

IN THE SUPREME COURT OF THE STATE OF FLORIDA

Case No: SC02-2645

SECOND INTERIM REPORT  
OF THE  
SEVENTEENTH STATEWIDE GRAND JURY

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**REPORT ON RECIPIENT FRAUD IN  
FLORIDA'S MEDICAID PROGRAM**

**I. Introduction**

In our last report we detailed how corrupt drug wholesalers were marketing adulterated pharmaceutical products in Florida and throughout the United States. We noted there that the wholesalers had a variety of illicit sources but did not delve into great detail. Instead we focused on the illegal distribution of the drugs by wholesalers and what we felt were lax laws and oversight that allowed the wholesalers to thrive. Today, we turn our attention to one of the ways that illegal wholesalers acquire adulterated products - the diversion of tens of millions of dollars worth of drugs by large numbers of recipients of the Medicaid program.

Over the last year, the Grand Jury has heard from investigators and regulators from the Bureau of Pharmacy Services, the Florida Department of Law Enforcement, the Medicaid Fraud Control Unit, Medicaid Program Integrity and the Department of Health. We have also taken testimony from representatives of private industry, and from the Federal government. Finally, we took testimony from some Medicaid recipients who were directly involved in this fraud.

We have found that there are few, if any, consequences to Medicaid recipients who sell their expensive medications to wholesalers. One reason is that Florida has a patchwork of agencies, each with limited authority to address issues concerning fraud by recipients. We found that where there is authority, there appears to be a reluctance to aggressively pursue the issue of recipient eligibility. Efforts to deal with the problem of recipient fraud have been hampered by a lack of effective state statutes, federal limitations that restrict Florida's attempts 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. While Florida has taken some positive steps recently, our efforts pale compared to what other states are doing and, in some cases, have been doing for a long time.

We are hopeful that Florida's newly enacted pedigree paper statute, which we recommended in our last report, will shrink the black market for these diverted pharmaceuticals, but the statute will not take full effect until 2006. Without a strong pedigree paper requirement, the flow of adulterated and diverted pharmaceuticals will continue to have a ready market. Therefore, we believe it is imperative that law enforcement investigators and regulators increase their efforts to stem the supply side by targeting individuals that have so far received little attention.

Provider fraud has been traditionally viewed as the greater threat to the financial stability of the Medicaid program and, as such, has drawn the most attention from law enforcement and regulators. However, significant increases in the cost of medical care, especially in the costs of modern bio-engineered drugs used to treat diseases like AIDS and cancer, have created the potential for recipients to defraud the system on a much larger scale than could have been imagined even five years ago. Legislation has not kept up with this new trend. Unfortunately, criminals, as always, have kept up with this new development and it's costing our state millions.

We have found that many recipients have turned to the black market to make a living by selling

their medications paid for by Florida's taxpayers. Criminals have taken advantage of both loopholes in the law and the lax treatment of recipients engaged in fraud to steal millions of Medicaid dollars. While provider fraud may still account for the majority of money lost due to fraud, it is clear that mushrooming recipient fraud is threatening to give them a run for their money.

The societal costs of this illicit trade in pharmaceuticals cannot be overstated. It undermines public confidence in the safety of our drug supply, it endangers the health of those exposed to tainted, diluted or counterfeit drugs. It exploits gravely ill Medicaid recipients and it costs the state millions of dollars, which is not only a burden on taxpayers, it decreases the resources available to our most vulnerable citizens.

## **II. Recipient Fraud**

Professional recipient is a term coined by anti-fraud investigators to refer to certain recipients that routinely defraud one or more entitlement programs. Specifically, those recipients that regularly sell either their recipient numbers for others to use or bill under, or who sell their prescription drugs for a fraction of their costs. Some recipients support themselves strictly on the basis of this fraud. This report focuses on two ways in which such recipients defraud the Florida Medicaid program.

### **A. Street Sales**

It is not unusual for investigators to find pharmacy dispensing labels belonging to Medicaid recipients discarded in the trash cans of drug wholesale facilities. Invariably investigators will find solvents, such as lighter fluid or cleaning products, at those facilities. The solvents are used to remove the pharmacy dispensing label, without damaging the manufacturer's label, so that the medicine can be resold in the original bottles. In just one such case in March of 2002, Bureau of Statewide Pharmacy Services (BSPS) inspectors found prescription labels belonging to ten (10) Medicaid recipients. The cost to Medicaid for the prescription drugs listed on the labels amounted to over \$18,000. Over \$75,000 worth of other drugs, also

suspected to be diverted from Medicaid were found on the premises. Those ten (10) recipients alone had received over \$280,000 in drugs from Medicaid in just the previous six (6) months. Some of the recipients had been selling their medications for years, making as much as \$5,000 a month selling their drugs to wholesalers.

