AUDITOR GENERAL

WILLIAM O. MONROE, CPA

DEPARTMENT OF LEGAL AFFAIRS
MEDICAID FRAUD CONTROL UNIT
PRIOR AUDIT FOLLOW–UP

Operational Audit

SUMMARY

The Department of Legal Affairs' Medicaid Fraud Control Unit (MFCU) is responsible for investigating and prosecuting corruption in the administration of the Medicaid Program and fraud perpetrated by medical service providers. Of the 316 cases completed by MFCU during the period February 2004 through January 2005, 21 percent resulted in convictions or settlements with total restitution of approximately $54.8 million. In audit report No. 2004-033, we disclosed significant findings related to the MFCU. The scope of this audit focused on the current status of those findings during the period February 2004 through January 2005. Our audit disclosed the following:

Finding No. 1: MFCU data systems did not provide complete and accurate case information, thereby inhibiting accurate computation and reporting of overpayments and the costs associated with investigation and prosecution.

Finding No. 2: MFCU continued recipient fraud investigations for 18 of 129 cases identified in audit report No. 2004-033 as not authorized for Federal financial participation.

Finding No. 3: Some MFCU efforts to identify potential fraud included activities and costs that were not allowable under Federal regulations.

Finding No. 4: MFCU did not always appropriately and timely distribute restitution received to compensate the Medicaid Program.

Finding No. 5: MFCU distributed $5.4 million to the Agency for Health Care Administration that should have been made available to the Legislature for appropriation.

Finding No. 6: MFCU did not always timely transfer checks received to the Department's Finance and Accounting Office. Additionally, MFCU did not establish procedures for collecting outstanding restitution amounts.

Finding No. 7: MFCU did not ensure a proper skills mix among its staff. Additionally, MFCU employed individuals who did not meet established minimum qualifications.

Finding No. 8: The MFCU motor vehicle fleet was not utilized effectively and efficiently.

Finding No. 9: MFCU did not ensure that evidence room inventories were properly conducted or documented.

BACKGROUND

In accordance with Federal regulations and State law, the State has established three separate entities that are responsible for the investigation of Medicaid fraud or abuse. The Agency for Health Care Administration (AHCA) is responsible for analyzing paid claims data to detect potential fraud, abuse, or errors and investigating cases related to abuse or errors; the Department of Law Enforcement's (FDLE) Division of Public Assistance Fraud is responsible for recipient fraud cases; and the Department of Legal Affairs' Medical Fraud Control Unit (MFCU) is responsible for cases related to corruption in the administration of the Medicaid program and provider fraud committed

by doctors, clinics, and other health care providers who bill for services not performed, overbill for services provided, and bill for tests, services, and products which are not medically necessary. MFCU is also responsible for investigating the abuse, neglect, or exploitation of patients in any long-term care facility that accepts Medicaid funds. In addition to investigating fraud, MFCU is responsible for representing the State in civil and criminal court actions against alleged perpetrators of Medicaid fraud. Expenditures related to MFCU activities for the 2003-04 fiscal year totaled $14.9 million. The Federal Government reimburses the State 75 percent of MFCU costs.

MFCU completed 316 cases during the period February 2004 through January 2005 and had 410 active investigations at January 31, 2005. Of the 316 cases completed, 183 (58 percent) were closed due to lack of evidence or no evidence of fraud or abuse and 66 (21 percent) resulted in convictions or settlements with total restitution of approximately $54.8 million. The remaining cases were closed due to administrative referrals, pre-trial interventions, or other reasons. Restitution payments resulting from legal settlements or court orders are collected by MFCU and the Department of Corrections (DOC) and transferred to AHCA to reimburse overpayments.

In January 2003, the U. S. Department of Health and Human Services' Office of Inspector General (USDHHS) issued a report on their review of MFCU and, as a result of its findings, classified MFCU as a "high risk" grantee. In March 2004, after MFCU refunded $185,095.85 that was used in the investigation of recipient fraud, the "high risk" status was removed.

We have conducted this audit to follow up on the findings from audit report No. 2004-033, dated August 2003, to determine whether appropriate corrective actions have been taken. Our audit indicated that Department management has not implemented sufficient actions to resolve the prior audit findings. Specifically, the Department's corrective actions have been insufficient to correct findings related to MFCU data systems, the distribution of restitution, staff analyses, fleet management, and evidence room inventories.

