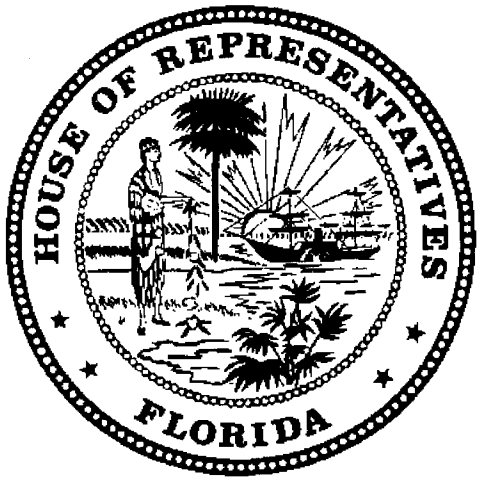

Committee on Health Innovation

Tuesday, October 2, 2007
9:30 AM – 12:00 Noon
Morris Hall (17 HOB)

Marco Rubio
Speaker

Rene Garcia
Chair

House of Representatives

Committee on Health Innovation

AGENDA

October 2, 2007
9:30 AM - 12:00 Noon
Morris Hall

I. Opening Remarks by Chair Garcia

II. Workshop on Medicaid Fraud

Tom Arnold
Deputy Secretary for Medicaid
Agency for Health Care Administration

Richard E. Lober, Director
Medicaid Fraud Control Unit
Office of the Attorney General

III. Closing Remarks by Chair Garcia

IV. Adjournment

AHCA

Medicaid Fraud
Control Unit

RICHARD E. LOBER
Office of the Attorney General
Medicaid Fraud Control Unit
PL-01, The Capitol
Tallahassee, Florida 32399-1050
850-414-3600

Mr. Lober was appointed Director of the Medicaid Fraud Control Unit (MFCU) by Attorney General Bill McCollum in February, 2007. The MFCU is responsible for the prevention, detection, investigation and prosecution, both criminally and civilly, of healthcare providers who commit acts of fraud involving government funding and/or persons who abuse, exploit, or neglect the elderly or those victims unable to care for themselves. The Unit has 232 full-time employees, which include sworn and non-sworn investigators, attorneys/prosecutors, analysts, auditors, other professional staff and administrative support positions. The Unit has statewide authority.

Prior to coming to the Office of the Attorney General, Mr. Lober was the Chief Inspector of the Office of Executive Investigations in the Florida Department of Law Enforcement (FDLE). There he oversaw the public integrity unit, which handles investigations of criminal matters related to public corruption and Governor-ordered investigations, in addition to internal investigations. Mr. Lober has served in various functions at FDLE since 1992, including program administrator for the Forensic Services Section and assistant general counsel. He was formerly a sergeant with the Miami-Dade Police Department, and holds degrees in public administration and law.

Home Health Agency Trends and Enforcement Activities

Office of the Attorney General

Medicaid Fraud Control Unit 2002-2007

Medicaid Home Health Services Overview

A. Medicaid Fraud Control Unit (MFCU)
    a. Florida Statute 409.920
        i. Investigate the possible criminal violation of any applicable state law pertaining to fraud in the administration of the Medicaid program, in the provision of medical assistance, or in the activities of providers of health care under the Medicaid program.
        ii. Investigate the alleged abuse or neglect of patients in health care facilities receiving payments under the Medicaid program, in coordination with the agency.
        iii. Investigate the alleged misappropriation of patients' private funds in health care facilities receiving payments under the Medicaid program.
    b. 232 FTEs in 9 offices Statewide
    c. 75% federally funded

B. Referral Sources
    a. Referral sources include AHCA, private citizens, the Department of Children and Families, recipients, other law enforcement agencies, and MFCU self-generated leads.

C. Medicaid Home Health Service Types
    a. Home visit services provided by a RN or LPN
    b. Home visits provided by a qualified home health aide
    c. Private duty nursing
    d. Personal care services
    e. Therapy
    f. Medical supplies, appliances, durable medical equipment

D. Guidelines for Medicaid Home Health Services
    a. Services must be medically necessary in the home

b. Nursing and Aide visits limited to 4 per day and 60 per lifetime unless an exception is approved through the Medicaid contracted peer review agency (KeyPRO)
c. Private duty nursing, personal care and therapy services limited to medically complex (generally requiring specialized care) children < 21
d. $2 Recipient copayment per provider, per day

MFCU Investigative Trends

A. AHCA referred to MFCU 2 home health cases in 2002, 1 in 2003, 3 in 2004, 7 in 2005, and 13 in both 2006 and 2007.
B. MFCU opened 8 home health cases in 2002, 6 in 2003, 7 in 2004, and 17 each in 2005-2007.
C. From 2005-2007, Dade County centered cases accounted for approximately 70% of new MFCU cases opened.
D. Over $2.6 million dollars in damages identified from these investigations ($1.3 million in one whistle blower case).

Current Fraudulent Activities and Schemes within both Medicaid and Medicare Home Health Services

A. Kickbacks to Physicians
    a. Paying physicians cash kickbacks to sign Plans of Treatments
    b. Authorizing physicians employed as Medical Directors for Home Health Agencies
    c. Home Health Agencies provide gratuities to authorizing physicians. (Expensive lunches, etc.)
B. Patients Recruited by Home Health Agencies and their employees
    a. Employees are paid "finder fees" for soliciting new patients.
    b. Agencies and employees coach Medicaid Recipients in faking or exaggerating symptoms in order to be qualified for Home Health services.
    c. Medicaid recipients are paid a direct cash kickback for participating in the billing of unnecessary or non-rendered services.
C. Medicaid Home Health Agencies appear to be collaborating with Medicare Home Health Agencies to pass off Home Health Aide visits to Medicaid using the T1021 procedure code with dual eligible recipients
    a. T1021 Procedure Code- Home Health Aide (HHA) Visit, Unassociated with skilled nursing services. $17.46/per visit.

*Based upon anecdotal information from South Florida MFCU Offices.

D. Subject Demographics
    a. All subjects arrested were Registered Nurses (RNs) who either worked at or operated Home Health Agencies.

E. Investigative Challenges
    a. Unlike traditional law enforcement, fraud is normally discovered after the fact. Time has elapsed making the collection of evidence and testimony more difficult.
    b. In general, elderly and disabled witnesses may have a poor recollection of events, making claims verification more difficult.
    c. Conspiracies such as kickback schemes involving multiple participants (providers, referring physicians and recipients) are extremely difficult to pierce as each party profits from the scheme.

Home Health Services

Office of the Attorney General

Medicaid Fraud Control Unit

Medicaid Fraud Control Unit

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  - Investigate the possible criminal violation of any applicable state law pertaining to fraud in the administration of the Medicaid program, in the provision of medical assistance, or in the activities of providers of health care under the Medicaid program.
  - Investigate the alleged abuse or neglect of patients in health care facilities receiving payments under the Medicaid program, in coordination with the agency.
  - Investigate the alleged misappropriation of patients' private funds in health care facilities receiving payments under the Medicaid program.
- 232 FTEs in 9 offices Statewide
- 75% federally funded

Case Referral Sources

- Referral sources include AHCA private citizens, the Department of Children and Families, recipients, other law enforcement agencies, and MFCU self-generated leads.

MFCU Investigations Data

	2002	2003	2004	2005	2006	2007
Convictions	93	30	23	32	14	7
Pending	60	32	27	34	51	101
Warrants/Arrests All provider types	166	65	58	67	67	108

Medicaid Home Health Service Types

- Home visit services provided by a RN or LPN
- Home visits provided by a qualified home health aide
- Private duty nursing
- Personal care services
- Therapy
- Medical supplies, appliances, durable medical equipment

Guidelines for Medicaid Home Health Services

- Services must be medically necessary in the home
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MFCU Investigative Trends

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- From 2005-2007, Dade County centered cases accounted for approximately 70% of new cases opened.
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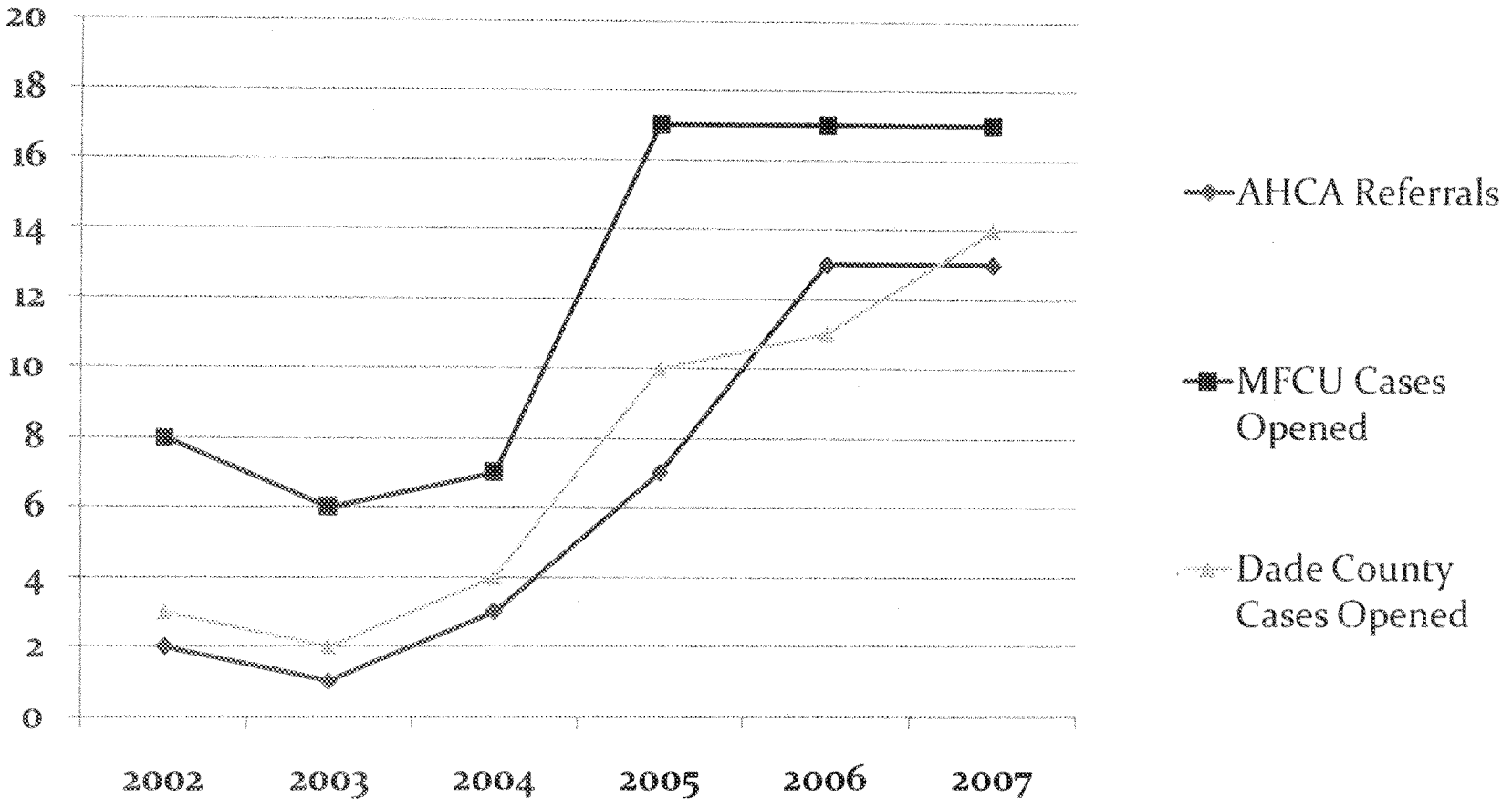
Home Health Case Trends



Fraudulent Activities and Schemes within Medicaid & Medicare Home Health Services

- Kickbacks to Physicians
- Patients recruited by Home Health Agencies and their employees
- Medicaid Home Health Agencies appear to be collaborating with Medicare Home Health Agencies to pass off Home Health Aide visits to Medicaid using the T1021 procedure code with dual eligible recipients
- All subjects arrested were Registered Nurses (RNs) who either worked at or operated Home Health Agencies.

Durable Medical Equipment Trends and Enforcement Activities

Office of the Attorney General

Medicaid Fraud Control Unit 2002-2007

Medicaid Durable Medical Equipment (DME) Overview

A. DME is equipment that can be used repeatedly, services a medical purpose, and is appropriate for use in the patient's home.

B. Medical supplies are medical or surgical items that are consumable, expendable, disposable or non-durable, and are appropriate for use in the patient's home.
C. Medical necessity must be documented by a prescription, a statement of medical necessity, a plan of care, or a hospital discharge plan.
D. No copayment is associated with DME.
E. Examples:
    a. Examples of DME include: ambulatory equipment, diabetic supplies, orthotics and prosthetics, oxygen and related equipment, and wheelchairs.
    b. Examples of medical supplies include: ostomy and urological supplies.
F. DME may be rented or purchased.
G. Most medical supplies are limited to one per day per recipient.

MFCU Investigative Trends

A. AHCA referred to MFCU 3 DME cases in 2002, 3 in 2003, 15 in 2004, 12 in 2005, 17 in 2006, and 6 in 2007.
B. Other referral sources include private citizens, recipients, other law enforcement agencies, and MFCU self-generated leads.
C. MFCU opened 117 DME cases from 2002-2007, with 64 cases centered in Dade County.

D. 78 DME case related arrest warrants issued from 2002 through 2007, representing 14.8% of total warrants issued during this time period (note: 43 arrests in 2007 attributable to DME Strike Force Operation).
E. Over $2 million dollars in damages identified from these investigations.

Current Fraudulent Activities and Schemes within both Medicaid and Medicare Durable Medical Equipment Companies

A. Change of ownership with strawman purchasers submitting false claims for nebulizers and associated pharmaceutical products (a nebulizer is an electrically powered machine that turns liquid medication into a mist so that it can be breathed directly into the lungs through a face mask or mouthpiece).
    a. "Bust Out Schemes": submitting large numbers of fictitious claims for short periods of time. Proceeds are laundered through various bank accounts and "check cashing" businesses.
B. Kickback Schemes between Durable Medical Equipment providers and other healthcare providers.
    a. Kickback arrangements between pharmacies, Durable Medical provider and Assisted Living Facilities for the purchase and sale of compounded medications used in conjunction with nebulizers.
C. South Florida Multi-Agency Strike Force
    a. This strike force was activated on March 1, 2007 under the direction of the U.S. Attorney's Office for the Southern District of Florida and in cooperation with the Medicaid Fraud Control Unit, Federal Bureau of Investigation, Department of Health and Human Service (Office of the Inspector General) and the Hialeah Police Department. The strike force consists of four (4) Teams, and each Team has an assigned Assistant U.S. Attorney or cross-designated attorney from the Department of Health and Human Services for prosecution purposes.
    b. The strike force was created to consolidate investigative efforts to combat Medicaid and Medicare fraud occurring in South Florida.
    c. Both of the noted schemes are currently the focus of the South Florida Multi-Agency Strike Force and account for the current surge in enforcement activity.
D. Subject Demographics
    a. The vast majority of subjects arrested were owners/operators of Durable Medical Equipment Companies.
E. Investigative Challenges
    a. Unlike traditional law enforcement, fraud is normally discovered after the fact. Time has elapsed making the collection of evidence and testimony more difficult.
    b. In general, elderly and disabled witnesses may have a poor recollection of events, making claims verification more difficult.

c. Conspiracies such as kickback schemes involving multiple participants (providers, referring physicians and benefit recipients) are extremely difficult to pierce as each party profits from the scheme.
d. Many of the items paid for by the Durable Medical Equipment program are consumables (blood glucose strips, diabetic supplies, enteral nutrition supplements, etc.) and as such are difficult to field verify product delivery.

Durable Medical Equipment (DME)

Office of the Attorney General

Medicaid Fraud Control Unit

Durable Medical Equipment (DME)

- DME is equipment that can be used repeatedly, serves a medical purpose, and is appropriate for use in the patient's home.
- Medical supplies are medical or surgical items that are consumable, expendable, disposable or non-durable, and are appropriate for use in the patient's home.
- Medical necessity must be documented by a prescription, a statement of medical necessity, a plan of care, or a hospital discharge plan.
- No copayment is associated with DME.

Durable Medical Equipment (DME)

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- Examples of medical supplies include : ostomy and urological supplies.

MFCU Investigative Trends

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- Other referral sources include private citizens, recipients, other law enforcement agencies, and MFCU self-generated leads.

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MFCU Investigative Trends

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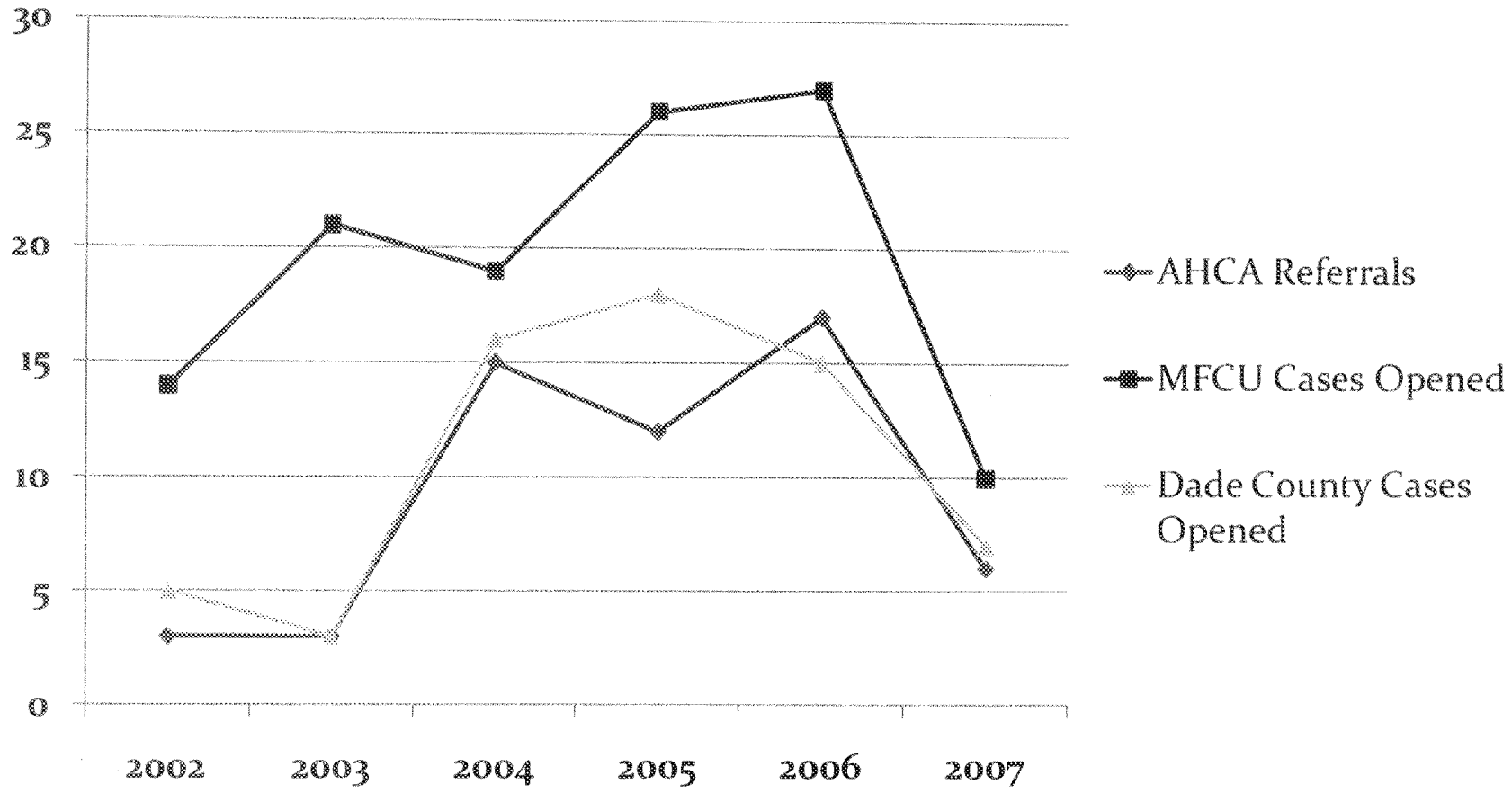
- Over $2 million dollars in damages identified from these investigations.

DME Trends


30
25
20
15
10
5
0
2002
2003
2004
2005
2006
2007
AHCA Referrals
MFCU Cases Opened
Dade County Cases Opened

Fraudulent Activities and Schemes within Durable Medical Equipment Companies

- Change of ownership with strawman purchasers submitting false claims for nebulizers and associated pharmaceutical products.
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- The vast majority of subjects arrested were owners/operators of Durable Medical Equipment Companies.

