

Justification Review



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Report No. 01-39

Medicaid Program Integrity Efforts Recover Minimal Dollars, Sanctions Rarely Imposed, Stronger Accountability Needed

at a glance

The Agency for Health Care Administration is responsible for administering Florida's Medicaid program. To receive federal Medicaid funds, the agency is required to develop methods and criteria for identifying and investigating Medicaid providers suspected of abuse and procedures for referring cases of suspected fraud to the state's Medicaid Fraud Control Unit, located in the Department of Legal Affairs. The agency's Office of Program Integrity is responsible for these functions.

During the six-year period, from Fiscal Year 1995-96 to Fiscal Year 2000-01, the agency recovered \$96.7 million from providers that overbilled the Medicaid program. During this same period of time, estimates of Florida's losses due to Medicaid fraud and abuse range from \$2.1 billion to \$4.3 billion, or between 5% and 10% of total Medicaid health services expenditures. By recovering \$96.7 million, the agency in effect recovered only from 2.3% to 4.5% of the money likely lost to fraud and abuse during that time period.

Overall, the agency needs to improve its efforts to detect and deter Medicaid provider fraud and abuse and its methods of assessing the effectiveness of program integrity functions. To assist the agency in accomplishing these goals, we recommend that the Legislature direct the Agency for Health Care Administration to

- develop measures and standards for evaluating the success of program integrity efforts;

- report to the Legislature on the extent to which the agency is meeting Program Integrity performance goals;
- determine the extent of Medicaid fraud and abuse;
- impose fines and other appropriate sanctions on providers that exhibit egregious behavior; and
- develop and use detection and estimation methods that maximize the likelihood of identifying and recovering Medicaid funds lost to fraud and abuse.

Purpose

Section 11.513, *Florida Statutes*, directs the Office of Program Policy Analysis and Government Accountability to complete a program evaluation and justification review for each state agency that is operating under a performance-based budget. Justification reviews assess agency performance measures and standards, evaluate program performance, and identify policy alternatives for improving services and reducing costs.

This report is one of four that reviews the Medicaid program administered by the Agency for Health Care Administration. In the other three reports we address program accountability and performance; cost control policies for prescription drug services; and the use of disease management organizations to

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improve health outcomes and reduce costs. This report

- highlights estimates of fraud and abuse in the Medicaid program;
- evaluates how well the agency is doing in identifying and deterring provider fraud and abuse;
- assesses the agency's methods for evaluating and reporting on the effectiveness and efficiency of its efforts to combat provider fraud and abuse; and
- recommends additional steps to increase productivity and accountability of the agency's efforts to identify and deter provider fraud and abuse.

Background

Florida's Medicaid program, administered by the Agency for Health Care Administration, is among the largest in the country.¹ Medicaid provides health care coverage to selected low-income persons who meet federal and state eligibility requirements. Medicaid serves mainly low-income families and children, elderly persons who need long-term care services, and persons with disabilities. For Fiscal Year 2001-02, the Legislature appropriated \$9.9 billion to provide health services to Medicaid clients. Over 77,000 providers will provide services to around 1.9 million Medicaid clients each month.

Like other healthcare insurance programs, Medicaid is vulnerable to abusive and fraudulent practices of providers.² These practices can take several forms. For example, providers may sometimes over-bill because of simple errors, with no intent to increase their income. In other instances, providers may bill Medicaid for healthcare services that are not

medically necessary, for expensive procedures when less costly alternatives are available, or for services that were not actually rendered as a means of increasing their income. Some of the more sophisticated types of fraud schemes involve providers that pay "kickbacks" to other providers for client referrals and providers that "hit and run," producing a large volume of claims and disappearing before the volume is discovered by detection methods. Some of these schemes are outlined in Appendix A.

To receive federal Medicaid funds, the Agency for Health Care Administration must develop methods and criteria for identifying and investigating Medicaid providers suspected of abuse. The agency must also develop procedures for referring cases of suspected fraud to the state's Medicaid Fraud Control Unit (MFCU), located in the Department of Legal Affairs.

The agency's Office of Medicaid Program Integrity is responsible for preventing, detecting, and deterring Medicaid provider fraud and abuse. To meet these responsibilities, staff develop and use statistical methodologies to identify providers that exhibit aberrant billing patterns; conduct investigations and audits of these providers; calculate provider overpayments; recommend sanctions; initiate recovery of overpayments in instances of provider abuse; and refer cases of suspected provider fraud to MFCU. (See Appendix B.) The MFCU conducts investigations of suspected fraud and, when warranted, provides its findings to state attorneys for possible criminal action.

In an effort to assist the agency in preventing and deterring Medicaid provider fraud and abuse, Florida's Legislature has made a number of substantive changes to state law affecting the agency's program integrity functions since 1996. These changes, described in detail in Appendix C, include clarifying agency processes related to entering into provider agreements; and requiring follow-up reviews of providers with a history of overpayments, that certain providers post surety bonds, and that the agency conduct criminal background checks of potential providers.

¹ According to the Health Care Financing Administration, in 1998, Florida ranked fourth nationally in the number of Medicaid clients served and seventh in Medicaid expenditures.

² Abuse refers to provider practices that are inconsistent with generally accepted business or medical practices that result in unnecessary costs to the Medicaid program or for reimbursement for goods or services that are not medically necessary or do not meet professional health care standards.

Fraud refers to intentional deception or misrepresentation with the knowledge that the deception will benefit the provider or another person.

The Office of Medicaid Program Integrity is funded through federal and state revenues. With the exception of the OMNI Subsystem of the Florida Medicaid Management System (FMMIS), the federal match for program integrity activities is 50%.³ The federal match for the OMNI Subsystem is 75%. For Fiscal Year 2000-01, Program Integrity was allotted \$7,144,654 and 79 full-time positions.

The agency recently entered into a contract with TRAP Systems, Inc., a firm that has expertise in developing and using complex algorithms and data mining to detect potential fraud and abuse. The agency paid TRAP \$1 million for services through the end of the 2000-01 fiscal year and will pay TRAP \$2.5 million for services during Fiscal Year 2001-02.⁴

In addition to expenses incurred by the Office of Program Integrity, the agency's costs for identifying and deterring provider fraud and abuse include services provided by Consultec, the Medicaid fiscal agent. These services comprise producing claims reports, service utilization reports, and claims information from specific providers. The Consultec computer processing and programming costs that directly support the program integrity's activities are not accounted for separately. For Fiscal Year 2000-01, the Legislature appropriated \$66.8 million for Consultec services.

Findings

Medicaid Recoveries Low

Florida's Medicaid program could lose between \$445 million and \$890 million to fraud and abuse in Fiscal Year 2000-01

Florida expended around \$8.9 billion to pay for health care services provided to Medicaid clients during Fiscal Year 2000-01. Estimating that from 5% to 10% of these funds will be misspent due to abusive or fraudulent practices suggests that Florida may have spent between \$445 million and \$890 million for claims that it should not have paid.⁵

However, the amount that Florida loses to Medicaid fraud and abuse could be even higher. While the actual amount of Medicaid fraud and abuse is not known, stakeholders generally agree that 10% is a likely estimate. In fact, some stakeholders believe the incidence of Medicaid fraud and abuse in Florida to be significantly higher, especially in southern Florida.

Further, the amount of fraud and abuse has at times surpassed estimates when in-depth investigations have been conducted. For example, in 1996, Florida's Statewide Grand Jury reported that the Agency for Health Care Administration estimated the state would save \$20 million annually in durable medical equipment (DME) expenditures after implementing new fraud prevention controls, including re-enrolling all DME providers.⁶ This estimate was nearly six times the agency's original estimate that the state was losing \$3.5 million annually because of fraudulent behavior of DME providers.

³ The FMMIS is a computerized system used to process claims and to provide the agency with information it can use to manage and administer the Medicaid program. The OMNI Subsystem succeeds the FMMIS SURS Subsystem and is a data warehouse program intended to increase claims analyses and automated fraud and abuse detection capabilities.

⁴ The agency may renew this contract for two one-year periods.

⁵ Estimates of the prevalence of Medicaid fraud and abuse vary, from as low as 3% (when considering fraud alone) to 15% or higher (when considering fraud, abuse, and errors).

⁶ The \$20 million was an estimate of cost avoidance based on over 50% of the DMEs dropping out of the Medicaid program after the agency instituted the re-enrollment process.

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Medicaid funds lost to fraud and abuse contributed to the state's Medicaid budget deficit and has serious implications for Medicaid clients. Paying for unnecessary claims financially burdens the Medicaid program by having contributed to the state's recent Medicaid budget deficits. Florida's Medicaid program experienced a budget deficit of \$78.7 million in Fiscal Year 1999-00. In February 2001, the Social Services Estimating Conference projected a Medicaid deficit of \$546 million for Fiscal Year 2000-01 and \$1.5 billion for Fiscal Year 2001-02. The 1999-00 and 2000-01 deficits were funded from excess general revenue and unappropriated tobacco settlement payments. The projected 2001-02 deficit has been offset by the Legislature appropriating 18.5% more to pay for Medicaid health services for Fiscal Year 2001-02 than it did the previous year.

