FLORIDA'S EFFORTS TO CONTROL MEDICAID FRAUD & ABUSE

FISCAL YEAR 2020-2021

December 21, 2021

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

Dear Governor DeSantis:

Pursuant to Section 409.913, Florida Statutes, enclosed is the annual report of the activities related to the fight against fraud and abuse in the Medicaid program for the FY 2020-21. This report has been prepared jointly by staff of the Agency for Health Care Administration (Agency) and the Medicaid Fraud Control Unit (MFCU) within the Office of the Attorney General. Our two organizations continue to collaborate, with a goal of innovative and effective approaches to aggressively combat fraud, abuse, and waste in the Medicaid program.

Sincerely,

Ashley Moody
Attorney General

Sincerely,

Simone Marstiller
Secretary

cc:The Honorable Wilton Simpson
The Honorable Chris Sprowl

Statutory Authority:

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

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

As this report details, the Agency for Health Care Administration (AHCA or the Agency) and the Medicaid Fraud Control Unit (MFCU) have continued their joint efforts to prevent, reduce, and mitigate health care fraud, abuse, and waste in accordance with their statutory obligations. This joint report presents specific results of efforts by the Agency and MFCU to control Medicaid fraud and program abuse during FY 2020-21.

TABLE OF CONTENTS

OFFICE OF THE ATTORNEY GENERAL

Medicaid Fraud Control Unit

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

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

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

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

Control and Enforcement Strategy

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

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

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

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

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

- Community Outreach - Training and education programs are provided to citizen groups, provider groups, and law enforcement groups. The purpose of such outreach is to encourage referrals or reports of Medicaid fraud, supplement the MFCU's enforcement

efforts through use of local law enforcement, educate citizens how to avoid becoming victims, and create partnerships with citizens and the medical community or other provider groups to assist antifraud efforts.

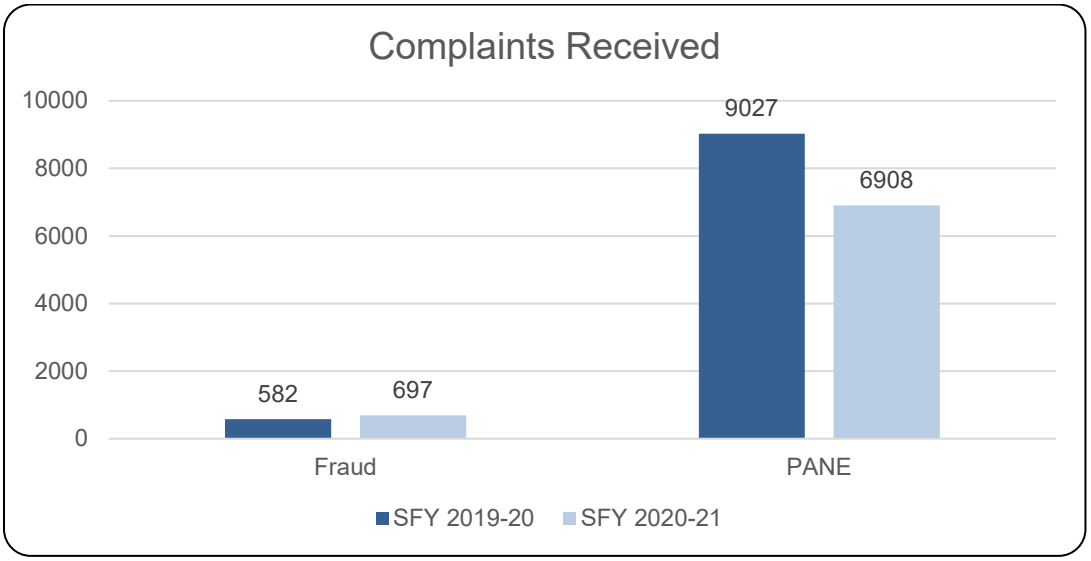
- Intelligence - Emphasis is placed on developing and fostering key partnerships with agencies such as AHCA, Department of Health (DOH), Agency for Persons with Disabilities (APD), state and federal prosecutors, and the criminal justice community in order to promote better sharing of data. Use of information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

Complaints

The Unit's policy requires a 60-day review of complaints and allegations to determine whether the matter merits further investigation, should be referred to another agency, or is unfounded. A 30-day extension may be applied for and granted. Case openings occur only when there is a criminal or civil predicate that warrants further investigative activity by the MFCU. During FY 2020-21, the Unit received 7,605 complaints. Of the 7,605 complaints received in FY 2020-21, 697 were related to fraud and 6,908 were related to PANE allegations.

Of the total 697 fraud complaints received, referrals from Managed Care Special Investigative Units were the primary source of fraud complaints in FY 2020-21, at 385. Complaints from Citizens accounted for 70 Medicaid fraud complaints. *Qui tam* complaints accounted for 59 of the Medicaid fraud complaints received. Thirty-seven complaints were received from Family Members. There were 33 complaints from AHCA Medicaid Program Integrity (MPI), 23 from Medicaid Recipients, 20 from Employees and 13 from Medicaid Providers.

The majority of PANE complaints were derived through the Department of Children and Families (DCF), Adult Protective Services (APS)/Florida Safe Families Network (FSFN.) In FY 2020-21, of the 6,908 PANE complaints, 6,778 came from DCF/APS/FSFN. The next highest sources of PANE complaints received were Family Members with 60 and Citizens with 26.



Case Investigations

Complaints are first reviewed to determine issues such as jurisdiction, and likely viability of the complaint. The opening of a case indicates that a criminal investigation or civil case has begun.

Thereafter, MFCU expends significant investigative resources and time to identify those involved in the origin of the wrongdoing, possible criminal misconduct, scope of the activity, and to establish sufficient evidence to prove the requisite elements.

During FY 2020-21, the Unit's internal intake team has continued to assist with front end decision-making regarding opening or closing criminal investigations. This successful process preserved valuable investigative resources and allowed the Unit to be more selective in its case focus. Of the 414 total cases opened, 221 were Fraud cases and 193 were PANE cases.

The following is a list of the top five Medicaid Provider types for MFCU fraud cases opened in FY 2020-21:

1. Physician
2. Home & Community Based Services
3. Community Alcohol/Drug/Mental Health
4. Durable Medical Equipment
5. Independent Laboratory

The following is a list of the top five Provider types for MFCU PANE cases opened in FY 2020-21:

1. Facility Employee
2. Family Member
3. Administrator of Facility
4. Owner of Business or Facility
5. Power of Attorney Privilege

Disposition of Cases

Following an investigation, a determination is made whether to pursue criminal prosecution or initiate civil actions. All case investigations are formally closed because of either a successful prosecution, a lack of evidence, or other classification. Several classifications are currently 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 2020-21, the MFCU closed 444 cases. Of those, 211 involved Medicaid fraud investigations and 233 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 2020-21 were 21 Fraud and 12 PANE for a total of 33.

Warrants for arrests for FY 2020-21 were 22 Fraud and 12 PANE for a total of 34.

Case Highlights

Novartis Pharmaceuticals Corp.

On or about September 9, 2020, Florida joined the United States to settle allegations against Novartis Pharmaceuticals Corporation (Novartis) by reaching an agreement in principle along with twenty-six other states and the District of Columbia. The settlement resolved allegations that Novartis paid kickbacks to health care practitioners in the form of cash, meals, entertainment, and honoraria payments to induce them to prescribe various medications that treat hypertension or Type

2 diabetes. Under the settlement Novartis agreed to pay $678 million to the United States, Florida and twenty-six other states and the District of Columbia, $103 million of which resolves claims pertaining to state Medicaid Programs. As part of the settlement Florida received $5,775,400 in restitution and other recoveries.

The settlement resolves allegations that from January 2002, through November 2011, Novartis paid kickbacks to doctors to prescribe Lotrel, Valturna, Starlix, Tekamlo, Diovan HCT, Tekturna HCT, and Exforge HCT and that between January 2010, and November 2011, Novartis also did so for Exforge, Diovan and Tekturna. In court documents it was alleged that Novartis systemically paid doctors to speak about certain drugs at sham events, with a veneer of education applied in an attempt to avoid the law and covered the costs of lavish meals and entertainment for attendee doctors, to induce doctors to write prescriptions for these Novartis drugs in violation of the Federal False Claims Act and the Florida False Claims Act.

Novartis admitted aspects of the scheme in a stipulation filed in federal court in connection with the settlement, to include admissions concerning excessive meal and alcohol spending, minimal medical discussions at Novartis's events and repeat attendance.

This settlement arose from a whistleblower action originally filed in 2011 in the United States District Court for the Southern District of New York under the federal False Claims Act and the named plaintiff states' respective false claims/anti-fraud statutes.

Universal Health Services, Inc.

On or about July 7, 2020, Florida, along with 49 states, territories, and the federal government, settled allegations of fraud against Universal Health Services, Inc. (UHS). UHS is a for-profit holding company that directly or indirectly owns the assets or stock of inpatient and residential psychiatric and behavioral health facilities that provide services to individuals, including beneficiaries of various federal health care programs, and UHS of Delaware, Inc., a subsidiary of UHS that provides management services to UHS and its subsidiaries.

UHS is based in King of Prussia, Pennsylvania and is one of the nation's largest providers of hospital and health care services. The total value of the settlement is $117 million. Florida received approximately $3.7 million.

The agreement resolves allegations that during the period from January 1, 2007, through December 31, 2018, UHS and certain enumerated UHS entities submitted or caused to be submitted false claims for services provided to Medicaid beneficiaries resulting from UHS's:

- Admission of beneficiaries not eligible for inpatient or residential treatment;
- Failure to properly discharge beneficiaries when they no longer needed inpatient or residential treatment;
- Improper and excessive lengths of stay;
- Failure to provide adequate staffing, training and /or supervision of staff;
- Billing for services not rendered;
- Improper use of physical and chemical restraints and seclusion; and
- Failure to provide inpatient acute or residential care in accordance with federal and state regulations, including, but not limited to, failure to develop and /or update individualized assessments and treatment plans, failure to provide adequate discharge planning and failure to provide required individual and group therapy.

The government agencies alleged that UHS's conduct violated the Federal False Claims Act and the Florida False Claims Act, resulting in the submission of false claims to the Florida Medicaid program.

This agreement results from 18 whistleblower lawsuits originally filed in the U.S. District Court for the Middle District of Florida, Northern District of Illinois, Eastern District of Pennsylvania, Northern District of Georgia, Middle District of Georgia, Eastern District of Virginia, Western District of Virginia, Western District of Michigan, and Eastern District of Michigan. Fourteen of the 18 whistleblower suits named at least one plaintiff state and all but three of the cases were transferred to the U.S. District Court for the Eastern District of Pennsylvania. A National Association of Medicaid Fraud Control Units Team participated in the investigation and settlement negotiations on behalf of the states and included representatives from the Offices of the Attorneys General for the states of California, Florida, Indiana, Massachusetts, North Carolina, Ohio, Texas, and Virginia.

