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OFFICE OF PROGRAM POLICY ANALYSIS & GOVERNMENT ACCOUNTABILITY

November 2004 **Report No. 04-77**

AHCA Takes Steps to Improve Medicaid Program Integrity, But Further Actions Are Needed

at a glance

Since our 2001 report, the Legislature and the Agency for Health Care Administration (AHCA) have taken steps to address fraud and abuse in the Medicaid program. The Legislature has changed state law to establish additional provisions to prevent and deter fraud and abuse, authorized AHCA to study the extent of improper Medicaid payments, and increased agency staffing for program integrity functions. During this same time, AHCA has reorganized the program integrity office, hired additional staff, and developed a new provider case tracking and management system.

However, AHCA has not fully implemented our recommendations to combat fraud and abuse, and it has also been slow to implement legislative directives to sanction providers that over-bill Medicaid or violate Medicaid policies. In addition, return on investment for program integrity functions has fallen since Fiscal Year 2001-02.

To ensure that AHCA improves its efforts to protect Medicaid dollars, the 2004 Legislature required OPPAGA to biennially review these efforts. Our next report will be provided to the President of the Senate and the Speaker of the House in January 2006 on agency efforts to prevent, detect, deter, and recover Medicaid dollars lost to fraud and abuse.

Scope

In accordance with state law, this progress report informs the Legislature of actions taken by Florida's Agency for Health Care Administration (AHCA) in response to a 2001 OPPAGA review.[1, 2] This report assesses the extent to which the agency has taken action to address the findings and recommendations in our prior review and reports on the effectiveness of these actions.

Background

Florida's Medicaid program, administered by the Agency for Health Care Administration (AHCA), is among the largest in the country. Medicaid provides health care coverage to selected low-income persons who meet federal and state eligibility requirements. Medicaid serves low-income families and children, elderly persons who need long-term care services, and persons with disabilities. For Fiscal Year 2004-05, the Legislature appropriated nearly $14.7 billion to provide health services to approximately 2.1 million Medicaid clients each month. Of this amount, $4.1 billion is general revenue; the other $10.6 billion comes from trust funds that include federal matching funds as well as other state funds derived from drug rebates, hospital taxes, and county contributions.

[1] Section 11.51(6), *F.S.*

[2] *Medicaid Program Integrity Efforts Recover Minimal Dollars, Sanctions Rarely Imposed, Stronger Accountability Needed*, Report No. 01-39, September 2001.

Like other healthcare insurance programs, Medicaid is vulnerable to abusive and fraudulent practices, which can take on many forms.[3] For example, providers may over-bill because of error, with no intent to increase their income. In other instances, providers may fraudulently bill Medicaid for healthcare services that are not medically necessary, for expensive procedures when less costly alternatives are available, or for services that were never delivered. 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. Estimates of the extent of Medicaid fraud and abuse generally range from 5% to 20%, depending on the type of service or geographic area.

To receive federal Medicaid funds, Florida must develop and use methods and criteria for identifying and investigating Medicaid providers suspected of abuse. The state must also refer cases of suspected fraud to the Medicaid Fraud Control Unit, located in the Department of Legal Affairs. The Agency for Health Care Administration's Office of Program Integrity is responsible for these functions, and is funded through federal and state revenues.[4] For Fiscal Year 2003-04, AHCA expended $8,621,775 for program integrity functions. This paid for 92 full-time positions and nearly $1.9 million in contracts to assist in detection and case management efforts. For Fiscal Year 2004-05, AHCA has allotted $11,031,017 for program integrity functions.

Prior Findings

In our 2001 report, we noted that AHCA recovered only a small portion (from 2.3% to 4.5%) of the Medicaid funds likely lost to fraud and abuse between Fiscal Years 1995-96 and 2000-01. Based on analyses of the program integrity provider tracking system, we concluded that the agency's use of imprecise methods to detect and estimate overpayments contributed to the low recoveries. In addition, the agency rarely sanctioned providers by applying disincentives such as fines and pre-payment reviews of claims. Rather than sanctioning, the agency generally required providers who had over-billed Medicaid only to repay money they should not have received in the first place. Further, the agency did not have an accountability system to evaluate and report on the effectiveness and efficiency of program integrity efforts.

We recommended that the Legislature direct the agency to

- improve its accountability system by establishing measures and standards to evaluate the success of program integrity efforts, reporting on the extent to which performance goals are met, and improving its case tracking system to provide the information needed to assess performance;
- impose fines and other sanctions on providers that exhibit egregious behavior;
- develop and use detection and estimation methods that maximize the likelihood of identifying and recovering funds lost to fraud and abuse; and
- determine the extent of Medicaid overpayments.

Current Status

Since our 2001 review, the Legislature and AHCA have acted to address fraud and abuse in the Medicaid program. While these actions have been beneficial, more steps need to be taken by AHCA to fully meet legislative requirements and to more aggressively combat Medicaid fraud and abuse.

