FLORIDA'S EFFORTS TO CONTROL

MEDICAID FRAUD & ABUSE

FISCAL YEAR 2022-2023

January 15, 2024

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 FY 2022-23. 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,

Jason Weida
Secretary

cc:
The Honorable Kathleen Passidomo
The Honorable Paul Renner

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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, 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 patient abuse, neglect, and financial exploitation (PANE) of those persons 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 also concerned with the quality of care being provided for Florida's ill, elderly, and disabled citizens.

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 (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 the Florida 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. A 30-day extension may be applied for and granted. Case openings occur only when there is a criminal or civil predicate that warrants further investigative activity by the MFCU. During FY 2022-23, the Unit received 5,186 complaints. Of the 5,186 complaints received in FY 2022-23, 641 were related to fraud and 4,545 were related to PANE allegations.

Of the total 641 fraud complaints received, referrals from Managed Care Special Investigative Units were the primary source of fraud complaints in FY 2022-23 at 379. Complaints from Citizens accounted for 52 Medicaid fraud complaints. Qui tam complaints accounted for 50 of the Medicaid fraud complaints received. Thirty-four complaints were received from Family Members.

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 2022-23, of the 4,545 PANE complaints, 4,492 came from DCF/APS/FSFN. The next highest sources of PANE complaints received were Family Members with 14 and AHCA MPI with 10.

Case Investigations

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

During FY 2022-23, 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. Of the 302 total cases opened, 185 were Fraud cases and 117 were PANE cases.

The following is a list of the top four Medicaid Provider types for MFCU fraud cases opened in FY 2022-23:

1. Durable Medical Equipment/Medical Supplies
2. Community Alcohol/Drug/Mental Health
3. Home and Community Based Services – Waiver
4. Physicians

The following is a list of the top four Provider types for MFCU PANE cases opened in FY 2022-23:

1. Facility Employee
2. Family Member
3. Certified Nursing Assistant (CNA)
4. Administrator of Facility

Disposition of Cases

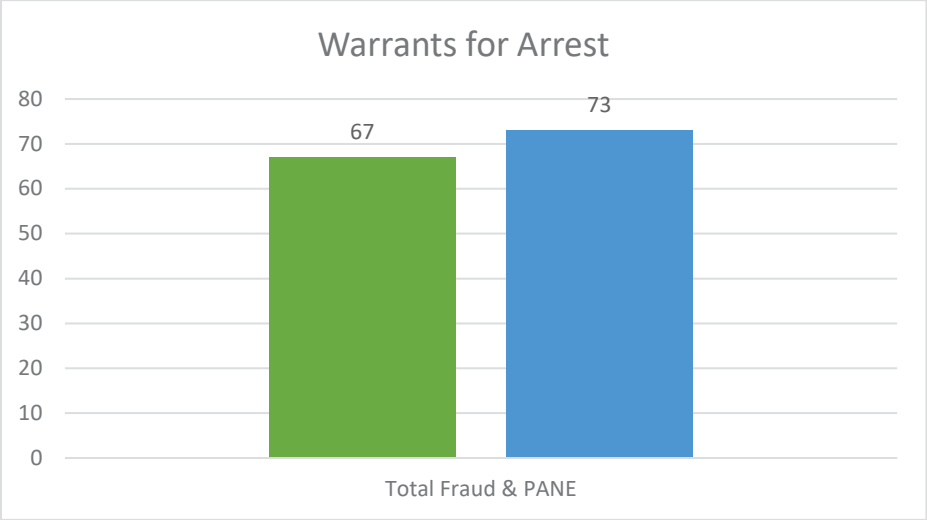
Following an investigation, a determination is made whether to pursue criminal prosecution or initiate civil actions. All case investigations are formally closed because of either a successful prosecution, a lack of evidence or other classification. Several classifications are presently used to track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

In FY 2022-23, the MFCU closed 335 cases. Of those, 218 involved Medicaid fraud investigations and 117 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 2022-23 were 61 Fraud and 15 PANE for a total of 76.

Warrants for arrests for FY 2022-23 were 60 Fraud and 13 PANE for a total of 73.



Case Highlights

Physicians Group Services

Physicians Group Services, P.A. (PGS) has agreed to pay the United States and the State of Florida $700,000 to resolve allegations that PGS violated the False Claims Act by submitting false or fraudulent claims to the Florida Medicaid Program, which is a state and federal partnership that provides access to health care coverage for low-income families and individuals in Florida.

The investigation focused on urine drug testing (UDT) by PGS. UDT occurs in a variety of health care settings. In a pain management practice, UDT is used to monitor whether a patient is taking prescribed drugs, is taking non-prescribed drugs, or is consuming with prescribed drugs other dangerous substances, such as alcohol. UDT is either “qualitative” or “quantitative.”

The clinical value of quantitative UDT depends in part on whether the qualitative UDT result is expected or unexpected, as well as the patient’s history of drug abuse, history of medication adherence and compliance, clinical presentation, and medical history. The settlement resolves allegations that PGS submitted claims to Florida Medicaid for quantitative urine drug testing, which claims the United States and the State of Florida allege were medically unnecessary because the testing was not individualized to the particular needs of the patient.

Advanced Bionics Corporation

Attorney General Ashley Moody's Medicaid Fraud Control Unit secured a payment of more than $600,000 to Florida Medicaid through a multistate action against the Advanced Bionics Corporation (ABC), a manufacturer and distributor of cochlear implants. ABC allegedly violated the federal and various state False Claims Acts by submitting false or fraudulent claims for reimbursement to federal healthcare programs, including Medicaid.

The action resolves allegations that ABC knowingly submitted, or caused to be submitted, false or fraudulent claims for reimbursement for cochlear device systems with Neptune and Naida sound processor components during a nine-year period. Specifically, ABC allegedly misled the Food and Drug Administration to receive approval of the Neptune and Naida sound processors by lying about how items were tested. The company also allegedly misrepresented the processors' compliance with radiofrequency emission standards. FDA approval is a necessary requirement for reimbursement by federal healthcare programs, such as Medicaid.

These radiofrequency standards are in place because the FDA recognizes some devices, like cochlear implant systems, interfere with other devices that use radiofrequency, including telephones, alarm and security systems, televisions and radios. The FDA is trying to limit the extent to which interference occurs.

The multistate agreement results from a whistleblower lawsuit originally filed in the United States District Court for the Eastern District of Pennsylvania. Florida's MFCU participated in the negotiations, along with a team from the National Association of Medicaid Fraud Control Units. Including Florida, the negotiating team is made up of representatives from the Offices of the Attorney General for the states of California, North Carolina, Pennsylvania, Texas and Virginia.

Essilor Laboratories of America, Inc.

Attorney General Ashley Moody announced that Florida has joined 34 other states in settling allegations of kickbacks paid to referring providers against Essilor International, Essilor of America Inc., Essilor Laboratories of America Inc., and Essilor Instruments USA (Essilor), headquartered in Dallas. Essilor manufactures, markets, and distributes optical lenses and equipment used to produce optical lenses. Pursuant to the settlement, Essilor will pay the Florida Medicaid Program $515,180.20.

The settlement resolves allegations that between January 1, 2011, and December 31, 2016, Essilor knowingly and willfully offered or paid remuneration to eye care providers, such as optometrists and ophthalmologists, to induce those providers to order and purchase Essilor products for their patients, including Medicaid beneficiaries. The State alleged that Essilor's conduct violated the Florida False Act and resulted in the submission of false claims to the Florida Medicaid program.

This settlement arises from two whistleblower lawsuits filed in the United States District Court for the Northern District of Texas and the Eastern District of Pennsylvania. A team from the National Association of Medicaid Fraud Control Units ("NAMFCU") participated in the settlement negotiations on behalf of the states. The NAMFCU Team included representatives from the Offices of the Attorneys General for the states of California, Colorado, Indiana, Pennsylvania, and Texas.

Alliance/Ancor

Attorney General Ashley Moody announced that Florida joined two other states in settling allegations of kickbacks paid to independent-contractor neurologists against Alliance Parent, Inc. and its current and former subsidiaries (Alliance) and Ancor Holdings LP d/b/a Ancor Capital Partners (Ancor), headquartered in Irving, Texas. Alliance provides ambulatory electroencephalography (EEG) testing services for patients referred by physicians and other health care providers. Pursuant to the settlement, the Florida Medicaid Program will receive a total of $209,861.42, including restitution and other recoveries from Alliance and Ancor.

The settlement resolves allegations that between January 1, 2013, through January 1, 2020, Alliance paid independent-contractor neurologists to interpret EEG tests and provide test-interpretation reports for free to non-neurologist referring physicians in return for the non-neurologist physicians ordering EEG tests from Alliance. Alliance chose the neurologists that it paid to provide interpretations of tests ordered by other physicians in return

for those neurologists ordering EEG tests for their own patients from Alliance. Alliance also falsely billed for video ambulatory EEG testing when it did not perform the work required for such billing. This agreement likewise resolves claims against Ancor for the period July 1, 2017, through January 1, 2020, as Ancor was paid monthly fees by Alliance under a Management Services Agreement and held two seats on Alliance's Board of Directors. The State contends that Ancor caused false claims when it allowed the alleged conduct described above to continue.

This settlement arises from four whistleblower lawsuits filed in the United States District Court for the Northern District of Texas, the Southern District of Texas, and the Eastern District of Pennsylvania. A team from the National Association of Medicaid Fraud Control Units (NAMFCU) participated in the settlement negotiations on behalf of the settling states.

Southeast Florida Hematology & Oncology Group

Southeast Florida Hematology and Oncology Group (SEFHOG), a now-defunct specialty medical practice in Fort Lauderdale, Fla., has agreed to pay $100,000 to resolve allegations that it violated the False Claims Act with respect to the Florida Medicaid program by receiving "upfront discounts" from its specialty pharmaceutical distributor, Cardinal Health, in violation of the Anti-Kickback Statute.

The Anti-Kickback Statute prohibits pharmaceutical distributors from offering or paying any compensation to induce physicians to purchase drugs for use on Medicare patients. When a pharmaceutical distributor sells drugs to a physician practice for administration in an outpatient setting, the distributor may legally offer commercially available discounts to its customers under certain circumstances prescribed by the Office of Inspector General for the Department of Health and Human Services (HHS-OIG). HHS-OIG has advised that upfront discount arrangements present significant kickback concerns unless they are tied to specific purchases and distributors maintain appropriate controls to ensure that discounts are clawed back if the purchaser ultimately does not purchase enough product to earn the discount. According to admissions contained in the settlement agreement, the payments that SEFHOG received were not attributable to identifiable sales.

Florida Cardiology, P.A.

Florida Cardiology, P.A., Sandeep Bajaj, Karan Reddy, and eight other physicians have agreed to pay the United States and the State of Florida $199,497.62 to resolve allegations that they violated the False Claims Act by submitting inflated claims to Medicaid and for billing while the physicians were outside the United States.

The United States and the State of Florida previously intervened in a whistleblower lawsuit against Florida Cardiology and the physician-defendants. The lawsuit and settlement relate to the submission of claims that were improperly billed or performed, and submitted or caused to be submitted by Florida Cardiology, Sandeep Bajaj, Abbas Ali, Karan Reddy, Claudio Manubens, Milan Kothari, Saroj Tampira, Sayed Hussain,Raviprasad Subraya, Harish Patil, and Edwin Martinez.

According to the lawsuit and settlement agreement, Dr. Bajaj and Dr. Reddy caused Florida Cardiology to bill for more intravascular stents than were actually inserted into patients; Dr. Bajaj caused Florida Cardiology to bill for radiofrequency ablations that were not performed by him and in some instances, were not performed by a qualifying provider; and all ten physician-defendants caused Florida Cardiology to bill for procedures and services while they were outside the United States. According to the Complaint in Intervention, except in limited circumstances, providers cannot bill for services while outside the United States.

