The State's Efforts to Control Medicaid Fraud and Abuse

FY 2009 - 2010

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

December 2010

December 31, 2010

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 FY 2009-10. 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,

Elizabeth Dudek
Interim Secretary

BM/ED/kjn

cc: The Honorable Denise Grimsley
The Honorable Matt Hudson
The Honorable Robert Schenck
The Honorable Gayle Harrell
The Honorable John Wood
The Honorable Dean Cannon
The Honorable J.D. Alexander
The Honorable Joe Negron
The Honorable Rene Garcia
The Honorable Mike Haridopolos

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Statutory Authority

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 to collaborate closely with each other as well as other partners in the efforts to combat fraud, including, DOH, Florida Department of Law Enforcement (FDLE), Department of Children & Families (DCF), Agency for Persons with Disabilities (APD) 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 2009-10.

Medicaid Program Overview

Medicaid serves Florida's most vulnerable citizens -27% of children, 51.2% of newborn deliveries, 63% of nursing home days and 1,162,020 adults – parents, aged and disabled. If a state chooses to participate in the Medicaid program, the state is then obligated to provide services to all individuals who are eligible for the program. A state cannot limit the number of people its Medicaid program will serve and cannot limit provision of medically necessary state plan services to enrollees based on budgetary constraints. For this reason, states that participate in the program are not able to exercise complete control over program enrollment or program expenditures. As a result, during times of economic stress and/or high unemployment, program enrollment and expenditures can grow dramatically. According to the National Bureau of Economic Research, the current recession began in December 2007. On November 30, 2007, there were 2.12 million recipients enrolled in the Florida Medicaid program. As of July 31, 2010, there were 2.82 million enrollees. This represents an increase of 33%.

Enrollment growth has been the primary driver of increased program costs. While states can exercise some control over per recipient costs through program efficiencies, elimination of inappropriate utilization and most recently for Florida, reductions in the rates paid to Medicaid institutional providers, they are not able to control overall program growth. Additionally, federal legislation may factor into a state's ability to control program growth. The Affordable Care Act of 2010 requires states to maintain certain eligibility criteria which may effectively preclude the reduction of eligibility. Under the maintenance of effort requirement in the Affordable Care Act, states must maintain their current Medicaid eligibility levels for adults through December 31, 2013. States are prohibited from reducing eligibility levels for children through September 30, 2019.

Total expenditures for the Florida Medicaid Program for FY 2007-08 were $14.8 billion with a per member/per month (PMPM) cost of $574.10. The Florida Medicaid Program for FY 2010-11 is appropriated $20.8 billion, with a PMPM cost of $587.14. It is estimated that program costs for FY 2010-11 will be approximately 20.3 billion, with a PMPM cost of $572.72. In summary, enrollment in the Florida Medicaid program increased by 33%, while expenditures are anticipated to have increased by 40% by the end of FY 2010-11. During this same period, per member per month costs have been reduced by .2%.

Over the past several budget years, program reductions have been implemented, including reductions in rates for hospice, nursing home diversion, MediPass, prepaid mental health, managed care, county health department clinic services, non-emergency transportation, pharmacy and dialysis providers. In addition, the Agency has continually reviewed the Florida Medicaid program and worked to reduce costs through improved efficiency, utilization review and prior authorization of services. As these cost reduction efforts were being implemented, the Agency also increased accountability and programs to eliminate fraud, abuse and overpayments within the program.

While there continues to be growth in the Medicaid program and the Agency has implemented efforts to manage costs, the Agency recognizes the continuing need to be persistent about deterrence and detection of fraud and abuse. Health care fraud is a serious and costly problem that affects all Floridians. Although there are varying estimates of the amount of program loss due to fraud and abuse, no one knows for certain how much fraud exists in the Medicaid program. While the national estimates range from a low of one percent to a high of 20 percent, these estimates should be applied to each distinct provider type and not to the program as a whole.

The following chart identifies expenditures for different service categories, ranked from largest to smallest, and identifies utilization management controls employed to mitigate the risk of fraud for each service type. For example, while it is known that fraud and abuse for home health and DME is high, the Agency has been very aggressive in implementing programs to better manage these services to reduce the risk to the state. Many of the larger provider types identified on this chart have experienced very low rates of fraud and abuse. As a result, it is difficult to apply an overall rate of fraud and abuse to the entire Medicaid program.

Service	FY 2009-10 Estimated Spending (Feb 2010 SSEC)	Percent of Total Medicaid Expenditures	Internal Controls in Use
Hospital Inpatient Services	$3,332,571,982	17.72%	Agency employs utilization management, prior authorization and independent cost report audits.
Prepaid Health Plans	$2,833,819,324	15.07%	Health plans have incentive to prevent fraud or abuse within their networks. No indication of systemic issues of fraud or abuse.
Nursing Home Care	$2,746,546,910	14.60%	No history of systemic issues of fraud or abuse.
Prescribed Medicine	$1,156,907,611	6.15%	Prior authorization, Preferred Drug List, Point-of-sale controls and step therapy have all succeeded in driving fraud rates down.
Low Income Pool	$1,123,827,163	5.97%	Limited opportunity for cost savings through fraud and abuse prevention efforts.
Supplemental Medical Insurance	$1,042,010,812	5.54%	No opportunity for cost savings through fraud and abuse prevention efforts.
Home & Community Based Services	$1,018,388,733	5.41%	Additional utilization management and systems edits being implemented. Additional opportunities for program oversight are being identified.
Physician Services	$978,796,614	5.20%	Utilization management, provider profiling, prior authorization and systems edits in place. Additional measures resulting from SB 1986 are decreasing potential for fraud and abuse. Additional opportunities for program oversight are being identified.
Hospital Outpatient Services	$930,839,668	4.95%	Utilization management, prior authorization, already in place.
Medicare Part D	$463,049,976	2.46%	No opportunity for cost savings or changes in utilization through fraud and abuse prevention efforts. Part D Clawback is a fixed payment to CMS.
Hospice Services	$351,607,323	1.87%	No indication of systemic issues of fraud or abuse.
Nursing Home Diversion Waiver	$338,177,729	1.80%	Diversion providers have incentive to prevent fraud or abuse within their networks.
Intermediate Care Facility/DD	$332,781,031	1.77%	Limited indication of systemic issues of fraud or abuse or overpayments.
Disproportionate Share Hospital Payments	$246,570,577	1.31%	Limited opportunity for cost savings through fraud and abuse prevention efforts.
Private Duty Nursing	$188,643,923	1.00%	Utilization management, provider profiling, prior authorization and systems edits in place. Additional measures resulting from SB 1986 are decreasing potential for fraud and abuse. Additional opportunities for program oversight are being identified.
Home Health Services/ Durable Medical Equipment	$133,963,435	0.71%	Utilization management, provider profiling, prior authorization and systems edits in place. Additional measures resulting from SB 1986 are decreasing potential for fraud and abuse. Additional opportunities for program oversight are being identified.
Hospital Insurance Benefits	$150,979,835	0.80%	No opportunity for cost savings or changes in utilization through fraud and abuse prevention efforts.
Physician UPL	$95,000,000	0.51%	Limited opportunity for cost savings or changes in utilization through fraud and abuse prevention efforts.
Other	$1,345,571,141	7.15%	
Total	**$18,810,053,787**	100%	

Medicaid Fraud Control Unit

Overview of the Medicaid Fraud Control Unit

There were 217 full-time employees (FTEs) assigned to the MFCU in FY 2009-10, although the Unit has 30 positions frozen due to budget constraints. One hundred twenty-six FTEs are investigators and their supervisors/managers, 27 FTEs 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 44 assigned FTEs and has offices in Jacksonville (14 FTEs), Tallahassee (22 FTEs) and Pensacola (eight FTEs). The Central region has 46 assigned FTEs and has offices in Orlando (14 FTEs), Tampa (30 FTEs), St. Petersburg (two FTEs). The South region has 88 assigned FTEs and has offices in Miami (49 FTEs), Ft. Lauderdale (21 FTEs) and West Palm Beach (18 FTEs). Additionally, there are two other entities within MFCU, the Director's office (24 FTEs) and the Complex Civil Enforcement Bureau (15 FTEs).

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 2009-10, the Unit received a total of 1,866 complaints. For FY 2008-09, the Unit received a total of 1,236 complaints. Of the 1,866 complaints received in FY 2009-10, 388 were opened as operational cases. Of the 1,236 complaints received in FY 2008-09, 372 were opened as operational cases. The Unit's policy requires a 30-day review of complaints and allegations to determine whether the matter has merit, can be referred or is unfounded. Case openings occur only when there is a criminal or civil predicate that warrants further investigative activities. As a result, complaints are screened more quickly and complaints or allegations that are more viable lead to the opening of a full investigation.

Of the 1,866 complaints received in FY 2009-10, 1,035 were related to fraud and 831 were related to PANE allegations. For FY 2008-09, of the 1,236 complaints received, 508 were related to fraud and 728 were related to PANE. In FY 2009-10, the primary source of Medicaid fraud complaints was citizens; 440 complaints received were made by private citizens. (This is an increase of over 150 percent from 175 the previous year– likely due to the implementation of the Informant Reward Program, Florida Statute 409.9203.) The Agency's Medicaid Program Integrity was the next highest source of fraud complaints with 103 and *qui tam*, or whistleblower, complaints followed with 94. Other sources of Medicaid fraud complaints included 85 from Medicaid recipients and 56 from family members.

The primary source of fraud complaints in FY 2008-09 was again citizens with 175 complaints reported. The Agency, via its Medicaid Program Integrity (MPI) unit, accounted for 84 of the Medicaid fraud complaints received. Fifty-six *qui tam* complaints were received.

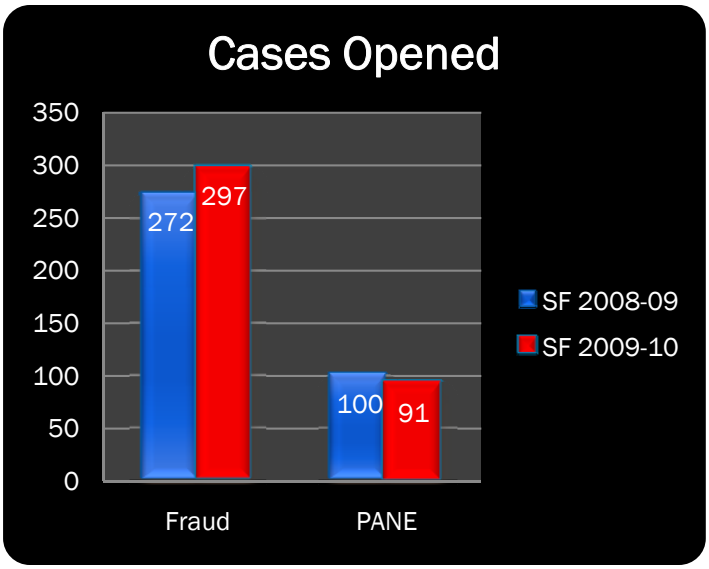
The overwhelming majority of PANE complaints are generated by the Department of Children & Families (DCF). In FY 2009-10, of the 831 PANE complaints, 690 came from DCF. The next-highest source of PANE complaints was citizens, who accounted for 67 complaints. In FY 2008-09, of the 728 PANE complaints, 594 came from DCF. Citizen complaints accounted for 51 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 identified, and significant investigative resources and time will be expended to identify those involved in possible misconduct, determine the scope of the activity and establish sufficient evidence to prove the requisite 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 2008-09, the MFCU opened 372 total cases. Of those cases, 272 cases were related to Medicaid fraud. The remaining 100 cases were PANE cases. The North Region opened a total of 118 cases. Of those cases, 66 were related to Medicaid fraud and 52 were PANE cases. The Central Region opened a total of 111 cases, of which 77 were related to Medicaid fraud. The remaining 34 case openings were PANE cases. In the South Region, there were a total of 97 cases opened in FY 2008-09. Eighty-three of the case openings were related to Medicaid fraud and the remaining 14 were PANE cases. The Complex Civil Enforcement Bureau (CCEB) opened 46 *qui tam* litigation cases which are included in the fraud case total.

In FY 2009-10, the MFCU opened a total of 388 cases. This is a 4.3 percent increase in the number of operational cases opened. In FY 2009-10, the North Region opened a total of 107 cases. Of those cases, 54 were related to Medicaid fraud. The remaining 53 case openings were PANE cases. In the Central Region, there were a total of 136 cases opened. Of these, 115 were related to Medicaid fraud. The remaining 21 were PANE cases. In the South Region, there were a total of 66 cases opened in FY 2009-10. Of these, 49 were related to Medicaid fraud and the remaining 17 cases were PANE cases. The Complex Civil enforcement Bureau (CCEB) opened 79 *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 Medicaid fraud in FY 2008-09 and the specified period of FY 2009-10, ranked most to least frequent:

FY 2008-09	FY 2009-2010
Home & Community Based Service	Home & Community Based Service
Pharmaceutical Manufacturer	Pharmaceutical Manufacturer
Physician (MD)	Physician (MD)
General Hospital	Medical Supplies/Durable Medical Equipment
Therapist	Community Alcohol/Drug/Mental Health

The following is a list of the top five Provider types for PANE cases in FY 2008-09 and the specified period of FY 2009-10, ranked most to least frequent:

FY 2008-09	FY 2009-10
Home & Community Based Service	Facility Employee
Care Giver	Home & Community Based Service
Certified Nursing Assistant (CNA)	Assisted Living Facility
Assistive Care Services	Nursing Home
Assisted Living Facility	Certified Nursing Assistant (CNA)

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

Disposition of Cases

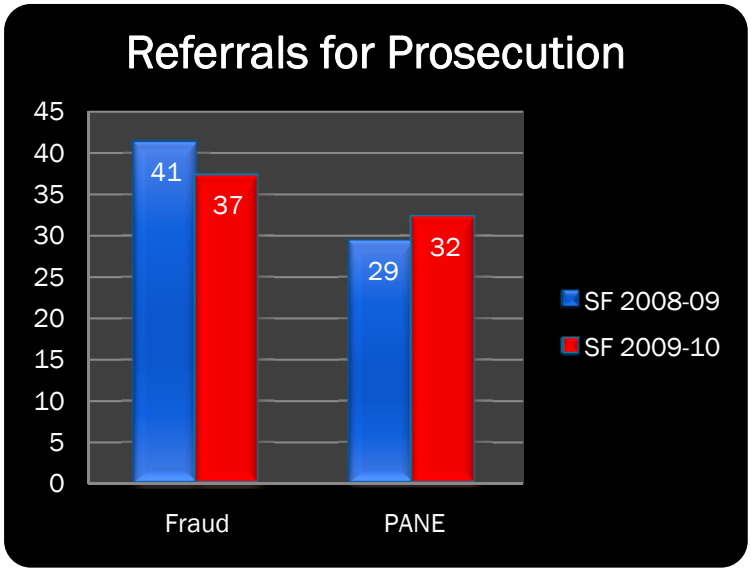
Following an investigation, a determination is made whether to pursue criminal prosecution or file civil actions. All case investigations will eventually be formally closed because of either a successful prosecution or a lack of evidence. There are several classifications presently used that track the ultimate disposition of closed cases. It is important to note that cases closed during a particular fiscal 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 fiscal year, whether the case is pursued civilly or criminally.

In FY 2008-09, the MFCU closed 464 cases. Of those, 343 involved Medicaid fraud investigations and 121 involved PANE cases. In FY 2009-10, the MFCU closed 383 cases. Of those, 276 involved Medicaid fraud investigations and 107 involved PANE cases.

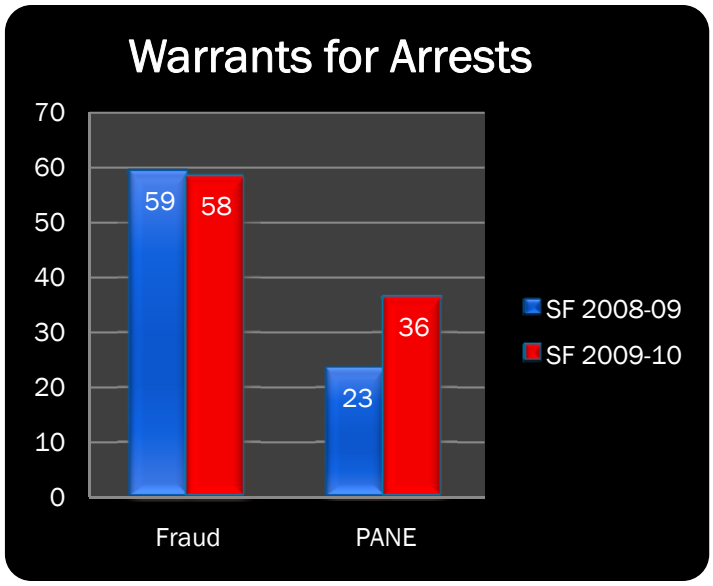
Enforcement actions are a paramount consideration for the MFCU. At the conclusion of any investigation, referrals for prosecutions, execution of arrest warrants and monetary recoveries are indicators of successful case outcomes. In FY 2008-09, 70 cases were referred for prosecution. Forty-one of these cases were based upon Medicaid fraud investigations and the other 29 were based upon PANE investigations. The Northern Region accounted for 33 of these referrals for prosecution, the Southern Region accounted for 19 prosecution referrals and the Central Region accounted for 18 prosecution referrals.

For FY 2009-10, 69 cases were referred for prosecution. Thirty-seven of these cases were based upon Medicaid fraud investigations and the other 32 were based upon PANE investigations. The Northern Region accounted for 31 of these referrals for prosecution, the Southern Region accounted for 22 prosecution referrals and the Central Region accounted for 16 prosecution referrals.



In FY 2008-09, there were 82 arrests/warrants made based upon MFCU criminal investigations. Fifty-nine of these arrests/warrants were related to Medicaid fraud investigations and 23 were for PANE investigations. The South Region accounted for 50 of these arrests/warrants, which were predominantly for Medicaid fraud. The Northern Region accounted for 17 arrest/warrants and the Central Region accounted for 15 arrests warrants in FY 2008-09.

For FY 2009-10, there were 94 arrests/warrants made. Fifty-eight of these were Medicaid fraud investigations and 36 were for PANE investigations. The South Region accounted for 39 of the arrests/warrants. The North Region accounted for 33 arrests/warrants and the Central Region accounted for 22 arrests/warrants.



Investigative Strategy

The MFCU has two primary areas of enforcement responsibility: fraud perpetrated against the Medicaid Program and Patient Abuse, Neglect & 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:

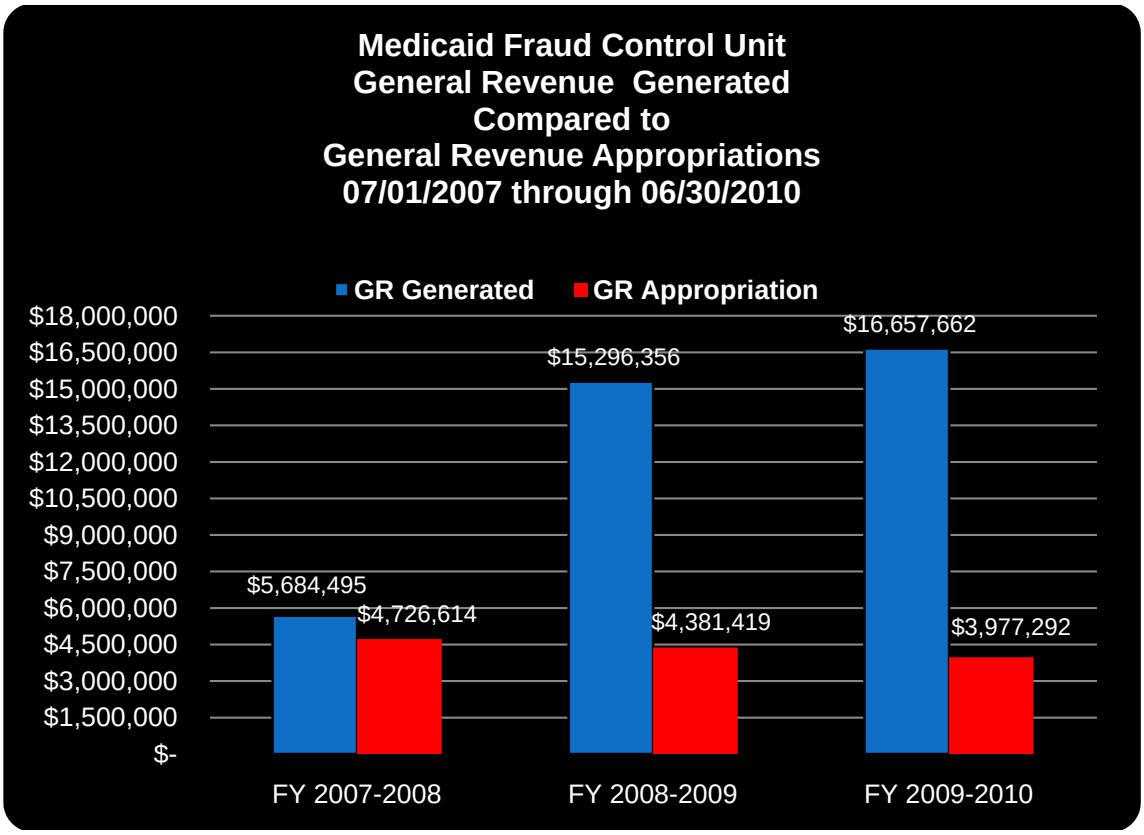
- Medicaid Provider Fraud – Case investigations will focus on types of fraud, types of subjects/targets and types of providers having a widespread impact on the Medicaid program or involving public safety. Emphasis will be placed on case investigations/prosecutions that have a deterrent effect.
- PANE 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,

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 and program income used as match. In FY 2009-10, the MFCU budget was as follows:

Federal Financial Participation	$13,023,228
Florida General Revenue/Match	$ 4,250,129
TOTAL	$17,273,357

Due to the critical general revenue shortfalls in FY 2008-09 and in FY 2009-10, the Medicaid Fraud Control Unit's general revenue budget reduction was approximately $631,290 which resulted in an additional loss of $1.89 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 $16.6 million dollars in FY 2009-10 in collections to the state's General Revenue Fund.