Despite the best efforts of these thieves, removing labels often leaves some residue of the label glue on the medicine bottle. BSPS investigators routinely find large quantities of such tacky bottles in drug wholesaler facilities throughout Florida. In every case the wholesalers were either unable to provide any pedigree papers, or the papers provided turned out to be false. While dispensing labels can be removed from any prescription bottle, in instances where investigators have been able to trace the suspicious drugs to its source, they have found that over 90% were paid for by Medicaid.

Witnesses involved in diversion have described to investigators buying large quantities of medicine on the streets from Medicaid recipients to be resold to wholesalers. Many of the medications would arrive still in the paper bag with the pharmacy's logo. The drugs would then be removed from the bag, stripped of its dispensing label, and boxed up and sent off to local wholesalers. From there, the drugs were either resold to regional wholesalers out of state or sold to local pharmacies.

We heard testimony that one illegal wholesaler bought and sold approximately \$2.4 million in Procrit, Epogen and Panglobulin, in just the first three months of 2002, most of which was bundled up by a runner from Medicaid recipients.

These sales by Medicaid recipients are not random, spur of the moment transactions. These diversions are orchestrated by highly organized rings who recruit recipients, some right in the parking lot of clinics or doctors' offices, to sell their drugs on a regular basis. Some of the runners that are recruiting recipients have developed vertically integrated operations. They pick up recipients in vans on a weekly or monthly basis, drive them to clinics or doctor's

offices for the prescriptions to be written, drive them to the pharmacies to have the prescriptions filled and then buy the drugs on the spot from the recipients. Most of these drugs spend a good part of the day in the van, unrefrigerated, before they are dumped at a wholesaler at the end of the day. Quite a few of the more expensive bio-engineered drugs must be kept refrigerated in a narrow temperature range or they will break down and lose their potency.

We heard testimony that once the drugs were at the wholesalers, buyers would appear with briefcases full of cash to buy the drugs that had now been bundled up from the street buys. One runner was present when over \$300,000 in Medicaid drugs were sold in just one transaction.

Some recipients sell only a part of the extensive list of medications they receive, deciding for themselves on a month to month basis what drugs to sell and which to take, all determined by their self-diagnosis as to their health and which medications they feel were working or not working for them. Different drugs command different prices which would also determine a recipients' choice of what to sell. To the degree that their health declines, and their blood tests reveal a lack of response to the prescribed medications, we believe, it would be likely that the treating physician would increase the dosage or recommend additional drugs and thereby provide even more medications for the recipient to sell.

## **B. Infusion Clinics**

The recent proliferation of infusion clinics has provided another way for recipients to sell their drugs. Many of the medications prescribed for HIV/AIDS patients can be, or must be, infused. That is, the drugs are mixed in a solution which is then administered intravenously over a period of time. The time varies, depending on the type of drug, the quantity being infused and other factors, but can be as much as several hours at a time.

We have seen evidence that many infusion clinics exist today solely to administer infusion

drugs to HIV/AIDS patients and are doing so free of charge. While some clinics may be doing so for benevolent purposes, investigations have revealed that many are not. The following scenario, pieced together by investigators from a variety of witnesses, as well as surveillance, is typical.

An infusion clinic recruits Medicaid recipients, either directly or through runners, to come to their clinic for infusion, in return for a small payment, perhaps \$80-\$100. The recipient is directed to a pharmacy to have the prescription filled. The drugs are usually delivered directly to the clinic by the pharmacy whether they are Medicaid registered or not. If, for example, the patient is prescribed 40,000 units of a certain medication to be infused, the pharmacy will deliver several infusion bags of lower dosages, which together total 40,000 units. The clinic receives the different bags, but only one will be mixed and infused and the others become available to sell on the black market. The clinic does not bill Medicaid for the infusion since it is not a Medicaid provider. The pharmacy does, however, bill Medicaid for the drugs and gets the profits of the increased business, and perhaps a kickback from the clinic. The clinic gets the profits from the sale of the diverted drugs and the recipient receives a small bribe for his participation. What the recipient doesn't get is his full dosage, or in some cases any dosage at all. Once at the clinic, the recipient can't possibly know with what he's being infused. It may be, and is in some cases, nothing more than an infusion of vitamins or plain saline solution. In these cases the entire amount of prescribed drugs is diverted.

Its not by chance that this fraud has been structured this way. Criminals are far more flexible, resilient and adept at exploiting loopholes than government is at closing them off. Under s. 409.920(8) and 409.9131(3) F.S., the Medicaid Fraud Control Unit (MFCU) has the authority to do routine inspections of any Medicaid provider or facility. These routine inspections include review of both business records and patient files. This ability to have unannounced inspections is a powerful fraud fighting tool. Knowing this, criminals have shifted their fraudulent conduct out of the hands of Medicaid providers in an attempt to limit MFCU's reach. Most, if not all, infusion clinics where diversion is occurring are non-Medicaid clinics. Because they are not Medicaid providers, MFCU does not have the authority to do inspections at these

clinics. The clinics forego billing for the infusion procedures and, instead, make their profits by diverting the expensive infusion medications that Medicaid is paying for.

