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OFFICE OF PROGRAM POLICY ANALYSIS & GOVERNMENT ACCOUNTABILITY

March 2006 **Report No. 06-23**

Enhanced Detection and Stronger Use of Sanctions Could Improve AHCA's Ability to Detect and Deter Overpayments to Providers

at a glance

Since our 2004 review, the Agency for Health Care Administration (AHCA) has worked to implement legislative actions to safeguard the state against waste, abuse, and fraud in the Medicaid program. Although these actions are beneficial, AHCA has not yet fully implemented all prior OPPAGA recommendations related to performance measures and detection efforts. In addition, AHCA should consider strengthening its sanctioning process to ensure that it deters providers from repeating abusive billing patterns, and expand oversight of Medicaid managed care to prevent and reduce waste, abuse, and fraud in managed care plans.

Scope

Chapter 2004-344, *Laws of Florida,* directs OPPAGA to biennially review the Agency for Health Care Administration's (AHCA) efforts to prevent, detect, deter, and recover funds lost to fraud and abuse in the Medicaid program. This report assesses AHCA's Medicaid Program Integrity's performance and updates AHCA's progress in addressing issues raised in prior OPPAGA reports. [1]

Background

Florida's Medicaid program, administered by the Agency for Health Care Administration (AHCA), is among the largest in the country serving approximately 2.2 million persons each month. Medicaid provides health care coverage to persons who meet federal and state eligibility requirements, including low-income families and children, elderly persons who need long-term care services, and persons with disabilities. For Fiscal Year 2005-06, the Legislature appropriated $15.6 billion to operate the Medicaid program. Of this amount, $4.5 billion is general revenue; the other $11.1 billion comes from trust funds that include federal matching funds and other state funds derived from drug rebates, hospital taxes, and county contributions.

Like other healthcare insurance programs, Medicaid is vulnerable to abusive and fraudulent practices, which can take on many forms. [2]

[1] *Progress Report: AHCA Takes Steps to Improve Medicaid Program Integrity, But Further Actions Are Needed,* Report No. 04-77, November 2004 and *Justification Review: Medicaid Program Integrity Efforts Recover Minimal Dollars, Sanctions Rarely Imposed, Stronger Accountability Needed,* Report No. 01-39, September 2001.

[2] 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.

For example, providers may overbill Medicaid because of error, which wastes Medicaid dollars. 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 never delivered. Sophisticated fraud schemes can involve providers that pay "kickbacks" to other providers for client referrals or 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 waste, abuse, and fraud 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 to identify and investigate Medicaid providers suspected of abuse. The state must also refer suspected fraud to the Medicaid Fraud Control Unit, located in the Office of the Attorney General. AHCA's Office of Program Integrity is responsible for these functions and is funded through federal and state revenues.[3] For Fiscal Year 2005-06, AHCA allotted $7,558,869 for program integrity functions, including 96 full-time equivalent positions.

Findings

Since our 2004 review, AHCA has taken steps to meet legislative requirements to safeguard the state against Medicaid waste, abuse, and fraud. While these actions have been beneficial, AHCA has not implemented some of our recommendations related to reporting performance on outcome measures to the Legislature and adopting stronger detection methods. In addition, AHCA should consider strengthening its sanctioning process to ensure that it deters providers from repeating abusive billing patterns and expand its oversight of Medicaid managed care plans to help prevent waste, abuse, and fraud in these plans.

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

AHCA should supplement its annual report to the Legislature by providing more information on trends and describing overall performance using outcome measures

As required by the 2002 Legislature, AHCA annually reports key statistics to the Legislature on its efforts to prevent, detect, deter, and recover misspent Medicaid funds, including the number of program integrity cases opened, the amount of overpayments identified, the amount of overpayments recovered, and the number of imposed fines and/or penalties. (See Appendix A for a list of these data.) While this annual report provides useful information, it would be more useful if it contained information about the program's overall performance in combating Medicaid waste, abuse, and fraud. As we recommended in prior reports, AHCA has begun to formalize outcome measures to supplement the information in the annual report. In its 2006 annual report, AHCA reported the return on investment for program integrity's efforts to avoid and recover overpayments.[4] Another useful measure to include in subsequent annual reports would be the percentage of identified overpayments that are actually recovered.

As we recommended, AHCA reported return on investment ratios for overpayments and costs avoided in its Fiscal Year 2004-05 annual report. Providing these ratios can help legislators evaluate AHCA's overall performance in combating Medicaid waste, abuse, and fraud. AHCA currently collects and tracks information needed to calculate these investment ratios. AHCA tracks the overpayments it recovers from providers, accounts for its expenses that support program integrity activities, and estimates the Medicaid costs it avoids through these activities.[5, 6]

[4] This report covers Fiscal Year 2004-05.

[5] These include costs associated with the general counsel, finance and accounting, the fiscal agent, external contracts, and other services that support program integrity activities.

[6] Activities that MPI considered as avoiding costs included reviewing claims prior to payment for certain high-risk providers, focused projects that involved on-site review of the billing practices of providers that delivered or prescribed goods or services known to be abusively billed (such as durable medical equipment or atypical anti-psychotic drugs), and terminating contracts for certain abusive providers.

During Fiscal Year 2004-05, AHCA recovered $20.5 million in overpayments and estimated that it avoided paying about $38.7 million through program integrity interventions. AHCA's costs related to these efforts were $10.9 million. While AHCA does not separately track its costs for activities that support identifying overpayments and those related to preventing inappropriate payments, staff apportioned these costs for Fiscal Year 2004-05 so that separate return on investment ratios could be calculated. In the future AHCA should track and report costs separately for these two activities.

