Annual Report on
The State's Efforts to Control Medicaid Fraud and Abuse
FY 2007 - 08

Submitted by:
The Agency for Health Care Administration
and
Medicaid Fraud Control Unit (MFCU)
Department of Legal Affairs

December 2008

ATTORNEY GENERAL
STATE OF FLORIDA

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

December 29, 2008

The Honorable Charlie Crist
Governor
PL-05 The Capitol
Tallahassee, FL 32399-0001

Dear Governor Crist:

Pursuant to Section 409.913, Florida Statutes, enclosed is the annual report of the activities related to the fight against fraud and abuse in the Medicaid program for the 2007-2008 fiscal year. This report has been prepared jointly by staff of the Agency for Health Care Administration and the Medicaid Fraud Control Unit within the Office of the Attorney General.

Sincerely,

Bill McCollum
Attorney General

Sincerely,

Holly Benson
Secretary

BM/HB/cls
cc: The Honorable Ed Homan
The Honorable Jimmy Patronis
The Honorable Gary Aubuchon
The Honorable Kevin Ambler
The Honorable Carl J. Domino
The Honorable Tom Anderson
The Honorable Jeff Atwater
The Honorable Durell Peaden, Jr.
The Honorable Ken Pruitt
The Honorable Don Gaetz
The Honorable Burt Saunders

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COORDINATION AND COOPERATION BETWEEN AHCA AND MFCU

The Agency for Health Care Administration (Agency) and the Medicaid Fraud Control Unit (MFCU) have continued their joint efforts on investigative projects, Medicaid program issues, enhancement of processes and development of protocols for improved coordination. Members of both the Agency and MFCU, as well as the Department of Health (DOH), meet regularly to discuss major issues, strategies, joint projects and other matters of interest.

The Agency and MFCU also continue to refine the process by which fraud referrals are made to MFCU. For the third consecutive year, approximately 200 referrals were made to MFCU.

Senior managers of the Office of the Inspector General, the Division of Medicaid, MFCU and DOH provide regular briefings to the Secretary of the Agency regarding collaborative efforts. Medicaid Program Integrity (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 is no duplication of effort and that suspected overpayments 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 prospective MPI investigations.

MFCU coordinated the Elder Abuse Summit for Orange County that was attended by MPI field staff members. MPI made a brief presentation on respective roles and responsibilities. A contact list was compiled and subsequently a referral was made to MPI concerning alleged nursing home abuse.

The Agency and MFCU meet each month to discuss managed care issues. To strengthen fraud and abuse initiatives, the Agency and MFCU staff collaborate on managed care contract language, marketing schemes involving fraud and abuse and referrals to MFCU from managed care organizations.

MEDICAID FRAUD CONTROL UNIT

BACKGROUND AND PERSPECTIVE

In FY 2006-07[1], the Medicaid program provided services nationwide for 50.3 million recipients living in the United States and Puerto Rico with payments totaling $324.3 billion. Coupled with the costs of Medicare, 34 cents of every dollar spent by the United States government was directly related to health care. While 48 percent of Medicaid recipients are children, they only account for 18 percent of the Medicaid provider billings. The majority of billings, 65 percent, are for the elderly and disabled adults who make up 29 percent of the Medicaid population. The projected annual growth for government-sponsored health care costs is seven percent, but Florida's population of the elderly, disabled and lower income individuals is likely to reach double-digit growth in the foreseeable future.

In FY 2007-08, Florida's Medicaid program appropriated $16.2 billion to provide health care benefits to some of the state's most needy citizens. Florida's program is among the largest in the country, serving approximately 2.1 million people each month. In a February 2008 report from the Office of Program Policy Analysis and Government Accountability, estimates of fraud, waste and abuse in Florida's Medicaid program ranged from five percent to 20 percent. Just taking the average of these estimates, which is 12.5 percent, fraud, waste and abuse could amount to as much as $2 billion each year.

The Office of the Attorney General, through its Medicaid Fraud Control Unit (MFCU), has two primary areas of enforcement responsibility – fraud perpetrated against the Medicaid program by service providers, and abuse, neglect and exploitation of patients residing in a Medicaid-funded facility. Enforcement in these areas, which includes both criminal and civil actions, is designed to prevent, detect and prosecute these types of misconduct in order to protect the integrity of the Medicaid program as well as the health and safety of Florida citizens.

The economic impact of health care fraud and patient abuse, although enormous, is not the only harm done to Florida's citizens. Health care fraud is not a victimless crime. As noted in case illustrations described later in this report, the people who depend on Medicaid, including their friends and their families, are the ones who suffer the most as a result of fraud and abuse or neglect.

The Attorney General's Office and the men and women who work in MFCU are responsible for protecting Florida's most vulnerable citizens physically, emotionally and financially. They are also responsible for protecting the health care funds that are earmarked for their care. While the scope of this challenge is daunting, the Attorney General's Office and its partner agencies, especially the Agency for Health Care Administration (AHCA), have met this challenge.

[1] The fiscal year for the State of Florida runs July 1 – June 30.

OVERVIEW OF THE MEDICAID FRAUD CONTROL UNIT

There are 232 full-time employees (FTEs) assigned to MFCU, although the unit averages a 10 percent vacancy rate throughout the fiscal year. One hundred thirty-nine positions are investigators and their supervisors/managers, 26 are attorneys, and the remaining are professional support positions such as auditors, analysts and administrative staff. For most operational purposes, the organizational structure of the unit is divided into three regions: North, Central and South. The North region has 46 assigned FTEs and has offices in Jacksonville (13 FTEs), Tallahassee (24 FTEs) and Pensacola (nine FTEs). The Central region has 47 assigned FTEs and has offices in Orlando (14 FTEs), Tampa (25 FTEs), St. Petersburg (two FTEs) and Ft. Myers (six FTEs). The South region has 93 assigned FTEs and has offices in Miami (55 FTEs), Ft. Lauderdale (22 FTEs) and West Palm Beach (16 FTEs). Additionally, there are three other entities within MFCU, the Director's office (12 FTEs), Statewide Operations (18 FTEs) and the new Complex Civil Enforcement Bureau (16 FTEs).

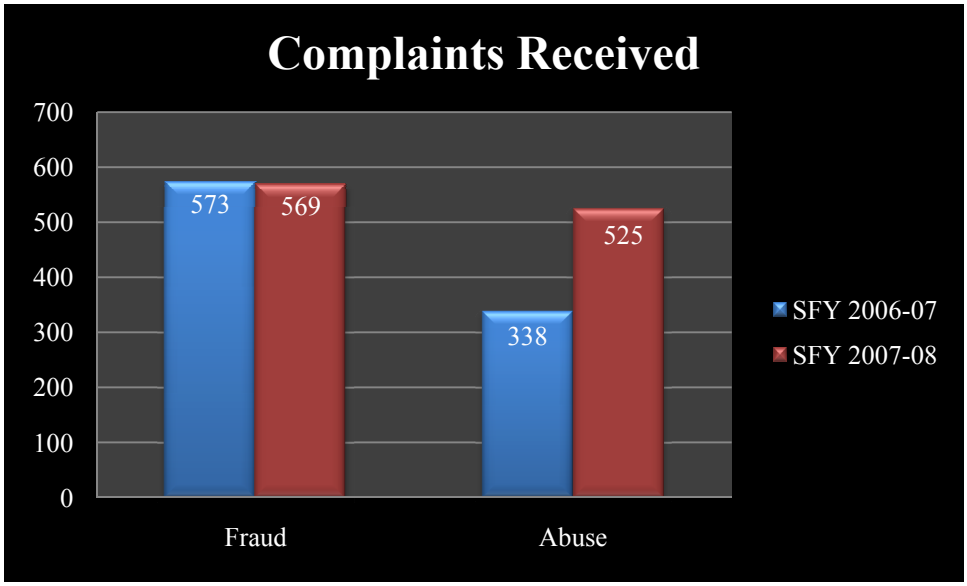
The primary investigative focus of MFCU is Medicaid Fraud and Patient Abuse, Neglect and Exploitation (PANE) cases. Each office has separate squads/investigators assigned to handle either fraud investigations or PANE cases. The attorneys assigned to the unit provide legal advice to the investigative staff on both types of cases. Prosecution has traditionally been handled by the local State Attorney's Office (SAO) or the Office of Statewide Prosecution. However, recent efforts to obtain cross-designation of MFCU attorneys by SAO and United States Attorney's Offices have been successful, thus enabling MFCU attorneys to prosecute cases generated by the unit.

COMPLAINTS

Complaints serve as the basis for most investigations opened by the unit. In FY 2006-07 the unit received a total of 911 complaints. For FY 2007-08, the unit received a total of 1,094 complaints. Of the 911 complaints received in FY 2006-07, 568 were opened as operational cases. Of the 1,094 complaints received FY 2007-08, 377 were opened as operational cases. This decline resulted from an MFCU policy change regarding thresholds for opening an investigation. Prior unit policy called for the opening of an operational case, whenever possible, based upon the mere receipt of a complaint. There was little, if any, review to determine the validity or viability of a complaint or an allegation. Unlike the complaint review process, the case opening and case closing process was identified as a cumbersome process, particularly when no sufficient predicate was established that the complaint or allegation had merit. The unit's policy has been changed to require a 30-day review of complaints and allegations to determine whether the matter had merit, could be referred or was unfounded. Case openings will now occur only when there is a criminal or civil predicate that warrants further investigative activities. As a result, complaints are being screened more quickly and complaints and/or allegations that are more viable lead to the opening of a full investigation.

Of the 911 complaints received in FY 2006-07, 573 were related to fraud and 338 were related to PANE allegations. For FY 2007-08, of the 1,094 complaints received, 569 were related to fraud and 525 were related to PANE. In FY 2006-07, the primary source of Medicaid fraud complaints was citizens. Two hundred sixty complaints received were made by private citizens.

AHCA was the next-highest source of fraud complaints with 192 of the total Medicaid fraud complaints received in FY 2006-07. Other sources of Medicaid fraud complaints included Qui Tam cases, also known as whistleblower claims, and cases generated by MFCU. Qui Tam cases are cases filed under the Florida False Claims Act, which allows MFCU to sue on behalf of the State of Florida when individuals or companies defraud the state Medicaid program.



The primary source of fraud complaints in FY 2007-08 was nearly equal between citizens and AHCA. AHCA, via its Medicaid Program Integrity (MPI) unit, accounted for 183 of the Medicaid fraud complaints received. One hundred and fifty-five fraud complaints came from citizens. The number of Qui Tam complaints increased to 50 from the previous year's total of 31.

Regarding PANE complaints and allegations, one of the responsibilities of the unit is to review the Department of Children & Families (DCF) Hotline reports for possible patient abuse incidents. In FY 2007-08, the supervisors and investigators assigned to the PANE squads reviewed 13,735 such reports. Although the vast majority of these reviews do not lead to open investigations, 120 were referred to the appropriate state agency such as AHCA or the Department of Health for handling. Others were opened as complaints by MFCU and led to formal investigations.

The overwhelming majority of PANE complaints are generated by DCF. In FY 2006-07, of the 338 PANE complaints, 238 came from DCF. The next-highest source of PANE complaints was citizens, who accounted for 47. Likewise in FY 2007-08, of the 525 PANE complaints, 453 came from DCF. Citizen complaints accounted for 26 complaints.

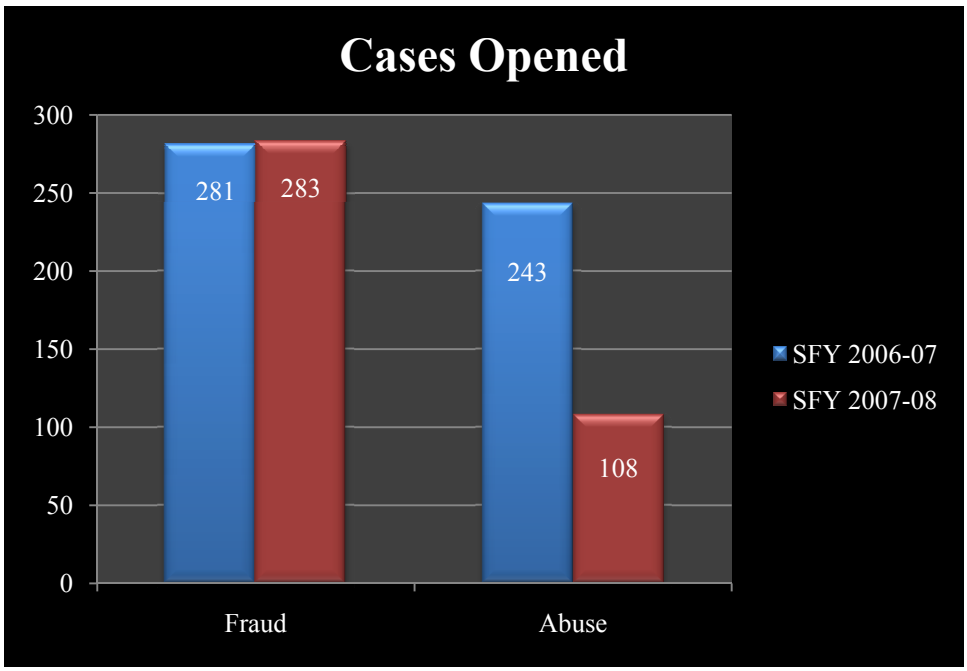
CASE INVESTIGATIONS

Complaints are reviewed to determine issues such as MFCU jurisdiction, administrative referral, referral to another agency or viability of the complaint. The opening of a case indicates that a criminal investigation or civil case has been opened and significant investigative resources and time will be expended to identify those involved in possible criminal misconduct, determine the

scope of the criminal activity and establish sufficient evidence to prove the requisite criminal elements. Most of the decision-making regarding opening or closing criminal investigations is made at the regional level. Presently, there are mandatory monthly case reviews during which the Regional Chief and Captain review the cases assigned to a specific office. Monthly summary reports of these case reviews are then submitted to the Director's Office for review. Interaction on case investigations is also conducted by supervisors, primarily Lieutenants, on a case-by-case basis.

