The State's Efforts to Control Medicaid Fraud and Abuse

FY 2016-17

December 15, 2017

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 2016-17. 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
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 (AHCA or Agency) and the Medicaid Fraud Control Unit (MFCU) of the Department of Legal Affairs have continued their joint efforts to prevent, reduce, and mitigate health care fraud, abuse, and waste in accordance with their statutory obligations. Additionally, other components and subject matter experts from several state agencies that administer public benefits and health care programs contributed to the joint projects and efforts described in this report.

This joint report presents specific results of efforts by the Agency and MFCU to control Medicaid fraud and program abuse during FY 2016-17.

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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, Title 42 of the Code of Federal Regulations (CFR), and Chapter 409, Florida Statutes (F.S.)].

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

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

The MFCU is also responsible for investigating the physical abuse, neglect, and financial exploitation of patients residing in long-term care facilities such as nursing homes, facilities for the mentally and physically disabled, and assisted care living facilities. The MFCU is greatly concerned with the quality of care being provided for Florida's ill, elderly, and disabled citizens. 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, helps prevent, detect, prosecute, and deter misconduct in order to protect the citizens of Florida. Case management, including case openings, investigative activities, legal review/prosecution, prioritization, utilization of investigative/legal resources, and other related issues, is handled on a case-by-case or office-by-office basis.

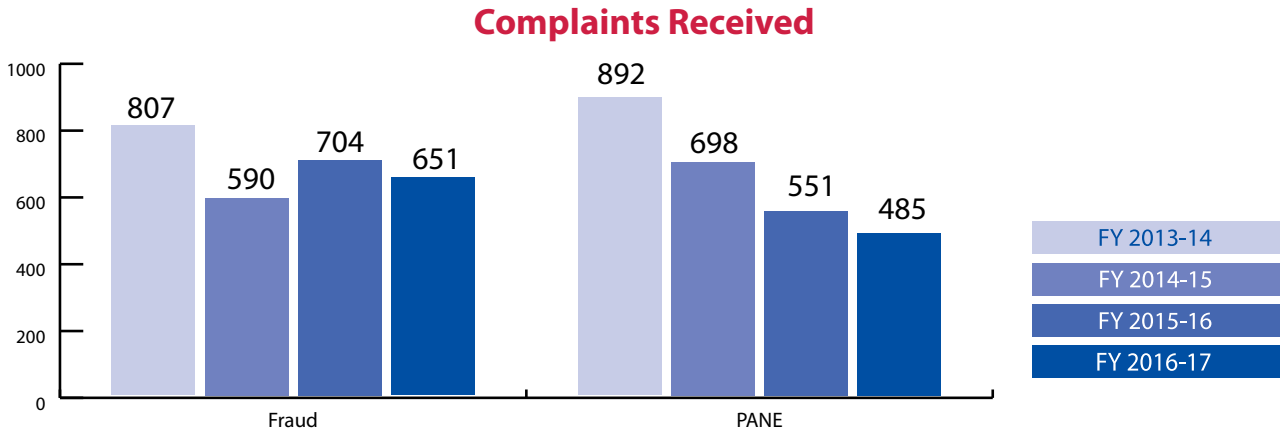
MFCU's Control and Enforcement Strategy requires unit members to focus on the following:

- 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; and

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

Complaints

The Unit's policy requires a 30-day review of complaints and allegations to determine whether the matter merits further investigation, should be referred to another agency, or is unfounded. Case openings occur only when there is a criminal or civil predicate that warrants further investigative activity by the MFCU. During FY 2016-17, the Unit received 1,136 complaints. Of those 1,136 complaints, 303 were opened as operational cases. Of the 1,136 complaints received in FY 2016-17, 651 were related to fraud and 485 were related to PANE allegations.



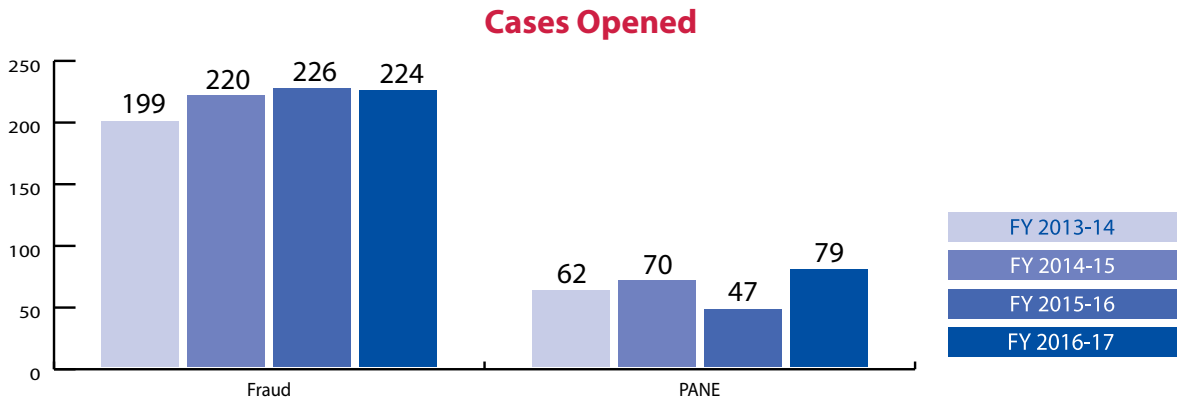
Medicaid recipients were the primary source of fraud complaints in FY 2016-17, with 148 complaints reported. One hundred fifteen complaints from citizens were received. AHCA, via the Bureau of Medicaid Program Integrity (MPI), accounted for 92 of the Medicaid fraud complaints received. Eighty-six qui tam complaints were received.

The majority of PANE complaints were derived through the Department of Children and Families (DCF), Adult Protective Services (APS)/Florida Safe Families Network (FSFN). MFCU reviews information placed in the FSFN system and determines if opening a complaint is appropriate. In FY 2016-17, of the 485 PANE complaints, 437 came from DCF/APS/FSFN. Family members relayed the next highest source of PANE complaints accounting for 10 complaints.

Case Investigations

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

During FY 2016-17, 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 five Medicaid Provider types for MFCU fraud cases opened in FY 2016-17:

1. Home & Community-Based Service
2. Pharmaceutical Manufacturer
3. Physician
4. Home Health Agency
5. Pharmacy

The following is a list of the top five Medicaid Provider types for PANE cases opened in FY 2016-17:

1. Facility Employee
2. Family Member
3. Skilled Nursing Facility
4. Administrator of Facility
5. Home & Community-Based Service

Disposition of Cases

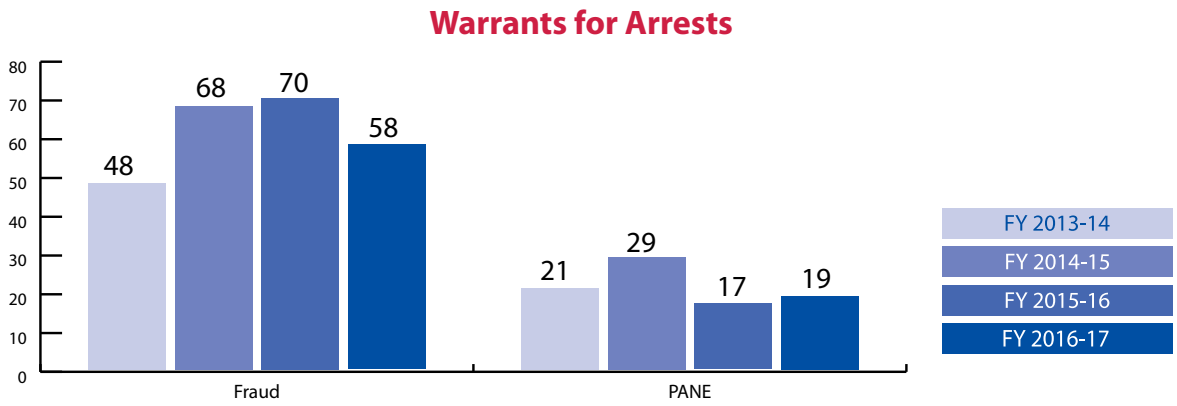
Following an investigation, a determination is made whether to pursue criminal prosecution or initiate civil actions. All case investigations are formally closed because of either a successful prosecution or a lack of evidence. Several classifications are presently used to track the ultimate disposition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

In FY 2016-17, the MFCU closed 203 cases. Of those, 154 involved Medicaid fraud investigations and 49 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 2016-17, were 64 Fraud and 24 PANE for a total of 88. In FY 2015-16, referrals for prosecution were 60 Fraud and 19 PANE, for a total of 79. FY 2014-15 had 85 Fraud and 39 PANE for a total of 124 referrals for prosecution. In FY 2013-14, there were 46 Fraud and 31 PANE for a total of 77 referrals for prosecution.

Warrants for arrests in FY 2016-17, are indicated in the chart below.



Case Highlights

CareCore National, LLC

Florida, along with 20 other states, joined the federal government in a settlement with CareCore National, LLC (CareCore), resolving allegations that the company caused false claims to be submitted to government health care programs. CareCore provides utilization management services that determine whether services are medically necessary. CareCore allegedly instituted a scheme to auto-approve hundreds of radiology service requests on a daily basis, deeming the diagnostic services as reasonable and medically necessary, even though appropriate medical personnel did not evaluate the cases.

CareCore developed and implemented an auto-approval program in an effort to keep up with the volume of preauthorization requests for services and to allegedly avoid a contractual monetary penalty for untimely reviews. The program improperly approved more than 200,000 prior authorization requests that CareCore initially determined could not be approved. This practice caused millions of dollars in false or fraudulent claims to be submitted and reimbursed by the states' Medicaid programs.

As part of the settlement, CareCore will pay the federal government $54 million, including $18 million that will go to the 21 state Medicaid programs. Florida will receive $1.4 million in restitution and other recoveries for the Medicaid program.

The settlement resolves allegations asserted in a qui tam action brought by a whistle-blower[1] in the U.S. District Court for the Southern District of New York. On behalf of the states, a National Association of Medicaid Fraud Control Units team participated in the investigation and conducted the settlement negotiations with CareCore. The team includes representatives of the Florida, Georgia, New York, and Ohio Medicaid Fraud Control Units. The states coordinated their investigation in conjunction with the U.S. Attorney's Office for the Southern District of New York.

Shire Pharmaceuticals, LLC

Florida joined the federal government in a multi-state settlement with Shire Pharmaceuticals, LLC (Shire) and other subsidiaries of Shire. Shire is a multinational pharmaceutical company headquartered in Ireland, with United States operations headquartered in Lexington, MA. The agreement in principle settles allegations that Shire and the company it acquired in 2011, Advanced BioHealing (ABH), employed kickbacks and other unlawful methods to improperly promote a medical device called Dermagraft. Dermagraft is a bioengineered human skin substitute approved by the Food and Drug Administration (FDA) for the treatment of diabetic foot ulcers.

The agreement resolves allegations that from 2007 to 2014, Dermagraft salespersons unlawfully induced clinics and physicians to use Dermagraft with payment of remuneration. These payments included lavish dinners, drinks, entertainment and travel; medical equipment and supplies; unwarranted payments for purported speaking engagements and bogus case studies; cash, credits, and rebates. According to the federal government, the U.S. settlement with Shire represents the largest False Claims Act recovery by the U.S. in a kickback case involving a medical device.

The Federal Anti-Kickback Statute prohibits the payment of remuneration to induce the use of medical devices covered by Medicare, Medicaid, and other federally-funded health care programs. Under the False Claims Act, claims filed in violation of the Anti-Kickback Statute are considered false or fraudulent. Additionally, the settlement resolves allegations that Shire and ABH unlawfully marketed Dermagraft for uses not approved by the FDA, made false statements to inflate the price of Dermagraft, and caused improper coding, verification, or certification of Dermagraft claims and related services.

As part of the settlement, Shire will pay the federal government $350 million. More than $14 million of this payment is going to the Medicaid program to resolve allegations that Shire's improper promotion and marketing of Dermagraft caused false claims to be submitted to government health care programs. The states will receive more than $6 million for their share of the Medicaid program.

The settlement also resolves allegations asserted in six qui tam actions brought by whistle-blowers in, or transferred to, the U.S. District Court for the Middle District of Florida. Two of the qui tam actions named various states and included allegations that Shire submitted or caused to be submitted false claims to the Medicaid program under the Federal False Claims Act and various state false claims statutes.

A National Association of Medicaid Fraud Control Units' team participated in the investigation and conducted the settlement negotiations with Shire on behalf of the states. The team included representatives of Florida, Illinois, Ohio, and New York Medicaid Fraud Control Units. The states coordinated their investigation in conjunction with the Department of Justice's Civil Division's Commercial Litigation Branch, and the U.S. Attorneys' Offices for the Middle District of Florida, District of Columbia, and Eastern District of Pennsylvania.

Dr. Rasiklal Dhanji Nagda

A $1.1 million settlement was reached with an obstetrician and gynecologist in Ocala. Dr. Rasiklal Dhanji Nagda is a Medicaid provider and owner of Nagda Medical, Inc. According to MFCU's investigation, Nagda submitted more than 700 claims to Medicaid for intrauterine devices not approved by the (FDA), and received reimbursements from the Medicaid program. Nagda allegedly used a credit card to order large quantities of Bayer's Mirena IUDs from an online pharmacy, GetCanadianDrugs.com, on a monthly basis.

Footnote 1: This term refers to *qui tam* or false claims lawsuits, not actions related to Florida's Whistle-blower's Act (sections 112.3187-112.31895, Florida Statutes).

The Mirena IUDs that Nagda allegedly ordered and used are not intended for distribution in the United States and are not approved by the FDA, and therefore not authorized for Medicaid reimbursement. The active ingredient in the Mirena IUDs is Levonorgestrel, a female hormone initially approved for use in the U.S. in 2000, but must still be approved for U.S. distribution.

Odette Barcha, Arnaldo Carmouze, and Philip Esformes

The MFCU announced the arrests of three individuals for operating a $1 billion Medicare and Medicaid fraud scheme involving numerous Miami-based health care providers. The MFCU, as part of the Health Care Fraud Prevention and Enforcement Action Team (HEAT) Strike Force, assisted in identifying more than $100 million of Medicaid fraud in connection to this scheme. Odette Barcha, 49, Arnaldo Carmouze, 56, and Philip Esformes, 47, of Miami-Dade County, are charged with conspiracy, obstruction, money laundering, and health care fraud.

According to the indictment, Philip Esformes, 47, operated a network of more than 30 skilled nursing facilities and assisted living facilities that gave access to thousands of Medicare and Medicaid beneficiaries. Many of these beneficiaries did not qualify for skilled nursing home care or for placement in an assisted living facility. However, Esformes and co-conspirators admitted the beneficiaries to Esformes Network facilities, and received medically unnecessary services billed to Medicare and Medicaid. The defendants also allegedly received kickbacks by steering the beneficiaries to other health care providers, including community mental health centers and home health care providers, who also performed medically unnecessary treatments billed to Medicare and Medicaid. To hide the kickbacks from law enforcement, the kickbacks were often paid in cash, or were disguised as payments to charitable donations, payments for services, and sham lease payments.

The Federal Bureau of Investigation (FBI), the Florida MFCU, and the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) investigated the case, which was brought as part of the Medicare Fraud Strike Force, supervised by the Criminal Division's Fraud Section and the U.S. Attorney's Office for the Southern District of Florida. The Criminal Division's Fraud Section and the U.S. Attorney's Office for the Southern District of Florida are prosecuting the case.

Francisco Calderon and Zulima Calderon

The MFCU and the Florida Department of Law Enforcement (FDLE) announced the arrest of a Naples couple in connection with a drug diversion scheme fueled by Medicaid fraud. According to the MFCU and FDLE investigation, Francisco Calderon, 53, and his wife Zulima Calderon, 51, trafficked more than $3.9 million of contraband prescription drugs between 2005 and 2013.

