FLORIDA'S EFFORTS TO CONTROL

MEDICAID FRAUD & ABUSE

FISCAL YEAR 2023-2024

January 16, 2025

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 2023-24. 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 Ben Albritton
The Honorable Daniel Perez

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OFFICE OF THE ATTORNEY GENERAL

MEDICAID FRAUD CONTROL UNIT
Department of Legal Affairs

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

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

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

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

Civil Recoveries - Regardless of whether an investigation is criminal or civil in nature, emphasis is placed upon the recovery of the State's monetary losses caused by fraud through use of 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 2023-24, the Unit received 4,333 complaints. Of the 4,333 complaints received in FY 2023-24, 628 were related to fraud and 3,705 were related to PANE allegations.

Of the total 628 fraud complaints received, referrals from Managed Care Special Investigative Units were the primary source of fraud complaints in FY 2023-24 at 292. Complaints from Citizens accounted for 108 Medicaid fraud complaints. Qui tam complaints accounted for 46 of the Medicaid fraud complaints received. Thirty-five complaints were received from Family Members and thirty-five were also received from AHCA Medicaid Program Integrity (MPI).

The majority of PANE complaints were derived through the Department of Children and Families (DCF), Adult Protective Services (APS)/ formerly Florida Safe Families Network (FSFN), now known as Serving Adults and Families Effectively (SAFE). In FY 2023-24, of the 3,705 PANE complaints, 3,678 came from DCF/APS/FSFN/SAFE. The next highest sources of PANE complaints received were Family Members with 11 and Citizens with 9.

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 2023-24, 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 348 total cases opened, 188 were Fraud cases and 160 were PANE cases.

The following is a list of the top four Medicaid Provider types for MFCU fraud cases opened in FY 2023-24:

1. Non-Emergency Transportation
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 2023-24:

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

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.

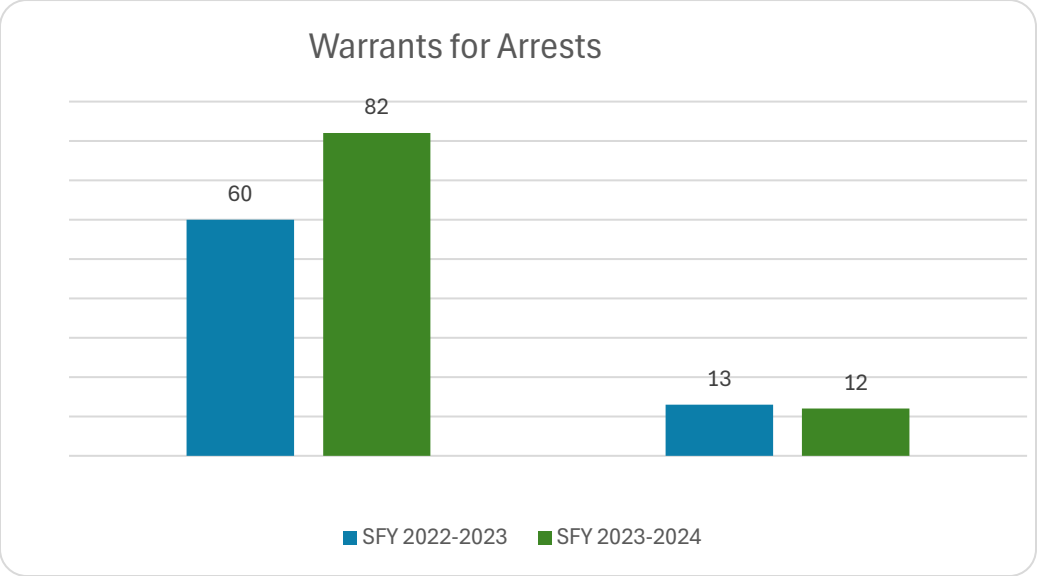
The number of cases closed during a particular fiscal year has no relationship to the number of cases opened during the same year. In almost all Medicaid fraud case investigations, PANE investigations, and qui tam actions, the time from initial review to case closing will be more than one fiscal year.

In FY 2023-24, the MFCU closed 334 cases. Of those, 188 involved Medicaid fraud investigations and 146 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 2023-24 were 83 Fraud and 9 PANE for a total of 92.

Warrants for arrests for FY 2023-24 were 82 Fraud and 12 PANE for a total of 94.



Case Highlights

Lincare, Inc

Attorney General Ashley Moody's Medicaid Fraud Control Unit secured nearly $150,000 through a multistate action against Lincare Inc., a durable medical equipment supplier. The action resolves allegations that Lincare knowingly submitted, or caused to be submitted, false claims to various government health care programs, including Medicaid, for conduct related to its rentals of non-invasive home ventilation devices.

The agreement resolves allegations that from Jan. 1, 2013, to Feb. 29, 2020, Lincare violated the federal and state False Claims Acts by knowingly submitting false claims for payment to the Medicaid program for NIV rentals. The agreement resolves these allegations—both when Lincare provided medically unnecessary NIV rentals and when Lincare did not maintain sufficient documentation to show, or otherwise verify, continued use or continued need, in violation of the FCA and Lincare's own internal policies.

The multistate agreement results from a whistleblower lawsuit originally filed in the United States District Court for the Southern District of New York. Attorney General Moody's MFCU participated in the negotiations, along with a team from the National Association of Medicaid Fraud Control Units. In addition to Florida, the negotiating team included the states of California, Indiana, Pennsylvania, Texas, Virginia and Washington.

Bluestone Physician Services of Florida, LLC, Bluestone Physician Services, P.A. and Bluestone National, LLC

Attorney General Ashley Moody's Medicaid Fraud Control Unit secured nearly $600,000 for Florida Medicaid from a chronic disease management health care provider. In a multistate action with Florida, Minnesota and the federal government, Bluestone Physician Services of Florida, LLC, Bluestone Physician Services, P.A. and Bluestone National, LLC agreed to pay millions of dollars for False Claims Act violations. Bluestone allegedly

violated the federal False Claims Act, and the False Claims Acts of Florida and Minnesota, by submitting false or fraudulent claims for certain evaluation and management codes for services provided to chronic care patients in assisted living and other care facilities that did not conform to Medicare, Medicaid and TRICARE requirements. Florida Medicaid will receive $593,038.00 as a result.

The multistate action resolves allegations that Bluestone submitted false claims for two evaluation and management codes, the domiciliary rest home visit code for established patients and the chronic care management code. The services billed did not conform with Medicare, Medicaid, and TRICARE requirements.

This action results from a whistleblower lawsuit originally filed in the United States District Court for the Middle District of Florida.

Jose Enrique Hernandez Fernandez

Attorney General Ashley Moody announced the arrests of 20 defendants in a fraudulent transportation scheme that caused more than $5 million in losses to the Florida Medicaid program. An investigation by the Attorney General's Medicaid Fraud Control Unit uncovered that the defendants, led by Jose Enrique Hernandez Fernandez, operated a nonemergency medical transportation service that billed Medicaid for thousands of trips never provided. The Jacksonville Sheriff's Office, Clay County Sheriff's Office and the Columbus Police Department of Columbus, Georgia, arrested the defendants.

The MFCU investigation revealed that Jose Enrique Hernandez Fernandez owned Sweet Transportation, LLC, which contracted to provide non-emergency medical transportation services to Medicaid recipients. Over the course of at least two years, Hernandez Fernandez and Sweet Transportation, LLC employees billed Medicaid for thousands of trips never provided and inflated mileage on trips that were completed. GPS data uncovered in the investigation revealed that drivers frequently submitted claims for trips while staying at home, going on vacation, or traveling out of state.

Defendants include: Hernandez Fernandez, Carlos Omar Tellez Janez, Timothy Lambert, Luis Alberto Sierra Bernal, Luz Angela Daza Estupian, Marcia Vargas, Omar Andres Sanchez Buitrago, Yilber Ricardo Martinez Quintero, Aldo Nordelo Janez, Ana Isabel Maure, Dairon Dominguez Santana, Fabio Francisco Castaneda Amaya, Iliana Garcia Avila, Astrid Viviana Lineros Orjudle, Joseph Chacon, Juan Carlos Dulzaides Ortega, Juan Gabiel Perez Castro Gutierrez, Martha G. Guevara Paz, Renier Arencibia Perera, Yoahna Betancourt Fernandez, Yunier Felix Hernadez Lopez, and Michelle Conde Monteiro.

Twenty-one of the defendants were arrested individually accused of organized schemes to defraud over $50,000. Michelle Conde Monteiro was arrested for Medicaid Fraud. Nine defendants are additionally charged with racketeering, another first-degree felony.
Hernandez Fernandez and Tellez Janez are each charged with conspiracy to commit racketeering; racketeering; organized scheme to defraud over $50,000; Medicaid provider fraud over $50,000; and money laundering.

The cases are being prosecuted by Attorney General Moody's Medicaid Fraud Control Unit through an agreement with Melissa Nelson, State Attorney for the Fourth Judicial Circuit.

Latrena Marie Thomas

Attorney General Ashley Moody's Medicaid Fraud Control Unit announced the arrest of the owner of a home health services agency and a parent of a disabled child for Medicaid provider fraud. Latrena Marie Thomas is the owner of A River's Journey, a home health care agency with residential home care facilities located in Yulee and Jacksonville. Thomas is accused of hiring non-licensed individuals to provide hands-on personal care services to Medicaid recipients. In addition, Thomas paid Donald Ray Adams II, a parent of a disabled Medicaid recipient, to provide medically licensed care for his own child. In total, Thomas fraudulently billed Medicaid claims for thirty distinct medically-needy Medicaid recipients, which caused a total loss of more than $1.6 million.

According to the investigation, Thomas and the agency hired employees not licensed as certified nursing assistants or home-health aides to provide hands-on personal care to Medicaid recipients. Several of these unqualified employees would have failed the Level 2 background screening that is required by the Florida Agency for Health Care Administration. Thomas did not have a Director of Nursing on staff to provide oversight of the licensed practical nurses and other staff employed by A River's Journey. Thomas falsified the agency's employee roster, progress notes, service logs and plan of care documents, and billed for a recipient's 24/7 nursing care

while paying Adams. Thomas' negligent assignment of unqualified staff to recipients created three separate medical emergencies, including a trach tube dislodging, extreme sunburn and a delay in contacting Emergency Medical Services.

A River's Journey paid Adams for providing unsigned progress notes for his own child's care. Adams received payments in cash, gift cards and bank deposits from the agency. In total, Adams received $7,320 for involvement in the scheme to defraud Medicaid.

The Jacksonville Sheriff's Office is credited in arresting Thomas, while the Clay County Sheriff's Office was involved in the arrest of Adams.

Thomas faces one count of Medicaid provider fraud, $50,000 or more: a first-degree felony. Adams faces one count of Medicaid provider fraud, $10,000 or less: a third-degree felony.

Attorney General Moody's MFCU is prosecuting the case through the State Attorney's Office for the Fourth Judicial Circuit.

Dayanais Lopez, Osmany Recano and Yosvany Rodriguez

Florida's MFCU announced the arrests of three Miami-Dade County health care workers for committing Medicaid fraud. For more than two years, Dayanais Lopez, 38, Osmany Recano, 45, and Yosvany Rodriguez, 43, paid kickbacks to Medicaid recipients for psychosocial rehabilitation services (PSR). The defendants paid recipients up to $500 a month, or gift cards redeemable for cash, to attend PSR sessions—resulting in a loss to the state Medicaid program in excess of $100,000.

Acting on a complaint from Humana, investigators found Cutler Bay Mental Health Corp recruited numerous Medicaid recipients to attend PSR therapies for monetary kickbacks. Lopez and Rodriguez owned and operated the mental-health facility, while Recano acted as a driver of the facility and recruited the recipients to attend the sessions. PSR therapies are services to restore a recipient's skills and abilities necessary for independent living, including food planning and preparation, money management and more. The investigation revealed that recipients reported illegal concerns with the kickbacks to the defendants. However, the defendants told all recipients to be careful and to not say anything to anyone.

Dayanais Lopez and Yosvany Rodriguez pled guilty and were sentenced to probation and must pay restitution. The case was prosecuted by Attorney General Moody's MFCU through an agreement with the State Attorney for the 11th Judicial Circuit.

Marianna Zadov and Shimon Leizgold

Attorney General Ashley Moody announced the arrest of a Florida dentist and her husband, a co-owner of a dental practice. Marianna Zadov, DDS, and Shimon Leizgold, also known as Simon Leizgold, own and operate at least seven dental offices located throughout Florida's southeast and southwest coasts. Investigators with Attorney General Moody's Medicaid Fraud Control Unit discovered that, for a period of years, Zadov and Leizgold systematically engaged in a scheme to defraud and steal from Florida Medicaid and thousands of recipients.

According to the investigation, Zadov and Leizgold orchestrated a complex scheme charging patients for services covered by Medicaid and then stole from the program itself. The defendants collected fees from Medicaid recipients for covered services, collected fees over and above authorized copayment amounts and collected payment from Medicaid for services never rendered. The investigation identified more than $1.5 million worth of fraud encompassing more than 5,000 Medicaid recipients.

The offices Zadov and Leizgold operated include the following:

- Happy Smiles in Port St. Lucie and Fort Myers;
- Elite Dental in Jupiter;
- Polo Dental in Boca Raton, Naples and West Palm Beach;
- Royal Dental in Boynton Beach.

The defendants are charged with one count each of violating the Racketeer Influenced and Corrupt Organization Act, a first-degree felony; conspiracy to commit RICO, a first-degree felony; grand theft, a second-degree felony; Medicaid fraud, a second-degree felony; and Medicaid fraud as a third-degree felony.

Attorney General Moody's MFCU for the southern region will prosecute the case through the Office of Statewide Prosecution. Asset forfeitures will be handled by Attorney General Moody's Asset Forfeiture Unit.

Sherell Breus

Florida's MFCU and the Polk County Sheriff's Office arrested an owner of a medical transportation service for Medicaid fraud. Sherell Breus, owner and operator of A-Time Transport LLC, submitted false claims to the Medicaid program for more than 400 fake trips to medical appointments. The scheme caused more than $50,000 in Medicaid billings.

A-Time Transport is a subcontractor of Medical Transportation Management (MTM), which coordinates transportation services for Medicaid recipients who need help getting to and from medical appointments. According to the investigation, Breus called in to MTM as the alleged representative of a Medicaid recipient and scheduled transport appointments for the recipient. Breus then claimed those appointments as A-Time Transport, saying the company regularly provided transportation for the recipient from Tampa to Gainesville for appointments. Breus billed MTM for these appointments causing more than $50,000 in fraudulent billings. Breus had the monies deposited into a personal bank account.