As shown in Exhibit 1, in Fiscal Year 2004-05, AHCA realized a return of $2.73 for every $1 expended to investigate, identify, and recover provider overpayments and a return of $11.55 for every $1 expended to safeguard Medicaid from paying inappropriate claims. The combined return on investment for these activities was $5.45 for each $1 expended. It is important to report separate ratios for recovery and cost avoidance activities because reporting a combined ratio alone can mask their relative contributions.

Exhibit 1
In Fiscal Year 2004-05, AHCA's Return on Investment Was $2.73 and $11.55 for Identifying and Recovering Overpayments and for Activities Related to Avoiding Payments, Respectively

	Overpayment or Cost-Avoidance Activities	Expenditures	Return on Investment
Overpayments Recovered	$20.47 M	$ 7.51 M	$ 2.73
Costs Avoided	38.71M	3.35 M	11.55
Total	**$59.18 M**	**$10.86 M**	**$ 5.45**

Source: OPPAGA analysis of information provided by AHCA's Office of Program Integrity.

AHCA should also report information on the proportion of provider overpayments recovered. Providing this information would enable the Legislature to evaluate AHCA's effectiveness in ensuring that providers repay the state when they overbill for Medicaid services. AHCA tracks the amount and percentage of overpayments recovered in relation to the fiscal year in which they were identified. Because recoveries lag behind the year in which they were identified, it can take several years to fully assess how effective AHCA is at recovering funds. In addition to tracking collections, AHCA also tracks the amounts written off due to factors such as provider bankruptcy or disappearance, and the amount of identified overpayments still outstanding. As shown in Exhibit 2, as of December 2005, AHCA had collected less than half of the provider overpayments that it identified over the past three fiscal years. This percentage, however, will increase as AHCA is likely to receive some of the overpayments not yet recovered.

Exhibit 2
As of December 2005, AHCA Had Collected 41% of Provider Overpayments Identified in Fiscal Years 2002-03 Through 2004-05

Fiscal Year	Overpayments Identified	Collected	Write-Offs and Adjustments	Receivable Balance
2002-03	$ 44,704,010	41.8%	55.9%	2.3%
2003-04	43,398,891	42.6%	47.3%	10.1%
2004-05	47,577,786	38.8%	5.3%	55.9%
Total	**$135,680,687**	**41.0%**	**35.4%**	**23.6%**

Source: AHCA's Office of Medicaid Program Integrity.

In addition to reporting this information, AHCA should set targets to increase the proportion of overpayments it recovers. For example, as of December 2005, AHCA had collected 39% of the overpayments identified in Fiscal Year 2004-05. AHCA should set a goal to improve its collection rate each year.

AHCA should evaluate detection methods, make better use of advanced detection techniques, and expand data linking

AHCA has not fully evaluated its efforts to detect Medicaid overpayments and continues to rely on traditional detection methods. In addition, AHCA does not have a sustainable advanced detection system that can identify patterns of Medicaid abuse and fraud that other methods may miss. AHCA also should automate processes to identify unintentional billing errors and explore additional opportunities to link data to identify providers with suspicious billing practices.

AHCA should evaluate its traditional methods for identifying overpayments and create a sustainable advanced detection system to identify changes in provider billing patterns. AHCA has relied on several methods to identify potential Medicaid overpayments, abuse, and fraud, including complaints from other agencies and the public and statistical analyses that identify providers with aberrant billing patterns. While OPPAGA has recommended that the agency evaluate the effectiveness of these methods and explore more advanced techniques, it has been slow to do so. [7]

AHCA's program integrity staff reported that it recently has begun to evaluate its detection methods. This evaluation should include assessing the relative effectiveness of each detection method by comparing the costs of the investigations to the overpayments identified through each method. This would enable AHCA to determine whether to expand, modify, or discontinue any of these methods.

AHCA's ability to fully use advanced detection methods has been constrained by changes in its vendors. Since 2001, AHCA has contracted with two vendors for advanced detection. AHCA ended its three-year contract with TRAP Systems, Inc., in December 2004, and in mid-2005 began using an advanced detection tool operated by its Medicaid fiscal agent, Affiliated Computer Services (ACS). [8] AHCA reports that it will stop using ACS's advanced detection if it switches to a new fiscal agent in 2007. [9] AHCA should establish a contracting process that facilitates building and sustaining an advanced detection system that can be enhanced and modified over time and which is based on Florida's changing patterns of suspicious billings and activities.

To develop advanced detection methods requires extensive planning and a long-term commitment. For example, Texas has developed an artificial intelligence system that is based on algorithms that examine billing patterns over time to identify suspicious providers. The system currently uses five detection models with a sixth under development. Each model required up to one year and approximately $250,000 to develop. Texas officials indicated that developing this system required a long-term commitment to develop, use, and steadily expand the system's detection methods. [10, 11] Texas has used a single vendor to develop its artificial intelligence algorithms since 1998. The

[7] OPPAGA made this recommendation in both our 2001 and 2004 reports. In December 2005, program integrity staff reported they had begun to evaluate detection methods.

[8] HealthSPOTLIGHT is an advanced detection tool that can be adapted to different situations and analyzes billing patterns to identify cases with overpayments. It is proprietary software developed by the fiscal agent, ACS.

[9] AHCA may change its fiscal agent in 2007 pending the outcome of a legal challenge to its procurement process.

[10] Artificial intelligence systems learn from normal billing activities to identify when activities change. For example, these systems will identify a provider who has billed for podiatry services but suddenly begins submitting pediatric claims. These systems can also identify collusion within provider networks.