The Calderons did not have a license to engage in wholesaling pharmaceuticals and allegedly used their Florida-based corporation, All Technician Specialty, Inc., to launder money from the sales of contraband pharmaceuticals to a previously charged co-defendant Jorge Castillo. In 2013, authorities arrested Castillo for involvement in the scheme and Castillo is now serving 25 years in prison.

According to the investigation, the couple used illegal profits to purchase homes in Naples and Miramar for hundreds of thousands of dollars each. At the time of the arrests, the MFCU seized the Miramar property pursuant to Florida's civil racketeering laws.

Francisco and Zulima Calderon each face one count of trafficking in contraband prescription drugs, Medicaid fraud, organized scheme to defraud, and money laundering, all first-degree felonies. Each count is punishable up to 30 years in prison. The Attorney General's Office of Statewide Prosecution is prosecuting the case.

The Calderons are the 37th and 38th persons charged or convicted since 2010 by the Attorney General's task force targeting Medicaid-related drug diversion. Since 2010, the task force has seized close to $10 million in cash and property, and more than $7 million of contraband pharmaceuticals off the streets. Additionally, task force investigators assisted law enforcement efforts in similar cases in New York, New Jersey, Ohio, Tennessee, and Puerto Rico. The combined amount of fraud perpetrated by these individuals in Florida is estimated to be more than $250 million.

Kim Jones

The supervisor of targeted case management services at PlayBig Therapy was arrested for allegedly defrauding the Florida Medicaid program out of more than $12,000. According to the MFCU investigation, while supervising and billing targeted case management services at PlayBig Therapy, Kim Jones, 53, also held full-time employment at the Florida Department of Highway Safety and Motor Vehicles (DHSMV).

The MFCU investigation revealed that Jones allegedly did not provide many of the services billed to Florida Medicaid. Further, analysis of Jones' DHSMV computer and time card submissions revealed that on numerous occasions, Jones left DHSMV after only a few hours of work but submitted time cards as if working all day. Jones' PlayBig Therapy service logs corroborated this activity.

Jones pleaded no contest to grand theft charges. She was sentenced to five years' probation and ordered to pay $13,100 in restitution and other costs. The Attorney General's MFCU investigation is ongoing and further arrests are anticipated.

Maria Navarro and Judith Benech

The Attorney General's MFCU, U.S. Immigration and Customs Enforcement's Homeland Security Investigations, and the Seminole County Sheriff's Office arrested two Seminole County women for allegedly defrauding the Medicaid program out of more than $4 million. Maria Navarro, 44, owner of Angels Creative Children's Therapy, and office manager, Judith Benech, 37, allegedly billed Medicaid for behavioral therapy services for disabled children that the defendants never provided.

The MFCU began investigating Benech and Navarro after receiving information from the parent of a Medicaid recipient, who noticed an unusually high amount of Medicaid billings on their explanation of benefits. According to the investigation, the defendants billed eight hours a day for services supposedly provided by a school that is not open long enough for such billings. A review of billing records revealed that Angels Creative Children's Therapy allegedly inflated the Medicaid invoices to reflect eight hours of one-to-one therapy per child every day when the children rarely, if ever, received such therapy. Not only did Angels Creative Children's Therapy allegedly fail to provide vital therapy to the children, but also significantly over billed for the services not provided, drawing millions from Medicaid resources.

Benech and Navarro each face one count of Medicaid provider fraud and one count of organized scheme to defraud, both first-degree felonies. If convicted, Benech and Navarro face up to 30 years in prison and more than $59,000 in fines and restitution. The State Attorney's Office for the Ninth Judicial Circuit will prosecute the case. Attorney General Pam Bondi's MFCU and U.S. Immigration and Customs Enforcement's Homeland Security Investigations investigated the case.

Alashi Denise Lurry

The MFCU, with the assistance of the Gadsden County Sheriff's Office, arrested a former Gadsden County Florida State Hospital employee for alleged physical abuse of a disabled patient. Following an altercation, hospital staff allegedly physically removed the defendant, Alashi Denise Lurry, 29, from a disabled patient's room. According to the MFCU investigation, Lurry repeatedly returned to the patient's room, climbed on the bed and kicked the restrained patient on the head and face.

Lurry pleaded no contest to felony battery – great bodily harm, a third-degree felony. She was sentenced to two years' probation, 30 days jail work camp, and anger management counseling.

Haymee Hernandez

The MFCU and the Miami-Dade County Police Department arrested a former nursing home employee for exploitation of the elderly and disabled. Haymee Hernandez, 49, is a former employee at Claridge House Nursing and Rehabilitation Center, a nursing home located in North Miami.

According to the MFCU investigation, while employed at the facility, Hernandez allegedly took ATM cards belonging to three elderly and disabled residents and spent more than $13,000 without the knowledge or consent of the residents. The facility terminated Hernandez's employment.

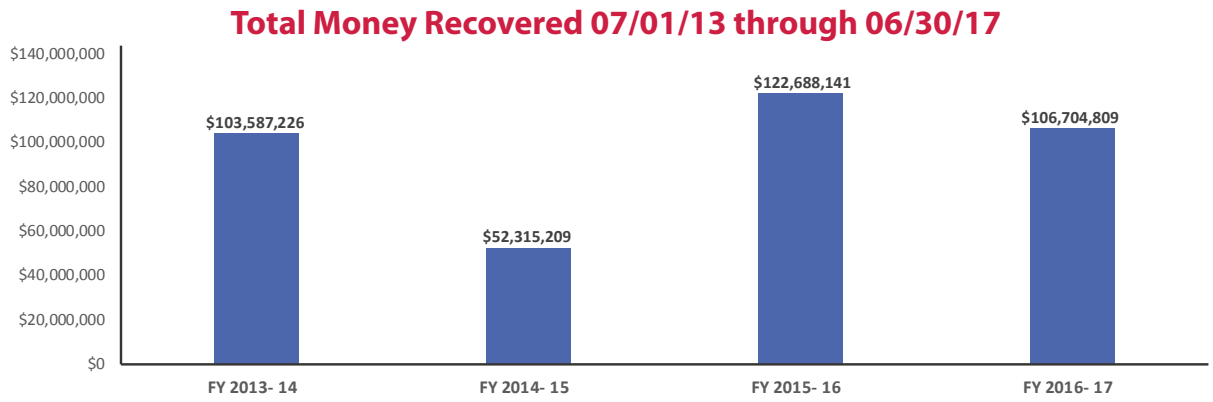
The defendant was accepted into Deferred Prosecution and agreed to complete 100 hours of community service, one-year probation, and to pay court costs and restitution in the amount of $4,796.

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 2016-17, the total amount for civil recoveries, which include civil settlements arising from qui tam cases brought under Florida's False Claims Act, was $45,756,741. The total amount for criminal recoveries based upon Medicaid fraud cases was $60,948,068. The total amount of the monies recovered by the MFCU for FY 2016-17, was $106,704,809.



Training

MFCU continues to emphasize mission critical training to stay professionally current. During FY 2016-17, MFCU staff attended a total of 3,425 hours of training.

The Office of the Attorney General continued to offer many career and personal enhancement training opportunities via webinars, video conferences, and classroom settings. Law enforcement personnel continued to obtain most of their mandatory training for recertification online with FDLE, free of charge. Other courses include training for Techniques for Financial Investigations, database searches for FMMIS Claims Analysis, Managed Care, Crime, Money, the Web, Criminal Justice Information Services (CJIS) Certification, and other courses offered by AHCA and FDLE.

In-house training provided through a variety of delivery methods included courses such as Leadership/ Supervision and Performance Evaluation, Ethics, Electronic Discovery, Statewide Managed Care, Public Records, and Workplace Law and Policy. Classroom and range firearms qualification and Use of Force training were provided to our law enforcement personnel locally by MFCU certified instructors at no cost.

MFCU training in FY 2016-17, included Elder Abuse and Financial Exploitation, Facebook Investigations for Law Enforcement, Cellular Telephone Investigations, Fundamentals of Search and Seizure, 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, the U.S. Department of Health and Human Services (HHS) Secretary Kathleen Sebelius granted the Florida MFCU a waiver of a portion of 42 CFR 1007.19, allowing Federal Financial Participation (FFP) in data mining activity. Data mining refers to the practice of electronically sorting Medicaid Management Information System's claims through statistical models and intelligent technologies to uncover patterns and relationships contained within the Medicaid claims activity and history to identify aberrant utilization and billing practices that are potentially fraudulent. The waiver, initially granted for a duration of three years, limited the amount of MFCU staff time to be utilized on data mining, and required submission of a detailed plan describing how the MFCU would ensure its data mining efforts were coordinated with, and not duplicative of, those efforts of AHCA. 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 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, 2017, the MFCU has submitted 94 data mining projects to AHCA for review and approval. Of the 94 submitted, 68 were approved by AHCA. On June 30, 2017, MFCU had 13 cases and one complaint in an active status from these projects. For FY 2016-17, one arrest was made and there were three convictions resulting in recoveries of $169,153.

Health Care Fraud Prevention and Enforcement Action Team (HEAT)

In May 2009, HHS 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 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 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 that 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 US Social Security Administration (SSA) regarding medical treatment and condition of SSA disability benefits of applicants and recipients; and made false statements to the US Citizenship and Immigration Services regarding the status, medical treatment, and medical condition of applicants for immigration benefits.

The Florida MFCU has been an active participant in the federal Health Care Fraud task force. MFCU specially assigned a team of investigators, an analyst, and prosecution staff, and achieved an unprecedented number of convictions and successes during FY 2016-17; illustrated in the chart below.

HEAT Team Cases and Outcomes

Case Name	Defendant	Arrest Date	Conviction Date	Sentencing Date	Total Recovery	Prison	Probation
Fernando Mendez-Villamil	Fernando Mendez-Villamil	01/08/16	05/10/16	07/22/16	$50,697,081.00	151 months	3 years
Fernando Mendez-Villamil	Arnaldo O. Jimenez	01/08/16	6/16/16	07/22/16	$248,311.00	6 months	3 years
Florida Pharmacy, Inc. 2	Maria Serrano	10/20/16	12/09/16	02/17/17	$1,213,306.00	30 months	3 years
Florida Pharmacy, Inc. 2	Zugeilys Castillo	09/28/16	01/12/17	04/28/17	$2,602,997.00	40 months	3 years
Florida Pharmacy, Inc. 2	Annia Marrero	09/28/16	01/12/17	04/28/17	$2,603,097.00	24 months	3 years
Norma Alicia Casanova	Norma Alicia Casanova	10/25/16	02/15/17	05/03/17	$37,125.00	12 months	3 years
La Reina ALF	Osniel Vera	10/25/16	02/15/17	05/03/17	$9,920.00	12 months	3 years
Orozco Blanca	Orozco Blanca	10/25/16	02/23/17	05/10/17	$46,300.00		3 years
Paradise Adult Care	Yeny De Erbiti	10/26/16	02/15/17	06/21/17	$22,500.00	12 months	3 years
PM Adult Home Care	Dianelys Perez	10/25/16	02/23/17	05/10/17	$7,200.00	8 months	3 years
Rodriguez Jorge	Jorge Rodriguez	10/25/16	03/29/17	6/21/17	$11,700.00	12 months	3 years
Senior Palace ALF, Inc.	Marlene Marrero	10/25/16	04/05/17	06/28/17	$64,000.00	12 months	3 years
Rene Vega	Rene Vega	10/25/16	03/30/17	05/30/17	$28,380.00	12 months	3 years

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 $26 billion state and federal partnership that provides for health care to over 4.1 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, 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 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 the Agency) responsibilities such as prior authorization, utilization management, and program and provider monitoring that occurred under FFS, became primarily the responsibility of the health plans. The transition of Medicaid to a predominantly managed care program provides the Agency an opportunity to competitively bid for Health plan services, develop contract standards for quality and access, and focus more efforts on monitoring activities, which directly impact the Agency's efforts in combatting potential fraud and abuse in the Medicaid program.

The Division of Medicaid has adopted a strategic approach to combatting fraud and abuse. Developing and implementing the SMMC program allowed the Agency to adopt a ground up approach to combat fraud and abuse by embedding control efforts into the transition and future infrastructure of the program. These strategic control efforts are focused in three key areas: Provider Enrollment/Review, Provider 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 have a background screening that is conducted through the Care Provider Background Screening Clearinghouse (Clearinghouse). Medicaid also monitors and prepares a quarterly report of terminated Medicaid providers, and has taken steps to improve provider accountability, and to increase provider enrollment requirements. In addition to the measures taken to monitor and evaluate all Medicaid health care providers, Medicaid also requires all Medicaid health plans to credential and re-credential all providers in their network using Agency-approved, written criteria.

Centralized Background Screening

Florida Medicaid provider background screenings have been conducted through the Clearinghouse since 2013. The Clearinghouse conducts Level 2 background checks, 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. All Medicaid providers, including Medicaid FFS providers and Medicaid health plan network providers, are required to be screened through the Clearinghouse. The Clearinghouse provides a single data source for background screening results of persons required to be screened by law for employment in positions that provide services to children, the elderly, and people with disabilities. Fingerprints are retained in the Clearinghouse for five years, which enables a provider to be automatically notified of an arrest of their employee as soon as the information is reported to the Agency by the 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 (MFAO) is responsible for reviewing eligibility for all Medicaid provider initial and renewing 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 MFAO in better screening and monitoring of Medicaid providers and include:

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

- In-Person Provider Review - Provider types that are deemed a moderate or high-risk for fraud and abuse must be reviewed in person by Medicaid staff prior to enrollment in the program.

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

- License Compliance - The Agency holds weekly coordination meetings between Medicaid, HQA, Medicaid Program Integrity (MPI), and 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 leverages automated verification of National Provider Identifiers (NPI) 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 Florida Medicaid Management Information System (FMMIS). 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 NPI 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), the Agency's 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 analyze 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 the credentialing and re-credentialing of its provider network. The plans' credentialing and re-credentialing policies and procedures are established by health plan contract as outlined in the SMMC 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 its scope of authority;
- A process that provides for the verification of the credentialing and re-credentialing criteria required under the contract;
- Approval of new providers;
- Imposition of sanctions, termination, suspension, and restrictions on existing providers; and
- Identification of quality deficiencies that result in the health plan's restriction, suspension, termination, or sanctioning of a provider.

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

- A copy of each provider's current medical, 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 (Title 42 of the Code of Federal Regulations (CFR) 455.104), business transactions (42 CFR 455.105), and conviction of crimes (42 CFR 455.106);
- Evidence of a satisfactory Level 2 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 (UM) process, or individual authorization process to obtain necessary services.

In addition, the contract must prohibit the provider from seeking payment from the enrollee for any covered services provided to the enrollee within the terms of the contract. The provider contract must also include several reporting and practice oversight provisions. The contract must:

- Specify that any claims payment be accompanied by an itemized accounting of the individual claims included in the payment;
- Require an adequate record system be maintained for recording services, charges, dates, and all other commonly accepted information elements for services rendered to the health plan;
- Require that records be maintained for a period not less than six years from the close of the contract, and retained further if the records are under review or audit until the review or audit is complete. Prior approval for the disposition of records must be requested and approved by the health plan if the provider contract is continuous;
- Require the provider to cooperate with the health plan's peer review, grievance, quality improvement and UM 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 in accordance with the requirements of Section VIII.E.;

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

The Streamlined Credentialing Project

The Agency recognizes that credentialing requirements can create an administrative burden on the health plans and providers who participate in multiple health plans. Since 2015, the Agency has utilized the Streamlined Credentialing Project, a process wherein the Agency performed the basic credentialing functions on behalf of the health plans. Providers can submit a limited enrollment application online via the Medicaid Public 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. Providers submit their identifying information once to Medicaid through the streamlined credentialing and limited enrollment process, eliminating the need for providers 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, but can 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 plan's network. 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 can lead to fraud and abuse. Medicaid offers many educational resources to providers and, as part of the contractual agreement with all health plans, the plans are responsible for providing education and training to

their network providers to prevent fraud and abuse and have a monitoring plan in place for fraud prevention. The following highlights many of the education and outreach efforts conducted by Medicaid in FY 2016-17 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 training 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 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 plans are 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 plans are also required to provide training and education to providers regarding the plans' enrollment and credentialing requirements and processes, and for one year following the implementation of the contract. The plans are required to conduct monthly education and training for providers regarding claims submission and payment processes, which must 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 Claims Act;
- The penalties and administrative remedies for submitting false claims and statements;
- Whistle-blower protections under federal and state law;
- The entity's role in preventing and detecting fraud, 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 the hospital admission for medical necessity prior to the admission and determined the need for ongoing care. As health care has grown more complex, the need for UM 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 UM approach.