The alleged transportation services occurred over an eight-month period. However, during this time period, the Medicaid recipient was actually serving time on a criminal sentence in a work-release program in Fort Lauderdale. The investigation revealed Breus to be in a relationship with the recipient. Electronic ankle monitoring records confirmed it to be impossible for A-Time Transport to be driving the recipient for appointments in North and Central Florida. Monitoring records showed the recipient to be constantly within a 10-mile radius in South Florida.

Breus faces one count of Medicaid fraud greater than $50,000 and one count of scheme to defraud greater than $50,000, both first-degree felonies. The Office of Statewide Prosecution will prosecute this case.

Sheretta Qushawn Joseph

Attorney General Ashley Moody's Medicaid Fraud Control Unit, with the assistance of the Jacksonville Sheriff's Office, announced the arrest of the owner of a company providing personal supports services to Medicaid recipients. Sheretta Qushawn Joseph is accused of submitting claims to Medicaid for persons with disabilities for services not rendered—resulting in a loss of $50,000 to the program.

According to the investigation, Joseph owned and operated Caring Hands Supports & Services LLC, a personal supports health care provider that provides assistance and training to recipients in daily-living activities. In this capacity, Joseph billed Medicaid for services the company provided and paid employees for the time worked.

The investigation revealed Joseph billed Medicaid for $55,423 in services never provided to recipients, some of whom have disabilities, submitting falsified service logs in excess of the hours of service actually performed. Supported by witness accounts, incomplete documentation and bank records, investigators discovered Joseph did not pay workers for the total hours claimed to Medicaid and intentionally received the overpayments.

Joseph pled guilty to Medicaid Fraud and was ordered to pay $55,423.48 restitution. She was also sentenced to two years' probation and one hundred hours' of community service. Attorney General Moody's MFCU prosecuted the case through an agreement with the State Attorney's Office for the Fourth Judicial Circuit.

Juliana Horta

The Miami MFCU arrested a Miami-Dade County healthcare worker, Juliana Horta, 41, for committing Medicaid fraud. According to the investigation, Juliana Horta billed the State Medicaid program in excess of $50,000 for targeted case management services she never provided. The purpose of mental health targeted case management services is to assist Medicaid recipients in gaining access to needed medical, social, educational, and other services.

The defendant is charged with one count of Medicaid fraud, a first-degree felony. The charge is punishable by up to 30 years in prison. The case will be prosecuted by a special designated Medicaid Fraud Control Unit attorney through the Office of the State Attorney, Eleventh Judicial Circuit.

Caridad Abreu Gonzalez

Attorney General Ashley Moody's Medicaid Fraud Control Unit announced the arrest of Hillsborough County resident Caridad Abreu Gonzalez for Medicaid fraud. Abreu Gonzalez worked as a direct-service worker providing personal-support services to disabled adults under the Medicaid program. The investigation revealed that Abreu Gonzalez falsified time sheets and reported more than 800 hours of services never provided—causing more than $13,000 in overpayments.

An investigation by the MFCU revealed that Abreu Gonzalez regularly provided personal-support services to multiple disabled adults, including one client functioning as a 3-year-old. Personal-support services help Medicaid recipients with daily activities, including eating, bathing, dressing, personal hygiene and more. The investigation revealed that instead of reporting an accurate count of hours to Medicaid under the group reimbursement rate, Abreu Gonzalez falsified hours both to bill the higher individual reimbursement rate and to inflate total hours worked.

Abreu Gonzalez faces one count of Medicaid-provider fraud and one count of scheme to defraud, both third-degree felonies. The case will be prosecuted by Attorney General Moody's Office of Statewide Prosecution.

Leslie Diane Minor

Florida's MFCU announced the arrest of the owner of a home and community-based services company for Medicaid provider fraud. Leslie Diane Minor, owner of Minors Helping Hands Support Services, allegedly caused a loss of more than $12,000 to Florida Medicaid for billing for services never rendered.

According to the investigation, Minor owned Minors Helping Hands Support Services, a Jacksonville-based company that assisted with day training for adults with developmental disabilities. During the time period of June 2019 through December 2022, Minor billed for services never rendered to four Medicaid recipients causing a total loss to Medicaid of $12,335. The Jacksonville Sheriff's Office assisted in the arrest of Minor, who faces one count of Medicaid provider fraud, a second-degree felony.

Minor pled guilty and adjudication was withheld. Minor was sentenced to 5 years' probation (ET stipulated) with the following special conditions: up-front restitution of $6,500, balance of $5,835.93 restitution due during probation (total restitution $12,335.93), 100 community service hours, no employment in healthcare or facility that receives Medicaid funds, maintain fulltime employment or proof of 10 job applications/month, court costs $516 Public Defender fee $50 and civil judgment $61,679.65 pursuant to section 409-920(2)(b)3, F.S.

Lisa Michelle Phelts and Amanda Lanette Thomas

Attorney General Ashley Moody's Medicaid Fraud Control Unit, with the assistance of the Clay County Sheriff's Office, announced the arrest of Lisa Michelle Phelts for one count of Medicaid Provider Fraud and Amanda Lanette Thomas for one count of Scheme to Defraud. Lisa Michelle Phelts is accused of submitting claims for homemaker and personal care services that she provided to her disabled adult Medicaid recipient brother using Amanda Lanette Thomas' credentials. Lisa Michelle Phelts is related to Amanda Lanette Thomas. Lisa Michelle Phelts was deemed to be ineligible by AHCA to provide these services as she failed a Level 2 background check based on her prior criminal history.

According to the investigation, Phelts billed Medicaid using Thomas' credentials for services that she provided to the Medicaid recipient during the time period of August 3, 2021, through June 30, 2023. Thomas admitted during a non-custodial interview that she was aware that someone else could not bill Medicaid using her credentials. This caused a total loss to Medicaid of $12,251.73.

Phelts faces one count of Medicaid Provider Fraud, a second-degree felony punishable by up to 15 years in prison. Thomas faces one count of Scheme to Defraud, a third-degree felony punishable by up to 5 years in prison. The Attorney General's Medicaid Fraud Control Unit is prosecuting the cases through an agreement with the State Attorney's Office for the Fourth Judicial Circuit.

Deonis McQueen

Attorney General Ashley Moody's Medicaid Fraud Control Unit announced the arrest of Deonis McQueen for Medicaid Provider Fraud. Deonis McQueen is accused of receiving $6,785.46 from the Medicaid Program for services he did not provide.

According to the investigation, Deonis McQueen, Owner of DNE Direct Care Services LLC, submitted multiple claims for services he did not provide to his disabled and/or elderly clients between December 2019 and July 2020. Records uncovered during the investigation showed that at the times Mr. McQueen claimed to be assisting his clients out in the community, he was in fact still at home and remotely working for a local business.

Mr. McQueen pled nolo contendre to one count of Grand Theft 3rd Degre and was sentenced to twelve months probation and must pay restitution of $6,785.46 plus court costs. The Attorney General's Medicaid Fraud Control Unit prosecuted the case through an agreement with the State Attorney's Office for the First Judicial Circuit.

Kristin Marie Stiggleman

Attorney General Ashley Moody's Medicaid Fraud Control Unit announced the arrest of a speech-language pathologist for defrauding Florida Medicaid. Kristin Marie Stiggleman, a therapy provider in Hillsborough County, inflated hours by billing for services not provided and misappropriating more than $5,000 from the taxpayer-funded program. The Hillsborough County Sheriff's Office assisted in arresting Stiggleman who is charged with Medicaid provider fraud and grand theft.

Stiggleman worked as a licensed speech-language pathologist, tasked with the assessment and treatment of children with speech, language, voice and fluency disorders. An investigation by Attorney General Moody's MFCU revealed that between March 2020 and September 2021, Stiggleman inflated hours by billing for services not provided on numerous occasions. Stiggleman billed for services even when personally canceling sessions, when children discontinued services, or when children were unavailable for services due to hospitalization—stealing more than $5,700 of public funds in the process.

Stiggleman faces one count of Medicaid-provider fraud and one count of grand theft, both third-degree felonies. Attorney General Moody's MFCU is prosecuting the case, through the Attorney General's Office of Statewide Prosecution.

James Dixon, Jr.

Attorney General Ashley Moody's Medicaid Fraud Control Unit, with the assistance of the Columbia County Sheriff's Office, announced the arrest of the adult son of a disabled, elderly wheelchair bound veteran for one count of grand theft. James Dixon Jr., who has power of attorney over his father ("victim"), is accused of making multiple withdrawals from the victim's bank account without his permission. These funds were used to purchase an F-150 truck and for numerous purchases at businesses in the surrounding area.

According to the investigation, James Dixon Jr. removed the victim from Riverwood Health and Rehab Center, the Medicaid facility where he resided, and he demanded the victim's debit card, threatening the victim with violence if he did not comply. The victim had not given any money to James Dixon Jr., nor had he given him permission to withdraw funds from his bank account. On June 7, 2023, James Dixon Jr. purchased a 2005 Ford F-150 from a car dealership in Starke, Florida. The sales contract listed James Dixon Jr. as the only purchaser/buyer and showed a total purchase price of $14,520.18. An analysis of the victim's bank account statements showed that two withdrawals on June 7, 2023, matched the total paid for the truck, which corroborated the initial complaint through Department of Children and Families ("DCF") that funds were taken from the victim's bank account without his knowledge or permission. The victim was the only person listed on the account on the date of the truck purchase. Two days after the truck purchase, James Dixon Jr. was added as a joint account holder on the victim's bank account. Bank record transactions revealed that James Dixon Jr. made numerous withdrawals from the victim's bank account, totaling thousands of dollars. Transactions occurred between June and July 2023 and included ATM withdrawals, bank drafts and Cash App. These funds were used to make purchases in Starke and Lake City, Florida. The MFCU auditor performed a financial analysis of the victim's bank account and James Dixon Jr.'s Cash App account, which revealed that there was a total of $52,397.38 withdrawn from the victim's bank account by James Dixon Jr. between June 6, 2023, and July 31, 2023.

James Dixon Jr. faces one count of grand theft, victim 65 years of age or older, $50,000 or more, a first-degree felony punishable by up to 30 years in prison. The Attorney General's Medicaid Fraud Control Unit is prosecuting the case through the State Attorney's Office for the Eighth Judicial Circuit.

Ira Roberts

Attorney General Ashley Moody's Medicaid Fraud Control Unit announced the arrest of Ira Roberts for financially exploiting an elderly Escambia resident. According to the MFCU investigation, Roberts systematically took more than $17,000 from the senior's bank account over an 18-month period, spending the funds on personal bills and purchases from DoorDash, Netflix, Amazon among other stores.

According to the investigation, Roberts, while in a position of trust with the 82-year-old victim, transferred more than $44,000 from the victim's account into his own account between June 2021 and December 2022. Based on witness accounts, facility records and bank records, Roberts spent more than $17,000 of those transferred funds on personal expenses—not for the use or benefit of the victim.

Roberts faces one count of exploitation of an elderly person or disabled adult, less than $50,000—a second-degree felony.

Attorney General Moody's MFCU is prosecuting the case through an agreement with the State Attorney's Office for the First Judicial Circuit.

Cheri Lynn Meyer

Attorney General Ashley Moody's Medicaid Fraud Control Unit announced the arrest of a power of attorney for financially exploiting an elderly Okaloosa resident. Cheri Lynn Meyer is accused of taking more than $43,600 from the victim despite being responsible for the resident's finances to be used for health care.

According to the investigation, Meyer, while in a position of trust with a 79-year-old victim suffering from aging infirmities, systematically withdrew funds directly from the victim's account in the form of ATM transactions and checks between October 2021 to September 2022. Witness accounts, facility records and bank records show the funds deposited into Meyer's account did not benefit the victim while residing at a care facility.

Over the course of being the victim's power of attorney, Meyer submitted only one $500 payment that successfully cleared the victim's bank. Meyer gave numerous reasons for not paying for the victim's medical services and proved to be uncooperative when pressed to make the payments and how to properly manage the victim's financials.

Meyer faces one count of exploitation of an elderly person or disabled adult less than $50,000, a second-degree felony. Attorney General Moody's MFCU is prosecuting the case through an agreement with the State Attorney's Office for the First Judicial Circuit.

Cristian Cabanes Rodriguez

MFCU announced the arrest of a Miami-Dade County health care worker for committing battery on a Medicaid recipient. According to the investigation, Cristian Cabanes Rodriguez forcibly kissed and struck a 92-year-old resident of an assisted living facility.

According to the MFCU investigation, Miami-Dade Police Department alerted investigators to the abuse. Video recordings obtained through the investigation show Rodriguez abusing the victim, a 92-year-old senior, several times. In one recording, the defendant kissed the victim multiple times on the mouth. Rodriguez is also heard threatening to backhand the victim on the face. The defendant is also seen smashing the victim's nose, first with the defendants' left hand five times, then two times with the right hand.

Rodriguez is charged with three counts of battery on a person 65 years or older, all third-degree felonies. He was arrested in Portland, Oregon.

Juvena Tanis

Attorney General Ashley Moody's Medicaid Fraud Control Unit and the Miami-Dade Police Department arrested Juvena Tanis, former employee of MAC Town, for the abuse of a disabled adult.

The victim was a resident of a residential facility that provides habilitation services and other care and treatment to adults diagnosed with developmental and intellectual disabilities. According to the investigation, multiple individuals witnessed Tanis strike the victim several times. Tanis has since been terminated from her employment at the residential facility.

Tanis is charged with one count of Abuse of a Disabled Adult, a third-degree felony. If convicted, Tanis faces up to 5 years in prison and $5,000 in fines. This case is being prosecuted by the Office of the Miami-Dade State Attorney.

Jean Sheldon

Attorney General Ashley Moody announced the arrest of Citrus County resident Jean Sheldon, 57, for Abuse of an Elderly Adult.

In June 2023, Sheldon was employed as a Resident Service Aide at an Assisted Living Facility in Homosassa, Florida, charged with the responsibility of assisting vulnerable adults with the activities of daily life. While working with an elderly resident, Sheldon was witnessed striking one such disabled adult across the face.

The MFCU opened an investigation, and Sheldon was arrested and has been charged with one count of Abuse of an Elderly or Disabled Adult, a third-degree felony, and one count of Battery on a Person 65 or Older, also a third-degree felony. Sheldon pled nolo contendre to one count of Felony Battery – Great Bodily Harm and was sentenced to 24 months of probation and must pay court costs. Sheldon's case was prosecuted by the Office of the State Attorney for the Fifth Judicial Circuit of Florida.

