The State's Efforts to Control Medicaid Fraud and Abuse FY 2011 - 2012

ATTORNEY GENERAL
STATE OF FLORIDA

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

December 31, 2012

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 2011-12. 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

cc: The Honorable Seth McKeel
The Honorable Matt Hudson
The Honorable Richard Corcoran
The Honorable Kenneth Roberson
The Honorable Gayle Harrell
The Honorable John Wood
The Honorable Will Weatherford
The Honorable Joe Negron
The Honorable Aaron Bean
The Honorable Denise Grimsley
The Honorable Don Gaetz

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Statutory Authority

Section 409.913, Florida Statutes, requires in part that

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

The Agency for Health Care Administration (Agency) and the Medicaid Fraud Control Unit (MFCU) of the Attorney General's Office have continued their joint efforts to prevent, reduce and mitigate health care fraud, waste and abuse. Staff from the Agency, MFCU and the Department of Health (DOH) meet 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 their efforts to combat fraud. Other partners that are engaged to ensure that Medicaid funds are directed appropriately include 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).

This joint report presents the results of the Agency's and MFCU's efforts to control Medicaid fraud and abuse for FY 2011-12.

Medicaid Fraud Control Unit

Overview of the Medicaid Fraud Control Unit

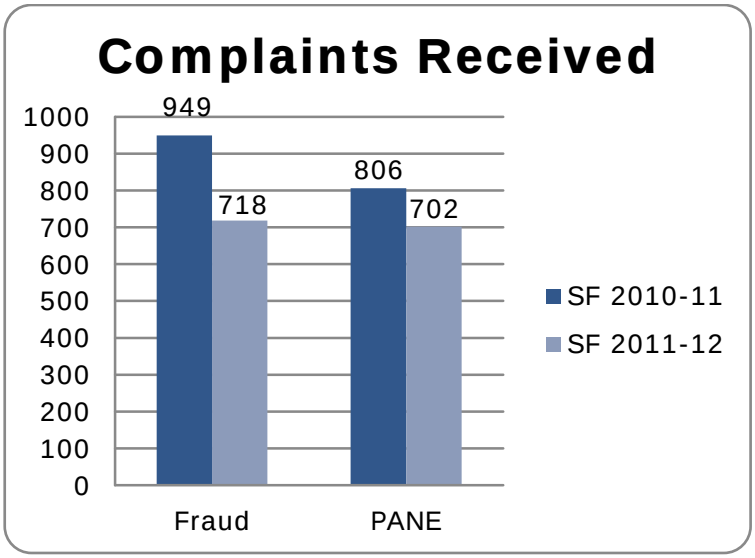
There were 210 full-time employees (FTEs) assigned to the MFCU in FY 2011-12. One hundred sixteen positions are investigators and their supervisors or managers, 27 are attorneys and the remaining are professional support positions such as auditors, analysts and administrative staff. For most operational 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 (19 FTEs) and Pensacola (seven FTEs). The Central region has 42 assigned FTEs and has offices in Orlando (14 FTEs), Tampa (27 FTEs) and St. Petersburg (one FTE). The South region has 70 assigned FTEs and has offices in Miami (37 FTEs), Ft. Lauderdale (18 FTEs) and West Palm Beach (15 FTEs). Additionally, there are two other entities within MFCU, the Director's office (14 FTEs) and the Complex Civil Enforcement Bureau (22 FTEs). MFCU had 23 positions in reserve that were not funded for FY 2011-12.

The primary investigative focus of the MFCU is Medicaid fraud and Patient Abuse, Neglect and Exploitation (PANE) cases. Each office has separate squads and investigators assigned to handle either fraud investigations or PANE cases. The attorneys assigned to the Unit provide legal advice to the investigative staff on both types of cases. Prosecution has traditionally been handled by the local State Attorney's Offices (SAOs) or the Office of Statewide Prosecution. However, efforts to receive "special-designation" of MFCU attorneys by State's Attorneys' Offices and United States Attorney's Offices have been productive, thus enabling MFCU attorneys to prosecute 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 2011-12, the Unit received a total of 1,420 complaints of which 324 were opened as operational cases. For FY 2010-11, the Unit received a total of 1,755 complaints of which 356 were opened as operational cases.



For FY 2010-11, of the 1,755 complaints received, 949 were related to fraud and 806 were related to PANE. Of the 1,420 complaints received in FY 2011-12, 718 were related to fraud and 702 were related to PANE allegations.

The primary source of fraud complaints in FY 2010-11 was citizens with 314 complaints reported. AHCA, via its Medicaid Program Integrity (MPI) unit, accounted for 100 of the Medicaid fraud complaints received. One hundred thirty-four *qui tam* complaints were received.

In FY 2011-12, the primary source of Medicaid fraud complaints was again citizens; 187 complaints received were made by private citizens. Medicaid recipient complaints were the next highest source of fraud complaints with 105 and *qui tam* complaints followed with 84. Other sources of Medicaid fraud complaints included 70 from family members and 52 from employees of providers. AHCA, via its Medicaid Program Integrity (MPI) unit, accounted for 47 of the Medicaid fraud complaints received.

The overwhelming majority of PANE complaints are generated by the Department of Children & Families (DCF). In FY 2010-11, of the 806 PANE complaints, 589 came from DCF. Citizen complaints accounted for 85 complaints.

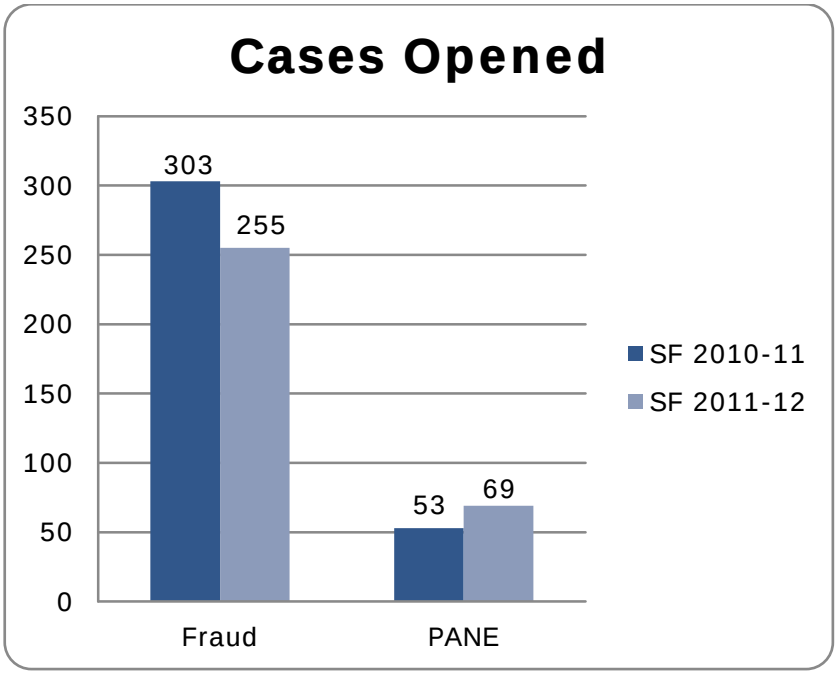
In FY 2011-12, of the 702 PANE complaints, 557 came from DCF. The next highest source of PANE complaints were family members, who accounted for 33 complaints

Case Investigations

Complaints are reviewed to determine issues such as MFCU jurisdiction, administrative referral, referral to another agency and viability of the complaint. The opening of a case indicates that a criminal investigation or civil case has been opened; and significant investigative resources and time will be expended to identify those involved in possible criminal misconduct, determine the scope of the criminal activity and establish sufficient evidence to prove the requisite criminal elements. Most of the decision-making regarding opening or closing of criminal investigations is made at the regional level. Presently, there are mandatory monthly case reviews during which the Regional Chief and Captain review the cases assigned to a specific office with the case team. Interaction on case investigations is also conducted by supervisors, primarily Lieutenants, on a case-by-case basis.

In FY 2010-11, the MFCU opened 356 total cases. Of those cases, 303 cases were related to Medicaid fraud. The remaining 53 cases were PANE cases. The North Region opened a total of 79 cases. Of those cases, 53 were related to Medicaid fraud and 26 were PANE cases. The Central Region opened a total of 73 cases, of which 62 were related to Medicaid fraud. The remaining 11 case openings were PANE cases. In the South Region, there were a total of 77 cases opened in FY 2010-11. Sixty-one of the case openings were related to Medicaid fraud and the remaining 16 were PANE cases. The Complex Civil Enforcement Bureau (CCEB) opened 126 *qui tam* litigation cases which are included in the fraud case total.

In FY 2011-12, the MFCU opened a total of 324 cases. In FY 2011-12, the North Region opened a total of 105 cases. Of those cases, 60 were related to Medicaid fraud. The remaining 45 case openings were PANE cases. In the Central Region, there were a total of 83 cases opened. Of these, 68 were related to Medicaid fraud. The remaining 15 were PANE cases. In the South Region, there were a total of 50 cases opened in FY 2011-12. Of these, 41 were related to Medicaid fraud and the remaining nine cases were PANE cases. The Complex Civil Enforcement Bureau (CCEB) opened 86 *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 fraud cases in FY 2010-11 and the specified period of FY 2011-12, ranked most to least frequent:

FY 2010-11	**FY 2011-12**
Pharmaceutical Manufacturer	Physician (MD)
Home & Community Based Service	Pharmaceutical Manufacturer
Physician (MD)	Home & Community Based Service
Pharmacy	Pharmacy
Medical Supplies/Durable Medical Equipment	Assistive Care Services, Dentist, General Hospital

The following is a list of the top five Provider types for PANE cases in FY 2010-11 and the specified period of FY 2011-12, ranked most to least frequent:

FY 2010-11	**FY 2011-12**
Facility Employee	Skilled Nursing Facility
Assistive Care Services	Home & Community Based Service
Home & Community Based Service	Facility Employee
Assisted Living Facility	Assistive Care Services Certified Nursing Assistant
Care Giver	Assisted Living Facility

For 2011-12, physicians (MDs) were the predominant provider type for Medicaid fraud investigations, while Skilled Nursing Facilities and Home & Community Based Services were the predominant type for PANE case openings.

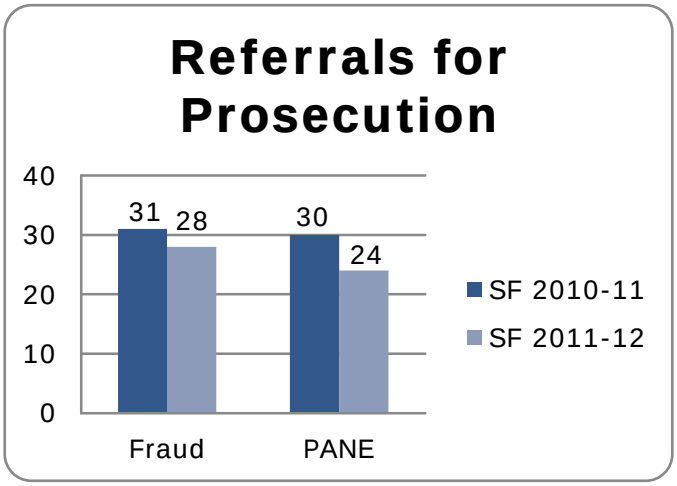
Disposition of Cases

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 or a lack of evidence. There are several classifications presently used that track the ultimate disposition of closed cases. It is important to note that cases closed during a particular fiscal year have no relationship to cases opened during the same year. In almost all Medicaid fraud case investigations, PANE investigations and *qui tam* actions, the time from initial review to case closing will encompass 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 2011-12, the MFCU closed 269 cases. Of those, 213 involved Medicaid fraud investigations and 56 involved PANE cases.

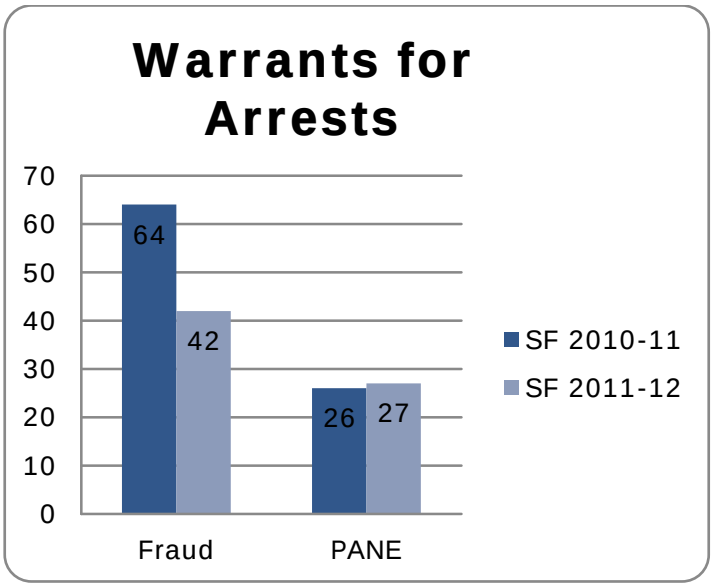
Enforcement actions are a paramount consideration for the MFCU. At the conclusion of any investigation, referrals for prosecutions, execution of arrest warrants and monetary recoveries are indicators of successful case outcomes. In FY 2010-11, 61 cases were referred for prosecution. Thirty-one of these cases were based upon Medicaid fraud investigations and the other 30 were based upon PANE investigations. The Southern Region accounted for 19 of these referrals for prosecution, the Northern Region accounted for 23 prosecution referrals and the Central Region accounted for 19 prosecution referrals.

For FY 2011-12, 52 cases were referred for prosecution. Twenty-eight of these cases were based upon Medicaid fraud investigations and the other 24 were based upon PANE investigations. The Northern Region accounted for 20 of these referrals for prosecution, the Southern Region accounted for 19 prosecution referrals and the Central Region accounted for 13 prosecution referrals.



In FY 2010-11, there were 90 arrests/warrants made based upon MFCU criminal investigations. Sixty-four of these arrests/warrants were related to Medicaid fraud investigations and 26 were for PANE investigations. The South Region accounted for 35 of these arrests/warrants, which were predominantly for Medicaid fraud. The Northern Region accounted for 32 arrest/warrants and the Central Region accounted for 23 arrests warrants in FY 2010-11.

