Crime, No Punishment

By all accounts, Florida is a hotbed of Medicaid fraud. The state spends $25 million and has 300 people to detect and investigate it but is lousy at catching Medicaid crooks.

In September 2011, eight months into her job as Florida attorney general, Pam Bondi made her first visit to the Miami office of her agency's Medicaid Fraud Control Unit. "I was appalled, shocked to learn that there were so many vacant offices, (with) lights out," Bondi says. She says she was particularly disturbed that the Miami office wasn't fully staffed given Miami's reputation as a hotbed of Medicaid fraud.

"We have so many vacant positions that can be filled," Bondi told Jim Varnado, her inspector general, who was conducting an internal review of the unit to determine, among other things, why it wasn’t producing more arrests and convictions.

Varnado’s report ultimately confirmed what Bondi says she saw in Miami — 45 vacant positions and "no clear chain of command." Law enforcement officers lacked the training to investigate fraud. Top managers were faulted for intimidating employees from talking forthrightly about problems within the unit. Ultimately, Bondi demoted the fraud unit's director, fired the head of law enforcement and named Varnado director.

Medicaid fraud in Florida is big-dollar crime. The health care program for the poor in Florida costs taxpayers $21.2 billion, nearly a third of the state's overall budget ["Pac-Man," page 94]. Of the total, $11.6 billion is paid for by the federal government. Estimates put the amount lost to fraud in Florida each year at between 5% and 10% of the state budget.

For criminals like Patrick Crisler, the owner of a physical therapy clinic in Inverness in southwest Florida, the program was a giant ATM that he accessed by submitting claims for treatment...
Attorney General Pam Bondi says it will take time for her changes — including adding seven investigators — to yield results.

Just as bad — the state’s efforts at combating the fraud have had a history of futility for decades. The unit has been the target of state audits, reform bills by the Legislature, investigative reports in newspapers and wrongful termination lawsuits alleging discrimination. In 2003, the federal government put the unit on probation.

Today, the state spends $25 million, with a force of 300 people split between the Attorney General’s Office and the state Agency for Health Care Administration, to detect and investigate fraud.

The results? Florida Medicaid investigators made 85 arrests in 2011 and 28 as of August this year. That averages to less than two arrests per law enforcement officer each year — making the state 36th in the number of Medicaid fraud convictions and civil settlements per fraud unit employee. States such as Ohio, with a third of the fraud-fighting budget and less than half the staff, have more convictions than Florida. The state says comparing Florida to other states isn’t fair and that some states may have more resources than what is reported.

Bondi isn’t the first Florida attorney general to be “shocked and appalled” at Medicaid fraud. Incoming attorneys general, from Bob Butterworth in 1994 to Charlie Crist in 2003, have tended to follow similar scripts — outrage, followed by vows to do a better job and replacement of a few top managers.

So far, Bondi hasn’t taken any more dramatic steps than her predecessors, and Varnado acknowledges there will be “no radical departure” in how the state investigates Medicaid fraud.

A flawed system

In part, Medicaid fraud is difficult to detect and investigate because the barriers to entry for crooks are low. A criminal needs little more than a Medicaid provider number and Medicaid billing software to file claims and a bank account to receive payments. Medicaid patient recipient numbers can also be obtained easily. Because of the government’s “pay first, investigate later” system, fraud can go undetected for years after it was committed — and long after the criminal has moved on.

In addition, the fraud-fighting effort in Florida is disjointed and rife with bureaucratic politics, beginning with the relationship between the Attorney General’s Office and the state Agency for Health Care Administration. AHCA’s primary focus is to reimburse Medicaid health care providers as quickly as possible. However, because it writes the

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Source: Agency for Health Care Administration

that he never provided or by billing for more expensive procedures than he did provide. Over three years, Crisler pocketed $450,000 by submitting fraudulent claims. He was arrested in 2011 and convicted this year, caught only after a fraud investigator noticed unusual billing patterns.

“People don’t want to know how bad it is. The amount of money stolen, wasted or abused in the system is frighteningly bad,” Varnado says.

