FLORIDA'S EFFORTS TO CONTROL MEDICAID FRAUD AND ABUSE

FISCAL YEAR 2019-2020

January 14, 2021

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

Dear Governor DeSantis:

Pursuant to Section 409.913, Florida Statutes, enclosed is the annual report of the activities related to the fight against fraud and abuse in the Medicaid program for the FY 2019-20. This report has been prepared jointly by staff of the Agency for Health Care Administration (Agency) and the Medicaid Fraud Control Unit (MFCU) within the Office of the Attorney General. Our two organizations continue to collaborate, with a goal of innovative and effective approaches to aggressively combat fraud, abuse, and waste in the Medicaid program.

Sincerely,

Ashley Moody
Attorney General

Sincerely,

Shevaun L. Harris
Acting Secretary

cc: The Honorable Wilton Simpson
The Honorable Chris Sprowls

Statutory Authority:

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

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

As this report details, the Agency for Health Care Administration (AHCA or the Agency) and the Medicaid Fraud Control Unit (MFCU) have continued their joint efforts to prevent, reduce, and mitigate health care fraud, abuse, and waste in accordance with their statutory obligations. This joint report presents specific results of efforts by the Agency and MFCU to control Medicaid fraud and program abuse during FY 2019-20.

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OFFICE OF THE ATTORNEY GENERAL

Medicaid Fraud Control Unit

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

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

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

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

Control and Enforcement Strategy

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

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

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

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

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

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

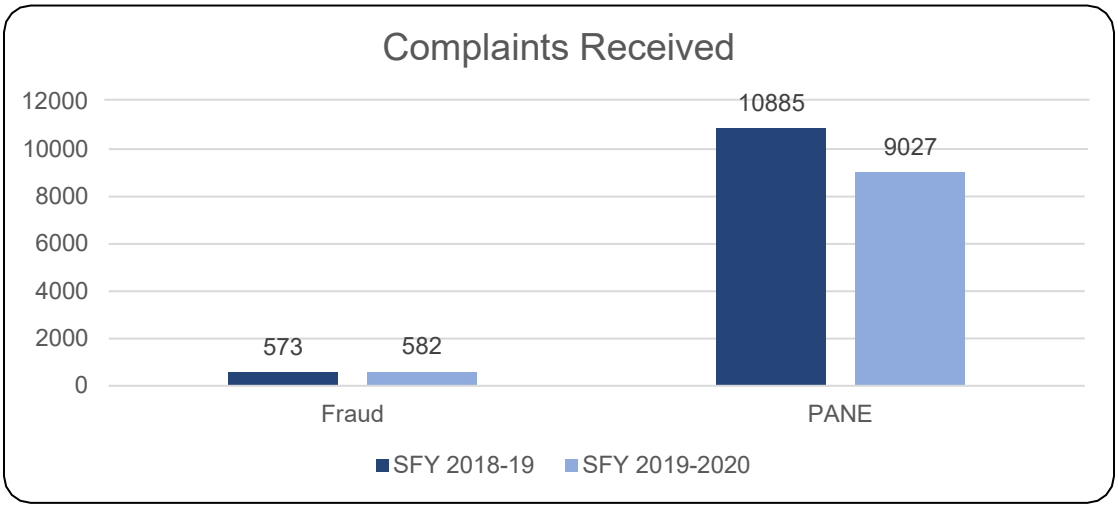
- Intelligence - Emphasis is placed on developing and fostering key partnerships with agencies such as AHCA, DOH, APD, state and federal prosecutors, and the criminal justice community in order to promote better sharing of data. Use of information technology resources to obtain, share, and disseminate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

Complaints

The Unit's policy requires a 60-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 2019-20, the Unit received 9,609 complaints. Of those 9,609 complaints, 490 were opened as operational cases. Of the 9,609 complaints received in FY 2019-20, 582 were related to fraud and 9,027 were related to PANE allegations.

Of the total 582 fraud complaints received, referrals from managed care Special Investigative Units were the primary source of fraud complaints in FY 2019-20 at 146. Complaints from Citizens accounted for 91 Medicaid fraud complaints. Qui tam complaints accounted for 89 of the Medicaid fraud complaints received. Seventy-seven complaints were received from AHCA Medicaid Program Integrity (MPI).

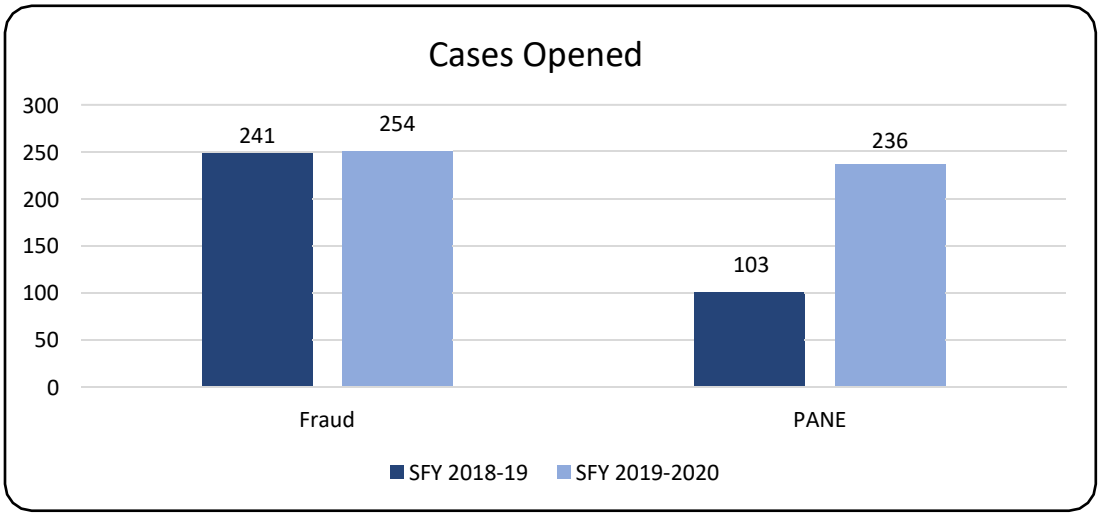
The majority of PANE complaints were derived through the Department of Children and Families (DCF), Adult Protective Services (APS)/Florida Safe Families Network (FSFN.) In FY 2019-20, of the 9,027 PANE complaints, 8,807 came from DCF/APS/FSFN. Family Members relayed 82 and Citizens relayed 48 making them the next highest source of PANE complaints.



Case Investigations

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

During FY 2019-20, the Unit's internal intake team has continued to assist with front end decision-making regarding opening or closing criminal investigations. This successful process preserved valuable investigative resources and allowed the Unit to be more selective in its case focus.



The following is a list of the top six Medicaid Provider types for MFCU fraud cases opened in FY 2019-20:

1. Home & Community Bases Services
2. Pharmacy
3. Pharmaceutical Manufacturer
4. Physician
5. Independent Lab
6. Home Health Services

The following is a list of the top six Provider types for MFCU PANE cases opened in FY 2019-20:

1. Facility Employee
2. Family Member
3. Certified Nursing Assistant (CNA)
4. Care Giver
5. Administrator of Facility
6. Guardian

Disposition of Cases

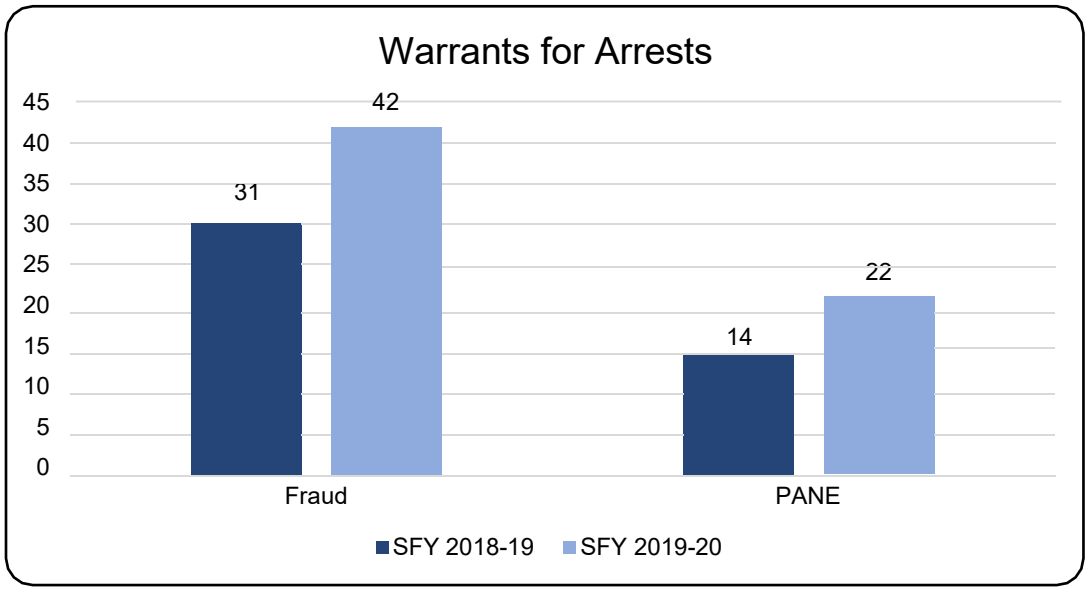
Following an investigation, a determination is made whether to pursue criminal prosecution or initiate civil actions. All case investigations are formally closed because of either a successful prosecution, a lack of evidence or other classification. Several classifications are presently used to track 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 2019-20, the MFCU closed 411 cases. Of those, 258 involved Medicaid fraud investigations and 153 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 2019-20 were 36 Fraud and 24 PANE for a total of 60. In FY 2018-19 the referrals for prosecution were 30 Fraud and 24 PANE for a total of 54.

