Annual Report on

The State's Efforts to Control Medicaid Fraud and Abuse

FY 2006 - 07

Submitted by:

The Agency for Health Care Administration

and

Medicaid Fraud Control Unit (MFCU)

Department of Legal Affairs

December 2007

AHCA

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Table of Contents

Introduction

Coordination and Cooperation between AHCA and MFCU

AHCA and MFCU have continued to work together on joint investigative projects, Medicaid program issues, enhancement of processes and development of protocols for improved coordination. The senior management teams for both AHCA and MFCU, as well as the Department of Health (DOH), meet monthly to discuss major issues, strategies, joint projects and other relevant matters.

The Agency and MFCU also continued to work closely on improving the fraud and abuse referral process. For the second consecutive year, the number of referrals made to MFCU exceeded 200. Between August 2006 and March 2007, MFCU made at least eight arrests that were a result of referrals made by Medicaid Program Integrity. These arrests involved over $4.3 million in fraudulent overpayments.

Senior managers of the Office of the Inspector General, the Division of Medicaid, MFCU and DOH provide a quarterly briefing to the Secretary of the Agency regarding collaborative efforts. MPI managers and investigators continue to coordinate and work closely with MFCU bureau chiefs and lead attorneys, as needed, on specific cases to ensure that there are no duplications of effort and to ensure that funds suspected of having been misspent due to fraud and abuse are pursued. Additionally, MPI and MFCU continue to coordinate with regard to MFCU settlements to ensure that each resolution includes all appropriate Agency issues and does not impact any ongoing or future MPI investigations.

The Agency and MFCU again collaborated with the DOH on a Medicaid Fraud and Abuse Summit in June 2007. While Medicaid Reform and issues specific to fraud and abuse initiatives related to managed care were emphasized, other matters of concern to the attendees were discussed.

The Agency and MFCU have established regular meetings with the Medicaid managed care organizations. These meetings are intended to allow an exchange of information among the parties as we work together to address fraud and abuse issues within a managed care environment.

Medicaid Fraud Control Unit

Health care fraud is an immense societal problem, both nationally and within Florida's $16 billion-a-year Medicaid program. The Medicaid Fraud Control Unit (MFCU) is responsible for policing the Medicaid Program, as well as investigating allegations of corruption and fraud in the administration of the program. This authority is granted under both federal and state law (Section 1903 of the Social Security Act, Section 42 of the Code of Federal Regulations, and Chapter 409, Florida Statutes).

The MFCU investigates a wide range of provider fraud involving doctors, dentists, psychologists, home health care companies, pharmacies, drug manufacturers, laboratories and durable medical equipment companies. Some of the most common forms of provider fraud include billing for services not provided, overcharging for services that are provided or billing for services that are medically unnecessary. Health care providers arrested by the MFCU personnel are prosecuted by local state attorneys, the Office of Statewide Prosecution, the United States Attorney or the MFCU attorneys who are cross-designated as Special Assistant State Attorneys or Special United States Attorneys. In the FY 2006-07, the Medicaid Fraud Control Unit made 109 warrants/arrests and had 46 convictions/pre-trial interventions. Sometimes cases that may not be suitable for arrest and criminal prosecution are litigated by unit attorneys using a variety of civil statutes. For FY 2006-07, the MFCU recovered $70,114,222.

The MFCU is also responsible for investigating the physical abuse, neglect and financial exploitation of patients residing in long-term care facilities such as nursing homes, facilities for the mentally and physically disabled and assisted living facilities. The quality of care provided to Florida's ill, elderly and disabled citizens is an issue of great concern and a priority within the MFCU.

MFCU Highlights

Durable Medical Equipment Initiative

The Medicaid Fraud Control Unit has continued to increase enforcement activity in the durable medical equipment (DME) program during the previous fiscal year. The number of complaint referrals from the Agency for Health Care Administration has continued to trend upwards (16) with the majority of referrals occurring in the South Florida area. In addition to the upward trend in referrals, this fiscal year has seen a significant surge of arrests (43) related to DME providers. This surge in arrests is principally the result of a multi-agency strike force comprised of State, Local and Federal Law Enforcement agencies working the South Florida area.

The Medicaid Fraud Control Unit and the Agency for Health Care Administration are currently working on joint initiatives to identify and prosecute DME providers fraudulently billing the Florida Medicaid Program.

Home Health Services Initiative

During the previous fiscal year, the Medicaid Fraud Control Unit received 17 referrals for Home Health investigations from the Agency for Health Care Administration. This reflected a trend of increasing numbers of referrals and subsequent full investigations opened. Approximately 70% of all Home Health provider investigations are centered in Dade County. Investigations of Medicaid Home Health providers are inherently linked to Medicare Home Health providers due to the higher reimbursement rates paid by Medicare. As a result, the Medicaid Fraud Control Unit has partnered with Federal Law Enforcement Agencies (Department of Health and Human Services/ Office of the Inspector General and the Federal Bureau of Investigation) to jointly investigate allegations of Medicaid/Medicare fraud.

During this fiscal year, the Medicaid Fraud Control Unit and the Agency for Health Care Administration have implemented specific initiatives to enhance the number of referrals for investigations of Home Health providers. These initiatives include regularly scheduled meetings on both a statewide and regional level to identify and assess current billing patterns and utilization trends within the Home Health program.

Patient Abuse Neglect and Exploitation Initiative

During the previous fiscal year, the Medicaid Fraud Control Unit has continued to pursue allegations of abuse, neglect and exploitation in Nursing Homes, Assisted Living Facilities, Adult Family Care Homes and Group Homes (Agency for Persons with Disabilities). The Agency received and reviewed 13,626 complaints, which resulted in the opening of 253 full investigations. The Agency effected 22 arrests of individuals accused of abuse, neglect and exploitation during this fiscal year.

In addition to the above noted investigations, the Medicaid Fraud Control Unit, in cooperation with various state and local regulatory agencies, conducted 223 unannounced Spot-Checks of licensed facilities. These Spot-Checks have identified numerous sanitation, health care, fire safety and structural deficiencies which resulted in various regulatory actions. During this fiscal year, the Spot-Check Program was extended to include approximately 1,374 group homes regulated by the Agency for Persons with Disabilities (APD).

South Florida Multi-Agency Strike Force

The South Florida Multi-Agency Strike Force was initiated On March 1, 2007, for the purpose of targeting widespread fraud being perpetrated within the durable medical equipment (DME) industry.

In addition to the Office of Attorney General (OAG), Medicaid Fraud Control Unit (MFCU), the participating agencies are the Federal Bureau of Investigation (FBI), Health and Human Services - Office Inspector General (HHS - OIG) and the Hialeah Police Department. Initially, there were four teams of investigators with an attorney assigned to each team. A fifth team was formed to investigate additional defendants, who were videotaped paying a physician for writing prescriptions.

Since the inception of the Strike Force, 74 indictments have been filed charging 120 individuals with criminal health care fraud offenses. Forty-three (43) guilty pleas have been negotiated. Five jury trials have been conducted winning guilty verdicts on all counts. Pending cases include 72 defendants charged with health care fraud offenses, including six Medicaid providers.

Agency for Persons with Disabilities Waiver Initiative

The Medicaid Fraud Control Unit, the Agency for Health Care Administration's Bureau of Medicaid Program Integrity (MPI) and the Inspector General for the Agency for Persons with Disabilities (APD) have created an initiative to increase fraud referrals pertaining to APD programs. Representatives from the three agencies meet regularly to discuss fraud prevention, detection and referral. The initiative is developing improvements in waiver program administration and has resulted in referrals to both MPI and the MFCU.

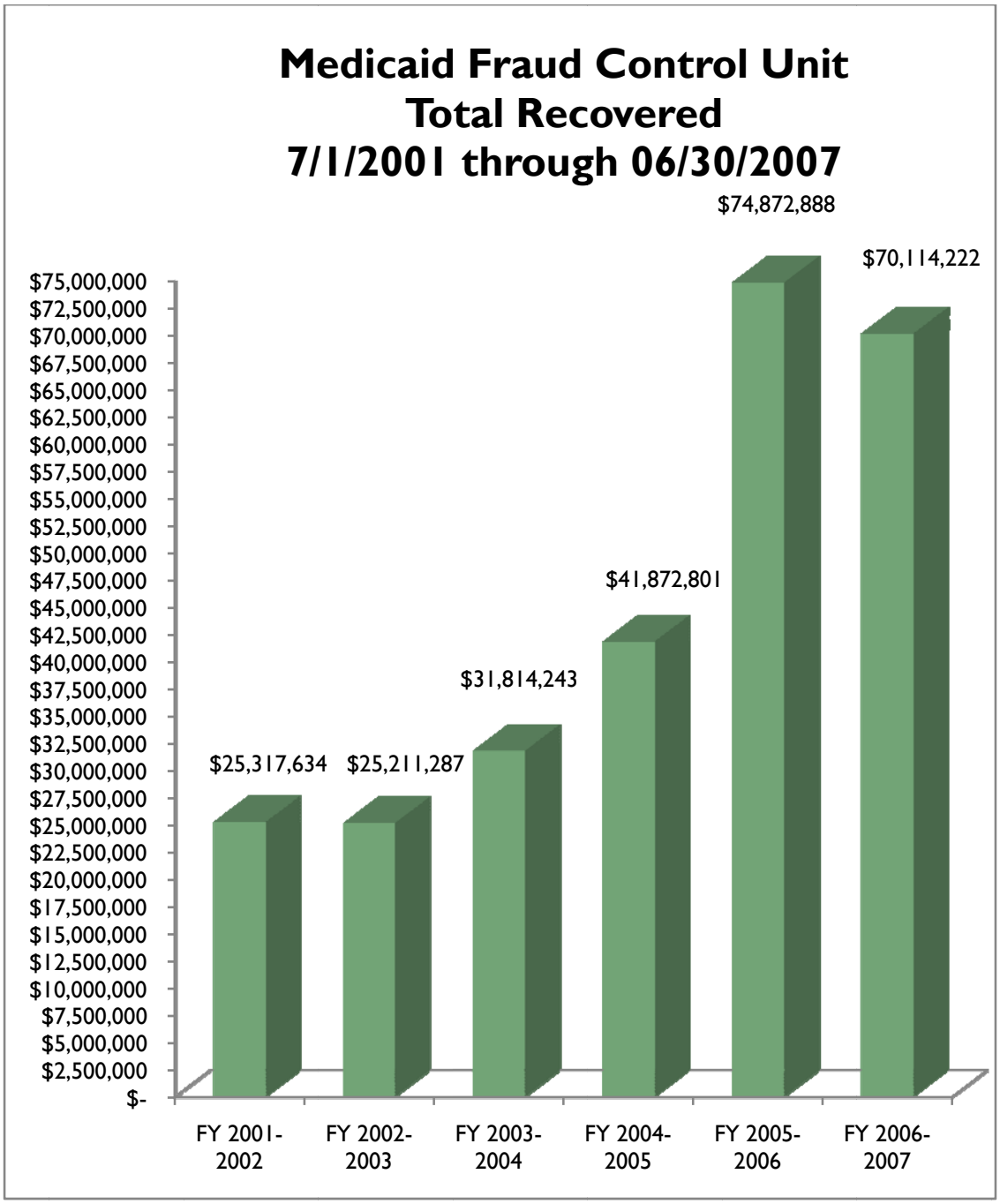
Additionally, the Orlando MFCU is leading a proactive spot check program that randomly selects APD waiver providers for on-sight visits. These visits consist of an inspection of the provider's Medicaid billing records and supporting documentation to verify compliance with current Medicaid statutory and regulatory guidelines.

Complex Civil Enforcement Bureau

The Complex Civil Enforcement Bureau (CCEB) was established within the MFCU to investigate and litigate multi-state False Claims Act cases that involve false claims to the Florida Medicaid program. The majority of these cases are Qui Tam actions filed in Federal Court, which contain allegations that the Florida False Claims Act has been violated. Plaintiffs in these federal actions include the United States and the various states whose Medicaid programs have paid false claims pursuant to the alleged scheme to defraud.

The CCEB evaluates Qui Tam complaints and prioritizes them according to their underlying merit and value to the State of Florida. The decisions to intervene or decline are made in a timely fashion. Those complaints that allege facts involving substantial claims paid by the Florida program, and that have a reasonable likelihood of obtaining a favorable verdict, are actively and aggressively investigated and litigated by the CCEB. The CCEB will expand Florida MFCU's leadership role amongst the multi-state working groups litigating Medicaid fraud issues.

The CCEB is staffed with a Bureau Chief, six attorneys, a Law Enforcement Lieutenant, two Law Enforcement Investigators, two paralegals, two analysts and two administrative support staff.



Top Criminal Cases of FY 2006-07

John Q. Durfey

Dr. John Q. Durfey, a Panama City physician who held himself out as a specialist in pain management, excessively prescribed controlled substances outside the normal course of professional medical practice and without any legitimate medical purpose.

From August 2001 through August 2006, Durfey operated the Emerald Coast Pain Center in Panama City. During the course of a criminal investigation into Durfey's practices, a medical expert in the field of pain management and addiction determined that Durfey failed to meet the usual standards of care when prescribing controlled substances and often lacked the proper documentation to support his prescriptions.

