MEDICAID & PUBLIC ASSISTANCE FRAUD

STRIKE FORCE

ANNUAL REPORT

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Respectfully Submitted by

CHIEF FINANCIAL OFFICER JEFF ATWATER, CHAIRMAN

STRIKE FORCE MEMBERS

Chairman, Jeff Atwater, Chief Financial Officer, Florida Department of Financial Services

Vice Chair, Pam Bondi, Attorney General, Florida Office of Attorney General

Gerald Bailey, Commissioner and Executive Director of the Florida Department of Law Enforcement

Elizabeth Dudek, Secretary, Florida Agency for Health Care Administration

David Wilkins, Secretary, Florida Department of Children and Family Services

Harry Frank Farmer, Jr., M.D., Ph.D., FACP, State Surgeon General, Florida Department of Health

Katherine Fernandez-Rundle, State Attorney, Eleventh Judicial Circuit (Miami-Dade)

Sheriff David Gee, Hillsborough County Sheriff's Office

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Juan Jesus Santana, Division Chief, Miami-Dade Police Department

ABOUT THE STRIKE FORCE

The Medicaid and Public Assistance Fraud Strike Force (hereafter referred to as "Strike Force") was established by the 2010 Florida Legislature under Chapter 624.351, Florida Statutes. It was established based upon a finding "that there is a need to develop and implement a statewide strategy to coordinate state and local agencies, law enforcement entities, and investigative units in order to increase the effectiveness of programs and initiatives dealing with the prevention, detection, and prosecution of Medicaid and public assistance fraud," Section 624.351(1), Florida Statutes.

Responsibilities of the Strike Force

The legislation directed that the Strike Force serve in an advisory capacity and provide recommendations and policy alternatives to help achieve the overall mission of the Strike Force: "to eliminate Medicaid and public assistance fraud and to recover state and federal funds," Section 624.351(2), Florida Statutes. To help the Strike Force achieve its purpose, in Section 624.351(6)(a) the Legislature authorized the Strike Force to advise on activities to include, but not be limited to:

1. Conducting a census of local, state, and federal efforts to address Medicaid and public assistance fraud in this state, including fraud detection, prevention, and prosecution, in order to discern overlapping missions, maximize existing resources, and strengthen current programs.

2. Developing a strategic plan for coordinating and targeting state and local resources for preventing and prosecuting Medicaid and public assistance fraud. The plan must identify methods to enhance multiagency efforts that contribute to achieving the state's goal of eliminating Medicaid and public assistance fraud.

3. Identifying methods to implement innovative technology and data sharing in order to detect and analyze Medicaid and public assistance fraud with speed and efficiency.

4. Establishing a program to provide grants to state and local agencies that develop and implement effective Medicaid and public assistance fraud prevention, detection, and investigation programs, which are evaluated by the strike force and ranked by their potential to contribute to achieving the state's goal of eliminating Medicaid and public assistance fraud. The grant program may also provide startup funding for new initiatives by local and state law enforcement or administrative agencies to combat Medicaid and public assistance fraud.

5. Developing and promoting crime prevention services and educational programs that serve the public, including, but not limited to, a well-publicized rewards program for the apprehension and conviction of criminals who perpetrate Medicaid and public assistance fraud.

6. Providing grants, contingent upon appropriation, for multiagency or state and local Medicaid and public assistance fraud efforts, which include, but are not limited to:
   a. Providing for a Medicaid and public assistance fraud prosecutor in the Office of the Statewide Prosecutor.
   b. Providing assistance to state attorneys for support services or equipment, or for the hiring of assistant state attorneys, as needed, to prosecute Medicaid and public assistance fraud cases.
   c. Providing assistance to judges for support services or for the hiring of senior judges, as needed, so that Medicaid and public assistance fraud cases can be heard expeditiously.

The legislation also authorized the Strike Force to receive periodic reports from state agencies, law enforcement officers, investigators, prosecutors, and coordinating teams regarding Medicaid and public assistance criminal and civil investigations. Such reports may include discussions regarding significant factors and trends relevant to a statewide Medicaid and public assistance fraud strategy.

Supports Established for the Strike Force

Within two months of the 2011 transition in gubernatorial and cabinet administrations, planning staff initiated a number of strategies to support Strike Force activities. Planners identified two full-time equivalent positions to staff the Strike Force and support its activities. These included an Executive Director and a second position to provide support in the areas of research, analysis, planning and funding strategies.

Prior to the first Strike Force meeting on February 25, 2011, staff also created a Web site (http://www.myfloridacfo.com/strikeForce/default.aspx) to provide a vehicle for allowing public access to information about the Strike Force and its activities. Also prior to the initial meeting, Strike Force staff had already undertaken a search of funding sources that could be used to defray the costs of staffing and strategies supported by the Strike Force.

Prior to the third meeting of the Strike Force, staff identified funds available for contracted services to retain the expertise of the ERS Group, a consulting firm providing economic analysis and consulting. At the time of this report, the scope of services for the economic study has been refined to address the fraud rate in the Supplemental Nutrition Assistance Program (hereafter referred to as "SNAP", formerly known as food stamps) administered by the Department of Children and Families (hereafter referred to as "DCF"). The contractor has identified a sample group that will be reviewed by the Division of Public Assistance Fraud in the Department of Financial Services (hereafter referred to as "DFS") to investigate the occurance of fraud within the sample group. Currently, the Contractor and the Strike Force have identified certain parameters for the identification of fraud that could be immediately discerned by link analyses in order to refine the number of cases from the sample group that the Division of Public Assistance Fraud (hereafter referred to as "DPAF") will need to review. Once this work is completed, the ERS Group should have sufficient data to establish a fraud rate for the SNAP program.

In addition, Advanced Systems Design (hereafter referred to as "ASD"), an information technology and government consulting firm was hired as a process mapping consultant. At the time of this report, ASD had completed a preliminary, high level visual representation of the prevention, detection, investigation and recoupment of funds processes across the agencies that are primarily responsible for combating fraud in the Medicaid and public assistance service systems. The Mapping Committee is currently reviewing the work product.

ABOUT THIS REPORT

In accordance with Section 624.351, Florida Statutes, "The strike force shall annually prepare and submit a report on its activities and recommendations, by October 1, to the President of the Senate, the Speaker of the House of Representatives, the Governor, and the chairs of the House of Representatives and Senate committees that have substantive jurisdiction over Medicaid and public assistance fraud."

This report is intended to meet this obligation without duplicating the requirements for the annual report on *The State's Efforts to Control Fraud and Abuse* prepared by the Agency for Health Care Administration (hereafter referred to as "AHCA") and the Medicaid Fraud Control Unit (hereafter referred to as "MFCU") within the Office of Attorney General (hereafter referred to as "OAG"). That report should be considered a reference source for more detailed information about the activities, processes, and operations of AHCA and MFCU.

