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## AHCA Making Progress But Stronger Detection, Sanctions, and Managed Care Oversight Needed

### *at a glance*

Since our 2006 review, AHCA has taken steps we recommended to improve performance reporting and to strengthen its ability to safeguard the state against provider waste, abuse, and fraud in the Medicaid program. However, AHCA has not implemented our recommendations to develop a sustainable advanced detection system using artificial intelligence and to strengthen its sanctioning process by establishing fines that represent a minimum percentage of identified overpayments. While AHCA has strengthened its oversight of Medicaid managed care organizations, more steps are needed to deter and detect corporate level abusive and fraudulent practices.

### Scope

Chapter 2004-344, *Laws of Florida*, requires 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 second biennial report assesses AHCA's performance and updates AHCA's progress in addressing issues raised in prior OPPAGA reports.<sup>1</sup>

<sup>1</sup> *Enhanced Detection and Stronger Use of Sanctions Could Improve AHCA's Ability to Detect and Deter Overpayments to Providers*, [Report No. 06-23](#), March 2006; *AHCA Takes Steps to Improve Medicaid Program Integrity, But Further Actions Are Needed*, [Report No. 04-77](#), November 2004 and *Medicaid Program Integrity Efforts Recover Minimal Dollars, Sanctions Rarely Imposed, Stronger Accountability Needed*, [Report No. 01-39](#), September 2001.

### Background

Florida's Medicaid program, administered by the Agency for Health Care Administration (AHCA), is among the largest in the country, serving around 2.1 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 2007-08, the Legislature appropriated \$16.2 billion to operate the Medicaid program. Of this amount, \$4.8 billion is general revenue; the other \$ 11.4 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 health care programs, Medicaid is vulnerable to abusive and fraudulent practices, which can take on many forms.<sup>2</sup> For example, while some providers may overbill Medicaid because of error, others may bill for health care services that are not medically necessary, for expensive procedures when less costly alternatives are available, or for services that were never delivered. Providers may also

<sup>2</sup> Abuse refers to provider practices that are inconsistent with generally accepted business and/or medical practices that result in unnecessary cost to the Medicaid program, or reimbursement for goods and 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.

operate sophisticated fraud schemes in which they pay kickbacks to other providers for client referrals, or operate “hit and run” schemes in which they are paid for a large volume of false claims and then close their business before they are identified by fraud detection methods. Estimates of Medicaid waste, abuse, and fraud range from 5% to 20% of total Medicaid funds, depending on the type of service and geographic area.

In addition, fraud or abuse can occur at the corporate level of a managed care organization. Corporate fraud occurs when funds are diverted away from health care services to increase profits to corporate officers and shareholders. For example, managed care plans may withhold or delay payments to providers, pay excessive salaries or administrative fees, engage in practices to exclude enrolling sicker beneficiaries, deny medically necessary treatment, or falsify provider networks.

To receive federal Medicaid funds, Florida must 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 Medicaid Program Integrity is primarily responsible for these functions. The office has traditionally focused its efforts on detecting and deterring waste, abuse, and fraud of providers paid on a fee-for-service basis. More recently, the office has also taken steps to detect and deter abusive and fraudulent practices in managed care organizations. For Fiscal Year 2007-08, AHCA allotted \$8,685,374 for program integrity functions, including 96 full-time equivalent positions.<sup>3</sup>

## Findings

Since our 2006 review, AHCA has taken steps to improve performance reporting and to strengthen its ability to safeguard the state against provider waste, abuse, and fraud in the Medicaid program.<sup>4</sup> However, AHCA has

not implemented our recommendations to develop a sustainable advanced detection system using artificial intelligence or to strengthen its sanctioning process by establishing fines that represent a minimum percentage of identified overpayments. While AHCA has strengthened its oversight of managed care organizations, it needs to take more steps to deter and detect corporate level abusive and fraudulent practices.

### ***AHCA has not developed a sustainable advanced detection system using artificial intelligence***

While artificial intelligence technology holds great promise in combating Medicaid fraud and abuse, AHCA has not yet developed a system to use this advanced detection technology. Artificial intelligence systems are computer systems that examine Medicaid billings and identify suspicious claims. They are programmed to learn from normal billing activities and identify changing billing patterns. For example, these systems can identify a provider who has billed for podiatry services and suddenly begins submitting pediatric claims. These systems can also identify collusion within provider networks.