Michael Calderon and Nieves Lopez

Two Orange County residents were arrested for neglecting a vulnerable adult after barricading him in his room. Michael Calderon and Nieves Lopez were arrested on charges of Neglect of a Vulnerable Adult and False Imprisonment.

Attorney General Ashley Moody's Medicaid Fraud Control Unit investigated allegations that two Devereux Advanced Behavioral Health employees left a vulnerable adult unsupervised for nearly four hours. On April 8, 2023, Calderon's and Lopez's supervisor found that Calderon had wedged a chair against the vulnerable adult's door, preventing it from opening, and then left the group home for nearly four hours.

The investigation revealed that Calderon was assigned to care for the vulnerable adult, who requires constant direct supervision to prevent self-injurious behaviors. Lopez, who was assigned to other clients that day, was found to be falsifying supervision logs for the vulnerable adult even though she never actually checked on his well-being. Lopez admitted to investigators that she had allowed Calderon to leave the vulnerable adult locked in his room on other occasions while Calderon left the facility. The vulnerable adult involved has a history of hospitalization because of his self-injuring behavior.

Calderon and Lopez both face one charge of Neglect of Vulnerable Adult and Calderon faces an additional charge of false imprisonment. Both charges are third degree felonies punishable by up to 5 years in prison and up to a $5,000 fine. The case will be prosecuted by the Ninth Judicial Circuit's State Attorney's Office.

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 2023-24, 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 $4,676,899. The total amount for criminal recoveries based upon Medicaid fraud cases was $46,752,445. The total amount of the monies recovered by the MFCU for FY 2023-24 was $51,429,344.

Training

MFCU continues to emphasize mission critical training to stay professionally current.
During FY 2023-24, MFCU staff attended a total of 4,658 hours of training.

The OAG 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.

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.

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, 2024, the MFCU has submitted 102 data mining projects to AHCA for review and approval. Of the 102 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.

As part of the June 27, 2024, Medicare Fraud Strike Force Takedown, the MFCU along with its state and federal partners indicted and arrested the following individuals:

In *U.S. v. Marco Antonio Ramos Izquierdo, et al.*, Case No. 24-20238-CR-Becerra, Marco Antonio Ramos Izquierdo, 42, of Cuba, Marelys Ruiz Ulloa, 45, of Miami, Fla., Jakeline Canova Cebrian, 58, of Miami, Fla., Roberto Cisneros Cebrian, 53, of Miami, Fla., Jose Antonio Rio Roche, 53, of Miami, Fla., Reiniel Claro Estrada, 42, of Phoenix, Ariz., Maria De Los Angeles Abreu Perez, 37, of Houston, Tex., Nelson Enrique Gonzalez Diaz, 38, of Doral, Fla., Jonathan Jose Martinez Lambrano, 41, of Houston, Tex., Ana Maria Gomez Contreras, 42, of Houston, Tex., Levy Alberto Colina Garcia, 37, of Doral, Fla., and Gloria Guillibeth Diaz Salas, 34, of Doral, Fla., were charged by indictment with conspiracy to commit money laundering and money laundering for their role in distributing the proceeds of fourteen durable medical equipment (DME) companies. According to the indictment, Medicare and Medicaid paid these fourteen companies approximately $17,600,000 as a result of false and fraudulent claims for DME. The indictment details how the DME companies transferred approximately $3,906,649 of the fraud proceeds to shell companies, including those owned by Ramos Izquierdo, Ruiz Ulloa, Canova Cebrian, Cisneros Cebrian, Rio Roche, and Claro Estrada. Those defendants then made cash withdrawals from their shell companies and also wrote checks from the shell companies that received these fraud proceeds to individual check cashers, including individual checks between $4,000 and $9,000 totaling a combined approximate amount of $2,513,381 made out to Abreu Perez, Gonzalez Diaz, Martinez Lambrano, Gomez Contreras, Colina Garcia, and Diaz Salas. HHS-OIG, FBI Miami, USMS and MFCU investigated the case. Assistant U.S. Attorney Will J. Rosenzweig of the U.S. Attorney's Office for the Southern District of Florida is prosecuting the case. Assistant U.S. Attorney Marx Calderon of the U.S. Attorney's Office for the Southern District of Florida is handling asset forfeiture.

In *U.S. v. Santiago Garcia Jorge*, Case No. 24-20237-CR-Altman, Santiago Garcia Jorge, 49, of Land O' Lakes, Fla., was charged by indictment with conspiracy to commit money laundering and money laundering for his role in distributing the proceeds of a fraudulent DME company. The indictment alleges that in connection with his role as the president and registered agent of Gold Medical Supply Inc., a company that submitted false and fraudulent claims to Medicare and Medicaid in the approximate amount of $7,498,260 and was paid approximately $1,402,478 by Medicare and Medicaid, Garcia Jorge transferred approximately $1,384,875 of the fraud proceeds to shell companies located in the Southern District of Florida. Garcia Jorge did so by writing approximately $174,990 in checks directly to those shell companies, but also by transferring approximately $1,209,855 to three other Gold Medical bank accounts that he controlled before then transferring them to the same shell companies. HHS-OIG, FBI Miami and MFCU investigated the case. Assistant U.S. Attorney Will J. Rosenzweig of the U.S. Attorney's Office for the Southern District of Florida is prosecuting the case. Assistant U.S. Attorney Marx Calderon of the U.S. Attorney's Office for the Southern District of Florida is handling asset forfeiture.

In *U.S. v. Omar Cabrera Hernandez*, Case No. 24-20245-CR-Damian, Omar Cabrera Hernandez, 55, of Miami, Fla., was charged by information with conspiracy to offer and pay health care kickbacks to patients. Hernandez, as the administrator of the clinic Advanced Community Wellness Center, Inc. in Hialeah, Fla., participated in a conspiracy to pay patients illegal kickbacks to attend psychosocial rehabilitation services at the clinic which were then billed to Medicaid. This conduct resulted in an improper benefit of at least $400,597 and submission of claims to Medicaid totaling over approximately $3.5 million. HHS-OIG Miami, FBI Miami and MFCU investigated the case. Assistant U.S. Attorney Timothy Abraham of the U.S. Attorney's Office for the Southern District of Florida is prosecuting it. Assistant U.S. Attorney Emily Stone of the U.S. Attorney's Office for the Southern District of Florida is handling asset forfeiture.

In *U.S. v. Yordany Rivera Bermudez*, Case No. 24-20256-CR-Damian, Yordany Rivera Bermudez, 35, of Ft. Myers, Fla., was charged by indictment with health care fraud in connection with a scheme to defraud Medicare and Medicaid of nearly $3 million for DME that was never supplied to Medicare beneficiaries and Medicaid recipients. As alleged in the indictment, Rivera Bermudez was the president and operator of Acqualina Health Medical Solutions Inc. (Acqualina), a company located in North Miami, Fla., that purported to provide DME to eligible Medicare and Medicaid recipients. In a ten-month period, Acqualina submitted approximately $2.9 million in allegedly fraudulent health care claims to Medicare and Medicaid for DME that Acqualina never provided, and that Medicare and Medicaid recipients never requested or needed. As a result, Medicare and Medicaid paid approximately $1.2 million to Acqualina. HHS-OIG, FBI Miami and MFCU investigated the case. Special Assistant U.S. Attorney Marc Canzio of the U.S. Attorney's Office for the Southern District of Florida is prosecuting the case. Assistant U.S. Attorney Mitchell Hyman of the U.S. Attorney's Office for the Southern District of Florida is handling asset forfeiture.

In *U.S. v. Jorge Luis Pajon Rodriguez*, Case No. 24-20260-CR-Williams, Jorge Luis Pajon Rodriguez, 58, of Miami, Fla., was charged by information with conspiracy to offer and pay health care kickbacks to patients in connection with a scheme to defraud Medicaid. As alleged in the information, Pajon Rodriguez, as the owner of the Miami clinic Gables Community Wellness Center, Inc., participated in a conspiracy to pay patients illegal kickbacks to attend psychosocial rehabilitation services at the clinic which were then billed to Medicaid. This conduct resulted in an improper benefit of at least $1,338,184 and approximately $6 million in claims to Medicaid. HHS-OIG Miami, FBI Miami and MFCU investigated the case. Assistant U.S. Attorney Timothy Abraham of the U.S. Attorney's Office for the Southern District of Florida is prosecuting it. Assistant U.S. Attorney Emily Stone of the U.S. Attorney's Office for the Southern District of Florida is handling asset forfeiture.

In *U.S. v. Wesley Jackson*, Case No. 24-cr-20269-Smith, Wesley Jackson, 28, of Long Island City, N.Y., was charged by information with health care fraud in connection with an alleged scheme to fraudulently bill Medicare for over $2.1 million for medically unnecessary orthotic braces, using sham contracts and invoices to disguise the payments. According to the information, Jackson, the owner of a marketing company called Jackson Media LLC, sold doctors' orders for medically unnecessary orthotic braces to DME suppliers in exchange for kickbacks and bribes. HHS-OIG and MFCU investigated the case. The case is being prosecuted by Trial Attorney Jacqueline DerOvanesian of the Florida Strike Force. Assistant U.S. Attorney Jorge Delgado of the U.S. Attorney's Office for the Southern District of Florida is assisting with asset forfeiture.

In addition to the Medicare Fraud Strikeforce National Takedown, the MFCU, along with its federal partners investigated and arrested the following individual:

In *U.S. v. Omar N Del Rio*, according to the Indictment, Defendant Omar Naranjo Del Rio was the sole officer and registered agent of Triple State, Naranjo Energy, Naranjo 5 Start, Del Rio Windows, and Efficient Transport, and a resident of Miami-Dade County, Florida. From on or about July 17, 2023, and continuing through on or about November 16, 2023, in Miami-Dade and Broward Counties, in the Southern District of Florida, the defendant, Omar Naranjo Del Rio, in connection with the delivery of and payment for health care benefits, items, and services, did knowingly and willfully execute, and attempt to execute, a scheme and artifice to defraud a health care benefit program affecting commerce, as defined by Title 18, United States Code, Section 24(b), that is, Medicare and Medicaid, and to obtain, by means of materially false and fraudulent pretenses, representations, and promises, money and property owned by, and under the custody and control of, said health care benefit program. The Indictment further alleges, it was a purpose of the scheme and artifice for the defendant to unlawfully enrich himself by, among other things: (a) submitting and causing the submission of false and fraudulent claims to health care benefit programs; (b) concealing the submission of false and fraudulent claims to health care benefit programs; (c) concealing the receipt of the fraud proceeds; (d) diverting the fraud proceeds to shell companies to distribute and conceal proceeds of the fraud scheme; and (e) diverting the fraud proceeds for their personal use and benefit, the use and benefit of others, and to further the fraud scheme. The Indictment charges Defendant Naranjo Del Rio with seven counts of Healthcare Fraud and one count of Money Laundering.

The MFCU, through its SAUSA, was able to secure successful outcomes on outstanding prosecutions like the one listed below:

On May 22, a Miami federal district judge sentenced a fugitive to 87 months in prison followed by three years of supervised release for his role in a multimillion-dollar conspiracy to commit money laundering. The judge also ordered him to pay $3,709,860 in restitution.

From August 2020 to August 2022, Julio Arsenio Rodriguez, 62, Hialeah, Florida, conspired with a network of South Florida clinics to submit millions of dollars in fraudulent claims to Medicare and Medicaid for durable medical equipment (DME) that was medically unnecessary and that was not provided to the patients. Also, Rodriguez served as the legal owner and registered agent of several fictitious companies which he used to launder those health care fraud proceeds.

In March 2023, Rodriguez failed to appear at a calendar call and a federal judge issued a warrant for his arrest. Eight months later, Rodriguez was located in the Dominican Republic, attempting to open businesses in that country. In November 2023, Rodriguez surrendered to the United States authorities and returned to Miami to face charges for the money laundering conspiracy. Rodriguez pleaded guilty to conspiracy to commit money laundering in January.

U.S. Attorney Markenzy Lapointe for the Southern District of Florida; Special Agent in Charge Jeffrey B. Veltri of the FBI, Miami Field Office; Special Agent in Charge Stephen Mahmood of the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG), Miami Region; and Florida Attorney General Ashley Moody for the Florida Office of the Attorney General made the announcement.

FBI Miami, HHS-OIG Miami, and the Florida Office of the Attorney General Medicaid Fraud Control Unit (MFCU) investigated the case. The U.S. Marshals Service Office of International Operations (OIO) Dominican Republic Foreign Field Office (DRFFO) and the Drug Enforcement Administration (DEA) Caribbean Division Financial Investigative Team provided valuable assistance in securing the arrest and deportation of Rodriguez back to the United States. Special Assistant U.S. Attorney Marc Canzio prosecuted the case. Assistant U.S. Attorney Marx Calderon handled asset forfeiture.

AGENCY FOR HEALTH CARE ADMINISTRATION

The Agency for Health Care Administration (Agency) is required, pursuant to section 409.913, 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.

Division of Health Care Policy and Oversight

Division Overview

The Division of Health Care Policy and Oversight (HCPO) 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:

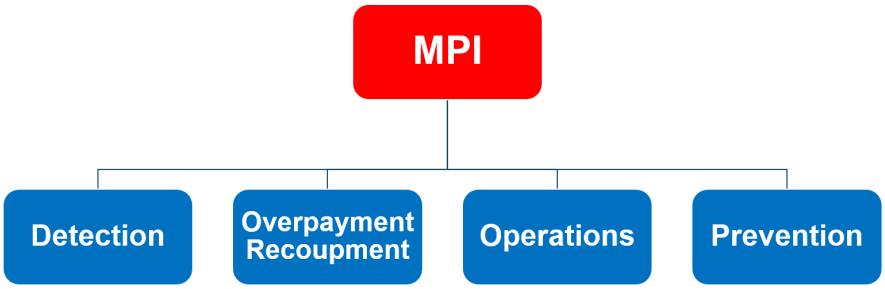
- The Bureau of Central Services includes the Care Provider Background Screening Clearinghouse.
- The Bureau of Field Operations who is responsible for state licensure and federal certification surveys (inspections).
- The Bureau of Health Facility Regulation which licenses, registers, regulates, and provides exemptions for certain providers, including assisted living facilities, hospitals, laboratories, home health care, and nursing home providers.
- The Bureau of Medicaid Program Integrity who serves 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 annual report is focused on the Agency's Medicaid program oversight activities within MPI and the Division of Medicaid.