Clive McIntosh and Tymeka Hester

Florida's Medicaid Fraud Control Unit shut down a fraud ring that stole millions of dollars from Medicaid. Attorney General Moody's MFCU announced the arrests of the ringleader, Clive McIntosh, and accomplice, Tymeka Hester, on charges of racketeering, Medicaid fraud, money laundering and scheme to defraud. According to the investigation by MFCU, McIntosh recruited Medicaid providers, like Hester, to enroll in Medicaid, and then used the providers' individual numbers to fraudulently bill for services not rendered. The scheme ultimately defrauded the taxpayer-funded program out of more than $3.5 million.

MFCU began its investigation upon receiving information provided by the Florida Agency for Health Care Administration. The investigation revealed Clive McIntosh recruited respiratory therapists to enroll in Medicaid and provide McIntosh the provider numbers to fraudulently bill Medicaid.

In 2018, McIntosh recruited Tymeka Hester to join the scheme. From 2018-2020, Hester worked for McIntosh, billing for services never rendered for McIntosh. Hester is not McIntosh's first recruit. In 2014, McIntosh recruited James Tenpenny to become a Medicaid provider, so McIntosh could use Tenpenny's Medicaid number to fraudulently bill for services. The Clearwater Police Department arrested Tenpenny last year, and the defendant is currently facing charges for Medicaid fraud and scheme to defraud in Pinellas County for participating in the criminal enterprise.

Due to the fraudulent scheme, from June 2018 to August 2020, McIntosh and accomplices caused more than $3.5 million to be paid out for services not rendered as billed. In return for allowing McIntosh to use their provider numbers, both Tenpenny and Hester received financial kickbacks. McIntosh used the fraudulent Medicaid funds to purchase vehicles and opened a used-car business in Fort Lauderdale and Fort Pierce.

Florida's MFCU, with the assistance of the Fort Lauderdale Police Department, arrested McIntosh on the following charges: one count of RICO, one count of Medicaid fraud more than $50,000 and one count of money laundering—all first-degree felonies.

If convicted, Clive McIntosh faces up to 90 years in prison and $30,000 in fines. MFCU, with the assistance of the Polk County Sheriff's Office, also arrested Hester on the following charges: one count Medicaid fraud more than $50,000 and one count of scheme to defraud—both first-degree felonies.

If convicted, Tymeka Hester faces up to 60 years in prison and $20,000 in fines. Both cases will be prosecuted by Attorney General Moody's Office of Statewide Prosecution.

Carlos Cabrera

Attorney General Ashley Moody's Medicaid Fraud Control Unit announced the arrest of a man who stole hundreds of thousands of dollars from a state taxpayer-funded program. MFCU charged Carlos Cabrera with Medicaid provider fraud. Cabrera ran Angels on Earth, a prescribed pediatric extended care (PPEC) business, and submitted fraudulent claims for services that should have been provided to children with medically-complex conditions, bilking Florida Medicaid out of more than $400,000.

According to an investigation by the MFCU, Cabrera worked as the administrator for Angels on Earth PPEC. PPEC businesses provide continual care for children with medically-complex conditions in a nonresidential setting. Cabrera, the person responsible for all Medicaid PPEC billing, billed a nearly 100% attendance rate to get the maximum payment per patient despite knowing that not everyone attended every day.

Further analysis of Medicaid recipient data and the Angels on Earth Daily Census Reports showed that services were not rendered for up to 34% of the claims submitted for reimbursement. The overall pattern of billing and submitting claims to Medicaid, despite children being absent, demonstrates an intent to maximize billing without regard for accuracy.

Cabrera faces one count of Medicaid provider fraud, a first-degree felony. The case will be prosecuted by Attorney General Moody's Office of Statewide Prosecution.

Keondra Vernessa Burch

Florida's Medicaid Fraud Control Unit announced the arrest of the owner of a personal care company for forging doctor referrals and fraudulently billing Medicaid. With the assistance of the Ocoee Police Department, an investigation found that Keondra Vernessa Burch, owner of Divinely Chosen Services, submitted fraudulent documents for nearly three years, causing a loss of nearly $400,000 to Medicaid.

According to the investigation, Burch owned Divinely Chosen Services, a Medicaid provider of personal care services. In order for Medicaid recipients to qualify for these services, a referring physician must deem the care medically necessary and submit appropriate documentation. However, the MFCU investigation revealed that

Burch and the company repeatedly submitted forged doctors' referrals to Medicaid so that Burch could bill for providing the unnecessary services. From January 2020 through November 2022, Burch submitted fraudulent documents and billed for these services resulting in the loss of thousands of dollars to the Medicaid program.

Burch faces one count of Medicaid provider fraud, a first-degree felony.

Gladys Aracely Gomez and Edward Exequiel Garcia-Gomez

Florida's Medicaid Fraud Control Unit announced the arrest of two Miami-Dade County healthcare workers for paying illegal kickbacks to Medicaid recipients. According to an investigation by MFCU, a mother-son duo, Gladys Aracely Gomez and Edward Exequiel Garcia-Gomez, paid illegal kickbacks to patients to receive psychosocial rehabilitation services to defraud the state Medicaid program of more than $300,000.

According to an investigation by MFCU, Gladys Gomez and Edward Garcia-Gomez illegally paid Medicaid recipients kickbacks to attend psychosocial rehabilitation services. Psychosocial rehabilitation is a therapy service that provides daily medication use, independent living and social-skills training, support to clients and families, housing, pre-vocational and transitional employment, structured activities to diminish tendencies toward isolation and withdrawal, education for the recipient and family about symptom management, medication and treatment options—all billable to the Medicaid program. One witness claimed that the defendants paid clients to sign progress sheets for the whole week. The investigation uncovered that the defendants gave some patients $250 biweekly or $500 monthly in return for attending the rehabilitation sessions.

Both defendants are charged with Medicaid-provider fraud, a first-degree felony. The case will be prosecuted by MFCU attorneys cross-designated as an Assistant State Attorney with the Miami-Dade State Attorney's Office.

Greter Brito Acosta

Attorney General Ashley Moody's Medicaid Fraud Control Unit announced the arrest of a registered behavior technician. According to an investigation by the MFCU and the Hialeah Police Department, Greter Brito Acosta defrauded the Florida Medicaid program out of more than $119,000 for falsifying documentation and receiving money for services not rendered.

The investigation shows that Acosta claimed to provide care for two minors who received Medicaid. Instead of providing the registered behavior technician services though, Acosta would visit the homes of the recipients, log in via a cellphone application to verify the visit, turn off the GPS function of the cellphone and leave. Hours later, Acosta returned to the residence, turned the GPS function of the cellphone back on and logged out of the application, making it appear as though the defendant stayed at the residency for hours.

Acosta bribed the recipient's parents with monetary kickbacks to go along with the falsified documentation, progress reports and more. The investigation also revealed that Acosta originally paid someone to fraudulently take the defendant's registered behavior technician certification exam.

Acosta is charged with one count of Medicaid fraud, a first-degree felony.

The case will be prosecuted by MFCU attorneys cross-designated as an Assistant State Attorney with the Miami-Dade State Attorney's Office.

Andrea Lozada Granados and Virna Granados

Florida's Medicaid Fraud Control Unit and the Miami-Dade Police Department arrested Andrea Lozada Granados and Virna Granados for defrauding the Medicaid Program out of more than $100,000. The mother-daughter duo allegedly billed Medicaid for psycho-social rehabilitation services never rendered for six recipients.

According to the investigation, the duo's scheme involved billing Medicaid for PSR services supposedly provided by Virna for individuals residing in an assisted living facility. During an interview, the Medicaid recipients stated that the defendants did not provide PSR services, and in fact, the recipients did not even reside at the assisted living facility claimed by the Granadoses.

For more than a year, Andrea and Virna allegedly used the personal information of these unwitting Medicaid recipients to create fictitious progress notes and attendance sheets, in addition to falsifying other personal information, to fraudulently cause Medicaid to pay more than $106,000 for PSR services never provided. Additionally, Andrea paid kickbacks to another employee in order to fraudulently bill for a Medicaid recipient who also never received PSR services.

Andrea and Virna are each charged with one count of Medicaid fraud, a first-degree felony, and one count of grand theft, also a first-degree felony. Additionally, Andrea is charged with a second count of Medicaid fraud, a second-degree felony. Both Andrea and Virna face up to 30 years in prison and $30,000 in fines, if convicted. Attorney General Moody's Office of Statewide Prosecution will prosecute this case.

Paola Granados and Ingrid Garcia

Attorney General Ashley Moody's Medicaid Fraud Control Unit announced the arrest of two therapists for defrauding the Florida Medicaid program out of more than $76,000. Paola Maria Ewing, also known as Paola Granados, and Ingrid Garcia swindled the taxpayer-funded program to pay for psycho-social rehabilitation services never provided. Granados and Garcia each falsified documentation, personal information, progress notes and reports to fraudulently bill Medicaid more than $53,000 and $23,000, respectively.

According to an MFCU investigation, Granados and Garcia deceptively claimed that their clients receiving Medicaid services resided at an assisted living facility, but instead the recipients lived at home or with family members. During the course of the investigation, Granados and Garcia claimed to be working with clients who, when asked, did not even recognize the two defendants. The investigation uncovered that the defendants knowingly falsified documentation, personal information, progress notes and reports as part of the scam to claim the defendants provided PSR services.

Granados is charged with one count of Medicaid fraud more than $50,000, a first-degree felony and Garcia is charged with one count of Medicaid fraud more than $10,000 but less than $50,000, a second-degree felony. Attorney General Moody's Office of Statewide Prosecution is prosecuting the case.

Ladrica Denise Gibbs

Florida's Medicaid Fraud Control Unit arrested a Miami-Dade County healthcare worker for billing Medicaid for services never provided. According to the investigation, Ladrica Denise Gibbs falsely claimed to have provided companion services to Medicaid recipients, causing a loss to the state Medicaid program of more than $20,000.

According to an MFCU investigation, Gibbs worked as a manager at a group home for disabled adults and allegedly provided life-companion services to some of the Medicaid recipients. However, one of Gibbs's supposed patients claimed that the defendant never provided care. The investigation concluded that Gibbs caused a loss to Florida Medicaid of more than $20,000 between Aug. 5, 2019, to Feb. 10, 2022.

The defendant is charged with one count of Medicaid provider fraud/filing a false claim, more than $10,000 but less than $50,000, a second-degree felony. The case will be prosecuted by MFCU attorneys cross-designated as an Assistant State Attorney with the Miami-Dade State Attorney's Office.

Kimberly Green Byrd

The Florida Medicaid Fraud Control Unit, with the assistance of the Jacksonville Sheriff's Office, arrested a self-employed care provider for one count of Medicaid provider fraud. Kimberly Greene Byrd is accused of submitting more than $11,000 worth of fraudulent claims to the Agency for Persons with Disabilities (APD), including billing for hours not worked.

According to the investigation, Byrd provided personal support services to Medicaid recipients who needed assistance with the activities of daily living. Medicaid required Byrd to submit daily service logs to the program via the APD. Over the course of several months, Byrd submitted billing claims for hours not worked, along with service logs that did not match the hours billed or absent entirely, causing a loss to the Medicaid program of more than $11,000.

Byrd pled guilty to Medicaid fraud and adjudication of guilt was withheld. She was ordered to pay restitution of $11,191.54 and court costs. The case was prosecuted by Attorney General Moody's MFCU through an agreement with the State Attorney for the Fourth Judicial Circuit of Florida, Melissa Nelson.

Melissa Wilson Clea

Attorney General Ashley Moody's Medicaid Fraud Control Unit and the Jacksonville Sheriff's Office arrested a disabled care provider for Medicaid fraud. Melissa Wilson Clea is accused of failing to render services and falsifying documentation logs for two disabled Medicaid recipients. Clea fraudulently billed Medicaid for 77 claims totaling more than $11,000.

According to the investigation, Clea worked as a waiver support coordinator for Hands That Care, Inc. For more than three years, Clea billed for and received reimbursements for services purportedly rendered to two disabled Medicaid recipients in Clay and Duval counties. Clea submitted 77 claims totaling more than $11,400—the program denied seven of the claims and Clea received more than $10,400 deposited into a personal bank account.

