

The State's Efforts to Control Medicaid Fraud and Abuse FY 2012-13





December 31, 2013

The Honorable Rick Scott
Governor
PL-05 The Capitol
400 South Monroe Street
Tallahassee, FL 32399-0001

Dear Governor Scott:

Pursuant to Section 409.913, Florida Statutes, enclosed is the annual report of the activities related to the fight against fraud and abuse in the Medicaid program for the FY 2012-13. This report has been prepared jointly by staff of the Agency for Health Care Administration and the Medicaid Fraud Control Unit within the Office of the Attorney General.

Sincerely,

A handwritten signature in blue ink that reads "Pam Bondi".

Pam Bondi
Attorney General

Sincerely,

A handwritten signature in blue ink that reads "Elizabeth Dudek".

Elizabeth Dudek
Secretary

cc: The Honorable Don Gaetz
The Honorable Will Weatherford

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STATUTORY AUTHORITY

Section 409.913, Florida Statutes, requires in part that

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

The Agency for Health Care Administration (Agency) and the Medicaid Fraud Control Unit (MFCU) of the Department of Legal Affairs have continued their joint efforts to prevent, reduce and mitigate health care fraud, waste and abuse. Members and subject matter experts from many state agencies dealing with public benefits health care programs meet to discuss major issues, strategies, joint projects and other matters.

This joint report presents the results of the Agency's and MFCU's efforts to control Medicaid fraud and abuse for FY 2012-13.

MEDICAID FRAUD CONTROL UNIT

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

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

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

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

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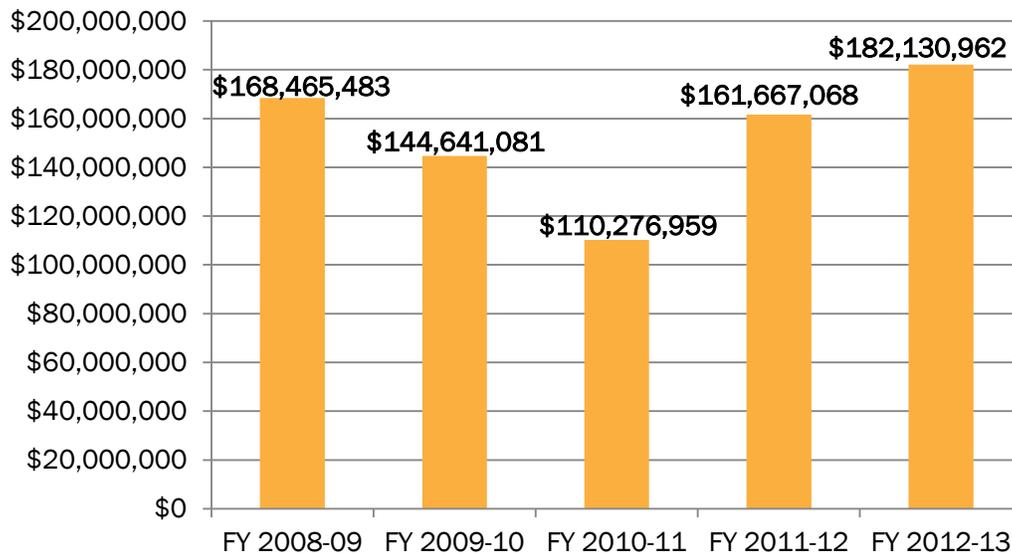
TOTAL RECOVERIES

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

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

In addition to its role in multi-state investigations, the CCEB successfully resolved a number of false claims cases against major pharmaceutical manufacturers which were litigated in Leon County, Florida. The defendant drug manufacturers artificially inflated the prices of their drugs in a scheme that has cost the Florida Medicaid Program millions of dollars.

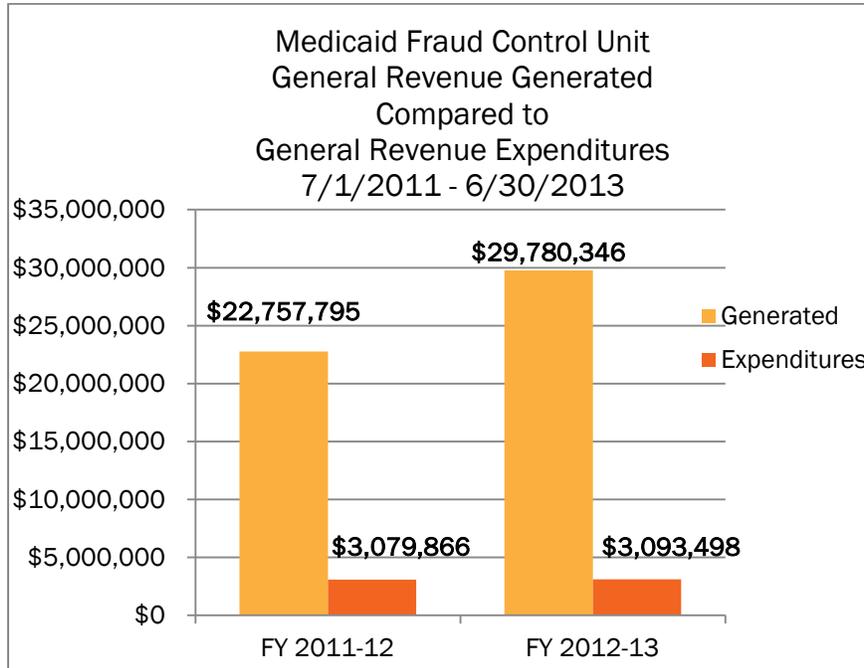
**Medicaid Fraud Control Unit
Total Recovered
7//1/2008 0 6/30/2013**



In FY 2012-13, the total amount for *civil* recoveries, which include civil settlements arising from *qui tam* cases brought under Florida's False Claims Act, was \$175,225,473. The total amount for *criminal* recoveries based upon Medicaid fraud cases was \$6,346,811. The total amount of the monies recovered by the MFCU for FY 2012-13 was \$182,130,962.

GENERAL REVENUE GENERATED

The unit has improved efficiency and brought in \$29.78 million dollars in FY 2012-13 in collections to the state's General Revenue Fund.



In the previous chart, for FY 2011-12, for every General Revenue dollar spent, the MFCU generated approximately \$7.39 through penalties imposed and interest that was deposited into General Revenue. For FY 2012-13, for every General Revenue dollar spent, the MFCU generated approximately \$9.63 through penalties imposed and interest deposited into General Revenue.

SIGNIFICANT CASE HIGHLIGHTS

The following are brief summaries of significant cases that resulted in successful convictions or civil settlements for the Florida Medicaid Fraud Control Unit during FY 2012-13.

GLAXOSMITHKLINE (GSK)

Florida MFCU participated in the largest healthcare fraud settlement in U.S. history. Florida received more than \$56 million as part of a \$3 billion settlement with GlaxoSmithKline (GSK) that involved the federal government, Florida and various other states. The settlement resolves allegations that GSK engaged in a pattern of: unlawfully marketing certain drugs for uses that were not approved by the Food and Drug Administration (FDA); making false representations regarding the safety and efficacy of certain drugs; offering kickbacks to medical professionals and underpaying rebates owed to government programs for various drugs paid for by Medicaid and other federally funded healthcare programs.

The total Medicaid settlement amount for the State of Florida with the state and federal share combined is \$56,682,425.59 plus \$157,462.11 in interest. The federal share of this settlement

was \$31,831,523.06, with the state share of Florida being \$24,850,902.53. Florida's state share of Medicaid damages is comprised of \$11,577,717.05 in Medicaid restitution and \$11,742,619.83 in additional recoveries.

The settlement was based on four qui tam, or whistleblower, actions brought by private individuals pursuant to state and federal false claims acts, as well as investigations conducted by the federal government. A National Association of Medicaid Fraud Control Units team combined with several federal agencies to investigate the matter and conduct settlement negotiations with the defendants. Florida's civil investigation was handled by the Attorney General's Complex Civil Enforcement Bureau, which is part of the Medicaid Fraud Control Unit.

Specifically, the government alleged that GSK engaged in the following activities:

- Marketing the depression drug Paxil for off-label uses, such as for use by children and adolescents;
- Marketing the depression drug Wellbutrin for off-label uses, such as for weight loss and treatment of sexual dysfunction and at higher-than-approved dosages;
- Marketing the asthma drug Advair for off-label uses, including first-line use for asthma;
- Marketing the seizure medication Lamictal for off-label uses, including bipolar depression, neuropathic pain and various other psychiatric conditions;
- Marketing the nausea drug Zofran for off-label uses, including pregnancy-related nausea;
- Making false representations regarding the safety and efficacy of Paxil, Wellbutrin, Advair, Lamictal, Zofran and the diabetes drug Avandia;
- Offering kickbacks, including entertainment, cash, travel and meals to healthcare professionals to induce them to promote and prescribe Paxil, Wellbutrin, Advair, Lamictal, Zofran, the migraine drug Imitrex, the irritable bowel syndrome drug Lotronex, the asthma drug Flovent and the shingles and herpes drug Valtrex; and
- Submitting incorrect pricing data for various drugs, thereby underpaying rebates owed to Medicaid and other federal healthcare programs.

As part of the settlement, GSK agreed to plead guilty to criminal charges that it violated the federal Food, Drug and Cosmetic Act ("FDCA") in connection with certain activities. The government alleged that GSK introduced Wellbutrin and Paxil into interstate commerce when the drugs were misbranded, meaning they contained labels that were not in accordance with their FDA approvals and that GSK failed to report certain clinical data regarding Avandia to the FDA.

MCKESSON CORPORATION

Florida received more than \$11.4 million as part of a global settlement totaling more than \$151 million with McKesson Corporation, one of the largest drug wholesalers in the country. The settlement resolves allegations that McKesson violated the Federal False Claims Act and various state false claims acts by reporting inflated pricing data for prescription drugs, causing the state Medicaid programs to overpay McKesson. The complaint alleged that McKesson inflated average wholesale pricing (AWP) data to First Data Bank, a publisher of drug prices, thereby inflating many AWP's that are used by Florida to set reimbursement. AWP is the benchmark used by most states to set pharmacy reimbursement rates for pharmaceuticals dispensed to Florida Medicaid beneficiaries.

The \$11.4 million Florida's state share of Medicaid damages included \$10,882,742.99 in Medicaid restitution and \$108,976.51 in interest. This case was handled by the Attorney General's Complex Civil Enforcement Bureau, which is part of the Medicaid Fraud Control Unit.

DR. YONG AM PARK

Dr. Yong Am Park, 68, was sentenced to two years in prison for Medicaid fraud and prescription drug-related charges. The Attorney General's Medicaid Fraud Control Unit partnered with multiple agencies to investigate the Lake City pill mill doctor, the last defendant sentenced in a case involving now-defunct Trinity Community Hospital in Jasper.

Park was convicted of three counts of Medicaid fraud, five counts of prescription fraud, two counts of unauthorized possession of a prescription form, one count of scheme to defraud and one count of selling a controlled substance.

Investigators conducted a series of undercover visits and were prescribed controlled substances, such as oxycodone and hydrocodone, outside the course of Park's professional practice. Investigators discovered that the Florida Medicaid program was paying for many of these illegal prescriptions.

Park has relinquished his medical license. This case was prosecuted by the Attorney General's Office and the State Attorney's Office for the 3rd Judicial Circuit. Participating agencies include the Columbia County Sheriff's Office, the Lake City Police Department and the Florida Department of Law Enforcement.

NORIEL BATISTA, PHARMACY OWNER AND EDUARDO MARCOS-MONE, PHARMACIST

The Medicaid Fraud Control Unit and the Miami-Dade County Police Department arrested three Miami-Dade County residents for Medicaid fraud and grand theft. Noriel Batista, the owner of Westchester Pharmacy, Eduardo Marcos-Mone, a pharmacist, and Barbara Iglesias, a Medicaid recipient, allegedly participated in a scheme that resulted in billing the Medicaid program for more than \$143,000 for prescribed medications that were never dispensed.

According to the investigation, between 2008 and 2011, Westchester Pharmacy recruited Medicaid recipients by offering cash payments for prescriptions in lieu of receiving their prescribed medications. Batista would then bill the Medicaid program for the medications that were never actually dispensed.

Batista and Marcos-Mone were each convicted of one count of first-degree Medicaid fraud and one count of first-degree grand theft. Batista was sentenced to 18 months in prison, 10 years' probation and ordered to pay restitution of \$143,843.71 to the Medicaid program. Additionally, he agreed never to own or work with a company that accepts Medicaid.

Marcos-Mone's adjudication of guilt was withheld. He was sentenced to five years' probation and relinquished his pharmacist license. He was ordered to pay joint and severally with Batista, \$74,593.62 for costs of investigation.

TITILAYO OSHOLAJA DOKUN, HOME SERVICES COMPANY OWNER

Titilayo Osholaja Dokun, owner of Capital City Area Care, a Leon County Medicaid home services company, was sentenced on February 1, 2013, to eight years in state prison for submitting more than \$100,000 in false claims to the Florida Medicaid Program. Dokun was convicted in December 2012 on four counts of Medicaid provider fraud and grand theft.

The investigation by the Attorney General's Medicaid Fraud Control Unit established that Dokun overbilled the Medicaid program by charging for more hours of services than were actually provided. Additionally, Dokun billed Medicaid for services to recipients who were not enrolled in an authorized home and community based program.

In addition to her prison sentence, Dokun was sentenced to 22 years' probation and ordered to pay more than \$100,000 in restitution to Florida's Medicaid program. The State Attorney's Office for the Second Judicial Circuit prosecuted the case.

DR. THOMAS FLOYD, DENTIST

On February 8, 2013, the Medicaid Fraud Control Unit arrested a West Palm Beach dentist on charges of Medicaid fraud, grand theft and employing a person to perform duties outside the scope of their license. Dr. Thomas Floyd, 61, surrendered and was taken into custody following an investigation by the Attorney General's Medicaid Fraud Control Unit.

Medicaid Fraud Control Unit investigators alleged that between 2008 and 2012, Floyd employed an unlicensed dental hygienist and allowed her to perform periodontal root cleaning and scaling on 71 different children. Under Florida law, this procedure is only authorized to be performed by a licensed dentist or dental hygienist. Floyd then billed the Medicaid program for these procedures.

On June 5, 2013, Floyd was convicted of one count of employing a person to perform duties outside the scope of their license, a third-degree felony. He was sentenced to five years' probation, ordered to pay \$6,506.50 in restitution to the Medicaid program, \$3,000 in cost of investigation, \$100 in cost of prosecution and \$398 in court costs. The case was prosecuted by the State Attorney's Office for the 15th Judicial Circuit.

EDNA LORRAINE WATKINS, OWNER OF HOMECARE UNLIMITED, LLC.

On February 14, 2013, a Duval County woman was accused of stealing more than \$400,000 from Florida's Aged and Disabled Adult Waiver Program. The Attorney General's Medicaid Fraud Control Unit charged Edna Lorraine Watkins, 34, with two counts of Medicaid provider fraud and one count of grand theft. She was accused of billing Medicaid for services that were never rendered and billing for services to recipients who were ineligible for Medicaid. Some of the people to whom she claimed to have provided services were in jail at the time the services were supposedly rendered.

Watkins was the owner of HomeCare Unlimited, LLC. She was accused of defrauding Medicaid between January 2008 and June 2011. She was also accused of falsifying her application to become a Medicaid provider by concealing prior felony convictions and using a false social security number.

On April 2, 2013, Watkins entered a guilty plea and signed a Plea Agreement. She was sentenced to six years in prison and ordered to pay \$402,424.00 in restitution to the Medicaid program. She was also ordered to pay a \$150 fine, \$100 for cost of prosecution and \$466 in court costs. She was already serving time in prison for prescription drug trafficking charges. The case was prosecuted by the State Attorney's Office for the Fourth Judicial Circuit.

HEALTHPOINT LTD. – PHARMACEUTICAL COMPANY

Florida Medicaid Fraud Control Unit, 46 other states and the federal government reached a \$48 million agreement with pharmaceutical company Healthpoint, Ltd. over allegations of misrepresenting the regulatory status of Xenaderm, an ointment used to treat skin conditions and submitting false Medicaid claims. As part of the national settlement, Florida's Medicaid program will receive nearly \$900,000.

