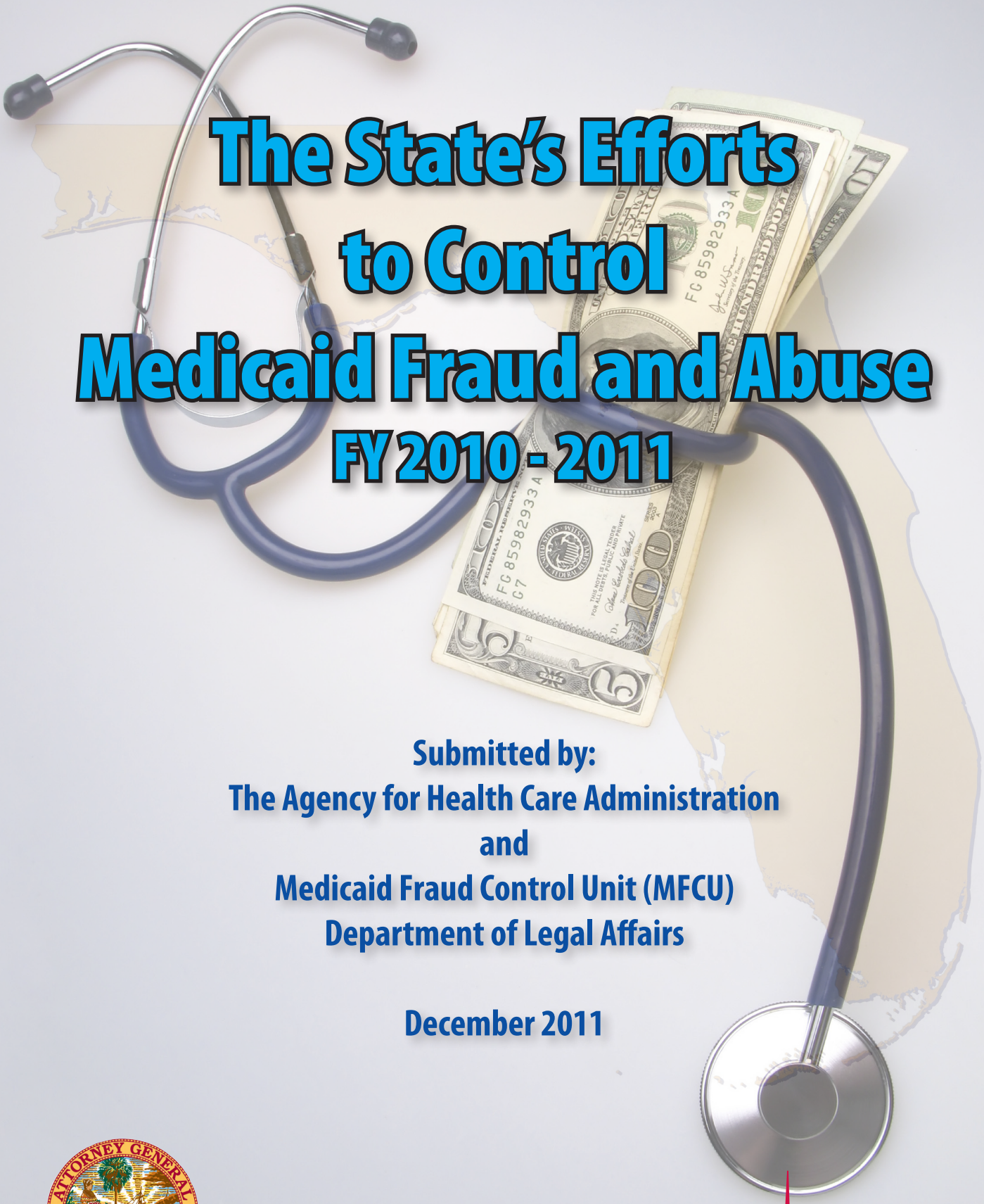
The State's Efforts to Control Medicaid Fraud and Abuse

FY 2010 - 2011



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

December 2011

ATTORNEY GENERAL
STATE OF FLORIDA

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

December 31, 2011

The Honorable Rick Scott
Governor
PL-05 The Capitol
Tallahassee, FL 32399-0001

Dear Governor Scott:

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 2010-11. 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,

Pam Bondi
Attorney General

Sincerely,

Elizabeth Dudek
Secretary

FY 2010-11

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

Table of Contents

Table of Contents i
Statutory Authority 1
Medicaid Fraud Control Unit 3
Overview of the Medicaid Fraud Control Unit 3
Complaints 3
Case Investigations 4
Disposition of Cases 6
Investigative Strategy 8
Data Mining 8
Budget 9
Total Recoveries 10
Training 11
Significant Case Highlights 13
- Teva Pharmaceuticals 13
- Novartis Pharmaceuticals Corporation 13
- AstraZeneca – Pharmaceutical Manufacturer 14
- Dr. Manuel Javier Fernandez 14
- Eric West – In home care services 15
- Oliver Workman – Speech Pathologist 15
- Amanda Capers – Personal Care Attendant 16
- Joyce Gibbs – Operating Unlicensed Assisted Living Facility 16

Agency for Health Care Administration 19
Division of Medicaid 19
- Utilization Norms and Utilization Management 21
- Provider Accountability and Increased Provider Enrollment Requirements 24
- Fraud and Abuse Initiatives 24
- Fee for Service 25
- Medicaid Managed Care 26
- Cooperative Projects and Workgroups: 28
- Special Projects and Pilots 28

Telephonic Home Health Services Delivery Monitoring and Verification (DMV) Program 28
Comprehensive Care Management Project 29
Program Structure/Structural Changes: 30
Provider Education 30
System Improvements 33
Office of the Inspector General 34
Bureau of Internal Audit 34
10-09 Aging Out Program – Aged and Disabled Adult Waiver 34
10-10 Medical Claims Review Process Improvement 35
Provider Data Analysis 35
Investigations Unit 36
Fraud and Abuse Efforts 36
Top Atypical Anti-Psychotic Medicaid Prescribers 36
Two Physician Prescribers in Miami-Dade County 36
Central Florida Atypical Anti-Psychotic Prescriber 37
Plea Agreement - Radiological and Diagnostic Imaging Review 37
South Florida Dentist 38
Central Florida Home and Community Based Waiver Provider 38
Medicaid Project AIDS Care (PAC) Waiver 38
Bureau of Medicaid Program Integrity 39
Intake and Assessment Unit 39
Field Office Initiatives 41
October 2010 Home Health Prescriber Project 41
Home Health Initiatives – Update 42
March 2011 DME Initiative 42
Speech Therapy Initiative in Miami 43
Data Analysis Unit 43
Medicaid Program Integrity Detection Methods 44
Detection Tools 44
Special Analysis – "Pill Mill" Data Initiative Update 46
Joint MPI and MFCU Referral and Data Mining Meetings 47
Data Mining and Detection Projects 47
Quad State Teleconference 47

Case Management Units 48
Medicaid Program Integrity Prevention Activities 48
Prepayment Reviews 49
Termination Recommendations 50
Focused Projects 50
Site Visits 51
Administrative Sanctions 52
Medicaid Program Integrity Recovery Activities 53
MPI Audits 54
Paid Claims Reversals 54
Offsets to Future Payments 54
Contractual Assessments 55
Third Party Liability Contractor-Assisted Audits 55
Performance Trends 55
Referral Activities 55
Recoveries of Overpayments – MPI Audits 56
Closed Cases 56
Providers Selected at Random for Audit 56
MPI Highlights 57
Funding for Medicaid Program Integrity and Return on Investment 60
MPI and Managed Care 61
Division of Operations 66
Bureau of Finance and Accounting 66
Third Party Liability Unit 68
Health Quality Assurance 70
Bureau of Long Term Care Services 71
Bureau of Health Facility Regulation 71
Bureau of Managed Health Care 71
Bureau of Field Operations 71
The Office of Plans and Construction 72
Florida Center for Health Information and Policy Analysis (Florida Center) 72
Background Screening 72
HQA-Overpayments, Suspensions, Terminations, Cases 74

Field Operations 76
HQA and MPI-News Clips 77
Home Health Agencies 77
Laboratory Unit Fraud and Abuse Efforts 79
Office of the General Counsel 79
Inter-Agency Coordination and Cooperation 80
Medicaid and Public Assistance Fraud Strike Force 80
Recommendations 82
Other Opportunities 83
Florida Department of Health 83
Prescription Drug Monitoring Program 84
Division of Medical Quality Assurance, Emergency Action Process 86
Statutory Reporting Requirements 91
Number of cases opened and investigated each year 91
Sources of the cases opened 91
Disposition of the cases closed each year 92
Amount of overpayments alleged in preliminary and final audit letters 92
Number and amount of fines or penalties imposed 93
Reductions in overpayment amounts negotiated in settlement agreements or by other means 93
Amount of final agency determinations of overpayments 93
Amount deducted from federal claiming as a result of overpayments 93
Amount of overpayments recovered each year 93
Amount of cost of investigation recovered each year 94
Average length of time to collect overpayment in full 94
Amount determined as uncollectible 94
Number of providers terminated from the Medicaid program 94
All costs associated with Medicaid overpayments recoveries 95
Providers prevented from enrolling in or reenrolling as a result of suspected fraud or abuse 95
Policy Recommendations 96

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 2010-11.

This page intentionally left blank

Medicaid Fraud Control Unit

Overview of the Medicaid Fraud Control Unit

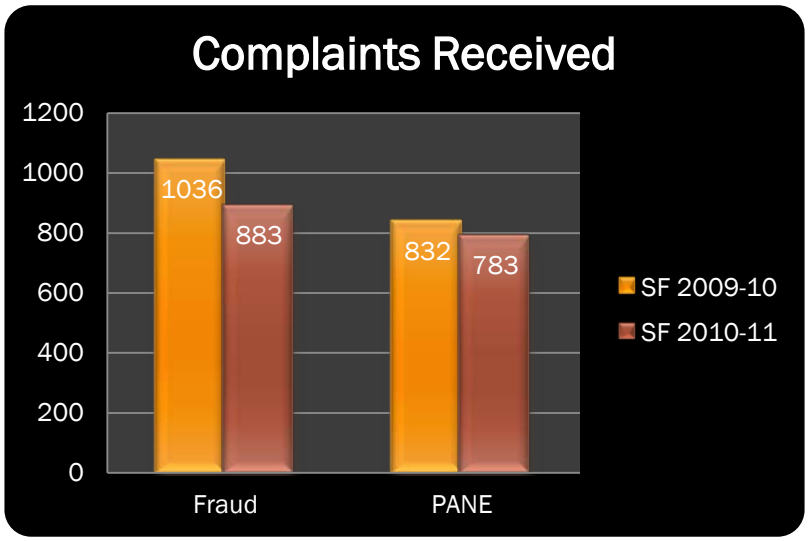
There were 214 full-time employees (FTEs) assigned to the MFCU in FY 2010-11. One hundred nineteen positions are investigators and their supervisors or managers, 27 are attorneys and the remaining are professional support positions such as auditors, analysts and administrative staff. For most operational purposes, the organizational structure of the Unit is divided into three regions: North, Central and South. The North region has 39 assigned FTEs and has offices in Jacksonville (13 FTEs), Tallahassee (18 FTEs) and Pensacola (eight FTEs). The Central region has 42 assigned FTEs and has offices in Orlando (14 FTEs), Tampa (28 FTEs) and St. Petersburg (one FTE). The South region has 71 assigned FTEs and has offices in Miami (37 FTEs), Ft. Lauderdale (18 FTEs) and West Palm Beach (16 FTEs). Additionally, there are two other entities within MFCU, the Director's office (14 FTEs) and the Complex Civil Enforcement Bureau (21 FTEs). MFCU had 27 positions in reserve that were not funded for FY 2010-11.

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

Complaints

Complaints serve as the basis for most investigations opened by the Unit. The Unit's policy requires a 30-day review of complaints and allegations to determine whether the matter merits further investigation, should be referred to another agency or is unfounded. Case openings occur only when there is a criminal or civil predicate that warrants further investigative activity by the MFCU. As a result, complaints are screened more timely and complaints and/or allegations that are more viable lead to the opening of a full investigation.

During FY 2010-11, the Unit received a total of 1,666 complaints. Of those 1,666 complaints, 356 were opened as operational cases. For FY 2009-10, the Unit received a total of 1,868 complaints. Of those 1,868 complaints, 388 were opened as operational cases.



For FY 2009-10, of the 1,868 complaints received, 1,036 were related to fraud and 832 were related to PANE. Of the 1,666 complaints received in FY 2010-11, 883 were related to fraud and 783 were related to PANE allegations.

The primary source of fraud complaints in FY 2009-10 was citizens with 440 complaints reported. AHCA, via its Medicaid Program Integrity (MPI) unit, accounted for 103 of the Medicaid fraud complaints received. Ninety-four qui tam complaints were received.

In FY 2010-11, the primary source of Medicaid fraud complaints was again citizens: 299 complaints received were made by private citizens. Qui tam, or whistleblower complaints were the next highest source of fraud complaints with 137 and AHCA-Medicaid Program Integrity complaints followed with 75. Other sources of Medicaid fraud complaints included 54 from Medicaid recipients and 49 from family members.

The overwhelming majority of PANE complaints are generated by the Department of Children & Families (DCF). In FY 2009-10, of the 832 PANE complaints, 690 came from DCF. Citizen complaints accounted for 68 complaints.

In FY 2010-11, of the 783 PANE complaints, 574 came from DCF. The next-highest source of PANE complaints was citizens, who accounted for 81 complaints.

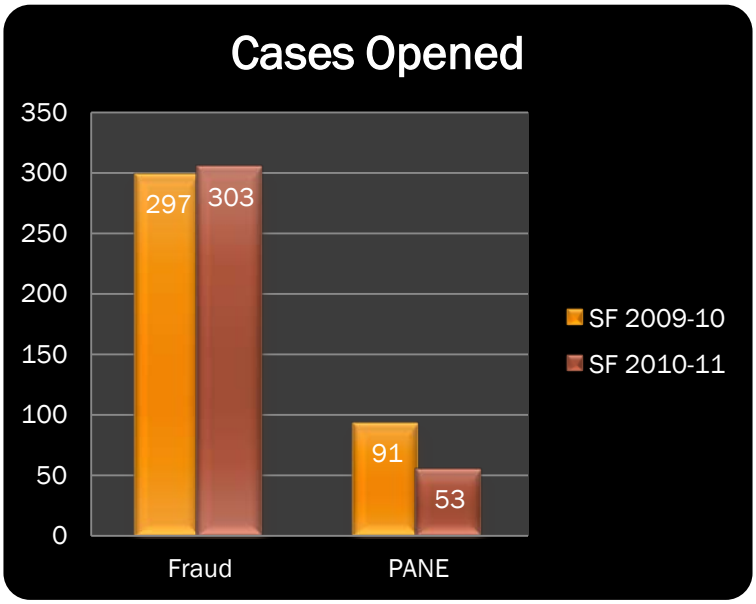
Case Investigations

Complaints are reviewed to determine issues such as MFCU jurisdiction, referral to another agency and viability of the complaint for further investigation. The opening of a case indicates that a criminal or civil investigation has been opened and significant 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 criminal or civil elements. Most of the decision-making regarding opening or closing 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. More frequent, ongoing interaction on case investigations is also conducted by attorneys and supervisors, primarily Lieutenants, on a case-by-case basis.

During FY 2010-11, the MFCU opened a total of 356 cases. The North Region opened a total of 82 cases. Of those cases, 56 were related to Medicaid fraud. The remaining 26 case openings were PANE cases. In the Central Region, there were a total of 73 cases opened. Of these, 62 were related to Medicaid fraud. The remaining 11 were PANE cases. In the South Region, there were a total of 77 cases opened. Of these, 61 were related to Medicaid fraud and the remaining 16 cases were PANE cases. The Complex Civil enforcement Bureau (CCEB) opened 124 qui tam litigation cases which are included in the fraud case total.

In FY 2009-10, the MFCU opened 388 total cases. Of those cases, 297 cases were related to Medicaid fraud. The remaining 91 cases were PANE cases. The North Region opened a total of 87 cases. Of those cases, 41 were related to Medicaid fraud and 46 were PANE cases. The Central Region opened a total of 135 cases, of which 114 were related to Medicaid fraud. The remaining 21 case openings were PANE cases. In the South Region, there were a total of 86 cases opened. Sixty-two of the case openings were related to Medicaid fraud and the remaining 24 were PANE cases. The Complex Civil Enforcement Bureau (CCEB) opened 80 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 2009-10 and the specified period of FY 2010-11, ranked most to least frequent:

FY 2009-10	FY 2010-11
Pharmaceutical Manufacturer	Pharmaceutical Manufacturer
Home & Community Based Service	Home & Community Based Service
Physician (MD)	Physician (MD)
Medical Supplies/Durable Medical Equipment	Pharmacy
Community Alcohol/Drug/Mental Health	Medical Supplies/Durable Medical Equipment

The following is a list of the top five Provider types for PANE cases in FY 2009-10 and the specified period of FY 2010-11, ranked most to least frequent:

FY 2009-10	FY 2010-11
Facility Employee	Facility Employee
Home & Community Based Service	Assistive Care Services
Assisted Living Facility	Home & Community Based Service
Certified Nursing Assistant (CNA)	Assisted Living Facility
Nursing Home	Care Giver

For both years, Pharmaceutical Manufacturers were the predominant provider type for Medicaid fraud investigations, while Facility Employees were the predominant type for PANE case openings.

Disposition of Cases

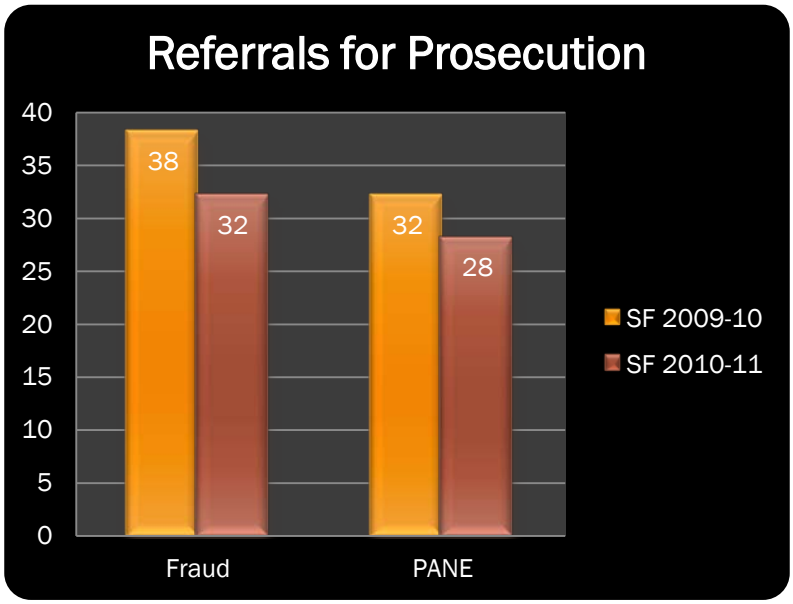
Following an investigation, a determination is made whether to pursue criminal prosecution or file civil actions. All case investigations will eventually be formally closed because of either a successful prosecution, referral to another agency or a lack of evidence. There are several classifications presently used that track the ultimate disposition of closed cases. It is important to note that cases closed during a particular fiscal year often 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 2010-11, the MFCU closed 350 cases. Of those, 269 involved Medicaid fraud investigations and 81 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. For FY 2010-11, 60 cases were referred for prosecution. Thirty-two of these cases were based upon Medicaid fraud investigations and the other 28 were based upon PANE investigations. The Northern Region accounted for 22 of these referrals for

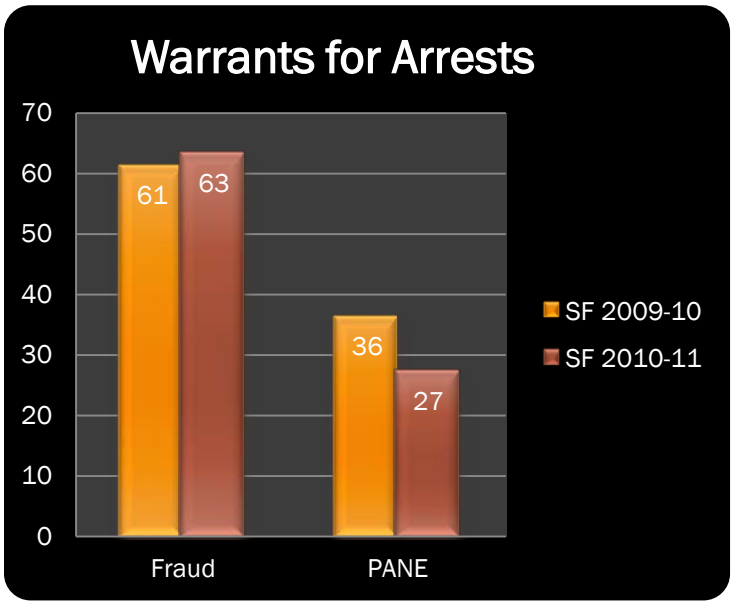
prosecution, the Southern Region accounted for 19 prosecution referrals and the Central Region accounted for 19 prosecution referrals.

In FY 2009-10, 70 cases were referred for prosecution. Thirty-eight of these cases were based upon Medicaid fraud investigations and the other 32 were based upon PANE investigations. The Southern Region accounted for 27 of these referrals for prosecution, the Northern Region accounted for 26 prosecution referrals and the Central Region accounted for 17 prosecution referrals.



For FY 2010-11, there were 90 arrest warrants issued. Sixty-three of those were Medicaid fraud investigations and 27 were for PANE investigations. The South Region accounted for 35. The North Region accounted for 32 and the Central Region accounted for 23.

In FY 2009-10, 97 arrest warrants were issued based upon MFCU criminal investigations. Sixty-one of those were related to Medicaid fraud investigations and 36 were for PANE investigations. The South Region accounted for 41, which were predominantly for Medicaid fraud. The Northern Region accounted for 33 and the Central Region accounted for 23.