Medicaid Program Integrity

Overview

MPI's functional organizational structure is depicted below and briefly summarized in the sections which follow.



Detection Activities

This annual report has previously described how fraud and abuse detection involves varied methodologies and techniques that identify program vulnerabilities, threats, and risks to the Medicaid program. MPI detection activities fall within three sub-units. One unit is involved in the intake and assessment of complaints from a variety of sources, and they conduct the preliminary review of those complaints. A second unit is responsible for data support for MPI as well as the internal development of leads through data analysis. A third unit is

involved in the program integrity-related activities of the Medicaid Managed Care Plans (MCP); although there are prevention and enforcement components to these efforts, ensuring the plans are actively and diligently working to detect fraud and abuse is a primary focus.

MPI focuses on three main philosophies related to detection efforts (1) the need to use technology but not to the exclusion of reliance on personnel and human experience, (2) aiming toward efforts that detect fraud (as opposed to abuse or waste), and (3) detection efforts must utilize data sources beyond claims data.

Focusing on healthcare fraud and abuse detection methodologies that utilize both technology and human resources, whether it is personnel used to review technology driven leads and adjust analytic tools or personnel with considerable experience relied upon to drive the development of new leads, the human resources continue to be invaluable to MPI. Furthermore, MPI personnel (human resources) are a key factor in the review of incoming fraud and abuse complaints from the Agency's online complaint form. Without human intervention, these complaints would be difficult to effectively process. The immense array of topics, schemes, and provider types, make the task of a technology automation of complaint intake both costly and resource intensive.

Focusing efforts on fraud detection, as opposed to abuse or waste detection, leads to a greater likelihood that an instance of a false positive (a lead that would not result in a referral to law enforcement) will have a successful MPI outcome from an audit or other administrative activity. Furthermore, the concept (of aiming for fraud detection) is intended to ensure that scarce program integrity resources are directed at the individuals and entities that create the most significant hindrances for the Medicaid program and create the most significant risk for program abuse.

Data detection at MPI utilizes both claims-based and non-claims-based indicators of fraud and abuse risks. The MPI Detection team has urged inclusion of this concept as a part of the Agency's enterprise system, Florida Health Care Connections (FX), which will include several tools and resources for MPI. MPI detection and investigative activities will likely always utilize claims data in some fashion. However, licensure information, enrollment prerequisites, ownership information, geographical information and other publicly available information about providers, their owners and other affiliated individuals, and non-providers, as well non-claims-based information gathered through collaboration with other state partners, law enforcement partners, and others are used by MPI to enhance the detection efforts. The non-claims-based information is often a critical element in ensuring that the highest risk (for fraud or abuse) providers are prioritized for review.

At any given time, around 75-85% of the Medicaid population is enrolled in a managed care plan. The MPI Managed Care team works to both oversee the MCP program integrity efforts and collaborate with them regarding detection and prevention of fraud and abuse in the Medicaid program. The main goals of the team each year are to (1) ensure that the MCPs submit a high volume of high quality reports of suspected/detected provider fraud and abuse, (2) refer providers to the MCPs based upon information MPI has available across all plans and that the MCPs would not otherwise have the ability to detect (as they can see their data and no other plan's), and (3) monitoring (reviews) of the MCPs' contract and other regulatory compliance related to program integrity efforts.

Overpayment Recoupment Activities

Through audits, MPI identifies overpayments that need to be recovered and determines whether a provider has adhered to Medicaid policy and Florida Statutes regarding documentation or service delivery. MPI audits managed care encounter claims as well as fee-for-service (FFS) claims. Audit activities at MPI involve collaboration with Medicaid Services, the Office of the General Counsel, Agency for Persons with Disabilities (Home and Community Based Waiver Services), Florida Certification Board (Mental Health Services), and the Behavior Analyst Certification Board (Behavior Analysis Services). Each Overpayment Recoupment unit meets with these entities on a regular basis to discuss issues MPI encounters in our audits. Through these collaborations, MPI is able to maintain open lines of communication with these organizations in order to assist with policymaking, process improvements, ensure services rendered to Florida Medicaid recipients are provided, and combat the potential for fraud, waste, and abuse in the Medicaid program.

Overpayment recoupment activities are predominately carried out through three teams in MPI and organized according to the audited provider types. Other MPI units may have potential overpayments that a provider agrees to return or may be more involved in voluntary disclosures and repayments of overpayments (typically

referred to as self-audits). However, the three Overpayment Recoupment units (ORUs), with the assistance of the Special Projects section within ORU, handle both MPI conducted audits as well as management and oversight of contractor assisted audits.

The Practitioner Care team audits most non-institutional providers including physicians, waiver providers, and behavioral health providers. The focus during this year has been the development of additional clinical peers to increase the audit capabilities, particularly in behavioral analysis services. The practitioner care team focused on the maintenance of the Claims Sample Program (CSP) and the development of the next iteration of the CSP through FX, which allows for the unit to choose a random sample of recipients for an audit period and extend the overpayment to the universe. The CSP is an essential tool for conducting comprehensive audits for the team. Although any of the units can utilize the sampling program, the Practitioner Care team is the unit that typically relies upon it.

The Pharmacy and Durable Medical Equipment (DME) team consists of Florida licensed pharmacists and a pharmacy technician who audit Medicaid providers of prescribed drug services and durable medical equipment and supplies. Audits of prescribed drug service providers are impacted by the provisions of section 465.188, F.S. which impacts MPI's audit methodologies for pharmacies. This statutory section limits the review (audit) period, requires audits be conducted only by a Florida licensed pharmacist, and does not allow overpayment determinations to be based upon statistical sampling and extrapolation. The limitations included in this provision greatly hinders MPI's ability to identify overpayments effectively and efficiently for the entire universe of provider claims, impedes detection of areas of abuse and waste, and stifles the unit's recovery capabilities. However, the group employs several auditing techniques, including, but not limited to, the review of top billed drugs or procedure codes, analysis of billing patterns, and data mining of outlier payments of claims.

The Institutional team audits several provider types, including hospitals, nursing homes, assisted living facilities and hospice providers. These audits are typically performed as a part of large-scale audit projects. The team also works very closely with several contractors who assist MPI with audits. The efforts with these contractors ensure that the audits are based upon accurate application of policies and laws, and that they utilize methodologies that are consistent with MPI processes.

The ORU Special Projects team processes Final Orders for MPI, receives and processes checks that come to MPI (typically for repayment of overpayments), opens self-audit cases upon receipt of voluntary disclosure of overpayments, and works with our Third-Party Liability (TPL), Health Management Services (HMS), on recoupment projects.

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 MPI'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 the office management.

The new Electronic-Personnel Action Request (ePAR) system was rolled out by Human Resources (HR) on March 1, 2024. The new system allows for 15 different types of actions to be sent through the system, which includes new hires, transfers, promotions, separations, etc. Most of the information on the ePAR form is populated from PeopleFirst data. The Operations unit has worked diligently to adjust internal procedures to accommodate the new changes.

Due to an internal audit, HR requested all position descriptions be updated to ensure the correct Equal Employment Opportunity, Collective Bargaining Unit, Security Role, and the proper wording be used in the Knowledge Skills & Abilities and other job-related requirement sections. HR had also requested the advertisements be updated to make sure they matched the language in the position descriptions. This year, the Operations unit reviewed and updated all 79 MPI position descriptions and any open advertisements.

The Operations Unit is responsible for coordinating efforts with all auditors as well as 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 performs a function which 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 subsections 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.

Prevention Activities

MPI continues to emphasize fraud and abuse prevention efforts. There are five main functions related to program integrity activities in Florida Medicaid within the Prevention unit, including field operations, administrative sanctions, law enforcement collaboration, payment restrictions, programmatic assessments, and program 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, fully 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 deemed 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 nonpayment of obligations to the Agency.

Law enforcement activities include collaboration with state and federal partners. This includes not only serving as a liaison to the Medicaid Fraud Control Unit (MFCU), but also Health and Human Services-Office of Inspector General (HHS-OIG), the Federal Bureau of Investigation (FBI), Department of Financial Services (DFS), and any other government agency involved in fraud-fighting. MPI continues to partner with the MCPs 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 MCPs (even those that are “prevention” in nature) are described under the detection activities section of this annual 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 section 409.913(3), F.S.
- Payment withholds (referred to as a “25A withhold”) consistent with section 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 (based on a credible allegation of fraud, 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’ annual reports, many of the activities MPI and other organizational units in the Agency engage in have a value, typically a fraud and abuse prevention value, that is not readily known or easily calculated. This may include MPI referrals to other agencies as well as the policy and system edit recommendations to the Division of Medicaid. MPI continues to work toward additional prevention value calculations that can fairly and reasonably demonstrate the efforts. During this past year a methodology to identify the prevention value for the referrals from MPI to the MCPs to increase their fraud-fighting efforts was developed.

Recommendations for policy/handbook revisions and system edits, are typically coordinated through the Bureau's Prevention units and all MPI continues to work closely with Medicaid to collaborate 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 this year's recommendations are in the *Highlights of MPI Activities* section of this annual report.

MPI investigative efforts are focusing more on topics such as:

- Patient brokering or misuse of recipient information, the use of straw (false) owners, creation of companies solely to abuse or engaged in fraud in Medicaid and other payer systems, and other financial crimes.
- On-site visits and interviews with providers, provider employees, and recipients.
- Compliance and program integrity-related oversight of MCPs, including recommendations for liquidated damages or sanctions (against the MCPs).
- Litigation support for overpayment audits, sanctions, and criminal prosecutions as well as MCP 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 MCPs make to MFCU.

Highlights of MPI Activities for FY 2023-2024

MPI's efforts to curtail fraud and abuse continue to predominately focus on a broad array of schemes which include coverage and limitation (policy) provision violations, billing for non-covered services as covered services (e.g., billing for therapy when some form of daycare is furnished without any therapy), billing for services not rendered (an absence of service delivery), and billing for services during periods of time where the provider (billing provider or rendering provider) is not eligible for participation. MPI is also seeing an increase in instances of non-Medicaid providers (individuals) involved in assisting providers in the submission of large volumes of inappropriate claims. Detection efforts continue to identify potentially complex financial crimes which typically lead to law enforcement referrals. Examples of the broad array of activities MPI engages in to identify and mitigate program losses due to fraud and abuse are highlighted below:

Combatting Fraud and Abuse within Behavioral Health

Behavioral health services can be a very broad topic and regarding program integrity interventions it is important to be clear about which service (or topic) is being referenced. The list below is not intended to be exhaustive, but rather exemplifies the extent of the topic of behavioral health services.

- Substance Abuse/Medication Assisted Treatment Services
- Community Behavioral Health Services (Substance Abuse/Mental Health)
- Targeted (Mental Health/Child Health/Other) Case Management Services
- On-Site/Overlay Therapeutic Services
- Outpatient Mental Health/Therapy Services
- Inpatient Behavioral Health/Substance Abuse Services
- Residential Behavioral Health/Substance Abuse Services
- Psychiatric/Medication Management Services
- Early Intervention Services
- Medical Foster Care Services
- State Mental Health Services
- Therapeutic Group Care Services
- Behavior Analysis

While is it not unheard of for MPI to have interactions with providers regarding any of these services, substance abuse, community behavioral health, targeted case management, and therapy services are typically identified in the cases that MPI has been working over the past several years. These are all critical services for the population of recipients served through the Medicaid program. However, there has been an increasing awareness of the incidence of fraud (and abuse and waste) regarding these service areas and provider types. For the purposes

of this annual report, Community Mental Health Clinics and Behavior Analysis providers are discussed in more detail.

Community Mental Health Clinics

Since Fall 2019, MPI has been evaluating what is believed to be pervasive abuse, if not fraud, in the community behavioral health services provider community. It is believed that individuals with little to no business knowledge and little to no mental health services-related experience are recruited or otherwise lured into opening these "clinics" for the sole purpose of seeking reimbursement from the Medicaid program for medically unnecessary and often non-compensable services.

MPI understands that typically a qualified community behavioral health services provider would offer a broad array of medical, clinical, and therapeutic mental health services to people of all ages in need of mental health services within their communities. MPI has observed a high incidence of the provider's enrolled as these community mental health clinics (CMHCs) instead nearly exclusively billing for a single procedure code or limited codes that are necessary to support billing for the exclusive code.

Furthermore, MPI investigations have revealed instances of a higher-than-expected incidence of recipients who are suspected of not meeting the eligibility requirements for the services; particularly related to psychosocial rehabilitation (PSR) services. According to Florida Medicaid policy and subject matter experts, PSR services are one of several community behavioral health treatment modalities geared toward individuals who suffer from significant, functional impairment because of serious, chronic mental illness. Medicaid policies state that the purpose of psychosocial rehabilitation services is to teach life management skills to assist people to reach maximum independence in academic, vocational, and independent living skills, and should be combined with multiple wrap-around services.

Florida Medicaid's definition of medically necessary services requires that services be consistent with generally accepted medical standards, individualized, specific and consistent with symptoms, and reflect a level of service that can be safely furnished. Therefore, to be consistent with policy guidelines, the typical clinical presentation of a recipient in need of PSR services should reflect the presence of a chronic, severe mental illness resulting in significant functional impairment in several life domains, and the provider's claims data and documentation should reflect wrap-around services that are both individualized and medically necessary.

Numerous investigations regarding provider claims data and recipient diagnostic history gleaned from recipient claims data suggest that providers are billing PSR for ineligible recipients. Medical record reviews by clinical peers are underway. However, the volume of cases is increasing and other interventions beyond that of a traditional overpayment recovery audit have been employed by MPI. Due to the volume of potential cases, MPI has prioritized investigations of the most suspect providers. For example, often, a limited number (sometimes only one) rendering provider is listed for all services for a provider. If that single rendering provider is linked to multiple billing providers, which are also listing the rendering provider on many claims, it calls into question the probability that the individual reasonably could perform or personally supervise the extreme volume of services.

While each case and record review is unique, it is common (and in almost every case) for MPI to identify issues such as documentation does not support that the patient suffers from serious and persistent mental illness or significant functional impairment due to their mental illness; assessments lack policy required components, are not consistent with generally accepted medical standards for psychosocial assessments, are lacking in depth and detail, and are clinically insufficient to support the diagnoses given; documentation fails to support that services were medically necessary; service notes describe non-compensable service activities (e.g., adult day care type services) that are not consistent with service description requirements for the billed services per Medicaid policy; and service intensity is contraindicated and potentially harmful to recipients.

