STATE MEDICAID FRAUD ENFORCEMENT PRIORITIES AND INITIATIVES IN FLORIDA

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I. ORGANIZATION OF THE FLORIDA MEDICAID FRAUD CONTROL UNIT[1]

a. *An overview of the Florida Medicaid Fraud Control Unit (MFCU).*

1. Pursuant to Florida Statutes and in accordance with federal directives, the Medicaid Fraud Control Unit (MFCU) operates within the Office of the Attorney General.[2]

2. MFCU is a state law enforcement agency. See § 409.9205 Fla. Stat.

3. MFCU is lead by Director David Lewis.

4. MFCU has approximately 200 employees consisting of attorneys, sworn law enforcement officers, analysts, auditors, paralegals, unsworn investigators, nurses and support staff.

5. MFCU does not administer the Medicaid program. However, the unit is responsible for investigating fraud in the administration of the program.

[1]The enactment of the Medicare and Medicaid Anti-Fraud and Abuse Amendments of 1977 authorized the establishment of, and Federal funding for, the State Medicaid Fraud Control Units. Currently 49 states and the District of Columbia participate in the Medicaid fraud control grant program. (This information was obtained from the United States Department of Health and Human Services, Office of Inspector General web site)

[2]The majority of the Units are located within the Office of State Attorneys General. A small number of the Units are located in various other State Agencies. The mission of the Medicaid fraud units is to investigate and prosecute Medicaid provider fraud and incidences of patient abuse and neglect. Id.

The Florida Medicaid Program is administered by the Florida Agency for Healthcare Administration.

6. MFCU's focus is on provider not recipient fraud.

7. MFCU has offices located in the following cities:

   i. Tallahassee,

   ii. Pensacola,

   iii. Jacksonville,

   iv. Orlando,

   v. Tampa,

   vi. West Palm Beach,

   vii. Ft. Lauderdale,

   viii. and Miami.

8. MFCU's budget is a hybrid of federal and state dollars.[3] Seventy-five percent of the MFCU budget is federally funded and the remaining 25 percent comes from the State of Florida's general revenue fund pursuant to federal statutes and regulations.

   i. In FY 2010-11, MFCU's budget was as follows:

Federal Financial Participation	$11,931,876
Florida General Revenue	$3,977,292
TOTAL	$15,909,168

9. While the MFCU budget was again reduced from the previous year's budget the unit continued to improve its efficiency. In the FY 2010-11 (FY refers to the state fiscal year which begins July 1st each year and ends June 30th) the MFCU brought $16.8 million in collections to Florida's General Revenue Fund. In FY 2009-10 MFCU recoveries added $16.6

[3]Each State Medicaid Fraud Control Unit is eligible to receive Federal grant funds under the Medicaid fraud control program. The Medicaid fraud units receive 90 percent Federal funding for the first 3 years of operation and 75 percent thereafter. Id.

million to the States General revenue Fund. In FY 2008-09 MFCU recoveries added $15.3 Million to the State of Florida's General Revenue Fund and in FY 2007-08 MFCU recoveries added $5,684,855 to the State of Florida's General Revenue Fund.

b. *MFCU has several enforcement responsibilities.*

1. MFCU conducts a statewide program for the investigation of fraud and abuse in the Medicaid Program. MFCU is authorized to investigate possible criminal violations of any applicable state law pertaining to fraud in the administration of the Medicaid program, in the provision of medical assistance, or in the activities of providers of healthcare under the Medicaid program. See § 409.920 Fla. Stat.

2. MFCU conducts investigations and assists in the prosecution of abuse, neglect or exploitation of persons housed in Medicaid provider facilities. See § 409.920(8)(b) Fla. Stat.

i. Each MFCU office has separate squads/investigators assigned to fraud investigations and to Patient Abuse, Neglect and Exploitation (PANE) cases. Attorneys within the Unit provide legal advice to the investigative staff for both case types.

3. MFCU investigates the alleged misappropriation of patients' private funds in health care facilities receiving payments under the Medicaid program.

See § 409.920(8)(c) Fla. Stat.

4. The Department of Legal Affairs (Office of Attorney General) has jurisdiction to investigate possible violations of the Florida False Claims Act and is authorized to file civil actions pursuant to the Florida False Claims Act. See §§ 68.081-68.09 Fla. Stat.