Support coordination services include ongoing case management to ensure recipients access services needed to maintain health, safety and welfare. Coordinators are required to contact recipients regularly and have face-to-face visits. Coordinators are also required to maintain progress notes for all contacts, visits and assistance provided on behalf of the recipient. During the investigation, authorities contacted the caregivers of the disabled recipients, who stated Clea did not contact them except for once a year to sign a yearly support plan. Investigators also reviewed Clea's files and found expired eligibility worksheets, required provider documentation missing and minimal case notes lacking specifics.

Clea faces one count of scheme to defraud, a third-degree felony. Attorney General Moody's MFCU will prosecute the case through an agreement with the State Attorney's Office for the Fourth Judicial Circuit.

Priscilla M. Sluder

Florida's Medicaid Fraud Control Unit and the Orange Park Police Department announced the arrest of the former office manager of a nursing and rehab facility for grand theft. Priscilla M. Sluder is accused of stealing nearly $30,000 from resident trust fund accounts for personal benefit.

Sluder worked as an assistant business office manager for Orange Park Nursing LLC d/b/a The Palms Nursing and Rehab at Orange Park—a 120-bed skilled nursing facility. The Palms provides both short-term treatment and long-term care through comprehensive medical services, 24-hour skilled nursing care and programs in both rehabilitation and restorative care. According to the investigation, Sluder took cash from the Patient Trust Fund, an account set up for residents to access cash to purchase personal items.

The investigation revealed Sluder stole funds for more than two years totaling $29,504 from at least 40 patients. The Palms reimbursed all of the patients' accounts for the losses and terminated Sluder.

Sluder faces one count of grand theft $20,000 or more, but less than $100,000, a second-degree felony. Attorney General Moody's MFCU will prosecute the case through an agreement with the State Attorney's Office for the Fourth Judicial Circuit.

Jessica Lyn Duvall

Attorney General Ashley Moody announced the arrest of a woman for stealing more than $12,000 from a disabled adult. According to an investigation by Attorney General Moody's Medicaid Fraud Control Unit and the Okaloosa County Sheriff's Office, Jessica Lyn Duvall served as the victim's primary guardian before a new guardian was appointed. Duvall collected the victim's Social Security funds and spent the money on personal items instead of paying for the victim's care.

According to the investigation, Duvall collected funds from the victim for more than a year. During part of that time, Duvall acted as the victim's guardian. At first, the victim lived with Duvall but eventually moved into a nursing home. Throughout the entire process, Duvall stole more than $12,000 from the victim, using the money to pay

for non-care related expenses. The investigation found that once the victim moved to a nursing facility, Duvall never paid for the victim's care.

Duvall pled to one count of Grand Theft and received a sentence of 30 days incarceration, 5 years probation and restitution of $12,705. The case was prosecuted by Attorney General Moody's MFCU through an agreement with the State Attorney for the First Judicial Circuit of Florida, Ginger Bowden Madden.

Charles Victor Currington and Crystal Sherlock

Florida's Medicaid Fraud Control Unit and the Walton County Sheriff's Office announced the arrest of two criminals for stealing money and the personal identification of a Florida senior. The two criminals used the victim's debit card to spend more than $8,000, purchasing an inflatable swimming pool, gourmet barbeque and other frivolous items.

The MFCU investigation revealed that the 70-year-old victim previously resided with the suspects Charles Victor Currington and Crystal Sherlock. During that time, the victim assisted with household bills, including repairs to the home following a fire. After five years, the victim moved into a nursing home and no longer authorized Currington and Sherlock to use the debit card. Instead of returning the victim's debit card, Currington and Sherlock used the card to spend more than $8,000 on frivolous purchases. Currington and Sherlock are each charged with one count of criminal use of personal identification information of an individual more than 60 years old, a second-degree felony; one count of criminal use of personal identification information of more than $5,000, a second-degree felony; and one count of theft from persons 65 years of age or older, more than $300, but less than $10,000, a third-degree felony.

The case was prosecuted by Attorney General Moody's MFCU through an agreement with the State Attorney for the First Judicial Circuit of Florida, Ginger Bowden Madden.

Currington pled nolo contendre to Theft from persons 65 Years of Age or Older and was sentenced to ninety days incarceration. Sherlock pled nolo contendre to Theft from persons 65 Years of Age or Older, and, Criminal use of personal identification information and was sentenced to eighteen months incarceration.

Veronica Milbry

Attorney General Ashley Moody announced the arrest of a caregiver for exploiting a Florida senior for thousands of dollars. According to an investigation by Attorney General Moody's Medicaid Fraud Control Unit, Veronica Milbry accepted a position as a resident caregiver and, within three weeks, stole the banking information of an elderly resident. Milbry proceeded to pilfer thousands of dollars from the resident.

According to the investigation, Milbry admitted to recording a senior patient's banking information covertly and without permission. Milbry then spent more than $5,000 paying insurance bills, storage units and other personal expenses.

The Hillsborough County Sheriff's Office arrested Milbry on one count of exploitation of an elderly person, a third-degree felony.

Milbry pled guilty to one count of Exploitation of an Elderly Person. She was sentenced to 36 months probation and must pay $5,400 restitution.

Makala Malcolm

Florida's Medicaid Fraud Control Unit, with the help of the Leon County Sheriff's Office, announced the arrest of a care provider for abusing an adult with disabilities. According to the MFCU investigation, Makala Malcolm dragged an adult with disabilities directly by the hair, tearing out several braids in the process.

The MFCU investigation revealed that during an altercation in a Sunrise private developmental care facility, Malcolm dragged an adult with disabilities by the hair to the point of pulling the hair out, leaving a bald spot with redness and blood on the patient's scalp.

Malcolm pleaded No Contest to Misdemeanor Battery and was sentenced to two days incarceration and twelve months probation and must pay court costs. The case was prosecuted by Attorney General Moody's MFCU through an agreement with the State Attorney for the Second Judicial Circuit of Florida, Jack Campbell.

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) focuses 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 2022-23, the total amount for civil recoveries, which include civil settlements arising from qui tam cases brought under the Florida False Claims Act and civil judgments was $10,241,194. The total amount for criminal recoveries based upon Medicaid fraud cases was $14,489,227. The total amount of the monies recovered by the MFCU for FY 2022-23 was $24,730,421.

Training

MFCU continues to emphasize mission critical training to stay professionally current.
During FY 2022-23, MFCU staff attended a total of 4,186 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 Interviews and Interrogations, Financial Crimes Training and many more.

In-house training provided through a variety of delivery methods included courses such as Response to an Active Shooter and other OAG Annual Required Training. 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 2022-23 included Elder Abuse Investigations, Fraud Analytics, Prosecuting Professional Fraud: Investigative Case Studies and Upcoding, A Common Medical Fraud Exposed.

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 June 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. On June 14, 2022 MFCU was granted approval to data mine through June 19, 2025.

From July 15, 2010 through June 30, 2023, the MFCU has submitted 100 data mining projects to AHCA for review and approval. Of the 100 submitted, 72 were approved by AHCA.

Medicare Fraud Strike Force Teams

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.

Julio Arsenio Rodriguez

A federal magistrate judge has unsealed an indictment charging Miami resident Julio Arsenio Rodriguez, 61, with running a money laundering operation involving millions of Medicare and Medicaid health care fraud proceeds.

These proceeds stemmed from multiple clinics located throughout South Florida that allegedly provided durable medical equipment (DME) to eligible Medicare and Medicaid beneficiaries.
Instead, the DME was never requested, needed, or supplied. These clinics received millions from Medicare and Medicaid and Rodriguez used his companies to launder those proceeds.
The indictment charges Rodriguez with one count of conspiracy to commit money laundering and 14 counts of money laundering.

The conspiracy to commit money laundering and the act of money laundering are punishable by a penalty of 10-20 years in prison for each count. A federal district judge will determine any sentence after considering the U.S. Sentencing Guidelines and other statutory factors.

An indictment is a charging instrument containing allegations. A defendant is presumed innocent unless and until proven guilty in a court of law.

Juan Antonio Gonzalez, United States Attorney for the Southern District of Florida; Special Agent in Charge Omar Pérez Aybar, Health and Human Services–Office of Inspector General (HHS-OIG), Miami Region; acting Special Agent in Charge Robert M. DeWitt, Federal Bureau of Investigation (FBI), Miami Field Office, and Florida Attorney General Ashley Moody announced the charges. HHS-OIG, Miami Region, FBI, Miami Field Office, and the Florida Office of the Attorney General Medicaid Fraud Control Unit investigated the case. Special Assistant U.S. Attorney Marc Canzio is prosecuting the case and Assistant U.S. Attorney Marx Calderon is handling asset forfeiture.

Fraudulent Nursing Diploma Scheme

More than two dozen individuals have been charged in the Southern District of Florida for their alleged participation in a wire fraud scheme that created an illegal licensing and employment shortcut for aspiring nurses.

According to three recently unsealed indictments returned by a South Florida federal grand jury and two informations filed by federal prosecutors, defendants engaged in a scheme to sell fraudulent nursing degree diplomas and transcripts obtained from accredited Florida-based nursing schools to individuals seeking licenses and jobs as registered nurses (RNs) and licensed practical/vocational nurses (LPN/VNs).

The bogus diplomas and transcripts qualified purchasers to sit for the national nursing board exam and, after passing it, to obtain licenses and jobs in various states as RNs and LPN/VNs. The overall scheme involved the distribution of more than 7,600 fake nursing diplomas issued by three South Florida-based nursing schools: Siena College in Broward County, Fla., Palm Beach School of Nursing in Palm Beach County, Fla., and Sacred Heart International Institute in Broward County. These schools are now closed.

Each defendant faces up to 20 years in prison.

The charges speak to the purpose of a nursing license which is to protect the public from harm by setting minimum qualifications and competencies.

Charges Related to Fraudulent Nursing Diplomas and Transcripts from Siena College

The charging documents describe Siena College as a Broward County school licensed by the Florida Commission for Independent Education and the Florida Board of Nursing that offers a Practical Nursing Program and an RN to Bachelor of Science in Nursing Program. Eunide Sanon managed Siena College.

The indictment charges defendants Stanton Witherspoon of Burlington County N.J.; Alfred Sellu of Burlington County N.J.; and Rene Bernadel of Westchester County, N.Y. with conspiring to commit and committing wire fraud. The indictment alleges that Witherspoon, Sellu, and Bernadel solicited and recruited individuals who sought nursing credentials to gain employment as an RN or LPN/VN. It is alleged that these defendants arranged with Sanon, who managed Siena College and is charged by information with wire fraud conspiracy, to create and distribute false and fraudulent diplomas and transcripts. These fake documents represented that the aspiring RN and LPN/VN candidates had attended Siena College's nursing program in Broward County and completed the necessary courses and clinicals to obtain RN or LPN/VN diplomas. In fact, the aspiring nurses never completed the necessary courses and clinicals.

The information against Sanon alleges that he and others sold thousands of fake Siena College nursing diplomas and educational transcripts to nursing applicants who used them to obtain RN or LPN/VN licenses in various states and nursing jobs with unwitting health care providers throughout the country.

Charges Related to Fraudulent Nursing Diplomas and Transcripts from Palm Beach School of Nursing

According to the charging documents, Palm Beach School of Nursing's objective was to prepare students to meet Florida's licensing and nursing board requirements and become eligible to take the national licensing exam in order to work as registered nurses.

The indictment charges Gail Russ of Broward County; Cheryl Stanley of Collier County, Fla.; Krystal Lopez of Palm Beach County; Ricky Riley of Broward County; Norberto Lopez of Palm Beach County; Damian Lopez of Palm Beach County; Francois Legagneur of Nassau County, N.Y.; Reynoso Seide of Union County, N.J.; Cassandre Jean of Palm Beach County; Yelva Saint Preux of Suffolk County, N.Y.; Evangeline Naissant of Nassau County, N.Y.; Rony Michel of Monmouth County, N.J.; Vilaire Duroseau of Essex County, N.J.; and Yvrose Thermitus, a/k/a "Yvrose Thompson," of Union County, N.J., with conspiring to commit, and committing, wire fraud. The indictment alleges that these defendants solicited and recruited individuals who sought nursing credentials to gain employment as an RN or LPN/VN.