FINDINGS AND RECOMMENDATIONS

Finding No. 1: Data Systems

MFCU has two databases that are used to record, track, and report (internally and to the Federal Government) case investigations.

- The Case Tracking database contains a myriad of data related to each case, including but not limited to, case number, provider name and license number, investigator's and attorney's names, source of the investigation, dates the case was opened and closed, total Medicaid overpayment, the amount of investigative costs, the quarter the case was reported to USDHHS, and where applicable, trial dates, criminal disposition, or the settlement amount.
- The Time Tracking database, revised in August 2003, contains the investigators' and prosecuting attorneys' time and expenses related to each case.

MFCU investigators, attorneys, and support staff are responsible for entering data into the two databases.

Accurate determination of the amount overpaid to a provider and the resulting investigative costs is essential to ensure sufficient restitution by the provider. To assist in determining the amount of overpayment, MFCU investigators may access AHCA's paid claims data and use statistical software. Upon request by a MFCU attorney, MFCU personnel perform a manual calculation of investigative costs using time and other expenses recorded in the Time Tracking database and add indirect costs.

MFCU has established written standard operating procedures that include general instructions for case and time tracking. However, the instructions do not adequately provide guidance as to how to properly compute the Medicaid overpayment amounts and

investigative costs and enter accurate court-ordered restitution and investigative costs. Additionally, MFCU did not have procedures requiring an independent review of the reasonableness and completeness of the data entered into the databases.

Our review of the Case Tracking and Time Tracking databases disclosed that neither system provided complete and accurate case information. Specifically, our review of data entered into the Case Tracking database for 40 sampled cases disclosed 32 cases (80 percent) where data was not accurately or completely recorded in the Case Tracking database (e.g., total overpayment identified, restitution ordered, amounts payable to AHCA, and MFCU investigative costs). As a result of these errors, the amounts reported to USDHHS on the MFCU Quarterly Statistical Reports were understated by $12.5 million.

Generally, Medicaid overpayments are based on a review of the actual fraudulent claims that have been submitted. However, in some instances, MFCU will use a sample of paid claims to determine if fraud exists. Of the four cases where a sample was used to determine the existence of fraud, two used the sample to determine the Medicaid overpayment, while for the two other cases, the overpayment was based on the projection of the sample results to the population. Documentation was not included in the case files explaining why the sample was or was not projected to the population.

Of the 40 cases reviewed, we identified 23 in which investigative costs should have been calculated. Our review of the calculation and recovery of investigative costs for these 23 cases disclosed errors in 22 cases:

- Three cases where investigative costs were not calculated or recovered. Investigative costs for these cases totaled $51,715. Additionally for one case, no calculation of investigative costs was performed; however, $5,000 in investigative costs was recovered. Costs for this case totaled $19,051.
- Sixteen (70 percent) cases where significant amounts of time and expense were incurred after the date the investigative costs were calculated. Costs incurred after the calculation of investigative costs represented 30 percent of the total costs of investigation.
- For 4 (17 percent) cases, 2 of which are included in the 16 noted above, investigative hours and expenses that had occurred prior to the date the investigative costs were calculated were added to the Time Tracking database after the investigative costs were calculated.
- For one case, which is also included in the 16 noted above, the investigative costs were not mathematically correct. As a result, $9,585 in investigative costs that were eligible to be recovered was not included within the settlement document.

Our review of time recorded in the Time Tracking database for 141 MFCU employees during the period January 2004 through December 2004 disclosed 87 (62 percent) employees had not entered all available working hours into the database, 35 of which had not entered at least 95 percent of their time. As a result of this error, 10,378 of 237,192 (4 percent) available working hours were not recorded in the Time Tracking database and, therefore, were not available for use in the calculation of investigative costs.

The recording of incomplete and inaccurate information into MFCU's databases, along with the inaccurate computation of investigative costs, lessens MFCU's ability to seek appropriate restitution from providers to compensate the State. In response to our inquiries, MFCU personnel indicated that edits have been added to the databases to help ensure accurate data entry. MFCU personnel also provided us with revised procedures, dated June 2005, that require documentation be maintained in the case file for amounts recorded in the Case Tracking System.

Recommendation:

MFCU should enhance its policies and procedures to provide guidance for:

- **Identifying amounts entered into MFCU databases to ensure accurate and complete**

information is available to determine restitution needed to cover overpayments and investigative costs and also to ensure the information reported to USDHHS is accurate.

