The State's Efforts to Control Medicaid Fraud and Abuse

FY 2017-18

December 20, 2018

The Honorable Rick Scott
Governor
PL-05 The Capitol
400 South Monroe Street
Tallahassee, FL 32399-0001

Dear Governor Scott:

Pursuant to Section 409.913, Florida Statutes, enclosed is the annual report of the activities related to the fight against fraud and abuse in the Medicaid program for the FY 2017-18. 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. Although many of the investigational details must remain confidential, both the Agency and MFCU have focused efforts in recent years on fraudulent and abusive *behavior* to ensure that detection and prevention efforts are directed at the most egregious and pervasive conduct, which may not be evident solely through claims analysis. 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,

Pam Bondi

Pam Bondi
Attorney General

Sincerely

Justin M. Senior
Secretary

cc: The Honorable Bill Galvano
The Honorable Jose Oliva

Statutory Authority:

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

"…Beginning January 1, 2003, and each year thereafter, the Agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs shall submit a joint report to the Legislature documenting the effectiveness of the state's efforts to control Medicaid fraud and abuse and to recover Medicaid overpayments during the previous fiscal year. The report must describe the number of cases opened and investigated each year; the sources of the cases opened; the disposition of the cases closed each year; the amount of overpayments alleged in preliminary and final audit letters; the number and amount of fines or penalties imposed; any reductions in overpayment amounts negotiated in settlement agreements or by other means; the amount of final Agency determinations of overpayments; the amount deducted from federal claiming as a result of overpayments; the amount of overpayments recovered each year; the amount of cost of investigation recovered each year; the average length of time to collect from the time the case was opened until the overpayment is paid in full; the amount determined as uncollectible and the portion of the uncollectible amount subsequently reclaimed from the Federal Government; the number of providers, by type, that are terminated from participation in the Medicaid program as a result of fraud and abuse; and all costs associated with discovering and prosecuting cases of Medicaid overpayments and making recoveries in such cases. The report must also document actions taken to prevent overpayments and the number of providers prevented from enrolling in or reenrolling in the Medicaid program as a result of documented Medicaid fraud and abuse and must include policy recommendations necessary to prevent or recover overpayments and changes necessary to prevent and detect Medicaid fraud. All policy recommendations in the report must include a detailed fiscal analysis, including, but not limited to, implementation costs, estimated savings to the Medicaid program, and the return on investment. The Agency must submit the policy recommendations and fiscal analyses in the report to the appropriate estimating conference, pursuant to s. 216.137, by February 15 of each year. The Agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs each must include detailed unit-specific performance standards, benchmarks, and metrics in the report, including projected cost savings to the state Medicaid program during the following fiscal year…."

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

This joint report presents specific results of efforts by the Agency and MFCU to control Medicaid fraud and program abuse during FY 2017-18.

TABLE OF CONTENTS

Department of Legal Affairs – Office of the Attorney General 1

Overview of the Medicaid Fraud Control Unit 1

Control and Enforcement Strategy 1
Complaints 2
Case Investigations 2
Disposition of Cases 3
Case Highlights 4
Total Recoveries 7
Training 7
Data Mining 8
Health Care Fraud Prevention and Enforcement Action Team (HEAT) 8
HEAT Team Cases and Outcomes 9
Medicaid Fraud Reporting Reward Payments FY 2017-18 9

The Agency for Health Care Administration's Role in Protecting the Medicaid Program from Fraud and Program Abuse 10

Behavior Analysis Agency Initiative 10

Background 10
Provider Enrollment Protocols 11
Provider Authorization Processes 11
Billing and Utilization Assessment 12
Provider Enrollment Moratorium in Miami-Dade and Broward Counties 13
Preliminary Fraud Investigations 14

Division of Medicaid 14

Provider Enrollment/Review 15
Centralized Background Screening 15
Monitoring and Reporting of Terminated Providers 16
Provider Accountability and Increased Provider Enrollment Requirements 16
Medicaid Health Plan Contract Requirements for Provider Credentialing 17
The Streamlined Credentialing Project 18
21st Century Cures Act 18
Referring and Ordering Providers 18
Behavior Analysis Services Providers Enhanced Review 19
Terminations of BA Providers 19
Fraud and Abuse Related Reporting Requirements 19
SMMC Health Plan Fraud and Abuse Related Reporting Requirements 19
Provider Outreach and Education 20
Program-Wide Provider Education 20
Health Plan Education and Training Requirements 20
Utilization Management 20
Program-Wide Utilization Management 21
Medicaid Preferred Drug List 21
Data Analysis 21
SMMC Health Plan Utilization Management 22
SMMC Contractual Provisions and Plan Responsibilities 22
SMMC Health Plan Prior Authorization 22
Medicaid Fee-for-Service Utilization Management 23
Pharmacy Claims Processing 23
Pharmacy Prior Authorization 23
Utilization Management of Home Health Services 24
Home Health Visit Prior Authorization 24
Comprehensive Care Management for Children with Special Health Care Needs 25
Ancillary Medicaid and Other Services 25
Inpatient Behavioral Health 26
Outpatient Advanced Diagnostic Imaging 26
Medicaid Certified School Match Program 27
Behavior Analysis Services Utilization Management 27

Medicaid Program Integrity 28
Organizational Overview 28
Prevention 29
Calculating Return on Investment through Prevention Measures 29
Payment Restrictions 31
Referrals 32
Sanctions 32
Field Initiatives/Focused Projects 33
Detection 35
Data Analysis 35
Detection Project Management 35
Intake 36
Certified Out of Business 37
Managed Care Unit 38
Overview 38
Detection Related Activities 38
Prevention Related Activities 40
Investigation of an MHP 40
Overpayment Recoupment 41
Audits and Investigations 42
Administrative Support 43
MPI Collaborative Efforts and Training 44
Collaborative Efforts 44
MPI Training Program 44
National Association for Medicaid Program Integrity 45
National Health Care Anti-fraud Association 45
Medicaid Integrity Institute 46
MPI Data for Fiscal Year 2017-18 46
MPI Activity Trends 50
Division of Operations 53
Financial Services 53
Third Party Liability Unit 55
Division of Health Quality Assurance 56
Care Provider Background Screening Clearinghouse 56
Regulatory Reform 57
Licensure Protections Senate Bill 1986 Reporting 57
Final and Emergency Orders 58
Transparency in Controlling Interests 58
Office of the General Counsel 58
Department of Health 59
Coordination and Cooperation Between DOH, AHCA, and MFCU 59
Statutory Reporting Requirements 60
Number of cases opened and investigated 60
Disposition of the cases closed 60
Sources of the cases opened 61
Amount of overpayments alleged in preliminary and final audit letters 62
Number and amount of fines or penalties imposed 62
Reductions in overpayment amounts negotiated in settlement agreements or by other means 62
Amount of final Agency determinations of overpayments 63
Amount deducted from federal claiming as a results of overpayments 63
Amount of overpayments recovered each year 63
Amount of cost of investigation recovered 63
Average length of time to collect from the time the case was opened until the overpayment is paid in full 63
The amount determined as uncollectible and the portion of the uncollectible amount subsequently reclaimed from the Federal Government 63
Providers, by type, terminated from participation in the Medicaid program as a result of fraud and abuse 63
All costs associated with discovering and prosecuting cases of Medicaid overpayments and making recoveries in such cases 64
Providers prevented from enrolling in Medicaid or re-enrolling as a result of suspected fraud or abuse 64
Policy recommendations necessary to prevent or recover overpayments and changes necessary to prevent and detect Medicaid fraud 66
Acronyms 67

Overview of the Medicaid Fraud Control Unit

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

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

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

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

Control and Enforcement Strategy

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

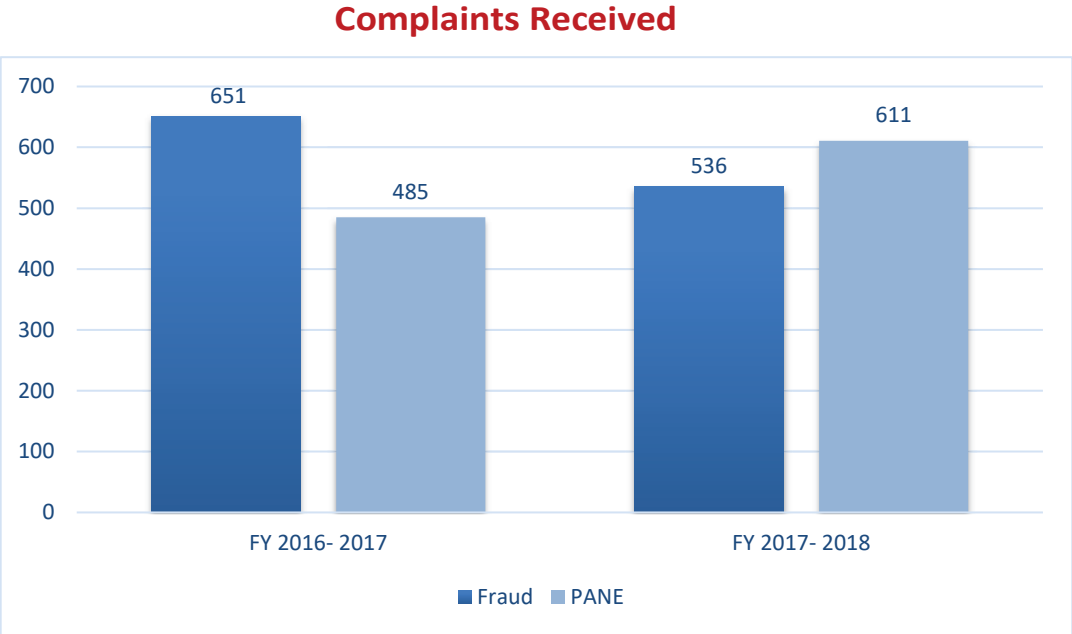
MFCU's Control and Enforcement Strategy requires unit members to focus on the following:

- **Medicaid Provider Fraud** - Case investigations focus on types of fraud, types of subjects/targets, and types of providers having a widespread impact on the Medicaid program or involving public safety. Emphasis is placed on case investigations and prosecutions that have a deterrent effect.
- **PANE investigations** - Focus is placed on activities and investigations involving prevention and timely criminal enforcement. Emphasis is placed on facilities which have incidents with immediate public safety issues and those which have widespread impact on potential victims.
- **Civil Recoveries** - Regardless of whether an investigation is criminal or civil in nature, emphasis is placed upon the recovery of the State's monetary losses caused by fraud through use of Florida's Contraband Forfeiture Act, Florida's False Claims Act, and any other available legal remedies. The Complex 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 on 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 the Agency for Health Care Administration (AHCA), the Department of Health (DOH), the Agency for Persons with Disabilities (APD), state and federal prosecutors, and the criminal justice community in order to promote better sharing of data. Use of information technology resources to obtain, share, and disseminate data to assist in the detection, investigation, and ultimately the deterrence of Medicaid fraud is promoted.

Complaints

MFCU's policy requires a 30-day review of complaints and allegations to determine whether the matter merits further investigation, should be referred to another agency, or is unfounded. Complaints are first reviewed to determine issues such as jurisdiction, and likely viability of the complaint. Case openings occur only when there is a criminal or civil predicate that warrants further investigative activity by the MFCU. During FY 2017-18, the MFCU received 1,147 complaints. Of those 1,147 complaints, 307 were opened as operational cases, 536 were related to fraud, and 611 were related to PANE allegations.



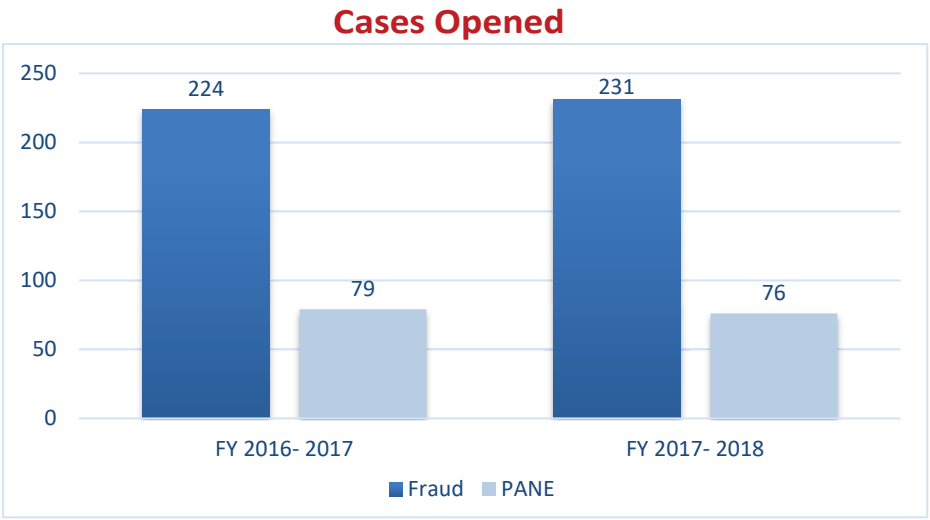
Managed Care Special Investigation Units (SIUs) were the primary source of fraud complaints in FY 2017-18, with 98 complaints reported. Ninety-seven complaints were received from citizens. Qui tam accounted for 80 of the Medicaid fraud complaints received. Sixty-one complaints were received from Medicaid Program Integrity (MPI).

The majority of PANE complaints were derived from the Department of Children and Families (DCF), Adult Protective Services (APS), and Florida Safe Families Network (FSFN). MFCU reviews information placed in the FSFN system and determines if opening a complaint is appropriate. In FY 2017-18, of the 611 PANE complaints, 545 came from DCF, APS, and FSFN. Citizens relayed the next highest source of PANE complaints accounting for 24 complaints.

Case Investigations

The opening of a case indicates that a criminal investigation or civil case has begun. Thereafter, significant time and investigative resources are expended to identify those involved in the origin of the wrongdoing, possible criminal misconduct, scope of the activity, and establish sufficient evidence to prove the requisite elements.

During FY 2017-18, the MFCU'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 MFCU to be more selective in its case focus.



The following is a list of the top four Medicaid Provider types (or related subjects) for MFCU fraud cases opened in FY 2017-18:

1. Home & Community Based Services Waiver
2. Physician
3. Pharmaceutical Manufacturer
4. Pharmacy

The following is a list of the top four Provider types (or related subjects) for PANE cases opened in FY 2017-18:

1. Facility Employee
2. Family Member
3. Skilled Nursing Facility
4. Home & Community Based Services Waiver

Disposition of Cases

Following an investigation, a determination is made whether to pursue criminal prosecution or initiate civil actions. All case investigations are formally closed because of either a successful prosecution or a lack of evidence. Several classifications are presently used to track the ultimate disposition of closed cases. The number of cases closed during a particular fiscal year 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.

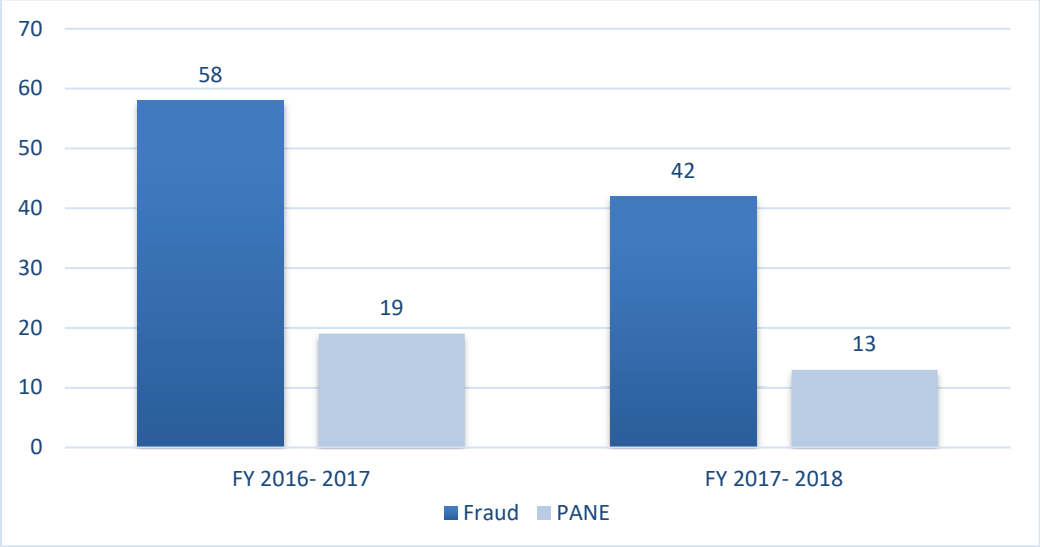
In FY 2017-18, the MFCU closed 330 cases. Of those, 248 involved Medicaid fraud investigations and 82 involved PANE cases.

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 2017-18 were 51 Fraud and 19 PANE, making a total of 70. In FY 2016-17, referrals for prosecution were 64 Fraud and 24 PANE for a total of 88.

Warrants for arrests for FY 2016-17 and FY 2017-18 are indicated in the chart below.

Warrants for Arrest



Case Highlights

Celgene Corporation

The MFCU joined 28 other states and the federal government to settle allegations that Celgene Corporation, a biopharmaceutical company, engaged in a variety of marketing schemes to promote the off-label use of two drugs, Thalomid® and Revlimid®. The company also allegedly promoted the drugs by paying kickbacks to providers in order to induce the providers to prescribe the drugs.

As part of the settlement, Celgene paid the states and the federal government $280 million, of which more than $20 million will go to state Medicaid programs. The payment to the Medicaid programs resolved civil allegations that the company unlawfully marketed the two drugs, causing false claims to be submitted to government health care programs. Florida received more than $1.4 million as part of the settlement.

The settlement stems from a whistleblower lawsuit, U.S., et al, ex. rel. Beverly Brown v Celgene Corporation, Civ. Action No. CV10-03165, filed in the United States District Court for the Central District of California.

Mylan Inc.

The MFCU joined the federal government, the District of Columbia, and all 49 other states in a multimillion dollar settlement with an international pharmaceutical company. This nationwide settlement resolved allegations that Mylan Inc. and its wholly-owned subsidiary, Mylan Specialty L.P. knowingly underpaid rebates owed to the Medicaid program for the drugs EpiPen® and EpiPen Jr.®. The drugs are injections containing epinephrine, a chemical that narrows blood vessels and opens airways in the lungs. These effects can reverse severe low blood pressure, wheezing, severe skin itching, hives, and other symptoms of an allergic reaction.

Mylan allegedly misclassified EpiPen to avoid paying rebate obligations to the Federal Government and the states, violating the federal False Claims Act and various state false claims statutes. As part of the settlement, Mylan paid a total of $465 million to the federal government and the states. Florida received more than $9 million in restitution and other recovery.

The investigation stemmed from two qui tam actions, United States ex rel. Sanofi-Aventis US LLC v. Mylan Inc., et al. No. 16-cv-11572-ADB, and United States ex rel. Ven-A-Care of the Florida Keys, Inc. v. Mylan Inc., et al. No. 17-10140-ADB, pending in the U.S District Court for the District of Massachusetts.

Antrisa Fontae Butler

The MFCU and the Baker County Sheriff's Office arrested a former Northeast Florida State Hospital employee for abusing a disabled adult. Antrisa Fontae Butler, 27, a human services worker, allegedly struck a schizophrenic resident multiple times in the head and neck.

During the course of the investigation, the MFCU discovered Butler used non-approved training techniques against the disabled patient. Butler allegedly struck the victim in the chin and tackled the victim, causing the victim's head to hit the floor and a door. The defendant continued the abusive behavior by pinning the victim down and punching the victim several times with a closed fist.

Evidentiary documents show Butler to be current on all required training related to restraint and physical interaction with patients. Butler entered a plea of nolo contendere to one count of abuse of an elderly or disabled adult, a third-degree felony. Butler was sentenced to two years community control and one year probation. The State Attorney's Office (SAO) for the Eighth Judicial Circuit prosecuted the case.

Ryan Todd Powers

The MFCU announced the sentencing of a Lee County man for exploiting an elderly relative residing in a nursing home. A jury found Ryan Todd Powers, 41, guilty on four counts of first-degree exploitation involving an elderly person. The Honorable J. Frank Porter, Circuit Judge for the 20th Judicial Circuit, sentenced Powers to 20 years in prison.

The MFCU investigated this case and discovered that Powers unlawfully obtained funds from an elderly relative suffering from physical limitations. Powers obtained a durable power of attorney on behalf of the victim to manage the relative's affairs. Using this power of attorney, Powers misappropriated the victim's funds and property for personal purposes. The SAO for the 20th Judicial Circuit prosecuted the case.

Christina Benson

The MFCU secured a prison sentence for an Orlando woman who exploited homeless men and women to commit Medicaid fraud. Christina Benson, owner of Tranquility Health Care Solutions, defrauded Medicaid out of more than $200,000 by billing Medicaid for services not provided and not warranted. Last year, Benson pleaded guilty to one count of Medicaid provider fraud, a first-degree felony.

Benson's scheme involved offering gas cards and temporary housing to homeless individuals in return for the homeless seeking services at Tranquility Health Care. Benson used untrained personnel, some with criminal arrest records, to operate this scheme using Medicaid IDs to bill Medicaid for psychosocial rehabilitation services that were never rendered.

The Honorable A. James Craner, Circuit Judge for the Ninth Judicial Circuit sentenced Benson to four and half years in prison. Benson previously forfeited more than $170,000 to the state.

Attorney General Bondi's Medicaid Fraud Control Unit investigated the case. The State Attorney's Office for the Ninth Judicial Circuit prosecuted the case.

Shawn Thorpe, Ruben McLain

The MFCU, the U.S. Department of Health and Human Services (HHS), and U.S. Attorney's Office (USAO) announced the sentencing of two medical care providers. Shawn Thorpe, 30, and Ruben McLain, 46, both of Winston Salem, NC, have been sentenced to federal prison for participation in a conspiracy to commit healthcare fraud.

The court sentenced Thorpe to two years' imprisonment and McLain was sentenced to four years and nine months in federal prison for illegally billing federal healthcare programs. The convicted must also pay approximately $211,000 and $1.1 million in restitution to the victims.

According to the investigation, Thorpe and McLain worked together to create and manage Coastal Bay

Behavioral Health, Inc. (Coastal Bay), a company that provided medical care to Medicaid patients. McClain had been excluded from billing federal healthcare programs based on a 2011 conviction for healthcare fraud. In an effort to conceal involvement, McLain took on the name Julian Winchester, and performed a variety of illegal activities related to defrauding Medicaid. McLain routinely traveled to Jacksonville from his home in North Carolina to assist in Coastal Bay's operations.

Florida's MFCU and the HHS investigated the case. Assistant United States Attorney Jay Taylor prosecuted the case.

Maritza Lazcano and Luis Garcia Fragoso

The MFCU and the Pembroke Pines Police Department arrested a dentist and office manager for defrauding the Medicaid program out of more than $50,000. According to the MFCU investigation, Maritza Lazcano, owner of Lazcano Family Dental, and Luis Garcia Fragoso, the office manager, fraudulently billed the Medicaid program for numerous dental procedures never performed. These procedures included cleanings, crowns, root canals, x-rays, etc.

Lazcano, 51, and Fragoso, 45, each face one count of Medicaid fraud, a first-degree felony, and one count of grand theft, a second-degree felony. If convicted, both defendants face up to 45 years in prison. Attorney General Bondi's Office of Statewide Prosecution is prosecuting this case.

Lanre Saad Kelani

The MFCU and the Miramar Police Department arrested an unlicensed nurse for defrauding the Medicaid program out of more than $715,000. According to the investigation, Lanre Saad Kelani, 61, practiced as a health care professional without a license for a Medicaid recipient with a serious disease that needed 24-hour home nursing care. Kelani used a sibling's name and license number to provide the services.

Kelani faces one count of Medicaid fraud, grand theft and organized fraud, all first-degree felonies, and one count of practicing as a health care professional without a license, a third-degree felony. If convicted, Kelani faces up to 95 years in prison. The Miami-Dade State Attorney's Office is prosecuting the case.