Budget constraints caused by spending Medicaid funds inappropriately can potentially place limits on the nature and scope of Medicaid services or client eligibility. On the other hand, the state can provide more services and increase eligibility when Medicaid funds are spent appropriately. To illustrate this, the estimated \$445 million that was likely lost to

fraud and abuse in Fiscal Year 2000-01 could provide assisted living facility waiver services to over 115,000 additional clients or nearly 20 times the number of clients expected to have received these services in that year. As such, it is critically important that the agency safeguard Medicaid funds by operating an effective and efficient program integrity function.

Agency recoveries represent a small proportion of the estimated dollars lost to fraud and abuse

For Fiscal Years 1995-96 through 2000-01, the agency recovered \$96.7 million from providers that over billed Medicaid, or about \$16.1 million per year. While this is a large amount of money, it represents only a small percentage of the Medicaid funds likely lost to fraud and abuse during that period. As shown in Exhibit 1, Florida likely lost from \$2.1 billion to \$4.3 billion between Fiscal Years 1995-96 and 2000-01 because of Medicaid fraud and abuse. By recovering \$96.7 million during this six-year period, the agency only recovered from 2.3% to 4.5% of the Medicaid funds lost to fraud and abuse during that time.

Exhibit 1

The Agency Recovered Between 2.3% and 4.5% of the Estimated Dollars Lost to Medicaid Fraud and Abuse During the Six-Year Period From Fiscal Year 1995-96 Through 2000-01¹

Fiscal Year	Recoveries	Estimated Losses Using 5% Loss Ratio	Percentage of Losses Recovered	Estimated Losses Using 10% Loss Ratio	Percentage of Losses Recovered
1995-96	\$11.8 m	\$ 307.0 m	3.8%	\$ 613.9 m	1.9%
1996-97	17.3 m	314.1 m	5.5%	628.1 m	2.8%
1997-98	22.0 m	330.6 m	6.7%	661.2 m	3.3%
1998-99	12.6 m	347.3 m	3.6%	694.7 m	1.8%
1999-00	13.6 m	387.7 m	3.5%	775.5 m	1.8%
2000-01	19.4 m	443.9 m	4.4%	887.8 m	2.2%
Total	\$96.7m	\$2,130.6 m	4.5%	\$4,261.2 m	2.3%
Average	\$16.1 m	\$355.1 m	4.5%	\$710.2 m	2.3%

¹ We calculated recovery rates by assuming that Florida annually loses from 5% to 10% of its Medicaid service expenditures to fraud and abuse, the level of fraud commonly cited by stakeholders.

Source: OPPAGA analysis.

Detection Methods Contribute to Low Recoveries

Techniques for detecting and estimating overpayments are imprecise

An effective Medicaid program integrity system should include detection techniques that accurately identify providers that have over-billed Medicaid and the amount of their overpayments. However, based on our review and analyses of Program Integrity's provider case tracking system, we concluded that the agency's methods for detecting and estimating overpayments are imprecise and contribute to low recoveries.⁷ Specifically, we found that

- detection methods yield a large number of "false positives" and
- overpayment estimates often become significantly reduced.

Program Integrity uses detection techniques that result in large numbers of "false positives."

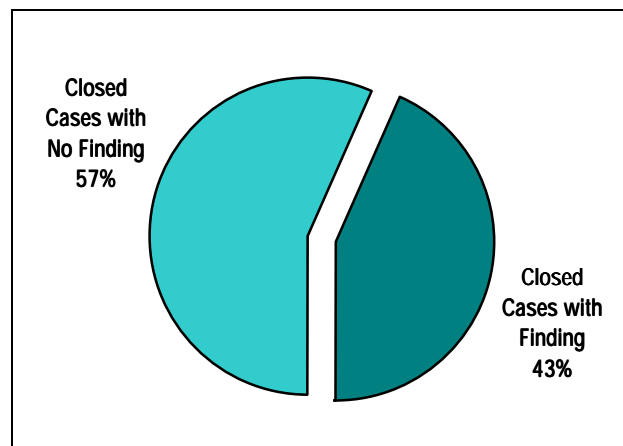
According to information contained in the provider case tracking system, the methods used by Program Integrity staff to detect potential provider fraud and abuse tend to over-identify such providers.⁸ Exhibit 2 illustrates this phenomenon. For Fiscal Years 1997-98 through 1999-00, 57% of the cases opened by program integrity were closed with no overpayment findings.

⁷ The provider case tracking system contains information such as the date the case is opened, provider type and identifier, investigator, detection method, status changes and dates associated with these changes, overpayment amounts identified, dates of provisional and final agency action letters, and case disposition information.

⁸ Program Integrity staff use a variety of techniques to identify providers who have misspent Medicaid funds. These techniques focus on finding violations of Medicaid policy (e.g., billing for an inpatient and outpatient procedure on the same day); significant variations in billing patterns (e.g., sudden increase in overall billings); and unusual concentrations of billing for services reimbursed at a higher level (e.g., billing most patient visits as comprehensive office visits).

Exhibit 2

57% of the 6,420 Cases Opened by Program Integrity Investigators Between 1997-98 and 1999-00 That Were Closed by December 2000 Did Not Identify Any Overpayments



Source: OPPAGA analyses of provider case tracking system.

Agency staff argue that closing a high number of cases with no overpayments reflects an efficient use of resources as staff investigators close suspect cases quickly when their preliminary reviews indicate providers have not violated Medicaid policy. However, as shown in Exhibit 3, we found little difference in the time it takes Program Integrity staff to complete and close investigations of providers that violated Medicaid policies and providers that did not violate policies. Both types of cases took an average of six months (184 days) to close.

Exhibit 3

Investigators Take Nearly as Much Time to Complete Provider Cases Without Overpayment Findings as They Take to Complete Cases With Overpayment Findings

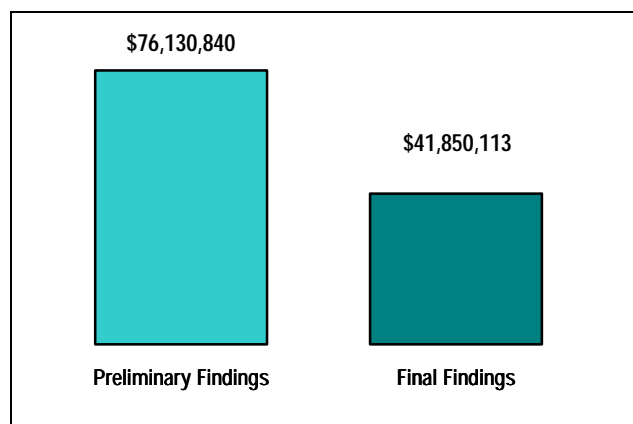
	Closed Cases	
	With Overpayments	Without Overpayments
Number of Cases	2,781	3,639
Mean	184 days	184 days
Median	109 days	94 days
Range	0 – 1,245 days	0 – 1,164 days

Source: OPPAGA analysis of provider case tracking system.

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After allowing for providers to produce additional information and taking into account appeals and administrative hearings, final overpayment amounts are substantially lower than initial estimates. Exhibit 4 provides further evidence that Program Integrity's techniques are imprecise. Between Fiscal Years 1997-98 and 1999-00, the provider case tracking system showed that investigators, after their preliminary investigations, identified approximately \$76 million in provider overpayments. However, after adjustments were made, the providers comprising this group only had to repay a total of around \$42 million (or 55% of the initially identified overpayments).

Exhibit 4 Initial Findings of Overpayment Are Substantially Reduced



Source: OPPAGA analysis of provider case tracking system.

According to the provider case tracking system, the majority of this reduction (\$32 million out of \$34 million) occurred after investigators reviewed additional information from providers.⁹ The rest of the reduction (around \$2 million) reflects adjustments made after appeals or administrative hearings.¹⁰

⁹ When providers receive written notice of the Medicaid policies they violated and the amount of overpayments owed, they can accept the findings, provide additional records to support their claims, or request one of two types of hearing, an appeal or an administrative hearing.

¹⁰ An administrative hearing is a formal meeting before a Department of Management Services hearing officer; an appeal is sometimes referred to as an informal hearing and is a meeting with designated agency representatives.

However, we could not determine the extent to which these providers actually have repaid the money they owe the Medicaid program. As explained on page 12 of this report, the provider case tracking system does not link recovery payments to specific provider cases; instead, recoveries are received by the agency's Office of Revenue Management, which only reports aggregate payment information to program integrity.

More precise detection methodologies should increase Program Integrity's return on investment.