MFCU does have the authority to seek a subpoena or a search warrant. However, subpoenas are unlikely to elicit incriminating evidence from a clinic engaged in wholesale fraud and search warrants can't be issued unless there has already been a time consuming criminal investigation that establishes probable cause. Congress and the Florida Legislature authorized MFCU to have inspections done to begin with because of these limitations on subpoenas and search warrants. Criminals have sidestepped the inspection process by simply moving their fraud to a non-Medicaid clinic.

Doctors and medical labs are often part of these fraudulent diversions, this ruse is not limited only to clinics. Because Medicaid will pay for a recipient's drugs even when prescribed by non-Medicaid doctors, or when documented by a non-Medicaid lab, criminals have recruited doctors and labs to provide services to Medicaid recipients free of charge. We are dismayed that not only does current Florida law require Medicaid to pay for prescriptions ordered by non-Medicaid doctors, it also must pay for prescriptions ordered by doctors previously terminated from the Medicaid program. The impact of prescriptions written by doctors terminated from the Medicaid program should not be underestimated. While we do not have complete figures, one investigator testified that records reviewed for just five (5) previously terminated doctors, chosen at random, showed they had written over \$14 million in prescriptions combined. One doctor wrote \$2.7 million since he was terminated in 1996; the other four wrote almost \$12 million since their terminations in 2000.

Recruiting Medicaid recipients, particularly those suffering from serious illnesses, has been extremely profitable for criminals. However, using seriously ill recipients can be problematic, as diverting too much of the drugs can prove to be fatal to the recipient. Therefore, some criminals have resorted to recruiting recipients to pretend to have AIDS by using impostors to take blood tests for them. One such recipient received over \$600,000 in medications over

the last three years after falsely claiming to have AIDS.

They will also use corrupt labs to either exaggerate a recipient's illness or, as in one case we heard, completely falsify lab reports to come up with a phony diagnosis of AIDS. In this way, criminals can divert 100% of the prescribed medication since the recipient is not truly ill, and therefore, has no need for the drugs. As in the prior examples, MFCU cannot inspect these labs because they are not Medicaid providers. Nonetheless, Medicaid will accept a lab report from a non-Medicaid lab to document a diagnosis. AHCA does not require a second opinion or follow-up lab work to verify the initial diagnosis. Therefore, a Medicaid recipient can see a non-Medicaid doctor and be diagnosed with a serious illness supported by a lab result from a non-Medicaid lab. The recipient can then go to a non-Medicaid infusion clinic to receive the drugs that Medicaid will pay for, sometimes as much as \$20,000 a week. Not all entitlement programs pay for prescriptions written by non-providers. The Veteran's Administration, for example, will not pay for a prescription unless it is verified or confirmed by a VA doctor.

Phony diagnoses are not limited to HIV/AIDS. As Medicaid clamps down on the abuse of some drugs by limiting the uses for which they may be prescribed, some corrupt doctors will change the patient's diagnosis. For example, in order to avoid restrictions on the use of the expensive IV/IG drugs, some criminals have resorted to falsely diagnosing AIDS patients with Chronic Inflammatory Demyelinating Polyneuropathy (CIDP). Medicaid accepts a simple report from a doctor, even a non-Medicaid doctor, that a patient has tested positive for CIDP pursuant to a nerve conduction study. One Miami-Dade clinic claimed to have treated 132 patients, all with identical diagnoses of CIDP, and billed Medicaid for over \$2.3 million in just ten months. Most of these phony claims could be avoided if Medicaid simply required a second opinion, as the VA does, from a doctor of their own, not the recipients', choosing. This seems to us a simple and common sense requirement that would effectively weed out a significant amount of fraud.

### **C. POTENTIAL COSTS TO THE MEDICAID PROGRAM**

The costs to the Medicaid program, as we have seen in the previous examples, are not insignificant. Analyses conducted by the federal Medicare program can also shed light on the potential level of abuse in the Medicaid program. Medicare is a federal entitlement program that provides seniors with medical coverage. Medicare beneficiaries pay a 20% co-insurance payment. Medicare does not generally pay for prescription drugs. However, it will pay for prescription drugs infused by a Medicare provider. Many individuals that qualify for Medicare simultaneously qualify for state Medicaid benefits. They are referred to as dual enrollees.