Massive Nationwide Health Care Fraud Takedown

The MFCU, the U.S. Department of Justice (DOJ), the Federal Bureau of Investigation (FBI), and HHS, announced a nationwide health care fraud take down stopping schemes defrauding Medicare and Medicaid out of $2 billion. Nationally, 601 defendants were charged, including more than 165 doctors, nurses, and other licensed medical professionals in schemes involving approximately $2 billion in false billings. As a result of the nationwide operation, Florida's MFCU, working with federal agencies, arrested five individuals on charges involving more than $12.5 million in fraudulent billing, and brought several additional local cases.

As part of the nationwide takedown, Florida's MFCU, FBI, and HHS-OIG arrested Evelio Ramirez, 58, and Rosana P. Ramirez, 58, for defrauding the Medicaid and Medicare programs while working at F&E Home Health Care, Inc., a home health agency in Miami. The defendants allegedly defrauded Part A of the Medicare program out of more than $7 million and Medicaid out of more than $368,000 by billing for home health services never provided to beneficiaries, as well as, paying kickbacks to patient recruiters in exchange for patient referrals. USAO, Attorney Miesha Shonta Darrough, will prosecute the case.

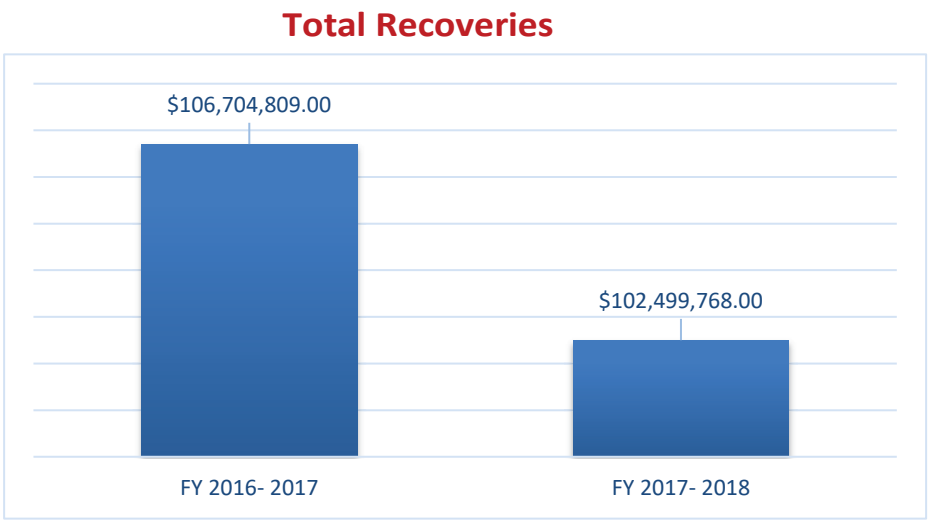
In another Florida case that is part of the nationwide effort, the MFCU, FBI, the U.S. Department of Defense, Office of Inspector General, Defense Criminal Investigative Service and HHS-OIG arrested Stephen Chalker, 42, of Wellington, Christopher Liva, 39, of Boca Raton, and Elaina Liva, 66, of Pompano Beach, for conspiracy to commit health care fraud. Chalker is also charged with three counts of health care fraud. According to the indictment, the Livas owned and operated Pop's Pharmacy, LLC where Chalker worked as a pharmacist. The defendants allegedly submitted false and fraudulent claims to Medicare, TRICARE, and Medicaid for compounded drugs and other prescription medications, including expensive pain and scar creams, deemed not medically necessary or never provided. As a result of these false and fraudulent claims, Medicare, TRICARE, and Medicaid made payments totaling more than $5 million. DOJ will prosecute the case.

Total Recoveries

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

The MFCU is also responsible for enforcement of the Florida False Claims Act. With the conversion to the Florida Statewide Medicaid Managed Care (SMMC) program, the Complex Civil Enforcement Bureau (CCEB) will focus investigative and litigation efforts on more managed care cases against providers and national suppliers who attempt to defraud the SMMC program. In addition to its role in multi-state nationwide cases, CCEB has seen a shift in Medicaid fraud investigations to more Florida-only state cases, Federal court cases with the United States Attorneys' offices where Florida is the only named state, and regional cases with fewer co-plaintiff states.

In FY 2017-18, the total amount for civil recoveries, which include civil settlements arising from qui tam cases brought under Florida's False Claims Act and civil judgements, was $40,925,748. The total amount for criminal recoveries based upon Medicaid fraud cases was $61,574,020. The total amount of the monies recovered by the MFCU for FY 2017-18 was $102,499,768.



Training

MFCU continues to emphasize mission critical training to stay professionally current. During FY 2017-18, MFCU staff attended a total of 4,130 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 included training for database searches for FMMIS Claims Analysis, Elder Abuse Investigations, Criminal Justice Information Services (CJIS) Certification, and other courses offered by AHCA and the FDLE.

In-house training provided through a variety of delivery methods included courses such as Leadership and Supervision and Performance Evaluation, Ethics, Electronic Surveillance Support, CPR and AED Certification, and Blood Borne Pathogen and Infectious Disease 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 2017-18 included Financial Crimes Against Seniors, eDiscovery, Accessing Inaccessible Apps, Criminal Investigations Using Cellular Technologies, Ensuring Defensible Preservation and Collection, and Financial and Money Laundering Crimes in Healthcare.

Mandatory training for law enforcement certification included Criminal Justice Officer Ethics, Domestic Violence, Juvenile Sex Offender Investigations, and Discriminatory Profiling.

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 Florida Medicaid Management Information System's (FLMMIS) 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 AHCA. The initial waiver was extended by the Centers for Medicare and Medicaid Services (CMS) through July 30, 2016.

Under 42 CFR §1007.20, the MFCU produced an application on May 18, 2016, through the HHS-OIG to continue data mining. HHS-OIG granted approval for MFCU to data mine through June 20, 2019, with the data mining efforts coordinated with and not duplicative of AHCA.

As of June 30, 2018, the MFCU has submitted 95 data mining projects to AHCA for review and approval. Of the 95 submitted, 69 were approved by AHCA. On June 30, 2018, MFCU had 10 cases in an active status from these projects, and two arrests were made for FY 2017-18.

Health Care Fraud Prevention and Enforcement Action Team (HEAT)

In May 2009, the HHS and the DOJ created the Health Care Fraud Prevention and Enforcement Action Team (HEAT). With its creation, the fight against Medicare fraud became a federal cabinet-level priority. The HEAT brings together the efforts of the Office of Inspector General, the DOJ, USAO, FBI, local law enforcement, state MFCUs, and others.

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

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

The MFCU has been an active participant in the Federal Health Care Fraud task force. The MFCU specially assigned a team of investigators, an analyst, and prosecution staff, which achieved a number of convictions and successes during FY 2017-18. The chart below illustrates:

HEAT Team Cases and Outcomes

Defendant	Arrest Date	Conviction Date	Sentencing Date	Total Recovery	Prison	Probation
Beatriz Carrasco	07/07/17	08/24/17	11/20/17	$1,013,344.00	24 months	3 years
Francisco Palacios	07/28/17	09/27/17	11/27/17	$280,292.00	27 months	3 years
Bertha Blanco	07/12/17	10/16/17	12/15/17	$114,400.00	57 months	3 years
Jason Valdes	12/29/16	08/01/17	01/08/18	$55.00	888 days	5 years
Zulima Calderon	03/30/17	01/12/18	01/12/18	$825.00	289 days	1 year
Ramon Hernandez	12/07/16	01/24/18	01/24/18	$19,017.00	5 years	2 years
Robert Joyner	03/01/16	04/27/18	04/27/18	$22,417.00	1 year	5 years
Mayrelis Lopez	11/15/17	02/20/18	05/29/18	$1,260,663.00	46 months	3 years
Oscar Ventura- Rodriguez	02/06/18	04/26/18	06/15/18	$396,528.18	60 months	3 years

Medicaid Fraud Reporting Reward Payments FY 2017-18

Under Florida law, persons who report Medicaid Fraud (under certain conditions) are eligible to receive a financial reward. During the report period, $219,450.13 was paid pursuant to this law. See Section 409.9203, Florida Statutes (2018).

THE AGENCY FOR HEALTH CARE ADMINISTRATION'S ROLE IN PROTECTING THE MEDICAID PROGRAM FROM FRAUD AND PROGRAM ABUSE

Behavior Analysis Agency Initiative

Background

The most significant Medicaid program integrity efforts during FY 2017-18 involved the Medicaid Behavior Analysis program. In 2012, following a federal court order, which so mandated, the Agency implemented Applied Behavioral Analysis (ABA) services for children in Medicaid. ABA services are a form of therapy used to treat people with maladaptive behaviors (e.g., injuring self or others). The services are designed to decrease the frequency of undesirable behaviors and replace them with desired behaviors. The service can be provided for adults or children, but the service referred to in this report is only provided for children under the age of 21.

Subsequent to the implementation of ABA services, the Agency began the process of drafting and implementing coverage policies, fee schedules, and provider qualification rules for that ABA services. These are the Agency's written guidance to program participants and must be promulgated into administrative rule. The rules, or in some cases the lack of rules, significantly impact the Agency's ability to implement program safeguards. Hindrances to rule promulgation often include litigation, rule-making process requirements of state law, and administrative aspects of the federal-state partnership regarding the Medicaid program.

In March 2017, the ABA program transitioned to Behavior Analysis (BA) services. The Agency promulgated rules that were designed to strengthen provider qualifications and ensure all services were reviewed by appropriate clinicians for medical necessity. Medicaid personnel closely monitored the implementation of the new rules. A competitively procured prior authorization program by Beacon Health Options (Beacon) was put in place to ensure services were medically necessary and to achieve the desired changes.

Through extensive collaboration between Agency organizational units, program integrity efforts are carried out by both MPI and other organizational units. The transition to BA services was no different, in that both the Division of Medicaid and MPI endeavored to anticipate potential vulnerabilities and address them prior to, and immediately following, the March 2017 launch. Early discussions regarding program vulnerabilities also included MFCU leadership to ensure that referrals were timely, following thorough preliminary investigations. MFCU and MPI have continued to collaborate at each step in the Agency's efforts to combat the fraud and abuse in BA.

MPI began developing a number of projects to address fraud and abuse, particularly based upon non-claims-based risk factors. Waiting to use claim-based risk factors was not thought to be an effective way to achieve early detection of providers and others taking advantage of program vulnerabilities. These projects included an assessment of recipients allegedly receiving ABA services but did not appear to continue to receive BA services (as evidenced by a lack of a prior authorization for children who were believed to still be residing in Florida). The projects also included several pilot projects in South Florida to identify high risk BA group providers. The detection efforts to identify the subjects heavily relied upon non-claims-based indicators with the specific intent of identifying factors that could later be reliably used in provider enrollment screening processes. In fact, during FY 2017-18, a number of these factors were implemented into enrollment safeguard practices.

For purposes of this report, five significant program integrity efforts will be addressed:

- Provider enrollment protocols;
- Prior authorization processes;
- Billing and utilization assessment;
- Temporary provider enrollment moratorium; and
- Preliminary fraud investigations.

Provider Enrollment Protocols

The most notable safeguard, from a program integrity standpoint, was the enrollment of all service providers rather than just the billing provider. BA service has four levels of providers- (1) a billing group, (2) a lead analyst, (3) an associate analyst, and (4) a registered technician. Even prior to launching the BA services, Agency provider enrollment personnel were experiencing significantly higher than expected application volumes. As such, in an effort to ensure a smooth transition from ABA to BA, and particularly to ensure that immediately upon transition between the two service types (ABA to BA), there would be sufficient providers available, many applications were approved following receipt of an attestation from the applicant certifying that he or she met the requirements for enrollment.

Providers attesting to their qualifications quickly became recognized as an area of vulnerability and, although this practice has changed and applications now require documentation of qualifications, the continued issues of applications submitted with information that is believed to be false resulted in this being a significant area of focus for MPI and the Division of Medicaid during FY 2017-18. MPI launched a state-wide review (of which approximately 25% was completed during FY 2017-18) of all enrolled BA providers to ensure they met the required qualifications. The Division of Medicaid simultaneously enhanced enrollment protocols for new provider applications and assisted MPI with the review of the existing provider network. All BA applications must undergo an Application Quality Check. In addition, depending on the provider type, additional screening requirements must be met. For example,

- Associate Behavior Analysts and Lead Analysts must undergo License and Certification Verification.
- Behavior Assistants must attest to being in compliance with all requirements and must submit supporting documentation to have all education, training, and work history verified.
- Provider Groups must submit for review a complete Financial and Business History including any bankruptcy, foreclosure, sanctions, fines, and other information.
- After the application and qualifications are reviewed and approved, all BA providers and groups must undergo an in-person interview or onsite review.

The Agency's swift and decisive actions in identifying and stamping out suspected fraud in BA services underscore its commitment to ensuring Florida Medicaid recipients receive quality, appropriate care from qualified providers.

Prior Authorization Processes

Prior to the March 2017 launch of Florida's BA services and as previously indicated, the Agency procured the services of Beacon as the vendor to perform prior authorization reviews which ensure that services were medically necessary and to mitigate the risk for overuse of the services and fraud. The vendor was expected to evaluate the recipient's eligibility to receive the services and the provider's plan for addressing the child's maladaptive behavior. The vendor's contract required it to identify and communicate risks to the Agency, to ensure effective utilization management, to demonstrate high quality administrative leadership, to provide assurances regarding the expenditures of public funds, and to ensure that only necessary services were authorized. The contract required the vendor to collect data and provide analysis to determine aberrant billing and utilization patterns. Agency personnel took a hands-on approach to managing the vendor's contract, in an effort to ensure a smooth launch and to ensure that the vendor was fulfilling its contract obligations.

As a result of these efforts, the Agency was able to identify shortcomings in the vendor's efforts and, at first, initiate corrective measures. However, these efforts also allowed the Agency to make an early determination to terminate the contract with Beacon and hire a new vendor.

In February 2018, the Agency began transitioning its prior authorization process for BA services from Beacon to eQHealth Solutions. eQHealth Solutions began authorizing services in March 2018.

Throughout the transition from Beacon to eQHealth Solutions, in order to ensure continuity of care, the Agency honored existing authorizations and reimbursed for services approved by Beacon as long as the provider had received a letter with a prior authorization number. The Agency has continued to honor service authorizations and is providing full funding for medically necessary BA services. As long as their provider is in full compliance with Florida Medicaid's standards, recipients have continued to receive services without issue.

Billing and Utilization Assessment

MPI initially took the lead in conducting billing and utilization assessments for the purposes of determining potential overpayments. Medicaid took the lead in conducting assessments for the purpose of determining areas of potential service needs and areas of potential overutilization or improper utilization. However, following initial preliminary data reviews, it became evident that there were significant and pervasive issues of fraud, which warranted MPI taking the primary lead on the program assessment and have resulted in increased and significant collaboration with MFCU. As such, much, if not all, of the data and investigative information regarding the program assessment is substantive investigative information which is or may be pertinent to ongoing criminal investigations. Details regarding this investigative information are furnished to the greatest extent possible without obstruction or impediment to a criminal investigation. Of particular concern, due to the alarming increase in what is believed to be fraudulent and abusive billing, along with the apparent pervasive and extensive organization of the schemes that have unfolded, is the paramount interest of ensuring that targets of investigation are not alerted or otherwise given an opportunity to obfuscate investigations, destroy evidence, or intimidate witnesses.

The program assessment has identified a number of issues that have been used for purposes of fraud and abuse detection. The subject of the review is then fully processed through MPI investigative and/or audit protocols to validate any findings and determine whether the findings bring rise to Agency-authorized actions, such as sanctions, overpayment recovery, referrals, or contract actions. Some of the identified issues, all of which remain the subject of active investigations, include:

- **Unqualified service providers**- Rendering providers who have been determined by MPI to not meet the qualifications for enrollment are identified. They are then re-reviewed through a two-step validation process. An overpayment determination may be based on the claims submitted by (and reimbursed to) the billing group for the unqualified rendering provider.
- **Biller impossible days**- Biller impossible days occur when a biller submits claims for payment such that a renderer on the claims would have worked in excess of 24 hours in a single day. Each unique individual rendering occurrence of the above criteria is considered an impossible day.
- **Recipient impossible days**- Recipient impossible days occur when a biller submits claims for payment such that a recipient on the claims would have received BA services in excess of 24 hours in a single day. Each unique individual recipient occurrence of the above criteria is considered an impossible day.
- **Biller excessive days**- Biller excessive days occur when a biller submits claims for payment such that a renderer on the claims would have worked in excess of ten hours in a single day but not more than 24 hours. Each unique individual rendering occurrence of the above criteria is considered an excessive day.
- **Recipient excessive days**- Recipient excessive days occur when a biller submits claims for payment such that a recipient on the claims would have received BA services in excess of eight hours in a single day but not more than 24 hours. Each unique individual recipient occurrence of the above criteria is considered an excessive day.
- **Biller impossible weeks**- Biller impossible weeks occur when a biller submits claims for payment such that a recipient on the claims would have received services in excess of 40 hours per week, which is above Medicaid policy limits.
- **Renderer consecutive days**- Consecutive days are dates of service worked in a row, without interruption, by a renderer for a biller. This means no breaks for weekends, holidays, or sick days.
- **Denied claims**- An evaluation of denied claims is not used to determine an overpayment or sanction

cases; however, denied claims may be an indication of efforts to identify system vulnerabilities.

- **Background screening**- The Agency-operated Care Provider Background-Screening Clearinghouse (Clearinghouse) provides a determination of whether a provider/licensee/employee is "eligible" for participation in Medicaid or licensed facilities. However, a Clearinghouse-eligible result does not mean that a screened individual is without any criminal history. Indications of personnel with criminal history does not bring rise to an overpayment or sanction, but may indicate a heightened risk for fraud or abuse in the Medicaid program and is used solely for detection purposes.
- **Recipient providers**- In the course of conducting a review with regard to another project, instances of actively enrolled Medicaid recipients who also appeared to be active providers were discovered. Although it is not improbable for a provider to also be a recipient with regard to some provider types, the number of instances was unexpected. Particularly in BA, the issue has been discovered as a potential fraud and abuse risk. While these providers are not receiving BA services, they are Medicaid recipients who, in many cases, are purportedly receiving services as a recipient.
- **Renderer impossible days**- Renderer impossible days occur when a renderer appears on claims for payment such that the renderer would have worked in excess of 24 hours in a single day. Unlike biller impossible days, renderer impossible days may have been submitted on behalf of one or more billers for a single date of service.
- **Renderer excessive days**- Renderer excessive days occur when a renderer appears on claims for payment such that the renderer would have worked in excess of ten hours in a single day, but not more than 24 hours. Unlike biller excessive days, renderer excessive days may have been submitted on behalf of one or more billers for a single date of service.
- **Renderer impossible weeks**- Renderer impossible weeks occur when a renderer appears on claims for payment such that a recipient on the claims would have received services in excess of 40 hours per week, which is above Medicaid policy limits. Unlike biller impossible weeks, renderer impossible weeks may have been submitted on behalf of one or more billers for the same renderer/recipient combination.
- **Renderer expected days**- It is generally expected that BA renderers will perform services, on average, five days a week or less. Renderer expected days are determined by evaluating a renderer's most recent date of service compared to their oldest date of service (regardless of billers) and calculating how many days they would have worked assuming a five-day workweek. Renderers must have worked for a period of at least 60 days to be considered for this analysis.

As a part of the aforementioned collaboration, on an ongoing basis, MPI summary findings are shared as needed to develop system edits and policy changes. The preliminary findings are also the subject of ongoing, routine discussions with MFCU and CMS officials.

Provider Enrollment Moratorium in Miami-Dade and Broward Counties

In May 2018, the Agency announced a temporary moratorium on enrollment of new Behavioral Analysis (BA) providers in Miami-Dade and Broward counties, with the approval of CMS. A preliminary investigation of providers in those counties identified Medicaid fraud and abuse including extraordinary overbilling. The Agency imposed the moratorium to prevent significant fraud that impacts taxpayers and potentially compromises the quality of care patients receive. The moratorium began on May 14, 2018 and is initially set to be implemented for a 6-month period. The moratorium did not affect any Medicaid recipient's ability to access necessary BA services. All existing BA providers continue to be reimbursed for legitimate services while the Agency further investigates fraud and abuse.

The moratorium came after many months of investigation and analysis of the BA providers and services in south Florida. The Agency's number one priority remains the children who rely on this service and making sure that they have access to high quality providers. The Agency will continue to take aggressive action against any fraudulent providers, or those who attempt to abuse the Medicaid system.

As soon as the Agency determined that the predominant issues regarding potentially false enrollment

applications may have been geographically limited, at least with regard to how pervasive it appeared to be in Miami-Dade and Broward counties, the Agency sought and obtained concurrence from CMS for a geographically limited temporary moratorium on enrollment for BA providers. The temporary moratorium has allowed the Agency an opportunity to conduct a comprehensive assessment of a portion of the current provider population and remove from the provider network those individuals and entities who are not qualified to participate or whose participation is believed to have been based solely on seeking the opportunity to commit fraud.

At the time of seeking concurrence from CMS, the Agency had identified numerous instances of Medicaid fraud and abuse. More than a dozen providers had already been referred to MFCU and it was believed that tens if not hundreds of millions of dollars may have been misspent due to fraud by these and other providers. Since implementation of enhanced enrollment practices, in the several months prior to implementing the moratorium, the program has determined that more than 75% of the applications for BA enrollment failed to demonstrate that the applicant is qualified and eligible to participate.

During the period of the temporary moratorium, all new applications for individuals or group BA providers for Miami-Dade and Broward counties are being denied. Furthermore, applicants attempting to circumvent the moratorium will be denied, as well as, sanctioned and/or referred to MFCU, as deemed appropriate by the Agency. Additional details regarding the moratorium are posted on the Agency's website. http://ahca.myflorida.com/Executive/Communications/Press_Releases/pdf/BA_provider_release5142018.pdf

The moratorium did not affect any Medicaid recipient's ability to access necessary BA services. All existing BA providers continue to be reimbursed for legitimate services while the Agency further investigates fraud and abuse.

Preliminary Fraud Investigations

As FY 2017-18 neared its end, at the time of the imposition of the aforementioned moratorium, MPI had conducted preliminary investigations of more than 700 individual rendering providers and nearly 200 group providers, many of which were placed on a payment restriction for reasons which included not responding to record requests, preliminary determinations of unqualified providers, and suspected false claims. The payment restrictions most commonly used are as previously described in an earlier section regarding MPI prevention activities.

Most providers suspected of lacking qualifications or otherwise warranting a payment restriction are placed on PPR, which is a very resource-intensive process requiring record reviews. Typically, during the review process, the Agency is able to gather sufficient evidence to transition the restriction to a 25A or CAF, with appropriate referrals.

By the end of the fiscal year, there had been more than 20 referrals to MFCU, 14 BA providers (both rendering and group/billing providers) had sanction notices issued (either for termination, suspension, fine, or a combination of suspension and fine), there was over $1.2 million dollars in identified overpayments, and over 180 cases in process or completed.

Investigations remain ongoing and will continue into FY 2018-19.

Division of Medicaid

The Division of Medicaid administers the Florida Medicaid program, a more than $27 billion state and federal partnership that provides health care to almost four 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 was implemented as a fee-for-service (FFS) program more than four decades ago and since the beginning, has been primarily a FFS based program. Over the years, enrollment grew rapidly and costs soared until Medicaid expenditures were more than one-fourth

of the state budget. The rapid growth in enrollment and costs made it increasingly important to find ways to manage the diverse needs of the Medicaid population while also being able to better predict and plan for cost increases.

Medicaid's roles and responsibilities have been evolving since it moved away from a completely FFS program and the first Medicaid health plan was established in 1984. Eventually the Medicaid program became a mix of special programs, waiver programs, a FFS population, a FFS primary care case management population (known as MediPass), and a population in prepaid health plans. Between 2013 and 2014, Florida Medicaid implemented the Statewide Medicaid Managed Care (SMMC) program and with it significant program changes resulting in improved efficiency, cost predictability and accountability for the program, and enhanced services to recipients.

Upon full implementation of the SMMC program in August 2014, there was a significant shift toward contracting, contract monitoring, and policy-related functions. Previous Agency for Health Care Administration (AHCA or the Agency) responsibilities such as prior authorization, utilization management, and program and provider monitoring that occurred under FFS, became primarily the responsibility of the health plans. The transition of Medicaid to a predominantly managed care program provided the Agency an opportunity to competitively bid plans, develop contract standards for quality and access, and focus more efforts on monitoring activities which directly impact the Agency's efforts in combatting potential fraud and abuse in the Medicaid program.