During the year, MPI personnel interacted in some capacity (provider onsite visit, MPI audit, contractor assisted audit, provider self-audit, payment restriction, administrative sanction, and/or other referrals) with more than 400 CMHC providers or the related (therapists, etc.) service providers, consultants, and other affiliated individuals. The efforts to address the preserved pervasive fraud in this service area remains ongoing.

Behavior Analysis

In the previous five or more annual fraud reports, MPI has described the alarming incidence of and extensive efforts toward combatting fraud and abuse within the Behavioral Analysis (BA) services provider community. MPI recognized the need for the availability of services provided to vulnerable recipients. However, the high risk for fraud necessitates that it is an area for consideration of future reviews and audits. Planning efforts must evaluate the clinical aspects of the service delivery and look at the potential for erroneous billing, even to the point of potential harm to recipients. BA services are highly structured interventions, strategies, and approaches provided to decrease maladaptive behaviors and increase or reinforce appropriate behaviors.

The Florida Medicaid BA program came about following a federal court order which mandated the Agency to reimburse providers for the delivery of BA services for children in Medicaid. After the BA program rules were created in March 2017, the program immediately faced challenges with false enrollment applications and fraudulent/abusive claims submission in a volume which the program would not be able to readily detect and address. Although the Agency had adopted rules that were designed to strengthen provider qualifications, the volume of applications received made it unreasonable to expect pre-enrollment validation; thus, the statewide review by MPI and the many terminations subsequent to enrollment which came about in the years to follow. Likewise, despite several attempted safeguards aimed at ensuring all services were delivered properly, significant post-payment reviews would become necessary.

MPI began developing several projects related to BA. One project was a post-enrollment validation of attestations regarding non-certified behavioral analysis technicians. These technicians would ultimately be required to become certified by the Behavior Analysis Certification Board (BACB) as Registered Behavioral Technicians (RBTs), but for the first approximately twenty-month period of enrollment, individuals who attested to a minimal set of qualifications were allowed to be enrolled. The MPI initiative would result in many of these technicians being terminated and referred to law enforcement; and to the extent that a provider group was believed to have participated in the false application process or have knowingly benefited from it, the groups would also have been addressed.

The Agency had also contracted with a vendor to evaluate recipient's eligibility to receive BA services and to identify and communicate risks to the Agency. Because the Agency was very hands-on with this contract, they were able to identify shortcomings in the vendor's efforts and, at first, initiate corrective measures, then ultimately terminated the contract and hired a new vendor. Internally, the Agency also conducted routine billing and utilization assessments that were joint efforts between MPI and Medicaid. Through these reviews, following initial preliminary data analysis, it became evident that there were significant and pervasive issues of fraud, which resulted in increased and significant collaboration with law enforcement (several of which cases and issues remain ongoing) and ultimately also resulted in Medicaid seeking an enrollment moratorium.

In May 2018, the Agency announced a temporary moratorium on enrollment of new BA providers in Miami-Dade and Broward counties, with the approval of the Centers for Medicare and Medicaid Services (CMS). The moratorium did not affect any Medicaid recipient's ability to access necessary BA services. All existing BA providers continue to be reimbursed for legitimate services while the Agency further investigated fraud and abuse. Prior to the moratorium, MPI identified instances of non-BA services being rendered, services not being rendered at all, services rendered by an unenrolled individual (falsely billed using an enrolled provider's credentials), services rendered by unqualified individuals, and billing for services rendered by group providers who enrolled in the Medicaid program through deceptive methods. During the implementation of the moratorium, MPI continued to conduct reviews of BA providers in Miami-Dade and Broward counties to identify providers who may have entered the Medicaid program through deceptive practices to circumvent the moratorium. MPI recommended terminations of BA group providers circumventing the moratorium who enrolled into the Medicaid program using a service address located in non-moratorium counties (ex. Palm Beach) and primarily rendered services to recipients located in moratorium counties (Miami-Dade/Broward). In May 2022, the Agency issued a final extension of the temporary moratorium on enrollment of new BA group providers and individual providers practicing independent of a group in Miami-Dade and Broward counties for an additional six months through November 13, 2022. At the behest of CMS, the Agency made operational and systematic updates to allow enrollment to begin at the expiration of this moratorium.

By the time of the COVID-19 public health emergency (PHE), MPI had significantly adjusted resources from BA into other areas of high fraud risk services and providers. Notwithstanding, MPI had begun to develop a stronger working relationship with the BACB and was more collaborative about common issues between the BACB and the Agency regarding provider qualifications and fraudulent activities. During the PHE, the BACB had amended its processes to allow RBT candidates to take the certification examination via online testing. Mass online cheating was discovered and MPI has been working closely with the BACB to identify individuals who may have become enrolled in the Florida Medicaid program improperly. Through these efforts numerous RBTs have been terminated over the years and overpayments have been pursued.

Because of the program changes over the years, the review and identification of overpayments requires a more in-depth clinical analysis. This has necessitated the inclusion of peers (either licensed or certified clinicians, with experience in BA). MPI has contracted with one or more peer but has only recently been able to realize results from these audit cases. In the meantime, the BACB collaboration continues to yield results, and further reviews have been ongoing. Some of the reviews include efforts simply to locate the providers (for example rendering providers who have not updated their address) and will likely result in further terminations.

In past years, MPI has reported working closely with the BACB in ongoing efforts to fight fraud and abuse in the enrollment and testing of RBTs and other behavior analysis providers. This past fiscal year, MPI has continued this collaboration and now utilizes monthly reports from the BACB of disciplinary action taken against certificants. This activity has resulted in the for-cause terminations of approximately 25 RBTs who either fraudulently enrolled, tested or committed some ethical violation related to behavior analysis services. Current efforts in this collaboration include the verification of over 10,000 behavior analysis certificants who have not renewed their certification or properly reported their renewal to Medicaid. It is anticipated that this collaboration will result in more than 6,000 terminations of unqualified Medicaid provider enrollees in the upcoming year.

Since the end of the moratorium, Medicaid has seen a substantial increase in the enrollment of BA group and individual providers. Due to this increase in enrollment, MPI has renewed its efforts to detect and prevent fraud and abuse in BA services, a service intended for one of the most vulnerable segments of the Medicaid population. If left unchecked, fraudulent and abusive behavior in BA services can potentially compromise the quality-of-care patients receive. Current MPI reviews of BA providers have identified improper behavior in this high-risk provider type. Below are some of the issues identified:

- Use of Artificial Intelligence (AI) by BA providers to generate false service notes. These notes do not correlate with treatments and interventions.
- BA group providers billing for more units of service than rendered to recipients.
- Falsification of caregiver's signature on documents.
- Falsification of assessments by embellishing the document with false diagnoses and medical conditions that the recipient does not have to obtain Medicaid approval for BA services.
- The noninvolvement of the caregiver in the assessment evaluation process.
- BA group providers at the same service location to facilitate improper billing by sharing mutual recipients.
- BA group practices continue to employ rendering providers with suspect experience and qualifications to deal with Medicaid recipients with autism or with mental health issues. Many of the experience and education indicated on the resumes and applications of these individual treating providers are difficult to verify due to the experience and/or education being outside of the country.
- There have been allegations of BA rendering providers providing false credentials to include the use of suspect credentialing/translating companies (inaccurate and false translations).
- There have been allegations that some BA rendering providers have a master's degree from an accredited U.S. institution of higher learning but do not speak English.
- BA rendering providers affiliated with multiple group providers such as targeted case management, community behavioral health services, and BA group practices leading to the billing of impossible (24 or more hours of service in a single day) and excessive (more than 10 hours of service in a single day) days.
- Suspect BA owners affiliated with other high risk provider types, such as targeted case management agencies (TCMs) and community behavioral health services group practices.
- BA provider groups with common recipients with other BA provider groups or TCMs.
- BA claims overlap with claims submitted by another provider type.

Non-Medicaid Enrolled Consultants

Over the past several years, MPI has become increasingly aware of individuals not enrolled as providers contributing to fraud and abuse within the Medicaid program. These non-providers may participate in a variety of capacities. Numerous ongoing investigations, particularly within behavioral health services, has brought to light how pervasively these consulting firms/consultants have potentially intruded upon the typical owner or provider duties, including providing clinical direction to practitioners. Consultants are furnishing the group providers with personnel and assisting the groups with enrollment of these rendering providers. Through this process, the consultants obtain rendering providers' information to use with group enrollment but also have it available to use across many provider groups, possibly without the rendering provider's knowledge or permission.

In some of the examples MPI has identified, the consultants enter into agreements to pay clinicians thousands of dollars to serve in various capacities in the Medicaid clinics, sometimes to perform little or no work for the business. Then the consultants collect double (or more) that amount from the clinic owners for the service of providing the clinician. All the while, the owners are billing Medicaid for services that are not properly rendered, not properly supervised, and possibly not rendered at all.

As a result of this focus on the consultants and other non-enrolled individuals, MPI has conducted numerous interviews of clinicians and clinic owners. The clinicians identified for interview were not otherwise affiliated with the type of services allegedly rendered by the billing groups or were involved in a significant (and suspect) volume of claims for services. Through the interviews it was discovered that these non-enrolled individuals create the businesses, develop the contracts and other documents for the business to use (for Medicaid documentation and other business purposes), and sometimes provided direction to the clinicians about how to fulfill their clinical duties.

Through these reviews, and with the assistance of several other Agency and non-Agency personnel, MPI has referred at least one of these consultants to law enforcement due to suspected scheme to defraud, conspiracy to commit a criminal offense (Medicaid Fraud), false statements or false representations of a material fact in a Medicaid claim, false or misleading information for the purpose of being accepted as a Medicaid provider, unlawful use of a two-way communication device to facilitate or further the commission of any felony offense, and conducting or attempting to conduct a financial transaction involving the proceeds of unlawful activity.

Overpayment Recoveries and Cost Avoidance

MPI Special Projects Unit (SPU) worked with Health Management Services (HMS), a Third-Party Liability (TPL) vendor, to assist in facilitating the recoveries of overpayments through various audit projects. Through MPI efforts working with HMS, the Agency recovered over $9.8 million with the Episodes of Care project this past year. The Episodes of Care Project was the largest recovery of the more than 30 projects currently in the works between MPI and HMS, with total recoveries amounting to over $23.8 million dollars to the Agency.

Utilizing the Unified Program Integrity Contractor (UPIC) to perform additional audits and investigations maximizes MPI's resources. Through the work of SafeGuard Services (SGS), MPI Institutional Unit was able to accomplish more audits, 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 determined whether Medicaid managed care plan payments made to providers for hospice services were in accordance with State and federal laws, regulations and policies. The state recovered more than $2.5 million by utilizing the resources of SGS, with collaboration and consistent communication with MPI. The Hospice 2.0 project was completed this year and the one day stay project currently has three cases still open.

The Pharmacy Unit recovery efforts included: comprehensive pharmacy audits, including invoice and prescription reviews; comprehensive and focused audits of durable medical equipment and supplies, and focused audits of improper payments of prescription drugs and devices. A review of claims in one such audit identified an overpayment of nearly $225,000.00, where the unit quantity for the procedure code for certain prescription drugs was improperly billed. The total overpayment was recovered by the provider voiding the affected claims. This fiscal year, pharmacy and DME audits identified overpayments totaling approximately $2 million.

The Institutional Unit created an audit project to identify instances where nursing facilities billed for services upon dates where the Payroll Based Journal Reports (PBJ) indicated they were understaffed and did not meet the minimum daily direct-care staffing requirements. The audit identified days upon which facilities were out of compliance due to understaffing and recovered Medicaid funds paid for room and board to the facility upon the specified service dates due to facility noncompliance with State and Federal rules. A pilot project with 17 cases was opened, and all but one of those cases is now closed with recoupment of nearly $180,000.00 for the year. As this was a pilot project, some of the cases had dates of service that were only for a few months. Based on the success of the pilot project, the Institutional Unit opened a 2.0 version that will cover dates of service January through December 2022 with 11 cases and may add more during FY 2024-2025.

MPI recommended adjustments to the pharmacy claims pricing and payment system to ensure claims are being paid in accordance with the reimbursement methodology in Rule 59G-4.251, Prescribed Drugs Reimbursement Methodology. Some pharmacy audit reviews revealed certain drugs were not paid with the correct reimbursement methodology which resulted in overpayments totaling more than $720,000.00. The claims for these drugs did not pay in the amount of the lesser pricing for the National Drug Code. Extensive recommendations were also made regarding the coverage policy for Prescribed Drug Services (pharmacies) and the DME policies for several specialty areas, including provisions which may increase provider compliance and enhance enforcement capabilities for noncompliance. Finally, MPI provided preliminary recommendations to the Division of Medicaid about providers MPI has encountered that are not operational consistent with the service type they are enrolled for or applying to render. The recommendations included additional pre-enrollment safeguards to mitigate fraud and abuse.

MPI continues to prioritize overpayment recovery and promote self-audits and vendor assisted audits as well as internal MPI audits. This proactive approach minimizes the provider's future risk of additional costs and sanctions if the self-audit is determined to be valid and not an attempt to alleviate liability for fraudulent practices. For example, if a single provider identifies inappropriate billing and repays an overpayment, MPI may share this information with other-like providers to determine if they 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 three years, the number of self-audits processed by MPI has increased, as well as the overpayments.

The Managed Care team continued its monitoring of the MCPs 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 MCPs related to fraud, abuse, and waste. In an effort to have the MCPs report case updates on the Quarterly Fraud and Abuse Activity Report and the Annual Fraud and Abuse Activity Report, the Managed Care team worked with the MCPs and the MPI Data team on new report templates that will ensure data integrity and efficiency in reporting that is a priority for both the Agency and the MCPs.

Engaging with the MCPs in a review of program integrity related efforts each year is a priority. This monitoring effort can vary from using the federal regulations, state statutes and contract requirements as a basis for a varied review to narrowing to a focused review on a singular topic. During the year, the Managed Care team engaged in a review of how the MCPs imposed payment restrictions of providers that were under a payment withhold. MPI imposes payment restrictions including "pending" claims in the Medicaid claims processing system for one or more specific, legally authorized purposes. A payment withhold (referred to as a "25A withhold") consistent with section 409.913(25)(a), F.S. may be imposed following a determination of existing reliable evidence of circumstances related to fraud, abuse, willful misrepresentation, or a crime committed while providing services to Medicaid recipients. The MCPs are required to restrict/withhold the payment to the providers under a 25A as well and this review will determine if a provider was accidentally paid with Medicaid dollars while under a restriction and what recommendations should be made to remediate any issues found.