Royal Pharmaceuticals LLC and Seton Pharmaceuticals, LLC

On or about December 11, 2020, Florida took action to claw back money owed to Florida's Medicaid Program. Following a multistate investigation into Royal Pharmaceuticals LLC and Seton Pharmaceuticals LLC, Florida's Medicaid Fraud Control Unit, and a bipartisan group of attorneys general from across the country secured more than $10 million for the states' Medicaid programs. The nationwide investigation found that the two jointly held pharmaceutical companies underpaid Medicaid drug rebates to all 50 states from 2013 to 2017. Florida's Medicaid program received more than $4 million.

In July 2018, Royal and Seton self-reported an error in the companies' Medicaid Drug Rebate Program (MDRP) data to the North Carolina Medicaid Fraud Control Unit. As part of the MDRP, drug manufacturers are required to pay rebates to state Medicaid programs for each of the company's drugs that are covered by Medicaid. From September 2013 to January 2017, Royal and Seton inadvertently, yet inaccurately, reported the market date data element that is part of the Centers for Medicare and Medicaid Services' (CMS) calculation of each drug's rebate amount.

The drugs at issue were two low-potency topical steroid products: Derma-Smoothe, made by Royal, and its generic equivalent, fluocinolone, made by Seton. This error caused CMS's rebate calculation to result in a lower calculated rebate amount, and consequently Royal and Seton's rebate underpayments to several state Medicaid programs.

Indivior

On or about April 21, 2021, the Florida Medicaid Fraud Control Unit, working with state and federal partners, secured $300 million following a nationwide investigation. Florida's Medicaid Fraud Control Unit worked with the U.S. Department of Justice and other state MFCU's to investigate allegations that Indivior plc. and Indivior Inc., d/b/a Indivior, falsely and aggressively marketed and otherwise promoted the drug Suboxone, resulting in improper expenditures of state Medicaid funds. Suboxone is a drug product approved for use by recovering opioid addicts to avoid or reduce withdrawal symptoms while they undergo treatment. Suboxone and its active ingredient, buprenorphine, are powerful and addictive opioids.

As a result of the investigation, Indivior agreed to pay a total sum of $300 million to resolve various civil-fraud allegations impacting Medicaid and other government health care programs, with more than $203 million going to Medicaid. Florida's Medicaid share of the nationwide recovery is approximately $1.3 million.

The investigation arose from six separate *qui tam* actions filed in the U.S. District Courts for the Western District of Virginia and the District of New Jersey. The agreement resolves allegations that Indivior directly or through its subsidiaries:

- Promoted the sale and use of Suboxone to physicians who were writing prescriptions that were not for a medically accepted indication in that they lacked a legitimate medical purpose,

were issued without any counseling or psychosocial support, were for uses that were unsafe, ineffective, medically unnecessary, and often diverted.

- Knowingly promoted the sale or use of Suboxone Sublingual Film (SSF) based on false and misleading claims that SSF was less subject to diversion and abuse than other buprenorphine products and that SSF was less susceptible to accidental pediatric exposure than Suboxone Sublingual Tablets; and

- Submitted a petition to the Food and Drug Administration, fraudulently claiming that Suboxone Tablet had been discontinued due to safety concerns about the tablet formulation of the drug and took other steps to fraudulently delay the entry of generic competition for various forms of Suboxone in order to improperly control pricing of Suboxone, including pricing to the states' Medicaid programs.

Regarding the federal criminal case against Indivior on July 24, 2020, Indivior Solutions pleaded guilty to a one-count felony information and together with its parent companies Indivior Inc. and Indivior plc., agreed to pay a total of $289 million to resolve criminal liability associated with the marketing of Suboxone. In its guilty plea, Indivior Solutions admitted to making false statements to promote Suboxone Film to the Massachusetts Medicaid program relating to the safety of Suboxone Film around children.

On Nov. 12, 2020, U.S. District Judge James P. Jones of the Western District of Virginia sentenced Indivior Solutions to pay $289 million in criminal fines, forfeiture, and restitution. In addition to the criminal and civil resolutions, Indivior executed a five-year Corporate Integrity Agreement with the U.S. Department of Health and Human Services, Office of Inspector General, requiring Indivior to implement numerous accountability and auditing provisions.

On June 30, 2020, Indivior plc.'s former CEO Shaun Thaxton pleaded guilty to a one-count misdemeanor information related to the same conduct. On October 22, 2020, the court sentenced Thaxton to a six-month term of incarceration and to pay $600,000 in criminal fines and forfeiture. On August 26, 2020, Indivior's former medical director, Tim Baxter, pleaded guilty to a one-count misdemeanor information related to the same conduct, conduct for which Baxter was sentenced on December 17, 2020, to six months home detention, 100 hours of community service, and a $100,000 criminal fine.

This agreement with Indivior followed the Reckitt Benckiser Group plc. $1.4 billion agreement with the federal government and the states in 2019, which resolved Reckitt's potential criminal and civil liability related to substantially similar allegations involving Suboxone. The 2019 agreement resulted in a total civil agreement of $700 million, with $400 million paid to the federal and state governments to resolve Medicaid fraud allegations resolved in the agreement.

Apria Healthcare LLC

On or about December 14, 2020, Attorney General Moody's Medicaid Fraud Control Unit worked with the U.S. Department of Justice and other state MFCUs to investigate false Medicaid claims made by Apria Healthcare Group Inc. and Apria Healthcare LLC. There are more than 300 Apria branch offices across the nation, including Florida. According to the federal-state investigation, Apria submitted false claims to state Medicaid programs for the ongoing rental of non-invasive ventilators (NIV) that Medicaid beneficiaries either did not use or medical professionals deemed not medically necessary.

As a result of the investigation, Apria paid a total sum of $40 million, of which $4,812,000 reimbursed state Medicaid programs. Florida's share of the nationwide recovery was approximately half a million dollars.

The investigation arose from a *qui tam* action filed in the United States District Court for the Southern District of New York in 2017 under the federal False Claims Act and various state false claims statutes. The settlement resolves allegations that, from January 1, 2014, through December 31, 2019, Apria violated the FCA by submitting false claims to state Medicaid programs to seek reimbursement for NIV rentals in certain circumstances.

The circumstances outlined in the settlement included: when the NIVs were not medically necessary or reasonable due to the lack of continued use or continued need by the beneficiaries; or when certain NIV models that were only to be used in a bi-level pressure support setting called Pressure Assist Control mode, were not medically necessary or reasonable.

Merit Medical Systems, Inc.

On or about November 30, 2020, Florida joined with other states and the federal government to reach an agreement with Merit Medical Systems, Inc. ("Merit") to settle allegations that Merit offered unlawful kickbacks to healthcare providers in order to induce them to purchase Merit medical devices. Merit is a Utah-based medical device manufacturer that markets and sells embolotherapeutic devices used to treat arteriovenous malformations, symptomatic uterine fibroids, and hypervascular tumors. Merit agreed to pay the states and the federal government $18 million dollars, $5,580,000.00 of which went to the Medicaid programs, to resolve civil allegations that Merit's unlawful promotion of its medical devices caused false claims to be submitted to government health care programs. As part of the settlement, Florida received approximately $210,924 in restitution and other recoveries.

Specifically, the settlement resolved allegations that from September 1, 2010, to March 31, 2017, Merit offered and paid physicians, medical practices, and hospitals (collectively, "Healthcare Providers") millions of dollars through its Local Advertising Program ("LAP") in free advertising assistance, practice development, practice support, and purportedly unrestricted "educational" grants to induce the Healthcare Providers to purchase and use Merit products in medical procedures performed on Medicaid beneficiaries. Merit used the LAP to reward their high-volume customers with patient referrals and financial advertising support but removed those customers from the program if they did not convert to or increase their use of Merit's devices in their Uterine Fibroid Embolization procedures. This settlement arose from a *qui tam* action filed in the United States District Court for the District of New Jersey in 2016 under the federal False Claims Act and various state false claims statutes.

Mori, Bean and Brooks, P.A.

On or about November 2, 2020, the Florida Medicaid Fraud Control Unit secured an agreement with Mori, Bean and Brooks, P.A. (MBB), a radiology practice in Jacksonville, to resolve allegations of health care fraud. According to a joint investigation conducted by the Medicaid Fraud Control Unit and the United States Attorney's Office for the Middle District of Florida, MBB knowingly submitted false claims to the Medicaid program for the interpretation of radiological images that were ineligible for reimbursement. MBB agreed to pay the state of Florida $161,694 to resolve the allegations.

According to the joint investigation, from April 27, 2012, through February 5, 2019, MBB billed Medicaid for the interpretation of radiological images outsourced overseas. Medicaid requires teleradiology services to be completed within the U.S. to qualify for reimbursement. MBB cooperated with the U.S. government upon being informed of the investigation.

A lawsuit originally filed in the U.S. District Court for the Middle District of Florida by Thomas Heyck spurred the agreement. Heyck is a radiologist previously employed by MBB.

The case is captioned U.S. ex rel. Thomas Heyck v. Mori, Bean and Brooks, P.A, No. 3:18-cv-590-J-39PDB.

Medicrea USA, Inc.

On or about April 21, 2021, Florida joined the United States and six other states, California, Colorado, Georgia, New York, North Carolina, and Texas in settling allegations against Medicrea USA, Inc. and Medicrea International, d/b/a Medicrea, for involvement in purported kickbacks.

According to the investigation, Medicrea allegedly provided items of value in the form of alcoholic beverages, entertainment, meals, and travel expenses to U.S.-based physicians at events surrounding the Scoliosis Research Society's September 2013, Congress in Lyon, France. The U.S. alleged that Medicrea provided the benefits to persuade the physicians to purchase, order, or recommend Medicrea's spinal devices, resulting in false payment claims to federal health care programs under the provisions of the Anti-Kickback Statute.

The Anti-Kickback Statute prohibits medical device manufacturers from directly or indirectly offering or paying anything of value to induce the referral of items or services, such as device orders or purchases, covered by Medicare, Medicaid, TRICARE, or other federal health care programs. Florida contended that this conduct violated the Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b)(1)(B), the related state false claims act statutes and resulted in claims submitted to, or purchases made by, the Florida Medicaid program between October 1, 2013, and December 31, 2015. As part of the agreement, the state of Florida received more than $160,000 in restitution and other recoveries.