Annual Report on
The State's Efforts to Control Medicaid Fraud and Abuse
FY 2005 - 06

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

December 2006

Florida Attorney General
Charlie Crist

AHCA

Table of Contents

Introduction

During Fiscal Year 2005-06, the Florida Medicaid Program assisted more than 2.2 million Floridians with their healthcare needs. Over 100.6 million claims totaling nearly $15 billion were paid, which included $5.2 billion for institutional claims (hospitals, nursing homes, etc.), $1.8 billion in pharmacy claims, and $700 million in physician services claims. Florida Medicaid is funded with approximately 60 percent federal tax monies and 40 percent state tax monies.

The Agency for Health Care Administration ("AHCA" or "the Agency") and the Medicaid Fraud Control Unit (MFCU) work closely together to ensure that fraud and abuse are dealt with aggressively. Staff engaged in anti fraud and abuse activities consists of investigators, data analysts, health care professionals, attorneys, and others. A wide array of tools and techniques are utilized to deter, detect, and recover overpayments due to fraud and abuse.

Coordination and Cooperation between AHCA and MFCU

AHCA and MFCU work closely together on joint investigative projects, discussions of policy and other Medicaid program issues, and continue to work toward enhancing processes and developing protocols for improved coordination. The senior management teams for both AHCA and MFCU, as well as the Department of Health (DOH), meet monthly to discuss major issues, strategies, joint projects and other relevant matters.

Senior managers from the Office of the Inspector General (OIG), the Division of Medicaid, MFCU and DOH provide a monthly briefing to the Agency's Secretary regarding collaborative efforts. MPI managers and investigators continue to coordinate and work closely with MFCU bureau chiefs and lead attorneys, as needed, on specific cases to ensure that there are no duplications of effort and to ensure that all monies suspected of having been misspent due to fraud and abuse are pursued. Additionally, MPI and MFCU continue to coordinate with regard to MFCU settlements to ensure that each resolution includes all appropriate Agency issues and does not impact any ongoing or future MPI investigations.

The Agency and MFCU again collaborated with the DOH on a Medicaid Fraud and Abuse Summit in January 2006. While Medicaid Reform and issues specific to fraud and abuse initiatives related to managed care were the primary focus of the summit, issues related to institutional provider types were also discussed.

Report from the Medicaid Fraud Control Unit

Health care fraud is an immense societal problem, both nationally and within Florida's $15 billion-a-year Medicaid program. The Medicaid Fraud Control Unit (MFCU) is responsible for policing the Medicaid program, as well as investigating allegations of corruption and fraud in the administration of the program. 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 wide range of provider fraud involving doctors, dentists, psychologists, home health care companies, pharmacies, drug manufacturers, laboratories and durable medical equipment companies. 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. Local state attorneys prosecute health care providers who are arrested by MFCU personnel, the Office of Statewide Prosecution, the United States Attorney or MFCU attorneys who are Special Assistant State Attorneys or Special United States Attorneys cross-designated by those agencies. Since 2003, the Medicaid Fraud Control Unit has made more than 200 arrests, resulting in 123 convictions. Sometimes cases that may not be suitable for arrest and criminal prosecution are litigated by unit attorneys using a variety of civil statutes. The MFCU has recovered more than $171 million from January 1, 2003 through September 12, 2006. For FY 2005-06, MFCU recovered $74,872,888.

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 living facilities. The quality of care being provided to Florida's ill, elderly and disabled citizens is an issue of great concern and a priority within the MFCU.

MFCU Highlights

Managed Care

Effective July 1, 2006, AHCA began implementation of Medicaid Reform through managed care organizations in Broward and Duval counties. At the end of the first year of implementation, Medicaid Reform will be extended to Nassau, Clay and Baker counties. With Legislative approval, the program will extend statewide in the future.

The Medicaid managed care program to date has been a smaller portion of the program compared to fee-for-service programs. Prior to Medicaid Reform, approximately 700,000 recipients were enrolled in managed care out of an average of 2.2 million recipients. Under Medicaid Reform, individual recipients will have the ability to select their own health plan. The state should maintain strict oversight of managed care plans and will adapt its fraud efforts to discovery of fraud and abuse within the managed care system. The Florida Medicaid Fraud Control Unit has developed and provided training to MFCU investigators throughout the state on unique issues involved in managed care investigations. Individuals from MFCU and AHCA will conduct regular meetings with Medicaid Reform HMOs and non-Reform HMO representatives to provide training on topics of interest to all concerned. The meetings will also be used to discuss issues pertinent to all entities.

As the State of Florida moves into Medicaid Reform, the MFCU will continue efforts to investigate fraud in the managed care arena through referrals from AHCA, training, liaisons with HMOs and refocusing of investigative resources.

Statewide Patient Abuse, Neglect and Exploitation (PANE) Team

The Medicaid Fraud Control Unit is charged by state statute with responsibility for investigating allegations of abuse, neglect or exploitation of elderly or disabled adults residing in health care facilities. Currently there are dedicated Patient Abuse Neglect and Exploitation (PANE) Teams in Tallahassee, Tampa and Miami and PANE investigators located in the other MFCU offices. During the last fiscal year, the MFCU reviewed 11,249 reports made to the Florida Abuse Hotline and, as a result, opened 312 PANE investigations.

The MFCU coordinates Operation Spot Checks throughout the State of Florida, providing for unannounced multi-agency inspections of residential health care facilities. These inspections ensure the

health, safety and well-being of the residents. During the last fiscal year, the MFCU conducted 211 such inspections, resulting in approximately 17 PANE investigations.

When the State of Florida is beset by natural disasters such as hurricanes, floods or man-made disasters, which impact communities beyond the capacity of local departments to manage, MFCU personnel make visits to Nursing Homes, Assisted Living Facilities, Adult Family Care Homes and Residential Group Homes within the affected area. The purpose of these visits is to offer assistance to the facility and ensure the health, safety and well-being of the residents. The MFCU coordinates the post-disaster facility checks with AHCA and the Agency for Persons with Disabilities. During the last fiscal year, the MFCU conducted 1,653 facility checks following hurricanes Dennis, Katrina, Wilma and Tropical Storm Alberto.

The MFCU provided PANE training presentations to the Department of Children & Families/Adult Protection Services investigators, Department of Health investigators, the Long Term Care Ombudsman volunteers, the Adult Protection Teams and the Florida Sheriff's Association. The MFCU Statewide PANE Unit will continue to maintain strong productive liaison with outside agencies and increase the frequency and number of Operation Spot Checks statewide.

Florida Diversion Response Teams

In July 2004, four Florida Diversion Response Teams (DRTs) were formed. The teams' core members are investigators and agents from the Attorney General's Medicaid Fraud Control Unit, the federal Drug Enforcement Agency (DEA) and the Florida Department of Law Enforcement (FDLE). Based upon the success of the groups' efforts, additional teams were formed. To date, eight teams are strategically located throughout the state.

The teams work in partnership with local, state and federal law enforcement, as well as with regulatory agencies, to prevent, investigate and present for prosecution crimes associated with the organized diversion of pharmaceutical drugs.

The diversion of pharmaceuticals is a critical issue, because historically:

- Pharmaceuticals have been the fastest growing part of the Medicaid budget;
- For every five Medicaid dollars, nearly one dollar has been spent on pharmaceuticals;
- In 2004, 19.1 million Americans were current illicit prescription drug users;
- According to a study conducted by the Partnership for a Drug-Free America, 19 percent of teens report abusing prescription medications to get high;
- According to the 2005 Florida Medical Examiner's Report, 72 percent of deaths associated with illicit drugs were the result of pharmaceutical drugs.

The DRTs have had significant successes. For example, Osteopath Dr. Thomas G. Merrill was convicted in January 2006 on 98 of 100 federal charges. Jurors found Dr. Merrill's actions led to the deaths of five patients. In July 2006, Dr. Merrill was sentenced to life imprisonment.

Exclusion Project

When an individual or entity is reported to the HHS/OIG due to a criminal conviction, the HHS/OIG determines whether the individual or entity should be excluded from further participation in federal health care programs. Under the process developed and encouraged by the MFCU, after obtaining a criminal conviction of a Medicaid provider or healthcare worker, local prosecutorial authorities throughout the state are encouraged to submit a "Referral Form to the MFCU to Process Exclusions". This referral form is reviewed by MFCU before being sent to HHS/OIG for possible exclusion. After discussions and mailing information to Florida sheriffs and state attorneys, MFCU received 72 referrals for submission during the State FY 2005-06.

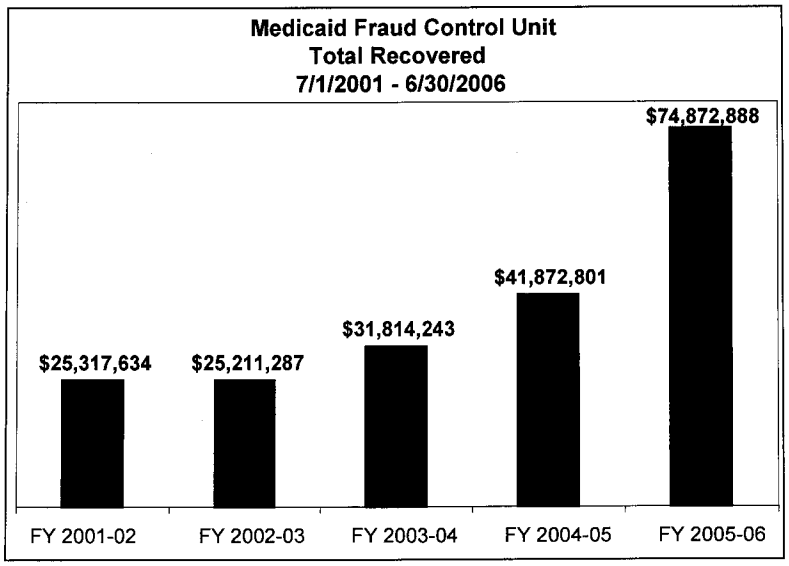
The Florida Department of Health currently sends notice of emergency suspensions to MFCU for licensed medical professionals that have had actions taken against their license. This information is also reported to HHS/OIG. This initiative is ongoing and is expected to yield additional exclusions to the federal health care programs.

Intelligence Team

The statewide Intelligence Team has as its mission to conduct in-depth analyses of circumstances that are brought to the attention of the Medicaid Fraud Control Unit and to determine whether a Medicaid nexus can be established.

An evaluation of the circumstances (i.e., complaint, news event or referral from a source outside the Agency) is completed by the Intel Unit. If a nexus to Medicaid is established and the allegations support additional field investigation, an MFCU case will be opened and forwarded to the appropriate field office.

The Intel Unit has established and will maintain a close working relationship with the Agency for Health Care Administration - the Bureau of Medicaid Program Integrity, Florida Department of Health, Florida Department of Children & Families, Agency for Persons with Disabilities – Inspector General's Office, Florida Department of Law Enforcement, United States Department of Defense, Drug Enforcement Agency, Federal Bureau of Investigation, United States Attorneys Offices, the Florida Intelligence Unit and local law enforcement agencies in order to create a steady exchange of information.



Top Criminal Cases of 2005-06

Dr. Thomas G. Merrill

In January 2006, a federal jury in Pensacola returned a verdict against Thomas G. Merrill, convicting him on charges of wire fraud, health care fraud and distribution of controlled substances.

The federal grand jury charged that Merrill, a licensed osteopathic physician formerly practicing at Magnolia Medical Clinic in Apalachicola, prescribed controlled substances to patients without performing a physical examination and without determining a sufficient medical necessity to prescribe the drugs. Many of Merrill's patients appeared to be "doctor shopping" to support their drug habits. Other charges included prescribing excessive and inappropriate quantities of controlled substances, failing to monitor the use and abuse of the prescribed controlled substances by patients, and prescribing controlled substances to patients knowing that the patients were addicted to or misusing the controlled substances and wanted additional quantities for their drug habit. Five patients died from overdoses of the medications.

Merrill was convicted on January 30, 2006, of 98 counts of dispensing or distributing controlled substances, defrauding health care benefit programs and wire fraud. He was sentenced on July 10, 2006, to life in prison, and ordered to pay $115,017 in fines and restitution to health care benefit programs.

Dr. Suzanne Abergel-Nahon

Dr. Abergel-Nahon, a dentist, who practices in Dade County, was arrested in October 2004 and charged in a three count Information filed in the 11th Judicial Circuit through the Statewide Prosecutor's Office. The indictment charged Dr. Abergel with conducting an organized scheme to defraud the State of Florida of more than $50,000 (1st degree felony); grand theft in excess of $100,000 (1st degree felony) and employment of a non-dentist to perform dentistry (3rd degree felony). Dr. Abergel had been paid in excess of three million dollars ($3,000,000) by Medicaid during the last four years. Staff members, patients and the care providers of other patients had confirmed that much of the dental work for which this dentist billed Medicaid had been performed by persons lacking the qualifications to perform properly such procedures. On November 23, 2005, Dr. Abergel-Nahon entered a plea of no contest. She was sentenced to five years probation, 500 hours of community service and ordered to pay restitution and costs totaling $250,000.

Dr. Lehel Kadosa

(Owner/operator of America Spine and Pain/Rehabilitation Institute)

On October 15, 2004, Dr. Lehel Kadosa was arrested for one count of knowingly assisting a patient or other person in obtaining a controlled substance through deceptive, untrue, or fraudulent representations and Medicaid Provider Fraud. The arrest took place after a joint investigation by the DEA and the MFCU, which revealed that Dr. Kadosa made false entries in medical records to justify prescribing pain medication to his patients, when no medical need existed. He also billed Medicaid for providing services for which he had already billed and been paid for under Medicare. Dr. Kadosa was convicted of two counts of Assisting in Obtaining Controlled Substances by Fraud on May 16, 2006. He was sentenced to one year and six months probation and 25 hours of community service. Civil litigation is ongoing.

Mayra Del Olmo

(Facility Administrator, The Gardens at Kendall)

The Miami PANE team investigated a death at The Gardens at Kendall, an assisted living facility. The investigation revealed that facility administrator, Mayra Del Olmo, did not provide prompt medical attention to the victim after a fall that seriously injured the victim's leg. Even though records indicated the victim fell at approximately 10:30 a.m., she did not receive any medical attention until 5:00 p.m. As a result of complications from the injury, the victim died two days later. Del Olmo was the administrator and main caregiver at the facility. On February 28, 2006, she was convicted of Aggravated Neglect of an Elderly Person or Disabled Adult and sentenced to one year of community control; five months probation, 300 hours of community service and MFCU investigative costs of $11,000.

Bio-Med Plus, Martin J. Bradley, III and Martin J. Bradley, Jr.

Bio-Med Plus, a Miami-based pharmaceutical wholesaler, was primarily engaged in the buying and selling of prescription drugs used to treat conditions such as AIDS and hemophilia. Martin J. Bradley, III, and his father, Martin J. Bradley, Jr., owned Bio-Med Plus. The Bradleys, who resided in both Savannah, Georgia and Miami, allegedly conspired to defraud the Florida Medicaid program out of millions of dollars for AIDS and hemophilia prescription drugs. The MFCU's investigation revealed that the Bradleys allegedly facilitated the diversion of these drugs through various Florida-, Georgia- and Puerto Rico-based companies and pharmacies they either owned or influenced.

In March 2005, nine individuals in Miami and Savannah, Georgia were arrested on charges stemming from the investigation of the Bradleys. The arrests followed a 288-count indictment returned by a federal grand jury sitting in Savannah, Georgia. According to the indictment, pharmaceutical treatments were ordered by associated Miami area physicians who did not administer the drugs as prescribed. Through the use of certain pharmacies, the Florida Medicaid program was billed for these drugs and subsequently it paid for them, often as much as $4,000 to $6,000 per treatment. The pharmacies would deliver mass quantities of medications to the physicians' offices, but the drugs would later be collected by co-conspirators and returned to either area pharmacies or Bio-Med Plus and were never administered to patients.

These drugs were fraudulently re-billed to Medicaid through several pharmacies, or unlawfully transferred, distributed and diverted to other pharmacies or wholesalers, including Bio-Med Plus, for sale on the open market. The Bio-Med Plus scheme cost the Florida Medicaid program more than $10 million.

The defendants, including the Bradleys, were charged under the Federal Racketeer Influenced and Corrupt Organization Act, which carries a potential sentence of 30 years to life in a federal prison. Martin J. Bradley, Jr., Martin J. Bradley III, and Alberto Tellechea were adjudicated guilty on March 29, 2006. On September 6, 2006, Martin Bradley III was sentenced to 25 years in federal prison, and ordered to pay $27.8 million in restitution and a $5 million fine. Martin Bradley Jr., was sentenced to 18 years in federal prison and ordered to pay $1.5 million in restitution. Alberto Tellechea, owner of Infustat, Inc., was sentenced to five years in federal prison and ordered to pay a $100,000 fine. Bio-Med Plus Corporation was fined $26.5 million. Total forfeiture, restitution and fines are approximately $72.5 million. This case was prosecuted by the United States Attorney for the Southern District of Georgia. The amount awarded to the Florida Medicaid program is $10,157,828 and the total amount forfeited is $39.5 million.

Selected Civil Cases and Settlements

Serono Laboratories

Serono Laboratories, Inc. marketed Serostim as a drug used to treat AIDS patients for severe weight loss, despite lack of approval by the U.S. Food and Drug Administration and the absence of evidence that it was clinically effective. The company also used non-FDA-approved software designed to justify the medical need for Serostim. Serono Laboratories provided kickbacks and other illegal inducements to pharmacies and physicians who purchased and administered Serostim. Each of these practices was in violation of FDA regulations. The case was originally filed as four whistleblower actions.

Serono Laboratories, which also does business as Serono, Inc., Serono S.A. and Ares Trading S.A., pled guilty in federal court in Boston to two counts involving use of interstate commerce to introduce and deliver adulterated medical devices and conspiring to pay health care providers to gain referrals of patients and pharmacies paid for by Medicaid.

Florida attorneys and investigators worked with the U.S. Department of Justice in Washington and the U.S. Attorney's Office in Boston on the case. The settlement was negotiated by the U.S. Department of Justice, the U.S. Attorney's Office in Boston and several state attorneys general working through the National Association of Medicaid Fraud Control Units. Florida's Medicaid Fraud Control Unit played a key role in negotiating the settlement on behalf of all 50 states.

Six states – Florida, California, Illinois, Missouri, New Jersey and New York – received double damages for off-label marketing and the kickbacks to pharmacies and physicians. The total federal and states settlement was $717 million. The recovery obtained by Florida was $54.1 million of which AHCA received $9.1 million.

King Pharmaceuticals

A federal investigation revealed that King Pharmaceuticals improperly reported prices for its products to the federal government. These incorrect prices were used by the government to calculate rebates King Pharmaceuticals was required to pay to state Medicaid programs in order to keep its products eligible for Medicaid reimbursement. By reporting the wrong prices, King Pharmaceuticals cheated the various states' Medicaid programs out of millions of dollars in rebates. As a result, taxpayers were forced to pay a greater amount to maintain the Medicaid program.

Florida's portion of this settlement was $4.2 million out of the $124 million nationwide settlement negotiated by the Justice Department and the National Association of Medicaid Fraud Control Units. Florida MFCU was one of four state MFCUs that brokered the national settlement.

Gambro Healthcare

A lawsuit filed by a whistleblower in 2001 against Gambro Healthcare and Gambro Supply Corporation, resulted in a federal investigation. The investigation revealed that Gambro Healthcare and its supply company improperly billed both the federal Medicare program and the individual Medicaid programs in

each state. Gambro operated a chain of clinics that provided care for end-stage kidney disease, a terminal condition that requires regular dialysis treatment. Gambro Supply was operated as a shell company, which allowed the parent company to bill Medicaid for dialysis supplies at a much higher rate than otherwise would have been allowed.

The August 15, 2005, settlement resolved allegations surrounding Gambro's bogus Medicaid billings for renal dialysis, and unnecessary diagnostic tests and associated medications, as well as allegations of kickback payments to physicians who referred patients. The total nationwide settlement was $308.4 million, most of which was for the federal Medicare program to provide healthcare for elderly patients. A total of $36 million of the settlement was set aside for federal and state Medicaid programs, with Florida receiving a federal and state share of $2.4 million.

HCA, Inc.

Pursuant to HCA's voluntary self reporting to the MFCU of certain possible improper claims for and receipt of Medicaid payments from Florida's Agency for Health Care Administration, the MFCU conducted an investigation of HCA concerning HCA's billings under hospital outpatient Code 510 for the years 1998 through 2003.

Reimbursement under Code 510 is generally limited to only those routine clinic services, which are provided in conjunction with specified therapy, or rehabilitation services (such as respiratory therapy, infusion therapy or chemotherapy). Other types of routine clinic service are not covered under Revenue Code 510. In this investigation, a number of HCA's clinics incorrectly billed for services using Code 510 and received Medicaid overpayments of $978,089. As determined and settled, HCA repaid the $978,089 owed to AHCA.