Our 2006 report noted that AHCA’s ability to use advanced detection methods such as artificial intelligence had been constrained by changes in its vendors. Between 2001 and 2006, AHCA contracted with two vendors to provide advanced detection services. In 2001, AHCA entered into a three-year contract with Transaction Review and Audit Processing Systems, Inc., to develop an advanced detection system using complex algorithms and neural networking technology (a form of artificial intelligence). AHCA ended its contract with this provider in December 2004 and in 2005 began using HealthSPOTLIGHT, proprietary software owned by Affiliated Computer Services, Medicaid’s fiscal agent. While HealthSPOTLIGHT is an advanced detection system, it does not use artificial intelligence

<sup>3</sup> The Office of Medicaid Program Integrity is funded through state and federal revenues; the federal match for these functions is 50%.

<sup>4</sup> AHCA now includes in its annual report to the Legislature trend information on key statistics such as the number of referrals to the Medicaid Fraud Control Unit, the disposition of closed cases,

and the average number of days until closed cases are paid in full. AHCA also now tracks costs and reports return on investment separately for prevention and recovery activities. In addition, AHCA has developed a strategic plan to better detect and control Medicaid fraud, abuse, and waste. (See Appendix A for information required by statute for Fiscal Years 2001-02 to 2006-07.)

technology. We recommended that AHCA develop a sustainable advanced detection system capable of identifying emerging patterns of fraud and abuse that other methods may miss. In 2007, AHCA applied for a federal grant to develop advanced detection techniques but did not receive the grant.

Two states with large Medicaid programs, Texas and California, use neural networking technology to identify complex patterns of Medicaid fraud and abuse and increase recoveries. Texas Medicaid has used neural networking algorithms as part of its Medicaid Fraud and Abuse Detection System since December 1997. These algorithms detect overpayments to medical practitioners (physicians, nurses, and chiropractors) and dentists. Texas is currently developing another algorithm to identify fraudulent billings from long-term care providers.<sup>5</sup> For Fiscal Years 2006 and 2007, Texas attributed \$859,902 in cash recoveries to neural networking.

California has recently begun using neural networking and is financing this effort through a cost-sharing agreement with its Medicaid fiscal agent.<sup>6</sup> The California Medicaid program requires its fiscal agent to apply advanced algorithms at no additional cost to the state. In return, California Medicaid shares 10% of the overpayments identified as a result of these techniques with the fiscal agent.<sup>7</sup> Florida should consider pursuing a similar arrangement with its new Medicaid fiscal agent, Electronic Data Systems.<sup>8</sup>

### ***AHCA has not strengthened its sanctioning process by setting minimum fines***

In July 2005, AHCA implemented a new sanctioning rule which establishes a process to

impose fines against providers that violate Medicaid laws and policies through actions such as overbilling.<sup>9</sup> (See Appendix B for a summary of AHCA's sanctioning guidelines.) Our 2006 review examined AHCA's use of fines and concluded that the fines being levied represented only a small percentage of provider overbillings, and thus were not high enough to deter providers from overbilling. We recommended that AHCA amend its sanctioning rule to set minimum fines based on a percentage of identified overpayments.

From Fiscal Year 2005-06 through Fiscal Year 2006-07, AHCA imposed sanctions on 749 (or 42%) of the 1,791 providers that were found to have overbilled Medicaid. AHCA did not sanction the other providers that overbilled Medicaid because the violation occurred prior to AHCA implementing the sanction rule, or the case was settled before AHCA issued a final sanctioning order or was part of the AHCA-initiated amnesty program.<sup>10</sup>

In addition to requiring providers to repay misspent monies, sanctions for violating Medicaid laws and policies can include a corrective action plan, a monetary fine or both. Corrective action plans may require providers that have violated Medicaid policy to write acknowledgement statements, participate in provider education, conduct self-audits, and/or develop comprehensive quality assurance programs. Monetary fines range from \$100 to \$5,000 per violation, with a maximum cap of \$20,000 for each investigation.<sup>11, 12</sup>

<sup>9</sup> AHCA repealed its previous sanctioning rule in December 1998. While it had statutory 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. AHCA subsequently developed a new rule to guide the sanctioning process.

<sup>10</sup> Section 409.913(25)(e), *F.S.*, authorizes AHCA to institute amnesty programs allowing Medicaid providers to voluntarily repay overpayments without being sanctioned. To date, AHCA has granted amnesty to 59 providers that self-initiated audits or participated in recovery efforts for overbillings that were due to changes in Medicaid policies.

<sup>11</sup> The sanction rule establishes criteria to distinguish violations and places limits on fines based on individual claim violations, patterns of claims, and for multiple claims identified during the course of an agency investigation.

<sup>12</sup> Per s. 409.913(23)(a), *F.S.*, AHCA can also recover investigative,

<sup>5</sup> Texas estimates that it cost \$225,000 to develop each neural networking model or algorithm. The operational costs associated with these models (once developed) are incorporated as part of the Texas Medicaid Fraud and Abuse Detection System.