In most instances, the illegally dispensed prescriptions were paid for by health care benefit programs including the Florida Medicaid program. The investigation further revealed that in numerous instances Durfey billed benefit programs for personally seeing patients at Emerald Coast Pain Center on dates when he was out of town, sometimes even out of the country.

The investigation was conducted by a task force of law enforcement agencies including the Attorney General's Medicaid Fraud Control Unit, the United States Attorney's Office, the FBI, the Drug Enforcement Agency, the Florida Department of Law Enforcement, the Florida Department of Health and the Defense Criminal Investigations Service.

Durfey was indicted by a federal grand jury in the Northern District of Florida on 124 counts of Health Care Fraud, Wire Fraud, Conspiracy and violations of the Controlled Substances Act. Further, the indictment charged that three deaths occurred as the result of health care fraud and illegal dispensing of controlled substances. Fraudulent claims on the Florida Medicaid program from Durfey's criminal enterprise totaled $268,960.23.

On May 30, 2007, Durfey pled guilty in Federal Court to six counts of health care fraud and six counts of dispensing controlled substances outside the normal course of professional medical practice. He was sentenced to 20 years in prison, three years probation and ordered to pay $268,960.23 in restitution to the Medicaid program.

Acute Care Team Inc.

Six Manatee County women were arrested on charges of Medicaid fraud and organized fraud. The women, all employees of Acute Care Team, Inc., allegedly defrauded the state Medicaid program out of more than $2.6 million in counterfeit billing claims. The case was investigated by authorities with the Attorney General's Medicaid Fraud Control Unit.

Investigators with the Medicaid Fraud Control Unit began investigating the facility in April 2006 after receiving information from the Agency for Health Care Administration (AHCA). The facility, which provides respiratory therapy to children, was submitting substantial billing claims to the Medicaid program, which later could not be verified by the patients' parents. Often, the facility claimed it provided care to patients several times per week. Parents of the children told investigators they only visited the facility once or twice and for much shorter times than were reported. Additionally, other staff at the facility claim they were pressured to bill for patients they never treated.

Each woman was charged with one count of Medicaid fraud, a third-degree felony, and one count of organized fraud, a first-degree felony. If convicted on both counts, each woman could face up to 30 years in prison and fines of $15,000. The case is being prosecuted by the State Attorney's Office for the 12th Judicial Circuit.

Radiant Star billing as Rising Sun Assisted Living Facility

On February 23, 2007, a Daytona woman was found liable for fraudulently billing Medicaid more than $210,000. A civil lawsuit filed by the Attorney General's Medicaid Fraud Control Unit determined that Vidya Bhoolai must pay more than $640,000 for numerous violations of Florida's False Claims Act. Bhoolai, the owner and operator of two Volusia County assisted living facilities, repeatedly billed the Medicaid program for services she never provided.

According to an investigation conducted by the Medicaid Fraud Control Unit in 2005, Bhoolai filed multiple claims for Medicaid recipients who either never resided at her facilities or resided there for fewer days than she reported when seeking Medicaid reimbursements. The civil lawsuit claimed that Bhoolai submitted more than 300 false claims to Medicaid.

Florida's Agency for Health Care Administration assisted with the investigation, providing the Medicaid Fraud Control Unit with Bhoolai's billing and claim submission history. Bhoolai's facilities have since been shut down. Bhoolai was also criminally charged in the case and pled no contest to the charges. She was sentenced to ten years of probation and must reimburse the Medicaid program $60,000. She must also repay the state for the cost of investigation and prosecution. Additionally, a civil judgment for $648,282.24 was entered against Bhoolai on February 20, 2007.

Ed's House

On January 31, 2007, a Georgia woman was arrested on charges that she defrauded the Florida Medicaid program out of more than $17,000. Deborah Rowe Tompkins was arrested in Georgia after investigators with the Attorney General's Medicaid Fraud Control Unit determined that she had fraudulently billed the Medicaid program.

Tompkins, 54, is the former owner and administrator of Ed's House, a long-term residential group home located in Port St. Lucie. The investigation revealed that Tompkins, originally of Ft. Pierce, was fraudulently billing the Medicaid program for habilitation therapy, supervision and specific training activities intended to help patients acquire, maintain or improve skills related to daily living. The billing occurred on days the residents were not at the facility and therefore could not have possibly received the services for which Tompkins billed.

Investigators estimate that the improper billing took place between July 2003 and January 2005. Tompkins then sold the group home and moved to Douglas, Georgia. The arrest was made by Georgia law enforcement officers. The group home has since closed and its residents have moved to different facilities.

Tompkins was charged with one count of organized fraud and one count of grand theft, both third-degree felonies. If convicted, she faces up to ten years in prison and a $10,000 fine. The case is being prosecuted by the State Attorney's Office in the Nineteenth Circuit.

Angel Children's Therapies, Inc.

On December 15, 2006, a Palm Beach County woman was arrested for defrauding the Florida Medicaid program out of more than $371,000. Law enforcement officers with the Medicaid

Fraud Control Unit arrested Margarita Cristina Gutierrez after investigators determined that she was using her speech therapy company to improperly bill Medicaid.

An investigation that began December 2006 revealed that Angel Children's Therapies, Inc., owned by Gutierrez, billed the Medicaid program for providing eligible children with individual speech therapy. In reality, Gutierrez, 40, was merely giving the children English lessons and tutoring them in math, reading and writing. In the few instances where children actually received speech therapy, it took place in a group setting rather than the more costly individual therapy for which Gutierrez billed the Medicaid program.

Investigators estimate that Gutierrez defrauded the Medicaid program out of more than $371,000 between January 2005 and October 2006. The Medicaid Fraud Control Unit began its investigation after receiving information from a former Gutierrez employee. Gutierrez was charged with one count each of organized fraud, grand theft and Medicaid fraud. If convicted, she faces up to 65 years in prison and a $25,000 fine. The Attorney General's Office of Statewide Prosecution is prosecuting the case.

Sunrise Opportunities

On December 14, 2006, a Broward County man was arrested for abusing a disabled resident of a Deerfield Beach group home at which he worked. Oliver Alexander Caison, a staff member at Sunrise Opportunities, Inc., was arrested after an investigation revealed that he allegedly repeatedly struck one of the residents in the head.

Acting on information received from the Department of Children and Families, the Medicaid Fraud Control Unit's Patient Abuse, Neglect and Exploitation (PANE) team began investigating the incident in August. A witness told MFCU investigators that Caison, 27, became angered at a 27-year-old mentally disabled resident and struck him several times in the head with various objects, including a DVD player and a bowling pin. According to the witness, Caison also poured rubbing alcohol over the victim's head, causing the man extreme discomfort.

The victim was taken to a nearby hospital where medical personnel observed redness and abrasions to his head, shoulder, neck, left leg, right foot and right thumb. A doctor's assessment revealed multiple contusions, which are injuries to the soft tissue caused by a blunt force.

Caison was charged with one count of abuse of a disabled adult, a third-degree felony. If convicted, he faces up to five years in prison and a $5,000 fine. The case is being prosecuted by the Broward County State Attorney's Office.

Capital City Area Care

On December 5, 2006, a Medicaid provider was arrested on charges of grand theft. Titilayo I. Dokun, the owner and chief executive officer of Capital City Area Care, was charged with illegally billing Medicaid for services that either were not provided or were fraudulently billed to a waiver program the elderly and disabled patients did not qualify. Dokun is believed to have defrauded the Florida Medicaid program out of more than $100,000.

The Medicaid Fraud Control Unit began investigating Dokun, 43, and her company in October after receiving information from the Agency for Health Care Administration. Investigators discovered that fraudulent billing claims had been filed through the Home and Community Based Adult Waiver Service program, a Medicaid program that provides home and community based services to eligible recipients. Dokun's company had at least five caregivers who would go into the homes of their patients and cook, perform light housekeeping tasks and provide other basic companion services.

Further investigation revealed that not only was Dokun billing Medicaid for services to patients who were not enrolled in the waiver program, but also in some cases, she billed the program for services that were never provided. MFCU investigators believe Dokun was electronically depositing the Medicaid payments into bank accounts owned by herself or by Capital City Area Care. To date, $5,500 has been recovered and the investigation is ongoing.

Dokun was charged with one count of grand theft, a first-degree felony. If convicted, she faces up to 30 years in prison and fines of $10,000. Dokun is being prosecuted by the State Attorney's Office for the Second Judicial Circuit.

Omnicare Inc.

Florida recovered $2.2 million as part of a 43-state $49.5 million settlement with OmniCare, Inc. A national investigation, led in part by Florida's Medicaid Fraud Control Unit, revealed that OmniCare was allegedly switching patients' prescriptions to avoid federal price ceilings. Price ceilings limit the maximum amount of reimbursement that the government would pay for the most commonly prescribed forms of certain medications. OmniCare allegedly switched its patients to medications that did not have a reimbursement limit in order to circumvent the government-mandated price ceiling.

The agreement deals specifically with allegations that patients taking Ranitidine, a popular antacid, were unlawfully switched from tablets to capsules. In addition, patients taking Prozac capsules were unlawfully switched to the generic Fluoxetine tablet and patients taking Buspirone tablets, a popular medication to treat anxiety, were switched to Buspirone tablets of a different dosage. The investigation revealed no medically justifiable reason for the switches other than to inflate government reimbursement and increase OmniCare's profits.

As part of the settlement, OmniCare has entered into a Corporate Integrity Agreement with the United States Department of Health and Human Services' Inspector General. The agreement will ensure future Medicaid compliance. The Medicaid Fraud Control Unit assisted the prosecution of the case, along with the Department of Justice, the U.S. Attorney for the Northern District of Illinois, and other state attorneys general.

Pediatric Services of America

On August 24, 2006, a Pinellas County nurse was arrested on charges of Medicaid fraud and identity theft. Carla Ann Mejia formerly worked at a Medicaid-enrolled provider of pediatric home health care services. By falsifying employee schedules, Mejia defrauded the Medicaid program out of more than $150,000.

Mejia, 39, was the branch office manager of the St. Petersburg nursing office owned and operated by PSA Healthcare, Inc. She created false work schedules for other employees, causing Medicaid to be billed for more than $150,000 for services that had not been provided. The false schedules also caused fraudulent paychecks to be issued in the names of the employees whose schedules had been falsified. Mejia, a Hillsborough County resident, intercepted those paychecks, forged the employees' signatures and deposited more than $14,000 into her own bank account. PSA Healthcare discovered Mejia's scheme and immediately alerted the Medicaid Fraud Control Unit.

Once PSA Healthcare discovered the discrepancies, they audited the records and reported their findings to the Medicaid Fraud Control Unit, which independently verified the facts. The company fired Mejia and repaid the entire sum that was improperly billed to the taxpayer-supported Medicaid program.

Mejia is charged with one count of organized fraud, a first-degree felony, and four counts of criminal use of personal identification information, a third-degree felony. Mejia was convicted on all counts March 1, 2007. She was sentenced to five years probation and ordered to pay the state $9,812.54 in costs and fines. The case was prosecuted by the Attorney General's Office of Statewide Prosecution.

Agency for Health Care Administration

Office of the Inspector General

In November 2006, Charlie Crist, the Attorney General for the state of Florida, was elected Governor of Florida. With his record and resolve to fight fraud and abuse within the state, it was no surprise that he appointed new leadership in the Agency for Health Care Administration to continue those efforts. He appointed Secretary Andrew Agwunobi, a medical physician with a broad and diverse career as a pediatrician, hospital and hospital system administrator and an accomplished business leader.

Dr. Agwunobi then appointed Linda Keen, R.N., M.S., J.D., to the Inspector General position at the Agency. With this renewed focus and effort to deter fraud and abuse in the Medicaid program, several new units were created, with added authority and responsibility given to the Bureau of Medicaid Program Integrity.

Within the Office of the Inspector General, the External Investigations Unit (EIU) was created. This unit employs experienced law enforcement investigators who are charged with conducting investigations and documenting alleged fraud and abuse in order to prepare a case for civil procedures, when necessary. This unit has integrated both internal and external investigation skills and procedures that will adhere to standards in both the Division of Administrative Hearings and the civil prosecution arena. The EIU works under Sec. 20.055, F.S., the statute giving the Inspector General the authority to investigate, as well as Sec. 409.913, F.S., the statute that governs Medicaid Program Integrity. With these units working together as well as joining forces with sworn officers of the MFCU, the FBI and FDLE, this newly formed unit will conduct special projects throughout the state, investigating specific instances of fraud and abuse as well as investigating recipient fraud.

The Office of the Inspector General has also formed a special legal unit that will work in tandem with the Office of the General Counsel and the Chief of Staff to recover, through civil litigation, Medicaid funds paid out fraudulently or erroneously. This legal unit also assists with Medicaid Program Integrity issues to ensure success in recoveries with abuse cases.

These two units have combined strong, experienced investigative skills with keen legal expertise. The Agency looks forward to reporting their accomplishments in FY 2007-08.

Bureau of Medicaid Program Integrity

The Office of Inspector General's Bureau of Medicaid Program Integrity (OIG-MPI) is responsible for minimizing fraud and abuse losses in the Medicaid program. MPI carries out fraud and abuse preventive activities, performs detection analyses, conducts audits, imposes sanctions as appropriate and refers certain providers to the Medicaid Fraud Control Unit (MFCU) and to other regulatory and investigative agencies.