Investigative Strategy

The MFCU has two primary areas of enforcement responsibility: fraud perpetrated against the Medicaid Program by providers and Patient Abuse, Neglect & Exploitation (PANE). Enforcement activity in these areas helps prevent, detect, prosecute and deter these types of misconduct, providing protection for the citizens of Florida. Case management, including case openings, investigative activities, legal review/prosecution, prioritization, utilization of investigative/legal resources and other related issues are handled on a case-by-case and office-by-office basis.

MFCU's formal Investigative Strategy requires unit managers to consider, among other factors, 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.

Data Mining

On July 15, 2010 U. S. Department of Health & Human Services Secretary Kathleen Sebelius granted the Florida MFCU a waiver of a portion of 42 CFR 1007.19 allowing Federal financial participation in

data mining activity. Data mining refers to the practice of electronically sorting Medicaid Management Information Systems claims through statistical models and intelligent technologies to uncover patterns and relationships contained within the Medicaid claims activity and history to identify aberrant utilization and billing practices that are potentially fraudulent. Terms of the waiver include: a time-frame of three years; limits the amount of MFCU staff time to be utilized; and, submission of a detailed plan describing how the MFCU will ensure its data mining efforts will be coordinated with, and not duplicate, the data mining efforts of Florida's single-state-agency, AHCA.

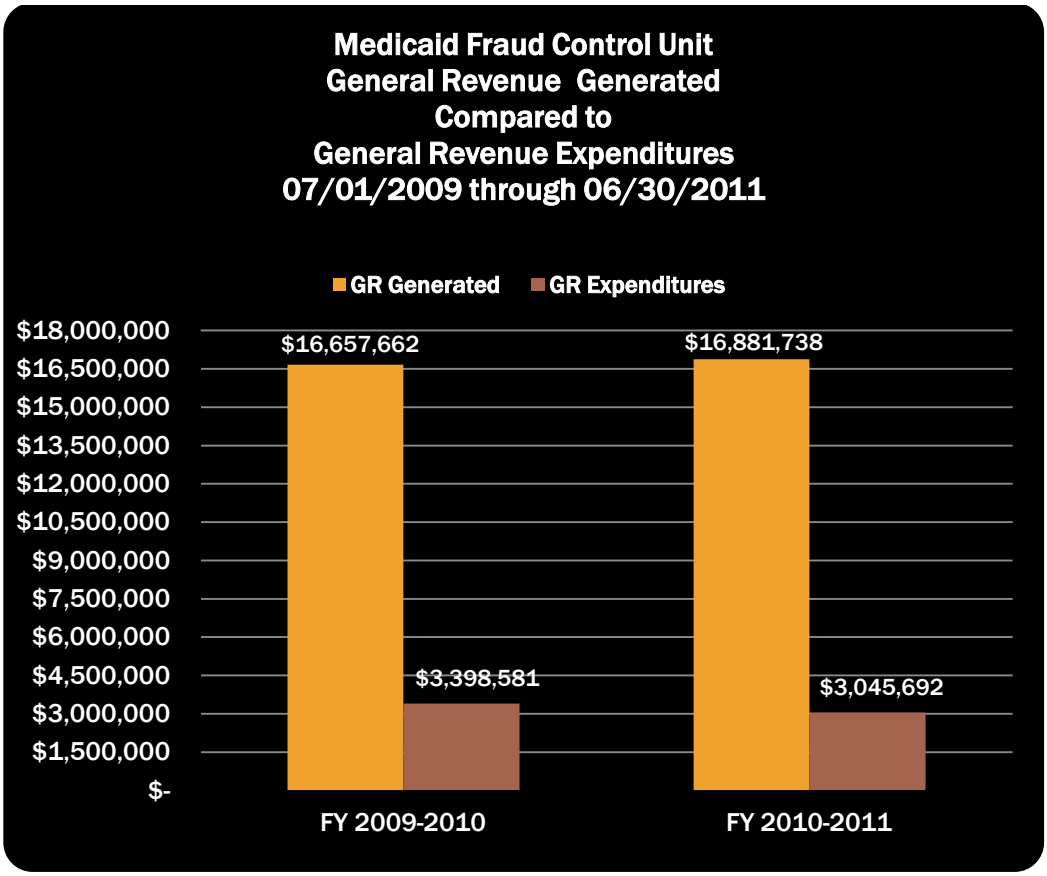
The waiver required that the Memorandum of Understanding between the MFCU and the single-state-agency be amended to provide a system to ensure the data mining efforts would be coordinated with, and not duplicate efforts of the single-state-agency. By October 2010, the MFCU commenced data mining activity. As of June 30, 2011, the MFCU submitted 24 data mining projects to the single-state-agency for review. MFCU has 2 cases and 18 complaints opened from these projects and are currently developing additional targets.

Budget

The Medicaid Fraud Control Unit's budget is a hybrid of State General Revenue and Federal grant dollars. Federal Financial Participation (FFP) accounts for 75 percent of its total budget. Pursuant to requirements of Federal statutes and regulations governing 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 2010-11, the MFCU budget was as follows:

Federal Financial Participation	$11,931,876
Florida GR/Program Income	$ 3,977,292
TOTAL	**$15,909,168**

General Revenue expenditures over several past fiscal years have been reduced, with resulting decreases in matching Federal grant dollars. The reduced expenditures for the MFCU come at a time when the Unit has improved efficiency. During FY 2010-11 the Unit generated $16.8 million dollars in damages and penalties, in addition to the restitution to the Medicaid program. These funds were deposited in the state's General Revenue Fund.

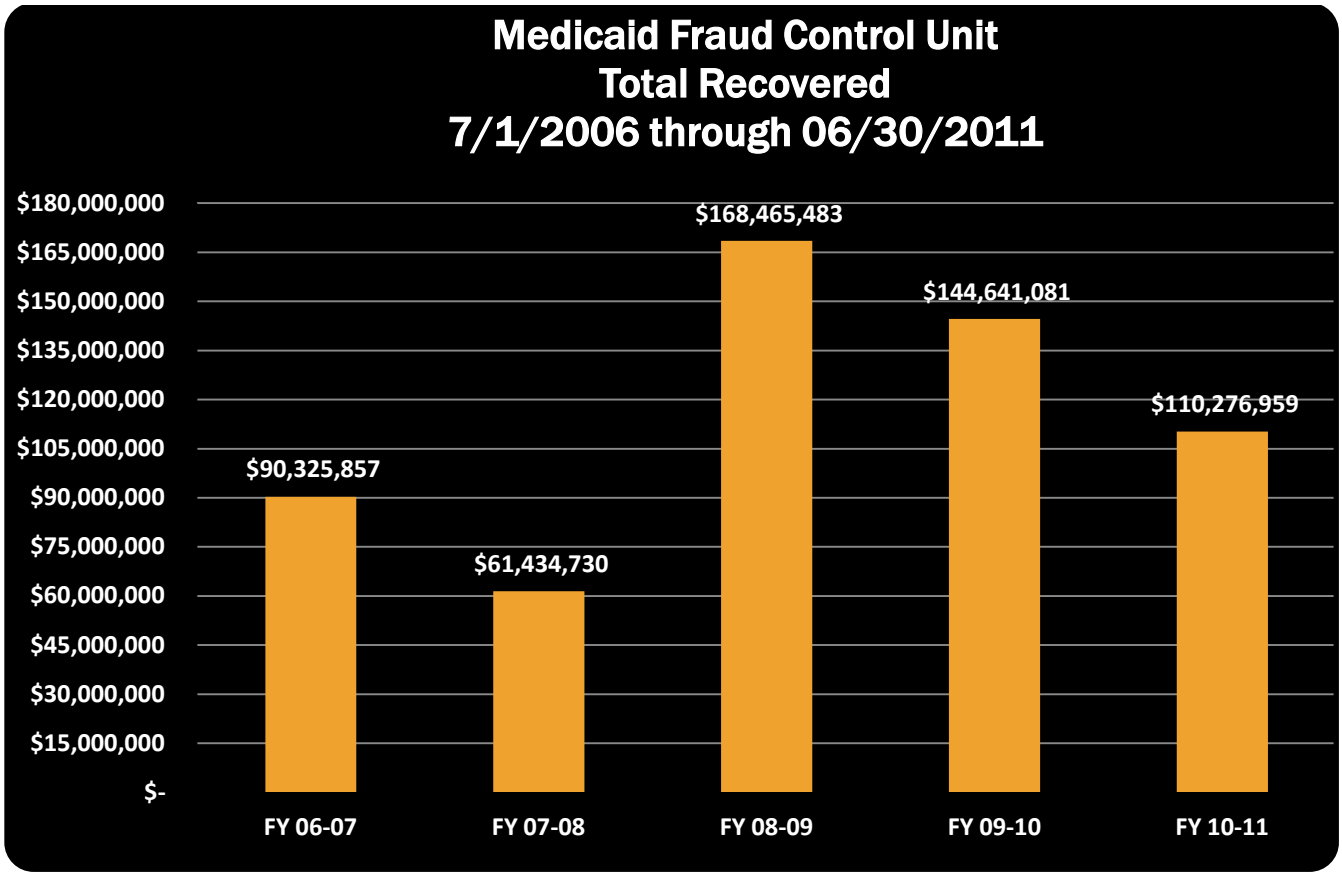


In the previous chart, for FY 2010-11, for every General Revenue dollar spent, the MFCU generated approximately $5.54 through penalties and interest deposited into General Revenue. During FY 2009-10, for every General Revenue dollar spent, the MFCU generated approximately $4.90 through penalties and interest that was deposited into General Revenue.

Total Recoveries

The MFCU recovers funds in both civil and criminal cases. The MFCU is responsible for enforcement of criminal statutes whose dispositions may include restitution, fines, investigative costs and forfeitures. The MFCU also uses the Florida False Claims Act as a mechanism for recoveries in civil cases, whose dispositions may include restitution, damages and penalties.

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



In FY 2010-11, the total amount for civil recoveries, which include civil settlements arising from qui tam cases brought under Florida's False Claims Act, was $107,079,438.

In FY 2010-11, the total amount for criminal recoveries based upon Medicaid fraud cases was $3,197,521.

The total amount of the monies recovered by the MFCU for FY 2010-11 was $110,276,959. It should be noted that during this fiscal year the Attorney General's Office Medicaid Fraud Control Unit's recoveries generated $16,414,495 through penalties imposed and $467,2443 in interest that was deposited into the State of Florida's General Revenue Fund.

Training

With ever more complex investigations and expanded duties due to a reduced workforce, investigators and analysts had to become more self reliant. Therefore investigators and analysts took additional specialized training classes. These specialized classes included training to query databases for Claims Analysis, Managed Care, Provider, Recipient and Payment Management, Data Mining, CJIS Certification and others offered by the Agency for Health Care Administration (AHCA) and the Department of Law Enforcement (FDLE). Medicaid Fraud Control Unit staff attended a total of 4,738.3 hours of training.

The Office of the Attorney General continued to offer a large number of career and personal enhancement training opportunities via Webinars, Video Conferences and classroom settings. Law Enforcement personnel continued to obtain most of their mandatory training for recertification online with the Florida Department of Law Enforcement (FDLE) free of charge. Other training was offered or conducted mostly free of charge by local and national organizations and Criminal Justice Academies.

Classroom training offered at no cost, included providers such as the National Association of Medicaid Fraud Control Units (NAMFCU), the National Association of Attorneys General (NAAG), the Florida OAG Crime Prevention Institute (FCPTI), Florida Regional Community Policing Institute (RCPI), The United States Attorney's Office, Area Agencies on Aging, the Department of Homeland Security, the Multi-jurisdictional Counterdrug Taskforce, High Intensity Drug Trafficking Area (HIDTA) Intelligence Center, State Agencies, in particular the Agency for Health Care Administration (AHCA) and the Florida Department of Law Enforcement (FDLE), local Law Firms and Bar Associations, Criminal Justice Academies, Sheriff's Offices and even a Tallahassee Judge, to name a few.

Classroom training focused, in part, on Managed Care Training, Medicaid Fraud Training, Overview of the Florida Medicaid Assistive Care Services (ACS), Analyst Academies, Crimes Against the Elderly, Law Enforcement's Role in Elder Crime, The Trusting Elder – Investigating Elder Financial Exploitation, Prescription Drug Abuse, Computer Crimes & Fraud, Intelligence Officer Course, Pill Mill Investigation Seminar, North Florida HIDTA and Office of Statewide Prosecution's Electronic Surveillance, High Liability Instructor Training Seminar, Cardio Pulmonary Resuscitation (CPR) Instructor Training, Advance Report Writing, Advanced Financial Investigations, Money Laundering and Asset Forfeiture, Statistical Sampling, Medicaid Provider Compliance Program & Provider Self Audits, Health Care Reform and Provider Regulation, Brady/Giglio Awareness & Training, Statutory Interpretation, Preservation of Evidence and the Litigation Hold Process, NAGTRI Deposition Training, DSS Training for Data Mining Analysts, Criminal Justice Information Services (CJIS) Certification, Interviews and Body Language Techniques, Field Training Officer and Security Awareness 2011.

In-house training provided through a variety of delivery methods focused on topics such as Defensive Tactics, Leadership/Supervision and Performance Evaluation, Customer Service, Performance Coaching, Recruitment and Selection, Ethics, PowerPoint Basic, Performance Evaluation for Supervisors, Performance Evaluation from the Employee Perspective, Basic Business Grammar, Excel, Word 2007 Template & Recording Macros, Lotus Notes 8.5 Email & Calendar Upgrade, Introduction to Electronic Discovery, Public Record Email, Navigating the MFCU Complaint/Case Database, Stepping Through the Complaint/Case Process, Workplace Law & Policy, etc.

Additionally, classroom and range firearms qualification and Use of Force training was provided to our law enforcement personnel at local Academies by Medicaid Fraud Control Unit certified instructors at no cost.

In order to maintain law enforcement certification, sworn personnel once again obtained mandatory training online with FDLE, also free of charge. Training included: Criminal Justice Officer Ethics, Domestic Violence, Juvenile Sex Offender Investigations, Discriminatory Profiling and Professional Traffic Stops.

Significant Case Highlights

Teva Pharmaceuticals

On July 19, 2010, Florida entered into a $27 million settlement agreement with Teva Pharmaceuticals and its corporate affiliates to resolve claims of Medicaid fraud. The settlement, which partially resolves two Leon County Medicaid fraud lawsuits, was negotiated by the Attorney General's Complex Civil Enforcement Bureau.

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

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

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

Novartis Pharmaceuticals Corporation

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

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

Additionally, the United States Attorney's Office for the Eastern District of Pennsylvania filed a charge against Novartis in the United States District Court alleging a misdemeanor violation of the Food,

Drug and Cosmetic Act. In a plea agreement with the United States, Novartis agreed to plead guilty and pay $185 million to resolve the criminal case.

As a result of the civil settlement, Novartis paid the states and the federal government a total of $237.5 million in damages and penalties for losses to the Medicaid and other federal health care programs. The total criminal and civil settlement value is $422.5 million. As one of the conditions of the settlement, Novartis entered into a Corporate Integrity Agreement[1] with the Office of the Inspector General of the United States Department of Health and Human Services, which will closely monitor Novartis' practices going forward.

AstraZeneca – Pharmaceutical Manufacturer

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

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

In addition to the $4.25 million to the Florida state Medicaid program, $3.8 million was deposited into Florida's General Revenue fund. Additional funding will reimburse the federal government for its contributions to the Medicaid program. Also, AstraZeneca entered into a Corporate Integrity Agreement with the United States Department of Health and Human Services' Inspector General. The agreement included provisions that will ensure that AstraZeneca will market, sell and promote its products in accordance with all Federal health care program requirements.

Dr. Manuel Javier Fernandez

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

[1] A Corporate Integrity Agreement (CIA) is a document that outlines the obligations an entity agrees to as part of a civil settlement. An entity agrees to the CIA obligations in exchange for the OIG's agreement that it won't seek to exclude entity from participation in Medicare, Medicaid or other Federal health care programs. The CIAs have common elements, but each one is tailored to address the specific facts of the case and CIAs are often drafted to recognize the elements of a pre-existing compliance program.

Investigators with the Medicaid Fraud Control Unit began investigating Fernandez, 77, when the Agency for Healthcare Administration (AHCA) received Explanation of Medicaid Benefits (EOMB) surveys from seven Medicaid recipients who stated that they did not receive the services listed on the EOMB from Fernandez. Over 60 Medicaid recipients were contacted and all stated that they did not receive the services that Fernandez billed Medicaid for. Subsequently, AHCA terminated Fernandez as a Florida Medicaid provider. Based upon further investigation, it was determined that Fernandez received payment from the Florida Medicaid Program of more than $656,000 for services that he did not render. In June 2010, Fernandez pled guilty as charged. Fernandez was investigated and prosecuted as a joint effort between the MFCU, the Federal Bureau of Investigation and the United States Attorney's Office for the Northern District of Florida.

Eric West – In home care services

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

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

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

Oliver Workman – Speech Pathologist

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

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

Workman was prosecuted by an attorney from the Medicaid Fraud Control Unit who was specially designated for the case by the State Attorney's Office for the Seventh Judicial Circuit. After completing his prison sentence, Workman must serve 10 years of probation. He was also ordered to reimburse the Medicaid program $485,909.07 for the full amount he defrauded.

Amanda Capers – Personal Care Attendant

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

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

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

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

Joyce Gibbs – Operating Unlicensed Assisted Living Facility

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

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

On May 20, 2011, Gibbs entered a plea of guilty to one count of Operating an Unlicensed Assisted Living Facility, a third-degree felony. Adjudication of guilt was withheld and she was put on five

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

This page intentionally left blank

Agency for Health Care Administration

Division of Medicaid

The Division of Medicaid administers the Florida Medicaid Program, a $21.2 billion state and federal partnership that provides health care to more than 3.19 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, 11 field 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 14 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 reenrollment 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, as well as 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 requests, as well as the development and implementation of Medicaid managed care policies, contracts, applications and procedures along with other special projects.

[1] These figures represent the budgeted amount and budgeted caseload for FY 2011-12.

Bureau of Pharmacy Services (Pharmacy Services) develops and implements Medicaid policies for administering the Medicaid prescription drug program. The Bureau ensures that 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.

The 11 Medicaid Field Offices throughout the state serve as the local liaisons to Medicaid providers and recipients. The Field Offices are responsible for exceptional claims processing (and resolve more than 167,000 claims issues that cannot be addressed through standard processing), provider relations and training (conducting nearly 300 training classes annually and providing other educational services to providers), consumer relations (handling more than 700,000 phone calls, more than 58,000 requests to change provider assignments and more than 9,000 prior authorizations for goods and services), managing the Child Health Check-Up program, transportation and School Match programs on a local level and conducting provider site visits (conducing more than 3,000 visits annually).

The staff under the Deputy Secretary for Medicaid, also referred to as the Office of the Medicaid Director, 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, which coordinates the efforts of the bureaus within the Division in the development and implementation of policy and programs to prevent improper payments, with specific focus on fraud controls and assists with the facilitation of the detection, prevention and recovery of misspent funds

due to fraud, abuse and overpayments. Other staff within the Office of the Medicaid Director 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 and utilization management, provider accountability and increased provider enrollment requirements, cooperative projects, special projects and pilots, program structure and structural changes and provider education and system improvements.

Utilization Norms 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 2010-11 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.
- The Agency has continued to implement prior authorization requirements for home health services to strengthen the Agency's efforts in combating the misuse or abuse of home health services, including eliminating authorization exceptions and requiring the submission of additional supporting documentation and information from the ordering physician to determine medical necessity.
- Implemented, on July 1, 2010, 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. By applying these more stringent criteria prior to payment, the opportunity for overpayments is significantly reduced.
- Continued other utilization controls such as managing lengths of stay for inpatient hospital services through prior authorization reviews, monitoring abnormal billing patterns and proactive efforts to reduce average lengths of stay for inpatient residential care through the use of on-site Regional Care Coordinators and prior authorization reviews.

In January 2010, the Florida Statewide Quality Assurance Program for people with developmental disabilities moved into a new contract. The new contract has a new provider oversight process for individuals receiving services through the Developmental Disabilities Home and Community-Based Services waivers or the Consumer Directed Care Plus program. The contractor, Delmarva Foundation, conducts Provider Discovery Reviews to provide AHCA and the Agency for Persons with Disabilities (APD) information about providers and the Developmental Disabilities waivers service delivery systems.

During the contract year 2010, Delmarva reviewers completed 2,579 Provider Discovery Reviews. Providers were reviewed to determine compliance with policies and procedures as dictated in the Florida Medicaid Developmental Disabilities Waiver Services and Limitations Handbook (the Handbook). Reports from these reviews of services delivered to recipients were mailed to providers, waiver support coordinators, AHCA and the Agency for Persons with Disabilities (APD) , the waiver operations agency and posted to the Delmarva public Web site, providing public knowledge of provider performance.

Delmarva's Web site dashboards include provider criminal background screening information. The website lists providers or their employees who did not meet criminal background screening standards, including the reasons the standards were not met for each employee.

At any time during a review, if a situation is noted that could cause harm to an individual, the reviewer immediately informs the local APD office and, if appropriate, calls the abuse hotline and/or the APD Central Office if appropriate. These types of alerts can be related to health, safety or rights. In addition, when any provider or employee who has direct contact with recipients does not have all the appropriate background screening documentation on file, an alert is recorded and both APD Area Office and Central Office are notified.

Recoupment of provider payments is recommended if the standard applies to billing documentation requirements. If a provider does not meet a standard, the reviewer flags the claim as a potential recoupment and notifies the APD Area Office and AHCA.

The Division 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.

The Medicaid Field Offices also carry-out compliance and quality management functions, which provider oversight and guidance to the program monitoring and audit responsibilities. Field Office staff perform both retrospective and prospective activities. Retrospective program monitoring and utilization review activities ensure that correct payment was made for services rendered. The Field Offices also conduct annual and periodic reviews of services provided by schools and specialty providers, such as Behavioral Health, Case Management and Waiver Programs, prospectively authorize, in whole or in part, payment for certain services such as behavioral health, medical foster care, Prescribed Pediatric Extended Care, wheelchairs and related components to ensure that medical necessity criteria are met; and, conduct regular provider trainings both in the Field Offices

and in provider offices, to promote proper provision of Medicaid services and improved patient outcomes.

