The State's Efforts to Control Medicaid Fraud and Abuse
FY 2013-14

ATTORNEY GENERAL · STATE OF FLORIDA

AGENCY FOR HEALTH CARE ADMINISTRATION · STATE OF FLORIDA

December 31, 2014

The Honorable Rick Scott
Governor
PL-05 The Capitol
400 South Monroe Street
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 2013-14. 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 Andy Gardiner
        The Honorable Steve Crisafulli

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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 Department of Legal Affairs have continued their joint efforts to prevent, reduce, and mitigate health care fraud, waste, and abuse. Members and subject matter experts from many state agencies dealing with public benefits health care programs meet to discuss major issues, strategies, joint projects, and other matters.

This joint report presents the results of the efforts by the Agency and MFCU to control Medicaid fraud and abuse during FY 2013-14.

Department Of Legal Affairs – Office of the Attorney General

Overview of the Medicaid Fraud Control Unit

The MFCU is responsible for investigating fraud committed upon the Medicaid Program by providers and program administrators. This authority is granted under both federal and state law (Section 1903 of the Social Security Act, Section 42 of the Code of Federal Regulations, and Chapter 409, Florida Statutes).

The MFCU investigates a diverse mix of health care providers including doctors, dentists, psychologists, home health care companies, pharmacies, drug manufacturers, laboratories, and more. Some of the most common forms of provider fraud involve billing for services that are not provided, overcharging for services that are provided, or billing for services that are medically unnecessary. The MFCU also plays a leadership role in a variety of multi-state false claims investigations. Many of these investigations have focused on the pharmaceutical industry, and several of these investigations have resulted in multi-million dollar settlements for Florida.

Medicaid providers, and others who are arrested by MFCU personnel, are prosecuted by the Office of Statewide Prosecution, State Attorneys, United States Attorneys, or MFCU attorneys.

The MFCU is also responsible for investigating the physical abuse, neglect, and financial exploitation of patients residing in long-term care facilities such as nursing homes, facilities for the mentally and physically disabled, and assisted care living facilities. The MFCU is greatly concerned with the quality of care being provided for Florida's ill, elderly, and disabled citizens. In 2004, MFCU implemented its ongoing PANE (Patient Abuse, Neglect, and Exploitation) Project in Miami-Dade County. This project was designed to be a collaborative effort among several agencies to address the abuse and exploitation of patients in long-term care facilities. PANE was expanded statewide during fiscal years 2005 and 2006 and is an ongoing initiative.

Control and Enforcement Strategy

The MFCU has two primary areas of enforcement responsibility: fraud perpetrated against the Medicaid Program and Patient Abuse, Neglect and Exploitation. Enforcement in these areas, which includes both criminal and civil enforcement

actions, should help prevent, detect, prosecute, and deter these types of misconduct in order to protect the citizens of Florida. Case management including case openings, investigative activities, legal review, prosecution, prioritization, utilization of investigative and legal resources, and other related issues are handled on a case-by-case or office-by-office basis.

MFCU's Control and Enforcement Strategy requires unit members to focus on the following:

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

Complaints

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. During FY 2013-14, the Unit received 1,699 complaints. Of those 1,699 complaints, 261 were opened as operational cases. Of the 1,699 complaints received in FY 2013-14, 807 were related to fraud and 892 were related to PANE allegations.

Complaints Received

(Bar chart: Fraud — SF 2012-13: 842, SF 2013-14: 807. PANE — SF 2012-13: 601, SF 2013-14: 892.)
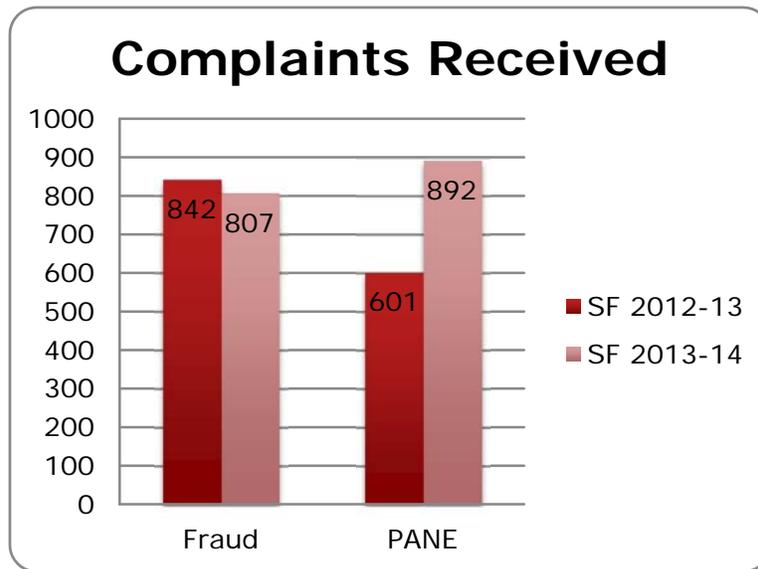
The primary source of fraud complaints in FY 2013-14 was Medicaid recipients with 174 complaints reported. The Agency, via its MPI unit, accounted for 24 of the Medicaid fraud complaints received. Ninety-seven qui tam complaints were received.

The Department of Children and Families (DCF) generated the majority of PANE complaints. In FY 2013-14, of the 892 PANE complaints, 790 came from DCF. Family members relayed the next highest source of PANE complaints, accounting for 25 complaints.

Case Investigations

Complaints are first reviewed to determine issues such as jurisdiction, and likely viability of the complaint. The opening of a case indicates that a criminal investigation or civil case has begun. Thereafter, significant investigative resources and time is expended to identify those involved in the origin of the wrongdoing, possible criminal misconduct, scope of the activity, and establish sufficient evidence to prove the requisite elements.

During FY 2013-14, the Unit's internal intake team has continued to assist with front-end decision-making regarding opening or closing criminal investigations.

This successful process preserved valuable investigative resources and allowed the MFCU to be more selective in its case focus.

Cases Opened
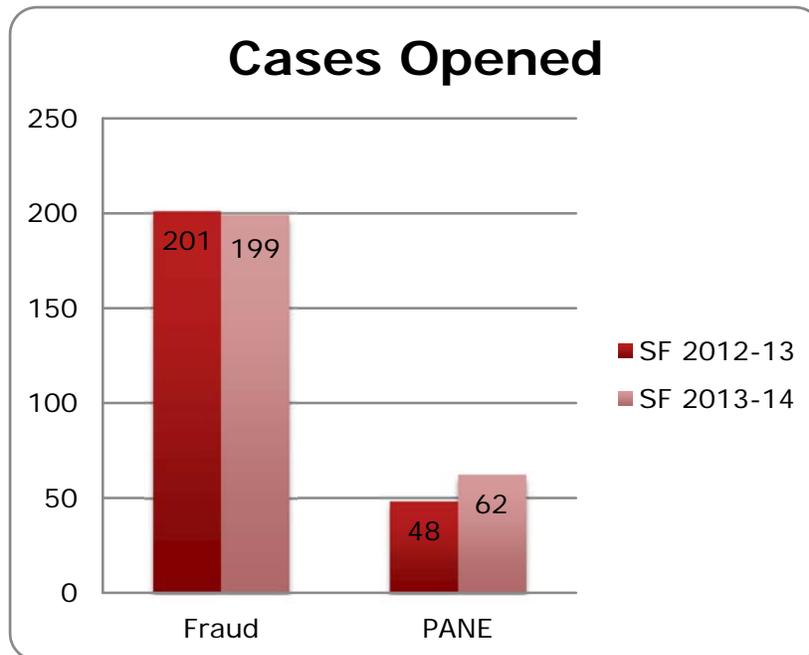
The following is a list of the top five Medicaid Provider types for MFCU fraud cases in FY 2013-14, ranked most to least frequent:

FY 2013-14
Pharmaceutical Manufacturer
Pharmacy
Case Management Agency
Physician/Medical Doctor
Home & Community Based Services

The following is a list of the top five Provider types for PANE cases in FY 2013-14, ranked most to least frequent:

FY 2013-14
Facility Employee
Certified Nursing Assistant
Care Giver
Assisted Living Facility
Skilled Nursing Facility (tied)
Assisted Care Services (tied)

Disposition of Cases

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

In FY 2012-13, the MFCU closed 300 cases. Of those, 238 involved Medicaid fraud investigations and 62 involved PANE cases.

In FY 2013-14, the MFCU closed 312 cases. Of those, 251 involved Medicaid fraud investigations and 61 involved PANE cases.

Enforcement actions are a primary consideration for the MFCU. At the conclusion of an investigation, a referral for prosecution is an important outcome and determinant of success.

In FY 2013-14, the total referrals for prosecution has increased 36% from the previous fiscal year. The Northern region continues to have successful referrals, and the Central and Southern regions have ramped up their referrals.

Referrals for Prosecution		
	FY 2012-13	FY 2013-14
Fraud	30	47
PANE	28	32
Total	58	79

Warrants for Arrests		
	FY 2012-13	FY 2013-14
Fraud	37	47
PANE	27	21
Total	64	68

The warrants for arrests have also increased within FY 2013-14. The key component of the 6% increase is the Central region.

Significant Case Highlights

The following are brief summaries of significant cases that resulted in successful convictions or civil settlements for the MFCU during FY 2013-14.

Johnson & Johnson and Janssen Pharmaceuticals, Inc.

On October 31, 2013, Florida, 39 other states, the District of Columbia, and the federal government reached a global settlement with New Jersey pharmaceutical manufacturer Johnson & Johnson (J & J) and its subsidiary, Janssen Pharmaceuticals, Inc., to resolve civil and criminal allegations of unlawful marketing practices to promote the sales of their atypical antipsychotic drugs, Risperdal and Invega. Under the terms of the civil settlement, the companies paid more than $1.2 billion to the states and the federal government. Florida received almost $21.6 million of this settlement.

The settlement resolves four qui tam, or false claims, lawsuits filed in the United States District Court for the Eastern District of Pennsylvania, under the provisions of the federal False Claims Act and similar state False Claims statutes. In addition, Janssen Pharmaceuticals, Inc. pled guilty in federal court to a criminal misdemeanor charge of misbranding Risperdal in violation of the Food, Drug, and Cosmetic Act. As part of the criminal plea, Janssen agreed to pay $400 million in criminal fines and forfeitures.

J&J and Janssen allegedly promoted, marketed, and introduced Risperdal and Invega into interstate commerce for uses that were not approved by the Food and Drug Administration and for uses that were not medically indicated. Once the FDA approves a drug as safe and effective, a manufacturer cannot market or promote a drug for an "off-label" use, i.e., any use not specified in the FDA-approved product label. The states contend that during the period January 1, 1999, through December 31, 2005, the companies promoted Risperdal for off-label uses, made false and misleading statements about the safety and efficacy of Risperdal, and paid illegal kickbacks to health care professionals and long-term care pharmacy providers to induce them to promote or prescribe Risperdal to children, adolescents, and the elderly when there was no FDA approval for Risperdal use in these patient populations. The states further contend that from January 1, 2007, through December 31, 2009, the companies promoted Invega for off-label uses and made false and misleading statements about the safety and efficacy of Invega. The manufacturers' alleged unlawful conduct caused false and fraudulent claims to be submitted to or caused purchases by government funded health care programs, including the state Medicaid programs.

As part of the global resolution, the companies entered into a Corporate Integrity Agreement with the United States Department of Health and Human Services, Office of the Inspector General, which will closely monitor the companies' future marketing practices.

The Florida Medicaid program received $10,586,623 in restitution, $10,586,623 in additional recoveries, and $409,180 in interest.

Endo Pharmaceuticals

Florida joined 46 other states and the federal government in a $173 million global settlement with Endo Pharmaceuticals to resolve civil allegations of unlawful marketing practices aimed at promoting the drug Lidoderm for conditions not approved by the Food and Drug Administration. According to the qui tam lawsuit, Endo unlawfully marketed Lidoderm for use in connection with lower back pain or chronic pain. The FDA approved Lidoderm only for the treatment of pain associated with post-herpetic neuralgia, more commonly known as "shingles." Endo's alleged unlawful conduct caused false and fraudulent claims to be submitted to the Florida Medicaid program, causing the Florida Medicaid program to pay for a drug that would not have been prescribed, but for Endo's conduct.

Under the terms of the civil settlement, Endo paid $172,916,967 to the states and federal government and paid a $20.8 million criminal fine. Florida's portion of the settlement is nearly $1.5 million. The Florida Medicaid damages included $609,058 in Medicaid restitution, $862,833 in additional recoveries, and $20,502 in interest. The Office of the Attorney General of Florida worked with New York, Texas, Oregon, and the federal government on this settlement agreement.

Wyeth Pharmaceuticals, Inc. and Pfizer, Inc.

On July 24, 2013, Florida was part of a national settlement with other states and the federal government against Wyeth Pharmaceuticals, Inc. and Pfizer, Inc. over off-label marketing allegations. Rapamune is only approved by the U. S. Food and Drug Administration for use in treating kidney transplant patients. The settlement resolves allegations that the company, now owned by Pfizer, Inc., promoted the drug for the treatment of other kinds of transplant patients, which resulted in the submission of false or fraudulent Medicaid claims.

To resolve the federal government's concurrent criminal charges, Wyeth Pharmaceuticals, Inc. pled guilty in federal court in Oklahoma to violations of the Federal Food, Drug, and Cosmetic Act, and agreed to pay more than $233 million in criminal fines and forfeitures. Florida received $1.4 million from the settlement which was allocated to Medicaid restitution, additional recoveries, and interest.

All Children's Health System, Inc.

MFCU joined the federal government and a qui tam relator in a $7 million settlement with All Children's Hospital, Inc., Pediatric Physician Services, Inc., and All Children's Health System, Inc. (ACH) to resolve civil allegations of violations of the False Claims Act. According to the qui tam lawsuit, ACH allegedly made inappropriate payments to physicians in the form of inflated salaries, bonuses, perks, on-call payments, and excessive compensation to acquire physician practices.

Florida's $2,209,816 state share of the settlement included $1,104,908 in Medicaid restitution and $1,104,908 in additional recoveries. This case was handled by the Office of the Attorney General's Complex Civil Enforcement Bureau, which is part of the MFCU.

Jennifer Kester and Lucy Watson - Fraudulent Claims

A mother and daughter-in-law duo was arrested for committing more than $70,000 in Medicaid fraud. Jennifer Kester and Lucy Watson ran a scheme that involved Kester and Watson billing the Medicaid program for services that were not actually provided to Watson's developmentally disabled son. According to the investigation, Watson, as the guardian of her son, submitted timesheets for work that was not provided. The MFCU and the Tampa Police Department arrested Watson, and the Chesterfield County Sheriff's Department in South Carolina arrested Kester.

Kester and Watson were both convicted of one count of Medicaid Fraud, a third degree felony, and ordered to pay $70,000 in restitution. Kester was sentenced to 18 months in prison and 36 months probation. Watson was sentenced to five years probation, 100 community service hours, and ordered not to work for any company which bills the Medicaid program.

Randall Ritch- Owner of Unlicensed Healthcare Clinic

The MFCU arrested a Lake County resident, Randall Ritch, for committing more than $300,000 in Medicaid fraud. Ritch, owner of Lake County Preferred OBGYN, allegedly billed the Florida Medicaid program for services that were never rendered and used the Medicaid provider number of a physician no longer in Ritch's employment. According to the investigation, Ritch submitted more than 2,500 fraudulent claims to the Medicaid program.

The Office of the MFCU began its investigation after receiving a complaint from a physician who accused Ritch of using her Medicaid provider number to bill and

receive payments from the Medicaid program for services when she did not work for Ritch.

Ritch was charged with two counts of Medicaid fraud, one count of criminal use of a personal identification number, and one count of operating an unlicensed health care clinic. Ritch pled guilty to all four counts and was sentenced to 15 years probation and ordered to pay restitution to the Agency of $83,494 and pay court costs of $1,048.

James and Grisselle Davis, Director/Owner — Targeted Case Management

James and Grisselle Davis, owners of Kingdom Builders Ministries, were arrested for defrauding Florida's Medicaid program. An investigation conducted by the MFCU revealed that the couple allegedly billed the Medicaid program for nearly $80,000 for targeted case management services that were never rendered. Targeted case management services are designed to link Medicaid recipients with a documented mental health condition to services in the community. The Lake County Sheriff's Office assisted with the arrests.

According to the investigation, the Davises directed employees to bill for an entire family when only one member received services, and to bill for unauthorized expenses, such as travel time, employee staff meetings, and phone calls. Additionally, records indicated that Kingdom Builders Ministries received payment for services allegedly provided to young children who did not have any documented mental health condition and continued to submit invoices months after terminating services.