5. In the event of natural disasters such as hurricanes or tornadoes, MFCU personnel visit nursing homes and Assisted Living Facilities in the affected area to determine whether those facilities are capable of continued operation and to assist in coordinating assistance as needed.

II. INVESTIGATIONS

a. *The first stage of the MFCU investigative process is the review of a complaint.*

1. The receipt of a complaint is the basis for most investigations opened by MFCU.

2. Review Process

i. Complaints are reviewed to determine issues such as jurisdiction, matters for referral to another agency and viability of the complaint. Under this policy a MFCU case is only opened when there is a criminal or civil predicate that warrants further investigation.

3. The primary sources of MFCU fraud complaints.

i. The primary source of MFCU fraud related complaints in state Fiscal Year (FY) 2010-11 was private citizens as it had been the previous year. The MFCU received 229 complaints from private citizens. The second highest source of fraud complaints was whistleblower complaints or *qui tam filings* with 137 complaints. Florida received 137 new *qui tam* case filings in FY 2010-11. *Qui Tam* filings have increased the past three fiscal years. Florida received 94 new *qui tam* filings in FY 2009-10 after receiving 56 new filings in FY 2008-09. The Florida Agency for Health Care Administration (AHCA) provided the third highest referral source for fraud complaints.

ii. The primary sources of fraud complaints in FYs 2007-09 were private citizens and AHCA.

4. The primary sources of Patient Abuse, Neglect and Exploitation (PANE) Complaints.

i. MFCU monitors the Florida Department of Children & Families (DCF) Hotline for possible patient abuse incidents. As a result of the continual monitoring an overwhelming majority of PANE complaints are generated by DCF.

ii. In both FY 2010-11 and FY 2009-10 the majority of PANE complaints were generated by DCF. The second highest source of complaints was private citizens.

b. *Case openings are the second stage of MFCU investigations.*

1. A case opening by MFCU indicates that a criminal investigation or civil case has been opened and significant investigative resources and time will be expended to identify the following:

i. The individuals involved in the possible criminal and/or civil misconduct;

ii. The scope of the criminal and/or fraudulent activity;

iii. Sufficient evidence to prove the requisite criminal and/or civil elements.

2. The number of new MFCU complaints and cases.

i. In FY 2010-11, 1,666 complaints were received by the MFCU and 356 were opened as operational cases. Of those cases 303 were related to Medicaid fraud

ii. In FY 2009-10, 1,866 complaints were received by the MFCU and 388 were opened as operational cases. Of those cases 297 were related to Medicaid fraud.

A. MFCU **Policy** requires a 30-day review period for new complaints during which the allegations contained in the complaint are investigated. Case openings only occur when there is a criminal or civil predicate that warrants further investigative activities.

c. *Various types of Fraud and Abuse investigated by MFCU. The types of fraud include but are now limited to:*

1. Upcoding and Modifiers,

2. Unbundling,

3. Billing for services not rendered,

4. Billing for ineligible recipients,

5. Billing for work done by ineligible employees,

6. Billing for unnecessary services,

7. Drug diversion and trafficking,

8. Short filling prescriptions,

9. Unlawful marketing of pharmaceuticals (Kickbacks, off label),

10. Misuse of a provider number,

11. Drug substitution,

12. Cost report fraud,

13. Pharmaceutical price manipulation,

14. and Best Price Violations.

d. *Medicaid program areas with high rates of abuse include:*

1. Waiver Programs,

2. Case Management,

3. Durable Medical Equipment (DME),

4. Pharmacy,

5. and Home and Community based Service.

e. *The top 5 provider types subject to new MFCU cases in FY 2010-11 and FY 2009-10.*

1. The top five provider types (ranked most to least frequent) that were the focus of cases opened by MFCU in the FY 2010-11 were, in order:

i. Pharmaceutical Manufacturer,

ii. Home & Community-Based Care,

iii. Physician,

iii. Pharmacy,

iv. Medical Supplies/Durable Medical Equipment.