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

Below is a chart of information which represents FFS pharmacy claims denials for FY 2010-11. As the chart indicates, there were 7,966,507 unique claims denials and the dollar amount associated with these denials totals $968,905,153.07. However, because providers are not precluded from resubmitting 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.

Denied claims summary for claims adjudicated between 07/01/10 and 06/30/11			
NCPDP[1] Reject Code	Claims Count	Amount Associated with Denied Claims	NCPDP[1] Reject Code Description
22	2,028	$215,528.24	M/I Dispense as written code
60	210,338	$27,385,782.91	Product/Service Not Covered For Patient Age
61	2,995	$453,548.80	Product/Service Not Covered For Patient Gender
70	1,430,180	$72,950,444.76	NDC not covered
73	12,829	$414,467.15	Refills are not covered
75	1,832,287	$358,816,198.08	Prior authorization required
76	1,309,275	$191,618,670.40	Plan limitations exceeded
83	195,447	$17,805,979.15	Duplicate paid/Captured claim
88	2,971,128	$299,244,533.58	DUR reject error
	7,966,507	$968,905,153.07	Totals

[1] NCPDP is an acronym for the National Council for Prescription Drug Program.

Provider Accountability and Increased Provider Enrollment Requirements

The Division continually works to increase provider compliance and accountability through many different avenues. Several activities were undertaken in FY 2011-12 to aid the Division in better monitoring providers after enrollment are set forth below:

- Continued implementation regarding the submission of background screening results for managed care plans' principals and executive management, as well as continued evaluation of processes to ensure accountability by plans of their provider network controls.

- Conducted additional on-site monitoring to ensure compliance and recoupment of non-compliant claims.

- Continued to conduct pre-enrollment activities designed to reduce the likelihood of non-compliance. Pre-enrollment onsite visits are conducted 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 nearly 1,000 applicants during FY 2010-11 and more than 130 ineligible applicants were denied enrollment through this process. Also, nearly 9,000 individuals' fingerprints were processed for background screening during FY 2010-11, resulting in approximately 80 denied applications due to background screening.

- Completed installation of an automated re-enrollment process in the FMMIS in January of 2010 which runs daily and identifies any provider with a provider agreement end date 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 waiver and Targeted Case Management.

The Agency implemented a rule amendment to increase accountability with regard to the submission of cost reports so that a provider can be sanctioned for filing the cost report late.

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 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 and 2 provide 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 1: Cost Avoidance[1]: Home Health Aide Visits and Skilled Nursing FY 2010-11

Type of Service	Denial Hours	Cost Avoidance*
Home Health Aide Visits Unassociated with a Skilled Nursing Visit	302,089	$5,274,473.94
Home Health Aide Visits with a Skilled Nursing Visit	16,796	$293,258.16
Skilled Nursing Provided by a Licensed Registered Nurse	29,279	$908,820.16
Skilled Nursing Provided by a Licensed Practical Nurse	22,435	$587,572.65
	Total Cost Avoidance	$7,064,124.91

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

[1] There is additional information regarding Cost Avoidance later in this report.

Table 2: Cost Avoidance: Private Duty Nursing FY 2010-11

Type of Service	Denial Hours	Cost Avoidance*
Personal Care Services	2,385,154	$35,777,310.00
Private Duty Nursing Provided by a Registered Nurse	1,363,001	$39,663,329.10
Private Duty Nursing Provided by a Licensed Practical Nurse	1,603,256	$37,323,799.68
	Total Cost Avoidance	$112,764,438.78

*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 and 2 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 forth 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 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: http://ahca.myflorida.com/Medicaid/quality_mc/index.shtml. 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.

Additionally, the Dade and Broward County Field Offices are active in managed care reform team meetings to provide insight and input to both policy and operational decisions from the local perspective with a strong focus on ensuring a smooth transition for the Medicaid recipients and providers. Field Offices offer Medicaid Managed Care Pilot outreach and education programs for beneficiaries, advocates and providers. Field Offices assist the Enhanced Benefit Call Center in helping beneficiaries understand the Enhanced Benefit Program and trouble shoot credit discrepancies between health plans and beneficiaries. In the grievance system for Provider Service Networks, the Field Office participates as a member of the Beneficiary Assistance Panel and serves as the Agency representative for all Medicaid Fair Hearings. These field offices continue to manage the service provider network and process exceptional claims for excluded, dual eligible and medically needy populations.

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 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]
- 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
- 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 2010-11 the Agency continued to furnish training about managed care to assist its partners in the efforts against fraud (specifically for MFCU and MPI) 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. Further training of this nature will continue to be developed and is

[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.

expected to foster further dialogue between MFCU and the Agency and result in earlier development of leads for investigation in the managed care arena.

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 field offices coordinate to detect fraud and abuse early and work closely with Medicaid Program Integrity (MPI).

The Division continues participation in an interagency Anti-Fraud Working Group with MPI, MFCU and other state-government partners, as well as participation with other taskforces or work groups such as the Medicaid and Pubic Assistance Fraud Workgroup and the FDLE workgroups related to overprescribing/pill mills.

The Agency continues to contract with a vendor to conduct reviews of the Developmental Disabilities Waivers and the Consumer Directed Care Plus program to evaluate quality from both the perspective of the Medicaid recipients of services and provider performance and compliance.

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 2010-11, 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 part of the anti-fraud and abuse provisions in Senate Bill 1986, passed by the 2009 Florida Legislature, the Agency contracted with Sandata, LLC to operate a program in Miami-Dade County to verify the utilization and delivery of home health visits reimbursed through the Medicaid program. The Telephonic Home Health Services Delivery Monitoring and Verification (DMV) Program began July 1, 2010. Home health visits are telephonically verified using a technology called "voice biometrics." Sandata's Santrax Payor Management (SPM) System maintains databases for each home health agency in the program pilot area that contain information on home health agency staff, recipients, service authorizations, visit schedules, visit verification and billing activity. Each home health agency logs in to the SPM System to access its database.

Sandata receives data feeds from the Florida Medicaid Management Information System (FMMIS) that contain prior authorization information for home health visits granted to home health agencies in Miami-Dade County. When the nurse or home health aide arrives and leaves the recipient's

residence, he or she calls a toll-free number assigned to their home health agency, enters their staff identification number and completes the speaker verification process. Using interactive voice response authentication technology, the voice of the nurse or home health aide is matched to a pre-recorded voice print to verify that the assigned staff is providing a home health visit to a specific recipient. This accomplishes the voice biometrics component of the program.

The program also requires providers to submit claims for home health visits electronically through the vendor's system. Once a home health visit has occurred and the verification process is complete, Sandata's SPM System automates the generation of the claims file and after provider review, electronically submits the claims to the Florida Medicaid fiscal agent. System edits in the FMMIS result in denial of reimbursement claims for home health visits provided by home health agencies in the project pilot area if they are not submitted through Sandata's SPM System.

Comprehensive Care Management Project

The purpose of the Comprehensive Care Management pilot project in Miami-Dade County is to identify potential overutilization and fraud or abuse of Medicaid services by ensuring that the level of home health visit services provided matches the needs of the recipients. Formerly managed by KePRO, the Agency's new quality improvement organization, eQHealth Solutions, Inc. began managing the comprehensive care management project June 1, 2011. Modifications have been made to the process in order to enhance outcomes and include all prior authorization requests submitted to eQHealth for home health aide visits unassociated with a skilled nursing visit, which is referred to a physician for a medical necessity determination.

A sample of the requests is pended in order to conduct a face-to-face assessment in the recipient's home prior to approval of services. If an assessment is conducted, eQHealth's physician must make the decision within five days of the request.

The Comprehensive Care Management (CCM) Pilot began July 2010 and has yielded the following results through July 2011:

Face-to-Face Assessment Data	Total (Recipients)
Recipient Face-to-Face Assessment Completed	3,450
Recommended Termination of Services	116
Recommended Reduction of Services	114

Since the implementation of these projects in July 2010, the Agency has successfully terminated several home health agencies from the Medicaid program and identified additional agencies for review/audit as a result of the project findings. The Agency continues to look toward aggressive and proactive measures to ensure provider compliance and to control the provider network. For FY 2010-11, Medicaid expenditures for home health visits in Miami-Dade County totaled $23,628,538, representing a 50 percent reduction from the $43,286,703 in expenditures for home health visits in Miami-Dade County during FY 2009-10. Note that this represents *projected* cost savings. Providers

have twelve months from the date of service to submit a claim for reimbursement, so these figures will change.

The Agency is identifying aberrant trends when reviewing the ordering physician information. Referrals have been made to MPI of potentially fraudulent 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. 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. The Agency is also working with the contracted vendors for these pilot projects to establish benchmarks and develop recommendations for policy changes and program enhancements.

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.

The Division has been working 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. This process is nearing completion of the rule promulgation process.

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 follow.

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 2010-11, the Division of Medicaid routinely referred these types of self disclosures to MPI for formal recoupment actions.

During FY 2010-11 the Medicaid Field Offices, located throughout the state, were responsible for:

- responding to over 700,000 phone calls from recipients and providers;
- processing over 58,000 Provider Assignment Change Requests received by fax or email;
- processing over 9,000 prior authorizations (wheelchairs, prescribed pediatric extended care, medical foster care);
- resolving over 167,000 exceptional claims for providers (claims that cannot be billed electronically or need additional service documentation);
- providing over 61,000 publications containing Medicaid policy, covered services and health care information to over 30,000 Medicaid beneficiaries and community participants through health fairs, Medicaid overview presentations and partnerships with providers and community agencies;
- conducting over 3,000 provider monitoring/site visits at provider offices or service locations;
- representing the Agency in over 1,000 fair hearing requests; and
- conducting over 290 provider trainings, with over 2,600 attendees.

In addition to provider outreach activities, the Field Offices provide recipient support which serves to aid the program in efficient administration. Field Office staff perform a recipient/network management function and serve as the first point of contact for problem resolution for both recipients and providers. This includes answering questions, clarifying policy and explaining service coverage and limitations, assisting providers to resolve claims payment issues for excluded, dual eligible and medically needy populations, maintain active telephone systems to track and resolve reported issue, participate in outreach and education programs in the community to ensure proper use of Medicaid benefits and promote improved patient outcomes, conducting on-site provider training and offering technical assistance, responding to inquiries from legislative offices and partner agencies and assist in resolving complex beneficiary health care issues, working on behalf of individuals by linking beneficiaries with participating primary care and specialty providers, assisting MediPass beneficiaries with reassignments to primary care physicians and recruiting, credentialing and developing a quality managed care network for the MediPass, excluded, dual eligible and medically needy populations and performing provider outreach to clarify policy on Child Health Check Up 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.

Delmarva Foundation, a Medicaid contractor, provided training sessions for Developmental Disability Waiver Service providers statewide educating providers on the Florida Medicaid Developmental Disability Waiver Services Coverage and Limitations Handbook. Training was also provided on the processes that Delmarva would follow during their monitoring visits.

The Division conducted a series of successful teleconferences reaching a large number of audiences and avoiding transportation costs for speakers and participants. Additionally, busy medical health care providers were able to attend without leaving their place of work. Furthermore, the teleconferences have allowed the Division to provide a consistent Medicaid policy message. This activity of increasing the knowledge of Medicaid policies will augment the compliance requirements and avoid overpayments for Medicaid services.

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

The table below summarizes the main educational teleconference activities:

Medicaid Policy Trainings	Outcome
Medicaid Provider Compliance Program & Provider Self Audits Teleconferences	Five training sessions were offered to all interested Medicaid providers on a high level overview of how to create and implement a Medicaid Compliance Program; the value of self audits and details on how to perform a self audit were discussed. This teleconference had an outstanding number of participants, totaling 1,021 callers.
Medicaid Policy Training for Obstetrical Ultrasound Providers	Twelve training sessions were delivered to 142 obstetrical ultrasound providers. This was developed in response to the large numbers of claims being inappropriately or incorrectly billed. Participants gained an understanding of key Medicaid obstetrical ultrasound services policies, the need for submitting appropriate documentation when submitting ultrasound claims to Medicaid for medical review and the value of submitting claims with correct modifiers. Since the providers received this education, the number of inappropriate or incorrect claims dropped dramatically. This allows the medical reviewer to focus more attention on the remaining claims and has increased the number of claims that are denied due to medically unnecessary obstetrical ultrasounds. Medicaid staff conducts individual education to providers whose claims are denied. The Division is scheduling a second round of training sessions to review current policy with emphasis on medical necessity for Fetal Biophysical Profile ultrasound.
Lessons Learned from the Miami-Dade Home Health Pilots	Six training sessions were offered to home health providers in Miami-Dade and later was expanded to home health providers statewide. The findings from the Miami-Dade Comprehensive Care Management Program were shared with participants. Providers have the opportunity to receive Home Health Medicaid policy reminders and information about how to help prevent fraud and or abuse of the Medicaid Program. There were 168 participants who reported an increased understanding of home health Medicaid policy.
Florida Medicaid Assisted Living Services	Two training sessions were provided to the staff from the 11 Medicaid Field offices, staff from the Medicaid Fraud Control Unit and Medicaid Program Integrity. Ninety-five participants received training on the distinction between Assistive Care Services and the Assisted Living waiver and how to better assist providers to avoid duplication of services and overbilling the Medicaid program.

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.

Florida Medicaid continued to evaluate and implement service limit edits on any existing DME codes that do not currently have maximum service limit edits in place. These audits will trigger an immediate and automatic denial of payment for claims that do not comply with Medicaid's policies, preventing the need for Medicaid auditors to later try to recoup these funds. As a result of the DME Audit Initiative, Florida Medicaid will potentially save approximately $1.3 million per year.

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.

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.

10-09 Aging Out Program – Aged and Disabled Adult Waiver

At the request of the Agency for Health Care Administration (Agency) management, IA audited the Aging-Out Program (Program) within the Aged and Disabled Adult (ADA) Waiver. The purpose of this audit was to evaluate the effectiveness of internal controls for program administration and claim payments.

The audit disclosed overall weaknesses in the areas of administration, monitoring and recipient case management. These control weaknesses resulted in missing and incomplete documentation, delivery of waiver services by unqualified providers, certain services provided concurrently contrary to waiver requirements, provider payments exceeding authorized amounts, services not properly authorized and improper provider payments for the unauthorized delivery of waiver services.

To improve and strengthen controls over the Program, it was recommended that the Bureau of Medicaid Services (Bureau) implement the following:

- Develop monitoring and audit policies and procedures to be utilized by the Bureau and independent case managers to ensure compliance with program requirements;
- When the Bureau acts as the "case manager," conduct face-to-face visits with recipients at least annually to ensure that services are only rendered as authorized and included in the written plan of care;

- Utilize referral agreements or contracts for independent case management service providers to establish responsibilities, improve coordination of services and increase effectiveness to ensure the program is being administered in accordance with program requirements;
- Develop tools to track issuance of authorization letters and the receipt of file documents such as the plan of care and level of care;
- Reword authorization letters to clarify the effective date of authorization and types of waiver services that cannot be provided concurrently;
- Audit a sample of provider claims quarterly for compliance with authorized amounts; and
- Recoup provider overpayments, where applicable.

10-10 Medical Claims Review Process Improvement

As part of the Agency's FY 2009-10 audit plan, Internal Audit conducted a consulting engagement on the Bureau of Medicaid Services' manual medical claims review process. The focus of this consulting engagement was to analyze and summarize medical claims data submitted for manual review to assist in management's evaluation of the medical claims review process.

During this engagement, IA worked with Medicaid staff to develop test scenarios to analyze and summarize claims submitted for medical review. The data analyzed for this engagement included all claims submitted with a Modifier 22 which forces the claim into manual review and/or included a system edit of 4345 which identifies procedure codes requiring manual medical review. The data pulled included paid and denied claims adjudicated between January 1, 2010 and June 30, 2010. IA provided a breakdown and summary of the claims submitted for medical review by Clerk ID, Duplicate Claims, Claims submitted with a Modifier 22, Location Codes, Procedure Codes and Denial Reasons to the Bureau of Medicaid Services for further analysis and review in order to improve the medical claims review process. IA recommended that management ensure that manual claim reviews are not performed on claims that the system would have denied based on other edits and audits. IA also recommended that procedure codes with extremely high rates of approval or denial be excluded from the medical claim review process.

Provider Data Analysis

IA assisted investigators from the OIG Investigations Unit in analyzing 80/20 claims data submitted by a Medicaid provider for calendar year 2009 and encounter data submitted for FY 2007-08 and FY 2008-09. Queries were run of three heavily used procedure codes and their applicable modifiers to identify any discrepancies in amounts that the Medicaid provider claimed versus the specified contract amount. IA specifically looked for duplicate claims and claims paid at above or below contracted amounts. The Investigations Unit presented the results of the analysis to the Medicaid Fraud Control Unit and requested an official investigation of the provider's claim process.

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 2010-11, the IU opened 119 fraud and abuse files and made 11 referrals for action by other agencies. Seven of these referrals were sent to the Medicaid Fraud Control Unit (MFCU) for potential criminal investigation. The IU identified and recovered $389,153 in overpayments. Additionally, the IU provided technical support for MPI general analysis projects.

Top Atypical Anti-Psychotic Medicaid Prescribers

In FY 2009-10, the IU initiated the review of Florida's top atypical anti-psychotic prescribers. These prescribers were identified and ranked based on the total dollars paid by Medicaid for pharmacy claims. The highest ranked FY 2009-10 prescriber was terminated from the Medicaid program. The IU continued its review of these prescribers during this reporting period. The results are discussed below.

Two Physician 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 onsite investigations of both physicians' clinics, attempted interviews with 54 of their Medicaid recipients and completed 28 recipient interviews. Ninety percent of all recipients interviewed 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. As a result of these findings, the IU made referrals to the Agency's Division of Health Quality Assurance, the Office of the Attorney General's Medicaid Fraud Control Unit (MFCU), the Florida Department of Health and other federal agencies. In addition, one physician was terminated from the Florida Medicaid Program. The second physician had no adverse findings.

The IU expanded the above investigation and compared encounter data submitted by one of the contracted health plan providers in Miami for Pre-Paid Mental Health Services with the correlating Medicaid recipient files. During this review, the IU found discrepancies in the data submitted by the contract provider, the recipient files and the cost actually paid to one of the sub-contracted mental health providers described above. Further investigation revealed the encounter data submitted by the contract provider and other mental health HMO providers conflicted with the signed contracts in effect and appeared to be in violation of Section 409.912(4)(b), F. S., that states in part, "If the

managed care plan expends less than 80 percent of the capitation paid for the provision of behavioral health care services, the difference shall be returned to the Agency." Preliminary review of this matter indicated that several claims exceeded the contracted amount and the 80/20 submission and appeared to be consistently adjusted to increase direct care services by ten percent to be in compliance with the 80/20 rule. Claims analysis revealed that of the one million plus encounters in the 80/20 data, approximately 9,000 did not contain mandatory reporting information. The data demonstrated a significant amount of encounters that were submitted, voided and then resubmitted at a higher dollar amount for unknown reasons, but were consistently a 10 percent increase in reported cost. This investigation was referred to MFCU for consideration and continues to be an active investigation.

Central Florida Atypical Anti-Psychotic Prescriber

An analysis of paid Medicaid pharmacy claims for FY 2009-10 identified a physician as causing more than $2.4 million to be billed to the Medicaid Program. The review determined that the physician treated patients in clinics located in central and north Florida. The patients ranged in age from six to more than 90 years old. Patient interviews resulted in allegations that the physician appears to write prescriptions for powerful anti-psychotic medications that have a high street value with minimal evaluation and monitoring of the patients. This investigation was referred to MFCU, where it remains an active investigation. Termination of the medical provider from the Medicaid program is pending..

Plea Agreement - Radiological and Diagnostic Imaging Review

In 2009, the IU conducted an onsite investigation of 10 clinics billing Medicaid for radiological and diagnostic imaging services in the Miami-Dade county area. The IU's preliminary findings determined that certain physicians were falsifying records, performing unnecessary tests and evaluations on patients, altering medical charts and committing insurance fraud. These findings were forwarded to MFCU and to the Florida Department of Financial Services, Division of Insurance Fraud.

During this reporting period one Medicaid physician pleaded guilty to grand theft, was ordered to pay restitution to the Agency and to MFCU, pay court costs and relinquished his Florida medical license.

A Medicaid clinic owner pleaded guilty to grand theft, was ordered to pay restitution and was ordered to no longer participate in any health care related business in Florida.

A second physician was referred to the Florida Department of Financial Services Division of Insurance Fraud. The physician was arrested for participating in a scheme to defraud private automobile insurance companies by participating in a staged automobile accident scheme. The physician was receiving kickback monies for signing treatment forms for persons falsely claiming to be injured in automobile crashes. The physician was charged with Insurance Fraud and Grand Theft. All the providers discussed in this radiological and diagnostic imaging review were terminated from the Florida Medicaid program.

South Florida Dentist

The IU initiated an investigation to determine if actively billing Medicaid dental providers were treating patients in long term care facilities. Medicaid policy states that "*Medicaid will reimburse for dental treatment provided in an office, inpatient hospital, outpatient hospital, or ambulatory surgical center (ASC) setting. Any treatment provided in a facility setting, as opposed to a non-facility office setting, must be related to at least one of the following conditions: the recipient's health will be so jeopardized that the procedures cannot be performed safely in the office, or "the recipient is uncontrollable due to emotional instability or developmental disability and sedation has proven to be an ineffective intervention."* Long term care facilities rarely have a designated area for the dental treatment of recipients and are responsible for transporting recipients in need of dental procedures to a dental provider. Provided dental care in unequipped long term care facilities creates health risks and allows facilities to eliminate their cost for transportation of the recipients. The investigation identified a dentist who was performing extractions and other invasive procedures on Medicaid recipients in a salon sink, a conference room and other potentially unsanitary and unequipped spaces in a long term care facility. An audit of the records of the dentist determined that he had provided services to mobile residents in the facility in violation of Medicaid policy. The dentist remitted the sum of $125,738 to the Agency for the identified violations. The dentist was referred to the Florida Department of Health for potential standard of care violations, where it is an active investigation. This provider has come into compliance with all Medicaid rules, regulations and handbooks and continues to maintain compliance based on random follow-up audits.

