HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1811 (PCB HC 04-01) Medicaid Fraud and Abuse
SPONSOR(S): Committee on Health Care and Farkas
TIED BILLS: None. **IDEN./SIM. BILLS:** CS/SB 1064 (s)

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care	20 Y, 0 N	Garner	Collins
2)			
3)			
4)			
5)			

SUMMARY ANALYSIS

HB 1811 broadens the authority of the Agency for Health Care Administration (AHCA) related to combating fraud and abuse in the Medicaid program, particularly focused on prescribed drugs. The bill also gives the Medicaid Fraud Control Unit (MFCU) in the Department of Legal Affairs broader authority to pursue entities that try to defraud the Medicaid program. Most significantly, the bill:

- Authorizes the Office of Statewide Prosecution to investigate and prosecute any criminal violation of ss. 409.920 or 409.9201; F.S.;
- Requires a Medicaid applicant to forfeit their entitlement in the Medicaid program if found to have abused or defrauded the program;
- Gives AHCA the authority to require a confirmation or second physician's opinion for a diagnosis;
- Authorizes AHCA to terminate certain practitioners from the Medicaid program if they are prescribing inappropriately or inefficiently, as determined by AHCA;
- Gives AHCA the authority to mandate a recipient's participation in a provider lock-in program for a specified period of time;
- Requires the agency to seek a federal waiver to terminate the eligibility of a Medicaid recipient from the program if he or she commits a third offense of fraud or abuse;
- Allows the agency to implement provider network controls;
- Authorizes AHCA to deny payment for inappropriate, medically unnecessary, or excessive goods or services;
- Authorizes AHCA to seek any remedy provided by law when false or a pattern of erroneous claims are submitted;
- Clarifies provider suspension or termination from the Medicaid program;
- Authorizes AHCA to withhold payment to a provider upon receipt of evidence of fraud or abuse under Medicaid;
- Authorizes AHCA to deny payments or require repayments to a provider terminated or suspended from the Medicaid or Medicare program by the Federal government or any state;
- Authorizes AHCA to implement amnesty programs;
- Authorizes AHCA to limit, restrict, or suspend Medicaid recipient eligibility for a period of time;
- Makes it unlawful to knowingly use or endeavor to use a Medicaid provider's or recipient's identification number in the making of a claim for items or services that are not authorized to be reimbursed under the Medicaid program;
- Specifies that a Medicaid participating physician is required to make available to MFCU any accounts or records relevant to investigations of alleged abuse or neglect of patients, or to investigations of alleged misappropriation of patients' private funds;
- Establishes new criminal violations relating to Medicaid fraud;
- Provides an additional ground under which a health care practitioner who prescribes medicinal drugs or controlled substances may be subject to discipline; Deletes the requirement that AHCA give pharmacists at least 1 week's notice prior to an audit;
- Expands the definition of "racketeering activity" to include crimes relating to Medicaid;
- Provides that the Statewide Grand Jury's jurisdiction includes criminal violations of Medicaid; and
- Provides an effective date of July 1, 2004.

There could be extra revenue generated through the fines stipulated in the bill, although the extent of the fines to be levied is unknown. AHCA estimates that it will need an additional 17 FTEs in order to increase the Agency's efforts in deterring and detecting Medicaid fraud and abuse. In addition, AHCA requested funding to contract for prescribed drug cost control planning and for the development of guidelines and tools to promote cost effective drug use. The estimated cost of the positions and funding for additional fraud control activities in FY 2004-2005 is $1,690,478.

STORAGE NAME: h1811.hc.doc
DATE: March 23, 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[X]	No[]	N/A[]
5. Empower families?	Yes[]	No[]	N/A[X]

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

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

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 will expand the role of government in the Medicaid recipient's behavior.

B. EFFECT OF PROPOSED CHANGES:

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 Agency for Health Care Administration (AHCA) and the Medicaid Fraud Control Unit (MFCU) have been working to combat fraud and abuse in all aspects of the Florida Medicaid program. AHCA is responsible for coordinating Medicaid overpayment and abuse prevention, detection, and recovery efforts. MFCU is responsible for investigating and prosecuting Medicaid fraud.

The bill makes several statutory changes broadening AHCA's authority related to combating fraud and abuse in the Medicaid program, particularly focused on prescribed drugs. The bill also makes several statutory changes giving MFCU broader authority to pursue entities who try to defraud the Medicaid program.