Schering-Plough Corporation - Claritin®

A federal investigation revealed that Schering Sales Corporation, a unit of Schering-Plough, engaged in a wide variety of misconduct that included misreporting the "best price" for several of its drugs, among which is the popular allergy drug Claritin®. By inflating the best prices, Schering-Plough undercut the value of rebates the state Medicaid programs were supposed to receive for the drugs.

The investigation also revealed that Schering-Plough engaged in improper marketing of a drug intended to treat brain tumors. The company pushed the drug for other purposes not approved by the FDA. Schering-Plough was also accused of paying improper kickbacks to doctors to encourage them to use Schering-Plough's products when they treated patients.

The settlement resolves allegations surrounding Schering-Plough's fraudulent best price reporting practices as well as the improper off-label marketing practices and the kickbacks. The total federal and state share of the nationwide settlement is $435 million. The recovery obtained by Florida is $10.4 million.

Report from the Agency for Health Care Administration

Office of the Inspector General

AHCA's Office of the Inspector General (OIG) handles the functions normally found in any state Agency's Inspector General's office, such as Internal Audit and intra-agency investigations. Additionally, however, the OIG is responsible for coordinating the Medicaid fraud and abuse prevention and detection activities. This entails monitoring the business practices of over 80,000 providers, who annually submit nearly $15 billion in claims. The OIG ensures their compliance with many contractual obligations as well as compliance with state and federal laws, regulations and policies. While many parts of the Agency contribute to ensuring compliance, the OIG's Bureau of Medicaid Program Integrity is recognized as largely responsible for developing cases from detection to collection. Additionally, the OIG created the Bureau of Compliance and Strategy (BOCS) to develop new strategies to deter and detect fraud and abuse and to enhance coordination in and outside the Agency in this ever-changing field of compliance with state and federal regulations. The reports from these two bureaus follow.

Bureau of Compliance and Strategy

Created in December 2005, the Bureau of Compliance and Strategy (BOCS) is responsible for designing and planning strategic initiatives for the purposes of improving fraud and abuse prevention, detection and collection efforts. Some efforts target improved efficiency in current programs or entail offering completely new methods of achieving compliance or collecting monies owed to the Agency. Since formation of BOCS, many initiatives have been undertaken. The following are three key examples:

Collaboration with the Department of Health

Florida law makes it possible to refer noncompliant Medicaid providers to the Department of Health (DOH) for disciplinary action for non-payment of debt. BOCS worked with the Department of Health and the Office of General Counsel to develop a complaint process to maximize the disciplinary jurisdiction DOH would have over the provider. The process was designed to include charges of both improper billing activity and failure to repay the debt. In this way, a provider simply filing bankruptcy to stop a proceeding merely based on nonpayment of a legal obligation would not thwart a DOH action. The sentinel effect of tying improper billing practices to disciplinary jurisdiction of DOH will boost billing compliance statewide.

Out-of-Business Certification

Medicaid is a partially federally funded program administered by the state and whenever an overpayment is identified as having been made to a Medicaid provider, federal law requires that the state return the portion of the federal financial participation (FFP) to the Centers for Medicare & Medicaid Services (CMS). This means that Florida must pay back to the federal government approximately 60 percent of the overpayment, (the FFP amount), regardless of whether Florida has collected it from the provider. In general, when the state does collect from the provider, it may keep the amount collected.

Significant amounts of money, however, may end up being uncollectible due to a number of circumstances such as insolvency, bankruptcy, etc. This means that Florida carries the loss of not only state monies earmarked for Medicaid, but also for the federal financial participation. Florida may make a reclaiming adjustment of those federal monies, i.e. get the 60 percent back if it shows, pursuant to federal guidelines that the service provider is either out of business or bankrupt.

The problem presented to BOCS was fitting Agency practices and Florida laws into meeting the federal guidelines in order to maximize the reclaiming adjustment. The importance of creating such a process could result in millions of dollars staying with the state of Florida. BOCS designed the *Out of Business Certification* program, which requires Agency personnel and third party collection entities to provide specific information regarding collection efforts and findings that comply with federal regulations for presentation to AHCA's Inspector General, who then can certify the provider is out of business. The program at the end of FY 2005-06 was in the design phase.

Explanation of Medicaid Benefits

Federal regulation requires that Medicaid recipients, on a random basis, receive an Explanation of Medicaid Benefits (EOMB) that have been paid on their behalf for services they have received. The purpose of the program is to get the recipient to report inconsistencies between their actual receipt of services and what the provider is claiming as listed on the EOMB.

Florida passed legislation in 2005 requiring that the EOMB be sent to all recipients for all services billed to Medicaid (409.913 (36) F.S). The federal regulations state that no explanation shall be included for services which the state determines to be confidential.

The BOCS has been spearheading two efforts in this program. First, to make sure the explanations of services that should be confidential, are correct, current, and indeed, confidential. Secondly, the BOCS has been working at ways to make the governmental form letter more user-friendly. Through the use of graphic arts, which plainly illustrate the proper purpose of the letter, it is believed that the EOMB will become a more potent tool in fighting fraud and abuse.

Bureau of Medicaid Program Integrity

The Bureau of Medicaid Program Integrity (MPI) has the principal responsibility within the Agency for minimizing losses in the Medicaid program due to fraud and abuse. MPI, in meeting its responsibilities, carries out fraud and abuse preventive activities, performs detection analyses, conducts audits, imposes sanctions as appropriate and refers certain providers to the Medicaid Fraud Control Unit (MFCU) and to other regulatory and investigative agencies.

Prevention activities in MPI are of great importance. If an overpayment is prevented, the Agency does not have to detect, audit and recover the funds. There are no appeals and protracted legal proceedings. To the extent that it is possible to prevent overpayments, that is the most efficient way to deal with Medicaid fraud and abuse. In FY 2005-06, MPI prevention efforts resulted in avoided costs of approximately $37 million. This cost avoidance is discussed in some detail in the section below headed **Prevention**.

Overpayments do occur, however, in the Medicaid programs of every state. It is therefore necessary that fraud and abuse detection methods be employed that are effective and prompt. MPI has pioneered the development of unique and effective detection tools and employs them continually along with detection software supplied by the fiscal agent contractor. These programs detect upcoding, identify rapid increases in billings by and payments to providers, compare providers' billings to those of their peers and identify combinations of billings that are unusual and may be improper.

Medicaid provider audits are carried out by MPI when possible fraud and abuse is detected through the use of detection activities or when it is reported from external sources through the MPI Intake Unit. In connection with these, MPI employs tools that enable the investigator to isolate all of the provider's claims to be reviewed, take a random sample of the claims, include or exclude specified procedure codes and print report formats to be used in the audit. When the claims review is complete, the investigator typically uses an MPI developed tool to extend the sample results to the population of claims sampled and thus determine the overpayment by statistical calculations.

In FY 2005-06, MPI recovered $28 million in overpayments, an increase of 37 percent from the prior fiscal year. The recoupment of overpayments is discussed in some detail in the section below headed **Recovery**.

Coordination with Other Organizations

MPI continues to work with other agencies, both federal and state, in order to foster communications and cooperation that benefit fraud and abuse control actions. This work enables the exchange of information on the nature of fraud and abuse schemes, perpetrators of such schemes and prevention, detection and auditing methodologies.

South Florida Health Care Fraud Working Group

In the fall of 2005, the South Florida Fraud and Abuse Working Group was formed at the instigation of AHCA and other agencies to seek to enhance Medicaid fraud and abuse prevention, detection and recovery efforts. The Working Group consists of representatives of state and federal agencies and the Miami Dade Police Department. State agencies include AHCA, the Medicaid Fraud Control Unit, the Department of Health, the Department of Children & Families and the Florida Department of Law Enforcement. Federal agencies include the Department of Health & Human Services Office of Inspector General and Centers for Medicare & Medicaid Services, Office of the U.S. Attorney, the Federal Bureau of Investigation and the Drug Enforcement Administration.

The Working Group has facilitated improved communications among the agencies represented and has resulted in actions that have aided in fraud and abuse control. For example, based on a November 2005 criminal complaint furnished to AHCA by the U.S. Attorney's Office in early December 2005, AHCA was able to intercept a Medicaid payment to a provider whose principals had been criminally charged by the U.S. Attorney. The Working Group has also enabled the interchange of information on a number of subjects pertinent to fraud and abuse control, such as the location of useful databases, the availability of training programs, procedures for the exclusion of providers from the several programs and means of related interagency actions, functioning of the Medicare Part D prescribed drug program, availability of detection methods such as the AHCA Early Warning System that shows sudden upsurges in Medicaid provider billings and payments, and the need for increased background checks of would-be Medicare and Medicaid providers.

Florida Diversion Response Teams

The Agency partners with the Florida Department of Law Enforcement (FDLE), MFCU and the U.S. Department of Justice – Drug Enforcement Administration in working on the problem of drug diversion. Drug diversion can be many different things. One of the most serious examples is when drugs are sold to a recipient by a pharmacy and returned to the pharmacy via illicit means for resale. During the time the drug was being passed around, it may have been compromised and the same drug may be sold many times over. The Diversion Response Team (DRT), headed by FDLE, works throughout the state to investigate potential crimes specifically related to drug diversion and pharmaceutical abuses. The Agency provides data and technical support to the law enforcement efforts of the DRT.

Department of Health

MPI management meets with representatives of the Department of Health (DOH) monthly to discuss referrals of specific providers, confirm referrals between the two agencies and share information about relevant projects and specific cases. Through these processes, MPI and DOH have been able to improve communications and develop a greater working relationship. Referrals between the agencies are expected to improve and increase as a result. Also as a result of these meetings, training needs and informational access are better addressed. A Data Sharing Agreement was put in place in 2004, and has allowed for increased cooperation between the two agencies due to the ability to share pertinent data. During recent years, this data sharing has significantly increased as have actions taken on referrals from both agencies. MPI and DOH continue to discuss and develop further means of collaboration. Additionally, in some instances, DOH finds it necessary to issue emergency suspension orders. They notify the Agency of these suspensions. If the licensee is a Medicaid provider, MPI determines, among other Agency actions, whether withholding the provider's payments or suspending the claims for prepayment review is appropriate and in the best interest of the Medicaid program.

Medicaid Integrity Program

An announcement in May 2006 discussed planning for the Medicaid Integrity Program (MIP) in the Centers for Medicare & Medicaid Services (CMS). The Deficit Reduction Act (DRA) of 2005 created the MIP in CMS in the U.S. Department of Health & Human Services. MIP dramatically increases both CMS' obligations and resources to combat fraud and abuse at the federal level. Five million dollars have been appropriated in FY 2006 with an additional $50 million in each of FY 2007 and 2008 and $75 million annually in FY 2009 and each year thereafter. In addition, the DRA requires CMS to hire 100 new full time employees (FTEs) "whose duties consist solely of protecting the integrity of the Medicaid program."

Successful implementation will require a detailed understanding of state Medicaid operations and a high degree of coordination with the states and with Medicare Program Integrity (PI). CMS will provide overall leadership for MIP and coordinate with PI in all aspects of the program.

It is clear that the federal government intends that substantially increased and more effective effort will be devoted by both federal and state governments to fraud and abuse control. The Agency looks forward to partnering with CMS in this enhanced initiative.

Medicare

MPI works regularly with the Miami Office of the Centers for Medicare & Medicaid Services as well as the Program Safeguard Contractor (PSC) for Florida, which investigates potential fraud and abuse within the Medicare system. Referrals are made between MPI and either CMS or the PSC and additional coordination is arranged on specific cases or issues, as needed. MPI has assisted in Medicare projects that could have an impact on Medicaid issues. During this past fiscal year, the Miami MPI staff conducted joint pharmacy site visits with CMS Miami office staff. MPI further continues to develop lines of communication with other CMS contractors such as Health Integrity and TrustSolutions in order to combat fraud and abuse more effectively. This relationship will allow us to share and exchange information with all of our CMS partners and to continue to expedite the referral process.

MPI continues to develop a working relationship with the contractor in Florida responsible for the Senior Medicare Patrols (SMP). The SMP include senior volunteers who have educated themselves on Medicare topics in order to counsel other Medicare recipients. Among the various functions of the SMP is to report suspected Medicaid and Medicare fraud to the appropriate authorities.

MPI provided the SMP with MPI fraud and abuse brochures as well as alerted the SMP to issues that dealt with seniors and Medicare fraud. Earlier this year, MPI assisted the SMP in getting a Spanish-speaking staff person from the Tampa Medicaid office to participate in a local TV news station's live Medicare and Medicaid hotline. MPI will continue to meet with the SMP to educate them on Medicaid, share information and share best practices so that they can be better prepared to identify and report potential Medicaid fraud to MPI.

Medi-Medi

The Medi-Medi project was established to prevent and detect fraud and abuse in the Medicare and Medicaid programs by performing computerized analysis and matching of Medicare and Medicaid data. Through this program and using statistical analysis, relationships and trends in Medicaid billing can be discerned. Abuse and potential fraud cases can be developed for referral to appropriate health care and law enforcement agencies. There have been delays associated with the transitioning of projects from the previous CMS vendor to the current vendor and, accordingly, access to matched data by Medicaid has been delayed. Information has continued to be provided, however, to the Bureau of Medicaid Program Integrity and other entities with regard to apparent excessive billing, duplicate payments for original prescriptions on pharmacy claims and abuses by other types of providers. The Medi-Medi project complements the efforts of the Bureau of Medicaid Program Integrity in the matching of Medicare and Medicaid data, and enhances coordination among agencies that identify, analyze and investigate possible fraud and abuse.

Department of Children & Families

Medicaid pays for certain services that are within programs under the auspices of the Department of Children & Families (DCF). Since policy development and clarification were necessary, MPI and DCF have worked closely through the years. DCF assists Medicaid by performing the Medicaid recipient eligibility process. During FY 2005-06, MPI coordinated with DCF appropriately to refer suspected eligibility violations for investigation.

Agency for Persons with Disabilities

MPI initiated a workgroup with representatives from the Agency for Persons with Disabilities (APD), AHCA's Division of Medicaid and MFCU to review the Developmental Disabilities Home and Community-Based Services waiver (DD waiver). The purpose of the workgroup was two-fold: to review newly implemented safeguards to determine if there were apparent deficiencies that may warrant further

analysis, and to identify areas for potential audit. Data analysis of specified program areas resulted in a determination that the safeguards that were put in place beginning July 1, 2004, were working as designed and were in fact preventing misspent funds in the first place. As such, the focus of the workgroup shifted to identifying areas for potential audit. The workgroup initiated detailed analysis of paid claims data to try to narrow the field of potential providers for audit. This analysis has not been completed to initiate the audits and therefore will continue into FY 2006-07 to attempt to identify providers for further review.

Managed Care Organizations

MPI has continued its efforts to increase communications with Medicaid managed care organizations (MCOs). Also, during FY 2005-06, MPI took additional steps to increase internal communications with the Agency's Division of Medicaid and Division of Health Quality Assurance. By increasing communications, the Agency can ensure more, better and timelier referrals of potential fraud or abuse from the managed care organizations. In fact, during FY 2005-06 MPI worked directly with several of the MCOs to improve the quality and quantity of referrals and to establish protocols for obtaining additional information when necessary to further an MPI investigation or referral to MFCU.

MPI also coordinated with our partners at MFCU to identify areas related to fraud and abuse detection, prevention and recovery that should be addressed by the Agency as Medicaid Reform is implemented. During FY 2005-06, MPI assisted the Agency's Division of Medicaid in ensuring that these areas were addressed in the Agency's model contracts for MCOs and Provider Service Networks (PSNs). This coordination and assistance will continue as Medicaid Reform continues to be implemented. These efforts will be in addition to MPI's ongoing auditing activities, and will assist MPI as its auditing activities pertaining to managed care evolve with Medicaid Reform.

Prevention

MPI dedicates approximately 40 percent of its staff to the prevention of fraud and abuse. As discussed previously, it is believed that this use of resources will pay dividends in the future inasmuch as the prevention of misspent funds is less costly than attempts to recover such funds. Among the prevention activities engaged in by MPI are the use of prepayment reviews to identify improper claims and deny payment; recommendations for termination of providers suspected of misusing the Medicaid program; focused projects to address areas that are believed to be more susceptible to fraud and abuse, that have a deterrent effect and that result in cost savings for the Medicaid program; referrals to other regulatory and law enforcement entities that may result in restrictions on providers' ability to continue to participate in the Medicaid program and that serve as a deterrent; use of a provision of law that allows Medicaid to decline reimbursement for prescription drugs prescribed by practitioners who were terminated from the Medicaid program; and other measures that serve to allow the Agency to better control its network of providers.

Prepayment Reviews

Prepayment reviews encompass examination of claims associated with "intercepted payments" and evaluation of "pended claims." The "intercepted payments" are made up of Medicaid claims that have been processed for payment, but for which the payment has not yet been sent to the provider. "Pended claims" are claims that have not yet been processed for payment. Both claims related to intercepted payments and those that have been pended may undergo a prepayment review. A provider is required to submit supporting documentation for claims under prepayment review so that MPI can determine whether the claim should be paid or denied.

In prepayment review, claims not having proper documentation are denied. MPI may place a provider on prepayment review if there is suspicion of fraudulent or abusive behavior; suspicion of neglect of a recipient; suspected overpayment; receipt of a complaint against the provider; suspicion of the rendering of goods or services that are not medically necessary, are of inferior quality, or have not been provided in accordance with applicable provisions of all Medicaid or professional requirements; suspicion of billing for goods or services that have not actually been furnished; suspicion of billing for goods or services for which appropriate documentation is not made at the time the goods or services were provided; random

selection based upon a fraud or abuse prevention initiative; or suspicion of any of the violations set forth in s. 409.913(15), F.S.

Cost savings are calculated based on funds that would have been paid but for the intervention by MPI in conducting the prepayment review. For intercepted payments, the amount avoided is the amount of the reduction in the payment to the provider. The full amount of the reduction is considered cost avoided, because the claim has been through the Medicaid system edits. For pended claims denied, the cost-avoided amount is the billed amount of the denied claims factored by the ratio of actual payments to billed amounts for the type of provider involved. This ratio factors in the proportion of the billed amount that would have been denied due to system edits. (MPI is not credited for amounts that would have been denied or adjusted even without MPI intervention.) During FY 2005-06, the claims of 245 providers were pended and payments of approximately $5.5 million were cost avoided.

The following table shows the types of providers whose claims were pended and reviewed, and the savings due to denied pended claims.

Provider Type	Number of Providers	Amount of Denied Claims
Pharmacy	62	$1,915,979
Physician (MD)	104	1,866,053
H & C Based Services	25	886,138
Independent Laboratory	5	347,175
Medical Supplies/Durable Medical Equipment	26	212,156
Assistive Care Services	9	132,432
Physician (DO)	3	78,364
Home Health Agency	3	30,761
Hearing Aid Specialist	1	5,689
Dentist	3	2,994
Physician Assistant	1	563
Podiatrist	1	250
Chiropractor	1	202
Audiologist/Speech Pathologist	1	32
Total	**245**	**$5,478,787**

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), F.S. 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.

It is expected that when a provider who is suspected of fraudulent or abusive billing is terminated from the Medicaid program, Medicaid expenditures will decline with respect to the recipients served by the terminated provider, taking into account services provided by other providers of like type. For a terminated provider, the savings are the difference in payments for the one-year periods prior to and following termination for services provided by the terminated and other like providers to all recipients served by the terminated provider. Because the analysis requires an evaluation of payments for one year

following the termination, the savings as a result of termination during July 2003 – June 2004 are reported for FY 2005-06. For FY 2005-06, these terminations saved Medicaid $13.3 million. This figure represents only those terminations that followed from a recommendation to the Division of Medicaid from MPI.

Focused Projects

Atypical Antipsychotic Drug Project

The Atypical Antipsychotic Drug Project took place in South Florida during November 2004. Ten MPI and MFCU teams visited pharmacies and prescribing physicians. The focus of the project was to evaluate the medical necessity of prescriptions for Zyprexa®, Risperdal® and Seroquel®. It was anticipated that this effort would materially reduce the prescribing and dispensing of these drugs within the Medicaid program. For this project, the savings for FY 2005-06 are the difference in payments for this type drug for the periods twelve months prior to and twelve months following November 1, 2004 on behalf of all recipients who had received prescriptions for the drug from one or more of forty-five named physicians during the first twelve-month period and who maintained eligibility for all of both one-year periods. This project saved a total of $16.3 million for the one-year period following November 1, 2004 and, subtracting the amount of $6.5 million attributable to FY 2004-05, this project cost-avoided $9.8 million for FY 2005-06 for the Medicaid program.

Durable Medical Equipment Project

While investigating select Durable Medical Equipment (DME) providers for potential fraudulent and/or abusive billing activity, it became apparent that some DME providers had not renewed their surety bonds as required by Medicaid policy. The *DME/Medical Supply Services Coverage and Limitations Handbook,* dated April 2001 and effective in March 2003, pages 1-7, states that, "A surety bond must be submitted as part of the enrollment application by the provider type unless it is owned and operated by government entities. One $50,000 bond is required for each provider location up to a maximum of five (5) bonds statewide or an aggregate bond of $250,000 statewide."