The settlement resolves allegations that Healthpoint marketed Xenaderm without Food and Drug Administration approval by modeling it on a pre-1962 drug that the FDA had never reviewed. According to the federal and state complaints, Healthpoint misrepresented the regulatory status of Xenaderm when it submitted quarterly reports to the government and, as a result, knowingly caused false claims to be submitted for Xenaderm to Medicaid programs.

The settlement is the result of joint litigation by the United States Attorney's Office for the District of Massachusetts, the U.S. Department of Justice and fifteen states, including the State of Florida.

SHANTA BROWN – ABUSE AND NEGLECT

March 14, 2013, the Medicaid Fraud Control Unit and the Jackson County Sheriff's Office arrested Shanta L. Brown and charged her with abuse of a disabled adult. An investigation conducted by the Attorney General's Medicaid Fraud Control Unit revealed that Brown physically assaulted a disabled adult while employed at Sunland-Marianna state facility. On April 29, 2013, Brown entered into a Deferred Prosecution Agreement for 365 days and was ordered to pay \$1,103 in court costs. The case was prosecuted by the Attorney General's Office under the authority of the State Attorney for the Fourteenth Judicial Circuit.

JANIE VITTINI, IMPROVING TOGETHER, INC.

On March 27, 2013, the Medicaid Fraud Control Unit, the Metropolitan Bureau of Investigation, Homeland Security Investigations and the Florida Department of Law Enforcement arrested an Orange County resident for \$3 million in Medicaid fraud, racketeering and identity theft. Janie Vittini, owner of Improving Together, Inc., allegedly billed the Medicaid program for more than \$3 million for services that were never provided. According to the investigation, Vittini then used Medicaid funds to purchase luxury vehicles, trips and jewelry, including Cadillac Escalades, a Ducati Superbike, a seven-person Carnival cruise, a trip to Cozumel, Mexico and more than \$175,000 of Louis Vuitton products.

According to the investigation, between 2012 and 2013, Vittini billed Medicaid more than \$3 million for services provided to Medicaid recipients with mental health needs, which were never rendered. Additionally, it is alleged that Vittini obtained Medicaid recipient numbers by enticing Medicaid recipients to complete applications for services in exchange for gift cards.

On July 10, 2013, Vittini pled guilty to one count of Racketeering and one count of Fraudulent Use of Personal Identification Information. She was sentenced to three years in prison, eight years' probation and ordered to pay \$86,000 in restitution to the Medicaid program, \$3,625.89 in cost of prosecution and \$418 in court costs. The Office of Statewide Prosecution prosecuted the case. The assets seized in this case are being handled through civil forfeiture.

IRENE TERRERO, SPEECH THERAPIST

On March 29, 2013, the Medicaid Fraud Control Unit, along with the West Palm Beach Police Department, arrested a 75-year-old Palm Beach County speech therapist for allegedly defrauding the Medicaid program out of \$500,000. Irene Terrero, a Medicaid therapist provider, allegedly employed speech therapists, who were not properly licensed pursuant to state law, to work at the Ismaelillo Learning Centers I and II. According to the investigation, she then billed the Medicaid program for speech therapy provided to children by these unlicensed individuals. She was charged with Medicaid Fraud and Grand Theft, both first degree felonies. On June 27, 2013, Terrero pled guilty to one count of Grand Theft with adjudication of guilt withheld. She was sentenced to five years' probation and ordered to pay \$105,247.20 in restitution to the Medicaid program, \$3,625.89 in cost of prosecution, \$3,000 cost of investigation and \$398 in court costs. The case was prosecuted by the Attorney General's Office of Statewide Prosecution.

RANBAXY LABORATORIES LIMITED

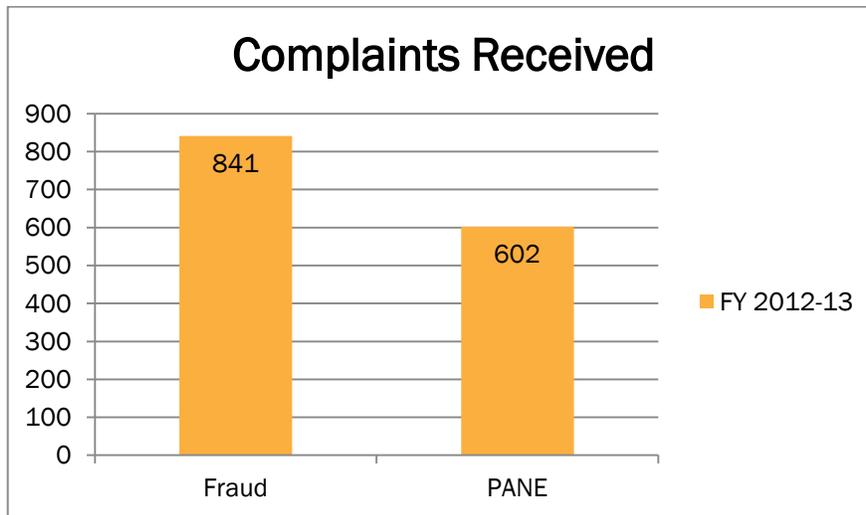
May 14, 2013, Florida entered a \$350 million national settlement with Ranbaxy Laboratories Limited and its subsidiaries resolving claims of drug adulteration. The settlement entered by all 50 states, the District of Columbia and the federal government resolves allegations that Ranbaxy knowingly manufactured, distributed and sold generic pharmaceutical products whose strength, purity and/or quality fell below the standards required by the Food and Drug Administration. The products consisted of 26 generic pharmaceuticals manufactured between 2003 and 2010 at two of Ranbaxy's facilities in India. Florida received more than \$3 million as a result of the settlement.

The Florida Medicaid program received \$1,531,368.17, additional recoveries were \$1,531,368.17 and \$62,032.47 in interest was received.

To resolve the federal government's concurrent criminal charges, Ranbaxy USA, a subsidiary, pleaded guilty to seven felony counts alleging violations of the U.S. Food, Drug and Cosmetic Act and has agreed to pay \$150 million dollars in criminal fines and forfeitures. Additionally, Ranbaxy entered into a consent decree in January 2012 with the federal government to address manufacturing practices and data integrity issues in the two Indian manufacturing plants at issue. These provisions include a wide range of requirements to correct its violations and to ensure that the violations do not occur again.

COMPLAINTS

The Unit's policy requires a 30-day review of complaints and allegations to determine whether the matter merits further investigation, should be referred to another agency or is unfounded. Case openings occur only when there is a criminal or civil predicate that warrants further investigative activity by the MFCU. During FY 2012-13, the Unit received a total of 1,443 complaints. Of those 1,443 complaints, 249 were opened as operational cases. Of the 1,443 complaints 841 were related to fraud and 602 were related to PANE allegations.



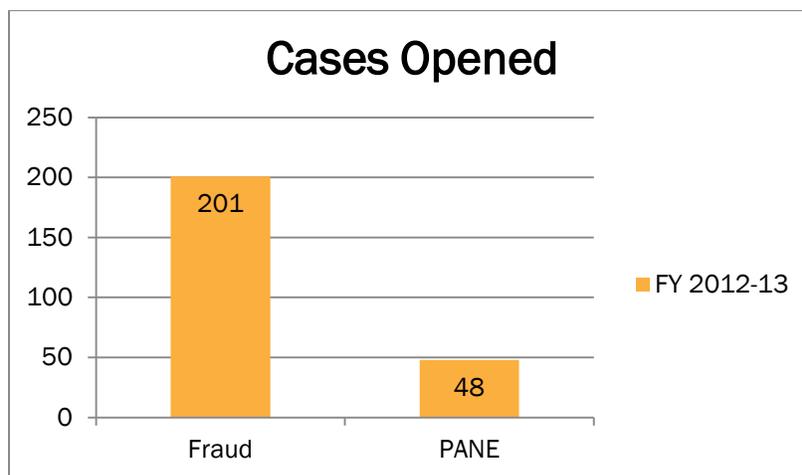
The primary source of fraud complaints in FY 2012-13 was Medicaid recipients with 215 complaints reported. AHCA, via its Medicaid Program Integrity (MPI) unit, accounts for 27 of the Medicaid fraud complaints received and 119 *qui tam* complaints were received.

The majority of PANE complaints are generated by the Department of Children and Families (DCF). In FY 2012-13, of the 602 PANE complaints, 421 came from DCF. The next highest source of PANE complaints was AHCA Health Quality Assurance, which accounted for 42 complaints.

CASE INVESTIGATIONS

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

During FY 2012-13 the Unit formed an internal intake team to assist with front end decision-making regarding opening or closing criminal investigations. This innovative process preserved valuable investigative resources and allowed the Unit to be more selective in its case focus.



The following is a list of the top five Medicaid provider types for fraud cases in FY 2012-13, ranked most to least frequent:

FY 2012-13

Pharmaceutical Manufacturer
 Pharmacy
 Home & Community Based Services
 Medical Equipment Manufacturer
 Physician (MD)

The following is a list of the top five provider types for PANE cases in FY 2012-13, ranked most to least frequent:

FY 2012-13

Skilled Nursing Facility
 Home & Community Based Services
 Assisted Living Facility
 Care Giver
 Certified Nursing Assistant and Group Home

DISPOSITION OF CASES

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

In FY 2012-13, the MFCU closed 301 cases. Of those, 239 involved Medicaid fraud investigations and 62 involved PANE cases.

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

For FY 2012-13, 56 cases were referred for prosecution. Twenty-eight of these cases were based upon Medicaid fraud investigations and the other 28 were based upon PANE investigations. The Northern Region accounted for 29 of these referrals for prosecution, the Southern Region accounted for 13 prosecution referrals and the Central Region accounted for 14 prosecution referrals.

For FY 2012-13, there were 64 arrests/warrants made. Thirty-seven of these were Medicaid fraud investigations and 27 were for PANE investigations. The Southern Region accounted for 17 of the arrests/warrants. The Northern Region accounted for 32 arrests/warrants and the Central Region accounted for 15 arrests/warrants.

INVESTIGATIVE STRATEGY

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

MFCU's formal Investigative Strategy requires unit members to focus on the following:

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

PANE investigations – Focus will be placed on activities/investigations that involve prevention and timely criminal enforcement. Emphasis will be placed on facilities/incidents with immediate public safety issues and those which have widespread impact regarding possible victims.

Civil Recoveries – Regardless of whether an investigation is criminal or civil in nature, emphasis will be placed upon the recovery of the State's monetary losses caused by fraud through use of Florida's Contraband Forfeiture Act, Florida's False Claims Act and any other available legal remedies. The Complex Civil Enforcement Bureau (CCEB) will be proactive in Florida regarding *qui tam* litigation.

Community Outreach – Training and education programs will be provided to citizen groups, provider groups and law enforcement groups. The purpose of such outreach will be to encourage referrals/reports of Medicaid fraud, supplement the MFCU's enforcement efforts through use of local law enforcement, educate citizens how to avoid becoming victims and create partnerships with citizens and the medical community or other provider groups to assist antifraud efforts.

Intelligence – Emphasis will be placed on developing and fostering key partnerships with agencies such as AHCA, the state Department of Health, the Agency for Persons with Disabilities, state and federal prosecutors and the criminal justice community in order to promote better sharing of data.

Use of information technology resources to obtain, share and disseminate data to assist in the detection, investigation and ultimately the deterrence of Medicaid fraud will be promoted.

DATA-MINING

On July 15, 2010, U.S. Department of Health & Human Services Secretary Kathleen Sebelius granted the Florida MFCU a waiver of a portion of 42 CFR 1007.19 allowing federal financial participation in data mining activity. Data mining refers to the practice of electronically sorting Medicaid Management Information Systems (MMIS) claims through statistical models and intelligent technologies to uncover patterns and relationships contained within the Medicaid claims activity and history to identify aberrant utilization and billing practices that are potentially fraudulent. The waiver provides for duration of three years, limits the amount of MFCU staff time to be utilized and requires submission of a detailed plan describing how the MFCU will ensure its data mining efforts will be coordinated with, and not duplicate, those efforts of Florida's single-state-agency. The current waiver has been extended by DHHS through December 31, 2014.

The Memorandum of Understanding between the MFCU and the single-state-agency was amended to provide a system to ensure the data mining efforts would be coordinated with, and not duplicate efforts of the single-state-agency. As of June 30, 2013, the MFCU has submitted 74 data mining projects to the single-state-agency for review. On June 30, 2013, MFCU had 13 cases and 3 complaints in an active status from these projects and the Regional offices are currently developing additional facts. One arrest has been made as a result of the current Data Mining Initiative.

While the data mining project has been successful, the Unit has recently received additional funding authority from the Florida legislature, to acquire state of the art data mining technology. The technology procurement process is under way and it is anticipated that it will enhance the Unit's data mining efforts when approved.

TRAINING

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

During FY 2012-13, Medicaid Fraud Control Unit staff attended a total of 4,698 hours of training. The Office of the Attorney General continued to offer a large number of career and personal enhancement training opportunities via webinars, video conferences and classroom settings. Law enforcement personnel continued to obtain most of their mandatory training for recertification online with the Florida Department of Law Enforcement (FDLE) free of charge. Other training was offered or conducted mostly free of charge by local and national organizations and Criminal Justice Academies.

Classroom training offered at no cost, included providers such as the National Association of Medicaid Fraud Control Units (NAMFCU), the National Association of Attorneys General (NAAG), the Florida OAG Crime Prevention Institute (FCPTI), Area Agencies on Aging, the Department of Homeland Security, the Multi-jurisdictional Counterdrug Task Force, High Intensity Drug Trafficking Area (HIDTA) Intelligence Center, the U. S. Attorney's Office, State Agencies, in particular the Agency for Health

Care Administration (AHCA) and the Florida Department of Law Enforcement (FDLE), local law firms and Bar Associations, Criminal Justice Academies and Sheriff's Offices to name a few.

Classroom training focused, in part, on Medicaid Fraud Training, Overview of the Florida Medicaid Assistive Care Services (ACS), Analyst Academies, Crimes Against the Elderly, Law Enforcement's Role in Elder Crime, Prescription Drug Abuse, Computer Crimes and Fraud, Civil False Claims Act and Qui Tam Enforcement, Cardio Pulmonary Resuscitation (CPR), Advanced Financial Investigations, Money Laundering and Asset Forfeiture, Medicaid Provider Compliance and Regulation, Analytical Investigative Techniques, DSS Training for Data Mining Analysts, Criminal Justice Information Services (CJIS) Certification, Photographic Lineups in Eyewitness Identification, Pharmaceutical Drug Investigations.

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

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

In order to maintain law enforcement certification, sworn personnel once again obtained mandatory training online with FDLE, also free of charge. Training included Criminal Justice Officer Ethics, Domestic Violence, Juvenile Sex Offender Investigations, Discriminatory Profiling, Florida Silver Alert and Fourth Amendment Practical Guidelines for Search and Seizure.

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AGENCY FOR HEALTH CARE ADMINISTRATION

DIVISION OF MEDICAID

The Division of Medicaid administers the Florida Medicaid program, a \$22.2 billion state and federal partnership that provides health care to more than 3.3 million recipients in Florida. The Division is responsible for overseeing the management and operation of a broad range of health care services offered through Medicaid to low-income families, the elderly and the disabled.

PROVIDER RELATED ACTIVITIES

The Bureau of Medicaid Contract Management conducted several provider-related compliance activities during FY 2012-13. Some of these activities are listed below.

- Performed education outreach, in the form of provider alerts, Medicaid bulletin articles and a statewide webinar to the Statewide Medicaid Managed Care (SMMC) plans regarding the treating provider registration process and to the provider population regarding how to become a Medicaid provider for SMMC.
- Increased oversight of registered providers to ensure accurate eligibility screening and data reporting by both the existing managed care plans and the SMMC plans.
- Implemented system changes to prevent multiple plans from registering the same provider for the same type of service; thereby increasing the integrity of the Medicaid data.
- Researched and resolved duplicate registrations submitted by the managed care plans prior to the system enhancements to eliminate data conflicts which impacted the submission of the managed care plan's encounter data.
- Designed, developed and implemented operations and system changes to support requirements under the Affordable Care Act for increased provider screening including fingerprint-based background screen for previously exempt applicants and performing site visits based on risk factors.
- Installed an enhanced data interface with Versa Regulation, the Agency's facility licensing database to ensure no facility is able to enroll or remain enrolled without a valid facility license. The enhancements include reporting features to capture any change in facility ownership, operating address or the status of the license to support more timely and accurate handling of Medicaid provider maintenance.
- Installed a data interface with the Care Provider Background Screening Clearinghouse, the Agency's central background screening database. Background screening results, including local and federal criminal history as well as Medicaid exclusion checks, are automatically loaded to the Medicaid Management Information System (FMMIS). The installation included reporting mechanisms to capture any change in eligibility for existing provider owners or operators to ensure prompt action by Medicaid to loss of eligibility.
- Participated in an Agency-wide workgroup on facility license actions whose goal was to increase visibility to facility license compliance and to ensure a coordinated enforcement of

license regulation, provider enrollment requirements and recoupment of overpayments throughout the Agency.