[11] Texas owns the models they have developed with their vendor. They also require their fiscal agent to send claims data to the vendor conducting the advanced detection.

Texas system costs $3 million per year to operate and helps recover up to $27 million in overpayments each year. [12]

AHCA should automate activities that require linking information from various databases. Although AHCA has identified substantial amounts of overpayments in the past by comparing information from various databases, it does not routinely do so. For example, in Fiscal Years 1998-99 and 2004-05, AHCA compared Medicaid nursing home payments to patients' share of these costs. [13] AHCA identified $10 million in overpayments through this effort in Fiscal Year 1998-99 and $4 million through the 2004-05 review. [14] These reviews are important as patient share of costs can change periodically based on availability of other insurance, spousal income, and family assets, and Medicaid overbilling can occur if these changes are not accurately reflected. AHCA does not routinely conduct this analysis because it currently cannot link the two databases, requiring extensive staff resources to manually reconcile the patient's share of costs.

AHCA should develop methods to automate this and similar data analyses. For example, as suggested at the January 2006 Second Annual Medicaid Fraud and Abuse Summit, AHCA could link data on nursing home violations with nursing home financial information to identify high-risk providers.

AHCA has implemented a sanctioning process but should consider establishing minimum fines and terminating providers using the sanctioning process

AHCA implemented a new sanctioning process in July 2005 to better deter providers from violating Medicaid laws and policies through actions such as overbilling. (See Appendix B for a summary of AHCA's sanctioning guidelines.) [15] AHCA could strengthen these guidelines by considering rule changes to ensure that fines represent a minimum percentage of providers' overpayments. In addition, to better protect Medicaid and other health care insurers, AHCA should remove providers with egregious billing practices from the Medicaid program by using the sanctioning process.

AHCA has implemented sanctioning practices, but should consider amending the sanction rule by setting fines as a percentage of identified overpayments. From July through September 2005, AHCA sanctioned 211 providers that had overbilled Medicaid by requiring them to write acknowledgement statements. These statements are letters that acknowledge the providers' need to comply with the violated law or policy that resulted in an overpayment. These acknowledgement letters are considered to be a corrective action plan and generally are applied to a first violation. AHCA also fined 18 of these providers, with fines ranging from $500 to $4,000. AHCA did not fine the other 193 providers because they were part of a targeted

[12] For certain overpayments, Texas's artificial intelligence system automatically generates letters requesting repayment that totals around $4 million annually. The system also generates investigative leads that annually yield up to $23 million in recoveries.

[13] Patient share of costs represents the amount the patient must contribute toward their monthly long-term care. This amount is based on family income and assets and on whether the patient has other insurance to help defray the costs.

[14] The Department of Children and Families, Office of Economic Self-Sufficiency determines patient eligibility for Medicaid and the patient's responsibility for nursing home costs.

[15] AHCA repealed its previous sanctioning rule in December 1998. Despite continuing authority to sanction providers, without a sanctioning rule for guidance, AHCA was reluctant to impose fines. The 2002 Legislature reinforced its intent that AHCA use a range of sanctions, including fines, against providers that violate Medicaid policies and misspend Medicaid dollars. At the time of our last report in 2004, AHCA had not finalized a rule to guide the sanctioning process. This rule, however, was adopted in April 2005 and AHCA implemented the rule on July 1, 2005.

investigation of over 600 nursing home providers and AHCA had closed all but 193 of these cases before July 1, 2005. [16] AHCA staff indicates that under its new rule, future sanction activity should include a higher percentage of cases with assessed fines as part of the sanction.

AHCA currently determines fine amounts based on the cause of an overpayment instead of the amount of an overpayment. As a result, assessed fines as a proportion of the overpayments vary widely. [17] For example, the fines imposed against the 18 providers ranged from 0.4% to 15.2% of their respective overpayments, with approximately half of the providers receiving fines that were less than 2% of their overpayments. Fines that reflect only a small percentage of a provider's overpayment may not provide an adequate disincentive to discontinue overbilling. AHCA should consider amending its rule to include a minimum fine based on a percentage of the overpayment for each sanctioned violation. For example, the rule could set fines as the higher of a minimum dollar amount or a percentage of the overpayment, such as 5% or 10%.

AHCA should use the sanctioning process to ensure that fee-for-service providers with egregious billing practices are prohibited from participating in all aspects of the Medicaid program. With the recent implementation of the sanctioning process, AHCA can remove a fee-for-service provider that has committed abuse or fraud by using the sanctioning process. This process bars the provider from participating in any aspect of the state's Medicaid program, including managed care. AHCA also reports providers that were removed from Medicaid using the sanction process to the federal Health and Human Services Office of the Inspector General, which lists these providers in the Healthcare Integrity and Protection Data Bank. [18] Registration in this database not only prevents participation in government insurance programs but also would likely prevent the provider from participating in most private insurance programs. Now that AHCA has implemented the sanctioning guidelines, it should use these guidelines to remove providers with egregious billing practices from further participation in all aspects of the Medicaid program, including managed care.

AHCA's role in preventing waste, abuse, and fraud in Medicaid managed care should expand

To date, AHCA has focused its efforts on preventing, detecting, and deterring Medicaid waste, abuse, and fraud in the program's fee-for-service delivery system. However, approximately 780,000 of Florida's 2.2 million Medicaid recipients now receive health care services provided by managed care organizations, and this number will expand under Medicaid reform. Managed care organizations experience the same types of waste, abuse, and fraud that have historically occurred in the Medicaid fee-for-service system. [19] Thus, it will be important for AHCA to ensure that fraud, abuse, and overbilling are controlled in the managed care system.