Warrants for arrests for FY 2019-20 and FY 2018-19 are indicated in the chart below.



Case Highlights

Reckitt Benckiser Group

Attorney General Ashley Moody announced that Florida and 49 other states have reached an agreement with the pharmaceutical distributor Reckitt Benckiser Group ("Reckitt") to settle allegations that the company, either directly or through a subsidiary, improperly marketed and otherwise promoted the drug Suboxone, resulting in improper expenditures of state Medicaid funds. Suboxone is a drug product approved for use by recovering opioid addicts to avoid or reduce withdrawal symptoms while they undergo treatment. Suboxone and its active ingredient, buprenorphine, are powerful and addictive opioids.

Reckitt is an English public limited company headquartered in Slough, England, the United Kingdom. Until December 23, 2014, Reckitt's wholly owned subsidiary Indivior Inc. (then known as Reckitt Benckiser Pharmaceuticals, Inc.) distributed, marketed, and sold Suboxone Sublingual Tablets and Suboxone Sublingual Film in the United States. In December 2014, Reckitt spun off Indivior Inc. The settlement described in this statement is with Reckitt, alone. Reckitt has paid the Florida Medicaid program a total of $2,698,249.47 to resolve various civil fraud allegations impacting the Florida Medicaid program. To resolve its potential criminal liability stemming from conduct alleged in the indictment of Indivior, Inc., Reckitt has entered into a separate non-prosecution agreement.

The civil settlement resolves allegations that, from 2010 through 2014, Reckitt, directly or through its subsidiaries, knowingly: (a) promoted the sale and use of Suboxone to physicians who were writing prescriptions (1) to patients without any counseling or psychosocial support, such that the prescriptions were not for a medically accepted indication and (2) for uses that were unsafe, ineffective, and medically unnecessary and that were often diverted for uses that lacked a legitimate medical purpose; (b) promoted the sale or use of Suboxone Sublingual Film based on false and misleading claims that Suboxone Sublingual Film was less subject to diversion and abuse than other buprenorphine products and that Suboxone Sublingual Film was less susceptible to accidental pediatric exposure than Suboxone

Sublingual Tablets; (c) submitted a petition to the Food and Drug Administration on September 25, 2012, fraudulently claiming that it had discontinued manufacturing and selling Suboxone Sublingual Tablet "due to safety concerns" about the tablet formulation of the drug; and (d) took other steps to fraudulently delay the entry of generic competition for various forms of Suboxone in order to improperly control pricing of Suboxone, including pricing to federal healthcare programs.

The civil settlement resolves the claims against Reckitt brought in six qui tam lawsuits pending in federal courts in the Western District of Virginia and the District of New Jersey.

Avanir Pharmaceuticals, Inc.

Attorney General Ashley Moody announced that Florida has joined other states, the District of Columbia, and the federal government in an agreement in principle to settle allegations that Avanir Pharmaceuticals, Inc. ("Avanir") paid remuneration to health care professionals ("HCPs") and engaged in off-label marketing tactics that improperly promoted Avanir's flagship drug Neudexta. Avanir will pay $7 million to the participating states' Medicaid programs to resolve allegations that Avanir unlawfully marketed Neudexta and thereby caused false claims to be submitted to the government health care programs. The Florida Medicaid program will receive $635,732.78 in restitution and other recoveries.

Avanir, a wholly owned subsidiary of Otsuku Pharmaceutical Co., Ltd, is headquartered in Aliso Viejo, California. In October 2010, Avanir's Nuedexta was approved by the FDA for the treatment of Pseudobulbar Affect ("PBA"). According to the FDA-approved label for Nuedexta, "PBA occurs secondary to a variety of otherwise unrelated neurologic conditions, and is characterized by involuntary, sudden, and frequent episodes of laughing and/or crying. PBA episodes typically occur out of proportion or incongruent to the underlying emotional state. PBA is a specific condition, distinct from other types of emotional lability that may occur in patients with neurological disease or injury." Neudexta was not approved for any other uses.

This agreement in principle resolves allegations that, from October 29, 2010 through December 31, 2016, Avanir marketed Neudexta to HCPs treating patients in long-term care ("LTC") facilities for uses other than PBA, which were not FDA approved and were also not medically accepted indications as defined by the statutes and regulations governing the Federal health care programs. Specifically, to counter the objection by certain HCPs that they had few, if any, patients that exhibited signs of PBA in their facilities, Avanir instructed sales representatives to provide false and misleading information to HCPs regarding PBA patient "behaviors." Avanir also sought to capitalize on efforts by the Centers for Medicare and Medicaid Services ("CMS") to reduce the use of anti-psychotics on dementia patients in LTCs. For example, in 2015, Avanir instructed its sales force to initiate discussions regarding anti-psychotic use and how Nuedexta could be used to reduce a LTC facility's reliance on anti-psychotics even though Avanir's own studies demonstrated that the actual population of patients with PBA is limited. This agreement in principle also resolves allegations that, during this same time period, Avanir provided remuneration to HCPs, including payment for giving talks known as "speaker's programs," to induce those HCPs to write prescriptions for Nuedexta.

As a condition of the settlement, Avanir will enter into a Corporate Integrity Agreement with the United States Department of Health and Human Services, Office of the Inspector General.

The investigation resulted from a qui tam action originally filed in the United States District Court for the Northern District of Georgia under the federal False Claims Act and various state false claims statutes.

Logan Laboratories/Tampa Pain Relief Centers, Inc.

Attorney General Ashley Moody announced that Florida, along with Colorado, Georgia, North Carolina, Virginia and the federal government, have reached an agreement with Logan Laboratories LLC and Tampa Pain Relief Centers, Inc. to resolve allegations that the companies billed government health care programs for unnecessary medical laboratory tests. As part of the agreement, Logan Labs, Tampa Pain,

and two former executives will pay $535,449 for submitting or causing the submission of false claims to the Florida Medicaid program.

Logan Labs and Tampa Pain, both wholly owned subsidiaries of Surgery Partners, Inc., are based in Tampa. Logan Labs is a toxicology laboratory that provides urine testing services. Tampa Pain is a pain management medical practice. The two former executives involved in the case are Michael T. Doyle, former CEO of Surgery Partners and Logan Labs and Christopher Utz Toepke, former Group President for Anciallary Services at Surgery Partners, with oversight of Logan Labs, and a former Vice President at Tampa Pain.

The agreement resolves allegations that, from Jan. 1, 2012 through Dec. 31, 2017, the defendants developed and implemented a policy and practice of automatically ordering both presumptive and definitive urine drug testing for all patients at every visit, without any physician making an individualized determination that the testing was medically necessary for those specific patients. Presumptive UDTs are tests that screen for the presence of drugs, and definitive UDTs identify the amounts of those drugs in a patient's system. According to the allegations, the medically unnecessary presumptive UDTs were performed at Tampa Pain, the medically unnecessary definitive UDTs were performed at Logan Labs. Both Logan Labs and Tampa Pain submitted the resulting false claims to federal health care programs for payment with taxpayer dollars.

As a condition of the settlement, Logan Labs entered into an integrity agreement and Tampa Pain entered into a corporate integrity agreement with the United States Department of Health and Human Services, along with the Office of the Inspector General.

The allegations were brought in qui tam actions filed in the U.S. District Courts for the Middle District of Florida and the Eastern District of Pennsylvania under the federal False Claims Act, the Florida False Claims Act, and various state false claims act statutes.