Other units within the Division continually work to increase provider compliance and accountability through many different avenues. Several activities undertaken in FY 2012-13 to aid the Division in better monitoring providers after enrollment are set forth below.

- The Bureau of Medicaid Field Operations performed random and mandatory site visits for a variety of provider types who applied to become Medicaid providers. The focus of the visits was to ensure the existence of a physical site, that the licensure was complete and current and that necessary inventory and equipment existed, prior to enrollment in the Medicaid program.
- The Bureau of Medicaid Services and the Fraud Prevention and Control Unit (FPCU) cooperatively developed Assisted Living Facility (ALF) Awareness and Observation Training for Agency staff, Medicaid operating partners and other individuals who are routinely in ALFs to assist them in knowing when to make referrals to the Agency. Increased referrals to the Agency promote an increase in provider accountability.
- The Medicaid Certified School Match Program, managed by the Bureau of Medicaid Services, reimburses providers for medically necessary services provided by or arranged by a school district for Medicaid eligible students. During FY 2012-13, field office staff monitored all school districts billing the program quarterly to increase compliance with program policy and procedures. The Bureau of Medicaid Field Operations also assisted school-based services providers with self-audits; approximately \$45,000 in voids and adjustments resulted from these efforts.
- The FPCU coordinated and facilitated compliance efforts related to provider accountability. To ensure that Agency resources were maximized in these efforts, the team assisted with ongoing compliance-related training for Agency staff to increase fraud-fighting efforts. Training for operating partners and Medicaid contractors regarding referrals to MPI was also offered in FY 2012-13.
- The FPCU continued to work with Medicaid managed care plans to increase coordination and anti-fraud efforts as well as increase referrals of suspected fraud and abuse to the Agency.
- The Bureau of Medicaid Contract Management placed several MPI-related deliverables in its vendor contract for the conversion of Agency functions to the new ICD-10 diagnosis code set. The ICD-10 Transition Team and the Agency's vendor, CSG, met several times with MPI. The Fraud and Abuse Changes Plan was the first deliverable submitted by the vendor. The plan assesses the impact of the ICD-10 transition on fraud and abuse prevention, detection and case management activities.
- The Florida Statewide Quality Assurance Program contract with the Delmarva Foundation initiated a project in 2013 to provide missing provider background screening information to MPI as a component of the alert system for the Developmental Disabilities Waiver. This effort seeks to ensure corrective actions can be initiated for any period in which the provider does not have all screening elements required for billing. Administrative actions for Area 7 resulting from this small initiative (also carried out in Areas 5 and 6) resulted in provider educational opportunities and included one MPI/MFCU referral.

TERMINATING PROVIDERS FROM MANAGED CARE NETWORKS

The Bureau of Medicaid Program Analysis and its vendor, APS Health Intelligence, prepare a *Terminated Providers Report: Quarterly Report*. The purpose of the report is to provide a tool to ensure that fraudulent or terminated providers are not participating in Medicaid, either by registering again with Medicaid using different information, or by registering with a Medicaid managed care organization (MCO) in an attempt to indirectly participate in Medicaid. The *Terminated Providers Report* is run each quarter and has three parts.

1. The first part is sent to the Medicaid MCOs. This portion of the report identifies providers that have been terminated by the Agency for fraudulent behavior and informs the MCOs that they are not, under any circumstances, to contract with these providers or include them as part of their provider network. This portion of the report checks against several alternate forms of identification to make certain that there is no link between each of the terminated providers and an active provider that has been allowed back into Medicaid.
2. The second part of the report focuses on active providers that have at some point in the past, through some form of identification, been linked to a provider terminated for fraudulent activity. The Agency uses this information to make sure that these active providers have the clearance to participate in the Medicaid program.
3. The third part of the report checks the providers that have been terminated (identified in part 1), but share a common form of identification with a currently active provider. Since the providers shown in this portion of the report have some link to a legitimate active provider, they are double-checked by the Agency to determine whether they should be excluded from Medicaid MCO networks.

THE FRAUD PREVENTION AND COMPLIANCE UNIT

The FPCU handles pre-enrollment site visits in Agency geographic areas 6, 7, 10 and 11 and coordinate and implement monitoring visits of all providers statewide for specific team projects.

During FY 2012-13 the team conducted projects related to behavioral health providers, dentists, physician prescribers, pharmacies, home health agencies and other specialized issues such as specialized licensure issues within a particular provider type. Preliminary work was also performed related to anticipated projects in a variety of areas, including durable medical equipment, speech therapy and home and community based waivers.

The team also continued several ongoing projects related to managed care, including efforts to increase coordination and communication with managed care plans to aid in fraud prevention efforts as well as coordinate the exchange of information to maximize provider network controls. Additionally, the team assisted the Medicaid area offices, developed and implemented training, coordinated provider terminations and related activities and assisted with the development and implementation of fraud prevention measures. During FY 2012-13 the FPCU met with each area office and identified issues of concern, including risks for fraud and abuse that may be unique to the given geographic area or provider-type specific. These issues were then used to prioritize provider reviews and initiate preliminary analysis of providers for additional provider education or referral and further review by the Agency's Office of Medicaid Program Integrity. Through provider education efforts to deter and prevent fraud and abuse, in cooperation with other Bureaus and the Medicaid area offices, FPCU initiated provider contact to several thousand Medicaid providers throughout the

state, including more than 200 provider monitoring reviews and approximately 125 referrals to MPI on behalf of the Division of Medicaid.

FRAUD AND ABUSE INITIATIVES: FEE FOR SERVICE

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

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

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

The Florida Medicaid fee-for-service pharmacy program ensures quality and cost effective pharmacy practices. The combination of cost containment programs and preferred drug policies minimize expenditures and contribute to maximization of rebate collections. System driven edits and prior authorization procedures ensure that Medicaid recipients have access to needed medications while program costs are controlled and fraud and overutilization is minimized.

The claims processing system has thousands of payment system "edits" that use a cost avoidance philosophy to prevent inappropriate expenditure of Medicaid funds. These point-of-sale "edits" are a critical component in ensuring an efficiently run Medicaid program as they prevent payments that could otherwise be characterized as abusive practices. They also save the state from a "pay and chase" scenario in which payment is made and then additional manpower is needed to recoup the funds. The payment system's edits generate denied claims related to promotion of generic utilization, appropriate age and gender restrictions, drug utilization review (such as high dose, therapeutic duplication, early refill), coverage limits and duplicate paid claims to mention a few. Other programs implemented to contain costs and prevent misuse and overutilization include, but are not necessarily limited to:

- HIV/AIDS drug product initiatives which provide safeguards against contraindicated regimens;
- Controlled substance initiatives which limit the number of controlled substances allowed depending on diagnoses;

- Oral oncology product initiatives to ensure proper utilization of these agents through clinical prior authorization review, quantity and age limits.

The following chart represents fee-for-service pharmacy claims denials for FY 2012-13. As the chart indicates, there were 8,829,196 unique claims denials and the dollar amount associated with these denials totals \$1,276,281,067.71. However, because providers are not precluded from resubmitting claims, to the extent that technical deficiencies can be corrected, a portion of these claims will be processed and paid at a later date. Based on prior year information, it is expected that between 20-25% of these claims could be resubmitted and paid based on medical documentation.

FFS Denied Pharmacy Claims Summary for Service Dates between 07/01/12 - 06/30/13			
NCPDP Reject Code	Claims Count	Amount Associated with Denied Claims	NCPDP Reject Code Description
22	307,638	\$22,183,478.23	M/I Dispense as written code
60	161,977	\$23,187,095.16	Product/Service not covered for patient age
61	835	\$51,009.72	Product/Service not covered for patient gender
70	1,453,142	\$84,745,234.53	Product/Service not covered
73	10,266	\$359,579.31	Refills are not covered
75	1,511,808	\$459,095,575.07	Prior authorization required
76	1,336,464	\$249,851,143.74	Plan limitations exceeded
83	234,143	\$19,834,334.82	Duplicate paid/Captured claim
88	3,812,923	\$416,973,617.13	DUR reject error
	8,829,196	\$1,276,281,067.71	

NOTE: WHEN A SINGLE CLAIM DENIES WITH MULTIPLE REJECT CODES, IT IS COUNTED UNDER EACH REJECT CODE.

FFS Denied Claims Summary for Service Dates between 07/01/12 - 06/30/13: All NCPDP ¹ Reject Code Errors		
All NCPDP Error Codes (198 codes)	Claims Count	Amount Associated with Denied Claims
Total	17,460,090	\$1,584,812,307.85

NOTE: WHEN A SINGLE CLAIM DENIES WITH MULTIPLE REJECT CODES, IT IS COUNTED UNDER EACH REJECT CODE

During FY 2012-13, Area 11 staff continued its efforts to minimize fraud and abuse among the area's providers by conducting monitoring related activities among its community based waiver

¹ National Council for Prescription Drug Programs' Billing Unit Standard helps ensure consistency in how pharmaceutical products are distributed and billed. Payers and providers use the standard for processing claims, so it is important for manufacturers to determine the standardized billing unit for a product before it is packaged, labeled and submitted to drug compendia.

providers. Area 11 monitored 17 Project AIDS Care waiver providers; 11 were case management agencies and six were direct service providers. The monitoring helped reduce the financial impact on the Medicaid program by ensuring all participating providers operate within Medicaid guidelines.

Area 11 staff, in conjunction with Medicaid Program Integrity, monitored program compliance of certain behavioral health care providers. These activities are representative of activities undertaken by each of the Agency's 11 area offices. Seven community mental health facilities were reviewed which resulted in the Agency requiring each reviewed facilities to create and implement a Corrective Action Plan. Staff conducted nine reviews resulting in seven of nine community mental health centers being placed on Performance Improvement Plans. The monitoring of these agencies resulted in the identification of millions of dollars in inappropriately paid claims. When fraudulent or abusive patterns were detected, referrals were made to Medicaid Program Integrity.

SPECIAL PROJECTS AND PILOTS

Throughout the year, the Agency was involved with several special projects and pilot programs including the home health services pilot projects that began during FY 2010-11, referred to as the Telephony Project and the Comprehensive Care Management Project. [Reference The State's Efforts to Combat Medicaid Fraud and Abuse FY 2010-11, Special Projects and Pilots.] These projects were included as part of the anti-fraud and abuse provisions passed by the 2009 Florida Legislature. During the 2012 Florida Legislative session, legislation was passed to expand both of these projects statewide in counties where expansion was deemed cost-effective by the Agency and to include private duty nursing and personal care services. The expansion legislation was effective July 1, 2012.

TELEPHONIC HOME HEALTH SERVICES DELIVERY MONITORING AND VERIFICATION (DMV) PROGRAM

The Telephonic Home Health Service Delivery Monitoring and Verification (DMV) Project helps ensure appropriate utilization and expenditures for Medicaid home health services, improves the quality of care for Medicaid recipients and prevents Medicaid fraud and abuse. The DMV Project now includes monitoring of all home health services (i.e., home health visits, private duty nursing and personal care services). The project was initially only authorized for Miami-Dade county, however, during the 2012 legislative session, the Legislature directed the Agency to expand the DMV Project statewide. This expansion is complete and the Agency is closely monitoring providers for compliance with an Agency rule promulgated in June 2013 that allows the Agency to enforce compliance with project requirements.

COMPREHENSIVE CARE MANAGEMENT PROJECT

The Agency included management of the Comprehensive Care Management project in its contract with eQHealth Solutions, Inc., which provides utilization management for home health visits, private duty nursing, personal care services and inpatient medical and surgical services. The purpose of this project is to identify potential overutilization and fraud or abuse of Medicaid services by ensuring that the level of home health aide and private duty nursing services provided to recipients receiving home health care matches the needs of the recipients. eQHealth Solutions provided the Agency with a utilization report of the home health agencies that routinely submit requests that are well above

the average for their area. This information is reviewed by Medicaid Program Integrity to determine if an investigation is needed.

The Comprehensive Care Management (CCM) pilot began July 2010; following are the results for FY 2012-13:

Face-to-Face Assessment Data	Total Recipients
Recipient Face-to-Face Assessment Completed	4,299
Recipients w/Fully Approved Request	3,840
Recipients w/Fully Denied Request	73
Recipients w/Partially Approved Request	308
Reconsideration Complete	62
At Fair Hearing	7
At Reconsideration	8

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

PROVIDER EDUCATION

One of the most effective tools that the Agency has at its disposal is the opportunity to educate providers about Medicaid program rules. Many overpayments are the result of inadvertent provider errors and misunderstandings or lack of understanding about program rules. By educating providers, the Agency proactively addresses the issue of potential overpayments. Provider education activities continued in FY 2012- 13 with emphasis on extending the reach of prevention activities by partnering with other Agency divisions and the Centers for Medicare and Medicaid Services. More than 9,000 providers participated in these trainings.

From July 1, 2012, through June 30, 2013, the following educational activities were carried out to impact identified areas at risk for fraud or abuse:

Partnering with the Centers for Medicare and Medicaid Services, Florida Medicaid presented:

- Managed Care Plan Critical Partners in the Fight against Fraud, Waste and Abuse in Medicaid for the Medicaid managed care plans. The training described the elements of an effective compliance plan. It also listed the steps to prevent, detect and report fraud, waste and abuse in a managed care context. More than 260 participants from the managed care plans participated in this training.
- Do You Know Where the Drugs Are Going? Partners in Integrity. The training identified common types of drug diversion activities, listed the drug classes that are targets for drug diversion and described recipients' drug diversion behaviors. The target audience included 149 pharmacists, pharmacist technicians and clerical staff in pharmacies.
- In partnership with the Medicaid area offices, the Agency continued delivering the popular "Verify Medicaid Recipient Eligibility" training. Over 1,955 providers participated in this training during FY 2012-13.
- Training for mental health providers about the Top Findings from the Community Behavioral Health On-Site Reviews. During this training the top compliance issues found during the community behavioral health on-site reviews were shared as well as key policy reminders. Approximately 420 providers participated in these training sessions.

- Medicaid Coverage & Prior Authorization for Applied Behavior Analysis (ABA) Services training was offered to provide guidance on Medicaid policy for ABA services, prior authorization request process and to increase understanding about service codes, reimbursement rates and the billing process. Over 475 providers participated in this training.
- An overview of current Medicaid policy stated in the Florida Medicaid Dental Services Coverage and Limitations Handbook was offered as Policy Reminders Florida Medicaid Dental Services. 123 providers participated in these training sessions.
- Two employee sessions on Managed Care 101 were offered to Agency for Health Care Administration employees to present a general overview about Florida Medicaid managed care programs, including the Statewide Medicaid Managed Care program and major aspects of Part IV, Chapter 409, Florida Statutes and to share existing managed care resources. Over 177 Agency staff participated in these training sessions.
- Augmenting the Agency's efforts to improve quality of care in Assisted Living Facilities, the Bureau developed training sessions on an Overview of the Florida Medicaid Assistive Care Services Program and the Home & Community-Based Characteristics: Home-Like Environment and Community Integration for Medicaid Waiver Recipients in Assisted Living Facilities. The target audience for these trainings was Assisted Living Facility owners, operators and administrators. Ninety-three assisted living facility staff participated in these training sessions.
- In coordination with the FPCU, the Agency developed a comprehensive Compliance Tips for Florida Medicaid Providers training to increase providers' understanding of a compliance program and share basic Florida Medicaid compliance tips with new Florida Medicaid providers. More than 1,476 providers participated in the training sessions. This training was converted to a video format and posted on the Florida Medicaid Provider Training e-Library at <http://ahca.myflorida.com/Medicaid/e-library/index.shtml>
- Along with the Division of Operations' Third Party Liability Unit, three training sessions were delivered on Florida Medicaid Recipients with Other Medical Insurance with participation by 1,050 participants.
- In collaboration with Medicaid Program Integrity, training sessions were offered to the current Medicaid managed care plans on the Contract Highlights Attachment II- Section X, Item E Fraud and Abuse Prevention to increase participants' knowledge on how to apply these contractual requirements to the plans' current fraud and abuse prevention efforts. There were 154 participants from Medicaid managed care plans.