This report, instead, focuses on what the Strike Force has done in its first six months, information that has been gathered and recommendations being proposed to support "a statewide strategy to coordinate state and local agencies, law enforcement entities, and investigative units in order to increase the effectiveness of programs and initiatives dealing with the prevention, detection, and prosecution of Medicaid and public assistance fraud," as required in Section 624.351(1), Florida Statutes.

Every effort has been made to ensure that data contained in this report are accurate as of the date this report was written. Because information used in generating data or making projections is routinely updated, minor inconsistencies between information in this report and that contained in subsequent reports will result.

COMMITTEES AND MEMBERS

Grants

The Strike Force established a Grants Committee in July 2011 with representation from each of the state agencies that hold seats on the Strike Force. The purposes of this Committee are:

1. To research and identify appropriate grant programs for the Strike Force and/or its partners to pursue.

2. To assist with pursuing funding opportunities for the Strike Force and/or the partner agencies.

3. To provide guidance on the development of a grant initiative for the Strike Force in which the Strike Force is the grantor.

4. To review applications and make recommendations to the Strike Force for grant awards under the Strike Force grant initiative.

The following members of the committee were designated by Strike Force members to represent their agencies:

Larry Daugherty, OAG
Cynthia Godbey, DFS
Jennifer Green, AHCA
Phil Street, DOH
Clayton Wilder, FDLE
Fred Young, DCF

Mapping

The Strike Force also established a Mapping Committee in July 2011 with representation from each of the state agencies that hold seats on the Strike Force. The purposes of this Committee are:

1. To advise the Strike Force in the development of a tool that can provide a succinct picture of the anti-fraud processes in the Medicaid and public assistance service systems.

2. To advise the Strike Force on priorities for mapping business processes on vulnerable points within the Medicaid and public assistance service systems.

Guidance from this group helped direct the work of ASD to develop a high level visual representation of the prevention, detection, investigation and recoupment of funds processes across the agencies that are primarily responsible for combating fraud in the Medicaid and public assistance service systems.

The following members of this committee were designated by Strike Force members to represent their agencies:

Lisa Allen, DFS
Randy Burkhalter, DFS
Matt Dempsey, DCF
Russ Fernandez, DFS
Maria Leon, DCF
David Lewis, OAG
Mike Magnuson, AHCA
Charlene Willoughby, DOH

Legislative and Policy

The Strike Force then established a Legislative and Policy Committee in August 2011 with representation from each of the state agencies that hold seats on the Strike Force. The purposes of this Committee are:

1. To develop a legislative platform for the 2012 Legislative Session that will support the implementation of Strike Force initiatives and strategies.

2. To review initiatives of other states that address Medicaid and public assistance fraud.

3. To make proposals to the Strike Force regarding innovative policy initiatives.

This committee reviewed and recommended adoption of the recommendations contained in this report.

The following members of this committee were designated by Strike Force members to represent their agencies:

Kimberly Berfield, DOH
Kim Case, OAG
Chris Chaney, AHCA
Matt Dempsey, DCF
Lynn Dodson, FDLE
Robin Westcott, DFS

Technology

The Strike Force also established a Technology Committee in August 2011 with representation from each of the state agencies that hold seats on the Strike Force. The purposes of this Committee are:

1. To interact with the Interagency Technology working group to guide policy regarding the implementation of technology solutions throughout the Medicaid and public assistance service systems.

2. Provide advice/guidance on specific technology options.

This committee met once as an orientation and members briefed the committee on an interagency working committee and current technology solutions being developed. They are prepared to advise the Strike Force, as needed, in implementing technology solutions to improve anti-fraud efforts within the Medicaid and public assistance service systems.

The following members of this committee were designated by Strike Force members to represent their agencies:

John Croft, DCF
Bob Dillenschneider, DOH
Tammy Joiner-Philcox, OAG
Terry Kester, DFS
Penny Kincannon, FDLE
Scott Ward, AHCA

STRIKE FORCE MEETINGS

The minutes from the first three meetings of the Strike Force can be found on the website at: http://www.myfloridacfo.com/strikeForce/default.aspx. Here is a summary of what has transpired at those meetings.

February 25, 2011

Strike Force members offered brief descriptions of the functions of their agency and the role they play in preventing, detecting, investigating and prosecuting Medicaid and public assistance fraud and recouping funds wrongfully obtained. In particular, Strike Force members representing local law enforcement and prosecutorial functions offered ways in which they have supported and are willing to do more to support such efforts. The Strike Force heard presentations from DCF on the eligibility determination process carried out through the Automated Community Connection to Economic Self Sufficiency (hereafter referred to as "ACCESS") and related statistics. AHCA gave an overview of their primary functions and related statistics. They also gave an overview of a pilot project being implemented in the Miami-Dade area in which home health care services were telephonically monitored and verified. The Department of Health (hereafter referred to as "DOH") provided an overview of their responsibilities related to licensure of professionals. DPAF and MFCU provided overviews of their functions and related statistics. The presentations included recommendations for improving system operations.

May 16, 2011

AHCA provided updates on recent legislation that will move the Florida Medicaid program to managed care statewide. DOH presented an overview of the 2009 Senate Bill 1986, which enhanced their efforts to sanction licensed practitioners and facilitated interagency communications. DCF reported on organizational changes being made in that department to improve anti-fraud efforts in recipient eligibility determination. MFCU reported on a federal Medicaid data mining waiver they are piloting, which allows their unit to review claims data to develop leads for prosecuting Medicaid fraud. The Medicaid Program Integrity unit in AHCA reported on a budget allocation they have received from the Legislature to support the move to a more advanced case tracking system that will incorporate analytic technology to help detect fraud. They also reported on an interagency working group that has been meeting for years to focus on planning improvements in prevention and detection techniques.

The Strike Force Director reported on Strike Force initiatives that are underway to develop a tool for measuring the extent of fraud within the system(s), an initial cross-agency mapping of prevention, detection, investigation, prosecution and recoupment of funds processes within the system(s) and an initial review of barriers to data sharing. The Director also called on the Strike Force members to identify representatives to serve on committees to support the efforts of the Strike Force.

September 14, 2011

The Strike Force heard presentations from local, state and federal agencies on multi-jurisdictional collaborations to combat public assistance fraud. Strike Force members gave reports on current activities in their agencies of interest to the Strike Force and the Strike Force committees reported on their activities.

THE REPORT TO THE LEGISLATURE

The Problem

In 2010, the Legislature found "that there is a need to develop and implement a statewide strategy to coordinate state and local agencies, law enforcement entities, and investigative units in order to increase the effectiveness of programs and initiatives dealing with the prevention, detection, and prosecution of Medicaid and public assistance fraud," Section 624.351(1), Florida Statutes. This finding has been validated by recent trends in utilization that reflect an increasing need for Medicaid and public assistance services. A major driving force behind these trends is the current economic downturn.

