FLORIDA'S EFFORTS TO CONTROL MEDICAID FRAUD & ABUSE

FISCAL YEAR 2018-2019

AGENCY FOR HEALTH CARE ADMINISTRATION
STATE OF FLORIDA

ATTORNEY GENERAL
STATE OF FLORIDA
LEX

December 30, 2019

The Honorable Ron DeSantis
Governor
PL-05 The Capitol
400 South Monroe Street
Tallahassee, FL 32399

Dear Governor DeSantis:

Pursuant to Section 409.913, Florida Statutes, enclosed is the annual report of the activities related to the fight against fraud and abuse in the Medicaid program for the FY 2018-19. This report has been prepared jointly by staff of the Agency for Health Care Administration (Agency) and the Medicaid Fraud Control Unit (MFCU) within the Office of the Attorney General. Although many of the investigational details must remain confidential, both the Agency and MFCU have focused efforts in recent years on fraudulent and abusive behavior to ensure that detection and prevention efforts are directed at the most egregious and pervasive conduct, which may not be evident solely through claims analysis. Our two organizations continue to collaborate, with a goal of innovative and effective approaches to aggressively combat fraud, abuse, and waste in the Medicaid program.

Sincerely,

Ashley Moody
Attorney General

Sincerely,

Mary C. Mayhew
Secretary

cc: The Honorable Bill Galvano
The Honorable Jose Oliva

Statutory Authority:

Section 409.913, Florida Statutes (F.S.), requires in part that:

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

As this report details, the Agency for Health Care Administration (AHCA or the Agency) and the Medicaid Fraud Control Unit (MFCU) of the Department of Legal Affairs have continued their joint efforts to prevent, reduce, and mitigate health care fraud, abuse, and waste in accordance with their statutory obligations. Additionally, other components and subject matter experts from several state agencies that administer public benefits and health care programs contributed to the joint projects and efforts described in this report.

This joint report presents specific results of efforts by the Agency and MFCU to control Medicaid fraud and program abuse during FY 2018-19.

TABLE OF CONTENTS

THE DEPARTMENT OF LEGAL AFFAIRS – OFFICE OF THE ATTORNEY GENERAL

Overview of the Medicaid Fraud Control Unit

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

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

Medicaid providers, and others, who are arrested by MFCU personnel, are prosecuted by the Office of Statewide Prosecution, State Attorneys, United States Attorneys, or MFCU attorneys. MFCU attorneys lack original jurisdiction for prosecution but in some cases are cross-designated through one of the above-mentioned entities which has prosecutorial authority.

The MFCU is also responsible for investigating the physical abuse, neglect, and financial exploitation of patients residing in long-term care facilities such as nursing homes, facilities for the mentally and physically disabled, and assisted care living facilities. To ensure the quality of care being provided for Florida's ill, elderly, and disabled citizens, MFCU implemented its ongoing PANE (Patient Abuse, Neglect, and Exploitation) Project in 2004. This project was designed as a collaborative effort among several agencies to address the abuse and exploitation of patients in long-term care facilities. PANE was expanded statewide and continues to be an ongoing initiative.

Control and Enforcement Strategy

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

MFCU's Control and Enforcement Strategy requires unit members to focus on the following:

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

- PANE investigations - Focus is placed on activities and investigations involving prevention and timely criminal enforcement. Emphasis is placed on facilities which have incidents with immediate public safety issues and those which have widespread impact on potential victims.

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

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

- Intelligence - Emphasis is placed on developing and fostering key partnerships with agencies such as AHCA, DOH, APD, state and federal prosecutors, and the criminal justice community in order to promote better sharing of data. Use of information technology resources to obtain, share, and disseminate data to assist in the detection, investigation, and ultimately the deterrence of Medicaid fraud is promoted.

Complaints

The Unit's policy requires a 30-day review of complaints and allegations to determine whether the matter merits further investigation, should be referred to another agency, or is unfounded. Case openings occur only when there is a criminal or civil predicate that warrants further investigative activity by the MFCU. During FY 2018-19, the Unit received 11,458 complaints. Of those 11,458 complaints, 344 were opened as operational cases. Of the 11,458 complaints received in FY 2018-19, 573 were related to fraud and 10,885 were related to PANE allegations.

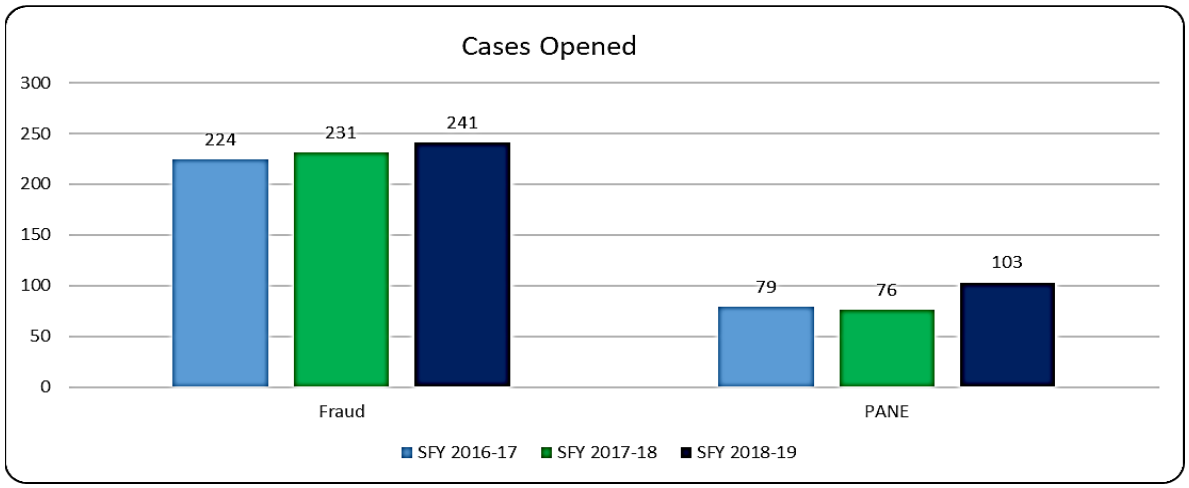
Of the total 573 fraud complaints received, referrals from managed care Special Investigative Units were the primary source of fraud complaints in FY 2018-19 at 125. Qui tam complaints accounted for 104 Medicaid fraud complaints. Complaints from citizens accounted for 89 of the Medicaid fraud complaints received. Seventy-two complaints were received from AHCA Medicaid Program Integrity (MPI).

The majority of PANE complaints were derived through the Department of Children and Families (DCF), Adult Protective Services (APS)/Florida Safe Families Network (FSFN.) In order to ensure more accurate and complete reporting, during FY 2018-19 the MFCU started entering all FSFN reports into the case management database, which accounts for the spike in PANE complaints. In FY 2018-19, of the 10,885 PANE complaints, 10,778 came from DCF/APS/FSFN. Citizens relayed 24 and Family Members relayed 24 making them the next highest source of PANE complaints.

Case Investigations

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

During FY 2018-19, the Unit's internal intake team has continued to assist with front end decision-making regarding opening or closing criminal investigations. This successful process preserved valuable investigative resources and allowed the Unit to be more selective in its case focus.



The following is a list of the top five Medicaid Provider types for MFCU fraud cases opened in FY 2018-19:

1. Physician
2. Pharmaceutical Manufacturer
3. Behavior Analysis
4. Community Alcohol/Drug/Mental Health
5. Home Health Agency

The following is a list of the top five Provider types for PANE cases opened in FY 2018-19:

1. Facility Employee
2. Family Member
3. Certified Nursing Assistant (CNA)
4. Licensed Practical Nurse (LPN)
5. Administrator of Facility

Disposition of Cases

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

In FY 2018-19, the MFCU closed 277 cases. Of those, 204 involved Medicaid fraud investigations and 73 involved PANE cases.

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

The referrals for prosecution in FY 2018-19 were 30 Fraud and 24 PANE for a total of 54. In FY 2017-18 the referrals for prosecution were 51 Fraud and 19 PANE for a total of 70 and in FY 2016-17, the referrals for prosecution were 64 Fraud and 24 PANE for a total of 88.

Case Highlights

Covidien LP

Florida joined the United States Department of Justice and California to secure a multimillion-dollar recovery following an investigation into a multistate health care fraud scheme. Covidien LP, a former global health care products company, allegedly provided free or discounted development and marketing services to Florida health care providers to induce them into purchasing Covidien products. These alleged actions violate the Anti-Kickback Statute and both federal and state false claims acts.

According to the multistate investigation, Covidien used customized marketing plans to entice health care providers to purchase ClosureFAST^{tm} catheters, used in procedures that treat venous reflux disease. The disease is often marked by the presence of varicose veins. The practice and market development support services Covidien provided included customized marketing plans for specific vein practices. The plans provided substantial assistance to specific vein practices in connection with planning, promoting and conducting screening events to cultivate new patients for those practices.

The agreement resolves the allegations contained in two lawsuits, all pending in federal court in California. The lawsuits were filed under whistleblower provisions of the Federal False Claims Act and state false claims acts, permitting individuals to sue on behalf of the U.S. and the named plaintiff states.

Under the agreement, Covidien paid approximately $20 million, plus interest in Medicaid restitution and other recoveries. Florida received more than a million dollars.

Health Management Associates, LLC

Florida's Attorney General announced a multimillion-dollar settlement with former hospital chain Health Management Associates, LLC (HMA). The settlement resolves allegations that during the period of 2003 through 2011, two HMA hospitals, Charlotte Regional Medical Center and Peace River Medical Center, billed the Florida Medicaid program for services referred by physicians to whom HMA provided remuneration in return for patient referrals.

According to an investigation by the Medicaid Fraud Control Unit, Charlotte Regional provided a local physician group with free office space and staff, as well as direct payments, that purportedly covered over-head and administrative costs incurred by the group for its management of a Charlotte Regional physician in an effort to induce patient referrals. HMA also provided another local physician with free rent and upgrades to his office space.

The investigation resulted from a qui tam action filed in 2014 in the United States District Court for the Middle District of Florida under the federal False Claims Act. HMA paid $5.54 million in restitution and other recoveries to the State of Florida to resolve these civil allegations.

AmerisourceBergen Corporation

Florida's Attorney General announced a $625 million multistate and federal settlement with a major pharmaceutical distributor. The settlement resolved allegations that AmerisourceBergen Corporation (ABC) introduced adulterated drugs into interstate commerce. As a result, ABC, a Delaware corporation headquartered in Chesterbrook, Pennsylvania, paid the states and the federal government $625 million dollars—including nearly $100 million going directly the state Medicaid programs. AmerisourceBergen Corporation paid $4.9 million in restitution and other recoveries to the State of Florida to resolve these civil allegations.

As part of the massive national litigation, ABC subsidiary AmerisourceBergen Specialty Group (ABSG) pled guilty to illegally distributing misbranded drugs. ABSG is the parent entity for companies in the specialty pharmaceutical market, including biotechnology and oncology, in addition to pharmaceutical manufacturers and providers. ABSG agreed to pay $260 million in criminal fines and forfeitures.

The national federal and state civil settlement resolved allegations concerning conduct of a purported pharmacy ABSG opened in Dothan, Alabama named Medical Initiatives, Inc. (MII). MII pooled vials of oncology supportive care drugs used during chemotherapy to create Pre-filled Syringes (PFS) to sell to practitioners. The drugs involved in the scheme include Aloxi®, Anzemet®, Kytril®, Neupogen®, Procrit®, as well as the generic version of Kytril®. The investigation revealed that MII was not a pharmacy, but a repackager, and as such, required to apply for a New Drug Application (NDA) for the PFS. To prepare the PFS, MII broke the seal of the FDA-approved drug vials and repackaged them into plastic syringes that allowed MII to sell the excess drug product in the vials, known as overfill. The PFS that were prepared in an unsterile environment and often contained particles of foreign matter, were then shipped to providers through another branch of ABSG, Oncology Supply Company.

MII was neither a pharmacy in producing and selling the PFS nor did it comply with pharmacy regulations in any state where it was licensed. Additionally, since there was no new NDA, the drugs were unapproved by the FDA and adulterated, therefore not eligible for reimbursement by government healthcare programs. The civil settlement also resolved double billing for the same vial of drug as a result of using the overfill drug product and unlawful kickbacks provided to physicians to induce them to purchase Procrit® in PFS rather than vials.

The investigation resulted from three qui tam actions originally filed in 2010, 2012 and 2014 in the United States District Court for the Eastern District of New York under the federal False Claims Act and various state false claims statutes.

A National Association of Medicaid Fraud Control Units Team participated in the investigation and conducted the settlement negotiations with ABC on behalf of the states. The Team included representatives from the Offices of the Attorneys General for the states of California, Florida, Illinois, New York and Oregon.

Victoria Hoseah

Florida's Medicaid Fraud Control Unit arrested a former care facility employee for allegedly neglecting a disabled patient. Acting on a referral from the Florida Department of Children and Families, MFCU investigators discovered that Victoria Hoseah failed to properly oversee the well-being of a Medicaid patient while on duty. The investigation revealed that Hoseah, 26, slept in a break room while the disabled patient crawled down a facility hallway.

According to the investigation, Hoseah went to a break room along with two other colleagues and fell asleep. A visiting staff member found Hoseah's patient crawling on the floor in the hallway. Other staff members helped return the patient to his room. The primary care physician examined the patient after the incident and discovered a minor bruise, though it is not conclusive if the incident caused it. One week later, the patient's health declined. The patient needed to be placed in hospice care in another facility. The patient passed away in December 2018.

Hoseah worked at Dorchester Cluster, an intermediate care facility for the developmentally disabled. Hoseah's main task focused on providing personal support to a 60-year-old disabled patient while on duty. The patient's diagnosis consists of intellectual disability, diabetes, high blood pressure, reflux disease and other severe conditions. The patient required constant supervision from one staff member, as listed on a behavior program sheet.

Hoseah is charged with one count of neglect of a disabled adult, a third-degree felony. The Leon County Sheriff's Office assisted in this case.

Evelyn Rankin, Amber Griffith, and Leaundra Jones

The Attorney General's Medicaid Fraud Control Unit (MFCU) announced the arrests of three individuals for exploiting elderly persons and disabled adults. According to the investigations, all three defendants separately stole thousands of dollars from the bank accounts and trust funds of eight elderly and disabled Floridians. The MFCU launched all three investigations after receiving tips from the Florida Department of Children and Families Adult Protective Services.

According to one investigation, Hillsborough County resident Evelyn Rankin used a power of attorney form to transfer $25,000 from an elderly victim's annuity fund into a personal checking account. Rankin moved the money into another personal checking account and then a personal savings account, before using the funds to obtain a cashier's check to pay off a car. MFCU worked with the Hillsborough County Sheriff's Office to arrest Rankin on one count of exploitation of an elderly person or disabled adult, a second-degree felony. Rankin will be transported to Escambia County to face the charge.

In a similar case, MFCU and the Okaloosa County Sheriff's Office arrested Okaloosa resident Amber Griffith on one count of exploitation of an elderly person. Investigators discovered that Griffith used power of attorney to spend more than $31,000 of the victim's money. Griffith's expenditures included taking out more than $8,000 in cash withdrawals, rent payments, utilities and medical bills.

MFCU also worked with the Escambia County Sheriff's Office to arrest Escambia resident Leaundra Jones for exploiting six male group home residents. Jones served as the group home manager for the victims. Combined, the defendant used more than $6,000 of the victims' personal funds to purchase women's clothing, children's items and multiple personal lunches. Jones faces a third-degree felony charge of exploitation.

Armando Gonzalez

Florida's Medicaid Fraud Control Unit and the Miami-Dade Police Department arrested a Miami man for defrauding the Medicaid program. According to the investigation, Armando Gonzalez, 57, worked as a targeted case manager at New Beginning Case Management Agency, LLC., located in the City of Hialeah. As a targeted case manager, Gonzalez assisted Medicaid recipients in gaining access to needed educational, medical, and social services—with the goal to optimize the functioning of patients with complex needs. Unfortunately, the defendant cataclysmically neglected to perform these duties in the best interest of Medicaid recipients.

As a case manager, Gonzalez managed the facilitation of specific treatment plans for appropriate care and service to patients. Gonzalez is alleged to have created fraudulent progress notes in patients' files to make it appear that he rendered services to Medicaid recipients.

The MFCU began investigating the agency after receiving a complaint by an anonymous caller, stating the agency billed Medicaid for services not rendered. As a result of the investigation, investigators discovered Gonzalez fraudulently billed Medicaid more than $9,500.

Gonzalez was convicted of Medicaid fraud and grand theft, both third-degree felonies. He was sentenced to three years' probation and ordered to pay $9,084 in restitution. The Attorney General's Office of Statewide Prosecution is prosecuting this case.

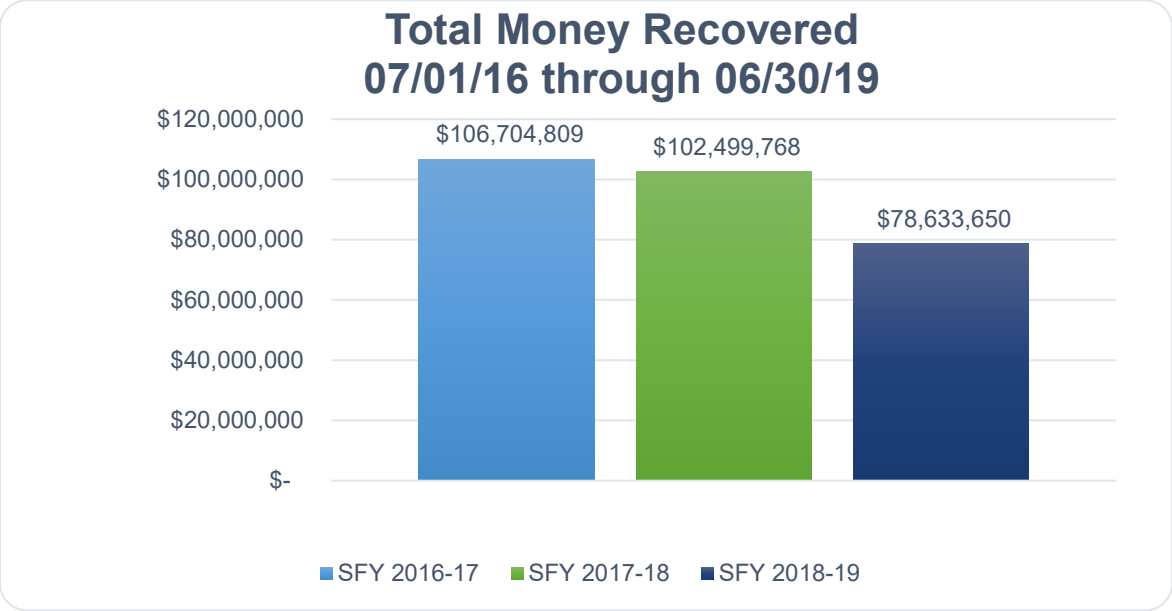
Total Recoveries

The MFCU recovers funds in both civil and criminal cases. The MFCU is responsible for enforcement of criminal case dispositions, which may include restitution, fines, and investigative costs.

The MFCU is also responsible for enforcement of the Florida False Claims Act. With the conversion to the Florida Statewide Medicaid Managed Care (SMMC) program, the Civil Enforcement Bureau (CEB) will focus investigative and litigation efforts on more managed care cases against providers and national

suppliers who attempt to defraud the SMMC program. In addition to its role in multi-state nationwide cases, CEB has seen a shift in Medicaid fraud investigations to more Florida-only state cases, Federal court cases with the United States Attorneys' offices where Florida is the only named state, and regional cases with fewer co-plaintiff states.

In FY 2018-19, the total amount for civil recoveries, which include civil settlements arising from qui tam cases brought under Florida's False Claims Act and civil judgments was $50,266,420. The total amount for criminal recoveries based upon Medicaid fraud cases was $28,367,230. The total amount of the monies recovered by the MFCU for FY 2018-19 was $78,633,650.



Training

MFCU continues to emphasize mission critical training to stay professionally current. During FY 2018-19, MFCU staff attended a total of 4,989 hours of training.

The Office of the Attorney General continued to offer many career and personal enhancement training opportunities via webinars, video conferences, and classroom settings. Law enforcement personnel continued to obtain most of their mandatory training for recertification online with the Florida Department of Law Enforcement (FDLE), free of charge. Other courses include training for database searches for FMMIS Claims Analysis, Elder Abuse Investigations, CJIS Certification, and other courses offered by AHCA and the FDLE.

In-house training provided through a variety of delivery methods included courses such as Active Shooter/Threat Awareness Training, Ethics, Blood Borne Pathogen/Infectious Disease Training, and CPR/AED Certification. Classroom and range firearms qualification and Use of Force training was provided to our law enforcement personnel locally by MFCU certified instructors at no cost.