Florida Medicaid has historically employed several methods for UM 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 UM 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 UM for the remaining FFS population. The following sections provide a brief overview of the UM 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 care being provided is necessary and appropriate. Similar to, but distinct from UM, 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 PDL, though providers may request drugs not on the PDL when medically necessary. Florida Medicaid's PDL typically provides enough alternatives to allow several options to meet recipients' needs. Medicaid has a Pharmaceutical and Therapeutics Committee that makes recommendations to the Agency for the purpose of developing and maintaining the Florida Medicaid PDL. The committee performs ongoing scheduled review of the PDL with continued updating of prior authorization and step therapy protocols for drugs not on the PDL. The committee may recommend prior authorization protocols for Medicaid-covered prescribed drugs to ensure compliance with clinical guidelines, for indications not approved in labeling, and for prevention of potential overuse, misuse, or abuse.

Data Analysis

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

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

SMMC Health Plan Utilization Management

SMMC Contractual Provisions and Plan Responsibilities

Utilization management in SMMC is primarily the responsibility of the Medicaid health plans. The Agency's contracts with the health plans require each plan have a UM program in place. Each health plan's UM 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 UM 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 has to ensure that applicable evidence-based criteria is utilized with consideration given to characteristics of the local delivery systems available for specific members, as well as member-specific factors, such as member's age, co-morbidities, complications, progress in treatment, psychosocial situations, and home environment. The health plan must also ensure that reimbursement for UM activities are 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 UM system, health plans are required to have automated authorization systems and may not require additional paper authorization as a condition for providing treatment. The health plan's service authorization systems must provide written confirmation of all denials, service limitations, and reductions of authorization to providers, the authorization number, and effective dates for authorization to providers and non-participating providers. The health plan cannot delay service authorization if written documentation is not available in a timely manner, but the plan is not required to approve claims for which it has received no written documentation. As part of the authorization system, health plans are required to have a toll-free provider help line that must be staffed 24 hours a day, seven days a week (24/7) to respond to prior authorization requests.

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

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 plans are 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 24/7 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 Medicaid pharmacy services provided to the FFS population are both appropriate and cost effective. Medicaid also has point-of-sale monitoring available to track medication usage and has thousands of claims edits in place to automatically prevent inappropriate expenditures. The system of automated claim edits is continuously refined and improved to support safe prescribing, adherence to the PDL, and prevention of fraud and abuse. In FY 2016-17, the contracted prescription benefit manager vendor processed almost 2.4 million FFS pharmacy claims, more than 197,000 per month.

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

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 risks 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 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 UM 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. They are discussed in the Utilization Management of Home Health Services section 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 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 whether a request is to be approved or denied.

The following chart shows the total number of prior authorization requests received in FY 2016-17 for the Medicaid FFS pharmacy program.

Pharmacy Prior Authorization Requests FY 2016-17		
Total Prior Authorization Requests	36,839	100.0%
Average Per Day	101	--
Total Requests Approved	34,499	93.6%
Total Requests with Change in Therapy	2,232	6.1%
Total Requests Denied	108	0.3%

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., from FY 2010-11 through 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. During FY 2016-17, the Agency re-procured the contract with Centric Consulting, Inc., as the vendor for continuation of electronic visit verification services from FY 2017-18 through FY 2019-20. 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).

Home Health Visit Prior Authorization

One of the primary areas where Medicaid continues prior authorization for FFS recipients is for home health visits. The Agency's vendor, eQHealth Solutions, Inc., (eQHealth), conducts prior authorization for home health visits to ensure that the proposed services are medically necessary and appropriate. During FY 2016-17, eQHealth conducted 7,276 home health prior authorizations, an average of 606 per month. Of these, an average of 7,092 were approved giving a denial rate of 3.6 percent. The following table shows the total number of home health prior authorization requests, approvals, denials, and denial percentage for each month during FY 2016-17. 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 2016-17 for Medicaid Home Health services.

Home Health Prior Authorization Requests FY 2016-17	
Total Visits Requested	7,276
Total Reviews Completed	7,092
Approved	6,836
Denials	256
Denial %	3.6%

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, which provides UM 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 PDN services, provided to recipients receiving home health care, match the needs of the recipients. During FY 2016-17, the vendor conducted 1,023 home health visits and 4,880 care coordination visits and team meetings.

The vendor provided the Agency with a utilization report of the home health agencies that routinely submit requests that are well above the average for their area. This information is reviewed by MPI to determine if an investigation is warranted. The following are the results for FY 2016-17.

Comprehensive Care Monitoring FY 2016-17 Statewide		
1,023 Total On-Site Home Visits to Recipients		
Recipients with Fully Approved Requests	856	83.67%
Recipients with Fully Denied Requests	23	2.25%
Recipients with Partial Approval	135	13.20%
Reconsideration is Complete	7	0.68%
At Fair Hearing	0	0.00%
At Reconsideration	2	0.20%

Ancillary Medicaid and Other Services

The Agency contracts with eQHealth for comprehensive UM of several ancillary Medicaid services, as well as hospital inpatient services in the FFS population. The UM 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 that are not covered or not medically necessary in the following categories:

- 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 2016-17, the Agency contracted 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 UM of outpatient diagnostic imaging services. The vendor utilizes real-time predictive modeling and evidence-based criteria in the decision-making process. This prior authorization UM process facilitates increased efficiency and cost effectiveness, and ensures that Medicaid recipients receive the most clinically appropriate advanced imaging services according to approved clinical guidelines. Advanced diagnostic imaging procedures include:

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

Outpatient Diagnostic Imaging Prior Authorization Requests FY 2016-17		
PA Requests Received	22,011	--
Ineligible for Review	1,290	5.86%
Completed Reviews	19,335	--
Referred for Physician Review	938	4.85%
Reviews Denied	91	0.47%

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 generated almost $104 million in reimbursements for participating school districts. During FY 2016-17, Agency staff monitored all participating school districts quarterly to increase compliance with program policy and procedures.

Medicaid Program Integrity

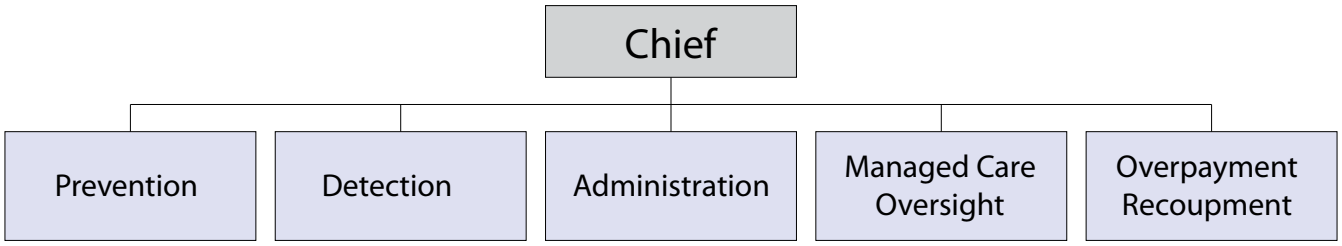
Organizational Overview

The Bureau of Medicaid Program Integrity (MPI or Bureau) is located within the Office of Inspector General (OIG). There were no significant organizational changes for MPI during Fiscal Year (FY) 2016-17, and details about the organization are described within several prior year reports. During FY 2016-17, MPI endeavored to improve processes, increase productivity, and continue to prepare for the future of program integrity as the Medicaid program evolves.

MPI continues to serve as the primary office within the Agency for Health Care Administration (AHCA or the Agency) 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 Medicaid provider oversight program to ensure that fraudulent and abusive behavior occurs to the minimum extent possible in the Medicaid program. Additionally, MPI recovers Medicaid overpayments, imposes sanctions for violations against the Medicaid program, 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.

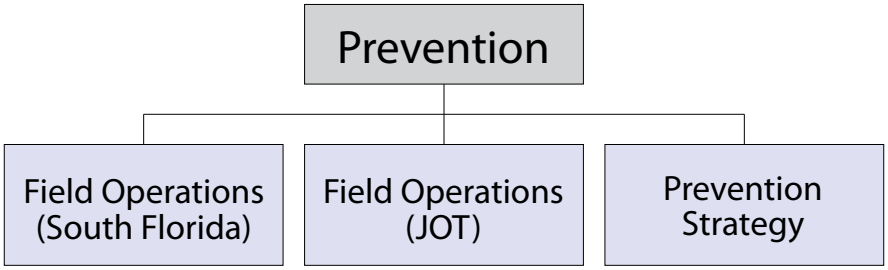
During FY 2016-17, MPI emphasized an internal examination of processes, especially those, which identify behaviors of individuals engaged in practices that result in misspent funds and abusive practices. Improved investigative planning processes focused efforts, limited false positives, and increased efficiency. Detection and prevention processes moved beyond a singular focus on Medicaid claims data to an examination of social, economic, and societal risk factors that highlight potentially abusive provider behaviors. The broad use of available data from a variety of sources has assisted MPI in identifying suspected fraud and abuse, which allows efforts to be focused on the more egregious program vulnerabilities. These efforts have been ongoing simultaneously with traditional detection and recoupment efforts to collect overpayments. Through these improved internal processes and systems, MPI endeavored to increase productivity and improve its return on investment.

MPI's efforts to prevent, detect, and audit fraud, abuse, and waste, align with the organizational units within MPI, depicted in the following graphic. MPI's internal organization is optimized to prepare for future vulnerabilities to the Medicaid program.



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

Prevention



The Prevention Unit consists of three subunits with responsibilities for prevention activities in designated geographical areas in Florida. The Tallahassee-based subunit is also responsible for strategic planning and other specific prevention-related investigative activities. The subunits 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, 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 (focused project). Focused projects are data-driven field initiatives designed to address identified program needs and vulnerabilities and may include staff from various state and federal regulatory agencies.

MPI utilizes on-site visits to discern whether the circumstances of the suspected or reported allegations are more of the nature that warrants law enforcement intervention, termination from the Medicaid program, or an audit to recover overpayments. Field operations are aimed at this high standard to ensure that even where the suspected abuse is not substantiated, the lesser product (waste or overpayments) may be discovered and result in the recovery of overpayments and imposition of administrative sanctions due to non-compliance with Medicaid policy. 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 subunit for further investigation and potential referral to the Medicaid Fraud Control Unit (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 assisting MPI operations through the development of referral and audit leads, these field activities increase MPI's presence in the provider community. 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 investigations for MFCU referrals; subsequent investigations for the imposition of payment restrictions and sanctions; and project development for potential audit referrals to other MPI units. The Prevention Strategy subunit 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 subunit also has responsibilities regarding MPI process and organizational assessments to ensure that MPI engages in routine improvements.

Increasing Return on Investment through Prevention Measures

MPI, along with internal Agency partners and external partners, engages in a variety of activities best categorized as fraud, abuse, and waste prevention. These activities involve early detection (of fraud, abuse, and waste) and avoidance of ongoing loss. In the realm of health care (in the context of disease and other health-related factors), prevention is considered "the best medicine". However, the value of fraud prevention is often difficult to calculate. If the amount of the loss that was prevented is readily known (which, in some instances is the case), it has historically been calculated and reported as a part of the cost avoidance or prevention return on investment (ROI). For example, the value of a Medicaid claim for reimbursement found to be improper and denied before payment is processed, has a quantifiable value (the value of the claim). However, the value of most prevention activities are not as easily calculated. Often, these efforts are not valued or are undervalued for purposes of measuring ROI.

A provider on-site inspection may identify current program policy violations (for which recoupment of overpayments may be had), and also encourage a provider to remedy practices to avoid future violations. Collaborative efforts with other regulatory and law enforcement agencies may result in the other agencies identifying and referring problematic providers, which would not have otherwise been detected, or would have been detected much later through traditional methods, to MPI. Referrals to other regulatory or law enforcement agencies where the other agency is in a better position (by way of legal authority) to enact change – either through corrections to the provider's behavior or determinations that result in the provider ceasing to participate in the program – also serve as a cost-avoidance (prevention) activity that is not readily quantified. In an effort to calculate a value for many of these activities, MPI looks to a number of sources for guidance.

The Association of Certified Fraud Examiners (ACFE), an international anti-fraud organization committed to reducing the incidence of fraud and white-collar crime through training and education of its members, suggests focusing less on the precise value of the prevention efforts and more on the concept that prevention efforts positively impact a company's bottom line.[2] The suggestion includes data from a variety of resources, which concludes that losses due to fraud are doubled when an organization lacks anti-fraud controls. The ACFE focuses on both external fraud (committed by customers, vendors, and other parties), as well as internal fraud (committed by employees, managers, officers, or owners of a company). This internal fraud is also called occupational fraud. Many of the methods of committing and concealing occupational fraud relate to fraud schemes historically identified within the context of health care provider fraud and abuse. Therefore, the analysis of these schemes, including the methods of prevention and deterrence, as well as the perceived value of these activities, is relevant to the discussion of the MPI prevention ROI.[3] Even if the value of any given prevention activity was a mere tenth of a percent of the overall program expenditures, the cumulative value of the efforts would be staggering.

A history of the growth of the Medicaid program further emphasizes the need for a robust fraud and abuse prevention program. In 2000, the Florida Medicaid program was an approximately $9 billion health care program serving approximately 2.5 million Floridians.[4] During FY 2001-02, the Agency began aggressively overhauling its program integrity functions. An integral aspect of these efforts was an internal refocus on the responsibility for fraud and abuse efforts. This began a shift in strategy to ensure all Agency resources were utilized in the fight against fraud. The Agency began to implement coordinated efforts among multiple organizational units. While MPI continued (and continues) as the organizational unit with the primary responsibility for minimizing fraud and abuse, the Agency began to recognize that other internal organizational units had to have a significant role in the fight against fraud and had to play a greater role in the efforts toward increased provider compliance.

Footnote 2: See, generally, ACFE resources at acfe.com and specifically, *Selling Fraud Prevention to Management*, March 2014.

Footnote 3: Although the Agency is not a company in the same sense as a typical business combatting fraud (both internally and externally), and a government regulatory agency is neither a typical organization, nor engages in the type of business that lends itself to the same levels of asset misappropriation as would be a vulnerability for a commercial enterprise, the lessons from professional organizations such as the ACFE may assist with the valuation of MPI's prevention activities. Understanding the typical value of these losses demonstrates the need for continued commitment to prevention activities. Occupational fraud, as reported by the ACFE in the *2016 Report to the Nations* is estimated to involve losses of 5% of annual revenues for the typical organization.

Footnote 4: Here and elsewhere in this section, the data or statistical references were obtained from the specified years' report entitled The State's Efforts to Control Medicaid Fraud and Abuse, also known as the Agency's fraud report.

In 2002, the Division of Medicaid increased the emphasis on compliance monitoring and analysis of trends within programs to assist in the efforts to minimize fraud and abuse to the greatest extent possible. These efforts were a first of its kind in both Florida and nationally, where a state Medicaid program was itself taking a very proactive approach to maximize prevention efforts. Additionally, in 2002 and 2003, the Division of Medicaid implemented significant fraud control measures, which included matching provider exclusion data from the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG). During that same period, the Agency increased scrutiny of managed care provider networks and Health Maintenance Organization (HMO) policies regarding fraud prevention. Other Agency activities included the start of rule development to allow for a comprehensive provider sanctioning process.