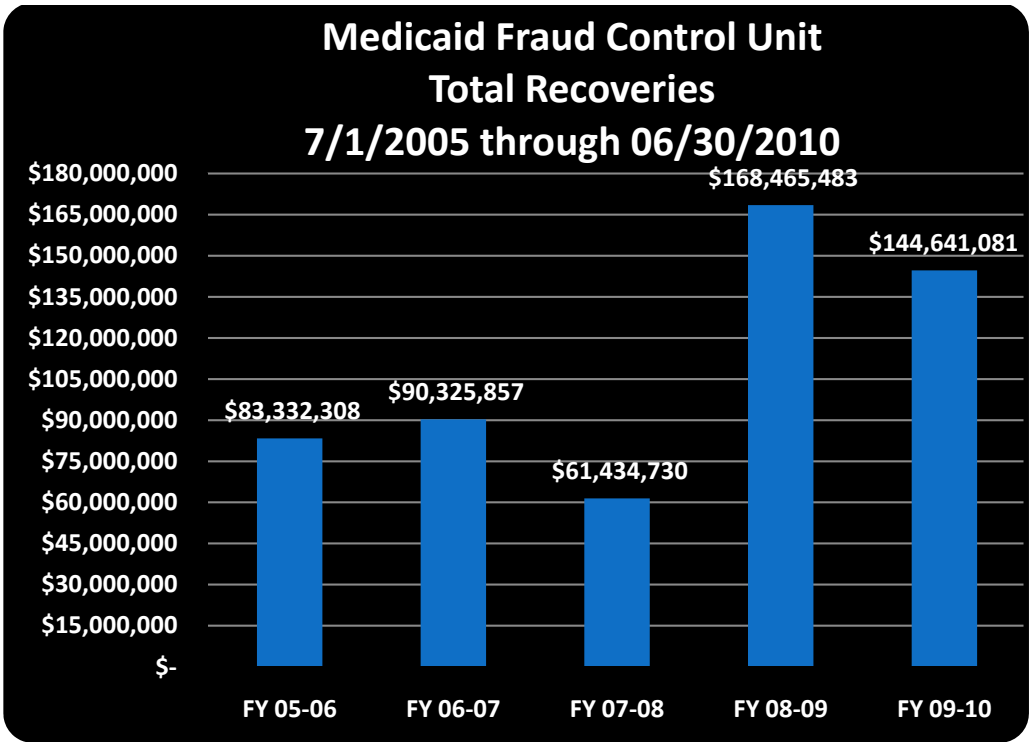
In the previous chart, for FY 2007-08, for every General Revenue dollar appropriated, the MFCU generated approximately $1.20 through penalties imposed that was deposited into General Revenue. For FY 2008-09, for every General Revenue dollar appropriated, the MFCU generated approximately $3.49 through penalties imposed, and deposited into General Revenue. For FY 2009-10, for every General Revenue dollar appropriated, the MFCU generated approximately $4.19 through penalties imposed and deposited into 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.

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 actively litigated 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 2009-10, the total amount for civil recoveries, which include civil settlements arising from *qui tam* cases brought under Florida's False Claims Act, was $99,377,962.93.

In FY 2009-10, the total amount for criminal recoveries based upon Medicaid fraud cases was $45,263,117.87.

The total amount of the monies recovered by the MFCU for FY 2008-09 was $144,641,080.80. It should be noted that during this fiscal year the Attorney General's Office Medicaid Fraud Control Unit's recoveries generated $16,657,662.48 through penalties imposed that was deposited into the State of Florida's General Revenue Fund.

Training

Due to continuing budgetary constraints, only mission critical training was approved. However, the Medicaid Fraud Control Unit staff was able to realize over 4,200 hours of training by a combination of in-house classroom training, Webinars, Video Conferences, online training offered by the Florida Department of Law Enforcement (FDLE), the FBI Virtual Academy, and training offered or conducted at local organizations and Criminal Justice Academies, mostly free of charge.

Classroom training offered locally at no cost, included providers such as the Agency for Persons with Disabilities (APD), The U. S. Department of Justice (DOJ) – Office for Victims of Crime, Florida Regional Community Policing Institute (RCPI), The United States Attorney's Office, Area Agencies on Aging, The Multi-jurisdictional Counterdrug Task Force, State Agencies, and local Academies, to name a few.

Classroom training focused on Florida Adult Protective Services, Victims with Disabilities, Analytical Investigative Techniques, Computer, Business and Forensic Auditing, Supervision, Counterintelligence, Communication Analysis, Data Analysis, Analyst Training, Identity Theft and the Drug Connection, International Money Laundering Investigations, Interview and Interrogation, Legal Assisting, Pharmaceutical Drug Investigations, The Latest Tools and Techniques for Auditors, Follow the Money, State and Federal Approaches to Fraud, Schemes and other Financial Crimes, Durable Medical Equipment (DME) Providers, among others.

Additionally, classroom and range firearms qualification and Use of Force training was provided to law enforcement personnel at local academies by Medicaid Fraud Control Unit certified instructors.

In order to maintain law enforcement certification, sworn personnel is obtaining mandatory training online with FDLE, free of charge. Training includes: Ethics, Domestic Violence, Juvenile Sex Offender Investigations, Discriminatory Profiling and Professional Traffic Stops and Elder Abuse Investigations.

Substantial savings were realized by providing an in-house 16-hour Report Writing class attended by investigators, analysts, auditors, and some members of the management team. The class was offered at a facility obtained free of charge in Lakeland, Florida, on September 15 – 16, 2009.

Considerable savings were also realized by having a nurse on staff qualify to train and certify MFCU Law Enforcement officers and other employees in Cardio Pulmonary Resuscitation (CPR) and Automatic External Defibrillator (AED). The training was offered in all district offices throughout the fiscal year; 98 employees were trained and certified.

Significant Case Highlights

Physician – Robert L. Ignasiak, Jr.

On November 3, 2008, Dr. Robert L. Ignasiak Jr. was found guilty of 43 charges including: health care fraud; dispensing controlled substances, including fentanyl, hydrocodone, diazepam, clonazepam, morphine, and alprazolam, the use of which resulted in the death of two persons; and unlawfully dispensing controlled substances including oxycodone, morphine, fentanyl, hydrocodone, alprazolam, diazepam, clonazepam, and carisoprodol.

The guilty verdict followed nineteen days of trial, during which jurors heard evidence that Dr. Ignasiak, a licensed physician, who owned and operated Freeport Medical Clinic, prescribed controlled substances to patients in quantities and dosages that would cause patients to abuse and misuse the substances without determining a sufficient medical necessity for the prescription of these substances.

The government presented evidence that Dr. Ignasiak prescribed controlled substances to patients knowing the patients were addicted to the substances, misusing the substances, or were "doctor shopping," and were requesting additional quantities of controlled substances for their drug habits. The use of controlled substances dispensed by Dr. Ignasiak resulted in the death of two patients. Evidence at trial illustrated that Dr. Ignasiak attracted patients from all across the southeast United States because of his willingness to prescribe controlled substances with little or no medical justification. Evidence showed that nearly all his patients were prescribed controlled substances, even though he claimed to be a family practitioner with no specialty in pain management or in psychiatric medications. Many of Dr. Ignasiak's patients testified that his prescribing caused them to unknowingly become dependent or addicted to the medications. Others testified they were drug seekers and were able to get the controlled substances they wanted from Dr. Ignasiak with little medical history, work ups, or examinations. Medical examiners testified that several of Dr. Ignasiak's patients died at least in part because of the prescribed medications.

The guilty verdict is the result of a four-year joint investigation by the North Florida Health Care Fraud Task Force, comprised of the Florida Attorney General's Office, Drug Enforcement Administration – Miami Division, Federal Bureau of Investigation – Jacksonville Division, National Drug Intelligence Center Document Exploitation Division, Defense Criminal Investigative Service, Florida Department of Law Enforcement, Walton County Sheriff, and State Surgeon General, Florida Department of Health. The investigation was initiated by a referral from AHCA's Bureau of Medicaid Program Integrity.

The case was prosecuted by the United States Attorney's Office for the Northern District of Florida. Dr. Ignasiak was sentenced on January 27, 2009, to 292 months in federal prison and three years probation. He was ordered to pay $1,000,000 in fines and $4,300 in a special assessment.

Physician – David W. Webb

On September 30, 2009, Destin physician Dr. David W. Webb was convicted of 130 charges brought against him by federal agents. Webb and his wife Bonnie Webb were charged with 36 counts of health care fraud and 79 counts of illegally dispensing drugs. They were also charged with identity theft, conspiracy and the drug distribution charge involving four deaths. Dr. Webb was also charged with making fraudulent health care benefit claims for patients another physician was seeing.

Bonnie Webb, who worked as her husband's office manager, pled guilty to the charges she faced and was sentenced to nine months in federal prison, three years probation, and ordered to pay restitution in the amount of $28,744.32 and a special monetary assessment of $600.

Dr. Webb was sentenced to life in federal prison for Health Care Fraud Resulting in Death, Conspiracy to Distribute, Dispense and Possess with intent to Distribute and Dispense Controlled Substances Resulting in Death, and Dispensing and Causing to be Dispensed Controlled Substances Involving a Quantity of Oxycodone and Alprazolam Resulting in Death from the Use of Oxycodone. Upon his release from prison, he will remain on five years' probation. He was also ordered to pay $27,375 in restitution and is joint and severally ordered to pay the $28,744.32 ordered for Bonnie Webb.

The guilty verdict is the result of an investigation by the North Florida Health Care Fraud Task Force, comprised of the Florida Attorney General's Office, Drug Enforcement Administration – Miami Division, Federal Bureau of Investigation – Jacksonville Division, National Drug Intelligence Center Document Exploitation Division, Defense Criminal Investigative Service, Florida Department of Law Enforcement, Walton County Sheriff, and State Surgeon General, Florida Department of Health. The case was prosecuted by the United States Attorney's Office for the Northern District of Florida.

Pharmaceutical Company – Pfizer

Florida received a total of $58.9 million as part of a global settlement with Pfizer Inc. The agreement resolves civil and criminal allegations that Pfizer and its subsidiaries paid kickbacks and engaged in off-labeling marketing campaigns that improperly promoted numerous drugs that Pfizer manufactures. Pfizer paid the states and the federal government a total of $1 billion in civil damages and penalties to compensate Medicaid, Medicare, and various federal health care programs for harm suffered as a result of its conduct. Florida's civil case was handled by the Attorney General's Complex Civil Enforcement Bureau, which is a part of the Medicaid Fraud Control Unit.

The settlement is the largest in history for the Florida Medicaid Control Unit and sent approximately $9.7 million to the State's General Revenue Fund. Another $10.8 million was returned to the state's Medicaid program for Pfizer's alleged improper actions.

The government entities alleged that Pfizer, the largest pharmaceutical manufacturer in the world, engaged in a pattern of unlawful marketing activity to promote multiple drugs for certain uses which the U.S. Food and Drug Administration (FDA) had not approved. While it is not illegal for a physician to prescribe a drug for an unapproved use, federal law prohibits a manufacturer from promoting a drug for uses not approved by the FDA.

The improper behavior included marketing Bextra for conditions and dosages other than those for which it was approved; promoting the use of antipsychotic drug Geodon for a variety of off-label conditions; selling pain medication Lyrica for unapproved conditions; and making false representations about the safety and efficacy of Zyvox, an antibiotic only approved to treat certain drug resistant infections.

Pfizer also allegedly paid illegal kickbacks to health care professionals to induce them to promote and prescribe Bextra, Geodon, Lyrica, Zyvox, Aricept, Celebrex, Lipitor, Norvasc, Relpax, Viagra, Zithromax, Zoloft and Zyrtec. These payments allegedly took many forms, including entertainment, cash, travel and meals. Federal law prohibits payment of anything of value in exchange for the prescribing of a product paid for by a federal health care program.

In addition to the civil fines, Pfizer subsidiary Pharmacia & Upjohn Company, Inc. will plead guilty to a felony violation of the federal Food, Drug, and Cosmetic Act (FDCA) and will pay a criminal fine and forfeiture of $1.3 billion. The criminal component of the resolution centers on the illegal marketing and promotion of Bextra, an anti-inflammatory drug that Pfizer pulled from the market in 2005.

The settlement is based on nine whistleblower cases that were filed in the United States District Court for the District of Massachusetts, the United States District Court for the Eastern District of Pennsylvania and the United States District Court for the Eastern District of Kentucky by private individuals who filed actions under state and federal false claims statutes. A National Association of Medicaid Fraud Control Units team participated in the investigation and conducted settlement negotiations with Pfizer.

As a condition of the settlement, Pfizer entered into a Corporate Integrity Agreement with the United States Department of Health and Human Services, Office of the Inspector General, which will closely monitor the company's future marketing and sales practices.

A separate $33 million civil settlement was also reached with 43 states, including Florida, over allegations that Pfizer engaged in unfair and deceptive practices when it marketed Geodon for off-label uses. Geodon is the brand name for the prescription drug ziprasidone. The drug has been approved by the FDA for treatment of schizophrenia in adults and for manic or mixed episodes of bipolar disorder in adults. However, Pfizer allegedly promoted Geodon for a number of off-label uses, including promoting Geodon for pediatric use and for use at higher than FDA-approved dosages. Pfizer has agreed to change how it markets Geodon.

Pharmaceutical Company- Roxane Laboratories

Florida received $8.5 million from a settlement with Roxane Laboratories, Inc., and its corporate affiliates. The settlement, which partially resolves a Leon County Medicaid fraud lawsuit, was negotiated by the Attorney General's Complex Civil Enforcement Bureau. Boehringer Ingelheim Roxane, Inc., Boehringer Ingelheim Pharmaceuticals, Inc., Boehringer Ingelheim Corporation and Ben Venue Laboratories, Inc. are included in the settlement.

The $8.5 million dollar settlement resolves allegations that Roxane set and reported false and inflated prices for medications dispensed by pharmacies and other providers which were then reimbursed by the Florida Medicaid program. The Medicaid program sets the reimbursement rates it pays to Medicaid providers based on the prices reported by drug manufacturers. By reporting inflated prices, the drug manufacturers caused the Florida Medicaid Program to overpay millions of dollars in pharmacy reimbursements.

The allegations constituted violations of the Florida False Claims Act and were originally filed by whistleblower Ven-A-Care of the Florida Keys, Inc. on behalf of the State of Florida. The Attorney General's office investigated the claims and subsequently intervened in the lawsuit. The Agency for Health Care Administration, which is responsible for administering the Medicaid Program, will receive over $4.4 million for the losses sustained by the Medicaid Program. Additionally, more than $1.69 million will be deposited in the State of Florida's General Revenue Fund, and over $188,000 will fund rewards for persons who report and provide information relating to Medicaid fraud.

Pharmaceutical Company – Mylan Pharmaceuticals & UDL Laboratories

Several states and the federal government reached agreement with four pharmaceutical companies to resolve claims that they violated the False Claims Act by failing to pay appropriate rebates for drugs paid for by Medicaid. Florida will receive more than $7 million from settlements with AstraZeneca Pharmaceuticals LP, Ortho McNeil Pharmaceutical, Inc., Mylan Pharmaceuticals, Inc. and UDL Laboratories Inc. Over $101,000 will go to the state's Medicaid Fraud Informant Reward Program.

These settlements resolve allegations that, between 1998 and 2005, AstraZeneca Pharmaceuticals LP, Ortho McNeil Pharmaceutical, Inc., Mylan Pharmaceuticals, Inc. and UDL Laboratories Inc. knowingly made false statements about several prescription medications, including albuterol, Dermatop and nifedipine. The misinformation triggered a substantial discount in the rebates the companies were required to pay to the Florida Medicaid program.

While participating in the Medicaid drug rebate program, companies are required to report their drugs as "innovators" or "non-innovators". AstraZeneca, Ortho McNeil, Mylan and UDL Laboratories allegedly misrepresented their drugs as non-innovators so they could improperly receive a substantial discount in the rebate payments they were required to pay. Had these drugs been reported properly, the Florida Medicaid program would have received millions of dollars in additional rebate payments from these companies.

The settlement sent approximately $914,000 to the State's General Revenue Fund. Nearly $2.2 million was returned to the state's Medicaid program and the remainder was returned to the federal Medicaid program for Florida. A team from the National Association of Medicaid Fraud Control Units participated in the investigation and conducted settlement negotiations with the defendants. Florida's civil investigation was handled by the Complex Civil Enforcement Bureau which is part of the Medicaid Fraud Control Unit.

Pharmaceutical Company – Dey

Florida received $6.5 million from a settlement with Dey L.P. and Dey, Inc. This settlement resolved a Medicaid fraud lawsuit over allegations of drug price manipulation. Of the $6.5 million, $3.3 million was deposited to the state's General Revenue fund.

The settlement resolves the allegations that Dey set and reported inflated prices for Albuterol inhalants, solutions, and other related products dispensed by pharmacies and other providers. The inflated prices were then reimbursed by the Florida Medicaid Program, causing the Florida Medicaid program to overpay millions of dollars in pharmacy reimbursements. The Medicaid program sets the reimbursement rates it pays to Medicaid providers based upon the prices reported by drug manufacturers.

The allegations constitute violations of the Florida False Claims Act and were originally filed by whistleblower Ven-A-Care of the Florida Keys, Inc. on behalf of the State of Florida. The Attorney General's office investigated the claims and subsequently intervened in the lawsuit. In addition to the funds that were deposited into the state's General Revenue fund, $1.3 million reimbursed the Agency for Health Care Administration for overcharges it paid Dey as a result of the alleged conduct, and $369,000 was deposited to the Attorney General's Medicaid Fraud Informant Program to reward individuals who report and provide information leading to convictions for Medicaid fraud.

Respiratory Therapist – Eddy Jean-Louis

On July 2, 2009, a Broward County man was arrested after he allegedly defrauded the Florida Medicaid Program out of more than $30,000. Eddy Jean-Louis, a respiratory therapist in Pembroke Pines, was arrested by law enforcement officers with the Attorney General's Medicaid Fraud Control Unit.

Acting on information received from a Medicaid recipient's primary care physician, Medicaid Fraud investigators discovered that Jean-Louis, 40, was allegedly billing the Medicaid program from 2006 to 2008 for services he did not have medical authorization to provide. Respiratory therapy must be prescribed by the recipient's primary care provider, an advanced registered nurse practitioner or a designated physician's assistant.

Jean-Louis entered a Pretrial Intervention Program with a Deferred Prosecution Agreement and was ordered to repay $30,000 in restitution to AHCA, $4,000 in investigative cost and $100 for cost of prosecution.

Home and Community-based Service Provider – Latasha Marie Brothers

A Brevard County woman was arrested on July 16, 2009, for defrauding the Florida Medicaid program out of more than $8,000. Latasha Marie Brothers of Rockledge was arrested by law enforcement officers with the Attorney General's Medicaid Fraud Control Unit.

Investigators with the Medicaid Fraud Control Unit discovered the fraud after being contacted by Hidden Potentials, Inc., a home and community-based service provider in Titusville that employed Brothers, 29, as an independent contractor. The investigation revealed that Brothers submitted falsified service logs for services never performed. As a result, Hidden Potentials, Inc. paid Brothers $8,430 with reimbursements from the Florida Medicaid program.

Brothers pled guilty to one count of Medicaid fraud and one count of grand theft, both third-degree felonies. She was sentenced to five years probation and ordered to pay restitution to the Medicaid program of $8,430. The case was prosecuted by the State Attorney's Office for the 18th Judicial Circuit.

Elder Exploitation - Director of Admissions – Frances Minaya

On July 22, 2009, a former director of admissions for Aldersgate Healthcare was arrested on charges of elder exploitation. Frances Minaya, formerly worked at Aldersgate Healthcare, which operated under the name of the Susannah Wesley Health Center in Hialeah. Investigators with the Medicaid Fraud Control Unit's Patient Abuse, Neglect and Exploitation (PANE) team began investigating Minaya, 43, after receiving a complaint from the Florida Department of Children & Families, Adult Protective Services.

The investigation revealed that Minaya convinced new residents to make cash payments directly to her. She lied to residents, telling them a portion of their care was not covered by Medicare or Medicaid, and only cash would be accepted or the patients would lose their beds at the facility. Investigators with the PANE unit identified 20 elderly victims who made cash payments to Minaya totaling over $58,885.

Minaya pled guilty to one count of second-degree organized fraud and five counts of exploitation of an elderly or disabled person, a third-degree felony. She was sentenced to 10 years probation and ordered

to pay $58,885 in restitution to the victims. She must complete at least five years probation, make all payments required and complete 250 hours of community service before her probation can terminate early. The case was prosecuted by the State Attorney's Office for the 11th Judicial Circuit.

Home Health Company Owner – Jean Joseph Paul

On October 29, 2009, a Miami-Dade County man was arrested on charges he defrauded the Florida Medicaid program out of more than $54,000. Jean Joseph Paul, 32, was arrested by law enforcement officers with the Attorney General's Medicaid Fraud Control Unit with assistance from the Miami-Dade Police Department.

Acting on information received from AHCA's Bureau of Medicaid Program Integrity, Medicaid Fraud investigators discovered that Jean Joseph Paul, who owned and operated God Cares, Inc., submitted numerous claims for services he never provided. God Cares, Inc. is a home health company that provides residential and non-residential care services on behalf of Medicaid recipients.

On February 8, 2010, Paul pled guilty to one count of grand theft. He was sentenced to five years probation and ordered to pay restitution of $54,546.09 to AHCA, $8,000 for cost of investigation, $4,000 for cost of prosecution and $583 in court cost. The case was prosecuted by a Medicaid Fraud Control Unit attorney cross-designated by the Office of Statewide Prosecution.

Agency for Health Care Administration

Agency Overview

The Agency for Health Care Administration (Agency) is committed to "Better health care for all Floridians". The Agency was statutorily created within Chapter 20, Florida Statutes, as the chief health policy and planning entity for the state and is responsible for administering Florida's Medicaid program as well as for the licensure and regulation of the state's 42,000 health care facilities and the sharing of health care data through the Florida Center for Health Information and Policy Analysis.

Division of Medicaid

The Division of Medicaid administers the Florida Medicaid Program, a $20.8 billion state and federal partnership that provides health care to more than 2.9 million recipients in Florida.[1] The Division is responsible for overseeing the management and operation of a broad range of health care services offered through Medicaid to low-income families and the elderly and disabled. The operation of the Medicaid program is conducted by six bureaus, eleven area offices and staff reporting directly to the Deputy Secretary for Medicaid. Below is a summary of the responsibilities of each bureau and office:

- Bureau of Medicaid Contract Management (MCM) supervises the Medicaid Fiscal Agent in validating recipient eligibility, enrolling qualified providers and processing Medicaid claims. MCM processes an average of more than 12.5 million claims and 1,400 provider enrollment applications each month. It manages the information interfaces with various entities and the Florida Medicaid Management Information System (FMMIS). The Bureau is also responsible for assisting providers with enrollment and re-enrollment into the Medicaid program and all systems hardware and software processes, changes and additions. In addition, the Bureau is responsible for assisting recipients with plan enrollment through the Choice Counseling and Medicaid Option contracts and manages the contract for the Enhanced Benefits program under the Reform pilot.
- Bureau of Medicaid Services (Medicaid Services) develops policies, procedures and programs to promote access to quality acute and long-term medical, behavioral, therapeutic and transportation services for Medicaid beneficiaries. The Bureau develops and maintains the Medicaid State Plan, administrative rules and manuals for all Medicaid covered services except prescription drugs, coordinates policy development with other state agencies, advocacy organizations, provider associations and health care organizations. The Bureau also manages federal Medicaid waivers, oversees utilization management contracts, is the lead for the Children's Health Insurance Program (Title XXI –CHIP), manages the Florida Healthy Kids Corporation contract and administers the MediKids program.
- Bureau of Health Systems Development (HSD) is responsible for the development and oversight of Medicaid's managed care programs including managing contracts with Health Maintenance Organizations (HMOs), Provider Service Networks (PSNs), Minority Physician Networks (MPNs), prepaid dental health plans and the MediPass program. The Bureau is also responsible for Disease Management initiatives, management of the 1915 (b) Managed Care Waiver, the 1115 Medicaid Reform Waiver and preparation of any federal Medicaid managed care waiver

[1] These figures represent the budgeted amount and budgeted caseload for FY 2010-11.

requests, as well as the development and implementation of Medicaid managed care policies, contracts, applications and procedures along with other special projects.