2. The top five provider types (ranked most to least frequent) that were the focus of cases opened by MFCU in the FY 2009-10 were, in order:

i. Home & Community-Based Care,

ii. Pharmaceutical Manufacturer,

iii. Physician,

iv. Medical Supplies/Durable Medical Equipment,

v. Community Alcohol/Drug/Mental Health.

3. In FY 2010-11 and FY 2009-10 Facility Employees were the predominant subjects of PANE case openings.

III. INVESTIGATIVE STRATEGY

a. *MFCU shall conduct criminal and civil enforcement actions designed to prevent, detect, prosecute and deter misconduct in MFCU's areas of enforcement responsibility in order to protect the integrity of the Medicaid program and the citizens of Florida.*

b. *MFCU's investigative focus centers on three areas.*

1. **Medicaid Provider Fraud**- Case investigations focus on types of fraud, types of subjects/targets, provider types and fraud which have a widespread impact on the Medicaid program or that involve public safety. Emphasis is placed on case investigations/prosecutions that have a deterrent effect. Additional efforts to identify fraud in conjunction with quality of care issues are also being stressed.

2. **PANE Investigations**- The focus is placed on activities/investigations that involve prevention and timely criminal enforcement. Emphasis is placed on facilities/incidents with immediate public safety concerns and those which have widespread impact regarding possible victims.

3 **Civil Recoveries**- Regardless of whether an investigation is criminal or civil in nature emphasis is placed upon the recovery of the State's monetary losses caused by fraud, through use of Florida's Contraband Forfeiture Act, Florida's False Claims Act and any other available legal remedies.

i. The Medicaid Fraud Control Unit's Civil and Criminal Recoveries over the past few years.

A. In the Calendar Year 2011 the total amount of recoveries by the Florida Medicaid Fraud Control Unit was over $200M.

B. In FY 2010-11 the total amount of recoveries by the Florida Medicaid Fraud Control Unit was over $110.2M.

C. In FY 2009-10 the total amount of recoveries by the Florida Medicaid Fraud Control Unit was over $144.6M.

1. In FY 2009-10 the total amount for civil recoveries, which includes civil settlements arising from *qui tam* cases brought under the Florida False Claims Act, was $99.3M.

D. In FY 2008-09 total recoveries by the Florida Medicaid Fraud Control Unit were over $168,000,000.00.

E. In FY 2007-08 civil recoveries arising from Qui Tam cases brought pursuant to the Florida False Claims Act were $51,120,765.00.

F. FY 02-03 $25.2 M; FY 03-04 $31.8M; FY 04-05 $41.8 M; FY 05-06 $83.3M; FY 06-07 $90M; and FY 07-08 $61.1M.

c. MFCU's *criminal enforcement methods.*[4]

1. In appropriate cases, MFCU arrests individuals and works with the local State Attorney, United States Attorney or the Statewide Prosecutor.

2. In many instances MFCU attorneys are cross-designated with a prosecuting agency.

3. Criminal charges are varied and include Medicaid fraud, identity theft, money laundering, organized fraud, and aggravated white collar crime.

4. In FY 2010-11 there were 90 arrests/warrants made. Sixty-three of these were Medicaid fraud investigations and 27 were for PANE investigations.

5. In FY 2009-10 there were 97 arrests/warrants made. Sixty-one of these were Medicaid fraud investigations and 36 were for PANE investigations.

d. *MFCU's civil enforcement methods*.

1. ***Florida False Claims Act***

[4] The Florida Medicaid Fraud Control Unit does not have independent prosecutorial authority in criminal matters.

i. MFCU's primary vehicles for civil enforcement are the federal and state False Claims Acts, 31 U.S.C. § 3729 and §§ 68.081-68.09 Fla. Stat.

A. Both Acts provide for treble damages and fines for knowingly filing a false claim.

ii. The purpose of the Florida False Claims Act.

A. Deter persons from knowingly causing or assisting in causing state government to pay claims that are false or fraudulent, and to provide remedies for obtaining treble damages and civil penalties for state government when money is obtained from state government by reason of a false or fraudulent claim. § 68.081(2) Fla. Stat.

iii. The definition of a claim under the Florida False Claims Act.