Grisselle and James Davis were sentenced to 10 years probation and ordered to pay $50,000 restitution to the Agency, and each will pay court costs and cost of prosecution of $4,070. The Attorney General's Office of Statewide Prosecution prosecuted the cases.

Tiffany Campbell, Speech Pathologist

The MFCU and the Orange County Sheriff's Office arrested Tiffany Campbell, a licensed speech pathologist, for falsifying records to collect payment for services never rendered during the summer of 2013. Campbell's employer billed Medicaid for more than $8,000 in speech therapy services never rendered based on Campbell's fraudulent logs.

The MFCU interviewed parents of children assigned to receive speech therapy from Campbell. The parents stated that Campbell regularly cancelled appointments and

did not provide any services during the summer or holidays, depriving children between 3 – 13 years old of needed speech therapy.

Campbell pled guilty to Medicaid fraud and was sentenced to four years and 364 days probation and ordered to pay fines of $12,389. She was also ordered to pay restitution to the Agency of $8,486, and pay court costs and cost of prosecution of $3,903.

Tammi Carnes, Group Home Owner

Tammi Marie Carnes owned O'Carroll Homes, Inc., group homes for disabled adults, where she stole more than $20,000 from 13 disabled residents. According to the investigation, Carnes used these stolen funds for personal expenses such as credit card debt and gift cards. The MFCU arrested her, with assistance from the Putnam County Sheriff's Office, for one count of organized scheme to defraud, a second-degree felony, and 13 counts of exploitation of a disabled adult, all third-degree felonies. Carnes was convicted of organized fraud, incarcerated for 180 days, and ordered to pay $21,053 in fines. The case was prosecuted by the State Attorney's Office for the Seventh Judicial Circuit. O'Carroll Homes Inc. was closed by the APD.

Destiny TCM Corporation – Targeted Case Management

An investigation conducted by the MFCU revealed that the Destiny TCM Corporation, under the ownership of Lorna Holmes and the management of Rosalyn Gentry and Deidre Padilla, billed the Medicaid program for $27,000 worth of illegitimate targeted case management services and bribed individuals in order to obtain Medicaid recipient numbers. Targeted case management services link Medicaid recipients with mental health services. Allegedly, the Destiny TCM Corporation billed for services never provided to Medicaid recipients, some of which included claims for three-month-old infants, and violated the Medicaid fraud kick-back statute, s. 409.920(2)(a)(5), F.S.

Holmes, Gentry, and Padilla were each charged with one count of Medicaid provider fraud. Holmes was also charged with an additional count of Medicaid provider fraud for paying kickbacks to people in order to gain access to additional Medicaid numbers for billing. The defendants were convicted and ordered to pay $31,000 in restitution and over $11,000 in other case costs. Holmes' was ordered to pay an additional $4,000 fine for the second charge. The Attorney General's Office of Statewide Prosecution prosecuted the case.

Lakeisha Ann Roberson — Home and Community Based Services

Following an investigation by the MFCU, the Alachua County Sheriff's Office arrested a Gainesville woman, Lakeisha Anne Roberson, for defrauding the Medicaid program out of more than $12,000. The Florida Department of Children and Families (DCF) referred the case to the MFCU.

Roberson was charged with one count of Medicaid Fraud, a second-degree felony. She was sentenced to two years of probation and ordered to pay $12,494 in restitution to the Agency and $671 in court costs. The State Attorney's Office for the Eighth Judicial Circuit of Florida prosecuted the case.

Everett and Catherine Ashby — Assisted Care Services

The MFCU arrested Everett Ashby, 69, and Catherine Ashby, 64, on September 3, 2013, for Medicaid fraud. The MFCU investigated the two for allegedly billing the Medicaid program for $13,000 for services that were never provided. The Ashbys operated an adult family care home from their residence in Tampa.

Both defendants were arrested and charged with one count of organized scheme to defraud for submitting false claims to the Medicaid program for reimbursement. The defendants entered into a plea agreement and were sentenced to five years probation and ordered to pay over $11,000 in restitution to the Medicaid program and satisfy court costs.

Arthur Moodie — Abuse and Neglect

Arthur Moodie was convicted on June 25, 2014, of abusing a mentally disabled person. The MFCU investigated allegations that Moodie, who was employed at the Primrose Center Inc. in Orlando, Florida, struck a mentally disabled adult under his care. According to Moodie's coworkers who witnessed the abuse, Moodie struck the victim across the face while the victim was in his care. Moodie was convicted of battery, placed on probation for a year, ordered to pay a $524 fine, and complete an anger management class. The Orange County State Attorney's Office prosecuted the case.

Omnicare

As part of a national settlement against Omnicare, Inc., Florida recovered nearly $70,000. The settlement resolved allegations that Omnicare violated federal and state law, including the Federal False Claims Act, the Federal Anti-Kickback Statute, and certain states' False Claims Acts with respect to the prescription drug Aranesp, a drug used for patients with chronic kidney disease.

Allegedly, Omnicare solicited and received payment from Amgen, Inc. in the form of purported discounts, purported market-share rebates, grants, honoraria, speaker fees, consulting services, dinners, travel, or fees for the purchase of data, and that this payment was solicited and received in exchange for influencing health care providers' selection and use of Aranesp. Due to this alleged conduct, false and fraudulent claims for Aranesp were submitted to state Medicaid programs for reimbursement.

This settlement covers the qui tam action styled as United States et al., ex rel. Frank Kurnik v. Amgen, Inc., et al. (Civil Action No. 3:11-CV-01464-JFA), filed in the United States District Court for South Carolina.

Total Recoveries

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

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 Florida's False Claims Act. Several of the investigations resulted in multi-million dollar settlements for Florida.

In addition to its role in multi-state investigations, the CCEB successfully resolved a number of 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 Florida's Medicaid Program millions of dollars.

The state fiscal year recoveries from 2008-2014 have surpassed $100 million each year for a total of $870.8 million. FY 2012-13 was the highest due to the largest healthcare fraud settlement in U.S. history. Florida received more than $56 million as part of the pharmacy settlement that involved the federal government and various other states.

In FY 2013-14, the total amount for civil recoveries, which include civil settlements arising from qui tam cases brought under Florida's False Claims Act, was $96,081,097. The total amount for criminal recoveries based upon Medicaid fraud

cases was $7,525,738. The total amount of the monies recovered by the MFCU for FY 2013-14 was $103,606,835.

General Revenue Generated

MFCU brought in almost $15 million in FY 2013-14 to the state's General Revenue Fund. For FY 2013-14, for every General Revenue dollar spent, the MFCU generated approximately $4.35 through penalties imposed and interest deposited into General Revenue.

Training

MFCU continues to emphasize mission critical training to stay professionally current. Courses include training for complex civil litigation, database searches for FMMIS Claims Analysis, Managed Care, Provider, Recipient and Payment Management, Data Mining, CJIS Certification, and others offered by the Agency and the Florida Department of Law Enforcement (FDLE).

During FY 2013-14, MFCU staff attended a total of 4,896 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 FDLE free of charge. Other training was offered or conducted mostly free of charge by local and national organizations and regional 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, the U.S. Attorney's Office, state agencies, in particular the Agency, FDLE, local law firms and bar associations, criminal justice academies, and sheriff's offices, to name a few.

Classroom training included courses and subjects such as 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, and Pharmaceutical Drug Investigations.

In-house training provided through a variety of delivery methods included courses 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 and Case Database, Stepping Through the Complaint and Case Process, and Workplace Law & Policy.

Additionally, classroom and range firearms qualification and Use of Force training was provided to law enforcement personnel at local academies by MFCU 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, Florida Silver Alert, and Fourth Amendment Practical Guidelines for Search and Seizure.

Data Mining

On July 15, 2010, U.S. Department of Health & Human Services Secretary Kathleen Sebelius granted the Florida MFCU a waiver of a portion of 42 CFR 1007.19 allowing Federal financial participation in data mining activity. Data mining refers to the practice of electronically sorting Florida Medicaid Management Information System's 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. The waiver, granted for a duration of three years, limits the amount of MFCU staff time to be utilized on data mining, and requires submission of a detailed plan describing how the MFCU will ensure its data mining efforts will be coordinated with, and not duplicate, those efforts of Florida's Medicaid single state agency, the Agency for Health Care Administration. The current waiver was extended by the Centers for Medicare and Medicaid Services (CMS) through December 31, 2014. The Agency is in negotiations with CMS on an additional three-year extension.

The Memorandum of Understanding between the MFCU and the Agency was amended to ensure the data mining efforts would be coordinated with, and not duplicate the Agency's efforts. As of June 30, 2014, the MFCU has submitted 77

data mining projects to the Agency for review. On June 30, 2014, MFCU had 23 cases and 10 complaints in an active status from these projects and the Regional offices are currently developing additional facts. One arrest was made as a result of the current Data Mining Initiative.

AGENCY FOR HEALTH CARE ADMINISTRATION

Division of Medicaid

The Division of Medicaid administers the Florida Medicaid Program, a $22.3 billion state and federal partnership that provides for health care to over 3.5 million recipients in Florida. 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. Medicaid began as a Fee-for-Service (FFS) program more than four decades ago. Over the years, enrollment grew rapidly and costs soared until Medicaid expenditures were more than one-fourth of the state budget. The rapid growth in enrollment and costs made it increasingly important to find ways to manage the diverse needs of the Medicaid population while also being able to better predict and plan for cost increases.

Medicaid's roles and responsibilities have been evolving since it moved away from a completely Fee-for-Service program and the first Medicaid managed care plan was established in 1984. Eventually, this led to a program that was a mix of special programs, waiver programs, a FFS population, a FFS primary care case management population (known as MediPass), and a population in prepaid health plans. Florida Medicaid has recently implemented significant program changes that have resulted in improved efficiency, cost predictability, and accountability for the program and enhanced service provision for program recipients. The most significant change, perhaps the single greatest change in Medicaid since the program was adopted, is the implementation of the Statewide Medicaid Managed Care (SMMC) program. The Agency, along with sister agencies, has worked diligently for more than three years to successfully implement the SMMC program.

Upon full implementation of the SMMC program in August 2014, there was a significant shift toward contracting, contract monitoring, and policy-related functions. Previous Agency responsibilities such as prior authorization, utilization management, and program and provider monitoring that occurred under FFS became primarily the responsibility of the managed care plans under the SMMC program. The transition of Medicaid to a predominantly managed care program provides the Agency an opportunity to competitively bid managed care plans, develop contract standards for quality and access, and focus more efforts on monitoring activities, which directly impact the Agency's efforts in combatting potential fraud and abuse in the Medicaid program.

The Division of Medicaid has adopted a strategic approach to combatting Medicaid fraud and program abuse. Developing and implementing the SMMC program allowed the Agency to adopt a ground up approach to combat fraud and abuse by embedding anti-fraud control efforts into the transition and future infrastructure of the program. These strategic control efforts are focused in four key areas including Provider Enrollment and Review, Outreach and Education, Prior Authorization, and Utilization Management.

Provider Enrollment and Review

Prevention of fraud and abuse and the prevention of inappropriate practices, whether intentional or not, begin with the Medicaid providers. This includes individual FFS providers, and managed care plans and their provider networks. The Agency has implemented several programs to ensure that Medicaid providers are eligible to provide care and have processes in place to provide the necessary and appropriate health care in a safe and effective environment. All Medicaid providers are required to have a fingerprint-based background screening that is conducted through the Care Provider Background Screening Clearinghouse (Clearinghouse) and Medicaid creates a quarterly report of terminated Medicaid providers. During the transition to SMMC, Medicaid undertook several processes to ensure managed care plan readiness and have included several provisions relating to plan adequacy, provider credentialing, and reporting in the managed care plan contracts.

Centralized Background Screening

Florida Medicaid provider background screenings have been conducted through the Clearinghouse since 2013. All Medicaid providers, including Medicaid FFS providers and members of a managed care plan network, are now required to be screened through the Clearinghouse. The Clearinghouse provides a single data source for background screening results of persons statutorily required to be screened for employment in positions that provide services to children, the elderly, and disabled individuals. Fingerprints are retained in the Clearinghouse for five years, which automatically enables a provider to be notified of an arrest of their screened employee as soon as the Florida Department of Law Enforcement reports the information to the Agency.

Monitoring and Reporting of Terminated Providers

Medicaid prepares a Terminated Providers Report: Quarterly Report. The purpose of the report is to provide a tool to ensure that fraudulent or terminated providers are not participating in Medicaid, either by registering again with Medicaid using different information, or by registering with a Medicaid managed care plan in an

attempt to participate indirectly in Medicaid. The Terminated Providers Report is run each quarter by Medicaid and has three parts.

The first part is sent to the Medicaid managed care plan. This portion of the report identifies providers that have been terminated by the Agency for fraudulent behavior and informs the plan that these providers are ineligible to participate in the plan's network or to be contracted with under any circumstances.

The second part of the report focuses on active providers that have at some point in the past, through some form of identification, been linked to a provider terminated for fraudulent activity. The Agency uses this information to make sure that these active providers have the clearance to participate in the Medicaid program.

The third part of the report checks the providers that have been terminated (identified in the first part), but share a common form of identification with a currently active Medicaid provider. Since the providers shown in this portion of the report have some link to a legitimate active provider, they are double-checked by the Agency to determine if they should be excluded from Medicaid managed care plan networks.

SMMC Plan Readiness Activities

Prior to the implementation of SMMC, the Agency thoroughly reviewed its contracted managed care plans to ensure network adequacy and to verify that all of the necessary elements for plan oversight were in place. These activities included provider site visits to ensure the existence of a physical site and the completeness of licensing requirements, as well as making sure there were appropriate levels of inventory and equipment on hand prior to enrollment of even one Medicaid recipient.

The Medicaid team reviewing plan readiness for implementation was tasked with identifying critical milestones, activities, and deliverables necessary to ensure SMMC managed care plans had the capability for fulfilling contract obligations and were fully prepared to implement the SMMC program. This team coordinated and oversaw the planning and execution of review processes and tools to ensure plan readiness in advance of the transition of Medicaid recipients into the SMMC program. This team ensured compliance with all state and federal requirements. Some of the main project deliverables and milestones included:

- Development of a plan readiness strategy
- Development and implementation of a transition or roll-out schedule
- Desk reviews

- On-site surveys
- Development of an Implementation Action Plan
- Receipt of managed care plan document submissions in preparation for contract execution
- Provider network verification

Managed Care Plan Contract Requirements

Under SMMC, each managed care plan is responsible for the credentialing and recredentialing of its provider network. The plan's credentialing and recredentialing policies and procedures are required to be in writing and include at least the following:

- Formal delegations and approvals of the credentialing process;
- A designated credentialing committee;
- Identification of providers who fall under its scope of authority;
- A process that provides for the verification of the credentialing and recredentialing criteria required under the contract;
- Approval of new providers;
- Imposition of sanctions, termination, suspension and restrictions on existing providers; and
- Identification of quality deficiencies that result in the managed care plan's restriction, suspension, termination, or sanctioning of a provider.
- The managed care plan must establish and verify credentialing and recredentialing criteria for all providers that, at a minimum, meet the Agency's Medicaid participation criteria, including:
- A copy of each provider's current medical license for medical providers, or occupational or facility license as applicable to provider type, or authority to do business, including documentation of provider qualifications; if the provider is located in Georgia or Alabama, the provider's license and permit must be current and applicable to the respective state in which the provider is located;
- No revocation, moratorium or suspension of the provider's state license by the Agency or the Department of Health, if applicable;
- Evidence of the provider's professional liability claims history;
- Any sanctions imposed on the provider by Medicare or Medicaid;
- Disclosure related to ownership and management (42 CFR 455.104), business transactions (42 CFR 455.105), and conviction of crimes (42 CFR 455.106);
- A satisfactory Level II (fingerprint based) background check pursuant to s. 409.907, F. S., for all treating providers not currently enrolled in Medicaid's fee-for-service program;

- Documentation of the education, experience, prior training, and ongoing service training for each staff member or provider rendering services; and
- The contract that the plan has with the provider must contain specific provisions required by the Agency to ensure both the provider and the plan adhere to accepted practice standards. Providers and plans cannot limit a patient's access to necessary medical treatment. Providers must provide documentation for all care including maintaining an adequate system for recording services, charges, dates and all other commonly accepted information elements for services rendered.   Information must be retained for a period of six years.

