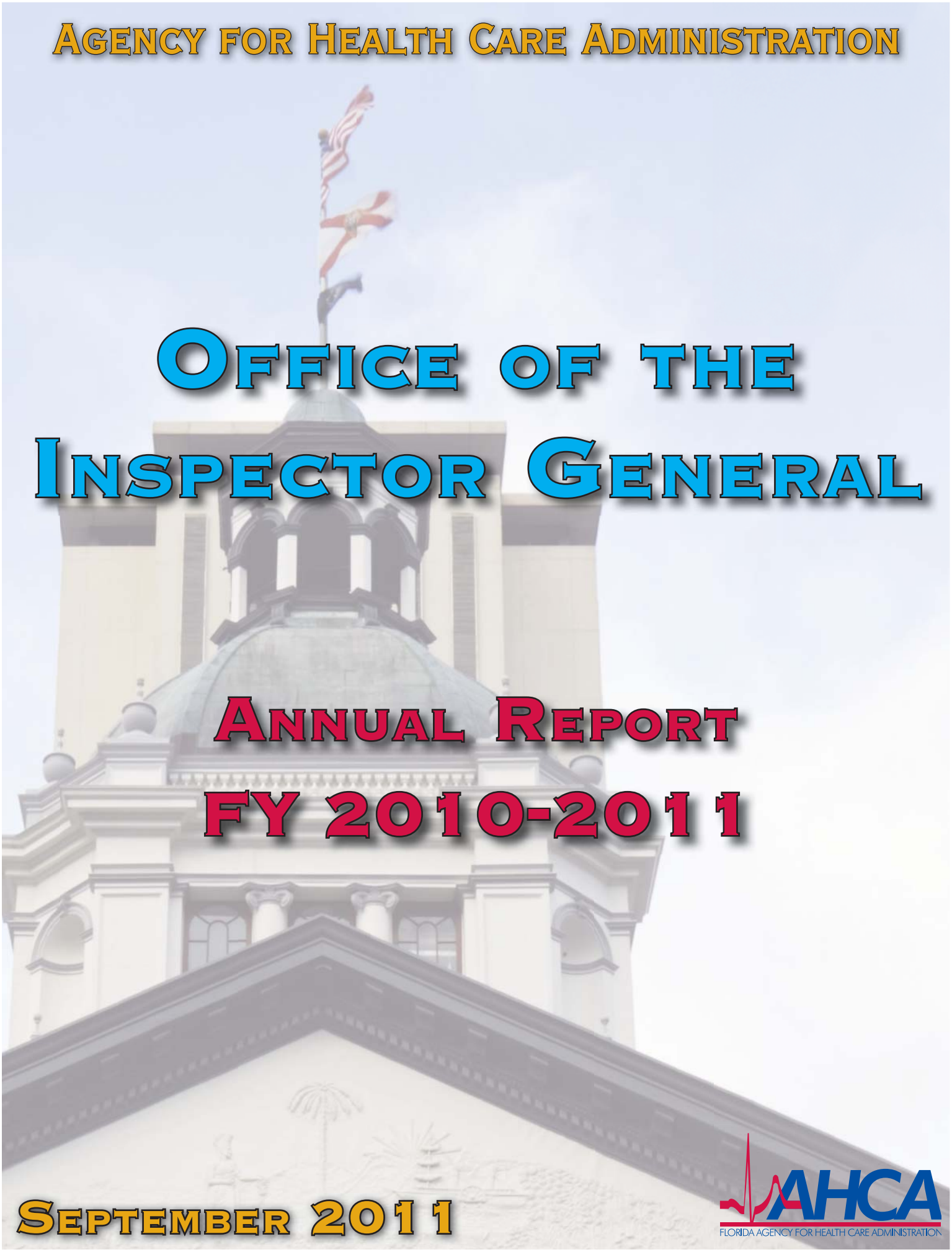


AGENCY FOR HEALTH CARE ADMINISTRATION

OFFICE OF THE INSPECTOR GENERAL

ANNUAL REPORT FY 2010-2011

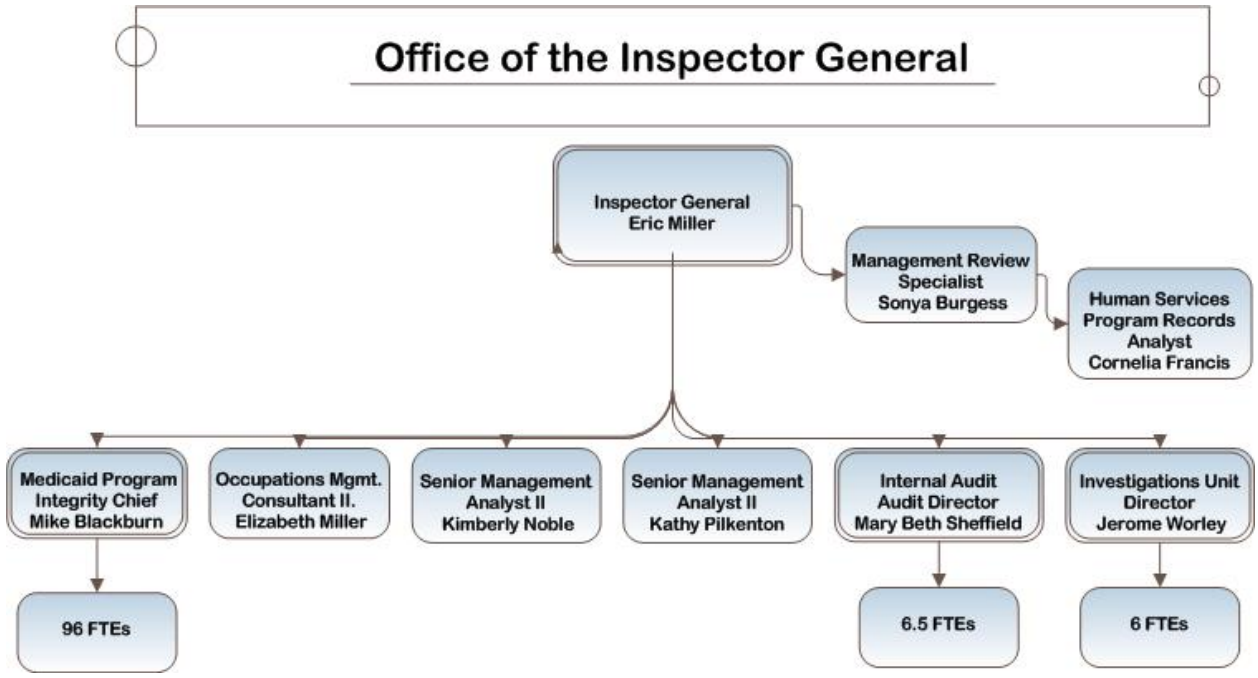
SEPTEMBER 2011

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Table of Contents

Office of the Inspector General

OIG Organization and Staff



Background

The Office of the Inspector General (OIG) is an integral part of the Agency for Health Care Administration (Agency). The purpose of the OIG is to provide a central point for coordination of, and responsibility for, activities that promote accountability, integrity and efficiency in the Agency. Section 20.055, Florida Statutes (F. S.), defines the duties and responsibilities of each inspector general, with respect to the state agency or department in which the office is established.

The statute requires that the OIG submit to the Agency Secretary an annual report, not later than September 30 of each year, summarizing its activities during the preceding state fiscal year. This report includes but is not limited to:

A description of significant abuses and deficiencies relating to the administration of programs and operations of the Agency disclosed by investigations, audits, reviews or other activities during the reporting period;

A description of recommendations for corrective action made by the Inspector General during the reporting period with respect to significant problems, abuses or deficiencies identified;

The identification of each significant recommendation described in previous annual reports on which corrective action has not been completed; and

A summary of each audit and investigation completed during the reporting period.

This document is presented to the Secretary to comply with these statutory requirements and to provide information on the OIG's progress in completing its mission as defined by Florida law.

Mission Statement

The primary mission of the OIG is to assist the Secretary and other Agency management in championing accessible, affordable, quality health care for all Floridians by assessing the efficiency and effectiveness of Agency resource management.

This is accomplished by providing an independent examination and evaluation of Agency programs, activities and resources and by conducting internal investigations of alleged violations of Agency policies, procedures, rules or laws. Reports of findings are prepared and distributed to appropriate management. Also, the OIG provides oversight for the Internal Audit Section, the Investigations Unit and for the Bureau of Medicaid Program Integrity. The organizational chart on page 1 provides the structure of the OIG. In addition to the typical audit and investigative functions of an Office of Inspector General, the OIG for the Agency for Health Care Administration has responsibility for the Bureau of Medicaid Program Integrity (MPI), whose primary mission is to prevent, deter, detect and recoup Medicaid fraud and abuse related overpayments.

OIG Responsibilities

The specific duties and responsibilities of the Inspector General, according to Section 20.055(2), F. S., include:

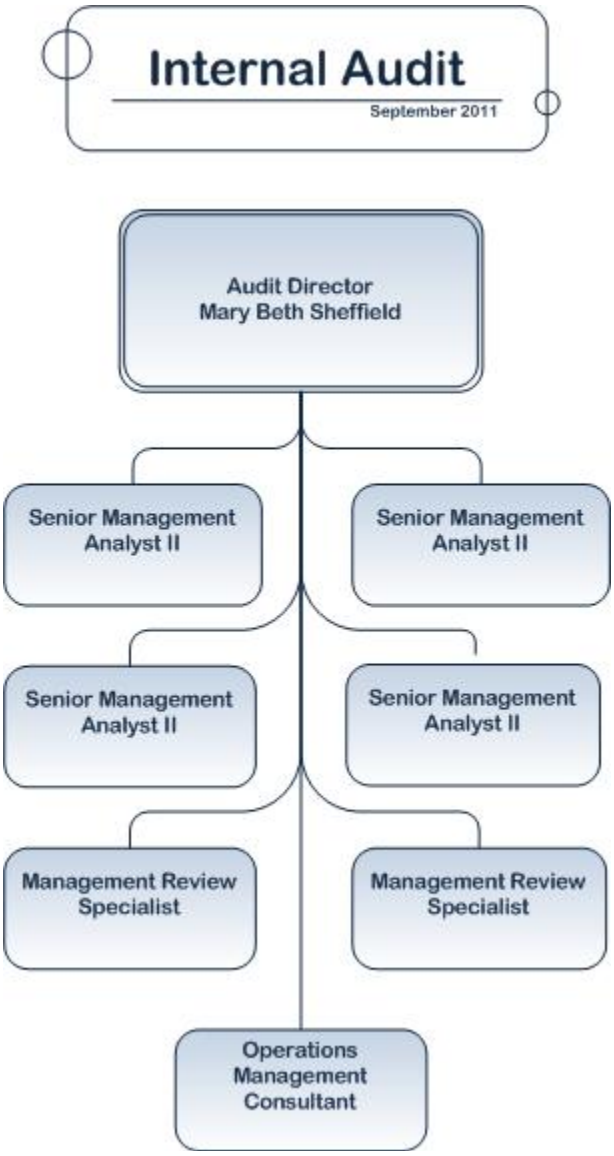
- Reviewing actions taken by the Agency to improve program performance and meet program standards;
- Conducting, supervising or coordinating other activities to promote economy and efficiency in the administration of, or preventing and detecting fraud and abuse in its programs and operations;
- Reporting to the Agency head concerning fraud, abuses and deficiencies, recommending corrective action and reporting on the progress made in implementing corrective action;
- Ensuring effective coordination and cooperation between the Auditor General, federal auditors and other governmental bodies;
- Reviewing rules, as appropriate, relating to the programs and operations of the Agency; and
- Ensuring that an appropriate balance is maintained between audit, investigative and other accountability activities.

