FLORIDA'S EFFORTS TO CONTROL

MEDICAID FRAUD & ABUSE

FISCAL YEAR 2021-2022

AGENCY FOR HEALTH CARE ADMINISTRATION
STATE OF FLORIDA

ATTORNEY GENERAL
LEX
STATE OF FLORIDA

January 10, 2023

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

Dear Governor Desantis:

Pursuant to Section 409.913, Florida Statutes, enclosed is the annual report of the activities related to the fight against fraud and abuse in the Medicaid program for the FY 2021-22. 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
Interim Secretary

cc:The Honorable Kathleen Passidomo
The Honorable Paul Renner

TABLE OF CONTENTS

OFFICE OF THE ATTORNEY GENERAL

THE AGENCY FOR HEALTH CARE ADMINISTRATION

STATUTORY REPORTING REQUIREMENTS

OFFICE OF THE ATTORNEY GENERAL

MEDICAID FRAUD CONTROL UNIT

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

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

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

The MFCU is also responsible for investigating patient abuse, neglect, and financial exploitation (PANE) of those persons residing in long-term care facilities such as nursing homes, facilities for the mentally and physically disabled, and assisted care living facilities. The MFCU is also concerned with the quality of care being provided for Florida's ill, elderly, and disabled citizens.

Control and Enforcement Strategy

The MFCU has two primary areas of enforcement responsibility: fraud perpetrated against the Medicaid Program and 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 2021-22, the Unit received 5,644 complaints. Of the 5,644 complaints received in FY 2021-22, 605 were related to fraud and 5,039 were related to PANE allegations.

Of the total 605 fraud complaints received, referrals from Managed Care Special Investigative Units were the primary source of fraud complaints in FY 2021-22 at 324. Complaints from Citizens accounted for 75 Medicaid fraud complaints. Qui tam complaints accounted for 52 of the Medicaid fraud complaints received. Thirty-five complaints were received from Family Members.

The majority of PANE complaints were derived through the Department of Children and Families (DCF), Adult Protective Services (APS)/Florida Safe Families Network (FSFN). In FY 2021-22, of the 5,039 PANE complaints, 4,992 came from DCF/APS/FSFN. The next highest sources of PANE complaints received were Family Members with 15 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 is expended to identify those involved in the origin of the wrongdoing, possible criminal misconduct, scope of the activity, and to establish sufficient evidence to prove the requisite elements.

During FY 2021-22, 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 312 total cases opened, 208 were Fraud cases and 104 were PANE cases.

The following is a list of the top three Medicaid Provider types for MFCU fraud cases opened in FY 2021-22:

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

The following is a list of the top three Provider types for MFCU PANE cases opened in FY 2021-22:

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

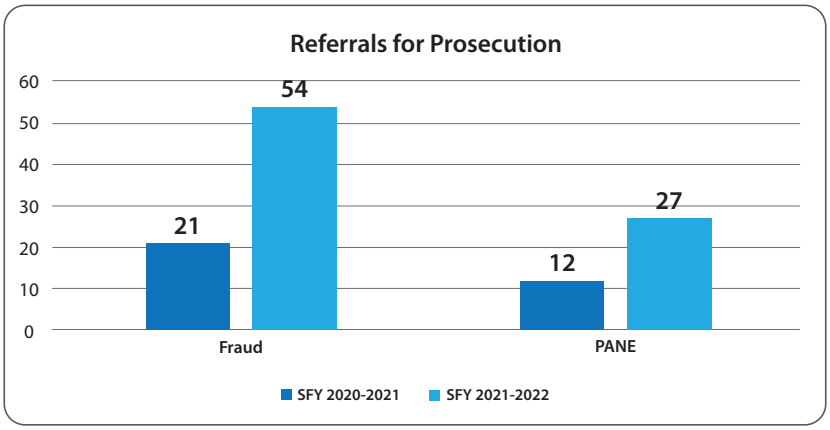
Disposition of Cases

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.

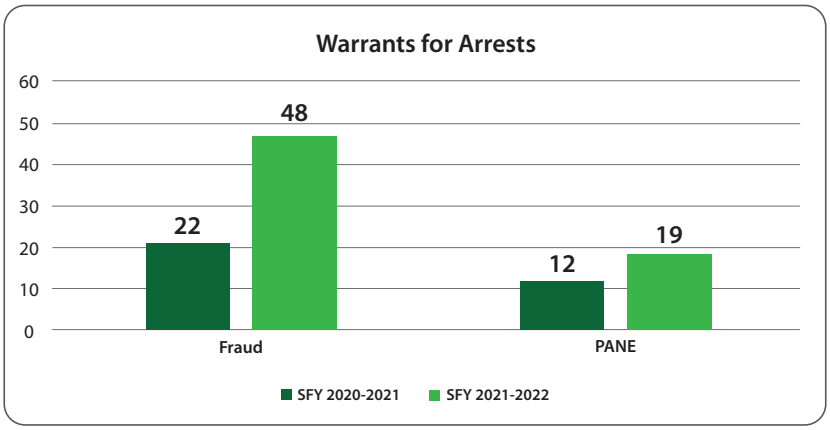
In FY 2021-22, the MFCU closed 447 cases. Of those, 279 involved Medicaid fraud investigations and 168 involved PANE cases.

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 2021-22 were 54 Fraud and 27 PANE for a total of 81.



Warrants for arrests for FY 2021-22 were 48 Fraud and 19 PANE for a total of 67.



Case Highlights

Mallinckrodt ARD, LLC

The Florida Medicaid Fraud Control Unit helped secure more than $233 million through a multistate action alleging that a nationwide pharmaceutical company defrauded Medicaid. Mallinckrodt ARD, LLC, formerly known as Questcor Pharmaceuticals, Inc, sells and markets pharmaceuticals nationwide. Of the more than $233 million secured through this nationwide effort, more than $14 million will go to the Florida Medicaid program.

The multistate effort resolves allegations that from January 1, 2013, through June 30, 2020, Mallinckrodt knowingly underpaid Medicaid rebates due for its drug H.P. Acthar Gel ("Acthar"). Under the Medicaid Drug Rebate Program, when a manufacturer increases the price of a drug faster than the rate of inflation, it must pay the Medicaid program a per-unit rebate of the difference between the drug's current price and the price of the drug if its price had gone up at the general rate of inflation since 1990 or the year the drug first came to market, whichever is later.

However, Florida and the other government plaintiffs alleged that Mallinckrodt and its predecessor Questcor began paying rebates for Acthar in 2013 as if Acthar was a new drug just approved by the U.S. Food and Drug Administration, rather than a drug that was first introduced to market in 1952. Allegedly, this practice meant the companies ignored all pre-2013 price increases when calculating and paying Medicaid rebates for Acthar from 2013 until 2020. In particular, Florida alleged that Acthar's price had already risen to more than $28,000 per vial by 2013; therefore, ignoring all pre-2013 price increases for Medicaid rebate purposes had the effect of significantly lowering Mallinckrodt's Medicaid rebate payments for Acthar. Mallinckrodt is now admitting that Acthar was not a new drug as of 2013 but rather approved by the FDA and marketed prior to 1990. Mallinckrodt agreed to correct Acthar's base date Average Manufacturer Price and that it will not change the date in the future.

This civil settlement results from a whistleblower lawsuit originally filed in the United States District Court for the District of Massachusetts. Florida, the federal government, 25 other states, the District of Columbia and Puerto Rico intervened in the civil action in 2020. The recent agreement, based on Mallinckrodt's financial condition, required final approval of the U.S. Bankruptcy Court for the District of Delaware, which approved the terms on March 2.

A team from the National Association of Medicaid Fraud Control Units participated in the litigation and conducted negotiations on behalf of the states. The team included representatives from the Offices of the Attorneys General for the states of Florida, California, Massachusetts, Michigan, Nevada, New York, Texas and Wisconsin.

Bristol Myers Squibb Company
A National Association of Medicaid Fraud Control Units ("NAMFCU") Team participated in the investigation and conducted the settlement negotiations with Bristol-Myers Squibb Company ("BMS") on behalf of the states and included representatives from the Offices of the Attorneys General for the states of California, Florida, New York, North Carolina, and Texas.

This settlement resolved allegations that from October 1, 2007 to March 31, 2016, BMS improperly underpaid its Medicaid Rebate obligations by falsely under-reporting Average Manufacturer Prices ("AMP") to CMS. The whistleblower's complaint alleged that BMS improperly treated certain fees paid to wholesalers as "discounts," and improperly failed to include certain "price appreciation" amounts it received from wholesalers in its AMP calculations. The effect of these accounting practices was to falsely decrease the AMP the companies reported to the federal government and improperly decreased the rebates paid to the states. As part of the settlement, Florida Medicaid received $2,920,060.07 in restitution and other recoveries.

Astellas Pharma U.S. Inc.
This settlement resolved allegations that Astellas Pharma U.S. Inc. ("Astellas") improperly treated compensation provided to the wholesalers pursuant to Services Agreements with wholesalers as price reductions, rather than as bona fide service fees, when calculating and reporting quarterly AMPs to CMS for the Covered Drugs.

Consequently, as a result of Astellas's reporting such improperly reduced AMPs, Astellas underpaid quarterly rebates owed to the states for the Covered Drugs under the Medicaid Drug Rebate Program and caused the United States to be overcharged for its payments to the states for the Medicaid Program. As part of the settlement, Florida Medicaid received $1,469,464.62 in restitution and other recovery.

Cardinal Health Inc.
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Florida Neurological Center, LLC
The Florida Medicaid Fraud Control Unit, working with federal partners, is recovering thousands of dollars for Florida's Medicaid program. The recovery follows an investigation into an Ocala neurologist allegedly submitting false claims for medically unnecessary and unreasonable prescription drugs. As a result of the joint state and federal investigation, Florida Neurological Center, LLC and its owner, Dr. Lance Kim, have agreed to pay $800,000 to resolve allegations that Dr. Kim fraudulently prescribed drugs.

One drug that Dr. Kim allegedly falsely prescribed is Acthar Gel®, which cost government health care programs more than $32,000 each time Dr. Kim prescribed a five-day supply. Pursuant to the agreement, the Florida Medicaid program will receive more than $113,000 in restitution.

According to the joint investigation, the defendants allegedly submitted, or caused to be submitted, false claims to Medicare and Medicaid from January 2013 through July 2020.

The settlement agreement following the investigation partially resolves claims brought under the qui tam or whistleblower provisions of the Federal False Claims Act and Florida False Claims Act statutes. Under those provisions, a private party can file an action on behalf of the U.S. and/or the state of Florida and receive a portion of any recovery. The suit, filed in the Middle District of Florida, is captioned United States ex rel. Singbush v. Florida Neurological Center, LLC, Case No. 5:19-cv-603-Oc-GPB-PRL (M.D. Fla.).