- Bureau of Pharmacy Services (Pharmacy Services) develops and implements Medicaid policies for administering the Medicaid prescription drug program. The Bureau ensures Florida Medicaid recipients are provided access to medication that is clinically and economically effective and produces the desired medical outcome. The Bureau's responsibilities include policy development and implementation and rulemaking necessary to implement statutes to optimize drug therapy for Medicaid recipients by ensuring access to pharmaceuticals that are clinically efficient, cost effective and produce desired outcomes. Fiscal and operational analysis of policy and legislative proposals to determine the impact to the program and statutory reports to the Legislature are produced. Medicaid Pharmacy Services is also responsible for managing the prescribed drug program for the Fee for Service Florida Medicaid Program.
- Bureau of Medicaid Program Analysis (MPA) is the fiscal branch of Medicaid. The Bureau deals directly with legislative budget requests, statutes and appropriations that impact every facet of the Medicaid program. The Bureau reviews cost reports for rate-setting, calculates reimbursement rates including developing capitation rates, manages the Disproportionate Share (DSH) program and the Low Income Pool (LIP) and coordinates and prepares budget analysis, including information for use during the Impact Conference, a part of the Social Services Estimating Conference (SSEC) process.
- Bureau of Medicaid Quality Management (MQM) is responsible for overall Medicaid program efforts to optimize and improve quality in the program, for research regarding health information to be utilized by Agency management when making programmatic decisions, for coordinating quality standards for the Medicaid health care programs and for project management and process improvement functions. The Bureau also pursues research grants and prepares reports and analysis to support Agency decision-making. MQM analyzes managed care performance measures, serves as the contract manager for the External Quality Review Organization and maintains the state's Quality Assessment and Improvement Strategy. MQM also serves as the primary bureau to aide in improving the quality and efficiency of services within the Medicaid program. This Bureau uses project and process management to support the implementation of many Medicaid projects.
- Medicaid Area Offices – the eleven area offices throughout the state that serve as the local liaisons to Medicaid providers and recipients. The area offices are responsible for exceptional claims processing, provider relations and training, consumer relations, managing the Child Health Check-Up program, transportation and School Match programs on a local level and conducting provider site visits.
- The Deputy Secretary for Medicaid's Office – the staff within the Medicaid Director's Office performs a variety of functions to aid the Division in its operational and administrative responsibilities. The Office of the Medicaid Director includes the Fraud Prevention and Compliance Unit (FPCU), who coordinates the efforts of the bureaus within the Division in development and implementation of policy and programs to prevent improper payments, with specific focus on fraud controls. The FPCU also works with other internal and external organizations to facilitate the detection, prevention and recovery of misspent funds due to fraud, abuse and overpayments. Other staff within the Medicaid Director's Office coordinate Medicaid correspondence, public records requests, contracts/procurements, State Plan amendments and legislation in an attempt to provide the most efficient internal and external customer service possible. As is described further below, the Division's fraud and abuse detection and deterrence efforts frequently touch upon the responsibilities of the entire Division.

The Division of Medicaid continues to engage in a number of activities that can be described as aiding in the detection, prevention and recovery efforts related to Medicaid fraud, abuse and overpayments. For purposes of the following discussion, the Division has categorized those activities by the manner in which they aid in these efforts. The categories are: utilization norms/utilization management; provider accountability/increased provider enrollment requirements; cooperative projects; special projects and pilots; program structure/structural changes; provider education; and system improvements.

Utilization Norm and Utilization Management

The Agency maintains contracts with several vendors and also internally performs utilization management functions which include onsite and desk reviews of quality of care and claims monitoring for various provider types. Utilization management processes and the use of utilization norms help the Agency monitor the use of services to prevent unnecessary, excessive, duplicative or otherwise inappropriate expenditures as well as provide information to develop tools to increase positive outcomes as a result of the programs. Some examples of these efforts during FY 2009-10 include:

- Developed a monitoring program for Targeted Case Management (TCM) to ensure compliance with TCM policies to allow on-site monitoring during FY 2010-11.
- Revised the school-based monitoring process, including development of a standardized tool and uniform method for reviewing paid claims for compliance with policy, verifying provider credentials, reviewing progress notes and other documentation of medical need and following up on claims that should be voided.
- Developed new prior authorization requirements for home health services to strengthen the Agency's efforts in combating the misuse or abuse of home health services. The new requirements were implemented in November 2009 and include eliminating authorization exceptions and requiring the submission of additional supporting documentation and information from the ordering physician to determine medical necessity.
- Developed an authorization process for inpatient emergency services for undocumented aliens to determine the point of stabilization, including prospective and retrospective reviews of hospital admissions for undocumented aliens to determine whether the stay meets standardized criteria for emergency services. This process was implemented on July 1, 2010. By applying these more stringent criteria, the opportunity for overpayments is reduced.
- Continued other utilization controls such as managing lengths of stay for inpatient hospital services by way of medical reviews, monitoring abnormal billing patterns and proactive efforts to reduce average lengths of stay for inpatient psychiatric care by way of review by Regional Care Coordinators.
- Continued to evaluate audits, system edits, process changes and any other improvements to reduce the risk for overpayments, abuse, or fraud, including processes for such high-risk goods such as wheelchairs, power operated vehicles and wheelchair repairs.

Provider Accountability and Increased Provider Enrollment Requirements

The Division continually works to increase provider compliance and accountability through many different avenues. Several activities undertaken in FY 2010-11 to aid the Division in better monitoring providers after enrollment are set forth below:

- Implemented requirement for submission of background screening results for managed care plans' principals and executive management.

- Conducted additional on-site monitoring to ensure compliance and recoupment of non-compliant claims.
- Incorporated background screenings and conducted pre-enrollment onsite visits to ensure that providers have met all the provider requirements and qualifications and their practices are fully operational before they can be enrolled as Medicaid providers. The Division conducted site visits for more than 900 applicants during FY 2009-10 and more than 100 ineligible applicants were denied enrollment through this process. Also, 4,082 fingerprints were processed during FY 2009-10, resulting in 40 denied applications due to background screening.
- Developed amendments to the contract for Nursing Home Diversion (a waiver program that operates in a fashion similar to managed care to manage services for individuals who may otherwise be institutionalized) to address fraud and abuse by requiring that the contractor maintain a mandatory compliance plan that is designed to guard against fraud and abuse. The mandatory compliance plan and related policy and procedures are verified during each year's provider monitoring.
- Completed installation of an automated reenrollment process in the FMMIS in January of 2010 which runs daily and identifies any provider with a provider agreement end date ninety (90) days in the future; flags the file as needing to reenroll; creates a report for tracking purposes; and sends the reenrollment packet to the provider. The provider has 90 days from that date to return the completed reenrollment packet in order to remain active in Florida Medicaid. Providers who fail to respond within the 90-day window are suspended in the system to prevent claims with dates of service after the agreement end date from processing.
- Recoupment of claims found to be non-compliant in program monitoring in such areas as behavioral health, certified school match, Project Aids Care (PAC) waiver and Targeted Case Management.
- Required providers to develop and adhere to Performance Improvement Plans to correct deficiencies found as a result of program monitoring.

Fraud and Abuse Initiatives

For the federal Medicare & Medicaid programs, the issue of fraud and abuse within the systems is a key issue – and has been a central topic for debate and discussion on a state and national level, particularly during this time of economic downturn. Much of the news centers on fraud within the federal Medicare program, which is run by the federal government without either regulatory or financial participation from states. The experience of the Florida Medicaid program with regard to provider fraud is distinguishable from much of the media publicity on fraud, in part, due to the strong partnership with Office of the Attorney General's Medicaid Fraud Control Unit (MFCU), the front-end controls and strong monitoring programs. Additionally, while there are often references made to varying percentages of expenditures that are attributable to fraud, in fact, the amount of fraud in the Medicaid program is unknown.

Fee for Service

The Florida Medicaid fee-for-service program, including medical and pharmacy services, has integrated system driven peer group and utilization norms and prior authorization procedures to ensure that Medicaid recipients have access to needed medical services and prescription drugs while program costs are controlled and the risk of fraud and/or overutilization is minimized.

For medical services, utilization management and prior authorization parameters are designed as a result of peer review by professional nurse staff and contracted physicians within the Medicaid program of coverage norms based on guidance from professional resources such as the Food and Drug Administration. In addition, the program utilizes a contracted vendor that provides the Agency with health technology assessments to assist in making evidence-based coverage policy and medical management decisions regarding new, evolving, or controversial health technologies. Utilization management tools and prior authorization parameters are then implemented based on the peer group norms established through this process and codified through the Medicaid coverage and limitation handbooks.

Tables 1 – 3 estimate the cost savings to the state for select preventive activities. The estimates in these tables are based on denied requests for prior authorization (because the requested services did not meet the criteria for approval).

Cost avoidance resulting from prior authorization for hospital claims is estimated to have resulted in approximately 3% savings during each of the past three fiscal years. The savings are the result of the front-end controls precluding payment for services that do not meet Medicaid program guidelines (either policy, eligibility or clinical standards).

Table 1: Cost Avoidance: Hospital Services FY 2007-08 through FY 2009-10

Fiscal Year	Denial Percentage	Cost Avoidance
FY 2007-08	3.67%	$73,494,671.00
FY 2008-09	2.91%	$81,801,853.00
FY 2009-10	3.30%	$97,879,190.00

Tables 2 and 3, provides an estimate on the cost avoidance due to front-end or prepayment controls with regard to home health and private duty nursing services due to an increase in the denial of services that did not meet the prior authorization criteria. These denials are examples of AHCA's increased prevention activities and the cost savings are summarized below:

Table 2: Cost Avoidance: Home Health Aide Visits and Skilled Nursing FY 2009-10

Type of Service	Denial Hours	Cost Avoidance*
Home Health Aide Visits Unassociated with a Skilled Nursing Visit	201,319	$3,515,029.74
Home Health Aide Visits with a Skilled Nursing Visit	12,383	$216,207.18
Skilled Nursing Provided by a Licensed Registered Nurse	18,823	$584,265.92
Skilled Nursing Provided by a Licensed Practical Nurse	9,843	$257,788.17
	Total Cost Avoidance	$4,573,291.01

*Cost Savings are calculated by multiplying the denied hours by the Medicaid reimbursement rate for the particular service.

Table 3: Cost Avoidance: Private Duty Nursing FY 2009 - 10

Type of Service	Denial Hours	Cost Avoidance*
Personal Care Services	1,123,455	$16,851,825.00
Private Duty Nursing Provided by a Registered Nurse	1,757,869	$51,153,987.90
Private Duty Nursing Provided by a Licensed Practical Nurse	91,818	$2,137,523.04
	Total Cost Avoidance	$70,143,335.94

*Cost Savings are calculated by multiplying the denied hours by the Medicaid reimbursement rate for the particular service.

Note: For the services reflected in Tables 1 through 3 above, the only way a claim denial would be reversed is if the recipient receives a fair hearing. If a fair hearing is requested the services would be continued until the hearing is resolved.

Medicaid Managed Care

Managed care can be a tool for Medicaid programs to more effectively use resources while improving outcomes. Medicaid managed care organizations are paid a monthly capitation rate and have financial incentive to be vigilant about preventing, identifying and combating fraud and abuse, thus limiting the state's exposure for the risk of fraud. Managed care plans can serve as the state's partner in their efforts to fight fraud and abuse, as plans must implement fraud and abuse detection and deterrence activities. Although the plans are obligated to assist in these efforts, it is important for the state to have stringent managed care fraud and abuse prevention and reporting requirements in place through contract and statutory provisions.

As the Agency and the State continue to look for new ways to control the Medicaid budget and ensure that fraud and abuse is minimized, the Agency has implemented a series of program improvements relating to increasing quality and accountability in managed care. The Agency began a process to audit HMO and Prepaid Mental Health Plans to determine whether the plans met the 80 percent behavioral health expenditure requirement on approved and specified services. (The statutory obligation that is referred to as the 80/20 rule for behavioral health is set for at Section 409.912(4)(b), F. S.) These audits are described in further detail in the section below regarding the Division of Medicaid initiatives.

Florida Medicaid has increased Medicaid managed care plan accountability and quality with initiatives to enhance managed care performance on key quality measures such as prenatal care, behavioral health, well-child visits and more. The Agency has implemented a comprehensive strategy to require health plans to work towards a three year goal of operation at the national 75th percentile on numerous health plan performance measures. To ensure transparency, performance measure submission information and other quality activities occurring are posted on the Agency's internet website. In addition, the Agency has undertaken initiatives to ensure the accuracy of plan provider network information that is made available to beneficiaries. Medicaid's Field Office staff conducts quarterly reviews by contacting medical providers to confirm accuracy of the provider network files submitted monthly by Medicaid managed care organizations.

As managed care enrollment has expanded within the Florida Medicaid program, requirements regarding fraud and abuse prevention and reporting for managed care plans have been continually reviewed and strengthened. Under the current (2009-2013) contract, managed care plans are required

to develop and maintain written policies and procedures for fraud prevention; have an adequately staffed Medicaid compliance office; have a system for provider profiling, credentialing and recredentialing, including a review process for claims and encounters for providers who are suspected of potential fraud and abuse activities; and have internal controls and policies and procedures in place that are designed to prevent, reduce, detect, correct and report known or suspected fraud and abuse activities.[1] Plans are required to report all instances of suspected fraud or abuse to the Agency on a monthly basis.

Finally, to ensure that all potential avenues for fraud detection are being maximized, the Agency continues to address potential methods to more efficiently detect and deter fraud and abuse in the Medicaid program. Specifically, with regard to potential fraud by managed care plans or the participating network providers, one such example is that during FY 2009-10 the Agency began to develop a training program about managed care designed to help those individuals working in the area of fraud, abuse and overpayments to better understand a variety of aspects of managed care in Florida that are integral to their success at early detection of fraud. Development of the training continued into FY 2010-11 and is expected to be conducted during the later part of calendar year 2010 for an audience of MFCU and MPI investigators and prosecutors. Further training of this nature will continue to be developed and is expected to foster further dialogue between MFCU and the Agency and result in earlier development of leads for investigation in the managed care arena.

Bureau of Pharmacy Services

The Florida Medicaid Fee-For-Service (FFS) Pharmacy Services program is an extremely efficient program—combining smart purchasing and preferred drug policies that maximize rebate collections with system driven utilization norms and prior authorization procedures to ensure that Medicaid recipients have access to needed medications while program costs are controlled and fraud and/or overutilization is minimized.

Cost control efforts within the FFS pharmacy program have been very successful over the last two fiscal years. An article published in 2009 in the New York Times indicated that wholesale prices for name brand drugs increased by 9.3% between October 2008 and September 2009 and combined prices for brands and generics increased by 5.4%. In FY 2008-09, the Florida Medicaid FFS pharmacy program prescription costs declined by 8.66% and in FY 2009-10 were reduced another 4.13%.

Furthermore, the claims processing system has thousands of edits that save hundreds of millions of dollars using a proactive cost avoidance philosophy. These front end edits are a critical component of ensuring an efficiently run Medicaid program as they prevent payments that could otherwise be characterized as abusive practices. Front end edits save the state from a pay and chase scenario in which payment is made and then additional manpower is needed to recoup the funds.

Medicaid pharmacy payment system edits are designed as a result of peer review by professional pharmacists within the Medicaid program, guidance from professional resources such as First Data Bank and the Food and Drug Administration, and recommendations from the professionals who serve on the Drug Utilization Review Board (DUR) and work with the Agency on its Medication Drug Therapy

[1] During the 2010 Legislative Session, Senate Bill 1484 was passed by the Florida Legislature and signed by Governor Crist. Senate Bill 1484 created Section 409.91212, F. S., which amends managed care contracts requiring the plans to adopt policies and procedures relating to fighting fraud and abuse. Planning for the implementation of this legislation took place during FY 2009-10 and implementation has continued into FY 2010-11.

Management Program (MDTMP), which are programs designed to identify aberrant prescribing patterns. Point of sale intervention (through systems edits and prior authorization) is implemented based on the peer group norms established through peer review and the work of the DUR and MDTMP programs.

Cost controls and fraud prevention are achieved while ensuring that recipients have access to all needed medications. Strict call center protocols ensure that:

- the Pharmacy Benefits Management (PBM) point of sale system is available 100% of the time (24/7);
- electronic inquiries from pharmacies are responded to in a average of 2.4 seconds;
- the average hold time for callers is less than one minute; and
- calls are handled by clinical pharmacists and pharmacy technicians who are up to date on diseases and conditions that affect the Florida Medicaid population.

In addition, the program is continuously assessing the changing pharmaceutical marketplace to determine areas where additional prior authorization policies or utilization limits are needed.

Summary Data Related to Ongoing Fraud and Abuse Efforts at Point-Of-Sale

- Summary of Plan Limitations: A report that the Agency posts and circulates to pharmacies so that they know the dose/quantity limits that are programmed into the First Health System (http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/Pharmacy/Florida%20Limitations%20Web.pdf).
    - Total Cost Avoidance: $771,100,294.00 (detail report below)

Denied Claims Summary for Claims Adjudicated in FY 2009-10

NCPDP Reject Code	Claims Count	Amount Associated with Denied Claims	NCPDP Reject Code Description
22	3,684	$436,260.75	Missing or invalid "Dispense as written" code
60	223,256	$29,501,414.20	Product/Service Not Covered For Patient Age
61	3,348	$425,925.16	Product/Service Not Covered For Patient Gender
70	1,370,311	$73,617,571.35	National Drug Code (NDC) not covered
73	9,772	$380,655.61	Refills are not covered
75	1,866,651	$321,033,636.66	Prior authorization required
76	1,084,200	$165,812,115.40	Plan limitations exceeded
83	179,896	$14,917,239.15	Duplicate paid/Captured claim
88	2,812,164	$277,708,842.75	Drug Utilization Review (DUR) reject error
Unique Claims Summary	6,807,425	$771,100,294.00	

Note: The information presented here represents denials for State FY 2009-10. Providers are not precluded from resubmitting these claims. To the extent that technical deficiencies can be corrected, a portion of these claims will be processed and paid at a later date. Based on prior year information, it could be expected that between 20-25% of these claims could be resubmitted and paid based on medical documentation.

- FY 2009-10 Drug Utilization Review Paid Claims Savings Report: This report describes savings associated with edits that force a pharmacy to reverse an inappropriate claim, and resubmit it correctly. Total Cost Avoidance: $69,211,777.89.
- FY 2009-10 Drug Utilization Review Denied Claims Savings Report: This report describes the savings associated with denying inappropriate claims. These are claims that are denied, but never resubmitted. Total Cost Avoidance: $801,369,545.79. This number may seem high but it is important to note that the point of sale (POS) system rejects 40% of all submitted claims due to strict adherence to program edits and norms.

Summary of Pharmacy Initiatives: Completed July 1, 2009 - June 30, 2010

The Federal government (through the Controlled Substances Act) created five schedules (classifications) with varying qualifications for a substance to be included in each. Those schedules are commonly referred to as "Class 1 through Class 5" and are abbreviated as CI through CV when referenced below.

August Limit certain CIII-CV narcotics (same drug/same strength) to four prescriptions per month. Rationale: Limit doctor shopping, yet allow legitimate pain specialists to manage patients on weekly prescription quantities.

November Expand CIII-CV narcotic limitation (four prescriptions/month) to multiple drugs/multiple strengths. Rationale: Expand limitations on ability to doctor shop, yet allow pain specialists to manage patients on weekly prescription quantities.

February Limit CII narcotic prescriptions for all recipients (including cancer and sickle cell patients) to six prescriptions per month. Rationale: Limit doctor shopping without impacting care to cancer and sickle cell patients. Data analysis shows that the majority of Medicaid patients are receiving fewer than six prescriptions per month.

Removal of Seroquel Immediate Release tablets from the PDL for Adults. Rationale: Seroquel IR is being prescribed off label for sleep and also has some street value. Psychiatry patients can be easily switched to Seroquel XR Sustained Release tablets. The XR product is still clinically appropriate for psychiatry patients and yet the off-label use as a sleep agent is greatly reduced as it is not a useful sleep agent and it has no street value.

March Prior authorization required for prescriptions that trigger "high dose" warnings. Rationale: Through data analysis it was determined that pharmacists are using the "high dose" over ride codes inappropriately. Implementing a "hard edit" requires the prescriber to submit a prior authorization for the high dose prescription.

June Restrict CII narcotic prescriptions to four prescriptions per month for all patients except cancer and sickle cell patients. They will remain limited to six prescriptions per month. Rationale: Limit doctor shopping and over utilization without impacting care to cancer and sickle cell patients.

Cooperative Projects and Workgroups:

The Agency is involved with external partners, stakeholders and internal bureaus and offices to advance the coordination of prevention of fraud and abuse of the Medicaid program. This coordination is done

via workgroups, adoption of Medicaid policy changes to safeguard the Medicaid program and by continuous analysis of cost of Medicaid services. Medicaid headquarters and Medicaid area offices coordinate to detect fraud and abuse early and work closely with MPI.

- Continued participation in an interagency Anti-Fraud Working Group with MPI, MFCU and other state-government partners.
- On January 1, 2010, the Agency contracted with a vendor to conduct reviews regarding the Developmental Disabilities Waivers and the Consumer Directed Care Plus program to evaluate quality from both the perspective of the clients receiving services and provider performance and compliance.
- Medicaid provider handbook updates for the new Assistive Care Services Coverage and Limitations Handbook and the Aged/Disabled Adult Waiver Services Coverage and Limitations Handbook were completed to assist in the prevention of fraud and abuse in the two programs. The new information provided in the handbooks on the issues of fraud and abuse provides a greater emphasis on prevention, education and accountability in the Medicaid programs.
- The Agency created public service announcements to run in several high-risk areas of the state, issued a letter to recipients and also amended several of its publications to better promote the fraud hotline managed by the Office of the Attorney General. These efforts are intended to increase awareness about the public's ability to report suspected fraud to the state and are a result of the Agency's increased efforts to detect and deter fraud.
- Medicaid Area Offices routinely receive calls about suspected fraud and abuse from recipients and providers. During FY 2009-10 the Area Offices implemented processes to increase accuracy and efficiency in the referral of these calls to MPI and MFCU, including increased tracking measures for future evaluation of the effective use of resources, a uniform protocol for use during these calls and procedures to implement (in FY 2010-11) an auto-transfer for fraud-related calls directly to MPI.