According to the National Bureau of Economic Research, the current recession began in December of 2007. Between December 2007 and December 2010, requests for Assistance submitted through ACCESS increased by 33%. Food stamp caseloads increased 118% and Temporary Assistance for Needy Families (hereafter referred to as "TANF") caseloads increased by 40%. Although not as dramatic, other public assistance programs in various state agencies receiving some General Revenue funding report increasing caseloads as well.

Along with increases in these caseloads, there has been an increase in referrals to DPAF, as the investigative unit dedicated to fraud detection in these public assistance programs and among Medicaid beneficiaries. Between December 2007 and December 2010, the number of referrals to DPAF has increased 35.6%.

During the same time frame, Medicaid increased its caseload by 36.86%. Using projected enrollment figures from AHCA, the average monthly caseload is projected to have increased by 48.5% from SFY 2007-2008 through SFY 2011-2012. By the end of the state fiscal year, enrollment is expected to reach 3.192 million. Florida Medicaid is, and has been the fourth largest Medicaid program in the country based upon number of recipients.

Florida's Medicaid program is the fifth largest in terms of Medicaid expenditures with an estimated spending of over $21.2 billion for SFY 2011-2012; state funds make up about 45% of that budget. In general, services provided to the elderly and the disabled cost more per person/per month than services provided to children or healthy adults. Approximately 30.7% of the Florida Medicaid population is elderly or disabled. This same population accounts for approximately 59.6% of the Medicaid expenditures.

While there continues to be growth in the Medicaid program and AHCA has implemented efforts to manage costs, AHCA recognizes the continuing need to be persistent about deterrence and detection of fraud and abuse. Health care fraud is a serious and costly problem that affects all Floridians. Although there are varying estimates of the amount of program loss due to fraud and abuse, no one knows for certain how much fraud exists in the Medicaid program. While there are national estimates that range from a low of one percent to a high of 20 percent, these estimates are just that – estimates. To be most accurate these figures would actually have to be calculated for each distinct provider type and not the program as a whole. By the time such calculation could be completed on a particular provider type, dynamics within the system and the naturally occurring environment in which it operates would likely result in any findings being dated.

This actually points to another vulnerability of the system in that the scope of services available is very broad. Florida's current Medicaid enrollment is divided among four broad service delivery systems, which are categorized by the general payment/reimbursement methods used in each. However, within those broad areas, services are broken down into 25 service types, each with different methods used to determine the rates for reimbursement.

A 2010 white paper, *Combating Health Care Fraud*, published by SAS Institute, Inc. states:

> Amid these dynamics, fraudsters have become more resourceful than ever. Recruitment and transport of patients for bogus procedures, trading narcotics in exchange for member IDs, identity theft, doctor and pharmacy shopping – all result in claims that appear legitimate when viewed in isolation. Timely

> payment requirements, automated claims processing and lack of widespread, prepayment fraud detection capabilities have helped make health care fraud a low-risk, high return criminal activity – second only to tax evasion in economic crime. Today's fraudsters also have a good understanding of fraud detection systems, frequently recruit insiders into their schemes, and actively test and exploit thresholds and detection rules to avoid exposure.

Herein lies a significant challenge to fighting Medicaid fraud: it is the practice of some to test the system, detect new detection tools or enforcement strategies and move their activities to more vulnerable targets within the program. This is exacerbated by the fact that, with the recession, it is becoming easier for sophisticated criminal enterprises to recruit less sophisticated cohorts to assist them, who, also become victims in the process.

Ongoing Efforts to Combat Medicaid and Public Assistance Fraud

Currently, AHCA has a multitude of processes in place to prevent and detect fraud and recoup overpayments. These are covered in great detail in the Agency's annual report, *The State's Efforts to Control Fraud and Abuse*, and will not be reiterated here. However, the results of their efforts are important to note. In 2010-2011, overpayments identified by the Bureau of Medicaid Program Integrity (MPI) totaled approximately $39.2 million. In addition, MPI identified approximately $13.3 million in contractual assessments, fines/sanctions, and costs. Identified amounts due AHCA for SFY 2010-2011 totaled $52.5 million. At the time of publication, the Agency has collected $48.2 million. Through the employment of Third Party Liability (hereafter referred to as "TPL") contractors using computer assisted analyses of paid claims, an additional $30 million was recovered for the State of Florida.

MFCU is the referral point for AHCA when cases are determined to entail fraud, an intentional deception or misrepresentation made by a person with the expectation that the deception results in unauthorized benefit to herself or himself or another person. In SFY 2010-2011, MFCU reported receiving 99 fraud referrals from AHCA. They also report recoveries totaling $110,276,959 for the year.

As a result of the efforts by DPAF in the Department of Financial Services during SFY 2010-2011, $15,428,238 in public assistance dollars was withheld. Cases involving an additional $1,524,053 were referred back to the Department of Children and Families for Administrative Hearings and almost 99% of those cases resulted in public assistance disqualification. Cases with an additional $5,244,118 in potential loss due to fraud were referred to State Attorney Offices for prosecution and 86.91% of those cases were accepted for prosecution.

New and Innovative Local, State and Federal Initiatives

In the six months that the Strike Force has been organized and staffed, an effort has been made to identify innovative strategies for combating fraud. This is an initial census of those that have been identified.

Telephonic Delivery Monitoring and Verification. As a result of anti-fraud and abuse provisions included in 2009 Senate Bill 1986, AHCA contracted with a vendor, Sandata Technologies, LLC, to implement the Telephonic Home Health Service Delivery Monitoring and Verification (hereafter referred to as "DMV") Program. Sandata utilizes the Santrax Payor Management (hereafter referred to as "SPM") system to address aberrant billing practices, potential fraud and the quality of recipient care in home health care. The contract was signed April 8, 2010 and the DMV project was successfully launched on July 1, 2010.

The goal of the project is to ensure that home health nurses and aides actually go to the homes of the recipients that have been prior authorized to receive home health visits to provide the services outlined in the recipients' plans of care and ensure that home health service providers receive reimbursement for services actually provided.

Medicaid reimbursable home health visits provided by registered nurses (RNs), licensed practical nurses (LPNs) and home health aides are scheduled, verified and tracked through Sandata's SPM system.

After one full year of piloting this strategy, AHCA reports a decrease of 50% in claims paid for home health visits in SFY 2010-2011 when compared to the prior year. This program also resulted in a reduction in home health care visits by 51% during the same time period.

Link Analysis. Link Analysis is a technique used to evaluate relationships (connections) between nodes, as they are called in network theory. Relationships may be identified among various types of nodes or objects, including organizations, people and transactions. Link analysis has been used for investigation of criminal activity (fraud detection, counterterrorism, and intelligence). Link analysis is used for 3 primary purposes: 1) To find matches in data for known patterns of interest; 2) To find anomalies where known patterns are violated; and 3) To discover new patterns of interest (social network analysis, data mining). Two of the agencies represented on the Strike Force have been conducting pilot projects using link analysis.