[3] Abuse refers to provider practices that are inconsistent with generally accepted business or medical practices that result in unnecessary cost 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.

[4] The federal match for program integrity functions is 50%.

The Legislature has taken steps to combat Medicaid fraud and abuse

The Senate convened a select sub-committee prior to the 2002 session to review issues related to identifying and recovering Medicaid provider overpayments. After these hearings, the Legislature authorized AHCA to contract for a study to determine the amount of Medicaid fraud, abuse, and error and increased agency staffing related to detecting and deterring Medicaid fraud and abuse. The Legislature also required the agency to annually report specific information to document its efforts to detect, deter, and recover misspent Medicaid dollars.

In addition, the Legislature has made a number of changes to state law to strengthen program integrity operations. As discussed in Appendix A, these changes tightened participation requirements for Medicaid providers, and authorized AHCA to impose additional sanctions against providers found to violate program requirements.

AHCA has made organizational changes, reported on most legislatively required information, and improved its case tracking system, but needs to develop outcome measures and targets

Since our prior report, AHCA has made several organizational changes to improve program integrity efforts. In October 2001, AHCA created a deputy inspector general position, responsible for improving the effectiveness of agency efforts to address Medicaid fraud and abuse. Since then, AHCA has reorganized the Office of Program Integrity and hired additional staff. Program integrity staff meet periodically with Medicaid Fraud Control Unit investigators to discuss current cases and potential fraud and abuse investigations.

AHCA also has worked to collect and annually report on information required by the Legislature. The 2001 Legislature revised s. 409.913, *Florida Statutes*, to require AHCA and the Medicaid Fraud Control Unit within the Department of Legal Affairs to issue an annual report listing statistics such as the number of cases opened, amount of overpayments recovered, and average time to collect overpayments once a case is opened. With the exception of one statistic (the number of providers prevented from enrolling or re-enrolling due to documented fraud/abuse), AHCA reported on all of the required information for Fiscal Year 2002-03 (see Appendix B). Although much of this information is not yet available for Fiscal Year 2003-04, AHCA officials stated that they will have the information needed to report on all of the required statistics in time for the January 2005 annual report.

To assist in reporting this information to the Legislature, AHCA has developed a new provider case tracking and management database. This new system, the FACTSystem, tracks case status, reminds staff to record key activities and to carry out case management steps, and contains scanned electronic copies of letters and legal correspondence. In addition, the system links monies repaid by providers and information related to the status of appeals and administrative hearings to individual cases in the database. [5]

The FACTSystem also helps managers to monitor program integrity operations, such as the length of time and the costs to complete cases. The FACTSystem can generate reports that detail the extent to which providers actually repay misspent Medicaid funds, how long it takes providers to repay these funds, which providers have a history of over-billing Medicaid or have previously violated Medicaid policies, and the type and extent to which the agency imposes sanctions on providers.

While the FACTSystem has substantially improved AHCA's ability to track program activity, program integrity managers only recently have established monthly and annual benchmarks to monitor internal operations such as the length of time to complete cases and the extent to which targeted overpayment goals are met. By monitoring this information, AHCA will be able to identify program integrity activities that need improving as well as those that are effective.

[5] Information is provided by the Offices of Finance and Accounting and the General Counsel.

However, AHCA also should develop outcome measures and targets to supplement the information required by the Legislature. These measures should focus on effectiveness and efficiency of overall efforts. As noted in our 2001 report, some measures to consider include the percentage of identified overpayments that are actually recovered; the return on investment; and the savings or costs avoided due to using better detection methods, new pre-payment edits, and preventive strategies. This type of information is needed to assist AHCA managers and other policymakers in judging success and making decisions related to program integrity funding.

AHCA has not implemented required sanctioning process to deter providers from over-billing or violating Medicaid policies

To reinforce its expectation that AHCA impose sanctions against providers that violate Medicaid policies and misspend Medicaid dollars, the 2002 Legislature strengthened state law by authorizing the agency to use a wide range of sanctions to deter providers from continuing to over-bill or violate Medicaid policy. [6]

Despite this legislative directive, the agency has been slow to change its sanctioning practices. Although AHCA now conducts prepayment reviews of some providers that have potentially over-billed Medicaid and removes providers that commit egregious violations from serving Medicaid clients, it continues to rarely impose fines. For example, during Fiscal Year 2003-04, the agency subjected 103 providers to pre-payment reviews of claims and recommended removing 160 providers from Medicaid, but fined only 3 providers.