Teva Pharmaceuticals

Settlement was reached in this matter to resolve allegations that Teva Pharmaceuticals USA Inc. ("TEVA") used its speaker programs to promote off-label uses of the drugs Copaxone and Azilect. The Teva speaker program allegedly involved promoting Copaxone for off-label use in connection with brain atrophy, neuro-protection, and the history of relapse rates in multiple sclerosis clinical trials relating to Copaxone. As a result of these off-label speaker programs, healthcare providers submitted false claims for payment of drugs that were neither medically indicated or necessary for the off label uses.

The settlement also resolved allegations that illegal kickbacks were paid to physicians in amounts anywhere from $1,500 to $2,700 for each speaker, which were disguised as an "honorarium." Between 2011 and 2012, the number of speaker programs for the subject drugs increased nearly four-fold. The honoraria associated with these programs average between $2,000 and $2,500 per program. It was alleged that in 2012 alone, Teva paid over $10 million to doctors for speaking at these programs. These programs came in several forms, such as "Journal Clubs," peer-to-peer programs, and patient programs. However, they were sparsely attended, if at all, and the physicians were generously paid for doing minimal, if any work. Teva allegedly promoted these programs as a way for physicians to make money in exchange for increased Copaxone and Azilect prescriptions. These programs were allegedly Teva's "silver bullet" to increase prescriptions.

As a result of the settlement, Florida Medicaid received $448,732.54.

Lorna Dukes

Attorney General Ashley Moody's Medicaid Fraud Control Unit and the St. Lucie County Sheriff's Office, along with the U.S. Marshall Fugitive Task Force, arrested a home and community-based services (HCBS) business owner for defrauding the Medicaid program out of more than $200,000. Lorna Dukes

owned and operated 3D Living & Home Services Inc., that provided HCBS to Medicaid recipients.

According to the investigation by the MFCU, Dukes submitted falsified claims for services not rendered to several Medicaid recipients and received payments from the Florida Medicaid program based on the falsified claims. The MFCU investigation revealed that 3D Living & Homes Services Inc. did not provide HCBS as frequently as billing indicated and provided no service to a number of the recipients billed. From Jan. 1, 2017 through July 31, 2019, Dukes allegedly caused the Medicaid program to pay approximately $204,022 for a total of 2,038 fraudulent claims for HCBS services neither she nor her company rendered.

Dukes is charged with one count of Medicaid fraud and one count of grand theft, both first-degree felonies. If convicted, Dukes faces up to 30 years in prison on each count. Attorney General Moody's Office of Statewide Prosecution will prosecute the case.

Laura Leace

Attorney General Ashley Moody's Medicaid Fraud Control Unit and the Brevard County Sheriff's Office arrested an individual on charges of Medicaid provider fraud. Laura Leace is accused of engaging in a systematic scheme to fraudulently bill the Medicaid system, including billing for services not rendered and submitting false claims totaling more than $45,000.

The Agency for Persons with Disabilities (APD) referred the case to the MFCU after an audit found that Leace regularly submitted identical receipts for reimbursement. Further investigation revealed that Leace also reported claims for in-home care services that were not provided. Leace, acting as a patient's representative under the Consumer Directed Care Plus program in the APD, submitted a total of more than $45,000 in fraudulent claims to APD and Medicaid.

APD administers the Consumer Directed Care Plus program for Medicaid that allows a qualifying family member of a disabled adult to directly manage the adult's care. The representative can submit reimbursement requests for qualified medical expenses and can directly manage third-party in-home care.

Leace is charged with one count of Medicaid provider fraud and one count of Organized Fraud, both second-degree felonies.

A MFCU Assistant Attorney General cross-designated with the State Attorney's Office in the 18th Judicial Circuit will prosecute the case.

Willie T. Barnes

Attorney General Ashley Moody's Medicaid Fraud Control Unit and the St. Petersburg Police Department arrested a Pinellas County man for willfully and intentionally engaging in Medicaid fraud for more than two years. Willie T. Barnes allegedly received more than $15,000 in Medicaid payments for therapy never provided to clients. Barnes is the owner and operator of Barnes Holistic Counseling Therapies Institute located in St. Petersburg.

The arrest is the result of an investigation conducted by the MFCU, with the assistance of the U.S. Department of Health and Human Services' Office of the Inspector General. According to the investigation, Barnes allegedly caused the Florida Medicaid program to be billed for therapy services claimed to be provided to Medicaid recipients by a former employee.

From June 1, 2016 to around Oct. 31, 2018, Barnes allegedly generated service claims for 392 patients using the former employee's information to portray services rendered, when the employee had not. As a result, Barnes received more than $15,000 in payments from the Florida Medicaid program. The investigation also revealed Barnes allegedly offered kickbacks for patient referrals and patient retention, which is prohibited by Medicaid provider fraud statutes.

Barnes is charged with one count of Medicaid provider fraud, a second-degree felony, and one count of scheme to defraud, a third-degree felony. If convicted, Barnes faces up to 20 years in prison and more than $30,000 in fines and restitution. Attorney General Moody's Office of Statewide Prosecution will prosecute the case.

Kharma Rogers

Attorney General Ashley Moody announced the arrest of a Manatee County resident for Medicaid fraud and scheme to defraud. The arrest by the Bradenton Police Department follows an investigation by Attorney General Moody's Medicaid Fraud Control Unit acting on information received from the Agency for Health Care Administration. The investigation revealed that Kharma Rogers allegedly falsified academic degrees and certified medical credentials to become an approved Medicaid program provider.

According to the investigation, Rogers worked with the Medicaid program as a provider for Behavior Analysis Services (BAS) through her business, Community Abilities & Beyond. BAS must be performed by a provider with board-certified credentials in the field. Rogers allegedly submitted falsified credentials to the Medicaid program to become an approved provider. In addition to a fraudulent master's degree and doctorate, Rogers submitted falsified certificates indicating she and one of her employees were certified to perform the services. As a result, the company received more than $3,500 by the Medicaid program for providing specialized services to recipients without being properly trained to administer them.

Rogers is charged with one count of Medicaid fraud less than $10,000, and one count of scheme to defraud, both third-degree felonies. If convicted, Rogers faces up to 10 years in prison and $10,000 in fines. The Attorney General's Office of Statewide Prosecution will prosecute the case.

Juliet Haimes

Attorney General Ashley Moody announced the arrest of an individual who allegedly abused a mentally disabled adult. Following an investigation by the Attorney General's Medicaid Fraud Control Unit, the Orange County Sheriff's Office (OCSO) arrested Juliet Haimes on one count of aggravated abuse of a mentally disabled person. The investigation found that Haimes, a former employee at the LaMirada group home in Winter Springs, maliciously punished a mentally disabled adult under Haimes' care.

A complaint to the MFCU from a co-worker of Haimes initiated the investigation. The coworker observed Haimes pin a disabled resident to the ground and punch him repeatedly in the back. The witness also alleges that Haimes locked the disabled resident's arms behind his back and forced his head into a towel, obstructing his ability to breathe. Investigators received photographs taken by the coworker that corroborate the abuse and bruising caused by the abuse. Florida Mentor, the company that operates the LaMirada group home, has fired Haimes.

The OCSO arrested Haimes on one count of aggravated abuse of a mentally disabled person, a second-degree felony. If convicted, Haimes faces up to 15 years in prison and up to $10,000 in fines. A MFCU Assistant Attorney General cross-designated with the Seminole County State Attorney's Office will prosecute the case.

Total Recoveries

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

The MFCU is also responsible for enforcement of the Florida False Claims Act. With the conversion to the Florida Statewide Medicaid Managed Care (SMMC) program, the Civil Enforcement Bureau (CEB) will focus investigative and litigation efforts on more managed care cases against providers and national suppliers who attempt to defraud the SMMC program. In addition to its role in multi-state nationwide cases, CEB has seen a shift in Medicaid fraud investigations to more Florida-only state cases, Federal

court cases with the United States Attorneys' offices where Florida is the only named state, and regional cases with fewer co-plaintiff states.

In FY 2019-20, the total amount for civil recoveries, which include civil settlements arising from qui tam cases brought under Florida's False Claims Act and civil judgments was $5,350,331. The total amount for criminal recoveries based upon Medicaid fraud cases was $6,484,885. The total amount of the monies recovered by the MFCU for FY 2019-20 was $11,835,216.

Training

MFCU continues to emphasize mission critical training to stay professionally current. During FY 2019-20, MFCU staff attended a total of 3,726 hours of training.

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

In-house training provided through a variety of delivery methods included courses such as Taking Steps into Windows Memory Forensics, Ethics and CPR/AED Certification. Classroom and range firearms qualification and Use of Force training was provided to our law enforcement personnel locally by MFCU certified instructors at no cost.