MFCU training in FY 18-19 included Fighting Elder Financial Exploitation, Interviews and Body Language Techniques, Mobile Device Investigations, Prescription Opioids/Opiate Investigations and Overdose Response, Social Media, Open Source Intelligence & Cyber Crime Investigations, Resident Abuse Training Program.

Mandatory training for law enforcement certification included Criminal Justice Officer Ethics, Domestic Violence, Juvenile Sex Offender Investigations and Discriminatory Profiling.

Data Mining

On July 15, 2010, the U.S. Department of Health and Human Services (HHS) Secretary Kathleen Sebelius granted the Florida MFCU a waiver of a portion of 42 CFR 1007.19, allowing Federal Financial Participation (FFP) in data mining activity. Data mining refers to the practice of electronically sorting Medicaid Management Information System's claims through statistical models and intelligent technologies to uncover patterns and relationships contained within the Medicaid claims activity and history to identify aberrant utilization and billing practices that are potentially fraudulent. The waiver, initially granted for a duration of three years, limited the amount of MFCU staff time to be utilized on data mining, and required submission of a detailed plan describing how the MFCU would ensure its data mining efforts were coordinated with and not duplicative of those efforts of the Agency for Health Care Administration. The initial waiver was extended by the Centers for Medicare and Medicaid Services (CMS) through July 30, 2016.

Under 42 CFR §1007.20, MFCU made application on May 18, 2016, through the Department of Health and Human Services, Office of Inspector General (HHS-OIG) to continue data mining. DHHS-OIG granted approval for MFCU to data mine through 06/20/2019 with the data mining efforts coordinated with and not duplicative of AHCA. On September 4, 2019 MFCU was granted a temporary extension to data mine through October 1, 2019.

As of June 30, 2019, the MFCU has submitted 95 data mining projects to AHCA for review and approval. Of the 95 submitted, 69 were approved by AHCA. On June 30, 2019, MFCU had 4 cases in an active status from these projects.

Health Care Fraud Prevention and Enforcement Action Team (HEAT)

In 2013, to maximize the effective investigation and prosecution of Medicaid fraud, the MFCU joined the South Florida Health Care Fraud Prevention and Enforcement Action Team (HEAT) (currently known as the Medicare Fraud Strike Force.) The Medicare Fraud Strike Force is a federal and state strike force created by the Department of Justice (DOJ) and Health and Human Services, Office of the Inspector General (HHS-OIG).

The Medicare Fraud Strike Force harnesses data analytics and the combined resources of federal, state, and local law enforcement entities to prevent and combat health care fraud, waste, and abuse. Strike Force teams currently operate in nine areas: Miami, Florida; Los Angeles, California; Detroit, Michigan; southern Texas; Brooklyn, New York; southern Louisiana; Tampa, Florida; Chicago, Illinois; and Dallas, Texas.

These teams have a proven record of success in analyzing data and investigative intelligence to quickly identify fraud and bring prosecutions. The interagency collaboration also enhances the effectiveness of the Strike Force model. Strike Force teams have shut down health care fraud schemes around the country, arrested more than a thousand criminals, and recovered millions of taxpayer dollars.

The Florida MFCU has been an active participant in the Medicare Fraud Strike Force and achieved a number of convictions and successes during FY 2018-19. The chart below illustrates:

Defendant	Arrest Date	Conviction Date	Sentencing Date	Total Recovery	Prison	Probation
Sampath-Grant Nadira	02/06/18	04/23/18	07/27/18	$ 100.00	18 months	3 years
Mensah John	02/06/18	06/15/18	08/27/18	$ 100.00		3 years
Mencia Andres Julio	02/06/18	06/29/18	09/07/18	$ 250,100.00	78 months	3 years
Lopez Isabel Cristina	03/07/17	05/10/18	10/26/18	$ 425,570.29		5 years
Mustelier Gustavo Enrique	03/07/17	05/10/18	10/26/18	$ 15,713.11		3 years
Hurtado Elaine Giralt	05/07/18	08/17/18	10/30/18	$ 100.00	37 months	3 years
Huici Eusebio	05/07/18	08/31/18	10/30/18	$ 100.00	6 months	3 years
Liva Elaina G	07/05/18	08/15/18	11/01/18	$ 4,980,779.50	24 months	3 years
Liva Christopher M	07/05/18	08/15/18	11/14/18	$ 100.00	48 months	3 years
Chalker Stephen M	06/22/18	09/07/18	11/29/18	$ 300.00	78 months	3 years
Ramirez Rossana P	06/26/18	09/26/18	12/18/18	$ 100.00	46 months	3 years
Ramirez Jr Evelio	06/26/18	09/26/18	12/18/18	$ 7,383,029.02	46 months	3 years
Deluca Robert Ferdinand	10/19/18	11/29/18	02/20/19	$ 5,656.00		2 years
Barcha Odette C	07/22/16	01/23/19	04/03/19	$ 704,616.00	15 months	3 years
Carmouze Arnaldo	07/22/16	01/09/19	04/10/19	$12,590,861.00	80 months	3 years
Kumar Sheetal Kanar	10/11/18	02/15/19	04/19/19	$ 335,210.00	24 months	3 years
Enriquez Derek	03/04/15	05/17/16	08/20/18	$ 15,417.00	6 years	5 years

Medicaid Fraud Reporting Reward Payments FY 2018-19

Under Florida law persons who report Medicaid Fraud (under certain conditions) are eligible to receive a financial reward. During the report period $71,216 was paid pursuant to this law. See s. 409.9203, F.S. (2018).

THE AGENCY FOR HEALTH CARE ADMINISTRATION

Division of Medicaid

The Division of Medicaid administers the Florida Medicaid program, a more than $28 billion state and federal partnership that provides for health care to almost 4 million recipients in Florida. The Division is responsible for overseeing the management and operation of a broad range of health care services offered through Medicaid to low-income families, the elderly, and people with disabilities. Medicaid was implemented as a fee-for-service (FFS) program more than four decades ago and since the beginning, had been primarily a FFS based program. Over the years, enrollment grew rapidly, and costs soared until Medicaid expenditures were more than one-fourth of the state budget. The rapid growth in enrollment and costs made it increasingly important to find ways to manage the diverse needs of the Medicaid population while also being able to better predict and plan for cost increases.

Medicaid's roles and responsibilities have been evolving since it moved away from a completely fee-for-service program and the first Medicaid health plan was established in 1984. Eventually the Medicaid program became a mix of special programs, waiver programs, a FFS population, a FFS primary care case management population (known as MediPass), and a population in prepaid health plans. Between 2013 and 2014, Florida Medicaid implemented the Statewide Medicaid Managed Care (SMMC) program and with it significant program changes resulting in improved efficiency, cost predictability and accountability for the program, and enhanced services recipients.

Upon full implementation of the SMMC program in August 2014, there was a significant shift toward contracting, contract monitoring, and policy-related functions. Previous Agency responsibilities such as prior authorization, utilization management, and program and provider monitoring that occurred under FFS became primarily the responsibility of the health plans. The transition of Medicaid to a predominantly managed care program provided the Agency an opportunity to competitively bid plans, develop contract standards for quality and access, and focus more efforts on monitoring activities which directly impact the Agency's efforts in combatting potential fraud and abuse in the Medicaid program.

During Fiscal Year 2018-19 Medicaid completed re-procurement of the health plans for the next five-year period as well as procuring separate Dental plans as required by the Florida Legislature. Where the original SMMC program had both an MMA and LTC plans (with dental services provided through the MMA plans), under the new contract period, all plans will provide MMA services to their enrollees and any enrollee with both LTC and MMA services needs will receive all of their services from one plan.

The Agency negotiated with both MMA and Dental plans to ensure continuous coordination of care so that the increases in quality of care seen in the initial contract period would continue. This is particularly important for Dental plans so that the large, recent improvements in access to dental services under the Medicaid program will continue to have a significant upward trajectory. In the new contract period, Dental plans agreed to provide a rich adult dental benefit through expanded benefits and the new Dental plans are responsible for providing dental services to all eligible members.

SMMC plans are held to high standards of service, quality, and transparency. These requirements include enhanced provider networks, which help ensure that Medicaid recipients can conveniently, and quickly access health care services. To assist health care providers there are enhanced standards for claims processing, prior authorization, enrollee/provider help line, and call center operations. All of these increased standards help ensure provider and recipient satisfaction are high and that care provided is of the highest quality possible.

The Division of Medicaid has adopted a strategic approach to combatting fraud and abuse. Developing and implementing the SMMC program allowed the Agency to adopt a ground up approach to combat fraud and abuse by embedding control efforts into the transition and future infrastructure of the program.

These strategic control efforts are focused in three key areas including Provider Enrollment/Review, Outreach and Education, and Prior Authorization and Utilization Management.

Provider Enrollment/Review

Prevention of Medicaid Program fraud and abuse begins with thorough screening of incoming Medicaid provider applicants as well as the population of active Medicaid providers. This includes health plans and their provider networks as well as individual FFS (fee-for-service) providers. The Division of Medicaid employs many different strategies to ensure all Medicaid providers are eligible to provide necessary and appropriate health care in a safe and effective environment. All Medicaid providers are required to have a background screening that is conducted through the Care Provider Background Screening Clearinghouse (the "Clearinghouse"). Medicaid also prepares quarterly and monthly reports of terminated Medicaid providers for dissemination to the Medicaid health plans, has taken steps to improve provider accountability, and has increased provider enrollment requirements. In addition to the measures taken to monitor and evaluate all Medicaid health care providers, Medicaid also requires all Medicaid health plans to credential and re-credential all providers in their network using Agency-approved, written criteria.

Centralized Background Screening

Florida Medicaid provider background screenings have been conducted through the Clearinghouse since 2013. The Clearinghouse conducts Level 2 background checks, a state and national fingerprint-based check and consideration of disqualifying offenses, which applies to employees designated by law as holding positions of responsibility or trust. All Medicaid providers, including Medicaid FFS providers and Medicaid health plan network providers, are required to be screened through the Clearinghouse. The Clearinghouse provides a single data source for background screening results of persons required to be screened by law for employment in positions that provide services to children, the elderly, and people with disabilities. Fingerprints are retained in the Clearinghouse for five years, which enables a provider to be automatically notified of an arrest of their employee as soon as the information is reported to the Agency by the FDLE.

Monitoring and Reporting of Terminated Providers

Medicaid collaborates with its health plans to ensure that fraudulent or terminated providers are not illegitimately participating in Medicaid, either by registering again with Medicaid using different information, or by contracting with a Medicaid health plan in an attempt to indirectly participate in the Medicaid program. In doing so, Medicaid identifies providers that have been terminated by the Agency for fraudulent behavior and informs the health plans that these providers are ineligible to participate in the plan's networks. Medicaid also evaluates providers that have at some point in the past been linked to a provider terminated for fraudulent activity. The Agency researches this information to make sure that active providers have the clearance to participate in the Medicaid program.

Provider Accountability and Increased Provider Enrollment Requirements

The Bureau of Medicaid Fiscal Agent Operations (MFAO) is responsible for reviewing eligibility for all Medicaid provider initial and renewal applications, including compliance with state and local license regulations, fingerprinting, and searches of federal and state exclusion databases. Enhanced screening is required for applicants with criminal records, prior denials, sanctions, terminations, or exclusions from Medicare or Medicaid, adverse licensure actions, overpayment or sanction monies owed to Medicaid, changes of ownership, or suspended payments. On-going provider eligibility and compliance activities aid the Division of Medicaid in better screening and monitoring of Medicaid providers and include:

- **Provider Risk Factors** - All applicants to Medicaid are evaluated and scrutinized based upon their assigned risk factor. The provider type and any adverse history, including previous denials and terminations, loss of or discipline on a license, criminal history, and money owed to the Agency, determine if a provider presents a limited, moderate, or high risk of fraud and abuse. Fraud prevention protocols involve offering research and guidance on new enrollments and re-enrollments of providers with escalated risk factors or other anomalies discovered in the application process. Medicaid staff utilize internal and external research tools to identify such anomalies and make recommendations to deny or terminate high risk providers to minimize possible fraud and abuse to the Medicaid program.

- **In-Person Provider Review** - Provider types that are deemed to be a moderate or high risk for fraud and abuse must be reviewed in person by Medicaid staff prior to enrollment in the program unless they undergo an alternative thorough national credentialing review

- **License Verification** – Medicaid verifies the status of providers' practitioner and facility licenses through an automated process that compares license data on provider records with data in the Agency's Division of Health Quality Assurance (HQA) and the Department of Health (DOH) license databases. All initial and renewing applicants are verified upon submission of their applications and active providers are verified on a daily basis thereafter. Providers who have lost active license status are immediately restricted for claims processing and a system generated letter is produced to notify them of the action.

- **License Compliance** – The Agency holds weekly coordination meetings between Medicaid, the Division of HQA, Medicaid Program Integrity (MPI), and the DOH to ensure a timely response when action is taken against a provider's license. Medicaid staff review all Agency and DOH final orders related to licensure actions including emergency restriction, suspension, and revocation orders related to licensee misconduct, in an effort to identify connections between the affected license holders and other providers. Based on the nature or characteristics of the license violation, Medicaid staff take the appropriate action to terminate or exclude the provider and all related providers from the program.

- **Identifier and Exclusion Verification** – Medicaid conducts automated verification of National Provider Identifiers (NPI) and excluded entities or individuals. Data from the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals and Entities (LEIE), the System for Awards Management (SAM), and Medicare's Provider Enrollment Chain Ownership System (PECOS) are uploaded to the Florida Medicaid Management Information System (FLMMIS). All new and renewing applicants are matched against the databases upon application, and all active Medicaid providers are matched against these sources monthly. This check ensures all providers have a valid NPI on their file and that no excluded entity or individual is enrolled in Medicaid.

- **Interoffice Communication** - Medicaid staff serve as a liaison between MPI, MFCU, HQA, DOH, APD, Medicaid health plans, and other federal and state regulatory departments with regard to provider enrollment and eligibility. Constant communication between these entities supports the Agency's ability to monitor provider eligibility and compliance.

- **Outside Referrals** – Medicaid staff routinely analyzes data obtained from investigations conducted by MPI, MFCU, other units within the Division of Medicaid, Medicaid health plans, and other agencies, to identify any relationships between the Medicaid providers terminated for misconduct and the list of active providers. Medicaid uses these analyses and consideration of any adverse history to make referrals to MPI to seek sanctions by Final Order, recommend contractual termination from Medicaid of a related provider, or recommend denial of enrollment.

Medicaid Health Plan Contract Requirements for Provider Credentialing

Beyond the activities carried out by the Agency for all providers, under the SMMC program each health plan is also responsible for the credentialing and re-credentialing of its provider network. The plans are responsible for:

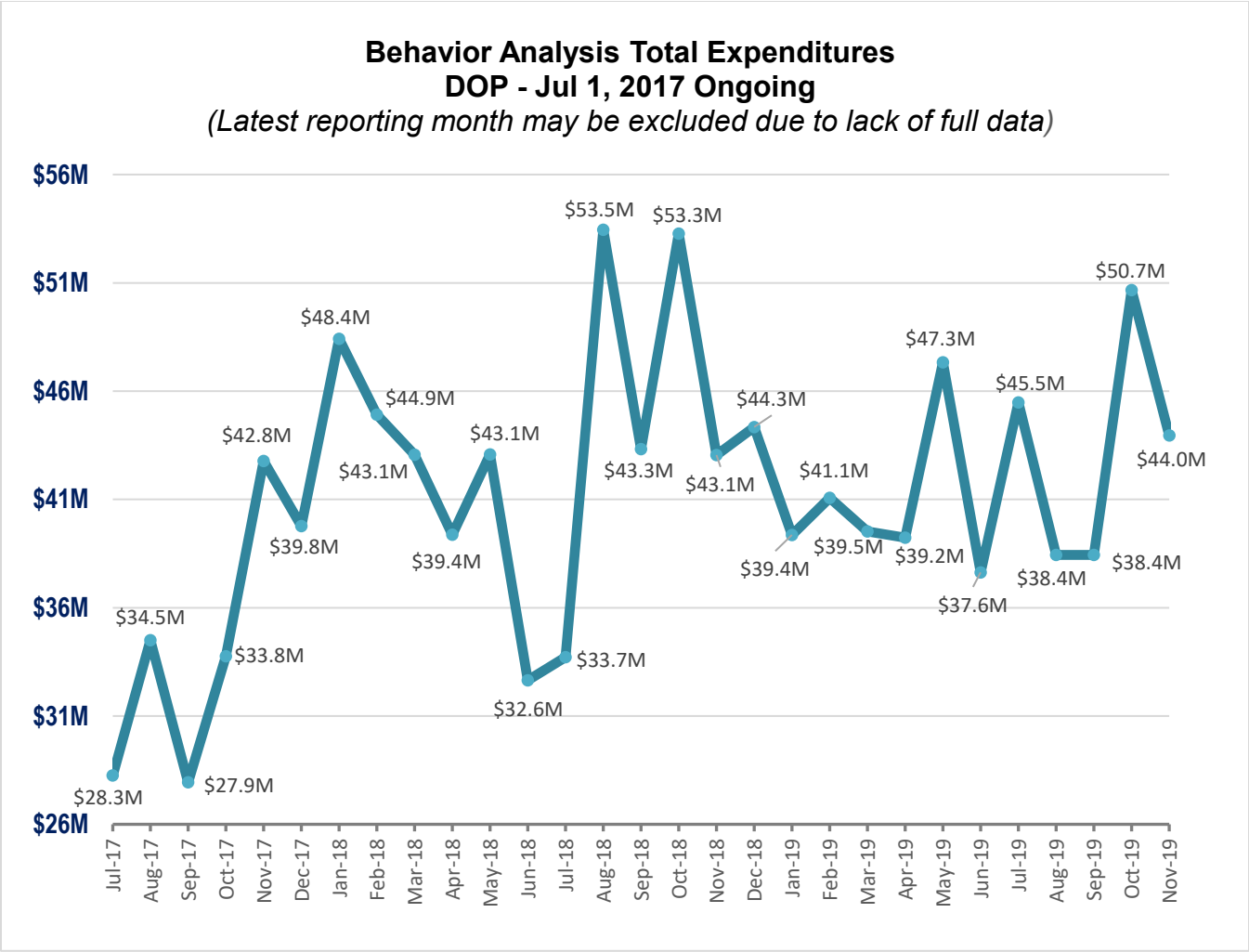
- Ensuring that all providers are eligible for participation in the Medicaid program;
- Using the CAQH app ProView® application throughout the life of the contract to collect data from providers;
- Ensuring all providers have a current provider agreement with the Agency;
- Fully enrolling/on-boarding all new providers within 60 days;
- Terminating a network provider immediately upon notification from the state that the network provider cannot be enrolled; and
- Requiring that each provider have a NPI number.

Behavior Analysis (BA) Services Providers Enhanced Review

The Agency continues to focus efforts on ensuring that medically necessary behavior analysis services are provided to recipients by appropriate and effective providers.

The Agency has taken multiple steps to address concerns related to the provision of Behavior Analysis (BA) services. The Agency required all Registered Behavior Technician (RBT) BA providers to provide proof of RBT certification by December 31, 2018. All RBT providers who did not provided documentation of RBT certification were placed on prepayment review (i.e., are suspended from receiving reimbursement from the Medicaid program) and were terminated from the Medicaid program if they could not provide proof of certification. The Agency also requested and received approval from CMS to extend the moratorium on enrollment of new BA group providers and individual providers practicing independent of a group in Miami-Dade and Broward counties for an additional six-month period on November 1, 2019. The extension will end in May 2020. Finally, on December 1, 2019, the Agency initiated a soft-launch of an electronic visit verification (EVV) system for BA services as a pilot in southeast FL (Regions 9, 10, and 11) for all BA services, except assessments and reassessments. Electronic Visit Verification, or EVV, is a system which tracks arrival and departures of health care providers who provide care at a recipient home or other non-office site. This will allow providers to begin to use the system and all functionality (e.g., scheduling visits, checking in/out, handling exceptions, etc.), or providers may continue submitting claims as they do today. The anticipated mandatory launch date will be no earlier than March 1, 2020. After this date, all BA providers delivering services to recipients who reside in Regions 9, 10, 11 will be required to bill through the EVV system.

While BA expenditures increased significantly during the 2017-18 fiscal year, the Agency has begun to see a decline during the 2018-19 fiscal year and beyond.



Terminations of Behavior Analysis Providers

Rigorous reviews of active Behavior Analysis providers by Medicaid Program Integrity and the Provider Eligibility and Compliance Unit (PECU) led to a high volume of terminations within this program. Prior to enrollment, risk assessments conducted by PECU led to a high volume of denials of applications into this program. During Fiscal Year 2018-19, 645 Behavior Analysis providers were terminated from Medicaid and 654 BA providers were denied enrollment in Medicaid.