In FY 2006-07, MFCU opened 524 total cases. Of those cases, 281 cases were related to Medicaid fraud. The remaining 243 cases were PANE cases. The North Region opened a total of 132 cases. Of those cases, 75 were related to Medicaid fraud and 57 were PANE cases. The Central Region opened a total of 97 cases, of which 56 were related to Medicaid fraud. The remaining 41 case openings were PANE cases. In the South Region, there were a total of 261 cases opened in FY 2006-07. One hundred and sixteen of the case openings were related to Medicaid fraud and the remaining 145 were PANE cases.

In FY 2007-08, MFCU opened a total of 391 total cases. This is a reduction in the number of operational cases opened. The primary explanation for this reduction is the use of the complaint review process to screen out cases that can otherwise be referred, are not viable or do not warrant a full criminal investigation. The basis for this conclusion is attributed to the fact that the number of complaints (911 in FY 2006-07 and 1,094 for FY 2007-08) remains essentially the same. In FY 2007-08, the North Region opened a total of 128 cases. Of those cases, 80 were related to Medicaid fraud. The remaining 48 case openings were PANE cases. In the Central Region, there were a total of 144 cases opened. Of these, 114 were related to Medicaid fraud. The remaining 30 were PANE cases. In the South Region, there were a total of 109 cases opened. Of these, 79 were related to Medicaid fraud and the remaining 109 cases were PANE cases.



The following is a list of the top five Medicaid provider types for the last two fiscal years, ranked most to least frequent:

FY 2006-07	FY 2007-08
Nursing Home	Home & Community-Based Care
Home & Community-Based Care	Pharmaceutical
Physician	Nursing Home
Assistive Care	Therapist
Medical Supplies/DME	Physician

For both years, nursing homes were the predominant provider type for PANE case investigations, while physicians and home health care/home & community-based care were the predominant types for Medicaid fraud case openings.

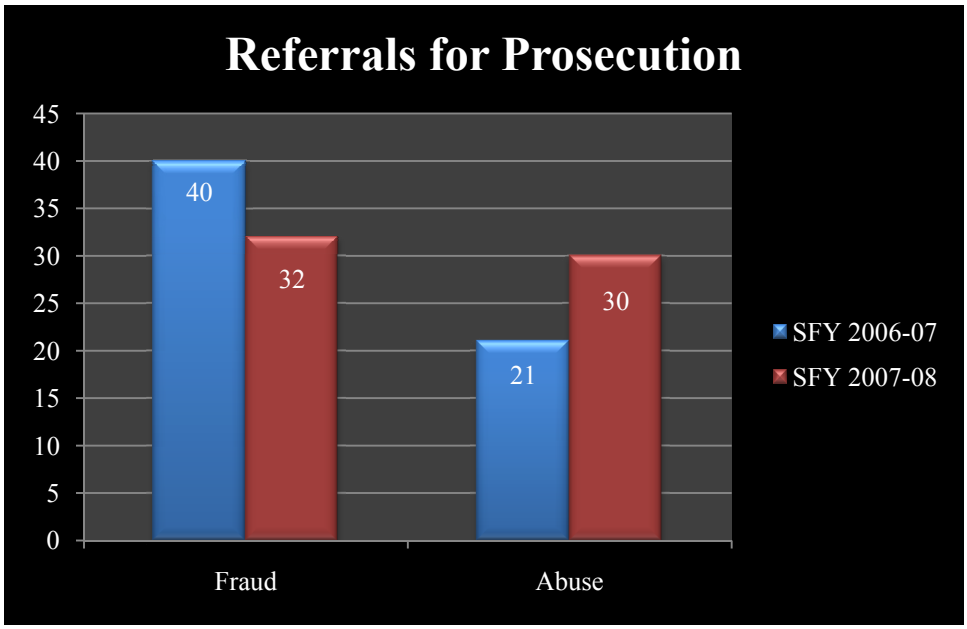
DISPOSITION OF CASES

Following an investigation, a determination is made on whether to pursue criminal prosecution or file civil actions. All case investigations will eventually be formally closed as a result of either a successful prosecution or lack of evidence. There are several classifications presently used that track the ultimate disposition of closed cases. It is important to note that cases closed during a particular year have no relationship to cases opened during the same year. In almost all Medicaid fraud case investigations, PANE investigations and Qui Tam actions, the time from initial review to case closing will be more than one year, whether the case is pursued civilly or criminally.

In FY 2006-07, MFCU closed 620 cases. Of those, 333 involved Medicaid fraud investigations and 287 involved PANE cases. In FY 2007-08, MFCU closed 464 cases. Of those, 289 involved Medicaid fraud investigations and 175 involved PANE cases.

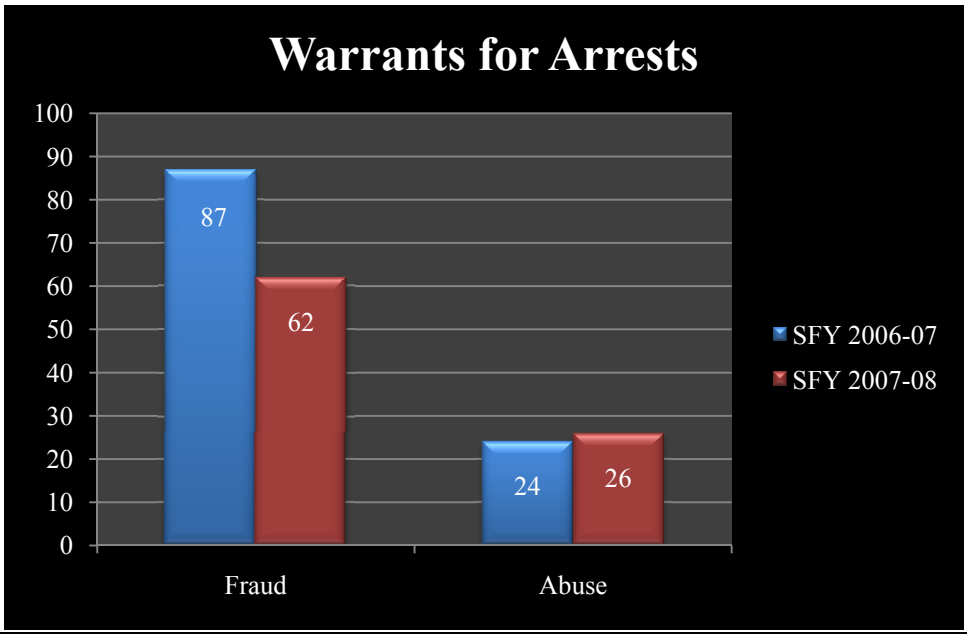
Enforcement actions are a paramount consideration for MFCU. At the conclusion of any investigation, referrals for prosecutions, execution of arrest warrants and monetary recoveries are indicators of successful case outcomes. In FY 2006-07, 61 cases were referred for prosecution. Forty of these cases were based upon Medicaid fraud investigations and the other 21 were based upon PANE investigations. The South Region accounted for 25 of these referrals for prosecution, the North Region accounted for 28 prosecution referrals and the Central Region accounted for eight prosecution referrals.

For FY 2007-08, 62 cases were referred for prosecution. Thirty-two of these cases were based upon Medicaid fraud investigations and the other 30 were based upon PANE investigations. The North Region accounted for 24 of these referrals for prosecution, the Central Region accounted for 23 prosecution referrals and the South Region accounted for 15 prosecution referrals.



In FY 2006-07, there were 111 arrests/warrants made based upon MFCU criminal investigations. Eighty-seven of these arrests/warrants were related to Medicaid fraud investigations and 24 were for PANE investigations. The South Region accounted for 60 of these arrests/warrants, which were predominantly for Medicaid fraud. The Central Region accounted for 16 arrests/warrants and the North Region accounted for 35 arrests/warrants.

For FY 2007-08, there were 88 arrests/warrants made. Sixty-two of these were Medicaid fraud investigations and 26 were for PANE investigations. The South Region accounted for 42 of the arrests/warrants made. The North Region accounted for 26 arrests/warrants and the Central Region accounted for 20 arrests/warrants.



INVESTIGATIVE STRATEGY

As mentioned earlier in this report, MFCU has two primary areas of enforcement responsibility: fraud perpetrated against the Medicaid program and Patient Abuse, Neglect and Exploitation (PANE). Enforcement in these areas, which includes both criminal and civil enforcement actions, should help prevent, detect, prosecute and deter these types of misconduct in order to protect the citizens of Florida. Case management, including case openings, investigative activities, legal review/prosecution, prioritization, utilization of investigative/legal resources and other related issues were handled on a case-by-case or office-by-office basis.

During the early part of FY 2007-08, a working group of MFCU members, including attorneys, investigators, professional support staff, supervisors and managers identified several focus areas and presented recommendations to the Director's Office. Additionally, numerous discussions were held with MFCU's senior leadership team to identify ways to better utilize existing resources to enhance MFCU's enforcement efforts. As a result of this meeting and subsequent discussions, MFCU released a formal investigative strategy that required unit members to focus on the following:

- Medicaid Provider Fraud – Case investigations will focus on types of fraud, types of subjects/targets and types of providers having a widespread impact on the Medicaid program or involving public safety. Emphasis will be placed on case investigations/prosecutions that have a deterrent effect.
- PANE investigations – Focus will be placed on activities/investigations that involve prevention and timely criminal enforcement. Emphasis will be placed on facilities/incidents with immediate public safety and those which have widespread impact regarding possible victims.
- Civil Recoveries – Regardless of whether an investigation is criminal or civil in nature, emphasis will be placed upon the recovery of the State's monetary losses caused by fraud through use of Florida's Contraband Forfeiture Act, Florida's False Claims Act and any other available legal remedies. The Complex Civil Enforcement Bureau (CCEB) will be proactive in Florida regarding Qui Tam litigation.
- Community Outreach – Training and education programs will be provided to citizen groups, provider groups and law enforcement groups. The purpose of such outreach will be to encourage referrals/reports of Medicaid fraud, supplement MFCU's enforcement efforts through use of local law enforcement, educate citizens on how to avoid becoming victims and create partnerships with citizens and the medical community or other provider groups to assist antifraud efforts.
- Intelligence – Emphasis will be placed on developing and fostering key partnerships with agencies such as AHCA, the Florida Department of Health (DOH), the Agency for Persons with Disabilities (APD), state and federal prosecutors and the criminal justice community in order to better share data. Use of information technology resources to obtain, share and disseminate data to assist in the detection, investigation and ultimately the deterrence of Medicaid fraud will be promoted.

BUDGET

MFCU's budget is a hybrid of federal grant dollars from Federal Financial Participation (FFP) which accounts for 75 percent of its total budget. According to the requirements of the federal statutes and regulations concerning the FFP, the remaining 25 percent must come from the State of Florida's general revenue fund. In FY 2007-08, MFCU budget was as follows:

Federal Financial Participation	$13,634,255
Florida General Revenue	$ 4,726,614
TOTAL	$18,360,869

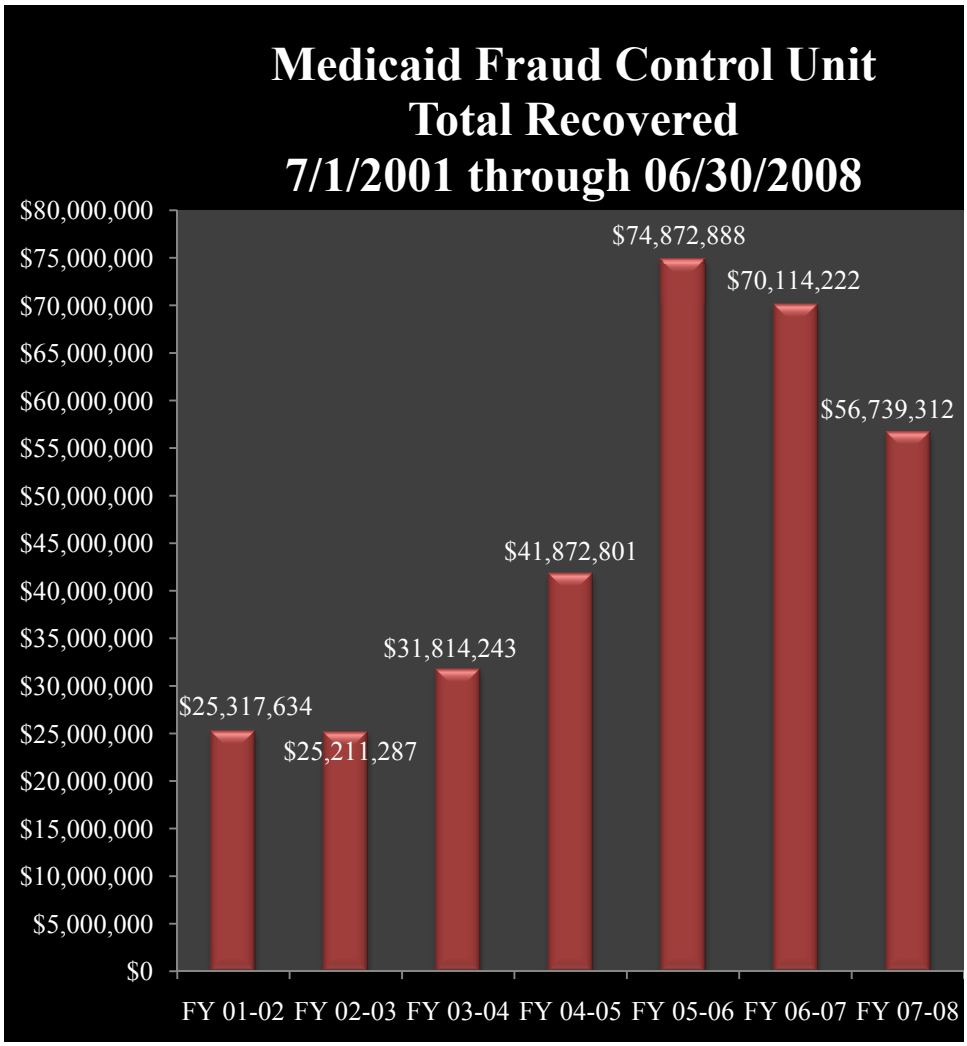
Based upon the request and justification for additional resources to combat Medicaid fraud and patient abuse or exploitation in Florida, the Department of Health and Human Services increased Florida's FFP by nearly $2 million.