MFCU training in FY 2019-20 included Physiological Response Dynamics, Money Laundering and Commingling, Guide to the New Senior Abuse Financial Tracking and Accounting, Prosecuting Covid-19 Related Crimes, Thriving in a Remote Workplace, Financial Exploitation: Does a Power of Attorney Mean Game Over for the Prosecutor and Advanced Digital Forensics.

Data Mining

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

Under 42 CFR §1007.20, MFCU made application on May 18, 2016, through the Department of Health and Human Services, Office of Inspector General (DHHS-OIG) to continue data mining. DHHS-OIG granted approval for MFCU to data mine through 06/20/2019 with the data mining efforts coordinated with and not duplicative of AHCA. On September 4, 2019 MFCU was granted a temporary extension to data mine through October 1, 2019 and on January 21, 2019 MFCU was granted approval to data mine through June 19, 2022.

As of June 30, 2020, the MFCU has submitted 95 data mining projects to AHCA for review and approval. Of the 95 submitted, 69 were approved by AHCA. On June 30, 2020, MFCU had 3 cases in an active status from these projects.

Health Care Fraud Prevention and Enforcement Action Team (HEAT)

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

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

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

The Florida MFCU has been an active participant in the Medicare Fraud Strike Force and achieved a number of convictions and successes during FY 2019-20. The chart below illustrates:

Defendant	Arrest Date	Conviction Date	Sentencing Date	Total Recovery	Prison	Probation
Figueroa Carlos Perez		8/5/2019	8/5/2019	$26,517	18 Months	5 Years
Rojas Antonio	9/25/2018	8/13/2019	8/13/2019	$26,517	4 Years	5 Years
Esformes Philip	7/22/2016	4/5/2019	9/12/2019	$5,532,207	240 Months	3 Years
Gonzalez Annie Suarez	2/7/2019	5/14/2019	10/25/2019	$100		1 Year
Marrero-Castellanos Fidel Alejandro	2/7/2019	5/14/2019	10/25/2019	$26,506	13 Months	3 Years
Garcia Dr. Rodolfo Gonzalez	2/7/2019	8/20/2019	12/16/2019	$100	96 Months	3 Years
Gonzalez Arlene Alexandra	2/7/2019	8/20/2019	12/16/2019	$100	4 Months	1 Year

Medicaid Fraud Reporting Reward Payments FY 2019-20

Under Florida law persons who report Medicaid Fraud (under certain conditions) are eligible to receive a financial reward. During the report period $25,000 was paid pursuant to this law. See Section 409.9203, Florida Statutes (2018).

THE AGENCY FOR HEALTH CARE ADMINISTRATION

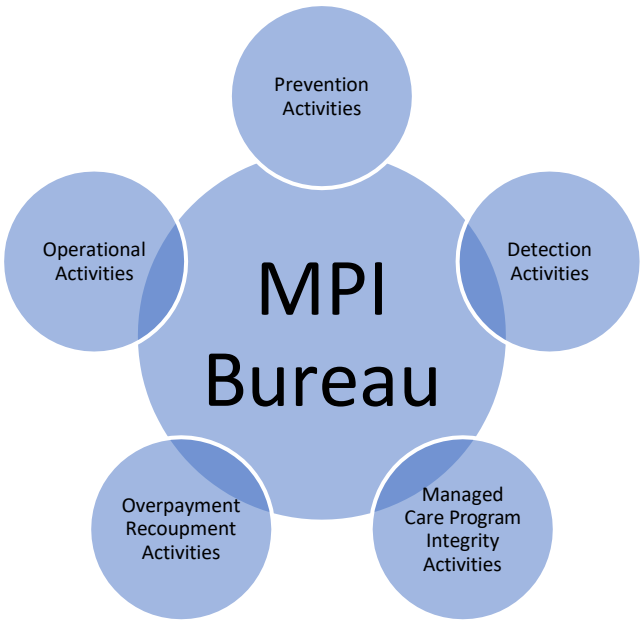
The Agency for Health Care Administration is required, pursuant to s. 409.913, Florida Statutes (F.S.), to operate a Medicaid provider oversight program to ensure that fraudulent and abusive behavior occurs to the minimum extent possible in the Medicaid program. The Agency's Bureau of Medicaid Program Integrity (MPI) continues to serve as the lead office to design, coordinate, and implement the Medicaid program's fraud, abuse, and waste prevention and detection efforts.

Highpoints of actions by the Division of Medicaid, and Division of Health Quality Assurance follows the Medicaid Program Integrity overview.

Medicaid Program Integrity

Overview

MPI's functional organizational structure is depicted below and briefly summarized in the sections which follow. Previous years' reports have detailed these functions.



Prevention

The Prevention Units are responsible for five main functions related to program integrity activities in Florida Medicaid: Field operations, programmatic assessments and special projects, administrative sanctions, payment restrictions, and law enforcement referrals and law enforcement liaison activities with state and federal partners. Prevention activities include oversight, reviews, investigations, and enforcement activities regarding high-risk provider types. MPI personnel continue to work closely with the Division of Medicaid, collaborating on known and anticipated program vulnerabilities. Details of these efforts are explained in a separate section of this report.

FY 2019- 20 Payment Restrictions	
Payment Restriction Type	**Number**
Prepayment Review (PPR)	17
Payment Withheld (25A Withholds)	6
Payment Suspension due to Credible Allegation of Fraud (CAF)	39

FY 2019-20 Denied Claims (PPRs, 25A, CAF)		
	Number	**Amount**
Claims Reviewed	37,042	$7,034,236
Claims Denied	15,722	$4,564,966

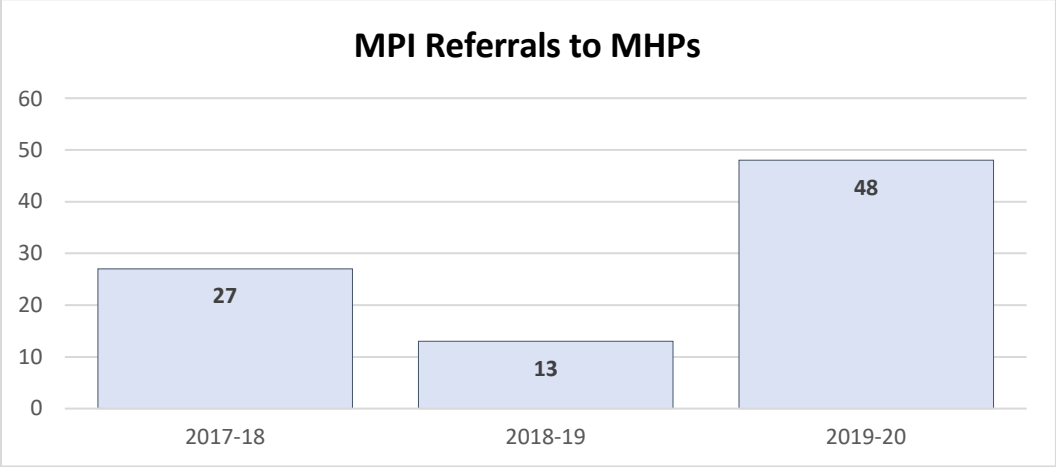
Detection

Fraud and abuse detection activities continue to involve both the intake and assessment of complaints from a variety of sources, as well as the internal development of leads through data analysis. MPI continues to work toward increasing the complexity or depth of preliminary investigations. Particularly, MPI efforts strive toward fraud detection, as opposed to abuse or waste detection.

During FY 2019-20, MPI received and assessed 2,806 complaints. Of these complaints, 361 came from internal sources. MPI's internally generated complaints and cases typically come from the Detection unit or from other unit's projects and initiatives, with support from or initiated by the Data Analysis team.

Managed Care

The MPI Managed Care Unit has primary oversight of the program integrity efforts of Medicaid Health Plans (MHPs) and serves in a consultative role for the rest of the Bureau as duties related to managed care fraud and abuse spread to all MPI areas. MPI continues to receive the Suspected/Confirmed Fraud and Abuse Reports (also referred to as 15-day reports) from the MHPs and during FY 2019-20 introduced the idea of benchmarks for the MHPs relative to their submission of suspected fraud referrals. Another area of managed care focus has been on formal referrals of program integrity issues from MPI to the MHPs for investigation.



Overpayment Recoupment

Overpayment Recoupment activities are predominately carried out through three teams in MPI, organized by audited provider types. Audits determine if there has been noncompliance with Medicaid policy and identify overpayments for recovery. MPI also conducts audits through contracted audits. Although audits of Fee-For-Service (FFS) claims to identify overpayments for recoupment continues to yield high-dollar results for the Agency, MPI also recovers overpayments that are time limited by provisions of section 641.3155, F.S., or if the Medicaid Health Plan has not properly reported to the Agency the suspected fraud, abuse, or waste.