Prevention is of great importance. If an overpayment is prevented, the Agency does not have to detect, audit and recover the funds. There are no appeals and protracted legal proceedings. The most efficient way to overcome Medicaid fraud and abuse is by preventing overpayments whenever possible. In FY 2006-07, MPI prevention efforts saved the Medicaid program $29 million. This cost avoidance is discussed in some detail in the section below headed **Prevention**.

Because overpayments do occur in the Medicaid programs of every state, it is necessary to use effective fraud and abuse detection methods. MPI has developed such detection tools to use along with detection software supplied by the fiscal agent contractor. These programs detect upcoding, identify rapid increases in billings by and payments to providers, compare providers' billings to those of their peers and identify combinations of billings that are unusual and may be improper.

MPI audits Medicaid providers when detection activities find possible fraud and abuse or when it is reported from external sources through the MPI Intake Unit. MPI also uses tools that allow the investigator to isolate all of the provider's claims to be reviewed, take a random sample of the claims, include or exclude specified procedure codes and print report formats to be used in the audit. When the claims review is complete, the investigator typically uses an MPI developed tool to generalize the sample results to the population of claims sampled and thus determine the overpayment by statistical calculations.

In FY 2006-07, MPI recovered $34.6 million in overpayments, an increase of 24 percent from the prior fiscal year. The recoupment of overpayments is discussed in some detail in the section below headed **Recovery**.

National Recognition

As a result of achievements in preventing and recovering overpayments in the Medicaid program, Medicaid Program Integrity has received favorable notice during the past fiscal year. The following is taken from an announcement of The Prudential Financial — Davis Productivity Awards:

"The 100-person Bureau of Medicaid Program Integrity, Agency for Health Care Administration, is responsible for minimizing fraud and abuse in the Florida Medicaid program. The most efficient way to control fraud, abuse and overpayments is to preclude them. Development and application of new statistical programs and algorithms, and advanced statistical auditing methods, helped increase prevention and recovery of overpayments from $41 million in FY 2003-04 to $65 million in 2005-06, for a reported return on investment of 5.9:1."

In January 2007, the Bureau of National Affairs reported that, "Florida health regulators prevented or recovered $65 million in Medicaid overpayments in fiscal year 2005-06…the Bureau of Medicaid Program Integrity recovered $28 million and prevented spending of another $37 million…" In March 2007, All Headline News reported that, "the United States Department of Health and Human Services named Florida as one of only three states that referred more than 100 fraud cases to the state Attorney General's office last year. Florida led the nation with 197 referrals."

Managed Care

MPI has increased communications with Medicaid managed care organizations (MCOs) and during FY 2006-07, took additional steps to increase internal communications with the Agency's Division of Medicaid and Division of Health Quality Assurance. In doing so, the Agency can ensure more, better and timelier referrals of potential fraud or abuse from the managed care organizations. During FY 2006-07, MPI worked directly with several of the MCOs to improve the quality and quantity of referrals and to establish protocols for obtaining additional information when necessary to further an MPI investigation or referral to MFCU.

MPI also worked with our partners at MFCU to identify areas related to fraud and abuse detection, prevention and recovery that the agency should address as Medicaid Reform is implemented. During FY 2005-06, MPI helped the Agency's Division of Medicaid in making sure that the Agency's model contracts for MCOs and Provider Service Networks (PSNs) addressed these areas. This is in addition to MPI's ongoing auditing activities and will help MPI as auditing activities related to managed care change with Medicaid Reform.

In conjunction with other units of the Agency for Health Care Administration, staff members of Medicaid Program Integrity conducted site visits of managed care organizations holding Medicaid contracts to ascertain contract compliance for the 2006 – 2009 contract period. The other units are the Bureau of Managed Health Care in the Division of Health Quality Assurance and the Bureau of Health Systems Development in the Division of Medicaid. Medicaid Program Integrity was responsible for the review of the Contract Section on Administration and Management, Fraud Prevention. Twenty managed care organizations were visited: fourteen health maintenance organizations and six provider service networks. Additionally, one limited health service organization (a prepaid dental health plan) was visited.

The objectives of the visits were to ascertain compliance with contract provisions regarding the contract section on fraud prevention and to complete findings for the survey tool; establish rapport with plan representatives; ascertain whether viable mechanisms are in place for fraud and abuse prevention activities; and educate and inform plan representatives.

Educational aspects dealt with Agency structure and how Medicaid Program Integrity became involved in the compliance survey activity; the increasing cost of the Medicaid program with no room for fraud, abuse, or waste; the need for collaborative effort to combat fraud and abuse; plan responsibility for reporting fraud and abuse; and the availability of resource documents for improving understanding of matters relating to Medicaid fraud and abuse.

Coordination with Other Organizations

MPI works with other federal and state agencies to foster communications and cooperation that benefit fraud and abuse control actions. Such actions enable the exchange of information on the nature of fraud and abuse schemes; perpetrators of such schemes; and prevention, detection and auditing methodologies.

Medicaid Fraud Control Unit Operation Spot-check

The Medicaid Fraud Control Unit investigates the abuse, neglect and exploitation of the elderly, ill and disabled residents of long-term care facilities, such as nursing homes, facilities for the mentally and physically disabled and assisted care living facilities. One of the ways this is accomplished is by conducting random spot-check visits to these types of facilities. Medicaid Program Integrity field staff participate in these spot-check visits.

Each month random visits are made to a few of the abovementioned facilities. Other entities that attend these visits include the Agency for Persons with Disabilities, Department of Health, Ombudsmen, Building Code Compliance officials, local fire inspectors and the Health Quality Assurance Division of the Agency for Health Care Administration.

The visits help to further the efforts to work with the Medicaid Fraud Control Unit and also allow Medicaid Program Integrity to review records on site in order to determine whether Medicaid policy and procedures are being followed. As a result of these visits, Medicaid Program Integrity has requested termination of a provider, requested several prepayment reviews, assisted with a Change-of-Ownership situation and sent a provider education letter.

Health Quality Assurance Unlicensed Assisted Living Facilities

The Medicaid Program Integrity field offices participated in the Unlicensed Assisted Living Facility task force meetings spearheaded by Health Quality Assurance. During these meetings, different assisted living facilities and issues associated with those facilities were discussed. Staff members used this information as a tool to identify problem facilities and also to help identify those facilities in need of review to ensure that Medicaid policy and procedures are being followed. As a result of these discussions and reviews, some of these facilities have been placed on prepayment review.

South Florida Health Care Fraud Working Group

In the fall of 2005, the South Florida Fraud and Abuse Working Group was formed at the instigation of AHCA and other agencies to seek to enhance Medicaid fraud and abuse prevention, detection and recovery efforts. The Working Group consists of representatives of state and federal agencies and the Miami Dade Police Department. State agencies include AHCA, the Medicaid Fraud Control Unit, the Department of Health, the Department of Children & Families and the Florida Department of Law Enforcement. Federal agencies include the Department of Health & Human Services Office of Inspector General and Centers for Medicare & Medicaid Services, Office of the U.S. Attorney, the Federal Bureau of Investigation and the Drug Enforcement Administration.

The working group has improved communications among the agencies represented and has resulted in actions that have aided in fraud and abuse control. During FY 2006-07, The Centers for Medicare & Medicaid Services, the FBI, the U.S. Attorney's Office, the Medicaid Fraud Control Unit and Florida Department of Health have taken actions that have allowed AHCA to terminate and prevent future enrollment of seven providers in the Florida Medicaid program.

The exclusion of these providers such as pharmacies and medical clinics leads to significant cost avoidance.

Florida Diversion Response Teams

The Agency partners with the Florida Department of Law Enforcement (FDLE), MFCU and the U.S. Department of Justice — Drug Enforcement Administration in working on the problem of drug diversion. Drug diversion can be accomplished in many different ways. One common, but serious, example is when drugs are sold to a recipient by a pharmacy and that drug is returned to the pharmacy in an unlawful manner for resale.

During the time the drug was being passed around, it may have been sold many times over and become contaminated. The Diversion Response Team (DRT), headed by FDLE, works throughout the state to investigate potential crimes specifically related to drug diversion and pharmaceutical abuses. The Agency provides data and technical support to the law enforcement efforts of the DRT.

Department of Health

MPI management meets with representatives of the Department of Health (DOH) monthly to discuss referrals of specific providers, confirm referrals between the two agencies and share information about relevant projects and specific cases.

In 2004, a Data Sharing Agreement was initiated and this has allowed for increased cooperation between the two agencies due to the ability to share pertinent data. Since the inception of the Agreement, data sharing has significantly increased as have actions taken on referrals from both agencies. Through these processes, MPI and DOH have greatly improved communications and developed a greater working relationship. An example of this effort is the initiative involving recommendations for rule changes to the Board of Pharmacy. As a result of our collaborative efforts, we expect the Board to strengthen the requirements for Pharmacy Managers and Pharmacy Technicians, and to better define the description and requirements for Change of Ownership.

Referrals between the two agencies are improving and increasing. Training needs and informational access are also better addressed. MPI and DOH continue to discuss and develop further means of collaboration. Suspension actions taken by DOH are quickly reported to MPI. If the licensee is a Medicaid provider, MPI determines, among other Agency actions, whether withholding the provider's payments or suspending the claims for prepayment review is appropriate and in the best interest of the Medicaid program.

Medicaid Integrity Program

The Deficit Reduction Act (DRA) of 2005 created the Medicaid Integrity Program (MIP) in the Centers for Medicare & Medicaid Services (CMS) in the U.S. Department of Health & Human Services. MIP dramatically increases both CMS' obligations and resources to combat fraud and abuse at the federal level. Five million dollars were appropriated in FY 2006 with an additional $50 million to be received in each of FYs 2007 and 2008 and $75 million annually in FY 2009 and each year thereafter. The DRA also required CMS to hire 100 new full-time employees

(FTEs) "whose duties consist solely of protecting the integrity of the Medicaid program." Successful implementation will require a detailed understanding of state Medicaid operations and a high degree of coordination with the states and with Medicare Program Integrity (PI). CMS will provide overall leadership for MIP and coordinate with PI in all aspects of the program. The federal government intends that federal and state governments will devote substantially increased and more effective effort to fraud and abuse control.

The Medicaid Integrity Program is being implemented within CMS by the Medicaid Integrity Group (MIG). The MIG has been managing strategic contractors that assist MIG in formulating program implementation, procuring Medicaid Integrity Contractors (MICs) to audit providers of Medicaid services, and conducting oversight reviews of and assisting State Medicaid integrity programs. The Florida Bureau of Medicaid Program Integrity has been working with the MIG to devise performance measures, supply lists of providers for possible audit, furnish information on Florida Medicaid program policies, describe Medicaid Program Integrity audit operations, and explain Florida sampling methods and software.

Medicare

The Inspector General's Medicaid Program Integrity continues to work closely and regularly with the Centers for Medicare & Medicaid Services (CMS) and their contractors for Florida. During FY 2006-07, MPI Miami office staff participated in site visits with staff from the CMS satellite office; these visits included those to pharmacies, physicians and home health agencies. Additionally, MPI has increased the number of referrals to CMS of dually enrolled providers suspected of abusing the Medicaid program. Also during the past fiscal year, MPI has continued to develop and enhance the lines of communication with CMS and their subcontractors; as a result, there is an easier exchange and sharing of information with positive results for all entities.

During FY 2006-07, MPI and CMS have collaborated along with other state and federal agencies in recommending statutory and rule changes that will enhance the ability to deter and prevent Medicaid fraud and abuse. Through the collaborative efforts, the group has also contributed to the innovative development of a local ordinance regarding occupational licenses for health care providers within the city of Doral in Dade County.

Medi-Medi

The Medi-Medi project was designed to prevent and detect fraud and abuse in the Medicare and Medicaid programs through computerized analysis and matching of Medicare and Medicaid data. In combination with statistical analysis, this program can detect relationships, and trends in Medicaid billing can be discerned. Abuse and potential fraud cases can be developed for referral to appropriate health care and law enforcement agencies. Delays have been associated with transitioning projects from the previous CMS vendor to the current vendor and, therefore, access to matched data by Medicaid has also been delayed. Despite such delays, information has continued to be provided to the Bureau of Medicaid Program Integrity and other entities about apparent excessive billing, duplicate payments for original prescriptions on pharmacy claims and abuses by other types of providers. The Medi-Medi project complements the efforts of the Bureau of Medicaid Program Integrity in the matching of Medicare and Medicaid data and

enhances coordination among agencies that identify, analyze and investigate possible fraud and abuse.

Department of Children & Families

Medicaid pays for certain services that are within programs under the auspices of the Department of Children & Families (DCF). Since policy development and clarification have been required in the past, MPI and DCF have worked closely through the years. DCF also assists Medicaid by performing part of the Medicaid recipient eligibility process. During FY 2006-07, MPI coordinated with DCF to resolve questions related to eligibility and services that are provided under the auspices of DCF.