<sup>6</sup> California began piloting the system in January 2007 but did not begin using the system until late 2007.

<sup>7</sup> Recovery information resulting from cases generated by California's neural networking system is not yet available.

<sup>8</sup> Electronic Data Systems (EDS) will become the Florida Medicaid fiscal agent on July 1, 2008. EDS is also the fiscal agent for California's Medicaid program, and thus has experience with neural networking.

As shown in Exhibit 1, the only sanction AHCA imposed against most (72%) providers that were found to have overbilled Medicaid during Fiscal Years 2005-07 was to require them to repay the overbilling and write a letter acknowledging their violation. It imposed fines for the remaining providers (28%). Thus, most providers who overbilled Medicaid were only required to repay monies received as a result of their overbilling and acknowledge their wrongdoing, which may not dissuade them from repeating these behaviors.

**Exhibit 1**  
**During Fiscal Years 2005-07, AHCA Sanctioned**  
**749 Providers That Overbilled the Medicaid Program**

Type of Sanction	Number of Providers	Percentage
Provider acknowledgement statement only	539	72.0%
Fine and Provider acknowledgement statement	173	23.1%
Fine and Provider education program	1	0.1%
Fine and Quality assurance program	1	0.1%
Fine only	35	4.7%
<b>Total</b>	<b>749</b>	<b>100.0%</b>

Source: OPPAGA analysis of Agency for Health Care Administration data.

While ACHA imposed fines against the remaining 28% of sanctioned providers that overbilled Medicaid, these fines were small relative to the identified overpayments. AHCA bases fines on the cause of a violation and the number of times the violation has occurred rather than the size of the overbilling. During Fiscal Years 2005-07, AHCA levied \$363,593 in fines against providers that overbilled Medicaid \$8.3 million, which represented 4.4% of the total overpayments.<sup>13</sup>

In addition to imposing sanctions, AHCA is required to report providers that are sanctioned for certain violations (those typically involving quality of care issues) to other state regulatory entities.<sup>14, 15</sup> AHCA staff told us they believe

legal, and expert witness costs.

<sup>13</sup> The actual overall percentage of fines relative to their overpayments for these providers may be less than 4.4%, as AHCA also sanctioned 52 of the providers for additional violations (such as withholding records or quality of care issues).

<sup>14</sup> Section 409.913(24), *F.S.*, requires AHCA to report providers who commit certain violations to other responsible regulatory state entities, including the Department of Health's Division of

that providers' fear of being reported to regulatory entities is a greater deterrent to overbilling than fining providers. However, in practice, AHCA rarely reports providers that have overbilled Medicaid. During Fiscal Years 2005-07, AHCA was only required to report 11% of providers that it sanctioned, as the majority of sanctions issued were for simple overbilling violations which are exempt from reporting requirements.

When fines are rarely applied and minimal, providers may consider having to repay funds to Medicaid simply as "the cost of doing business" and may not be dissuaded from repeating abusive behavior and poor billing habits. To provide a sufficient deterrent, we continue to recommend that AHCA set minimum fines based on identified overpayments. As we recommended in 2006, AHCA should amend its sanctioning rule to set minimum fines based on a percentage of the overpayment for each sanctioned violation. For example, AHCA could set fines as a minimum dollar amount or a percentage of the overpayment, whichever is greater. The Legislature could also consider giving AHCA statutory authority to levy fines similar to those assessed by the Arizona Medicaid program, which levies fines equal to twice the amount of the overpayment plus up to \$2,000 per incorrect claim submitted.

AHCA's ability to evaluate the effectiveness of its sanctioning process is limited by the information captured in its Fraud and Abuse Case Tracking System.<sup>16</sup> Currently, the only information maintained in the system's sanction reporting module relates to cases in which AHCA levied fines. This module does not maintain

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Medical Quality Assurance which is responsible for licensing and regulating practitioners for quality of care issues, and AHCA's Division of Health Quality Assurance which is responsible for licensing and regulating ambulatory, acute, and long-term healthcare facilities, and for regulating managed care organizations for quality of care.

<sup>15</sup> The types of violations required to be reported to the other state regulatory entities typically involve quality of care issues, such as failure to furnish medical records within established timeframes; furnishing or ordering goods or services that are inappropriate, unnecessary or excessive, of inferior quality, or that are harmful; submitting false or a pattern of erroneous Medicaid claims; and failure to demonstrate sufficient quantities of goods or sufficient time to support billings or claims.