Exhibit 5 shows Program Integrity's return on investment since Fiscal Year 1996-97.¹¹ According to a nationally recognized expert in health care fraud, the ratio of dollar savings to costs for virtually all fraud control activities generally ranges from a low of 2 to 1 to as high as 80 to 1.¹² The federal Health Care Financing Administration (HCFA) tends to achieve returns on investment ranging between 10 to 1 and 12 to 1 for its nationwide Medicare program integrity efforts.¹³ Or stated another way, HCFA's efforts tend to return from \$10 to \$12 for every \$1 it invests to identify and deter Medicare fraud and abuse. In contrast, Florida's Medicaid Program Integrity efforts have recovered from \$2.51 to \$4.87 for every \$1 invested.

With the exception of Texas, the program integrity officials that we interviewed from other states do not typically use return on investment as a performance measure. According to a Texas annual report, the return on investment for the Texas Office of Investigations and Enforcement, the entity within the Health and Human Services Commission responsible for program integrity functions, was \$7.92 for Fiscal Year 1999-00. Thus, Texas's reported return on investment was three times Florida's for that year. While there could be several reasons to explain the success of Texas's efforts, Texas staff attribute

¹¹ Return on investment refers to the ratio of dollars collected to dollars spent.

¹² *License to Steal: How Fraud Bleeds America's Health Care System*, Malcolm K. Sparrow (2000).

¹³ Medicare provides health insurance to individuals age 65 and older and is funded entirely with federal dollars. HCFA, recently renamed the Centers for Medicare and Medicaid Services, administers the Medicare program for the federal government.

success to using neural networking technology and to conducting random on-site reviews of Medicaid providers.¹⁴

Exhibit 5

While Florida's Return on Investment for Medicaid Program Integrity Decreased in 1998-99 and 1999-00, the Return on Investment for 2000-01 Was Higher

Fiscal Year	Return on Investment
1996-97	\$ 3.79
1997-98	4.87
1998-99	2.51
1999-00	2.55
2000-01	3.62

Source: OPPAGA analysis.

Recent agency initiatives should produce more recoveries. In 1999, the agency's fiscal agent, Consultec, subcontracted with Heritage Systems, Inc., to perform several activities related to pharmacies, including conducting pharmacy audits. And, in early 2001, the agency entered into a contract with TRAP Systems, Inc., a firm that has expertise in developing and using complex algorithms to detect potential fraud and abuse.¹⁵ Both of these efforts can potentially identify more cases involving providers that have over-billed Medicaid, which, in turn, can lead to increased recoveries.

In fact, early results from the Heritage audits are promising. According to the agency, these audits, conducted in 1999 and 2000, identified around \$78 million in potential overpayments to pharmacies.¹⁶ However, as of mid-July 2001, the agency had not recovered any of this money. According to staff, by that time, investigators had received information from Heritage on 633 cases and had mailed overpayment letters to 85 pharmacy

providers.¹⁷ Because many of these pharmacies have requested administrative hearings, the agency will not be able to collect from them until the appeal process is resolved. However, if these audits hold up under scrutiny, the agency should seek to recover the total amount of the overpayments identified by Heritage.

Agency Rarely Sanctions Providers

The agency rarely sanctions providers by applying disincentives such as fines, comprehensive follow-up reviews, or pre-payment reviews of claims

In addition to accurately identifying providers that have over-billed Medicaid, an effective program integrity system should include disincentives that are routinely applied to providers that over-bill Medicaid. Although authorized to do so, the agency rarely sanctions providers by imposing fines, conducting comprehensive follow-up reviews, or requiring manual reviews of provider claims prior to payment for a specified period of time. For the most part, the agency only requires providers that have over-billed Medicaid to repay the money they should not have received in the first place. When sanctions are rarely applied, providers may consider having to repay funds to Medicaid simply "the cost of doing business" and not be dissuaded from repeating abusive behavior.

The agency fines only a small number of providers that violate Medicaid policies. According to state law, the agency may impose a fine of up to \$5,000 for each Medicaid violation made by a provider.¹⁸ While the agency can fine providers for violations that do not involve over-billings, it is more likely to fine providers that over-bill Medicaid. Nevertheless, the agency fines only a small proportion of over-

¹⁴ Neural network technology can identify new fraud and abuse schemes by learning from existing patterns of fraud and abuse.

¹⁵ TRAP assisted HCFA in uncovering a Medicare fraud ring in South Florida that bilked over \$200 million from Medicare. Also, TRAP was selected to work with both New Jersey and Massachusetts to detect Medicaid fraud.

¹⁶ Heritage audits include on-site visits of pharmacies to compare claims information to records maintained at the pharmacies.

¹⁷ These 633 cases identified about \$64 million in potential overpayments. The 85 providers that were notified of overpayments accounted for around \$38 million or 60% of the potential recoveries.

¹⁸ Such violations encompass improper billing of a Medicaid client, reporting unallowable costs on a hospital or nursing home Medicaid cost report, furnishing inappropriate goods or services to a Medicaid client, and inappropriate prescribing of drugs.

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billing providers. As shown in Exhibit 6, during the last six fiscal years, the proportion of providers that over-billed Medicaid and were fined by the agency ranged from 1.2% to 8.8%.¹⁹

Exhibit 6

The Agency Imposed Fines on Only a Small Proportion of Providers That Over-Billed Medicaid Between Fiscal Years 1995-96 and 2000-01

Fiscal Year	Investigations Completed	Over-Billing Cases ¹	Cases With Fines	Percent Fined
1995-96	3,273	1,309	63	4.8%
1996-97	3,177	1,271	49	3.9%
1997-98	2,771	1,108	78	7.0%
1998-99	2,766	1,106	13	1.2%
1999-00	3,853	1,541	24	1.6%
2000-01	3,293	1,317	116 ²	8.8%

¹ Since agency staff were unable to determine the number of completed investigations that identified provider over-payments, we conservatively estimated these to be 40% (based on our analyses presented in Exhibit 3) of the completed investigations reported by the agency.

² The majority of these fines were imposed on nursing homes for billing infractions and, according to staff, the agency subsequently did not require the nursing homes to pay the fines.

Source: OPPAGA analysis of information provided by Office of Medicaid Program Integrity.

Program Integrity staff admit they rarely recommend imposing fines on providers and gave two reasons for this. Staff said they stopped recommending fines after several administrative rules that provided guidance related to Program Integrity activities were repealed, including guidelines for imposing fines and other sanctions.²⁰ However, the Legislature did not repeal the state law that provides authority for imposing monetary fines, thereby expecting the agency to consider fining providers as a way of deterring future violations of Medicaid policy.

¹⁹ These are likely over-estimates of the proportion of providers actually fined as agency counts of investigations completed contain duplications and because the tracking system does not indicate whether the recommended fine was actually imposed and collected.

²⁰ Rules repealed in December 1998 included rules for applying administrative sanctions, determining the amount of provider overpayments, and peer reviews of Medicaid providers.

Staff also believe that fines do not serve as a deterrent but cause conflict between providers and the agency. According to Program Integrity staff, providers are more likely to contest a small fine than a large overpayment because fines are reported to professional licensing boards. However, for exactly this reason, the threat of and actual imposition of fines should serve as a strong incentive for providers to ensure they appropriately spend Medicaid dollars and adhere to Medicaid policies.

While the agency conducts follow-up reviews, it has not established criteria for determining the extent and comprehensiveness of these reviews. As we recommended in two prior reports and as directed by the Legislature in 1996, Program Integrity staff report they conduct follow-up reviews of providers six months after cases are closed.²¹ However, the agency has not established written guidelines or criteria to guide these reviews. In the absence of specific guidelines, an investigator may choose not to conduct a comprehensive review of a provider without having to justify this decision.

According to office procedures, staff investigators conduct follow-up reviews of all cases in which providers received education letters, repaid money to Medicaid, or were sanctioned.²² Investigators receive notice each month of providers that had cases closed six months previously.²³ Investigators must then determine the level of review to conduct, from a cursory review of claims to a comprehensive investigation, thereby opening up a new case. However, in the absence of written guidelines, decisions of whether or not to open a new

²¹ *Efforts to Identify and Deter Provider Fraud and Abuse in Florida's Medicaid Program*, Report No. 12287, April 1994.

Follow-up Review on Efforts to Identify and Deter Provider Fraud and Abuse in Florida's Medicaid Program, Report No. 96-14, November 1996.

Chapter 96-387, *Laws of Florida*.

²² While the office has not developed an internal operating procedure specifically for follow-up reviews, Procedure No. 7, which establishes guidelines for maintaining the provider case tracking system and for managing hardcopies of case files, provides a general description of these reviews.

²³ The provider case tracking system contains a flag that identifies these providers. At the beginning of each month, the staff person responsible for maintaining the system gives investigators a list of the providers that are due for a follow-up review during that month.

case rests on individual program integrity administrators and investigators. As such, individual criteria are likely to vary which, in turn, may result in decisions not to open an in-depth investigation of some providers that should be reviewed.²⁴

Program integrity follow-up reviews tend to focus mainly on whether providers are continuing to violate the same Medicaid policies. In contrast, some states that conduct follow-up reviews use a more comprehensive approach. For example, New Jersey, Ohio, and Texas sometimes require and periodically monitor corrective action plans (CAPs) as a mechanism to conduct follow-up reviews. A CAP is a formal agreement between the Medicaid agency and a provider that has inappropriately billed Medicaid. States typically monitor providers for compliance to CAPs at 6- or 12-month intervals. CAPs remain in effect for varying periods of time and tend to focus on large volume providers.