OFFICE OF MEDICAID PROGRAM INTEGRITY

The Office of Medicaid Program Integrity (MPI), in the Office of the Inspector General (OIG), operates under Section 409.913, Florida Statutes. It oversees the activities of Medicaid recipients and Medicaid providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible. The Office identifies and recovers overpayments made to Medicaid providers and imposes sanctions as appropriate. This is accomplished through detection analyses, fraud and abuse prevention activities, audits and investigations, imposition of sanctions and referrals to the Medicaid Fraud Control Unit (MFCU) of the Office of the Attorney General, to the Department of Health and to other regulatory and investigative agencies.

MPI collaborates with other state and federal agencies, including the MFCU, the Department of Health (DOH), the Department of Children and Families (DCF), the Agency for Persons with Disabilities (APD), the Division of Public Assistance Fraud (DPAF) and the federal Centers for Medicare and Medicaid Services (CMS).

REORGANIZATION

In early June, 2013, the Office began the task of reorganizing, in an effort to meet the challenging demands presented by the Agency's implementation of Statewide Medicaid Managed Care (SMMC). With the transition to SMMC, the Office assumes the major task of managed care organization (MCO) oversight pertaining to fraud, abuse and waste. These duties are specifically delineated in Section 409.91212, Florida Statutes, which provides for the reporting of fraud, abuse and waste to MPI by the health plans and generally outlines the required state oversight of each plan's fraud prevention and detection activities. Additional performance requirements are outlined in the Agency's contracts with the plans. These contractual requirements are routinely reviewed by MPI.

Even as managed care expands, MPI will continue to be charged with conducting retrospective audit and review activities on fee-for-service claims for those recipients who are exempt from SMMC and who receive services on a fee-for-service basis. In addition, traditional audits will continue for the five-year look-back period for individual providers billing fee-for-service up to the full SMMC transition date in June 2014. This look-back period will impact the MPI caseload to some degree into the year 2019. MPI will also audit the "churn" population, those persons entering SMMC who have not yet selected a provider, as well as some waiver programs that will remain fee-for-service after SMMC implementation.

In response to this major business change, the Office, through realignment, doubled the number of staff members specifically assigned to the managed care oversight role. This realignment added a second MCO oversight unit with a second supervisor. Other MPI functions were streamlined and coordination improved. The Intake Unit and the recently strengthened Data Analysis Unit were placed under the same administrator. This will permit the efficient intake of complaints and case leads and effective preliminary data analysis, to facilitate determination of the merits of complaints or information, thereby allowing for referral to the appropriate investigative unit.

APPROPRIATIONS

During the 2013 legislative session, the Agency was appropriated \$3 million for the procurement of advanced data analytical services as part of a statewide public benefits fraud enterprise initiative. An Invitation to Negotiate was issued on October 10, 2013 and will initially be used in the Medicaid program to identify patterns in fraud, abuse and waste using advanced data algorithms and data link analysis on multiple data sets. This cutting edge technology is currently used in only a few states and initial success has been very promising with returns on investment of ten to one.

Additionally, the legislature certified forward funding of approximately \$800,000 for the acquisition of a new MPI case management system. Inadequate response to previous invitations to negotiate resulted in a delay in the procurement. MPI expects to implement a new system in the third quarter of FY 2013-14.

KEY ANTI-FRAUD LEGISLATION

During the 2013 session, the legislature passed HB939/SB844, an act that enhanced Medicaid provider controls and increased provider accountability. The highlights of the legislation are:

Provider Oversight:

- Adds an additional notification provision relating to a change in principal that must be included in a Medicaid provider agreement.
- Defines and clarifies "administrative fines" and "outstanding overpayment."
- Revises provisions relating to the Agency's onsite inspection responsibilities.
- Allows the Agency to seek administrative remedies against providers that authorize services to a recipient that are inappropriate, unnecessary, excessive or harmful.
- Revises provisions regarding who is subject to Level 2 (fingerprint based) background screening in Section 409.90 7(8)(a).
- Expands grounds for terminating a Medicaid provider from the Medicaid program and removed the safe harbor for providers who left the Medicaid Program in advance of a negative audit or review.

Sanctions for Overpayment. The legislation clarified the Agency's sanction authority and increased accountability for repayment of overpayments and fines, specifically:

- Required the "with cause" termination of providers that close or voluntarily relinquish their Medicaid provider status while an Agency-imposed termination or other sanction is pending and allows hearing rights for such terminations.
- Required that provider records be prepared contemporaneously with the Medicaid service provided and not created after the fact to present in an overpayment defense.
- Required documentation to be presented at least 14 days prior to an administrative hearing in an overpayment or sanction case.
- Revised when a Medicaid provider must reimburse overpayments to the program and changed the venue for administrative sanction cases to Leon County.
- Clarified that fines are due upon issuance of an Agency final order.
- Extended immunity from tort liability for persons who provide or share information about Medicaid fraud and Medicaid program abuse.

- Clarified accrual of interest for provider payments withheld due to suspicion of fraud or abuse, when it is determined that no fraud or abuse occurred.

Third-Party Liability (TPL). The language also amended Section 409.910(17) and provided the following cost saving provisions for the Agency's TPL unit:

- Shifted the burden of proof to the petitioner seeking to challenge third party liability recoveries by the Agency.
- Allowed the Agency to rely on its own fiscal records as prima facie evidence as to the amount of the Medicaid lien.
- Required both the State and the petitioner challenging third party liability recoveries by the Agency to bear their own attorney's fees and costs.

INTAKE UNIT

The Intake Unit receives reports of suspected Medicaid fraud or abuse made to MPI from both internal and external sources. Reports are made via the online reporting function on the Agency's website, the fraud and abuse hotline and returned Explanation of Medicaid Benefits forms (EOMBs). EOMBs are mailed three times a year to Medicaid recipients who are not in Managed Care Organizations listing the services billed to Medicaid during the previous four months on behalf of the recipient. The mailing, which includes a business reply envelope, instructs the recipient to report any Medicaid services listed that they did not receive. Discrepancies are investigated by the Intake Unit and, if it is determined that the services were not provided, the provider is requested to void the claim. If a pattern is noted, the provider is referred to the appropriate Case Management Unit or to the Medicaid Fraud Control Unit. Complaints received through the internet or telephone may or may not be Medicaid fraud or abuse related. Complaints that are not so related are forwarded to the appropriate agency for action. MPI-related referrals are evaluated and, if substantiated, are referred to the appropriate MPI unit or MFCU for further investigation.

In addition to the overpayments recovered from EOMB paid claim reversals, the unit was responsible for two special projects that resulted in recovery of overpayments in FY 2012-13. The Targeted Case Management and Home and Community Based Services project identified waiver recipients who received both Targeted Case Management Services and Home and Community Based Services in the same month (in violation of Medicaid policy). This project not only recovered overpayments, but also alerted providers that their clients are not eligible for Targeted Case Management and prevents future overpayments. The other project involved recovery of overpayments to Durable Medical Equipment providers whose Medicare identification numbers had been revoked. These two projects accounted for \$554,266 of the \$818,289 in total overpayments recovered by the Intake Unit during the fiscal year.

Under Florida law, Medicaid Managed Care Organizations are required to report suspected fraud or abuse within fifteen days of detection. These reports are received by the Intake Unit. All reports, which are received online, are recorded for reconciliation with required quarterly and annual fraud and abuse reports submitted to the MPI Managed Care Unit. If MPI receives a report from an MCO of possible fraud or abuse by a Medicaid provider, the Intake Unit reviews the provider's Medicaid fee-for-service claims for similar patterns and, if they are noted, appropriate action is taken.

The Intake Unit also monitors press releases on the Internet and articles in the Bureau of National Affairs Reporter for any information relating to an investigation, arrest or conviction of a Florida

Medicaid provider. Providers who are under indictment for unlawful activity relating to health care practices are suspended from participation in the Florida Medicaid program for the duration of the legal proceedings. Similarly, a conviction for a criminal offense related to the delivery of any health care goods or services, including the performance of management or administrative functions relating to the delivery of health care goods or services, or a criminal offense under federal law or the law of any state relating to the practice of the provider's profession, results in action by the Agency to terminate the offending provider from the Florida Medicaid program.

DATA DETECTION UNIT

The Data Detection Unit utilizes the tools, resources and reports described below in an effort to identify instances of possible Medicaid fraud and abuse. The Unit analyzes claims data, develops leads for the Case Management Units and works closely with MPI's Medicare partners to identify fraud and abuse issues related to claims paid by both the Medicaid and Medicare programs. The unit works with the Medicaid Fraud Control Unit (MFCU) to coordinate data detection projects and detects violations using several detection tools and methods. Apparent violations are referred to the Case Management Units or to MFCU for further investigation. Case Management Units conduct audits, pursue recovery and make referrals to outside agencies as appropriate. The Data Detection Unit also assists in the development of generalized analyses and provides programming support for other MPI units.

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

DETECTION TOOLS

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

The *DSSProfiler* is the basis of the Surveillance and Utilization Review Subsystem (SURS) and is used to determine possible overutilization and other deviations from expected values and norms associated with reimbursement for Medicaid goods and services. An example is an analysis of the number of hours per day a provider billed a specific code within an age- or gender-adjusted peer group established by the *DSSProfiler*. The system calculates the expected amounts or values for this parameter (hours per day) based on the number of recipients served by the provider and the age range/gender/morbidity mix of those recipients, for each provider in the group. For all providers in the group, the distribution is obtained on the differences between the expected and actual amounts and the standard deviation of the distribution is calculated. Each provider's actual amount is compared with the value of the standard deviation. Providers that stand out based on the standard deviation statistical analysis may be selected for auditing.

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

First Health Pharmacy reports include top member rankings, top 100 prescribers by amount, quarterly "doctor shopping" reports, prescriber ranking reports and "most utilized" pharmacies report.

Ad hoc reports are used by MPI auditors to access Medicaid claims information within the FMMIS and DSS. The FMMIS processes and pays provider claims and contains claim-related information on Medicaid providers, recipients, drugs and medical services. The DSS stores seven years of providers' claims history and contains the *DSSProfiler* datamart, a type of SURS for claims utilization review and provider and recipient analysis profiling.

The 1.5 report is produced weekly and provides a listing of each Medicaid provider who is scheduled to receive a check for that week in an amount that exceeds 1.5 times the average amount received for the immediately preceding 26 weeks. This report includes all Medicaid provider types and is useful for spotting providers that have an unusually high payment amount for a given week. The report is received by MPI at the beginning of the week and is analyzed quickly so that, if necessary, certain payments for that week can be delayed until a thorough review can be completed. Frequently, if a payment is stopped, it is found to have been paid in error and needs to be nullified or corrected. When the report leads to the identification of providers who are misbilling the Medicaid program, an audit is initiated.

Chi-square reports utilize a nonparametric statistical analysis developed by MPI to determine possible overpayments to providers who engage in upcoding, or using a higher-paying procedure code (in a series of codes) than warranted. The analysis yields estimates of overpayments at a very high confidence level. For providers of a given type, the analysis determines an overpayment indicator, which is proportional to an overpayment amount, for each of the providers having the largest overpayment indicators. Several types of providers are analyzed. The chi-square report is issued quarterly and lists providers in descending order of overpayment indicator, along with provider number, total payment, number of claims paid and other information.

Early Warning System reports were developed by MPI to determine projected rates and amounts of increase in payments to providers. Regression analyses are performed using exponential curve fitting. Very rapid increases in payments may be due to the fact that providers are new or due to other legitimate reasons. Or they may be due to unwarranted billings by providers. Payments for a number of weeks are read by the program, which calculates the equation of a curve reflecting the trend in payments. The slope of the curve is calculated at the latest week. This slope is indicative of the rate of increase in payments at that time. Total projected payments for the next year are calculated and compared to actual payments for the year just ended. Payment data are obtained from the FMMIS.

The Medi-Medi project was established to detect and prevent fraud, waste and abuse in the Medicare and Medicaid programs by performing computerized matching and analysis of Medicare and Medicaid data. This matching is performed to detect claims paid by Medicaid that should have

been paid only by Medicare. Through this program's statistical analysis, trending activities and development of valuable potential fraud cases for referral to appropriate health care and law enforcement agencies are completed. Through these collaborative efforts, information is provided to MPI that is related to excessive billing patterns, duplicate payments, services billed in both programs with no crossover in place and other abuses. Medi-Medi complements MPI's efforts not only with the matching of Medicare and Medicaid data, but also with the enhanced coordination among agencies and with law enforcement authorities to prevent, identify, analyze and investigate Medicaid fraud and abuse.

Another tool that has been used by MPI is social network analysis. Analysis of relationships among individuals, entities and regulatory agencies' data is used to identify Medicaid providers excluded by the federal government, excluded by other state Medicaid programs or disciplined by the Department of Health's (DOH) Board of Medicine.

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

PILL MILL DATA INITIATIVE UPDATE

The Pill Mill Project was developed by the Agency in conjunction with the contractors for Medicare Part A and Medicare Part B to perform a statewide data analysis on the top prescribed narcotics within those two programs. The goal of the initiative was to analyze and report potential overutilization patterns to local, state and federal law enforcement agencies in order to combat fraud and abuse relating to the illegal prescribing, dispensing and consumption of these powerful controlled substances (oxycodone, hydrocodone and Xanax). FY 2009-10 was the first year that the Agency, Medicare contractors and local, state and federal law enforcement agencies performed an initiative of this type.

The Agency made the initial presentation on this initiative to local and state law enforcement officials in the Tampa area. The findings included top area prescribers, top pharmacies for filling prescriptions and the recipients involved in the transactions. Subsequently, the Agency expanded the project to include the Jacksonville, Miami, Broward County and North Florida areas. Agency staff members presented the findings for these areas to local, state and federal law enforcement agencies. Since October 2009, MPI has been furnishing Pill Mill information to state enforcement and regulatory entities. MPI also sent information on providers overprescribing these targeted drugs to the Florida Department of Law Enforcement. The Data Detection Unit periodically refreshes the Pill Mill data models and analyzes the results for potential referrals.

MPI AND MFCU REFERRAL AND DATA MINING MEETINGS

Staff members of MPI and MFCU continue to meet biweekly to discuss potential referrals to MFCU and to share ideas for data mining and detection projects. During these meetings, potential referrals for criminal investigation are vetted for additional information and strategic planning. A referral is either accepted, deferred pending further information or rejected for sufficient reason. The provider's billing history and any prior actions against the provider taken by MPI or MFCU are presented and discussed. If a referral is accepted, payments to the provider are generally

suspended in compliance with state and federal law, until such time as the allegation is resolved. Staff members participating in these meetings are from MPI Tallahassee, MPI field offices, the Division of Medicaid, MFCU and the Medi-Medi contractor.

DATA MINING AND DETECTION PROJECTS WITH MFCU

Through a joint request by AHCA and the Office of the Attorney General of Florida, CMS has approved a waiver to allow MFCU to data mine Medicaid data using the AHCA Decision Support System (Data Warehouse). At the conclusion of the biweekly case referral meeting, the participants from MPI and MFCU convene a second meeting specifically to discuss the coordination of data mining projects. All projects are tracked to ensure that no duplication of data mining efforts takes place.

EDITS AND AUDIT TASK FORCE

The Edits and Audits Task Force was established to identify overpayments caused by deficient edits and audits within the Medicaid claims adjudication process. In addition, this activity identifies vulnerabilities present due to inappropriate or nonexistent edits. The edit and audit processing function in the FMMIS/DSS ensures that claim records are validated in accordance with the state's claim processing policy. An Error Status Code is assigned to each edit and audit and is posted to the claim to indicate that an action has occurred in the processing of the claim to alter the otherwise anticipated outcome. The disposition status of the non-history-related edits and history-related audits is determined based on table-driven instructions that can cause a claim to pay and list, deny or suspend. As of January 2013, the Edits and Audit Task Force has been under the direction of the Division of Medicaid.