Joshua Maywalt
U.S. District Judge Mary S. Scriven has sentenced Joshua Maywalt (42, Tampa) to five years and five months in federal prison for healthcare fraud, aggravated identity theft, filing a false income tax return, and failing to file an income tax return. As part of his sentence, the court also entered an order forfeiting $2,257,029.86 and real property located at 5346 Northdale Boulevard in Tampa, which are traceable to proceeds of the offense. Maywalt had pleaded guilty on December 1, 2021.

According to court documents, Maywalt worked as a medical biller at a company in Clearwater that provided credentialing and medical billing services for its medical provider clients. In this capacity, Maywalt had access to the company's financial, medical provider, and patient information. Maywalt was assigned to a Tampa Bay area physician's account ("Physician #1") and was responsible for submitting claims to Florida Medicaid Health Maintenance Organizations (HMO) for services rendered by Physician #1 to Medicaid recipients.

Maywalt abused his role as a medical biller by wrongfully accessing and utilizing the company's patient information and Physician #1's name and identification number to submit false and fraudulent claims to a Florida Medicaid HMO for medical services purportedly rendered by Physician #1, which were not actually rendered. Maywalt also altered the "pay to" information associated with the HMO's payment processor so that the payments for the non-rendered medical services were sent to bank accounts under Maywalt's control.

Maywalt knowingly signed and filed a false federal income tax return for tax year 2019 which substantially understated his income and reported only his employment wages, and not the substantial amount of money he was depositing into his bank accounts as a result of his fraudulent activities. In addition, Maywalt failed to file federal income tax returns for 2017 and 2018, as required by the Internal Revenue Service.

This case was investigated by the Department of Health and Human Services -Office of Inspector General, the Federal Bureau of Investigation, the Florida Medicaid Fraud Control Unit, Office of the Florida Attorney General, and the Internal Revenue Service – Criminal Investigation. It was prosecuted by Assistant United States Attorneys Maria Guzman and Suzanne Nebesky.

Myoka Bowens and Jazmin Raulerson
On or about May 22, 2022, Florida's Medicaid Fraud Control Unit arrested a nurse and the mother of a Medicaid recipient for bilking more than $100,000 from Medicaid. Throughout several months, Myoka Bowens, a licensed practical nurse, worked with a Medicaid recipient's mother, Jazmin Raulerson, to swindle the Medicaid program by falsifying progress notes for time overseeing a high-risk infant.

According to the investigation, Bowens provided private duty nursing services to a high-risk infant. Bowens's employers required daily progress notes to be submitted. Over the course of several months, Bowens submitted falsified skilled progress notes for reimbursement, causing a loss to the Medicaid program for more than $100,000. Meanwhile, Raulerson participated in the fraud by signing and approving the progress notes, as well as clocking in and out for Bowens. Raulerson received several thousands of dollars from Bowens for taking part in the scheme.

Bowens's employing company, Sonas, hired a private investigation company that obtained photographic evidence proving Bowens's absence during the scheduled and billed hours. After gathering the evidence, Sonas terminated Bowens and offered Raulerson another LPN, but Raulerson refused and instead willfully continued the scheme by hiring Bowens under another Medicaid provider company.

Bowens and Raulerson each face one count of Medicaid provider fraud for more than $50,000, a first-degree felony, one count of second-degree grand theft and one count of money laundering, a third-degree felony. Attorney General Moody's Medicaid Fraud Control Unit will prosecute this case through an agreement with the State Attorney's Office for the Fourth Judicial Circuit.

Desiree Maddox
Florida's Medicaid Fraud Control Unit announced the arrest of a respiratory therapist who defrauded the Florida Medicaid program. The MFCU with the assistance of the Osceola County Sheriff's Office, arrested Desiree Maddox on one count of

Medicaid provider fraud. Maddox falsified documentation to bilk Medicaid out of more than $4,000. Maddox worked for a home health care agency, EZ Inspiration, and provided respiratory therapy to a child Medicaid recipient and submitted timesheets for services never provided.

According to the MFCU investigation, the owner of EZ Inspiration learned from the recipient's doctor that the child was no longer receiving respiratory therapy despite having an ongoing need for it. When questioned, the family of the child believed that the services formerly provided by Maddox had been terminated. However, Maddox continued to submit timesheets and service notes to EZ Inspirations for four months after not providing the therapy.

Maddox faces one count of Medicaid provider fraud, a third-degree felony punishable by up to five years in prison. Attorney General Moody's Medicaid Fraud Control Unit will prosecute this case with a cross-designation from the Ninth Judicial Circuit.

Jose Troche
Florida's Medicaid Fraud Control Unit and the Hernando County Sheriff's Office arrested an ineligible Medicaid provider for defrauding Medicaid of more than $68,000. In applying to become a Medicaid provider, Jose Troche failed to disclose former felony convictions that precluded Medicaid from accepting the application. Due to the false statement, Troche received the funds from Medicaid.

According to an MFCU investigation, Troche owned My Journey JMT Inc., created to provide home and community-based services to Medicaid recipients. However, Troche's past criminal record makes him ineligible to be a Medicaid provider. While awaiting sentencing after pleading to and being adjudicated guilty on two felonies in 2017—False, Fictious or Fraudulent Claims against the U.S. and Aggravated Identity Theft—Troche enrolled to become a Medicaid provider. On the application, however, Troche failed to disclose the felony convictions. The false report led to the application being accepted under false pretenses and Troche fraudulently receiving a total of $68,667 from the Medicaid program.

Troche is charged with one count of Medicaid fraud more than $50,000, a first-degree felony. If convicted, Troche faces up to 30 years in prison and $10,000 in fines. Attorney General Moody's Office of Statewide Prosecution will prosecute this case.

Michael Jacob Rothman
On or about April 27, 2022, Florida's Medicaid Fraud Control Unit announced the arrest of an Indian River County resident for Medicaid fraud. Michael Jacob Rothman worked for a home health care agency and provided behavior analyst services to three Medicaid recipients, all three with disabilities and two being children. Rothman submitted timesheets for services never provided, stealing nearly $12,000 from the Medicaid program.

According to an investigation by MFCU, a parent of one of the children noticed incorrect information on a Medicaid online portal. The parent saw Medicaid bills for services not provided to her son. After further investigation, MFCU found that Rothman cheated three victims out of services by billing the Medicaid program for four months on 16 alleged visits to patients.

Rothman faces one count of Medicaid provider fraud, organized fraud and grand theft, all third-degree felonies and punishable up to a term of five years. The State Attorney's Office for the 19th Judicial Circuit will prosecute this case.

Senetta Wilson Carter
The Florida Medicaid Fraud Control Unit and the Hollywood Police Department arrested the owner and operator of a Medicaid-provider facility for committing more than $77,000 in Medicaid fraud. Senetta Wilson Carter operated Rayfield Family Literacy (RFL), a school that provided services for Medicaid recipients, many with severe disabilities. According to the MFCU's investigation, Carter submitted falsified claims to Medicaid for online-based services not provided.

The investigation revealed that Carter fraudulently billed Medicaid for 10 months. Several interviews with parents or relatives of the Medicaid recipients revealed that RFL attempted to move much of its care online by using electronic tablets. Many patients who could not use the tablets did not receive any help; however, Carter still billed Medicaid for services not rendered.

Carter is charged with one count of Medicaid provider fraud, a first-degree felony and grand theft, a second-degree felony. If convicted, Carter faces up to 45 years in prison. The Broward County State Attorney's Office in the 17th Judicial Circuit is prosecuting the case.

Andrew James Jones and Johanna Courts
The Florida Medicaid Fraud Control Unit and the Broward Sheriff's Office arrested Andrew James Jones and Johanna Courts for falsely billing the Florida Medicaid program for services not rendered. Jones and Courts are the owner and chief operating officer of Cornerstone Community Mental Health Services (CCMHS). An investigation by MFCU revealed that the duo defrauded the Medicaid program out of more than $148,000.

According to the investigation, Jones and Courts formed and operated CCMHS, a company authorized to provide to Medicaid recipients—under the age of 21—specialized therapeutic services that included comprehensive behavioral health assessments, specialized therapeutic foster care and therapeutic group home services. CCMHS purported to serve patients with mental health, substance use and co-occurring disorders. The investigation disclosed that Jones and Courts submitted falsified claims for services not rendered to Medicaid recipients and received payment from the Florida Medicaid program for those falsified claims—amounting to $148,211.80 collected in a six-month period.

The investigation also revealed that Jones and Courts used the large deposits from Medicaid for payroll, personal expenses, mortgage payments and withdrawals at the Hard Rock Casino.

On 8/15/2022, a jury in Broward County returned guilty verdicts on both Defendants. Andrew Jones was found guilty of Medicaid Provider Fraud, a first-degree felony, and grand theft, a second-degree felony. Co-Defendant Johanna Courts was found guilty of Medicaid Provider Fraud, a second-degree felony, and grand theft, a third-degree felony.
Attorney General Moody's Medicaid Fraud Control Unit prosecuted this case with a cross-designation from the Attorney General's Office of Statewide Prosecution.

Leita Tanis Apollon
On or about February 23, 2022, the Florida Medicaid Fraud Control Unit, with the assistance of the Hollywood Police Department, arrested Leita Tanis Apollon, a Medicaid provider. Apollon worked as a certified nursing assistant and defrauded the Florida Medicaid program out of more than $38,000 by submitting fraudulent claims.

According to the investigation, Apollon submitted falsified claims for payment of personal care services to the Florida Medicaid program. The investigation revealed Apollon caused Medicaid to pay for services rendered by an unauthorized and ineligible individual.

Apollon is charged with one count of Medicaid-provider fraud, a second-degree felony; and one count of grand theft, also a second-degree felony. If convicted, Apollon could face up to 30 years in prison.

Rasheia James
Florida's Medicaid Fraud Control Unit, with the assistance of the Hillsborough County Sheriff's Office, arrested a business owner for stealing thousands of dollars from the Florida Medicaid program. Rasheia James owned a home health care service company that provided services for Medicaid recipients. According to the investigation, James knowingly created and submitted falsified documents to Medicaid for services not rendered. James allegedly billed Medicaid more than $9,600 for services never provided to customers that needed health and personal support care.

In an ongoing scheme, James benefited from willfully and intentionally defrauding the Florida Medicaid program by creating false billing information and progress notes used to obtain reimbursement from Medicaid. As an authorized Medicaid provider for respite care services, James's company is supposed to help consumers be active in the community and provide a home-like environment for consumers living in group homes, assisted-living facilities or adult-family care homes and help them make personal choices. However, when James's company discontinued work with a client, James continued to bill Medicaid for services not provided and lied to employees about the claims.