Plan Reporting Requirements

Managed care plans in Florida Medicaid have comprehensive reporting requirements related to every phase of their operations. These reports allow the Agency to monitor not only provider networks, but also monitor all phases of care provided by the plans. These reports help the Agency ensure that care provided to Medicaid recipients is medically necessary and appropriate, while ensuring cost-effectiveness and preventing inappropriate utilization. Plans are required to report their Provider Network File, Provider Termination, and New Provider Notification Report weekly. These reports supply the Agency with up-to-date provider network information including information on the suspension, termination, or withdrawal of providers from participation in the plan's network. This allows the Agency to monitor the managed care plan's compliance with required provider network composition, provider-to-member ratios, and for other uses deemed pertinent.

Plans are required to report any suspected fraud and abuse activity to the Agency within 15 days. This includes enrollee and provider fraud, and the report must contain detailed information on the nature of the fraud and abuse. Plans must also provide quarterly and annual fraud and abuse activity reports. These reports provide the Agency with ongoing comprehensive fraud and abuse prevention activity information from the managed care plans regarding their investigative, preventive, and detection efforts. This allows the plans to demonstrate their due diligence for anti-fraud and abuse compliance, including utilization control; to safeguard against unnecessary or inappropriate use of Medicaid services, excess payments, and underutilization; assess quality, and take necessary corrective action to ensure program effectiveness. The reports also allow the Agency to track and trend data across all managed care plans. These reports also provide supplemental, comprehensive summaries regarding the quarterly and annual status, progression, and outcome of the plan's previously reported referrals of suspected or confirmed fraud and abuse.

Outreach and Education

Communication and understanding are key elements in helping to prevent fraud and abuse. Understanding how the program works, the roles, and responsibilities of all participants, and what the rules and regulations are that govern the program can help significantly reduce errors, misunderstandings, and problems that can lead to fraud and abuse. Medicaid conducts a comprehensive education program for Medicaid providers as well as Agency staff, and during the transition to SMMC, both before and during rollout, Medicaid conducted wide-ranging outreach activities that included providers, recipients, and other stakeholders. Also, as part of the contractual agreement with all managed care plans, the plans are responsible for providing education and training to their network providers to prevent fraud and abuse and have a monitoring plan in place for fraud prevention. The following highlights many of the education and outreach efforts conducted by Medicaid in FY 2013-14 as well as the SMMC contractual provisions related to provider education requirements.

Provider Education

The Florida Medicaid Provider Training e-Library, an online resource, contains training resources for Medicaid providers on Medicaid policy. Many Medicaid overpayments are the result of unintentional provider errors and lack of understanding about program rules. By educating providers, the Agency proactively addresses the issue of potential overpayments. The e-Library, online at http://ahca.myflorida.com/Medicaid/e-library/, enhances existing training opportunities about the Medicaid program and its policies by providing 24-hour access to online training materials.

The e-Library contains PowerPoint presentations and videos that providers can review at times that are convenient to them and which include self-paced learning materials. A video section is linked to the Agency's YouTube channel at: http://www.youtube.com/user/AHCAFlorida. The e-Library's reference section contains training materials developed by the CMS on Medicaid Program Integrity Education.

Providers receive information about topics, training dates, and how to access upcoming training opportunities via the electronic Medicaid Provider Alert system.

Medicaid has also offered training to highlight covered services, policy updates, and areas of past non-compliance, and to address questions. The Florida Medicaid program collaborated with Medicaid Program Integrity to offer the following training sessions in FY 2014:

- Medicaid Abuse and Fraud
- Do You Know Where the Drugs Are Going? Partners in Integrity
- Ambulance Transportation Services Audits by the Bureau of Medicaid Program Integrity
- Florida Payment Error Rate Measurement Program (PERM)
- How to Verify Medicaid Recipient Eligibility
- Florida Medicaid Practitioner Services Coverage and Limitations Handbook
- Florida Medicaid Ambulance Transportation Services Coverage and Limitations Handbook
- Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook
- Reminders on Documentation Requirements Project AIDS Care (PAC) Waiver Services
- Highlights of the Florida Medicaid Ambulatory Surgical Center Services Coverage and Limitations Handbook
- Florida Medicaid Therapy Services Coverage and Limitations Handbook
- Overview of the Specialized Therapeutic Services Coverage and Limitations Handbook
- Behavioral Health Overlay Services Coverage and Limitations Handbook
- Community Behavioral Health Services Coverage and Limitations Handbook
- Targeted Case Management Services for Children at Risk of Abuse and Neglect Coverage and Limitations Handbook
- The Statewide Medicaid Managed Care (SMMC) program and Assisted Living Facilities
- Section XII MPI Reporting Requirements, Attachment II of the 2012 - 2015 Health Plan Contract
- Managed Medical Assistance Program & Project AIDS Care Waiver Services
- Florida Medicaid Optometric Services Coverage and Limitations Handbook

More than 5,000 providers participated in these training sessions.

The Medicaid Fraud Prevention and Compliance Unit (FPCU)

The Medicaid Fraud Prevention and Compliance Unit handles many pre-enrollment site visits for the Agency and coordinates and implements monitoring visits of all providers statewide for specific team projects. During FY 2013-14 the team conducted several projects including continuing several ongoing projects related to managed care and the implementation of SMMC. Their outreach included efforts to increase coordination and communication with managed care plans to aid in their fraud prevention efforts and coordinate the exchange of information to maximize provider network controls. The team also developed and implemented training,

coordinated provider terminations and related activities, and assisted with the development and implementation of fraud prevention measures.

During FY 2013-14, the FPCU coordinated with Medicaid stakeholders and regional offices on issues of concern, including risks for fraud and abuse that may be unique to the given geographic area or specific provider-type. These issues were then used to prioritize provider reviews and initiate preliminary analyses of providers for additional provider education or referral and further review by the Agency's Bureau of Medicaid Program Integrity. Through provider education efforts to deter and prevent fraud and abuse, and in cooperation with other Medicaid bureaus and regional offices, the FPCU initiated provider contact and review for several thousand Medicaid providers throughout the state. This contact and review included more than 300 provider-monitoring referrals and 130 referrals to MPI. The following table details the referrals.

FPCU Referrals	
Total provider IDs referred	333
Providers referred	284
Discrete referral notices to MPI	130
Large group of providers (155) for General Analysis Audit (refraction code used by pediatricians)	1
Multiple-providers referred together (11 in first and 25 in a second) for related program integrity concerns (Targeted Case Management)	2

SMMC Outreach Activities

Outreach is another form of education and communication that ensures all stakeholders have a thorough and common understanding of the Medicaid program. As SMMC was implemented statewide, Medicaid undertook a number of outreach activities to ensure all stakeholders understood the changes and what those changes meant, to prepare providers to ensure Medicaid recipients received continued care during the program implementation, and to obtain stakeholder input on the implementation of SMMC. Stakeholder input is essential for ensuring buy-in of a new program. Commitment and acceptance of new program parameters can improve overall understanding, as well as increase the understanding, willingness, and ability to follow new rules and requirements. This in turn helps minimize the level of inappropriate behaviors and can significantly reduce the incidence of fraud and abuse.

The comprehensive outreach approach taken by Medicaid during SMMC rollout provided multiple opportunities for the public and interested parties to provide

input, ask questions, and submit complaints about the SMMC program. These opportunities included public meetings; creation of a section of the Agency website devoted to the SMMC program; creation of a SMMC inbox and comprehensive list of Frequently Asked Questions (FAQs); outreach to multiple advocacy groups; use of social media; and, creation of a complaint hub to expeditiously handle complaints and issues from Medicaid recipients and providers.

Medicaid also provided a series of webinars for providers and recipients. The webinars covered important topics such as explaining the impact of SMMC on specific provider types and services. Examples of topics include basic overviews of the SMMC program, how the Long-term Care and Managed Medical Assistance programs work together, how recipients enroll in the program, enrolling as a Medicaid provider and changes in the process, recipient eligibility verification, prescription drug benefits, and specialty plan benefits. During the webinars, participants could submit questions to be answered verbally during the presentation. Written answers were subsequently posted to the comprehensive online list of FAQs.

The Agency has posted a series of white papers on its website to provide information and clarification on a number of important topics related to the SMMC program. Examples include Continuity of Care Requirements, Transportation Service Requirements, Coordinating Dual Eligibles' Medicare and Medicaid Managed Medical Assistance Benefits, Services New to the MMA Program, and the Complaint Process in the SMMC Program.

Finally, the Agency's choice counseling vendor conducted outreach to local community partners, including health care and long-term care facilities, to provide them with information about the SMMC program. More information on SMMC, the outreach activities described above, and the FAQs and white papers can be viewed online at http://ahca.myflorida.com/SMMC.

Managed Care Plan Education and Training Requirements

Managed care plans are required to provide education and training to ensure providers in their provider network understand all required performance criteria. This includes training all providers and their staff regarding the requirements of the Medicaid managed care contract and special needs of enrollees. The plan is required to conduct initial training within thirty days of placing a newly contracted provider, or provider group, on active status. They also must conduct ongoing training, as deemed necessary by the plan or the Agency, in order to ensure compliance with program standards.

The managed care plan is also required to provide training and education to providers regarding the plan's enrollment and credentialing requirements and processes and for one year following the implementation of the contract. The plan is required to conduct monthly education and training for providers regarding claims submission and payment processes, which must include, at a minimum, an explanation of common claims submission errors and how to avoid those errors.

Each managed care plan is also required to provide details and educate employees, subcontractors, and providers about the following as required by Section 6032 of the Federal Deficit Reduction Act of 2005:

- The Federal False Claim Act
- The penalties and administrative remedies for submitting false claims and statements
- Whistleblower protections under federal and state law
- The entity's role in preventing and detecting fraud, waste and abuse
- Each person's responsibility relating to detection and prevention
- The toll-free state telephone numbers for reporting fraud and abuse

Additionally, if the managed care plan is approved to provide telemedicine, the plan must include a review of telemedicine in its fraud and abuse detection activities.

Prior Authorization

Prior authorization is a utilization control that many health insurers and health care programs like Medicaid employ to ensure that care being provided is necessary and appropriate. Similar to but distinct from utilization management, prior authorization requires a provider to obtain permission prior to implementing a treatment plan which is different from accepted practice, or where a more expensive or resource-intensive treatment alternative is being requested over other readily available treatment options. A frequent use of prior authorization is in pharmacy programs where a provider must obtain authorization for use of an expensive brand name drug over a generic equivalent. As is the case with most of the functions in Medicaid, the bulk of the responsibility for prior authorization now falls to the Medicaid managed care plans after the implementation of SMMC. However, Medicaid has contracted with several vendors to provide prior authorization and utilization management for many of the remaining FFS services. Here we highlight prior authorization of Home Health and Pharmacy services.

Home Health Visit Prior Authorization

One of the primary areas where Medicaid continued to have FFS prior authorization is for home health visits. The Agency's vendor, eQHealth Solutions, Inc.

(eQHealth), conducts prior authorization for home health visits to ensure that the proposed services are medically necessary and appropriate. During FY 2013-14, eQHealth conducted an average of 125,792 home health prior authorizations per month. Of these, an average of 117,865 was approved indicating an average denial rate of 3.9 percent. The following table shows the total number of home health prior authorization requests, approvals, denials, and denial percentages for each month during FY 2013-14. Note that in addition to being approved or denied, requests may also be pended for more information, held for additional review because of new information received, still be under reconsideration, or could also be at the fair hearing stage.

Home Health Visit Prior Authorization Activities FY 2013-14

	7/13	8/13	9/13	10/13	11/13	12/13	1/14	2/14	3/14	4/14	5/14	6/14
Total Visits Requested*	148,102	140,343	135,189	152,878	124,935	120,154	117,021	104,202	115,362	118,912	113,891	118,518
Approved	139,631	132,432	125,298	141,946	116,836	111,330	109,333	97,557	109,097	111,875	107,110	111,932
Denials	4,183	5,086	6,162	7,182	4,684	5,208	4,714	4,669	4,304	4,858	4,297	2,862
Denial Percentage	2.82%	3.62%	4.56%	4.69%	3.75%	4.33%	4.03%	4.48%	3.73%	4.09%	3.77%	2.41%

Prior authorization for home health is expected to drop by more than 60 percent in FY 2014-15, as most recipients will have transitioned to managed care.

Medicaid Pharmacy Prior Authorization

The Florida Medicaid fee-for-service pharmacy program ensures quality and cost effective pharmacy practices. The combination of cost containment programs and preferred drug policies minimize Medicaid expenditures and contribute to maximization of drug rebate collections. System driven edits and prior authorization procedures ensure that Medicaid recipients have access to needed medications while program costs are controlled and fraud and overutilization are minimized. The automated claims processing system has thousands of pre-programmed payment system "edits" that use a cost avoidance philosophy to prevent inappropriate expenditure of Medicaid funds. These "edits" are a critical component in ensuring an efficiently run Medicaid program as they prevent payments that could otherwise be characterized as abusive practices. The payment system's edits promote utilization of generic drugs, appropriate age and gender restrictions, drug utilization review (such as high dose, therapeutic duplication, and early refill), coverage limits, and duplicate paid claims.

Other prior authorization activities include, but are not limited to:

- HIV/AIDS drug product initiatives which provide safeguards against contraindicated regimens;
- Controlled substance initiatives which limit the number of controlled substances allowed depending on diagnoses; and
- Oral oncology product initiatives to ensure proper utilization of these agents through clinical prior authorization review, quantity, and age limits.

The following chart shows the total number of prior authorization requests received in FY 2013-14 for the Medicaid FFS pharmacy program.

Prior Authorizations for Medicaid FFS	
Total Prior Authorization Requests	84,050
Average Per Day	306.8
Total Requests Approved	71,036
Percent Requests Approved	84.5%

Utilization Management

Utilization management ensures that Medicaid recipients receive high quality health care that is necessary and appropriate. By implementing appropriate utilization controls, the Agency is able to guard against inappropriate or unnecessary services and avoid excess payments, while also being able to establish and apply quality standards which can be used to assess and monitor the care provided. Managing and monitoring utilization of services is an important protection against potential fraud and abuse.

Programs to manage health care utilization have existed for more than 20 years. Early efforts focused on reducing the number of inpatient hospital admissions and eliminating unnecessary hospital days. In order to achieve this objective, health plan administrators reviewed hospital admissions for medical necessity prior to admission and determined the need for ongoing care. As health care has grown more complex, the need for utilization management has expanded beyond hospital stays to include almost every facet of health care, though the basic principles of prior authorization and utilization monitoring are still key components of an overall utilization management approach.

Florida Medicaid has historically employed several methods for utilization management, including several disease management initiatives and programs, a pharmaceutical Preferred Drug List (PDL), and Medicaid claims analysis, as well as independent research to assess policy implementation and program performance. With the implementation of SMMC, most of the responsibility for utilization management will belong to the Medicaid managed care plans. However, the Agency will continue to have a significant role in monitoring plan activities and overseeing its vendors who provide utilization management for the remaining FFS

population. The following sections provide a brief overview of the utilization management efforts in Florida Medicaid.

Data Analysis

Florida Medicaid collects claims and encounter data for almost all provider and enrollee health service interactions in Medicaid. Medicaid collects individual level encounter and claims data related to levels of care, resource use, costs, and other data elements. This in turn allows the Agency to conduct data-based plan performance analyses.

SMMC Contractual Provisions and Plan Responsibilities

The transition of the Florida Medicaid program to a managed care based delivery model means that utilization management is primarily the responsibility of the Medicaid managed care plans. The core managed care contract requires that each plan have a utilization management program in place. Each managed care plan's utilization management program must be reflected in a written Utilization Management Program Description and include, at minimum:

(1) Procedures for identifying patterns of over-utilization and under-utilization of services and for addressing potential problems identified as a result of these analyses;

(2) Procedures for reporting fraud and abuse information identified through the Utilization Management program to the Agency's Bureau of Medicaid Program Integrity;

(3) Procedures for enrollees to obtain a second medical opinion at no expense to the enrollee and for the plan to authorize claims for such services; and

(4) Protocols for prior authorization and denial of services; the process used to evaluate prior and concurrent authorization; objective evidence-based criteria to support authorization decisions; mechanisms to ensure consistent application of review criteria for authorization decisions; consultation with the requesting provider when appropriate; hospital discharge planning; physician profiling; and retrospective review, meeting the predefined criteria below. The plan is responsible for ensuring the consistent application of review criteria for authorization decisions and consulting with the requesting provider when appropriate.

A Medicaid managed care plan must ensure that applicable evidence-based criteria are utilized, with consideration given to characteristics of the local delivery systems available for specific members as well as member-specific factors, such as member's age, co-morbidities, complications, progress in treatment, psychosocial situation, and home environment. The plan must also ensure that reimbursement

for utilization management activities is not structured in such a way that it provides incentives for the denial, limitation, or discontinuation of medically necessary services to any enrollee.