Central Florida Home and Community Based Waiver Provider

Information was received from an Agency employee after hearing concerns from a Home and Community Based Service Medicaid Provider. It was reported that a former Agency employee may have taken patient information to start their own business as a Project AIDS Care (PAC) Waiver provider. The allegations included monetary incentives to transfer Medicaid recipients and that the personal medical information relating to the recipient's HIV status had been shared with another agency without the patients' knowledge or consent. Staff from the IU and the Medicaid Field Office completed an onsite visit to the home office of the newly enrolled PAC Waiver provider. The IU also interviewed Medicaid recipients and other PAC Waiver providers who substantiated the allegations. This case was referred to the U. S. Department of Health and Human Services, Office of the Inspector General, for issues relating to possible HIPAA violations. The IU closed the case as the provider was terminated from the Medicaid Program prior to the Agency making any Medicaid disbursements and prior to the provider rendering any recipient care.

Medicaid Project AIDS Care (PAC) Waiver

In January 2011, the IU received a complaint from an Agency Field Field Office staff member who stated a Medicaid Project AIDS Care (PAC) Waiver recipient had reported that a pharmacy employee solicted his business by offering him gift cards. The gift cards were to be received in exchange for the recipient agreeing to use the pharmacy exclusively to fill his HIV medications. The Medicaid recipient was upset that his confidential information was used or shared without his consent. The IU completed two site visits to obtain additional information and investigated the allegations as well as

contacted Medicaid recipients in the PAC Waiver program. The IU verified that Medicaid PAC Waiver recipients were solicited for their business with offers of gift cards, elimination of co-payments, delivery of services and that the pharmacy staff contacted other PAC Waiver providers attempting to obtain recipient information (telephone and addresses) without the consent of the recipient. This case was referred to MFCU, where it was combined with another case that remains an active investigation.

Bureau of Medicaid Program Integrity

The Bureau of Medicaid Program Integrity (MPI), in the Office of the Inspector General, operating under Section 409.913, Florida Statutes, oversees 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. The Bureau identifies and recovers overpayments made to Medicaid providers and imposes 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 (DOH) or to other regulatory and investigative agencies.

MPI has approximately 100 full-time employees charged with preventing, detecting 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, the Department of Children & Families (DCF), the Agency for Persons with Disabilities (APD), the Division of Public Assistance Fraud (DPAF) and the federal Centers for Medicare & Medicaid Services (CMS).

MPI is organized into the following major units:

Intake and Assessment Unit

All referrals made to MPI, whether from complaints, the hotline, or submission of Explanation of Medicaid Benefits (EOMBs), are the responsibility of the Intake and Assessment Unit. Each referral undergoes an initial review to validate the information and determine the appropriate course of action. EOMBs are mailed quarterly to Medicaid recipients listing the services each received during the previous quarter. The recipients are asked to report any services listed that they did not receive. The Intake Unit follows up on each discrepancy. Providers are requested to void the claim if it is determined that the services were not provided. If a pattern is noted, the provider will be referred to the appropriate MPI Case Management Unit (CMU) or to MFCU. Complaints received by telephone or the Internet may or may not be Medicaid fraud or abuse related. Complaints that are not MPI issues are forwarded to the appropriate agency for action. Any information regarding possible fraud or abuse is evaluated and, if substantiated, referred to the appropriate MPI unit or to MFCU for further investigation.

The Intake Unit also monitors press releases on the Internet and articles by the Bureau of National Affairs for any news relating to an investigation, arrest or conviction of a Florida Medicaid provider. Providers who are under indictment for activity relating to health care practices are suspended from participation in the Florida Medicaid program for the duration of the legal proceedings and a conviction results in termination. This past fiscal year, MPI recommended the imposition of 24 suspensions and 13 terminations as a result of these monitoring efforts.

The Field Assessment Unit operates throughout the state from offices located in Jacksonville, Orlando, Tampa and Miami. This presence in the community is vital to MPI's efforts in combating fraud, waste and abuse in the Medicaid program. Field office employees are responsible for conducting comprehensive onsite visits and for performing recipient interviews to ascertain whether services were rendered and, if rendered, determining if they were appropriate. Based on observations during the site visit and from review of records, any one of several actions may be taken, including:

- Application of administrative sanction;
- Placement on prepayment review;
- Initiation of paid claims reversal;
- Referral to MFCU;
- Referral to an MPI Case Management Unit;
- Referral to another agency;
- Referral to self-audit unit to initiate a provider self-audit; and
- Recommendation for termination.

The Field Assessment Unit also performs several field initiatives (focused projects) each year. These initiatives focus on simultaneous reviews of recipients, providers and prescribers. They often include collaboration with state and federal partners, such as the Division of Health Quality Assurance, the Medicaid Division, the Department of Health, the Agency for Persons with Disabilities, MFCU and the Centers for Medicare & Medicaid Services.

Field office staff members serve as the primary communication channel among MPI and Medicaid Field Offices, local governments and law enforcement entities. The staff members participate in regularly scheduled meetings that include federal, state and local health care regulators with the goal of improving interagency communication. Presentations on the roles of MPI are made for other agencies and providers.

Field office staff members also participate in Operation Spot-Check visits throughout the state. These unannounced visits are managed by MFCU and are made to nursing homes, assisted living facilities and licensed group homes. Operations of these facilities are reviewed to ensure that Medicaid policies and procedures are being followed. Additional action by MPI may include prepayment reviews, records requests and referrals, as determined appropriate.

Field Office Initiatives

Field office initiatives have resulted in sanctions, reversal of claims, referrals and placing providers on prepayment review. Some of the initiatives completed during the last fiscal year are described below.

October 2010 Home Health Prescriber Project

MPI, in conjunction with the Division of Medicaid's Fraud Prevention and Compliance Unit and the Centers for Medicare & Medicaid Services' Medicaid Integrity Group, conducted 60 physician site visits as part of a home health prescriber initiative that focused on the top ordering physicians of home health services in Miami-Dade County. MPI, with the assistance of its State and Federal partners, reviewed the home health prescribers' medical records to determine overall compliance with Medicaid policy as it relates to rendering home health services as outlined in both the Home Health and the Physician Services Coverage and Limitations Handbooks.

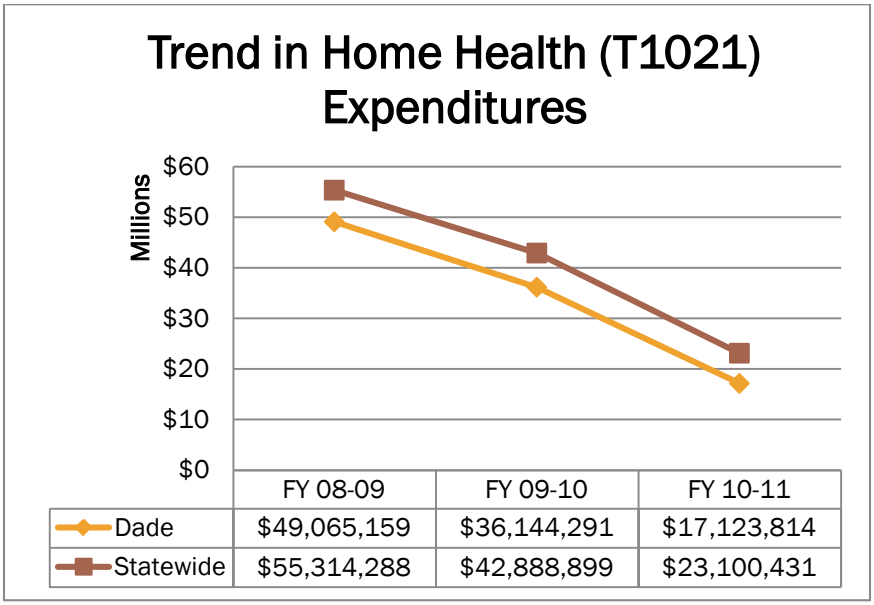
The primary goals of the October 2010 Home Health Prescriber Project were to determine whether prescribers of home health services were in compliance with Medicaid policy, including new requirements that apply to the ordering of physicians' prescriptions for services and maintenance of required documentation.

Actions resulting from this initiative included:

- 18 sanctions - 7(c) & 7(e) violations - with $49,000 in total fines. This money was recovered by the Agency.
- Paid Claim Reversals - ($5,100). This money was received by the Agency.
- 36 Department of Health referrals. DOH verified that they have contacted the physicians involved in this initiative. Referrals range from minor infractions to potential licensure action.
- One prepayment review. The physician has produced all records in question.
- 15 CMS referrals. CMS has verified receipt of the referrals and will notify MPI as they review them.
- Three CMU referrals. MPI Field staff continues to work these cases.
- One Department of Business and Professional Regulation referral. MPI has not been notified of the receipt or outcome of this referral and will continue to monitor.
- One AHCA - Medicaid Contract Management referral. This provider was placed on pre-payment review and has stopped billing the Florida Medicaid program.

Home Health Initiatives – Update

As the chart below illustrates, the continual efforts on the part of the Agency and the addition of the telephony project in July 2010 to control the overutilization of home health aide visits, have produced a steady decrease in the amount of Medicaid expenditures for home health services. 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 $49.1 million for FY 2008-09 to $17.1 million in FY 2010-11. This represents a decrease of $32 million or 65 percent in two fiscal years. Since expenditures in Miami-Dade County represent a large percentage of the state's expenditures, the statewide trend closely mirrors the numbers found in Miami-Dade County.



	FY 08-09	FY 09-10	FY 10-11
Dade	$49,065,159	$36,144,291	$17,123,814
Statewide	$55,314,288	$42,888,899	$23,100,431

March 2011 DME Initiative

This initiative targeted 11 durable medical equipment (DME) providers that were top billers for procedure code E1390 (Oxygen Concentrator) for dates of service from January 1, 2010 through February 25, 2011 in Miami-Dade and Broward counties. Nine teams of investigators conducted 11 provider compliance site visits and interviewed 85 Medicaid recipients who received oxygen concentrators and additional medical equipment during the review period.

The primary goals of the DME project were to verify that oxygen-related services were being rendered and were medically necessary; to determine whether the medical equipment at the recipient's home was in working condition and properly maintained by the provider; to ensure that recipients were trained on how to use the medical equipment; and to ensure compliance with Medicaid policies.

During the last fiscal year Medicaid spent approximately $126 million for durable medical equipment on behalf of approximately 232,000 Medicaid recipients. The top five durable medical equipment expenditure categories were oxygen concentrators, blood glucose test strips, nebulizers, enteral

feeding support kits and urinary catheters. These five made up 29 percent of the total funds spent on durable medical equipment. Oxygen concentrators were the top durable medical equipment expenditure category. In the Miami-Dade area alone, Medicaid reimbursement for oxygen concentrators exceeded $1.6 million (14 percent of the $11.5 million spent statewide).

Action resulting from this initiative included:

- Six sanctions - (7 (e) violations - $24,000 in total fines). This money has been recovered by the Agency.
- Paid Claim Reversals - ($30,255). This money has been recovered by the Agency.
- Two CMS referrals. CMS continues to investigate these referrals.
- One AHCA-Health Quality Assurance referral. HQA followed up and all deficiencies were remedied.

Speech Therapy Initiative in Miami

The MPI field office in Miami initiated a Speech Therapy Project in Miami-Dade and Broward county areas to determine whether speech therapy services were rendered, documented and billed in accordance with Medicaid guidelines outlined in the *Therapy Coverage and Limitations Handbook*.

The primary goals of the Speech Therapy project included determining whether services were rendered in compliance with policy and procedures, were medically necessary, were properly documented and followed plans of care.

Action resulting from this initiative included:

- Two sanctions - (7(e) violations - $13,000 in total fines). The money has been recovered by the Agency.
- Paid Claim Reversals - ($16,187). All claims have been voided.
- Two prepayment reviews - ($10,977 in denied claims). All documentation was received and the reviews were closed.
- One CMU referral. This continues to be an active investigation
- One provider under MFCU investigation. MFCU requested the patient records and MPI is waiting for direction from MFCU.

Data Analysis Unit

The Data Analysis Unit detects potential fraud and abuse in the Medicaid program. This unit, through its Data Detection Section and the Special Projects, Research, Development and Coordination Section (RDU), provides programming support for other MPI units and develops generalized analyses.

The Data Detection Section reviews detection reports and analyzes claims data. It develops leads for the Case Management Units and works closely with MPI's Medicare partners to identify fraud and abuse issues related to claims paid by both Medicaid and Medicare. The section works with MFCU

to coordinate data detection projects. The Data Detection Section detects violations through various detection tools and methods. On the basis of apparent violations, investigations are conducted to determine whether overpayments exist. Recoveries of any overpayments are initiated by Case Management Units and referrals to outside agencies may occur. The Data Detection Section utilizes the tools, resources and reports described below in an effort to identify instances of Medicaid fraud and abuse activities.

The RDU has the primary responsibility of developing generalized analyses and providing programming support for other MPI units. A generalized analysis is a computer-assisted review of all of the claims involving specified procedure codes of all providers of a given type. Overpayments relating to these claims are determined and summarized for providers. The unit examines prior generalized analyses that have resulted in finding overpayments and reruns them as appropriate for subsequent time periods. The unit meets regularly to discuss leads from the CMUs and Data Detection Section, analyzes policy to identify potential violations and monitors requests for generalized analysis programming for assignment to the CMUs. It also provides additional programming support to other MPI units on complex issues. The section guides providers in performing self-audits for overpayments due to Medicaid abuse or mistake and is responsible for coordinating all Medicaid policy clarifications for MPI through the Bureau of Medicaid Services. It serves as MPI's contact point for overpayment recovery projects performed by the third party liability vendor, ACS.

Medicaid Program Integrity Detection Methods

Detection efforts by MPI can result from leads from incoming complaints and referrals, information from other regulatory agencies, newspaper articles or advertisements, Explanation of Medicaid Benefits (EOMBs), the Agency's Division of Medicaid and the Medi-Medi partnership with the Medicare program, as well as from data mining.

Detection Tools

MPI's primary detection tools include the DSS*Profiler*, First Health Pharmacy reports, BusinessObjects ad hoc data mining reports, 1.5 reports of unexpectedly high payments, Chi-square statistical reports of overpayments due to upcoding and Early Warning System reports of projected steeply rising payments. These tools provide a means for MPI to analyze Medicaid claims data and detect aberrant behaviors, overutilization patterns and noncompliance that result in referrals to MFCU and other regulatory agencies. They produce leads for further investigation by MPI's field staff and Case Management Units.

The *DSSProfiler* 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 is 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 *DSSProfiler*. 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 value of the standard deviation. Providers that stand out based on the standard deviation analysis 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 Surveillance and Utilization Review System (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 utilized pharmacies report.

BusinessObjects ad hoc reports are used by auditors to access Medicaid claim information within the FMMIS and DSS. The FMMIS processes and pays provider claims and contains claim-related information on Medicaid providers, recipients, drugs and medical services. The DSS stores seven years of providers' claims history and contains the *DSSProfiler* datamart, a type of 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. When the report leads to the identification of providers who are misbilling the Medicaid program, an audit is initiated.

Chi-square reports utilize a nonparametric statistical analysis developed by MPI to determine possible overpayments to providers who engage in upcoding, or using a higher-paying procedure code (in a series of codes) than warranted. The analysis yields estimates of overpayments at a very high confidence level. 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 System reports were developed by MPI to determine projected rates and amounts of increase in payments to providers. Regression analyses are performed using exponential curve fitting. 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. Total projected payments for the next year are calculated and compared to actual payments for the year just ended. Payment data are obtained from the 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 are 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 authorities to prevent, identify, analyze and investigate Medicaid fraud and abuse. The Medi-Medi contractor is Safeguard Services, LLC.

Another tool used this past year was social network analysis. Analysis of relationships between individuals, entities and regulatory agencies' data was used to identify Medicaid providers excluded by the federal government, excluded by other State Medicaid programs or against whom DOH had taken adverse action.

The detection tools described above identify outlier providers who exhibit general patterns of aberrant behavior including overutilization, upcoding, unbundling and double billing. Each provider type has specific benchmarks applicable to these aberrant patterns. These tools identified providers for audits or referrals to MFCU for potential criminal investigation and helped identify areas that require comprehensive reviews or prepayment reviews.

Special Analysis – "Pill Mill" Data Initiative Update

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). Fiscal Year 2009-10 was the first year that the Agency, Medicare contractors and local, state and federal law enforcement agencies 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. 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 recommended Medicaid program termination on nine physicians in the Medicaid prescription payment system and they were terminated.

Since October 2009, MPI has been furnishing pill mill information to various state entities. Most recently, data were refreshed for the Governor's statewide pill mill effort. MPI is currently working with FDLE to report providers who are overprescribing these targeted drugs.

Joint MPI and MFCU Referral and Data Mining Meetings

Staff members of MPI and MFCU continue to meet biweekly to discuss potential referrals to MFCU and to share ideas for data mining 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.

Data Mining 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 convene 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. MFCU has concluded its first set of data mining initiatives and has shared their findings with the Agency.

Quad State Teleconference

The Data Detection Section of MPI organized a teleconference with peers to discuss fraud and abuse detection activities. Medicaid Program Integrity staff members from New York, California and Texas were invited to attend. 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, 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 *DSSProfiler*, a discussion was held concerning the use and efficacy of that software. Based on positive response to this initial

teleconference, additional meetings have been held quarterly. This new avenue of networking and exchanging information and ideas enhances Florida's efforts to prevent, detect and recover Medicaid overpayments.

Case Management Units

Each of the Case Management Units identifies misspent Medicaid funds by performing comprehensive audits and generalized analyses. Once providers have been selected for audit, generally accepted statistical methods are used in the generation of a random sample of the provider's claims. If, after a review of provider documentation, an overpayment is determined for the sampled claims, the sample 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 administrative hearings.

CMUs perform claim reviews, prepayment reviews, make policy or edit recommendations and assist with the litigation process. The CMUs are organized primarily by the types of providers each investigates, as follows:

- The Institutional Unit conducts audits of institutional providers such as hospitals, nursing facilities, health maintenance organizations and ambulatory surgical centers.
- The Medical Unit conducts audits primarily of non-institutional providers, such as physicians, independent laboratories, advanced registered nurse practitioners and county health departments.
- The Pharmacy and Durable Medical Equipment Unit conducts audits primarily of non-institutional types of providers such as pharmacies and durable medical equipment providers.
- The Waiver Unit conducts audits related to the Home and Community Based Waiver Program and of providers such as dentists, audiologists, podiatrists and chiropractors.
- The Case Management Unit also serves as the Bureau's point of contact for the Federal Audit Program. The Centers for Medicare & Medicaid Services (CMS) created the Medicaid Integrity Group (MIG) to carry out the program. CMS has also established contracts with private firms referred to as Medicaid Integrity Contractors (MICs) to conduct the audit program. The three primary MIC functions are:
  1. The "review MIC," which analyzes Medicaid claims data to determine whether provider fraud, waste or abuse has or may have occurred;
  2. The "audit MIC," which audits provider claims and identifies overpayments; and
  3. The "education MIC," which provides education to providers and others on payment integrity and quality-of-care issues.

Medicaid Program Integrity 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 Medicaid 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, site visits to certain Medicaid providers in specified geographic areas and the application of administrative sanctions, as appropriate. These steps are discussed below.

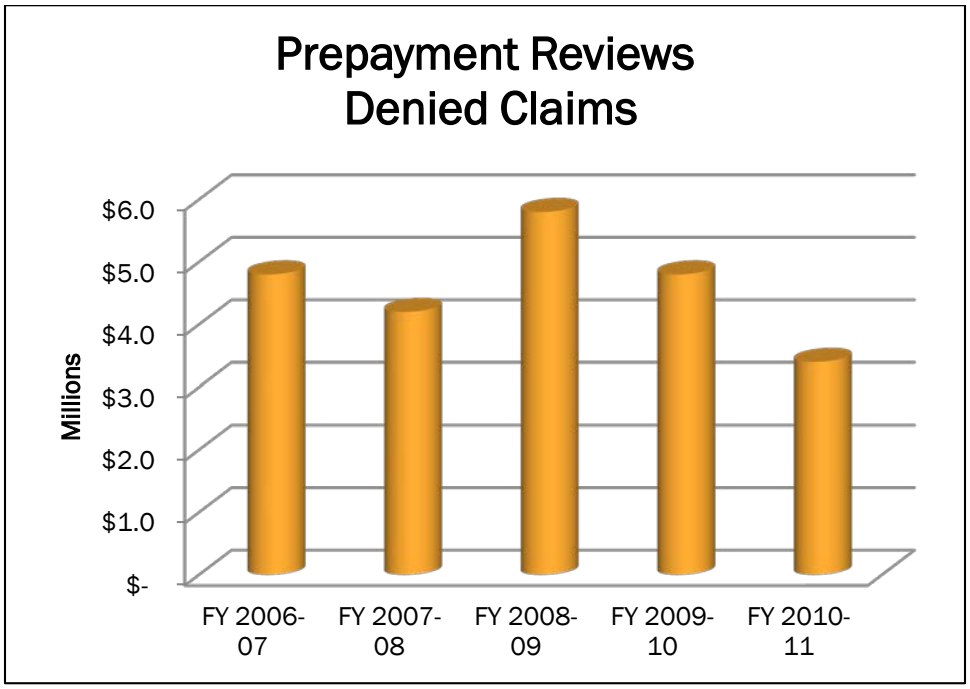
Prepayment Reviews

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 for questionable claims has not yet been sent to the provider. "Pended claims" are questionable claims that have not yet been processed for payment. In prepayment review, claims not having proper documentation are denied.

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. 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.

During FY 2010-11, MPI initiated 373 prepayment reviews. Claims denied for 272 different providers resulted in cost avoidance of $3.4 million as shown below:

Prepayment Reviews	FY 2010-11
Number of Claims Reviewed	108,408
Number of Claims Denied	93,991
Amount of Claims Reviewed	$5,636,700
Amount of Claims Denied	$3,379,731



Termination Recommendations

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 a 30-day 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 2010-11, these terminations saved Medicaid $1.8 million.

