FY 2015-16

The State's Efforts to Control Medicaid Fraud and Abuse

December 16, 2016

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 2015-16. 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,

Justin M. Senior
Interim Secretary

cc: The Honorable Joe Negron
The Honorable Richard Corcoran

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 2015-16.

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DEPARTMENT OF LEGAL AFFAIRS – OFFICE OF THE ATTORNEY GENERAL

Overview of the Medicaid Fraud Control Unit

The Medicaid Fraud Control Unit (MFCU) is responsible for investigating fraud committed upon the Medicaid Program by providers 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 (CFR), and Chapter 409, Florida Statutes).

The MFCU investigates a diverse mix of health care providers including doctors, dentists, psychologists, home health care companies, pharmacies, drug manufacturers, laboratories, and more. Some of the most common forms of provider fraud involve billing for services not provided, overcharging for services that are provided, or billing for services that are medically unnecessary. The MFCU also plays a leadership role in a variety of multi-state false claims investigations. 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 living facilities. The MFCU is greatly concerned with the quality of care being provided for Florida's ill, elderly, and disabled population. MFCU implemented its ongoing Patient Abuse, Neglect, and Exploitation (PANE) Project in 2004. This project was designed as a collaborative effort among several agencies to address the abuse and exploitation of patients in long-term care facilities. PANE was expanded statewide and continues to be an ongoing initiative.

Control and Enforcement Strategy

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

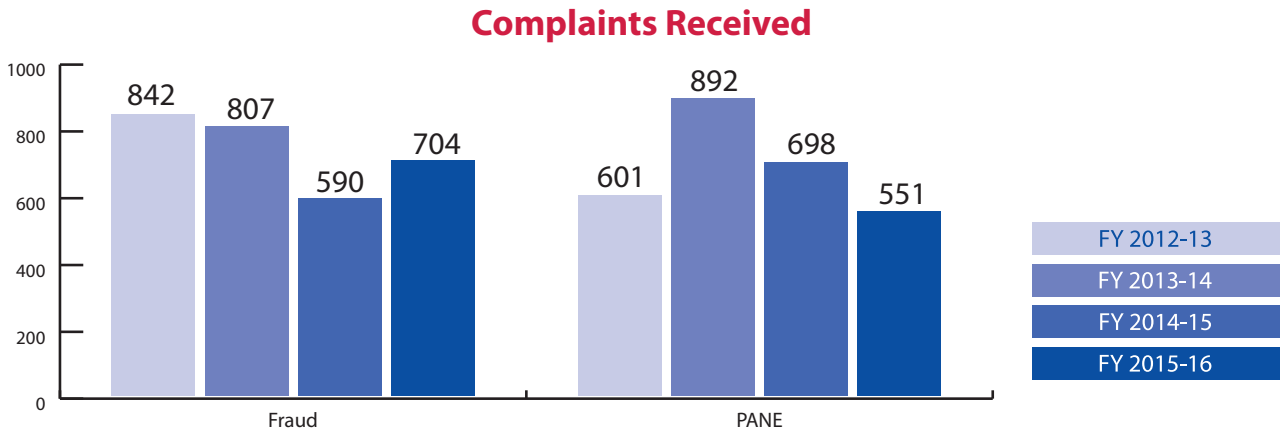
MFCU's Control and Enforcement Strategy requires unit members to focus on the following:

- Medicaid Provider Fraud - Case investigations focus on types of fraud, types of subjects/targets, and types of providers having a widespread impact on the Medicaid program or involving public safety. Emphasis is placed on case investigations/prosecutions that have a deterrent effect.
- PANE Investigations - Focus is placed on activities and investigations involving prevention and timely criminal enforcement. Emphasis is placed on facilities that have incidents with immediate public safety issues and those that 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 on 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 the Agency for Health Care Administration (AHCA or the 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[1]. Case openings occur only when there is a criminal or civil predicate that warrants further investigative activity by the MFCU. During FY 2015-16, the Unit received 1,255 complaints. Of those 1,255 complaints, 273 were opened as operational cases. Of the 1,255 complaints received in FY 2015-16, 704 were related to fraud and 551 were related to PANE allegations.



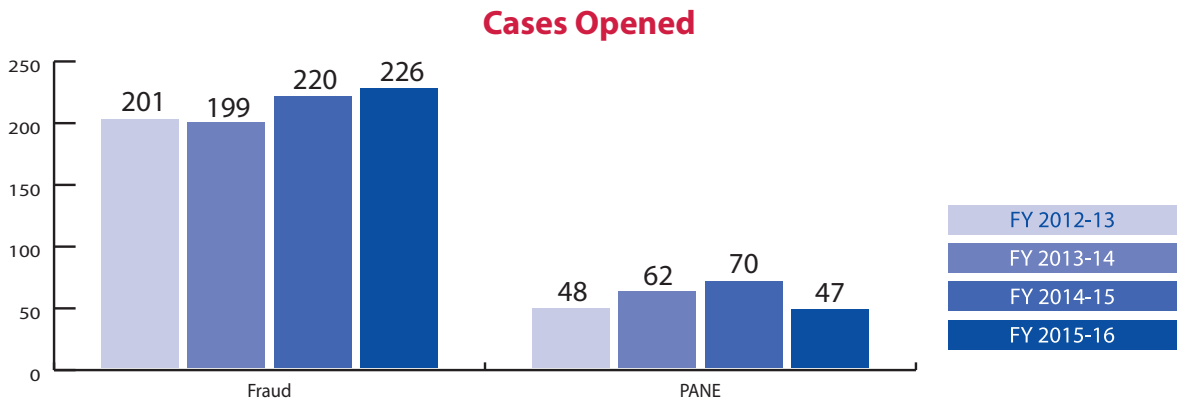
Citizens were the primary source of fraud complaints in FY 2015-16, with 147 complaints reported. AHCA, via its Bureau of Medicaid Program Integrity (MPI), accounted for 144 of the Medicaid fraud complaints received. 88 complaints from Medicaid recipients were received during this time period.

The majority of PANE complaints were generated by the Department of Children and Families (DCF), Adult Protective Services (APS)/Florida Safe Families Network (FSFN). In FY 2015-16, of the 551 PANE complaints, 459 came from DCF/APS/FSFN. Citizens relayed the next highest source of PANE complaints, accounting for 30 complaints.

Footnote: 1 Several variables impact the relationship between the number of complaints and cases; frequently, duplicate complaints are filed or the Unit already has a case opened when a complaint arrives. When appropriate, multiple complaints will be merged into one case for efficiency. Significantly, the number of "complaints received" have trended downward, with the implementation of Statewide Managed Care.

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, and scope of the activity, to establish sufficient evidence to prove the requisite elements.



During FY 2015-16, 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.

The following is a list of the top six Medicaid Provider types for MFCU fraud cases opened in FY 2015-16:

1. Home & Community Based Service
2. Physician
3. Pharmaceutical Manufacturer
4. Pharmacy
5. HMO/PHP/PMHP
6. Home Health Agency

The following is a list of the top five Medicaid Provider types for PANE cases opened in FY 2015-16:

1. Facility Employee
2. Skilled Nursing Facility
3. Certified Nursing Assistant/Nurse's Aide
4. Family Member
5. Care Giver

Disposition of Cases

Following an investigation, a determination is made as to 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 2014-15, the MFCU closed 345 cases. Of those, 267 involved Medicaid fraud investigations and 78 involved PANE cases.

In FY 2015-16, the MFCU closed 249 cases. Of those, 199 involved Medicaid fraud investigations and 50 involved PANE cases.

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

The referrals for prosecution in FY 2015-16 were 60 Fraud and 19 PANE for a total of 79. In FY 2014-15, referrals for prosecution were 85 Fraud and 39 PANE for a total of 124. FY 2013-14 had 51 Fraud and 32 PANE for a total of 83 referrals for prosecution. In FY 2012-13, there were 41 Fraud and 31 PANE for a total of 72 referrals for prosecution.

Warrants for arrests for FY 2015-16, were 70 Fraud and 17 PANE for a total of 87.

Case Highlights

Millennium Health

On November 23, 2015, MFCU, 48 other states and the District of Columbia, reached a settlement totaling $256 million, with Millennium Health, formerly Millennium Laboratories, to resolve alleged violations of the False Claims Act. Millennium allegedly billed Medicare, Medicaid, and other federal health care programs for medically unnecessary urine drug and genetic testing, and provided free items to physicians who agreed to refer expensive laboratory testing business to Millennium. Millennium, headquartered in San Diego, is one of the largest urine drug testing laboratories in the United States and conducts business nationwide.

As part of the settlements, Millennium agreed to pay $227 million to resolve allegations for billing federal health care programs for excessive and unnecessary urine drug testing from January 1, 2008, through May 20, 2015. The states alleged Millennium caused physicians to order excessive numbers of urine drug tests, in part through the promotion of custom profiles, instead of assessing individual patients' needs. This practice violated federal healthcare program rules limiting payment to services that are reasonable and medically necessary.

The states also alleged that Millennium's provision of free point of care urine drug test cups to physicians, expressly conditioned on the physicians' agreement to return the urine specimens to Millennium for hundreds of dollars' worth of additional testing, violated the Stark Law and the Anti-Kickback Statute. The Stark Law and the Anti-Kickback Statute generally prohibit laboratories from giving physicians anything of value in exchange for referrals of tests.

Millennium also agreed to pay $10 million to resolve allegations that it submitted false claims to federal health care programs from January 1, 2012, through May 20, 2015, for genetic testing that was performed routinely and without an individualized assessment of need.

In connection with the False Claims Act settlements, Millennium entered into a corporate integrity agreement with the Department of Health and Human Services, Office of Inspector General. In addition, Millennium will pay $19.2 million to the Centers for Medicare and Medicaid Services to resolve certain administrative actions related to Millennium's urine drug test billing practices.

Florida's share of the Millennium Medicaid settlement was $4,143,654. Restitution to the Medicaid program was $2,033,832, additional recoveries of $2,033,832, and interest amounted to $75,988.

A team representing the National Association of Medicaid Fraud Control Units, led by Florida's Medicaid Fraud Control Unit, conducted settlement negotiations with Millennium Health on behalf of the states. The team also included Georgia, New York, North Carolina, and Washington Medicaid Fraud Control Units. The states coordinated the investigation in conjunction with the Department of Justice Civil Division, Commercial Litigation Branch, and the U.S. Attorney's Office of the District of Massachusetts.

Adventist Health System

A $3.5 million settlement was reached with Adventist Health System Sunbelt Healthcare Corporation and Adventist Health System/Sunbelt, Inc., to resolve civil allegations of violations of the Physician Self-Referral Law and the Florida False Claims Act.

According to two whistle-blower lawsuits, Adventist maintained improper financial relationships with physicians, and submitted claims to Florida Medicaid for services and items the physicians referred. The settlement resolves allegations that Adventist submitted false Medicaid claims and awarded referring doctors based on the number of tests and procedures the doctors ordered. When this type of fraud is suspected, the False Claims Act allows for civil actions to recover taxpayer money.

Florida's share of the Medicaid settlement was $2,819,623. Restitution to the Medicaid program was $2,715,123 and additional recoveries of $104,499.

Adventist also entered into separate civil settlements with the federal government, North Carolina, and Texas, agreeing to pay more than $115 million. The MFCU's Complex Civil Enforcement Bureau worked in conjunction with North Carolina and Texas on behalf of the states in these cases.

PharMerica

On October 8, 2015, Florida, joined by 43 other states and the federal government, announced a multimillion dollar settlement with PharMerica over civil allegations of healthcare fraud. According to the allegations, PharMerica conspired with Abbott Laboratories, a drug manufacturer, through a number of disguised kickback arrangements, to increase overall utilization of the drug Depakote, and to promote misbranded Depakote.

The states contend that from January 1, 2001 through December 31, 2008, PharMerica knowingly solicited and received illegal payment from Abbott Laboratories through rebate agreements. The illegal agreements required PharMerica to engage in certain grants, promotional programs, and other financial support programs, resulting in false claims to Medicaid and other federal healthcare programs.

As part of the settlement, PharMerica will pay the states and the federal government a total of $9.25 million in civil damages to compensate Medicaid, Medicare, and various federal healthcare programs for harm suffered as a result of PharMerica's conduct.

This settlement is based on two qui tam cases consolidated and pending in the United States District Court for the Western District of Virginia in Abingdon, Virginia. The cases were filed under federal and state false claims statutes. Florida's share of the Medicaid settlement was $137,983. Restitution to the Medicaid program was $67,225, plus additional recoveries of $67,225, and interest of $3,532.

Wyeth/Pfizer, Inc.

On May 3, 2016, Florida joined a multi-state agreement settling allegations against Wyeth, a wholly owned subsidiary of Pfizer, Inc. The settlement resolves allegations that Wyeth knowingly underpaid rebates owed under the Medicaid Drug Rebate Program for the sales of Protonix Oral and Protonix IV. As part of the settlement, Wyeth agreed to pay a total of $784.6 million to multiple state governments and the federal government. More than $371 million of this amount will go to the Medicaid Program.

In 2009, Pfizer, a Delaware corporation headquartered in New York City, acquired Wyeth, Inc., a Delaware corporation headquartered in Madison, New Jersey. At all relevant times, Wyeth distributed, marketed, and sold pharmaceutical products in the United States, including Protonix Oral and intravenous Protonix IV. Protonix Oral and Protonix IV are in a class of drugs called Proton Pump Inhibitors, which inhibit the production of gastric acid.

According to allegations, Wyeth concealed, avoided, or decreased its obligation to pay Medicaid Drug Rebates to states for both inhibitors. During the third quarter from 2001 to 2006, Wyeth allegedly sold Protonix Oral tablets and Protonix IV to hospitals at bundled discounted prices by linking discounts on the intravenous inhibitor to discounts on the oral inhibitor. Wyeth did not treat the sales of the two inhibitors as bundled within the meaning of the Medicaid Drug Rebate Program, and therefore, failed to properly allocate the discounts available under the contract.

Florida and several other states, working with the United States Department of Justice, the United States Attorney's Office for the District of Massachusetts, and the United States Department of Health and Human Services, Office of Inspector General, negotiated the state settlements.

The settlement stemmed from two whistle-blower (qui tam) lawsuits, U.S., et al., ex rel. Kieff v. Wyeth Pharmaceuticals, Inc., Civ. No. 03-cv-12366, and U.S., et al., ex rel. William St. John LaCorte v. Wyeth, Civ. No. 06-cv-11724, both filed in the United States District Court for the District of Massachusetts. The United States federal government, 35 states, and the District of Columbia intervened in the lawsuits.

As part of the settlement, Florida received more than $7.9 million. Restitution to the Medicaid program was $6,517,504 and additional recoveries were $1,414,215.

Megan Sanai

On February 15, 2016, the Florida Medicaid Fraud Control Unit arrested Megan Sanai for the third time in six months on charges related to Medicaid fraud. While at a court hearing on February 12, 2016, for charges related to previous Medicaid fraud investigations, Sanai was arrested on new charges of grand theft and falsifying records for stealing more than $11,000 from the Social Security Administration and falsifying Vital Statistics Records.

The MFCU and the Okaloosa County Sheriff's Office first arrested Sanai for exploitation of a Florida senior citizen. She purchased goods with the private funds of an elderly adult, whom she knew to be mentally incapable of making legal and financial decisions. The second arrest was for withdrawing more than $2,000 from the same victim's private bank account.

On March 14, 2016, Megan Sanai pled nolo contendere and was adjudicated guilty on two counts of Exploitation of the Elderly, one count of Grand Theft, one count of Providing False Information on a Vital Statistics Record, and one count of Possession of Controlled Substance. She was sentenced to 28 to 35 months in state prison and three years' probation. She was ordered to pay $615 in fines and court costs, pay restitution to the Social Security Administration in the amount of $11,878, and pay restitution to the victim in the amount of $3,499.

Shanqual Marshall-Gunn

Shanqual Marshall-Gunn was arrested on September 5, 2014, for billing more than $47,000 worth of targeted case management services that were fraudulent or not authorized by the Medicaid program. Marshall-Gunn, the owner of Second Chances TCM, Inc., paid monetary incentives or kickbacks, to both employees and clients who referred new business to her company.