GENERALIZED ANALYSIS/SELF-AUDIT UNIT

The Generalized Analysis/Self-Audit Unit (GA Unit) within MPI conducted several computer-assisted reviews of potential Medicaid abuse by all providers of a given provider type for specific issues for selected audit periods. Generalized analyses involve the development of an initial conceptualization of possible Medicaid policy abuse perceived by, or suspected by, various sources. Research of historical Medicaid policy with respect to the issue is initially required in order to determine the probable validity of projected recoupment action. A case is opened in the MPI case tracking system to track audit and recoupment activities for each provider involved in the analysis. In a GA Unit project, a group of providers is tracked as a project within the case management system. Printouts of data in the form of individual provider reports are customarily obtained through the AHCA fiscal agent and the Decision Support System (Data Warehouse) and are subsequently furnished to the Medicaid provider after the GA Unit has performed quality control review for accuracy.

After preliminary audit reports are prepared and mailed to the concerned providers, the unit handles any provider inquiries and processes any follow-up documentation that is received from the provider that may affect audit findings. A Final Audit Report is then issued unless the provider reimburses the Agency in full in response to the Preliminary Audit Report. Monitoring continues in the Unit until all the cases within the GA project are closed and the project itself is closed. A Memorandum for the Record is written to summarize the project and its results. This document must address any recommended changes to Medicaid policy or claims processing system edits that would prevent future payment errors.

Generalized analyses are beneficial in that reviews cover similar claims for all providers of a particular provider type with one analytical review of those data. The data provide support of the assessment and, therefore, document review is generally minimal. Generalized analyses provide a cost-effective means by which to determine overpayments and recover funds. The process identifies claims and providers that might not otherwise be audited and serves to educate like providers having similar abuse issues.

PROVIDER SELF-AUDITS

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

MANAGED CARE UNIT

On June 14, 2013, Florida received approval to amend the 1115 Demonstration Waiver, authorizing implementation of Statewide Medicaid Managed Care (SMMC). SMMC will allow the state to expand and improve the Medicaid Managed Care Pilot Program originally adopted in 2006 for the five-county reform demonstration and extend it to each county in Florida. Program operations have been enhanced and additional fraud, waste and abuse safeguards have been implemented. SMMC will create changes in how some individuals receive health care services from the Florida Medicaid program.

In preparing for SMMC implementation, MPI has reassigned staff to allow for an increased focus on detection of Medicaid fraud and abuse associated with services provided by Managed Care Organizations. Extensive training has been provided to staff members in an effort to provide a seamless transition for Medicaid enrollees from the existing service structure to SMMC. The transition will occur within the next fiscal year (FY 2013-14) and specific efforts are underway to ensure that all existing and new providers have a complete understanding of compliance with federal and state laws in preparation for program implementation. MPI's Managed Care Unit (MCU) has implemented multiple strategies to ensure that fraud, waste and abuse are kept to a minimum:

1. MPI participated in each Agency readiness review for MCO – Long Term Care contracted plans.
2. MPI will continue to enhance partnerships with each contracted MCO.
3. Internal Operating Procedures specifically related to the work of MCU were developed.
4. Provision of educational webinars was made to all MCOs regarding specific reporting requirements.
5. Consistent and timely feedback was provided on required documents, such as the anti-fraud plan, quarterly reports (QFAAR), annual reports (AFAAR) and required ad hoc 15-day reporting. MCU staff members analyze and reconcile the ad hoc 15-day reports to align with the QFAAR for each MCO to ensure that all reported incidences of suspected fraud are being

reported appropriately with timely follow-up and referral to the appropriate entity for subsequent action.

6. Data analysis, in coordination with the MPI Data Detection Unit, is performed in order to identify trends in operations.
7. MCU staff members attend joint bi-weekly meetings between MPI and MFCU.
8. A risk assessment is conducted of each plan to determine the level of risk specific to each plan based on previous reporting, compliance history and staffing patterns of executive management and compliance officers.
9. Scheduled and unannounced site visits are conducted to each participating MCO.

It is anticipated that the continued development of the MCU, ongoing staff development efforts and provision of education to the contracted managed care plans will enhance current efforts to detect and address instances of fraud, abuse and waste in the provision of Medicaid services by Managed Care Organizations.

CASE MANAGEMENT UNITS

Each of the Case Management Units (CMU) identifies misspent Medicaid funds by performing comprehensive audits and generalized analyses. MPI uses accepted and valid auditing procedures that include statistical methodology. Generally accepted statistical methods are used in the generation of a random sample of the provider's claims. If, after a review of provider documentation, an overpayment is determined for the sampled claims, the sample findings are extended to the population of claims for the time period under review. The statistical methodology for determining the total overpayment utilizes a 95 percent confidence level and has been affirmed in administrative hearings. As appropriate, the Case Management Units conduct claim-by-claim reviews and invoice purchase verification reviews.

CMUs perform claim reviews, prepayment reviews, make policy or edit recommendations and assist with the litigation process. During FY 2012-13, the CMUs were organized primarily by the types of providers each audits, as follows:

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

The Case Management Unit continues to serve as the point of contact for the Federal Audit Program. The Centers for Medicare and Medicaid Services (CMS) has committed resources to a "collaborative audit" process and has dedicated audit resources to augment the capabilities of MPI. The substantial change in this adjustment is that MPI was asked to identify areas in which audit assistance was needed. CMS approved and responded with resources. During this fiscal year, 30

audits were initiated in support of Florida's Medicaid Integrity program. CMS, through the Medicaid Integrity Group (MIG), contracted with private firms referred to as Medicaid Integrity Contractors (MICs) to conduct the audit mission. The three primary MIC functions are:

- The "Review MIC" analyzes Medicaid claims data to determine whether provider fraud, waste or abuse has or may have occurred.
- The "Audit MIC" performs audits in support of the state Medicaid Integrity Program.
- The "Education MIC" provides education to providers and others on payment integrity and quality-of-care issues.

The CMUs are being restructured as part of MPI's reorganization. See reorganization section earlier in this report for more details.

PREVENTION ACTIVITIES

MPI dedicates a significant portion of staff resources to the prevention of fraud and abuse. Stopping overpayments before they happen avoids recovery costs and allows Medicaid funds to be used as intended. Among MPI prevention activities are the use of prepayment reviews to identify improper claims and deny payment, recommendations for termination of providers suspected of misusing the Medicaid program, site visits to certain Medicaid providers in specified geographic areas, the application of administrative sanctions, the prevention impact of MPI audits and the pending of claims per Section 409.913(25)(a), F. S. These are discussed below.

PREPAYMENT REVIEWS

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

For intercepted payments, the amount avoided is the amount of the reduction in the payment to the provider. The full amount of the reduction is considered cost avoided, because the claim has been through the Medicaid system edits. Prepayment review cost savings are calculated based on funds that would have been paid but for the intervention by MPI in conducting the prepayment review.

During FY 2012-13, MPI initiated 127 prepayment reviews. Claims denied for these providers resulted in cost avoidance of \$623,098 as shown below.

Prepayment Reviews	FY 2012-13
Number of claims reviewed	8,968
Number of claims denied	5,502
Amount of claims reviewed	\$996,686
Amount of claims denied	\$623,098

TERMINATION OF PROVIDERS

Providers may be involuntarily terminated from the Medicaid program in accordance with the provisions of Sections 409.913 (13) through (18) and (30), Florida Statutes. Providers may also be terminated from the Medicaid program pursuant to the provisions of the Medicaid provider agreement (“contract”). A provider may be terminated under the contract, with or without cause, with 30 days’ notice.

When a provider suspected of fraudulent or abusive billing is terminated from the Medicaid program, Medicaid expenditures should decline with respect to the recipients served by the terminated provider, taking into account services furnished by other providers of a similar type. For a terminated provider, the savings are the difference in payments for the one-year periods before and following termination for services provided by the provider and other like providers to all recipients who were served by the terminated provider and who had maintained eligibility for all of both one-year periods. For FY 2012-13, the terminations for the previous fiscal year saved Medicaid \$5.7 million. For more information on terminated providers, please [see page 54](#).

SITE VISITS

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

Site visit savings are based on payments made to the provider during the one -year periods prior to and following the visit. New providers are not included in the calculation of savings; a provider must have been active for at least one year prior to the visit to be included. Because of the Medicare Part D effect, pharmacies are not included. Cost savings for FY 2012 -13 resulting from site visits conducted in the prior year were \$4.1 million. Site visits conducted during FY 2012-13 by provider type are noted below.

Site Visits Conducted During FY 2012-13	
Provider Type	Number of Visits
Assistive Care Services	236
Community Alcohol, Drug, Mental Health	4
Home and Community Based Services	112
Home Health Agency	6
Medical Supplies/Durable Medical Equipment	26
Nursing Home	2
Pharmacy	24
Physician (DO)	1
Physician (MD)	17
Therapist	5
Total Site Visits	433

FOCUSED PROJECTS

The cost avoidance amount for focused projects is the sum of the decline in total payments to all of the providers visited for the twelve months prior to and following the date of the project. Cost savings for FY 2012-13 for those projects conducted during the previous fiscal year are \$839,188.

MIAMI-DADE COUNTY DEVELOPMENTAL DISABILITIES (DD) WAIVER INITIATIVE

Medicaid Program Integrity collaborates with state and federal regulatory partners to curtail health care fraud and abuse in Florida by conducting several field initiatives (focused projects) each fiscal year. As a follow up to the Tri-County DD Waiver - Residential Habilitation Initiative of September 2011, MPI coordinated with the Centers for Medicare and Medicaid Services, Medicaid Integrity Group (CMS MIG) in a joint field initiative that focused on group homes in Miami-Dade County to ascertain their overall compliance with Medicaid policy and to ensure that these facilities are safe environments for our most vulnerable citizens.

During April 2013, MPI in conjunction with CMS MIG conducted compliance site visits to 56 Developmental Disabilities Waiver-Residential Habilitation Service providers (group homes) in Miami-Dade County that billed for procedure code T2023U6 (Residential Habilitation) for dates of service from January 1, 2012, to March 31, 2013. Procedure code T2023U6 was the most reimbursed procedure code for DD waiver providers in calendar year 2012.

Actions resulting from this initiative were 16 sanctions [7 (e) violations with \$32,000 in total fines], 25 Agency for Persons with Disabilities referrals, and three prepayment reviews.

ASSISTED LIVING FACILITY/ADULT FAMILY CARE HOMES - JACKSONVILLE

The Jacksonville Assistive Care Services (ACS) initiative was conducted during October 2012. Medicaid Program Integrity visited ACS providers throughout the state and found Medicaid policy violations in employee training, background screening and resident quality of care. The primary goals of the initiative were to determine whether Assistive Care Services providers were rendering, billing and documenting services in accordance with Medicaid policy and if Assistive Care Services were being rendered by staff members who had been successfully background screened. It was also necessary to ensure that providers, staff members, relief persons and all adult household members had submitted a statement from a licensed health care provider that he or she was free from apparent signs and symptoms of communicable diseases, including tuberculosis; to ensure that annual TB updates had been received by the provider; and to ensure the health and safety of the residents in these facilities. Thirty-eight providers were sanctioned in the amount of \$233,000. Thirteen prepayment reviews were initiated. There were two paid claims reversals, two termination requests and two provider education letters.

ASSISTED LIVING FACILITY/ADULT FAMILY CARE HOMES - TAMPA

The goals of the initiative conducted in March 2013, were to determine whether Assistive Care Services providers were rendering, billing and documenting services in accordance with Medicaid policy; to ensure that the homes with provider numbers were not sharing the number with other homes that did not have numbers; to verify that all enrollment information on the Florida Medicaid Management Information System (FMMIS) was correct; to determine whether Assistive Care Services were rendered by staff members who have been successfully background screened; to ensure that providers, staff members, relief persons and all adult household members had submitted a statement from a licensed health care provider that he or she was free from apparent signs and

symptoms of communicable diseases, including tuberculosis; to ensure that annual TB updates had been received by the provider; to ensure the health and safety of the residents in these facilities; and to ensure that the residents with services billed to Medicaid were in fact residing in the licensed facility that billed Medicaid. The initiative resulted in twenty-four sanctions, \$108,500 in fines and four prepayment reviews.

SANCTIONED PROVIDERS

During FY 2012-13, 831 Medicaid providers received 841 sanctions or assessments as shown in the table below for violations set forth in Rule 59G-9.070, F. A. C., under Section 409.91212, F. S., or under enrollment contract. These included suspensions and terminations from the Medicaid program and fines or assessments for the current fiscal year totaling \$3.6 million, as shown in the following table. Cost savings for FY 2012-13 based on providers sanctioned during the previous fiscal year are \$5,084,026. These cost savings are included in the prevention data shown in the MPI Prevention of Overpayments table in the section headed FUNDING for MPI and RETURN on INVESTMENTS.

Provider Sanctions and Managed Care Organizations Assessments				
	FY 2011-12		FY 2012-13	
Sanctions under Rule 59G-9.070, F. A. C.	Number	Amount	Number	Amount
Fine Sanctions	590	\$2,643,713	688	\$3,505,686
Suspensions	85		60	
Terminations with Cause	106		91	
Terminations without Cause*	*160		0	
Total for Rule 59G-9.070, F. A. C. Sanctions		2,643,713		3,505,686
Total for Managed Care Organization Section 409.91212, F. S., or Contract Assessments	*7	3,555,600	*2	50,200
Grand Total Sanctions and Managed Care Organization Assessments	788	\$6,199,313	841	\$3,555,886

*NOT A SANCTION UNDER RULE 59G-9.070, F. A. C.

AUDITED PROVIDERS

The effects of MPI audits on providers should include the reduction in future inappropriate billings from, and payments to, providers. In order to estimate the amount of this effect, analyses are carried out concerning payments to those providers whose audit cases were closed during the fiscal year immediately prior to that being reported. Audit savings are based on payments made to the provider during the one-year periods prior to and following the date on which the applicable audit case was closed during the prior fiscal year. Audits accompanied by sanctions and self-audits are not included in this analysis. Cost savings for FY 2012-13 based on audits performed in the previous fiscal year, excluding providers used in any other savings calculation, are \$5,628,357, as shown in the MPI Prevention of Overpayments table in the section headed FUNDING for MPI and RETURN on INVESTMENTS.

CLAIMS PENDED PER SECTION 409.913(25)(A), F. S.

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

MEDICAID PROGRAM INTEGRITY RECOVERY ACTIVITIES

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

MPI AUDITS

Recovery efforts by MPI emphasize conducting comprehensive audits and generalized analyses of Medicaid providers. These audits are comprehensive evaluations of all aspects of a provider's billings and computer-assisted generalized analyses that evaluate specific aspects of the billings by many providers. A comprehensive audit using statistical methodology determines all of the provider's paid claims (the population) for a specific period of time and takes a statistically valid random sample of claims from that population. The sampled claims are carefully reviewed with respect to Medicaid policy and any overpayments found in the sample are extended by generally accepted statistical methods to the population of claims in order to determine the total overpayment in the population. There were 2,203 cases of both types concluded during FY 2012-13. Of these, 496 were sanction only cases, two were Managed Care Organization contractual assessments cases, 136 cases had no findings, seven cases resulted in provider education letters and 1,562 cases identified overpayments. These cases identified overpayments of \$26,511,641.

PAID CLAIM REVERSALS

Several functions within MPI identify erroneous claims that are corrected by the provider's reversal of previously submitted claims rather than by repayment of overpayments. For example, licensed pharmacists within MPI review claims paid to pharmacies in order to identify probable misbillings. Pharmacies submit claims electronically to Medicaid as the pharmaceuticals are dispensed. Occasionally, pharmacies overstate the amount of the drug that is dispensed and are thus overpaid. MPI detection methods identify atypical claims. The provider is contacted and may submit supporting documentation justifying the paid claim amount or reverse the claim in the electronic claims submission system. When the claim is reversed, Medicaid is credited with the original

amount paid to the provider. The provider may resubmit the claim with the corrected quantity and then is paid the correct, reduced amount. The difference between the original payment and the reduced payment is considered recovery as a paid claims reversal. Providers who do not adjust or reverse the payment are subject to further audit or other administrative action by the Agency. Paid claim reversals for FY 2012-13 were \$1,291,535.