The civil agreement included the resolution of claims brought under the *qui tam* or whistleblower provisions of the False Claims Act statute. Under those provisions, a private party can file an action on behalf of the U.S. and receive a portion of any recovery. The suit was filed in the Eastern District of Pennsylvania and is captioned United States of America, et al., ex rel. Dory Frain v. Medicrea USA Corporation, Civil Action No. 16-1986.

Pacira Pharmaceuticals, Inc.

On or about July 22, 2020, Florida's Medicaid Fraud Control Unit announced a multistate, multimillion-dollar agreement against a national pharmaceutical company. Florida was one of 15 states, along with the federal government, settling allegations of kickback violations against Pacira Pharmaceuticals, Inc., d/b/a Pacira, a developer and manufacturer of pharmaceutical products based in Parsippany, New Jersey. Pursuant to the settlement terms, Pacira agreed to pay $3.5 million plus interest, to Florida, the U.S. government and 14 additional states. Florida's Medicaid program received more than $101,000.

The settlement resolved allegations, dating back to 2012, that Pacira paid kickbacks in the form of research grants to certain health care providers or institutions in order to increase sales of its product EXPAREL®, a single-dose injectable local anesthetic indicated for the treatment of post-surgical pain. The government alleged that Pacira's conduct violated the Federal Anti-Kickback Statute and the Florida False Claims Act, resulting in the submission of false claims to the Florida Medicaid program.

This settlement resulted from a whistleblower lawsuit originally filed in the U.S. District Court for the District of New Jersey.

Carolyn Ausherman

On or about November 16, 2020, Florida's Medicaid Fraud Control Unit and the Levy County Sheriff's Office arrested a woman for organized fraud and fraudulent use of personal identification information to defraud a Medicaid provider. Carolyn Ausherman forged fraudulent Medicaid employee service logs, defrauding the Medicaid program out of more than $15,000.

According to the investigation, Ausherman entered into an agreement with an employee of a Medicaid provider wherein Ausherman used the employee's name to submit forged and fraudulent service logs to the Medicaid provider. The service logs submitted by Ausherman claimed that the employee provided caregiving services to the Medicaid recipient, a disabled adult. The investigation revealed that the employee never provided services to the disabled adult. The Medicaid provider issued paychecks to the employee that were then cashed and split with Ausherman.

Ausherman pled nolo contendre to one count of Organized Scheme to Defraud and one count of Fraudulent use of Personal Identification Information. She was sentenced to three years' probation and restitution of $15,620. The Attorney General's Medicaid Fraud Control Unit prosecuted the case through an agreement with the State Attorney's Office for the Eighth Judicial Circuit.

Pamela Anne Peterson

On or about November 10, 2020, the Florida's Medicaid Fraud Control Unit, with the assistance of the Pasco County Sheriff's Office, arrested a Pasco County resident for one count of Medicaid provider fraud. Pamela Anne Peterson, a transportation provider for Medicaid recipients, defrauded the Medicaid program out of more than $15,000 by falsifying documents for services not rendered.

According to an investigation conducted by MFCU, from July 4, 2017, through December 1, 2018, Peterson provided non-emergency transportation services for Medicaid recipients, as authorized under the Medicaid program. While Peterson did drive a recipient to an appointment once a week, the defendant submitted transport logs claiming to drive the recipient more frequently, often once a day. Over a period of several months, Peterson submitted false logs for reimbursement and repeatedly cashed checks for services not rendered.

Peterson pled guilty to one count of Medicaid provider fraud, a second-degree felony. She was sentenced to 6 years-probation and ordered to pay $15,606 restitution. The Attorney General's Office of Statewide Prosecution prosecuted the case.

Wendy Lynn Borden

On or about August 31, 2020, Florida's Medicaid Fraud Control Unit, with the assistance of the Polk County Sheriff's Office arrested a behavior analyst for defrauding the Medicaid program out of more than $6,500. Wendy Lynn Borden was employed by a Medicaid provider in Monroe County and provided behavior analyst services to Medicaid recipients. Borden is accused of falsifying progress notes and sign-in logs in order to be paid for services not rendered.

According to the investigation, between January 17, 2019, through February 27, 2019, Borden copied and pasted the same progress notes for four separate Medicaid recipients for services not rendered. Borden also forged recipients' signatures on sign-in logs to falsely confirm services the recipients never received. Borden's falsified notes and sign-in logs caused the Medicaid program to pay more than $6,500 for behavior analyst services not provided.

Borden was charged with one count of Medicaid fraud, a third-degree felony. She pled nolo contendre and was sentenced to 180 days incarceration, 30 months' probation, and restitution of $6,598.92. The State Attorney's Office for the Sixteenth Judicial Circuit prosecuted the case.

Dorothy L. Mitchem

On or about April 13, 2021, Florida's Medicaid Fraud Control Unit and the Alachua County Sheriff's Office arrested a former caregiver for grand theft. Dorothy L. Mitchem submitted fraudulent timesheets and accepted payment for services not rendered to a disabled Medicaid recipient. Mitchem previously worked as a direct service worker for Consumer Direct Care Network Florida (CDCNF) to provide in-home, personal care services to a disabled adult. CDCNF assists clients who need attendant care services in their home to select, train, and manage their own caregiver.

According to the MFCU investigation, Mitchem submitted timesheets to CDCNF and received payment for services not rendered by the Medicaid program while the client was admitted in the hospital or while working at another place of employment.

Mitchem pled nolo contendre and was sentenced to six days incarceration, three years probation and 360 hours of community service along with restitution of $2,711.52. The Attorney General's MFCU prosecuted the case through an agreement with the State Attorney's Office for the Eighth Judicial Circuit.

Ratonia Thompson

On or about June 9, 2021, Ratonia Thompson was arrested by the Florida Medicaid Fraud Control Unit and the Plant City Police Department for stealing more than $180,000 from the Medicaid program, over the course of four years, instead of distributing the funds to caregivers.

According to a joint investigation by the Medicaid Fraud Control Unit and the U.S. Department of Health and Human Services Office of Inspector General, a disabled adult placed in Ratonia Thompson's care and custody was enrolled as a Medicaid recipient in the Consumer Directed Care+ (CDC+) program. CDC+ is jointly funded by the federal government and the Florida Medicaid program and allows disabled recipients and family members to personally direct the recipient's care.

Ratonia Thompson registered with CDC+ as the disabled adult's representative, an unpaid position that empowered Thompson to hire employees to aid with the adult's activities of daily living, such as bathing, cleaning, and feeding. Instead, Ratonia Thompson routinely submitted falsified service logs claiming the services rendered and pocketed the Medicaid payments intended for caregivers through debit cards registered in the names of caregivers who previously provided services, but no longer worked for the disabled adult.

The investigation began after the Agency for Persons with Disabilities received a complaint from a former caregiver citing timesheets fraudulently submitted in the caregiver's name. Upon review, it was found that Gregory Thompson, Ratonia Thompson's husband, became the representative for the disabled adult and was responsible for submitting caregiver timesheets for payment. However, APD found that Gregory Thompson had died, but timesheets continued to be submitted by someone claiming to be him. Further investigation found that the caregivers reported on the timesheets no longer worked for the disabled adult, and the former caregivers did not receive payment for the services claimed. The investigation found that instead of the intended payments going to the former caregivers, Ratonia Thompson allegedly spent the funds on the debit cards for personal expenses.

Additionally, a former caregiver for the disabled adult received notice of an audit after the Internal Revenue Service discovered more than $23,000 not reported in tax filings. The caregiver never made that amount of money while working for the disabled adult and realized Ratonia Thompson illegally submitted timesheets claiming the services rendered and subsequently pocketed the money. According to the MFCU investigation, from December 2017 through March 2021, Ratonia Thompson allegedly illegally collected more than $180,000 from the Medicaid program.

Ratonia Thompson was charged with one count of Medicaid fraud more than $50,000, and one count of organized fraud more than $50,000; both are first-degree felonies. If convicted, Thompson faces up to 60 years in prison and $20,000 in fines. Attorney General Moody's Office of Statewide Prosecution will prosecute the case.

Quantara Clarke

On or about April 16, 2021, Florida's Medicaid Fraud Control Unit and the Leon County Sheriff's Office arrested the owner of a home and community-based services provider for more than $50,000

in Medicaid fraud. Quantara Clarke, 49, is the owner of Golden Angels Professional Services, LLC in Gadsden County and allegedly over-billed Medicaid for services not provided. The investigation also revealed that Clarke, on multiple occasions, did not provide quality care or one-on-one support to patients.

Clarke was responsible for providing home and community-based services for Medicaid recipients and is specialized in traumatic brain injury, developmental disabilities, Autism specifications, and aged or disabled adults. Clarke and her employees are intended to provide homemaker services, supported living coaching, and life skills development. These services can range from helping with household upkeep, running errand s, assisting with paying bills, taking patients to doctor appointments, and more.

MFCU's investigation revealed that Clarke allegedly billed Medicaid in excess of time limits set by the Medicaid program and for unauthorized services to patients who were in a hospital or incarcerated. Pursuant to Florida Medicaid regulations, the billed services must be provided to recipients at their home, a family member's home or in the community. Clarke also overstated the time spent with patients, and several victims allege that Clarke and her employees intimidated them. In one instance, Clarke and employees brought multiple patients together in one home to make it "easier" to provide services, although one-on-one supported living coaching services were billed to Medicaid.

Clarke is charged with one count of Medicaid provider fraud $50,000 or more, a first-degree felony. If convicted, Clarke faces up to 30 years in prison and more than $300,000 in fines and restitution. The Attorney General's MFCU will prosecute the case through an agreement with the State Attorney's Office in the Second Judicial Circuit.

Rodney Burt

On or about July 17, 2020, Florida's Medicaid Fraud Control Unit, with the assistance of the Leon County Sheriff's Office, arrested a Medicaid provider on charges related to $50,000 in fraud. The arrest follows a MFCU investigation that revealed Rodney Burt, 57, allegedly billed the Florida Medicaid Program for services not rendered from May 2016 through November 2019.

Additionally, the investigation uncovered that Burt, owner of No Place Like Home, a home and community based services provider, allegedly assigned inaccurate billing codes to claims submitted to the Florida Medicaid Program in order to increase reimbursements, a fraudulent billing practice known as upcoding.

Burt is charged with one count of Medicaid provider fraud $50,000 or more, a first-degree felony. If convicted, Burt faces up to 30 years in prison and more than $300,000 in fines and restitution.

The Attorney General's MFCU will prosecute the case through an agreement with the State Attorney's Office in the Second Judicial Circuit.