- **Reviewing databases to ensure timely updates, completeness, and accuracy.**
- **Properly and consistently computing overpayment amounts and investigative costs.**

Finding No. 2: Recipient Fraud Cases

Pursuant to Title 42, Section 1007.19(e)(5), Code of Federal Regulations, Federal financial participation is not available to MFCU for expenditures related to the investigation or prosecution of cases of suspected recipient fraud not involving provider conspiracy. Our analysis of MFCU cases as of January 2005 indicated that MFCU has not opened any new recipient fraud investigations since our last audit. However, our review of the 129 recipient fraud investigations identified during our previous audit disclosed 18 cases where investigation and prosecution have continued since the issuance of our audit report in August 2003. The investigative costs associated with the 18 cases totaled $13,935 ($10,451 Federal share). Two of these cases remained open as of May 31, 2005. MFCU provided correspondence from the USDHHS Office of Inspector General that authorizes the Unit to carry these two investigations through to their conclusions.

Recommendation: MFCU should reimburse USDHHS for the identified costs of the closed cases, as determined necessary by USDHHS.

Finding No. 3: Efforts to Identify Potential Fraud

Pursuant to Title 42, Section 1007.19(e)(2), Code of Federal Regulations, Federal financial participation is not available for expenditures attributable to efforts to identify situations in which a question of fraud may exist, including analysis of patterns of practice. Clarification provided by the USDHHS Office of Inspector General, indicated that this regulation is interpreted to prohibit the duplication of routine screens conducted by AHCA. In March 2004, MFCU created an Intel Unit currently consisting of four employees. The Unit's primary responsibility is to research tips and leads for potential Medicaid fraud. The Intel Unit also receives reports from AHCA on the top 100 providers and drug rankings that are used to identify potential fraud and for comparisons to open cases.

The activities of the Unit are, in some instances, duplicative of activities performed by AHCA. For example, one of the investigators performed a data analysis to detect claims paid with dates of service subsequent to a recipient's date of death. However, AHCA, in cooperation with a contractor, performs a periodic review of paid claims to detect dates of service subsequent to dates of death. Any claims indicative of suspected fraud are reviewed by AHCA, and, if determined necessary, referred to MFCU.

Salaries and benefits totaling $76,751 ($57,563 Federal share) were paid in support of efforts to identify potential fraud during the period April 1, 2004, through May 9, 2005.

Recommendation: MFCU should ensure and document that activities of the Intel Unit are allowable under Federal regulations and are not duplicative of activities performed by AHCA.

Finding No. 4: Distribution of Restitution

USDHHS policy requires MFCU ensure that restitution received through negotiated settlements or courts orders be used to make the Medicaid Program (i.e., AHCA) whole for both the State and Federal share of overpayments before moneys received are allocated for investigative costs, penalties, or damages. Our review of 35 cases in which payments were due to AHCA disclosed 5 in which MFCU did not appropriately distribute restitution:

- Two cases in which MFCU did not make AHCA whole prior to using restitution totaling $41,187 to reimburse investigative costs.

- One case where MFCU retained $787,620 of a settlement totaling $1,524,163. Based upon review of the case file, it appears that the full amount should have been remitted to AHCA.
- Two cases in which restitution payments totaling $42,485 received in October 2003 have not been transferred to AHCA. Department personnel indicated that the amounts were not transferred due to pending documentation and an error in coding the payments in the Case Tracking database.

Recommendation: MFCU should ensure restitution amounts are properly allocated to make the Medicaid Program whole prior to using moneys received for investigative or other costs. Additionally, MFCU should follow up to ensure pending information is received timely and accurately recorded in the Case Tracking database.

Finding No. 5: Distribution of Penalties

In some instances, civil or criminal cases result in the State receiving restitution for Medicaid overpayments and penalties as punishment for the perpetrators' alleged fraudulent activities. As noted in Finding No. 4, restitution for Medicaid overpayments is distributed to AHCA for reimbursement of previously paid claims. Penalties are not restricted by the Federal program as to their use. Our review of 40 cases included 3 cases in which penalties totaling $5.4 million were assessed and transferred to AHCA. However, given that these funds are not restricted in their use, it appears that the Department should have deposited these funds into the General Revenue Fund.[1]

Recommendation: Absent specific legal authority to transfer penalties to AHCA, MFCU should deposit these amounts into the General Revenue Fund.