Agency for Persons with Disabilities

MPI continued participation in a workgroup initiated during FY 2005-06 with representatives of the Agency for Persons with Disabilities (APD), AHCA's Division of Medicaid and MFCU to review the Developmental Disabilities Home and Community Based Services waiver. The purpose of the workgroup is two-fold: to continue review of safeguards implemented to determine if there were apparent deficiencies that may warrant further analysis, and to identify areas for potential audit. The workgroup continued to evaluate detailed reports of claims data in an attempt to identify areas of potential fraud or abuse.

During FY 2006-07, the billings for providers engaged in environmental modifications and assessments were targeted for review. The workgroup also addressed referral and communication modalities between MPI and APD. The workgroup discussed issues concerning the implementation of the new fiscal agent contract and potential safeguards that will be implemented. The workgroup continues to identify areas of concern and plans to continue meeting in FY 2007-08 in an attempt to identify additional providers and programs for comprehensive review.

Prevention

The Inspector General's Bureau of MPI dedicates approximately 40 percent of its staff to the prevention of fraud and abuse because we believe that this use of resources will pay dividends in the future; the prevention of misspent funds is less costly than attempts to recover funds. Among MPI prevention activities are the use of prepayment reviews to identify improper claims and deny payment; recommendations for termination of providers suspected of misusing the Medicaid program; focused projects to address areas most susceptible to fraud and abuse that have a deterrent effect and that result in cost savings for the Medicaid program; referrals to other regulatory and law enforcement entities that may result in restrictions on providers' ability to continue to participate in the Medicaid program and that serve as a deterrent; use of a provision of law that allows Medicaid to decline reimbursement for prescription drugs prescribed by practitioners who were terminated from the Medicaid program; and other measures that allow the Agency to better control its network of providers.

Prepayment Reviews

Prepayment reviews encompass examination of claims associated with "intercepted payments" and evaluation of "pended claims." The "intercepted payments" are Medicaid claims that have been processed for payment but the payment has not yet been sent to the provider. "Pended claims" have not yet been processed for payment. Both types of claims may undergo a prepayment review. A provider must submit supporting documentation for claims under prepayment review so that MPI can determine whether to pay or deny the claim.

In prepayment review, claims not having proper documentation are denied. MPI may place a provider on prepayment review if there is suspicion of fraudulent or abusive behavior; suspicion of neglect of a recipient; suspected overpayment; receipt of a complaint against the provider; suspicion of the rendering of goods or services that are not medically necessary, are of inferior quality, or have not been provided in accordance with applicable provisions of all Medicaid or professional requirements; suspicion of billing for goods or services that have not actually been furnished; suspicion of billing for goods or services for which appropriate documentation is not made at the time the goods or services were provided; random selection based upon a fraud or abuse prevention initiative; or suspicion of any of the violations set forth in s. 409.913(15), F.S.

Cost savings are calculated based on funds that would have been paid but for the intervention by MPI in conducting the prepayment review. For intercepted payments, the amount avoided is the amount of the reduction in the payment to the provider. The full amount of the reduction is considered cost avoided, because the claim has been through the Medicaid system edits. For pended claims denied, the cost-avoided amount is the billed amount of the denied claims factored by the ratio of actual payments to billed amounts for the type of provider involved. This ratio factors in the proportion of the billed amount that would have been denied due to system edits. (MPI is not credited for amounts that would have been denied or adjusted even without MPI intervention.) During FY 2006-07, the claims of 217 providers were pended and payments of approximately $4.8 million were cost avoided.

The following table shows the types of providers whose claims were pended and reviewed in FY 2006-07, and the savings due to denied pended claims.

Provider Type	Number of Providers	Amount of Denied Claims
Pharmacy	26	$1,906,528
H & C Based Services	23	1,274,833
Dentist	5	433,122
Physician (MD)	73	424,493
Medical Supplies/Durable Medical Equipment	50	235,406
Home Health Agency	6	221,611
Physician (DO)	5	130,755
Therapist	7	69,439
Assistive Care Services	9	40,978
Audiologist/Speech Pathologist	2	30,456
Hearing Aid Specialist	4	25,536
Advance Nurse Practitioner	2	4,810
Physician Assistant	2	4,430
Chiropractor	1	3,419
Independent Laboratory	1	953
Portable X-Ray Company	1	144
Total	217	$4,806,913

Termination of Providers

Providers may be involuntarily terminated from the Medicaid program in accordance with the provisions of Sections 409.913 (13) through (18) and (30), F.S. Providers may also be terminated from the Medicaid program pursuant to the provisions of the Medicaid provider agreement ("contract"). A provider may be terminated under the contract, with or without cause, with 30 days notice.

When a provider suspected of fraudulent or abusive billing is terminated from the Medicaid program, Medicaid expenditures should decline with respect to the recipients served by the terminated provider, taking into account services provided by other providers of a similar type. For a terminated provider, the savings are the difference in payments for the one-year periods before and following termination for services provided by the provider and other like providers to all recipients served by the terminated provider. Because the analysis requires an evaluation of payments for one year following the termination, the savings as a result of termination during July 1, 2004 – June 30, 2005 are reported for FY 2006-07. For that fiscal year, these terminations saved Medicaid $13.2 million. This figure represents only those terminations that followed from a recommendation to the Division of Medicaid from Medicaid Program Integrity.

Site Visits

Staff members in the field offices of the Bureau of Medicaid Program Integrity visit certain newly-enrolled Medicaid providers in specified geographic areas in an effort to control Medicaid provider fraud and abuse and to prevent the misuse of State funds. These visits are to ensure that the provider is still at the address given, appears to have the assets required to perform the services that will purportedly be furnished, has necessary Medicaid manuals and forms, is generally familiar with Medicaid policies, and knows how to obtain Medicaid information. Following the site visits, the Bureau of Medicaid Program Integrity sends provider education letters to the providers advising them of any issues identified during the visits, including those found in the review of records. A follow-up visit to the provider may be conducted to ensure that the provider has corrected any deficiencies and is in compliance with Medicaid policy.

Site visit savings are based on payments made to the provider during the one-year periods prior to and following the visit. New providers are not included in the calculation of savings; a provider must have been active one year prior to the visit to be included. Because of the Medicare Part D effect, pharmacies were not included. Cost savings for FY 2006-07 resulting from 253 site visits are $2.8 million.

Focused Projects

Durable Medical Equipment
Oxygen Concentrator and Oxygen-Related Equipment Project

In the process of interviewing recipients to verify services, Miami office of Medicaid Program Integrity investigators noted that in many instances Medicaid was being billed for oxygen concentrators along with portable oxygen tanks for the same recipients. In face-to-face encounters with the recipients, however, it appeared that much of the equipment was not used. Subsequent research determined that many Durable Medical Equipment (DME) providers were billing almost exclusively for procedure codes E1390 (oxygen concentrator) and E0431 (portable oxygen) for the same recipients. Medicaid Program Integrity initiated a project to identify providers billing for both procedure codes for the same recipient.

The project required conducting site visits to as many DME providers as possible to determine whether services were being provided according to Medicaid guidelines. As part of the project, Medicaid Program Integrity staff members conducted records reviews at the providers' offices to determine, first, whether all required components were found in the medical records and, second, whether services were being rendered in accordance with Medicaid policy. Subsequently, recipients were interviewed to determine whether the equipment was being used and, if so, whether the services were medically necessary. In some instances, prescribing physicians were interviewed and medical records were reviewed. The information in the physicians' records was compared to that in records obtained from the DME providers.

This year-long project identified 47 DME providers who were billing for both procedure codes for the same recipients. At the conclusion of this project, Medicaid Program Integrity recommended termination of twelve of the 47 providers (26 percent) in the project for multiple and severe cases of fraud or abuse; four of the providers recommended for termination were referred to the Medicaid Fraud Control Unit as well. Ten providers were given education letters

for minor policy violations. Four providers were referred to other regulatory agencies for licensing and enrollment violations. Several providers in the project were placed on prepayment review that resulted in further savings. It has been calculated that this project saved the Medicaid program $2.1 million during FY 2006-07. The savings were calculated as the difference between total payments to durable medical equipment providers for the one year periods prior to and following July 1, 2006.

Home Health Agencies

This project was initiated in December 2006 as a result of the dramatic increase in Medicaid reimbursements for procedure code T1021 (Home Health Aide Service Unassociated with Skilled Nursing Service) over the last few years. The project was to be conducted by the Miami Discovery Unit of Medicaid Program Integrity and its goals were to identify the reasons for this rapid and unexplained rise in reimbursements, recoup any Medicaid funds inappropriately paid, recommend actions regarding identified providers, make referrals to other pertinent agencies and to make any appropriate policy recommendations.

Initially, 24 home health agencies were selected and assigned for investigation. The project required the investigators to select Medicaid recipients exclusively receiving services for procedure code T1021 and conduct a site visit accompanied by a nurse. Both the investigator and the nurse would interview the recipients to ascertain whether services were being rendered, the frequency of the service and the medical necessity of the service. Subsequently, they would visit the home health agency and request records including those for the patients visited and compare the information with the statements given by the recipients.

As a result of the project, Medicaid Program Integrity found a number of instances of questionable practices at home health agencies: Some home health aides were each employed by several home health agencies. The same patients were being served by more than one home health agency. Some home health aides appeared to be transferring patients from one home health agency to another for the aides' economic benefit. Some records had been altered. Medicaid patients being provided with home health aide services were found not to need assistance with the activities of daily living. Certain home health agencies were providing some housekeeping and companionship, but were billing for home health aide services. Some home health agencies appeared not to have any direct patients, instead serving as "staffing pools" for other home health agencies. Some home health agencies appeared to be engaging in patient brokering and paying physicians for referrals.

As a result of this project, MPI recommended the termination of 13 of 24 (54%) of the home health agencies inspected for multiple abusive and or fraudulent activities. Twelve of the same 24 providers were referred to the Medicaid Fraud Control Unit for criminal investigation. These twelve were placed on prepayment review, resulting in a high percentage of denials of abusive claims. Six of the 24 providers received education letters due to minor policy violations and three of those six were asked to reverse claims for exceeding service limitations. It has been calculated that this project saved the Medicaid program $2.9 million during FY 2006-07. Savings respecting the home health providers were the difference between the payments to twenty-one providers for the one-year periods prior to and following January 1, 2006, irrespective of procedure codes involved.

Denial of Reimbursement for Prescription Drugs

Based on legislation enacted in 2004, the Agency is authorized to deny reimbursement for prescription drugs prescribed by practitioners who have been terminated from the Medicaid program. The Agency is further authorized to deny payments for goods or services caused to be furnished by a provider terminated or suspended from the Medicaid program. [Sec. 409.913(25)(b), F.S.] The Agency implemented these provisions in January 2005, believing that the denial of these payments would significantly reduce the abusive prescribing and dispensing of Medicaid goods and services. The denial of reimbursement for prescription drugs savings relate to providers terminated during the period August 1, 2005 - June 30, 2006 and are the sum of the differences between payments for drugs for the one-year periods prior to and following the date of termination on behalf of all recipients who had received drugs prescribed by the terminated prescriber and who had maintained eligibility for all of both one-year periods. During FY 2006-07, 66 providers were the subjects of this action, which resulted in cost avoidance for the Medicaid program for $0.8 million.

Policy Change – Routine Drug Screens

Policy changes recommended by Medicaid Program Integrity to and adopted by the Medicaid Division sometimes lead to savings as a result of the elimination of medically unnecessary services or of provisions permitting improper billing. For example, during the past fiscal year Medicaid Program Integrity noted the existence of a policy provision permitting excessive billing for a screening code.

When independent laboratory providers perform a certain routine drug screening, it is equitable that they bill and be paid for one drug screening or one unit of service using procedure code CPT 80101. The Medicaid fee schedule, however, provided for laboratories to bill for up to seven units of service for one screening. This situation was pointed out by Medicaid Program Integrity to the Bureau of Medicaid Quality Management in the Division of Medicaid and the number of units billable for one screening was adjusted to one, as should be the case. It was determined that this change saved the Medicaid program $2.4 million during FY 2006-07. The savings were calculated based upon the annualized average monthly payments for that code prior to and following the date the change was effected.

Other Projects

Explanation of Medicaid Benefits Program

Explanation of Medicaid Benefits forms (EOMBs) are mailed for the Bureau of Medicaid Program Integrity by the Medicaid fiscal agent contractor to approximately 800,000 recipients per quarter, a significant increase from the 7,500 quarterly mailings previously done. The EOMBs pertain to all claims adjudicated during the previous month, with the exception of claims for services that are specified by state or federal law to be confidential. The Intake Unit of Medicaid Program Integrity receives Explanation of Medicaid Benefits forms returned by Medicaid recipients and their representatives. The EOMBs provide recipients the opportunity of indicating that they received, or did not receive, services for which Medicaid was billed on their behalf. Recipients utilize EOMBs to comment on any aspect of the Medicaid program. The

Intake Unit is responsible for processing the EOMBs, opening files when appropriate, and conducting investigations of files open in preliminary status.

Of the 800,000 EOMBs mailed each quarter, approximately two percent (16,000) are returned to MPI by recipients or recipients' representatives. Four staff members, including one solely dedicated to EOMBs, process the forms as they arrive at MPI and identify those with discrepancies noted by recipients or the representatives. Those EOMBs are then screened by investigators to determine whether the offending claims may have been voided, the recipient may have misunderstood the services shown on the EOMB, or there may be other reasons why the complaint should not be further investigated.