It is alleged that these recruiter defendants then arranged with Palm Beach School of Nursing's owner Johanah Napoleon and school employees Gail Russ, Cheryl Stanley, Krystal Lopez, and Ricky Riley to create and

distribute false and fraudulent diplomas and transcripts representing that the aspiring RN and LPN/VN candidates had attended Palm Beach School of Nursing and completed the necessary courses and clinicals to obtain RN or LPN/VN diplomas. In fact, the aspiring nurses never completed the necessary courses and clinicals.

The nursing applicants used the fake diplomas and transcripts they purchased from the owner and employees of Palm Beach School of Nursing to obtain RN or LPN/VN licenses in various states and nursing jobs with unwitting health care providers throughout the country. Napoleon was previously charged by information and has pled guilty to conspiring to commit health care fraud and wire fraud, as well as wire fraud (case nos. 22-60111-Cr-Smith and 22-60118-Cr-Smith).

Charges Related to Fraudulent Nursing Diplomas and Transcripts from Sacred Heart International Institute

According to charging documents, Sacred Heart International Institute was a Broward County School licensed by the Florida Board of Nursing that offered a nursing program designed to prepare students for employment as practical nurses.

The indictment charges Ludnie Jean of Harris County, Texas; Serge Jean of Harris County, Texas; Simon Itaman of Harris County, Texas; Anna Itaman of Harris County, Texas; Rhomy Louis of Suffolk County, N.Y.; and Nadege Auguste of Broward County with conspiring to and committing wire fraud. It is alleged that these defendants solicited and recruited individuals who sought nursing credentials to gain employment as an LPN/VN. These recruiters then arranged with Charles Etienne, Sacred Heart's owner, to create and distribute false and fraudulent transcripts and diplomas representing that the aspiring candidates had attended Sacred Heart and completed the necessary courses and clinicals to obtain LPN/VN diplomas. In fact, the aspiring nurses never completed the necessary courses and clinicals. Etienne is charged by information with conspiracy to commit wire fraud.

The nursing candidates used the fake diplomas and transcripts they purchased from Sacred Heart to obtain LPN/VN licenses in various states and nursing jobs with unwitting health care providers throughout the country.

FBI Miami and HHS-OIG Miami investigated these cases. Valuable assistance was provided by Homeland Security Investigations, Miami Field Office; U.S. Department of Veterans Affairs-Office of Inspector General; United States Postal Inspection Service, Miami; and Florida Attorney General-Florida Medicaid Fraud Contro.

AGENCY FOR HEALTH CARE ADMINISTRATION

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

Highlights of actions by other Agency organizational units follow the Medicaid Program Integrity overview and summary of activities.

Division Of Health Care Policy and Oversight[1] (HCPO)

Division Overview

The Division of Health Care Policy and Oversight protects Floridians through oversight of health care providers, including the regulation of 40 different types of health care providers through licensure and certification. HCPO includes:

- The Bureau of Central Services includes the Care Provider Background Screening Clearinghouse.
- The Bureau of Field Operations is responsible for state licensure and federal certification surveys (inspections).
- The Bureau of Health Facility Regulation licenses, registers, regulates, and provides exemptions for certain providers, including assisted living facilities, hospitals, laboratories, home health care, and nursing home providers.
- The 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.
- The Florida Center for Health Information and Transparency collects, compiles, and analyzes health related data.
- The Office of Plans and Construction is responsible for safety, functionality, and regulatory compliance regarding the design and building of specific health care facilities.

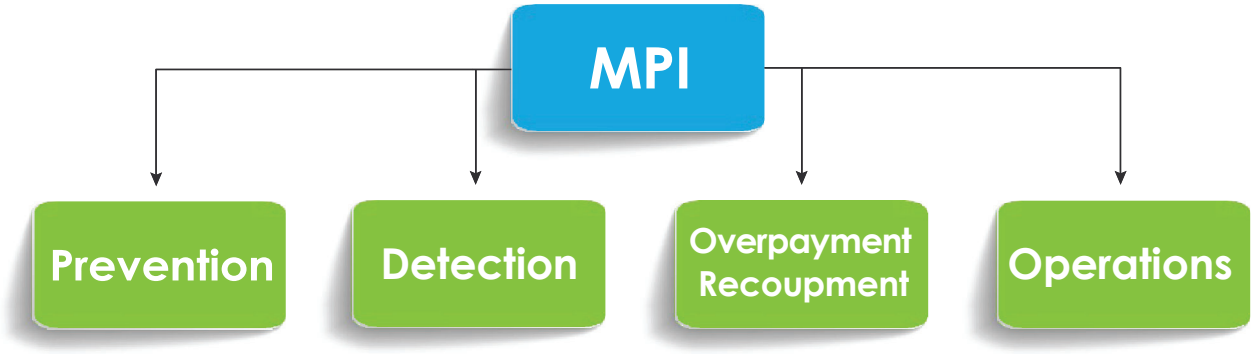
This report is focused on the Agency's Medicaid program oversight activities. As it relates to HCPO, it includes the efforts of MPI and activities pertaining to the Care Provider Background Screening Clearinghouse.

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. There were no organizational or significant functional changes during FY 2022-23.

[1] HCPO was formerly known as Health Quality Assurance or HQA



Prevention Activities

MPI has placed much more emphasis on fraud and abuse prevention over the past several years. There are five main functions related to program integrity activities in Florida Medicaid within the Prevention Unit, which include field operations, administrative sanctions, law enforcement collaboration, payment restrictions, and programmatic assessments and recommendations.

Field operations are conducted throughout the state and MPI has offices in Tallahassee, Tampa, Orlando, and Miami. Central and South Florida initiatives continue to be a significant method of discerning if a provider is at their reported service location, operational, and properly participating in the program. Personnel in Tallahassee primarily handle provider sanctions, which typically involve administrative fines and programmatic suspensions and terminations, however, as deems appropriate, resources can be deployed for North Florida site visits.

The personnel handling administrative sanctions treat the issuance of every notice as if it would end up in court. Although, most sanctions are imposed without legal challenges, sanctions are often imposed for loss of license, criminal interventions, ineligibility to participate due to enrollment issues, and non-payment of obligations to the Agency.

Law enforcement activities include collaboration with state and federal partners. This includes not only serving as a liaison to MFCU, but also HHS-OIG, the FBI, DFS, and any other government agency involved in fraud-fighting. MPI also continues to partner with the Medicaid Health Plans (MHP) to increase the quality and quantity of suspected fraud referrals to MFCU. Since the management of most of the managed care activities falls within the Detection Unit, other efforts related to the MHPs (even those that are "prevention" in nature) are described under the detection activities section of this report.

Payment restrictions include "pending" claims in the Medicaid claims processing system for one or more specific, legally authorized purposes. MPI imposes the following payment restrictions:

- Prepayment Review (PPR) consistent with s. 409.913(3), F.S.
- Payment withhold (referred to as a "25A withhold") consistent with s. 409.913(25)(a), F.S., following a determination there exists reliable evidence of circumstances related to fraud, abuse, willful misrepresentation, or a crime committed while providing services to Medicaid recipients.
- Payment suspension (referred to as a "CAF payment suspension") consistent with 42 C.F.R. 455.23, following a determination there are credible allegations of fraud.

As was described in detail in previous years' reports, it is well understood many of the activities MPI (and other organizational units in the Agency) engage in support fraud-fighting efforts and have a value, typically a fraud and abuse prevention value, that is not readily known or easily calculated. To that end, MPI routinely evaluates its activities and endeavors to define the prevention value calculation in a fashion that fairly and reasonably assesses the monetary impact of the efforts. MFCU referrals were one of the most significant prevention values added in years' past. However, referrals to other agencies, including state or federal law enforcement, prosecutors, and regulatory agencies, have a value that has yet to be routinely calculated.

Likewise, the policy and system edit recommendations to the Division of Medicaid have a value that is not routinely included in the calculations. MPI is working to better include those calculations in future year reports.

MPI identifies issues for recommendation to the Division of Medicaid for program changes. These recommendations include policy/handbook revisions, system edits, or more broad adjustments to program operations. During FY 2022-23 MPI continued to work closely with Medicaid on the development of the upcoming changes to the Medicaid Management Information System and related components. MPI also has continued to work closely with Medicaid enrollment and provider assistance teams in increasing enrollment safeguards and increase provider compliance with enrollment requirements. Prevention activities are typically focused on high-risk provider types for Medicaid fraud. MPI personnel continue to work closely with the Division of Medicaid, collaborating on known and anticipated program vulnerabilities with particular emphasis on those programs that are both high fraud risks as well as high priority programs and services. Further details about provider enrollment related recommendations are in the Highlights of MPI Activities section of this report.

Detection Activities

Fraud and abuse detection involves varied methodologies and techniques that identify program vulnerabilities, threats, and risks to the Medicaid program. 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. Medicaid Health Plan (MHP) program integrity-related activities are also included in detection, although there are prevention and enforcement components to those efforts as well. Detection methodologies which utilize both technology and human resources continue to prove to be most successful.

MPI continues to work toward *fraud* detection, as opposed to *abuse* or *waste* detection. During FY 2022-23, MPI received and assessed more than 2,300 complaints. Data detection, through internal MPI analytics assessing both claims-based, and non-claims-based indicators of fraud and abuse risks, continues to be a high priority for MPI. During FY 2022-23 MPI data analytics resources were more dedicated to supporting prevention and audit activities as opposed to generating new leads already developed in previous years and the need to dedicate resources to Florida Health Care Connections (FX) development.

During FY 2022-23, MPI personnel worked with the FX team in developing new systems and tools for future use; some of these systems will replace the Agency's current Medicaid Management Information System and related query tools. These include the data warehouse of all Medicaid claims and the tools used to query the data. Several MPI mangers, particularly the Detection Manager, spent a considerable amount of time during FY 2022-23 ensuring the needs of both MPI and MFCU were built into the FX processes.

Additionally, although MHP oversight related to program integrity includes elements of prevention, detection, and enforcement (e.g., overpayment recoupment) activities, these efforts are coordinated within the detection unit. In addition to education and oversight related to the MHPs' program integrity efforts, MPI continues to receive the Suspected/Confirmed Fraud and Abuse Reports (also referred to as 15-day reports) from the MHPs. These are the MHPs reports to AHCA of their investigations which have risen to the level of suspected (or confirmed) fraud or abuse. The fraud referrals are also concurrently sent to MFCU. During FY 2022-23, the MHPs made 378 referrals of fraud to MPI and MFCU and 770 referrals of abuse to MPI. As with the referrals received by MFCU from MPI, the vast majority (if not all) of the referrals are initially accepted. However, ultimately a significant portion of the referrals are later, fairly quickly closed as unfounded. MPI has addressed its concern about the high volume of leads which are closed, both with MFCU and the MHPs. The concern and efforts to improve the success rate of MHP fraud referrals is further discussed in the Highlights of MPI Activities section of this report.

Overpayment Recoupment Activities

Overpayment recoupment activities are predominately carried out through three teams in MPI and organized according to the audited provider types. The Practitioner team audits most non-institutional provers, including physicians, waiver providers, and behavioral health providers. The Institutional team audits institutional providers and typically performs large-scale audit projects. The Pharmacy and DME team consist of pharmacists and a pharmacy tech and audits pharmacies and DME providers. The Overpayment Recoupment Unit also includes a team for special projects. This team is responsible for processing Final Orders for MPI, receipt and processing of checks that come to MPI, and opening self-audit cases upon receipt of self-audit records and/or checks. In addition, the special projects team will also work with the other teams on projects when additional assistance is needed and will work with outside contractors coordinating and collaborating on various projects.

Audits are a means for MPI to determine if a provider has not followed Medicaid policy with regard to service delivery or documentation. Through audits, MPI identifies overpayments for recovery. MPI audits fee-for-service (FFS) claims and managed care encounters (claims) where the MHP's are time limited by provisions of section 641.3155, F.S. MPI may also identify and recover overpayments on claims that are not time limited for the MHPs, but only when the MHP has failed to properly report the suspected fraud, abuse or waste.