THIRD PARTY LIABILITY CONTRACTOR-ASSISTED AUDITS

MPI coordinated and assisted the Third Party Liability contractor's development of computer-assisted analyses of paid Medicaid claims. These efforts resulted in recovery of \$43,629,683 for the State of Florida.

MEDICAID PROGRAM INTEGRITY HIGHLIGHTS

The Generalized Analysis/Self Audit Unit conducted a generalized analysis project dealing with fee-for-service payments that were billed and paid for recipients that were enrolled in the Nursing Home Diversion Waiver Program, a managed care plan, at the time the service was performed. These services were supposed to be billed to, and paid by, the recipient's managed care plan. Data analysis reporting was conducted and it was determined that overpayments existed due to provider failure to bill the appropriate managed care entity as required by Florida Medicaid policy. During FY 2012-13, the GA Unit identified \$3,144,601 in overpayments, \$417,129 in administrative fines and \$7,246 in investigative costs, for 604 Florida Medicaid providers. For more information of managed care plans' fraud and abuse efforts, [see page 30](#).

The Pharmacy/DME Case Management Unit of MPI discovered that a dialysis center provider had been overpaid on paper claims submitted to Medicaid. The provider had submitted the correct quantities on the claims, but apparently when the fiscal agent scanned the paper claims, the system did not read the decimal point. Therefore, quantities shown were 100 times more than the provider had submitted, resulting in significant overpayments for certain drugs. MPI verified with the provider the correct quantities and requested that the claims be reversed and rebilled with those quantities. This left the provider with a credit balance of \$1,645,500, which is currently being tracked as it is collected from the provider.

The Pharmacy/DME Case Management Unit of MPI opened a small project to collect overpayments for certain codes, including those for nebulizers, orthotics and prosthetics. The project focused on billings that exceeded the limits set by Medicaid policy. The unit opened 143 cases and identified \$108,872 in overpayments. The majority of the providers paid at the preliminary audit report, with only a small number advancing to Final Audit Report status. As of June 30, 2013, no providers in this project had requested a hearing to contest the audit findings and almost all had paid the overpayments identified.

The Pharmacy/DME Case Management Unit of MPI identified overpayments totaling \$4,500,057 for the FY 2012-13. Of the total amount, \$833,642 was collected through direct contacts with the providers who then reversed and rebilled the indicated claims. The remainder of the total identified was the result of cases opened for audit, originating from complaints and referrals, on-site visits, data reviews, random audits and follow-up reviews.

The Waiver Case Management Unit opened an audit of a speech therapy group provider in May 2007 to review the dates of service for the period February 1, 2005 through September 30, 2007. It was

noted that the provider routinely billed for four units of service, but failed to provide the required prescriptions, evaluations, plans of care or dates of service. The identified overpayment was \$284,914. The provider requested an informal hearing, which was granted. The Agency's audit was upheld. During a conversation with representatives of the Medicaid Fraud Control Unit regarding a different case, it was determined that this same provider had been referred to MFCU under an individual speech therapist's name as a "time bandit" or billing more hours than possible in a work day. After the MPI case was closed, MPI continued to work with MFCU and during this reporting year MFCU obtained a conviction of the agency owner who was sentenced to 30 months in jail, seven years of probation and total financial restitution of \$1,145,712, of which \$1,130,922 is to be paid to AHCA. The provider was terminated from the Medicaid program, referred to DOH and has lost their license as a speech therapist.

In September 2011, the Waiver Case Management Unit opened a case on a Medicaid-enrolled provider who was providing residential nursing services under the Developmental Disabilities Home and Community Based Waiver. During the investigation it was determined that the provider was billing the Residential Nursing Services at the registered nurse rate, but was routinely using licensed practical nurses to provide the services. The audit identified \$147,386 in overpayments. The provider entered into a repayment plan with AHCA Finance and Accounting to repay the overpayment plus fines and costs.

Alien Audit Program: In 2009, the Agency initiated a corrective action program to resolve coverage and payment issues identified in Health and Human Services Office of the Inspector General (HHS OIG) Report A-04-07-07032. The HHS OIG found that Medicaid claims were allowed for ineligible services that were associated with the Emergency Medicaid for Aliens (EMA) program. MPI then undertook a retrospective audit of EMA paid claims. Medicaid policy allows reimbursement for emergency services provided to aliens who meet all Medicaid eligibility requirements except for citizenship or alien status. Eligibility can be authorized only for the duration of the emergency. Medicaid should not pay for continuous or episodic services after the emergency has passed. The MPI pilot audit confirmed the HHS OIG reported findings and the retrospective audit was initiated in 2010. Overpayments are currently being pursued.

The Medical Case Management Unit received a complaint from a managed care organization that a physician provider group billed excessively for inpatient low birth weight visits and subsequent inpatient visits. This was a physician provider group with a specialty in neonatology. MPI reviewed claims data and found that this provider had higher costs per recipient for subsequent inpatient visits when compared with other providers of the same specialty. In March 2012, MPI opened an investigation. The provider's documentation revealed that the group billed inpatient visits that were performed by ARNPs employed by the hospital. The compensation of ARNPs was included in the facility's cost report and should not have been billed to Medicaid. These claims were denied and the physician group was provided with educational assistance regarding this practice. Levels of service and enrollment issues were also identified. The provider paid the Agency \$116,338 in restitution, sanctions and costs in February 2013.

A Medicaid general practice group provider located in Hialeah, Florida, was identified for questionable billing of Evaluation and Management codes. A review of the provider's claims from July 1, 2008, through December 31, 2010, identified an area of concern. This area was the failure to provide the documentation to substantiate the billings for the review period. A Final Audit Report was completed in July 2012, with an overpayment of \$375,157 plus \$75,031 in fines and \$59 in costs. The Default Final Order was filed in November 2012. The provider entered into a repayment plan in June 2013, in which the full amount of \$450,247 was to be repaid within 12 months.

A Medicaid psychiatry and neurology group provider located in Miami, Florida, was identified for questionable billing of Evaluation and Management codes. A review of the provider's claims from June 1, 2007 through May 31, 2009, identified two areas of concern. These areas were upcoding of services rendered and no documentation of services. A Final Audit Report was completed in November 2010, with an overpayment of \$389,540 plus \$25,000 in fines and \$5,022 in costs. A review of additional documentation that was provided after the issuance of the Final Audit Report resulted in a revised overpayment of \$249,142 plus fines of \$15,000 and costs of \$6,022. The provider has repaid the overpayment and has paid the fines and costs in full. The Final Order was filed in the first quarter of this annual reporting period.

A Medicaid pediatric infectious disease group provider located in Miami, Florida, was identified for questionable billing of Evaluation and Management codes. A review of the provider's claims from April 1, 2008, through September 30, 2010, identified four areas of concern. These areas were upcoding of services rendered, no documentation of services, double billing and no documentation of time for services requiring time documentation. A Final Audit Report was completed in January 2013, with an overpayment of \$214,766 plus \$42,953 in fines and \$2,365 in costs. The provider has repaid the overpayment and has paid the sanctions and costs in full. The Final Order was filed in March 2013.

A Medicaid individual family practice provider located in Clearwater, Florida, was identified for questionable billing of Evaluation and Management codes. A review of the provider's claims from September 1, 2008, through February 28, 2011, identified five areas of concern. These areas were upcoding of services rendered, double billing of services, records not signed and/or dated at the time of the service, illegible documentation and billing of procedures as global when only the professional component was performed. A Final Audit Report was completed in February 2013, with an overpayment of \$148,323 plus \$29,665 in fines and \$671 in costs. The provider entered into a repayment plan in March 2013, agreeing to repay fully the amounts owed within 12 months. The Final Order was filed in May 2013.

A Medicaid community behavioral health services group provider located in Jacksonville, Florida, was identified for questionable billing of Evaluation and Management codes. A review of the provider's claims from February 1, 2007, through January 31, 2009, identified two areas of concern. These areas were upcoding of services rendered and no documentation of services. An Amended Final Audit Report was completed in March 2013, with an overpayment of \$1,379,500 plus \$111,000 in fines and \$2,941 in costs. A review of additional documentation that was provided after the issuance of the Amended Final Audit Report resulted in a revised overpayment of \$336,210, fines of \$33,621 and costs of \$3,121. The provider entered into a repayment plan in March 2013, agreeing to repay fully the amounts owed within 36 months. The Final Order was filed in June 2013.

During a review of Medicaid Assistive Care Service (ACS) providers, Tampa MPI field staff noted that a Marion County ACS provider was billing Medicaid for services even though she was no longer properly licensed. A requirement for providers of ACS services is that the home/facility must be licensed through AHCA as an Adult Family Care Home, Assisted Living Facility or Residential Treatment Facility. Tampa staff interviewed recipients involved in this case and further discovered that some of the recipients did not know the provider nor had they ever lived in any type of facility owned by the provider. The case was referred to the Medicaid Fraud Control Unit which in turn referred the matter to the Inspector General's Office in the Department of Health and Human Services. As a result of the investigation, the provider was arrested and pled guilty to Aggravated Identity Theft and Health Care Fraud charges. The matter was in the sentencing phase as this was written. The total dollar amount identified respecting the Health Care Fraud charge is \$128,052.

Two similar ACS cases discovered by Tampa MPI have also been referred to MFCU and are under investigation.

The Tampa MPI Field Office referred to MFCU two Developmental Disability waiver providers for suspicious billing activity and services not rendered. This has resulted in one arrest and two other providers are facing arrest. These investigations are ongoing.

FUNDING FOR MPI AND RETURN ON INVESTMENT

MPI is funded through the Medical Care Trust Fund. The Medical Care Trust Fund is funded through federal funds and recoveries generated by MPI. During the year, expenditures of \$10.4 million were devoted to recovery work resulting in collections of \$79.5 million and a return on investment for recovery operations of 7.6:1. In addition, MPI achieved \$21.9 million in cost avoidance with expenditures of \$7.0 million, producing a return on investment for prevention efforts of 3.1:1. Overall, in FY 2012-13, audit recoveries and cost avoidance amounts totaled \$101.4 million, yielding a return of 5.8:1, as shown on the following chart:

MPI Recovery Activities (\$ Millions)				
	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13
MPI Audits (Overpayments Collected by F&A)	\$16.4	38.8	\$18.4	\$31.4
Costs (Collected by F&A)		1.5	0.2	0.2
Fines (Collected by F&A)		1.0	5.0	3.0
Paid Claims Reversals	1.5	1.0	2.5	1.3
Contractual Assessments		10.8	0.3	N/A
MCO Statutory or Contractual Assessments*			3.6	N/A
TPL Contractor-Assisted Claims Adjustments	40.6	30	32.2	43.6
Recovery Total	\$58.5	\$83.1	\$62.2	\$79.5

*ANY MONIES COLLECTED DURING THE FISCAL YEAR ARE REPORTED UNDER FINES.

MPI Prevention of Overpayments (\$ Millions)								
	FY 2009-10		FY 2010-11		FY 2011-12		FY 2012-13	
	No.	Amount	No.	Amount	No.	Amount	No.	Amount
Prepayment Review	116	\$4.8	272	\$3.4	270	\$1.3		\$0.6
Termination of Providers	68	1.8	99	1.8		5.5		5.7
Focused Projects	7	5.1		1.2	3	0.9	3	0.8
Pill Mill Drug Denials						1.2		
Site Visits	410	7.4		12.1		6.4		4.1
Sanctioned Providers				3.6		3.2		5.1
Claims Denied Per Statute					63	2.1		
Audit Impact						7.3		5.6
Total		\$19.1		\$22.1		\$27.9		\$21.9

Medicaid Program Integrity Return on Investment					
Benefits and Costs in \$ Millions					
FY 2009-10			Benefits	Costs	ROI
	Recovery		\$58.5	\$9.1	6.4:1
	Prevention		19.8	6.0	3.3:1
		Total	\$78.3	\$15.1	5.2:1
FY 2010-11			Benefits	Costs	ROI
	Recovery		\$83.1	\$8.5	9.8:1
	Prevention		22.1	5.7	3.9:1
		Total	\$105.2	\$14.2	7.4:1
FY 2011-12			Benefits	Costs	ROI
	Recovery		\$62.2	\$7.9	7.9:1
	Prevention		27.9	5.3	5.3:1
		Total	\$90.1	\$13.2	6.8:1
FY 2012-13			Benefits	Costs	ROI
	Recovery		\$79.5	\$10.4	7.6:1
	Prevention		21.9	7.0	3.1:1
		Total	\$101.4	\$17.4	5.8:1

NOTE: PREVENTION BENEFITS FY 2009-10 ADJUSTED BY THE REMOVAL OF FINES IMPOSED.

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DIVISION OF OPERATIONS

THIRD PARTY LIABILITY UNIT

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

During FY 2012-13, over \$161 million in Medicaid funds were collected. Annual TPL collections over the last four years have averaged over \$139 million, exceeding the target of \$100 million. In addition, the TPL Unit has held Xerox accountable to its contract requirements by vigorously monitoring Xerox's performance. These efforts have helped to ensure maximum recoveries are generated for the State of Florida. Types of recoveries include:

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

Estate – Medicaid files an estate claim on behalf of a deceased Medicaid recipient for Medicaid payments made after age 55. Medicaid is to be paid after attorney and personal representative fees and funeral costs (class 3 creditor) and must be notified by the estate attorney or personal representative when an estate is opened on any individual over age 55.

Trusts - Trusts relating to a person's eligibility in the Medicaid program stipulate that upon the death of the trust beneficiary, or if the trust is otherwise terminated, the balance of the trust up to the amount that Medicaid paid for services on the beneficiary's behalf is to be paid to the Medicaid program.

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

Other Recoupment Projects – The TPL Unit also works in conjunction with the Agency's Office of Medicaid Program Integrity to conduct other Medicaid recoupment projects. Recoveries from other recoupment projects during FY 2012-13 include the following:

- **Date of Death** – Claims paid after the dates of death of recipients and Medicaid providers are recovered.
- **Hospital Audits** – Hospital accounts payable ledgers are reviewed in connection with collecting Medicaid overpayments.
- **Long-Term Care Audits** – Long-term care facility accounts payable ledgers are reviewed in connection with collecting Medicaid overpayments.

Medicaid Overpayments – Funds are recovered from providers where Medicaid has overpaid for a service. Medicaid overpayments include:

- Duplicate Crossover Payments (two Medicaid payments for Medicare Crossover liability);
- Medicaid Secondary Liability (two Medicaid payments for the same services);
- Inpatient Duplicate Payments (two Medicaid payments for inpatient services for the same date(s) of service);
- Inpatient Mother-Baby Overpayments (two Medicaid payments for inpatient services for the same date(s) of service, one for a newborn and the other for his/her mother);
- Outpatient Payment During Inpatient Stay (an outpatient Medicaid payment immediately preceding an inpatient stay);
- HMO/Long-Term Care Overpayments (overpayments identified are capitation payments made for Medicaid recipients who were admitted to long-term care facilities);
- Overutilization - Outpatient Payments Over \$1500 (payments made in excess of the \$1,500 limit for outpatient claims during a fiscal year);
- Duplicate payments (payments were made to the same or different provider for pharmacy, professional, institutional, dental, or managed care services on the same date of service);
- Age Limitations (claims paid outside the allowed age limitations);
- Durable Medical Equipment (DME) Rent to Purchase Equipment (violations of limitations, per DME item); and
- Fee for Service Payments While Recipient is Enrolled in Managed Care (fee for service claims are recovered from providers on the dates of service a Medicaid recipient was enrolled in a Managed Care Plan).

Cost Avoidance - Cost avoidance is new and/or updated insurance information that is derived from data matches with insurance carriers. Cost avoidance is also derived from insurance information obtained at the time of eligibility, through Medicaid area office staff and Medicaid providers. When new and/or updated insurance information is obtained, that information is added to the Florida Medicaid Management Information System (FMMIS) in order to cost avoid future claims that are submitted by Medicaid providers. When a provider submits a claim and a recipient has other insurance, the provider is instructed to bill the other insurance prior to billing Medicaid. The Agency utilizes a matrix maintained in the FMMIS to determine whether a claim shall be paid or denied based upon other third party information contained on the Medicaid recipient's file. Cost avoidance is the amount that was denied based upon third party information contained on the Medicaid recipient's file.

