

**THE STATE'S
EFFORTS TO
CONTROL
MEDICAID
FRAUD
AND ABUSE
FY 2014-15**





RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

December 15, 2015

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

Dear Governor Scott:

Pursuant to Section 409.913, Florida Statutes, enclosed is the annual report of the activities related to the fight against fraud and abuse in the Medicaid program for the FY 2014-15. This report has been prepared jointly by staff of the Agency for Health Care Administration and the Medicaid Fraud Control Unit within the Office of the Attorney General.

Sincerely,

Pam Bondi
Attorney General

Sincerely,

Elizabeth Dudek
Secretary

Cc: The Honorable Andrew Gardiner
The Honorable Steve Crisafulli



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 and the Medicaid Fraud Control Unit (MFCU) of the Department of Legal Affairs have continued their joint efforts to prevent, reduce, and mitigate health care fraud, waste, and abuse 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 2014-15.

TABLE OF CONTENTS

Department of Legal Affairs – Office of the Attorney General	1
Overview of the Medicaid Fraud Control Unit	1
Control and Enforcement Strategy	1
Complaints	2
Case Investigations	2
Disposition of Cases	3
Case Highlights	5
Total Recoveries	10
General Revenue Generated	11
Training	11
Data Mining	12
Health Care Fraud Prevention and Enforcement Action Team (HEAT)	12
The Agency for Health Care Administration’s Role in Protecting the Medicaid Program from Fraud and Program Abuse	13
Division of Medicaid	13
Provider Enrollment and Accountability	14
Program-Wide Provider Enrollment and Accountability	14
Centralized Background Screening	14
Monitoring and Reporting of Terminated Providers	14
Provider Accountability and Increased Provider Enrollment Requirements	14
SMMC Health Plan Provider Enrollment and Accountability	15
Medicaid Health Plan Contract Requirements for Provider Credentialing	15
The Streamlined Credentialing Project	17
Fraud and Abuse Related Reporting Requirements	17
SMMC Health Plan Fraud and Abuse Related Reporting Requirements	17
Provider Outreach and Education	17
Program-Wide Provider Education	18
SMMC Health Plan Education and Training Requirements	18
Prior Authorization	19
SMMC Health Plan Prior Authorization	19
Medicaid Fee-for-Service Prior Authorization	19
Home Health Visit Prior Authorization	19
Home Health Visit Prior Authorization Activities FY 2014-15:	20
Medicaid Pharmacy Prior Authorization	20
Utilization Management	20
Program-Wide Utilization Management	21
Medicaid Preferred Drug List	21
Data Analysis	21
SMMC Health Plan Utilization Management	21
SMMC Contractual Provisions and Plan Responsibilities	21
Medicaid Fee-for-Service Utilization Management	22
Pharmacy	22
Utilization Management of Home Health Services	23
Ancillary Medicaid and Other Services	23
Comprehensive Care Management for Children with Special Health Care Needs	23
Inpatient Behavioral Health	24
Outpatient Advanced Diagnostic Imaging	24
Medicaid Certified School Match Program	24

Medicaid Program Integrity	25
Organizational Overview	25
Prevention	25
Detection	28
Data Analytics	28
Intake	28
Managed Care Oversight	30
Overpayment Recoupment	32
Administrative Support	33
MPI Accomplishments	33
Audits and Investigations	33
Collaborative Efforts	34
Field Initiatives/Focused Projects	34
Payment Restrictions	37
Provider Education	38
Referrals	38
Sanctions	38
Other Medicaid Program Integrity Projects	39
MPI Data for Fiscal Year 2014-15	41
Division of Operations	44
Third Party Liability Unit	45
Division of Health Quality Assurance	47
Care Provider Background Screening Clearinghouse	47
Office of the General Counsel	47
Department of Health	48
Coordination and Cooperation Between DOH, AHCA, AND MFCU	48
Statutory Reporting Requirements	49
Number of cases opened and investigated	49
Disposition of the cases closed	49
Sources of the cases opened	50
Amount of overpayments alleged in preliminary and final audit letters	51
Number and amount of fines or penalties imposed	51
Reductions in overpayment amounts negotiated in settlement agreements or by other means	51
Amount of final Agency determinations of overpayments	51
Amount deducted from federal claiming as a result of overpayments	52
Amount of overpayments recovered each year	52
Amount of cost of investigation recovered	52
Average length of time to collect from the time the case was opened until the overpayment is paid in full	52
The amount determined as uncollectible and the portion of the uncollectible amount subsequently reclaimed from the Federal Government	52
Providers, by type, terminated from participation in the Medicaid program as a result of fraud and abuse	52
All costs associated with discovering and prosecuting cases of Medicaid overpayments and making recoveries in such cases	54
Providers prevented from enrolling in Medicaid or re-enrolling as a result of suspected fraud or abuse	54
Policy recommendations necessary to prevent or recover overpayments and changes necessary to prevent and detect Medicaid fraud	54
Acronyms	56

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 and program administrators. This authority is granted under both federal and state law (Section 1903 of the Social Security Act, Section 42 of the Code of Federal Regulations, and Chapter 409, Florida Statutes (F.S.)).

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. Many of these investigations have focused on the pharmaceutical industry and several of these investigations have resulted in multi-million dollar settlements for Florida.

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

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

Control and Enforcement Strategy

The MFCU has two primary areas of enforcement responsibility: fraud perpetrated against the Medicaid Program and Patient Abuse, Neglect, and Exploitation. Enforcement in these areas, which includes both criminal and civil enforcement actions, help with preventing, detecting, prosecuting, and deterring misconduct in an effort to protect the citizens of Florida. Case management including case openings, investigative activities, legal review/prosecution, prioritization, utilization of investigative/legal resources, and other related issues were handled on a case-by-case or office-by-office basis.

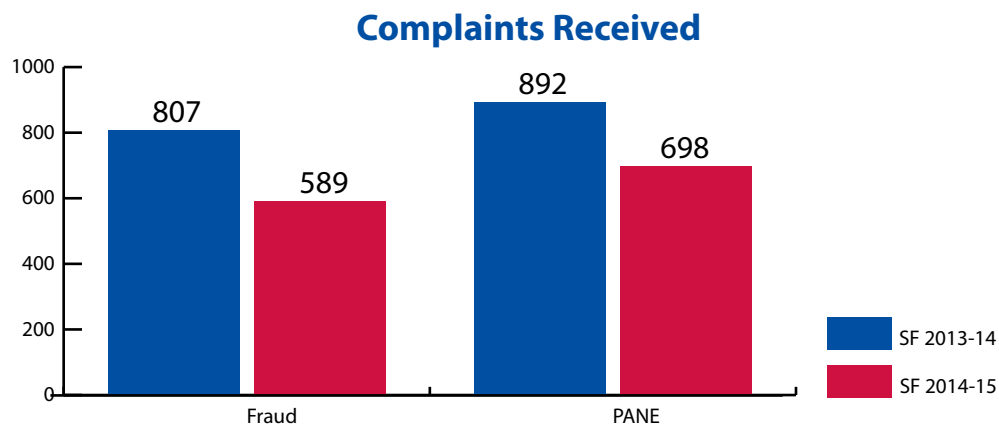
MFCU's Control and Enforcement Strategy requires unit members to focus on the following:

- 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 Contraband Forfeiture Act, Florida's False Claims Act, Common Law counts, and any other available legal remedies. The Complex Civil Enforcement Bureau will be proactive in Florida regarding *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 anti-fraud efforts.
- Intelligence – Emphasis is placed on developing and fostering key partnerships with agencies such as Agency for Health Care Administration (AHCA or Agency), Department of Health (DOH), Agency for Persons with Disabilities (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 2014-15, the Unit received 1,287 complaints. Of those 1,287 complaints, 289 were opened as operational cases. Of the 1,287 complaints received in FY 2014-15, 589 were related to fraud and 698 were related to PANE allegations.



Medicaid recipients were the primary source of fraud complaints in FY 2014-15 with 130 complaints reported. The Agency, via its Medicaid Program Integrity (MPI) unit, accounted for 23 original Medicaid fraud complaints received. Ninety *qui tam* complaints were received.

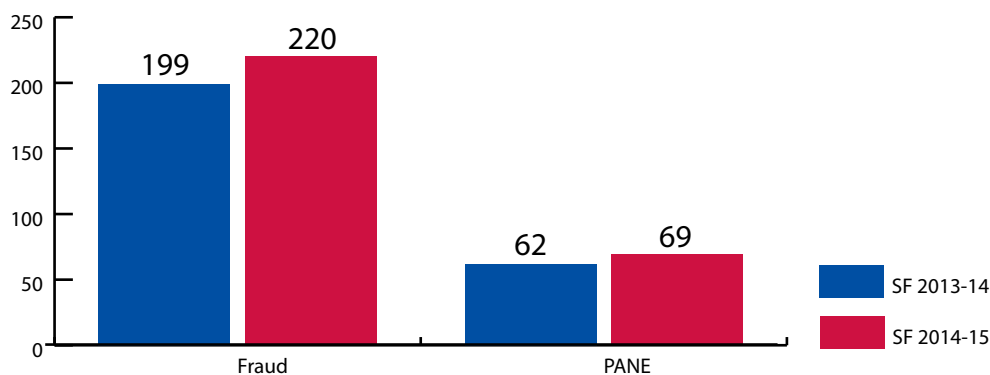
The majority of PANE complaints were generated by the Department of Children and Families (DCF). In FY 2014-15, of the 698 PANE complaints, 601 came from DCF. Family members relayed the next highest source of PANE complaints accounting for 19 complaints.

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 are 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 2014-15, the Unit’s internal intake team 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.

Cases Opened



The following is a list of the top five Medicaid provider types for MFCU fraud cases in FY 2014-15:

1. Physician
2. Home and Community Based Service
3. Pharmaceutical Manufacturer
4. Medical Supplies/Durable Medical Equipment
5. Pharmacy

The following is a list of the top five provider types for PANE cases in FY 2014-15:

1. Facility Employee
2. Certified Nursing Assistant
3. Skilled Nursing Facility
4. Care Giver
5. Licensed Practical Nurse

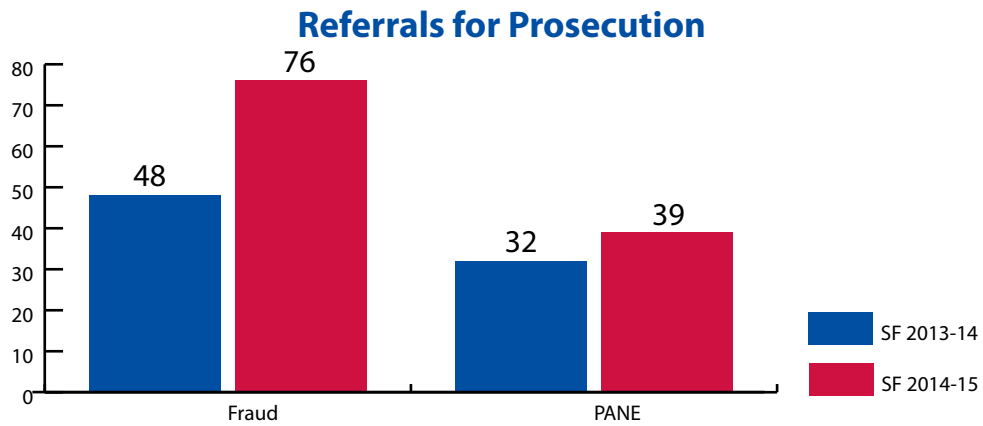
Disposition of Cases

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 has 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.

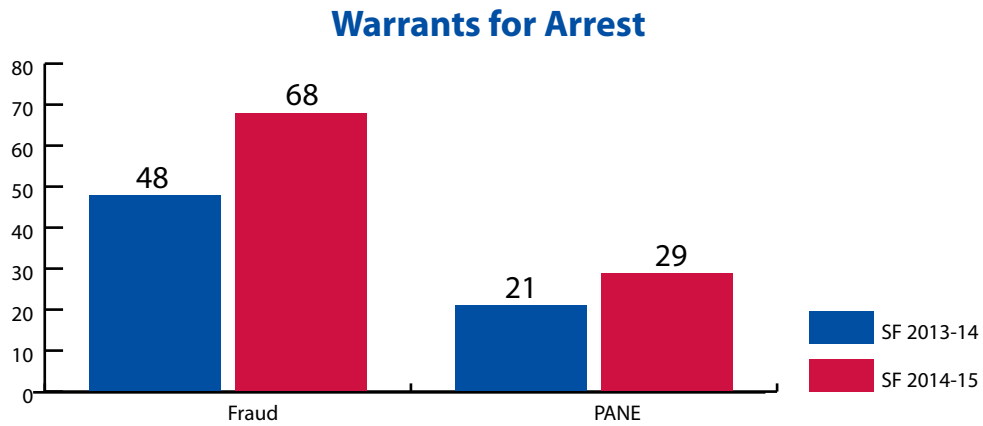
In FY 2013-14, the MFCU closed 311 cases. Of those, 250 involved Medicaid fraud investigations and 61 involved PANE cases.

In FY 2014-15, the MFCU closed 344 cases. Of those, 267 involved Medicaid fraud investigations and 77 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.



In FY 2014-15, the total referrals for prosecution increased 39% from the previous fiscal year. The Southern Region ramped up their referrals by 79%. The Northern and Central Regions continue to have successful referrals with increases of 17% and 26%, respectively.



The warrants for arrests increased by 41% in FY 2014-15. The key component of this increase was the Southern region which had 15 warrants for arrests in FY 2013-14 and 40 warrants in FY 2014-15.

Case Highlights

Shire Pharmaceuticals, LLC

On September 25, 2014, Attorney General Pam Bondi, 49 other attorneys general, and the federal government reached a \$56.5 million settlement with Shire Pharmaceuticals, LLC, a Pennsylvania based company, to resolve allegations that the company engaged in off-label marketing campaigns that improperly promoted five of its drugs: Adderall XR, Vyvanse, Daytrona, Lialda, and Pentasa. Adderall XR, Vyvanse, and Daytrona are United States Food and Drug Administration (FDA) approved treatment for Attention Deficit Hyperactivity Disorder (ADHD), and Lialda and Pentasa are approved for treatment of mildly to moderately active ulcerative colitis. The Medicaid program received \$48.1 million of the settlement to resolve civil allegations of false submitted claims to government health care programs. The settlement is the first national settlement in which Medicaid managed care damages have been calculated and included as part of a recovery.

The settlement alleges Shire Pharmaceuticals, LLC, promoted:

- Adderall XR as clinically superior to other ADHD drugs despite a lack of clinical data to support such claims and for the treatment of Conduct Disorder, an indication not approved by the FDA;
- Vyvanse as preventing certain negative consequences of ADHD and less abusable than Adderall XR or other ADHD medications despite a lack of clinical data to support such claims;
- Daytrona as less abusable than pill-based medications despite a lack of clinical data to support such claims. Daytrona, a patch applied product, demonstrated difficulty in sticking to the patient's body making it therapeutically less effective;
- Lialda for the prevention of colorectal cancer, an indication not approved by the FDA, and marketed Lialda as having greater efficacy than other medications, despite a lack of clinical data sufficient to support such a claim; and
- Pentasa for the treatment of indeterminate colitis and Crohn's Disease, indications for which it had not been approved by the FDA.

The settlement resulted from two *qui tam* lawsuits originally filed by whistle-blowers in the United States District Courts for the Eastern District of Pennsylvania and the Northern District of Illinois under the federal False Claims Act and various state false claims statutes.

Florida's share of the total settlement was for \$311,849.64 fee-for-service payments, \$118,591.82 related to Medicaid managed care, and additional recoveries of \$493,793.45, with interest of \$17,490.36.

Belie Brock Williams – Assisted Living Facility Administrator and Adrienne Taylor

– Assistant Administrator

Two Escambia County Assisted Living Facility employees were arrested on July 17, 2014, for abuse and neglect. According to the investigation, Belie Brock Williams, 73, former Administrator for Kipling Manor, refused psychological nursing caregivers entrance to the facility. Due to this refusal, some residents did not receive care for approximately two to three weeks. Adrienne Taylor, 44, former Assistant Administrator of Kipling Manor, failed to perform as a caregiver by not protecting the residents from abuse and not assuring the residents received the prescribed nursing services. Investigators received information regarding the alleged abuse and neglect from the Northwest Florida Long Term Care Ombudsman Program Office.

Williams pled as charged to three counts of abuse. Taylor pled to one count of neglect. On a separate case, Taylor pled to tampering with a witness, tampering with evidence, and providing false information to a law enforcement officer during an investigation. Belie Williams was sentenced to 33 months in prison and ordered to pay court costs. Adrienne Taylor was sentenced to two years of community control and ordered to pay court costs. This case was prosecuted by the State Attorney's Office of the First Judicial Circuit. The Agency for Health Care Administration played a significant role in these matters.