AHCA is beginning efforts to address this concern. In January 2006, Florida's Second Medicaid Fraud and Abuse Summit focused on issues related to fraud and abuse in managed care. Officials from Tennessee discussed that state's experience with and lessons learned about fraud and abuse in managed care.

[16] In anticipation of implementing the sanction rule, AHCA required all nursing home providers with overpayments to write acknowledgement letters. The agency did not fine any of these providers to ensure they treated the cases that were not closed until after July 1, 2005, in the same manner as those closed prior to that date.

[17] Overpayments result from violations of program rules or ordering goods or services that are inappropriate, unnecessary, or of inferior quality. AHCA increases fines if the number of overbilled claims suggests a pattern of error, as defined by rule.

[18] This is a national registry of providers, suppliers, or practitioners who have a history of health-care related convictions and judgments due to poor medical practice and/or billing violations, licensure actions, exclusions from government health care programs and other adjudicated actions.

[19] These include billing for services not rendered, not providing or denying needed services, billing multiple times for the same service, and submitting separate claims for services generally billed as a group.

In addition, Florida's 2006 Legislature will consider a bill that would require that each managed care organization serving Medicaid recipients develop and adhere to procedures prescribed by state law. [20] If passed, this bill designates AHCA's Office of the Inspector General as responsible for ensuring that managed care organizations serving Medicaid recipients adhere to prescribed requirements and for reporting suspicions of abuse or fraud by a Medicaid recipient or provider to Program Integrity, the Medicaid Fraud Control Unit, or the Department of Law Enforcement. [21]

If the proposed bill does not pass, AHCA should take steps to strengthen its oversight of managed care plans serving Medicaid recipients. AHCA should develop mechanisms to ensure that managed care plans adhere to federal and state regulations related to anti-fraud and abuse policies which AHCA has traditionally monitored through its contracting process. AHCA also should require managed care plans to report providers they suspect of fraud or abuse so that AHCA can determine if these providers are committing the same abusive or fraudulent behaviors in other aspects of the Medicaid program, thereby ensuring its ability to prevent these providers from participating in both fee-for-service and managed care.

[20] The bill under consideration is SB 1412. This bill directs all managed care organizations in Florida serving Medicaid recipients to establish fraud and abuse investigative units, file annual fraud and abuse prevention plans, report suspected fraud and abuse to AHCA, and authorizes designated personnel to share information related to suspected fraud and abuse. The bill also requires AHCA to report to the Legislature on its internal efforts to prevent and detect fraud and abuse in managed care and how it coordinates and shares information among managed care organizations and other government entities with similar responsibilities. In addition, the proposed bill requires AHCA to establish a system to validate encounter data used to track services provided to Medicaid recipients through managed care organizations.

[21] The Florida Department of Law Enforcement is responsible for investigating recipient fraud.

Recommendations

To improve AHCA's ability to prevent, detect, deter, and recover Medicaid overpayments, we recommend that AHCA implement the actions described below.

- Report additional information to the Legislature in its required annual report on Program Integrity. Including information on performance outcomes will assist the Legislature in evaluating Program Integrity's effectiveness and whether program expenditures adequately support activities. In addition to reporting return on investment ratios, AHCA should report the percentage of identified provider overpayments that are ultimately collected. The report also should describe trends in indicators such as overpayments identified, overpayments recovered, and average length of time to work cases that result in overpayments.
- Increase its ability to detect more potential overpayments. As we have previously recommended, AHCA should evaluate its current methods to detect potential overpayments, abuse, and fraud. Part of this evaluation should compare the resources AHCA expends for each detection method to the overpayments identified and modify methods as needed to maximize the state's return on this investment. AHCA also should modify its contracting process to create a sustainable advanced detection system capable of identifying patterns of Medicaid abuse and fraud that other methods may miss. In addition, AHCA should automate processes to identify unintentional billing errors. AHCA also should explore additional opportunities to link data that can identify providers with suspicious billing practices.

- Strengthen deterrence by considering setting fines based on overpayment amounts and using the sanctioning process to remove providers with egregious billing practices from the Medicaid program. To ensure that fines serve to deter providers from repeating misbillings, AHCA should consider amending its sanction rule to set fines based on the higher of a minimum dollar amount or a set percentage of a provider's identified overpayment. AHCA also should use its sanction process to remove fee-for-service providers with egregious billing practices from Medicaid to permanently prevent them from participating in any aspect of the Medicaid program, including managed care.
- Expand oversight of Medicaid managed care to prevent and reduce abuse and fraud. Under Medicaid reform Florida will increase enrollment in managed care organizations. AHCA should expand its oversight of Medicaid managed care plans to ensure that it prevents providers with egregious billing practices from participating in managed care as well as fee-for service, that recipients are protected, and that Medicaid dollars are wisely spent.

Agency Response

In accordance with the provisions of s. 11.51(5), *Florida Statutes,* a draft of our report was submitted to the Secretary of the Agency for Health Care Administration for his review and response.

The Secretary's written response has been reproduced here in Appendix C.

Appendix A

AHCA Reports Annually on Information Required by the Legislature to Document Its Program Integrity Efforts

The 2001 Florida Legislature required the Agency for Health Care Administration (AHCA) to annually report specific information related to AHCA's efforts to prevent, detect, deter, and recover misspent Medicaid funds. Table A-1 details the information provided by AHCA in its annual reports for Fiscal Years 2001-02 through 2004-05.

