AHCA estimates that the effect with regard to recovery of overpayments, imposition of monetary sanctions, and Medicaid program cost savings is unknown but expected to be favorable to the Medicaid program. The agency’s fiscal analysis provided no revenue or expenditure effects related to the bill, except for the previous statement.

The bill provides an effective date of July 1, 2004.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. DOES THE BILL:

1. Reduce government?	Yes[]	No[X]	N/A[]
2. Lower taxes?	Yes[]	No[X]	N/A[]
3. Expand individual freedom?	Yes[]	No[X]	N/A[]
4. Increase personal responsibility?	Yes[]	No[]	N/A[X]
5. Empower families?	Yes[]	No[]	N/A[X]

For any principle that received a "no" above, please explain:

1. This bill expands the regulatory and oversight abilities of both the Office of the Attorney General and the Agency for Health Care Administration.

2. This bill may require additional funds to implement the oversight and regulatory activities of these two entities, or require funds to be moved from a current funding source.

3. This bill expands the role of government in Medicaid providers' and recipients' behavior.

B. EFFECT OF PROPOSED CHANGES:

HB 1257 expands the ability of the Office of the Attorney General to investigate and prosecute cases involving Medicaid provider and recipient fraud, especially as it relates to prescription drugs. The impetus for the bill is the report of the Seventeenth Statewide Grand Jury report issued in December 2003. The Grand Jury report found widespread prescription drug diversion and adulteration by both Medicaid providers and recipients.

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PRESENT SITUATION

Medicaid fraud and abuse have been a high profile problem in recent years. Dollars are drained off through fraud which should be used to benefit those people the Medicaid program was designed to benefit. Fraud can be perpetrated by Medicaid providers, non-Medicaid providers, clinics, pharmacists, drug companies, Medicaid recipients, and industrious entrepreneurs.

The level of fraud, abuse and error in the Medicaid program has been estimated from between 5% and 20% of all Medicaid payments. In 2002, the Agency for Health Care Administration completed a scientific study and found that 6.25% of its sampled claims were paid in error. This study was unable to separate this into a percentage of fraud versus abuse versus simple error, and in fact, may have not captured the effect of fraud because of its illicit nature.

To address these concerns, the Legislature has enacted a number of laws to prevent, deter, detect, and recover funds lost to fraud, abuse and error, including fines and other penalties, including criminal prosecution.

The Office of the Attorney General's Medicaid Fraud Control Unit (MFCU) and the Agency for Health Care Administration (AHCA) with have been working together in cooperation to combat fraud and abuse in all aspects of the Florida Medicaid program. The MFCU is responsible for investigating and

prosecuting Medicaid fraud. The AHCA Program Integrity Unit is responsible for coordinating Medicaid overpayment and abuse prevention, detection, and recovery efforts.

STATEWIDE GRAND JURY REPORT

On December 4, 2003, the Seventeenth Statewide Grand Jury released a report on recipient fraud in Florida's Medicaid program. The Grand Jury studied the diversion of tens of millions of Medicaid dollars worth of prescription drugs by large numbers of Medicaid recipients. The Statewide Grand Jury found that there are few, if any, consequences to Medicaid recipients who sell their expensive medications to illegal drug wholesalers. According to the report, efforts to deal with the problem of recipient fraud have been hampered by the lack of effective state statutes, federal limitations that restrict Florida's attempt to control this fraud, and a lack of awareness by some state and federal officials of the extent of the problem of recipient fraud. The result is the waste of hundreds of millions of dollars, exploitation of Medicaid recipients, and the tainting of our supply of critical lifesaving medication. Accordingly, the Statewide Grand Jury further found that "the societal cost of this illicit trade in pharmaceuticals cannot be overstated."

The Statewide Grand Jury discussed the fact that the proliferation of infusion clinics has provided another way for Medicaid recipients to sell their drugs. Some infusion clinics recruit Medicaid recipients by offering them a small payment. The recipient is directed to a particular pharmacy, which then delivers the drugs in smaller doses (rather than one dose) directly to the clinic. The clinic turns around and sells the remaining doses on the black market. The pharmacy, however, bills Medicaid for all of the doses of drugs. The clinic then infuses perhaps one dose of the diluted drugs or in some instances, unbeknownst to the patient, simply infuses saline solutions into the Medicaid recipient. The clinic profits from the re-sale of the diverted drugs; and while the Medicaid recipient receives a small bribe for his or her participation, the patient is oftentimes not receiving any of the drugs that are medically appropriate. Thus, the losses are two-fold. First, some Medicaid recipients are receiving bad health care. Second, tax dollars that could be used elsewhere are being used to pay providers and recipients for drugs that are prescribed, bought, sold, and used fraudulently.