A. A claim includes any written or electronically submitted request or demand for money, property or services which is made to any employee, officer, or agent of an any contractor, guarantee, or other recipient provides any portion of the money or demanded, or if the agency will grantee or other recipient of property requested or Stat.

agency, or to
if the agency
property requested or
reimburse the contractor,
any portion of the money or
demanded. See § 68.082(1)(b) Fla.

iv. What constitutes a false claim against the state?

A. Knowingly Presents or Causes to Be Presented a False Claim for Payment. § 68.082(2)(a) Fla. Stat.

B. Knowingly Uses a False Record or Statement to Get a or Fraudulent Claim Paid or Approved by an Agency. § 68.082(2)(b) Fla. Stat.

False

C. Conspires to Submit a False Claim. §68.082(2)(c) Fla. Stat.

D. Knowingly Delivers Less Property than the Amount Required by Receipt. § 68.082(2)(d) Fla. Stat.

E. Makes or Delivers a Receipt Without Knowing the Information on the Receipt Is True. § 68.082(2)(e) Fla.

Stat.

F. Knowingly Use False Record to Conceal, Avoid, or Decrease an Obligation to Pay or Transmit Money or Property to an Agency. § 68.082(2)(g) Fla. Stat.

v. Conduct giving rise to a false claims liability under the Florida False Claims Act:

A. Overbilling,

B. Upcoding,

C. Billing for Services not Rendered,

D. Improper physician referrals - (Stark Violations) Patient Self-Referral Act of 1992 which is contained in Chapter 456 Florida Statutes,

E. Improper substitution of services or goods,

F. Off-Label Marketing,

G. Drug Price Manipulation,

H. and Best Price Violations.

vi. Defendant's knowledge standard - Actual knowledge of the false claim is not required for a person to be liable under the Act. See § 68.081(1)(c) Fla. Stat.

A. Actual Knowledge or,

B. Deliberate Ignorance or,

C. or Reckless Disregard of Truth or Falsity.

D. Specific intent to submit a false claim is not required to be liable under the Act.

E. Innocent mistake is a defense to a False Claims action.

vii. The burden of proof for a plaintiff in a False Claims action.

A. Preponderance of the Evidence

See § 68.089 Fla. Stat.

viii. A defendant who submits a false claim may be liable for treble damages, fines and attorney fees.
See § 68.082 Fla. Stat.

A. **Treble of Actual Damages**, unless the Court finds one of the following:

1. Self disclosure within 30 days after the date on which the person first obtained the information.

2. Defendant fully cooperated with the investigation.

3. At the time the person furnished the information about the violation there was not a civil or criminal action filed and the person was unaware of the investigation.

B. Fines of $5,500 to $11,000 for Each False Claim
See § 68.082 (2)(g) Fla. Stat.

ix. Relators- private individuals and corporations can bring a False Claims Action on behalf of the state. § 68.083(2) Fla. Stat.

A. Relators can get share of the recovery.
See § 68.085(1)-(6) Fla. Stat.

x. Deficit Reduction Act of 2005 (DRA)
See Section 1909 of the Social Security Act, 42 U.S.C. 1396h

A. DRA provides incentive for adoption of State False Claims Acts by decreasing the Federal medical assistance percentage by 10 percentage points for recoveries from legal actions brought pursuant to such laws.

B. Centers for Medicare and Medicaid Services ("CMS") encouraged the states to adopt State False Claims Acts in a letter addressed to State Medicaid Directors dated September 19, 2006.

C. To be eligible for the increased recovery rate, States must enact or already have had in effect a law the Health and Human Services' Office of Inspector General (HHS OIG)

in consultation with the Department of Justice determines meets several criteria. See HHS OIG published guidelines Published on Monday August 21, 2006 (71 *Fed. Reg*. 48552-48554). The criteria include:

1. The law establishes liability to the State for false or fraudulent claims.

2. The law contains provisions that are at least as effective in rewarding and facilitating qui tam actions as the Federal False Claims Act.

3. The law contains a requirement for filing an action under seal for 60 days with review by the State Attorney General.

4. The law contains a civil penalty that is not less than the amount of the civil penalty authorized by the Federal False Claims Act.