Focused Projects

Home Health (#268)

Medicaid Program Integrity, in conjunction with the Medicaid Integrity Group of the Centers for Medicare and Medicaid Services (CMS) and other organizations, conducted site visits to the offices of 96 physicians who were prescribers of home health services. The purpose of the visits was to assess and improve providers' compliance with Medicaid policy. Practices were evaluated, modifications were instituted and sanctions as appropriate were applied. The visits led to estimated cost savings of $420,000 as discussed below.

Speech Therapy

Medicaid Program Integrity's Miami field office initiated a Speech Therapy Project in Miami-Dade and Broward Counties to determine whether speech therapy services were rendered, documented and billed according to the Medicaid policies. Speech Therapy is provided to children under the age of twenty- one. Providers were visited, operations assessed and sanctions were applied as appropriate. The visits led to estimated cost savings of $222,000 as discussed below.

Home Health (#309)

Medicaid Program Integrity, again in conjunction with CMS and other organizations, conducted sixty (60) physician site visits as part of a home health prescriber initiative that focused on the top ordering physicians of home health services in Miami-Dade County. Home health prescribing practices were evaluated, modifications instituted and in some instances sanctions were applied. The visits led to estimated cost savings of $523,000 as discussed below.

Cost Savings

The calculation of cost savings attributed to focused projects is based on the difference in total payments to the providers for the twelve month periods before and after the date of the project. If a particular set of procedures was the focus of the project, only costs related to those procedures may be considered in the cost analysis. For the projects described above, the estimated cost savings were $1.2 million for FY 2010-11.

Site Visits

Staff members from the Bureau of Medicaid Program Integrity visited a number of Medicaid providers this past fiscal year. These visits ensured 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 2010-11 resulting from site visits conducted in the prior year were $12.1 million. Actual site visits conducted during FY 2010-11 by provider type are noted below.

Site Visits Conducted During FY 2010-11	
Provider Type	**Number of Visits**
Assistive Care Services	42
Community Alcohol, Drug, MH	3
Dentist	5
Home & Community Based Services	292
Hearing Aid Specialist	1
Home Health Agency	16
Medical Supplies/Durable Medical Equipment	41
Nursing Home	1
Pharmacy	44
Physician (DO)	6
Physician (MD)	74
Physician Assistant	1
Therapist	25
Other	1
Total Site Visits	552

Administrative Sanctions

The Office of Program Policy Analysis and Government Accountability (OPPAGA) in March 2010 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 concerned strengthening 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 Sanctions 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 sanctions rule, as amended, provides for the termination of providers with egregious billing practices from the Medicaid program and increased 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 for the first violation from $1,000 per record request to $2,500 per record request and suspension until the records are made available. 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 percent 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 percent of the overpayment amount; and upon third violation a $5,000 fine per claim up to 50 percent 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.

During FY 2010-11, 643 Medicaid providers received the sanctions shown in the table below for violations set forth in Rule 59G-9.070, F.A.C. These sanctions included suspensions and terminations from the Medicaid program, fines totaling $957,609 and corrective action plans.

	FY 2009-10		FY 2010-11	
Type Sanction (Rule 59G-9.070, F. A. C.)	Number of Sanctions	Total Fines	Number of Sanctions	Total Fines
Fine Sanctions	420	$666,740	565	$957,609
Suspensions	12		106	
Terminations with cause	37		44	
Terminations without cause*	18*		55*	
Corrective Action Plans	38		2	
Total Sanctions	507		717	

*Not a sanction under the Rule.

The application of an administrative sanction, such as a fine, upon a provider may be expected, on average, to have the effect of reducing future inappropriate billings from and payments to the provider. In order to estimate the amount of this effect, payments to sanctioned providers for the years prior to and following the application of the sanction have been examined. Sanctions include requirements for corrective action plans, application of administrative fines, provider suspensions and terminations. The types of providers studied include only those having billings of a magnitude likely to be influenced by the sanctions. This effect has been examined for providers sanctioned in FY 2009-10, so that the payments for the years prior to and following the date of application of the sanction could be reviewed. Providers receiving the sanction of termination were not included in this analysis, since they are reviewed and reported on separately. It is estimated that a total of $3.6 million was cost-avoided in FY 2010-11 as a result of the application of administrative stations during the prior fiscal year.

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, the coordination of 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. In addition, amounts were recovered through offsets to future payments and through contractual assessments.

MPI Audits

Recovery efforts by MPI 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 statistically valid random sample of claims from that population. The sampled 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 3,841 cases concluded during FY 2010-11. Of these, 300 were sanction only cases, 115 cases concluded with contractual assessments, 513 required provider education letters and 1,907 identified overpayments. These cases identified overpayments of $39,011,157. For the remaining cases, no fraud or abuse was found.

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, licensed pharmacists within MPI 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.

Offsets to Future Payments

Subsection 409.9124(5), F. S., states with regard to managed care reimbursement: "The Agency shall develop two rates for children under 1 year of age. One set of rates shall cover the month of birth through the second complete month subsequent to the month of birth and a separate set of rates shall cover the third complete month subsequent to the month of birth though the eleventh complete month subsequent to the month of birth. The Agency shall amend the payment methodology for participating Medicaid-managed health care plans to comply with this subsection." Information obtained from the Florida Medicaid Management Information System (FMMIS) revealed rate errors in the payment of the first rate set during the period August 1, 2005, through October 31, 2005, resulting in overpayments to 10 Health Maintenance Organizations. A total of $20,031,041

was recouped with $17,305,273 recouped by the Agency's fiscal agent from future payments due to the HMOs and the remaining $2,725,768 being paid by certain HMOs to the Agency's Bureau of Finance and Accounting.

Contractual Assessments

Pursuant to Subsection 409.913 (19), F. S., this project was a follow-up review of the newborn enrollment and unborn activation process. A previous audit of this process was conducted by MPI for dates of service of July 1, 1996 – June 30, 2000. In that project, it was determined that the Health Maintenance Organizations failed to implement fully the newborn enrollment and unborn activation process. In the follow-up project, demand letters were sent to the plans on July 1, 2008, identifying suspect Medicaid recipient fee-for-service claims and requesting documentation for newborns whose mothers were members of the HMO, thereby making the newborn's enrollment and activation the responsibility of the plan. The subsequent records review confirmed that the plans did not comply with the proper process in all cases. At the completion of the project, contractual assessments totaling $11,137,903 and costs of $1,389,668 were determined. All monies have been received.

Third Party Liability Contractor-Assisted Audits

MPI coordinated and assisted the Third Party Liability contractor's development of computer-assisted analyses of paid Medicaid claims. These efforts identified and collected overpayments of more than $30 million for the State of Florida.

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 585 referrals in FY 2010-11. Of the 80 MFCU referrals, five were closed and 75 remain under investigation. Criminal charges have been filed in one referral. There was one arrest of a provider who was suspended from the Medicaid program by AHCA upon notification of their arrest. Allegations were unsubstantiated in one referral and no fraud predicate was found in the other two.

Number of MPI Referrals	
Referral to:	**FY 10-11**
Department of Health	80
Florida Department of Law Enforcement	20
Health Quality Assurance Division	58
Medicaid Division	41
Medicaid Fraud Control Unit	80
Other	306
Total	**585**

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. 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 and collected by Finance and Accounting for the last four fiscal years. The overpayments collected at August 31, 2011 reflect collections, regardless of the year collected, on the overpayments identified during a fiscal year. There is a lag between the date that an overpayment is identified and the date that it is collected due to payment plans, liens and other collection efforts. In addition to the recoveries of overpayments noted in this table, overpayments in excess of $18 million were identified and recovered through paid claims reversals (PCRs).

Fiscal Year	Type of Recovery	Overpayments Identified In Indicated Year	Accounts Receivable Collections as of August 31, 2011	Percent Collected
2007-08	Accts. Receivable	$15,628,918	$12,661,064	81.0
2008-09	Accts. Receivable	15,625,437	13,285,314	85.0
2009-10	Accts. Receivable	18,800,058	14,346,406	76.3
	Accts. Receivable	$20,755,570	$18,144,792	87.4
	Offsets Against Future Payments and PCRs	18,255,588	18,255,588	100.0
2010-11	**Total** Audits, Offsets and PCRs	$39,011,157	$36,400,380	93.3

Closed Cases

MPI closed 3,841 cases during FY 2010-11. Of these, 1,907 cases identified overpayments.

MPI Closed Cases by Fiscal Year					
Fiscal Year	**2006-07**	**2007-08**	**2008-09**	**2009-10**	**2010-11**
Overpayments Identified[1]	**811**	**791**	**1,288**	**1,807**	**1907**
No Fraud or Abuse Found	**177**	**331**	**309**	**401**	**1006**
Provider Education Letter	**30**	**4**	**17**	**158**	**513**
Sanctions Only[1]					**300**
Contract Assessments[1]					**115**
Total Cases Closed	**1,018**	**1,126**	**1,614**	**2,366**	**3,841**
Percentage with Findings	**79.7%**	**70.2%**	**79.8%**	**76.4%**	**60.5%**

[1] Cases with Findings.

Providers Selected at Random for Audit

For FY 2010-11, the Case Management Units initiated ten random comprehensive audits pursuant to Subsection 409.913(2), F. S. "At least 5 percent of all audits shall be conducted on a random

basis." The providers selected for audit were randomly selected contingent on their billing Medicaid for the audit time period and being an active provider. The randomly selected provider's ID number was validated in FACTS to determine the provider's prior audit history and to ensure the provider was not currently being reviewed by MFCU. If the provider had been audited within the past four years or was under review by MFCU, then another provider was randomly selected for audit.

Of the ten random audits initiated during FY 2010-11, results at year's end showed that five audits had been completed and closed. In these five audits, the review of the requested records/documentation revealed no findings of abuse or fraud in the billing of Medicaid. These five providers had been paid a total of $1,870,027 for the audit review period. Five audits remain under review and analysis of the provider's documentation has not been completed.

During the prior fiscal year, five of the 11 random audits initiated during FY 2009-10 had been completed and closed at the time of the prior annual report. All eleven random audits initiated during FY 2009-10 have now been completed and closed. The final results show that, in six of those audits, the review of the requested records/documentation revealed no findings of abuse or fraud in the billing of Medicaid. The providers had been paid a total of $4,597,252 for the audit review period. In the other five audits, findings of improper billing resulted in overpayment identification of $56,416, or 2.56% of the total dollars paid ($2,200,866) to the providers during the audit review period. Those providers have either fully repaid the identified overpayment or are making payments based on repayment plans.

MPI Highlights

Following their audit, a Managed Care Organization notified MPI that there was an allegation of billing for services not rendered against a pharmacy provider. The Pharmacy Case Management Unit opened a comprehensive case on the provider, located in Miami, Florida. A review of the provider's purchase/acquisition records for a one-year period revealed a shortage of drugs available to support the payments made to the provider by Florida Medicaid for all 25 of the drugs that were reviewed, with an overpayment identified of $444,193. Additionally, a fine of $5,000 was applied and the provider was referred to the Medicaid Fraud Control Unit. As of November 2010, the fine had been paid and $175,000 of the overpayment had been collected. When only partial payment was collected and no payment arrangements were made, the provider was terminated from the Medicaid program. The criminal investigation at MFCU is ongoing.

The Pharmacy Case Management Unit referred a pharmacy provider to the Intake and Field Analysis Unit for a site visit. The site visit resulted in the opening of a case on the provider, located in Hialeah Gardens, for a comprehensive audit by the Pharmacy Case Management Unit. The review of the provider's purchase/acquisition records for a one-year period revealed a shortage of drugs available to support the payments made to the provider by Florida Medicaid for 24 of the 29 drugs that were reviewed. An overpayment of $231,113 was identified. Additionally, a fine of $24,000 was applied. The provider arranged a payment plan and signed a payment agreement. As of July 2011, the fine had been paid and $133,470 of the overpayment had been collected.

A Medicaid Home and Community Based Services waiver provider was reported using the Medicaid Fraud & Abuse hot line alleging that the provider was billing for more units of service than actually provided. In addition, on an alert report monitored by MPI, the provider was repeatedly ranked #1 in amounts billed. MPI reviewed claims with dates of service from January 2003 through December 2004. The provider had billed over $12 million for the period and the final audit report listed the overpayment at $1,647,961 with a $2,000 fine. The provider requested a hearing and after additional documentation was submitted and reviewed, the overpayment was adjusted to $312,774. After a three-day administrative hearing in July and August 2010, the final overpayment was established at $284,568 with a $2,000 fine sanction. The *Final Order* including a payment plan and settlement agreement was issued in February 2011. The provider is making the prescribed repayments and MPI continues to monitor their billings.

A Medicaid provider of hearing aid services was referred to MPI by Medicaid Services in June 2009. It was alleged that the provider was rendering services to recipients in skilled nursing and assisted living facilities without proper authorization and that he was soliciting for services. MPI audited for the period January 2007 through December 2008. The provider was enrolled as an individual practice but operated as a group. After review by a peer, it was determined that the provider did not have required prescriptions, lacked the appropriate candidacy requirements and billed for services not rendered. In November 2009, the provider was referred to MFCU, which opened a case and reviewed the provider. MFCU closed their case in January 2010 and referred him back to MPI for administrative collection. MPI identified an overpayment of $182,637 in the preliminary audit report. The provider responded to the report with additional information, but after review the peer did not make any changes to his findings and the final audit report was issued for the same amount plus a fine sanction of $6,500 and costs of $609 for a total amount due of $189,746. After initially requesting a hearing, the provider agreed to settlement for the full amount. The *Final Order* was signed in May 2011 and the provider has made full repayment.

A Medicaid neurological physician provider located in St. Petersburg was identified for inaccurate billing of Evaluation and Management codes. A review of the provider's claims from November 1, 2006 through October 31, 2008 identified three areas of concern. These areas were upcoding, no documentation of services and services billed that were not medically necessary. A Final Audit Report was completed in January 2011, with an overpayment in the amount of $75,837, plus $3,500 in fines and costs in the amount of $1,699. The provider has paid the overpayment and identified sanctions and costs in full. The *Final Order* was filed in March 2011.

A Medicaid pediatric physician provider located in Hollywood was identified for inaccurate billing of Evaluation and Management codes. A review of the provider's claims from January 2008 through May 2009 identified three areas of concern, namely, upcoding, no documentation of services billed and billing for laboratory services that are to be included in the routine office visit. A Final Audit Report was completed in March 2011, with an identified overpayment in the amount of $314,837, plus a fine of $3,000 and costs of $1,160. The provider paid the overpayment, sanction and costs in full. The *Final Order* was filed in May 2011.

In addition to performing comprehensive and focused audits, the Pharmacy Case Management Unit does ongoing reviews of paid claims to identify those claims that appear to be overpaid due to

overbilled quantities. When such a claim is identified, the provider is contacted and once it is determined that the claim was in fact overbilled, the provider is requested to reverse the claim and rebill it correctly. In this manner, Medicaid recoups the money paid in error. In FY 2010-11, 144 files were opened by the Pharmacy/DME Case Management Unit to initiate and monitor paid claims reversals, with some files involving multiple claims. A total of $237,552 was saved by these reversals. This represented an increase from the previous fiscal year when paid claims reversals by the unit totaled $168,831.

A review of HMO newborn enrollment and unborn activation processes established that HMOs did not fully comply with the process as specified and required under contract. This resulted in Medicaid paying fee-for-service claims for babies that the HMOs, according to the contract, were responsible for paying. For the period of July 1, 2004 through December 31, 2007, contractual assessments of $11,137,903 and costs of $1,389,668 were determined. As reported earlier under Contractual Assessments, this project has resulted in the recoupment of contractual assessments in the amount of $10,842,903 and costs in the amount of $1,389,668.

The Bureau's Tampa field office, working in conjunction with the Agency's Division of Health Quality Assurance, referred a Vero Beach woman who owned and operated an ALF to the Medicaid Fraud Control Unit. After investigating, the MFCU subsequently charged her with defrauding the Florida Medicaid program. She was arrested for fraudulently billing the Medicaid program by claiming that six Medicaid recipients were living at the assisted living facility when they actually were in an independent living environment collocated within the facility. She was charged with one count of Medicaid fraud and one count of grand theft, both second-degree felonies. If convicted, she faces up to 30 years in prison and a $20,000 fine. The case will be prosecuted by the State Attorney's Office for the Nineteenth Judicial Circuit. The arrest resulted from an investigation initiated by the Medicaid Fraud Control Unit after receiving information from the Agency for Health Care Administration. AHCA field offices for Medicaid Program Integrity and Health Quality Assurance worked together to share information that each office had obtained. This provider was suspended from the Florida Medicaid program upon notification of arrest.

In August, MPI field staff assisted the Patient Abuse Neglect and Exploitation (PANE) Team within the Attorney General's Medicaid Fraud Control Unit with an inspection of an assisted living facility. The inspection revealed that the facility's license had been expired for over a year and the owner was operating the facility with an expired license. MPI completed a paid claims reversal request for the provider to reverse claims that were billed while the facility's license was expired. The provider did not respond and was subsequently sanctioned and terminated.

Funding for Medicaid Program Integrity and Return on Investment

In FY 2010-11, MPI efforts resulted in the collection of $83.1 million in overpayments, investigative costs and fines, as shown in the table below. MPI prevention efforts resulted in cost savings of $22.1 million as shown in the second table below.

MPI Recovery Activities (Millions)				
	FY 07-08	FY 08-09	FY 09-10	FY 10-11
MPI Audits (Overpayments Collected)	$14.9	$15.4	$16.4	$38.8
Costs (Collected by F&A)				1.5
Fines				1.0
Paid Claims Reversals	0.5	0.3	1.5	1.0
Contractual Assessments				10.8
TPL Contractor-Assisted Claims Adjustments	12.8	34.6	40.6	30.0
Total	$28.2	$50.3	$58.5	$83.1

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

MPI Prevention of Overpayments ($ Millions)								
	FY 2007-08		FY 2008-09		FY 2009-10		FY 2010-11	
	No.	Amount	No.	Amount	No.	Amount	No.	Amount
Prepayment Review	156	$4.2	99	$5.8	116	$4.8	272	$3.4
Termination of Providers	255	5.4	152	3.2	68	1.8	99	$1.8
Focused Projects	3	9.8	3	2.6	7	5.1		$1.2
Denial of Reimbursement for Prescription Drugs	40	0.5	3	0.3	-	-	-	-
Policy Changes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Site Visits	229	1.8	481	6.5	410	7.4	-	$12.1
Sanctioned Providers	-	-	-	-	-	-	525	$3.6
Total		$21.7		$18.40		$19.10		$22.1

(Prior year totals adjusted by the removal of Fine Sanctions Imposed.)

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 $8.5 million were devoted to recovery work resulting in collections of $83.1 million and a return on investment for recovery operations of 9.8:1. In addition, MPI achieved $22.1 million in cost avoidance with expenditures of $5.7 million, producing a return on investment for prevention efforts of 3.9:1. Overall, in FY 2010-11, audit recoveries and cost avoidance amounts totaled $105.2 million, yielding a return of 7.4:1, as shown on the following chart.

Medicaid Program Integrity Return on Investment ($ Millions)					
			Benefits	**Costs**	**ROI**
FY 2007-08	Recovery		$28.2	$7.5	3.8:1
	Prevention		$21.5	$5.0	4.3:1
		Total	$49.7	$12.4	4.0:1
			Benefits	**Costs**	**ROI**
FY 2008-09	Recovery		$50.3	$9.1	5.5:1
	Prevention		$18.9	$6.0	3.2:1
	Pharmacy Rebates		$13.4		
		Total	$82.6	$15.1	5.5:1
			Benefits	**Costs**	**ROI**
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**
			Benefits	**Costs**	**ROI**
FY 2010-11	Recovery		$83.1	$8.5	9.8:1
	Prevention		$22.1	$5.7	3.9:1
		Total	$105.2	$14.2	7.4:1

(Prevention Benefits adjusted by the removal of fines Imposed for prior fiscal years.)

MPI and Managed Care

The Florida Senate pointed out the challenges of auditing managed care organizations when it issued in November 2005 Interim Project Report 2006-133, which stated that fraud and abuse does not go away with the advent of managed care, but rather it changes form. Medicaid Program Integrity subscribes to the findings and recommendations of that report.

As the Legislature has pointed out, with managed care organizations, Medicaid fraud and abuse potentially can take many forms. Fraud and abuse can arise in procurement of the managed care contract; in marketing, enrollment and disenrollment activities; through underutilization by recipients of necessary care; through billings by the MCO and its subcontractors; through fee-for-service fraud experienced by the MCO; through embezzlement and theft; and in the form of kickbacks.

Fraud and abuse in managed care organizations can be complex and varied. Medicaid Program Integrity must understand how such fraud and abuse can occur, how it can be detected and how to audit for it. Each managed care organization with which Medicaid is involved must itself have an organizational unit, frequently termed a Special Investigations Unit or SIU, to detect and investigate abuse and potential fraud. Medicaid Program Integrity must work with and monitor SIUs in each MCO.

It is clear that even though the vast majority of MCO employees deal with the Medicaid program with probity, there are opportunities in so large and complex a program for fraud and abuse to occur. It is therefore necessary for Medicaid Program Integrity to do the following:

- Audit providers serving Medicaid managed care plans, or see that they are audited, in order to detect and deal with providers' fraudulent and abusive practices, including misbilling, balance billing and multiple collecting.
- Audit managed care plans to ensure that they have in place and utilize appropriate fraud and abuse control practices relating to their employees, providers and suppliers.
- Audit managed care plans to ensure that appropriate and necessary medical services and products are reasonably available to recipients and are properly and timely delivered to recipients by the plans.
- Audit plans to ensure that appropriate and accurate encounter information and data certifications are available timely to the Agency and encourage appropriate Agency offices to timely analyze encounter information (1) to ensure that services and goods are properly and timely delivered by plans to recipients and (2) to detect and deal with or refer any apparently fraudulent or abusive practices that may be revealed by analysis of encounter information.
- Ensure that appropriate penalties are applied for failure to supply required encounter information.
- Monitor Medicaid managed care plan procurements in order to see that true and correct procurement-related information has been supplied by prospective plans and that such plans have not entered into fraudulent subcontracts or engaged in bid-rigging, self-dealing, collusion, misappropriation of funds or kickbacks.
- Audit managed care plans to ensure that contract provisions have been and are being followed by the plans.