James is charged with one count of Medicaid provider fraud, a third-degree felony, and scheme to defraud, another third-degree felony. If convicted, James faces up to 10 years in prison and $10,000 in fines. Attorney General Moody's Medicaid Fraud Control Unit will prosecute this case with a cross-designation from the Attorney General's Office of Statewide Prosecution.

Wilzer Bruno
On or about October 19, 2021, Florida's Medicaid Fraud Control Unit, with the assistance of the Palm Beach County Sheriff's Office, arrested a Florida man for falsifying time sheets resulting in Medicaid fraud. The MFCU's investigation found that Wilzer Bruno, assigned to provide homemaker services to a disabled adult, submitted time sheets falsely claiming work and services that were not completed. The fraudulent time sheets caused the employer to bill Florida Medicaid more than $13,000 for services not rendered.

According to the MFCU investigation, Bruno falsified time sheets from March 17, 2020, to December 31, 2020. As a result, Bruno pled guilty to one count of Medicaid provider fraud more than $10,000; a second-degree felony, and grand theft $10,000 or more; a third-degree felony. Bruno was sentenced to five years' probation and must pay restitution of $13,648.96. The State Attorney's Office in the 19th Judicial Circuit prosecuted this case.

Roselande Baptiste
Florida's Medicaid Fraud Control Unit, with the assistance of the Fort Pierce Police Department, arrested a St. Lucie County home-health aide for Medicaid provider fraud. According to an MFCU investigation, Roselande Baptiste billed Medicaid for thousands of dollars' worth of personal support services that Baptiste did not provide.

MFCU received a complaint about Baptiste after the mother of a vulnerable adult could not secure respite care services. Upon further investigation, the mother learned that Baptiste continued to bill for services from April 1, 2020, until December 6, 2020, even after the mother requested to stop the services due to COVID-19.

Baptiste pled nolo contendre to one count of Fraud Swindle-Obtain Property under $20,000. She was sentenced to five years' probation and must pay $20,534.16 in restitution. This case was prosecuted by the Medicaid Fraud Control Unit cross-designated with the State Attorney for the Ninth circuit.

Angela Harper
The Florida Medicaid Fraud Control Unit announced the arrest of a Leon County woman for Medicaid Fraud. Angela Harper, owner of Harper's Heavenly Hands, LLC, a Home and Community Based Services provider, allegedly employed multiple persons with prior criminal convictions to provide direct care services to Medicaid recipients in North Florida. Harper billed Medicaid for the services provided by these employees despite them having failed background screenings.

Harper faced one count of Medicaid Fraud, a second-degree felony. Harper agreed to a pre-trial diversion program and was ordered to pay restitution of $23,856.45. The Attorney General's MFCU prosecuted the case through an agreement with the State Attorney's Office for the Second Judicial Circuit.

Sophia Cooks
The Florida Medicaid Fraud Enforcement Unit announced the arrest of Sophia Cooks, age 59, for defrauding the Florida Medicaid program. Following an investigation by the MFCU, Cooks was taken into custody with the assistance of the Leon County Sheriff's Office.

The Medicaid Fraud Control Unit's investigation revealed that Cooks fraudulently caused Medicaid to be billed for services that she unlawfully provided to Medicaid recipients under her niece's Medicaid Provider Number. Cooks was not authorized to provide Medicaid services because of her prior felony convictions.

Cooks is charged with 1 count of Grand Theft $750 or More, a third-degree felony. If convicted, Cooks faces up to 5 years in prison and $5,000 in fines.

The case will be prosecuted by the Attorney General's Medicaid Fraud Control Unit through a special agreement with the Second Circuit State Attorney.

Felicia Arnett
Florida's Medicaid Fraud Control Unit announced the arrest of the owner of a Home and Community Based Services provider company named Caring and Loving Hands Services, LLC. Owner, Felicia Arnett, a Gadsden County woman, paid ineligible employees more than $67,000 and fraudulently billed Florida Medicaid nearly $100,000. Since the company's inception in 2018, Arnett allegedly employed multiple persons who did not pass required background screenings due to prior criminal convictions.

Caring and Loving Hands Services, LLC employs individuals to do household chores and provide companionship to the elderly and adults with disabilities. Interviews with employees of the company exposed Arnett for overlooking failed requirements and screenings. Knowing employees were not eligible, Arnett still wrongly charged the Florida Medicaid program nearly $100,000.

Arnett was charged with one count of Medicaid Fraud, a first-degree felony, punishable by up to 30 years in prison and $600,000 in fines and restitution. The Attorney General's MFCU will prosecute the case through an agreement with the State Attorney's Office for the Second Judicial Circuit.

Diane Johnson
Florida's Medicaid Fraud Control Unit and the Jacksonville Sheriff's Office arrested a Duval County home health aide employee for falsifying time spent helping a disabled Medicaid recipient. According to the MFCU investigation, Diane Johnson did not provide any services to a disabled adult for five weeks, and instead sat in the car outside of the patient's home. Unable to care and clean the house due to a disability, the patient's home became a mess and Johnson refused to do the services required.

The investigation began when a social worker visited the house of the disabled adult and found Johnson sitting in the car outside. The social worker called Tamba Momorie, the owner of Tambolina Services Inc., the home and community-based service provider company that employed Johnson. Momorie drove to the home and found Johnson sitting in the car. After confronting Johnson, Momorie claimed that Johnson violently cursed and fled the scene and never returned—stealing the tablet the company provided.

Johnson faces one count of Medicaid fraud, a third-degree felony, and one count of grand theft, also a third-degree felony. If convicted, Johnson faces up to 10 years in prison and more than $25,000 in fines. Attorney General Moody's MFCU will prosecute this case with the State Attorney for the Fourth Judicial Circuit.

Charles Brown and Taquan Dozier
Florida's Medicaid Fraud Control Unit, with the assistance of the Ocoee Police Department and Winter Haven Police Department, arrested two Central Florida men for abusing a disabled adult. According to an investigation by MFCU, the group-home caregivers, Charles Brown and Taquan Dozier, kicked and slapped a patient during a power outage at a group home facility. A night-vision camera captured the assault in the dark.

Beechdale Group Home formerly employed the defendants as caregivers to the disabled residents. During a power outage, the victim became upset and began destroying the blinds at the facility. Surveillance video equipped with night vision showed Brown kick, and Dozier slap, the disabled adult, instead of employing approved de-escalation procedures.

Brown and Dozier each face one count of abuse of a disabled adult, a third-degree felony. The State Attorney for the Ninth Judicial Circuit will prosecute this case.

Kari Faye Luper
The Florida Medicaid Fraud Control Unit, with the assistance of the Hamilton County Sheriff's Office, arrested a former employee from a skilled rehabilitation center for exploiting a disabled senior. According to the investigation, Kari Faye Luper obtained the credit card of a vulnerable adult under her care and used the funds for personal benefit.

Luper worked as a housekeeping aide for Dolphin Pointe Health Center, a skilled nursing home and rehabilitation center that provides health care services, including occupational, physical and speech therapies. According to the investigation, Luper gained access to the disabled adult's credit card and used the card over the course of several days to make hundreds of dollars' worth of personal purchases.

Luper pled guilty to one count of criminal use of the personal identification, one count of exploitation of a disabled adult and one count of fraudulent use of a credit card. The MFCU prosecuted the case through an agreement with the State Attorney's Office for the Fourth Judicial Circuit. Luper was sentenced to fifty-four days incarceration, three years' probation, one hundred hours of community service and must pay $856 in restitution.

Gregory Marler
On or about May 17, 2022, Florida's Medicaid Fraud Control Unit arrested a man who used power of attorney to steal tens of thousands of dollars from an incapacitated senior. An investigation by the MFCU resulted in the Okaloosa County Sheriff's Office taking Gregory Marler into custody.

The MFCU investigation revealed that Marler obtained power of attorney rights from an elderly victim residing in a Medicaid-receiving facility, who lacked capacity to make financial decisions. Marler removed more than $40,000 through multiple withdrawals from the victim's personal bank account for personal use, including using the funds to partially pay off rent to a marina.

Due to Marler's actions, the victim owed more than $90,000 to the Medicaid treatment facility for patient services, along with back-property taxes for 2020. Instead of maintaining the house of the elderly victim, Marler left the house so unkempt there were maggots in the refrigerator. When the court held an estate sale for the abandoned property, Marler arrived—angry about the sale of his belongings stored in the home—and admitted to spending the victim's Medicaid money.

Marler faces one count of exploitation of an elderly person, a second-degree felony. If convicted, Marler faces up to 15 years in prison and $10,000 in fines. Attorney General Moody's MFCU will prosecute this case with the State Attorney for the First Judicial Circuit, Ginger Bowden Madden.

Twicka Jones
On or about October 21, 2021, the Florida Medicaid Fraud Control Unit, with the assistance of the Escambia County Sheriff's Office, arrested a former senior caregiver for abusing senior residents. According to the MFCU investigation, Twicka Jones, aka Tumicka Jones or Nikki Jones, pushed two elderly dementia residents resulting in them falling to the ground.

Jones worked at The Beacon at Gulf Breeze, a Medicaid receiving facility in Santa Rosa County. The MFCU investigation found video footage showing Jones aggressively pushing two elderly individuals to the ground. The first incident resulted in an elderly dementia resident bleeding from the back and head. The resident then had to be transported by ambulance for further care. Another video shows a confrontation with a separate dementia resident who may have tried to assist the first victim. Jones then pushed the second victim, who fell on their hip and back. The video then shows Jones stepping around the second victim and walking away without helping or requesting further care for the victim.

Jones is pled to one count abuse and one count battery on a person 65 or older. She was sentenced to 6 months in jail. Attorney General Moody's MFCU prosecuted the case through an agreement with the State Attorney for the First Judicial Circuit.

Shauney Rashaun Wilson
On October 1, 2021, the Florida Medicaid Fraud Control Unit, with the assistance of the Jacksonville Sheriff's Office, announced the arrest of a former mental health technician for abusing a disabled adult. Shauney Rashaun Wilson allegedly physically abused and caused injury to a disabled adult while under Wilson's care and supervision as an inpatient resident at Wekiva Springs Hospital.

According to the investigation, Wilson worked as a mental health technician for Wekiva Springs, a licensed hospital that provides behavioral health and substance use treatment to adults and senior adults. On Nov. 30, 2020, Wilson allegedly tackled a disabled adult into the patient's room and onto the floor. The following morning, during another confrontation, Wilson struck the same disabled adult in the head several times using a fist. A nurse heard screaming and then witnessed Wilson exiting the disabled adult's room, observing Wilson's clenched fists and swollen knuckles. The nurse found the disabled adult moaning in pain and observed blood inside the room. An ambulance transported the disabled adult to a general hospital to be treated for an abrasion and contusion to the forehead. Further investigation revealed that Wekiva Springs' surveillance systems captured both incidents on camera. Wekiva Springs subsequently terminated Wilson for the abusive actions.