D. In addition to Florida, the cities of New York and Chicago, and the District of Columbia, the following states now have False Claims Acts: Connecticut, Maryland, Colorado, California, Delaware, Georgia, Hawaii, Illinois, Indiana, Kansas, Louisiana, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, Oklahoma, Rhode Island, Tennessee, Texas, Virginia, North Carolina and Wisconsin.[5]

1. Colorado, Connecticut, Maryland, Texas, Georgia, Louisiana, and Michigan's False Claims Acts are Medicaid only False Claims Acts.[6]

2. Michigan, Rhode Island, California, Georgia, Hawaii, Illinois, Indiana, Massachusetts, Nevada, New York, Tennessee, Texas, Virginia and Wisconsin's have qualified for an increased share under the Deficit Reduction Act.[7]

[5] This information was obtained from the Taxpayers Against Fraud web site.

[6] Id.

[7] Id.

E. The Florida False Claims Act was most recently amended in 2009.

1. The standard for awarding a prevailing defendant attorney fees and costs was amended to mirror the language contained in the Federal False Claims Act.

2. **Florida Contraband Forfeiture Act**

i. §§ 932.701 - 707 Fla. Stat. are known and may be cited as the Florida Contraband Forfeiture Act.

ii. Contraband articles may be seized by and forfeited to MFCU.

A. Any contraband article, vessel, motor vehicle, aircraft, personal property or real property used in violation of the any provision of the Florida Contraband Forfeiture Act, or in, upon, by means of which any violation of the Florida Contraband Forfeiture Act was taken or is taking place, may be seized and shall be forfeited subject to the provisions of the Florida Contraband Forfeiture Act. § 932.703(1)(a) Fla. Stat.

other
of

B. Definition of Contraband articles includes: Any personal property which was used, attempted to be used as an instrumentality in the commission of a felony whether or not comprising an element of the felony or which was acquired by proceeds obtained as a result of a violation of the act. See § 932.701(2)(a)(5) Fla. Stat.

C. Definition of Contraband articles also includes: any property which was acquired by proceeds obtained as a result of Medicaid Fraud. See § 932.701(2)(a)(11) Fla. Stat.

3. Other civil actions that may be brought by MFCU include:

i. Common Law Civil Causes of Action,

vi. and Civil Theft.

e. *Rewards for Reporting Medicaid Fraud*

1. Subject to the availability of funds and the satisfaction of certain statutory requirements persons who furnish and report original information relating

to a violation of the state's Medicaid fraud laws may be entitled to a reward. See § 409.9203 Fla. Stat.

2. The reward may not exceed the lesser of 25% of the amount recovered or $500,000 in a single case. See § 409.9203(2) Fla. Stat.

3. A person who receives a reward pursuant to this program is not eligible for any funds pursuant to the Florida False Claims Act for Medicaid fraud for which a reward is received pursuant to this section. See § 409.9203(4) Fla. Stat.

IV. FLORIDA MFCU'S DATA MINING WAIVER

a. *Federal law does not permit state MFCUs to conduct analysis to independently identify Medicaid fraud.*

1. Initial fraud and abuse prevention traditionally occurred through alerts provided to state MFCUs by Medicaid enrollees, providers, other members of the public and the efforts of the state Medicaid Agencies.

2. The federal code prohibits Federal Matching Participation (FMP) to reimburse efforts by any state MFCU for the following: "Efforts to identify situations in which a question of fraud may exist, including the screening of claims, analysis of patterns of practice, or routine verification with recipients of whether services billed by providers were actually received."
42 CFR 1007.19(e)(2). These described efforts are known as data mining.

3. U.S. Health and Human Services (HHS) addressed the potential value of encouraging a state MFCU data mining demonstration project in 2006. It was believed that a demonstration project could help determine whether it would be more effective and efficient to permit MFCUs to conduct data mining.[8]

4. On July 10, 2010 the Secretary of the Florida Agency for Healthcare Administration, the designated single state agency responsible for administering the Florida Medicaid program; and the Attorney General of the State of Florida, who is in charge of the Medicaid Fraud Control Unit, jointly requested an expedited review and approval of Florida's data mining demonstration project.

