The State's Efforts to Control Medicaid Fraud and Abuse

FY 2008 - 09

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

December 2009

December 31, 2009

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 2008-2009 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,

Thomas W. Arnold
Secretary

BM/TWA/cls

cc: The Honorable Jeff Atwater
The Honorable JD Alexander
The Honorable Durell Peaden, Jr.
The Honorable Don Gaetz
The Honorable Ronda Storms
The Honorable Larry Cretul
The Honorable David Rivera
The Honorable Denise Grimsley
The Honorable Nick Thompson
The Honorable Ed Homan
The Honorable Tom Anderson
The Honorable Paige Kreegel

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Coordination and Cooperation

Section 409.913, Florida Statutes, requires in part that

> *"...Beginning January 1, 2003, and each year thereafter, the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs shall submit a joint report to the Legislature documenting the effectiveness of the state's efforts to control Medicaid fraud and abuse and to recover Medicaid overpayments during the previous fiscal year. The report must describe the number of cases opened and investigated each year; the sources of the cases opened; the disposition of the cases closed each year; the amount of overpayments alleged in preliminary and final audit letters; the number and amount of fines or penalties imposed; any reductions in overpayment amounts negotiated in settlement agreements or by other means; the amount of final agency determinations of overpayments; the amount deducted from federal claiming as a result of overpayments; the amount of overpayments recovered each year; the amount of cost of investigation recovered each year; the average length of time to collect from the time the case was opened until the overpayment is paid in full; the amount determined as uncollectible and the portion of the uncollectible amount subsequently reclaimed from the Federal Government; the number of providers, by type, that are terminated from participation in the Medicaid program as a result of fraud and abuse; and all costs associated with discovering and prosecuting cases of Medicaid overpayments and making recoveries in such cases. The report must also document actions taken to prevent overpayments and the number of providers prevented from enrolling in or reenrolling in the Medicaid program as a result of documented Medicaid fraud and abuse and must include policy recommendations necessary to prevent or recover overpayments and changes necessary to prevent and detect Medicaid fraud. All policy recommendations in the report must include a detailed fiscal analysis, including, but not limited to, implementation costs, estimated savings to the Medicaid program, and the return on investment. The agency must submit the policy recommendations and fiscal analyses in the report to the appropriate estimating conference, pursuant to s. 216.137, by February 15 of each year. The agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs each must include detailed unit-specific performance standards, benchmarks and metrics in the report, including projected cost savings to the state Medicaid program during the following fiscal year...."*

The Agency for Health Care Administration (Agency) and the Medicaid Fraud Control Unit (MFCU) of the Attorney General's Office have continued their joint efforts to prevent, reduce and mitigate health care fraud, waste and abuse. Staff from the Agency, MFCU and the Department of Health (DOH)

meets regularly to discuss major issues, strategies, joint projects and other matters concerning health care.

Any suspected fraud is referred to MFCU for full investigation and prosecution. The Agency and MFCU continue to refine the referral process and continue to collaborate closely with each other and with DOH, Florida Department of Law Enforcement (FDLE), Department of Children & Families (DCF), and Centers for Medicare & Medicaid Services (CMS) to assure that Medicaid funds are directed to the most vulnerable citizens.

This joint report presents the results of these efforts to control Medicaid fraud and abuse for FY 2008-09.

Medicaid Fraud Control Unit

BACKGROUND AND PERSPECTIVE

The Centers for Medicare and Medicaid Services website provides the following National Health Expenditures information on the Medicaid program: 1) In the United States, Medicaid spending grew to $329 billion in 2007. Medicaid spending was projected to grow 6.9 percent to $352 billion in 2008 and projected to grow on the average of 8.4 percent in 2009 to $386 billion. 2) The Medicaid program provided services nationwide for an average of 50 million people in 2008. 3) Medicaid is the largest source of general revenue spending on health care for both the federal government and the states. It represents 40 percent of federal government general revenue spending on health care and 41 percent of such spending by states.

In FY 2008-09, Florida's Medicaid program's budget was $15.7 billion dollars to provide health care benefits to some of the state's most needy citizens. Florida's program is the fourth largest in the nation, serving approximately 2.6 million people. 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 heath 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, 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 the Medicaid Fraud Control Unit are responsible for protecting Florida's most vulnerable citizens physically, emotionally and financially. They are also responsible for protecting the health care funds earmarked for those citizens' 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), continue to work to meet this challenge.

OVERVIEW OF THE MEDICAID FRAUD CONTROL UNIT

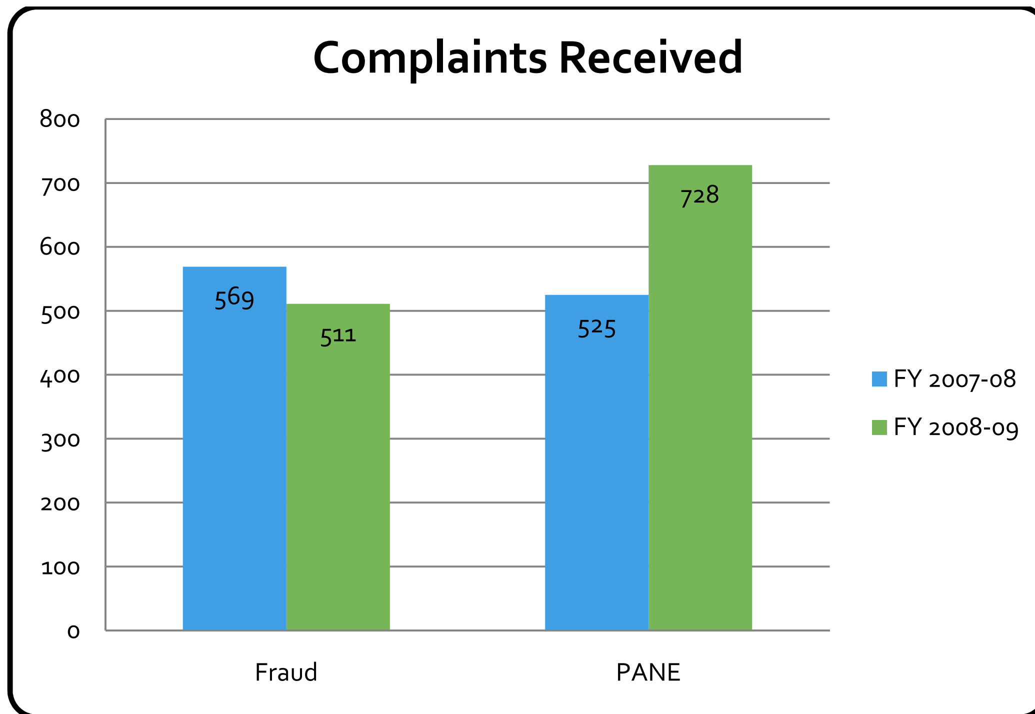
There were 232 full-time employees (FTEs) assigned to the MFCU in FY 2008-09, although the Unit averages a 10 percent vacancy rate throughout the FY 2008-09. One hundred thirty-nine positions are investigators and their supervisors/managers, 26 are attorneys, and the remaining are professional support 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 47 assigned FTEs and has offices in Jacksonville (14 FTEs), Tallahassee (24 FTEs) and Pensacola (nine FTEs). The Central region has 52 assigned FTEs and has offices in Orlando (14 FTEs), Tampa (30 FTEs), St. Petersburg (two FTEs) and Ft. Myers (six FTEs). The South region has 94 assigned FTEs and has offices in Miami (55 FTEs), Ft. Lauderdale (22 FTEs) and West Palm Beach (17 FTEs). Additionally, there are three other entities within MFCU, the Director's office (13 FTEs), Statewide Operations (10 FTEs) and the Complex Civil Enforcement Bureau (16 FTEs).

As mentioned previously, the primary investigative focus of the 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 Offices (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 2008-09, the Unit received a total of 1,239 complaints. For FY 2007-08, the Unit received a total of 1,094 complaints. Of the 1,239 complaints received in FY 2008-09, 372 were opened as operational cases. Of the 1,094 complaints received in FY 2007-08, 391 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 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 are a criminal or civil predicate that warrant 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 1,239 complaints received in FY 2008-09, 511 were related to fraud and 728 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 2008-09, the primary source of Medicaid fraud complaints was citizens; 175 complaints received were made by private citizens. AHCA-Medicaid Program Integrity and MFCU generated the next-highest sources of fraud complaints with 84 each (168) out of the total Medicaid fraud complaints received in FY 2008-09. Other sources of Medicaid fraud complaints included 56 *qui tam* cases, also known as whistleblower claims, and cases generated from other units in AHCA. *Qui tam* cases are civil cases filed under the Florida False Claims Act, which allows the office 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 eighty-five fraud complaints came from citizens. The MFCU received 51 *qui tam* complaints.

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 2008-09, the supervisors and investigators assigned to the PANE squads reviewed 11,553 such reports. Although the vast majority of these reviews do not lead to open investigations, 410 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.

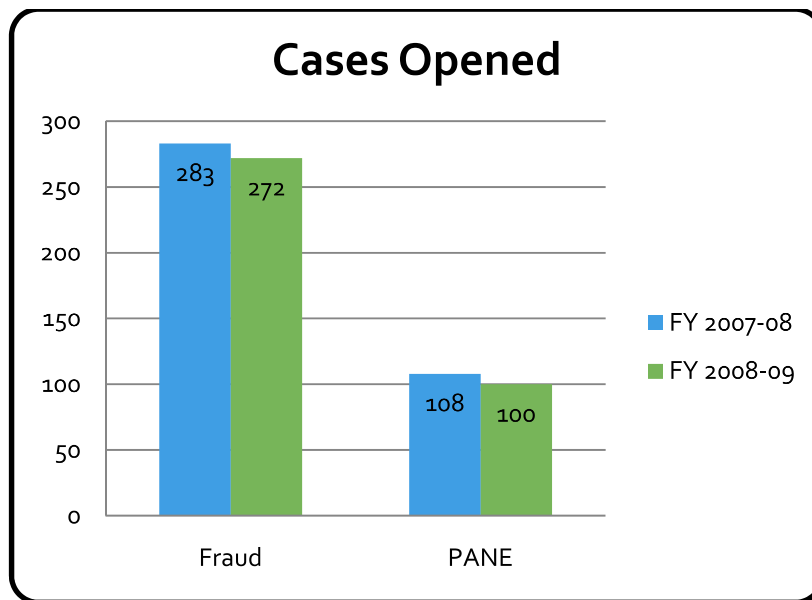
The overwhelming majority of PANE complaints are generated by DCF. In FY 2008-09, of the 728 PANE complaints, 588 came from DCF. The next-highest source of PANE complaints was citizens, which accounted for 50. In FY 2007-08, of the 525 PANE complaints, 453 came from DCF. Citizen complaints accounted for 28 complaints.

CASE INVESTIGATIONS

Complaints are reviewed to determine issues such as MFCU jurisdiction, administrative referral, referral to another agency and 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 of 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. Quarterly 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 2007-08, the MFCU opened 391 total cases. Of those cases, 283 cases were related to Medicaid fraud. The remaining 108 cases were PANE cases. The North Region opened a total of 97 cases. Of those cases, 49 were related to Medicaid fraud and 48 were PANE cases. The Central Region opened a total of 140 cases, of which 110 were related to Medicaid fraud. The remaining 30 case openings were PANE cases. In the South Region, there were a total of 110 cases opened in FY 2007-08. Eighty of the case openings were related to Medicaid fraud and the remaining 30 were PANE cases. The Complex Civil Enforcement Bureau (CCEB) opened 44 *qui tam* litigation cases which are included in the fraud case total.

In FY 2008-09, the MFCU opened a total of 372 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 (1,094 in FY 2007-08 and 1,239 for FY 2008-09) increased by 14 percent. While the MFCU opened fewer cases, these cases resulted in higher quality investigations. In FY 2008-09, the North Region opened a total of 92 cases. Of those cases, 49 were related to Medicaid fraud. The remaining 43 case openings were PANE cases. In the Central Region, there were a total of 111 cases opened. Of these, 77 were related to Medicaid fraud. The remaining 34 were PANE cases. In the South Region, there were a total of 125 cases opened in FY 2008-09. Of these, 102 were related to Medicaid fraud and the remaining 23 cases were PANE cases. The Complex Civil enforcement Bureau (CCEB) opened 44 *qui tam* litigation cases which are included in the fraud case total.



The following is a list of the top five Medicaid Provider types for FY 2007-08 and the specified period of FY 2008-09, ranked most to least frequent:

FY 2007-08	**FY 2008-09**
Home & Community-Based Service	Home & Community-Based Service
Pharmaceutical Manufacturer	Pharmaceutical Manufacturer
Therapist	Physician (MD)
Nursing Home	General Hospital
Home Health Agency	Therapist

For both years, Home & Community-Based Service was the predominant provider type for Medicaid fraud investigations, while Nursing Home and Home and Community Based Service were the predominant types for PANE case openings.

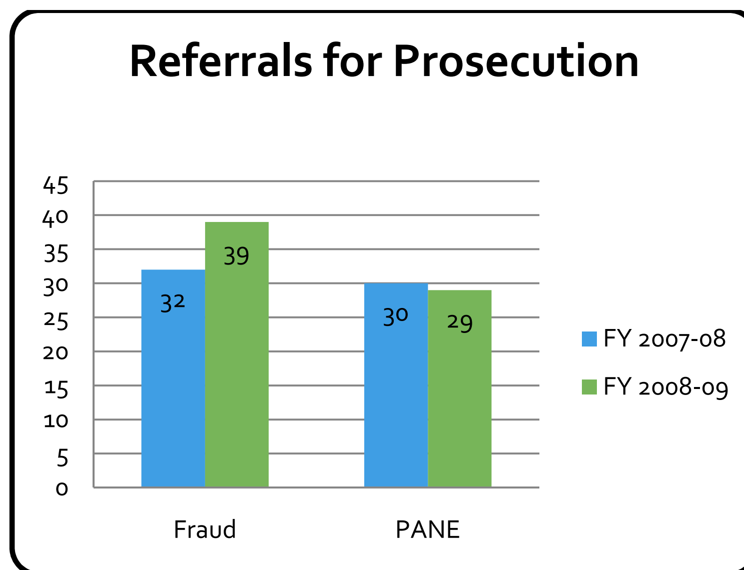
DISPOSITION OF CASES

Following an investigation, a determination is made whether to pursue criminal prosecution or file civil actions. All case investigations will eventually be formally closed because of either a successful prosecution or a 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 calendar 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 calendar year, whether the case is pursued civilly or criminally.

In FY 2007-08, the MFCU closed 464 cases. Of those, 289 involved Medicaid fraud investigations and 175 involved PANE cases. In FY 2008-09, the MFCU closed 464 cases. Of those, 343 involved Medicaid fraud investigations and 121 involved PANE cases.

Enforcement actions are a paramount consideration for the 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 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 Central Region accounted for 23 of these referrals for prosecution, the North Region accounted for 22 prosecution referrals and the South Region accounted for 17 prosecution referrals.

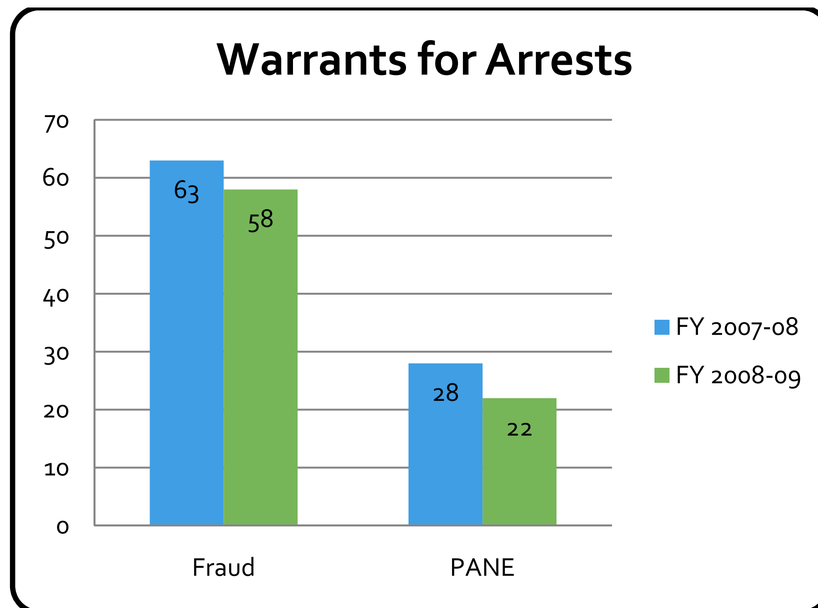
For FY 2008-09, 68 cases were referred for prosecution. Thirty-nine of these cases were based upon Medicaid fraud investigations and the other 29 were based upon PANE investigations. The South Region accounted for 34 of these referrals for prosecution, the Central Region accounted for 18 prosecution referrals and the North Region accounted for 16 prosecution referrals.



In FY 2007-08, there were 91 arrests/warrants made based upon MFCU criminal investigations. Sixty-three of these arrests/warrants were related to Medicaid fraud investigations and 28 were for PANE investigations. The South Region accounted for 44 of these arrests/warrants, which were predominantly for Medicaid fraud. The Central Region accounted for 20 arrest/warrants and the North Region accounted for 27 arrests warrants in FY 2007-08.

For FY 2008-09, there were 80 arrests/warrants made. Fifty-eight of these were Medicaid fraud investigations and 22 were for PANE investigations. The South Region accounted for 50 of the

arrests/warrants. The North Region accounted for 15 arrests/warrants and the Central Region accounted for 15 arrests/warrants.



INVESTIGATIVE STRATEGY

As mentioned in the introduction to this report, the MFCU has two primary areas of enforcement responsibility: fraud perpetrated against the Medicaid Program and Patient Abuse, Neglect and Exploitation. 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.

MFCU's formal investigative strategy requires 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 issues 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.

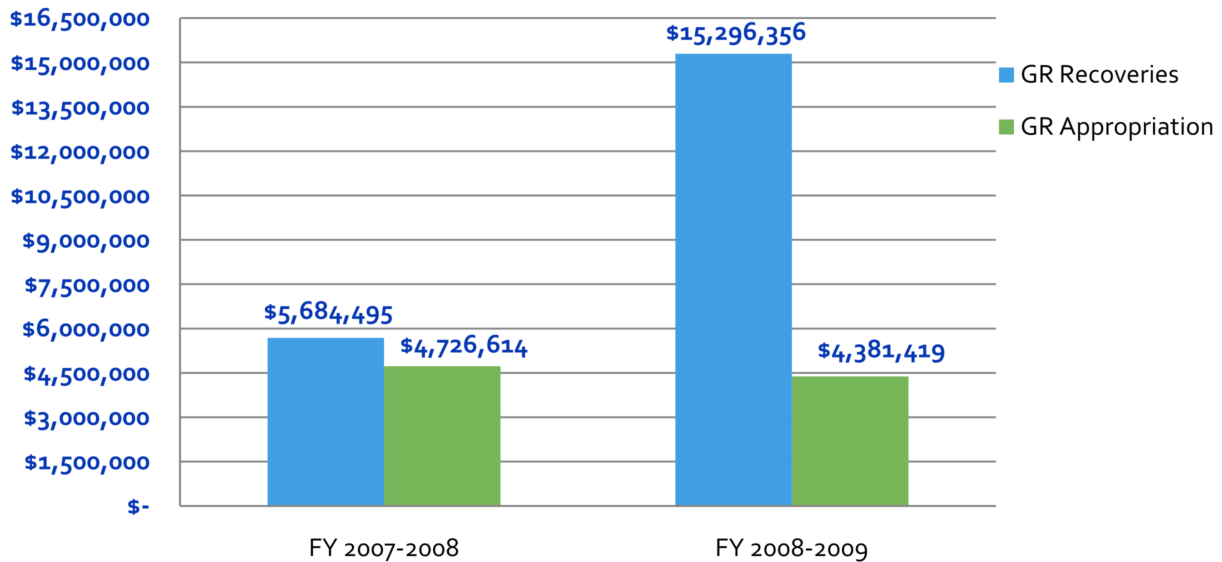
- Community Outreach – Training and education programs will be provided to citizen groups, provider groups and law enforcement groups. The purpose of such outreach will be to encourage referrals/reports of Medicaid fraud, supplement the MFCU's enforcement efforts through use of local law enforcement, educate citizens 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 state Department of Health, the Agency for Persons with Disabilities, state and federal prosecutors and the criminal justice community in order to promote better sharing of 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

The Medicaid Fraud Control Unit'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 2008-09, the MFCU budget was as follows:

Federal Financial Participation	$14,436,235.
Florida General Revenue	$ 4,381,419.
TOTAL	$18,817,654.

Due to the critical general revenue shortfalls in FY 2007-08 and in FY 2008-09, the Medicaid Fraud Control Unit's general revenue budget reduction was approximately $418,000 which resulted in an additional loss of $1.672 million in federal funds to the State of Florida. The loss of funding for the MFCU comes, at a time when the Unit has improved efficiency and brought in $15.3 million dollars in FY 2008-09 in collections to the state's General Revenue Fund.