One recent study concluded that Medicare paid for approximately \$100 million in infusion drugs between January 2002 and June 2003, just in Miami-Dade County, for just five different billing codes (Rho D, Epogen, Immuno Globulin and two different strengths of Neupogen). Another \$50 million was paid by Medicare for just two infusion drugs, Rho D and Neupogen, in just the third quarter of this year. These figures, which have been increasing at an accelerating pace, are a huge increase over pre-2002 figures.

Some factors convinced federal investigators that these billings are fraudulent. One is that use of these infusion drugs in the private sector has stayed steady and at a fraction of the amount seen in the Medicare program during the same time that billings have skyrocketed within the program. Another reason for suspicion is the unusual treatment pattern. The average dosage given to patients has risen steadily to around 250-350 units per infusion, at an average price of \$20.00 per unit. That comes to roughly \$7000 per infusion, which is administered two to three times per week.

Standard protocol for treatment with these infusion drugs calls for a blood test after the first week and a decrease in dosage over time, as the patient responds to the medication. Instead, the billings showed the same levels of infusion indefinitely, with no tapering off. Finally, when the claims were investigated more thoroughly, investigators found that blood tests were not being conducted and in fact almost none of the recipients were being infused.

Federal fraud investigators conservatively estimate that at least one thousand recipients are involved in receiving kickbacks to allow their numbers to be used in these infusion clinic scams. Most disturbing for Florida is that many of these recipients are dual enrollees and were billing Medicaid and Medicare for the same medications at the same time.

In February of this year, the Medicare program embarked on an anti-fraud initiative aimed at uncovering recipient fraud. Modeled after a successful project in California, Medicare developed a computer software program to analyze the recipient database for Miami-Dade County. The program discovered approximately 7,000 beneficiaries whose claims statistically were two standard deviations higher than the norm on four different measures of claims.

Preliminary analysis of some of these claimants' files showed there to be suspicious claims, not the least of which were simultaneous diagnoses of obesity and anorexia for the same claimant. Medicare is following up the database analysis with in-home visits by two-person clinical teams to a representative sample of recipients to determine if they are using the equipment, services or drugs that were prescribed. If the visits validate the computer model, Medicare intends to deny the claims as medically unnecessary. What's important to bear in mind about this number is that these 7,000 beneficiaries represent only those with claims well above average. While not all of these 7,000 beneficiaries are necessarily engaged in fraud, it by no means captures all recipients engaged in fraud. There could be, and likely are many more beneficiaries engaged in fraud at lower claims levels. As we said earlier, many Medicare beneficiaries are also simultaneously enrolled in the Medicaid program. Common sense and experience, tells us that beneficiaries or recipients who engage in fraud against one program, are likely to be engaged in similar fraud against the other.

Analysis conducted by MFCU investigators reveal results similar to those found by federal investigators. MFCU investigators have examined prescription patterns over the last few years to determine where diversion is occurring and what drugs are being targeted. Many of the drugs diverted by recipients from the Medicaid program to the black market are

intravenously administered Immunoglobulin (IV/IG) drugs. According to MFCU, 89% of the IV/IG drugs billed to Medicaid were prescribed in Miami-Dade County. Between 1999 and the third quarter of 2003, Medicaid was billed over \$270,000,000 for infusion medications in Miami-Dade County alone.

As in the case of Medicare, analysis showed that many of these billings are suspicious and that the volume of specific drugs prescribed undergo dramatic changes in an apparent effort to avoid Medicaid's attempts to clamp down on fraud and abuse. The problem appears to be more acute in Miami-Dade County.

For example, in 1999, Medicaid was billed \$14,000,000 for Cytogam prescriptions in Miami-Dade. That figure dropped by more than half in 2000, and plummeted again in 2001, to just over \$1,000,000.

At around the same time, prescriptions for Venoglobulin skyrocketed from \$91,000 in 2000, to over \$18,000,000 the following year. Iveegam, another immunoglobulin drug, also shot up from \$2,5000 in 1999, to over \$12,000,000 in 2000, and then back down to zero for the last two (2) years.

Other drugs used in the treatment of HIV/AIDS also underwent wild fluctuations in the numbers of prescriptions written. Miami-Dade doctors wrote approximately \$15,000,000 in Neupogen prescriptions for Medicaid recipients in 1999. That figure almost tripled to just under \$40,000,000 in 2000, before plummeting to \$7,000,000 the next year.

There may be several factors that would affect prescription patterns over time, but we believe that such wild fluctuations in such a short period of time are likely the result of diverters' attempts to avoid Medicaid's restrictions on the reimbursement for specific drugs. It appears Medicaid's efforts in this regard may be too narrowly drawn, causing the criminals to switch

from one to another similar drug.

#### **D. Agencies involved with Medicaid Recipient Eligibility**

Several state agencies are involved in one way or the other with Medicaid recipient eligibility.