For FY 2011-12, there were 69 arrests/warrants made. Forty-two of these were Medicaid fraud investigations and 27 were for PANE investigations. The South Region accounted for 30 of the arrests/warrants. The North Region accounted for 21 arrests/warrants and the Central Region accounted for 18 arrests/warrants.



Investigative Strategy

The MFCU has two primary areas of enforcement responsibility: fraud perpetrated against the Medicaid Program and Patient Abuse, Neglect & Exploitation. Enforcement in these areas, which includes both criminal and civil enforcement actions, should help prevent, detect, prosecute and deter these types of misconduct in order to protect the citizens of Florida. Case management, including case openings, investigative activities, legal review/prosecution, prioritization, utilization of investigative/legal resources and other related issues were handled on a case-by-case or office-by-office basis.
MFCU's formal Investigative Strategy requires unit members to focus on the following:

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

Data-Mining

On July 15, 2010, U. S. Department of Health & Human Services Secretary Kathleen Sebelius granted the State of Florida a waiver of a portion of 42 CFR 1007.19, allowing Federal financial participation in MFCU 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 provided for a duration of three years, limiting the amount of MFCU staff time to be utilized in data mining, and the required submission of a detailed plan describing how the MFCU ensured its data mining efforts were coordinated and did not duplicate data mining efforts of AHCA's Bureau of Medicaid Program Integrity.

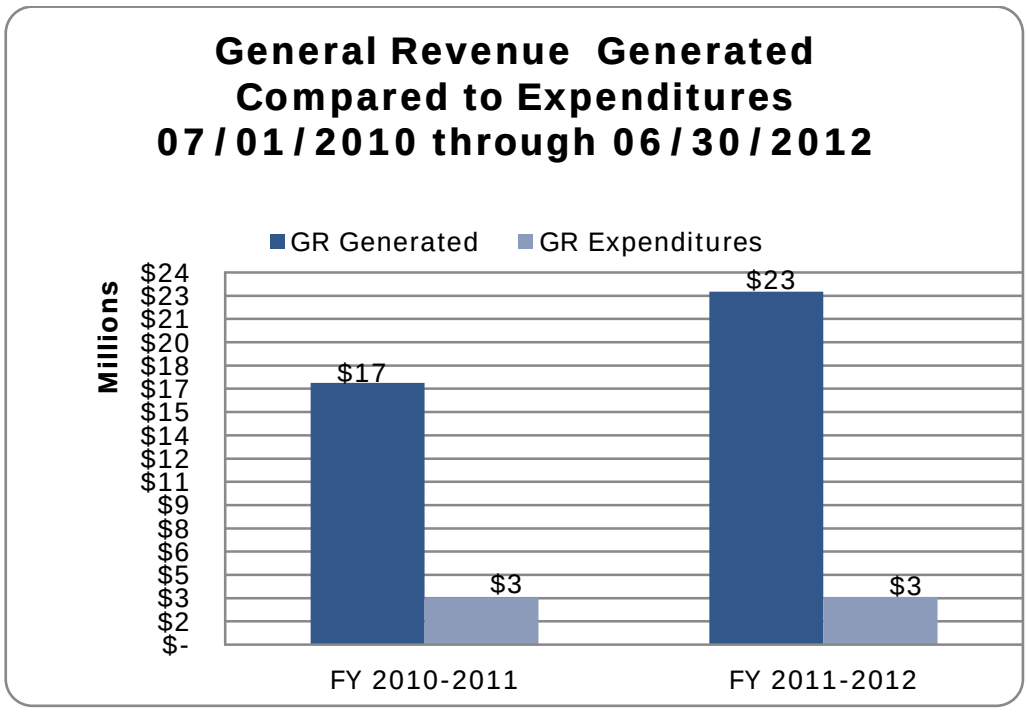
The Memorandum of Understanding between the MFCU and the single-state-agency was amended to provide a system to ensure the data mining efforts would be coordinated with and not duplicate efforts of the single-state-agency. As of June 30, 2012, the MFCU has submitted 63 data mining projects to the single-state-agency for review. MFCU has 36 cases and 13 complaints opened from these projects and are currently developing additional facts.

Budget

The Medicaid Fraud Control Unit's budget is a hybrid of federal grant dollars from Federal Financial Participation (FFP) which accounts for 75 percent of its total budget and state dollars. According to the requirements of the federal statutes and regulations concerning the FFP, the remaining 25 percent must come from the State of Florida's General Revenue Fund and program income (used as matching dollars). In FY 2011-12, the MFCU budget was:

Federal Financial Participation	$12,537,301
Florida General Revenue/Match	$ 4,179,100
TOTAL	$16,716,401

Due to the critical general revenue shortfalls in previous FYs and continuing in FY 2011-12, the Medicaid Fraud Control Unit's general revenue budget reduction was approximately $631,290 which resulted in an additional loss of $1.89 million in federal funds to the State of Florida. The loss of funding for the MFCU comes at a time when the unit has improved efficiency and brought in $22.7 million dollars in FY 2011-12 in collections to 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 imposed and interest that was deposited into General Revenue.

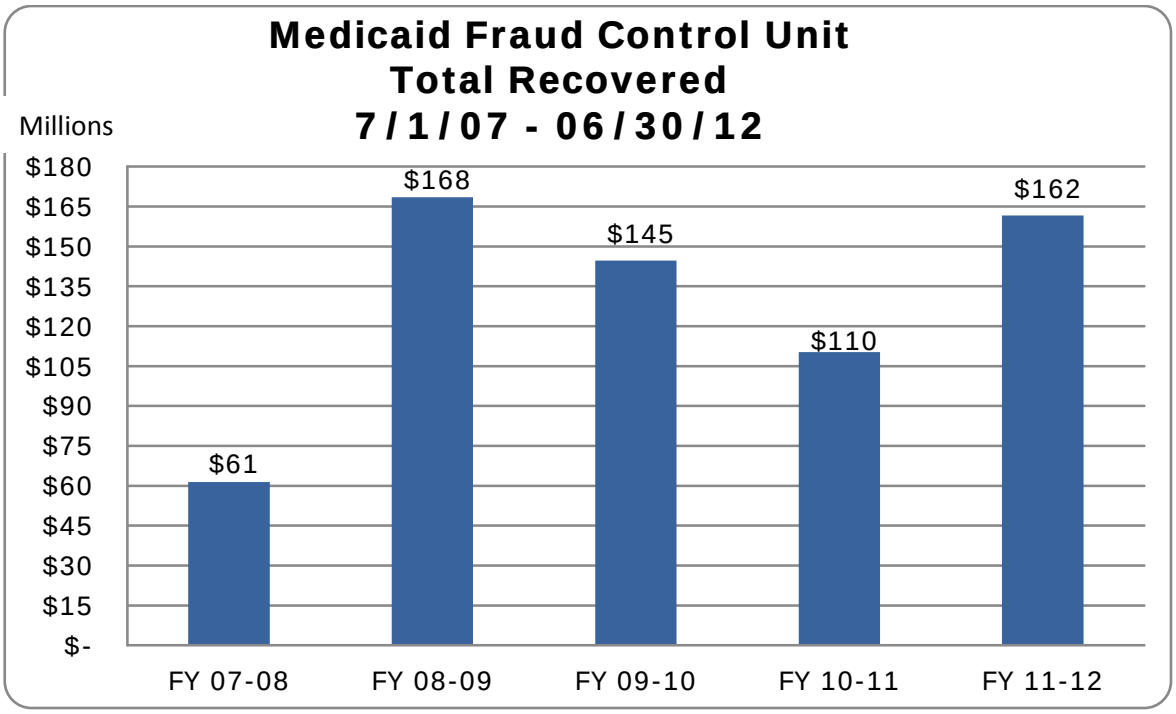
For FY 2011-12, for every General Revenue dollar spent, the MFCU generated approximately $7.39 through penalties imposed and interest deposited into General Revenue.

Total Recoveries

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

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

In addition to its role in multi-state investigations, the CCEB successfully resolved several false claims cases against major pharmaceutical manufacturers which were litigated in Leon County, Florida. The defendant drug manufacturers artificially inflated the prices of their drugs in a scheme that has cost the Florida Medicaid Program millions of dollars. This litigation is continuing and is expected to result in additional recoveries for the State of Florida.



In FY 2011-12, the total amount for civil recoveries, which include civil settlements arising from *qui tam* cases brought under Florida's False Claims Act, was $145,374,604.

In FY 2011-12, the total amount for *criminal* recoveries based upon Medicaid fraud cases was $14,020,038.65.

The total amount of the monies recovered by the MFCU for FY 2011-12 was $161,667,067.96. It should be noted that during this fiscal year, the Attorney General's Office Medicaid Fraud Control Unit's recoveries generated $22,720,363.51 through penalties imposed and $37,431.82 in interest that was deposited into the State of Florida's General Revenue Fund.

Training

Once again, due to continuing budgetary constraints, only mission critical training was approved. However, "mission critical" took on a new meaning for Investigators and Analysts. With more complex investigations, expanded duties and a reduced workforce, investigators and analysts had to become more self-reliant. Therefore investigators and analysts had to take additional specialized training classes. These specialized classes included training for complex civil litigation, query databases for FMMIS 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).

During FY 2011-12, Medicaid Fraud Control Unit staff attended a total of 4,269.75 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 the New York Office of the Medicaid Inspector General (webinar) and 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), Area Agencies on Aging, the Department of Homeland Security, the Multi-jurisdictional Counterdrug Task Force, 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 and Sheriff's Offices, to name a few.

Classroom training focused, in part, on 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, Prescription Drug Abuse, Computer Crimes & Fraud, Civil False Claims Act and Qui Tam Enforcement, Cardio Pulmonary Resuscitation (CPR), Advanced Financial Investigations, Money Laundering and Asset Forfeiture, Medicaid Provider Compliance and Regulation, Analytical Investigative Techniques, DSS Training for Data Mining Analysts, Criminal Justice Information Services (CJIS) Certification, Photographic Lineups in Eyewitness Identification, Pharmaceutical Drug Investigations.

In-house training provided through a variety of delivery methods focused on topics such as Leadership/Supervision and Performance Evaluation, Customer Service, Performance Coaching, Recruitment and Selection, Ethics, 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

Par Pharmaceuticals, Inc.

On August 9, 2011, Florida entered into a $26.6 million settlement agreement with Par Pharmaceuticals and its corporate affiliates to resolve claims of Medicaid fraud. These companies 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, the drug manufacturers caused the Florida Medicaid Program to overpay millions of dollars in pharmacy reimbursements.

The allegations constituted violations of the Florida False Claims Act and were originally filed by the 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 qui tam lawsuits.

The Agency for Health Care Administration, which is responsible for administering the Medicaid Program, received more than $3.8 million for the losses sustained by the Medicaid program. Florida's general revenue fund received more than $5 million and the Moiety reward program received $557 thousand. The 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.

L'Image Physical Therapy and Rehabilitation

Investigators with the Medicaid Fraud Control Unit began investigating L'Image Physical Therapy and Rehabilitation based on information received from the Agency for Health Care Administration. The investigation revealed that Nasim Hashmi, owner of the company in Miami-Dade County, fraudulently billed the Medicaid program for therapy provided by unlicensed therapists and overbilled for work provided by assistant therapists. The defendant was paid more than $484,000 by the Agency for Health Care Administration for these fraudulent claims.

On February 24, 2012, Nasim Hashmi pled no contest to two counts of Medicaid fraud, one count of grand theft and one count of organized scheme to defraud. He was sentenced to five years probation and ordered to repay $484,223.40 to the Medicaid program.

Watson Pharmaceuticals

Florida received a total of $20.2 million as part of a settlement with the states of Texas and New York and Watson Pharmaceuticals. Florida joined with the other states and the federal government to reach an agreement with Watson to settle allegations it knowingly set and reported false and inflated prices for

medications dispensed by pharmacies and other providers who were then reimbursed by the Florida Medicaid program.

The allegations constituted violations of the Florida False Claims Act and were originally filed by the 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 qui tam lawsuits.

The Agency for Health Care Administration received more than $1.6 million for the losses sustained by the Medicaid program. Florida's general revenue fund received more than $4.8 million and the Moiety award program received $537 thousand. The remaining funds from the settlement were paid directly from the settlement to the federal government and to the Relator.

Physician

The Northwest Florida Health Care Task Force referred information to MFCU after reviewing Dr. Bourlier's prescribing practices. The joint investigation resulted in a Federal Grand Jury returning a 151 count indictment against Dr. Bourlier. A jury trial resulted in Dr. Bourlier's conviction of 17 counts of health care fraud, 125 counts of dispensing a controlled substance and two counts of dispensing a controlled substance resulting in death. He was sentenced on October 28, 2011, to 360 months incarceration, three years of probation and ordered to pay restitution of $32,562.30 and a special assessment of $14,300.

Additionally, the office manager, Karen Bourlier was indicted by the Federal Grand Jury for obstruction of justice. She was convicted on May 24, 2011 and sentenced on October 21, 2011, to 30 months incarceration and two years of probation and ordered to pay a special assessment of $100 and a fine of $1,500.

The case was handled by the U. S. Attorney's Office of the Northern District of Florida.

Capricorn Retirement Home, Inc.

On November 16, 2011, Eldridge Charles Pratt was arrested by the Miami-Dade Police Department on a felony warrant by the Medicaid Fraud Control Unit. Mr. Pratt, the administrator of Capricorn Retirement Home, fraudulently billed the Medicaid program for assistive care services rendered to individuals who were not at the facility during the dates for which claims were submitted to the state. Records revealed that between January 2007 and January 2011, the assisted living facility was paid more than $45,000 for these fraudulent claims.

Pratt entered a guilty plea to one count of Medicaid fraud, one count of organized fraud and one count of grand theft. He was sentenced on February 23, 2012, to five years of probation and ordered to pay the Agency for Health Care Administration $45,943.52 and pay cost of investigation and cost of prosecution. This case was prosecuted by the Attorney General's Office of Statewide Prosecution.

Active Life Rehab, Inc.

As part of a health care fraud strike force investigation, Patrick Crisler, owner of Active Life Rehab, was indicted by a federal grand jury charged with submitting $1.28 million in fraudulent claims for occupational therapy services that were not provided. Crisler used Medicaid provider numbers of licensed therapists without their consent to bill for the never-performed services. He also inflated the

billing amounts for services rendered to Medicaid and Medicare patients by certified therapy assistants by using higher reimbursable billing codes for the services provided, commonly known as "upcoding".