Instead, AHCA has used six-month follow-up reviews as its primary sanction, notifying providers that have over-billed Medicaid that they are subject to follow-up reviews. These reviews involve examining provider billing patterns and other information such as medical records to assess whether over-billing practices have continued. While follow-up reviews are important, AHCA should not rely on them as the primary sanction as this practice does not penalize providers that have over-billed Medicaid, and it inefficiently uses resources that could more productively be used to complete investigations of other cases. For example, of the 383 follow-up reviews completed in Fiscal Year 2003-04, only 1 identified continuing overpayments. [7] As recommended in three prior OPPAGA reports, AHCA should develop criteria for targeting providers for follow-up reviews and use these reviews as part of its full array of authorized sanctions. [8]

The agency has been slow to implement other sanctions such as corrective action plans, fines, and provider self audits. To provide legal guidance for these sanctions, the agency initially expected to have an administrative rule in place by June 2002. However, the agency did not file a Notice of Proposed Rulemaking until February 2004, and as of October 2004, the rule is still not finalized. Agency management reported that the delay in filing was due to extended internal agency review of the proposed rule. Once in place, the agency should develop an internal review process to ensure that sanctioning guidelines are followed.

Program integrity return on investment has decreased since 2001-02, indicating that AHCA has not focused detection methods in order to best identify provider overpayments

To ensure that AHCA maximizes program integrity resources, we recommended in 2001 that the agency monitor and assess program integrity detection methods. At that time, we noted that AHCA's detection methods resulted

[6] Sanctions can include requiring provider self-audits, agency conducted follow-up reviews, prepayment review of claims, payment of monetary fines, corrective action plans, and suspension or termination from the Medicaid program. Sanctions should be imposed based on the nature and extent of over-billing or policy violation and the risk of a repeat violation.

[7] As of October 2004, an additional 85 follow-up reviews were still under investigation and the findings were unknown.

[8] *Medicaid Program Integrity Efforts Recover Minimal Dollars, Sanctions Rarely Imposed, Stronger Accountability Needed,* Report No. 01-39, September 2001.

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

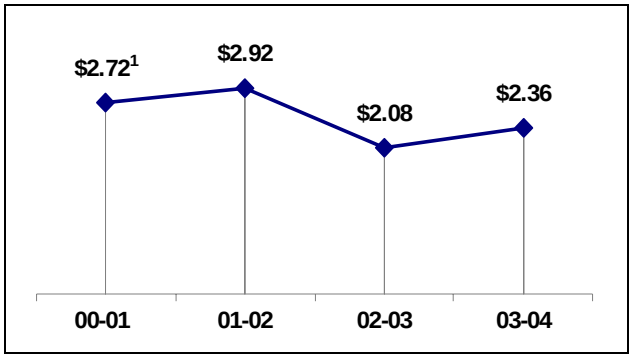
Efforts to Identify and Deter Provider Fraud and Abuse in Florida's Medicaid Program, Report No. 12287, April 1994.

in a high proportion of cases that were closed with no identified overpayments. To maximize return on investment, it is important that AHCA target its program integrity resources on activities and cases that identify the largest overpayments and potential for recovery. [9]

As shown in Appendix B, in Fiscal Year 2002-03 (the most recent year for which complete data is available), AHCA investigated 4,731 cases of potential overpayments due to fraud, abuse, or error. Of these cases, AHCA identified 1,603 instances of provider overpayment totaling $39.7 million after allowing providers to submit additional documentation to support their billing. [10] During the same time period, AHCA recovered $20.5 million in provider overpayments identified in the current and prior years. AHCA spent $9.8 million on program integrity activities in Fiscal Year 2002-03, resulting in a return on investment of $2.08 for each $1 invested.

However, as shown in Exhibit 1, the agency's return on investment for program integrity has declined since 2001-02, although it increased in Fiscal Year 2003-04.

Exhibit 1
Program Integrity's Return on Investment Has Fallen Since Fiscal Year 2001-02, Although It Increased Last Year



[1] This return on investment differs from our 2001 report. The revised measure excludes Medicaid Fraud Control Unit recoveries that had been transferred to program integrity.

Source: OPPAGA analysis of information provided by the Agency for Health Care Administration.

AHCA officials report that return on investment decreased for two reasons. Legal issues have delayed case recoveries for several large projects and pharmacy audits. For example, pharmacy audits have identified $44 million in overpayments, but these cases are pending legal review. In addition, AHCA reports placing a greater emphasis on prevention activities which do not generate cash recoveries and therefore are not included in these return on investment calculations. [11] However, we also note other possible explanations. AHCA has continued to rely on traditional methods to identify potential overpayments, has not evaluated which detection methods identify the most significant overpayments, and has not fully used information provided by its contract with Transaction Review and Audit Processing (TRAP) Systems, Inc. Since 2001, AHCA has contracted with TRAP Systems, Inc., to develop and use complex algorithms to detect potential fraud and abuse. TRAP also uses neural network technology which can identify new fraud and abuse schemes by learning from existing patterns of fraud and abuse. AHCA's contract with TRAP extends through December 2004 for a total cost of $7.5 million. [12] Although TRAP provides AHCA with periodic reports on suspicious billing practices, the agency has not routinely used these reports to identify potential overpayments. [13]

Program integrity managers gave two primary reasons for not using TRAP reports: a lack of resources to follow up on the information provided by these reports and a belief that their traditional detection methods tend to identify the same sources of overpayments. However, program integrity staffing has increased from

[9] Return of investment refers to the ratio of dollars collected to dollars spent.