On July 2, 2015, she pled guilty and was sentenced to 18 months in prison, five years of supervised probation, prohibited from future employment by any Medicaid provider, and ordered to pay more than $47,000 in restitution to the Medicaid program. The investigation was conducted by the Attorney General's Medicaid Fraud Control Unit and prosecuted by the Attorney General's Office of Statewide Prosecution.

Barbara Oldham-Kennedy, Robert Patrick Garcia, Grisel Pena

Robert Patrick Garcia was sentenced on July 10, 2015, for improperly billing more than one million dollars' worth of targeted case management services to the Florida Medicaid program while employed as a corporate officer at Family Behavior Services, LLC., located in Hallandale Beach.

In September 2014, the Florida Medicaid Fraud Control Unit, 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 the three corporate officers from Family Behavior Services for defrauding the Florida Medicaid program by fraudulently billing for targeted case management services. Targeted case management services are designed to link Medicaid recipients with serious mental health disorders to community-based services. In January 2015, Barbara Oldham-Kennedy, the ringleader of this scheme, was sentenced to 30 months in prison, five years' probation, and ordered to pay restitution to the Medicaid program. Grisel Pena, who played a smaller role in this scheme, was sentenced in January 2015, to 60 days in jail followed by five years' probation. Robert Patrick Garcia was sentenced to two years in prison, five years of probation, and ordered to pay restitution to the Medicaid program. Restitution of $1,033,332 to the Medicaid program was ordered joint and several with co-defendants. The Attorney General's Office of Statewide Prosecution prosecuted the case.

Dr. Merys Downer-Garnette

On September 24, 2015, the MFCU and the Altamonte Springs Police Department arrested an Orange County dentist for allegedly defrauding the Florida Medicaid program. According to the investigation, Dr. Merys Downer-Garnette billed for services that were never rendered, not rendered as billed, or double-billed, causing more than $5,500 in fraudulent claims to the state's Medicaid program.

On December 17, 2015, Downer-Garnette pled guilty to one count of Organized Scheme to Defraud and was sentenced to three years of community control with no early termination. She voluntarily relinquished her license to practice dentistry, and agreed to never reapply for a license, nor practice as a dentist in the State of Florida. She was ordered to pay restitution of $120,000 to the Medicaid program.

David & Karen Bledsoe

The MFCU and the Palm Beach County Sheriff's Office arrested a West Palm Beach couple for more than $40,000 in Medicaid fraud on October 28, 2015. According to the investigation, David and Karen Bledsoe, owners of a durable medical equipment company named A Plus Medical Equipment and Supply, Inc., accepted payment from Medicaid for purportedly providing wheelchairs and bath chairs to Medicaid recipients; in this case, severely disabled children. David Bledsoe measured the recipients for the equipment, directed the billing, and engaged in a campaign to mislead the recipients' caregivers into believing the equipment was on its way. Karen Bledsoe was aware of the fraud and knew that her husband billed Medicaid even though the equipment had not been delivered.

On April 15, 2016, the defendants each plead guilty to one count of Medicaid Fraud and one count of Grand Theft. David Bledsoe was sentenced to 23.7 months in prison, followed by four years of probation. Karen Bledsoe was sentenced to six years of probation and two years Community Control. The pair were ordered to pay $40,020 in restitution.

Dr. Marino F. Vigna

The MFCU arrested a Broward County dentist on April 15, 2016, for allegedly billing the Medicaid program more than $14,000 for services not rendered. Dr. Marino F. Vigna allegedly billed Medicaid for dentures that recipients never received and for tooth extractions Vigna never performed.

According to the investigation, Vigna billed for services performed at times he vacationed out of the country and on days he closed his dental office. Additionally, Vigna allegedly billed for services provided to recipients at a time after the recipients passed away.

On May 11, 2016, Vigna pled nolo contendere to one count Grant Theft in the third degree, with adjudication of guilt withheld. He was sentenced to one year of Community Control and five years' probation. Vigna was also ordered to pay restitution of $14,835 to the Medicaid program, costs of prosecution of $3,690, and court costs of $517.

Lynda Gonsalves-Barnes and Jessica Allen

The MFCU and the Osceola County Sheriff's Office and the Osceola County Probation and Parole Services arrested two Osceola County women on May 21, 2016, for allegedly billing the Medicaid program for more than $94,000 in fraudulent services.

According to the investigation, Lynda Gonsalves-Barnes and Jessica Allen, fraudulently billed the Medicaid program for mental health targeted case management services that were never provided. Gonsalves-Barnes, owner of Omega Alpha Nu Ministries, allegedly used recipients' personal identification to fraudulently submit claims without the recipients' knowledge. Some recipients had never heard of Omega Alpha Nu Ministries prior to the investigation. The investigation also revealed that most recipients were not qualified to receive mental health targeted case management services, and those who were qualified did not receive the needed help.

Allen, who worked as Gonsalves-Barnes' executive assistant, was implicated after the investigation and revealed that she created false service logs and approved billing for services to recipients, including billing for her own children and the children of other employees. Allen did not provide these services nor was she qualified to provide services under the Medicaid program.

On April 8, 2016, Gonsalves-Barnes pled nolo contendere and was adjudicated guilty of one count Medicaid Provider Fraud. She was sentenced to 21 months in prison, followed by 10 years of probation, and ordered to pay $97,000 in restitution and $1,043 in court costs.

On April 14, 2016, Allen pled nolo contendere to one count of Medicaid Fraud. She was sentenced to 69 days in jail, followed by two years of probation, and ordered to pay $1,043 in fines and court costs. As a special condition, Jessica Allen cannot work in any capacity where she receives or has anything to do with Medicaid funds.

Dr. Daniel Ronchetta, John Crowe, and Frank Barrios

On February 26, 2015, the MFCU and the U.S. Department of Health and Human Services, Office of Inspector General, arrested two individuals in Miami and one individual in Colombia for more than $2.4 million in Medicare and Medicaid fraud. The defendants allegedly defrauded Medicaid and Medicare by paying and receiving kickbacks in return for providing false and fraudulent home health prescriptions and plans of care to patient recruiters.

A federal grand jury in Miami returned a four-count indictment charging Dr. Daniel Ronchetta, Chiropractic Physician Assistant John Crowe, and patient recruiter Frank Barrios, with Medicare and Medicaid fraud. The defendants were charged with Conspiracy to Commit Health Care Fraud and Wire Fraud, substantive counts of Health Care Fraud, Conspiracy to Defraud the United States and Pay and Receive Health Care Kickbacks.

On July 20, 2015, Frank Barrios pled guilty to one count of Attempt and Conspiracy to Commit Health Care Fraud. He was sentenced to 41 months' incarceration and three years' probation. He was ordered to pay $497,786 in restitution and pay a $100 fine.

On September 28, 2015, Daniel Ronchetta pled guilty to one count of Attempt and Conspiracy to Commit Health Care Fraud, and was sentenced to seven months' incarceration and three years' probation. He was ordered to pay $650,000 in restitution and pay a $100 fine.

John Crowe is a fugitive at this time.

This case, brought as part of the Medicare Fraud Strike Force, under the supervision of U.S. Attorney's Office for the Southern District of Florida, was prosecuted by Special Assistant United States Attorney Hagerenesh Simmons of the Medicaid Fraud Control Unit.

Arleisa Richardson

The MFCU arrested a former Florida State Hospital employee, Arlesia Richardson, for abuse of a disabled adult. Acting on a referral by Adult Protective Services, a division of the Department of Children and Family Services, MFCU investigators discovered that Richardson provoked a disabled adult resident, with a history of self-injurious behavior, into hitting his head against a door multiple times. Richardson is no longer employed at the Florida State Hospital.

On October 6, 2015, Richardson entered a plea of nolo contendere to one count of Abuse of a Disabled Adult. She was sentenced to two years' probation, and ordered to pay investigative costs of $150 and court costs of $648.

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. 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.

In FY 2015-16, the total amount for civil recoveries, which includes civil settlements arising from qui tam cases brought under Florida's False Claims Act and civil judgments, was $69,396,994. The total amount for criminal recoveries based upon Medicaid fraud cases was $53,291,147. The total amount of the monies recovered by the MFCU for FY 2015-16 was $122,688,141[2].

Training

MFCU continued to emphasize mission critical training to stay professionally current. During FY 2015-16, MFCU staff attended a total of 4,983.6 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 Florida Department of Law Enforcement (FDLE), free of charge. Other courses included training for complex civil litigation, database searches for FMMIS Claims Analysis, Managed Care, Provider, Recipient, and Payment Management, Data Mining, Criminal Justice Information Services (CJIS) Certification, and other courses offered by AHCA and the FDLE.

In-house training provided through a variety of delivery methods included courses such as Leadership/ Supervision and Performance Evaluation, Performance Coaching, Recruitment and Selection, Ethics, Performance Evaluation from the Employee Perspective, Excel, Word 2007, Template and Recording Macros,

Footnote: 2 Recoveries have been trending down, in part, due to smaller global case recoveries nationwide.

Lotus Notes, Electronic Discovery, Statewide Managed Care, Public Records, and Workplace Law and Policy. Classroom and range firearms qualifications and Use of Force training was provided to our law enforcement personnel locally by MFCU certified instructors at no cost.

MFCU training in FY 2015-16, included Digital Evidence, Long Term Care - Skilled Nursing Facilities, New Federal e-Discovery Rules, and Law Enforcement Access to Data: Cellphones, Computers, the Internet, and the Fourth Amendment.

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

Under 42 CFR §1007.20, MFCU made application on May 18, 2016, through the Department of Health and Human Services, Office of Inspector General (HHS-OIG) to continue data mining. HHS-OIG granted approval for MFCU to data mine through June 20, 2019, with the data mining efforts coordinated with, and not duplicative of, AHCA.

As of June 30, 2016, the MFCU has submitted 89 data mining projects to AHCA for review and approval. Of the 89 submitted, 68 were approved by AHCA. On June 30, 2016, MFCU had 12 cases and one complaint in an active status from these projects, and the regional offices are currently developing additional facts. For FY 2015-16, two arrests were made and two settlements were completed on data mining cases. Three convictions and one pre-trial intervention resulted in recoveries of $47,159. The two settlements from data mining generated $165,974 in recoveries.

Health Care Fraud Prevention and Enforcement Action Team (HEAT)

In May 2009, HHS-OIG and the U.S. Department of Justice (DOJ) created the Health Care Fraud Prevention and Enforcement Action Team (HEAT). With its creation, the fight against Medicare and Medicaid 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 U.S. Attorneys, the Federal Bureau of Investigation (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, abuse, and waste. 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.

One example of a HEAT team's case involved a scheme by a licensed psychiatrist who provided his employees with false and fraudulent diagnoses of debilitating psychiatric conditions, so the defendants could fraudulently obtain benefits in exchange for money. The investigation further revealed that the defendants submitted false and fraudulent claims to Medicare and Medicaid; made false statements to the U.S. Social Security Administration (SSA) regarding medical treatment and condition of SSA disability benefits applicants and recipients; and made false statements to the U.S. Citizenship and Immigration Services regarding the status, medical treatment, and medical condition of applicants for immigration benefits.

The Florida Medicaid Fraud Control Unit has been an active participant in the Federal Health Care Fraud task force. MFCU assigned a special team of investigators, an analyst, and prosecution staff, and achieved an unprecedented number of convictions and successes during FY 2015-16. The chart below illustrates:

HEAT TEAM Cases and Outcomes

Case Name	Defendant	Arrest Date	Conviction Date	Sentencing Date	Total Recovery	Prison	Probation
FL Health Care Plus	Illanes, Edys	07/28/15	09/02/15	11/12/15	$ 2,454,711.59	18 months	3 years
FL Health Care Plus	Ramirez, Jose Alejandro	08/05/15	11/30/15	11/30/15	$ 796,621.00	21 months	3 years
Fleitas Dolores A	Fleitas, Dolores A	10/06/15	10/16/15	12/23/15	$ 297,476.00	14 months	3 years
Mendez Villamil Fernando	Mendez-Villamil, Dr Fernando	01/08/16	05/10/16	07/22/16	$ 50,697,081.00	151 months	3 years
Mendez Villamil Fernando	Exposito, Maritza	01/08/16	03/07/16	05/13/16	$ 33,551,222.00	48 months	3 years
Mendez Villamil Fernando	Vila, Yomara	01/08/16	03/02/16	05/10/16	$ 502,726.00	33 months	3 years
Mendez Villamil Fernando	Jimenez, Arnaldo	01/08/16	06/16/16	07/22/16	$ 248,311.00	6 months	3 years
Garcia Ruth Aracely	Garcia, Ruth Aracely	06/17/16	Pending				

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

Division of Medicaid

The Division of Medicaid administers the Florida Medicaid Program, a $23.8 billion state and federal partnership that provides for health care to over 3.97 million recipients in Florida. The Division is responsible for overseeing the management and operation of a broad range of health care services offered through Medicaid to low-income families, the elderly, and the disabled. 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 soared until Medicaid expenditures were more than one-fourth of the state budget. The rapid growth in enrollment and costs made it increasingly important to find ways to manage the diverse needs of the Medicaid population while also being able to better predict and plan for cost increases.

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

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

The Division of Medicaid has adopted a strategic approach to combating fraud and abuse. Developing and implementing the SMMC program allowed the Agency to adopt a ground up approach to combat fraud and abuse by embedding control efforts into the transition and future infrastructure of the program. These strategic control efforts are focused in three key areas, including Provider Enrollment/Review, Outreach and Education, and Prior Authorization and Utilization Management.

Provider Enrollment / Review

Prevention of 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 undergo 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, takes steps to improve provider accountability, and increases provider enrollment requirements. In addition to the measures taken to monitor and evaluate all Medicaid health care providers, Medicaid also requires all Medicaid health plans to credential and re-credential all providers in their network using Agency-approved, written criteria.

Centralized Background Screening

Florida Medicaid provider background screenings have been conducted through the Clearinghouse since 2013. The Clearinghouse conducts Level Two background checks, which refers to a state and national fingerprint based check and consideration of disqualifying offenses, and applies to those employees designated by law as holding positions of responsibility or trust. 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 contracting with a Medicaid health plan in an attempt to indirectly participate in the Medicaid program. In doing so, Medicaid identifies providers that have been terminated by the Agency for fraudulent behavior and informs the health plans that these providers are ineligible to participate in the plans' networks. Medicaid also evaluates providers that have at some point in the past been linked to a provider terminated for fraudulent activity. The Agency researches this information to make sure that active providers have the clearance to participate in the Medicaid program. 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 other active providers.

Provider Accountability and Increased Provider Enrollment Requirements

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

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

- In-Person Provider Review - Provider types that are deemed to be a high risk for fraud or abuse, and a certain number of randomly selected providers, must be reviewed in person by Medicaid staff prior to enrollment in the program.

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

- Identifier and Exclusion Verification - Medicaid implemented automated verification of National Provider Identifiers and excluded entities or individuals. Data from the National Plan and Provider Enumeration System, the List of Excluded Individuals and Entities, and the System for Awards Management are uploaded to the Medicaid Management Information System. All new and renewing applicants are matched against the excluded entities' or individuals' data upon application. Additionally, all active Medicaid providers are matched against these sources monthly. This check ensures all providers have a valid National Provider Identifier on their file and that no excluded entity or individual is enrolled in Medicaid.
- Coordination of Interoffice Communication - Medicaid staff serve as a liaison between MPI, the Office of the Attorney General's Medicaid Fraud Control Unit (MFCU), HQA, 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 Agency's ability to monitor provider eligibility and compliance.
- Outside Referrals - Medicaid staff routinely analyzes data obtained from investigations conducted by MPI, MFCU, other units within the Division of Medicaid, Medicaid health plans, and other agencies, to identify any relationships between the Medicaid providers terminated for misconduct and the list of active providers. Using these analyses coupled with, where appropriate, consideration of any adverse history, Medicaid makes referrals to MPI to seek sanctions by final order, recommends contractual termination from Medicaid of a related provider, or recommends denial of enrollment when such actions are deemed warranted.