The quarterly mailings generate approximately 300 to 350 leads that should be further investigated. Most of these leads result in preliminary investigations whose outcome may be recoupment, reversal of paid claims, provider education, referral to the Discovery Data Unit or a Case Management Unit, or referral to the Medicaid Fraud Control Unit. Some EOMBs contain complaints not related to Medicaid fraud and abuse and are referred to appropriate entities, such as the AHCA Division of Health Quality Assurance, the appropriate Medicaid area office, and the Florida Department of Health.

Administrative Sanction Rule

The administrative sanction rule (Rule 59G-9.070, F.A.C.) became final in April 2005 and was fully implemented on July 1, 2005. In addition, modifications to the rule were finalized in April 2006. The modifications addressed issues brought out during a rule challenge to the initial adoption of the rule; they also sought to ensure fairness and consistency in its application. During FY 2006-07, 491 Medicaid providers were sanctioned for violations set forth in the rule. Of these, 222 received fines totaling over $373,000 and 10 were suspended from the Medicaid program. The others, including some of those fined, received other sanctions, principally in the form of 428 acknowledgement statements. While some portion of those fines remain under review due to litigation or are otherwise in the collection process, approximately two thirds of the fines have been collected and are further detailed in the section dealing with Statutory Reporting Requirements. The violations, in general, included the failure to comply with the provisions of the Medicaid provider handbooks, which includes the failure to maintain and/or furnish specified records.

Recovery

Medicaid Program Integrity investigations into allegations and indications of violations of Medicaid policy fall into three categories: MPI conducted audits, paid claims reversals, and vendor-assisted audits. MPI's recovery efforts tend to concentrate on conducting comprehensive investigations and focused audits of Medicaid providers. MPI also uses the knowledge of Florida licensed pharmacists to review claims paid to pharmacies to identify probable misbillings. The pharmacy is contacted and, as a result of the MPI activities, the erroneous claims are reversed, resulting in recovery of the misspent funds. MPI also uses vendors to augment its efforts so that recovery projects can be conducted that would not otherwise be completed because of staffing limitations. MPI staff members, however, assist in and oversee all aspects of these projects.

MPI Audits

During FY 2006-07, MPI concluded 1,018 audits of Medicaid providers. These audits were comprehensive investigations evaluating all aspects of a provider's billings or focused investigations that evaluated specific aspects of providers' billings. Comprehensive audits typically involve determining all of the paid claims of a provider (the population) for a specific period of time and taking a random sample of claims from the population. The sample claims are carefully reviewed with respect to Medicaid policy and any overpayments found in the sample are extended by generally accepted statistical methods to the population of claims in order to determine the total overpayment in the population. At present, however, Florida Statutes preclude the use of statistical sampling in audits of pharmacies, which inhibits the ability of MPI to find and recover overpayments made to those providers. During FY 2006-07, more than $23.7 million was identified as overpayments as a result of MPI audit activities. The projects discussed in the following paragraphs are illustrative of Medicaid Program Integrity audit activities.

Risperdal Antipsychotic Drug Project

This project was initiated to recover overpayments resulting from misbillings for the Risperdal Consta injectable drug. Risperdal Consta Injection is a long-acting antipsychotic injection given to patients once every two weeks or semimonthly. The project began when the MPI Discovery Unit detected that several pharmacies were billing for the injection Risperdal Consta incorrectly. A factor contributing to the misbillings was a change in dosage units (from milliliters to dose packs) by the drug manufacturer. A team from the Pharmacy Case Management Unit began telephoning providers to have them reverse overbilled prescriptions and to rebill them correctly, which resulted in recoveries by Medicaid. For prescriptions that were too old to be reversed electronically, the Pharmacy Case Management Unit sent letters requesting payment from the provider for overpayments resulting from misbillings of quantities of Risperdal Consta Injection. The total amount recovered by this project is $808,183.

Transportation – Ambulance Providers

It was noted that certain ambulance providers were billing a high proportion of Advanced Life Support services as contrasted with Basic Life Support. Cases were opened on 26 providers on a statewide basis. Records were requested and reviewed to determine whether services had been billed in accordance with federal guidelines. For 24 of the providers, it was determined that claims had been billed inappropriately. From those providers were collected $350,000 in repayments of overpayments and $10,500 in fines.

Targeted Case Management – Primary Care

The State Plan Amendment for Targeted Case Management precludes providers from billing for those services rendered to individuals enrolled in Home and Community Based services. When Targeted Case Management Services are seen to be billed for those recipients, they are considered to be duplicative and payments for them are recouped. Cases were opened on fifteen providers, who were requested to complete self-audits. All have complied. Eight providers have

paid and payment is expected from the other seven. Total recoupment is expected to be approximately $200,000.

Paid Claims Reversals

Pharmacies submit claims to Medicaid as the pharmaceuticals are dispensed. Occasionally, pharmacies overstate the amount of the drug that is dispensed and are thus overpaid. Using MPI detection methods, atypical claims can be identified. The provider is contacted and may submit supporting documentation justifying the paid claim amount or is requested to reverse the claim in the electronic claims submission system. When the claim is reversed, Medicaid is credited with the original amount paid to the provider. The provider may resubmit the claim with the corrected quantity and then is paid the correct, reduced amount. The difference between the original payment and the reduced payment is recorded as recovered overpayments to Medicaid. Providers who do not adjust or reverse the payment are subject to further audit or other administrative action by the Agency. During FY 2006-07, paid claims reversals resulted in net recoveries to Medicaid of about $700,000.

Vendor Assisted Projects

The Agency contracts with a vendor to assist in several fraud and abuse recovery efforts. The vendor is able to focus on projects involving large volumes of data, which allows the Agency for Health Care Administration to process claims adjustments on projects involving numerous providers. The vendor works closely with MPI to ensure that the policy basis for the project is sound and that there are no conflicts between providers under investigation by MPI or MFCU and those reviewed by the vendor. MPI reviews and approves all fraud and abuse projects initiated by the vendor. During FY 2006-07, the vendor assisted in the collection of approximately $15.0 million from projects involving: claims paid after the recipients' date of death, credit balance adjustments from hospitals and nursing homes, provider self audits and duplicate billing.

Date of Death Audits

This project involves reviewing the FMMIS Medicaid paid claims file and comparing the date of service to the date of death on the Florida Medicaid Management Information System (FMMIS) recipient file. If claims were paid for dates of service after the date of death, the provider is notified of the amount of overpayments that are to be recouped. The providers are given the opportunity to review the claims in question and submit documentation refuting the date of death (e.g., copy of a death certificate or nurse's/doctor's notes). If the provider's documentation is acceptable, those claims are removed from the recoupment listing. In order to recover the funds, adjustments are submitted to the fiscal agent for posting to the FMMIS. In FY 2006-07, the date of death project yielded recoveries of $3.9 million.

On-site Facility Audits

The credit balance reports of hospitals and nursing homes were reviewed in order to identify overpayments by Medicaid. A credit balance appears on a provider's accounts payable ledger as

an amount owed to another entity, such as Medicaid. This project yielded recoveries of $2.4 million in FY 2006-07.

Provider Self Audits

This past fiscal year renal dialysis centers were mailed letters requesting that they review their credit balances and voluntarily refund any overpayments to Medicaid. This ongoing project yielded recoveries of $1.0 million in FY 2006-07 from the renal dialysis centers as well as other provider types that had overpayments identified in earlier fiscal years.

Duplicate Billing

This review identified Medicaid payments to hospitals for inpatient services for duplicate or overlapping periods and resulted in the recovery of $7.7 million in FY 2006-07.

Performance Trends

MPI has begun tracking several performance measures in order to manage the Bureau's workload more efficiently. The initial areas that have been reviewed are referrals to outside agencies, collections on overpayments, cases with findings, and the average number of days from case opened until the overpayment is repaid in full.

Referral Activities

Number of Referrals			
Activity	FY 2004-05	FY 2005-06	FY 2006-07
Referrals to MFCU	197	225	212
Referrals to Others	210	307	350

As may be seen from the above chart, the Agency for Health Care Administration has remained diligent in referring to other agencies providers who may be engaging in abusive conduct.

Recoveries of Overpayments

In an attempt to increase the amount of overpayments recovered, MPI has begun monitoring the rate of recovery of identified overpayments as well as the amounts written-off or adjusted. Historically, a significant number of overpayments have not been recovered because the provider declared bankruptcy or disappeared, resulting in the amounts being written off. This is the downside of attempting to recover funds in a system in which payments are made first and then claims are reviewed later. This is known as "pay and chase," which makes it very difficult to recover 100 percent of the identified overpayments. In addition, recoveries often do not occur in the year that the overpayment is identified making it difficult to track the repayments. This occurs primarily because cases go to litigation, providers opt to pay over time, or the payment occurs in a following fiscal year. Prior to implementation of the Fraud and Abuse Case Tracking System (FACTS), the rate of recovery was a difficult measure to calculate and as a result was not routinely reported. This information is now obtainable, however, and is included in quarterly

reports. Management has made it a priority to conclude cases in a timely manner in order to increase the recovery rate.

Fiscal Year	Overpayments Identified	Recoveries	
2004-05	$ 47,346,371	$ 25,705,233	54.3%
2005-06	29,915,991	21,531,865	72.0%
2006-07	$ 39,369,849	$ 24,802,833	63.0%

The above figures indicate that this effort is showing positive results. The June 30, 2007 report shows that for FY 2006-07 collections of $24.8 million or 63 percent of identified overpayments of $39.4 million had already been effected, no receivables had been written off, and $14.6 million or 37 percent remained to be collected. These figures also reflect that a better job is being done of identifying overpayments that can actually be collected.

Cases with Findings

Disposition of Cases	Fiscal Year		
	2004-05	2005-06	2006-07
Overpayment Identified	849	1002	811
No Fraud or Abuse Found	566	199	177
Provider Education Letter	44	27	30
Total Cases Closed	1,459	1,228	1,018
Percent with Overpayment	**58.2%**	**81.6%**	**79.7%**

MPI has increased its efforts to ensure that resources are expended only on investigative leads that have the potential of recovering Medicaid funds. These improved preliminary screening processes have resulted in closing fewer cases without an overpayment being identified, as shown above.

Days to Fully Recover an Overpayment

The average number of days from the case opened date to the date the overpayment is fully recovered has steadily decreased, as shown below. These reductions have occurred, because investigative cases are being completed in a timelier manner and collection efforts have been increased.

Days to Paid In Full			
Fiscal Year	2004-05	2005-06	2006-07
Cases	652	878	819
Average Days	500	452	328

Return on Investment

Medicaid Program Integrity efforts resulted in the recovery of $34.6 million in overpayments in FY 2006-07, an increase of 24 percent from the previous fiscal year.

MPI Recovery of Overpayments (millions)			
Activity	FY 2004-05	FY 2005-06	FY 2006.07
MPI Audits	$11.6	$16.3	$18.9
Reversals	1.5	0.9	0.7
Claims Adjustments	7.4	10.8	15.0
Total	$20.5	$28.0	$34.6

In addition, MPI prevention efforts resulted in cost savings of $29 million in overpayments in FY 2006-07, as shown below.

MPI Prevention of Overpayments (millions)						
	FY 2004-05		FY 2005-06		FY 2006-07	
Activity	**No.**	**Amount**	**No.**	**Amount**	**No.**	**Amount**
Prepayment Review	285	$14.2	245	$ 5.5	217	$ 4.8
Termination of Providers	224	14.7	194	13.3	194	13.2
Focused Projects	2	8.6	3	11.4	2	5.0
Denial of Reimbursement for Prescription Drugs	124	1.3	124	5.9	66	0.8
Policy Changes	n/a	n/a	1	0.9	1	2.4
Site Visits	n/a	n/a	n/a	n/a	253	2.8
Total		**$38.8**		**$37.0**		**$29.0**

During the year, expenditures of $8.0 million were devoted to recovery work resulting in a return on investment for recovery operations of 4.3:1. In addition, MPI achieved $29 million in cost avoidance with expenditures of $3.6 million, producing a return on investment for prevention efforts of 8.1:1. Overall, in FY 2006-07, recoveries and cost avoidance totaled $63.6 million, yielding a return of 5.5:1.

Return on Investment (millions)				
		Benefits	Costs	ROI
FY 2004-05	Recovery	$20.5	$7.5	2.7:1
	Prevention	38.8	3.4	11.6:1
	Total	**$59.3**	**$ 10.9**	**5.5:1**
FY 2005-06	Recovery	$28.0	$7.6	3.7:1
	Prevention	37.0	3.4	10.9:1
	Total	**$65.0**	**$11.0**	**5.9:1**
FY 2006-07	Recovery	$34.6	$8.0	4.3:1
	Prevention	29.0	3.6	8.1:1
	Total	**$63.6**	**$11.6**	**5.5:1**

Division of Medicaid

Bureau of Medicaid Quality Management

The Bureau of Medicaid Quality Management consists of three offices: the Office of Medicaid Research and Policy (formerly the Bureau of Medicaid Research); the Office of Medicaid Program Oversight (formerly the Monitoring Unit); and the Office of Project Management. The three units' focus is on optimizing and improving quality in Medicaid programs, Medicaid policies and the implementation of projects and research. The Office of Medicaid Program Oversight is the unit more involved with anti-fraud and anti-abuse activities, and which works closely with other Agency entities to help deter fraud and abuse in Florida Medicaid.