One of the collaborative efforts of the Managed Care team was working with the Division of Medicaid on a project related to the Florida managed care program. The Managed Care team worked on the CMS Managed Care Program Annual Report (MCPAR), a newer reporting requirement related to the following categories: (1) Program Characteristics and Enrollment, (2) Financial Performance, (3) Encounter Data Reporting, (4) Grievance, Appeals, and State Fair Hearings, (5) Availability, Accessibility, and Network adequacy, (6) Topic reserved, (7) Quality and Performance Measures, (8) Sanctions and Corrective Action Plans, (9) Beneficiary

Support System, and (10) 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.

The Prevention units have continued their efforts to review providers for compliance issues related to enrollment of Medicaid providers. MPI has enhanced the compliance letter sent to providers to include common issues of noncompliance. This encouraged providers to conduct self-assessments of the information in their provider portal and the Care Providers Clearinghouse to ensure they were following enrollment requirements pursuant to Medicaid enrollment policies. These efforts have also increased overpayment recovery efforts and issuance of administrative fines to more than 90 providers. The review of noncompliance issues contributed substantially to the recovery of over $8,000,000.00 in overpayments and administrative fines.

Collaboration Activities

Florida MPI personnel are routinely sought after by national audiences to share expertise, demonstrating the Agency's commitment to recruiting, retaining, and training highly qualified fraud fighters. Several national organizations have selected MPI personnel to serve on educational advisory panels and working groups, participate in information sharing, and have been selected to present on their efforts toward combating fraud in health care. Among these organizations are the National Health Care Anti-Fraud Association (NHCAA), the Healthcare Fraud Prevention Partnership (HFPP), the Association of Certified Fraud Examiners (ACFE), Medicaid Integrity Institute (MII), and the National Association for Medicaid Program Integrity (NAMPI).

The NHCAA is a public private partnership that has a mission of improving the detection, investigation, civil and criminal prosecution and prevention of health care fraud and abuse. The NHCAA has a certification (Accredited Health Care Fraud Investigator, or AHFI) which is a designation granted to individuals who demonstrate a high level of experience and training as well as knowledge (through an application and examination) in the detection, investigation, and prosecution/enforcement related to health care fraud. The HFPP is also a public private partnership managed by the CMS and is charged with national data analytics efforts. MPI personnel actively participate in the development and assessment of the HFPP leads and has a current member on the executive board for the organization. The ACFE is not focused on health care fraud but has a strong focus on fraud prevention and deterrence, investigations, fraud schemes, the law pertaining to fraud, and financial transactions. The ACFE also has a certification (Certified Fraud Examiner, or CFE) for individuals who meet an academic and professional criteria and attain a passing score on the certification examination. MPI has had several personnel attain and maintain the AHFI and CFE designations. NAMPI is the only all-volunteer, all state government run, organization dedicated to Medicaid programs and program integrity efforts nationally. MPI personnel have served on several committees, have been elected to positions serving to represent the southeastern region (CMS Region 4) in an advisory position across all regions, and have been elected to serve on the association board (NAMPI vice-president and president). MPI personnel are active members in NAMPI working groups to develop fraud-fighting resources.

Collaboration has always been a priority for MPI, and particularly when the collaboration will assist law enforcement partners. This year at several Florida-based law enforcement workgroup meetings MPI was asked to present on identified investigations and schemes. One of the complex schemes MPI has spoken about with several different workgroups and conferences has been the issue of the use of health care consultants, a topic which is discussed elsewhere in this annual report. MPI continues to assist with law enforcement cases, providing data for law enforcement investigations, background information to assist law enforcement partners in understanding the Medicaid program rules, and serving as witnesses. Included in these collaborative efforts were cases that were a part of the 2024 National Health Care Fraud Takedown effort in June of 2024.

MPI's increased emphasis on law enforcement referrals includes agencies in addition to MFCU. There are often cases that may not be appropriate for referral to MFCU but should be reviewed by other law enforcement agencies. MPI held a meeting with several of these other agencies and the MCPs to increase awareness and collaboration regarding potential referrals that either fall outside the scope of authority for MFCU or for which MFCU is unable to pursue. During this meeting, MPI and the MCPs were introduced to the National Insurance Crime Bureau (NICB), HHS-OIG, FBI, Florida Department of Financial Services (DFS), the Drug Enforcement Agency (DEA), and the Veteran Administration.

The NICB is a conglomerate of property-casualty, vehicle rental, vehicle finance, and other insurance-related entities with the exclusive purpose of helping coordinate collaborative efforts to combat fraud. Although the

NICB (and its members) are not healthcare fraud-specific organizations, MPI and the MCPs have identified numerous cross-over situations where a Medicaid provider is also doing personal injury-related work for auto accidents and engaged in fraudulent activity both in Medicaid and the auto-related insurance coverage. Referrals to the NICB are also referred to the DFS who investigates non-Medicaid health and other insurance related fraud cases. DFS will also collaborate with MFCU and other state and federal law enforcement and prosecutors.

HHS-OIG also presented and discussed a vast array of federal funding programs they can investigate for fraud-related activities. Many of these programs are not Medicaid-related but may touch on Medicaid. Health related grants, substance abuse programs, low-cost housing, and exclusion-related violations are some of the examples covered and discussed. As with the NICB, these non-Medicaid investigations routinely cross over into the Medicaid program. HHS-OIG highlighted several of these non-Medicaid investigations that could have a clear nexus to the efforts of MPI and the MCPs. For example, a medical billing software company that created a tool which helped providers overbill insurance may not have had a Medicaid provider arrest but, clearly, the HHS-OIG intervention could have some impact on mitigating fraud in the Medicaid program. HHS-OIG covered provider types and geographic regions they are seeing as a higher fraud risk – which serves as a real time alert to the MCPs to evaluate their billing and provider networks.

The FBI presented their collaborative efforts with the NICB and HHS-OIG; and detailed schemes that are emerging and are consistently ongoing throughout the state. The FBI brought personnel from not only South Florida where the meeting was held, but also from other offices, including North Florida. Their presentation included a plea to not just focus on South Florida providers and schemes but that the schemes are statewide and can sometimes be more readily identified and prosecuted in other regions of the state. The FBI, in collaboration with HHS-OIG, hosts regional healthcare fraud working groups with other law enforcement agencies; these working groups were detailed, and the discussions included collaboration with MPI and the MCPs going forward.

DFS is one of Florida's largest law enforcement agencies. DFS provided an overview of the bureaus within the Division of Insurance Fraud (DIF). DFS-DIF investigates workers compensation fraud, arson and explosives crimes, and other insurance fraud. Additionally, they are authorized to investigate any misappropriation or misuse of state assets. Although MFCU has primary jurisdiction over Medicaid fraud in Florida, DFS-DIF can investigate Medicaid fraud cases. Among the crimes the DIF investigates, that have a nexus to Medicaid fraud, are insurance application fraud, life insurance fraud, homeowners and commercial insurance fraud, healthcare fraud, and personal injury protection (PIP) fraud. The discussions regarding this presentation and the collaboration during breaks and after the meeting very much focused on the types of fraud that are not Medicaid fraud but are very likely to include the same players. There appears to be cross over between the organizations who stage vehicle accidents or property damage claims and the organizations who are engaged in health care fraud.

The DEA also presented its enforcement activities, including drug diversion cases. MPI and the MCPs are familiar with the DEA permitting and schedule of drugs and have made referrals to the DEA, but this collaboration helped clarify other types of cases that may be appropriate for referral to the DEA. Examples may include prescribing of drugs for atypical uses and high-volume prescribing of controlled substances. The presentation showed the importance of our collaboration with the DEA, when there are any cases with controlled substances, because of the DEA's particular authority in this space. This presentation resulted in several additional discussions about DEA permit surrenders and HHS-OIG and MPI's authority to potentially take further action against Medicaid providers.

The Veteran Administration also participated in the meeting and committed to a future presentation about their investigative efforts and the relationship between their work and that of Medicaid fraud fighting.

MPI has collaborated with other units within HCPO, particularly the Background Screening Unit, the Complaint Administration Unit, Health Facility Regulation, and Field Operations. MPI routinely utilizes the Agency's healthcare provider background screening clearinghouse in compliance-related reviews of Medicaid providers and has worked closely with the Background Screening Unit on investigations which involve interpretation of information in the clearinghouse. MPI also routinely refers complaints to and receives complaints from the HCPO Complaint Administration Unit, ensuring that Medicaid fraud and abuse allegations are handled by MPI, and facility regulatory issues are handled by the appropriate licensure unit. Likewise, MPI has collaborated with the

licensure units within Health Facility Regulation regarding licensure violations that may also be violations under the Medicaid program.

Field Operations and MPI have been developing a more comprehensive approach to the reviews of assisted living facilities and nursing homes that have been found deficient during the HCPO Field Operation survey visits. The enhanced approach utilizes share drive reports from HCPO and HCPO Field Office referrals. MPI has opened cases on several assisted living facilities and nursing homes, resulting in administrative fines issued of more than $100,000.00. MPI and HCPO Field Operations will continue this collaboration to improve the overall services to the vulnerable populations that are served by assisted living facilities and nursing homes.

Program Assessment and Innovation

As a part of MPI's consistent commitment to the most effective and efficient means to mitigate fraud and abuse in the Medicaid program as well as recovery of payments made for goods or services not in compliance with Medicaid rules, MPI engages in routine programmatic reviews. These reviews are done as often as needed, not typically formalized, and not limited to any concept or idea. In fact, innovation is expected, and considering concepts that are not typically employed in health care or compliance arenas are encouraged.

The means by which MPI engages in the assessment of the program and MPI operations is based upon the fact that fraud and abuse in the Medicaid program is very fluid; the program changes, high level priorities change, fraud schemes evolve, and therefore, MPI's prioritization of the interventions it deploys as well as the provider/service types that are addressed also must be flexible. Performance targets have not previously been formalized because the goal is always to engage in as many high-quality program integrity interventions as possible and to contemplate the value (both monetary and nonmonetary) for the Medicaid program. This is an ongoing process handled through routine discussions of interventions and subjects (e.g., provider types) and appropriate adjustments to the use of resources to engage in as many interventions as can be done in a high-quality manner.

The outcomes are typically in the form of the policy and system edit recommendations discussed elsewhere in this annual report, internal MPI process adjustments, recommendations to the Division of Medicaid for broad program changes, analysis of risk areas, and the development of potential MPI projects. The concept behind these reviews is simple; MPI recognizes it has an important role in providing guidance, research, support to other parts of the Agency and our partners outside of the Agency, and to maximize the limited available resources to engage in the best, most adept and productive program integrity efforts possible. This concept results in an almost constant assessment and reassessment of the Medicaid program and its processes including, but not limited to, provider enrollment, coverage and limitation policies, contracts with MCPs, existing and developing program safeguards, and program integrity efforts both within MPI and elsewhere in the Agency.

The programmatic assessment and development of appropriate intervention activities involve all aspects of program integrity (prevention, detection, enforcement/recovery, and operations). For example, as was reported last year and (the continuation of the law enforcement aspects of the case were) further detailed in this year's highlights, MPI was involved in a preliminary investigation and fraud referral related to a Prescribed Pediatric Extended Care (PPEC) facility. These efforts would likely be categorized as prevention activities. However, further detection activities then resulted in the identification of additional PPEC providers for potential audit (recovery) or further investigations for potential sanctions or referrals.

PPEC services provide skilled nursing supervision and therapeutic interventions in a nonresidential setting to medically dependent recipients under the age of 21. MPI has seen an increase of complaints from the community regarding the services not being provided in an adequately supervised environment. Potential exposure, based upon total reimbursements for the nearly 200 PPEC providers in the Medicaid program is more than $200 million over the past several years. Preliminary data analysis already suggests the potential for further onsite reviews (prevention) and audits (recovery).

Elsewhere in this annual report there have been discussions of prevention values and detection efforts. These MPI activities are not possible without the ongoing efforts to enhance the use of technology. During the year, 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

managers, particularly the Detection Manager, spent a considerable amount of time during the year ensuring the needs of both MPI and MFCU were built into the FX processes.

Recovery Activities

Costs collected through overpayment actions, fines assessed, and paid claims reversals are data that is reviewed by MPI management, but not for establishing performance targets. The information is used to ensure that identified overpayments and other financial data is properly tracked and recorded. Some data elements include information collected for MPI operational management but may not be financial figures that MPI can greatly influence. For example, MCP damages are recommendations from MPI to the Division of Medicaid based upon contract noncompliance issues MPI has identified. MPI does not have the final say in whether the damages will be assessed or the amount that will be assessed. Historically, there has been a significant delay from the point of referral from MPI to the determination of assessment of the damages by the Division of Medicaid. Additionally, the Division of Medicaid has typically assessed only a small percentage of the amount of damages specified in contract for the contract violation. The data is, therefore, not used for an MPI performance target; it is used to inform MPI management, for ongoing discussions with the Division of Medicaid, and, as appropriate, for MPI to seek further leadership direction.

As has been previously stated, MPI's goal about all aspects of performance is always to engage in as many high-quality program integrity interventions as possible. Regarding overpayment recovery activities, this equates to identifying as much money as possible. Although MPI does not have a formal performance standard for overpayment recoveries, there is an expectation to maximize resources and maintain a high level of recovery activities. Should overpayment identification fall below $20 million in any given year, MPI would analyze the decline and strategize whether to shift resources to maintain a high level of recovery. The MPI management team conducts reviews of monthly and quarterly case information to strive to attain the highest level of recoveries each year.

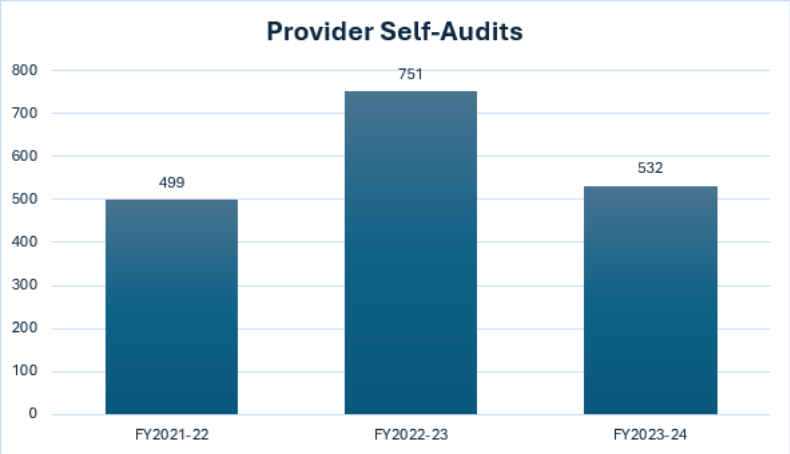
Recovery Activities – Identified Amounts			
	FY 2021-22	FY 2022-23	FY 2023-24
Overpayments (MPI/MPI-CMS Audits)	$22,764,935	$23,964,017	$23,681,284
Costs	$26,037	$20,328	$47,691
Fines	$687,123	$767,719	$2,214,416
Paid Claims Reversals	$388,479	$4,862,944	$301,864
MCP Assessments	$129,300	$0.00	$39,500
Certified Out of Business Adjustments	$2,960,304	$1,199,341	$19,705,532
Total	**$26,956,178**	**$30,814,349**	**$45,990,188**

Provider Self-Audits

Also in this annual report, there is a brief description of self-audits, typically handled through the MPI ORUs. MPI continues to emphasize and encourage providers to assess for noncompliance issues and to repay overpayments. Self-audits serve to potentially reduce litigation for the Agency because the provider agrees to repay the overpayment and waive any administrative hearing rights. They also have a future prevention value because of increased compliance by the provider. While self-audits are voluntary, MPI does engage in efforts to encourage providers to perform their own compliance reviews.