Medicaid Health Plan Contract Requirements for Provider Credentialing

Beyond the activities carried out by the Agency for all providers, under the SMMC program, each health plan is also responsible for credentialing and re-credentialing its provider network. The plans' credentialing and re-credentialing policies and procedures are established by health plan contract as outlined in the Statewide Medicaid Managed Care Core Contract. 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 a health plan's 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, 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 Two 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 utilization management 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, the Agency, the Florida Department of Elder Affairs, 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;
- 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 privacy and security provisions.

The Streamlined Credentialing Project

The Agency recognized that credentialing requirements can create an administrative burden on the health plans and 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 implemented the project during FY 2015-16. Providers are now 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 are 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 requires 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. Limited enrolled providers are not authorized to provide services to Medicaid recipients enrolled in FFS Medicaid program; limited enrolled providers may only contract with Medicaid health plans to serve recipients enrolled in those plans.

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 plans' networks. This allows the Agency to monitor the health plans' 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 by a provider or enrollee to the Agency within 15 days. The report must contain detailed information on the nature of the fraud and abuse. Plans must also provide quarterly and annual fraud and abuse activity reports.

Provider Outreach and Education

Communication and understanding are key elements in helping to prevent fraud and abuse. Understanding how the program works, the roles and responsibilities of all participants, and what the rules and regulations are that govern the program can help significantly reduce errors, misunderstandings, and problems that may lead to fraud or abuse. Medicaid offers many educational resources to providers and, as part of the contractual agreement with all health plans, the plans are responsible for providing education and training to their network providers to prevent fraud and abuse and have a monitoring plan in place for fraud prevention. The following highlights many of the education and outreach efforts conducted by Medicaid in FY 2015-16, as well as the SMMC contractual provisions related to provider education requirements.

Program-Wide Provider Education

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

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 managed care contract and special needs of enrollees. The plan is required to conduct initial training within 30 days of placing a newly contracted provider, or provider group, on active status. They also must conduct ongoing training, as deemed necessary by the 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, and for one year following the implementation of the contract. The plan is required to conduct monthly education and training for providers regarding claims submission and payment processes, which has to include, at minimum, an explanation of common claims submission errors and how to avoid those errors.

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

- The Federal False Claim 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, abuse, and waste;
- Each person's responsibility relating to detection and prevention; and
- The toll-free state telephone numbers for reporting fraud and abuse.

Utilization Management

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

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 hospital admissions for medical necessity prior to the admissions 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: several disease management initiatives and programs, a pharmaceutical Preferred Drug List (PDL), prior authorization of certain services, and Medicaid claims analysis, as well as independent research to assess policy

implementation and program performance. With the implementation of SMMC, most of the responsibility for utilization management belongs to the Medicaid health plans. However, the Agency continues to have a significant role in monitoring plan activities 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.

Prior authorization is a utilization control that many insurers and health care programs like Medicaid employ to determine member eligibility, benefit coverage, medical necessity, location, and appropriateness of services, as well as ensuring that the 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, which is different from accepted practice, or where 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 where a provider must often obtain authorization for use of an expensive brand name drug over a generic equivalent.

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 typically provides enough alternatives to allow several options to meet recipients' needs. Medicaid consults with 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 reviews 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 provider/enrollee health service interactions in Medicaid health plans. Medicaid collects individual encounters and claims data related to levels of care, resource use, costs, and other data elements. This in turn allows the Agency to conduct data-based plan performance analyses.

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

During meetings held with each health plan in March 2016, to discuss base data for rate setting, the Agency's rate setting vendor asked each plan a series of questions regarding the way fraud/abuse/waste recoveries are incorporated into the plans' financial statements and encounters. The questions included the following:

- When a fraud/abuse/waste recovery is received, is it reported on an incurred or paid basis?
- Are the claims re-processed to account for the recovery, or is the recovery reported as a separate settlement (or separate fraud/abuse/waste/third party liability recovery)?

Plans have each handled these situations a little differently as shown in the table below. Understanding these differences can provide more insight for preventing fraud and abuse.

Plan Name	Recovery on Incurred or Paid Basis	Claims Reprocessed or Separate Settlement for Recoveries
Amerigroup	Incurred	Reprocessed
Better	Incurred	Reprocessed
Clear Health Alliance	Incurred	Reprocessed
Community Care Plan	Incurred	
Coventry	-	Reprocessed
Humana	Incurred	Reprocessed
Magellan	-	Reprocessed
Molina	-	Settlement
Positive	Paid	Settlement
Prestige	Incurred	Reprocessed
Simply	Incurred	Reprocessed
Staywell	Incurred	Reprocessed
Sunshine	-	Reprocessed
United	Paid	Both

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 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 must 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 members' 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 cannot require additional paper authorization as a condition for providing treatment. The health plans' service authorization systems must provide written confirmation of all denials, service limitations, and reductions of authorization to providers, the authorization number, and effective dates for authorization to providers and non-participating providers. The health plan cannot delay service

authorization if written documentation is not available in a timely manner, but the plan is not required to approve claims for which it has received no written documentation. As part of the authorization system, health plans are required to have a toll-free provider help line that must be staffed 24 hours a day, seven days a week, to respond to prior authorization requests.

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

SMMC Health Plan Prior Authorization

The majority of Medicaid recipients were 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 that apply to their enrollees. 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.

Medicaid Fee-for-Service Utilization Management

Pharmacy Claims Processing

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 claim 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 2015-16, the contracted prescription benefit manager vendor processed approximately 232,000 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 recommendations provide specific efforts for the different needs of adults and children, coordination of care for behavioral health drug therapy management, improved patient and provider education, compliance with drug therapies, and improved outcomes.

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 the rate of inappropriate spending on Medicaid prescription drugs.

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

Pharmacy Prior Authorization

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

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

The following chart shows the total number of prior authorization requests received in FY 2015-16 for the Medicaid FFS pharmacy program.

Pharmacy Prior Authorization Requests FY 2015-16		
Total Prior Authorization Requests	46,871	100.0%
Average Per Day	128	--
Total Requests Approved	42,619	90.9%
Total Requests with Change in Therapy	2,742	5.9%
Total Requests Denied	1,510	3.2%

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 of Home Health Services

The Agency contracted with Sandata Technologies, Inc., during FY 2015-16, to implement and run the Telephonic Home Health Services Delivery Monitoring and Verification (DMV) project. The project, initially authorized for Miami-Dade County, was expanded to a statewide program during the 2012 legislative session and was subsequently targeted to key, high utilization counties in which the program was determined to be cost-effective. The Agency is considering re-procuring a vendor for the continuation of electronic visit verification services. 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 to verify that those visits occurred as reported by the home health service provider as authorized. 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 includes monitoring of all home health services (i.e., home health visits, private duty nursing, and personal care services). During FY 2015-16, there were almost 1.56 million calls placed to verify more than one million visits.

Home Health Visit Prior Authorization

One of the primary areas where Medicaid continues prior authorization for FFS recipients is home health visits. The Agency's vendor, eQHealth Solutions, Inc. (eQHealth), conducts prior authorization for home health visits to ensure that the proposed services are medically necessary and appropriate. During FY 2015-16, eQHealth conducted an average of 39,144 home health prior authorizations per month. Of these, an average of 37,345 were approved giving an average denial rate of 1.5 percent. The following table shows the total number of home health prior authorization requests, approvals, denials, and denial percentage during FY 2015-16. Note that in addition to being approved or denied, requests may also be pended for more information, held for additional review because of new information received, still be under reconsideration, or could also be awaiting a fair hearing.

The following chart shows the total number of prior authorization requests received in FY 2015-16 for Medicaid Home Health services.

Home Health Prior Authorization Requests FY 2015-16	
Total Visits Requested	469,726
Approved	448,143
Denials	7279
Denial %	1.55%

Comprehensive Care Management for Children with Special Health Care Needs

The Agency has also included management of the Comprehensive Care Management project in its contract with eQHealth Solutions, Inc., which provides utilization management and care coordination for home health visits, private duty nursing, personal care services, prescribed pediatric extended care (PPEC) services, and inpatient medical and surgical services. The purpose of this project is to improve care coordination and to identify potential overutilization and fraud or abuse of Medicaid services by ensuring that the level of home health aide and private duty nursing services provided to recipients receiving home health care matches the needs of the recipients. During FY 2015-16, the vendor conducted 826 home health visits and 5,016 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 Medicaid Program Integrity to determine if an investigation is needed. The following are the results for FY 2015-16:

Comprehensive Care Monitoring FY 2015-16 Statewide		
826 Total On-Site Home Visits to Recipients		
742	89.8%	recipients w/ fully approved requests
8	1.0%	recipients w/ fully denied requests
72	8.7%	recipients w/ partial approval
0	0.0%	reconsideration is complete
1	0.1%	at Fair Hearing
3	0.4%	at reconsideration

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, to ensure Medicaid does not pay for services in the following categories that are not covered or that may not be medically necessary:

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

Inpatient Behavioral Health

In FY 2015-16, the Agency had a contract 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 Statewide Inpatient Psychiatric Program facility, as well as quality of care oversight for the Agency. The QEN is a network of licensed psychologists or psychiatrists who can perform statutorily-required suitability assessments. Whenever Department of Children and Families (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 eQHealth to perform prior authorization utilization management of outpatient diagnostic imaging services. The vendor utilizes real-time predictive modeling and evidence-based criteria in the decision-making process. This prior authorization utilization management process facilitates increased efficiency and cost effectiveness, and ensures that Medicaid recipients receive the most clinically appropriate advanced imaging services according to approved clinical guidelines. Advanced diagnostic imaging procedures include:

- Three Dimensional Imaging;
- Computerized Tomography;
- Computerized Tomography Angiography;
- Magnetic Resonance Imaging;
- Magnetic Resonance Angiography; and
- Positron Emission Tomography.

Outpatient Diagnostic Imaging Prior Authorization Requests FY 2015-16		
PA Request Received	24,640	--
Ineligible for Review	1,385	5.60%
Completed Reviews	20,744	--
Referred for Physician Review	1,073	5.20%
Reviews Denied	78	7.30%

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.

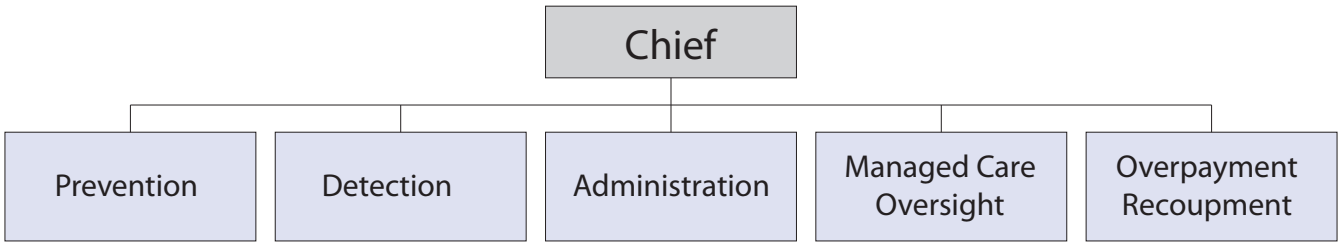
School districts are allowed to claim administrative costs related to the coordination and delivery of health care services within their schools. Administrative claiming generates more than $85 million in reimbursements for participating school districts. During FY 2015-16, Agency staff monitored all participating school districts quarterly to increase compliance with program policy and procedures.

Medicaid Program Integrity

Organizational Overview

The Bureau of Medicaid Program Integrity[3] (MPI) is located within the Office of the Inspector General (OIG). MPI is a unique component of the Agency for Health Care Administration (AHCA or Agency), Office of the Inspector General, in that most Florida inspectors general offices do not house an administrative enforcement arm within their structure. MPI derives its authority from ss. 409.913 and 409.91212, Florida Statutes (F.S.), laws relating to the integrity of the Medicaid program, and s. 20.055, F.S., the Agency inspectors general statute.

MPI serves as the primary office within AHCA to fulfill the federal law requirements to operate a fraud, abuse, and waste prevention and detection program within the single state agency responsible for the administration of the Medicaid program. Moreover, state law requires the Agency to operate a program to oversee Medicaid provider activities to ensure that fraudulent and abusive behavior occurs to the minimum extent possible in the Medicaid program, and to recover Medicaid overpayments, and impose sanctions for violations against the Medicaid program. MPI also identifies and refers to the appropriate investigatory or regulatory agency, those activities of recipients engaged in potentially fraudulent or abusive behavior, as well as instances of potential neglect of Medicaid recipients. These efforts to prevent, detect, and audit fraud, abuse, and waste, as well as initiating overpayment recovery in the Medicaid program, align with the organizational units within MPI, depicted in the following graphic.



During FY 2015-16, MPI sought to increase its efforts to ensure that Medicaid payments were made to appropriate providers for valid services rendered to eligible Medicaid recipients. These efforts are accomplished through a number of operational functions that begin with detection of possible fraud, program abuse, or overpayments within the Medicaid program. Detection is one of the most important and challenging aspects of the work due to the dynamic nature of fraud and abuse and the sheer volume of claims for payment received annually by the Florida Medicaid program. While Fee-for-Service (FFS) claims processed through the Medicaid program are subjected to system edits, edits alone cannot discover the intent of the individual or entity submitting the claim; they cannot detect when goods or services were not medically necessary or were not actually provided; and they cannot determine when the goods or services were rendered contrary to established Medicaid policy.

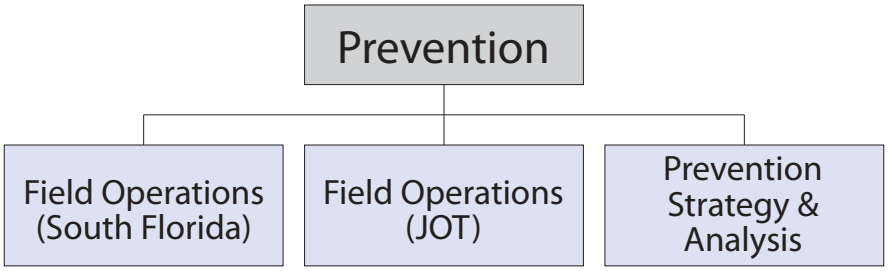
Once a suspected overpayment or program abuse activity is identified, whether it is a suspicious claim submission by a Medicaid provider or some other complaint that suggests a Medicaid provider warrants closer review, MPI initiates a preliminary investigation of the activity to determine the nature and potential extent of the violations. This preliminary investigation assists MPI in determining whether the allegations should be referred to other entities, including the Office of the Attorney General's Medicaid Fraud Control Unit (MFCU), for investigation of potential fraud. MFCU referrals are among the priorities that fall within MPI's prevention activities. When activity appears to involve improper payments without rising to the level of fraud, MPI conducts comprehensive audits with the recovery of Medicaid overpayments as the intended outcome.

Footnote: 3 Also referred to as the Office of Medicaid Program Integrity in s. 409.91212, Florida Statutes.

MPI also has responsibilities both with regard to ensuring that the Medicaid managed care plans are fulfilling their obligations related to program integrity activities, and has the responsibility for the investigation of suspected fraud or abuse committed by a health plan. MPI engages in on-site inspections of each contracted Medicaid health plan, conducts audits each fiscal year related to the health plans' obligations related to program integrity activities, and receives and evaluates each instance of suspected or confirmed fraud or abuse that is submitted by the health plans. MPI's activities with the managed care plans, both in a collaborative role and in an oversight role, are critical to the future program integrity efforts of the Florida Medicaid program.

MPI's efforts toward detection, prevention, overpayment recovery, managed care oversight, and MPI administrative support functions are further detailed below.