[10] Providers also may request a formal or informal hearing which can result in adjustments to the determination of the overpayment.

[11] AHCA reports over $20 million in cost avoidance in Fiscal Year 2003-04 including $16 million in reduced payments for one drug: Intravenous Immune Globulin (IVIG).

[12] As part of its multiyear contract with AHCA, TRAP has trained AHCA program integrity staff to use VeriClaim, an enhanced fraud detection and analysis product; developed numerous algorithms to identify overpayments and patterns of fraud and abuse; run standard reports and ad hoc queries established by AHCA; and has produced periodic reports that identify providers with suspicious billing practices.

[13] For example, TRAP reports identify aberrant billing practices such as providers that bill for procedures or equipment for an unusually large number of recipients and providers that bill for excess procedures.

79 to 92 FTEs since 2001. Moreover, until recently program integrity staff had not systematically reviewed TRAP reports to determine the extent to which these reports identify additional sources of potential overpayments.[14] As a result, AHCA does not know the extent to which the reports produced by TRAP as part of its $7.5-million investment identified additional sources of overpayments.

We continue to believe that AHCA should assess its detection methods to identify those that best identify potential overpayments. Doing so would help program integrity investigators focus their efforts on methods that accurately and efficiently identify overpayments. Furthermore, while we support AHCA's efforts to improve prevention activities, it must also develop a standard method to calculate a separate return on investment for these efforts.

AHCA's 2003 payment accuracy study cannot be used as a baseline, but can help identify systemic problems with Medicaid policies that can increase inappropriate payments and mask abusive and fraudulent behavior

As directed by the Legislature, AHCA contracted for a payment accuracy study, completed in the fall of 2003, which reported an overall fee-for-service error rate of 6.25%.[15] This equated to approximately $450 million overpaid to Medicaid providers in Fiscal Year 2001-02.[16] However, this error rate only reflects errors in individual payments as the study was not designed to identify patterns of error due to sophisticated over-billing practices or fraudulent schemes.[17]

In addition, the reported error rate of 6.25% likely understates the level of payment errors. The study identified "administrative errors" in 12.5% of the claims which did not count towards the payment error rate. Administrative errors were typically associated with incomplete or poorly documented medical records, out-of-date policies, poorly documented policy exceptions, and programming errors. Although the study indicated that such errors did not affect payment, poorly documented or incomplete medical records may mask abusive billing practices.

Future payment error rate studies required by the federal government must use a different methodology and thus results will not be comparable to the 2003 study.[18] AHCA has contracted for a new study that uses the model proposed by the Centers for Medicare and Medicaid. The study is expected to be completed in December 2004 and differs from the 2003 study in several ways. The new study uses a different sampling framework and will include payments for services provided to ineligible persons as errors. The new study will determine payment accuracy by checking for processing errors related to the sampled claim and reviewing medical records to verify eligibility and medical necessity. In contrast, the 2003 study also involved reviewing additional recipient claims to assess the reasonableness of the sampled claims and contacting recipients to verify they received services. Because of the differences in methodology, the new study

[14] Program integrity staffs are currently reviewing information from TRAP reports involving 101 instances of potential provider overpayments identified between January and June 2004. Thus far, staff have decided not to pursue 10, are actively investigating 23, and are still reviewing preliminary information for 68 of the 101 instances.

[15] To estimate payment error, reviewers sampled claims from March 2002 in three service categories (acute care, prescription drugs, and long-term care) and developed error rates for each of these categories, as well as an overall error rate. Reviewers evaluated three sources of information: recipient medical records to determine medical necessity and identify payment or policy errors; recipients' claims four weeks before and four weeks after the date of the sample claims to assess consistency of services rendered; and recipient contacts to verify whether services in sample claims were received. For a copy of the report, see Medicaid Claims Payment Accuracy Study 2003.

[16] We derived this estimate by multiplying the extrapolated payment error amount for March 2002 by 12 months, which may not account for seasonal variations in expenditures.

[17] Identifying abusive and fraudulent billing patterns generally necessitates reviewing claims for multiple recipients submitted by the same providers. Fraudulent schemes are typically detected through sting operations and other types of investigations, leads from citizens, and application of sophisticated algorithms and data mining techniques capable of detecting suspicious billing patterns.

[18] The Improper Payments Information Act of 2002 (Public Law 107-300) requires federal agencies to annually review and identify programs and activities susceptible to significant erroneous payments and to estimate the amount of improper payments. To comply with this directive, the federal Centers for Medicare and Medicaid (CMS) will require states to estimate the percentage and amount of improper Medicaid payments.

should provide a better baseline for assessing improvements in AHCA's payment procedures and for comparing Florida with other states.