<sup>16</sup> AHCA developed the Fraud and Abuse Case Tracking System in 2003 to track investigations from their preliminary stages through the legal process and through collections.

information related to corrective action plans or the number of prior agency actions against a provider. Maintaining this information would enable AHCA to better review cases to ensure that sanctions are applied consistently and fairly as well as to assess the effectiveness of its overall sanctioning procedures.

***AHCA has expanded its role in preventing fraud and abuse in the Medicaid managed care program but needs to take additional steps***

AHCA has taken steps to detect and deter provider fraud and abuse in Medicaid managed care organizations (MCOs).<sup>17</sup> It has strengthened managed care contracts by requiring MCOs to establish comprehensive anti-fraud and abuse prevention and detection components and to report suspicious provider activity. However, because fraud can occur at the corporate level, AHCA should develop ways to ensure that MCOs use capitated payments to provide medically necessary services and that medical loss ratios are reasonable.<sup>18</sup>

AHCA has strengthened the anti-fraud and abuse provisions in its contracts with Medicaid managed care organizations. As recommended in our 2006 review, AHCA has increased its oversight of Medicaid managed care organizations and now requires each Medicaid MCO to designate a compliance officer who has the training, experience, and authority to identify and control provider abuse and fraud. In addition, Medicaid MCOs are required to submit written anti-fraud and abuse policies to AHCA. These policies must describe how the Medicaid MCO will identify and mitigate suspicious provider activity, train employees about fraud detection, and report suspected

fraud and abuse to AHCA. In addition, Medicaid MCOs must report to AHCA information regarding their finances, provider networks, marketing strategies, beneficiary satisfaction survey results, and enrollment data. AHCA can apply penalties to Medicaid MCOs that fail to meet contract requirements, including monetary fines, a freeze on plan enrollment, and suspension of payments.

To monitor and assist managed care organizations in meeting these contract requirements, AHCA staff have conducted site visits at all 14 of the state's Medicaid HMOs and the seven PSNs participating in the Medicaid Reform pilot project to review their fraud and abuse units. These site visits, conducted from November 2006 to August 2007, involved interviews with each plan's compliance officer, reviews of anti-fraud policies, and assessments of how well plans had implemented contract requirements. AHCA found that Medicaid MCOs' implementation of anti-fraud and abuse requirements varied widely, ranging from meeting 17% to 93% of the relevant contract provisions. AHCA required the MCOs to develop corrective action plans to address identified deficiencies.<sup>19, 20</sup>

AHCA also has more diligently levied fines against Medicaid MCOs for contract violations such as not submitting required reports on time and engaging in inappropriate marketing practices. In Fiscal Year 2006-07, AHCA assessed fines totaling \$401,825 on 13 Medicaid HMOs. In addition, AHCA assessed \$10,000 fines on two PSNs.<sup>21</sup> This represents a four-fold increase in fines over Fiscal Year 2005-06 when AHCA fined nine Medicaid HMOs a total of \$98,000.

Although Medicaid HMOs have policies and procedures in place requiring that they notify AHCA of suspected fraud and abuse, few have reported suspicious providers.<sup>22</sup> In Fiscal Year

<sup>17</sup> Florida's Medicaid program has two primary types of managed care organizations, health maintenance organizations (HMOs) which are paid a per-member, per-month fee for each beneficiary, referred to as a capitated payment; and Provider Service Networks (PSNs) which are currently paid on a fee-for-service basis but under Medicaid Reform will be paid on a capitated basis after three years.

<sup>18</sup> Medical loss ratio (MLR) is defined as the percentage of a plan's capitated payment that pays for medical services, rather than administrative costs (overhead, salaries and employee benefits, advertising, profits, etc.). A low MLR can indicate that a plan is not using sufficient funds to provide medical services; a high MLR can indicate that a plan is financially unstable. The Florida Office of Insurance Regulation considers reasonable medical loss ratios for commercial HMOs to be from 0.80 to 0.90.

<sup>19</sup> Violations included incomplete protocols for detecting fraud and abuse, weak fraud reporting requirements to the agency, and fragmented responsibilities for conducting anti-fraud activities.

<sup>20</sup> As of December 31, 2007, 13 of the 14 HMOs and three of the seven Medicaid Reform PSNs had satisfactorily implemented the provisions of their fraud and abuse corrective action plans.

<sup>21</sup> These two PSNs are in the process of appealing the fines.

<sup>22</sup> At the September 2007 AHCA meeting with HMOs, plans stated that they fear lawsuits from providers whom they report to AHCA for suspicion of committing fraud or abuse. However,

2006-07, 5 of the 14 Medicaid HMOs reported a total of 13 instances of suspicious provider behavior. AHCA staff indicate that Medicaid HMOs are reluctant to report providers and would rather handle problem providers internally. However, to preserve the integrity of the Medicaid program, AHCA should ensure that managed care organizations report suspicious activity so that it can use this information to identify unscrupulous providers that also participate in fee-for-service Medicaid and other health care networks.