PRESENT SITUATION

Medicaid is a health care program that is jointly funded by the federal, state, and county governments to provide medical care to eligible individuals. Medicaid is the largest program providing medical and health-related services to the nation's poorest citizens. Within broad national guidelines, which the federal government establishes, each of the states:

- Establishes its own eligibility standards;
- Determines the type, amount, duration, and scope of services;
- Sets the rate of payment for services; and
- Administers its own program.

The Agency for Health Care Administration (AHCA) is the single state agency responsible for the Florida Medicaid Program. The statutory provisions for the Medicaid program appear in ss. 409.901 through 409.9205, F.S. Florida's Medicaid budget for fiscal year 2003-2004 is $12.5 billion. The

Prescribed Drug portion of this budget is $2.3 billion. The Federal government currently contributes 61.88 percent of this total for Florida (58.93 percent Federal Medicaid Assistance Percentage plus a 2.95 percent supplemental through June 2004). Florida's general revenue contribution to the Medicaid Prescribed Drug program will be approximately $877 million for the state fiscal year ending June 30, 2004.

MEDICAID FRAUD AND ABUSE

Federal law requires states to establish programs designed to educate physicians and pharmacists regarding fraud, abuse, and inappropriate prescribing. In the past few years, federal and state agencies have expanded investigation and prosecution of Medicaid (and Medicare) fraud and abuse. In almost all cases, the investigations are focused on providers who may be double billing, over-billing, or charging for services not actually delivered to recipients. A 1999 General Accounting Office report on Medicaid (and Medicare) fraud and abuse suggests that this area deserves the ongoing attention of state government.

MEDICAID PROGRAM INTEGRITY

Sections 409.913 and 409.9131, F.S., prescribe the activities of AHCA related to oversight of the integrity of the Medicaid program. Staff of the Medicaid Program Integrity (MPI) section develop and use statistical methodologies to identify providers who exhibit aberrant billing patterns, conduct investigations and audits of these providers, calculate provider overpayments, initiate recovery of overpayments in instances of provider abuse, and recommend administrative sanctions for providers who have abused or defrauded Medicaid. Any suspected criminal violation identified by Agency for Health Care Administration (AHCA) must be referred to Medicaid Fraud Control Unit (MFCU) in the Office of the Attorney General. AHCA and MFCU are required to develop a memorandum of understanding which includes protocols for referral of cases of suspected criminal fraud and return of those cases when investigation determines that administrative action by AHCA is appropriate.

In an effort to assist AHCA in preventing and deterring Medicaid provider fraud and abuse, Florida's Legislature has made a number of substantive changes to state law affecting AHCA's program integrity functions since 1996. These changes include clarifying agency processes related to entering into provider agreements; and requiring follow-up reviews of providers with a history of overpayments, that certain providers post surety bonds, and that AHCA conduct criminal background checks of potential providers.

The Office of Medicaid Program Integrity is funded through federal and state revenues. With the exception of the OMNI Subsystem of the Florida Medicaid Management Information System (FMMIS), the federal match for program integrity activities is 50 percent. The federal match for the OMNI subsystem is 75 percent.

REGULATION OF MEDICAID PROVIDERS

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.

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.

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.

MEDICAID PEER REVIEW PROCESS

Certain Medicaid services are subject to utilization review by a Peer Review Organization (PRO) under contract with the Agency for Health Care Administration (AHCA). The purpose of the utilization review program is to safeguard against unnecessary and inappropriate medical care rendered to Medicaid recipients. Medical services and/or records are reviewed for medical necessity, quality of care, appropriateness of place of service and length of stay (inpatient hospital). The following Medicaid services are subject to review by a PRO:

- Inpatient Hospital Services;
- Home Health Services;
- Community Mental Health Services;
- Targeted Case Management; and
- Home and Community Based Waiver Services for the Developmentally Disabled.

The Bureau of Medicaid Program Integrity (MPI) monitors this information on an ongoing basis in an effort to control fraud and abuse. If the MPI staff suspect that there is a problem with a provider's records based on their initial review of the records, they are required to send the records to another physician to review.

There are certain procedures or types of services for which Medicaid can only reimburse on a limited basis or a certain number of times per month. If a procedure can only be performed three times in a one-month period, and Medicaid is billed a fourth time or more, the MPI staff know that this is a problem and can take the necessary measures to seek repayment for claims that exceed the three allowable reimbursements. Currently, the way the statute is written, MPI staff would have to send the records of the physician who over-billed to a peer for review, even though MPI staff knows that all they need to do is seek repayment for the unallowable claims. The current statute implies that AHCA must use its limited resources to have a practicing physician review the medical records, even where the basis of the overpayment is not within the purview of the physician's review.