The number of provider self-audits each year is a measure MPI considers when evaluating its overall performance. When evaluating the trend related to provider self-audits, MPI would consider it a success to have processed more than 500 provider self-audits. However, since the previous FY was considerably higher, and

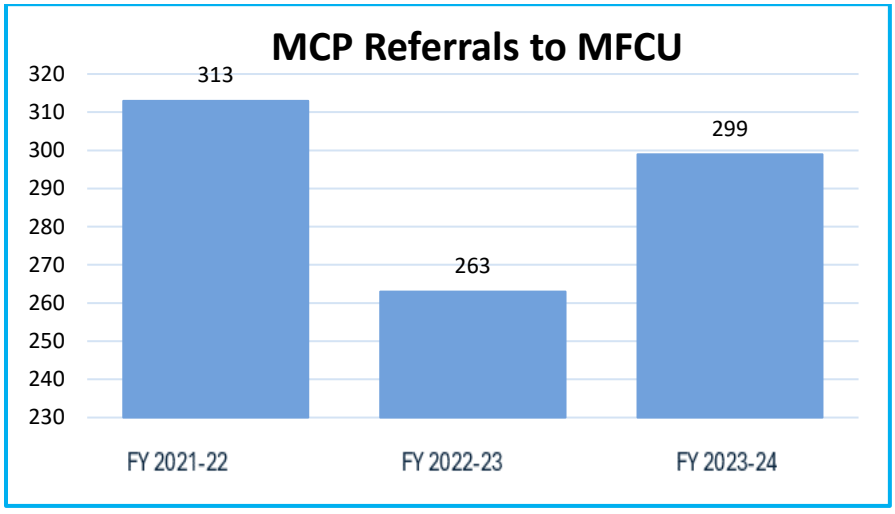
MPI does not want the trend to continue downward, MPI management would have on-going discussions about how to maintain a high volume of self-audits. MPI might encourage Medicaid providers to conduct self-audits in those areas of policy that are often identified in audits as minor noncompliance issues. Other efforts to increase self-audits might involve further collaboration with the Division of Medicaid through issuing compliance-related provider alerts and collaboration with other partners to identify common issues of noncompliance. Self-audit opportunities are encouraged by MPI particularly within topics that are unlikely to be the focus of more in-depth reviews.



Law Enforcement and Other Referrals

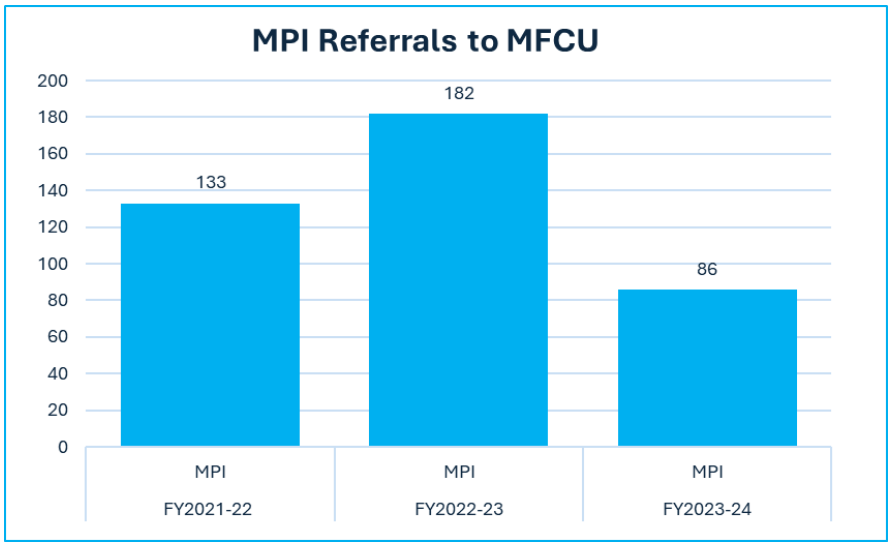
The emphasis on MPI law enforcement referrals should be evident throughout this annual report. MPI personnel strive toward a strong working relationship with personnel from MFCU, HHS-OIG, and other law enforcement agencies. MPI participates in several fraud-fighting working groups with law enforcement and prosecutorial agencies. Furthermore, law enforcement referrals, whether to MFCU or other agencies with jurisdiction over the suspected criminal violation, have always been a priority.

MPI has continued to encourage the MCPs to produce a high volume of referrals to MFCU by utilizing an established performance target. The referrals measured relate to the Statewide Medicaid Managed Care (SMMC) MCPs (and do not include other managed care programs, such as the Dual Special Needs Plans). This volume of referrals from the MCPs to MFCU demonstrates the commitment to the identification of suspected provider fraud. In future years, MPI intends to work more proactively with the non-SMMC managed care programs related to the Medicaid program, which may result in an adjustment of the overall target for MFCU referrals. It is critical the MCPs are not encouraged to merely meet or exceed a number, or the quality of referrals may significantly drop. To that end, MPI has fostered more engagement and promoted additional training between the MCPs and MFCU personnel. MPI began providing more real-time feedback to the MCPs with suggestions for improvements to their referrals that may assist in producing higher quality referrals to MFCU. MPI also implemented a process to supplement the MCP referrals where the allegations so warrant.

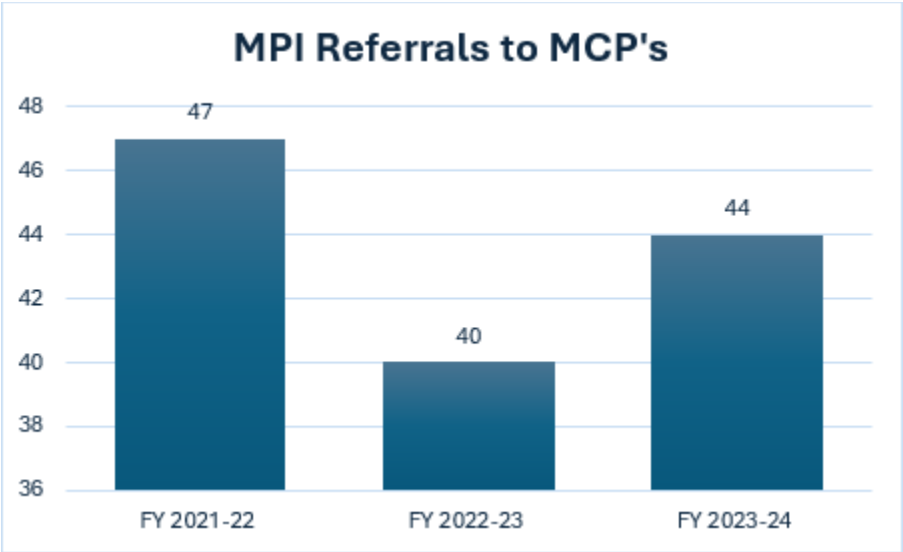


MPI has always emphasized referrals from MPI to MFCU as a key measure of effectiveness of program integrity interventions. Over the past several years, through standard process improvement reviews and discussions, MPI has adjusted the complaint intake processes to ensure that the team who has primary responsibility for MFCU referrals receives incoming complaints alleging fraud as fast as possible. Also, that same team is now reviewing all suspected fraud referrals from the MCPs to ensure that any additional information that MFCU might need is furnished or a full referral is prepared.

Based on the size of the Florida Medicaid program–whether calculated based on expenditures or number of providers–cumulatively between the health plans and MPI, approximately 500 or more referrals are expected. Approximately 20% of that is the amount that MPI strives toward each year.



As a part of MPI's managed care-related program integrity efforts, MPI evaluates its own audits and investigations to determine whether the provider or scheme should be referred to the MCPs. MPI also holds routine meetings with the MCPs to ensure active information sharing about schemes. MPI referrals can have a positive overall impact on program integrity efforts in managed care based upon a variety of considerations, including the fact that MPI may identify issues which have not yet emerged widely within the managed care environment. Additionally, MCPs can only see their own claims and a referral from MPI can provide them with data from the whole program. Each year MPI proactively works toward ensuring that at least 24 referrals to the MCPs are made and strives toward an upper range of approximately 48 total; however, some referrals end up not being documented as official referrals because of how often the plans and MPI communicate – inevitably, some providers or schemes are discussed informally and result in an MCP investigation.



MPI also refers providers to other entities where warranted, based upon that other entity's authority. MPI does not typically strive toward a high volume of referrals to any particular entity other than MFCU and the MCPs (as is discussed elsewhere in this annual report). However, all referrals are reviewed and considered when MPI is developing projects and evaluating its overall effectiveness. MPI reviews the three-year trend related to the volume of referrals and considers whether there should be more focus on referrals to other entities.

MPI Referrals to Others			
	FY 2021-22	**FY 2022-23**	**FY 2023-24**
Agency for Persons with Disabilities	9	2	5
Department of Children and Families	5	59	157
Department of Health	16	20	16
Department of Health and Human Services – Office of Inspector General	10	45	23
Department of Public Assistance Fraud	97	22	15
Division of Medicaid	14	2	3
Division of Health Care Policy and Oversight (Licensure)	144	107	70
Medicaid Fraud Control Unit – Attorney General	76	457	86
SafeGuard Services (CMS)	34	4	285
Managed Care Plans			44
Total	**405**	**718**	**704**

Prevention Values

Throughout this annual report, MPI has emphasized a high value on prevention or mitigation of fraud, abuse, and waste. Each year the Agency determines the impact, to the greatest extent possible, of the cost avoidance value based on actions taken by MPI. Most of these values are calculated based upon a one-year period both prior to and after the MPI intervention. Therefore, the three-year trend cannot be used to influence the subsequent year. However, MPI routinely reviews the trends to evaluate whether there are other interventions that should be put in place or whether resources should be shifted.

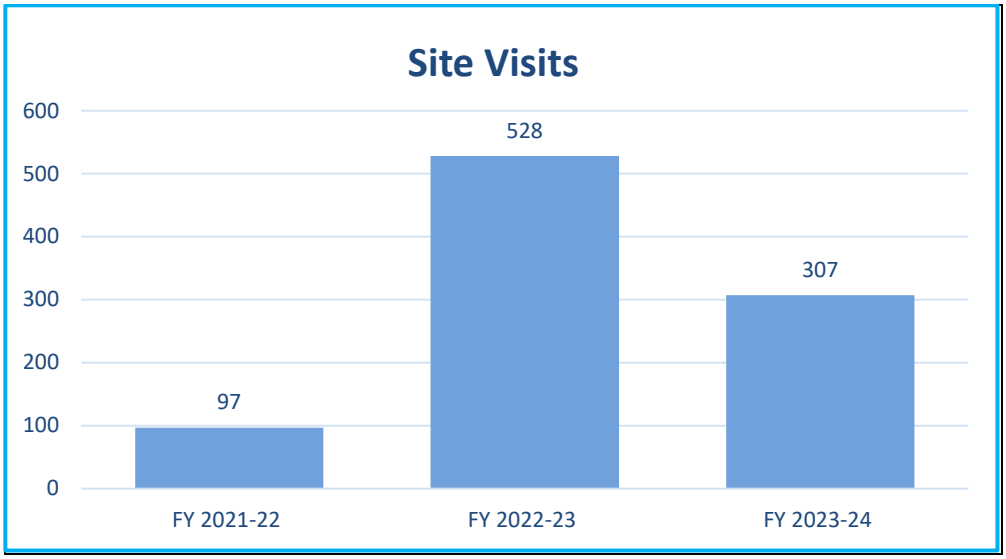
Additionally, analysis of the data may lead to adjustments in MPI processes, prioritization of efforts, discussions about future projects, or development of policy or system edit recommendations. As with other data elements that may be tracked for investigative management or fiscal accountability purposes, some measures do not lend themselves to a performance target. MPI strives for all of its program integrity interventions to have the greatest value as possible. But measuring the values, particularly prevention values, is impacted by more than just the work of MPI. Providers may quit billing after their misdeeds are detected therefore a measure that evaluates the dollar amount of denied claims following the imposition of a payment restriction would not accurately measure the value of that intervention. Also, MPI attempts to identify suspected fraud and abuse as early as possible; efforts that evaluate the dollar amount of claims both before and after the intervention would also potentially identify a lower value than the true impact of the intervention.

Prevention of Overpayments			
	FY 2021-22	FY 2022-23	FY 2023-24
Denied Claims Impact	$3,885,097	$8,054,048	$12,387,987
Termination of Providers Impact	$598,126	$1,879,457	$4,483,884
Program Suspensions Impact	$593,772	$5,389,875	$8,576,767
Denial of Reimbursement for Prescription Drugs	$951,231	$311,892	$165,237
Site Visits Impact	$24,709,888	$41,435,712	$16,528,415
Sanctioned Provider Impact	$2,462,460	$13,586,412	$11,503,444
Audit Impact	$101,735,293	$88,824,725	$88,897,155
PPR and 25(A) Impact	$30,172,734	$71,161,356	$33,653,833
MFCU Referrals Impact	$6,163,143	$14,591,273	$60,092,004
Total	**$171,271,744**	**$245,234,750**	**$236,288,816**

Provider Sanctions and Managed Care Plan Assessments			
	FY 2021-22	FY 2022-23	FY 2023-24
Fines	67	60	93
Suspensions	41	31	31
Terminations	95	104	114
Health Plan	7	0	10
Total	**210**	**195**	**248**

Provider Site Visits

The main purpose of provider site visits is to determine whether allegations of fraud or abuse against Medicaid providers are sufficiently substantiated to warrant other MPI interventions such as law enforcement referrals, recovery activities, or other administrative actions. During the recent public health emergency (PHE) the volume of provider site visits, understandably, was dramatically reduced. Following the PHE, MPI intentionally and significantly increased the number of provider site visits that were conducted. In the years to follow, MPI will try to maintain a high volume of these visits with an ongoing goal of at least 200, annually. This target would be adjusted with changes to the number of active providers, emerging trends, or other considerations which may impact MPI priorities.