However, due to the critical general revenue shortfall in FY 2007-08, the State of Florida was not able to provide the $250,000 needed for the state's 25 percent match. This resulted in a loss of $750,000 in federal funds to the State of Florida.

Due to the current four percent hold back in the state's FY 2007-08 general revenue appropriation and the anticipated additional general revenue reduction, MFCU's general revenue budget reduction will be approximately $418,670, which will result in an additional loss of $1.2 million in federal funds to the State of Florida.

CIVIL RECOVERIES

The loss of funding for MFCU comes, ironically, at a time when the unit has improved efficiency and brought in several million dollars in recoveries to the state's General Revenue fund. MFCU is responsible for enforcement of criminal case dispositions, which may include restitution, fines, investigative costs and forfeitures. Qui Tam cases, which were previously handled by several field offices, particularly Tallahassee and Tampa, are now being handled centrally by the Complex Civil Enforcement Bureau (CCEB). The CCEB is assigned 16 FTEs including a bureau chief, attorneys, paralegals, analysts, investigators and support staff.



In FY 2007-08, the amount for civil recoveries, which include civil settlements arising from Qui Tam cases brought under Florida's False Claims Act, was $51,120,765.

In FY 2007-08, the amount for criminal recoveries based upon Medicaid fraud cases was $5,601,932.

The total amount of the monies recovered by MFCU was $56,722,698. It should be noted that during this fiscal year MFCU's recoveries added $5,684,855 to the State of Florida's General Revenue Fund.

COMMUNITY OUTREACH

As noted above, one of MFCU's focus areas is community outreach. In March 2008, Attorney General McCollum announced a new community outreach initiative during a presentation at Aventura Hospital in South Florida. This initiative is an effort by the Attorney General's Office to prevent and identify fraud and/or patient abuse occurring in Medicaid provider facilities. This prevention and education effort is targeted toward three types of citizens:

- First, the vulnerable elderly and disabled population who may be victimized by health care fraud schemes or are subject to physical or mental abuse or financial exploitation. These community outreach presentations also attempt to reach the family members of vulnerable citizens who are housed in Medicaid provider facilities or who receive home health care. MFCU investigators or attorneys in each of the nine field offices are expected to conduct presentations that explain how to identify victims of fraud or abuse and the critical need to report it. Moreover, they put a "face on health care fraud" through real-life examples to show that it is not a victimless crime.
- Second, the criminal justice agencies and personnel who are most likely to have contact with the victim population. These groups are provided information about the Attorney General's Office's role in Medicaid fraud and abuse cases and expertise and assistance are offered to local law enforcement, prosecutors or local state agency contacts. These presentations are designed to increase the resources "on the street" who can better identify fraud and abuse incidents and refer them or contact MFCU. MFCU, in turn, is then able to evaluate or open an investigation on incidents such as patient financial exploitation, which is sometimes viewed as merely a civil matter.
- Third, the medical community. The medical community is a group with which the Attorney General's Office wants to partner in order to combat Medicaid fraud and abuse. The overwhelming majority of healthcare professionals are dedicated women and men who are sickened by the abuses that they see or hear about. The Attorney General's Office is reaching out to these professionals who often are closest to possible fraud and abuse situations in facilities. The community outreach presentation explains not only their duty to report but provides a variety of reporting mechanisms that will more easily facilitate their ability to report and/or assist in identifying and preventing such misconduct. Meetings with groups such as the Florida Medical Association and the South Florida Hospital Association have provided positive examples of the cooperation and partnerships that have already led to referrals and assistance in MFCU's investigative efforts.

These three distinct types of presentations are being conducted by MFCU staff. During the last three months of FY 2007-08, approximately 50 presentations were conducted. This community outreach initiative has already reached approximately 2,500 persons and resulted in actual referrals and/or commitments to partner with MFCU to protect these vulnerable victims.

AHCA – DURABLE MEDICAL EQUIPMENT (DME)

In October 2007, investigators with MFCU teamed up with investigators and other field staff from the Agency for Health Care Administration to inspect approximately 40 medical equipment companies that were providing nebulizers (breathing apparatus) and supplies to Medicaid recipients with respiratory conditions. Many of these Medicaid recipients were children. Investigators conducted this sweep in South Florida during a three-day period. Not only were administrative issues identified, but numerous referrals concerning suspected fraud were made by AHCA to MFCU.

In December 2007, a second sweep was conducted with investigators from MFCU and AHCA. Ten DMEs which provided oxygen supplies were inspected by AHCA investigators and field staff, along with six investigators from MFCU's Tampa office. This initiative covered Hillsborough and Pinellas counties. Again, not only were administrative issues identified but this partnership contributed to an increase in the number and quality of the referrals received from AHCA.

AGENCY FOR PERSONS WITH DISABILITIES (APD) – ORLANDO PILOT

MFCU developed a partnership and an investigative approach between the APD Inspector General and attorneys/investigators assigned to MFCU's Orlando office. The purpose was to develop effective enforcement efforts, particularly in the area of APD's waiver program, based upon meaningful referrals and a clear exchange of information. Several referrals and investigations resulted from this pilot program and the referrals are now occurring statewide.

OFFICE OF STATEWIDE INTELLIGENCE – AHCA MPI

The following information includes all initiatives generated through MFCU's Statewide Intelligence Unit and the Agency for Health Care Administration's Bureau of Medicaid Program Integrity. These initiatives were implemented during the FY 2007-08.

INITIATIVE #SIU 2007-01-01
NAME OF INITIATIVE: TRANSPORTATION
PROVIDER TYPE: AMBULANCE (40)

Total # of Referrals Accepted by MFCU:	22
Total # opened as case:	20
Total # closed as complaint:	1
Total # closed case(s):	1

Details of referrals by MFCU office:

- Ft. Myers: Two referrals were sent 11/07/2007; case numbers were requested for both complaints; cases are still active
- Ft. Lauderdale: Two referrals were sent 10/26/2007; case numbers were requested for both cases; cases are still active

- Jacksonville: One referral was sent 10/26/2007; closed in complaint status
- Miami: Three referrals were sent 10/26/2007; case numbers were requested for each referral; cases are still active
- Orlando: Three referrals were sent 10/26/2007; case numbers were requested for each referral; cases are still active
- Tallahassee: Three referrals were sent 10/26/2007; case numbers were requested for each referral; two cases still active and one was closed
- Tampa: Five referrals were sent 10/26/2007, case numbers were requested for each referral; four cases still active and one was closed
- West Palm Beach: Two referrals were sent 10/26/07/2007, case numbers were requested for each referral; cases are still active

INITIATIVE #SIU 2007-02-02
NAME OF INITIATIVE: CHIROPRACTOR
PROVIDER TYPE: CHIROPRACTOR (28)

Total # of Referrals Accepted by MFCU:	7
Total # opened as case:	4
Total # closed in as complaint:	3
Total # closed case(s):	0

Details of referrals by MFCU office:

- Ft. Myers: One referral was sent 11/07/2007; case number was requested; case is still active
- Jacksonville: One referral was sent 11/07/2007; case number was requested; case is still active
- Miami: Two referrals were sent 11/07/2007; one case number was requested and one was closed in complaint status
- Pensacola: One referral was sent 11/07/2007; case number was requested; case still active
- Tampa: Two referrals were sent 11/07/2007; both referrals were closed in complaint status

INITIATIVE #SIU 2008-01-03
NAME OF INITIATIVE: THERAPIST
PROVIDER TYPE: THERAPIST (83)

Total # of Referrals Accepted by MFCU:	6
Total # opened as case:	4
Total # closed in as complaint:	2
Total # closed case(s):	2

Details of referrals by MFCU office:

- West Palm Beach: 13 referrals sent on 01/27/2008

    - 5 referrals were assigned case numbers; 2 cases were later closed
    - 8 referrals were closed in complaint status
- Ft. Lauderdale: 15 referrals were sent 04/08/2008
    - 5 referrals were assigned case numbers
    - 5 referrals were closed in complaint status but merged other cases (included in the total assigned case numbers)
    - 5 referrals were closed in complaint status
- Tallahassee: 3 referrals were sent 03/28/2008
    - 2 referrals were assigned case numbers
    - 1 referral was closed in complaint status
- Tampa: 13 referrals were sent 02/13/2008
    - 12 referrals were assigned case numbers, 8 cases were later closed
    - 1 referral was closed in complaint status
- Miami: 10 referrals were sent 05/02/08
    - 10 referrals were assigned case numbers

INITIATIVE #SIU 2008-02-04
NAME OF INITIATIVE: DENTIST
PROVIDER TYPE: DENTIST (35)

Total # of Referrals Accepted by MFCU:	6
Total # opened as case:	4
Total # closed in as complaint:	2
Total # closed case(s):	2

Details of referrals (by MFCU office):

- Ft. Lauderdale: One referral was sent 01/08/2008; referral was closed in complaint status
- Orlando: One referral was sent 01/08/2008; case number was requested; case is still active
- Tampa: Three referrals were sent 01/08/2008; case numbers were requested for two referrals and were later closed; one referral was already an open case and is still being investigated
- West Palm Beach: One referral was sent 01/08/2008; referral was closed in complaint status

INITIATIVE #SIU 2008-04-06
NAME OF INITIATIVE: HOME HEALTH PROJECT (AHCA IG INITIATIVE)
PROVIDER TYPE: HOME HEALTH AGENCY (65)

Total # of Referrals Accepted by MFCU:	8
Total # opened as case:	8
Total # closed in as complaint:	0
Total # closed case(s):	0

- Miami received all 8 referrals (04/15/2008) and requested a case number for each referral

OPERATION SPOT CHECK

The Office of the Attorney General Medicaid Fraud Control Unit has continued this very valuable initiative and partnership with other stakeholder state agencies to educate, prevent and deter provider facilities from abusing, neglecting or exploiting elderly, disabled or adolescent residents. Operation Spot Check, which involves unannounced inspections of Medicaid provider facilities by partner state and local agencies, has identified numerous substandard conditions that were rectified by most providers after being brought to their attention. Some of these inspections led to facility closures and relocation for the safety and well-being of the residents. Some resulted in administrative, civil or criminal sanctions against those who failed to provide the quality of care that the residents deserve.

In FY 2007-08, 218 Operation Spot Checks were conducted statewide by MFCU's nine offices. Additionally, MFCU investigators conducted 90 Cold Weather Facility Checks statewide in order to insure that the Medicaid facilities provided an adequate environment for their often frail residents. This initiative has become a national model for meeting MFCU's core mission regarding the protection of these residents.

TRAINING

Based upon the Attorney General's Transition Team report in early 2007 and a survey of MFCU members, it was determined that there was a critical need for training specific to the investigation of Medicaid fraud and patient abuse or exploitation. Previously, MFCU had relied upon external training for its new members. Such training is not routinely locally provided and is both costly and generic regarding many of Florida's particular needs and circumstances.

During the first part of FY 2007-08, MFCU's Senior Leadership identified several training milestones and opportunities that the unit could provide for its members at minimal costs. These milestones included the following:

- Conducted a three-day supervisory training program for all MFCU managers and supervisors. Training focused on personnel matters, performance measures and the development of enhanced quality of investigations and cases.
- Held the first-ever Analysts Symposium/Training Session over a three-day period. This highly technical training was attended by 36 MFCU auditors and analysts in Orlando. Seven different state agencies provided in-state expertise and either participated or assisted in the training.
- Arranged for attendance at the HHS-OIG annual training conference in Orlando by approximately 20 MFCU members. There was no registration fee for this conference.
- Arranged for free attendance by 25 MFCU members at the Florida Narcotic Officers Training Conference.

- Facilitated the hosting of the National Association of Medicaid Fraud Control Units (NAMFCU) Practical Skills training course in Orlando. Such facilitation allowed Florida's MFCU to represent approximately 20 percent of the course attendees.
- Arranged for free training by seven MFCU members who attended the one-week NAMFCU Global Case in Santa Fe, New Mexico. Out of the 40-45 attendees for this extensive training opportunity, Florida's MFCU had a total of eight attendees. This training has enhanced MFCU's knowledge and ability to handle complex multi-state litigation, which has the potential for large civil recoveries.

During the latter part of FY 2007-08, MFCU Senior Leadership discussed the development of an in-house training academy for its new investigators, attorneys, auditors and analysts. A training lieutenant was recruited and directed, along with the assistance of MFCU staff, to develop a basic curriculum for new members. This first-ever Medicaid Fraud and Patient Abuse curriculum was completed in June 2008. We plan to conduct two 40-hour academies during FY 2008-09 with 40 attendees for each class. By hosting this statewide training at the Pat Thomas Law Enforcement Academy, substantial cost savings will be realized in lieu of the cost for external training.

SIGNIFICANT CASE HIGHLIGHTS

OPERATION DIRTY DOZEN

Eleven South Florida residents were arrested on May 31, 2007, for their role in a multi-county health care fraud scheme that also involved criminal racketeering, money laundering and grand theft. The arrests were the result of a joint investigation by Florida's MFCU, the Office of Statewide Prosecution and the U. S. Department of Health and Human Services into allegations of fraudulent Medicaid and Medicare billing by Belle Glade Family Health Group, Inc., a Belle Glade clinic located in Palm Beach County. Arrested were clinic owner Hortensia Escoto and her husband Ricardo Escoto, as well as Blanca Marquez, Emelina Marquez, Zoraida Bayon, Maria Poncelon, Dinorah Mateu and Luis Diaz of Miami-Dade County and Mary Lucey of Palm Beach County. Clinic owner Nieves Delgado and her husband, William Alvarez, were arrested shortly following the announcement of the first eight arrests. The arrests were made by law enforcement officers with Florida's MFCU, the Palm Beach County Sheriff's Office and the Miami-Dade Police Department. The remaining fugitive, Jacqueline Reigosa, was arrested on September 5, 2007.