On July 1, 2005, 166 DME providers who had not renewed their surety bonds as required were terminated. It was anticipated that this action would reduce Medicaid expenditures for recipients being served by these terminated providers. The savings resulting from this action are the difference in payments for the one-year periods prior to and following termination for services provided by the terminated and other like providers to all recipients served by the terminated provider. The recipients maintained eligibility for all of both one-year periods. For FY 2005-06, the savings due to this action are $285,000.

Assisted Living Facilities

The Assisted Living Facilities (ALF) project took place in South Florida during June 2005. Twenty-four ALFs were randomly selected, visited and recipient records reviewed. The goal of this project was to detect areas of fraud and abuse. It was expected that after these visits we would see a reduction in expenditures for unnecessary services.

As a result of these site visits, two ALFs were terminated from the Medicaid program for multiple policy violations and their payments were suspended. The prepayment reviews yielded over $70,000 in savings to Medicaid. In addition, MPI recommended that three independent laboratories be further reviewed, since the project revealed that many of the ALFs were routinely having their residents tested for substance abuse. A records review indicated that this practice lacked medical necessity. All three laboratory providers were placed on prepayment review and one was terminated from the Medicaid program. The prepayment reviews yielded hundreds of thousands of dollars in savings to the Medicaid program. Savings resulting from prepayment reviews are reported under that section.

An evaluation of the expenditures for these twenty-four ALFs revealed a savings of $1.3 million in FY 2005-06. The savings are based on the difference in payments made during the one-year periods prior to and following the dates of the visits on behalf of recipients who were served by the ALFs during the one-year period prior to the visits and who retained eligibility during both one-year periods.

Denial of Reimbursement for Prescription Drugs

Based on legislation that was enacted in 2004, the Agency is authorized to deny reimbursement for prescription drugs that are prescribed by practitioners who have been terminated from the Medicaid program. The Agency is further authorized to deny payments for goods or services caused to be furnished by a provider terminated or suspended from the Medicaid program. [Sec. 409.913(25) (b), F.S.] The Agency implemented these provisions in January 2005, believing that the denial of these payments would significantly reduce the abusive prescribing and dispensing of Medicaid goods and services. For this denial of prescribing rights action, the savings for July 1 – December 31, 2005 are the difference between payments for drugs for the one-year periods prior to and following January 1, 2005 on behalf of all recipients who had received drugs prescribed by one of the terminated prescribers and who had maintained eligibility for all of both one-year periods. During FY 2004-05, 74 providers were the subjects of this action, which resulted in cost avoidance for the Medicaid program in the amount of $3.7 million for calendar year 2005, of which $1.3 million was previously reported, with the remaining $2.4 million attributable to the July 1 – December 31, 2005 period.

In addition to the providers reported on in the immediately preceding paragraph, an additional 50 providers lost their prescribing rights as of July 31, 2005. Using a methodology analogous to that of the preceding paragraph, it was determined that the prescribing rights action respecting these additional providers saved Medicaid approximately $6 million in FY 2005-06.

Policy Change

Dental Behavior Management

MPI routinely coordinates and consults with the Division of Medicaid with regard to proposed changes in policies or to system edits. These activities continued during FY 2005-06. While it is difficult to ascertain actual dollars saved as a result of these efforts, analysis of Medicaid expenditures pre- and post-changes provide an estimated cost avoidance amount. Many of these efforts will yield additional savings in subsequent years.

A recent example of the effectiveness of policy changes on reducing overpayments involved procedure code D9920, *Dental Behavior Management*, which is the use of a clinically verbal technique when a child is apprehensive and it is applied in a situation in which it takes extended time to control and treat the child because of the anxiety. Prior to the change in policy, the claim could be submitted and would be reimbursed without any substantiation of the need for the behavior management. Subsequent to the policy change, the provider was required to submit a report describing the specific nature of the recipient's management problem and the management technique utilized.

During the 12-month period prior to the policy change in November 2004, the Medicaid program reimbursed providers more than $1.5 million statewide for this single procedure code. Of this amount, approximately $490,000 was reimbursed in a county that has subsequently had other cost-containment measures put in place. Therefore, that county is excluded from this cost savings analysis, leaving approximately $1 million paid for this procedure in the remaining 66 counties. Subsequent to the policy change, the statewide expenditures were approximately $157,000. This single policy change has resulted in a net savings of approximately $850,000 in FY 2005-06.

Other Projects

Site Visits

In its efforts to control Medicaid provider fraud and abuse and to prevent the misuse of State funds, staff members in the field offices of the Bureau of Medicaid Program Integrity visit certain newly enrolled Medicaid providers in specified geographic areas. The purpose of these visits is to 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. Following the site visits, the Bureau of Medicaid Program Integrity sends provider education letters to the providers advising them of the issues identified during the visits, including those found in the review of records. Subsequently, a follow-up visit to the

provider may be conducted in ninety days to ensure that the provider has corrected any deficiencies and is in compliance with Medicaid policy.

These provider site visits were implemented believing that this initiative would result in cost savings to the Medicaid program. For example, during site visits, MPI staff members have noted that some providers bill Medicaid for higher paying procedure codes than is warranted or do not have documentation to substantiate claims. In such instances, MPI requests that the providers void or adjust the claims.

Calculating cost savings due to site visits is difficult in that factors other than the visits may have impacted the expenditures. Additionally, some providers who were visited may have increases in their Medicaid reimbursements. This would be anticipated when the site visit was to a relatively new provider. Likewise, some of the reductions may be the result of factors beyond the sentinel effect of the Agency's review. While cost savings specifically due to the site visits are not available, the expenditures for many of those 203 providers that had site visits in FY 2004-05 were reduced substantially following the site visits.

Administrative Sanction Rule

The administrative sanction rule (Rule 59G-9.070, F.A.C.) became final in April 2005 and was fully implemented on July 1, 2005. Additionally, modifications to the rule were finalized in April 2006. The modifications addressed issues brought out during a rule challenge to the initial adoption of the rule, and as well sought to ensure fairness and consistency in its application. During FY 2005-06, 505 Medicaid providers were sanctioned for violations set forth in the rule. In 352 instances, the sanction imposed did not include a monetary fine, but rather required a corrective action plan in the form of a provider acknowledgement statement. In the remaining 153 instances, the provider received a monetary fine (which may or may not have been in addition to the corrective action plan). As a result, fines totaling over $289,000 were imposed. While some portion of those fines remain under review due to litigation or are otherwise in the collection process, approximately half of the fines have been collected and are further detailed in the section dealing with Statutory Reporting Requirements.

The violations, generally, included the failure to comply with the provisions of the Medicaid provider handbooks, including the failure to maintain and/or furnish specified records. The chart below identifies the types of violations for which sanctions were imposed during FY 2005-06.

Rule 59G-9.070(7)	Type of Violation	Number
(b)	Failure to make available records	7
(c)	Failure to furnish records	2
(d)	Failure to maintain Medicaid records	27
(e)	Failure to comply with Medicaid laws	616
(f)	Furnishing inappropriate or unnecessary goods or services	2
(h)	Submitting false Medicaid claims	2
(n)	Failure to have sufficient goods or time	11
	Total	**667**

The following chart identifies the provider types sanctioned during FY 2005-06:

Provider Type	Number
Nursing Home	266
Physician (MD)	109
Dentist	53
Medical Supplies/Durable Medical Equipment	13
General Hospital	10
Pharmacy	8
Therapist	8
Independent Laboratory	7
ICF/MR - Private Facility	6
Ambulance	5
Rural Health Clinic	5
Home & Community Based Services	3
Optometrist	3
Physician (DO)	2
Advanced Nurse Practitioner	1
Assistive Care Services	1
Chiropractor	1
Community Alcohol, Drug, Mental Health	1
ICF/MR - State Facility	1
Licensed Midwife	1
Skilled Nursing Unit	1
Total	**505**

Recovery

MPI conducts investigations into allegations and indications of violations of Medicaid policy. These investigations fall into three categories: MPI conducted audits, paid claims reversals, and vendor-assisted audits. Most of MPI's recovery efforts are concentrated on conducting comprehensive investigations and focused audits of Medicaid providers. MPI also utilizes the knowledge of Florida licensed pharmacists to review pharmacy paid claims to identify apparent misbillings. The pharmacy is contacted and as a result of the MPI activities, the erroneous claims are reversed, resulting in recovery of the misspent funds. In addition, MPI uses vendors to augment its efforts so that recovery projects can be conducted that would not otherwise be completed due to staffing limitations. MPI staff members, however, assist in and oversee all aspects of these projects.

MPI Audits

During FY 2005-06, MPI concluded more than 1,200 audits of Medicaid providers. These audits consisted of comprehensive investigations evaluating all aspects of a provider's billings or focused investigations that evaluated specific aspects of providers' billings. Comprehensive audits typically involve determining all of the paid claims of a provider (the population) for a specific period of time and taking a random sample of claims from the population. The claims in the sample are carefully reviewed relative to Medicaid policy and any overpayments found in the sample are projected by generally accepted statistical methods to the population of claims in order to determine the total overpayment in the population. At present, however, Florida Statutes preclude the use of statistical sampling in audits of pharmacies, thereby inhibiting the ability of MPI to find and recover overpayments made to those providers. During the fiscal year, more than $18 million was identified as overpayments as a result of MPI audit activities.

Paid Claims Reversals

Pharmacy claims are submitted to Medicaid by pharmacies as the pharmaceuticals are dispensed. Occasionally pharmacies overstate the amount of the drug that is dispensed and are overpaid. Utilizing

MPI detection methods, atypical claims are identified. The provider is contacted and may submit supporting documentation justifying the paid claim amount or is requested to 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 recorded as recovered overpayments to Medicaid. If the provider does not adjust or reverse the payment, they are subject to further audit or other administrative action by the Agency. During FY 2005-06, paid claims reversals resulted in net recoveries to Medicaid of about $870,000.

Vendor Assisted Projects

The Agency has a contract in place with a vendor to assist in several fraud and abuse recovery efforts. The vendor is able to focus on projects involving large volumes of data, which enables us to process claims adjustments on projects involving numerous providers. The vendor works closely with MPI to ensure that the policy basis for the project is sound and that there are no conflicts between providers under investigation by MPI or MFCU and those reviewed by the vendor. MPI reviews and approves all fraud and abuse projects initiated by the vendor. During FY 2005-06, the vendor assisted in the collection of approximately $10.8 million from projects involving: claims paid after the recipients' date of death, credit balance adjustments from hospitals and nursing homes, provider self audits, duplicate billing, and several policy violations.

Date of Death Audits

This project involves reviewing the FMMIS Medicaid paid claims file and comparing the date of service to the date of death on the Florida Medicaid Management Information System (FMMIS) recipient file. If claims were paid for dates of service after the date of death, the provider is notified of the amount of overpayments that are to be recouped. The providers are given the opportunity to review the claims in question and submit documentation refuting the date of death (e.g., copy of a death certificate or nurse's/doctor's notes). If the provider's documentation is acceptable, those claims are removed from the recoupment listing. In order to recover the funds, adjustments are submitted to the fiscal agent for posting to the FMMIS. In FY 2005-06, the date of death project yielded recoveries of $1.9 million.

On-site Facility Audits

The credit balance reports of hospitals and nursing homes were reviewed in order to identify overpayments by Medicaid. A credit balance appears on a provider's accounts payable ledger as an amount owed to another entity, such as Medicaid. This project yielded recoveries of $3.9 million in FY 2005-06.

Provider Self Audits

This past fiscal year renal dialysis centers were mailed letters requesting that they review their credit balances and voluntarily refund any overpayments to Medicaid. This ongoing project yielded recoveries of $1.1 million in FY 2005-06 from the renal dialysis centers as well as other provider types that had overpayments identified in earlier fiscal years.

Duplicate Billing

This review identified Medicaid payments to hospitals for inpatient services for duplicate or overlapping periods and resulted in the recovery of $1.4 million in FY 2005-06.

Mother/Newborn Project

This project involved identifying atypical payments made to providers for newborns. Medicaid policy is that reimbursement is for the mother only and this audit identified those providers that billed for both the mother and newborn resulting in an overpayment. This project resulted in the recovery of more than $2.2 million in FY 2005-06.

45-Day Inpatient Stay

This review identified payments made to providers for Medicaid inpatient hospital days that exceeded the 45-day maximum for an individual recipient and resulted in the recovery of more than $200,000 in FY 2005-06.

Performance Trends

MPI has begun tracking several performance measures in order to better manage the Bureau's workload. The initial areas that have been reviewed are referrals to outside agencies, collections on overpayments, cases with findings, and the average number of days from case opened until the overpayment is repaid in full.

Referral Activities

MPI Referral Activities			
	Number of Referrals		
Activity	FY 2003-04	FY 2004-05	FY 2005-06
Referrals to MFCU	96	197	225
Referrals to Others	156	210	307

As may be seen from the chart on the left, the Agency for Health Care Administration has continued to be diligent in referring to other agencies providers who may be engaging in abusive conduct.

Collections on Overpayments

Fiscal Year	Overpayments Identified	Collections through FY 2005-06	
	Millions		
2003-04	$43.4	$18.4	42.4%
2004-05	47.6	22.3	46.8%
2005-06	$29.9	$18.0	60.2%

In an attempt to increase the amount of overpayments recovered, MPI has begun monitoring the rate of recovery of identified overpayments as well as the amounts written-off or adjusted. Historically, a significant number of overpayments have not been recovered because the provider declared bankruptcy or disappeared, resulting in the amounts being written off. This is the downside of attempting to recover funds in a system in which payments are made first and then claims are reviewed a year or more later. This is known as "pay and chase," which makes it virtually impossible to recover 100 percent of the identified overpayments. In addition, recoveries often do not occur in the year that the overpayment is identified making it difficult to track the repayments. This occurs primarily because cases go to litigation, providers opt to pay over time, or the payment occurs in a following fiscal year. Prior to implementation of the Fraud and Abuse Case Tracking System (FACTS), the rate of recovery was a particularly difficult measure to make and as a result was not routinely reported. This information is now obtainable, however, and is included in quarterly reports. Management has made it a priority to conclude cases in a timely manner in order to increase the recovery rate.

The above figures clearly indicate that this effort is showing positive results. The June 30, 2006 report shows that collections of $18.0 million or 60 percent have already been made for FY 2005-06 identified overpayments of $29.9 million, no receivables have been written off, and $11.9 million or 40 percent remains to be collected. These figures also reflect that we are doing a better job of identifying overpayments that can actually be collected.

Cases with Findings

Disposition of Cases	Fiscal Year		
	2003-04	2004-05	2005-06
Overpayment Identified	944	849	1002
No Fraud or Abuse Found	905	566	199
Provider Education Letter	104	44	27
Total Cases Closed	**1,953**	**1,459**	**1,228**
% with Overpayment	**48.3%**	**58.2%**	**81.6%**

MPI has increased its efforts to ensure that resources are expended only on investigative leads that have the potential of recovering Medicaid funds. These improved preliminary screening processes have resulted in a reduced number of cases being closed without an overpayment being identified, as shown at left.

Days to Fully Recover an Overpayment

The average number of days from the case opened date to the date the overpayment is fully recovered has steadily decreased, as shown to the right. These reductions have occurred because investigative cases are being completed in a timelier manner and collection efforts have been increased.

Days to Paid in Full		
Fiscal Year	Cases	Average Days
2003-04	677	780
2004-05	652	500
2005-06	878	452

Return on Investment

MPI Recovery of Overpayments (millions)			
Activity	FY 2003-04	FY 2004-05	FY 2005-06
MPI Audits	$13.4	$11.6	$16.3
Reversals	0.4	1.5	0.9
Claims Adjustments	2.9	7.4	10.8
Total	**$16.7**	**$20.5**	**$28.0**

Program integrity efforts resulted in the recovery of $28 million in overpayments in FY 2005-06, an increase of 37 percent from the previous fiscal year (left.)

In addition, MPI prevention efforts resulted in cost savings of $37 million in overpayments in FY 2005-06, as shown below.

MPI Prevention of Overpayments (millions)						
Activity	FY 2003-04		FY 2004-05		FY 2005-06	
	No.	Amount	No.	Amount	No.	Amount
Prepayment Review	103	$ 7.7	285	$14.2	245	$ 5.5
Termination of Providers	160	0.5	224	14.7	194	13.3
Focused Projects	1	16.5	2	8.6	3	11.4
Denial of Reimbursement for Prescription Drugs	n/a	0.0	124	1.3	124	5.9
Policy Changes	n/a	0.0	n/a		1	0.9
Total		**$24.7**		**$38.8**		**$37.0**

During the year, expenditures of $7.6 million were devoted to recovery work resulting in a return on investment for recovery operations of 3.7:1. In addition, MPI achieved $37 million in cost avoidance with expenditures of $3.4 million, producing a return on investment for prevention efforts of 10.9:1. Overall, in FY 2005-06, recoveries and cost avoidance totaled $65 million, yielding a return of 5.9:1 compared to 5.5:1 for the previous fiscal year.

Return on Investment (millions)				
		Benefits	Costs	ROI
FY 2004-05	Recovery	$20.5	$7.5	2.7:1
	Prevention	38.8	3.4	11.6:1
	Total	**$59.3**	**$ 10.9**	**5.5:1**
FY 2005-06	Recovery	$28.0	$7.6	3.7:1
	Prevention	37.0	3.4	10.9:1
	Total	**$65.0**	**$11.0**	**5.9:1**

Division of Medicaid

Florida Medicaid is a $15 billion program with more than 2.2 million recipients and thousands of providers. It is one of three divisions in the Agency for Health Care Administration. The Division of Medicaid is responsible for the management and operation of the broad range of health care services offered through Medicaid to low-income families. The program is a state/federal partnership and provides health care coverage through both fee-for-service and managed care arrangements.

Policy issues and development of pilot programs are managed through Medicaid bureaus that include the Bureau of Medicaid Quality Management, which focuses on optimizing and improving quality in the Medicaid program; the Bureau of Program Analysis, the financial arm; the Bureau of Contract Management, which administers the contract with the fiscal agent to pay Medicaid claims; the Bureau of Pharmacy Services, the prescription drug program; the Bureau of Medicaid Services, which develops Medicaid policies; the Bureau of Health Systems Development, the managed care arm; and Field Offices that work with providers and constituents at the local level. Eligibility for Medicaid is determined through an agreement with the Department of Children & Families, as permitted by federal regulation.

Florida is leading the nation in changing the Medicaid program. For the first time, Medicaid will offer true flexibility in the program so health plans can better target the needs of the program's participants. AHCA believes this innovative approach will better match health care services with the needs of the citizens we serve.

Bureau of Medicaid Quality Management

The Bureau of Medicaid Quality Management consists of three offices: the Office of Medicaid Research and Policy (formerly the Bureau of Medicaid Research); the Office of Medicaid Program Oversight (formerly the Monitoring Unit); and the Office of Project Management. The three units are focused on optimizing and improving quality in Medicaid programs, Medicaid policies and the implementation of projects and research. It is the Office of Medicaid Program Oversight that is very much involved with anti-fraud and anti-abuse activities and works closely with other Agency entities to help deter fraud and abuse in Florida Medicaid.

Office of Medicaid Program Oversight

The Office of Medicaid Program Oversight (MPO) is charged with developing standards and tools for effectively monitoring Medicaid service programs; preventing unnecessary and inappropriate utilization of Medicaid services; reducing duplicative Medicaid services; ensuring compliance of program operations with policy, and comparing alternative managed care models/programs. MPO reviews program policies to ensure the edits in the Florida Medicaid Management Information System (FMMIS) reflect Medicaid program policy and program operations; samples claims and eligibility data for trend analysis of programs and services, and to identify best practices and make recommendations based on findings. Finally, MPO conducts random site visits (statutorily mandated) and targeted site visits (based on data analysis). The following activities are some of the unit's oversight projects.

Payment Error Rate Measurement

The Office of Medicaid Program Oversight coordinated AHCA's participation in the third year of the Payment Error Rate Measurement study (PERM), in conjunction with the Centers for Medicare & Medicaid Services (CMS) under a contract with Navigant Consulting using 2004 claims data. As in the past, claims samples were reviewed to identify errors in payments stemming from a lack of documentation, inappropriate billing and other causes. The general underlying conditions giving rise to the errors were identified and corrective measures to address them were developed. These general corrective measures will be disseminated throughout the Medicaid provider community and implemented.

Improved Random Site Visit Process for New Medicaid Provider Applicants

Pursuant to s. 409.907(7), Florida Statutes, the Office of Medicaid Program Oversight spearheaded a workgroup comprised of Medicaid area office representatives to identify and address inefficiencies in the random site visit process. The original implementation selected providers for site visits based on a random sample from the daily total of all approved Medicaid provider applicants, regardless of their billing status or group affiliation.

The random site visit process was modified to incorporate a desk review of new applicants who join established groups and facilities as non-billing providers. This allows existing resources to review more provider applicants and to focus actual on-site visits on new billing applicants.