TPL Collections	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13
Casualty	\$18,747,553	\$22,165,885	\$24,336,688	\$22,303,548
Estate	5,479,473	5,486,256	6,017,391	7,061,816
Trusts	5,369,002	6,011,888	7,124,616	5,471,792
Medicare and Other Third Party Payor	44,673,737	72,081,890	78,428,755	77,922,624
Other Recoupment Projects*	40,582,911	29,958,148	32,208,128	48,455,372
Total Collections	114,852,676	135,704,067	148,115,578	161,215,152
Cost Avoidance (Matrix)	\$778,611,980	\$966,902,977	\$1,259,088,849	\$1,423,986,005

*THIS AMOUNT, LESS APPLICABLE FEES, IS REPORTED UNDER MEDICAID PROGRAM INTEGRITY'S COLLECTION, AS MPI CONTRACTS THESE SERVICES UNDER THE CONTRACT MANAGED BY THE THIRD PARTY LIABILITY UNIT.

FINANCE AND ACCOUNTING

Medicaid payments identified as “overpayments” are generally referred to the Agency’s Division of Operations, Bureau of Finance and Accounting (the Bureau), for collections. The Bureau then pursues collection of the overpayments from the Medicaid provider by direct payments from providers or through liens to withhold Medicaid or Medicare payments.

When payments are not received or Medicaid/Medicare cannot be liened, the Bureau investigates to determine if there are other means of collection available or if the case will be referred to an outside collection agency. The Agency cannot authorize any reductions in monies due back to the Agency, as reductions in overpayments must be negotiated during the settlement process prior to the issuance of a Final Order.

During FY 2012–13, there was \$67.7 million booked as accounts receivable. As of June 30, 2012, the Medicaid accounts receivable balance for fraud and abuse was \$41.2 million. The balance as of June 30, 2013 was \$47.8 million. During FY 2012-13, total collections, net of adjustments and refunds approached \$81.9 million. The collections were \$78.4 million in overpayments (\$47 million collected from Medicaid Fraud Control Unit (MFCU) cases and \$31.4 million collected from Medicaid Program Integrity (MPI) cases), \$212,000 in investigation costs, \$3 million in fines/sanctions and \$281,000 in interest.

AHCA must obtain approval from the Department of Financial Services (DFS) for write-off of all accounts receivable determined to be uncollectible and \$3.7 million were approved by DFS for write-off for FY 2012 -13. Accounts can be written off for one of the following reasons:

- The provider has declared bankruptcy,
- The corporation is out of business,
- The defendant is unable to pay due to being incarcerated, or
- The business is insolvent, or is beyond the State’s current collection enforcement authority.

Once overpayments are credited back to the Federal Grantor, the federal requirements only allow federal funding to be reclaimed by the State when the write-off is due to a bankruptcy in which the Agency has filed a claim (even if the bankruptcy had already been discharged at the time the Agency discovers the bankruptcy); for an individual who is deceased and the Agency files a claim on the estate; or, when the write-off is due to a business that is certified as being out of business. Once the receivable is approved for write-off, the qualified federal share of each write-off is reclaimed. During FY 2012-13, \$5.5 million in accounts receivable were approved for write-offs. The Bureau also continues to work with the Agency’s Division of Health Quality Assurance (HQA) to determine if a facility’s license renewal can be affected until the Agency receives the overpayment amount from the provider.

The Bureau uses the Medicaid Accounts Receivable (MAR) system as its business process tool, which records extensive financial detail on Medicaid accounts. The MAR system tracks each case as it moves through the receivables process, identifying which department, bureau or unit has current action responsibility for a case. The system tracks state and/or federal allocation of receivables amounts and produces necessary reports for case management and audit purposes. Examples of reports include: Case Financial Summaries, Case Financial Histories, Case Aging, Summary by Status and Department, “tickler file” and reports for follow-up monitoring.

The MAR system maintains the required accounting data for financial statements and federal reporting purposes related to fraud and abuse cases and other overpayment cases. Examples of other overpayment cases include, but are not limited to hospital and nursing home retroactive rate adjustments and gross adjustments.

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

The Bureau continues to focus on communications with MPI and MFCU to coordinate audit collection efforts. They work with AHCA's Office of General Counsel, Division of Health Quality Assurance, Bureau of Medicaid Finance, Bureau of Long Term Care Services, Office of Third Party Liability and Office of Inspector General to coordinate collection efforts and pursue additional avenues of collection.

The Bureau continues to take steps during the year to reduce the duration of the terms for negotiated payment plans and as well as increase the percentages of the liens placed on provider Medicaid/ Medicare payments. It is the Bureau's objective to collect all overpayments within the 12 months or less as this is the period of time allotted by Federal guidance to credit back the Federal Grantor, the federal share of overpayments.

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OFFICE OF GENERAL COUNSEL

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

The attorneys comprising the Medicaid legal staff provide guidance about improvements to programmatic aspects of Medicaid operations as well as procedural recommendations to improve the likelihood of success should the Agency's actions be challenged in court. The attorneys represent the Agency in Medicaid-related litigation before administrative tribunals, as well as state and federal courts. The attorneys are involved in litigation resulting from record reviews (audits) performed by the Agency or contracted vendors related to the recovery of overpayments from providers, protests related to public procurement activities and challenges to Agency rules. Additionally, litigation can result from actions taken by the Division of Medicaid or the Office of Medicaid Program Integrity related to the provider's enrollment status (termination from the program), real-time reviews of claims for reimbursement (pre-payment reviews), the withholding of reimbursements upon evidence of fraud or other complaints by providers, recipients or advocacy groups.

During this time period, the number of Medicaid Program Integrity cases more than doubled, but the General Counsel's Office assisted in getting these cases closed in a timely manner.

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MEDICAID AND PUBLIC ASSISTANCE FRAUD STRIKE FORCE

Pursuant to Section 624.351, F. S., the Medicaid and Public Assistance Fraud Strike Force (Strike Force) organized in March 2011. The first tasks the Strike Force took on were reviews of the status of the Medicaid and public assistance fraud systems and the anti-fraud resources in place.

Information provided by the Agency for Health Care Administration and the Department of Children and Families painted a picture of burgeoning caseloads of Medicaid and public assistance beneficiaries, between 2007 and 2010. More significant, though, were the trends of increasing referrals to the Medicaid Fraud Control Unit, within the Office of Attorney General and the Division of Public Assistance Fraud, within the Department of Financial Services for fraud investigations.

The initial Strike Force inventories of the resources available to combat fraud indicated there were numerous processes and strategies already in place to do just that. However, in light of the evidence that fraudulent activity was increasing, the Strike Force began to investigate different and innovative approaches.

The Strike Force organized working committees made up of representatives from member agencies that came together to share their concerns and ideas for possible enhancements that could improve the results of our fraud fighting efforts. The Strike Force also invited speakers to meetings who could share information on different facets of federal, state and local anti-fraud activities so that linkages could be identified where resources could be leveraged.

Some proposed enhancements were technological, like the potential that advanced detection systems offered. The value of organizational analyses, through business process mapping, was demonstrated by the Department of Health as a way to identify points in processes where changes could enhance prevention, detection and recoupment. Other suggestions entailed considering ways to leverage existing resources together to produce results that far exceeded what any single resource could attain.

Over the years, these efforts produced numerous recommendations that were formally embraced by the Strike Force, many of which eventually came to fruition. The Strike Force placed primary emphasis on improving prevention efforts to escape the “pay and chase” approach that is systemically inherent in public assistance systems. In particular, Strike Force members noted that the systems needed to make better use of available data. It was also widely accepted that if prevention efforts were to be maximally effective, it was necessary to improve enforcement, investigative and prosecutorial strategies that could serve as deterrents.

Twenty-four of the forty unique recommendations proposed by the Strike Force have been or are being addressed. Here are some highlights of Strike Force recommendations that have been or are being implemented which hold great promise for reducing fraud in Florida's Medicaid and public assistance systems.

- A new Department of Children and Families' Customer Authentication System verifies the identity of applicants for assistance before public assistance is disbursed.
- The Department of Children and Families has implemented enhanced automated data matching to help detect ineligible applicants and beneficiaries.

- The Department of Children and Families procured a new Electronic Benefit Transfer vendor system which incorporates automated anti-fraud analytics which can enhance detection of Electronic Benefit Transfer retail fraud.
- The Agency for Health Care Administration is procuring a new case management system to replace the existing legacy system with one that will include predictive modeling and other advanced techniques for detecting emerging fraud and abuse patterns.
- The Agency for Health Care Administration is also procuring a new Public Benefits Integrity Data Analytics that will detect and deter fraud, waste and abuse in Medicaid and other public benefit programs.
- The Medicaid Fraud Control Unit has extended their federal authorization to engage in data mining and is seeking vendor services to provide technology with advanced data analytics that will greatly enhance the efficiency of those efforts.
- The leveraging of resources between federal, state and local law enforcement to collaborate on investigative operations and maximize charges against perpetrators of fraud is gaining momentum. Local agencies like Manatee County Sheriff's Office, Miami-Dade Police Department and Palm Beach County Sheriff 's Office are establishing interagency models that can be replicated.
- Through its role as the State Law Enforcement Bureau for the United States Department of Agriculture Food and Nutrition Services, the Division of Public Assistance Fraud is continuing to build these partnerships around the state.
- Through the State Law Enforcement Bureau educational conferences, the Strike Force was introduced to prosecutorial strategies that capitalize on the use of existing statutes that can be promulgated throughout the state so perpetrators of public assistance fraud are prosecuted to the maximum extent of the law.
- In addition, another thirteen issues were raised just in the past year and all of them have been addressed or reviewed and determined unnecessary.

One key to sustaining these Strike Force accomplishments will be how effectively the Strike Force transitions its more vital functions to member agencies. This will be the primary focus of the Strike Force as the sunset deadline of June 30, 2014 nears. In addition to completing pending projects so that member agencies can benefit from the results, the Strike Force will be consulting with the members to determine the most relevant ways in which the agencies can continue effective collaborations, including assisting with forging ongoing interagency agreements and promulgating successful strategies whenever appropriate.

COORDINATION AND COOPERATION BETWEEN DOH, AHCA AND MFCU

The Department of Health continues its partnership with the Agency for Health Care Administration (AHCA) and the Attorney General's Medicaid Fraud Control Unit (MFCU) to strengthen interagency coordination and enhance processes and protocols in fraud investigation and prosecution. An interactive partnership is essential for effective, collaborative investigative efforts aimed at protecting the people of Florida against healthcare fraud and substandard health care.

The DOH Division of Medical Quality Assurance (MQA) director and enforcement leadership meet regularly with AHCA and MFCU directors and senior managers to coordinate joint projects, investigations and enforcement strategies and to identify emerging issues or threats. During the past year, these meetings have grown to include several additional state agencies, including the Department of Children and Families, the Department of Financial Services Fraud Strike Force, the Department of Economic Opportunity and the Agency for Persons with Disabilities. Expanding participation in the bi-monthly meetings fosters a multi-agency approach to fraud mitigation, identifies potential, emerging areas of fraud and areas in which agency resources can be more effectively leveraged.

In an example of enhanced agency collaboration, AHCA and DOH recently identified an opportunity to work more closely together to combat the growing problem of unlicensed assisted living facilities. At the first of scheduled quarterly meetings in August, the two agencies reviewed processes, shared best practices and trained staff on statutory and administrative rule requirements. By leveraging field resources in the identification of unlicensed assisted living facilities and streamlining reporting requirements, both agencies expect to see more regulatory and criminal prosecutions in the future.

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

As a result of collaborative efforts, in the past year DOH received a total of 11 legally sufficient referrals from AHCA. Of those cases, 5 were closed with revocation or voluntary surrender of license; one was closed because the practitioner's license had already been revoked; and five are pending.

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STATUTORY REPORTING REQUIREMENTS

NUMBER OF CASES OPENED AND INVESTIGATED EACH YEAR

MFCU opened 249 cases and had 1,006 active cases in FY 2012-13.. MPI investigated 3,393 cases which included 2,108 opened during the year.

SOURCES OF THE CASES OPENED

Sources of the Cases Opened	MFCU	PANE	AHCA	Total
AHCA - Field Offices			3	3
AHCA - Division of Medicaid	1		187	188
AHCA - Health Quality Assurance	2	3	13	18
AHCA - Medicaid Program Integrity	12		1,502	1,514
AHCA - Finance and Accounting			58	58
AHCA - Other			10	10
Agency for Persons with Disabilities	4			4
Adult Protective Services	2	335		337
Citizen	10	3	4	17
Contractor for Centers for Medicare & Medicaid Services	2		15	17
DEA (U.S. Drug Enforcement Agency)	1			1
Employee	10	1		11
Family Member	4			4
Federal Bureau of Investigation	3			3
Florida Department of Law Enforcement	1		7	8
Health & Human Services Inspector General	3	1	7	11
HMO Investigative Unit	2		14	16
Law Enforcement Agency	5	2		7
Medicaid Provider	6	2	132	140
Medicaid Recipient	6		12	18
MFCU Data Mining Initiative	6			6
MFCU - Other than Florida	1			1
Operation Spot Check		1	1	2
Office of Statewide Prosecution	1			1
Press Report			23	23
Qui Tam	118			118
Spin-off Case	1			1
State Agency - Other			13	13
Federal Agencies - Other			107	107
Total	201	48	2,108	2,357

DISPOSITION OF THE CASES CLOSED EACH YEAR

Disposition of Closed Cases				
	MFCU	PANE	AHCA	Total
Administrative Closure	6	1		7
Administrative Referral	55	8		63
Assistance to Other Agencies	10			10
Case Dismissed	14	2		16
Civil Intervention Declined	2			2
Civil Judgment	1			1
Civil Settlement	22			22
Consolidated	6	3		9
Contract Assessments (MCO)			2	2
Conviction	8	4		12
Defendant Deceased	1			1
Deferred Prosecution Agreement	1			1
Fugitive Defendant	8			8
Lack of Evidence	26	15		41
No Fraud or Abuse Found			136	136
Nolle Prosequi		2		2
Overpayment Identified			1,562	1,562
Plea Agreement	14	8		22
Pretrial Intervention	4	1		5
Probation	3	2		5
Prosecution Declined	3	9		12
Provider Education Letter			7	7
Resolved with Intervention		1		1
Sanction Only			496	496
Unfounded	27	6		33
Voluntary Dismissal	28			28
Total	239	62	2,203	2,504

AMOUNT OF OVERPAYMENTS ALLEGED IN PRELIMINARY AND FINAL AUDIT LETTERS

Typically, MPI sends a preliminary audit report explaining the overpayment provisionally identified and giving the provider an opportunity to provide additional documentation. After review of any additional documentation submitted, MPI sends a final audit report that reflects the overpayments identified and offers the provider hearing rights under Chapter 120, Florida Statutes. For the 2,203 cases closed during the fiscal year there were 1,562 cases with overpayments identified.

Preliminary audit reports were issued on 1,104 cases with potential identified overpayments in the amount of \$36,550,414. MPI closed 570 of those cases when the provider agreed to repay the overpayment after the preliminary audit report with identified overpayments of \$1,972,509. In the

remaining 534 cases, final audit reports were issued identifying potential overpayments of \$23,387,961. These cases ultimately were closed after Final Orders with identified overpayments of \$20,127,368. The total overpayments identified for collection in these 1,104 cases amounted to \$22,099,877

In addition to the overpayments identified in those 1,104 cases, MPI identified overpayments in the amount of \$4,411,764 through other mechanisms. These efforts included recovery of overpayments prior to the issuance of preliminary audit reports, overpayments identified through provider self-audits and overpayments collected through paid claim reversals. There were 143 cases closed with no findings including seven where providers were sent education letters and 498 cases closed as sanctions only and MCO assessments. The total identified overpayments amounted to \$26,511,641 for all 2,203 cases closed during the fiscal year – fines and costs are not included in this overpayment amount.

NUMBER AND AMOUNT OF FINES OR PENALTIES IMPOSED

During the fiscal year, MPI initiated 127 prepayment reviews, imposed fines under Rule 59G-9.070, F. A. C., of \$3,505,686 and assessed MCOs under statutory or contractual authority \$50,200, recommended 60 suspensions and recommended 91 “with cause” terminations. There were also 517 referrals to MFCU and others within and outside the Agency.

REDUCTIONS IN OVERPAYMENT AMOUNTS NEGOTIATED IN SETTLEMENT AGREEMENTS OR BY OTHER MEANS

There were no reductions in the overpayment amounts of negotiated settlements during FY 2012-13.