Prevention

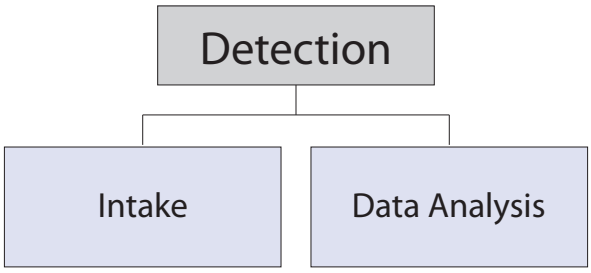


The Prevention Unit consists of three sub-units with responsibilities for prevention activities in specific geographical areas. The Tallahassee-based sub-unit is also responsible for strategic planning and other specific prevention-related investigative activities. The sub-units include (1) South Florida Field Operations, located in the Miami Area Office; (2) Jacksonville, Orlando, and Tampa (JOT) Field Operations, with staff in the respective area offices and a manager in the Tampa Area Office; and (3) Prevention Strategy & Analysis, located in AHCA headquarters in Tallahassee.

The Prevention Unit conducts a variety of activities designed to achieve cost savings related to fraud, abuse, and waste in the Medicaid program. One such activity is the field operations carried out through Medicaid provider on-site visits, either as a part of a complaint or case investigation, or as a component of a field initiative (project). MPI utilizes on-site visits to discover the nature of the suspected or reported provider abuse. When the abuse is determined to be more of the nature of fraudulent behavior, the provider is referred internally within MPI to the Prevention Strategy & Analysis sub-unit for further investigation and potential referral to MFCU. When the program abuse is determined to be more wasteful in nature, one of several overpayment recovery activities may be engaged. In addition to the ability to assist MPI operations through the development of referral and audit leads, these field activities increase the OIG's presence in the Medicaid provider community in the Medicaid program. By increasing the perception of detection, field operations help to deter fraud and abuse in the Medicaid program.

Other prevention activities include conducting prepayment reviews, strategic planning, preliminary investigation for MFCU referrals, preliminary review, and project development for potential audit referrals to other MPI units. The Prevention Strategy & Analysis sub-unit has a lesser focus on provider site visits and a greater focus on collaborative and research efforts related to fraud and abuse prevention and early detection. Examples of such efforts include providing guidance, research, and support to the Division of Medicaid to prevent enrollment of fraudulent and high-risk providers, and coordinating with the Division of Health Quality Assurance (HQA) related to provider types licensed by HQA to ensure a loss of licensure or restriction on a required license is quickly addressed from a Medicaid program standpoint. This sub-unit also has responsibilities regarding MPI process and organizational assessments to ensure that MPI engages in routine improvements.

Detection



Detection efforts continue to be a key factor in MPI's success. Without efforts to find the anomalies and conduct preliminary investigations, other MPI 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 expanded.

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. For FY 2015-16, 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 creating visualizations for complex datasets, including the mapping of social networks and geospatial mapping and analysis. The team's experience 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 for investigations and audits. 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 2015-16, the unit served as a lead unit for the development and implementation of the MPI data analytics project.

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. MPI's contracted vendor continues to incorporate additional external data sources and integrate 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.

Intake

In years past, the Detection sub-unit for the intake of complaints answered the fraud and abuse hotline, received complaints through the online 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 2015-16, there was a shift in duties to increase effectiveness and to account for changes in the Medicaid program. The Intake sub-unit has transitioned to conduct the preliminary investigations of all leads before referring the matter to other units.

This shift has resulted in increased referrals to external entities and is expected to result in increased efficiencies with recoupment because the units responsible for recoupment are able to spend less time evaluating and triaging cases and dedicate more time conducting recoupment activities. Additionally, with an increase in complaints anticipated due to enhanced internal 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 as the 5-year look back period for Medicaid recovery audits will include the 2013-2014 claims years, which experienced the highest volume of Medicaid FFS claims in the program's history. However, as the workload normalizes, the transition of Medicaid's service delivery model from FFS to managed care will necessitate a similar shift in staff within MPI; the Detection Unit's transition planning, and long-range goals will consider those future needs.

The Intake sub-unit has developed processes for conducting preliminary investigations. To implement these extensive triage and preliminary investigation processes, the Detection Unit has engaged in extensive training activities and has 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 online fraud and abuse complaint forms, internal AHCA referrals, news media reports, MFCU closing reports, the fraud and abuse (telephone) hotline, Explanation of Medicaid Benefits (EOMB) 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 allegation(s);
- The subject's Medicaid provider 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 determination of sufficient predication to warrant further review of the issue(s);
- The completion of the preliminary investigation of the issue(s), given sufficient predication; and
- The focus on the allegation and consistency with the plan developed specific for the issue matter.

This initial triage is a necessary process to ensure that preliminary investigations are conducted when there is sufficient predication and are properly assigned, when applicable.

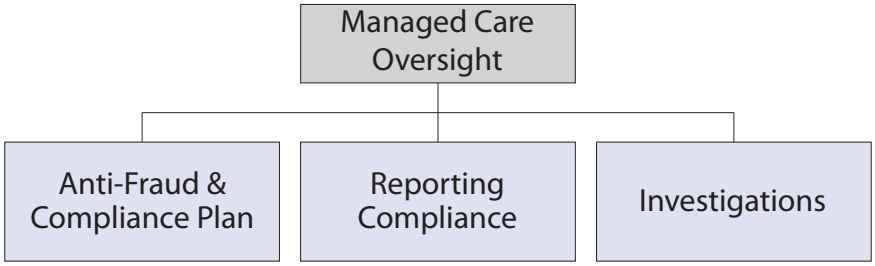
Following the triage process, the assigned investigator will conduct a preliminary investigation with the expected outcome of one of the following typical dispositions:

- Referral to an MPI Overpayment Recoupment Unit (where there is a potential overpayment exposure);
- Referral to MPI Prevention Strategy & Analysis sub-unit (if there is a potential "for cause" termination, suspension, or a potential MFCU referral);
- Referral to MPI Managed Care Oversight and Compliance Unit (when the complaint was submitted by a health plan);
- Referral to the Division of Health Quality Assurance;
- 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 regarding 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 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 violation, a recommendation is made to the appropriate unit administrator 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 and Compliance



The Managed Care Oversight and Compliance Unit (MCU) consists of three sub-units: (1) The Reporting sub-unit has responsibilities related to the statutory and contracted reporting requirements of the Medicaid health plans; (2) The Anti-Fraud and Compliance Plan sub-unit responsibilities pertain to the statutory and contractual requirements of the Medicaid health plan documents regarding corporate culture surrounding fraud, abuse, and waste; and (3) The Investigations sub-unit is dedicated to the investigation of allegations involving the Medicaid health plan itself and suspected issues of fraud, abuse, or waste within the plan or committed by the plan. All staff members of the MCU participate in making appropriate recommendations related to contract, report guide, and statutory language on fraud and abuse efforts by the Medicaid health plans. In fact, during FY 2015-16, there were a number of recommendations, which are detailed further below.

Reporting Sub-unit

The Reporting sub-unit is responsible for the oversight of three contractually and statutorily required reports submitted by the Medicaid health plans: the Suspected/Confirmed Fraud Abuse Report,[4] the Quarterly Fraud Abuse Activity Report[5] (QFAAR), and the Annual Fraud Abuse Active Report[6] (AFAAR). The sub-unit reviews each of these reports from the Medicaid health plans and provides assistance in the form of guidance to the Medicaid health plans regarding accurate reporting. The Suspected/Confirmed Fraud Abuse Reports are submitted at various times throughout the year. During FY 2015-16, there were more than 900 reports submitted to MPI for review. While the Reporting sub-unit's primary responsibilities center around reporting, they also contribute to audits and monitoring.

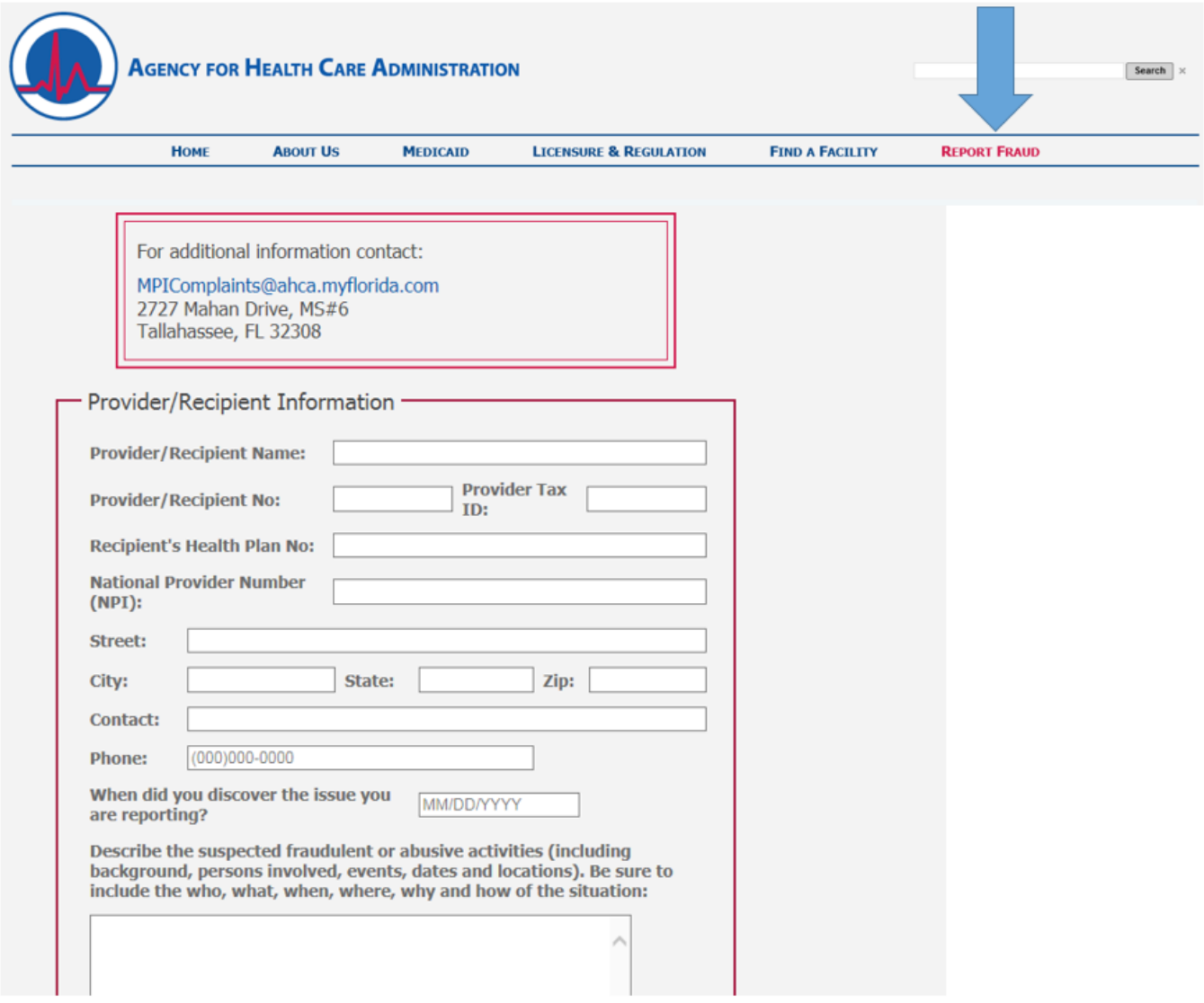
Footnote: 4 The Suspected/Confirmed Fraud Abuse Report, sometimes referred to as 15-day reports, is required pursuant to the SMMC Contract (Attachment II, Section VIII., F., 5.) and s.409.91212 (6), F.S., and is described in detail in Chapter 17, SMMC Report Guide.

Footnote: 5 The Quarterly Fraud Abuse Activity Report, also sometimes referred to as the QFAAR, is required pursuant to the SMMC Contract (Attachment II, Section VIII., F., 5.) and is described in detail in Chapter 16, SMMC Report Guide.

Footnote: 6 The Annual Fraud Abuse Activity Report, also sometimes referred to as the AFAAR, is required pursuant to the SMMC Contract (Attachment II, Section VIII., F., 5.) and s.409.91212 (4), F.S., and is described in detail in Chapter 5, SMMC Report Guide.

A Suspected/Confirmed Fraud Abuse report is submitted to MPI through the Agency's online fraud reporting system. The Medicaid health plans use the same online form used by the general public to report suspected fraud and abuse. The form is available at www.ahca.myflorida.com, under the "Report Fraud" link.

Guidance on the reporting requirements is in the Statewide Medicaid Managed Care (SMMC) Report Guide, which is updated quarterly; however, during FY 2015-16, each plan was afforded a one-on-one educational opportunity to go over this specific reporting requirement with anyone at the Medicaid health plan that may use the form. Medicaid health plans have significantly improved the timeliness of their report submissions, and as a result, MPI utilizes these educational opportunities to focus on the quality of the reporting as the next steps in developing a better program with the Medicaid health plans. In the educational opportunity, the report was reviewed section by section with subject matter experts providing detailed guidance as to the information required to be in the report. In each opportunity, there was time to review redacted examples of low quality and high quality reports in order to educate the Medicaid health plan on the expectations for reports. At each quarterly meeting with the Medicaid health plans, education was also provided related to this specific reporting requirement.



These Suspected/Confirmed Fraud Abuse reports are first assessed and then undergo a preliminary investigation by another unit within MPI (see Detection Unit discussion of the intake, assessment, and investigative processes). After all potential MPI actions (such as referrals to appropriate agencies, determination that an audit should be conducted, or determination that a referral to MFCU should be

considered), the complaints are referred to the MCU Reporting sub-unit concurrently with other appropriate actions. The Reporting sub-unit performs a quality check of each report. The quality check generally includes an internal review to assess the Medicaid health plans' compliance with the standards and all required components set forth in the SMMC Report Guide. This quality check is done based on the type of report, recipient or provider, and is facilitated by a checklist of requirements. Based upon the outcome of the quality check, the Reporting sub-unit will facilitate follow-up education with the Medicaid health plan to ensure the report is accurate for purposes of ongoing monitoring by this unit. The ongoing monitoring of the Medicaid health plans' investigations occur throughout the quarter within which the Suspected/Confirmed Fraud Abuse report was submitted.

The below chart demonstrates the number of Suspected/Confirmed Fraud Abuse Reports MPI received during FY 2015-16, from the Medicaid health plans.

The Number of Suspected/Confirmed Fraud Abuse Reports Submitted During FY 2015-16 by Month			
Month	No. of Reports	Month	No. of Reports
July 2015	146	January 2016	74
August 2015	107	February 2016	53
September 2015	133	March 2016	72
October 2015	116	April 2016	47
November 2015	65	May 2016	29
December 2015	55	June 2016	54

The Number of Suspected/Confirmed Fraud Abuse Reports Submitted During FY 2015-16 by Each of the Medicaid Health Plans					
Medicaid Health Plan	No. of Reports	Medicaid Health Plan	No. of Reports	Medicaid Health Plan	No. of Reports
Amerigroup (AMG)	68	Integral[7] (IHP)	2	Clear (CHA)	1
Better (BET)	7	Magellan (MCC)	6	SFCCN (NBD)	4
CMSN (CMS)	76	Molina (MOL)	77	Sunshine (SUN)	233
Coventry (COV)	64	Preferred[8] (PRE)	2	United (URA)	46
Freedom (FRE)	10	Prestige (PRS)	17	Wellcare (STW)	178
Humana (HUM)	150	Simply (SHP)	10		

Within 15 days of the end of each fiscal year quarter, there is a QFAAR submission. The QFAAR encompasses updates from each investigation (which brought rise to a Suspected/Confirmed Fraud Abuse report to MPI) that remains open with the Medicaid health plan. The updates include investigative activities, actions, or additional discoveries. Medicaid health plans are also encouraged to provide updates on investigations between the QFAARs. Additionally, the Reporting sub-unit may inquire with a Medicaid health plan for an update on an as-needed basis. The Reporting sub-unit assesses the investigation update information to ascertain whether the additional information potentially warrants any MPI activities in addition to the ongoing monitoring of the investigation. Finally, with regard to the investigation monitoring, the Reporting sub-unit ensures that the Medicaid health plans, through follow up and monitoring of the reporting activities, have diligent investigative activities. The Reporting sub-unit provides the Medicaid health plans necessary direction and guidance as identified through the reporting monitoring. This guidance is generally related to details, which should be determined as part of the assessment phase of the Medicaid health plan process, tips for constructing a strong referral, and follow up to ensure that overpayment recoveries will in the future be maximized. In addition, the follow up processes allow the Reporting sub-unit to aid in the identification of suspected fraud earlier, when something arises to suspicion of fraud as opposed to suspicion of abuse. The result is that all resources, both within MPI and at the Medicaid health plan, are better utilized.