Finding No. 6: Collection of Restitution

Upon execution of a settlement agreement or court order in which restitution is awarded to the State, MFCU becomes responsible for collecting restitution. When restitution is received by MFCU, MFCU updates the Case Tracking database and forwards the check to Finance and Accounting for deposit.

Pursuant to Section 116.01(1), Florida Statutes, funds received on behalf of the State are to be deposited not later than seven working days from the close of the week in which the funds were received. Also, the Department's accounting policy requires all checks and attached supporting documentation to be remitted to Finance and Accounting within a 24-hour period.

Our review of 71 checks received for restitution payments disclosed:

- Fourteen checks totaling $4,123,478 were deposited from 1 to 32 working days after the statutory due date.
- MFCU did not remit to Finance and Accounting 21 checks totaling $857,924 from 2 to 53 days after receipt. For example:
  - A check totaling $3,140 was received in one of MFCU's field offices on June 25, 2004; however, it was not forwarded to Finance and Accounting until August 10, 2004 and was deposited on August 20, 2004.
- Two checks totaling $24,767 were received by MFCU in February 2003 and never deposited. After determining the checks had expired, MFCU requested the defendant to reissue the checks in May 2004.

In response to our inquiry, MFCU personnel indicated that payments were held at the specific direction and agreement between parties involved awaiting the final signature or while awaiting the necessary documentation to identify the appropriate coding for use in processing the payments.

Additionally, MFCU has not established procedures to ensure restitution due to the State is timely collected. Our review of 40 cases disclosed 9 (23 percent) cases with outstanding balances totaling $4.8 million where payments had not been received since December

[1] Section 215.32(2)(a), Florida Statutes.

2004. In three cases, totaling $1.6 million, no payments had been received in more than a year.

Recommendation: MFCU should enhance their check receipt process to ensure that checks are timely remitted to Finance and Accounting for deposit as required by Florida law and Departmental policy. MFCU should also establish collection procedures addressing nonpayment.

Finding No. 7: Staff Qualifications

MFCU is responsible for investigating Medicaid fraud committed by providers, such as hospitals, nursing homes, pharmacies, and health care professionals. Examples of the more common fraud schemes include upcoding (billing for a higher level of service than actually provided), billing for services not rendered, and performing unnecessary services. The investigative nature of complex cases requires a thorough understanding of the Medicaid system, along with the ability to understand financial and medical data and perform comparative and trend analyses. A comparison of Florida's MFCU with MFCUs in four other states, prepared by the Department in April 2004, showed that staffing levels for attorneys and investigators were comparable with other states. However, staffing levels for auditors were at 4 percent, lower than all four of the other states whose percentage of auditors ranged from 11 to 31 percent. As of May 2005, MFCU employed 82 sworn investigators, 16 non-sworn investigators, 5 auditors, 12 analysts, 21 attorneys, and 28 administrative employees.

Our review of MFCU personnel files, job descriptions, and hiring policies disclosed:

- MFCU personnel provided documentation indicating that a number of factors were considered in making decisions regarding current positions, classification of positions, and anticipated future needs. Our review of the documentation provided disclosed that MFCU continues to employ a lower percentage of audit-related positions than other states.
- Of the five auditors employed by MFCU as of May 2005, four did not possess the minimum qualifications established for the position. In response to our inquiry, MFCU personnel indicated that it was MFCU's prerogative to substitute various experience and degrees for those listed in the minimum qualifications. Notwithstanding MFCU's explanation, there was no documentation in the personnel files justifying variances from the previously established qualifications in making their hiring selections. This is particularly significant given the minimal number of auditors on the MFCU staff.

Recommendation: We recommend that MFCU ensure sufficient audit-related staffing is maintained. We also recommend MFCU hire staff that meet minimum qualifications or document the substitute qualifications used in making hiring decisions.

Finding No. 8: Motor Vehicle Fleet

During the 2003-04 fiscal year, MFCU had assigned 97 vehicles to its investigative staff. MFCU policy allows investigators and law enforcement officers to use the State vehicles to commute between home and office and for conducting official State business. MFCU employees assigned a State vehicle must complete a vehicle expense worksheet and log that provides information on total mileage, commuting mileage, and any maintenance and repair costs.