As part of their overall utilization management system, plans are required to have an automatic service authorization system and minimize delays in service. Plans have a short timeframe in which to notify the enrollee, provider, and Agency if a Medicaid service is denied. Plans are also required to develop comprehensive practice guidelines, which are based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field, and consider the needs of the enrollees. They are required to review and update the guidelines to ensure the care remains appropriate and the plans are required to disseminate any changes in a timely manner. A plan must obtain written approval from the Agency prior to making any changes in the utilization management protocols and the Agency must be notified of any changes to a plan's utilization management program within 30 days.

Other Agency Utilization Management Activities

In addition to the utilization management performed by Medicaid managed care plans, Medicaid also contracts with several vendors to provide utilization management of several program components in the FFS population. Medicaid works with school districts to ensure Medicaid services provided in a school setting are effective and consistent with federal guidelines.

SanData Technologies, Inc. – Telephonic Home Health Services Delivery Monitoring and Verification (DMV) Project

The Agency contracted with SanData Technologies, Inc. to implement and run the Telephonic Home Health Services Delivery Monitoring and Verification (DMV) project. The project was initially only authorized for Miami-Dade County, but was expanded to a statewide program during the 2012 legislative session. The primary purpose of the DMV project is to implement an automated database system that tracks the time spent in the home by a person providing home health visits and to verify that those visits occurred as reported by the home health service provider as authorized. This helps ensure appropriate utilization and expenditures for Medicaid home health services, improves the quality of care for Medicaid recipients, and prevents 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). During FY 2013-14, there were more than 3.7 million calls placed to verify 83 percent of more than three million visits.

EQHealth Solutions – Ancillary Medicaid and Other Services

The Agency contracts with eQHealth Solutions, a federally designated Quality Improvement Organization, for comprehensive utilization management of several ancillary Medicaid services in the FFS population. The utilization management efforts of eQHealth include medical consultation regarding the necessity and scope of services, data analyses and monitoring of selected cases, resulting in a reduction of inappropriately billed services:

- Dental
- Vision and Hearing
- Physician Outpatient Surgery
- Chiropractic
- Podiatry
- Durable Medical Equipment (DME)
- Special Services for Children
- Physician Services

EQHealth Solutions – Comprehensive Care Management (CCM)

The Agency has also included management of the Comprehensive Care Management project in the contract with eQHealth Solutions, Inc. that provides utilization management and care coordination for home health visits, private duty nursing, personal care services, prescribed pediatric extended care (PPEC) services, and inpatient medical and surgical services. The purpose of this project is to identify potential overutilization and fraud or abuse of Medicaid services by ensuring that the level of home health aide and private duty nursing services provided to recipients receiving home health care matches the needs of the recipients. During FY 2013-14, the vendor conducted 3,421 home health visits and 4,067 care coordination visits and team meetings.

The vendor provided the Agency with a utilization report of the home health agencies that routinely submitted requests that were well above the average for their area. This information was reviewed by Medicaid Program Integrity to determine if an investigation was needed. The following are the results for FY 2013-14:

Comprehensive Care Monitoring 2013-14 Statewide		
3,421 Total On-Site Home Visits to Recipients		
3,006	87.87%	recipients w/ fully approved request
48	1.40%	recipients w/ fully denied request
313	9.15%	recipients w/ partial approval
52	1.52%	reconsideration is complete
0	0.00%	at Fair Hearing
2	0.06%	at reconsideration

Magellan Medicaid Administration – Inpatient Behavioral Health

Magellan provides utilization management for all in-state, inpatient behavioral health services provided to children in Statewide Inpatient Psychiatric Program (SIPP) facilities. They are responsible for on-site care coordination for all children and adolescents admitted into SIPP. In addition to on-site care coordination, Magellan manages the Qualified Evaluator Network, which provides face-to-face assessment of all children prior to their being placed in a psychiatric residential treatment facility. The evaluators also review the child's progress toward treatment goals every 90 days.

MedSolutions, Inc. – Outpatient Advanced Diagnostic Imaging

MedSolutions ensures that Medicaid recipients receive the most clinically appropriate advanced imaging services according to approved clinical guidelines. Advanced diagnostic imaging procedures include:

- Computerized Tomography (CT)
- Computerized Tomography Angiography (CTA)
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Positron Emission Tomography (PET)

They ensure that there are multiple avenues to obtaining prior authorization so that there is a minimal disruption in services. The non-disruptive prior authorization process requires that they develop advanced imaging decision criteria and protocols for use in the approval process including developing and providing a full set of codes used in all advanced imaging procedures. They are responsible for reviewing prior authorization requests and for educating providers about denials or adverse determinations by explaining why the imaging study is not covered or what diagnostic alternatives might be available.

Medicaid Certified School Match Program

The Medicaid Certified School Match Program reimburses providers for medically necessary services provided by or arranged by a school district for Medicaid eligible students. School districts are reimbursed for the following services provided in a school setting by a Medicaid eligible provider:

- Therapy services
- Nursing services
- Behavioral health services
- Transportation
- Alternative augmentative communication devices

School districts are allowed to claim administrative costs related to the coordination and delivery of health care services within their schools. Administrative claiming generates more than $80 million in reimbursements for participating Florida school districts. During FY 2013-14, Agency staff monitored all participating school districts quarterly to increase compliance with program policy and procedures.

Utilization Management for Medicaid Pharmacy

There are several activities that Medicaid has undertaken to ensure that Medicaid pharmacy services provided to the FFS population are both appropriate and cost effective. Medicaid also has point-of-sale monitoring available to track medication usage and has thousands of automated claims edits in place to prevent inappropriate expenditures. The system of automated claims edits is continuously refined and improved to support safe prescribing, adherence to the Preferred Drug List, and prevention of fraud and abuse. In FY 2013-14, the contracted prescription benefit manager vendor, Magellan Medicaid Administration (Magellan), processed approximately 1.3 million fee-for-service drug claims per month.

The Medicaid Pharmaceutical and Therapeutics Committee makes recommendations to the Agency for the purpose of developing and maintaining the Florida Medicaid Preferred Drug List (PDL). The Committee performs ongoing scheduled review of the PDL, with negotiated state supplemental rebates from manufacturers and continued updating of prior authorization and step therapy protocols for drugs not on the PDL. The Committee may also recommend prior authorization protocols for Medicaid-covered prescribed drugs to ensure compliance with clinical guidelines, for indications not approved in labeling, and for prevention of potential overuse, misuse, or abuse.

Authorization prior to reimbursement for certain drugs in specific circumstances continues. Age related prior authorization has been established for certain drugs to

ensure safe and appropriate prescribing. In addition, Medicaid pharmacists throughout the state continue to review prior authorization requests for non-PDL approved drugs. They may make initial contact with patients who choose to receive comprehensive reviews of their drug therapies.

Medicaid contracts with the Florida Mental Health Institute (FMHI) at the University of South Florida to develop and disseminate best practice guidelines for behavioral health drug therapy. FMHI recommendations provide specific efforts for the different needs of adults and children, coordination of care for behavioral health drug therapy management, improved patient and provider education, compliance with drug therapies, and improved outcomes.

Through a contract with the University of Florida Medication Therapy Management Call Center, trained pharmacists conduct comprehensive prescribed drug case management, which involves direct patient contact if the patient chooses to participate. This statewide Medication Therapy Management Program can help resolve medication-related and health-related problems, optimize medication use for improved patient outcomes, and promote patient self-management of medication and disease states. This in turn helps reduce clinical risk and lowers prescribed drug costs to the Medicaid program including reducing the rate of inappropriate spending on Medicaid prescription drugs.

Medicaid Program Integrity

Since the inception of the Medicaid program in Florida in 1970, the program has paid nearly $300 billion to Medicaid providers of goods and services. During the 1970s, the agency in which Medicaid was then located utilized predominately manual processes in efforts to recover overpayments. Even with a 1970s claims volume, there was opportunity to improve efforts to combat fraud and abuse effectively. By 1980, when the Medicaid program had grown to cost nearly a half billion dollars annually, it was determined that it was necessary to make a concerted effort to advance the integrity of the program. A unit was formed within the Agency to make a greater effort to find overpayments and recover them.

The initial unit, which led to today's MPI, consisted of an administrator, an analyst, and a secretary. At that time, desktop computers were not available for departmental staff members. The first year, 1980, still using manual methods, saw recovery amounts of just $55,000. Nevertheless, this small unit was resourceful, obtaining the assistance of the Medicaid fiscal agent contractor with its large mainframe computer. Through these early days of "generalized analysis" (GA) reviews, recoveries increased significantly for a relatively low cost. Generalized analysis reviews, data driven projects finding policy violations and overpayments, continue to be excellent detection and recovery tools for MPI.

The key indicator of MPI performance is return on investment (ROI) and that figure has been relatively high over the years. For recovery activities in MPI, ROI has exceeded 7.3:1 for each of the past three years, meaning that for each dollar expended in detecting and recovering overpayments, $7.30 has been recovered. If up-front costs, such as those related to detection and litigation, are lowered, the result will be a higher ROI. MPI efforts over the years have been focused on mechanisms to reduce up-front costs and raise ROI (through endeavors such as prevention efforts, advanced system edits, provider education, implementation of self-audit processes, and performance of on-site reviews) while continuing to maintain high levels of recoveries. Detection capabilities continue to improve, becoming more advanced and more comprehensive. During FY 2013-14, MPI launched a procurement to obtain an advanced analytical detection contractor. The procurement should be completed during FY 2014-15, with implementation later that year. Additionally, MPI procured a new case tracking system with more sophisticated connectivity across Agency systems.

As the Florida Medicaid program shifts to using predominantly managed care delivery systems, fraud and abuse oversight by the Agency will continue. Additionally, under Medicaid managed care, goods and services will be provided generally by the same clinics, hospitals, nursing homes, pharmacies, practitioners and others who provided them under the fee-for-service (FFS) model. It will continue to be necessary for their claims to be reviewed for misbillings. While some of the responsibilities with regard to the review of these providers are shifting to the Managed Care Organizations (MCOs), the ultimate responsibility for program integrity in the Medicaid program continues to lie with the state and federal governments.

MPI will continue to work with the MCOs to ensure that there is a cooperative relationship in the program integrity efforts, while also assuming a regulatory role with regard to oversight of the fraud, waste, and abuse provisions of the managed care contracts.

In conclusion, MPI continues to serve as the primary point of contact for the Agency with regard to issues of a program integrity nature. MPI's goal is, and will continue to be, to prevent and detect fraud, abuse, and overpayments to the greatest extent possible and to recover the funds that have been identified as overpayments. Detection via more sophisticated methods will continue to be a priority along with increased efficiencies and productivity within MPI. Analysis of functions to align with the evolution of the Medicaid program is an ongoing process. Furthermore, MPI efforts to ensure managed care organization compliance related to issues of fraud and abuse prevention, as well as efforts to assist the organizations in

increasing the effectiveness of reporting fraud and abuse, will continue to grow as an oversight priority.

Inception Unit

The Inception Unit within Medicaid Program Integrity is comprised of the Intake and Data Detection units. This is where MPI work begins; namely, the initial review and analysis of allegations of fraud, waste, and abuse. Providers are constantly changing their behavior and they have learned not to bill erroneously in the same manner all the time. They are changing the ways in which they abuse the program. The goal of the Inception Unit is to stay ahead of the patterns, schemes, and changes in abusive behavior and to be proactive in dealing with providers who engage in misbilling.

The Intake Unit studies incoming complaints and information relating to preliminary investigations of Medicaid provider misconduct, misbehavior, instances of arrest, licensure issues, and other areas of concern. The Data Detection Unit provides data analytical support to MPI by self-generating leads for the office. It also provides analytical support to the units, the Inspector General, and other components of the Agency when needed.

The Inception Unit works closely with the MFCU in the detection of suspected fraudulent provider activities and in the coordination of data detection projects. Suspicious provider activities are referred to the MPI Case Management units (CMU) or to MFCU for further investigation. CMUs conduct audits, pursue recovery, and make referrals to outside agencies as appropriate.

Intake Unit

The Intake Unit receives reports of suspected Medicaid fraud or abuse made to MPI from both internal and external sources. Reports are made via the online reporting function on the Agency's website, the fraud and abuse telephone hotline, and returned Explanation of Medicaid Benefits forms (EOMBs). EOMBs are mailed three times a year to Medicaid recipients who are not in Managed Care Organizations, listing the services billed to Medicaid on behalf of the recipient during the previous four months. The mailing, which includes a business reply envelope, instructs the recipient to report any Medicaid services listed that they did not receive. Complaints received through the internet or telephone may or may not be program integrity related. Complaints that are not so related are forwarded to the appropriate regulatory agency for action. Discrepancies that are of a program integrity nature are investigated by the Intake Unit and handled appropriately. For example, if it is determined that Medicaid services were not provided, so long as there is an absence of suspicion of fraud or abuse, the provider is requested to void

the Medicaid claim. If analysis of the investigation results in a finding or suspicion of abusive or fraudulent conduct, the provider would be referred to the appropriate MPI CMU or to the MFCU.

The Intake Unit also monitors press releases on the Internet and articles in the Bureau of National Affairs Reporter for any information 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 action by the Agency to terminate the offending provider from the Florida Medicaid program.

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, waste, and program abuse. The unit analyzes claims data, develops leads for the CMUs, and works closely with MPI's federal Medicare partners to identify fraud and abuse issues related to claims paid by both the Medicaid and Medicare programs.

Data Detection analyses of suspicious provider activities that are not fraudulent in nature are referred to the CMUs. Suspected fraud is referred to MFCU for further investigation. The Data Detection Unit also assists in the development of generalized analyses and provides programming and analysis support for other units of the Office of the Inspector General, the Agency, and MPI.

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

Detection Tools

MPI's primary detection tools include the DSSProfiler, 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 up-coding and Early Warning System reports of projected steeply rising payments. These detection tools provide a means for MPI to analyze Medicaid claims data and

identify 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 CMUs.

The DSSProfiler is the basis of the Surveillance and Utilization Review Subsystem (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 using a specific code within an age-adjusted or gender-adjusted peer group established by the DSSProfiler. The system calculates the expected values for this parameter (hours per day) based on the number of recipients served by the provider and the age range/gender/morbidity mix for 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 value is compared with the value of the standard deviation for the group. Providers who stand out based on the standard deviation obtained in the statistical analysis have a greater likelihood of being audited.

The Florida Medicaid Management Information System (FMMIS)/Decision Support System (DSS) provides Fraud and Abuse Detection (FAD) and SURS capabilities. The DSS stores seven years of Medicaid providers' claims history, providing substantial information for analysis and trend identification. The FAD/SURS is fully integrated within the Medicaid fiscal agent's data warehouse and provides the Agency with the ability to research Medicaid providers and recipients in order to investigate potential misuse of the Medicaid program. The review process allows for evaluation of the delivery and utilization of medical services to safeguard the quality of care and protect against abusive use of Medicaid funds.

First Health Pharmacy reports include top member rankings, top 100 prescribers by amount, quarterly "doctor shopping" reports, prescriber ranking reports, and "most utilized" pharmacies reports. Ad hoc reports are used by MPI investigators to access Medicaid claims information within the FMMIS and DSS. The FMMIS processes and pays provider claims and contains claim-related information on Medicaid providers, recipients, drugs, and medical services. The *1.5 Report* is produced weekly and provides a listing of each Medicaid provider who is scheduled to receive a Medicaid payment for that week in an amount that exceeds 1.5 times the average amount received for the immediately preceding 26 weeks. This report takes into account 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 at the beginning of the week and is analyzed quickly so that, if necessary, questionable payments for that week can be delayed 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 inappropriately billing the Medicaid program, a Medicaid Program Integrity audit is initiated.

Chi-square reports utilize a nonparametric statistical analysis method developed by MPI to determine possible overpayments to providers who engage in up-coding, or using a higher-paying medical 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 specified 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 provider types are analyzed each quarter. The chi-square report is issued quarterly and lists providers in descending order of overpayment indicator amount, 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 increases 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. Alternatively, 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 that 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 analyses, 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 crossover (from Medicare to Medicaid) 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 law enforcement authorities to prevent, identify, analyze, and investigate Medicaid fraud and abuse.

Social Network Analysis is another tool that MPI utilizes. Analyses of relationships among individuals, entities, and regulatory agencies' data are used to identify Medicaid providers excluded by the federal government, excluded by other state Medicaid programs, or disciplined by DOH's Board of Medicine.