FY 2002-03 brought a significant increase in coordination between the Divisions of Medicaid and HQA to further the efforts to reduce fraud and abuse in the Medicaid program. In addition, the Bureau of Financial Services developed a new system to track outstanding receivables. By this time, Medicaid had become a $13 billion program. During this timeframe, substantive programmatic prevention initiatives were developed and implemented by the Division of Medicaid specifically to minimize the risk of loss due to provider noncompliance, as well as fraud.[5] Prior authorizations, increased pre-enrollment on-site reviews, increased monitoring of high-risk programs, further managed care initiatives, and numerous pharmacy control initiatives were put in place, which demonstrated the Agency's commitment to utilize its full resources for these joint prevention efforts. Additionally, these efforts have significantly increased the amount and quality of referrals made from Division of Medicaid staff to MPI.

Over the next several years, AHCA continued its coordination with other federal and state agencies, and focused on its internal communications to better increase compliance and deter fraud in the health care provider community. There was an increased focus on managed care, as well as the provider types that require a license regulated by AHCA. Additionally, Medicaid began designing a system to capture encounter data for all Medicaid managed care plans for all services.[6] The Division of Medicaid also increased its communication and coordination with MPI by establishing protocols for selecting providers to monitor and, as appropriate, refer to MPI for further investigation. There was also an increase in collaboration regarding recommendations for policy changes to reduce the potential for fraud. The Agency also increased its focus on high-risk provider types and MPI took on several initiatives related to suspect providers; the Division of Medicaid has carried the initiatives forward with increased standards for enrollment, ongoing oversight and monitoring with regard to these high-risk providers, and increased efforts to implement comprehensive compliance education and monitoring. There was also a significant increase in collaboration internally among the various organizational units in the Agency, not only with regard to increased referrals to MPI, but also the development of program safeguards by way of licensure regulations.

In the 2009 Legislative Session, Senate Bill 1986 (Law of Florida, Chapter 2009-223) amended several sections of law, administered by multiple agencies, to address health care fraud. As a result, several new initiatives were implemented, existing projects were enhanced, and the Agency's overall strategies to detect and deter fraud were refined and improved. These enhanced processes impacted every division and every bureau in AHCA, and once again demonstrated that fraud prevention initiatives, specifically those geared toward provider non-compliance, are not the responsibility of any one agency, or that of a single bureau.

During the years that followed, the Division of Medicaid began a comprehensive shift in payment methodologies, and by the end of 2014, the Medicaid program transformed from a predominately fee-for-service model to a managed care model of service delivery. With this shift, prevention efforts across all aspects of the Agency continued to be necessary. While operational functions continue to evolve in order to align with the programmatic changes, prevention activities have continued to be comprehensively integrated into those programmatic changes in order to continue to be effective. The comprehensive approach, where compliance efforts and fraud prevention is everybody's business, remains the most effective avenue to ensure that with the programmatic changes, effective safeguards continue, and new safeguards are developed.

Footnote 5: Please note that program integrity issues are often labeled as fraud, abuse, and overpayments. It should be noted that regardless of the term used, all misspent funds are overpayments – whether the result of fraud (intentional), abuse (noncompliance), or mistake. The focus of this unit has always been non-fraudulent noncompliance.

Footnote 6: Encounter data is the term used to reference a claim related to a managed care encounter.

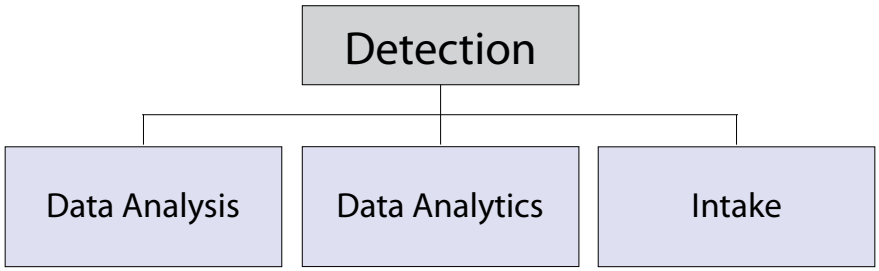
Fraud prevention is ~~my~~ everybody's business.

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

1. Conducting outreach activities with internal and external stakeholders to aide in their awareness and efforts to ensure provider and health plan compliance.
2. Coordinating with health plans to aide in fraud prevention efforts, including reviews of their provider networks for ineligible providers, discussions of fraud prevention and detection techniques/ methodologies, providing a forum for discussions of best practices, and coordinating and facilitating periodic meetings with health plans, MFCU, and MPI regarding fraud prevention and best practices.
3. Development of relationships with other entities, whose efforts can aid in the fight against fraud, including coordination with other federal and state agencies, and facilitating strong and consistent internal communications.
4. Monitoring high-risk programs and provider types to aid in the development of training, as well as to serve as a deterrent; additional results include increased referrals to MPI from Division of Medicaid personnel.
5. Analyzing trends within programs/provider types/service types to assess high-risk issues and engage in strategic planning of MPI and Agency efforts.
6. Facilitating and participating in the review and amendment of the Agency's policies (e.g., HMO contracts, provider handbooks, etc.) as it relates to fraud prevention and increasing compliance.
7. Implementing and conducting pre-payment reviews of providers in conjunction with provider contract terminations.
8. Coordinating and facilitating activities specific to assisting in the prosecution of fraud; such activities may involve policy confirmation/clarification, witness coordination/preparation, and serving as an expert witness.
9. Coordinating and facilitating activities related to the review and amendment of Agency systems and processes in order to increase effectiveness of fraud prevention and detection efforts.
10. Facilitating/aiding in the use of encounter data in fraud prevention and detection efforts.
11. Ensuring effective communication between the Division of Medicaid and MPI.
12. Coordinating efforts regarding the Agency's Fraud Steering Committee, an internal working group designed to ensure comprehensive and continuous Agency anti-fraud efforts, including co-leading the subcommittees.
13. Coordinating and assisting other Agency personnel with issues related to fraud, abuse, and compliance.
14. Conducting provider on-site inspections and provider audits, which furthers deterrence and prevention activities.
15. Engaging in managed care plan oversight activities related to program integrity efforts of the health plans, as well as comprehensive assessment of activities that impact the detection and prevention of fraud, abuse, and waste within managed care.
16. Conducting appropriate preliminary investigations and, as appropriate, making referrals to other agencies, including MFCU, DOH, DCF, and Department of Financial Services (DFS).
17. Identifying instances of suspected fraud and abuse, conducting appropriate investigations, and imposing payment restrictions to protect program funds against further fraud and abuse.

While MPI, with help from others, will continue to endeavor to increase prevention activities (and thus, necessarily, detection and recovery activities), it is critical to understand how greatly understated the value of prevention activities are in these, and other, reports; particularly the value of fraud referrals to MFCU and the coordination and consultative role of MPI within the Agency. During FY 2017-18, MPI will be placing particular focus on developing a process to measure the value of these and other prevention activities. Such measurement processes may include calculating the average amount of recovery of Medicaid monies from MFCU prosecutions that were referred by or coordinated with MPI or calculating the level of improvement (e.g., reduced overpayments) of providers during subsequent reviews (e.g., audits, on-sight inspections, pre-payment reviews) by provider type and projecting a value across the provider type for the deterrent effect. As new processes are developed to quantify the significant value of prevention activities in combatting fraud and abuse in the Medicaid program, MPI continues to strive for further awareness (both internally within the Agency and externally) that fraud prevention is everybody's business.

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 Analysis

The Data Analysis subunit is comprised of a team of analysts with knowledge in statistical programming and modeling, database coding, and health data analysis. Additionally, the team has experience visualizing complex datasets, including the mapping of social networks and geospatial mapping and analysis. This team helps MPI develop and grow with changes in technology, including continuing work on the advanced data analytics project in FY 2016-17.

In addition to serving as a data support unit for other MPI units, the Data Analysis subunit develops sophisticated tools and analyses to identify potential fraud and overpayment leads for investigations and audits. This includes the development of complex queries and algorithms, visualizations, and statistical reviews. The team also serves as a resource for other MPI units to train and assist them with data queries and analysis techniques.

As the advanced data analytics project ended at the end of FY 2016-17, the Data Analysis subunit is preparing to develop an in-house analytics solution, leveraging a variety of data analysis software tools and Agency expertise. This effort includes filling recent vacancies in the subunit with staff knowledgeable in Structured Query Language (SQL), statistical analysis, and database integration across multiple platforms. The team is also seeking to expand access to a variety of agency and state databases to further increase insights for investigators and auditors. MPI anticipates these developments will posture the Agency to develop deeper and more meaningful audit leads, resulting in an increase in comprehensive overpayment audits, comprehensive investigations, and referrals to other agencies and external entities, including MFCU.

Data Analytics

In April 2015, MPI entered into an agreement with a data analytics vendor to procure a data analytics system. The purpose of the data analytics system was to compile, leverage, and analyze multiple datasets that could be processed through the data analytics system to produce investigation-ready leads, which would be sufficient for audit, pre-payment review, outside agency referral, or other secondary investigation actions deemed appropriate for MPI staff to carry out. This system was procured under the assumption that an outside vendor had the capabilities that were not currently available to the state, including server capacity, maintenance, staffing resources, and analytics knowledge. The contract stated that the vendor would provide investigation-ready leads for further review.

Contract requirements included a summary level and a detailed level of each lead. On the summary information, a scoring system was implemented for prioritizing purposes; this included the provider's demographic information, and information regarding disposition, the investigator, and the analysis range. Once inside the lead, further demographic information was available and a greater depiction of the leads that provided alerts and details were given to help the investigator substantiate the lead. Third party background information, along with the multiple datasets, were incorporated and added to the detailed provider information. Changes to the contract continued to provide enhancements throughout the project.

As the contract continued into year two and three, refinements to the system were continuously added with each new release. Thousands of enhancements were added and reviewed, as a part of the system refinements, through the life of the contract. Tickets included items such as adding, removing, or moving fields, adding new algorithms, refining existing algorithms, adding new functionalities based on contract terms, and leveraging external data sources and the fields that would be the most beneficial for the Bureau and its investigations.

The dollar amounts identified by the vendor were found to encompass the entirety of the provider's claims and did not appropriately signify those flagged that were available for an overpayment. This hindrance continued throughout the life of the contract. While MPI has identified a dollar amount attributed to the prevention activities and the overpayments, all cases have not been closed and the monies have not yet been recouped due to the detailed recoupment process. The audit leads accepted as being investigation-ready leads were established in the Fraud and Abuse Case Tracking System (FACTS) and are easily identifiable.

Through the life of the contract, eight releases produced a multitude of leads. One of the more intricate enhancements to the contract was to have the ability to export the leads at the summary level from the data system. This enhancement allowed MPI to better analyze, prioritize, and distribute the leads for review. The large volume of leads in the early releases combined with limited staff resources made sorting through the thousands of leads a burdensome process. Many of the initial releases included an excessive number of false positives.

Through enhancements and lead refinements, MPI continued to refine the leads down to a number that was more manageable in the time allotted before the subsequent releases. The releases varied from once a quarter to bi-monthly depending on the contract terms for that fiscal year.

The data analytics contract ended June 30, 2017, due to funding restrictions, which prevented the Agency from continuing a procurement for the subsequent fiscal year.

Intake

The Intake subunit receives complaints from the fraud and abuse hotline and the online reporting tool on the Agency's website, identifies leads through a variety of other resources and forwards the complaints to other units for analysis. During FY 2016-17, there was a shift in duties to increase effectiveness and to account for changes in the Medicaid program. The Intake subunit has transitioned to conducting 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 five-year look back period for Medicaid recovery audits will include the 2013-2014 claim years, which experienced the highest volume of Medicaid fee-for-service (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 subunit has developed processes for conducting preliminary investigations. To implement these extensive triage and preliminary investigation processes, the subunit 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 subunit 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 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 assessed and forwarded to the appropriate unit for investigation.

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 process is a necessary process to ensure that preliminary investigations are conducted when there is sufficient predication, and that complaints are assigned to the proper unit, 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 subunit (where there is a potential overpayment exposure);
- Referral to an MPI Prevention Strategy subunit (if there is a potential "for cause" termination, suspension, or a potential MFCU referral);
- Referral to the MPI Managed Care 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 applicable Overpayment Recoupment subunit. 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 Prevention Strategy subunit 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 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 Unit for continued monitoring of the health plan's diligence in conducting their anti-fraud investigations.

Working in conjunction with the Managed Care Unit, the Intake subunit assisted in the development of an updated Report Fraud online complaint tool for the reporting of Medicaid fraud, abuse, and waste. This updated format allows the complainant (submitter) to identify more information, attach supporting documentation, and receive acknowledgement of the receipt of the complaint.

During FY 2016-17, the Intake subunit assessed over 1,800 complaints. The chart below represents the source of the complaint and the number triaged.

Source of Complaint	Number of Complaints Received & Triaged
Fraud and Abuse Hotline	7
Agency's Online Fraud and Abuse Complaint Form (includes Medicaid health plans)	1,131
AHCA Division of Medicaid	95
AHCA Health Quality Assurance (HQA)	16
Internet / Media	132
Explanation of Medicaid Benefits (EOMB)	113
Florida Department of Health (DOH)	57
AHCA Financial Services	43
Analytics Vendor	81
Medicaid Program Integrity (MPI) - Internal	28
Florida Agency for Persons with Disabilities (APD)	4
Investigator Initiative	56
Other - Miscellaneous	50
Centers for Medicare & Medicaid Services (CMS)	34
General Public	7
Office of the Florida Attorney General, Medicaid Fraud Control Unit (MFCU)	4
Florida Department of Children and Families (DCF)	1
Federal Medi-Medi	1
U.S. Department of Health & Human Services, Office of Inspector General (HHS-OIG)	15
MPI Projects	3
Total	1,878

Certified Out of Business

Under Federal law, Title 42 of the Code of Federal Regulations (CFR) 433.318(d), the states are not required to refund to the Centers for Medicare & Medicaid Services (CMS) the federal share of an overpayment if the Medicaid provider is "out of business" or if the provider goes "out of business" before the end of the one-year

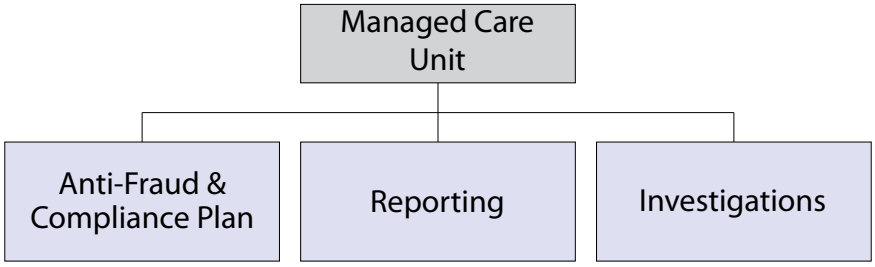
period following the identification of the overpayment. Furthermore, the provider must be deemed out of business under state law.

During the 2016 Legislative Session, state law (see SB 1370 and HB 1245) was created to address the treatment of Medicaid overpayments when a Medicaid provider is "out of business," and the identified overpayments cannot be collected. Under Sections 409.907(12) and 409.908(26), Florida Statutes (F.S.), the Agency may certify that a Medicaid provider is out of business and that any overpayments made to the provider cannot be collected under state law and procedures. This will allow the State of Florida to retain the federal share of funds that otherwise would be required to be remitted back to CMS. As a result, this legislation had the immediate potential to save the State of Florida approximately $1 million per year.

During FY 2016-17, MPI developed a process for coordination with the Bureau of Financial Services and the Division of Medicaid to identify potential out of business instances and to evaluate whether the matter met the legal parameters for treatment under the state and federal law. Immediately after development and implementation of the new processes, the Bureau of Financial Services and MPI identified more than a dozen instances for review.