Melissa Simmons – Home Health Care Provider

On March 12, 2015, MFCU announced the plea of a Gadsden County Home Health Care Provider, Melissa Simmons, for defrauding the Florida Medicaid program out of more than \$13,000.00. After receiving an anonymous tip through the Florida Medicaid Fraud Hotline, the Attorney General's MFCU began an investigation that revealed Simmons conspiring with two Leon County residents in billing Medicaid for services Simmons never rendered to a developmentally disabled child. The conspirators allegedly caused more than \$13,000.00 in fraudulent claims to the Florida Medicaid program.

Simmons entered a plea to one count of patient brokering and one count of grand theft of more than \$10,000.00, both third degree felonies. The conditions of Simmons' plea include six months incarceration in the Leon County Jail and nine months of probation. Simmons is also required to pay restitution to Florida Medicaid along with additional fines and costs. The Second Judicial Circuit State Attorney's Office prosecuted the case.

Lana Goldfinger – Pines Nursing Home

Lana Goldfinger was arrested on December 19, 2013, for alleged Medicaid fraud. According to an investigation by the Attorney General's MFCU, Goldfinger allegedly conspired to commit Medicaid fraud by submitting false invoices from Pines Nursing Home totaling more than \$395,000.00. Investigators with the MFCU acted on a referral from the Agency.

On April 14, 2015, Goldfinger pled guilty to one count of Medicaid Fraud. She was sentenced to one year probation and ordered to pay \$500,000.00 in restitution to the Medicaid program, cost of prosecution of \$3,448.57, and court costs.

Baptist Health System

On April 25, 2015, Baptist Health System Inc. (Baptist Health), the parent company for a network of affiliated hospitals and medical providers in the Jacksonville, Florida, area, agreed to pay \$2.5 million to settle allegations that its subsidiaries violated the False Claims Act by submitting claims to federal health care programs for medically unnecessary services and drugs. The alleged misconduct involved Medicare, Medicaid, TRICARE, and the Federal Employee Health Benefits Program.

This settlement resolves allegations that, from September 2009 to October 2011, two neurologists in the Baptist Health network misdiagnosed patients with various neurological disorders, such as multiple sclerosis, which caused Baptist Health to bill for medically unnecessary services. Although Baptist Health placed one of the physicians at issue on administrative leave in October 2011, it did not disclose any misdiagnoses to the government until September 2012.

Florida's share of the total settlement was \$9,564.77 in restitution to the Medicaid program and additional recoveries of \$9,564.77.

Daiichi Sankyo Inc.

Daiichi Sankyo Inc., a global pharmaceutical company with its U.S. headquarters in New Jersey, agreed to pay the United States and state Medicaid programs \$39 million to resolve allegations that it violated the False Claims Act by paying kickbacks to induce physicians to prescribe Daiichi drugs, including Azor, Benicar, Tribenzor, and Welchol.

The Anti-Kickback Statute was enacted to ensure that physicians' medical judgment is not compromised by improper payments and gifts by other health care providers. The statute generally prohibits anyone from offering, paying, soliciting, or receiving remuneration to induce referrals of items or services covered by federal health care programs, including Medicare and Medicaid.

In this case, the government alleged that Daiichi paid physicians improper kickbacks in the form of speaker fees as part of Daiichi's Physician Organization and Discussion programs, known as "PODs," which were run

from January 1, 2005, through March 31, 2011, as well as other speaker programs that were run from January 1, 2004, through February 4, 2011. Allegedly, payments were made to physicians even when physician participants in PODs took turns “speaking” on duplicative topics at Daiichi-paid dinners, when the recipient spoke only to members of his or her own staff in his or her own office, or when the associated dinner was so lavish that its cost exceeded Daiichi’s own internal cost limitation of \$140.00 per person.

As part of the settlement, Daiichi has agreed to enter into a corporate integrity agreement with the Department of Health and Human Services–Office of Inspector General (HHS-OIG), which obligates the defendants to undertake substantial internal compliance reforms for the next five years.

The investigation and litigation was conducted by the Civil Division, the U.S. Attorney’s Office, the U.S. Department of Veterans Affairs, the Department of Defense Criminal Investigative Services, HHS-OIG, the National Association of Medicaid Fraud Control Units, and the Federal Bureau of Investigation (FBI).

Florida’s share of the Medicaid settlement was \$60,752.49 in restitution to the Medicaid program, \$60,752.50 in additional recoveries, and \$986.10 in interest.

Family Behavior Services LLC- Targeted Case Management Services

On September 4, 2014, the Florida MFCU, the Miami-Dade Police Department, the Kansas Medicaid Fraud Control Unit, the Shawnee County Sheriff’s Office, and the New Jersey Medicaid Fraud Control Unit arrested Grisel Pena, 63, Barbara Oldham-Kennedy, 40, and Robert Patrick Garcia, 38, on felony warrants for allegedly defrauding Medicaid out of more than \$1 million. The defendants allegedly submitted falsified claims for services not rendered to several Medicaid recipients and received payment based on falsified claims. This case originated from MFCU’s Data Mining Initiative.

According to the investigation, Pena, Oldham-Kennedy, and Garcia were corporate officers of Family Behavior Services, LLC, in Hallandale Beach and were allegedly paid more than \$1 million by the Medicaid program for Targeted Case Management services that were never provided. Targeted Case Management services are designed to link Medicaid recipients with serious mental health disorders to community-based services. The investigation revealed services were not provided as frequently as billing indicated or were not rendered at all.

On January 26, 2015, Grisel Pena entered into a plea agreement and pled guilty to one count of Medicaid fraud and one count of organized fraud. She was sentenced to 60 days in the Broward County Jail, followed by five years probation. Barbara Oldham-Kennedy also entered into a plea agreement and pled guilty to one count of Medicaid fraud and one count of organized fraud. She was sentenced to 30 months in jail, followed by five years probation. Robert Patrick Garcia entered into a plea agreement and pled guilty to one count of Medicaid fraud and one count of organized fraud. He was sentenced to two years in jail, followed by five years probation. The three defendants were ordered to pay \$1,033,332.00 in restitution joint and several to the Medicaid Program, \$27,662.30 cost of investigation jointly and severally, costs of prosecution of \$3,448.57 each, and a fine of \$2,500.00 for each convicted count. Other conditions in the plea agreements included cooperation in all meetings, interviews, depositions, hearings, grand juries, and trials as required by the State of Florida and/or the MFCU. All three defendants agreed to refrain from any employment that involves the Medicaid or Medicare programs and will not take a position that is in control of any Medicaid or Medicare funds.

Organon – Drug Manufacturing Company

Florida, 49 other attorneys general, and the federal government reached a \$31 million settlement with Organon, a drug manufacturing company, to settle allegations that the company underpaid rebates to the Florida Medicaid program, offered improper financial incentives to nursing home pharmacy companies, promoted its antidepressants for unapproved uses, and misrepresented its drug prices. Organon's headquarters are in Oss, Netherlands, and the company's assets are now owned by Merck. Florida's net share of the total settlement was \$483,465.80 for the Medicaid program.

The settlement resolves allegations that Organon:

- Underpaid rebates to Florida's Medicaid program by not including rebates and discounts in its best price reporting. The federal Medicaid Drug Rebate Program requires that all drug manufacturers that supply products to Medicaid recipients provide Medicaid the benefit of the "best price" available for that product;
- Offered nursing home pharmacy companies market share discounts and rebates to encourage the use of Remeron and Remeron SolTab over competing antidepressants, which violated the federal Anti-Kickback Statute and resulted in the submission of false claims to Florida's Medicaid program;
- Promoted the sale and use of antidepressants Remeron and Remeron SolTab for conditions that were not approved as safe and effective by the FDA. Specifically, Organon marketed drug side effects as possible benefits and promoted the use of Remeron in children and adolescents; and
- Reported false and inflated prices to Florida's Medicaid program, then offered the drugs at a lower cost as a financial inducement to nursing home pharmacy companies by increasing the "spread" between the actual cost of the drug to pharmacies versus the amount that the Medicaid program reimburses for the drugs.

The settlement resulted from two whistle-blower lawsuits filed in the United States District Court for the District of Massachusetts and the United States District Court for the Southern District of Texas.

Operation Otter Creek – Home and Community Based Service

Following an investigation by the MFCU, three Levy County residents were arrested on January 30, 2014, by the Levy County Sheriff's Office and the Chiefland Police Department. Allegedly, Laurie Meeks and Stephanie Tindall fraudulently billed the Medicaid program for nearly \$80,000.00 for services never rendered and Barbara Gamble fraudulently billed the Medicaid program for more than \$3,500.00 for services never rendered.

Barbara Gamble entered a plea of nolo contendere on September 10, 2014, to one count of Medicaid fraud. Adjudication of guilt was withheld. She was sentenced to 18 months probation, ordered to pay \$3,609.70 in restitution to the Medicaid program, \$18,950.93 in fines, and \$565.00 in court costs.

On May 6, 2015, Laurie Meeks pled nolo contendere to one count of Medicaid fraud. She was sentenced to 120 days in jail, followed by four years probation. She was ordered to pay \$66,539.32 in restitution to the Medicaid program, \$349,331.43 in fines, and \$6,665.00 in court costs.

Stephanie Tindall's case is still pending in court.

The cases were referred to the Attorney General's Office by the Agency. The State Attorney's Office for the Eighth Judicial Circuit prosecuted the cases.

Christopher Days – Better Days of North Central Florida LLC

On March 3, 2015, the MFCU and the Alachua County Sheriff's Office arrested Christopher A. Days, 43, for more than \$65,000.00 in Medicaid fraud. Days, the owner of Better Days of North Central Florida, LLC, allegedly defrauded the Florida Medicaid program by overbilling, billing for services not rendered, and failing to properly document for services rendered for several Medicaid recipients.

On June 9, 2015, Christopher Days pled nolo contendere to one count of Medicaid fraud. He was adjudicated guilty and sentenced to 364 days in jail followed by 20 years probation. Days was ordered to pay \$68,134.23 in restitution to the Medicaid program, \$340,671.15 in fines, and \$671.00 in court costs.

Michelle Caroline Hatton – Occupational Therapist

A Columbia County woman was arrested on a felony warrant for nearly \$160,000.00 of Medicaid fraud. The MFCU arrested Michelle Caroline Hatton Broach, 39, after an investigation revealed that she was overbilling the Medicaid program. Although Lake City Christian Academy is only in session for six hours per day, Monday through Thursday, and is closed at noon on Friday, Broach allegedly billed the Medicaid program for services provided for more than 12 hours per day at the school. Also according to the investigation, Broach billed Medicaid for services provided at the school when she was actually working a second job during school hours.

Broach entered into a plea agreement and pled guilty to one count of Medicaid fraud and one count of organized fraud. On July 28, 2014, she was sentenced to 30 years probation and ordered to pay \$159,564.49 in restitution to the Medicaid program. Broach was also ordered to pay \$164,797.92 in fines, \$3,384.76 for cost of prosecution, \$1,500.00 for cost of investigation, and court costs.

The case was prosecuted by the Attorney General's Office of Statewide Prosecution.

Priscilla Smith Johnson – Owner of Adult Family Care Home

On September 3, 2014, a judge sentenced Priscilla Smith Johnson, the owner of an adult family care home in Williston, Florida, to more than eight years in prison. Johnson was arrested in October 2013, following an investigation by the MFCU and the Levy County Sheriff's Office. Allegations against Johnson included neglecting residents, failing to provide medical services for a resident's wounds, restraining a disabled adult with handcuffs both in the family care home and restraining residents at a remote location, willfully abusing a disabled adult and causing wounds on her wrists and permanent disfigurement, and financially exploiting residents at her family care home.

State Attorney Bill Cervone's Office for the Eighth Judicial Circuit prosecuted Johnson. The defendant entered a plea to Aggravated Abuse of a Disabled Adult, a first degree felony, along with third degree felonies for False Imprisonment, Neglect of a Disabled Adult, and Exploitation of a Disabled Adult.

Covenant Hospice Inc.

On June 18, 2015, Covenant Hospice Inc., agreed to pay \$10,149,374.00 to reimburse the government for allegedly overbilling of Medicare, TRICARE, and Medicaid for hospice services. Covenant Hospice Inc., is a non-profit hospice care provider which operates in southern Alabama and the Florida panhandle.

Medicare, TRICARE, and Medicaid hospice benefits are available for patients who have a life expectancy of six months or less if their disease runs its normal course. Patients admitted to a hospice stop receiving care to cure their illnesses and instead receive medical care focused on providing them with relief from the symptoms, pain, and stress of a terminal illness.

Medicare, TRICARE, Alabama Medicaid, and Florida Medicaid reimburse for four different levels of hospice care: routine home care, continuous home care, inpatient respite care, and general inpatient care. The routine home care level is the lowest reimbursement rate. The highest reimbursement rate paid by the federal health care programs is for general inpatient care. The level of care provided to a patient is subject to change based upon a variety of factors, including the patient's condition and needs, and the availability of family members or other caregivers to meet those needs. The reimbursement for general inpatient care is greater than that provided for routine home care based upon the expectation that patients requiring the former level of care have more acute medical and psychosocial needs that must be provided in an inpatient setting and are more costly to treat. It is the responsibility of the hospice provider to ensure that a patient's medical record contains the appropriate documentation to support the level of hospice care that is billed.

This settlement resolved allegations that between January 1, 2009, and December 31, 2010, Covenant Hospice Inc., improperly submitted hospice claims for general inpatient care that should have been billed at the routine home care level for Medicare, TRICARE, and Medicaid patients. The government alleged that Covenant Hospice Inc.'s medical records did not support the medical necessity of the general inpatient care.

The settlement amount for federal Medicare and TRICARE was \$9,597,118.44. The Florida Medicaid program received \$548,567.99 and the Alabama Medicaid program received \$3,687.57.

This case was handled by the Civil Division's Commercial Litigation Branch, the U.S. Attorney's Office of the Northern District of Florida, the HHS-OIG, the Defense Health Agency of the U.S. Department of Defense, the Alabama Attorney General's Office, and the Florida Attorney General's Office.

Barbara Hilliard Brown

A Naples woman was arrested January 8, 2014, on charges of Medicaid fraud and grand theft for allegedly defrauding the Medicaid program out of more than \$60,000.00. Barbara Hilliard Brown was arrested on a felony warrant by investigators from the Attorney General's MFCU, with assistance from the Collier County Sheriff's Office.

The Florida APD referred the case to the MFCU alleging that Brown submitted fraudulent billing to the Medicaid Waiver Consumer "Directed Care Plus Program (CDC+)" for services not provided to her son. The CDC+ Program is a Medicaid Waiver funded long-term care program.

On January 6, 2015, Barbara Hilliard Brown pled nolo contendere, and was adjudicated guilty of one count of Medicaid fraud and two counts of Grand Theft. She was sentenced to two years of community control, 10 years probation, and 200 hours of community service. She was ordered to pay restitution to the Medicaid program of \$61,721.50, costs of investigation of \$10,000.00, costs of prosecution of \$3,448.57, fines of \$2,880.39, and court costs.

Jennifer Lareine Sewell – Home Health Aide

The MFCU and the Marion County Sheriff's Office arrested Marion County resident Jennifer Sewell for allegedly making \$60,000.00 in fraudulent Medicaid claims. Sewell was formerly employed by Hanna House of Care.

The Attorney General's MFCU investigated allegations that Sewell was falsifying billing logs and failing to provide the services she was paid to provide. Sewell, who worked as both the primary Medicaid biller and a care provider for Hanna House of Care, was assigned to provide in-home care to three disabled adults. The investigation revealed that Sewell allegedly regularly failed to provide proper care services, falsified billing logs, and billed her employer for services she did not provide.

On December 9, 2014, Sewell pled guilty to one count of organized fraud. Adjudication of guilt was withheld and she was sentenced to 12 years probation, ordered to make restitution of \$50,000.00 to the Medicaid program, and was ordered to pay \$1,000.00 in fines and court costs.

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, investigative costs, and forfeitures.

The MFCU is also responsible for enforcement of the Florida False Claims Act. More False Claims Act settlements will incorporate managed care recoveries. The \$56.5 million settlement with Shire Pharmaceuticals, LLC, is the first national settlement in which Medicaid managed care damages have been calculated and included as part of a recovery. The Medicaid programs received \$48.1 million of the settlement, and Florida's share of the total Medicaid settlement was more than \$900,000.00.

With the conversion to the Florida Statewide Medicaid Managed Care (SMMC) program, the Complex Civil Enforcement Bureau (CCEB) 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, CCEB 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.

The state fiscal year recoveries from 2008-2015 total \$905 million. FY 2012-13 was the highest year due to the largest healthcare fraud settlement in U.S. history. Florida received more than \$56 million as part of the pharmacy settlement that involved the federal government and various other states.

In FY 2014-15, the total amount for civil recoveries, which include civil settlements arising from *qui tam* cases brought under Florida's False Claims Act, was \$28,882,195.00 and civil judgments of \$208,035.00. The total amount for criminal recoveries based upon Medicaid fraud cases was \$5,144,505.00. The total amount of the monies recovered by the MFCU for FY 2014-15 was \$34,234,735.00.

General Revenue Generated

MFCU brought in almost \$3.9 million in FY 2014-15 to the state's General Revenue Fund.