The detection tools described above identify outlier providers who exhibit general patterns of aberrant behavior including overutilization, up-coding, 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 examination or prepayment reviews.

MPI and MFCU Referral and Data Mining

Staff members of MPI and MFCU continue to meet biweekly to discuss suspected criminal or fraudulent provider activities and to share ideas for data mining and detection projects. During these meetings, referrals for criminal investigation are vetted for additional information and strategic planning. The provider's billing history and any prior actions against the provider taken by MPI or MFCU are presented and discussed. If a referral is accepted by MFCU, payments to the provider are generally suspended in compliance with state and federal law until the allegation is resolved. Staff members participating in these meetings represent MPI Tallahassee, MPI field offices, the Division of Medicaid, MFCU, and the Medi-Medi contractor.

In addition, through a joint request by the Agency and the Office of the Attorney General of Florida (discussed of this report), CMS has approved a waiver to allow MFCU to data mine Medicaid data using the Agency Decision Support System (Data Warehouse). At monthly meetings, participants from MPI and MFCU discuss the coordination of data mining projects. All projects are tracked to ensure that no duplication of data mining activity takes place.

Managed Care Unit

During FY 2013-14, the Florida Medicaid program was in various stages of Statewide Medicaid Managed Care (SMMC) Program implementation. During this transitional period, the MPI Managed Care Unit focused on managed care compliance with standards of the implemented SMMC program. The Managed Care Unit also began the initial stages of realigning to better match the structure of the SMMC program.

The MPI Managed Care Unit's functional realignment has focused on those plans going into SMMC Managed Medical Assistance (MMA) and those moving into the

Long-term Care (LTC) program. Staff continues to focus on the prior managed care models to ensure that the Provider Service Networks (PSNs) and Specialty Plans are included in the unit's oversight. Continued transition will follow to further increase efficiencies and allow for an increased focus on the managed care plans' statutory and contractual requirements related to reducing, preventing, and deterring improper and fraudulent conduct.

MPI Managed Care Unit responsibilities include:

- Reviewing Quarterly Fraud and Abuse Activity Reports (QFAAR): Providing MPI with a quarterly ongoing comprehensive fraud and abuse prevention activity report from the managed care plan regarding their investigative, prevention, and detection activity efforts.
- Reviewing Annual Fraud and Abuse Activity Reports (AFAAR): Providing MPI with a summarized annual report on the managed care plan's experience in implementing an anti-fraud plan and conducting or contracting for investigations of possible fraudulent or abusive acts for the prior fiscal year.
- Reviewing suspected or confirmed fraud and abuse reports: Under s. 409.91212, F.S., each managed care plan must report all suspected or confirmed instances of provider or recipient Medicaid fraud or abuse within 15 calendar days after detection to Medicaid Program Integrity.
- External training: Related to Medicaid fraud prevention, this training is provided to unit staff members who attend courses offered by the Medicaid Integrity Institute and the Agency. During the past year, two staff members earned Certified Program Integrity Professional (CPIP) credentials from the Medicaid Integrity Institute and all of the managed care staff members attended all required training.
- Contract language: Contract amendments are reviewed to ensure that MPI's responsibilities are comprehensible and clear. This promotes a full understanding of contract requirements and a collaborative environment for MCOs to ensure successful strategies that align with MPI's mission.
- Collaborative partnerships: Medicaid and Florida International University are collaborating on a project to determine the best strategies for the prevention and detection of fraud and abuse within the environment of managed care. They are also working with MPI field staff in assisting the managed care plans with provider complaints.

Case Management Units

Each of MPI's CMUs identifies improper Medicaid payments by performing comprehensive audits and generalized analyses. MPI uses accepted and valid auditing procedures that include statistical methodologies. 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 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 CMUs also conduct non-extrapolated claim-by-claim reviews, invoice purchase verification reviews, and policy-based claims reviews.

CMUs perform both claims reviews and prepayment reviews. They also make policy or payment program edit recommendations and assist with the litigation process to defend state audits. The CMUs are organized primarily by the types of Medicaid providers each unit audits, as follows:

- Institutional Unit — Conducts audits of institutional providers such as hospitals, nursing facilities, health maintenance organizations, and ambulatory surgical centers.
- Pharmacy and Durable Medical Equipment Unit — Conducts audits primarily of non-institutional types of providers such as pharmacies and DME providers.
- Practitioners Care Unit — Conducts audits primarily of non-institutional providers, such as physicians, independent laboratories, advanced registered nurse practitioners and county health departments. Conducts audits related to the Home and Community Based Waiver Program and of providers such as dentists, audiologists, podiatrists, and chiropractors.
- Generalized Analysis (GA) Unit — Conducts data-based policy reviews for all types of providers, resulting in overpayment recoveries.
- The CMU Manager: Serves as the point of contact for the Federal Audit Program. CMS has committed resources to a "collaborative audit" process and has dedicated audit resources to augment the capabilities of MPI.
- The CMS Medicaid Integrity Group (MIG): The MIG has contracted with private firms referred to as Medicaid Integrity Contractors (MICs) to expand audit coverage. The three primary MIC functions include:
  - The "Review MIC" analyzes Medicaid claims data to determine whether provider fraud, waste, or abuse has or may have occurred.
  - The "Audit MIC" performs audits in support of the state Medicaid Integrity Program.
  - The "Education MIC" provides education to Medicaid providers and others on payment integrity and quality-of-care issues.

MPI Highlights

Testing Qualitative Drug. While investigating physician providers providing pain management services, Practitioners Care Unit staff members observed high utilization of CPT code 80101 (drug screen, qualitative, chromatographic, single drug class method). At the time of the review, Medicaid allowed providers to bill up to seven units of service to account for separate tests for multiple drug classes resulting in an average test reimbursement of $67. Innovations in point-of-care drug screening have resulted in "multiplex" kits that allow providers to assay qualitatively multiple drugs simultaneously by running multiple tests in a single procedure. These kits may be purchased by providers for less than $6 each and provide results in less than five minutes. Further investigation revealed that CPT code 80104 (drug screen, qualitative, multiple drug classes other than chromatographic method, each procedure), introduced in 2011, most accurately reflects the resources utilized in the multiplex tests. Unit staff members presented these findings to Medicaid Services with the recommendation that providers submit claims for qualitative drug tests using multiplex test kits. These kits utilize CPT code 80104, which is reimbursed at the lower rate of $14.88. Additionally, the Practitioners Care Unit recommended that the allowed units of service for multiplex tests be limited to one per patient encounter. These recommendations were implemented, effective July 1, 2014, and are anticipated to result in substantial cost savings to Medicaid of during FY 2014-15.

Advanced Life Support vs. Basic Life Support Project. In January 2011, the MPI Waiver (now Practitioners Care) Unit opened a project to review ambulance providers who were billing over 75 percent of their claims as Advanced Life Support (ALS) rather than as Basic Life Support (BLS). Medicaid bases reimbursement for ALS or BLS on the severity of the recipient's medical condition at the time of transport. Due to the additional complexity of ALS services, reimbursement is at a significantly higher level than for BLS services. The goal of the project was to detect those providers billing for ALS ambulance transportation services that did not meet the requirements for ALS services and to recoup the identified overpayments. As of June 30, 2014, the Agency collected $423,170 in reimbursement of identified overpayments from the audited ambulance providers. The investigatory cases for all but six had closed by the end of FY 2013-14. The audit identified several consistent trends and staff collaborated to develop and present two (internet communicated) webinars for ambulance providers on the lessons learned and on relevant portions of the new Ambulance Transportation Services Coverage and Limitations Handbook promulgated in 2013. The training clarified the appropriate use of the Medicare Ambulance Medical Condition Code list by providers; the mistaken understanding that level of service was solely determined by the certification or license level of staff responding; and the mistaken assumption that

the condition reported upon dispatch determined the level of service billed rather than condition of the recipient upon transport.

Nursing Home Diversion F

Waiver Project. The GA Unit continued with a project dealing with fee-for-service payments that were made on behalf of recipients who were at the time enrolled in the Nursing Home Diversion Waiver Program, a managed care plan. These services were supposed to be billed to, and paid by, the recipient's managed care plan. It was determined that the overpayments resulted from provider failure to bill the appropriate managed care organization as required by Florida Medicaid guidelines. For this project, during FY 2013-14, the Unit identified $4,482,219 in overpayments, $439,763 in administrative fines, and $19,676 in investigative costs, involving 319 Florida Medicaid providers.

Dental Services Project. The GA Unit conducted a project dealing with dental services fee-for-service payments that were billed and paid in violation of Medicaid exclusions and limitations guidelines. During FY 2013-14, this project identified $870,227 in overpayments, $22,837 in administrative fines, and $2,081 in investigative costs involving 310 Florida Medicaid Dental Services providers.

Child Health Check-Up Services Project. The GA Unit conducted a project dealing with Child Health Check-Up Services fee-for-service payments that were billed and paid in violation of Medicaid handbook guidelines. During FY 2013-14, there were $304,031 in overpayments, $13,647 in administrative fines, and $824 in investigative costs involving 170 Florida Medicaid providers.

Reversed Claims. In addition to performing comprehensive and focused audits, the Pharmacy and DME CMU performs paid claims reversals involving ongoing reviews of paid claims to identify those claims that appear to be overpaid due to errors in billing. When such a claim is identified, the provider is contacted, the claim amount verified, and, if there appears to be an error, a request is made to reverse and re-bill the claim for proper payment. In this manner, Medicaid recoups the money paid in error. In FY 2013-14, eighty-one files (cases) that may have included multiple claims were opened to initiate and monitor paid claims reversals by the Unit. A total of $1,149,382 was recovered by these reversals. This was an increase from the previous fiscal year when paid claims reversals by the Unit totaled $833,642.

Overlapping Coverage Audit. The Institutional Unit conducted an audit to detect recipients who had overlapping coverage periods for Medicaid Hospice and Medicaid HMO services. Medicaid exclusions and limitation guidelines require recipients to be disenrolled from HMO coverage upon enrollment in Hospice coverage. The project

identified 701 recipients with overlapping enrollments and during FY 2013-14 recovered $1,353,132 in overpayments.

Medicaid Program Integrity Prevention Activities

The prevention of fraud and abuse requires a large portion of staff resources in order to preclude overpayments, which in turn avoids recovery costs and ensures that Medicaid funds are used for intended purposes. Prevention activities include the use of prepayment reviews, termination of providers, site visits to providers, administrative sanctions, MPI audits, and the pending of Medicaid claims per s. 409.913(25)(a), F. S. Each is discussed in further detail in the following sections.

Prepayment Reviews

Intercepted questionable payments and pended claims are subject to prepayment reviews. Intercepted payments relate to those questionable Medicaid claims that have been processed, but for which payments have not yet been transferred to the providers. Pended claims are also questionable claims, which have not yet been processed for payment. Claims without proper documentation are denied.

The amount avoided for intercepted payments is the amount by which the payment to the provider is reduced. After the claim has been through the Medicaid system's automated edits, the amount of the reduction is considered cost avoided. 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 2013-14, MPI initiated 72 prepayment reviews. Claims denied for these providers resulted in cost avoidance of $440,351 as indicated in the table below.

Prepayment Reviews	FY 2013-14
Number of claims reviewed	13,391
Number of claims denied	6,351
Amount of claims reviewed	$851,860
Amount of claims denied	$440,351

Termination of Providers

In accordance with the provisions of Subsections 409.913 (13) through (18), (25) and (30), F. S. and Rule 59G-9.070, Florida Administrative Code (F.A.C.), providers may be involuntarily terminated from the Medicaid program. They may also be terminated based on the provisions of the Medicaid provider agreement ("contract"). A provider may be terminated under the contract, with or without cause, after written notice.

Medicaid expenditures normally decline with respect to the recipients formerly served by a terminated provider, taking into account similar services by other providers. For a terminated provider, the savings are the difference in payments for the one-year periods before and after 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 2013-14, terminations during the previous fiscal year saved Medicaid approximately $1.6 million.

Site Visits

Site visits ensure that the provider is still at the address of record, appears to have the assets required to perform the services that purportedly will be furnished, has necessary Medicaid manuals and forms, is generally familiar with Medicaid policies, and knows how to obtain Medicaid information. Staff members of Medicaid Program Integrity field offices visited many Medicaid providers during this past fiscal year, as indicated in the following graphic.

MPI Site Visits Conducted During FY 2013-14

Provider Type	Number
Assistive Care Services	166
Case Management Agency	6
Community Alcohol, Drug, Mental Health	5
Federally Qualified Health Center	1
Home and Community Based Services	261
Home Health Agency	4
Medical Supplies/Durable Medical	23
Nursing Home	6
Pharmacy	26
Physician (MD)	20
Therapist	8
Total Site Visits	**526**

Cost savings from site visits are based on payments to providers during the one-year periods before and after the visit. A provider must be active for at least one year before the site visit to be included. Pharmacies, because of Medicare Part D, are not included. Cost savings for FY 2013-14 resulting from site visits conducted in the prior year were approximately $2.1 million.

Focused Projects

Prepaid Dental Health Plan Program Initiative

In 2010, the Legislature directed the Agency to contract with appropriately licensed Prepaid Dental Health Plans (PDHPs) to provide dental services to most Medicaid-enrolled children statewide, with the exception of those in the Medicaid Pilot Program counties (Baker, Broward, Clay, Nassau, and Duval) and Miami-Dade County. In Miami-Dade, a prepaid dental pilot program had been operational since 2004.

Prepaid Dental Health Plans are capitated Medicaid managed care dental plans available to Medicaid recipients 20 years of age and younger. Except for children enrolled in acute care Medicaid managed care plans offering optional dental services and a few specifically excluded groups of children, Medicaid children were enrolled in one of two PDHPs. Florida Medicaid contracted with two PDHPs, DentaQuest and MCNA Dental Plans, to provide such children's dental services.

The Bureau of Health Systems Development requested that Medicaid Program Integrity conduct a project with the objective of validating the dental provider networks of the Prepaid Dental Health Plans of DentaQuest and MCNA.

Proceeding under the authority of s. 409.913 and 20.055, F. S., MPI coordinated a field initiative that focused on validating the provider networks of DentaQuest and MCNA Dental in the following seven Florida counties: Brevard, Escambia, Hillsborough, Martin, Orange, Palm Beach, and Santa Rosa.

During the week of October 20, 2013, staff members from MPI's field offices (Jacksonville, Orlando, Tampa, and Miami) and Tallahassee Headquarters, conducted 275 focused project visits to providers, namely, general dentists and pedodontists located in the named counties that contracted with DentaQuest and MCNA Dental Plans. The objective was to confirm participation and accessibility within the plans' provider networks. Additionally, MPI checked for deficiencies or lack of plan support for providers, evaluated the PDHPs' internal and external communications and information sharing processes with the providers, and made recommendations for improvement.

The Miami field office was tasked with verifying the PDHPs' provider networks in Martin and Palm Beach counties. The field office identified 158 general dentists and pedodontists at 86 different addresses (physical locations) contracted with DentaQuest or MCNA dental plans in the listed counties.

No network providers listed as participating with the two managed care dental plans were found not to be participating.

Joint Field Initiatives

As part of its ongoing anti-fraud and anti-abuse efforts, MPI collaborated with federal regulatory agencies to combat health care fraud and abuse in Florida by conducting joint field initiatives (focused projects) this fiscal year. Operating under the provisions of s.409.913, F.S., the MPI Miami field office coordinated with the CMS/MIG in conducting the following two joint field initiatives in FY 2013-14.

Monroe County Initiative

During the week of January 13, 2014, MPI in conjunction with CMS/MIG conducted compliance-focused project site visits to 30 Medicaid providers of various specialties in Monroe County for dates of service from January 1, 2013, through November 30, 2013. MPI focused on the following provider types:

- Nursing Facility Services
- Assistive Care Services
- Physician Services
- Home & Community-Based Services Waiver (Developmental Disability)
- Therapy Services
- Durable Medical Equipment and Medical Supply Services
- Mental Health Targeted Case Management

The primary goals of the Monroe County initiative were:

- To determine whether the providers were rendering, billing, and documenting services in accordance with Medicaid policy as required by Federal and State law, rules, regulations, and manuals;
- To determine whether services were being rendered by qualified and properly trained staff; and
- To identify, document, and refer quality-of-care issues to appropriate regulatory entities.

As a result of this initiative, 26 of 30 providers were found to be in compliance with Medicaid policy and procedures. Medicaid billing and reimbursements were substantiated. All places of business were found appropriate and suitable for care to Medicaid recipients in the provision of services, with the exception of one provider. The majority of the providers expressed a desire to continue to provide excellent services to the Medicaid recipients in their care. The initiative resulted in the following:

- One sanction [7 (e) violations — $1,000 in fines];
- One Department of Health referral;
- One Medicaid Contract Management referral; and
- One prepayment review.