As previously explained, two projects were conducted in the managed care arena, the Newborn Rate Reconciliation project that resulted in the return of $20,031,041 in overpayments created and the culmination of a project related to HMO use of the unborn activation process, resulting in contractual assessments totaling $11,137,903, along with $1,389,668 for investigative costs incurred by the Agency.

The Agency has over $9 billion obligated in 24 contracts with managed care organizations (18 with HMOs and 6 with PSNs). MPI's two FTEs and one full-time OPS staff dedicated to managed care conducted 12 on-site visits of health plans to ensure contract compliance with contract fraud and abuse provisions. In addition to the 24 managed care contracts mentioned above, staff began working more intensively with the Agency's six Pre-Paid Mental Health Plans (PMHPs) in terms of

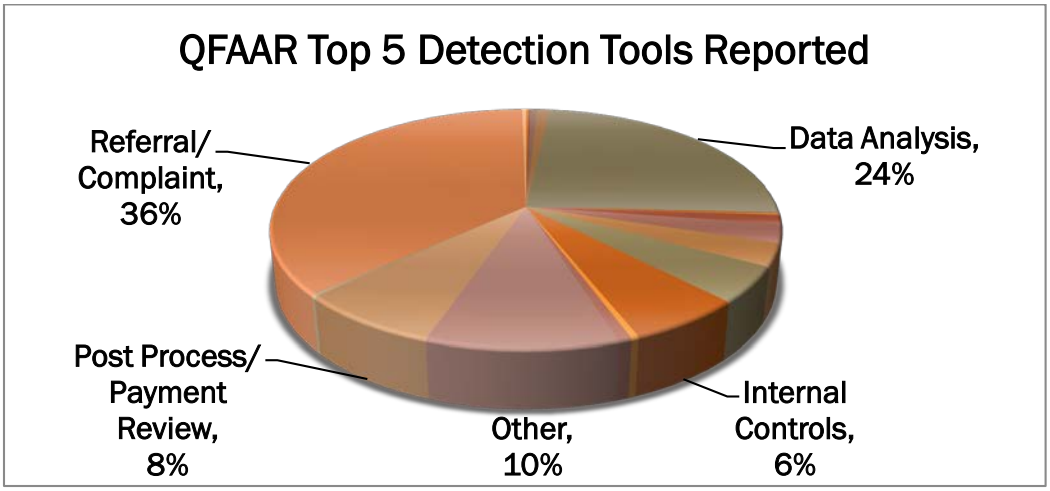
reviewing their antifraud policies and procedures, annual fraud and abuse reports and assisting Medicaid staff in aligning the fraud and abuse provisions in those contracts with provisions in the HMO and PSN contracts. MPI staff also conducted two on-site investigations, reviewed two applications from new health plans, conducted on-going review of anti-fraud policies and procedures from all health plans and moved into full implementation of an automated, web-based Quarterly Fraud and Abuse Activity Reporting (QFAAR) system through which health plans report the fraud and abuse case activity of their Special Investigations Units.

The table below presents a profile of the average case reported by the health plans by type of allegation (drawn from QFAAR data for FY 2010-11). Similar to last year, the top three primary allegations against providers continued to be for a pattern of overstated claims (upcoding), billing for services not rendered and billing for excessive services.

Average Quarterly Count of Managed Care Cases by Primary Allegation	
Provider	**AVG**
Pattern of overstated reports (upcoding)	76
Billing for services not rendered	46
Billing excessive services	23
Other, not operating within Medicaid guidelines	14
Billing for services that are medically unnecessary	13
Pattern of unbundling services	12
Overcharging for services that are provided	9
Charging enrollees for covered services	7
Failing to render medically necessary services	6
Federally Excluded Provider	6
Misrepresenting medical information to justify referral	4
Pattern of falsified encounter or service reports	3
Altering, falsifying, or destroying clinical record documentation	3
Prior Authorization -- Provider billing for non-covered/unauthorized services	1
False statements related to credentials	1
Kickbacks	1
Enrollee	
Eligibility Issues	21
Inappropriate use of Medicaid ID#	6
Forgery of prescriptions	5
Other (not elsewhere specified)	116

Analysis of the "Other" category from this first full fiscal year of QFAAR data has revealed at least two additional major subcategories of allegation type that are being reported by the health plans: enrollee drug-seeking behavior and concerns with provider/prescriber practices in relation to

controlled substances. Analysis of the top five detection tools used by health plans in their anti-fraud/abuse efforts suggested they rely heavily on referrals/complaints and data analysis.



As a reporting mechanism, the QFAAR will continue to be refined and reporting categories are expected to evolve as additional health plan data are available.

MPI staff members continued to conduct work related to the implementation of s. 409.91212, F. S., whereby health plans are required to submit anti-fraud plans for review and approval by MPI, including any anticipated subcontracts let by the health plans for investigative services. Staff members also compiled results of the new Annual Fraud and Abuse Activity Report (AFAAR) that is due annually on September 1. Results from the first AFAAR, which covered FY 2009-10, reflected some recoveries being made by the health plans. For FY 2010-11, of the health plans reporting by September 1, 2011, data reported reflects increased recoveries over the prior fiscal year.

Health Plan Reported Annual Fraud and Abuse Activity Report (unaudited) Report Due Date: September 1, 2011 for FY 2010-11			
Overpayments Identified for Recovery[1]	Overpayments Recovered[2]	Dollars Identified as Lost to Fraud and Abuse[3]	Dollars Identified as Lost to Fraud and Abuse That Were Recovered[4]
$16,475,688	**$13,655,842**	**$2,847,598**	**$371,748**

Table Notes:

[1] Overpayments identified for recovery include dollars lost to fraud and abuse, as well as dollars overpaid as a result of systems or claims processing errors. These dollars are reported if they were identified during the fiscal year being reported (FY 2010-11).

[2] Overpayments recovered are dollars recovered during the fiscal year being reported, regardless of when they were identified. (They may have been identified in an earlier fiscal year.)

[3] Dollars identified as lost to fraud and abuse are a subset of identified overpayments. These dollars are reported if they were identified during the fiscal year being reported.

[4] Dollars lost to fraud and abuse that were recovered are a subset of overpayments recovered. These dollars are reported if they were recovered during the fiscal year being reported, regardless of when they were identified. (They may have been identified in an earlier fiscal year.)

This past year the legislature passed major reforms that enacted the beginning of what, with federal approval, will be a statewide transformation of Medicaid to a managed care model. The anticipated timeline includes full transition of Medicaid recipients in long term care to managed care by October 1, 2013 and the remainder of the population (excluding some recipients) by October 1, 2014.

In anticipation of these sweeping changes, the Executive-level Fraud Steering Committee formed a Managed Care Fraud and Abuse Subcommittee in April 2011. The subcommittee's charge is to provide Agency coordination and oversight for Medicaid managed care fraud and abuse issues through:

- Increasing the effectiveness of program integrity functions including, but not limited to, prevention, detection and recoupment processes;
- Promoting the sharing of information across bureaus, divisions and agencies as needed in order to reduce workload and eliminate duplicative processes; and
- Serving as the Agency's central coordinating point for managed care fraud and abuse issues requiring elevation to the Fraud Steering Committee for informational and decision purposes.

The Managed Care Fraud and Abuse Subcommittee set several goals to be pursued through at least the next fiscal year. These goals include completion of an analysis of information systems relevant in preventing and detecting corporate-level fraud and abuse, (e.g., business practices intended to inappropriately delay or discourage access to care and encourage disenrollment of unhealthy members, fraudulent reporting, exploitation of system and policy vulnerabilities, or any other practices resulting in unauthorized benefits to the health plan and unnecessary costs to the Medicaid program.) Additionally, the Subcommittee's overarching goals include developing new and streamlining existing, processes to prevent and detect corporate-level fraud and abuse, ensuring

managed care organizations maintain robust anti-fraud programs and staying abreast of industry standards applicable to Florida's efforts in auditing and monitoring fraudulent activity in managed care organizations.

Division of Operations

Bureau of Finance and Accounting

When Medicaid overpayments are identified, they are generally referred to the Agency's Division of Operations, Bureau of Finance and Accounting (Finance and Accounting), for collections. Finance and Accounting then pursues collection of the overpayments from the Medicaid provider and collects by direct payments from providers or through withholding of Medicaid or Medicare payments. When payments are not received or Medicaid/Medicare cannot be liened, Finance and Accounting investigates to determine other means of collection or if the case will be referred to an outside collection agency. Finance and Accounting cannot authorize any reductions in monies due back to the Agency; any reductions in overpayments must be negotiated during a settlement process prior to the *Final Order* being issued by the Agency.

The amount booked as accounts receivable during FY 2010-11 was $67.7 million. As of June 30, 2010, the Medicaid accounts receivable balance for fraud and abuse was $42.3 million and the balance as of June 30, 2011 was $46 million. During FY 2010-11, total collections, net of adjustments and refunds approached $63.7 million. The collections were: $50.3 million in overpayments ($28.8 million collected from MFCU cases and $21.5 million collected from MPI cases); $1.5 million in investigation costs; $11.7 million in fines/sanctions; and, $.2 million in interest.

For all accounts receivable determined to be uncollectible, AHCA must obtain approval from the Department of Financial Services for write-off. During FY 2010-11, $390,990.24 in accounts receivable were approved 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 federal 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. Once the accounts receivable is approved for write-off, the qualified federal share of each accounts receivable write-off is reclaimed. Finance and Accounting also continues to work with the Agency's Division of Health Quality Assurance to determine if a facility's license can be held-up pending receipt of overpayment amounts.

Finance and Accounting uses 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, identifying which department, bureau or unit has current responsibility for a case. The system tracks state and 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.

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 Finance and Accounting 30 days after the final audit report was mailed. Status codes were added to the FACTS system that identify the process steps noted in the MAR system following receipt of the final audit report. Finance and Accounting continues to emphasize communications with MPI and MFCU to coordinate audit collection efforts and worked with AHCA's Office of General Counsel, Division of Health Quality Assurance, Bureau of Medicaid Program Analysis, Bureau of Long Term Care Services, Office of Third Party Liability and the Office of Inspector General to coordinate collection efforts and pursue additional avenues of collection.

Finance and Accounting has taken aggressive steps during the year to reduce the duration of the terms for negotiated payment plans and to increase the percentages of the liens placed on Medicaid and Medicare provider payments. Finance and Accounting worked to centralize nearly all payment plans in the Bureau. This year, the Bureau worked with the Office of Third Party Liability to begin negotiating, as well as handling, collections for Third Party Liability lien and payment plans agreements.

The Bureau works with Medicaid Program Integrity (MPI) to implement payment plans on paid claim reversals. MPI may conduct audits and request for providers to resubmit and void claims previously submitted. In some cases, providers are unable to void all the claims at once due to financial hardships. The provider may submit a request for a payment plan. Finance and Accounting and the provider will negotiate the payment terms. Finance and Accounting, MPI and the Bureau of Medicaid Contract Management created a process allowing providers to enter into a payment plan agreement while ensuring that the claims have been voided in the system.

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 payor 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 2010-11, over $135 million in Medicaid funds were collected. Annual TPL collections over the last four years have averaged approximately $116 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 2010-11 include the following:

- Date of Death – Claims paid after the dates of death of recipients and Medicaid providers are recovered.
- Hospital Audits – Hospital accounts payable ledgers are reviewed in connection with collecting Medicaid overpayments.
- Long-Term Care Audits – Long-term care facility 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); Duplicate 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); Age Limitations (claims paid outside the allowed age limitations); Durable Medical Equipment (DME) Rent to Purchase Equipment (violations of limitations, per DME item); and Fee for Service Payments While Recipient is Enrolled in Managed Care (fee for service claims are recovered from providers on the dates of service a Medicaid recipient was enrolled in a Managed Care Plan).

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 Field office staff and Medicaid providers. When new 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 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11
Collections					
Casualty	$18,062,167	$17,681,026	$16,537,665	$18,747,553	$22,165,885
Estate Recovery	$10,671,334	$8,590,471	$7,236,087	$5,479,473	$5,486,256
Trusts	$3,397,559	$4,166,134	$3,879,248	$5,369,002	$6,011,888
Medicare and Other Third Party Payor	$70,338,609	$47,040,782	$50,658,788	$44,673,737	$72,081,890
Other Recoupment Projects	$16,513,992	$14,621,051	$43,813,456	$40,582,911	$29,958,148
Total Collections	$118,983,661	$92,099,463	$122,125,244	$114,852,676	$135,704,067
Cost Avoidance (Matrix)	$654,376,686	$747,168,091	$933,411,564	$778,611,980	$966,902,977

Health Quality Assurance

The Division of Health Quality Assurance is responsible for the regulation of over 40 types of health care facilities and businesses (providers) and managed care organizations, 44,000 facilities/providers including health maintenance organization, nursing homes, hospitals, assisted living facilities, home health agencies, health care clinics, clinical laboratories and others. Duties include:

- State licensure, federal certification and criminal background checks for owners, operators and certain health care provider staff;
- Routine and complaint inspections and plans and construction reviews for certain facilities;
- Consumer and public information regarding health care facilities including licensure and inspection information to the public and public record requests;
- Financial reviews and analysis for licensure and regulatory assessments; and
- Managed Care Regulation including network verification licensure, complaint investigations, subscriber grievance review, Medicaid managed care organizations and Medicaid Health Plan Contract compliance monitoring.

Bureau of Long Term Care Services

The Bureau of Long Term Care Services includes three licensure units; the Long Term Care Unit, the Assisted Living Facility Unit and the Home Care Unit, which oversee the regulation of nursing homes, assisted living facilities, home health agencies, hospices and ten other long-term care provider programs. The Bureau also includes the Central Systems Management Unit, which is responsible for background screening checks for persons employed by or affiliated with certain regulated providers and handles all incoming mail, application intake activities, check processing and document scanning for all of the HQA licensure units. The Assisted Living Facility Unit partners with the Department of Elder Affairs in the development of rules for assisted living programs.

Bureau of Health Facility Regulation

This Bureau oversees the regulation of hospitals, ambulatory surgical centers, home health agencies, hospices, clinical laboratories, health care clinics, risk managers and over 20 other types of health care providers. Four licensure units are housed within this bureau: Hospital and Outpatient Services, Clinical Laboratory, Home Care and Health Care Clinic. The Bureau also includes the Certificate of Need (CON) and Hospital Financial Analysis programs.

Bureau of Managed Health Care

This Bureau regulates commercially licensed and Medicaid managed care organizations to ensure that beneficiaries and subscribers receive quality health care services. It conducts quality assurance surveys, investigates complaints against managed care organizations and oversees national accreditation surveys. The Bureau also reviews applications for commercial health maintenance organizations, Medicaid managed care organizations and prepaid health clinics. Through the Subscriber Assistance Program, it handles the external grievance process for managed care subscribers whose complaints are not resolved to their satisfaction by their commercial or Medicaid HMOs. In regard to Workers' Compensation, the Bureau is responsible for initial authorization of managed care arrangements, annual surveys and annual authorization of plan expansions. The Contract Management Unit oversees the contract for the Provider Dispute Resolution Program and manages the administration of Florida's Health Care Responsibility Act.

Bureau of Field Operations

Through eight Field Offices, the Bureau conducts health care facility and services inspections for all facilities and services licensed or otherwise regulated by the Agency. It also conducts surveys for all facilities and services certified by the Centers for Medicaid and Medicare Services. The Bureau's Complaint Administration Unit is responsible for the intake and referral to the field offices for the inspections related to consumer complaints and is responsible for oversight of the Agency's Complaint and Information Call Center. The Survey and Certification Support Branch is responsible for staff and provider training, quality assurance activities and assures compliance with the federal data requirements.

The Office of Plans and Construction

Through three offices located around the state, this Bureau is responsible for ensuring that hospitals, nursing homes, ambulatory surgical centers and Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) are physically safe, functional and provide appropriate, building code-compliant shelter for patients and residents. It reviews and approves facilities' plans and specifications and inspects their construction. Architects, engineers and other specially trained personnel also inspect facilities.

Florida Center for Health Information and Policy Analysis (Florida Center)

A proposal has been submitted to move the Florida Center for Health Information and Policy Analysis (Florida Center) from under Executive Direction to be administratively housed within the Division of Health Quality Assurance.

The Florida Center performs several important functions to improve the effectiveness and efficiency of health care services in the state and to support consumers in health care decision making. The Florida Center is responsible for collecting, compiling, coordinating, analyzing and disseminating health related data and statistics for the purpose of developing public policy and promoting the transparency of consumer health care information through www.FloridaHealthFinder.gov. These data provide accurate and timely health care information to consumers, policy analysts, administrators and researchers in order to evaluate cost, quality and access to care.

The Florida Center promotes the exchange of secure, privacy-protected health care information, the adoption of electronic health records among providers, electronic prescribing and the use of personal health records by all consumers. The Florida Center is responsible for the implementation of statewide plans for health information exchange and electronic health records adoption funded by the HiTech Act of 2009.

The Florida Center is also responsible for collecting adverse incident reports from hospitals, ambulatory surgery centers, health maintenance organizations, nursing homes and assisted living facilities. The Florida Center works closely with facilities and regulatory agencies to assure that corrective actions have been implemented.

Recent division activities related to fraud and abuse are summarized below.

Background Screening

The Division of Health Quality Assurance licenses, registers and regulates 29 health care provider types on the basis of Florida Statutes, Florida Administrative Codes and federal regulations governing Medicare and Medicaid if applicable. The majority of health care providers licensed by the Agency are required by law to conduct background screening for certain employment positions including:

- The licensee, if an individual;
- The administrator or a similarly titled person who is responsible for the day-to-day operation of the provider;
- The financial officer or similarly titled individual who is responsible for the financial operation of the licensee or provider;
- A controlling interest if the Agency has reason to believe that such person has been convicted of any offense prohibited by section 435.04, F. S.;
- Any person employed or seeking employment with a licensee or provider who is expected to, or may require him or her to provide personal care or services directly to clients or have access to client funds, personal property or living areas; and
- Any person contracting with a licensee or provider whose responsibilities requires him or her to provide personal care or personal services directly to clients.

All screening results from requests processed through the Agency are reviewed by Agency staff to determine if the person screened is eligible to work pursuant to the requirements of Chapter 435, F. S. In 2009, legislation was passed that expanded the disqualifying offenses for health care employees to include financial crimes such as fraud, including Medicaid fraud, forgery and uttering a forged instrument. These additional disqualifying offenses are provided in section 408.809, F. S.

Upon making an eligibility determination, Agency staff post the results in a database that licensed health care providers may access through a secured web site with an assigned user ID and password. Health care providers may use screening results conducted within the last five years, so this database avoids the costs of re-screening for persons that may change jobs.

Legislation passed in 2010 significantly modified the background screening process and hiring practices for many service providers regulated by a variety of state agencies including health care providers licensed by the Agency. These changes included:

- The requirement for Level 2 fingerprint screening of the state (Florida Department of Law Enforcement) and national (Federal Bureau of Investigations) criminal history repositories for all positions required to undergo screening;
- Submission of fingerprints through electronic (LiveScan) devices;
- Five-year rescreening requirement; and
- Enhanced requirements for the Exemption from Disqualification.

This legislation brought a significant increase in the number of screenings conducted through the Agency. Prior to 2010, the Background Screening section processed an average of 65,000 screenings annually. In FY 2010-11, the section processed 209,012 screenings. Of those screenings, 44,076 had a criminal history record and 8,289 were determined to be not eligible for employment. Of the criminal history records reviewed since August 1, 2010, 27 individuals were disqualified due to Medicaid fraud.

If a person is determined to be not eligible for employment, section 435.07, F. S., contains guidelines for issuing an exemption from disqualification. A person applying for an exemption must

meet certain criminal history criteria, demonstrate rehabilitation and meet other requirements. A granting of an exemption does not change a person's criminal history record; it merely provides eligibility for employment.

In addition to screening activities, the Background Screening section also reviews news clips and other sources for information related to health care workers that have been arrested for a disqualifying criminal offense. If the individual was previously screened through the Agency, the reported incident is researched and if confirmed as a disqualifying offense, the individual's screening status is changed to not eligible. The status change is reflected on the secure results website available to the providers and the employing health care provider is notified if the information is on record.

The Background Screening section was awarded a $3 million grant in October 2010 through the Centers for Medicare and Medicaid Services National Background Screening Program. The purpose of the two-year grant is to enhance background screening in the state. The Agency has four primary goals:

1. Enhance data systems to improve processes and create more efficiencies;
2. Reduce duplicative screening within health care;
3. Expand screening criteria to include review of the Office of Inspector General's List of Excluded Individuals/Entities; and
4. Implement a retained fingerprint program (rap back).

HQA-Overpayments, Suspensions, Terminations, Cases

The Agency's Division of Health Quality Assurance (HQA) developed a Fraud and Abuse team to help combat fraud and collect overpayments through the health care provider licensing process. According to s. 408.831, F. S:

> *(1) In addition to any other remedies provided by law, the Agency may deny each application or suspend or revoke each license, registration, or certificate of entities regulated or licensed by it:*
>
> > *(a) If the applicant, licensee, or a licensee subject to this part which shares a common controlling interest with the applicant has failed to pay all outstanding fines, liens, or overpayments assessed by final order of the Agency or final order of the Centers for Medicare and Medicaid Services, not subject to further appeal, unless a repayment plan is approved by the Agency; or*
> >
> > *(b) For failure to comply with any repayment plan*.

The HQA team researches all *Final Orders* related to licensure and Medicaid providers issued by the Agency's Office of General Counsel, all outstanding fines reported by the Agency's Bureau of Finance and Accounting, Florida entities and individuals on the Office of Inspector General's List of Excluded Individuals/Entities (LEIE) and all individuals and entities on the Medicaid Fraud Control Unit's monthly report of convictions, arrests and warrants. If a respondent is located in the Agency's

licensing system, Florida Regulatory Administration Enforcement System (FRAES), the status is downgraded to ineligible for licensure. Once the respondent is no longer eligible for licensure, the team evaluates any connections the respondent may have to an existing licensed provider.