Operations Activities

The Operations Unit activities are the critical support functions which increase MPI's opportunity for success in carrying out its duties to combat fraud, abuse, and waste. The other MPI units could not function without this support. The unit manages the bureau's annual operating budget, purchases all supplies, subscriptions, and tools needed to carry out MPI's mission, engages in oversight and processing of personnel actions, coordinates public record requests, handles incoming and outgoing mail, coordinates MPI's records (case management) and record storage, and oversees generally all of the office management. The Operations Unit is also responsible for coordinating efforts with vendors such as the MPI case tracking system developer, organizing and coordinating bureau training, managing accreditation requirements of bureau personnel, and assessing and addressing technology and other needs to optimize bureau activities.

The Operations Unit also performs a function that involves the review of providers deemed noncompliant with repayment obligations by Financial Services who may be out of business. The reviews may result in an official certification pursuant to sections 409.907(12) and 409.908(26), F.S., that the provider is out of business which 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. These activities result in savings to the state (for the returned federal share) by allowing the Agency to retain that portion of the federal funding.

Operations Activities Certified Out of Business	
Providers Reviewed	18
Certified Out of Business Adjustments	$1,199,341

Additionally, during FY 2022-23 MPI began to develop a process to evaluate providers earlier, before the overpayment is formally identified through the standard audit processes. Where appropriate, providers may be certified as out of business related to these "potential overpayments". The purpose of this proposed process (which is under development) is to further protect the state's entitlement to retain the federal share.

Highlight's of MPI Activities for FY 2022-23

MPI's fraud and abuse detection and prevention efforts continue to predominately focus on schemes such as the failure to follow coverage and limitation (policy) provisions, billing for non-covered services as covered services (e.g., billing for therapy when some form of daycare is furnished without any therapy), and billing for services not rendered (an absence of service delivery). However, misrepresenting material details on claims (or in documentation) such as dates or location of service, or rendering/ordering/authorizing provider(s) is often discovered and may form the basis for further investigation of suspected criminal activity.

MPI is seeing an increase in cases which are suggestive of patient brokering or misuse of recipient information, the use of straw (false) owners, creation of shelf corporations for later use, and financial crimes such as kickbacks and bribery. These are schemes that MPI personnel do not routinely investigate but are commonly implied in investigations which ultimately lead to law enforcement referrals.

MPI continues to engage in a broad array of activities that serve to identify and mitigate program losses due to fraud and abuse. These activities include:

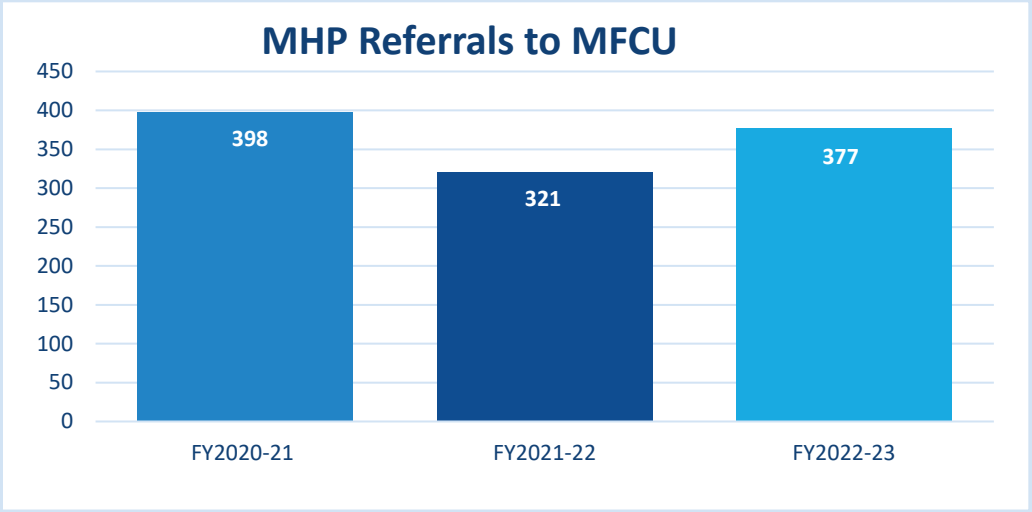
- On-site visits and interviews with providers, provider employees, and recipients.
- Sanctions which may include administrative fines, and termination or suspension from participation in the Medicaid program.
- Payment restrictions which include prepayment reviews (s. 409.913(3), F.S.), payment suspensions (42 CFR 455.23), and payment withholds (s. 409.913(25)(a), F.S.).

- Referrals to other entities including law enforcement (MFCU and HHS-OIG) as well as other state agencies with regulatory oversight or enforcement authority.
- Consultation with the Division of Medicaid about program safeguards.
- MPI-Conducted Overpayment Audits.
- Vendor-Assisted Overpayment Audits.
- Compliance and program integrity-related oversight of MHPs, including recommendations for liquidated damages or sanctions (against the MHPs).
- Litigation support for overpayment audits, sanctions, and criminal prosecutions.

Examples of these activities are highlighted below:

MHP Referrals To/Interactions with MFCU

MPI interactions with MFCU relate both to the referrals MPI makes directly to the MFCU of suspected criminal violations (see s. 409.913(4), F.S.) or credible allegations of fraud (see 42 CFR 455.23), as well as the referrals the MHPs make to MFCU. MPI continues to emphasize the MHP referrals to MFCU and has sought to ensure that the MHPs make a high volume of referrals while also striving toward high-quality referrals.



MPI established benchmarks for each health plan and throughout the year monitors and educates the plans to assist them toward meeting the goal. The benchmark is a contractual provision and is referred to as a Performance Target. In FY 2022-23, targets totaled across all plans 343 referrals. During FY 2022-23, the MHPs made 377 referrals to MFCU; this figure is based only upon the referrals from the Statewide Medicaid Managed Care MHPs (and does not include other managed care programs, such as the Dual Special Needs Plans). This volume of referrals demonstrates the commitment to the identification of suspected fraud. In future years, MPI intends to more proactively work with the other (non SMMC) managed care programs related to the Medicaid program, which may result in an increased overall target for MFCU referrals.

Although, overall, the MHPs exceeded the annual goal for fraud referrals to MPI, only eight (8) of the 13 plans met or exceeded their specific goals. Five (5) plans were slightly under their goal and have or will be engaged in further discussions with MPI and MFCU to increase the volume in subsequent years. However, it is critical the plans are not encouraged to merely meet or exceed a number, or the quality of referrals may significantly drop.

In FY 2023-24, MPI is placing greater emphasis on law enforcement referrals. Agencies other than MFCU will be asked to present to the plans so that fraud issues which may not be as attractive of referrals for MFCU may instead be referred to other agencies such as the Department of Financial Services (insurance fraud) or HHS-OIG or the FBI who also investigate Medicaid fraud cases.

During FY 2022-23 MPI and MFCU personnel had routine communication about the MHP referrals. An issue (or concern) MPI and the MHPs have is how readily MFCU accepts a referral only to shortly thereafter close it as unfounded. The terminology ("unfounded") could serve to preclude civil or administrative recovery actions when what MFCU may have meant to convey was that they would not pursue criminal charges. In the discussions with MFCU it has been made clear that in

many of the closed investigations the allegations were not refuted but, due to a number of reasons, the cases were not pursued criminally. Additionally, MPI will engage in additional training and, as necessary, propose contractual requirements regarding best practices for fraud referrals. MPI is also hopeful the MFCU will engage with the plans earlier following a referral to give the plans an opportunity to discuss referrals and be available for questions.

Behavioral Health Prevention Project

In the FY 2020-21 annual report, MPI reported on a Community Behavioral Health project related to providers billing the Medicaid program for behavioral health services. The project continued throughout FY 2022-23 and continues to create many opportunities for MPI. The project is based, in part, on the high priority placed on mental health services to mitigate fraud and abuse in an effort to ensure funds reimbursed to providers support valid/legitimate services.

Previously identified issues have now been corrected, including ending the allowance of services billed through the FFS program when patients were assigned to Dual Special Needs Plans, and the correction of a claims processing system edit which had inadvertently allowed FFS payments for recipients in Statewide Medicaid Managed Care (SMMC).

In FY 2022-23, there was a significant increase in on-site provider visits to behavioral health providers which resulted in the discovery that many of these groups are non-operational; providers closed their facilities or have moved from behavioral health to another type of service. We also continue to identify ineligible providers. Our efforts have resulted in payment restrictions, overpayment recoveries, terminations, and law enforcement referrals.

As mentioned in last year's annual report, schemes included potential financial improprieties such as money laundering, payments to recipients and providers to participate in the scheme, the use of straw owners, and efforts to avoid detection of disbursement of funds. This fiscal year, our previous referrals related to these schemes led to arrests by law enforcement partners. Another scheme identified that is still currently being explored involves the relationship between providers and other entities such as enrollment brokers or consultants.

Hospital Acquired Condition Project

Hospital acquired conditions (HAC) are conditions occurring in any inpatient hospital setting which are identified as a HAC. This project was created by the Institutional unit and opened based on HAC diagnosis codes that were possibly miscoded or up coded. The Hospital Acquired Conditions (HAC) Pilot Project audit dates were July 1, 2015, through September 30, 2015. This pilot project looked at providers who appeared to have billed and have been reimbursed for hospital acquired conditions. These claims were both fee for service and encounter claims and the health plans are aware of the project. An overpayment recovery of $68,620.63 for FY 2022-2023 has been identified. The project is not yet completed, but once finished, will be reviewed with a possibility of expansion in the future.

Home Health and Hospital Overlap

MPI's Institutional unit was able to identify certain home health service claims that overlapped dates of service with inpatient hospital and nursing home stays. This audit captured those home health service claims that were billed for the same date and time as a hospital or nursing facility, resulting in an overpayment. In addition to identifying overlapped claims per Medicaid policy, MPI reviewed fee for service claims for sufficient documentation and record-keeping requirements. Through these efforts, MPI opened 58 cases in this project. This has been an ongoing project involving medical records reviews of both the hospital and the home health provider, with a projected recoupment of $239,262. Of that, $58,178.78 was recouped for FY 2022-2023.

Medicaid Health Plan Monitoring Reviews

In FY 2022-23, the Managed Care Team continued its monitoring of the Medicaid health plans to ensure compliance with federal, state, and contractual requirements related to program integrity in the Medicaid program. Among these requirements are somewhat robust reporting requirements for the MHPs related to fraud, abuse and waste. In an effort to have the health plans report case updates on the Quarterly Fraud Abuse Activity Report, the Managed Care Team worked with the MHPs and the MPI Data Team on a new template that will ensure data integrity and efficiency in reporting that is a priority for the Agency and the MHPs.

Additionally, the Managed Care Team worked in collaboration with the Division of Medicaid on two projects related to the Florida managed care program. The first was the Managed Care Rule Compliance (MCRC) review where various federal standards were reviewed as part of a collective audit. The second was working on the Centers for Medicare and Medicaid

(CMS) Managed Care Program Annual Report (MCPAR) a newer reporting requirement related to the following different categories: (I) Program Characteristics and Enrollment;(II) Financial Performance;(III) Encounter Data Reporting;(IV) Grievance, Appeals, and State Fair Hearings;(V) Availability, Accessibility, and Network adequacy;(VI) Topic reserved;(VII) Quality and Performance Measures;(VIII) Sanctions and Corrective Action Plans;(IX) Beneficiary Support System; and (X) Program Integrity. The Managed Care Team and MPI had input in several areas, which was a great way to collaborate with other bureaus in the Agency for both projects.

Collaboration With Outside Contractors

Another opportunity for MPI to increase prevention, detection, and overpayment recoveries includes working with low-cost (or even no-cost) vendors to supplement MPI efforts. Particularly through collaboration with the Division of Medicaid and the Agency's third-party liability (TPL) vendor, as well as the Centers for Medicare and Medicaid Services (CMS) and their Unified Program Integrity Contractor (UPIC), MPI has been able to realize additional overpayment recoveries and expand investigative capabilities. During FY 2022-23, MPI continued to use these resources predominantly for audits (overpayment recoveries), but referrals may also be made when fraudulent provider behavior. Use of these contractors allows MPI to increase its efforts and maximize the program integrity benefits for the state of Florida.