AHCA should expand its oversight of Medicaid managed care organizations by developing strategies to detect and deter corporate level fraud and abuse. In addition to detecting and deterring fraud and abuse committed by individual providers against managed care organizations, AHCA should expand its efforts to monitor for potentially abusive or fraudulent corporate practices. AHCA currently monitors Medicaid MCOs for marketing irregularities and has begun to assess the validity of plans' provider networks. However, AHCA should also develop procedures to monitor Medicaid MCOs to ensure that they provide high quality and medically necessary services to beneficiaries and that Medicaid managed care dollars are spent wisely.

Arizona and Tennessee, two states with large Medicaid managed care programs, have both experienced corporate-level fraud in which Medicaid HMOs received capitated payments but did not pay their providers. In 1982, when Arizona began its managed care program, the state lost \$22 million to this type of fraud. In the early 1990s Tennessee providers complained that Medicaid HMOs were not reimbursing providers for services. One of these providers, a hospital, sued the Medicaid HMO for \$40 million. In other instances, states have encountered corporate Medicaid fraud when the managed care plan showed a pattern of failing to provide necessary health care services. For example, in 2004, one of Arizona's Medicaid managed care plans was found to have routinely ignored phone calls from Medicaid beneficiaries

which resulted in a failure to provide needed services.<sup>23</sup>

Arizona now requires that its Medicaid HMOs meet a minimum medical loss ratio. Because this ratio reveals the proportion of a plan's capitated payment that is spent on health care services, it is a useful indicator of whether beneficiaries are being adequately served. Arizona annually rewards plans that demonstrate spending at least 85% of their capitated payments on services.<sup>24</sup> Both Arizona and Tennessee conduct studies to verify that their Medicaid HMOs' reported medical loss ratios correspond with the amount of services they provide to beneficiaries. During one review, Arizona discovered that a Medicaid HMO had inflated the value of the services it was delivering to beneficiaries.

Currently, AHCA requires Medicaid HMOs to report medical loss ratios but does not use the information to enforce minimum standards to ensure the delivery of medical care. AHCA should develop ways to compare managed care encounter data, once available, with managed care organizations' medical loss ratios to identify irregularities and to ensure appropriate care is being provided to beneficiaries.<sup>25</sup>

The Legislature could also consider directing AHCA to establish a minimum medical loss ratio for Medicaid HMOs. Minimum medical loss ratios are already in place for Medicaid managed care behavioral health service providers and for managed care organizations that contract with the Florida Healthy Kids Corporation.<sup>26, 27</sup>

<sup>23</sup> In response to recent concerns related to one of Florida's Medicaid HMOs, AHCA has initiated a review of Medicaid managed care contracting policies and procedures to identify weaknesses and opportunities for more accountability. AHCA anticipates completing the report by April 30, 2008.

<sup>24</sup> Funds to pay this bonus are withheld from the monthly capitated rate that plans receive. The annual bonus amounts to about 0.5% of the plans' annual premiums.

<sup>25</sup> Encounter data documents delivery of managed care services to beneficiaries.

<sup>26</sup> Section 409.912(4)(b), *F.S.*, requires a minimum medical loss ratio of 0.80 for capitated behavioral health care providers that contract with Medicaid.

<sup>27</sup> Section 624.91(5)(b)10, *F.S.*, establishes minimum medical loss ratio requirements of 0.85 for authorized insurers or any provider of health care services that contract with The Florida Healthy Kids Corporation.

plan representatives also acknowledged that they were unaware of any cases resulting from a provider suing a health plan for reporting them.



Plans that fail to meet these minimum medical loss ratios are required to reimburse Medicaid.<sup>28</sup>

## Recommendations

To improve AHCA's ability to prevent, detect, deter, and recover funds lost to fraud and abuse in Medicaid, OPPAGA recommends that the Legislature direct AHCA to implement the actions described below.