For example, the Department of Children and Families (DCF) initially determines a recipient's eligibility based on the recipient's application and a review of the recipient's finances. Once deemed eligible, recipients are enrolled in the Medicaid program which is administered by the Agency for Health Care Administration (AHCA). Medicaid Program Integrity (MPI), which is part of AHCA's Office of Inspector General, is tasked with detecting and avoiding fraud and abuse against the Medicaid Program by both providers and recipients. Suspected criminal fraud is referred to the Florida Department of Law Enforcement in the case of recipient fraud or the Medicaid Fraud Control Unit for provider fraud. AHCA believes it does not have the authority to terminate a recipient's eligibility for engaging in fraud against the program. Furthermore, once a recipient is referred to another agency, AHCA takes no further action, not even to recover overpayments based on fraud.

Eligibility issues raised by a recipient's fraudulent conduct are rarely referred back to the Department of Children and Families (DCF). When they are, DCF refers the case to the Public Assistance Fraud investigations unit (PAF). DCF contracts with PAF to investigate eligibility issues raised after a recipient is enrolled in the program.

#### **Public Assistance Fraud Investigations Unit**

The Public Assistance Fraud investigations unit (PAF) is part of the Florida Department of Law Enforcement (FDLE). The unit was transferred to FDLE from the Office of Auditor General in 1999. They have the authority to investigate fraud in state administered public assistance programs including Medicaid, the Food Stamp Program and Work And Gain for

Economic Self-Sufficiency (WAGES). There are four investigators in Palm Beach, two in Broward and nineteen in Miami-Dade county. These investigators are non-sworn and their investigations are limited to eligibility issues. They essentially investigate recipients who have falsely claimed eligibility initially or who fail to report subsequent changes in circumstances (such as an increase in income) that would disqualify the recipient from the program. Currently, approximately 80-85% of their case load consists of investigating fraud within the food stamp program. Less than 5% of their resources are devoted to investigating Medicaid fraud in Southeast Florida. Investigators with PAF are not asked to, nor do they have the training and background to, investigate criminal conduct like that found by FDLE and MFCU in its investigations into drug diversion. Unlike MFCU, these investigators do not have authority to inspect provider facilities or their records, nor do they have arrest powers.

Most of PAF's cases consist of referrals from DCF. PAF's contract with DCF to investigate fraud concerning eligibility issues is tied to the number of cases closed by PAF, without regard to the nature or size of the case. PAF receives approximately half of their budget dollars under this contract. While investigators with PAF would like to pursue some proactive cases, including Medicaid recipient fraud, they are hamstrung by the funding formula, which will penalize them for taking the longer, more complex fraud cases.

### **AHCA**

The Agency for Health Care Administration (AHCA) employs approximately 1,600 employees and is responsible for administering the Medicaid budget in Florida. Approximately 700 of its employees are directly involved with Medicaid. In fiscal year 2002-2003, Florida's Medicaid budget was \$11.7 billion; approximately \$2 billion of that budget was spent on medication. For fiscal year 2003-2004, AHCA anticipates the Medicaid budget to rise to \$13 billion. Approximately 2.8 million of Florida's 16 million people are enrolled in the Medicaid program. Of that number, over 56,000 recipients have been diagnosed with HIV/AIDS and over 15,000 with cancer.

The Medicaid Program Integrity Unit (MPI) is housed within the Office of Inspector General for AHCA and employs approximately 90 people. MPI uses a variety of strategies to detect suspicious billing patterns by providers which may indicate waste, abuse or fraud. Medicaid providers voluntarily join the Medicaid program and sign a contract which stipulates that either side can terminate the contract, without cause, on 30 days notice.

Despite AHCA's dominant role in the Medicaid Program, including anti-fraud efforts through MPI, AHCA believes it does not have the authority to suspend or terminate any recipient from the Medicaid program other than for a federal conviction of Medicaid fraud. Any eligibility issues raised by recipient's fraudulent conduct are left to DCF.

## **E. AHCA'S RESPONSE**

In response to the increasing problem of recipient fraud, AHCA has take some positive steps to address the problem. We detail some of the current and proposed responses here.

### **1. Florida Pharmacy Lock-in Program**

Recipients who abuse or over utilize pharmacy services can be directed into the pharmacy lock-in program. In a pharmacy lock-in the recipient is restricted to using just one pharmacy. AHCA began planning for a pharmacy lock-in program in early 2002. Since October of last year, the program has added approximately 600 recipients to the lock-in based on a variety of referrals. AHCA anticipates adding approximately 200 more each month for the foreseeable future. Other states have had lock-in programs, some for many years, and have been proven to be cost effective.