Training

MFCU continues to emphasize mission critical training to stay professionally current. Courses include training for complex civil litigation, database searches for FMMIS Claims Analysis, Managed Care, Provider, Recipient, and Payment Management, Data Mining, CJIS Certification, and other courses offered by the Agency and the Florida Department of Law Enforcement (FDLE).

During FY 2014-15, MFCU staff attended a total of 4,297 hours of training.

The Office of the Attorney General continued to offer a large number of career and personal enhancement training opportunities via webinars, video conferences, and classroom settings. Law Enforcement personnel continued to obtain most of their mandatory training for recertification online with the FDLE, free of charge. Other training was offered or conducted, mostly free of charge, by local and national organizations, and regional criminal justice academies.

Classroom training offered at no cost, included providers such as the National Association of Medicaid Fraud Control Units (NAMFCU), the National Association of Attorneys General (NAAG), the OAG Florida Crime Prevention Training Institute (FCPTI), Area Agencies on Aging, the Department of Homeland Security, the Multi-jurisdictional Counterdrug Task Force, High Intensity Drug Trafficking Area (HIDTA) Intelligence Center, the U.S. Attorney's Office, state agencies, in particular, the Agency and the FDLE, local law firms and bar associations, criminal justice academies, and Sheriff's Offices, to name a few.

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

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

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

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

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, Florida's Medicaid single state agency. The initial waiver was extended by the Centers for Medicare and Medicaid Services (CMS) through December 31, 2015. As of this writing, the Agency is in negotiations with CMS about an additional three-year extension.

The Memorandum of Understanding between the MFCU and the Agency was amended to ensure that data mining efforts would be coordinated with, but not duplicate the Agency's efforts. As of June 30, 2015, the MFCU has submitted 79 data mining projects to the Agency for review and approval. Of the 79 submitted, 61 were approved by the Agency. On June 30, 2015, MFCU had 19 cases and 0 complaints in an active status from these projects and the regional offices are currently developing additional facts. Ten arrests have been made and \$1,538,127.78 recovered as a result of the current Data Mining Initiative.

Health Care Fraud Prevention and Enforcement Action Team (HEAT)

In May 2009, the HHS and the Department of Justice (DOJ) created the Health Care Fraud Prevention and Enforcement Action Team (HEAT). With its creation, the fight against Medicare fraud became a federal Cabinet-level priority. This strike force brings together the efforts of the Office of Inspector General, the DOJ, Offices of the United States Attorneys, the FBI, local law enforcement, state MFCUs, and others.

HEAT 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.

Florida MFCU has a team of law enforcement officers, an analyst, and an attorney assigned to work on HEAT cases involving Medicaid fraud.

For FY 2014-15, five HEAT cases in Florida involving \$5.4 million in Medicaid fraud resulted in 18 arrests. One defendant was sentenced to 5.5 years in prison, the remaining defendants have pending court cases.

THE AGENCY FOR HEALTH CARE ADMINISTRATION'S ROLE IN PROTECTING THE MEDICAID PROGRAM FROM FRAUD AND PROGRAM ABUSE

The Agency for Health Care Administration (AHCA or Agency) is designated under Chapter 20, Florida Statutes, as the chief health policy and planning entity for the state. AHCA, through its component divisions, is responsible for administering the state's Medicaid program; regulating the licensure and activities of more than 45,000 healthcare facilities; providing legal advice to the Agency and litigating on behalf of the Agency; managing the financial, human resources, and other support services of the Agency; and coordinating those activities that promote accountability, integrity, and efficiency in the Agency. The contributions of these divisions specifically related to combatting fraud and abuse are detailed as follows:

Division of Medicaid

The Division of Medicaid administers the Florida Medicaid program, a \$23.5 billion state and federal partnership that provides health care to over 3.8 million recipients in Florida. The Division of Medicaid is responsible for overseeing the management and operation of a broad range of health care services 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, has been primarily a FFS-based program. Over the years, Medicaid enrollment grew rapidly and costs rose in a corresponding manner until Medicaid expenditures constituted 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 FFS program and the first Medicaid health plan was established in 1984. Eventually, this led to a program that was a mix of service delivery systems including home and community based waiver programs for long-term care services, FFS, FFS primary care case management (known as MediPass), and prepaid health plans (including dental and behavioral health plans). Florida Medicaid has recently implemented significant program changes that have resulted in improved efficiency, cost predictability, and accountability for the program, and enhanced service provision for program recipients. The most significant and single greatest change in Medicaid since the program was adopted, is the implementation of the Statewide Medicaid Managed Care (SMMC) program. The Agency, along with sister agencies, worked diligently for more than three years to successfully implement the SMMC program.

During planning and implementation of the SMMC program, based on input and analysis from both internal and external stakeholders, the Agency determined that an organizational structure where similar types of functions are grouped together, wherever feasible and practical, would result in an organization that is more effective and efficient. This meant Medicaid was better prepared for the enhanced monitoring and accountability associated with the administration of the SMMC program.

Medicaid completed an extensive reorganization to move from a program-based model of organization to a function-based model and to migrate most of the Agency's role from FFS claims payment (for example, claims processing and utilization management) to a focus on enhancing current monitoring capabilities, improving plan accountability, and an increased focus on quality outcomes. This directly impacted the Agency's ability to combat potential fraud and abuse in the Medicaid program.

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 by embedding control efforts into the infrastructure of the program. These strategic control efforts are focused in six key areas including provider enrollment and accountability, health plan fraud and abuse related reporting, provider outreach and education, recipient information protection, prior authorization, and utilization management.

Provider Enrollment and Accountability

Prevention of fraud, program abuse, and inappropriate practices, whether intentional or not, begins with the Medicaid providers. This includes health plans and their provider networks as well as individual FFS providers. The Division of Medicaid employs many different strategies to ensure all Medicaid providers are eligible to provide care and can provide the 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 (Clearinghouse). Medicaid also monitors and prepares a quarterly report of terminated Medicaid providers, has taken steps to improve provider accountability, and 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.

Program-Wide Provider Enrollment and Accountability

Centralized Background Screening

Florida Medicaid provider background screenings have been conducted through the Clearinghouse since 2013. While first implemented in SMMC, all Medicaid providers including Medicaid FFS providers and members of a Medicaid health plan network are now 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 Florida Department of Law Enforcement (FDLE).

Monitoring and Reporting of Terminated Providers

Medicaid collaborates with Medicaid 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 registering 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 plans' networks under any circumstances. Medicaid also evaluates providers that have at some point in the past, through some form of identification, been linked to a provider terminated for fraudulent activity. The Agency researches this information to make sure that active providers have the clearance to participate in the Medicaid program. This research includes examining the relationship between providers that have been terminated and share a common form of identification (such as the same last name) with a currently active Medicaid provider and active providers.

Provider Accountability and Increased Provider Enrollment Requirements

Certain provider types and a certain number of randomly selected providers must be reviewed in person by Medicaid staff prior to enrollment in the program. Prior to the reorganization of the Medicaid Division, the Medicaid Fraud Prevention and Compliance Unit (FPCU) and the Medicaid Field offices were responsible for pre-enrollment site visits for the Agency. During FY 2014-15, due to the reorganization of the Medicaid Division, these duties transitioned to the Bureau of Medicaid Fiscal Agent Operations (FAO). The FAO undertook several new and on-going activities to aid the Division in better screening and monitoring of Medicaid providers. These initiatives and activities include:

- Coordination of Interoffice Communication - The FAO's Provider Eligibility and Compliance Unit (PECU) serves as a liaison between the Division of Medicaid, Medicaid Program Integrity (MPI), the Office of the Attorney General's Medicaid Fraud Control Unit (MFCU), the Agency's Bureau of Health Quality Assurance (HQA), the Department of Health (DOH), Medicaid health plans, and other federal and state regulatory

departments with regard to provider enrollment and eligibility. Constant communication between these entities supports the Division's ability to monitor provider eligibility and compliance.

- License Compliance – The FAO participates in weekly coordination meetings between Medicaid, HQA, MPI, and DOH to ensure a timely response when action is taken against a provider's license. The FAO reviews 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, PECU coordinates the appropriate action to terminate or exclude the provider and all related providers from the program.
- Provider Risk Factors - All applicants to Medicaid are evaluated and scrutinized based on their 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. 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. The PECU 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.
- Outside Referrals – The PECU staff conducts evaluations of investigative information received from MPI, MFCU, other units within the Division of Medicaid, Medicaid health plans, and other agencies, and routinely conduct research to identify any relationships between the Medicaid providers terminated for misconduct and active providers. The PECU takes into consideration the adverse history and as appropriate makes a referral to MPI to seek a sanction by final order, recommends contractual termination from Medicaid of a related provider, or recommends denial of enrollment.
- Identifier and Exclusion Verification – The FAO implemented 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), and the System for Awards Management (SAM) are uploaded to tables within the Medicaid Management Information System. All new and renewing applicants are matched against the NPPES, LEIE, and SAM data upon application. Additionally, all active Medicaid providers are matched against these sources on a monthly basis. This check ensures all providers have a valid NPI on their file and that no excluded entity or individual is enrolled in Medicaid.

SMMC Health Plan Provider Enrollment and Accountability

Medicaid Health Plan Contract Requirements for Provider Credentialing

Beyond the activities carried out by the Agency and the Division of Medicaid 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' credentialing and re-credentialing policies and procedures are established by health plan contract and outlined in the Statewide Medicaid Managed Care Report Guide. Medicaid health plan policies and procedures are required to be in writing and must include at least the following:

- Formal delegations and approvals of the credentialing process;
- A designated credentialing committee;
- Identification of providers who fall under its scope of authority;
- A process that provides for the verification of the credentialing and re-credentialing criteria required under the contract;
- Approval of new providers;
- Imposition of sanctions, termination, suspension, and restrictions on existing providers; and
- Identification of quality deficiencies that result in the health plan's restriction, suspension, termination, or sanctioning of a provider.

Medicaid health plans must establish and verify credentialing and re-credentialing criteria for all their network providers that, at a minimum, meet the Agency's Medicaid participation criteria, including:

- A copy of each provider's current medical license for medical providers, or occupational or facility license as applicable to provider type, or authority to do business, including documentation of provider qualifications. If the provider is located in Georgia or Alabama, the provider's license and permit must be current and applicable to the respective state in which the provider is located;
- No history of revocation, moratorium, or suspension of the provider's state license by the Agency or the DOH, if applicable;
- Disclosure of the provider's professional liability claims history;
- Disclosure of any sanctions imposed on the provider by Medicare or Medicaid;
- Disclosure related to provider ownership and management (42 CFR 455.104), business transactions (42 CFR 455.105), and conviction of crimes (42 CFR 455.106);
- Evidence of a satisfactory Level II background check pursuant to s. 409.907, Florida Statutes (F.S.), for all treating providers not currently enrolled in Medicaid's FFS program; and
- Documentation of the education, experience, prior training, and ongoing service training for each staff member or network provider rendering services.

The contract that the Medicaid health plan has with the provider must contain specific provisions required by the Agency to ensure enrollees have access to all appropriate care as authorized in the Medicaid State Plan. Specifically, the provider's contract with the plan may not prohibit a provider from:

- Acting within the lawful scope of practice;
- Advising or advocating on behalf of an enrollee for the enrollee's health status, medical care, or treatment or non-treatment options; or
- Advocating on behalf of the enrollee in any grievance system or UM process, or individual authorization process to obtain necessary services.

In addition, the contract must prohibit the provider from seeking payment from the enrollee for any covered services provided to the enrollee within the terms of the contract.

The provider contract must also include several reporting and practice oversight provisions. The contract must:

- Specify that any claims payment be accompanied by an itemized accounting of the individual claims included in the payment;
- Require an adequate record system be maintained for recording services, charges, dates, and all other commonly accepted information elements for services rendered to the health plan;
- Require that records be maintained for a period not less than six years from the close of the contract, and retained further if the records are under review or audit until the review or audit is complete. Prior approval for the disposition of records must be requested and approved by the health plan if the provider contract is continuous;
- Require the provider to cooperate with the health plan's peer review, grievance, quality improvement and utilization management activities, provide for monitoring and oversight, including monitoring of services rendered to enrollees, by the health plan (or its subcontractor), and identify the measures that will be used by the health plan to monitor the quality and performance of the provider;
- Specify that the U.S. Department of Health and Human Services (HHS), the Agency, the Florida Department of Elder Affairs (DOEA), MPI and MFCU shall have the right to inspect, evaluate, and audit all of the following related to such contracts:
 - o Pertinent books;
 - o Financial records;
 - o Medical/case records; and
 - o Documents, papers, and records of any provider involving financial transactions.

- Require providers to submit timely, complete, and accurate encounter data to the health plan in accordance with the requirements of Section VIII.E.;
- Require providers to cooperate fully in any investigation by the Agency, MPI, MFCU, or other state or federal entities, and cooperate in any subsequent legal action that may result from such an investigation involving such contracts;
- Require compliance with the background screening requirements of the contract;
- Require safeguarding of information about enrollees according to 42 CFR 438.224; and
- Require compliance with the Health Insurance Portability and Accountability Act (HIPAA) privacy and security provisions.

The Streamlined Credentialing Project

The Agency recognized that credentialing requirements can create an administrative burden on the health plans and the network providers who participate in multiple health plans. So in FY 2014-15, the Agency initiated the Streamlined Credentialing Project to develop a process wherein the Agency performed the basic credentialing functions on behalf of the health plans. The Agency anticipates implementing the project during FY 2015-16. Providers will be able to submit a limited enrollment application online via the Medicaid Web Portal. The limited enrollment application captures all demographic information which is used to screen the provider against licensure and exclusion databases and conduct background screening in compliance with the Affordable Care Act provider screening requirements. Limited enrolled providers will be required to complete a renewal process every three years similar to the current renewal process for fully enrolled providers.

The streamlined credentialing and enrollment process will have providers submit their basic information once to Medicaid, which eliminates the need to submit the same information to each health plan with which they seek to contract. The elimination of multiple credentialing applications means the Agency and health plans have access to real-time, consistent screening results. It reduces the chances for duplicative or erroneous information and ensures everyone shares the same reliable provider background information.

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 the health plan's compliance with required provider network composition, provider-to-member ratios, and allows for other uses deemed pertinent.

Plans are required to report any suspected fraud and abuse activity to the Agency within 15 days. This includes enrollee and provider fraud, and 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 conducts a comprehensive education program for providers. Also,

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 must have a monitoring plan in place for fraud prevention. The following highlights many of the education and outreach efforts conducted by Medicaid in FY 2014-15 as well as the SMMC contractual provisions related to provider education requirements.

Program-Wide Provider Education

The Florida Medicaid Provider Training e-Library, an online resource, contains training resources for Medicaid providers on Medicaid policy. Many overpayments are the result of unintentional provider errors and lack of understanding about program rules. By educating providers, the Agency proactively addresses the issue of potential overpayments. The e-Library, online at <http://ahca.myflorida.com/Medicaid/e-library/index.shtml>, enhances existing training opportunities about the Medicaid program and its policies by providing 24/7 access to online training materials.

The e-Library contains PowerPoint presentations and videos that providers can review at times that are convenient to them and are self-paced learning materials. A video section is linked to the Agency YouTube channel at: <http://www.youtube.com/user/AHCAFlorida>. The reference section contains links to training materials developed by the Centers for Medicare and Medicaid Services (CMS) on program integrity education.

Providers receive information about topics, training dates, and how to access upcoming training opportunities via the electronic [Medicaid Provider Alert](#) system as well as the [Medicaid Provider Bulletins](#), which are updated on the Agency website quarterly.

Medicaid has also offered training to highlight covered services, policy updates, areas of past non-compliance, and offered training to address specific questions. The following is a list of new trainings offered by Florida Medicaid in FY 2014-15:

- Preadmission Screening and Resident Review (PASRR);
- Home and Community-Based Settings Rule: General Information;
- Residential and Non-Residential Tool Training, Home and Community-Based Settings;
- Residential Treatment Services for Children in the Dependency System Under Managed Care;
- Florida Medicaid Optometric Services Coverage and Limitations Handbook;
- Community Behavioral Health Services Coverage and Limitations Handbook;
- Florida Medicaid Targeted Case Management for Children at Risk of Abuse and Neglect Coverage and Limitations Handbook; and
- Managed Medical Assistance Program & Project AIDS Care Waiver Services.

SMMC 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 Medicaid health plan contract and special needs of enrollees. Each health plan is required to conduct initial training within 30 days of placing a newly contracted provider, or provider group, on active status. The health plans must also conduct ongoing training, as deemed necessary by the health plan or the Agency, in order to ensure compliance with program standards.

The health plan is also required to provide training and education to providers regarding the plan's enrollment and credentialing requirements and processes. The health plan is required to conduct monthly education and training for providers regarding claims submission and payment processes, which has to include, at a minimum, an explanation of common claims submission errors and how to avoid those errors.

Each health plan is also required to provide details and educate employees, subcontractors, and network 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;
- Whistle-blower protections under federal and state law;
- The entity's role in preventing and detecting fraud, waste, and abuse;
- Each person's responsibility relating to fraud detection and prevention; and
- The toll-free state telephone numbers for reporting fraud and abuse.