The strike force included the U. S. Attorney's Office, the Federal Bureau of Investigation and the Florida Medicaid Fraud Control Unit. Crisler pled guilty to two counts of health care fraud on January 4, 2012 and was sentenced on May 9, 2012, to 30 months incarceration, 36 months of probation and ordered to pay $455,537.30 in restitution. The case was prosecuted by the U. S. Attorney's Office for the Middle District of Florida.

Heaven Sent Group Home

Acting in response to a referral from Department of Children & Families-Adult Protective Services, MFCU and AHCA investigated Heaven Sent Group Home in Ft. Pierce, Florida. The referral indicated that the residents of the home were not clean, the facility had a bad odor and the facility was filthy. Investigators found the home had no licenses and medications were stored in a locked cabinet only accessible with keys by facility personnel, which indicated evidence of the operating of an unlicensed assisted living facility.

Subsequent to the findings from interviews of the home's staff and residents, a Notice of Violation (Cease and Desist Order) was issued by AHCA. MFCU investigators obtained an arrest warrant for the owner and on May 26, 2011, Chan Gobin was arrested. On September 20, 2011, Gobin pled no contest to two counts of operating and/or owning an assisted living facility without a license. His adjudication was withheld and he was sentenced to three years of probation, 100 hours of community service, fined $1,050 and ordered to pay court costs and costs of prosecution.

Abuse and Neglect / Drug Diversion

MFCU received a referral from the Department of Children & Families-Adult Protective Services which indicated that a registered nurse was diverting pain medication prescribed for a patient in a skilled nursing facility. An investigation revealed the Kathleen Pimental, RN, was diverting Oxycodone pills and substituting other medication for the prescribed Oxycodone. Two substitute pills that were given to the patient were sent to the lab at the Florida Department of Law Enforcement which indicated that they were not Oxycodone, but were indicated as Risperidone (antipsychotic medication,) which was not prescribed for the patient by his physician.

On February 9, 2012, Kathleen Pimental was arrested on one count of neglect of a disabled adult and one count of obtaining a controlled substance by fraud. She pled no contest to the two charges on June 12, 2012. She was sentenced on June 18, 2012, to one year probation, ordered to undergo a Drug and Alcohol evaluation and if treatment was deemed necessary, to successfully complete treatment. Additionally, she was ordered to forfeit her nursing license.

Exploitation of an Elderly / Disabled Adult

In response to a referral from the Department of Children & Families-Adult Protective Services, MFCU investigated the allegation of a group home manager exploiting Medicaid recipients at the home. A review of the group home's documentation indicated that Stephanie Miller had stolen the recipients' Social Security funds. On April 28, 2011, she was arrested on five counts of exploitation of an elderly/disabled adult, one count of grand theft and one count of forgery. She pled no contest to the

charges on August 11, 2011, with adjudication of guilt withheld and was sentenced to three years probation, 150 hours of community service and ordered to pay restitution to the victims.

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 3.29 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, the elderly and the disabled. The operation of the Medicaid program is conducted by the Deputy Secretary for Medicaid, staff reporting directly to the Deputy Secretary for Medicaid, three Assistant Deputy Secretaries and six bureaus reporting to these Assistant Deputy Secretaries.

Utilization Norm and Utilization Management

The Agency maintains contracts with several vendors and also internally performs utilization management functions which include onsite and desk reviews of quality of care and claims monitoring for various provider types. Utilization management processes and the use of utilization norms help the Agency monitor the use of services to prevent unnecessary, excessive, duplicative or otherwise inappropriate expenditures as well as provide information to develop tools to increase positive outcomes as a result of the programs. Some examples of these efforts during FY 2011-12 are described below.

The Bureau of Field Operations monitors Behavioral Health providers, in conjunction with a vendor agency and tracks recoupments for non-compliant claims. During FY 2011-12, more than $3 million in overpayments were preliminarily identified and more than $1 million in overpayments were finalized and collected.

The Bureau of Field Operations also monitors school services and assists with provider self-audits; almost $47,000 in recoupments as a result of these efforts was realized in FY 2011-12.

The Agency's Bureau of Medicaid Services contracts with a federal *Quality Improvement Organization* (QIO), eQHealth Solutions Inc., for utilization management of fee-for-service Medicaid inpatient and home health services. EQHealth began conducting prior authorization reviews for these services June 1, 2011. Effective November 1, 2011, eQHealth began utilization management of speech language pathology, physical and occupational therapy services, as well as prescribed pediatric extended care (PPEC) services.

The Bureau of Medicaid Services implemented a prior authorization process through a contract with Med Solutions, Inc., including prospective and retrospective reviews for advanced diagnostic imaging services for fee-for-service recipients to determine medical necessity of magnetic resonance imaging (MRI), computed tomography (CT) and positron emission tomography (PET) studies. This contract has allowed

[1] These figures are from the July 31, 2012 monthly enrollment report.

the Division of Medicaid to identify providers who have an unusually large volume of referrals that may indicate fraud or abuse.

The Bureau of Medicaid Services, through a contract with Magellan Medicaid Administration (MMA), performs functions required to certify and enroll Medicaid providers, to ensure quality of services and to assist in the prevention and detection of Medicaid program fraud and abuse. MMA monitors compliance with service eligibility determination procedures, service authorization policy, staffing requirements and service documentation requirements in accordance with s. 409.913, F. S. and 42 CFR 456. MMA conducts utilization, monitoring and certification (where applicable) reviews for Community Behavioral Health Services and Mental Health Targeted Case Management. They also conduct prior authorization and continued stay reviews for the Statewide Inpatient Psychiatric Program and for Mental Health and Substance Abuse Inpatient hospitalizations. MMA also conducts retrospective reviews in certain programs and performs quality of care monitoring reviews. All of these monitoring activities have resulted in a reduction of excess lengths of stay, which has in turn resulted in a reduction of expenditures of more than $30 million.

December 2011 marked the completion of the second year of the Florida Statewide Quality Assurance Program (FSQAP) contract. This contract provides for utilization management through oversight of provider performance and person-centered review activities for individuals receiving services through the Developmental Disabilities (DD) Home and Community-Based Services waivers or the Consumer Directed Care Plus (CDC+) program. The Delmarva Foundation, under a contract with the Agency, conducts Provider Discovery Reviews (PDR) and Person Centered Reviews (PCR) to provide AHCA and the Agency for Persons with Disabilities (APD) performance information about providers, individuals receiving services and service delivery systems.

Protocols are in place to ensure that any situation which might cause harm to an individual, including situations related to individuals having direct contact with recipients without appropriate background screening documentation, is appropriately reported. APD has the primary responsibility for remediating provider issues for individuals receiving services through the Developmental Disabilities (DD) Home and Community-Based Services waivers or the Consumer Directed Care Plus (CDC+) program and to verify that providers have corrected deficiencies. Where corrections are not implemented, APD may enforce corrective action, recommend recoupment and refer the provider to AHCA's Bureau of Medicaid Program Integrity or the Medicaid Fraud Control Unit for further investigation. APD may also terminate the provider agreement.

During the contract year 2011 (the latter six months of which fall within the time period of this report) Delmarva reviewers completed 2,688 Provider Discovery Reviews to determine compliance with policies and procedures as dictated in the Florida Medicaid Developmental Disabilities Waiver Services and Limitations Handbook. Results from these reviews are posted to the Delmarva public Web site, providing public knowledge of provider performance. A summary of the Provider Discovery Review (PDR) Activity for the entire calendar year of 2011 is below:

Provider Discovery Review Activity: January – December 2011				
APD Area	Number of PDRs	Waiver Participants Served	CDC+ Participants Served	Non-Compliant Providers
1	75	2,403	35	0
2	206	3,577	93	2
3	149	2,786	82	6
4	300	5,047	172	13
7	246	5,399	269	14
8	116	2,388	44	1
9	103	2,766	81	1
10	229	4,872	212	2
11	359	8,632	243	12
12	118	2,109	27	1
13	141	3,301	69	6
14	70	1,829	15	3
15	124	1,974	140	3
23	432	11,349	380	21
State Total	2,668	58,432	1,862	85

The Florida Medicaid Fee-For-Service 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 ensures 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 payment system 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.

The following chart represents FFS pharmacy claims denials for FY 2011-12. As the chart indicates, there were 7,357,807 unique claims denials and the dollar amount associated with these denials totals $1,001,773,904.14. 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.

FFS denied claims summary for claims adjudicated between 07/1/11 - 06/30/12			
NCPCP Reject Code	Claims Count	Amount Associated with Denied Claims	NCPDP Reject Code Description
22	43,427	$3,739,235.84	M/I dispense as written code
60	187,029	$27,524,059.24	Product/Service not covered for patient age
61	2,616	$395,614.96	Product/Service not covered for patient gender
70	1,515,635	$86,003,747.07	Product/Service not covered
73	11,681	$535,703.31	Refills are not covered
75	1,800,455	$443,050,469.59	Prior authorization required
76	1,296,271	$229,710,053.61	Plan limitations exceeded
83	239,928	$22,782,787.77	Duplicate paid/Captured claim
88	3,106,874	$349,963,452.24	Drug utilization review reject error
Unique Claims Summary	7,357,807	$1,001,773,904.14	

Note: The claims counts in lines 5 through 13 are unique to relevant reject code only. If a single claim denies with multiple reject code, it is counted under each reject code. The unique claims summary claims are counted only once even if multiple reject codes were associated with the claims.

Provider Accountability and Increased Provider Enrollment Requirements

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

- The Bureau of Medicaid Contract Management has implemented a system enhancement to ensure that all enrolled providers are notified at least 90 days' in advance of their provider agreement expiring that they will need to go through the re-enrollment process to ensure they maintain a continuously active Medicaid status. This automated process will better ensure that all enrolled providers have current provider agreements, background screening results and up-to-date address data and ownership data for their FMMIS records.
- The Bureau of Field Operations performs random and mandatory site visits for a variety of provider types who have applied to become Medicaid providers. The focus of the visits is to ensure the existence of a physical site, that the licensure is complete and current and that necessary inventory and equipment exists, prior to enrollment in the Medicaid Program.
- The Division of Medicaid's Bureau of Medicaid Services and the Fraud Prevention and Control Unit (FPCU) have cooperatively developed Assisted Living Facility (ALF) Awareness and Observation Training for Agency staff, Medicaid operating partners and other individuals who are routinely in ALFs to assist them in knowing when to make referrals to the Agency. Increased referrals to the Agency promote an increase in provider accountability.
- The Bureau of Medicaid Services coordinates the Medicaid Certified School Match Program. The purpose of the Medicaid Certified School Match Program is to provide reimbursement for medically necessary services provided by or arranged by a school district for Medicaid eligible

students. During FY 2011-12 this program has moved from voluntary monitoring to mandatory monitoring in an effort to increase compliance of program policy and procedures.

- The Bureau of Medicaid Services educated providers regarding a tangible definition of the term "compliance," which provided guidance on how to remain compliant with program policy.
- The Bureau of Medicaid Services instituted the therapy utilization review process which offered medically necessary therapy services to qualified and eligible beneficiaries while resulting in Agency reductions in expenditures.
- The Division of Medicaid's FPCU has responsibility for coordination and facilitation of compliance efforts related to provider accountability. To ensure that Agency resources are maximized in these efforts, the team assists with ongoing compliance-related training for AHCA staff to increase fraud-fighting efforts. Substantive topics such as drug diversion or procedure code training, provider-type specific training such as ALFs or nursing homes, programmatic or operational training such as a class regarding how to analyze any program to determine if it meets the needs of the targeted population. Training for operating partners and Medicaid contractors about referrals to MPI were also offered in FY 2011-12.
- The FPCU continues to work with Medicaid health plans to increase coordination and anti-fraud efforts as well as increase referrals of suspected fraud and abuse to the Agency.

Fraud and Abuse Initiatives: Fee-for-Service

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

For medical services, utilization management and prior authorization parameters are designed as a result of peer review by nurses 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.

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

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

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

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

Personal Care Services and Private Duty Nursing FY 2010-11		
Type of Service	Denial Hours	Cost Avoidance*
Personal Care Services	1,820,315	$27,304,725.00
Private Duty Nursing Provided by a Registered Nurse	862,313	$25,093,308.30
Private Duty Nursing Provided by a Licensed Practical Nurse	1,131,196	$26,334,242.88
Total Estimated Cost Avoidance		$78,732,276.18

*Cost Savings are calculated by multiplying the denied hours by the Medicaid reimbursement rate for the particular service.
Note: For the services reflected in Tables 1 through 3 above, the only way a claim denial would be reversed is if the recipient receives a fair hearing pursuant to 42 CFR 431.220. If a fair hearing is requested the services would be continued until the hearing is resolved.

Cooperative Projects and Workgroups

The Agency is involved with external partners, stakeholders and internal bureaus and offices to advance the coordination of prevention of fraud and abuse of the Medicaid program. This coordination is done via workgroups, adoption of Medicaid policy changes to safeguard the Medicaid program and by continuous analysis of cost of Medicaid services. Medicaid headquarters and Medicaid area offices coordinate to detect fraud and abuse early and work closely with the Bureau of Medicaid Program Integrity (MPI).

The staff in the Bureau of Field Offices is active on a variety of fraud prevention and compliance teams including the Fraud Steering Committee subcommittees and the Facility Actions Committee.

The Unit has been coordinating with Medicaid Program Integrity (MPI) and Health Quality Assurance (HQA) regarding licensure actions taken by HQA to ensure that there is ongoing communication and coordination; to facilitate timely Medicaid actions to correspond with licensure actions.

The Unit, along with the Bureau of Medicaid Services and others within the Agency, including MPI, participate in an ongoing workgroup to evaluate Medicaid policy and ensure appropriate claims processing system edits are in place.

The Unit in Miami coordinates cooperative efforts with the Department of Health, Drug Enforcement Administration and Medicare (via a contractor) to increase provider monitoring efforts in select provider types.

The Unit has coordinated specific anti-fraud projects with the Medicaid health plans to ensure a comprehensive evaluation of suspect providers across all health plans as well as the Medicaid fee-for-service program. During FY 2011-12 these efforts focused on general issues of non-compliance with physician providers.

Special Projects and Pilots

Throughout the year, the Agency was involved with several special projects and pilot programs related to the Florida Medicaid program.