The outcome of the workgroup efforts is a streamlined random site visit process, which ensures that existing operational resources are most effectively utilized while realizing the intent of the Legislature to minimize fraud and abuse.

Medicaid Encounter Data System (MEDS) Development

The Medicaid Encounter Data System (MEDS) project was mandated by HB 3B during the Florida Legislature 2005 Special Session "B" and is in compliance with Title XIX of the Social Security Act, the Balanced Budget Act of 1997, 42 CFR 438, Chapters 409 and 641, Florida Statutes.

The Office of Medicaid Program Oversight is the lead on this project and a MEDS team was formed, comprised of internal subject matter experts and external consultants with experience in the collection and processing of encounter claim data. As a start-up phase to comply with the requirements for Medicaid Reform, the Medicaid R_x model was selected for risk adjustment and the Agency began collecting pharmacy data from health plans in November 2005. Pharmacy data for FY 2003-04 and forward have been collected by the Agency and the data have undergone a series of testing and validation.

The Agency is currently designing and developing the MEDS to capture encounter data from all health plans for all Medicaid covered services. The MEDS will support many reform requirements such as the risk model computations that set capitated payments for managed health care entities, enhanced benefits program and quality performance measures. The MEDS will also be used for specific information requests on service utilization trends, quality of care and access to care.

Assisting in Implementing the New Florida Medicaid Management Information System/Decision Support System (FMMIS/DSS)

The Office of Medicaid Program Oversight staff is part of the implementation team working on the design, development and implementation of the new Medicaid Management Information System (MMIS) and Decision Support System (DSS).

Optimizing MediPass Credentialing/Recredentialing in Medicaid Area 6

Following the recommendations of the Office of Program Policy Analysis and Government Accountability (OPPAGA), a quality improvement initiative is underway to assist MediPass providers to improve their practices. This includes recommending provider recredentialing every three years per the industry standard and the elimination of duplicate applications for individual providers joining multiple groups. These measures will reduce the workload of the field offices in this area and free up additional time for other oversight activities.

Targeted Provider Site Visits

The office of Medicaid Program Oversight field staff worked with Medicaid area offices and the Bureau of Medicaid Program Integrity in identifying specific programs and individual providers as candidates for on-site visits based on billing histories and practices that indicated possible irregularities. Pharmacies and durable medical equipment suppliers were among the provider types targeted during the previous year.

Coordination with the Bureau of Medicaid Program Integrity

The Office of Medicaid Program Oversight and the Bureau of Medicaid Program Integrity continued to share information and observations pertaining to potential fraud/abuse and programmatic issues to lessen opportunities for erroneous overpayment.

Analyses of Medicaid Programs and Services

The Office of Medicaid Program Oversight continues to assist all Medicaid bureaus and the eleven Medicaid area offices through general analyses and targeted studies related to Medicaid programs and services.

Bureau of Program Analysis

Third Party Liability Unit

The Division of Medicaid's Third Party Liability Unit is responsible for identifying and recovering funds for claims paid by Medicaid for which a third party was liable. Some examples of third parties include casualty settlements, insurance companies, recipient estates and Medicare. Third Party Liability recovery services are contracted with Health Management Systems, Inc. (HMS).

1. **Casualty** – Medicaid imposes a lien against liable third parties for the amount Medicaid has paid on behalf of a recipient who has been involved in an accident or incident, which resulted in injury. Attorneys are required to notify Medicaid that they represent a Medicaid recipient involved in an accident or incident.
2. **Estate/Trusts** – Medicaid files an estate claim on behalf of a deceased Medicaid recipient for Medicaid payments made after age 55. Medicaid is to be paid after attorney and personal representative fees and funeral costs (class 3 creditor) and must be notified by the estate attorney or personal representative when an estate is opened on any individual over age 55. Trusts relating to a person's eligibility in the Medicaid program stipulate that upon the death of the trust beneficiary, or if the trust is otherwise terminated, the balance of the trust up to the amount that Medicaid paid on the beneficiary's behalf is to be paid to the Medicaid program.
3. **Medicare and Other Third Party Payer** – Medicaid bills and is reimbursed by insurance carriers, providers and Medicare for claims previously paid for by Medicaid for which Medicare or another third party such as a private insurance may have been liable. HMS matches data with more than 90 percent of commercial insurance coverage in Florida.
4. **Recovery Performance** – The basic third party liability contract with HMS calls for recoveries from casualty claims, estates/trusts, Medicare and other third party payors and cost avoidance information. Cost avoidance is new and/or updated insurance information that is derived from data matches with insurance carriers. When new and/or updated insurance information is obtained, that information is added to the Medicaid database 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. Total recoveries have increased 29 percent from FY 2004-05 to FY 2005-06. Cost avoidance has increased six percent from FY 2004-05 to FY 2005-06.

THIRD PARTY LIABILITY RECOVERIES						
	FY 2001-02	FY 2002-03	FY 2003-04	FY 2004-05	FY 2005-06	% Increase
Casualty	$16,717,277	$18,511,913	$22,431,466	$27,252,053	$26,648,342	(2)
Estate/Trusts	10,545,646	10,983,169	13,673,588	15,922,663	14,836,825	(7)
Medicare & Other Third Party	29,041,444	36,618,240	42,134,384	43,790,077	70,807,531	62
Total	$56,304,367	$66,113,322	$78,239,438	$86,964,793	$112,292,698	29

THIRD PARTY LIABILITY COST AVOIDANCE					
FY 2001-02	FY 2002-03	FY 2003-04	FY 2004-05	FY 2005-06	% Increase
$788,382,786	$1,015,490,436	$1,262,123,941	$1,321,878,989	$1,409,616,013	6

Special Medicaid Projects

Recoveries from special Medicaid projects completed for FY 2005-06, in conjunction with Medicaid Program Integrity and Pharmacy Services, include the following:

OTHER RECOVERIES[1]	
Provider Amnesty (Credit Balance)	$1,142,768
Date of Death	1,945,758
On-Site Hospital Audits	2,109,116
On-Site Nursing Home Audits	2,253,438
J-Code Rebates	7,684,193
Medicare Part B Physician Claims	1,406,786
Medicaid Duplicate Payments	1,384,079
Medicare Drug Recovery (DMERC)	6,567,800
Mother-Newborn	2,216,296
45-Day Limitation	217,412
TOTAL	$26,927,647

Audit Services Unit

The Division's Audit Services Unit is responsible for compliance with cost reporting requirements for costs used to determine the per diem rates established for nursing homes and intermediate care facilities for the developmentally disabled. Along with the review and acceptance of all the nursing home cost reports, the unit oversees the periodic audits of the financial and statistical records of the participating providers. Contracted CPA firms perform such audits. The Attorney General's MFCU receives a copy of all cost reports accepted and audits issued.

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[1]**Provider Amnesty (Credit Balance)** – Providers refund to Medicaid any Medicaid overpayments contained on their accounts. **Date of Death** – Claims paid for services allegedly rendered after the dates of death of recipients are recouped from providers. **On-Site Hospital Audits** – Hospital accounts payable ledgers are reviewed in connection with collecting Medicaid overpayments. It is estimated 90 percent of the collections result from general Medicaid overpayments and ten percent result from other third party payments received by providers. **On-Site Nursing Home Audits** – Nursing Home accounts payable ledgers are reviewed in connection with collecting Medicaid overpayments. It is estimated 90 percent of the collections result from general Medicaid overpayments and ten percent result from other third party payments received by providers. **J-Code Rebates** – Drug rebates due from pharmaceutical manufacturers and labelers are recovered for "J-Code" class drugs (J-codes are used to bill a drug that is administered by the physician during the office visit; therefore, the drug has not been included in the calculation of eligible rebates.) **Medicare Part B Physician Claims** – Payments are recovered from physicians who were originally paid by Medicaid for claims for which Medicare was liable. **Medicaid Duplicate Payment** – Funds are recovered when Medicaid made a duplicate payment for a service. **Medicare Drug Recovery (DMERC)** – Pharmacy claims are identified and pursued from the Medicare intermediary when Medicaid has paid but Medicare may be liable. **Mother-Newborn** – Overpayments are identified from hospitals billing for two separate per diems (one on the mother and one on the newborn) for the same dates of service or overlapping dates of service. **45-Day Limitation** – Overpayments are identified when a recipient has exceeded the maximum number of inpatient days allowed during a particular fiscal year.

Upon request, Audit Services works directly with MFCU staff providing technical assistance or records. Some examples of technical assistance include information relating to cost reporting requirements, policy interpretations, estimate or calculation advice and providing work papers from audits overseen.

Bureau of Medicaid Contract Management

The Bureau of Medicaid Contract Management (MCM) is responsible for monitoring the Agency's contract with Affiliated Computer Services (ACS), the fiscal agent responsible for operating, programming and maintaining the Florida Medicaid Management Information System (FMMIS) and Decision Support System (DSS). FMMIS is the state-owned electronic data processing system for processing Medicaid provider claims, maintaining eligibility files, enrolling providers, printing and mailing Medicaid identification cards and accumulating statistical data. DSS is the Medicaid database that is maintained and utilized for data mining and analysis.

Provider Enrollment Initiatives

Medicaid staff conducts on-site inspections of certain prospective Medicaid providers to ensure that they meet enrollment requirements pursuant to s. 407.907(7), F.S. and Medicaid policy. Medicaid area office staff members conduct site visits. For the period from July 2005 through June 2006, 914 site visits were conducted, leading to 771 approvals for enrollment and 143 denials.

The MCM Provider Enrollment Unit implemented new procedures wherein a provider's Medicaid prescribing privileges are terminated in the Prescribed Drug Claims System (PDCS) once they lose their Medicaid enrollment eligibility due to fraud and abuse. Since the implementation of the program in February 2006, 40 terminations have been processed in the PDCS, thus preventing further expenditures of Medicaid dollars as required by Federal guidelines.

Bureau of Pharmacy Services

The Bureau of Pharmacy Services is responsible for managing the $1.8 billion drug program for Medicaid. The Bureau has taken the lead in implementing the following initiatives to reduce the growth in drug expenditures.

Prescribing Pattern Review Panel

This group of physician and pharmacist practitioners appointed by the Governor, Senate President and Speaker of the House is charged with reviewing the prescribing practices of Medicaid providers.

The Panel evaluates practitioner prescribing patterns based on national and regional practice guidelines and by comparing practitioners to their peer groups. In coordination with the Drug Utilization Review Board and the Department of Health, this advisory panel is responsible for evaluating treatment guidelines and recommending ways to incorporate their use in the practice pattern identification program. The Panel may recommend that practitioners who are prescribing inappropriately or inefficiently have their prescribing of certain drugs subject to prior authorization or recommend termination from participation in the Medicaid program.

Gold Standard Multimedia Project

The Gold Standard Multimedia Project (GSM) wireless contract is designed to help prescribers readily detect "doctor shopping," multiple pharmacy use, patient compliance and duplicative therapies, which has resulted in a reduction in one of the identified areas of waste, fraud and abuse by Medicaid recipients. In FY 2003-04, top prescribers (1,000 physicians) were provided with a hand-held Portable Digital Assistant (PDA) giving them wireless electronic access to a 60-day patient drug manifest in order to make them aware of the total drug therapy for a Medicaid recipient, whether the recipient is seeing other prescribers and whether the recipient is compliant with the prescribed regimen. In FY 2004-05 the contract was amended to provide for 3,000 total units and full capacity was reached in early 2005. In June 2004, electronic prescribing was added to the program at no additional cost. The secure transfer of electronic prescriptions and interface with GSM's eMPOWER$_x$ system offers several benefits, including:

- **Efficiency** – checks for problems such as drug interactions, allergies, duplicate therapies and formulary conflicts without having to reference patient files and materials beforehand.
- **Safety** – eliminates medication errors caused by misread handwritten prescriptions and by medications with similar names or likeness.

- **Security** – reduces potential for fraud and abuse, such as forging, that may occur with paper prescriptions.

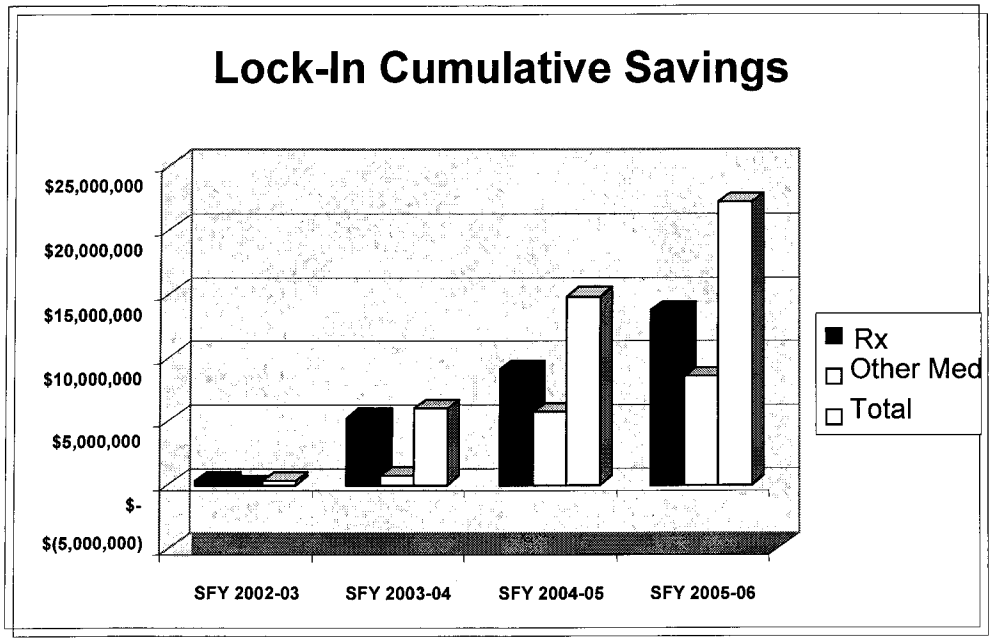
The program experienced the budget reduction of $4 million taken in anticipation of savings. Additionally, an analysis reflects that users of the device write an average of 13 to 20 percent fewer prescriptions than nonusers. Over-prescribing and duplicate therapies have been eliminated, and costs associated with hospitalization due to drug interactions have been avoided.

PDA users were alerted to 17,483 drug interactions of a high or very high severity ranking. During FY 2005-2006, Florida providers transmitted 430,109 electronic prescriptions since the inception of e-Prescribing for the eMPOWER$_x$ program in late 2005.

Pharmacy Lock-in Program

AHCA was given the authority to restrict certain recipients to a single pharmacy provider. There were 1,064 recipients enrolled in this program for FY 2005-06. The Federal waiver states that a recipient may be restricted in this manner for one year.

Despite this limitation, savings associated with the Lock-in Program total $22,062,169 since it began in October 2002. Savings from the program totaled $7.3 million for FY 2005-2006. This can be attributed not only to a reduction in the number of prescriptions for drugs with the potential for misuse or abuse, but also to significant reductions in the number of office visits and associated medical claims. By limiting access to one pharmacy provider, it appears drug-seeking behaviors are modified as well.



Sentinel Program

Medicaid Pharmacy Services has a contract with ACS Heritage of Richmond, Virginia, which is a consulting firm specializing in pharmacy auditing, drug utilization review, disease management and related pharmacy managed care consulting services. Throughout the course of the contract, which began in February 2003, ACS Heritage has made clinical recommendations to the state and has identified cost savings opportunities, overbilled pharmacy claims, package size discrepancies, and quantity errors.

One of the main components of the Sentinel program is to query pharmacy claims that have been billed through the Medicaid pharmacy point-of-sale system. In early 2005, ACS Heritage began contacting pharmacies directly and requesting supporting documentation for claims that appear to have been misbilled. If supporting documentation is found to be insufficient, the pharmacy is requested to rebill the claim with the proper quantity, days supply, etc., thereby nullifying the identified overpayment. In FY

2005-06, 403 claims were identified as erroneously billed and reversed as a result of the Sentinel program. These claims reversals have resulted in direct savings to the Medicaid program of $337,531.

Office of the General Counsel

The Office of the General Counsel is involved with other offices of the Agency in efforts to curb fraud and abuse in the Florida Medicaid program. The Office provides legal guidance and recommendations to the Division of Medicaid and to the Bureau of Medicaid Program Integrity regarding ways in which to curtail and deal with Medicaid fraud and abuse.

Medicaid reform is a matter with which the Office has been involved in assisting the Division of Medicaid with the legal aspects of implementation of reform and with the evaluation of fraud and abuse implications of reform.

The fifteen attorneys comprising the Medicaid legal staff defend the Agency in Medicaid-related litigation before administrative tribunals, and litigate violations of state and federal laws pertaining to the administration of the Medicaid program before state and federal courts. The attorneys are involved in litigation related to the recovery of overpayments from providers and have worked with Medicaid Program Integrity in bringing a substantial number of audit cases to satisfactory closure.

At the beginning of FY 2005-06, there were 246 overpayment recovery cases in litigation with a total potential recovery value of more than $36 million. As the year progressed, more cases were added, bringing the total of cases in litigation to 373, with a total value of more than $45 million. Attorneys in the Office of the General Counsel reached resolution on 211 cases and orders were issued for these cases with a final overpayment determination of more than $15.8 million. As of June 30, 2006, there was a net reduction for the year of 84 in the number of cases in litigation.

Division of Health Quality Assurance

More than 32,000 Florida health care services and facility providers of 33 different types fall under the regulatory jurisdiction of the Division of Health Quality Assurance. The Division surveys and licenses health care facilities (services such as home health care), oversees surveys/monitors, and licenses managed care plans in Florida. The Division is also responsible for certification surveys of health care facilities in coordination and cooperation with the Centers for Medicare & Medicaid Services of the U. S. Department of Health & Human Services. Field office staff members are responsible for complaint investigations in both licensed and certified facilities. The Office of Plans and Construction, one of the bureaus in the Division, reviews and approves facilities' construction and renovation plans to ensure that hospitals, nursing homes, ambulatory surgical centers, and intermediate care facilities for the developmentally disabled are safe, functional and properly built to provide an appropriate physical environment for patients and residents. The Division is engaged in a number of activities that assist in combating fraud and abuse in the Medicaid program.

Fraud Referrals to the Office of the Attorney General and to the Bureau of Medicaid Program Integrity

The Division of Health Quality Assurance referred six complaints on five different licensees to the Attorney General during FY 2005-06. Two of the referrals were home health agencies involved in home health care fraud; one was a nursing home potentially involved in a referral and kickback scheme; one was a referral for a homemaker/companion contract fraud, and one was a "double" referral of two complaints against one home medical equipment company for failure to provide legitimate refunds to its clients.

Facility Type	# Referred
Assisted Living Facilities	4
Ambulatory Surgery Center	1
Home Health Agencies	25
Hospitals	3
Health Maintenance Organizations	1
Nursing Homes	8
Adult Family Care Homes	1
Home Medical Equipment Providers	1
Health Care Clinics	5
Total	49

During FY 2005-06, Health Quality Assurance also made 49 referrals to Bureau of Medicaid Program Integrity – up 75 percent over the previous fiscal year's 28 referrals. The 49 referrals represented a broad spectrum of providers as shown above.

Infusion Clinic Initiative

In August 2005, the Executive Office of the Governor requested the Agency, the Centers for Medicare & Medicaid Services (CMS), the Department of Health and the Attorney General's Office, to investigate the practices of certain HIV infusion clinics in Florida. Massive fraud was suspected. CMS determined that these clinics appeared to be billing millions of dollars to Medicare for services that either were provided inadequately or were not provided at all.

CMS approached Florida because Florida's Health Care Clinic Act requires many types of health care clinics to obtain licenses from the Agency for Health Care Administration. Where state licensure laws exist, Medicare payments from CMS are generally contingent upon state licensure. The Health Care Clinic Act permits the Agency to issue an emergency suspension of a clinic's license under only two circumstances:

1. The clinic fails to allow full and complete access to the premises and to billing records or information to any representative of the Agency who makes a request to inspect the clinic.
2. The clinic fails to employ a qualified medical director or clinic director.

Emergency suspensions prevent the clinic from continuing operations as of the date the emergency suspension order (ESO) is imposed.

The Agency may also institute injunctive proceedings in court, but this is generally a lengthy process. Any subsequent revocation action is subject to appeal under Chapter 120, F.S. The appeal process can involve extended litigation and settlement discussions. During the revocation process, a clinic can continue to operate and bill; consequently, whenever supportable, the Agency opted for emergency suspension orders. Of the 17 clinics initially scheduled for review, action was taken on 11. There were ten revocations and one voluntary relinquishment/surrender of the clinic license. Development of fraud cases is an involved process, generally requiring specialized investigation. CMS had hoped to use state licensure loss as a means of expediting denial of further payment to these clinics. The Agency has no authority for criminal investigation and prosecution and no regulatory authority over licensed health care practitioners, which are regulated by the various health care boards under the umbrella of the Department of Health. The Attorney General's Office has criminal prosecutorial authority and continues to assist with these cases.