If the health plan is using telemedicine, the health plan must include a review of telemedicine in its fraud and abuse detection activities.

Prior Authorization

Prior authorization is a utilization control that many insurers and public health care programs employ to determine member eligibility, benefit coverage, medical necessity, location, appropriateness of services, and to ensure that care being provided is necessary and appropriate. Similar to, but distinct from utilization management, prior authorization requires a provider to obtain permission prior to implementing a treatment plan. Prior authorization may be implemented for any service, for a service which is different from accepted practice, or when a more expensive or resource-intensive treatment alternative is being requested over other readily available treatment options. A frequent use of prior authorization is in pharmacy programs when a provider must often obtain authorization for use of an expensive brand name drug over a generic equivalent.

SMMC Health Plan Prior Authorization

The majority of Medicaid recipients are enrolled in Medicaid health plans after the implementation of SMMC and for those enrollees the health plan is responsible for coordinating their care and for setting prior authorization policies. Medicaid health plans are also required to have their prior authorization policies outlined in their provider handbooks and must have a help line staffed 24 hours a day, seven days a week to respond to prior authorization requests. Health plans may not have prior authorization policies in place that are more restrictive than those for Medicaid FFS recipients.

Medicaid Fee-for-Service Prior Authorization

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 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 (PDN) and Personal Care Services are two more FFS services that require prior authorization and are discussed under Utilization Management, below.

Home Health Visit Prior Authorization

One of the primary areas where Medicaid continues prior authorization for FFS recipients is for home health visits. The Agency's vendor, eQHealth Solutions, Inc. (eQHealth), a federally designated quality improvement organization, conducts prior authorization for home health visits to ensure that the proposed services are medically necessary and appropriate. During FY 2014-15, eQHealth conducted an average of 40,250 home health prior authorizations per month. Of these, an average of 38,197 were approved resulting in an average denial rate of 1.8 percent. The following table shows the total number of home health prior authorization requests, approvals, denials, and denial percentage for each month during FY 2014-15. 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 pending a fair hearing.

Home Health Visit Prior Authorization Activities FY 2014-15

	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Total Visits Requested	44,312	35,094	42,003	41,294	37,633	45,087	42,011	34,083	44,253	38,701	38,778	39,746
Approved	41,720	33,308	39,511	38,361	35,909	42,441	39,938	32,389	42,479	36,656	37,323	38,329
Denials	805	425	1,017	1,271	473	893	439	558	771	1,012	629	367
Denial %	1.82%	1.21%	2.42%	3.08%	1.26%	1.98%	1.04%	1.64%	1.74%	2.61%	1.62%	0.92%

The number of prior authorizations for home health dropped 68 percent in FY 2014-15 compared to FY 2013-14 as most recipients transitioned into Medicaid health plans.

Medicaid 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 is minimized. The claims processing system has thousands of payment system “edits” that use a cost avoidance philosophy to prevent inappropriate expenditure of Medicaid funds. These “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, 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 Medicaid Administration (Magellan), a federally designated Quality Improvement Organization-like vendor, reviews prior authorization requests for drugs not on the Preferred Drug List (PDL) 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 2014-15 for the Medicaid FFS pharmacy program.

Number of Requests	
Total Prior Authorization Requests	107,370
Average Per Day	294
Total Requests Approved	90,850
Percent Requests Denied	15.39%

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

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.

Programs to manage health care utilization have existed for more than 20 years. Early efforts focused on reducing the number of inpatient hospital admissions and eliminating unnecessary hospital days. In order to achieve this objective, health plan administrators reviewed the hospital admission for medical necessity prior to the admission and determined the need for ongoing care. As health care has grown more complex, the need for utilization management has expanded beyond hospital stays to include almost every facet of health care, though the basic principles of prior authorization and utilization monitoring are still key components of an overall utilization management approach.

Florida Medicaid has historically employed several methods for utilization management, including disease management initiatives and programs, the pharmaceutical PDL, and Medicaid claims analysis, as well as independent research to assess policy implementation and program performance. The responsibility for utilization management belongs to the Medicaid health plans for the majority of recipients. However, the Agency will continue to have a significant role in monitoring plan activities and overseeing its vendors who provide utilization management for the remaining FFS population. The following sections provide a brief overview of the utilization management efforts in Florida Medicaid.

Program-Wide Utilization Management

Medicaid Preferred Drug List

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. Health plans as well as FFS providers must adhere to the Medicaid PDL, though providers may request drugs not on the PDL when medically necessary. Florida Medicaid's PDL tries to provide enough alternatives to provide several options to meet all 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 FFS recipients and encounter data for almost all 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.

SMMC Health Plan Utilization Management

SMMC Contractual Provisions and Plan Responsibilities

Utilization management in SMMC 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 (24/7) to respond to prior authorization requests.

The health plans have a short time frame in which to notify the enrollee, provider, and Agency if a service is approved or 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. A health plan must obtain written approval from the Agency prior to making any changes in the service authorization protocols. 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

Pharmacy

There are several activities that Medicaid has undertaken to ensure that Medicaid pharmacy services provided to the 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 PDL, and prevention of fraud and abuse. In FY 2014-15, the contracted prescription benefit manager, Magellan, processed approximately 1.25 million FFS drug claims 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 provides recommendations to meet the different, specific, needs of adults and children while improving coordination of care for behavioral health drug therapy management, increasing patient and provider awareness and education, and improving overall compliance with drug therapies for improved outcomes.

Through a contract with the University of Florida Medication Therapy Management Call Center, trained pharmacists conduct comprehensive prescribed drug case management, which involves direct patient contact if the patient chooses to participate. This statewide Medication Therapy Management Program can help resolve medication-related and health-related problems, optimize medication use for improved patient outcomes, and promote patient self-management of medication and disease states. This in turn helps reduce clinical risk and lowers prescribed drug costs to the Medicaid program, including reducing inappropriate spending on Medicaid prescription drugs.

Utilization Management of Home Health Services

The Agency contracts with Sandata Technologies, Inc., to implement and run the Telephonic Home Health Services Delivery Monitoring and Verification (DMV) project. The project was initially only authorized for Miami-Dade County, but was expanded to a statewide program during the 2012 legislative session. The primary purpose of the DMV project is to implement an automated database system that tracks the time spent in the home by a person providing home health visits and serves to verify that those visits occurred as reported and authorized by the home health service provider. This helps ensure appropriate utilization and expenditures for Medicaid home health services, improves the quality of care for Medicaid recipients, and prevents Medicaid fraud and abuse. The DMV project now includes monitoring of all home health services (i.e., home health visits, private duty nursing, and personal care services). During FY 2014-15, there were almost 984,000 DMV calls placed to verify 1.5 million home health visits.

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 in 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, ensuring that Medicaid does not pay for services in the following categories that are not covered or are not medically necessary:

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

Comprehensive Care Management for Children with Special Health Care Needs

The Agency contracts with eQHealth for comprehensive care management, which provides utilization management and care coordination for children receiving home health visits, private duty nursing, personal care services, prescribed pediatric extended care services, and inpatient medical and surgical services. This program helps 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 2014-15, the vendor conducted 360 home visits and 4,284 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 or audit is needed. The following are the results for FY 2014-15:

Comprehensive Care Management FY 2014-15 Statewide			
360 Total On-Site Home Visits to Recipients			
301	83.60%	recipients w/ fully approved requests	
5	1.40%	recipients w/ fully denied requests	
48	13.30%	recipients w/ partial approval	
5	1.40%	reconsideration is complete	
1	0.30%	at Fair Hearing	

Inpatient Behavioral Health

The Agency contracts with Magellan to operate the Florida Medicaid Behavioral Health Utilization Management Program. The program includes On-Site Care Coordination services and management of the Qualified Evaluator Network (QEN). Care coordination includes on-site treatment and discharge planning for both dependent and non-dependent children who reside in a State Inpatient Psychiatric Program as well as quality of care oversight for the Agency. The QEN is a network of licensed psychologists or psychiatrists who can perform suitability assessments for the Department of Children and Families (DCF) and the Agency. Whenever DCF believes that a child in its legal custody is emotionally disturbed and may need residential treatment, an examination and suitability assessment must be conducted by a qualified evaluator. The suitability assessments provide a clinical status and treatment plan for children in residential settings.

Outpatient Advanced Diagnostic Imaging

The Agency contracts with MedSolutions, Inc., 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).

	3D	CT All	MR All	PET	TOTAL
Total PA Requests	135	22,936	26,277	3,636	52,984
Total Approved	93	19,466	23,419	1,290	44,268
Total Denied	42	3,470	2,858	2,346	8,716
% Denied	31.10%	15.10%	10.90%	64.50%	16.50%

Medicaid Certified School Match Program

The Medicaid Certified School Match Program reimburses providers for medically necessary services provided by or arranged by a school district for Medicaid eligible students. School districts are reimbursed for the following services provided in a school setting by a Medicaid eligible provider:

- Therapy services;
- Nursing services;
- Behavioral health services;

- Transportation; and
- Alternative augmentative communication devices.

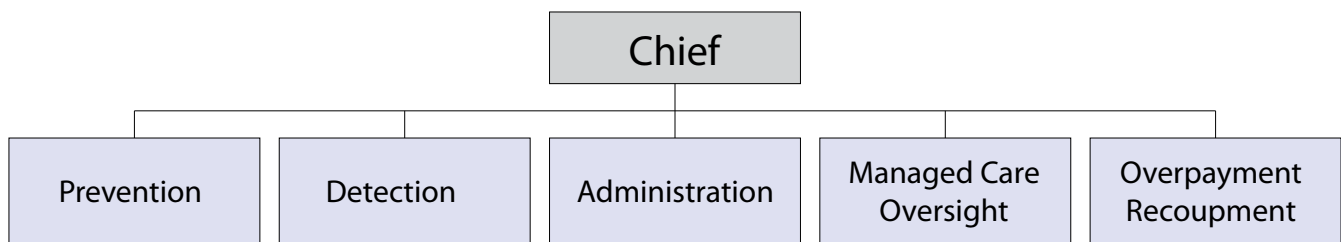
School districts are allowed to claim administrative costs related to the coordination and delivery of health care services within their schools. Administrative claiming generates more than \$80 million in reimbursements for participating school districts. During FY 2014-15, Agency staff monitored all participating school districts quarterly to increase compliance with program policy and procedures.

Medicaid Program Integrity

Organizational Overview

The Office of Medicaid Program Integrity (MPI) is located within the Office of the Inspector General (OIG) and is charged under state law with preventing, detecting, and auditing fraud, waste, and abuse, and initiating the recovery of overpayments in the Medicaid program. MPI also serves as the primary office within the Agency for Health Care Administration (Agency) to fulfill the federal law requirements to operate a fraud, waste, and abuse prevention and detection program. These broad categories of operations align with the organizational units within MPI.

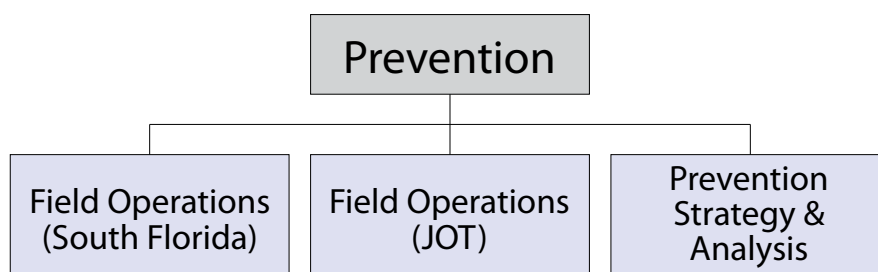
The Chief of MPI has five direct reporting operational and organizational units. The Assistant Chief manages units responsible for recoupment activities; an AHCA Administrator manages the unit responsible for managed care oversight activities; an AHCA Administrator manages administrative support activities; an AHCA Administrator manages detection activities; and, there is a unit responsible for the prevention of fraud, waste, and abuse (presently managed directly by the Chief).



In the summer of 2014, MPI conducted a functional assessment, which served as guidance for several organizational adjustments. One such adjustment was to take a management position that was supervising both prevention and health plan activities, and have it focus on the health plan activities only. That adjustment has the prevention area managers directly reporting to the Chief.

Prevention

Among the organizational changes that have occurred following the functional assessment has been the creation of sub-units within Prevention responsible for strategic planning and prevention analysis in specific geographical areas. These units predominately focus on on-site provider reviews and prevention projects. One of the units is located in the Agency's Miami Area Office (Area 11), and takes a lead responsibility for field operations in South Florida. The second unit includes staff based in Jacksonville, Orlando, and Tampa (JOT), and is managed out of the Agency's Tampa Area Office (Area 6). Prior to the addition of the third sub-unit, which now assists with Florida panhandle activities, this team had primary responsibilities for field operations throughout the rest of the state.



Some field operations activities are well known outside of MPI—for example, on-site provider visits. On-site visits not only identify potential non-compliance, but they also simultaneously serve as a deterrent for committing fraud, waste, and abuse by increasing the perception of detection. This is just one of the efforts to combat fraud and abuse through prevention activities.

Field operations also help the Agency combat fraud, waste, and abuse through early detection and extensive prevention efforts. It is essential to have MPI staff located throughout the state to serve as the eyes and ears of MPI (“boots on the ground”) by routinely engaging with the provider community. Field staff can respond quickly to visit provider facilities and recipient homes, assess situations, and report the findings in an expeditious fashion. Many times field activities involve the safety, welfare, and well-being of Medicaid recipients that require immediate action or immediate referral to appropriate authorities.

Other examples of the benefits of having MPI staff assigned to field operations are:

- MPI field staff are involved in multi-agency collaborations concerning issues that directly or indirectly involve Medicaid providers. Because of these collaborations, field staff perform joint site visits with many different regulatory agencies. Many times, these visits are conducted on short notice and outside of regular working hours.
- Field staff understand the nuances within each community and are better equipped to detect the subtle changes within a community that are the early stages of an emerging fraud trend. The presence of field offices allows MPI to have local staff become familiar with the provider environment within their areas. Local MPI field staff assist in bridging the gap between MPI headquarters in Tallahassee and what transpires in the rest of the state. This familiarity with the local culture has been invaluable in identifying, preventing, and combatting fraud and abuse perpetrated by providers and recipients.
- By conducting on-site visits, field staff can review records on-site and observe provider activities. On-site record reviews also allow MPI to obtain documentation immediately, reducing the chances for providers to alter or fabricate records.
- MPI field staff perform several field initiatives (focused projects) each fiscal year. The field initiatives focus on simultaneous reviews of recipients and providers and often include our state and federal partners. The MPI field offices’ joint field initiatives have served as examples for other states to emulate and have been topics of discussion at the Centers for Medicare and Medicaid Services (CMS) Medicaid Integrity Institute (MII) in South Carolina.

Some of the benefits of the partnerships and collaborative efforts that MPI has engaged in include:

- Building strong relationships with federal partners to fight health care fraud, waste, and abuse;
- Collaboration of experienced state and federal investigators, health care professionals, and auditors;
- Mutual education of the provider community;
- Development of stronger policies;
- Identification of improper payments to the Medicaid and Medicare programs; and
- Reduction in abusive, fraudulent, and wasteful Medicaid provider billings.

The newly-created Prevention Strategy sub-unit supports the broader role of MPI related to fraud prevention by providing guidance, research, and support to the Division of Medicaid's provider enrollment office to assist in minimizing the risk of fraud, waste, and abuse. Through these efforts, Medicaid is able to create provider enrollment processes designed to minimize enrollment of fraudulent and high-risk providers. MPI also has a role in assisting with the design and implementation of the Division of Medicaid's fraud-fighting efforts through Medicaid policy and training activities that minimize unintentional provider errors. Additionally, MPI coordinates efforts with the Division of Health Quality Assurance (HQA) to investigate and monitor compliance through large-scale investigation and enforcement projects related to provider types licensed by HQA.

MPI also ensures that the Agency continues to share information regarding Medicaid providers who may be engaging in abusive conduct by referring the information to parties within and outside of the Agency, as appropriate. In FY 2013-14, there were 508 referrals made by MPI, which were detailed in the FY 2013-14 Annual Report on Medicaid Fraud and Abuse. As noted in this year's report, the number of referrals to all external sources decreased in FY 2014-15, however, other collaborative efforts continued and increased, including the volume of referrals to the Medicaid Fraud Control Unit (MFCU).