Table A-1
The Agency for Health Care Administration Reports Program Integrity Information Required by State Law

Required Information: Medicaid Program Integrity	Fiscal Year			
	2001-02 [1]	2002-03 [2]	2003-04 [3]	2004-05 [4]
Cases: Investigated	5,783	4,731	3,145	2,556
Cases: Opened New During Fiscal Year	2,598	1,516	658	1,497
Cases: Sources of Opened Cases (sources defined by agency)				
Medicaid Program Integrity	2,162	1,372	550	1,316
Other AHCA	42	120	44	12
Services (Health Systems Development)	285	0	0	77
Public	19	9	23	70
Other State Agencies	20	2	0	2
Federal Agencies	8	7	20	7
Law Enforcement	5	4	21	13
Other	57	2	0	0
Cases: Disposition of Closed Cases (disposition defined by agency)				
Total Closed Cases	3,087 [5]	2,270	1,953	1,459
No Finding of Overpayment	1,447	568	905	566
Provider Education Letter	263	99	104	44
Overpayment Identified	1,150	1,603	944	849
Amount of Overpayments Alleged in Preliminary Action Letters	$80,980,180	$56,541,435	$75,300,070	$63,256,733
Amount of Overpayments Alleged in Final Action Letters	$42,214,700	$36,162,432	$40,747,041	$26,871,573
Reduction in Overpayments Negotiated in Settlement Agreements, etc.	Not Available	$139,454	$856,746	$116,059
Amount of Final Agency Determinations of Overpayments [6]	Not Available	$39,704,010	$40,154,928	$25,384,338
Amount of Overpayments Recovered	$26,097,172	$20,482,607	$16,674,923	$20,468,894
Average Time to Collect from Case Opened until Paid in Full	Not Available	603 days	780 days	500 days
Amount of Cost of Investigations Recovered	Not Available	$45,587	$119,648	$67,295
Number of Fines/Penalties Imposed	0	0	3	1
Amount of Fines/Penalties Imposed	0	0	$20,500	$2,000
Amount Deducted in Federal Claiming Due to Overpayment	$44,668,724	$17,151,138	$8,872,964	$25,143,952
Amount Determined as Uncollectible	$21,169,765	$34,290,850	$11,518,098	$4,008,607
Portion of Uncollectible Amount Reclaimed by Federal Government	$11,840,303	$19,225,633	$5,749,373	$2,095,662
Number of Providers by Type Terminated Due to Fraud/Abuse	129	28	160	224
Community Alcohol, Drug Abuse or Mental Health	2	0	0	0
Pharmacy	13	3	35	29
Physicians	63	15	74	114
Physician Assistants	1	0	3	0
Chiropractors	1	0	0	0
Podiatry Services	1	0	0	0

Required Information: Medicaid Program Integrity	Fiscal Year 2001-02 [1]	2002-03 [2]	2003-04 [3]	2004-05 [4]
Nurses	1	0	2	0
Dental	27	2	4	5
Laboratory	5	3	3	0
Durable Medical Equipment and Home Health Care [7]	2	0	0	5
Home and Community Based	3	0	9	13
Therapy	2	0	0	1
Durable Medical Equipment Suppliers	8	4	22	49
Public Health Provider	0	1	0	0
Assisted Living Care	0	0	5	3
Transportation	0	0	0	2
Other	0	0	3	3
All Costs Associated with Discovering, Prosecuting, and Recovering Overpayments: Total Reported Costs	$8,944,480	$11,907,940	$9,143,570	$9,851,188 [8]
Office of Medicaid Program Integrity	$8,944,480	$9,823,862	$7,063,566	$7,317,546
Office of General Council, Accounts Receivable, and Medicaid Contract Management	Not Available	$1,220,525	$1,302,924	$1,477,310
Indirect Costs	Not Available	$863,553	$777,080	$1,056,332
Number of Providers Prevented From Enrolling or Re-Enrolling Due to Documented Fraud/Abuse	Not Available	Not Available	Not Available	Not Available
Document Actions Taken to Prevent Overpayments	Annual Report	Annual Report	Annual Report	Annual Report
Recommended Changes to Prevent or Recover Overpayments	Annual Report	Annual Report	Annual Report	Annual Report

[1] *Fighting Medicaid Fraud and Abuse FY 2001-02*, Agency for Health Care Administration and Medicaid Fraud Control Unit, 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 Medicaid Fraud Control Unit, Department of Legal Affairs, January 2004.
[3] *Annual Report on the State's Efforts to Control Medicaid Fraud and Abuse FY 2003-2004*, Agency for Health Care Administration and Medicaid Fraud Control Unit, Department of Legal Affairs, January 2005.
[4] *Annual Report on the State's Efforts to Control Medicaid Fraud and Abuse FY 2004-2005*, Agency for Health Care Administration and Medicaid Fraud Control Unit, Department of Legal Affairs, January 2006.
[5] 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.
[6] 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.
[7] 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.
[8] Does not include $629,427 for contractual services or $376,776 for ACS support services.

Appendix B

AHCA's Sanction Guidelines Provide Penalties and Disincentives for Violating Any Medicaid-Related Law

In July 2005, the Agency for Health Care Administration (AHCA) implemented sanctioning guidelines, Rule 59G-9.070, *Florida Administrative Code,* with a primary objective to encourage providers' compliance with Medicaid laws and policies, including accurate billing.

Sanctions apply to different types of violations. AHCA sanctions providers for a variety of overpayment and administrative violations.[22] Based on our review, AHCA most commonly cites the first three of the general violations listed below.