The investigation revealed that the defendants ran a sophisticated criminal organization that fraudulently billed the Medicaid and Medicare program for HIV infusion treatments and drugs. The investigation further revealed that the defendants laundered the proceeds of their scam through a check cashing store, a durable medical equipment company and diagnostic center in Miami-Dade County, and a medical transportation company in Palm Beach County. They also used these businesses to provide cover for the organization's racketeering activities. Investigators estimate that the defendants fraudulently billed more than $5 million to the Medicaid and Medicare programs over a 12-month period.

Each defendant will be charged with multiple counts of racketeering, organized fraud, money laundering and grand theft. If convicted, each individual faces up to 105 years in prison. The defendants' court dates are pending.

MERCK & CO., INC. – LACORTE AND STEINKE

Florida received a total of $32.8 million as part of two separate global settlements totaling $649 million with Merck & Co., Inc. The settlements resolve allegations that the company failed to pay rebates for at least three prescription drugs due to state Medicaid Programs under the Federal Medicaid Drug Rebate statute.

Merck is the manufacturer of the prescription medications Zocor, a cholesterol-lowering drug; Vioxx, a non-steroidal anti-inflammatory which has since been pulled from the market; and Pepcid, a drug used to treat stomach and intestinal ulcers. Pharmaceutical manufacturers that supply these and other products to Medicaid recipients are required by the Federal Medicaid Drug Rebate law to give the Medicaid programs the benefit of the "best price," or lowest price, available for those products. The best price information is used to calculate rebates these manufacturers must pay to the state Medicaid programs. The investigation led by the states and the federal government alleged that the best prices were not being accurately reported and therefore the required rebates were not being paid to the states.

The two whistleblower cases which were pending in Pennsylvania and Nevada involved two Merck discount programs where Merck attempted to use a "nominal price" exemption instead reporting the best prices for the prescriptions Zocor and Vioxx. Prices that are considered "merely nominal" are exempted from the reporting requirement but should not be tied to any conditions. Each discount program was based on an agreement that Merck would sell the drugs to hospitals at a 92 percent discount from the catalog price only if the hospitals reached certain market shares for the drugs. Because the discounts had conditions attached, the states contended that the resulting discounted prices were not merely nominal and should have been reported. By failing to do so, Florida and the other states claimed that Merck deprived the state Medicaid programs of deserved rebates.

An additional case pending in Louisiana involved Merck's drug Pepcid and its associated discount plan. Under this program, Merck sold various forms of Pepcid to hospitals in bundled pricing arrangements. If the hospitals met a certain market share or other purchase requirements, Merck provided Pepcid tablets at discounts ranging up to 92 percent and made lesser discounts available on other variations of Pepcid. According to the government, the transactions under this program required Merck to adjust its best price among the different formulations to reflect these discounts. Because Merck failed to reflect these discounts in its best price reports, fewer rebates were allegedly paid to the state Medicaid programs.

The Florida Medicaid program received $9.7 million, the state General Revenue Fund received $2.5 million and the Federal Medicaid program received $20.6 million from the settlements. In addition to the monetary recovery, Merck entered into a corporate integrity agreement with the United States Department of Health and Human Services' Inspector General. The agreement includes provisions that will ensure that Merck will market, sell and promote its products in accordance with all federal health care program requirements. Merck had begun voluntary

compliance initiatives associated with its sales and marketing activities prior to learning of the investigation into the conduct associated with these settlements.

In addition to Florida, 48 states, the District of Columbia and the Federal Government participated in the settlements, which also resolve three claims filed by whistleblowers in federal court.

WALGREENS COMPANY

Florida received more than $9.8 million from a $35-million multistate settlement with Walgreens over claims the company switched dosage forms for several medications commonly prescribed for Medicaid recipients. The switches allegedly caused Medicaid programs nationwide to pay substantially more for these drugs than necessary.

This settlement was the result of a joint federal-state investigation that was initiated by the filing of a false claims act lawsuit in U. S. District Court in Chicago in 2003. The lawsuit alleged Walgreens filled prescriptions for numerous Medicaid recipients by aggressively switching dosage forms of ranitidine, the generic form of Zantac, a commonly-prescribed anti-ulcer medication; fluoxetine, the generic form of Prozac; and selegiline, the generic form of Eldepryl, which is used in the treatment of Parkinson's disease and senile dementia. This conduct allegedly violated various federal and state statutes and regulations.

Government investigators contended that these improper practices continued from July 2001 through 2005, and that the wholesale substitution of alternate dosage forms of these drugs resulted in higher payments under the automated Medicaid reimbursement system, with no corresponding medical benefit to the individuals receiving the prescriptions. The settlement also resolves allegations that Walgreens made these wholesale switches without physician involvement and therefore violated numerous state regulations governing pharmaceutical dispensing.

Of Florida's share of the settlement, the state's Medicaid program received more than $1.8 million in recoveries; with over $1.8 million in damages received by the state's General Revenue Fund; and $100,000 to reimburse MFCU for its cost of investigation. The remaining $6.3 million was received by the Federal Medicaid program. In addition to the payment of cash settlements to the state and federal governments, Walgreens has agreed to the terms of a corporate integrity agreement with the Office of the Inspector General of the United States Department of Health and Human Services. The agreement will include provisions to ensure that Walgreens does not switch dosage forms of medications if the result would increase the costs to third-party payers, including Medicaid, and will subject the company's billing practices to ongoing federal scrutiny.

This settlement was the result of negotiations jointly conducted by the United States Attorney's Office for the Northern District of Illinois and the National Association of Medicaid Fraud Control Units, with the Attorneys General of Florida, Ohio, Illinois, Massachusetts and Texas leading the effort for the states.

PALM BEACH TRANSPORTATION, INC.

MFCU recovered more than $423,000 in a settlement resolving a potential false claims lawsuit against a Palm Beach County company. Employees of Palm Beach Transportation, Inc. allegedly used the names of Florida Medicaid patients to create false trip tickets, causing the Florida Medicaid program to reimburse the company for medical transport never provided. The settlement required the company to fully reimburse the state and pay more than $35,000 to the state for fees and costs under the Florida False Claims Act.

MFCU's investigation revealed that Palm Beach Transportation, Inc. used falsified transport tickets, submitted by the company's employees, to bill the state for medical transportation on days when the Medicaid patients never saw a doctor or received any medical treatment. MFCU investigated the company's records from 2003 through March 2004, and found evidence that the company was paid more than $423,000 for the purported false claims during that time period.

Two of the company's employees, Joyce Khan and Gloria Thompson, were arrested in 2005 by authorities with MFCU and the Palm Beach County Sheriff's Department. Thompson was charged with Medicaid fraud and Kahn was charged with grand theft for their participation in the scheme. Some months later, Thompson was referred to a pre-trial diversion program and Kahn was adjudicated guilty of grand theft.

WE CARE INC. OF TAMPA

MFCU reached a civil settlement with a Tampa company which provides personal care assistance, companion services and supported living services. The settlement resolves allegations that an employee of We Care, Inc. improperly billed the Florida Medicaid program for services never provided to mentally disabled Medicaid recipients. The fraudulent billing resulted in a loss of more than $41,000 from the Florida Medicaid program.

Investigators with MFCU began investigating the company after receiving a complaint from a disabled adult who reported that he had not received the services described on his explanation of benefits. Authorities discovered more than $41,000 worth of billing fraud which had been committed by an employee, who also stole more than $10,000 from a victim's savings account. The employee was arrested and charged criminally for his actions.

Under the civil settlement reached with the Attorney General's Office, We Care will reimburse $41,636 to the Agency for Health Care Administration. In addition to the civil settlement, We Care reimbursed the victim of the theft $10,000.

A & S RESPIRATORY HOME MEDICAL

An Orange County man was sentenced to 15 years in prison after being convicted for organized fraud and identity theft. Alexis Robinson defrauded the Medicaid program by submitting more than $519,000 in false claims using stolen identification information. He was prosecuted by the Attorney General's Office of Statewide Prosecution, which urged the Court to consider that while

Robinson was a first-time offender, the crimes for which he had been convicted warranted a more severe sentence than the minimum allowed under Florida law.

An investigation conducted by the Attorney General's MFCU revealed that Robinson used the Medicaid identification numbers of more than 40 victims, many of them children, to perpetrate his scheme. He gained access to the identification information through two medical equipment supply companies, Tampa Bay Home Medical Supplies and A&S Respiratory Home Medical, both of which he owned and operated. Although Robinson submitted hundreds of claims to the Medicaid program, most victims never received any medical equipment or received substandard equipment. Additionally, victims of the scheme had difficulty obtaining services from legitimate medical service providers because of the fraudulent charges associated with their personal Medicaid numbers.

Robinson was convicted of organized fraud involving more than $50,000, a first-degree felony, and criminal use of personal identification information involving $75,000 or more, a second-degree felony. He was also convicted of criminal use of personal identification information involving $100,000 or more, a first-degree felony as amended by the Florida Legislature in 2003 to provide more severe penalties to criminals engaged in identity theft. In addition to his prison sentence, Robinson was also ordered to pay full restitution in the amount of $519,416.40 to the Medicaid program.

EXPO TECH SERVICES, INC.

On April 22, 2008, a Miami-Dade County jury returned a guilty verdict against Roman Arias, convicting him of grand theft and organized scheme to defraud the Florida Medicaid program. The case was investigated by the Attorney General's MFCU and was jointly prosecuted by MFCU and the State Attorney's Office for the 11th Judicial Circuit.

Arias was the owner of Expo Tech Services, a durable medical equipment company in Miami. Durable medical equipment is characterized as equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, and is appropriate for use in the patient's home. Investigators with MFCU determined Arias fraudulently billed the Medicaid program more than $250,000 for numerous orthopedic devices by using the names and Medicaid numbers of Medicaid recipients who neither needed nor received the equipment for which their accounts were billed. The fraud continued over the course of a nine-month period and Arias was arrested in June 2006 by law enforcement officers with MFCU. During the trial, the attorney from MFCU also produced evidence establishing that Arias never even purchased the equipment for which he billed. Arias was immediately remanded into custody upon the return of the jury's verdict. He was sentenced to five years in prison and 15 years probation and ordered to reimburse the Florida Medicaid program $225,048.51.

JOHN Q. DURFEY - PHYSICIAN

From August 2001 through August 2006, Dr. 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. Dispensing these prescriptions under such circumstances, even by a physician, is a violation of the Federal Controlled Substances Act.

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 part of a joint Federal/State North Florida Health Care Fraud Task Force investigation that involved the Federal Bureau of Investigation, the Drug Enforcement Administration, the Defense Criminal Investigative Service, the National Drug Intelligence Center, the Florida Department of Law Enforcement, the Florida Attorney General's Office MFCU, the Florida Department of Financial Services - Fraud Division, and the Florida Department of Health.

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 on six counts of distribution of controlled substances and six counts of health care fraud. At the sentencing hearing, it was revealed that two of the drug counts involved patients who died of drug overdoses resulting from the defendant's improper prescribing of controlled substances. The United States District Court judge also ordered Durfey to pay a special assessment of $1,200 to the United States, and to pay restitution in the amount of $466,723.03 to Medicare, Tricare, BlueCross BlueShield of Florida and the State of Florida's Medicaid program.

DONNA GATCH – REGISTERED NURSE

Investigators with MFCU and deputies with the Gadsden County Sheriff's Office arrested Donna Gatch on charges that she misused her job at Big Bend Hospice of Gadsden County to fraudulently obtain controlled substances including Ambien and hydrocodone. An investigation revealed that she was using her position as a registered nurse to phone in fraudulent prescriptions and causing Big Bend Hospice to be billed.

Gatch obtained more than 50 unauthorized prescriptions for controlled substances by using her patients' names, three of whom were Medicaid recipients. After phoning in the prescriptions, she would then pick up the prescriptions herself and let the pharmacies charge Big Bend Hospice for the cost of the prescriptions. Investigators were able to confirm that no patients of Big Bend Hospice failed to receive medications that were prescribed for them.

The case was investigated by the Diversion Response Team, a task force of agencies formed to combat the illegal trade in pharmaceutical drugs. Participating agencies include MFCU, the Florida Department of Law Enforcement (FDLE), the Florida Department of Health, and the U.S. Drug Enforcement Administration.

Donna Gatch pled no contest to 12 counts of fraudulently obtaining controlled substances and one count of grand theft. She was sentenced to four months incarceration and five years probation. Gatch was also ordered to pay restitution to Big Bend Hospice, costs of

investigation, court costs and fines. Gatch was prosecuted by attorneys for the Attorney General's MFCU who were specially designated for the case by the State Attorney's Office for the Second Judicial Circuit.

TERENCE POLLARD – TOTAL MOTIVATIONAL SERVICES

Terence Pollard owned and operated Total Motivational Services, a company that operated under the Medicaid Waiver program and claimed to provide support employment services, which are defined as efforts made to assist the beneficiary with acquiring and retaining paid employment. An investigation conducted by MFCU revealed that Pollard repeatedly billed the Medicaid program for services he never provided to Medicaid recipients over an extended period of time. As part of the investigation, the company's Medicaid claims and other records were subpoenaed and reviewed and authorities determined that Pollard submitted at least 14 separate claims on behalf of one Medicaid recipient yet never met with the recipient or provided her with any services.

The investigation into Pollard's fraudulent billing was initiated by a complaint referred by AHCA's MPI. Pollard pled no contest to both Medicaid provider fraud and grand theft. He was sentenced to five years probation, 120 months of community service, and ordered to pay $4,474.50 in restitution to the Medicaid program. His Medicaid provider license is permanently revoked and he is permanently excluded from the Medicaid program.

DORIS CUEVAS AND AMANDA ECKHARDT – CERTIFIED NURSING ASSISTANTS

Two certified nursing assistants were arrested for incidents of elder abuse or exploitation. Doris L. Cuevas was arrested on charges she struck a nursing home patient who was under her care. Amanda Marie Eckhardt was arrested on charges she stole the credit card of a disabled group home resident and used the card for her own personal gain. Both women were arrested by MFCU with assistance from local law enforcement.

Investigators with MFCU began investigating Cuevas, of Bay County, after receiving a complaint from the Department of Children & Families. Cuevas, an employee of the Panama City Development Center, allegedly struck a disabled resident who was under her care. A staff member at the facility reported the incident and notified authorities. Cuevas was immediately fired.