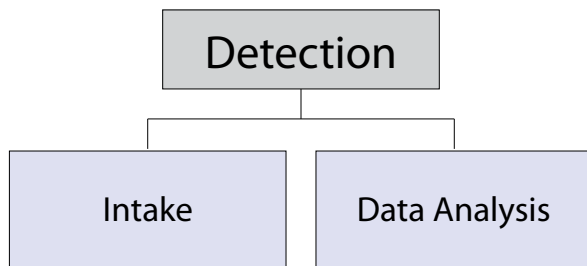
In FY 2013-14 there were 29 fraud referrals to MFCU, a number that the Agency recognized was too low for a state such as Florida with the number of providers and volume of reimbursements. Increasing the quantity and quality of fraud referrals was a priority for MPI during FY 2014-15. Throughout the year, MPI increased efficiencies with regard to communication across all organizational units within the Agency and within MPI. This increased communication resulted in more, and more timely, detection of issues that were appropriate for referral to MFCU. Additionally, MPI has designated specific staff to research and prepare referrals to MFCU. Utilizing a designated referral team allows MPI to mitigate the time consuming detraction from other duties that occurs as a result of preparing a referral related to complex fraud issues. A referral must not only be well written, but must also carefully and thoroughly detail the issues of fraud so that MFCU can readily assess the referral. The number of referrals to MFCU more than doubled during FY 2014-15 as a result of these efforts. MPI is continuing to assess and refine processes so that it may efficiently master an approach to high-volume referrals to MFCU that also maintain high quality.

Additional efforts continue to be developed and will be implemented after they are assessed, tested, and incorporated into the Memorandum of Understanding between the Agency and MFCU. Among the additional efforts in development are communication protocols between MFCU and MPI, incorporating more training between the units, incorporating a consultative effort by MFCU with regard to preliminary leads that are anticipated from MPI's data analytic system, and improving the triage and preliminary review processes related to the intake of complaints received at MPI.

The newly formed Prevention Strategy sub-unit brought the following additional responsibilities under the efforts of Prevention:

- Analytical support to the field operations to improve effectiveness and prioritize on-site provider reviews;
- Coordination with the Division of Medicaid for efforts to combat fraud through provider enrollment, policy, and training;
- Coordination with the Division of HQA for efforts to combat fraud in provider types licensed by HQA;
- Development of referrals to MFCU and assisting others within MPI with the development of referrals to MFCU;
- Initiation of additional projects involving prepayment reviews for the specific purpose of identifying referrals to MFCU, health plans, the Division of Medicaid, and other agencies;
- Implementation of quality and functional assessment reviews of bureau operations to ensure maximum effectiveness;
- Development and implementation of strategic plans for MPI operations; and
- Increasing field presence in North Florida, especially in the panhandle.

Detection



Detection efforts continue to be a key factor in MPI's success. Without efforts to find the anomalies and conduct preliminary investigations, other office efforts would decrease in effectiveness. While there have been few organizational changes over the years in the Detection Unit, the activities performed within the unit have changed.

Data Analytics

Staff turn-over in the Data Analysis sub-unit during FY 2014-15, provided MPI the opportunity to make adjustments in the classification of positions and in the knowledge, skills, and abilities required for these positions. The team is now comprised of very experienced data analysts with knowledge in statistical programming and modeling, database coding, and health data analysis. Additionally, the team has experience visualizing complex datasets, including the mapping of social networks and geospatial mapping and analysis. The experience the new team brings helps MPI develop and grow with changes in technology, including the implementation of advanced data analytics.

With the enhancement of capabilities within the sub-unit, the team has shifted from serving as a data support unit for the other MPI units to performing sophisticated and complex data assessment and validation to develop fraud and overpayment leads. The team continues to serve as a resource for the other MPI units to train and assist them with data queries. For much of FY 2014-15, the unit has served as a lead unit for the development and implementation of the MPI data analytics project. These efforts are further detailed in the subsequent section pertaining to the data analytics project.

Intake

In years past, the Detection sub-unit for the intake of complaints answered the fraud and abuse hotline, received complaints through the on-line reporting tool on the Agency's website, identified leads through a variety of other resources, and forwarded the complaints to other units for analysis. During FY 2014-15, there was a shift in duties to increase effectiveness as well as prepare for the beginning of a shift in staff responsibilities to account for changes in the Medicaid program, which included a shift from predominately fee-for-service (FFS) recoupments to increased managed care-related efforts. The Intake sub-unit has begun the transition to conduct the preliminary investigations of all leads before referring the matter to other units.

This shift is expected to result in increased referrals to external entities and increased efficiencies with recoupment because the units responsible for recoupment are able to spend less time evaluating and triaging cases and more time conducting the recoupment activities. Additionally, with an increase in complaints anticipated due to enhanced detection capabilities, aligning functional responsibilities appropriately within the units is important to ensure overall MPI success in handling the increase in workload. The increased workload is expected to continue for the next several years. Additionally, as the workload normalizes, Medicaid's service delivery model transition from FFS to managed care necessitates a similar shift in staff within MPI; the Detection Unit's transition planning and long-range goals also consider those future needs.

The Intake sub-unit has developed the processes for conducting preliminary investigations. To implement these extensive triage and preliminary investigation processes, the Detection Unit has been engaged in

extensive training activities and worked to hire staff with credentials and/or experience to meet the unit's needs. The Intake sub-unit receives a high volume of complaints from the fraud and abuse (telephone) hotline, on-line fraud and abuse complaint forms, internal AHCA referrals, news media reports, MFCU closing reports, and the data analytics detection system. The preliminary investigation process varies depending on several factors. Therefore, prior to conducting preliminary investigations, the complaints are triaged to ensure proper assignment of preliminary investigations.

The complaint triage process is geared toward identifying and comprehending the following:

- The subject (or named party) of the complaint;
- The nature of the allegations;
- The subject's enrollment status (whether a current or former provider, an applicant, a fully-enrolled FFS provider, a managed care only provider, or a cross-over only provider);
- The potential complexity of the preliminary investigation based upon the perceived nature of the allegations and issues involved; and
- The level of potential risk associated with the subject's activities and participation in Medicaid.

This initial triage is a necessary process to ensure that preliminary investigations are properly assigned. Preliminary investigations may be assigned to Prevention and Program Oversight Unit staff (if the triage process indicates a potential "for cause" termination or suspension is warranted, or suggests a potential MFCU referral), Managed Care Oversight and Compliance Unit staff (when the subject is a health plan), and Overpayment Recoupment unit staff (where there is an extensive need for a subject matter expert to review the allegations). However, most of the triage is now conducted within the Detection Unit.

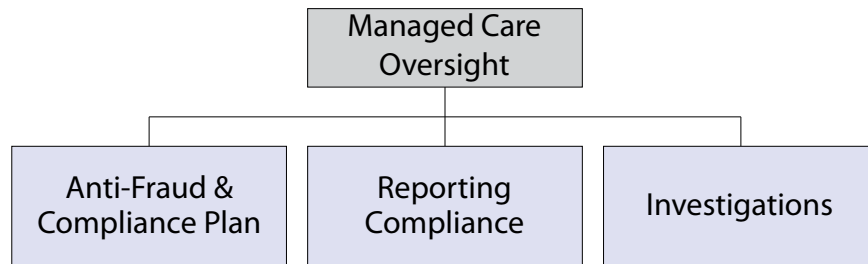
Following the triage process, the assigned investigator will conduct a preliminary investigation with the intended outcome of one of the following typical dispositions:

- Referral to an MPI Overpayment Recoupment unit;
- Referral to MPI Prevention and Program Oversight Unit staff;
- Referral to MPI Managed Care Oversight and Compliance Unit staff;
- Referral to the Division of HQA;
- Referral to MFCU;
- Referral to other organizations such as other state or federal agencies or a health plan; or
- Closure of the complaint with no further MPI action.

The preliminary investigation process also involves extensive research about the provider, including their history with Medicaid, MPI audits, and MFCU investigations. The investigation also involves an assessment of Medicaid claims reimbursement, business associations, licensure status, known complaints about the provider, and history about the provider's business and owners, as can be readily obtained. An assessment of the information leads to a recommendation to close the complaint, issue a provider education letter, initiate referrals for follow-up to other components within MPI, or to make an external referral to another agency for follow-up.

If there is a reasonable probability that the alleged violation has resulted in an overpayment or policy violations, a recommendation is made to the Assistant Chief of MPI for the complaint to be reassigned to the appropriate overpayment recoupment unit. The preliminary investigation will not try to determine the extent of the violation, just that a violation has occurred. If there is a reasonable probability the violation is criminal in nature, a recommendation is made to the Tallahassee-based prevention manager for the complaint to be reassigned for further review and subsequent referral to MFCU. When the subject of the complaint is a health plan, the complaint is reassigned to the Managed Care Oversight and Compliance Unit for investigation. Furthermore, when the source of the complaint is a Medicaid health plan (Medicaid health plans are obligated to refer suspected and confirmed fraud and abuse to MPI), after the MPI-related preliminary investigation activities are completed, the matter is referred to the Managed Care Oversight and Compliance Unit for continued monitoring of the health plan's diligence in conducting their anti-fraud investigations.

Managed Care Oversight



As stated previously, a management organizational change, which has resulted in the three Prevention sub-units reporting directly to the MPI Chief, allowed the Managed Care Oversight unit manager to focus solely on managed care oversight and health plan compliance issues. During FY 2014-15 the Managed Care Oversight unit was restructured from a focus on plan type (provider service networks vs. health maintenance organizations) to a functional model. Three sub-units were created. One of the sub-units has responsibilities related to the health plan requirements for filing organizational strategies and documents pertaining to their corporate culture (anti-fraud and compliance plans), another with responsibilities related to the fraud and abuse investigation requirements (reporting compliance), and a third related to the investigation of allegations of the health plan itself being involved in fraudulent or abusive activities (investigations).

Anti-Fraud and Compliance Plan sub-unit: This sub-unit is responsible for the review and approval of managed care anti-fraud and compliance plan submitted to MPI, annually and/or upon revision of such plans. The health plans submit a compliance plan and anti-fraud plan, including related fraud and abuse policies and procedures, and any changes to these items, to MPI for written approval at least 45 days before those plans and procedures are implemented (see s. 409.91212 and s. 409.967(2)(f), Florida Statutes (F.S.)). This sub-unit assesses both the acceptability of the submissions as well as the manner in which they have been implemented.

With regard to anti-fraud plans, s. 409.91212, F.S., requires that:

Each Medicaid health plan, as defined in s. 409.920(1)(e), F.S., shall adopt an anti-fraud plan addressing the detection and prevention of overpayments, abuse, and fraud relating to the provision of and payment for Medicaid services and submit the plan to the Office of MPI within the Agency for approval.

The Agency's contract with the health plans further delineates requirements for the anti-fraud plan.

With regard to compliance plans, federal regulations (42 CFR 438.608) require that the health plans "have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse." The law provides for specific procedures, including designated policies, staff, training requirements, and organization. There are further requirements, as well as clarification regarding compliance plan requirements, set forth in the managed care contract.

The Model Managed Care Contract requires, generally, written policies and procedures, a compliance officer and compliance committee, training and education, internal monitoring and auditing, and prompt response and corrective action to detected offenses.

The Anti-Fraud and Compliance Plan sub-unit is finalizing the development and implementation of standard guidelines for MPI staff review of the health plans' documentation requirements as well as the development of audit protocols, compliance review protocols, and on-site monitoring tools and protocols.

The Reporting Compliance sub-unit is responsible for the review and monitoring of all reports of suspected or confirmed fraud and abuse submitted by the health plans. Because the health plans are required to report

within 15 days of detecting, these reports are often referred to as the 15-day report. The sub-unit is not to assess what MPI-related actions (such as referrals) should be taken, although it does include a re-validation of the preliminary investigation conducted by the Intake sub-unit. It also assesses the timeliness and quality of the referral itself. This sub-unit is responsible for monitoring the health plans' investigations to ensure that they are diligently pursuing overpayments. The sub-unit is developing processes and written protocols for these new functions.

Additionally, the Reporting Compliance sub-unit provides assistance and guidance to the health plans regarding accurate reporting of suspected fraud and abuse to the Agency. Through monitoring of the required 15-day reporting of suspected fraud and abuse, and reconciliation with other required submissions, the health plans are challenged to provide accurate, detailed, and up-to-date information about investigations. The sub-unit is also exploring new mechanisms to identify and report on emerging fraud or program abuse trends that extend across multiple Medicaid health plans.

With the shift in responsibilities related to the intake of complaints, this sub-unit assisted in a significant portion of the triage and preliminary investigation of complaints from health plans. The tracking of these complaints as well as analysis of information provided by other units within MPI, have identified areas for focus, trends to alert the health plans to for further review, and have resulted in referrals to MFCU, the Department of Children and Families (DCF), the Centers for Medicare and Medicaid Services (CMS), and other regulatory and enforcement entities outside of the Agency.

The Managed Care Oversight unit also has an Investigations "team" which presently consists of one Registered Nurse Consultant as the senior investigator. This investigator is responsible for evaluating all complaints in which the subject of the alleged fraud or abuse is a Medicaid health plan. The allegations are first assessed to determine if they should immediately be referred to MFCU (in instances when there is a high level of reliability of the complainant and the supporting evidence suggests a high level of validity to the allegations, they are immediately referred) or whether the allegations are too ambiguous to determine if they actually allege a violation of law. Many of the complaints received by MPI are not alleging fraudulent activity, rather the complaints involve a complainant expressing frustration about a provider or health plan.

Health plan investigations during FY 2014-15 may have involved an alleged failure to comply with legal requirements for a program integrity (or special investigative) unit regarding functions to pursue fraud and abuse. The allegations are typically related to inefficient auditing or a lack of Special Investigative Unit (SIU) expertise sufficient to diligently pursue anti-fraud activities, or allegations that a health plan is contracting with a provider or providers who have been excluded from Medicare or Medicaid.

Other investigative topics include:

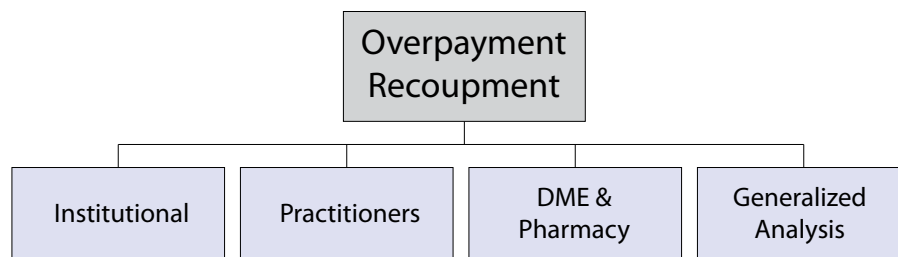
- Potential Stark Law violations (specific laws related to practitioners referring patients to other practices for which they have an ownership interest) as well as investigations surrounding the many business arrangements that arise in a managed care environment. For example, Management Service Organizations (MSOs) are entities created to provide practice management and administrative services. The MSOs contract with the health plans and create provider networks to render patient care. These types of arrangements decrease the direct oversight of key provisions of the managed care contract, such as provider networks and credentialing, and add to the complexities of the current business arrangements in managed care.
- Contract compliance and health plan activities require routine tracking and monitoring. Assessing the health plan trends related to compliance, including potential fraud and abuse, would be a key component in program integrity. With several of the Medicaid health plans' reimbursements for Medicaid services reaching the billion dollar mark yearly for services, our efforts must measure the impact that health plan fraud and abuse can have upon the Medicaid program.

The Managed Care Oversight unit also facilitates periodic meetings that are held with the contracted health plans. The meetings have evolved over the last few years and provide a collaborative environment for the health plans, the Agency, and other state and federal partners to share current concerns regarding providers

that may be contributing towards fraud, waste, and abuse. The shared information assists the plans as well as MPI and MFCU in furthering effective investigations. These meetings also provide a forum for investigative best-practices discussions, including referral processes, and provide a deeper insight into the processes and practices of the Agency, MFCU, and the health plans. This collaboration and developing trust between the health plans, the Agency, and MFCU aids in fighting fraud in the Medicaid program and encourages the health plans to improve their internal quality controls regarding fraud and abuse reporting to the Agency.

Overpayment Recoupment

After many years of ongoing quality improvements, MPI continues to increase its overall return on investment. Much of this is attributable to the Overpayment Recoupment units (f/k/a the Case Management Units) who efficiently audit providers, and identify and recover overpayments. The organizational structure of the MPI recoupment teams has not changed over the past several years. However, during FY 2014-15, several key staff began the process to become certified as contract managers in anticipation of organizational changes planned for FY 2015-16. The office changes included the shifting of full time employees from the Overpayment Recoupment units to fill gaps in prevention, detection, and managed care oversight activities. MPI anticipates continuing to conduct a high volume of audits through a combination of MPI staff and contracted audit firms.



MPI anticipates that in FY 2016-2017 the Overpayment Recoupment units will be reduced to only three teams. The three teams will work with contractors to continue to achieve the high level of results that have been historically attained. Furthermore, the teams will work more closely with the health plans to increase effectiveness within the managed care environment so that the recoupments that the health plans identify are increased to meet or exceed MPI's historical averages. According to data received from the health plans for FY 2013-14, the overpayments recovered by all health plans totaled approximately \$28 million.

Traditionally, the efforts of MPI have focused on the recoupment activities in a FFS environment. While there is a significant decrease in FFS claims with the move to Statewide Medicaid Managed Care (SMMC), MPI activities are actually increasing. With the efforts to ensure comprehensive retrospective reviews and audits able to effect recoveries for services rendered as far back as five years, FFS recoupment activities are at an all-time high. Additionally, MPI recoupment activities are beginning to touch on the period immediately preceding the implementation of the SMMC program, a time period that saw the annual FFS claims volume expand to as many as 127,000,000 claims.