AHCA. AHCA is currently performing link analyses on the individuals and groups found in the following databases:

- All 130,000 providers in the Medicaid Management Information System (hereafter referred to as "MMIS") database
- All owners in the MMIS database
- All provider groups in the MMIS database
- All prescribing doctors in the Medicaid pharmacy system
- All providers in the managed care networks
- All providers in the Health Quality Assurance (hereafter referred to as "HQA") licensure files

Match and link technologies are being used to gather information from the following sources that may be related to the entities identified above:

- Federal List of Excluded Individuals and Entities
- Other states' exclusion lists
- Department of Health adverse actions & previous terminations
- Other criminal databases
- Florida Corporate records
- Medicaid prescribing database
- MMIS ownership records
- National Provider Identifier records (National Provider and Plan Enumeration System)
- Tax records
- Property records
- Familial and social records

Potential relationships with excluded/criminal entities are identified on the providers using different parts of their names, abbreviations and/or without providing social security numbers. These technologies are intended to uncover providers providing false identity information to evade exclusion matching and people hiding as disclosed owners and officers of companies; people hiding as non-disclosed owners, directors, or officers; people using their immediate relatives to reopen new companies or continue existing companies often at the same business address; people using their partners to continue doing business or open related businesses; people using multiple electronic funds transfer accounts; and prescribing/referring services (Part D, Labs, and Durable Medical Equipment) in states which either do not require them to be enrolled for these referrals or do not check valid referral national provider identifiers (NPI) on claims.

From July 2011 through September 2011 there have been 120 providers identified and actions taken which involved one or more of the following:

- Termination from the program
- Denial of prescriptions written by the provider
- Placement on pre-payment review
- Referrals to Medicaid Managed Care Organizations (hereafter referred to as "MCO")
- Referrals to field staff
- Potential sanctions and fines

DCF. DCF has recently worked with LexisNexis in a pilot project using technology to perform link analyses between information available in distinct databases. This pilot project demonstrated the capacity of such link analyses to aid in the verification of applicant identities. Incorporating this technology into the current ACCESS system can prevent identity fraud at the entry point for eligibility determination.

MFCU Data Mining. One obstacle MFCU faced concerned using already accessible data to generate leads for investigations. MFCU operates on a budget that includes Federal matching grant funds. A federal grant restriction for MFCU was it could not conduct routine reviews of Medicaid claims data to look for patterns in billing that would identify fraud. The rationale for the restriction was that AHCA receives federal funds to do this data mining and the federal government didn't want to pay two agencies to do the same thing, since it had historically been a costly process.

However, since the initial enactment of the restriction, processes have become more automated and there have been huge advances in computer hardware, software and the ability to manage data. In addition, MFCUs have developed the capability to undertake such tasks. However, the restriction remained in place.

The Florida MFCU, in collaboration with AHCA, asked the Centers for Medicare and Medicaid Services (hereafter referred to as "CMS") for a waiver of the grant restriction. The objective is to supplement AHCA's data mining activities. CMS granted the waiver request as a three year pilot project. For the first year, three Medicaid Fraud Analysts will devote up to 15% of their time to the project. During the last two years they will devote up to 25%.

As of October 1, 2010, MFCU began data mining. All leads are still under investigation, and no investigations have been resolved yet. Florida is the only state that has been granted such a waiver. In fact, although they have not yet been adopted, the U.S. Department of Health and Human Services recently proposed amendments to the Federal Code to allow more flexibility for MFCUs to do data mining.

MFCU's Complex Civil Enforcement Bureau. The Complex Civil Enforcement Bureau (hereafter referred to as "CCEB") is a section within MFCU. CCEB investigates and litigates cases that allege violations of the Florida False Claims Act when the false claims were submitted to the Florida Medicaid Program. The majority of the cases are *qui tam* actions filed in federal court containing allegations that the Florida False Claims Act has been violated. CCEB evaluates *qui tam* complaints and prioritizes them according to their underlying merit and value to the State of Florida. In addition, CCEB has expanded Florida MFCU's role among the multi-state working groups litigating Medicaid fraud issues.

Problem Solving through Process Mapping. As used here, process mapping is another term for business process mapping. Business process mapping refers to activities involved in defining exactly what a business entity does, who is responsible, to what standard a process should be completed and how the success of a business process can be determined. Once this is done, there can be no uncertainty as to the requirements of every internal business process. The first step in gaining control over an organization's performance is to know and understand the basic processes.

Emergency Suspension Orders. As an outgrowth of the new provisions of Senate Bill 1986, DOH undertook an initiative to map the processes that are involved in issuing an Emergency Suspension Order (hereafter referred to as "ESO"). This mapping began on May 5, 2011, and an initial map was completed by May 31, 2011. DOH used the activity of mapping to define current processes and identify where they could be improved. After the initial mapping to define improved processes, DOH identified and incorporated additional improvements. As a result of this initiative, DOH has been able to reduce the time required to issue an ESO from 121 days to 19 for Category 1 suspensions and down to 21 days for Category 2 suspensions.

High Level Cross Agency Mapping. The Strike Force has also undertaken a project to develop a very high level representation of the prevention, detection, investigation and recoupment of funds processes across the agencies that are primarily responsible for combating fraud in the Medicaid and public assistance service systems. The Strike Force has worked with AHCA to utilize the prevention, detection, recoupment process maps developed as a result of Senate Bill 1986 (2009 Legislative Session). AHCA's process maps, while focused on provider fraud, are ones that can be replicated for recipient and public assistance business practices. Although this high level cross-agency visual is not yet complete, the high level mapping has already revealed minimal fraud prevention processes in the eligibility determination processes. Mapping the ACCESS processes will, as was the case for DOH, help identify where processes can be improved to prevent fraud.

Multi-Jurisdictional Partnering. The following descriptions represent examples of how multi-jurisdictional partnerships have been of value in combating fraud.

Federal/Local Collaborations. The Palm Beach County Sheriff's Office (hereafter referred to as "PBSO") began investigating public assistance fraud several years ago. In 2009 a joint investigative team was established in collaboration with the State Attorney's Office for the Fifteenth Judicial Circuit, and the U.S. Department of Housing & Urban Development Office of Inspector General to investigate criminal activity relating to federal or state funded public assistance. Recently the Sheriff has formally created a PBSO Public Assistance Fraud Unit.

The investigative group has expanded to include the Inspectors General for the U.S. Departments of Veteran's Affairs, Agriculture, and the Social Security Administration as well as many housing authorities in public assistance providers. Through the collaboration with these agencies, numerous public assistance fraud investigations are conducted including housing assistance, food stamp/Electronic Benefit Transfer (hereafter referred to as "EBT") fraud, and other federal and state welfare programs.