Office of Medicaid Program Oversight

The Office of Medicaid Program Oversight (MPO) is charged with developing standards and tools for effectively monitoring Medicaid service programs; preventing unnecessary and inappropriate utilization of Medicaid services; reducing duplicative Medicaid services; ensuring compliance of program operations with policy and comparing alternative managed care models/programs. MPO reviews program policies to ensure the edits in the Florida Medicaid Management Information System (FMMIS) reflect Medicaid program policy and program operations; samples claims and eligibility data for trend analysis of programs and services, and to identify best practices and make recommendations based on findings. MPO facilitated modifications of the random and mandatory site visit processes for new Medicaid providers. Finally, MPO is working with Medicaid Program Integrity to coordinate the review of Medicaid program change recommendations and provide additional monitoring of selected providers' billing patterns. Examples of oversight activities include:

Site Visit Processes for New Medicaid Provider Applicants

In March 2006, the random site visit process was modified to incorporate a desk review of new applicants who join established groups and facilities as non-billing providers. In FY 2006-07 this change allowed Medicaid Field Office staff to increase new applicant reviews by an additional eight percent while saving 795 staff hours.

In February 2007, MPO facilitated a review of the mandatory site visit process. Recommendations to standardize the process were made based on best practices identified during the random site visit process review and Medicaid Field Office input.

Payment Error Rate Measurement Program (PERM)

The Agency began development of a foundation for the PERM program in Florida by participating collaboratively with the Centers for Medicare & Medicaid Services (CMS) in three of four pilot programs (Payment Accuracy Measurement and Payment Error Rate Measurement) beginning in 2002 and extending through 2005. PERM is authorized under the Improper Payments Information Act of 2002 (IPIA; Public Law 107-300), and Sec. 1902(a)(27) of the Social Security Act.

As part of the process, MPO also began to increase Medicaid provider awareness of its oversight functions by educating providers on PERM with articles in the Agency Provider Bulletins. Three of these educational articles were disseminated over the past year, with a fourth one on the way. MPO was also in the process of negotiating a contract for conducting reviews of the State's eligibility determination processes for Medicaid, and Florida KidCare, the State's Children's Health Insurance Program, which is another program jointly funded by the State and the Federal government. That contract is expected to be finalized in FY 2007-08. One expected outcome of the eligibility determination reviews would be the development and implementation of corrective action plans that will result in fewer improper payments.

Medicaid Encounter Data System (MEDS) Development

The Medicaid Encounter Data System (MEDS) project was mandated by HB 3B during the Florida Legislature 2005 Special Session "B" and is in compliance with Title XIX of the Social Security Act, the Balanced Budget Act of 1997, 42 CFR 438, and Chapters 409 and 641, Florida Statutes.

The Office of Medicaid Program Oversight is the lead on this project and a MEDS team, including internal subject matter experts and external consultants with experience in the collection and processing of encounter claims data, was formed. To comply with the risk adjusted capitation rate requirements for Medicaid Reform, in the start-up phase, the Medicaid R_x model was selected for risk adjustment and the Agency began collecting pharmacy data from health plans in November 2005. Pharmacy data for FY 2003-04 and forward were collected by the Agency and the data were subjected to a series of validation and completeness tests prior to the generation of risk factors through the model.

The Agency has designed and developed MEDS to capture encounter data from all health plans for all Medicaid covered services. The actual collection and processing of the encounter data are at their infancy at the close of FY 2006-07. MEDS will support the risk model computations that set capitated payments for managed health care entities, enhanced benefits program and quality performance measures. MEDS will also be used for specific information requests on service utilization trends, quality of care and access to care. Once mature, MEDS will be a valuable resource for the Agency in its analyses of Medicaid health care and related services rendered to

beneficiaries enrolled in managed care plans, thereby helping to expand the Agency's fraud and abuse initiatives beyond the traditional fee-for-service model.

Assisting in Implementing the New Florida Medicaid Management Information System/Decision Support System (FMMIS/DSS)

The Office of Medicaid Program Oversight staff is participating in user acceptance testing of the new Florida Medicaid Management Information System (FMMIS) and Decision Support System (DSS).

Coordination with the Bureau of Medicaid Program Integrity

The Office of Medicaid Program Oversight and the Bureau of Medicaid Program Integrity continued to share information and observations pertaining to potential fraud and abuse and programmatic issues to lessen opportunities for overpayment.

Beginning in March 2007, Medicaid Program Integrity and MPO set up a process for MPO to provide additional review of selected providers' billing patterns. Based on these reviews, further actions may be recommended for additional MPI or Medicaid Field Office action. Ten providers are currently under monthly review.

In January 2007, the MPO and Medicaid Program Integrity established a process for tracking MPI policy change recommendations to Medicaid Handbooks. MPO coordinates and tracks recommended policy changes. MPO is currently tracking 25 policy recommendations made through this process. The status of active recommendations is monitored monthly.

Analyses of Medicaid Programs and Services

The Office of Medicaid Program Oversight continues to assist all Medicaid bureaus and the eleven Medicaid area offices through general analyses and targeted studies related to Medicaid programs and services.

A statewide home health agency provider claims profile for CY 2006 was prepared for the Bureau of Medicaid Services. Two review tools were developed for Medicaid Field Office staff in evaluating home health agencies: administrative review of operational policies and clinical record review.

Bureau of Program Analysis
Third Party Liability Unit

The Division of Medicaid's Third Party Liability Unit is responsible for identifying and recovering funds for claims paid by Medicaid for which a third party was liable. Some examples of third parties include casualty settlements, insurance companies, recipient estates and Medicare. Third Party Liability recovery services are contracted with Health Management Systems, Inc. (HMS).

Casualty – Medicaid imposes a lien against liable third parties for the amount Medicaid has paid on behalf of a recipient who has been involved in an accident or incident, which resulted in

injury. Attorneys are required to notify Medicaid that they represent a Medicaid recipient involved in an accident or incident.

Estate/Trusts – Medicaid files an estate claim on behalf of a deceased Medicaid recipient for Medicaid payments made after age 55. Medicaid is to be paid after attorney and personal representative fees and funeral costs (class 3 creditor) and must be notified by the estate attorney or personal representative when an estate is opened on any individual over age 55. Trusts relating to a person's eligibility in the Medicaid program stipulate that upon the death of the trust beneficiary, or if the trust is otherwise terminated, the balance of the trust up to the amount that Medicaid paid on the beneficiary's behalf is to be paid to the Medicaid program.

Medicare and Other Third Party Payer – Medicaid bills and collects from insurance carriers and Medicaid providers for claims previously reimbursed by Medicaid for which Medicare or another third party such as private insurance may have been liable.

Cost avoidance – Cost avoidance is new and/or updated insurance information that is derived from data matches with insurance carriers. When new and/or updated insurance information is obtained, that information is added to the Medicaid database in order to cost avoid future claims that are submitted by Medicaid providers. When a provider submits a claim and a recipient has other insurance, the provider is instructed to bill the other insurance prior to billing Medicaid. HMS matches data with more than 90 percent of commercial insurance coverage in Florida.

THIRD PARTY LIABILITY RECOVERIES					
	FY 2002-03	FY 2003-04	FY 2004-05	FY 2005-06	FY 2006-07
Casualty	$18,511,913	$22,431,466	$27,252,053	$26,648,342	$18,062,167
Estate/Trusts	10,983,169	13,673,588	15,922,663	14,836,825	14,068,893
Medicare & Other Third Party Payer	36,618,240	42,134,384	43,790,077	70,807,531	60,410,981
Total	$66,113,322	$78,239,438	$86,964,793	$112,292,698	$92,542,041

THIRD PARTY LIABILITY COST AVOIDANCE				
FY 2002-03	FY 2003-04	FY 2004-05	FY 2005-06	FY 2006-07
$1,015,490,436	$1,262,123,941	$1,321,878,989	$1,409,616,013	$1,769,377,975

Recoveries from special Medicaid projects completed for FY 2006-07 include the following:

OTHER RECOVERIES[1]	
Provider Amnesty (Credit Balance)	$983,536
Date of Death	3,949,296
Hospital Audits	2,348,008
Nursing Home Credit Balance Reviews	299,888
J-Code Rebates	1,265,843
Medicare Part B	7,946,222
Medicaid Overpayments	7,667,421
TOTAL	$24,460,214

Bureau of Medicaid Contract Management

The Bureau of Medicaid Contract Management (MCM) is responsible for monitoring the Agency's contract with Affiliated Computer Services (ACS), the fiscal agent responsible for operating, programming and maintaining the Florida Medicaid Management Information System (FMMIS) and Decision Support System (DSS). FMMIS is the state-owned electronic data processing system for processing Medicaid provider claims, maintaining eligibility files, enrolling providers, printing and mailing Medicaid identification cards and accumulating statistical data. DSS is the Medicaid database that is maintained and utilized for data mining and analysis.

Provider Enrollment Initiatives

Medicaid staff conducts on-site inspections of certain prospective Medicaid providers to ensure that they meet enrollment requirements pursuant to Sec. 407.907(7), F.S. and Medicaid policy. . For the period from July 2006 through June 2007, 956 site visits were conducted, leading to 822 approvals for enrollment and 134 denials.

The MCM Provider Enrollment Unit terminates a provider's Medicaid prescribing privileges in the Prescribed Drug Claims System (PDCS) once they lose their Medicaid enrollment eligibility due to fraud and abuse. Fifty-two (52) terminations have been processed in the PDCS, thus preventing further expenditures of Medicaid funds as required by Federal guidelines.

[1] **Provider Amnesty (Credit Balance) –** Providers refund to Medicaid any Medicaid overpayments contained on their accounts. **Date of Death –** Claims paid after the dates of death of recipients are recovered from providers. **Hospital Audits –** Hospital accounts payable ledgers are reviewed in connection with collecting Medicaid overpayments. **Nursing Home Credit Balance Reviews –** Nursing Home accounts payable ledgers are reviewed in connection with collecting Medicaid overpayments. **J-Code Rebates –** Drug rebates due from pharmaceutical manufacturers and labelers are recovered for "J-Code" class drugs. **Medicare Part B Physician Claims –** Payments are recovered from providers who were originally paid by Medicaid for claims for which Medicare was liable. **Medicaid Overpayments –** Funds are recovered from providers where Medicaid has overpaid for a service. Medicaid overpayments include: Duplicate Crossover Payments (two Medicaid payments for Medicare Crossover liability), Medicaid Secondary Liability (two Medicaid payments for the same services), Inpatient Duplicate Payments (two Medicaid payments for inpatient services for the same date(s) of service), Inpatient Mother-Baby Overpayments (two Medicaid payments for inpatient services for the same date(s) of service, one for a newborn and the other for his/her mother) and Outpatient Payment During Inpatient Stay (an outpatient Medicaid payment immediately preceding an inpatient stay).

MCM Provider Enrollment processes fingerprint cards for applicants to the program in compliance with Sec. 409.907 (8)(a), F.S. In October 2006, MCM Provider Enrollment, in conjunction with the Florida Department of Law Enforcement (FDLE), implemented a new automated system that scans fingerprint cards and submits them in an electronic file simultaneously to FDLE and the Federal Bureau of Investigation for processing. This replaces the old manual process wherein fingerprint cards had to be physically delivered to FDLE and results were not received for 10 to 14 days. Results from the FBI took several months to receive and if the FBI rejected the fingerprint card for any reason then a new card had to be obtained, thus delaying the process even more. Because of the delay in receiving the FBI results, Medicaid policy allowed for approval of applicants upon receipt of a clear FDLE screening. This created situations in which a provider could be paid Medicaid funds for months before MCM Provider Enrollment would be notified of criminal histories in other states that might lead to termination of the provider. Any funds paid to the provider during the period when they were active were subject to recoupment. The new automated scanning system is certified by the FBI as having been tested and found to comply with the FBI's Integrated Automated Fingerprint Identification System (IAFIS) Image Quality Specifications (IQS). With this new system, results are received from both FDLE and the FBI within 24 to 48 hours of submission of the scanned fingerprints. This quick response allows MCM Provider Enrollment to review all criminal history records before determining an applicant's eligibility to enter the program. The new process eliminates many pay-and-chase scenarios, because no applicant is approved for the program until both FDLE and the FBI reports are reviewed and it is determined that the applicant is eligible under Medicaid rules.

Bureau of Pharmacy Services

The Bureau of Pharmacy Services is responsible for managing the $1.2 billion drug program for Medicaid fee-for-service recipients. The Bureau has taken the lead in implementing the following initiatives to reduce the growth in drug expenditures.