Fraud and Abuse Related Reporting Requirements

SMMC Health Plan Fraud and Abuse Related Reporting Requirements

Health plans in Florida Medicaid have comprehensive reporting requirements related to every phase of their operations. These reports allow the Agency to monitor not only provider networks, but also monitor several important phases of care provided by the plans. These reports help the Agency ensure that care provided to Medicaid recipients is medically necessary and appropriate, while ensuring cost-effectiveness and preventing inappropriate utilization.

Plans are required to report their Provider Network File, Provider Termination File, and New Provider Notification Report weekly. These reports supply the Agency with up-to-date provider network information including information on the suspension, termination, or withdrawal of providers from participation in the plan's network. This allows the Agency to monitor plans' compliance with required provider network composition, provider-to-member ratios, and allows for other uses deemed pertinent. Plans are required to provide pre-notification to the Agency within five days of detection of any suspected

fraud and abuse activity by a provider or enrollee, with a report due to the Agency within 10 days. The report must contain detailed information on the nature of the fraud and abuse. Plans must also provide quarterly and annual fraud and abuse activity reports.

Provider Outreach and Education

Communication and understanding are key elements in helping to prevent fraud and abuse. Understanding how the program works, the roles and responsibilities of all participants, and what the rules and regulations are that govern the program, can help significantly reduce errors, misunderstandings, and problems that can lead to fraud and abuse. Medicaid offers many educational resources to providers and, as part of the contractual agreement with all health plans, the plans are responsible for providing education and training to their network providers to prevent fraud and abuse and have a monitoring plan in place for fraud prevention. The following highlights some of the education, training, and outreach efforts conducted by Medicaid for providers.

Program-Wide Provider Education

Medicaid maintains a Provider Services portal on its website to assist providers with the many facets of navigating the Medicaid system. This includes a Provider Enrollment Help Line, registration for local trainings, and information on filing claims and many other reference materials. Providers routinely receive information about topics, training dates, and how to access upcoming training opportunities via the electronic Medicaid Provider Alert system.

Health Plan Education and Training Requirements

Health plans are required to provide education and training to ensure providers in their provider network understand all required performance criteria. This includes training all providers and their staff regarding the requirements of the SMMC contract and special needs of enrollees. The plan is required to conduct initial training within 30 days of placing a newly contracted provider, or provider group, on active status. The provider or provider group also must conduct ongoing training, as deemed necessary by the plan or the Agency, in order to ensure compliance with program standards.

The plan is also required to provide training and education to providers regarding the plan's enrollment and credentialing requirements and processes, and for one year following the implementation of the contract must provide monthly focused training on monitoring, QI processes, claims submission and payment processes. The plan is required to conduct monthly education and training for providers regarding claims submission and payment processes, which has to include at minimum, an explanation of common claims submission errors and how to avoid those errors.

Each plan is also required to provide details and educate employees, subcontractors, and providers about the following as required by s. 6032 of the federal Deficit Reduction Act of 2005:

- The Federal False Claims Act;
- The penalties and administrative remedies for submitting false claims and statements;
- Whistleblower protections under federal and state law;
- The entity's role in preventing and detecting fraud, abuse, and waste;
- Each person's responsibility relating to detection and prevention; and
- The toll-free state telephone numbers for reporting fraud and abuse.

Utilization Management

Utilization management ensures that Medicaid recipients receive high quality health care that is necessary and appropriate. By implementing appropriate utilization controls, the Agency is able to safeguard against inappropriate or unnecessary services and protect against excess payments, while also being able to establish and apply quality standards which can be used to assess and monitor the care provided. Managing and monitoring utilization of services is an important protection against potential fraud and abuse.

Florida Medicaid has historically employed several methods for utilization management including: several disease management initiatives and programs, a pharmaceutical Preferred Drug List, prior authorization of certain services, and Medicaid claims analysis, as well as independent research to assess policy implementation and program performance. With the implementation of Statewide Medicaid Managed Care, most of the responsibility for utilization management belongs to the Medicaid health plans. However, the Agency continues to have a significant role in monitoring plan activities. The Agency also oversees vendors who provide utilization management for the remaining fee-for-service population, which, while consisting mainly of limited benefit eligibility groups, also includes certain high need groups such as those enrolled in the iBudget waiver, certain children receiving Prescribed Pediatric Extended Care (PPEC) services, and those receiving Medicaid services through the Medically Needy program. The following sections provide a brief overview of the utilization management efforts in Florida Medicaid.

Program-Wide Utilization Management

Medicaid Preferred Drug List (PDL)

The PDL is a tool that has been widely used by both public health plans such as Medicare and Medicaid as well as private health plans. The PDL provides a list of safe and effective drugs that can be used to treat patients with specific diagnoses. This has the advantage of allowing providers to prescribe drugs that are known to be effective while helping to constrain costs. Medicaid health plans as well as fee-for-service providers must adhere to the Medicaid PDL, though providers may request drugs not on the PDL when medically necessary. Florida Medicaid's PDL typically provides enough alternatives to allow several options to meet recipients' needs. Medicaid has a Pharmaceutical and Therapeutics Committee that makes recommendations to the Agency for the purpose of developing and maintaining the Florida Medicaid PDL. The committee performs ongoing scheduled review of the PDL with continued updating of prior authorization and step therapy protocols for drugs not on the PDL. The committee may recommend prior authorization protocols for Medicaid-covered prescribed drugs to ensure compliance with clinical guidelines, for indications not approved in labeling, and for prevention of potential overuse, misuse, or abuse.

Data Analysis

Data analysis of health services provided to Medicaid recipients is another tool that Florida Medicaid uses to evaluate utilization of services. This analysis can provide information to assist with the development of treatment guidelines and policies. Florida Medicaid collects claims data for fee-for-service recipients and encounter data for provider/enrollee health service interactions in Medicaid health plans. Medicaid collects individual level encounter and claims data related to levels of care, resource use, costs, and other data elements. This in turn allows the Agency to conduct data-based plan performance analyses.

Part of the data analyses includes how each plan makes fraud/waste/abuse recoveries once a payment has been made. Understanding these processes provides additional data to better understand and interpret the performance analysis findings.

SMMC Health Plan Utilization Management

SMMC Contractual Provisions and Plan Responsibilities

Utilization management in Statewide Medicaid Managed Care is primarily the responsibility of the Medicaid health plans. The Agency's contracts with the health plans require that each plan have a utilization management program in place. Each health plan's utilization management program must be reflected in a written Utilization Management Program Description and include, at minimum:

- Procedures for identifying patterns of over-utilization and under-utilization of services and for addressing potential problems identified as a result of these analyses;

- Procedures for reporting fraud and abuse information identified through the Utilization Management program to the MPI;

- Procedures for enrollees to obtain a second medical opinion at no expense to the enrollee and for the plan to authorize claims for such services; and

- Protocols for prior authorization and denial of services; the process used to evaluate prior and concurrent authorization; objective evidence-based criteria to support authorization decisions; mechanisms to ensure consistent application of review criteria for authorization decisions; consultation with the requesting provider when appropriate; hospital discharge planning; physician profiling; and retrospective review, meeting predefined criteria. The plan is responsible for ensuring the consistent application of review criteria for authorization decisions and consulting with the requesting provider when appropriate.

The health plan has to ensure that applicable evidence-based criteria are utilized with consideration given to characteristics of the local delivery systems available for specific members as well as member-specific factors, such as member's age, co-morbidities, complications, progress in treatment, psychosocial situations, and home environment. The health plan must also ensure that reimbursement for utilization management activities is not structured in such a way that it provides incentives for the denial, limitation, or discontinuation of medically necessary services to any enrollee.

As part of their overall utilization management system, health care plans are required to have automated authorization systems and may not require additional paper authorization as a condition for providing treatment. The health plan's service authorization systems must provide written confirmation of all denials, service limitations, and reductions of authorization to providers, the authorization number, and effective dates for authorization to providers and non-participating providers. The health plan cannot delay service authorization if written documentation is not available in a timely manner, but the plan is not required to approve claims for which it has received no written documentation. As part of the authorization system, health plans are required to have a toll-free provider help line that must be staffed 24 hours a day, seven days a week to respond to prior authorization requests.

The health plans have seven days in which to notify the enrollee, provider, and Agency if a service is denied. They are also required to develop comprehensive practice guidelines which are based on valid and reliable clinical evidence, or a consensus of health care professionals in a particular field and consider the needs of the enrollees. They are required to review and update the guidelines to ensure the care remains appropriate and are required to disseminate any changes in a timely manner. The Agency must be given at least 30 days written notice before the plan makes any changes to the administration, management procedures, authorization, denial, or review procedures.

Medicaid Fee-for-Service Utilization Management

The following section discusses specific aspects of utilization management for services provided through the FFS delivery system. It is important to note that, although denial rates for services may appear low, utilization management of a service also has the effect of instructing providers on what services are allowable and medically necessary. Over time, this deters providers from submitting prior authorization requests for services they know will not be approved because they are medically unnecessary. Thus, in a mature utilization management program, denial rates for services are typically low, but it continues to prevent unnecessary services.

Pharmacy Claims Processing

There are several activities that Medicaid has undertaken to ensure that Medicaid pharmacy services provided to the fee-for-service (FFS) population are both appropriate and cost effective. Medicaid also has point-of-sale monitoring available to track medication usage and has thousands of claims edits in place to automatically prevent inappropriate expenditures. The system of automated claim edits is

continuously refined and improved to support safe prescribing, adherence to the Preferred Drug List, and prevention of fraud and abuse. In FY 2018-19, the contracted prescription benefit manager vendor processed more than 1.9 million fee-for-service pharmacy claims, almost 159,000 per month.

Medicaid contracts with the Florida Mental Health Institute (FMHI) at the University of South Florida to develop and disseminate best practice guidelines for behavioral health drug therapy. FMHI recommendations provide specific efforts for the different needs of adults and children, coordination of care for behavioral health drug therapy management, improved patient and provider education, compliance with drug therapies and improved outcomes.

Many of the Medicaid recipients who are not enrolled in Medicaid health plans have special needs and there is a high demand for several services that Medicaid provides. Medicaid has contracted with several specialized vendors to provide prior authorization and utilization management for many of the remaining FFS services. Prior authorization efforts for two of the services with high demand, home health services and pharmacy benefits, are highlighted in the following sections. Private Duty Nursing and Personal Care Services are two more FFS services that require prior authorization and are discussed under Utilization Management below.

Pharmacy Prior Authorization

The Florida Medicaid FFS pharmacy program ensures quality and cost-effective pharmacy practices. The combination of cost containment programs and preferred drug policies minimize expenditures and contribute to maximization of drug rebate collections. System driven edits and prior authorization procedures ensure that Medicaid recipients have access to needed medications while program costs are controlled, and fraud and overutilization are minimized. The claims processing system has thousands of payment system "edits" that use a cost avoidance philosophy to prevent inappropriate expenditure of Medicaid funds. These "edits" prevent payments for what could be characterized as abusive practices. The payment system's edits promote utilization of generic drugs, appropriate age and gender restrictions, drug utilization reviews (such as high dose, therapeutic duplication, and early refills), coverage limits, and prevent duplicate paid claims.

Authorization prior to reimbursement for certain drugs continues in FFS pharmacy. Clinical criteria and some edits (such as age limits and quantity limits) have been established for certain drugs to ensure safe and appropriate prescribing. The Agency's contracted pharmacy benefits manager, Magellan Rx, a federally designated Quality Improvement Organization-like vendor, reviews prior authorization requests for drugs not on the Preferred Drug List and determines whether a request is to be approved or denied.

The following chart shows the total number of prior authorization requests received in FY 2018-19 for the Medicaid FFS pharmacy program.

Pharmacy Prior Authorization Requests FY 2018-19		
Total Prior Authorization Requests	12,598	100.0%
Average Per Day	35	--
Total Requests Approved	10,467	83.1%
Total Requests with Change in Therapy	2,050	16.3%
Total Requests Denied	81	0.6%

Other prior authorization activities include, but are not limited to:

- HIV/AIDS drug product initiatives which provide safeguards against contraindicated regimens;
- Controlled substance initiatives which limit the number of controlled substances allowed depending on diagnoses;
- Oral oncology product initiatives to ensure proper utilization of these agents through clinical prior authorization review, quantity, and age limits.

Utilization Management of Home Health Services

The Agency contracts with Centric Consulting, Inc. as the vendor for continuation of home health electronic visit verification (EVV) services from FY 2017-18 through FY 2020-21. The primary purpose of the EVV contract is to verify the utilization and delivery of home health services using technology that is effective for identifying delivery of the service and deterring fraudulent or abusive billing for the service. EVV provides an electronic billing interface and requires the electronic submission of claims for home health services. This helps ensure appropriate utilization and expenditures for Medicaid home health services, improves the quality of care for Medicaid recipients, and prevents Medicaid fraud, abuse, and waste. EVV includes monitoring of all home health services (i.e., home health visits, private duty nursing, and personal care services).

Home Health Visit Prior Authorization

One of the primary areas, in addition to inpatient hospital services, where Medicaid continues prior authorization for FFS recipients is for home health services. The Agency's vendor, eQHealth Solutions, Inc. (eQHealth), conducts prior authorization for home health services to ensure that the proposed services are medically necessary and appropriate.

Medicaid reimburses for home health services that are rendered by licensed, Medicaid-participating home health agencies and Medicaid enrolled independent personal care providers. Medicaid reimburses for the following services:

- Home visit services provided by a registered nurse or a licensed practical nurse;
- Home visits provided by a qualified home health aide;
- Private duty nursing for children age 20 or younger; and
- Personal care services for children age 20 or younger.

During FY 2018-19, eQHealth conducted 9,720 home health prior authorizations, an average of 810 per month. Of these, 9,372 were approved, giving a denial rate of 3.6 percent. The following table shows the total number of home health prior authorization requests, approvals, denials, and denial percentage for each month during FY 2018-19. Note that in addition to being approved or denied, requests may also be pended for more information, held for additional review because of new information received, still be under reconsideration, or could also be awaiting a fair hearing.

Comprehensive Care Management for Children with Special Health Care Needs

The Agency has also included Comprehensive Care Management in its contract with eQHealth, Inc., which provides utilization management and care coordination for home health visits, private duty nursing, personal care services, prescribed pediatric extended care (PPEC) services, and inpatient medical and surgical services. The purpose is to improve care coordination and to identify potential overutilization and fraud or abuse of Medicaid services by ensuring that the level of home health aide and private duty nursing services provided to recipients receiving home health care matches the needs of the recipients. During FY 2018-19, the vendor conducted 1,059 home visits and 5,851 care coordination visits and team meetings.

The vendor provided the Agency with a utilization report of the home health agencies that routinely submit requests that are well above the average for their area. This information is reviewed by MPI to determine if an investigation is needed. The following are the results for FY 2018-19:

Comprehensive Care Monitoring FY 2018-19 Statewide		
1,059 Total On-Site Home Visits to Recipients		
Requests Fully Approved	829	78.28%
Requests Fully Denied	15	1.42%

Partially Approved Requests	180	17.00%
Reconsideration is Complete	35	3.31%
At Fair Hearing	0	0.00%
At Reconsideration	0	0.00%

Ancillary Medicaid and Other Services

The Agency contracts with eQHealth for comprehensive utilization management of several ancillary Medicaid services, as well as hospital inpatient services for the FFS population. The utilization management efforts of eQHealth include medical consultation regarding the necessity and scope of services, data analyses, and monitoring of selected cases, to ensure Medicaid does not pay for targeted services in the following categories that are not covered or are not medically necessary:

- Chiropractic;
- Dental;
- Durable Medical Equipment;
- Inpatient Hospital Services;
- Physician Outpatient Surgery;
- Physician Services;
- Podiatry;
- Special Services for Children; and
- Vision and Hearing.

Outpatient Advanced Diagnostic Imaging

The Agency contracts with eQHealth, to perform prior authorization utilization management of outpatient diagnostic imaging services. The vendor utilizes real-time predictive modeling and evidence-based criteria in the decision-making process. This prior authorization utilization management process facilitates increased efficiency and cost effectiveness and ensures that Medicaid recipients receive the most clinically appropriate advanced imaging services according to approved clinical guidelines. Advanced diagnostic imaging procedures include:

- Three-Dimensional Imaging (3D);
- Computerized Tomography (CT);
- Computerized Tomography Angiography (CTA);
- Magnetic Resonance Imaging (MRI);
- Magnetic Resonance Angiography (MRA); and
- Positron Emission Tomography (PET).

Outpatient Diagnostic Imaging Prior Authorization Requests FY 2018-19		
PA Requests Received	22417	--
Ineligible for Review	3524	15.7%
Completed Reviews	17541	78.2%
Referred for Physician Review	862	4.71%
Reviews Denied	101	0.57%

BA Services Utilization Management

Before providing BA services to Medicaid recipients, and at least every 180 days thereafter, providers must obtain authorization from eQHealth Solutions. Providers may request authorization more frequently if the recipient's condition changes so that an increase or decrease in services is required. The following tables show the number of prior authorizations for BA treatment services and assessment services during SFY 2018-19.

Prior Authorization for BA Treatment Services		
PA Status	Total Recipients	Percent of Total
Approved	14,829	90.70%
Partially Approved	1,141	6.98%
Denied	380	2.32%
Pending Provider Info	10,478	--
Fair Hearings	148	--

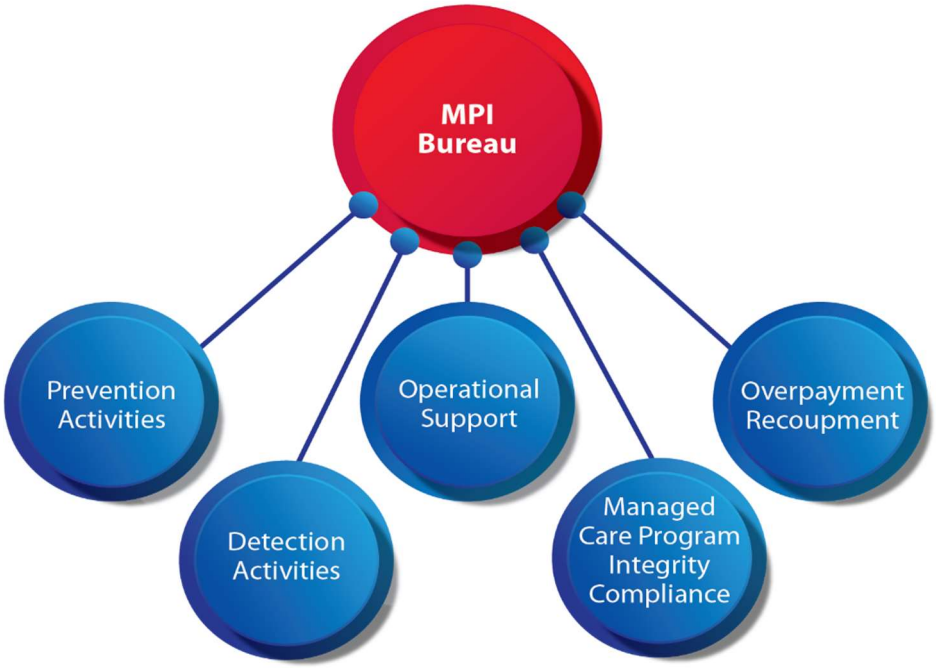
Prior Authorization for BA Assessment Services		
PA Status	Total Recipients	Percent of Total
Approved	16,546	94.98%
Partially Approved	0	0.00%
Denied	874	5.02%
Pending Provider Info	10,972	--
Fair Hearings	111	--

During SFY 2018-19 Medicaid paid for BA services for 18,213 unique recipients totaling more than $500 million.

Medicaid Program Integrity

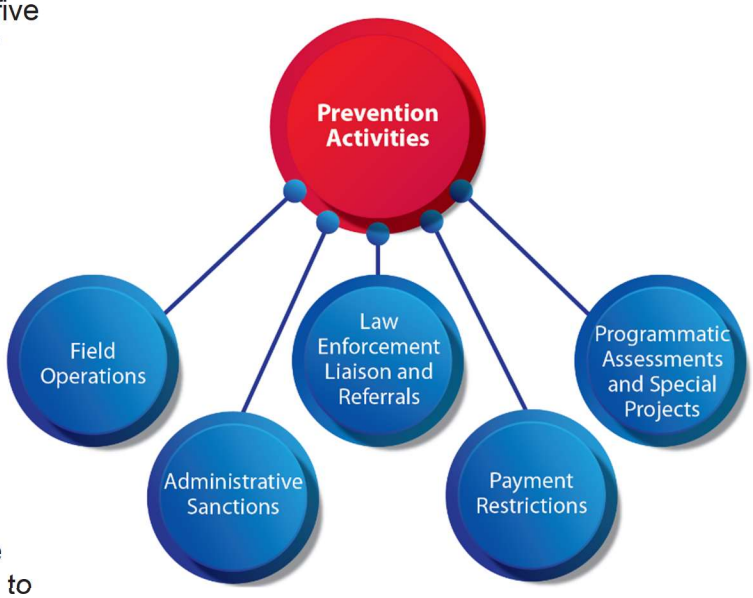
The Agency for Health Care Administration is required, pursuant to s. 409.913, Florida Statutes (F.S.), to operate a Medicaid provider oversight program to ensure that fraudulent and abusive behavior occurs to the minimum extent possible in the Medicaid program. The Agency's Bureau of Medicaid Program Integrity (MPI) continues to serve as the lead office to design, coordinate, and implement the Medicaid program's fraud, abuse, and waste prevention and detection efforts. In recent years, MPI efforts have been focused on provider *behavior*. MPI has expanded efforts over the past several years to look beyond Medicaid claims, incorporating risk-based approaches to address suspected fraudulent and abusive behavior.