Footnote: 7 Integral health plan was purchased by another Medicaid health plan that assumed their Special Investigation Unit (SIU) activities.

Footnote: 8 Preferred health plan was purchased by another Medicaid health plan that assumed their SIU activities.

Last year, significant changes were made to the AFAAR to allow MPI to continue reporting events related to program integrity efforts in a fashion that considers the programmatic changes that have occurred over the past several years. These reporting changes allow for the collection of more information surrounding the investigations that a Medicaid health plan has during the fiscal year. Items that are reported starting with the FY 2015-16, include a fiscal year overview, which encompasses items such as how many cases were worked, overpayment identification and recoveries, dollars lost to fraud and abuse, and other items that MPI generally presents in the annual report. The MCU expects this data to be ready in the FY 2017-18 Annual Report. This report will allow collection of corresponding data, which reflects the collaborative efforts between the Medicaid health plans and the Agency to provide the high quality program integrity efforts that have been traditionally carried out nearly exclusively by the Agency (in a predominately FFS environment). The changes help to better align the Medicaid health plans' reporting requirements and MPI's reporting requirements, as addressed in statute.

Anti-Fraud and Compliance Plan Sub-unit

The Anti-Fraud and Compliance Plan sub-unit (Compliance sub-unit) has the primary responsibility of reviewing the Medicaid anti-fraud plans and compliance plans that are required by statute (s. 409.91212, F.S.), as well as contract provisions. As this sub-unit's primary functions generally focus on these reviews, which happen annually and upon change, they have also taken on the primary audit/review and monitoring functions with assistance from all MCU sub-units. The Compliance sub-unit also serves as the primary unit within MPI to consult on subcontracts that a Medicaid health plan has or seeks to execute related to program integrity functions. Because the Compliance sub-unit has functional expertise related to these contractual obligations, there is also much interaction with Medicaid Plan Management Operations. This is done to ensure that there is no duplication of efforts related to these contract functions.

The anti-fraud plans are submitted annually by each Medicaid health plan. Section 409.91212, F.S., requires that each managed care plan, as defined in s. 409.9201(1)(e), F.S., must adopt an anti-fraud plan that addresses the detection and prevention of overpayments, abuse, and fraud relating to Medicaid. The SMMC Core Contract requires plans, when changing their anti-fraud plans, to submit changes for review and approval to MPI 45 days prior to the changes taking effect. The members of this sub-unit review all aspects of the anti-fraud plan, including policies and procedures that are a part of the plan. Each anti-fraud plan is required to reference parts of the SMMC contract and statutes relevant to the anti-fraud efforts of the Medicaid health plan. The anti-fraud plans vary in length, and when considering attachments such as the policies and procedures, some plans may consist of over 200 pages.

The MPI review of the anti-fraud plans includes verification that the submission by the plan was timely, encompassed all required elements, and that it is representative of the work that is reasonable to be accomplished. The required elements of an anti-fraud plan are outlined in s. 409.91212, F.S., and the SMMC Core Contract. Each element is reviewed on a requirement "met" versus "not met" basis. For an approval, all elements must be "met." Most anti-fraud plans incorporate policies and procedures into their practices to meet these standards. These policies and procedures are also reviewed and considered to be an integral part of a successful anti-fraud plan.

The assigned reviewer identifies health plan activities that may be considered potential best practices that are contrary to, or in conflict with, perceived best practices, or are practices that may be difficult or impractical to implement as described by the health plan. During the annual plan monitoring, the "impractical" activities may receive additional scrutiny to determine if the plan is really carrying out the activities as they indicated they would. Likewise, the areas that are identified as potentially contrary to, or in conflict with, perceived best practices will be discussed further with the health plan (either by this sub-unit or the Reporting sub-unit). Best practices are also identified and shared with all of the health plans to encourage improved practices. MPI is always working to encourage the health plans' best practices and has ongoing discussions and workgroups related to standing topics.

Best Practice Topic	
Prevention techniques	Internal Claims Department/Units using various analytical systems to review billing patterns on both a post- and pre-payment basis when identifying FAW within their provider networks.
Detection tools	Special Investigations Unit (SIU) departments utilization of systems, such as Claim Check, McKesson, and SIRIS. Identifying specific red flag areas where fraud, abuse, and waste (FAW) are present, such as: Gender appropriate billing, Clinical Peer Claims Review, Predictive Analytics, Utilization Reviews, Un-bundling Data Analysis, Age appropriate procedure billing, and Explanation of Medicaid Benefits (EOMB)-providers billing for services not rendered.
Investigations	Medicaid health plans using an outlined process when triaging complaints that may turn into cases or credible allegations of fraud and then using the same process structure to complete the evaluation. One common outline is [1] Detection or receipt of referral, [2] Initial assessment, [3] Investigative strategy outline, [4] Information gathering, [5] Evaluation of evidence, [6] Determination of action. Medicaid health plans use of case-specific investigative methodology when reviewing allegations. Example: Use of a case questionnaire to the witnesses in the case, such as Member, Provider, or Employee.
Corrective action methodologies	Medicaid health plan designation of staff to educate providers, correct issues, prevent future risk, perform time specific reviews, and conduct monitoring and follow-up reports.
Provider education and training	The Medicaid health plan Special Investigations Unit (SIU) Manager and Compliance Officer provide education through newsletters, webinars, public symposiums, educational materials, and computer based learning systems. Medicaid health plans that have personnel devoted to education, training and compliance with regulatory standards that focus on provider education, recoveries, cost prevention, and sanctions.
Plan employee education and training	Medicaid health plan training opportunities for investigators within the SIU: National Health Care Anti-Fraud Association (NHCAA), Certified Fraud Examiner (CFE), Accredited Healthcare Fraud Investigator (AHFI). Training for staff related to properly identifying FAW and overpayments. Training courses with specific curriculum based on job description and annual training requirements. Computer-based training that includes fraud schemes, fraud indicators, red flags, allegations, and the Deficit Reduction Act of 2005.
Reporting	Internal Medicaid health plan reporting protocols outlining processes that define the point of detection, enabling clear referral guidelines.

The Compliance sub-unit also reviews the health plans' compliance plans. Compliance plans are submitted 45 days prior to a change taking effect for review and approval. A recommendation has been made by the MCU to the Division of Medicaid, to have the SMMC contract require that the compliance plans be reviewed and submitted annually for approval. This change will facilitate regular review of compliance programs within the Medicaid health plans during which the objective is to strengthen the compliance plan. Compliance plans are required to comply with 42 CFR 438.608. Part of the requirements for a compliance plan are provisions for internal monitoring and auditing. This requirement helps establish that risk assessment is part of a strong compliance program.

The MPI review of the compliance plans includes verification that the documents submitted by the plan encompass all elements as required in s. 409.967(2)(g), F.S., 42 CFR 438.608, as well as the SMMC Core Contract. As in the anti-fraud plan review, the compliance plans are reviewed on a "met" or "not met" elemental basis. All components must have a "met" categorization for an approval.

Examples of Best Compliance Practices and Needs Improvement Practices are provided below.

Best Compliance Practices	Needs Improvement Practices
Create a culture within the organization to learn to look for the "red flags" of fraud. A well-versed staff regarding these issues can be a great tool in combating fraud and abuse.	All detected FAW patterns within the organization, should be referred to the health plan's SIU for further investigation.
Plans consult with their Compliance Officer during the course of an investigation, with issues, such as: review of documents for potential fraud indicators, interviewing the provider of services to determine if the member actually received the services, or cases that may involve a suspected employee.	Develop and implement a plan for ongoing monitoring of all high and moderate risk providers within their network.
Plan establishes an Audit Committee that will look at complaints, questionable accounting, internal controls, and various auditing procedures.	Develop monitoring tools to measure the success and efficiency of the training program.
Plan has annual Compliance and Ethics Program training that is distributed through an online learning tool. Plan provides training through fraud scenarios, questionnaires, Code-of-Conduct, and Compliance Plan.	Offer staff incentives for alerting and filing complaints and for suggesting quality improvement measures within the organization geared towards reducing fraud and abuse.
Plans arrangement of a Compliance officer and Compliance Committee for oversight of FAW. Committee oversight of audit protocols, investigations, and deficiencies when monitoring compliance and assessing the effectiveness of their corrective actions measures.	Create the culture of reporting to the organization off- duty misconduct issues, such as pleading guilty or non contendere to felonies; especially when these felonies may cause them to be excluded from employment with the organization.

Additionally, the Compliance sub-unit initiated the second engagement of an audit of financial arrangements between hospitals and Medicaid health plans with s. 409.975(6), F.S., as well as a review of each of the Medicaid health plan's proficiency of carrying out fraud, abuse, and compliance programs, as outlined in the anti-fraud and compliance plans. Audit, inspection, and investigations conducted during FY 2015-16 are described below.

Investigation Sub-unit

The Investigation sub-unit is a smaller team consisting of individuals with a broad knowledge-base of the internal workings of Medicaid health plans, statutes, rules, federal regulations, and micro-level investigative processes and procedures. The Investigation sub-unit is responsible for investigation of the Medicaid health plans when there is an allegation of activity related to fraudulent or abusive behavior. As these staff members have the potential to investigate many aspects of fraud and abuse, continued education is vital. To further their knowledge, staff members attended the annual Florida Insurance Fraud Education Committee (FIFEC) Conference. Staff members received training targeted for investigators within the insurance arena.

There are approximately six complaints under review in FY 2015-16 by this sub-unit. It is important to understand that these investigations will typically require more time than other MPI investigations due to the nature and scope of the allegations.

The Investigation sub-unit receives complaints from the Intake sub-unit once it is determined that a Medicaid health plan or one of their employees is the subject of the complaint, and that there is possibly a violation of policy or regulation. The staff in this sub-unit then assesses the various aspects of a complaint, deciding the predication to proceed with an investigation. Once the determination has been made that there is predication to proceed, the accusations are further reviewed to assess how best to complete the investigation to determine if there were violations of policy or regulations. Standard activities include data analyses, interviews, and site visits, though every investigation is different, which means every investigative plan is different. Once the investigation begins, notes are kept to help develop the summarization of the facts or the preliminary report. The facts in the preliminary report guide the determination of action.

In the case of an investigation of wrong-doing by a Medicaid health plan, there are many paths that a complaint can take once an investigation has been completed. There could be findings that lead to facts representing that a law has been broken, which would lead to a referral to MFCU or the regulatory oversight entities over managed care plans (the Office of Insurance Regulation or the Department of Financial Services'

Division of Insurance Fraud). There could be findings that policies were violated, which could lead to education, sanction, or appropriate contract actions, such as liquidated damages or corrective action. There is also a possibility that there are no findings, at which point the complaint and case would be closed.

MCU Highlights and Summary of Audits/Investigations

The MCU facilitates contractually required periodic meetings with the Medicaid health plans. The meetings have evolved over the past few years and have provided a collaborative environment for the Medicaid health plans, the Agency, and other state and federal partners to share current program vulnerabilities, provider risks, and other issues that may address fraud, abuse, and waste. The shared information assists the plans as well as MPI and MFCU in furthering effective investigations. These investigatory meetings also provide a forum for investigative best practice discussions, including referral processes, and provide a deeper insight into the processes and practices of the Agency, MFCU, and the Medicaid health plans. This collaboration and developing trust between the Medicaid health plans, the Agency, and MFCU aid in fighting fraud in the Medicaid program and encourage the Medicaid health plans to improve their internal quality controls regarding fraud and abuse reporting to the Agency. During FY 2015-16, four such meetings were held.

During FY 2015-16, the MCU concluded a program-wide (inclusive of all health plans) rate audit related to compliance with s. 409.975(6), F.S. This audit was led by the Compliance sub-unit with assistance from all sub-units within MCU. Due to the volume of documentation, a sample of 10% of the hospitals identified by the plans was included; the final audit report was released on December 16, 2015.

Also during FY 2015-16, the MCU initiated, but has not completed (as of this writing), a second audit related to compliance with s. 409.975(6), F.S. This second audit was initiated on January 19, 2016. The audit plan included a review of the health plan-specific findings related to the previous program-wide audit regarding compliance with this statutory provision. While this audit was not finalized during FY 2015-16, it is believed that it will likely conclude with a recommendation to complete further audits of a similar nature (assessing a broader scope of the hospitals with financial arrangements with the Medicaid health plans). Additionally, any non-compliances identified in the audit will be referred to the Division of Medicaid with documentation to provide justification for any action, such as corrective action, sanctions, or liquidated damages, as appropriate.

In FY 2015-16, the on-site portion of Medicaid health plan monitoring audits was completed. The MCU audits/monitors (approximately annually) the ability of the Medicaid health plan to carry out their anti-fraud plans within the Medicaid business line. The monitoring also assesses compliance with statutes, federal regulations, rules, and contract provisions pertaining to detection, investigation, and audit of fraud, abuse, and waste. The FY 2015-16 monitoring visits will be memorialized by way of an audit report and finalized during FY 2016-17. Preliminary findings do, however, indicate that there continue to be deficiencies in overall organizational knowledge of the plans' program integrity efforts. These monitoring visits and the findings that follow through the audit process are designed to increase the overall program integrity mindset of the health plan corporate culture.

Also during FY 2015-16, the preliminary development of audits for FY 2016-17 was underway. Such audits included:

- Transportation Vendor Oversight
- Ineligible Provider Use
- Suspended Provider Payment
- Participant Directed Option Vendor Oversight

Investigations conducted during FY 2015-16 included allegations from recipients claiming they were still enrolled with the same health plan after having requested and obtained disenrollment. MCU has also investigated allegations that managed care organizations contracted with entities to provide medical services to Medicaid enrolled members outside the scope of their license. Additionally, the unit initiated investigations on health plans for allegations of illicit kickback schemes between Medicaid health plan staff and several

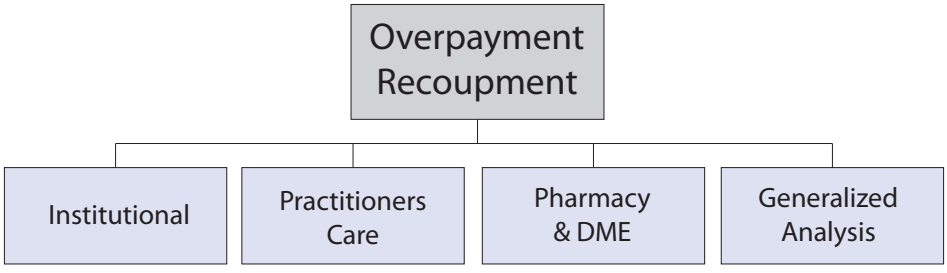
ancillary services providers. MCU has also initiated investigation of an allegation from a medical supplier that managed health care plan may have authorized a contracted service broker to deny service authorizations for services to various suppliers in order to financially benefit other supplier companies with a common ownership.

Finally, a FY 2016-17 work plan was developed (in FY 2015-16) which identifies proposed future audits topics. The goal of these audits would be to increase risk management efforts (including program integrity efforts) for the plans, to result in support for stronger regulatory language as appropriate, to identify program vulnerabilities, to identify and substantiate, or to refute risk of fraud, abuse, and waste, and to identify potential recoveries. Potential audit topics include:

- Transportation Vendor Oversight
- Electronic Health Record Use
- Participant Directed Option Vendor Oversight
- Ineligible Provider Use
- Suspended Provider Payment
- FQHC/RHC Duplicative Billing
- Member Date of Death PMPM repayments
- Non-Participating Provider Use
- Expanded Benefit Utilization
- Home Health Agency Services

Overpayment Recoupment

MPI's return on investment is a major measurement used to monitor the effectiveness and efficiency of the staff's endeavors. Much of this is attributable to the Overpayment Recoupment Unit, which performs audits on Medicaid providers and identifies overpayments for recovery. During FY 2014-15, several key staff began the process to become certified as contract managers in anticipation of organizational changes planned for the future. The office changes included the shifting of full time employees from the Overpayment Recoupment sub-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 audits.