Even though the agency sometimes withholds claims of suspect providers, it does not target providers who have over-billed Medicaid for pre-payment review of their claims. In addition to imposing fines and conducting six-month follow-up reviews, the agency can systematically review the claims of problematic providers before paying them. Pre-payment reviews can involve reviewing claims before paying, reviewing medical records to support these claims, or both. During the pre-payment review period, the agency can automatically withhold (or pend) providers' claims from processing or can intercept or stop payments to providers.

However, the agency typically conducts this form of pre-payment review only of those providers for which it has suspended claims processing or excluded from providing services for a period of time. Thus, staff use this only infrequently and only for the most egregious

cases. If the agency were to disassociate pre-payment reviews from pending claims, program integrity staff might be more likely to use pre-payment reviews as a sanction for certain providers. For example, California conducts manual claims reviews of providers that have exhibited patterns of questionable billing behaviors.

Conducting focused pre-payment reviews of claims submitted by providers who meet specified criteria (such as magnitude of over billing, risk of continuing to over-bill, etc.) could be beneficial to the agency. Such reviews put the agency in a position of denying payments rather than chasing after claims it should not have paid, thus avoiding unnecessary costs.

Because of the severity of potential consequences resulting from fraud investigations, referring cases for fraud investigations could also serve to deter providers from committing Medicaid fraud or abuse. While the agency does refer cases to the Department of Legal Affairs' Medicaid Fraud Control Unit (MFCU), most of the fraud investigations opened by MFCU come from other referral sources. As shown in Exhibit 7, in 2000, the agency was responsible for referring to MFCU only 10% of the Medicaid fraud cases that MFCU opened during that year. Florida citizens referred 38% of the opened cases, other state agencies referred 28% of the opened cases, and MFCU investigators opened 24% of the cases.

Other southeastern states' program integrity offices appear to contribute to a larger share of the fraud investigations opened by their states' MFCUs. A survey of seven southeastern states conducted by South Carolina's Legislative Audit Council in October 2000, found that, with the exception of South Carolina, MFCUs in these other states opened from three times to nearly eight times the percentage of cases based on program integrity referrals than does Florida's MFCU.²⁵ While there could be a number of reasons for this, we believe it suggests that Florida's program integrity

²⁴ To learn more about how Program Integrity staff approach follow-up reviews, we reviewed the documentation associated with follow-up reviews conducted during November and December 2000. While 20 of the 26 cases recommended no additional action or monitoring of the providers, it was not always clear how the investigator reached this decision. For example, information about the nature of previous case findings and/or the rationale for not further investigating the provider was sometimes missing.

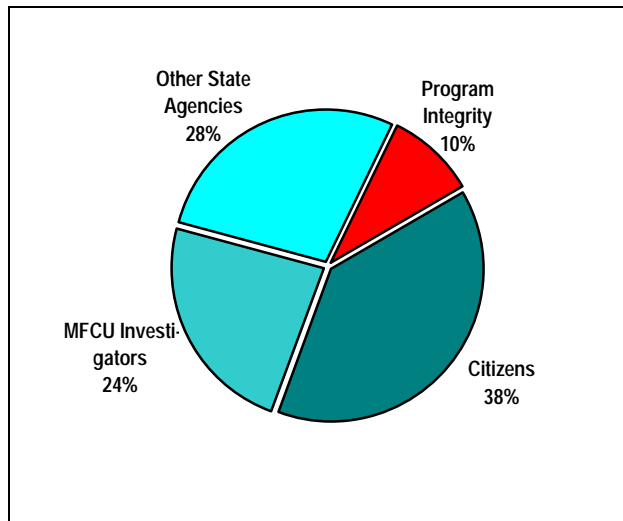
²⁵ Specifically, this survey asked MFCUs what percentages of their cases are referred to them by the state's Medicaid agency, for Fiscal Years 1995-96 through 1999-00. State responses were Alabama (75% to 80%); Florida (10%); Georgia (60% to 70%); Kentucky (75%); Mississippi (no response); North Carolina (60%); South Carolina (less than 10%); and Virginia (33%).

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detection techniques are not ferreting out enough potential fraud cases or once identified that investigators are not referring cases to MFCU that could be fraudulent. Regardless of the reason, with so few MFCU fraud investigations coming from program integrity referrals, the “threat” of being referred to MFCU is unlikely to be much of a deterrent.

Exhibit 7

Program Integrity Referrals Accounted for Only 10% of the Fraud Investigations Opened by MFCU in 2000



Source: Medicaid Fraud Control Unit.

Limited Accountability Affects Program Success

The agency does not have an effective system of accountability that evaluates and reports on the extent to which Program Integrity functions are effective and efficient

As the steward of Medicaid funds, the Agency for Health Care Administration is responsible for safeguarding these funds to the greatest extent possible and for informing policymakers and other stakeholders of its accomplishments. The agency through its Program Integrity office should have an accountability system that informs policymakers and program managers

about the effectiveness and efficiency of its efforts to detect and deter Medicaid provider fraud and abuse.

To judge the effectiveness of program integrity efforts, decision makers need to know how much fraud and abuse exists in the Medicaid system, how well the agency is doing in detecting and deterring Medicaid provider fraud and abuse, and the extent to which providers repay identified over-payments and discontinue abusive behavior. However, the agency does not routinely measure, track, and report this information, hindering the ability of policymakers to make informed decisions.

Understanding the extent of Medicaid fraud and abuse would facilitate policymakers' ability to evaluate the effectiveness and efficiency of Program Integrity efforts. In the absence of knowing the amount of Medicaid fraud and abuse in Florida, it is difficult for policymakers to judge the success of the agency's program integrity efforts. For example, even if the actual extent of Medicaid fraud and abuse is relatively small, such as 5% of total expenditures, Program Integrity's recoveries represent, on average, only about 4.5% of the estimated losses.

A rigorous assessment that provides a solid estimate of the amount of fraud and abuse in the Medicaid system would assist policymakers in determining how much to invest in Medicaid fraud and abuse detection and control activities. It would also provide a baseline for establishing benchmarks for assessing performance and for setting future performance goals, thus increasing agency accountability.

Until fairly recently, the health care industry, including Medicaid programs, had made few attempts to measure the extent of fraud and abuse. However, several states have taken steps to better estimate the extent of improper Medicaid payments. Texas recently completed its second study that estimates the percentage of overpayments in the state's Medicaid and worker's compensation programs.²⁶ Illinois and Kansas also have conducted similar

²⁶ *Texas Health Care Claims Study*, Office of the Comptroller, January 2001.

studies.²⁷ These studies estimated payment error rates varying from 4.7% to 24%. While these studies may not fully capture improper payments due to fraudulent behavior, mostly because of fraud's covert nature, they represent a good first step towards quantifying Medicaid losses.

By conducting a similar study, Florida could diffuse debates among stakeholders that focus on guesses about the extent of Medicaid improper payments due to error, abuse, and fraud and instead, focus efforts on finding solutions to curtail the problem. See Appendix D for the steps involved in conducting a study to validly estimate the amount of Medicaid dollars lost because of error, abuse, or fraud.

The agency does not routinely assess the effectiveness and efficiency of Program Integrity functions. In spite of prior OPPAGA recommendations from reports issued in 1994 and 1996, the agency still has not established outcome measures and benchmarks for judging the success of program integrity efforts to identify and deter Medicaid provider fraud and abuse.²⁸ Unless the agency develops, tracks, and reports on performance measures for Program Integrity, it will be difficult for policymakers to make decisions related to Program Integrity funding needs.

While the Legislature included measures related to program integrity in the agency's performance-based budget (PB²) for Fiscal Years 1998-99 and 1999-00, it did not include program integrity measures for Fiscal Years 2000-01 and 2001-02. The prior measures included the number of fraud and abuse cases opened and closed, the number of referrals to the MFCU, and the amount of recoveries.

These measures reflect information that the agency provides to the Health Care Financing

Administration (HCFA) each quarter. While this information is required by HCFA, it is not particularly useful to policymakers who must assess whether the agency is doing a reasonable job at identifying and deterring provider Medicaid fraud and abuse. The agency should develop, track, and report on measures that program managers and policymakers can use to judge success and make decisions related to funding needs and policy changes.

At the program level, the agency should develop measures to assess how effective various methods are in identifying providers that engage in abusive and fraudulent practices. Program Integrity staff could then fine tune or eliminate methods that do not effectively identify such providers. Other program level measures that would be useful for management purposes include the length of time it takes to complete investigations and the cost of completed investigations.