Special Projects and Pilots

Throughout the year the Agency was involved with several special projects and pilot programs related to the Florida Medicaid program. During FY 2009-10, the Division of Medicaid was engaged in several projects specifically related to the prevention and detection of fraud, abuse and overpayments, which included the *Telephonic Home Health Services Delivery Monitoring and Verification (DMV) Program*, also known as the "Telephony Project" and the Comprehensive On-Site Care Management projects.

Telephonic Home Health Services Delivery Monitoring and Verification (DMV) Program

As a result of anti-fraud and abuse provisions included in 2009 Senate Bill 1986, the Agency has contracted with a vendor, Sandata Technologies, LLC, to implement the Telephonic Home Health Service Delivery Monitoring and Verification (DMV) Program. Sandata utilizes the Santrax Payor Management (SPM) system to address aberrant billing practices, potential fraud and the quality of recipient care in home health care. The contract was signed April 8, 2010 and the DMV project was successfully launched on July 1, 2010.

The goal of the project is to ensure that home health nurses and aides actually go to the homes of the recipients that have been prior authorized to receive home health visits to provide the services outlined in the recipients' plans of care and ensure that home health service providers receive reimbursement for services actually provided. Medicaid reimbursable home health visits provided by registered nurses

(RNs), licensed practical nurses (LPNs) and home health aides are scheduled, verified and tracked through Sandata's SPM system.

Comprehensive On-Site Care Management Project

As a result of provisions included in the 2009 Senate Bill 1986, the Agency amended its current contract with KePRO, who was responsible for utilization management for home health visits, private duty nursing, personal care services and inpatient medical and surgical services in FY 2009-10 to include a Comprehensive On-Site Care Management Project in Miami-Dade County for home health visits. The purpose of this pilot project is to identify potential overutilization and fraud or abuse of Medicaid services by ensuring that the level of services provided matches the needs of the recipients. The Comprehensive Care Management (CCM) Pilot began July 2010 and has yielded the following results through September 2010:

Face-to-Face Assessment Data	Total (Recipients)
Recipient Face-to-Face Assessment Completed	991
Recommended Termination of Services	26
Recommended Reduction of Services	57
Recommended MPI Referrals	95
Recommended HQA Referrals	7

In the first three months of these projects (during FY 2010-11), the Agency successfully terminated two large home health agencies from the Medicaid program and continues to look toward aggressive and proactive measures to ensure provider compliance and to control the provider network. The Agency is identifying aberrant trends when reviewing the ordering physician information and MPI has been furnished a list of physicians who are suspected of potentially fraudulent activity. There have been referrals to MPI of potentially fraudulent and/or abusive billing, referrals to HQA reporting potential licensure violations as well as some recipients voluntarily terminating their home health services citing that they "are no longer needed". Recipients and providers are becoming better educated about what is reimbursable through the Florida Medicaid home health program. Information from both pilots is being used as further detection tools for MPI and for the Agency to consider further program safeguards; and the Agency is working closely with MFCU in order to continue this collaborative relationship and share the information that is being gathered as a result of these projects.

Program Structure/Structural Changes:

The Division of Medicaid routinely reviews policy and program structure to ensure that resources are used efficiently and to ensure effective program safeguards are in place.

- During FY 2009-10, the Division began the process to set specific procedure codes, reimbursement rates and monthly limits for specific medical supplies that are presently billed under several of the Home and Community Based Waiver programs. By implementing this plan, these programs will be able to more accurately track recipient utilization.

- The Agency utilized an Invitation to Negotiate (ITN 1008) to solicit responses from qualified vendors to provide post-payment identification and recovery of improper payments on behalf of the Florida Medicaid Program. The ITN was drafted and processed (vendor conference, response to questions, coordination of evaluations, etc.) in coordination with the Agency's Bureau of Procurement Services. The procurement process was finalized and a contract implemented in FY 2010-11.
- HMO's and Pre-Paid Mental Health Plans are required to report the amount of their capitation payments that were expended for the provision of behavioral health care services. They are further required to return to the Agency the amount of capitation payments to make up the difference when they fail to expend the required 80 percent. In addition to these recoveries, the Division engaged in audits of the 2006 reporting for select HMO's. Prior to completion of audits, two HMO's voluntarily refunded more than $500,000 (total) to the Agency. The Agency has collected an additional $2,567,045 to date and estimates potential recoveries from these audits are expected to be approximately $3 million. Furthermore, the Agency continues to review audit methodologies and will continue with the audits for prepaid plans and conduct additional audits for subsequent years.

Provider Education

One of the most effective tools that the Agency has at its disposal is the opportunity to educate providers about program rules. Many overpayments are the result of inadvertent errors as well as misunderstandings or lack of understanding about program rules. By educating providers, the Agency proactively addresses the issue of potential overpayments. Some examples of provider education initiatives included:

- The Division is very proactive in educating providers about their obligations to ensure that their reimbursements are accurate – and to encourage providers to conduct self-audits to determine whether overpayments have been made. Many of these provider education opportunities result in self-audits being conducted and recoupment of overpayments. During FY 2009-10, the Division of Medicaid routinely referred these types of self disclosures to MPI for formal recoupment actions.
- Performed provider outreach to clarify policy on CHCUP billing to differentiate between sick and well child visits.
- The Agency held a meeting to educate school-based service providers on program policy and highlighted areas where there is potential for misuse and abuse as well as encouraged school districts to implement internal controls.
- The Division delivered regional training sessions on an overview of key Medicaid Durable Medical Equipment (DME) policies. These sessions were aimed to increase the providers' understanding of the value of a Medicaid Compliance Program, the elements of an effective compliance program and to understand the Medicaid provider's role in safeguarding the integrity of the Medicaid program. The training sessions were held in Alachua, Hillsborough, Orange, Broward and Miami-Dade counties.
- The Division conducted a series of teleconferences for obstetrical ultrasound providers to present an overview of key Medicaid obstetrical ultrasound services policies, assist providers in gaining an understanding of the need for submitting appropriate documentation when submitting ultrasound claims for medical review and to increase the understanding of providers of the value of submitting claims with correct modifiers.

- Distribution of fraud prevention posters and brochures at provider outreach and recruitment visits, provider trainings and beneficiary outreach events.

System Improvements

In addition to programmatic changes, the Agency recognizes the need for continual evaluation, expansion and improvement of technology uses within the Medicaid program as a means of addressing fraud, abuse and overpayment issues. Through system improvements, the Agency can increase its prevention efforts. Below are some examples of system improvements during FY 2009-10:

- Partnerships with other state agencies can increase the accuracy of data used by the Agency to process claims. For example, in December 2009, the Agency entered into an interagency agreement with Florida Healthy Kids Corporation (FHKC), Agency for Workforce Innovation (AWI), Department of Revenue (DOR) and Affiliated Computer Systems (ACS) to access electronic income information available through AWI and DOR. The electronic income information will ensure the correct income is used to determine eligibility for Florida KidCare families at the time of application and renewal and prevent fraud. FHKC will also use electronic verification to monitor and validate eligibility determinations.
- During FY 2009-10 and continuing into FY 2010-11, Florida Medicaid is evaluating and implementing service limit edits[1] on any existing DME codes that do not currently have maximum service limit edits in place. These audits will cause a provider claim to deny when a service limit has been exceeded.
- After a data review indicated that there were adults obtaining medications on the eligibility status of children, the Agency implemented a "Date of Birth" edit to require the date of birth on each prescription claim transaction for each recipient to match the recipient's date of birth on the Medicaid eligibility file. The "Date of Birth" edit was completed in September 2009.

[1] There is a distinction within the claims process system wherein "edits" and "audits" are technically separate items that serve to establish payment criteria (e.g., to deny claims over a certain limit). For purposes of this report these items are both referred to as system edits.

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 the MPI to prevent, detect and recoup Medicaid fraud and abuse overpayments.

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 & 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 2009-10, Medicaid Program Integrity referred 198 cases to the Attorney General's Medicaid Fraud Control Unit for criminal prosecution, 108 cases to the Department of Health for disciplinary review of providers and 67 providers for termination from the Medicaid program.

In order to ensure that taxpayers' dollars are being used efficiently, the Agency continuously looks for cost prevention avenues and seeks the recovery of overpayments to Medicaid providers throughout the state. An Agency-wide mapping system (shown on the next page) was developed and is used to identify how every unit of the Agency can help prevent, detect or recoup fraud and abuse overpayments. Although the Bureau of Medicaid Program Integrity (MPI), under the Office of Inspector General, has the primary responsibility for combating fraud, abuse and waste in the Florida Medicaid program, every division and bureau on this diagram has made important contributions to the effort as documented in this report.

Diagram of AHCA's Fraud Prevention, Detection and Recoupment Activities

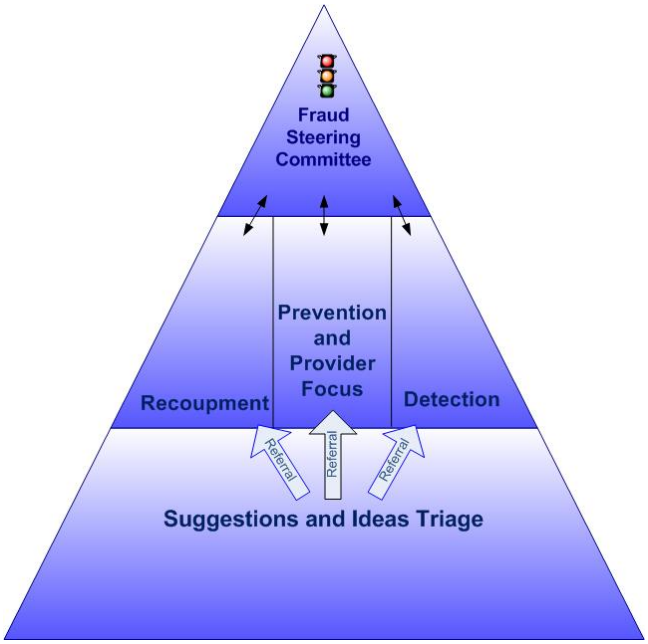
Fraud Steering Committee

The Inspector General established the Fraud Steering Committee which is responsible for coordinating and improving the Agency's overall Medicaid program integrity efforts. Efforts to identify and reduce fraud and abuse are woven throughout the Agency's divisions and not solely focused in the Bureau of Medicaid Program Integrity. The Fraud Steering Committee is a decision-making body charged with aligning Agency goals with fraud fighting efforts, and establishing and prioritizing initiatives. The Steering Committee employs the following sub-committees to accomplish the project goals:

1. The Recoupment Sub-committee works with all ideas and suggestions regarding the recoupment of Medicaid funds paid out for abusive or fraudulent claims.

2. The Prevention and Provider Focus Sub-committee works with ideas and suggestions regarding proposed changes in Medicaid policies and procedures, proposed changes to the provider enrollment agreement, provider site-visits, termination/denial of providers, provider education and situations regarding the interpretation or implementation of Medicaid policy.

3. The Detection Sub-committee works with all ideas and efforts regarding the detection of fraudulent and abusive behavior regarding the claims process.



Senate Bill 1986

In late 2009 the Agency's Medicaid Quality Management Bureau, Project Management Unit, was assigned to work with the Bureau of Internal Audit to coordinate and assist in implementing the provisions of Senate Bill 1986, which was passed during the 2009 legislative session. Senate Bill 1986 is a comprehensive bill impacting several agencies in order to help prevent and detect fraud and abuse. Many of the provisions of this bill took effect on July 1, 2009. Internal Audit established the following objectives:

- Improve the ways in which the Agency communicates and shares information on Medicaid providers;
- Implement measures to help reduce Medicaid fraud and abuse by increasing standards that health care facilities and practitioners must meet;
- Add new penalties for committing fraud; and
- Offer incentives to encourage more people to report suspected Medicaid fraud.

The resulting products were process maps, data inventories and gap identification, which ultimately led to the development of processes to better utilize all existing data. The long-term goal will be an integrated system, which defers to primary sources of data without duplication and provides proper notification to all concerned parties.

Other accomplishments of the Agency's SB 1986 teams in FY 2009-10 include:

Additional committees were created to address the Data Connectivity Issues and the Background Screening concerns.

The Agency's bureaus and divisions worked together to create one uniform process whereby a Final Order is issued every time a sanction or termination for cause is imposed on a Medicaid provider. The Agency clerk is responsible for notifying other licensing entities and all Final Orders are posted on the website in a searchable format.

Final Audit Reports (FAR) are issued to providers and serve as a "probable cause" determination. When a FAR results in a finding that a provider must repay the Agency, Finance and Accounting will withhold 100% of future payments to the provider 31 days after the FAR is issued. If a provider requests a hearing, a lien is imposed unless the provider enters into a satisfactory repayment plan with the Agency. Accounts are reconciled at the issuance of a Final Order.

Thirty-one days after sending a Final Order, the Agency will terminate a provider who has not repaid the identified overpayment or entered into a satisfactory repayment plan with the Agency.

An internet application was developed to provide a searchable database of all Final Orders issued by the Agency since 1992. The online Final Orders are located at http://apps.ahca.myflorida.com/dm_web.

Senate Bill 1986 amended Section 409.913(38)(b), Florida Statutes, to require the Agency to develop a strategic plan to connect all databases that contain health care fraud information. Such a strategic plan was developed and adopted in 2010 and will serve as a roadmap for facilitating the electronic exchange of health information used to identify and prevent fraud and abuse in the Florida Medicaid program. The strategic plan is a working document that will be revised and modified as necessary to adapt to changing regulations, as well as to reflect current health care trends and new technology.

Post Service Audit Contractor

The Agency was authorized through the 2009 General Appropriations Act to contract on a contingency fee basis for a vendor to perform post-payment claims analysis to identify and recover overpayments for the Florida Medicaid Program. The Vendor will employ advanced detection techniques to identify providers who have submitted improper claims. The vendor will then conduct audits of those providers using Agency approved audit and sampling techniques and seek reimbursement for any overpayments

identified. This ITN was issued in the summer of 2010 and the Decision to Award posted in August 2010. When fully implemented the vendor expects to complete 1000 audits per year and recover up to $20 million per year.

Bureau of Internal Audit

The Bureau of Internal Audit (IA) provides independent, objective assurance and consulting services designed to add value and improve the Agency's operations. The IA's mission is to bring a systematic, objective approach to evaluating and improving the effectiveness of risk management, control, and governance processes. Below are examples of audits and reviews completed in FY 2009-10 that served to help prevent, detect or recoup Medicaid fraud and abuse overpayments.

Provider Files Audit

At the request of Agency management, IA conducted a review of the process for updating provider file changes to the Florida Medicaid Management Information System (FMMIS), specifically, provider Change of Address (COA) requests. The objectives for this review were to determine if the Bureau of Medicaid Contract Management (MCM) was:

- Monitoring the fiscal agent to ensure that appropriate controls and procedures were in place for the provider COA process and properly administered, and
- Utilizing all resources available to them to ensure that providers are actively self reporting COA information to the fiscal agent for processing.

Over the course of the fieldwork the Agency transitioned from Affiliated Computer Services (ACS), as the Medicaid fiscal agent to HP, formerly known as Electronic Data Systems (EDS), who holds the contract through June 2013.

The review revealed inefficiencies in the provider COA process. These inefficiencies led to additional efforts on the part of the provider and the fiscal agent. IA found that the fiscal agent was not in compliance with the contractual responsibility to perform provider file changes within 24 hours of receipt of a change request. IA also found that MCM was aware that the fiscal agent was not meeting the 24 hour contractual requirement and had assessed penalties for non-compliance.

IA recommended the development of new procedures and technology that would give Medicaid providers the ability to electronically update their addresses. By giving the provider the ability to perform this update, the Agency can hold them solely responsible for ensuring the correct address is maintained in FMMIS. IA also recommended that the Medicaid Handbook be updated to clearly define the timeframe in which providers should notify the Agency of address changes. Additional HP personnel should be assigned to assist with inputting address changes while this technology is being developed to address the backlog of COA requests. IA further recommended MCM continue to monitor the fiscal agent and assess penalties as appropriate where contractual requirements are not being met.

Investigations Unit

Fraud and Abuse Efforts

The Investigation Unit's (IU) fraud and abuse efforts included assisting MPI as well as generating cases from data claims and citizen complaints. The IU utilized the strengths of investigators with law enforcement experience coupled with the skill set of a veteran data analyst to accomplish their goals. These focused investigations included the use of data analysis, witness interviews and in some cases, the collection of physical evidence. During FY 2009-10, the IU opened 115 fraud and abuse files and made 57 referrals for action by other agencies. Twenty-four of these referrals were sent to the Medicaid Fraud Control Unit (MFCU) for potential criminal investigation. The IU identified and recovered $177,677 in overpayments and identified $264,945 worth of claims that were subsequently voided or reversed, for an overall savings to the Medicaid Program of $442,622. Additionally, the IU provided technical support for MPI general analysis projects, which recovered approximately two million dollars.

Non-Specialized Physicians Practicing and Prescribing for Pain Management

This investigation focused on physicians operating outside their scope of practice. Licensed physicians, such as ophthalmologists, were writing large numbers of prescriptions for powerful controlled substances normally associated with pain management, such as oxycodone, hydrocodone, methadone and Dilaudid. Evidence from field initiatives and record reviews revealed that some Medicaid recipients paid up to $250 cash for office visits, and received prescriptions for pain medications. Some of these prescriptions were then filled using Medicaid benefits while others were paid in cash. In some instances, there were indications that these narcotics were sold for profit. Throughout Florida, these types of abuses have led to overdoses, sometimes resulting in death. In FY 2009-10, the IU referred eight such physicians for potential criminal investigation, as well as for standard of care violations.

Tampa Physician

The IU identified the arrest of a physician in Tampa, Florida and tracked his patients through Medicaid pharmacy claims to another prescribing ophthalmologist. According to a review of paid Medicaid prescription claims from January 2009 through July 2009, there were 178 claims totaling $24,470, for which this ophthalmologist was the prescriber. The majority of all prescriptions were for pain management medications such as oxycodone, morphine sulfate, hydromorphone and Endocet. All of the controlled substances were prescribed in April 2009, just after the first physician's arrest in March 2009.

The following are examples of prescriptions written by this ophthalmologist for just one Medicaid recipient:

- April 15, 2009 – 3 prescriptions - oxycodone 30mg for 400 pills each, a total of 1,200 pills
- April 29, 2009 – 2 prescriptions - oxycodone 30mg for 480 pills each, a total of 960 pills
- May 13, 2009 – 2 prescriptions - oxycodone 30mg for 420 pills each, a total of 840 pills
- May 28, 2009 – 2 prescriptions - oxycodone 30mg for 480 pills each, a total of 960 pills
- June 8, 2009 – 2 prescriptions - oxycodone 30mg for 420 pills each, a total of 840 pills

Samples of prescription copies and signature logs requested from area pharmacies indicated that this recipient used Medicaid benefits for some of the prescribed medications but paid $480 cash for an oxycodone prescription and $700 cash for an Oxycontin prescription.

Five Tampa-area pharmacies provided copies of original prescriptions written by the ophthalmologist. The header on the prescriptions identified his practice as pain management; although this physician's Florida Department of Health profile did not indicate any other specialty than optometry.

During an on-site visit to the facility in Tampa, Agency personnel were told that the ophthalmologist left the practice and had moved out of state. Further investigation determined that four other physicians were involved in the same pain management practice.

The clinic submitted the requested records and a review noted the following:

- Many recipients were former patients of the arrested ophthalmologist;
- Diagnostic tests and/or laboratory tests were rarely performed and recorded as ordered;
- No referrals were made to other medical community professionals for therapy or treatment;
- The progress notes contained little information to justify the diagnoses;
- Duplicate prescriptions for the same medications appeared to have been written, in order for one to be filled using Medicaid benefits and the other with cash; and
- Many records were not signed by a physician.

A physician peer review of 15 medical records contained many instances of standard of care violations such as grossly inadequate documentation, suggesting face-to-face visits may not have occurred, and practicing beyond the scope of training. The findings of this case were referred to both state and federal administrative and law enforcement agencies.

Central Florida Physician

A physician practicing in Winter Garden was investigated after an analysis determined that she had prescribed large amounts of highly abusive and diverted pain management medications to a Medicaid recipient who paid in cash.

According to a review of Medicaid prescription claims from January 2007 through February 2010, this prescriber caused 2,021 pharmacy claims to have been submitted, totaling $88,952. The prescriptions were for pain management medications such as oxycodone and Oxycontin. The physician's Medicaid-paid prescription summary was atypical of a family practice physician.

Further review determined that many of the recipients resided outside of the Central Florida area. One group of the recipients resided in the Florida panhandle, where the physician's prescriptions were being filled (and billed to Medicaid) by local pharmacies.

Twelve Medicaid recipients from the panhandle area were interviewed by IU staff. These recipients resided in cities as far west as Milton. The following concerns were identified:

- The recipients (individually and collectively) traveled to the cash-only pain management clinic in Winter Garden every 28 days.
- The Central Florida physicians' facility had a cash-only pharmacy. Many of the Medicaid recipients stated that they could not afford to pay cash and instead went to other pharmacies in

the area that take Medicaid. However, records submitted by the facility indicate that some of the recipients paid cash for medications dispensed at the clinic instead of going to area pharmacies to use their Medicaid benefits.
- Many of the patients had followed the physician from a previous employer at a nearby facility designated as a pain center.
- The facility charged $150 cash for an office visit.

Many of the interviewed individuals did not appear to be in pain and moved fluidly without interruptions. Below are examples of medications prescribed to certain recipients by the physician (30 day supply):

- Recipient A – Methadone – 540 pills, Diazepam (Valium) – 75 pills and oxycodone – 240 pills
- Recipient B – Methadone – 600 pills, Alprazolam (Xanax) – 120 pills and oxycodone – 150 pills
- Recipient C – Methadone – 360 pills, Oxycodone – 150 pills and Alprazolam (Xanax) – 90 pills
- Recipient D – Oxycodone – 180 pills, Diazepam (Valium) – 45 pills and oxycodone – 60 pills

A review of original prescription copies provided by several Central Florida area pharmacies determined that the physician practiced from two locations. Selected records from the physician were also reviewed and validated that Medicaid-eligible recipients were being seen at both clinics as "cash patients". Some of the patients (who were on Medicaid for being financially indigent) paid as much as $700 in cash at one single visit. One clinic charged $160 for an office visit and the second clinic charged $150 for an office visit.

It was also found that many of the panhandle area recipients followed the physician from clinic to clinic and utilized two specific pharmacies in the Central Florida area. These pharmacies were inconveniently located, with one being 14 miles further south from the physician's offices, in the opposite direction of travel for panhandle residents returning home. Some recipients described the pharmacies as having "what they need" and "amount (volume of pills) they need".