The staff of the Overpayment Recoupment Unit continues to perform audits and will work with contractors to achieve substantial results. The staff will work with the health plans to increase effectiveness within the managed care environment so the recoupments that the health plans identify are increased to meet or exceed MPI's historical averages.

Traditionally, the efforts of MPI have focused on the recoupment activities in a FFS environment. While there is a decrease in FFS claims with the move to SMMC, MPI activities are actually increasing. MPI recoupment

activities will continue to reach back five years to identify and recoup overpayments not yet claimed. It should be noted that the reach back period includes the time immediately preceding the implementation of the SMMC program, a time period that saw the annual FFS claims volume expand.

Furthermore, the need to audit FFS claims will continue into the future in light of the fact that 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. These populations continue to have a high volume of reimbursements that will warrant ongoing auditing and recoupment activities.

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 operational activities (e.g., audits, investigations, and inspections) cannot be effectively carried out without support in the form of office management, administrative functions, and supplemental staffing. Within MPI, there is a unit responsible for this operational support. The unit has primary responsibility for purchasing, budget, personnel, administration of office management activities, coordination of audits within MPI, activities that do not result in MPI actions (such as responding to public record requests, referrals to other agencies), Bureau travel, record retention, record storage, obtaining external training materials and memberships, developing Bureau operating policies, overseeing MPI property management, equipment reconciliation, and audit processes.

During FY 2015-16, the MPI Administrative Support Unit responded to 345 public records requests. The unit coordinated carpet installation in MPI for over 107 rooms (including common areas and individual offices) and converted workspace to more efficiently accommodate the increased volume of investigations and the related documentation. Also during FY 2015-16, MPI significantly increased its training activities in an effort to increase overall personnel performance. The Administrative Support Unit staff took responsibility for coordinating the increase of both external and internal training. The unit processes all nominations and coordinates travel and attendance at the Medicaid Integrity Institute in Columbia, South Carolina for Agency staff. During FY 2015-16, more than 86 trainings were made available to MPI staff. A final unit highlight, among the many activities of this highly efficient staff, included the MPI project to transition from hundreds of thousands of manually compiled hard copy records to automated electronic processes. The unit has been coordinating a pilot project with other MPI units to receive electronic records and to convert paper records to electronic format. Often unrecognized, the support of this behind-the-scenes unit contributes greatly to the overall success of the Bureau.

MPI Accomplishments

Audits and Investigations

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

A major ongoing audit project addresses paid inpatient claims related to Emergency Medicaid for Aliens (EMA). The Agency, the Centers for Medicare & Medicaid Services (CMS), and CMS' Medicaid Integrity Contractor have identified substantial overpayments for recoupment in this project. The completion of the project has been slowed by legal challenges due to the large sums subject to recovery by the State.

In October 2012, a rule challenge (Case No.12-2757RU), alleging non-rule policy, was filed with the Division of Administrative Hearings (DOAH). A hearing followed in which an Administrative Law Judge (ALJ) ordered the Agency to immediately discontinue all reliance upon the "stabilization" standard or any substantially similar statement as a basis for declaring overpayments in the EMA audits. The Agency appealed the order, but subsequently withdrew the appeal. The Agency complied with the ALJ's order accordingly and continued the EMA audit program based on the policies established in the Florida Medicaid Provider General Handbook and the Hospital Services Coverage and Limitations Handbook. In October 2014, a second non-rule policy challenge (Case No. 14-4758RU) was filed. The same ALJ issued an order on April 20, 2015, favorable to the Agency. The order was appealed to the First District Court of Appeal (1D15-2299). Oral arguments were held June 21, 2016. On June 28, 2016, the Court filed a "per curiam affirmed" order thus affirming the ALJ's order. Approximately $7.7 million in overpayments were pending litigation at the close of FY 2015-16.

In January 2013, CMS proposed a Hospice collaborative audit project. The project addresses Medicaid recipients that have been in hospice care for six months or longer to review compliance with length of stay. In May 2013, CMS expressed their intent to perform a limited number of related audits. Subsequently, MPI/CMS initiated the Hospice audit project. The project is proceeding with approximately $2.2 million in overpayments identified at the close of FY 2015-16.

The 2013 Refugee Project was opened in 2013, but continues as new providers are identified for audit. This project was initiated to review Medicaid providers serving a significant number of Medicaid recipients with refugee status as their Medicaid eligibility category. This project arose from audits conducted on providers serving a significant number of refugees and MPI identifying a pattern of excessive billing for medically unnecessary visits and unnecessary testing. In addition, it was noted that documentation submitted by these providers was either absent or not supportive of the service billed. As of June 2016, MPI opened audits on 33 providers serving a significant refugee population. Thus far, MPI has identified a total of approximately $3 million dollars in overpayments related to the Refugee Project.

In another audit case, the Pharmacy/DME Overpayment Recoupment Unit conducted an on-site visit of a Miami pharmacy provider, resulting in a comprehensive review of the provider by a MPI pharmacist. A review of the provider's purchase/acquisition records for a one-year period[9] revealed a shortage of drugs available to support the payments made to the provider by Florida Medicaid. A judgmental prescription review found 41 individual discrepant claims. The final audit report was issued with a Medicaid overpayment of $351,996 identified. Additionally, a fine of $24,111 was assessed along with costs incurred for the audit. A hearing request was submitted by the provider, but prior to the hearing, the provider signed a payment plan agreement with Medicaid Accounts Receivable, agreeing to return the funds to Florida Medicaid. A final order was filed for the full amount of the overpayment, sanctions, and costs identified in the final audit report.

In another matter, the Detection Unit referred information to the Practitioner Care sub-unit indicating a physician practitioner was prescribing controlled substances at a volume that was suspicious due to few instances of corresponding medical claims. The sub-unit opened the case and proceeded to audit the appropriateness of the Medicaid reimbursements. The provider failed to respond to the audit requests, and did not send records to substantiate reimbursements. A preliminary audit report was issued for an overpayment of almost $200,000. The final audit report identified an amount of approximately $240,000 when costs and fines were assessed. A final order was issued and the provider established a repayment agreement.

Collaborative Efforts

While the value of the collaborative efforts of fraud fighting activities is difficult to quantify, MPI believes there is a significant positive value in working with others toward the common goal of identifying, reducing, preventing, and taking enforcement action against appropriate individuals and entities engaged in fraudulent or abusive behavior contributing to overpayments in the Medicaid program. Collaboration helps all participating agencies work toward improved outcomes.

Footnote: 9 MPI audits of pharmacy are limited by statute (s. 465.188, F.S.) to a one-year period, unless MPI has reliable evidence that the claim(s) reviewed in the audit involve fraud, willful misrepresentation, or abuse under the Medicaid program. This one-year limitation does not apply to any other Medicaid provider type.

Specifically, MPI is able to identify: emerging trends related to fraud, abuse, and waste; develop partnerships to more effectively combat fraud and abuse; and enlist the assistance of others in increasing awareness, both as to the detrimental impact of participating (even inadvertently) in fraud schemes, as well as, the significant value of reporting suspected fraud and abuse. During FY 2015-16, MPI continued its collaborative efforts with:

- U.S. Department of Health and Human Services - Centers for Medicare and Medicaid Services;
- U.S. Department of Health and Human Services - Office of Inspector General;
- U.S. Department of Justice - Office of Legal Education;
- U.S. Drug Enforcement Administration;
- The Executive Office of the Governor;
- Florida Agency for Health Care Administration - Division of Health Quality Assurance;
- Florida Agency for Health Care Administration - Division of Medicaid;
- Florida Agency for Persons with Disabilities;
- Florida Department of Children and Families;
- Florida Department of Economic Opportunity;
- Florida Department of Education - Office of Early Learning;
- Florida Department of Elder Affairs;
- Florida Department of Financial Services - Division of Insurance Fraud;
- Florida Department of Health;
- Florida Department of Law Enforcement;
- Florida Office of the Attorney General - Medicaid Fraud Control Unit;
- Florida Office of Insurance Regulation;
- Medicaid Health Plan Quarterly Meetings;
- Judicial Circuit Adult Interagency Meetings;
- National Insurance Crime Bureau Meetings;
- Senior Medicare/Medicaid Patrol Project Meetings;
- FBI Health Care Fraud Working Group Meetings;
- Florida County Government Financial Abuse Workgroup Meetings; and
- State Attorney Multidisciplinary Task Force Meetings.

Field Initiatives/Focused Projects

The Prevention Unit is responsible for provider on-site visits and field initiatives. A field initiative is a series of on-site visits, typically of the same provider type in a single geographic area. In FY 2014-15, MPI began to modify field operation protocols to attempt to engage providers that were the greatest risks of abusive behavior. Through the field initiatives, MPI staff engaged in on-site verification of medical records, office locations, provider employee information, and other details required by the Medicaid program policies and laws. The field initiatives gather information to support allegations of suspected fraud, abuse, or waste.

During FY 2015-16, protocol modification continued to encourage staff to take a greater leadership role in the field initiatives. Additionally, many initiatives were established as pilot projects in locations not typically visited by MPI personnel. This was intended to allow the projects to be further developed and modified before being deployed in the higher risk areas of the Medicaid program. Also during FY 2015-16, field initiatives were developed to be more focused, data-driven projects in order to identify Medicaid providers suspected of abusive behavior. Projects began incorporating additional data elements beyond Medicaid claims data. These efforts are expected to continue to increase the complexity of the methodology for project subjects and to improve on-site protocols.

During FY 2015-16, MPI conducted a number of pilot field initiatives related to the following Medicaid provider types, services, and counties:

- Applied behavior analysis in Broward County;
- Speech therapy in DeSoto, Hardee, Highlands, Okeechobee, Orange, and Duval Counties;
- Durable medical equipment (back orthoses) in Miami-Dade County;
- Durable medical equipment (continuous positive airway pressure, CPAP) in Seminole County;
- Assisted living facilities in Palm Beach County;
- Unlicensed home health agencies in Miami-Dade County;
- Home Health and Development Disabilities (DD) Waiver in Orange County; and
- Buprenorphine/Naloxone (Suboxone) in the Florida Panhandle, Duval, and Miami-Dade Counties.

The FY 2015-16 pilot field initiatives resulted in fines and other sanctions, and referrals both internally within MPI, as well as to external agencies. One example of how the pilot project concept was deployed is described below.

Buprenorphine/Naloxone (Suboxone) is a prescription drug used to treat opioid addiction. The HHS-OIG Work Plan Mid-Year Update for FY 2015-16 identified several Medicare Part D program vulnerabilities resulting in an increase in fraud complaints related to drug diversion and inappropriate dispensing of medications. MPI conducted Suboxone-related field initiatives in three geographic areas in Florida, covering six counties and 52 providers. The goals of the initiative were: (1) to identify, document, and refer suspected fraudulent activities to the MFCU, as appropriate; (2) to identify, document, and refer suspected improper prescribing practices to the Department of Health (DOH) and other appropriate regulatory entities, as applicable; (3) to identify, document, and refer policy and edit recommendations to the Division of Medicaid, as applicable; and (4) to establish additional detection methodologies that might be deployed by MPI to identify other providers for future field initiatives and overpayment audits. Findings from each geographic area are listed below.

Panhandle Initiative – Three teams completed site visits on 17 providers in Bay, Holmes, Washington, and Leon Counties. Of the completed site visits, seven resulted in referrals to the Provider Eligibility and Compliance Unit (PECU) within the Bureau of Medicaid Fiscal Agent Operations (MFAO).

Miami-Dade – Two teams conducted site visits on 12 providers in Miami-Dade County. Of the completed site visits, five resulted in referrals to regulatory entities, including two referrals to the Office of the Attorney General, MFCU for further investigation.

Duval – One team completed site visits on 12 providers in Duval County. Site visits resulted in three PECU referrals and four provider education consultations.

During the FY 2016-17, the outcomes of the pilot field initiatives will result in expanded, and sometimes modified, efforts.

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 other organizational units within AHCA. MPI payment restrictions are imposed by way of a notice to the Division of Medicaid, requesting that the provider's Medicaid reimbursements be pended. MPI also provides notice to the provider and the Medicaid health plans. 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.

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, the graphic below indicates the number and type of payment restrictions implemented by MPI during FY 2015-16.

Number of Pre-Payment Reviews, 25As, CAFs	
PPRs	159
25As	47
CAFs	114

Referrals

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

During FY 2015-16, improved information-sharing and stronger collaboration between MPI and key partners contributed to a marked increase in referrals made by MPI to internal and external agencies. In FY 2015-16, there were 515 referrals made by MPI, compared to 337 referrals in FY 2014-15, including referrals to MFCU. During FY 2015-16, MPI's internal process improvements, including having Prevention Strategy & Analysis sub-unit staff dedicated to conducting preliminary investigations related to referrals, resulted in 154 referrals to MFCU, an increase from the 63 referrals made in FY 2014-15.

Sanctions

Administrative sanctions applied against a provider are typically imposed in accordance with s. 409.913, F.S., and Rule 59G-9.070, Florida Administrative Code (F.A.C.). Although the sanctions typically imposed by MPI include fines, suspension, and termination, 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 Medicaid program or closes their business. In most circumstances, these terminations do not come to the attention of MPI. However, when such voluntary terminations are 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 suspension of participation in the Medicaid program in which the provider did not choose to relinquish their provider number; an instance when a provider voluntarily relinquishes its Medicaid provider number or an associated license; when a provider allows an associated licensure to expire after receiving written notice that the Agency is conducting a review; or when a provider voluntarily terminates after the Agency has conducted an audit, survey, inspection, or investigation where 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 may 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 informally 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 or suspension 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, termination from the Medicare program or the Medicaid program in any other state, provider actions or inactions that are harmful to recipients, convictions of certain criminal offenses, as well as repeated instances of certain violations. Similarly, the sanction of suspension may be imposed for reasons including licensure suspensions, suspension from the Medicare program or the Medicaid program in any other state, the provider was charged by information or indictment with fraudulent billing practices or certain other offenses, or the provider fails to comply with an agreed-upon repayment schedule.

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. Sanctions typically include fines, suspension, and termination.

MPI Training Program

In January 2016, MPI formalized an assessment and training process to ensure that professional development needs were identified and addressed. The MPI training protocol identifies eight core educational components to serve as the basis for professional development. MPI personnel assess their knowledge in these core components and, consistent with the training protocol, develop and implement a professional development plan to attain and maintain knowledge in the core components.

Additionally, MPI implemented a voluntary certification process that allows MPI personnel to demonstrate their knowledge of the eight core educational components. Knowledge within the eight core educational components will optimize the ability for MPI personnel to perform effectively within MPI. The eight components are: (1) Florida Medicaid, (2) Federal Medicaid, (3) Florida Law Related to Program Integrity, (4) Federal Law Related to Program Integrity, (5) Florida Program Integrity Procedure, (6) Principles of Program Integrity, (7) Principles of Investigations, and (8) Theory and Principles of Fraud/Criminology.

Because MPI serves in a lead role for the Agency with regard to oversight and accountability within the Florida Medicaid program, MPI personnel require a basic understanding of the state's medical assistance program, including eligibility, service delivery options (e.g., managed care vs. FFS), categories of service (optional vs. mandatory), and the operational structure of the single state agency and its operating partners. Also, because Medicaid is a federal-state partnership, MPI personnel are encouraged to develop an understanding of the federally mandated coverage obligations and the availability of certain waivers to the state, as well as the broad federal programmatic obligations that frame the state program.