The validation of the FY 2016-17 cost savings, due to the certified out of business processes, is ongoing and the figures for the initial validation follows in the MPI Data section.

Managed Care Unit



Overview

The MPI Managed Care Unit (MCU) operates similarly to a traditional program integrity model with responsibilities that align with key functions: detection, prevention, and enforcement/recoupment activities. There is a Reporting subunit with responsibilities aligned with detection, an Anti-Fraud and Compliance Plan subunit responsible for prevention activities, and an Investigations subunit dedicated to the investigation of fraud and abuse allegations where the subject is a Medicaid health plan (MHP).

Detection Related Activities

Detection is a critical aspect of program integrity. With regard to the MCU activities, detection occurs through the analysis of reports that the MHPs are required, by statute or contract, to submit to MPI. The primary reports are the Suspected/Confirmed Fraud Abuse Report (also referred to as 15-day reports), the Quarterly Fraud Abuse Activity Report (QFAAR), and the Annual Fraud Abuse Activity Report (AFAAR). The analysis of these reports serves as a detection tool related to fraud, abuse, and waste by both network providers and the MHPs themselves. Personnel reviewing these reports require knowledge not only related to Medicaid and the Statewide Medicaid Managed Care (SMMC) contract, but also the inner workings of a MHP and fraud and abuse schemes and concepts. Personnel reviewing these reports evaluate both the timeliness and accuracy of the reports and monitor the ongoing investigations by the MHPs to ensure their program integrity efforts are robust and in compliance with governing laws.

MHPs are required to report suspected or confirmed fraud and abuse within 15 days. The 15-day reports are reviewed by the MCU first to revalidate the complaint review process employed by MPI personnel in the

Detection unit, and second to ensure that the plan investigation is comprehensive, timely, and effective. The QFAAR includes updates regarding each 15-day report up through the quarter following the MHPs conclusion of their audit or investigation. QFAARs are received within 15 days of the end of each calendar quarter. Updates include investigative activities, actions, or additional discoveries. The AFAAR is an annual summary of the MHP's activities related to program integrity efforts for the state fiscal year and provides a high-level summary of the MHPs Special Investigative Unit (SIU) activities.

MPI implemented requirements to have the MHPs report additional items in the AFAAR, similar to those required to be reported in this Annual Fraud Report (see s. 409.913, F.S.). It is expected that the MHPs FY 2016-17 submission will be the first year with comprehensive data reflective of the MHPs activities. MCU will complete a full reconciliation between the Suspected Fraud/Abuse Reports, the QFAAR, and the AFAAR to ensure that reporting is complete and accurate.

During FY 2016-17, MCU staff reviewed 16 AFAARs, 64 QFAARs, and 533 Suspected/Confirmed Fraud and Abuse reports. The Suspected/Confirmed Fraud and Abuse reports received each month are depicted in the chart below.

Month	Number of Reports	Month	Number of Reports
July 2016	28	January 2017	14
August 2016	35	February 2017	49
September 2016	32	March 2017	35
October 2016	26	April 2017	60
November 2016	22	May 2017	125
December 2016	23	June 2017	84

The Suspected/Confirmed Fraud and Abuse reports received during FY 2016-17, by MHP is depicted in the chart below.

Medicaid Health Plan	Number of Reports	Medicaid Health Plan	Number of Reports
Amerigroup (AMG)	11	Molina (MOL)	48
CCP (NBD)	5	Prestige (PRS)	9
CMSN (CMS)	59	Simply (SHP)	2
Coventry (COV)	22	Sunshine (SUN)	231
Freedom (FRE)	8	United (URA)	57
Humana (HUM)	30	Wellcare (STW)	45
Magellan (MCC)	6		

Additionally, MCU staff made recommendations to the Division of Medicaid for contractual action related to the timeliness of fraud and abuse reporting for two instances of late reporting that were assessed and closed during FY 2016-17. Historically, the issue of timeliness of the Suspected/Confirmed Fraud and Abuse reports was a significant concern. However, due to the extensive efforts by both the Division of Medicaid and MPI over the past five years, the issue of untimely reporting is believed to be minimal and, as evidenced by this year's reporting, virtually non-existent. By having remedied issues regarding timeliness, MCU personnel are now able to focus on quality of referrals and investigations by the MHPs.

Prevention Related Activities

To the extent that MPI can engage in efforts to prevent fraud and abuse, particularly within a managed care environment, inexpensive efforts may have significant returns. The MCU engages in prevention through a variety of efforts, which includes reviewing the MHP's required anti-fraud and compliance plans. Additionally, the MCU develops and carries out health plan related projects, including on-site inspections or reviews focused on particular issues related to MHP compliance with program integrity requirements, as well as issues of suspected abuse. MCU projects are designed to address suspected abuse among MPHs, identify resulting overpayment recoupment issues, and then determine potential referrals, sanctions or contractual remedies,

such as liquidated damages. During FY 2016-17, the MCU engaged in two projects and conducted on-site contract compliance reviews for all MHPs.

Anti-Fraud and Compliance Plans

MHPs submit anti-fraud and compliance plans annually, and each is reviewed with the related policies, procedures, and trainings. The review of the anti-fraud and compliance plans includes a review of each MHPs' anti-fraud and compliance plan, the related policies and procedures, and related trainings.[7] The review includes compliance with substantive requirements set forth in the contract, statute, and federal law, as well as, an evaluation of the MHP's operationalization of the plan. Through these reviews, MPI is able to identify potential program risks and vulnerabilities. MPI also uses the reviews to identify areas for subsequent audit, inspection, or review of specific MHPs. These ongoing efforts to detect and prevent issues of fraud, abuse, and waste offer some level of risk mitigation for the Medicaid program. During FY 2016-17, MCU personnel reviewed 24 Anti-Fraud and Compliance Plan submissions, including the numerous related policies, procedures, and training documentation.

Subcontracts

The MCU reviews the program integrity-related subcontracts that an MHP may seek, including any aspects of the MHP SIU activities. This statutory requirement (see s. 409.91212(3), F.S.) ensures that not only is the potential subcontract reviewed for compliance with SMMC contract requirements, but also, by having MPI review these contracts, ensures that personnel with program integrity experience are reviewing the SIU subcontracts. MCU personnel use these reviews to identify potential program or health plan vulnerabilities, including aspects of the anti-fraud and compliance plans that are going to be addressed by a subcontractor. These reviews are critical because, while the MHP may transfer responsibilities for specific tasks, the MHP remains obligated to ensure that all regulations are met and the SIU functions are effective. In FY 2016-17, MPI reviewed two subcontracts.

Monitoring Related to Program Integrity

As required by federal law, MCU also monitors each MHP's program integrity efforts (see 42 CFR 438.66). The MCU conducts preliminary analysis of data pertaining to the MHP's overall compliance related to program integrity issues to create an on-site inspection tool specific to each MHP. The general focus of the on-site inspection is an evaluation of how well the MHP has implemented its anti-fraud and compliance plans and adherence to all statutes, federal regulations, or rules with relation to detection, investigation, and audit of fraud, abuse, and waste.[8] However, the extent of review in any of the categories is weighted by the perceived risk. In FY 2016-17, the MCU completed the on-site portion of the inspections for all 16 MHPs. The MCU will continue to improve the monitoring process by including additional risk-based vulnerabilities to the on-site tool, expand the program integrity review to include encounter validation, and ensure timely completion of on-site reviews and written reports.

Other Prevention Activities

The MCU also engages in a number of processes to assist with verification of information that is programmatic in nature, but which touches on program integrity issues such as overpayment, prevention, or recovery. For example, the MHPs are required to notify the Agency when they receive information regarding a recipient's date of death, and the Agency has not already stopped the capitation payments for that recipient. The MCU verifies the recipient's date of death and processes notice for appropriate actions.

Two other critical aspects of fraud, abuse, and waste prevention include routine communication and collaboration with the MHPs on issues of investigations and other program integrity matters. This ensures appropriate recommendations are made to amend the SMMC contract to continue to improve on the provisions that impact program integrity.

Footnote 7: Anti-fraud plans and Compliance plans are submitted to MPI at least annually. However, if the plans are amended, additional submissions are required and result in further MPI review.

Footnote 8: The state is required to monitor program integrity efforts of the MHPs as outlined in 42 CFR 438.66.

The MCU facilitates periodic meetings with the MHPs, appropriate law enforcement, and other government agencies. At least four of these meetings are held face-to-face each year. The meetings are investigative in nature and are not open to the public. During the meetings, specific fraud and abuse investigations are discussed. The meetings have evolved over the last few years and provide a collaborative environment for the health plans, the Agency, and other state and federal partners to share current concerns regarding providers that may be involved in schemes of fraud, abuse, and waste. The shared information assists the plans, MPI, and MFCU to conduct effective investigations. These meetings also provide a forum to discuss investigative best practices and offer a deeper insight into the processes and practices of the Agency, MFCU, and the health plans. This collaboration and developing trust among the health plans, the Agency, and MFCU aids in fighting fraud in the Medicaid program and encourages the health plans to improve their internal quality controls regarding fraud, abuse, and compliance efforts with regard to their Medicaid business lines. While this effort facilitates both detection and prevention efforts, it is more relied upon as a prevention measure. This is in part, because the forum is also used to provide peer-to-peer education, which helps to enhance processes for detecting and preventing issues of fraud and abuse.

SMMC Contract Recommendations

The MCU furnishes contract amendment recommendations for the Division of Medicaid's SMMC contract where there are perceived deficiencies or risk-mitigating opportunities identified by MPI. Having these recommendations funneled through the MCU, which has a broad-base of program integrity and managed care experience, allows for the recommended amendments to be well-written and more suitable for adoption by the Division of Medicaid. In FY 2016-17, the MCU requested 16 changes to the contract. Some of the changes recommended include:

- Provision to make reporting of waste required for the Medicaid health plans as required by federal regulation.
- Update to strengthen an existing provision, which requires the Medicaid health plans to restrict payments for different types of payment ineligibility.
- Updates to liquidated damages chart to include a provision for failure to restrict payment to providers who are ineligible for payment.

Additionally, MCU makes recommendations to the Division of Medicaid to amend the report guide tied to the SMMC contract. The MPI online fraud complaint reporting form was originally created as a mechanism for the public to report suspected fraud. When MHPs became statutorily required to report suspected and confirmed fraud and abuse to MPI, this online reporting form was the mechanism used for those submissions. However, the form was insufficient to capture details of MHP reporting. During FY 2016-17, in a joint effort between MPI's Detection Unit and the MCU, improvements and upgrades to the form were implemented. These improvements allow the MHPs to submit more robust information regarding the suspected or confirmed fraud or abuse. Additionally, the MCU was able to update the SMMC report guide chapter to accompany the changes and increase the requirements for quality referrals.

Investigation of an MHP

The MCU is also responsible for investigation of the health plans when there is an allegation of activity related to fraudulent or abusive behavior by an MHP. Traditionally this function, preliminary investigations related to provider fraud, is referred to the Prevention Strategy subunit; however, MCU conducts the preliminary investigation as it relates to a MHP. These investigations require individuals with broad knowledge of managed care plans, statutes, rules, federal regulations relating to Medicaid and Medicaid Managed care, and micro-level investigative processes and procedures.

Fraud and abuse within MHPs is not typically readily detected. The business practices of an MHP are not routinely known to the Agency without requests for specific information. The vastness of the MHPs' business practices (many operational aspects within an MHP and variations by plan) add to the complexity of fraud or abuse detection by a health plan using standard detection methods. MPI continues to modify and enhance its tools and conducts projects designed to better comprehend and detect deceptive practices by MHPs. In FY 2016-17, MCU conducted 10 individual MHP-related investigations. The investigations conducted by the

MCU were varied in topic. They included investigations for allegations that a health plan submitted falsified or altered reports to the Agency; allegations of violations of marketing practices; allegations that a plan was contracting the services of an unlicensed entity; and several others.

MHP Projects

Vulnerabilities within managed care may be passed to the MHPs, and MCU evaluates how well the MHPs address these vulnerabilities. These efforts may lead to projects, which evaluate a larger concern across the program. Other project ideas may originate from investigator initiative or publications, such as the Health and Human Services Office of the Inspector General (HHS-OIG) Annual Report, which reports on potential risks to managed care programs. The MCU conducted two focused projects on perceived areas of program vulnerability: (1) subcontracted transportation vendors and compliance and (2) MHP use of ineligible providers. The transportation vendor compliance project resulted in 11 MHP reviews, and the ineligible provider project resulted in 12 reviews. Although both of these projects were ongoing as of the end of the fiscal year, conducting the project itself may initiate corrective measures and create positive change within MHPs.

Projects result in enforcement activities. At the end of each project, MCU evaluates MHP non-compliance issues. Where appropriate, the project concludes with compliance recommendations or actions to the Division of Medicaid. Because MPI does not have the authority to issue a contractual action for the SMMC contracts (e.g., sanction or liquidated damages), recommendations are filed with the Division of Medicaid. These recommendations are followed through the Medicaid processes to their conclusion.

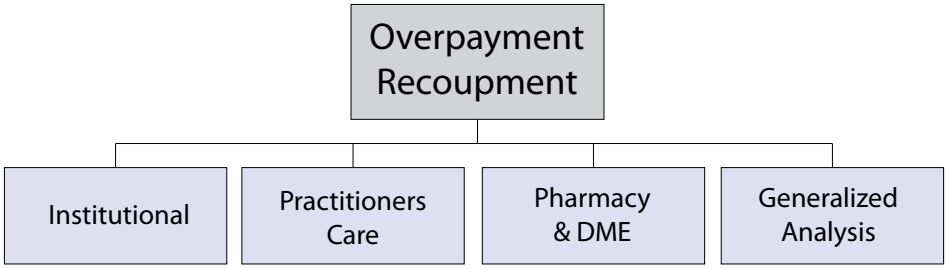
In addition to the two investigation projects, MCU conducted hospital rate reviews. During the past two years, the MCU led the efforts to complete two reviews related to compliance with s. 409.975 (6), F.S., as pertaining to negotiated rate for hospitals and managed care plans. The second review was MHP specific and addressed each of the MHPs with identified issues in the first FY 2016-17 review.[9] The FY 2016-17 review is still in process. However, preliminary results indicate significant increased compliance subsequent to these reviews.

In 2016, revisions to the federal managed care rule (see 42 CFR 438) required both operational changes for the MCU and changes to the SMMC contract. While most other revisions to the rule were anticipated and previously implemented, the most notable change relates to a requirement that the managed care contract between the Agency and the MHP must define who can and should identify and recover overpayments. The MCU has offered recommended contract language to ensure the Agency is compliant with the federal law and to increase the recovery opportunities for the MHPs. Contract amendment language has been drafted, which will result in the MCU facilitating a process wherein MPI will identify potential overpayments and provide notice to the MHPs. MPI may either develop the process internally or obtain reports and referrals from other plans to develop the process. The MHPs will be encouraged to conduct recovery efforts and will retain the recoveries made. The contract language is designed to increase reports of suspected fraud, abuse, and waste and to increase MHP recovery opportunities.

Footnote: 9 The hospital rate review in FY 2015-16, was a broad, programmatic review. Also, due to the volume of documentation, the first review consisted of a 10% sample. The second review, during FY 2016-17, is focused on individual health plans and the compliance issues identified during the first review.