The Agency sought and received a five-year extension of the federal waiver for the SMMC program through June 2022. In addition, the Agency has completed the statutorily required re-procurement of SMMC contracts for health and dental plans for a new five-year period. Contracts were awarded in April 2018 for SMMC health plans and in June 2018 for SMMC dental plans, which both will be operational before January 2019. Where the original SMMC program had both Managed Medical Assistance (MMA) and Long Term Care (LTC) plans (with dental services provided through the MMA plans), under the new contract period, all plans will provide MMA services to their enrollees and any enrollee with both LTC and MMA service needs will receive all of their services from one plan. While the new contracts place a greater emphasis on helping achieve Medicaid medical quality milestones, the fraud and abuse prevention components in the contracts remain rigorous and comprehensive.

The Division of Medicaid has adopted a strategic approach to combatting fraud and abuse. Developing and implementing the SMMC program allowed the Agency to adopt a ground up approach to combat fraud and abuse by embedding control efforts into the transition and future infrastructure of the program. These strategic control efforts are focused in three key areas including Provider Enrollment/Review, Outreach and Education, and Prior Authorization and Utilization Management.

Provider Enrollment/Review

Prevention of fraud, program abuse, and inappropriate practices, whether intentional or not, begins with thorough screening of the Medicaid providers. This includes health plans and their provider networks, as well as, individual FFS providers. The Division of Medicaid employs many different strategies to ensure all Medicaid providers are eligible to provide care, and can provide the necessary and appropriate health care in a safe and effective environment. All Medicaid providers are required to have a background screening that is conducted through the Care Provider Background Screening Clearinghouse (Clearinghouse). Medicaid also monitors and prepares a quarterly report of terminated Medicaid providers, 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 (MHPs) to credential and re-credential all providers in their network using Agency-approved, written criteria.

Centralized Background Screening

Florida Medicaid provider background screenings have been conducted through the Agency's Care Provider Background Screening Clearinghouse (Clearinghouse) since 2013. The Clearinghouse serves as a single state repository for Level 2 background checks, a state and national fingerprint-based check and

consideration of disqualifying offenses, which applies to persons designated by law as holding positions of responsibility or trust. All Medicaid providers, including Medicaid FFS providers and Medicaid health plan network providers, are required to be screened through the Clearinghouse. The Clearinghouse provides a single data source for background screening results of persons required to be screened by law for employment in positions that provide services to children, the elderly, and people with disabilities. Fingerprints are retained in the Clearinghouse for five years, which enables a provider to be automatically notified of an arrest of their employee as soon as the information is reported to the Agency by the FDLE.

Monitoring and Reporting of Terminated Providers

Medicaid collaborates with MHPs to ensure that fraudulent or terminated providers are not illegitimately participating in Medicaid, either by registering again with Medicaid using different information, or by contracting with a Medicaid health plan in an attempt to indirectly participate in the Medicaid program. In doing so, Medicaid identifies providers that have been terminated by the Agency for fraudulent behavior and informs the health plans that these providers are ineligible to participate in the MHP's networks. Medicaid also evaluates providers that have at some point in the past been linked to a provider terminated for fraudulent activity. The Agency researches this information to make sure that active providers have the clearance to participate in the Medicaid program. This research includes examining the relationship between providers that have been terminated and share a common form of identification (such as the same last name) with a currently active Medicaid provider and other active providers.

Provider Accountability and Increased Provider Enrollment Requirements

The Bureau of Medicaid Fiscal Agent Operations (MFAO) is responsible for reviewing eligibility for all Medicaid provider initial and renewal applications, including compliance with state and local license regulations, fingerprinting, and searches of federal and state exclusion databases. Enhanced screening is required for applicants with criminal records, prior denials, sanctions, terminations, or exclusions from Medicare or Medicaid, adverse licensure actions, overpayment or sanction monies owed to Medicaid, changes of ownership, or suspended payments. On-going provider eligibility and compliance activities aid the Division of Medicaid in better screening and monitoring of Medicaid providers and include:

- **Provider Risk Factors** - All applicants to Medicaid are evaluated and scrutinized based upon their assigned risk factor. The provider type and any adverse history, including previous denials and terminations, loss of or discipline on a license, criminal history, and money owed to the Agency, determine if a provider presents a limited, moderate, or high risk of fraud and abuse. Fraud prevention protocols involve offering research and guidance on new enrollments and re-enrollments of providers with escalated risk factors or other anomalies discovered in the application process. Medicaid staff utilize internal and external research tools to identify such anomalies and make recommendations to deny or terminate high risk providers to minimize possible fraud and abuse to the Medicaid program.
- **In-Person Provider Review** - Provider types that are deemed to be a moderate or high risk for fraud and abuse must be reviewed in person by Medicaid staff prior to enrollment in the program.
- **License Verification** – Medicaid verifies the status of providers' practitioner and facility licenses through an automated process that compares license data on provider records with data in the Agency's Division of Health Quality Assurance (HQA) and the Department of Health (DOH) license databases. All initial and renewing applicants are verified upon submission of their applications and active providers are verified on a daily basis thereafter. Providers who have lost active license status are immediately restricted for claims processing and a system generated letter is produced to notify them of the action.
- **License Compliance** – The Agency holds weekly coordination meetings between Medicaid, the Division of HQA, Medicaid Program Integrity (MPI), and the DOH to ensure a timely response when action is taken against a provider's license. Medicaid staff review all Agency and DOH final orders related to licensure actions including emergency restriction, suspension, and revocation orders related to licensee misconduct, in an effort to identify connections between the affected license holders and other providers. Based on the nature or characteristics of the license

violation, Medicaid staff take the appropriate action to terminate or exclude the provider and all related providers from the program.

- **Identifier and Exclusion Verification** – Medicaid conducts automated verification of National Provider Identifiers (NPI) and excluded entities or individuals. Data from the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals and Entities (LEIE), the System for Awards Management (SAM), and Medicare's Provider Enrollment Chain Ownership System (PECOS) are uploaded to the Florida Medicaid Management Information System (FLMMIS). All new and renewing applicants are matched against the databases upon application, and all active Medicaid providers are matched against these sources monthly. This check ensures all providers have a valid NPI on their file and that no excluded entity or individual is enrolled in Medicaid.
- **Interoffice Communication** - Medicaid staff serve as a liaison between MPI, MFCU, HQA, DOH, APD, MHPs, and other federal and state regulatory departments with regard to provider enrollment and eligibility. Constant communication between these entities supports the Agency's ability to monitor provider eligibility and compliance.
- **Outside Referrals** – Medicaid staff routinely analyzes data obtained from investigations conducted by MPI, MFCU, other units within the Division of Medicaid, Medicaid health plans, and other agencies, to identify any relationships between the Medicaid providers terminated for misconduct and the list of active providers. Medicaid uses these analyses and consideration of any adverse history to make referrals to MPI to seek sanctions by Final Order, recommend contractual termination from Medicaid of a related provider, or recommend denial of enrollment.

Medicaid Health Plan Contract Requirements for Provider Credentialing

Beyond the activities carried out by the Agency for all providers, under the SMMC program each health plan is also responsible for the credentialing and re-credentialing of its provider network. The plans are responsible for:

- Ensuring that all providers are eligible for participation in the Medicaid program;
- Using the CAQH app ProView® application throughout the life of the contract to collect data from providers;
- Ensuring all providers have a current provider agreement with the Agency;
- Fully enrolling/on-boarding all providers it chooses to contract within 60 days;
- Terminating a network provider immediately upon notification from the state that the network provider cannot be enrolled, or the expiration of the 60- day period without enrollment of the provider, and notifying affected enrollees; and
- Requiring that each provider have a NPI number.

The plans' credentialing and re-credentialing policies and procedures are required by the SMMC contract to be in writing and include at least the following:

- Formal delegations and approvals of the credentialing process;
- A designated credentialing committee;
- Identification of providers who fall under its scope of authority;
- A process that provides for the verification of the credentialing and re-credentialing criteria required under the contract;
- Approval of new providers and imposition of sanctions, termination, suspension, and restrictions on existing providers; and
- Identification of quality deficiencies that result in the plan's restriction, suspension, termination, or sanctioning of a provider.

The contract that the Medicaid health plans have with their providers must contain specific provisions required by the Agency to ensure enrollees have access to all appropriate care as authorized in the Medicaid

State Plan and that the Agency can adequately monitor plan and provider performance. All records are open to investigation by the Agency and providers must fully cooperate with any investigations. Records must be maintained for a minimum of 10 years.

Additional information on the SMMC plan Model Contract is available on the Agency's website: http://ahca.myflorida.com/Medicaid/statewide_mc/plans_FY18-23.shtml

The Streamlined Credentialing Project

The Agency recognizes that credentialing requirements can create an administrative burden on the health plans and providers who participate in multiple health plans. Since 2015, the Agency has utilized the Streamlined Credentialing Project, a process wherein the Agency performs the basic credentialing functions on behalf of the MHPs. Providers can submit a limited enrollment application online via the Medicaid Public Web Portal. The limited enrollment application captures all demographic information, which is used to screen the provider against licensure and exclusion databases, and conduct background screenings in compliance with the Affordable Care Act provider screening requirements. Limited enrolled providers are required to complete a renewal process every three years similar to the current renewal process for fully enrolled providers. Providers submit their identifying information once to Medicaid through the streamlined credentialing and limited enrollment process, eliminating the need for providers to submit the same information to each health plan with which they seek to contract. The elimination of multiple credentialing applications means the Agency and MHPs have access to real-time, consistent screening results. It reduces the chances for duplicative or erroneous information and ensures everyone shares the same reliable provider background information. Limited enrolled providers are not authorized to provide services to Medicaid recipients enrolled in FFS Medicaid, but can contract with MHPs to serve recipients enrolled in those plans.

21st Century Cures Act

The Agency initiated a project to implement provider enrollment requirements as specified within the federal 21st Century Cures Act. Under the 21st Century Cures Act, all health plan network providers must disclose their ownership and controlling interest to the Agency, similar to FFS provider disclosures. The providers must submit to a background screening and must enter into an agreement with the Agency. Providers who do not comply cannot participate in the network of a MHP.

As part of the initial activities under the project, the Agency identified all network providers who were not enrolled and engaged the MHPs to assist with communication and outreach to the affected providers. Providers must submit applications to enroll as either a fully enrolled provider or they can choose the streamlined limited enrollment option. The Agency utilizes encounter data to monitor provider and health plan compliance with the 21st Century Cures Act requirement.

Referring and Ordering Providers

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

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

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

Behavior Analysis Services Providers Enhanced Review

Due to the critical nature of Behavior Analysis (BA) Services, the Agency implemented an enhanced review process for providers seeking to enroll in Medicaid to provide BA services. All BA applications must undergo an Application Quality Check, and any deficient applications are returned for correction. In addition, depending on the provider type additional screening requirements must be met, including an in-person interview or on-site review. Please refer to the *Behavior Analysis Agency Initiative* section in this report for additional information regarding BA and the work that has been conducted by the Agency.

Between January 1, 2018 and the end of the fiscal year, the Agency received 24,284 new applications from BA providers, and as of July 2, 2018, there were 13,925 total BA providers. Due to the enhanced and rigorous review, application processing for new BA providers is approximately 90 days. The table below shows the number and disposition of BA applications received between January 1 and July 2, 2018.

Application Status since January 1, 2018		
New Applications	24,284	--
Applications Completed	21,155	87%
Complete Approved	15,847	75%
Complete Closed/Denied	5,308	25%
Total	66,594	

Terminations of BA Providers

Along with the enhanced application review procedures, MPI undertook rigorous investigations of suspected fraud related to providers of BA services. As of July 2018, more than 1,700 providers have been terminated or had their payments suspended. The provider status for those actions are shown below:

Provider Status- January 2018-July 2018[1]	
Terminated for Cause	1
Terminated Without Cause	499
Payments Suspended	1,010
Pre-payment Review	193
Total	1,703

Fraud and Abuse Related Reporting Requirements

SMMC Health Plan Fraud and Abuse Related Reporting Requirements

MHPs in Florida Medicaid have comprehensive reporting requirements related to every phase of their operations. These reports allow the Agency to monitor not only provider networks, but also monitor several important phases of care provided by the plans. These reports help the Agency ensure that care provided to Medicaid recipients is medically necessary and appropriate, while ensuring cost-effectiveness and preventing inappropriate utilization. Plans are required to report their Provider Network File, Provider Termination File, and New Provider Notification Report weekly. These reports supply the Agency with up-to-date provider network information including information on the suspension, termination, or withdrawal of providers from participation in the plan's network. This allows the Agency to monitor the MHPs' compliance with required provider network composition, provider-to-member ratios, and allows for other uses deemed pertinent. Plans are required to report any suspected fraud and abuse activity by a provider or enrollee to the Agency within 15 days. The report must contain detailed information on the nature of the fraud and abuse. Plans must also provide quarterly and annual fraud and abuse activity reports (QFAAR and AFAAR).

[1] Prior to January 2018, BA applications went through the normal review process. Data was not separated prior to this date.

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, abuse, and waste. Medicaid offers many educational resources to providers, and as part of the contractual agreement with all MHPs, the MHPs are responsible for providing education and training to their network providers to prevent fraud and abuse, and have a monitoring plan in place for fraud prevention. The following sections highlight some of the education, training, and outreach efforts conducted by Medicaid for providers.

Program-Wide Provider Education

Medicaid maintains a Provider Services portal on its website to assist providers with the many facets of navigating the Medicaid system. This includes a Provider Enrollment Help Line, registration for local trainings, information on filing claims and many other reference materials. Providers routinely receive information about topics, training dates, and how to access upcoming training opportunities via the electronic Medicaid Provider Alert system, as well as, the Medicaid Provider Bulletins which are updated on the Agency website quarterly.

Health Plan Education and Training Requirements

Health plans are required to provide education and training to ensure providers in their provider network understand all required performance criteria. This includes training all providers and their staff regarding the requirements of the SMMC contract and special needs of enrollees. The MHP is required to conduct initial training within 30 days of placing a newly contracted provider, or provider group, on active status. The provider or provider group also must conduct ongoing training, as deemed necessary by the MHP or the Agency, in order to ensure compliance with program standards.

The MHP is also required to provide training and education to providers regarding the MHP's enrollment and credentialing requirements and processes, and for one year following the implementation of the contract. The MHP is required to conduct monthly education and training for providers regarding claims submission and payment processes, which has to include at minimum, an explanation of common claims submission errors and how to avoid those errors.

Each MHP is also required to provide details and educate employees, subcontractors, and providers about the following as required by s. 6032 of the federal Deficit Reduction Act of 2005:

- The Federal False Claims Act;
- The penalties and administrative remedies for submitting false claims and statements;
- Whistleblower protections under federal and state law;
- The entity's role in preventing and detecting fraud, abuse, and waste;
- Each person's responsibility relating to detection and prevention; and
- The toll-free state telephone numbers for reporting fraud and abuse.

Utilization Management

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

Programs to manage health care utilization have existed for more than 20 years. Early efforts focused on reducing the number of inpatient hospital admissions and eliminating unnecessary hospital days. In order to achieve this objective, health plan administrators reviewed the hospital admission for medical necessity prior to the admission and determined the need for ongoing care. As health care has grown more complex, the need for 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 (PDL), prior authorization of certain services, and Medicaid claims analysis, as well as, independent research to assess policy implementation and program performance. With the implementation of SMMC, most of the responsibility for utilization management belongs to the MHPs. 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. The following sections provide a brief overview of the utilization management efforts in Florida Medicaid.

Prior authorization is a utilization control that many insurers and health care programs like Medicaid employ to determine member eligibility, benefit coverage, medical necessity, location, and appropriateness of services, as well as, ensuring that care being provided is necessary and appropriate. Similar to, but distinct from 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.

Program-Wide Utilization Management

Medicaid Preferred Drug List

The Medicaid Preferred Drug List (PDL) is a tool that has been widely used by both public health plans such as Medicare and Medicaid, as well as, private health plans. The PDL provides a list of safe and effective drugs that can be used to treat patients with specific diagnoses. The PDL has the advantage of allowing providers to prescribe drugs that are known to be effective while helping to constrain costs. MHPs, as well as, FFS providers must adhere to the Medicaid PDL, though providers may request drugs not on the PDL when medically necessary. Florida Medicaid's PDL typically provides enough alternatives to allow several options to meet recipients' needs. Medicaid has a Pharmaceutical and Therapeutics Committee that makes recommendations to the Agency for the purpose of developing and maintaining the PDL. The committee performs ongoing scheduled reviews of the PDL with continued updating of prior authorization and step therapy protocols for drugs not on the PDL. The committee may recommend prior authorization protocols for Medicaid-covered prescribed drugs to ensure compliance with clinical guidelines, for indications not approved in labeling, and for prevention of potential overuse, misuse, or abuse.

Data Analysis

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

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

the performance analysis findings.

SMMC Health Plan Utilization Management

SMMC Contractual Provisions and Plan Responsibilities

Utilization management in SMMC is primarily the responsibility of the MHPs. The Agency's contracts with the health plans require that each plan have a utilization management program in place. Each health plan's utilization management program must be reflected in a written Utilization Management Program Description and include, at minimum:

- Procedures for identifying patterns of over-utilization and under-utilization of services and for addressing potential problems identified as a result of these analyses;
- Procedures for reporting fraud and abuse information identified through the Utilization Management program to MPI;
- Procedures for enrollees to obtain a second medical opinion at no expense to the enrollee and for the plan to authorize claims for such services; and
- Protocols for prior authorization and denial of services, the process used to evaluate prior and concurrent authorization, objective evidence-based criteria to support authorization decisions, mechanisms to ensure consistent application of review criteria for authorization decisions, consultation with the requesting provider when appropriate, hospital discharge planning; physician profiling, and retrospective review, meeting predefined criteria.

The MHPs have to ensure that applicable evidence-based criteria are utilized with consideration given to characteristics of the local delivery systems available for specific members, as well as member-specific factors such as, member's age, co-morbidities, complications, progress in treatment, psychosocial situations, and home environment. The MHP must also ensure that reimbursement for utilization management activities is not structured in such a way that it provides incentives for the denial, limitation, or discontinuation of medically necessary services to any enrollee.

As part of their overall utilization management system, MHPs are required to have automated authorization systems and may not require additional paper authorization as a condition for providing treatment. The health plans' service authorization systems must provide written confirmation of all denials, service limitations, and reductions of authorization to providers, the authorization number, and effective dates for authorization to providers and non-participating providers. The MHP cannot delay service authorization if written documentation is not available in a timely manner, but the plan is not required to approve claims for which it has received no written documentation. As part of the authorization system, MHPs are required to have a toll-free provider help line that must be staffed 24 hours a day, seven days a week to respond to prior authorization requests.

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

SMMC Health Plan Prior Authorization

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

Medicaid Fee-for-Service Utilization Management

Pharmacy Claims Processing

There are several activities that Medicaid has undertaken to ensure that Medicaid pharmacy services provided to the FFS population are both appropriate and cost effective. Medicaid also has point-of-sale monitoring available to track medication usage and has thousands of claims edits in place to automatically prevent inappropriate expenditures. The system of automated claims edits is continuously refined and improved to support safe prescribing, adherence to the PDL, and prevention of fraud, abuse, and waste. In FY 2017-18, the contracted prescription benefit manager vendor processed more than 2.3 million FFS pharmacy claims, which is more than 194,000 per month.

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

Through a contract with the University of Florida Medication Therapy Management Call Center, trained pharmacists conduct comprehensive prescribed drug case management, which involves direct patient contact if the patient chooses to participate. This statewide Medication Therapy Management Program can help resolve medication-related and health-related problems, optimize medication use for improved patient outcomes, and promote patient self-management of medication and disease states. This in turn helps reduce clinical risk and lowers prescribed drug costs to the Medicaid program including reducing the rate of inappropriate spending on Medicaid prescription drugs.

Many of the Medicaid recipients who are not enrolled in MHPs have special needs and there is a high demand for several services that Medicaid provides. Medicaid has contracted with several specialized vendors to provide prior authorization and utilization management for many of the remaining FFS services. Prior authorization efforts for two of the services with high demand, home health services and pharmacy benefits, are highlighted in the following sections. Private Duty Nursing, Personal Care Services, and BA services are three more FFS services that require prior authorization and are discussed under Utilization Management below.

Pharmacy Prior Authorization

The Florida Medicaid FFS pharmacy program ensures quality and cost effective pharmacy practices. The combination of cost containment programs and preferred drug policies minimize expenditures and contribute to maximization of drug rebate collections. System driven edits and prior authorization procedures ensure that Medicaid recipients have access to needed medications while program costs are controlled, and fraud and overutilization are minimized. The claims processing system has thousands of payment system "edits" that use a cost avoidance philosophy to prevent inappropriate expenditure of Medicaid funds. These "edits" prevent payments for what could be characterized as abusive practices. The payment system's edits promote utilization of generic drugs, appropriate age and gender restrictions, drug utilization reviews (such as high dose, therapeutic duplication, and early refills), coverage limits, and prevent duplicate paid claims.

Authorization prior to reimbursement for certain drugs continues in FFS pharmacy. Clinical criteria and some edits (such as age limits and quantity limits) have been established for certain drugs to ensure safe and appropriate prescribing. The Agency's contracted pharmacy benefits manager, Magellan Medicaid Administration, a federally designated Quality Improvement Organization-like vendor, reviews prior authorization requests for drugs not on the PDL and determines whether a request is to be approved or denied.

The following chart shows the total number of prior authorization requests received in FY 2017-18 for the Medicaid FFS pharmacy program.

Pharmacy Prior Authorization Requests FY 2017-18		
Total Prior Authorization Requests	35,762	100.0%
Average Per Day	98	--
Total Requests Approved	32.417	90.6%
Total Requests with Change in Therapy	2,966	8.3%
Total Requests Denied	379	1.1%

Other prior authorization activities include, but are not limited to:

- HIV/AIDS drug product initiatives which provide safeguards against contraindicated regimens;
- Controlled substance initiatives which limit the number of controlled substances allowed depending on diagnoses; and
- Oral oncology product initiatives to ensure proper utilization of these agents through clinical prior authorization review, quantity, and age limits.

Utilization Management of Home Health Services

The Agency contracts with Centric Consulting, Inc. as the vendor for continuation of home health electronic visit verification (EVV) services from FY 2017-18 through FY 2020-21. The primary purpose of the EVV contract is to verify the utilization and delivery of home health services using technology that is effective for identifying delivery of the service and deterring fraudulent or abusive billing for the service. EVV provides an electronic billing interface and requires the electronic submission of claims for home health services. This helps ensure appropriate utilization and expenditures for Medicaid home health services, improves the quality of care for Medicaid recipients, and prevents Medicaid fraud, abuse, and waste. EVV includes monitoring of all home health services (i.e., home health visits, private duty nursing, and personal care services).

Home Health Visit Prior Authorization

One of the primary areas where Medicaid continues prior authorization for FFS recipients is for home health services. The Agency's vendor, eQHealth Solutions, Inc. (eQHealth), conducts prior authorization for home health services to ensure that the proposed services are medically necessary and appropriate.

Medicaid reimburses for home health services that are rendered by licensed, Medicaid-participating home health agencies and Medicaid enrolled independent personal care providers. Medicaid reimburses for the following services:

- Home visit services provided by a registered nurse or a licensed practical nurse;
- Home visits provided by a qualified home health aide;
- Private duty nursing for children age 20 or younger; and
- Personal care services for children age 20 or younger.

During FY 2017-18, eQHealth conducted 8,633 home health prior authorizations, an average of 719 per month. Of these, 8,339 were approved, giving a denial rate of 3.4 percent. The following table shows the total number of home health prior authorization requests, approvals, denials, and denial percentage for each month during FY 2017-18. Note that in addition to being approved or denied, requests may also be pended for more information, held for additional review because of new information received, still be under reconsideration, or could also be awaiting a fair hearing.

The following chart shows the total number of prior authorization requests received in FY 2017-18 for Medicaid Home Health services.