These investigations have also led to several arrests and convictions for public corruption and official misconduct. In addition, as a result of these targeted investigations, other organized criminal operations are being uncovered.

In the past year, over 100 public assistance recipients have been arrested for fraud with more than $2,000,000 ordered in restitution.

Federal/State/Local Collaborations. Ten years ago, the U.S. Department of Agriculture (hereafter referred to as "USDA") designated DPAF as the State Law Enforcement Bureau (hereafter referred to as "SLEB") for EBT cards. In that role, they serve as the liaison between local and state agencies and USDA in carrying out targeted investigations and prosecution of EBT fraud. DPAF supports the investigations by creating and funding EBT cards that can be used in undercover buys by investigative units. DPAF works with the local law enforcement agencies to ensure that targeted retail establishments are cleared for investigative units to enter under cover and gather the necessary evidence to create a case of fraud against the retail operator. DPAF then collaborates with any involved law enforcement and prosecutorial agencies in the pursuit of criminal prosecutions. DPAF also follows up with USDA to provide the information necessary to disqualify the retail locations and with investigations of recipient fraud that may have been integral to the retailer fraud.

Needs Assessment

As part of its mission, the Strike Force has gathered information through meetings of the Strike Force and its committees in an effort to identify needs or additional improvements that can be made in the Florida Medicaid and public assistance delivery systems. The member agencies were asked to identify what they considered to be weaknesses in the system at the very first Strike Force

meeting. However, such an inventory would not be complete without a full recognition of concomitant strengths that can be built upon. The following needs have been identified as areas to address in order "to develop and implement a statewide strategy to coordinate state and local agencies, law enforcement entities, and investigative units in order to increase the effectiveness of programs and initiatives dealing with the prevention, detection, and prosecution of Medicaid and public assistance fraud," Section 624.351(1), Florida Statutes.

Increase Emphasis on Prevention. Reports from and interviews with law enforcement agencies, investigative units and prosecutorial entities have made it clear that efforts to enhance enforcement and prosecution once fraud has occurred is not the most cost-effective approach to minimizing fraudulent activity. It is not possible to have the greatest impact after a crime has already occurred if insufficient efforts have been made to prevent the criminal activity at the front end of the system. The Strike Force has identified a number of ways to improve the system's prevention processes.

Changes to Statutes. Currently, AHCA has a multitude of processes in place to prevent inappropriate payments to providers. There are approximately 18 processes and programs in place that address background screening and initial eligibility determination of providers, education of providers, promulgation of policies and rules, audits and edits of claims and institution of oversight and controls. All are intended, in some way, to prevent fraud or abuse before a payment is ever made. In addition, these processes are connected to other detection and recoupment processes to provide feedback that can be used to continuously improve prevention efforts. However, additional statutory authority is needed to broaden their power to restrict potentially fraudulent providers from entering the system. In particular, licensure exemptions that currently exist for health care clinics need to be statutorily minimized.

DOH also identified a need for statutory changes to assist them in doing more comprehensive background checks to prevent fraudulent providers from being licensed in the State of Florida. Chapter 456, Florida Statutes, identifies the health care providers for which DOH is authorized to conduct background screenings. This authority needs to be expanded to allow for screenings of all health care professionals licensed by DOH.

Improvements in Eligibility Determination. Upon his appointment, DCF Secretary David Wilkins began a thorough review of his agency's efforts to prevent, detect and recover from public assistance fraud and abuse within the temporary cash assistance, SNAP and Medicaid programs. DCF's ACCESS program conducts eligibility determinations not only for the programs which DCF administers, but also for Medicaid. In examining this function, it was determined that critical components in the eligibility process, such as information technology and organizational design, were primarily intended to meet the goal of the federal SNAP program which is to increase participation. The ACCESS Program has enjoyed tremendous success in this regard, most recently by being awarded more than $11 million in federal bonuses for reporting the lowest "payment error rate" in the nation for the Federal Food Stamp Program. However, its error rate for conducting Medicaid eligibility remains among the highest in the country: 9.2%. This is well above the national average of 6.7%, according to the latest CMS Payment Error Rate Measurement (PERM) analysis.

Access Process Mapping. While it is important to ensure that all the Federal programs that DCF administers comply with applicable Federal rules and guidelines relating to payment timeliness and accuracy, it has also become clear that fraud prevention must also begin to occur during the same eligibility determination process and continue throughout the time that benefits are being distributed and received. ACCESS, as the entry portal to the Florida Medicaid Program and other public assistance programs, is the first line

of defense against fraud. Therefore, the Mapping Committee determined that mapping the ACCESS processes should be the first priority for the Strike Force's mapping initiative. This will require a legislative appropriation.

Identity Verification. Reflecting society's "virtual environment", over 90% of all applications for public assistance are received virtually through the technology program designed for that purpose; ACCESS On-line. While this method is very useful in expediting payment of benefits, it also means that verification of eligibility must also occur on-line. Fortunately, technology and innovation have evolved to develop meaningful tools to rapidly verify applicants' identities as well as information which impacts eligibility. The current ACCESS On-line system does not have the capability of using any type of link analysis to verify identity. DCF needs funding and/or technology resources that will enable the system to accurately verify applicant identity.

Make Better Use of Available Data. A major strength in the Medicaid and public assistance service systems is the prolific availability of data on recipient applicants and Medicaid claims. In AHCA's data connectivity plan, there were 14 databases identified and the inventory continues to grow as more agencies join this endeavor. Unfortunately, there are a number of weaknesses that compromise the ability to make the best use of this data. This is particularly critical in efforts to detect criminal behavior patterns.

Currently, the technology is not in place that connects all the databases that contain health care fraud and related data. Section 409.913(38)(b), Florida Statutes, requires AHCA to develop a strategic plan to connect these databases. In addition, a recent bi-annual audit from the Office of Program Policy Analysis and Government Accountability (OPPAGA) recommended that AHCA expand its detection tools to include neural networking and other advanced techniques for detecting emerging fraud and abuse patterns.

Implement AHCA's Data Connectivity Plan. AHCA completed *The Strategic Plan for Data Connectivity – Health Care Fraud Databases* in December 2010. AHCA designed the plan to be a dynamic document that can be adjusted to meet the needs of an ever changing Medicaid service system. AHCA is currently enhancing the strategic plan to connect the databases, bridge gaps between silos and make the best use of this data to combat fraud and abuse in the Medicaid program.

The plan provides for replacing an aging case tracking system and incorporating advanced detection methodologies. These are essentially detection devices that are able to learn from existing automated audit processes. As it goes through the normal audit processes and identifies inappropriate claims, they are flagged so the system begins to learn what an inappropriate claim looks like. Over time, it is able to work in the background, automatically reviewing all the data that is available.