MEDICAID PREPAYMENT REVIEW

The Agency for Health Care Administration (AHCA) currently has the authority under s. 409.913(3), F.S., to conduct, or contract for, prepayment review of provider claims to ensure cost-effective purchasing, billing, and provision of care to Medicaid recipients. The prepayment reviews may be conducted as determined appropriate by AHCA, without any suspicion or allegation of fraud, abuse, or neglect. The current statute does not specify the length of time the prepayment review can last or how quickly claims must be adjudicated for denial or payment, whether or not there is evidence of fraud, misrepresentation, abuse, or neglect.

WITHHOLDING OF PAYMENTS

Section 409.913(24), F.S., gives the Agency for Health Care Administration (AHCA) the authority to withhold Medicaid payments, in whole or in part, to a provider upon receipt of reliable evidence that the circumstances giving rise to the need for a withholding of payments involve fraud, willful misrepresentation, or abuse under the Medicaid program, or a crime committed while rendering goods or services to Medicaid recipients, pending the completion of legal proceedings. This section does not currently give AHCA the authority to deny payment, or require repayment, where the goods or services were furnished, supervised, or caused to be furnished by a person who has been suspended or terminated from the Medicaid or Medicare program by the Federal Government or any state.

MEDICAID AMENSTY PROGRAM

Currently, there is no amnesty program in place under the Medicaid program, and the Agency for Health Care Administration (AHCA) is without authority to institute one. Such programs would serve as an incentive for repayment by providers who would otherwise be reluctant to come forward out of fear of penalties and sanctions from AHCA.

MEDICAID PHARMACY AUDITS

Section 409.913(2), F.S., requires the Agency for Health Care Administration (AHCA) to conduct, or cause to be conducted audits to determine possible fraud or abuse in the Medicaid program. AHCA currently contracts for audits of pharmacies to determine compliance with Medicaid policy, rules and regulations. Under this contract, all audits are conducted or supervised by a pharmacist licensed in the State of Florida. During the 2003 Legislative Session, CS/CS/SB 1428 passed requiring AHCA to give pharmacists at least one weeks' prior notice of a pharmacy audit.

PRACTICE PATTERN IDENTIFICATION PROGRAM

The Agency for Health Care Administration (AHCA) is responsible for identifying health care utilization and practice patterns within the Medicaid program which are not cost effective or medically appropriate. AHCA and the Drug Utilization Review Board are involved in a practice pattern utilization program under s.409.912(16)(b)(1), F.S., which evaluates practitioner prescribing patterns. Currently, AHCA and the Board do not consult with DOH under the practice pattern identification program. Also, the current statute specifies that practitioners who are prescribing inappropriately or inefficiently, as determined by AHCA, may have their prescribing of certain drugs subject to prior authorization. AHCA does not currently have the authority to terminate someone from prescribing in the Medicaid program if they find the practitioner is prescribing inappropriately or inefficiently.

SANCTIONING OF MEDICAID PROVIDER

Section 409.913(15), F.S., gives the Agency for Health Care Administration (AHCA) the authority to impose sanctions or disincentives on a provider or a person for various reasons. These sanctions include suspension or termination for specified periods of time. The statute does not clarify that an individual who is terminated or suspended cannot be involved in actions that result in a claim for payment to the Medicaid program as a result of furnishing, supervising a person who is furnishing, or causing a person to furnish goods or services.

DISPLINARY ACTIONS FOR PRACTICE PATTERNS

Section 456.072, F.S., specifies the acts that shall constitute grounds for which disciplinary actions can be taken against health care practitioners. This section does not currently allow the Department of Health (DOH) to investigate and discipline for bad practice patterns when prescribing medicinal drugs or controlled substances, which patterns aren't identified in a single, patient-specific case.

MEDICAID SANCTIONS AGAINST RECIPIENTS

Section 1128B of the Social Security Act provides for criminal penalties for acts involving federal health care programs, and allows for suspension of Medicaid benefits for up to one year, for individuals convicted of certain federal crimes. Florida currently does not have a law that authorizes suspension of eligibility if an individual is convicted of federal health care crimes provided in Section 1128B of the Social Security Act.

MEDICAID DISEASE MANAGEMENT

Results of disease-management studies conducted around the country indicate that closely managing patients with chronic diseases can reduce the higher cost services these patients often require and at the same time improve quality of life for the patient. Disease-management also can prevent or delay the onset of the more severe stages of a disease. Since 1995, a number of states have developed and implemented disease management programs.