In addition, the Inspector General is required to initiate, conduct, supervise and coordinate investigations designed to detect, deter, prevent and eradicate fraud, waste, mismanagement, misconduct and other abuses in the Agency. The investigative duties and responsibilities of the Inspector General, pursuant to Section 20.055(6), F. S., include:

- Receiving complaints and coordinating activities of the Agency as required by the Whistle-blower's Act pursuant to Sections 112.3187 – 112.31895, F. S.;
- Receiving and considering the complaints which do not meet the criteria for an investigation under the Whistle-blower's Act and conducting, supervising or coordinating such inquiries, investigations or reviews as the Inspector General deems appropriate;
- Reporting expeditiously to the Department of Law Enforcement or other law enforcement agencies, as appropriate, whenever the Inspector General has reasonable grounds to believe there has been a violation of criminal law;
- Conducting investigations and other inquiries free of actual or perceived impairment to the independence of the Inspector General or the OIG. This includes freedom from any interference with investigations and timely access to records and other sources of information; and
- Submitting final reports on investigations conducted by the Inspector General to the Agency head, except for Whistle-blower's investigations, which are conducted and reported pursuant to Section 112.3189, F. S.

Internal Audit

Internal Audit Organization and Staff



HIPAA Compliance Office Functions

The Health Insurance Portability and Accountability Act (HIPAA) Compliance Office, located within the Internal Audit (IA) section, coordinates Agency compliance with HIPAA requirements, pursuant to Title 45, Code of Federal Regulations, Parts 160, 162 and 164 (Public Law 104-191) and the Health Information Technology Economic and Clinical Health (HITECH) Act (Title XIII of Division A and Title IV of Division B of the American Recovery and

Reinvestment Act of 2009 (ARRA), Public Law 111-5). Responsibilities of the HIPAA Compliance Office include:

- Administering both the HIPAA and HITECH Privacy Training and Security Awareness Training online programs for all Agency employees;
- Providing in-person HIPAA and HITECH privacy training to all Agency employees as part of their new employee orientation and annual refresher training;
- Responding to requests for protected health information (PHI), HIPAA-related complaints against the Agency or its employees and other questions or requests involving HIPAA;
- Developing and implementing Agency policies and procedures to comply with HIPAA and HITECH regulations;
- Maintaining web sites, both internal and external to the Agency, containing general HIPAA and HITECH information for use by Agency employees and the general public;
- Reviewing Agency contracts to ensure compliance with HIPAA and HITECH requirements; and
- Updating and distributing the Agency's Notice of Privacy Practices to all Medicaid recipients.

Internal Audit Staff

Internal Audit staff brings various backgrounds and expertise to the Agency. Certifications and advanced degrees held by IA staff as of June 30, 2011 include:

- Certified Public Accountant
- Certified Internal Auditor
- Certified Fraud Examiner
- Certified Information Privacy Professional with specialty in Government Privacy Law
- Certified Information Systems Security Professional
- Certified in Risk and Information Systems Control
- Certified Government Auditing Professional
- Project Management Professional

The International Standards for the Professional Practice of Internal Auditing and Government Auditing Standards require IA staff members to maintain their professional proficiency through continuing education and training. Each auditor must receive at least 80 hours of continuing education every two years. This is accomplished by attending courses or conferences throughout the year. IA members have attended Association of Inspectors General chapter meetings and conferences, Tallahassee Chapter of the Institute of Internal Auditors (IIA) luncheon meetings, Information Systems Audit and Control Association (ISACA) e-symposiums, federally sponsored InfraGuard seminars dealing with Information Technology security and criminal issues, Association of Certified Fraud Examiners seminars, Agency employee training and government and nonprofit accounting video training.

Internal Audit Activities

Assurance Engagements, Consulting Engagements and Management Reviews

IA completed a total of 10 assurance engagements, consulting engagements or management reviews during FY 2010-11. IA continues to monitor progress of management actions taken to correct significant abuses or deficiencies noted in the administration of Agency programs and operations disclosed by these engagements. A listing of the engagements completed and in progress as of June 30, 2011 are below:

Report No.	Engagements	Type	Completed
10-09	Aging Out Program – Aged and Disabled Adult Waiver	Assurance	11/5/2010
10-10	Medical Claims Review Process Improvement	Consulting	1/27/2011
10-14	Office of Plans and Construction Process and System Consultation	Consulting	10/11/2010
10-46	2010 Disaster Recovery, Information Technology	Review	8/20/2010
11-09	ARRA Data Quality Review, QE 6/30/10	Review	8/5/2010
11-14	ARRA Data Quality Review, QE 9/30/10	Review	11/5/2010
11-16	ARRA Data Quality Review, QE 12/31/10	Review	1/21/2011
11-17	Review of the Florida Center for Health Information and Policy Analysis	Review	5/26/2011
11-18	Enterprise Wide Audit of Organizational Ethics	Assurance	5/5/2011
11-20	ARRA Data Quality Review, QE 3/31/11	Review	4/15/2011

The following summaries describe the results of the assurance engagements, consulting engagements and management reviews completed by IA during the past fiscal year:

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

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

The audit disclosed overall weaknesses in the areas of administration, monitoring and recipient case management. These control weaknesses resulted in missing and incomplete documentation, delivery of waiver services by unqualified providers, certain services provided concurrently contrary to waiver requirements, provider payments exceeding authorized

amounts, services not properly authorized and improper provider payments for the unauthorized delivery of waiver services.

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

- Develop monitoring and audit policies and procedures to be utilized by the Bureau and independent case managers to ensure compliance with program requirements;
- When the Bureau acts as the "case manager," conduct face-to-face visits with recipients at least annually to ensure that services are only rendered as authorized and included in the written plan of care;
- Utilize referral agreements or contracts for independent case management service providers to establish responsibilities, improve coordination of services and increase effectiveness to ensure the program is being administered in accordance with program requirements;
- Develop tools to track issuance of authorization letters and the receipt of file documents such as the plan of care and level of care;
- Reword authorization letters to clarify the effective date of authorization and types of waiver services that cannot be provided concurrently;
- Audit a sample of provider claims quarterly for compliance with authorized amounts; and
- Recoup provider overpayments, where applicable.

10-10 Medical Claims Review Process Improvement

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

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

10-14 Office of Plans and Construction Process and System Consultation

As part of the Agency's FY 2009-10 audit plan, the Bureau of Internal Audit conducted a consulting engagement with the Division of Health Quality Assurance's (HQA) Office of Plans and Construction (OPC) to evaluate their current processes and systems and whether they effectively and efficiently manage the OPC business requirements. During this engagement it was found that OPC had written policies regarding fee and document submission, but that these policies are not always enforced. They had not developed clear procedures relating to the OPC process or process flows to demonstrate how a review is conducted which would assist in the training of new employees as well as ensuring current employees are all following the same steps in the plan review process. It was ascertained that OPC could reduce spending by eliminating the mailing of paper documents and setting up a system to receive applications and transfer documentation electronically between the facilities, headquarters and the satellite offices. It was also determined that they need to develop a document retention and destruction policy to reduce the amount of stored paper documents and ensure proper back-up, and organized storage of, electronic documents.

Staff evaluated the current OPC Track system and found duplication of data that had been input into the system as well as manual tracking of data that should be tracked by the system. Staff looked at options for HQA to improve the OPC system including upgrading the current OPC Track system, upgrading the Versa Regulation system that is used by other Bureaus in HQA to incorporate OPC's needs, developing a new in-house system, or developing a contract to bring in a vendor to develop a new system. Staff detailed the pros and cons of these options in the report, leaving HQA to determine the best option.

10-46 2010 Disaster Recovery, Information Technology

As part of the Agency's FY 2009-10 audit plan, staff conducted a consulting engagement on the Division of Information Technology (IT) 2010 disaster recovery test effort. The focus of this consulting engagement was to provide recommendations for improvement within the disaster recovery process.

During this engagement, it was noted that the IT staff was very knowledgeable and capable of restoring the Agency's IT resources in the event of a disaster. Staff did not identify any issues or deficiencies in the disaster recovery team's technical capabilities. However, instances were identified where improvements could be made to strengthen the processes and associated documentation.

Staff recommended that the Division of IT conduct a post-test review, continue to regularly update the Information Technology Disaster Recovery Plan (ITDRP) and to ensure alignment with the Agency's Continuity of Operations Plan (COOP). Staff also recommended that the Bureau of Medicaid Program Analysis (MPA) align its data backup procedures with the Division of IT.

11-09, 11-14, 11-16, and 11-20 ARRA Data Quality Reviews

(For quarters ending 6/30/10, 9/30/10, 12/31/10 and 3/31/11)

The purpose of the American Recovery and Reinvestment Act of 2009 (ARRA) is to provide federal assistance designed to create and preserve jobs, stimulate economic development and provide help for people affected by the recession. The Agency received the following ARRA awards:

1. Ambulatory Surgical Center – Healthcare Associated Infection Prevention Initiative for 2009 and 2010 in the amounts of $16,250 and $659,273 respectively. The awards funded federal ambulatory surgical center surveys that utilized a new infection control survey tool.
2. Florida Health Information Exchange Cooperative Agreement Program in the amount of $20,738,582. The purpose of this project is to implement a statewide health information exchange (HIE) plan that will facilitate and expand the secure, electronic movement and use of HIE among organizations according to nationally recognized standards.

Staff completed four data quality reviews of the ARRA award data reported by the Agency in the FlaReporting System for the quarters ending June 30, 2010; September 30, 2010; December 31, 2010 and March 31, 2011. The objective was to determine if there were any material omissions or significant errors in the data. Throughout the reviews IA staff worked closely with Agency staff to help ensure that reported data was accurate and complete.

The reviews did not disclose any material omissions or significant errors in the data submitted to the federal government. However, it was noted in previous data quality reviews that the estimated number of jobs created/retained reported for one award was incorrect. At the time of the reports, the Federal Office of Management and Budget (OMB) had not provided guidance on when and how data corrections were to be made. OMB subsequently issued guidance on September 24, 2010, stating that "Changes to prior reports may not be initiated for the "Number of Jobs" field". As a result, no recommendations were made to the Agency to correct the "Number of Jobs" reported for prior period reports.

11-17 Review of the Florida Center for Health Information and Policy Analysis

At the request of the Agency Secretary, the Office of the Inspector General performed a management review of the Florida Center for Health Information and Policy Analysis (Florida Center) within the Agency for Health Care Administration (Agency). The review was limited to an overview of the Florida Center's operations and recommendations for improvement.