Florida law[2] provides that an agency head may assign motor vehicles to employees who perform duties related to law enforcement. Florida law also provides that motor vehicles may be assigned to other employees only if the employee is projected to drive the motor vehicle a minimum of 10,000 miles annually on official State business, unless an agency head annually provides written justification for the need of the assignment of a motor vehicle.[3] Our review of motor vehicle mileage records for the 2003-04 fiscal year disclosed:

[2] Section 287.17(4)(b), Florida Statutes.
[3] Section 287.17(4)(a), Florida Statutes.

- For 57 vehicles assigned to law enforcement officers, 40 (70 percent) were driven less than 10,000 miles.
- For 29 vehicles assigned to investigators, 20 (69 percent) were driven less than 10,000 miles.
- All 11 pool cars were driven less than 10,000 miles.
- One Assistant Attorney General used a vehicle for commuting and business purposes without written justification from the Attorney General documenting the need for an assigned motor vehicle.

MFCU purchased 29 vehicles during the 2004-05 fiscal year; however, no assessment was prepared to determine the need for new motor vehicles. A motor vehicle assessment was performed by MFCU in February 2005, which projected 95 of 116 (82 percent) vehicles would not be driven more than 10,000 miles for business annually.

Recommendation: While we recognize that the 10,000 mile minimum does not apply to law enforcement officers, given the significant underutilization of MFCU's vehicles we recommend:

- **MFCU reassess its motor vehicle assignment policy and consider the cost and benefit of alternatives such as leasing or renting vehicles, maintaining motor vehicle pools for employees to use only when needed for State business, and reimbursing employees for the use of personal vehicles.**
- **MFCU management utilize the results of its fleet evaluations when considering future vehicle assignments and purchases.**

Finding No. 9: Evidence Room Inventories

MFCU evidence and property policies require an annual inventory of each MFCU evidence room be conducted by August 1 of each year. The inventory shall be conducted by the evidence custodian and another independent member designated by the Chief of Law Enforcement and will be completed using the computerized inventory list. Our review of MFCU's evidence room inventories disclosed:

- In six of eight field offices, the custodian or the custodian and the alternate took the inventory without an independent party present.
- For all eight offices, documentation supporting the evidence room inventories did not include pertinent information, such as a list of the items reviewed, the date the inventory was performed, and the reviewers' signatures.
- For all eight offices, the evidence room inventories were conducted from 19 days to 5 months after August 1. Additionally, two offices conducted their evidence room inventories over a two to four month period of time.

A periodic inventory properly conducted by an independent party helps to ensure that theft or irregularities, if present, would be timely detected.

In April 2004, the Department became aware of a theft by an evidence custodian of approximately $22,000 in cash from one of MFCU's evidence rooms. In her August 2004 investigative report on the theft, the Inspector General recommended that management continue their efforts to revise policies and procedures and to conduct a complete and thorough inventory of all evidence vaults and safes.

In January 2005, MFCU implemented detailed evidence room inventory procedures that provided specific requirements for documenting who conducted the inventory, when the inventory was conducted, and how discrepancies noted should be identified. The procedures also require a copy of the listing used in the conduct of the inventory to be attached to the inventory documentation.

Recommendation: We again recommend MFCU continue to enhance its evidence room inventory procedures to ensure that the inventory process is conducted timely and documented appropriately. MFCU should also ensure the

inventories are conducted by an individual other than the evidence custodian.

OBJECTIVES, SCOPE, AND METHODOLOGY

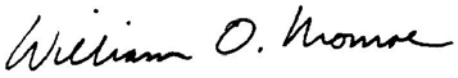
The scope of this audit focused on following up the Medicaid Fraud related findings from audit report No. 2004-033, dated August 2003. Our objectives were:

- To determine whether the Department had taken actions to correct the audit findings related to MFCU.
- To determine whether selected management controls promoted and encouraged the achievement of management's objectives of compliance with controlling laws, administrative rules, and other guidelines, the economic and efficient operation of the Department; the reliability of records and reports; and the safeguarding of assets.

In conducting our audit, we interviewed auditee's personnel, observed processes and procedures, and completed various analyses and other procedures as determined necessary. Our audit included examinations of various transactions (as well as events and conditions) occurring during the period February 2004 through January 2005.

AUTHORITY

Pursuant to the provisions of Section 11.45, Florida Statutes, I have directed that this report be prepared to present the results of our operational audit.