The Bureau of Medicaid Services continues its home health services pilot projects that began during FY 2010-11, referred to as the Telephony Project and the Comprehensive Care Management (CCM) Project. [Reference FY 2010-11 Fraud Report, Special Projects and Pilots.] These projects were included as part of the anti-fraud and abuse provisions in Senate Bill 1986, passed by the 2009 Florida Legislature. During the 2012 Florida Legislative session, legislation was passed to expand both of these projects statewide in counties where expansion was deemed cost-effective by the Agency and to include private duty nursing and personal care services. The expansion legislation was effective July 1, 2012.

The FPCU focused monitoring visits for high risk issues. Several statewide projects were carried out during FY 2011-12, which resulted in changes in policy to increase compliance, an increase in provider education in specific areas and recommendations to expand utilization control efforts. Some of these efforts also resulted in referrals to MPI, recommendations for termination of providers and recoupment of overpayments. The projects addressed Durable Medical Equipment (DME) services, managed care, physician services, prescription drug prescribing, community behavioral health, home health care and diagnostic testing.

The Bureau of Field Offices participates with MPI and the FPCU on targeted provider site visits and testing of pilots such as the Telephony project, described in the following narrative.

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

The Bureau of Medicaid Services within the Agency for Health Care Administration (Agency) manages the *Telephonic Home Health Service Delivery Monitoring and Verification (DMV) Project*. The purpose of the project is to ensure appropriate utilization and expenditures for Medicaid home health services, improve the quality of care for Medicaid recipients and prevent Medicaid fraud and abuse. The DMV Project now includes monitoring of all home health services (i. e., home health visits, private duty nursing and personal care services). The project was initially only operational in Miami-Dade County. However, during the 2012 legislative session, as mentioned earlier in this report, the Legislature directed the Agency to expand the DMV Project statewide.

Comprehensive Care Management Project

As a result of provisions included in the 2009 Senate Bill 1986, the Agency included management of the Comprehensive Care Management project in its contract with eQHealth Solutions, Inc., which provides utilization management for home health visits, private duty nursing, personal care services and inpatient medical and surgical services. The purpose of this pilot project is to identify potential overutilization and fraud or abuse of Medicaid services by ensuring that the level of services provided matches the needs of the recipients. The Comprehensive Care Management (CCM) pilot began July 2010; following are the results during FY 2011-12:

Face-to-Face Assessment Data	Total Recipients
Recipient Face-to-Face Assessment Completed	4,404
Recipients w/Fully Approved Request	3,781
Recipients w/Fully Denied Request	202
Recipients w/Partially Approved Request	342
Awaiting Supporting Documentation	54
Reconsideration Complete	30

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's FPCU has ensured that there is additional and ongoing managed care training for MFCU and MPI related to encounter data and systems, for the purposes of supporting fraud detection and enforcement efforts. The Unit has also included MFCU and MPI in coordination and discussions about managed care issues with the Medicaid health plans in quarterly fraud and abuse meetings.

The FPCU has also begun to develop and test compliance related tools for use in a managed care environment as well as develop agency-wide information about managed care to ensure that the entire Agency is mindful of efforts to prevent and detect fraud as we continue to implement statewide managed care.

Provider Education

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

The Bureau of Medicaid Services conducted a monitoring training to help providers understand policy requirements. The purpose was to review required documentation, to ensure providers are

appropriately credentialed, to assess how to properly submit claims and the process for voiding improperly submitted claims.

Additionally, the Bureau of Medicaid Services conducted training on *Top Findings from the AHCA Review of Submitted Claims for Physician Services in Nursing Facilities.* This presentation was developed as a result of a review of claim submissions from providers who requested overrides for the maximum limit for nursing facility visits and services. This and other presentations remain posted on the Agency's website for further reference for providers.

The Division of Medicaid's Bureau of Medicaid Services and FPCU Unit have cooperatively produced a number of provider training opportunities, including:

- *Medicaid Provider Compliance Program & Provider Self Audits*.
- *Overview of the Florida Medicaid Assistive Care Services Program*
- *Medicaid Policy & How to Access State Plan Services Teleconferences for: Developmental Disability Waiver Support Coordinators*
- *Verify Medicaid Recipient Eligibility*
- *Training Physician Services in Nursing Facilities*

The Division of Medicaid's Bureau of Medicaid Services FPCU have cooperatively launched the Florida Medicaid Provider Training e-Library[1] and implemented the use of *W*ebEx technology for the Bureau of Medicaid Services to continue with these training opportunities.

The Bureau of Field Offices routinely provides training to a variety of provider types on Medicaid policy and correct billing procedures. Additionally, while processing exceptional claims, they look for billing errors and use these as an opportunity to provide onsite education for those providers.

System Improvements

In addition to programmatic changes, the Agency recognizes the need for continual evaluation, expansion and improvement of technology uses within the Medicaid program as a means of addressing fraud, abuse and overpayment issues. Through system improvements, the Agency can increase its prevention efforts. Below are some examples of system improvements during FY 2011-12:

The Bureau of Medicaid Contract Management routinely evaluates the claims processing system to make adjustments consistent with changes in policy. These system edits are based upon collaboration with other operational units, including the Bureau of Medicaid Services. Some examples of these changes include limits on physician visits, home health nursing visits and medical supplies and services.

The Division of Medicaid's Fraud Prevention and Compliance Unit (FPCU) conducted research and coordination with outside entities with respect to increased technology assistance in fraud prevention and detection. These are ongoing efforts to ensure that we are maximizing the use of technology to aid in fraud fighting efforts. These efforts have included taking courses in grant writing and evaluating the availability of funding sources should the Agency be in a position to implement new technology as well as implementing the use of a new product for research and investigations related to providers and continued awareness within the Agency about the availability of technology for our use.

[1] http://ahca.myflorida.com/Medicaid/e-library/index.shtml

The FPCU coordinated several efforts with MPI and the staff within the Bureau of Medicaid Contract Management on the use of enhanced system protocols in anticipation of managed care to ensure continuity in our network validation efforts. The Unit has continued to evaluate the use of encounter data and make recommendations for improvements for use in fraud prevention and detection.

The FPCU evaluates program policy, existing edits and system needs to ensure that edits are put in place where possible. One edit that the Unit was instrumental in bringing to light had to do with physician providers who do not have the requisite lab license to bill particular services.

The Unit conducts ongoing quality reviews of the Agency's processes to ensure that involuntarily terminated providers are precluded from participation in the program. This includes processes to ensure that the Agency is no longer paying for prescription drugs for these providers nor allowing them to participate in Medicaid Managed care.

The Bureau of Field Offices frequently run queries if there is a suspicion of inappropriate provider billing. If sufficient evidence for concern is found, the Field Offices complete a referral to either the FPCU or to Medicaid Program Integrity (MPI).

Office of Inspector General

Internal Audit

Medicaid Program Integrity Advanced Detection Consultation

The Office of Inspector General's Bureau of Internal Audit assisted MPI in researching and analyzing Advanced Detection software to replace the current Fraud and Abuse Case Tracking System (FACTS). The improved case tracking system will incorporate advanced detection tools. These tools, such as predictive analytics and neural networking, will enhance MPI's ability to target investigations and audits by assigning resources to high-risk areas.

Investigations Unit

The Investigations Unit (IU) assisted the Bureau of Medicaid Program Integrity in generating cases through the analysis of provider data, paid claims and citizen complaints.

During FY 2011-12, the IU opened 56 fraud and abuse files, participated in the identification and recovery of overpayments and supported MPI in larger field initiatives.

Anti-Psychotic Medicaid Prescribers

In FY 2009-10, the IU initiated the review of Florida's top anti-psychotic prescribers. These prescribers were identified and ranked by the IU based on risk factors such as the total dollars paid by Medicaid for pharmacy claims. The highest ranked prescriber of 2009 was terminated from the Medicaid program after the initial IU investigation. Due to the coordinated efforts of the IU's investigative staff, the Agency's Bureau of Medicaid Program Integrity and the Bureau of Medicaid Pharmacy Services, total paid claims for antipsychotic drugs emanating from the top 25 prescribers declined by 15% in three years, saving approximately $4 million dollars. In the "top 25" prescribers identified in the initial review, three

have been terminated by AHCA after the findings of the IU team. In addition, four other prescribers discontinued prescribing antipsychotic medications to Medicaid recipients as of 2011.

Licensed Healthcare Clinic Initiative

The IU led a multi-agency onsite investigation of 63 healthcare clinics with current or pending license applications at the Agency. The clinics were identified as having "cookie cutter" licensure applications primarily utilizing the same Certified Public Accountant (CPA) firms and presenting a business model only existing in South Florida. The IU organized the multi-state agency investigation that included: The Florida Department of Health (DOH), Divisions of Medical Quality Assurance and Bureau of Radiation Control; The Office of the Chief Financial Officer, Division of Insurance Fraud; and the Agency's Office of the General Counsel, Bureau of Health Quality Assurance (HQA) and Health Facility Regulation (HFR). Nearly all of the clinic business models employed an owner, medical director, secretary, physician and a licensed massage therapist. Further investigation revealed nearly all the clinics were exclusively billing insurance companies under Florida Personal Injury Protection (PIP) laws for medical claims associated with vehicle crashes. The investigation included the following:

a) Verification that the clinics were operational and providing services within the scope of the licenses;
b) Verification of the Medical Directors and the number of clinics each Medical Director supervised;
c) Documentation of any changes in ownership;
d) Verification of the presence of radiological and diagnostic equipment and that the equipment was properly functioning and registered;
e) Verification that clinic staff was licensed or certified to operate the equipment onsite and
f) Documentation of "red flag" indicators of insurance fraud.

During the onsite investigation, 14 clinics were found to be out of business without notification to the Agency. Investigators only observed 17 patients in the 49 existing clinics and some clinic staff reported never having seen a patient in their clinic.

The investigation revealed regulatory violations in 43 of the 49 clinics, to include, but not limited to:

- A healthcare provider maintaining employment after failing his background screening;
- Failing to report change of ownership or changes in clinic staff as required; and
- Failing to post required licensing and numerous instances of clinic employees employed without Level 2 background screening.

Additionally, suspected criminal activity was observed regarding falsification of medical billing and suspected unlicensed activity by medical providers. One clinic operator immediately surrendered their clinic license to the IU due to the violations uncovered by IU investigators. Several referrals resulted in additional investigations which are still pending.

The IU referred 36 clinics to HQA with regulatory violations regarding missing Level 2 background screenings on their providers or staff. To date, two referred clinics have closed, one license was revoked, one sanction of $500 was imposed and one is pending disciplinary action. Twenty-four clinics referred to HQA rapidly completed and submitted the required Level 2 background screenings and the 24 clinics are now in regulatory compliance.

Medicaid Program Integrity

The Bureau of Medicaid Program Integrity (MPI), organizationally placed within AHCA's Office of Inspector General (OIG), operates under Section 409.913, Florida Statutes. It oversees the activities of Medicaid recipients, 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. These activities are accomplished through detection analyses, fraud and abuse prevention activities, audits and investigations, imposition of sanctions and through referrals to the Medicaid Fraud Control Unit (MFCU) of the Office of the Attorney General, to the Department of Health and to other regulatory and investigative agencies.

MPI has approximately 100 full-time employees charged with preventing, detecting and recouping Medicaid funds paid out due to fraudulent and abusive claims submitted to the Medicaid Program. MPI collaborates with other state and federal agencies, including MFCU, the Department of Health (DOH), the Department of Children & Families (DCF), the Agency for Persons with Disabilities (APD), the Division of Public Assistance Fraud (DPAF) and the federal Centers for Medicare & Medicaid Services (CMS).

The major units of MPI and the functions performed by each are described in the following paragraphs. Also, MPI's oversight efforts are summarized and the results for the fiscal year are presented.

Intake and Assessment Unit

All referrals made to MPI, whether from complaints, the fraud and abuse 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 three times a year to Medicaid recipients listing the services billed during the previous four months for the recipients. 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 unlawful activity relating to health care practices are suspended from participation in the Florida Medicaid program for the duration of the legal proceedings. Similarly, a conviction for a criminal offense related to the delivery of any health care goods or services, including the performance of management or administrative functions relating to the delivery of health care goods or services, or a criminal offense under federal law or the law of any state relating to the practice of the provider's profession, results in termination.

The Field Assessment Unit of the Bureau of Medicaid Program Integrity 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 performing recipient interviews to ascertain whether Medicaid services were actually rendered and, if rendered, determining if the services were appropriate. Based on observations during the site visit and from reviews of records, any one of several actions may be taken by the Bureau of Medicaid Program Integrity 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 the Self-audit Unit to initiate a provider self-audit
- Recommendation for termination

The Field Assessment Unit also performs several field initiatives (focused enforcement 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 Davison of Medicaid, 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 Initiatives (Focused Projects)

Field office initiatives have resulted in sanctions, reversal of claims, referrals and placing providers on prepayment review. Agency and CMS staff conducted three fraud and abuse field initiatives in South Florida from September 2011 through March 2012. The initiatives completed during the last fiscal year resulted in site visits to 244 active Medicaid providers. These compliance inspections produced 175 sanctions totaling $937,500 in fines. A summary of the administrative actions for each initiative is provided below.

Tri-County Developmental Disabilities Waiver—Residential Habilitation Initiative

During the week of September 26, 2011, the AHCA Office of the Inspector General, Bureau of Medicaid Program Integrity (OIG/MPI), in conjunction with the AHCA Division of Medicaid and the Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted compliance site visits to 52 Developmental Disabilities Waiver—Residential Habilitation Service providers (group homes) in Miami-Dade, Broward and Palm Beach counties. These group homes were high billers of procedure code T2023U6 (Residential Habilitation) for dates of service from January 1, 2011, to September 25, 2011.

Administrative actions resulting from this initiative included:

- 19 sanctions, totaling $87,000 in fines
- 14 Agency for Persons with Disabilities (APD) referrals
- 5 prepayment reviews
- 1 MFCU/PANE referral
- 1 Department of Health referral
- 1 Social Security Administration/OIG referral
- 2 provider education letters

Tri-County ALF / AFCH Project 2011

During the week of December 5, 2011, the AHCA Office of the Inspector General, Bureau of Medicaid Program Integrity staff members from the Jacksonville, Orlando, Tampa and Miami field offices, in conjunction with the Centers for Medicare & Medicaid Services, Medicaid Integrity Group targeted 92 Assistive Care Services providers in Broward, Palm Beach and St. Lucie Counties. MPI and CMS staff members conducted compliance site visits to Assisted Living Facilities (ALFs) and Adult Family Care Homes (AFCHs) billing for procedure code T1020 (Personal Care Service Per Diem) for dates of service from January 1, 2011, through November 30, 2011.