The objectives were to identify the Florida Center's mission and core business objectives as established by management and applicable laws, rules and regulations and make recommendations for improvement. Interviews with the Florida Center management and staff were conducted to determine individual roles in key functions and to obtain staff's observations and recommendations for operational improvements. The review disclosed that the Florida

Center needs permanent, strong and effective leadership to guide it, not only for the purpose of collecting, compiling and disseminating health related data to develop policy and promote transparency, but also for promoting the secure exchange of health information.

Therefore, to help ensure the most cohesive, coordinated effort by the Agency to improve the effectiveness and efficiency of health care services in the state and to support consumers in health care decision making, staff recommended that the current activities performed by the Florida Center remain within the Florida Center and that the Agency hire a Director to provide strong leadership to management and staff towards fulfilling the Florida Center's goals and objectives. IA also provided the following recommendations for consideration by management

- Consolidate the functions of promoting secure health information exchange including e-prescribing, electronic health records, personal health records, health information technology and informatics into a separate office within the Florida Center.
- Formally assign the budget function to an individual with the required skill set who would report directly to the Director.
- Consider transferring the Risk Management and Patient Safety unit back to the Division of Health Quality Assurance (HQA) since the unit's operations align with HQA's regulatory functions.

11-18 Enterprise Wide Audit of Organizational Ethics

Pursuant to Section 14.32, Florida Statutes, the Executive Office of the Governor, Office of the Chief Inspector General initiated an enterprise wide audit of organizational ethics. The Agency's Office of the Inspector General cooperated with the Chief Inspector General on this project. Agency results were included in a roll-up report published by the Office of the Chief Inspector General. The purpose of the audit was to evaluate the Agency's implementation of and compliance with the Governor's revised Code of Ethics and the effectiveness of the Agency's ethics-related objectives and activities.

The audit revealed that the Agency established the necessary steps to ensure that the Agency's ethics policy is in compliance with the Governor's revised Code of Ethics and is appropriately communicated and promoted. A review of the Agency's ethics policy and training materials revealed that specific subjects, as required by the policy, were not being covered in the annual training provided by the Agency. The Agency's ethics policy (#01-HR-55) states "The Agency's Secretary and all of its employees will attend training on the subjects of ethics, public records, open meetings, records retention, equal opportunity and proper personnel procedures. Thereafter, all employees will receive training on an annual basis." IA recommended that the Agency incorporate the missing subjects into the Agency's required training courses in order to comply with the Agency's ethics policy. IA also recommended that the Agency continue to ensure that all employees receive the required annual training on ethics.

Internal Audit Engagements in Progress as of June 30, 2011

Report No.	Engagements	Type	Completed
11-11	Agency Data Consolidation	Consulting	8/23/2011
11-25	ARRA Data Quality Review, QE 6/30/11	Review	7/20/2011

Other Projects

Other projects completed by IA during the fiscal year included: Schedule IX of the Legislative Budget Request; Summary Schedule of Prior Audit Findings; HHS Audit Resolution Letter; 2009-10 OIG and Fraud and Abuse Annual Reports and 2011-12 Risk Assessment and Audit Plan.

Provider Data Analysis

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

DD Service Waiver

At the request of the Governor's office, the Chief Inspector General formed a multi-agency team which included IA staff to conduct a review to validate information from the Agency for Persons with Disabilities (APD) concerning an alleged budget shortfall in the Home and Community-Based Services (HCBS) waiver program. IA assisted by providing information on how waiver payments are processed through the Florida Medicaid Management Information System (FMMIS), what types of edit checks are in the system to prevent mispayments and overpayments and researching how the Agency determines eligibility.

Under the HCBS waiver program, APD authorizes total cost plans of services that are deemed medically necessary to realize a client's potential for community living. The total value of cost plans approved exceeds the amount authorized and appropriated to carry out the HCBS waiver program. All services are not provided each year and APD estimates that the total liability is approximately 85% of the services approved. Even at a service rate of 85%, the services approved exceed the amount authorized by the Legislature and approved by the Governor. The review found that there are no financial controls to assure approved client cost plans match

the amount available to APD to provide the services. Because of this disconnect, APD has authorized expenditures in excess of the amounts authorized to carry out the HCBS waiver program and may have violated Section 216.311, F. S., which provides that no Agency or branch of state government shall contract to spend, or enter into any agreement to spend, any moneys in excess of the amount appropriated to such agency unless specifically authorized by law. This issue has existed since the creation of APD from the Department of Children and Families in 2004 with no resolution. Current APD management proposed measures to reduce the projected deficit, but those measures will not eliminate it. Implementation of these recommended measures will require actions by the Governor's office and the Legislature as well as support by the stakeholder communities.

Medicaid EHR Incentive Payment Program

The Florida Medicaid Electronic Health Record (EHR) Incentive Program was established by the Health Information Technology for Economic and Clinical Health (HITECH) Act of the American Recovery & Reinvestment Act of 2009. The program provides financial incentives to eligible hospitals and Medicaid professionals to adopt, implement, upgrade and meaningfully use certified electronic health record technology.

Internal Audit staff participated on the EHR Implementation Team. The purpose of this team was to develop a methodology, solution and budget for the identification of eligible providers, as well as different payment mechanisms. The team also focused on auditing and tracking payments and monitoring the compliance factors in regards to Meaningful Use criteria.

Prior Engagement Recommendations Follow-up

The *International Standards for the Professional Practice of Internal Auditing* and *Government Auditing Standards* require auditors to follow-up on reported findings and recommendations from previous assurance engagements and management reviews to determine whether Agency management has taken prompt and appropriate corrective action. The OIG provides status reports on internal engagement findings and recommendations to Agency management at six-month intervals after publication of an engagement report.

Pursuant to Section 20.055(5)(h), F. S., the OIG monitors the implementation of the Agency's response to external audit reports issued by the Auditor General and by the Office of Program Policy Analysis and Government Accountability (OPPAGA). The OIG is also required to provide a written response to the Secretary on the status of corrective actions taken no later than six months after a report is published. A copy of the response is also provided to the Legislative Auditing Committee. Additionally, pursuant to Section 11.51(6), F. S., OPPAGA submits requests (no later than 18 months after the release of a report) to the Agency to provide data and other information describing specifically what the Agency has done to respond to

recommendations contained in their reports. The OIG is responsible for coordinating these status reports and ensuring that they are submitted within the established time frames.

During FY 2010-11, status reports were submitted on the following external reports:

- Auditor General - Audit of AHCA's Medicaid Payments and Related Controls (Report #2010-139 - Dated September 2010)
- Auditor General - State of Florida - Compliance and Internal Controls Over Financial Reporting and Federal Awards, FYE 6/30/09 (Report #2010-165 - Dated September 2010)
- Auditor General - Audit of Agency Operational - Medicaid Facility Reimbursement Rates (Report #2010-189 - Dated October 2010)
- Auditor General - Operational Audit of AHCA, Prior Audit Follow-up (Report #2011-002 - Dated January 2011)
- Auditor General - Information Technology Operational Audit of AHCA, Florida Medicaid Management Information System and Decision Support System (Report #2011-057 - Dated June 2011)
- OPPAGA - Enhanced Detection, Stronger Sanctions, Managed Care Fiscal Safeguards, and a Fraud and Abuse Strategic Plan Are Needed to Further Protect Medicaid Funds (Report #10-32 – Dated March 2010)

Corrective Actions Outstanding From Previous Annual Reports

As of June 30, 2011 the following corrective actions for significant recommendations described in previous annual reports were still outstanding:

Durable Medical Equipment, Report 09-10 issued December 7, 2009 (Most Recent Management Response as of 6/21/11).

Recommendation: IA recommended that Medicaid develop formal written procedures to help ensure consistency and quality performance in the current DME process and coordinate with the Bureau of Information Technology to enhance the Oracle database design to capture needed dates.

Most Recent Management Response: Internal training documents were distributed to the local Area Offices on March 22, 2011. Extra dates to be captured are not required; however, enhanced reporting has been discussed with management. Medicaid Services will request better reporting to capture incoming and completed prior authorizations. A Programming Service Order was submitted to IT requesting the creation of a new report which will capture prior authorization data when "received" by Medicaid for better tracking/dashboard purposes. Anticipated completion date late 2011.

Recommendation: Medicaid Services should review the DME Handbook relating to DME trade-ins and make necessary revisions establishing criteria to specify applicable equipment eligible for trade-in value and a means for determining the depreciated value.

Most Recent Management Response: Medicaid is currently promulgating other rules assigned by priority. When the DME Handbook is reviewed and promulgated, it will be a complete handbook update, not just one section. An exact completion date cannot be determined at this time

Coordination with Other Audit and Investigative Functions

The OIG acts as the Agency's liaison on audits and reviews conducted by outside organizations such as the Office of the Auditor General, OPPAGA and the federal Department of Health and Human Services. The OIG also coordinates the Agency's responses.

Office of the Auditor General

During FY 2010-11 the Office of the Auditor General issued the following reports:

- Operational Audit of AHCA, Prior Audit Follow-up (Report #2011-002 - Dated July 2010)
- Information Technology Operational Audit of AHCA, Florida Medicaid Management Information System and Decision Support System (Report #2011-057 - Dated December 2010)
- State of Florida Compliance and Internal Controls Over Financial Reporting and Federal Awards (Report #2011-167 - Dated March 2011)

Office of Program Policy Analysis and Government Accountability

The following reports were issued by OPPAGA during FY 2010-11:

- Progress Report - Legislature Clarified Responsibility for Educating Exceptional Students in Residential Facilities (Report #10-51 - Dated August 2010)
- Profile of Florida's Medicaid Home and Community-Based Services Waivers (Report #11-03 - Dated January 2011)
- State Agency Travel Costs Are Down; Some Options Remain to Further Reduce Expenditures (Report #11-14 - Dated March 2011)

Federal Department of Health and Human Services

During FY 2010-11 the Federal Department of Health and Human Services issued the following reports on Agency operations:

- Review of Concurrently Enrolled State Children's Health Insurance Program and Medicaid Beneficiaries in Florida From April 1, 2007 Through March 31, 2008 (Report #A-04-09-03046 - Dated 9/13/10)
- Review of Medicaid Funding for Emergency Services Provided to Nonqualified Aliens (Report #A-04-07-07032, Dated 9/14/10)
- Oversight and Evaluation of the FY 2008 Payment Error Rate Measurement Program (Report #A-06-09-00037, Dated 10/26/10)

Risk Assessment

Internal Audit staff performs a Risk Assessment of the Agency's programs and activities each year to assist in the development of the Annual Audit Plan. The Risk Assessment is a formal process that includes identification of activities or services performed by the Agency and evaluation of various "risk factors" where conditions or events may occur that could adversely affect the Agency. Activities assessed consist of each Bureau's critical functions that allow the Bureau to achieve its mission. Risk factors used to assess the overall risk of each core function include but are not limited to:

- The adequacy and effectiveness of internal control;
- Changes in the operations, programs, systems, or controls;
- Changes in personnel;
- Maintenance of confidential information;
- Dependency on systems maintained by the Bureau;
- Complexity of operations; and
- Dependency on other programs or systems, both internal and external to the Agency.

The assessment of the overall risk of each activity is accomplished by appropriate management and IA ranking the areas of concern in importance using the risk factors. The ranking of the activities is reviewed and evaluated. Meetings are held with management to discuss the ranking and to identify any additional areas of concern.