- Failing to comply with Medicaid rules or the provider agreement including adequate documentation of services provided.
- Providing goods and services that are not medically necessary, are of poor quality, or are harmful.
- Failing to maintain records.
- Failing to provide goods or services that are medically necessary.
- Submitting Medicaid claims that are false or include false information.
- Continuing to serve Medicaid patients after the provider's license is suspended, revoked, or terminated.
- Failing to provide requested documents in a timely manner.
- Failing to comply with a repayment schedule.
- Abusing a patient or committing acts of negligence that harm a patient.

Sanctions generally include corrective action plans and monetary fines, and may include suspension and termination. AHCA approves corrective action plans and monitors compliance. There are four types of corrective action plans.

- Acknowledgement statement. This is a letter written by the provider acknowledging the provider's responsibility to comply with the Medicaid laws and rules that have been violated. This sanction generally applies to a first violation.
- Provider education. This refers to the successful completion of an educational course tailored to remediate the billing activities that generated overpayments by the provider.
- Self-audit. This requires the provider to review Medicaid claims for a specified period of time and to submit to AHCA a full description of claim errors along with repayment of overbilled claims.
- Comprehensive quality assurance program. This requires the provider to develop a plan to monitor internal efforts to comply with Medicaid laws, professional standards, and the Medicaid provider agreement. The provider's written plan must include a

[22] Providers who routinely reconcile their billing accounts and voluntarily return overpayments are not subject to sanctions for overpayments.

description of how the program will be developed, implemented, monitored, and improved.

Fines are financial penalties imposed on providers and can be in addition to a corrective action plan or other sanctions including suspension and termination. AHCA bases the fine amount on three factors.

- The type of violation, as previously described, includes acts such as failing to comply with Medicaid rules or failing to maintain records. Initial fines for most violations range from $100 to $1,000. Harmful acts, withholding necessary care, or falsifying records can result in initial fines of $5,000 to $10,000.
- A pattern of error generally doubles the fine amount. A pattern exists when the number of claims with violations exceeds 6.25% of all reviewed claims, if the overpayment exceeds 6.25% of the total reviewed payments, if a patient's record lacks documentation for five or more claims, or if there is more than one patient without any record.
- Subsequent violations over the next five years can result in increased fines and sanctions. Program Integrity determines that a subsequent violation has occurred following additional investigations covering a different period of time or a different set of service claims.

Suspension and termination also can be imposed as sanctions. AHCA can suspend a provider from participating in the Medicaid program for a set period of time or terminate a provider from future participation in the Medicaid program for certain activities, such as patient abuse, fraudulent billing, or a history of repeated violations.

Appendix C

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

JEB BUSH, GOVERNOR ALAN LEVINE, SECRETARY

March 10, 2006

Mr. Gary VanLandingham, Director
Office of Program Policy Analysis and Government Accountability
Claude Pepper Building, Room 312
111 West Madison Street
Tallahassee, Florida 32399-1475

Reference: *Enhanced Detection and Stronger Use of Sanctions Could Improve AHCA's Ability to Detect and Deter Overpayments to Providers,* March 2006

Dear Mr. VanLandingham:

Thank you for the opportunity to respond to the above-referenced report. We appreciate your acknowledgement throughout the report of our continued efforts to safeguard the state against waste, abuse and fraud in the Medicaid program. We also appreciate the opportunity to work with OPPAGA staff members as they conducted their recent review of program integrity activities and we commend their thorough analysis of those activities.

In our response to your prior report dated November 2004, entitled "*AHCA Takes Steps to Improve Medicaid Program Integrity, But Further Action is Needed,*" we documented some accomplishments of the Agency in dealing with Medicaid fraud and abuse prior to 2005. We feel it is important to discuss our recent accomplishments and to comment on your report recommendations.

Return on Investment

The unit within the Agency which is primarily involved in the effort to control Medicaid fraud and abuse is the Bureau of Medicaid Program Integrity (MPI), located within the Office of Inspector General. We believe the most important measure of MPI's performance is return on investment, taking into consideration not only recoveries of overpayments, but also the prevention of overpayments, since prevention properly requires and receives a significant proportion of MPI's resources. We are pleased to note your report also emphasizes return on investment. Our cash recoveries increased 23 percent from $16.7 million in fiscal year (FY) 2003-04 to $20.5 million in FY 2004-05, boosting our return on investment for recoveries, not including overpayments prevented, to 2.7:1 for the latter year.

Three years ago, prevention activities in MPI were at a modest level. However, we have greatly increased emphasis in that area since prevention does not require the extensive resources associated with auditing and collection of overpayments. It further recognizes the time value of money. As a result, during FY 2004-05, MPI cost avoided $38.7 million, up 57 percent from $24.7 million for the prior fiscal year, which resulted in a return on investment for prevention activities of 11.5:1. Our overall return on investment for FY 2004-05 for both recoveries and

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prevention was thereby boosted to 5.5:1. We plan to continue to stress our prevention efforts and make additional improvements where necessary.

Prevention Activities

Among the prevention activities engaged by MPI are the use of prepayment reviews to identify improper claims and deny payment, recommendations for termination of providers suspected of misusing the Medicaid program, focused projects to address areas believed to be more susceptible to fraud and abuse which have a deterrent effect and result in cost savings for the Medicaid program, use of a newly-enacted provision of law which allows Medicaid to decline reimbursement for prescription drugs prescribed by practitioners who were terminated from the Medicaid program, referrals to other regulatory and law enforcement entities which may result in restrictions on providers' ability to continue participation in the Medicaid program while also serving as a deterrent, and other measures which serve to allow the Agency to better control its network of providers.