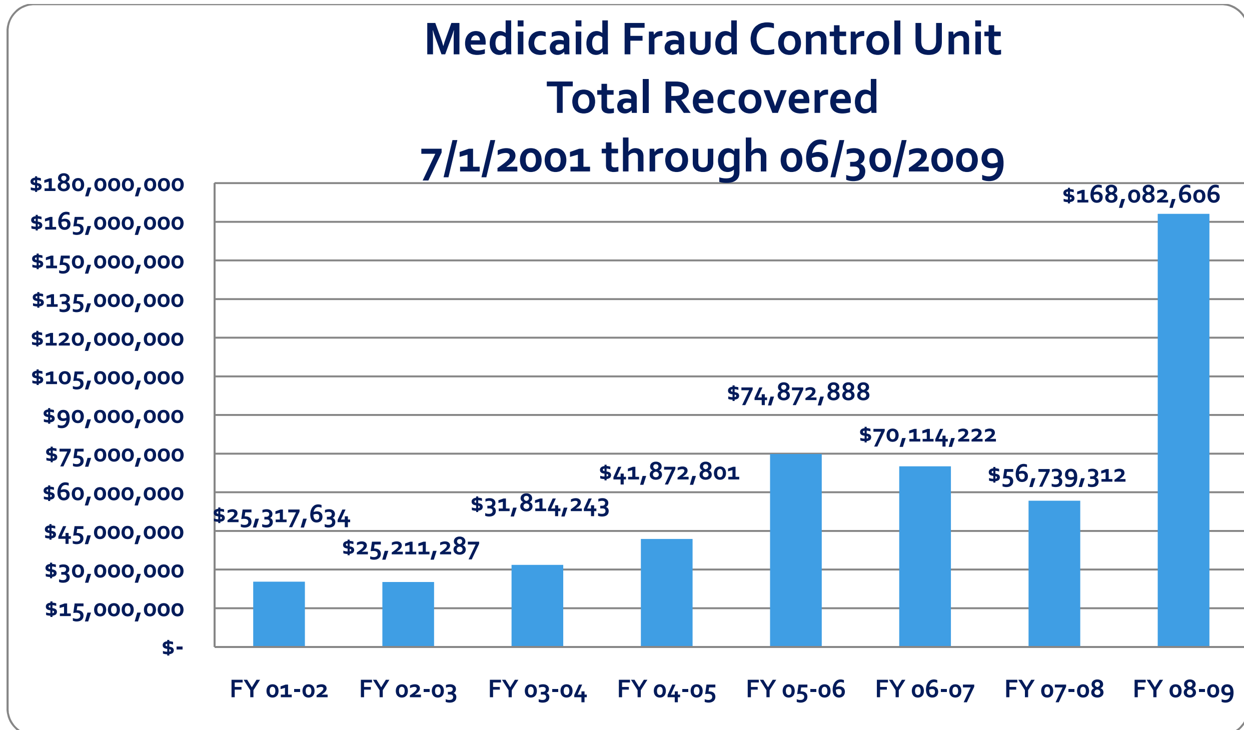
In the previous chart, for FY 2007-2008, for every General Revenue dollar appropriated, the MFCU returned approximately $1.20 back to General Revenue. For FY 2008-2009, for every General Revenue dollar appropriated, the MFCU returned approximately $3.49 back to General Revenue.

TOTAL RECOVERIES

The MFCU continued to increase its leadership role in a variety of multi-state false claims investigations. The Complex Civil Enforcement Bureau (CCEB) and MFCU's Central Region Offices were instrumental in the increased presence Florida had in multi-state Medicaid fraud investigations. The pharmaceutical industry was the subject of many of those investigations which often arose from *qui tam* filings pursuant to the Florida False Claims Act. Several of the investigations resulted in multi-million dollar settlements for Florida. In fact, total monetary recoveries in the Fiscal Year 2008-09 were more than double the recoveries in the previous year.

MFCU recovers funds in both civil and criminal cases. The MFCU is responsible for enforcement of criminal case dispositions, which may include restitution, fines, investigative costs and forfeitures. The MFCU is also responsible for enforcement of the Florida False Claims Act.

In addition to its role in multi-state investigations, the CCEB is actively litigating false claims cases against nine major pharmaceutical manufacturers in Leon County, Florida. The MFCU has determined that the defendant drug manufacturers artificially inflated the prices of their drugs in a scheme that has cost the Florida Medicaid Program millions of dollars. This litigation is expected to result in additional recoveries for the State of Florida.



In FY 2008-09, the total amount for *civil* recoveries, which include civil settlements arising from *qui tam* cases brought under Florida's False Claims Act, was $119,355,470.58.

In FY 2008-09, the total amount for *criminal* recoveries based upon Medicaid fraud cases was $48,727,135.18.

The total amount of the monies recovered by the MFCU for FY 2008-09 was $168,082,605.76. It should be noted that during this fiscal year the Attorney General's Office Medicaid Fraud Control Unit's recoveries added $15,296,356.38 to the State of Florida's General Revenue Fund.

Office of Statewide Intelligence – AHCA Medicaid Program Integrity

The following information includes all initiatives generated through the Medicaid Fraud Control Unit's Statewide Intelligence Unit and the Agency for Health Care Administration's Medicaid Program Integrity Unit. These initiatives were implemented during FY 2008-09.

Initiative #: SIU 2008-06-08:

Name of Initiative: Podiatry
Provider Type: Podiatrists (27)

- Total # of Referrals Accepted by MFCU: 1
- Total # opened as case: 1
- Total # closed as complaint: 0
- Total # closed case(s): 0

Details of referrals by the MFCU office:

- Ft. Lauderdale received the referral from this initiative in 2008 and after the complaint review requested a case number. This case is still an active investigation

Initiative #: SIU 2009-01-10:

Name of Initiative: Diabetes Home Care
Provider Type: Home Health Agency (65)

- Total # of Referrals Accepted by MFCU: 3
- Total # opened as case: 2
- Total # closed in as complaint: 1
- Total # closed case(s): 0

Details of referrals by MFCU office:

- Ft. Lauderdale received all referrals for this initiative in 2009 and requested case numbers for two cases which are still active. The third was closed as a complaint.

Initiative #: SIU 2009-02-11:

Name of Initiative: Diagnostic Testing
Provider Type: Physician (25)

- Total # of Referrals Accepted by MFCU: 7

- Total # opened as case: 7
- Total # closed in as complaint: 0
- Total # closed case(s): 0

Details of referrals (by MFCU office):

- Miami received all seven referrals from this initiative in 2009 and requested a case number for all seven, which are all still active cases.

Initiative #: SIU 2008-06-08:

Name of Initiative: Home Health
Provider Type: Home Health (65)

- Total # of Referrals Accepted by MFCU: 6
- Total # opened as case: 6
- Total # closed in as complaint: 0
- Total # closed case(s): 0

Details of referrals by MFCU office:

- Miami received six referrals from this initiative in 2008 and 2009 and requested a case number for all six, which are still active cases.

Initiative #: SIU 2008-04-06:

Name of Initiative: Psychiatry Time Bandit
Provider Type: Mental Health Provider (7)

- Total # of Referrals Accepted by MFCU: 7
- Total # opened as case: 2
- Total # closed in as complaint: 5
- Total # closed case(s): 2

Details of referrals by MFCU office:

- Ft. Lauderdale: One referral sent 11/12/08 and closed in complaint status
- Jacksonville: One referral sent 11/12/08 and closed in complaint status
- Orlando: One referral sent 10/16/08 and closed in complaint status
- Miami: One referral sent 10/16/08 and closed in complaint status
- Tampa: One referral sent 10/16/08 and a case number was requested
- West Palm Beach: One referral sent on 10/16/08 and closed in complaint status and one referral sent on 11/12/08 and a case number was requested.

TRAINING

The MFCU continued training specific to the investigation of Medicaid fraud and patient abuse or exploitation. Previously, the 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 FY 2008-09, the MFCU provided in-house training opportunities that the Unit could provide for its members at minimal costs. This training included the following:

- Two 40-hour Medicaid Fraud Investigation Academies were developed and offered at the Pat Thomas Law Enforcement Academy on August 11-15, 2008, and on January 5-9, 2009. The academies were attended by new investigators, attorneys, auditors and analysts, and covered a wide range of subjects related to Medicaid fraud and patient abuse. Over 40 students attended each session. By hosting this statewide training at the Pat Thomas Law Enforcement Academy, substantial cost savings were realized.
- Two 16-hour Report Writing Classes were attended by investigators, analysts, auditors and some members of the management team. The class was offered at facilities free of charge in the Northern Region at Pat Thomas Law Enforcement Academy on May 27-28, 2009, and in the Southern Region in Miami on June 10-11, 2009. The Central Region training was held in the next fiscal year.
- In-house training on Performance Management and Employee Motivation was presented in the Central Region of the state by the Chief of Law Enforcement on March 10, 2009, and on April 21, 2009. This training was attended by all Law Enforcement Lieutenants as first line supervisors.
- A MFCU analyst attended the National Association of Medicaid Fraud Control Units (NAMFCU) Data Analyst Training Program meetings as an instructor for the NAMFCU Global Case Analyst Subcommittee. The Ohio MFCU hosted the training which was attended by 33 MFCU analysts from around the United States and the Global Case Committee faculty. The focus of this training was on the global case process which included initiation, data collection, manipulation and analysis, extrapolations, allocations, settlement and distribution.
- In order to address issues pertaining to all MFCU analysts and case related issues, the Chief of Law Enforcement provided in-house training in the Central Region. Additionally, analysts continue to attend training conducted by the fiscal agent and AHCA on the Florida MMIS and DSS Claims Database.

Due to budgetary constraints, full advantage was taken of training offered locally at no cost by various entities, such as, the U. S. Department of Justice, the U. S. Attorney's Office, Area Agencies on Aging, the Office of the Attorney General's Florida Crime Prevention Training Institute, the Florida Regional Community Policing Institute, other state agencies, and local law enforcement academies. The training

focused on state and federal approaches to fraud, schemes and other financial crimes; victims with disabilities, pharmaceutical drug investigations, elder care and working with victims of elder abuse.

SIGNIFICANT CASE HIGHLIGHTS

Managed Care – WellCare Health Plans, Inc.

An Information and a Deferred Prosecution Agreement were filed on May 5, 2009, in the United States District Court for the Middle District of Florida, Tampa Division, concerning WellCare Health Plans, Inc. ("WELLCARE"). The Information charged WELLCARE with engaging, through its executives and employees, in a scheme to defraud the Florida Medicaid program and the Florida Healthy Kids Corporation ("Healthy Kids" or "FHKC") program of approximately $40,000,000.

On October 24, 2007, more than 200 Special Agents and Investigators from the FBI, the Office of the Inspector General of the United States Department of Health and Human Services ("HHIS/OIG"), and the State of Florida Medicaid Fraud Control Unit, Office of the Attorney General ("MFCU"), raided the WELLCARE office at 8735 Henderson Road in Tampa, Florida.

The investigation of WELLCARE focused upon allegations that WELLCARE, through its executives and employees, falsely and fraudulently inflated expenditure information that it submitted to the Florida Medicaid and Health Kids program from mid-2002 through 2006. The Information specifically charges that WELLCARE submitted fraudulently inflated expenditure information to the Florida Medicaid Program.

WELLCARE received money from the Florida health care programs each year under an "80/20" or "85/15" contractual arrangement: WELLCARE could retain either 20 percent or 15 percent of the contractual proceeds it received from AHCA and FHKC for overhead (depending on the contract), but it could only spend the remaining 80 percent or 85 percent of proceeds to provide health care services. If WELLCARE did not spend the 80 percent or 85 percent on services pursuant to these contracts, it had to return at least a portion of the unspent money to the Florida health care programs.

The Information alleged that WELLCARE engaged in several fraudulent strategies to avoid returning unspent money to the Florida health care programs. Primarily, WELLCARE established a wholly-owned entity, "Harmony Behavioral Health, Inc." ("Harmony"), to which it funneled a portion of the 80/20 and 85/15 money it received from its contracts with AHCA and FHKC. WELLCARE, however, fraudulently reported money that went to Harmony as expenditures on services. Thus, regardless of how much money WELLCARE actually expended for health care services during each year, WELLCARE fraudulently avoided refunding the Florida health care programs for money it had given to Harmony.

This joint federal and state investigation is continuing.

Pharmaceutical Company - Eli Lilly & Company

Florida entered into an agreement in principal for $35.6 million as part of a $738.4 million global settlement with Eli Lilly & Co., Inc. The settlement – which addresses four separate cases – resolves allegations the company illegally marketed untested and unapproved off-label uses of Zyprexa, including treatment of children and treatment of the elderly for dementia and depression. The total monetary recovery, including a $615 million criminal fine assessed by the United States Attorney, totaled $1.415 billion, the largest recovery in a health care fraud investigation to date.

In 2001, Eli Lilly began an aggressive marketing campaign called "Viva Zyprexa!" As part of that campaign, the company allegedly marketed Zyprexa for a number of off-label uses. While a physician is allowed to prescribe drugs for off-label uses, the law prohibits pharmaceutical manufacturers from marketing their products for such uses. As an "atypical antipsychotic," Zyprexa has been associated with an especially high risk of weight gain, hyperglycemia and diabetes.

Off-label uses include any uses for which the drug has not received approval from the U.S. Food and Drug Administration.

Eli Lilly caused off-label uses to be improperly billed to the states' Medicaid programs for reimbursement claims. Additionally, the United States Attorney for the Eastern District of Pennsylvania also charged Eli Lilly with a misdemeanor violation of the Food, Drug and Cosmetic Act for which Eli Lilly was criminally fined $615 million. Florida's civil case was handled by the Attorney General's Medicaid Fraud Control Unit.

The State of Florida received $6.9 million in Medicaid restitution, $6.9 million in penalties and $69,000 in interest for General Revenue.

In addition to the monetary recovery, Eli Lilly entered into a corporate integrity agreement with the United States Department of Health and Human Services' Inspector General. The agreement included provisions to ensure Eli Lilly will market, sell and promote its products in accordance with all federal health care program requirements.

Pharmaceutical Company- Bristol-Myers Squibb/Apothecon, Inc.

Florida received a total of $21.5 million as part of a global settlement with Bristol-Myers Squibb Company and its former wholly-owned subsidiary, Apothecon, Inc. The global settlement total, which included Medicaid amounts for all of the participating states, was $389 million plus interest. The settlement resolved allegations of illegal drug marketing and pricing of prescription medications. Florida's participation in the suit was handled by the Attorney General's Medicaid Fraud Control Unit.

The settlement addressed allegations including inflated prices for various prescription drugs, thus affecting the reimbursement amounts paid by Medicaid and various federal health care programs;

kickbacks allegedly provided to physicians, health care providers, and pharmacies to induce them to purchase Bristol-Myers Squibb and Apothecon products, promotion of the prescription Abilify, an antipsychotic drug, for uses which the U.S. Food and Drug Administration has not approved and misrepresentations of sales prices for Serzone, an antidepressant, which resulted in fewer rebates paid to the state Medicaid programs.

Florida received $8.1 million from its share of the settlement, of which $3.9 was returned to the Florida Medicaid program and $4.1 million was returned to the state's general revenue. The remaining $13.3 million was sent to the federal Medicaid program for the state. As part of the settlement, Bristol-Myers Squibb entered into a corporate integrity agreement with the Office of Inspector General of the U.S. Department of Health and Human Services, under which the company will be required to report accurately its average sales prices and average manufacturers' prices in the future.

A team from the National Association of Medicaid Fraud Control Units participated in the investigation and represented the states' interests in the settlement negotiations. Florida's role was negotiated by the Medicaid Fraud Control Unit's Tampa Bureau and the Complex Civil Enforcement Bureau. This settlement also resolved a number of state and federally-filed whistleblower lawsuits, known as *qui tam* lawsuits. A total of 44 states, the District of Columbia and the federal government participated in this settlement.

Pharmaceutical Company - Cephalon

Florida received a total of $8.5 million as part of a $375 million global Medicaid settlement with Cephalon, Inc., an international biopharmaceutical company. The settlement resolved allegations of improper marketing for three prescription drugs, Provigil, Gabitril and Actiq.

The settlement reimbursed the federal government and the participating states for excessive amounts paid by the Medicaid program alleged to have resulted from Cephalon's off-label marketing campaign. While a physician is allowed to prescribe drugs for off-label uses, the law prohibits pharmaceutical manufacturers from marketing their products for off-label uses, therefore claims to the Medicaid programs as a result of the off-label marketing are impermissible.

Provigil is a drug used for improving wakefulness in patients with excessive sleepiness. Gabitril is an anti-epilepsy drug. Actiq is intended to be used only in the care of cancer patients to treat pain.

Cephalon has also entered into a Corporate Integrity Agreement (CIA) with the Department of Health and Human Services, Office of the Inspector General, requiring strict scrutiny of its future marketing and sales practices. In addition to the civil investigation and settlement, the U.S. Attorney for the Eastern District of Pennsylvania filed criminal charges against the company, alleging a misdemeanor violation of the Food, Drug and Cosmetic Act. In a plea agreement with the United States, Cephalon has agreed to pay $50 million to resolve the charges.

The settlement resolved a number of state and federally-filed whistleblower lawsuits, known as *qui tam* lawsuits. All 50 states and the District of Columbia signed the settlement agreement.

Pharmacy Technicians-Ariel Sanchez and Pablo Mercade

Two Miami men were taken into custody on December 23, 2008, on charges of Medicaid fraud. Ariel Sanchez and Pablo Mercade used their positions as pharmacy technicians at local Walgreens stores to fraudulently bill the Florida Medicaid Program nearly $3,000 for prescription medications that were neither needed nor provided to patients for whom they were prescribed. Sanchez and Mercade were taken into custody by law enforcement with the Attorney General's Medicaid Fraud Control Unit and Miami-Dade warrant officers.

Acting on information received from Walgreens, the Medicaid Fraud Control Unit began investigating Sanchez, 30, and Mercade, 25. Investigators believed the two used their positions at the pharmacy to create phony refills for valuable and frequently abused medications, including Zanax, Vicodin and testosterone injections. After creating the refills, they billed the Medicaid program for reimbursement and sold the drugs for profit on the black market. Audits and interviews of multiple recipients, doctors and family members corroborated that certain prescriptions were neither prescribed to nor received by certain Walgreens patients.

Sanchez and Mercade were assigned to a Pre-Trial Intervention Program by the court, and were each ordered to perform 100 hours of community service.

Arrest for Neglect of Elderly Victim – Linda Shaw

On December 10, 2008, Linda Shaw, a Bradenton caregiver, was arrested and charged with neglecting a 47-year old disabled victim under the woman's care. Shaw, 48, worked at Personal Care II, an assisted living facility in Bradenton and was assigned to care for the victim and 15 other facility residents. The investigation revealed that, during the overnight shift one night in July, Shaw left the facility for personal reasons and did not return, even though she was the lone care giver on duty. The victim suffered a heat stroke and was found having seizures. The victim's roommate called 911 and the victim was taken to the hospital by EMS, where she arrived in critical condition. Upon learning of the allegations, the facility terminated Shaw's employment.

Shaw has been charged with one count of neglect of a disabled adult, a third-degree felony. If convicted, she faces up to five years in prison and a $5,000 fine. The case is being prosecuted by the State Attorney's Office for the 12th Judicial Circuit.

Certified Nursing Assistant – Karlene Brown

On December 5, 2008, Karlene Brown was arrested on charges she abused an elderly nursing home resident under her care. Brown, 39, was employed as a Certified Nursing Assistant by Bay Pointe Terrace, an assisted living facility in Broward County.

The arrest resulted from an investigation by the Attorney General's Medicaid Fraud Control Unit's Patient Abuse, Neglect and Exploitation (PANE) team, acting on information received from the Department of Children and Families. According to investigators, Brown became angered at an 88-year-old resident who suffers from dementia. She grabbed the resident by the collar and forcefully dragged the elderly woman into the woman's room. The events were captured by a video recorder in the resident's room.

Brown was adjudicated guilty on one count of abuse of a disabled adult and sentenced to three years probation. Under Florida law, she is also prohibited from working in the health care field.

Durable Medical Equipment Company-Fernando and Ileana Fonts

A South Florida husband and wife were convicted on November 20, 2008, on charges of organized fraud for falsely billing the Florida Medicaid program. Fernando and Ileana Fonts, the owners and operators of Free Line Medical Equipment, Inc., were arrested on July 6, 2007, by investigators with the Attorney General's Medicaid Fraud Control Unit.

The investigation of the couple's company began after the MFCU received information from the Agency for Health Care Administration. The Hialeah-based business was licensed as a retailer of durable medical equipment such as oxygen concentrators and nebulizers for treating patients with severe breathing problems. The Fonts delivered faulty equipment or never delivered the equipment, but billed the Medicaid program for fully functional equipment ostensibly delivered to Medicaid recipients. The false billing continued for approximately 20 months.

Fernando Fonts was adjudicated guilty on one count of grand theft and organized scheme to defraud, both first-degree felonies. He was sentenced to 10 years probation and 500 hours of community service. Additionally, he was ordered to pay restitution in the amount of $148,760.50 to the Agency for Health Care Administration, $5,000 for the cost of prosecution and $38,772.66 for investigative costs.

Ileana Fonts was assigned to a Pre-Trial Intervention program by the court. The couple was prosecuted by the State Attorney's Office for the 11th Judicial Circuit.

Pharmacist – Viko O. Osagie, owner, Viko Drug Store

A former Miami pharmacist was sentenced in Miami-Dade County for defrauding the Florida Medicaid program out of over $1.7 million. Victor O. Osagie, owner of Viko Drug Store in Miami, was convicted

by a Miami jury in May 2009 of fraudulently billing the Medicaid program for prescription drugs never purchased or delivered to Medicaid recipients. During the trial, an audit was introduced in evidence relating to the purchases, inventory and sales of prescription drugs at Viko Drug Store. The audit and the investigation revealed Osagie was paying recipients to let him keep their prescribed medications, but was billing the Medicaid program for refills that were neither authorized nor delivered to the recipients.

Osagie, 53, was sentenced on June 24, 2009, on one count of grand theft, a first-degree felony and one count of Medicaid fraud, a third-degree felony. He received a total of 10 years in prison which will run concurrently with a drug trafficking sentence he is currently serving. Osagie was also ordered to pay restitution in the amount of $1.7 million.

Adult Family Care Home - Paula Jo McAlexander

Paula Jo McAlexander, 57, a former owner and operator of an adult family care home in Milton, was taken into custody in May 2008 based on allegations that she forged fire safety inspection reports to operate her facility. Knowing that the Agency for Health Care Administration largely based her license renewal on the annual fire inspection reports, McAlexander forged the inspection reports. The facility was immediately shut down by AHCA because of the direct threat to the health, safety and welfare of the residents. On May 15, 2009, McAlexander pled no contest to Medicaid fraud, wire fraud, two counts of forgery and five counts of uttering a forged instrument, all third degree felonies. She was sentenced to two years of house arrest and eight years of probation, and ordered to pay restitution to the Medicaid program, costs of investigation, fines and court costs.