MPI's organizational structure by functions is depicted below and is detailed in the sections which follow.



Prevention

The Prevention Units are responsible for five main functions related to program integrity prevention activities in Florida Medicaid. Field operations conducts Medicaid provider on-site visits as part of a complaint or case investigation. Staff in three field offices and headquarters conduct activities to achieve cost-savings related to fraud, abuse, and waste in the Medicaid program, including programmatic assessments for developing special projects, which are typically designed by the headquarters team, and carried out by field staff as a joint collaborative effort. Special projects are focused, data-driven, field initiatives designed to address identified program needs and vulnerabilities and may include various state and federal regulatory agencies to increase efficiency and on-going information-sharing efforts.



Other prevention activities include prepayment reviews; administrative investigations for the imposition of sanctions, payment restrictions, and/or law enforcement referrals; law enforcement liaison activities with state and federal partners; communications with the Medicaid managed care plans focused on collaborative and research efforts related to fraud and abuse prevention, and early detection; and project development for potential audit referrals to other MPI units. The Prevention Unit's activities also include providing guidance, research, and support to the Division of Medicaid to prevent enrollment of fraudulent and high-risk providers, coordinating with Agency's health care facility licensing regarding licensure actions that affect Medicaid participation, and assessing MPI processes to ensure that MPI continuously engages in quality improvements.

Prevention Units are heavily involved in activities pertaining to oversight, reviews, investigations, and enforcement activities regarding several high-risk provider types. MPI personnel continued to work closely with the Division of Medicaid, collaborating on known and anticipated program vulnerabilities; details of these efforts are explained in a separate section of this report.

Calculating Return on Investment through Prevention Measures

While prevention activities are considered to be the most cost-effective approach to combatting fraud, abuse, and waste, the value of fraud prevention is often difficult to calculate. If the amount of the loss that was prevented is known, it has historically been calculated and reported as a part of the cost avoidance or prevention return on investment (ROI). For example, the value of a Medicaid claim for reimbursement found to be improper and denied before payment is processed, has a quantifiable value (the value of the claim). However, the value of most prevention activities is not easily calculated. Often, these efforts are not valued or are undervalued for purposes of measuring ROI. MPI has prioritized the evaluation of prevention values for many prevention activities, such as provider education, programmatic assessments driving efficient practices, collaboration with the managed care plans on anti-fraud efforts and preparing more complex and robust referrals to MFCU for faster prosecution.

Additional information on MPI's historical prevention calculations demonstrating the continuous development and refinement of the ROI methodology are detailed further in previous annual reports at: http://ahca.myflorida.com/MCHQ/MPI/

MPI personnel take a lead role in the Medicaid fraud and abuse prevention efforts, including:

- Analyzing trends within programs, provider types, and service types to assess high-risk issues and engage in strategic planning of MPI efforts;
- Engaging with health plans to aide in fraud prevention efforts by providing a forum for discussions of best practices, including discussions of fraud prevention and detection techniques and methodologies;
- Facilitating periodic joint meetings between health plans, law enforcement partners, and MPI regarding fraud prevention and best practices in investigations;
- Conducting reviews of health plan provider networks for ineligible providers;
- Development of relationships with other entities, whose efforts can aide in the fight against fraud, including other federal and state agencies;
- Conducting outreach activities with internal and external stakeholders to aide in awareness and efforts to ensure provider and health plan compliance;
- Conducting provider on-site inspections and provider reviews, which furthers deterrence;
- Conducting appropriate preliminary investigations and, as appropriate, making referrals to other agencies, including Office of the Attorney General, Department of Health (DOH), Department of Children and Families (DCF), and Department of Financial Services (DFS); and
- Identifying instances of suspected fraud and abuse, conducting appropriate investigations, and imposing payment restrictions to protect program funds against further fraud and abuse.

Payment Restrictions

Payment restrictions include the "pending" of claims in the Medicaid claims processing system for one or more specific, legally authorized purposes. Payment restrictions used by MPI include:

- Prepayment Review (PPR) consistent with s. 409.913(3), F.S., requiring claims be reviewed and approved prior to payment;
- Withholding payment (referred to as a "25A withhold") following a determination that there exists reliable evidence of circumstances related to fraud, abuse, willful misrepresentation, or a crime committed while providing services to Medicaid recipients consistent with s. 409.913(25)(a), F.S.; and
- Payment suspension following a determination that there are Credible Allegations of Fraud (CAF) consistent with 42 C.F.R. 455.23.

The number and type of payment restrictions implemented by MPI during FY 2018-19 as provided below.

Type and Number of Payment Restrictions	
Prepayment Review	10,518
Payment Withheld (25A Withholds)	255
Payment Suspension due to Credible Allegation of Fraud	27

Referrals

MPI routinely coordinates with other Agency units, Medicaid stakeholders, program integrity/anti-fraud professionals, and other related agencies on common issues, such as fraud and abuse risks, preliminary review findings, and complaints requiring participation/collaboration. Generally, suspected facility licensure violations are referred to the Agency's licensing bureau, practitioner license violations to the DOH Division of Medical Quality Assurance (MQA), Medicare compliance issues to federal Centers for Medicare and Medicaid Services (CMS), and enrollment concerns to the Division of Medicaid, or the Department of Children and Families. Suspected fraudulent provider activity is referred to the MFCU.

During FY 2018-19, improved information-sharing and stronger collaboration efforts between MPI and key partners contributed to more robust referrals made by MPI to internal and external agencies. Further details about FY 2018-19 referrals from MPI to internal and external partners for actions deemed appropriate are set forth in the statutory reporting requirements section of this report.

Sanctions

Administrative sanctions applied against a provider are imposed in accordance with s. 409.913, F.S., and Rule 59G-9.070, Florida Administrative Code (F.A.C.). Sanctions typically imposed by MPI include fines, suspension, and termination from the Medicaid program. Provider terminations as a result of grounds specified in legal cases are often referred to as "for cause" or "with cause" terminations. Involuntary terminations and suspensions may be issued when a provider involuntarily loses a required license; fails to repay or defaults on a repayment plan to the Agency; has a controlling interest who is charged or convicted of a disqualifying criminal offense; is terminated from the Medicare program or the Medicaid program in any other state; causes harm to recipients; or voluntarily terminates after the Agency has conducted an audit or investigation that would result in suspension or termination.

When the Agency exercises its authority under the statutes and rules that govern the imposition of sanctions, it is required to provide notice of the basis for the termination or suspension and provide due process hearing rights. The sanction becomes final upon issuance of the Final Order against the provider. All sanctions that are issued by MPI are imposed by way of a Final Order and are posted on the Agency's website. Further details about sanctions imposed by MPI are set forth in the statutory reporting requirements section of this report.

Field Initiatives/Focused Projects

A field initiative is a series of on-site visits, typically of the same provider type in a single geographic area. MPI uses multiple data sources and risk indicators beyond Medicaid claims data to identify those site-visit subjects with the greatest risk of potential fraud or abuse to the Medicaid program. The field initiatives gather information in support of MPI's attempts to further discern whether the circumstances are of the nature that should be handled as an MP overpayment recovery audit or referred to MFCU for a fraud investigation.

During FY 2018-19, MPI focused more efforts on developing indicators to better identify those providers at a heightened risk for committing fraud or abuse, to allow MPI to focus program integrity efforts. This risk-based approach using data driven information and indicators, also supports efforts to conduct reviews in the least intrusive manor; shifting focus away from compliant providers.

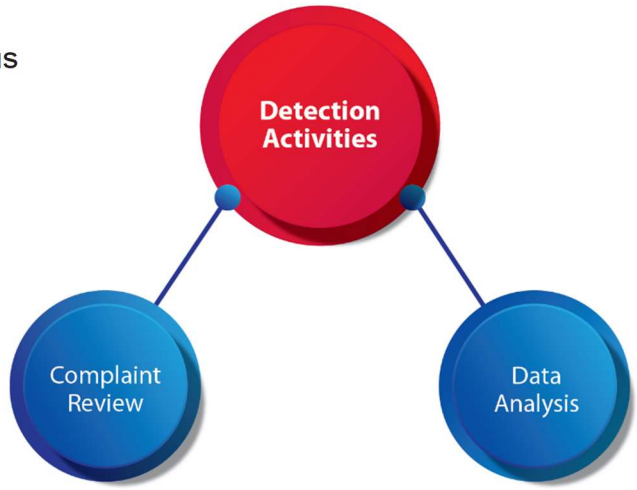
During FY 2018-19, MPI conducted a number of field initiatives related to the following Medicaid provider types and counties:

1. Providers Related To Behavior Analysis in Miami-Dade and Broward counties - August 2018
2. Miami Dade and Broward Home Health Project - September 2018
3. Targeted Case Management Rendering Employee Review - October 2018
4. Home Health Agency Rendering Employee Review - December 2018
5. Behavior Analysis Groups Review in Higher Risk Areas/Counties - January 2019
6. Behavior Analysis Providers in Non-Moratorium Counties Serving Behavior Analysis Clients in Moratorium Counties - February 2019

These initiatives resulted in provider audits, sanctions and contract actions, and referrals to managed care organizations and the Division of Medicaid for additional review.

Detection

Fraud and abuse detection involves numerous methodologies and techniques that identify program vulnerabilities, threats, and risks to the Medicaid program. Program vulnerabilities are the potential weaknesses within the Medicaid program and its operating organizations. A threat is an individual/entity who may potentially cause harm (capitalize on vulnerabilities). Risk is the measure of the potential for the threats to capitalize on Medicaid vulnerabilities to defraud the program through a variety of schemes. MPI's fraud and abuse detection efforts predominately focus on the following schemes:



- Failure to follow coverage and limitation (policy) provisions
- Upcoding procedure codes
- Unbundling procedure codes
- Billing non-covered services as covered services
- Misrepresenting material details on claims (or in documentation) such as dates or location of service, or rendering/ordering/authorizing provider
- Patient brokering/misuse of recipient information
- Falsified documents
- Straw owners/shell corporations/shelf corporations
- Billing for services not rendered
- Corruption/kickbacks/bribery/other financial crimes
- False or unnecessary prescriptions/orders for drugs, medical equipment/supplies, services

Detection efforts continue to be a key factor in MPI's success. Without efforts to discover potentially fraudulent or abusive behavior, and conducting preliminary investigations, other MPI efforts would decrease in effectiveness. MPI continues to work toward increasing the complexity or depth of preliminary investigations. Particularly, MPI efforts strive toward fraud detection, as opposed to abuse or waste detection. With ongoing efforts within every organization, MPI included, to maximize the effectiveness of limited resources, it is important to avoid or minimize detection of risks that will not lead to actionable cases. Aiming for fraud has proven to be a particularly effective approach to avoid what is commonly referred to as a "false positive" – leads that will not result in an actionable case. By aiming for fraud, leads that miss this high mark for fraud often still result in cases such as overpayment recoveries or provider sanctions. Leads that hit the mark are then developed for MFCU or other law enforcement referrals.

Detection efforts are carried out by two Detection sub-units. The Complaint Review sub-unit is responsible for the preliminary review of the thousands of complaints that MPI evaluates each year. The Data Analysis sub-unit is responsible for the development of complex queries and algorithms, visualizations, and statistical reviews. Notable recent activities include the ongoing refinement of the complaint review process and continued development, refinement, and implementation of risk-based detection tools and techniques. Information regarding the risk model development is further described in the Medicaid Program Integrity Approaches and Priorities section.

The complaint review process involves the intake of a complaint or referral, assessment of the initial information gathered, determining whether there is predication to proceed with further review, investigative planning, and conducting the preliminary investigation. Emphasis is placed on the

predication determination and investigative planning because these steps are vital to maximizing effectiveness for both the unit and bureau. The determination of predication requires consideration of whether fraud, abuse, overpayment, or other violation falling within the authority of MPI has occurred, is occurring, or will occur. Any complaint without predication to warrant further review is referred to the appropriate entity and/or closed. For complaints with predication to warrant further review, a tailored investigative plan is developed, and the preliminary investigation is conducted in accordance with the plan. Adherence to this complaint review process has resulted in both increased referrals to external entities and increased efficiencies with recoupment.

During FY 2018-19, the Complaint Review sub-unit assessed 2,790 complaints. The charts below represent the source of the complaints received and reviewed, as well as additional breakdowns for provider type and county.

Source of Complaint	Number of Complaints Received
AHCA - Financial Services	14
AHCA - HQA-Facility Regulation	23
AHCA - HQA-Field Operations	15
AHCA - Medicaid Quality	33
AHCA - Medicaid-Area Offices	4
AHCA - Medicaid-Medicaid Services	1
AHCA – Medicaid Fiscal Agent Operations (MFAO)	38
AHCA - MPI Detection	21
AHCA - MPI Generalized Analysis	1
AHCA - MPI Institutional	104
AHCA - MPI Jacksonville Orlando Tampa (JOT)	4
AHCA - MPI Managed Care Unit (MCU)	11
AHCA - MPI Miami	9
AHCA - MPI Pharmacy	5
AHCA - MPI Practitioners Care	14
AHCA - MPI Prevention Strategy	24
AHCA - Other Bureaus	23
Department of Children and Families	8
Department of Health	13
Explanation of Member Benefits (EOMB)	75
Federal Agency - CMS	175
Florida - MFCU	63
Florida - Other Agencies	5
Florida Agency For Persons with Disabilities	5
HHS-OIG	5
Hotline	1
Internet / Media	71
Investigator Initiative	151
Online Complaint Form - Other	1,106
Online Complaint Form - Managed Care Plans	712
Other - See Description	39
Previous File or Case	12
Provider	3
Public	2
Total	**2,790**

Complaint Subject / Provider Type	Number of Complaints Received
Ambulance	3
Ambulatory Surgery Center	4
Assistive Care Services	101
Behavior Analysis	261
Birth Center	1
Case Management Agency	39
Community Behavioral Health Services	81
County Health Department	3
Dentist	70
Durable Med Equip / Medical Supplies	47
Federally Qualified Health Center	7
General Hospital	151
Hearing Aid Specialist	2
HMO	171
Home & Community-Based Services Waiver	251
Home Health Agency	115
Hospice	37
Independent Laboratory	14
Licensed Midwife	3
Managed Care Treating Provider – Non-Medicaid	10
Non-Emergency Transport	20
Nurse Practitioner (ARNP)	16
Optician	1
Optometrist	4
Pharmacy	123
Physician (D.O.)	21
Physician (M.D.)	289
Physician Assistant	6
Podiatrist	4
Portable X-Ray Company	1
Prepaid Mental Health Services	6
Prescribed Medical Rehab Services (PPEC)	8
Private ICF/DD Facility	12
Professional Early Intervention Services	3
Rural Health Clinic	6
School District	1
Skilled Nursing Facility	260
Social Worker / Case Manager	12
Specialized Therapeutic Services	40
State Inpatient Psychiatric Program	6
State Mental Hospital	2
Therapist (PT, OT, ST, RT)	35
Unknown – Non-Medicaid Providers or Recipients	543
Total	**2,790**

County	Number of Complaints Received
Alachua	35
Baker	3
Bay	10
Bradford	6
Brevard	53
Broward	235
Calhoun	5
Charlotte	13
Citrus	10
Clay	28
Collier	16
Dade	535
Desoto	4
Duval	107
Escambia	38
Flagler	4
Gadsden	2
Hamilton	1
Hardee	1
Hernando	28
Highlands	9
Hillsborough	146
Holmes	6
Indian River	18
Jackson	2
Lake	29
Lee	68
Leon	26
Levy	7
Madison	4
Manatee	20
Marion	18
Martin	20
Monroe	3
Nassau	2
Okaloosa	5
Okeechobee	1
Orange	126
Osceola	43
Other State	23
Palm Beach	142
Pasco	63
Pinellas	97
Polk	51
Putnam	3
Santa Rosa	5
Sarasota	32

Seminole	37
St. Johns	7
St. Lucie	36
Sumter	9
Taylor	1
Unknown*	544
Union	1
Volusia	42
Walton	1
Washington	4
Total	**2,790**

*Complaints reported on a recipient or non-Medicaid provider whose county location is unknown

Managed Care

The MPI Managed Care Unit (MCU) has primary oversight of Medicaid Health Plans (MHPs) and serves in a consultative role for the rest of the Bureau as duties related to managed care fraud and abuse spread to all MPI areas. MCU also assists with detection efforts related to the development of the managed care risk-based detection tools and updated audit tools and protocols.

Detection Related Activities

Detection efforts in managed care involve both plan network providers and health plans. This includes analysis of MHP reports submitted to MPI and information requested by MPI. The primary reports are the Suspected/Confirmed Fraud and Abuse Report (also referred to as 15-day reports), the Quarterly Fraud and Abuse Activity Report (QFAAR), the Suspected/Confirmed Waste Report, Denied/Suspended/Terminated Provider Report, and the Annual Fraud and Abuse Activity Report (AFAAR). MPI will continue to enhance techniques to utilize the MHPs reports, along with other date sources, to expand risk assessment and detection tools.

During FY 2018-19, MPI personnel reviewed 16 AFAARs, 75 QFAARs, and 523 Suspected/Confirmed Fraud and Abuse reports from the health plans. The Suspected/Confirmed Fraud and Abuse Reports received each month are depicted in the chart below.

Month	Number of Reports
July 2018	40
August 2018	34
September 2018	17
October 2018	27
November 2018	30
December 2018	47
January 2019	52
February 2019	45
March 2019	60
April 2019	58

May 2019	69
June 2019	44
Total	**523**

The Suspected/Confirmed Fraud and Abuse Reports received during FY 2018-19, by the MHP are depicted in the charts below.

Medicaid Health Plan	Number of Reports
Amerigroup (AMG)	4
Better Health, LLC (BET)	0
Community Care Plan (NBD)	5
Clear Health Alliance (CHA)	3
Children's Medical Services Network (CMS)	6
Coventry (COV)	4
Florida Community Care (FCC)	1
Freedom (FRE)	17
Humana (HUM)	42
Lighthouse (LHT)	2
Magellan (MCC)	2
Miami Children's (MCH)	1
Molina (MOL)	18
Positive Health Care (PHC)	1
Prestige (PRS)	28
Simply (SHP)	25
Sunshine (SUN)	244
United (URA)	16
Vivida (BST)	2
Wellcare (STW)	98
Dentaquest (DQT)	1
Liberty (LIB)	3
MCNA (MCA)	0
Total	**523**

Complaint Subject / Provider Type	Number of Complaints Received
Ambulance	1
Ambulatory Surgery Center	1
Assistive Care Services	32
Case Management Agency	8
Community Behavioral Health Services	30
County Health Department	2
Dentist	18
Durable Med Equip / Medical Supplies	10
Federally Qualified Health Center	2
General Hospital	5
HMO	11
Home & Community-Based Services Waiver	49
Home Health Agency	33
Hospice	32

Independent Laboratory	8
Licensed Midwife	1
Managed Care Treating Provider – Non-Medicaid	5
Non-Emergency Transport	3
Non-Medicaid Provider	36
Nurse Practitioner (APRN)	1
Pharmacy	49
Physician (D.O.)	6
Physician (M.D.)	90
Podiatrist	1
Recipient	49
Rural Health Clinic	1
Skilled Nursing Facility	12
Social Worker / Case Manager	8
Specialized Therapeutic Services	14
State Inpatient Psychiatric Program	1
Therapist (PT, OT, ST, RT)	4
Total	**523**

County	Number of Complaints Received
Alachua	11
Bay	1
Brevard	10
Broward	40
Calhoun	1
Charlotte	5
Citrus	2
Clay	4
Collier	5
Dade	63
Desoto	2
Duval	16
Escambia	5
Hernando	10
Highlands	1
Hillsborough	29
Holmes	1
Lake	3
Lee	12
Leon	3
Levy	2
Madison	1
Manatee	6
Marion	8
Martin	3
Okaloosa	2
Orange	30
Osceola	16

Other State	7
Palm Beach	31
Pasco	10
Pinellas	11
Polk	10
Sarasota	7
Seminole	9
St. Johns	2
St. Lucie	7
Sumter	4
Unknown/Not Reported*	122
Volusia	10
Washington	1
Total	**523**

*Complaints reported on a recipient or non-Medicaid provider whose county location is unknown

During FY 2018-19, there were four instances of late reporting, three related to late 15-day reports, and one related to a late Annual Fraud Abuse Activity Report (AFAAR), by an MHP. Historically, the issue of timeliness of the Suspected/Confirmed Fraud and Abuse Reports was a significant concern. However, due to the extensive efforts by both the Division of Medicaid and MPI over the past several years, the issue of untimely reporting is believed to have been minimized and nearly eliminated. The MHPs involved in these issues, Prestige, Molina (late 15-day and AFAAR), and Amerigroup were issued liquidated damages by the Division of Medicaid for these instances of late reporting at the request of MPI. The liquidated damages were paid and the cases were closed during the FY 2018-19.