Audit Plan

IA has developed an Annual Audit Plan for the FY 2011-12. This plan also includes audit issues that will be addressed in FY 2012-13 and FY 2013-14. The audit plan includes activities that are to be audited or reviewed, audit and review schedules, budgeted hours and assignment of staff. Steps taken in developing the audit plan include:

- Performing a Risk Assessment to identify auditable activities and ranking each activity using established criteria to determine the relative significance of, and likelihood that, conditions or events may occur that could adversely affect the Agency;
- Reviewing and evaluating the auditable activities that rank the highest in risk and that could potentially adversely affect the Agency, its providers or health care recipients; and
- Meeting with Agency management and the Secretary to obtain feedback on these auditable activities and on any additional areas of concern.

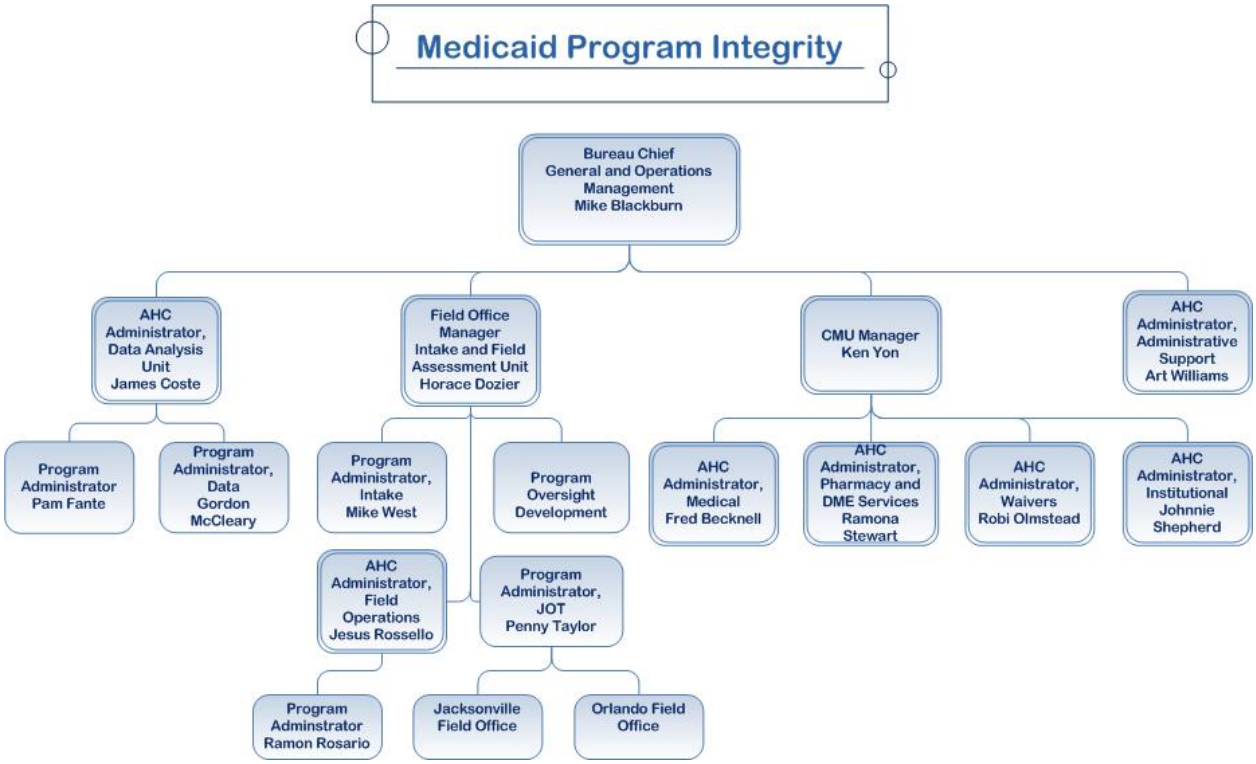
The audit plan was approved by the Agency Secretary and provides the most effective coverage of the Agency's programs and processes while optimizing the use of internal audit resources.

Medicaid Program Integrity

MPI Organization and Staff

The Bureau of Medicaid Program Integrity (MPI) is located within the Office of the Inspector General and is charged under Section 409.913, F.S., with preventing, detecting, auditing for fraud and abuse and initiating the recovery of overpayments in the Medicaid program that exceeds $20 billion in annual payments for goods and services. MPI conducts prepayment reviews and site visits as part of overpayment prevention efforts. It utilizes the Decision Support System (Data Warehouse), data mining tools and statistical analyses to detect possible overpayments. Computer-assisted analytical and statistical methods are used to audit Medicaid claims for possible overpayments. Upon completion of audits and any legal proceedings, amounts found to be due are referred to the Agency's Bureau of Finance and Accounting for collection.

The bureau has approximately 100 full time employees located in Tallahassee, Miami, Tampa, Jacksonville and Orlando and includes investigators, data analysts, nurses, pharmacists, physicians, programmers and administrative support personnel. The organizational structure is as follows:



Intake and Field Assessment Unit

All incoming referrals, whether from complaints, the hotline or Explanation of Medicaid Benefits (EOMBs) are the responsibility of the Intake Section. Staff performs an initial review of each referral to validate the information and determine the course of action required. EOMBs are mailed quarterly to Medicaid recipients listing the services received during the previous quarter. The recipients are asked to report any services they did not receive. The Intake Section follows up on each discrepancy. Providers are requested to void the claim if it is determined that the services were not provided. If a pattern of services not provided is noted, the provider will be referred to the appropriate case management unit (CMU) or to the Attorney General's Medicaid Fraud Control Unit (MFCU). Complaints received over the telephone or via the Internet may or may not be Medicaid fraud or abuse related. Non-MPI issues are forwarded to the appropriate agency for action. Any information regarding possible fraud or abuse is evaluated and, if substantiated, referred to the appropriate MPI unit or to MFCU for further investigation.

The Intake Section also monitors press releases via the Internet for any news relating to an investigation, arrest or conviction of a Medicaid provider. Providers found to be under indictment for activity relating to health care practices will be suspended from participation in the Medicaid program for the duration of the legal proceedings, and a conviction will result in termination. This past fiscal year, MPI imposed 24 suspensions and 13 terminations as a result of these monitoring efforts.

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

- Sanctioning
- Prepayment review
- Paid claims reversal
- Referral to MFCU
- Referral to an MPI case management unit
- Referral to other agencies
- Referral to self audit unit to initiate a provider self audit
- Termination recommendation

The Field Assessment Section also performs several field initiatives (focused projects) each year. These initiatives focus on simultaneous reviews of recipients, providers and prescribers and often include collaboration with state and federal partners such as the Division of Health

Quality Assurance, the Medicaid Division, the Department of Health, the Agency for Persons with Disabilities, MFCU and the Centers for Medicare & Medicaid.

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

Field office staff also participates in Operation Spot-Check visits throughout the state, which are managed by MFCU. Unannounced visits are made to nursing homes, assisted living facilities and licensed group homes. Operations of these facilities are reviewed to ensure that Medicaid policies and procedures are being met. If more action is needed, MPI pursues necessary remedies including prepayment reviews, records requests and referrals.

Field Office Initiatives

Final results of field initiatives will be reflected in *The State's Efforts to Control Medicaid Fraud and Abuse*, a report to the Legislature due by calendar year end. These initiatives resulted in sanctions, reversal of claims, referrals and placing providers on prepayment review.

October 2010 Home Health Prescriber Project

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

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

March 2011 DME Initiative-Project

This initiative targeted eleven durable medical equipment (DME) providers that are top billers for procedure code E1390 (Oxygen Concentrator) for dates of service from January 1, 2010, to February 25, 2011, in Miami-Dade/Broward Counties. Nine teams of investigators conducted

11 provider compliance site visits and interviewed 85 Medicaid recipients that received oxygen concentrators and additional medical equipment during the targeted review period.

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

Speech Therapy Miami Initiative

MPI Miami field office initiated a Speech Therapy Project in Miami-Dade and Broward counties to verify whether Speech Therapy services were rendered, documented and billed according to the Medicaid guidelines outlined in the *Therapy Coverage and Limitations Handbook*.

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

Data Analysis Unit

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

The Data Detection Section reviews detection reports and analyzes claims data. It develops leads for the case management units and works closely with MPI's Medicare partners to identify fraud and abuse issues related to claims paid by both entities. The section works with MFCU on data projects. Data Detection Section detects violations through various detection tools and methods. On the basis of apparent violations, investigations are conducted to determine whether overpayments exist. Recoveries of any overpayments are initiated or referrals to outside agencies are recommended. The Data Detection section utilizes various tools, resources and reports in an effort to identify Medicaid fraud and abuse activities.

MPI detection efforts include development of advanced detection software as well as use of software supplied by the fiscal agent contractor. Primary detection tools include DSS Profiler, First Health Pharmacy reports, Business Objects ad hoc reports, 1.5 reports, Chi-square upcoding reports, Early Warning System reports and the Medi-Medi project. Another tool used this year was social network analysis. Analysis of relationships between individuals, entities and regulatory agencies' data was used to identify Medicaid providers excluded by the federal government, excluded by other State Medicaid programs, or against whom DOH had taken

adverse action. These tools provide a means for analyzing Medicaid claims data and for detecting over-utilization and aberrant behavior. They result in referrals to MFCU and other regulatory agencies and in recommendations for termination of providers. Investigative leads are also produced for investigation by MPI's field staff and the CMU.

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

The RDU is the primary source for generalized analyses referrals in MPI. The section reviews previously successful generalized analyses for possible reproduction or expansion, meets regularly to discuss leads from the CMUs and Data Detection Section, analyzes policy to identify possible violations and develops and monitors requests for generalized analyses programming for assignment to the CMUs. It also provides additional programming support to MPI on complex issues. The section guides providers in performing self audits for overpayments due to Medicaid abuse or mistake and is responsible for coordinating all Medicaid policy clarifications for MPI through Medicaid Services. And, it serves as MPI's contact point for overpayment recovery projects performed by the third party liability vendor, ACS.

Case Management Unit

CMU identifies misspent Medicaid funds by performing comprehensive audits and generalized analyses. Once providers have been selected for audit, statistical methodology is used in the generation of a random sample of claims. After a review of provider documentation, if an overpayment is determined for the sampled claims, the sample findings are extrapolated or extended to the population of claims for the time period under review. The statistical methodology for determining the total overpayment utilizes the 95 percent confidence level and has been affirmed in administrative hearings.

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

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

The CMU also serves as the Bureau's point of contact for the Federal Audit Program. CMS created the Medicaid Integrity Group (MIG) to carry out the program. CMS has also established contracts with private firms referred to as Medicaid Integrity Contractors (MICs) to conduct the audit program. The three primary MIC functions are:

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

CMU 2010-11 Highlights

A Medicaid Home and Community-Based Services waiver provider was identified from a quality assurance contractor review that found the provider lacked appropriate documentation to support the services billed to Medicaid and failed to have the required Level II Background Screening performed on direct service staff. MPI reviewed claims from January 2007 through December 2008. The allegations were substantiated and a final audit report dated October 12, 2010 reflected an overpayment of $340,845.75, costs of $788.85 and a fine of $2,500. The Medicaid provider contract was terminated in December 2010. A Final Order was issued in January 2011. A lien has been placed on any Medicaid payments and the Bureau of Medicaid Accounts Receivable is pursuing collection.