Wilson pled guilty to two counts of abuse of a disabled adult, a third-degree felony punishable by up to five years in prison. He was sentenced to five years' probation and one hundred hours of community service. The Attorney General's MFCU prosecuted the case through an agreement with the State Attorney's Office for the Fourth Judicial Circuit.

Monique Mejia
Florida's Medicaid Fraud Control Unit, with the assistance of the St. Johns County Sheriff's Office, arrested a Florida woman for exploiting a senior. The MFCU's investigation found that Monique Mejia, entrusted as the senior's power of attorney, allegedly stole more than $12,000 from the elderly victim for personal benefit.

According to the investigation, Mejia obtained a durable power of attorney for the elderly victim. Abusing this authority, Mejia gained access to the victim's personal bank account and transferred more than $12,000 to a personal account. Mejia also took out a cashier's check to pay court costs in an unrelated matter, all while leaving the victim's health care expenses unpaid. Mejia's criminal actions prevented the victim from fulfilling financial obligations at the victim's residency and did not allow the victim to receive a proper burial after passing.

Mejia pled nolo contendre to one count of exploitation of an elderly person—a second-degree felony. She was sentenced to 5 years' probation and one hundred hours community service and must pay $12,140.72 in restitution.

Christina Hison, Linda Moore and Christopher Rodriguez Lazada
The Florida Medicaid Fraud Control Unit, with the assistance of the Orange County Sheriff's Office and Groveland Police Department, announced the arrests of three Metro Orlando registered nurses for aggravated abuse and neglect of a disabled adult. Christina Hison, Linda Moore and Christopher Rodriguez Lozada are accused of causing third-degree burns to a disabled adult.

According to the investigation, Hison, Moore and Rodriguez Lozada worked as registered nurses for Select Specialty Hospital Orlando North, a long-term care hospital in Orlando. In September 2019, the three provided care to a disabled adult suffering from hypothermia. Against hospital policy and established medical procedure, Hison, Moore and Rodriguez Lozada applied ice bags filled with hot water—allegedly from a coffee maker with a hot water dispenser—to the disabled adult's body in an attempt to counter the patient's hypothermia. The disabled adult was then left alone for at least two hours before another employee discovered that the victim sustained several third-degree burns. As a result, the patient required transportation to Orlando Regional Medical Center to undergo several skin-graft surgeries.

Hison, Moore, and Rodriguez Lozada each pled nolo contender to one count of Failure to Report Abuse. The Office of the State Attorney for the Ninth Circuit prosecuted the case.

Aariran Devore Batson
Florida's Medicaid Fraud Control Unit and the Jackson County Sheriff's Office arrested a former Sunland Center Pathways of Marianna employee for abuse of a disabled adult. Aariran Devore Batson allegedly threw a disabled resident out of the door of a dining hall and then slammed the resident into a gate multiple times before placing the resident in a headlock. Investigators with MFCU received information regarding the alleged abuse from the Florida Department of Children and Families, Adult Protective Services program.

According to the investigation, on May 25, 2021, the victim allegedly tried to use a phone at the Sunland Center campus to call the police. Batson began pulling on the disabled adult to stop the phone call and subsequently threw the victim out the door. After administering a headlock, Batson attempted to cover up his actions by cleaning up an elbow injury sustained by the victim.

Batson pled nolo contender to Breach of the peace, disorderly conduct. He was sentenced to 6 months' probation. The Attorney General's MFCU prosecuted the case through an agreement with the Office of the State Attorney, Larry Basford, in the 14th Judicial Circuit.

Jasmine Horne
Florida's Medicaid Fraud Control Unit and the Gadsden County Sheriff's Office arrested a former Florida State hospital employee for abuse of a disabled adult. Jasmine Horne allegedly taunted and then began to choke a disabled resident during an argument between them.

Investigators with the Medicaid Fraud Control Unit received information regarding the alleged abuse from the Florida Department of Children and Families, Adult Protective Services Program. Horne pled nolo contendre to one count of Breach of the peace. The Attorney General's MFCU prosecuted the case through an agreement with the Office of the State Attorney, Jack Campbell, in the Second Judicial Circuit.

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 2021-22, 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 $20,039,176. The total amount for criminal recoveries based upon Medicaid fraud cases was $61,757,506. The total amount of the monies recovered by the MFCU for FY 2022-21 was $81,796,682.

Training

MFCU continues to emphasize mission critical training to stay professionally current. During FY 2021-22, MFCU staff attended a total of 4,238 hours of training.

The Office of the Attorney General continued to offer many career and personal enhancement training opportunities via webinars, video conferences, and classroom settings. Law enforcement personnel continued to obtain most of their mandatory training for recertification online with the Florida Department of Law Enforcement (FDLE), free of charge. Other courses include CJIS Certification, Cognitive Interviewing Techniques and Misuse of Electronic Databases.

In-house training provided through a variety of delivery methods included courses such as NUIX Software and other OAG Annual Required Training. Classroom and range firearms qualification and Use of Force training was provided to our law enforcement personnel locally by MFCU certified instructors at no cost.

MFCU training in FY 2021-22 included Resident Abuse Training, Ensuring Accuracy of Specialty Drug Claims, Boot Camp for Health Care Fraud Investigators and Analysts and Picking Patients for Profit: Admissions Discrimination in Nursing Homes.

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, 2022, the MFCU has submitted 100 data mining projects to AHCA for review and approval. Of the 100 submitted, 72 were approved by AHCA. As of June 30, 2022, MFCU had 3 cases in an active status from these projects.

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 the following areas: Miami, Florida; Los Angeles, California; Detroit, Michigan; Houston, Texas; Brooklyn, New York; Baton Rouge and New Orleans, Louisiana; Tampa and Orlando, Florida; Chicago, Illinois; Dallas, Texas; Washington, D.C.; Newark, New Jersey/Philadelphia, Pennsylvania; New England; and the Appalachian Region.

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.

AGENCY FOR HEALTH CARE ADMINISTRATION

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

Highlights of actions by other bureaus in the Division of Health Quality Assurance and the Division of Medicaid follows the Medicaid Program Integrity overview and summary of activities.

Division Of Health Quality Assurance

The Division of Health Quality Assurance (HQA) protects Floridians through oversight of health care providers, including the regulation of 40 different types of health care providers through licensure and certification. HQA includes:

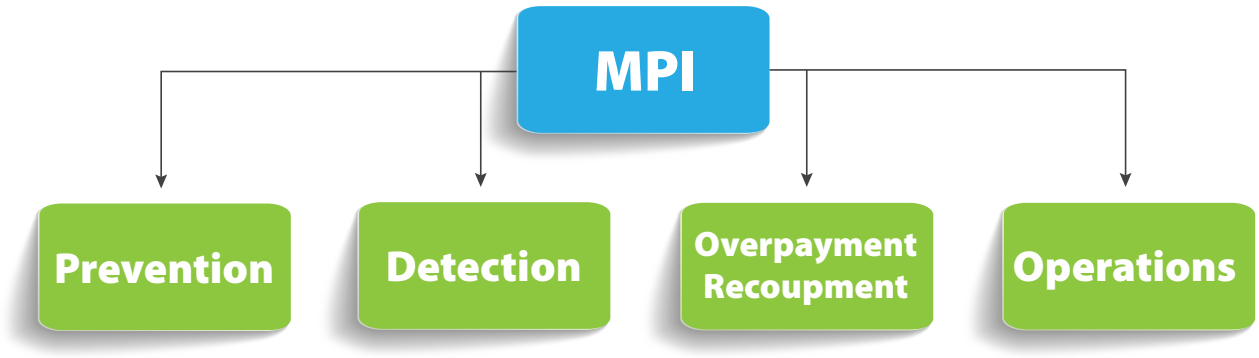
- The Bureau of Central Services, which includes the Care Provider Background Screening Clearinghouse.
- The Bureau of Field Operations is responsible for state licensure and federal certification surveys (inspections).
- The Bureau of Health Facility Regulation licenses, registers, regulates, and provides exemptions for certain providers, including assisted living facilities, hospitals, laboratories, home health care, and nursing home providers.
- The Bureau of Medicaid Program Integrity (MPI) continues to serve as the lead office to design, coordinate, and implement the Medicaid program's fraud, abuse, and waste prevention and detection efforts.
- The Florida Center for Health Information and Transparency collects, compiles, and analyzes health related data.
- The Office of Plans and Construction is responsible for safety, functionality, and regulatory compliance regarding the design and building of specific health care facilities.

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

Medicaid Program Integrity

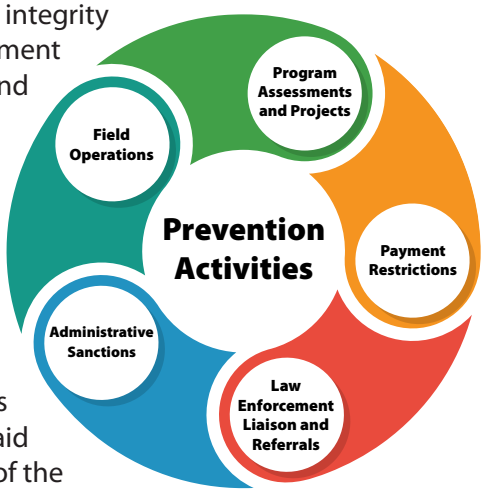
Overview

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



Prevention Activities

The Prevention Units are responsible for five main functions related to program integrity activities in Florida Medicaid: field operations, administrative sanctions, law enforcement liaisons and referrals, payment restrictions, and programmatic assessments and special projects.



Field operations are primarily conducted throughout South and Central Florida and continue to be a significant method of discerning if a provider is at their reported service location, operational, and properly participating in the program. Provider sanctions, which typically involve administrative fines and programmatic suspensions and terminations, are primarily handled by personnel in Tallahassee. Law enforcement activities include liaison activities with state and federal partners, particularly law enforcement agencies. Other prevention activities include ongoing MPI efforts to increase the quality and quantity of the Medicaid health plan referrals of suspected fraud to MFCU. Since the management of most of the managed care activities falls within the Detection Unit, other efforts related to the Medicaid Health Plans (MHPs) are described under the detection activities section of this report.

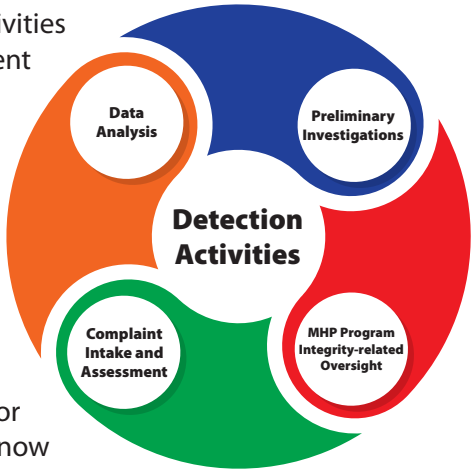
Payment restrictions include the "pending" of claims in the Medicaid claims processing system for one or more specific, legally authorized purposes. Payment restrictions used by MPI include:

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

Prevention activities are typically focused on provider types which are considered high-risk (for Medicaid fraud). MPI personnel continue to work closely with the Division of Medicaid, collaborating on known and anticipated program vulnerabilities with particular emphasis on those programs that are both high fraud risks as well as high priority programs and services.