Julio Suarez

On or about March 4, 2021, Florida's Medicaid Fraud Control Unit and the Miami-Dade Police Department arrested a dental hygienist illegally practicing as an unlicensed dentist for committing Medicaid fraud. Julio Suarez allegedly performed unlicensed and unauthorized procedures on patients, defrauding the Medicaid program out of more than $8,000.

For more than two years, Suarez allegedly worked as an unlicensed dentist for Art Dental Services, Inc. While employed at Art Dental, Suarez knowingly performed unlicensed dental services and procedures on unwitting and unsuspecting patients. Suarez then billed the unlicensed services to the Medicaid program. By performing and billing these unlicensed dental procedures, Suarez

fraudulently caused the Medicaid program to pay more than $8,000.

Julio Suarez is charged with one count of Medicaid fraud, a second-degree felony and one count of grand theft, a third-degree felony. If convicted, Suarez faces up to 15 years in prison and $10,000 in fines. The Attorney General's Office of Statewide Prosecution will prosecute the case.

Diane Ellis

On or about June 24, 2021, Florida's Medicaid Fraud Control Unit and the Leon County Sheriff's Office arrested a Medicaid home and community-based services provider. According to an investigation by MFCU, Diane Ellis allegedly defrauded the Florida Medicaid program out of more than $5,000 over the course of three years.

The investigation revealed that from January 1, 2017, through October 2, 2020, Ellis allegedly defrauded the Florida Medicaid program by submitting claims for services that overlapped multiple recipients and for services not rendered, including purported Medicaid services provided while Ellis also received payment for driving a school bus for Leon County Schools. Ellis is cited for billing deficiencies numerous times by the Florida Medicaid program and on multiple occasions, billing for more than 24 hours' worth of services in a single-day period.

Ellis is charged with one count of Medicaid provider fraud, $10,000 or less, a third-degree felony. If convicted, Ellis faces up to five years in prison.

The Attorney General's MFCU will prosecute the case through an agreement with the State Attorney's Office in the Second Judicial Circuit.

Chenelle Weaver

On or about August 12, 2020, Florida's Medicaid Fraud Control Unit and the Martin County Sheriff's Office arrested a behavior health analyst for defrauding the Florida Medicaid program out of thousand s of dollars. Chenelle Weaver, employed by Behavior Basics, Inc., provided behavioral health services to Medicaid recipients in St. Lucie County. However, not only did Weaver fail to provide services, but the defendant also fraudulently charged the Florida Medicaid program thousand s of dollars.

According to the investigation by the MFCU, Weaver allegedly submitted falsified progress notes for services not rendered to a Medicaid recipient and received payments from the Florida Medicaid program based on the falsified claims. The MFCU investigation revealed that upon learning Weaver did not regularly work or provide services to a Medicaid recipient, the owner of Behavior Basics obtained security video showing all persons leaving and entering the facility. The video surveillance confirmed, from February 15, 2018, through March 30, 2018, Weaver falsified the dates and times provided on progress notes submitted to Behavior Basics totaling more than $6,800 in false claims paid by the Medicaid program.

Weaver is charged with one count of Medicaid fraud, a third-degree felony. If convicted, Weaver faces up to five years in prison. The State Attorney of the 19th Judicial Circuit will prosecute the case.

Amand a Shaw

On or about August 10, 2020, the Florida's Medicaid Fraud Control Unit, with the assistance of the Rotterdam New York Police Department, arrested a Schenectady, New York woman for elder exploitation. Authorities arrested Amand a Shaw on one count of exploitation of an elderly person and one count of organized scheme to defraud for abusing a power of attorney to exploit almost $100,000 from a Deland resident. Shaw is a relative of the victim who resides in a Medicaid-funded

facility in Florida.

According to the investigation, conducted jointly by MFCU and the Deland Police Department, Shaw allegedly falsely signed a power of attorney to gain control of two bank accounts of the elderly person without the victim's knowledge or consent. Shaw used the exploited funds to buy cell phones, electronics, and other purchases from the relative's account, including a new car purchased in Orange County and later registered in New York. Once gaining power of attorney, Shaw allegedly cut off contact with the victim and completely depleted the funds in both accounts, leaving the victim to pursue Medicaid eligibility to afford current support and residence.

Shaw pled nolo contendre to one count of exploitation of an elderly person was adjudicated guilty and sentenced to 10 years' probation and ordered to pay $98,498.84 restitution to the victim. Shaw was also ordered to sell the vehicle and provide the funds to the victim. The State Attorney in the Ninth Judicial Circuit prosecuted the case.

Emily Royster

On or about July 1, 2020, Florida's Medicaid Fraud Control Unit arrested Emily Royster for exploiting an elderly and disabled adult. The investigation revealed that Royster siphoned more than $14,000 from an elderly victim's bank account over a seven-month period. Royster allegedly transferred funds for personal use with the intent to deprive the victim of the use or benefits of the funds, including making nursing home payments.

Acting on a complaint received from the Florida Department of Children and Families' Adult Protective Services, MFCU began investigating Royster after the victim's nursing home bill went unpaid and the victim's bank account lacked funds to pay bills. Royster allegedly removed money from the victim's account using the mobile application Zelle. Zelle is a mobile app that allows individuals to easily transfer money to others. The investigation revealed that Royster withdrew the money from the victim's account multiple times for personal use, including Airbnb stays in Georgia and Massachusetts.

Royster turned herself into custody at the Leon County Sheriff's Office. Royster is charged with one count of exploitation of an elderly adult $10,000 or more, a second-degree felony. Royster pled nolo contendre to one count of Unauthorized Access of a Computer System. MFCU prosecuted the case through an agreement with the State Attorney's Office in the Second Judicial Circuit.

Pamela Grice

On or about January 21, 2021, Florida's Medicaid Fraud Control Unit and the Gadsden County Sheriff's Office arrested a former assisted living facility resident aide shift supervisor for neglect of a resident. Pamela Grice, employed by Magnolia House to provide assistance to residents of the senior living facility, failed to report the fall of a 98-year-old, wheelchair-bound dementia resident, resulting in excruciating injuries.

Acting on a referral by Adult Protective Services, a division of the Department of Children and Families, MFCU investigators discovered that on August 24, 2019, Grice failed to report the fall of a disabled adult. The investigation revealed that nurses from Big Bend Hospice (BBH) returned to Magnolia House after the weekend to discover a 98-year-old bedridden dementia patient in excruciating pain with severe bruising on the left leg. When BBH nurses inquired to Magnolia House staff about what caused the injury, no incident reports were made. An X-ray determined the resident suffered a broken hip, with multiple medical opinions concluding the resulting injury could have only been sustained from a fall. Given the resident's inability to walk, the only cause for the fall was being dropped by an employee.

Interviews conducted throughout the investigation revealed that a Magnolia House employee had

difficulty pushing the resident in a wheelchair and accidentally caused the wheelchair to tip over and eject the resident from the chair. The employee immediately called for assistance from Grice, the shift supervisor and only other employee working that shift. Grice assisted in placing the resident back into the wheelchair without proper evaluation of injuries or planning of future medical evaluation.

The employee reported the fall to the direct supervisor, Grice; however, Grice neglected to contact family members, medical staff, facility supervisors, ambulatory care services, or a hospital to have the resident evaluated for the fall. Furthermore, Grice made no report to alert the resident's caregivers of the fall. Grice's failure to report the fall resulted in a delay of proper care and treatment for the resident's pain and injuries upwards of two days.

Grice pled guilty to Culpable Negligence and was sentenced to eleven months and twenty-nine days probation. The Attorney General's MFCU prosecuted the case through an agreement with the Office of the State Attorney, Jack Campbell, in the Second Judicial Circuit.

Amy Latasha Curtis

On or about April 13, 2021, Florida's Medicaid Fraud Control Unit and the Alachua County Sheriff's Office arrested a Licensed Practical Nurse for exploitation of an elderly person. According to an investigation by MFCU, Amy Latasha Curtis took advantage of an elderly person who resided as a patient in the Gainesville nursing home where Curtis worked as an LPN, stealing nearly $2,000 from the senior victim.

According to the investigation, Curtis often took the victim's debit card to purchase breakfast for the patient. Eventually, she used ill-obtained financial information from the victim to open a joint-checking account funded solely by deposits from the victim's primary account. Through a series of illegal transactions, Curtis used the joint account to make personal purchases, including beauty products and a trip to Miami.

MFCU investigators received information regarding the exploitation from the Florida Department of Children and Families' Adult Protective Services Program and then launched an inquiry into the illegal activity.

As a result of the investigation, Curtis pled nolo contendre to exploitation of an elderly person, less than $10,000, a third-degree felony. She was sentenced to 65 days incarceration, one year of community control, one year of probation, and restitution of $1,833.62. The Attorney General's MFCU prosecuted the case through an agreement with the State Attorney's Office in the Eighth Judicial Circuit.

Total Recoveries

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

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

In FY 2020-21, the total amount for civil recoveries, which include civil settlements arising from *qui*

tam cases brought under the Florida False Claims Act and civil judgments was $21,781,115. The total amount for criminal recoveries based upon Medicaid fraud cases was $941,171. The total amount of the monies recovered by the MFCU for FY 2020-21, was $22,722,286.

Training

MFCU continues to emphasize mission critical training to stay professionally current. During FY 2020-21, MFCU staff attended a total of 5,713 hours of training.

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

In-house training provided through a variety of delivery methods included courses such as Personal Protective Equipment & Other Field Deployment Equipment, Ethics. 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 2020-21, included The Neuroscience Behind Financial Scams, Fighting Financial Exploitation, How Money Moves, Dental Fraud: Oral Surgery Schemes, Financial Crimes Against Seniors, and Overcoming Obstacles to Elder Abuse Prosecutions.

Data Mining

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

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

From July 15, 2010, through June 30, 2021, the MFCU has submitted 98 data mining projects to AHCA for review and approval. Of the 98 submitted, 71 were approved by AHCA. As of June 30, 2021, MFCU had 2 cases in an active status from these projects.

Medicare Fraud Strike Force Teams

In 2013, to maximize the effective investigation and prosecution of Medicaid fraud, the MFCU joined the South Florida Health Care Fraud Prevention and Enforcement Action Team (HEAT) (currently

known as the Medicare Fraud Strike Force.) The Medicare Fraud Strike Force is a federal and state strike force created by the Department of Justice (DOJ) and Health and Human Services, Office of the Inspector General (HHS-OIG).