Adult Day Treatment Program - Mark Harris

On June 5, 2009, Pensacola resident, Mark Stephen Harris pleaded guilty to several felony charges stemming from sexually abusing three mentally disabled women under his supervision. Harris, 31, used his position as a direct care worker at an adult day treatment program to sexually abuse his victims, ages 24-36. Harris pled guilty to three counts of lewd or lascivious battery of an elderly or disabled person, and two counts of lewd or lascivious exhibition in the presence of an elderly or disabled person. Harris was adjudicated guilty on all counts and sentenced to 12 years in prison, three years of probation, and was ordered to pay court costs and fines. Additionally, Harris was sentenced as a sexual offender and will be required to complete a sex offender treatment program.

Speech Pathologist - Oliver Workman

Oliver Workman, a speech pathologist in Jacksonville, surrendered to law enforcement on June 6, 2009, after learning the MFCU issued a warrant for his arrest. Workman, 59, fraudulently billed the Medicaid program for over $262,000 from 2003 to 2007. According to information from parents of recipients, Workman repeatedly billed the Medicaid program for their children's speech therapy, but never

performed the services. Workman is charged with Medicaid fraud, a third-degree felony, and grand theft over one hundred thousand dollars, a first-degree felony. If convicted, he faces up to 35 years in prison and a $15,000 fine.

Pharmacy – Rolando and Mercedes Fraga, former owners, Excellent Care Pharmacy, Inc.

The former owners of a Hialeah pharmacy were arrested on February 19, 2009, for defrauding the Florida Medicaid program out of more than $1.6 million. Rolando Fraga and his wife, Mercedes Fraga, were arrested by law enforcement officers with Attorney General's Medicaid Fraud Control Unit. The two formerly owned and operated Excellent Care Pharmacy, Inc. in Hialeah.

The Medicaid Fraud Control Unit began investigating Rolando Fraga, 64, and Mercedes Fraga, 49, after the two were arrested in 2005 by federal authorities for selling diverted pharmaceuticals which were paid for by the New York Medicaid program. That federal investigation led to a detailed examination of their billing activity through Excellent Care to the Florida Medicaid program. The Medicaid Fraud Control Unit's investigation revealed the Fragas allegedly used Excellent Care to fraudulently bill the Medicaid program for prescription medications that were never dispensed from August 2003 to January 2006.

The Fragas were found guilty of one count of organized fraud and one count of grand theft. They were sentenced to 10 years in prison and ordered to pay restitution to AHCA in the amount of $275,000. The case was prosecuted by the Medicaid Fraud Control Unit through the State Attorney's Office for the 11th Judicial Circuit.

Physician - Urmundalavaru Mallikarjuna

A Walton County doctor, Urmundalavaru Mallikarjuna pled no contest on March 5, 2009, to Medicaid fraud charges and must pay $100,000 in restitution to the Medicaid program. Mallikarjuna, a pediatrician, was investigated by the Attorney General's Medicaid Fraud Control Unit.

Mallikarjuna, 53, was arrested July 2008 after an investigation determined he was double billing the Medicaid program for services provided to child Medicaid recipients. Mallikarjuna also billed the Medicaid program on several occasions for office visits with patients although records indicated that visits were actually brief telephone conversations with parents of Medicaid patients.

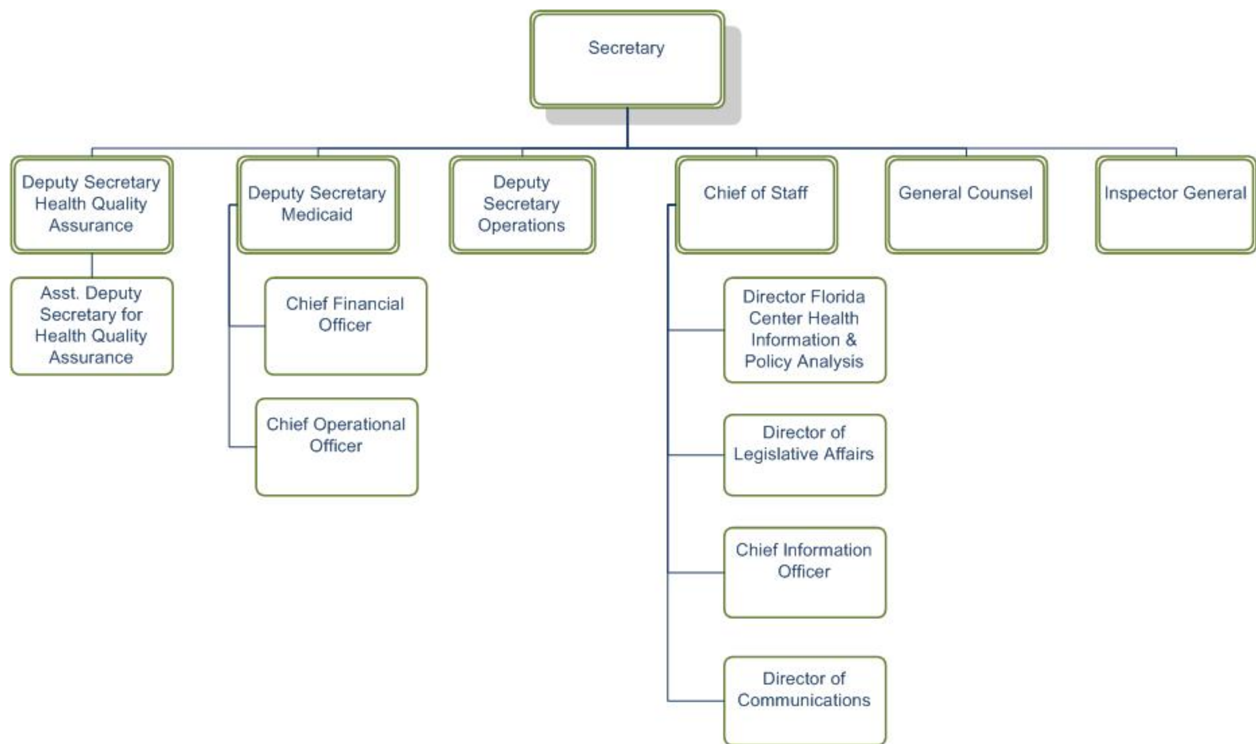
Mallikarjuna was adjudicated guilty for organized scheme to defraud and wire fraud. He was sentenced to five years probation during which time he will be required to make full restitution to the Medicaid program for the entire amount he defrauded from the program. Mallikarjuna will also compensate the Attorney General's Office for the full cost of the investigation and will pay all court costs and fines.

The case has been turned over to the Florida Department of Health for review on whether the Department will terminate Mallikarjuna's medical license.

Agency for Health Care Administration

The Agency for Health Care Administration (AHCA) is committed to "Better Health Care for all Floridians." AHCA was statutorily created within Chapter 20, Florida Statutes, as the chief health policy and planning entity for the state. AHCA is primarily responsible for administering Florida's $17.5 billion (FY 2009-10 budget) Medicaid program that serves over 2.5 million Floridians, the licensure and regulation of the state's 37,000 health care facilities and the sharing of health care data through the Florida Center for Health Information and Policy Analysis.

AHCA ORGANIZATION



Organizational Chart of the AHCA Management Team

FIGHTING MEDICAID FRAUD

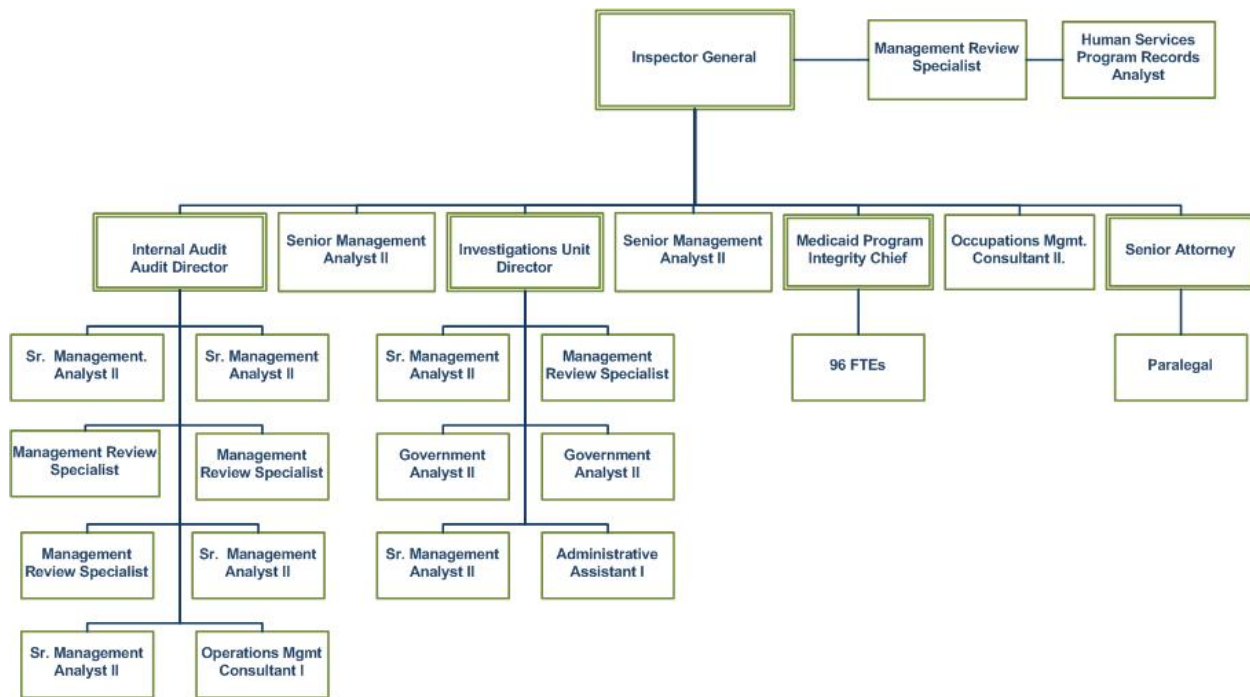
Protecting taxpayers from fraud and abuse in the Medicaid system is a team effort involving the entire agency. Over the last year, the Bureau of Medicaid Program Integrity (MPI) improved and strengthened external partnerships with the Attorney General's Medicaid Fraud Control Unit, Centers for Medicare and Medicaid Services, the Department of Health and the Agency for Persons with

Disabilities in the fight against Medicaid fraud. Bi-monthly inter-agency meetings are held to coordinate action against fraud. During FY 2008-09, Medicaid Program Integrity referred 123 cases to the Attorney General's Medicaid Fraud Control Unit for criminal prosecution, 163 cases to the Department of Health for disciplinary review of providers and 90 providers for termination from the Medicaid program.

In order to ensure that taxpayers' dollars are being used efficiently, AHCA continuously looks for cost prevention avenues and seeks the recovery of overpayments to Medicaid providers throughout the state. AHCA has developed an agency-wide mapping system (shown on page 29) used to identify how every unit of the Agency can help prevent, detect or recoup fraud and abuse overpayments in the Medicaid system. This year, Medicaid Program Integrity made significant gains in cost avoidance and overpayment recoupment efforts. MPI conducted multiple field office operations involving coordinated interviews of providers, prescribers and recipients. These field office operations produced both the recoupment of overpayments and recommendations for policy enhancements, as well as an enhanced deterrence effect.

Office of the Inspector General

The Office of the Inspector General is comprised of the Bureau of Medicaid Program Integrity (MPI), the Bureau of Internal Audit (IA) and the Investigations Unit (IU). The IU and the IA complement the efforts of MPI to prevent, detect and recoup Medicaid fraud and abuse overpayments.



Organizational Chart for the Office of the Inspector General

BUREAU OF INTERNAL AUDIT

The purpose of the Bureau of Internal Audit (IA) is to provide independent, objective assurance and consulting services designed to add value and improve the AHCA's operations. The IA's mission is to assist the Secretary in ensuring better health care for all Floridians by bringing a systematic, objective approach to evaluating and improving the effectiveness of risk management, control and governance processes. Below are examples of audits completed in FY 2008-09 that served to help prevent, detect or recoup Medicaid fraud and abuse overpayments.

08-06 Enhanced Benefits

The Enhanced Benefits program, a component of Medicaid Reform, is designed as an incentive program to promote and reward participation in healthy behaviors. The audit disclosed that, in general, management and system controls were effective in safeguarding program funds. In addition, program transactions were generally processed by the Enhanced Benefits Information System (EBIS) and the Prescription Drug Claims System in accordance with program policies and procedures. However, there were some controls and activities within the program that could be improved. Specifically:

- AHCA has not developed a process to identify individuals who lose their Medicaid eligibility and restrict them from accessing their Enhanced Benefits account if their income exceeds 200 percent of the Federal Poverty Level, and
- EBIS edits have not caught questionable drug transactions submitted for healthy behavior credit by the health plans.

A potential fraud risk associated with the use of the Enhanced Benefits universal form was noted. This form is used to report healthy behavior activities not associated with paid claims. One example is participation in smoking cessation or alcohol and drug treatment programs. AHCA policy does not require health plans to verify the beneficiaries' participation in the program with the provider or sponsor of the activity since this would impose an additional administrative burden for the health plans. Currently, there is minimal fraud risk due to low or no participation in healthy behavior activities that require the submission of the universal form. However, the potential for fraud will grow as the activities reported on the universal form increase unless AHCA requires the health plans to verify beneficiary participation with the provider or sponsor of the activity.

The Division of Medicaid responded that a review of systematic means to identify and restrict access to those beneficiaries who exceed the Federal Poverty Level will be undertaken. Medicaid is also exploring opportunities to add new front end edits to address this concern, during the renewal of the contract for FY 2010-11. The edits will be designed to capture duplicate drug transactions that have different quantities. Currently, Medicaid has requested that the health plans be more diligent in checking their maintenance drug submissions. Medicaid reports that although very few credits are earned via the universal form, AHCA will explore methods for health plans to verify beneficiary participation in programs prior to providing a credit.

08-19 Medicaid Drug Rebate Process

The purpose of this audit was to determine if AHCA and its contracted providers have sufficient internal controls in place to govern the Medicaid drug rebate process. The scope of the audit included rebates invoiced and payments collected through the Medicaid drug rebate process during the period of January 1, 2006 through December 31, 2007. The following objectives were established for this audit:

- Ensure compliance with federal regulations and AHCA policies and procedures,
- Determine if AHCA is adequately monitoring the performance of the providers for compliance with contract terms, and
- Determine if AHCA is successfully collecting rebate monies from pharmaceutical manufacturers.

The audit revealed that, in general, AHCA and its contracted providers have sufficient internal controls. Unisys was found to be committed to the tracking and successful collection of Medicaid drug rebates and to identifying improvements to the rebate process. However, there were some controls and

activities within the drug rebate process that could be improved in order to strengthen effectiveness and efficiency. Numerous J-Code (physician administered) claims were not invoiced for rebate, and claims were approved without the required national drug code (NDC). The audit also revealed that a lack of written procedures surrounding the drug rebate process within the Bureau of Pharmacy Services. Deficiencies were noted in the management and monitoring of contracts.

In order to address these deficiencies, it was recommended that the Bureau of Pharmacy Services continue to work collaboratively with Unisys and the Bureau of Medicaid Program Integrity to develop methods for ensuring maximum rebate invoicing and collection, and that AHCA enforce the requirement for the NDC to be included on all claims and work cooperatively with the fiscal agent to ensure the appropriate edits are in place in FMMIS. It was further recommended that the Bureau of Pharmacy Services develop formal written procedures, to include procedures to ensure coordination between the contract manager and liaisons, and the promotion of more effective management and monitoring of the contracts.

Medicaid responded that an advanced planning document was approved by CMS to implement a "J-code crosswalk" that includes validation of NDC numbers on claims for physician administered drugs. This programming enhancement is in the queue for EDS, the fiscal agent, to implement. Once the enhancement is completed, EDS will be able to create the necessary edits to require NDC numbers on all claims for physician administered drugs. The Bureau of Pharmacy Services worked with Unisys Corp. to create a formal written protocol regarding pharmacy rebate operations which addressed the above recommendations.

In addition to the two engagements discussed above, IA worked with the Bureau of Medicaid Quality Management to perform an extensive review of AHCA's fraud and abuse prevention activities. This analysis allowed AHCA to identify the business units and processes that are currently in place to prevent, detect and recoup fraud and abuse. Communication and coordination of these efforts are illustrated in the diagram below. By identifying the efforts currently in place to combat Medicaid fraud and abuse, the Agency can ensure that coordination of these efforts is enhanced and that taxpayer dollars are spent on legitimate services. Preventing, detecting and recovering fraudulent payments will ensure that more Medicaid funds are available to provide health care services to needy Floridians.

DIAGRAM OF AHCA'S FRAUD PREVENTION, DETECTION AND RECOUPMENT ACTIVITIES

Medicaid

OIG

HQA

General Counsel's Office

Finance & Accounting

Recoupment

Processes designed to recoup the funds and/or resources spent as a result of an identified fraud and/or abuse.

Examples include:

- Voids & reconciliation (1-3)
- Sanctioning (4-5)
- Litigation support (6-7)
- Collections (8)

1 - Area Office – Provider Voids/ Reversals

2 - MCM – Claims Reconciliation

3 – Provider Self-Audits (about 70 last year)

4 - Medicaid Director's Office – Sanctioning

5 - MPI – Sanctioning

6 - General Counsel's Office – Mediation after PAL

7 - General Counsel's Office – Hearings/Final Orders

8 - Finance & Accounting – Collections, Sanctioning

Prevention

Any action or process to avoid fraud and/or abuse prior to the payment being made.

Examples include:

- Background screening (1-6)
- Provider Education (7-8)
- Policies and Handbooks (9-11)
- Claim edits and reviews (12-15)
- Oversight & Controls (16-18)

1 - HQA – Facility Licensure

2 – BMHC/Field Operations – Pre Enrollment Site Visit Coordination

3 - MCM – Provider Enrollment

4 - Medicaid Director's Office – Pre-Enrollment Site visit

5 - Director's Office Provider Enroll. Rvw Post Termination

6 - HSD MedPass Credentialing

7 - MCM – Provider Alerts & Banners

8 - Areas/Director's Office – Provider Ed (Billing/Policy), Monitoring

9 - HSD – Managed Care Org Contracts

10 - MS/Pharmacy – Policy/Handbooks/ PDL

11 - MPI – Policy Review

12 - MS/ Pharmacy – PRO and PAs

13 - MCM - FMMIS – Edits

14 – MS/Areas – Medical Review of claims

15 - MPI – Pre Payment Review

16 - Area Office – Utilization Reviews - First Health

17 - IA – Auditing of Prevention Controls

18 - MQM – Prevention recommendation tracking

Detection

Any action or process to detect or investigate the possibility of fraud and/or abuse after the particular instance of abuse has occurred.

Examples include:

- Site visits & audits (1-8)
- Data mining and detection (9-12)
- Investigations & case management (13-15)

1 - BMHC – Post Enrollment Site visit Coordination

2 - HSD – MediPass Audits

3 – HQA Facility Regulation Site Visits

4 - MPA - Nursing Home CPA Audits

5 - MPI – Self-Audit Tracking

6 – MQM - QPS Team – MCO Performance Measurement

7 - PERM Audit

8 - MPI – EOMB Reviews

9 – MQM – Program Oversight

10 - MPI – Data Detection – in-house reports/ analysis

11 - APS – Contracted Data Detection consulting

12 - TPL Vendor – Data detection

13 - MPI – Intake/ Field Discovery

14 - IG Investigations

15 - MPI - Case Management

Investigations Function

The OIG Investigations Unit (IU) has the primary responsibility of initiating, conducting and coordinating investigations that are designed to detect, deter, prevent and eradicate fraud, waste, mismanagement, misconduct and other abuses within AHCA. Often, IU staff initiates and investigates Medicaid fraud and abuse cases in support of the Bureau of Medicaid Program Integrity, maximizing the number of personnel under the direction of the Inspector General that are focused on Medicaid fraud and abuse.

The Investigations Unit's fraud and abuse efforts during FY 2008-09 included assisting the Bureau of Medicaid Program Integrity with field initiatives requiring in-person interviews and onsite review of professional records. The IU also generated cases from data analysis and citizen complaints.

During FY 2008-09, the IU developed and spearheaded four field initiatives involving 58 providers. A total of 144 in-person interviews were conducted with providers, recipients and witnesses. The unit made 55 referrals to other licensing oversight authorities within AHCA as well as to the Department of Health, Florida Department of Law Enforcement and to the Office of the Attorney General. Thirty-three of these referrals were to MFCU for potential criminal prosecution or civil action.

Examples of In-Field Initiatives

Diagnostic and Radiological Test Project

The IU led an initiative that reviewed 99 selected non-invasive procedure codes with a total Medicaid reimbursement of $24,159,979 during a 12 month period for all diagnostic and radiological provider specialties and all recipient ages. Miami-Dade County providers accounted for the highest billing in Florida with a reimbursed total of $7,956,987. The Diagnostic and Radiological test project conducted in Miami-Dade County in January 2009, included a review to identify waste, fraud and abuse in Radiological and Diagnostic Procedures. Fifty Medicaid providers were selected for visits in 32 separate locations. Five teams of two AHCA OIG/MPI members plus DOH and MFCU members visited the provider locations. The initiative resulted in 14 referrals to MFCU, 22 to DOH and 23 to MPI for comprehensive audits. Additionally, eight referrals to other agencies were made for administrative review. As a result of this initiative there are pending plea agreements that include criminal convictions, restitution and the surrendering of a physician's medical license as well as other ongoing criminal investigations.

DME (oxygen and oxygen-related equipment) Bay County

Two Bay County Durable Medical Equipment (DME) providers and ten recipient records from each provider were selected and reviewed. Collectively, the two DME's billed Medicaid $105,698 for oxygen

concentrators and related equipment from January 2008 through February 2009. Bay County was the eighth highest billing county for oxygen concentrators in Florida. Each recipient was interviewed to verify the provider billing records and to inspect the medical equipment. Agency for Persons with Disabilities (APD) staff assisted with visits to recipients who receive Medicaid waiver services. This effort yielded one provider with numerous documented violations that closed after the onsite visit. The other provider was found to be in compliance with Medicaid policy. A recommendation for a comprehensive audit was forwarded to MPI.