There are several actions that may take place depending on the reason for the status change. If money is owed to the Agency, a license will not be issued to any provider the respondent is connected until all monies are collected. A respondent terminated or suspended from the Medicaid or Medicare program may have an application for license denied or an existing license suspended or revoked. If the individual or provider is not connected to any licensed provider or applicant, the record will continue to remain in an ineligible status for licensure and the licensing system will prevent application approvals as long as the respondent remains downgraded.

The HQA team also researches each individual or entity in the Agency's Background Screening Database, Florida Medicaid Management Information System, Fraud and Abuse Case Tracking System, Comprehensive Case Information System, Florida Department of State Division of Corporations, Judicial Inquiry System and Florida Department of Health License Verification Information as needed. These databases are utilized to obtain and confirm information received and to aid the team in making an identity match.

Since January 2010, 399 providers were placed in a not eligible status due to money due or Medicaid or Medicare termination or exclusion. Another 1585 were placed in a "verify eligible" status due to information received that may exclude the provider from licensure. Lastly, 554 providers were placed in a not eligible status but have since reconciled and are now in an eligible status.

Field Operations

Below is a listing of referrals made by provider type by Field Operations during FY 2010-11. During each Field Office Mangers' meeting 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 or department for referral. In early 2010 Field Operations established an email address that streamlines the referral process for receipt and processing of referrals to the Medicaid Fraud Control Unit (MFCU). Of the 29 MFCU referrals made by HQA, one resulted in the arrest of an unlicensed operator, 13 referrals are still open and 15 referrals were closed with no findings. This process has been a positive step and allowed for a better tracking and reconciliation to ensure accuracy.

Provider Type	Number of Referrals	Referred to MPI, Closed, No Findings	Referral to MFCU	Other Including No Jurisdiction
Home Health	4	3		1
Nursing Home	10	9		1
ALF	16*	16	16	
Hospital	4	4		
Hospice	2	1		1
Nurse Registry	0			
ICF/DD	2		2	
Health Care Clinics	1	1		
Health Care Services Pool	1	1		
Adult Family Care Home	1*	1	1	
Lab	2			2
End Stage Renal Dialysis	0			
Home Medical Equipment	1	1		
Unlicensed Activity	10*	10	10	
Total	55			

*Joint referrals to both MPI and MFCU

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, field operations survey staff completed 55 Operation Spot Checks throughout the state. Of the 55 visits, one was conducted in an Intermediate Care Facility for the Developmentally Disabled, ten in Nursing Homes, five in Adult Family Care Homes and 39 in Assisted Living Facilities.

Additionally, Field Operations staff 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.

HQA and MPI-News Clips

The Division of Health Quality Assurance (HQA) and the Office of the Inspector General's Medicaid Program Integrity work together to prevent fraud and abuse by researching news articles and press releases daily. Each section reviews news articles and press releases related to health care facilities, practitioners and Medicaid and Medicare fraud in Florida.

The individuals and entities involved in the article or release are fully researched in all Agency databases and some external databases. The databases include the Agency's Background Screening Database, Florida Medicaid Management Information System, Fraud and Abuse Case Tracking System, Florida Regulatory Administration Enforcement System, Prescribing Database, Comprehensive Case Information System, Public Access to Court Electronic Records, Accurint, Florida Department of State Division of Corporations, Office of Inspector General's List of Excluded Individuals/Entities, Judicial Inquiry System and Florida Department of Health License Verification Information as needed.

If an individual or entity is located in the licensing system, the record is downgraded to ineligible for licensure. Once the record is no longer eligible for licensure, the team evaluates any connections the individual or entity may have to an existing licensed provider. If the individual or entity has been arrested or convicted, licensure suspension or revocation may be initiated. If the individual is part of a licensure application in process, the application is denied. If the individual is not connected to any licensed provider or applicant, the record will continue to remain in an ineligible status for licensure. The licensing system will prevent application approvals as long as the respondent remains downgraded.

Information is gathered and presented to Agency management via a central repository located on the Agency's intranet. This repository can be viewed any time to see the progress being made in researching the individuals and entities. As more information becomes available, the repository is updated. A central repository was created for this information to avoid duplicative research, to ensure all parties are notified of the same incidents and information and to make sure action is being taken by the appropriate areas as needed. Once the information is gathered and presented, management will take any necessary action(s) ranging from Medicaid suspension or termination to license revocation.

Home Health Agencies

Miami-Dade County was designated as a health care fraud area of concern in Senate Bill 1986 passed by the 2009 Florida Legislature. The bill included additional penalties for fraudulent activities. That same year, Senate Bill 2658 stopped the licensing of new home health agencies in Miami-Dade and Broward Counties for a year and strengthened laws regarding the applicant's financial ability to operate a home health agency. In addition, the Agency's Medicaid office stopped approving new home health agencies for those counties. The U. S. Department of Health and Human Services, Centers for Medicare & Medicaid Services revised its federal regulations to reduce outlier payments and require current evidence of sufficient capitalization prior to issuing new Medicare provider numbers for billing. As of June 30, 2011, there were 799 home health agencies

in Miami-Dade County. This is still a large number of agencies, with one home health agency for every 450 persons age 65 and older. However, it is a decrease from the 988 agencies that were licensed on July 1, 2009.

There continues to be growth in the numbers of home health agencies applying for licenses statewide, as well as voluntary closings and legal actions to close agencies. As of June 30, 2011, there were 2,315 home health agencies licensed statewide.

There were 44 licensure denials and 55 revocations upheld by *Final Order* in FY 2010-11. The fraud-related reasons for the denial and revocations included:

1) home health agencies not serving any patients and not operating;
2) applicants for licenses for new agencies submitting fraudulent financial statements that were not for the services and staff in the applications;
3) applicants not having valid proof of start-up funding and contingency funding;
4) financial instability with unpaid fines;
5) unreported changes of ownership; and
6) failure to obtain FBI background screening for the administrator and financial officer.

Twenty-four home health agencies were found not to be operating, with 22 in Miami-Dade County. Of the 24 HHAs that were non-operational and had their licenses revoked/denied, 23 were never enrolled in the Florida Medicaid program. One HHA was enrolled in Medicaid for home health services and its Medicaid provider number was terminated. Another was never enrolled in Medicaid for home health services. Four of the HHAs applied for Medicaid home health services but were denied enrollment.

The home health agency licenses were revoked for all of those agencies. Four home health agencies were found with fraudulent patient records. Two alleged fraudulent billing. One was referred to Medicare fraud for investigation and one was referred to Medicaid Program Integrity for investigation. One home health agency found with fraudulent patient records is pending in the legal process and another had a fine upheld for $40,000.

Fines were upheld for seven home health agencies with a pattern of three or more missed visits. The agencies failed to provide skilled nursing, physical therapy and other services as ordered, admitting patients they were unable to serve and failing to notify the patients' physicians when the services could not be provided. The fines ranged from $3,750 to $10,000 per agency.

Four home health agencies were fined for non-compliance with state law regarding payment of physicians to serve as the agency's medical director. Two home health agencies did not have a contract with the physician and the other two did not have invoices for work done by the physician as required in state law. Also, two of the agencies paid the physician large amounts, above fair market value. Patients were referred to the agencies by the physicians. Fines were imposed for all four agencies. Sixteen home health agencies were assessed fines for not having a director of nursing for more than 30 days. Thirteen of the agencies were in Miami-Dade County. Three Miami-Dade agencies voluntarily closed rather than pay the fine. In total, 28 fines were assessed for a total of $198,500.

Laboratory Unit Fraud and Abuse Efforts

Under the direction of the federal Clinical Laboratory Improvement Amendment (CLIA) program, the unit reviews clinical laboratory applications using CLIA procedural guidance for potential fraudulent activities. Examples of indicators include:

- CMS-116 indicates an out-of-state mailing address unless the lab is known to actually be located in another state;
- CMS-116 lists an 800 number and the lab is not a recognized chain;
- Director qualifications submitted with the CMS-116 were printed from the web;
- Faxes from the lab come from "Office Depot" or similar public facsimile services;
- Lab keeps putting off or rescheduling a survey without a good reason; and
- Unable to reach to schedule an initial survey.

Staff uses these guidelines to check owner information, laboratory structures, addresses and directors. No referrals of questionable practices based on this type of review were made to Medicaid during FY 2010-11. Questionable practices were brought to the federal CLIA program's attention, investigated and substantiated. No fine was imposed.

Staff keeps up with trends in clinical laboratory testing and practices and screen applications using that knowledge. One instance of probable fraudulent billing was identified this fiscal year and Medicaid was alerted. The investigation is pending.

State Anti-kickback/Rebate Regulations: Under existing regulation, specifically section 483.245, F. S., subsection 59A-7.020(14) and section 59-A.037, F. A. C., kickbacks and rebates in clinical laboratories are largely reviewed as a result of complaints being filed by individuals or other providers. During FY 2010-11, eight complaints were filed against clinical laboratories for alleged violations. Two complaints are closed; in one instance the allegations were unsubstantiated and in the other, the allegations were substantiated but the provider voluntarily corrected in response to the primary inquiry letter. Six of the eight are currently under investigation.

Office of the General Counsel

The Office of the General Counsel (OGC) provides legal advice and representation for AHCA on all legal matters. The mission of the OGC 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; and
- Civil litigation related to various Agency programs.

The General Counsel is assisted by the Deputy General Counsel, the Chief Medicaid Counsel, the Chief Facilities Counsel, the Chief Appellate Counsel, the Agency Clerk and the attorneys and support staff that work in the various sections within the OGC. There are 65 attorneys and support staff throughout the state.

The OGC's Medicaid Unit is lead by the Chief Medicaid Counsel and is comprised of 14 attorneys who handle various matters. 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, the Medicaid 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 in 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.

The OGC also assists the Office of the Inspector General, predominately through work with Medicaid Program Integrity (MPI). The OGC assists MPI with the planning aspect of various projects that might have more complex legal considerations, provides advice on a case-by-case basis, assists with collections and bankruptcy matters related to MPI overpayment determinations and handles 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. In the past year, the OGC has been actively working with the Agency on fraud and abuse matters related to managed care.

Inter-Agency Coordination and Cooperation

Medicaid and Public Assistance Fraud Strike Force

The Medicaid and Public Assistance Fraud Strike Force (hereafter referred to as "Strike Force") was established by the 2010 Florida Legislature under Chapter 624.351, Florida Statutes. The Attorney General and the Secretary of the Agency for Health Care Administration are members of the Strike Force. It was established based upon a finding "that there is a need to develop and implement a statewide strategy to coordinate state and local agencies, law enforcement entities and investigative units in order to increase the effectiveness of programs and initiatives dealing with the prevention,

detection and prosecution of Medicaid and public assistance fraud," Section 624.351(1), Florida Statutes.

The legislation directed that the Strike Force serve in an advisory capacity and provide recommendations and policy alternatives to help achieve the overall mission of the Strike Force: "to eliminate Medicaid and public assistance fraud and to recover state and federal funds," Section 624.351(2), Florida Statutes. To help the Strike Force achieve its purpose, in Section 624.351(6)(a) the Legislature authorized the Strike Force to advise on activities to include, but not be limited to:

1. Conducting a census of local, state and federal efforts to address Medicaid and public assistance fraud in this state, including fraud detection, prevention and prosecution in order to discern overlapping missions, maximize existing resources and strengthen current programs.
2. Developing a strategic plan for coordinating and targeting state and local resources for preventing and prosecuting Medicaid and public assistance fraud. The plan must identify methods to enhance multiagency efforts that contribute to achieving the state's goal of eliminating Medicaid and public assistance fraud.
3. Identifying methods to implement innovative technology and data sharing in order to detect and analyze Medicaid and public assistance fraud with speed and efficiency.
4. Establishing a program to provide grants to state and local agencies that develop and implement effective Medicaid and public assistance fraud prevention, detection and investigation programs, which are evaluated by the strike force and ranked by their potential to contribute to achieving the state's goal of eliminating Medicaid and public assistance fraud. The grant program may also provide startup funding for new initiatives by local and state law enforcement or administrative agencies to combat Medicaid and public assistance fraud.
5. Developing and promoting crime prevention services and educational programs that serve the public, including, but not limited to, a well-publicized rewards program for the apprehension and conviction of criminals who perpetrate Medicaid and public assistance fraud.
6. Providing grants, contingent upon appropriation, for multiagency or state and local Medicaid and public assistance fraud efforts, which include, but are not limited to:
    a. Providing for a Medicaid and public assistance fraud prosecutor in the Office of the Statewide Prosecutor;
    b. Providing assistance to state attorneys for support services or equipment or for the hiring of assistant state attorneys, as needed, to prosecute Medicaid and public assistance fraud cases; and
    c. Providing assistance to judges for support services or for the hiring of senior judges, as needed, so that Medicaid and public assistance fraud cases can be heard expeditiously.

The legislation also authorized the Strike Force to receive periodic reports from state agencies, law enforcement officers, investigators, prosecutors and coordinating teams regarding Medicaid and

public assistance criminal and civil investigations. Such reports may include discussions regarding significant factors and trends relevant to a statewide Medicaid and public assistance fraud strategy.

In order to address these authorized activities, the Strike Force established a number of committees that are made up of representatives of each of the state agencies that are represented on the Strike Force. These committees helped to identify recommendations that should be presented to the Legislature.

Recommendations

Based upon this review of needs and in consideration of the innovative initiatives currently underway, the Strike Force compiled the following recommendations to the Legislature:

1. Minimize the licensure exemptions that currently exist for clinics through AHCA.
2. Give DOH the statutory authority to conduct state and national criminal history record checks on all professions they regulate. Create statutory or rule provisions for timely reporting of arrests of practitioners to DOH via retention of fingerprints by FDLE.
    a. In conjunction with the Interagency Workgroup on Background Screening, examine methods to maximize the sharing of criminal history information to reduce additional costs for licensees and duplicative processes by state licensing agencies.
3. Give DOH and AHCA the authority to collect the National Provider Identifier from providers.
4. Establish a funding source for the Strike Force to use to enhance anti-fraud efforts.
5. Provide contractual services to map ACCESS, as the entry to public assistance programs, in order to identify technological and organizational processes that can be reengineered to improve prevention and detection processes and support the feasibility study for replacement of the FLORIDA System.
6. Fund the incorporation of identification verification and fraud prevention processes into the ACCESS On-Line capabilities in the immediate future.
7. Support a feasibility study for ultimately replacing the FLORIDA System with an updated system that incorporates identification verification and fraud prevention technology.
8. Continue to fund the implementation of AHCA's Data Connectivity Plan.

In addition, there are recommendations that have been presented that the Strike Force can take the lead on implementing:

1. Expand participation on Strike Force working committees to include other public assistance agencies (e.g., Department of Education, Agency for Persons with Disabilities).
2. Coordinate training sessions around the state to empower local government and law enforcement to partner on initiatives to fight Medicaid and public assistance fraud and train citizens in identifying and reporting suspicious activity in order to support local initiatives.

Other recommendations have been presented to the Strike Force, but have not been fully evaluated to determine how to proceed. These will be followed up on in the upcoming year:

1. Find a way to get more timely information from employers in order to verify employment status on benefit applicants and recipients.

2. Secure cooperation from the federal government on a Treasury Offset Program to allow recoupment of overpayments through an offset of income tax returns.
3. Provide statutory authority to garnish state employee wages for recoupment of overpayments.
4. Incorporate the use of biometrics into current system processes to help ensure that services are, in fact, provided to eligible applicants.

Other Opportunities

The Strike Force has just begun to explore the opportunities available to fight fraud in the State of Florida. In the coming year, the Strike Force will investigate the potential of other strategies to enhance efforts to prevent, detect, investigate and prosecute fraud and recoup overpayments. The Technology Committee will continue to review other technological advances. The Grants Committee will review the impact of a Background Screening Grant that AHCA has received. The Mapping Committee will follow the progress in mapping the ACCESS processes and provide direction to this initiative. The Strike Force, as a whole, will follow AHCA's progress in the move to statewide managed care and offer assistance and support wherever possible.

Florida Department of Health

The Department of Health (DOH) continues its partnership with The Agency for Health Care Administration (AHCA) and the Medicaid Fraud Control Unit (MFCU) to streamline intraagency 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), as well as Enforcement leadership, meet regularly with directors and senior managers of the AHCA Office of the Inspector General, the Division of Medicaid and MFCU to coordinate participation in joint projects, investigations and enforcement strategies. This includes the regular briefing of the Secretary for AHCA on the nature and progress of these collaborative efforts.

DOH collaborated with AHCA to implement SB 1986 (2009). AHCA and DOH continue to build upon their sharing of information to effectuate provisions of the law. DOH data is transferred nightly to AHCA to identify practitioners who are billing Medicaid, but who do not have an active DOH license.

The Consumer Services Unit continues to develop working relationships with AHCA through contacts established as a result of the bi-monthly meetings. Licensing information is provided to AHCA on an ongoing ad-hoc basis, with recent emphasis on fraud in pain clinic settings. Additionally, the Investigative Services Unit (ISU) field offices continue to work within the relationships established prior to and strengthened by implementation of anti-fraud legislation.

In FY 2010-11 a total of 77 legally sufficient referrals were received; 11 cases were closed with no violation found; one case was closed with a letter of guidance; a notice of Non-Compliance was issued in 29 cases and 36 cases are still pending.

The Miami ISU office coordinated investigations with or obtained assistance from MFCU and MPI in the completion of two licensed mental health counselor investigations, one social work intern investigation, one registered nurse investigation and one medical doctor investigation. Two of the investigations are on-going and one investigation resulted in an arrest. The Alachua ISU office coordinated with MFCU on an investigation of a physician in Lake City, resulting in an arrest and emergency suspension of the physician for inappropriate prescribing of a controlled substance resulting in eight deaths. The provider was terminated with cause from the Florida Medicaid program.

Prescription Drug Monitoring Program

The Florida Prescription Drug Monitoring Program (PDMP) was created by the 2009 Florida Legislature as an initiative to encourage safer prescribing of controlled substances and to reduce drug abuse and diversion within the State of Florida. Section 893.055, *Florida Statutes (*F. S.), created the PDMP within the Florida Department of Health (DOH) for the purpose of providing information that can help guide a health care practitioner's prescribing and dispensing decisions regarding highly abused controlled substance prescription drugs. Additionally, the PDMP database will assist law enforcement and MQA in active investigations of cases involving diversion, over-prescribing and dispensing of controlled substances pursuant to Section 893.055(7)(c)1-3., Florida Statutes.

In FY 2010-11, the Electronic-Florida Online Reporting of Controlled Substances Evaluation program (E-FORCSE) and Florida's Prescription Drug Monitoring Program (PDMP) were initiated. Expected outcomes of the PDMP are the reduction of the rate of inappropriate use of prescription drugs through department education and safety efforts; reduction of the quantity of pharmaceutical controlled substances obtained by individuals attempting to engage in fraud and deceit; increased coordination among partners participating in the prescription drug monitoring program and involvement of stakeholders in achieving improved patient health care and safety and reduction of prescription drug diversion.

The table below shows the number of pharmacies and dispensers who have reported controlled substance prescription data to the PDMP and the total number of prescriptions reported to the PDMP as of November 15, 2011.

Number of Pharmacies/Dispensers and prescriptions reported	
Number of Pharmacies/Dispensers who have reported to the PDMP	5,502
Number of prescription records reported to the PDMP	21,248,872

The table below shows the number of registered users of the PDMP by license type, as of November 15, 2011.

Number of PDMP Registered Users	
License Type	**Number of Registered Users**
Pharmacists	2,595
Medical Doctors	2,007
Osteopathic Physicians	341
Podiatric Physicians	33
Physician Assistants	247
Advanced Registered Nurse Practitioners	317
Dentists	247
Total	5,787

A prescriber or dispenser who wishes to view their patient-specific information must submit a query in order to generate a patient advisory report. The table below shows the number of queries submitted by registered users since the system became available for queries on October 17, 2011.

Number of PDMP Queries by Registered User	
Month	**Number of Queries**
October 2011	34,486
November 2011	71,928
Total	106,414

Section 893.055, F. S., authorizes law enforcement agencies to request information from the PDMP during the course of an active investigation. The table below shows the number of requests submitted by law enforcement agencies since the system became available on November 14, 2011.

Number of Data Requests by Law Enforcement	
Month	Number of Queries
November 2011	36
Total	36

Division of Medical Quality Assurance, Emergency Action Process

Emergency Action Process

In May 2011 MQA streamlined the process to take emergency actions against licensed health care practitioners who pose an immediate threat to the public health and safety. A root cause analysis revealed that threats to the public health, safety and welfare had changed over the last few years, requiring redefining what constituted a priority investigation. In addition to several other improvements, a unit was created in the Prosecution Services Unit specifically for handling emergency actions. In FY 2010-11, emergency actions were issued in an average of 106 days. As a result of the process improvements, an aggressive target was set to issue emergency actions in less than 30 days from receipt of a priority complaint. As of November 10, 2011, 103 emergency actions were issued in an average of 30.6 days for complaints received since these improvements were put in place and 60.2% of emergency actions were issued in less than 30 days.

SB 1986 (2009)

SB 1986 (2009) created section 456.0635, F. S., prohibiting Medicaid fraud in the practice of health care professions. The law requires the Department of Health to deny licenses and renewal of licenses for those persons who have engaged in certain acts. Additionally, the law requires the Department of Health to work cooperatively with the Agency for Health Care Administration and the judicial system to recover overpayments by the Medicaid program. Below is a status report of actions taken by the Department of Health since the implementation of these requirements.