Return on Investment

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, MCP 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 2021-22	**FY 2022-23**	**FY 2023-24**
Benefits	Recovery	56.54	43.48	53.25
	Prevention	171.27	245.23	236.28
	Total	**227.81**	**288.71**	**289.54**
Costs	Recovery	9.46	7.24	7.33
	Prevention	4.40	4.60	4.60
	Total	**13.86**	**11.81**	**11.93**
ROI Ratio	Recovery	5.97:1	6.01:1	7.26:1
	Prevention	38.90:1	53.60:1	51.35:1
	Total	**16.43:1**	**24.43:1**	**24.26:1**

STATUTORY REPORTING REQUIREMENTS

Number Of Cases Opened and Investigated

MFCU opened 348 cases and had 1002 active cases during FY. MPI investigated 3,326 cases, which included 1,435 opened during the year.

SOURCES OF THE CASES OPENED				
	MFCU		AHCA	
Source	Fraud	PANE	MPI	Total
AHCA - Division of Medicaid			2	**2**
AHCA - Financial Services			72	**72**
AHCA - Heath Quality Assurance			33	**33**
AHCA - Medicaid Fiscal Agent Operations			56	**56**
AHCA - Medicaid Program Integrity (MPI)	7			**7**
AHCA - MPI Detection			39	**39**
AHCA - MPI Detection - Data			3	**3**
AHCA - MPI Detection - Intake			4	**4**
AHCA - MPI Institutional			85	**85**
AHCA - MPI Orlando/ Tampa			45	**45**
AHCA - MPI Managed Care Unit			149	**149**
AHCA - MPI Miami			112	**112**
AHCA - MPI Pharmacy			437	**437**
AHCA - MPI Practitioners Care			43	**43**
AHCA - MPI Prevention Strategy			632	**632**
AHCA – Office of Inspector General			1	**1**
AHCA – Other Bureaus or Divisions			6	**6**
APD - Agency for Persons with Disabilities	2			**2**
APS - Adult Protective Services	1	155		**156**
Citizen	19	1		**20**
Centers for Medicare & Medicaid Services	1		9	**10**
CMS Contractor			2	**2**
DCF Dept of Children & Families	1	1		**2**
DEA Dept of Elder Affairs			1	**1**

SOURCES OF THE CASES OPENED, cont.				
	MFCU		AHCA	
Source	Fraud	PANE	MPI	Total
Employee	8			**8**
EOMB			3	**3**
Family Member	7	3		**10**
FBI - Federal Bureau of Investigation	1		2	**3**
Florida - Medicaid Fraud Control Unit – Data Mining Initiative	3		22	**25**
Florida - Other Agencies			10	**10**
Generalized Analysis			1	**1**
Healthcare Fraud Prevention Part. (HFPP)			1	**1**
Health & Human Services Inspector General	11			**11**
Internet/Media			17	**17**
Investigator Initiative			44	**44**
Law Enforcement Agency	1			**1**
Mail/Email			22	**22**
Managed Care Provider			12	**12**
Managed Care Special Investigations Unit	62		1	**63**
Medicaid Provider	4		1	**5**
Medicaid Recipient	1			**1**
Online Complaint Form			53	**53**
Previous File or Case			15	**15**
Projects			675	**675**
Qui Tam	44			**44**
Self-Audit			661	**661**
Site Visits			55	**55**
Spinoff Case	14			**14**
USAO US Attorney's Office	1			**1**
Total	**188**	**160**	**3326**	**3674**

DISPOSITION OF THE CASES CLOSED				
	MFCU		AHCA	
Case Type	Fraud	PANE	MPI	Total
Acquittal	1			1
Administrative Closure	4			4
Administrative Referral	21	24		45
Case Dismissed	4			4
Certified Out of Business - Validated			32	32
Certified Out of Business - Invalidated			1	1
Change of Ownership (CHOW)			1	1
Civil Settlement	6			6
Consolidated	6	3		9
Conviction	24	10		34
Death of the Offender		1		1
Facts Alleged Not Indicative of Exploitation		1		1
Fines Issued			38	38
Fugitive Defendant	1			1
Investigated by Another Law Enforcement Agency	7	8		15
Lack of Evidence	47	55		102
Liquidated Damages Applied			10	10
Liquidated Damages Not Applied			12	12
Medicaid Fraud Control Unit - Accepted			58	58
No Abuse			9	9
No Findings			3	3
Nolle Prosequi	2	1		3
No Further Action Required			300	300
Not a Medicaid funded Board & Care Facility		1		1
Not a Medicaid Provider		1	1	2
Pre-Trial Intervention	4	3		7
Project Completed			43	43

DISPOSITION OF THE CASES CLOSED, cont.				
	MFCU		AHCA	
Case Type	Fraud	PANE	MPI	Total
Prosecution Declined	3	2		5
Provider Education			12	12
Provider No Longer Operational			6	6
Provider Suspended			33	33
Provider With Cause Termination			116	116
Provider Without Cause Termination			19	19
Referred			288	288
Resolved with Intervention	6	3		9
Statute of Limitations Expired	1			1
Sustained			704	704
Unfounded	1	1		2
Unsubstantiated	31	32		63
Voluntary Dismissal	19			19
Voluntary Termination			1	1
Total	**188**	**146**	**1687**	**2021**

Amount of overpayments alleged in preliminary and final audit letters.

Preliminary	Final
$30,595,039	$19,774,205

Number and amount of fines or penalties imposed

During the year, MPI imposed 233 fines (under s. 409.913, F.S., and Rule 59G-9.070, F.A.C.) in the amount of $2,214,316.00.

Amount of final Agency determinations of overpayments

MPI identified overpayments in the amount of $23,681,284.00 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. The Agency reduced its federal share, on quarterly cost reports, by $32,096,152.14 for net overpayments.

Amount of overpayments recovered

The MFCU collected $2,050,210.00 in overpayments that were returned to the Agency. Additionally, MFCU collected $1,720,045.00 in Federal Medicaid overpayments that were sent directly to the United States Department of Health and Human Services for a total of $3,770,255.00 in Medicaid overpayments collected in FY 2023-24. Overpayments recovered as a result of the MPI, and MPI-CMS audits were $9,404,100.00. Total recoveries by MPI, MPI-CMS, and MPI-TPL were

$53,255,092.00 (This includes collections of overpayments, fines, costs, and paid claims reversals during the fiscal year).

Amount of cost of investigation recovered

During the year, the MFCU collected $2,273.00 in program income investigative costs. MFCU also collected $2,456.00 in state share investigative costs and $73,028.00 in federal share investigative costs for a grand total of $77,757.00 for all investigative costs.

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

MFCU expenditures for the year were $21,086,513.00 which included indirect costs of $2,170,977.00.

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 was less than 1 year (0.34).

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

The Bureau of Financial Services deemed there was not an amount determined 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	259
Best Interest of The Program	1407
Total	**1666**

Denials by Provider Type	Totals
05 - Community Behavioral Health Services	66
07 - Specialized Therapeutic Services	10
14 - Assistive Care Services	18
20 - Prescribed Drug Services	7
24 - Prescribed Pediatric Extended Care (PPECC)	12
25 - Physician (M.D.)	85
26 - Physician (D.O.)	38
28 - Chiropractor	1
30 - Advanced Practice Registered Nurse (APRN)	21
32 - Social Worker/Case Manager	13
35 - Dentist	3
39 - Behavior Analysis	1215
40 - Ambulance	1
41 – Non-Emergency Transport	3
42 – Air Ambulance	1
46 – Non-Profit Transportation	1
65 - Home Health Services	28
67 - Home & Community-Based Services Waiver	33
70 – Medicaid Health Plan	1
81 - Professional Early Intervention Services	3
83 - Therapist (PT, OT, ST, RT)	40
89 – Dialysis Center	2
90 – Durable Med Equipt/Medical Supplies	1
91 - Case Management Agency	58
99 - Trading Partner	2
Total	**1666**

Additionally, 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	80
Criminal History	111
Total	**191**

Denials by Provider Type	Totals
05 - Community Behavioral Health Services	17
07 - Specialized Therapeutic Services	9
20 - Prescribed Drug Services	2
23 - Medical Foster Care/Personal Care Provider	1

25 - Physician (M.D.)	11
26 - Physician (D.O.)	4
29 - Physician Assistant	1
30 - Advanced Practice Registered Nurse (APRN)	41
31 – Registered Nurse/Registered Nurse First Assistant	1
35 - Dentist	3
39 - Behavior Analysis	36
40 - Ambulance	1
41 - NON-Emergency Transport	3
42 – Air Ambulance	1
50 - Independent Laboratory	7
51 – Portable X-Ray Company	1
61 – Hearing Aid Specialist	1
65 - Home Health Services	19
67 - Home & Community-Based Services Waiver	6
81 – Professional Early Intervention Services	2
83 - Therapist (PT, OT, ST, RT)	19
90 - Durable Med Equipment/Medical Supplies	5
Total	**191**

Finally, there were 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	70
Terminated - Adverse Association	240

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	98
With-Cause Termination Under Medicaid Final Order	115
Total	**213**

Terminations by Provider Type	Totals
05 - Community Behavioral Health Services	50
07 - Specialized Mental Health Practitioner	14
10 - Skilled Nursing Facility	1
14 - Assistive Care Services	6
20 - Prescribed Drug Services	2
24 – Prescribed Pediatric Extended Care (PPEC)	1
25 - Physician (M.D.)	18
30 - Advanced Practice Registered Nurse (APRN)	3
32 - Social Worker/Case Manager	1
39 - Behavior Analysis	63
65 - Home Health Services	10
67 - Home & Community-Based Services Waiver	20
81 – Professional Early Intervention Services	1
83 – Therapist (PT, OT, ST, RT)	8
91 - Case Management Agency	15
Total	**213**

Policy Recommendations to Enhance Prevention and Detection of Medicaid Fraud

MPI has four recommendations for consideration; two are broad concepts for consideration for the public good and two are specific to MPI-related statutes. The first relates to the initiation of a business in the State of Florida and strengthening the controls to ensure greater mitigation of criminals creating businesses in Florida. The second relates to increasing the ability for the state to employ forfeiture actions for administrative overpayments. The third relates to revisiting a statutory limitation on pharmacy audits. The fourth relates to the requirements for this report.

Enrollment as a Medicaid provider typically starts with a business becoming eligible to operate in the State of Florida. Even prior to the business obtaining local and state licenses, typically the business registers with the Department of State. This registration is not extensive enough to ensure an entity which may apply to become a Medicaid provider is a legitimate business which has provided accurate information about the owners, officers, directors, and affiliated persons for the business. There is no indication there is any type of reconciliation of discrepancies upon registration. It appears that applicants may declare owners, officers, and principal representatives with very little due diligence by the Department of State to identify high risk counties partnerships or regions. In an effort to streamline the process to operate a business in Florida, the Department of State has created areas of security vulnerabilities for the citizens of this state and taxpayer funds. Over the years, the Agency has identified numerous applicants who provide ownership or other business-related information which greatly varies from the information filed with the Department of State. However, there is a void as it relates to the enforceability of the accuracy of the information filed with the Department of State; it appears this responsibility may only rest with the management of the business; which may include corrupt individuals seeking to commit fraud, and federal agencies such as the Federal Trade Commission. It may be in the State of Florida's best interest to ensure there are stronger mechanisms in place to ensure that those businesses seeking to operate in Florida have a foundation based upon valid information which has been at least preliminarily vetted for accuracy and completeness.

There is a great public interest in ensuring that businesses are not created to commit fraud, to hide the proceeds of fraud and other crimes, or to engage in other unfair or criminal conduct which may go well beyond the scope of this Agency's recommendations. Also beyond the scope of this Agency's typical duties are the processes for seizing assets and forfeiture of assets to compel a provider (or its owners) to repay overpayments. A review of these laws may be warranted. The forfeiture process is typically reserved for law enforcement and prosecutorial agencies. Perhaps, the process could begin with a notice to the provider of proposed forfeiture. The implementation of any type of protocol for administrative forfeiture may entice providers with identified overpayments to repay the program and resolve administrative audits in a more expedient

manner. Therefore, improving the Agency's collection efforts since most overpayments are identified through administrative audits. Without a more aggressive approach to these actions, the people behind the provider groups may be able to steal from the Medicaid program and then avoid repayment by declaring the business as insolvent. Providers with criminal intentions would be more likely to forfeit assets in lieu of termination from the Medicaid program because it would avoid a cascade effect to their other earnings and income streams.

As was previously described in this report, section 465.188, F.S. creates limitations on MPI audits which may once have been based upon a perception of disparate treatment of pharmacies during MPI audits. However, the law now only serves to limit the potential for recoveries without having to engage in many audits of a pharmacy. The prohibition against statistical sampling is no longer supportable where sampling and extending an overpayment to the population is used in most if not all other audit categories. Furthermore, the limitation to a one calendar year audit simply means MPI would have to conduct two or three audits to have a more standard review period, which is also burdensome on the provider. These two limitations should be considered for future amendment to the statute.

Finally, a tremendous amount of effort is put into this report, particularly the sections of the report which detail the efforts of both MPI and MFCU. The Agency takes seriously the responsibility to operate the program to maximize the integrity of the Medicaid program. The preparation of a report annually, jointly with MFCU, is an opportunity to collectively review the efforts to control fraud and abuse and recover overpayments. However, the statutory requirement includes numerous specific reporting requirements (see the section of the report titled *Statutory Reporting Requirements*). Many of the specific requirements no longer represent the most informative manner to gauge fraud fighting activities and consequently limits their usefulness. Moreover, these reporting requirements influence the manner that information is assembled and hinders the collaborative efforts between MFCU and MPI to present a meaningful report to the Legislature demonstrating efforts. These requirements may no longer be necessary to ensure the Agency and MFCU submit a report that provides a clear and accurate picture of fraud and abuse prevention activities.

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
MCP – Managed Care Plan
MCU - Managed Care Unit
MFAO - Medicaid Fiscal Agent Operations
MFCU - Medicaid Fraud Control Unit, within the Florida Department of Legal Affairs
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
SGS – SafeGuard Services
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
UPIC – Unified Program Integrity Contractor
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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