DME (oxygen and oxygen-related equipment) Escambia County

Medicaid billing for oxygen concentrators by DME's in Escambia County from January 2007 through April 2009 was analyzed and the two top billing providers were selected for review. These two providers collectively billed Medicaid $245,614 for the review period. Fifteen recipients for each provider were selected and the billing records were compared with the recipient interviews and site visits. One provider was determined to be in compliance with Medicaid policy. The second provider was found to be in violation of numerous Medicaid policies and the findings were forwarded to MFCU. This same provider was also a provider in Alabama and the IU findings were forwarded to the Alabama Medicaid Agency Investigations Unit for their review. The final disposition of this investigation is still pending.

At the conclusion of field initiatives, OIG staff used the findings to determine ways to strengthen Medicaid policy. As a result of the Escambia and Bay County initiatives, numerous recommendations for policy enhancement were made to AHCA Medicaid Services related to oxygen and oxygen related equipment, including:

- Reducing the excessive Medicaid reimbursement rate for oxygen concentrators,
- Requiring a Medicaid recipient or legal guardian's signature and date on the quarterly home visit documentation,
- Requiring oxygen usage meter hours to be recorded at the time of the quarterly home visits for the oxygen concentrator,
- Requiring DME providers to attach a sticker on top of the oxygen concentrator machine in the recipients' residences at the time of each quarterly visit recording the visit date, DME provider staff person who completed the visit, oxygen output and the oxygen meter (hours) reading,
- Prohibiting DME providers from billing and receiving Medicaid reimbursement for oxygen concentrators when the provider is not able to document in-person, home visits as required by Medicaid policy,
- Requiring DME providers to provide the latest available oxygen concentrator models (older machines consume more energy and burden Medicaid recipients with higher electric bills, therefore promoting non-compliance), and
- Requiring physician's orders to justify medical necessity when specifically prescribing portable oxygen devices.

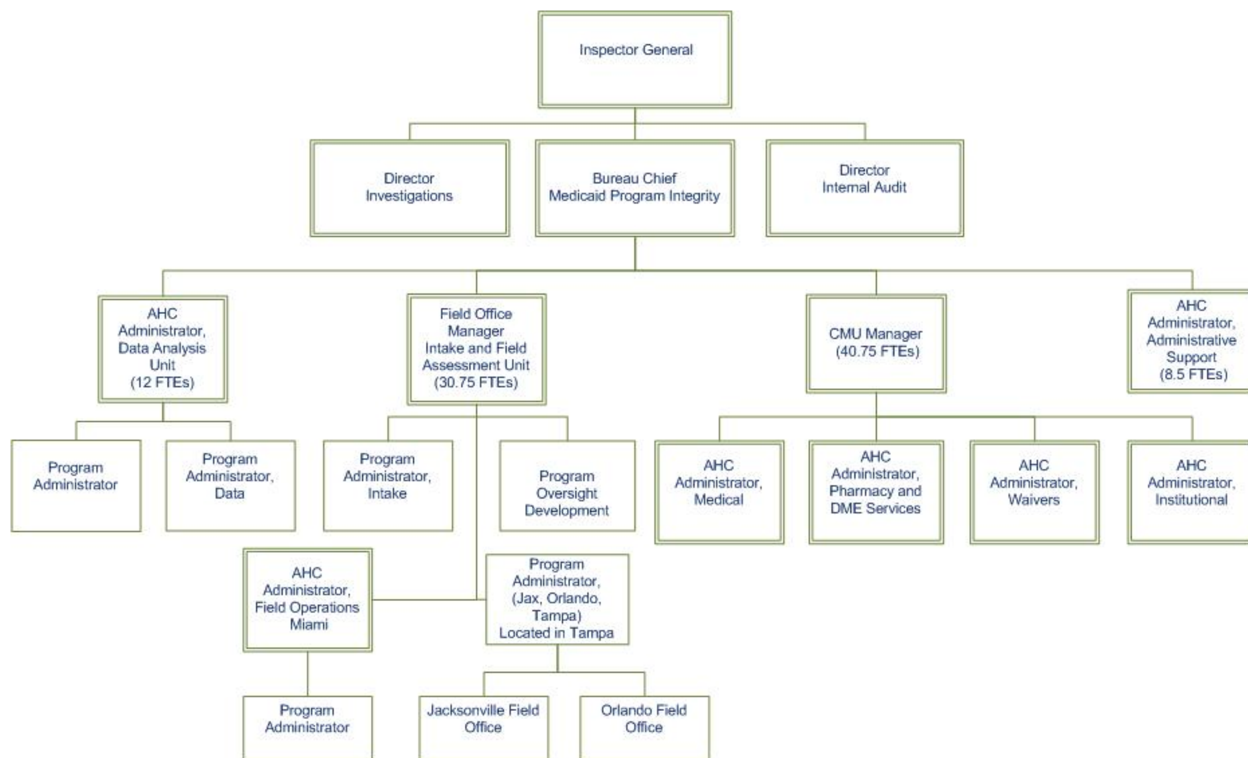
Medicaid responded to these recommendations by meeting with the staff members of the Office of the Inspector General. Medicaid Services is currently in the process of updating and promulgating the DME handbook incorporating many of the above recommendations. Additionally, Medicaid will form an internal workgroup for the specific purpose of enhancing oxygen-related policy and will include staff from the OIG.

BUREAU OF MEDICAID PROGRAM INTEGRITY

The Agency for Health Care Administration's Bureau of Medicaid Program Integrity (MPI) reports to the Inspector General. Under Section 409.913, Florida Statutes, MPI is responsible for overseeing the activities of Medicaid recipients, and Medicaid providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible and for recovering overpayments and imposing sanctions as appropriate. This is accomplished through detection analyses, fraud and abuse prevention activities, audits and investigations, imposition of sanctions and referrals to the Medicaid Fraud Control Unit (MFCU) of the Office of the Attorney General, to the Department of Health or to other regulatory and investigative agencies.

MPI consists of approximately 100 full time employees charged with detecting, deterring and recouping funds paid out erroneously due to fraudulent and abusive claims submitted to the Medicaid Program. MPI collaborates with other state and federal agencies including MFCU, the Department of Health (DOH), the Department of Children & Families (DCF), the Agency for Persons with Disabilities (APD), the Florida Department of Law Enforcement (FDLE) and the Centers for Medicare & Medicaid Services (CMS).

Medicaid Program Integrity Organization



Organizational Chart for the Bureau of Medicaid Program Integrity

In addition to the Administrative Support Unit, MPI is organized into the following major units:

Intake and Field Assessment Unit

The Intake and Field Assessment Unit is responsible for all incoming referrals including the toll-free Medicaid fraud hotline, complaints and Explanation of Medicaid Benefits (EOMBs). The members of this section perform an initial review of each referral to validate the information and determine the course of action required. EOMBs are mailed quarterly to hundreds of thousands of Medicaid recipients listing the services provided the previous quarter and asking the recipients to report any discrepancies. Intake staff follows up on each discrepancy. Complaints received over the telephone or via the Internet may or may not be Medicaid fraud or abuse related. Non-MPI issues are forwarded to the appropriate agency for action. Information regarding possible fraud or abuse is evaluated and if substantiated, is referred to the appropriate MPI unit or to MFCU for further investigation.

Field offices are staffed in Jacksonville with two investigators, Orlando with two investigators and Tampa with one Administrator and two investigators. The 13 staff members assigned to the Miami office includes nurses, investigators and an administrator. This presence in the community is vital to MPI's efforts in combating fraud, waste and abuse in the Medicaid program. Field office staff is

responsible for conducting comprehensive onsite visits and for performing recipient interviews to ascertain if services were rendered and appropriate.

The Jacksonville, Tampa and Orlando field offices accounted for 46% of total prepayment reviews (PPR) completed by MPI in FY 2008-09 (PPRs take 90-120 days to complete), and denied $895,794 in claims, an average of $8,613 per PPR. They opened 477 investigative files resulting in referrals, terminations and sanctions and participated in four major field initiatives in Tampa, Jacksonville and Miami.

The Miami field office denied $4.3 million in claims, an average of $147,000 per PPR. They opened 374 investigative files and coordinated four major field initiatives in Miami.

The field initiatives focused on "full chain" interviews of recipients, providers and prescribers and often included collaboration with state and federal partners such as the Department of Health (DOH), the Agency for Persons with Disabilities (APD), MFCU and CMS as well as other bureaus within AHCA such as the Division of Health Quality Assurance (HQA) and the Division of Medicaid (Medicaid). Field office staff acts as liaisons with Medicaid Area Offices, local governments and law enforcement entities and participates in regularly scheduled meetings with federal, state and local health care regulators with the goal of improving interagency communication and promoting the sharing of information.

Additionally, field office staff participates in Operation Spot-check visits throughout the state, which are managed by MFCU. These unannounced visits are made to nursing homes, assisted living facilities and Agency for Persons with Disabilities licensed group homes. MPI's role in these visits is to review the billing and documentation of these facilities to ensure that Medicaid policies and procedures are being followed. If more action is needed, MPI staff pursues necessary remedies, including prepayment reviews, records requests and referrals.

Data Analysis Unit

The Data Analysis Unit contains the Data Detection Unit and the Special Projects, Research and Development and Coordination Unit (RDU). The Data Analysis Unit searches for potential fraud and abuse in the Medicaid program. The members of this unit are responsible for developing generalized analyses (GAs) and provide programming support for other MPI units. A Generalized Analysis is normally a discovery that a code has been consistently billed or paid erroneously due to either a mistake in Medicaid policy interpretation or a programming error in FMMIS. These overpayments, once discovered, are run as an overpayment on a specific billing code and letters are sent to providers to recoup the overpayment. This unit also facilitates provider self audits and coordinates Medicaid policy clarification requests.

Data Detection staff is responsible for reviewing detection reports and analyzing claims data. They develop leads for the case management units and work closely with Medicare partners to identify fraud and abuse issues related to claims paid by both entities. They work with MFCU on data-mining

projects. Data detection efforts are geared to detect violations through several detection methods. On the basis of apparent violations, investigations are conducted to determine whether overpayments exist. Recoveries of any overpayments are initiated or referrals to outside agencies are recommended. The Data Detection Unit utilizes various tools, resources and reports, which are discussed in the Detection section of this report, in an effort to identify Medicaid fraud and abuse activities.

The RDU staff reviews previously successful GAs for possible reproduction or expansion. The unit staff meets regularly to discuss leads from the CMUs and data analysis. They use handbooks to analyze policy and identify possible policy violations that can be addressed in a GA process. The RDU staff develops requests for GA programming and monitors the development of programming and report development. They also provide programming support to MPI and produce Generalized Analysis reports using Business Objects and Microsoft Access for data analysis and reporting. The RDU guides providers in performing self-audits for inappropriate payments due to a misunderstanding of a policy and billing the Medicaid system in error. The RDU also develops and refers self audits to the CMUs for execution. The RDU is responsible for contacting the Medicaid Division for clarification regarding various Medicaid policies.

Case Management Units

Case Management Units (CMUs) are the heart of MPI's recovery efforts in performing comprehensive audits and generalized analyses. Statistical methodology is used in the generation of a random sample of provider claims. CMU investigators review provider documentation that supports the claims and determine whether there has been an overpayment. If an overpayment is determined for the sampled claims, the findings are extended to the population of claims for the time period under review. The statistical methodology for determining the total overpayment utilizes a 95 percent confidence level and has been affirmed in all administrative hearings involving inferential statistics. CMU investigators also conduct claim-by-claim reviews and compare quantities of goods purchased to quantities of goods billed. They perform prepayment reviews, make policy or edit recommendations and assist with the litigation process. The CMUs are organized by the types of provider each investigates.

- Institutional Unit - Conducts audits of institutional providers such as hospitals, nursing facilities, health maintenance organizations and ambulatory surgical centers.
- Medical Unit - Conducts audits of non-institutional types of providers such as physicians, independent laboratories, advanced registered nurse practitioners, and county health departments.
- Pharmacy/Durable Medical Equipment Unit - Conducts audits of non-institutional providers such as pharmacies and durable medical equipment providers.
- Waiver Unit - Conducts audits related to the Home and Community-Based Waiver Program and of providers such as dentists, audiologists, podiatrists and chiropractors.

The CMU also serves as MPI's point of contact for the Federal Audit Program. The Deficit Reduction Act of 2005 (DRA) was signed into law in February 2006. Section 6034 (42 U.S.C. ss. 1396u-6) created the federal Medicaid Integrity Program. This created the first national program for combating Medicaid provider fraud and abuse. CMS created the Medicaid Integrity Group (MIG) to carry out the program. The program is intended to support the Medicaid program integrity efforts of the states. CMS has established contracts with private audit firms referred to as Medicaid Integrity Contractors (MICs) to carry out the program. The three primary MIC functions are:

- The "review MIC" analyzes Medicaid claims data to determine whether provider fraud, waste, or abuse has occurred or may have occurred,
- The "audit MIC" audits provider claims and identifies overpayments, and
- The "education MIC" provides education to providers and others on payment integrity and quality-of-care issues.

Florida participated as one of four states in the Federal Audit Pilot Program that resulted in six audits being completed by the audit MIC. As the program continues, 18 Florida Medicaid providers are currently being audited by the CMS audit MIC.

FY 2008-09 Challenges

Four principal factors influenced MPI operations during FY 2008-09:

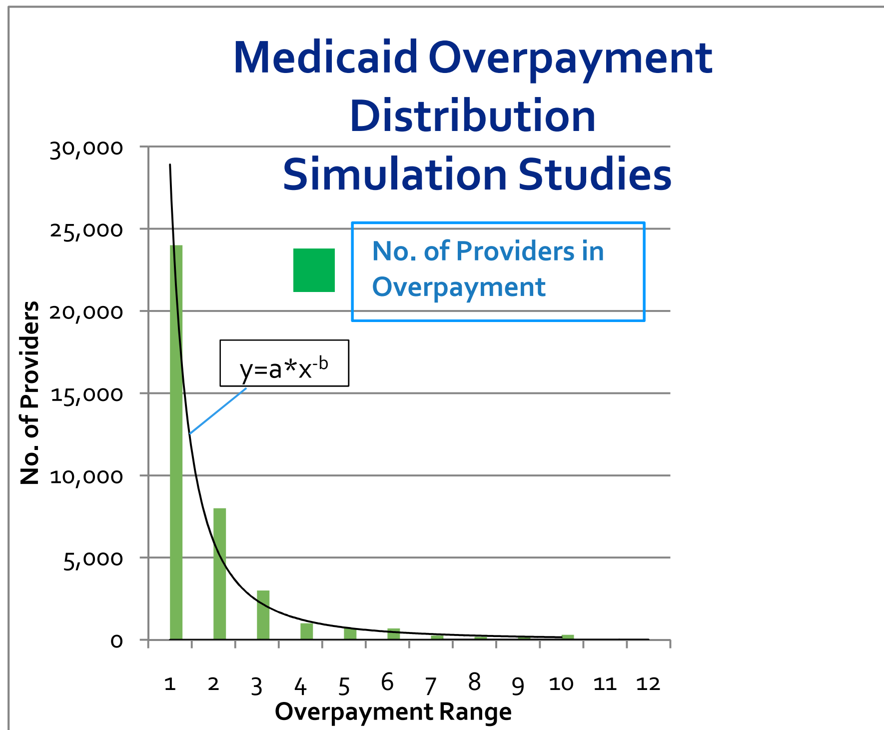
1. MPI continued to be influenced by the transition to the new Florida Medicaid Management Information System and Decision Support System (FMMIS/DSS) that began in FY 2007-08. MPI was necessarily and extensively involved in the testing and fine tuning of the systems, since they are critical to the fraud and abuse detection and investigation activities of the bureau.
2. AHCA's contract with the vendor engaged by the Third Party Liability Unit ended during FY 2007-08 and transitioned to another vendor through a competitive bidding process. This resulted in litigation challenging the selection. The interruption of this important service affected MPI's efforts to detect abusive claims and to effect recoveries of overpayments.
3. MPI continues to actively assist CMS in the development of provider audit protocols for the Federal Audit Program. MPI has been actively involved by conducting detection work to identify prospective providers for audit, vetting CMS nominated providers for audit and sharing information about Florida's extensive provider audit capabilities. CMS audit protocol requires MPI to review draft audit reports submitted by the audit MIC and to produce the Final Audit Report (FAR) that is sent to the provider. AHCA is then responsible for managing the administration or litigation of cases to closure.
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 MPI's practices in this

regard, but not before AHCA was precluded for more than a year from issuing binding audit reports incorporating statistical sampling. Deferred reports were issued during FY 2008-09.

Medicaid Overpayment Distribution

In FY 2008-09, MPI completed simulation studies in order to determine the distribution of overpayments in the Medicaid program. These studies produced a distribution that plotted the number of providers having significant annual overpayments against specified overpayment ranges arranged from small to large. The results of these simulation studies are shown in the chart below.

A review of overpayments identified by 2, 611 MPI audits carried out in FY 2005-06 through FY 2007-08 showed precisely the same distribution curve produced by the simulation studies.



No.	Overpayment, $		No.	Overpayment, $	
	Range			Range	
	From	To		From	To
1	$0	$20,000	6	$100,000	$200,000
2	20,000	40,000	7	200,000	300,000
3	40,000	60,000	8	300,000	400,000
4	60,000	80,000	9	400,000	500,000
5	80,000	100,000	10	500,000	1,000,000

Medicaid Overpayment Distribution Results

This overpayment distribution indicated that the average MPI overpayment case produced approximately $21,000. Thus, while the majority of audited providers have relatively small overpayments, in the aggregate they add up to most of the overpayments in the program. These simulation studies support the conclusion that in order to recover a substantial portion of Medicaid overpayments, it is necessary to perform many audits of providers having smaller, yet significant, overpayments. Audits of providers are unavoidably labor intensive at this time and often require the manual review of documents and medical records. Although MPI employs a computerized claims sampling program to select claims for audits, and inferential statistics are used in all appropriate audits, the audits must be meticulously performed and providers must be granted the opportunity to appeal audit results.

Detection

Detection efforts by MPI can be initiated by leads from complaints, other regulatory announcements or actions, incoming referrals, newspaper articles or advertisements, Explanation of Medicaid Benefits (EOMBs), leads from Medicaid, the Medi-Medi partnership with the Medicare program and data mining with advanced detection software developed internally as well as software supplied by the fiscal agent contractor.

Detection Tools

MPI's primary detection tools include DSS Profiler, First Health Pharmacy reports, Business Objects Ad Hoc reports, 1.5 reports, Chi-Square upcoding reports and Early Warning System reports. These tools provide a means for MPI to analyze Medicaid claims data and detect aberrant behaviors, over-utilization patterns and non-compliance that result in referrals to MFCU and other regulatory agencies and produce leads for further investigation by MPI's field staff and case management units.

The DSS*Profiler* is the basis of the Surveillance and Utilization Review System (SURS) and is used to determine possible overutilization and other deviations from expected values and norms associated with reimbursement for Medicaid goods and services. An example would be a need to analyze the number of hours per day a provider billed a specific code within an age- or gender-adjusted peer group established by the DSS*Profiler*. The system calculates the expected amounts or values for this parameter (hours per day) based on the number of recipients served by the provider and the age range/gender/ morbidity mix of those recipients, for each provider in the group. For all providers in the group, the distribution is obtained on the differences between the expected and actual amounts and the standard deviation of the distribution is calculated. Each provider's actual amount is compared with the standard deviation. Providers that stand out from the standard deviation may be selected for auditing.

The Florida Medicaid Management Information System (FMMIS)/Decision Support System (DSS) is a comprehensive solution providing complete Fraud and Abuse Detection (FAD) and SURS capabilities.

The FAD/SUR system is fully integrated within the Medicaid fiscal agent's data warehouse. FAD provides AHCA with the ability to research Medicaid providers and recipients in order to investigate potential misuse of the Medicaid program. The review process allows for evaluation of the delivery and utilization of medical services to safeguard the quality of care and protect against abusive use of Medicaid funds.

First Health Pharmacy reports include top member rankings, top 100 prescribers by amount, quarterly doctor shopper reports, prescriber ranking reports and most utlized pharmacies report.

Business Objects Ad Hoc reports are used by auditors with several payment systems accessible to them for claims review. The Florida Medicaid Management Information System (FMMIS) which is used in the processing and payment of provider claims, contains information on Medicaid claims, providers, recipients, drugs and other matters. The Decision Support System (DSS) stores seven years of providers' claims history and is accessed using Business Objects. It contains the DSS*Profiler* datamart, a type of Surveillance and Utilization Review Subsystem (SURS), for claims utilization review and provider and recipient profiling.

1.5 reports are produced weekly and provide a listing of each Medicaid provider who is scheduled to receive a check for that week in an amount that is 1.5 or more times the average amount received for the immediately prior 26 weeks. This report comprehends all types of Medicaid providers. The report is useful for spotting providers that have an unusually high payment amount for a given week. The report is received by MPI at the beginning of the week and is analyzed quickly so that, if necessary, the payment for that week can be held up until a thorough review can be completed. Frequently, if a payment is stopped, it is found that it is stopped in error and needs to be nullified or corrected. If the report leads to the identification of providers who are misbilling the Medicaid program, an audit is initiated.

Chi-Square Upcoding reports consist of a type of statistical analysis that is used by MPI to determine possible overpayments to providers at a very high confidence level. It applies when a provider bills for services using procedure codes in a series of codes paying different amounts, so that upcoding, or using a higher-paying code than warranted, is possible. For providers of a given type, the analysis determines an overpayment indicator, which is proportional to an overpayment amount, for each of the providers having the largest overpayment indicators. Several types of providers are analyzed. The Chi-Square report is issued quarterly and lists providers in descending order of overpayment indicator, along with provider number, total payment, number of claims paid and other information.

Early Warning reports were developed by MPI to determine the rates of increase in payments to providers. Very rapid increases in payments may be due to the fact that providers are new or to other legitimate reasons. Or, they may be due to unwarranted billings by providers. Payments for a number of weeks are read by the program, which calculates the equation of a curve reflecting the trend in

payments. The slope of the curve is calculated at the latest week. This slope is indicative of the rate of increase in payments at that time. Payment data are obtained from FMMIS.