Self-Audits			
	FY 2017-18	**FY 2018-19**	**FY 2019-20**
Audits Completed	163	142	212
Overpayments Identified	$2,267,008	$1,352,956	$5,880,930

Recovery Activities – Identified Amounts			
	FY 2017-18	**FY 2018-19**	**FY 2019-20**
Overpayments (MPI/MPI-CMS Audits)	$18,863,353	$32,889,358	$29,926,776
Costs	$300,880	$516,739	$114,638
Fines	$1,986,083	$3,242,626	$2,541,756
Paid Claims Reversals	$20,601	$102,359	$82,949
Total	**$21,170,918**	**$36,751,083**	**$32,666,121**

Operations

Operational activities are critical to MPI in carrying out its duties to combat fraud, abuse, and waste. These activities include public record requests, provider self-audits, record storage, coordination with vendors, training, and ongoing efforts to identify and address technology and other needs to optimize bureau activities.

Self-audits have been a specific area of focus this year and resulted in increased recoveries. MPI has promoted self-audits through sharing potential overpayment or billing errors with providers after a concern is identified. For example, if a single provider identified inappropriate billing and repays an overpayment, MPI may share this information with other like providers to determine if they may have a similar billing error. Providers who conduct such a self-audit may avoid an MPI audit for the same billing error or overpayment issue.

Pursuant to sections 409.907(12) and 409.908(26), F.S., the Agency may certify that a Medicaid provider is out of business. This certification renders the amount of the overpayment uncollectable for purposes of refunding the federal share of the overpayment but does not release the provider from liability of the debt. The Operations unit conducts reviews of providers deemed noncompliant with repayment obligations by Financial Services to determine if the circumstances suggest that non-payment is due to a provider no longer being in operation.

Certified Out of Business	
Providers Reviewed	34
Certified Out of Business Adjustments	$1,891,589

Fraud and Abuse Schemes

Report Medicaid Fraud or Abuse

https://apps.ahca.myflorida.com/mpi-complaintform/

MPI's fraud and abuse detection efforts predominately focus on the following schemes:

- Failure to follow coverage and limitation (policy) provisions
- Upcoding procedure codes

- Unbundling procedure codes
- Billing non-covered services as covered services
- Misrepresenting material details on claims (or in documentation) such as dates or location of service, or rendering/ordering/authorizing provider
- Patient brokering/misuse of recipient information
- Falsified documents

- Straw owners/shell corporations/shelf corporations
- Billing for services not rendered
- Corruption/kickbacks/bribery/other financial crimes
- False or unnecessary prescriptions/orders for drugs, medical equipment/supplies, services

MPI Strategic Plan

Historical program integrity efforts have been predominately based on looking for outliers in paid claims, which involves tedious efforts to audit providers and often fails to distinguish legitimate providers with billing errors from providers engaged in fraudulent and abusive behavior. Today's MPI efforts rely on innovative approaches and place greater emphasis on the use of fraud risk models and advanced analytic techniques to focus program integrity activities on the greatest vulnerabilities. Furthermore, as has been detailed in previous year's reports, the MPI strategic plan continues to emphasize the importance of robust program integrity efforts even with a predominately managed care delivery model; managed care does not eliminate program vulnerabilities.

An organization's mandate – it's authorization and directive – is typically static (without a change in law or other authorizing directive). MPI's mandate is based upon federal regulations and state statutes that set forth the parameters of our operations. 42 CFR Part 455 includes requirements for the Medicaid State Plan and other requirements regarding program integrity, including the identification, investigation (preliminary and full), and referrals/cooperation with MFCU, and the imposition of payment suspensions. Section 409.913, F.S. further provides authority and directive for MPI operations.

> *The agency shall operate a program to oversee the activities of Florida Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate.*

MPI's mission includes:

- Increase overall value to the Medicaid program through recovery of overpayments, cost avoidance, and other activities that include monetary and non-monetary program impact
- Mitigate/reduce risk of fraud and abuse through network controls, programmatic assessments, and collaboration and outreach
- Maximize a team approach to optimize efforts through collaboration internally within MPI, across Agency organizational units, and external to the Agency

The mission must remain in focus when developing the objectives and ultimately the organization's measures of achievement of the objectives.

Operating objectives are organizational goals that are ongoing and necessary to sustain the organization. These objectives do not go away when new priorities emerge and include topics related to the organization's core objectives. Examples for MPI include specific detection activities, overpayment recovery, MFCU referrals, and managed care plan oversight. Other objectives, described as opportunity objectives for purposes of the MPI strategic planning, are organizational goals that may originate outside MPI, typically due to external requirements or as required to mitigate obstacles or hinderances to successful attainment of other objectives.

Some of the Bureau objectives include improving the impact of investigations, improving identified overpayments, expanding the use/success of advanced data analytics, increasing provider self-audits, improving the quality and quantity of MFCU referrals, and improving the quality and quantity of MPI to MCO referrals. Additionally, objectives include: refine MPI reporting; conduct complaint intake and assessment; impose sanctions and payment restrictions; conduct audits; investigations; novel and non-claims-data driven projects; and field operations/site visits; identify and take advantage of training opportunities; continue to recruit and retain highly-qualified personnel; and conduct topic specific research.

MPI Activity Data

MPI Referrals to Others	
Agency for Persons with Disabilities	10
Department of Children and Families	176
Department of Health	16
Division of Medicaid	13
Division of Health Quality Assurance	190
Managed Care Organization	48
Medicaid Fraud Control Unit – Attorney General	84
Total	**537**

Provider Sanctions and Medicaid Health Plan Assessments						
	FY 2017-18		**FY 2018-19**		**FY 2019-20**	
Sanctions	**Number**	**Amount**	**Number**	**Amount**	**Number**	**Amount**
Fines	140	$1,986,083	171	$3,242,626	186	$2,541,756
Suspensions	59	-	62	-	50	-
Terminations	91	-	91	-	33	-
Health Plan	9	$110,400	8	$134,000	3	$117,750
Total	**299**	**$2,096,483**	**332**	**$3,376,626**	**272**	**$2,659,506**

Recovery Activities – Collections and Reversals			
	FY 2017-18	**FY 2018-19**	**FY 2019-20**
Overpayments, Costs, and Fines	$22,259,884	$15,217,521	$18,584,224
Paid Claims Reversals	$20,601	$102,359	$82,949
Total	**$22,280,445**	**$15,319,880**	**$18,667,173**

MPI Prevention of Overpayments			
	FY 2017-18	**FY 2018-19**	**FY 2019-20**
Denied Claims (PPRs, 25A, CAF) Impact	$1.78	$4.24	$4.56
Termination of Providers Impact	$0.62	$0.68	$14.23
Program Suspensions Impact	$0.16	$0.04	$0.36
Focused Projects Impact	$0.17	$3.4	$2.78
Site Visits Impact	$1.82	$5.94	$4.31
Sanctioned Providers Impact	$1.31	$12.4	$32.19
Audit Impact	$3.73	$42.9	$42.19
PPR and 25A Impact	$0.04	$56.5	$119.2
MFCU Referrals Impact	$38.4	$58.9	$14.3
Total	**$48.03**	**$185.05**	**$234.12**

Return on Investment (ROI)				
		Benefits	**Costs**	**ROI Ratio**
FY 2017-18	Recovery	48.00	8.35	5.75:1
	Prevention	48.03	4.30	11.16:1
	Total	**96.03**	**12.65**	**7.59:1**
FY 2018-19	Recovery	35.48	7.56	4.69:1
	Prevention	185.05	4.14	44.68:1
	Total	**220.53**	**11.7**	**18.84:1**
FY 2019-20	Recovery	30.92	5.21	5.94:1
	Prevention	234.12	3.94	59.43:1
	Total	**265.04**	**9.15**	**28.96:1**

In order to calculate MPI's Return on Investment (ROI), data related to operating costs (salaries, audit vendor costs, and outside litigation), recoveries (collections of MPI and CMS audit overpayments, costs, & fines, paid claims reversals, certified out of business adjustments, MHP assessments, and TPL contractor-assisted collections/adjustments), and prevention dollars (also known as Cost Avoidance dollars) for several categories, such as denied claims, provider terminations, site visits, sanctions, audits are considered. Historically, prevention activities have been considered the most cost-effective approach to combatting fraud, abuse, and waste; however, the value of prevention is often difficult to calculate and has been a focus of the Agency for the past several years. Additional information on MPI's historical prevention calculations demonstrate the continuous development and refinement of the ROI methodology are detailed further in previous annual reports at http://ahca.myflorida.com/MCHQ/MPI/.