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

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

THE AGENCY FOR HEALTH CARE ADMINISTRATION

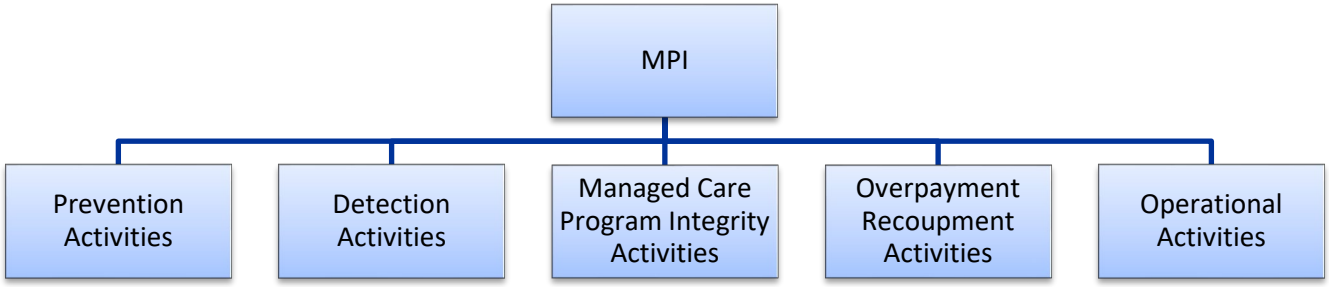
The Agency for Health Care Administration (Agency or AHCA) is required, pursuant to section 409.913, Florida Statutes (F.S.), to operate a Medicaid provider oversight program to ensure that fraudulent and abusive behavior occurs to the minimum extent possible in the Medicaid program. The Agency's Bureau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

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

Medicaid Program Integrity (MPI)

Overview

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



Prevention Activities

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

Fraud and Abuse Prevention Project

MPI routinely develops projects to detect and prevent fraud and abuse in the Medicaid program in an effort to identify audit and investigation candidates. In late 2019 MPI began to develop a provider related to providers billing the Medicaid program for behavioral health services. The MPI project is based, in part, on the high priority placed on mental health services and interest to mitigate fraud and abuse to allow funds to support valid/legitimate services. The project was also based, in part on a history of complaints and reviews which suggest a high risk for fraud and abuse. The project's scope has been narrowed to a particular subset to services for which fee-for-services reimbursements and provider enrollment have been increasing at a rate which warranted further review. MPI's initial preliminary findings indicate abusive, if not suspected fraudulent, billing for these services for recipients who do not appear to have the requisite mental health needs to substantiate the billings.

Historically, MPI has had numerous credible complaints which allege possible kickbacks, patient brokering, billing for services not rendered, and possible sharing of recipient lists. In the past

(approximately) five years, MPI has made more than 75 referrals to MFCU related to these issues. These figures also do not include referrals MPI would have made to supplement other investigations by MFCU or HHS-OIG that were not initiated by an MPI referral. MPI has initiated record requests, imposed payment restrictions, conducted audits, and referred, in total almost double that number of providers on issues related to this project.

The potential value of the project MPI is embarking on is presently unknown, however, a small sample of the providers under consideration for investigation have an aggregated reimbursement total of more than $22 million. The potential impact is believed to be much greater when you consider that several of the rendering providers in the initial groups under review are connected to (through group membership affiliation) with numerous other billing groups – in fact, the initial sample of rendering providers appear to be responsible for more than $95 million in Medicaid reimbursements. Some of these rendering providers have already been the subject of an intelligence sharing or other referrals to HHS-OIG and /or MFCU, and others are under investigation and further referrals are anticipated.

The scope of this project is anticipated to extend beyond MPI activities -- recommendations to Medicaid for changes in policy, enrollment protocols, and reimbursement protocols that either were made in FY 2020-21 or are anticipated throughout the project (in periods of time outside this reporting period). In fact, there are already ongoing collaborative efforts with the remainder of Health Quality Assurance (licensure) as it relates to several aspects of the projects and licensed entities.

As part of this project, MPI has initiated record requests, imposed payment restrictions, made recommendations for action related to program participation, and made referrals to law enforcement and the Centers for Medicare and Medicaid Services. During FY 2020-21, MPI activities on this project included:

- 143 payment restrictions
- 50 recommendations to the Division of Medicaid
- 31 referrals to law enforcement

During the remainder of the project, which will continue through FY 2021-22 and after as resources allow, MPI anticipates other activities, including:

- Additional policy and enrollment recommendations (e.g., recipient and provider eligibility criteria)
- Follow-up regarding potential system edit failures, including both evaluating edit functionality and recovery of overpayments

Referrals to/Interactions with MFCU

Previously in this report (See Office of the Attorney General, Medicaid Fraud Control Unit, Complaints, page 2) MFCU referenced two statistics that directly relate to MPI efforts. One is the number of referrals MPI made to MFCU, and the other is the number of referrals from managed-care special investigative units to MFCU.

From FY 2015-16 to FY 2020-21, MPI had achieved at least 150 MFCU referrals each year. In FY 2017-18 the number of referrals exceeded 300. As described further in this report, MPI initiated a large-scale project (see Behavioral Health Prevention Project, page 20) which shifted prevention resources from standard referrals to MFCU to extensive provider research, analysis, and interactions, as well as informational referrals to both state and federal law-enforcement which are not recorded as standard MFCU referrals for reporting purposes.

While the combined referrals (standard MFCU referrals and the other law enforcement referrals

described in this report) did not reach a total of the historical minimum 100 referrals, with the COVID-19 public health emergency, MPI and MFCU had many discussions regarding referrals and the reduction in referrals. MPI had an intentional shift in resources to other prevention activities.

FY 2020-21 Payment Restrictions	
Payment Restriction Type	**Number**
Prepayment Review (PPR)	175
Payment Withhold (25A)	140
Payment Suspension due to Credible Allegation of Fraud (CAF)	14

FY 2020-21 Denied Claims (PPRs, 25A, CAF)		
	Number	**Amount**
Claims Reviewed	54,222	$7,180,297
Claims Denied	53,470	$7,123,651

Detection Activities

Fraud and abuse detection involves numerous methodologies and techniques that identify program vulnerabilities, threats, and risks to the Medicaid program. Detection activities continue to involve both the intake and assessment of complaints from a variety of sources, as well as the internal development of leads through data analysis. MPI continues to work toward increasing the intricacy or complexity of preliminary investigations. Particularly, MPI efforts strive toward fraud and abuse detection, as opposed to waste detection. During FY 2020-21, MPI received and assessed 2,422 complaints.

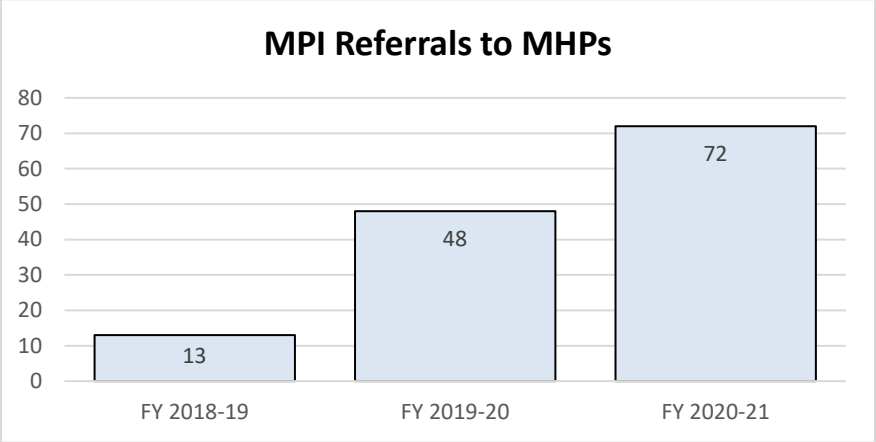
Fraud and Abuse Schemes

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

- Failure to follow coverage and limitation (policy) provisions
- Upcoding procedure codes
- Unbundling procedure codes
- Billing non-covered services as covered services
- Misrepresenting material details on claims (or in documentation) such as dates or location of service, or rendering/ordering/authorizing provider
- Patient brokering/misuse of recipient information
- Falsified documents
- Straw owners/shell corporations/shelf corporations
- Billing for services not rendered
- Corruption/kickbacks/bribery/other financial crimes
- False or unnecessary prescriptions/orders for drugs, medical equipment/supplies, services

Managed Care Activities

The MPI Managed Care Unit has primary oversight of the program integrity efforts of Medicaid Health Plans (MHPs) and serves in a consultative role for the rest of the Bureau as duties related to managed care fraud and abuse spread to all MPI areas. MPI continues to receive the Suspected/Confirmed Fraud and Abuse Reports (also referred to as 15-day reports) from the MHPs and during FY 2020-21 made 72 formal referrals of program integrity issues from MPI to the MHPs for investigation.



Among the other prevention activities, there have been ongoing MPI efforts to emphasize the Medicaid health plan referrals to MFCU. Although MFCU did not specify that the referrals they received were from Medicaid health plans (see page 2 reference to referrals from Managed Care Special Investigative Units), MPI has established benchmarks for each health plan, and throughout the year monitored and educated the plans to ensure both validity and quality of referrals to MFCU. During FY 2020-21, MPI records indicate that the Medicaid health plans made 390 referrals to MFCU. This volume of referrals demonstrates the commitment to the identification and reporting of suspected fraud.

Overpayment Recoupment Activities

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

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

Self-Audits			
	FY 2018-19	**FY 2019-20**	**FY 2020-21**
Audits Completed	142	212	313
Overpayments Identified	$1,352,956	$5,880,930	$2,911,735

Operational Activities

Operational activities are critical to MPI's success in carrying out its duties to combat fraud, abuse, and waste. These activities include managing the bureau's annual operating budget, purchasing, personnel actions, office management, public record requests, mail, and records coordination, record storage, coordination with vendors, organizing bureau training, managing accreditation requirements of bureau personnel, and ongoing efforts to identify and address technology and other needs to optimize bureau activities.

The Operations unit also conducts reviews of providers deemed noncompliant with repayment obligations by the Bureau of Financial Services to determine if the circumstances suggest that non-payment is due to a provider no longer being in operation. Pursuant to sections 409.907(12) and 409.908(26), F.S., the Agency may certify that a Medicaid provider is out of business. This certification renders the amount of the overpayment uncollectable for purposes of refunding the federal share of the overpayment but does not release the provider from liability of the debt. A provider with a delinquent debt, including a provider declared out of business, is not a provider in good standing with the Medicaid program. The provider is precluded from participation in the Florida Medicaid program, including Medicaid managed care, until any outstanding debt is remedied.