The Medi-Medi project was established to detect and prevent fraud, waste and abuse in the Medicare and Medicaid programs by performing computerized matching and analysis of both Medicare and Medicaid data. This matching is to detect claims paid by Medicaid that should have been paid only by Medicare. Through this program statistical analysis, trending activities and development of valuable potential fraud cases for referral to appropriate health care and law enforcement agencies can be completed. Through these collaborative efforts, information is provided to MPI related to excessive billing patterns, duplicate payments, services billed in both programs with no cross-over in place and various other abuses. Medi-Medi complements MPI's efforts not only with the matching of Medicare and Medicaid data, but also with the enhanced coordination among agencies and with law enforcement authority to prevent, identify, analyze and investigate Medicaid fraud and abuse.

The detection tools described above identified outlier providers who exhibited general patterns of aberrant behavior including overutilization, upcoding, unbundling and double billing. Each provider type had specific benchmarks that highlighted these aberrant patterns. For instance, home health providers with excessively high billed amounts for nursing services were compared to the state average billed amounts for all home health agencies. These results identified providers for audits or referrals to MFCU for potential criminal investigation. These detection tools also help identify areas that require comprehensive reviews or prepayment reviews.

"Pill Mill" Analyses

The Pill Mill Initiative was developed by AHCA in a combined effort with the contractors for Medicare Part-B and Medicare Part-A to perform a statewide data analysis on certain top prescribed drugs within the two programs. The main goal of the initiative was to analyze and report potential overutilization of certain narcotics to local, state and federal law enforcement. The objective was to combat fraud and abuse in the illegal prescribing, dispensing and consumption of powerful narcotics without proof of medical necessity.

The initiative focused on the top three controlled substances in Florida's Medicaid Program, which are Oxycodone, Hydrocodone and Xanax. Targeted areas were identified based on prescribing information. The Tampa area was number one in the state in terms of prescriptions written for the drugs in question. The findings included top area prescribers, top pharmacies where the prescriptions were being filled and the recipients involved in the transaction. To date, AHCA has made 69 referrals to the law enforcement agencies. MPI is running and analyzing data for other counties throughout the state, including Miami-Dade, Duval and Broward Counties.

MFCU Referral Results

Regular bi-monthly meetings are held by MPI and MFCU to discuss major issues and to plan strategies for joint projects. One project, "Time Bandit," focused on behavioral therapy providers and the number of units billed during a period of time. (The "Psychiatry Time Bandit" initiative reported under MFCU's SIU 2008-04-06, on page 14 of this report, represents a different project.) Outliers were identified and referred to MFCU. This project resulted in numerous arrests and civil actions by MFCU. Of the MFCU cases closed with criminal or civil judgments during FY 2008-09, MPI was responsible for referring 42 of them. These 42 cases involved 49 individuals who were charged or convicted of criminal offenses.

Quad State Meetings

The Data Detection Unit of MPI organized and invited Medicaid Program Integrity staff from New York, California and Texas to attend a teleconference with peers to discuss fraud and abuse detection activities. The first teleconference was held in June 2009, with Florida, New York, California and Texas, the "Quad States," participating. The goal of the teleconference was to provide an opportunity for frontline staff to share and learn from each other. Approximately 15 attendees discussed best practice fraud detection tools, MFCU referrals, Surveillance and Utilization Review (SURS), Medi-Medi and effective case studies. These topics generated a great deal of discussion and information sharing on the similarities and challenges each state has experienced in efforts to detect and reduce Medicaid fraud. Since several of the states use the detection tool DSS*Profiler*, a discussion was held concerning the use and efficacy of that software. Based on positive response to this initial teleconference, additional meetings will be held quarterly. This new avenue of networking and exchanging information and ideas will enhance efforts to prevent, detect and recover Medicaid overpayments.

Prevention

Prevention efforts enhance the efficiency of the Medicaid Program in that detection, auditing and recovery of prevented overpayments become unnecessary. Stopping overpayments before they happen avoids recovery costs and allows those funds to be used as intended. Prevention efforts by MPI include:

- The use of prepayment reviews to identify improper claims and deny payment,
- Recommendations for termination of providers suspected of misusing the Medicaid program,
- The use of a provision of law that allows Medicaid to decline reimbursement for prescription drugs prescribed by practitioners who have been terminated from the Medicaid program,
- Site visits by field staff,
- 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,
- EOMBs to recipients verifying receipt of services,
- Sanctions as appropriate under Rule 59G-9.070, Florida Administrative Code,

- Referrals to other regulatory and law enforcement entities that may result in restrictions on providers' abilities to continue to participate in the Medicaid program and that serve as a deterrent, and
- Other measures that allow the AHCA to better oversee 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 payments for 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 to deny the claim.

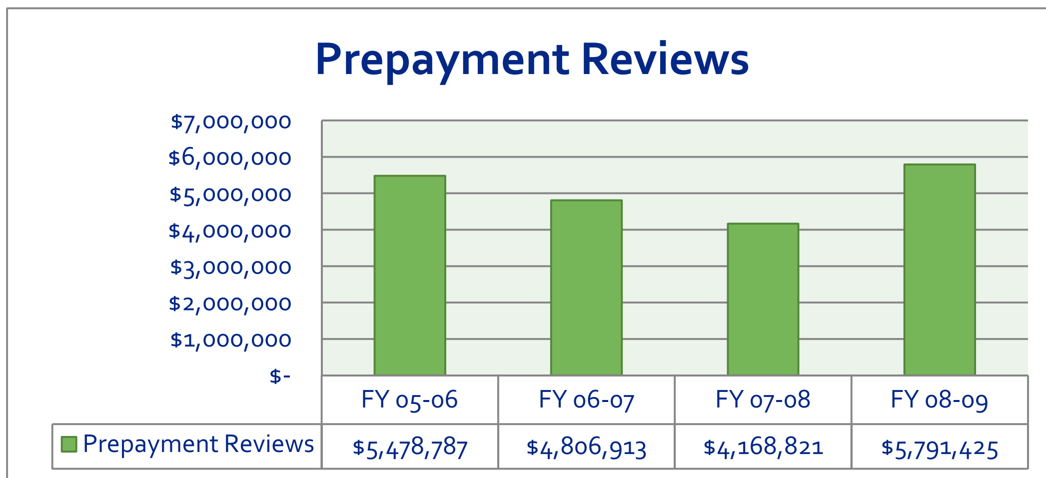
In prepayment reviews, claims without proper documentation are denied. MPI may place a provider on prepayment review for suspicion of fraudulent or abusive behavior, suspicion of neglect of a recipient, suspected overpayment, receipt of a complaint against the provider, suspicion of the rendering of 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 or suspicion of any of the violations set forth in Section 409.913(15), Florida Statutes.

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 without MPI intervention.) During FY 2008-09 the claims of 99 providers were pended and payments of approximately $5.8 million were cost avoided. The following table shows the types of providers whose claims were pended and reviewed in FY 2008-09, and the savings due to denied pended claims.

Provider Type	Count	Amount
ASSISTIVE CARE SERVICES	5	$62,782.34
COMMUNITY ALCOHOL, DRUG, MH	1	52,603.02
H & C BASED SERVICES	74	1,434,058.79
HOME HEALTH AGENCY	2	701,837.97
MEDICAL SUPPLIES/DURABLE MED	3	142,614.95
PHARMACY	4	7,633.83
PHYSICIAN (MD)	8	3,378,905.86
BIRTHING CENTER	2	10,988.00
Total	**99**	**$5,791,424.76**

FY 2008-09 Costs Avoided by Denied Claims

The chart below provides a historical look at dollars associated with prepayment reviews over the last four years. In FY 2008-09, MPI prepayment reviews produced cost savings of $5.8 million.



Recommendations for 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), Florida Statutes. 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 terminations during July 1, 2007 through June 30, 2008, resulted in cost savings of $3.2 million in FY 2008-09.

Denial of Reimbursement for Prescription Drugs

Based on legislation enacted in 2004, AHCA is authorized to deny reimbursement for prescription drugs prescribed by practitioners who have been terminated from the Medicaid program. AHCA is further authorized to deny payment for goods or services caused to be furnished by a provider terminated or suspended from the Medicaid program, as stated in Section 409.913(25) (b), Florida Statutes. AHCA 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 denials of reimbursement for prescription drugs savings relate to providers terminated during the period July 1, 2007, through June 30, 2008, 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. The cost savings reported for FY 2008-09 as a result of this action is $0.3 million.

Site Visits

MPI field office staff visits 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 ensure that the provider is still at the address of record, has 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.

In addition to newly enrolled Medicaid providers, MPI conducts site visits on providers in an area of concern. The cost savings calculations are estimates only. It is recognized that additional factors in conjunction with site visits may have impacted the estimated cost savings. For example, as a result of these site visits, subsequent preventive or recoupment actions may have been initiated. These calculated savings are based on the provider having been active 12 months prior to and 12 months after the site visit. The projected savings are estimated to be the difference between payments to the provider for the 12 months prior to the site visit and the payments to the provider for the 12 months immediately following the site visit. The site visit cost savings for FY 2008-09 that resulted from 481 site visits and any subsequent actions are $6.5 million.

Explanation of Medicaid Benefits (EOMBs)

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. 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. Each EOMB mailed is currently written in English and Spanish. The EOMBs pertain to all claims paid during the previous month, with the exception of claims for services that are specified by state or federal law to be confidential. The MPI Intake Unit receives the EOMB forms returned by Medicaid recipients and their representatives and is responsible for processing the EOMBs, opening files when appropriate and conducting preliminary investigations. Every EOMB returned with comments is examined and reviewed. EOMBs stating that services were not provided are recorded and scanned in order to detect patterns of fraudulent claims.

Administrative Sanctions

During FY 2008-09, 686 Medicaid providers received 826 sanctions for violations set forth in Rule 59G-9.070, Florida Administrative Code. These sanctions included suspensions and terminations from the Medicaid program, fines totaling $481,228 and other sanctions, such as corrective action plans.

Type Sanction	Number of Sanctions	Total Fines
Fine Sanctions	501	$ 481,228
Suspensions	30	N/A
Terminations	13	N/A
Other	282	N/A
Totals	**826**	**$ 481,228**

FY 2008-09 Administrative Sanctions

Field Initiatives

MPI field staff conducted a number of focused projects or field initiatives in FY 2008-09. These field initiatives resulted in such preventive measures as prepayment reviews, terminations, referrals, sanctions and recoupment of overpayments. The outcomes of the focused projects are reflected below:

Durable Medical Equipment (DME) Project (Miami-Dade County) – October, 2007

DME providers in Miami-Dade County were audited in October 2007 to review claims for nebulizers. More than 500 recipients and providers were randomly selected for onsite 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. The cost savings from this project were reported in FY 2007-08.

DME Project (Hillsborough and Pinellas Counties) – December 2007

Claims for oxygen and related supplies submitted by providers in Hillsborough and Pinellas counties were reviewed in December 2007. 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. The cost savings from this project were reported in FY 2007-08.

Assisted Living Facility Sweep (Miami-Dade County) – September 2007 through December 2008

On August 29, 2007, the Office of Inspector General, Medicaid Program Integrity's Miami field office initiated an Assisted Living Facility (ALF) Project in Miami-Dade County. The primary goal of the project was to verify the ancillary services received by ALF residents and to check for duplication of services such as home health and waiver services.

From 535 active ALF providers active in the Miami-Dade County area during calendar year 2007, 46 facilities were visited during the time period from September 2007 through December 2008. Initial and follow-up site visits, and review of reports and patient records revealed several non-compliance issues and resulted in provider education letters, sanctions, prepayment reviews, termination recommendations and referrals. The calculated savings were based on the provider having been active seven months prior to and seven months after the site visit, the projected savings are estimated to be the difference between payments to the provider for the seven months prior to the site visit and the payments to the provider for the seven months immediately following the site visit. The cost savings as a result of this project for FY 2008-09 were $67,000.

Home Health Providers (Miami-Dade County) – January 2008

A review of home health agency reimbursements for calendar years 2005 through 2007 revealed a marked increase in Miami-Dade County for reimbursements for procedure code T1021, Home Health Aide Services Unassociated with Skilled Nursing Services. An analysis of these services resulted in recommended termination of several of the home health agencies (HHAs) and referrals to MFCU and DOH. 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. The cost savings from this project were reported in FY 2007-08.

Home Health Providers (Miami-Dade County) – March 2008

This Home Health aides project in Miami-Dade County was initiated in March 2008 and field visits were conducted in the summer of 2008. Calendar year 2007 reimbursement data was used to identify Medicaid home health providers with reimbursement of procedure code T1021, unskilled nursing visit. Twelve providers were selected for review. Two of these were under active investigation by MFCU. The MFCU investigator assigned to these two investigations participated in the field visits.

Three hundred and thirty six recipients of procedure T1021 were identified from the provider reviews. Two additional providers were added due to information collected during the visits. This project involved a total of 14 providers and resulted in placement of several providers on prepayment review and three referrals to MFCU. The calculated savings were based on the provider have being active 12 months prior to and 12 months after the site visit and the projected savings are estimated to be the difference between payments to the provider for the 12 months prior to the site visit and the payments to the provider for the 12 months immediately following the site visit. The cost savings for FY 2008-09 from this project were $2.4 million.

Diagnostic and Radiological Test (Miami-Dade County) – January 2009

A review of radiological and diagnostic procedures lead to the selection of approximately 50 Medicaid providers at approximately 32 separate locations for field visits. Five teams consisting of two AHCA members plus DOH and MFCU members visited these providers. Survey information was gathered and facilities were toured. Facility, staff and equipment were photographed or recorded and recipient records were reviewed.

This initiative resulted in 14 referrals to MFCU, 22 referrals to DOH and 23 referrals to MPI case management for comprehensive audits. There were eight referrals to other agencies for administrative review. As a result of this initiative, there are ongoing criminal investigations and pending plea agreements that include criminal convictions, restitution and the surrendering of a physician's medical license.

Cost saving calculations are based on the provider being active six months prior to and six months after the site visit and the projected savings are estimated to be the difference between payments to the provider for the six months prior to the site visit and the payments to the provider for the six months immediately following the site visit. The cost savings for FY 2008-09 from this project were $106,000.

Home Health Agency Project (Miami-Dade County) - March 2009

An initiative to review Medicaid billings and reimbursement for home health services was conducted in March 2009. It included the identification and interview of 82 prescribers and the identification and interview of 111 recipients at five home health agencies. The prescriber interviews resulted in 13 sanctions, 13 DOH referrals and 13 voluntary terminations. Visits to the five home health agencies

resulted in sanctions, paid claim reversals and referrals to MFCU, CMS and FDLE as well as a termination recommendation. This project was initiated late in the fiscal year and does not yet meet the criteria of a minimum of a six month post review period. The project results will be reported in FY 2009-10.

DME Project (Bay County) – April 2009

Two Bay County durable medical equipment (DME) providers and ten recipient records from each provider were selected and reviewed by the Investigations Unit (IU) staff. Each recipient was interviewed to verify the provider billing records and to observe the medical equipment. Staff from the Agency for Persons with Disabilities visited recipients who received Medicaid waiver services. (For a full description, see page 30.) This project was initiated late in the fiscal year and does not yet meet the criteria of a minimum of a six month post review period. The project results will be reported in FY 2009-10.

DME Project (Escambia County) – May 2009

The two top billing DME providers in Escambia County were selected by IU staff for review. Fifteen recipients for each provider were selected and the billing records were compared with information gathered during the recipient interviews and site visits. (For a full description, see page 31.) This project was initiated late in the fiscal year and does not yet meet the criteria of a minimum of a six month post review period. The project results will be reported in FY 2009-10.

Home Health Agency Project (Duval County)—May 2009

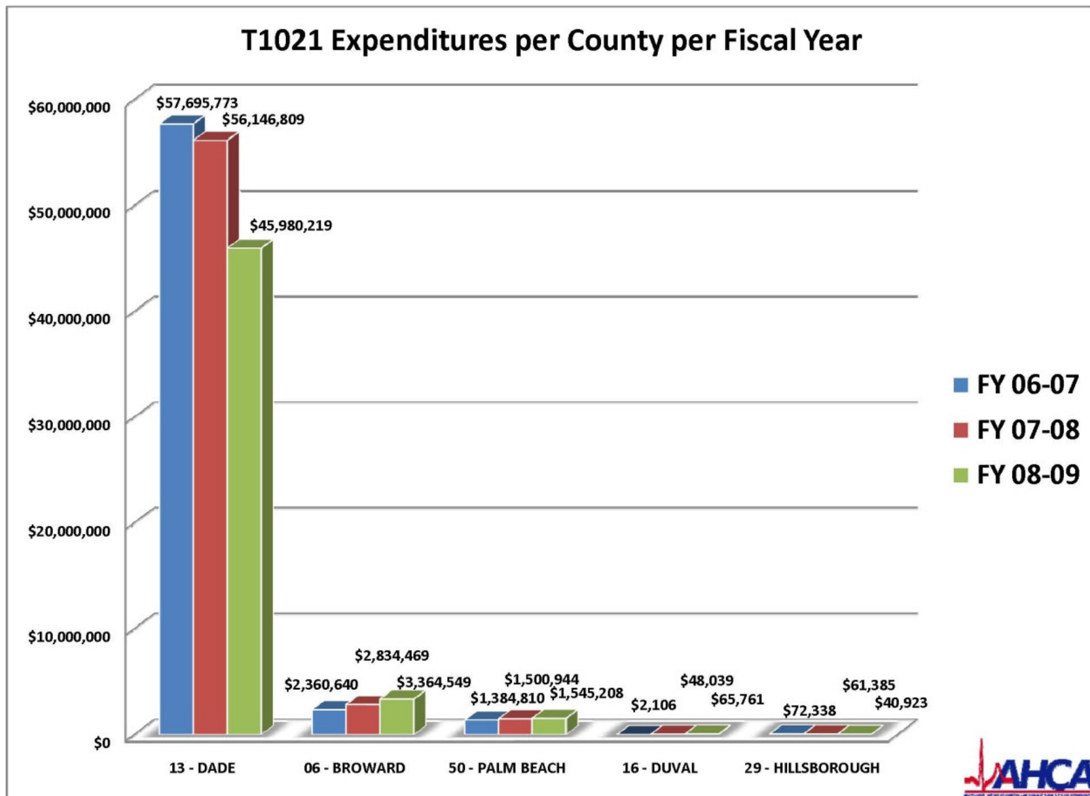
In May 2009, Jacksonville, Orlando and Tampa Medicaid Program Integrity staff and Jacksonville Medicaid Fraud Control Unit staff conducted an onsite visit of a home health agency in Jacksonville, Florida. The purpose of this visit was to obtain documentation related to the Medicaid billing and reimbursement for home health services. During the week of May 11 through May 14, one team visited the home health agency and obtained copies of the current plans of care for 45 severely disabled children receiving Medicaid services. Two teams were assigned to interview 32 physicians. Each recipient's current plan of care for the review period was exactly the same as their initial plan of care even though several of the recipients had aged considerably since the initial order and their conditions had changed. Of the physicians interviewed, many stated they routinely just signed the plan of care and faxed it back to the home health agency. Several voiced surprise that they were signing a "prescription" for the home health service and in some instances had never seen the patient for which they were ordering the service. Results of this initiative were not complete at the time this report went to press. This project was initiated late in the fiscal year and does not yet meet the criteria of a minimum of a six month post review period. The project results will be reported in FY 2009-10.

DME Focus (Miami-Dade/Broward Counties) - June 2009

During the week of June 15, 2009, the Bureau of Medicaid Program Integrity targeted 12 durable medical equipment (DME) providers that were top billers for procedure code E1390 (Oxygen Concentrator) for dates of service January 1, 2008 to June 1, 2009 in Miami-Dade and Broward Counties. Six teams of two investigators each, conducted 12 provider compliance site visits and visited 120 Medicaid recipients that received oxygen concentrators and additional medical equipment during the review period. A total of 120 Medicaid recipients were interviewed. Results from this initiative included provider education letters, paid claims reversals, sanctions, placement on prepayment review, referrals to MFCU and termination recommendation for one provider. This project was initiated late in the fiscal year and does not yet meet the criteria of a minimum of a six month post review period. The project results will be reported in FY 2009-10.

Overall Results from the Home Health Initiatives

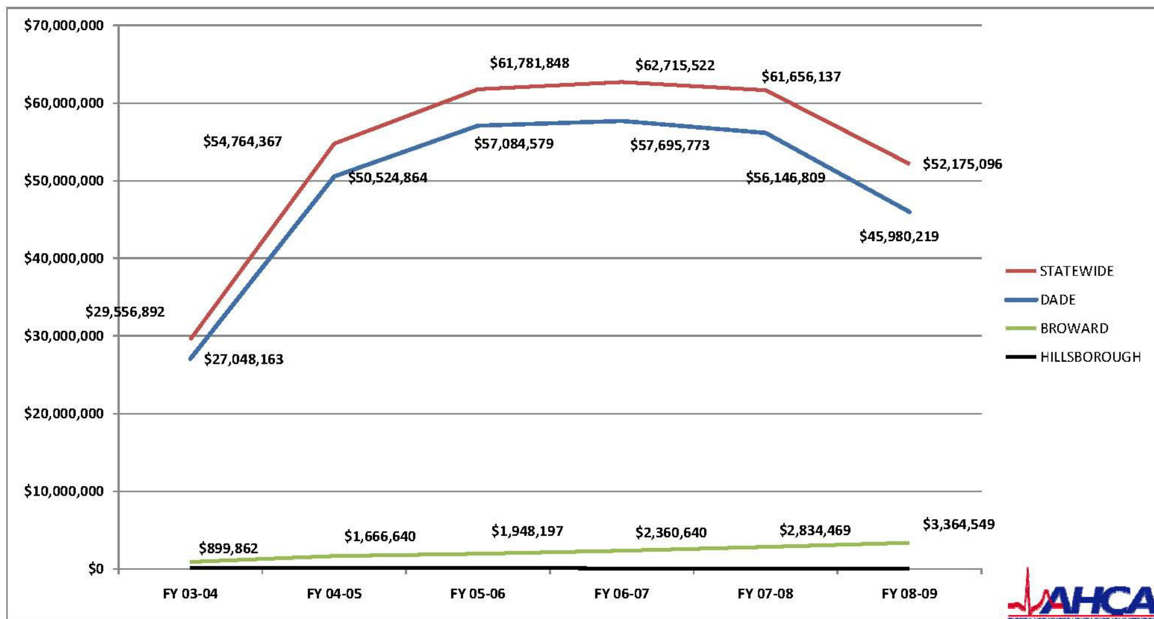
In 2007, 90% of home health visits in Florida were provided to 20% of the Medicaid population, residing in Miami-Dade County. Ninety percent of recipients receiving home health visits are over the age of 65, making them dual-eligible for Medicare and Medicaid, with Medicare being the first payor. Through further investigation, it was determined that certain home health aides billed for 18-20 hours/day, were in two places at the same time, billed for two separate visits while only making one, billed for multiple persons separately when the recipients resided in the same location and billed for care to immediate family members. Additionally, it was determined that Plans of Care (POC) was not being followed and that the recipients were receiving house-keeping help rather than assistance with their health-care needs (receiving house-keeping chores rather than help with bathing, wound changing, medical assessment, for example.)