The Statewide Grand Jury reviewed how some criminals have recruited Medicaid recipients to pretend to have AIDS by using imposters to take blood tests for them. One such Medicaid recipient received over $600,000 in AIDS medications by falsely claiming to have AIDS. In some instances, corrupt labs either exaggerate a Medicaid recipient's illness or completely falsify lab reports to come up with a phony AIDS diagnosis. Though these are often not Medicaid approved labs, Medicaid does accept lab reports from non-Medicaid labs to document the diagnosis. AHCA does not require a second opinion or follow-up lab work to verify the initial diagnosis.

The Statewide Grand Jury concluded, "While drug diversion is only part of that fraud, the other societal costs of diversion – dollars lost to the system, the exploitation of recipients, the tainting of our pharmaceuticals – leaves too much at stake for Florida taxpayers to be content to chase after the fraud. The Agency for Health Care Administration must make greater efforts to get ahead of this fraud and stop it before it starts. We are confident that the Legislature will recognize the seriousness of the problems that we have identified and will be supportive of Agency for Health Care Administration's efforts to address this fraud with renewed vigor."

At the conclusion of the report, the Statewide Grand Jury issued a series of recommendations to the Florida Legislature and to the Agency for Health Care Administration (AHCA). Many of these proposals can be accomplished under current state and federal law. Some, however, require changes to state law, while others could be realized after changes to federal law.

Grand Jury Recommendations to the Legislature

- Criminalize the sale of Medicaid drugs by recipients making an offense of Medicaid fraud under Chapter 409.
- Criminalize the purchase of Medicaid drugs from a recipient and tie the degree of felony to the value of drugs.
- Give AHCA the authority to enroll recipients in the disease management or drug benefit/management program, where there is evidence they have engaged in fraud or abuse against Medicaid in conjunction with, or as an alternative to, a lock-in program and clarify that enrollment of recipients in categories listed in the statute is mandatory.
- Explore the option of privatizing the provision of pharmacy services for Medicaid recipients.

Grand Jury Recommendations to AHCA

- Recipients who abuse or defraud the Medicaid program should have all of their Medicaid services locked in to one provider for each category of service. Recipients should be locked in for a period of one year the first time they are found to be defrauding the Medicaid system and three years the second time they are caught.
- AHCA should seek authority from the Federal Centers for Medicare and Medicaid Services and the Florida Legislature to terminate the eligibility of recipients who are found to be abusing or defrauding the Medicaid system for the third time.
- The Recipient enrollment form should be amended to include an agreement that recipients may lose their eligibility for abusing or defrauding the Medicaid program.
- Prohibit Medicaid from reimbursing for drugs, goods, or services prescribed by non-Medicaid providers and prohibit Medicaid from reimbursing for medications infused by non-Medicaid providers.
- Medicaid should require a second opinion by a Medicaid enrolled physician to confirm all diagnoses of serious medical conditions such as HIV/AIDS, cancer, etc.
- Broaden Medicaid's restrictions and pre-authorizations to simultaneously include all drugs within a class likely to be diverted.
- Require Medicaid cards to be presented and swiped electronically before receiving medications and/or services.
- Require inclusion of recipient's photograph on Medicaid cards.
- Mail Explanation of Benefits forms to all recipients so that they can be alerted to all billings made under their Medicaid number.
- Mail information about infusion clinics to recipients receiving infusion services.
- Survey other states' program integrity units and determine what steps they have taken that have been successful in curbing recipient fraud such as software applications for detecting over-utilizations.
- Encourage Medicaid to improve communications and information sharing with all agencies involved in anti-fraud efforts.

OFFICE OF THE ATTORNEY GENERAL'S MEDICAID FRAUD CONTROL UNIT

Section 16.59, F.S., creates the Medicaid Fraud Control Unit (MFCU) within the Department of Legal Affairs. The unit is authorized to investigate all violations of s. 409.920, F.S., relating to Medicaid provider fraud, and any criminal violations discovered during the course of those investigations. The unit is authorized to refer any criminal violation to the appropriate prosecuting authority. As part of ongoing investigations, MFCU may request physician's accounts or records if MFCU suspects fraud. Currently, the statute does not allow MFCU to request a physician's accounts or records if MFCU suspects patient neglect or abuse, or theft of patient funds.