Prescribing Pattern Review Panel

This group of physician and pharmacist practitioners appointed by the Governor, Senate President and Speaker of the House is charged with reviewing the prescribing practices of Medicaid providers. The Panel evaluates practitioner prescribing patterns based on national and regional practice guidelines and by comparing practitioners to their peer groups. In coordination with the Drug Utilization Review Board and the Department of Health, this advisory panel is responsible for evaluating treatment guidelines and recommending ways to incorporate their use in the practice pattern identification program. The Panel may recommend that practitioners who are prescribing inappropriately or inefficiently have their prescribing of certain drugs subject to prior authorization or recommend termination from participation in the Medicaid program.

Wireless Hand-held Portable Digital Assistant (PDA)

In 2002, the Legislature directed the Agency to seek a contractor to provide a wireless handheld drug information application for physicians to use at point of care. The device was envisioned to provide continuous updates of clinical pharmacology information, reference to the Medicaid Preferred Drug List (PDL), specific patient medication history, and ongoing education and

support. A major benefit of the program is that prescribers may readily detect "doctor shopping," multiple pharmacy use, and duplicative therapies, which has resulted in a reduction in one of the identified areas of waste, fraud and abuse by Medicaid recipients.

In November 2002, Gold Standard Multimedia gave secure, wireless access to its publication of Clinical Pharmacology by releasing the drug information industry's first "real time" drug information database, providing our online users with access to a live database that is updated contemporaneously with new developments in drug information.

In 2003, the Agency contracted with Gold Standard Multimedia (GSM) to provide a pilot group of 1,000 prescribers with a wireless handheld device that gave access to a comprehensive clinical drug database and a 90-day prescription history for patients and the Medicaid Preferred Drug List. The technology gave the prescriber a specific patient drug profile and access to clinical drug information at the point of care.

In FY 2004-05, the contract with Gold Standard was amended to provide for 3,000 total PDA units and full capacity was reached in early 2005. Further, e-prescribing capability was added for users, giving prescribers hand-held access to continuous updates of clinical pharmacology information, reference to the Medicaid PDL and specific patient medication history at the point of care through the eMPOWERx system. Users then had the ability to electronically submit prescriptions to the patient's pharmacy of choice. A budget reduction of $4 million was taken from base appropriation in anticipation of savings from use of the device by prescribers. Savings result in elimination of waste, fraud and abuse, and avoidance of the cost and risk of adverse drug interactions.

The secure transfer of electronic prescriptions and interface with GSM's eMPOWERx system offers several benefits, including:

Efficiency – checks for problems such as drug interactions, allergies, duplicate therapies and formulary conflicts without having to reference paper patient files and materials beforehand.

Safety – eliminates medication errors caused by misread handwritten prescriptions and by medications with similar names or likeness.

Prevention of Waste and Abuse – eliminates "doctor shopping" and duplicative therapies.

Security – reduces potential for fraud and abuse, such as forging, that may occur with paper prescriptions.

Over-prescribing and duplicate therapies have been eliminated and costs associated with hospitalization due to drug interactions have been avoided. PDA users are alerted to approximately 18,000 interactions of a high or very high severity ranking each quarter. PDA users wrote approximately 25 percent fewer prescriptions than non-users, and the total cost of the prescriptions they ordered was about 23 percent less than those for non-PDA users.

Pharmacy Lock-in Program

AHCA was given the authority to restrict certain recipients to a single pharmacy provider. At the end of FY 2006-07, 446 recipients were enrolled in this program. The federal waiver that approved the lock-in program states that a recipient may be restricted in this manner for one year. Despite this limitation, savings associated with the Lock-in Program total approximately $250,000 per quarter. Savings can be attributed not only to a reduction in the number of prescriptions for drugs with the potential for misuse or abuse, but also to significant reductions in the number of office visits and associated medical claims.

Office of the General Counsel

The Office of the General Counsel is a critical part of the Agency's efforts to combat fraud and abuse in the Florida Medicaid program. The General Counsel's Office has fifteen attorneys dedicated to providing legal guidance to the Division of Medicaid and to the Bureau of Medicaid Program Integrity. These attorneys are primarily responsible for litigating Medicaid-related cases before administrative tribunals and state and federal courts. During FY 2006-07, there were approximately 273 cases in litigation.

In addition, attorneys from the General Counsel's Office coordinate with the Florida Attorney General's Medicaid Fraud Control Unit and participate in the South Florida Health Care Fraud Work Group. Further, the General Counsel's Office has worked on several initiatives to contribute to the Agency's efforts to fight Medicaid fraud and abuse during the past year. The attorneys have also formed special teams for reviewing various Medicaid-related issues, including a review of the change of ownership process and the procedures for recouping the costs associated with the prosecution of Medicaid overpayment cases.

Division of Health Quality Assurance

More than 33,000 Florida health care services and facility providers of 35 different types fall under the regulatory jurisdiction of the Division of Health Quality Assurance. The Division surveys and licenses health care facilities and services such as home health care and oversees, licenses and surveys/monitors managed care plans in Florida. The Division is also responsible for certification surveys of health care facilities in coordination and cooperation with the Centers for Medicare & Medicaid Services (CMS) of the U. S. Department of Health & Human Services. Field office staff members are responsible for complaint investigations in both licensed and certified facilities. The Division is engaged in a number of activities that assist in combating fraud and abuse in the Medicaid program.

Fraud Referrals to the Office of the Attorney General (Medicaid Fraud Control Unit) and to the Bureau of Medicaid Program Integrity

During FY 2006-07, the Division of Health Quality Assurance made 35 referrals to Bureau of Medicaid Program Integrity and to the Office of the Attorney General. Those 35 referrals represented a broad spectrum of providers as shown below.

Type of Provider or Service	Number Referred
Assisted Living Facilities	9
Adult Day Care Centers	2
Home Health Agencies	8
Hospitals	1
Intermediate Care Facilities	1
Skilled Nursing Facilities	6
Rehabilitation Agencies	1
Home Medical Equipment Providers	2
Clinical Laboratories	1
Homemaker & Companion Services	2
Health Care Clinics	2
Total	**35**

Attacking Fraud and Abuse in Home Health

Since the elimination of Certificate of Need (CON) reviews in July 2000, the extraordinary increase in the number of licensed home health agencies in Miami-Dade County has attracted Agency interest and concern. This unusually rapid growth, coupled with current information about licensure application practices, and growing indicators of quality-of-care problems, has established home health agencies as an area of particular concern to the Agency.

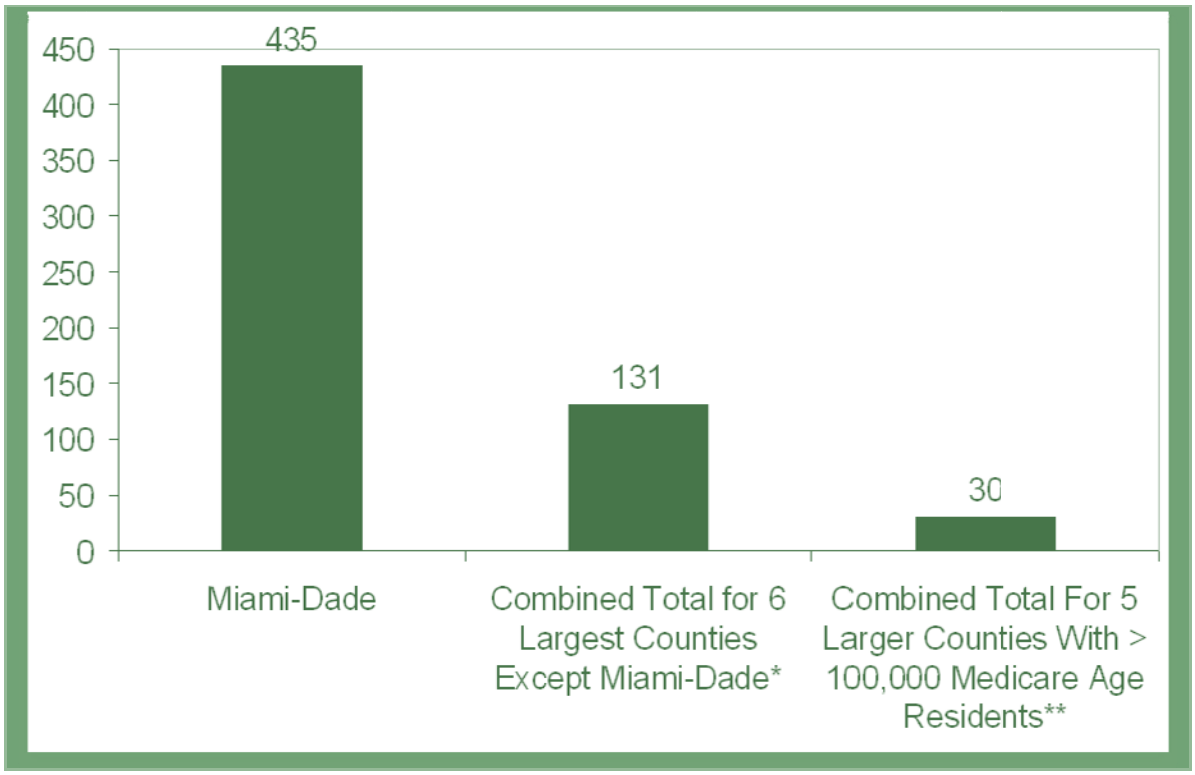
Prior to July 2000, new home health agencies seeking Medicare certification were required to receive a CON from the Agency in order to apply for a license to serve a single or multi-county area. CONs were not required for a home health agency to treat Medicaid, private insurance or privately paying patients. Florida's CON process is a complicated regulatory procedure that requires a high level of interest and commitment on the part of participating health care providers.

While CON has been criticized as a barrier to free market activity in the health care sector, the Agency is beginning to see signs that the lack of a barrier may be making it too easy for poorly qualified providers to deliver lower-quality home health services. There has been a substantial increase in the number of federal conditions of participation not met by Medicare certified home health agencies since the elimination of the CON requirement. Although there was an increase of 109 percent in the number of Medicare certified home health agencies from 2001 through 2006, the number of federal conditions of participation not met increased by 1,100 percent.

Of greatest concern is the use of a very small number of consultants to prepare inexperienced providers to deliver home health services, resulting in serious regulatory problems the first time the Agency surveys home health providers on an unannounced basis. The first unannounced survey may occur up to 36 months after initial licensure and certification.

No other county comes close to the growth of home health agencies in Miami-Dade and that growth cannot be justified by any per capita measure. In fact, between April 13, 2007 and August 21, 2007, an additional 73 home health agencies were added to the provider listing in Miami-Dade County.

GROWTH IN THE NUMBER OF LICENSED HOME HEALTH AGENCIES FOR SELECTED COUNTIES BETWEEN 1999 AND 2007



*** Broward, Palm Beach, Hillsborough, Pinellas, Orange, Duval**
**** Sarasota, Lee, Volusia, Brevard, Polk**
Source: AHCA Licensed Home Care Program Licensure Unit

The Agency's Bureau of Medicaid Program Integrity investigates suspected fraudulent activity at home health agencies. In the area of home health care, the Bureau's interest stems in part from the fact that while just over 13 percent of the state's population resides in Miami-Dade, approximately 85 percent of Medicaid home health payments are made to Miami-Dade home health agencies.

Medicaid Program Integrity investigators have found the following situations at home health agencies:

- The same home health aide was employed by several home health agencies.
- The same patients were served by more than one home health agency.

- Patient records were altered and changed. Twenty-four home health agencies were visited and 11 were terminated for this reason.
- Home health agencies were providing some housekeeping and companionship, but were billing for home health aide services.
- There are concerns of home health agencies not having any direct patients and serving as "staffing pools" for other home health agencies. Some of these agencies were eliminated from billing Medicaid but now are paid indirectly.
- There is concern about patient brokering and paying physicians for referrals.
- A physician told a Medicaid Program Integrity investigator that he writes what the home health agency tells him in the order for home health services. He refers lonely people who do not need skilled care--just company.
- At a recent visit by Agency staff and others, one building in the Doral area of Miami-Dade had more than 300 home health agencies and home medical equipment businesses located in very small offices. Many were not available during core hours of operation they posted on their door.

The Agency has developed and is proposing to begin solving these problems through legislative changes and cooperative "partnering" initiatives. Proposed legislative changes will:

- Limit the number of new licensure applications that can be processed per month
- Limit the number of agencies that a single administrator or director of nursing can work with
- Prohibit home health agencies from serving as staffing pools for other agencies
- Prohibit more than one home health agency in each location
- Increase fines and penalties
- Establish criminal penalties for fraudulent billing or referrals
- Link existing state and federal databases

In addition, the Division of Health Quality Assurance will work with appropriate professional boards to investigate the business practices of consultants, accountants and attorneys who have assisted applicants to apply for home health agency licenses in Miami-Dade County since 2000.

The Agency will work with its federal counterparts to evaluate the impact of the rapid growth in Medicare-certified home health agencies on quality of care, patient safety and appropriateness of billing.

Division of Administrative Services

Amounts identified as overpayments are generally referred to the Agency's Division of Administrative Services, Bureau of Finance and Accounting, for collections. Once an overpayment has been determined, the federal share is returned within 60 days. The state then pursues collection of the receivables from the Medicaid provider. The Bureau of Finance and Accounting collects accounts as either direct payments from providers or through withholding of Medicaid or Medicare payments. The Bureau investigates problem cases to pursue collection or provide the necessary information to an outside collection agency. Agency staff continues to work aggressively to reduce outstanding receivables within the Medicaid program.