Home Health Prior Authorization Requests FY 2017-18	
Total Visits Requested	8,850
Total Reviews Completed	8,633
Approved	8,339
Denied	294
Denied %	3.4%

Comprehensive Care Management for Children with Special Health Care Needs

The Agency has also included Comprehensive Care Management in its contract with eQHealth, Inc., which provides utilization management and care coordination for home health visits, private duty nursing, personal care services, prescribed pediatric extended care (PPEC) services, and inpatient medical and surgical services. The purpose is to improve care coordination and to identify potential overutilization and fraud or abuse of Medicaid services by ensuring that the level of home health aide and private duty nursing services provided to recipients receiving home health care matches the needs of the recipients. During FY 2017-18, the vendor conducted 1,073 home visits and 4,628 care coordination visits and team meetings.

The vendor provided the Agency with a utilization report of the home health agencies that routinely submit requests that are well above the average for their area. This information is reviewed by MPI to determine if an investigation is needed. The following are the results for FY 2017-18:

Comprehensive Care Monitoring FY 2017-18 Statewide		
1,072 Total On-Site Home Visits to Recipients		
Recipients with Fully Approved Requests	863	80.43%
Recipients with Fully Denied Requests	7	0.65%
Recipients with Partial Approval	195	18.17%
Reconsideration is Complete	7	0.65%
At Fair Hearing	0	0.00%
At Reconsideration	0	0.00%

Ancillary Medicaid and Other Services

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

- Chiropractic;
- Dental;
- Durable Medical Equipment;
- Inpatient Services;
- Physician Outpatient Surgery;
- Physician Services;
- Podiatry;
- Special Services for Children; and
- Vision and Hearing.

Inpatient Behavioral Health

In FY 2017-18, the Agency had a contract with Magellan to operate a Medicaid Behavioral Health Care Program. The Vendor provided care coordination services for FFS Florida Medicaid recipients receiving Statewide Inpatient Psychiatric Program (SIPP) services or receiving inpatient behavioral health services with an out-of-state residential treatment provider. The care coordination services are necessary to ensure that the recipients receive the necessary services and that proper discharge planning occurs.

After release from inpatient behavioral health treatment, patient/provider follow-up is critical for ensuring that the recipient's health is maintained and that resources are used appropriately and effectively. Medicaid requires providers to follow up with recipients within 30 days of discharge and assess the recipient's status and need for continuing care. Recipients not receiving necessary services after discharge are at an increased risk for readmission for inpatient treatment. During this Fiscal Year reporting period there were 25 FFS recipients served in a SIPP level of care. Of the 25 recipients, none were determined to be readmissions within 30 days. Nine were considered multiple admissions (admitted to a SIPP facility more than once).

Compliance Rates from the 30-day Follow-up: 30-Day Outpatient		
Individual Therapy	8	89%
Family Therapy	5	56%
Targeted Case Management (TCM)	5	56%
Behavior Analyst	1	11%
Substance Abuse	0	--
Medication Management	9	100%
Extracurricular Activities	0	--
Other Support Services	6	67%

Outpatient Advanced Diagnostic Imaging

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

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

Outpatient Diagnostic Imaging Prior Authorization Requests FY 2017-18		
PA Requests Received	20,081	--
Ineligible for Review	1,457	7.25%
Completed Reviews	17,541	--
Referred for Physician Review	761	4.34%
Reviews Denied	101	0.57%

Medicaid Certified School Match Program

The Medicaid Certified School Match Program reimburses providers for medically necessary services provided by or arranged by a school district for Medicaid eligible students. School districts are reimbursed for the following services provided in a school setting by a Medicaid eligible provider:

- Therapy Services;
- Nursing Services;
- Behavioral Health Services;
- Transportation; and
- Alternative Augmentative Communication Devices.

School districts are allowed to claim administrative costs related to the coordination and delivery of health care services within their schools. Administrative claiming generated almost $104 million in reimbursements for participating school districts. During FY 2017-18, Agency staff monitored all participating school districts quarterly for compliance with program policy and procedures.

Behavior Analysis Services Utilization Management

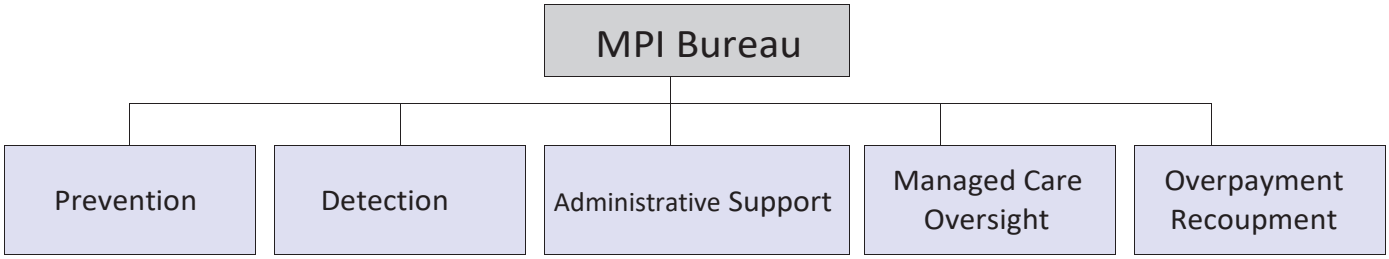
Before providing Behavior Analysis (BA) services to Medicaid recipients, and at least every 180 days thereafter, providers must obtain authorization from eQHealth. Providers may request authorization more frequently if the recipient's condition changes so that an increase or decrease in services is required. The following tables show the number of prior authorizations for BA treatment services and assessment services through June 23, 2018.

Prior Authorization for BA Treatment Services- Since March 26, 2018		
Approved	7,669	97.99%
Partially Approved	126	1.61%
Denied	31	0.40%
Pending Provider Information	5,387	--
Fair Hearings	4	--

Prior Authorization for BA Assessment Services- Since March 26, 2018		
Approved	10,566	99.97%
Partially Approved	0	0.00%
Denied	3	0.03%
Pending Provider Information	2,017	--
Fair Hearings	--	--

Between January 1, 2018, and June 27, 2018, Medicaid paid for BA services for 15,552 unique recipients totaling more than $251 million.

Medicaid Program Integrity



Organizational Overview

During Fiscal Year (FY) 2017-18, the Bureau of Medicaid Program Integrity (MPI or Bureau) relocated within the Agency for Health Care Administration (AHCA or the Agency) from the Office of Inspector General (OIG) to the Division of Health Quality Assurance (HQA). Although this was a significant organizational change, it did not otherwise result in organizational changes within MPI for FY 2017-18. Details about the organization which are described within several prior year reports remain an accurate reflection of the ongoing efforts of the Agency and MPI to combat fraud and abuse. Other activities, which are described throughout this report, which impacted MPI operations, included efforts pertaining to emergency preparedness and responses for which MPI personnel assisted following Hurricane Irma (September 2017) and the necessary adjustment of MPI activities to accommodate provider and recipient post-hurricane recovery efforts. Additionally, during FY 2017-18, MPI endeavored to transition resources to adjust as the Medicaid program evolves; however, program changes regarding the addition of a provider type (and related services) in March 2017, also resulted in a significant focus on fee-for-service (FFS) oversight and delayed some aspects of the transition. In fact, increasing oversight efforts pertaining to FFS programs and providers will likely continue into FY 2018-19.

As has been the case for decades, MPI continues to serve as the primary office within the Agency to design, coordinate, and implement the Medicaid program's fraud, abuse, and waste prevention and detection efforts. The Agency is required, pursuant to s. 409.913, Florida Statutes (F.S.), to operate a Medicaid provider oversight program to ensure that fraudulent and abusive behavior occurs to the minimum extent possible in the Medicaid program. In recent years, MPI efforts have very carefully focused on the aspects of the Agency's charge that require prevention and detection efforts regarding provider behavior. MPI has expanded efforts over the past several years to look beyond Medicaid claims data as evidence of suspected fraudulent or abusive behavior. Claims are one of many data sources that may be utilized to identify potential subjects for investigation.

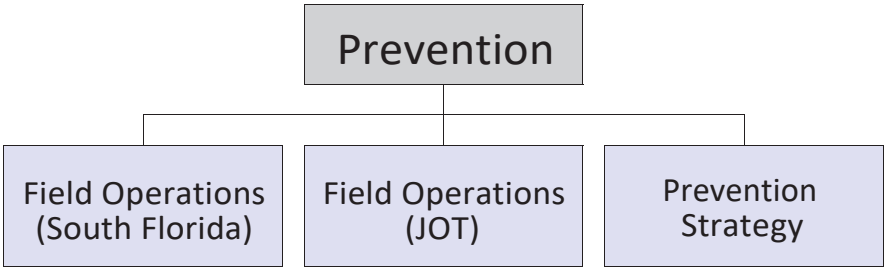
Although many aspects of MPI operations are based upon principles and foundations long established, the Agency strives to be a national leader in program integrity efforts. MPI takes great value on innovation, particularly with regard to fraud and abuse prevention and detection.

MPI has, concurrent with the efforts to enhance prevention and detection efforts, continued to emphasize the need to increase efforts to recover Medicaid overpayments, impose sanctions for violations against the Medicaid program, and identify and make referrals to other investigatory or regulatory agencies as a means to further the Agency efforts to combat fraud, abuse, and waste, as well as the neglect or abuse of recipients.

In the Annual Report regarding FY 2016-17, MPI emphasized an internal examination of processes, especially those which identify behaviors of individuals engaged in practices that result in misspent funds and abusive practices. During FY 2017-18, the improved investigative planning processes, and processes which included a broader examination of potentially abusive provider behaviors, brought rise to earlier detection of potentially extensive and pervasive fraud schemes in the Medicaid program. These efforts were deployed concurrent with the launch of the Behavior Analysis (BA) services program in March 2017, and very early were used to identify significant issues of suspected criminal activity. These and other efforts are further described throughout this report.

MPI's organizational structure by unit is depicted in the above graphic and is detailed further in the sections which follow.

Prevention



The Prevention Unit consists of three sub-units with responsibilities for prevention activities in designated geographical areas in Florida. The Tallahassee-based sub-unit is also responsible for strategic planning and other specific prevention-related investigative activities. The sub-units include: (1) South Florida Field Operations, located in the Miami Area Office; (2) Jacksonville, Orlando, and Tampa (JOT) Field Operations, with staff in the respective area offices and a manager in the Tampa Area Office; and (3) Prevention Strategy, located at AHCA headquarters in Tallahassee.

The Prevention Unit conducts a variety of activities designed to achieve cost-savings related to fraud, abuse, and waste in the Medicaid program. One such activity is the field operations carried out through Medicaid provider on-site visits, either as a part of a complaint or case investigation, or as a component of a field initiative (focused project). Focused projects are data-driven field initiatives designed to address identified program needs and vulnerabilities and may include staff from various state and federal regulatory agencies.

During FY 2017-18, the Prevention Unit was heavily involved in activities pertaining to oversight, audits, investigations, and enforcement activities regarding the Behavior Analysis (BA) services which were launched in March 2017. MPI personnel had previously been closely collaborating with the Division of Medicaid regarding known and anticipated program vulnerabilities. MPI's efforts, particularly those of the Prevention Unit, are further detailed in the section titled *Behavior Analysis Agency Initiative*.

Other prevention activities include: conducting prepayment reviews; strategic planning; preliminary investigations for MFCU referrals; subsequent investigations for the imposition of payment restrictions and sanctions; and project development for potential audit referrals to other MPI units. The Prevention Strategy sub-unit has a lesser focus on provider site-visits and a greater focus on collaborative and research efforts related to fraud and abuse prevention, as well as, early detection. Examples of such efforts include providing guidance, research, and support to the Division of Medicaid to prevent enrollment of fraudulent and high-risk providers, as well as, coordinating with the HQA, about provider types licensed by them to ensure a loss of licensure or restriction on a required license is quickly addressed from a Medicaid program standpoint. This sub-unit also has responsibilities regarding MPI process and organizational assessments to ensure that MPI engages in routine improvements.

Calculating Return on Investment through Prevention Measures

MPI, along with internal Agency partners and external partners, engages in a variety of activities best categorized as fraud, abuse, and waste *prevention*. These activities involve early detection of fraud, abuse, and waste, and avoidance of ongoing loss. In the realm of health care, particularly within the context of disease and other health-related factors, prevention is considered "the best medicine". However, the value of fraud prevention is often difficult to calculate. If the amount of the loss that was prevented is readily known (which, in some instances is the case), it has historically been calculated and reported as a part of the cost avoidance or prevention return on investment (ROI). For example, the value of a Medicaid claim for reimbursement found to be improper and denied

before payment is processed, has a quantifiable value (the value of the claim). However, the value of most prevention activities are not as easily calculated. Often, these efforts are not valued or are undervalued for purposes of measuring ROI. MPI has prioritized the evaluation of prevention values for provider interactions and education particularly by way of on-site visits, program assessment and consultation with Medicaid operations, and the early detection of fraud and more complex referrals to MFCU.

We recognize that any dollar of potential loss (exposed amount) that is preliminarily identified by MPI may not, in fact, be later recovered or later determined to be a loss due to fraud. However, but for the detection, preliminary investigation, and referral to MFCU by MPI, it is likely that the dollars would have remained undiscovered. At the time of the referral to MFCU, MPI determines the value of the exposed amount due to the suspected criminal activity. The exposed amount is calculated based upon the reimbursements to the referred subject which are reasonably believed to be losses to the Medicaid program or other reasonable calculation of the impact of the suspected criminal activity. Sometimes this figure is based upon an actual identified loss. For example, MPI may have completed a more comprehensive review of data and evidence and thus can reasonably calculate the likely exposed amount. Other times, however, the evidence of suspected criminal activity arises and becomes sufficiently reliable for a referral before MPI is able to calculate suspected actual losses. In those instances, MPI attempts to reasonably estimate the value of the exposed amount which may be related to the suspected criminal activity.

MPI recognizes that the exposed amount could be reduced, for purposes of calculating ROI, due to both the risk that some portion of the dollars are ultimately not recoverable for a variety of reasons and due to the present day value of the future recovery. Future years' calculations may be adjusted to reflect additional calculations and the continued development of the methodology. MPI will attempt to obtain data to better calculate the proportion of MPI referrals that result in recoveries and the typical length of time within which the recoveries are realized so that the methodology can be further refined.

While MPI, with help from others, will continue to endeavor to increase prevention activities (and thus, necessarily, detection and recovery activities), it is critical to understand how great the value of prevention activities are in these, and other, reports; particularly the value of fraud referrals to MFCU and the coordination and consultative role of MPI within the Agency. In the FY 2016-17 Annual Report, it was reported that MPI would continue to focus on developing a process to measure the value of MFCU referrals. During FY 2017-18, MPI implemented a process to identify the prevention value of MFCU referrals that is based upon the Centers for Medicare and Medicaid Services (CMS) guidance *Best Practices for Medicaid Program Integrity Units' Interactions with Medicaid Fraud Control Units, September 2008*, using the estimated exposure amounts of the suspected fraudulent activity. As new processes are developed to quantify the significant value of prevention activities in combatting fraud and abuse in the Medicaid program, MPI continues to strive for further awareness (both internally within the Agency and externally) that fraud prevention is everybody's business.

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

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

- Conducting outreach activities with internal and external stakeholders to aide in their awareness and efforts to ensure provider and health plan compliance;
- Coordinating with health plans to aide in fraud prevention efforts, including reviews of their provider networks for ineligible providers, discussions of fraud prevention and detection techniques/ methodologies, providing a forum for discussions of best practices, and coordinating and facilitating periodic meetings with health plans, MFCU, and MPI regarding fraud prevention and best practices in investigations and other program integrity activities;

- Development of relationships with other entities, whose efforts can aide in the fight against fraud, including coordination with other federal and state agencies, and facilitating strong and consistent internal communications;
- Monitoring high-risk programs and provider types to aide in the development of training, as well as, to serve as a deterrent; additional results include increased referrals to MPI from Division of Medicaid personnel;
- Analyzing trends within programs, provider types, and service types to assess high-risk issues and engage in strategic planning of MPI and Agency efforts;
- Facilitating and participating in the review and amendment of the Agency's policies (e.g., Health Maintenance Organization (HMO) contracts, provider handbooks, etc.) as it relates to fraud prevention and increasing compliance;
- Implementing and conducting pre-payment reviews of providers in conjunction with provider contract terminations;
- Coordinating and facilitating activities specific to assisting in the prosecution of fraud; such activities may involve policy confirmation/clarification, witness coordination/preparation, and serving as an expert witness;
- Coordinating and facilitating activities related to the review and amendment of Agency systems and processes in order to increase effectiveness of fraud prevention and detection efforts;
- Facilitating/aiding in the use of encounter data in fraud prevention and detection efforts;
- Ensuring effective communication between the Division of Medicaid and MPI;
- Coordinating efforts regarding the Agency's Fraud Steering Committee, and sub-committees, an internal working group designed to ensure comprehensive and continuous Agency anti-fraud efforts, including co-leading the subcommittees;
- Coordinating and assisting other Agency personnel with issues related to fraud, abuse, and compliance;
- Conducting provider on-site inspections and provider audits, which furthers deterrence and prevention activities;
- Engaging in managed care plan oversight activities related to program integrity efforts of the health plans, as well as, comprehensive assessment of activities that impact the detection and prevention of fraud, abuse, and waste within managed care;
- Conducting appropriate preliminary investigations and, as appropriate, making referrals to other agencies, including Office of the Attorney General, Department of Health (DOH), Department of Childrens and Families (DCF), and Department of Financial Services (DFS); and
- Identifying instances of suspected fraud and abuse, conducting appropriate investigations, and imposing payment restrictions to protect program funds against further fraud and abuse.

Payment Restrictions

Payment restrictions include the "pending" of claims in the Medicaid claims processing system for one or more specific, legally authorized purposes. Claims may be pended due to enrollment issues, claim processing issues, or other administrative matters handled by other organizational units within AHCA. MPI payment restrictions are imposed by way of a notice to the Division of Medicaid requesting the provider's Medicaid reimbursements be pended. MPI also provides notice to the provider and the Medicaid health plans (MPHs). Payment restrictions used by MPI include:

- Prepayment Review (PPR) consistent with s. 409.913(3), F.S.;
- A payment withhold following a determination that there exists reliable evidence of circumstances related to fraud, abuse, or willful misrepresentation (referred to as a "25A withhold") consistent with s. 409.913(25)(a), F.S.; or
- A payment suspension following a determination that there are credible allegations of fraud (referred to

as a "CAF payment suspension") consistent with 42 CFR 455.23.

The nature of the basis for these payment restrictions is confidential under federal and state law due to the ongoing investigation regarding suspected fraud or abuse. While case-specific highlights cannot be furnished, the graphic below indicates the number and type of payment restrictions implemented by MPI during FY 2017-18.

Type and Number of Payment Restrictions	
Pre-Payment Review	203
25A Withholds	807
Credible Allegation of Fraud	33

Referrals

MPI routinely coordinates with Medicaid stakeholders, program integrity/anti-fraud professionals, and other related agencies on common issues, such as fraud and abuse risks, preliminary review findings, and received complaints requiring participation/collaboration with another AHCA unit or outside agency. Generally, suspected facility licensure violations are referred to the Agency's Division of HQA, practitioner license violations to the DOH-Division of Medical Quality Assurance (MQA), as appropriate, Medicare implications to CMS, and enrollment concerns to the Division of Medicaid, or the Department of Children and Families, as appropriate. Suspected fraudulent provider activity is referred to the MFCU.

During FY 2017-18, improved information-sharing and stronger collaboration efforts between MPI and key partners contributed to an increase in referrals made by MPI to internal and external agencies. In FY 2017-18, MPI made 852 referrals to other parties for action deemed appropriate. At present, MPI is considering ways to project prevention determinations for referrals made to other entities.

Sanctions

Administrative sanctions applied against a provider are typically imposed in accordance with s. 409.913, F.S., and Rule 59G-9.070, Florida Administrative Code (F.A.C.). Sanctions typically imposed by MPI include fines, suspension, and termination. However, not all Medicaid provider terminations are imposed by MPI. Voluntary terminations include situations in which the provider withdraws from the Medicaid program or closes their business. In most circumstances, these terminations do not come to the attention of MPI. However, when such voluntary terminations are perceived as an attempt to avoid further regulatory action, subsequent Medicaid sanctions may apply. Involuntary terminations and suspensions involve: any termination or suspension from participation in the Medicaid program in which the provider did not choose to relinquish their provider number; an instance when a provider voluntarily relinquishes a required license; or when a provider voluntarily terminates after the Agency has conducted an audit, survey, inspection, or investigation where a sanction of suspension or termination will or would be imposed for non-compliance discovered as a result of the audit, survey, inspection, or investigation.

Involuntary terminations may be contractual actions carried out by the Division of Medicaid when the Medicaid provider agreement is terminated under the provision that indicates either party may terminate the contract with a 30-day notice to the other party. Contract terminations are often referred to informally as "without cause" terminations. Involuntary terminations may also involve administrative sanctions imposed following the issuance of a Final Order, which serves to terminate or suspend the provider's participation in the Medicaid program. Provider terminations emanating from sanctions and Final Orders are often referred to as "for cause" or "with cause" terminations.

When the Agency exercises its authority under the statutes and rules that govern the imposition of sanctions, it is required to provide notice of the basis for the termination or suspension and provide due process hearing rights. The sanction becomes final upon issuance of the Final Order against the provider. The sanction of

termination may be imposed for reasons including; licensure revocations, failure to repay overpayments owed to the Agency, termination from the Medicare program or the Medicaid program in any other state, provider actions or inactions that are harmful to recipients, convictions of disqualifying criminal offenses, and repeated instances of certain violations. Similarly, the sanction of suspension may be imposed for reasons including licensure suspensions, suspension from the Medicare program or the Medicaid program in any other state, the provider was charged by information or indictment with fraudulent billing practices or other disqualifying offenses, or the provider failed to comply with an agreed-upon repayment schedule.

All sanctions that are issued by MPI are imposed by way of a Final Order. All Agency Final Orders are posted on the Agency's website[2]. Further details about sanctions imposed by MPI are set forth in the statutory reporting requirements section of this report.

Field Initiatives/Focused Projects

The Prevention Unit is responsible for provider on-site visits and field initiatives. A field initiative is a series of on-site visits, typically of the same provider type in a single geographic area. MPI uses multiple data sources and risk indicators beyond Medicaid claims data to identify those site-visit subjects with the greatest risk of potential fraud or abuse to the Medicaid program. Through the field initiatives, MPI staff participate in on-site verification of medical records, office locations, provider employee information, and other details required by the Medicaid program policies and laws. The field initiatives gather information to support or refute allegations of suspected abuse. Through the field initiatives, MPI attempts to further discern whether the circumstances are of the nature that should be referred to MFCU for a fraud investigation or that should be referred for an overpayment recovery audit by the appropriate unit within MPI. During FY 2017-18, MPI conducted a number of field initiatives related to the following Medicaid provider types and counties:

- Targeted Case Management Orange County Phase 2;
- Targeted Case Management Northeast Region (Area 4);
- Broward County Behavior Analysis Initiative;
- Statewide Physicians Initiative; and
- 2017 Statewide Review of Behavior Analysis.

A summary of outcomes related to the FY 2017-18 projects are described below. Calculations regarding the "value" of those projects will include standard processes for calculating the value of provider terminations and overpayment recoveries, they will also include the calculations previously described and later detailed regarding MFCU referrals. At present, MPI does not have a formalized process for calculating the value to Medicaid operations regarding sharing lessons learned and helping implement any enhanced safeguards. Also, MPI does not have a method for valuing the impact of the increased perception of detection on the broader provider community. However, as is thoroughly detailed throughout this report, there is an unarticulated value in these efforts.

Targeted Case Management Orange County Phase 2

The purpose of the Orange County Phase 2 project was to visit the remaining targeted case management (TCM) providers who were not included in the February 2017 Orange County TCM project. The goal was to validate or refute the information submitted to the state Medicaid agency regarding the provider (and the implied statement regarding employee qualifications) was accurate. The focus of this project was information gathering, specifically:

- To identify the owners and operators of the business;
- To identify the affiliated rendering TCM providers, both known and unknown to the Florida Medicaid program and documented in provider enrollment files; and

[2] http://apps.ahca.myflorida.com/dm_web/(S(z10oxk3rg53lh0rhtm0d0hmo))/default.aspx

- To assess relationships, qualifications, and other risk indicators.