Disease-management programs emphasize treatment of patients with chronic disease such as diabetes, asthma, heart disease, and HIV/AIDS. Goals of state disease management programs include controlling Medicaid costs and improving the quality of health care provided to the chronically ill. For example, Medicaid cost savings are realized through the reduction in emergency room services for chronic disease. Disease-management programs throughout the states are not uniform; differences among disease management programs include disease coverage, program administration, and the type of service and professionals offered to patients.

In 1997, the Florida Legislature authorized disease management and directed AHCA to “select methods for implementing the program that included best practices, prevention strategies, clinical-practice improvement, clinical interventions and protocols, outcomes research, information technology, and other tools.” The Florida disease-management initiative has been designed to promote and measure: health outcomes, improved care, reduced inpatient hospitalization, reduced emergency room visits, reduced costs, and better educated providers and patients. The Agency for Health Care Administration (AHCA) contracts with disease-management organizations to provide disease management services to Medicaid recipients enrolled in the Primary Care Case Management Program (MediPass) who have been diagnosed with diabetes, HIV/AIDS, asthma, hemophilia, congestive heart failure, end stage renal disease, mental illness, or hypertension.

MEDICAID PHARMACY LOCK-IN

A state may require (lock in) a beneficiary who has utilized Medicaid services or items at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the state, to receive goods and services from a single provider or limited group of providers for a reasonable period of time.

The Medicaid Bureau of Pharmacy Services recently implemented a program that may restrict a patient to filling all of his or her prescriptions at one pharmacy. The purpose of this program is to control duplicate and inappropriate drug therapies. Any patient is eligible for the lock-in. Patients most likely to benefit from this service are those who see multiple physicians with complicated drug regimens. Also, patients suspected of “doctor shopping” could be restricted to one pharmacy for their Medicaid prescriptions.

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.

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.

RACKETEERING AND ILLEGAL DEBTS

Section 895.02, F.S., provides definitions for ss. 895.01- 895.08, F.S., regarding offenses concerning racketeering and illegal debts. Medicaid provider fraud is covered under this section, but Medicaid recipient fraud is not.

FLORIDA CONTRABAND FORFEITURE ACT

Sections 932.701- 932.707, F.S., are known as the Florida Contraband Forfeiture Act. Section 932.701(2), F.S., provides a definition for a "contraband article" under the act. The definition does not currently include any contraband obtained as a result of Medicaid provider fraud under s. 409.920, F.S.

DISPOSITION OF LIENS AND FORFEITED PROPERTY

Section 932.7055, F.S., relates to the disposition of liens and forfeited property. Currently, this section does not specify where proceeds accrued pursuant to the Contraband Forfeiture Act, by the Medicaid Fraud Control Unit, shall be deposited.

WHISTLE-BLOWER'S ACT

Sections 112.3187-112.31895, F.S., are the "Whistle-blower's Act." The legislative intent for the act is to prevent agencies or independent contractors from taking retaliatory action against an employee who reports to an appropriate agency violations of law on the part of a public employer or independent contractor or who discloses information to an appropriate agency alleging improper use of governmental office, gross waste of funds, or any other abuse or gross neglect of duty on the part of an agency, public officer, or employee. An agency is defined to include any state, regional, county, local, or municipal government entity. An independent contractor is defined to include a person, other than an agency, engaged in any business and who enters into a contract with an agency.

The Agency for Health Care Administration (AHCA) has implemented a number of initiatives to combat Medicaid prescription drug fraud and abuse. These initiatives include:

- In early 2002, AHCA hired five area pharmacists to meet with physicians in their offices to discuss issues such as recipient doctor shopping, coordination of care, and appropriate utilization of pain medications. AHCA is in the process of adding four more area pharmacists.
- In FY 2002-2003, AHCA implemented a Diverted Pharmaceuticals Pilot Project in Broward, Miami-Dade, Monroe, and Palm Beach counties to prevent the fraudulent practice of reselling Medicaid prescribed drugs to wholesalers and pharmacies.
- In October 2002, AHCA implemented a recipient lock-in program. This program requires a recipient who has been identified as a high user and potential abuser of prescribed drugs, or who obtains prescriptions from multiple physicians, to obtain all of their medications from a single pharmacy. The program currently has 589 recipients enrolled, 200 of which were enrolled in the lock-in program in just the last quarter. The majority of lock-in recipients are using Oxycontin and other targeted medications. The intent is to ensure that at least one medical professional, the pharmacist, is aware of all the medications that the recipient is receiving.