Administrative actions resulting from this initiative included:

- 76 sanctions, totaling $461,000 in fines
- 10 paid claim reversals, saving $64,443
- 32 prepayment reviews
- 59 Division of Health Quality Assurance (HQA) referrals
- 2 MPI case management unit referrals
- 3 AHCA—Medicaid Contract Management referrals
- 1 Department of Health (DOH) referral
- 1 HIPAA Compliance Referral
- 1 termination

Miami-Dade County ALF Project 2012

During the week of March 26, 2012, the AHCA Office of the Inspector General, Bureau of Medicaid Program Integrity and the AHCA Division of Health Quality Assurance (HQA) in conjunction with the Centers for Medicare & Medicaid Services, Medicaid Integrity Group conducted compliance site visits to 100 Assisted Living Facilities (ALFs) in Miami-Dade County. These ALFs billed for procedure code T1020 (Personal Care Service Per Diem) for dates of service from January 1, 2011, to February 29, 2012.

Administrative actions resulting from this initiative included:

- 80 sanctions, totaling $389,500 in fines
- 13 paid claim reversals, saving $69,979
- 24 prepayment reviews
- 76 Division of Health Quality Assurance (HQA) referrals

- 1 case management unit referral
- 3 AHCA Medicaid Contract Management referrals
- 2 Department of Health referrals
- 2 termination recommendations
- 1 MFCU PANE referral

Managed Care Unit

MPI recently repurposed existing staff to concentrate on managed care program integrity oversight and implemented an official MPI Managed Care Unit. Previously, MPI staff worked diligently to strengthen managed care contract language and establish more robust reporting of fraud and abuse through systems and methodologies. The MPI Managed Care Unit is responsible for a variety of related activities including monitoring MCOs' fraud and abuse prevention plans and managed care contract compliance, to ensure the MCOs' oversight of fraud and abuse is diligent and effective. The MPI Managed Care Unit staff review materials submitted by the managed care health plans related to the plans' fraud and abuse prevention strategies, staffing and procedures. Such material is submitted by existing health plans to comply with s. 409.91212, F.S., mandatory contract language and by new health plans as part of their Medicaid program application process. MPI assigns corrective action for any findings of deficiencies. MCOs are required to report to MPI within fifteen (15) calendar days of detection, all suspected or confirmed instances of internal and external fraud and abuse relating to the provision of, and payment for, Medicaid services. In addition, the MCOs report the progression of their anti-fraud casework quarterly via MPI's web-based reporting application that allows tracking statewide of all cases reported to MPI. Health Plans are also required to submit an Annual Fraud and Abuse Activity Report citing their respective identified overpayments and recoveries.

Generalized Analysis/Self-audit Unit

The Generalized Analysis/Self-audit Unit (GA Unit) conducts computer-assisted reviews of potential Medicaid policy abuse by all providers of a given provider type or class for specific issues. Generalized analyses involve the development of an initial conceptualization of possible Medicaid policy abuse perceived by or suspected by the MPI Data Detection Unit, Medicaid Services, the Area Medicaid offices, the Medicaid Fraud Control Unit in the Attorney General's Office and Medicaid providers themselves. Research of historical Medicaid policy with respect to the issue is initially required to determine the validity of projected recoupment action. A case is opened in the MPI case tracking system to track audit and recoupment activities for each provider in the analysis. In a GA Unit project, a group of providers is tracked as a project within the case management system. Printouts of data generally obtained through the AHCA fiscal agent and the Decision Support System (Data Warehouse) are furnished to the Medicaid provider after the GA Unit reviews them for accuracy. After audit reports are prepared and mailed and provider inquiries and follow-up documentation are reviewed that may affect audit findings, a final audit report is issued. Monitoring continues until all the cases within the GA project are closed and the project itself is closed. A Memorandum for the Record is written to summarize the project and its results.

Generalized analyses are beneficial in that reviews cover similar claims for all providers of a particular provider type or class with one general review of those data. The data provide support of the assessment and, therefore, document review is minimal. Generalized analyses provide a cost-effective manner in which to determine overpayments and recoup funds. The process identifies claims and

providers that might not otherwise be audited and serves to educate like providers with similar abuse issues. The process also identifies areas in which prepayment edits or policy changes are needed.

Provider Self-audits

Medicaid providers have an obligation to ensure that claims submitted to the Medicaid program are proper. When a provider becomes aware that Medicaid payments to it were in excess of Medicaid program allowable amounts, the provider is obligated to return the excess payments. Providers should return the overpayment along with supporting documentation. The GA Unit reviews this documentation and confirms the accuracy of the provider's audit and payment or assesses any additional amount due. Self-audits by providers allow the provider more control over the parameters of the audit and generally result in a greater likelihood of future compliance. Self-audits and corrective action by the provider may avoid the identification of overpayments under future Agency audits and may avoid the imposition of sanctions as required under Section 409.913, F. S. and Rule 59G-9.070, F. A. C.

Data Detection Unit

The Data Detection Unit utilizes the tools, resources and reports described below in an effort to identify instances of possible Medicaid fraud and abuse. It analyzes claims data, 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 the Medicaid and Medicare programs. The unit works with MFCU to coordinate data detection projects and detects violations using multiple detection tools and methods. Apparent violations are referred to the case management units or to MFCU for further investigation. Case management units conduct audits, pursue recovery and make referrals to outside agencies as appropriate. The Data Detection Unit also assists in the development of generalized analyses and provides programming support for other MPI units.

Detection findings can result from computerized detection tools, leads from incoming complaints and referrals, information from other regulatory agencies, newspaper articles and advertisements, Explanation of Medicaid Benefits (EOMBs) forms, the Agency's Division of Medicaid and the Medi-Medi partnership with the Medicare program, as well as from data mining and from edit and audit reviews.

Detection Tools

MPI's primary detection tools include the DSS*Profiler*, First Health Pharmacy reports, Business Objects 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 exploitation 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 amounts prescribed, quarterly "doctor shopper" reports, prescriber ranking reports and "most utilized pharmacies" reports.

Business Objects ad hoc reports are used by auditors to access Medicaid claims information within the FMMIS and DSS. 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 analysis 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, certain payments for that week can be held 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 who are 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 due 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 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 that is related to excessive billing patterns, duplicate payments, services billed in both programs with no cross-over in place and 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. Another tool that has been used in the Data Detection Unit is social network analysis. Analysis of relationships among individuals, entities and regulatory agencies' data was used to identify Medicaid providers who were still billing the Medicaid program, but were listed as excluded entities by the federal government, excluded by other state Medicaid programs, or were providers 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 identify providers for audits or referrals to MFCU for potential criminal investigation and help identify areas that require comprehensive reviews or prepayment reviews.

Special Analysis – "Pill Mill" Data Initiative Update

The "Pill Mill" Project 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 relating to the illegal prescribing, dispensing and consumption of powerful controlled substances including 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 for filling prescriptions 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. Since October 2009, MPI has been furnishing Pill Mill information to a number of state entities. The Pill Mill data were refreshed for the Governor's statewide Pill Mill effort. MPI also sent to FDLE reports on providers who have been overprescribing these targeted drugs.

In 2011, MPI embarked on a new process to terminate the prescribing rights of non-Medicaid providers who were prescribing "pill mill" type drugs in suspicious amounts. MPI has terminated the Medicaid prescribing rights of 437 non-Medicaid providers who were prescribing "pill mill" type drugs during FY 2011-12.

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 rejected for sufficient reason. 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 with MFCU

Through a joint request by AHCA and the Office of the Attorney General of Florida, CMS has approved a waiver to allow MFCU to data mine Medicaid data using the AHCA Decision Support System (Data Warehouse). At the conclusion of the biweekly case referral meetings, 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.

Edit and Audit Task Force

There may be opportunities to enhance claims edits and audits within the Florida Medicaid Management Information System. The Edits and Audits Task Force was established by AHCA to identify overpayments caused by edits and audits not operating as intended. In addition, this activity identifies vulnerabilities present due to inappropriate or nonexistent edits. The Edit and Audit Task Force reports to the Detection Subcommittee of the Agency's Fraud Steering Committee. To date, there have been a total of 90 file maintenance requests and 37 policy recommendations with a total of $11.5 million identified as potential overpayments.

The Edit and Audit Processing function in the *FMMIS/DSS* system ensures that claim records are validated in accordance with the State's claim processing policy. An Error Status Code is assigned to each edit and audit and is posted to the claim to indicate that an action has occurred in the processing of the claim to alter the otherwise anticipated outcome. The disposition status of the non-history-related edits and history-related audits is determined based on table-driven instructions that can cause a claim to pay and list, deny or suspend.

An edit is defined as a verification of claim data on the submitted claim. These edits consist of checks for required presence, format, consistency, reasonableness and allowable values. The criteria to determine the disposition the claim will take when it sets an edit during claims processing include: claim region, claim type, recipient service program, status of the edit (active, inactive), provider type, provider specialty, claim effective date of service, claim effective date of receipt and the location to which the claim will suspend if the disposition of the edit is to suspend.

An audit is defined as a verification of claim data against other claims in history. These audits consist of checks for duplicate services, service limits being exceeded and billing more than once for a once-in-a-lifetime service. The system allows the data element definition to be either positive or negative. This is accomplished through the use of the inclusion or exclusion indicator on the audit definition.

Public Assistance Reporting Information System (PARIS)

The federal PARIS reporting system was originally created to allow both state and federal programs the opportunity to compare public assistance files to ensure no recipient received the duplicate benefits from different programs or different government agencies. The Agency is currently working with the

Department of Children and Families on the development of an interagency agreement that would mandate PARIS checks for all of Florida public assistance and Medicaid recipients and applicants.

Case Management Units

Each of the case management units identifies misspent Medicaid funds by performing comprehensive audits and generalized analyses. MPI uses accepted and valid auditing procedures that include statistical methodology. 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. As appropriate, the case management units conduct claim by claim reviews and invoice purchase verification reviews.

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

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

The case management units also serve as the Bureau's points of contact for the Federal Audit Program. The Centers for Medicare & Medicaid Services (CMS) created the Medicaid Integrity Group (MIG) to carry out the Federal Audit 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:

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

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, the analysis of data and information to support a termination of providers suspected of misusing the Medicaid program, denial of reimbursement for prescription drugs prescribed by

terminated providers, site visits to certain Medicaid providers in specified geographic areas, the application of administrative sanctions, the prevention impact of MPI audits, the denial of claims for specified drugs and the pending of claims per Section 409.913(25)(a), F. S. These are discussed in further detail 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 dispatched 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 2011-12, MPI initiated 270 prepayment reviews. Claims denied for these providers resulted in cost avoidance of $1.3 million as shown below.

Prepayment Reviews	FY 2011-12
Number of claims reviewed	28,545
Number of claims denied	15,607
Amount of claims reviewed	$2,296,776
Amount of claims denied	$1,326,833

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 30 days' notice.

When a provider suspected of fraudulent or abusive billing is terminated from the Medicaid program, Medicaid expenditures should decline with respect to the recipients served by the terminated provider, taking into account services furnished by other providers of a similar type. For a terminated provider, the savings are the difference in payments for the one-year periods before and following termination for services provided by the provider and other like providers to all recipients who were served by the terminated provider and who had maintained eligibility for all of both one-year periods. For FY 2011-12, the terminations for the previous fiscal year saved Medicaid $5.5 million.

Site Visits and Focused Projects

Staff members in the Bureau of Medicaid Program Integrity field offices visited a number of Medicaid providers this past fiscal year. These visits ensured that the providers were till at the address of record, appeared to have the assets required to perform the services that would purportedly be furnished, possessed the s necessary Medicaid manuals and forms and were generally familiar with Medicaid policies and knew 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 2011-12 resulting from site visits conducted in the prior year were $6.4 million. Actual site visits conducted during FY 2011-12 by provider type are noted below.

Site Visits Conducted During FY 2011-12	
Provider Type	Number of Visits
Assistive Care Services	303
Community Alcohol, Drug, Mental Health	1
Dentist	2
Home & Community Based Services	135
Home Health Agency	17
ICF/MR - Private Facility	1
Medical Supplies/Durable Medical	30
Pharmacy	44
Physician (DO)	1
Physician (MD)	4
Therapist	5
Total Site Visits	543

Administrative Sanctions and Managed Care Organization Assessments

During FY 2011-12, 738 Medicaid providers received 788 sanctions or assessments shown in the following table for violations set forth in Rule 59G-9.070, F. A. C., under Section 409.91212, F. S., or under enrollment contract. These included suspensions and terminations from the Medicaid program and fines or assessments totaling $6,199,313.

Provider Sanctions and Managed Care Organization Assessments				
	FY 2010-11		FY 2011-12	
Sanctions under Rule 59G-9.070, F. A. C.	Number	Amount	Number	Amount
Fine Sanctions	565	$957,609	590	$2,643,713
Suspensions	106		85	
Terminations with cause	44		106	
Terminations without cause*	*55		*160	
Corrective Action Plans	2		0	
Total for Rule 59G-0.070, F. A. C. Sanctions	717	$957,609		$2,643,713
Total for Managed Care Organization Section 409.91212 F. S. or Contract Assessments			*7	$3,555,600
Grand Total Sanctions and Managed Care Organization Assessments	717	$957,609	788	$6,199,313

*Not a sanction under the Rule 59G-9.070, F. A. C.

Cost Prevention Resulting from MPI Audits

The effects of MPI audits on providers should include the reduction in immediate payments to the Medicaid providers and the elimination of future inappropriate billings. In order to estimate the amount of this effect, analyses are carried out concerning payments to those providers whose audit cases were closed during the fiscal year immediately prior to that being reported. Audit savings are based on payments made to the provider during the one-year periods prior to and following the date on which the applicable audit case was closed during the prior fiscal year. Audits accompanied by sanctions and self-audits are not included in this calculation.

Savings Resulting from Denial of Claims for "Pill Mill" Type Drugs

Medicaid does not pay for certain specified drugs such as Oxycodone, Hydrocodone and Xanax prescribed by non-Medicaid providers. The Data Unit determines claims received but not yet paid by the Magellan System (the State's contracted pharmacy benefits manager) for drugs prescribed by non-Medicaid providers and initiates denial reports rejecting those claims**.** The prevented amount is the value of denied claims factored by the ratio of paid to billed amounts (for Medicaid providers) for those drugs. Savings for FY 2011-12 were $1.157 million.