This project also sought to identify providers for potential referral to MFCU, for possible termination, or referral to the Overpayment and Recoupment Unit (ORU) audit. Twenty-three providers were included in this project. MPI actions were initiated against 74% of the TCM providers visited. These actions included recommendations for termination, referrals to managed care organizations, referrals to the Medicaid Fiscal Agent Operations (MFAO), and provider education. An additional 14 provider numbers affiliated with our TCM project providers were also recommended for termination.

Targeted Case Management Northeast Florida

In August 2017, MPI conducted a TCM initiative that focused on 15 active, Medicaid enrolled, group providers. The goals and focus of this project were the same as the TCM Orange County Phase 2 project. MPI actions were initiated against 80% of the providers visited, which included recommendations for termination, voluntarily termination of provider number, or provider education. An additional three provider numbers affiliated with our TCM project providers were also recommended for termination.

Broward County Behavior Analysis Initiative

In August 2017, MPI coordinated an information gathering field initiative that focused on 10 active, Medicaid enrolled, group BA providers in Broward County suspected of having rendered services that are not compensable and of using ineligible/unqualified providers. The focus was on reviewing the credentials of the Registered Behavioral Technicians (RBTs) and Behavior Assistants, who may not have had the experience or education to which they attested for purposes of provider enrollment. The provider site-visits conducted by MPI staff confirmed that 90% of the providers visited had enrollment issues that warranted MPI administrative actions. The findings of this project resulted in nine referrals to MFAO to remove 89 individual rendering providers not employed by the group. In addition, 11 individual rendering provider referrals were made to MFAO for evaluation of non-qualified rendering providers.

Statewide Physicians Initiative

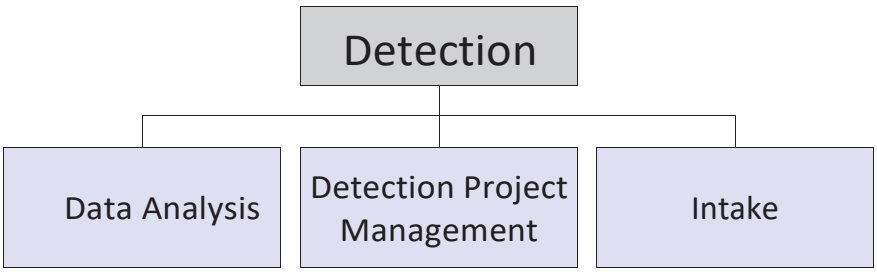
MPI routinely conducts overpayment recovery audits on physicians, which may result in identified overpayments. In October 2017, MPI conducted a field initiative that focused on five Florida Medicaid enrolled physician providers statewide that billed exclusively, or nearly exclusively, at the lower (level 1 Procedure Codes 99201, 99211, and level 2 Procedure Codes 99202, 99212) levels of E&M codes. While typical projects focus on higher codes or potential "upcoding", this project was evaluating whether an algorithm could be developed to reliably detect billing for services not rendered or "add on" billing. As a result of the focused site-visits conducted by MPI personnel, 40% of the providers visited warranted MPI action. One provider was referred to the Tallahassee-based Prevention Strategy sub-unit for consideration for referrals to other regulatory entities or agencies, including law enforcement. A second provider was referred to the ORU for consideration of a comprehensive audit. While these findings did not yield as high of a percentage of actionable leads as MPI typically expects, the project was testing a new and innovative approach which may be further refined as additional data becomes available for MPI detection activities.

2017 Statewide Review of Behavior Analysis

Subsequent to a BA pilot project in Miami-Dade County in May 2017 and an additional project in Broward County in August 2017, it was determined that program vulnerabilities appeared as, if not more, pervasive. Findings in both site-visit pilot projects and other MPI investigations and audits suggest that BA providers with false or erroneous applications posed a significant risk for abusive and fraudulent behavior specifically; ineligible BA providers were being enrolled in the Medicaid program based upon fabricated documentation and other deceptive practices. Because of pervasiveness of the issues and the evidence of fabricated documentation in many investigations, MPI personnel initiated a statewide BA project. The statewide BA project focused on all active, enrolled BA group providers (provider type 39) and the rendering providers affiliated with the groups.

The first phase of the project was to conduct a statewide records request followed by desk-review of provider eligibility and qualifications. This also involved MPI personnel conducting information-gathering site-visits to providers who were not forthcoming with a response to the documentation request. Other site-visits are scheduled as circumstances warrant. This project is currently ongoing.

Detection



Detection efforts continue to be a key factor in MPI's success. Without efforts to discover potentially fraudulent or abusive behavior and conducting preliminary investigations, other MPI efforts would decrease in effectiveness. While there have been few organizational changes over the years in the Detection Unit, the activities performed within the unit have expanded both as to the volume or scope and complexity or depth of the preliminary investigation efforts.

Data Analysis

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

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

As the advanced data analytics project concluded at the end of FY 2016-17, the Data Analysis sub-unit began is developing in-house solutions, leveraging a variety of data analysis software tools and Agency expertise. This effort includes filling recent vacancies in the sub-unit with staff knowledgeable in Structured Query Language (SQL), statistical analysis, and database integration across multiple platforms.

The team is also expanding access to a variety of Agency and state databases to further increase insights for investigators and auditors. These developments will posture the Agency to develop deeper and more meaningful audit leads, resulting in an increase in comprehensive overpayment audits, comprehensive investigations, and referrals to other agencies and external entities, including MFCU.

Detection Project Management

Following the conclusion (June 2017) of MPI's vendor assisted data analytics project, this team's resources were shifted toward the development of an in-house analytics solution. Using a combination of custom-developed algorithms, data tools, ESRI investigative techniques and methods training, conducting investigations, and coordinating projects, the Detection Project Management and the Data Analysis sub-units built an analytics system to assist investigators in the detection of fraudulent and abusive behavior in the BA program.

The in-house analytics system was built primarily for the BA program and continues to be expanded as new

schemes and detection methodologies are added to the underlying models. However, the design of the system is modular and will be expanded to include new provider types and managed care risks in the coming fiscal year and beyond. For example, the Data Analysis sub-unit is working with the MPI Managed Care Unit (MCU) to develop a managed care risk assessment tool in the near future.

MPI believes there is value in an in-house solution, not only from a cost perspective, but also on a programmatic level. With this approach, MPI is able to control the development cycle and have more input on the creation of leads, ensuring the leads are investigation-ready.

Intake

In years past, the Detection sub-unit for the intake of complaints received complaints through the on-line reporting tool on the Agency's website, and answered the fraud and abuse hotline. All complaints, and identified leads through a variety of other resources, were reviewed and forwarded to other units for analysis as applicable. During FY 2015-16, there was a shift in duties to increase effectiveness and to account for changes in the Medicaid program. During FY 2016-17, the Intake sub-unit developed processes for conducting preliminary investigations of all leads before referring the matter to other units.

As expected for FY 2017-18, the shift resulted in increased referrals to external entities and increased efficiencies with recoupment, because the units responsible for recoupment were able to spend less time evaluating and triaging cases and more time conducting the recoupment activities. Additionally, with enhanced detection capabilities, aligning functional responsibilities appropriately within the units is important to ensure overall MPI success in handling the increase in workload. The increased workload is expected to continue for the next several years. However, as the workload normalizes, the transition of Medicaid's service delivery model from FFS to managed care will necessitate a similar shift in staff within MPI.

The Intake sub-unit has developed enhanced processes for conducting complaint reviews. To implement these extensive triage and preliminary investigation processes, the Detection Unit has continued to engage in extensive training activities and has worked to hire staff with credentials and/or experience to meet the sub-unit's needs.

The complaint review process includes complaint intakes, assessment, determination of predication and clarification of allegations, planning and preliminary investigation. The complaint intake and assessment process is geared toward identifying and comprehending the subject (or named party) of the complaint, the nature of the allegation(s), the subject's enrollment status (whether a current or former provider, an applicant, a fully-enrolled FFS provider, a managed care only provider, or a cross-over only provider); and other preliminary information to allow for a determination of sufficient predication to warrant further review of the issue(s).

The preliminary investigation process typically involves research about the provider, including their history with the Division of Medicaid, MPI audits, and MFCU investigations. The investigation also involves an evaluation of Medicaid claims reimbursement, business associations, licensure status, known complaints about the provider, and history regarding the provider's business and owners, as can be readily obtained. An assessment of the information leads to a recommendation to close the complaint, issue a provider education letter, initiate referrals for follow-up to other components within MPI, or make an external referral to another agency for follow-up.

Working with others in MPI, the Intake sub-unit assisted in the development of an updated Report Fraud Online Complaint Tool for the reporting of Medicaid fraud, abuse, and waste. This updated format allows the complainant (submitter) to identify more information, attach supporting documentation, and receive acknowledgement of the receipt of the complaint.

During FY 2017-18, the Intake sub-unit assessed nearly 2,400 complaints. The chart below represents the source of the complaints and the number triaged.

Source of Complaint	Number of Complaints Received & Triaged
AHCA - Financial Services	34
AHCA - Health Quality Assurance (HQA)-FACILITY REGULATION	15
AHCA - Health Quality Assurance (HQA)-FIELD OPERATIONS	18
AHCA - Medicaid Quality	13
AHCA - MEDICAID-FRAUD LIAISON	1
AHCA - Medicaid Fiscal Agent Operations (MFAO)	53
AHCA - Medicaid Program Integrity (MPI) DETECTION	1
AHCA - Medicaid Program Integrity (MPI) INSTITUTIONAL	4
AHCA - Medicaid Program Integrity (MPI) Jacksonville Orlando Tampa (JOT)	17
AHCA - Medicaid Program Integrity (MPI) Managed Care Unit (MCU)	11
AHCA - Medicaid Program Integrity (MPI) MIAMI	1
AHCA - Medicaid Program Integrity (MPI) PHARMACY	1
AHCA - Medicaid Program Integrity (MPI) PRACTITIONERS CARE	12
AHCA - Medicaid Program Integrity (MPI) PREVENTION STRATEGY	9
AHCA - OTHER BUREAUS	21
DEPARTMENT OF CHILDREN AND FAMILIES	10
DEPARTMENT OF HEALTH (DOH)	64
Explanation Of Member Benefits (EOMB)	65
FEDERAL AGENCY - Centers for Medicare and Medicaid Services (CMS)	167
FLORIDA - Medicaid Fraud Control Unit	76
FLORIDA - OTHER AGENCIES	9
FLORIDA AGENCY FOR PERSONS WITH DISABILITIES	2
HEALTH AND HUMAN SERVICES-Office of the Inspector General (HHS-OIG)	4
HOTLINE	1
INTERNET / MEDIA	95
Investigator Initiative	119
ONLINE COMPLAINT FORM- Other	888
ONLINE COMPLAINT FORM- Managed Care Plans	603
OTHER - SEE DESCRIPTION	20
PREVIOUS FILE OR CASE	30
PROJECTS	7
PROVIDER	1
PUBLIC	1
Total	2,373

Also during FY 2017-18, the Intake sub-unit was heavily involved in activities pertaining to oversight, audits, investigations, and enforcement activities regarding the BA program. MPI personnel in the Intake sub-unit conducted the initial service record reviews for MPI generated BA projects. The Intake sub-unit's efforts are further detailed in the section titled *Behavior Analysis Agency Initiative*.

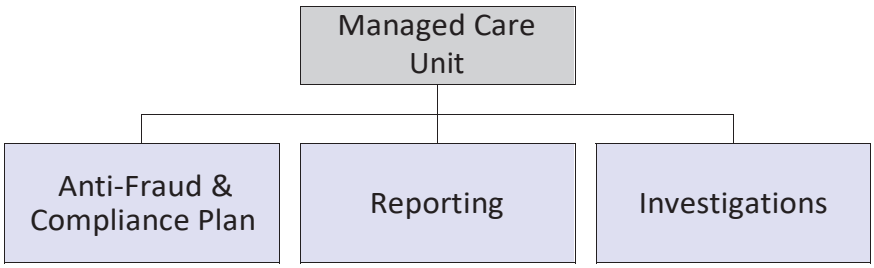
Certified Out of Business

Under Federal law, 42 CFR 433.318(d), states are not required to refund to the Centers for Medicare and Medicaid (CMS) the federal share of an overpayment if the Medicaid provider is "out of business" or if the provider goes "out of business" before the end of the one-year period following the identification of the overpayment. Under Sections 409.907(12) and 409.908(26), F.S., the Agency may certify that a Medicaid provider is out of business

(here after referred to as COOB) and that any overpayments made to the provider cannot be collected under state law and procedures. This COOB, allows the State of Florida to retain the federal share of funds that otherwise would be required to be remitted back to the CMS.

During FY 2017-18, MPI continued to develop and refine a process for coordination with the Bureau of Financial Services and the Division of Medicaid to identify potential out-of-business instances and to evaluate whether the matter met the legal parameters for treatment under the state and federal law. The review of 43 probable candidates for certification of being out of business was undertaken and is still in process. This validation of the cost savings due to the certified out of business processes is ongoing and the figures for this review will not be finalized until FY 2018-19.

Managed Care Unit



Overview

The MPI Managed Care Unit (MCU) operates similarly to a traditional program integrity model with responsibilities that align with key functions: detection, prevention, and enforcement/recoupment activities. This design was intentional to allow for future organizational adjustments where Managed Care-related program integrity functions are merged back into the remainder of MPI operations (as opposed to a stand-alone MPI unit).

Detection Related Activities

With regard to the MCU activities, detection occurs through the analysis of reports that the MHPs are required, by statute or contract, to submit to MPI. The primary reports are the Suspected/Confirmed Fraud and Abuse Report (also referred to as 15-day reports), the Quarterly Fraud and Abuse Activity Report (QFAAR), the Suspected/Confirmed Waste Report, Denied/Suspended/Terminated Provider Report, and the Annual Fraud and Abuse Activity Report (AFAAR). The analysis of these reports serves as a detection tool related to fraud, abuse, and waste by both network providers and the MHPs themselves. Personnel reviewing these reports require knowledge not only related to Medicaid and the Statewide Medicaid Managed Care (SMMC) contract, but also the inner workings of a MHP and fraud and abuse schemes and concepts. MPI is continuing to develop techniques to better utilize the MHPs reports, along with other date sources, to develop robust risk assessment and detection tools.

MHPs are required to report suspected or confirmed fraud and abuse within 15 days of detection. Although the primary detection activities with these reports occurs in the Detection Unit, the 15-day reports are also reviewed by the MCU to revalidate the complaint review process but particularly to ensure that the plan investigation is comprehensive, timely, and effective. Through the QFAAR (updates regarding each 15-day report) the MCU further evaluates the MHPs investigative effectiveness. The MCU also uses AFAAR (an annual summary of the MHP's activities) to evaluate the MHPs Special Investigative Unit (SIU) activities. These reports will also be included in further detection (of fraud or abuse by MHPs) efforts.

Also, MPI implemented new reporting requirements through additional reports and amended requirements of current reports. The new reports, as of the April 1, 2018 SMMC Report Guide, are the Suspected/Confirmed *Waste* Report and the Denied/Suspended/Terminated Provider Report. The Suspected/Confirmed Waste Report requires the MHPs to report all issues related to waste of Medicaid dollars by their providers and recipients. The

Denied/Suspended/Terminated Provider Report requires the MHPs to report all instances of provider denials, suspensions or terminations from the MHP provider network. These reports will further aid in the detection and prevention efforts of MPI relative to managed care.

During FY 2017-18, MCU staff reviewed 16 AFAARs, 64 QFAARs, and 605 Suspected/Confirmed Fraud and Abuse reports. The Suspected/Confirmed Fraud and Abuse Reports received each month are depicted in the chart below.

Month	Number of Reports
July 2017	52
August 2017	69
September 2017	76
October 2017	50
November 2017	51
December 2017	37
January 2018	31
February 2018	46
March 2018	57
April 2018	27
May 2018	29
June 2018	80

The Suspected/Confirmed Fraud and Abuse Reports received during FY 2017-18, by the MHP are depicted in the chart below.

Medicaid Health Plan	Number of Reports
Amerigroup (AMG)	21
Better Health, LLC (BET)	9
Community Care Plan (NBD)	12
Clear Health Alliance (CHA)	8
Children's Medical Services Network (CMS)	72
Coventry (COV)	11
Freedom (FRE)	8
Humana (HUM)	78
Magellan (MCC)	11
Molina (MOL)	20
Positive Health Care (PHC)	1
Prestige (PRS)	26
Simply (SHP)	13
Sunshine (SUN)	191
United (URA)	20
Wellcare (STW)	104

During FY 2017-18, there was one instance of late reporting by an MHP. Historically, the issue of timeliness of the Suspected/Confirmed Fraud and Abuse Reports was a significant concern. However, due to the extensive efforts by both the Division of Medicaid and MPI over the past several years, the issue of untimely reporting is believed to have been minimized and nearly eliminated.

MPI has also enhanced detection efforts through formal referrals of investigative information from MPI to the MHPs of program integrity issues for the plans to investigate, the referrals sent during FY 2017-18,

included providers that MPI received complaints on from other MHPs, providers that MPI detected through investigator initiatives, and topics that MPI has successfully audited. In FY 2017-18, there were 27 formal referrals of investigative information sent to all MHPs.

Prevention Related Activities

To the extent that MPI can engage in efforts to prevent fraud and abuse, particularly within a managed care environment, inexpensive efforts may have significant returns. The MCU engages in prevention through a variety of efforts, which includes reviewing the MHP's required anti-fraud and compliance plans. The anti-fraud and compliance plans provide the foundational frame work within which the MHPs assure the Medicaid program that it (the MHP) will diligently engage in program integrity efforts. MPI's evaluation, discussions with the MHPs, and monitoring/audits of the MHPs efforts help ensure that the shift to managed care doesn't result in an increase of fraud and abuse within the provider network.

Additionally, the MCU develops and carries out health plan related projects, including on-site inspections or reviews focused on particular issues related to MHP compliance with program integrity requirements, as well as issues of suspected abuse. During FY 2017-18 the MCU completed the second hospital rate audit project initiated in the previous fiscal year. While not all enforcement actions were finalized in FY 2017-18, MPI recommended actions totaling $102,000 in liquidated damages. Actions were completed regarding $46,000 in liquidated damages. The MCU also reviews all program-integrity subcontracts, engages in contract monitoring review of the MHPs and makes recommendations to the Division of Medicaid for contract enhancement.

The review of the Anti-Fraud and Compliance Plans includes a review of each MHPs' Anti-Fraud and Compliance Plan, the related policies and procedures, and related trainings. The review includes assessing compliance with substantive requirements set forth in the contract, statute, and federal law, as well as, an evaluation of the MHP's operationalization of the plan. Through these reviews, MPI is able to identify potential program risks and vulnerabilities. MPI also uses the reviews to identify areas for subsequent audit, inspection, or review of specific MHPs. The MCU conducts preliminary analysis of data pertaining to the MHP's overall compliance related to program integrity issues to create an on-site inspection tool specific to each MHP for use during the Federally required (see 42 CFR 438.66) review of each MHP. The general focus of the announced on-site inspection is an evaluation of how well the MHP has implemented its Anti-Fraud and Compliance Plans and adherence to all statutes, federal regulations, or rules with relation to detection, investigation, and audit of fraud, abuse, and waste. The extent of review in any of the categories is weighted by the perceived risk. MPI continues to enhance monitoring processes by including risk-based vulnerabilities to the on-site tool, expand the program integrity review to include encounter validation, and ensure timely completion of on-site reviews and written reports.

Another critical aspect of fraud, abuse, and waste prevention in managed care is the continued education, collaboration, and communication between MPI, the MHPs, and the appropriate law enforcement. Sharing best practices regarding program integrity efforts, case study discussion, and investigative summaries assists in ensuring enhanced fraud and abuse detection and prevention activities throughout all of the Medicaid program integrity efforts.

Investigation of an MHP

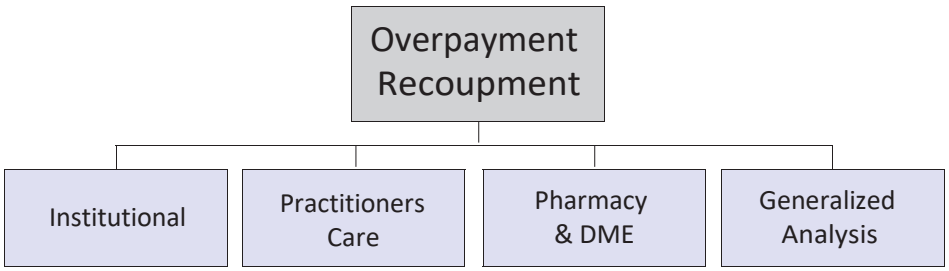
The MCU is also responsible for investigation of the health plans when there is an allegation of activity related to fraudulent or abusive behavior by an MHP.

In FY 2017-18, MCU conducted 11 individual MHP-related investigations. The investigations conducted by the MCU were varied in topic. The investigations included allegations of:

- MHPs allegedly contracting with unlicensed facilities;
- An MHP allegedly contracting with providers on the ineligible providers list;
- An MHP allegedly altering reports before they were submitted to the Agency; and
- An MHP that allegedly paid a non-participating network provider excluded from participation in the Florida Medicaid program.

Of the 11 referenced investigations, four closed during FY 2017-18, three resulted in *sanctions* totaling of $10,000, and one resulted in a *liquidated damage* of $5,000.

Overpayment Recoupment



MPI was created in 1980 to combat fraud, abuse, and waste in the Medicaid program. Medicaid policy, in part, is written to establish program parameters, and addresses safeguards for the delivery of goods and services provided to recipients. The ORU, within MPI, has historically been a main stay of the oversight program and has been developed using the concept, "Trust, but Verify." The ORU staff conducts audits to determine if non-compliance with Medicaid policy has occurred and to subsequently identify overpayments for recovery through a combination of audits performed by MPI staff, collaborative efforts, and contracted audits.

MPI's ROI is a major measurement used to monitor the effectiveness and efficiency of MPI staff endeavors. MPI has historically maintained an excellent ROI. Recoveries generated as a result of actions in whole or in part by the ORU is a major contributor to the ROI. For FY 2017-18, the MPI ROI for recoupment and prevention actions was over $7.00 returned for each dollar expended. MPI's ROI is reported in the data section of this report (See MPI Data for FY 2017-18).

The need to audit FFS claims to identify overpayments for recoupment continues even though the transition to primarily a managed care delivery system has occurred. MPI processes have, however, began to include projects of both encounter validation and FFS claims audits. Payments to providers for numerous Medicaid-eligible populations will continue to generate a high volume of FFS reimbursements. For FY 2017-18, the total FFS amount reimbursed was approximately $4.8 Billion dollars. The provider types in the FFS payment model include:

- Behavior Analysis;
- County Health Department Certified Match Program;
- Developmental Disabilities Individual Budgeting (iBudget) Home and Community-Based Services Waiver;
- Familial Dysautonomia Home and Community-Based Services Waiver;
- Hemophilia Factor-Related Drugs Distributed through the Comprehensive Hemophilia Disease Management Program;
- Intermediate Care Facility Services for Individuals with Intellectual Disabilities;
- Medicaid Certified School Match Program;
- Model Home and Community-Based Services Waiver;

- Newborn Hearing Services;
- Prescribed Pediatric Extended Care;
- Program for All-Inclusive Care for Children;
- Program of All-Inclusive Care for the Elderly; and
- The Substance Abuse County Match Program.

In this reporting period, the ORU continued to utilize staff experience to apply 'oversight accountability'. The ORU's top operational priorities were: assist with detection to identify audit candidates; perform audits to identify overpayments for recoupment based on non-compliance; apply related sanctions; and assist with litigation proceedings for ORU audits. Looking forward, the ORU plans to continue with the priorities previously referenced, work to complete audits with potential overpayments under review in the amount of approximately $70 Million (as of June 30, 2018), and assist the Managed Care Unit (MCU) with the further development of audit options.

Audits and Investigations

ORU activities, in addition to identifying overpayments for recovery, includes conducting investigations of other allegations that may not bring rise to the recovery of overpayments. Often, these investigations result in referrals to other regulatory entities, the imposition of sanctions, or broad-scale initiatives and projects within MPI.