The MPI educational program also includes emphasis on the law and theories related to program integrity. In Florida, the provisions of section 409.913, F.S., are critical for every day operations of MPI. Also, other laws such as ss. 409.9131 and 409.91212, F.S., as well as F.A.C. provisions pertaining to Florida Medicaid provider sanctions, Medicaid policies, and Medicaid coverage and limitation handbooks (as well as the incorporated handbooks) are critical knowledge areas for MPI personnel to assist with achieving the Bureau's goals. Staff are encouraged to be familiar with other state laws pertaining to health care fraud and related misconduct that MPI may encounter routinely, including ss. 409.920 and 456.053, F.S., also known as the "Patient Self-Referral Act of 1992." Staff are also afforded opportunities to become proficient with provisions of state Inspector General (IG) laws and numerous federal laws, including 42 CFR 455.23 and 42 CFR 1007, as well as the laws that establish the federal Medicaid program framework.

Additionally, the principles of investigations and the theory and principles of fraud/criminology establish the framework for MPI operations. Principles of Investigations form the framework used to conduct all investigations at MPI. An important consideration is that all cases or complaints should be investigated from the outset with the understanding that the case may result in judicial proceedings, either in criminal or civil court, or administrative hearings. The principles and theories of fraud (especially white collar crime and financial crimes) and criminology offer a foundation to approach almost all prevention and detection activities. These theories may also cross the commonly recognized academic disciplines and become something similar to hybrid theories or principles, wherein an interdisciplinary approach or understanding forms the bases for theories. In some cases, theories predominant in criminology may be fused with theories

from cultural anthropology, education, or political science to form a unique perspective for research or practice involving investigations related to fraud, abuse, and waste. These theories aid MPI in developing innovative approaches to emerging trends and the dynamic nature of program integrity in health care.

As of the end of FY 2015-16, more than half of the MPI personnel attained the voluntary associate level MPI certification. Additionally, MPI has approximately 10 Certified Fraud Examiners, approximately 10 Certified Professional Coders, two Accredited Healthcare Fraud Investigators, and one Certified Inspector General Auditor. MPI anticipates increasing the internal and external certifications held by its staff as further demonstration of the high-caliber personnel working within the Bureau.

MPI Data for Fiscal Year 2015-16

Site Visits	
Provider Type	Number
Assistive Care Services	110
Chiropractor	4
Community Alcohol, Drug, MH	1
Dentist	1
DME/ Medical Supplies	20
Federally Qualified Health Center	2
General Hospital	1
H & C Based Services	71
Home Health Agency	19
Optometrist	1
Pharmacy	80
Physician (DO)	10
Physician (MD)	107
Physician Assistant	1
Podiatrist	2
Prescribed Medical Rehab Services (PPEC)	2
Rural Health Clinic	1
Skilled Nursing Facility	2
Therapist	25
Grand Total	460

Prepayment Reviews	
Number of Claims Reviewed	44,063
Number of Claims Denied	31,312
Amount of Claims Reviewed	$5,310,806
Amount of Claims Denied	$4,086,239

25A Withholds		
	Number	Amount
Fiscal Year 2015-16	47	$0

Random Audits Concluded	
Audits Completed	6
Audits with Findings	6
Audits with No Findings	0
Overpayments Identified	$105,724

MPI Referrals	
Agency for Persons with Disabilities	5
Department of Health	11
Department of Health & Human Services - OIG	1
Division of Health Quality Assurance	57
Division of Medicaid	73
Managed Care Organization	2
Medicaid Fraud Control Unit - AG	154
Department of Children and Families	202
Other	10
TOTAL:	515

Provider Sanctions Imposed and Managed Care Organization Assessments				
	FY 2014-15		FY 2015-16	
Sanctions under Rule 59G-9.070, F.A.C.	Number	Amount	Number	Amount
Fine Sanctions	394	$1,516,201	282	$1,374,034
Suspensions	25	N/A	38	N/A
Terminations	42	N/A	67	N/A
Total for Rule 59G-9.070, F.A.C. Sanctions		$1,516,201		$1,374,034
Total for Managed Care Organization Section 409.91212 F.S., or Contract Assessments			2	$102,000
Grand Total Sanctions and Managed Care Organization Assessments	461	$1,516,201	382	$1,476,034

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 2012-13	Accounts Receivable, Offsets, 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
FY 2015-16	Accounts Receivable and PCRs	$21,515,784	$21,458,880

MPI Prevention of Overpayments ($ Millions)[10]				
	FY 2012-13	FY 2013-14	FY 2014-15	FY 2015-16
Prepayment Review	$0.6	$0.4	$1.1	$4.1
Termination of Providers	$5.7	$1.6	$6.2	$2.0
Focused Projects	$0.8	$6.6	$3.0	$2.8
Site Visits	$4.1	$2.1	$2.9	$5.1
Sanctioned Providers	$5.1	$6.9	$7.0	$13.3
Claims Denied Per Statute		$2.9	$1.9	$0
Audit Impact	$5.6	$8.8	$13.0	$18.3
Total:	$21.90	$29.30	$35.1	$45.6

MPI Recovery Activities ($ Millions)				
	FY 2012-13	FY 2013-14	FY 2014-15	FY 2015-16
MPI Audits (OP's Collected by Accounts Receivable)	$31.4	$21.2	$37.8	$19.5
Costs (Collected by Accounts Receivable)	$0.2	$0.2	$0.4	$0.2
Fines (Collected by Accounts Receivable)	$3.0	$2.4	$1.5	$1.4
Paid Claims Reversals	$1.3	$2.6	$0.5	$0.2
Contractual Assessments	N/A	N/A	$0.0	$0.1
TPL Contractor - Assisted Claims Adjustments	$43.6	$61.6	$42.5	$18.8
Recovery Totals:	$79.5	$88.0	$82.7	$40.2

Medicaid Program Integrity Return on Investment (ROI)			
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	5.54	6.44:1
Total:	117.80	15.8	7.46:1
FY 2015-16	Benefits	Costs	ROI
Recovery	40.2	7.4	5.43:1
Prevention	45.6	5.3	8.60:1
Total:	85.8	12.7	6.76:1

Footnote: 10 This amount does not include the prevention value that is realized by the Medicaid health plans as a result of the Agency's program integrity efforts. The prevention value has not been calculated, but could reasonably be projected as high as the total amount reported as MPI's prevention activities, meaning the Agency's efforts have a value likely significantly higher than reported.

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 a lien cannot be placed on Medicaid/Medicare payment or payments are not received, Financial Services pursues other means of collection or determines if the case should 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, 2015, the Medicaid accounts receivable balance for fraud and abuse was $42.8 million. During the 2015-16 state fiscal year (FY), $44.5 million was recorded as Medicaid accounts receivables. As of June 30, 2016, the balance was $49.3 million. During FY 2015-16, total collections including refunds and net of adjustments approached $38.1 million. The collections were: $36.2 million in overpayments ($16.7 million collected from Medicaid Fraud Control Unit (MFCU) cases and $19.5 million collected from Medicaid Program Integrity (MPI) cases); $227,000 in investigation costs; $1.5 million in fines/sanctions; and $308,000 in interest.

The Agency must obtain approval from the Department of Financial Services (DFS) 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 are 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 Finance, Division of Health Quality Assurance, Office of Third Party Liability, Medicaid Fiscal Agent Operations, and Office of Inspector General 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. This results in more funds being recouped sooner, as well as increase the percentages of the liens placed on provider Medicaid/ Medicare payments.

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 is reported on the last appropriate quarterly report. During FY 2015-16, the Agency reduced its federal claims by $42.2 million for net overpayments.

Third Party Liability Unit

The Division of Operations' Third Party Liability (TPL) Unit is responsible for identifying and recovering funds for claims paid by Medicaid for which a third party was liable, thereby ensuring Medicaid is the payor of last resort. Some examples of third parties include casualty settlements, insurance companies, recipient estates, Medicare, and commercial carriers. TPL recovery services are performed by a state procured outside vendor. Effective September 1, 2015, the Agency negotiated and executed a five-year contract with Health Management Systems, Inc. (HMS).

During FY 2015-16, over $96 million in Medicaid funds were collected. Annual TPL collections over the last four years have averaged over $143 million. In addition, the TPL Unit has held Xerox (previous vendor) and HMS accountable to contract requirements by vigorously monitoring Xerox and HMS's performance. These efforts have helped to ensure maximum recoveries are generated for the State of Florida. Types of recoveries include:

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

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

Trusts and Annuities - Trusts and Annuities relating to a person's eligibility in the Medicaid program stipulate that upon the death of the beneficiary, or if the trust/annuities 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 by Medicaid for which Medicare or another third party, such as private insurance, may have been liable.

Other Recoupment Projects - The TPL Unit also works in conjunction with the Agency's Bureau of Medicaid Program Integrity to conduct other Medicaid recoupment projects. Recoveries from other recoupment projects during FY 2015-16 include the following:

- Date of Death - Claims paid after the dates of death of recipients and Medicaid providers are recovered.
- Hospital Credit Balance Audits - Hospital accounts payable ledgers are reviewed in connection with collecting Medicaid overpayments.

- Freestanding Dialysis Center Credit Balance Audits - Freestanding Renal Dialysis Center providers' payable ledgers are reviewed in connection with collecting Medicaid overpayments.
- Long-Term Care Audits (project ended on April 30, 2016) - Long-term care facility accounts payable ledgers are reviewed in connection with collecting Medicaid overpayments.

Medicaid Overpayments - Funds are recovered from providers when 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;
- 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;
- Drug Limitations - claims paid outside of the limitations in the Prescribed Drug Services Coverage, Limitations and Reimbursement Handbook;
- Service Exclusions - claims paid for services that are excluded per the respective Services Coverage and Limitations Handbook(s) and provider fee schedules for pharmacy, professional, institutional, and dental claim types;
- Durable Medical Equipment (DME) Rent-to-Purchase Equipment - violations of service limitations, per DME fee schedule; and
- Fee-for-Service Payments While Recipient is Enrolled in Managed Care - Fee-for-service claims are recovered from providers on the dates of service a Medicaid recipient was enrolled in a Managed Care 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 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15	FY 2015-16
Casualty	$22,165,885	$24,366,688	$22,303,548	$22,794,142	$21,985,243	$21,877,491
Estate	$5,486,256	$6,017,391	$7,061,816	$6,967,623	$7,092,510	$8,507,538
Trusts	$6,011,888	$7,124,616	$5,471,792	$6,615,113	$8,595,999	$5,887,889
Medicare and Other Third Party Payor	$72,081,890	$78,428,755	$77,922,624	$72,834,387	$67,061,300	$41,544,352
Other Recoupment Projects*	$29,958,148	$32,208,128	$48,455,372	$61,607,714	$42,525,211	$18,831,428
Total Collections	$135,704,067	$148,115,578	$161,215,152	$170,818,979	$147,260,262	$96,648,698
Cost Avoidance (Matrix)	$966,902,977	$1,259,088,849	$1,423,986,005	$2,366,574,378	$2,366,574,378	$2,031,929,708

* 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 for Health Care Administration (Agency) continues to move forward in the development of the Care Provider Background Screening Clearinghouse (Clearinghouse). The Clearinghouse is a secure, web-based database used to house and manage background screening results of multiple state agencies allowing the following agencies to share those results: The Agency, Managed Care Health Plans, Medicaid providers, the Agency for Persons with Disabilities (APD), the Department of Elder Affairs (DOEA), the Department of Children and Families (DCF), the Department of Health (DOH), the Department of Juvenile Justice (DJJ), and Vocational Rehabilitation at the Department of Education (DOEVR). Integration with the state agencies began in January 2013. With the addition of DJJ joining the Clearinghouse in July 2016, all specified agencies are now participating. 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. During FY 2015-16, the Background Screening Unit processed 16,373 RapBacks. Of these, 31.6 percent were found to be for criminal charges that resulted in the applicant's eligibility status being updated to not eligible. The Agency providers benefit by being able to use more than 48,000 screenings per year from the Clearinghouse saving AHCA providers over $3.5 million for the fiscal year. During FY 2015-16, 91,445 background screening results were shared among participating agencies and Medicaid health plans resulting in an overall cost savings of $6,858,375 to Agency providers, DOH licensees, Medicaid health plans, Medicaid providers, DCF, DOEA, DOEVR, and APD providers.

Senate Bill 1986 Reporting

In 2009, the Legislature passed Senate Bill (SB) 1986 addressing regulatory reforms and fraud and abuse prevention. The Agency reports to the Senate Committee on Health Regulation detailing the implementation of provisions within SB 1986. Highlights of the June 2016 report include:

Home Health Agencies - Home health agencies, which have demonstrated a pattern of billing the Medicaid program for medically unnecessary services, have either received an administrative penalty for violating s. 400.474(6)(e), Florida Statutes (F.S.), or denied a renewal application based on the provisions of s. 400.471(10), F.S. In FY 2015-16, no home health agencies were identified to have met these criteria.

Remuneration Complaints - Complaints received against nurse registries for providing remuneration in violation of s. 400.506, F.S. There were none identified in FY 2015-16.

Nonimmigrant Aliens - Nonimmigrant aliens who have applied for a home health agency, home medical equipment or health care clinic license, and met the requirements of s. 408.8065, F.S. Nine applicants met these criteria in FY 2015-16.

Financial Requirements - Home health agency licensure applicants that failed to meet the financial requirements of s. 408.8065, F.S. There were 226 home health agency applications, 206 home medical equipment applications, and 482 health care clinic applications in FY 2015-16.

Revocations and Terminations - Providers that were revoked, denied a renewal application or surrendered their license based on a Medicare or Medicaid suspension, termination or exclusion from either program related specifically to fraud based on the provisions of s. 408.815(1)(e) and s. 408.815(4), F.S. There were 20 providers that met these criteria in FY 2015-16.

Final and Emergency Orders

During FY 2015-16, the Agency issued final or emergency orders to 113 providers for failure to meet licensure requirements, resulting in closure:

- 52 final orders revoking an existing licensure;
- 29 final orders denying the license renewal application;
- 15 final orders resulting in the provider surrendering their license; and
- 17 emergency orders resulting in either suspension and/or an immediate moratorium on admissions.

During FY 2015-16, the Agency collected $2,873,558 in fines and administrative fees from licensure actions imposed by final orders.

Health Care Alerts Webpage

In May of 2016, the Agency announced a new Health Care Alerts webpage. This addition expanded the process that was already available for interested parties to receive information about the Medicaid program and its providers. The change has made it easier for the public to sign up for health care alerts that interest them and has created a uniform system for sending out email alerts.

Interested parties have the ability to sign up for alerts by provider type or health care topic. One such topic is emergency orders, which allows users to subscribe specifically to notices of moratoria and other emergency actions. As of November 2016, the Agency currently has 123 subscribers signed up to receive alerts about emergency orders.

Transparency about emergency orders is crucial because it allows immediate notification to the public of concerns with a facility or provider. The Division of Health Quality Assurance and the Bureau of Medicaid Program Integrity work closely together to coordinate actions against associated Medicaid providers and facilities to reduce fraud and abuse and ensure the safety of vulnerable populations.

Assisted Living Facility Comparison Tool

In October of 2015, the Agency launched a new comparison tool for assisted living facilities (ALFs). This tool, which is the latest addition to a collection of consumer resources hosted at www.FloridaHealthFinder.gov, allows Floridians to compare inspection results, facility complaints, nurse availability, imposed fines, special programs and other service/quality measures for more than 3,000 assisted living facilities around the state.

Florida Health Finder has been helping consumers make educated decisions about their health care since 2005. With over three million visitors per year, the Florida Health Finder website is widely considered a national leader in the area of consumer education and health care transparency. During the 2015 legislative session, the passage of House Bill (HB) 1001 directed AHCA to expand its selection of consumer resources for assisted living facilities.

In addition to the recently-added ALF comparison tool, Florida Health Finder also offers comparison tools for hospitals, nursing homes, and health plans. These resources are part of a larger initiative to empower consumers to make informed decisions about their health care.