A review of the patient records revealed no justifications or medical necessity documented for the pain management medications and no new patient complaints to justify a change of medications. Diagnostic or laboratory tests were rarely performed and recorded as ordered. There were no referrals to other health care professionals for therapy or treatment, and there was no coordination of care or information regarding other non-pain management medications.

Submitted medical records along with Medicaid claims data were reviewed by an AHCA peer physician, who concluded that in a number of cases the patient's case fell below the standard of care as practiced by a board certified pain medicine physician. The peer believed that the physician was possibly in violation of Section 458.331(o), Florida Statutes and Standards for the Use of Controlled Substances for the Treatment of Pain, 64B-9.013 (1) (c), (d), (e); (3) (a), (b), (c), (d), (e) and (f) (F.A.C). Accordingly, the IU forwarded all information to the United States Drug Enforcement Administration and the Florida Department of Health. The physician was terminated from the Medicaid program.

Medicaid Anti-Psychotic Medication Prescriber in South Florida

A South Florida Medicaid provider became the topic of a national discussion due to his high volume of prescriptions for atypical anti-psychotic medications. The physician had been reimbursed by Medicaid a relatively low dollar amount for his office visits. However, after a Medicaid claims review, it was

discovered that Medicaid paid for more than $7 million in prescription claims written by this physician from January 2008 through June 2009. The IU, teamed with federal Medicare program investigators, conducted a site visit during which medical records were reviewed. Teams of investigators also conducted recipient visits to verify they were, in fact treated by the physician. A majority of interviewed recipients could not produce medications that were recently prescribed or filled, which could be an indication of drug diversion. The provider was terminated from the Medicaid program and the findings of the investigation have been forwarded to other state and federal administrative and law enforcement agencies for criminal investigation.

Additional Identification of Top Atypical Anti-Psychotic Medication Prescribers

The IU expanded its review of top anti-psychotic prescribers in Florida to include the next two highest prescribers in Miami-Dade County. These two prescribers' disbursements for Medicaid prescriptions in 2009 totaled $3.4 million and $2.4 million. The IU conducted on-site investigations of both physicians' clinics, attempted interviews with 54 of their Medicaid recipients and completed 28 recipient interviews. Ninety percent of all recipients could not produce their anti-psychotic medications for IU investigators and the majority of recipients interviewed utilized the same two pharmacies for their medications. The IU requested and collected 50 recipient medical records for peer review to determine medical necessity. The peer review revealed a pattern of poor documentation and questionable medical necessity, as well as claims for recipient clinic visits with a physician when the documents revealed the patients actually met with a nurse practitioner or a physician assistant. The IU made referrals to the Agency's Division of Health Quality Assurance, the Florida Department of Health and other federal agencies. In addition, the IU referred both prescribers to Medicaid Program Integrity for a comprehensive audit and possible termination from the Medicaid program. Findings are still pending on this case.

DME Provider Duval County – Improper Coding

The IU conducted a review of Medicaid claims for procedure code E1406 from January 2007 through July 2009. Procedure code E1406 is for "Oxygen and Water Vapor Enriching System without heated delivery". This particular machine has been obsolete since September 1, 2009. A DME provider located in Duval County was one of eight in the state that billed and received Medicaid reimbursement for this particular procedure code during the review period and was the number one provider by dollar amount and by unduplicated number of Medicaid recipients.

The Agency's Bureau of Medicaid Services was notified that the only qualifying products for billing codes E1405 and E1406 had been discontinued and the procedure codes were obsolete. Medicaid Services agreed and requested that Medicaid Contract Management instruct the fiscal agent to discontinue reimbursement for procedure codes E1405 and E1406.

Additionally, the overpayment amount was determined to be $293,222 for erroneously billed claims for the review period. The provider agreed with the overpayment determination and requested a payment plan, repaying approximately $24,000 per month.

DME Provider in Citrus County – Delivery of Oxygen Concentrators

The IU received a complaint alleging that a specific DME provider in Citrus County, Florida, had failed to use a licensed therapist to deliver and set up oxygen concentrators to Medicaid recipients' residences in violation of Medicaid Policy. The complaint was unfounded, but the IU determined that the DME provider billed and received reimbursement from Medicaid without reporting a change of ownership of

the business as required. Billing for the period during the unreported ownership was identified as $35,610. The current owners of the DME provider entered into a repayment plan to reimburse Medicaid for the violation.

DME (oxygen concentrators and related equipment) Providers in Columbia County

The IU conducted field investigations in an effort to combat fraudulent reimbursement for durable medical equipment (DME), specifically oxygen and oxygen concentrators and related equipment providers in Columbia County. Field visits were conducted in February 2010. The IU identified procedure code E1390, Oxygen Concentrators as the top procedure code (by dollar amount) for DME providers in Columbia County. The purpose of this investigation was to determine compliance with Medicaid rules, regulations and Florida Statutes by the DME providers and to ensure that the services were rendered. The IU selected and interviewed 15 Medicaid recipients and obtained all recipient medical records for analysis. The IU discovered Medicaid policy violations with respect to record keeping practices. Recipient interviews revealed that oxygen concentrators paid for by Medicaid were not being used or had been in storage making it impossible for the DME provider to complete the quarterly inspections as required. Review of the medical records also revealed instances where no prescriptions or physician orders for portable oxygen of any type were documented and the providers were delivering portable oxygen while also billing for the oxygen concentrator.

One DME provider continued to bill Medicaid for an oxygen concentrator and a Continuous Positive Airway Pressure (CPAP) machine, a device which delivers air to persons with abnormal breathing during sleep. This billing was for a Medicaid recipient who had no electricity for over one year. Additionally, oxygen concentrator maintenance visits were not performed as required. Another DME provider billed and received Medicaid reimbursement for two claims for a recipient after his date of death. The provider's participation in the Medicaid program is pending the findings of the MFCU.

The Columbia County DME initiative concluded with the IU completing referrals to the Office of the Attorney General Medicaid Fraud Control Unit, the Florida Department of Health and the Medicaid Program Integrity for comprehensive audits. At the conclusion of field initiatives, the IU staff used the findings to recommend changes to Medicaid policy upon the promulgation of a new DME handbook by Medicaid Services.

DME (oxygen concentrators and related equipment) Orange County

The IU initiated a review of the Medicaid billing for oxygen concentrators to persons over 21 years old by DME providers in Orange County for dates of service from January 2008 through February 2010. Orange County ranked fifth in Florida for oxygen concentrators claims. The two top billing providers were selected for review. Medicaid collectively paid these two providers $234,394. 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 Medicaid Program Integrity for a comprehensive audit. The initiative also assisted in outlining areas of Medicaid policy that need improvement or clarification, and recommendations to strengthen Medicaid policy and deter fraud were forwarded to management.

Central Florida Dentist

The IU received a citizen complaint that a Central Florida dentist billed Medicaid for services that were not performed. A preliminary review determined that the dentist had received Medicaid reimbursements of $1,095,373 for calendar year 2009. The IU investigated the provider's billing practices by conducting an onsite visit coupled with interviews of the provider, staff and recipients. Nearly all recipients interviewed described a dentist other than the provider performing the services. Further investigation determined that the provider was paying non-Medicaid enrolled dentists a daily fee to perform dental work from two locations. It was determined that the second location was not enrolled in Medicaid and therefore, had not been properly inspected to ensure compliance. Immediately after the Agency review started, the provider voided 10,599 claims totaling $248,341. This case has been referred to both law enforcement and administrative agencies. The provider was terminated from the Medicaid program.

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).

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 those received on the toll-free Medicaid fraud hotline, the online complaint intake form 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 Miami, Jacksonville, Orlando and Tampa. 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. These field initiatives focus on "full chain" interviews of recipients, providers and prescribers and often include 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 the Agency such as the Division of Health Quality Assurance (HQA) and the Division of Medicaid (Medicaid). Field office personnel act as liaisons with Medicaid Area Offices, local governments and law enforcement entities and participate 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 personnel participate 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 typically based on a discovery that a procedure 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 analyzed across all applicable providers to determine the extent of the overpayment 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 analysts review detection reports, analyze claims data, develop leads for the Case Management Units (CMUs) and work closely with Medicare partners to identify fraud and abuse issues related to claims paid by both entities. They also 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 Research and Development Unit (RDU) reviews previously successful generalized analyses for possible reproduction or expansion. RDU staff meets regularly to discuss leads, analyze Medicaid policies and identify possible violations that can be addressed in a GA process. RDU personnel develop requests for GA programming and monitor the associated programming and report development. The RDU also guides providers in performing self-audits for inappropriate payments due to a misunderstanding of a policy. This unit works with Medicaid to clarify Medicaid handbook policies.

Case Management Units

Case Management Units (CMUs) are the heart of MPI's recovery efforts, performing comprehensive audits and generalized analyses. When conducting a comprehensive audit, statistical methodology is used in the generation of a random sample of provider claims. CMU investigators request documentation from the provider that supports the sampled claims and a nurse or investigator reviews the documentation to 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.

Challenges Met in FY 2009-10

Medicaid Program Integrity completed the remaining transition issues associated with the implementation of the new Florida Medicaid Management Information System (FMMIS). MPI completed testing for their various detection tools, including Chi Square Analysis, Early Warning System and the 1.5 Report (see *Detection Tools,* below) to insure that the detection capabilities remain strong. Audit support applications that required additional attention were the BusinessObjects application and several statistical programs. A significant effort was devoted to addressing and passing the FMMIS certification process for the new system and subsystems.

MPI continued to assist the Centers for Medicare & Medicaid Services (CMS) in all phases of the federal program for audits conducted in Florida. These included vetting lists of providers for audit, reviewing claims data pulled by the CMS Medicaid Integrity Contractor, pursuing policy clarifications, evaluating preliminary and final audit results prior to release and assisting the Agency's Office of General Counsel with defending the final audit report during litigation.

Senate Bill 1986 was adopted on July 1, 2009. This bill expanded the Agency's abilities to combat fraud, abuse and waste in the Medicaid program. Staff resources were used to implement the requirements established by the bill to enhance the Agency's prevention, detection and auditing efforts. The investment of resources devoted to implementation is expected to result in improved provider compliance.

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.

Medicaid Program Integrity Detection Methods

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), the Division of Medicaid and the Medi-Medi partnership with the Medicare program, as well as data mining.

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 an analysis of 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 and provides the Agency 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 to access Medicaid claim information within FMMIS and DSS. The FMMIS system processes and pays provider claims and contains claim related information on Medicaid providers, recipients, drugs and medical services . The Decision Support System (DSS) stores seven years of providers' claims history and contains the DSS*Profiler* datamart, a

type of Surveillance and Utilization Review Subsystem (SURS), for claims utilization review and provider and recipient profiling.

The 1.5 report is produced weekly and provides a listing of each Medicaid provider who is scheduled to receive a check for that week in an amount that exceeds 1.5 times the average amount received for the immediately prior 26 weeks. This report includes all Medicaid provider types and 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 to have been paid 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.

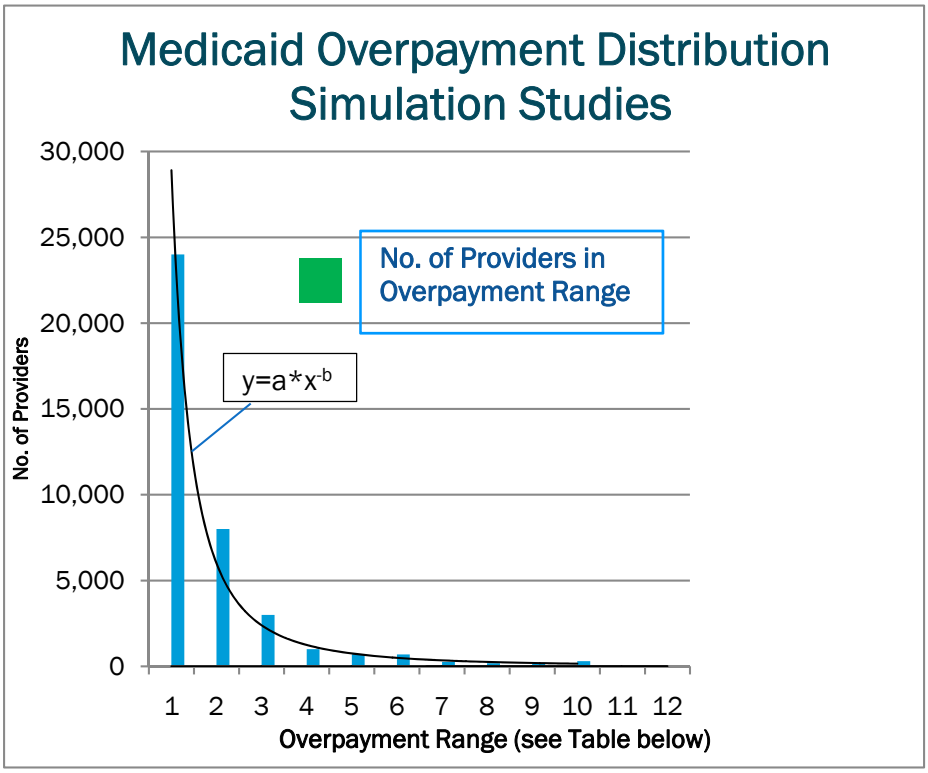
Early Warning reports were developed by MPI to determine the rates of increase in payments to providers. Very rapid increases in payments may be due to the fact that providers are new or to other legitimate reasons. Or, they may be due to unwarranted billings by providers. Payments for a number of weeks 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 is 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 performed to detect claims paid by Medicaid that should have been paid only by Medicare. Through this program's 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.

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.



Overpayment Range		
	From	To
1	$0	$20,000
2	20,000	40,000
3	40,000	60,000
4	60,000	80,000
5	80,000	100,000
6	$100,000	$200,000
7	200,000	300,000
8	300,000	400,000
9	400,000	500,000
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.

Special Analysis – "Pill Mill" Data Initiative

The "Pill Mill" Data Initiative was developed by the Agency in conjunction with the contractors for Medicare Part A and Medicare Part B to perform a statewide data analysis on the top prescribed narcotics within those two programs. The goal of the initiative was to analyze and report potential overutilization patterns to local, state and federal law enforcement agencies in order to combat fraud and abuse regarding the illegal prescribing, dispensing and consumption of these powerful controlled substances (oxycodone, hydrocodone and Xanax).

This was the first time that the Agency, Medicare contractors and local, state and federal law enforcement agencies have performed an initiative of this type.

In October 2009, the Agency made the initial presentation on this initiative to local and state law enforcement officials in the Tampa area. The findings included top area prescribers, top pharmacies where the prescriptions were being filled and the recipients involved in the transactions. Subsequently, the Agency expanded the project to include the Jacksonville, Miami, Broward County and North Florida areas. Agency staff members presented the findings for these areas to local, state and federal law enforcement agencies. In FY 2009-10**,** the Pill Mill Project resulted in 103 referrals to law enforcement agencies. Out of the 103 referrals, 23 recipients were referred to the Medicaid Pharmacy Services unit for the pharmacy lock-in program. These 23 recipients were also referred to FDLE for a doctor shopping investigation. Fifty doctors and 30 pharmacies are still under investigation at MFCU or HHS/OIG. MPI has made nine recommendations to terminate the physicians in the Medicaid prescription payment system.

Joint MPI and MFCU Referral and Data Mining Meetings

Staff members from MPI and MFCU meet biweekly to discuss potential referrals to MFCU and to share ideas for data drilling and detection projects. During these meetings, potential referrals are vetted for additional information and strategic planning. A referral is either accepted, deferred pending further information or denied for various reasons. The provider's billing history and any prior actions against the provider taken by MPI or MFCU are presented and discussed. Staff members participating in these meetings are from MPI Tallahassee, MPI field offices, the Division of Medicaid, MFCU and the Medi-Medi contractor, Safeguard Services, LLC.

Data Drilling and Detection Projects

Recently, through a joint request by AHCA and the Office of the Attorney General of Florida, CMS has approved a temporary waiver to allow MFCU the ability to data mine Medicaid data using the Decision

Support System (Data Warehouse). At the conclusion of the biweekly case referral meeting, the participants from MPI and MFCU initiate a second meeting specifically to discuss the coordination of data mining projects. All projects are tracked to ensure that no duplication of data mining efforts takes place.

Quad State Meeting

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. The 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 are held quarterly. This new avenue of networking and exchanging information and ideas enhances efforts to prevent, detect and recover Medicaid overpayments.

Prevention Activities

MPI dedicates a significant amount of staff resources to the prevention of fraud and abuse. Stopping overpayments before they happen avoids recovery costs and allows those funds to be used as intended. Among MPI prevention activities are the use of prepayment reviews to identify improper claims and deny payment, recommendations for termination of providers suspected of misusing the Medicaid program, denial of reimbursement for prescription drugs prescribed by terminated providers, site visits to certain Medicaid providers in specified geographic areas and the application of administrative sanctions, as appropriate.

Prepayment Reviews

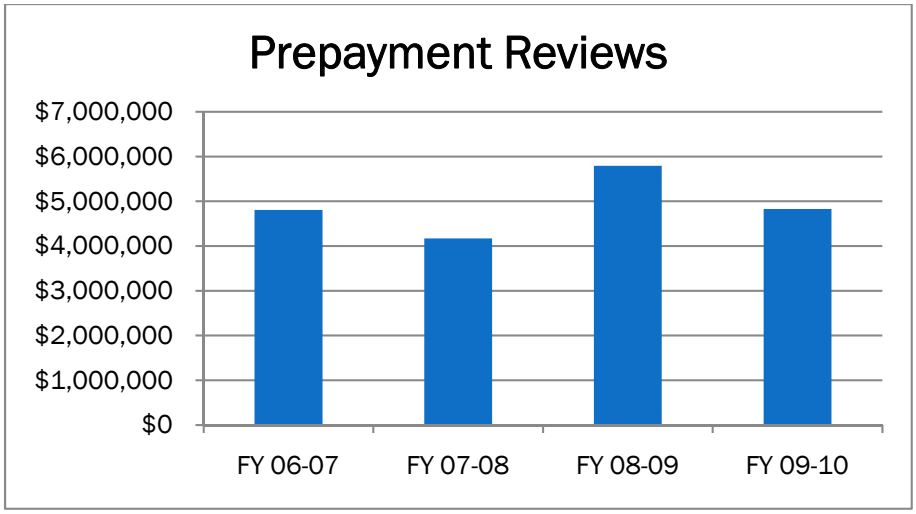
Prepayment reviews encompass examination of claims associated with "intercepted payments" and evaluation of "pended claims". The "intercepted payments" relate to Medicaid claims that have been processed for payment, but the payment has not yet been sent to the provider. "Pended claims" have not yet been processed for payment. In prepayment review, claims not having proper documentation are denied.

Prepayment review 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 multiplied by the ratio of actual payments to billed amounts for a substantial portion of the applicable fiscal year for the type of provider involved. This ratio factors in the proportion of the billed amount that would have been denied due to system edits. (MPI is not credited for amounts that would have been denied or adjusted even without MPI intervention.) During FY 2009-10, MPI initiated 263 prepayment reviews

in which providers' claims were pended. MPI closed 116 prepayment review cases where claims were denied resulting in cost avoidance of $4.8 million as shown below:

Prepayment Reviews FY 2009-10		
Provider Type	Count	Amount
Assistive Care Services	6	$68,918
Chiropractor	1	$18,531
Dentist	1	$16,043
H & C Based Services	66	$1,950,842
Home Health Agency	14	$1,029,464
Medical Supplies/Durable Med	3	$373,043
Personal Care	1	$1,733
Pharmacy	1	$18,412
Physician (DO)	1	$246
Physician (MD)	13	$155,081
Podiatrist	1	$2,281
Therapist	8	$1,193,114
Total	116	**$4,827,707**

The chart below provides an historical look at dollars associated with prepayment reviews over the last four years. In FY 2009-10, MPI prepayment reviews produced cost savings of $4.8 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 furnished 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 who were served by the terminated provider and who had maintained eligibility for all of both one-year periods. For FY 2009-10, these terminations saved Medicaid $1.8 million.

Site Visits

Staff members in the Bureau of Medicaid Program Integrity field offices visit certain Medicaid providers. These visits are to ensure that the provider is still at the address given, appears to have the assets required to perform the services that will purportedly be furnished, has necessary Medicaid manuals and forms, is generally familiar with Medicaid policies and knows how to obtain Medicaid information.

Site visit savings are based on payments made to the provider during the one-year periods prior to and following the visit. New providers are not included in the calculation of savings; a provider must have been active for one year prior to the visit to be included. Because of the Medicare Part D effect, pharmacies are not included. Cost savings for FY 2009-10 resulting from 410 site visits were $7.4 million.

Site Visits Performed in FY 2009-10	
Provider Type	**No. Completed**
Assistive Care Services	105
Community Alcohol, Drug MH	3
Dentist	9
Dialysis Center	4
EIS Professional	1
Federally Qualified Health Center	1
H&C Based Services	111
HMO or PHP	1
Home Health Agency	27
Medical Foster Care	1
Medical Supplies/Durable Medical Equipment	27
Nursing Home	25
Personal Care	1
Pharmacy	89
Physician (DO)	1
Physician (MD)	60
Therapist	15
Total	**481**

Administrative Sanctions

During FY 2009-10, 453 Medicaid providers received 525 sanctions for violations set forth in Rule 59G-9.070, F.A.C. These sanctions included suspensions and terminations from the Medicaid program, fines totaling $666,740 and corrective action plans.

Type Sanction	Number of Sanctions	Total Fines
Fine Sanctions	420	$666,740
Suspensions	12	—
Terminations	37	—
Corrective Action Plans	38	—
Totals	**507**	**$666,740**

In March 2010, the Office of Program Policy Analysis and Government Accountability (OPPAGA) released Report No. 10-32 outlining several recommendations that the Bureau of Medicaid Program Integrity could implement to strengthen its Medicaid fraud and abuse program. One of the recommendations directed MPI to strengthen the sanctioning process to impose higher fines based on the provider's identified overpayment. The enactment of Senate Bill 1986 which was introduced in the 2009 Legislative Session affected multiple sections of law administered by several agencies. Amendments to existing laws and rules were required to enhance the activities and authority of the various agencies in combating fraud and abuse in the delivery of health care services. One such rule was the Administrative Sanction Rule, Rule 59G-9.070, F.A.C. The Agency amended the rule to comply with the OPPAGA recommendation and to meet the legislative intent of Senate Bill 1986 to reduce and prevent fraud in the Medicaid program. As a deterrent for violating laws governing the Medicaid program, monetary sanctions were significantly increased by the amended rule which became effective September 7, 2010. The following is a link to the rule as amended: https://www.flrules.org/gateway/ruleNo.asp?id=59G-9.070.