SB1986 (2009) Status Report June 30, 2011

Initial Licensure Denials		
Profession	Licensure Denials/Withdrawals	Reason
Certified Nursing Assistant	186	Ch. 893, F. S. (131) Ch. 817, F. S., (36) Ch. 893 & 817, F. S., (2) Ch. 409, F. S. (11) Unknown (6)
Clinical Laboratory Personnel	1	21 USC (1)
Clinical Social Worker	3	Unknown (3)
Dentist	1	Unknown (1)
Dental Hygienist	2	Ch. 893, F. S. (2)
Hearing Aid Specialist	1	Ch. 817, F. S. (1)
Licensed Clinical Social Worker	2	Ch. 893, F. S. (2) Unknown (1)
Licensed Practical Nurse	14	Ch. 893, F. S., (8) Ch. 817, F. S., (2) 21 USC (1) Ch. 409, F. S. (2) Unknown (1)
Massage Therapist	9	Ch. 893, F. S. (8) Unknown (1)
Medical Physician	1	Ch. 893, F. S. (1)
Mental Health Counselor Intern	2	Ch. 893, F. S. (1) Unknown (1)
Osteopathic Training Registration	1	Ch. 893, F. S. (1)
Pharmacist	1	Ch. 893, F. S. (1)
Physical Therapist	1	21 USC (1)
Physical Therapist Assistant	1	Unknown (2)
Psychologist	1	Ch. 893, F. S. (1)
Registered Nurse	13	Ch. 893, F. S., (5) Ch. 817, F. S., (4) Ch. 893 & 817, F. S., (2) Ch. 409, F. S. (1) Unknown (1)
Registered Pharmacy Technician	12	Ch. 893, F. S. (8) Ch. 817, F. S. (2) UNK (2)
Registered Respiratory Therapist	1	Ch. 893 & 817, F. S. (1)
Total	253	

Biennial Licensure Renewal Denials		
Profession	Renewal Denials	Provision Type
Certified Pod X-ray Assistant	1	Ch. 893, F. S. (1)
Certified Nurse Assistant	27	Ch 817, F. S. (6) Ch. 893. F. S. (18) 21 USC (1) Unknown (2)
Chiropractic Physician	1	Ch. 893, F. S. (1)
Dental Hygienist	3	Ch. 893, F. S. (3)
Licensed Practical Nurse	14	Ch. 893, F. S. (11) Ch. 817, F. S. (3)
Massage Therapist	3	Ch. 893, F. S. (1) Ch. 817, F. S. (2)
Medical Physician	10	Ch. 893, F. S. (2) 21 USC (4) Ch. 409, F. S. (2) Ch. 817, F. S. (1) Unknown (1)
Optometrist	1	Unknown (1)
Orthotic Fitter Assistant	1	Ch. 893, F. S. (1)
Osteopathic Physician	1	21 USC (1)
Pharmacist	2	Ch. 893, F. S. (2)
Physician Assistant	1	Ch. 893, F. S. (1)
Psychologist	1	Ch. 893, F. S. (1)
Registered Nurse	24	Ch. 893, F. S. (20) Ch. 817, F. S. (3) 21 USC (1)
Registered Pharmacy Technician	3	Ch. 893, F. S. (2) Ch. 409, F. S. (1)
Registered Respiratory Therapist	3	Ch. 409, F. S. (3)
Speech-Language Pathologist	1	Ch. 409, F. S. (1)
Total	97	

Enforcement Activities					
		Complaints	Pending	ESOs	Discipline
Termination for cause from Medicaid	Chiropractic Physician	3	1	0	0
	Massage Therapist	1	0	0	0
	Medical Doctor	12	5	1	1
	Mental Health Counselor Intern	1	0	0	0
	Midwifery	1	0	0	1
	Occupational Therapist	1	1	0	0
	Pharmacy	1	1	0	0
	Physical Therapist	4	2	0	0
	Physician Assistant	1	1	0	0
	Podiatric Physician	1	1	0	0
	Reg. Respiratory Therapist	3	1	0	0
	Registered Nurse	1	1	0	0
	Sub-total	**30**	**14**	**1**	**2**
Conviction as defined in 456.0635	Cert. Respiratory Therapist	4	2	0	1
	Certified Nursing Assistant	44	10	20	23
	Chiropractic Physician	2	2	0	0
	Dental Hygienist	2	1	1	0
	Key Personnel-Individual	8	0	0	0
	Licensed Practical Nurse	15	8	9	6
	Massage Therapist	6	3	0	3
	Medical Doctor	12	5	7	4
	Non Jurisdictional Complaints	1	0	0	0
	Occupational Therapist	2	2	0	0
	Osteopathic Physician	1	0	1	1
	Pharmacist	2	0	2	2
	Pharmacy	5	5	0	0
	Physical Therapist	2	0	0	2
	Physical Therapist	1	0	0	0

	Assistant				
	Physician Assistant	2	2	1	0
	Reg. Respiratory Therapist	4	0	0	1
	Registered Nurse	50	14	23	24
	Registered Pharmacy Technician	2	1	2	1
	Speech-Language Pathologist	1	0	0	1
	Sub-total	**166**	**55**	**66**	**69**
Failure remit Medicaid overpayment to state	Certified Nursing Assistant	1	1	0	0
	Medical Doctor	19	10	0	1
	Midwifery	1	0	0	1
	Osteopathic Physician	1	0	0	0
	Pharmacist	1	0	0	0
	Pharmacy	11	0	0	0
	Reg. Respiratory Therapist	1	1	0	0
	Registered Nurse	2	0	0	1
	Sub-total	**37**	**12**	**0**	**3**
		Complaints	**Pending**	**ESOs**	**Discipline**
	Overall Totals	**233**	**81**	**67**	**74**

Statutory Reporting Requirements

Number of cases opened and investigated each year

MFCU opened 356 cases and had 1,054 active cases in FY 2010-11. MPI investigated 5,368 cases which included 4,119 opened during the year.

Sources of the cases opened

	MFCU	PANE	AHCA
AHCA – Field Offices	5	1	6
AHCA – Division of Medicaid	1		779
AHCA – Health Quality Assurance	3	3	
AHCA – Medicaid Program Integrity	36	1	3048
AHCA – Office of Inspector General	1		
AHCA – Finance and Accounting			56
AHCA – Other			53
Anonymous	1		
APD – Agency for Persons with Disabilities	14	1	
APS - Adult Protective Services	6	38	
Citizen	22	1	8
CMS – Centers for Medicare & Medicaid Services	1		31
Confidential Informant	1		
Contractor for Centers for Medicare & Medicaid Services	1		
DOJ – US Department of Justice	1		
Employee	14	3	
Family Member	10	1	
FBI – Federal Bureau of Investigation	2		
Government Employee	1		
HHS – OIG Health & Human Services Inspector General	6	1	
HHS Health & Human Services	4		66
HMO Investigative Unit	4		2
Joint Taskforce	2		
Law Enforcement Agency	3	1	
Medicaid Provider	5	1	9
Medicaid Recipient	6		3
MFCU Data Mining Initiative	2		
MFCU Statewide Intel Team	1		19
Operation Spot Check	1	1	5
Press Report	2		
QUI TAM	135		
SSA - Social Security Administration	1		
Spin-off Case	10		
State Agency - Other	1		24
Federal Agencies – Other			10
Grand Total	303	53	4,119

Disposition of the cases closed each year

Disposition of Cases Closed	MFCU	PANE	AHCA
Acquittal		1	
Administrative Closure	31	17	
Administrative Referral	55	8	
Assistance to Other Agencies	1		
Case Dismissed	19	1	
Case Remanded	3		
Civil Intervention Declined	5		
Civil Judgment	2		
Civil Settlement	52		
Consolidated	17		
Contract Assessments			115
Conviction	27	13	
Defendant filed Bankruptcy	1		
Lack of evidence	28	14	
No Fraud or Abuse Found			1,006
Nolle Prosequi	2	2	
Overpayment Identified			1,907
Plea Agreement	6	2	
Pretrial Intervention	1	4	
Prosecution declined	1	6	
Provider Education Letter			513
Sanction Only			300
Unfounded	16	13	
Voluntary Dismissal	2		
Total	**269**	**81**	**3,841**

MPI closed 3,841 cases during FY 2010-11. For 1,006 cases there were no findings of fraud and abuse and, therefore, no further action was taken. There were 513 cases closed after findings of non-compliance, but there were no resulting overpayments and the providers were issued a provider education letter. There were 115 cases for which contractual assessments were imposed, 300 cases for which sanctions only were imposed and 1,907 cases that 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 amounts due.

Amount of overpayments alleged in preliminary and final audit letters

Typically, MPI sends a preliminary report explaining the overpayment provisionally identified and giving the provider an opportunity to provide additional documentation. After review of any additional documentation submitted, MPI sends a final audit report that reflects the overpayments identified

and offers the provider hearing rights under Chapter 120, Florida Statutes. For the 3,841 cases closed during the fiscal year there were 1,907 cases with findings. Preliminary audit reports were issued on 1,030 cases with potential identified overpayments in the amount of $29,485,094.09. MPI closed 510 of those cases when the provider agreed to repay the overpayment after the preliminary audit report with identified overpayments of $1,734,512.32. In the remaining 520 cases, final audit reports were issued identifying potential overpayments of $15,424,287.87. These cases ultimately were closed after *Final Orders* with identified overpayments of $10,699,828.94. The total overpayments identified for collection in these 1,030 cases amounted to $12,434,341.26.

In addition to the overpayments identified in those 1,030 cases, the bureau identified overpayments in the amount of $26,576,816.05 through other mechanisms. These efforts included recovery of overpayments prior to the issuance of preliminary audit reports, overpayments identified through provider self audits and overpayments collected through paid claim reversals and offsets from future payments. The total identified overpayments amounted to $39,011,157.31 for all 1,907 cases closed with findings during the fiscal year.

Number and amount of fines or penalties imposed

During the fiscal year, MPI initiated 373 prepayment reviews, required two corrective action plans, imposed fines of $ 957,609.11, recommended 106 suspensions and recommended 44 "with cause" terminations. They also made 585 referrals to MFCU and others within and outside the Agency.

Reductions in overpayment amounts negotiated in settlement agreements or by other means

There were no negotiated settlements during FY 2010-11.

Amount of final agency determinations of overpayments

MPI recovery activities on closed cases for the fiscal year determined overpayments of $39,011,157.31.

Amount deducted from federal claiming as a result of overpayments

Requirements have changed to allow up to one year for the return of the federal share of overpayments. The Agency reports the federal portion of the total overpayment on the corresponding *CMS-64* quarterly reports as payments are received. If the payment plan exceeds one year, the full amount due to CMS is reported on the last appropriate quarterly report. During FY 2010-11, AHCA reduced its federal claiming by $31 million for net overpayments determined.

Amount of overpayments recovered each year

MFCU collected $28,607,110.95 in overpayments that were returned to AHCA. Additionally, MFCU collected $61,766,805.01 in federal Medicaid overpayments which were sent directly to the U. S. Department of Health and Human Services for a total of $90,373,915.96 in Medicaid overpayments collected in FY 2010-11.

During FY 2010-11, total collections for the Agency for Health Care Administration, net of adjustments and refunds approached $63.7 million. The collections were: $50.3 million in overpayments ($28.8[1] million collected from MFCU cases and $21.5 million collected from MPI cases); $1.5 million in investigation costs; $11.7 million in fines/sanctions; and, $.2 million in interest.

Amount of cost of investigation recovered each year

During FY 2010-11, the MFCU collected $89,591.09 in investigative costs.

Average length of time to collect overpayment in full

For cases that were 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 332 days.

Amount determined as uncollectible

For all accounts receivable determined to be uncollectible, AHCA must obtain approval from the Department of Financial Services for write-off. $390,990.24 in accounts receivable were approved for write-off.

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

In addition to the providers terminated as referenced in the following graphic, two providers were terminated due to a federal exclusion. An additional 29 providers were identified as potentially connected to issues of fraud or abuse – these are providers who were terminated either voluntarily or involuntarily but not related to specific acts of fraud or abuse. Often-times, these are providers under review by MPI who voluntarily withdraw from the program.

[1]This figure does not reconcile with MFCU as there are timing issues involved in the reporting and collection of the money. Additionally, money is returned directly to the Agency without going through MFCU, even though MFCU's enforcement actions triggered the recovery, such as sums received from the Department of Corrections through court-imposed orders of restitution against convicted parties.

FY 2010-11 Terminations	
Community Behavioral Health Services	2
Assistive Care Services	9
Birth Center	1
Chiropractor	2
Dentist	2
Durable Med Equipment/ Medical Supplies	0
Hearing Aid Specialist	1
Home & Community-Based Services Waiver	42
Home Health Agency	14
Nurse Practitioner (ARNP)	1
Pharmacy	8
Physician (D.O.)	2
Physician (M.D.)	29
Physician Assistant	1
Podiatrist	1
Professional Early Intervention Services	3
Rural Health Clinic	1
Specialized Mental Health Practitioner	3
Therapist (PT, OT, ST, RT)	9
Total	131

All costs associated with Medicaid overpayments recoveries

MFCU expenditures for FY 2010-11 were $15,382,691.49, which included indirect costs of $1,119,648.74.

Expenditures for MPI in FY 2010-11 were $8,516,519, which included salaries, expenses and contractual services. In addition, costs of $1,373,866 were allocated for support from the Office of General Counsel, Office of Inspector General, Bureau of Finance and Accounting and Medicaid Contract Management. Additionally there was an allocation for Agency indirect costs of $1,384,342 and the Bureau of Medicaid incurred expenses for services related to MPI activities for $2,925,022. Therefore, total costs of $14,199,749 were associated with MPI operations.

Providers prevented from enrolling in or reenrolling as a result of suspected fraud or abuse

In addition to the providers denied or prevented reenrollment as referenced below, an additional 143 providers were denied due to findings during an on-site pre-enrollment visit, 144 providers were denied due to disqualifying criminal offenses and one provider was denied due to a federal exclusion.

Prevented from Enrolling or Reenrolling	
Type of Provider	Number
Assistive Care Services	1
Billing Agent	0
Case Management Agency	1
Children's Medical Services	2
Chiropractor	2
Community Behavioral Health Services	3
Dentist	1
Durable Medical Equipment/Medical Supplies	4
Home & Community Based Services Waiver	4
Home Health Agency	22
Nurse Practitioner (ARNP)	4
Paraprofessional Early Intervention Services	2
Pharmacy	5
Physician (D.O.)	1
Physician (M.D.)	17
Physician Assistant	0
Portable X-ray Company	1
Prescribed Medical Rehab Services (PPEC)	1
Skilled Nursing Facility	1
Social Worker/Case Manager	2
Specialized Mental Health Practitioner	3
Therapist (PT, OT, ST, RT)	1
Total	78

Policy Recommendations

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

In order to continue to enhance the capabilities of AHCA and the Attorney General's Medicaid Fraud Control Unit with respect to anti-fraud and abuse efforts, the following recommendations are presented:

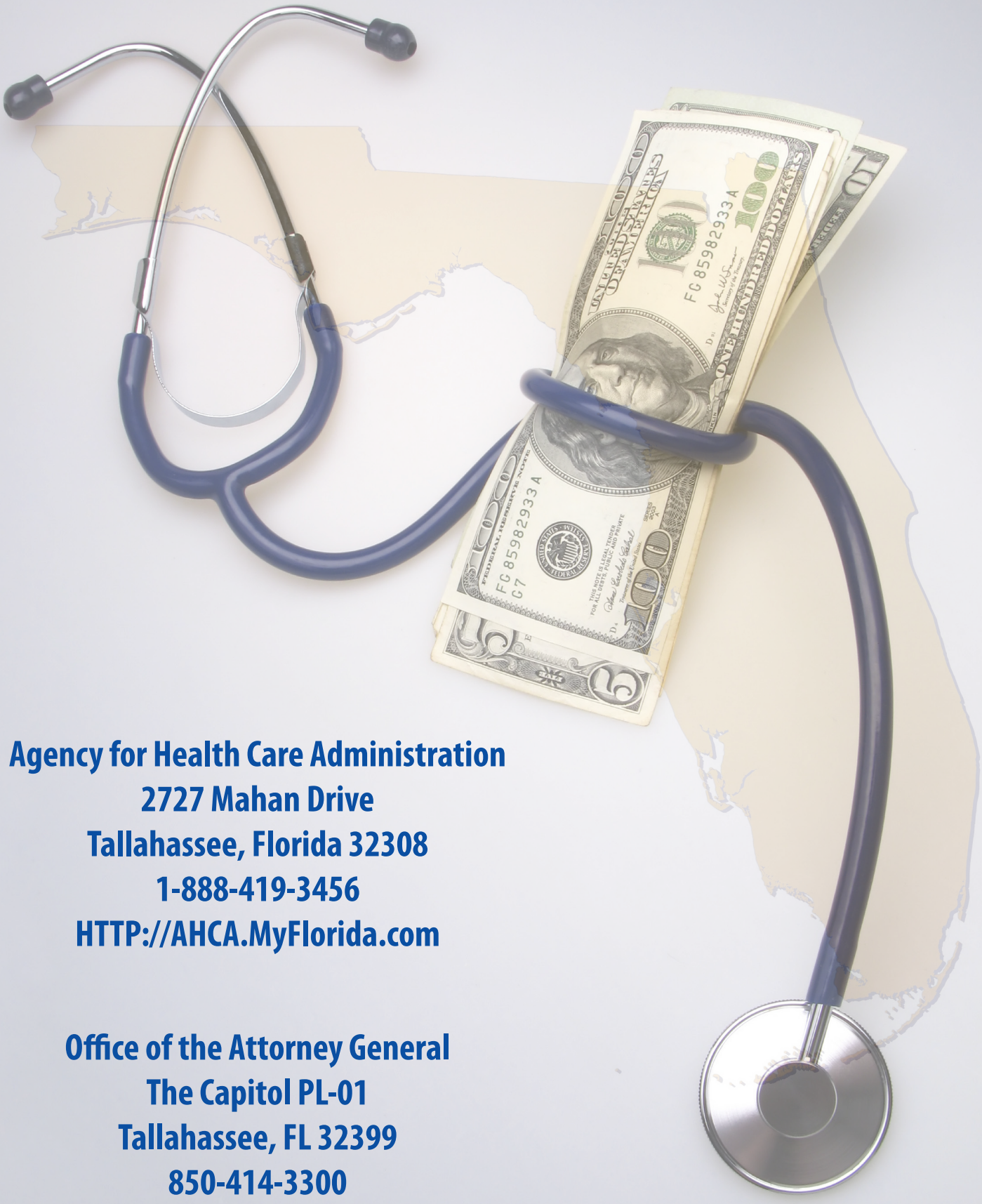
- Stakeholders in Florida's Medicaid program should support AHCA's efforts to obtain a grant from the U. S. Office of Management & Budget for the development of the nation's first Medicaid Program Integrity Network. Such a network would facilitate the secure exchange of information used to prevent and detect health care fraud and abuse within state health care

administration agencies, state agencies maintaining fraud databases and federal entities. The pilot project proposed by AHCA involves the development of the nation's first Program Integrity Network in three phases with the following goals:

- Establish a common technical architecture for states to utilize in their information exchanges;
- Create data standardization methods; and
- Integrate systems that house health care fraud information (case management systems, background screening systems, online licensing systems); and, using the integrated systems to provide effective and efficient oversight of the Medicaid program.

- Florida's Legislature should support and pass the proposed Medicaid Program Accountability Bill introduced by Senator Don Gaetz. This bill (SB1316) contains several enhancements to existing law that would serve to combat fraud and abuse within Florida's Medicaid program. Among the many accountability measures included in this proposed bill, this legislation would:
  - Clarify the applicability of immunity from civil liability extended to persons who provide information about fraud or suspected fraudulent acts by a Medicaid provider;
  - Provide that all persons who were denied renewal of licensure, certification or registration under s. 456.0635(3), F. S., may regain licensure, certification or registration only by completing the application process for initial licensure;
  - Revise the background screening requirements for persons rendering care in the consumer-directed care program administered by the Agency for Health Care Administration;
  - Extend the records-retention period for certain Medicaid provider records;
  - Revise the provider agreement to require Medicaid providers to report changes in any principal of the provider to the Agency;
  - Define the term "administrative fines" for purposes of revoking a Medicaid provider agreement due to changes of ownership;
  - Specify the principals of a hospital or nursing home provider for the purposes of submitting fingerprints for background screening;
  - Authorize the Agency to review and analyze information from sources other than Medicaid-enrolled providers for purposes of determining fraud, abuse, overpayment or neglect;
  - Require that payment arrangements for overpayments and fines to be made within a certain time; and
  - Specify that the venue for all Medicaid program integrity cases lies in Leon County.
- In accordance with 2009-223, Laws of Florida, the Agency developed a strategic plan to link all state databases containing health care fraud information. AHCA's Fraud Steering Committee should continue its implementation of the resulting *Strategic Plan for Health Care Fraud Database Connectivity*, including the coordination of inter-agency and intra-agency communications with stakeholders, identifying and developing standards to interface with state and federal health care fraud databases whenever possible.

- As the Medicaid program continues to shift from a fee-for-service environment to a managed care model, re-purposing fraud and abuse detection specialists from fee-for-service activities to managed care payment monitoring and oversight will ensure that the savings realized from a shift to managed care are not reduced by fraud and abuse. Existing Medicaid Program Integrity resources should continue to be trained and re-assigned to review managed care anti-fraud plans and analyze the annual fraud and abuse experience reports submitted by the managed care plans to assist in the development and coordination of anti-fraud strategies for the managed care plans. Additional staff currently assigned to fee-for-service audits and oversight should be systematically transitioned to review managed care plans' financial information, encounter data and other operational data reported by managed care organizations, as fee-for service provider arrangements are phased out.
- AHCA and the MFCU should improve relationships with managed care organizations' s*pecial investigative units* (SIUs).
    - As previously mentioned, these SIUs are required to develop anti-fraud plans and report their anti-fraud experiences annually to AHCA's Bureau of Medicaid Program Integrity. Forging stronger partnerships with the SIUs, including conducting joint training classes and sharing information on suspected fraud and abuse, can enhance fraud detection and further suppress fraud and abuse in the Medicaid program.
- The Memorandum of Agreement between AHCA and the Department of Children & Families should be revised to increase the emphasis on recipient eligibility errors 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 in Florida. Ensuring that Medicaid recipients who are simultaneously enrolled in other states' Medicaid programs are detected, utilizing such tools as the federal Public Assistance Reporting Information System (PARIS), can identify unnecessary or duplicative Florida Medicaid capitation payments and eliminate them.
- AHCA and the MFCU should continue to work with other State of Florida agencies, federal agencies and local law enforcement to improve Florida's ability to identify medical service delivery fraud and abuse trends in other jurisdictions and prevent, detect and prosecute such emerging offenses in Florida.
- AHCA should continue to expand the use of contingency or no-cost contracts designed to detect and prevent improper Medicaid payments and recover overpayments.



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

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

Designed and Produced by AHCA Multimedia Design