New York has had a Recipient Restriction Program since 1980. With 5,000 recipients in the

program, New York conservatively estimates it saves \$231 per month, per recipient, for a total savings of \$13.9 million per year. Pennsylvania, which has had a lock-in program since 1976, last did a cost savings analysis in 1994 and determined it was saving approximately \$6,600 per recipient yearly. The stated purpose of the lock-in program is to prevent recipients from receiving redundant amounts or types of medications. These situations arise when recipients go to multiple doctors without alerting each of them of their other doctor visits. The result is extra medications being prescribed that the recipient can sell on the streets.

The lock-in relies on the pharmacist to voluntarily question or report excessive dosages or redundant medications. Pharmacists, however, may be reluctant to question doctors, except in the most obvious cases and, while they are encouraged to do so, nothing in the law requires that they report their suspicions or concerns to AHCA.

Other states that have a lock-in program invariably have it go hand-in-hand with a physician lock-in. While a pharmacy lock-in may provide some success against fraud, we believe that only a joint program of pharmacy, doctor and clinic lock-in will deter a determined recipient.

## **2. Drug Benefit Management Program**

We heard testimony that AHCA intends to ask the legislature for authority to mandate enrollment into a drug therapy management or disease management program for those patients who are identified as over-utilizers or abusers of services or medicines. We believe this to be a positive step and encourage the legislature to approve such a measure. However, we note that current Florida law s. 409.912(40)(a)(3), directs AHCA to implement a drug benefit management program to manage drug therapies for HIV/AIDS patients, patients using 20 or more unique prescriptions in a six (6) month period and the top 1,000 patients in annual spending. It appears that AHCA believes they do not have the authority to require recipients in these categories to enroll in the program. Therefore, Medicaid's drug benefit management program is limited to those recipients that voluntarily respond to Medicaid's request.

We encourage AHCA to pursue its stated goal of broadening the program and also to ask the legislature for authority to mandate enrollment in the current program.

### **3. Medi-Medi Project**

Virtually all witnesses agree that there is a serious lack of communication between Medicare and Medicaid fraud investigators as a result of both state and federal privacy provisions. In order to address this problem, AHCA has embarked on a joint effort with Medicare to improve communications between the two agencies. The project, dubbed “Medi-Medi”, will allow Medicare and Medicaid fraud investigators to share information on providers and beneficiaries and recipients suspected of fraud and allow each agency to have access to the other agency’s database. We believe this to be an important and significant anti-fraud measure and encourage both agencies to also cover the provision of pharmacy services which Medi-Medi will initially not address.

### **FINDINGS**

AHCA needs to be more proactive in seeking out and identifying patterns of fraud by recipients and taking stronger measures to prevent and stop fraud. We recognize that AHCA is limited to some extent, by state law as well as federal statutes and regulations. However, we are also aware that other states, working under the same restrictions, have done much more to address the issue of recipient fraud. As an example, Florida’s program for locking in recipients is a step in the right direction. While this is a positive step, it is difficult to ignore that other states have instituted similar lock-in programs many years ago. New York has had a Recipient Restriction Program since 1980; Pennsylvania since 1976. Virginia has had a client Medical Management Program since 1978. There is no excuse, in our minds, for Florida to be 20 years behind other states in moving to stop recipient fraud.

Even with the advent of the pharmacy lock-in program, Florida’s efforts still lag behind these

and other states. Other states have found that locking abusive recipients into one physician, combined with the pharmacy lock-in, is critical to the success of anti-fraud efforts. Florida does not have such a restriction, nor has it asked the federal government for a waiver in order to impose this restriction. Based on the testimony we have heard, we have doubts as to whether a pharmacy lock-in alone will lead to significant savings. AHCA's concern is that locking recipients into a physician infringes on a recipient's free choice, which the states are obligated to provide to recipients. But, as we noted, other states have restricted free choice where recipients have engaged in abusive or fraudulent conduct against the Medicaid program pursuant to waivers granted from the federal government.

We think AHCA would do well to explore the option of requiring recipients involved in fraud to be locked-in to one doctor to be the primary care physicians, as other states do. Though all lock-ins tend to diminish recipients' free choice of provider, only recipients found to have engaged in fraud or abuse will find themselves in the program.

AHCA's position is that they do not have authority to implement what may appear to be some common sense restrictions on how services are delivered. We understand there are both state and federal statutory limitations on AHCA's ability to act. We encourage AHCA to make a greater effort to seek the removal of statutory obstacles to a more balanced approach to the issue of recipient fraud. There is simply too much at stake to not make a greater effort. We do not see sufficient evidence of AHCA's efforts to secure necessary authority from either the Legislature or by petitioning the Center for Medicare and Medicaid Services to secure a waiver of federal rules.

For example, AHCA recognizes that paying for medications prescribed by a non-Medicaid physician, especially a physician that has been terminated from the Medicaid program, is an invitation to fraud. So is paying for medications being infused by a non-Medicaid provider or relying on lab reports from non-Medicaid labs. AHCA may be right to conclude that it has no present authority to refuse to pay for medications prescribed or dispensed under these

circumstances, but it certainly has the right and, we say, the obligation to seek that authority.