As amended, the sanction rule now terminates providers with egregious billing practices from the Medicaid program and increases fines as a deterrent from repeated misbillings. Fines for first violations have more than doubled. For example, the fine under Rule 59G-9.070(7)(c), F.A.C., for failure to furnish records has increased from $1,000 per record request to $2,500 per record request and suspension until the records are made available at the first violation. Another example, under Rule 59G-9.070(7)(e), F.A.C., failure to comply with Medicaid laws subjects the provider to an increased fine from $500 per provision to a $1,000 fine per claim found in violation up to 20% of the overpayment amount for the first offense, for a second violation the fine increases to $2,500 per claim found in violation up to 40% of the overpayment amount, and upon third violation a $5,000 fine per claim up to 50% of the overpayment amount. Termination from the program may occur as early as the first violation in some instances and in most situations is definite at the second or third violation.

As an example, two recent audits performed on pharmacy providers found violations of Rule 59G-9.070(7)(n), F.A.C., shortages of goods or time. Both cases found shortages of goods, which carries a $1,000 fine per type of good found to be short for the first violation. The first provider had a total overpayment of $109,545.94 and a sanction of $21,909.19 was applied. The sanction was capped at 20% of the overpayment since this was a first offense. The second provider had a total overpayment of $231,112.79, and the full sanction of $24,000 – a $1,000 fine was issued for each of the 24 types of

goods found to be short. For each of these cases, the sanction amount under the prior version of the rule would have been only $5,000.

Field Initiatives

Durable Medical Equipment

A disproportionately large percentage of Florida Medicaid expenditures for durable medical equipment is made to providers located in the Miami-Dade County area. Accounting for the largest share of those DME expenditures have been oxygen concentrators (Procedure Codes E0431, E0570 and E1390). In a project concluded in the current fiscal year and previously unreported, Medicaid Program Integrity investigated the billings of the twelve Medicaid DME providers in Miami-Dade and Broward Counties who were the top suppliers of oxygen concentrators for the seventeen month period ending June 1, 2009. Investigators visited the providers and 120 recipients who had reportedly received concentrators and other medical equipment from the providers during that period. In the visits to recipients, investigators determined whether the billed services had been properly rendered, the equipment in the home was maintained and operating correctly, the recipients had been adequately trained on the equipment and Medicaid policies were being followed.

It was determined during the investigation that some providers had failed to conduct or document quarterly home visits, had billed for equipment not delivered or not needed, had failed to obtain required medical information concerning recipients, had not posted required "Oxygen in Use" signs, or had engaged in other violations of Medicaid policy. One provider billed for services for a recipient who was deceased. Two providers were referred to the Medicaid Fraud Control Unit. Action is pending with respect to another provider. One provider of the twelve had no adverse findings.

Home Health Initiatives

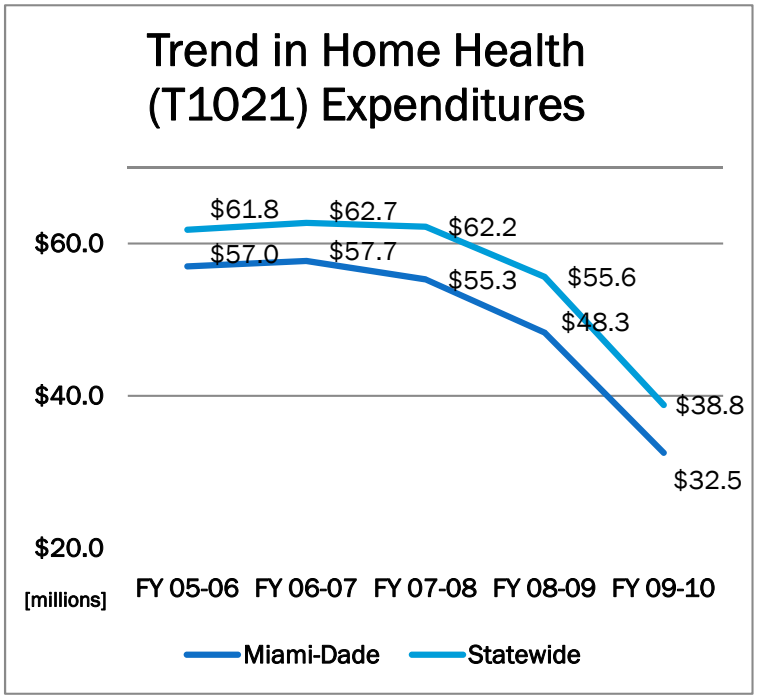
Home health agencies have been an acknowledged area of health care fraud in recent years. For the four fiscal years ending June 30, 2009, approximately 90 percent of Medicaid expenditures for home health aide visits were made to providers in Miami-Dade County, while only about 20 percent of Medicaid recipients reside in that area. At the end of the fiscal year there were 339 home health agencies in Miami-Dade County actively enrolled in the Medicaid program and only 293 in the other 66 counties combined. The Agency has devoted a significant amount of resources to preventing and detecting fraud and abuse in home health services in Miami-Dade County. Specifically the Agency conducted two major field initiatives during the prior fiscal year. The first initiative occurred during the period August through October 2009. Medicaid Program Integrity, in conjunction with the Division of Medicaid and the Centers for Medicare & Medicaid Services (CMS) Medicaid Integrity Group, investigated six home health agencies in Miami-Dade County that had billed procedure code T1021 (Home Health Aide Visit — Associated/Unassociated with Skilled Nursing Services) at an extremely high rate. The objectives for this initiative were to determine if home health services were appropriately billed to the Medicaid program, were rendered as billed and were medically necessary to meet the needs of recipients.

Staff members from MPI and the Division of Medicaid conducted 113 recipient interviews visited 125 prescribing physicians. Interviews revealed that more than 10 percent of recipients had been receiving fewer services than billed and a similar percentage was not even homebound. The home health agency reviews resulted in three provider terminations, two prepayment reviews totaling $62,000 in claims

denied, four paid claim reversals totaling $39,000, five referrals to CMS, one referral to MFCU, one referral to HQA and one $1,000 sanction that was imposed for failure to submit Medicaid-related documentation.

As a follow-up to the physician visits conducted as part of the fall project, MPI initiated a home health prescriber project in February 2010 that resulted in an additional ninety-six (96) physician site visits. The objectives of this second project were to determine if Medicaid providers prescribing home health services were prescribing services in compliance with Medicaid policy and to verify that the providers were maintaining required documentation in recipients' medical records as required by the *Physician Services Coverage and Limitations Handbook*. As a result of both fraud and abuse initiatives, MPI and its State and Federal partners reviewed records associated with two hundred and twenty-one (221) home health prescribing physicians. The final analysis revealed a sizeable proportion of physicians, nearly 40 percent, had one or more Medicaid violations. Examples of violations identified included providers not located at the address of record, no plan of care in recipients' files, expired drugs in stock, missing patient records, or plans of care on which the diagnosis did not comport with that on the prescription. As a result, 52 sanctions were levied resulting in $26,500 in fines and 58 referrals were made to the Department of Health.

As the chart below illustrates, the continuous efforts on the part of the Agency to control the overutilization of home health aide visits have produced a steady decrease in the amount of Medicaid expenditures for home health services. Specifically, for Home Health Aide Visits Associated/Unassociated with Skilled Nursing Services (procedure code T1021) these efforts reduced expenditures in Miami-Dade County from an average of $56.7 million dollars for FY 2005-06 through FY 2007-08 to $48.3 million in FY 2008-09 and finally to $32.5 million in FY 2009-10. This represents a cumulative decrease of almost $23 million in just two fiscal years. Since expenditures in Miami-Dade County represent such a large percentage of the State's expenditures, the statewide trend closely mirrors the numbers found in Miami-Dade County.



Medicaid Program Integrity Recovery Activities

MPI continues its investigative and recovery efforts through comprehensive audits involving reviews of professional records, generalized analyses involving computer-assisted reviews of paid claims pursuant to Medicaid policies, paid claim reversals involving adjustments to incorrectly billed claims, focused audits involving reviews of certain types of providers in specific geographic areas, coordinating provider self-audits, and referrals to MFCU and other regulatory and enforcement agencies. The three general recovery categories are: MPI conducted audits, paid claims reversals by MPI and vendor-assisted audits.

MPI Audits

MPI's recovery efforts emphasize conducting comprehensive audits and generalized analyses of Medicaid providers. These audits are comprehensive evaluations of all aspects of a provider's billings or computer-assisted generalized analyses that evaluate specific aspects of the billings of many providers. Typically, a comprehensive audit determines all of the provider's paid claims (the population) for a specific period of time and takes a random sample of claims from that 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. There were 2,366 cases that were concluded during FY 2009-10. Of these, 401 cases closed with no fraud or abuse found, 158 cases required provider education letters and 1,807 cases identified overpayments of $18.8 million.

Paid Claims Reversals

Several functions within MPI identify erroneous claims and these claims are corrected by the provider's reversal of previously submitted claims rather than by repayment of overpayments. For example, MPI's licensed pharmacists review claims paid to pharmacies in order to identify probable misbillings. 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. MPI detection methods identify atypical claims. The provider is contacted and may submit supporting documentation justifying the paid claim amount or 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 considered recovery as a paid claims reversal. Providers who do not adjust or reverse the payment are subject to further audit or other administrative action by the Agency. For FY 2009-10, paid claims reversals resulted in recoveries of approximately $1.5 million.

Third Party Liability Contractor-Assisted Audits

During the fiscal year, in coordination with the Agency's Division of Operations, MPI participated with the Third Party Liability (TPL) contractors to direct the activities needed to launch the work of the new contractor. MPI coordinated and assisted the TPL contractor's development of computer-assisted analyses of paid Medicaid claims. These efforts identified and collected overpayments of more than $40 million for the State of Florida. This productive year continued MPI's successful trend for TPL identification and recovery efforts, with results trending upwards from the total of $15 million three years ago.

FY 2009-10 TPL Results	
Activity	Amount (in millions)
MPI Audits (Identified Overpayments)	$18.8
Paid Claims Reversals	1.5
TPL Contractor Assisted Claims Adj.	40.6[1]
Total	$60.9

Performance Trends

Referral Activities

MPI continues to share information regarding Medicaid providers who may be engaging in abusive conduct by referring the information within and outside the Agency as appropriate. There were 894 referrals in FY 2009-10.

Number of Referrals				
	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10
Department of Health	181	70	163	108
Florida Department of Law Enforcement	1	13	40	117
Division of Health Quality Assurance	42	59	56	40
Division of Medicaid	82	48	60	67
Medicaid Fraud Control Unit	212	218	123	198
Others	44	127	118	364
Totals	562	535	560	894

Recoveries of Overpayments – MPI Audits

The Medicaid Accounts Receivable Unit of the Bureau of Finance and Accounting is responsible for collecting identified overpayments from Medicaid providers. Historically, a significant number of overpayments identified had not been recovered, because the provider declared bankruptcy or could not be located. MPI strives to conclude cases in a timely manner in order to increase the recovery rate; and amendments to Section 409.913, F. S., in 2009, require earlier withholding of funds by Finance and Accounting. The table below lists and sums overpayments identified by fiscal year for the last four fiscal

[1] This amount is also reported under Third Party Liability as they manage the contract for services requested by Medicaid Program Integrity.

years. The overpayments collected were based on the overpayments identified for that fiscal year, regardless of the year the overpayments were received. There is a natural lag between the date that overpayments are identified and the date that they are collected due to payment plans, liens and other collection efforts.

	Overpayments Identified	Overpayments Collected
FY 2006-07	$19,973,393	$15,365,162
FY 2007-08	15,628,918	12,469,052
FY 2008-09	15,625,437	13,303,432
FY 2009-10	18,800,058	13,231,593
Over 4 Years	$70,027,806	$54,369,240

For FY 2006-07, the overpayments identified have been restated from those originally reported to reflect only overpayments identified as the result of an MPI audit. No overpayments identified include claims adjustments or reversals. Claims adjustments and reversals are reported in the MPI Identified Overpayments table and in the table in the Return on Investment section.

Cases with Findings

MPI closed 2,366 cases during FY 2009-10. Of these, 1,807 cases had identified overpayments.

MPI Closed Cases by Fiscal Year				
	2006-07	2007-08	2008-09	2009-10
Overpayments Identified	811	791	1,288	1,807
No Fraud or Abuse Found	177	331	309	401
Provider Education Letter	30	4	17	158
Total Cases Closed	1,018	1,126	1,614	2,366
Percent with Overpayment	79.7%	70.2%	79.8%	76.4%

Providers Selected at Random for Audit

Florida Statutes provide in Section 409.913(2), F. S., that, for Medicaid Program Integrity, "At least five percent of all audits shall be conducted on a random basis". For FY 2009-10, the Case Management Units initiated eleven comprehensive audits of providers selected at random. The providers selected for audit had billed Medicaid during the audit time period and were active providers. Randomly selected provider's ID number was validated in FACTS to determine the provider's prior audit history and whether the provider was under review by MFCU. If a provider had been audited within the past four (4) years or was under review by MFCU, another provider was selected.

Of the eleven random audits, eight have been completed and closed. In five of these audits, the review of the requested documentation revealed no findings of abuse or fraud. These five providers were paid a total of $3,927,566 for the audit review period. In three cases having findings of improper billing, the overpayment identified totaled $43,468 or 3.26% of the total dollars paid ($1,334,853) to the providers for the audit period. The providers have either fully repaid the identified overpayment or are in a

repayment plan. The total of the overpayments to the eleven providers represents less than one percent of total payments to them.

Of the eleven cases, three audits were in progress at the time of preparation of this report.

Completed Random Audits FY 2009-10				
Results	**Number**	**$ Overpayment**	**Total $ Paid**	**Overpayment as % of Total Paid**
No Overpayment Found	5	0	$3,927,566	0.0%
Overpayment Found	3	$46,560	$1,334,853	3.3%
Total	8	$46,560	$5,262,419	.9%

MPI Highlights

A Medicaid Home and Community-Based Services waiver provider was identified from a Delmarva (quality assurance contractor) review that found the provider lacked appropriate documentation to support the services billed to Medicaid. MPI reviewed claims for the period of January 1, 2006 through December 31, 2007. Allegations were substantiated. A final audit report dated March 8, 2010 showed an overpayment of over $339,000 and a fine sanction of $8,000. The provider paid in full in April 2010 and a Final Order was issued.

In May 2007, the MPI Data Analysis Unit identified a Medicaid therapy services provider who was improperly documenting services provided. A comprehensive audit was conducted for the period of July 1, 2004 through June 30, 2006. The audit confirmed that the provider did not document the recipient's primary care physician review in the recipient's file or did not approve the plans of care in a timely manner. In addition, MPI found that records were not signed or dated at the time services were rendered and that documentation for many services was missing. After the Final Audit Report was issued in January 2010, the provider requested a hearing. Additional records were submitted and the overpayment adjusted to $204,000 with a fine sanction of $3,000. In April 2010 the provider agreed to a payment plan and the hearing request was withdrawn. A Final Order was issued in June 2010 and the provider entered into a payment plan.

Based on a referral from the Centers for Medicare & Medicaid Services, MPI conducted an audit of a Medicaid provider for the period of June 1, 2004 through June 30, 2006. The provider had billed over $5 million to Medicaid. The audit revealed that many services billed were not documented, services were billed when there was no valid plan of care, services were billed when no care was rendered and more hours were billed than documented. The provider submitted additional records and requested a provider meeting. The Final Audit Report identified an overpayment of $208,000 and costs of $4,000. The provider entered into a settlement agreement, the Final Order was issued in April 2010 and the provider paid in full.

A Medicaid internal medicine physician provider located in Melbourne, Florida, was identified for inaccurate billing of Evaluation and Management (E&M) codes. A review of the provider's claims for the period of January 1, 2002, through September 30, 2004, identified seven areas of concern. These areas were: enrollment issues, upcoding, no documentation, payment for laboratory tests that were performed outside the provider's facility by an independent laboratory, billing and receiving payment for conducting procedures the provider was not licensed to perform, illegible or missing signatures and

illegible records. A Final Audit Report was completed in October 2008 and the Final Order was filed in November 2009. An overpayment was identified in the amount of $184,000 and the provider paid in full.

A Medicaid pediatric physician provider located in Miami, Florida, was identified for inaccurate billing of Evaluation and Management (E&M) codes. A review of the provider's claims for the period June 1, 2006, through May 31, 2008, identified six areas of concern. These areas were: upcoding, no documentation, documentation not supporting billing for supervised ARNP services, not all elements of CHCUP (Child Health Check-Up) performed, erroneous coding and billing of services that are part of the CHCUP. A Final Audit Report completed in September 2009 identified an overpayment in the amount of $137,000. The Final Order was filed in February 2010 and the provider did not comply. The Agency has placed an involuntary lien on the provider and is pursuing termination from the Medicaid program.

A Medicaid general practice physician provider located in Miami, Florida, was identified for inaccurate billing of Evaluation and Management (E&M) codes. A review of the provider's claims for the period January 1, 2005, through February 28, 2006, identified seven areas of concern. These areas were: upcoding, erroneous coding, no documentation, not documenting time spent providing services, enrollment issues, services billed that were not medically necessary and billing for radiology services when the reading and interpretation was done by a radiologist outside of the physician group. A Final Audit Report completed in April 2007 identified an overpayment in the amount of $177,000. The Final Order was filed in August 2009, the provider did not comply with the repayment terms, and was subsequently terminated from participation in the Medicaid program.

A Medicaid general practice physician provider located in Naranja, Florida, was identified for inaccurate billing of Evaluation and Management (E&M) codes. A review of the provider's claims for the period April 1, 2006, through February 28, 2008, identified four areas of concern. These areas were: upcoding, no documentation, services billed that were not medically necessary and billing for the global fee when only the professional component was performed. A Final Audit Report completed in October 2009 identified an overpayment in the amount of $150,000. The Final Order was filed in February 2010 and the provider entered into a payment plan.

A Medicaid general practice physician provider located in Naranja, Florida, was identified for inaccurate billing of Evaluation and Management (E&M) codes. A review of the provider's claims for the period June 1, 2006, through May 31, 2008, identified six areas of concern. These areas were: no documentation, services billed that were not medically necessary, upcoding, enrollment issues, erroneous coding and billing for radiology services when the reading and interpretation was done by a radiologist outside of the physician group. A Final Audit Report completed in November 2009 identified an overpayment in the amount of $145,000. The Final Order was filed in February 2010.

Payments to durable medical equipment suppliers were reviewed in two separate Generalized Analyses (computer-assisted analyses) for the calendar years 2005 through 2007. One analysis dealt with recipients age 21 and under and the other with those older than 21. These analyses determined instances in which Medicaid had reimbursed suppliers for amounts in excess of payment limits specified in applicable fee schedules. Providers having apparent overpayments were notified by mail and given an opportunity to review the matter with Medicaid representatives. A total of 556 cases were opened for the two analyses and, of those, 471 were closed in FY 2009-10 with overpayments totaling $625,000, all of which have been recovered.

Funding for Medicaid Program Integrity and Return on Investment

MPI prevention efforts resulted in cost savings of $19.8 million in FY 2009-10, as shown in the first table below. Also in FY 2009-10, MPI efforts resulted in the collection of $58.5 million in overpayments as shown in the second table below:

MPI Prevention of Overpayments (Millions)								
	FY 2006-07		FY 2007-08		FY 2008-09		FY 2009-10	
	No.	Amount	No.	Amount	No.	Amount	No.	Amount
Prepayment Review	217	$4.8	156	$4.2	99	$5.8	116	$4.8
Termination of Providers	194	13.2	255	5.4	152	3.2	68	1.8
Focused Projects	2	5.0	3	9.8	3	2.6	7	5.1
Denial of Reimbursement for Prescription Drugs	66	0.8	40	0.5	3	0.3	0	0
Policy Changes	1	2.4	N/A	N/A	N/A	N/A	N/A	N/A
Site Visits	253	2.8	229	1.8	481	6.5	410	7.4
Fine Sanctions Imposed	222	0.4	155	0.1	501	0.5	420	.7
Total		$29.4		$21.6		$18.9		$19.8

MPI Collected Overpayments (Millions)				
	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10
MPI Audits (Collected by F&A)[1]	$18.8	$14.9	$15.4	$16.4
Paid Claims Reversals	0.7	0.5	0.3	1.5
TPL Contractor-Assisted Claims Adjustments	15.0	12.8	34.6	40.6
Total	$34.5	$28.2	$50.3	$58.5

[1] Restated for FYs 2006-07 and 2007-08 to show collections instead of identified amounts.

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 collections of $58.5 million and a return on investment for recovery operations of 6.4:1. In addition, MPI achieved $19.8 million in cost avoidance with expenditures of $6.0 million, producing a return on investment for prevention efforts of 3.3:1. Overall, in FY 2009-10, audit recoveries and cost avoidance amounts totaled $78.3 million, yielding a return of 5.2:1, as shown on the following chart.

MPI Return on Investment (Millions)[1]				
		Benefits	Costs	ROI
FY 2006-07	Recovery	$34.5	$8.0	4.3:1
	Prevention	29.0	3.6	8.1:1
	Total	63.5	11.6	5.5:1
FY 2007-08	Recovery	28.2	7.5	3.8:1
	Prevention	21.5	5.0	4.3:1
	Total	49.7	12.4[2]	4.0:1
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[3]	-
	Total	82.6	15.1	5.5:1
FY 2009-10	Recovery	58.5	9.1	6.4:1
	Prevention	19.8	6.0	3.3:1
	Total	$78.3	$15.1	5.2:1

Managed Care

During FY 2009-10, MPI, with assistance from the Medicaid Division, conducted initiatives that identified noncompliance and recoupment issues involving Managed Care Organizations (MCOs). The three primary areas addressed included:

(1) receipt of capitation payments when the recipient was enrolled in hospice,

(2) failure to comply with the provisions of the "Unborn Activation Process" for pregnant plan members that subsequently resulted in fee-for-service claim payments to other providers and,

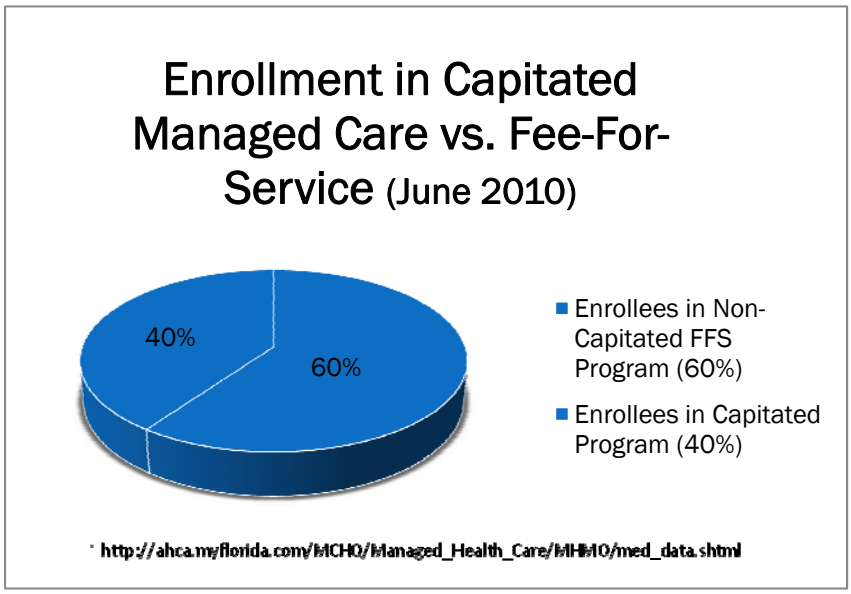
(3) recoupment of partial capitation rates based on a change in policy for amounts paid by categories of age for newborns.