MPI has also continued to enhance detection efforts for the MHPs through formal referrals of program integrity issues to the MHPs for investigation. The referrals sent during FY 2018-19, included provider complaints submitted by other plans, providers that MPI detected through investigator initiatives, and topics that MPI has successfully audited. In FY 2018-19, there were 13 formal referrals of investigative information sent to all MHPs. Referrals to the MHPs are an area of focus for MPI and are expected to increase in the future.

Prevention Related Activities

To the extent that MPI can engage in efforts to prevent fraud and abuse, particularly within a managed care environment, inexpensive efforts can provide significant return. Prevention activities include reviewing and discussing the MHP's required anti-fraud and compliance plans which provide the plan's frame work for program integrity efforts. MPI's evaluation, discussions with the MHPs, and monitoring/audits of the MHPs efforts help ensure that the shift to managed care does not result in an increase of fraud and abuse within provider networks.

Other managed care related prevention activities include projects focused on MHP compliance with program integrity requirements, and issues of suspected abuse. During FY 2018-19, MPI projects included a review 13 areas or items related to program integrity efforts for each of the MHPs that were awarded a contract for the 2018-2023 Statewide Medicaid Management Care (SMMC) Contract and 2018-2023 Dental Contract. Reviews included topics such as policies and procedures related to eliminating providers that are no longer eligible for Medicaid. Each health plan, in some cases after multiple resubmissions, was found to meet the minimal criteria set forth for each of the 13 areas of review.

During the year, MPI began a project to review MHPs imposition of Credible Allegation of Fraud (CAF) payment suspensions as required under 42 CFR 455.23. MPI notifies the MHPs when a provider suspension has been implemented based upon CAF as the MHPs are also required to suspend payments. This project is ongoing.

MPI personnel review all program integrity subcontracts for MHPs, engage in contract monitoring reviews of the MHPs, and make recommendations to the Division of Medicaid for contract enhancement. The MHP monitoring reviews are the subject of the risk-based detection efforts that MPI is developing so that health plans are audited on issues that appear to be the greater risks for the Medicaid program. An assessment will be developed for FY 2019-20 to determine if delegation of program integrity responsibilities to a contractor creates an increased risk of fraud and abuse.

Another critical aspect of fraud, abuse, and waste prevention in managed care is the continued education, collaboration, and communication between MPI, the MHPs, and the appropriate law enforcement. Sharing best practices regarding program integrity efforts, case study discussion, and investigative summaries assist in ensuring enhanced fraud and abuse detection and prevention activities throughout Medicaid program integrity efforts. During FY 2018-19, MPI held three in-person collaborative meetings with MHPs regarding program integrity related matters. Of those meetings, three included the Medicaid Fraud Control Unit and one included the Federal Bureau of Investigation (FBI). These meetings have transitioned to focus on the four key areas of program integrity with the MHPs – Detection, Prevention, Overpayments/Audits, and Managed Care Program Integrity Compliance. This focus has improved collaboration and partnership with the MHPs by encouraging the sharing of related practices. During this time MPI also held four conference calls with the Medicaid health plans to discuss projects and other upcoming issues that arose in between the face-to-face meetings.

Health Plan Audits

Federal regulations (42 CFR 438.66) require a "monitoring system" for Medicaid managed care program integrity functions that uses data collected from monitoring activities to improve performance. Historically, MPI used a checklist approach and attempted to assess a broad array of functions but is transitioning to leverage data to improve MHP program integrity efforts. Data sources include use of MHP reports and responses to requests for information to assist in developing a risk-based monitoring program. This transition has been hindered by resource demands for intervening priorities but continues to be an important initiative. A focused review of an MHP based on perceived vulnerabilities is expected to yield audit findings that will allow MPI to give guidance that is specific to the MHP.

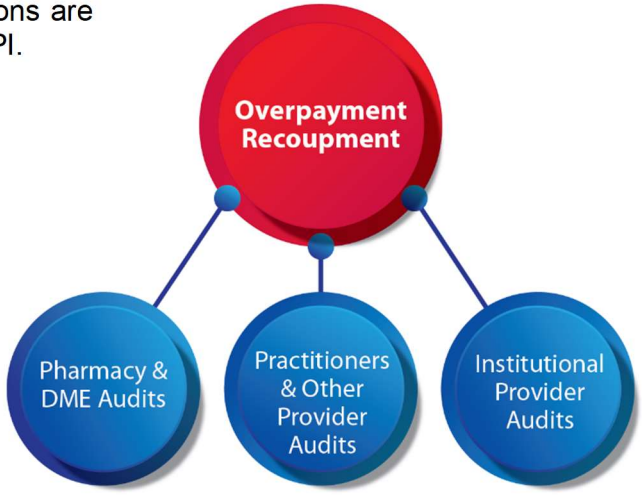
Sanctions

MPI collaborates with the Division of Medicaid in the areas of contract compliance to prevent issues of non-compliance by the MHPs. The contracts with MHPs includes liquidated damages to ensure compliance with contract requirements. Liquidated Damages are monetary damages for failure to meet aspects contract. These damages may be issued by the Division of Medicaid by the request of the area of the agency with oversight of that portion of the contract. For instance, MPI oversees the Annual Fraud Abuse Activity Report (AFAAR), so if the report is inaccurate, missing information, or late, MPI would recommend a liquidated damage to the contract manager in the Division of Medicaid. MPI would include all appropriate documentation to support the liquidated damages.

The SMMC contract also contains a section regarding sanctions, including required corrective action plans and other penalties. There are specific sanction authorities listed with regards to managed care plans and their work, such as s. 409.967(2)(i)1., F.S. which addresses the sanction of an MHP leaves a region before the end of the contract term.

Overpayment Recoupment

The Overpayment Recoupment Unit (ORU) operations are predominately carried out through three teams in MPI. The teams are currently organized by audited provider types. Audits determine if there has been noncompliance with Medicaid policy and identify overpayments for recovery. MPI also conducts audits through contracted audits.



ORU reviews not only result in overpayments but may also generate a referral to other regulatory entities, imposition of sanctions, or lead to other projects. The ORU reports suspected fraud to the Prevention Unit to evaluate for possible referral to MFCU.

Audits of FFS claims to identify overpayments for recoupment continues to yield high-dollar results for the Agency. MPI processes now include encounter data validation with FFS claims audits. Language in the 2018-2023 State Medicaid Managed Care Plan Model Health and Dental Plan Contract allows MPI to identify and recover overpayments that are time limited by provisions of s. 641.3155, F.S., or if the Managed Care Plan has not properly reported to the Agency the suspected fraud, abuse, or waste. In addition, if the Agency provides notice to the Managed Care Plan of the identification of overpayments, and the Managed Care Plan does not engage in recovery efforts, the Agency is entitled to the overpayment recovery.

In this reporting period, the ORU worked to identify audit candidates, performed audits to identify overpayments for recoupments due to non-compliance, applied related sanctions, and assisted with litigation. ORU staff assist subject matter experts to evaluate complaints, develop audits with outside contractors, consult with detection regarding certain claims information, and assist the MCU in developing oversight reviews.

The ORU is also responsible for coordinating and processing self-audits by Medicaid providers. MPI encourages providers to incorporate internal quality control and auditing functions in their business practices. When a provider determines payments made in excess of the amount due, the provider is obligated to return the improper amounts to the state in the form of a self-audit. This proactive approach will minimize the provider's future risk of additional costs and sanctions if the self-audit is determined to be valid, and not an attempt to alleviate liability for fraudulent practices. In FY 2018-19, the ORU confirmed $1,352,956.20 in 132 self-disclosures after validating the overpayments. The majority of this overpayment has been collected.

MPI assists the Agency's legal counsel during litigation by answering discovery, preparing exhibits, and testifying in depositions and hearings. When the Agency's determinations are challenged at hearing, it is important to make the State and the taxpayers of Florida whole, if the Agency ultimately prevails, as outlined in Section 409.913, F.S. Part of making the State whole is to recover all investigative, legal, and expert witness costs that the Agency absorbs through the litigation process. These costs are to be passed on to the non-prevailing party in these situations. The cost of this litigation grows each year.

MPI has been involved in litigation with in number of audit projects. Some of those projects include contracted outside counsel to represent the Agency at hearing. The Agency has sought to recover legal costs and fees in the cases in which they prevailed. However, in a recent case the Division of Administrative Hearings (DOAH) administrative law judge ruled that s. 409.913(23)(a), F.S., does not authorize the Agency to recover full attorney's fees on Medicaid Program Integrity legal cases. The specific ruling came in DOAH case number 18-5986F involving Covenant Hospice. The case had an

overpayment of $637,973.10 and sanction of $127,594.62; the Agency was seeking fees and costs in the amount of $330,186.14 as of February 7, 2019. The Agency has the ability to collect the "costs" amount of the $330,186.14 but not the "fees" amount. While sympathetic to the Agency's position, the court felt it was not at liberty to rule in the Agency's favor due to the statutory limitation.

The Florida Department of Health (DOH) experienced a similar problem in their previous statute s. 456.624, F.S. (now renumbered 456.072, F.S.). The First District Court of Appeals ruled that DOH's previous statute did not state legal fees, therefore no fees could be collected. An example of case with this ruling is DOAH case number 1D02-4457 from 2004. As a result, the department made changes to allow for collection of fees in their current statute, s. 456.072(4), F.S. To address this issue, the Agency is seeking a statutory change modeled after the DOH language to secure the authority to collect all costs associated with the case.

Medicaid Program Integrity Hospital Retrospective Review

The Agency performs routine pre- and post-payment claim reviews to determine the appropriateness of historical, existing, and future provider reimbursement. MPI conducts provider audits based on probable cause through the Alien Audit Program, under s. 409.913, F.S. which was developed after a 2009/2010 audit report from the Health and Human Services Office of Inspector General, mandated that the state return the federal share of erroneous payment for certain hospital claims related to Emergent Medicaid for Aliens.

Medicaid Program Integrity has recovered millions of dollars in the Alien Audit Program, yet recently the First District Court of Appeals ruled that s. 409.905(5)(a), F.S.,1 precludes post-payment audits to determine the appropriateness of reimbursement, including whether prior authorization was obtained under false pretenses. The decision relied on an obsolete reference limiting retroactive audits that applied to a program that no longer exists. The entire Alien Audit Program, which began in 2010 and included 668 total closed cases, has collected $57,056,455.79. The Agency lost $13,449,595.12 related to 42 cases that have been or will be closed at zero overpayment due to the First District Court of Appeals ruling. The cases are Lee Memorial Health System Gulf Coast Medical Center vs. AHCA, No. 1D16-1969 and No. ID16-3975, and Cape Memorial Hospital, Inc. d/b/a Cape Coral Hospital vs. AHCA, No 1D16-5310. The Agency's position that there is no statute of limitations for retrospective reviews. The Centers for Medicare and Medicaid Services does not consider any time limit with respect to recoupment of the federal share of overpayments. However, because some laws limit record retention to five years, MPI generally limits review to a five year look back period. The Agency has no distinction related to payment type (fee-for-service or managed care). Federal regulation under 42 CFR § 456.23 requires that the Agency have a post-payment review process for all Medicaid services. Additionally, federal regulation under 42 CFR § 455.12 sets forth requirements of the State plan for the identification, investigation, and referral of suspected fraud and abuse cases, which includes compliance with the 42 CFR § 456.23 requirement to have a post-payment review process. Federal regulation under 42 CFR 455.16, states that one of the possible resolutions to an investigation is seeking recovery of payments made to the provider.

The directive in s. 409.905(5)(a), F.S., to discontinue an inpatient retrospective review program was intended by the Legislature to refer to a specific program conducted in the Division of Medicaid when the Division shifted to a prior authorization review. It is a misconception that this discontinuance was meant for retrospective reviews conducted by Medicaid Program Integrity. The Agency is seeking a statutory change to eliminate the perceived contradiction that s. 409.905, F.S. supersedes s. 409.913, F.S., and allow Medicaid Program Integrity to continue retrospective reviews.

Recent Audit Activities

During FY 2018-19, the ORU participated in a wide range of audit activities. Examples of audits performed by the MPI ORU include:

- Hospice Length of Stay is a collaborative hospice project between MPI and CMS which is continuing. The project addresses Medicaid recipients that have been in hospice care for six months or longer and the medical necessity of the hospice stay. At the close of FY 2018-19, the hospice audit project generated approximately $16.3 million in recoupments, $1.8 million in sanctions, and $450,000 in costs related to 30 closed cases.
- Assisting the Bureau of Medicaid Quality with a corrective action plan for the Payment Error Rate Measurement (PERM) program for FY 2017. MPI sanctioned providers who were non-complaint with medical records requests from the CMS PERM federal review contractor. Sanctions imposed on 15 providers totaled $37,500.
- Conducting a Generalized Analysis project on nursing facilities identified as receiving reimbursements for Medicaid services while the recipient(s) were enrolled in hospice. Once a recipient elects to receive hospice services, hospice is responsible for all services provided for the terminal illness and related conditions. Room and board payments become the responsibility of the hospice provider, not the nursing facility. MPI has identified 117 nursing facility providers with a total identified overpayment over $300,000.
- Ongoing audit of 68 providers for potential payment for home health visits billed when a recipient is admitted to a hospital or nursing facility. This audit was previously conducted in FY 2017-18, and a total of $503,467 was collected.
- Restitution cases to Medicaid for services received by non-immigrant visitors during a visit to the US/Florida, typically under a B1/B2 “non-immigrant” visitor Visa. The recipients become aware of their situation when their local US embassy denies new Visa applications. The embassy requests documentation from state Medicaid agencies that demonstrates the recipient has repaid Medicaid for previous reimbursed services. The restitution to Medicaid is a voluntary repayment of Medicaid funds. Once repaid, a letter is issued providing proof of payment. MPI offers this voluntary program to any person who wishes to repay Florida Medicaid for claims reimbursed on their behalf. Through the end of the FY 2018-19, there have been 43 closed cases with a total of $198,474 collected.
- Comprehensive pharmacy audits, including invoice and prescription reviews. A review of documentation in one such audit identified an overpayment of $174,340, where the quantity paid for drugs reviewed exceeded the quantity available to dispense to Medicaid recipients. The total final amount owed was $189,160 based on a fine and investigative costs. In FY 2018-19, 47 pharmacy audits were conducted with identified overpayments totaling $1,369,926.
- Behavioral analysis overpayment cases and assistance in eligibility review of behavior assistants enrolled in Medicaid and employed by Behavior Analysis group providers. The ORU closed 191 reviews during the fiscal year 2018-19 and identified overpayment of $14,894,827 for 92 of the 191 behavior analysis agencies.
- Emergency Medicaid for Aliens (EMA) audit project to address inpatient claims. The Agency, CMS, and CMS’ Medicaid Integrity Contractor identified substantial overpayments for recoupment in this project. Since the EMA audit project’s inception in 2010, MPI has recovered approximately $57 million in overpayments, with another $13 million in open cases at the end of the fiscal year. The completion of this project slowed due to legal challenges.

Operations

The Operational Support Unit (OSU) provides critical support to MPI in the combatting of fraud, abuse, and waste, included: gathering and preparing documentation in response to public record requests, reconciling incoming payments for provider self-audits, and coordinating record storage or the recall of casefiles. The unit has also worked with the Agency’s Office of the General Counsel to create a contract template to use with vendors who seek to pilot fraud detection tools with MPI. By offering this opportunity, MPI is better equipped to identify technology needs and the availability of services to meet those needs.

Strategic Planning

MPI's philosophy about strategic management

Strategic planning is not a one-time occurrence – it is an ongoing commitment that involves creating new strategies and approaches to continuously evaluate strengths, weaknesses, opportunities, and threats based on high level organizational goals, priorities, and objectives. Building a good strategic plan takes significant upfront work and requires a team effort of both leaders and team members, to be ambitious enough to motivate but practical enough to be implemented. MPI considers whether the appropriate capabilities and resources are available to support strategic execution and must prioritize strategic initiatives as resources are limited. MPI's strategic plan is routinely evaluated and adjusted to ensure it serves as the roadmap of how goals and objectives are achieved.

MPI's Priorities and Approaches

Historical program integrity efforts have been predominately based on looking for outliers in paid claims, which involves tedious efforts to audit providers. Today's efforts must rely on innovative approaches and place greater emphasis on the use of fraud risk models and advanced analytic techniques to focus program integrity activities on the greatest vulnerabilities. The following discussion outlines MPI's priorities.

Managed Care

Program Integrity remains critical in Managed Care

Fraud in the health care system has become incredibly sophisticated and difficult to detect. With the added layers of managed care, it can be difficult to track if services are rendered and billed accurately. Many recipients are unable to verify the services they received versus those billed and providers may exploit this limitation. With managed care, the health care system still sees falsification of documents, billings for services that are not rendered or unnecessary, and other improprieties.

Managed care does not eliminate program losses. If health plans are ill-equipped to absorb losses, fail to detect or report fraud, vulnerabilities remain undetected and are not mitigated for future operations. Undisclosed losses can further inflate costs if not addressed in plan rate methodologies. Health plan Special Investigations Unit's (SIU) activities are considered administrative expenses, which count against a plan's Medical Loss Ratio, and health plans' disclosure of certain fraudulent activities are reportable in Securities Exchange Commission (SEC) filings, which may create a disincentive to discovery and disclosure of fraud. The Agency is actively working to reform these practices to ensure greater integrity of the Medicaid program.

The concept of program integrity is complex and must include innovation to be effective and relevant. A lead team or person within an organization, with responsibilities to ensure that efforts are spread throughout the organization, is considered a critical component in an effective program integrity model. Important program integrity concepts are not easily learned and maintained unless they are a primary focus of an organization and the organization immerses itself in an understanding of and application of the concepts. It is necessary to have a strong working knowledge of program integrity concepts in Medicaid, both locally and at the Federal level, including: Florida and Federal law related to Medicaid and program integrity; theories and principles of program integrity and investigations; understanding principles of criminal behavior and how it is learned and shared; motives, and rationalizations for committing crimes; and social network theory.

Prevention continues to be highly relevant in a managed care environment. MPI prevention activities related to managed care include: investigations to determine whether law enforcement referrals, sanctions, or payment restrictions are legally and factually appropriate; consultation with Medicaid program offices, health plans and stakeholders; centralized management of payment restriction mandates of federal and state laws; expertise in Medicaid–related activities such as Medicaid policy development, provider enrollment safeguards, and preliminary law enforcement investigations; terminations and suspensions to control provider networks; and onsite visits for real-time intelligence. Onsite visits allow MPI staff to gather documentation that otherwise could be fabricated if requested by mail. Health plans do not typically engage in this type of deterrence and information gathering activities.

National reporting continues to suggest that health plans do not typically report expected volumes of fraud referrals to the Medicaid Fraud Control Units (MFCU). Therefore, detection of fraud and abuse continues to be a necessary program integrity function for MPI, to ensure the health plans are doing their due diligence and to protect the Medicaid program. MPI staff utilize in-house and external tools to detect patterns of abusive behavior in a constantly evolving environment of providers who engage in both intentional and unintentional erroneous billing, as well as fraudulent and abusive activities. Abusive behavior may be demonstrated through claims-based and non-claims-based information or data. Through detection efforts, MPI is able to deploy resources to prevent further misspent funds, recover overpayments, implement deterrence activities, and engage in a broad array of program integrity activities. MPI continues to develop internal data analytics and risk models to detect sophisticated fraud and abuse schemes that have occurred or appear to be emerging. This analysis of large, complex data sets, with specific focus on program integrity-related concerns, is critical for early detection and prevention of fraud and abuse. In addition, MPI is uniquely positioned to cultivate relationships with other organizations to better understand their data/information, which the Agency can use in the fight against fraud and abuse or even for basic compliance efforts.

Overpayment recovery continues to be a relevant endeavor for the Agency. MPI continues to identify overpayments that are comparable to the dollars that were identified when Medicaid was predominately FFS and continues to explore additional activities to increase recoveries. The Medicaid health plans have legal limitations pursuant to s. 641.3155, F.S., technical limitations (e.g. data availability), and other disincentives to collect overpayments. Dollars that the plans would not likely identify and collect can be identified and collected by the Agency for submission to the state treasury. If the Agency ceases to have a primary responsibility for overpayment recovery, there are a number of other legal considerations that would have to be explored.