Division of Medicaid

Medicaid's Response and Program Adaptability Related to COVID-19

In the last four months of Fiscal Year 2019-20, the emergence and spread of COVID-19 dominated national attention. The virus had far-reaching effects on the nation's health care system, and Florida's health care providers and the Medicaid program were also significantly impacted. Building on recent experiences with hurricanes and developments in Disaster Planning, the Division of Medicaid immediately focused on making sure vital health services were not interrupted, leveraging federal waiver authority to offer providers extra flexibilities to deal with the crisis.

Florida was the first state to use the 1135 waiver authority to extend flexibilities in provider enrollment and waive prior authorization requirements. The 1135 waiver also temporarily waived nursing facility Pre-Admission Screening and Resident Review and allowed enrollees more time to request a fair hearing or plan appeal. To ensure there were enough providers ready to provide services, the 1135 waiver allowed out-of-state providers to be reimbursed for services if they were already enrolled in Medicare or in another state Medicaid program and implemented a provisional enrollment process for 180-days which waived payment of criminal background checks, licensure, and site visits. Medicaid also implemented a rule to permit home health agencies not Medicare/Medicaid certified to enroll provisionally during the state of emergency.

In addition, Medicaid implemented other flexibilities to ensure critical coverage and access to health care services. All limits were removed for COVID-related testing and services and all co-pays were waived for all Medicaid services. Pharmacy refills of maintenance medications were allowed for up to 100 days, and early refills were allowed in certain circumstances. Long-term care home and community-based services were expanded, and face-to-face requirements for many services were waived.

One of the most important and effective interventions was expansion of telehealth protocols. Medicaid expanded the services that could be provided by telehealth including Behavior Analysis (caregiver training/supervision), Early Intervention Services (sessions), Therapy Services (all), and Medical (store and forward/remote patient monitoring/telephone only).

The following is a list of flexibilities implemented sorted by topic, showing the dates implemented:

Topic	Description	Implementation Date
Benefits	Lift early refill edit on prescription medication	3/9/2020
Benefits	Add coverage of COVID lab testing codes (U0001/U0002)	3/13/2020
Benefits	Lift limits on services for COVID-19 patients and for services needed to safely maintain someone in the home	3/16/2020
Benefits	Allow 100-day supply of maintenance medications	3/16/2020
Benefits	Maximize mail order delivery of medications	3/16/2020
Cost Sharing	Waive co-payments for all services	3/16/2020
Eligibility	Extend Medicaid eligibility approval periods (DCF)	3/31/2020
Eligibility	Delay processing of Medicaid eligibility applications when all information has not been submitted – preserve date for 120 days (DCF)	3/31/2020
Provider Enrollment	Implement provisional provider enrollment for up to 180-days, which waives: - Criminal background checks - 42 CFR 455.43 - In-state/territory licensure - 42 CFR 455.412 - Site visits - 42 CFR. 455.432	3/16/2020
Fair Hearing	Allow enrollees more time to request a fair hearing or plan appeal	3/16/2020
HCBS (All)	Extend electronic visit verification compliance date	3/25/2020

HCBS (All)	Waive face-to-face case management requirements	3/12/2020
HCBS (LTC/iBudget)	Expand participant directed option/consumer directed care option for additional services	3/20/2020
HCBS (All)	Waive level of care assessment redeterminations	3/12/2020
HCBS (LTC/iBudget)	Expand provider qualifications – allowing already enrolled providers to act in other capacities to meet the need of members (e.g., adult day health care centers providing services in the home).	3/20/2020
Payment	Implement retainer payments for iBudget services	3/18/2020
PASRR	Level 1 and Level 2 assessments are waived for 30 days. All new admissions can be treated like exempted hospital discharges. After 30 days, new admissions should receive a Resident Review as soon as resources become available. (red not communicated)	3/16/2020
Prior Authorization	Waive prior authorization requirements (hospital, home health, DME, physician, physician extenders, LTC hospital, SNF, ambulance transport for COVID patients)	3/16/2020
Prior Authorization	Extend prior authorizations of elective procedures that have been postponed.	3/25/2020
Telemedicine	Expand telemedicine capabilities - Behavior Analysis (caregiver training/supervision) - Early Intervention Services (sessions) - Therapy services (all) - Medical (store and forward/remote patient monitoring/telephone only) - Behavioral (some)	3/18/2020 - 4/3/2020
Network	Require plans to pay providers that are not in their network for COVID patients, when necessary	3/18/2020
Physician's Orders	Honoring expired physician's order for DME items (existing patients only)	4/10/2020
Benefits	Waiving the 95% occupancy requirement for payment for nursing facility bed hold days	4/10/2020
Benefits	Allow Prescribed Pediatric Care Centers to provide services in the home setting	3/27/2020
Enrollment	Permit home health agencies not Medicare/Medicaid certified to enroll provisionally during the state of emergency	3/31/2020

Communication During the Emergency

Florida Medicaid worked diligently to ensure recipients and providers remained informed regarding steps being taken to ensure continued access to safe, quality healthcare as well as federal funding opportunities available to providers to help them treat COVID-19 patients and adapt to the new healthcare environment. Medicaid created a COVID-19 specific website which included all provider flexibilities, provider alerts, and information on funding opportunities as well as guidance for recipients on receiving services. Between March and June, Medicaid made more than 130 web updates to ensure information was accurate and current.

The Agency also used email alerts and “eblasts” to share critical information. Medicaid produced more than 90 COVID-related email alerts during the final 3 months of Fiscal Year 2019-20. Medicaid also worked closely with Medicaid health plans to ensure they were fully informed on all updates and changes related to COVID-19. Medicaid sent multiple emails to plans each week as well as holding at least one “All-Plan Call” per week to ensure all important information was relayed as quickly as possible.

Medicaid also took part in statewide efforts to respond to the pandemic and ensure stakeholders were informed of all details pertaining to the state and federal response as soon as the information was available. Medicaid and the Agency took part in weekly calls with the Florida Health Care Association, the Florida Hospital Association, the Florida Department of Health, and Florida Department of Emergency

Management to coordinate the response, convey important information, and identify and respond to stakeholder concerns.

COVID-19 Isolation Facilities

The Agency established 23 COVID isolation centers throughout the state and worked to ensure that all providers were aware of the availability of these facilities as a resource. Hospitals, nursing facilities, and assisted living facilities can use these facilities to discharge patients who require nursing facility level of care and who lack an appropriate discharge setting while recovering from COVID-19. Florida is phasing out its support of these facilities in fall 2020 due to decreased demand, but many of the facilities are continuing to accept COVID positive patients to their established isolation units.

Medicaid and the Agency worked closely with the federal entities, the Governor's Office, Emergency Management, and its sister state agencies to ensure the safety and continued access to quality health services for the State's most vulnerable citizens.

Third Party Liability (TPL)

The Division of Medicaid's TPL Unit is responsible for identifying and recovering funds for claims paid for by Medicaid for which a third party was liable, thereby ensuring Medicaid is the payor of last resort. Some examples of third parties include casualty settlements, insurance companies, recipient estates, Medicare and commercial carriers. TPL recovery services are performed by a state procured outside vendor, Health Management Systems, Inc (HMS). The Agency recently extended its contract with HMS through August 31, 2025.

During FY 2019-20, $76.8 million in Medicaid funds were collected. Annual TPL collections over the last five years have averaged $87.7 million. In addition, the TPL Unit has held HMS and their subcontractor Conduent Payment Integrity Solutions (Conduent) accountable to its contract requirements by vigorously monitoring their performance. These efforts have helped to ensure maximum recoveries are generated for the State of Florida. Types of recoveries include:

- **Casualty** – Medicaid imposes a lien against liable third parties for the amount Medicaid has paid for services on behalf of a recipient who has been involved in an accident or incident, which resulted in injury. Attorneys are required to notify Medicaid that they represent a Medicaid recipient involved in an accident or incident;
- **Estate** – Medicaid files an estate claim on behalf of a deceased Medicaid recipient for Medicaid payments made after age 55. Medicaid is to be paid, as class 3 creditor, after attorney and personal representative fees and funeral costs, and must be notified by the estate attorney or personal representative when an estate is opened on any individual over age 55;
- **Trusts and Annuities** – Trusts and Annuities relating to a person's eligibility in the Medicaid program stipulate that upon the death of the beneficiary, or if the trust/annuity is otherwise terminated, the balance of the trust up to the amount that Medicaid paid for services on the beneficiary's behalf is to be paid to the Medicaid program;
- **Medicare and Other Third Party Payor** – Medicaid bills and collects from insurance carriers and Medicaid providers for claims paid for by Medicaid for which Medicare or another third party such as private insurance may have been liable;
- **Other Recoupment Projects** – The TPL Unit also works in conjunction with the Agency's Bureau of Medicaid Program Integrity to conduct other Medicaid recoupment projects. Recoveries from other recoupment projects during FY 2019-20 include:
  - **Date of Death** – Claims paid after the dates of death of Medicaid recipients are recovered;
  - **Hospital Credit Balance Audits** – Hospital accounts payable ledgers are reviewed in connection with collecting Medicaid overpayments; and

- **Freestanding Dialysis Center Credit Balance Audits**- Freestanding Renal Dialysis Center provider's payable ledgers are reviewed in connection with collecting Medicaid overpayments.
- **Nursing Facility Services Provider Retrospective Review**- The TPL Vendor conducted Nursing Facility Services Provider Retrospective Reviews of all fee-for-service payments made on behalf of Medicaid-eligible residents of nursing homes and other Nursing Facility Services providers.