We have been told that AHCA is seeking statutory authority this year to deny claims for goods and services prescribed by providers that have been terminated from the program. Once again, we believe this is a positive step, but it simply does not go far enough. We have seen ample evidence that criminals are deliberately using non-Medicaid providers in order to defraud Medicaid. Paying for services prescribed by providers outside the program is not only an invitation to fraud, it creates unnecessary obstacles for MFCU investigators. AHCA should seek authority to deny claims for services prescribed by providers outside the program, not just those previously terminated.

Other states, as we've noted, have taken a stronger stance against recipient fraud. Alabama, for example, working under the same federal constraints, has had a state statute on the books since 1975, which requires Medicaid recipients who have abused, defrauded or deliberately misused benefits to become ineligible for a period of at least one (1) year and until full restitution is made to the state.

This seems to us to be a common-sense consequence for abusing an entitlement program. Other entitlement programs, including the federal food stamp program, have similar provisions.

In Florida, not only do Medicaid recipients who have sold their medications remain eligible, but also no effort is made to recover the amount of overpayment. We believe that, at a minimum, recipients that have defrauded or abused the program multiple times should lose their benefits for some period of time.

It appears to us that the resources of the Public Assistance Fraud (PAF) investigations unit could be better utilized. Referrals to PAF appear to be limited to those cases where recipients

have failed to truthfully disclose all circumstances relevant to their eligibility either at the time of application, or subsequently, when there has been a change in circumstances. It is unlikely that recipients are reporting the extra income they make from selling their Medicaid drugs on the black market. Most of these sales are likely to make recipients ineligible, even under current law. While this may be a roundabout way of addressing the problem, it ultimately serves the purpose of allowing Florida to deal with recipients cheating the system. We believe DCF and AHCA should make greater use of PAF resources, to the extent possible.

Looking forward, AHCA believes that Congress may soon approve a change in the law that would allow states to declare recipients ineligible for benefits upon a conviction of a state offense of Medicaid Fraud. This seems to us the very least that should be done. We believe that AHCA should take the lead on this issue and make every effort to see that this legislation is passed. Moreover, we believe AHCA should push for a broader statutory change allowing Florida to declare recipients ineligible for having committed fraud against the program based on an administrative hearing, not just a criminal conviction.

In either case, we believe the legislature would do well to criminalize the specific conduct of selling or buying goods or services provided by the Medicaid program, making it a Medicaid fraud offense under Chapter 409.

There is one particular issue which the pharmaceutical industry can help to resolve. Some time ago, drug manufacturers began shipping their medications to pharmacies in typical dosages prescribed by doctors. This has led to greater efficiency in the pharmacy as pharmacists have increasingly moved away from counting out pills from large (500-5,000 pill) bottles to place in the familiar amber pharmacy vials. While leading to greater efficiency, this new development has played into the hands of drug diverters by making it easier to market drugs bought back from recipients. In response AHCA by rule, required pharmacists dispensing Medicaid drugs to either re-bottle the drugs, remove the manufacturer's seal or mark the bottle with an "M" in indelible ink. Not surprisingly, pharmacists opted for marking the bottles with a black "M". Investigators have determined this to be ineffective, as even

indelible ink can be removed with the right commercial solvent. AHCA intends to amend the rule to remove the option of using an indelible marker and requiring pharmacists to either break the seal, or re-bottle the drugs. Based on the testimony we have heard we assume pharmacists will opt for breaking the seal, which we frankly think will be inadequate. Drugs dispensed in the manufacturer's bottle are much more marketable and are a serious issue in the diversion of these pharmaceuticals. We understand the reluctance of pharmacists to give up the efficiency of pre-measured dosages. It seems unfair to place the burden on a group with no responsibility for the fraud in issue. No doubt requiring pharmacists to change the medication to pharmacy vials will create some extra measure of work, though how much work and what impact it will have on a pharmacy's bottom line is beyond our ability to predict.

However, pharmacists in the Medicaid program are paid \$4.23 for each Medicaid prescription dispensed. Last year, Medicaid paid for over 31 million individual prescriptions. We believe this is an issue worthy of further discussion with the industry to determine the most cost efficient manner to keep these manufacturer's bottles out of the hands of diverters. Alternatively, drug manufacturers could look into using labels that will easily smear or break down in the presence of solvents used to remove pharmacy labels or, pharmacists could switch to labels that will permanently adhere or that cannot be removed without destroying the manufacturer's label.

#### **IV. Conclusion**

Billing Medicaid for medications for recipients based on phony diagnosis is criminal and reprehensible. Soliciting vulnerable people, living in poverty and gravely ill, to sell their life-saving drugs is the lowest form of human exploitation.