The 2011 Florida Legislature approved a Legislative Budget Request (hereafter referred to as "LBR") in the amount of $800,000 that will enable AHCA to replace the current case tracking system and incorporate advanced detection capabilities. It will be necessary for the Legislature to continue to fund AHCA's implementation of *The Strategic Plan for Data Connectivity – Health Care Fraud Databases.*

Incorporate Advanced Analytics in Upgrades to Information Systems. In addition to the ability to connect databases, the pilot projects that have been done on link analyses have demonstrated the value of identifying connections between information maintained in various diverse databases on providers and recipients in detecting fraudulent activity. It is important to these efforts that every consideration is given to providing the resources to incorporate such analytics or predictive modeling software into any upgrades to databases that help to prevent, detect, investigate and prosecute fraud as well as to recoup wrongful payments. In the immediate

future, this would include the incorporation of such technology into upgrades to the FLORIDA System and the EBT system. In order for DCF to proceed with these plans, they will need a legislative appropriation to conduct a feasibility study to plan for these enhancements.

Gather the Standard National Identifier for Practitioners to Enable Link Analyses. One standard data element on providers that is needed to link provider information across databases is the National Provider Identifier. Currently, DOH and AHCA do not collect this information because statutory authority is required to enable them to do so.

Increase Leveraging of Resources. A recurring theme in reports to the Strike Force is the lack of resources available to support existing processes intended to prevent, detect, investigate and prosecute fraud. From the need for additional staff, to more competitive salaries, to better training, no agency is funded at the level they would prefer. As indicated in the previous section, some of these needs can be met in part through better, more advanced technology. This will require an investment in resources, as well. However, there are other ways in which resources can be leveraged to increase the effectiveness of our efforts.

AHCA dedicates a significant amount of resources to the prevention of fraud and abuse. Prevention activities include prepayment reviews, site visits, terminations, and sanctions. The most recent data available (SFY 2009-2010) from AHCA on return on investment demonstrate that funding to support detection and investigation has been well directed. AHCA's Bureau of Medicaid Program Integrity (hereafter referred to as "MPI") documented that for every dollar spent to avoid costs, $3.3 is saved. In addition, for every dollar spent on recovery efforts, the MPI has been able to recoup $6.4 dollars. Similarly, DPAF has documented (SFY2010-2011) that for every dollar spent to fund their operations (both State and Federal shares), they provide a return of $6.05 in benefits saved/denied, prosecuted, or collected through their partner agencies (DCF, Agency for Workforce Innovation-Office of Early Learning, DOH, and the Social Security Administration). Similarly, during SFY 2010-2011, for every dollar of General Revenue expended, MFCU recovered $32.44.

Establish Funding Sources. Given these Return on Investment (ROI) figures, it is justifiable to direct more resources to combating fraud and abuse in order to increase returns to General Revenue or prevent unnecessary expenditures. While there are generally not surplus General Revenue funds available to do this, the Strike Force believes it important to continue to explore additional funding sources to support its administrative and operational costs and the anti-fraud projects it approves as a body. Recommendations that have been raised to the Strike Force that would require additional budget allocations from the legislature would be among the first considered for funding by the Strike Force.

Maximize External Resources through Partnerships. Another opportunity that exists to help leverage resources is the opportunity to partner with local and federal agencies to enhance detection, investigation and enforcement efforts. There are already numerous multi-jurisdictional task forces in place that enable cooperative initiatives. Supporting and growing these collaborative relationships can result in aggressive investigations into fraudulent practices from various levels. An added benefit to being more aggressive with these cases through partnerships is that illegally gained assets could be seized, preventing the perpetrators from passing along the infrastructure needed to continue the criminal activity. The Strike Force can be integral in maximizing this opportunity by advocating for and supporting these initiatives in any way possible, including coordinating the provision of training for local law enforcement, other partner agencies and lay citizens. Having funds available through whatever funding sources the Strike Force secures would provide the resources to support these initiatives.

RECOMMENDATIONS

Based upon this review of needs and in consideration of the innovative initiatives currently underway, the Strike Force compiled the following recommendations to the Legislature.

1. Minimize the licensure exemptions that currently exist for clinics through AHCA.

2. Give DOH the statutory authority to conduct state and national criminal history record checks on all professions they regulate. Create statutory/rule provisions for timely reporting of arrests of practitioners to DOH via retention of fingerprints by FDLE. (See Appendix A "Criminal History Record Checks" for explanation of the criminal history record check process and the retention of fingerprints).
   i. In conjunction with the Interagency Workgroup on Background Screening, examine methods to maximize the sharing of criminal history information to reduce additional costs for licensees and duplicative processes by state licensing agencies.

3. Give DOH and AHCA the authority to collect the National Provider Identifier from providers.

4. Establish a funding source for the Strike Force to use to enhance anti-fraud efforts.

5. Provide contractual services to map ACCESS, as the entry to public assistance programs, in order to identify technological and organizational processes that can be reengineered to improve prevention and detection processes and support the feasibility study for replacement of the FLORIDA System.

6. Fund the incorporation of identification verification and fraud prevention processes into the ACCESS On-Line capabilities in the immediate future.

7. Support a feasibility study for ultimately replacing the FLORIDA System with an updated system that incorporates identification verification and fraud prevention technology.

8. Continue to fund the implementation of AHCA's Data Connectivity Plan.

In addition, there are recommendations that have been presented that the Strike Force can take the lead on implementing:

1. Expand participation on Strike Force working committees to include other public assistance agencies (e.g., Department of Education, Agency for Persons with Disabilities).

2. Coordinate training sessions around the state to empower local government and law enforcement to partner on initiatives to fight Medicaid and public assistance fraud and train citizens in identifying and reporting suspicious activity in order to support local initiatives.

Other recommendations have been presented to the Strike Force, but have not been fully evaluated to determine how to proceed. These will be followed up on in the upcoming year:

1. Find a way to get more timely information from employers in order to verify employment status on benefit applicants and/or recipients.

2. Secure cooperation from the federal government on a Treasury Offset Program to allow recoupment of overpayments through an offset of income tax returns.

3. Provide statutory authority to garnish state employee wages for recoupment of overpayments.

4. Incorporate the use of biometrics into current system processes to help ensure that services are, in fact, provided to eligible applicants.

Other Opportunities

The Strike Force has just begun to explore the opportunities available to fight fraud in the State of

Florida. In the coming year, the Strike Force will investigate the potential of other strategies to enhance efforts to prevent, detect, investigate and prosecute fraud and recoup overpayments. The Technology Committee will continue to review other technological advances. The Grants Committee will review the impact of a Background Screening Grant that AHCA has received. The Mapping Committee will follow the progress in mapping the ACCESS processes and provide direction to this initiative. The Strike Force, as a whole, will follow AHCA's progress in the move to statewide managed care and offer assistance and support wherever possible.