Detection Activities

Fraud and abuse detection involves numerous methodologies and techniques that identify program vulnerabilities, threats, and risks to the Medicaid program. Detection activities continue to involve both the intake and assessment of complaints from a variety of sources, as well as the internal development of leads through data analysis. MHP program integrity-related activities are now also included in detection; although there are prevention and enforcement components to those efforts as well.



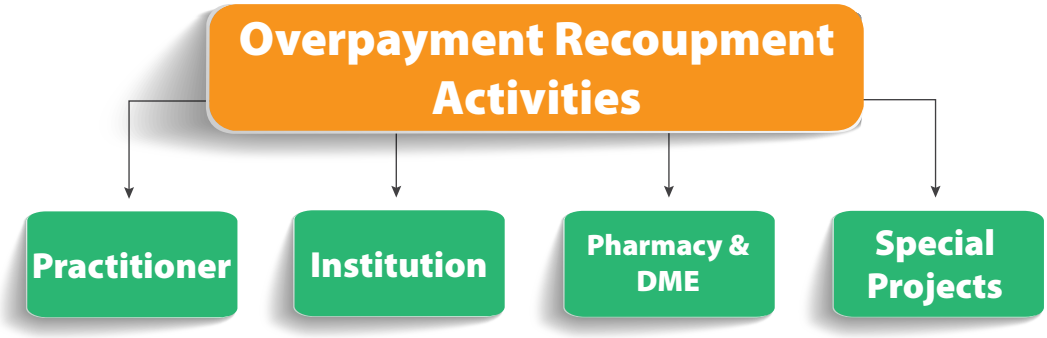
MPI continues to work toward increasing the complexity and depth of preliminary investigations. Particularly, MPI efforts strive toward fraud detection, as opposed to abuse or waste detection. During FY 2021-22, MPI received and assessed more than 2,600 complaints. Data detection, through internal MPI analytics assessing both claims-based, and non-claims-based indicators of fraud and abuse risks, continues to be a high priority for MPI. MPI personnel continue to develop complex queries and algorithms for use by MPI. During FY 2021-22, data detection was also a high priority for the Agency as it is developing new systems and tools for future use. The data analysis personnel within MPI are key to these efforts, both now and going forward.

Additionally, although MHP oversight related to program integrity includes elements of prevention, detection, and enforcement (e.g., overpayment recoupment) activities, these efforts are coordinated within the detection unit. In addition

to education and oversight related to the MHPs' program integrity efforts, MPI continues to receive the Suspected/ Confirmed Fraud and Abuse Reports (also referred to as 15-day reports) from the MHPs. These are the MHPs reports to AHCA of their investigations which have risen to the level of suspected (or confirmed) fraud or abuse. The fraud referrals are also concurrently sent to MFCU. During FY 2021-22, the MHPs made 321 referrals of fraud to MPI and MFCU and 931 referrals of abuse to MPI.

Overpayment Recoupment Activities

Overpayment recoupment activities are predominately carried out through three teams in MPI and organized according to the audited provider types. The Overpayment Recoupment Unit now includes an additional team for special projects. This team is responsible for processing Final Orders for MPI, receipt and processing of checks that come to MPI, and opening self-audit cases upon receipt of self-audit records and/or checks. In addition, the special projects team will also work with the other teams on projects when additional assistance is needed and will work with outside contractors coordinating and collaborating on various projects.



Audits determine if there has been noncompliance with Medicaid policy and identify overpayments for recovery. MPI audits fee-for-service (FFS) claims and managed care encounters (claims) where the MHP's are time limited by provisions of section 641.3155, F.S. Overpayments not properly reported to the Agency by the MHP for suspected fraud, abuse, or waste may also be recovered.

MPI continues to promote self-audits through sharing potential overpayment or billing errors with providers once a concern is identified. For example, if a single provider identified inappropriate billing and repays an overpayment, MPI may share this information with other like providers to determine if they may have a similar billing error. Providers who conduct a self-audit may subsequently avoid an MPI audit for the same billing error or overpayment issue, thereby potentially avoiding investigative costs and sanctions.

Overpayment Recoupment Activities Self-Audits			
	FY 2019-20	FY 2020-21	FY 2021-22
Self-Audits Completed	212	319	498
Overpayments Identified	$5,880,930	$2,924,821	$2,320,339

Operations Activities

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

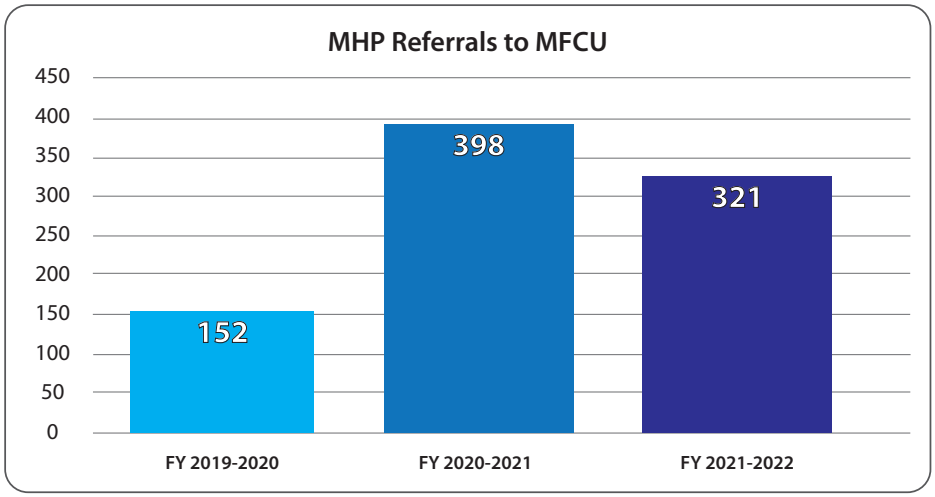
The Operations Unit also performs a function that involves the review of providers deemed noncompliant with repayment obligations by Financial Services. The reviews assist MPI in efforts to determine what further actions to take regarding the provider and whether the circumstances suggest that non-payment is due to a provider no longer being in operation. Pursuant to sections 409.907(12) and 409.908(26), F.S., the Agency may certify that a Medicaid provider is out of business. This certification renders the amount of the overpayment uncollectable for purposes of refunding the federal share of the overpayment but does not release the provider from liability of the debt. These activities result in savings to the state (for the returned federal share).

Operations Activities Certified Out Of Business	
Providers Reviewed	15
Certified Out of Business Adjustments	$2,960,304

Highlight's of MPI Activities for FY 2021-22

Referrals To/Interactions with MFCU

MPI interactions with MFCU relate both to the referrals that 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 that the MHPs make to MFCU. There have been ongoing efforts to emphasize the MHP referrals to MFCU each year. MPI has sought to ensure that the MHPs make a high volume of referrals to MFCU while also striving toward high-quality referrals.



MPI established benchmarks for each health plan and throughout the year monitors and educates the plans to assist them toward meeting the goal. The benchmark is a contractual provision and is referred to as a Performance Target.

The Performance Target is based on a combination of each MHPs number of enrollees, amount of capitation received from that Agency, and number of providers during July of each fiscal year. It is calculated by dividing the total number of plan enrollees on the July Monthly Enrollment Report by the number of unique providers in the plan's first submission of the July Provider Network Validation file; this amount is rounded to the ten thousandth's place, and then multiplied by a factor established by MPI based upon the total capitation payments for July. This amount is then rounded to the nearest whole number and serves as the subsequent year's Performance Target.

In FY 2021-22, which was the first full fiscal year of the MHPs having a contractually required Performance Target, the targets as calculated were:

FY 2021-22 Performance Target		
Health Plan Name	**Type**	**2021-2022 Mfcu Referral Goal**
AETNA BETTER HEALTH (COV)	MMA/LTC	30
AMERIHEALTH CARITAS (PRS)	MMA	15
CHILDREN'S MEDICAL SERVICES NETWORK (CMS)	SPEC	5
COMMUNITY CARE PLAN (NBD)	MMA	17
DENTAQUEST OF FLORIDA (DQT)	DENTAL	12
FLORIDA COMMUNITY CARE (FCC)	MMA/LTC	3
HUMANA MEDICAL PLAN (HUM)	MMA/LTC	70
LIBERTY DENTAL PLAN OF FLORIDA (LIB)	DENTAL	7
MANAGED CARE OF NORTH AMERICA (MCA)	DENTAL	5
MOLINA HEALTHCARE OF FL, INC. (MOL)	MMA/LTC	16
SIMPLY HEALTHCARE PLAN, INC. (SHP)	MMA/LTC/SPEC	46
SUNSHINE STATE HEALTH PLAN (SUN)	MMA/LTC/SPEC	35
UNITED HEALTHCARE OF FL, INC. (URS)	MMA/LTC	30
VIVIDA HEALTH (BST)	MMA	5
Total expected referrals:		**296**

During FY 2021-22, the MHPs made 321 referrals to MFCU; this figure is based only upon the referrals from the Statewide Medicaid Managed Care MHPs (and does not include other managed care programs, such as the Dual Special Needs Plans). This volume of referrals demonstrates the commitment to the identification of suspected fraud. In future years, MPI intends to more proactively work with the other managed care programs related to the Medicaid program, which may result in an increased overall target for MFCU referrals.

Behavioral Health Prevention Project

In the FY 2020-21 annual report, MPI reported on a Community Behavioral Health project related to providers billing the Medicaid program for behavioral health services. That MPI project was based, in part, on the high priority placed on mental health services and interest to mitigate fraud and abuse to allow funds to support valid/legitimate services. The project has continued throughout FY 2021-22.

Through the project, MPI has continued its fraud and abuse prevention efforts which include consultation with the Division of Medicaid about areas of vulnerability in the program. Through this consultation, MPI assisted in bringing several issues to the forefront of program operations.

One issue involved a previous allowance of specific services to be billed through the FFS program when the patients were assigned to Dual Special Needs Plans. This exception had been allowed to facilitate continuity of care for the patients. The end of this exception for specific codes (including two behavioral health codes that have been determined to be a high risk for fraud and abuse) is believed to have resulted in decreased costs for the program overall (both through FFS payments and managed care payments) because of a reduction in erroneous (fraudulent and abusive) billing. MPI's initial preliminary

project findings indicated abusive, if not suspected fraudulent, billing for these services for recipients who do not appear to have the requisite mental health needs to substantiate the billings. Many of the providers ceased billing altogether after the exception ended.