- Expand Florida's capabilities to detect Medicaid fraud, abuse, and overbillings by developing advanced detection models. Advanced detection systems such as those using artificial intelligence can identify fraud and abuse that other detection methods may miss. To help defray the costs, AHCA could consider a cost-sharing arrangement, similar to the one used by the California Medicaid program, which requires its Medicaid fiscal agent to develop neural networks at no additional cost to the state. In return, California Medicaid shares a portion of the overpayments recovered as a result of the neural networking technology. By doing this, Florida could increase overpayment recoveries and realize a greater overall return on investment.
- Establish minimum fine amounts based on the amount of a provider's overpayments. As we recommended in 2006, AHCA should amend its sanctioning rule to establish fines based on the higher of a minimum dollar amount or a set percentage of a provider's identified overpayment. Increasing these fines should serve to deter providers from overbilling. AHCA should also modify its Fraud and Abuse Case Tracking System to capture information on the type of sanction and the number of times that the provider has been sanctioned. This information is important to ensure that the agency applies sanctions fairly and to assess the effectiveness of sanctions on deterring repeat offenses.

- Expand oversight of Medicaid managed care organizations to detect and deter corporate fraud and abuse. To guard against excessive profits and ensure prudent use of state and federal dollars, AHCA should develop strategies for reviewing financial information, encounter data, and other operational data reported by managed care plans. The Legislature could also consider requiring that all Medicaid managed care plans achieve a minimum medical loss ratio such as 0.85, the ratio required by the Florida Healthy Kids Corporation. Further, similar to the Florida Healthy Kids Corporation, AHCA should consider requiring plans to repay the state when ratios fall below the established level. Alternatively, AHCA could consider rewarding managed care organizations that exceed the established minimum medical loss ratio.

## Agency Response

In accordance with the provision 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 in Appendix C.

<sup>28</sup> AHCA required a behavioral health plan to repay a total of \$5.2 million for the two year period encompassing Calendar Years 2004 and 2005 for not meeting its minimum MLR for behavioral health services. In addition, AHCA fined the plan \$115,800 for failure to comply with the behavioral health contract reporting requirements.

## Appendix A

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

The Florida Legislature requires AHCA to annually report specific information related to its efforts to prevent, detect, deter, and recover misspent Medicaid funds. Table A-1 details the information provided by AHCA's annual reports for Fiscal Years 2001-02 through 2006-07.

**Table A-1**  
**AHCA Has Reported on Most of the Program Integrity Information Required by State Law**

	Fiscal Year					
	2001-02 <sup>1</sup>	2002-03 <sup>2</sup>	2003-04 <sup>3</sup>	2004-05 <sup>4</sup>	2005-06 <sup>5</sup>	2006-07 <sup>6</sup>
Cases: Investigated	5,783	4,731	3,145	2,556	1,694	1,860
Cases: Opened New During Fiscal Year	2,598	1,516	658	1,497	612	1,406
Cases: Sources of Opened Cases (sources defined by agency)						
Medicaid Program Integrity	2,162	1,372	550	1,316	526	1,337
Other AHCA	42	120	44	12	14	18
Services (Health Systems Development)	285	0	0	77	0	0
Public	19	9	23	70	49	31
Other State Agencies	20	2	0	2	2	3
Federal Agencies	8	7	20	7	12	16
Law Enforcement	5	4	21	13	9	1
Other	57	2	0	0	0	0
Cases: Disposition of Closed Cases (disposition defined by agency)						
Total	3,087 <sup>7</sup>	2,270	1,953	1,459	1,228	1,018
No Finding of Overpayment	1,447	568	905	566	199	177
Provider Education Letter	263	99	104	44	27	30
Overpayment Identified	1,150	1,603	944	849	1002	811
Amount of Overpayments Alleged in Preliminary Action Letters	\$80,980,180	\$56,541,435	\$75,300,070	\$63,256,733	\$50,927,504	\$41,612,084
Amount of Overpayments Alleged in Final Action Letters	\$42,214,700	\$36,162,432	\$40,747,041	\$26,871,573	\$31,117,205	\$20,114,948
Reduction in Overpayments Negotiated in Settlement Agreements, etc.	Not Available	\$139,454	\$856,746	\$116,059	\$236,970	\$0
Amount of Final Agency Determinations of Overpayments <sup>8</sup>	Not Available	\$36,795,546	\$30,368,463	\$25,384,338	\$25,427,878	\$19,973,393
Amount of Overpayments Recovered	\$26,097,172	\$20,482,607	\$16,674,923	\$20,468,894	\$28,049,039	\$34,527,935
Average Time to Collect from Case Opened Until Paid in Full	Not Available	603 days	780 days	500 days	452 days	328 days
Amount of Cost of Investigations Recovered	Not Available	\$45,587	\$119,648	\$67,295	\$187,282	\$113,917
Number of Fines/Penalties Imposed <sup>11</sup>	0	0	3	1	153	222
Amount of Fines/Penalties Imposed	0	0	\$20,500	\$2,000	\$289,000	\$373,073
Amount Deducted in Federal Claiming Due to Overpayment	\$44,668,724	\$17,151,138	\$8,872,964	\$25,143,952	\$14,800,000	\$22,700,000
Amount Determined as Uncollectible	\$21,169,765	\$34,290,850	\$11,518,098	\$4,008,607	\$5,600,000	\$11,600,000
Portion of Uncollectible Amount Reclaimed by Federal Government	\$11,840,303	\$19,225,633	\$5,749,373	\$2,095,662	\$25,000	\$0
Number of Providers by Type Terminated Due to Fraud/Abuse	129	28	160	224	194	194