- **Medicaid Overpayments** – Funds are recovered from providers where Medicaid has overpaid for a service, for example:
  - **Duplicate Crossover Payments** – Two Medicaid payments for Medicare Crossover liability;
  - **Outpatient Payment During Inpatient Stay** – An outpatient Medicaid payment immediately preceding an inpatient stay;
  - **Overutilization** - Outpatient Payments Over $1,500 – payments made in excess of the $1,500 limit for outpatient claims during a fiscal year;
  - **Service Exclusions** – Claims paid for services that are excluded per the respective Services Coverage and Limitations Handbook(s) and provider fee schedules for pharmacy, professional, institutional, and dental claim types:
    - Inpatient Stay over 45 days;
    - Non-covered Outpatient Revenue Codes;
    - Revenue Codes Not on Promulgated Billing Code; and
    - Outpatient to Inpatient Transfers.
- **Cost Avoidance** - Cost avoidance is new and/or updated insurance information that is derived from data matches with insurance carriers. Cost avoidance is also derived from insurance information obtained at the time of eligibility, through Medicaid field office staff and Medicaid providers. When new and/or updated insurance information is obtained, that information is added to the Florida Medicaid Management Information System (FLMMIS) in order to cost-avoid future claims that are submitted by Medicaid providers. When a provider submits a claim and a recipient has other insurance, the provider is instructed to bill the other insurance prior to billing Medicaid. The Agency utilizes a matrix maintained in FLMMIS to determine whether a claim shall be paid or denied based upon other third party information contained on the Medicaid recipient's file. Cost avoidance is the amount that was denied based upon third party information contained on the Medicaid recipient's file.

Below is a summary of Historical Medicaid TPL collections:

TPL Collections	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019- 20
Casualty	$22,819,897	$15,233,111	$14,202,145	$12,577,721
Estate	$7,709,297	$8,190,939	$10,485,571	$10,080,512
Trusts	$9,905,343	$11,498,094	$12,157,443	$13,418,416
Medicare and Other Third Party Payor	$36,444,209	$30,040,263	$28,160,938	$30,443,886
Other Recoupment Projects*	$12,074,137	$25,935,208	$20,400,459	$10,240,320
Total Collections	$88,952,883	$90,985,339	$85,406,555	$76,760,855
Cost Avoidance (Matrix)	$1,338,770,174	$1,215,514,268	$1,362,581,538	$1,290,186,179

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

Division of Health Quality Assurance

Care Provider Background Screening Clearinghouse

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

The Clearinghouse also includes a RapBack requirement, also known as "retained prints," which enables immediate notification to the Agency of the recent arrest of an employee to determine if the arrest affects access to vulnerable clients. The Clearinghouse also notifies providers of an arrest and prompts the Provider to check eligibility. The immediacy of notification through RapBack improves the Agency's response time in prevention of Medicaid fraud. The Clearinghouse provides the ability to keep an employee roster. Facilities are required to maintain a current employee roster, with updates to be made within 10 business days of a change, including a new hire, termination, or position change. With this requirement, the Agency can know immediately when a facility has employees who are not eligible on their roster and take action against the facility if it does not comply. From Clearinghouse implementation to the end of FY 2019-20, the Agency has imposed 554 background screening violations and 246 employee roster violations.

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

During FY 2019-20, the Background Screening Unit processed 24,662 RapBacks. Of these, nearly sixty percent were found to be for criminal charges that resulted in the applicant's eligibility status being updated to not eligible. During FY 2019-20, 170,816 background screening results were shared among participating agencies and Medicaid health plans (MHPs) and 69,687 renewal screenings were requested resulting in an overall cost savings of $15,110,871 to Agency providers, Department of Health licensees, MHPs, Medicaid providers, Department of Children and Families, Department of Elder Affairs programs, Department of Education's Vocational Rehabilitation providers, and Agency for Persons with Disabilities providers.

Licensure Protections to Prevent Fraud and Abuse

Since 2009, the Legislature has passed various regulatory reforms and fraud and abuse prevention; key provisions include:

- **Home Health Agencies** – Home Health Agencies which have demonstrated a pattern of billing the Medicaid program for medically unnecessary services, have either received an administrative penalty for violating s. 400.474(6)(e), F.S., or denied a renewal application based on the provisions of s. 400.471(8), F.S. In FY 2019-20, 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 FY2019-20;

- **Nonimmigrant Aliens** - Nonimmigrant aliens who have applied for a home health agency, home medical equipment or health care clinic license, and met the requirements of s. 408.8065, F.S. One applicant met these criteria in FY 2019-20;
- **Financial Requirements** - There were 27 home health agency applications, 19 home medical equipment applications, and 41 health care clinic applications in FY 2019-20 that failed to meet the financial requirements of s. 408.8065, F.S. This includes applicants that did not reply to omissions related to proof of financial ability to operate during the application process; and
- **Revocations and Terminations** - Providers that were revoked, denied a renewal application or surrendered their license based on a Medicare or Medicaid suspension, termination or exclusion from either program related specifically to fraud based on the provisions of s. 408.815(1)(e) and s. 408.815(4), F.S.

Final and Emergency Orders

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

Licensure Final and Emergency Orders					
Fiscal Year	**2015-16**	**2016-17**	**2017-18**	**2018-19**	**2019-20**
Denying the renewal application	29	31	57	25	36
Revoking an existing license	52	22	24	20	14
Emergency orders	17	13	16	15	15
Provider surrendering their license	15	11	9	4	11
Total	113	77	106	64	76
Imposed Fines and Administrative Fees	$2,873,568	$2,218,876	$2,247,434	$3,017,176	$4,014,291

STATUTORY REPORTING REQUIREMENTS

Number of cases opened and investigated

MFCU opened 490 cases and had 1,261 active cases in FY 2019-20. MPI investigated 3,434 cases, which included 1,106 opened during the year.

Sources of the cases opened

	MFCU		AHCA	
Source	**Fraud**	**PANE**	**MPI**	**Total**
AHCA - Financial Services			22	**22**
AHCA - Heath Quality Assurance		2	5	**7**
AHCA - Medicaid Fiscal Agent Operations			19	**19**
AHCA - Medicaid Program Integrity (MPI)	37	9		**46**
AHCA - Medicaid Services			23	**23**
AHCA - MPI Detection			2	**2**
AHCA - MPI Institutional			62	**62**
AHCA - MPI Jacksonville/Orlando/Tampa			2	**2**
AHCA - MPI Managed Care Unit			14	**14**
AHCA - MPI Miami			11	**11**
AHCA - MPI Pharmacy			260	**260**
AHCA - MPI Practitioners Care			2	**2**
AHCA - MPI Prevention Strategy			5	**5**
AHCA - Other Offices			1	**1**
APD - Agency for Persons with Disabilities	4		2	**6**
APS - Adult Protective Services	3	188		**191**
Attorney	1			**1**
Citizen	16	14		**30**
CMS - Centers for Medicare & Medicaid Services			2	**2**
Contractor for Center for Medicare & Medicaid			1	**1**
DCF - Department of Children & Families	1	1		**2**
DOH - Department of Health	1		4	**5**
Employee	14	1		**15**
EOMB			11	**11**
Family Member	13	15		**28**
Florida - Medicaid Fraud Control Unit			34	**34**
Generalized Analysis			12	**12**
Health & Human Services Inspector General	5		9	**14**
Internet/Media			12	**12**
Investigator Initiative			49	**49**
Joint Task Force	3			**3**
Law Enforcement Agency		2		**2**
Managed Care Special Investigations Unit	47			**47**
Medicaid Provider	7	1		**8**
Medicaid Recipient	2	3		**5**
National Association of MFCU	4			**4**
Online Complaint Form			40	**40**
Other			10	**10**
Press Report	1			**1**