- In February 2003, AHCA contracted with Heritage Information Systems to analyze and apply sophisticated drug algorithms used to detect unusual drug utilization patterns and assist AHCA in determining the cause. Prescription data are analyzed on a daily basis and summarized for AHCA on a weekly basis. Information is then disseminated to the appropriate drug utilization program for follow-up and action.
- In April 2003, AHCA began promoting the use of a website which allows a physician to view 90 days' history of all the Medicaid prescriptions filled for his or her patients. This allows the physician to check for abuse, compliance, and multiple prescribers.

To further provide physicians with the necessary information to monitor their patients' drug use, in the spring of 2003, AHCA contracted with Gold Standard MultiMedia to provide 1000 handheld, wireless Personal Digital Assistants (PDAs) to the top prescribing Medicaid physicians. The PDAs provide the physician with 60 days' history of all the Medicaid prescriptions for their patients along with clinical information to assist in the appropriate prescribing of medications.

STATEWIDE GRAND JURY REPORT

The Seventeenth Statewide Grand Jury released a report on December 4, 2003, 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. Recommendations of the Statewide Grand Jury to the Legislature included the following:

- 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.

C. SECTION DIRECTORY:

Section 1. Amends s. 16.56, F.S., providing that the Office of Statewide Prosecution may investigate and prosecute any criminal violation of s. 409.920 or s. 409.9201, F.S., which cover the operation of the Medicaid program.

Section 2. Amends s. 400.408, F.S., including the Medicaid Fraud Control Unit of the Department of Legal Affairs in the AHCA local coordinating workgroups for identifying unlicensed assisted living facilities.

Section 3. Amends s. 400.434, F.S., giving the Medicaid Fraud Control Unit of the Department of Legal Affairs the authority to enter and inspect facilities licensed under part III of ch. 400, F.S., relating to assisted living facilities.

Section 4. Creates s. 409.9021, F.S., requiring a Medicaid applicant, subject to federal approval, to forfeit their entitlement to goods and services in the Medicaid program if he or she is found to have abused or defrauded the program.

Section 5. Amends s. 409.912, F.S., relating to the cost-effective purchasing of health care for Medicaid recipients, to:

- Give AHCA the authority to require a confirmation or second physician's opinion of the correct diagnosis before authorizing payment for medical treatment, except in the case of a patient in an emergency department. The confirmation or second opinion shall be rendered in a manner approved by AHCA.
- Give AHCA the authority to mandate prior authorization, drug-therapy-management, or disease-management participation for certain Medicaid recipients or for certain drugs.
- Require AHCA and the Drug Utilization Review Board to consult with DOH under the practice pattern identification program.
- Authorize AHCA to terminate certain practitioners from the Medicaid program if they are prescribing inappropriately or inefficiently, as determined by AHCA.
- Give AHCA the authority to mandate a recipient's participation in a provider lock-in program, limiting the receipt of goods or services to a single provider for a period of no less than one year, and for the duration of the recipient's participation in the program if he or she commits a second offense of fraud or abuse. The lock-in programs shall include, but are not limited to, pharmacies, medical doctors, and infusion clinics. Provides that the lock-in program shall not by applicable to emergency services and care provided to the recipient in a hospital emergency department. AHCA is given authority to seek federal waivers necessary to implement this subsection.
- Require the agency to seek a federal waiver to terminate the eligibility of a Medicaid recipient from the program if he or she commits a third offense of fraud or abuse.
- Allow the agency to mail an explanation of benefits to Medicaid recipients in order to detect fraud or abuse, including a toll-free telephone number for the Medicaid recipient to report any discrepancies on the explanation of benefits.
- Require the agency to conduct a study and recommend a plan to implement an electronic verification system in the Medicaid program.
- Allow the agency to implement provider network controls, including but not limited to, competitive bidding and provider credentialing.

Section 6. Amends s. 409.913, F.S., relating to oversight of the integrity of the Medicaid program, to:

- Specify that AHCA can conduct or contract for prepayment review of provider claims to ensure that billing by a provider is in accordance with applicable Medicaid rules, regulations,

handbooks, and policies and is in accordance with all state and federal laws, and to ensure that appropriate care is rendered to Medicaid recipients.
- Specify that prepayment reviews may last for up to one year, and that unless AHCA has reliable evidence of fraud, misrepresentation, abuse, or neglect, claims shall be adjudicated for denial or payment within 90 days from the date complete documentation is received by AHCA for review. If there is reliable evidence of fraud, misrepresentation, abuse, or neglect, claims shall be adjudicated for denial or payment within 180 days from the date complete documentation is received by AHCA for review.
- Further specify a provider's obligation with regard to submitting claims to the Medicaid program by adding language that the agency may not reimburse any person or entity for any prescription for medications, medical supplies, or medical services if the prescription was written by a physician or other prescribing practitioner who is not enrolled in the Medicaid program. Requires the agency to report to the Legislature on its efforts to implement this provision.