	Fiscal Year					
	2001-02 <sup>1</sup>	2002-03 <sup>2</sup>	2003-04 <sup>3</sup>	2004-05 <sup>4</sup>	2005-06 <sup>5</sup>	2006-07 <sup>6</sup>
Community Alcohol, Drug Abuse or Mental Health	2	0	0	0		0
Pharmacy	13	3	35	29	24	11
Physicians	63	15	74	114	85	60
Physician Assistants	1	0	3	0	2	0
Chiropractors	1	0	0	0	1	4
Podiatry Services	1	0	0	0	3	0
Nurses	1	0	2	0	1	0
Dental	27	2	4	5	1	2
Laboratory	5	3	3	0	1	1
Durable Medical Equipment and Home Health Care <sup>9</sup>	2	0	0	5	31	46
Home- and Community-Based Therapy	3	0	9	13	30	47
Durable Medical Equipment Suppliers	2	0	0	1	1	9
Public Health Provider	8	4	22	49	0	0
Assisted Living Care	0	1	0	0	0	0
Transportation	0	0	5	3	9	7
Other	0	0	0	2	0	0
All Costs Associated with Discovering, Prosecuting, and Recovering Overpayments:						
Total Reported Costs	\$8,944,480	\$11,907,940	\$9,143,570	\$9,851,188	\$10,754,917	\$9,956,835 <sup>10</sup>
Office of Medicaid Program Integrity	\$8,944,480	\$9,823,862	\$7,063,566	\$7,317,546	\$6,801,325	\$7,330,164
Office of General Council, Accounts Receivable, and Medicaid Contract Management	Not Available	\$1,220,525	\$1,302,924	\$1,477,310	\$2,698,901	\$1,378,926
Indirect Costs	Not Available	\$863,553	\$777,080	\$1,056,332	\$1,254,691	\$1,247,745
Number of Providers Prevented from Enrolling or Re-Enrolling Due to Documented Fraud/Abuse	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
Document Actions Taken to Prevent Overpayments	Annual Report	Annual Report	Annual Report	Annual Report	Annual Report	Annual Report
Recommended Changes to Prevent or Recover Overpayments	Annual Report	Annual Report	Annual Report	Annual Report	Annual Report	Annual Report

<sup>1</sup> *Fighting Medicaid Fraud and Abuse FY 2001-02*, Agency for Health Care Administration and Department of Legal Affairs, January 2003.

<sup>2</sup> *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.

<sup>3</sup> *Annual Report on the State's Efforts to Control Medicaid Fraud and Abuse FY 2003-2004*, Agency for Health Care Administration and Department of Legal Affairs, January 2005.

<sup>4</sup> *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.

<sup>5</sup> *Annual Report on the State's Efforts to Control Medicaid Fraud and Abuse FY 2005-2006*, Agency for Health Care Administration and Medicaid Fraud Control Unit Department of Legal Affairs, December 2006.

<sup>6</sup> *Annual Report on the State's Efforts to Control Medicaid Fraud and Abuse FY 2006-2007*, Agency for Health Care Administration and Medicaid Fraud Control Unit Department of Legal Affairs, December 2007.

<sup>7</sup> 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.

<sup>8</sup> 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.

<sup>9</sup> 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.

<sup>10</sup> Does not include \$1,184,627 for contractual services or \$489,088 for ACS support services.

<sup>11</sup> The number of sanctions imposed as reported in the annual report is based on cases in which fines were identified after the final agency report. However, the number identified in the text of this report is the number of cases with fines assessed in the fiscal year after the final order was issued.

## Appendix B

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

In July 2005, the Agency for Health Care Administration 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.<sup>29</sup> Based on our review, most providers (96%) were cited for the first of the general violations listed below, which typically include simple overbilling violations.

- Failing to comply with Medicaid rules or the provider agreement including adequate documentation of services provided.
- Failing to provide requested documents in a timely manner.
- 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 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. Based on our review, the majority of providers sanctioned with a corrective action plan (95%) were required to submit an acknowledgement statement, the first of the four listed below.