The Institutional Unit is the primary contact and collaborator with the UPIC, currently Safeguard Services (SGS). The Unit verifies policy by working with Medicaid policy personnel, coordinates meetings with other MPI units and the UPIC, reviews the UPIC's overpayment letters, and sends out the final audit reports for any institutional audits by the contractor. If there is litigation, the Institutional Unit coordinates all activities with the Agency's attorneys and prepares to act as witness in any hearings that involve work done by SGS. The state was able to recover $4,979,922.91 in overpayment through the institutional unit's efforts with the UPIC in FY 2022-2023, in audits of Institutional providers, including hospitals, nursing homes, and hospices.

In addition, the Institutional Unit meets frequently with the TPL contractor to discuss policy, claims reviews, and possible projects for the vendor. During FY 2022-2023 the Institutional Unit has been working with the TPL contractor on records reviews, utilizing analysts and nurses in the Institutional Unit to work with the contractor on disputes.

Third Party Liability (TPL) MPI Support

The Agency contract MED175 w/4 Amendments establishes program integrity audit support provided by Health Management Services, Inc (HMS), the Agency's third-party liability (TPL) vendor. Overall, the vendor's contracted scope of work supports the Agency in several important areas with specific support to program integrity included as Other Recovery Projects. In FY 2022-23 HMS recovery totaled $24,179,823. As in years past, these Audit projects and recoveries are for fee-for-service (FFS) paid claims only. However, MPI continues to explore options to include State Medicaid Managed Care (SMMC) provider payments for services made to providers contracted and paid by SMMCs. These payments are referred to as encounter claims. FFS audits continue to be the mainstay of HMS overpayments at the present time and the foreseeable future.

Unified Program Integrity Contractor

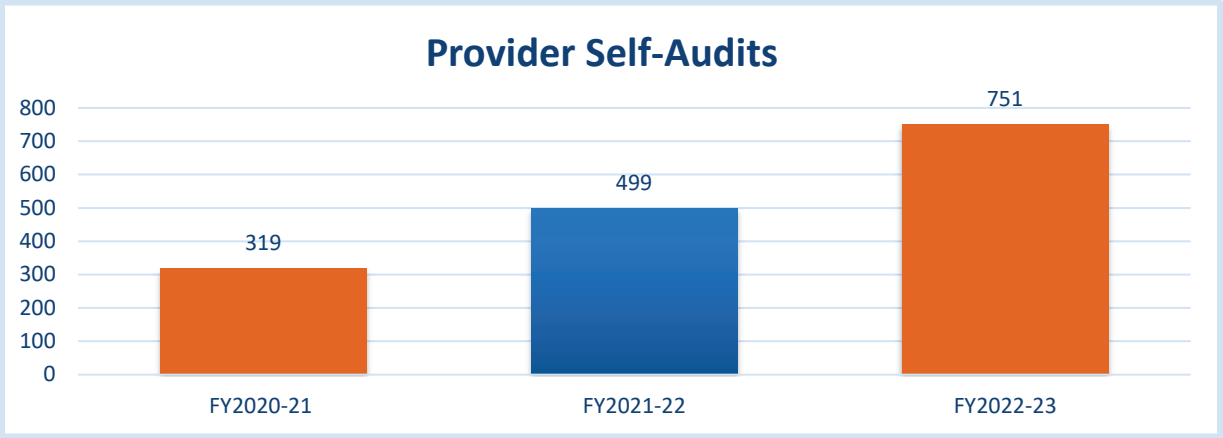
Unified Program Integrity Contractors (UPIC) are contracted with the Centers for Medicare and Medicaid Services (CMS) to support the states' efforts to deter fraud, abuse, and waste. SafeGuard Services (SGS) is an organization contracted by CMS to perform specific program integrity functions as the UPIC for the United States' Southeastern Jurisdiction which includes Florida. The UPIC provides additional resources to the state at no additional cost, promoting program integrity initiatives. In addition, SGS has access to Florida Medicaid's paid claims data, and federal Medicare data. This resource offers the potential for MEDI-MEDI audits for Florida Medicaid's dual-eligible population.

Utilizing the UPIC to perform additional audits and investigations maximizes MPI's resources. During FY 2022-23 through the work of SGS, MPI was able to accomplish more audits, some more complex, including a one day stay audit utilizing claim samples and extrapolation to review records for medical necessity for certain inpatient stays, and a Hospice 2.0 project where SGS reviewed and determine whether Medicaid managed care organization (MCO) payments made to providers for hospice services were in accordance with State and federal laws, regulations and policies. The state recovered $4,979,922.91 by utilizing the resources of SGS, with collaboration and consistent communication with MPI.

Self-Audits

MPI continues to promote self-audits through sharing potential overpayment or billing errors with providers once 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 a self-audit

may subsequently avoid an MPI audit for the same billing error or overpayment issue, thereby potentially avoiding investigative costs and sanctions. Over the past two years the number of self-audits processed by MPI have increased, as well as the overpayments. This FY MPI collected $3,485,346 in overpayments for 751 self-audits.



Pharmacy Project

This fiscal year's overpayment recovery efforts included a focused effort on recoupment of improper payments made for prescription legend drugs and devices. Over $1.1 million was recovered for FFS and crossover claims involving: J-code duplicate payments, overbilled quantity payments, payments for malfunctioning legend devices, payments resulting from the improper use of modifiers, and payments on overlapping legend devices. Additionally, $1.9 million was recovered from comprehensive reviews of 340B pharmacy payments.

Policy Recommendations related to Provider Enrollment

During FY 2022-23 the Division of Medicaid indicated to MPI there would upcoming discussions regarding the rules pertaining to provider enrollment. MPI has held several informational meetings with Medicaid personnel and has drafted extensive written recommendations for Medicaid's consideration. Among the recommendations are provisions related to provider ownership, changes in ownership, operational status, disclosure of affiliated persons including agents and trading partners, and greater clarity in language to ensure that enforcement of program integrity issues is well-supported. In addition to the extensive written recommendations regarding policy amendments, MPI has offered recommendations regarding program operations. One such recommendation is to increase efforts to ensure that when Medicaid discovers issues of non-compliance, the Medicaid Health Plans are notified and required to restrict provider payments (where Medicaid has restricted the fee-for-service payments). MPI has also shared examples of enrollment anomalies with Medicaid in an effort to collaboratively increase the network controls.

Provider Site Visits

During fiscal year 2022-23, the MPI field offices took a much more proactive approach to conducting on-site provider visits. The primary focus was on identifying high risk providers who were still enrolled in the Medicaid program but were not operational at their service address of record. These providers might have abandoned their service location, ceased billing the Medicaid program, or ceased providing services altogether. Other providers might have continued to bill and engage in potential fraudulent behavior. MPI's increased presence in the provider community creates a deterrent effect on fraudulent and abusive behavior and the removal of providers from the network, who are not operational, mitigates the fraud risks. During fiscal year 2022-23, the MPI field offices conducted over 400 site visits to Community Behavioral Health Services group providers and over 60% of the groups were not operational at their service locations. These provider site visits have led to multiple MPI actions such as payment restrictions, terminations from the Medicaid program, and referrals to law enforcement.

From February to April 2023, the MPI Miami field office conducted a total of 162 site visits to Community Behavioral Health Services group providers (PT 05s) identified as not having an active, Medicaid enrolled physician linked to their group provider number. Over 70% (117 out of 162 - 72%) of the groups visited were not operational at their service address of record.

Prior to February 2023, MPI Miami also conducted over 240 site visits (two rounds of visits) to Community Behavioral Health Services group providers (PT 05s) that were overpaid by the Agency due to FFS Medicaid reimbursements for PSR services for recipients enrolled in managed care plans. Over 60% (152 out 242) of the groups visited were not operational (62.80 %) at their service address of record.

Prepayment Reviews

Conducting a pre-payment review (PPR) is not only labor intensive for MPI, but also for the providers. Over the years, MPI has intentionally reduced the volume of PPRs it conducts and focused on only those situations that appear to be the most egregious or the provider otherwise appears to need this level of resource – intensive intervention. Orlando and Tampa MPI worked collectively together on conducting four separate PPRs for four Prescribed Pediatric Extended Care (PPEC) locations from August 2022 through March 2023. The four locations were for the same provider which was reimbursed approximately $7 million in the seven-month period from August 2021 to March 2022, the year before the beginning of the PPRs. Multiple beneficiary parents submitted complaints leading to a site visit to the Orlando location conducted by Orlando MPI, which resulted in collaborative analysis, PPR's for all four provider locations, an MFCU referral, and ultimately an arrest of the provider's administrator.

Fraudulent Behavior Analysis Enrollments

During the public health emergency, the Behavior Analysis Certification Board (BACB) amended its processes to allow candidates for Registered Behavior Therapist (RBT) certification to take the certification examination via online testing. Following the discovery of mass online cheating in the Florida markets, the BACB discontinued allowing Florida residents to take the RBT certification examination online. As a result of the fraudulent testing scheme, unqualified people may have become enrolled in the Florida Medicaid program. The scheme involved registrant's utilizing out-of-state addresses in the application process and online registration with the BACB. In collaboration with the BACB, the Tallahassee Prevention unit successfully terminated approximately 90 fraudulently enrolled (based upon the fraudulently obtained certification) RBTs and identified more than $840,000.00 in overpayments from inappropriate claims. This is a great example of the continued efforts and collaboration between MPI and other entities to combat fraud and prevent future fraud, waste, and abuse.

Other MPI Activity Data

The following reflects several of the MPI activities.

MPI Referrals to Others			
	FY 2020-21	FY 2021-22	FY 2022-23
Agency for Persons with Disabilities	4	9	2
Department of Children and Families	12	5	59
Department of Health	10	16	20
Department of Health and Human Services - Office of Inspector General	22	10	45
Department of Public Assistance Fraud	117	97	22
Division of Medicaid	269	14	2
Division of Health Care Policy and Oversight (Licensure)	131	144	107
Medicaid Fraud Control Unit - Attorney General	33	76	457
SafeGuard Services (CMS)	5	34	4
Total	**603**	**405**	**718**

Provider Sanctions and Medicaid Health Plan Assessments			
	FY 2020-21	FY 2021-22	FY 2022-23
Fines	89	67	60
Suspensions	27	41	31
Terminations	96	95	104
Health Plan	2	7	0
Total	**214**	**210**	**195**

Recovery Activities - Identified Amounts			
	FY 2020-21	FY 2021-22	FY 2022-23
Overpayments (MPI/MPI-CMS Audits)	$19,198,102	$22,764,935	$23,964,017
Costs	$97,758	$26,037	$20,328
Fines	$387,402	$687,123	$767,719
Paid Claims Reversals	$4,150,361	$388,479	$4,862,944
MHP Assessments	$98,500	$129,300	$0.00
Certified Out of Business Adjustments	$5,300,691	$2,960,304	$1,199,341
Total	**$29,232,814**	**$26,956,178**	**$30,814,349**

Prevention of Overpayments			
	FY 2020-21	FY 2021-22	FY 2022-23
Denied Claims (PPRs, 25A, CAF) Impact	$7,123,651	$3,885,097	$8,054,048
Termination of Providers Impact	$633,693	$598,126	$1,879,457
Program Suspensions Impact	$6,490,366	$593,772	$5,389,875
Denial of Reimbursement for Prescription Drugs	$10,122,775	$951,231	$311,892
Site Visits Impact	$1,799,891	$24,709,888	**$41,435,712**
Sanctioned Provider Impact	$81,979,476	$2,462,460	$13,586,412
Audit Impact	$131,855,355	$101,735,293	$88,824,725
PPR and 25(A) Impact	$13,934,407	$30,172,734	$71,161,356
MFCU Referrals Impact	$561,749	$6,163,143	$14,591,273
Total	**$254,501,363**	**$171,271,744**	**$245,234,750**

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, and 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 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 demonstrating the continuous development and refinement of the ROI methodology is available in previous annual reports at http://ahca.myflorida.com/MCHQ/MPI/.