At the policy level, the agency should develop measures that focus on the results of Program Integrity activities. Some measures to consider include the

- percentage of identified overpayments that are actually recovered;
- return on investment;
- the ratio of Medicaid recoveries to Medicaid service expenditures; and
- extent to which providers repeat abusive behavior.

Until the agency develops, tracks, and reports on outcome measures for program integrity, stakeholders and policymakers will not have sufficient information with which to judge success or to make decisions related to funding needs.

The agency should also develop measures that reflect the savings or costs avoided due to using better detection techniques and preventive strategies. Specifically, the agency could determine the extent to which providers decrease over-billings after being notified of policy violations. The agency should also assess the costs avoided due to adding new prevention techniques such as pre-payment edits as well as the costs avoided due to other

²⁷ *Payment Accuracy Review of the Illinois Medical Assistance Program: A Blueprint for Continued Improvement*, Illinois Department of Public Aid, August 1998.

Payment Accuracy Review of the Kansas Medical Assistance Program, Kansas Medical Policy Department, April 2000.

²⁸ *Efforts to Identify and Deter Provider Fraud and Abuse in Florida's Medicaid Program*, Report No. 12287, April 1994.

Follow-up Review on Efforts to Identify and Deter Provider Fraud and Abuse in Florida's Medicaid Program, Report No. 96-14, November 1996.

Justification Review

agency actions such as fining providers or terminating them.

The agency does not have a mechanism for measuring whether providers repay funds or repeat abusive behavior. While the provider case tracking system contains information the agency can use to report on most of the performance measures we recommend, the system does not currently link recoveries to specific cases or current cases with prior cases. Because of these deficiencies, the agency does not know the extent to which providers actually repay monies, nor can it easily identify providers that have repeatedly abused Medicaid. However, with some modifications, the provider case tracking system could provide this information.

Currently, once the agency determines the final overpayment amount due from a provider, the agency's Office of Revenue Management contacts providers to set up a method of repayment.²⁹ Although Office of Revenue Management staff provide Program Integrity staff the total amount of recoveries received each quarter, this information is aggregated and not linked to specific cases or investigations. Program Integrity staff should refine the provider case tracking system so that repayment information (amounts and dates received) is linked to cases. The staff should also work with revenue management staff to ensure that case level repayment information is provided to Program Integrity staff.

In addition, Program Integrity staff should enhance the provider case tracking system so that it is capable of linking current cases with prior cases. While the tracking system currently includes a data field that indicates the number of previous cases opened against the provider under investigation, it does not contain information about prior infractions, findings, or outcomes. Since a large proportion of cases opened by program integrity are closed without findings, the number of prior cases opened against a provider is not very meaningful. By linking current cases to previous cases that

identified overpayments or other policy violations, the agency would be better able to identify providers that should be dealt with strongly with sanctions such as fines, pre-payment reviews of claims for a period of time, and in-depth follow-up reviews.

Conclusions and Recommendations

The Agency for Health Care Administration is responsible for administering Florida's Medicaid program. To receive federal Medicaid funds, the agency is required to develop methods and criteria for identifying and investigating Medicaid providers suspected of abuse and procedures for referring cases of suspected fraud to the state's Medicaid Fraud Control Unit, located in the Department of Legal Affairs. The agency's Office of Program Integrity is responsible for these functions.

During the six-year period, from Fiscal Year 1995-96 to Fiscal Year 2000-01, the agency recovered \$96.7 million from providers that over billed the Medicaid program. During this same period of time, estimates of Florida's losses due to Medicaid fraud and abuse range between \$2.1 billion and \$4.3 billion, or between 5% and 10% of total Medicaid health services expenditures.

Based on our review and analyses of the provider case tracking system, we concluded that low recoveries are likely because the agency's methods of detecting and estimating overpayments are imprecise. For example, Program Integrity investigators identified overpayments in less than one-half (43%) of the cases they opened between 1997-98 and 1999-00 and had closed by December 2000. In addition, although investigators identified \$76 million in overpayments during this three-year period, after allowing providers to produce more information and taking into account appeals and administrative hearings, the agency required the providers to repay only \$42 million or 55% of the initially identified overpayments.

We also concluded that the agency's efforts to deter provider fraud and abuse could be improved. The agency rarely sanctions

²⁹ Providers may make a lump sum payment or repay in monthly installments. In the event that a provider does not adhere to the agreement, agency staff may take further action such as not paying current claims, renegotiating the amount due, or taking legal action against the provider.

providers by applying disincentives such as fines, comprehensive follow-up reviews, and pre-payment review of claims. For the most part, providers need only repay money they should not have received in the first place.

Further, the agency needs to strengthen its accountability for Program Integrity efforts. While the agency reports information to the federal government, it does not have a system of accountability that evaluates and reports on effectiveness and efficiency of Program Integrity efforts. We therefore recommend the Legislature take the actions described below.

- ***Direct the Agency for Health Care Administration to develop measures and standards for evaluating the success of Program Integrity efforts.*** The agency should develop measures that are useful for assessing internal operations as well as measures that policymakers can use to judge how well the agency is doing in detecting and deterring provider fraud and abuse. In addition to typical output measures such as the number of investigations completed, number of providers sanctioned, etc., the agency should include measures that program managers and policymakers can use to judge success and make decisions related to funding needs.

To support operational or program level decisions, the agency should develop measures that assess the effectiveness of various detection techniques, the length of time it takes to complete investigations, and the cost of completed investigations.

To support policy level decision making, the agency should develop measures that focus on results such as the percentage of identified overpayments that are actually recovered; return on investment; ratio of Medicaid recoveries to expenditures; and extent to which providers repeat abusive behavior.

- ***Require the agency to report to the Legislature on the extent to which the agency is meeting program integrity performance objectives.*** The agency should design an accountability process that routinely collects all information needed to support Program

Integrity performance measures and standards. The agency should track measures quarterly and report results to the Legislature at least annually or more frequently if desired by the Legislature.

The agency should enhance its provider case tracking system to track and report recoveries by investigation. Currently, providers repay money to the agency's Office of Revenue Management. However, since repayment information is not linked to individual cases or investigations, the agency cannot currently answer questions related to how much of the identified overpayments providers actually repay.

The agency should also make other needed refinements to the case tracking system so that investigators and policymakers can easily identify providers that continue to over-bill Medicaid and track the extent to which sanctions are actually imposed.

- ***Direct the agency to determine the extent of Medicaid fraud and abuse.*** In the absence of knowing how much money is lost to Medicaid fraud and abuse, it is difficult for policymakers to judge how well the state is doing in controlling Medicaid fraud and abuse. To assist policymakers in determining how much money to invest in Medicaid fraud and abuse detection and control activities as well as to establish baselines and benchmarks for assessing performance, the agency should contract with an appropriate firm to conduct a study to estimate the proportion of expenditures lost to Medicaid fraud, abuse, and error.
- ***Require the agency to impose fines and other appropriate sanctions on providers that exhibit egregious behavior.*** To receive Medicaid dollars, providers are expected to adhere to Medicaid guidelines and policies. When providers do not adhere to guidelines whether due to simple errors or abusive or fraudulent behavior, the agency spends money unnecessarily. While the agency has the authority to sanction providers in addition to requiring providers to repay misspent funds, it rarely does so. Thus,

Justification Review

providers typically only need repay Medicaid funds and may not be dissuaded from repeating abusive behavior.

To effectively deter providers from over-billing Medicaid the agency should establish procedures for applying disincentives such as imposing fines, conducting manual pre-payment reviews of certain providers prior to paying claims, and conducting comprehensive follow-up reviews of providers to ensure they are billing Medicaid correctly. Fining providers should serve particularly well as a deterrent, since fines are reported to professional licensing boards. For providers that exhibit particularly egregious behavior, the agency should consider requiring providers to enter into corrective action plans (CAPs). Such plans could remain in effect for several years and should be monitored every 6 to 12 months.

Further, to ensure that sanctions are applied fairly, the agency should establish criteria for imposing each type of sanction and develop internal operating procedures for ensuring that guidelines and criteria are followed.

- ***Direct the agency to develop and use detection and estimation methods that maximize the likelihood of identifying and recovering Medicaid funds lost to fraud and abuse.*** Because of the dynamic nature of fraud and abuse, the agency should include in its repertoire of detection methodologies,

algorithms capable of detecting emerging fraud and abuse schemes.

The agency has recently taken steps, through contracts with Heritage Systems and TRAP Systems, to develop and use detection methods that should produce more “hits” and, in turn, more recoveries. While still too early to assess results, preliminary information from the Heritage pharmacy audits are promising. These audits identified \$78 million in potential overpayments to pharmacies that the agency can seek to recover. In addition, TRAP Systems’ advanced techniques, which include neural networking, should increase the ability of the agency to identify providers who are abusing or defrauding Medicaid.

However, to ensure that it maximizes resources, the agency should monitor the accuracy of its detection methods and make adjustments as needed.