Also, there are several Medicaid eligible populations that remain FFS following the full implementation of SMMC, including: Presumptively Eligible Pregnant Women; Emergency shelter/Department of Juvenile Justice residential; Family Planning waiver participants; women enrolled through the Breast and Cervical Cancer Program; Emergency Medical Assistance for Noncitizens; Working Disabled; and Medically Needy. Currently, the Medicaid population enrolled in the Developmental Disabilities Individual Budgeting (i-Budget) Waiver program also remains FFS. To the extent that the health plans are able to keep would-be fraudsters out of their networks, these remaining FFS populations create an increased vulnerability for the state related to fraud, waste, and abuse. These populations continue to have a high volume of reimbursements (approximately \$800,000,000) that will warrant ongoing auditing and recoupment activities.

Furthermore, program integrity efforts by MPI, including recoupment activities to identify and recover overpayments, continue to be essential in a predominately managed care environment because the health plans are unable to achieve the same volume of overpayment recoveries as MPI.

Administrative Support

MPI could not effectively function without the unit that provides operational support for both the Tallahassee office as well as the MPI field staff. The unit has primary responsibility for budget management, personnel, and purchasing. Unit staff serve as the first point of contact for recipients, providers, and the public. The unit also coordinates all MPI correspondence assignments, public records requests, contracts/procurements, purchasing, external audits, and tracking through the Agency's CorrFlow system.

During FY 2014-15, MPI significantly increased its training activities. The Administrative Support Unit staff took responsibility for coordinating the increase of both external and internal training. They also process nominations, and coordinate travel and attendance for the MII courses.

The highly efficient staff of this unit coordinates meetings for others in MPI, perform record management, manage office equipment inventories, and have served as lead in MPI's project to transition to automated electronic processes. Often unrecognized, all of the MPI accomplishments result from not only the efforts of the operational units, but also the support of this team.

MPI Accomplishments

Audits and Investigations

MPI activities include audits of Medicaid providers for the purposes of identifying overpayments as well as investigations of other allegations that may not bring rise to the recovery of overpayments. Often, these other investigations result in referrals to other entities, the imposition of sanctions, or broad-scale initiatives and projects within MPI. Some of FY 2014-15 notable audits and investigations include:

- The pharmacy audit team conducts invoice reviews of pharmacy records to identify shortages in purchases compared to the claims that are billed and paid for by Medicaid. In two such audits, the purchase shortages were the result of incorrect billing of claims for compounded prescriptions. The resulting identified overpayments for the two cases totaled more than \$300,000.00.
- During an audit of a pain management provider, MPI's Practitioner Care Unit discovered that providers were billing multiple units of procedure code 80101 (Drug screen, qualitative, chromatographic, single drug class method). This code reimbursed \$10.00 per test to a maximum of seven units or \$70.00. However, MPI believed the test was typically performed as a "multiplex" test kit. MPI recommended that a different code be implemented to reflect the proper services performed. The Division of Medicaid concurred and implemented the new code, which will now pay only \$14.88, an amount more appropriate for the services rendered. Unquantified cost savings as a result of this investigation are expected.
- MPI recoupment staff and prevention staff frequently collaborate on investigations. In one such case, the recoupment staff requested site visits in collaboration with an investigation by one of MPI's pharmacists. Based on information from these site visits, MPI opened 23 compliance audits, identifying overpayments totaling \$1,959,005.00.
- In 2010, the Agency initiated an audit program composed of 11 audit projects to audit Emergency Medicaid Alien (EMA) services. Over 700 comprehensive audits will be completed to review EMA paid claims for inpatient hospital EMA for the period July 1, 2005, through June 30, 2010. As of the close of FY 2014-15, over 400 audits have been completed with nearly \$25 million in overpayments recouped since the inception of the audit program. Litigation activities associated with the EMA audit program have resulted in a reduction in recoupments during FY 2014-15.

- Another form of recoupment activity that MPI engages in, referred to as Paid Claims Reversals (PCR), serves as both a recoupment activity and a prevention activity. When MPI discovers overpayments that appear to be due to more clerical-type errors in billing, a decision is made about whether PCR with provider education will be the most effective means of recoupment and prevention. In a PCR, the provider is contacted, the claim amount verified, and a request is made to reverse and re-bill the claim for proper payment.
- A review of claims documentation in a compliance audit for a Durable Medical Equipment (DME) provider identified overpayments of \$175,645.65, of which the majority were for inappropriate billing of services that required a licensed professional when none were present.

Collaborative Efforts

The nature and complexity of health care fraud, waste, and abuse simply makes it impossible for any one organization or entity to be successful on its own. Through collaborative efforts, MPI improves its effectiveness and assists others in the larger-picture issues addressing fraud in Medicaid. Among the collaborative efforts that MPI engages in are:

- Central and South Florida Interagency Compliance Meetings;
- Health Plan Quarterly Plan Meetings;
- Health Quality Assurance Quarterly Meetings;
- Judicial Circuit Adult Interagency Meetings;
- National Insurance Crime Bureau Meetings;
- Department of Elder Affairs Ombudsman Meetings;
- Senior Medicare/Medicaid Patrol Project Meetings;
- FBI Healthcare Fraud Working Group Meetings;
- County Government Financial Abuse Workgroup Meetings; and
- State Attorney Multidisciplinary Task Force Meetings.

MPI also conducts joint site visits and initiatives with:

- The Agency's Division of Health Quality Assurance;
- CMS Contractor Safeguard Services/Medi-Medi Project;
- Agency for Persons with Disabilities;
- Medicaid Fraud Control Unit;
- Health Plan Organizations;
- Centers for Medicare and Medicaid Services - Medicaid Integrity Group;
- MPI Case Management Units; and
- Bureau of Medicaid Services.

Field Initiatives/Focused Projects

Each year, MPI field staff conduct a number of on-site field initiatives as part of its ongoing efforts to combat health care fraud, waste, and abuse in Florida. These are either site visits of a single provider or several related providers in furtherance of an MPI investigation, or are a part of a field initiative. A field initiative is a focused on-site review project to review multiple Florida Medicaid providers, enrolled and registered, regarding compliance with Medicaid policy and laws. These field initiatives involve compliance site visits to provider locations to review recipient and employee records, and may include Medicaid recipient interviews. Additionally, these field initiatives often include MPI's federal and state regulatory partners, or other anti-fraud professionals that MPI collaborates with, and usually target specific geographic areas of the state to focus on a specified provider type or service area.

At the conclusion of each site visit conducted during this reporting period, MPI staff held educational conferences with the providers to address the identified deficiencies. As the reviews indicated or required, referrals were made to other internal and external entities and administrative sanctions were imposed, as necessary.

Operating under the provisions of Section 409.913, F.S., the MPI Miami and JOT field offices coordinated the following initiatives/focused projects in FY 2014-15:

Developmental Disabilities Waiver in St. Johns County – September 2014

In September 2014, MPI field staff, along with Agency for Persons with Disabilities (APD) staff, visited 12 residential habilitation facilities located in St. Johns County. Nine facilities were visited during evening hours to ensure the residents would be home. In addition, there were concerns involving staff schedules during evening hours. APD conducted monitoring of the facilities. MPI checked for compliance with the Florida Medicaid Provider General Handbook.

Areas of concern included: documentation issues, staffing concerns/minimum staffing requirements, medication errors, and staff training issues. APD addressed many of these issues. All Medicaid issues and concerns were discussed with staff from the Division of Medicaid, Federal Authorities Unit, as the new Developmental Disabilities Individual Budget Handbook was under review at that time.

Area 9 Durable Medical Equipment Initiative - October 27-29, 2014

From October 27 through October 29, 2014, MPI conducted a field initiative that focused on Durable Medical Equipment (DME) providers located in Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie counties (Area 9).

MPI conducted site visits on 65 DME providers located in Area 9 to ascertain compliance with Medicaid policy as required in the Florida Medicaid Provider General Handbook (July 2012) and the Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook (July 2010). The primary objective of this initiative was to review for enrollment and operational compliance.

The compliance site visits assessed sign visibility, posted hours of operations, possession of a current surety bond and approved accreditation, compliance with personnel and licensing requirements for certain goods or services rendered (oxygen, orthopedic, or prosthetic services, etc.), proof of Level II background checks for applicable parties, and determined whether the provider was operating. These site visits resulted in the identification of issues for referral to the appropriate regulatory entities (e.g., licensing).

This initiative found 17% of the DME providers in Area 9 failed to notify the Florida Medicaid Fiscal Agent of any status changes, such as changes in ownership, changes in service address, and the closure of their business. Additionally, 6% of the providers failed to obtain or renew surety bonds, which were required to participate in the Florida Medicaid program. Referrals were made, as appropriate, to other internal and external entities. Additionally, as appropriate, administrative sanctions were imposed. The initiative resulted in the following:

- Thirteen Medicaid Fiscal Agent Operations referrals were accomplished;
- Five prepayment reviews were initiated;
- One sanction for violation of s. 409.913(7)(e), F.S., was imposed; and
- One Division of HQA referral was made.

JOT Durable Medical Equipment Provider Network Compliance Review – October, November, and December, 2014

MPI field offices located in Jacksonville, Orlando, and Tampa conducted site visits to 135 DME providers located in Areas 1, 3, and 4 to ascertain compliance with Medicaid policy. The primary objective of this initiative was to assess enrollment and operational compliance with applicable Medicaid provisions. Specific

areas assessed included ensuring the provider was operational, had proper sign visibility, had their hours of operations properly posted, were in possession of a current surety bond and approved accreditation, met personnel and licensing requirements for certain goods or services rendered (oxygen, orthopedic, or prosthetic services, etc.), and had completed Level II background checks for applicable parties.

Areas of concern noted in this initiative included providers failing to notify the Florida Medicaid Fiscal Agent of status changes, such as changes in ownership/officers, changes in service address, and closure of their business. Additionally, many of the providers mentioned their difficulty in dealing with a specific DME subcontractor for the health plans. Providers were advised by MPI to submit complaints to Medicaid via the online SMMC program complaint form. The field office administrator also discussed the issue with MPI's Chief.

Results of the visits were as follows:

- Twenty-one Medicaid Fiscal Agent Operations referrals were accomplished;
- One prepayment review was initiated;
- One Division of HQA referral was made;
- One Department of Business and Professional Regulation referral was made;
- One Department of Health referral was made;
- One Medicare referral was accomplished; and
- Five provider educational conferences were conducted.

Miami-Dade County Assisted Living Facility (ALF) Initiative - January 26-29, 2015

From January 26 through January 29, 2015, MPI and the Agency's Division of HQA conducted a joint field initiative that focused on Assistive Care Services providers in Miami-Dade County.

MPI conducted site visits on 40 Assisted Living Facilities (ALF) located in Miami-Dade County to determine their compliance with Medicaid policy and HQA's licensure requirements, and to ascertain that the facilities were safe environments for Medicaid recipients. The primary objectives of this initiative were as follows:

- To determine if the ALFs were rendering, billing, and documenting services as required by the Florida Medicaid Provider General Handbook (July 2012) and the Assistive Care Services Coverage and Limitations Handbook (July 2009);
- To determine if Assistive Care Services were being rendered by qualified and properly trained staff;
- To identify Adult Day Care issues when the circumstances involved a residential situation, and to determine if the ALFs were housing more residents than allowed by their license; and
- To identify quality of care and environmental issues.

This initiative found 17 out of 40 providers failed to maintain documentation in Medicaid recipient records as required by the Assistive Care Services Coverage and Limitations Handbook. The documentation was either missing from patient records, incomplete, or was not current. Additionally, Adult Day Care participants were residing as full-time residents in the facilities, leading to overcapacity and erroneous billing. Referrals were made, as appropriate, to other internal and external entities. Additionally, as appropriate, administrative sanctions were imposed. The initiative resulted in the following:

- Sixteen sanctions for s. 409.913(7)(e), F.S., violations totaling \$19,500.00 in fines;
- Four paid claim reversals, amounting to \$13,264.00 in overpayments;
- One MFCU referral; and
- One managed care health plan referral.

Miami-Dade/Broward County Behavior Analysis Services Initiative - April 28-29, 2015

From April 28 through April 29, 2015, MPI conducted a field initiative that focused on monitoring the activities of Behavior Analysis Services providers in Miami-Dade and Broward counties.

MPI conducted site visits on 20 i-Budget Medicaid Waiver-Behavior Analysis Services providers located in Miami-Dade and Broward counties to determine their compliance with Medicaid policy and to ensure that these entities provide necessary and ordered services to Medicaid recipients. These providers billed for procedure code H2019 (Therapeutic Behavioral Services) and its corresponding modifiers (HR, HO, HN, and HM) with the Diagnostic Code Range 299-299.91.

The primary objectives of this initiative were as follows:

- To determine if Behavior Analysis Services providers were rendering, documenting, and billing services according to Medicaid policy as required by Chapter 65G, Florida Administrative Code (F.A.C.);
- To determine if Behavior Analysis Services providers were in compliance with the Florida Medicaid Provider General Handbook (July 2012);
- To determine if Behavior Analysis Services providers were in compliance with provider qualifications of the Board Certified Behavior Analyst (BCBA) and Certified Assistant Behavior Analyst (CABA) as required by Chapter 65G, F.A.C., and Chapters 490/491, F.S.; and
- To identify, document, and refer quality of care issues to APD and other appropriate regulatory entities, as applicable.

This initiative found three providers failed to maintain complete and accurate progress notes and service logs in Medicaid recipient records. One provider billed and received payment for services rendered after his CABA certification expired. Additionally, the provider billed at a level above his certification credentialing and failed to maintain required documentation in patient records. Referrals were made, as appropriate, to other internal and external entities. Additionally, as appropriate, administrative sanctions were imposed. The initiative resulted in the following:

- One sanction for s. 409.913(7)(e), F.S., violation, totaling a fine of \$3,000.00;
- Three paid claim reversals, amounting to \$28,704.84 in overpayments;
- One prepayment review;
- One MFCU referral; and
- Two APD referrals.

Payment Restrictions

Payment restrictions include the “pending” of claims in the Medicaid claims processing system for one or more specific, legally-authorized, purposes. Claims may be pended due to enrollment issues, claim processing issues, or other administrative matters handled by the Medicaid Bureau of Fiscal Agent Operations (FAO). Claims may also be pended at the direction of another bureau (via notice to FAO) and, typically, are due to an investigation by or in coordination with MPI. Typical pends or payment restrictions used by MPI include:

- (1) Prepayment review (PPR) consistent with s. 409.913(3), F.S.,
- (2) A payment withhold following a determination that there exists reliable evidence of circumstances related to fraud or abuse (referred to as a “25A withhold”) consistent with s. 409.913(25)(a), F.S., or
- (3) A payment suspension following a determination that there are credible allegations of fraud (referred to as a “CAF payment suspension”) consistent with 42 CFR 455.23.

Notice of a payment restriction is sent to the provider from the Agency’s organizational unit initiating the action. When MPI initiates one of the aforementioned payment restrictions, notice is also furnished to the Medicaid health plans with instructions about whether the notice is informational or a requirement to take action (25A withholds and CAF payment suspension).

The nature of the basis for these payment restrictions is confidential under federal and state law due to the ongoing investigation regarding suspected fraud or abuse. While case-specific highlights cannot be furnished, it is noted that during FY 2014-15, MPI was involved in well over 100 provider payment restrictions. In fact, there were nearly 100 instances of either credible allegations of fraud (federal law provisions applied) or reliable evidence of circumstances involving fraud or abuse (state law provisions applied) necessitating payment restrictions.

The federal law provisions that trigger payment suspensions are 42 CFR 1007.9 and 42 CFR 455.23. These federal provisions are triggered when either MFCU or MPI have determined that there are credible allegations of fraud under the Medicaid program involving an individual or entity. There are exceptions, most commonly when the law enforcement agency investigating the allegations requests that MPI delay notification to the Medicaid provider (to preserve the confidentiality of the active investigation and/or to protect confidential sources) or when the Division of Medicaid has determined that it is in the Medicaid program's best interest to not impose the payment suspension. Both of the exceptions, however, have limitations. The law enforcement exception may only be imposed for a specified period of time and, even where the determination is made by law enforcement, the state must be aware of sufficient information about the investigation to comprehend the credible allegations forming the grounds for the payment suspension. The Medicaid program's best interest exception also has limitations and cannot be invoked in most situations when credible allegations of fraud exist.

Provider Education

MPI participates with CMS and the Division of Medicaid in their efforts to educate Medicaid providers about best practices, inform providers about fraud, waste, and abuse, and offer educational opportunities to increase compliance and reduce the likelihood of an MPI audit. MPI is very proactive with encouraging providers to conduct self-audits and routinely assists Medicaid in ensuring that message is widely conveyed. Additionally, MPI routinely engages in provider education as a part of the audit process.

MPI has also issued Medicaid provider alerts and published Medicaid provider bulletin articles about upcoming and past initiatives to educate providers and to increase voluntary compliance. The MPI internet landing page (on the Inspector General landing page of the Agency's website) has been updated to include additional information about self-audits and other useful resources. These educational efforts increase the program integrity presence in a very cost-effective manner.