Return on Investment (ROI)				
		FY 2020-21	FY 2021-22	FY 2022-23
Benefits	Recovery	28.44	56.54	43.48
	Prevention	254.50	171.27	245.23
	Total	**282.94**	**227.81**	**288.71**
Costs	Recovery	4.36	9.46	7.24
	Prevention	3.84	4.40	4.60
	Total	**8.21**	**13.86**	**11.81**
ROI Ratio	Recovery	6.52:1	5.97:1	6.01:1
	Prevention	66.23:1	38.90:1	53.60:1
	Total	**34.47:1**	**16.43:1**	**24.43:1**

NON-MPI

The other HCPO Bureaus' activities also aide the Medicaid program in increasing compliance and mitigating fraud and abuse. Strong regulatory controls help ensure the highest levels of integrity within the provider populations that are also AHCA licensees. The HCPO Bureau which houses the Care Provider Background Screening Clearinghouse (Clearinghouse or BGS) may have one of the most significant roles through its efforts which greatly impact Medicaid provider network controls (provider enrollment).

Care Provider Background Screening Clearinghouse

The Agency's healthcare provider background screening clearinghouse helps in the overall efforts toward Medicaid program integrity. 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: AHCA, the Agency for Persons with Disabilities, the Department of Elder Affairs, the Department of Children and Families, the Department of Health, the Department of Juvenile Justice, and Vocational Rehabilitation at the Department of Education. For the selected agencies and persons subject to background screenings, as well as the managed care health plans and providers, 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 also 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 2022-23, the Agency has imposed 684 background screening violations and 549 employee roster violations. During FY 2022-23, the Background Screening Unit processed 28,778 RapBacks. Of these, nearly seventy percent were found to be for criminal charges that resulted in the applicant's eligibility status being updated to not eligible. During FY 2022-23, 218,958 background screening results were shared among participating agencies and Medicaid health plans (MHPs) and 79,405 renewal screenings were requested resulting in an overall cost savings of $19,042,215 to Agency providers, DOH licensees, MHPs, Medicaid providers, DCF, DOEA, DOEVR, and APD providers.

These efforts, by the Agency having developed and maintained the Clearinghouse, help numerous state agencies and their operating partners ensure greater access to healthcare and help mitigate against the instance of ineligible individuals participating in their programs. For Medicaid, these efforts have greatly improved the overall integrity of the program and have resulted in provider denials and terminations. Additionally, through the internal efforts to review and reconcile provider screening information, the Division of Medicaid (provider enrollment), and HCPO (both the Background Screening Unit and MPI) have continued to increase collaboration and communication to further ensure sound and consistent practices.

DIVISION OF MEDICAID

Division of Medicaid Overview

The Division of Medicaid administers the Florida Medicaid program, a more than $35 billion state and federal partnership that provides health care to more than 5 million recipients in Florida. The Division is responsible for overseeing the **management and operation of a broad range of health care services offered through Medicaid to low-income families, the elderly, and people with disabilities. Medicaid expenditures are almost a third of the state budget. The rapid growth in enrollment and costs has made it increasingly important to find ways to manage** the diverse needs of the Medicaid population while also being able to better predict and plan for cost increases.

Medicaid's roles and responsibilities have been evolving since it moved away from a completely fee-for-service (FFS) program into a mix of special programs. The Statewide Medicaid Managed Care (SMMC) program brought significant program changes to Medicaid resulting in improved efficiency, cost predictability and accountability for the program, and enhanced services to recipients. Upon full implementation of the SMMC program in August 2014, responsibilities such as prior authorization, utilization management, and program and provider monitoring that occurred under FFS became primarily the responsibility of the health plans.

Provider Enrollment/Review

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

Monitoring and Reporting of Terminated Providers

Medicaid collaborates with its health plans to ensure that fraudulent or terminated providers are not illegitimately participating in Medicaid, either by registering again with Medicaid using different information, or by contracting with a Medicaid health plan in an attempt to indirectly participate in the Medicaid program. In doing so, Medicaid identifies providers that have been terminated by the Agency for fraudulent behavior and informs the health plans that these providers are ineligible to participate in the plan's networks. Medicaid also evaluates providers that have at some point in the past been linked to a provider terminated for fraudulent activity. The Agency researches this information to make sure that active providers have the clearance to participate in the Medicaid program. 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 renewal applications, including compliance with state and local license regulations, fingerprinting, and searches of federal and state exclusion databases. Enhanced screening is required for applicants with criminal records, prior denials, sanctions, terminations, or exclusions from Medicare or Medicaid, adverse licensure actions, overpayment or sanction monies owed to Medicaid, changes of ownership, or suspended payments. On-going provider eligibility and compliance activities aid the Division of Medicaid in better screening and monitoring of Medicaid providers.

Medicaid Health Plan Contract Requirements for Provider Credentialing

Beyond the activities carried out by the Agency for all providers, under the SMMC program each health plan is also responsible for the credentialing and re-credentialing of its provider network. The plans are responsible for contract-specific compliance requirements to increase the quality of the provider networks.

The contract that the Medicaid health plans have with their providers must contain specific provisions required by the Agency to ensure enrollees have access to all appropriate care as authorized in the Medicaid State Plan and that the Agency can adequately monitor plan and provider performance. All records are open to investigation by the Agency and providers must fully cooperate with any investigations. Records must be maintained for a minimum of 10 years.

Additional information on the SMMC plan Model Contract is available on the Agency's website: https://ahca.myflorida.com/medicaid/statewide-medicaid-managed-care/2012-2018-smmc-plans.

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 performs the basic credentialing functions on behalf of the plans. Limited enrolled providers are not authorized to provide services to Medicaid recipients enrolled in FFS Medicaid but can contract with plans to serve recipients enrolled in those 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 screenings 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 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.

Referring and Ordering Providers

The Agency now requires all physicians, and other professional practitioners, who order or refer services in conjunction with the provision of services to Medicaid recipients, but who do not participate in managed care or FFS, enroll with Medicaid.

In support of this requirement, the Agency implemented a fully automated provider enrollment application for use by ordering and referring providers. The application imports data from four other systems to populate the application: the DOH professional license database, the Care Provider Background Screening Clearinghouse (Clearinghouse), the NPPES, and Medicare's PECOS. The data from these systems ensure that all ordering and referring providers meet disclosure and screening requirements for enrollment in Medicaid.

Ordering and referring providers are not authorized to provide services to Medicaid recipients enrolled in FFS Medicaid or to contract with Medicaid health plans. Ordering and referring providers are required to renew their enrollment every three years.

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.

Medicaid Preferred Drug List (PDL)

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

authorization and step therapy protocols for drugs not on the PDL. The committee may recommend prior authorization protocols for Medicaid-covered prescribed drugs to ensure compliance with clinical guidelines, for indications not approved in labeling, and for prevention of potential overuse, misuse, or abuse.

Data Analysis

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

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

SMMC Contractual Provisions and Plan Responsibilities

Utilization management in Statewide Medicaid Managed Care is primarily the responsibility of the Medicaid health plans. The Agency's contracts with the health plans require that each plan have a utilization management program in place. Each health plan's utilization management program must be reflected in a written Utilization Management Program Description and include contractually required elements (procedures and protocols).

SMMC Health Plan Prior Authorization

The majority of Medicaid recipients were enrolled in Medicaid health plans after the implementation of SMMC and for those enrollees, the health plan is responsible for coordinating their care and for setting prior authorization policies that apply to their enrollees. Medicaid health plans are also required to have their prior authorization policies outlined in their provider coverage policies and must have a help line staffed 24 hours a day, 7 days a week to respond to prior authorization requests.

Pharmacy Claims Processing

There are several activities that Medicaid has undertaken to ensure that Medicaid pharmacy services provided to the fee-for-service (FFS) population are both appropriate and cost effective. Medicaid also has point-of-sale monitoring available to track medication usage and has thousands of claims edits in place to automatically prevent inappropriate expenditures. The system of automated claim edits is continuously refined and improved to support safe prescribing, adherence to the Preferred Drug List, and prevention of fraud and abuse. In FY 2022-23 the contracted prescription benefit manager vendor processed nearly 1.1 million fee-for-service pharmacy claims, more than 88,000 per month.

Pharmacy Prior Authorization

The Florida Medicaid FFS pharmacy program ensures quality and cost-effective pharmacy practices. The combination of cost containment programs and preferred drug policies minimize expenditures and contribute to maximization of drug rebate collections. System driven edits and prior authorization procedures ensure that Medicaid recipients have access to needed medications while program costs are controlled, and fraud and overutilization are minimized.

The following chart shows the total number of prior authorization requests received in FY 2022-23 for the Medicaid FFS pharmacy program.

Pharmacy Prior Authorization Requests FY 2022-23		
Total Prior Authorization Requests	9,555	100.0%
Average Per Day	26	--
Total Requests Approved	6,305	66%
Total Requests with Change in Therapy	3,166	33%
Total Requests Denied	84	1%

Home Health Electronic Visit Verification

The Agency contracts with Netsmart Technologies, Inc. as the vendor for continuation of home health electronic visit verification (EVV) services from FY 2017-18 through January 31, 2024. The primary purpose of the EVV contract is to verify the utilization and delivery of home health services using technology that is effective for identifying delivery of the service and deterring fraudulent or abusive billing for the service. EVV provides an electronic billing interface and requires the electronic submission of claims for home health services. This helps ensure appropriate utilization and expenditures for Medicaid home health services, improves the quality of care for Medicaid recipients, and prevents Medicaid fraud, abuse, and waste. EVV includes monitoring of all home health services (i.e., home health visits, private duty nursing, and personal care services).

Home Health Visit Prior Authorization

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

During FY 2022-23, Acentra completed 2,356 home health prior authorizations, an average of 196 per month. Of these, 2,131 were approved, giving a denial rate of 10 percent. The following table shows the total number of home health prior authorization requests, approvals, denials, and denial percentage for each month during FY 2022-23. Note that in addition to being approved or denied, requests may also be pended for more information, held for additional review because of new information received, still be under reconsideration, or could also be awaiting a fair hearing.

Comprehensive Care Management for Children with Special Health Care Needs

The Agency has also included Comprehensive Care Management in its contract with Acentra, which provides utilization management and care coordination for home health visits, private duty nursing, personal care services, and prescribed pediatric extended care (PPEC) services. Only utilization management is provided for inpatient medical and surgical services. The purpose of Comprehensive Care Management is to improve care coordination and to identify potential overutilization and fraud or abuse of Medicaid services by ensuring that the level of home health aide and private duty nursing services provided to recipients receiving home health care matches the needs of the recipients. During SFY22/23, the vendor conducted 33,860 telephonic visits and 7,148 care coordination and multidisciplinary team meetings.

Ancillary Medicaid and Other Services

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

Outpatient Advanced Diagnostic Imaging

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

BA Services Prior Authorization

Before providing BA services to Medicaid recipients, and at least every 180 days thereafter, providers must obtain authorization from Acentra. Providers may request authorization more frequently if the recipient's condition changes so that an increase or decrease in services is required. The following tables show the total number of prior authorization requests for BA services, approvals, denials, and denial rate during SFY 2022-23.

Prior Authorizations for BA Services for SFY 2022-23			
117,982* Total BA Prior Authorization Requests Received			
	Approvals	**Denials**	**Denial Rate**
July 2022	27,341	901	3.30%
August	16,596	994	5.99%
September	10,018	1,192	11.90%
October	9,967	997	10.00%
November	9,384	927	9.88%
December	9,162	1,015	11.08%
January 2023	10,280	1,050	10.21%
February	10,435	1,008	9.66%
March	11,634	1,354	11.64%
April	10,493	1,489	14.19%
May	11,223	1,671	14.89%
June	10,493	1,701	16.21%
Total Completed Reviews = 161,325*	147,026	14,299	9.73%
* 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.			