The plans have been notified of these issues and it is anticipated that in FY 2010-11 progress will be made toward resolving them and substantial recoveries will be made by the Agency.

During FY 2009-10, enrollment of Medicaid recipients in managed care health plans continued to increase, though at a slower pace than prior years. Still, the percentage of Florida's Medicaid recipients enrolled in managed care is significant. As of June 2010, 60% of Florida's Medicaid recipients were

[1] Figures for FYs 2006-07 and 2007-08 have been restated to reflect collections rather than funds identified.
[2] Does not add due to rounding.
[3] Included with Recovery Costs.

enrolled in the traditional Fee-For-Service (FFS) or a non-capitated form of managed care (i.e., primary care case management) and 40% were enrolled in capitated managed care (Health Maintenance Organizations (HMOs) or capitated Provider Service Networks (PSNs).



Of particular relevance for fraud and abuse prevention and detection are the differences presented by a managed care environment in terms of MPI and Agency oversight. In a managed care environment Medicaid delegates provider network oversight to the managed care organizations (MCOs) The plans are also responsible for service authorization, claims payment, case management and care coordination and while this presents certain advantages over a FFS system, it also presents the challenge of ensuring the MCOs conduct due diligence in overseeing their provider network and in providing covered services. Additionally, over $9 billion in Medicaid funding is committed to the 2009-2012 managed care contracts. This delegation highlights the need to recognize the distinctively different issues in fraud detection and prevention in a managed care environment versus the traditional FFS environment, and to integrate these into the Agency's fraud-fighting strategy.

MPI and OIG staff were heavily involved in drafting contract language to better address fraud and abuse detection and prevention in the health plan contract. Development of a secure internet portal site for reporting has enhanced communication capabilities between MPI and the health plans. Staff conducted on-site contract compliance monitoring visits where face-to-face instruction and review of health plans' fraud and abuse prevention and detection efforts occurred.

Other activities include participation in an interagency planning group along with representatives from the Attorney General's Office Medicaid Fraud Control Unit (MFCU), the Florida Department of Law Enforcement (FDLE) and the Department of Financial Services Division of Insurance Fraud (DIF). The workgroup's purpose is to develop communication and coordination processes related to new statutory provisions resulting from Senate Bill 1484 passed in the 2010 legislative session. These provisions established a Medicaid and Public Assistance Fraud Strike Force, require increased interagency training, coordination and communication, and require the co-location of MFCU positions dedicated to Medicaid managed care fraud with the DIF. The bill also re-located the public assistance fraud investigative function from the FDLE to the DIF.

Senate Bill 1484 also created a new statute, Section 409.91212, F.S., "Medicaid Managed Care Fraud". This statute requires managed care plans providing Medicaid services to: 1) adopt anti-fraud plans; 2) establish and maintain fraud investigative units; 3) obtain approval of MPI prior to outsourcing fraud/abuse investigations; and 4) report annually to MPI the dollar amount of losses and recoveries attributable to overpayment, abuse, and fraud and on the number of referrals to MPI during the prior year. The statute also implements specific fines and sanctions for failure to submit or implement a timely acceptable anti-fraud plan, failure to timely submit an annual report, and failure to timely report suspected or confirmed instances of provider or recipient fraud and abuse. As of the date of this report, all plans have met the requirements and have submitted the anti fraud plans and the annual report. These contract requirements and resulting plan compliance are expected to strengthen oversight in managed care.

In accordance with Section 409.91212, F. S., MPI implemented an Annual Fraud and Abuse Activity Report (AFAAR). Unaudited data reported by the HMOs and PSNs for this first year of reporting reflected 314 cases referred to MPI with overpayments and recoveries as follows:

- $9,626,029 in overpayments was identified for recovery and includes dollars lost to fraud and abuse, as well as dollars overpaid as a result of systems or claims processing errors.
- $4,624,358 in overpayments was recovered during the fiscal year, regardless of when they were identified.
- $5,225,173 was identified as lost to fraud and abuse.
- $248,561 was recovered that had previously been reported as lost to fraud and abuse.

Additionally, the Quarterly Fraud and Abuse Activity Report (QFAAR) was implemented beginning in the fall of 2009. The QFAAR provides a method for health plans to report on their detection, investigative, referral, corrective action and recoupment activities. MPI staff continued to make progress in automating the QFAAR, whereby investigative case information reported by the health plans can be more readily tracked and trended for internal cross-over use in fee-for-service (FFS) provider audits as well as for statewide tracking of suspected abusive or fraudulent providers.

Due to the newness of this reporting mechanism, the data reported through the initial spreadsheet format is not yet mature enough for confident trending on case progression and overpayment recoveries. However, a few trends emerged in this early data. These include that larger, more established health plans are consistently submitting quarterly data. The data reported thus far reflects a health plan statewide investigative caseload ranging from approximately 200 to 350 per reported quarter with some of the newer or smaller health plans not yet consistently reporting. Examination of data from the first quarter reported and the most recent quarter reported reveals that the most frequent allegation is a pattern of overstated reports (upcoding, or billing for higher level of service than was necessary or provided).

During FY 2009-10, work continued on two major managed care audit projects carried over from the prior year: one on HMO use of the "Unborn Activation Process" (a process to pre-register babies before they are born so that the baby can be enrolled in Medicaid at birth and enrolled in the mothers' managed care plan or the managed care plan chosen by the mother as timely as possible and the appropriate capitation payment made, thereby avoiding F.F.S. costs). Settlement negotiations began during the fiscal year with fines totaling approximately $3 million to date. Settlement negotiations continue and additional fines are expected in FY 2010-11.

The second major managed care audit project related to HMO members receiving hospice services while enrolled in a managed care plan. Managed care plans are not authorized to provide hospice services and Medicaid recipients who receive hospice services are disenrolled from the managed care plan. The disenrollment from the plan avoids the potential for overpayment for curative care services since individuals who elect hospice do not receive these services. Initial recoupment of approximately $300,000 in identified capitation paid to plans for recipients receiving hospice services while enrolled in the plan has begun. Additional recoveries are expected in FY 2010-11.

Health Quality Assurance

The Division of Health Quality Assurance regulates 40 types of health care service providers, through licensure or certification of more than 42,000 health care service providers and over 100 managed care providers.

The largest groups of regulated providers as of June 30, 2010, include:

- 17,176 laboratories
- 2,035 health care clinics
- 7,484 health care clinic exemptions
- 2,883 assisted living facilities
- 1,202 home medical equipment providers
- 2,358 home health agencies
- 671 nursing homes
- 417 ambulatory surgery centers
- 286 hospitals
- 51 health maintenance organizations (HMO), both Medicaid and commercial

The Division of Health Quality Assurance (HQA) has implemented a number of reporting and review mechanisms during the last fiscal year, including:

- Enhanced criminal background screening of providers including adding fraud-related crimes for licensure and Medicaid enrollment;
- Expanded and improved financial reviews for initial or change of ownership licensure applications submitted by outpatient service providers including health care clinics, home medical equipment operators and home health agencies; and
- Increased anti-fraud reporting for licensed home health agencies.

Home Health and Related Programs

Home health agencies have been an acknowledged area of health care fraud in recent years. Statutes were changed in 2008 and 2009 to specifically address fraudulent activities in home health.

Forty-seven licensure denials for home health agencies were upheld in FY 2009-10 for fraud-related reasons. Thirty-one of the denials (66 %) were in Miami-Dade County. Reasons for these denials included:

- Submitting fraudulent financial statements that were not for the services and staff in the applications;
- No valid proof of start-up funding;
- Attempting a change of ownership while processing an application for a license;
- Owners that were also administrators and/or chief financial officer who did not pass required FBI background screening;
- Failure to serve any patients in the past year and fraudulent patient records; and
- Financial instability with unpaid fines.

During agency inspections, 18 home health agencies were identified as not providing at least one service directly and did not have any patients. Of these, 12 agencies were located in Miami-Dade County. Home health licenses were revoked for six agencies for that reason, including one case initiated in FY 2008-09. Fines were upheld for five agencies for the same reason and legal cases are pending for the others. In all, 22 home health agency licenses were revoked for various reasons for the 13-month period ending July 31, 2010.

Twelve home health agencies were found with fraudulent patient records. Of the seven home health agencies found this year, five were in Miami-Dade County. One agency had a fine upheld and legal action is pending on the others. The twelve home health agencies included five agencies in which fines were upheld by Final Order this year after they were initially found to have fraudulent patient records in the prior fiscal year. Four of the five were in Miami- Dade County. Examples of fraudulent patient records include making patients appear sicker than they are with false clinical information in medical records; records showing services were provided that were in fact not provided; and forms signed by patients a week in advance that said services were received.

Twenty-one home health agencies were found without a director of nursing for more than 30 days. Of those, thirteen home health agencies, nine of which were in Miami-Dade, had fines imposed by Final Order during FY 2009-10. There are an additional eight home health agencies, four from Miami-Dade, with legal action pending based on inspection results.

Home health agencies were also found providing inappropriate remuneration for patient referrals. Remuneration is a monetary inducement provided by a home health agency to a person, such as a physician or a hospital discharge planner, who is in a position to refer patients to the home health agency. The statute was changed in 2009 allowing certain remuneration activities that are not violations of federal law, which accounts for a decreasing number of citations for inappropriate remuneration to referring physicians. Six fines were imposed by Final Order and two are pending legal action. Of the six cases that have been upheld, two were in Martin County, one was in St. Lucie, one was in Broward, one was in Hillsborough and one was in Sarasota County. One Palm Beach County home health agency was fined for providing staff for free or less than fair market value to assisted living facilities in exchange for receiving patient referrals. One Broward County home health agency had a fine upheld and one Miami-Dade agency has a fine pending legal action for remuneration when free staffing services were provided in exchange for referrals.

For the 13 months ended July 21, 2010, a total of 76 home health agencies were denied renewal licensure and 22 existing agencies had their licenses revoked.

Home Health Agencies Applications Denied & Licenses Revoked By Final Order

	FY 2009-10	Total
Denied License Application[1]	65	76
Revoked Licenses[2]	21	21

As of the end of July 2010, 1,033 fines had been imposed against home health agencies. Fines for survey deficiencies were imposed against 146 home health agencies. Fines for failure to submit quarterly

[1] Applications for initial, renewal and change of ownership licenses
[2] Revocation done during the licensure period

reports were filed in 745 cases and 21 fines were levied for failure to have a director of nursing and to notify the Agency of that failure within 30 days.

Home Health Agency Fines Imposed

Type of Fine	FY 2009-10	Total
Survey deficiency	137	146
Failure to submit quarterly report	687	745
Late application fine[1]	111	121
No director of nursing for 30+ days & failed to notify AHCA	21	21
Total Fines	956	95

[1] This also includes fines for late notification of change of address.

The following table summarizes the number of home health agencies (HHA), home medical equipment providers (HME) and health care clinic (HCC) applications that failed to meet the proof of financial ability to operate requirements of Section 408.8065, F.S. and their status.

FY 2009-10	HHA	HME	HCC
Number of initial and change of ownership applications received	217	201	399
Number of cases (Notices of Intent sent to applicants that failed to meet financials)	63	10	36
Denials upheld to date	34	6	9
Status of Remaining Cases			
Applicant withdrew	6	1	5
Formal hearing requested	0	0	1
Informal hearing requested	8	0	5
No response to notice – 2nd notice sent	0	0	0
No response yet to recent notices	0	0	0
Settlement	9	3	14
Final Orders in process	6	0	2

Section 408.815(4), F.S, requires denial of licensure for termination by Medicare or Medicaid if the applicant or person with controlling interest has been convicted of certain criminal offenses or terminated from Medicare or Medicaid. At this time, there are 14 pending denials for home health agency licenses due to termination by Medicare & Medicaid in another state. The Agency has also denied one adult family care home application for this reason.

Clinical Laboratories

The Agency's Clinical Laboratory Licensure Unit scrutinizes both state and federal applications, carefully checking owner information, laboratory structures, addresses and directors. This activity is based in part on federal guidelines to combat fraudulent Clinical Laboratory Improvement Act (CLIA) applications.

In 2008, the Centers for Medicare & Medicaid Services' CLIA program issued a memo providing procedural guidance for potential fraudulent clinical laboratory applications. The memo lists indicators

for possible fraudulent applications and procedures to follow if they are found. Examples of indicators are:

- Lab has an out-of-state mailing address unless the lab is known to be located in another state;
- Lab has an 800 telephone number and it is not a part of a recognized chain;
- Lab director qualifications submitted with the application were printed from the Internet;
- Faxes from the lab come from "Office Depot" or similar public facsimile services;
- Lab reschedules Agency inspections without a good reason; and
- Lab cannot be reached to schedule an initial inspection.

Based on these procedures, staff have identified questionable practices and brought them to the attention of Medicaid Program Integrity, where they are being investigated.

Under existing regulations, specifically subsection 59A-7.020(14) and section 59-A.037, Florida Administrative Code, staff reviews allegations of kickbacks and rebates in clinical laboratories. In 2010, the Agency formed a 16-member technical advisory panel from a diverse group of interested parties that included large and small clinical laboratories, as well as other professional and provider associations that interact with laboratories, to assist in determining if rule development is needed related to existing anti-kickback regulations. The panel met three times during the spring and summer of 2010. The Agency has received complaints about violations of existing anti-kickback regulations, which were resolved when laboratory providers admitted their violations. In these cases, laboratories were advised of the complaint against them and asked to respond. If the response indicated a violation of existing regulations, the laboratory was instructed to cease the deficient practice.

The advisory panel made a number of recommendations and revealed a lack of consensus on major discussion points. Should the Agency decide to pursue rule amendments, it is likely that the process will be controversial.

Medicare Certification-Only Facilities

Medicare certified-only facilities are not subject to state licensing and are regulated solely by federal regulations to participate in Medicare. With the proliferation of Medicare certification-only facilities in south Florida, the Agency's Hospital and Outpatient Services Unit has partnered with the Centers for Medicare & Medicaid Services and their Medicare fraud investigation contractor, SafeGuard Services, to identify potentially fraudulent activities in Florida. This collaboration, which initially focused on comprehensive outpatient rehabilitation facilities (CORFs) in south Florida, has evolved into a broader, more comprehensive effort to prospectively review and investigate unusual activity related to initial enrollment applications and requests for changes for all Medicare certification-only facilities statewide.

Health Care Clinics

The Health Care Clinic Licensure Unit works closely with investigators and prosecutors of the Department of Health supplying documentation and technical assistance to the Boards of Medicine and Chiropractic Physicians. The Agency was involved in three active federal cases based upon false or misleading exemption applications, in which the clinic licensure applicants asserted that they were licensed practitioners. All defendants entered various plea agreements. The Agency has assisted the special health fraud prosecution unit of the Miami-Dade County State Attorney's Office and dealt directly with prosecutors, not only there, but in Broward and Hillsborough Counties on a regular basis.

The primary tool used by law enforcement, prosecutors and insurance fraud investigators is the public records request. Law enforcement requests copies of license and exemption files on a routine basis. The most active public requestors are insurance companies dealing with potential false insurance claims, followed by the Division of Insurance Fraud of the Department of Financial Services. Each of these requestors and the Medical Quality Assurance unit of Medicaid receive daily licensing and exemption information from the Agency and request public records on at least a weekly basis. Requests by law enforcement, replies by the Agency and documents disclosed are exempt from public disclosure when requested for criminal intelligence or active criminal cases.

The 2010 legislature made sweeping changes to the Pain Management Clinic permit laws that became effective January 4, 2010. The changes, found in Senate Bill 2722, were effective October 1, 2010 and require all pain management clinic registrants of the Department of Health not "fully owned" by currently licensed Florida medical or osteopathic physicians to be licensed by the Agency as health care clinics under Part X, Chapter 400, Florida Statutes by October 1, 2010. The new law authorizes the Department to revoke any pain management clinic permit for a clinic that must, but has not, complied with the dual licensing requirement by October 1, 2010.

Financial Analysis

The ideal way to stop fraud among health care providers is never to license those who would commit fraud in the first place. The proof of financial ability to operate (PFA) review process is a tool to deter those who are not serious about running a health care business or those who have ulterior motives. The PFA schedules or financial projections required to be completed are detailed. The nature of the schedules alone limits those who would obtain a license for the purposes of committing fraud to the more sophisticated perpetrators. At present, this review is required for home health agencies, home medical equipment providers, health care clinics and assisted living facilities.

The PFA review process is designed to determine how much funding an applicant would need to begin operations, sustain operations until profitability and fund any unforeseen contingencies. Inadequate funding is the primary reason for PFA denials. Over the last seven years, there has been a pattern of manipulation of the financial projections by some applicants that cannot be related to a sound business plan or to reasonable market research. In 2006, 2008 and 2009 the Agency was granted greater statutory authority to curb the ability of applicants to manipulate the financial projections. For example, if an applicant projects its costs at too low of a level in order to reduce the contingency funding requirement, it can easily exceed an operating margin of 15%, which is prohibited by statute.

At present, an applicant is unlikely to gain PFA approval with less than $40,000 in available funding. In the past, some applicants have attempted to begin providing licensed health care services with much less. Current PFA requirements help to ensure that each licensee will be in a position to deliver adequate services to patients, rather than establishing a health care business for fraudulent purposes and delivering substandard care or no care at all.

Other issues revealed by PFA review include the use of "canned" financial projections (financials that are virtually identical to one another) and the use of common or identical sources of funding for different purposes at the same time. The concern about "canned" financials arises from the apparent disconnect between a reasonable business plan and the financial projections submitted by some licensure applicants. It appears that some applicants hire a certified public accountant (CPA) or licensure application consultant to produce a pre-made set of financials that are designed to limit total funding

and gain approval. The ability to reign in "canned" financials is limited. However, because a CPA is required to compile the financials, staff has been able to track the CPAs who sign off on "canned" financials. The Agency has initiated an ethics complaint with the Board of Accountancy on this issue believing that "canned" financial statements are not consistent with a CPA's compilation standards under Generally Accepted Accounting Principles (GAAP).

Regarding common source of funds, the concern is that funds are moved in and out of different accounts to give the appearance that the funds exist and are available. The recent promulgation of rule 59A-35 related to uniform licensing procedures for health care facilities clearly defines the dates in which the proof of funds must be available. In addition, documentation that the funds still exist in the account in cases where a large deposit was made immediately before the account statement was made is being requested.

Field Operations

Below is a listing of referrals made by provider type by Field Operations during FY 2009-10. During each Field Office Mangers' Meeting this year (January, April and July), management discussed the awareness of fraud and abuse referrals and included representatives from Medicaid Program Integrity. The Agency is continually making revisions to the HQA-Field Operations Survey Findings Referrals Matrix, which provides guidance to staff as to the identified findings or issues on survey and the appropriate agency/department for referral. In addition Field Operations established a new email address that streamlines the referral process for receipt and processing of referrals to the Medicaid Fraud Control Unit (MFCU).

Provider Type	Number of Referrals	Referred to MPI, Closed, No Findings	Referral to MFCU	Other Including No Jurisdiction
Home Health	16	13	0	3
Nursing Home	3	2		1
ALF	6	3	2	1
Hospital	2	2		
Hospice	2			2
Nurse Registry	2			2
ICF/DD	2	2		
Health Care Clinics	1			1
Health Care Services Pool	6			6
Adult Family Care Home	1	1		
Lab	2		1	1
End Stage Renal Dialysis	1	1		
Unlicensed Activity	4		1	3
Total	48	24	4	20

As part of the normal survey activity, Field Operations staff has for several years been conducting Operation Spot Checks with multi-agency involvement. During the past year staff has conducted eight additional joint visits with local staff of MFCU and/or MPI were conducted in St. Petersburg and Delray

Beach specific to assisted living facilities and adult family care homes for unlicensed activity and pre-payment review and care concerns.

Lastly, Field Operations participates in bi-weekly joint meetings with MFCU, MPI and Safe Guard Services to review and discuss the status of current and ongoing referrals from the Bureau as well as to work on joint ventures in the Agency and in conjunction with MFCU.

Office of the General Counsel

The Office of the General Counsel (OGC) provides legal advice and representation for the Agency on all legal matters. The mission of the General Counsel's Office is to provide high quality legal counsel and vigorous advocacy to the Agency in championing better heath care for all Floridians. Some of the duties are as follows:

- Administration of the Medicaid plan and recovery of Medicaid overpayments due to abuse or third party liability
- Licensure and regulation of health care facilities including nursing homes, hospitals, assisted living facilities, clinical laboratories and home health agencies
- Regulation of managed care plans
- Civil litigation related to various Agency programs

The OGC is an active partner with other offices of the Agency in efforts to deter fraud and abuse in the Florida Medicaid program to the greatest extent possible. Specifically, this unit of the office provides legal guidance and recommendations to the Division of Medicaid and to the Office of Inspector General regarding ways in which to curtail and deal with Medicaid fraud and abuse. The advice includes recommendations related to prevention, detection and enforcement. In addition, the attorneys are involved in litigation resulting from record reviews (audits) performed by the Agency or contracted vendors related to the recovery of overpayments from providers, protests related to public procurement activities and challenges to Agency rules. Litigation can result from actions taken by the Division of Medicaid or MPI related to the provider's enrollment status (termination from the program), real-time reviews of claims for reimbursement (pre-payment reviews), the withholding of reimbursements upon evidence of fraud, or other complaints by providers, recipients, or advocacy groups. Additional duties include assisting Medicaid Contract Management carrying out contracting functions, assisting with provider relations issues and providing advice and consultation on various activities including provider terminations; assisting Medicaid Services with rule writing and review, reviewing policy and providing legal interpretations on various issues; assisting Health Systems Development in rewriting the Medicaid HMO contract and working on various managed care issues.

This unit assists the Inspector General's Office predominately through work with Medicaid Program Integrity. The OGC assists MPI with the planning aspect of various projects that might have more complex legal considerations, provide advice on a case-by-case basis, assist with collections and bankruptcy matters related to MPI overpayment determinations and handle the litigation that may arise from the issuance of a final audit report (overpayment, sanction or both) or other MPI actions such as prepayment reviews or terminations.