[8] OEI-07-04-00180 Factors Impacting Referral of Suspected Medicaid Fraud Cases: State Medicaid Agency and Medicaid Fraud Control Unit Experiences.

i. The demonstration waiver request filed by Florida stated: "Given the pervasive and nefarious nature of fraud and the unique characteristics of the state, the provision of additional resources would significantly enhance the state's efforts to more effectively identify fraud cases. Florida believes that it is uniquely situated to implement a demonstration that will provide meaningful results as AHCA and MFCU work in partnership to combat fraud and abuse."

b. *U.S. Health and Human Services approved Florida's request to allow the Florida Medicaid Fraud Control Unit to engage in data mining*[9]

1. On July 15, 2010 U.S. Health and Human Services Secretary Katherine Sebelius approved Florida's Medicaid waiver request that will allow the Florida Medicaid Fraud Control Unit to "mine" Medicaid Management Information System (MMIS) data to identify cases of potential Medicaid fraud.

2. Data Mining will allow Florida's MFCU to sort electronic claims through the use of statistical models and intelligence technologies to uncover patterns and relationships. Using the identified patterns, investigators can review Medicaid claims activity and history to find abusive or abnormal use of services and billing that may be potentially fraudulent.

3. Data mining is done with software programs which include algorithms that analyze the MMIS data.

4. Currently all other state MFCUs are prohibited from using federal Medicaid matching funds to detect potential fraud through routine claims review procedures such as screening of claims, analysis of billing practice patterns, or routinely verifying that billed services were actually received by patients, since these functions are a primary program operation function of the state Medicaid agency. Instead they rely on referrals from their state Medicaid agency.

5. The waiver approved by HHS will allow Florida MFCU to use federal matching funds to conduct electronic data mining.

6. The Centers for Medicare and Medicaid Services (CMS) will monitor the progress of the waiver.

[9] The information contain in Section IV (b) was obtained from a HHS New Release dated July 15, 2010.

c. *Florida MFCU data mining projects.*

1. As of June 30, 2011 the MFCU has submitted 24 data mining projects to the single state agency for review. MFCU has 2 cases and 18 complaints opened from these projects and are currently developing additional targets.

FLORIDA MEDICAID FRAUD CONTROL UNIT SIGNIFICANT CASE HIGHLIGHTS

Teva Pharmaceuticals

On July 19, 2010, Florida entered into a $27 million settlement agreement with Teva

Pharmaceuticals and its corporate affiliates to resolve claims of Medicaid fraud. The settlement, which partially resolved two Leon County Medicaid fraud lawsuits, was negotiated by the Attorney General's Complex Civil Enforcement Bureau.

The settlement resolved allegations against the Teva Pharmaceutical group of companies that allegedly engaged in a practice of knowingly setting and reporting inflated prices for medications dispensed by pharmacies and other providers who were then reimbursed by the Florida Medicaid program. The Medicaid program set the reimbursement rates it paid to Medicaid providers based upon the prices reported by drug manufacturers. By reporting inflated prices, drug manufacturers caused the Florida Medicaid Program to overpay millions of dollars in pharmacy reimbursements.

The Agency for Health Care Administration, which is responsible for administering the Medicaid Program, received more than $7.1 million for losses sustained by the Medicaid program. Florida's general revenue fund received more than $3.4 million. Remaining funds from the settlement were paid directly from the settlement to the federal government and to the Relator, Ven-A-Care of the Florida Keys.

The allegations constitute violations of the Florida False Claims Act and were originally filed by whistleblower Ven-A-Care of the Florida Keys, Inc. on behalf of the State of Florida. The Attorney General's office investigated the claims and subsequently intervened in the lawsuits.

Novartis Pharmaceuticals Corporation

Florida received a total of $8.5 million as part of a global settlement with Novartis Pharmaceuticals Corporation (Novartis). Florida joined with other states and the federal government to reach an agreement in principle with Novartis to settle allegations it improperly promoted Trileptal and engaged in unlawful kickback schemes to induce physicians to prescribe Trileptal, Diovan, Zelnorm, Sandostatin, Exforge and Tekturna.

The civil settlement also resolved allegations claiming Novartis promoted the sale and use of Trileptal for certain uses not approved by the FDA. Although Trileptal is an anti-epileptic drug, allegedly Novartis promoted it for unapproved uses, such as the treatment of bipolar disorder and neuropathic pain. The settlement also resolved claims that Novartis provided illegal compensation to health care professionals to induce them to promote and prescribe the drugs Trileptal, Diovan, Zelnorm, Sandostatin, Exforge, and Tekturna.