This section does not apply:

- In instances involving bona fide emergency medical conditions as determined by the agency,
- To a provider of medical services to a patient in a hospital emergency department, hospital inpatient or hospital outpatient setting,
- To bona fide pro bono services by pre-approved non-Medicaid providers as determined by the agency,
- To prescribing physicians who are board certified specialists treating Medicaid recipients referred for treatment by a treating physician who is enrolled in the Medicaid program, or
- To prescriptions written for dually eligible Medicare beneficiaries by an authorized Medicare provider who is not enrolled in the Medicaid program.

AHCA may also deny payment or require repayment for other goods or services that are not presented as required in s. 409.913(7), F.S.

- Authorize AHCA to deny payment, rather than just requiring repayment, for inappropriate, medically unnecessary, or excessive goods or services.
- Authorize AHCA to seek any remedy provided by law when false or a pattern of erroneous claims are submitted, but deleting the requirement that the claims must result in overpayments to a provider or exceed those to which the provider was entitled under the Medicaid program.
- Clarify AHCA's authority to sanction providers and others who do not abide by Medicaid law. Among the sanctions provided, current law authorizes suspension for a period of not more than one year, and termination for a specific period of from more than one year to 20 years. The bill clarifies that suspension or termination from the Medicaid program precludes participation in Medicaid during that period, which includes any action that results in a claim for payment to the Medicaid program as a result of furnishing, supervising a person who is furnishing, or causing a person to furnish goods or services.
- Provide that AHCA would only report administrative sanctions for certain specified violations to the appropriate licensing entity for the provider or other person being sanctioned.
- Authorize AHCA to withhold payment to a provider upon receipt of evidence of fraud, willful misrepresentation, or abuse under Medicaid, or a crime committed while rendering goods or services to Medicaid recipients, regardless of whether there are ongoing legal proceedings related to that evidence.
- Authorize AHCA to deny payments or require repayments where the goods or services were furnished, supervised, or caused to be furnished by a provider terminated or suspended from the Medicaid or Medicare program by the Federal government or any state.
- Authorize AHCA to implement amnesty programs that encourage voluntary repayment of overpayments, and authorize rules for such programs.

- Authorize AHCA and MFCU to review a provider's non-Medicaid-related records in order to determine the total output of a provider's practice to reconcile quantities of goods or services billed to Medicaid with quantities of goods or services used in the provider's total practice.
- Authorize AHCA to limit, restrict, or suspend Medicaid eligibility for a period of up to one year for those recipients convicted of a fraudulent act under or against a federal health care program, as determined by the agency head or designee.
- Authorize AHCA to limit the number of Schedule II and Schedule III refill prescription claims submitted from pharmacy providers. AHCA must limit the allowable amount of reimbursement of prescription refill claims for Schedule II and Schedule III pharmaceuticals if AHCA or the Medicaid Fraud Control Unit determines that the specific prescription refill was not requested by the Medicaid recipient or authorized representative for whom the refill claim is submitted, or was not prescribed by the recipient's medical provider or physician. Any such refill request must be consistent with the original prescription.
- Require the Office of Program Policy Analysis and Government Accountability to provide regular reports to the Legislature regarding the agency's efforts to prevent, detect, deter, and recover Medicaid fund lost to fraud and abuse.
- Require the agency to conduct random telephone audits of Medicaid recipients to verify services received.

Section 7. Amends s. 409.9131, F.S., to change the definition of "peer review" so that peer review is required in cases involving determination of medical necessity, to determine whether the documentation in the physician's records is adequate. This section also provides that a peer review is required when preliminary analysis of a claim indicates that an evaluation of medical necessity, appropriateness, and quality of care is needed to determine a potential for overpayment and before any proceedings are initiated.