Medicaid Program Integrity worked with the Medicaid Fraud Control Unit, the Medicaid Integrity Group of CMS (MIG/CMS) and the Department of Health. They visited hundreds of home health care recipients, home health care provider agencies and physicians who prescribed the home health services.

As the chart above demonstrates, total dollars spent on unskilled home health visits (T1021) in FY 2006-07 in Miami-Dade County was $57,695,773, while $62,715,522 was spent on unskilled home health visits in the entire state. In FY 2007-08, $56,146,809 was spent in Miami-Dade County while $61,656,137 was spent in the entire state for the same services. In FY 2008-09, $45,980,219 was spent in Miami-Dade County while $52,175,096 was spent in the entire state, demonstrating a savings of nearly $10 million as a result of AHCA's efforts, but this cannot be confirmed until the next fiscal year, as providers have 12 months to submit claims to Medicaid. This encouraging downward trend in unskilled home health visits in Miami-Dade County is also illustrated in the graph below.

Trend in Home Health (T1021) Expenditures 2006-09



In 2008, the Florida Legislature enacted Senate Bill 1986, which gave AHCA more tools to strengthen Medicaid policies and procedures, increased licensing requirements and procedures for home health agencies, created new incentives for the reporting of suspected fraud and abuse as well and gave Medicaid a greater presence in the community to reinforce provider and recipient compliance. Senate Bill 1986 became law on July 1, 2009 and the AHCA will report outcomes from this legislation in the FY 2009-10 report.

Recovery

Investigation and recovery efforts by MPI include comprehensive audits involving reviews of professional records, generalized analyses involving computer-assisted reviews of paid claims in the light of Medicaid policies, paid claim reversals involving adjustments to incorrectly billed claims, and focused audits involving reviews of certain types of providers in specific geographic areas, as well as referrals to MFCU and other regulatory and enforcement agencies.

Investigations into allegations and indications of violations of Medicaid policy fall into three categories: MPI-conducted audits, paid claims reversals by MPI and vendor-assisted audits.

MPI's recovery efforts tend to concentrate on conducting comprehensive audits 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. MPI staff members assist in and oversee all aspects of these projects.

MPI Audits

During FY 2008-09, MPI concluded 1614 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 numerous providers' billings. Comprehensive audits typically involve determining all of the provider's paid claims (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. During FY 2008-09, MPI closed 1614 cases with identified overpayments on those cases of $15.6 million.

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. During FY 2008-09, paid claims reversals resulted in net recoveries to Medicaid of about $317,782.

Third Party Liability Contractor-Assisted Audits

In coordination and consultation with Medicaid Third Party Liability (TPL), MPI directed specific audit analyses by the contractor. AHCA, through Third Party Liability, contracts for assistance in several fraud and abuse recovery efforts that have little or no room for dispute. The vendor is able to focus on projects involving large volumes of data, which allows AHCA 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. During FY 2008-09, the vendor assisted in the collection of approximately $34.6 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 - 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.

- Onsite Facility Audits - The credit balance reports of hospitals and nursing homes are 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.
- Provider Self Audits - Providers are mailed letters requesting that they review their credit balances and voluntarily refund any overpayments to Medicaid.
- Duplicate Billing - This review identifies Medicaid payments to hospitals for inpatient services that are duplicates or for overlapping periods.

MPI Identified Overpayments (millions)					
Activity	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09
MPI Audits (Identified Overpayments)	$25.4	$25.4	$20.0	15.6	$15.6
Paid Claims Reversals	1.5	0.9	0.7	0.5	0.3
TPL Contractor Assisted Claims Adj.	7.4	10.8	15.0	12.8	34.6
Total	$34.3	$37.1	$35.7	$28.9	$50.5

Performance Trends

Referral Activities

As illustrated by the chart below, AHCA has continued to refer providers who may be engaging in abusive conduct to other agencies.

Number of MPI Referrals				
Referral to:	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09
DOH	194	181	70	163
FDLE	0	1	13	40
Division of HQA	36	42	59	56
Division of Medicaid	42	82	48	60
MFCU	225	212	218	123
Others	35	44	127	118
Totals	**532**	**562**	**535**	**560**

Recoveries of Overpayment – MPI Audits

In an attempt to increase the amount of overpayments actually collected, MPI has begun monitoring the rate of actual 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 collection rate.

FY Year	Overpayments Identified	Collections to date on those Overpayments	Collection Rate
2004-05	$25,384,337	$13,662,970	**53.8%**
2005-06	25,427,878	18,189,241	**71.5%**
2006-07	19,973,393	15,348,406	**76.8%**
2007-08	15,628,918	12,284,967	**78.6%**
2008-09	15,625,437	12,722,243	**81.4%**
Total	**$102,039,964**	**$72,207,826**	**70.8%**

The overpayments identified above have been restated for FYs 2004-05, 2005-06 and 2006-07 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. The results of all recovery efforts are available on the MPI Recovery of Overpayments table or under Return on Investment (see page 57 of this report). The funds collected in a given year do not correspond to overpayments identified in that year because of the lag time in collections.

Cases with Findings

Another MPI goal is to increase the proportion of audits that have the potential of recovering significant Medicaid funds. In FY 2008-09, MPI succeeded in increasing the audit overpayment rate to 80%.

Disposition of Cases	Fiscal Years			
	2005-06	**2006-07**	**2007-08**	**2008-09**
Overpayments Identified	1,002	811	791	1,288
No Fraud or Abuse Found	199	177	331	309
Provider Education Letter	27	30	4	17
Total Cases Closed	1,228	1,018	1,126	1,614
Percent with Overpayment	81.6%	79.7%	70.2%	80.0%

Days to Fully Recover an Overpayment

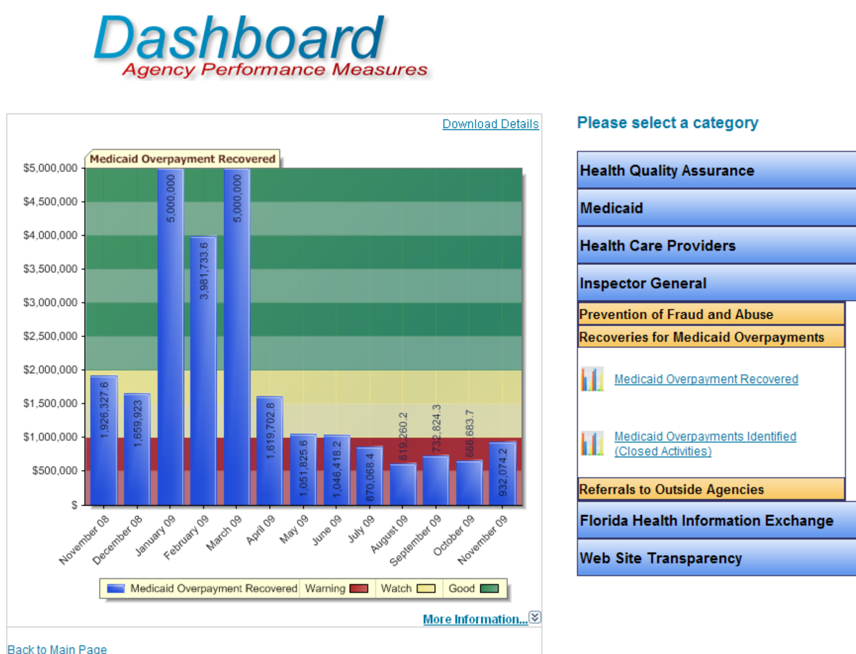
The average number of days from when a case is opened to the date the overpayment is fully recovered has decreased, as shown below. These reductions have occurred because investigative cases are being completed in a more timely fashion and collection efforts have been increased. Finance and Accounting reports the average case was paid in full in 311 days during FY 2008-09.

Days to Paid In Full					
Fiscal Year	**2004-05**	**2005-06**	**2006-07**	**2007-08**	**2008-09**
Cases	652	878	819	736	1,349
Average Days	500	452	328	328	311

AHCA's Dashboard

AHCA performance measures are posted on the AHCA Internet site, available to the public. Office of the Inspector General/Bureau of Medicaid Program Integrity performance measures include the denial of claims, the identification and collection of overpayments on closed cases, and referrals. (Link: Agency Dashboard[1]) Below is an example of the type of information available on the dashboard. The dashboard is updated monthly.

Dashboard Glossary



[1] http://ahcaxnet.fdhc.state.fl.us/dashboard/

MPI Highlights

Some particularly noteworthy actions and accomplishments by MPI during FY 2008-09 include the following:

- MPI assisted in the identification and reclaiming of $1.4 million for unpaid drug rebates on the drug Lupron from a drug manufacturer. MPI staff reviewed numerous medical records obtained from the prescriber to document that the drug was administered. MPI staff analyzed the records and converted the J-code billings to a National Drug Code. AHCA collected $1,413,200.
- Under MPI management, coordination and consultation and in conjunction with Medicaid Third Party Liability, MPI directed audit analyses by the TPL contractor. Issues addressed included overpayments to institutions for simultaneously billing for mother and newborn, overpayments to nursing homes for costs covered by patients and overpayments to nursing homes for errors reported in bed occupancy. These efforts produced over $34.6 million in recoveries during FY 2008-2009.
- A Medicaid recipient may choose hospice services when they have a medical condition that is expected to reduce their life expectancy to less than six months. While the person is in hospice, the range of non-hospice services for which Medicaid will pay is reduced. Medicaid Program Integrity identified and recovered approximately $690,000 for non-hospice related services that were not covered by the Medicaid program.
- For uncomplicated pregnancies, Medicaid will pay for a limited amount of prenatal services called a Fetal Biophysical Profile. Many instances were identified in which Medicaid paid for services beyond the stated limit. After examination of medical records to confirm that the limit was appropriate for each pregnancy, Medicaid Program Integrity recovered approximately $393,000 from 148 providers during FY 2008-2009 for the prenatal services that exceeded the number allowed.
- A Medicaid provider was identified for upcoding Evaluation and Management (E&M) codes. A review of the provider's claims for the period of January 1, 2006, through December 31, 2005, identified four areas of concern. These areas were upcoding, enrollment issues, services billed that were not medically necessary and records maintenance. A Final Audit Report completed in September 2008 identified an overpayment in the amount of $152,267. The Final Order was filed in January 2009.
- MPI's Pharmacy Case Management Unit developed and successfully implemented audits for 340B-covered entities. Covered 340B entities may not properly bill Florida Medicaid more than the 340B acquisition cost plus the state's dispensing fee. Pharmacies were notified of the impending audits with document request letters and required to submit documentation showing their purchases in the 340B program. Approximately $245,000 was recovered in five audits. As of October 2008, Florida was one of only three states to investigate 340B covered

Medicaid billing practices in pharmacies and one of only two states that had collected overpayments in 340B covered entity investigations.

Return on Investment

MPI calculates a return on investment (ROI) by first totaling all FY 2008-09 cost avoidance and recoveries of fraud and abuse overpayments. Prevention efforts resulted in cost savings of $18.9 in FY 2008-09, as shown below:

MPI Prevention of Overpayments (millions)								
Activity	FY 2005-06		FY 2006-07		FY 2007-08		FY 2008-09	
	No.	Amount	No.	Amount	No.	Amount	No.	Amount
Prepayment Review	245	$ 5.5	217	$ 4.8	156	$4.2	99	$5.8
Termination of Providers	194	13.3	194	13.2	255	5.4	152	3.2
Focused Projects	3	11.4	2	5.0	3	9.8	3	2.6
Denial of Reimbursement for Prescription Drugs	124	5.9	66	0.8	40	0.5	3	0.3
Policy Changes	1	0.9	1	2.4	N/A	N/A	N/A	N/A
Site Visits	n/a	n/a	253	2.8	229	1.8	481	6.5
Fine Sanctions Imposed	153	.3	222	.4	155	.1	501	0.5
Total		$37.3		$29.4		$21.6		$18.9

MPI efforts resulted in the recovery of $50.3 million in overpayments in FY 2008-09, as shown below:

MPI Recovery of Overpayments (millions)					
Activity	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09
MPI Audits(Collections by F&A)[1]	$12.2	$16.3	$18.8	$14.9	$15.4
Paid Claims Reversals	1.5	0.9	0.7	0.5	0.3
TPL Contractor Asst. Claims Adj.	7.4	10.8	15.0	12.8	34.6
Total	$21.1	$28.0	$34.5	$28.2	$50.3

MPI also recovered $13.4 in pharmacy rebates in FY 2008-09.

Other MPI Recovery of Overpayments (millions)	
Activity	FY 2008-09
Pharmacy Rebates	$13.4
Total	$13.4

[1] MPI Audit figures have been restated to show actual collections reported by Finance and Accounting in each of the respective years.

MPI is funded through the Medical Care Trust Fund. The Medical Care Trust Fund is funded through federal funds and recoveries generated by MPI. During the year, expenditures of $9.1 million were devoted to recovery work resulting in a return on investment for recovery operations of 7.0:1. In addition, MPI achieved $18.9 million in cost avoidance with expenditures of $6.0 million, producing a return on investment for prevention efforts of 3.2:1. Overall, in FY 2008-09, audit recoveries, cost avoidance and pharmacy rebate recoveries totaled $82.6 million, yielding a return of 5.5:1.

Return on Investment (millions)				
		Benefits	**Costs**	**ROI**
FY 2004-05	Recovery	$20.5	$7.5	2.7:1
	Prevention	38.8	3.4	11.6:1
	Total	**$59.3**	**$ 10.9**	**5.5:1**
FY 2005-06	Recovery	$28.0	$7.6	3.7:1
	Prevention	37.0	3.4	10.9:1
	Total	**$65.0**	**$11.0**	**5.9:1**
FY 2006-07	Recovery	$34.6	$8.0	4.3:1
	Prevention	29.0	3.6	8.1:1
	Total	**$63.6**	**$11.6**	**5.5:1**
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**
FY 2008-09	Recovery	$50.3	$9.1	5.5:1
	Prevention	$18.9	$6.0	3.2:1
	Pharmacy Rebates	$13.4	0.0[2]	-
	Total	**$82.6**	**$15.1**	**5.5:1**

Managed Care

MPI and OIG staff was heavily involved this year in developing standard contract language for the fraud and abuse sections of AHCA's new managed care organization (MCO) contract, which became effective September 1, 2009. Development of fraud and abuse related language for this three-year contract was seen as a critical endeavor requiring establishment of a workgroup to review all aspects of the contract in which language enhancements or additions could improve MCO accountability as well as aid in the prevention, detection and reporting of suspected fraud and abuse. The workgroup aligned this effort with the broader contract development team, while coordinating with MFCU and AHCA General Counsel staff. Many of the OIG/MPI workgroup's recommended contract language changes were adopted, resulting in a core managed care contract with strengthened reporting requirements and an emphasis on encouraging MCOs to establish effective fraud and abuse compliance programs.

[1] Does not add due to rounding.
[2] Included in recovery costs

OIG/MPI staff also began strategic planning for retooling MPI to better address the unique characteristics of fraud and abuse oversight in managed care. This included identifying key AHCA MCO oversight activities and processes that produced information indicative of fraud or abuse at the plan, provider, subcontractor or enrollee level. Progress was also made on implementing necessary MPI managed care fraud and abuse oversight infrastructure. For example, MPI staff established a casework system and assigned case tracking responsibility for MCO referrals of suspected fraud or abuse. A secure FTP site was also established by MPI for MCOs to report case activity and status on a quarterly basis as well as to provide a secure electronic means for MCOs to submit supplemental investigative information. OIG and MPI staff collaborated on development of a report template to be included in the new AHCA Managed Care Report Guide, which is part of the 2009-12 contract. The data reported by MCOs will be used to track statewide MCO fraud and abuse detection and prevention activity, to assist MCOs in enhancing their fraud and abuse related activities, and in demonstrating MCO due diligence regarding their oversight of providers. The data will also assist in detecting fraud and abuse patterns among MCO providers and in coordinating with MFCU on active investigations.

Referrals of suspected fraudulent or abusive providers from MCO Special Investigative Units (SIUs) to MPI have increased significantly over last year. The Fraud and Abuse Case Tracking System reports 41 referrals were received from MCOs in FY 2007-08, while 146 were received in FY 2008-09, an almost four-fold increase. MPI staff assigned to the managed care area continues to monitor and track these referrals, as well as participates in MCO application reviews and onsite reviews as a means of educating the MCOs about the referral process and to ensure that MCOs have strong fraud and abuse compliance programs in place. Specifically, MPI staff conducted managed care oversight through participation in the following activities:

1. Review of MCO application materials related to fraud and abuse prevention contract provisions, as a means of assessing MCO readiness prior to contract execution,
2. Onsite contract compliance reviews and staff interviews to assure MCOs have active and effective compliance programs in place, including viable communication pathways for reporting fraud and abuse,
3. Assigning corrective action to MCOs when required as a result of MPI fraud and abuse compliance review findings, and providing follow-up assessment of MCO corrective action implementation,
4. Attending monthly managed care contract oversight meetings with the Bureau of Health Systems Development and the Bureau of Managed Health Care,
5. Hosting monthly to bi-monthly meetings with the Medicaid Fraud Control Unit on managed care issues,
6. Staffing managed care casework with MPI's Intake Unit, including coordinating referral of any complaint not involving a fraud or abuse issue to the appropriate AHCA bureau,
7. Conference calling with MCOs on an as-needed basis,
8. Authoring MPI internal operating procedures related to managed care,

9. Responding to information requests and serving on workgroups related to managed care such as the task force for the Managed Care Application Process, focused reviews conducted by the external quality review vendor, the CMS review of Florida's Medicaid Integrity Program and
10. Technical and operations conference calls with managed care plans hosted by the Bureau of Health Systems Development.

MPI staff also conducted two major managed care audit projects this year. One involved HMO use of the unborn activation process (a process to pre-register babies before they are born so that their HMO coverage and related capitation payments can begin at birth). The other project related to HMO members who received hospice services. The findings of both projects are currently under review at the MCOs' request and per contract stipulations. Both projects demonstrated a need to review the functionality of preventive systems edits.

Senate Bill 1986 enacted as Laws of Florida, Chapter 2009-223

In the 2009 Legislative Session, Senate Bill 1986 amended multiple sections of law that are administered by several agencies in an effort to enhance the activities and authority of these agencies in combating fraud and abuse in the delivery of health care services.

The bill grants regulatory authority to address Medicaid fraud in the home health industry by strengthening application requirements, enhancing administrative penalties, increasing transparency regarding provider sanctions and terminations, identifying certain actions as felonies, establishing fraud reporting incentives, offering monetary rewards for reporting Medicaid fraud, removing disincentives to pursue action under the Florida False Claims Act, and providing civil immunity for reporting alleged Medicaid fraud.

The bill also strengthens home health agency licensing and renewal requirements and oversight measurements, provides remedies for non-compliance issues, strengthens licensing requirements of home health agencies, durable medical equipment providers, equipment and health care clinics, requires surety bonds for home health agencies, home medical equipment providers and health care clinics, and addresses duplication in regulation of providers licensed or registered by AHCA.

This bill amends Section 409.905, Florida Statutes, to require prior authorization of Medicaid home health services when aberrant billing practices are identified in the provision of home health aide visits unassociated with a skilled nursing service. This bill further outlines guidelines for the provision of Medicaid reimbursable home health services. In addition, the bill requires Florida Medicaid to implement two pilot projects in Miami-Dade County to prevent the overutilization of home health services and to control, verify, and monitor the delivery of these services.

The bill requires notification to patients regarding Medicaid fraud and the Medicaid fraud hotline, requires immediate suspension and termination of providers for the provider's actions or the actions of

certain affiliated persons, requires termination of a provider that fails to repay an overpayment and requires public disclosure of providers that have been terminated or sanctioned by Medicaid.

SB 1986 authorizes rewards for persons reporting information relating to Medicaid fraud, requires AHCA and the Department of Health (DOH) to work together to recover overpayments, requires DOH to take certain actions on Medicaid providers related to non-compliance with Medicaid policies and requires DOH to conduct background checks on pharmacy applications and enhances reasons for denial of permits.

Finally, the bill requires a major collaborative effort by the Medicaid Fraud Control Unit, Department of Health, Agency for Persons with Disabilities and AHCA's Health Quality Assurance Division, Medicaid Division and Office of the Inspector General/Bureau of Medicaid Program Integrity. These agencies are currently working together to implement the directives and embrace the authority granted under this extensive bill that calls for immediate and proactive measures to prevent, reduce and mitigate health care fraud, waste and abuse.

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. These three units focus on optimizing and improving quality in Medicaid programs, Medicaid policies and implementation of projects and research. The Office of Medicaid Program Oversight, profiled below, is also involved with anti-fraud and anti-abuse activities, working closely with other bureaus to help deter fraud and abuse in the Florida Medicaid program.