During FY 2017-18, the ORU participated in activities pertaining to oversight, audits, investigations, and enforcement activities associated with the BA program. Examples of audits performed by MPI ORU include:

- Medicaid does not reimburse for home health visit services for a recipient when the recipient is admitted to a hospital or nursing facility. An audit was opened and a review of this issue identified 25 providers that had been overpaid. As of the end of FY 2017-18, a total of $503,467 has been collected.
- Medicaid does not reimburse for durable medical equipment (DME) when the recipient is admitted to a Skilled Nursing Facility. DME, medical supplies, orthotics, and prosthetic devices are reimbursed only for Medicaid recipients residing in non-institutional settings. An audit was opened and a review of this issue identified 76 providers that had been overpaid. As of the end of FY 2017-18, a total of $160,029 has been collected.
- A major ongoing audit project addresses paid inpatient claims related to Emergency Medicaid for Aliens (EMA). The Agency, CMS, and CMS' Medicaid Integrity Contractor have identified substantial overpayments for recoupment in this project. The completion of the project has been slowed by legal challenges. At the close of FY 2017-18, the EMA project had approximately $12 million in pending litigation involving 36 cases. Since the EMA audit project's inception in 2010, approximately $57.6 million has been identified for recoupment.
- MPI has also continued with a hospice collaborative audit project with CMS. The project addresses Medicaid recipients that have been in hospice care for six months or longer and the medical necessity of the hospice stay. At the close of FY 2017-18, the hospice audit project had generated approximately $5.92 million in recoupments related to 20 closed cases. The majority of the remaining open cases have been slowed to completion due to provider appeals and litigation activities.
- The Pharmacy/DME Unit opened a comprehensive review of a community pharmacy following an on-site visit. A review of the provider's purchase/acquisition records for a one-year period revealed a shortage of drugs available to support the payments made to the provider by Florida Medicaid, and revealed numerous prescription discrepancies. The Final Audit Report identified an overpayment of $144,078. A Final Order finalized the overpayment of $144,078, and imposed a sanction in the form of a fine for $7,096 and costs of $1,000. The overpayment, sanction, and costs amounts were collected and the case was closed.
- An on-site pharmacy review project identified a pharmacy with a possible shortage of drugs and prescription discrepancies. The Pharmacy/DME Unit opened a comprehensive audit and a review of the documentation received upon a records request indicated the drug quantity paid for by

Medicaid exceeded the quantity available to dispense to Medicaid recipients for six of the drugs reviewed. There were also 104 prescription discrepancies noted. The audit identified an overpayment of $115,328. A Final Order finalized the overpayment, a sanction in the form of a fine of $23,065, and costs of $1,360. The provider paid a total of $139,753, and the case was closed.

- An audit of a neurologist who had certified compliance with provisions of federal law, resulting in an enhanced reimbursement rate for calendar years 2013 and 2014 resulted in the following findings: not eligible for the applicable ACA rate, up-coding, lack of medical necessity, and inadequate documentation to support services billed. A settlement agreement and payment plan for the aggregate amount of $638,539 was executed for the overpayment, fine, and costs and has been paid in full.

Administrative Support

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

ASU achievements in FY 2017-18, in assisting MPI in the combatting of fraud, abuse, and waste, included: responding to public record requests; reconciling incoming payments for provider self-audits; and coordinating record storage or the recall of casefiles.

The ASU continued to work on process improvement, including the MPI document management project. This project included scanning historical documents and entering information into a data management system aligned with the MPI case tracking system. The ASU worked diligently behind the scenes contributing to the overall productivity and efficiency of the Bureau.

During the fourth quarter of FY 2017-18, restructuring of the ASU began. This restructuring included changing operational activities with the returning of duties and assignments that were previously reassigned to other units within MPI. For FY 2018-19, the ASU will be known as the Operations Support Unit (OSU).

This change of functionality and the reassignment of duties will improve efficiencies and free up MPI staff that had to take on duties of ASU.

MPI Collaborative Efforts and Training

Collaborative Efforts

While the value of the collaborative efforts of fraud fighting activities is difficult to quantify, MPI believes there is a significant positive value in working with others toward the common goal of identifying, reducing, preventing, and taking enforcement action against individuals and entities engaged in fraudulent or abusive behavior contributing to overpayments in the Medicaid program. Collaboration helps all participating agencies work toward improved outcomes.

Specifically, MPI is able to: identify emerging trends related to fraud, abuse, and waste; develop partnerships to more effectively combat fraud and abuse; and enlist the assistance of others in increasing awareness, both to the detrimental impact of participating (even inadvertently) in fraud schemes, as well as, the significant value of reporting suspected fraud and abuse.

During FY 2017-18, MPI continued its collaborative efforts with the following organizations:

- U.S. Department of Defense – Defense Criminal Investigative Service;
- U.S. Department of Health and Human Services - Centers for Medicare and Medicaid Services;
- U.S. Department of Health and Human Services - Office of Inspector General;
- U.S. Department of Justice - Office of Legal Education;
- U.S. Drug Enforcement Administration;
- Florida Agency for Health Care Administration - Division of Medicaid;
- Florida Agency for Persons with Disabilities;
- Florida Department of Children and Families;
- Florida Department of Economic Opportunity;
- Florida Department of Education - Office of Early Learning;
- Florida Department of Elder Affairs;
- Florida Department of Financial Services - Division of Insurance Fraud;
- Florida Department of Health;
- Florida Department of Law Enforcement;
- Florida Office of the Attorney General - Medicaid Fraud Control Unit;
- Florida Office of Insurance Regulation;
- Medicaid Health Plans;
- National Insurance Crime Bureau;
- FBI Regional Health Care Fraud Working Groups; and
- Other states' Medicaid Program Integrity Units and Medicaid Fraud Control Units.

MPI Training Program

MPI continues to operate under the belief that because fraud and abuse schemes are ever changing, MPI must continue to ensure effective training regarding the underlying concepts, theories, and principles that govern the Bureau's work.

The four primary sources offer training for MPI are through the National Association for Medicaid Program

Integrity (NAMPI), the National Health Care Anti-Fraud Association (NHCAA), the Medicaid Integrity Institute (MII), and through MPI developed training (which may be presented by MPI personnel or others).

MPI continues to hold monthly in-house trainings for its personnel on topics ranging from administrative issues particular to the Agency, to investigative-specific topics; training often includes summary presentations by personnel who have attended external trainings. Training is also presented through webinars, of either MPI-developed topics or externally available topics.

During FY 2017-18, MPI trainings have included topics such as, opioid abuse and pertinent issues for program integrity professionals (through collaboration with the Federal Bureau of Investigations and related Health Care Fraud Task Forces), investigative processes, internet-based investigations and research, risk assessment methodologies, Medicaid claims processing, Medicaid program integrity concepts (further described in the FY 2016-17 report), fraud detection and investigations, and investigative planning.

National Association for Medicaid Program Integrity

NAMPI is the only professional association specifically dedicated to Medicaid program (state agency) integrity professionals. The association (formally the National Association of Surveillance Officers, or NASO) has been in existence for more than 30 years. While MPI has been a consistent participant, Florida has taken on a greater leadership role with the organization and will continue to do so, to use this resource to the greatest benefit possible for the Agency and Florida Medicaid. The organization holds an annual conference that includes a broad array of technology, clinical, and investigative training for MPI attendees. Florida's involvement is intended, among other outcomes, to bring more substantive, on-point training, to program integrity units throughout the year.

Through NAMPI, not only can MPI attain much-needed training, there are opportunities for collaboration and information sharing that is simply unmatched through any other resource. Through collaboration with other state program integrity units, MPI has received referrals about individuals and entities who are avoiding adverse actions in other states by relocating to Florida where they will attempt to resume their unscrupulous activities as a participant in the Medicaid program. Additionally, through collaboration with other states, MPI is better able to assist our MFCU with the specific law enforcement points of contact who are working on investigations related to similar or same subjects.

National Health Care Anti-fraud Association

The NHCAA is a national organization dedicated to fighting health care fraud through collaboration and education of partner organizations, which include commercial and government-sponsored insurance, as well as, federal, state, and local law enforcement. The NHCAA is the only professional organization with a certification specific to health care fraud investigators. They also offer specialized training regarding detection, investigation, and

prosecution or other regulatory enforcement related to health care fraud.

As with NAMPI, Florida has begun to take a more active role with the NHCAA to ensure that MPI personnel have access to the latest resources in the most cost-effective manner possible. MPI now has approximately 20 personnel with the NHCAA investigative certification, Accredited Health Care Fraud Investigator (AHFI), and continues to offer opportunities for all personnel to benefit from training hosted by NHCAA throughout the year. MPI personnel have served on the educational advisory panel for the NHCAA and will continue to offer educational topics and to serve as faculty at training sessions. Through this participation, MPI will have access to additional low or no-cost training.

Medicaid Integrity Institute

The MII was developed by the Centers for Medicare and Medicaid Services (CMS) with the U.S. Department of Justice, Office of Legal Education, to meet the training and educational needs of state Medicaid program integrity employees. Florida has taken advantage of many of the no-cost training opportunities for its personnel. FY 2017-18 courses offered by MII included basic and specialized skills and techniques in Medicaid fraud detection, managed care, emerging trends regarding opioids, medical record auditing, evaluation and management coding (claims coding), third-party liability issues, beneficiary fraud, and interactions between program integrity units and MFCUs.

MPI routinely sends staff to attend courses and serve as instructors at MII, but has begun to be more thoughtful in its decision-making regarding attendance to the courses. Furthermore, MPI will continue to urge CMS and the MII team to adjust the curriculum to better meet the evolving needs of the states. Many of the courses that are repeated throughout the year are courses that were previously in high demand but may need to be updated.

MPI personnel are active participants in advisory groups that assist in the development of the course calendar and curriculum for individual classes and will continue to do so in an effort to ensure that MPI can attain the best value from these resources. The collaboration with other state program integrity units, which MII affords, typically allows MPI to have access to additional training opportunities and oversight projects conducted by other states due to the close working relationships that are developed through MII. Participation at MII contributes to MPI's efforts in combating fraud, abuse, and waste in the Florida Medicaid program, as well as the Bureau's ROI.

MPI Data for Fiscal Year 2017-18

Site-Visits	
Provider Type	Number
Ambulance	0
Assistive Care Services	0
Case Management Agency	37
Behavior Analysis (BA)	58
Community Behavioral Health Services	0
Dentist	0
Durable Medical Equipment/Medical Supplies	0

Site-Visits	
Provider Type	Number
Health Maintenance Organization (HMO)	0
Home & Community-Based Services Waiver	2
Home Health Agency	0
Nurse Practitioner (ARNP)	0
Optometrist	0
Other – No Description Available	0
Pharmacy	0
Physician (D.O.)	1
Physician (M.D.)	8
Professional Early Intervention Services	0
Rural Health Clinic	0
Social Worker/Case Manager	2
Therapist (PT, OT, ST, RT)	0
Grand Total	108

Denied Claims (PPRs, 25a, CAF)	
Number of Claims Reviewed	10,948
Number of Claims Denied	7153
Amount of Claims Reviewed	$2,877,898
Amount of Claims Denied	$1,784,284

Random Audits Concluded	
Audits Completed	2
Audits with Findings	1
Audits with No Findings	1
Overpayments Identified	$7,819

MPI Referrals	
Agency for Persons with Disabilities	4
Department of Children and Families	73
Department of Health	34
Division of Medicaid	274
Division of Health Quality Assurance	128
Medicaid Fraud Control Unit – Attorney General	302
Managed Care	27
Other	7
Safe Guard Services – Centers for Medicare and Medicaid (CMS)	3
Total	852

Provider Sanctions Imposed and Managed Care Organization Assessments per MPI's Case Tracking System				
	FY 2016-17		FY 2017-18	
Sanctions under Rule 59G-9.070, F.A.C.	Number	Amount	Number	Amount
Fine Sanctions	151	$1,983,816	139	$1,929,650
Suspensions	94	N/A	59	N/A
Terminations	64	N/A	96	N/A
Total for Rule 59G-9.070, F.A.C. Sanctions		$1,983,816		$1,929,650
Total for Managed Care Organization Section 409.91212 F.S.,or Contract Assessments	1	$1,000	9	$110,400
Grand Total Sanctions and Managed Care Organization Assessments	310	$1,984,816	303	$2,040,050

Overpayment Collections and Paid Claims Reversals (PCRs) as reported in MPI's Case Tracking System			
Fiscal Year	Type of Recovery	Overpayment Identified	A/R Collections and Reversals
FY 2014-15	Accounts Receivable and PCRs	$30,380,115	$27,640,256
FY 2015-16	Accounts Receivable and PCRs	$21,515,784	$21,458,880
FY 2016-17	Accounts Receivable and PCRs	$33,996,021	$37,644,700
FY 2017-18	Accounts Receivable and PCRs	$18,177,542	$19,875,170

MPI Prevention of Overpayments ($ Millions)[3]				
	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
Denied Claims (PPRs, 25A, CAF)[4]	$1.1	$4.1	$1.9	$1.78
Termination of Providers Impact	$6.2	$2.0	$0.7	$0.62
Program Suspensions Impact	N/A	N/A	$0.2	$0.16
Focused Projects Impact	$3.0	$2.8	$0.08	$0.17
Site-Visits Impact	$2.9	$5.1	$5.1	$1.82
Sanctioned Providers (Fine Impact)	$7.0	$13.3	$2.3	$1.31
Claims Denied Per Statute (25A/CAF)	$1.9	-	-	-
Audit Impact	$13.0	$18.3	$4.6	$3.73
PPR and 25a Impact	-	-	-	$0.04
MFCU Referrals[5]	-	-	-	$38.40
Total	$35.1	$45.6	$14.9	$48.03

[3] This amount does not include the prevention value that is realized by the Medicaid health plans as a result of the Agency's program integrity efforts. The prevention value has not been calculated, but could reasonably be projected as high as the total amount reported as MPI's prevention activities, meaning the Agency's efforts have a value likely significantly higher than reported.

[4] Beginning in FY 2015-16, all denied claims are listed in one category above.

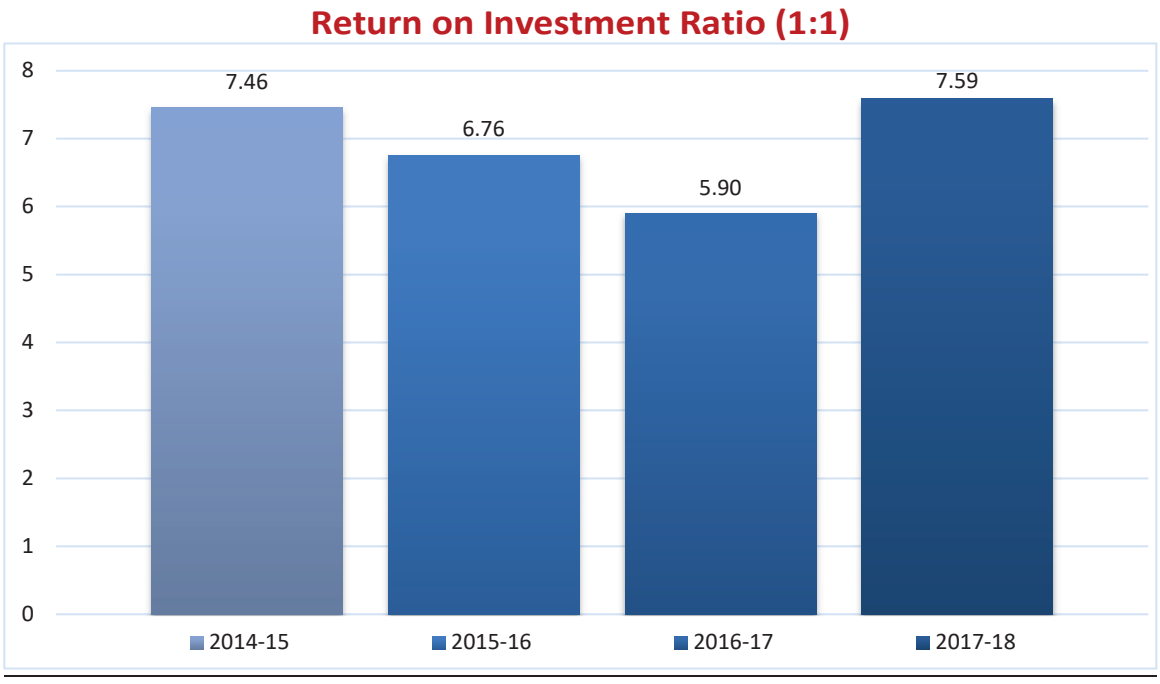
[5] The exposed dollar amount is the total value of all MFCU referrals by fiscal year. The total exposed dollars for FY 2017-18 is $169,083,664.78. Prior to FY 17-18, the exposed amount related to the MFCU referrals was not calculated, and thus not captured for purposes of reporting. For purposes of calculating a return on investment regarding this prevention value, while a more formalized methodology is being developed for future calculations, 22.71 % of the preceding amount will be included for this fiscal year ROI. This percentage is based upon the 2017 HHS report regarding MFCU investigations (nationally) and likely still undervalues the relationship between a state MPI and MFCU unit (where, presumably, the percentage of successful cases may be greater than stated here).

Refer to:
https://www.oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2017-statistical-chart.pdf
The MFCU Statistical Data for FY 2017 report indicates the Florida MFCU results exceeded the national average success rate. However, for the purpose of projecting the prevention amount for this line item, the MFCU national average success rate of 22.71% (18,713 cases investigated which resulted in 1,761 indicted/charged; 1,528 convictions; and 961 civil settlements and judgements) was used to project the prevention amount (Total Exposed Dollars X MFCU 2017 National Average Success Rate).

MPI Recovery Activities ($ Millions)				
	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
MPI/MPI-CMS Audits (OP's Collected by Accounts Receivable)	$37.8	$19.5	$37.7	$19.85
Costs (Collected by Accounts Receivable)	$0.4	$0.2	$0.3	$0.22
Fines (Collected by Accounts Receivable)	$1.5	$1.4	$2.4	$1.86
Paid Claims Reversals	$0.5	$0.2	$0.1	$0.02
Certified Out of Business (COOB)	N/A	N/A	$3.2	$0.00
Contractual Assessments	$0.0	$0.1	$0.001	$0.11
TPL Contractor - Assisted Claims Adjustments	$42.5	$18.8	$12.1	$25.94
Recovery Totals	$82.7	$40.2	$55.8	$48.00

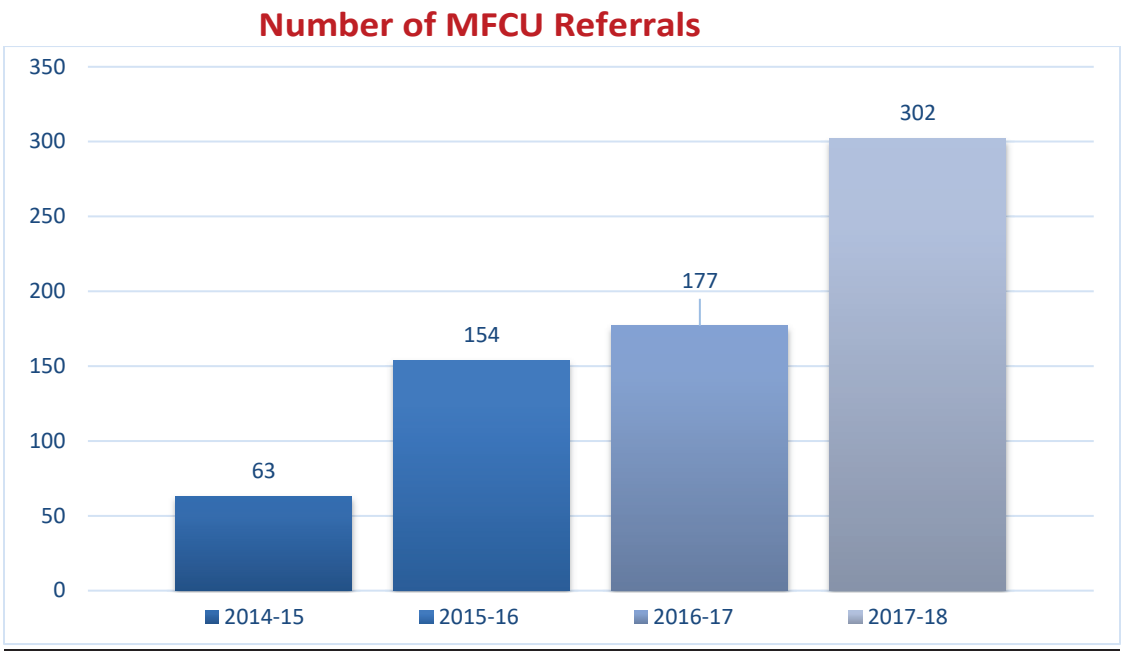
Medicaid Program Integrity Return on Investment (ROI)			
FY 2014-15	Benefits	Costs	ROI
Recovery	82.7	10.35	7.99:1
Prevention	35.1	5.54	6.44:1
Total:	117.8	15.8	7.46:1
FY 2015-16	Benefits	Costs	ROI
Recovery	40.2	7.4	5.43:1
Prevention	45.6	5.3	8.60:1
Total:	85.8	12.7	6.76:1
FY 2016-17	Benefits	Costs	ROI
Recovery	55.8	7.26	7.7:1
Prevention	14.9	4.62	3.2:1
Total:	70.7	12.0	5.9:1
FY 2017-18	Benefits	Costs	ROI
Recovery	48.00	8.35	5.75:1
Prevention	48.03	4.30	11.16:1
Total:	96.03	12.65	7.59:1

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



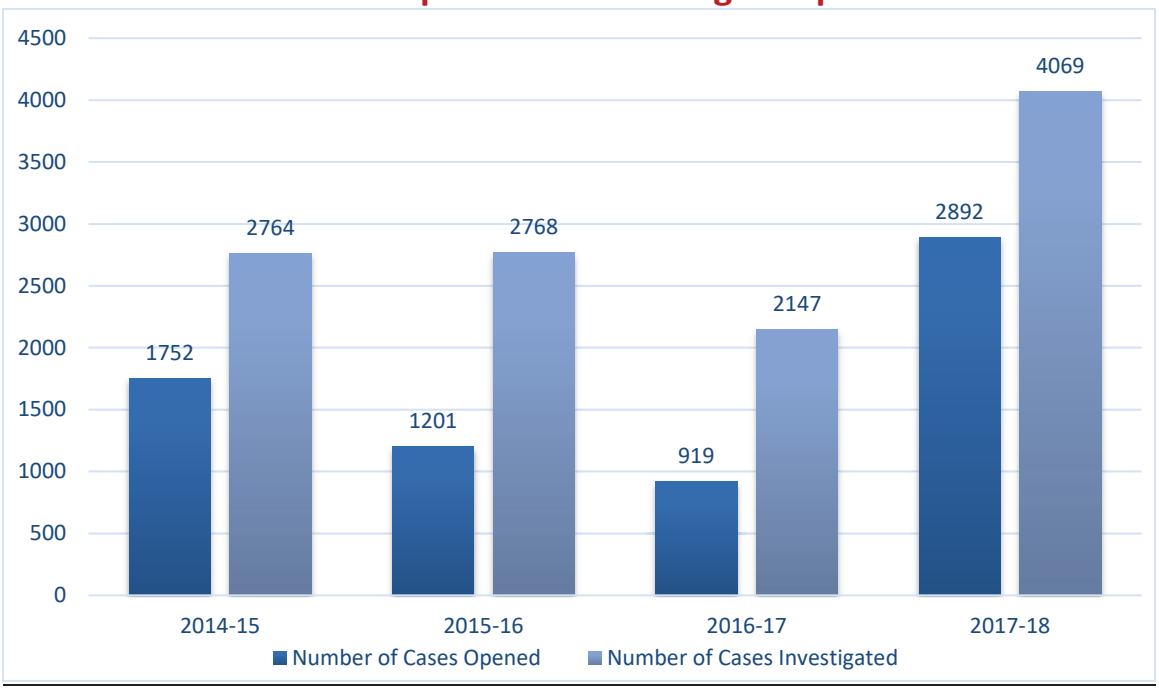
MPI Activity Trends

In the Office of Program Policy and Government Accountability (OPPAGA) Report 18-03, released in January 2018, OPPAGA indicated that "AHCA has not identified useful measures to evaluate MPI's performance." The Agency responded that MPI is generally measured by a return on investment (ROI) calculation, followed by the many standards published annually in AHCA's report on The State's Efforts to Control Medicaid Fraud and Abuse. Furthermore, the Agency agreed that that evaluation of performance trends could be better documented and, as such, is publishing multi-year, side-by-side, comparison charts that have been included under multiple charts throughout the remainder of this section.