Cost Prevention Resulting from Claims Pended per Sec. 409.913(25)(a),F.S.

In accordance with Sec. 409.913(25)(a), F. S, the Agency shall withhold Medicaid payments, in whole or in part, to a provider upon receipt of reliable evidence that the circumstances giving rise to the need for a withholding of payments involve fraud, willful misrepresentation, or abuse under the Medicaid program, or a crime committed while rendering goods or services to Medicaid recipients. If it is determined that fraud, willful misrepresentation, abuse, or a crime did not occur, the payments withheld must be paid to the provider within 14 days after such determination with interest at the rate of 10 percent a year. Any money withheld in accordance with this paragraph shall be placed in a suspended account, readily accessible to the agency, so that any payment ultimately due the provider shall be made within 14 days. Claims pended per this section are termed "25(a) pends." Claims pended under Sec. 409.913(25)(a), F. S., are subsequently denied and represent cost prevention. Savings for FY 2011-12 were $2.1 million in denied claims.

Medicaid Program Integrity Recovery Activities

MPI performs its investigative and recovery efforts through comprehensive audits involving inferential analyses, generalized analyses involving computer-assisted reviews of paid claims pursuant to Medicaid policies, paid claims 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.

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 2,842 cases concluded during FY 2011-12. Of these, 371 were "sanction only" cases (not involving an overpayment recovery), seven were Managed Care Organization contractual assessments cases, 248 required provider education letters, 229 had no findings and 1,987 identified overpayments. These cases associated with identified overpayments totaled $36,053,930.

Paid Claims Reversals

Several functions within MPI identify erroneous claims that 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 electronically to Medicaid as the pharmaceuticals are dispensed. Occasionally, pharmacies overstate the amount of the drug that is dispensed and are thereby overpaid. MPI detection methods identify these 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 is then 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. Paid claim reversals for FY 20011-12 were $2.5 million.

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 $32.2 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 to parties within and outside the Agency, as appropriate. There were 509 referrals in FY 2011-12.

Number of MPI Referrals in FY 2011-12	
Referral to:	**Number**
Department of Health	35
Division of Public Assistance Fraud	20
Health and Human Services - OIG	124
Division of Health Quality Assurance	178
Medicaid Division	33
Medicaid Fraud Control Unit	47
Others including MFCU information only	72
Total	**509**

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 State's recovery rate. Amendments to Section 409.913, F. S., in 2009, require earlier withholding of funds by Finance and Accounting. The table below lists overpayments identified by fiscal year and collected by Finance and Accounting for the last four fiscal years. There can be an expected 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.

Contractual Assessments

As reported in the 2010-11 Medicaid Fraud and Abuse Annual Report, a follow-up review of the newborn enrollment and unborn activation process was completed. However, one of the cases was not closed until FY 2011-12. Therefore $295,000 is being reported this year for that project.

Collection of Overpayments by Accounts Receivable or Paid Claims Reversals (PCRs)

Fiscal Year	Type of Recovery	Overpayments Identified	Accounts Receivable Collections or Reversals Updated as of Aug. 31, 2012	Percent
2008-09	Accounts Receivable	$15,625,437	$13,285,314	85.0
2009-10	Accounts Receivable	$18,800,058	$14,346,406	76.3
2010-11	Accounts Receivable, Offsets and PCRs	$39,011,157	$36,400,380	93.3
2011-12	Accounts Receivable and PCRs	$36,053,930	$28,554,143	79.2

Closed Cases

MPI Closed Cases by Fiscal Year					
Fiscal Year	2007-08	2008-09	2009-10	2010-11	2011-12
Overpayments Identified*	791	1,288	1,807	1,907	1,987
No Fraud or Abuse Found	331	309	401	1,006	229
Provider Education Letter	4	17	158	513	248
Sanctions Only*				300	371
MCO Statutory or Contractual Assessments*				115	7
Total Cases Closed	1,126	1,614	2,366	3,841	2,842
***Cases with Findings**					
Percentage with Findings	70.2%	79.8%	76.4%	60.5%	83.2%

MPI closed 2,842 cases during FY 2011-12. Of these, 1,987 cases had identified overpayments.

Random Audits

In FY 20112-12, Medicaid Program Integrity performed statutorily required random audits as summarized in the table below. Random audits are not predicated upon suspicion, data analyses, or referrals. They are, as the name implies, random. As indicated below, 20 random audits were initiated and overpayments totaling $15,489 were identified during this past fiscal year.

Medicaid Program Integrity Random Audits			
Fiscal Year	2009-10	2010-11	2011-12
Initiated	11	9	20
Completed	11	8	12
Findings	5	2	8
No Findings	6	6	4
Overpayments Identified	$56,416	$20,949	$15,489

MPI Highlights

Managed care reimbursement is addressed in Subsection 409.912(5), F. S., as follows: "The Agency shall develop two rates for children under one 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 completed month subsequent to the month of birth through 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."

Subsequently, the Agency developed two rates for children under one year of age. The first set of rates covered the month of birth through the second complete month subsequent to the month of birth. For this set of rates, MPI Audit Project #307 compared the paid per diem with the payment rate tables, the age of the recipient child and the HMO contracts with the Agency that were in place at the time. Over $20 million in overpayments was recovered and reported in FY 2010-11. The second set of rates covered the third month subsequent to the month of birth through the eleventh complete month subsequent to the month of birth. For this set, MPI Audit Project #319 performed a similar comparison and identified $18,346,733 in overpayments. During FY 2011-12 and subsequently, respecting Project #319, $14,690,697 (80 percent of the identified amount) has been recouped with another $3,620,818 being recovered through payment agreements. These audits were performed by the MPI Institutional Case Management Unit.

A Medicaid internal medicine group provider was identified for questionable billing of Evaluation and Management codes. A review by the MPI Medical Case Management Unit of the provider's claims from February 1, 2007, through January 31, 2009, identified two areas of concern. These areas were upcoding of billing of services rendered and a lack of documentation of services. A Final Audit Report was completed in January 2011, with an identified overpayment of $303,903 plus fines of $63,281 and costs in the amount of $1,510. A review of additional documentation that was provided after the issuance of the Final Audit Report resulted in a revised overpayment of $241,822, fines in the amount of $2,500 and costs in the amount of $1,858. The provider has repaid the overpayment and has paid the sanction amount and costs in full. A Medicaid urological group provider was identified for questionable billing of Evaluation and Management codes. A review by the MPI Medical Case Management Unit of the provider's claims from July 1, 2008, through June 30, 2010, identified two areas of concern. These areas

were upcoding of billings of services rendered and lack of documentation of services. A Final Audit Report was completed in January 2012, with an overpayment in the amount of $180,450 plus fines of $36,090 and costs of $1,586. The provider has repaid the overpayment and has paid the identified sanctions and costs in full.

In September 2009, the MPI Waiver Case Management Unit opened an investigation of a Medicaid-enrolled physician provider with a specialty in neurology who appeared to be billing an excessively high volume of procedure codes for nerve conduction tests. The provider's documentation revealed that he was using a machine called the Axion 2 on the majority of his patients; however, this machine does not capture sufficient measurements to meet the criteria for billing the procedure code that was utilized. With minor exceptions, the Agency's position was upheld at a hearing at the Division of Administrative Hearings (DOAH). After issuance of the final order by the Agency, the provider appealed to First District Court of Appeals (DCA). After oral arguments on June 12, 2012, the DOAH hearing officer's recommendation was upheld and the final order as issued by the Agency stands. Although the provider has terminated his Medicaid participation, he still has an overpayment of $105,353 due, plus fines, costs and interest.

In March 2010 the MPI Waiver Case Management Unit opened an investigation of a Medicaid-enrolled podiatric provider who was serving a majority of recipients who lived in congregate facilities in north and northwest Florida. The physician documented an extensive examination and detailed history of patients, but the treatment was always the same: "trim nails" or "shave benign neoplastic lesion" (i. e., corn or callus). The peer reviewer engaged by the Agency determined that there was no medical necessity for the billed exams and histories as documented. In a hearing, DOAH found for the Agency and the provider overpayment of $99,568 plus interest and costs was upheld.

According to the Medicaid Prescribed Drugs Coverage, Limitations and Reimbursement Handbook, Medicaid does not reimburse for drugs used in the treatment or relief of pain or in symptom control related to a hospice terminal illness and related conditions. The costs of these drugs are included in the hospice's Medicaid per diem rate. The pharmacy must bill the hospice for all drugs related to the terminal illness and related conditions, including nutritional products, total parenteral nutrition and analgesics. Medicaid will pay for prescription drugs unrelated to the patient's terminal illness.

An analysis of these services by MPI prompted a Generalized Analysis project for the review period of July 1, 2006 through October 31, 2010. Claims were queried by therapeutic class for the drugs the handbook indicated would be covered if the patient were on hospice and matched up with recipients who had a hospice payment for the month of the drug claim. This review identified claims paid to Florida Medicaid pharmacy services providers for prescription drugs that should have been covered by the hospice plan to which the recipient was assigned. As a result of the review, the Pharmacy/DME Case Management Unit opened a total of 273 audit cases with potential overpayments. After the providers were notified and documentation was reviewed, $303,779 in overpayments was recovered.

The Generalized Analysis/Self Audit Unit conducted a generalized analysis project dealing with Florida Medicaid Home Health Care services that were provided contemporaneously to two or more recipients at a single location. These services were to be paid at 100 percent for the first recipient and at a reduced rate for all additional recipients at the same location. Data analysis reporting was conducted and it was determined that overpayments existed due to provider failure to downwardly adjust reimbursements for the additional recipients as required by Florida Medicaid policy. During FY 2011-12, the GA Unit identified $2,957,262 in overpayments to 149 Medicaid Home Health Care services providers.

Funding for Medicaid Program Integrity and Return on Investment

In FY 2011-12, MPI audit and investigations efforts resulted in the collection of $62.2 million in overpayments, investigative costs and fines, as shown in the table immediately below. MPI prevention efforts resulted in cost savings of $27.9 million as shown in the table second table below.

MPI Recovery Activities ($ Millions)				
	FY 08-09	FY 09-10	FY 10-11	FY 11-12
MPI Audits (Overpayments Collected)	$15.4	$16.4	$38.8	$18.4
Costs (Collected by F&A)			1.5	.2
Fines (Collected by F&A)			1	5.0
Paid Claims Reversals	0.3	1.5	1	2.5
Contractual Assessments			10.8	.3
MCO Statutory or Contractual Assessments				3.6
TPL Contractor-Assisted Claims Adjustments	34.6	40.6	30	32.2
Total	$50.3	$58.5	$83.1	$62.2

MPI Prevention of Overpayments ($ Millions)								
	FY 2008-09		FY 2009-10		FY 2010-11		FY 2011-12	
	No.	Amount	No.	Amount	No.	Amount	No.	Amount
Prepayment Review	99	$5.8	116	$4.8	272	$3.4	270	$1.3
Termination of Providers	152	3.2	68	1.8	99	1.8		5.5
Focused Projects	3	2.6	7	5.1		1.2	3	.9
Pill Mill Drug Denials	3	0.3				0		$1.2
Site Visits	481	6.5	410	7.4		12.1		6.4
Sanctioned Providers						$3.6		3.2
Claims Denied Per Statute							63	2.1
Audit Impact								7.3
Total		$18.40		$19.10		$22.1		$27.9

MPI Funding

MPI is funded through the Medical Care Trust Fund. The Medical Care Trust Fund is funded through federal funds and overpayment recoveries generated by MPI. During the year, expenditures of $7.9 million were devoted to recovery work resulting in collections of $62.2 million and a return on investment for recovery operations of 7.9:1. In addition, MPI achieved $27.9 million in cost avoidance with expenditures of $5.3 million, producing a return on investment for prevention efforts of 5.3:1. Overall, in FY 2010-11, audit recoveries and cost avoidance amounts totaled $90.1 million, yielding a return of 6.8:1, as shown on the following chart.

Medicaid Program Integrity Return on Investment					
Benefits and Costs in $ Millions					
			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**
			Benefits	**Costs**	**ROI**
FY 2011-12	Recovery		$62.2	$7.9	**7.9:1**
	Prevention		27.9	5.3	**5.3:1**
		Total	**$90.1**	**$13.2**	**6.8:1**

(Prevention Benefits FY 2008-09 and 2009-10 adjusted by the removal of fines imposed.)

Office of General Counsel

The Office of the General Counsel (OGC) is involved with other offices of the Agency in efforts to deter fraud and abuse in the Florida Medicaid program to the greatest extent possible. The OGC provides legal guidance and recommendations to the Division of Medicaid and to the Office of Inspector General regarding ways in which to curtail and deal with Medicaid fraud and abuse. The advice includes recommendations related to prevention, detection and enforcement.

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

In the past year, the attorneys have represented the Agency in the numerous federal court actions filed against the Agency. The attorneys also participated in a high number of fair hearings.

Division of Operations

Third Party Liability Unit

AHCA's 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 Xerox State Healthcare, LLC (Formerly ACS State Healthcare, LLC). During FY 2011-12, over $148 million in Medicaid funds were collected. Annual TPL collections over the last four years have averaged approximately $130 million, exceeding the target of $100 million. In addition, the TPL Unit has held Xerox accountable to its contract requirements by vigorously monitoring Xerox's 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 for services 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 – 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 (as a 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 - 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 for services 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 2011-12 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);
- 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); and
- Cost Avoidance - Cost avoidance is new and/or updated insurance information that is derived from data matches with insurance carriers. Cost avoidance is also derived from insurance information obtained at the time of eligibility, through Medicaid area office staff and Medicaid providers. When new and/or updated insurance information is obtained, that information is added to the Florida Medicaid Management Information System (FMMIS) in order to cost avoid future claims that are submitted by Medicaid providers. When a provider submits a claim and a recipient has other insurance, the provider is instructed to bill the other insurance prior to billing Medicaid. The Agency utilizes a matrix maintained in the FMMIS to determine whether a claim shall be paid or denied based upon other third party information contained on the Medicaid recipient's file. Cost avoidance is the amount that was denied based upon third party information contained on the Medicaid recipient's file.