Agency Response

In accordance with the provisions of s. 11.45(7)(d), *Florida Statutes*, a draft of our report was submitted to the Secretary of the Agency for Health Care Administration to review and respond.

The Secretary's written response is reprinted herein beginning on page 20.

OPPAGA provides objective, independent, professional analyses of state policies and services to assist the Florida Legislature in decision making, to ensure government accountability, and to recommend the best use of public resources. This project was conducted in accordance with applicable evaluation standards. Copies of this report in print or alternate accessible format may be obtained by telephone (850/488-0021 or 800/531-2477), by FAX (850/487-3804), in person, or by mail (OPPAGA Report Production, Claude Pepper Building, Room 312, 111 W. Madison St., Tallahassee, FL 32399-1475).

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John W. Turcotte, OPPAGA Director

Appendix A

Fraud Schemes

A multitude of schemes have been designed to defraud the Medicaid system. These schemes may involve a single provider or a complicated network of providers, beneficiaries, and organized crime.

One study on health care fraud investigations found that 37% of cases involved services not being rendered; 23% of cases were either medically unnecessary or involved over-utilization of resources; 21% involved upcoding, fraudulent cost reporting, or kickbacks and bribes; and 19% involved falsifying records or misrepresenting services.

The most common forms of health care scams active in Florida include those described below.³⁰

- *Phony clinics.* These are also known as “drop box” or “mail drop” operations, established by individuals who create fictitious medical clinics by incorporating under false credentials. The perpetrators use rental mailboxes for mailing addresses so they can submit bills and collect insurance payments. After setting up a phony clinic, the perpetrator obtains insurance and Medicaid numbers of patients and providers and submits claims using those numbers.
- *Patient brokering operations.* These clinics send “runners” to recruit patients from large corporations that provide comprehensive health benefits or from low-income areas that have high concentrations of Medicaid beneficiaries. These clinics open for only a few days each week and are often stocked with only minimal medical equipment. Clinics bill Medicaid for tests and procedures that are not actually done. Patients receive a small payment in return for their efforts.³¹
- *Solicitation of accident victims.* In these situations, clinics that are often chiropractic offices, hire “runners” to recruit patients who have been victims of accidents. Runners bring victims to the chiropractic office for assessment and treatment. The chiropractic office then refers patients to a diagnostic center for additional tests in return for a financial payment.

In many of these schemes, the patients and legitimate providers have no idea they are involved in an illegal operation. It is usually through investigations or secondary paperwork (such as explanation of benefits forms) that they become aware of their involvement.

³⁰ *Report on Health Care Fraud Claims*, Statewide Grand Jury Report, Supreme Court of the State of Florida, 1998.

Health Care: Fraud Schemes Committed by Career Criminals and Organized Criminal Groups and Impact on Consumers and Legitimate Health Care Providers, General Accounting Office, Office of the Inspector General, 1999.

³¹ This practice is common in many states. In an interview with an official of another state's program integrity office, the official indicated that such practices are becoming more harmful to patients because these clinics perform many tests and do not follow up when problems are identified.

Appendix B

Investigative Process for Cases of Suspected Medicaid Provider Fraud or Abuse

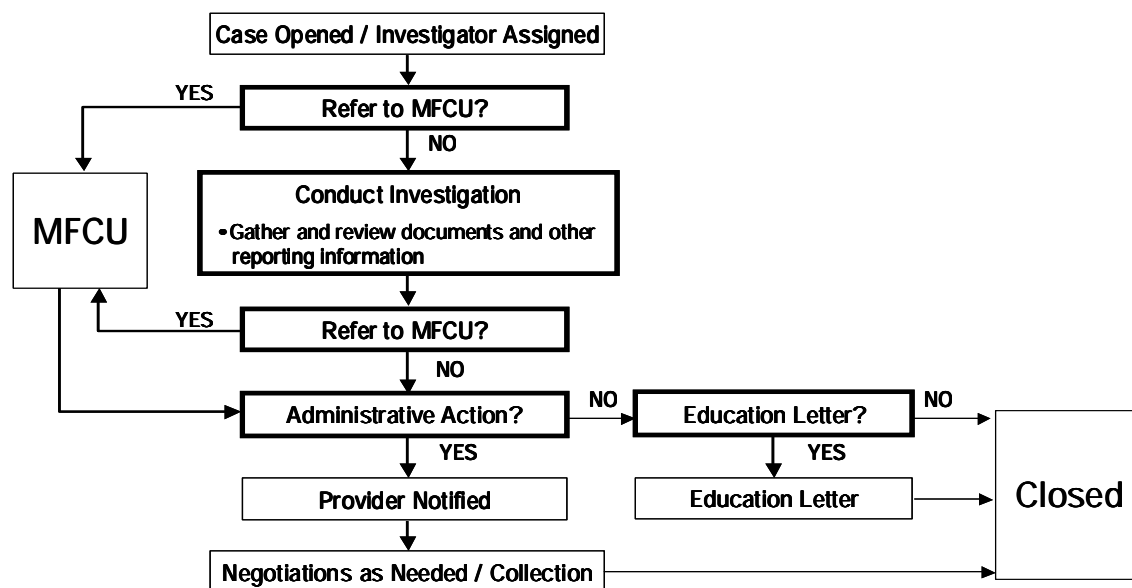
Medicaid Program Integrity staff open cases on providers for a variety of reasons. Staff open cases based on their review of the results of analyses of claims data that identify providers whose billing patterns are aberrant or depart significantly from their peers. Staff also open cases based on audits or reviews conducted by private firms and peer review organizations. In addition, staff open cases on providers based on complaints from other Medicaid providers, Medicaid recipients, concerned citizens, district Medicaid staff, and staff from other agencies.

As detailed below, cases of alleged provider fraud and abuse are assigned to staff investigators. If the nature of the allegation indicates potential fraud, the investigator refers the case to the Medicaid Fraud Control Unit (MFCU) located in the Office of the Attorney General. If it does not indicate potential fraud, the investigator conducts an investigation of the provider.

An investigation's scope varies according to the circumstances of the case, the amount of provider overpayment, and the type of policy violation. Investigative activities may include gathering and reviewing information such as provider claims, policy manuals, billing guidelines, medical records, and financial records. If, at any time during an investigation, the investigator determines there is sufficient evidence to substantiate fraud, the investigator refers the case to MFCU. If the investigator does not find sufficient evidence of abuse or provider overpayment, the investigator closes the case. Otherwise, the investigation continues until the investigator determines the amount of overpayment and the appropriate corrective action. Corrective actions may include education letters to providers regarding proper billing procedures, or, for cases involving overpayment, letters to providers relaying investigation findings and requesting repayment of the identified overpayments.

Table B-1

Program Integrity Investigations of Providers Should Follow This Process



Appendix C

Revisions to Substantive Law Related to Medicaid Program Integrity and the Medicaid Fraud Control Unit

As shown below, since 1996 the Florida Legislature has made several changes to state law intended to assist the Agency for Health Care Administration to prevent and deter Medicaid provider fraud and abuse.

State Law	Topic(s) Addressed
Chapter 96-280, <i>Laws of Florida</i>	Medicaid provider fraud – This law ranked Medicaid provider fraud offenses at level 7 of the state’s criminal sentencing guidelines, making Medicaid provider fraud a third degree felony.
Chapter 96-331, <i>Laws of Florida</i>	Medicaid provider fraud; Medicaid Fraud Control Unit (MFCU) – This law established the Medicaid Fraud Control Unit (MFCU) and its investigative jurisdiction under the Attorney General. It also established that investigators employed by the MFCU are law enforcement officers.
Chapter 96-387, <i>Laws of Florida</i> (sections 1-4)	Medicaid fraud and abuse – This law established procedures for enrolling Medicaid providers and conditions for which the application may be denied. It also established definitions of fraud and abuse, as well as medical necessity. It authorized onsite inspection of a provider’s service location prior to entering a provider agreement. Further, this law established procedures for the Agency of Health Care Administration to investigate possible Medicaid overpayments to providers. It specified conditions for when and how to terminate and/or fine a provider for Medicaid fraud or abuse. This law also established a requirement that follow-up reviews be conducted of providers with a history of overpayments. And, it established policies for the withholding of payments and for the imposition of other administrative sanctions.
Chapter 96-417, <i>Laws of Florida</i> (section 5)	Medicaid provider surety bonds – This law allowed the agency to require a \$50,000 surety bond from a provider to participate in Medicaid.
Chapter 97-290, <i>Laws of Florida</i> (sections 1-2)	Medicaid provider agreements – This law established requirements for Medicaid providers to undergo criminal background checks prior to entering a provider agreement.
Chapter 99-397, <i>Laws of Florida</i> (sections 70-71)	Payment withholds, overpayment determinations - This law established additional conditions for which provider payments may be withheld if fraud or abuse is suspected. The law established the right of the agency to conduct onsite record reviews. It also authorized certain techniques for the agency to use to determine amounts of overpayments paid to physicians.
Chapter 2000-163, <i>Laws of Florida</i> (sections 6-9, and 16)	Access to medical records; MFCU processes; and Medicaid provider agreements – This law clarified the confidentiality of patient records, waiving that protection when records are needed for purposes of an investigation conducted by the Medicaid Fraud Control Unit. It also made changes related to surety bonds, allowing the agency to require a surety bond based on the amount of a provider’s total Medicaid payments during the most recent calendar year or \$50,000, whichever is greater. The surety bond may also be based on expected billings for new providers. In addition, this law authorized the agency to consider a number of factors, including the availability of services in a particular geographic area, when deciding whether to enroll a provider.
Chapter 2000-256, <i>Laws of Florida</i> (section 53)	Medicaid provider agreements – This law established that the agency may require providers to post a surety bond prior to enrolling them as Medicaid providers.