AHCA is using the results of its 2003 study to identify problems with Medicaid policies that contribute to overpayment and can mask abusive and fraudulent behavior. For example, the study identified a substantial rate of administrative errors resulting from problems such as poor medical record documentation, out-of-date policies, poorly documented policy exceptions, and programming errors. Most of the administrative errors (71%) were associated with pharmacy claims, a service area that is increasingly vulnerable to fraud and abuse.

Agency program integrity staff are currently reviewing claims that the payment error study identified as having administrative errors. Once this review is completed, AHCA should identify strategies to update and improve payment policies. Such strategies might include improving provider education related to practice standards and contract requirements, updating provider handbook policies, and clarifying guidance for granting exceptions to policies.

OPPAGA will conduct biennial studies of Medicaid fraud and abuse

To ensure that the agency improves its efforts to prevent, detect, deter, and recover misspent Medicaid dollars, the 2004 Legislature required OPPAGA to biennially report on the success of these efforts. OPPAGA will report to the President of the Senate and the Speaker of the House every two years beginning January 31, 2006. Our 2006 report will include an update on the agency's progress in improving program integrity efforts.

Agency Response

In accordance with the provisions of s. 11.51, *Florida Statutes,* a draft of our report was submitted to the Agency for Health Care Administration for its review and response. The agency's written response is reproduced in its entirety in Appendix C.

Legislature Has Continued to Revise Substantive Law Related to Medicaid Program Integrity and the Medicaid Fraud Control Unit

As shown below, the Florida Legislature has continued to change state law since 2001 to assist the Agency for Health Care Administration and related entities in preventing and deterring Medicaid provider fraud and abuse. A summary of legislative changes from 1996-2000 is included in our 2001 review.

State Law	Topic(s) Addressed
Chapter 2001-377 *Laws of Florida* (sections 6 and 12)	***Provider agreements, payment withholds.*** This law addresses provider participation, including requiring providers to notify the agency of pending bankruptcies and allowing the agency to deny participation if additional providers are not needed. It also authorizes the agency to withhold provider payments even for providers that have requested administrative hearings and prescribes additional sanctions that may be imposed on providers.
Chapter 2002-400 *Laws of Florida* (sections 21 and 30)	***Provider enrollment, disincentives, investigations and agency reporting.*** This law prescribes on-site inspections for provider enrollment, requires the agency to deny provider applications based on certain financial circumstances, requires imposition of sanctions or disincentives except in certain circumstances, expands circumstances where the agency can withhold payments or terminate a provider from the Medicaid program, and requires the agency and the Medicaid Fraud Control Unit to submit a joint annual report to the Legislature.
Chapter 2004-344 *Laws of Florida* (sections 4-7,10 and 32)	***Medicaid eligibility, provider network, provider payments, overpayments and pharmacy audits.*** This law eliminates Medicaid eligibility to any person found to have committed fraud twice within five years and requires the agency to seek a federal waiver to terminate eligibility in certain circumstances. This law also allows the agency to limit the provider network using credentialing criteria, service need, past program integrity history, and compliance with billing and record keeping. Further, this law allows the agency to conduct prepayment reviews of providers for up to one year, deny payments for prescriptions or services by non-Medicaid providers except in emergency or other limited circumstances, and allows the agency to develop an amnesty program to collect overpayments. In addition, this law directs the agency to use peer reviews to assess medical necessity; requires providers to acknowledge, in writing, their understanding of Medicaid laws and regulations; and further clarifies the criteria the agency must use when auditing pharmacies and eliminates a requirement to provide advance notification of an audit.

The Agency Has Developed and Reports Annually on Information Required by the Legislature to Document Its Program Integrity Efforts

The 2001 Florida Legislature required AHCA to annually report specific information related to the agency's efforts to prevent, detect, deter, and recover misspent Medicaid funds. Table B-1 details the information provided by AHCA in its annual reports for Fiscal Years 2001-02 and 2002-03. The table also includes some Fiscal Year 2003-04 information. The agency's annual report to the Legislature, due in January 2005, will include all required information.

Table B-1
Agency Has Reported on Most of the Program Integrity Information Required by State Law