Additionally, the United States Attorney's Office for the Eastern District of Pennsylvania filed a charge against Novartis in the United States District Court alleging a misdemeanor violation of the Food, Drug and Cosmetic Act. In a plea agreement with the United States, Novartis agreed to plead guilty and pay $185 million to resolve the criminal case.

As a result of the civil settlement, Novartis paid the states and the federal government a total of $237.5 million in damages and penalties for losses to the Medicaid and other federal health care

programs. The total criminal and civil settlement value is $422.5 million. As one of the conditions of the settlement, Novartis entered into a Corporate Integrity Agreement with the Office of the Inspector General of the United States Department of Health and Human Services, which will closely monitor Novartis' practices going forward.

AstraZeneca – Pharmaceutical Manufacturer

The Florida Medicaid Program received more than $4.25 million as part of a global settlement totaling $520 million with AstraZeneca Pharmaceuticals LP. The settlement resolved allegations that the company illegally marketed the antipsychotic drug Seroquel for uses which have not been tested or approved by the Food and Drug Administration.

Seroquel is one of a newer generation of antipsychotic medications used to treat certain psychological disorders. From January 1, 2001 through December 31, 2006, AstraZeneca allegedly promoted the sale and use of Seroquel for certain treatments that the Food and Drug Administration had not approved. The settlement resolved a government investigation into promotional activities that were directed not only toward psychiatrists but also toward primary care physicians and other health care professionals for unapproved uses in the treatment of medical conditions such as aggression, Alzheimer's, anger management, anxiety, attention deficit hyperactivity disorder, dementia and sleeplessness.

In addition to the $4.25 million to the Florida state Medicaid program, $3.8 million was deposited into Florida's General Revenue fund. Additional funding will reimburse the federal government for its contributions to the Medicaid program.

Also, AstraZeneca entered into a corporate integrity agreement with the United States Department of Health and Human Services' Inspector General. The agreement included provisions that will ensure that AstraZeneca will market, sell and promote its products in accordance with all Federal health care program requirements.

Dr. Manuel Javier Fernandez

On October 27, 2010, Monroe County physician Manuel Javier Fernandez was convicted and sentenced in Federal court for one count of Health Care Fraud for defrauding the Florida Medicaid program. He was sentenced to three years in federal prison followed by three years of supervised release. He was also ordered to repay the Medicaid program over $656,000.

Investigators with the Medicaid Fraud Control Unit began investigating Fernandez, 77, when the Agency for Healthcare Administration (AHCA) received Explanation of Medicaid Benefits (EOMB) surveys from seven Medicaid recipients who stated that they did not receive the services listed on the EOMB from Fernandez. Over 60 Medicaid recipients were contacted and all stated that they did not receive the services that Fernandez billed Medicaid for. Subsequently, AHCA terminated Fernandez as a Florida Medicaid provider. Based upon further

investigation, it was determined that Fernandez received payment from the Florida Medicaid Program of more than $656,000 for services that he did not render. In June 2010, Fernandez pled guilty as charged. Fernandez was investigated and prosecuted as a joint effort between the MFCU, the Federal Bureau of Investigation and the United States Attorney's Office for the Northern District of Florida.

Eric West – In home care services

On July 9, 2010 a St. Lucie County man was arrested for his role in the theft of over $31,000 from the Florida Medicaid program. Eric West, 42, was arrested by the St. Lucie County Sheriff's Office based on a warrant from the Attorney General's Office Medicaid Fraud Control Unit.

The investigation was conducted by the Medicaid Fraud Control Unit acting on information received from a Medicaid Waiver Support Coordinator. The investigation revealed that West fraudulently billed for in-home care services on behalf of Medicaid recipients. Authorities allege that he submitted numerous reimbursement claims to the Medicaid program for services that he never provided to Medicaid recipients. Employment records from The ARC of Florida, a non-profit organization in St. Lucie County where West was employed, showed that he was present at the ARC office during the times he claimed to have provided services to at-home Medicaid recipients in their homes. Additionally, interviews with the parents of Medicaid recipients revealed that West did not provide the services for which reimbursements were requested.