Below is a summary of historical TPL collections:

TPL Collections	FY 2007-08	FY 2008-09	FY2009-10	FY 2010-11	FY 2011-12
Casualty	$17,681,026	$16,537,665	$18,747,553	$22,165,885	$24,336,688
Estate	8,590,471	7,236,087	5,479,473	5,486,256	6,017,391
Trusts	4,166,134	3,879,248	5,369,002	6,011,888	7,124,616
Medicare and Other Third Party Payor	47,040,782	50,658,788	44,673,737	72,081,890	78,428,755
Other Recoupment Projects*	14,621,051	43,813,456	40,582,911	29,958,148	32,208,128
Total Collections	92,099,463	122,125,244	114,852,676	135,704,067	148,115,578
Cost Avoidance (Matrix)*	$747,168,091	$933,411,564	$778,611,980	$966,902,977	$1,259,088,849
*** This amount is reported under Medicaid Program Integrity's Collection, as MPI contracts these services under the contract managed by the Third Party Liability Unit.**					

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, (F&A) for collections. F&A 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 providers cannot be liened, the Agency must determine other means of collection or refer the case to an outside collection agency. The Agency 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.

AHCA must obtain approval from the Department of Financial Services for write-off of all accounts receivable determined to be uncollectible. $13.8 million in accounts receivable were approved for write-off during this reporting period. 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 allow federal funding to be reclaimed only 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 receivable is approved for write-off, the qualified federal share of each write-off is reclaimed. F&A also continues to work with the Agency's Division of Health Quality Assurance to determine if a facility's license renewal can be held-up pending receipt of overpayment amounts from the provider.

F&A uses the Medicaid Accounts Receivable (MAR) system, which records extensive financial detail as its business process tool. 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/or 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 related to fraud and abuse cases and other overpayment cases. Examples of other overpayment cases include hospitals, nursing home retroactive rate adjustments and gross adjustments.

F&A provides 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, enabling it to reflect the latest financial and account status information.

F&A has continuous communication processes with MPI and MFCU to coordinate audit collection efforts. The Bureau works 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 Office of Inspector General to coordinate collection efforts and pursue additional avenues of collection. The Agency takes aggressive steps during the year to reduce the duration of the terms for negotiated payment plans and as well as increase the percentages of the liens placed on provider.

Coordination and Cooperation between DOH, AHCA and MFCU

The Agency continues to work with the Department of Health and the Medicaid Fraud Control Unit (MFCU) to streamline inter-agency coordination and enhance processes and protocols. An interactive partnership is essential for effective, collaborative investigative projects aimed at protecting the people of Florida against healthcare fraud and substandard health care.

Directors and senior managers of the AHCA Office of the Inspector General, the Division of Medicaid and MFCU meet regularly with the DOH Director for the Division of Medical Quality Assurance (MQA) and enforcement leadership to coordinate participation in joint projects, investigations and enforcement strategies. This includes the regular briefing of the AHCA Secretary on the nature and progress of these collaborative efforts.

AHCA and DOH have continued to enhance methods of information sharing so that provisions of anti-fraud legislation are fully implemented. The DOH transfers data nightly to AHCA to identify practitioners who are billing Medicaid, but who do not have an active DOH license.

DOH Consumer Services continues in working relationships with AHCA through contacts established as a result of bi-monthly meetings. They exchange licensing information on an on-going ad-hoc basis, with

recent emphasis on fraud in pain clinic settings. Additionally, the DOH Investigative Service Unit (I SU) field offices continue to work within the relationships established prior to and strengthened by implementation of anti-fraud legislation.

This past year a total of 15 legally sufficient referrals were received. One case was closed with no violation found, two cases were closed because the subject is deceased, one case was closed for insufficient evidence, one case was closed because the practitioner's license had already been revoked and 10 cases are still pending.

The Orlando ISU office coordinated investigations with or obtained assistance from MFCU in the completion of two investigations – one MD and one PMC. Both cases resulted in an arrest of the physician owner and Emergency Suspension Order (ESO).

The Miami ISU office coordinated with AHCA on an investigation of a Certified Nursing Assistant (CNA) in Miami. No action was taken against the CNA. However, this resulted in a partnership between the two agencies for future operations.

The Tallahassee ISU office coordinated investigations with or obtained assistance from MFCU during two investigations on one MD and one Osteopathic Physician. These are both ongoing investigations.

Medicaid and Public Assistance Fraud Strike Force

Background

In 2010, the Florida Legislature established the Medicaid and Public Assistance Fraud Strike Force under Section 624.351, *Florida Statutes.* The Legislature based the formation of this Strike Force 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), *Florida Statutes* the Legislature authorized the Strike Force to "advise the Chief Financial Officer on initiatives that include, but are not limited to:

- 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.
- 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.
- Identifying methods to implement innovative technology and data sharing in order to detect and analyze Medicaid and public assistance fraud with speed and efficiency.
- 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.
- 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.
- Providing grants, contingent upon appropriation, for multiagency or state and local Medicaid and public assistance fraud efforts, which include, but are not limited to:

    - Providing for a Medicaid and public assistance fraud prosecutor in the Office of the Statewide Prosecutor.

- 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.
- 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.

Medicaid and Public Assistance Fraud Strike Force Annual Report

The work of the Strike Force to date is described in more detail in the *Strike Force Annual Report: October 1, 2012* and will not be reiterated. However, the needs assessment and recommendations that resulted from the work of the Strike Force, follow here.

As part of its mission, the Strike Force has continued its efforts to gather information through meetings of the Strike Force and its committees. In June 2012, a survey of Strike Force members was conducted to identify needs to be addressed or additional improvements that can be made in the Florida Medicaid and public assistance delivery systems. The survey requested input on activities that Strike Force staff had proposed for the next year, other areas of need that the members were aware of and a prioritization of strategies to be supported by the Strike Force. The following needs were identified as areas to address in order "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*.

These are listed by general activity area in priority order, as ranked by the Strike Force members. However, the recommendations under each priority area are listed in no particular order. Those requiring legislative action are noted as such.

Priority Activity Area 1: Secure Adequate Funding

A recurring theme in reports to the Strike Force is the lack of resources available to support existing processes intended to prevent, detect, investigate and prosecute fraud. From the need for additional staff, to more competitive salaries, to better training, no agency is funded at the level they would prefer. Some of these needs can be met in part through better, more advanced technology. However, this will require an investment in resources, as well. There are certainly indications that there are already significant returns on investment being achieved.

AHCA dedicates a significant amount of resources to the prevention of fraud and abuse. Prevention activities include prepayment reviews, site visits, terminations and sanctions. For FY 2010-11, the return on investment demonstrates that funding to support detection and investigation has been well directed. AHCA's MPI documented that for every dollar spent to avoid costs, almost four dollars are saved ($3.9:1). In addition, for every dollar spent on recovery efforts, MPI has been able to recover nearly ten dollars ($9.8:1). Similarly, during FY 2011-12, for every dollar of General Revenue expended, MFCU recovered $7.39.

Given these Return on Investment (ROI) figures, it is justifiable to direct more resources to combating fraud and abuse in order to increase returns to General Revenue and to prevent unnecessary expenditures. Although surplus General Revenue funds have not been available in recent years to do this, the Strike Force believes it important to continue to explore legislative appropriations and other funding sources to support Strike Force administrative and operational costs and the anti-fraud projects it supports as a body.

Recommendation #1. Secure funding to support the administrative and operational costs of the Strike Force in order that they can continue to coordinate and enhance interagency communications and support the implementation of the other recommendations identified here.

Recommendation #2. Continue the efforts of the Strike Force Grant Committee to identify and facilitate procurement of funding for agencies for anti-fraud activities.

Recommendation #3. Secure funding that can be used to leverage existing resources by providing seed grants for anti-fraud initiatives.

Priority Activity Area 2: Seek and Implement Technology Solutions

A major strength in the Medicaid service systems is the prolific availability of data on recipient applicants and Medicaid claims. Unfortunately, there are a number of weaknesses that compromise the ability to make the best use of this data. This is particularly critical in efforts to detect criminal behavior patterns. Currently, the technology is not in place that connects all the databases that contain health care fraud and related data. Section 409.913(38)(b), *Florida Statutes*, requires AHCA to develop a strategic plan to connect these databases.

In December 2010, AHCA developed a *Strategic Plan for Data Connectivity of Health Care Fraud Databases.* This working strategic plan provided goals and objectives aligned with the strategic priorities provided in Section 409.913(38)(b), *Florida Statutes*. These priorities serve as drivers for combating fraud and abuse in the Florida Medicaid program by addressing detection and prevention activities, as well as methods to recover improper payments to Medicaid providers. AHCA designed the plan to be a dynamic document that can be adjusted to meet the needs of an ever changing Medicaid service system.

Recommendation #4. Facilitate funding requests and/or advocate for legislative appropriations to support the implementation of AHCA's Data Connectivity Plan.

During the past fiscal year, the agency revised the Strategic Plan to document new databases that were identified that could assist in the fight against health care fraud and abuse, as well as to identify new opportunities to connect databases storing health care fraud related information. The revised Strategic Plan was issued on March 7, 2012. In AHCA's 2010 data connectivity plan update, there were 14 databases identified and the inventory continues to grow as more agencies are engaged in this endeavor.

Recommendation #5. Make better use of available data by completing an inventory of available databases, the owners of the databases, the relevance to anti-fraud efforts, the data they contain and the restrictions/limitations on access.

This is necessary to begin the process of ensuring that data is shared between agencies in the most efficient means available to prevent, detect and recoup funds lost to fraud, waste and abuse within the Medicaid and public assistance program delivery systems.

In addition, a recent bi-annual audit from the Office of Program Policy Analysis and Government Accountability (OPPAGA) recommended that AHCA expand its detection tools to include neural networking and other advanced techniques for detecting emerging fraud and abuse patterns. Recent pilot projects that used link analyses have demonstrated the value of identifying connections between information maintained in various diverse databases on providers and recipients in detecting fraudulent activity. These link analyses can be facilitated with certain additional standard data elements.

Recommendation #6. Track affiliated owner and business managers, (and others) of pain clinics, pharmacies and other sources of medical supplies/ drugs to enable link analyses that could identify potential fraud. One standard data element on providers that is needed to link provider information across databases is the National Provider Identifier. Currently, DOH and AHCA do not collect this information because statutory authority is required to enable them to do so.

Recommendation #7. Request statutory authority to enable AHCA and DOH to collect the National Provider Identifier for practitioners, a unique 10-digit identification number for covered health care providers, to enable link analyses that could identify potential fraud.

It is important to the Strike Force efforts that every consideration is given to providing the resources to incorporate such analytics or predictive modeling software into any upgrades to databases that help to prevent, detect, investigate and prosecute fraud as well as to recoup wrongful payments. In the immediate future, this would include the incorporation of such technology into AHCA's case management system replacement, which is underway.

Recommendation #8. Incorporate advanced analytics in upgrades to information systems.

Support LBRs for Identity Verification technology, Asset Verification technology and advanced analytics in the Medicaid Eligibility System Replacement for DCF.

Priority Activity Area 3: Maintain/Enhance Communications

A major role that the Strike Force plays in the fight against Medicaid and public assistance fraud is as facilitator of intra- and inter-agency coordination and communications. This communication must be facilitated among all the stakeholders with an interest in eliminating fraud.

Recommendation #9. Incorporate routine reports to the Strike Force members on suggestions and feedback from the front line staff on what needs to be done to improve our inter-agency efforts to eliminate Medicaid and public assistance fraud and recover state and federal funds

Recommendation #10. Expand participation on Strike Force working committees to include other public assistance agencies (e. g., Department of Education, Agency for Persons with Disabilities).

Recommendation #11. As part of the overall efforts to reduce Medicaid and public assistance fraud, the Strike Force needs to more aggressively pursue relationships with the media and keep them informed of activities and outcomes from the Strike Force and member agencies. Part of this effort needs to entail public awareness of the impact of perpetrators on law-abiding citizens.

Recommendation #12. In conjunction with the efforts to enhance media relations on the problem of Medicaid and public assistance fraud, the Strike Force needs to reach out to community groups,

organizations and entities to engage their assistance in efforts to educate the public on the impact of Medicaid and public assistance fraud on law-abiding citizens.

Priority Activity Area 4: Enhanced Prevention and Detection

This has been an area of emphasis for the Strike Force and member agency staff continues to identify critical activities that will enhance prevention efforts.

Track, Oversee and Solve Fraud Issues in the Transition to Managed Care

Recommendation #13. As the state moves to statewide Medicaid managed care, ensure that new, anti-fraud prevention tools are put in place and that MPI and MFCU are prepared for the transition to Managed Care and the new challenges it will create for the agencies.

Ensure the state is paying capitated insurance payments only on behalf of qualified beneficiaries.

Properly enroll Medicaid applicants and quickly disenroll recipients who are no longer eligible, due to other third party insurance, a move out-of-state, a lengthy incarceration, an increase in income, or death to prevent unauthorized payments to managed care entities.

3. Ensure that benefit recoveries are coordinated so that Federal Medical Assistance Percentage refunds due do not exceed the project's collections.

Conduct Anti-Fraud Policy Reviews and Make Recommendations

A number of policy areas have been identified where changes could be made to enhance Strike Force agencies' efforts to prevent fraud.

Recommendation #14. Request statutory authority to enable DOH to conduct state and national criminal history record checks on all professions they regulate.

Recommendation #15. Request expansion of the authority provided by Chapter 456, *Florida Statutes*, to allow DOH to conduct background screenings of all health care professionals licensed by DOH.

Recommendation #16. Request expansion of AHCAs authority to restrict potentially fraudulent providers from entering the system, in particular, to minimize licensure exemptions that currently exist for health care clinics.

Recommendation #17. In follow up to the SNAP Fraud Rate study, identify federal and state legislative changes needed to strengthen the program (i. e., agency oversight, stronger penalties for fraud, etc.).

Prompt and Motivate Agencies to Continuously Enhance Prevention Efforts

Recommendation #18. Examine the entire spectrum of public assistance delivery systems, not just at eligibility determination but also during receipt of benefits (e. g., EBT card trafficking, retailer fraud, provider billing fraud, overpayments, etc.).

- Seek and implement solutions to identity theft in every facet of beneficiary service delivery.
- Seek and implement employee fraud prevention and detection initiatives.
- Seek and implement solutions to provider and retailer fraud.