Overpayment Recoupment

MPI's ROI 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 (ORU), 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 subunits 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 ORU staff continues to perform audits and work with contractors to achieve substantial results. The staff works 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 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 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 there are several Medicaid-eligible populations that remain FFS following the full implementation of SMMC, including: Adult Cystic Fibrosis Home and Community-Based Services Waiver; Applied Behavior Analysis; Child Health Service Targeted Case Management; County Health Department Certified Match Program; Developmental Disabilities Individual Budgeting Home and Community-Based Services Waiver; Early Intervention Services for Recipients Birth to Three Years of Age; Familial Dysautonomia Home and Community-Based Services Waiver; Intermediate Care Facility Services for Individuals with Intellectual Disabilities; Medicaid Certified School Match Program; Medical Foster Care; Model Home and Community-Based Services Waiver; Newborn Hearing Services; Prescribed Pediatric Extended Care; Program for All-Inclusive Care for Children; Project AIDS Care Home and Community-Based Services Waiver; Substance Abuse County Match Program; and Traumatic Brain Injury and Spinal Cord Injury Home and Community-Based Services Waiver.

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

The Administrative Support Unit (ASU) is responsible for carrying out operational support for MPI staff. The unit is primarily responsible for budget, purchasing, personnel, and office management activities, which include answering and directing incoming telephone calls, fulfilling supply orders, and distributing incoming correspondence, records, and packages. Other duties include record storage and retention, responding to public record requests, and coordinating external audits of MPI.

ASU achievements in FY 2016-17, to assist MPI in combatting fraud, abuse, and waste include:

- Responded to 336 public record requests;
- Reconciled over 200 incoming payments for provider self-audits;
- Coordinated record storage or recall of more than 228 boxes of casefiles; and
- Assisted with processing more than 144 peer reviews as required by s. 409.9131, F.S.

The ASU continues to work on process improvement, including spearheading the MPI document management project. This project includes scanning historical documents and entering information into a data management system aligned with the MPI case tracking system.

The ASU works diligently behind the scenes contributing to the overall productivity and efficiency of the Bureau.

MPI Accomplishments

Audits and Investigations

MPI activities include audits of Medicaid providers for the purposes of identifying overpayments for recovery and 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, 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. At the close of FY 2016-17, the EMA project has approximately $13 million in pending litigation involving 42 cases. Since the EMA audit project's inception in 2010, approximately $39.8 million has been identified for recoupment.

In January 2013, CMS proposed a Hospice collaborative audit project. The project addresses Medicaid claims where recipients have been in hospice care for six months or longer. The audit reviews for compliance with the requirements to receive hospice services (medical necessity, election criteria, certification of terminal illness, certification documentation, etc.) per the Florida Medicaid Hospice Services Coverage and Limitations Handbook. In May 2013, CMS expressed their intent to perform a limited number of related audits. Subsequently, MPI/CMS initiated the Hospice audit project comprised of 33 provider audits. At the close of FY 2016-17, the Hospice audit project has generated approximately $2 million in recoupments related to 10 closed cases.

The Refugee Project was opened in 2013 and 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 after MPI identified 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 part of the Refugee Project, the ORU Practitioners Care subunit identified excessive over-billing and upcoding for providers with an infectious disease specialty, both pediatric and adult. One case resulted in an overpayment of approximately $241,000, specifically for insufficient records, services not medically necessary, billing for services rendered by another provider, injections that should have been included in the office visit, and submitting documentation not created at the time of service. A second provider with a pediatric infectious disease specialty failed to document many services, provided medically unnecessary services, and billed excessively, which resulted in an overpayment of $1,051,993.

The Practitioners Care subunit initiated a project to review dental and oral surgery providers billing for a non-covered Medicaid CDT (Code of Dental Procedures and Terminology) service when it was found that the providers were instead using two specific oral surgery CPT (Current Procedural Terminology) codes. The ORU

submitted a recommendation to Medicaid, which initiated programming in FMMIS to restrict the use of the codes to providers with an oral and maxillofacial surgery specialty on file. One specific audit was on an oral and maxillofacial enrolled provider who was incorrectly applying the two CPT codes for the non-covered CDT codes. Subsequent to a DOAH hearing, the Agency filed a Final Order and the provider reimbursed the Agency over $630,000 towards the overpayment.

The ORU Pharmacy/Durable Medical Equipment (DME) subunit opened a comprehensive review of a hospital outpatient pharmacy following an on-site visit. A review of the provider's purchase/acquisition records for a one-year period revealed a shortage of drugs available to support the payments made to the provider by Florida Medicaid. The Final Audit Report identified an overpayment of $209,161. A Final Order finalized the overpayment of $209,161, imposed a sanction in the form of a fine for $18,000, and applied costs of $1,000. The overpayment, sanction, and cost amounts have been collected, and the case is closed. Similar audits opened during the fiscal year after on-site visits resulted in a total of $550,404 in identified overpayments.

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 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.

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 2016-17, MPI continued its collaborative efforts with the following organizations:

- 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;
- National Insurance Crime Bureau Meetings;
- FBI Health Care Fraud Working Group Meetings;
- State Attorney Multidisciplinary Task Force Meetings; and
- Other states' Medicaid Program Integrity units and Medicaid Fraud Control Units.

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. MPI has modified and improved field operation protocols in an attempt to engage providers that demonstrated the greatest risks of abusive behavior. Through the field initiatives, MPI staff participate 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 or refute allegations of suspected abuse. Through the field initiatives, MPI attempts to further discern whether the circumstances are of the nature that should be referred to MFCU for a fraud investigation or that should be referred for an overpayment recovery audit by the appropriate unit within MPI.

In FY 2016-17, field initiatives resulted in referrals to MPI units and to other agencies. Projects incorporated additional data elements beyond Medicaid claims data, including provider enrollment indicators, identity theft risk indicators, and physician evaluation and management coding levels.

During FY 2016-17, MPI conducted a number of field initiatives related to the following Medicaid provider types and counties:

- Miami-Dade County Speech Therapy Initiative;
- Orange County Targeted Case Management (TCM) Initiative;
- Miami-Dade County Physician Initiative;
- Statewide Non-Ophthalmology Specialty Physicians Initiative;
- Duval County Physician Initiative; and
- Miami-Dade County Behavioral Analysis Initiative.

Additionally, other identified projects from FY 2016-17, now in various stages of development, have become project ideas for FY 2017-18. In FY 2017-18, projects are expected to include replications of FY 2016-17 projects in different locales and new ideas for projects pertaining to different provider types, including several physician specialties, facilities, prescribing-related issues, and personal care. A summary of outcomes related to the FY 2016-17 projects are described below.

Miami-Dade County Speech Therapy Initiative

In September 2016, MPI coordinated a field initiative that focused on eight Florida Medicaid group speech therapy providers in Miami-Dade County suspected of engaging in abusive behavior. These providers were found to be billing and being reimbursed by Medicaid FFS and Medicaid Managed Medical Assistance (MMA) health plans for more units of speech therapy sessions than were practical. Seven of the eight speech therapy providers were confirmed to be non-compliant with Medicaid policies and procedures. Modifications to this project are underway to further attempt to identify the most abusive practices.

Orange County Targeted Case Management Initiative

Based upon a variety of risk indicators, a field initiative was conducted in Orange County in February 2017. The objective of the project was to determine whether the owners, operators, and case managers, both known and unknown to Medicaid, met the requirements for the Medicaid program. Additionally, information gathered will be used for future assessment of program vulnerabilities and risk indicators. Forty providers were included in the project. "MPI actions" were initiated against 34 of the providers, which included a recommendation for termination, suspension, audit, prepayment review, or referral to MFCU. As a result of the outcomes for the Orange County TCM Project, this project will be expanded to other areas of the state.

Miami-Dade County Physician Initiative

MPI routinely conducts overpayment recovery audits on physicians, which result in identified overpayments due to upcoding (instances where a practitioner bills the Medicaid program for a service code at a higher level than is warranted by the records and conditions). In March 2017, MPI conducted a field initiative that focused on 13 Miami-Dade County physicians suspected of upcoding. Nine of the 13 physicians identified by an internally developed algorithm were preliminarily confirmed; further analysis and refinement is ongoing; and the physician claims related to potential upcoding have been referred for overpayment recovery audit.

Statewide Non-Ophthalmology Specialty Physicians Initiative

This initiative began in early FY 2016-17 as a data project to identify providers billing FFS claims who did not have the required ophthalmology specialty but had been reimbursed the refraction procedure code, 92015. Eighty providers were included in this initiative. Initially, self-audit letters were mailed to the providers with suspected overpayments, affording them an opportunity to voluntarily repay the overpayment. Providers who did not respond to the letter or repay the identified overpayment were subject to on-site visits by MPI field staff. While this project was not completed in its entirety during FY 2016-17, currently, 72 providers have repaid the overpayment, and one provider was recommended for a comprehensive audit.

Duval County Physician Initiative

This project was developed to explore whether medical (practitioner) identity theft posed a vulnerability for Florida Medicaid. More specifically, the project examined the use of practitioners' identities to obtain Medicaid provider identification information. Through collaboration with CMS, MPI investigators gathered and evaluated information regarding the potential population of Medicaid providers at risk for identity theft. In May 2017, MPI coordinated a field initiative with the CMS program integrity contractor that included visits to eight active Medicaid enrolled providers located in Duval County who were identified as a potential high-risk for identity theft. Preliminary findings included referrals to the Bureau of Medicaid Fiscal Agent Operations (MFAO), referrals to the Department of Health (DOH), and further on-site reviews throughout other parts of Florida.

Miami-Dade County Behavioral Analysis Initiative

In May 2017, MPI conducted an initiative that focused on nine active, Medicaid enrolled, group Behavioral Analysis (BA) providers in Miami-Dade County, which included more than 800 rendering providers, suspected of employing personnel whom did not have the proper qualifications at the time of enrollment and possibly having engaged in deceptive practices to obtain enrollment for these personnel. Employee record reviews conducted during the initiative revealed that many of the personnel did not meet enrollment criteria. All nine-group BA providers were referred to MFAO for removal of identified rendering providers not currently working for the groups. In addition, referrals are being made to MFAO for evaluation of non-qualified rendering providers. Further MPI actions are under consideration at the time of this report.

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 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 2016-17.

Type and Number of Payment Restrictions	
PPR	109
25A	48
CAF	23

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 MFCU.

During FY 2016-17, improved information-sharing and stronger collaboration efforts between MPI and key partners contributed to an increase in referrals made by MPI to internal and external agencies. In FY 2016-17, there were 686 referrals made by MPI, compared to 515 referrals in FY 2015-16, including referrals to MFCU. During FY 2016-17, MPI's continuing internal process improvements contributed to 177 referrals to MFCU, an increase from the 154 referrals made in FY 2015-16.

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 from participation in the Medicaid program in which the provider did not choose to relinquish their provider number; an instance when a provider voluntarily relinquishes a required license; 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 serves 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 disqualifying criminal offenses, and 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 other disqualifying offenses, or the provider failed 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.

MPI Training Program

Fraud schemes are ever changing, and it is imperative that MPI staff members, whose job it is to combat fraud and abuse, stay abreast of current deceptive practices. Over the past year, MPI has significantly increased its training efforts to ensure staff have working knowledge of the underlying concepts, theories, and principles that govern the Bureau's work.

During FY 2015-16, MPI identified Eight Core Educational Components to serve as the educational basis for assessing professional development needs and addressing those needs through training. Further, MPI utilized much of its educational resources on building internal capacity to share and explain the work of each unit with the Bureau. While MPI also utilized national experts for specific areas, MPI staff conducted the majority of training opportunities and included topics, such as drug diversion, the Affordable Care Act, fraud examination, health care fraud and abuse laws, and managed care.

In FY 2016-17, professional development moved from locally developed and implemented training, which focused on information sharing between units, to a focus on comprehending the principles of program integrity and how they direct MPI's work, including the early identification of high-risk providers and limiting the damage from fraudulent behaviors.

Developed internally by the Prevention Strategy administrator, the Program Integrity Concepts Model served as the basis for much of MPI's training efforts during the year. Building on Complex Systems and Social Learning theories, training participants explored Cressy's Fraud Triangle/Diamond, Mankiw's Economic Theory, Sutherland's Differential Association, and Granovetter's Social Network Theory to identify how each theory contributes to understanding and detecting deceptive behaviors that cost the Medicaid program millions each year. The model outlines how deceptive practices move from individual decisions on the economic margins and often lead to an integrated, well-organized fraud scheme perpetrated by loosely and tightly connected groups within a social network.

MPI also sought expertise from sources outside of the Agency to expand staff skills and knowledge. The National Alliance of Medical Auditing Specialists (NAMAS) trained more than half of the Bureau on the basics of evaluation and management (E&M) coding. E&M coding is the process by which the billing coding for a physician encounter is calculated. As a result, 33 MPI staff members hold the Certified E&M Auditor (CEMA) credential. More importantly, MPI is better equipped with a strong understanding of documentation needs and the medical necessity required to properly audit Medicaid claims.

The National Health Care Anti-Fraud Association (NHCAA) is a national organization dedicated to fighting health care fraud. Each year, the NHCAA certifies investigators across the country who "meet certain qualifications related to professional experience, specialized training, formal education and demonstrated knowledge in the detection, investigation, and/or prosecution of health care fraud." In May 2017, MPI entered into a unique contract with NHCAA to offer the national training at the local level to all interested MPI staff members who met the criteria and who were committed to obtaining the certification. In FY 2015-16, only two MPI staff members had attained the credential. However, in FY 2016-17, an additional 20 people participated in the May 2017 training and 17 received the designation of Accredited Health Care Fraud Investigator (AHFI). In addition to the AHFI, individual staff members also worked diligently to meet personal professional goals. Two staff members received their Certified Inspector General Auditor (CIGA) credentials.

The Association of Inspectors General provides the certification course and subsequent examination to signify recipients have met professional standards related to the credential. To date, there are three CIGAs and one Certified Inspector General at MPI.

Finally, MPI administrators are committed to strong leadership and the guidance of quality management. All managers and prospective managers within MPI attended a two-day training conducted by SkillPath on various topics related to managing staff, encouraging teamwork, leadership, and eliciting the best work from their teams.

Although MPI contracted with national providers to conduct trainings, personnel also took advantage of online trainings offered through CMS, i-Sight, and NHCAA. Furthermore, each month, the Bureau Chief holds staff meetings to share information pertaining to the organization. Additionally, there is always an educational component to ensure a continued learning environment. Typical training topics relate to the MPI core educational components and may include presentations about the Florida Medicaid program structure and policies, MPI procedures, and investigative practices. Topics also routinely include effective processes through teamwork and the use of technology.

Continued training is critical to ensuring MPI staff members are armed with the necessary information and skills required to detect potential risks to the program early, to identify deceitful provider behaviors, and to combat fraud and abuse overall. The commitment to education is evidenced by the quality of and frequency in training opportunities afforded to staff members throughout the year.

Medicaid Integrity Institute

The Medicaid Integrity Institute (MII) was developed by CMS with the U.S. Department of Justice, Office of Legal Education, to meet the training and educational needs of state Medicaid program integrity employees. MII is located at the National Advocacy Center (NAC) in Columbia, South Carolina, on the campus of the University of South Carolina. Students and faculty attending courses at MII are able to learn in this collaborative environment at no cost to the state.

MPI routinely sends staff to attend courses and serve as instructors at MII. During FY 2016-17, courses included fundamental and basic skills regarding program integrity, interviewing skills, data analysis and other fraud detection methodologies, new and emerging trends related to topics of interest such as personal care and managed care. MII also offers courses in health care coding, for both non-coders and a course to become a Certified Professional Coder. Courses continue to evolve to meet the needs of the states, and MII continues to be a vital source of education for state program integrity personnel, including Florida MPI. In fact, MPI personnel are active participants in advisory groups that assist in the development of the course calendar and curriculum for individual classes.

MPI's key management personnel, over the functional areas for prevention, detection, managed care, and recoupment, regularly participate as instructors for MII courses. Furthermore, the collaboration with other state program integrity units allows MPI to have access to additional training opportunities and oversight projects conducted by other states due to the close working relationships that are developed through MII. Participation at MII contributes to MPI's efforts in combating fraud, abuse and waste in the Florida Medicaid program, as well as the Bureau's ROI.