Referrals

The coordination of efforts with Medicaid (and program integrity/anti-fraud professionals) stakeholders regarding common issues of concern, including risk for fraud and abuse, findings following preliminary review of matters, and complaints received that fall under the authority of another agency, is critical to the success of MPI. Suspected fraudulent provider activity is referred to MFCU and, to the extent that Medicare implications are included, they are also referred to CMS. Suspected licensure violations are referred to the respective licensure agency, which may include the Agency's Division of HQA. Other referrals to partner agencies and health plans are a routine part of MPI's activities. Important referrals from FY 2014-15 include:

A joint Medicaid, MPI, and MFCU project originated from a referral from the Division of Medicaid regarding the billing practices and business relationships of a number of associated providers. One of the providers had been arrested and convicted of health care fraud. The associates were analyzed by staff in the Division of Medicaid to determine potential risk factors and program vulnerabilities. Providers believed to be engaged in fraud were identified for referral to MFCU for further investigation. The referrals resulted in numerous arrests to date and the project continues to be furthered by MFCU. Additional outcomes have been the denial of participation for high-risk provider applicants, and changes in enrollment practices to reduce the incidence of would-be fraudsters enrolling.

Sanctions

While provider terminations are not the only sanction imposed by MPI, some background about terminations is warranted to distinguish those carried out by MPI versus those carried out by other offices within the Agency. Voluntary terminations include situations in which the provider withdraws from the program or closes their business. Typically, these terminations do not come to the attention of MPI. However, when such voluntary termination is perceived as an attempt to avoid further regulatory action, subsequent licensure actions or Medicaid sanctions may apply. Involuntary terminations and suspensions involve any termination

(or a suspension of participation in the Medicaid program) in which the provider did not choose to relinquish their provider number, or an instance when a provider voluntarily relinquishes its Medicaid provider number or an associated license, or allows the associated licensure to expire after receiving written notice that the Agency is conducting, or has conducted, an audit, survey, inspection, or investigation and that a sanction of suspension or termination will or would be imposed for non-compliance discovered as a result of the audit, survey, inspection, or investigation.

Involuntary terminations can be contractual actions, when the Medicaid provider agreement is terminated under the provision that indicates either party may terminate the contract with a 30 day notice to the other party. Involuntary terminations may also involve administrative sanctions imposed following the issuance of a Final Order, which serve to terminate or suspend the provider's participation in the Medicaid program. Contract terminations are often referred to as "without cause" terminations. Provider terminations emanating from sanctions and final orders are often referred to as "for cause" or "with cause" terminations.

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 and provide due process hearing rights. The sanction becomes final upon issuance of the Final Order against the provider. The sanction of termination may be imposed for reasons such as licensure revocations, failure to repay overpayments owed to the Agency, provider actions or inactions that are harmful to recipients, convictions of certain criminal offenses, as well as repeated instances of certain violations.

All sanctions that are issued by MPI are imposed by way of a Final Order. All Agency Final Orders 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. Additionally, the sanctions applied against a provider are imposed in accordance with s. 409.913, F.S. and Rule 59G-9.070, F.A.C. Sanctions typically include fines, suspension, and termination.

Other Medicaid Program Integrity Projects

- MPI anticipates that there will be a significant increase in audit leads through the implementation of advanced data analytics. The initial implementation of data analytics was accomplished in August 2015, with continued refinement into 2016. The vendor is continuing to incorporate additional external data sources and integrating more sophisticated algorithms to produce investigation-ready leads for MPI. The leads are anticipated (following preliminary investigation by MPI) to result in a significant increase in comprehensive overpayment audits, comprehensive investigations, and referrals to other Agency and external entities, including MFCU.
- In 2012, the Agency obtained a waiver from the federal requirement imposed by the Affordable Care Act (ACA) to engage a Medicaid Recovery Audit Contractor (RAC) and has subsequently renewed such waiver. The Agency is now drafting staff augmentation contract terms to incorporate several of the RAC requirements, but emphasizing greater control of claims audit assignments, processes, and litigation support. By design, the draft contract does not incorporate all of the federal RAC requirements, but does emphasize staffing requirements, expected return on investment provisions, and includes an emphasis on provider education. The draft also ensures that the selected audit vendor(s) utilize a process substantially similar to those employed currently by MPI and contemplates that the MPI contract manager and audit manager (as assigned by provider type) are closely involved in the audit processes to ensure consistency in the contracted audits.
- During FY 2014-15, MPI implemented a new case tracking system to enhance capabilities for analysis of historical case information to inform MPI staff about potential trends in fraud, waste, and abuse. The tracking system will continue to be enhanced to achieve this purpose and will be modified as funding allows to integrate with the contracted data analytics system and other Agency systems.
- MPI hosts an interagency fraud and abuse meeting with participants from the DCF, the Department of Health, the Department of Economic Opportunity, the Florida Department of Law Enforcement, the Department of Elder Affairs, the Department of Financial Services, the Agency for Persons with Disabilities,

the Office of Early Learning, the Office of Insurance Regulation, the Department of Management Services, and the MFCU. This collaborative meeting is an opportunity for the agencies to share emerging trends in fraud and abuse, provide best practices for combatting fraud and abuse, and creates an environment for training and information sharing.

- In 2010, Florida's data mining partnership between the Agency and MFCU was the first of its kind to be approved nationally by HHS. The Agency, at MFCU's request, proposed to HHS that data mining activities by MFCU be included in the Florida Medicaid Medications for Aged and Disabled (MEDS-AD) Demonstration Waiver for the purpose of enhancing detection activities related to suspected fraud. HHS approved the proposal with the requirement that the Agency ensure that the practices between the Agency and MFCU not be duplicative. In the first five years, 82 data mining projects have been deliberated with 62 being approved and 20 denied. In an effort to enhance effectiveness through increased specificity, MPI and MFCU are incorporating data from an advanced data analytics system into the process to produce actionable ready leads for MFCU.

MPI Data for Fiscal Year 2014-15

Site Visits	
Provider Type	Number
Assistive Care Services	199
Chiropractor	1
Community Alcohol, Drug, MH	1
Dentist	1
Dialysis Center	1
DME	2
EIS Professional	1
H & C Based Services	135
Home Health Agency	1
Medical Supplies/Durable Med	255
No Provider Type Indicated	7
Non Provider/Mail Only	8
Nursing Home	2
Optician	1
Optometrist	1
Pharmacy	23
Physician (MD)	8
Podiatrist	1
Therapist	2
Grand Total	650

Prepayment Reviews FY 2014-15	
Number of Claims Reviewed	22,753
Number of Claims Denied	12,810
Amount of Claims Reviewed	\$1,846,656.43
Amount of Claims Denied	\$1,092,338.57

25A Withholds		
	Number	Amount
Fiscal Year 2014-15	93	\$1,868,517.78

Random Audits Concluded in FY 2014-15	
Audits Completed	10
Audits with Findings	8
Audits with No Findings	2
Overpayments Identified	\$125,935.74

MPI Referrals in FY 2014-15	
Department of Health	10
Division of Public Assistance Fraud	4
Department of Health & Human Services - OIG	32
Division of Health Quality Assurance	65
Division of Medicaid	46
Medicaid Fraud Control Unit - AG	63
Department of Children and Families	57
Other	60
TOTAL:	337

Provider Sanctions and Managed Care Organization Assessments				
	FY 2013-14		FY 2014-15	
	Number	Amount	Number	Amount
Sanctions under Rule 59G-9.070, F.A.C.				
Fine Sanctions	545	\$2,810,147	394	\$1,516,201
Suspensions	49	N/A	25	N/A
Terminations	73	N/A	42	N/A
Total for Rule 59G-9.070, F.A.C. Sanctions		\$2,810,147		\$1,516,201
Total for Managed Care Organization Section 409.91212 F.S., or Contract Assessments	1	\$1,600		
Grand Total Sanctions and Managed Care Organization Assessments	668	\$2,811,747	461	\$1,516,201

MPI Tracking Entries of Collection of Overpayments by Accounts Receivable and Paid Claims Reversals (PCRs)			
Fiscal Year	Type of Recovery	Overpayment Identified	A/R Collections and Reversals
FY 2011-12	Accounts Receivable, Offsets and PCRs	\$36,053,930	\$30,320,245
FY 2012-13	Accounts Receivable and PCRs	\$26,511,641	\$20,507,303
FY 2013-14	Accounts Receivable and PCRs	\$28,640,118	\$21,301,711
FY 2014-15	Accounts Receivable and PCRs	\$30,380,115	\$27,640,256

MPI Prevention of Overpayments (\$ Millions)				
	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Prepayment Review	\$1.3	\$0.6	\$0.4	\$1.1
Termination of Providers	\$5.5	\$5.7	\$1.6	\$6.2
Focused Projects	\$0.9	\$0.8	\$6.6	\$3.0
Site Visits	\$6.4	\$4.1	\$2.1	\$2.9
Sanctioned Providers	\$3.2	\$5.1	\$6.9	\$7.0
Claims Denied Per Statute	\$2.1		\$2.9	\$1.9
Audit Impact	\$7.3	\$5.6	\$8.8	\$13.0
Total:	\$26.70	\$21.90	\$29.30	\$35.1

MPI Recovery Activities (\$ Millions)				
	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
MPI Audits (OP's Collected by Accounts Receivable)	\$18.4	\$31.4	\$21.2	\$37.8
Costs (Collected by Accounts Receivable)	\$0.2	\$0.2	\$0.2	\$0.4
Fines (Collected by Accounts Receivable)	\$5.0	\$3.0	\$2.4	\$1.5
Paid Claims Reversals	\$2.5	\$1.3	\$2.6	\$0.5
Contractual Assessments	\$0.3	N/A	N/A	\$0.0
TPL Contractor - Assisted Claims Adjustments	\$32.2	\$43.6	\$61.6	\$42.5
Recovery Totals:	\$58.6	\$79.5	\$88.0	\$82.7

Medicaid Program Integrity Return on Investment (ROI)			
FY 2011-12	Benefits	Costs	ROI
Recovery	62.2	7.9	7.9:1
Prevention	27.9	5.3	5.3:1
Total:	90.1	13.2	6.8:1
FY 2012-13	Benefits	Costs	ROI
Recovery	79.5	10.4	7.6:1
Prevention	21.9	7.0	3.1:1
Total:	101.4	17.4	5.8:1
FY 2013-14	Benefits	Costs	ROI
Recovery	88.0	12.0	7.3:1
Prevention	29.4	4.4	6.7:1
Total:	117.5	16.4	7.2:1
FY 2014-15	Benefits	Costs	ROI
Recovery	82.7	10.35	7.99:1
Prevention	35.1	5.45	6.44:1
Total:	117.80	15.8	7.46:1

Division of Operations

When Medicaid overpayments are identified, they are generally referred to the Agency's 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 payments are not received or Medicaid/Medicare cannot be liened, Financial Services pursues other means of collection or determines if the case will be referred to an outside collection agency. Financial Services cannot authorize any reductions in monies due back to the Agency; any reductions in overpayments must be negotiated during a settlement process prior to the Final Order being issued by the Agency.

As of June 30, 2014, the Medicaid accounts receivable balance for fraud and abuse was \$41.2 million. During the 2014–15 state fiscal year (FY), \$49.9 million was recorded as Medicaid accounts receivables. The balance as of June 30, 2015 was \$42.8 million. During FY 2014-15, total collections including refunds and net of adjustments approached \$48.5 million. The collections were: \$46.3 million in overpayments (\$8.5 million collected from Medicaid Fraud Control Unit (MFCU) cases and \$37.8 million collected from Medicaid Program Integrity (MPI) cases); \$374,000.00 in investigation costs; \$1.5 million in fines/sanctions; and, \$286,000.00 in interest.

The Agency must obtain approval from the Department of Financial Services to write-off all accounts receivable deemed to be uncollectible. Accounts are generally written off because of one of the following reasons:

- The provider has declared bankruptcy;
- 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 a bankruptcy in which the Agency has filed a claim (even if the bankruptcy had already been discharged at the time the Agency discovers the bankruptcy); for an individual who is deceased and the Agency files a claim on the estate; or, when the write-off is due to a business that is certified as being out of business. Once the 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) to determine if a facility's license renewal can be held-up 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 receivables, as its business process tool. The MAR system tracks each case as it moves through the receivables process, identifying which department, bureau or unit has current responsibility for a case. The system tracks state and/or federal allocation of receivables amounts, and produces necessary reports for case management and audit purposes. Examples of available reports include Case Financial Summaries, Case Financial Histories, Case Aging, Summary by Status and Department, "tickler file," 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 not limited to, hospital and nursing home retroactive rate adjustments and gross adjustments.

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 current status for each case in the MAR system. The file is created by an automated process that runs from the MAR system each night and then updates FACTS, enabling it to reflect the latest financial and account status information.

Financial Services continues to emphasize communications with MPI and MFCU to coordinate audit collection efforts. The Bureau also works with the Agency's Office of General Counsel, Bureau of Medicaid Program Analysis, Bureau of HQA, Office of Third Party Liability, and Office of the Inspector General (OIG) to coordinate collection efforts and pursue additional avenues of collection.

Financial Services continues to take aggressive steps during the year to reduce the duration of the terms for negotiated payment plans, resulting in more funds being recouped sooner, as well as increase the percentages of the liens placed on provider Medicaid/Medicare payments.

Third Party Liability Unit

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

During FY 2014-15, over \$147 million in Medicaid funds were collected. Annual TPL collections over the last four years have averaged over \$156 million, exceeding the target of \$100 million. In addition, the TPL Unit has held the contractor accountable to its contract requirements by vigorously monitoring their performance. These efforts have helped to ensure maximum recoveries are generated for the State of Florida. Types of recoveries include:

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

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

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

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

Other Recoupment Projects – The TPL Unit also works in conjunction with the Agency's Office of MPI to conduct other Medicaid recoupment projects. Recoveries from other recoupment projects during FY 2014-15 include the following:

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

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

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

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

Below is a summary of historical TPL collections:

Medicaid Third Party Liability - Historical Collections						
TPL Collections	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Casualty	\$18,747,553	\$22,165,885	\$24,336,688	\$22,303,548	\$22,794,142	\$21,985,243
Estate	\$5,479,473	\$5,486,256	\$6,017,391	\$7,061,816	\$6,967,623	\$7,092,510
Trusts	\$5,369,002	\$6,011,888	\$7,124,616	\$5,471,792	\$6,615,113	\$8,595,999
Medicare and Other Third Party Payor	\$44,673,737	\$72,081,890	\$78,428,755	\$77,922,624	\$72,834,387	\$67,061,300
Other Recoupment Projects*	\$40,582,911	\$29,958,148	\$32,208,128	\$48,455,372	\$61,607,714	\$42,525,211
Total Collections	\$114,852,676	\$135,704,067	\$148,115,578	\$161,215,152	\$170,818,979	\$147,260,262
Cost Avoidance (Matrix)	\$778,611,980	\$966,902,977	1,259,088,849	1,423,986,005	1,720,174,663	\$2,366,574,378

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

Division of Health Quality Assurance

Care Provider Background Screening Clearinghouse

The Agency continues to move forward in the development of the Care Provider Background Screening Clearinghouse (Clearinghouse). 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, along with 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 on the vulnerable population. During FY 2014-15, the Background Screening Unit processed 7,398 RAP backs. Of these, 2,512 were found to be for criminal charges that resulted in the applicant’s eligibility status being updated to not eligible.

Integration with the state agencies began in January 2013 and currently the Agency, the DOH, VR at DOE, health plans, Medicaid providers, the DCF, the DOEA, and the APD are participating, with the DJJ expected to be brought on in 2016. Approximately 1,200 individuals a month applying for initial licensure or their licensure renewals with the DOH are able to use a Clearinghouse screening, reducing duplicative screening and costs. The Agency providers benefit by being able to use more than 1,000 screenings per month from the Clearinghouse. During FY 2014-15, more than 50,000 background screening results were shared among participating agencies and Medicaid health plans resulting in an overall cost savings of over \$4 million to Agency providers, DOH licensees, Medicaid health plans, Medicaid providers, and DCF and APD providers.

Office of the General Counsel

The Office of the General Counsel (OGC) actively partners with other offices of the Agency to help deter fraud and abuse in the Florida Medicaid program. 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 mistake or third party liability; regulation of health 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 mission of the OGC is to provide high quality legal counsel and vigorous advocacy to the Agency in championing better health care for all Floridians.

The 10 attorneys comprising the Medicaid legal staff defend the Agency in Medicaid-related litigation before administrative tribunals, and litigate violations of state and federal laws pertaining to the administration of the Medicaid program before state and federal courts. The 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. During FY 2014-15, the OGC Agency Clerk issued 523 MPI Final Orders. Additionally, the OGC Agency Clerk received 144 MPI hearing requests, which is almost twice as many MPI hearing requests it received in FY 2013-14.

DEPARTMENT OF HEALTH

Coordination and Cooperation Between DOH, AHCA, AND MFCU

The Department of Health (DOH) continues its partnership with the Agency for Health Care Administration (Agency) 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 effective, collaborative investigative efforts aimed at protecting the people of Florida against healthcare fraud and substandard health care.