Appendix D

Assessing the Amount of Medicaid Dollars Lost Because of Error, Abuse, or Fraud

The health care industry generally relies on national estimates of fraud and abuse produced by the United States General Accounting Office (GAO) to judge the extent of the health care fraud and abuse problem. GAO calculations have produced estimates of losses due to inappropriate billing that generally range from 5% to 10 % of all expenditures. However, many experts agree that these estimates fail to accurately gauge the full extent of the problem, because they have typically relied on surveys.

However, Texas, Illinois, and Kansas have attempted to measure Medicaid losses due to fraud, abuse, and errors using audit protocols that capture fraudulent claims as well as processing errors and insufficiently documented claims. And, according to Malcolm Sparrow, a nationally known expert in health care fraud, several other states are considering conducting similar studies.³² Also, the Health Care Financing Administration is likely in the future to require states to conduct such studies. To assist states in achieving this task, Sparrow offers the following guidance.

Methodology Steps

In general, analysts responsible for conducting a study to estimate losses due to Medicaid fraud, abuse, and error should pull a statistically valid, randomly selected sample of claims (based on the total number of claims during a set period of time) and then evaluate these claims for accuracy and legitimacy using the components below.

Claims examination. Analysts should examine claims for problems of medical necessity, logic violations (e.g., an adult receiving pediatric services), violations of Medicaid payment policy (e.g., inpatient and outpatient services received on the same service date), and price. Analysts should also focus on anything else suspicious, for example, signs of deception or patterns previously identified through investigative efforts.

Contextual data analysis. Analysts should examine claims within their broader data context including

- provider's aggregate billing behaviors and billing profile;
- patient's aggregate treatment pattern and profile;
- duplicate, similar, or related claims;
- referral patterns, coincidences, clusters, or structures in surrounding billings; and
- business relationships between providers and referring physicians, ownership arrangements, potential kickbacks, etc.

Patient interview. Analysts should interview patients, preferably in person or by telephone (avoid mailed surveys) to confirm the patient's relationship to the provider, the diagnosis, and the services rendered. In some instances, analysts may need to contact relatives of the patient.

Unannounced visits. If warranted by the previous steps, analysts should make an unannounced visit to the provider and conduct a medical chart review and billing audit. For less severe infractions, a desk audit of medical records could be conducted.

³² *License to Steal: How Fraud Bleeds America's Health Care System*, Malcolm K. Sparrow (2000).

Methodology Guidelines

To ensure the best results, the guidelines below should be considered.

- Conduct the study as soon as possible after services are delivered. This will aid patient memory and will reduce the time for providers to manipulate patient records.
- The number and types of claims to be examined should represent their relative proportions in the total population of claims. For example, if inpatient hospitalizations constitute 7% of all Medicaid claims, they should constitute 7% of the sample claims. This will allow the analyst conducting the study to generalize results to the population of claims.
- Conduct the study primarily by manually examining claims. While computer claims analysis is useful, a manual examination can provide information that a computer may not identify (e.g., separate service dates in records modified with the same ink or style of handwriting).
- Compare all electronic claims to their paper counterparts. This can identify manipulation from one medium to another.
- Use persons with medical backgrounds or with relevant experience to conduct the reviews of medical charts.
- Consider patient responses in context of the layman's understanding of medical procedures. For example, rather than asking a diabetic patient if a particular blood test (e.g., an HbA1C test) was conducted on a specific date, ask the patient if blood was drawn for tests on that date of service.
- If the cost to conduct such a study becomes an issue, the study should focus on the rigor of the review rather than the number of claims. In other words, conduct a rigorous review of a smaller number of claims rather than a less rigorous review of more claims.



JEB BUSH, GOVERNOR

RHONDA M. MEDOWS, MD, FAAFP, SECRETARY

August 30, 2001

Mr. John W. Turcotte, Director
Office of Program Policy Analysis
And Government Accountability
111 West Madison Street, Room 312
Claude Pepper Building
Tallahassee, Florida 32399-1475

Dear Mr. Turcotte:

Thank you for the opportunity to respond to the preliminary and tentative findings and recommendations included in your justification review of the Medicaid Program Integrity function. Please find enclosed our response to statements found in the report narrative and the report recommendations. We have also noted other accomplishments by the Medicaid Program Integrity unit related to cost savings and provider sanctions.

The report notes that the Agency has initiated several major projects in recent years. These projects are for the specific purpose of improving program performance and increasing operational efficiencies. This includes the development of performance measures and enhancing our technological capabilities to supplement and improve detection methods. These initiatives have been funded by the Legislature and have produced tangible results. The Agency is also applying for a federal grant and will work with the Governor's office and the Legislature to secure funding for a measurement study to determine the extent of Medicaid fraud and abuse.

If you have any questions regarding this response, please contact Rufus Noble at 921-4897 or Kathy Donald at 922-8448.

Sincerely,

/s/

Rhonda M. Medows, MD
Secretary

RMM/rn

Enclosure



Agency for Health Care Administration Medicaid Program Integrity

Agency Response to OPPAGA Report:

Report Section: at a glance

OPPAGA Statement - page 1, paragraph 2:

By recovering \$96.7 million, the agency in effect recovered only from 2.3% to 4.5% of the money likely lost to fraud and abuse during that time period (fiscal year 1995-96 to fiscal year 2000-01.)

Agency Response:

While recoveries of Medicaid funds lost to fraud and abuse is extremely important, up-front preventive enrollment measures and controls to keep potentially fraudulent and abusive providers out of the Medicaid program are essential. The agency has put a number of measures into effect to combat fraud and abuse to include a new provider enrollment application, mandatory re-enrollment of Medicaid providers, financial and criminal background checks, surety bond requirements, on-site provider inspections, and system edits. The agency has been active in these areas since 1996 and our success has been recognized and emulated by the federal government and other states.

In 1996, Medicaid Program Integrity (Program Integrity) initiated the South Florida Clinic Review Project. This ultimately resulted in the termination of 121 physicians, physician clinics and the referral of 57 cases to the Attorney General's Office, Medicaid Fraud Control Unit (MFCU). Cost Savings from this project amounted to \$30,027,273. Additionally, Program Integrity worked closely with Medicaid Program Development in recommending and implementing service limitations and creating Florida Medicaid Management Information System edits for identified abusive codes that physician providers were found to be billing. After the edits were put in place, a savings of \$3,698,526 were identified the following month. This would yield a yearly savings of \$44,382,312.

In February 1997, state budget officials announced that Florida's proactive anti-fraud measures were taking hold and that they would conservatively save taxpayers \$192.5 million over fiscal year 1996-97 and fiscal year 1997-98. These estimates were issued by the Social Services Estimating Conference. This success in deterring fraud and abuse in the Medicaid program was the result of a partnership between the agency, the federal Operation Restore Trust Program, the Florida Attorney General, the Statewide Prosecutor and the Florida Department of Law Enforcement.

In 1999, Program Integrity conducted investigations in cooperation with MFCU of dentists in the South Florida area that were involved in the unlawful solicitation and transportation of children and the submission of false Medicaid claims. As a result of these investigations, 76 dentists were terminated from participation in the Medicaid Program based on Program Integrity's recommendations, resulting in an estimated savings of \$20,449,687.00.

Report Section: Detection Methods Contribute to Low Recoveries

OPPAGA Statement - page 5, top left

Based on our review and analyses of Program Integrity's provider case tracking system, we concluded that the agency's methods for detecting and estimating overpayments are imprecise and contribute to low recoveries.

Agency Response:

Medicaid Program Integrity uses many types of detection systems and methods that identify and detect patterns of potential fraud and abuse. This type of detection activity is very valuable in identifying providers that are abusing the system in a most egregious manner and can assist in prioritizing cases to be recommended for further investigation. Other methods detect and estimate the extent of abuse, i.e., overpayments, very precisely. These detection methods used by Program Integrity are very precise, utilizing advanced technology and software to

Appendix E

determine exact overpayments instantaneously. Respecting the "false positives", there are a number of explanations for cases being identified that are subsequently closed with no identified overpayment. They could be SURS or OMNI Alert cases that are quickly opened due to parameters set by those systems to detect possible fraud or abuse. Subsequent review of many of these cases may result in closure after review by analysts and medical consultants. These cases increase the caseload but have little potential to be worked as abuse cases. Another example would be cases opened during the aforementioned South Florida Review Project. Recoupments were not identified during this project as the emphasis was on weeding out and terminating fraudulent and abusive providers. A great majority of these cases would not have been recoupable as the providers went out of business, or left the area or country when they realized they had been identified as suspects. If the agency had identified overpayments in these cases in which collection would have been almost impossible, the agency would have been liable to repay the Centers for Medicare and Medicaid Services (CMS) for the federal share of the overpayment.