Division of Operations

Bureau of Finance and Accounting

When overpayments are identified they are generally referred to the Agency's Division of Operations, Bureau of Finance and Accounting (F&A) for collections. The Bureau of Finance and Accounting then pursues collection of the overpayments from the Medicaid provider. The Bureau of Finance and Accounting collects by direct payments from providers or through withholding of Medicaid or Medicare payments. When payments are not received or a lien cannot be placed against Medicaid and Medicare payments, the Bureau of Finance and Accounting investigates to determine other means of collection or if the case will be referred to an outside collection agency. Agency staff continues to work aggressively to reduce outstanding receivables within the Medicaid program.

During FY 2009-10, collections, net of adjustments and refunds approached $37.8 million. The amount booked as accounts receivable for FY 2009-10 was $43.2 million and $4.1 million in receivables were approved for write-off.

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

- the provider has declared bankruptcy,
- the corporation is out of business,
- the defendant is unable to pay because they are incarcerated, or
- the business is insolvent or is beyond the State's current collection enforcement authority.

The federal requirements only allow funding to be reclaimed when the write-off is due to a bankruptcy in which the Agency has filed a claim (even if the bankruptcy had already been discharged at the time the Agency discovers the bankruptcy), for an individual who is deceased and the Agency files a claim on the estate, or when the write-off is due to a business that is certified as being out of business (a very detailed and in-depth process). Once the receivable is approved for write-off, the qualified federal share of each receivable write-off is reclaimed. During FY 2009-10, $4.1 million in receivables were approved for write-offs. The Agency is continuing to research and develop processes whereby a provider can be certified out of business and thereby reclaim the federal share for those cases.

- The Bureau of Finance and Accounting continues to refine the Medicaid Accounts Receivable (MAR) system, which 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 of Finance and Accounting calculates interest for cases as appropriate, while the system tracks state/federal allocation of receivables amounts 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 follow-up. The MAR system maintains the required accounting data for financial statements and federal reporting purposes for fraud and abuse cases and other overpayment cases, such as hospital and nursing home retroactive rate adjustments and gross adjustments.

- The Bureau of Finance and Accounting continues to provide transaction information files to update the Agency's Fraud and Abuse Case Tracking System (FACTS). The information in these files includes the original overpayment amount, payments received, adjustments applied, current balance and current status for each case in the MAR system. The 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 FACTS system was enhanced to add a notification process to alert the Bureau of Finance and Accounting 30 days after the final audit report is mailed. The staff will investigate if the U. S. Postal Service return-receipt card was received. Additionally activities have been added to the FACTS System to track the next step in the MAR System thirty (30) days after the Final Audit Report has been received.
- This fiscal year, the Bureau of Finance and Accounting worked with Medicaid Program Integrity to create a report to notify Finance and Accounting of cases that reach the 35th day following issuance of all the Final Audit Reports sent out to the providers when the return-receipt card was not received. The report is reviewed to determine if the cases have been paid in full or if the providers have entered into a satisfactory payment plan agreement with the Agency; if not a payment deduction of 100% is placed on the provider's Medicaid payments until the balance has been recouped.
- The Bureau of Finance and Accounting continues to emphasize communications with MPI and MFCU to coordinate audit collection efforts and works with the Agency's Office of General Counsel, Health Quality Assurance, Medicaid Program Analysis, Long Term Care Services and Office of Inspector General to coordinate collection efforts as well as pursue additional avenues of collection.
- The Bureau of Finance and Accounting has taken aggressive steps during the year to reduce the duration of the terms for negotiated payment plans, as well as increase the percentages of the liens placed on provider Medicaid/Medicare payments. The Bureau of Finance and Accounting will continue to strive to achieve repayments as promptly as possible.

Third Party Liability Unit

The Division of Operations' Third Party Liability (TPL) Unit is responsible for identifying and recovering funds for claims paid for by Medicaid for which a third party was liable, thereby ensuring Medicaid is the payer of last resort. Some examples of third parties include casualty settlements, insurance companies, recipient estates and Medicare. TPL recovery services are contracted with ACS State Healthcare, LLC (A Xerox Company). During FY 2009-10, over $114 million in Medicaid funds were collected. Annual TPL collections over the last four years have averaged approximately $112 million. ACS has exceeded this average in its efforts to collect much needed Medicaid funds. In addition, the TPL Unit has held ACS accountable to its contract requirements by vigorously monitoring ACS' performance. These efforts have helped to ensure maximum recoveries are generated for the State of Florida. Types of recoveries include:

Casualty. Medicaid imposes a lien against liable third parties for the amount Medicaid has paid on behalf of a recipient who has been involved in an accident or incident, which resulted in injury. Attorneys are required to notify Medicaid that they represent a Medicaid recipient involved in an accident or incident.

Estate/Trusts. Medicaid files an estate claim on behalf of a deceased Medicaid recipient for Medicaid payments made after age 55. Medicaid is to be paid after attorney and personal representative fees

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

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

Other Recoupment Projects. The TPL Unit also works in conjunction with the Agency's Bureau of Medicaid Program Integrity to conduct other Medicaid recoupment projects. Recoveries from other recoupment projects during FY 2009-10 include the following:

- 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.
- Medicaid Overpayments – Funds are recovered from providers where Medicaid has overpaid for a service. Medicaid overpayments include: Duplicate Crossover Payments (two Medicaid payments for Medicare Crossover liability); Medicaid Secondary Liability (two Medicaid payments for the same services); Inpatient Duplicate Payments (two Medicaid payments for inpatient services for the same date(s) of service); Inpatient Mother-Baby Overpayments (two Medicaid payments for inpatient services for the same date(s) of service, one for a newborn and the other for his/her mother); Outpatient Payment During Inpatient Stay (an outpatient Medicaid payment immediately preceding an inpatient stay); HMO/Long-Term Care Overpayments (overpayments identified are capitation payments made ,for Medicaid recipients who were admitted to long-term care facilities); Overutilization: Outpatient Payments Over $1500 (payments made in excess of the $1,500 limit for outpatient claims during a fiscal year); and Duplicate Capitation payments (payments were made to the same or different provider for pharmacy, professional, institutional, dental, or managed care services on the same date of service).

Cost avoidance. Cost avoidance is new and/or updated insurance information that is derived from data matches with insurance carriers. Cost avoidance is also derived from insurance information obtained at the time of eligibility, through Medicaid area office staff and Medicaid providers. When new and/or updated insurance information is obtained, that information is added to the Florida Medicaid Management Information System (FMMIS) 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 Agency utilizes a matrix maintained in the FMMIS to determine whether a claim shall be paid or denied based upon other third party information contained on the Medicaid recipient's file. Cost avoidance is the amount that was denied based upon third party information contained on the Medicaid recipient's file.

Below is a summary of TPL collections.

TPL Collections	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10
Casualty	$26,648,342	$18,062,167	$17,681,026	$16,537,665	$18,747,553
Estate Recovery	$11,084,708	$10,671,334	$8,590,471	$7,236,087	$5,479,473
Trusts*	$3,001,281	$3,397,559	$4,166,134	$3,879,248	$5,369,002
Medicare and Other Third Party Payor	$78,710,101	$70,338,609	$47,040,782	$50,658,788	$44,673,737
Other Recoupment Projects [1]	$38,017,961	$16,513,992	$14,621,051	$43,813,456	$40,582,911
Total Collections	**$157,462,393**	**$118,983,661**	**$92,099,463**	**$122,125,244**	**$114,852,676**
Cost Avoidance (Matrix)*	$402,663,184	$654,376,686	$747,168,091	$933,411,564	$778,611,980

*Trust collections were previously included in estate recoveries.

NOTE: TPL collections reported for FY 2008-09 totaled $89,784,958 in the Fraud and Abuse Annual Report. At that time, the close-out activities for the previous TPL Vendor, Health Management Systems, Inc. were not completed. Total collections from the HMS contract have now been reconciled and recovered amounts have been updated.

[1] This amount is reported under Medicaid Program Integrity's Collection, as MPI contracts these services under the contract managed by the Third Party Liability Unit.

Inter-Agency Coordination and Cooperation

Department of Health

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

DOH has collaborated with the Agency to implement Senate Bill 1986. AHCA and DOH built upon their sharing of information so that newly enacted provisions are effectuated. The DOH transfers data nightly to the Agency to identify practitioners who are billing Medicaid, but who do not have an active DOH license.

Additionally, DOH MQA and the Bureau of Vital Statistics coordinated with and supported the Agency MPI/MFCU Dead Doctor Project. By providing electronic sharing of DOH vital statistics information, the Agency is able to promptly terminate Medicaid providers that are deceased. This eliminates the potential fraudulent use of those provider numbers to fraudulently bill the Medicaid program. The Agency now shares electronic Final Orders with the DOH to identify sanctions and terminations of Medicaid providers so the DOH may pursue action against the practitioner's license. This will permit DOH's increased authority for licensure denial and disciplinary actions to be accomplished promptly against health care practitioners terminated from the Medicare and Medicaid programs or convicted of felony fraud crimes and misdemeanor fraud crimes involving health care.

DOH/MQA enforcement managers met regularly with managers and investigators from the Agency's Office of the Inspector General, Bureau of Medicaid Program Integrity (MPI), 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 109 legally sufficient referrals were received by the DOH. After investigation by DOH, no practice act violation was found in 18 cases, a letter of guidance was issued in one case, a notice of non-compliance was issued in 50 cases and 40 cases are still pending.

In addition, the Miami Investigative Services Unit (ISU) office coordinated with MFCU during the initial investigation of nine speech language pathologists and speech language pathologist assistants where there was an allegation of fraud. These resulted in nine arrests and are under review by the department's prosecution services unit. Further, several ISU offices participated in "Operation Spot Check" along with MFCU, AHCA, Ombudsman, local law enforcement and the State Attorney's Office. These multi-agency unannounced visits were made to assisted living and long term care facilities in an effort to identify Medicaid fraud, practitioner standard of care violations, patient safety issues, elder abuse and code violations.

The DOH/MQA Chief of ISU met 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. MFCU field investigators attended and participated in the DOH/MQA Regional Investigator training in Tampa, October 2009 and in Miami, September 2009.

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, an MFCU Investigator provided a program presentation for the MQA/ISU Regional Training held in St. Augustine.

Agency for Persons with Disabilities - Medicaid Developmental Disabilities Waiver Fraud

Fraud in Medicaid Waiver Developmental Disabilities (DD Waiver) programs came under increased focus and effort this fiscal year. Agency Inspector General, Agency Medicaid Program Integrity, the Attorney General's Medicaid Fraud Control Unit and the Agency for Persons with Disabilities (APD) Inspector General all increased their efforts, communication and cooperation against DD Waiver fraud.

Some examples of this increased effort include:

- The Medicaid Fraud Control Unit (MFCU) arrested thirteen (13) DD Waiver home-based care providers in North Florida for billing for services not rendered, falsification of records and abuse and neglect of waiver clients.
- Ten or more continuing Medicaid Program Integrity (MPI) investigations of overbilling and fraud by durable medical equipment (DME) providers serving DD Waiver clients. The APD Inspector General coordinated Agency support and arranged for disability-trained interviewers and counselors to assist in MPI investigations in Pensacola, Panama City, Jacksonville, Orlando and Tampa.
- The APD Inspector General's Office continues to host quarterly DD Waiver Fraud Working Group meetings. All of the above agencies, along with the Department of Elder Affairs and the Department of Children & Families participate in the working group. The increase in communication and teamwork has produced criminal and administrative investigations and increased programmatic support for anti-fraud activities. The inter-agency cooperation has led to changes in policies and procedures that improve investigative speed and effect.

Investigating DD Waiver fraud can be difficult due to unique sets of policies and procedures for each waiver program. However, the DD Waiver population is stable and does not move much, unlike the overall Medicaid population. The clients are closely monitored by multiple agencies and contractors, allowing comparison of multiple record sets. The population also uses DME and consumable medical supplies at higher rates over longer periods of time than the Medicaid state plan population.

One continuing issue in the DD Waiver population is violent crime. Many of these assaults are unfortunately committed by caregivers. The DD Waiver population is very vulnerable to fraud, violence and abuse. The agencies involved policing and administering DD Waiver programs are continuing to work together to efficiently use their resources to protect this most vulnerable Medicaid population.

Statutory Reporting Requirements

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

Sources of the cases opened in FY 2009-10

Sources of Cases Opened in FY 2009-10		MFCU	PANE	AHCA
AHCA	Area/District Office Staff	5	1	8
	Medicaid Headquarters Staff			163
	MPI Generated	45		2,269
	Finance and Accounting			52
	Other			35
Public	Anonymous	3		
	Citizens	22	3	6
	Provider	24		316
	Qui Tam[1]	95		
	Recipient	4		20
State Agencies	Department of Children & Families	4	59	
	Agency for Persons with Disabilities	17	1	
	Department of Health	1		
	Other State Agencies	2	2	12
Federal Agencies	Health & Human Services	10		7
	CMS	3		7
Law Enforcement	Florida MFCU Generated			15
	MFCU Spin-off Case	29	11	
	USAO US Attorney's Office	1		
	Federal Bureau of Investigation			1
	Law Enforcement	5	1	
	Joint Task Force	2		
Other	Family Member	10		
	HMO Investigative Unit	2		8
	Operation Spot Check	3	9	3
Employee		9	2	
Long Term Care Ombudsman Council			2	
Media		1		
	Total	**297**	**91**	**2,922**

Number of cases opened and investigated each year

MFCU reviewed 1,866 complaints that resulted in 379 cases being opened. MPI investigated 3,839 cases which included 2,922 opened during the year.

Disposition of the cases closed

MFCU closed 383 cases. MPI closed 2,366 cases. Disposition of cases closed is summarized below:

Disposition of Closed Cases in FY 2009-10			
	MFCU	PANE	AHCA
Acquittal			
Administrative Closure	11	19	
Administrative Referral	50	10	
Assistance to other Agencies	1	2	
Case Dismissed	1	2	
Civil Intervention Declined	2		
Civil Judgment	1		
Civil Settlement	27	2	
Consolidated	11	1	
Conviction	35	25	
Defendant Deceased			
Defendant Filed Bankruptcy			
Lack of Evidence	87	28	
No Fraud or Abuse Found			401
Nolle Prosequi	2		
Not a Medicaid Provider	1		
Overpayment Identified			1,807
Pretrial Intervention	5	3	
Prosecution Declined	1	1	
Provider Education Letter			158
Resolved with Intervention	3	1	
Statute of Limitations Expired	2		
Unfounded	36	13	
Total	276	107	2,366

MPI closed 2,366 cases during FY 2009-10. For 401 cases there were no findings of fraud and abuse and, therefore, no further action was taken. There were 158 cases closed after findings of non-compliance, but there were no resulting overpayments and the providers were issued a provider education letter. The remaining 1,807 cases were closed with identified overpayments. The provider may have repaid the overpayment amount or requested an administrative hearing, which was resolved by a 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 reports

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 2,366 cases closed during the fiscal year there were 1,807 with findings. Preliminary audit reports were sent on all 1,807. The preliminary audit reports identified overpayments of $38 million. There were 1,499 cases closed after the preliminary audit report with identified overpayments of $6.8 million. After receiving additional documentation, final audit reports were sent on the remaining 308 cases with identified overpayments of $14 million. Subsequently, Final Orders were issued on these 308 cases with identified overpayments of $12 million.

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 the fiscal year, MPI-placed 263 providers under prepayment review, required 38 corrective action plans, imposed fines of $666,740, recommended suspension and termination of 67 providers, made 198 referrals to MFCU and made referrals to others within and outside the Agency.

Reductions in overpayment amounts negotiated in settlements or by other means

There were no negotiated settlements during FY 2009-10.

Amount of final Agency determination of overpayments

Cases closed after the Preliminary Audit Reports (PARs) accounted for $6.8 million in identified overpayments. Cases closed after Final Order accounted for $12 million in identified overpayments, for final Agency determination of overpayments in the amount of $18.8 million. Any reductions from preliminary audit reports to Final Orders were based on the results of hearings or on additional documentation provided.

Amount deducted from federal claiming as a result of overpayments

Within 60 days of MPI's Final Order, the Agency reports the federal portion of the total overpayment on the corresponding federal CMS-64 quarterly reports. During FY 2009-10, the Agency reduced its federal claiming by $11.9 million for net overpayments determined.

Amount of overpayments recovered

During FY 2009-10, the Agency collected $37.8 million in overpayments. This includes $21.4 million collected from MFCU cases and $16.4 million collected from MPI cases. MFCU collected $46,293,279 in federal Medicaid payments which were sent directly to the U. S. Department of Health and Human Services.

Amount of cost of investigation recovered

During FY 2009-10, the Agency recovered $35,647 in investigation costs and MFCU collected $790,928 in investigative costs.

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

The average number of days from the date when a case is opened to the date when the overpayment is fully recovered has changed, as shown below. Investigative cases are being completed in a more timely fashion and collection efforts have been increased.

Days to Overpayment Paid in Full				
Fiscal Year	2006-07	2007-08	2008-09	2009-10
Number of Cases	819	736	1,349	2,366
Average No. of Days	328	328	311	283

For all cases paid in full during the fiscal year, the average length of time from the date that the case opened to the date the case was paid in full was 283 days.

Amount determined as uncollectible and the portion of the uncollectible amounts subsequently reclaimed from the Federal government

During State FY 2009-10, the Department of Financial Services deemed $4.1 million uncollectible and approved it for write-off. The total amount collected after the cases were written off was $28,865.49.

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

Suspended Providers by Type FY 2009-10	Count
Durable Medical Equipment/Medical Supplies	1
Home & Community-Based Services Waiver	4
Pharmacy	1
Physician (M.D.)	6
Physician Assistant	1
Specialized Mental Health Practitioner	1
Therapist (PT, OT, ST, RT)	1
Total	15

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

80 providers were terminated based on documented fraud and abuse and an additional five providers were terminated because they were on the Medicare exclusion list in accordance with Section 409.913(14), F. S. and Medicaid policy.

Terminated Providers by Type FY 2009-10	Count
Assistive Care Services	2
Birth Center	1
Durable Medical Equipment/Medical Supplies	16
Hearing Aid Specialist	2
Home & Community-Based Services Waiver	44
Home Health Agency	2
Licensed Midwife	1
Nurse Practitioner (ARNP)	1
Pharmacy	1
Physician (M.D.)	7
Prescribed Medical Rehab Services (PPEC)	1
Rural Health Clinic	1
Social Worker/Case Manager	1
Therapist (PT, OT, ST, RT)	5
Total	85

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

MFCU expenditures for FY 2009-10 were $16,279,848 which included indirect costs of $1,581,920.

Expenditures for MPI in FY 2009-10 were $8,558,901, which included salaries, expenses and contractual services. In addition, costs of $1,494,555 were allocated for support from the General Counsel's Office, Office of Inspector General, Bureau of Finance and Accounting and Medicaid Contract Management. Additionally there was an allocation for Agency indirect costs of $1,425,541 and the Bureau of Medicaid incurred expenses for services related to MPI activities for $3,613,043. Therefore, total costs of $15,092,040 were associated with MPI operations.

Number of providers prevented from enrolling/re-enrolling in the Medicaid Program as a result of documented Medicaid fraud and abuse

98 applicants were denied enrollment based on documented Medicaid fraud and abuse. One additional applicant was denied because they were on the Medicare exclusion list in accordance with Section 409.913(14), F. S. and Medicaid policy.

Providers Prevented from Reenrolling by Type FY 2009-10	Count
Assistive Care Services	3
Audiologist	1
Billing Agent	1
Case Management Agency	2
Chiropractor	1
Dialysis Center	1
Durable Med Equipment/ Medical Supplies	9
Home & Community-Based Services Waiver	2
Home Health Agency	23
Licensed Midwife	1
Optometrist	1
Pharmacy	14
Physician (M.D.)	34
Podiatrist	1
Professional Early Intervention Services	1
Social Worker/Case Manager	1
Specialized Mental Health Practitioner	3
Total	99

Recommendations for changes to prevent or recover overpayments

The Agency for Health Care Administration continues to improve both its internal and external partnerships to encourage a holistic approach to fighting Medicaid fraud, abuse and overpayment. The Fraud Steering Committee, implemented in FY 2008-2009, recorded many successes this past fiscal year, leading to the adoption of many internal steps to better fight fraud. These internal improvements included the development of a strategic plan to connect all databases that contain health care fraud information, as required by Section 409.913 (38) (b), Florida Statutes. This strategic plan shall serve as a roadmap for facilitating the electronic exchange of health information used to detect and prevent fraud and abuse in the Florida Medicaid program, as well as for the monitoring and adoption of new technologies.

This year, the Agency is making a number of recommendations for changes to prevent and/or recover overpayments:

- Expand the Medicaid reform pilot to all Florida counties. Managed care presents the best opportunity to control the growth of state Medicaid expenditures. If managed care is expanded, the Agency will redirect resources to the oversight of managed care entities.

- Enhance security reviews of new Medicaid provider applications. This will require expanded and improved database connectivity.
- Evaluate and if successful, adopt a smart card for Medicaid recipients that employs biometrics and provides a greater audit trail for verification of when and whether services were rendered as claimed.
- Increase the focus on the Agency's system of electronic "edits and audits" that reject improper claims before payments are made. These prepayment edits and audits serve to limit the number of questionable paid claims that have to be detected, audited and recouped.
- Expand the use of contingency or no-cost contracts to prevent improper payments, as well as detect and recoup overpayments.
- Acquire or develop advanced technologies to detect funds lost to fraud, abuse or error, as recommended by the Florida Office of Program Policy Analysis and Government Accountability (OPPAGA). These new detection tools will enhance the Agency's ability to target resources and produce a greater return on investment.
- Increase the use of prior authorizations on services with a high risk of overpayment. This also could be accomplished by contracts with private vendors.
- Greater use of competitive bidding for durable medical equipment.
- Seek legislation which would allow the Agency the ability to impose moratoriums on new Medicaid providers on a county-by-county basis, when the Agency determines that there is an excess number of providers for that service. Over supply can serve to create excess demand for Medicaid services.
- Evaluate the need for and benefit of greater use of medical loss ratios in managed care. Given modified managed care rate setting methodology (including plan financial information and plan encounter data in addition to historic fee-for-service data as the basis), the need for MLRs may be somewhat diminished. Currently, medical loss ratios are only used for behavioral health providers.
- Increase the emphasis on recipient eligibility and fraud. With the expansion of managed care comes an increased risk of making erroneous capitation payments for recipients who are no longer Medicaid eligible.
- Require physicians who order home health services or durable medical equipment to be Medicaid enrolled physicians. These are two of the Florida Medicaid Program services with the highest risk of fraud and abuse. Requiring all prescribing physicians for these services to be Medicaid enrolled would help prevent prescriptions for unnecessary home health services or durable medical equipment. (The Medicare program has already imposed this requirement to curb excess Medicare expenses for these services.)
- Continue to work with federal agencies to improve the ability to identify fraud and abuse in other states and federal programs and prohibit entry into Florida.

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

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