Required Information: Medicaid Program Integrity	Fiscal Year 2001-02 [1]	Fiscal Year 2002-03 [2]	Fiscal Year 2003-04 [3]
Cases: Investigated	5,783	4,731	Not Yet Available
Cases: Opened New During Fiscal Year	2,598	1,516	Not Yet Available
Cases: Sources of Opened Cases (sources defined by agency)			
Medicaid Program Integrity	2,162	1,372	
Other AHCA	42	120	
Services (Health Systems Development)	285	0	Not Yet Available
Public	19	9	
Other State Agencies	20	2	
Federal Agencies	8	7	
Law Enforcement	5	4	
Other	57	2	
Cases: Disposition of Closed Cases (disposition defined by agency)			
Total	3,087 [4]	2,270	1,953
No Finding of Overpayment	1,447	568	
Provider Education Letter	263	99	Not Yet Available
Overpayment Identified	1,150	1,603	
Amount of Overpayments Alleged in Preliminary Action Letters	$80,980,180	$56,541,435	$75,300,070
Amount of Overpayments Alleged in Final Action Letters	$42,214,700	$36,162,432	$40,747,041
Reduction in Overpayments Negotiated in Settlement Agreements, etc.	Not Available	$139,454	Not Yet Available
Amount of Final Agency Determinations of Overpayments [5]	Not Available	$39,704,010	$40,154,928
Amount of Overpayments Recovered	$26,097,172	$20,482,607	$16,674,923
Average Time to Collect from Case Opened until Paid in Full	Not Available	603 days	Not Yet Available
Amount of Cost of Investigations Recovered	Not Available	$45,587	$92,430
Number of Fines/Penalties Imposed	0	0	3
Amount of Fines/Penalties Imposed	0	0	$20,500
Amount Deducted in Federal Claiming Due to Overpayment	$44,668,724	$17,151,138	Not Yet Available
Amount Determined as Uncollectible	$21,169,765	$34,290,850	Not Yet Available
Portion of Uncollectible Amount Reclaimed by Federal Government	$11,840,303	$19,225,633	Not Yet Available

Required Information: Medicaid Program Integrity	Fiscal Year 2001-02 [1]	Fiscal Year 2002-03 [2]	Fiscal Year 2003-04 [3]
Number of Providers by Type Terminated Due to Fraud/Abuse	129	28	160
Community Alcohol, Drug Abuse or Mental Health	2	0	
Pharmacy	13	3	
Physicians	63	15	
Physician Assistant	1	0	Details Not Yet Available
Chiropractors	1	0	
Podiatry Services	1	0	
Private Duty Nursing	1	0	
Dental	27	2	
Laboratory	5	3	
Durable Medical Equipment and Home Health Care [6]	2	0	
Home- and Community-Based	3	0	
Therapy	2	0	
Durable Medical Equipment Suppliers	8	4	
Public Health Provider	0	1	
All Costs Associated with Discovering, Prosecuting, and Recovering Overpayments: Total Reported Costs	$8,944,480	$11,907,940	Not Yet Available
Office of Medicaid Program Integrity	$8,944,480	$9,823,862	$7,063,566
Office of General Council, Accounts Receivable, and Medicaid Contract Management	Not Available	$1,220,525	Not Yet available
Indirect Costs	Not Available	$863,553	Not Yet available
Number of Providers Prevented From Enrolling or Re-Enrolling Due to Documented Fraud/Abuse	Not Available	Not Available	Not Yet Available
Document Actions Taken to Prevent Overpayments	2003 Annual Report	2004 Annual Report	Not Yet Available
Recommended Changes to Prevent or Recover Overpayments	2003 Annual Report	2004 Annual Report	Not Yet Available

[1] *Fighting Medicaid Fraud and Abuse FY 2001-02*, Agency for Health Care Administration and Department of Legal Affairs, January 2003.
[2] *Annual Report on the State's Efforts to Control Medicaid Fraud and Abuse FY 2002-03*, Agency for Health Care Administration and Department of Legal Affairs, January 2004.
[3] Information provided by Agency for Health Care Administration; information not yet available will be contained in the annual report on controlling Medicaid fraud and abuse in January 2005
[4] Total closed cases in Fiscal Year 2001-02 includes 184 cases closed when the provider terminated from the Medicaid program and 43 cases that were prosecuted by a state attorney.
[5] These are derived by adding the amounts collected on preliminary action letters and final action letters to the total amount identified in agency final orders.
[6] Durable medical equipment (DME) and home health care refers to DME supplies provided through home health care providers as part of their in-home services while durable medical equipment suppliers applies to the retailers of this equipment.

JEB BUSH, GOVERNOR

ALAN LEVINE, SECRETARY

December 1, 2004

Mr. Gary VanLandingham
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Dear Mr. VanLandingham:

Thank you for allowing the Agency for Health Care Administration the opportunity to respond to the November 2004 Progress Report titled: *AHCA Takes Steps to Improve Medicaid Program Integrity, But Further Actions Are Needed.* We feel it is important to further document some recent accomplishments of the Agency subsequent to the last regular session of the Legislature. As such, we would like to offer the following comments, and share some barriers we feel are not addressed in the report which relate to our efforts to prevent, detect, deter and recover Medicaid dollars lost to fraud and abuse.

As your report suggests, the Agency's return on investment for program integrity has declined since 2001-02, although it increased slightly in 2003-04. The report further explains two reasons for the decline have been pending legal review of pharmacy audits, and a greater emphasis by the Agency on prevention activities not included in the return on investment (ROI) calculations. We appreciated the opportunity to initially discuss the report with the OPPAGA team and welcome the chance to once again clarify the Agency's position.