OFFICE OF MEDICAID PROGRAM OVERSIGHT

The Office of Medicaid Program Oversight (MPO) is responsible for maximizing the efficiency and effectiveness of the Medicaid programs and functions through:

- Identifying unnecessary and inappropriate utilization of Medicaid services, and reducing duplicative services,
- Ensuring that the Florida Medicaid Management Information System (FMMIS) reflects Medicaid program policy and program operations, with appropriate edits in place,
- Ensuring compliance of program operations with policy,
- Comparing alternative managed care models/programs,

- Sampling claims and eligibility data for analysis of programs and services, including trend analysis, and
- Developing the standards, tools and measurable quality indicators required to monitor Medicaid service programs.

MPO uses the information obtained through these activities to help optimize the use of Medicaid resources through analysis and evaluation of the costs, delivery, and service outcomes for the Medicaid program, and to identify best practices and make recommendations based on its findings.

Current MPO projects include Payment Error Rate Measurement (PERM), Medicaid Reform Risk Adjustment and the Medicaid Encounter Data System (MEDS). MPO also works with the Office of Medicaid Program Integrity (MPI) to coordinate the review of Medicaid program change recommendations with corresponding units, and provides additional monitoring of selected providers' billing patterns.

Several of the key oversight programs performed by the MPO unit are described below.

Payment Error Rate Measurement Program (PERM)

The Centers for Medicare & Medicaid Services (CMS) implemented the Payment Error Rate Measurement (PERM) program to measure improper payments in the Medicaid program and the Children's Health Insurance Program (CHIP). PERM is designed to comply with the Improper Payments Information Act of 2002 (IPIA; Public Law 107-300). For PERM, CMS is using a national contracting strategy consisting of three contractors to perform statistical calculations, medical records collection and medical/data processing review of selected State Medicaid and CHIP fee-for-service (FFS) and managed care claims. In federal FY 2006, CMS reviewed only FFS Medicaid claims. Starting in federal FY 2007, CMS expanded PERM to include reviews of FFS and managed care claims, as well as recipient eligibility, in both the Medicaid and CHIP programs. Florida started PERM in November 2007, completed the claims universe submission and federal sampling in May 2009, and the federal medical reviews and payment reviews in August 2009. The state dispute resolution process is expected to continue through December 2009.

Medicaid Program Oversight contracted for the recipient eligibility reviews because of the requirement for them to be performed by an independent entity. The contractor selected monthly samples of enrolled recipients from the Medicaid and State Children's Health Insurance Program (SCHIP) universes provided by MPO. Samples were selected for every month of the federal fiscal year beginning October 2007 and used to determine the level of error in the State's eligibility determination processes and associated payments. The process looked at both approvals and denials. At the end of the 12 month review, a Medicaid program eligibility error rate was computed using the CMS error rate calculator.

MPO also coordinated with the CMS national contractors (reviewers and statisticians). MPO submitted quarterly claim extracts from its Medicaid and SCHIP claim payments to the contracted reviewers at the end of each quarter of federal FY 2008. The Lewin Group created a statistically valid claims universe to be used by the sampling contractor, Livanta LLC. Livanta LLC selected statistically valid samples to be used to review payments, records and processes. The data processing reviews included both paid and denied claims. A third national contractor, Health Data Insights, reviewed claims payment information for sampled claims onsite in FMMIS, and reviewed medical records submitted by Medicaid providers.

To facilitate the medical reviews, MPO published five educational articles in the Provider Bulletin directed at Medicaid providers, the most recent of which are listed on the Florida Medicaid website. These publications are intended to increase provider awareness of MPO's functions and to remind them of the need to cooperate with the state and with national contractors in the implementation of PERM in Florida. Overall, advance notice of the PERM process in these bulletins, combined with PERM letters sent to the medical records department within each provider's office, and follow-up calls made by MPO staff during the 60 day submission period, resulted in approximately 99 percent submission of all PERM medical records requested.

It is still very early to identify specific benefits from PERM. MPO is anticipating the calculation of a state-specific payment error rate encompassing all portions of the PERM review to identify specific findings/benefits from PERM. One important outcome will be the identification of specific sources of improper payments as defined by PERM, and the development of corrective actions (currently under development) to address the underlying causes of the identified sources of improper payments.

Medicaid Encounter Data Systems (MEDS)

AHCA is required to capture medical services encounter data for all Medicaid-covered services in compliance with Title XIX of the Social Security Act, the Balanced Budget Act of 1997, 42 CFR 438, and Sections 409 and 641, Florida Statutes. In addition, Florida law requires that the rate setting process for capitated payments to Medicaid Reform health plans include a risk-adjustment component. The Medicaid Encounter Data System (MEDS) project was mandated by HB 3B during the Florida Legislature's 2005 Special Session "B" to implement these requirements, and MPO is responsible for administering the MEDS project.

A MEDS Team consisting of internal subject matter experts and external consultants with experience in encounter claims data collection and processing was created during FY 2005-06. The Medicaid Rx model was selected to comply with the risk adjusted capitation rate requirements for Medicaid Reform. In November 2005 AHCA began collecting pharmacy data from managed care plans, starting with FY 2003-04 and moving forward. Health plans statewide continue to submit pharmacy data on a quarterly basis. These data are validated and then utilized for the ongoing risk adjustment of capitation rates in the Medicaid Reform counties.

AHCA's MEDS program is designed to capture medical (X12) encounter data from all health plans for all Medicaid-covered services using the Florida Medicaid Management Information System (FMMIS). Collection and processing of encounter data began in FY 2006-07, with the initial submissions serving as an assessment and adaptation phase to determine HMO readiness. Encounter data collection and processing resumed in July 2009, after a hiatus during which the Agency transitioned to a new fiscal agent and implemented a new FMMIS.

As the MEDS project matures it will support the risk model computations that set capitated payments for managed health care entities, the enhanced benefits program and development of quality performance measures. MEDS data will also be used for specific information requests on such topics as service utilization trends, quality of care, and access to care. MEDS will enable transition of the pharmacy-based model now used for risk adjustment of capitation payments to reform health plans to a diagnostic-based model. Ultimately, MEDS will be a major component in the rate setting process for capitated health plans. Once mature, MEDS will provide a valuable resource for Agency analyses of health care and related services rendered to Medicaid beneficiaries enrolled in managed care plans, thereby helping to expand the service delivery and fraud and abuse initiatives beyond the traditional fee-for-service model.

Coordination with the Bureau of Medicaid Program Integrity

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

Beginning in March 2007, MPI and MPO set up a process by which MPO provides additional review of selected providers' billing patterns. These reviews may lead to recommendations for further actions by MPI or Medicaid Field Offices. Over the past two years, MPO has monitored 13 providers on a monthly basis.

In January 2007, the MPO and MPI established a tracking process for policy change recommendations by MPI to Medicaid Handbooks. MPO coordinates and tracks these policy change recommendations. MPO has tracked, on a monthly basis, 27 policy recommendations made through this process over the past two years.

Analyses of Medicaid Programs and Services

The Office of Medicaid Program Oversight continues to be available to assist all Medicaid bureaus and the 11 Medicaid area offices through general analyses and targeted studies related to Medicaid programs and services. MPO works to develop specific user tools for various facets of the Medicaid program to facilitate the detection of aberrant behaviors in utilization patterns and billing practices.

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

The Prescribing Pattern Review Panel (PPRP) is comprised of physician and pharmacist practitioners appointed by the Governor, Senate President and Speaker of the House. The PPRP 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 (DUR) 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 2008-09, outlier prescribers of the following drugs, or therapeutic classes of drugs were contacted and advised:

- Oxycodone doses over 180 mg.,
- Multiple controlled substance prescriptions,
- Controlled substances containing acetaminophen,
- Short and long acting narcotics,
- Non-compliance with atypical antipsychotics,
- Non-compliance with inhaled corticosteroids,
- Stimulant therapy in recipients under the age of 18 who lack a diagnosis of ADHD or narcolepsy, and
- Overutilization of beta agonists.

The PPRP and DUR Board also reviewed prescribing patterns of Class II narcotics. Oxycontin has been monitored within a structured prior authorization process for several years. This process eases accessibility for cancer and sickle cell patients, but imposes strict requirements on providers to submit medical documentation for other diagnoses.

Wireless Hand-held Portable Digital Assistant (PDA)

In 2002, the Legislature directed AHCA 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, AHCA 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.

In May 2009, AHCA realized that the physician adoption rate for the handheld device was not as great as anticipated. Gold Standard succeeded in deploying up to 2200 devices in the field, but never achieved the goal of 3000. Of the 2200 devices in the field, the overall utilization rate was low. In addition, new technology advances since 2002 provide new opportunities for physicians to access information. Many physicians now want information that is integrated with technology currently in their medical practices. Budgetary constraints combined with the comparative high cost per handheld device and the advancement of new technology required AHCA to re-examine the technology marketplace and plan to seek a more cost-effective alternative that could generate comparable or improved results to the handheld device. AHCA decided that the correct policy is to support the dissemination of Medicaid eligibility data; prescription refill data and Preferred Drug List data to Medicaid providers without specifically supporting one particular type of hardware or operating system platform. Starting July 1, 2009, the number of handheld devices in the field will be reduced to 1000, and the Bureau will develop an "Invitation to Negotiate" to find a vendor who can support a real time data feed of prescription drug program data to any certified medical practice management application that supports e-prescribing. At this time, providing a data feed to various e-prescribing applications rather

than just one application is more cost effective and the best way to assist physicians in adopting new technology.

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. In FY 2008-09 there were fewer than 50 individuals enrolled in the lock-in program. The program's major disadvantage is that it is a manual process that requires the time of an analyst and pharmacist to oversee. The Bureau is working with the fiscal agent to improve the use prescription data to identify specific behaviors, and seek electronic methods to "lock-in" behaviors rather than individual recipients.

Partnership with the Pharmacy Fiscal Agent, First Health Corp.

The Bureau of Pharmacy Services has worked pro-actively with the new fiscal agent to systematically review processes to prevent overbilling of pharmaceuticals, including:

- "Quantity Limitations" for numerous packaged products (such as inhalers) have been loaded into the point-of-sale (POS) system to ensure billing of appropriate quantities for up to a 34 day supply of medications.
- "Dose Limitations" have also been loaded into the POS system to ensure that pharmacists optimize tablet strengths at POS. Specifically, this prevents pharmacists from dispensing higher quantities of low dose tablets when a higher strength is more appropriate, and more cost effective.
- Injectable medications meant for IV infusion, often billed by home care or outpatient clinics, are being increasingly subjected to prior authorization criteria to ensure appropriate utilization.
- State Maximum Allowable Costs (SMAC) are uploaded quarterly to First Health, and the structured process has greatly increased uniform pricing for generic medications. Pharmacies can no longer find "gaps" in the SMAC database to facilitate overbilling of generics to the Medicaid program.

Starting June 2009, the "Date of Birth Edit" will be phased in over several months and across all benefit groups to require the date of birth on the prescription claim transaction to match the date of birth on the Medicaid eligibility file. This type of data matching has been implemented by commercial payors and many other state Medicaid programs. Historically, this type of data matching was not required

because of perceived errors in Medicaid eligibility processes at Department of Children & Families and the Social Security Administration. In 2008, review of three months of prescription data indicated that the birth date mismatch was less than one percent. However, the data review also indicated that there were adults obtaining medications on the eligibility status of children. The most cost effective and efficient course of action was to prevent this trend from increasing by requiring data matching.

Partnership with the Pharmacy Rebate Program, Unisys Corp.

The Bureau of Pharmacy Services worked with Unisys Corp to resolve rebate disputes from the POS System with WE Pharmaceuticals, Allergan Corporation and TEAMM Pharmaceuticals. The Bureau also worked collaboratively with Medicaid Program Integrity and Unisys to resolve rebates related to certain physician administered medications.

BUREAU OF MEDICAID CONTRACT MANAGEMENT

The Bureau of Medicaid Contract Management (MCM) is responsible for monitoring the AHCA'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 onsite inspections for prospective Medicaid providers to ensure they meet enrollment requirements pursuant to Section 409.907(7), Florida Statutes and Medicaid policy. For the period from July 2008 through June 2009, 543 site visits were conducted, leading to 418 approvals and 125 denials of applicants. This represents a significant drop in the total number of site visits conducted compared to the previous fiscal year which is directly attributed to a notable decrease in the total number of Durable Medicaid Equipment and Home Health Agency applications received for processing during this past fiscal year.

All applicants undergo fingerprinting for purposes of conducting a criminal history background check In accordance with Section 409.907(8), Florida Statutes and Medicaid policy. During FY 2008-09, 3,455 fingerprints were processed. This resulted in 20 denied applications and termination of six active providers.

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. One hundred and seventy three terminations are currently active in the PDCS, thus preventing further expenditures of Medicaid funds as required by federal guidelines.

The past fiscal year saw the transfer of the Medicaid fiscal agent contract from ACS State Healthcare to EDS which coincided with the launch of the new FMMIS. The design, development and implementation of the new FMMIS included expanded data elements to capture provider information in greater detail, increased reporting capabilities and automated data sharing with sister agencies and other divisions within AHCA.

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 housed in their provider records, request updates to that information, submit and track claims, retrieve remittance advice and verify recipient eligibility including prior authorizations.
- Application Processing – The new FMMIS uses a rules based engine to drive processing of provider enrollment applications. This includes an online provider enrollment application that guides applicants through completing the form using built-in edits that prevent submission of incomplete documents. Applicants may then track the progress of their application through the entire process using the online verification mechanism which gives real time status updates. Fiscal agent and AHCA staff utilizes an automated workflow management system that moves applications through each step of the verification process and notifies analysts when they have a pending task for an application. This allows greatly enhanced accountability for timeliness of application processing.
- 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 may be 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 FMMIS 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. This aids Medicaid staff in conducting site visits.

BUREAU OF PROGRAM ANALYSIS, THIRD PARTY LIABILITY UNIT

The Division of Medicaid's Third Party Liability Unit (TPL) 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 were contracted with Health Management Systems, Inc. through October 2008. Currently, Third Party Liability recovery services are contracted with ACS State Healthcare, LLC., for the following:

- 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, 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 for by Medicaid for which Medicare or another third party such as private insurance may have been liable.
- Cost avoidance - Cost avoidance is new and/or updated insurance information that is derived from data matches with insurance carriers. When new and/or updated insurance information is obtained, that information is added to the Medicaid database in order to cost avoid future claims that are submitted by Medicaid providers. When a provider submits a claim and a recipient has other insurance, the provider is instructed to bill the other insurance prior to billing Medicaid.

The chart below provides the TPL recoveries and cost avoidance for FYs 2004-05 through FY 2008-09:

Third Party Liability Recoveries					
	FY 2004-05	**FY 2005-06**	**FY 2006-07**	**FY 2007-08**	**FY 2008-09**
Casualty	$27,252,053	$26,648,342	$18,062,167	$17,681,026	$16,535,417
Estate/Trusts	$15,922,663	$14,836,825	$14,068,893	$12,756,605	$11,126,112
Medicare and Other Third Party Payer	$43,790,077	$70,807,531	$60,410,981	$45,006,352	$27,135,438
Total	$86,964,793	$112,292,698	$92,542,041	$75,443,983	$54,796,967

Third Party Liability Cost Avoidance				
FY 2004-05	**FY 2005-06**	**FY 2006-07**	**FY 2007-08**	**FY 2008-09**
$1,321,878,989	$1,409,616,013	$1,769,377,975	$1,783,550,123	$2,593,784,375

The Third party Liability Unit also made recoveries from the following special Medicaid projects completed in FY 2008-09:

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

Other TPL Special Project Recoveries for FY 2008-09	
Provider Amnesty (Credit Balance)	$2,018,682
Date of Death	74,611
Hospital Audits	3,841,103
Nursing Home Credit Balance Reviews	26,333,538
J-Code Rebates	182,335
Medicare Part B	182,427
Medicaid Overpayments	$2,355,295
Total[1]	**$34,987,991**

Office of the General Counsel

The Office of the General Counsel works in conjunction with other offices in the agency offices to deter fraud and abuse in the Florida Medicaid program to the greatest extent possible. The 14 attorneys comprising the Medicaid legal staff 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 AHCA or contracted vendors related to the recovery of overpayments from providers, protests related to public procurement activities and challenges to rules. Additionally, litigation can result from actions taken by the Division of Medicaid or Medicaid Program Integrity related to the provider's enrollment status (termination from the program), real-time reviews of claims for reimbursement (prepayment reviews), the withholding of reimbursements upon evidence of fraud, or other complaints by providers, recipients or advocacy groups.

During this past fiscal year, AHCA had a major victory in validating the use of statistical sampling when conducting Medicaid audits. The Florida courts rejected efforts by Custom Mobility, Inc., a Medicaid provider, to invalidate the use of a statistical formula when recouping overpayments from Medicaid providers. AHCA sent a Final Audit Report to Custom Mobility indicating that it had been overpaid. The overpayment amount was calculated by determining the amount of overpayments in a sample set of claims and then applying a statistical extrapolation formula to estimate the overpayment across the universe of claims during the subject audit period. Custom Mobility filed an administrative challenge to AHCA's authority to use the sampling without a rule. The administrative law judge ruled for Custom Mobility; however, the First District Court of Appeal unanimously reversed that decision and ruled that AHCA was within its authority to use its statistical sampling methodologies by holding that the statistical formula did not constitute a "rule" under Florida law. On February 2, 2009, the Florida Supreme Court declined to accept jurisdiction. During the pendency of the various appeals, the Bureau

[1] Some of these recoveries are reported in other areas.

held the cases that used statistical formulas in abeyance. As a result, several cases closed in the early part of 2009.

In addition to litigating Medicaid cases, the General Counsel's 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.

Division of Health Quality Assurance

ANTI-FRAUD ACTIVITY

The Division of Health Quality Assurance (HQA) has been involved in administrative actions of multiple types for 127 cases of fraudulent and abusive activity by home health agencies. The vast majority of these cases involved Miami-Dade County providers. Such activities were enabled by legislation passed in 2008 and are highlighted below.

Forty-eight home health agency licensure denials upheld (21 in Miami-Dade County, forty-two were licensed only, six Medicare only)

Home Health Agency licenses were denied for such reasons as submitting fraudulent financial statements that were not for the services and staff in the applications, having no valid proof of start-up funding, license fee check bounced, changes of ownership were made while processing the application for license, falsification of resumes of administrators, alternate administrators and directors of nursing or having no valid liability insurance. License renewals were denied for two agencies that reported not serving any patients in the past 12 months on their license renewal applications, for multiple unreported changes of ownership since licensed, for financial instability with non-payment of fines or for no valid insurance.

Twenty-four home health agencies found on survey that did not provide at least one service directly and did not have any patients (17 in Miami-Dade County -four Medicare & Medicaid, four Medicare only, 16 licensed only)

HQA revoked the license of one agency, upheld fines for five agencies and initiated legal action for the remainder.

Sixteen home health agencies found with fraudulent records (nine in Miami-Dade County, eight Medicare & Medicaid, eight Medicare only)

Fifteen of these agencies were found to have fraudulent patient records. Fines were imposed on three and legal action was initiated for the remainder.

Examples of fraudulent patient records included some that made the patients appear sicker than they were, records found to be incorrect when the patients were visited by nurse surveyors, and records demonstrating that certain documented nursing services could not possibly have been done, such as when two agencies reported giving the same patient the similar amounts of insulin morning and evenings.

One agency was found to have falsified health statements for their staff. Legal action is underway in the case.

Two home health agencies with confirmed billing for services not provided (Miami-Dade County, both Medicare & Medicaid)

Medicaid Program Integrity documented extensive fraudulent Medicaid billing for services not provided at a home health agency in Miami-Dade County. The Bureau of Health Facility Regulation prepared a Recommendation for Sanction using the Medicaid written findings for fines and revocation per Section 400.474(4), Florida Statutes.

The other agency was referred to the Medicaid Fraud Control Unit based on questionable Medicare billing found on an HQA field office survey.

Eleven home health agencies without a Director of Nursing for more than 30 days (eight in Miami-Dade County, one Medicare & Medicaid, three Medicare only, seven licensed only)

Four of these agencies had fines upheld and legal action is in process for the remainder.

Home health agencies found providing inappropriate remuneration for patient referrals

For inappropriate remuneration to discharge planners, case managers and facility staff from whom the home health agencies received referrals, four home health agencies (three in Palm Beach and one in Duval County; one Medicare and Medicaid, one Medicare only and two licensed only) had fines imposed and legal processes were initiated. Seventeen home health agencies, most in Palm Beach and St. Lucie Counties were found to have made unlawful remuneration to physicians (three Medicare and Medicaid, 13 Medicare only, and one licensed only).

Three agencies had fines imposed in Stuart, Winter Park and Sarasota. Sixteen agencies have fines in process.

The complaints included giving free air show tickets with food and beverages to 100 physicians, providing cookies to physician's offices and paying more than one medical director.

Two home health agencies (one Medicare, one licensed only) were found to have provided free or less than fair market value staffing services to Assisted Living Facilities (ALFs) in exchange for getting patient referrals (one in Broward and one in Palm Beach County). Fines were imposed for the Broward agency while the other has fines in the legal process.

Senate Bill 1986

Legislation passed in 2009 as Senate Bill 1986 designated Miami-Dade County as a health care fraud crisis area for purposes of implementing increased scrutiny of home health agencies, home medical equipment providers, health care clinics and other health care providers to strengthen the state's efforts to prevent Medicaid fraud, waste and abuse. The implementation of Senate Bill 1986 during the latter part of 2009 and 2010 is expected to have a further positive impact on conserving scarce public resources for appropriate use.

Health Care Clinics

Last Defendant Pleads Guilty in Chiropractic Health Care Fraud Scheme

Another area where the Division of Health Quality Assurance may occasionally become involved in fraud and abuse issues is with Health Care Clinics. In April 2009, the remaining federal defendants in U.S. v. Mike Williams, et al., pleaded guilty in Fort Lauderdale to defrauding 29 Florida insurance companies by submitting fraudulent health insurance claims forms to the carriers after using fraudulently obtained Health Care Clinic Certificates of Exemption. In order to be reimbursed by private health insurance carriers and automobile insurance companies, the defendants filed, and caused to be filed, fraudulent applications for certificates of exemption from licensure, falsely stating that the defendant clinics were wholly owned by licensed medical practitioners, in order to exempt the clinics from licensure under Section 400.9905, Florida Statutes. Certificates of Exemption from Licensure allow a health care clinic wholly owned by a licensed health care practitioner to operate without a required AHCA license. Managers of the Agency's Health Care Clinic Unit were witnesses in the case for the government and provided copies of the false applications for certificates of exemption for use at trial.