Doris Cuevas entered a Pretrial Intervention Program with 96 hours of Community Control, payment of court costs, a letter of apology to the victim and no further contact with the victim. Additionally, Cuevas was ordered to attend and complete an anger management course taught by Judicial Corrections in Bay County.

Eckhardt, of Martin County, was investigated by MFCU's Patient Abuse, Neglect and Exploitation (PANE) team. The PANE Project plays a key role in detecting abuse and neglect of elderly and disabled patients, helping to ensure that efficient and effective health care is being provided. Eckhardt was employed as a certified nursing assistant by Martin Nursing and Restorative Care Center, a nursing home located in Stuart. In early January 2007, Eckhardt allegedly stole a credit card from a 77-year-old nursing home resident and used it to purchase

several personal items, including a membership to an online dating service and clothes from a department store.

Amanda Eckhardt was adjudicated guilty and sentenced to six months incarceration, four years probation and two hundred hours of community service. Additionally, Eckhardt was ordered to make restitution to the victim.

ROBERT L. ASHLEY

Robert Ashley, who lived in Bay County, was arrested for the alleged exploitation of an elderly victim and for grand theft after investigators revealed that he fraudulently used more than $23,000 of the victim's money for his own personal benefit. Robert L. Ashley, of Panama City, was arrested by authorities with the Attorney General's MFCU.

Investigators with MFCU's Patient Abuse, Neglect and Exploitation (PANE) team began investigating Ashley, 56, after receiving information from the Florida Department of Children & Families, Adult Protective Services. The investigation revealed that Ashley obtained power of attorney over the 87-year-old victim's affairs while the victim was in a nursing facility. Using that power of attorney, Ashley took more than $23,000 out of the victim's bank accounts and used the funds for his own personal benefit. The victim is now deceased.

Ashley was arrested for one count of exploitation of an elderly adult and one count of grand theft, both second-degree felonies. Each felony carries a maximum penalty of 15 years in prison and a $10,000 fine.

A & L PROJECTS, INC.

Three Clearwater men were arrested and charged with defrauding the Florida Medicaid program out of more than $50,000 over a 30-month period. Licensed contractor Richard Allen Lehman and unlicensed subcontractors Gary G. Auffarth and Harry Sherman Lochbaum, Sr. were taken into custody for their involvement in the Medicaid fraud scheme by MFCU.

MFCU began its investigation after learning that A&L Projects, Inc. had allegedly obtained a contract from the Medicaid program to do bathroom renovations for a disabled recipient. The recipient filed a complaint alleging that the work was incomplete and substandard.

After interviewing several Medicaid recipients and reviewing copies of Medicaid records, investigators determined that Lochbaum, 65, had been paid for providing renovation cost estimates required by the Medicaid program, called "assessments," that he was neither eligible nor qualified to provide.

Auffarth, 51, and Lochbaum then used Lehman's contracting license to obtain contracts for A&L Projects, Inc. to perform renovations intended to allow disabled Medicaid recipients to live more independently. In some cases, A&L did no work at all or did such substandard work that the recipients were left with inoperable bathrooms and other equipment. A&L also double-billed the Medicaid program for services and materials.

On July 17, 2008, Lehman, Auffarth and Lochbaum were convicted of one count of organized scheme to defraud. The defendants were ordered to pay $69,415 in restitution to the Medicaid program. Auffarth and Lehman were each sentenced to five years probation. Lochbaum was sentenced to 30 months of community control.

EDWIN CINTRON

Edwin Cintron was arrested for allegedly submitting false Medicaid service logs for services not provided to a disabled recipient. MFCU was alerted to the fraudulent activities through its Operation Spot Check initiative, which facilitates surprise inspections of nursing homes and assisted living facilities to determine evidence of patient neglect or abuse. An investigation revealed that Cintron, 45, submitted false service logs showing he provided Medicaid services while he was working for a non-Medicaid employer. It was later determined that Cintron was reimbursed more than $38,000 by the Medicaid program for services he did not provide. The Agency for Persons with Disabilities assisted with the investigation.

Cintron was convicted on August 27, 2008 of one count of Organized Fraud of $20,000 or more and sentenced to three years of probation and ordered to make restitution to the Medicaid program of $38,216.76.

TIMOTHY TIMMER – COLLIER CONNECTIONS, INC.

Timothy Timmer, an independent Medicaid provider, and his employee, Lisa Lewis, were arrested for allegedly billing the Florida Medicaid program for services they never provided. Timmer, 42, is the owner and operator of Collier Connections, a service provider for the developmentally disabled. An investigation conducted by MFCU revealed that Timmer billed the Medicaid program for patient services even though he was working for another employer at the time he claimed to be providing services. The investigation also revealed that Lewis, 40, signed activity logs indicating she was providing recipients with in-home services even though she was simultaneously working for another employer. Timmer is also charged with making ATM withdrawals from Medicaid recipients' bank accounts without their permission. A provider for the Agency for Persons with Disabilities alerted MFCU about the fraudulent behavior.

Timmer and Lewis were each charged with three counts of Medicaid fraud, a third-degree felony punishable by up to five years in prison and a $5,000 fine; one count of second-degree grand theft, punishable by up to 15 years in prison and a $10,000 fine; and two counts of third-degree grand-theft, punishable by up to five years in prison and a $5,000 fine.

ESTHER ROMEU – DIAGNOSTIC MEDICAL CHOICE, INC.

Esther Romeu, a Miami health clinic owner and five South Florida physicians were arrested on charges of defrauding the Medicare and Medicaid programs out of more than $15 million. The doctors and clinic owner are alleged to have run an elaborate scheme involving costly treatments for HIV/AIDS.

Romeu owned and operated Diagnostic Medical Choice, Inc. , a health clinic located in Miami. Also arrested were Walter F. Proano, Manuel Barbeite, Alejandro Enrique Casuso, Carmen Lourdes Del Cueto and Marco Tulio Molinares, all doctors licensed in Florida and employed by Romeu.

The arrests culminated a joint investigation by MFCU and the Federal Bureau of Investigation into outrageous billing patterns for extremely expensive Intravenous Immune Globulin ("IVIG") medications used to treat HIV/AIDS-related conditions. IVIG medications are supposed to be infused into the patients once a month with careful monitoring of the patient's blood count and detailed reports on the infusions. Instead, the defendants alleged that they were infusing the patients three times a week with IVIG, in some cases for several years, without performing any of the necessary lab work or obtaining any infusion reports which are essential to meaningful treatment. The prescribing of these drugs in the frequency alleged is not only medically inappropriate, but could have been dangerous to patients' health.

Investigators believe Romeu and her physician accomplices billed the Medicare and Florida Medicaid programs $19,582,042 and were paid $15,968,424 for the IVIG medications from January 2003 through July 2006.

Romeu is charged with Conspiracy to Commit Health Care Fraud and eight counts of Health Care Fraud. Drs. Molinares, Del Cueto and Barbeite are each charged with Conspiracy to Commit Health Care Fraud and two counts of Health Care Fraud. Drs. Proano and Casuso are each charged with Conspiracy to Commit Health Care Fraud and one count of Health Care Fraud. Each defendant faces a maximum of 10 years in prison and a $250,000 fine for each count of the indictment in which they are named. Romeu's court case is pending.

BRIAN CASTEEL - THERAPIST

Brian Casteel, a Broward County therapist, was arrested on charges that he was involved in the theft of more than $50,000 from the Florida Medicaid program. Brian Casteel was arrested by investigators with the West Palm Beach MFCU. The arrest culminated an investigation by MFCU, acting on information received from the mother of a Medicaid recipient. The investigation revealed that Casteel, 40, worked as a Medicaid respiratory therapist in Broward County. Authorities alleged that he submitted numerous claims to the Medicaid program for reimbursement for respiratory therapy that he never provided to various children who are Medicaid recipients.

Casteel pled guilty to one count of grand theft and was ordered to pay $55,000 in restitution to the Medicaid program. He was sentenced to five years probation and 100 hours of community service. The court also withheld adjudication of guilt.

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AGENCY FOR HEALTH CARE ADMINISTRATION

OFFICE OF THE INSPECTOR GENERAL INVESTIGATIONS UNIT

The Investigations Unit (IU) led four major initiatives during FY 2007-08. These initiatives were conducted with various internal and external agency partners, including the Medicaid Fraud Control Unit (MFCU) and the Centers for Medicare & Medicaid Services (CMS).

INITIATIVES

October 2007 – The IU coordinated an initiative to review nebulizer claims in Miami-Dade County. The initiative included participants from the IU, AHCA Medicaid Program Integrity (MPI), MFCU and CMS. Over 500 recipients and providers were randomly selected for on-site review and more than 50 percent were visited and interviewed during a four-day period. This initiative resulted in 75 internal and external investigative referrals as well as policy recommendations to enhance identification of potential fraud and abuse.

December 2007 – Oxygen and related supply claims in Hillsborough and Pinellas Counties were reviewed by the personnel from the IU, MPI and MFCU. A follow-up audit by the MPI Case Management Unit has sought reimbursement of overpayments and additional penalties.

January 2008 – Home health aide services in the Miami-Dade County area were analyzed by the IU, MPI, AHCA Medicaid Services, MFCU and CMS. This review resulted in over 30 internal and external investigative referrals and additional follow-up investigations based on leads developed during the initial on-site review. The impetus for this review was questionable home health care claims discovered by Miami MPI staff.

March 2008 – Home health aide services in the Miami-Dade County area were again reviewed by the IU and MPI. Three referrals were sent to MFCU and several providers identified during the initiative were placed under additional review.

The IU also conducted several independent investigations of Medicaid providers.

Case Highlights:

- A preliminary investigation of a home health agency (HHA) determined that the HHA was billing and receiving Medicaid reimbursements for services rendered by a non-enrolled provider. The HHA owner reimbursed the State of Florida $38,435 when presented with these findings.
- A behavioral health provider was notified of erroneous claims after an investigation. The provider voided $172,628 in claims for the period August 1, 2007 through March 31, 2008, for a physician who was not employed by the provider. Additionally, the provider conducted an internal review and voided $3,000 in claims attributed to other departed providers.
- A pediatrician reimbursed AHCA $232,855 for Medicaid billing violations.

- An on-site investigation of an HHA identified violations of Medicaid policy by home health aides and the director of nursing. The provider terminated the director of nursing and the implicated home health aides. A total of $35,195 was recovered by the Agency which included $11,330 identified by the Agency, and $23,865 in erroneous billings identified by the provider during a self-audit.
- An on-site investigation of an HHA determined that a home health aide was not providing services as billed. The owner reimbursed Medicaid $14,241.

BUREAU OF MEDICAID PROGRAM INTEGRITY

The Bureau of Medicaid Program Integrity (MPI) is responsible for preventing, detecting and recovering overpayments relating to fraud and abuse in the Medicaid program. MPI carries out fraud and abuse prevention activities, performs detection analyses, conducts audits, imposes sanctions as appropriate and refers certain providers to MFCU and to other regulatory and investigative agencies.

MPI operations during the past fiscal year were influenced by four principal factors.

1. FY 2007-08 was devoted in substantial measure by the Agency to preparing for the transition to the new Florida Medicaid Management Information System and Decision Support System (FMMIS/DSS). MPI was necessarily and extensively involved in the testing and fine tuning of the systems, since they are critical to the fraud and abuse detection and investigation activities of the bureau.
2. The Agency's contract with the Third Party Liability contractor ended during the past fiscal year and that contractor also provided vital fraud and abuse detection services to MPI, including retrospective computer-based analyses of paid claims to determine overpayments. These services were not fully available during the last several months of FY 2007-08 and for the first several months of FY 2008-09. The temporary cessation of these important services adversely affected MPI's efforts to detect fraud and abuse claims and affected overpayment recoveries.
3. MPI has been actively assisting the Centers for Medicare & Medicaid Services (CMS) in the development of provider audit protocols involved in CMS' oversight of state Medicaid programs. MPI has been comprehensively involved in conducting detection work, suggesting providers for audit and sharing information concerning its extensive provider audit capabilities. Other states involved with CMS and Florida include Mississippi, Texas and Washington.
4. A provider challenged the use by the Agency of statistical sampling in audits on the basis that a formula had not been incorporated in an Agency Administrative Rule, notwithstanding that this formula and other pertinent formulas are published in many textbooks referenced by the Agency. A legal proceeding culminated in a court decision upholding the Agency's practices in this regard, but not before the Agency was precluded for more than a year from issuing binding audit reports incorporating statistical sampling. (Deferred reports are being issued during FY 2008-09.)

Prevention of fraud and abuse in Medicaid is of great importance. If an overpayment is prevented, it is not necessary for the Agency to detect, audit and recover the funds. There are no appeals and protracted legal proceedings. An efficient way to deal with Medicaid fraud and

abuse is by preventing overpayments whenever possible. In FY 2007-08, MPI prevention efforts are estimated to have saved the Medicaid program $21.5 million. This cost avoidance is discussed in some detail in the section below headed *Prevention*.

Because overpayments 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 generally accepted statistical methods.

In FY 2007-08, MPI identified $28.9 million in overpayments, categorized as follows: MPI Audits of $15.6 million, Claims Adjustments of $12.8 million and Paid Claims Reversals of $450,000. These overpayments are discussed in some detail in the section below headed *Recovery*.

CHANGE IN MEDICAID FISCAL AGENT CONTRACTOR

In June 2004, the Agency began the complex undertaking of procuring a new Florida Medicaid Management Information System (FMMIS) and Decision Support System (DSS) under a new contract for fiscal agent services. Electronic Data Systems (EDS) was the successful bidder and, after a protest by another bidder, a contract was signed in May 2006. The design, development and implementation phases of the project were accomplished in FY 2007-08. In September 2007, the Agency entered the acceptance testing phase of the system, which included beta testing with selected providers. As one of the users of the system, MPI participated in User Acceptance Testing and the concurrent parallel testing process. In January 2008, the Agency determined that more time was needed to adequately test the new system to determine its readiness. As a result, MPI staff continued participation in enhanced testing efforts for the system and conducted additional training activities to help ensure successful implementation. On June 21, 2008, the Pharmacy Benefit System, subcontracted by EDS to First Health Services Corporation, was brought on line. On June 26, 2008, EDS began to accept and process claims and commenced all fiscal agent claims processing activities.