Division of Administrative Services

Amounts identified as overpayments are generally referred to the Agency's Division of Administrative Services, Bureau of Finance and Accounting, for collection. Once an overpayment has been determined, the federal share is returned within 60 days. The state then pursues collection of the receivable from the Medicaid provider. The Bureau of Finance and Accounting collects accounts as either direct payments from providers or through withholding of Medicaid or Medicare payments. The Bureau investigates problem cases in order to pursue collection or provides the necessary information to an outside collection agency. Agency staff continues to work aggressively to reduce outstanding receivables within the Medicaid program.

During FY 2005-06, accounts receivable collections, net of adjustments and refunds, approached $28.6 million.

As of June 30, 2005, Medicaid accounts receivable for fraud and abuse stood at $59.9 million. As of June 20, 2006, the balance was $51.2 million. It is noted, however, that nearly 64 percent of the June 30, 2006 balance was within the jurisdiction of other agencies to conduct collection related activities, as shown below.

Collection Authority/Status	
Attorney General's Office	$6,359,153
Department of Corrections	1,227,024
Department of Financial Services	8,706,091
Cases Under Appeal	16,750,708
June 30, 2006 Balance	**$33,042,976**

For all receivables determined to be uncollectible, AHCA must obtain approval from the Department of Financial Services for write-off. Accounts are generally written off because the provider has declared bankruptcy, is a corporation out of business, is unable to pay because of incarceration, is otherwise insolvent, or is beyond the State's current collection enforcement policy. Once the receivable is approved for write-off, and written off, if deemed qualified the federal share of each receivable write-off is reclaimed. During FY 2005-06, $5.6 million in receivables were approved for write-off during the federal fiscal year, yielding a nominal amount in reclaimed federal funding. The federal requirements only allow funding to be reclaimed when the write off is due to a bankruptcy in which the Agency filed a claim (even if the bankruptcy had already been discharged at the time the Agency discovers the bankruptcy), or when the write off is due to a business that is certified as being out of business (a very detailed and in-depth process). The Agency's Bureau of Compliance and Strategy is currently developing processes whereby the Agency can certify that a provider is out of business and thereby reclaim the federal share. These accomplishments in dealing with Medicaid accounts receivable resulted from a number of actions taken by the Bureau of Finance and Accounting during the year.

It should be noted that even after write-off, monies are received from providers. In FY 2005-06, the Division of Administrative Services received $1.3 million in funds previously written off.

- The Bureau of Finance and Accounting continued to refine the Medicaid Accounts Receivable, or MAR system, that records extensive financial detail on Medicaid accounts receivable. The MAR system tracks each case as it moves through the receivables process, emphasizing which department, bureau or unit has current responsibility for a case. It calculates interest for cases as appropriate, tracks state/federal allocation of receivables activity, 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" reports for staff follow-up, and demand letters. The MAR system maintains the required accounting data for financial statement and federal reporting purposes for fraud and abuse cases as well as other overpayment cases, such as hospital and nursing home retroactive rate adjustments.
- The Bureau continues to provide transaction records for AHCA's Fraud and Abuse Case Tracking System (FACTS). These records include the original overpayment amount, payments received, adjustments applied, current balance, and current status for each case in the MAR system. This file is created by an automated process that runs from the MAR system each night, and then updates FACTS, allowing it to reflect the latest financial and account status information.
- The Bureau continues to emphasize communications with MPI and MFCU to coordinate audit collection efforts. The Bureau has also worked with AHCA's Office of General Counsel to coordinate efforts and pursue additional avenues of collection.
- The MAR Workgroup meets biweekly to discuss strategy and improve communications between the units. The group is comprised of representatives from the Office of Inspector General, the Office of General Counsel and the Bureau of Finance and Accounting.
- The Bureau has taken aggressive steps during the year to reduce the length of negotiated payment plans, and will continue to strive to achieve repayments as promptly as possible.

Statutory Reporting Requirements

Number of cases opened and investigated each year

MFCU investigated a total of 1766 cases, which included 756 opened during the year. MPI investigated 1,694 cases, which included 612 opened during the year.

Sources of the cases opened

		AHCA	MFCU
AHCA	Area/District Office Staff	6	2
	Medicaid Headquarters Staff	6	2
	MPI Generated	526	187
	Other	2	3
Public	Anonymous		78
	Citizens	14	59
	Media		1
	Provider	30	15
	Qui Tam[1]		36
	Recipient	5	20
State Agencies	Department of Children & Families		208
	Department of Health	1	7
	Florida Department of Law Enforcement		2
	Other State Agencies	1	6
Federal Agencies	Federal Trade Commission		1
	Health & Human Services	12	1
	Social Security Administration		1
Law Enforcement	Florida MFCU Generated	8	70
	U. S. Attorney's Office		
	US Drug Enforcement Administration		4
	Department of Justice		1
	Federal Bureau of Investigation	1	5
	Local Law Enforcement		7
	State Attorney's Office		2
Other:	MFCU (Other than Florida)		3
	MFCU Statewide Intel Team		8
	Operation Spot Check		2
	HMO Investigative Unit		2
Employee			20
Long Term Care Ombudsman Council			3
		612	756

[1] The False Claims Act allows an individual, often referred to as a whistleblower or a relator, who knows about a person or entity that is submitting false claims to sue, on behalf of the government, and to share in the damages recovered as a result of the suit.

Disposition of the cases closed

MFCU and MPI closed a total of 2,040 investigations. (MFCU closed 812; MPI closed 1,228) The cases closed are summarized below as to final disposition:

	AHCA	MFCU
Acquittal Count		1
Administrative Hearing	51	
Administrative Hearing Denied	22	
Administrative Referral		110
Assistance to other Agencies		2
Case Dismissed		3
Civil Settlement		26
Closed Upon Repayment	521	
Consolidated		32
Conviction		26
Default Final Order	261	
Defendant Deceased		1
Lack of Evidence		270
No Fraud or Abuse Found	199	
Noelle Prosequi		1
Not a Medicaid Provider		18
Pre-Trial Intervention		3
Prosecution Declined		9
Provider Education Letter	27	
Resolved with Intervention		1
Settlement Agreement	147	
Unfounded		309
Total	**1,228**	**812**

Amount of overpayments alleged in preliminary and final audit letters

Typically, MPI sends a report explaining the preliminary overpayment identified and giving the provider an opportunity to provide additional documentation. After review of any additional documentation submitted, MPI sends a final report, which reflects the overpayments identified and offers the provider hearing rights under Chapter 120, Florida Statutes. For the 1,228 cases closed during the fiscal year, 1,080 preliminary audit reports were sent totaling $50,927,504. A total of 336 cases totaling $1,501,433 were closed after the preliminary report. Based on a review of additional documentation, final audit reports totaling $31,117,205 were sent for the remaining 744 cases.

Number and amount of fines or penalties imposed

MPI has several tools available to address provider fraud and abuse. Suspected fraud is referred to MFCU for investigation of possible civil and/or criminal violations. During the fiscal year, MPI placed 245 providers under prepayment review, recommended termination of 194 providers and referred to MFCU 225 providers for investigation and an additional 55 providers for informational purposes. The Agency also fined 153 providers more than $289,000.

Reductions in overpayment amounts negotiated in settlements or by other means

Settlement agreements involving 40 individual cases were negotiated with four provider groups. The original overpayments of $2,359,609 were reduced to $2,122,639 or 90 percent of the original amount.

Amount of final agency determination of overpayments

A total of 257 cases totaling $3,001,545 were closed after the final audit report. Final orders issued on the remaining 487 cases totaled $20,924,900. The reductions were based on the results of hearings or on additional documentation provided during the hearing process.

Amount deducted from federal claiming as a result of overpayments

Within 60 days of MPI's final audit letter, the Agency reports the entire federal portion of the total overpayment to the federal government. These overpayment amounts are included on the corresponding federal CMS-64 quarterly reports. During FY 2005-06, AHCA reduced its federal claiming by $14.8 million for net overpayments determined.

Amount of overpayments recovered

During FY 2005-06, the Agency collected $33.5 million in overpayments. This includes $17.2 million collected from MFCU cases and $16.3 million collected from MPI cases. (In addition, the Agency collected $10.8 million in claims adjustments and $0.9 million in paid claims reversals.)

Amount of investigation costs recovered

During FY 2005-06, the Agency recovered $187,282 in investigation costs. MFCU recovered $832,247 in investigation costs.

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

For all cases paid in full during the fiscal year, the average length of time from the case opened date to the date the case was paid in full was 452 days.

Amount determined as uncollectible and the portion of the uncollectible amount subsequently reclaimed from the federal government

During State FY 2005-06, the Department of Financial Services deemed $5.6 million uncollectible and approved for write-off. Almost $287,000 was collected after the cases were written off. The reporting of qualified cases on the CMS-64 quarterly reports resulted in over $25,000 being reclaimed from the federal government.

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

Below is a summary of providers terminated based on information obtained as part of investigations by MPI and/or MFCU:

Provider Type	Total
Physician (MD)	80
H & C Based Services	30
Medical Supplies/Durable Medical Equipment	28
Pharmacy	24
Assistive Care Services	9
Physician (DO)	5
Home Health Agency	3
Podiatrist	3
Independent Laboratory	1
Licensed Midwife	2
Physician Assistant	2
Advanced Registered Nurse Practitioner	1
Audiologist/Speech Pathologist	1
Chiropractor	1
Dentist	1
Optometrist	1
Tape Intermediary	1
Therapist	1
Total	194

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

Expenditures for MPI in FY 2005-06 were $6,801,325, which includes salaries, expenses, and contractual services. In addition, costs of $2,698,901 were allocated for support from the General Counsel's Office, Office of Inspector General, Bureau of Finance and Accounting, and Medicaid Contract Management. This included an allocation for Agency indirect costs of $1,254,691. In addition, however, Medicaid incurred expenses for services related to MPI activities for $1,516,604. Therefore, total costs of $11,016,829 were associated with MPI operations.

MFCU's operating expenditures for FY 2005-06 were $15,170,049. In addition, indirect costs of $914,532 were incurred for the total MFCU expenditures for FY 2005-06 of $16,084,581.

Number of providers prevented from enrolling/re-enrolling in the Medicaid program

As has been reported in previous annual reports, the precise number of providers prevented from enrolling/re-enrolling in the Medicaid program is not obtainable due to the limitations (denial 'reason description' codes are limited) set forth in the Agency's current Medicaid Management Information System (MMIS). Medicaid Contract Management (MCM) does expect to be able to produce these numbers with the new MMIS that is scheduled to be up and running in 2008, by creating additional denial reason codes. Until that new system is in place, however, there is some information that has been obtained manually and will be reported here.

All provider applications received by the Agency or its designee, ACS State Healthcare, Inc., follow the same procedures, whether the application is received for the first time, or amended and submitted numerous times. Fingerprint cards are sent to the Florida Department of Law Enforcement (FDLE) and to the Federal Bureau of Investigation (FBI) where a background check is performed. In FY 2005-06, three

applications were denied based on the results of the background check. The provider application is also checked against the National Medicare Exclusion list. Those on the Medicare Exclusion list are denied enrollment into the Florida Medicaid program. Any active Florida Medicaid providers added to the Exclusion list are terminated immediately. Three applications received in FY 2005-06 were denied because of previous exclusions.

Providers may also be denied enrollment based on site visits. The basis for these denials includes technical violations of provider requirements, which may include suspected fraud and/or abuse. During FY 2005-06, 143 applications were denied due to failed site visits. There could be multiple reasons for these denials.

Additionally, a provider may have voluntarily terminated their provider number, or have been terminated for a non-fraud related reason (e.g., licensure action), and the Agency may have information about the provider regarding fraud or abuse. If the provider applies for re-enrollment later, the fraud or abuse information is available for consideration during the enrollment process. During FY 2005-06, 62 applications were denied for applicants when the Agency had information pertaining to prior fraud or abuse activity. These numbers could have included the same applicants applying multiple times for enrollment during the year.

Recommendations for Changes to Prevent and/or Recover Overpayments

Medicaid Reform beyond the pilot counties is itself a recommendation for change to curtail overpayments. Both the Agency and MFCU are well aware that the Reform model, too, has potential for abuse and fraud. Therefore, moving forward in Medicaid Reform must be accompanied by proper oversight by the state. In addition, the state requires each MCO to have a fraud-fighting unit. Thus, as Florida moves forward with Medicaid Reform and more managed care organizations join the Medicaid network, Florida will gain more entities dedicated to watching billing activity. Continuation of Medicaid Reform is therefore a recommendation for change that will help deter fraud and overpayments. As reform is further expanded, the agency and MFCU will continue to revise processes and activities to ensure that fraud and abuse is dealt with effectively.

Additionally, developing new techniques to collect overpayments from providers and maximize reclaiming adjustments from the federal government are areas to be expanded in FY 2006-07. Maximizing collection authority under both state and federal laws, working creatively with the Department of Financial Services (DFS) procured collection agency and seeking enforcement remedies in civil courts are all examples of areas in which the agency may be able to seek more recoveries.

An additional legislative solution could be provided for when a Medicaid provider sells their business. There is a lag time to when the new owner's Medicaid claims are appropriately paid. Current law allows the new owner to submit claims and avoid responsibility for any improper claims of the previous owner. When the Agency attempts to use administrative remedies of offset, prepayment review or sanctions, they are ineffective because the previous owner is no longer in the program. If civil remedies are sought, often the previous owner is gone. It is recommended that a "successor in interest" law be enacted to mirror the type seen in the environmental area where the successor in interest is strictly liable for violations of the business regardless of the date of change in ownership. The burden of doing due diligence would be put upon the purchaser to review the books of the seller in detail or hold the seller responsible through an indemnification agreement. The purchaser could insist on an indemnification agreement from the seller. In this way, the State of Florida would not be trying to track down former owners. Rather, the purchaser, the one best able to assess and reduce the risk, would have the burden of recovering from the seller.

Another legislative change pertains to section 456.074(4), F.S., which allows DOH to suspend a practitioner's license for failing to pay student loans. AHCA would be served well if the power to issue or apply emergency suspension orders (ESOs) were extended to those who fail to repay monies owned to Medicaid as a result of a final order or settlement agreement.

As Medicaid Reform progresses and new tools are implemented to reduce fraud and overpayments and the existing methods are applied consistently, the message that Florida is not the place for defrauders will be heard loudly and clearly.

Conclusion

The summary below highlights our significant progress in combating fraud and abuse within the Medicaid program.

AHCA and MFCU Fraud and Abuse Control Efforts at a Glance			
Activities	**Fiscal Year 2004-05**	**Fiscal Year 2005-06**	**Percent Improvement**
AHCA			
Cases with Identified Overpayments	849	1002	18
MPI Referrals to MFCU	197	225	14
Provider Terminations	224	194	(14)
Prepayment Reviews	285	245	(14)
Providers Sanctioned	-	505	*
MFCU			
Cases Investigated	1365	1766	29
Cases Closed	354	812	129
Benefits			
AHCA			
Recovery (millions)	$20.5	$28.0	37
Prevention (millions) -Prepayment Reviews -Provider Terminations -Focused Projects -Denial of Prescription Payments -Policy Changes	$38.8	$37.0	(5)
MPI Total (millions)	$59.3	$65.0	10
Pharmacy Lock-In Savings (millions)	$10.1	$7.3	(28)
Third Party Liability Recovery (millions)	$87.0	$112.3	29
Grand Total (millions)	$156.4	$184.6	18
MPI Return on Investment	5.5:1	5.9:1	7
MFCU			
Recovery (millions)	$41.9	$74.9	79

*Implementation of the sanction rule became effective on July 1, 2005

AHCA and MFCU continue to fight against fraud and abuse in the Medicaid program. The criminal cases brought and won by MFCU against those who would defraud the Medicaid program and the work of AHCA in preventing overpayments to abusive providers and in recovering overpayments from them have placed providers on notice that fraud and abuse will not knowingly be tolerated in Florida Medicaid. As an

approximately $15 billion program, Medicaid attracts some unsavory providers along with the tens of thousands who serve so well the disadvantaged citizens of Florida. MFCU and AHCA are dedicated to rooting out these undesirable providers, recovering overpayments, bringing appropriate legal action and ridding the program of those who abuse the Medicaid program in an egregious manner.

Again, AHCA and MFCU acknowledge with appreciation the assistance capably and willingly given to them by the Florida Legislature, the Office of the Governor, the Federal Government, and many Florida agencies, such as the Department of Health, the Department of Children & Families, the Department of Elder Affairs, the Agency for Persons with Disabilities and the Department of Law Enforcement.

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Office of the Attorney General
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Tallahassee, FL 32399
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Committee on Health Innovation

Addendum

Tuesday, October 2, 2007
9:30 AM – 12:00 Noon
Morris Hall (17 HOB)

Marco Rubio
Speaker

Rene Garcia
Chair

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

FLORIDA MEDICAID

Home Health and Durable Medical Equipment

Thomas W. Arnold

Deputy Secretary for Medicaid

Agency for Health Care Administration

Presented to the House Health Innovation Committee

October 2, 2007

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Fee-For-Service Medicaid Home Health Program

- Medicaid defines home health services as medically necessary care provided to a beneficiary whose condition, illness, or injury requires the care to be delivered in the recipient's place of residence.
- This program is authorized under s. 409.905 (4), Florida Statutes, and Chapter 59G-4.130, Florida Administrative Code.

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Fee-For-Service Medicaid Home Health Services

- Fee-for-Service Medicaid Home Health Services include:
  - Home Health Visits (includes services rendered by a licensed nurse or home health aide).
  - Home Health Private duty nursing and personal care (only available for beneficiaries under the age of 21).
- Expenditures for these items in FY 2006-2007 were more than $189 million.

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Fee-For-Service
Medicaid Home Health: Visits

- Home health visits are limited to 4 visits per day.
- Visits may be any combination of services rendered by a licensed nurse or home health aide as indicated on the beneficiary's plan of care.
- Home health agencies must obtain prior authorization for beneficiaries who require additional home health visits and have used their lifetime maximum of 60 visits.

Fee-For-Service
Medicaid Home Health:
Private Duty Nursing and Personal Care

- Private Duty Nursing and Personal Care services are for recipients that require more individual care than can be provided through a home health visit.
- Recipients can receive a minimum of 2 hours and up to 24 hours of private duty nursing and personal care services per day. Services rendered in less than 2 hours are a home health visit.
- Personal Care services are medically necessary assistance with the child's activities of daily living that support the child's medical care needs, such as:
  - Bathing
  - Grooming
  - Toileting
  - Oral hygiene.

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Fee-for-Service Medicaid Home Health Prior Authorization Requirements

- A physician writes an order for home health services:
  - The home health agency submits the beneficiary's medical information to the Medicaid peer review organization for review and authorization.
  - All prior authorization requests must meet the established medical necessity criteria for approval of services.
- Home Health Visits:
  - The home health agency submits a prior authorization request once the beneficiary has reached their 60 visit lifetime limit.
- Private Duty Nursing and Personal Care:
  - All private duty nursing and personal care services must be prior authorized by the Medicaid peer review organization before beginning services.