Florida Medicaid Numbers

- Enrollment: 3.3 million
- Total Medicaid Expenditures: $20.2 billion
- Fraud: No one knows for sure how much fraud costs the government but estimates range from 3% and 10% of total Medicaid expenditures

Source: Agency for Health Care Administration

Pac-Man

Medicaid is paid by federal and state dollars. It has long been a thorn in the side of Florida’s budget planners and political leaders because it consumes a bigger chunk of the budget each year, squeezing funding for education, transportation and other services. The problem worsens in lean budget years and has led to a push by Republican leaders to shift to a managed care model, which they say could help control costs. Critics worry this change could lead to cuts in services to the poor, elderly and disabled who qualify for Medicaid.
checks, AHCA — through its Medicaid Program Integrity Office — also shares frontline responsibility with the fraud control unit for detecting fraud.

But while AHCA is supposed to find fraud, federal law stipulates that AHCA can only stop payments of suspected fraud and must refer investigations to the fraud control unit. The AG’s fraud unit, meanwhile, can investigate a case but relies heavily on AHCA and its own fraud hot line system for referrals. So as AHCA receives tips from hot line callers, Medicaid recipients and its own data queries, it passes them along to the AG’s fraud unit, which then decides whether fraud has been committed. Despite mandatory biweekly meetings between officials from AHCA and the AG’s office, complaints about poor communication between the two agencies persist.

Meanwhile, there are other structural issues, including the lack of prosecutors on the fraud unit’s investigative teams. David Moyé, a Tallahassee attorney and a former assistant attorney general in charge of the Medicaid fraud unit, says California does a better job at fighting fraud because investigators work closely with prosecutors from the moment an investigation begins — eliminating the learning curve that occurs when an investigator passes along boxes of materials to a prosecutor who then has to

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Fraud Fighters

A small pharmacy in the Keys has earned millions exposing Medicaid fraud.

In August 2011, Attorney General Pam Bondi filed a three-paragraph statement announcing a $26.6-million settlement with Par Pharmaceutical Cos. At the bottom of that statement was a reference to a small Florida pharmacy called Ven-A-Care of the Florida Keys.

The company filed the initial whistleblower’s lawsuit that accused Par Pharmaceuticals of inflating prices of its drugs and overcharging Medicaid. As its reward, Ven-A-Care will receive at least $23 million from the $156 million multi-state settlement.

Since it won its first $40-million Medicaid fraud settlement in 2000, Ven-A-Care has become the most successful health care fraud whistleblower in the country, generating millions by blowing the whistle on drug companies that overcharge Medicare and Medicaid. According to Ven-A-Care, it has uncovered more than $2.5 billion in health care fraud since 2000, making it the most successful health care fraud whistleblower.

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success, none have come close, says Patrick Burns, spokesman for Taxpayers Against Fraud.

Ven-A-Care keeps a low profile and did not respond to a request for an interview. Company principals include Luis Cobo, Terry Mark Jones and John Lockwood. Zachary Bentley founded the company but is no longer listed on the company’s corporate registration documents. According to news accounts, the pharmacy started in 1987 as a way to supply drugs intravenously to AIDS patients. Its four founders discovered pricing discrepancies and filed the company’s first false claims suit in the early 1990s, settling that case in 2000.

Ven-A-Care’s success also highlights a weakness in Florida’s fraud-fighting efforts. Though Ven-A-Care is based in Florida, it often chooses to file lawsuits first in other states. That’s because Florida has a reputation for not wanting to aggressively pursue whistleblower lawsuits, Burns says. Most of Florida’s revenue from Medicaid fraud fines and settlements comes from multi-state investigations launched in other states. For instance, since Bondi took office in January 2011, 62%, or $182 million, of revenue from settlements and fines came from multi-state investigations. Public Citizen’s report shows Florida ranks at the bottom compared to other states when it comes to collecting single-state legal settlements from the pharmaceutical industry. It ranks third worst at Medicaid dollars recovered per $1,000 spent at $1.36 and its return on investment per enforcement dollars spent is 12 cents. States such as Texas, Louisiana and South Carolina do a far better job. But Florida does earn more money from financial penalties through multistate settlements than any other state, except Texas, according to Public Citizen.
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— Jim Varnado, director, Medicaid Fraud Control Unit

start from scratch to understand the case. Another weakness in the system involves the skills and priorities of the fraud unit’s investigative personnel. Florida investigators may lack the sophistication to recognize and pursue financial fraud, preferring instead to focus on another area of responsibility, cases of physical abuse and neglect, Moyé says. Nearly a third of arrests in 2010-11, for example, involved cases of physical abuse and neglect.