Other risks related to managed care that require Agency detection and investigation include: health plan employees who also serve as providers; health plan employees complicit in fraud schemes (e.g.: a plan employee arrested for Medicaid fraud); health plan compliance plans, anti-fraud plans, and other reports that require assessment by personnel with experience in program integrity to ensure the information is used for detection, prevention, and risk modeling; and providers who participate in deceptive practices that may be undetected within a single managed care plan. MPI can assist with program integrity across all plans.

The most useful tool in Florida's fight against fraud is its experienced program integrity personnel.

Initiatives to infuse managed care related efforts across other MPI operational areas

As more services shift to the managed care service delivery models, regulatory oversight of managed care plans is critical. MPI continues to infuse program integrity efforts related to managed care into other aspects of bureau operations, such as provider site visits, information collection projects and related reviews, data analysis, and audits. MPI is working to include encounter data into audits (network providers participating in managed care) and expand protocols for managed care-only providers, increase audit project referrals to managed care plans, and increase "clean-up" efforts where plans do not or cannot pursue overpayments. MPI must continue to transition organizationally to shift resources, as needed, to address the program vulnerabilities regarding managed care, and prepare for additional oversight of the managed care plans. This requires MPI to prepare additional pre-audit tools/surveys for managed care plans (as the subject of the audit), enhance current audit tools for managed care plan audits, and expand risk models to prioritize and focus plan audits. The risk models are further detailed, below. MPI must also continue to conduct programmatic assessments and make recommendations regarding system enhancements, law/policy/contract provisions, and to identify and elevate to senior management issues of particular significance (e.g., rate adjustments for suspected fraud; distribution of recoveries; etc.). As MPI continues to develop and modify programmatic assessment tools (legacy tools) relative to managed care and continues with the transition from a predominately fee-for-service delivery model to a predominately managed care delivery model, it is critical to ensure that MPI continues to develop and modify proactive (vs. reactive) approaches to program integrity strategies (which will drive prevention and audit processes).

Audits/Investigations

Many of MPI's Audit and Investigation activities were previously described in the functional overview. MPI's efforts to discover more involved fraud schemes aligns with an ongoing emphasis to increase MFCU referrals not only in volume, but in quality and complexity. With this emphasis, MPI is able to reduce true "false positives" because those investigations which fail to meet the higher standard of suspected fraud are likely to remain within MPI scope of authority, which includes suspected abuse. Among the types of fraud and abuse schemes that MPI attempts to discover are:

Program/Service Assessment

MPI is committed to routine evaluation of potential service specific vulnerabilities/risks, as resources allow. In fact, MPI is attempting to use risk-based detection methods to allow for a more efficient use of resources. MPI evaluates program vulnerabilities and risks including those identified by the Agency, identified in other programs (e.g. Medicare or even non-health care systems), or geographic locales (e.g. Medicaid schemes in other states), which may be a vulnerability/risk in Florida Medicaid. The potential vulnerabilities/risks are then prioritized. Priorities are then evaluated to determine what MPI activities should be deployed, ranging from audit projects, referrals, site visits, or policy and system edit recommendations. Recommendations may include addressing data integrity issues (such as reports submitted by health plans that are causing difficulty when infusing the data in detection models), contract provisions, or laws (rules or statutes). Ongoing assessment helps MPI develop additional provider type risk models. In addition to evaluation across the Medicaid program, MPI continues to evaluate and adjust legacy tools (e.g., FFS claims based detection tools) and develop more proactive (vs. reactive) approaches to detection strategies (which will drive prevention and audit processes).

Innovation

For the past several years, MPI has focused on a teamwork approach and the use of innovative ideas, processes, and techniques to strive toward increased productivity and results. The size of the Florida Medicaid program alone warrants utilizing a collaborative approach. Along with the dynamic nature of healthcare fraud, it also necessitates constant forward-thinking. Innovation is often associated with creativity, which is not commonly fostered in business and public sector enterprises.

Importance of Partnerships and Collaboration

Program integrity efforts include collaboration with internal and external stakeholders to aid in fraud prevention efforts, and to facilitate strong and consistent communications. MPI will continue a strong collaboration with the Office of Attorney General's Medicaid Fraud Control Unit (MFCU) and other state and federal law enforcement partners on investigations to provide analytical support. This will include cooperatively developing and refining data mining initiatives with MFCU in order to improve outcomes. MPI collaboration with partners is critical to develop additional risk models, process improvements, and increased detection and investigative skills. Furthermore, collaboration with other organizations, entities, and law enforcement help MPI identify training opportunities that were not otherwise known to it. Trainings on such topics as open-source intelligence (OSINT), financial fraud, and white collar crime, are increasing more important for fraud detection and investigation.

NHCAA Collaborative Medicaid Fraud Work Group

The National Health Care Anti-Fraud Association (NHCAA) is a professional association of health insurance plans, federal, state and local government law enforcement, and regulatory agencies. NHCAA's role as a private-public partnership makes it unique among associations and contributes to achieving its mission to protect and serve the public interest by increasing awareness and improving the detection, investigation, civil and criminal prosecution and prevention of health care fraud and abuse. Since there are no national standards by which to measure many of the Florida MPI's activities, the NHCAA association is often the sole "peer group" by which these efforts can be measured.

During FY 2018-19, NHCAA launched the NHCAA Collaborative Medicaid Fraud Work Group to serve as an environment to discuss the challenges of fraud and abuse in Medicaid and to examine best practices that could improve communication and coordination among Medicaid anti-fraud partners. The work group was comprised of individuals from Medicaid MCOs, state MFCUs, state MPI Units, the Center for Program Integrity at the Centers for Medicare and Medicaid Services, the Office of the Inspector General at the Department of Health and Human Services, the National Association for Medicaid Program Integrity, and the National Association of Medicaid Fraud Control Units. Florida MPI was selected to participate on this working group due to the strong collaborative relationships we have fostered with state and federal partners, our innovative approaches to combating fraud and abuse, and our national prominence.

It was the consensus view of this work group that strong communication and collaboration with health plan and MFCU partners is a critical factor in successful detection, prevention, investigation, and prosecution of health care fraud. The best opportunity to effectively address fraud in the Medicaid program is to advance private-public partnerships while continuously identifying and implementing efficiencies. Florida MPI continues to be a national leader in collaboration.

Risk-Based Focus

The Agency continues to yield high overall overpayment recoveries and a make significant volume of high-complexity fraud referrals to MFCU. However, the Agency also strives to focus program integrity activities on the greatest program vulnerabilities and risks. MPI continues to develop and maintain/refine tools that allow resources to shift toward more complex investigations and referrals to law enforcement, earlier identification of fraud and abuse schemes, and overall optimization of the use of resources. This includes developing models and methods to better identify *suspected criminal behavior*, recognizing that investigations that may fall short of this higher burden often still have an administrative overpayment recovery value; thus, producing fewer "false positives."

MPI's Use of Risk-Based Detection Methods

MPI operations strive for maximizing available resources to have the greatest impact overall toward detection, suppression, and recovery of misspent dollars due to fraud and abuse. MPI focuses on the program vulnerabilities and risks that are more widespread or egregious. Fraud and abuse are not as easy to detect with routine safeguards. Program growth in provider reimbursements and the numbers

of providers and recipients, as well as program changes in policy and reimbursement methodologies, have added additional challenges over the years which must be met with diligent and widespread program integrity efforts.

Historical program integrity efforts (both in Florida and elsewhere in Medicaid programs, and likely other health care insurers) were predominately claims-based outlier detection that involved tedious efforts to audit providers, often capturing "good" providers and treating them the same as providers engaged in much more egregious behavior. MPI's efforts today, however, have placed a much greater emphasis on the use of fraud risk models to potentially identify fraudulent and abusive behavior and focus program integrity activities on the greatest vulnerabilities and risks. MPI has more recently been using technology and innovations to develop and implement risk-based detection methods. This better allows MPI to take reasonable and appropriate action regarding provider non-compliances. In other words, these efforts allow MPI to distinguish the "good" providers who may have engaged in errors, waste, or unusual but valid clinical practices, from the more egregious misconduct upon which to focus its efforts.

A risk model draws on many sources of information to determine a level of risk. Risk models can be used as detection tools to guide investigations. They are used to identify risk elements, suspicious behaviors, and suspicious patterns. It is important to clarify that risk models are not used to impose administrative actions or sanctions without appropriate validation. MPI risk modeling efforts are used to identify the specific factors that we believe contribute to the risk of committing Medicaid fraud or abuse, and typically include characteristics of providers that were previously associated with fraudulent behavior. Factors considered are often weighted by relevance to build a model. Using a risk model in government fraud detection involves a balance of open government with the need for maintaining some degree of confidentiality regarding the details of models to avoid gaming the process.

Without risk-based models, efforts would typically be geared toward evaluating the largest dollar providers, presuming that the largest recoveries will follow. However, in large, multi-facetted programs, chasing the high-dollar providers does not always yield better recoveries. MPI has made a concerted effort to infuse their understanding about how people make financial decisions to focus efforts on where people are driven to capitalize on program vulnerabilities.[1] This shift in approach for MPI has proven valuable for the Agency's overall program integrity effort[i], and allowed MPI to significantly increase, both in numbers and in complexity of schemes, the referrals of suspected criminal activity to the Office of the Attorney General's Medicaid Fraud Control Unit.[2] Fraud referrals not only serve to increase the likelihood of fraudsters being convicted of their crimes and restitution back to the program, but serve as a deterrent when prosecutions of egregious conduct are successful.

Current models have been developed by an interdisciplinary team, using a variety of tools and programming including the MPI case tracking system (FACTS), structured query language (SQL), Python, R, and Oracle Business Objects (the Medicaid decision support system (DSS)). MPI has been able to integrate the use of external tools such as ESRI ArcGIS, IBM I-2 Analyst Notebook, LifeRaft Navigator, and Tableau. Assessment of other commercially available tools as well as resources for further integration into the risk model development is ongoing. The approach being used by MPI is designed to be innovative, transparent, and to promote teamwork and collaboration.

MPI is working to develop a sophisticated managed care risk model which considers broad issues of corporate culture, the plans' perceived financial health, other regulatory issues such as sanctions or adverse audit findings, analysis of providers (provider networks) and claims, considerations related to fraud and abuse prevention and detection as well as issues of priority from the Centers for Medicare and

[1] MPI has adjusted its approach to fraud and abuse detection and prevention, in part based upon foundational principals and theories such as Nicholas Mankiw's 10 Principles of Economics. Mankiw, N.G. (2012). *Principles of Economics* (6th ed.). Mason, OH: South-Western Cengage Learning.
[2] See, *Annual Report on the State's Efforts to Control Medicaid Fraud and Abuse*.

Medicaid, Florida or other State's Medicaid Fraud Control Units, and the Department of Health and Human Services Office of Inspector General.

For purposes of FY 2019-20 monitoring requirements, MPI intends to deploy (at whatever stage of development) the risk-based approach. That means some plans will likely be reviewed with a focus on fraud and abuse detection or prevention efforts (the two categories that are presently further developed). Detection is a critical program integrity activity and forms the foundation for all other activities (you cannot prevent what you do not know exists, you cannot audit what you cannot find, and if you cannot ever detect suspected fraud, you cannot ever make a valid referral to MFCU). Prevention is also critical in the sense that it includes both the highly valuable efforts to mitigate fraud and abuse, and activities such as referrals to MFCU.

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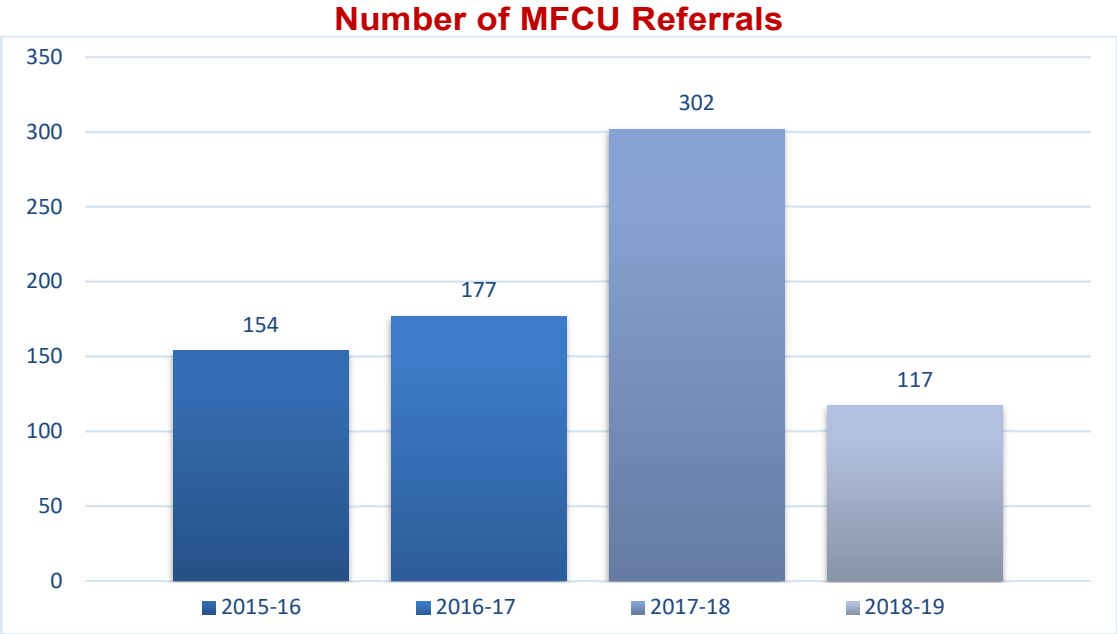
[i] MPI successes relative to a shift in approach

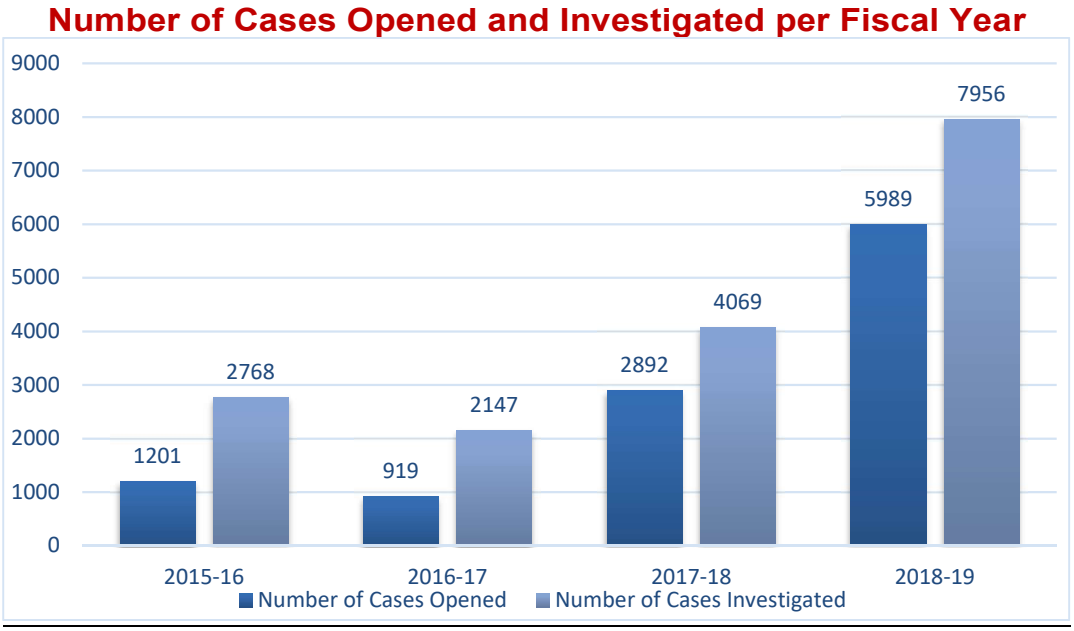
In 2004, MPI (and the Agency) published the first fraud report required by the Legislature. MPI had 92 full time equivalent positions and conducted (either through completion or initiated during the fiscal year) approximately 4,700 cases. Final overpayment determinations totaled in excess of $36 million. From a review of the annual report and other historical reporting statistics regarding MFCU referrals, it somewhat unclear as to whether there were 26 referrals from MPI or 58 (oftentimes the statistics did not distinguish the AHCA office where a referral originated). Fiscal year ending 2003 information also only vaguely references prevention activities and values them at approximately $20 million for that year. Compare that with more recent reports. From 2015 through present, MPI lost (through staffing reductions) FTEs; MPI is currently (September 2019) at 86 FTEs.

From fiscal year ending 2015 through 2018, the number of MFCU referrals first doubled (from 63 in FYE 15 to 154 in FYE 16) and continued to increase for FYE 17 (177) and nearly doubled again in FYE 18 (302). Similarly, the number of cases investigated has increased (although other processes has also assisted in ensuring that cases are investigated to a point of predication and cases where there is no MPI activity to be considered are closed earlier in the process, reducing the unnecessary use of resources). Prevention dollars are estimated in excess of $48 million, identified overpayments in excess of $18 million, collections nearly $20 million. MPI is encouraging more providers to repay overpayments earlier (at preliminary stages or through self-audits).

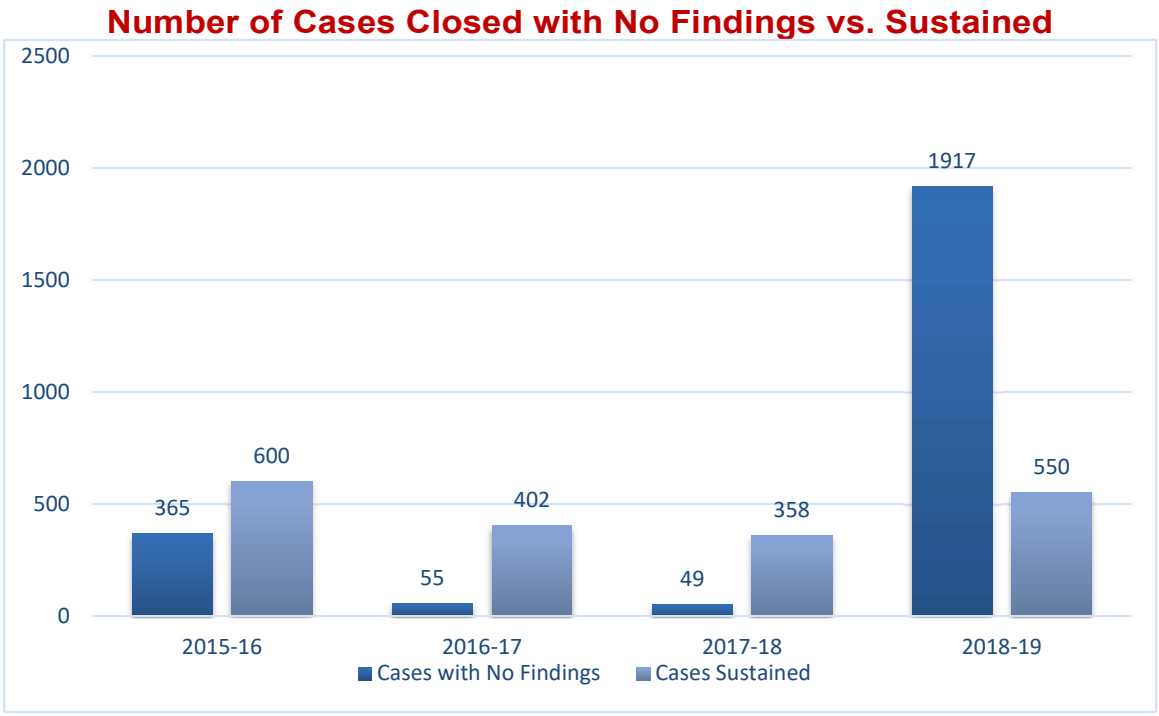
MPI Activity Trends



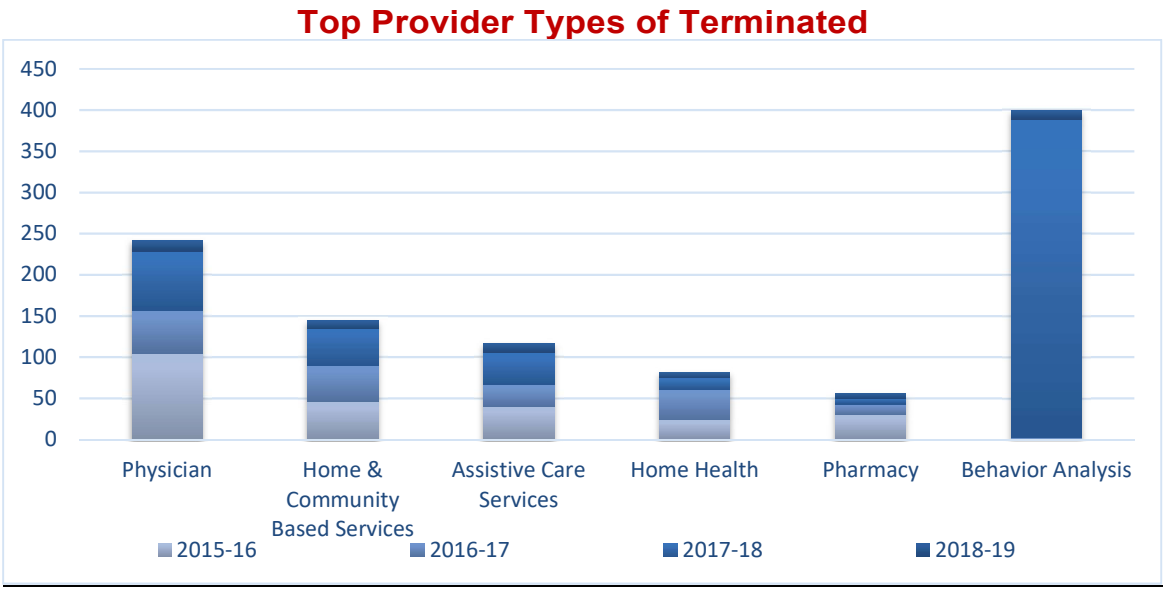
The Agency has a mandate to refer instances of suspected criminal activity to the Office of the Attorney General, Medicaid Fraud Control Unit (MFCU). These referrals lead to investigation of criminal and civil fraud. MFCU referrals have both a deterrent and preventative effect. MPI has given increased focus to MFCU referrals over the past several years. The efforts have focused on both the increase in the number of referrals as well as the complexity of suspected criminal activity that forms the basis for the referral.