William O. Monroe, CPA
Auditor General

AUDITEE RESPONSE

In a response letter dated September 13, 2005, the Department described corrective actions already taken or being planned to address the findings and recommendations. The letter is included in its entirety at the end of this report as Exhibit A.

To promote accountability in government and improvement in government operations, the Auditor General makes operational audits of selected programs, activities, and functions of State agencies. This operational audit was made in accordance with applicable ***Government Auditing Standards*** issued by the Comptroller General of the United States. This audit was conducted by Ying Ying Chen, CPA, and supervised by Lisa Norman, CPA. Please address inquiries regarding this report to Jane Flowers, CPA, Audit Manager, via e-mail at janeflowers@aud.state.fl.us or by telephone at **(850) 487-9136**.

This report and other audit reports prepared by the Auditor General can be obtained on our Web site (http://www.state.fl.us/audgen); by telephone (850 487-9024); or by mail (G74 Claude Pepper Building, 111 West Madison Street, Tallahassee, Florida 32399-1450).

EXHIBIT A
AUDITEE RESPONSE

CHARLIE CRIST
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September 13, 2005

Mr. William O. Monroe, CPA
Auditor General
G74 Claude Pepper Building
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Tallahassee, Florida 32399-1450

Dear Mr. Monroe:

The purpose of this letter is to acknowledge receipt of your letter dated August 10, 2005, providing the preliminary and tentative audit findings and recommendations of your follow-up audit of the Medicaid Fraud Control Unit.

I appreciate the opportunity to review your findings and recommendations and have enclosed for your information and consideration our response to each of your recommendations as well as, where appropriate, our proposed corrective action.

If you have any questions or require any additional information, please let me know.

Sincerely,

L. Clayton Roberts
Executive Deputy Attorney General

LCR/sdm

OAG Response to Auditor General Findings and Recommendations

At the time of his election to the post of Attorney General, Charlie Crist inherited a program that had just received notification from the federal government that it had been placed in a "high risk" status due to its failure to meet minimum program standards in five (5) of the twelve (12) performance standards established by the Department of Health and Human Services. The federal Department of Health and Human services, in its letter to the Attorney General dated January 29, 2003, gave notice to the Medicaid Fraud Control Unit of its findings and required that action be taken within a twelve month period to meet recertification criteria and conform with grant requirements. Immediately after assuming office, Attorney General Charlie Crist declared that the prevention, detection, investigation and prosecution of matters related to Medicaid Fraud and matters related to the abuse, neglect and exploitation of patients in long term care facilities would be priorities for his administration.

Within six months, Attorney General Crist assembled a new management team for the Medicaid Fraud Control Unit and shortly thereafter prepared a corrective action plan to deal with the many issues related to the "high risk" designation as well as the findings of the Auditor General's report dated July 30, 2003. To date, action has been taken to create and modify policies and procedures; enhance our case tracking and time management systems; propose new legislation combating Medicaid fraud; and increase staffing and resources to combat Medicaid Fraud.

These efforts have provided significant results by any measure. Using calendar year 2002 as a base year, the recovery of fraudulently expended Medicaid funds increased by 102% in year 1 and by an additional 109% in year 2. We have been able to expand our presence to nine locations throughout the state, and at the same time established PANE (Patient Abuse, Neglect and Exploitation) Teams in Miami, Tallahassee and Tampa. Additional teams will be established during fiscal year 2006 due to the generosity of the Legislature. Our activities involving Diversion Response Teams (DRTs), investigations of major pharmaceuticals, expansion of our Operation Spot Check, all have led to the recovery of millions of dollars for the state and federal governments and resulted in the closure of facilities which were not providing services to some of our most vulnerable citizens. Based on these accomplishments, the USDHHS, in its letter dated April 26, 2004, removed the Florida Medicaid Fraud Control Unit from its "high risk" status.

The following are our comments specific to the preliminary findings and recommendations of the Auditor General dated August 10, 2005.

Finding No. 1: MFCU data systems did not provide complete and accurate information, thereby inhibiting accurate computation and reporting of overpayments and the costs associated with investigation and prosecution.