MPI efforts also resulted in the identification and correction of a claims processing system edit which had inadvertently allowed FFS payments for recipients in Statewide Medicaid Managed Care (SMMC). The FFS-SMMC portion of the larger behavioral health project includes more than 600 providers and millions of potential exposure. Additionally, the system edit was corrected to prevent further erroneous billing related to recipients assigned to managed care plans, resulting in avoidance of further program losses. The project remains ongoing (into FY 2022-23).

The project has included ongoing dialogue with the Division of Medicaid for changes in policy and enhanced enrollment protocols, as well as continued communication and referrals to state and federal law enforcement. The project has included payment restrictions for providers that, among the many bases, are found to be ineligible, billing abusively or fraudulently, are unable to be located at their service location, or are non-responsive to Agency requests for information. The project has also included numerous referrals to MFCU, HHS-OIG, or CMS for assistance with overpayment recoveries, either through administrative, civil, or criminal remedies. Although all these MPI activities are detailed elsewhere in this report, this project has created many opportunities for MPI. There has been an increase in on-site provider visits, identification of ineligible providers, identification of non-operational providers, and numerous payment restrictions and law enforcement referrals; more than 200 payment restrictions and more than 50 law enforcement referrals.

While the project has continued into the subsequent fiscal year, the identified schemes remain fairly consistent in that often the billing is related to services which may not have been rendered at all or services which were not compensable services but billed as if they were (in other words, an activity that would not be reimbursed under the program may have occurred, but then was billed as if it was another activity or service that Medicaid covers; an ongoing scheme that is actively being investigated involves billing for social gatherings as if they were therapy sessions). Other schemes identified are suggestive of more significant criminal activity that does not fall within the purview of MPI's administrative activities but do form the basis for continued research and referrals to law enforcement. Such schemes include potential financial improprieties such as money laundering, payments to recipients and providers to participate in the scheme, the use of straw owners, and efforts to avoid detection of disbursement of funds.

Advanced Payment Projects

The advanced payment projects were implemented by MPI in FY 2020-21 and completed during FY 2021-22. A discussion of the project was included in the MPI portion of the FY 2020-21 annual report, Florida's Efforts to Control Medicaid Fraud and Abuse.

In response to the COVID-19 public health emergency, the Centers for Medicare and Medicaid Services (CMS) authorized retainer payments by the Agency to providers who render certain services under the Developmental Disabilities Individual Budgeting (iBudget) Waiver. Providers were directed to continue to render those services and either accept the monthly advanced payment in full or return the full advanced payment to the Agency; providers accepting the advanced payment were directed not to bill for those services for the month in which the advanced payment was made. Providers could choose to "opt out" of the advanced payment and continue to bill all services that were rendered. Overpayments were identified for those providers who accepted the advanced payments and continued to bill for the services it covered.

MPI opened over 1,200 cases to recover those overpayments identified by the Division of Medicaid for the months of April through July 2020. The projects included cost avoidance by providers voiding erroneous claims totaling more than $4 million. Recovery activities for repayment of claims or the advanced payment have exceeded $15 million. In total, the projects resulted in cost avoidance/recoveries of over $19 million.

FY 2020-2022 Totals for Advanced Payment Projects	
Repayment Method	**Amount**
Advanced Payment Returned	$ 9,444,810
Voided Claims	$ 4,440,172
Repayment of Claims	$ 5,726,210
Total	**$ 19,611,192**

Hospice Patient Responsibility Project

In August 2019, MPI received a letter from the Florida Hospice & Palliative Care Association regarding a potential recoupment of overpayments from the Hospice providers for patient room and board services where they failed to adjust the payment for patient responsibility. As a result, MPI created a self-audit opportunity for the Hospice providers to review their claims for any overpayments for patient responsibility payables. The Hospice Patient Responsibility project generated $751,807.77 in repayments to MPI during FY 2021-22.

Community Behavioral Health Services Audits

As described elsewhere in this report, MPI's Detection and Prevention Units have engaged in a focused efforts to look at provider type 05-Community Behavioral Health Services providers and focused the efforts on CPT code H2017 - psychosocial rehabilitation services (PSR). Through these efforts, overpayment recovery audits have been identified. Audits have been initiated to determine if FFS payments made to providers were incorrectly billed. The Overpayment Recoupment Unit is conducting audits to recover the overpayments. During FY 2021-22, identified overpayments from this project were $14,492,264.94. Audits remain ongoing.

Pharmacy Improper Payments

In addition to comprehensive claim reviews, this fiscal year's overpayment recovery efforts included a recoupment of improper payments made for prescription legend drugs and devices. Over $600,000 was recovered for FFS and crossover claims involving: J-code duplicate payments, overbilled quantity payments, payments for malfunctioning legend devices, payments resulting from the improper use of modifiers, and payments on overlapping legend devices.

Medicaid Health Plan Monitoring Reviews

During FY 2021-22, as a part of what is commonly referred to as the MHPs' annual monitoring, MPI reviewed three (3) areas or items related to program integrity efforts for each of the MHPs awarded a contract for the 2018-2023 SMMC Contract and the 2018-2023 Dental Contract. Reviews included topics such as policies and procedures related to the processes of their preliminary investigation process for complaints of fraud or abuse and how each plan systematically imposed individual provider payment suspensions as is contractually required. The preliminary results were issued to the plans at the time of this report. Preliminarily, nine of fourteen plans met the expectations related to their preliminary investigation process and seven of fourteen plans met the expectations related to the provider payment suspensions.

Collaboration With Outside Contractors

Another opportunity for MPI to increase prevention, detection, and overpayment recoveries includes working with low-cost (or even no-cost) vendors to supplement MPI efforts. Particularly through collaboration with the Division of Medicaid and the Agency's third-party liability (TPL) vendor, as well as the Centers for Medicare and Medicaid Services (CMS) and their Unified Program Integrity Contractor (UPIC), MPI has realized additional overpayment recoveries and expanded investigative capabilities. During FY 2021-22, MPI continued to use these resources predominantly for audits (overpayment recoveries) but also initiated discussions with both vendors to include preliminary investigations of potential fraudulent provider behavior. Use of these contractors allows MPI to increase its efforts and maximize the program integrity benefits for the state of Florida.

Third Party Liability (TPL) Support to MPI

The Agency's TPL contractor, Health Management Systems, Inc, continues to provide audit support to MPI under contract provisions of "Other Recovery Projects." The FY 2021-22 total recovery associated to TPL support is $44,880,474.06, the highest recovery total since FY 2013-14. This is a notable accomplishment when contrasted to the average annual recovery of $19,049,074.77, of the preceding seven years. This success is largely due to an increase in audit recovery projects. These are FFS paid claim recoveries making this achievement even more notable, given Medicaid's transition of recipient services to Managed Care that are paid as encounter claims. MPI and TPL are collaborating to develop audit protocols for encounter claim payments.

UPIC Contract

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

Utilizing the UPIC to perform additional audits and investigations maximizes MPI's resources. During FY 2021-22, through the work of SGS, MPI accomplished more audits, some more complex, including a one-day stay audit utilizing claim samples and extrapolation to review records for medical necessity for certain inpatient stays. The state recovered $797,564.09 by utilizing the resources of SGS, with collaboration and consistent communication with MPI.

Fraud and Abuse Schemes

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

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

Program Integrity Interventions

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

- On-site visits and interviews with providers, provider employees, and recipients.
- Sanctions which may include administrative fines, and termination or suspension from participation in the Medicaid program.
- Payment restrictions which include prepayment reviews (s. 409.913(3), F.S.), payment suspensions (42 CFR 455.23), and payment withholds (s. 409.913(25)(a), F.S.).
- Referrals to other entities including law enforcement (MFCU and HHS-OIG) as well as other state agencies with regulatory oversight or enforcement authority.
- Consultation with the Division of Medicaid about program safeguards.
- MPI-Conducted Overpayment Audits.
- Vendor-Assisted Overpayment Audits.
- Compliance and program integrity-related oversight of MHPs, including recommendations for liquidated damages or sanctions (against the MHPs).
- Litigation support for overpayment audits, sanctions, and criminal prosecutions.

Other MPI Activity Data

The following reflects several of the MPI activities.

MPI Referrals to Others			
	FY 2019-20	FY 2020-21	FY 2021-22
Agency for Persons with Disabilities	10	4	9
Department of Children and Families	176	12	5
Department of Health	16	10	16
Department of Health and Human Services – Office of Inspector General	-	22	10
Department of Public Assistance Fraud	-	117	97
Division of Medicaid	13	269	14
Division of Health Quality Assurance (Licensure)	190	131	144
Medicaid Fraud Control Unit – Attorney General	84	33	76
SafeGuard Services (CMS)	-	5	34
Total	**489**	**603**	**405**

Provider Sanctions and Medicaid Health Plan Assessments			
	FY 2019-20	FY 2020-21	FY 2021-22
Fines	186	89	67
Suspensions	50	27	41
Terminations	33	96	95
Health Plan	3	2	7
Total	**272**	**214**	**210**

Recovery Activities – Identified Amounts			
	FY 2019-20	FY 2020-21	FY 2021-22
Overpayments (MPI/MPI-CMS Audits)	$29,926,776	$19,198,102	$22,764,935
Costs	$114,638	$97,758	$26,037
Fines	$2,541,756	$387,402	$687,123
Paid Claims Reversals	$82,949	$4,150,361	$388,479
MHP Assessments	$117,750	$98,500	$129,300
Certified Out of Business Adjustments	$1,891,589	$5,300,691	$2,960,304
Total	**$34,675,458**	**$29,232,814**	**$26,956,178**

Prevention of Overpayments			
	FY 2019-20	FY 2020-21	FY 2021-22
Denied Claims (PPRs, 25A, CAF) Impact	$4,564,966	$7,123,651	$3,885,097
Termination of Providers Impact	$14,233,151	$633,693	$598,126
Program Suspensions Impact	$358,918	$6,490,366	$593,772
Denial of Reimbursement for Prescription Drugs	-	$10,122,775	$951,231
Site Visits Impact	$4,313,959	$1,799,891	$24,709,888
Sanctioned Providers Impact	$32,190,511	$81,979,476	$2,462,460
Audit Impact	$42,185,937	$131,855,355	$101,735,293
PPR and 25(A) Impact	$119,186,922	$13,934,407	$30,172,734
MFCU Referrals Impact	$14,291,269	$561,749	$6,163,143
Total	**$231,325,633**	**$254,501,363**	**$171,271,744**

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

Return on Investment (ROI)				
		FY 2019-20	FY 2020-21	FY 2021-22
Benefits	Recovery	30.92	28.44	56.54
	Prevention	234.12	254.50	171.27
	Total	**265.04**	**282.94**	**227.81**
Costs	Recovery	5.21	4.36	9.46
	Prevention	3.94	3.84	4.40
	Total	**9.15**	**8.21**	**13.86**
ROI Ratio	Recovery	5.94:1	6.52:1	5.97:1
	Prevention	59.43:1	66.23:1	38.90:1
	Total	**28.96:1**	**34.47:1**	**16.43:1**

OTHER HQA BUREAUS (NON-MPI)

Care Provider Background Screening Clearinghouse

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

The Clearinghouse also includes a RapBack requirement, also known as "retained prints," which enables immediate notification to the Agency of the recent arrest of an employee to determine if the arrest affects access to vulnerable clients. The Clearinghouse also notifies providers of an arrest and prompts the Provider to check eligibility. The immediacy of notification through RapBack improves the Agency's response time in prevention of Medicaid fraud. The Clearinghouse also provides the ability to keep an employee roster. Facilities are required to maintain a current employee roster, with updates to be made within 10 business days of a change, including a new hire, termination, or position change. With this requirement, the Agency can know immediately when a facility has employees who are not eligible on their roster and take action against the facility if it does not comply. From Clearinghouse implementation to the end of FY 2021-22, the Agency has imposed 661 background screening violations and 348 employee roster violations.