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

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<sup>29</sup> Providers that routinely reconcile their billing accounts and voluntarily return overpayments are not subject to sanctions for overpayments.

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. AHCA 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

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CHARLIE CRIST  
GOVERNOR

ANDREW C. AGWUNOBI, M.D.  
SECRETARY

February 12, 2008

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: *AHCA Making Progress But Stronger Detection, Sanctions, and Managed Care Oversight Needed*, February 2008

Dear Mr. VanLandingham:

Thank you for the opportunity to respond to the above referenced report. We appreciate your acknowledgement of our continued improvements as we work 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 March 2006, entitled "*Enhanced Detection and Stronger Use of Sanctions Could Improve AHCA's Ability to Detect and Deter Overpayments to Providers*," we documented some of the Agency for Health Care Administration's dealings with Medicaid fraud and abuse prior to 2006. We feel that it is important to discuss our recent accomplishments and to comment on your report recommendations.

### Detection Methods

We agree that enhanced detection methods are needed. Our previous efforts to obtain funding for an enhanced detection system have not been successful. Nevertheless, additional attempts to secure funding will be made. As well, we will continue to request funds from the Legislature to add positions in the Bureau of Medicaid Program Integrity (MPI) for both statisticians and computer programmers. This will add consistency in long-term data analysis and will meet the current demands required by the Medicaid Fraud Control Unit (MFCU) and AHCA for detecting fraud and abuse.



Mr. Gary VanLandingham  
February 12, 2008  
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#### **Sanction Rule**

We agree with this finding and, as reported, have begun imposing fines for providers who overbill Medicaid. For those who intentionally overbill, we continue to make every effort to remove the provider from the Medicaid program in addition to imposing fines. For the remainder of the overbillings deemed not intentional, we understand that these still represent a cost to the Agency in both personnel costs to identify and recoup the overbilling and interest lost on the improperly claimed Medicaid dollars. We submit however, that the revised sanction rule has only been in effect for a short period of time and additional time is needed to critique the effectiveness of the rule before making recommended amendments.

#### **Managed Care**

We agree with this finding and, at my direction, the Office of the Inspector General conducted a review of the Medicaid Reform Pilot project, which has been the template effort for potential statewide rollout of managed care. This review highlighted issues with the pilot program that bear directly on the State's ability to deter and detect fraud and abuse in the managed care arena. Subsequent to the report being issued, the Agency did not recommend expansion of the pilot this year.

An additional OIG/MPI effort currently underway involves reviewing the Agency's standard managed care contracts, policies and practices for potential fraud and abuse vulnerabilities. As part of this project we are examining how other states conduct program integrity functions with managed care organizations, giving particular focus to corporate level fraud and abuse. This effort is expected to assist MPI to better deal with fraud and abuse in a capitated environment. This effort is in addition to the managed care review the Division of Medicaid is conducting.

#### **In Conclusion**

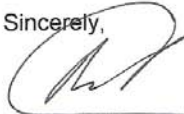
With OPPAGA's assistance, we have made significant improvements in the prevention, detection, and deterrence of Medicaid fraud and abuse. We have developed an agency-wide strategic plan to help the Bureau of Medicaid Program Integrity fight fraud and abuse. This strategic plan includes working closer with other state agencies such as the Department of Health, the Department of Children and Families, the Agency for Persons with Disabilities, and the Office of the Attorney General and promotes the sharing of information that could identify potential issues under the auspice of another agency. Strategic plan implementation has created a Policy Committee that has opened lines of communication between the Office of the Inspector General and the Division of Medicaid so policy solutions may be found that will reduce the possibility of fraud and abuse without any negative impact to the majority of quality providers involved in the Florida Medicaid program.

The Agency is participating in developing a fraud and abuse legislative package that is getting very positive consideration for the 2008 session and, if successful, will help manage the initial licensing of unscrupulous businesses and clarify language to strengthen the Agency's ability to collect Medicaid dollars paid for erroneous and/or fraudulent claims. The Office of the Inspector General has initiated more focused initiatives such as the Home Health initiatives and the Durable Medical Equipment initiative in collaboration with our external partners. Several more initiatives are planned for this fiscal year involving Hospice and Assisted Living Facilities.

Mr. Gary VanLandingham  
February 12, 2008  
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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 Linda Keen, Inspector General, at (850) 921-4897.

Sincerely,

A handwritten signature in black ink, appearing to read 'A. Agwunobi', with a large, stylized loop at the end.

Andrew C. Agwunobi, M.D.  
Secretary

ACA/mb





## *The Florida Legislature*

# *Office of Program Policy Analysis and Government Accountability*



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Gary R. VanLandingham, Ph.D., OPPAGA Director