Prepayment reviews encompass examination of claims associated with intercepted payments and evaluation of pended claims. A provider is required to submit supporting documentation for claims under prepayment review so MPI can determine whether or not the claim should be paid. In prepayment review, claims not having proper documentation are denied. MPI typically places a provider on prepayment review if there is suspicion of fraudulent or abusive behavior. During FY 2004-05, the claims of 285 providers were pended and payments in the amount of $14.2 million were cost-avoided. This compares to 103 providers pended and payments in the amount of $7.7 million cost-avoided in FY 2003-04.

Providers may be terminated from the Medicaid program in accordance with the provisions of Florida law or the provisions of the Medicaid provider agreement. It is expected when a provider who is suspected of abusive billing is terminated from the Medicaid program, Medicaid expenditures will decline for the recipients served by the terminated provider. For a terminated provider, the savings are the difference in payments for the year prior to and following termination for services provided by the terminated and other like providers to all recipients served by the terminated provider. Because the analysis requires an evaluation of payments for one year following the termination, the savings as a result of termination during FY 2003-04 are reported for FY 2004-05. For FY 2004-05, these terminations saved Medicaid $14.7 million. There were 224 providers terminated from the program in FY 2004-05, a 700 percent increase since FY 2002-03, when 28 providers were terminated.

An example of a focused project is the Atypical Antipsychotic Drug Project, which took place in South Florida during the week of November 15 - 19, 2004. Ten MPI and Medicaid Fraud Control Unit (MFCU) teams visited pharmacies and prescribing physicians. The focus of the project was to evaluate the medical necessity of prescriptions for Zyprexa, Risperdol and Seroquel. It was anticipated this effort would materially reduce the prescribing and dispensing of these drugs within the Medicaid program. For this project, the savings are the difference in payments for this type drug for the periods six months prior to and six months following November 1, 2004, on behalf of all recipients who had received prescriptions for the drug from

one or more of 45 named physicians during the first six-month period and who maintained eligibility for all of both six-month periods. During FY 2004-05, this project cost-avoided $6.5 million for the Medicaid program.

Another instrument of prevention is the denial of reimbursement for prescription drugs prescribed by practitioners who were terminated from the Medicaid program based on legislation passed in 2004. This legislation authorizes the Agency to deny payments for goods or services caused to be furnished by a provider terminated or suspended from the Medicaid program. The Agency began implementing this provision in January 2005. It is believed the denial of these payments would significantly reduce the abusive prescribing and dispensing of Medicaid goods and services. For this prescribing rights action, the savings are the difference between payments for prescription drugs for the six-month periods prior to and following January 1, 2005, on behalf of all recipients who had received drugs prescribed by one of the terminated prescribers and who had maintained eligibility for all of both six-month periods. During FY 2004-05, 124 providers were the subjects of this action, which resulted in cost avoidance for the Medicaid program in the amount of $1.3 million.

It should also be noted referrals to outside agencies and other AHCA bureaus can lead to the loss of the provider's license and/or convictions. While the value of these activities can't readily be quantified into cost-savings realized due to the referrals, we know increasing these activities increases the Agency's prevention efforts. The number of referrals to MFCU has increased from less than 100 per year for each of the fiscal years 2000-01 through 2003-04, to nearly 200 in the most recent FY 2004-05. Additionally, last year, the Agency made 138 referrals to the Department of Health and 72 to other entities for a total of more than 400 referrals.

Performance Measurements

In the past, OPPAGA has suggested, and we have agreed, the Agency needs benchmarks to facilitate the assessment of effective MPI operations. In your November 2004 Progress Report No. 04-77, for example, you indicated MPI should develop outcome measures and targets to supplement information required by the Legislature. We have had overall measures for some years, including return on investment, overpayments identified, and funds recovered, and have recently added the monitoring of the proportion of funds identified for recovery that is actually subsequently recovered.

In your March 2006 Biennial Report, you acknowledged the Agency had included in its annual report to the Legislature the return on investment ratios for both overpayments recovered and overpayments prevented. However, it should be acknowledged in addition to the efforts previously mentioned, there are other Agency-wide efforts taking place which impact the total return on investment, but are not as quantifiable.

In reference to your recommendation the Agency report on the percentage of identified overpayments which are ultimately collected, we plan to do so in our next annual report. Even though we expect our collection percentage for FY 2004-05 to be higher than the two previous fiscal years, this is just another example of the problems associated with a "pay and chase"

system. I have always felt the system we have of paying first and asking questions later will continue to be a challenge until we transform Medicaid completely. The "pay and chase" methodology results in a system which, by design, is imperfect, and without prevention activities, cannot possibly recover nearly what the taxpayers should demand. Because of mechanisms recently provided by the Legislature, the Agency has adopted a much more aggressive approach to fraud and abuse. This also includes activities designed to warn fraudulent providers the Agency is poised to take swift and serious actions against those who defraud the program.

In addition, the Agency is monitoring measures pertaining to individual case management units in MPI. We have established process measures for many of the activities in detection and investigation, including the time it should take to complete major steps in carrying out detection and investigation work. We are routinely reporting and assessing information such as files open for more than 90 days without disposition, files with no activity in the last 30 and 60 days, cases in the Preliminary Audit Report (PAR) stage for more than 90 days, cases in the Final Audit Report (FAR) stage for more than 45 days, cases with no activity in the last 60 and 90 days, and other similar indicators. We are monitoring the age of cases and have reduced the average case investigation time 36 percent between FY 2003-04 and FY 2004-05. In addition, we are tracking the number of cases with no findings and have noted a 37 percent decrease during the same time period.