At present, MFCU is not included in the list of agencies that form unlicensed assisted living facility working groups at local AHCA field offices. Since MFCU now has federal investigative authority over

such facilities, MFCU should be included in the group of agencies. Further, MFCU's state statutory right of entry found in s. 409.920(8)(a), F.S., is limited to the premises of providers participating in the Medicaid program. Recent amendments to MFCU's federal investigative authority [see 42 U.S.C.A.1396b(q)(4) and 42 CFR, 1001.1301(a)(1)(iv)], however, extended MFCU's authority to investigate complaints of patient abuse and neglect to all health care facilities that provide basic nursing care services or personal care services, regardless of whether the facility receives Medicaid funds or not.

For the past several years, MFCU has lead and participated in Operation Spotcheck, an operation where multi-agency teams perform unannounced inspections at nursing homes, assisted living facilities, and other similar health care premises around Florida. As part of the Spotcheck protocol, MFCU investigators ask permission for the team to enter the premises prior to the inspection. Permission has not yet been refused by any provider, however, there is the possibility that an administrator will refuse to allow MFCU or the Spotcheck team on the premises.

OFFICE OF STATEWIDE PROSECUTION

The Office of Statewide Prosecution is authorized to investigate and prosecute multi-circuit organized crime. The office utilizes a police/prosecutor team approach in multi-offender, multi-offense, multi-jurisdictional criminal cases. The goal of the teams is to dismantle the organizations through effective prosecution and civil, administrative, and regulatory sanctions where appropriate.

In order for the Statewide Prosecutor to handle a case, the crime must have occurred in more than one judicial circuit or be part of a conspiracy affecting more than one judicial circuit, and it must be one of the offenses enumerated in the law: bribery; burglary; usury; extortion; gambling; kidnapping; theft; murder; prostitution; perjury; robbery; home-invasion robbery; car-jacking; narcotics violations; antitrust violations; anti-fencing violations; crimes involving fraud and deceit; computer crimes; racketeering; and attempts, solicitations, or conspiracies to commit these offenses. The cases are filed where the majority of offenses are committed, where the criminal organization's center is operational, or where the case is allowed to be tried by general venue law. Currently, the office does not have specific authority to investigate and prosecute any criminal violations of ch. 409, F.S. The Statewide Prosecutor serves as the legal adviser to the Statewide Grand Jury, which is supervised by the Florida Supreme Court. The jurisdiction of the Statewide Grand Jury does not include violations of ch. 409, F.S.

REGULATION OF MEDICAID PROVIDERS

Section 409.920, F.S., contains provisions related to Medicaid provider fraud, and requires the Attorney General to conduct a statewide program of Medicaid fraud control. The duties of the program include investigation of possible criminal violations pertaining to the administration of the Medicaid program, in the provision of medical assistance, or in the activities of Medicaid providers. The Attorney General is required to investigate alleged abuse or neglect of patients in health care facilities receiving Medicaid payments, and misappropriation of patient's private funds in facilities receiving Medicaid payments, in coordination with AHCA. The Attorney General is required to refer all suspected abusive activities not of a criminal nature to AHCA, as well as each instance of overpayment which is discovered during the course of an investigation.

Section 409.913(28), F.S., enacted in the 2002 legislative session, gives Agency for Health Care Administration (AHCA) and the Medicaid Fraud Control Unit (MFCU) the authority to review Medicaid-related records to determine and reconcile a provider's total output of goods or services against Medicaid billings, notwithstanding any other law. To determine a provider's total output of goods and services, Medicaid and non-Medicaid records need to be examined. If a provider's total output of goods and services cannot be determined, reconciliation of whether or not the provider had adequate inventory to support their billings to the Medicaid program can not be completed. This prevents MFCU from developing evidence to determine whether or not Medicaid fraud has been committed.

Presently, non-Medicaid providers may write prescriptions for Medicaid recipients. Thus, a provider who is terminated from the Medicaid program, regardless of the egregiousness of the basis for termination, may continue to take actions that result in enrolled providers submitting claims to Medicaid. For example, a physician who has been terminated from the Medicaid program may continue to prescribe medications if they remain licensed to practice in Florida. Those prescriptions may then be filled at a pharmacy that is an enrolled Medicaid provider and billed to the Medicaid program.