Certified Out of Business	
Providers Reviewed	13
Certified Out of Business Adjustments	$5,300,691

Highlight's of MPI Activities for FY 2020-21

Program Integrity Interventions

- On-Site visits/interviews (providers, provider employees, and recipients)
- MPI-conducted overpayment audits
- Vendor-assisted overpayment audits
- Compliance and Program integrity oversight of Medicaid health plans
- Paid claim reversals (requirement for provider to void claims)
- Suspension from participation in the Medicaid program
- Termination from participation ("For Cause" Termination) in the Medicaid program
- Fines (sanctions)
- Provider self-audits (voluntary or at MPI recommendation)
- Provider education
- Payment restrictions
    - **PPR** (Pre-Payment Review) – Section 409.913(3), F.S.
        - Standard: conducted as determined appropriate by the Agency, without suspicion of fraud, abuse, or neglect; may last up to one year
    - **CAF** (Credible Allegation of Fraud) – 42 C.F.R § 455.23; Suspension of payments in cases of Medicaid fraud
        - Standard: credible allegations; requires referral to the state's Medicaid Fraud Control Unit (MFCU)
    - **25A Withhold** – Section 409.913(25)(a), F.S.; withholding of payments in circumstances of fraud, willful misrepresentation, abuse, or a crime committed while rendering goods or services to Medicaid recipients
        - Standard: reliable evidence
    - Notification sent to Medicaid health plans – PPR is informational only; CAF & 25A mandates restriction by health plan
- Referrals to MFCU, HHS-OIG, Department of Health (practitioner licensure), Health Quality Assurance (facility licensure), Department of Financial Services (other insurance fraud), Department of Children and Families (recipients), and other agencies.
- Consultation with Medicaid about program safeguards
- Litigation defense (overpayment audits, sanctions, prosecutions)
- Contract termination
- Recommendations for law, policy, system edit, contract

- Recommendations for liquidated damages or sanctions (against health plans)

Advanced Payment Project

The Agency sought and obtained authorization to temporarily include retainer payments for the Developmental Disabilities Individual Budgeting (iBudget) Waiver in response to the COVID-19 public health emergency. The authorization from the Centers for Medicare and Medicaid Services (CMS) was retroactive to January 27, 2020. This action temporarily amends the existing program to allow retainer payments (or advanced payments) for providers who render residential habilitation, life skills development level 1- companion, life skills development level 3 – adult day training, and in-home personal support services.

Advanced payments were made to providers of these services beginning on April 1, 2020, and continued through July 2020. The advanced payment amounts were calculated using the average of the claims paid to the provider for the eligible services during the months of October 2019 through February 2020, excluding any months with zero payment amounts. Providers were directed to continue to render services and either accept the monthly advanced payment in full or return the full advanced payment to the Agency; providers accepting the advanced payment were directed not to bill for the month in which the advanced payment was made. Providers could choose to "opt out" of the advanced payment and were told that the Agency would not recoup advanced payments unless a provider accepted the advanced payment and billed for services rendered during the month in which the advanced payment was made.

MPI opened over 1,200 cases to recover overpayments identified by the Division of Medicaid. This project included cost avoidance by providers voiding erroneous claims totaling more than $4 million. Recovery activities for repayment of claims or the advanced payment have so far exceeded $8 million. In addition, providers are in the process of repaying more than $4 million by way of repayment agreements which allow the return of the erroneous funds over a brief period. In total, the project has resulted in cost avoidance/recoveries of almost $17 million. This project is ongoing into FY 2021-22. Further activities may include review of providers to determine if additional actions are necessary, such as payment restrictions and /or recommendation for action by the Division of Medicaid related to program participation.

FY 2020-21 Repayment	
Repayment Method	**Amount**
Voided Claims	$4,163,353
Repayment of Claims	$1,988,472
Repayment of Advanced Payment	$6,423,498
Payment Plan Final Orders	$4,027,288
Total	**$16,602,611**

Although this was a great recoupment effort on one project, it virtually halted all other work. Because of the nature of the overpayments and unique funding situation due to the public health emergency, the Agency determined that this project was a high priority. As a result, MPI shifted much of its audit resources to this project.

Collaboration with Outside Contractors

Another opportunity for MPI to increase prevention, detection, and overpayment recoveries includes working with low-cost (or even no-cost) vendors to supplement MPI efforts. Particularly through collaboration with the Division of Medicaid and the Agency's third-party liability (TPL) vendor, as well as the Centers for Medicare and Medicaid Services (CMS) and their Unified Program Integrity Contractor (UPIC), MPI has been able to realize additional overpayment recoveries and expand investigative capabilities. During FY 2020-21, MPI continued to use these

resources predominantly for audits (overpayment recoveries) but also initiated discussions with both vendors to include preliminary investigations of potential fraudulent provider behavior. Through these contractors, MPI is able to increase its efforts to and maximize the program integrity benefits for the state of Florida.

TPL Contract

The Agency's TPL contract includes program integrity audit support provided by Health Management Services, Inc (HMS). Overall, the vendor's contracted scope of work supports the Agency in several important areas with specific support to program integrity included as Other Recovery Projects. As in years past, these audit projects and recoveries are for fee-for-service (FFS) paid claims only. In FY 2021, HMS recovery totaled $3,330,172.00 which is substantially lower than previous years. While no direct correlation to COVID-19 was reported, the most likely reason for this down-turn in recoveries may be linked to Medicaid transition to managed care services for a majority of Florida's recipient population. In managed care, providers are contracted and paid by several Managed Care Organizations (MCO). These payments are reflected in the Agency's systems as encounter claims, which have not traditionally been included in the TPL audits. MPI continues to work with the Division of Medicaid and HMS to include these encounter claims in future audit projects.

UPIC Contract

The UPIC is a vendor contracted with CMS to support the states' efforts to deter fraud, abuse, and waste. SafeGuard Services (SGS) is the UPIC contracted by CMS to perform specific program integrity functions for the United States' Southeastern region, which includes Florida. The UPIC provides additional resources to the state at no additional cost, promoting program integrity initiatives. In addition, SGS has access to Florida Medicaid's paid claims data, and federal Medicare data; allowing SGS to engage in detection activities as well as overpayment recoveries. This resource offers the potential for MEDI-MEDI (Medicaid-Medicare overlap) audits for Florida Medicaid's dual-eligible population.

Utilizing the UPIC to perform additional audits and investigations maximizes MPI's resources. During FY 2020-21 through the work of SGS, MPI was able to accomplish more audits, some more complex, including a one-day stay audit utilizing claim samples and extrapolation to review records for medical necessity for certain inpatient stays. The state recovered $1,700,661.84 by utilizing the resources of SGS, with collaboration and continuous communication with MPI. Additionally, during this time period, MPI initiated the first referrals to the UPIC to assist MPI with investigative (as opposed to audit) leads. These are more complex complaints which investigate questionable provider practices that may lead to law enforcement referrals.

Other MPI Activity Data

MPI Referrals to Others	
Agency for Persons with Disabilities	4
Department of Children and Families	12
Department of Health	10
US Department of Health and Human Services – Office of Inspector General	22
US Department of Public Assistance Fraud	117
Division of Medicaid	269
Division of Health Quality Assurance (Licensure)	131
Medicaid Fraud Control Unit – Attorney General	33
SafeGuard Services (CMS)	5
Total	**603**

Provider Sanctions and Medicaid Health Plan Assessments			
	FY 2018-19	**FY 2019-20**	**FY 2020-21**
Fines	171	186	89
Suspensions	62	50	27
Terminations	91	33	96
Health Plan	8	3	2
Total	**332**	**272**	**214**

Recovery Activities – Identified Amounts			
	FY 2018-19	**FY 2019-20**	**FY 2020-21**
Overpayments (MPI/MPI-CMS Audits)	$32,889,358	$29,926,776	$19,198,102
Costs	$516,739	$114,638	$97,758
Fines	$3,242,626	$2,541,756	$387,402
Paid Claims Reversals	$102,359	$82,949	$4,150,361
MHP Assessments	$134,000	$117,750	$98,500
Certified Out of Business Adjustments	-	$1,891,589	$5,300,691
Total	**$36,885,082**	**$34,675,458**	**$29,232,817**

Recovery Activities – Collections and Reversals			
	FY 2018-19	**FY 2019-20**	**FY 2020-21**
Overpayments, Costs, and Fines	$15,217,521	$18,584,224	$15,567,765
Paid Claims Reversals	$102,359	$82,949	$4,150,361
Total	**$15,319,880**	**$18,667,173**	**$19,718,126**

MPI Prevention of Overpayments			
	FY 2018-19	**FY 2019-20**	**FY 2020-21**
Denied Claims (PPRs, 25A, CAF) Impact	$4,242,806	$4,564,966	$7,123,651
Termination of Providers Impact	$683,515	$14,233,151	$633,693
Program Suspensions Impact	$42,013	$358,918	$6,490,366
Denial of Reimbursement for Prescription Drugs	-	-	$10,122,775
Focused Projects Impact	$3,369,599	$2,782,489	-
Site Visits Impact	$5,942,669	$4,313,959	$1,799,891
Sanctioned Providers Impact	$12,377,317	$32,190,511	$81,979,476
Audit Impact	$42,995,387	$42,185,937	$131,855,355
PPR and 25A Impact	$56,521,999	$119,186,922	$13,934,407
MFCU Referrals Impact	$58,879,691	$14,291,269	$561,749
Total	**$185,054,996**	**$234,108,122**	**$254,501,363**

Return on Investment (ROI)				
		Benefits	**Costs**	**ROI Ratio**
FY 2018-19	Recovery	35.48	7.56	4.69:1
	Prevention	185.05	4.14	44.68:1
	Total	**220.53**	**11.7**	**18.84:1**
FY 2019-20	Recovery	30.92	5.21	5.94:1
	Prevention	234.12	3.94	59.43:1
	Total	**265.04**	**9.15**	**28.96:1**
FY 2020-21	Recovery	28.44	4.36	6.52:1
	Prevention	254.50	3.84	66.23:1
	Total	**282.94**	**8.20**	**34.47:1**

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

Division of Health Quality Assurance

Care Provider Background Screening Clearinghouse

The Agency's Care Provider Background Screening Clearinghouse (Clearinghouse) is an integral initial tool in the Medicaid program's provider enrollment fraud and abuse prevention 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 2020-21, the Agency has imposed 595 background screening violations and 271 employee roster violations.

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

During FY 2020-21, the Background Screening Unit processed 22,564 RapBacks. Of these, nearly seventy percent were found to be for criminal charges that resulted in the applicant's eligibility status being updated to not eligible. During FY 2020-21, 202,482 background screening results were shared among participating agencies and Medicaid health plans (MHPs) and 82,342 renewal screenings were requested resulting in an overall cost savings of $17,903,436 to Agency providers, DOH licensees, MHPs, Medicaid providers, DCF, DOEA, DOEVR, and APD providers.