We are continuing to refine and supplement our operating indicators and outcome measures. We plan to expand our reporting of these types of trends in future annual reports.

Detection Methods

You further indicated in your November 2004 Progress Report No. 04-77, the Agency had not focused our detection methods in order to best identify provider overpayments. Your report mentioned it was important AHCA target its program integrity resources on activities and cases which identify the largest overpayments and potential for recovery. Your also stated in your March 2006 Biennal Report, AHCA should evaluate its traditional methods for identifying overpayments and create a sustainable advanced detection system to identify potential overpayments. We believe we have made progress in evaluating our detection methods. We have supplied your office with descriptions of our detection methods, including the chi-square statistical method for detecting upcoding and the early warning system for early and timely alerts to rapidly increasing provider billings. These detection methods are highly sophisticated. Both were developed by MPI without outside assistance and they demonstrate MPI's commitment to innovative and advanced technology. Additionally, we have significantly improved, and are implementing, new and revised detection methods such as OmniAlert and HealthSPOTLIGHT, which were also described in the paper which was previously furnished to your staff on detection methods. We have established as a priority for the current fiscal year the continued development of accurate measures of the effectiveness of our detection tools. The first step is to ensure our staff are properly trained and efficiently utilizing these tools.

We have completed the preliminary evaluation of each of our detection tools and have identified those provider types for which each tool is believed to be best suited. We continue to work with

the developers of our tools to ensure appropriate enhancements are developed and implemented, the capabilities of the tools are maximized, and MPI is properly utilizing each tool. We have correlated each of our detection tools with provider types and assigned those provider types with detection tools to specific organizational units within MPI. We also continue to train the staff members responsible for utilizing each tool to maximize efficiency and productivity.

We will continue to explore and develop sustainable advanced detection methods. When economically feasible, we will contract for outside assistance in our efforts to have the most sophisticated detection methods possible. However, in order to continue to increase our detection, prevention and recovery efforts, staffing resources will have to continue to be evaluated and increased as necessary to continue with efficient investigative management.

Sanction Rule

With regard to administrative sanctions, your November 2004 Progress Report No. 04-77, pointed out the fact the Agency had been slow to change sanctioning practices. With the cooperation of Agency management, we have made great strides in adopting an administrative sanction (Rule 59G-9.070, Florida Administrative Code) which became final in April 2005. During May 2005, Florida health care associations were notified of the final adoption of the rule and MPI training was developed for staff and management implementation. During June 2005, MPI staff and management were provided comprehensive training on the use of the sanction rule.

On July 1, 2005, the sanction rule was implemented. All Final Audit Reports (FAR) issued after July 1, 2005, have included a sanction. To ensure accuracy and consistency in the implementation of the rule, the MPI management team met twice a week to discuss all proposed FARs and the sanctions to be imposed. It is anticipated in the future all appropriate sanctions will be utilized to further ensure the integrity of the Medicaid program.

We appreciate your acknowledgement of our efforts in the March 2006 Biennial Report. In reference to your recommendation concerning setting fines based on a percentage of a provider's identified overpayment, we will consider the implications this will have on our efforts to deter fraud and abuse within the Medicaid program. If deemed appropriate, we will make adjustments to our current sanctioning rules to incorporate this recommendation.

Managed Care

In response to expanding our oversight of Medicaid managed care plans, Medicaid Program Integrity has initiated steps to enhance communication between MPI and Medicaid managed care organizations (MCOs). We have met with officials from several of the MCOs to gain a better understanding of their organizations and how they prevent and detect fraud and abuse. We have initiated communications specifically directed toward increasing and improving the referrals the Agency receives from MCOs regarding suspected fraud and abuse. We are also

working with the MCOs toward greater sharing of analytical findings and of information concerning actions taken respecting abusive providers.

Additionally, MPI continues to work with the Agency's Division of Medicaid and Division of Health Quality Assurance to enhance our contract language pertaining to preventing, detecting and reporting fraud and abuse. AHCA also initiated discussions with the Florida Association of Health Plans and MFCU to coordinate a joint effort with managed health care plan professionals to combat fraud and abuse. Representatives of AHCA, MFCU, and the MCOs met in September 2005 to begin discussions. Subsequently, workgroups have been formed to discuss fraud and abuse schemes, to develop best practice models and augmented fraud detection measures, to plan for future data needs and to identify areas in which legislation is needed.

We are committed to ensuring fraud, abuse, and overbilling are controlled in the managed care system.

In Conclusion

As noted above, we are cognizant of the challenges to be faced. The Medicaid program is, as you are aware, moving towards primarily managed care for our more than two million recipients. In a managed care environment, fraud and abuse will not vanish, but will be different in many respects. We must prepare for that and are beginning to do so. Our fraud and abuse efforts will continue to transition as the Medicaid program transitions.

With the assistance of OPPAGA, we feel we have made significant progress to date. We have (1) continued to increase our return on investment, (2) implemented an administrative rule to ensure consistent and fair application of sanctions, (3) begun the development of a means for evaluating the effectiveness of our detection methods, (4) established bureau benchmarks to assist our management team in identifying priority items as well as in evaluating our progress in investigatory improvements, and (5) started to report trends relating to our performance outcomes.

We appreciate your advice and guidance and look forward to continuing to work with you. If you have any questions or comments regarding our response, please call Jim Boyd, Inspector General, at (850) 921-4897.

Sincerely,

Alan Levine
Secretary

AL/mb

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