Tri - County Developmental Disabilities Waiver Initiative

During April 2014, MPI, the Office of the Inspector General, the Division of Medicaid, and CMS/MIG staff members conducted compliance site visits to 50 Developmental Disabilities (DD) Waiver-Residential Habilitation service providers in group homes. These providers were in Broward, Martin, and Palm Beach Counties that billed for procedure code T2023U6 (Residential Habilitation) for dates of service from January 1, 2013, through March 31, 2014. The primary goals of the Tri-County Developmental Disabilities Waiver Initiative were:

- To determine whether Residential Habilitation service providers were rendering, billing, and documenting services in accordance with Medicaid policy as required by federal and state laws, rules, regulations, and manuals;
- To determine whether Residential Habilitation services were being rendered by qualified and properly trained staff; and
- To identify, document, and refer quality of care and environmental issues to the APD and other appropriate regulatory bodies.

This initiative resulted in the following:

- Seven sanctions for 409.913(7)(e), F.S. violations, totaling $17,000 in fines;
- Eight referrals to APD; and
- One referral to the Division of Medicaid, Bureau of Medicaid Contract Management.

Area 1 - Assistive Care Services Initiative

During the week of February 10, 2014, the MPI field offices in Jacksonville, Orlando, and Tampa (MPI/JOT) conducted a successful Assistive Care Services Initiative in the counties of Escambia, Santa Rosa, Walton, and Okaloosa (Medicaid Area 1). Four investigative teams consisting of staff members from the Office of Inspector General, Bureau of Medicaid Program Integrity, and Division of Health Quality Assurance, Survey and Certification Support Branch conducted site visits to 29 facilities.

The primary goals of this initiative were:

- To determine whether Assistive Care Services providers were rendering, billing, and documenting services in accordance with Medicaid policy;

- To ensure that the facilities and homes with provider numbers were not "sharing" their provider numbers with other facilities and homes that do not have active provider numbers;
- To verify that all enrollment information on the FLMMIS system was correct and to determine whether Assistive Care Services were being rendered by staff members who have been successfully background screened; and
- To ensure that proper provisions have been taken respecting the health and safety of the residents residing in these facilities.

The following were the results of this initiative:

- Deficiencies were found in Medicaid required documentation;
- Corrections were effected concerning facility employees who had not been properly background screened or determined free of communicable disease or tuberculosis;
- Three providers were placed on prepayment review;
- Sixteen providers were sanctioned for a total amount of $60,000;
- Two homes had residents with recent injuries. The injuries did not happen in the homes, but there were questions concerning the actions that the facilities took regarding the follow-up for these injuries. The matter was referred to the Division of Health Quality Assurance;
- A deceased Medicaid provider with an active Medicaid number (no reimbursements had been made) was identified and the matter was referred to Medicaid Contract Management;
- Confusion was noted for some of the smaller providers regarding licensure issues. Some facilities thought that even if they did not have a license, they could still bill the Medicaid program, which is not permitted. Education was provided; and
- Providers were educated on-site concerning Medicaid policies.

Volusia County Developmental Services Waiver Initiative

During the week of June 2, 2014, MPI/JOT staff conducted 46 visits to Developmental Disability (DD) providers in the Volusia County area. Primary goals of this project were:

- To determine any overlapping services by reviewing all DD waiver records and times for recipients and comparing those to billings records;
- To ensure that services were being rendered;
- To determine whether waiver services were being rendered by staff members who were successfully background screened and properly trained in Core Competency and Zero Tolerance. If issues were discovered, an immediate referral to APD was effected concurrent with MPI actions; and

- To request provider documentation concerning current liability insurance. If no evidence of insurance was found, an immediate referral to APD would be effected.

After-action information concerning this initiative is being reviewed and a final report is in preparation at the time of this report.

Cost savings for FY 2013-14, based on focused projects conducted during the prior fiscal year, were approximately $6.6 million.

Sanctioned Providers

During FY 2013-14, 635 Medicaid providers received 668 sanctions or assessments as shown in the table below for violations proscribed or enforceable by s. 409.913, F. S., Rule 59G-9.070, F. A. C., s. 409.91212, F.S., or the Medicaid enrollment contract. These sanctions and assessments included suspensions and terminations from the Medicaid program as well as fine or assessment amounts for the current fiscal year totaling approximately $2.8 million, as shown in the table below.

Provider Sanctions and Managed Care Organizations Assessments				
	FY 2012-13		FY 2013-14	
Sanctions under Rule 59G-9.070, F.A.C.	Number	Amount	Number	Amount
Fine Sanctions	688	$3,505,686	545	$2,810,147
Suspensions	60		49	
Terminations with cause	91		73	
Total for Rule 59G-9.070,F.A.C. Sanctions		$3,505,686		$2,810,147
Total for Managed Care Organization Section 409.91212, F.S., or Contract Assessments*	2	$50,200	1	$1,600
Grand Total Sanctions and Managed Care Organization Assessments	841	$3,555,886	668	$2,811,747

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

Cost savings for FY 2013-14 based on providers sanctioned during the previous fiscal year are approximately $6.9 million. These cost savings are included in the prevention data shown in the MPI Prevention of Overpayments table in the section headed Funding for Medicaid Program Integrity and Return on Investment.

Audited Providers

A reduction in future fraudulent billings from, and payments to, providers should result from MPI audits. To determine whether this is the actual situation, analyses are carried out regarding payments to providers whose audit cases were closed in

the year immediately before the reporting year. Audit savings are based on payments to the provider during the one-year periods before and after the date the audit case was closed. Not included in the analysis are audits accompanied by sanctions and self-audits. Cost savings for FY 2013-14 based on audits performed in the previous fiscal year, excluding providers used in any other savings calculations, are $8.8 million, as shown in the MPI Prevention (Cost Savings) of Overpayments table in the section headed Funding for Medicaid Program Integrity and Return on Investment.

Withholding of Payments: Claims Pended Under s. 409.913(25)(a), F. S.

In accordance with s. 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. Cost savings realized during FY 2013-14 based on withholding actions taken under the statute were approximately $2.9 million.

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 principal recovery categories are MPI-conducted audits 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 and computer-assisted generalized analyses that evaluate specific aspects of the billings of many providers. A comprehensive audit using statistical methodology 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 2,089 cases concluded during FY 2013-14. Of these, 333 were sanction-only cases, five were Managed Care Organization contractual assessments

cases, 126 cases had no findings, three cases resulted in provider education letters, and 1,622 cases identified overpayments. These cases identified overpayments of $28,640,118.

Paid Claims Reversals

MPI has several processes that identify improper payments or erroneous claims that are corrected by the provider's reversal of previously submitted claims rather than through the repayment of overpayments. For example, licensed pharmacists within MPI review claims paid to pharmacies in order to identify probable errors in billing. Pharmacies submit claims electronically to Medicaid as the pharmaceuticals are dispensed. Pharmacies sometimes overstate the amount of the drug that is dispensed and are thus overpaid. Atypical claims identified by MPI detection methods result in the provider being contacted to supply supporting documentation justifying the paid claim amount or to effect a claim reversal in the electronic claims submission system. When the claim is reversed, Medicaid is credited with the original amount paid to the provider. The provider may resubmit the claim with the corrected quantity and then is paid the correct, reduced amount. The difference between the original payment and the reduced payment is considered to be a recovery as a paid claims reversal. Providers who do not adjust or reverse improper payments are subject to further audit or other administrative action by the Agency. Paid claim reversals for FY 2013-14 totaled $2,598,967.

Third Party Liability Contractor – Assisted Audits

MPI coordinated and assisted the Agency's Third Party Liability contractor in the development of computer-assisted analyses of paid Medicaid claims in an effort to recover large sums of overpayments due to Medicaid being billed for services when an alternative payor, such as commercial health insurance or personal injury protection insurance, should have funded the provided medical services. These joint efforts by MPI and the TPL vendor resulted in the recovery of $61,607,714 for Medicaid for FY 2013-14.

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 508 referrals in FY 2013-14 as summarized in the following table:

MPI Referrals in FY 2013-14

Referred to:	Number
Department of Health	7
Division of Public Assistance Fraud	11
Department of Health & Human Services - OIG	74
Division of Health Quality Assurance	68
Division of Medicaid	201
Medicaid Fraud Control Unit - AG	29
Other including MFCU info only	118
Total	**508**

Recoveries of Overpayments – MPI Audits

The Medicaid Accounts Receivable Unit of the Bureau of Financial Services within AHCA's Division of Operations is responsible for collecting identified overpayments from Medicaid providers. While MPI strives to conclude cases in a timely manner in order to increase the recovery rate, amendments to s. 409.913, F. S., codified in 2009 now require earlier withholding of funds by the Medicaid Accounts Receivable Unit to ensure the potential loss due to continued overpayments is minimized. The table below lists overpayments identified by fiscal year and collected by the Medicaid Accounts Receivable Unit for the last four fiscal years. The overpayments collected as of August 31, 2014, reflect collections of the overpayments identified during a fiscal year regardless of the year of the collection. There can be an expected lag between the date that an overpayment is identified and the date that it is collected due to the existence of payment plans, liens, and other collection arrangements and efforts.

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

Fiscal Year	Type Recovery	Overpayments Identified	Accounts Receivable Collections and Reversals*	Percent
FY 2010-11	Accounts Receivable, Offsets and PCRs	$39,011,157	$37,868,794	97.07
FY 2011-12	Accounts Receivable, Offsets and PCRs	$36,053,930	$30,320,245	84.10
FY 2012-13	Accounts Receivable and PCRs	$26,511,641	$20,507,303	77.35
FY 2013-14	Accounts Receivable and PCRs	$28,640,118	$21,301,711	74.38

* Updated as of August 31, 2014

Random Audits

During FY 2013-14, 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. Random audits are accorded the same review and appeal process as any other audit. Audits initiated in one fiscal year may or may not be completed during that same year. Nine of the eleven random audits completed during FY 2013-14 identified overpayments of $886,942 as shown below.

Random Audits Concluded in FY 2013-14	
Audits Completed	11
Audits with Findings	9
Audits with no Findings	2
Overpayments Identified	$886,942

MPI Closed Cases by Fiscal Year				
Disposition of Closed Cases	2010-11	2011-12	2012-13	2013-14
Overpayment Identified*	1,907	1,987	1,562	1,622
No Fraud or Abuse Found	1,006	229	136	126
Provider Education Letter	513	248	7	3
Sanctions Only*	300	371	496	333
MCO Statutory or Contractual Assessments*	115	7	2	5
Total Cases Closed	3,841	2,842	2,203	2,089
Percent with Findings (*Cases with Findings)	60.50%	83.20%	93.50%	94.00%

Funding For Medicaid Program Integrity and Return On Investment

MPI is funded through the State of Florida's Medical Care Trust Fund. The Medical Care Trust Fund is funded by both federal receipts and Medicaid overpayment recoveries generated by MPI. During the year, expenditures of $12.0 million were devoted to recovery work resulting in collections of $88 million and a return on investment for recovery operations of 7.3:1. In addition, MPI achieved $29.4 million in cost avoidance with expenditures of $4.4 million, producing a return on investment for prevention efforts of 6.7:1 (ROI using non-rounded numbers is 6.8:1). Overall, in FY 2013-14, audit recoveries and cost avoidance amounts totaled $117.5 million (actual total rounded figure), yielding a return of 7.2:1, as shown on the chart below.

MPI Recovery Activities ($ Millions)				
	2010-11	2011-12	2012-13	2013-14
MPI Audits (Overpayments Collected by Accounts Receivable)	$38.8	$18.4	$31.4	$21.2
Costs (Collected by Accounts Receivable)	1.5	0.2	0.2	0.2
Fines (Collected by Accounts Receivable)	1.0	5.0	3.0	2.4
Paid Claims Reversals	1.0	2.5	1.3	2.6
Contractual Assessments	10.8	0.3	N/A	N/A
MCO Statutory or Contractual Assessments (Note: any collected during the fiscal year are reported in Fines above)		3.6	N/A	N/A
TPL Contractor-Assisted Claims Adjustments	30.0	32.2	43.6	61.6
Recovery Total	$83.1	$62.2	$79.5	$88.0

MPI Prevention of Overpayments ($ Millions)				
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14
	Amount	Amount	Amount	Amount
Prepayment Review	$3.40	$1.30	$0.60	$0.40
Termination of Providers	1.8	5.5	5.7	1.6
Focused Projects	1.2	0.9	0.8	6.6
Pill Mill Drug Denials		1.2		
Site Visits	12.1	6.4	4.1	2.1
Sanctioned Providers	3.6	3.2	5.1	6.9
Claims Denied Per Statute		2.1		2.9
Audit Impact		7.3	5.6	8.8
Total	$22.10	$27.90	$21.90	$29.4*

*Does not add due to rounding

Medicaid Program Integrity Return on Investment (ROI)			
Benefits and Costs in $Millions			
FY 2010-11	Benefits	Costs	ROI
Recovery	83.1	8.5	9.8:1
Prevention	22.1	5.7	3.9:1
Total	105.2	14.2	7.4:1
FY 2011-12	Benefits	Costs	ROI
Recovery	62.2	7.9	7.9:1
Prevention	27.9	5.3	5.3:1
Total	90.1	13.2	6.8:1
FY 2012-13	Benefits	Costs	ROI
Recovery	79.5	10.4	7.6:1
Prevention	21.9	7.0	3.1:1
Total	101.4	17.4	5.8:1
FY 2013-14	Benefits	Costs	ROI
Recovery	88.0	12.0	7.3:1
Prevention	29.4	4.4	6.7:1
Total	117.5	16.4	7.2:1

Division of Operations

Bureau of Financial Services

When Medicaid overpayments are identified, they are generally referred to the Agency's Division of Operations, Bureau of Financial Services (Financial Services), for collections. Financial Services then pursues collection of the overpayments from the Medicaid provider. Financial Services collects overpayments by direct payments from providers or through withholding of Medicaid and Medicare payments.

When payments are not received, or Medicaid or Medicare cannot be liened, Financial Services pursues other means of collection or determines if the case will be referred to an outside collection agency. Financial Services cannot authorize any reductions in monies due back to the Agency, as any reductions in overpayments must be negotiated during a settlement process prior to the Final Order being issued by the Agency.

As of June 30, 2013, the Medicaid accounts receivable balance for fraud and abuse was $47.8 million. During FY 2013–14, $56.8 million was recorded as Medicaid accounts receivables. The balance as of June 30, 2014 was $41.4 million. During FY 2013-14, total collections including refunds and net of adjustments approached $56.2 million. The collections included:

- $53 million in overpayments ($31.8 million collected from MFCU cases and $21.2 million collected from MPI cases);
- $215,000.00 in investigation costs;
- $2.4 million in fines and sanctions; and,
- $555,000.00 in interest.

The Agency must obtain approval from the Department of Financial Services (DFS) to write-off all accounts receivable deemed to be uncollectible. DMS approved $4.5 million from Medicaid accounts receivables for write-off. Accounts are generally written off because of one of the following reasons:

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

Federal requirements only allow federal funding to be reclaimed by the State of Florida 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 under state law. Once the accounts receivable is approved for write-off, the qualified federal share of each accounts receivable write-off is reclaimed. During FY 2013-14, $4.5 million in accounts receivable were approved for write-offs. Financial Services also continues to work with the Agency's Division of Health Quality Assurance (HQA) to determine if a facility's license renewal can be held-up pending receipt of overpayment amounts from the provider as a means to induce satisfaction of an outstanding overpayment.

Financial Services uses the Medicaid Accounts Receivable (MAR) system, which records extensive financial detail on Medicaid accounts receivables 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 federal allocation of receivables amounts, and produces necessary reports for case management and audit purposes. Examples of available 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, but are not limited to hospital and nursing home retroactive rate adjustments and gross adjustments.

Financial Services continues to provide transaction information files to update the Agency's Fraud and Abuse Case Tracking System (FACTS). The information in these files includes the original overpayment amount, payments received, adjustments applied, current balance, and current status for each case in the MAR system. The file is created by an automated process that runs from the MAR system each night, and then updates FACTS, enabling it to reflect the latest financial and account status information.

Financial Services emphasizes communications with MPI and MFCU to coordinate audit collection efforts. Financial Services also works with the Agency's Office of General Counsel, Bureau of Medicaid Program Analysis, Bureau of Health Quality Assurance, Office of Third Party Liability, and Office of Inspector General to coordinate collection efforts and pursue additional avenues of collection.