The number of cases opened each year is relevant to the analysis of MPI performance. Specific attention is given to complaint intake and early data analysis efforts to ensure the most effective use of personnel resources, working on cases with the greatest likelihood of success.



Evaluating the proportion of cases with and without "findings" (some output or action that contributes to case success, whether a referral, overpayment recovery, or provider sanction) further assists management in directing the use of resources.



Terminations from Medicaid participation are typically a joint effort between MPI and the Division of Medicaid. The top provider types that have historically been the subject of these actions are Physicians, Waiver (HCBS) providers, Assistive Care, Home Health, and Pharmacy providers. As this chart demonstrates, efforts in FY 2017-18 resulted in a higher volume of network actions in Behavior Analysis.

MPI Data for Fiscal Year 2018-19

Site Visits	
Provider Type	**Number**
Ambulance	0
Assistive Care Services	0
Case Management Agency	30
Behavior Analysis (BA)	77
Community Behavioral Health Services	2
Dentist	0
Durable Medical Equipment/Medical Supplies	0
Health Maintenance Organization (HMO)	0
Home & Community-Based Services Waiver	6
Home Health Agency	20
Nurse Practitioner (APRN)	0
Optometrist	0
Other – No Description Available	0
Pharmacy	0
Physician (D.O.)	0
Physician (M.D.)	0
Professional Early Intervention Services	0
Rural Health Clinic	0
Social Worker/Case Manager	0
Therapist (PT, OT, ST, RT)	0
Total	**135**

Denied Claims (PPRs, 25A, CAF)	
Number of Claims Reviewed	19,702
Number of Claims Denied	17,044
Amount of Claims Reviewed	$4,880,139
Amount of Claims Denied	$4,242,806

Random Audits Concluded	
Audits Completed	10
Audits with Findings	4
Audits with No Findings	6
Overpayments Identified	$32,467

MPI Referrals	
Agency for Persons with Disabilities	9
Department of Children and Families	133
Department of Health	15
Division of Medicaid	3,048
Division of Health Quality Assurance	181
Medicaid Fraud Control Unit – Attorney General	117
Managed Care	6
Other	13

Safe Guard Services – Centers for Medicare and Medicaid (CMS)	0
Total	**3,512**

Provider Sanctions Imposed and Managed Care Organization Assessments				
	FY 2017-18		**FY 2018-19**	
Sanctions under Rule 59G-9.070, F.A.C.	**Number**	**Amount**	**Number**	**Amount**
Fine Sanctions	139	$1,929,650	170	$3,240,12
Suspensions	59	N/A	62	N/A
Terminations	96	N/A	91	N/A
Total for Rule 59G-9.070, F.A.C. Sanctions	-	$1,929,650	-	$3,240,12
Total for Managed Care Organization Section 409.91212 F.S., or Contract Assessments	9	$110,400	8	$134,000
Grand Total Sanctions and Managed Care Organization Assessments	303	$2,040,050	331	$3,374,126

Overpayment Collections and Paid Claims Reversals (PCRs)			
Fiscal Year	**Type of Recovery**	**Overpayment Identified**	**A/R Collections and Reversals**
FY 2015-16	Accounts Receivable and PCRs	$21,515,784	$21,458,880
FY 2016-17	Accounts Receivable and PCRs	$33,996,021	$37,831,179
FY 2017-18	Accounts Receivable and PCRs	$18,177,542	$19,875,170
FY 2018-19	Accounts Receivable and PCRs	$32,653,761	$13,443,420

MPI Prevention of Overpayments ($ Millions)				
	FY 2015-16	**FY 2016-17**	**FY 2017-18**	**FY 2018-19**
Denied Claims (PPRs, 25A, CAF)	$4.1	$1.9	$1.78	$4.24
Termination of Providers Impact	$2.0	$0.7	$0.62	$0.68
Program Suspensions Impact	N/A	$0.2	$0.16	$0.04
Focused Projects Impact	$2.8	$0.08	$0.17	$3.4
Site Visits Impact	$5.1	$5.1	$1.82	$5.94
Sanctioned Providers (Fine Impact)	$13.3	$2.3	$1.31	$12.4
Audit Impact	$18.3	$4.6	$3.73	$42.9
PPR and 25A Impact	-	-	$0.04	$56.52
MFCU Referrals	-	-	$38.4	$259.2
Total	**$45.6**	**$14.9**	**$48.03**	**$385.32**

MPI Recovery Activities ($ Millions)				
	FY 2015-16	**FY 2016-17**	**FY 2017-18**	**FY 2018-19**
MPI/MPI-CMS Audits (OP's Collected by Accounts Receivable)	$19.5	$37.7	$19.85	$13.34
Costs (Collected by Accounts Receivable)	$0.2	$0.3	$0.22	$0.45
Fines (Collected by Accounts Receivable)	$1.4	$2.4	$1.86	$1.1
Paid Claims Reversals	$0.2	$0.1	$0.02	$0.10
Certified Out of Business (COOB)	-	$3.2	$0.00	$0.00
Contractual Assessments	$0.1	$0.01	$0.11	$0.13

TPL Contractor - Assisted Claims Adjustments	$18.8	$12.1	$25.94	$20.4
Recovery Totals	**$40.2**	**$55.8**	**$48.00**	**$35.5**

Medicaid Program Integrity's Return on Investment (ROI)			
FY 2015-16	**Benefits**	**Costs**	**ROI**
Recovery	40.2	7.4	5.43:1
Prevention	45.6	5.3	8.60:1
Total:	85.8	12.7	6.76:1
FY 2016-17	**Benefits**	**Costs**	**ROI**
Recovery	55.8	7.26	7.7:1
Prevention	14.9	4.62	3.2:1
Total:	70.7	12.0	5.9:1
FY 2017-18	**Benefits**	**Costs**	**ROI**
Recovery	48.00	8.35	5.75:1
Prevention	48.03	4.30	11.16:1
Total:	96.03	12.65	7.59:1
FY 2018-19	**Benefits**	**Costs**	**ROI**
Recovery	35.48	7.56	4.69:1
Prevention	132.06	4.14	44.68:1
Total:	167.54	11.7	18.84:1

MPI, along with internal Agency partners and external partners, engages in a variety of activities best categorized as fraud, abuse, and waste prevention. These activities involve early detection (of fraud, abuse, and waste) and avoidance of ongoing loss. In FY 2018-19, there was a significant increase in value for MPI's prevention efforts related to denied claims, fined/sanctioned providers, focused projects, field initiatives, audits, PPRs and 25As, and MFCU referrals. The impact of these increased efforts is reflected in the substantial increase in MPI's ROI for FY 2018-19.

Division of Operations

Third Party Liability (TPL) Unit

The Division Operations' TPL Unit is responsible for identifying and recovering funds for claims paid for by Medicaid for which a third party was liable, thereby ensuring Medicaid is the payor of last resort. Some examples of third parties include casualty settlements, insurance companies, recipient estates, Medicare and commercial carriers. TPL recovery services are performed by a state procured outside vendor. The Agency negotiated and executed a five-year contract with Health Management Systems, Inc (HMS) through August 31, 2020. The TPL Unit has been realigned to the Division of Medicaid for FY 2019-20 going forward.

During FY 2018-19, approximately $85.4 million in Medicaid funds were collected. Annual TPL collections over the last four years have averaged approximately $90.5 million. In addition, the TPL Unit has held Conduent (previous vendor) and Health Management Systems, Inc. (HMS) accountable to its contract requirements by vigorously monitoring Conduent and HMS's performance. These efforts have helped to ensure maximum recoveries are generated for the State of Florida. Types of recoveries include:

- **Casualty** – Medicaid imposes a lien against liable third parties for the amount Medicaid has paid for services on behalf of a recipient who has been involved in an accident or incident, which resulted in injury. Attorneys are required to notify Medicaid that they represent a Medicaid recipient involved in an accident or incident;
- **Estate** – Medicaid files an estate claim on behalf of a deceased Medicaid recipient for Medicaid payments made after age 55. Medicaid is to be paid, as class 3 creditor, after attorney and personal representative fees and funeral costs, and must be notified by the estate attorney or personal representative when an estate is opened on any individual over age 55;
- **Trusts and Annuities** – Trusts and Annuities relating to a person's eligibility in the Medicaid program stipulate that upon the death of the beneficiary, or if the trust/annuity is otherwise terminated, the balance of the trust up to the amount that Medicaid paid for services on the beneficiary's behalf is to be paid to the Medicaid program;
- **Medicare and Other Third Party Payor** – Medicaid bills and collects from insurance carriers and Medicaid providers for claims paid for by Medicaid for which Medicare or another third party such as private insurance may have been liable;
- **Other Recoupment Projects** – The TPL Unit also works in conjunction with the Agency's Bureau of Medicaid Program Integrity to conduct other Medicaid recoupment projects. Recoveries from other recoupment projects during FY 2018-19 include:
  - **Date of Death** – Claims paid after the dates of death of Medicaid recipients are recovered;
  - **Hospital Credit Balance Audits** – Hospital accounts payable ledgers are reviewed in connection with collecting Medicaid overpayments; and
  - **Freestanding Dialysis Center Credit Balance Audits**- Freestanding Renal Dialysis Center provider's payable ledgers are reviewed in connection with collecting Medicaid overpayments.
- **Medicaid Overpayments** – Funds are recovered from providers where Medicaid has overpaid for a service, for example:
  - **Duplicate Crossover Payments** – Two Medicaid payments for Medicare Crossover liability;
  - **Outpatient Payment During Inpatient Stay** – An outpatient Medicaid payment immediately preceding an inpatient stay;
  - **Overutilization** - Outpatient Payments Over $1,500 – payments made in excess of the $1,500 limit for outpatient claims during a fiscal year;
  - **Service Exclusions** – Claims paid for services that are excluded per the respective Services Coverage and Limitations Handbook(s) and provider fee schedules for pharmacy, professional, institutional, and dental claim types:
    - Inpatient Stay over 45 days;
    - Non-covered Outpatient Revenue Codes;
    - Revenue Codes Not on Promulgated Billing Code; and

- Outpatient to Inpatient Transfers.

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

Below is a summary of Historical TPL collections:

Medicaid Third Party Liability - Historical Collections					
TPL Collections	**FY 2014-15**	**FY 2015-16**	**FY 2016-17**	**FY 2017-18**	**FY 2018-19**
Casualty	$21,985,243	$21,877,491	$22,819,897	$15,233,111	$14,202,145
Estate	$7,092,510	$8,507,538	$7,709,297	$8,190,939	$10,485,571
Trusts	$8,595,999	$5,887,889	$9,905,343	$11,498,094	$12,157,443
Medicare and Other Third Party Payor	$67,061,300	$41,544,352	$36,444,209	$30,040,263	$28,160,938
Other Recoupment Projects*	$42,525,211	$18,831,428	$12,074,137	$25,935,208	$20,400,459
Total Collections	$147,260,263	$96,648,698	$88,952,883	$90,985,339	$85,406,555
Cost Avoidance (Matrix)	$2,366,574,378	$2,031,929,709	$1,338,770,174	$1,215,514,268	$1,362,581,538

*This amount is reported under Medicaid Program Integrity's Collection, as MPI contracts for these services under the Third Party Liability contract.

Financial Services

When Medicaid overpayments are identified, they are generally referred to the Agency for Health Care Administration's (AHCA or Agency) Division of Operations, Bureau of Financial Services (Financial Services) for collections. Financial Services then pursues collection of the overpayments from the Medicaid provider. Financial Services collects by direct payments from providers or through withholding of Medicaid and/or Medicare payments.

When Financial Services is unable to place liens against Medicaid/Medicare payments for unpaid debts, Financial Services pursues other means of collection or determines if the case can be referred to the outside collection agency. Financial Services cannot authorize any reductions in monies due back to the Agency; any reductions in overpayments or fines must be negotiated during a settlement process prior to the Final Order being issued by the Agency.

As of June 30, 2018, the Medicaid accounts receivable balance for fraud and abuse was $76.1 million. During FY 2018-19 Financial Services recorded $42.1 million as Medicaid accounts receivable. As of June 30, 2019, the balance was $78.9 million. During FY 2018-19, total collections including refunds and net of adjustments approached $24.2 million. The collections were: $22.3 million in overpayments ($9 million collected from Medicaid Fraud Control Unit (MFCU) cases and $13.3 million collected from Medicaid Program Integrity (MPI) cases); $449,422.02 in investigation costs; $1.1 million in fines/sanctions; and $373,452.32 in interest.

The Agency must obtain approval from the Department of Financial Services (DFS) to write-off all accounts receivable deemed uncollectible. This year, DFS approved $15.1 million in accounts receivables for write-off. Accounts are generally written off because of one of the following reasons:

- The provider has declared bankruptcy;
- The provider is deceased;
- The corporation is out of business;
- The defendant is unable to pay because they are incarcerated; or
- The business is insolvent or is beyond the State's current collection enforcement authority.

The federal requirements only allow federal funding to be reclaimed when the write-off is due to one of the following reasons:

- Bankruptcy in which the Agency has filed a claim (even if the bankruptcy is discharged at the time the Agency discovers the bankruptcy);
- The Agency files a claim on the estate, for an individual who is deceased; or
- When the write-off is due to an out-of-business certification.

Once the accounts receivable is approved for write-off, the qualified federal share of each accounts receivable write-off is reclaimed. Financial Services also continues to work with the Agency's Division of Health Quality Assurance (HQA) and the Department of Health (DOH) to determine if a facility/provider's license renewal can be suspended pending receipt of overpayment amounts from the provider.

Financial Services uses the Medicaid Accounts Receivable (MAR) system, which records extensive financial detail on Medicaid accounts receivable, as its business process tool. The MAR system tracks each case as it moves through the receivable process, identifying which department, bureau or unit has current responsibility for a case. The system tracks state and/or federal allocation of receivable amounts and produces necessary reports for case management and audit purposes.

Examples of available reports include System Financial Summaries, Case Financial Histories, Case Aging, Summary by Status and Department, and the "tickler file" used for monitoring purposes and reports for follow-up. The MAR system maintains the required accounting data for financial statements and federal reporting purposes related to fraud and abuse cases, and other overpayment cases. Examples of other overpayment cases include but are not limited to hospital and nursing home retroactive rate adjustments, gross adjustments, and Agency for Persons with Disabilities' (APD's) overpayments.

Financial Services continues to provide transaction information files to update the Agency's Fraud and Abuse Case Tracking System (FACTS). The information in these files includes the original overpayment amount, payments received, adjustments applied, current balance, and status for each case in the MAR system. An automated process runs each night to create a data file from the MAR system, and then updates FACTS, enabling it to reflect the latest financial and account status information.

Financial Services continues to emphasize communications with MPI, Bureau of Medicaid Quality, and MFCU to coordinate audit collection efforts. Financial Services also works with the Agency's Office of the General Counsel (OGC), Bureau of Medicaid Program Finance (MPF), HQA, Office of Third Party Liability (TPL), Medicaid Fiscal Agent Operations (MFAO), and Office of Inspector General (OIG) to coordinate collection efforts and pursue additional avenues of collection.

The MAR Unit continues to diligently take all necessary steps to collect on all outstanding Medicaid Accounts Receivables and past due revenue debts related to fraud, abuse and overpayments.

Division of Health Quality Assurance

Care Provider Background Screening Clearinghouse

The Agency for Health Care Administration's (AHCA or the Agency) Care Provider Background Screening Clearinghouse (Clearinghouse) works to prevent, identify, coordinate, and support Medicaid Program Integrity (MPI) functions. The Clearinghouse is a secure, web-based database to house and manage background screening results of multiple state agencies, allowing the following agencies to share those results: The Agency, Managed Care Health Plans, Medicaid providers, the Agency for Persons with Disabilities (APD), the Department of Elder Affairs (DOEA), the Department of Children and Families (DCF), the Department of Health (DOH), the Department of Juvenile Justice (DJJ), and Vocational Rehabilitation (VR) at the Department of Education (DOE). For the selected agencies and persons subject to background screenings, the elimination of duplicative screenings for employees working in long-term care and other health care related provider types has resulted in an overall cost savings.

The Clearinghouse also includes a RapBack requirement, also known as "retained prints," which enables immediate notification to the Agency of the recent arrest of an employee to determine if the arrest affects access to vulnerable clients. The Clearinghouse also notifies providers of an arrest and prompts the Provider to check eligibility. The immediacy of notification through RapBack improves the Agency's response time in prevention of Medicaid fraud. The Clearinghouse provides the ability to keep an employee roster. Facilities are required to maintain a current employee roster, with updates to be made within 10 business days of a change, including a new hire, termination, or position change. With this requirement, the Agency can know immediately when a facility has employees who are not eligible on their roster and take action against the facility if it does not comply. From Clearinghouse implementation to the end of FY 2018-19, the Agency has imposed 519 background screening violations and 187 employee roster violations.

Beginning in January 2018, Clearinghouse Renewals were implemented to maintain the retention of fingerprints within the Clearinghouse. The process allows for faster processing time since the employee does not have to be re-fingerprinted, and also provides an updated criminal history, an extension of the retention period for another five years, and a cost savings of over $30 per employee compared to a new screening.

During FY 2018-19, the Background Screening Unit processed 28,155 RapBacks. Of these, over one third were found to be for criminal charges that resulted in the applicant's eligibility status being updated to not eligible. During FY 2018-19, 174,708 background screening results were shared among participating agencies and Medicaid health plans (MHPs) and 53,938 renewal screenings were requested resulting in an overall cost savings of $14,883,054 to Agency providers, DOH licensees, MHPs, Medicaid providers, DCF, DOEA, DOEVR, and APD providers.

Licensure Protections Senate Bill 1986 Reporting

In 2009, the Legislature passed Senate Bill (SB) 1986 addressing regulatory reforms and fraud and abuse prevention. From January 2010 to June 2016, the Agency submitted a monthly report on the implementation of the provisions of SB 1986 as requested by the Senate Committee on Health Regulation, with a calendar year 2016 report submitted in early 2017. Much of the information contained in the SB 1986 reports is already published in this report. Additionally, with the implementation of Statewide Medicaid Managed Care (SMMC), MPHs are now responsible and accountable for monitoring functions for their members, which was previously reported through home health monitoring projects for FFS recipients in the SB 1986 monthly report. To avoid duplication, the Agency has discontinued separate SB 1986 reports and instead included any information not already included in this report. The Agency reports the following information for FY 2018-19:

- **Home Health Agencies** – Home Health Agencies which have demonstrated a pattern of billing the Medicaid program for medically unnecessary services, have either received an administrative penalty for violating s. 400.474(6)(e), F.S., or denied a renewal application based on the provisions of s. 400.471(8), F.S. In FY 2018-19, no home health agencies were identified to have met these criteria;

- **Remuneration Complaints** - Complaints received against nurse registries for providing remuneration in violation of s. 400.506, F.S. There was one identified in FY 2018-19;

- **Nonimmigrant Aliens** - Nonimmigrant aliens who have applied for a home health agency, home medical equipment or health care clinic license, and met the requirements of s. 408.8065, F.S. One applicant met these criteria in FY 2018-19;

- **Financial Requirements** - There were 18 home health agency applications, 24 home medical equipment applications, and 24 health care clinic applications in FY 2018-19 that failed to meet the financial requirements of s. 408.8065, F.S. This includes applicants that did not reply to omissions related to proof of financial ability to operate during the application process; and

- **Revocations and Terminations** - Providers that were revoked, denied a renewal application or surrendered their license based on a Medicare or Medicaid suspension, termination or exclusion from either program related specifically to fraud based on the provisions of s. 408.815(1)(e) and s. 408.815(4), F.S. There were five providers that met this criteria in FY 2018-19.