Licensure Protections

Additionally, the Division of Health Quality Assurance, through its licensure activities, increases Medicaid provider accountability for those providers licensed by the Agency. Home Health Agencies are among the Medicaid provider types that are licensed by the Agency. For FY 2020-21:

- **Home Health Agencies** – Home Health Agencies which have demonstrated a pattern of billing the Medicaid program for medically unnecessary services, have either received an administrative penalty for violating s. 400.474(6)(e), F.S., or denied a renewal application

based on the provisions of s. 400.471(8), F.S. In FY 2020-21, no home health agencies were identified to have met these criteria.

- **Remuneration Complaints** - Complaints received against nurse registries for providing remuneration in violation of s. 400.506, F.S. There were none identified in FY 2020-21.

- **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. Three applicants met these criteria in FY 2020-21.

- **Financial Requirements** - There were 31 home health agency applications, 26 home medical equipment applications, and 22 health care clinic applications in FY 2020-21 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. No providers met these criteria in FY 2020-21.

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	**2016-17**	**2017-18**	**2018-19**	**2019-20**	**2020-21**
Denying the renewal application	31	57	25	36	30
Revoking an existing license	22	24	20	14	14
Emergency orders	13	16	15	15	11
Provider surrendering their license	11	9	4	11	23
Total	77	106	64	76	78
Imposed Fines and Administrative Fees	$2,218,876	$2,247,434	$3,017,176	$4,014,291	$5,703,887

Division of Medicaid

The Division of Medicaid administers the Florida Medicaid program. In FY 2020-21 the program budget was more than $34 billion state and federal partnership that provided for health care to almost 5 million recipients in Florida. The Division is responsible for overseeing the management and operation of a broad range of health care services offered through Medicaid to low-income families, the elderly, and people with disabilities. Medicaid expenditures are almost a third of the state budget. The rapid growth in enrollment and costs has made it increasingly important to find ways to manage the diverse needs of the Medicaid population while also being able to better predict and plan for cost increases.

Medicaid's roles and responsibilities have been evolving since it moved away from a completely fee-for-service (FFS) program and over the years Medicaid has improved efficiency, cost predictability and accountability for the program, and enhanced services to recipients.

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

Medicaid Strategic Approach to Combatting Fraud and Abuse

The Division of Medicaid has adopted a strategic approach to combatting fraud and abuse. Implementation of the SMMC program allowed the Agency to adopt a 'ground up' approach to combat fraud and abuse by embedding control efforts into the contractual and operational structure of the program.

These strategic control efforts are focused in three key areas including Provider Enrollment/Review, Outreach and Education, and Prior Authorization and Utilization Management.

- Prevention of Medicaid Program fraud and abuse begins with thorough screening of incoming Medicaid provider applicants as well as the population of active Medicaid providers. All Medicaid providers, including Medicaid FFS providers and Medicaid health plan network providers, are required to have a background screening – a Level 2 background check: a state and national fingerprint-based check and consideration of disqualifying offenses.

- Medicaid collaborates with its health plans to ensure that fraudulent or terminated providers are not illegitimately participating in Medicaid, either by registering again with Medicaid using different information, or by contracting with a Medicaid health plan in an attempt to indirectly participate in the Medicaid program.

- 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. Ongoing provider eligibility and compliance activities aid the Division of Medicaid in better screening and monitoring of Medicaid providers and include:

- Provider Risk Factors
- In-Person Provider Review
- License Verification
- License Compliance
- Identifier and Exclusion Verification
- Interoffice Communication
- Outside Referrals

Medicaid Health Plan Contract Requirements for Provider Credentialing

Medicaid has created enhanced Medicaid Health Plan contract requirements for provider credentialling.

- **The Streamlined Credentialing Project**: 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.

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

- **SMMC Health Plan Fraud and Abuse Related Reporting Requirements**: Plans are required to report their Provider Network File, Provider Termination File, and New Provider Notification Report weekly. This allows the Agency to monitor plans' compliance with required provider network composition, provider-to-member ratios, and allows for other uses deemed pertinent. Managed care and dental plans must achieve or exceed an Agency-specified performance target for the reporting of suspected provider fraud cases to the Medicaid Fraud Control Unit each SFY following the processes outlined in the contract and associated federal and state regulations. The Agency's Bureau of Medicaid Program Integrity calculates each plan's performance target each state fiscal year.

- **Provider Outreach and Education/ 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. Each plan 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.

- **Medicaid Preferred Drug List (PDL)**: The PDL is a tool that has been widely used by both public health plans such as Medicare and Medicaid as well as private health plans. The PDL provides a list of safe and effective drugs that can be used to treat patients with specific diagnoses. This has the advantage of allowing providers to prescribe drugs that are known to be effective while helping to constrain costs.

- **SMMC Home Health Electronic Visit Verification**: Effective January 1, 2021, home health providers contracted with SMMC were required to verify home health and personal care service visits through the plan's electronic visit verification (EVV) system and bill for service through that system. This is required by the federal 21st Century Cures Act and the Centers for Medicare & Medicaid Services. EVV electronically monitors provider visits and creates a digital record of the visit and services provided. 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.

Medicaid Fee-for-Service Utilization and Enrollment Controls

- **Medicaid FFS Pharmacy Claims Processing**: There are several activities that Medicaid has undertaken to ensure that Medicaid pharmacy services provided to the fee-for-service (FFS) population are both appropriate and cost effective. Medicaid also has point-of-sale monitoring available to track medication usage and has thousand s of claims edits in place to automatically prevent inappropriate expenditures. The system of automated claim edits is continuously refined and improved to support safe prescribing, adherence to the Preferred Drug List, and prevention of fraud and abuse. In FY 2020-21 the contracted prescription benefit manager vendor processed more than 1.3 million fee-for-service pharmacy claims, more than 111,400 per month.

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

The following chart shows the total number of prior authorization requests received in FY 2020-21 for the Medicaid FFS pharmacy program.

Pharmacy Prior Authorization Requests FY 2020-21		
Total Prior Authorization Requests	10,854	100.0%
Average Per Day	30	--
Total Requests Approved	7,943	73.2%
Total Requests with Change in Therapy	2,507	23.1%
Total Requests Denied	404	3.7%

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 diagnosis.
- Oral oncology product initiatives to ensure proper utilization of these agents through clinical prior authorization review, quantity, and age limits.

- **Home Health Electronic Visit Verification**: 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.

- **Home Health Provider Enrollment Moratorium**: In July 2013, the Centers for Medicare, and Medicaid Services (CMS) imposed a moratorium on enrollment of new home health agencies (HHA) in Medicare and Medicaid programs located in select counties in Florida and Illinois. This moratorium was later extended statewide in Florida, Illinois, Michigan, and Texas. CMS lifted this multistate moratorium in January 2019 after nearly six years. However, the Agency requested several extensions to the moratorium in Florida to ensure that appropriate fraud prevention measures were implemented. With the full implementation of Home Health EVV, the Agency lifted the moratorium on a statewide basis. The Agency is in the process of implementing operational and systematic updates to accommodate this change and began accepting applications on September 1, 2021.

- **Home Health Visit Prior Authorization**: One of the primary areas, in addition to inpatient hospital services, where Medicaid continues prior authorization for FFS recipients is for home health services. The Agency's vendor, eQHealth Solutions, LLC (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 2020-21, eQHealth conducted 11,566 home health prior authorizations, an average of 963 per month. Of these, 10,852 were approved, giving a denial rate of 6.17 percent. The following table shows the total number of home health prior authorization requests, approvals, denials, and denial percentage for each month during FY 2020-21. 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.

Prior Authorizations for Home Health for SFY 2020-21			
11,566 Total Home Health Prior Authorization Requests Received			
	Approvals	**Denials**	**Denial Rate**
July 2020	1,783	32	1.76%
August	1,036	30	2.81%
September	887	63	6.63%
October	946	98	9.39%
November	824	81	8.95%
December	893	51	5.40%
January 2021	723	62	7.90%
February	731	69	8.62%
March	853	90	9.54%
April	737	53	6.71%
May	700	34	4.63%
June	739	51	6.46%

Total	10,582	714	6.17%

- **Comprehensive Care Management for Children with Special Health Care Needs**: The Agency has also included Comprehensive Care Management in its contract with eQHealth, 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.

- **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 for the FFS population. The utilization management efforts of eQHealth include medical consultation regarding the necessity and scope of services, data analyses, and monitoring of selected cases, to ensure Medicaid does not pay for inappropriate services.

- **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.

- **BA Services Prior Authorization**: Before providing 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 total number of prior authorization requests for BA services, approvals, denials, and denial rate during SFY 2020-21.

Prior Authorizations for BA Services for SFY 2020-21			
85,547 Total BA Prior Authorization Requests Received			
	Approvals	**Denials**	**Denial Rate**
July 2020	5,923	437	7.38%
August	5,522	541	9.80%
September	5,672	656	11.57%
October	6,891	747	10.84%
November	5,794	678	11.70%
December	6,782	787	11.60%
January 2021	5,794	613	10.57%
February	6,180	785	12.70%
March	7,408	815	11.00%
April	7,065	1,095	15.50%
May	6,408	1,150	17.95%
June	6,720	1,084	16.13%
Total	76,159	9,388	10.97%

During SFY 2020-21 Medicaid paid for BA services for 24,435 unique recipients totaling more than $500 million.

- **BA 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 the Centers for Medicare and Medicaid Services. A thorough investigation of providers in those counties identified Medicaid fraud and abuse including extraordinary overbilling. The Agency imposed the moratorium to prevent significant fraud that impacts taxpayers and potentially compromises the quality-of-care patients receive. The moratorium began on May 14, 2018, and was initially set to be implemented for a 6-month period but was extended into FY 2021-22. The moratorium does 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.

STATUTORY REPORTING REQUIREMENTS

Number of cases opened and investigated

MFCU opened 415 cases and had 1,264 active cases in FY 2020-21. MPI investigated 3,682 cases, which included 2,858 opened during the year.