ACTION PLAN

Based upon the information that has been presented to the Strike Force it has become evident that there can never be enough resources in terms of traditional law enforcement activities to combat the fraud that is occurring each year throughout the Medicaid and Public Assistance programs. Prevention and detection of fraud are complicated by the fact that the many and varied public assistance programs are spread throughout state government and the funding sources for these programs are separated among various federal government agencies, each with its own criteria and rules relating to administration and oversight. Medicaid is especially complicated in that the qualification process for recipients is housed within DCF while the providers for Medicaid are licensed by DOH and regulated, as Medicaid providers, by AHCA. Investigations for suspected criminal activity are then referred to two separate agencies as well, with AHCA referring suspected provider fraud to MFCU and DCF and AHCA referring suspected recipient fraud to DPAF.

The resulting Action Plan for the Strike Force will place the greatest emphasis on prevention, particularly as it can be applied within the Medicaid program. However, the Strike Force recognizes the need to ensure that investigative and law enforcement agencies have tools and resources that can help maximize the effectiveness of their efforts. This led to a two-pronged approach for the Strike Force Action Plan for SFY 2011-2012 and laying the groundwork for action planning in subsequent years.

Initiative #1: Enhanced Prevention & Detection

This initiative is focused on establishing the necessary tools and then working to increase emphasis on prevention.

Phase I: Statutory Changes and Budget Authority

This first phase will focus on putting tools in place through legislative action that will enhance the ability of the key agencies to prevent likely fraudulent providers from working within the Medicaid program.
Goal: Secure the Tools and Resources to Improve Prevention Efforts

Statutory Changes are needed which will:

1. Minimize the licensure exemptions that currently exist for clinics through AHCA.
2. Give DOH the statutory authority to conduct state and national criminal history record checks on all professions they regulate.
3. Give DOH and AHCA the statutory authority to collect the National Provider Identifier from providers.
4. Establish a funding source for the Strike Force to use to enhance anti-fraud efforts.

Budget Authority is needed which will:

1. Provide contractual services to map ACCESS, as the entry to public assistance programs, in order to identify technological and organizational processes that can be reengineered to improve prevention and detection processes and support the feasibility study for replacement of the FLORIDA System.
2. Fund the incorporation of identification verification and fraud prevention processes into the ACCESS On-Line capabilities in the immediate future.
3. Support a feasibility study for ultimately replacing the FLORIDA System with an updated system that incorporates identification verification and fraud prevention technology.
4. Continue to fund the implementation of AHCA's Data Connectivity Plan.
5. Provide funding to support the Strike Force and its initiatives.

Phase II. Mapping and Establishing Performance Measures

Once the tools have been put in place in Phase I, Strike Force members will work to implement these tools to devise strategic, inter-agency approaches to improving prevention and detection activities.

Goal: Identify processes that can be improved and activities and resources that can be reallocated to prevention in the Medicaid service delivery system.

Objective 1. Map ACCESS to identify processes that can be improved and activities and resources that can be redirected to prevention.

Activities

1. The Strike Force will retain the services of a mapping consultant to map ACCESS and establish performance measures that accurately reflect the ability to prevent and detect fraud in the applicant eligibility determination stage.
2. Identify processes that can be improved and activities and resources that can be reallocated to prevention.
3. Reengineer technological and organizational processes to improve prevention and detection of fraud during eligibility determination and after to ensure recipient eligibility.
4. Monitor performance measures and take corrective action, as needed.
5. Refine the ACCESS map, as needed.

Objective 2. Continue iterations toward cross agency mapping of vulnerable process areas that have not previously been mapped.

Activities

1. The Mapping Committee will review the initial high level representation of the prevention, detection, investigation and recoupment of funds processes across the agencies that are primarily responsible for combating fraud in the Medicaid and public assistance service systems.
2. The Mapping Committee will work with Strike Force staff to refine this overview.
3. The Mapping Committee will recommend to the Strike Force a priority order for mapping other process areas that appear to be most vulnerable to fraud that should be mapped.
4. Subsequent mapping will be undertaken at the direction of the Strike Force following the steps identified for mapping ACCESS.

Objective 3. Identify activities and resources that can be redirected to prevention through technological and organizational process improvements.

Activities

1. A new subcommittee made up of Strike Force members that represent state agencies will be convened.
2. This committee will review the work of the mapping consultant and subsequent mapping initiatives and develop proposals and recommendations for reallocating technological and organizational resources to prevention.
3. When technological solutions are proposed to enhance prevention efforts, recommendations should include the incorporation of predictive modeling capabilities that will allow databases to also be mined to detect fraud, waste and abuse.
4. This committee will develop performance measures that will be used to effectively measure the cost savings for the program based upon the move to a prevention-focused model.
5. This committee will work with the agencies to redirect their resources to prevention.

Phase III. Implementation and Evaluation

Goal: Determine the effectiveness of reallocating resources to place even greater emphasis on prevention.

Objective 1. Implement the redirection of resources as recommended by the new subcommittee of the task force.

Activities

1. Individual agencies will be responsible for effecting the redirection within their agencies.

Objective 2. Evaluate the effectiveness of reallocating resources to place even greater emphasis on prevention.

Activities

1. Strike Force staff will design evaluation methodologies specific to each of the identified reallocations and the performance measures established for use in the evaluation.
2. Strike Force staff will work with member agencies to gather the data necessary to complete the evaluation.
3. The data will be compiled and analyzed and an evaluation written for each reallocation made.

Initiative #2: Geo-Centered Partnership Model.

(18-24 month implementation process)

This initiative will entail the development, refinement and deployment of a "geo-centered" model for targeting fraud, similar to the Palm Beach County Sheriff's Office example described in this report. Concentrating resources in geographic areas with higher rates of crime is not a new concept in law enforcement; historically, targeted investigations in specific high crime areas result in significant arrests and prosecutions. The "geo-centered" model for combating Medicaid recipient fraud and public assistance fraud would identify areas throughout the state where high rates of either recipient or provider fraud have been identified. The key to success with this model will be building collaborations throughout the state between state, local and federal partners.

Phase I: Identify Geographic Targets

This first phase will involve identifying geographic areas with high incidences of detected fraud in the public assistance programs, using data available from DPAF.

Objective 1. Identify geographic and public assistance programs with the potential for the greatest returns from a targeted enforcement initiative.

Activities

1. DPAF will identify the incidence of recipient fraud identified in individual public assistance programs.
2. Starting with the highest incidence rate, DPAF will identify the top three geographic areas in the state in which the fraud is occurring.

Phase II: Build Collaborations

This phase will involve building the relationships necessary to implement the geo-centered enforcement activities effectively. Agencies that should be considered in forming partnerships should be specific to the type of public assistance program and the geographic area being targeted. Agencies that should be considered in building these partnerships include local law enforcement agencies, other local agencies that may be able to support the initiative (e.g., Chambers of Commerce), federal agencies involved in the targeted public assistance program (e.g., HUD, USDA, U.S. Attorney), and other interested stakeholders.