Previous File or Case			3	**3**
Projects			278	**278**
Provider			2	**2**
Qui Tam	90			**90**
Self-Audit			209	**209**
Spinoff Case	5			**5**
Total	**254**	**236**	**1,106**	**1,596**

Disposition of the cases closed

	MFCU		AHCA	
Case Type	**Fraud**	**PANE**	**MPI**	**Total**
Administrative Closure	3			**3**
Administrative Referral	34	14		**48**
Assistance to Other Agencies	2			**2**
Bankruptcy			1	**1**
Case Dismissed	23			**23**
Certified Out of Business			34	**34**
Civil Settlement	32			**32**
Consolidated	2	1		**3**
Conviction	19	10		**29**
Death of the Offender		1		**1**
Facts Alleged Not Indicative of		2		**2**
Fines Issued			7	**7**
Info Previously Referred to Other Law Enforcement Agency		1		**1**
Investigation by Another Law	3	8		**11**
Lack of Evidence	21	44		**65**
Liquidated Damages Applied			4	**4**
Medicaid Fraud Control Unit			68	**68**
No Abuse			25	**25**
No Auditable Review Period			2	**2**
No Findings			58	**58**
Nolle Prosequi	3			**3**
No Further Action Required			1,178	**1,178**
Not a Medicaid Funded Board & Care Facility		1		**1**
Not an Overpayment Issue			1	**1**
Not Sustained			20	**20**
Pre-Trial Intervention	1	2		**3**
Project Completed			42	**42**
Prosecution Declined	4	6		**10**
Provider Education			3	**3**
Provider No Longer Operational			37	**37**
Provider Suspended			50	**50**
Provider With Cause Termination			33	**33**
Provider Without Cause Termination			67	**67**
Referred			35	**35**
Resolved with Intervention	4	4		**8**

Statute of Limitations Expired	1			**1**
Suspension Lifted			2	**2**
Sustained			575	**575**
Under Investigation by Another Entity			2	**2**
Unfounded	14	23		**37**
Unsubstantiated	28	36		**64**
Vacated Fines			2	**2**
Vacated Suspension			1	**1**
Voluntary Dismissal	64			**64**
Voluntary Termination			1	**1**
Total	**258**	**153**	**2,232**	**2,659**

Amount of overpayments alleged in preliminary and final audit letters

Preliminary	Final
$67,386,473	$50,728,295

Number and amount of fines or penalties imposed

During FY 2019-20, MPI imposed fines (under s. 409.913, F.S., and Rule 59G-9.070, F.A.C.) in the amount of $2,541,756.

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 2019-20. During FY 2019-20, the Agency's final settlements resulted in no reductions of overpayments in closed cases.

Amount of final Agency determinations of overpayments

MPI identified overpayments in the amount of $29,926,776 in closed audits.

Amount deducted from federal claiming as a result of overpayments

Federal requirements changed several years ago, and now, allow the state up to one year to return the federal share, through federal cost share adjustments of overpayments, if no revenues are received on the debt. To ensure federal shares are allocated as timely as possible, the Agency reports the federal portion of the total overpayment on the next available federal CMS-64 quarterly report and reduces a corresponding federal share draw. During FY 2019-20, the Agency reduced its federal share, on quarterly cost reports, by $11,965,088 for net overpayments.

Amount of overpayments recovered

MFCU collected $1,744,782 in overpayments that were returned to the Agency. Additionally, MFCU collected $2,617,128 in Federal Medicaid overpayments that were sent directly to the U.S. Department of Health and Human Services for a total of $4,361,910 in Medicaid overpayments collected in FY 2019-20. Overpayments recovered as a result of the MPI and MPI-CMS audits were $18,584,224. Total recoveries by MPI, MPI-CMS, and MPI-TPL for FY 2019-20 were $30,913,596 (This includes collections of overpayments, fines, costs, and paid claims reversals, certified out of business, and contract assessments during the fiscal year).

Amount of cost of investigation recovered

During FY 2019-20, the MFCU collected $2,644 in program income investigative costs. MFCU also collected $8,883 in state share investigative costs and $5,735 in federal share investigative costs for a grand total of $17,262 for all investigative costs.

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

MFCU expenditures for FY 2019-20 were $18,038,742 which included indirect costs of $1,778,319.

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 2019-20 was less than 1 year (0.59).

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

During FY 2019-20, the Bureau of Financial Services deemed $16,611,974 as uncollectible.

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

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

Summary by Denial Reason	Totals
Previous Program Termination	300
Best Interest of The Program	374
Total	**674**

Denials by Provider Type	Totals
05 - Community Behavioral Health Services	18
07 - Specialized Therapeutic Services	3
08 - School District	1
14 - Assistive Care Services	10
20 - Prescribed Drug Services	5
25 - Physician (M.D.)	37
26 - Physician (D.O.)	2
27 - Podiatrist	1
29 - Physician Assistant	1
30 - Advanced Practice Registered Nurse (APRN)	2
32 - Social Worker/Case Manager	11
39 - Behavior Analysis	321
62 - Optometrist	1
65 - Home Health Services	147
67 - Home & Community-Based Services Waiver	13
70 - Medicaid Health Plan	1
81 - Professional Early Intervention Services	1
83 - Therapist (PT, OT, ST, RT)	12
89 - Dialysis Center	1
90 - Durable Med Equipment/Medical Supplies	1
91 - Case Management Agency	84

99 - Trading Partner	1
Total	**674**

Additionally, 80 providers were prevented from enrolling or reenrolling due to findings during an onsite pre-enrollment visit, criminal background screening, or federal exclusion.

Summary by Denial Reason	Totals
Failed Onsite Review	73
Criminal History	5
Federal Exclusion	2
Total	**80**

Denials by Provider Type	Totals
05 - Community Behavioral Health Services	2
20 - Prescribed Drug Services	1
25 - Physician (M.D.)	11
26 - Physician (D.O.)	2
30 - Advanced Practice Registered Nurse (APRN)	1
39 - Behavior Analysis	8
51 - Portable X-Ray Company	1
61 - Hearing Aid Specialist	1
62 - Optometrist	1
65 - Home Health Services	38
67 - Home & Community-Based Services Waiver	5
83 - Therapist (PT, OT, ST, RT)	12
90 - Durable Med Equipment/Medical Supplies	3
91 - Case Management Agency	2
Total	**80**

Finally, there were 453 providers who were identified as potentially related to suspected fraud and abuse and other compliance-related considerations that were already terminated or denied at the time that the Agency discovered the program integrity related concern. These providers who are under review by the Agency or other entities may voluntarily terminate from the program to avoid an involuntary action by the Agency. Other providers in this category may have been terminated for other reasons that were non-adverse in nature, including failure to complete enrollment renewal or eighteen months of billing inactivity.

Summary by Denial/Termination Reason	Totals
Denied - Adverse Association	283
Terminated - Adverse Association	170

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

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

Summary by Termination Type	Totals
Criminal History	26
Contractual Termination Under Medicaid Authority	117
With-Cause Termination Under Medicaid Final Order	34
Failed Onsite Review	7
Total	**184**

Terminations by Provider Type	Totals
05 - Community Behavioral Health Services	8
07 - Specialized Mental Health Practitioner	3
10 - Skilled Nursing Facility	3
14 - Assistive Care Services	8
20 - Pharmacy	4
25 - Physician (M.D.)	23
26 - Physician (D.O.)	2
27 - Podiatrist	2
29 - Physician Assistant	1
30 - Advanced Practice Registered Nurse (APRN)	8
32 - Social Worker/Case Manager	8
39 - Behavior Analysis	46
50 - Independent Laboratory	3
65 - Home Health Services	12
67 - Home & Community-Based Services Waiver	30
83 - Therapist	10
90 - Durable Med Equipment/ Medical Supplies	3
91 - Case Management Agency	5
97 - Managed Care Treating Provider - Non-Medicaid	4
99 - Trading Partner	1
Total	**184**

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

Although the latter part of FY 2019-20 carried unique challenges, the routine communication between MPI, the Division of Medicaid, and others within the Agency concerning Agency policy changes to improve detection, prevention, investigation, and audit capabilities regarding Medicaid fraud and abuse continued to be a priority. As such, MPI will continue to collaborate with the Division of Medicaid and utilize Agency processes to enhance Medicaid fraud and abuse prevention and detection efforts.

A note on how this report was composed:

The Agency for Health Care Administration's Bureau of Medicaid Program Integrity oversees the development and production of this report. However, the compilation of information originated from many state agencies, bureaus, and units that have oversight of different functions of Florida's large and complex Medicaid program.

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