MPI Data for Fiscal Year 2016-17

Site Visits	
Provider Type	Number
Ambulance	1
Assistive Care Services	2
Case Management Agency	39
Community Behavioral Health Services	3
Dentist	5
Durable Medical Equipment/Medical Supplies	1
HMO	1
Home & Community-Based Services Waiver	13
Home Health Agency	1
Nurse Practitioner (ARNP)	1
Optometrist	5
Other – No Description Available	10
Pharmacy	38
Physician (D.O.)	2
Physician (M.D.)	78
Professional Early Intervention Services	1
Rural Health Clinic	1
Therapist (PT, OT, ST, RT)	9
Grand Total	211

Prepayment Reviews	
Number of Claims Reviewed	15,577
Number of Claims Denied	9,905
Amount of Claims Reviewed	$2,506,487
Amount of Claims Denied	$1,934,198

Random Audits Concluded	
Audits Completed	4
Audits with Findings	4
Audits with No Findings	0
Overpayments Identified	$100,196.21

MPI Referrals	
Agency for Persons with Disabilities	3
Department of Children and Families	68
Department of Health	47
Division of Medicaid	361
Division of Health Quality Assurance	95
Medicaid Fraud Control Unit - AG	177
Other	21
Safe Guard Services - CMS	7
Total	779

Provider Sanctions Imposed and Managed Care Organization Assessments per MPI's Case Tracking System				
	FY 2015-16		FY 2016-17	
Sanctions under Rule 59G-9.070, F.A.C.	Number	Amount	Number	Amount
Fine Sanctions	282	$1,374,034	151	$1,983,816
Suspensions	38	N/A	94	N/A
Terminations	67	N/A	64	N/A
Total for Rule 59G-9.070, F.A.C. Sanctions		$1,374,034		$1,983,816
Total for Managed Care Organization Section 409.91212 F.S., or Contract Assessments	2	$102,000	1	$1,000
Grand Total Sanctions and Managed Care Organization Assessments	389	$1,476,034	310	$1,984,816

Overpayment Collections and Paid Claims Reversals (PCRs) as reported in MPI's Case Tracking System			
Fiscal Year	Type of Recovery	Overpayment Identified	A/R Collections and Reversals
FY 2013-14	Accounts Receivable, Offsets, 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
FY 2016-17	Accounts Receivable and PCRs	$33,996,021	$37,644,700

MPI Prevention of Overpayments ($ Millions)[10]				
	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17
Prepayment Review	$0.4	$1.1	$4.1	$1.9
Termination of Providers	$1.6	$6.2	$2.0	$0.7
Program Suspensions	N/A	N/A	N/A	$0.2
Focused Projects	$6.6	$3.0	$2.8	$0.08
Site Visits	$2.1	$2.9	$5.1	$5.1
Sanctioned Providers	$6.9	$7.0	$13.3	$2.3
Claims Denied Per Statute (25A/CAF)	$2.9	$1.9	$0	$0
Audit Impact	$8.8	$13.0	$18.3	$4.6
Total	$29.30	$35.1	$45.6	$14.9

MPI Recovery Activities ($ Millions)				
	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17
MPI/MPI-CMS Audits (OP's Collected by Accounts Receivable)	$21.2	$37.8	$19.5	$37.7
Costs (Collected by Accounts Receivable)	$0.2	$0.4	$0.2	$0.3
Fines (Collected by Accounts Receivable)	$2.4	$1.5	$1.4	$2.4
Paid Claims Reversals	$2.6	$0.5	$0.2	$0.1
Certified Out of Business (COOB)	N/A	N/A	N/A	$3.2
Contractual Assessments	N/A	$0.0	$0.1	$0.001
TPL Contractor - Assisted Claims Adjustments	$61.6	$42.5	$18.8	$12.1
Recovery Totals	$88.0	$82.7	$40.2	$55.8

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.

Medicaid Program Integrity Return on Investment (ROI)			
FY 2013-14	Benefits	Costs	ROI*
Recovery	88.0	12.0	7.3:1
Prevention	29.4	4.4	6.7:1
Total:	117.4	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:	117.8	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
FY 2016-17	Benefits	Costs	ROI
Recovery	55.8	7.26	7.7:1
Prevention	14.9	4.62	3.2:1
Total:	70.7	12.0	5.9:1

*ROI: Calculation of the ROI includes use of some estimates related to MPI actions.

Division of Operations

Financial Services

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

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

As of June 30, 2016, the Medicaid accounts receivable balance for fraud and abuse was $49.3 million. During the 2016-17 state fiscal year (FY), Financial Services recorded $56.4 million as Medicaid accounts receivables. As of June 30, 2017, the balance was $43.5 million. During FY 2016-17, total collections including refunds and net adjustments approached $43.9 million. The collections were: $40.9 million in overpayments ($3.2 million collected from Medicaid Fraud Control Unit (MFCU) cases and $37.7 million collected from Medicaid Program Integrity (MPI) cases); $333,000 in investigation costs; $2.4 million in fines/sanctions; and $297,000 in interest.

The Agency must obtain approval from the Department of Financial Services (DFS) to write-off all accounts receivables deemed uncollectible. This year, DFS approved $12.1 million in accounts receivables for write-off. Accounts are generally written off because of one of the following reasons:

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

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

- Bankruptcy in which the Agency has filed a claim (even if the bankruptcy is discharged at the time the Agency discovers the bankruptcy);
- The Agency files a claim on the estate for an individual who is deceased; or
- When the write-off is due to 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 suspended pending the 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 receivable's 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" used for monitoring purposes and reports for follow-up. The MAR system maintains the required accounting data for financial statements and federal reporting purposes related to fraud and abuse cases and other overpayment cases. Examples of other overpayment cases include, but are not limited to, hospital and nursing home retroactive rate adjustments, gross adjustments, and the Agency for Persons with Disabilities (APD) overpayments.

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

Financial Services continues to emphasize communications with MPI, Bureau of Medicaid Quality, and MFCU to coordinate audit collection efforts. The Bureau also works with the Agency's Office of the General Counsel, Bureau of Medicaid Program Finance, HQA, 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 exercise due diligence in securing full payment of all accounts and claims due. This fiscal year, to further aid in the collections efforts of all revenue types, Financial Services implemented a pilot program by transitioning the collection of past due Nursing Home Quality Assessment Fees (NHQAF) and administrative fines to the MAR Unit. The purpose of the pilot program was to determine what processes worked best, identify the workload impact, develop a plan for allocating the workload between existing staff, and ensure the appropriate collection tools were in place prior to transitioning the remainder of the AHCA revenue types. After a successful pilot program, Financial Services is proceeding to consolidate all of the collection activities into the MAR Unit. In the current state fiscal year, the MAR Unit will assume full responsibility for the collection of outstanding debt for each source of revenue.

Federal requirements changed several years ago, and now, allow the state up to one year to return the federal share, through federal cost share adjustments of overpayments, if no revenues are received on the debt. To ensure that all federal shares are allocated as timely as possible, the Agency reports the federal portion of the total overpayment on the next available federal CMS-64 quarterly report and reduces a corresponding federal funds draw. During FY 2016-17, the Agency reduced its federal claims, on quarterly cost reports, by $28.2 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. The Agency negotiated and executed a five-year contract with Health Management Systems, Inc. (HMS) through August 31, 2020.

During FY 2016-17, approximately $89 million in Medicaid funds were collected. Annual TPL collections over the last four years have averaged nearly $126 million. In addition, the TPL Unit has held Conduent (previous vendor) and HMS accountable to its contract requirements by vigorously monitoring Conduent and HMS's performance. These efforts have helped to ensure maximum recoveries are generated for the State of Florida. Types of recoveries include:

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

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

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

Other Recoupment Projects – The TPL Unit also works in conjunction with the Agency's Bureau of Medicaid Program Integrity to conduct other Medicaid recoupment projects. Recoveries from other recoupment projects during FY 2016-17, include the following:

- Date of Death – Claims paid after the Medicaid recipients' date of death are recovered;
- Hospital Credit Balance Audits – Hospital accounts payable ledgers are reviewed in connection with collecting Medicaid overpayments; and
- Freestanding Dialysis Center Credit Balance Audits – Freestanding Renal Dialysis Center providers' payable ledgers are reviewed in connection with collecting Medicaid overpayments.

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

- Duplicate Crossover Payments – Two Medicaid payments for Medicare Crossover liability;
- 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; and
- 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.
    - o Inpatient Stay over 45 days.
    - o Non-covered Outpatient Revenue Codes.

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 in the Medicaid recipient's file.

Below is a summary of historical TPL collections:

Medicaid Third Party Liability - Historical Collections						
TPL Collections	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17
Casualty	$24,366,688	$22,303,548	$22,794,142	$21,985,243	$21,877,491	$22,819,897
Estate	$6,017,391	$7,061,816	$6,967,623	$7,092,510	$8,507,538	$7,709,297
Trusts	$7,124,616	$5,471,792	$6,615,113	$8,595,999	$5,887,889	$9,905,343
Medicare and Other Third Party Payor	$78,428,755	$77,922,624	$72,834,387	$67,061,300	$41,544,352	$36,444,209
Other Recoupment Projects*	$32,208,128	$48,455,372	$61,607,714	$42,525,211	$18,831,428	$12,074,137
Total Collections	$148,145,578	$161,215,152	$170,818,979	$147,260,263	$96,648,698	$88,952,883
Cost Avoidance (Matrix)	$1,259,088,849	$1,423,986,005	$1,720,174,663	$2,366,574,378	$2,031,929,709	$1,338,770,174

*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's (Agency) Care Provider Background Screening Clearinghouse (Clearinghouse) works to prevent, identify, coordinate, and support Medicaid Program Integrity (MPI) functions. The Clearinghouse is a secure, web-based database to house and manage background screening results of multiple state agencies, allowing the following agencies to share those results: The Agency, Managed Care Health Plans, Medicaid providers, the Agency for Persons with Disabilities (APD), the Department of Elder Affairs (DOEA), the Department of Children and Families (DCF), the Department of Health (DOH), the Department of Juvenile Justice (DJJ), and Vocational Rehabilitation at the Department of Education (DOEVR). Integration with the state agencies began in January 2013. 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 overall cost savings. The Clearinghouse also includes a RapBack requirement, also known as "retained prints," which enables immediate notification to the Agency of the recent arrest of an employee to determine if the arrest affects access to vulnerable clients. The Clearinghouse also notifies providers of an arrest and prompts the provider to check eligibility. The immediacy of notification through RapBack improves the Agency's response time in prevention of Medicaid fraud. The Clearinghouse provides the ability to keep an employee roster. Facilities are required to maintain a current employee roster, with updates to be made within 10 business days of a change, including a new hire, termination, or position change. With this requirement, the Agency can know immediately when a facility has employees who are not eligible on their roster and take action against the facility if it does not comply. Since Clearinghouse implementation, the Agency has imposed 244 background-screening violations and 118 employee roster violations.

During FY 2016-17, the Background Screening Unit processed 29,356 RapBacks. Of these, 23.6 percent were for criminal charges that resulted in the applicants' eligibility status being updated to ineligible. During FY 2016-17, 147,935 background screening results were shared among participating agencies and Medicaid

health plans, resulting in an overall cost savings of $11,095,125 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. From January 2010 to June 2016, the Agency submitted a monthly report on the implementation of the provisions of SB 1986 as requested by the Senate Committee on Health Regulation, with a calendar year 2016 report submitted in early 2017. Much of the information contained in the SB 1986 reports is already published in this report. Additionally, with the implementation of Statewide Medicaid Managed Care, health plans are now responsible and accountable for monitoring functions for their members, which was previously reported through home health monitoring projects for fee-for-service recipients in the SB 1986 monthly report. To avoid duplication, the Agency has discontinued separate SB 1986 reports and instead included any information not already included in this report. The Agency reports the following information for FY 2016-17:

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 2016-17, no home health agencies were identified to have met these criteria.

Remuneration Complaints - Complaints received against nurse registries for providing remuneration in violation of s. 400.506, F.S. There was one identified in FY 2016-17.

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. Five applicants met these criteria in FY 2016-17.

Financial Requirements - There were nine home health agency applications, four home medical equipment applications, and 20 health care clinic applications in FY 2016-17 that failed to meet the financial requirements of s. 408.8065, F.S.

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 four providers that met these criteria in FY 2016-17.

Final and Emergency Orders

During FY 2016-17, the Agency issued final or emergency orders to 77 providers for failure to meet licensure requirements, resulting in closure:

- 31 Final Orders denying the license renewal application;
- 22 Final Orders revoking an existing licensure;
- 13 emergency orders resulting in either suspension and/or an immediate moratorium on admissions; and
- 11 Final Orders resulting in the provider surrendering their license.

During FY 2016-17, the Agency imposed $2,218,876 in fines and administrative fees from licensure actions imposed by Final Orders.

Home Health Agency Comparison Tool

In November 2016, the Agency launched a new comparison tool for people interested in learning more about home health agencies hosted at www.FloridaHealthFinder.gov. These new resources are similar to those already available for assisted living facilities, hospitals, nursing homes, and health plans.

Home health agencies provide nursing care, home health aide services, nutritional guidance, and other therapeutic services in a patient's home or place of residence. The tool allows patients and their families to research their home health options before deciding how to best meet their health needs. Consumers can compare the state's nearly 2,000 home health agencies by county/service area, name, or Medicare/Medicaid certification status. Comparison measures include accreditation status, facility complaints, sanctions, fines, deficiency information, and more.

FloridaHealthFinder.gov has been helping consumers make educated decisions about their health care since 2005. With four million visitors last calendar year, the FloridaHealthFinder.gov website is widely considered a national leader in the area of consumer education and health care transparency. The website was recognized with the Digital Government Achievement Award in 2016.

Philip Esformes' Network of Facilities

On July 22, 2016, the U.S. Department of Justice issued a press release (link below) indicating that Philip Esformes, owner of several Miami-based skilled nursing and assisted living facilities, and two of his associates, Odette Barcha and Arnaldo Carmouze, had been indicted in a one billion dollar Medicare and Medicaid fraud scheme. Upon the unsealing of the indictment, the Agency became aware of the case, which had been investigated by the Federal Bureau of Investigation (FBI) and the Office of Inspector General within the U.S. Department of Health and Human Services (HHS-OIG), and has assisted law enforcement in their investigation.

This case impacts 17 health care facilities licensed by the Agency that are/were enrolled as Florida Medicaid providers. Agency personnel from the Bureau of Field Operations, the Bureau of Health Facility Regulation, MPI, and the Office of the General Counsel continue to assist HHS-OIG and the Centers for Medicare & Medicaid Services (CMS) on the investigation. The Agency has pursued licensure actions and Medicaid termination and suspension sanctions against the related facilities. Those legal cases are currently ongoing.

https://www.justice.gov/opa/pr/three-individuals-charged-1-billion-medicare-fraud-and-money-laundering-scheme

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: 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 including nursing homes, hospitals, assisted living facilities, clinical laboratories, and home health agencies.

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

During this past fiscal year, the OGC Agency Clerk issued 427 Final Orders for MPI. Additionally, the OGC Agency Clerk received 102 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 protecting the people of Florida against health care fraud and substandard health care.

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.

DOH and AHCA have continued collaboration on the creation of a web portal for consumer complaints. The portal was designed to reduce the number of complaints each agency receives that are not within their jurisdiction. This portal takes the consumer through a series of questions and, based upon the response, the consumer is routed to the agency best suited to handle the complaint. The first phase of the portal was completed in March of 2016. In the first year, the portal received over 225,900 views. For MQA, the portal has also decreased non-jurisdictional complaints received by 45 percent. DOH will continue to work with AHCA enhancements, which among other improvements will allow consumers to file complaints online, as well as upload supporting documents.

MQA has also created a fraud analytics unit. This unit will help field offices analyze records and identify areas of possible fraud. The unit will work closely with AHCA to share information and best practices.