Office of the General Counsel

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

The eight attorneys comprising the Medicaid Administrative Litigation legal staff defend and represent the Agency, and prosecute administrative complaints on behalf of the Agency, in relation to Florida Medicaid related matters heard before Florida and federal administrative tribunals. The OGC has also dedicated an attorney-liaison who serves as a point of contact between the OGC, Medicaid Program Integrity Fee-for-Service, and Medicaid Program Integrity Managed Care to help facilitate discussion and communication regarding ways to curb health care fraud and abuse. The attorney-liaison focuses on legal matters related to managed care oversight, including the following: contractual terms included in the Agency's Statewide Medicaid Managed Care contracts with managed care organizations and provider service networks; anti-fraud and compliance plans; reporting compliance; and investigations.

During this past fiscal year, the OGC Agency Clerk issued 430 Medicaid Program Integrity Final Orders. Additionally, the OGC Agency Clerk received 112 Medicaid Program Integrity hearing requests.

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 (AHCA) and the Attorney General's Medicaid Fraud Control Unit (MFCU) to strengthen inter-agency coordination and enhance processes and protocols in fraud investigation and prosecution. An interactive partnership is essential for effective, collaborative investigative efforts aimed at protecting the people of Florida against healthcare fraud and substandard health care. In recent years this interactive partnership has resulted in routine, thorough communications between DOH and agencies that investigate and prosecute fraud (Medicaid Program Integrity, Centers for Medicare and Medicaid Services, Health and Human Services - Office of the Inspector General, Division for Insurance Fraud, and National Insurance Crime Bureau). This has ensured appropriate action against the licenses of health care practitioners committing fraud.

The DOH Division of Medical Quality Assurance (MQA) director and enforcement leadership meet regularly with AHCA and MFCU directors and senior managers to coordinate joint projects, investigations and enforcement strategies, and to identify emerging issues or threats. Over the years, these meetings have grown to include additional state agencies, including the Department of Children and Families, the Department of Financial Services Fraud Strike Force, the Department of Economic Opportunity, the Division of Insurance Fraud, and the Agency for Persons with Disabilities. Expanding participation in the 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.

In the past year, DOH and AHCA collaborated on the design and creation of a web portal for consumer complaints. The portal was designed to facilitate the reporting of complaints by consumers; direct consumers to the appropriate reporting entity; and to reduce the number of complaints each agency receives that are not within their jurisdiction. The first phase of the portal was completed in March of 2016. In the first four months, the portal received over 70,000 views. DOH will continue to work with AHCA on the next phase of the portal, which will allow consumers to file complaints online as well as upload supporting documents. By facilitating the complaint reporting process, consumers may be encouraged to report suspected cases of fraud.

DOH has also created a fraud analytics unit in its headquarter's office. This unit will help DOH's field offices analyze records and identify areas of possible fraud. This unit will work closely with AHCA to share information and benchmark best practices.

AHCA and DOH continue to enhance information sharing to ensure anti-fraud legislation is implemented fully. For example, DOH transfers data every 24 hours to AHCA to flag practitioners who do not have an active license, but who may continue to bill Medicaid.

From July 1, 2009 through August 22, 2016, DOH has denied licensure to 460 applicants and denied the renewal of 175 healthcare practitioners for health care related fraud. DOH has also taken 185 emergency actions and disciplined 335 healthcare practitioners for violations related to Medicaid.

STATUTORY REPORTING REQUIREMENTS

Number of cases opened and investigated

MFCU opened 273 cases and had 876 active cases in FY 2015-16. MPI investigated 2,768 cases which included 1,201 opened during the year.

Disposition of the cases closed

Disposition of Cases Closed				
Case Type	MFCU	PANE	AHCA	Total
Acquittal	1	1		2
Administrative Closure	5			5
Administrative Referral	36	7		43
Bankruptcy			3	3
Case Dismissed	20			20
CHOW			2	2
Civil Judgment	3			3
Civil Settlement	16			16
Consolidated	3			3
Conviction	19	9		28
Deferred Prosecution Agreement	1	2		3
Fines Issued			34	34
Investigation by Another Law Enforcement Agency	7	3		10
Lack of Evidence	7	13		20
No Abuse			19	19
No Auditable Review Period			1	1
No Findings			365	365
Nolle Prosequi	1	2		3
Not an Overpayment Issue			2	2
Not Sustained			291	291
Plea Agreement	1			1
Pretrial Intervention	2	3		5
Prosecution Declined		2		2
Provider Education			36	36
Provider No Longer Operational			30	30
Provider Suspended			35	35
Provider Termination			14	14
Provider With Cause Termination			70	70
Provider Without Cause Termination			8	8
Referred			54	54
Resolved with Intervention	1			1
Sustained			600	600
Under Investigation by Another Entity			5	5
Unfounded	18	4		22

Disposition of Cases Closed				
Case Type	MFCU	PANE	AHCA	Total
Unsubstantiated	11	4		15
Vacated Suspension			5	5
Vacated Termination			5	5
Voluntary Dismissal	47			47
Voluntary Termination			7	7
Grand Total	199	50	1586	1835

Sources of the cases opened

Sources of Cases Opened				
Source	MFCU	PANE	AHCA	Total
AHCA - Bureau of Managed Care		1		1
AHCA - District Office	1			1
AHCA - Financial Services			15	15
AHCA - HQA-Facility Regulation			24	24
AHCA - HQA-Field Operations			6	6
AHCA - Medicaid-Area Offices			2	2
AHCA - Medicaid-Medicaid Services			4	4
AHCA - Medicaid Quality			2	2
AHCA - Medicaid Program Integrity MPI	29	1		30
AHCA - Other Bureaus			48	48
AMG - Amerigroup			2	2
APD - Agency for Persons With Disabilities	4		4	8
APS - Adult Protective Services	2	37		39
Attorney	1			1
Citizen	24	1	2	27
CMS - Children's Medical Services Network (CMSN) Plan			3	3
DCF - Department of Children & Families		3		3
DEA - US Drug Enforcement Administration	1			1
Detection Tool			301	301
DOH - Department of Health	1		9	10
Employee	13	1		14
EOMB	1			1
Family Member	9			9
Federal Agency - Federal Bureau of Investigation	1			1
Federal Agency - CMS			44	44
Federal Agency - Medi-Medi			1	1
Federal Agency - Others			1	1
Florida - MFCU			48	48
Florida - Other Agencies			1	1
Government Employee	1			1
HHS OIG Health & Human Services Inspector General	6	1	3	10
HUM - Humana			1	1
Internet / Media			66	66

Sources of Cases Opened				
Source	MFCU	PANE	AHCA	Total
Investigator Initiative			413	413
Law Enforcement Agency	2			2
Long Term Care Ombudsman Council	1			1
Managed Care Monitoring			16	16
Managed Care Provider	1			1
Managed Care SIU	4			4
MCO - Special Investigative Unit			4	4
Medicaid Provider	14		2	16
Medicaid Recipient	7			7
MFCU Data Mining Initiative	2			2
MOL - Molina			2	2
Online Complaint Form			17	17
Other - See Description			7	7
OSWP Office of Statewide Prosecution	1			1
Press Report	1	1		2
Previous File or Case			5	5
Projects			130	130
Qui Tam	79			79
Self-Audit			10	10
Site Visit			3	3
Spinoff Case	19	1		20
STW - Wellcare d/b/a Staywell Health			3	3
SUN - Sunshine			2	2
USAO US Attorney's Office	1			1
Grand Total	226	47	1,201	1,474

Amount of overpayments alleged in preliminary and final audit letters

Amount of Overpayments Alleged in Preliminary and Final Audit Letters FY 2015-16	
Preliminary	Final
$24,956,207	$21,515,784

Number and amount of fines or penalties imposed

During FY 2015-16, MPI imposed fines (under s. 409.913, F.S., and Rule 59G-9.070, F.A.C.) in the amount of $1,374,034.

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

There were no reductions in overpayments through negotiated settlements by MFCU during FY 2015-16. During FY 2015-16, the Agency negotiated final settlements resulting in a total reduction of overpayments in the amount of $69,834.

Amount of final Agency determinations of overpayments

MPI identified $21,515,784 in overpayments via audits on 1,586 closed cases. Total recoveries by MPI and MPI-TPL for FY 2015-16 were $40,224,950 (This includes collections of overpayments, fines, costs, and paid claims reversals, and contract assessments 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 2015-16, the Agency reduced its federal claims by $42.2 million for net overpayments.

Amount of overpayments recovered each year

MFCU collected $16,101,893 in overpayments that were returned to the Agency. Additionally, MFCU collected $35,244,376 in Federal Medicaid overpayments that were sent directly to the U. S. Department of Health and Human Services for a total of $51,346,269 in Medicaid overpayments collected in FY 2015-16. Overpayments recovered by the MPI audits were $19,504,333.

Amount of cost of investigation recovered

During FY 2015-16, the MFCU collected $6,539 in program income investigative costs. MFCU also collected $7,992 in state share investigative costs and $13,778 in federal share investigative costs for a grand total of $28,310 for all investigative costs. MPI total investigative costs for FY 2015-16 were $226,665.

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 265 days. This average length of time was substantially impacted by non-rule challenge litigation.

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

For FY 2015-16, the Agency did not report any uncollectable amounts. In FY 2015-16, Florida did not have a statute allowing the state to reclaim credits associated with identified overpayments remitted to the federal government for entities out of business[11]. 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	134
T5 - TERM - MCARE AUTH	161
T6 - TERM - MCAID FO	67

Footnote: 11 2016 - 65 and 2016 - 103, Laws of Florida, now allow reclamation of overpayments remitted to the federal government attributable to "out of business" providers. These laws took effect on July 1, 2016.

For the FY 2015-16, the following chart itemizes T2, T5, and T6 type terminations:

Terminations - MCAID AUTH, MCARE AUTH or Final Order	
05 - Community Behavioral Health Services	1
06 – Ambulatory Surgery Center	1
07 - Specialized Mental Health Practitioner	7
10 - Skilled Nursing Facility	5
14 - Assistive Care Services	40
20 - Pharmacy	30
25 - Physician (MD)	105
26 - Physician (DO)	9
27 - Podiatrist	3
28 - Chiropractor	6
29 – Physician Assistant	4
30 - Nurse Practitioner (ARNP)	5
32 - Social Worker/Case Manager	9
35 - Dentist	6
50 – Independent Laboratory	1
51 – Portable X-Ray Company	1
60 - Audiologist	3
61 – Hearing Aid Specialist	2
62 - Optometrist	2
65 - Home Health Agency	24
66 – Rural Health Clinic	4
67 - Home & Community-Based Services Waiver	46
81 - Professional Early Intervention Services	1
83 - Therapist (PT, OT, ST, RT)	4
89 – Dialysis Center	1
90 - Durable Med Equipt/ Medical Supplies	26
91 - Case Management Agency	3
97 - Managed Care Treating Provider - Non-Medicaid	10
99 – Trading Partner	3
TOTAL	362

Additionally, there were 208 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	208

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

MFCU expenditures for FY 2015-16 were $17,243,665 which included indirect costs of $1,617,675. MPI direct legal costs were $1,763,372.

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	50
DB - DENY - BEST INTEREST	77

For the FY 2015-16, the following chart represents denied provider types:

Denied Providers – D6 PRV TERM/EX and/or BEST INTEREST	
05 – Community Behavioral Health Services	3
07 - Specialized Mental Health Practitioner	6
14 – Assistive Care Services	5
20 – Pharmacy	4
25 – Physician (M.D.)	37
26 – Physician (D.O.)	7
29 - Physician Assistant	1
32 – Social Worker/Case Manager	2
35 – Dentist	1
39 – Behavior Analysis	1
65 – Home Health Agency	26
67 – Home & Community-Based Services Waiver	7
83 – Therapist (PT, OT, ST, RT)	3
90 – Durable Med Equipt/ Medical Supplies	1
91 – Case Management Agency	23
Total	127

Regarding providers that were prevented from enrolling or reenrolling due to program integrity considerations, there were an additional 66 providers who were denied due to findings during an on-site pre-enrollment visit; 53 providers were denied due to disqualifying criminal offenses, and 10 providers were denied due to a federal exclusion, for a total of 129 providers denied enrollment.

Number of Denials	
D2 - DENY - SV	66
D3 - DENY - BKGD SCRNG	53
DE - DENY - EXCLUSION	10

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

MPI routinely collaborates with the Division of Medicaid as it relates to policy (e.g., Medicaid handbook provisions or managed care contract provisions) that would assist in the prevention or recovery of overpayments or the prevention or detection of Medicaid fraud. Changes that are necessary to achieve these purposes are routinely developed and implemented. Often times, changes that are necessary to address these efforts require Legislative review and statutory revisions. MPI, along with the Divisions of Medicaid and Health Quality Assurance, routinely evaluate statutes, contracts, rules, and handbooks related to relevant issues, such as background screening provisions, redundancies in language, and areas which may benefit from further clarification. For example, the current definition of medical necessity is limited to only physicians where, in practice, a licensed practitioner of the same discipline (e.g., therapist or pharmacists) may be more appropriate to make the determination. Additionally, many provisions of current statute may require modification to properly address program integrity issues in a managed care environment. Routine evaluation of the statutes (along with contracts, rules, and handbooks) is necessary to ensure that the Agency's authority is not unnecessarily limited and allows for the necessary activities to detect and prevent, and where appropriate take enforcement actions such as sanctions or recovery of overpayments, of waste, abuse, and fraud, in the Florida Medicaid program.

ACRONYMS

AFAAR – Annual Fraud Abuse Active Report

Agency, the – Agency for Health Care Administration

AHCA – Agency for Health Care Administration

AHFI – Accredited Healthcare Fraud Investigator

ALF – Assisted Living Facilities

ALJ – Administrative Law Judge

APD – Agency for Persons with Disabilities

APS – Adult Protective Services

CAF – Credible Allegation of Fraud

CCEB – Complex Civil Enforcement Bureau

CFE – Certified Fraud Examiner

CFR – Code of Federal Regulations

CJIS – Criminal Justice Information Services

Clearinghouse – Care Provider Background Screening Clearinghouse

CMS – Centers for Medicare and Medicaid Services

CPAP – Continuous Positive Airway Pressure

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

DOAH – Division of Administrative Hearings

DOE – Department of Education

DOEA – Department of Elder Affairs

DOEVR – Vocational Rehabilitation at the Department of Education

DOH – Department of Health

DOJ – Department of Justice

EMA – Emergency Medicaid Alien

EOMB – Explanation of Medicaid Benefits

eQHealth – eQHealth Solutions, Inc.

FAW – Fraud, Abuse, and Waste

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

FDLE – Florida Department of Law Enforcement

FFS – Fee-for-Service

FFP – Federal Financial Participation

FIFEC – Florida Insurance Fraud Education Committee

FMHI – Florida Mental Health Institute

FMMIS – Florida Medicaid Management Information System

FSFN – Florida Safe Families Network

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 the Inspector General

HMS – Health Management Systems, Inc.

HQA – AHCA's Health Quality Assurance

i-Budget – Developmental Disabilities Individual Budgeting

JOT – Jacksonville, Orlando, and Tampa

MAGELLAN – Magellan Medicaid Administration

MAR – Medicaid Accounts Receivable

MCU – Managed Care Unit

MFAO – Medicaid Fiscal Agent Operations

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 within the Florida Department of Health

NHCAA – National Health Care Anti-Fraud Association

OGC – Office of General Counsel

PANE – Patient Abuse, Neglect and Exploitation

PCRs – Paid Claims Reversals

PDL – Preferred Drug List

PDN – Private Duty Nursing

PECU – Provider Eligibility and Compliance Unit

PPEC – Prescribed Pediatric Extended Care

PPR – Prepayment Review

QEN – Qualified Evaluator Network

QFAAR – Quarterly Fraud Abuse Activity Report

ROI – Return on Investment

SB – Senate Bill

SIU – Special Investigative Unit

SMMC – Statewide Medicaid Managed Care

SSA – Social Security Administration

TPL – Third Party Liability

UM – Utilization Management

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, Shannon Bagenholm 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. Bagenholm, with assistance from other staff members, assembled the information from the multiple sources into a single draft document. Ms. Bagenholm, 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. Bagenholm's efforts were most important in ensuring this report was submitted timely, with the statutorily required information. If you have questions or comments regarding this report, the Agency for Health Care Administration and the Office of the Attorney General will make every effort to address them.

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