MANAGED CARE

MPI has continued efforts to develop partnerships with Florida Medicaid managed care organizations (MCOs) dedicated to combating Medicaid fraud and abuse.

MPI auditors were responsible for the compliance follow-up review of the fraud prevention section of the contract between the Agency and MCOs. They also visited approximately half of

the managed care organizations that had deficiencies during the past fiscal year to assess compliance and implementation of planned corrective actions. MPI performed these follow-up reviews using measurements of an effective managed care fraud and abuse program, which include formal compliance plans and strategies for prevention, coordination, detection, enforcement and reporting of fraud and abuse.

Reporting by managed care organizations on fraud and abuse has increased during the past fiscal year. MPI continues to develop methods and strategies to coordinate efforts between MCOs and the Agency so that this partnership may work collaboratively to address fraud and abuse prevention and control within managed care.

COORDINATION WITH OTHER ORGANIZATIONS

Communication and cooperation with other state and federal agencies benefit efforts to control fraud and abuse. It enables the exchange of information on the nature of fraud and abuse schemes, on perpetrators of such schemes and on prevention, detection and auditing methodologies.

HEALTH QUALITY ASSURANCE UNLICENSED ASSISTED LIVING FACILITIES

The MPI field offices continued to participate 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 addressed. 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 policies and procedures are being followed.

SOUTH FLORIDA HEALTH CARE FRAUD WORKING GROUP

The South Florida Health Care Fraud Working Group was formed in 2005 at the initiation of AHCA and other agencies in order 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, MFCU, DOH, the Department of Children & Families (DCF) and the Florida Department of Law Enforcement (FDLE). Federal agencies include the Department of Health and Human Services Office of Inspector General, Centers for Medicare & Medicaid Services, the U. S. Attorney's Office, 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 control. 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 abusive providers in the Florida Medicaid program.

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 communication and developed a closer working relationship. An example of this effort is the initiative involving recommendations for rule changes to the Board of Pharmacy. As a result of these collaborative efforts, it is expected that the Board will strengthen the requirements for pharmacy managers and pharmacy technicians, and 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

All states and the Centers for Medicare & Medicaid Services (CMS) are responsible for protecting the integrity of the Medicaid program. Under the Deficit Reduction Act (DRA) of 2005, the Medicaid Integrity Program (MIP) was created under the Department of Health and Human Services Centers for Medicare & Medicaid 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. 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 Medicaid Integrity Program is being implemented within CMS by the Medicaid Integrity Group (MIG). The MIG has been managing strategic contractors that assist in formulating program implementation, procuring Medicaid Integrity Contractors (MICs) to audit providers of Medicaid services, and conducting oversight reviews of and assisting the 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 MPI audit operations and explain Florida sampling methods and software. As part of the MIP initiative, CMS's subcontractors are reviewing Florida's Medicaid claims history data and planning to do on-site audits throughout the state. The Agency is confident this cooperation between state and federal organizations will assist it in identifying more fraud prevention and monetary recovery opportunities, as well as identify areas in which state policies need to be strengthened.

MEDICARE

MPI and CMS continued their collaborative efforts in safeguarding the Medicaid and Medicare programs from fraudulent and abusive behavior committed by health care providers.

During FY 2007-08, MPI, CMS and MIG participated in the following focus projects as part of the State's initiative to address and combat health care fraud and abuse in South Florida, designated one of the nation's high-risk geographical areas for fraudulent billing:

- The DME (Nebulizer) Project - A field investigation conducted during the week of October 15, 2007 to combat fraudulent reimbursements for durable medical equipment, specifically nebulizers. (See *Durable Medical Equipment Suppliers* under *Focused Projects.*)
- The Home Health Agency Project - A field investigation conducted during the week of January 14, 2008 to determine if there is fraud or abuse committed by specific home health agencies in Miami-Dade County. As a result of this project, MPI initiated eight referrals to CMS for investigation of possible fraud against the Medicare program. (See *Home Health Agencies* under *Focused Projects*.)

MPI and CMS are committed to protecting the integrity of both the Medicaid and Medicare programs and the people whom they serve. During the past fiscal year, they continued to strengthen their partnership by participating in joint provider site visits, by referring for investigation dually enrolled providers suspected of aberrant billing practices, and by continuing to improve communication and promote the sharing of information between the two agencies.

Additionally, during August, 2007, the MPI Miami field office assisted in the Agency's training of Medicaid Integrity Group (MIG) staff on MPI's efforts to effectively curtail fraud and abuse in the Medicaid program. On August 30, 2007, after meeting with MPI Miami staff and receiving an overview on MPI's organizational structure and operations, MIG representatives, in their role as observers, accompanied MPI and CMS field office staff on a compliance inspection of a targeted home health agency in Miami-Dade County.

In November 2007, MPI staff participated in the annual training conference held in Orlando for HHS/OIG investigators. The MPI presentation consisted of an overview of Florida MPI along with handouts and contact information.

MEDI-MEDI

The Medi-Medi project is being carried out to detect and deal with fraud and abuse in the Medicare & Medicaid programs that would be difficult to find by analysis of data relating to either program individually. The project utilizes computerized analysis and matching of Medicare and Medicaid data. In combination with statistical analysis, this program can detect relationships among providers and billings. Abuse and potential fraud cases are developed for referral to appropriate health care and law enforcement agencies.

Information has continued to be provided to MPI and other entities about obvious 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 MPI in the matching of

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

DEPARTMENT OF ELDER AFFAIRS, OMBUDSMAN PROGRAM

Florida's Long-Term Care Ombudsman Program is a volunteer-based organization seeking to improve the quality of life of frail, vulnerable elders who live in long-term care settings, including nursing homes, assisted living facilities and adult family care homes by directly responding to their concerns. Volunteer ombudsmen spend time in licensed long-term care facilities, identifying, investigating and resolving the concerns of residents and their loved ones, as well as performing annual assessments of each facility throughout Florida.

This past fiscal year, MPI conducted a presentation for the South Central District Ombudsman group and also attended the West Central Ombudsman meetings. As a result of this outreach effort, referrals were made to MPI including one in the Miami area that resulted in MPI terminating an Assisted Living Facility provider. Additionally, some of the field staff attended the Ombudsman Town Hall meetings that were conducted throughout the state.

AREA AGENCY ON AGING/SENIOR MEDICARE/MEDICAID PATROL PROJECT

The Senior Medicare/Medicaid Patrol (SMP) Project is a statewide program funded by the Administration on Aging and administered by the Area Agency on Aging of Pasco-Pinellas, Inc. MPI continues to participate in SMP and received referrals concerning various provider types this past fiscal year.

Additionally, MPI staff presented an overview of MPI to a group of SMP volunteers. Within a day or two of this presentation, MPI had received its first referral from a volunteer who had attended the training. MPI and SMP have signed a memorandum of understanding to continue the work between the two organizations.

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 2007-08, 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 several years ago 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 the 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 continues to exchange information and claims data in an attempt to identify areas of potential fraud or abuse.

During FY 2007-08, the review of billings for providers engaged in environmental modifications and assessments continued and MFCU has opened several cases. The workgroup also addressed referral and communication processes between MPI and APD. Monthly reports of MPI audits of APD providers were enhanced. The workgroup discussed issues concerning the implementation of the new fiscal agent contract and has proposed changes for the system. The workgroup continues to identify areas of concern and plans to continue meeting in FY 2008-09 in an attempt to identify additional providers and programs for comprehensive review.

NATIONAL INSURANCE CRIME BUREAU (NICB) MEDICAL FRAUD TASK FORCE

Field staff members attended the National Insurance Crime Bureau (NICB) Medical Fraud Task Force meetings. At these meetings, various private insurance companies, law enforcement agencies and other regulatory agencies presented schemes being used throughout the state by medical professionals.

PREVENTION

The prevention of misspent funds is less costly than attempts to recover funds. Accordingly, MPI dedicates approximately 40 percent of its staff to the prevention of fraud and abuse. MPI's prevention activities include:

- 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,
- The 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 for 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; suspicion of any of the violations set forth in s. 409.913(15), F.S.; or for standard oversight evaluations.

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 2007-08, the claims of 156 providers were pended and payments of approximately $4.2 million were cost avoided.

The following table shows the types of providers whose claims were pended and reviewed in FY 2007-08, and the savings due to denied pended claims.

Provider Type	Number of Providers	Amount of Denied Claims
Home Health Agency	14	$1,532,047
H & C Based Services	74	903,175
Pharmacy	3	663,761
Physician (MD)	20	586,442
Medical Supplies/Durable Medical Equipment	9	184,095
Assistive Care Services	23	162,349
HMO OR PHP	1	124,834
Physician (DO)	2	4,698
Dentist	6	3,527
Independent Laboratory	1	1,479
Therapist	2	1,310
Podiatrist	1	1,105
Total	**156**	**$4,168,822**

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, 2006 – June 30, 2007 are reported for FY 2007-08. For that fiscal year, these terminations saved Medicaid $5.4 million. This figure represents only those terminations that followed from an MPI recommendation to the Division of Medicaid.

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 July 1, 2006 – June 30, 2007 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 2007-08, 40 providers were the subjects of this action, which resulted in cost avoidance for the Medicaid program for $0.5 million.

SITE VISITS

Staff members in the field offices of MPI 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, MPI sends 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.

Due to the number of site visits made to pharmacy providers and the effect of the implementation of Medicare Part D, site visit savings were based on payments made to the provider during the 100-day periods prior to and following the visit. New providers are not included in the calculation of savings as a provider must have been active for one year prior to the visit to be included. Cost savings for FY 2007-08 resulting from 229 site visits were $1.8 million.

FOCUSED PROJECTS

HOME HEALTH AGENCIES

A review of home health agency (HHA) reimbursements in Florida for calendar years 2005 through 2007 revealed a marked increase in Miami-Dade County for reimbursements for procedure code T1021, Home Health Aide Service Unassociated with Skilled Nursing Service. Although Miami-Dade County has approximately 20 percent of the Medicaid population of the state and approximately 33 percent of the over age 60 demographic, the county had 91 percent of total reimbursements for procedure code T1021 services. An analysis of these services by MPI prompted an investigation of HHAs in the county. The project involved MPI and the Investigations Unit, both of the Office of the Inspector General, several offices of the Division of Medicaid, the Centers for Medicare & Medicaid Services (CMS), and the CMS Medicaid Integrity Group.

The project was conducted in phases. The initial phase involved the local field office investigators and nurses. Five HHAs were chosen to be reviewed as test cases. Visits to these HHAs and their patients allowed investigators and field nurses to develop policy-specific and statute-specific tools for use in the second phase of the project.

The second phase of the project targeted HHAs for which procedure code T1021 reimbursements represented 60 percent or more of their total Medicaid reimbursements. Nine HHAs were selected and the HHAs, prescribing physicians and patients were all visited during one week in January 2008 by teams comprised of representatives of all the above mentioned agencies or units. HHAs and prescribing physicians were visited by teams of two investigators, while teams that visited patients were comprised of one investigator and one nurse. Each team visiting providers (9 HHAs and 36 physicians) had specific questionnaires and lists of documentation to be copied and sent to the local MPI office for review. Teams that visited the 336 patients had questionnaires that pertained to the services the patient received as well as a nurse's assessment.

The third and ongoing phase of the project entails reviewing all information gathered through the week-long project and making recommendations and referrals through appropriate channels. This includes follow-up and review of records of all ancillary services provided to the patients including DMEs, therapies and physician visits. The project is being expanded to other HHAs primarily offering T1021 services.

MPI has found that overall billing for procedure code T1021 services in Miami-Dade County has decreased by 20 percent since the project was undertaken. The following instances of questionable practices by HHAs, prescribing physicians, home health aides and patients were discovered during the course of the project:

- Aides allegedly working 20 to 25 hour days
- Patient brokering by aides
- Alteration of records
- Agencies that bill T1021 service when only housekeeping has been provided
- Agencies that bill for RN services when an LPN is attending

- Agencies using staffing pools of non-Medicaid approved providers
- Payment of physicians for referrals
- Payments to patients (in the form of gifts, services or funds)
- Patients receiving services that are not medically necessary
- Physicians with financial interests in the agencies referring to those entities.

As a result of the project, MPI has recommended termination of several of the involved HHAs. MPI has also made referrals to MFCU and, when appropriate, referred the directors of nursing to DOH. Several of the agencies have been placed on prepayment review. Appropriate action has been recommended concerning several of the involved prescribing physicians. It has been calculated that this project saved the Medicaid program $5.4 million during FY 2007-08 based on the difference in total payments to the home health providers involved for the six-month periods prior to and following January 2008.

DURABLE MEDICAL EQUIPMENT SUPPLIERS

Durable Medical Equipment (DME) providers in Miami-Dade County were audited in October 2007 to review claims for nebulizers. Coordinated by the Investigations Unit (IU) of the Office of Inspector General, personnel from MPI, MFCU and CMS participated. More than 500 recipients and providers were randomly selected for on-site review and over half of them were visited and interviewed during a four-day period. This initiative resulted in 75 internal and external investigative referrals as well as policy recommendations to enhance identification of potential fraud and abuse. This project saved the Medicaid program $3.1 million in FY 2007-08, based on the difference in total payments to the DME providers involved for the nine-month periods prior to and following October 1, 2007.

Claims for oxygen and related supplies submitted by providers in Hillsborough and Pinellas counties were reviewed in December 2007 by personnel of the OIG/IU, MPI and MFCU. This project saved Medicaid $1.3 million based on the difference in total payments to the DME providers involved for the seven-month periods prior to and following December 1, 2007. A follow-up audit by an MPI Case Management Unit sought reimbursement of overpayments plus penalties totaling approximately $86,000.