AMOUNT OF FINAL AGENCY DETERMINATIONS OF OVERPAYMENTS

MPI recovery activities on closed cases for the fiscal year determined overpayments of \$26,511,641.

AMOUNT DEDUCTED FROM FEDERAL CLAIMING AS A RESULT OF OVERPAYMENTS

The Agency was not able to reclaim any uncollected funds that were written off during FY 2012-13.

AMOUNT OF OVERPAYMENTS RECOVERED EACH YEAR

MFCU collected \$35,698,962 in overpayments that were returned to AHCA. Additionally, MFCU collected \$62,446,577 in Federal Medicaid overpayments which were sent directly to the U. S. Department of Health and Human Services for a total of \$98,145,539 in Medicaid overpayments collected in FY 2012-13.

During FY 2012-13, total collections, net of adjustments and refunds approached \$81.9 million. The collections were: \$78.4 million in overpayments (\$47 million collected from Medicaid Fraud Control Unit (MFCU) cases and \$31.4 million collected from Medicaid Program Integrity (MPI) cases); \$212,000 in investigation costs; \$3 million in fines/sanctions; and \$281,000 in interest.

AMOUNT OF COST OF INVESTIGATION RECOVERED

During FY 2012-13, the MFCU collected \$57,271.16 in program income investigative costs. MFCU also collected \$179,352.67 in state share investigative costs and \$196,063.49 in federal share investigative costs for a grand total of \$432,687.32 for all investigative costs. AHCA collected \$212,000 in investigations costs.

AVERAGE LENGTH OF TIME TO COLLECT FROM THE TIME THE CASE WAS OPENED UNTIL THE OVERPAYMENT IS PAID IN FULL

For cases that were paid in-full during the fiscal year, the average length of time was 228 days from the date that the case opened to the date the case was paid in full.

THE AMOUNT DETERMINED AS UNCOLLECTIBLE AND THE PORTION OF THE UNCOLLECTIBLE AMOUNT SUBSEQUENTLY RECLAIMED FROM THE FEDERAL GOVERNMENT

During FY 2012-13, the Department of Financial Services deemed \$3.7 million uncollectible and approved it for write-off. The federal requirements only allow federal funding to be reclaimed when the write-off is due to a bankruptcy, an individual who is deceased and the Agency files a claim on the estate; or, when the write-off is due to a business that is certified as being out of business. Based on the federal reporting requirements none of cases written off were subsequently reclaimed from the Federal Government.

The Agency collected \$120,098.35 after the cases were written off.

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PROVIDERS, BY TYPE, THAT ARE TERMINATED FROM PARTICIPATION IN THE
MEDICAID PROGRAM AS A RESULT OF FRAUD AND ABUSE

Terminated Providers	Number
Air Ambulance	1
Assistive Care Services	43
Case Management Agency	3
Chiropractor	2
Community Behavioral Health Services	8
Dentist	6
Durable Med Equipment/ Medical Supplies	7
Home & Community-Based Services Waiver	64
Home Health Agency	39
Independent Laboratory	3
Managed Care Treating Provider - Non-Medicaid	22
Medical Foster Care/ Personal Care Provider	4
Nurse Practitioner (ARNP)	2
Obsolete Provider Type	1
Pharmacy	30
Physician (D.O.)	5
Physician (M.D.)	97
Physician Assistant	1
Podiatrist	2
Professional Early Intervention Services	1
Skilled Nursing Facility	4
Social Worker/Case Manager	3
Specialized Mental Health Practitioner	7
Therapist (PT, OT, ST, RT)	6
Total	361

Additionally, there were 191 providers who were identified as potentially related to suspected fraud and abuse and other compliance-related considerations that were already terminated at the time that the Agency discovered the program integrity related concern. Often-times these are providers who are under review by the Agency or other entity who voluntarily terminate from the program to avoid the involuntary action by the Agency.

ALL COSTS ASSOCIATED WITH DISCOVERING AND PROSECUTING CASES OF MEDICAID OVERPAYMENTS AND MAKING RECOVERIES IN SUCH CASES

MFCU expenditures for FY 2012-13 were \$13,986,426.67, which included indirect costs of \$1,111,031.17.

During the year, MPI expenditures of \$10.4 million were devoted to recovery work resulting in collections of \$79.5 million and a return on investment for recovery operations of 7.6:1. In addition, MPI achieved \$21.9 million in cost avoidance with expenditures of \$7.0 million, producing a return on investment for prevention efforts of 3.1:1.

PROVIDERS PREVENTED FROM ENROLLING IN MEDICAID OR REENROLLING AS A RESULT OF SUSPECTED FRAUD OR ABUSE

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

Providers Denied Enrollment due to Fraud and Abuse Issues	No.
Assistive Care Services	12
Billing Agent	4
Community Behavioral Health Services	6
Dentist	2
Durable Med Equipment/Medical Supplies	2
Home & Community-Based Services Waiver	19
Home Health Agency	76
Independent Laboratory	1
Nurse Practitioner (ARNP)	1
Obsolete Provider Type	2
Pharmacy	8
Physician (D.O.)	6
Physician (M.D.)	84
Therapist (PT ,OT, ST, RT)	2
Total	225

There were an additional 129 providers who were denied enrollment due to findings during an onsite pre-enrollment visit and 46 providers denied enrollment due to disqualifying criminal offenses for a total of 175 providers denied enrollment based on program integrity considerations.

POLICY RECOMMENDATIONS NECESSARY TO PREVENT OR RECOVER OVERPAYMENTS AND CHANGES NECESSARY TO PREVENT AND DETECT MEDICAID FRAUD

AHCA's Divisions of Medicaid, Medicaid Program Integrity (MPI) and Health Quality Assurance will continue with collaborated efforts in identifying outstanding monies owed to the Medicaid program by controlling interests of licensed providers and enforcing statutory authority to deny or revoke licenses of those providers unless full payment is made.

The Agency would like to amend the Medicaid Provider Handbook to require enrolled or registered providers qualifying as a clinic to provide evidence of compliance with the health care clinic licensure law or evidence of meeting exemption from the law.

The Florida Legislature, through member and committee initiatives, has embraced many recommendations from past reports and enacted several statutory provisions that further supported the Attorney General's and AHCA's efforts to prevent and detect Medicaid fraud and abuse and enhanced the recovery of Medicaid overpayments. In order to continue to enhance the capabilities of AHCA and the Attorney General's Medicaid Fraud Control Unit with respect to anti-fraud and abuse efforts, the following recommendations are presented:

- Florida's Legislature should support the following significant enhancements to existing laws that would serve to combat fraud and abuse within Florida's Medicaid program. These enhancements include:
 - Requiring all providers contracting with managed care organizations within the Medicaid program to be fully-enrolled providers. As the Medicaid program continues to shift from a fee-for-service environment to full implementation of managed care, the traditional definition of "provider" found in statute may hinder the State's efforts to identify and combat fraud, waste and abuse. In some instances, the legacy statutory language does not address whether the State has granted the Office of Medicaid Program Integrity the statutory authority to audit or review non-enrolled, registered treating providers that are contracted by managed care organizations and so a significant regulatory and oversight tool is lost. This measure would increase provider and plan transparency and shift the burden of provider credentialing to the State, resulting in a cost savings to the plans while complementing the oversight of managed care organizations' network providers.
 - Repealing Section 465.188, F. S., in its entirety. This statute treats audits and investigations of Medicaid pharmacy records differently than all other Medicaid provider records and prevents the Agency from conducting audits on pharmacies with the same extrapolation methodology used for all other providers. These current restrictions, existing only since 2003, result in less efficient audits, overpayment recoveries limited to a one-year period and a hindrance to the effective oversight of the Medicaid program's pharmacy component.
- In FY 2013-14, the Legislature approved a one-time appropriation for advanced data analytics services. The Agency expects to go to contract with a vendor shortly after release of this report. The Agency recommends that the Legislature consider a request submitted by the Agency for two additional years of funding for this service in order to fully implement and

utilize the capability of this technology. Many other states are currently using or exploring these services and some report returns on investment far exceeding the cost.

The following recommendations are adopted from MPI's Strategic Plan and serve to prepare MPI for continued exemplary service in combatting fraud, waste and abuse in the Medicaid Program. MPI will:

- Continue to identify specific areas of oversight within managed care that best utilize staff expertise and experience, which will result in a more efficient method of delivering high quality services to Medicaid enrollees. In some instances these duties may require enhancing or augmenting staff skills.
- Review compliance with required stated plan networks and patient access to care.
- Investigate inferior quality of care as an indicator of fraud, waste or abuse.
- Verify the 85/15 medical loss ratio through cost report analysis.
- Investigate fraudulent enrollment activities such as enrolling only healthy individuals or dropping those with complex medical issues.
- Build upon and enhance relationships and information sharing with the MCO plans' Special Investigative Units (SIUs).
 - Hold regular fraud and abuse meetings in locations around the state. These meeting will serve as a forum for exchange on current trends, specific provider information and legislative and rule changes.
 - Publish alerts and advisories to plan SIUs as a means of information sharing between meetings.

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DETAILED PERFORMANCE STANDARDS, BENCHMARKS AND METRICS IN THE REPORT, INCLUDING PROJECTED COST SAVINGS TO THE STATE MEDICAID PROGRAM DURING THE FOLLOWING FISCAL YEAR

MPI PERFORMANCE TRENDS

REFERRAL ACTIVITIES

MPI continues to share information regarding Medicaid providers who may be engaging in abusive conduct by referring the information to parties within and outside the Agency, as appropriate. There were 517 referrals in FY 2012-13 as summarized in the following table:

MPI Referrals in FY 2012-13	
Referral to:	Number
Department of Health	12
Division of Public Assistance Fraud	18
Department of Health & Human Services - OIG	94
Division of Health Quality Assurance	80
Division of Medicaid	56
Medicaid Fraud Control Unit	27
Others including MFCU info only	230
Total	517

RECOVERIES OF OVERPAYMENTS – MPI AUDITS

The Medicaid Accounts Receivable Unit of the Bureau of Finance and Accounting is responsible for collecting identified overpayments from Medicaid providers. MPI strives to conclude cases in a timely manner in order to increase the recovery rate. Amendments to Section 409.913, F. S., in 2009 require earlier withholding of funds by Finance and Accounting. The table below lists overpayments identified by fiscal year and collected by Finance and Accounting for the last four fiscal years. The overpayments collected as of August 31, 2013 reflect collections on the overpayments identified during a fiscal year regardless of the year of the collection. There can be an expected lag between the date that an overpayment is identified and the date that it is collected due to payment plans, liens and other collection efforts.

COLLECTION OF OVERPAYMENTS BY ACCOUNTS RECEIVABLE AND PAID CLAIMS REVERSALS

Collection of Overpayments by Accounts Receivable and Paid Claims Reversals (PCRs)				
Fiscal Year	Type Recovery	Overpayments Identified	Accounts Receivable Collections or Reversals Updated as of August 31, 2013	Percentage
FY 2009-10	Accounts Receivable	\$18,796,744	\$14,720,767	78.3
FY 2010-11	Accounts Receivable, Offsets and PCRs	39,011,157	37,846,194	97
FY 2011-12	Accounts Receivable, Offsets and PCRs	36,053,930	30,147,043	83.6
FY 2012-13	Accounts Receivable and PCRs	\$26,511,641	\$18,741,368	70.7

RANDOM AUDITS

During FY 2012-13, Medicaid Program Integrity performed statutorily required random audits that are summarized in the table below. Random audits are not predicated upon suspicion, data analyses, or referrals. They are, as the name implies, randomly selected. Twelve random audits were initiated and overpayments totaling \$9,130 were identified. The table below reflects completed random audits as of the end of the current fiscal year.

Medicaid Program Integrity Random Audits				
Fiscal Year	2009-10	2010-11	2011-12	2012-13
Initiated	11	9	20	12
Completed	11	8	17	5
Findings	5	2	13	2
No Findings	6	6	4	3
Overpayments Identified	\$56,416	\$20,949	\$639,243	\$9,130

MPI Closed Cases by Fiscal Year				
Disposition of Closed Cases	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13
Overpayment Identified*	1807	1907	1987	1562
No Fraud or Abuse Found	401	1006	229	136
Provider Education Letter	158	513	248	7
Sanctions Only*		300	371	496
MCO Statutory or Contractual Assessments*		115	7	2
Total Cases Closed	2366	3841	2842	2203
Percentage of Cases with Findings	76.4	60.5	83.2	93.5

* CASES WITH FINDINGS

APPENDIX A: ACRONYMS USED IN THIS REPORT

ACA – Affordable Care Act
ACS – Assistive Care Services
AFAAR – Annual Fraud and Abuse Reports
AHCA – Agency for Health Care Administration
ALF – Assisted Living Facility
APD – Agency for Persons with Disabilities
AWP – Average Wholesale Pricing
BGS – Background Screening System
CCEB – Complex Civil Enforcement Bureau
CCM – Comprehensive Care Management
CFR – Code of Federal Regulation
CJIS – Criminal Justice Information Services
CMS – Centers for Medicare and Medicaid Services
CMU – Case Management Unit (within MPI)
CPR – Cardiac Pulmonary Resuscitation
DCF – Department of Children and Families
DD Waiver – Developmental Disabilities Waiver under the Florida Medicaid program
DFS – Department of Financial Services
DHHS – U. S. Department of Health and Human Services
DME – Durable Medical Equipment
DOH – Department of Health
DPAF – Division of Public Assistance Fraud
DSS – Decision Support System
E&M – Evaluation and Management
EMA – Emergency Medicaid for Aliens
F&A – Finance and Accounting
F. A. C. – Florida Administrative Code
F. S. – Florida Statutes
FACTS – Fraud and Abuse Case Tracking System
FAD – Fraud and Abuse Detection
FAL – Final Audit Letter
FAR – Final Audit Report
FCPTI – Florida Crime Prevention Institute
FDA – Food and Drug Administration
FDCA – Food, Drug and Cosmetic Act
FDLE – Florida Department of Law Enforcement
FFP – Federal Financial Participation
FMMIS – Florida Medicaid Management Information System
FO – Final Order
FPCU – AHCA's Division of Medicaid, Fraud Prevention and Compliance Unit
FY – Fiscal Year
GA – Generalized Analysis
HHS-OIG – U. S. Department of Health and Human Services, Office of the Inspector General
HIDTA – High Intensity Drug Trafficking Area
HQA – AHCA's Health Quality Assurance
ICD-10 – International Classification of Diseases

IOP – Internal Operating Procedure
ITN – Invitation to Negotiate
MAR – Medicaid Accounts Receivable
MCM – Medicaid Contract Management
MCO – Managed Care Organization
MCU – Managed Care Unit
MFCU – Medicaid Fraud Control Unit
MIC – Medicaid Integrity Contractors
MIG – Medicaid Integrity Group
MII – Medicaid Integrity Institute
MOA – Memorandum of Agreement
MOU – Memorandum of Understanding
MPA – Medicaid Program Analysis
MPI – AHCA's Medicaid Program Integrity
MQA – Medical Quality Assurance (Department of Health)
NAAG – National Association of Attorneys General
NAMFCU – National Association of Medicaid Fraud Control Units
OAG – Office of Attorney General
OGC – Office of General Counsel
OIG – Office of Inspector General
OIR – Office of Insurance Regulation
PAL – Preliminary Audit Letter
PANE – Patient Abuse, Neglect and Exploitation
PAR – Preliminary Audit Report
POC – Plan of Care
PPACA – Patient Protection and Affordable Care Act
PSN – Provider Service Networks
QFAAR – Quarterly Fraud and Abuse Reports
SFY – State Fiscal Year (July 1 – June 30)
SSA – Social Security Act
SURS – Surveillance and Utilization Review Subsystem
TPL – Third Party Liability

This report is published annually by the Office of Inspector General, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop #4, Tallahassee, Florida 32308. Section 409.913 requires that this report be submitted jointly by the Agency for Health Care Administration and the Medicaid Fraud Control Unit of the Department of Legal Affairs. This report is published to the internet at the following address:
http://ahca.myflorida.com/Executive/Inspector_General/index.shtml. If you have any questions regarding this report, you may submit them to the address above, ATTN: Kimberly Noble, SMAII, or email Kimberly.Noble@ahca.myflorida.com.



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

Produced by AHCA Multimedia Design