Priority Activity Area 5: Targeted Local Operations Partnerships

Another opportunity that exists to help leverage resources is the opportunity to partner with local and federal agencies to enhance detection, investigation and enforcement efforts. There are already numerous multi-jurisdictional task forces and initiatives in place that enable cooperative initiatives. Supporting and growing these collaborative relationships can result in aggressive investigations into fraudulent practices from various levels. An added benefit to being more aggressive with these cases through partnerships is that illegally gained assets could be seized, preventing the perpetrators from passing along the infrastructure needed to continue the criminal activity. The Strike Force can be integral in maximizing this opportunity by advocating for and supporting these initiatives in any way possible. Having funds available through whatever funding sources the Strike Force secures would help provide resources to support these initiatives.

Sustain/Expand Federal, State Local Interagency Relationships to Improve Anti-Fraud Efforts

Recommendation #19. Offer enhanced anti-fraud training opportunities and workshops involving both law enforcement and regulatory personnel within Florida to build collaborative, multi-agency efforts to suppress emerging fraud trends. Include training that will provide individual officers with the ability to identify indicators/evidence of Medicaid and public assistance fraud, as well as on:

- Coordinating investigations;
- Ensuring successful criminal and civil prosecution;
- The importance of seizing assets and how to do so; and
- Ensuring comprehensive media coverage.

Recommendation #20. Enhance communication between the criminal enforcement units and regulatory enforcement components to facilitate these efforts through the sharing of intelligence. Strike Force staff should maintain communications with all agencies that engage in these initiatives to bring awareness to problems that may arise from the perspectives of the diverse agencies involved and work with involved agencies to identify and implement solutions.

Replicate Successful Models for Multi-Jurisdictional Enforcement Operations

Recommendation #21. Identify high volume areas in the state where Medicaid and/or public assistance fraud is occurring, organize relevant agencies to carry out targeted enforcement initiatives and develop enforcement operational plans to launch prioritized enforcement and deterrent initiatives. The Strike Force has the agency personnel resources to identify schemes that cross program/jurisdictional lines and confront them with well-planned, data-driven, coordinated enforcement efforts. Drawing agents from local, state and federal agencies, minimally staffed and equipped initiatives can produce significant results.

Conduct Anti-Fraud Policy Reviews and Make Recommendations

One policy issue was identified where a change could be made to enhance the Strike Force's efforts to enhance Targeted Local Operations.

Recommendation #22. As a key agency in moving forward with the Targeted Local Operations Partnerships, support DPAF's Legislative request to provide them with subpoena power to assist them in the prosecution of their cases.

Statutory Reporting Requirements

Number of cases opened and investigated each year

MFCU opened 324 cases and had 1,028 active cases in FY 2011-12. MPI investigated 3,980 cases which included 2,301 opened during the year.

Disposition of the cases closed each year

Disposition of Closed Cases				
	MFCU	**PANE**	**AHCA**	**Total**
Administrative Closure	4			4
Administrative Referral	66	11		77
Assistance to Other Agencies		1		1
Case Dismissed	10			10
Civil Intervention Declined	1			1
Civil Judgment	1			1
Civil Settlement	16			16
Consolidated	3			3
Contract Assessments (MCO)			7	7
Conviction	13	6		19
Deferred Prosecution Agreement		2		2
Lack of evidence	27	9		36
No Fraud or Abuse Found			229	229
Nolle Prosequi		1		1
Overpayment Identified			1,987	987
Plea Agreement	9	9		18
Pretrial Intervention	4	6		10
Probation		3		3
Prosecution declined	4	3		7
Provider Education Letter			248	248
Resolved with Intervention	3	1		4
Sanction Only			371	371
Unfounded	24	4		28
Voluntary Dismissal	28			28
Total	213	56	2,842	3,111

Sources of the cases opened

	MFCU	PANE	AHCA
AHCA – Field Offices		1	
AHCA – Division of Medicaid	1		306
AHCA – Health Quality Assurance	5	1	114
AHCA – Medicaid Program Integrity	29		1,401
AHCA – Office of Inspector General	1		
AHCA – Finance and Accounting			57
AHCA – Other	1		23
Anonymous	4		
APD – Agency for Persons with Disabilities	5		
APS - Adult Protective Services	2	60	
Citizen	27		2
Confidential Informant	2		
Contractor for Centers for Medicare & Medicaid Services	5		
Department of Health	2		
Department of Health – Health Quality Assurance	1		
Employee	14	1	
Family Member	8	2	
FBI – Federal Bureau of Investigation	1		
Florida Department of Law Enforcement	2		
HHS – OIG Health & Human Services Inspector General	5		
HMO Investigative Unit			18
Joint Taskforce	2		
Insurance Company – Private	1		
Law Enforcement Agency	3		3
Long Term Care Ombudsman Council		2	
Medicaid Provider	8	1	148
Medicaid Recipient	3		4
MFCU Data Mining Initiative	22		
National Association of MFCU	1		
Operation Spot Check	1		4
Press Report			55
Qui Tam	86		
Spin-off Case	12	1	
U. S. Attorney's Office	1		
State Agency - Other			75
Federal Agencies – Other			91
Total	**255**	**69**	**2,301**

Amount of overpayments alleged in preliminary and final audit letters

Typically, MPI sends a preliminary audit report explaining the overpayment provisionally identified, giving the provider an opportunity to provide additional or clarifying documentation. After review of 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 2,842 cases closed during the fiscal year there were 1,987 cases with overpayments identified. Preliminary audit reports were issued on 1,208 cases with potential identified overpayments in the amount of $40,099,191. MPI closed 517 of those cases when the provider agreed to repay the overpayment after the preliminary audit report with identified overpayments of $5,777,709. In the remaining 551 cases, final audit reports were issued identifying potential overpayments of $25,201,196. These cases ultimately were closed after *Final Orders* with identified overpayments of $23,410,090. The total overpayments identified for collection in these 1,208 cases amounted to $29,187,799.

In addition to the overpayments identified in those 1,208 cases, the bureau identified overpayments in the amount of $6,866,130 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. The total identified overpayments amounted to $36,053,930 for all 1,987 cases closed with findings during the fiscal year.

Number and amount of fines or penalties imposed

During the fiscal year, MPI initiated 270 prepayment reviews, imposed fines under Rule 59G-9.070, F. A. C., of $2,643,713 and assessed MCOs penalties under statutory or contractual authority totaling $3,555,600, recommended 85 suspensions and recommended 106 "with cause" terminations. There were also 509 referrals to MFCU and others within and outside the Agency.

Reductions in overpayments negotiated in settlement agreements or by other means

AHCA did not negotiate any settlements during FY 2011-12.

Amount of final agency determinations of overpayments

MPI recovery activities on closed cases for the fiscal year determined overpayments of $36,053,930.

Amount deducted from federal claiming as a result of overpayments

Federal requirements have changed to allow the State up to one year to return the Federal share of overpayments. The Agency reports the federal portion of the total overpayment on the corresponding federal CMS-64 quarterly reports as payments are received or within a year for uncollected overpayments. If the payment plan exceeds one year, the full amount due to the Feds will be reported on the last appropriate quarterly report. During FY 2011-12, AHCA reduced its federal claims by $36 million for net overpayments.

Amount of overpayments recovered each year

During the FY 2011-12, $58.8 million was booked as accounts receivable. As of June 30, 2011, the Medicaid accounts receivable balance for fraud and abuse was $46 million. The balance as of June 30, 2012, was $41.2 million. During this fiscal year, total collections, net of adjustments and refunds, approached $49.7 million. The collections were: $44.2 million in overpayments ($25.8 million collected from Medicaid Fraud Control Unit (MFCU) cases and $18.4 million collected from Medicaid Program Integrity (MPI) cases); $200,000.00 in investigation costs; $5 million in fines/sanctions and $300,000 in interest.

MFCU collected $21,581,716.21 in overpayments that were returned to AHCA. Additionally, MFCU collected $74,227,964.58 in Federal Medicaid overpayments which were sent directly to the U. S. Department of Health and Human Services for a total of $95,809,680.79 in Medicaid overpayments collected in FY 2011-12.

Amount of cost of investigation recovered

AHCA recovered $200,000 in investigation costs. The MFCU collected $391,906 in investigative costs.

Average length of time to collect the overpayment

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 284 days.

The amount determined as uncollectible and reclaimed from the Federal Government

During FY 2011-12, the Department of Financial Services deemed $13.8 million uncollectible and approved it for write-off. The federal requirements only allow federal funding to be reclaimed when the write-off is due to a bankruptcy, 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. Based on the federal reporting requirements none of cases written off were subsequently reclaimed from the Federal Government.

The Agency collected $40,590.24 after the cases were written off.

Providers terminated from participation in the Medicaid program

The following chart references the number of providers, by type, that were terminated from the Medicaid program due to considerations or factors that are of program integrity nature. These figures represent both contractual and sanction-based terminations due to suspected fraud and abuse, federal exclusions and other compliance-related considerations that fall within the broader category of program integrity.

Provider Type	No. Terminated
Community Behavioral Health Services	4
Specialized Mental Health Practitioner	4
Skilled Nursing Facility	1
Assistive Care Services	28
Pharmacy	2
Physician (M.D.)	84
Physician (D.O.)	4
Physician Assistant	1
Nurse Practitioner (ARNP)	5
Portable X-Ray Company	1
Optometrist	1
Home Health Agency	14
Home & Community-Based Services Waiver	56
HMO	1
Professional Early Intervention Services	2
Therapist (PT, OT, ST, RT)	2
Durable Med Equipment/Medical Supplies	2
Managed Care Treating Provider - Non-Medicaid	3
Billing Agent	2
Total	217

In addition to the providers terminated as referenced in the above chart, providers that were terminated due to program integrity considerations, there were an additional 398 providers who were identified as potentially related to suspected fraud and abuse and other compliance-related considerations that were already terminated at the time that the Agency discovered the program integrity related concern. Often-times these are providers under review by the Agency or other reviewing entity who voluntarily terminate from the program to avoid regulatory action by the Agency.

All costs associated with discovering and prosecuting cases of Medicaid overpayments

MFCU expenditures for FY 2011-12 were $13,450,971.32, which included indirect costs of $822,321.57. During the year, MPI expenditures of $13.2 million were devoted to recovery resulting in collections and cost avoidance of $90.1 million.

Providers prevented from enrolling/reenrolling in Medicaid

The following chart references the number of providers, by type, that were denied enrollment or reenrollment in the Medicaid program due to considerations or factors that are of program integrity nature, which would include suspected fraud and abuse.

Provider Type	Denied
Community Behavioral Health Services	6
Specialized Mental Health Practitioner	1
Swing Bed Facility	1
Assistive Care Services	26
Pharmacy	7
Physician (M.D.)	66
Physician (D.O.)	9
Physician Assistant	1
Dentist	1
Home Health Agency	84
Home & Community-Based Services Waiver	14
Federally Qualified Health Center	1
Children's Medical Services	2
Therapist (PT, OT, ST, RT)	3
Durable Med Equipment/Medical Supplies	6
Managed Care Treating Provider-Non-Medicaid	1
Total	229

In addition to the providers denied as referenced in the above chart, providers that were prevented from enrolling or reenrolling due to program integrity considerations, there were an additional 110 providers who were denied due to findings during an onsite pre-enrollment visit and 79 providers denied due to disqualifying criminal offenses; no providers were denied due to a federal exclusion.

Policy recommendations necessary to prevent or recover overpayments and changes necessary to prevent and detect Medicaid fraud

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 supported 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:

- 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 antifraud strategies for the managed care plans. Additional MPI 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).
    - SIU units within managed care organizations are required to develop annual anti-fraud plans and report their anti-fraud experiences yearly 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, will enhance fraud detection and further suppress fraud and abuse in the Medicaid program.
- Efforts by AHCA and the Department of Children & Families should be coordinated to increase the emphasis on Medicaid recipient eligibility fraud and Medicaid eligibility determinations predicated upon inaccurate or false information. 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 or who are on Medicaid rosters in other states. Ensuring that Medicaid recipients who are simultaneously enrolled in other states' Medicaid programs are detected through the use of tools such as the federal Public Assistance Reporting Information System will identify unnecessary or duplicative Florida Medicaid capitation payments and allow Florida to eliminate them.
- The State of Florida should acquire advanced data technologies to detect funds lost to fraud, abuse or error, as recommended by the Florida Office of Program Policy Analysis and Government Accountability. Such detection tools would enhance AHCA's ability to detect billing and service provision anomalies earlier in the claims adjudication process to allow the targeted assignment of investigative and audit resources to produce a greater return on investment. These tools could also be used to provide oversight and early detection of offending providers in a managed care environment. Without such a tool, treating providers who perform services for multiple managed care organizations may evade detection by a single plan's non-coordinated oversight.
- AHCA and the MFCU should continue to support and monitor MFCU's data mining initiative and work to ensure MFCU's data mining efforts are as effective as possible in the detection of overpayments, fraud and program exploitation. AHCA, in collaboration with MFCU, requested a waiver from the Centers for Medicare and Medicaid Services to allow MFCU to supplement AHCA's data mining activities. CMS granted the waiver request as a three-year pilot project that began October 1, 2010. Conditions upon the waiver, established by CMS, require coordination of data mining efforts by AHCA and MFCU to prevent the federal funding of duplicative efforts and a performance report to be completed by AHCA and provided to CMS in 2013. Florida stakeholders should closely analyze the results of the data mining performance report to determine where data mining was most cost effective and productive.

- Florida's Legislature should support enhancements to existing laws that would serve to combat fraud and abuse within Florida's Medicaid program. These enhancements include:
    - Expanding the immunity from tort liability extended to persons who report fraud or suspected fraudulent acts by a Medicaid provider to also protect managed care companies, their employees and law enforcement and regulatory personnel who exchange information in good faith about suspected fraudulent acts and program abuses within the Medicaid program for the purpose of suppressing fraud and abuse.
    - Requiring that managed care providers' non-Medicaid-enrolled treating providers are subject to Level 2 background (fingerprint based) screening, thereby allowing such managed care providers to screen their providers through national criminal history records. (Without a Florida law mandating such background checks, federal laws disallow the use of the national crime information system for these checks by Florida managed care providers).
    - Specify that the venue for all Medicaid program integrity regulatory sanction cases lies within Leon County. Current law establishes the venue for all overpayment cases as Leon County, but does not similarly cover regulatory sanction cases.
- Stakeholders in Florida's Medicaid program should support AHCA's pending grant application before 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.

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http://ahca.myflorida.com/Executive/Inspector_General/index.shtml.
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