The DOH Division of Medical Quality Assurance (MQA) director and enforcement leadership meet regularly with the Agency 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 (DCF), 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 bi-monthly meetings fosters a multi-agency approach to fraud mitigation, identifies potential, emerging areas of fraud, and areas in which agency resources can be more effectively leveraged.

DOH and the Agency collaborated on a project that is still in process involving the creation of a web portal for consumer complaints in FY 2014-15. Currently, DOH and the Agency exert man hours on complaints that are not within their jurisdiction or authority. The portal is being designed to reduce the number of complaints each agency receives that are misrouted. The portal will take the consumer through a series of questions and based upon the response the consumer will be routed to the agency best suited to handle the complaint.

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

From July 1, 2009 through September 2, 2015, DOH has denied licensure to 451 applicants and denied the renewal of 142 healthcare practitioners for health care related fraud. In addition, DOH has taken 175 emergency actions and disciplined 304 healthcare practitioners for violations related to Medicaid.

STATUTORY REPORTING REQUIREMENTS

Number of cases opened and investigated

MFCU opened 289 cases and had 947 active cases in FY 2014-15. MPI investigated 2,764 cases which included 1,752 opened during the year.

Disposition of the cases closed

Disposition of Cases Closed				
Case Type	MFCU	PANE	AHCA	Total
Administrative Closure	5	5		10
Administrative Referral	37	6		43
Assistance to Other Agencies	2	1		3
Bankruptcy			2	2
Case Dismissed	44			44
CHOW			5	5
Civil Settlement	33			33
Consolidated	4	1		5
Conviction	15	15		30
Deferred Prosecution Agreement	1	2		3
Fines Issued			177	177
Fugitive Defendant	2			2
Investigation by Another Law Enforcement Agency	7	1		8
Lack of Evidence	16	21		37
Managed Care			2	2
No Abuse			64	64
No Findings			87	87
Not a Medicaid provider	1			1
Not Sustained			9	9
Plea Agreement	8	6		14
Pretrial Intervention	1	3		4
Probation	1			1
Prosecution Declined		7		7
Provider Education			4	4
Provider No Longer Operational			9	9
Provider Suspended			2	2
Provider Termination			2	2
Provider With Cause Termination			2	2
Provider Without Cause Termination			2	2
Referred			20	20
Resolved with Intervention	2	4		6
Sustained			930	930
Unfounded	16	2		18
Unsubstantiated	1	3		4
Voluntary Dismissal	71			71

Disposition of Cases Closed				
Case Type	MFCU	PANE	AHCA	Total
Voluntary Termination			2	2
Grand Total	267	77	1319	1663

Sources of the cases opened

Sources of Cases Opened				
Source	MFCU	PANE	AHCA	Total
AHCA - F&A			43	43
AHCA - HQA-Facility Regulation		4	40	44
AHCA - Medicaid-Area offices			4	4
AHCA - Medicaid-Fraud Liaison			6	6
AHCA - Medicaid-Medicaid Services			148	148
AHCA - Other Bureaus	1		9	10
AHCA - Bureau of Managed Care		2		2
AHCA - Medicaid Program Integrity MPI	16			16
AHCA - Office of Inspector General	1			1
APD - Agency For Persons With Disabilities	4			4
APS - Adult Protective Services	1	55		56
Attorney	2			2
Citizen	20	3		23
CMS - Children's Medical Services Network (CMSN) Plan			1	1
Contractor For Center For Medicare & Medicaid	1			1
DCF - Department of Children & Families		1		1
DOH - Department of Health	1		1	2
Detection Tool - 1.5 Report			2	2
Detection Tool - Ad Hoc Report			1	1
DFS - Department of Financial Services Division of Insurance Fraud	1			1
Employee	10	2		12
EOMB			6	6
Family Member	11			11
FDLE Florida Department of Law Enforcement	1			1
Federal Agency - CMS			32	32
Federal Agency - Others			2	2
Florida - MFCU			62	62
Florida - Other Agencies			6	6
Florida Agency For Persons With Disabilities			4	4
Generalized Analysis			782	782
HHS OIG Health & Human Services Inspector General	7			7
Hotline			1	1
HUM - Humana			2	2
Internet / Media			28	28
Investigator Initiative			304	304
Joint Task Force	2			2

Sources of Cases Opened				
Source	MFCU	PANE	AHCA	Total
Law Enforcement Agency	3			3
Managed Care SIU	5			5
MCO - Special Investigative Unit			26	26
Medicaid Provider	9	1	1	11
Medicaid Recipient	14		1	15
MFCU Data Mining Initiative	10			10
MFCU Other Than Florida	1			1
Online Complaint Form			7	7
Press Report	1	1		2
Previous File Or Case			30	30
Projects			18	18
Public			8	8
Qui Tam	89			89
Random Selection			9	9
Self Audit			159	159
Site Visit			6	6
Spinoff Case	9			9
STW - Wellcare dba Staywell Health			1	1
URA - United			1	1
Web Service			1	1
Grand Total	220	69	1752	2041

Amount of overpayments alleged in preliminary and final audit letters

Amount of Overpayments Alleged in Preliminary and Final Audit Letters FY 2014-15	
Preliminary	Final
\$35,713,819.91	\$21,638,398.76

Number and amount of fines or penalties imposed

During FY 2014-15, MPI imposed fines (under s. 409.913, F.S., and Rule 59G-9.070, F.A.C.) in the amount of \$1,516,201.00.

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

There were no reductions in overpayments through negotiated settlements during FY 2014-15.

Amount of final Agency determinations of overpayments

MPI identified \$30,380,115.00 in overpayments on 1,319 closed cases. Total recoveries by MPI and MPI-TPL for FY 2014-15 were \$82,729,279.00 (This includes collections of overpayments, fines, costs, and paid claims reversals during the fiscal year).

Amount deducted from federal claiming as a result of overpayments

The Federal requirements have changed to allow the State up to one year to return the federal share of overpayments. The Agency reports the federal portion of the total overpayment on the corresponding federal CMS-64 quarterly reports as payments are received or within a year for uncollected overpayments. If the payment plan exceeds one year, the full amount due to the federal government will be reported on the last appropriate quarterly report. During FY 2014-15, the Agency reduced its federal claims by \$34.5 million for net overpayments.

Amount of overpayments recovered each year

MFCU collected \$8,469,604.17 in overpayments that were returned to the Agency. Additionally, MFCU collected \$15,863,133.45 in Federal Medicaid overpayments that were sent directly to the U. S. Department of Health and Human Services for a total of \$24,332,737.62 in Medicaid overpayments collected in FY 2014-15. Overpayments recovered by the Agency/MPI were \$37,788,167.47.

Amount of cost of investigation recovered

During FY 2014-15, the MFCU collected \$43,467.73 in program income investigative costs. MFCU also collected \$10,227.23 in state share investigative costs and \$70,828.81 in federal share investigative costs for a grand total of \$124,523.77 for all investigative costs. MPI total investigative costs for FY 2014-15 were \$374,267.64.

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

For cases that were paid-in full during the fiscal year, the average length of time from the date that MPI opened a case to the date the case was paid in full was 234 days.

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

For FY 2014-15, the Agency did not report any uncollectable amounts. Florida does not have a statute allowing the state to reclaim credits associated with identified overpayments remitted to the federal government for entities now out of business. There were no credit amounts reclaimed from the Federal Government.

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, that 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, federal exclusions, and other compliance-related considerations that fall within the broader category of program integrity.

Number of Terminations	
T2 - TERM - MCAID AUTH	91
T5 - TERM - MCARE AUTH	2
T6 - TERM - MCAID FO	32

For the FY 2014-15, the following chart itemizes T2, T5, and T6 type terminations:

Terminations - MCAID AUTH, MCARE AUTH OR FINAL ORDER	
05 - Community Behavioral Health Services	1
07 - Specialized Mental Health Practitioner	1
10 - Skilled Nursing Facility	1
14 - Assistive Care Services	19
20 - Pharmacy	6
25 - Physician (MD)	25
26 - Physician (DO)	3
27 - Podiatrist	1
28 - Chiropractor	1
30 - Nurse Practitioner (AMP)	1
32 - Social Worker/Case Manager	2
35 - Dentist	2
60 - Audiologist	1
65 - Home Health Agency	13
67 - Home & Community-Based Services Waiver	30
81 - Professional Early Intervention Services	1
83 - Therapist (PT, OT, ST, RT)	3
90 - Durable Med Equipt/ Medical Supplies	3
91 - Case Management Agency	6
97 - Managed Care Treating Provider - Non-Medicaid	4
99 - Billing Agent	1
TOTAL	125

Additionally, there were 125 providers who were identified as potentially related to suspected fraud and abuse and other compliance-related considerations that were already terminated at the time that the Agency discovered the program integrity related concern. Often-times these are providers who are under review by the Agency or other entity who voluntarily terminate from the program to avoid the involuntary action by the Agency.

Number of Terminations	
T3 - TERM - MPI AUTH STK	125

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

MFCU expenditures for FY 2014-15 were \$15,816,493.26, which included indirect costs of \$1,159,779.03. MPI direct legal costs were \$930,775.00.

Providers prevented from enrolling in Medicaid or re-enrolling as a result of suspected fraud or abuse

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

Number of Denials	
D6 - DENY - PRV TERM/EX	47
DB - DENY - BEST INTEREST	61

For the FY 2014-15, the following chart represents denied provider types:

Denied Providers – D6 PRV TERM/EX and/or BEST INTEREST	
05 – COMMUNITY BEHAVIORAL HEALTH SERVICES	6
14 – ASSISTIVE CARE SERVICES	6
20 – PHARMACY	1
25 – PHYSICIAN (M.D.)	34
26 – PHYSICIAN (D.O.)	3
30 – NURSE PRACTITIONER (ARNP)	1
32 – SOCIAL WORKER/CASE MANAGER	5
35 – DENTIST	2
65 – HOME HEALTH AGENCY	33
67 – HOME & COMMUNITY-BASED SERVICES WAIVER	5
72 – PREPAID MENTAL HEALTH SERVICES	1
83 – THERAPIST (PT, OT, ST, RT)	1
91 – CASE MANAGEMENT AGENCY	10
TOTAL	108

Finally, providers that were prevented from enrolling or reenrolling due to program integrity considerations, there were an additional 97 providers who were denied due to findings during an on-site pre-enrollment visit, 67 providers denied due to disqualifying criminal offenses, and one provider denied due to a federal exclusion, for a total of 165 providers denied enrollment.

Number of Denials	
D2 - DENY - SV	97
D3 - DENY - BKGD SCRNG	67
DE - DENY - EXCLUSION	1

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

Section 409.913, F.S., requires this report to include policy recommendations necessary to prevent or recover overpayments and changes necessary to prevent and detect Medicaid fraud. However, it further requires that all policy recommendations include a detailed fiscal analysis, including, but not limited to, implementation costs, estimated savings to the Medicaid program, and the return on investment. Most innovations, including policy and programmatic changes, have unknown cost savings and unknown returns on investment. Even a recommendation to continue with the development and refinement of the advanced data analytics

system that MPI is employing comes with many unknowns. The investment is known (secured via a public procurement), but the projected return (to project cost savings and a return on investment) is very speculative. Due to the significant federal financial participation associated with the data analytics system, a respectable return on investment (ROI) should be anticipated; but when it will be realized and the extent with which it will be realized is too tenuous to meet the requirement of a detailed fiscal analysis appropriate for submission to an estimating conference.

Likewise, suggestions that the Medicaid program consider further fraud and abuse prevention activities such as provider enrollment moratoria with regard to high-risk provider types, increased provider enrollment standards, increases in the field presences of trained investigators to detect and combat fraud and abuse, increased collaboration with health plans while also increasing the scrutiny of the plans' fraud and abuse efforts, are all good ideas that do not lend themselves to the type of fiscal analysis required for submission in this report. Other ideas, such as continued collaboration between MPI and MFCU, including having MFCU offer training related to fraud (specifically fraud, as opposed to waste and abuse) and having MPI develop complex algorithms to implement with its data analytics system for the purpose of identifying leads for MFCU, likewise don't lend themselves to such a fiscal analysis. Until the idea is implemented, the ROI and cost savings simply can't be known to sufficient detail. As such, while many innovations will be encouraged and explored, the Agency will not officially recommend policy to prevent or recover overpayments or changes to prevent and detect Medicaid fraud.

ACRONYMS

3D – Three Dimensional Imaging

ACA – Affordable Care Act

ACS – Assistive Care Services

Agency, the (as used in this report) – Agency for Health Care Administration

AHCA – Agency for Health Care Administration

ALF – Assisted Living Facility

APD – Agency for Persons with Disabilities

BCBA – Board Certified Behavior Analyst

BGS – Background Screening Database

CABA – Certified Assistant Behavior Analyst

CAF – Credible Allegation of Fraud

CCEB – Complex Civil Enforcement Bureau

CFR – Code of Federal Regulation

CJIS – Criminal Justice Information Services

Clearinghouse – Care Provider Background Screening Clearinghouse

CMS – Centers for Medicare and Medicaid Services

CPR – Cardiac Pulmonary Resuscitation

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

DMV – Delivery Monitoring and Verification

DOE – Department of Education

DOEA – Department of Elder Affairs

DOH – Department of Health

DOJ – Department of Justice

DSS – Decision Support System

EMA – Emergency Medicaid Alien

EOMB – Explanation of Medicaid Benefits

eQHealth – eQHealth Solutions, Inc.

F&A – Finance and Accounting

F. S. – Florida Statutes

F.A.C. – Florida Administrative Code

FACTS – Fraud and Abuse Case Tracking System

FAO – Bureau of Medicaid Fiscal Agent Operations

FBI – Federal Bureau of Investigations

FCPTI – Florida Crime Prevention Training Institute

FDA – Food and Drug Administration

FDLE – Florida Department of Law Enforcement

FFS – Fee-for-Service

FMHI – Florida Mental Health Institute

FMMIS – Florida Medicaid Management Information System

FPCU – Under AHCA's Division of Medicaid, Fraud Prevention and Compliance Unit

FTEs – Full Time Employees

FY – Fiscal Year (Florida's fiscal year is July 1 – June 30)

HEAT – Health Care Fraud Prevention and Enforcement Action Team

HHS-OIG – Department of Health and Human Services-Office of Inspector General

HIDTA – High Intensity Drug Trafficking Area

HIPAA – Health Insurance Portability and Accountability Act

HQA – AHCA's Health Quality Assurance

I-Budget – Developmental Disabilities Individual Budgeting

LEIE – List of Excluded Individuals and Entities

MAGELLAN – Magellan Medicaid Administration

MAR – Medicaid Accounts Receivable

MCO – Managed Care Organization

MFCU – Medicaid Fraud Control Unit, within the Florida Department of Legal Affairs

MII – Medicaid Integrity Institute

MPI – AHCA's Medicaid Program Integrity

MQA – Medical Quality Assurance (Department of Health)

MRA – Magnetic Resonance Angiography

MRI – Magnetic Resonance Imaging

MSO – Management Service Organizations

NAAG – National Association of Attorneys General

NAMFCU – National Association of Medicaid Fraud Control Units

NPI – National Provider Identifiers

NPPES – National Plan and Provider Enumeration System

OAG – Office of Attorney General

OGC – Office of General Counsel

OIG – Office of Inspector General

PANE – Patient Abuse, Neglect and Exploitation

PASRR – Preadmission Screening and Resident Review

PCRs – Paid Claims Reversals

PDL – Preferred Drug List

PDN – Private Duty Nursing

PECU – Provider Eligibility and Compliance Unit

PET – Positron Emission Tomography

QEN – Qualified Evaluator Network

RAC – Recovery Audit Contractor

ROI – Return on Investment

SAM – System for Awards Management

SIU – Special Investigative Unit

SMMC – Statewide Medicaid Managed Care

TPL – Third Party Liability

VR – Vocational Rehabilitation

A message from AHCA's Inspector General on how this report was composed:

The Agency for Health Care Administration, Office of the Inspector General has exercised oversight of the production of this report for over a decade. 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, Elizabeth Miller of the AHCA Office of the Inspector General, Medicaid Program Integrity office initiated data calls and conveyed requests for up-to-date text to include in this report. Ms. Miller with assistance from other staff members assembled the information from the multiple sources into a single draft document. Ms. Miller, after the draft text was reviewed by officials responsible for the activities documented in this report, coordinated with Multimedia Design to publish the final report. While many dedicated state employees contributed to this report throughout the year, Ms. Miller'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.

The point-of-contact for this report is Elizabeth Miller, Office of the Inspector General, Medicaid Program Integrity, Agency for Health Care Administration, 2727 Mahan Drive, MS#6, Tallahassee, FL 32308, email Elizabeth.Miller@ahca.myflorida.com.



AGENCY FOR HEALTH CARE ADMINISTRATION
2727 MAHAN DRIVE
TALLAHASSEE, FL 32308
1-888-419-3456
[HTTP://AHCA.MyFLORIDA.COM](http://AHCA.MyFLORIDA.COM)

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