Following their audit, a Managed Care Organization (MCO) notified MPI that there was an allegation of billing for services not rendered against a pharmacy provider. The Pharmacy Case Management unit opened a case on the provider, located in Miami, Florida. A review of the provider's purchase/acquisition records for a one-year period revealed a shortage of drugs available to support the payments made to the provider by Florida Medicaid for all 25 of the drugs that were reviewed, with an overpayment identified of $444,193.49. Additionally, a fine of $5,000.00 was applied. As of November 2010, the fine has been paid and $175,000.00 of the overpayment has been collected. The provider was referred to the Medicaid Fraud Control Unit. When only partial payment was collected and no payment arrangements were made, the provider was terminated by the Medicaid program.

A Medicaid pediatric physician located in Hollywood, Florida, was identified for inaccurate billing of Evaluation and Management (E&M) codes. A review of the provider's claims from January 2008 through May 2009 identified three areas of concern, including upcoding, no documentation of services billed and billing for laboratory services that are to be included in the routine office visit. A Final Audit Report was completed in March 2011, with an identified overpayment in the amount of $314,837.13, a fine of $3,000.00, and cost in the amount of $1,160.25. The provider paid the overpayment and identified sanctions and cost in full. The Final Order was filed in May 2011.

Pursuant to Section 409.913 (19), F.S., MPI conducted a follow-up review of the unborn activation and enrollment process. A previous audit of this process was conducted by MPI for dates of service of July 1, 1996 – June 30, 2000. In that project, it was determined that the Health Maintenance Organizations (HMOs) failed to fully implement the enrollment and activation process. The recently completed audit reviewed dates of service of July 1, 2004 through December 31, 2007 and found noncompliance. The failure of the plans to produce documentation related to the unborn enrollment process, even to the demonstration of a "good faith effort," was a key observation in this audit. Subsequent litigation resulted in the recovery of $13,195,869.41.

Managed Care Activities

During FY 2010-11 MPI was involved in two major CMU/Generalized Analysis projects relating to managed care that resulted in recovery of overpayments. The first was a "Newborn Rate Reconciliation" project that resulted in the return of $20,031,041 in overpayments created when capitation payments were made using an incorrect rate.

The second was the culmination of a project related to HMO use of the unborn activation process (a process to pre-register babies before they are born so that their HMO coverage and related capitation payments can begin at birth). This project resulted in contractual assessments totaling $11,137,903 along with $2,057,966 for investigative costs incurred by the Agency, for a total of $13,195,869 in recovered dollars.

The Agency has over $9 billion obligated in 24 contracts with managed care organizations (18 contracts with HMOs and six contracts with PSNs). MPI's two FTEs and one full-time OPS staff dedicated to managed care conducted 12 onsite surveys of health plans to ensure contract compliance with contract fraud and abuse provisions. In addition to the 24 managed care contracts mentioned above, staff began working more intensively with the Agency's six Pre-Paid Mental Health Plans (PMHPs) in terms of reviewing their antifraud policies and procedures, annual fraud and abuse reports and assisting Medicaid staff in aligning the fraud and abuse provisions in those contracts with provisions in the HMO and PSN contracts. MPI staff also conducted two onsite investigations, reviewed two applications from new health plans, conducted on-going review of anti-fraud policies and procedures from all health plans

and moved into full implementation of an automated, web-based Quarterly Fraud and Abuse Activity Reporting (QFAAR) system through which health plans report the fraud and abuse case activity of their Special Investigations Units.

The table below presents a profile of the average case reported by the health plans by type of allegation (drawn from QFAAR data for SFY 2010-2011). Similar to last year, the top three primary allegations against providers continued to be for a pattern of overstated claims (upcoding), billing for services not rendered and billing for excessive services.

Average Quarterly Count of Managed Care Cases by Primary Allegation	
Provider	**AVG**
Pattern of overstated reports (upcoding).	76
Billing for services not rendered.	46
Billing excessive services.	23
Other, not operating within Medicaid guidelines	14
Billing for services that are medically unnecessary.	13
Pattern of unbundling services.	12
Overcharging for services that are provided.	9
Charging enrollees for covered services.	7
Failing to render medically necessary services	6
Federally Excluded Provider	6
Misrepresenting medical information to justify referral.	4
Pattern of falsified encounter or service reports.	3
Altering, falsifying, or destroying clinical record documentation.	3
Prior Authorization -- Provider billing for non-covered/unauthorized services.	1
False statements related to credentials.	1
Kickbacks	1
Enrollee	0
Eligibility Issues	21
Inappropriate use of Medicaid ID#.	6
Forgery of prescriptions.	5
Other (not elsewhere specified)	116

Additionally, MPI staff continued to conduct work related to the implementation of s. 409.91212, F.S., whereby health plans are required to submit anti-fraud plans for review and approval by MPI, including any anticipated subcontracts let by the health plans for investigative services. Staff also compiled results of the new Annual Fraud and Abuse Activity Report (AFAAR) that is due annually on September 1. Results from the first AFAAR, which

covered FY 2009-10, reflected some recoveries made by the health plans. It is expected these numbers will rise as reporting by the health plans is refined and recoupment barriers identified.

Health Plan Reported Annual Fraud and Abuse Activity Report
Report Due Date: September 2010 for FY 2009-10

Overpayments Identified for Recovery[1]	*Overpayments Recovered*[2]	*Dollars Identified as Lost to Fraud and Abuse*[3]	*Dollars Lost to Fraud and Abuse That Were Recovered*[4]
$9,626,029	**$4,624,358**	**$5,225,173**	**$248,561**

Table Notes:

[1] Overpayments identified for recovery include dollars lost to fraud and abuse, as well as dollars overpaid as a result of systems or claims processing errors. These dollars are reported if they were identified during the fiscal year being reported, FY 2009-10.

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

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

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

This year the legislature passed major reforms that enacted the beginning of what, with federal approval, will be a statewide transformation of Medicaid to a managed care model. The anticipated timeline includes full transition of Medicaid recipients in long term care to managed care by October 1, 2013, and the remainder of the population (excluding some waivers) by October 1, 2014. In anticipation of a statewide shift to managed care, the OIG has developed legislative budget requests for additional staff dedicated to oversight of managed care from a fraud and abuse perspective.

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

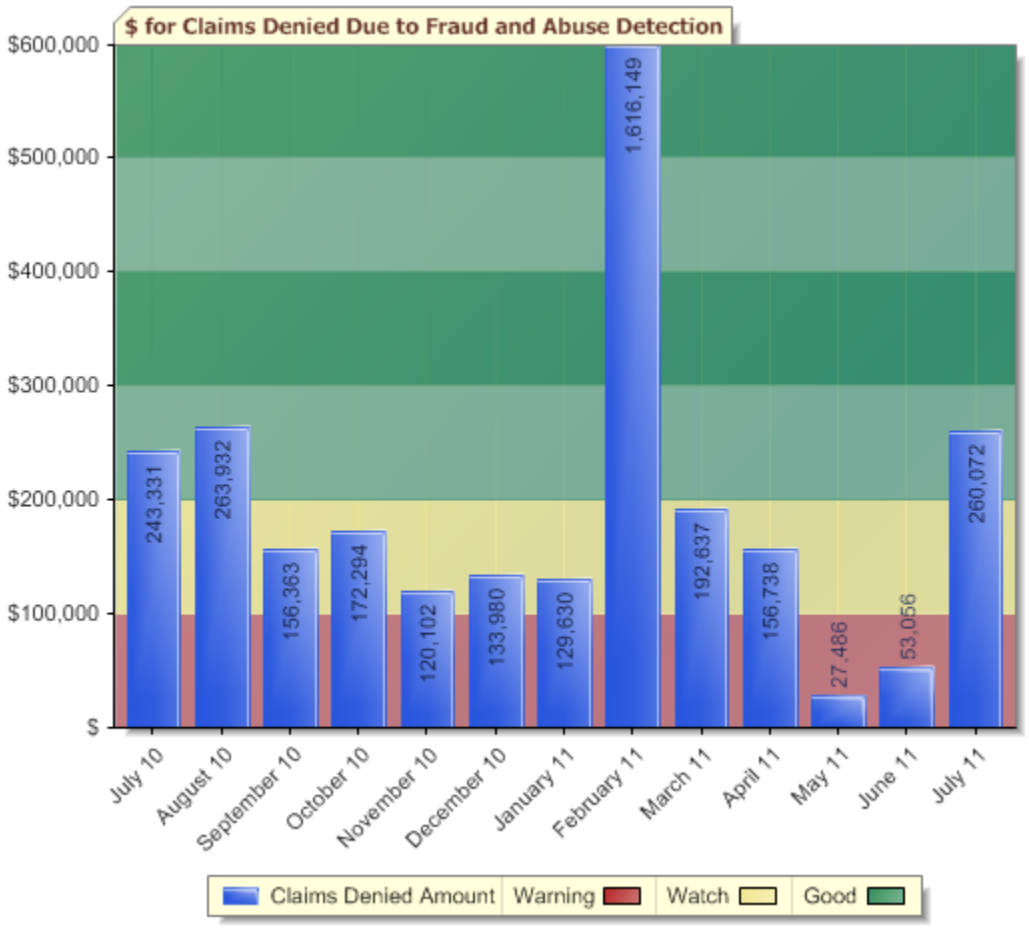
- Increasing the effectiveness of program integrity functions including, but not limited to, prevention, detection and recoupment processes;
- Promoting the sharing of information across bureaus, divisions, and agencies as needed in order to reduce workload and eliminate duplicative processes; and,
-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

The Managed Care Fraud and Abuse Subcommittee set several goals to be pursued through at least the next fiscal year. These goals include completion of an analysis of information systems relevant in preventing and detecting corporate-level fraud and abuse, (e.g., business practices

intended to inappropriately delay or discourage access to care and encourage disenrollment of unhealthy members, fraudulent reporting, exploitation of system and policy vulnerabilities, or any other practices resulting in unauthorized benefits to the health plan and unnecessary costs to the Medicaid program.) Additionally, the Subcommittee's overarching goals include developing new, and streamlining existing processes to prevent and detect corporate-level fraud and abuse; ensuring managed care organizations maintain robust anti-fraud programs; and staying abreast of industry standards applicable to Florida's efforts in auditing and monitoring fraudulent activity in managed care organizations.

Results

MPI performance measures are posted monthly on the Agency's Internet site and include claims denied, the identification and collection of overpayments on closed cases, and referrals. (*Click here to go to Agency Dashboard* or go to http://apps.ahca.myflorida.com/dashboard. Below is an example of the type of information available on the dashboard.



Prevention

Prevention efforts enhance the efficiency of the Medicaid program. Ensuring Medicaid claims are appropriate prior to issuing payments prevents unnecessary expenditure on recovery efforts and allows Medicaid funds to be used as intended. Prevention efforts by MPI include prepayment reviews, site visits, focused projects, denial of reimbursement for prescription drugs, policy change recommendations and field initiatives.