AHCA and DOH have continued to enhance methods of information sharing so that provisions of anti-fraud legislation are fully implemented. The DOH transfers data nightly to AHCA to identify practitioners who are billing Medicaid, but who do not have an active DOH license.

From July 1, 2009 through July 5, 2017, as a result of legislation passed in 2009, DOH has denied licensure to 457 applicants, and denied the renewal of 185 health care practitioners for health care related fraud. DOH has also taken 188 emergency actions and disciplined 351 health care practitioners for violations related to Medicaid.

STATUTORY REPORTING REQUIREMENTS

Number of cases opened and investigated

MFCU opened 303 cases and had 738 active cases in FY 2016-17. MPI investigated 2,147 cases which included 919 opened during the year.

Disposition of the cases closed

Disposition of Cases Closed				
Case Type	MFCU	PANE	AHCA	Total
Administrative Referral	38	6		44
Assistance to Other Agencies	1			1
Bankruptcy			1	1
Case Dismissed	12			12
Civil Settlement	7			7
CHOW			2	2
Consolidated	3			3
Conviction	16	7		23
COOB Invalidated			1	1
COOB Validated			17	17
Fines Issued			5	5
Investigation by Another Law Enforcement Agency	5	2		7
Lack of Evidence	18	12		30
Liquidated Damages Applied			1	1
No Abuse			19	19
No Auditable Review Period			11	11
No Findings			55	55
Nolle Prosequi		1		1
No Further Action Required			157	157
Not an Overpayment Issue			3	3
Not Sustained			49	49
Policy Does Not Support Referral			5	5
Pre-trial Intervention	1	3		4
Project Completed			17	17
Prosecution Declined	4	4		8
Provider Education			13	13
Provider No Longer Operational			4	4
Provider Suspended			98	98
Provider With Cause Termination			64	64
Provider Without Cause Termination			15	15
Referred			18	18
Resolved with Intervention	2	2		4
Suspension Lifted			2	2
Sustained			402	402
Under Investigation by Another Entity			10	10
Unfounded	14	5		19
Unsubstantiated	10	7		17

Disposition of Cases Closed				
Case Type	MFCU	PANE	AHCA	Total
Vacated Fines			1	1
Vacated Termination			1	1
Voluntary Dismissal	23			23
Voluntary Termination			1	1
Grand Total	154	49	972	1,175

Sources of the cases opened

Sources of Cases Opened				
Source	MFCU	PANE	AHCA	Total
AHCA - Financial Services			36	36
AHCA - Health Quality Assurance HQA		2		2
AHCA - HQA-Facility Regulation			3	3
AHCA - HQA-Field Operations			6	6
AHCA - Medicaid Quality			2	2
AHCA - Medicaid Program Integrity MPI	48			48
AHCA - Medicaid-Fraud Liaison			16	16
AHCA - Medicaid - Medicaid Services			1	1
AHCA - Medicaid - Pharmacy Services			1	1
AHCA - MFAO			71	71
AHCA - MPI JOT			18	18
AHCA - MPI MCU			2	2
AHCA - MPI Miami			3	3
AHCA - MPI Pharmacy			2	2
AHCA - Other Bureaus			8	8
AHCA - Third Party Recovery	1			1
APD - Agency for Persons With Disabilities	5		1	6
APS - Adult Protective Services		68		68
Citizen	20	1		21
CMS - Centers for Medicare & Medicaid Services	1			1
DCF - Department of Children & Families		1		1
DEA - US Drug Enforcement Administration	1			1
Detection Tool			27	27
DOH - Department of Health	1		5	6
Employee	15			15
EOMB			3	3
Family Member	11	2		13
FDLE - Florida Department of Law Enforcement	1			1
Federal Agency - CMS			14	14
Florida - MFCU			28	28
Generalized Analysis			26	26
Government Employee	2			2
HHS OIG Health & Human Services Inspector General	4		21	25
HUM - Humana			18	18
Internet/Media			44	44
Investigator Initiative			156	156

Sources of Cases Opened				
Source	MFCU	PANE	AHCA	Total
Law Enforcement Agency	2			2
Managed Care Monitoring			1	1
Managed Care SIU - Reported by MFCU	6			6
MCO - Special Investigative Unit - Reported by MPI			2	2
Medicaid Provider	8	4		12
Medicaid Recipient	3			3
MFCU Data Mining Initiative	5			5
MOL - Molina			1	1
Online Complaint Form			15	15
Other - See Description			4	4
Previous File or Case			7	7
Projects			259	259
Provider			40	40
Qui Tam	87			87
PRS - Prestige Health Choice			7	7
Public			1	1
SAO - State Attorney's Office	1	1		2
Self-Audit			36	36
Site Visit			16	16
Spinoff Case	1			1
STW - Wellcare d/b/a Staywell Health			1	1
SUN - Sunshine			1	1
USAO US Attorney's Office	1			1
Web Service			16	16
Grand Total	224	79	919	1,222

Amount of overpayments alleged in preliminary and final audit letters

Amount of Overpayments Alleged in Preliminary and Final Audit Letters FY 2016-17	
Preliminary	Final
$42,933,843	$28,197,955

Number and amount of fines or penalties imposed

During FY 2016-17, MPI imposed fines (under s. 409.913, F.S., and Rule 59G-9.070, F.A.C.) in the amount of $1,983,816.

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 2016-17. During FY 2016-17, the Agency's final settlements resulted in a total reduction of overpayments of $429,888.

Amount of final Agency determinations of overpayments

MPI identified $33,866,887 in overpayments via audits on 972 closed cases.

Amount deducted from federal claiming as a result of overpayments

Federal requirements changed several years ago, and now, allow the state up to one year to return the federal share, through federal cost share adjustments of overpayments, if no revenues are received on the debt. To ensure federal shares are allocated as timely as possible, the Agency reports the federal portion of the total overpayment on the next available federal CMS-64 quarterly report and reduces a corresponding federal share draw. During FY 2016-2017, the Agency reduced its federal share, on quarterly cost reports, by $28.2 million for net overpayments.

Amount of overpayments recovered each year

MFCU collected $3,343,313 in overpayments that were returned to the Agency. Additionally, MFCU collected $7,992,191 in Federal Medicaid overpayments that were sent directly to the U. S. Department of Health and Human Services for a total of $11,335,504 in Medicaid overpayments collected in FY 2016-17. Overpayments recovered as a result of the MPI and MPI-CMS audits were $37,702,045. Total recoveries by MPI, MPI-CMS, and MPI- TPL for FY 2016-17 were $55,845,758 (This includes collections of overpayments, fines, costs, and paid claims reversals, COOBs, and contract assessments during the fiscal year).

Amount of cost of investigation recovered

During FY 2016-17, the MFCU collected $3,101 in program income investigative costs. MFCU also collected $46,778 in state share investigative costs and $508,621 in federal share investigative costs for a grand total of $558,500 for all investigative costs. MPI total investigative costs recovered for FY 2016-17 was $332,655.

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

The average length of time for MPI cases open in any fiscal year to subsequently being paid in full during FY 2016-17 was 1.76 years. The median length of time was 1.24 years. The time periods were impacted by litigation proceedings.

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

During State FY 2016-17, the Bureau of Financial Services deemed $9,330,525.91 uncollectible and approved it for write-off. The Agency was successfully able to reclaim $2,942,384.60 in federal cost share due to the Agency implementing the out-of-business certification procedures.

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

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

Number of Terminations	
T1 - TERM – BCK SCRNG	11
T2 - TERM - MCAID AUTH	184
T5 - TERM - MCARE AUTH	4
T6 - TERM - MCAID FO	69

For the FY 2016-17, the following chart itemizes T1, T2, T5, and T6 type terminations:

Terminations – BCKD SCRNG, MCAID AUTH, MCARE AUTH or FINAL ORDER	
05 - Community Behavioral Health Services	12
06 - Ambulatory Surgery Center	1
07 - Specialized Mental Health Practitioner	9
10 - Skilled Nursing Facility	2
14 - Assistive Care Services	27
20 - Pharmacy	13
25 - Physician (MD)	52
26 - Physician (DO)	3
27 - Podiatrist	7
29 - Physician Assistant	2
30 - Nurse Practitioner (ARNP)	1
32 - Social Worker/Case Manager	22
35 - Dentist	1
39 - Behavior Analysis	2
65 - Home Health Agency	37
67 - Home & Community-Based Services Waiver	44
83 - Therapist (PT, OT, ST, RT)	9
89 - Dialysis Center	2
90 - Durable Medical Equipment/Medical Supplies	10
91 - Case Management Agency	5
97 - Managed Care Treating Provider - Non-Medicaid	6
99 - Trading Partner	1
Total	268

Additionally, there were 291 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. Oftentimes 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	291

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

MFCU expenditures for FY 2016-17 were $17,513,414, which included indirect costs of $1,761,145. MPI direct legal costs were $1,663,451 for prevention and recoupment cases. MPI's total cost for FY 2016-17 was $11,965,714.

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	76
DB - DENY - BEST INTEREST	81

For the FY 2016-17, the following chart represents denied provider types:

Denied Providers – D6 PRV TERM/EX and/or BEST INTEREST	
05 - Community Behavioral Health Services	2
07 - Specialized Mental Health Practitioner	2
14 - Assistive Care Services	3
20 - Pharmacy	3
25 - Physician (M.D.)	31
26 - Physician (D.O.)	3
28 - Chiropractor	1
29 - Physician Assistant	1
30 - Nurse Practitioner	1
32 - Social Worker/Case Manager	9
35 - Dentist	1
39 - Behavior Analysis	21
46 - Non-profit Transportation	1
62 - Optometrist	1
65 - Home Health Agency	46
67 - Home & Community-Based Services Waiver	11
83 - Therapist (PT, OT, ST, RT)	5
90 - Durable Medical Equipment/Medical Supplies	1
91 - Case Management Agency	14
Total	157

Regarding providers that were prevented from enrolling or reenrolling due to program integrity considerations, there were an additional 175 providers who were denied due to findings during an on-site pre-enrollment visit; 38 providers were denied due to disqualifying criminal offenses, and 2 providers were denied due to a federal exclusion, for a total of 215 providers denied enrollment.

Number of Denials	
D2 - DENY - SV	175
D3 - DENY - BKGD SCRNG	38
DE - DENY - EXCLUSION	2

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

Three areas to prevent or recover overpayments and to prevent and detect Medicaid fraud are described below.

First, MPI processes have evolved over the years in an effort to keep up with advancing technology and schemes to defraud the Medicaid program. When positions become vacant, it creates an opportunity for MPI to reclassify the position (if needed) and recruit personnel with the skills and abilities to keep up with the challenges of the future. Staffing changes over the past few years have resulted in heavier reliance on long-term use of OPS personnel. Funding consideration both to convert OPS positions to FTEs and to increase the pay for highly educated and skilled personnel would increase the ability of MPI to recruit and retain qualified personnel needed for success.

Second, MPI's experience with data analytics has evolved significantly. As the vendor contract for data analytics (see the Data Analytics section on page 29 of report) closes, MPI continues to explore partnerships that place a greater emphasis on MPI staff knowledge and expertise in conjunction with vendor analytic capabilities to more effectively use tools to target areas of potential concern. Further efforts in the area of advanced data analytics for fraud detection and predictive analysis with external partners will be more successful with greater engagement of key MPI personnel and greater emphasis on the changing dynamics of fraud and inappropriate billing.

Third, efforts to update statutory language (particularly in s. 409.913, F.S.) to ensure effective program integrity efforts in an evolving Medicaid program, have been proposed in the past. Without the tools (through statute) to ensure comprehensive program integrity efforts in today's Medicaid program, monetary losses due to fraud, abuse, and waste will continue to increase without corresponding capabilities to increase recoveries. One example is the varying complexities of financial/business arrangements today that were not contemplated when many of the program integrity statutes were adopted. For example, the arrangements to sell and then lease-back a business, the use of third party vendors to carry out key provider business functions, and contractual arrangements that are used today were simply not known previously and are, therefore, not specified in current statute.

ACRONYMS

3D - Three Dimensional Imaging

ABH - Advanced BioHealing

ACFE - Association of Certified Fraud Examiners

AFAAR - Annual Fraud Abuse Activity Report

Agency, the - Agency for Health Care Administration

AHCA - Agency for Health Care Administration

AHFI - Accredited Healthcare Fraud Investigator

ALF - Assisted Living Facilities

APD - Agency for Persons with Disabilities

APS - Adult Protective Services

ASU - Administrative Support Unit

BA - Behavioral Analysis

CAF - Credible Allegation of Fraud

CCEB - Complex Civil Enforcement Bureau

CDT - Code of Dental Procedures and Terminology

CEMA - Certified E&M Auditor

CFR - Code of Federal Regulations

CHOW - Change of Ownership

CIGA - Certified Inspector General Auditor

CEMA - Certified E&M Auditor Credential

CJIS - Criminal Justice Information Services

Clearinghouse - Care Provider Background Screening Clearinghouse

CMA - Certified E&M Auditor Credential

CMS - Centers for Medicare and Medicaid Services

COOB - Certified Out of Business

CPT - Current Procedural Terminology

CT - Computerized Tomography

CTA - Computerized Tomography Angiography

DCF - Department of Children and Families

DFS - Department of Financial Services

DHSMV - Florida Department of Highway Safety and Motor Vehicles

DJJ - Department of Juvenile Justice

DME - Durable Medical Equipment

DMV - Delivery Monitoring and Verification

DOAH - Division of Administrative Hearings

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.

F.A.C. - Florida Administrative Code

FACTS - Fraud and Abuse Case Tracking System

FAW - Fraud, Abuse, and Waste

FBI - Federal Bureau of Investigations

FDLE - Florida Department of Law Enforcement

FFP - Federal Financial Participation

FFS - Fee-for-Service

FMHI - Florida Mental Health Institute

FMMIS - Florida Medicaid Management Information System

F.S. - Florida Statutes

FSFN - Florida Safe Families Network

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

HB - House Bill

HEAT - Health Care Fraud Prevention and Enforcement Action Team

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

HIPAA - Health Insurance Portability and Accountability Act

HMO - Health Maintenance Organization

HMS - Health Management Systems, Inc.

HQA - AHCA's Health Quality Assurance

JOT - Jacksonville, Orlando, and Tampa

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

MHP - Medicaid Health Plan

MII - Medicaid Integrity Institute

MMA - Managed Medical Assistance

MPI - AHCA's Medicaid Program Integrity

MRA - Magnetic Resonance Angiography

MRI - Magnetic Resonance Imaging

MQA - Medical Quality Assurance within the Florida Department of Health

NAMAS - National Alliance of Medical Auditing Specialists

NHCAA - National Health Care Anti-Fraud Association

NHQAF - Nursing Home Quality Assessment Fees

NPI - National Provider Identifiers

OGC - Office of General Counsel

OIG - Office of the Inspector General

ORU - Overpayment Recoupment Unit

PA - Prior Authorization

PANE - Patient Abuse, Neglect and Exploitation

PCRs - Paid Claims Reversals

PDL - Preferred Drug List

PDN - Private Duty Nursing

PET - Positron Emission Tomography

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

SQL - Structured Query Language

SSA - Social Security Administration

TCM - Targeted Case Management

TPL - Third Party Liability

UM - Utilization Management

A note on how this report was composed:

The Agency for Health Care Administration, Bureau of Medicaid Program Integrity exercises oversight of the production of this report. However, the compilation of the information contained herein originated from many state agencies, bureaus, and units that have oversight of different functions of Florida's large and complex Medicaid program. Months prior to this report's publication, Shannon Bagenholm of the Bureau of Medicaid Program Integrity initiated data calls and conveyed requests for up-to-date text to include in this report. The information from the multiple sources was assembled into a single draft document with assistance from other staff members. The draft text was reviewed and approved by officials responsible for the activities documented and published in this final report, in coordination with Multimedia Design. While many dedicated state employees contributed to this report throughout the year, 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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