The legal issues relating to pharmacy audits involve the use of extrapolation in the calculation of overpayments or underpayments. Extrapolation is a statistical method of sampling and extension of sample results to the population of claims sampled in order to calculate overpayments or underpayments. This method has been used by the Agency's Bureau of Medicaid Program Integrity for the entire history of the Agency. It is a generally accepted and widely used auditing and statistical method endorsed by the American Institute of Certified Public Accountants, the Department of Health and Human Services and other bodies concerned with accounting, auditing and statistically-based surveys. Sampling is provided for in the Code of Federal Regulations and is used by the federal government and other states. Overpayments determined based upon statistical sampling have proven reliable throughout the nation and have been deemed to be fair to both providers and government payers. Typically, this approach provides a basis for negotiating a settlement, upon which both sides agree.

Effective July 2003, Section 465.188, F.S., relating to Medicaid audits of pharmacies, was amended to include the following prohibition on the use of extrapolation:

> *"(e) A finding of an overpayment or underpayment must be based on the actual overpayment or underpayment and may not be a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs."*

While this change was not effective until July 1, 2003, it was a change that was anticipated for several years prior to its passage. Many of the audits completed prior to that date resulted in litigation, we believe, as a means of delaying the process until the legislation could be contemplated. As a result, 249 pharmacy audit cases were on hold and have been on hold for several years. These cases would likely provide overpayment recoveries worth several millions of dollars and would have a positive impact on the Agency's return on investment. The Agency would welcome more discussion about the impact of extrapolation on the process of overpayment determination.

The second matter impacting return on investment is the Agency's increased emphasis on prevention activities. Generally, once an overpayment is made to a provider, it is often difficult to recover the overpayment in a timely manner, or even the entire overpayment at all. However, it is the opinion of the Agency that if the overpayment had been prevented in the first place, savings would be the obvious result. The Legislature has recognized this and during the last few years, has provided the Agency with important legislation, mentioned below, to prevent potentially fraudulent and abusive payments from being made. Although the cost avoidance resulting from these activities has not historically been included in the return on investment calculations, they represent a true savings to the State of Florida and we welcome their inclusion in future ROI calculations.

It is important to point out the design of Medicaid is predicated on a system of "pay and chase." That is, Medicaid has, in its entire history, paid claims under the assumption they were accurate, appropriate, and not fraudulent. This "pay and chase" methodology results in a system that, by design, is imperfect, and without prevention activities cannot possibly recover nearly what the taxpayers should demand. This is why the Agency has, particularly since the beginning of this fiscal year – with the tools provided by the Legislature - adopted an aggressive approach to fraud and abuse, inclusive of activities designed to let fraudulent providers – or those who would be – know the Agency is extremely serious about taking swift action where appropriate and necessary. Following are some examples:

> *Prepayment Review pursuant to Section 409.913(3) Florida Statutes (2002)*
> During the 2003-2004 fiscal year, the Bureau of Medicaid Program Integrity placed 103 providers under prepayment review and, of these, payments to providers in the amount of $7.7 million were denied and precluded through these reviews. During the first quarter of fiscal year 2004-05, the Bureau placed 150 providers on prepayment review. **Thus, AHCA has exceeded in the first quarter of 2004 the number of prepayment reviews utilized in the entire prior year.**

We have found prepayment review can be very effective in preventing overpayments and we have sought, during the last six months, to increase the use of this tool. However, we have recently faced litigation initiated by some providers as a result of our utilization of the provisions of Section 409.913, F.S. See Pharmanet, Inc. and MedScript, Inc. v. Alan M. Levine, Secretary, in his Official Capacity, and Agency for Health Care Administration, Case Number 04-1786, Circuit Court of the 2nd Judicial Circuit, in and for Leon County, FL. In ruling on a petition for expedited writ of mandamus filed against the Agency, the Court indicated Section 409.913(3), F.S., likely would not survive a constitutional challenge. However, the Court ultimately did not reach a conclusion on that issue. The Agency supports the actions the Legislature took in granting this authority and will vigorously defend it.

Pending Payment pursuant to Section 409.913(25)(a), Florida Statutes (2004)
During the 2003-04 fiscal year, the Bureau pended payments to 65 providers, and during the first quarter of the 2004-05 fiscal year, the Bureau has pended 15 payments to providers.

The Agency has increased the efforts to identify providers for whom payments should be pended; however, like prepayment review, we have been faced with litigation relating to our practice of pending payments. See, e.g., Larkin Community Hospital, Inc. v. State of Florida, Agency for Health Care Administration, Alan Levine, individually for acts done in his Official Capacity as Secretary, and Tim Byrnes individually for acts done in his official capacity as Chief of the Medicaid Program Integrity Bureau, Case Number 04-1715, Circuit Court of the 2nd Judicial Circuit, in and for Leon County, FL. Lawsuits that challenge the Agency's application of pends and prepayment review slow down the Agency's application of these tools while the legal issues are sorted out.