Prepayment Reviews encompass the examination of claims associated with intercepted payments and the evaluation of pended claims. Intercepted payments are payments for Medicaid claims that have been processed for payment but the payment has not yet been sent to the provider. Pended claims have not yet been processed for payment. Both types of claims may undergo a prepayment review. A provider must submit supporting documentation for claims under prepayment review so MPI can determine whether to pay or deny the claim.

Cost savings for prepayment reviews are calculated based on funds that would have been paid had the prepayment review not occurred. For intercepted payments, the amount avoided is the amount of the reduction in the payment to the provider. The full amount of the reduction is considered cost avoided, because the claim has been through the Medicaid system edits. For pended claims denied, the cost-avoided amount is the billed amount less the proportion of the billed amount that would have been denied due to system edits.

Referrals

The Agency for Health Care Administration and the Medicaid Fraud Control Unit of the Attorney General's Office continued their joint efforts to prevent, reduce and mitigate health care fraud, waste and abuse in Florida. Staff members from the Agency, MFCU and DOH meet regularly to discuss major issues, strategies, joint projects and other matters concerning health care.

Any suspected fraud is referred to MFCU for full investigation and prosecution. The Agency and MFCU continue to refine that referral process and continue to collaborate closely with each other and with DOH, the Division of Public Assistance Fraud, the Department of Children and Families and CMS to assure that Medicaid funds are utilized for those most vulnerable, as intended.

Referrals for FY 2010-11

Referred to:	Number
Department of Health	80
Division of Public Assistance Fraud	20
Division of Health Quality Assurance	58
Division of Medicaid	41
Medicaid Fraud Control Unit	80
Others	306
Totals	**585**

Summary of MPI Investigation and Recovery Activities

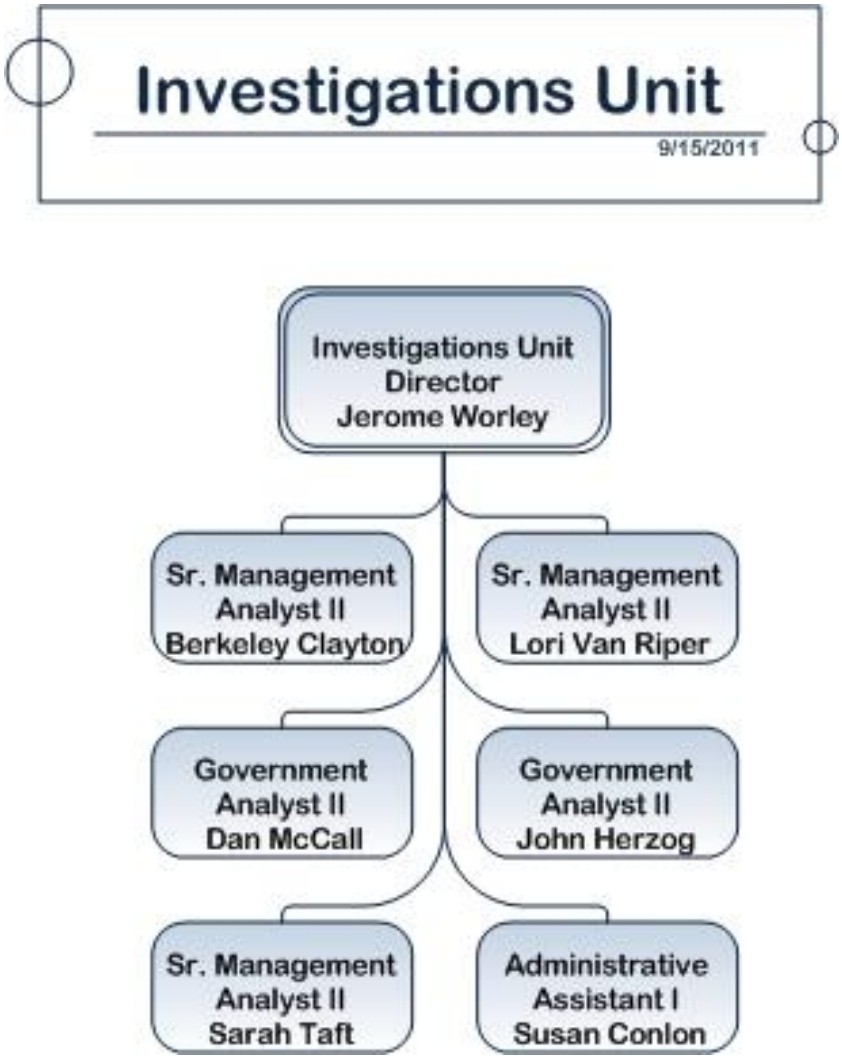
Through its investigative and recovery efforts MPI performs comprehensive audits involving reviews of professional records, generalized analyses involving computer-assisted reviews of paid claims pursuant to Medicaid policies, paid claims reversals involving adjustments to incorrectly billed claims and focused audits involving reviews of certain types of providers in specific geographic areas, as well as referrals to MFCU and other regulatory and enforcement agencies. Recovery activities include: MPI-conducted audits, fines, costs, collections on contract issues, paid claims reversals and denied claims initiated by MPI and vendor-assisted claims adjustments, such as the Third Party Liability (TPL) audits overseen by MPI.

Preliminary results of MPI activities for the fiscal year ended June 30, 2011, are as noted below. Final recovery results and details will be reported January 1, 2012, in *The State's Efforts to Control Medicaid Fraud and Abuse* submitted to the Legislature by the Agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs as required under Section 409.913, Florida Statutes.

MPI Recovery Activities (Millions) Preliminary Information from Closed Cases in FY 2010-11				
Activity				**Amount**
MPI Audits (Identified Overpayments)				$20.3
Fines – Sanction Rule				1.0
Costs				1.5
Collections on Contract Issues				10.8
Paid Claims Reversals (including Contract Issues)				18.3
TPL Contractor Assisted Claims Adj.				30.0
Total				**$81.9**

Internal Investigations Unit

Internal Investigations Organization and Staff



Investigations Function

The Office of the Inspector General (OIG), Investigations Unit (IU) is responsible for initiating, conducting and coordinating investigations that are designed to detect, deter, prevent and eradicate fraud, waste, mismanagement, misconduct and other abuses within the Agency for Health Care Administration (Agency). To that effort, the IU conducts internal investigations of Agency employees and contractors of alleged violations of policies, procedures, rules and Florida laws. Complaints may originate from the Office of the Chief Inspector General, the Whistleblower Hotline, the Chief Financial Officer's "Get Lean" Hotline, Agency employees, health care facilities, practitioners or the general public. Investigations conducted by the IU

may include alleged violations of Agency standards such as unprofessional conduct, unauthorized disclosure of confidential information, theft or misuse of property, records or documents, violation of the nepotism policy and falsification of records. Allegations of a criminal nature are referred to the appropriate law enforcement entity. When necessary or requested, the IU works closely with the local police, the Florida Department of Law Enforcement, the Attorney General's Office, the Office of the Chief Inspector General and the appropriate State Attorney's Office. The IU team includes four nationally certified inspector general investigators, four federally certified Equal Employment Opportunity investigators, one current auxiliary police officer, four former law enforcement officers, a data analyst with a background in the Florida Medicaid system and an administrative assistant. The IU also serves as support to the anti-fraud and abuse efforts of the Agency by addressing complaints of fraud and abuse, conducting field initiatives and assisting in the recoupment of Medicaid dollars.

In FY 2010-11, the IU assigned 153 case numbers to complaints or concerns that were reported or generated by this office. Investigations that resulted in published investigative reports were distributed to the leadership responsible for the employee or program investigated for appropriate personnel action or recommended policy changes. The published reports were also presented to the Agency Secretary and to the Agency Management Team (AMT) in regular briefings.

The following are examples of internal investigative reports published during FY 2010-11. A complete list of cases for this reporting period is included at the end of this section.

Internal Investigation 10-080

An Agency employee was alleged to have acted unprofessionally in a regulated facility. This allegation was founded.

The OIG received a written complaint from a health care facility regulated by the Agency. The complaint alleged that a Health Quality Assurance (HQA) Facility surveyor made inappropriate comments of a sexual nature to a nurse manager during an onsite inspection. During the investigation, information was obtained that the HQA employee demonstrated how flammable peat moss can be and then ignited the material he placed in a can on a patio deck attached to the facility. The HQA employee denied making any unprofessional comments and admitted to the moss demonstration. A review of past disciplinary actions against the employee revealed a pattern of similar unprofessional behavior. The unprofessional conduct was sustained by credible witness interviews, partially confirmed by the employee's own admission to using the word "attractive," and was similar to previous inappropriate conduct substantiated in AHCA OIG 07-028. The HQA employee's conduct was unbecoming and brought discredit upon the Agency. The employee was found to be in violation of the Agency's Ethics and Political Activities Policy # 01-HR-55: and Section 60L-36.005 (f), FAC: - Conduct Unbecoming a Public Employee and resigned during the internal investigation.

Internal Investigation 10-101

An Agency employee was alleged to have sexually harassed his subordinate employee. This allegation was founded.

The IU received a written complaint from an Agency analyst that alleged her supervisor made unwanted sexual advances and created a hostile work environment. Interviews with the complaintant and four other Agency employees in the same unit confirmed that the supervisor made inappropriate comments, of a sexual nature, while in the workplace. Review of the supervisor's previous employment record from another state agency revealed similar allegations and disciplinary action. The supervisor admitted the inappropriate behavior during an interview with OIG staff and was terminated by management.

Internal Investigation 10-116

Agency Survey Teams were alleged to have failed to address concerns from a citizen during four facility surveys. This allegation was unfounded.

The IU received a citizen complaint that was forwarded from the Office of the Governor, alleging that their family member received poor treatment while in four different nursing home facilities. Health Quality Assurance (HQA) completed four separate surveys and four Quality Assurance Review Reports (QA's). The OIG reviewed all survey documents and the QA Reviews and interviewed HQA staff. There was no evidence obtained or reviewed to substantiate the allegations.

Internal Investigation – 10-136

An Agency employee and her supervisor alleged racial discrimination and hostile work environment. These allegations were unfounded.

An Agency employee alleged that she applied for a promotion within her unit and was denied the promotion because of race discrimination. She also alleged that she was retaliated against and subjected to a hostile work environment for filing a discrimination complaint. The employee further alleged that management in her unit violated the Agency's recruitment and hiring policy and violated the performance evaluation rules. Her immediate supervisor subsequently alleged that management failed to follow performance evaluation rules, retaliated against him and subjected him to a hostile work environment for supporting the employee he supervised. All of the allegations were found to be unsubstantiated.

Internal Investigation 10-141

An Agency employee allegedly provided the HQA survey schedule to a facility for $500, the facility allegedly failed to obtain the proper approvals from the AHCA Office of Plans and Construction for remodeling and allegedly the facility was understaffed. These allegations were partially founded.