On February 21, 2011, Eric West pled guilty to one count Medicaid fraud and one count of Grand Theft. The judge withheld adjudication and sentenced West to five years probation and ordered him to pay $15,000 in restitution to the Medicaid program. The case was prosecuted by the State Attorney's Office for the 19th Judicial Circuit.

Oliver Workman – Speech Pathologist

On August 19, 2010 a Jacksonville man was sentenced to seven years in prison for his role in a scheme that defrauded the Florida Medicaid program out of more than $485,000. Oliver Workman, a former speech pathologist, was charged with billing the Medicaid program from 2003 to 2007 for services he never provided in Putnam, Clay, Baker, Duval and Nassau counties.

Based upon a referral from the Agency for Health Care Administration's Medicaid Program Integrity Unit, the Attorney General's Medicaid fraud investigators determined that Workman, 60, was repeatedly billing the Medicaid program for children's speech therapy without actually providing the services. Workman surrendered to law enforcement in 2009 after learning the Attorney General's Medicaid Fraud Control Unit had issued a warrant for his arrest.

Workman was prosecuted by an attorney from the Medicaid Fraud Control Unit who was specially designated for the case by the State Attorney's Office for the Seventh Judicial Circuit. After completing his prison sentence, Workman must serve 10 years of probation. He was also

ordered to reimburse the Medicaid program $485,909.07 for the full amount he defrauded.

Amanda Capers – Personal Care Attendant

On November 9, 2010, an Escambia County personal care attendant formerly employed by Community Outreach in Pensacola was arrested. Amanda Capers, 22, was arrested for neglecting a disabled adult under her care and forging official documents. Capers was arrested by the Attorney General's Medicaid Fraud Control Unit with assistance from the Santa Rosa County Probation Office.

Based on information from the Florida Department of Children and Families Adult Protective Services Division, investigators discovered that Capers violated facility policy. While on duty, Capers took a resident with her to a friend's house and permitted the disabled adult to ride on the back of a moped which collided with another moped. Due to the collision, the disabled man suffered a broken leg which required surgery.

Following the accident, Capers falsified the initial incident report. Upon closer examination, investigators determined that Capers also falsified her driving record she had submitted when applying for the position at Community Outreach. Capers' driver license has been suspended since 2007.

On February 8, 2011, Capers pled No Contest and was adjudicated guilty of Aggravated Neglect of an Elderly Person or Disabled Adult, Forgery, Grand Theft, and Uttering a Forged Instrument. She was sentenced to 25.8 months in state prison. The case was prosecuted by an attorney from the Medicaid Fraud Control Unit under the authority of the State Attorney's Office for the First Judicial Circuit.

Joyce Gibbs – Operating Unlicensed Assisted Living Facility

On December 20, 2010, a Joyce Gibbs was arrested for operating an assisted living facility without a license. She was arrested by law enforcement officers with the Attorney General's Medicaid Fraud Control Unit, with the assistance from the Jacksonville Sheriff's Office.

In August 2010, Ruth's Family Home Away From Home, an assisted living facility, was inspected by the Attorney General's Medicaid Fraud Control Unit's Patient Abuse, Neglect and Exploitation (PANE) Team revealing the facility's license had been expired for over a year and the owner was operating the facility with an expired license. The clients were moved out of the facility. A month later, Gibbs moved four of the clients from the original location to a different location and continued to operate without a license. In August 2010, the Agency for Health Care Administration (AHCA) issued a Notice of Unlicensed Activity and the facility was shut down.

On May 20, 2011, Gibbs entered a plea of guilty to one count of Operating an Unlicensed Assisted Living Facility, a third-degree felony. Adjudication of guilt was withheld and she was put on five years probation. She was ordered to pay investigative costs to MFCU and perform

150 hours of Community Service. Other special conditions included permanent revocation of any Medicaid Provider Number, surrender of any licenses, never apply for any future Medicaid Provider Number, never perform any services that might be compensated by AHCA/Medicaid, not to operate, own or perform any services in any ALFs, and refrain from working in any healthcare facility. The case was prosecuted by an attorney from the Medicaid Fraud Control Unit under the authority of the State Attorney's Office for the Fourth Judicial Circuit.