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

During FY 2021-22, the Background Screening Unit processed 25,489 RapBacks. Of these, nearly seventy percent were found to be for criminal charges that resulted in the applicant's eligibility status being updated to not eligible. During FY 2021-22, 216,756 background screening results were shared among participating agencies and Medicaid health plans (MHPs) and 91,820 renewal screenings were requested resulting in an overall cost savings of $19,286,760 to Agency providers, DOH licensees, MHPs, Medicaid providers, DCF, DOEA, DOEVR, and APD providers.

Licensure Protections Senate Bill 1986 Reporting

In 2009, the Legislature passed Senate Bill (SB) 1986 addressing regulatory reforms and fraud and abuse prevention. From January 2010 to June 2016, the Agency submitted a monthly report on the implementation of the provisions of SB 1986 as requested by the Senate Committee on Health Regulation, with a calendar year 2016 report submitted in early 2017. Much of the information contained in the SB 1986 reports is already published in this report. Additionally, with the implementation of Statewide Medicaid Managed Care (SMMC), MPHs are now responsible and accountable for monitoring functions for their members, which was previously reported through home health monitoring projects for FFS recipients in the SB 1986 monthly report. To avoid duplication, the Agency has discontinued separate SB 1986 reports and instead included any information not already included in this report. The Agency reports the following information for FY 2021-22:

- **Home Health Agencies** – Home Health Agencies which have demonstrated a pattern of billing the Medicaid program for medically unnecessary services, have either received an administrative penalty for violating s. 400.474(6)(e), F.S., or denied a renewal application based on the provisions of s. 400.471(8), F.S. In FY 2021-22, no home health agencies were identified to have met these criteria.
- **Remuneration Complaints** - Complaints received against nurse registries for providing remuneration in violation of s. 400.506, F.S. There were none identified in FY 2021-22.
- **Nonimmigrant Aliens** - Nonimmigrant aliens who have applied for a home health agency, home medical equipment, or health care clinic license, and met the requirements of s. 408.8065, F.S. Nine applicants met these criteria in FY 2021-22.

- **Financial Requirements** - There were 34 home health agency applications, 35 home medical equipment applications, and 41 health care clinic applications in FY 2021-22 that failed to meet the financial requirements of s. 408.8065, F.S. This includes applicants that did not reply to omissions related to proof of financial ability to operate during the application process.
- **Revocations and Terminations** - Providers that were revoked, denied a renewal application, or surrendered their license based on a Medicare or Medicaid suspension, termination or exclusion from either program related specifically to fraud based on the provisions of s. 408.815(1)(e) and s. 408.815(4), F.S. No providers met this criteria in FY 2021-22.

Final and Emergency Orders

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

Licensure Final and Emergency Orders					
	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22
Denying the renewal application	57	25	36	30	37
Revoking an existing license	24	20	14	14	25
Emergency orders	16	15	15	11	12
Provider surrendering their license	9	4	11	23	7
Total	**106**	**64**	**76**	**78**	**81**
Imposed Fines and Administrative Fees	$2,247,434	$3,017,176	$4,014,291	$5,703,887	$8,268,978

DIVISION OF MEDICAID

The Division of Medicaid administers the Florida Medicaid program, a more than $38 billion state and federal partnership that provides for health care to more than 5.5 million recipients in Florida. The Division is responsible for overseeing the management and operation of a broad range of health care services offered through Medicaid to low-income families, the elderly, and people with disabilities. Medicaid expenditures are almost a third of the state budget. The rapid growth in enrollment and costs has made it increasingly important to find ways to manage the diverse needs of the Medicaid population while also being able to better predict and plan for cost increases. Although MPI takes a lead role in fraud and abuse mitigation efforts, the Division has implemented many safeguards and continues to ensure that fraudulent and abusive behavior occurs to the minimum extent possible.

Medicaid's roles and responsibilities have been evolving since it moved away from a completely fee-for-service (FFS) program and particularly through the implementation of the Statewide Medicaid Managed Care (SMMC) program in 2013 and 2014. SMMC brought significant program changes to Medicaid resulting in improved efficiency, cost predictability and accountability for the program, and enhanced services to recipients.

Upon full implementation of the SMMC program in August 2014, responsibilities such as prior authorization, utilization management, and program and provider monitoring that occurred under FFS became primarily the responsibility of the health plans. The transition of Medicaid to a predominantly managed care program provided the Agency the opportunity to place more emphasis on improving quality and access and focus more efforts on monitoring activities which directly impact the Agency's efforts in combatting potential fraud and abuse in the Medicaid program.

During FY 2018-19 Medicaid completed re-procurement of the SMMC health plans for the next five-year period as well as procuring separate Dental plans as required by the Florida Legislature. Where the original SMMC program had both an MMA and LTC plans (with dental services provided through the MMA plans), under the current contract period, all plans provide MMA services to their enrollees and any enrollee with both LTC and MMA service needs receives all of their care from one plan.

The Agency requires MMA and LTC Dental plans to ensure continuous improvements in quality of care. This is particularly important for Dental plans so that access to dental services under the Medicaid program continues to have the significant upward trajectory reflected under the prior integrated model. In the current contract period, Dental plans provide a rich adult dental benefit through expanded benefits and are responsible for providing dental services to all eligible members.

In addition to requiring the continuous quality of care improvements, the health plans are required to engage in robust program integrity efforts and are held to high standards of service, quality, and transparency. These requirements include enhanced provider networks, which help ensure that Medicaid recipients can conveniently, and quickly access health care services and serves to mitigate fraud and abuse. To assist health care providers there are enhanced standards for claims processing, prior authorization, enrollee/provider help line, and call center operations. These increased standards help ensure provider and recipient satisfaction are high and that care provided is of the highest quality possible.

The Division of Medicaid has adopted a strategic approach to combatting fraud and abuse. Implementation of the SMMC program allowed the Agency to adopt a 'ground up' approach to combat fraud and abuse by embedding control efforts into the contractual and operational structure of the program. These strategic control efforts are focused in four key areas including Provider Enrollment/Review, Fraud and Abuse Related Reporting Requirements, Provider Outreach and Education, and Utilization Management.

I. Provider Enrollment/Review

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

II. Fraud And Abuse Related Reporting Requirements

Health plans in Florida Medicaid have comprehensive reporting requirements related to every phase of their operations. These reports allow the Agency to monitor not only provider networks, but also monitor several important phases of care provided by the plans. These reports help the Agency ensure that care provided to Medicaid recipients is medically necessary and appropriate, while ensuring cost-effectiveness and preventing inappropriate utilization.

Plans are required to report their Provider Network File, Provider Termination File, and New Provider Notification Report weekly. These reports supply the Agency with up-to-date provider network information including information on the suspension, termination, or withdrawal of providers from participation in the plan's network. This allows the Agency to monitor plans' compliance with required provider network composition, provider-to-member ratios, and allows for other uses deemed pertinent. Plans are required to provide pre-notification to the Agency within five days of detection of any suspected fraud and abuse activity by a provider or enrollee, with a report due to the Agency within 10 days. The report must contain detailed information on the nature of the fraud and abuse. Plans must also provide quarterly and annual fraud and abuse activity reports.

Since SFY 2020-21, managed care and dental plans must achieve or exceed an Agency-specified performance target for the reporting of suspected provider fraud cases to the Medicaid Fraud Control Unit each State fiscal year (SFY) following the processes outlined in the contract and associated federal and state regulations. The Agency's Bureau of Medicaid Program Integrity calculates each plan's performance target each state fiscal year.

III. Provider Outreach And Education

Communication and understanding are key elements in helping to prevent fraud and abuse. Understanding how the program works, the roles and responsibilities of all participants, and what the rules and regulations are that govern the program, can help significantly reduce errors, misunderstandings, and problems that can lead to fraud and abuse. Medicaid offers many educational resources to providers and, as part of the contractual agreement with all health plans, the plans are responsible for providing education and training to their network providers to prevent fraud and abuse and have a monitoring plan in place for fraud prevention.

Medicaid maintains a Provider Services portal on its website to assist providers with the many facets of navigating the Medicaid system. This includes a Provider Enrollment Help Line, registration for local trainings, and information on filing claims and many other reference materials.

Additionally, the health plans are required to provide education and training to ensure providers in their provider network understand all required performance criteria.

IV. Utilization Management

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

Programs to manage health care utilization have existed for more than 20 years. Early efforts focused on reducing the number of inpatient hospital admissions and eliminating unnecessary hospital days. In order to achieve this objective, health plan administrators reviewed the hospital admission for medical necessity prior to the admission and determined the need for ongoing care. As health care has grown more complex, the need for utilization management has expanded beyond hospital stays to include almost every facet of health care, though the basic principles of prior authorization and utilization monitoring are still key components of an overall utilization management approach.

Florida Medicaid has historically employed several methods for utilization management including: several disease management initiatives and programs, a pharmaceutical Preferred Drug List, prior authorization of certain services, Medicaid claims analysis, Electronic Visit Verification for Behavior Analysis and Home Health services, as well as independent research to assess policy implementation and program performance. Under the SMMC program, most of the responsibility for utilization management belongs to the Medicaid health plans. However, the Agency continues to have a significant role in monitoring plan activities and overseeing its vendors who provide utilization management for the remaining FFS population.

Prior authorization is a utilization control that many insurers and health care programs like Medicaid employ to determine member eligibility, benefit coverage, medical necessity, location, and appropriateness of services, as well as ensuring that care being provided is necessary and appropriate. Similar to, but distinct from, utilization management, prior authorization requires a provider to obtain permission prior to implementing a treatment plan which is different from accepted practice, or where a more expensive or resource intensive treatment alternative is being requested over other readily available treatment options. A frequent use of prior authorization is in pharmacy programs where a provider must often obtain authorization for use of an expensive brand name drug over a generic equivalent.