Objective 1. Establish the collaborations needed to address the targets identified in Phase I.

Activities

1. DPAF will identify the stakeholder agencies in the targeted public assistance program and local agencies that should be involved.
2. DPAF and Strike Force staff will meet with the key stakeholders and orient them to the type of collaboration envisioned using examples of successful collaborations from around the state.
3. DPAF and Strike Force staff will provide training for the partners using federal and state resources and initiating support for integrated databases between investigatory and law enforcement agencies.

Phase III. Carry Out Sweeps of the Targeted Program and Geographic Area

Objective 1. Develop the interagency strategy for carrying out the sweep.

Activities

1. A lead agency should be identified for carrying out the sweep based upon jurisdictional parameters for each agency.
2. The lead agency will develop the strategy in consultation with the other agencies depending upon the resources required and/or available from each agency.

Objective 2. Carry out the sweep.

Activities

1. The lead agency will schedule the sweep activities in coordination with the schedule of the other agencies.
2. The lead agency will direct the sweep.

Phase IV. Replication

This phase will be used to determine the extent to which this model can be replicated in targeting other public assistance programs, as well as Medicaid providers. This phase will take the successes and lessons learned from Phase I through III and expand the targeted sweeps to other types of public assistance benefits as well as to other areas of the state.

Objective 1. Identify geographic areas and public assistance programs with the potential for the greatest returns from a targeted enforcement initiative.

Activities

1. DPAF and AHCA will identify the incidence of recipient fraud identified in individual public assistance programs and provider fraud in the Medicaid service delivery system.
2. Starting with the highest incidence rate, DPAF and AHCA will identify the top three geographic areas in the state in which the fraud is occurring.

Objective 2. Establish the collaborations needed to address the targets identified in Objective 1.

Activities

1. DPAF and AHCA will identify the stakeholder agencies in the targeted public assistance or Medicaid program and local agencies that should be involved.
2. DPAF, AHCA and Strike Force staff will meet with the key stakeholders and orient them to the type of collaboration envisioned using examples of successful collaborations from around the state.
3. DPAF, AHCA and Strike Force staff will provide training for the partners using federal and state resources and initiating support for integrated databases between investigatory and law enforcement agencies.

Objective 3. Develop the interagency strategy for carrying out the sweep.

Activities

1. A lead agency should be identified for carrying out the sweep based upon jurisdictional parameters for each agency.
2. The lead agency will develop the strategy in consultation with the other agencies depending upon the resources required and/or available from each agency.

Objective 4. Carry out the sweep.

Activities

1. The lead agency will schedule the sweep activities in coordination with the schedule of the other agencies.
2. The lead agency will direct the sweep.

Subsequent to the replication of this strategy, a review of the results from instances of implementation will be carried out by the Strike Force to determine the extent to which it is facilitating accomplishment of the Strike Force mission. Plans for further expansion and replication will be determined based upon direction from the Strike Force.

Appendix A

Criminal History Record Checks Florida Department of Law Enforcement (January 2011)

Criminal History Record Check: The term "background check" is often used interchangeably with "criminal history check" or "criminal history record check." Some companies use the phrase "background check" to include driver's record, credit history, or interviews with neighbors and employers. From the Florida Department of Law Enforcement (FDLE) perspective, a background check as required by Florida Statutes for licensing, employment or regulation is a criminal history record check to determine if a person has been arrested and/or convicted of a crime. A criminal history record check is a search of the following databases:

- The Florida Computerized Criminal History (CCH) Central Repository for Florida arrests (STATE CHECK).
- The Florida Computerized Criminal History Central Repository for Florida arrests AND the national criminal history database at the FBI for federal arrests and arrests from other states (STATE AND NATIONAL CHECK).
- The Florida Crime Information Center for warrants and domestic violence injunctions (HOT FILES CHECK) Note: These are performed for both state and national checks.

A national criminal history record check is based on the submission of fingerprints. State criminal history record checks are based on a name (and other descriptors) or fingerprints.

How can a criminal history record be obtained?

The information is provided through a variety of means:

- Public record requests for criminal history information are provided over the Internet, through a modem system or through the mail.
- Applicant requests (licensing or employment, or a volunteer employee under the National Child Protection Act) are submitted with fingerprints through either an inked card or a livescan device.

What is the current fee for a criminal history check?

The fee for a Florida criminal history check is $24.00 as provided in Section 943.053(3)(b), F.S. The law also establishes specific rates for certain entities as follows:

- $18 for requests under the National Child Protection Act;
- $15 for requests through the Department of Agriculture and Consumer Services for checks such as concealed weapon license holders; and
- $8 for vendors of the Department of Children & Families, Department of Juvenile Justice and the Department of Elder Affairs; and Guardian Ad Litem and
- Public Defender Offices employees, conducting a check as part of their official duties, are not assessed a fee.

The fee for a FBI national criminal record check is:

- $19.25 if received electronically
- $30.25 if received by paper card
- $15.25 for volunteers submitted under the National Child Protection Act

What is a "retained" fingerprint?

An agency may request to have fingerprints retained at FDLE. When the subject of retained fingerprints is identified with fingerprints of an incoming Florida arrest, FDLE notifies the licensing or employing agency of the arrest (referred to as arrest hit notifications). The arrest hit notification will include the name of the arresting agency.

Currently only state arrests are searched against the applicant retained fingerprints file. The FBI is currently enhancing its systems to allow for retained prints and arrest hit notifications from other states; the FBI anticipates implementation in 2014.

What determines if a fingerprint will be "retained" by FDLE?

FDLE retains the fingerprints of applicants pursuant to Florida Statutes or upon request of the agency or entity head and notifies the licensing or employing agency or qualified entity if the retained subject is arrested in Florida. This system is partially automated and partially manual and includes fingerprint comparison to ensure that the arrest notification is sent only when there is assurance that it is the correct subject.

Those currently designated for fingerprint retention are:

- Criminal justice employees; sworn personnel must be submitted for retention and non-sworn at the option of the employing agency.
- School district instructional and non-instructional employees and contractors.
- Private school employees.
- Department of Juvenile Justice employees and contractors.
- Racino employees.
- Mortgage brokers and loan originators.
- Elder Affairs vendors.
- Professional guardians (when submitted electronically).

What period of time are the fingerprints retained for?

Fingerprints are retained until the individual is no longer in the capacity for which the agency submitted their prints. The agency must request deletion of the prints.

Is there a fee associated with the retention of fingerprints?

Agencies/Entities that request FDLE to retain fingerprints are charged a $6.00 annual fee per year following the initial year of submission and retention.

CHIEF FINANCIAL OFFICER

JEFF ATWATER

FLORIDA DEPARTMENT OF FINANCIAL SERVICES

MEDICAID & PUBLIC ASSISTANCE FRAUD

STRIKE FORCE