The IU received a complaint from a former assistant administrator at a nursing home facility, stating that the facility had a contact at the Agency who provided the survey schedule to the facility owner for a payment of $500. The former administrator reported several improvements to the facility were completed without Agency approval or required permitting, and that routine staffing shortages caused medication errors. This investigation was completed with the assistance of Health Quality Assurance (HQA) and the AHCA Office of Plans and Construction. The OIG completed an extensive site visit to the Agency Area Office, the facility and Office of Plans and Construction. There was no evidence to corroborate that the Agency survey schedule was sold to the facility. Subsequently, HQA Management completed steps to improve the confidentiality of the survey schedule and updated the method in which the survey schedules are developed for future use. The investigation revealed the nursing facility failed to obtain the required review for the renovation of a bathroom, in violation of section 395.0163(1) (a), F.S.: Construction inspections; plan submissions. However, the room was inspected by an HQA Survey Team and found no violations under Agency policy or federal regulation with the renovated room.

Internal Investigation 10-142

Agency HQA Surveyors allegedly failed to properly investigate complaints. This allegation was unfounded.

It was also alleged that the facility failed to provide quality care, violated patient rights and failed to train staff. These allegations were founded.

The IU received a citizen complaint forwarded from the Office of the Chief Inspector General alleging that her family member received questionable care at an assisted living facility. OIG staff referred the complaint to HQA. HQA completed seven site surveys and two Quality Assurance Reviews to address all the concerns outlined in the complaint. In addition, HQA conducted follow-up surveys in an effort to insure compliance within the facility and continued to find violations during all surveys and follow-up surveys. OIG reviewed all the related survey reports and notes; interviewed the complainant and other concerned family members (including interviews with HQA management); and confirmed the allegations against the facility. HQA management reported that the Agency is pursuing legal action against the facility in addition to sanctions and fines already imposed due to the facility's continued non-compliance. There was no evidence obtained or reviewed to substantiate that HQA staff failed

to properly and thoroughly address the complaint. The investigation revealed that HQA continued to be vigilant in addressing the concerns as documented in the seven HQA survey reports.

Internal Investigations – 11-016

A former Agency employee filed complaints with the Federal Equal Employment Opportunity Commission (EEOC) and the Florida Commission on Human Relations (FCHR) alleging he was terminated during his probationary status based on his age and gender. This allegation was unfounded. The former employee was hired November 30, 2009, as a Registered Nurse Specialist (Surveyor). In his specific position, he performed duties for three different supervisors, depending on the type of facility being surveyed. His employment was terminated on November 10, 2010, for failure to successfully complete the one year probationary period. The supervisors and the field office manager determined that he was unable to satisfactorily perform his job duties without assistance after almost a year. In collaboration with the other supervisors and the field office manager, his supervisor prepared a fourteen page document chronologically listing deficiencies in the former employee's job performance. After obtaining the required approvals, his employment was terminated on November 10, 2010.

The former employee then filed a complaint with the Florida Commission on Human Relations (FCHR) and the Equal Employment Opportunity Commission (EEOC) alleging that his employment was terminated because of his age and gender and that he was not provided training on how to perform his job duties.

Evidence demonstrated that the former employee was provided a considerable amount of orientation and training. The former employee's supervisor documented that the only training he was not allowed to attend was Long Term Basic training because the supervisors and Field Office Manager believed that he had not progressed sufficiently in learning the Long Term Care process to attend. No evidence was found to show that the former employee was terminated because of his age or gender. Deficiencies in the former employee's job performance were well documented as was the orientation and training provided to him.

In-house Fingerprinting

Agency employees are required to be fingerprinted when they are hired and then every five years thereafter for background screening. The IU has an established in-house fingerprinting station, managed by an IU Investigator who is an auxiliary police officer, enabling employees to be fingerprinted at headquarters without having to travel to a local law enforcement agency during working hours. This program produced a cost savings of approximately $32,569 and received Honorable Mention as a team achievement in 2010 from the Prudential-Davis Productivity Awards program. The IU fingerprinted 88 employees in FY 2010-11.

Fraud and Abuse Efforts

The IU's fraud and abuse efforts included assisting the Bureau of Medicaid Program Integrity (MPI) and generating cases from data claims and citizen complaints. The IU utilized the strengths of investigators with law enforcement experience coupled with the skill set of a data analyst to accomplish their goals. These focused investigations included the use of data analysis, witness interviews and the collection of physical evidence. During FY 2010-11, the IU opened 119 fraud and abuse files and made 11 referrals for action by other agencies to include the Medicaid Fraud Control Unit (MFCU) for potential criminal investigation. The IU identified and recovered $389,153 in overpayments. Additionally, the IU supported MPI in larger field initiatives to verify services ranging from the home health providers to durable medical equipment providers. This section of the report contains details of investigations initiated in previous fiscal years with the final disposition being determined during this reporting period.

Top Atypical Anti-Psychotic Medicaid Prescribers

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

Two Physician Prescribers in Miami-Dade County

These two prescribers' disbursements for Medicaid prescriptions in 2009 totaled $3.4 million and $2.4 million. The IU conducted onsite investigations of both physicians' clinics, attempted interviews with 54 of their Medicaid recipients and completed 28 recipient interviews. Ninety percent of all recipients interviewed could not produce their anti-psychotic medications for IU investigators and the majority of recipients interviewed utilized the same two pharmacies for their medications. The IU requested and collected 50 recipient medical records for peer review to determine medical necessity. The peer review revealed a pattern of poor documentation and questionable medical necessity, as well as claims for recipient clinic visits with a physician when the documents revealed the patients actually met with a nurse practitioner or a physician assistant. The IU made referrals to the Agency's Division of Health Quality Assurance, the Office of the Attorney General's Medicaid Fraud Control Unit (MFCU), the Florida Department of Health and other federal agencies. In addition, one physician was terminated from the Florida Medicaid Program. These referrals are still active investigations.

The IU compared encounter data submitted by one of the contracted providers in Miami for Pre-Paid Mental Health Services with the correlating Medicaid recipient files. During this review, the IU found discrepancies in the data submitted by the contract provider, the recipient files and the cost actually paid to the sub-contracted mental health provider. Further

investigation revealed the encounter data submitted by the contract provider and other mental health HMO providers conflicted with the signed contracts in effect and appeared to be in violation of Section 409.912(4)(b), F. S., that states in part, "If the managed care plan expends less than 80 percent of the capitation paid for the provision of behavioral health care services, the difference shall be returned to the agency." Preliminary review of this matter indicated that several claims exceeded the contracted amount and the 80/20 submission and appeared to be consistently adjusted to increase direct care services by ten percent to be in compliance with the 80/20 rule. The electronic analysis revealed that of the one million plus encounters in the 80/20 data, approximately 9,000 did not contain mandatory reporting information. The data demonstrated a significant amount of encounters that were submitted, voided and then resubmitted at a higher dollar amount for unknown reasons, but were consistently a 10 percent increase in reported cost. This investigation was referred to MFCU for consideration and continues to be an active investigation.

Central Florida Atypical Anti-Psychotic Prescriber

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

Plea Agreement - Radiological and Diagnostic Imaging Review

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

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

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

A second physician was referred to the Florida Department of Financial Services. The physician was arrested for participating in a scheme to defraud private automobile insurance companies by participating in a staged automobile accident clinic. The physician was receiving kickback

monies for signing treatment forms for persons falsely claiming to be injured in automobile crashes. The physician was charged with Insurance Fraud and Grand Theft.

South Florida Dentist

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

Central Florida Home and Community Based Waiver Provider

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

Medicaid Project AIDS Care (PAC) Waiver

In January 2011, The IU received a complaint from an Agency Area Field Office staff member who stated a Medicaid Project AIDS Care (PAC) Waiver Recipient had reported that a pharmacy employee solicted his business by offering him gift cards. The gift cards were to be received in exchange for the recipient agreeing to use the pharmacy exclusively to fill his HIV medications. The Medicaid recipient was upset that his confidential information was used or shared without his consent. The IU completed two site visits to obtain additional information and investigated the allegations as well as contacted Medicaid recipients in the PAC Waiver program. The IU verified that Medicaid PAC Waiver recipients were solicited for their business with offers of gift cards, elimination of co-payments, delivery of services and that the pharmacy staff contacted other PAC Waiver providers attempting to obtain recipient information (telephone and addresses) without the consent of the recipient. This case was referred to MFCU, where it was combined with another case that remains an active investigation.

List of Cases for FY 2010-11

Case No.	Case Type	Allegation	Disposition
10-073	PI	Alleged racial discrimination	Referred to DOH
10-074	PI	Alleged lack of medical service	Unfounded
10-075	PI	Alleged hiring policy violations	Unfounded
10-076	RF	Alleged conduct unbecoming	Referred to supervisor
10-077	PI	Alleged fraud	Unfounded
10-078	IN	Alleged investigation by MPI is flawed	Unfounded
10-079	PI	Alleged fraud	Unfounded
10-080	IN	Alleged misconduct of a public employee	Founded
10-081	MR	Alleged unwarranted termination	Referred to Legal
10-082	PI	Alleged employee had criminal record	Reviewed
10-083	PI	Alleged conduct unbecoming	Referred to management
10-084	PI	Alleged financial fraud	Unfounded
10-085	IN	Alleged conduct unbecoming	Unfounded
10-086	NF	Alleged fraud	Unfounded
10-087	PI	Alleged poor customer service	Resolved
10-088	RF	Alleged lack of patient care	Referred to HQA CAU
10-089	PI	Alleged overbilling	Resolved
10-090	IN	Alleged prescription fraud	Reviewed
10-091	PI	Alleged Medicaid fraud	Referred to DOH and US Dept HHS
10-092	PI	Alleged inadequate services	Referred to DCF
10-093	RF	Alleged improper patient care	Referred to HQA
10-094	PI	Alleged conduct unbecoming	Referred to management
10-095	IN	Alleged HIPAA violation	Founded
10-096	PI	Alleged standard of care violation by a hospice	Reviewed

Case No.	Case Type	Allegation	Disposition
10-097	PI	Alleged Pharmacy owes reimbursement	Resolved and Closed
10-098	PI	Alleged misuse of State funds	Previously reviewed by MFCU
10-099	PI	Alleged abuse and Medicaid fraud	Reviewed
10-100	IN	Alleged defamation of character / harassment	Unfounded
10-101	IN	Alleged sexual harassment	Founded
10-102	PI	Alleged unlicensed activity	Referred to Medicare
10-103	PI	Alleged fraudulent billing/Pill Mill	Reviewed
10-104	PI	Alleged lack of patient care	Unfounded
10-105	IN	Alleged sexual harassment and hostile work environment	Founded
10-106	PI	Alleged lack of Medicaid service	Unfounded and Closed
10-107	RF	Alleged unsanitary operating room	Referred to HQA CAU
10-108	PI	Alleged school district health issues	Referred to Medicaid Services
10-109	PI	Alleged falsification of building codes	Referred to HQA
10-110	PI	Alleged home health care fraud	Reviewed
10-111	PI	Alleged overpayment	Reviewed
10-112	PI	Alleged identity theft	Referred to Attorney General
10-113	PI	Alleged unlicensed operations	Referred to MFCU
10-114	PI	Alleged fraud	Reviewed
10-115	RF	Alleged conduct unbecoming	Referred to management
10-116	PI	Alleged AHCA review not thorough	Unfounded
10-117	PI	Alleged unfair restrictions placed on facility	Unfounded
10-118	RF	Alleged public assistance fraud	Referred to DCF IG
10-119	PI	Alleged Medicaid fraud	Not Medicaid provider
10-120	RF	Alleged unlicensed activity	Referred to HQA