- Recommendation: MFCU should enhance its policies and procedures to provide guidance for:

✓ Identifying amounts entered into MFCU databases to ensure accurate and complete information is available to determine restitution needed to cover overpayments and investigative costs and also to ensure the information reported to USDHHS is accurate

We concur with the intent of the recommendation and have taken the necessary action to develop and implement a new policy which provides guidance to all staff in creating case record documentation and completion of certain data fields to ensure timely and accurate recording into the MFCU databases and reporting to USDHHS. Further, the policy regarding investigative costs was amended on June 30, 2005, requiring staff to include explanations in the case tracking system when the court orders an amount that differs from the amount calculated. Current policies regarding determination of restitution and investigative costs will be reviewed and revised if necessary with appropriate training to follow.

As to system accuracy and completeness, a revised case tracking system was implemented in February 2004, the time frame for the beginning of the audit period. Due to implementation coinciding with the audit period, corrections and omissions were evident in some volume. Although information was under-reported on the Quarterly Statistical Reports, no funds were unaccounted for.

Finally, in recognition of the need to improve the system of reporting case time, a new system was implemented department-wide in August 2003. Errors have occurred but improvements have been noted and we will continue to emphasize to staff the importance of timely and accurate input of this information. MFCU will continue to implement checks and balances to the newly adopted system that was implemented during the period audited. Additional guidance has been provided to staff that should enhance the accuracy of the information entered into MFCU databases.

✓ Reviewing databases to ensure timely updates, completeness, and accuracy.

As mentioned above, MFCU developed during the month of July 2005 a new policy which has been implemented and was effective on August 9, 2005. This new policy requires a series of checks and balances which will ensure timely and accurate input of data into the case tracking system and also provides for specific reviews of information that is or should be entered into the database.

✓ Properly and consistently computing overpayment amounts and investigative costs.

Current policies will be reviewed for appropriate content and training will be conducted to ensure uniformity of application and execution.

Finding No. 2: MFCU continued recipient fraud investigations for 18 of 129 cases identified in audit report No. 2004-033 as not authorized for Federal financial participation.

- MFCU should reimburse USDHHS for the identified costs of the closed cases, as determined necessary by USDHHS.

In a letter dated June 21, 2005, Sharon Colby, Director of the Medicaid Fraud Unit Oversight Division, Department of Health and Human Services, Office of Inspector General, reiterated the USDHHS position that the matter had been addressed in their review of July 2004. On August 17, 2005, via conference call, we were advised that there is no need for further reimbursement relating to this issue and that the matter had been closed by their office.

Finding No. 3: Some MFCU efforts to identify potential fraud included activities and costs that were not allowable under Federal regulations.

- MFCU should ensure and document that activities of the Intel Unit are allowable under Federal regulations and are not duplicative of activities performed by AHCA.

The activities of the Intel Unit are authorized by federal regulations with certain limitations as indicated in the letter from the USDHHS dated June 21, 2005.

This issue was again discussed with staff of the USDHHS, Medicaid Fraud Unit Oversight Division, on August 17, 2005, and we were advised that the USDHHS saw no issues of concern regarding our Intel Unit.

We will continue to document the activities of the Unit, coordinate with USDHHS, and ensure no redundancy with AHCA.

Finding No. 4: MFCU did not always appropriately and timely distribute restitution received to compensate the Medicaid Program.

- MFCU should ensure restitution amounts are properly allocated to make the Medicaid Program whole prior to using moneys received for investigative or other costs. Additionally, MFCU should follow up to ensure pending information is received timely and accurately recorded in the Case Tracking database.

Within its power to do so, the Florida MFCU ensures that restitution amounts are properly allocated to make the Medicaid Program whole prior to using moneys received for investigative or other costs. MFCU and other prosecutorial authorities such as the Statewide Prosecutor's Office, State Attorneys and U.S. Attorneys present the facts of each case to the court. Final resolution of the case, and therefor the allocation of restitution, is determined by the court. Many of the defendants are ordered to make multiple payments which are "split" and frequently distributed by the Department of Corrections. Payments are sent to multiple recipients for a single defendant and this "causes" payments to be applied to costs and to restitution at the same time.

This matter has also been discussed with the USDHHS. MFCU will continue its discussions with the USDHHS regarding this matter to ensure that the receipt and distribution of funds by MFCU are in accordance with federal regulations and also comply with the orders of the court.

As to the recording of information in the Case Tracking database, the new policy previously mentioned and implemented on August 9, 2005, also addresses this issue. MFCU will monitor its implementation, track its results and, if necessary, amend it to ensure information is received timely and that the information is accurately recorded in the Case Tracking database.