Financial Services continues to take aggressive steps during the year to reduce the duration of the terms for negotiated payment plans, resulting in more funds being recouped sooner, as well as increase the percentages of the liens placed on provider Medicaid and Medicare payments.

Third Party Liability Unit

The Division of Operations' Third Party Liability (TPL) Unit is responsible for identifying and recovering funds for claims paid for by Medicaid for which a third party was liable, thereby ensuring Medicaid is the payor of last resort. Some examples of third parties include casualty settlements, insurance companies, recipient estates, and Medicare. TPL recovery services are contracted with Xerox State Healthcare, LLC. In April of 2013, the Agency negotiated and signed a two-year contract renewal with Xerox State Healthcare, LLC. The contract renewal included a three percent (3%) reduction in contingency fees paid to Xerox for services performed under the contract, pursuant to Chapter No. 2010-151, Laws of Florida, Section 47.

During FY 2013-14, over $170 million in Medicaid funds were collected by the TPL Unit. Annual TPL collections over the last four years have averaged over $153 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 under s. 733.707, F.S.) 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 2013-14 included the following:

- Date of Death – Medicaid claims paid for services rendered after the dates of death of recipients were recovered;
- Hospital Audits – Hospital accounts payable ledgers were reviewed in connection with collecting Medicaid overpayments;
- Long-Term Care Audits – Long-term care facility accounts payable ledgers were reviewed in connection with collecting Medicaid overpayments;
- Medicaid Overpayments – Funds were recovered from providers where Medicaid overpaid for a service. Such Medicaid overpayments included:
  - Duplicate Crossover Payments (two Medicaid payments for Medicare Crossover liability);
  - Medicaid Secondary Liability (two Medicaid payments for the same services);
  - Inpatient Duplicate Payments (two Medicaid payments for inpatient services for the same date(s) of service);
  - Inpatient Mother-Baby Overpayments (two Medicaid payments for inpatient services for the same date(s) of service, one for a newborn and the other for the mother);
  - Outpatient Payment During Inpatient Stay (an outpatient Medicaid payment immediately preceding an inpatient stay);
  - HMO/Long-Term Care Overpayments (overpayments identified were 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);
  - DME Rent to Purchase Equipment (violations of limitations, per DME item); and
  - Fee for Service Payments While Recipient is Enrolled in Managed Care (fee for service claims are recovered from providers on the dates of service a Medicaid recipient was enrolled in a Managed Care Plan).
- Cost Avoidance - Cost avoidance involves the identification of new and 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 Medicaid eligibility, through Medicaid field office staff and Medicaid providers. When new or updated insurance information is obtained, that information is added to the Florida Medicaid

Management Information System (FMMIS) in order to cost-avoid future claims that are submitted by Medicaid providers. When a provider submits a claim and a recipient has other insurance, the provider is instructed to bill the other insurance prior to billing Medicaid. The Agency utilizes a matrix maintained in the FMMIS to determine whether a claim shall be paid or denied based upon other third party information contained on the Medicaid recipient's file. Cost avoidance calculated as 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 2010-11	FY 2011-12	FY 2012-13	FY 2013-14
Casualty	$22,165,885	$24,336,688	$22,303,548	$22,794,142
Estate	$5,486,256	$6,017,391	$7,061,816	$6,967,623
Trusts	$6,011,888	$7,124,616	$5,471,792	$6,615,113
Medicare and Other Third Party Payor	$72,081,890	$78,428,755	$77,922,624	$72,834,387
Other Recoupment Projects*	$29,958,148	$32,208,128	$48,455,372	$61,607,714
Total Collections	**$135,704,067**	**$148,115,578**	**$161,215,152**	**$170,818,979**
Cost Avoidance (Matrix)	$966,902,977	$1,259,088,849	$1,423,986,005	$1,720,174,663

* 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.

Division of Health Quality Assurance

Care Provider Background Screening Clearinghouse

Chapter 2012-73, Laws of Florida, passed during the 2012 Legislative Session, allowed for retained fingerprints and authorized the creation of a secure, web-based "Care Provider Background Screening Clearinghouse" (Clearinghouse). The Clearinghouse is a secure, web-based database to house and manage screening results of selected state agencies allowing the following agencies to share those results: the Agency, APD, Department of Elder Affairs (DOEA), DCF, Department of Health (DOH), Department of Juvenile Justice (DJJ), and Vocational Rehabilitation at the Department of Education (DOE). For the selected agencies and persons subject to background screenings, sharing of results eliminates duplicative screenings for employees working in long-term care and other health care related provider types. The Clearinghouse also includes a RapBack requirement, also known as "retained prints," which enables notification to the Agency of the arrest of an employee to determine if the arrest affects access to vulnerable clients. The Agency immediately notifies the provider so appropriate action can be taken. The immediacy of notification through RapBack improves the Agency's response time in the prevention of Medicaid fraud.

The Agency continues to move forward in the development of the Clearinghouse. Integration with the state agencies began in January 2013 and currently the Division of Health Quality Assurance within the Agency, DOH, DOE/VR, and Managed Care Health Plans are participating with the remaining agencies expected to be brought on in 2015. AHCA Medicaid Provider Enrollment is expected to be implemented by spring of 2015 as well. Approximately 800 individuals a month applying for licensure or their licensure renewals with DOH are able to use a Clearinghouse screening, thereby reducing duplicative screening and costs. The Agency's providers benefit by being able to use more than 400 screenings per month from the Clearinghouse. During FY 2013-14, more than 14,000 background screening results were shared among participating agencies and managed care health plans resulting in an overall cost savings of $1,395,700.00 to Agency providers, DOH licensees, and managed care health plans.

The passage of SB 674 during the 2014 Legislative Session, codified as Chapter 2014-84, Laws of Florida, made some substantial changes regarding the Clearinghouse. The law authorized the Agency and the Department of Highway Safety and Motor Vehicles (DHSMV) to share driver's license photos with the Agency allowing for additional identity verification of individuals being screened by the Agency. The bill also requires that the registration and initiation of all criminal history background checks be made through the Clearinghouse for individuals

required to be screened, providing reduced costs from duplicative screening, enhanced tracking of the screening, and a copy of the Florida public criminal history report of the applicant for providers.

Assisted Living Facility (ALF) Enforcement Unit

In the past 10 years, assisted living facilities have become a more cost effective and less restrictive residential alternative to skilled nursing facilities for individuals not requiring full-time skilled nursing care. However, a continued increase of issues identified in assisted living facilities led to the creation of the Assisted Living Facility (ALF) Enforcement Unit in 2011. The Agency established a unit of 10 ALF surveyors to function as a team responsible for statewide oversight of ALF inspection enforcement and to serve as liaisons with local law enforcement and other partners such as the Long-Term Care Ombudsman, Department of Health, and DCF. The ALF Enforcement team's primary functions include:

- Assisting with the completion of high priority complaints;
- Collaborating with other agencies and law enforcement;
- Participating in unlicensed activity investigations;
- Participating in off hours or weekend inspections; and
- Conducting quality assurance reviews.

The Division's Bureau of Field Operations, Survey and Certification Support Branch enhanced the surveyor training and focus on core areas of compliance such as resident rights, nutrition and food service, medication management, staff training, and physical environment in addition to proper licensure with the State. Every surveyor must take this enhanced training course, ALF Surveyor Core Training, prior to be able to survey ALF's independently.

There has been a noted increase in unlicensed assisted living facilities, which causes the greatest concern in terms of resident care, background screening of staff, and facility safety. In addition to focused initiatives conducted in conjunction with the Agency's Bureau of Medicaid Program Integrity, the ALF Enforcement Team also conducted several investigations of unlicensed assisted living facilities in FY 2013-14. The Division's Complaint Administration Unit received 163 complaints of unlicensed ALF activity. Of those complaints, 114 were investigated and 41 were substantiated, requiring additional action and follow-up visits. The majority of the investigations were conducted by the ALF Enforcement Team in conjunction with DCF and local law enforcement.

The goal is to ensure that all ALF residents received appropriate healthcare. Facilities that provide substandard care as well as facilities providing care that exceeds the scope of the staff or the facility's licensure increase the cost of

healthcare for Medicaid recipients. In an effort to bring about ALF reform, the Agency continues to pursue legislation to increase fines and sanctions on non-compliant providers.

Assisted Living Facilities Initiatives During FY 2013-14

Additional efforts have been made to investigate and monitor compliance in ALFs through large-scale investigation and enforcement projects. These efforts include staff from MPI, HQA, and the federal Centers for Medicare and Medicaid Services Medicaid Integrity Group (MIG), as well as other state and local law enforcement agencies. In February 2014, a successful Assistive Care Services Initiative was conducted in Escambia, Santa Rosa, Walton, and Okaloosa counties. Four investigative teams consisting of staff members from the Office of Inspector General / Bureau of Medicaid Program Integrity, and from Health Quality Assurance / Survey and Certification Support Branch/ALF Enforcement Team conducted site visits to 29 facilities. The primary focus of the initiative was on Medicaid billing practices, background screening, and the health and safety of residents residing in these facilities. The initiative resulted in sanctions against 16 providers totaling $60,000 in fines as well as three providers being placed on prepayment review and referrals to Health Quality Assurance for two of the homes that had residents with injuries. Although the injuries did not happen in the homes, there were questions concerning the actions that the facilities took regarding the follow-up for these injuries. Providers were also educated on-site concerning Medicaid policies regarding the appropriate licensure required to bill the Medicaid program and corrections were effected concerning facility employees who had not been properly background screened or determined free of communicable disease or tuberculosis.

The Agency is striving to improve the coordination of surveys and referrals between HQA and Medicaid, which will enhance the Agency's ability to ensure facility compliance in both divisions and reduce the overlap and duplication of work. This collaboration will extend beyond ALFs to encompass other licensed providers that may be enrolled in Florida's Medicaid program under the Agency's purview.

Cross-Divisional Enforcement Efforts

In addition to collaborative investigation activities, the Agency continues to align legal actions and sanctions between HQA and Medicaid. Licensure actions, including facility closures, denials, revocations, and license surrenders are communicated to Medicaid and managed care plans to ensure no additional claims are paid and no residents or patients are referred to the facility if licensure is a requirement of enrollment or registration in the Medicaid program. Additionally, providers terminated for cause from the Medicaid program are reported to HQA and appropriate action is taken if the Medicaid provider is a licensed facility. The

Agency publishes a monthly press release identifying the Final Orders and other legal actions that are assessed against providers by HQA and Medicaid. The monthly press releases can be viewed on the Agency's website under Communications/Media Relations. The press releases serve to augment monthly reports submitted to the Senate Committee on Health Regulation documenting the effectiveness of Senate Bill (SB) 1986 (passed in 2009). The Agency has expanded the monthly SB 1986 report to include data on all licensed facilities for provisions that apply to all licensure programs. Several issues are outlined in the report including, but not limited to, Final Orders and fines assessed against providers by HQA and Medicaid. These reports include the number of license applications denied due to applicant(s) or person(s) with controlling interest being disqualified because of termination for cause from the Medicaid program, a conviction, or a plea of guilty/nolo contendere to Medicaid fraud, regardless of adjudication.

2014 Legislation that Enhances Provider Enforcement

The Agency strives to be proactive in focusing on mission critical functions. Legislation passed in 2014 made several changes, including the following:

SB 674 – Chapter 2014-84, Laws of Florida:

- Expanded disqualifying background screening offenses to include theft and fraud-related crimes;
- Eliminated the three-year waiting period for individuals that have completed all monetary sanctions for a felony disqualifying offense;
- Authorized the Agency and the Department of Highway Safety and Motor Vehicles to share driver's license photos; and
- Required the registration and initiation of all criminal history background checks be made through the Care Provider Background Screening Clearinghouse for individuals required to be screened.

HB 1179 – Chapter 2014-142, Laws of Florida:

- Clarified the relationship between a nurse registry and the persons referred for contract by the registry and provides an exemption from accreditation for home health agencies.

Online Licensing

The Agency's online licensing system is critical in the fight against fraud and abuse and is essential in a growing industry that includes an increasing percentage of providers that open, close, and re-open their facilities. The system is being developed with the ability to interact with other internal and external agency

databases for verification of Medicaid enrollment and appropriate business registration as well as identification of outstanding monetary obligations to facilitate the Agency's collections before licenses are issued or renewed. When completed, it is expected to have intra/inter-departmental connectivity with other automated systems, such as those used by Medicaid, Medicare, managed health care, background screening, accounts receivable, and practitioner regulation.

The online licensing system currently interacts with the Agency's licensure database, Versa Regulation (VERSA), and allows for online payment as well as electronic submission of required supporting documentation. Through limited data input provided by the applicant, the system prepopulates certain application fields with information already housed in VERSA, thus reducing the chance for incorrect or omitted information. Approximately 65 percent of the license applications currently received contain incorrect or missing information.

Currently, providers may submit licensure renewal applications through the online licensing portal for nursing homes, transitional living facilities, prescribed pediatric extended care centers, and intermediate care facilities for the developmentally disabled. Online renewal applications for abortion clinics, birth centers, multiphasic health testing centers, crisis stabilization units, homemaker and companion service providers, hospitals, and clinical laboratories are expected to be available for use by the end of September 2014 and the remaining provider types are scheduled to be available by June 2015. Submission of online renewal applications is voluntary however; the Agency anticipates significant adoption as there will be additional features to encourage use.

E-Prescribing of Controlled Substances

Section 408.0611, Florida Statutes, directs the Agency to disseminate information on e-prescribing and promote its adoption to prevent prescription drug abuse, improve patient safety, and reduce unnecessary prescriptions. The Agency created a clearinghouse of information on electronic prescribing and regularly convenes stakeholders to assess and accelerate the implementation of electronic prescribing. Electronic prescribing enables the electronic transmission of prescriptions and the recording of medication history for use by prescribing physicians. It improves prescription accuracy, increases patient safety, and reduces costs and fraudulent prescriptions. These benefits are derived from the accessibility of the medication history to the prescribing physician at the point of care and from the electronic transfer of the prescription.

There were perceived barriers in Florida Statute and Florida Administrative Code concerning the e-prescribing of controlled substances. In 2013, the Florida Board of Pharmacy researched s. 456.42(2), F.S., and researched authorizing rules

related to dispensing and determined that the statute is very clear on the issue of electronic prescribing of controlled substances and that modification of administrative rules was unnecessary. The Board determined that the electronic prescribing of controlled substances is recognized and authorized under Florida Law as long as the equipment utilized by the prescribing and receiving entities are fully compliant with Title 21, Code of Federal Regulations.

The Agency continues to work with stakeholders to promote e-prescribing in the interest of deterring prescription drug fraud in Florida.

Coordination and Cooperation of DOH, AHCA, and MFCU

The Department of Health continues its partnership with the Agency and the MFCU to strengthen inter-agency coordination and enhance processes and protocols in fraud investigation and prosecution. An interactive partnership is essential for effective, collaborative investigative efforts aimed at protecting the people of Florida against healthcare fraud and substandard health care.

The DOH Division of Medical Quality Assurance (MQA) director and enforcement leadership meet regularly with the Agency and MFCU directors and senior managers to coordinate joint projects, investigations, and enforcement strategies and to identify emerging issues or threats. Over the years, these meetings have grown to include additional state agencies and entities, including the DCF, the Department of Financial Services, the Medicaid and Public Assistance Fraud Strike Force, the Department of Economic Opportunity, the Office of Insurance Regulation, the Division of Insurance Fraud, and APD. Expanding participation in these bi-monthly meetings fosters a multi-agency approach to fraud mitigation, identifies potential, emerging areas of fraud, and highlights areas in which agency resources can be more effectively leveraged.

Last year the Agency and DOH identified an opportunity to work together to combat the growing problem of unlicensed assisted living facilities. By leveraging field resources in the identification of unlicensed assisted living facilities and streamlining reporting requirements, both agencies expect to see more regulatory and criminal prosecutions in the future. Some examples of other joint operations involve investigations where subjects made fraudulent disability claims for an individual that was not disabled, subjects fraudulently billing multiple insurance carriers for various therapies such as massage, and massage schools that issued fraudulent transcripts to individuals that had not completed required coursework. From July 1, 2009, through September 26, 2014, the DOH has denied licensure to 416 applicants and denied the renewal of 136 healthcare practitioners for health care related fraud, taken 152 emergency actions, and disciplined 249 healthcare practitioners for violations related to Medicaid.

The Agency and DOH continue to enhance information sharing to ensure anti-fraud legislation. For example, DOH transfers data every 24 hours to the Agency to flag practitioners who do not have an active license but who may continue to be billing Medicaid.