During SFY 2022-23 Medicaid paid for BA services for 29,358 unique recipients totaling more than $1.47 billion.

Behavior Analysis Provider Enrollment Moratorium in Miami-Dade and Broward Counties

The Agency lifted the behavior analysis provider enrollment moratorium in Miami-Dade and Broward Counties in November 2022. The moratorium had been in place since May 2018, when the Agency announced a temporary moratorium on enrollment of new Behavioral Analysis (BA) providers in Miami-Dade and Broward counties. The moratorium was approved by the Centers for Medicare and Medicaid Services. The moratorium was enacted after a thorough investigation of providers in those counties identified Medicaid fraud and abuse including extraordinary overbilling. The Agency imposed the moratorium to prevent significant fraud that impacts taxpayers and potentially compromises the quality-of-care patients receive. The moratorium did not affect any Medicaid recipient's ability to access necessary BA services. The moratorium began on May 14, 2018, and was lifted in November 2022.

Florida Health Care Connections (FX)

Florida Health Care Connections (FX) is a multi-year transformation project that modernizes the current Medicaid technology using a modular approach, while simultaneously improving overall Agency functionality and building better connections to other data sources and programs. The vision of FX is to transform Florida's Medicaid Enterprise to provide the greatest quality, the best experience, and the highest value in health care. FX includes a variety of projects (technology, policy and procedure, and business process analysis) to support the Agency and other Florida state agencies in improving the health care experience for our recipients and providers. This will include access to improved data, tools and processes that will greatly enhance our service to these various customer groups. FX is planning the release of several upcoming change events that will drive customer and worker experience improvements in Florida. The Enterprise Data Warehouse establishes the data foundation for modular transformation and will provide greater information sharing, optimized data access, enhanced data integration, increased security, and strengthened query and analytic capabilities for users of the system. The FX Unified Operations Center will provide a unified user experience for Medicaid customers while consolidating communications and enterprise-wide business services across functional areas, supported by a common platform technology. Medicaid Program Integrity champions the transformation efforts of FX as we provide regular design input that maximizes our Medicaid program oversight objectives to prevent, detect, recoup, and enforce fraud, waste, and abuse activities in Florida.

STATUTORY REPORTING REQUIREMENTS

Number Of Cases Opened and Investigated

MFCU opened 302 cases and had 989 active cases in FY 2022-23. MPI investigated 3,239 cases, which included 2,121 opened during the year.

SOURCES OF THE CASES OPENED				
	MFCU		AHCA	
Source	Fraud	PANE	MPI	Total
AHCA - Division of Medicaid			4	4
AHCA - Financial Services			15	15
AHCA - Heath Quality Assurance			13	13
AHCA - Medicaid Fiscal Agent Operations			17	17
AHCA - Medicaid Program Integrity (MPI)	9	2		11
AHCA - MPI Detection			20	20
AHCA - MPI Institutional			45	45
AHCA - MPI Orlando/ Tampa			29	29
AHCA - MPI Managed Care Unit			1	1
AHCA - MPI Miami			117	117
AHCA - MPI Pharmacy			475	475
AHCA - MPI Practitioners Care			11	11
AHCA - MPI Prevention Strategy			225	225
AHCA – Office of Inspector General			1	1
AHCA – Other Bureaus or Divisions			8	8
APD - Agency for Persons with Disabilities	4			4
APS - Adult Protective Services		101		101
Citizen	12	1		13
Centers for Medicare & Medicaid Services	5		2	7
Consumer Protective Agency		1		1
CMS Contractor	1			1
DCF Dept of Children & Families		1		1
DOE Dept of Elder Affairs		1		1

SOURCES OF THE CASES OPENED				
	MFCU		AHCA	
Case Type	Fraud	PANE	MPI	Total
DOH - Department of Health	1			1
Employee	6	5		11
EOMB			5	5
Family Member	4	1		5
FBI - Federal Bureau of Investigation	3		2	5
Florida - Medicaid Fraud Control Unit			12	12
Florida - Other Agencies			1	1
Government Employee	1			1
Healthcare Fraud Prevention Part. (HFPP)			1	1
Health & Human Services Inspector General	15		5	20
Internet/Media			4	4
Investigator Initiative			113	113
Law Enforcement Agency	1	2		3
Mail/Email			4	4
Managed Care Provider			8	8
Managed Care Special Investigations Unit	57	1		58
Medicaid Provider	2			2
Medicaid Recipient	3			3
Online Complaint Form			32	32
Previous File or Case			8	8
Projects			562	562
Qui Tam	51			51
Self-Audit			265	265
Site Visits			116	116
Spinoff Case	10	1		11
Total	185	117	2121	2423

DISPOSITION OF THE CASES CLOSED				
	MFCU		AHCA	
Case Type	Fraud	PANE	MPI	Total
Acquittal	1			1
Administrative Closure	2			2
Administrative Referral	32	18		50
Bankruptcy			1	1
Case Dismissed	12	2		14
Certified Out of Business - Validated			18	18
Change of Ownership (CHOW)			1	1
Civil Settlement	13			13
Consolidated	7			7
Conviction	21	8		29
Death of the Offender	1	1		2
Defendant Deceased		1		1
Facts Alleged Not Indicative of Exploitation		1		1
Fines Issued			10	10
HHS-OIG Accepted			3	3
Info Previously Referred to Other Law Enforcement Agency	1			1
Investigated by Another Law Enforcement Agency	8	3	1	12
Lack of Evidence	30	34		64
Liquidated Damages Not Applied			3	3
Medicaid Fraud Control Unit - Accepted			37	37
Medicaid Fraud Control Unit - Declined			2	2
No Abuse			6	6
No Auditable Review Period			1	1
No Findings			2	2
Nolle Prosequi		1		1
No Further Action Required			410	410

Not a Medicaid Provider			1	1
Not an Overpayment Issue			1	1
Not Sustained			2	2
Pre-Trial Intervention		2		2
Project Completed			27	27
Prosecution Declined	7			7
Provider Education			13	13
Provider No Longer Operational			5	5
Provider Suspended			30	30
Provider With Cause Termination			105	105
Provider Without Cause Termination			1	1
Referred			463	463
Resolved with Intervention	3	3		6
Statute of Limitations Expired	1			1
Suspension Lifted			2	2
Sustained			904	904
Unfounded	11	9		20
Unsubstantiated	24	32		56
Victim Deceased		1		1
Voluntary Dismissal	44	1		45
Voluntary Termination			1	1
Total	**218**	**117**	**2050**	**2385**

Amount of overpayments alleged in preliminary and final audit letters.

Preliminary	Final
$18,651,776	$12,980,234

Number and amount of fines or penalties imposed

During FY 2022-23, MPI imposed 195 fines (under s. 409.913, F.S., and Rule 59G-9.070, F.A.C.) in the amount of $767,719.

Amount of final Agency determinations of overpayments

MPI identified overpayments in the amount of $23,964,017 in closed audits.

Amount deducted from federal claiming as a result of overpayments

Federal requirements allow the state up to one year to return the federal share through federal cost share adjustments of overpayments. 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 2022-23, the Agency reduced its federal share, on quarterly cost reports, by $40,842,464 for net overpayments.

Amount of overpayments recovered

MFCU collected $2,484,361 in overpayments that were returned to the Agency. Additionally, MFCU collected $2,813,845 in Federal Medicaid overpayments that were sent directly to the United States Department of Health and Human Services for a total of $5,298,206 in Medicaid overpayments collected in FY 2022-23. Overpayments recovered as a result of the MPI, and MPI-CMS audits were $13,241,062. Total recoveries by MPI, MPI-CMS, and MPI-TPL for FY 2022-23 were $42,283,829 (This includes collections of overpayments, fines, costs, and paid claims reversals during the fiscal year).

Amount of cost of investigation recovered

During FY 2022-23, the MFCU collected $8,626 in program income investigative costs. MFCU also collected $3,095 in state share investigative costs and $9,003 in federal share investigative costs for a grand total of $20,724 for all investigative costs.

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

MFCU expenditures for FY 2022-23 were $21,021,253 which included indirect costs of $3,763,915.

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 2022-23 was less than 1 year (0.50).

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

During FY 2022-23, the Bureau of Financial Services deemed $10,473,720 as uncollectible.

Providers, by type, prevented from enrolling 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	166
Best Interest of The Program	1739
Total	**1905**

Denials by Provider Type	Totals
05 - Community Behavioral Health Services	60
07 - Specialized Therapeutic Services	21
14 - Assistive Care Services	13
20 - Prescribed Drug Services	5
23 – Medical Foster Care/Personal Care Provider	1
24 - Prescribed Pediatric Extended Care (PPECC)	8
25 - Physician (M.D.)	90
26 - Physician (D.O.)	6
27 - Podiatrist	1
28 - Chiropractor	2
30 - Advanced Practice Registered Nurse (APRN)	28
32 - Social Worker/Case Manager	11
35 - Dentist	1
39 - Behavior Analysis	1457
42 – Air Ambulance	1
50 – Independent Laboratory	2
65 - Home Health Services	28
67 - Home & Community-Based Services Waiver	45
81 - Professional Early Intervention Services	9
83 - Therapist (PT, OT, ST, RT)	30
91 - Case Management Agency	78
96 – Obsolete Provider Type	1
99 - Trading Partner	7
Total	**1905**

Additionally, 172 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	33
Criminal History	139
Total	**172**

Denials by Provider Type	Totals
05 - Community Behavioral Health Services	9
07 - Specialized Therapeutic Services	5
14 – Assistive Care Services	1
20 - Prescribed Drug Services	3
23 - Medical Foster Care/Personal Care Provider	1
25 - Physician (M.D.)	17
26 - Physician (D.O.)	5
29 - Physician Assistant	4

30 - Advanced Practice Registered Nurse (APRN)	35
32 – Social Worker/Case Manager	6
35 - Dentist	3
36 – Medical Assistant	1
39 - Behavior Analysis	28
41 - NON-Emergency Transport	2
50 - Independent Laboratory	1
51 – Portable X-Ray Company	1
60 - Audiologist	1
62 - Optometrist	2
65 - Home Health Services	14
67 - Home & Community-Based Services Waiver	20
81 – Professional Early Intervention Services	2
83 - Therapist (PT, OT, ST, RT)	9
90 - Durable Med Equipment/Medical Supplies	1
99 – Trading Partner	1
Total	**172**

Finally, there were 562 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	77
Terminated - Adverse Association	485

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
Contractual Termination Under Medicaid Authority	469
With-Cause Termination Under Medicaid Final Order	107
Total	**576**

Terminations by Provider Type	Totals
05 - Community Behavioral Health Services	318
07 - Specialized Mental Health Practitioner	7
10 - Skilled Nursing Facility	2
14 - Assistive Care Services	2
16 – Residential and Freestanding Psychiatric Facility	2
20 - Prescribed Drug Services	4
25 - Physician (M.D.)	32
26 - Physician (D.O.)	6
27 - Podiatrist	1
29 – Physician Assistant	2
30 - Advanced Practice Registered Nurse (APRN)	7
32 - Social Worker/Case Manager	5
35 - Dentist	4
39 - Behavior Analysis	98
50 - Independent Laboratory	1
65 - Home Health Services	10
66 – Rural Health Clinic	1
67 - Home & Community-Based Services Waiver	9
81 – Professional Early Intervention Services	1
83 – Therapist (PT, OT, ST, RT)	14
90 - Durable Med Equipment/Medical Supplies	10
91 - Case Management Agency	36
Total	**576**

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

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.

ACRONYMS

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

A note on how this report was composed:

The Agency for Health Care Administration, Bureau of Medicaid Program Integrity exercises oversight of the production of this report. However, the compilation of the information contained herein originated from many state agencies, bureaus, and units that have oversight of different functions of Florida's large and complex Medicaid program. Months prior to this report's publication, Mechelle Davis and Maureen Barker 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 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, Mechelle Davis and Maureen Barker'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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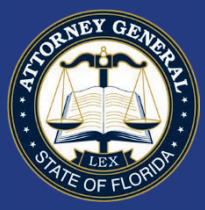

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