Final and Emergency Orders

During the following fiscal years, the Agency issued final or emergency orders to providers for failure to meet licensure requirements, resulting in closure, and imposed the following fines and administrative fees:

Licensure Final and Emergency Orders					
Fiscal Year	**2014-15**	**2015-16**	**2016-17**	**2017-18**	**2018-19**
Denying the renewal application	35	29	31	57	25
Revoking an existing license	47	52	22	24	20
Emergency orders	7	17	13	16	15
Provider surrendering their license	19	15	11	9	4
Total	108	113	77	106	64
Imposed Fines and Administrative Fees	$3,339,379	$2,873,568	$2,218,876	$2,247,434	$3,017,176

Office of the General Counsel

The Office of the General Counsel (OGC) is actively involved with other offices of the Agency for Health Care Administration (AHCA or the Agency) to help deter fraud and abuse in the Florida Medicaid program. The mission of the OGC is to provide high quality legal counsel and vigorous advocacy to the Agency in championing better heath care for all Floridians. The OGC provides legal advice and representation for the Agency on all legal matters, including: administration of the Medicaid plan and recovery of Medicaid overpayments due to mistakes or third party liability; regulation of managed care plans; civil litigation related to various Agency programs; and licensure and regulation of health care facilities, including nursing homes, hospitals, assisted living facilities, clinical laboratories, and home health agencies.

The OGC is comprised of 43 attorneys with 11 dedicated to Medicaid Administrative Litigation defending the Agency in Medicaid-related litigation before administrative tribunals and litigate violations of state and federal laws pertaining to the administration of the Medicaid program before state and federal courts. The OGC has also dedicated an attorney-liaison who serves as a point of contact between the OGC, Medicaid Program Integrity (MPI) fee-for-service (FFS), and MPI managed care to help facilitate discussion and communication regarding ways to curb health care fraud and abuse. The attorney-liaison assists with legal matters related to manage care oversight, including: anti-fraud and compliance plans, reporting compliance, and investigations.

During this past fiscal year, the OGC Agency Clerk issued 429 Final Orders for MPI. Additionally, the OGC Agency Clerk received 57 MPI hearing requests.

THE DEPARTMENT OF HEALTH

Coordination and Cooperation between DOH, AHCA, and MFCU

The Department of Health continues its partnership with the Agency for Health Care Administration (AHCA) and the Attorney General's Medicaid Fraud Control Unit (MFCU) to strengthen inter-agency coordination and enhance processes and protocols in fraud investigation and prosecution. An interactive partnership is essential for protecting the people of Florida against health care fraud and substandard health care. The DOH Division of Medical Quality Assurance (MQA) leadership meets regularly with AHCA and MFCU directors and senior managers to coordinate joint projects, investigations and enforcement strategies and to identify emerging issues or threats. Over the years, these meetings have grown to include additional state agencies, including the Department of Children and Families, the Department of Financial Services Fraud Strike Force, the Department of Economic Opportunity, the Division of Insurance Fraud, and the Agency for Persons with Disabilities. Expanding participation in the meetings fosters a multi-agency approach to fraud mitigation, identifies potential, emerging areas of fraud, and areas in which agency resources can be more effectively leveraged.

AHCA and DOH have continued to enhance methods of information sharing so that provisions of anti-fraud legislation are fully implemented. The DOH transfers data nightly to AHCA to identify practitioners who are billing Medicaid, but who do not have an active DOH license. Additionally, AHCA and DOH have participated in joint trainings to better understand each agencies role in combating fraud.

As a result of legislation passed in 2009, from July 1, 2009 through August 20, 2019, DOH has denied licensure to 448 applicants and denied the renewal of 194 health care practitioners for health care related fraud. DOH has also taken 211 emergency actions and disciplined 403 health care practitioners for violations related to Medicaid.

STATUTORY REPORTING REQUIREMENTS

Number of cases opened and investigated

MFCU opened 344 cases and had 771 active cases in FY 2018-19. MPI investigated 7,956 cases which included 5,989 opened during the year.

Disposition of the cases closed

Case Type	MFCU	PANE	AHCA	Total
Administrative Closure	9			9
Administrative Referral	38	8		46
Acquittal	1			1
Assistance to Other Agencies	1			1
Case Dismissed	34			34
Civil Settlement	18			18
Change of Ownership (CHOW)			2	2
Consolidated	3			3
Conviction	16	10		26
Death of the Offender	1	1		2
Fines Issued			11	11
Fugitive Defendant	1			1
Investigation by Another Law Enforcement	6	3		9
Lack of Evidence	10	18		28
Liquidated Damages Applied			8	8
Medicaid Fraud Control Unit (MFCU)			107	107
No Abuse			50	50
No Auditable Review Period			2	2
No Findings			108	108
Nolle Prosequi		1		1
No Further Action Required			1,737	1,737
Not a Medicaid Issue			1	1
Not an Overpayment Issue			6	6
Not Sustained			64	64
Pre-Trial Intervention	1			1
Project Completed			20	20
Prosecution Declined	2	6		8
Provider Education			13	13
Provider No Longer Operational			14	14
Provider Suspended			62	62
Provider With Cause Termination			87	87
Provider Without Cause Termination			2,216	2,216
Referred			893	893
Resolved with Intervention	4	3		7
Sustained			550	550
Under Investigation by Another Entity			1	1
Unfounded	16	14		30
Unsubstantiated	17	9		26
Vacated Fines			5	5
Vacated Termination			2	2

Voluntary Dismissal	26			26
Voluntary Termination			2	2
Total	**204**	**73**	**5,960**	**6,237**

Sources of the cases opened

Source	MFCU	PANE	AHCA	Total
AHCA - Financial Services			62	62
AHCA - HQA-Facility Regulation			15	15
AHCA - HQA-Field Operations			2	2
AHCA - Medicaid Quality			20	20
AHCA - Medicaid Program Integrity (MPI)	37			37
AHCA – Medicaid Fiscal Agent Operations			34	34
AHCA – MPI Detection			6	6
AHCA - MPI Generalized Analysis			3	3
AHCA - MPI Institutional			362	362
AHCA - MPI Jacksonville/Orlando/Tampa (JOT)			577	577
AHCA - MPI Managed Care Unit			14	14
AHCA - MPI Miami			834	834
AHCA - MPI Pharmacy			171	171
AHCA - MPI Practitioners Care			4	4
AHCA- MPI Prevention Strategy			15	15
AHCA - Other Offices		1	9	10
APD - Agency for Persons with Disabilities	2		1	3
APS - Adult Protective Services	2	77		79
Attorney	1	1		2
Citizen	23	7		30
CMS - Centers for Medicare & Medicaid Services	1			1
Contractor for Center for Medicare & Medicaid	2			2
DCF - Department of Children & Families	1			1
DEA - US Drug Enforcement Administration	1			1
DOH - Department of Health	1		3	4
Employee	7			7
EOMB			7	7
Family Member	4	5		9
FBI- Federal Bureau of Investigation	1			1
FDLE - Florida Department of Law Enforcement	2			2
Federal Agency – Centers for Medicare & Medicaid			1	1
Florida – Medicaid Fraud Control Unit			19	19
Generalized Analysis			40	40
HHS OIG Health & Human Services Inspector	3		1	4
Internet/Media			32	32
Investigator Initiative			207	207
Joint Task Force	12			12
Law Enforcement Agency		2		2
Managed Care Special Investigations Unit	27			27
Medicaid Provider	7	5		12
Medicaid Recipient	3	2		5
Online Complaint Form			14	14

Operation Spot Check		1		1
Other - See Description			8	8
Previous File or Case			27	27
Projects			3,370	3,370
Provider			18	18
Qui Tam	102			102
Random Audits			1	1
Random Selection			4	4
Self-Audit			107	107
Spinoff Case	2			2
State Agency Other		1		1
SUN - Sunshine			1	1
Veteran Affairs		1		1
Total	**241**	**103**	**5,989**	**6,333**

Amount of overpayments alleged in preliminary and final audit letters

Preliminary	Final
$62,298,905	$39,202,887

Number and amount of fines or penalties imposed

During FY 2018-19, MPI imposed fines (under s. 409.913, F.S., and Rule 59G-9.070, F.A.C.) in the amount of $3,240,126.

Reductions in overpayment amounts negotiated in settlement agreements or by other means

There were no reductions in overpayments through negotiated settlements by MFCU during FY 2018-19. During FY 2018-19, the Agency's final settlements resulted in no reductions of overpayments in closed cases.

Amount of final Agency determinations of overpayments

MPI identified overpayments in the amount of $32,551,402 in closed audits.

Amount deducted from federal claiming as a result of overpayments

Federal requirements changed several years ago, and now, allow the state up to one year to return the federal share, through federal cost share adjustments of overpayments, if no revenues are received on the debt. To ensure federal shares are allocated as timely as possible, the Agency reports the federal portion of the total overpayment on the next available federal CMS-64 quarterly report and reduces a corresponding federal share draw. During FY 2018-19, the Agency reduced its federal share, on quarterly cost reports, by $20.2 million for net overpayments.

Amount of overpayments recovered each year

MFCU collected $8,565,299 in overpayments that were returned to the Agency. Additionally, MFCU collected $13,226,826 in Federal Medicaid overpayments that were sent directly to the U. S. Department of Health and Human Services for a total of $21,792,125 in Medicaid overpayments collected in FY 2018-19. Overpayments recovered as a result of the MPI and MPI-CMS audits were $13,341,060. Total recoveries by MPI, MPI-CMS, and MPI-TPL for FY 2018-19 were $35,480,886 (This includes collections of overpayments, fines, costs, and paid claims reversals, COOBs, and contract assessments during the fiscal year).

Amount of cost of investigation recovered

During FY 2018-19, the MFCU collected $3,106 in program income investigative costs. MFCU also collected $11,542 in state share investigative costs and $28,064 in federal share investigative costs for a grand total of $42,712 for all investigative costs.

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

MFCU expenditures for FY 2018-19 were $18,007,463 which included indirect costs of $2,130,187.

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

The average length of time for MPI cases open in any fiscal year to subsequently being paid in full during FY 2018-19 was 0.60 years.

The amount determined as uncollectible and the portion of the uncollectible amount subsequently reclaimed from the Federal Government

During FY 2018-19, the Bureau of Financial Services deemed $15.1 million as uncollectible.

Providers, by type, prevented from enrolling in or re-enrolling in the Medicaid program as a result of documented Medicaid fraud and abuse

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

Summary by Denial Reason	Totals
Previous Program Termination	360
Best Interest of The Program	535
Total	**895**

Denials by Provider Type	Totals
05 - Community Behavioral Health Services	10
07 - Specialized Therapeutic Services	17
14 - Assistive Care Services	9
20 - Prescribed Drug Services	3
25 - Physician (M.D.)	32
26 - Physician (D.O.)	1
27 - Podiatrist	2
29 - Physician Assistant	1
30 - Advanced Practice Registered Nurse (APRN)	5
31 - Registered Nurse/Registered Nurse First Asst.	0
32 - Social Worker/Case Manager	10
35 - Dentist	1
39 - Behavior Analysis	553
62 - Optometrist	1
65 - Home Health Services	170
67 - Home & Community-Based Services Waiver	36
81 - Professional Early Intervention Services	1
83 - Therapist (PT, OT, ST, RT)	5

89 - Dialysis Center	1
90 - Durable Medical Equipment/Medical Supplies	3
91 - Case Management Agency	34
99 - Trading Partner	0
Total	**895**

Additionally, 335 providers were prevented from enrolling or reenrolling due to findings during an onsite pre-enrollment visit, criminal background screening, or federal exclusion.

Summary by Denial Reason	Totals
Failed Onsite Review	214
Criminal History	43
Federal Exclusion	3
Total	**260**

Denials by Provider Type	Totals
05 - Community Behavioral Health Services	13
07 - Specialized Therapeutic Services	5
14 - Assistive Care Services	0
20 - Prescribed Drug Services	4
25 - Physician (M.D.)	34
26 - Physician (D.O.)	2
27 - Podiatrist	2
29 - Physician Assistant	5
30 - Nurse Practitioner (APRN)	9
32 - Social Worker/Case Manager	1
35 - Dentist	0
39 - Behavior Analysis	101
51 - Portable X-Ray Company	1
61 - Hearing Aid Specialist	1
62 - Optometrist	1
65 - Home Health Services	60
67 - Home & Community-Based Services Waiver	5
83 - Therapist (PT, OT, ST, RT)	9
90 - Durable Medical Equipment/Medical Supplies	6
91 - Case Management Agency	1
Total	**260**

Finally, there were 426 providers who were identified as potentially related to suspected fraud and abuse and other compliance-related considerations that were already terminated or denied at the time that the Agency discovered the program integrity related concern. These providers who are under review by the Agency or other entities may voluntarily terminate from the program to avoid an involuntary action by the Agency. Other providers in this category may have been terminated for other reasons that were non-adverse in nature, including failure to complete enrollment renewal or eighteen months of billing inactivity.

Summary by Denial/Termination Reason	Totals
Denied - Adverse Association	144
Terminated - Adverse Association	256

Providers, by type, terminated from participation in the Medicaid program as a result of fraud and abuse

The following charts reference the number of providers, by total and by type, which were terminated from the Medicaid program due to considerations or factors that are of a program integrity nature. These figures represent both contractual and sanction-based terminations due to suspected fraud and abuse and other compliance-related considerations that fall within the broader category of program integrity.

Summary by Termination Type	Totals
Criminal History	9
Contractual Termination Under Medicaid Authority	744
With-Cause Termination Under Medicaid Final Order	88
Failed Onsite Review	12
Total	**853**

Terminations by Provider Type	Totals
05 - Community Behavioral Health Services	11
06 - Ambulatory Health Care Facility	1
07 - Specialized Mental Health Practitioner	7
10 - Skilled Nursing Facility	2
14 - Assistive Care Services	16
15 – Hospice	0
20 - Pharmacy	8
25 - Physician (M.D.)	27
26 - Physician (D.O.)	4
27 - Podiatrist	8
29 - Physician Assistant	2
30 - Advanced Practice Registered Nurse (APRN)	4
32 - Social Worker/Case Manager	15
35 - Dentist	11
39 – Behavior Analysis (Ba)	645
45 - Private Transportation	1
50 – Independent Laboratory	0
60 - Audiologist	1
65 - Home Health Services	21
67 - Home & Community-Based Services Waiver	36
81 - Professional Early Intervention Services	5
83 - Therapist (PT, OT, ST, RT)	5
89 - Dialysis Center	1
90 - Durable Medical Equipment/Medical Supplies	8
91 - Case Management Agency	10
97 - Managed Care Treating Provider - Non-Medicaid	3
99 - Trading Partner	1
Total	**853**

Policy recommendations necessary to prevent or recover overpayments and changes necessary to prevent and detect Medicaid fraud

As has been described in previous years, there is routine communication between MPI, the Division of Medicaid, and others within the Agency concerning AHCA policy changes needed to improve detection, prevention, investigation, and audit capabilities regarding Medicaid fraud and abuse. While there are little or no additional legislative needs to assist with this internal policy revision process, real financial crimes, outside the scope of the Agency's authority, warrant consideration regarding additional efforts to aide in combatting health care fraud. For example, the relative ease within which an entity can form and give the appearance of a going concern, with little or no oversight about the validity or ownership information, business assets, and business the entity may engage in, creates an attractive environment for money laundering and other illicit activities. Efforts to mitigate the risk of health care fraud and other criminal activity are often at odds with other legitimate state interests, such as promoting economic growth. Policy consideration should be given to the impact on the risk of a broad array of fraud schemes within a broad array of industries. MPI and others within the Agency, as well as other state agencies, should consider training in financial crime detection and investigation that addresses such issues as straw owners, shell and shelf corporations, kickbacks, bribery, and money laundering. These training efforts should be supported by continued training budget authority and travel authorizations.

ACRONYMS

3D - Three Dimensional Imaging
ABC - AmerisourceBergen Specialty Group
AFAAR - Annual Fraud Abuse Activity Report
AHCA - Agency for Health Care Administration
ALF - Assisted Living Facilities
APD - Agency for Persons with Disabilities
APRN - Advanced Practice Registered Nurse
APS - Adult Protective Services
BA - Behavioral Analysis
CAF - Credible Allegation of Fraud
CEB - Civil Enforcement Bureau
CFR - Code of Federal Regulations
CHOW - Change of Ownership
CMS - Centers for Medicare and Medicaid Services
CNA - Certified Nursing Assistant
COOB - Certified Out of Business
CPT - Current Procedural Terminology
CT - Computerized Tomography
CTA - Computerized Tomography Angiography
DCF - Department of Children and Families
DFS - Department of Financial Services
DJJ - Department of Juvenile Justice
DME - Durable Medical Equipment
DOAH - Division of Administrative Hearings
DOE - Department of Education
DOH - Department of Health
DOJ - Department of Justice
DSS - Decision Support System
EMA - Emergency Medicaid for Aliens
EOMB - Explanation of Medicaid Benefits
EVV - Electronic Visit Verification
F.A.C. - Florida Administrative Code
FACTS - Fraud and Abuse Case Tracking System
FBI - Federal Bureau of Investigations
FDLE - Florida Department of Law Enforcement
FFP - Federal Financial Participation
FFS - Fee-for-Service
FMHI - Florida Mental Health Institute
FLMMIS - Florida Medicaid Management Information System
F.S. - Florida Statutes
FSFN - Florida Safe Families Network
FTE - Full-time Equivalent
FY - Fiscal Year (Florida's fiscal year is July 1 – June 30)
GAO - Government Accountability Office
HCBS - Home & Community Based Services
HEAT - Health Care Fraud Prevention and Enforcement Action Team
HHS-OIG - Department of Health and Human Services - Office of the Inspector General
HIPAA - Health Insurance Portability and Accountability Act
HMA - Health Management Associates
HMO - Health Maintenance Organization
HMS - Health Management Systems, Inc.
HQA - AHCA's Health Quality Assurance
JOT - Jacksonville, Orlando, and Tampa
LEIE - List of Excluded Individuals and Entities
LPN - Licensed Practical Nurse
LTC - Long Term Care
MAR - Medicaid Accounts Receivable
MCO - Managed Care Organization
MCU - Managed Care Unit
MFAO - Medicaid Fiscal Agent Operations
MFCU - Medicaid Fraud Control Unit, within the Florida Department of Legal Affairs
MHP - Medicaid Health Plan
MII - Medical Initiatives
MMA - Managed Medical Assistance
MPF - Medicaid Program Finance
MPI - AHCA's Medicaid Program Integrity
MRA - Magnetic Resonance Angiography
MRI - Magnetic Resonance Imaging
MQA- Medical Quality Assurance within the Florida Department of Health
NDA - New Drug Application
NHCAA - National Health Care Anti- Fraud Association
NPI - National Provider Identifiers
NPPES - National Plan and Provider Enumeration System
OGC - Office of General Counsel
OP - Overpayment
HMO - Health Maintenance Organization
ORU - Overpayment Recoupment Unit
OSINT - Open-Source Intelligence
OSU - Operational Support Unit
PANE - Patient Abuse, Neglect and Exploitation
PCRs - Paid Claims Reversals
PDL - Preferred Drug List
PECOS - Provider Enrollment Chain Ownership System
PECU - Provider Eligibility and Compliance Unit
PERM - Payment Error Rate Measurement
PET - Positron Emission Tomography
PFS - Pre-Filled Syringes
PPEC - Prescribed Pediatric Extended Care
PPR - Prepayment Review
QFAAR - Quarterly Fraud Abuse Activity Report
ROI - Return on Investment
SAM - System for Awards Management
SB - Senate Bill
SIPP - Statewide Inpatient Psychiatric Program
SIU - Special Investigative Unit
SMMC - Statewide Medicaid Managed Care
SQL - Structured Query Language
TCM - Targeted Case Management
TPL - Third Party Liability
UM - Utilization Management
USF - University of South Florida
VR - Vocational Rehabilitation

A note on how this report was composed:

The Agency for Health Care Administration, Bureau of Medicaid Program Integrity exercises oversight of the production of this report. However, the compilation of the information contained herein originated from many state agencies, bureaus, and units that have oversight of different functions of Florida's large and complex Medicaid program. Months prior to this report's publication, Jessica Zeedyk and Fred Becknell of the Bureau of Medicaid Program Integrity initiated data calls and conveyed requests for up-to-date text to include in this report. The information from the multiple sources was assembled into a single draft document with assistance from other staff members. The draft text was reviewed and approved by officials responsible for the activities documented and published in this final report, in coordination with Multimedia Design. While many dedicated state employees contributed to this report throughout the year, Jessica Zeedyk and Fred Becknell's efforts were most important in ensuring this report was submitted timely, with the statutorily required information. If you have questions or comments regarding this report, the Agency for Health Care Administration and the Office of the Attorney General will make every effort to address them.

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