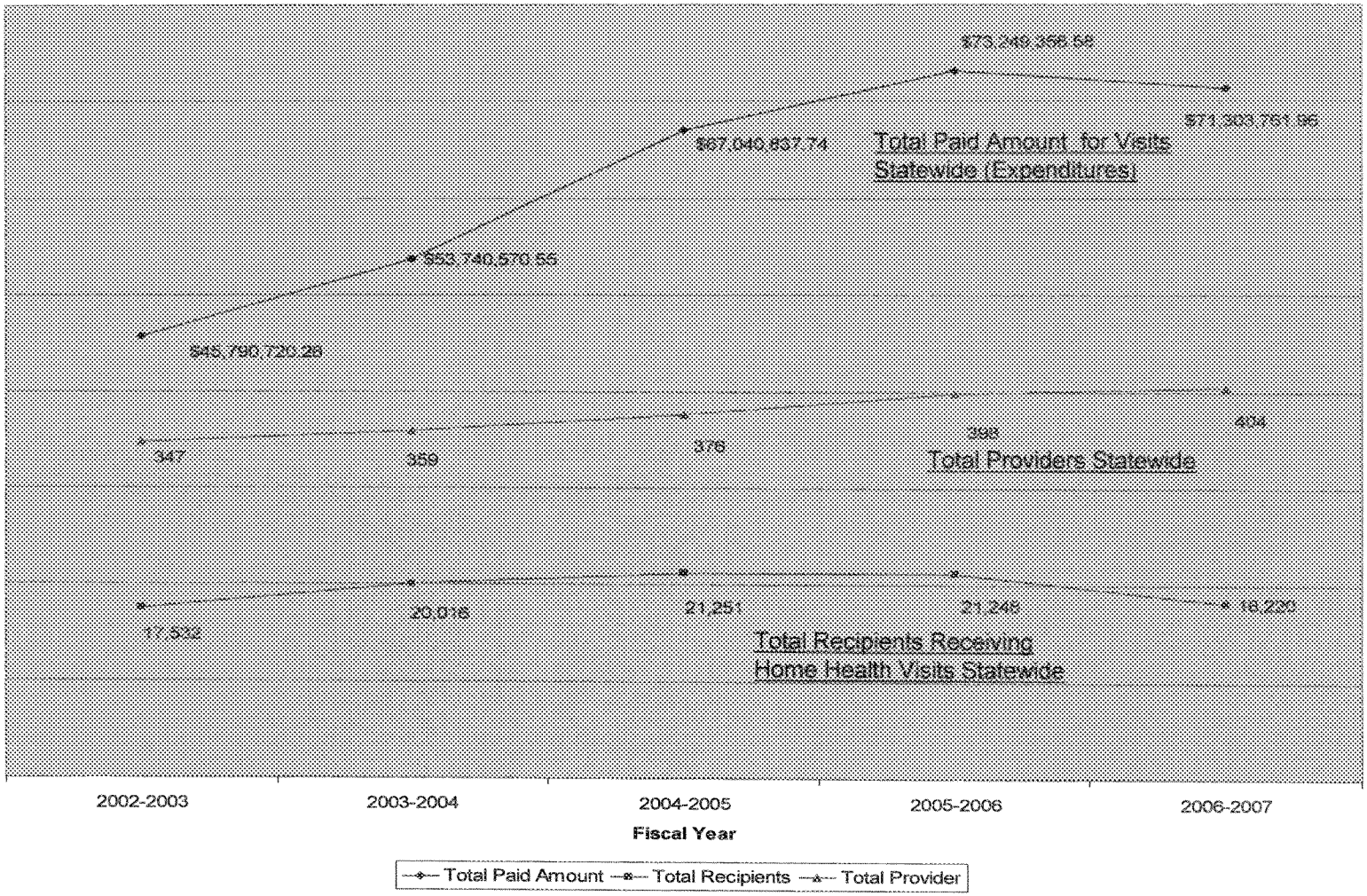
AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Fee-For-Service Medicaid Home Health Rates

- Rates for Home Health Visits:
  - Registered Nurse: $31.04
  - Licensed Practical Nurse: $26.19
  - Home Health Aide: $17.46

- Rates for hourly Private Duty Nursing/ Personal Care:
  - Registered Nurse: $29.10
  - Licensed Practical Nurse: $23.28
  - Aide: $9.70

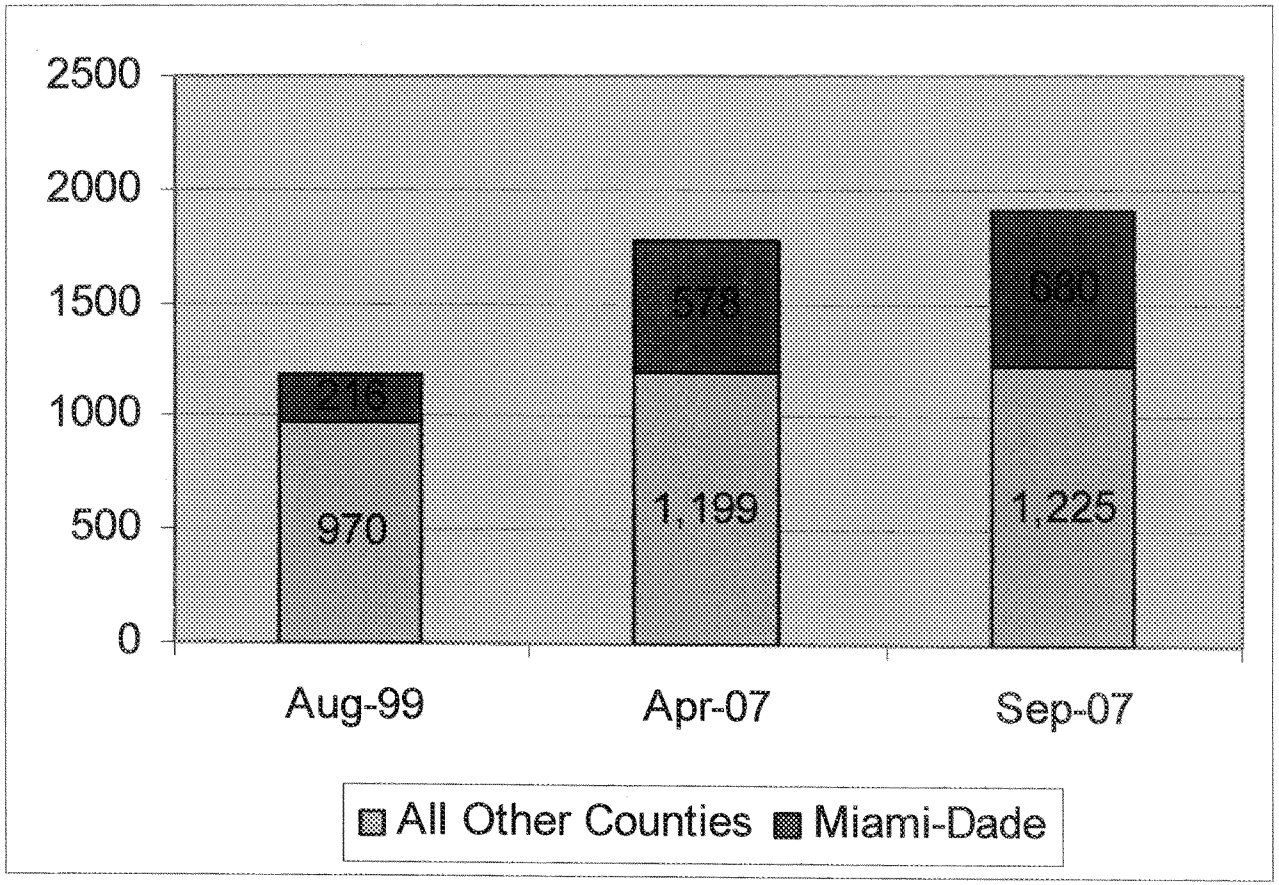
Fee-for-Service
Medicaid Home Health Trends



Note: Data for Fiscal Year 2006-2007 reflects claims paid as of 9/19/2007 for dates of service during Fiscal Year 2006-2007.

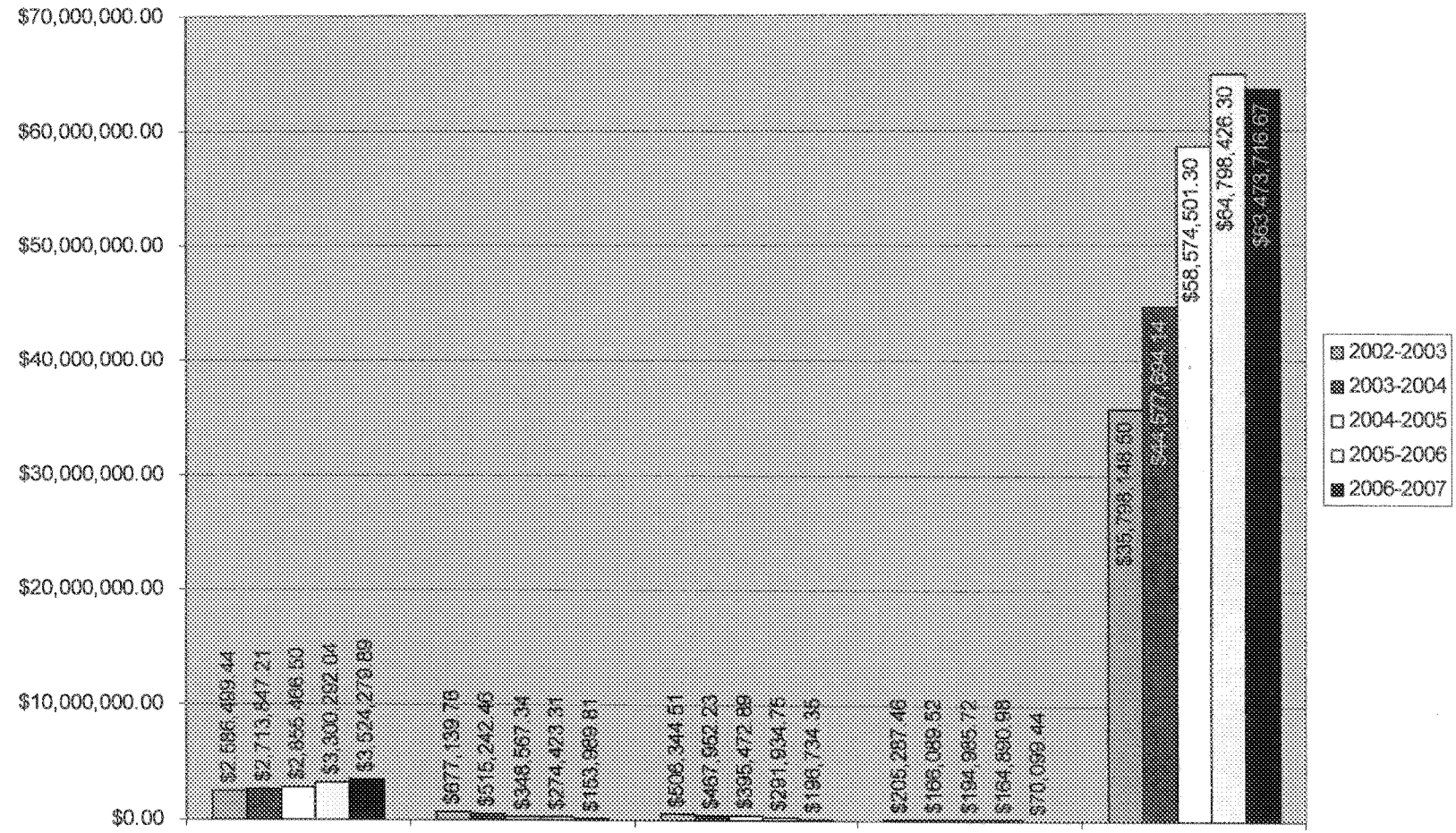
Growth in Licensed Home Health Agencies

Medicare, Medicaid and Private



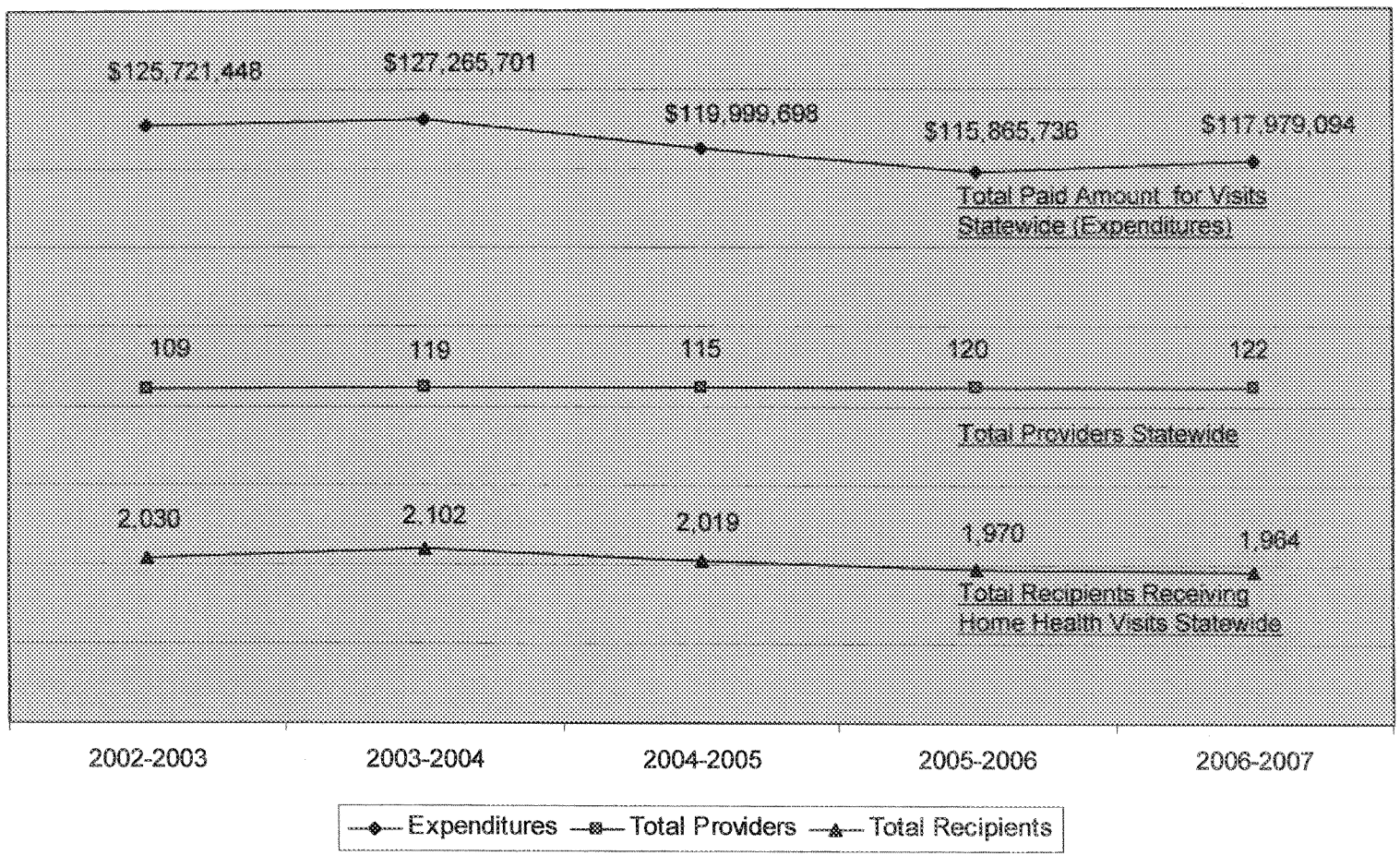
Expenditures for Counties with Highest Medicaid Enrollment

Medical Expenditures for Home Health Visits in Counties with Highest Medicaid Enrollment



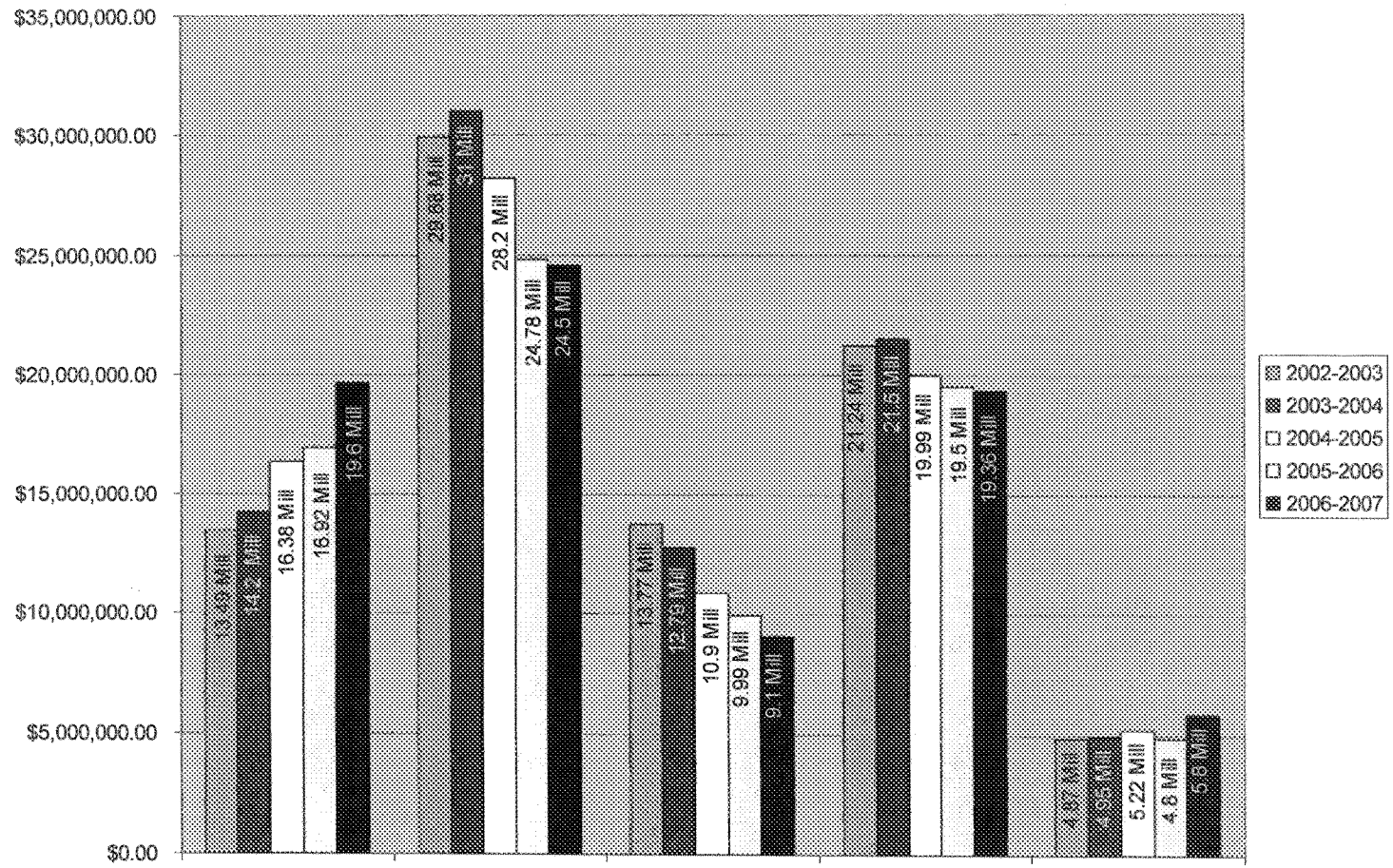
Note: Data for Fiscal Year 2006-2007 reflects claims paid as of 9/19/2007 for dates of service during Fiscal Year 2006-2007.

Fee-For-Service Medicaid
Private Duty Nursing/ Personal Care: Trends



Expenditures for Counties with Highest Medicaid Enrollment

Medicaid Expenditures for PDN/ PC Services in Counties with Highest Medicaid Enrollment



Beneficiary Enrollment:	433,048	170,200	152,737	121,761	111,136

Note: Data for Fiscal Year 2006-2007 reflects claims paid as of 9/19/2007 for dates of service during Fiscal Year 2006-2007.

Anti-Fraud Proposals in Home Health Licensure

- Restrict the number of new home health agencies licensed per month.
- Limit the number of agencies that can be supervised by individual administrators or directors of nursing.
- Prohibit home health agencies serving as staffing services for other home health agencies.
- Increase fines and sanctions for fraud-related problems.

Medicaid Durable Medical Equipment Program

- Durable Medical Equipment (DME):
  - Medicaid defines DME as medically necessary equipment that can withstand repeated use, serves a medical purpose, and is appropriate for use in the recipient's home.
  - Program is authorized under s. 409.906 (10), Florida Statutes, and Chapter 59G-4.070, Florida Administrative Code.

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Durable Medical Equipment

- Top DME items (by expenditure) are:
  - Oxygen Concentrator
  - Blood Glucose Test Strips
  - Enteral Feeding Supply Kit
  - Nebulizer
  - Wheelchair (manual and motorized)
- Expenditures for these items in FY 2006-2007 were more than $27 million.

DME Provider Enrollment Qualifications

- DME and medical supply entities must meet the following criteria:
  - Be licensed by the local government agency as a business or merchant.
  - Be licensed by the Department of Health if providing orthotics and prosthetic devices.
  - Be licensed by the Agency for Health Care Administration.
  - Have an in-state business location or be located not more than fifty miles from the Florida state line.
  - Background screening of Owners, Officers and Directors.
  - $50,000 Surety Bond.
  - Bond renewed annually.