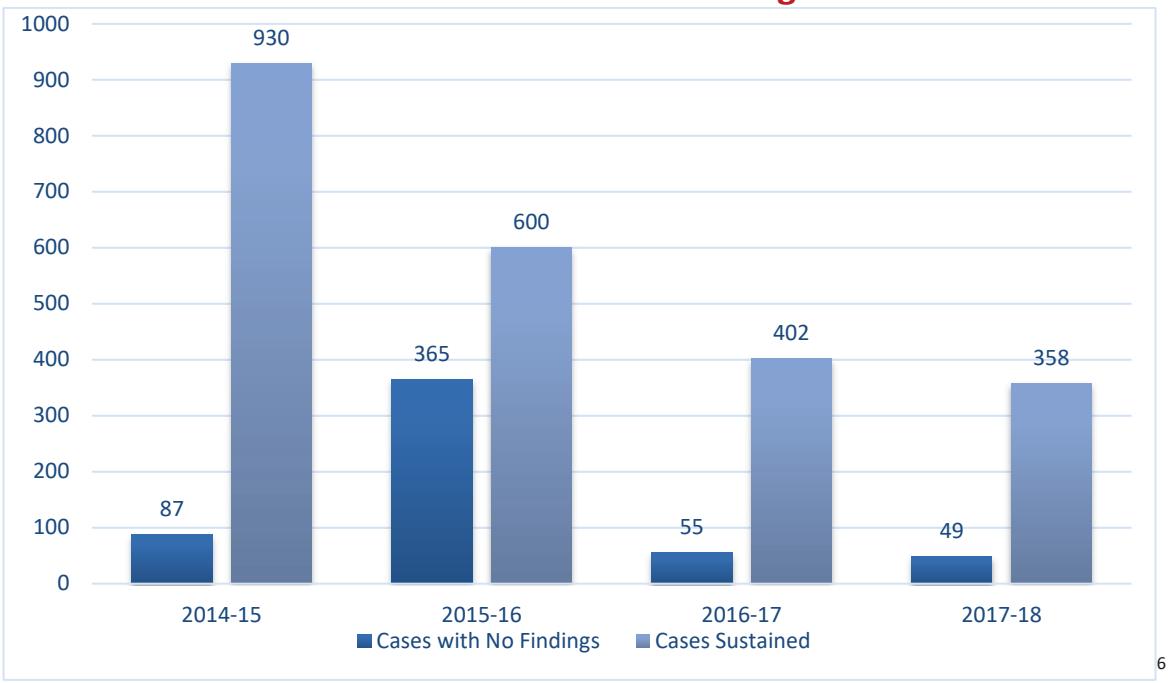
MPI has given increased focus to MFCU referrals over the past several years. The efforts have focused on both the increase in the number of referrals as well as the complexity of suspected criminal activity that forms the basis for the referral.

Number of Cases Opened and Investigated per Fiscal Year



The number of cases opened each year is relevant to the analysis of MPI performance. Specific attention is given to complaint intake and early data analysis efforts to ensure the most effective use of personnel resources, working on cases with the greatest likelihood of success.

Number of Cases Closed with No Findings vs. Sustained

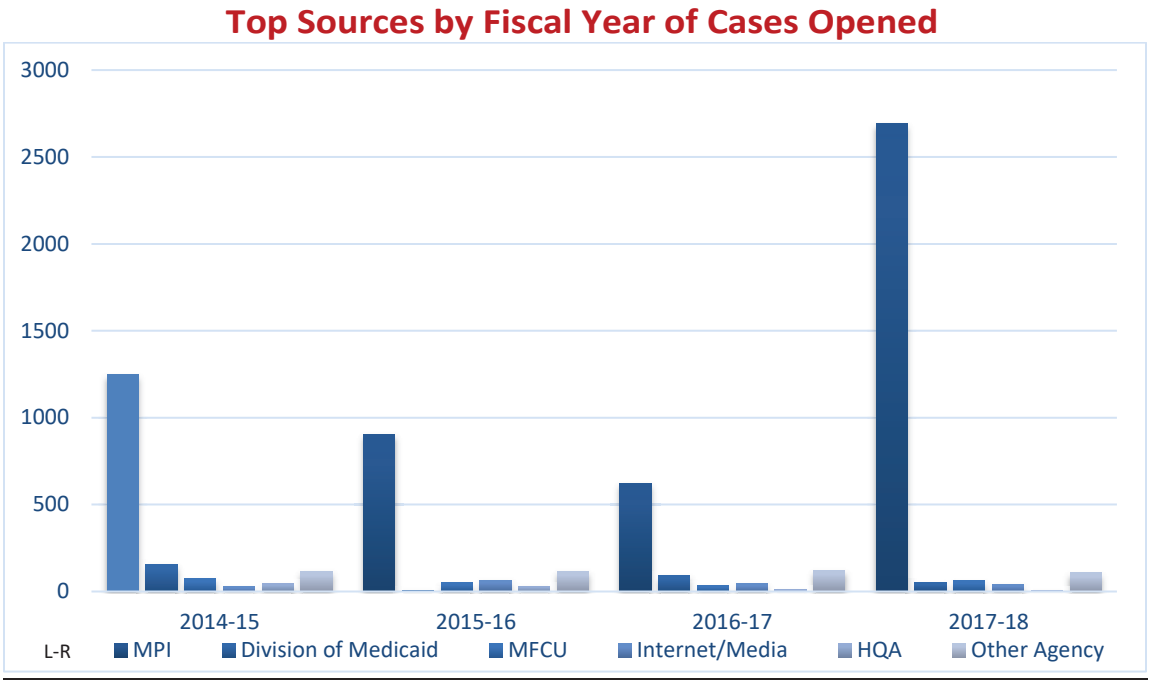


[6]

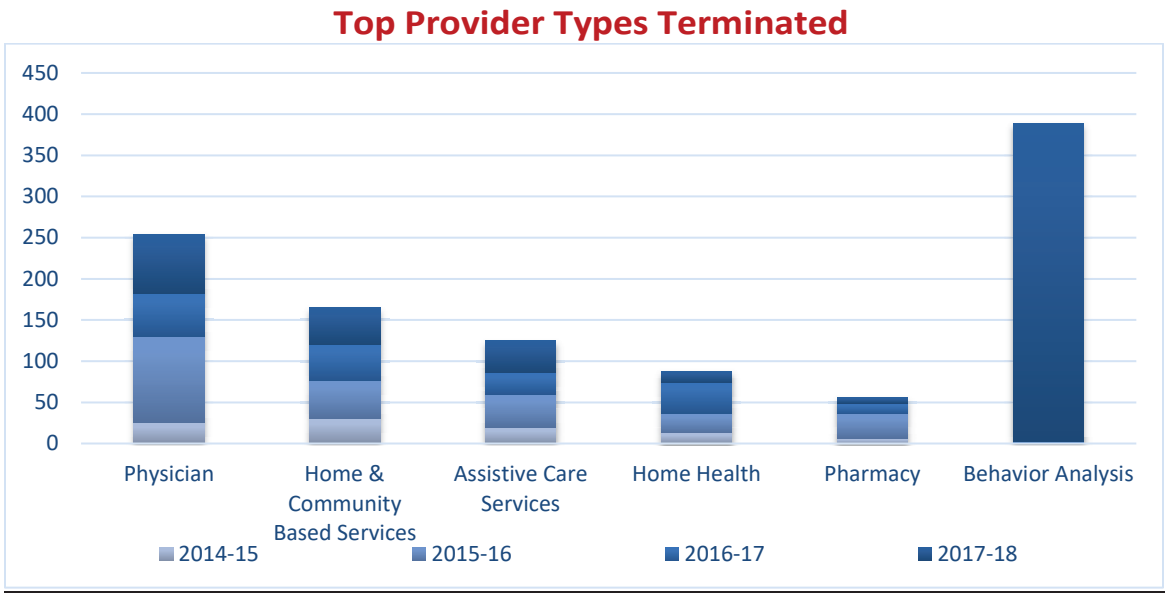
Evaluating the proportion of cases with and without "findings" (some output or action that contributes to case success, whether a referral, overpayment recovery, or provider sanction) further assists management

[6] Number of No Findings cases indicates no fraud or abuse found.
Number of Sustained cases indicates an overpayment was identified.

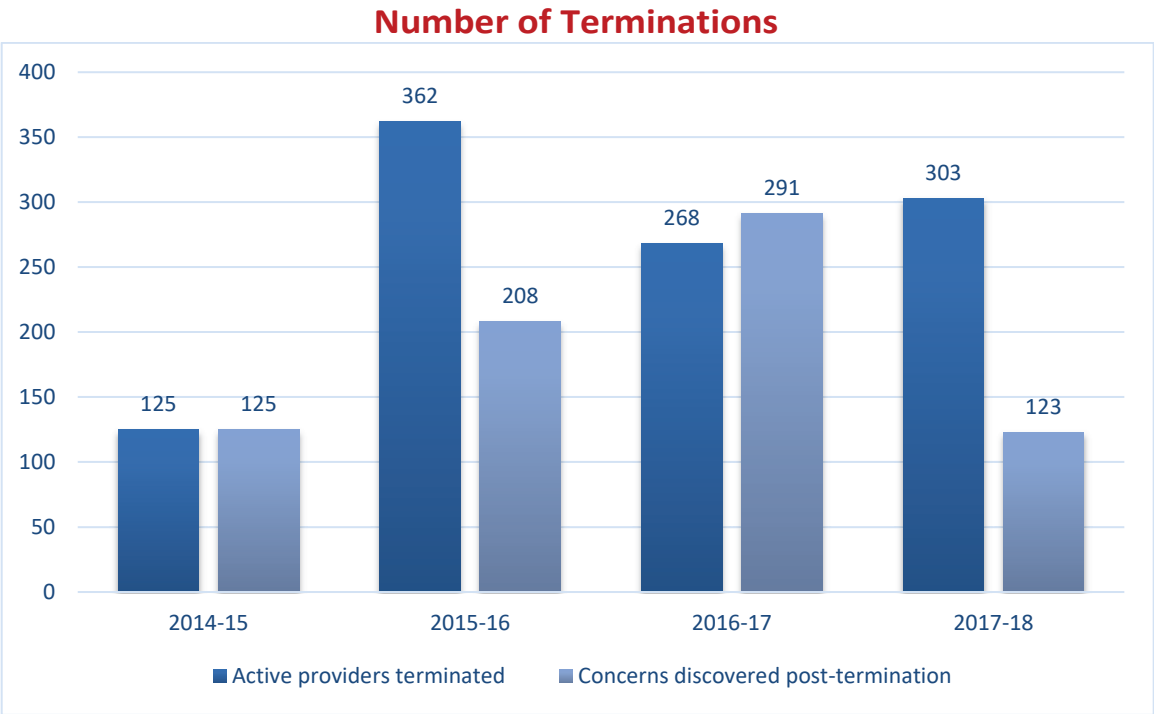
in directing the use of resources.



Ongoing evaluation of sources of cases assists MPI with resource allocations and adjustments in collaborative and educational efforts. Further refinement of tracking regarding sources to further increase effectiveness is an ongoing effort.



Terminations from Medicaid participation are typically a joint effort between MPI and the Division of Medicaid. The top provider types that have historically been the subject of these actions are Physicians, Waiver (HCBS) providers, Assistive Care, Home Health, and Pharmacy providers. As this chart demonstrates, however, FY 17-18 has resulted in a higher volume of network actions and Behavior Analysis, which is discussed throughout this Report, has been the subject for an increased volume of investigations.



Particular attention has been given to earlier detection of suspected fraudulent and abusive behavior. These efforts are difficult to document through data analysis but may contribute toward the figure for FY 17-18 which demonstrates a greater portion of termination actions of active providers vs. post-termination discovery.

Division of Operations

Financial Services

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

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

As of June 30, 2017, the Medicaid accounts receivable balance for fraud and abuse was $43.5 million. During FY 2017-18, Financial Services recorded $70.4 million as Medicaid accounts receivable. As of June 30, 2018, the balance was $76.1 million. During FY 2017-18, total collections including refunds and net of adjustments approached $37.9 million. The collections were: $35.5 million in overpayments ($15.6 million collected from Medicaid Fraud Control Unit (MFCU) cases and $19.9 million collected from Medicaid Program Integrity (MPI) cases); $220,990 in investigation costs; $1.9 million in fines/sanctions; and $331,620 in interest.

The Agency must obtain approval from the Department of Financial Services (DFS) to write-off all accounts receivable deemed uncollectible. Accounts are generally written off because of one of the following reasons:

- The provider has declared bankruptcy;
- The provider is deceased;
- The corporation is out of business;

- The defendant is unable to pay because they are incarcerated; or
- The business is insolvent, or is beyond the State's current collection enforcement authority.

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

- Bankruptcy in which the Agency has filed a claim (even if the bankruptcy is discharged at the time the Agency discovers the bankruptcy);
- The Agency files a claim on the estate, for an individual who is deceased; or
- When the write-off is due to an out-of-business certification.

Once the accounts receivable is approved for write-off, the qualified federal share of each accounts receivable write-off is reclaimed. Financial Services also continues to work with the Agency's Division of Health Quality Assurance (HQA) and the Department of Health (DOH) to determine if a facility/provider's license renewal can be suspended pending receipt of overpayment amounts from the provider.

Financial Services uses the Medicaid Accounts Receivable (MAR) system, which records extensive financial detail on Medicaid accounts receivable, as its business process tool. The MAR system tracks each case as it moves through the receivable process, identifying which department, bureau or unit has current responsibility for a case. The system tracks state and/or federal allocation of receivable amounts, and produces necessary reports for case management and audit purposes.

Examples of available reports include System Financial Summaries, Case Financial Histories, Case Aging, Summary by Status and Department, and the "tickler file" used for monitoring purposes and reports for follow-up. The MAR system maintains the required accounting data for financial statements and federal reporting purposes related to fraud and abuse cases, and other overpayment cases. Examples of other overpayment cases include, but are not limited to hospital and nursing home retroactive rate adjustments, gross adjustments, and Agency for Persons with Disabilities' (APD's) overpayments.

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

Financial Services continues to emphasize communications with MPI, Bureau of Medicaid Quality, and MFCU to coordinate audit collection efforts. Financial Services also works with the Agency's Office of the General Counsel (OGC), Bureau of Medicaid Program Finance (MPF), HQA, Office of Third Party Liability (TPL), Medicaid Fiscal Agent Operations (MFAO), and Office of Inspector General (OIG) to coordinate collection efforts and pursue additional avenues of collection.

Financial Services continues to exercise due diligence in securing full payment of all accounts and claims due. During FY 2016-17, to further aid in the collections efforts of all revenue types, Financial Services transitioned the collection of past due Nursing Home Quality Assessment Fees (NHQAF) and administrative fines to the MAR unit. These accounts receivable both have a Medicaid component. The MAR Unit's first initiative was to generate Final Orders on all past due fees and fines finalizing the amounts owed to the Agency. The issuance of the Final Orders on past due debt gives the Agency additional leverage to recoup debts during license renewal and Change of Ownership (CHOWs).

The MAR system has further ensured liens were set to recoup all past due fees for all facilities with FFS claims. On the administrative orders, the MAR system assumed all of the past due debt and began to maintain the current Final Orders issued which included setting up receivables, monitoring, sending past due notices, and referring cases to the collection agency and for write-off. The transition of the Nursing Home Quality Assessments and administrative orders has made a positive impact in recoupment. Financial Services further proceeded to consolidate all of the collection activities into the MAR unit. In FY2017-18, the MAR unit

assumed the past due debit memos and past due Office of Plans and Constructions (OPC) invoices, and has assumed full responsibility for collection of the outstanding debt.

Third Party Liability Unit

The Division of Operations' TPL Unit is responsible for identifying and recovering funds for claims paid for by Medicaid for which a third party was liable, thereby ensuring Medicaid is the payor of last resort. Some examples of third parties include casualty settlements, insurance companies, recipient estates, Medicare and commercial carriers. TPL recovery services are performed by a state procured outside vendor. The Agency negotiated and executed a five-year contract with Health Management Systems, Inc (HMS) through August 31, 2020.

During FY 2017-18, approximately $91 million in Medicaid funds were collected. Annual TPL collections over the last four years have averaged approximately $106 million. In addition, the TPL Unit has held Conduent (previous vendor) and Health Management Systems, Inc. (HMS) accountable to its contract requirements by vigorously monitoring Conduent and HMS's performance. These efforts have helped to ensure maximum recoveries are generated for the State of Florida. Types of recoveries include:

- **Casualty** – Medicaid imposes a lien against liable third parties for the amount Medicaid has paid for services on behalf of a recipient who has been involved in an accident or incident, which resulted in injury. Attorneys are required to notify Medicaid that they represent a Medicaid recipient involved in an accident or incident;
- **Estate** – Medicaid files an estate claim on behalf of a deceased Medicaid recipient for Medicaid payments made after age 55. Medicaid is to be paid, as class 3 creditor, after attorney and personal representative fees and funeral costs, and must be notified by the estate attorney or personal representative when an estate is opened on any individual over age 55;
- **Trusts and Annuities** – Trusts and Annuities relating to a person's eligibility in the Medicaid program stipulate that upon the death of the beneficiary, or if the trust/annuity is otherwise terminated, the balance of the trust up to the amount that Medicaid paid for services on the beneficiary's behalf is to be paid to the Medicaid program;
- **Medicare and Other Third Party Payor** – Medicaid bills and collects from insurance carriers and Medicaid providers for claims paid for by Medicaid for which Medicare or another third party such as private insurance may have been liable;
- **Other Recoupment Projects** – The TPL Unit also works in conjunction with the Agency's Bureau of Medicaid Program Integrity to conduct other Medicaid recoupment projects. Recoveries from other recoupment projects during FY 2017-18 include:
    - **Date of Death** – Claims paid after the dates of death of Medicaid recipients are recovered;
    - **Hospital Credit Balance Audits** – Hospital accounts payable ledgers are reviewed in connection with collecting Medicaid overpayments; and
    - **Freestanding Dialysis Center Credit Balance Audits**- Freestanding Renal Dialysis Center provider's payable ledgers are reviewed in connection with collecting Medicaid overpayments.
- **Medicaid Overpayments** – Funds are recovered from providers where Medicaid has overpaid for a service, for example:
    - **Duplicate Crossover Payments** – Two Medicaid payments for Medicare Crossover liability;
    - **Outpatient Payment During Inpatient Stay** – An outpatient Medicaid payment immediately preceding an inpatient stay;
    - **Overutilization** - Outpatient Payments Over $1,500 – payments made in excess of the $1,500 limit for outpatient claims during a fiscal year;
    - **Service Exclusions** – Claims paid for services that are excluded per the respective Services Coverage and Limitations Handbook(s) and provider fee schedules for pharmacy, professional, institutional, and dental claim types:
        - Inpatient Stay over 45 days;
        - Non-covered Outpatient Revenue Codes;

- Revenue Codes Not on Promulgated Billing Code; and
- Outpatient to Inpatient Transfers.

- **Cost Avoidance** - Cost avoidance is new and/or updated insurance information that is derived from data matches with insurance carriers. Cost avoidance is also derived from insurance information obtained at the time of eligibility, through Medicaid field office staff and Medicaid providers. When new and/or updated insurance information is obtained, that information is added to the Florida Medicaid Management Information System (FLMMIS) in order to cost-avoid future claims that are submitted by Medicaid providers. When a provider submits a claim and a recipient has other insurance, the provider is instructed to bill the other insurance prior to billing Medicaid. The Agency utilizes a matrix maintained in FLMMIS to determine whether a claim shall be paid or denied based upon other third party information contained on the Medicaid recipient's file. Cost avoidance is the amount that was denied based upon third party information contained on the Medicaid recipient's file.

Below is a summary of Historical TPL collections:

Medicaid Third Party Liability - Historical Collections						
TPL Collections	FY 2012-13	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
Casualty	$22,303,548	$22,794,142	$21,985,243	$21,877,491	$22,819,897	$15,233,111
Estate	$7,061,816	$6,967,623	$7,092,510	$8,507,538	$7,709,297	$8,190,939
Trusts	$5,471,792	$6,615,113	$8,595,999	$5,887,889	$9,905,343	$11,498,094
Medicare and Other Third Party Payor	$77,922,624	$72,834,387	$67,061,300	$41,544,352	$36,444,209	$30,040,263
Other Recoupment Projects*	$48,455,372	$61,607,714	$42,525,211	$18,831,428	$12,074,137	$25,935,208
Total Collections	$161,215,152	$170,818,979	$147,260,263	$96,648,698	$88,952,883	$90,985,339
Cost Avoidance (Matrix)	$1,423,986,005	$1,720,174,663	$2,366,574,378	$2,031,929,709	$1,338,770,174	$1,215,514,268

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

Division of Health Quality Assurance

Care Provider Background Screening Clearinghouse

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

The Clearinghouse also includes a RapBack requirement, also known as "retained prints," which enables immediate notification to the Agency of the recent arrest of an employee to determine if the arrest affects access to vulnerable clients. The Clearinghouse also notifies providers of an arrest and prompts the Provider to check eligibility. The immediacy of notification through RapBack improves the Agency's response time in prevention of Medicaid fraud. The Clearinghouse provides the ability to keep an employee roster. Facilities are required to maintain a current employee roster, with updates to be made within 10 business days of a change, including a new hire, termination, or position change. With this requirement, the Agency can know immediately when a facility has employees who are not eligible on their roster and take action against the facility if it does not comply. From Clearinghouse implementation to the end of FY 2017-18, the Agency has imposed 396 background screening violations and 155 employee roster violations.

During FY 2017-18, the Background Screening Unit processed 24,987 RapBacks. Of these, 30.8 percent were found to be for criminal charges that resulted in the applicant's eligibility status being updated to not eligible. During FY 2017-18, 169,368 background screening results were shared among participating agencies and Medicaid health plans (MHPs) resulting in an overall cost savings of $12,702,600 to Agency providers, DOH licensees, MHPs, Medicaid providers, DCF, DOEA, DOEVR, and APD providers.

Regulatory Reform

The Agency's regulatory reform package, CS/CS/SB 622, Health Care Facility Regulation, passed the 2018 Legislative Session after many years of effort, becoming law on July 1, 2018. The reform package aimed to clarify statutory requirements and allow the Agency and regulated providers to operate more efficiently. Many elements of the new law strengthen the Agency's ability to prevent fraud, abuse, and waste.

The new law requires Level 2 background screening for three additional categories of personnel including: hospital-based skilled nursing unit personnel, any person who is a controlling interest of a licensed health care facility or provider licensed by the Agency, and contractors who regularly work with vulnerable individuals in settings where employees are already required to be screened. Formerly, because controlling interest screening could only be triggered by evidence of conviction of a disqualifying offense, a person may have continued to operate even if they have been arrested for serious crimes.

An unlicensed entity may now be immediately sanctioned if the operator has previously applied for or held a license from the Agency to operate as a health care provider. Previously, Florida law required the Agency to issue an unlicensed facility notice and allow the owner or operator to correct the violation.

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 2017-18:

- **Home Health Agencies** - Home health agencies which have demonstrated a pattern of billing the Medicaid program for medically unnecessary services, have either received an administrative penalty for violating s. 400.474(6)(e), Florida Statutes (F.S.), or denied a renewal application based on the provisions of s. 400.471(8), F.S. In FY 2017-18, no home health agencies were identified to have met these criteria;
- **Remuneration Complaints** - Complaints received against nurse registries for providing remuneration in violation of s. 400.506, F.S. There was one identified in FY 2017-18;
- **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. Six applicants met these criteria in FY 2017-18;
- **Financial Requirements** - There were 25 home health agency applications, 13 home medical equipment applications, and 31 health care clinic applications in FY 2017-18 that failed to meet the financial requirements of s. 408.8065, F.S. This includes applicants that did not reply to omissions related to proof of financial ability to operate during the application process; and
- **Revocations and Terminations** - Providers that were revoked, denied a renewal application or surrendered their license based on a Medicare or Medicaid suspension, termination or exclusion

from either program related specifically to fraud based on the provisions of s. 408.815(1)(e) and s. 408.815(4), F.S. There were nine providers that met these criteria in FY 2017-18.