Requires Medicaid provider cost reports to AHCA to include a statement that immediately precedes the dated signature of the provider's administrator or chief financial officer and certifies that the individual signing the cost report is familiar with the laws and regulations regarding the provision of health care services under the Florida Medicaid Program, including the laws and regulations relating to claims for Medicaid reimbursements and payments, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Section 8. Amends s. 409.920, F.S., relating to Medicaid provider fraud, to:

- Redefine the term "knowingly" as: an act done voluntarily and intentionally and not because of mistake or accident. "Knowingly" also includes the word "willfully" or "willful" which, as used in this section, means that an act was committed voluntarily and purposely, with the specific intent to do something the law forbids; that is with bad purpose either to disobey or disregard the law.
- Make it unlawful to knowingly use or endeavor to use a Medicaid provider's identification number or a Medicaid recipient's identification number to make, cause to be made, or aid and abet in the making of a claim for items or services that are not authorized to be reimbursed by the Medicaid program.
- Create subsection (4) to define property "paid for" to include all property furnished to or intended to be furnished to any recipient of benefits under the Medicaid program, regardless of whether reimbursement is ever actually made by the program.
- Specify that a Medicaid participating physician is required to make available any accounts or records to investigate alleged abuse or neglect of patients, or to investigate alleged misappropriation of patients' private funds. Subject only to applicable Federal Statutes, but notwithstanding any other provision of law, the accounts or records of a non-Medicaid patient may be reviewed by the Medicaid Fraud Control Unit, without the patient's consent, pursuant to an investigation of suspected Medicaid fraud in or to determine consistency in the quality and appropriateness of treatment provided to Medicaid recipients as compared to non-Medicaid recipients.

Section 9. Creates s. 409.9201, F.S., relating to Medicaid fraud, to:

- Define "legend drug" as any drug, including, but not limited to, finished dosage forms or active ingredients that are subject to, defined by, or described by s. 503 (b) of the Federal Food, Drug, and Cosmetic Act or by s. 465.003 (8) , s. 499.007 (12) , or s. 499.0122 (1) (b) or (c), F.S.
- Define "Value" as the amount billed to the Medicaid program for the property dispensed or the market value of a legend drug or goods or services at the time and place of the offense. If the market value cannot be determined, the term means the replacement cost of the legend drug or goods or services within a reasonable time after the offense.
- Provide that a person who knowingly sells, attempts, conspires, or causes another to sell a legend drug that was paid for by the Medicaid program commits a felony.
    - If the value of the legend drug is less than $20,000, the crime is a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084, F.S.
    - If the value of the legend drug is $20,000 or more but less than $100,000, the crime is a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084, F.S.
    - If the value of the legend drug is $100,000 or more, the crime is a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084, F.S.
- Provide that a person who knowingly purchases, attempts, or conspires to purchase a legend drug that was paid for by the Medicaid program and intended for use by another person commits a felony.
    - ˜ If the value of the legend drug is less than $20,000, the crime is a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084, F.S.
    - If the value of the legend drug is $20,000 or more but less than $100,000, the crime is a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084, F.S.
    - If the value of the legend drug is $100,000 or more, the crime is a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084, F.S.

- Provide that a person who knowingly makes, causes, conspires, or attempts to make any false statement or representation for the purpose of obtaining goods or services from the Medicaid program commits a felony.
    - If the value of the goods or services is less than $20,000, the crime is a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084, F.S.
    - If the value of the goods or services is $20,000 or more but less than $100,000, the crime is a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084, F.S.
    - If the value of the goods or services is $100,000 or more, the crime is a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084, F.S.

When determining the punishment for the offense, the value of individual items of the legend drugs or goods or services involved in distinct transactions committed during a single scheme or course of conduct, whether involving a single person or several persons, may be aggregated.

Section 10. Amends s. 456.072, F.S., to provide that a health care practitioner who prescribes medicinal drugs or controlled substances may be subject to discipline by DOH or the appropriate board having jurisdiction over the health care practitioner if the practitioner is found to have engaged in a pattern of practice when prescribing medicinal drugs or controlled substances which demonstrates a lack of reasonable skill or safety to patients, a violation of any provision of this chapter, a violation of the applicable practice act, or for a violation of any rules adopted pursuant to this chapter or the applicable practice act of the prescribing practitioner. Notwithstanding s. 456.073(13), the department may initiate an investigation and establish such a pattern from billing records, data, or any other information obtained by the department.

Section 11. Amends s. 465.188, F.S., deleting the requirement that AHCA give pharmacists at least 1 week's notice prior to a pharmacy audit. Specifies that the audit criteria set forth in this section shall apply only to audits of claims submitted for payment subsequent to July 11, 2003.