Though some recipients are no doubt exploited by being convinced to sell their medications, they should bear responsibility for their actions. We believe that our state agencies should do more to hold these individuals accountable.

Despite the amount of fraud committed by recipients, we are not aware of any examples where recipients have lost their eligibility for selling their medications or otherwise committing fraud. For that matter, we are unaware of any recipients that have been required to repay benefits for having sold their medications.

There appears to be a mythology regarding recipient fraud among some people that nothing can be done about it; certainly not denying benefits to those caught cheating.

While it does appear that some state and federal statutes and regulations have inadvertently painted us into a corner, much of what we have been told can't be done, actually can be done either by statutory changes or by securing waivers from the federal government.

Although our report focuses much of our attention on AHCA, it is important to keep this in perspective. As the dominant player in all phases of the Medicaid program, from its command of the \$10 billion dollar plus budget to control of the Program Integrity Unit, AHCA naturally has the most to say and do in regards to the issue of Medicaid fraud. It should not be surprising, then, that AHCA's efforts will draw the most attention. We also acknowledge the positive steps AHCA has taken in the past and it's continuing efforts, even as we scrutinize this issue, to address developing trends in Medicaid fraud.

We do conclude, however, that there is much room for improvement and, if there was one overarching recommendation we would make to AHCA, it would be to put an even greater emphasis on anti-fraud efforts so that no one defrauding the system, not even recipients, would be given a pass. With a projected budget of \$13 billion next year, even losing 10% to fraud, a figure we believe to be unrealistically low, is a staggering amount of taxpayer money to lose to criminals.

While drug diversion is only a 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. AHCA 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 we have identified and will be supportive of AHCA's efforts to address this fraud with renewed vigor.

## **V. Recommendations**

### **Recommendations to the Legislature**

1. Criminalize the sale of Medicaid drugs by recipients making an offense of Medicaid fraud under Chapter 409.
2. Criminalize the purchase of Medicaid drugs from a recipient and tie the degree of felony to the value of drugs.
3. Amend s.409.912(40)(a)(3) to authorize AHCA 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.
4. Amend s.409.912(40)(a)(3) to clarify that enrollment of recipients in categories listed in the statute is mandatory.
5. Explore the option of privatizing the provision of pharmacy services for Medicaid recipients.

### **Recommendations to AHCA**

1. Recommend that recipients who abuse or defraud the Medicaid program have all of their Medicaid services locked in to one provider for each category of service.

2. We also recommend that recipients 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.
3. We recommend AHCA seek authority from the Center 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.
4. Amend the Recipient enrollment form to include an agreement that recipients may lose their eligibility for abusing or defrauding the Medicaid program.
5. Prohibit Medicaid from reimbursing for drugs, goods or services prescribed by non-Medicaid providers.
6. Prohibit Medicaid from reimbursing for medications infused by non-Medicaid provider.
7. We strongly recommend that Medicaid require a second opinion by a Medicaid enrolled physician to confirm all diagnoses of serious medical conditions such as HIV/AIDS, cancer, etc.
8. Broaden Medicaid's restrictions and pre-authorizations to simultaneously include all drugs within a class likely to be diverted.
9. Require Medicaid cards to be presented and swiped electronically before receiving medications and/or services.
10. Require inclusion of recipient's photograph on Medicaid cards.
11. Mail Explanation of Benefits forms to all recipients so that they can be alerted to all

billings made under their Medicaid number.

12. Mail information about infusion clinics to recipients receiving infusion services.
13. 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.
14. Encourage Medicaid to improve communications and information sharing with all agencies involved in anti-fraud efforts.

THIS REPORT IS RESPECTFULLY SUBMITTED to the Honorable Dale Ross, Presiding Judge of the Seventeenth Statewide Grand Jury, this \_\_\_\_ day of December 2003.

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James C. Ross  
Foreperson  
Seventeenth Statewide Grand Jury of Florida

I, OSCAR GELPI, Special Counsel and Assistant Legal Advisor, Seventeenth Statewide Grand Jury of Florida, hereby certify that I, as authorized and required by law, have advised the Grand Jury which returned this report on this \_\_\_\_ day of December, 2003.

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Oscar Gelpi  
Special Counsel  
Assistant Legal Advisor  
Seventeenth Statewide Grand Jury of Florida

The foregoing Report was returned before me this \_\_\_\_\_ day of December 2003.

Upon the Legal Advisor's oral motion for the disclosure for the purposes of furthering justice of the Report, the Legal Advisor is authorized to disclose the testimony and proceedings recounted in the foregoing document in furtherance of the criminal, investigative and civil administrative responsibilities of the Seventeenth Statewide Grand Jury.

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Honorable Dale Ross  
Presiding Judge  
Seventeenth Statewide Grand Jury of Florida