Final and Emergency Orders

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

Licensure Final and Emergency Orders					
Fiscal Year	2013-14	2014-15	2015-16	2016-17	2017-18
Denying the renewal application	38	35	29	31	57
Revoking an existing license	78	47	52	22	24
Emergency orders	6	7	17	13	16
Provider surrendering their license	25	19	15	11	9
Total	147	108	113	77	106
Imposed Fines and Administrative Fees	$3,420,891	$3,339,379	$2,873,568	$2,218,876	$2,247,434

Transparency in Controlling Interests

The public may view "Provider Profile" pages for facilities and providers under the Agency's regulation at www.FloridaHealthFinder.gov. The Provider Profile is a one-page overview of the facility that includes basic information such as addresses, license status, licensed beds, legal actions, and services and characteristics of the provider, among others. The licensee or owner of the facility is listed along with the date that licensee or owner became effective. The Agency recently expanded upon this information by including an option to view controlling interests for the facility and what percent ownership they have in the facility. A licensee or owner may often be a limited liability company or a parent organization, whereas a controlling interest is broader and also includes any person or entity that serves as an officer, is on the board of directors or, or has a five percent or greater ownership interest in the licensee or management company used by the licensee. The update provides greater transparency of ownership stakes certain individuals have in facilities.

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

Office of the General Counsel

The Office of the General Counsel (OGC) is actively involved with other offices of the Agency for Health Care Administration (AHCA or the Agency) to help deter fraud and abuse in the Florida Medicaid program. The mission of the OGC is to provide high quality legal counsel and vigorous advocacy to the Agency in championing better heath care for all Floridians. The OGC provides legal advice and representation for the Agency on all legal matters, including: administration of the Medicaid plan and recovery of Medicaid overpayments due to mistakes or third party liability; regulation of managed care plans; civil litigation related to various Agency programs; and licensure and regulation of health care facilities, including nursing homes, hospitals, assisted living facilities, clinical laboratories, and home health agencies.

The OGC is comprised of 40 attorneys with 11 dedicated to Medicaid Administrative Litigation defending the Agency in Medicaid-related litigation before administrative tribunals, and litigate violations of state and federal laws pertaining to the administration of the Medicaid program before state and federal courts. The OGC has also dedicated an attorney-liaison who serves as a point of contact between the OGC, Medicaid Program Integrity (MPI) fee-for-service (FFS), and MPI managed care to help facilitate discussion and communication regarding ways to curb health care fraud and abuse. The attorney-liaison assists with legal matters related to manage care oversight, including: anti-fraud and compliance plans, reporting compliance, and investigations.

During this past fiscal year, the OGC Agency Clerk issued 353 Final Orders for MPI. Additionally, the OGC Agency Clerk received 71 MPI hearing requests.

DEPARTMENT OF HEALTH

Coordination and Cooperation between DOH, AHCA, and MFCU

The Department of Health (DOH) continues its partnership with the Agency for Health Care Administration (AHCA or the Agency) and the Attorney General's Medicaid Fraud Control Unit (MFCU) to strengthen inter-agency coordination and enhance processes and protocols in fraud investigation and prosecution. An interactive partnership is essential for protecting the people of Florida against health care fraud and substandard health care.

The DOH Division of Medical Quality Assurance (MQA) leadership meet regularly with AHCA and MFCU directors and senior managers to coordinate joint projects, investigations, enforcement strategies, and to identify emerging issues or threats. Over the years, these meetings have grown to include additional state agencies, including the Department of Children and Families (DCF), the Department of Financial Services Fraud Strike Force, the Department of Economic Opportunity (DEO), the Division of Insurance Fraud, and the Agency for Persons with Disabilities (APD). Expanding participation in the meetings fosters a multi-agency approach to fraud mitigation, identifies potential, emerging areas of fraud, and areas in which agency resources can be more effectively leveraged.

DOH and AHCA have continued to collaborate on projects to reduce fraud in Florida. Currently DOH and AHCA are working together to identify and investigate Clinical Social Worker Interns, Marriage and Family Therapy Interns, and Mental Health Counseling Interns to ensure they are properly supervised and are billing in accordance with all statues and rules.

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

As a result of legislation passed in 2009, from July 1, 2009 through July 17, 2018, DOH has denied licensure to 455 applicants and denied the renewal of 191 health care practitioners for health care related fraud. DOH has also taken 199 emergency actions and disciplined 379 health care practitioners for violations related to Medicaid.

STATUTORY REPORTING REQUIREMENTS

Number of cases opened and investigated

MFCU opened 307 cases and had 1,034 active cases in FY 2017-18. MPI investigated 4,069 cases which included 2,892 opened during the year.

Disposition of the cases closed

Disposition of Cases Closed				
Case Type	MFCU	PANE	AHCA	Total
Administrative Closure	6	1		7
Administrative Referral	62	11		73
Acquittal		1		1
Assistance to Other Agencies				
Bankruptcy				
Case Dismissed	5			5
Civil Settlement	29			29
Change of Ownership (CHOW)				
Consolidated		1		1
Conviction	37	14		51
Certified Out of Business (COOB) Invalidated				
Certified Out of Business (COOB) Validated				
Death of the Offender	1			1
Deferred Prosecution Agreement	1	1		2
Fines Issued			11	11
Investigation by Another Law Enforcement Agency	1	2		3
Lack of Evidence	11	20		31
Liquidated Damages Applied			8	8
No Abuse			27	27
No Auditable Review Period			1	1
No Findings			49	49
Nolle Prosequi	2	2		4
No Further Action Required			913	913
Not an Overpayment Issue			2	2
Not Sustained			12	12
Policy Does Not Support Referral				
Pre-trial Intervention		2		2
Project Completed			11	11
Prosecution Declined	2	5		7
Provider Education			15	15
Provider No Longer Operational			34	34
Provider Suspended			55	55
Provider With Cause Termination			96	96
Provider Without Cause Termination			4	4
Referred			177	177
Resolved with Intervention	4	1		5
Suspension Lifted			5	5
Sustained			358	358
Under Investigation by Another Entity			3	3
Unfounded	17	8		25
Unsubstantiated	17	13		30

Disposition of Cases Closed				
Case Type	MFCU	PANE	AHCA	Total
Vacated Termination			1	1
Voluntary Dismissal	53			53
Voluntary Termination			4	4
Grand Total	248	82	1,786	2,116

Sources of the cases opened

Sources of Cases Opened				
Source	MFCU	PANE	AHCA	Total
AHCA - Financial Services			25	25
AHCA - Health Quality Assurance (HQA)				
AHCA - HQA-Facility Regulation			6	6
AHCA - HQA-Field Operations				
AHCA - Medicaid Quality				
AHCA - Medicaid Program Integrity (MPI)	33	1		34
AHCA – Medicaid - Fraud Liaison				
AHCA - Medicaid - Medicaid Services				
AHCA - Medicaid - Pharmacy Services				
AHCA – Medicaid Fiscal Agent Operations			50	50
AHCA - MPI Generalized Analysis			55	55
AHCA - MPI Institutional			28	28
AHCA - MPI Jacksonville/Orlando/Tampa (JOT)			2	2
AHCA - MPI Managed Care Unit			4	4
AHCA - MPI Miami			35	35
AHCA - MPI Pharmacy			39	39
AHCA- MPI Prevention Strategy			5	5
AHCA - Other Bureaus				
AHCA - Third Party Recovery				
APD - Agency for Persons With Disabilities	7			7
APS - Adult Protective Services	3	64		67
Attorney		1		1
BET- Better Health, LLC			1	1
Citizen	18	6		24
CMS - Centers for Medicare & Medicaid Services	3			3
DCF - Department of Children & Families		1		1
DEA - US Drug Enforcement Administration	1			1
Detection Tool			1	1
DOH - Department of Health	1			1
Employee	6			6
Explanation of Medicaid Benefits (EOMB)			3	3
Family Member	7			7
FBI- Federal Bureau of Investigation	1			1
FDLE - Florida Department of Law Enforcement	2			2
Federal Agency - Centers for Medicare & Medicaid Services (CMS)			12	12
Florida – Medicaid Fraud Control Unit			35	35
Florida- Other Agencies			1	1
Government Employee				
HHS OIG Health & Human Services Inspector General	7			7

Sources of Cases Opened				
Source	MFCU	PANE	AHCA	Total
HUM - Humana				
Internet/Media			41	41
Investigator Initiative			206	206
Joint Task Force	12			12
Law Enforcement Agency	4			4
Long Term Care Ombudsman Council		1		1
Managed Care Monitoring				
Managed Care Special Investigations Unit - Reported by MFCU	26			26
Managed Care Organization - Special Investigative Unit - Reported by MPI				
Medicaid Provider	7	1		8
Medicaid Recipient	2			2
MFCU Data Mining Initiative				
MOL - Molina				
Online Complaint Form			7	7
Other - See Description			2	2
Press Report		1		1
Previous File or Case			5	5
Projects			2,251	2,251
Provider			48	48
Qui Tam	81			81
PRS - Prestige Health Choice				
Public			1	1
Random Audits			7	7
Random Selection			3	3
SAO - State Attorney's Office				
Self-Audit			19	19
Site Visit				
Spinoff Case	6			6
State Agency Other	1			1
STW - Wellcare d/b/a Staywell Health				
SUN - Sunshine				
USAO US Attorney's Office	3			3
Web Service				
Grand Total	231	76	2,892	3,199

Amount of overpayments alleged in preliminary and final audit letters

Amount of Overpayments Alleged in Preliminary and Final Audit Letters FY 2017-18 (Closed Cases)	
Preliminary	Final
$26,483,346	$19,536,600

Number and amount of fines or penalties imposed

During FY 2017-18, MPI imposed fines (under s. 409.913, F.S., and Rule 59G-9.070, F.A.C.) in the amount of $1,929,650 for closed cases.

Reductions in overpayment amounts negotiated in settlement agreements or by other means

There were no reductions in overpayments through negotiated settlements by MFCU during FY 2017-18. During FY 2017-18, the Agency's final settlements resulted in a total reduction of overpayments of $468,103 in

closed cases.

Amount of final Agency determinations of overpayments

MPI identified overpayments in the amount of $18,156,941 in closed audits.

Amount deducted from federal claiming as a result of overpayments

Federal requirements changed several years ago, and now, allow the state up to one year to return the federal share, through federal cost share adjustments of overpayments, if no revenues are received on the debt. To ensure federal shares are allocated as timely as possible, the Agency reports the federal portion of the total overpayment on the next available federal CMS-64 quarterly report and reduces a corresponding federal share draw. During FY 2017-2018, the Agency reduced its federal share, on quarterly cost reports, by $38.4 million for net overpayments.

Amount of overpayments recovered each year

MFCU collected $14,987,003 in overpayments that were returned to the Agency. Additionally, MFCU collected $19,793,255 in Federal Medicaid overpayments that were sent directly to the U. S. Department of Health and Human Services for a total of $34,780,258 in Medicaid overpayments collected in FY 2017-18. Overpayments recovered as a result of the MPI and MPI-CMS audits were $ 19,854,569 Total recoveries by MPI, MPI-CMS, and MPI- TPL for FY 2017-18 were $48,004,431 (This includes collections of overpayments, fines, costs, and paid claims reversals, COOBs, and contract assessments during the fiscal year).

Amount of cost of investigation recovered

During FY 2017-18, the MFCU collected $3,210 in program income investigative costs. MFCU also collected $133,997 in state share investigative costs and $202,041 in federal share investigative costs for a grand total of $339,248 for all investigative costs. MPI total investigative costs recovered for FY 2017-18 was $220,989.

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 2017-18 was 1.04 years.

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

During State FY 2017-18, the Bureau of Financial Services deemed $0.00 uncollectible.

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

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

Summary by Termination Type	
CRIMINAL HISTORY	8
CONTRACTUAL TERMINATION UNDER MEDICAID AUTHORITY	524
WITH-CAUSE TERMINATION UNDER MEDICAID FINAL ORDER	95
FAILED ON-SITE REVIEW	25
Total	652

Terminations by Provider Type	
05 - COMMUNITY BEHAVORIAL HEALTH SERVICES	9
07 - SPECIALIZED MENTAL HEALTH PRACTITIONER	8
10 - SKILLED NURSING FACILITY	6
14 - ASSISTIVE CARE SERVICES	39
15 - HOSPICE	1
20 - PHARMACY	7
25 - PHYSICIAN (M.D.)	72
26 - PHYSICIAN (D.O.)	5
27 - PODIATRIST	6
29 - PHYSICIAN ASSISTANT	5
30 - NURSE PRACTITIONER (ARNP)	5
32 - SOCIAL WORKER/CASE MANAGER	12
35 - DENTIST	2
39 - BEHAVIOR ANALYSIS (BA)	387
50 - INDEPENDENT LABORATORY	1
65 - HOME HEALTH SERVICES	14
67 - HOME & COMMUNITY-BASED SERVICES WAIVER	45
83 - THERAPIST (PT, OT, ST, RT)	8
90 - DURABLE MED EQUIPT/ MEDICAL SUPPLIES (DME)	2
91 - CASE MANAGEMENT AGENCY	15
97 - MANAGED CARE TREATING PROVIDER - NON-MEDICAID	3
TOTAL	652

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

MFCU expenditures for FY 2017-18 were $14,176,635, which included indirect costs of $2,423,222. MPI direct legal costs were $1,975,968 for prevention and recoupment cases. MPI's total cost for FY 2017-18 was $12,652,520.

Providers prevented from enrolling in Medicaid or re-enrolling as a result of suspected fraud or abuse

The following charts reference the number of providers, by total and by type, that were denied enrollment or re-enrollment 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	
PREVIOUS PROGRAM TERMINATION	129
BEST INTEREST OF THE PROGRAM	792
TOTAL	921

For the FY 2017-18, the following chart represents denied provider types:

Denied Providers – by Provider Type	
05 - COMMUNITY BEHAVIORAL HEALTH SERVICES	5
07 - SPECIALIZED THERAPEUTIC SERVICES	6
14 - ASSISTIVE CARE SERVICES	4
20 - PRESCRIBED DRUG SERVICES	7
25 - PHYSICIAN (M.D.)	34
26 - PHYSICIAN (D.O.)	1
27 - PODIATRIST	1

Denied Providers – by Provider Type	
29 - PHYSICIAN ASSISTANT	2
31 - REGISTERED NURSE/REGISTERED NURSE FIRST ASSISTANT	1
32 - SOCIAL WORKER/CASE MANAGER	8
35 - DENTIST	1
39 - BEHAVIOR ANALYSIS	731
65 - HOME HEALTH SERVICES	74
67 - HOME & COMMUNITY-BASED SERVICES WAIVER	16
83 - THERAPIST (PT, OT, ST, RT)	2
90 - DURABLE MED EQUIPT/ MEDICAL SUPPLIES	4
91 - CASE MANAGEMENT AGENCY	23
99 - TRADING PARTNER	1
TOTAL	921

Additionally, 335 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	
FAILED ON-SITE REVIEW	308
CRIMINAL HISTORY	24
FEDERAL EXCLUSION	3
TOTAL	335

Number of Denials- by Provider Type	
05 - COMMUNITY BEHAVIORAL HEALTH SERVICES	9
07 - SPECIALIZED THERAPEUTIC SERVICES	2
14 - ASSISTIVE CARE SERVICES	1
20 - PRESCRIBED DRUG SERVICES	3
25 - PHYSICIAN (M.D.)	15
27 - PODIATRIST	2
29 - PHYSICIAN ASSISTANT	1
30 - NURSE PRACTITIONER (ARNP)	4
35 - DENTIST	1
39 - BEHAVIOR ANALYSIS	272
65 - HOME HEALTH SERVICES	19
67 - HOME & COMMUNITY-BASED SERVICES WAIVER	1
83 - THERAPIST (PT, OT, ST, RT)	2
90 - DURABLE MED EQUIPT/ MEDICAL SUPPLIES	3
TOTAL	335

Finally, there were 426 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. Often-times these are providers, who were under review by the Agency or another entity that voluntarily terminates from the program to avoid the involuntary action by the Agency.

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

Medicaid Program Integrity (MPI) routinely collaborates with the Division of Medicaid with regard to policy and contract recommendations to prevent and detect Medicaid fraud and abuse and to prevent or assist in the recovery of overpayments. Internal Agency for Health Care Administration (AHCA or the Agency) processes and working groups drive practices toward successfully accomplishing the Agency's mission, which includes the detection, prevention, and recovery or enforcement activities related to MPI efforts. As such, MPI will continue to utilize the current Agency processes regarding policy and contract recommendations. MPI anticipates continued collaboration with the Division of Medicaid regarding managed care contract provisions, fee-for-service (FFS) coverage and limitation manuals (particularly with regard to high risk provider types remaining in the FFS program), and other program safeguards that may become evident through investigations and audits.

As has been described throughout this report, the Agency is addressing fraud and abuse regarding the delivery of BA services. Throughout these efforts, MPI has consulted with other payers who are also experiencing similar fraud issues and the Agency believes this is not a Medicaid-only problem. The Agency is in the process of developing several projects to strengthen program protections including licensure and policy enhancements.

As was described in last year's report, MPI's success is, in part, dependent upon the continued staffing of highly educated and skilled personnel with the ability to carry out the vast array of complex MPI activities. Funding considerations will remain an ongoing need to ensure that the Agency is able to recruit and retain qualified personnel needed for success. Included in these considerations is an ongoing need for resources and support to allow MPI to engage external assistance to continue to develop advanced data analytics for complex and evolving fraud detection and predictive analysis. During FY 2017-18, MPI began testing data visualization tools such as social media crawlers, public record data aggregators, geo-coding and mapping, and network visualization and analysis tools. MPI will continue to use existing resources as efficiently as possible, but continues to strive for innovation within the program.

ACRONYMS

3D - Three Dimensional Imaging
ABA- Applied Behavior Analysis
ABH - Advanced BioHealing
ACFE - Association of Certified Fraud Examiners
AFAAR - Annual Fraud Abuse Activity Report
Agency, the - Agency for Health Care Administration
AHCA - Agency for Health Care Administration
AHFI - Accredited Healthcare Fraud Investigator
ALF - Assisted Living Facilities
APD - Agency for Persons with Disabilities
APS - Adult Protective Services
ASU - Administrative Support Unit
BA - Behavioral Analysis
CAF - Credible Allegation of Fraud
CCEB - Complex Civil Enforcement Bureau
CDT - Code of Dental Procedures and Terminology
CEMA - Certified E&M Auditor
CFR - Code of Federal Regulations
CHOW - Change of Ownership
CIGA - Certified Inspector General Auditor
CEMA - Certified E&M Auditor Credential
CJIS - Criminal Justice Information Services
Clearinghouse - Care Provider Background Screening Clearinghouse
CMA - Certified E&M Auditor Credential
CMS - Centers for Medicare and Medicaid Services
COOB - Certified Out of Business
CPT - Current Procedural Terminology
CT - Computerized Tomography
CTA - Computerized Tomography Angiography
DCF - Department of Children and Families
DEO- Department of Economic Opportunity
DFS - Department of Financial Services
DHSMV - Florida Department of Highway Safety and Motor Vehicles
DJJ - Department of Juvenile Justice
DME - Durable Medical Equipment
DMV - Delivery Monitoring and Verification
DOAH - Division of Administrative Hearings
DOEA - Department of Elder Affairs
DOEVR - Vocational Rehabilitation at the Department of Education
DOH - Department of Health
DOJ - Department of Justice
EMA - Emergency Medicaid Alien
EOMB - Explanation of Medicaid Benefits
eQHealth - eQHealth Solutions, Inc.
EVV- Electronic Visit Verification
F.A.C. - Florida Administrative Code
FACTS - Fraud and Abuse Case Tracking System
FAW - Fraud, Abuse, and Waste
FBI - Federal Bureau of Investigations
FDLE - Florida Department of Law Enforcement
FFP - Federal Financial Participation
FFS - Fee-for-Service
FMHI - Florida Mental Health Institute
FLMMIS - Florida Medicaid Management Information System
F.S. - Florida Statutes
FSFN - Florida Safe Families Network
FTE- Full-time Equivalent
FY - Fiscal Year (Florida's fiscal year is July 1 – June 30)
HB - House Bill
HEAT - Health Care Fraud Prevention and Enforcement Action Team
HHS-OIG - Department of Health and Human Services - Office of the Inspector General
HIPAA - Health Insurance Portability and Accountability Act
HMO - Health Maintenance Organization
HMS - Health Management Systems, Inc.
HQA - AHCA's Health Quality Assurance
iBudget- Disabled Disability Individual Budget
JOT - Jacksonville, Orlando, and Tampa
LEIE- List of Excluded Individuals and Entities
LTC- Long Term Care
MAR - Medicaid Accounts Receivable
MCU - Managed Care Unit
MFAO - Medicaid Fiscal Agent Operations
MFCU - Medicaid Fraud Control Unit, within the Florida Department of Legal Affairs
MHP - Medicaid Health Plan
MII - Medicaid Integrity Institute
MMA - Managed Medical Assistance
MPF- Medicaid Program Finance
MPI - AHCA's Medicaid Program Integrity
MRA - Magnetic Resonance Angiography
MRI - Magnetic Resonance Imaging
MQA- Medical Quality Assurance within the Florida Department of Health
NAMAS - National Alliance of Medical Auditing Specialists
NAMPI- National Association for Medicaid Program Integrity
NHCAA - National Health Care Anti-Fraud Association
NHQAF - Nursing Home Quality Assessment Fees
NPI - National Provider Identifiers
NPPES- National Plan and Provider Enumeration System
OGC - Office of General Counsel
OIG - Office of the Inspector General
OPC- Office of Plans and Constructions
OPPAGA- Office of Program Policy and Government Accountability
OPS- Other Personnel Services
ORU - Overpayment Recoupment Unit
OSU- Operations Support Unit
PA - Prior Authorization
PANE - Patient Abuse, Neglect and Exploitation
PCRs - Paid Claims Reversals
PECOS- Provider Enrollment Chain Ownership System
PDL - Preferred Drug List
PDN - Private Duty Nursing
PET - Positron Emission Tomography
PPEC - Prescribed Pediatric Extended Care
PPR - Prepayment Review
QEN - Qualified Evaluator Network
QFAAR - Quarterly Fraud Abuse Activity Report
RBT- Registered Behavior Technician
ROI - Return on Investment
SAM- System for Awards Management
SAO- State Attorney's Office
SB - Senate Bill
SIPP- Statewide Inpatient Psychiatric Program
SIU - Special Investigative Unit
SMMC - Statewide Medicaid Managed Care
SQL - Structured Query Language
SSA - Social Security Administration
TCM - Targeted Case Management
TPL - Third Party Liability
UM - Utilization Management
USAO- U.S. Attorney's Office
USF- University of South Florida
VR- Vocational Rehabilitation

A note on how this report was composed:

The Agency for Health Care Administration, Bureau of Medicaid Program Integrity exercises oversight of the production of this report. However, the compilation of the information contained herein originated from many state agencies, bureaus, and units that have oversight of different functions of Florida's large and complex Medicaid program. Months prior to this report's publication, Brittany Bechtel of the Bureau of Medicaid Program Integrity initiated data calls and conveyed requests for up-to-date text to include in this report. The information from the multiple sources was assembled into a single draft document with assistance from other staff members. The draft text was reviewed and approved by officials responsible for the activities documented and published in this final report, in coordination with Multimedia Design. While many dedicated state employees contributed to this report throughout the year, Ms. Bechtel's efforts were most important in ensuring this report was submitted timely, with the statutorily required information. If you have questions or comments regarding this report, the Agency for Health Care Administration and the Office of the Attorney General will make every effort to address them.

The point-of-contact for this report is Brittany Bechtel, Bureau of Medicaid Program Integrity, Agency for Health Care Administration, 2727 Mahan Drive, MS#6, Tallahassee, FL 32308, email Brittany.Bechtel@ahca.myflorida.com.

Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, FL 32308
1-888-419-3456
HTTP://AHCA.MyFlorida.com

Produced by AHCA Multimedia Design