Section 12. Creates s. 812.0191, F.S., relating to dealing in property paid for in whole or in part by the Medicaid program, to:

- Define "Property paid for in whole or in part by the Medicaid program" as any devices, goods, services, drugs, or any other property furnished or intended to be furnished to a recipient of benefits under the Medicaid program.
- Define "Value" as the amount billed to the Medicaid program for the property dispensed or the market value of a legend drug or goods or services at the time and place of the offense. If the market value cannot be determined, the term means the replacement cost of the legend drug or goods or services within a reasonable time after the offense.
- Provide that any person who traffics in, or endeavors to traffic in, property that he or she knows or should have known was paid for in whole or in part by the Medicaid program commits a felony.
    - If the value of the property is less than $20,000, the crime is a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084, F.S.
    - If the value of the property is $20,000 or more but less than $100,000, the crime is a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 75.084, F.S.
    - If the value of the property is $100,000 or more, the crime is a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084, F.S.

- Provide that when determining the punishment for the offense, the value of individual items of the devices, goods, services, drugs, or other property involved in distinct transactions committed during a single scheme or course of conduct, whether involving a single person or several persons, may be aggregated.
- Provide that any person who knowingly initiates, organizes, plans, finances, directs, manages, or supervises the obtaining of property paid in whole or in part by the Medicaid program, and who traffics in, or endeavors to traffic in, such property commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084, F.S.

Section 13. Amends s. 895.02, F.S., expanding the definition of "racketeering activity" to include crimes committed under s. 409.9201, F.S., relating to Medicaid recipient fraud.

Section 14. Amends s. 905.34, F.S., providing that the Statewide Grand Jury's jurisdiction includes any criminal violation of s. 409.920 or s. 409.9201, F.S.

Section 15. Amends s. 932.701, F.S., expanding the definition of "contraband article" to include any real property, including any right, title, leasehold, or other interest in the whole of any lot or tract of land, that is acquired by proceeds obtained as a result of Medicaid provider fraud under s. 409.920, F.S., any personal property, including, but not limited to, equipment, money, securities, books, records, research, negotiable instruments, currency, or any vessel, aircraft, item, object, tool, substance, device, weapon, machine, or vehicle of any kind in the possession of or belonging to any person that is acquired by proceeds obtained as a result of Medicaid provider fraud under s. 409.920, F.S.

Section 16. Amends s. 932.7055, F.S., requiring that proceeds collected under the Contraband Forfeiture Act be deposited in AHCA's Grants and Donations Trust Fund.

Sections 17 through 31. Amend ss. 394.9082, 400.0077, 409.9065, 409.9071, 409.908, 409.91196, 409.9122, 409.9131, 430.608, 636.0145, 641.225, and 641.386 F.S., correcting cross references; and reenact ss. 921.0022(3)(g), 409.920, 705.101(6), 932.701, 932.703(4), and 932.701, F.S.

Section 32. Provides an effective date of July 1, 2004.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   There could be extra revenue generated through the fines stipulated in the bill, although the extent of that fines would be levied is unknown.

2. Expenditures:

   AHCA estimates that it will need an additional 17 FTEs in order to increase the Agency's efforts in deterring and detecting Medicaid fraud and abuse. In addition, AHCA requested funding to contract for prescribed drug cost control planning and for the development of guidelines and tools to promote cost effective drug use. The estimated cost of the positions and funding for additional fraud control activities in FY 2004-2005 is $1,690,478.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill gives AHCA and MFCU additional powers to combat Medicaid fraud and abuse, potentially resulting in additional penalties to Medicaid providers and beneficiaries. The legislation provides authority for AHCA to implement amnesty programs designed to allow Medicaid providers the opportunity to voluntarily repay overpayments, with reduced, or no penalty to the provider. It could provide an incentive for repayment by providers who would otherwise be reluctant to come forward out of fear of penalties and sanctions from AHCA.

D. FISCAL COMMENTS:

None.

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 Agency for Health Care Administration and the Office of the Attorney General have the rulemaking authority to implement the provisions of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On March 11, 2004, the Committee on Health Care adopted four amendments to the proposed committee bill to include:

Amendment #1 – Amends s. 409.912, F.S., to allow the Agency for Health Care Administration to require, before payment, a second physician's opinion for a confirmation of a diagnosis in cases involving chronic infectious diseases or elective surgery, except for the case of a patient in a hospital emergency department.

Amendment #2 - Amends s. 409.912, F.S., to exempt emergency services and care provided in a hospital department from any lock-in program required by the agency.

Amendment #3 – Amends s. 409.913, F.S., to exempt providers in a hospital inpatient or hospital outpatient setting from the restriction against non-Medicaid providers writing prescriptions for medications, supplies, or services for Medicaid recipients.

Amendment #4 – Amends s. 409.920, F.S., to require a Medicaid participating physician to allow access to records to the Office of the Attorney General to determine the existence of fraud or alleged misappropriation of a patient's private funds.