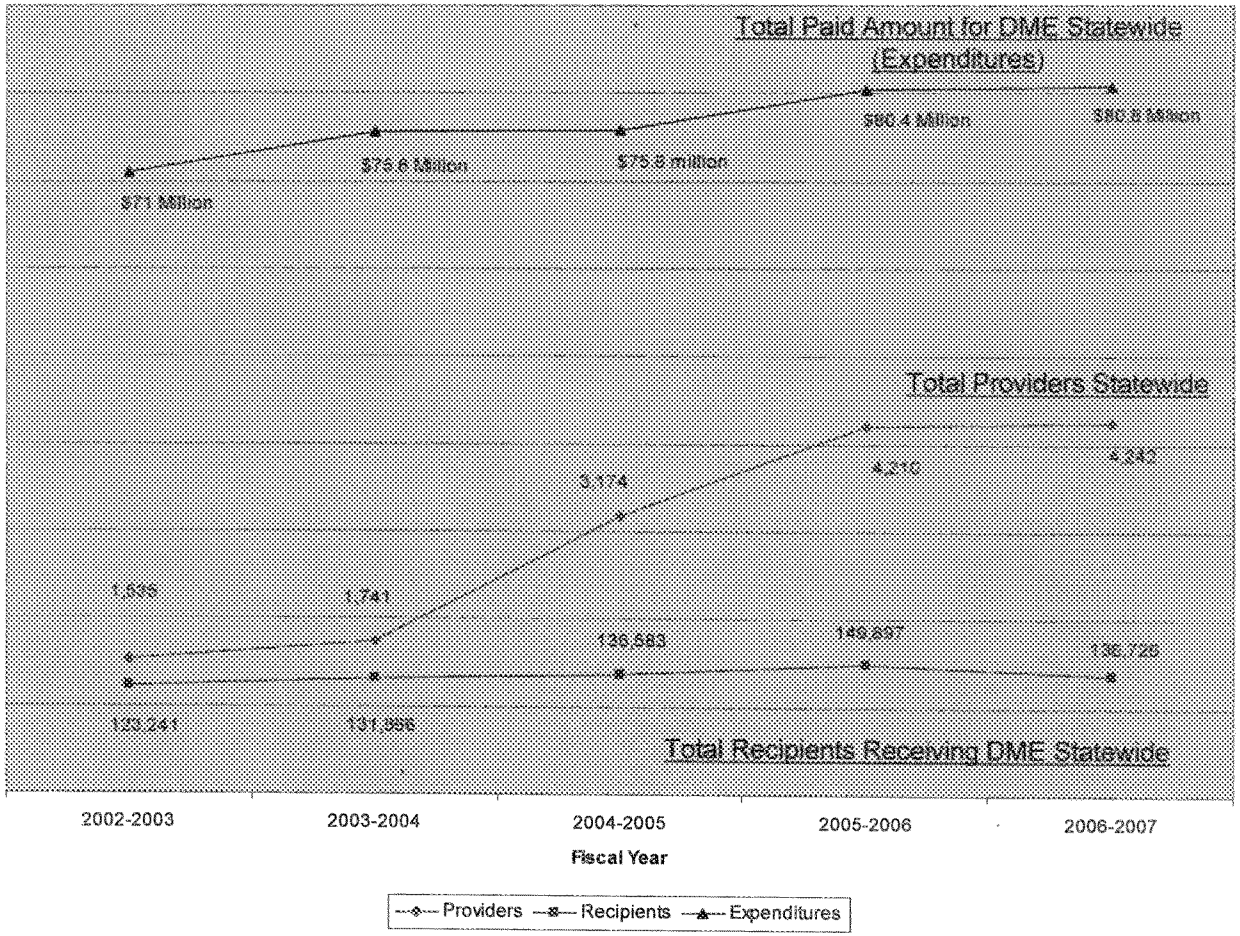
DME Provider Enrollment Qualifications

- If the applicant is a Medical Oxygen Retailer:
  - Must have a oxygen retailer permit issued by the Department of Health.
  - Pharmacy providers who bill Medicaid for oxygen must have Department of Health pharmacy permits.
  - Must have a licensed certified respiratory therapy technician, registered respiratory therapist, or a registered nurse under contract or on staff.
- Pharmacy Providers:
  - Pharmacy providers receive a durable medical equipment number when they first enroll as a pharmacy.
  - Must request activation of the DME number.

Mandatory Site Visit

- A DME provider must have an AHCA site visit before the provider's enrollment application can be approved.
- Site visits are not required for:
  - Providers who are associated with pharmacies.
- Denied 32% of all applications received statewide FY 03/04 – 06/07.

Durable Medical Equipment ~ Trends



Note: Data for Fiscal Year 2006-2007 reflects claims paid as of 9/19/2007 for dates of service during Fiscal Year 2006-2007.

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DME
Next Steps

- Upcoming DME Handbook and policy changes:
  - Requirement for accreditation.
  - Limiting Mail Order DME and Medical Supply Providers.
  - Limiting Mobile DME and Medical Supply Providers.
  - Enhanced enrollment requirements.
  - Requirement for increased documentation on Medical Necessity.
- In the licensure program, the Agency proposes to eliminate the oxygen waiver for medical equipment providers, requiring full licensure surveys for all licensees.

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Federal Medicare DME Pilot

- Federal Centers for Medicare and Medicaid Services (CMS) DME Pilot.
- Goal is to increase CMS ability to detect and prevent fraudulent activity:
  - Focusing on South Florida and Los Angeles.
  - Requiring all DME providers to re-enroll .
  - Accreditation required for providers and suppliers.
  - Prohibits billing by DME with owner or manager with felony conviction (past 10 years).
  - Enhanced review of authorized providers.

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Medicare Competitive Bid Pilot Program for DME

- Establishes single payment amounts for DME providers in Miami, Fort Lauderdale and Orlando phased in over next several years
- Will be expanded to additional areas in 2009.
- Intended to lower out-of-pocket expense for beneficiaries; provide cost savings to Medicare; and reduce the number of DME providers.
- Provider must be willing to service entire competitive bid area regardless of where the beneficiary resides for single payment amount.

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Fraud and Abuse Defined

Fraud: The "intentional deception or misrepresentation" that an individual knows, or should know, to be false, or does not believe to be true, and makes, knowing the deception could result in some unauthorized benefit to himself or some other person(s).

Abuse: Provider "practices that are inconsistent" with generally accepted business or medical practices and that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care.

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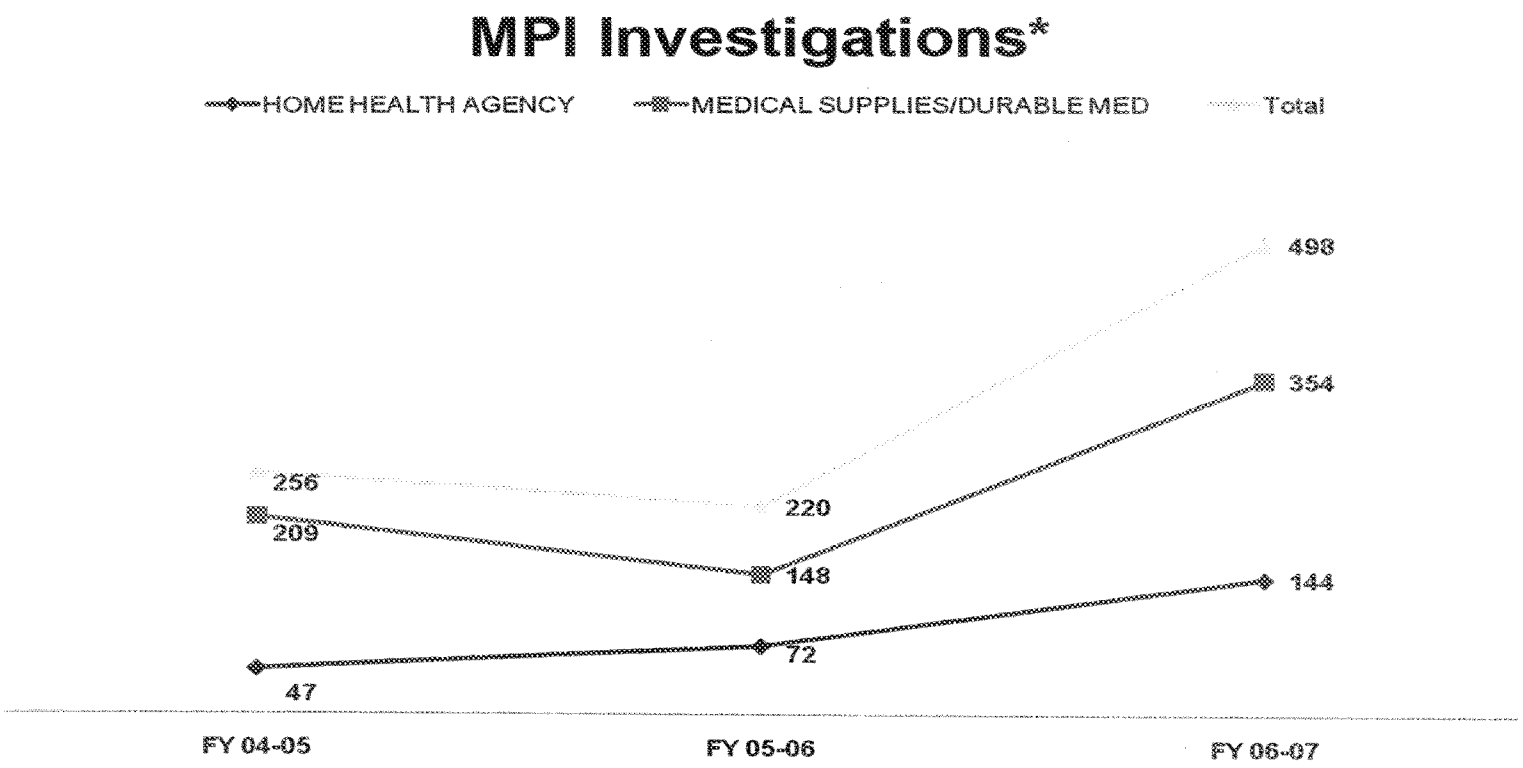
Medicaid Program Integrity (MPI)

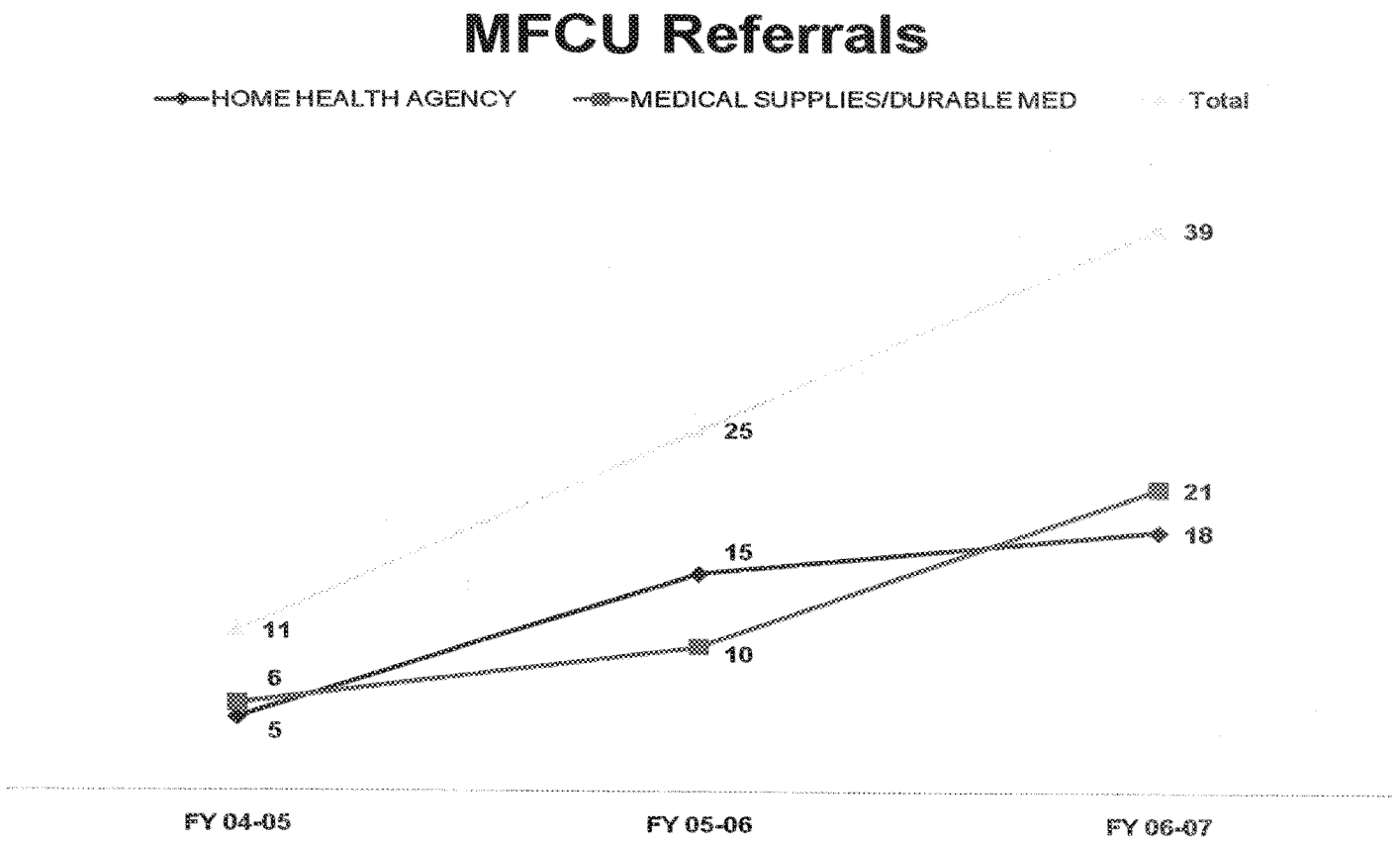
- Minimize fraud, abuse, and neglect of recipients (prevention).
- Review payments to Medicaid providers (detection).
- Recover overpayments (recovery).
- Impose sanctions (compliance).
- Emphasize prevention of fraud and abuse.
- Utilize advanced detection methods.
- Utilize efficient auditing methods.
- Coordinate closely with Medicaid Fraud Control Unit and other state and federal partners.

MPI Investigations



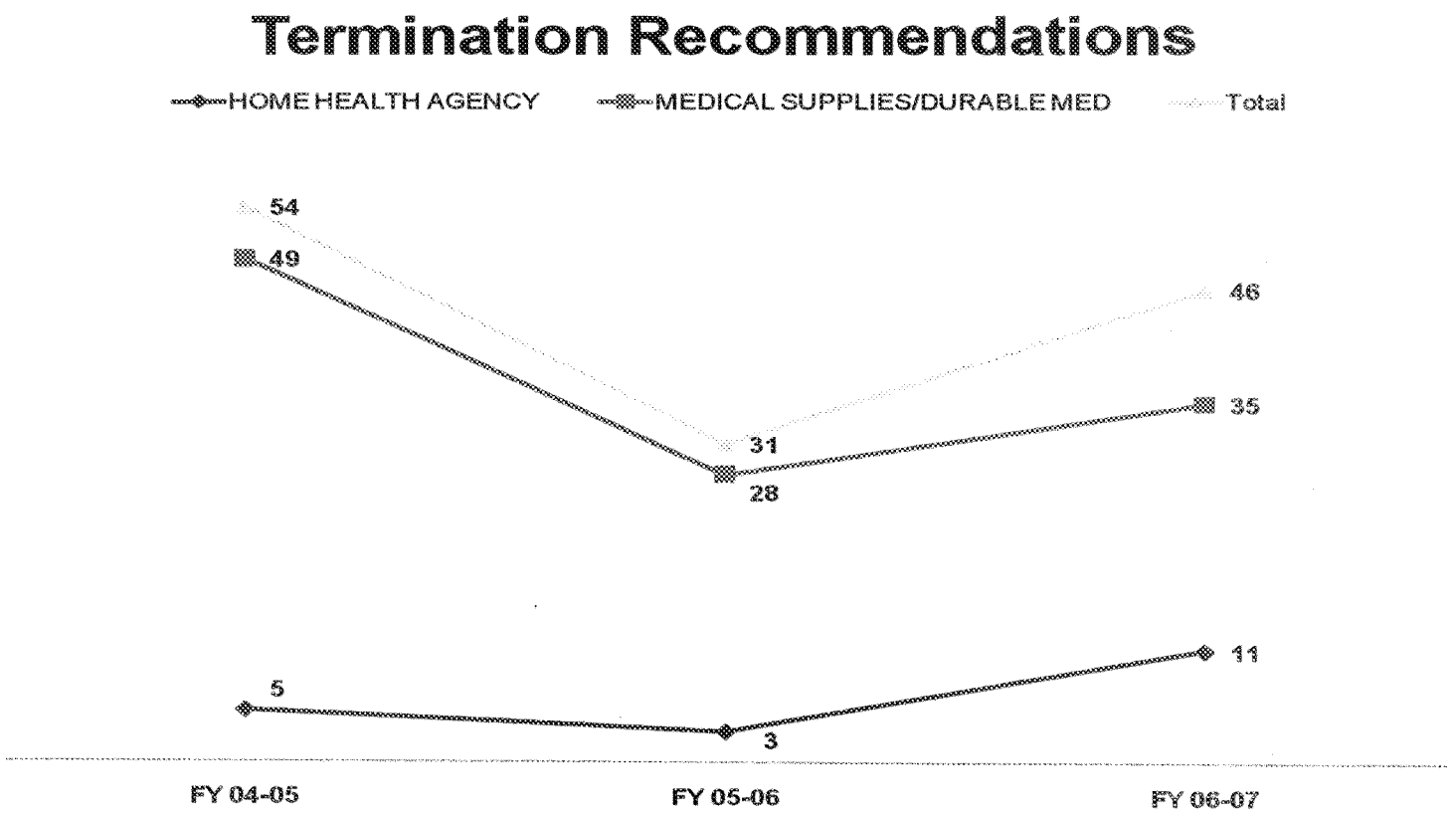
*Includes all files and cases
Note: Three year grand total: 974

Referrals to Medicaid Fraud Control Unit (MFCU)



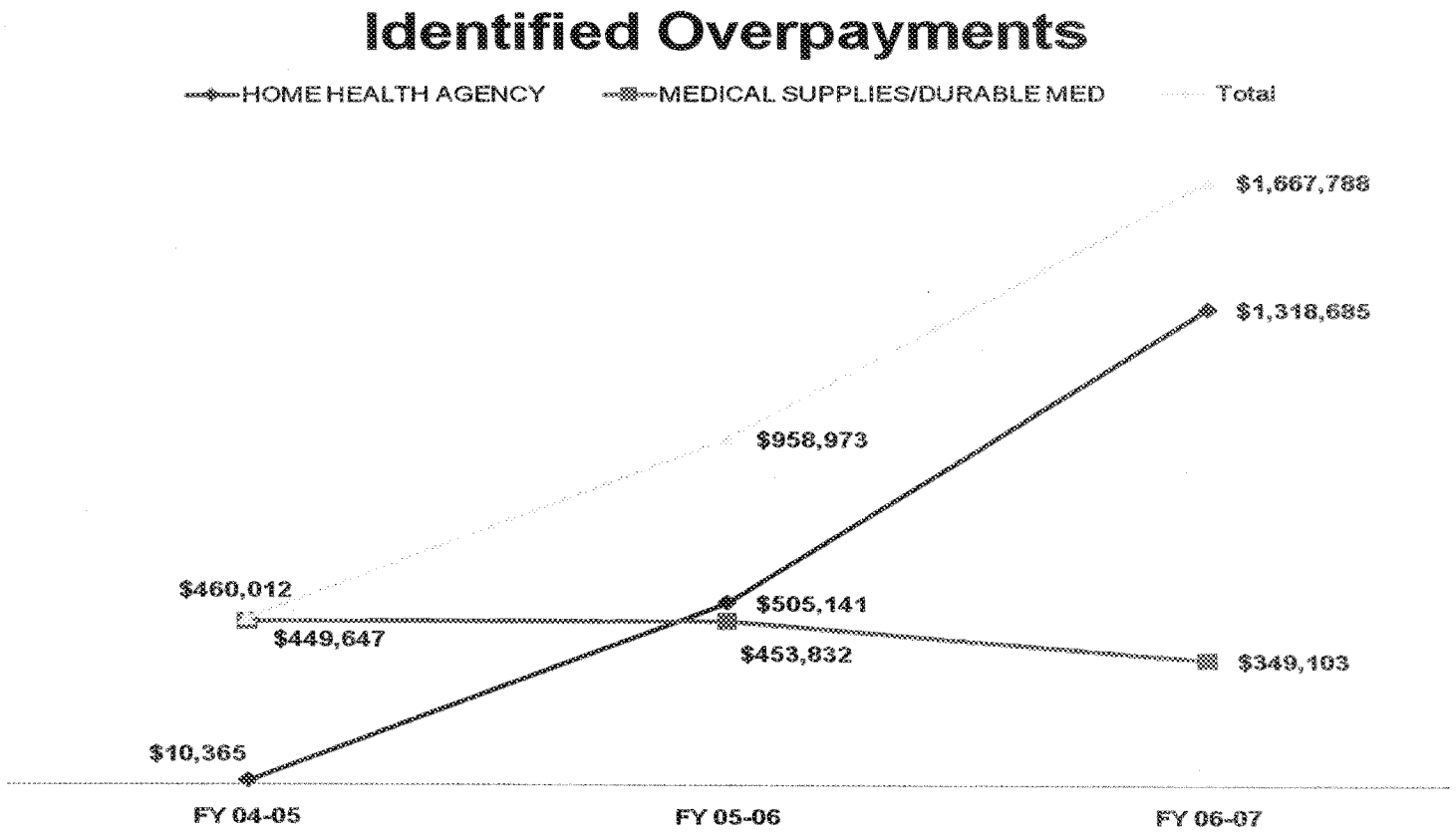
Note: Three year grand total: 75

Termination Recommendations



Note: Three year grand total: 131

Identified Overpayments



Note: Three year grand total: $3,086,773