OTHER PROJECTS

EXPLANATION OF MEDICAID BENEFITS PROGRAM

The EOMBs provide recipients the opportunity to confirm whether they received services for which Medicaid was billed on their behalf. Recipients utilize EOMBs to comment on any aspect of the Medicaid program. Explanation of Medicaid Benefits forms (EOMBs) are mailed 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 MPI receives the EOMB forms returned by Medicaid recipients and their representatives. The Intake Unit is responsible for processing the EOMBs, opening files when appropriate and conducting investigations of files opened in preliminary status.

Of the 800,000 EOMBs mailed each quarter, approximately two percent (16,000) are being 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 their 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 to be investigated further. 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 MFCU. 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 or the Florida Department of Health.

ADMINISTRATIVE SANCTION RULE

During FY 2007-08, 472 Medicaid providers were sanctioned for violations set forth in Rule 59G-9.070, Administrative Sanctions on Providers, Entities and Persons. Of these, 155 received fines totaling approximately $150,000, six were suspended and ten were terminated from the Medicaid program. The others, including some of those fined, received other sanctions, principally in the form of 452 acknowledgement statements. The violations included the failure to comply with the provisions of the Medicaid provider handbooks, which include the failure to maintain and/or furnish specified records.

RECOVERY

MPI investigations into allegations and indications of violations of Medicaid policy fall into three categories:

1. MPI conducted audits
2. Paid claims reversals
3. Vendor-assisted audits

MPI's recovery efforts tend to concentrate on conducting comprehensive investigations and generalized analyses of Medicaid providers. MPI also uses Florida licensed pharmacists to review claims paid to pharmacies in order 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 assist in and oversee all aspects of these projects.

MPI AUDITS

During FY 2007-08, MPI concluded 1,126 audits of Medicaid providers. These audits were comprehensive investigations evaluating all aspects of a provider's billings or generalized analyses 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 that type provider. During FY 2007-08, more than $15.6 million was identified as overpayments as a result of MPI audit activities.

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 by Medicaid as recovered overpayments. Providers who do not adjust or reverse the payment are subject to further audit or other administrative action by the Agency. During FY 2007-08, paid claims reversals resulted in net recoveries to Medicaid of about $450,000.

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 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 2007-08, the vendor assisted in the collection of approximately $12.8 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 Florida Medicaid Management Information System (FMMIS) paid claims file and comparing the date of service to the date of death on the 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, such as a copy of a death certificate or a doctor's note. 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 2007-08, the date of death project yielded recoveries of $2.3 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 $2.1 million in FY 2007-08.

PROVIDER SELF AUDITS

This past fiscal year providers were mailed letters requesting that they review their credit balances and voluntarily refund any overpayments to Medicaid. This ongoing project yielded recoveries of $1.5 million in FY 2007-08.

DUPLICATE BILLING

This review identified Medicaid payments to hospitals for inpatient services for duplicate or overlapping periods and resulted in the recovery of $7.0 million in FY 2007-08.

PERFORMANCE TRENDS

MPI has begun tracking several performance measures in order to manage the Bureau's workload more efficiently. 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

As may be seen from the chart below, the Agency has continued to be diligent in referring to other agencies providers who may be engaging in abusive conduct.

Number of Referrals			
Activity	FY 2005-06	FY 2006-07	FY 2007-08
Referrals to MFCU	225	212	218
Referrals to Others	307	350	317

RECOVERIES OF OVERPAYMENTS – MPI AUDITS

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

Fiscal Year	Overpayments Identified	Collections as of June 30, 2008	
2005-06	$ 25,427,878	$ 17,570,757	69.1%
2006-07	19,973,393	15,083,061	75.5%
2007-08	15,628,918	11,178,108	71.5%
Total	**$ 61,030,189**	**$ 43,831,926**	**71.8%**

The overpayments identified have been restated for FYs 05-06 and 06-07 to reflect only overpayments identified as the result of an MPI audit. These figures do not include claims adjustments and reversals as reported in prior years.

CASES WITH FINDINGS

Disposition of Cases	Fiscal Year		
	2005-06	2006-07	2007-08
Overpayment Identified	1,002	811	791
No Fraud or Abuse Found	199	177	331
Provider Education Letter	27	30	4
Total Cases Closed	1,228	1,018	1,126
Percent with Overpayment	81.6%	79.7%	70.2%

MPI is increasing its efforts to ensure that resources are expended only on investigative leads that have the potential of recovering Medicaid funds.

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 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	2007-08
Cases	652	878	819	736
Average Days	500	452	328	328

RETURN ON INVESTMENT

MPI efforts resulted in identification of $28.9 million in overpayments in FY 2007-08.

MPI Recovery of Overpayments (millions)				
Activity	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08
MPI Audits	$11.6	$16.3	$18.9	$15.6
Reversals	1.5	0.9	0.7	0.5
Claims Adjustments	7.4	10.8	15.0	12.8
Total	**$20.5**	**$28.0**	**$34.6**	**$28.9**

In addition, MPI prevention efforts resulted in cost savings of $21.5 million in overpayments in FY 2007-08, as shown below:

MPI Prevention of Overpayments (millions)						
Activity	FY 2005-06		FY 2006-07		FY 2007-08	
	No.	Amount	No.	Amount	No.	Amount
Prepayment Review	245	$ 5.5	217	$ 4.8	156	$4.2
Termination of Providers	194	13.3	194	13.2	255	5.4
Focused Projects	3	11.4	2	5.0	3	9.8
Denial of Reimbursement for Prescription Drugs	124	5.9	66	0.8	40	0.5
Policy Changes	1	0.9	1	2.4	N/A	N/A
Site Visits	n/a	n/a	253	2.8	229	1.8
Total		**$37.0**		**$29.0**		**$21.5**[1]

During the year, expenditures of $7.5 million were devoted to recovery work resulting in a return on investment for recovery operations of 3.9:1. In addition, MPI achieved $21.5 million in cost avoidance with expenditures of $5 million, producing a return on investment for prevention efforts of 4.3:1. Overall, in FY 2007-08, recoveries and cost avoidance totaled $50.4 million, yielding a return of 4.1:1.

[1] Does not add due to rounding.

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**
FY 2007-08	Recovery	28.9	7.5	3.9:1
	Prevention	21.5	5.0	4.3:1
	Total	**$50.4**	**$12.4**[1]	**4.1:1**

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; the Office of Medicaid Program Oversight; 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 the following:

- 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. MPO also samples claims and eligibility data for trend analysis of programs and services, and uses this information to identify best practices and make recommendations based on findings. Finally, MPO works with MPI to coordinate the review of Medicaid program change

[1] Does not add due to rounding.

recommendations with corresponding units and provides additional monitoring of selected providers' billing patterns. Examples of oversight activities follow below.

PAYMENT ERROR RATE MEASUREMENT PROGRAM (PERM)

The Agency is collaborating with the Centers for Medicare & Medicaid Services (CMS) on the implementation of the Improper Payments Information Act, passed by Congress in 2002 as Public Law 107-300, and authorized under Section 1902(a) (27) of the Social Security Act.

Following on the heels of four pilot programs to test the methodology over a period extending from 2002 through 2005, in federal FY 2008, Florida implemented the CMS-adopted, Payment Error Rate Measurement Program (PERM) methodology as part of the national strategy to identify and reduce the level of error in states' payments, whether from error, fraud, abuse or overutilization.

The Office of Medicaid Program Oversight has published five educational articles in the Agency Provider Bulletin directed at Medicaid providers. The publications are intended to increase provider awareness of the MPO oversight functions and to remind them of the need to cooperate with the state and CMS contractors in the implementation of PERM in Florida.

MPO has also entered into a contract with a private vendor to select monthly samples of enrolled beneficiaries from the universe of Medicaid (Title XIX) and SCHIP, the State's Title XXI Child Health Insurance Program. Samples are selected every month for the twelve months beginning October 2007 and used to determine the level of error in the State's eligibility determination processes. Following the review of each month's sample, an error rate based on the services provided to the sampled beneficiaries during the sample month will be computed for each program. The process will consider both approvals and denials. Florida started the PERM in November 2007 and will complete the PERM eligibility and claims universe submission process in April 2009 although the federal case reviews and payment reviews with state dispute resolution are expected to continue through December 2009.

As part of the PERM program, MPO is also coordinating with CMS-contracted reviewers and statisticians. At the end of each quarter of the federal FY 2008, MPO will submit quarterly claim extracts from its Medicaid and SCHIP claim payments to the CMS-contracted reviewers who will select statistically valid samples for review of payments, records and processes to determine the level of error in Florida's payments.

The preliminary results from the PERM efforts have highlighted the following areas where additional improvement may be realized in the eligibility determination processes:

- Data-sharing and communication between the State's authorized eligibility determination agencies – Florida Department of Children & Families and the Florida Kidcare Corporation (in process)
- More rigorous supporting documentation collection and retention

While it is still very early to identify specific benefits from PERM, one outcome will be the identification of specific sources of improper payments as defined in PERM, and the resulting

development of corrective actions to address the underlying causes of major sources of 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, which included internal subject matter experts and external consultants with experience in the collection and processing of encounter claims data, was formed during FY 2005-06. To comply with the risk adjusted capitation rate requirements for Medicaid Reform, the Medicaid R_x model was selected for risk adjustment and in November 2005, the Agency began collecting pharmacy data from FY 2003-04 onwards from health plans. On a quarterly basis, pharmacy data continues to be collected, validated and utilized for the on-going risk adjustment of capitation rates in the reform counties.

The Agency designed and developed MEDS to capture X12 encounter data, in the Florida Medicaid Management Information System (FMMIS), from all health plans for all Medicaid covered services. The collection and processing of the encounter data began in FY 2006-07 with the initial submissions serving as a HMO readiness assessment and adaptation period. As MEDS matures it 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. MEDS will be used to transition the risk adjustment model to a diagnostic based model for the risk adjustment of capitation payments to health plans. Ultimately, MEDS will be a major component in the actual rate setting process for capitated health plans. 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 participated in acceptance testing of the new Florida Medicaid Management Information System (FMMIS) and Decision Support System (DSS) to help develop, test and refine user defined tools that will facilitate the detection of aberrant trends in service utilization and expenditures.

COORDINATION WITH THE BUREAU OF MEDICAID PROGRAM INTEGRITY

The Office of Medicaid Program Oversight and the Bureau of Medicaid Program Integrity (MPI) continued to share information and observations pertaining to reducing potential fraud, abuse and overpayment.

Beginning in March 2007, MPI 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. Over the past year, MPO has been monitoring ten providers on a monthly basis.

In January 2007, the MPO and MPI established a process for tracking MPI policy change recommendations to Medicaid Handbooks. MPO coordinates and tracks recommended policy changes. MPO has tracked, on a monthly basis, 25 policy recommendations made through this process over the past year.

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. The unit works to develop specific user tools for Medicaid programs that will facilitate the detection of aberrant behaviors in utilization patterns and billing practices.

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 currently 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.

Third Party Liability Recoveries					
	FY 2003-04	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08
Casualty	$22,431,466	$27,252,053	$26,648,342	$18,062,167	$17,681,026
Estate/Trusts	13,673,588	15,922,663	14,836,825	14,068,893	12,756,605
Medicare & Other Third Party Payer	42,134,384	43,790,077	70,807,531	60,410,981	45,006,352

- 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 Cost Avoidance				
FY 2003-04	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08
$1,262,123,941	$1,321,878,989	$1,409,616,013	$1,769,377,975	$1,783,550,123

Recoveries from other special Medicaid projects completed for FY 2007-08 include the following:

- 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 dates of service, one for a newborn and the other for the mother); Outpatient Payment During Inpatient Stay (an outpatient Medicaid payment immediately preceding an inpatient stay) and HMO/Long-Term Care Overpayments (overpayments identified are

capitation payments made for Medicaid recipients who were admitted to long-term care facilities).

Other Recoveries	
Provider Amnesty (Credit Balance)	$1,485,341
Date of Death	$2,299,498
Hospital Audits	$2,205,227
Nursing Home Credit Balance Reviews	$1,298,654
J-Code Rebates	$353,242
Medicare Part B	$2,590,209
Medicaid Overpayments	$6,979,089

BUREAU OF MEDICAID CONTRACT MANAGEMENT

The Bureau of Medicaid Contract Management (MCM) is responsible for monitoring the Agency's contract with EDS, 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 2007 through June 2008, 1,059 site visits were conducted, leading to 957 approvals for enrollment and 102 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. There is a cumulative total of one hundred and eighty-four (184) terminations in the PDCS, thus preventing further expenditures of Medicaid funds as required by federal guidelines.

In June 2008 MCM staff oversaw the transfer of the Medicaid fiscal agent contract from ACS State Healthcare to EDS. This transfer coincided with the launch of the new MMIS. The design, development and implementation of the new MMIS included expanded data elements to capture provider information in greater detail, increased reporting capabilities and automated data sharing with sister agencies and other AHCA bureaus.

Some of these enhancements include:

- Web Portal – Applicants and providers have access to view public Medicaid information such as handbooks, bulletins, fee schedules, and training modules via the public portions of the new Web Portal. The secure portion of the Web Portal allows providers a chance to view demographic information on their provider records and request updates to that information, submit and track claims and verify recipient eligibility including prior authorizations.
- Application Processing – The new MMIS uses a rules based engine to drive processing of provider enrollment applications. This includes the online entry of provider enrollment applications, tracking and automated workflow management of the process and online verification of provider enrollment status.
- Enrollment Status Tracking – The new system has the capability of tracking in greater detail a provider's enrollment status including specific application denial and provider termination reasons. It also provides the ability to suspend an active provider due to disciplinary action until such time as the relevant issues are resolved.
- License Match – Daily files are received from the Department of Health and AHCA's Bureau of Health Quality Assurance containing all professional and facility licenses issued by those two entities. The data is matched against provider records and providers with inactive licenses are terminated by the system. This process is also used to validate licenses for new applicants to Florida Medicaid.
- Geographical Information Systems (GIS) – Helps Medicaid administrators, managers, and client service staff understand such things as quantity, density and proximity of providers to the Medicaid population.
- Address Standardization and Verification – The MMIS uses a product called GeoStan to verify addresses on provider records. This product automatically converts all addresses entered in the system into standard format and verifies that the address is a valid address.

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 to control drug expenditures by implementing the following initiatives related to potential fraud or abuse:

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.