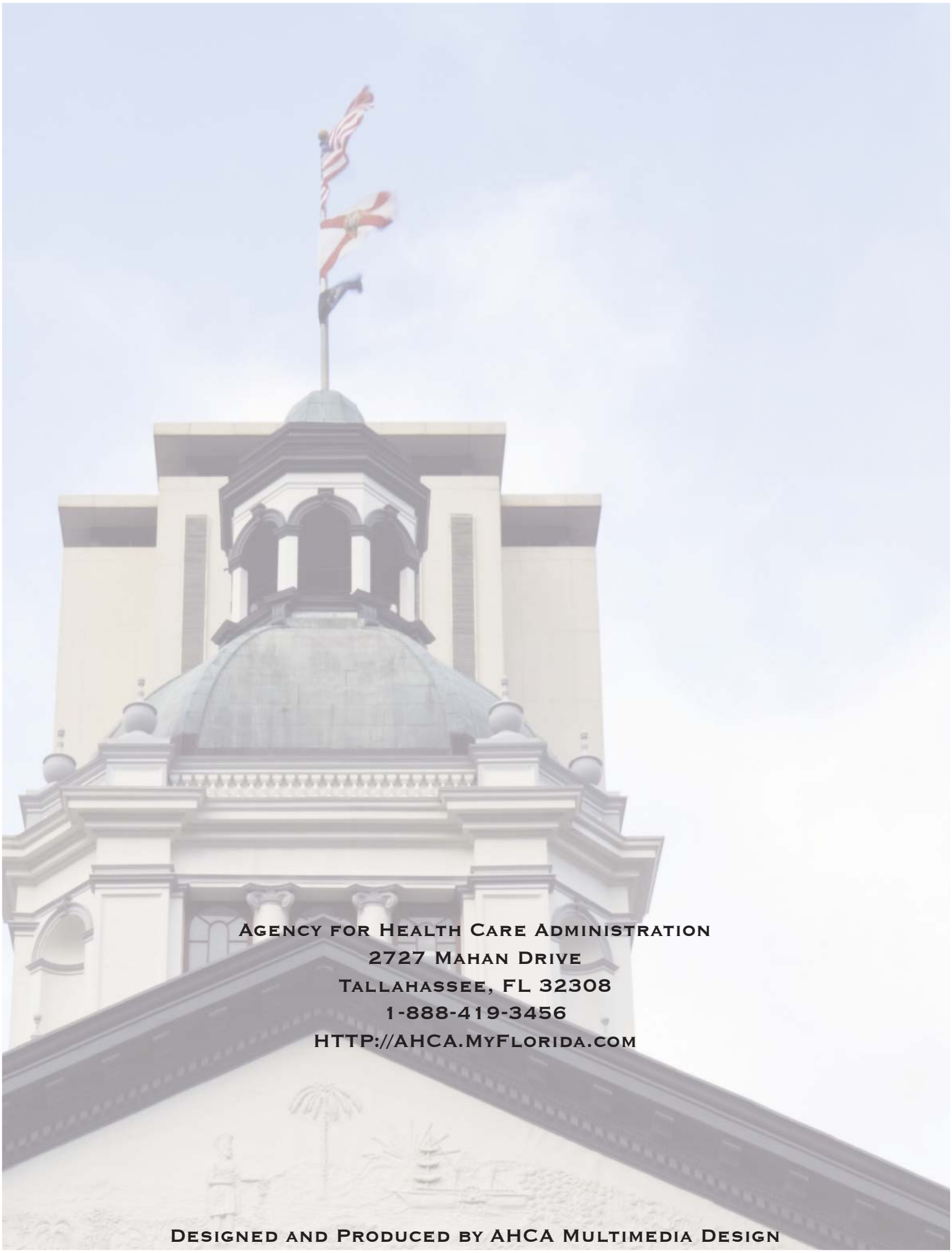
Case No.	Case Type	Allegation	Disposition
10-121	RF	Alleged conduct unbecoming	Referred to HR
10-122	PI	Alleged fraud	Unfounded
10-123	PI	Alleged Agency contractor was non-responsive to complaint	Unfounded
10-124	PI	Alleged employee conduct unbecoming	Unfounded
10-125	PI	Alleged wrongful termination	Unfounded
10-126	RF	Alleged inadequate patient care	Unfounded
10-127	PI	Alleged lack of patient care	Unfounded
10-128	PI	Alleged doctors of inadequate patient care	Unfounded
10-129	PI	Alleged patient identity theft / fraud	Unfounded
10-130	PI	Alleged fraud	Unfounded
10-131	PI	Alleged lack of service	Unfounded
10-132	PI	Alleged improper discharge of patient	Founded
10-133	PI	Alleged program issues	Unfounded
10-134	PI	Alleged concealing of radiographic images	Referred to DOH
10-135	PI	Alleged unlicensed medical activity	Referred to DOH
10-136	IN	Alleged discrimination	Unfounded
10-137	RF	Alleged medical insurance fraud	Referred to Third Party Liability
10-138	PI	Alleged violation of patient rights	Unfounded
10-139	PI	Alleged flawed survey at facility	Unfounded
10-140	IN	Alleged misconduct	Unfounded
10-141	IN	Alleged bribery and kickbacks	Partially Founded
10-142	IN	Alleged lack of patient care, abuse and kickbacks	Founded and Unfound
10-143	PI	Alleged abuse of residents	Unfounded
10-144	PI	Alleged fraudulent prescriptions	Unfounded
10-145	PI	Alleged employee abuse and lack of patient care	Unfounded

Case No.	Case Type	Allegation	Disposition
10-146	IN	Alleged conduct unbecoming	Founded and Unfound
10-147	PI	Alleged lack of patient care	Unfounded
10-148	NF	Alleged Medicaid billing error	Resolved
10-149	PI	Alleged patient abuse	Unfounded
11-001	PI	Alleged forgery	Unfounded
11-002	PI	Alleged ethics violation	Unfounded
11-003	PI	Alleged conduct unbecoming	Unfounded
11-004	PI	Alleged failure to provide employee training	Reviewed
11-005	PI	Alleged violation of the Stark Act	Not Medicaid provider
11-006	PI	Alleged inadequate service	Referred to Medicaid Area 10
11-007	PI	Alleged conduct unbecoming	Unfounded
11-008	PI	Alleged threatening telephone call	Referred to police
11-009	PI	Alleged FL Kid Care insurance problems	Resolved
11-010	IN	Alleged civil rights violations	Unfounded
11-011	RF	Alleged mismanagement / illegal acts	Referred to HQA
11-012	PI	Alleged HIPAA violation	Referred to MFCU
11-013	PI	Alleged extortion	Referred FDLE
11-014	PI	Alleged disclosure of pending AHCA survey	Unfounded
11-015	RF	Alleged poor work performance	Referred to HR
11-016	IN	Alleged discrimination based on age	Unfounded
11-017	IN	Alleged misrepresentation of data	Referred to MFCU
11-018	PI	Alleged violations at nursing home	Resolved
11-019	PI	Alleged false financial affidavit	Unfounded
11-020	PI	Alleged failure to compensate for services	Reviewed
11-021	IN	Alleged kickbacks	Unfounded
11-022	IN	Alleged inadequate patient care	Pending

Case No.	Case Type	Allegation	Disposition
11-023	IN	Alleged employee favoritism	Unfounded
11-024	PI	Alleged fraud	Referred to HQA
11-025	IN	Alleged disclosure of pending survey	Unfounded
11-026	PI	Alleged mismanagement	Unfounded
11-027	RF	Alleged quality of care violations	Referred to HQA
11-028	IN	Alleged fraud	Pending
11-029	PI	Alleged fraud	Referred to Pharmacy
11-030	PI	Alleged employee conducted personal business during Agency work hours	Reviewed and Resolved
11-031	PI	Alleged poor quality of care	Reviewed
11-032	PI	Alleged prescription fraud	Unfounded
11-033	RF	Alleged fraud	Referred to DOH
11-034	IN	Alleged unlicensed activity	Pending
11-035	IN	Alleged conduct unbecoming	Referred to management
11-036	PI	Alleged hiring practice violations	Unfounded
11-037	IN	Alleged patient endangerment	Pending
11-038	RF	Alleged lack of patient care	Referred to HQA
11-039	IN	Alleged discrimination	Unfounded
11-040	PI	Alleged unfair Medicaid rate reimbursement	Reviewed
11-041	RF	Alleged mismanagement of Low Income Pool (LIP) funding	Referred to Medicaid
11-042	PI	Alleged Medicaid fraud	Referred to MFCU and MPI
11-043	IN	Alleged abuse by nursing home staff	Pending
11-044	RF	Alleged fraud	Referred to MPI
11-045	RF	Alleged recipient abuse	Referred to DCF
11-046	IN	Alleged disclosure of pending survey	Unfounded

Case No.	Case Type	Allegation	Disposition
11-047	PI	Alleged two state agencies failed to serve a disabled citizen	Reviewed
11-048	IN	Alleged fraudulent license application	Pending
11-049	NF	Alleged administrative issues in hospital	Reviewed
11-050	PI	Alleged unauthorized USPS address change order	Reviewed
11-051	PI	Alleged fraud and HIPAA violation	Founded
11-052	IN	Alleged fraud	Pending
11-053	PI	Alleged fraud at ALF	Referred to MPI
11-054	PI	Alleged unethical behavior	Referred to HQA Director
11-055	PI	Alleged Medicaid fraud	Unfounded
11-056	PI	Alleged fraud at Podiatrist office	Unfounded
11-057	IN	Alleged failure by AHCA to enforce state and federal violations	Unfounded
11-058	PI	Alleged employee fears retaliation	Reviewed
11-059	IN	Alleged employee of harboring a fugitive	Founded
11-060	PI	Alleged unlicensed Home Medical Provider	Referred to Long Term Care
11-061	IN	Alleged Waiver provider fraud	Pending
11-062	NF	Alleged prescription fraud	Reviewed
11-063	PI	Alleged retaliation against former employee	Reviewed
11-064	IN	Alleged was wrongfully terminated waiver program	Pending
11-065	RF	Alleged conduct unbecoming a state employee	Referred to HQA
11-066	PI	Alleged inadequate home care service	Referred to CAU
11-067	PI	Alleged HIPAA violation	Resolved and Closed

Case No.	Case Type	Allegation	Disposition
11-068	PI	Alleged standard of care violations at rehab center	Pending
11-069	PI	Alleged wrongful termination at nursing facility	Pending
11-070	PI	Alleged patient endangerment	Pending
11-071	PI	Alleged disclosure of pending survey	Unfounded
11-072	IN	Alleged criminal action by employee	Founded
11-073	PI	Alleged inadequate patient care	Pending
11-074	PI	Alleged upcoding	Unfounded
11-075	RF	Alleged fraud	Referred to HQA
11-076	RF	Alleged inadequate patient care	Referred to HQA



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

Designed and Produced by AHCA Multimedia Design