Finding No. 5: MFCU distributed $5.4 million to the Agency for Health Care Administration that should have been made available to the Legislature for appropriation.

- Absent specific legal authority to transfer penalties to AHCA, MFCU should deposit these amounts into the General Revenue Fund.

Not all cases which are referred to MFCU can meet the statutory requirements necessary for a conviction. To ensure maximum recovery for both the state and federal governments, MFCU may "settle" or accept an amount that is less or more than what the record might reflect as the amount "owed." In order to maximize recovery to the Medicaid fund, funds in excess of the amount of restitution were sometimes transferred to AHCA, the agency defrauded.

Based on the recommendation of the Auditor General, expanded legal authority regarding penalties and other "program income" will be pursued.

Finding No. 6: MFCU did not always timely transfer checks received to the Department's Finance and Accounting Office. Additionally, MFCU did not establish procedures for collecting outstanding restitution amounts.

- MFCU should enhance their check receipt process to ensure that checks are timely remitted to Finance and Accounting for deposit as required by Florida law and Departmental policy. MFCU should also establish collection procedures addressing nonpayment.

In conjunction with our Finance and Accounting Office, MFCU will review the current "check receipt process." If modifications are needed for clarification or emphasis, amendments will be made and staff will be advised and trained. Should an order by the court require that the check be held until a time certain, completion of a particular action, or the terms of an agreement require the same, the record will reflect the reason for delay in processing the check.

MFCU will also work with Information Services, Finance and Accounting and other areas within the Office of the Attorney General to establish a procedure addressing nonpayment of obligations owed to the department.

Finding No. 7: MFCU did not ensure a proper skills mix among its staff. Additionally, MFCU employed individuals who did not meet established minimum qualifications.

- We recommend that MFCU ensure sufficient audit-related staffing is maintained. We also recommend MFCU hire staff that meet minimum qualifications or document the substitute qualifications used in making hiring decisions.

Federal regulation 42 CFR 1007.13 requires MFCU to employee "one or more experienced auditors....." Florida MFCU exceeds the minimum for this requirement and will continue to do so. Further, as stated in the Auditor General's prior report, Attorney General Crist approved a major reorganization of the MFCU that included the formation of teams, each having at least one audit related position. These positions, including additional ones authorized by the Legislature, have been established. We are also working with Departmental personnel and DMS to "retitle" our analyst positions to auditors, assuring an increased "mix" of staff.

In conjunction with People First and our Personnel Division, MFCU will continue to ensure that individuals recommended for hire in positions within MFCU meet or exceed minimum qualifications or documentation will be provided for substitute qualifications used in making the recommendation.

Finding No. 8: The MFCU motor vehicle fleet was not utilized effectively and efficiently.

- While we recognize that the 10,000 mile minimum does not apply to law enforcement officers, given the significant underutilization of MFCU's vehicles we recommend:

✓ MFCU reassess its motor vehicle assignment policy and consider the cost and benefit of alternatives such as leasing or renting vehicles, maintaining motor vehicle pools for employees to use only when needed for state business, and reimbursing employees for the use of personal vehicles.

MFCU has and will continue to assess its vehicle assignment policy. MFCU authorized the use of state-owned vehicles by law enforcement personnel to ensure activation as first responders, perform disaster-related duties if authorized by the USDHHS, and assist other law enforcement personnel in mission critical arrests, abuse and neglect investigations, or other cases requiring immediate transportation. Multiple factors are considered when assigning vehicles and these will be documented when assigning each vehicle.

As to the use of a vehicle by an Assistant Attorney General, this was a misunderstanding by the Assistant Attorney General and corrected immediately by management.

✓ MFCU management utilize the results of its fleet evaluations when considering future vehicle assignments and purchases.

MFCU has and will continue to use its "fleet evaluations" when considering future vehicle assignments and purchases.

Finding No. 9: MFCU did not ensure that evidence room inventories were properly conducted or documented.

- We again recommend MFCU continue to enhance its evidence room inventory procedures to ensure that the inventory process is conducted timely and documented appropriately. MFCU should also ensure the inventories are conducted by an individual other than the evidence custodian.

The MFCU policy regarding our evidence room inventory was significantly modified pursuant to the earlier recommendations by the Auditor General and posted in our policy forum on January 10, 2005. Inventories for all appropriate offices were completed on or before August 1 of this year and in accordance with the new policy. We will continue to refine this policy as necessary.