The defendants solicited victims of automobile accidents in order to file false and fraudulent insurance claims in excess of $3.4 million. The government also obtained final judgments against the defendants for the amounts of money they received as part of the conspiracy to defraud insurance companies.

A Chiropractic Physician, Christina Lapp, D.C., was at the center of the certificate of exemption scheme and received one year imprisonment, probation and a judgment of $500,000 for her part. She subsequently agreed to voluntarily relinquish her license to the Board of Chiropractic Medicine.

Summary of Health Care Clinic Unit Statistics

During FY 2008-09 the Health Care Clinic Unit took proposed Agency action against 96 clinics. Of these, four exemptions were denied for not meeting the statutory basis for an exemption which led to unlicensed letters being sent and referrals to law enforcement. During the same period, approximately 14 clinics lost exempt status based upon law enforcement determinations of unlicensed status and were subjects of criminal investigations. Numerous other referrals are under criminal investigation.

The Legislature requires licensed health care clinics that provide magnetic resonance imaging (MRI) to be accredited within the first year of operation and thereafter accredited at each two-year renewal period. This is to prevent cheap and unreadable MRI scans from being reimbursed by insurance, HMOs, Medicare or Medicaid. HQA issued eight notices of intent to deny the renewals based upon expired accreditations. In each case, the facility either went out of business, sold the assets to health care practitioners after the complaint was filed or obtained accreditation and paid a fine.

The Legislature mandated that licensed health care clinics be supervised by a medical (physician) or clinic (non-physician) director. Eighteen clinics received either an administrative complaint to revoke their licenses, deny an existing application for renewal or change of ownership application during FY2008-09. Most clinics obtained medical or clinic directors and paid a fine. In several instances the license applications were denied or the license was revoked by administrative complaint.

Division of Operations

Amounts identified as overpayments are generally referred to the Division of Operations, Bureau of Finance and Accounting, for collections. Once an overpayment has been determined, the federal share is returned within 60 days. The state then pursues collection of the receivables from the Medicaid provider. The Bureau of Finance and Accounting collects 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. Staff continues to work aggressively to reduce outstanding receivables within the Medicaid program.

During FY 2008-09, accounts receivable collections, net of adjustments and refunds approached $38.4 million. As of June 30, 2008, Medicaid accounts receivable for fraud and abuse stood at $38.8 million and the balance as of June 30, 2009 was $41 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 out of business,
- the defendant is unable to pay because of incarceration, or
- otherwise is insolvent, or is beyond the State's current collection enforcement policy.

Once the receivable is approved for write-off, and written off, if deemed qualified, the federal share of each receivable write-off is reclaimed. During FY 2008-09, $411,285.78 in receivables was approved for write-offs during the federal fiscal year. The federal requirements only allow funding to be reclaimed when the write-off is due to a bankruptcy in which AHCA filed a claim (even if the bankruptcy had already been discharged at the time the bankruptcy is discovered), for an individual who is deceased and AHCA 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). AHCA is continuing to research and develop processes whereby it can certify that a provider is out of business and thereby reclaim the federal share. AHCA has also implemented new policies and procedures involving the Bureau of Finance and Accounting working with the Bureau of Long-Term Care Services to increase monies recovered from Medicaid overpayments. These accomplishments in dealing with Medicaid accounts receivable resulted from a number of actions taken by the Bureau of Finance and Accounting during the year.

It should be noted that even after write-off, monies are received from providers. In FY 2008-09, the Division of Operations received over $297,000.00 in funds previously written off.

The Bureau of Finance and Accounting continues to refine the Medicaid Accounts Receivable, or MAR system, that records extensive financial detail on Medicaid accounts receivables. The MAR system tracks each case as it moves through the receivables process, emphasizing which department, bureau or unit has current responsibility for a case. The Bureau calculates interest for cases as appropriate, while the system tracks state or federal allocation of receivables activity, and produces necessary reports for case management and audit purposes. Examples of reports include case financial summaries, case financial histories, case aging, summary by status, and department, "tickler file" and reports for staff follow-up. The MAR system maintains the required accounting data for financial 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 has taken aggressive steps during the year to reduce the length of negotiated payment plans from a maximum of two years to a maximum of one year, unless a hardship is determined and will continue to strive to achieve repayments as promptly as possible.

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, Long-Term Care Services and the Office of Inspector General to coordinate efforts and pursue additional avenues of collection.

Partnerships with Other State Agencies

AGENCY FOR PERSONS WITH DISABILITIES

The Agency for Persons with Disabilities (APD) has a cooperative agreement with the Agency for Health Care Administration (AHCA) to administer the day-to-day operations of the federally approved Home and Community-Based Services waiver for persons with Developmental Disabilities (HCBS/DD or APD waiver). Home and community-based waivers are a waiver of Section 1915C (choice of community) of the Social Security Act. When a state requests a waiver, they are asking the Federal government to use money that would be spent on an eligible individual in an institutional setting (hospital, nursing home or Institutional Care Facility for Developmental Disabilities (ICF/DD)) in a community setting. States have to specify the services to be provided and then provide all services necessary to divert or deinstitutionalize a person from an institutional setting.

All waivers have to be cost effective in that the cost of the community setting cannot exceed the institutional setting. Some waivers measure cost-effectiveness against each individual in the waiver. An example is the Project Aids Care waiver that measures cost-effectiveness against hospital level of care. The person cannot receive services greater that the cost of 45 days of inpatient hospitalization (Florida's liability for inpatient hospitalization is capped at 45 days.) Other waivers look at aggregate costs to measure cost-effectiveness. The individual community services may greatly exceed the cost of the institutional placement, but when combined with all of the other participants in the waiver the aggregate cost per recipient does not exceed the aggregate cost of institutional care. An example of this type of cost-effective measure is the APD waiver.

Waiver programs identify specific services to be covered for enrolled recipients. Typical services include personal care assistance, day training, nursing, adult dental, consumable medical supplies and durable medical equipment not covered by the regular Medicaid program. All services must be identified and prescribed under an individual plan of care for each person on the waiver. Currently ACHA has approximately thirteen waiver programs. The largest of the waiver programs is the one administered by APD.

APD, AHCA, MPI and MFCU have increased their cooperation and communication over the past year in an effort to combat Medicaid fraud and abuse in Medicaid waiver programs. These agencies and other partners attend bimonthly Interagency Medicaid Fraud meetings held by AHCA. APD also holds quarterly Medicaid Waiver Fraud meetings that include representatives from MPI, MFCU, APD Operations and the APD Inspector General staff. The quarterly meetings focus specifically on waiver program fraud. Attendance at both meetings continues to grow.

There has been a significant increase in detection and enforcement activity against fraud in the Medicaid waiver programs. Both MPI and MFCU have increased the number of investigations of waiver fraud cases over the fiscal year. MPI has also increased the number of investigations and added resources to waiver program reviews and investigations.

Medicaid waiver program fraud can have direct and severely damaging effects on a very vulnerable recipient population. For example, APD assisted MPI and MFCU in an investigation of a building contractor defrauding Medicaid recipients with disabilities by failing to construct disability accommodations such as wheelchair ramps and modified bathrooms after contracting and being paid by Medicaid for the construction. This type of fraud can be devastating to people with disabilities, some of whom who cannot leave or may be those who were left with an inoperable bathroom. APD is helping fraud victims with recovery efforts.

This type of cooperation between Medicaid agencies establishes a successful pattern for the future. The exchange of information, program knowledge and field assistance can make the difference between making a case and not being able to prove any violation occurred. Medicaid waiver providers also need to become involved in efforts to combat fraud and overpayments. APD is emphasizing this need in its employee and provider training and is producing brochures and other informational materials about Medicaid waiver fraud.

DEPARTMENT OF HEALTH

The Department of Health (DOH) has continued its partnership with the Agency for Health Care Administration (AHCA) and the Medicaid Fraud Control Unit (MFCU) to streamline intra-agency coordination and to enhance processes and protocols. An interactive partnership is essential for effective, collaborative investigative projects aimed at protecting the people of Florida against health care fraud and substandard health care.

The DOH Director for the Division of Medical Quality Assurance (MQA) meets regularly with directors and senior managers of the AHCA Office of the Inspector General, the Division of Medicaid and MFCU to coordinate participation in joint projects, investigations and enforcement strategies. This includes the regular briefing of the AHCA Secretary on the nature and progress of these collaborative efforts. Of particular significance is the ongoing collaboration of legislative bill analysis and implementation of Senate Bill 1986. This legislation enables AHCA and DOH to build upon their sharing of information so that newly enacted provisions are effectuated. This will permit DOH's increased authority for licensure denial and disciplinary actions to be accomplished promptly against health care practitioners terminated from Medicaid or Medicare programs or convicted of felony fraud crimes and misdemeanor fraud crimes involving health care.

DOH/MQA enforcement managers meet regularly with managers and investigators from the AHCA Bureau of Medicaid Program Integrity (MPI) and the Office of the Inspector General to coordinate

referral of complaints to DOH, as well as to plan and organize participation in joint investigative projects. This past year a total of 42 legally sufficient referrals were received by DOH. After investigation by DOH, no practice act violation was found in 20 cases, Letters of Guidance were issued in four cases and 18 cases are under legal review or awaiting presentation before a probable cause panel. In addition the Southern District offices supported two AHCA Medicaid fraud and abuse projects. The DOH Miami Investigation Manager provided support to the MPI Home Health Agency project in Miami-Dade County and DOH investigators from multiple Southern District offices participated in the joint AHCA/MFCU/DOH Review of Waste, Fraud and Abuse in Radiological and Diagnostic Procedures Project. As a result, DOH opened investigations on one licensed massage therapist and six physicians for practice act violations revealed during the onsite inspections. Probable cause was found against the massage therapist for practicing outside the scope of licensure. The case against one physician was closed with no finding of probable cause and the remaining five cases are under legal review or pending probable cause determination. DOH/MQA and the Bureau of Vital Statistics coordinated with and supported the AHCA MPI-MFCU Dead Doctor Project. By providing electronic sharing of DOH vital statistics information, AHCA is able to promptly terminate Medicaid providers that are deceased. This eliminates the potential fraudulent use of those provider numbers to bill the Medicaid program.

The DOH/MQA Chief of Investigative Services Unit (ISU) meets bi-weekly with senior officers of MFCU to review current cases, coordinate investigative efforts and analyze trends in health care fraud. Specific initiatives this year included an increase in the number of reciprocal training opportunities to advance a better understanding of the mission, authority and scope of respective programs. The MQA/ISU Chief conducted DOH/MQA enforcement program presentations at two successive MFCU Basic Training Classes at Pat Thomas Law Enforcement Academy. In return the MFCU Statewide PANE Lieutenant provided a program presentation for the MQA/ISU Annual Investigator Training conference. Planning and coordination was completed for MFCU field investigators to attend and participate in DOH/MQA Regional Investigator training in FY 2009-10.

The Chief of the MQA Prosecution Services Unit (PSU) coordinated the revision of the DOH Emergency Suspension/Restriction Manual with a matrix from ISU that has been shared with the Office of the Attorney General, Medicaid Fraud Control Unit to facilitate better understanding of and closer collaboration between, criminal and administrative actions or prosecutions. Close coordination between MQA enforcement investigators or attorneys and MFCU investigators resulted in the issuance of Emergency Suspension Orders on David W. Webb, M.D. and Yong Am Park, Limited License M.D., as well as the disciplinary voluntary surrender of licensure from William Dana Holton, P.A.

Statutory Reporting Requirements

In accordance with requirements of Section 409.913, Florida Statutes, the Agency for Health Care Administration (AHCA) and the Medicaid Fraud Control Unit (MFCU) of the Attorney General's Office submit the following:

NUMBER OF CASES OPENED AND INVESTIGATED EACH YEAR

MFCU reviewed 1,239 complaints that resulted in 372 cases being opened. MPI investigated 2,619 cases, which included 1,438 opened during FY 2008-09.

SOURCES OF THE CASES OPENED IN FY 2008-09

	Source	MFCU	PANE	AHCA
AHCA	Area/District Office Staff	1		4
	Medicaid Headquarters Staff	1		16
	MPI Generated	64	2	1203
	Office of the Inspector General	15		
	Bureau of Managed Care	1		
	Other	2		8
Public	Anonymous	17		
	Citizens	9	1	3
	Provider	11		107
	Qui-Tam	50		
	Recipient	1		29
State Agencies	Department of Children & Families	5	66	
	Agency for Persons with Disabilities	9	5	
	Department of Health	2		
	Other State Agencies	3		10
Federal Agencies	Health & Human Services	3		41
	CMS	1		
Law Enforcement	Florida MFCU Generated	55	23	11
	MFCU Spin-off Case	10		
	Department of Justice	1		
	Federal Bureau of Investigation	2		
	Local Law Enforcement	3	1	
Other	Family Member	5		
	HMO Investigative Unit			6
	Operation Spot Check		1	
Employee		1		
Long Term Care Ombudsman Council			1	
	Total	**272**	**100**	**1438**

DISPOSITION OF THE CASES CLOSED

MFCU and MPI closed 2078 investigations. (MFCU closed 464, MPI closed 1,614.) The cases closed are summarized below:

Disposition of Closed Cases in FY 2008-09			
	MFCU	PANE	AHCA
Lack of Evidence	95	33	
Acquittal	1	1	
Administrative Closure	10	19	
Administrative Referral	39	9	
Assistance to Other Agencies	7	1	
Case Dismissed	6	1	
Civil Intervention Declined	7		
Civil Judgment	2		
Civil Settlement	40		
Consolidated	9	1	
Conviction	56	26	
Defendant Deceased	1		
Defendant Filed Bankruptcy	2		
No Fraud or Abuse Found			309
Nolle Prosequi	2	2	
Not a Medicaid Provider	1		
Overpayment Identified			1,288
Pretrial Intervention	2	1	
Prosecution Declined	1	6	
Provider Education Letter			17
Resolved with Intervention	1		
Statute of Limitations Expired	2		
Unfounded	59	21	
Total	**343**	**121**	**1,614**

MPI closed 1,614 cases during FY 2008-09 with 309 identified no findings of fraud and abuse. Therefore, no further action was taken. Seventeen of the cases closed after findings of non-compliance, but no resulting overpayments. Therefore, the provider was issued a provider education letter. One thousand, two hundred and eighty-eight cases closed identifying an overpayment. The provider may have repaid the overpayment amount or requested an administrative hearing, which was resolved by an administrative hearing or a settlement agreement. Both situations 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 all 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 audit report, which reflects the overpayments identified and offers the provider hearing rights under Chapter 120, Florida Statutes. For the 1,614 cases closed during the fiscal year, 1,288 preliminary audit reports were sent identifying overpayments of $25,019,516. Of these, 734 cases closed after the preliminary audit report with identified overpayments of $2,261,150. Based on a review of additional documentation, final audit reports totaling $14,872,291 were sent for the remaining 554 cases.

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 or criminal violations. During FY 2008-09, MPI placed 99 providers under prepayment review, recommended termination of 66 providers and referred 123 providers to MFCU for investigation and an additional 16 providers for informational purposes. AHCA also fined 501 providers $481,228.

REDUCTIONS IN OVERPAYMENT AMOUNTS NEGOTIATED IN SETTLEMENTS OR BY OTHER MEANS

No overpayments were reduced by negotiation during FY 2008-09.

AMOUNT OF FINAL AHCA DETERMINATION OF OVERPAYMENTS

In FY 2008-09, 734 cases totaling $2,261,150 were closed by MPI after preliminary audit reports. 210 cases totaling $6,201,081 were closed after final audit reports. Final orders issued on the remaining 344 cases totaled $7,163,207. The reductions were based on the results of hearings or on additional documentation provided during the hearing process.

AMOUNT DEDUCTED FROM FEDERAL CLAIMING AS A RESULT OF OVERPAYMENTS

Within 60 days of MPI's final order, AHCA 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 2008-09, AHCA reduced its federal claiming by $12.1 million for net overpayments determined.

AMOUNT OF OVERPAYMENTS RECOVERED

MFCU collected $22,226,989 in overpayments that were returned to AHCA. Additionally, MFCU collected $42,768,228 in federal Medicaid overpayments which were sent directly to the U. S. Department of Health and Human Services for a total of $64,995,217 in Medicaid overpayments collected in FY 2008-09. During FY 2008-09, AHCA collected $38.4 million in overpayments. This includes nearly $23 million collected from MFCU cases and $15.4 million collected from MPI cases.

AMOUNT OF INVESTIGATION COSTS RECOVERED

During FY 2008-09, the MFCU collected $414,851 in investigative costs. During this same time period, AHCA recovered $49,850 in investigation costs.

AVERAGE LENGTH OF TIME TO COLLECT FROM THE TIME THE CASE WAS OPENED UNTIL THE OVERPAYMENT IS PAID IN FULL

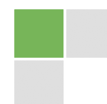
For all cases paid in full during FY 2008-09, the average length of time from the date the case was opened to the date the case was paid in full was 311 days.

AMOUNT DETERMINED AS UNCOLLECTIBLE AND RECLAIMED UNCOLLECTIBLE

During FY 2008-09, the Department of Financial Services deemed $411,286 uncollectible and approved for write-off. The total amount collected after the cases were written off was $297,903.

NUMBER OF PROVIDERS, BY TYPE, TERMINATED FROM THE MEDICAID PROGRAM AS A RESULT OF FRAUD AND ABUSE

Agency Terminated Providers in FY 2008-09	No.
Assistive Care Services	4
Pharmacy	1
Physician (ME)	15
Chiropractor	3
Dentist	1
Home Health Agency	7
Home and Community-Based Services Waiver	42
Therapist	3
Durable Medical Equipment and Supplies	2
Total	**78**



COSTS ASSOCIATED WITH DISCOVERING AND PROSECUTING CASES OF MEDICAID OVERPAYMENTS AND MAKING RECOVERIES IN SUCH CASES

MFCU costs associated with discovering and prosecuting cases of Medicaid fraud and overpayments for FY 2008-09 were $18,868,608, which included indirect costs of $2,177,106.

Expenditures for MPI in FY 2008-09 were $7,661,020 which includes salaries, expenses and contractual services. In addition, costs of $1,391,711 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 indirect costs of $1,296,339 and the Bureau of Medicaid incurred expenses for services related to MPI activities for $4,756,337 (primarily contingency fees). Therefore, total costs of $15,105,407 were associated with MPI operations.

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

In FY 2008-09, 98 applicants were denied enrollment based on documented Medicaid fraud and abuse. An additional six providers were terminated because they were on the Medicare exclusion list in accordance with Section 409.913(14), Florida Statutes and Medicaid policy.

RECOMMENDATIONS FOR CHANGES TO PREVENT AND/OR RECOVER OVERPAYMENTS

Over the years the Agency for Health Care Administration has made numerous recommendations for strengthening AHCA's fight against Medicaid fraud and abuse. Additionally, the Florida Legislature has enacted many statutory provisions that assist in MPI's efforts to prevent, detect and recoup Medicaid fraud and overpayments.

MPI was established in January 1980 and as of the end of FY 2007-08 had completed over 50,000 audits. The bureau has approximately 100 full time equivalent positions but over the past fifteen years has grown much more slowly than the Medicaid program or the Medicaid Fraud Control Unit.

MPI has staff members who are trained and competent in accounting, computer systems, pharmacy, nursing and statistical analysis. They have developed methods for performing computer-assisted inferential and analytical audits in an efficient and accurate manner. They have developed and utilized, to the degree permitted by resources, statistical methods for detecting fraud and abuse.

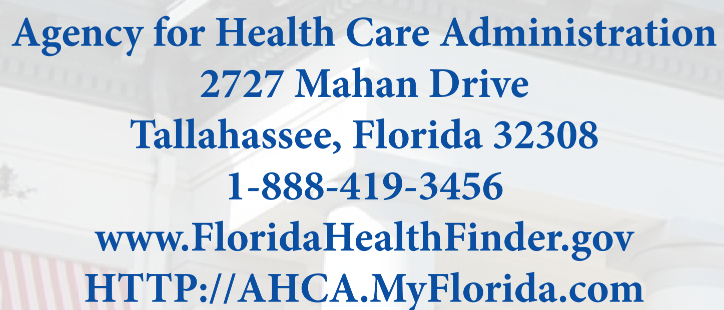
For FY 2008-09, the return on investment in MPI was over five to one (5:1), which is highly advantageous for the Medicaid program and the state budget.

In order to significantly increase overpayment recoveries, two actions should be considered:

- MPI and AHCA should develop a more sophisticated and effective overpayment detection system that would increase the probability of identifying questionable claims both before and after the claims are paid.
- MPI staffing levels should be evaluated to determine whether optimal resources exist to carry out the mission of preventing, detecting and recouping fraud and abuse overpayments. Detection and investigation has proved historically to be most effective when staff expertise by provider types can be utilized to review activities of those providers and compliance with Medicaid policies. Optimal staffing levels would permit MPI to:
    - Conduct more prepayment reviews,
    - Perform greater managed care oversight,
    - Conduct additional fee-for-serve provider oversight,
    - Develop and improve detection tools, and
    - Increase the general deterrent effect on provider fraud and abuse.

It should be noted that AHCA implemented a number of fraud oversight processes in FY 2008-09 to increase agency-wide awareness and involvement in the efforts to prevent, detect and recoup Medicaid fraud and abuse overpayments. AHCA established a new Fraud Steering Committee, comprised of the Secretary and six senior managers, supported by three sub-committees. This new program was designed to help AHCA identify, and take action in areas in which the staff can take internal steps to better fight fraud, but also serves to assist in such related areas as complying with the directives of Senate Bill 1986 or other legislation, and developing recommendations for statutory changes to be made to the Florida Legislature. In FY 2009-10, the Fraud Steering Committee will play an essential role in AHCA's mission to reduce overpayments in the Medicaid program.

To submit questions, comments or to obtain an electronic copy of this report, please refer to http://ahca.myflorida.com/Executive/Inspector_General/index.shtml, or contact the Office of the Inspector General, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop #4, Tallahassee, Florida 32308.



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