During FY 2006-07, accounts receivable collections, net of adjustments and refunds approached $28.7 million.

For all receivables determined uncollectible, AHCA must obtain approval from the Department of Financial Services for write-off. Accounts are generally written off because the provider has declared bankruptcy, is a corporation out of business, is unable to pay because of incarceration, is otherwise insolvent, or is beyond the State's current collection enforcement policy. Once the receivable is approved for write-off, and written off, if deemed qualified, the federal share of each receivable write-off is reclaimed. During FY 2006-07, $11.6 million in receivables were approved for write-offs during the federal fiscal year. The federal requirements only allow funding to be reclaimed when the write off is due to a bankruptcy in which the Agency filed a claim (even if the bankruptcy had already been discharged at the time the Agency discovers the bankruptcy), for an individual who is deceased and the Agency files a claim on the estate, or when the write off is due to a business that is certified as being out of business (a very detailed and in-depth process). The Agency's Office of Inspector General is currently developing processes whereby the Agency can certify that a provider is out of business and thereby reclaim the federal share. These accomplishments in dealing with Medicaid accounts receivable resulted from a number of actions taken by the Bureau of Finance and Accounting during the year.

It should be noted that even after write-off, monies are received from providers. In FY 2006-07, the Division of Administrative Services received $1.5 million in funds previously written off.

The Bureau of Finance and Accounting continued to refine the Medicaid Accounts Receivable, or MAR system, that records extensive financial detail on Medicaid accounts receivable. The MAR system tracks each case as it moves through the receivables process, emphasizing which department, bureau or unit has current responsibility for a case. The Bureau calculates interest for cases as appropriate, while the system tracks state/federal allocation of receivables activity, and produces necessary reports for case management and audit purposes. Examples of reports include case financial summaries, case financial histories, case aging, summary by status and department, "tickler file" and reports for staff follow-up. The MAR system maintains the required accounting data for financial statement and federal reporting purposes for fraud and abuse cases as well as other overpayment cases, such as hospital and nursing home retroactive rate adjustments.

The Bureau continues to provide transaction records for AHCA's Fraud and Abuse Case Tracking System (FACTS). These records include the original overpayment amount, payments received, adjustments applied, current balance, and current status for each case in the MAR system. This file is created by an automated process that runs from the MAR system each night, and then updates FACTS, allowing it to reflect the latest financial and account status information.

The Bureau has also worked with AHCA's Office of General Counsel and Office of Inspector General to coordinate efforts and pursue additional avenues of collection. The Bureau has taken aggressive steps during the year to reduce the length of negotiated payment plans, as well as increasing lien percentages on provider Medicaid/ Medicare payments and will continue to strive to achieve repayments as promptly as possible.

Statutory Reporting Requirements

Sources of the cases opened in FY 2006-07

Source		AHCA	MFCU
AHCA	Area/District Office Staff	8	3
	Medicaid Headquarters Staff	6	
	MPI Generated	1,337	86
	Other	4	
Public	Anonymous		37
	Citizens	31	8
	Provider		3
	Qui Tam[1]		40
	Recipient		9
State Agencies	Department of Children & Families		210
	Department of Health		1
	Florida Dept. of Law Enforcement		1
	Other State Agencies	3	14
Federal Agencies	Health & Human Services	15	
	Other	1	
Law Enforcement	Florida MFCU Generated	1	68
	U. S. Attorney's Office		1
	Department of Justice		2
	Local Law Enforcement		6
Other:	MFCU (Other than Florida)		1
	Family Member		12
	HMO Investigative Unit		2
Employee			17
Long Term Care Ombudsman Council			3
	Total	1,406	524

[1] The False Claims Act allows an individual, often referred to as a whistleblower or a relator, who knows about a person or entity that is submitting false claims to sue, on behalf of the government, and to share in the damages recovered as a result of the suit.

Number of cases opened and investigated each year

MFCU investigated 1,478 cases, which included 524 opened during the year. MPI investigated 1,860 cases, which included 1,406 opened during the year.

Disposition of the cases closed

MFCU and MPI closed 1,638 investigations. (MFCU closed 620; MPI closed 1,018.) The cases closed are summarized below:

	MFCU	MPI
Administrative Referral	65	
Assistance to Other Agencies	9	
Case Dismissed	14	
Civil Intervention Declined	3	
Civil Judgment	2	
Civil Settlement	16	
Consolidated	49	
Conviction	32	
Defendant Deceased	3	
Defendant Filed Bankruptcy	1	
Lack of Evidence	165	
Nolle Prosequi	3	
No Fraud or Abuse Found		177
Not a Medicaid Provider	6	
Overpayment Identified		811
Plea Agreement	1	
Pretrial Intervention	4	
Prosecution Declined	7	
Provider Education Letter		30
Resolved with Intervention	5	
Statute of Limitations Expired	2	
Unfounded	233	
TOTAL	**620**	**1018**[1]

[1] For the 1,018 MPI cases closed during FY 2006-07: 177 closed after no findings of fraud and abuse and therefore no further action was taken. 30 of the cases closed after minor findings of non-compliance, but no resulting overpayments; therefore, the provider was issued a provider education letter. 811 cases closed following the identification of an overpayment. The provider may have repaid the overpayment amount, resulting in case closure; the provider may have requested an administrative hearing, which was resolved by an administrative hearing or a settlement agreement, both of which would close following a final order; or the case may have closed following issuance of a default final order when a provider neither paid the amount due nor requested an administrative hearing. Collection activities are initiated for amounts overpaid.

Amount of overpayments alleged in preliminary and final audit letters

Typically, MPI sends a report explaining the preliminary overpayment identified and giving the provider an opportunity to provide additional documentation. After review of any additional documentation submitted, MPI sends a final report, which reflects the overpayments identified and offers the provider hearing rights under Chapter 120, Florida Statutes. For the 1,018 cases closed during the fiscal year, 903 preliminary audit reports were sent totaling $41,612,084. A total of 380 cases totaling $5,418,766 were closed after the preliminary report. Based on a review of additional documentation, final audit reports totaling $20,114,948 were sent for the remaining 523 cases.

Amount of final agency determination of overpayments

A total of 202 cases totaling $1,961,028 were closed after the final audit report. Final orders issued on the remaining 321 cases totaled $12,593,599. The reductions were based on the results of hearings or on additional documentation provided during the hearing process.

Number and amount of fines or penalties imposed

MPI has several tools available to address provider fraud and abuse. Suspected fraud is referred to MFCU for investigation of possible civil and/or criminal violations. During the fiscal year, MPI placed 217 providers under prepayment review, recommended termination of 194 providers and referred to MFCU 212 providers for investigation and an additional 43 providers for informational purposes. The Agency also fined 222 providers more than $373,000.

Reductions in overpayment amounts negotiated in settlements or by other means

There were no negotiated settlements during FY 2006-07.

Amount deducted from federal claiming as a result of overpayments

Within 60 days of MPI's final order, the Agency reports the entire federal portion of the total overpayment to the federal government. These overpayment amounts are included on the corresponding federal CMS-64 quarterly reports. During FY 2006-07, AHCA reduced its federal claiming by $22.7 million for net overpayments determined.

Amount of overpayments recovered

During FY 2006-07, MFCU recovered $70.1 million.

During FY 2006-07, the Agency collected $27.5 million in overpayments. This includes $8.7 million collected from MFCU cases and $18.8 million collected from MPI cases. (In addition, the Agency collected $25.2 million in claims adjustments and $0.3 million in paid claims reversals.)

Amount of investigation costs recovered

During FY 2006-07, the Agency recovered $113,917 in investigation costs. MFCU collected $223,024 in investigative costs.

Average length of time to collect from the time the case was opened until the overpayment is paid in full

For all cases paid in full during the fiscal year, the average length of time from the case opened date to the date the case was paid in full was 328 days.

Amount determined as uncollectible and the portion of the uncollectible amount subsequently reclaimed from the federal government

During State FY 2006-07, the Department of Financial Services deemed $11.6 million uncollectible and approved for write-off. Almost $1.5 million was collected after the cases were written off. No amounts were reclaimed from the federal government.

Number of providers, by type, that are terminated from participation in the Medicaid program as a result of fraud and abuse

Provider Type	Total
PHYSICIAN (MD)	55
H & C BASED SERVICES	47
MEDICAL SUPPLIES/DURABLE MED	35
PHARMACY	11
HOME HEALTH AGENCY	11
THERAPIST	9
ASSISTIVE CARE SERVICES	7
PHYSICIAN (DO)	5
CHIROPRACTOR	4
TAPE INTERMEDIARY	2
DENTIST	2
ADVANCE NURSE PRACTITIONER	2
SOCIAL WORKER/CASE MANAGER	1
MENTAL HEALTH PRACTITIONER	1
INDEPENDENT LABORATORY	1
AUDIOLOGIST/SPEECH PATHOLOGIST	1
Total	**194**

All costs associated with discovering and prosecuting cases of Medicaid overpayments and making recoveries in such cases

Expenditures for MPI in FY 2006-07 were $7,292,885, which includes salaries, expenses, and contractual services. In addition, costs of $2,663,950 were allocated for support from the General Counsel's Office, Office of Inspector General, Bureau of Finance and Accounting, and Medicaid Contract Management. This included an allocation for Agency indirect costs of $1,247,745. In addition, however, Medicaid incurred expenses for services related to MPI activities for $1,673,715. Therefore, total costs of $11,630,550 were associated with MPI operations.

MFCU's expenditures for FY 2006-07 were $17,733,866.32.

Number of providers prevented from enrolling/re-enrolling in the Medicaid Program

As has been reported in previous annual reports, the precise number of providers prevented from enrolling/re-enrolling in the Medicaid program is not obtainable due to the limitations (denial 'reason description' codes are limited) set forth in the Agency's current Medicaid Management Information System (MMIS). Medicaid Contract Management (MCM) does expect to be able to produce these numbers with the new MMIS that is scheduled to be up and running in 2008, by creating additional denial reason codes.

Until that new system is in place, however, there is some information that has been obtained manually and will be reported here. All provider applications received by the Agency or its designee, ACS State Healthcare, Inc., follow the same procedures, whether the application is received for the first time, or amended and submitted numerous times. Fingerprint cards are sent to the Florida Department of Law Enforcement (FDLE) and to the Federal Bureau of Investigation (FBI) where a background check is performed. In FY 2006-07, 59 applications were denied based on the results of the background check. The provider application is also checked against the National Medicare Exclusion list. Those on the Medicare Exclusion list are denied enrollment into the Florida Medicaid program. Any active Florida Medicaid providers added to the Exclusion list are terminated immediately. Fifteen applications received in FY 2006-07 were denied because of previous exclusions and four terminated provider files were flagged as excluded to prevent the possibility of the terminated provider attempting to re-enter the program.

Providers may also be denied enrollment based on site visits. The basis for these denials includes technical violations of provider requirements, which may include suspected fraud and/or abuse. During FY 2006-07, 749 applications were denied due to failed site visits. There could be multiple reasons for these denials. Additionally, a provider may have voluntarily terminated their provider number, or have been terminated for a non-fraud related reason (e.g., licensure action), and the Agency may have information about the provider regarding fraud or abuse. If the provider applies for re-enrollment later, the fraud or abuse information is available for consideration during the enrollment process. During FY 2006-07, 15 applications were denied for applicants when the Agency had information pertaining to prior fraud or abuse activity.

These numbers could have included the same applicants applying multiple times for enrollment during the year.

Recommendations for Changes to Prevent and/or Recover Overpayments

At the request of the Agency Secretary, and with the cooperation and support of the Chief of Staff, the Office of the Inspector General worked with over 200 employees of the Agency to create a comprehensive strategic plan to combat fraud and abuse. Staff from OIG met with groups from Medicaid, Managed Care, Medicaid Program Integrity, Human Resources and Finance and Accounting in order to compile input from all entities that are charged with administering the Florida Medicaid program. All these departments have specific and unique roles in managing parts of the program, and therefore, have specific and unique challenges associated with their enforcement and implementation.

The OIG staff then met with outside agencies, which collaborate with AHCA in our charge of managing more than 80,000 health care providers and more than 2.2 million recipients. They met with representatives from the Department of Health, who license pharmacies and other providers; MFCU, who also work independently to detect, investigate and prosecute fraud in the Medicaid program; the FBI, the DEA and FDLE who all work independently on fraud and abuse cases of providers and recipients. Together, an agency-wide strategic plan was created. In July 2007, Secretary Agwunobi approved the strategic plan, and the Agency is moving forward with its implementation. The creation of the plan was done in FY 2006-07, but the implementation will be reported in the FY 2007-08 report. This is a fluid plan and may be viewed on the AHCA intranet at http://ahcaweb/inspectorgeneral/docs/Strategic_Plan_Final.pdf or by requesting a copy from the AHCA IG office, 850.921.4897.

Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, Florida 32308
1-888-419-3456
www.FloridaHealthStat.com
HTTP://AHCA.MyFlorida.com

Office of the Attorney General
The Capitol PL-01
Tallahassee, FL 32399
850-414-3300
www.myfloridalegal.com