During FY 2007-08, outlier prescribers of drugs in the following therapeutic classes were contacted and advised:

- Gastrointestinal agents
- Polypharmacy
- Asthma disease management
- Short-acting opiates
- Coordination of care for atypical antipsychotics
- Carisoprodol overuse

As a result of the review of prescribing and utilization of carisoprodol (i.e., Soma® a muscle relaxant that is a controlled substance), a new prior authorization requirement and dosage limits were implemented to preclude potential abuse. Annual savings by eliminating inappropriate utilization of carisoprodol is estimated to be more than $1.6 million.

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, Inc. gave secure, wireless access to its publication of Clinical Pharmacology by releasing the drug information industry's first "real time" drug information database, providing 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 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.

In 2007-2008, the secure transfer of electronic prescriptions and interface with Gold Standard's eMPOWERx system continued to offer several benefits, including:

- Prescribing efficiency: It checks for problems such as drug interactions, allergies, duplicate therapies and formulary conflicts without having to reference paper patient files and materials beforehand.
- Patient safety: It eliminates medication errors caused by misread handwritten prescriptions and by medications with similar names or likeness
- Prevention of waste and abuse: It eliminates "doctor shopping" and duplicative therapies.
- Security: It reduces potential for fraud and abuse, such as forgery, that may occur with paper prescriptions.

PHARMACY LOCK-IN PROGRAM

AHCA was given the authority to restrict certain recipients who have shown outlier patterns of prescribed drug utilization to a single pharmacy provider. Initially implemented in FY 2002-03, the number of recipients enrolled in the lock-in program grew to approximately 1,000. Upon implementation of the Medicare Part D drug benefit in January 2006, the majority of recipients in the lock-in program transferred their drug coverage to Medicare. At the end of FY 2006-07, 446 recipients were enrolled in this program. Further refinement of prior authorization requirements and dose limits for Oxycontin eliminated the need for lock-in for some individuals, and by the close of FY 2007-08, 178 individuals were enrolled in the lock-in program.

Savings associated with the lock-in program total approximately $1 million per year. Savings can be attributed to a reduction in the number of prescriptions for drugs with the potential for misuse or abuse, and 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 an active partner with other offices of the Agency in efforts to deter fraud and abuse in the Florida Medicaid program to the greatest extent possible. The office provides legal guidance and recommendations to the Division of Medicaid and to the Office of Inspector General regarding ways in which to curtail and deal with Medicaid fraud and abuse. The advice includes recommendations related to prevention, detection and enforcement.

The fourteen attorneys comprising the Medicaid legal staff provide guidance about improvements to programmatic aspects of Medicaid operations as well as procedural recommendations to improve the likelihood of success should the Agency's actions be challenged in court. The attorneys represent the Agency in Medicaid-related litigation before administrative tribunals, as well as state and federal courts. The attorneys are involved in litigation resulting from record reviews (audits) performed by the Agency or contracted vendors related to the recovery of overpayments from providers, protests related to public procurement activities and challenges to Agency rules. Additionally, litigation can result from actions taken by the Division of Medicaid or MPI related to the provider's enrollment status (termination from

the program), real-time reviews of claims for reimbursement (pre-payment reviews), the withholding of reimbursements upon evidence of fraud, or other complaints by providers, recipients, or advocacy groups.

DIVISION OF HEALTH QUALITY ASSURANCE

HQA REFERRALS TO MEDICAID PROGRAM INTEGRITY AND THE ATTORNEY GENERAL

The Division of Health Quality Assurance is the licensure, regulatory and enforcement entity responsible for more than 34,000 facilities and health services of 37 different types. The Division is also responsible for certification surveys of health care facilities in coordination with the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services. Field office staff members are responsible for complaint investigations in both licensed and certified facilities. The Division often makes referrals to MPI and MFCU in the Attorney General's Office when staff members determine there is the potential to uncover fraudulent or abusive activities. During FY 2007-08, the Division made referrals of complaints and inspection results as noted in the table below:

Provider Type Referred	Number of Referrals to MFCU/MPI
Assisted Living Facilities	3
Health Care Clinics	2
Health Maintenance Organizations	3
Home Health Agencies	7
Homemaker & Companion Services	1
Home Medical Equipment Companies	2
Hospitals	3
Nursing Homes	4
Transitional Living Facilities	1
Total	**23**

LEGISLATIVE INITIATIVES

Division staff assisted the 2008 Legislature with the enactment of HB 7083 (Ch 2008-246, LOF) which addresses fraud and abuse among home health agencies and nurse registries. Some of the changes that are intended to target fraud and abuse include new financial reporting requirements for initial applicants and change of ownership applicants, a prohibition on locating new home health agencies too close to an existing agency from the same organization, restrictions on the number of agencies that an administrator or director of nursing can oversee, increased sanctions for failure to follow the plan of care, increased restrictions on the use of staffing services by home health agencies, limitations on marketing practices and the provision

of free services to other providers such as assisted living facilities, and a variety of increased fines.

COMMUNICATIONS

The Health Care Clinic Unit has active relationships with the National Insurance Crime Bureau, an investigative organization set up by the insurance industry to combat insurance fraud. The Unit has direct lines of communication with the Department of Financial Services, Division of Insurance Fraud and provides them with public records and other information. Weekly interchanges occur with Safeguard Services, a contract provider for CMS which investigates Medicare fraud and abuse. Internally, the Unit works with Medicaid Program Integrity and has liaisons with the Federal Bureau of Investigation, Drug Enforcement Agency, Health and Human Services and the Statewide Prosecutor's Office of the Florida Attorney General. Additionally, calls are received from Special Investigative Units of Florida insurance companies which investigate and deny unlawful claims. On occasion, unit staff serve as witnesses in criminal prosecutions, state and federal, and provide public records that are invaluable to anti-fraud investigators.

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 collection. 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 collects on accounts by direct payments from providers or through withholding of Medicaid or Medicare payments. The bureau investigates problem cases in order to pursue collection or provide the necessary information to an outside collection agency. Agency staff members continue to work aggressively to reduce outstanding receivables in the Medicaid program.

During FY 2007-08, accounts receivable collections, net of adjustments and refunds approached $30.3 million. As of June 30, 2007, Medicaid accounts receivable for fraud and abuse stood at $49.7 million and the balance as of June 30, 2008 was $38.8 million.

For all receivables determined to be uncollectible, AHCA must obtain approval from the Department of Financial Services for write-off. Accounts are generally written off because of one of the following reasons:

- The provider has declared bankruptcy.
- The corporation is out of business.
- The defendant is unable to pay because of incarceration.
- The provider is insolvent or beyond the State's current collection enforcement policy.

Once the receivable is approved for write-off, and has been written off, if deemed qualified, the federal share of each receivable write-off is reclaimed. During FY 2007-08, $5.5 million in receivables were approved for write-off. 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 the Inspector General is continuing to research and develop 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.

The bureau continues 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, indicating which department, bureau or unit has current responsibility for a case. The bureau calculates interest for cases as appropriate, while the system tracks state and 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 and reports for staff follow-up. The MAR system maintains the required accounting data for financial statements 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 continues to emphasize communications with MPI and MFCU to coordinate audit collection efforts. The bureau has also worked with AHCA's Office of General Counsel, Health Quality Assurance 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 and to increase the lien percentages on provider Medicaid/Medicare payments and will continue to strive to achieve repayments as promptly as possible.

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STATUTORY REPORTING REQUIREMENTS

As set forth in 409.913, Florida Statutes, the Agency and MFCU submit the following:

SOURCES OF THE CASES OPENED IN FY 2007-08

Source		AHCA	MFCU
AHCA	Area/District Office Staff	14	
	Medicaid Headquarters Staff	8	
	MPI Generated	1,520	108
	Other		3
Public	Anonymous		17
	Citizens	4	11
	Provider	65	7
	Qui Tam[1]		55
	Recipient	41	4
State Agencies	Department of Children & Families		91
	Agency for Persons with Disabilities		11
	Department of Health	1	2
	Florida Dept. of Law Enforcement		
	Other State Agencies	6	5
Federal Agencies	Health and Human Services	18	2
	Other		
Law Enforcement	Florida MFCU Generated	2	63
	U. S. Attorney's Office		
	Department of Justice		
	DEA		1
	Local Law Enforcement		2
Other:	MFCU (Other than Florida)		1
	Family Member		5
	HMO Investigative Unit		
Employee			2
Long Term Care Ombudsman Council			1
	Total	**1,679**	**391**

[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 reviewed 1094 complaints that resulted in 391 cases being opened. MPI investigated 2,402 cases, which included 1,679 opened during the year.

DISPOSITION OF THE CASES CLOSED

MFCU and MPI closed 1590 investigations. (MFCU closed 464, MPI closed 1,126.) The cases closed are summarized below:

Disposition of Closed Cases		
	MFCU	AHCA
Lack of evidence	126	
Administrative Closure	28	
Administrative Referral	72	
Assistance to Other Agencies	8	
Case Dismissed	7	
Civil Intervention Declined	3	
Civil Judgment	1	
Civil Settlement	23	
Consolidated	16	
Conviction	35	
Defendant Deceased	2	
No Fraud or Abuse Found	0	331
Nolle Prosequi	5	
Not a Medicaid provider	1	
Overpayment Identified		791
Pretrial Intervention	6	
Prosecution declined	7	
Provider Education Letter		4
Resolved with Intervention	4	
Statute of Limitations expired	3	
Unfounded	117	
Total	**464**	**1,126**[1]

[1]For the 1,126 MPI cases closed during FY 2007-08: 331 closed after no findings of fraud and abuse and therefore no further action was taken. 4 of the cases closed after minor findings of non-compliance, but no resulting overpayments; therefore, the provider was issued a provider education letter. 791 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 1,126 cases closed during the fiscal year, 849 preliminary audit reports were sent totaling $32,678,926. A total of 302 cases totaling $1,576,965 were closed after the preliminary report. Based on a review of additional documentation, final audit reports totaling $21,456,858 were sent for the remaining 547 cases.

AMOUNT OF FINAL AGENCY DETERMINATION OF OVERPAYMENTS

A total of 211 cases totaling $1,494,902 were closed after the final audit report. Final orders issued on the remaining 336 cases totaled $12,557,051. 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 156 providers under prepayment review, recommended termination of 59 providers and referred to MFCU 218 providers for investigation and an additional 52 providers for informational purposes. The Agency also fined 155 providers approximately $150,000.

REDUCTIONS IN OVERPAYMENT AMOUNTS NEGOTIATED IN SETTLEMENTS OR BY OTHER MEANS

No overpayments were reduced by negotiation during FY 2007-08.

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 2007-08, AHCA reduced its federal claiming by $19.3 million for net overpayments determined.

AMOUNT OF OVERPAYMENTS RECOVERED

During FY 2007-08, the Agency collected $30.3 million in overpayments. This includes $15.5 million collected from MFCU cases and $14.9 million collected from MPI cases. MFCU recovered and returned to AHCA $36,754,368 in overpayments.

AMOUNT OF INVESTIGATION COSTS RECOVERED

During FY 2007-08, the Agency recovered $72,156 in investigation costs. MFCU recovered $854,459 in investigation 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 RECLAIMED UNCOLLECTIBLE

During FY 2007-08, the Department of Financial Services deemed $5.5 million uncollectible and approved for write-off. The total amount collected after the cases were written off was $99,081.

NUMBER OF PROVIDERS TERMINATED FROM PARTICIPATION IN THE MEDICAID PROGRAM

Provider Type	Total
Physician (MD)	4
H & C Based Services	27
Medical Supplies/Durable Med	6
Pharmacy	3
Home Health Agency	7
Therapist	4
Assistive Care Services	4
Hearing Aid Specialist	2
Podiatrist	1
Dentist	1
Total	**59**

ALL COSTS ASSOCIATED WITH DISCOVERING AND PROSECUTING CASES OF MEDICAID OVERPAYMENTS

MFCU expenditures for FY 2007-08 were $20,489,330, which included indirect costs of $1,833,343. Expenditures for MPI in FY 2007-08 were $8,769,746 which included salaries, expenses, and contractual services. In addition, costs of $1,348,526 were allocated for support from the General Counsel's Office, Office of Inspector General, Bureau of Finance and Accounting and Medicaid Contract Management. Additionally there was an allocation for Agency indirect costs of $1,266,091. Medicaid also incurred expenses for services related to MPI activities of $1,036,332, resulting in total associated MPI costs of $12,420,695.

NUMBER OF PROVIDERS PREVENTED FROM ENROLLING/ RE-ENROLLING IN THE MEDICAID PROGRAM

Eighty-nine applicants were denied enrollment in the Medicaid program and 15 providers were terminated from enrollment based on the results of the background screening check. Eight providers were terminated because they were on the Medicare exclusion list and three previously terminated provider files were flagged as excluded to prevent their re-entry into the program. No applications were denied for exclusion.

RECOMMENDATIONS FOR CHANGES TO PREVENT AND/OR RECOVER OVERPAYMENTS

The Agency for Health Care Administration has made numerous past recommendations for strengthening the Agency's fight against Medicaid fraud and abuse. This year, the Agency is making two recommendations regarding fraud and abuse detection and staffing in MPI.

It is important to note that MPI was established in January 1980 and, as of the end of FY 2007-08, had completed over 50,000 audits and recovered more than $200 million in Medicaid overpayments. Over the past fifteen years, MPI has grown much more slowly than the Medicaid program or the Medicaid Fraud Control Unit, but continues to face growing challenges; the largest of these challenges is the anticipated growth of managed care in Florida.

Counting only recoveries achieved by MPI staff members and not those produced by vendors, the Agency's historical return on investment in MPI has averaged approximately 100 percent, or $2 for every $1 invested in MPI.

Accordingly, in order to greatly enhance overpayment recoveries, two actions are recommended:

1. Expand the Agency's capabilities to detect Medicaid fraud, abuse and overpayments by developing more advanced and sophisticated detection models.
2. Augment MPI staff in order to expand oversight of Medicaid managed care organizations to detect and deter corporate fraud and abuse. Additional staff will be utilized to review financial information, encounter data and other operational data reported by managed care organizations.

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