Statutory Reporting Requirements

Number of cases opened and investigated each year

MFCU opened 260 cases and had 969 active cases in FY 2013-14. MPI investigated 3,043 cases which included 1,647 opened during the year.

Disposition of the cases closed each year

Disposition of Closed Cases				
	MFCU	**PANE**	**AHCA**	**Total**
Administrative Closure	2	1		3
Administrative Referral	30	5		35
Assistance to Other Agencies	3	1		4
Case Dismissed	36	1		37
Civil Judgment	4			4
Civil Settlement	39			39
Consolidated	6	2		8
Contract Assessments (MCO)			5	5
Conviction	16	5		21
Deferred Prosecution		1		1
Deferred Prosecution Agreement	1	1		2
Fugitive Defendant	13	2		15
Investigation by another Law Enforcement Agency	4			4
Lack of evidence	26	15		41
No Fraud or Abuse Found			126	126
Nolle Prosequi		1		1
Overpayment Identified			1,622	1,622
Plea Agreement	22	4		26
Pretrial Intervention	1	1		2
Probation	6	9		15
Prosecution declined	1	6		7
Provider Education Letter			3	3
Resolved with Intervention	1			1
Sanction Only			333	333
Unfounded	12	6		18
Voluntary Dismissal	28			28
Total	**251**	**61**	**2,089**	

Sources of the cases opened

Sources of Cases Opened	MFCU	PANE	AHCA	Total
AHCA – Field Offices			6	6
AHCA – Division of Medicaid			137	137
AHCA – Health Quality Assurance			7	7
AHCA – Medicaid Program Integrity	10		1,099	1,109
AHCA – Finance and Accounting			76	76
AHCA – Other			38	38
APD – Agency for Persons with Disabilities	7			7
APS - Adult Protective Services	2	49		51
Attorney	3			3
Citizen	5	1	6	12
Consumer Protection Agency	1			1
Contractor for CMS	1		21	22
Department of Children and Families	1			1
Department of Health	1			1
Employee	16	2		18
Family Member	9	2		11
FBI – Federal Bureau of Investigation	2	1		3
Florida Department of Law Enforcement	1		7	8
Government Employee	1			1
HHS – OIG Health & Human Services Inspector General	6			6
Insurance Company – Private	1			1
Law Enforcement Agency	2	2		4
Medicaid Provider	13	2	149	164
Medicaid Recipient	1		3	4
MFCU			28	28
MFCU Data Mining Initiative	16			16
Operation Spot Check		2	1	3
Press Report			28	28
Qui Tam	95			95
Spin-off Case	4	1		5
State Agency – Other			15	15
Federal Agencies – Other			26	26
Total	**198**	**62**	**1,647**	

Amount of overpayments alleged in preliminary and final audit letters

Typically, MPI sends a preliminary audit report explaining the overpayment provisionally identified and giving the provider an opportunity to provide additional documentation or clarification. After review of any additional documentation submitted, MPI sends a final audit report that reflects the overpayments identified and offers the provider hearing rights under Chapter 120, Florida Statutes. For the 2,089 cases closed during the fiscal year there were 1,622 cases with overpayments identified. Preliminary audit reports were issued on 1,284 cases with potential identified overpayments in the amount of $45,300,753. MPI closed 668 of those cases prior to issuing final audit reports. Providers agreed to repay identified overpayments of $3,465,958 on those preliminary audit reports. In the remaining 616 cases, final audit reports were issued identifying potential overpayments of $23,297,293. These cases ultimately were closed after Final Orders with identified overpayments of $20,513,378. The total overpayments identified for collection in these 1,284 cases amounted to $23,979,336.

In addition to the overpayments identified in those 1,284 cases, MPI identified overpayments in the amount of $4,660,782 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. During the fiscal year there were 1,622 cases closed with identified overpayments totaling $28,640,118; fines and costs are not included in this overpayment amount. There were 129 cases closed with no findings including three in which providers were sent education letters and 338 cases closed as "sanctions only" (no overpayments were applicable) and managed care organization assessments.

Number and amount of fines or penalties imposed

During the fiscal year, MPI initiated 72 prepayment reviews, imposed fines (under s. 409.913, F.S. and Rule 59G-9.070, F. A. C.) in the amount of $2,810,147, issued MCO assessments under statutory or contractual authority in the amount of $1,600, recommended 49 Medicaid provider suspensions, and initiated 73 "with cause" Medicaid provider terminations. There were also 508 referrals to MFCU and others within and outside the Agency accomplished.

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

There were no reductions in overpayments through negotiated settlements during FY 2013-14.

Amount of final agency determinations of overpayments

MPI identified $28,640,118 in overpayments on 1,622 closed cases. See the MPI Recovery Activities table - total recoveries by MPI and MPI/TPL for FY 2013-14 were $88,017,587. (This includes collections of overpayments, fines, costs, and paid claims reversals during the fiscal year.)

Amount deducted from federal claiming as a result of overpayments

The Federal requirements have changed as a result of the Affordable Care Act to allow the State up to one year to return the Federal share of identified Medicaid 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 CMS will be reported on the last appropriate quarterly report. During FY 2013-14, the Agency reduced its federal claims by $26.5 million for net overpayments.

Amount of overpayments recovered each year

MFCU collected $32,177,045 in overpayments that were returned to the Agency. Additionally, MFCU collected $49,502,252 in Federal Medicaid overpayments that were sent directly to the U. S. Department of Health and Human Services for a total of $81,679,397 in Medicaid overpayments collected in FY 2013-14. For MPI collections, see Department of Financial Services.

Amount of cost of investigation recovered

During FY 2013-14, the MFCU collected $19,651 in program income investigative costs. MFCU also collected $8,004 in state share investigative costs and $364,014 in federal share investigative costs for a total of $391,669 for all investigative costs.

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

For cases that were paid in-full during the fiscal year, the average length of time from the date that MPI opened the case to the date the case was paid in full was 69 days. This is a substantial improvement over previous years when the average time was 228 days (FY 2012-13) and 284 days (FY 2011-12).

The amount determined as uncollectible and the portion of the uncollectible amount subsequently reclaimed from the Federal Government

The Agency must obtain approval from the Department of Financial Services to write-off all accounts receivable deemed uncollectible. During FY 2013-14, DFS approved $4.5 million in Medicaid accounts receivables for write-off. Of this $4.5 million, $158,650 was reclaimed from the federal government by the Agency.

Providers, by type, that are terminated from participation in the Medicaid program as a result of fraud and abuse

The following charts reference the number of providers, by type and by total, which were terminated from the Medicaid program due to considerations or factors that are of a 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.

Terminated Providers	Number
Assistive Care Services	21
Audiologist	1
Case Management Agency	6
Chiropractor	3
Community Behavioral Health Services	5
Dentist	8
Durable Medical Equipment/ Medical Supplies	8
Home & Community-Based Services Waiver	28
Home Health Agency	21
Independent Laboratory	2
Managed Care Treating Provider	14
Medical Foster Care/ Personal Care Provider	1
Nurse Practitioner (ARNP)	4
Optometrist	2
Pharmacy	20
Physician (D.O.)	3
Physician (M.D.)	91
Physician Assistant	6
Podiatrist	1
Skilled Nursing Facility	3
Social Worker/Case Manager	8
Specialized Mental Health Practitioner	7
Therapist (PT, OT, ST, RT)	6
Total	**269**

Additionally, there were 186 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. These providers may be under review by the Agency or other entity who voluntarily terminate from the program to avoid the involuntary action by the Agency.

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

MFCU expenditures for FY 2013-14 were $14,972,558, which included indirect costs of $1,069,027. MPI expenditures of $12,028,969 million were devoted to recovery work resulting in collections of $88,017,587 million and a return on investment for

recovery operations of 7.3:1.   In addition, MPI achieved $29,444,525 million in cost avoidance with expenditures of $4,350,075 million producing a return on investment for prevention efforts of 6.8:1.

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

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

Provider Type	Number
Community Behavioral Health Services	5
Assistive Care Services	14
Pharmacy	7
Physician (M.D.)	54
Physician (D.O.)	7
Chiropractor	2
Physician Assistant	1
Nurse Practitioner (ARNP)	3
Social Worker/Case Manager	10
Dentist	2
Home Health Agency	42
Home & Community-Based Services Waiver	10
Birth Center	1
Therapist (P, OT, ST, RT)	2
Durable Medical Equipment/Medical Supplies	2
Case Management Agency	37
Total	**199**

There were an additional 128 providers who were denied enrollment due to findings during an onsite pre-enrollment visit and 77 providers denied enrollment due to disqualifying criminal offenses for a total of 205 providers denied enrollment based on program integrity considerations.

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

As the Agency continues its efforts to realign organizational units to increase efficiencies and better manage the Medicaid program, fraud and abuse efforts

(prevention, detection, and enforcement/recoupment) will continue to be assessed. Agency processes, many within MPI, continue to evolve with the shift from a predominately fee-for-service environment to mainly managed care.

Requiring all providers contracting with Medicaid program managed care organizations to be fully enrolled will increase the ability to have uniform and comprehensive network controls. This will allow the Agency to capture critical demographic information to ensure that ineligible or excluded providers are not participating in the program. Furthermore, as the Medicaid program continues to shift from a fee-for-service environment, the statutory definition of "provider" may hinder the state's efforts to prevent, detect, and take action to combat fraud and abuse in Florida Medicaid unless all Medicaid network providers are fully enrolled. Additionally, requiring all providers to be fully enrolled would increase the ability of the State to ensure compliance with federal provider enrollment requirements.

In FY 2013-14, the Legislature approved a one-time appropriation for advanced data analytics services. The Agency has procured those services and as of September 1, 2014, is moving forward with the development and implementation of data analytics. Additional funding to ensure the full implementation and continuation of these services is critical to the State's ability to capitalize on the available technology and further enhance the identification of latent overpayments. Ensuring proper resources, both from a financial as well as a staffing standpoint, is critical to maximizing the return on this investment. Because the federal government is offering an increased financial match on these services, each dollar invested by the state is money well spent. Additionally, through funding appropriated by the Legislature in FY 2013-14, the Agency (specifically MPI) has procured a new automated fraud and abuse case tracking system that will be fully functional by March 2015. While the Agency has received prior waivers from the federal government's requirement for state Medicaid programs to have a Medicaid Recovery Audit Contractor (RAC), the Agency now believes pursuing such a contract is in the State's best interest to ensure that potential recoveries from retrospective fee-for-service audits reviews are identified before recoveries are time barred. The Agency plans to pursue a RAC contract in 2015 and is requesting spending authority for a contingency fee based contract to engage RAC services.

With regard to recoveries, from time to time the identified overpayment dollars are uncollectable due to the business status of the provider (bankrupt, business closed, non-operational, etc.). The Agency's ability to write-off the uncollectible debt and avoid a mandatory refund of the federal share to CMS is impeded because Florida law does not specify a process for certifying the Medicaid provider as being out of business. The Agency is seeking legislation in 2015 to authorize the Agency to certify a provider as being out of business to retain the federal share on these uncollectible sums.

Further efforts and recommendations include:

- Continued internal efforts through the Agency's Fraud Steering Committee and its sub-committees to maximize efforts to combat fraud and abuse in the Medicaid program;

- Continued activities to maximize communication and cooperative efforts with other government agencies with whom the Agency has a working relationship and common interests;

- Further development of cooperative relationships with Medicaid managed care organizations while also holding them accountable for anti-fraud requirements; and

- Continue to train staff on the ever-evolving manners in which a large health care system can be defrauded and maximize fraud prevention efforts.

Acronyms Used in This Report

ACA – Affordable Care Act
ACH – All Children's Health System
ACS – Assistive Care Services
AFAAR – Annual Fraud and Abuse Reports
Agency, the (as used in this report) – Agency for Health Care Administration
AHCA – Agency for Health Care Administration
ALF – Assisted Living Facility
ALS – Advanced Life Support
APD – Agency for Persons with Disabilities
AWP – Average Wholesale Pricing
BGS – Background Screening System
BLS – Basic Life Support
CCEB – Complex Civil Enforcement Bureau
CCM – Comprehensive Care Management
CFR – Code of Federal Regulation
CJIS – Criminal Justice Information Services
CMS – Centers for Medicare and Medicaid Services
CMU – Case Management Unit (within MPI)
CPIP – Certified Program Integrity Professional
CPR – Cardiac Pulmonary Resuscitation
CT – Computerized Tomography
CTA – Computerized Tomography Angiography
DCF – Department of Children and Families
DD Waiver – Developmental Disabilities Waiver under the Florida Medicaid program
DFS – Department of Financial Services
DHHS – U. S. Department of Health and Human Services
DHSMV – Department of Highway Safety and Motor Vehicles
DJJ – Department of Juvenile Justice
DME – Durable Medical Equipment
DOE – Department of Education
DOEA – Department of Elder Affairs
DOH – Department of Health
DPAF – Division of Public Assistance Fraud
DSS – Decision Support System
EOMB – Explanation of Medicaid Benefits
F&A – Finance and Accounting
F. S. – Florida Statutes
F.A.C. – Florida Administrative Code
FACTS – Fraud and Abuse Case Tracking System

FAD – Fraud and Abuse Detection

FAQ – Frequently Asked Questions

FCPTI – Florida Crime Prevention Institute

FDA – Food and Drug Administration

FDCA –Food, Drug, and Cosmetic Act

FDLE – Florida Department of Law Enforcement

FFP – Federal Financial Participation

FFS – Fee-for-Service

FMHI – Florida Mental Health Institute

FMMIS – Florida Medicaid Management Information System

FPCU – Under AHCA's Division of Medicaid, Fraud Prevention and Compliance Unit

FY – Fiscal Year (Florida's fiscal year is July 1 – June 30)

GA – Generalized Analysis

GSK – Glaxo Smith Kline Pharmaceutical

HIDTA – High Intensity Drug Trafficking Area

HQA – AHCA's Health Quality Assurance

ICD-10 - the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization (WHO)

LTC – Long-term Care

MAR – Medicaid Accounts Receivable

MCM – Medicaid Contract Management

MCO – Managed Care Organization

MFCU – Medicaid Fraud Control Unit, within the Florida Department of Legal Affairs

MIC – Medicaid Integrity Contractors

MIG – Medicaid Integrity Group

MII – Medicaid Integrity Institute

MMA – Managed Medical Assistance

MOU – Memorandum of Understanding

MPA – Medicaid Program Analysis

MPI –AHCA's Medicaid Program Integrity

MQA – Medical Quality Assurance (Department of Health)

MRA – Magnetic Resonance Angiography

MRI – Magnetic Resonance Imaging

NAAG – National Association of Attorneys General

NAMFCU – National Association of Medicaid Fraud Control Units

OAG – Office of Attorney General

OGC – Office of General Counsel

OIG – Office of Inspector General

OIR- Office of Insurance Regulation

PAC – Project AIDs Care

PANE – Patient Abuse, Neglect and Exploitation

PCRs – Paid Claims Reversals

PDHP – Prepaid Dental Health Plan

PDL – Preferred Drug List

PERM – Payment Error Rate Measurement

PET – Positron Emission Tomography

PPACA – Patient Protection and Affordable Care Act

PPEC – Prescribed Pediatric Extended Care

PSN – Provider Service Networks

QFAAR – Quarterly Fraud and Abuse Reports

ROI – Return on Investment

SIPP – Statewide Inpatient Psychiatric Program

SMMC – Statewide Medicaid Managed Care

SSA – Social Security Act

SURS - Surveillance and Utilization Review Subsystem

TCM – Targeted Case Management

TPL – Third Party Liability

VERSA – (also referenced as "VR" for VERSA Regulation) is AHCA's licensure
database

A message from AHCA's Inspector General on how this report was composed: The Agency for Health Care Administration, Office of the Inspector General has exercised oversight of the production of this report for over a decade. However, the compilation of the information contained herein originated from many state agencies, bureaus, and units that have oversight of different functions of Florida's large and complex Medicaid program. Months prior to this report's publication, Kimberly Noble of the AHCA Office of Inspector General initiated data calls and conveyed requests for up-to-date text to include in this report. Ms. Noble then assembled the information from the multiple sources into a single draft document. After the draft text was reviewed by officials responsible for the activities documented in this report, Ms. Noble constructed the print-ready edition, and secured cover graphics from AHCA's Multi-media Design Unit. While many dedicated state employees contributed to this report throughout the year, Ms. Noble's efforts were most important in ensuring this report was submitted timely, with the statutorily required information. If you have questions or comments regarding this report, the Agency for Health Care Administration and the Office of the Attorney General will make every effort to address them.

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