Sources of the cases opened

	MFCU		AHCA	
Source	**Fraud**	**PANE**	**MPI**	**Total**
AHCA - Division of Medicaid			2	**2**
AHCA - Financial Services			6	**6**
AHCA - Heath Quality Assurance			8	**8**
AHCA - Medicaid Fiscal Agent Operations			20	**20**
AHCA - Medicaid Program Integrity (MPI)	21	4		**25**
AHCA - MPI Detection			6	**6**
AHCA - MPI Institutional			64	**64**
AHCA - MPI Jacksonville/Orland o/Tampa			5	**5**
AHCA - MPI Managed Care Unit			18	**18**
AHCA - MPI Miami			3	**3**
AHCA - MPI Pharmacy			222	**222**
AHCA - MPI Practitioners Care			6	**6**
AHCA - MPI Prevention Strategy			37	**37**
APD - Agency for Persons with Disabilities	3		4	**7**
APS - Adult Protective Services	1	164		**165**
Citizen	15	10		**25**
CMS - Centers for Medicare & Medicaid Services	2		2	**4**
Contractor for Center for Medicare & Medicaid			1	**1**
DEA - Drug Enforcement Agency			1	**1**
DOH - Department of Health			1	**1**
DOJ - Department of Justice	1			**1**
Employee	2			**2**
EOMB			7	**7**
Family Member	8	10		**18**
FBI - Federal Bureau of Investigation	1			**1**
FDLE - Florida Department of Law Enforcement	1			**1**
Florida - Medicaid Fraud Control Unit			21	**21**
Florida - Other Agencies			2	**2**
Generalized Analysis			2	**2**
Health & Human Services Inspector General	4			**4**
Internet/Media			5	**5**
Investigator Initiative			170	**170**
Law Enforcement Agency	2	1		**3**
Mail/Email			2	**2**
Managed Care Provider	1			**1**
Managed Care Special Investigations Unit	75	1	3	**79**
Medicaid Provider	7		8	**15**
Medicaid Recipient	5	1		**6**

MFCU Other than Florida	3			**3**
NAMFCU - National Association of MFCU	1			**1**
OSWP - Office of State Prosecution		1		**1**
Online Complaint Form			52	**52**
Other			15	**15**
Previous File or Case			22	**22**
Projects			1,881	**1,881**
Qui tam	60			**60**
Self-Audit			262	**262**
Spinoff Case	8	1	1	**10**
Total	**221**	**194**	**2,858**	**3,273**

Disposition of the cases closed

	MFCU		AHCA	
Case Type	**Fraud**	**PANE**	**MPI**	**Total**
Administrative Closure	4	1		**5**
Administrative Referral	26	30		**56**
Assistance to Other Agencies	1			**1**
Bankruptcy			2	**2**
Case Dismissed	18			**18**
Certified Out of Business - Invalidated			6	**6**
Certified Out of Business - Validated			13	**13**
Change of Ownership (CHOW)			4	**4**
Civil Intervention Declined	1			**1**
Civil Settlement	21			**21**
Consolidated	2	2		**4**
Conviction	17	10		**27**
Death of the Offender	1	1		**2**
Defendant Deceased		2		**2**
Facts Alleged Not Indicative of Exploitation		1	1	**2**
Fines Issued			4	**4**
Info Previously Referred to Other Law Enforcement Agency	1	3		**4**
Investigated by Another Law Enforcement Agency	5	8		**13**
Lack of Evidence	27	44		**71**
Liquidated Damages Applied			2	**2**
Liquidated Damages Not Applied			5	**5**
Medicaid Fraud Control Unit - Accepted			27	**27**
Medicaid Fraud Control Unit - Declined			1	**1**
No Abuse			20	**20**
No Auditable Review Period			1	**1**
No Findings			9	**9**
Nolle Prosequi		1		**1**
No Further Action Required			208	**208**
Not a Medicaid Provider	2	1		**3**
Not an Overpayment Issue			2	**2**
Not Sustained			16	**16**

Pre-Trial Intervention		5		**5**
Project Completed			385	**385**
Prosecution Declined	4	4		**8**
Provider Education			5	**5**
Provider No Longer Operational			43	**43**
Provider Suspended			27	**27**
Provider With Cause Termination			95	**95**
Provider Without Cause Termination			6	**6**
Referred			36	**36**
Resolved with Intervention	6	4		**10**
Statute of Limitations Expired	1			**1**
Suspension Lifted			1	**1**
Sustained			1,690	**1,690**
Unfounded	21	27		**48**
Unsubstantiated	18	89		**107**
Vacated Termination			1	**1**
Voluntary Dismissal	35			**35**
Voluntary Termination			7	**7**
Total	**211**	**234**	**2,616**	**3,061**

Amount of overpayments alleged in preliminary and final audit letters

Preliminary	Final
$16,775,657	$9,569,652

Number and amount of fines or penalties imposed

During FY 2020-21, MPI imposed fines (under s. 409.913, F.S., and Rule 59G-9.070, F.A.C.) in the amount of $368,616.

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

During FY 2020-21, there were no reductions in overpayments through negotiated settlements by MFCU and the Agency's final settlements resulted in no reductions of overpayments in closed cases.

Amount of final Agency determinations of overpayments

MPI identified overpayments in the amount of $19,198,102 in closed audits.

Amount deducted from federal claiming as a result of overpayments

Federal requirements allow the state up to one year to return the federal share through federal cost share adjustments of overpayments. To ensure federal shares are allocated as timely as possible, the Agency reports the federal portion of the total overpayment on the next available federal CMS-64 quarterly report and reduces a corresponding federal share draw. During FY 2020-21, the Agency reduced its federal share, on quarterly cost reports, by $18,545,001 for net overpayments.

Amount of overpayments recovered

MFCU collected $6,994,196 in overpayments that were returned to the Agency. Additionally, MFCU collected $3,554,711 in Federal Medicaid overpayments that were sent directly to the U.S. Department of Health and Human Services for a total of $ 10,548,907 in Medicaid overpayments collected in FY 2020-21. Overpayments recovered as a result of the MPI, and MPI-CMS audits were $15,567,765. Total recoveries by MPI, MPI-CMS, and MPI-TPL for FY 2020-21 were $23,048,299 (This includes collections

of overpayments, fines, costs, and paid claims reversals during the fiscal year).

Amount of cost of investigation recovered

During FY 2020-21, the MFCU collected $1,371 in program income investigative costs. MFCU also collected $21,815 in state share investigative costs and $95,064 in federal share investigative costs for a grand total of $118,250 for all investigative costs.

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

MFCU expenditures for FY 2020-21 were $16,821,469 which included indirect costs of $1,802,606.

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 2020-21 was less than 1 year (0.42).

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

During FY 2020-21, the Bureau of Financial Services deemed $53,233,096 as uncollectible.

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

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

Summary by Denial Reason	Totals
Previous Program Termination	209
Best Interest of The Program	611
Total	**820**

Denials by Provider Type	Totals
05 - Community Behavioral Health Services	57
07 - Specialized Therapeutic Services	11
14 - Assistive Care Services	5
20 - Prescribed Drug Services	3
24 - Prescribed Pediatric Extended Care (PPECC)	1
25 - Physician (M.D.)	47
26 - Physician (D.O.)	3
29 - Physician Assistant	2
30 - Advanced Practice Registered Nurse (APRN)	7
32 - Social Worker/Case Manager	16
35 - Dentist	4
39 - Behavior Analysis	398
65 - Home Health Services	3
67 - Home & Community-Based Services Waiver	28
81 - Professional Early Intervention Services	2

83 - Therapist (PT, OT, ST, RT)	12
90 - Durable Med Equipment/Medical Supplies	3
91 - Case Management Agency	216
99 - Trading Partner	2
Total	**820**

Additionally, 172 providers were prevented from enrolling or reenrolling due to findings during an onsite pre-enrollment visit, criminal background screening, or federal exclusion.

Summary by Denial Reason	Totals
Failed Onsite Review	93
Criminal History	79
Total	**172**

Denials by Provider Type	Totals
05 - Community Behavioral Health Services	29
07 - Specialized Therapeutic Services	5
14 - Assistive Care Services	2
20 - Prescribed Drug Services	2
25 - Physician (M.D.)	22
26 - Physician (D.O.)	5
27 - Podiatrist	1
28 - Chiropractor	1
30 - Advanced Practice Registered Nurse (APRN)	21
35 - Dentist	1
39 - Behavior Analysis	14
61 - Hearing Aid Specialist	2
65 - Home Health Services	32
67 - Home & Community-Based Services Waiver	12
83 - Therapist (PT, OT, ST, RT)	17
90 - Durable Med Equipment/Medical Supplies	2
91 - Case Management Agency	4
Total	**172**

Finally, there were 353 providers who were identified as potentially related to suspected fraud and abuse and other compliance-related considerations that were already terminated or denied at the time that the Agency discovered the program integrity related concern. These providers who are under review by the Agency or other entities may voluntarily terminate from the program to avoid an involuntary action by the Agency. Other providers in this category may have been terminated for other reasons that were non-adverse in nature, including failure to complete enrollment renewal or eighteen months of billing inactivity.

Summary by Denial/Termination Reason	Totals
Denied - Adverse Association	120
Terminated - Adverse Association	233

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

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

Summary by Termination Type	Totals
Criminal History	15
Contractual Termination Under Medicaid Authority	71
With-Cause Termination Under Medicaid Final Order	96
Failed Onsite Review	20
Total	**202**

Terminations by Provider Type	Totals
01 - Hospital	1
05 - Community Behavioral Health Services	4
07 - Specialized Mental Health Practitioner	8
10 - Skilled Nursing Facility	1
14 - Assistive Care Services	11
20 - Prescribed Drug Services	6
25 - Physician (M.D.)	25
26 - Physician (D.O.)	3
30 - Advanced Practice Registered Nurse (APRN)	1
32 - Social Worker/Case Manager	4
35 - Dentist	5
39 - Behavior Analysis	79
50 - Independent Laboratory	1
65 - Home Health Services	14
67 - Home & Community-Based Services Waiver	23
83 - Therapist	3
90 - Durable Med Equipment/Medical Supplies	8
91 - Case Management Agency	2
97 - Managed Care Treating Provider	1
99 - Trading Partner	2
Total	**202**

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

Although the latter part of FY 2020-21, carried unique challenges, the routine communication between MPI, the Division of Medicaid, and others within the Agency concerning Agency policy changes to improve detection, prevention, investigation, and audit capabilities regarding Medicaid fraud and abuse continued to be a priority. As such, MPI will continue to collaborate with the Division of Medicaid and utilize Agency processes to enhance Medicaid fraud and abuse prevention and detection efforts.

A note on how this report was composed:

The Agency's Bureau of Medicaid Program Integrity oversees the development and production of this report. However, the compilation of information originated from many state agencies, bureaus, and units that have oversight of different functions of Florida's large and complex Medicaid program. Months prior to this report's publication, Jessica Zimmerman and Fred Becknell of the Bureau of Medicaid Program Integrity initiated data calls and requests for information to include in this report, and ensured this report was submitted timely and with the statutorily required information. If you have questions or comments regarding this report, the Agency and the Office of the Attorney General will make every effort to address them.

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

2727 Mahan Drive
Tallahassee, FL 32308
1-888-419-3456
www.ahca.myflorida.com

Designed and Produced In-House by AHCA Multimedia Design