Intravenous Immune Globulin Project (IVIG)
In January 2002, Medicaid policy was modified to require prior authorization for pharmacy claims for IVIG and to require physician claims for IVIG to be paid only for specific diagnosis codes. Shortly thereafter, Medicaid expenditures relating to IVIG fell by nearly 50 percent for the calendar year 2002. Although payments to pharmacies for IVIG drugs fell abruptly in early 2002, they began increasing again during the subsequent months until returning to previous levels. It was noted Medicaid expenditures for those drugs appeared to be unreasonably high in South Florida compared to similar expenditures in other parts of the state. As a result, the South Florida Intravenous Immune Globulin (IVIG) Initiative was carried out in August 2003.

It became widely known in the provider community that AHCA was reviewing billings and payments for IVIG drugs. Claims to Medicaid for IVIG drugs fell sharply and steadily, decreasing from an average of $1.5 million per month in the first six months of 2003, to an average of $783,000 per month for the last six months of 2003, and decreasing again to an average of $163,000 per month for the first six months of 2004. The reduction in payments by Medicaid for IVIG drugs from early 2003 to mid-2004 annualized is more than $16 million.

Durable Medical Equipment Project (DME)
Bureau of Medicaid Program Integrity staff members, in collaboration with Medicare investigators and state and federal law enforcement agencies, discovered a number of durable medical equipment (DME) providers who were billing both Medicare and Medicaid for an excessive number of services. Subsequent visits to their places of business revealed that a number of these businesses had been shut down for several months, but had billed Medicare and Medicaid for services rendered while the businesses were closed.

The Bureau immediately placed all of the identified Medicaid providers on prepayment review and intercepted payments of more than $73,000 that were ready to be mailed. In addition, sixteen of those providers have been terminated from the Medicaid program. Additionally, ten of the terminated provides have been referred to the Office of the Attorney General, Medicaid Fraud Control Unit for criminal investigation.

Medicaid Fraud Control Unit (MFCU)
The Agency and the Medicaid Fraud Control Unit have increased coordination and communication in the effort to prevent, detect, and deter fraud and abuse in the Medicaid program. Monthly meetings are being held between Agency and MFCU staff, investigators are in frequent contact regarding cases, joint projects are being carried out, and short-term and long-term work plans are being developed. This relationship has proven to be very beneficial in the Medicaid fraud and abuse effort. During the 2003-04 fiscal year, MPI made 96 referrals to MFCU. However, during the first quarter of 2004-05 alone, MPI has already made 59 referrals. Clearly, AHCA has significantly increased its referral activity in the current fiscal year.

Diversion Response Team
In November 2004, the Agency joined forces with the Florida Department of Law Enforcement, the Drug Enforcement Agency, the Florida Department of Health, the Attorney General, and several others to specifically target diverted drugs in Florida as part of the Governor's "Operation Stop Drug Diversion." We anticipate by sharing information and ideas and collaborating with these other agencies, we will have a significant prevention and recovery impact. While the return on this investment may not be directly attributable to this Agency, there will be a return to the taxpayers of Florida.

Health Care Clinic Act
In 2003, the Legislature passed Senate Bill 32A (Chapter 2003 - 411, Laws of Florida), the Florida Motor Vehicle Insurance Affordability Reform Act. Among its findings, the Legislature found: "It is further a matter of great public importance that, in order to protect the public's health, safety, and welfare, it is necessary to enact the provisions contained in this act in order to prevent PIP insurance fraud and abuse and to curb escalating medical, legal, and other related costs..." The resulting Part 400.990 - 400.995, Florida Statutes, known as the Health Care Clinic Act, was further amended in 2004 and provided for the licensure, establishment, and enforcement of basic standards for health care clinics and provided administrative oversight to the Agency. To date 2,630 temporary and 596 standard licenses, as well as 4,555 exemptions, have been

issued by the Agency. *Among the 40 applications denied by final order, 23 were denied as a result of the mandatory background screening requirements of licensure.*

Through its regulatory authority, which includes background screening, onsite inspections, the requirement for biennial licensure renewals and the ability to deny, suspend or revoke a license, the Agency will continue efforts to eliminate fraud and abuse.

Payment Accuracy Study
MPI is working closely with the Pharmacy Services Division to ensure any overpayments occurring because of administrative errors are recouped. Last fiscal year, the Agency recovered more than $400,000 in overpayments due to data entry errors.

The Agency recognizes it can be difficult to prove a negative. That is, if we are successful at preventing fraudulent or abusive practices, often we may not know it for the purposes of reporting. We are committed, however, to developing a reasonable methodology for forecasting the savings from these policies for the purpose of including these numbers in the calculation of ROI. We are grateful OPPAGA recognizes the validity of this issue and will hopefully have an acceptable model for the next review.

In summary, we appreciate the input provided by OPPAGA. We also appreciate the support we have received from the Legislature in our effort to address Medicaid fraud and abuse, and have been working diligently to utilize all available resources for maximum effectiveness.

We appreciate the professionalism demonstrated by your staff and we look forward to working with you on your next progress report on the Medicaid program integrity effort.

Sincerely,

/s/
James D. Boyd
Inspector General

The Florida Legislature

Office of Program Policy Analysis and Government Accountability

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