OPPAGA Statement - page 6, paragraph 1

After allowing for providers to produce additional information and taking into account appeals and administrative hearings, final overpayment amounts are substantially lower than initial estimates.

Agency Response:

The review indicates providers are allowed to submit additional documentation that reduces the overpayments. This cannot be avoided as providers are entitled to appeal any overpayment findings, and if there is a hearing, they may submit additional information at that time. Additional information submitted by a provider can, and in many instances will result in a reduced overpayment. Program Integrity policy allows for the provider to submit additional documentation and information after the Preliminary Audit Letter is sent to them. Program Integrity will accept what appears to be legitimate documentation and sometimes it is necessary to conduct further inquiries, such as recipient interviews, to determine if the documentation is legitimate.

Report Section: Agency Rarely Sanctions Providers

OPPAGA Statement - page 7, paragraph 3:

The agency rarely sanctions providers by applying disincentives such as fines, comprehensive follow-up reviews, or pre-payment reviews of claims.

Agency Response:

The agency agrees that applying sanctions are necessary. Sanctions are defined by statute as fines, suspensions and terminations from the Medicaid program. From FY 1995-1996 through FY 2000-2001, 378 providers were terminated from the Medicaid program upon recommendations from Program Integrity. Follow-up and pre-payment reviews are procedures and methods utilized by Program Integrity to review and analyze claims submitted by providers and are not considered sanctions. However, from FY 1995-1996 through FY 2000-2001, Program Integrity has pended 948 providers for pre-payment review. As the review reports, the Program Integrity administrative rule respecting guidelines for administrative sanctions was repealed in 1998. Program Integrity had previously used these guidelines to insure that sanctions were applied as uniformly as possible. When a sanction is imposed on a provider, it requires by statute a referral to the appropriate licensing board. In a number of instances, many of our analysts and medical consultants who review cases, in their professional judgment, do not feel a referral to the board is necessary or prudent, based on their findings even though an overpayment is identified.

OPPAGA Statement - page 8, paragraph 3:

In the absence of specific guidelines, an investigator may choose not to conduct a comprehensive review of a provider without having to justify this decision.

Agency Response:

On all follow-up reviews, which are completed six months after case closure, the investigator must prepare a report justifying the action being recommended. The report is reviewed and approved by the supervisor. It is frequently found that the provider has discontinued previous billing irregularities. The investigator will also look for new aberrant billing patterns that the provider may have instituted since the conclusion of the case. The content of a follow-up case may be brief or more extensive. The extent to which to investigate a follow-up case,

as any other case, is always a judgment call. Program Integrity would not expect a great number of cases to be opened as a result of follow-up reviews. The review indicated that in the two months they reviewed, 6 of 26 cases were recommended for further action or additional monitoring. We would consider this a rather significant indication that the follow-up process is working well and that the investigators are giving appropriate attention to the follow-up review. It should be noted that Program Integrity's resources are limited and working additional cases on the same providers without appropriate justification for doing so can hinder the proper allocation of resources and time. The opening of new cases for minimal allegations can also lead to claims of harassment by the provider, their attorney or even a member of the legislature.

OPPAGA Statement – page 9, paragraph 2:

Even though the agency sometimes withholds claims of suspect providers, it does not target providers who have over-billed Medicaid for per-payment review of their claims.

Agency Response:

The agency has been extremely active since the early 1990's in the pending and pre-payment review of provider claims. From FY 1995-1996 through FYI 2000-2001, Program Integrity has pended 948 providers for a pre-payment review. Program Integrity cannot conduct a pre-payment review without pending a provider's claims. While the statute states that the agency may conduct pre-payment reviews without any suspicion of fraud or abuse, the agency is extremely careful and deliberate before pending a provider and subjecting their claims for a pre-payment review. Pending a provider can affect their business interest, ability to meet expenses and put their facility or practice at risk. The agency must make an expedient determination of the appropriateness of the claims and either deny or approve claims. The pre-payment review process is very time consuming and requires investigative and consulting resources.

OPPAGA Statement – page 9, paragraph 5:

As shown in Exhibit 7, in 2000, the agency was responsible for referring to MFCU only 10% of the Medicaid fraud cases that MFCU opened during that year.

Agency Response:

The agency is required by statute to refer cases of suspected fraud to the MFCU. From FY 1995-1996 through FY 2000-2001, Program Integrity has referred 795 cases of suspected fraud to the MFCU. The agency has made great strides and efforts to refer quality cases to the MFCU. In 1996, the agency in conjunction with the MFCU, revised its referral format to include extensive background investigative information to assist the MFCU investigators. This is considered the preliminary fraud investigation aspect completed by the agency. The agency has communicated frequently with the MFCU, both verbally and in writing, respecting cases of mutual interest. In a number of instances, the agency will work cases that the MFCU is also investigating. The agency provides the MFCU with a monthly listing of all Program Integrity open cases. The MFCU has the option to discuss these cases with Program Integrity and request they be referred to the MFCU for criminal investigation. The MFCU also develops a good number of their own cases as they also have access to new and advanced technology and software to assist in the detection of fraudulent and abusive practices.

Report Section: Limited Accountability Affects Program Success

OPPAGA Statement - page 12, paragraph 1:

While the provider case tracking system contains information the agency can use to report on most of the performance measures we recommend, the system does not currently link recoveries to specific cases or current cases with prior cases.

Agency Response:

Recoveries are received by the Agency's Bureau of Finance and Accounting. The case tracking system tracks Program Integrity data and is not an accounting system. It could be modified to be one, in part, but that would duplicate an already existing accounting function and would entail additional staff and expense. If this were the case, less staff could be utilized for the true mission of Program Integrity, which is to ensure the integrity of the Medicaid program.

Appendix E

Agency Response to Recommendations to the Legislature:

Recommendation - page 13, paragraph 2:

Direct the Agency for Health Care Administration to develop measures and standards for evaluating the success of Program Integrity efforts.

Agency Response:

The agency agrees that a more sophisticated set of performance measures are needed and required to assess the effectiveness of Program Integrity's efforts and initiatives. We are currently working with TRAP Systems to develop better performance measures.

Recommendation - page 13, paragraph 5:

Require the agency to report to the Legislature on the extent to which the agency is meeting Program Integrity performance objectives.

Agency Response:

The agency agrees with this recommendation.

Recommendation - page 13, paragraph 8:

Direct the agency to determine the extent of Medicaid fraud and abuse.

Agency Response:

A study of the amount of fraud and abuse would be very beneficial. In July 2001, the CMS, announced a demonstration project to build on the experiences of various states in the development of a Payment Accuracy Measurement System for Medicaid. Under this initiative, states have the opportunity to work collaboratively in a study of methodologies for measurement of accuracy of payments made for Medicaid services. The federal government will cover One hundred percent of the costs. The Florida Medicaid program will apply to be part of this project. When the study is done it will require a rather large sample and every claim in the sample would have to be completely audited, including for over Florida and each locale would be subject to being visited, an enormous effort would be required.

Recommendation - page 13, paragraph 9:

Require the agency to impose fines and other appropriate sanctions on providers that exhibit egregious behavior.

Agency Response:

The agency agrees that fines and sanctions are appropriate for providers that exhibit patterns of extremely abusive billing practices. While authority to sanction is still contained in Florida Statute, the administrative rule that governed Program Integrity guidelines to administrative sanctions was repealed in 1998. This has hindered efforts to apply sanctions on a uniform and consistent basis. We will promulgate a new rule to assist in the sanctioning process. The application of a sanction against a provider results in a referral to the appropriate licensing board as provided for in the Florida Statute governing Program Integrity. Often, the investigator or medical consultant assigned to a case, feel that it is not necessary or prudent to sanction the provider based on their finding in the audit as these would lead to another unnecessary investigation by another entity.

Recommendation - page 14, paragraph 3:

Direct the agency to develop and use detection and estimation methods that maximize the likelihood of identifying and recovering Medicaid funds lost to fraud and abuse.

Agency Response:

The agency believes that its methods for detecting fraud and abuse are precise and have become even more sophisticated over the past several years with the addition of advanced technology and software. The agency cannot control the difference in overpayments identified initially to those determined after a provider has had an opportunity to supply additional documentation and information. They have that right to do so by law. Many cases that are opened may result in terminations from the Medicaid program rather than overpayments. The agency has recently contracted with TRAP Systems, Inc., which will provide for an even more powerful tool to detect fraud and abuse over the next several years.