STATUTORY REPORTING REQUIREMENTS

Number Of Cases Opened And Investigated

MFCU opened 312 cases and had 1,133 active cases in FY 2021-22. MPI investigated 2,035 cases, which included 1,215 opened during the year.

SOURCES OF THE CASES OPENED				
	MFCU		AHCA	
Source	Fraud	PANE	MPI	Total
AHCA - Division of Medicaid				
AHCA - Financial Services			25	25
AHCA - Heath Quality Assurance			11	11
AHCA - Medicaid Fiscal Agent Operations			24	24
AHCA - Medicaid Program Integrity (MPI)	9			9
AHCA - MPI Detection			77	77
AHCA - MPI Institutional			42	42
AHCA - MPI Jacksonville/Orlando/ Tampa			7	7
AHCA - MPI Managed Care Unit			2	2
AHCA - MPI Miami			3	3
AHCA - MPI Pharmacy			33	33
AHCA - MPI Practitioners Care			6	6
AHCA - MPI Prevention Strategy			123	123
AHCA – Other Bureaus or Divisions			2	2
APD - Agency for Persons with Disabilities	5			5
APS - Adult Protective Services		102		102
Citizen	14			14
Centers for Medicare & Medicaid Services			1	1
CMS Contractor			1	1
DEA - Drug Enforcement Agency				
DOH - Department of Health			1	1
DOJ - Department of Justice	1			1
Detection Tool – Ad Hoc Report			26	26
Employee	8			8

EOMB			1	1
Family Member	9	1		10
FBI - Federal Bureau of Investigation				
FDLE - Florida Department of Law Enforcement				
Florida - Medicaid Fraud Control Unit			12	12
Florida - Other Agencies	2		2	4
Generalized Analysis				
Health & Human Services Inspector General	13			13
Internet/Media			5	5
Investigator Initiative			199	199
Law Enforcement Agency	1			1
Mail/Email			3	3
Managed Care Provider				
Managed Care Special Investigations Unit	74			74
Medicaid Provider	4			4
Medicaid Recipient	1	1		2
MFCU Other than Florida				
MFCU Data Mining Initiative	3			3
NAMFCU - National Association of MFCU				
Non-Profit Organization	1			1
Online Complaint Form			26	26
Other			1	1
Previous File or Case			9	9
Projects			274	274
Qui Tam	51			51
Random Audits			1	1
Self-Audit			575	575
Site Visits			5	5
Spinoff Case	11			11
USAO US Attorney's Office	1			1
Total	208	104	1,497	1,809

DISPOSITION OF THE CASES CLOSED				
	MFCU		AHCA	
Case Type	Fraud	PANE	MPI	Total
Administrative Closure	5	1		6
Administrative Referral	38	29		67
Assistance to Other Agencies				
Bankruptcy				
Case Dismissed	18			18
Certified Out of Business - Validated			15	15
Change of Ownership (CHOW)			2	2
Civil Intervention Declined				
Civil Settlement	26			26
Consolidated	5	4		9
Conviction	20	16		36
Death of the Offender	1	2		3
Defendant Deceased				
Facts Alleged Not indicative of abuse/neglect		4		4
Facts Alleged Not Indicative of Exploitation		4		4
Fines Issued			9	9
Info Previously Referred to Other Law Enforcement Agency	1	1		2
Investigated by Another Law Enforcement Agency	6	4	3	13
Lack of Evidence	44	34		78
Liquidated Damages Applied			7	7
Liquidated Damages Not Applied			1	1
Medicaid Fraud Control Unit - Accepted			34	34
Medicaid Fraud Control Unit - Declined				
No Abuse			3	3
No Auditable Review Period			1	1
No Findings			5	5
Nolle Prosequi				
No Further Action Required			263	263

Not a Medicaid Provider	2			2
Not an Overpayment Issue				
Not Sustained			6	6
Pre-Trial Intervention	2	2		4
Project Completed			12	12
Prosecution Declined		4		4
Provider Education			13	13
Provider No Longer Operational			20	20
Provider Suspended			41	41
Provider With Cause Termination			95	95
Provider Without Cause Termination			7	7
Referred			99	99
Resolved with Intervention	10	5		15
Statute of Limitations Expired	1			1
Suspension Lifted			11	11
Sustained			748	748
Unfounded	14	18		32
Unsubstantiated	29	40		69
Vacated Termination			1	1
Voluntary Dismissal	57			57
Voluntary Termination			1	1
Total	**279**	**168**	**1,397**	**1,844**

Amount of overpayments alleged in preliminary and final audit letters

Preliminary	Final
$11,499,419	$4,115,244

Number and amount of fines or penalties imposed
During FY 2021-22, MPI imposed fines (under s. 409.913, F.S., and Rule 59G-9.070, F.A.C.) in the amount of $687,123.

Reductions in overpayment amounts negotiated in settlement agreements or by other means
During FY 2021-22, there were no reductions in overpayments through negotiated settlements by MFCU and the Agency's final settlements resulted in no reductions of overpayments in closed cases.

Amount of final Agency determinations of overpayments
MPI identified overpayments in the amount of $22,764,935 in closed audits.

Amount deducted from federal claiming as a result of overpayments
Federal requirements allow the state up to one year to return the federal share through federal cost share adjustments of overpayments. To ensure federal shares are allocated as timely as possible, the Agency reports the federal portion of the total overpayment on the next available federal CMS-64 quarterly report and reduces a corresponding federal share draw. During FY 2021-22, the Agency reduced its federal share, on quarterly cost reports, by $18,545,001 for net overpayments.

Amount of overpayments recovered
MFCU collected $1,192,486 in overpayments that were returned to the Agency. Additionally, MFCU collected $8,219,880 in Federal Medicaid overpayments that were sent directly to the United States Department of Health and Human Services for a total of $9,412,366 in Medicaid overpayments collected in FY 2021-22. Overpayments recovered as a result of the MPI, and MPI-CMS audits were $8,185,552. Total recoveries by MPI, MPI-CMS, and MPI-TPL for FY 2021-22 were $53,454,506 (This includes collections of overpayments, fines, costs, and paid claims reversals during the fiscal year).

Amount of cost of investigation recovered
During FY 2021-22, the MFCU collected $6,945 in program income investigative costs. MFCU also collected $4,409 in state share investigative costs and $16,240 in federal share investigative costs for a grand total of $27,594 for all investigative costs.

All costs associated with discovering and prosecuting cases of Medicaid overpayments and making recoveries in such cases
MFCU expenditures for FY 2021-22 were $19,600,286 which included indirect costs of $2,274,790.

Average length of time to collect from the time the case was opened until the overpayment is paid in full
The average length of time for MPI cases open in any fiscal year to subsequently being paid in full during FY 2021-22 was less than 1 year (0.19).

Amount determined as uncollectible, and the portion of the uncollectible amount subsequently reclaimed from the Federal Government
During FY 2021-22, the Bureau of Financial Services deemed $53,233,096 as uncollectible.

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

Summary by Denial Reason	Totals
Previous Program Termination	31
Best Interest of The Program	835
Total	**866**

Denials by Provider Type	Totals
05 - Community Behavioral Health Services	38
07 - Specialized Therapeutic Services	14
14 - Assistive Care Services	10
20 - Prescribed Drug Services	6
24 - Prescribed Pediatric Extended Care (PPECC)	5
25 - Physician (M.D.)	68
26 - Physician (D.O.)	4
30 - Advanced Practice Registered Nurse (APRN)	10
32 - Social Worker/Case Manager	12
35 - Dentist	3
39 - Behavior Analysis	513
41 - NON-Emergency Transport	1
45 - Private Transportation	1
65 - Home Health Services	30
67 - Home & Community-Based Services Waiver	37
81 - Professional Early Intervention Services	8
83 - Therapist (PT, OT, ST, RT)	16
89 - Dialysis Center	1
90 - Durable Med Equipment/Medical Supplies	2
91 - Case Management Agency	85
99 - Trading Partner	2
Total	**866**

Additionally, 150 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	48
Criminal History	102
Total	**150**

Denials by Provider Type	Totals
05 - Community Behavioral Health Services	18
07 - Specialized Therapeutic Services	4
12 - Private ICF/DD Facility	1
20 - Prescribed Drug Services	2
23 - Medical Foster Care/Personal Care Provider	1
25 - Physician (M.D.)	16
26 - Physician (D.O.)	1
29 - Physician Assistant	5
30 - Advanced Practice Registered Nurse (APRN)	36
35 - Dentist	6
39 - Behavior Analysis	20
40 - Ambulance	1
41 - NON-Emergency Transport	2
50 - Independent Laboratory	3
61 - Hearing Aid Specialist	3
65 - Home Health Services	10
67 - Home & Community-Based Services Waiver	8
83 - Therapist (PT, OT, ST, RT)	7
90 - Durable Med Equipment/Medical Supplies	4
91 - Case Management Agency	2
Total	**150**

Finally, there were 278 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	87
Terminated - Adverse Association	191

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

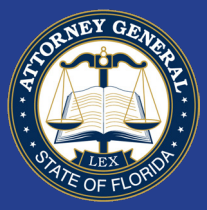
The following charts reference the number of providers by total and by type that were terminated from the Medicaid program due to considerations or factors that are of a program integrity nature. These figures represent both contractual and sanction-based terminations due to suspected fraud and abuse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

Summary by Termination Type	Totals
Contractual Termination Under Medicaid Authority	232
With-Cause Termination Under Medicaid Final Order	102
Total	**334**

Terminations by Provider Type	Totals
05 - Community Behavioral Health Services	99
07 - Specialized Mental Health Practitioner	5
10 - Skilled Nursing Facility	1
14 - Assistive Care Services	7
20 - Prescribed Drug Services	2
25 - Physician (M.D.)	22
26 - Physician (D.O.)	2
30 - Advanced Practice Registered Nurse (APRN)	2
32 - Social Worker/Case Manager	6
35 - Dentist	1
39 - Behavior Analysis	120
50 - Independent Laboratory	1
65 - Home Health Services	16
67 - Home & Community-Based Services Waiver	23
83 - Therapist (PT, OT, ST, RT)	5
90 - Durable Med Equipment/Medical Supplies	3
91 - Case Management Agency	19
Total	**334**

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

The routine communication between MPI, the Division of Medicaid, and others within the Agency concerning Agency policy changes to improve detection, prevention, investigation, and audit capabilities regarding Medicaid fraud and abuse continued to be a priority. As such, MPI will continue to collaborate with the Division of Medicaid and utilize Agency processes to enhance Medicaid fraud and abuse prevention and detection efforts.



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