STATE vs. GABRIEL HARDEN, ET AL., (FLA. 3RD DCA 2004)

In a January, 2004, ruling, the Third District Court of Appeal held that s. 409.920(2), F.S., the Medicaid provider fraud statute, is unconstitutional under the supremacy clause of the U.S. Constitution (Art. VI, c1.2). Section 409.920, F.S., makes certain specified activities relating to Medicaid claims unlawful and declares violations to be a third degree felony. The State of Florida charged Gabriel Harden and nine other defendants with violating the "anti-kickback" provision of s. 409.920(e), F.S., by paying drivers for the "solicitation of transportation" of Medicaid-eligible children to dental facilities for treatment. Those drivers were allegedly employed by three corporate entities providing dental services to children. In dismissing the state's complaint, the trial court in Miami-Dade County held that s. 409.920(2), F.S., was preempted by the federal Medicaid Act and a federal rule. On appeal to the Third District Court of Appeals, the state argued Florida's anti-kickback statute did not conflict with the federal version and that there was no preemption under the Supremacy Clause of the U.S. Constitution.

The federal Medicaid anti-kickback statute, 42 U.S.C. 1320-7b, does not apply to compensation paid through a bona fide employment relationship and expressly protects such arrangements from prosecution. In contrast, Florida's anti-kickback statute does not have a "safe harbor" provision for such conduct. The federal anti-kickback statute also contains a "knowing and willful" mens rea requirement. Florida's anti-kickback statute (s. 409.920(1)(d) and (2), F.S.) only requires that the defendant act "knowingly." Therefore, because Florida criminalizes conduct that is protected under federal law, the Third District Court of Appeal affirmed the trial court's decision by holding s. 409.920, F.S., violates the Supremacy Clause.

C. SECTION DIRECTORY:

Section 1. Creates s. 409.9201, F.S., making it unlawful to sell or attempt or conspire to sell, or to purchase or attempt or conspire to purchase, certain Medicaid program prescription drugs; making it unlawful to make certain false statements to obtain certain Medicaid program goods or services; provides criminal penalties; and providing a definition.

Section 2. Creates s. 812.0191, F.S., providing definitions; making it unlawful to deal in property paid for under the Medicaid program; making it unlawful to engage in activities to obtain or traffic in such property; and provides for criminal penalties.

Section 3. Amend s. 409.912, F.S., requiring the Agency for Health Care Administration to manage drug therapies for certain patients; and requires mandatory enrollment of certain persons in the Medicaid drug benefit management program.

Section 4. Amends s. 409.913, F.S., restricting unauthorized physicians from prescribing medications to certain patients; provides exceptions; restricts health care vendors from knowingly filling such prescriptions; provides for reimbursement; provides for civil penalties; and restricts the agency from reimbursing certain claims.

Section 5. Amends s. 16.56, F.S., expanding the authority of the Office of Statewide Prosecution to investigate and prosecute certain additional offenses.

Section 6. Amends s. 895.02, F.S., expands the definition of the term "racketeering activity" to include certain additional offenses.

Section 7. Amends s. 905.34, F.S., expands the subject matter jurisdiction of the statewide grand jury to include certain additional offenses.

Section 8. Amends s. 409.9071, F.S., revising cross references.

Section 9. Amends s. 409.9131, F.S., conforming language.

Section 10. Provides an effective date of July 1, 2004.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   See Fiscal Comments section.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill's higher criminal penalties associated with Medicaid fraud, especially as they relate to the illegal diversion of prescription medications, may make some private providers hesitant to participate in the Medicaid program. This will decrease their revenue to the extent that their patient mix contains a large or smaller number of Medicaid recipients.

D. FISCAL COMMENTS:

The effect with regard to recovery of overpayments, imposition of monetary sanctions, and Medicaid program cost savings is unknown but expected to be favorable to the Medicaid program.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not require counties or municipalities to spend funds or to take an action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The Office of the Attorney General and the Agency for Health Care Administration have the necessary rulemaking authority to implement the provisions of the bill, with the possible exception of the agency's ability to prevent non-Medicaid physicians from writing prescriptions for Medicaid recipients.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On March 30, 2004, the Subcommittee on Health Services adopted an amendment and reported the bill favorably to the Committee on Health Care. The amendment contained the following:

Amendment #1 – Specifies providers that would be excluded for the prohibition against non-Medicaid provider prescribing goods and services for Medicaid recipients.