Simply hiring more skilled investigators isn’t easy. Experienced white-collar crime investigators typically find better pay and benefits with federal agencies. “It’s difficult to hire qualified investigators in south Florida who do this type of work,” Varnado says.

In addition, the reports required by both the federal and state governments focus on the raw numbers of arrests and convictions, leading to an emphasis of quantity over quality. Last year, for example, an employee of a Brevard County home health provider was arrested for allegedly lying about the hours she worked. Total amount allegedly stolen from Medicaid: $1,327.

Solutions?

What might make a bigger dent in Medicaid fraud? Giving the fraud unit more training and investigative resources might help. The fraud unit has struggled to aggressively mine Medicaid data, largely abandoning these efforts during most of Attorney General Bill McCollum’s tenure, Moyé says. In 2010, the program got special permission to launch a data-mining project, digging into Medicaid claims to look for suspicious activity. So far, that experiment hasn’t led to a single arrest. “We can do better there, no question,” Varnado says.

Moyé is among those who think that the personnel changes need to go deeper than the top managers. Opinions differ on whether a shift by the state to a managed care system for Medicaid would help cut fraud. Propo-
Taking Credit

Critics say Medicaid fraud investigators exaggerate their role in fighting fraud.

In July 2009, Plant City resident Ben Bane was accused of stealing $5 million from Medicare over four years beginning in 2001. A 16-page federal indictment said Bane was regularly billing Medicare, the federal health care benefit program for older Americans, for home oxygen supply services that either his company didn’t perform or were in violation of Medicare policies. He was convicted in 2011 following a trial.

Nowhere in the indictment is the word “Medicaid” used. That’s because Bane was only being accused of violating Medicare law, not Medicaid.

That didn’t stop Florida’s Medicaid Fraud Control Unit from including Bane’s guilty conviction in 2011, along with the convictions of two of his accomplices, on a tally of its investigative successes provided to FLORIDA TREND. A spokesman for the Attorney General’s Office says it was within the bounds of federal rules to include Bane’s case as one of its own. While the original indictment doesn’t mention Medicaid fraud, spokesman John Lucas says state investigators spent 600 hours on the case. “From the beginning, it was a joint investigation with the U.S. Department of Health and Human Services and the FBI,” Lucas says. But somehow, Medicaid fraud charges were never brought against Bane.

David Moyé, former director of the Medicaid Fraud Control Unit, says state Medicaid fraud investigators count as victories arrests and convictions in which they played minor roles.

Lucas says because Medicaid dollars were included in the sentencing of Bane, the state could count the conviction.

Bane’s case illustrates a common criticism that state fraud investigators aren’t as successful as portrayed. The unit is required to keep track of its arrests and convictions and to submit data-driven reports to the Legislature each year. These statistics are used to keep tabs on the work of the unit.

“They are grossly exaggerated,” says David Moyé, a former assistant deputy attorney general in charge of the unit under then-Gov. Charlie Crist. He now works as an attorney in Tallahassee. Another former employee says “they are taking credit for work somebody else is doing,” calling the unit “massively overrated.”

According to the Attorney General’s Office, since January 2011 there have been 113 arrests and 119 convictions for Medicaid fraud. That tally includes nearly 30 cases on Medicaid patient abuse and neglect, which the unit is federally mandated to investigate. It isn’t clear how many of these cases were shared with federal or local investigators.

Moyé says in some cases Medicaid fraud investigators play an insignificant role but still count the arrests and convictions as an investigative victory.

U.S. Department of Health and Human Services’ Office of Inspector General spokesman Donald White says “there certainly are cases where the federal government is very involved and times when the federal government takes the lead.” Determining what agency gets “credit” on a case “is a difficult question to answer,” White says, because it varies depending on who is in charge. Lucas says investigative work is divided up on a case-by-case basis, taking into consideration subject expertise and jurisdictions.