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OFFICE OF PROGRAM POLICY ANALYSIS & GOVERNMENT ACCOUNTABILITY

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Enhanced Detection, Stronger Sanctions, Managed Care Fiscal Safeguards, and a Fraud and Abuse Strategic Plan Are Needed to Further Protect Medicaid Funds

at a glance

AHCA has taken steps to better safeguard Medicaid funds but has not implemented our prior recommendations to expand its use of advanced detection methodologies, increase fines on providers that overbill for services, and ensure that managed care plans provide needed services to Medicaid beneficiaries. We continue to believe these steps are necessary to improve AHCA's ability to safeguard Medicaid funds. AHCA recently established the Fraud Steering Committee to promote an agency-wide focus on safeguarding Medicaid funds and should direct this committee to develop a strategic plan to identify areas at high risk for fraud and abuse and develop interventions to reduce these risks.

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 report assesses AHCA's progress in addressing issues raised in prior OPPAGA reports and reviews how AHCA coordinates efforts across the agency to identify and prevent abusive and fraudulent activities.[1,2]

Background

Florida's Medicaid program, administered by the Agency for Health Care Administration (AHCA), is among the largest in the country, serving around 2.6 million persons each month. Medicaid provides health care coverage to persons who meet federal and state eligibility requirements, including low-income families, elders who need long-term care services, and persons with disabilities. For Fiscal Year 2009-10, the Legislature appropriated $18.2 billion to operate the Medicaid program. Of this amount, $2.7 billion is general revenue; the other $15.5 billion comes from trust funds that include federal matching funds and other state funds derived from drug rebates, hospital taxes, and county contributions.

[1] *AHCA Making Progress But Stronger Detection, Sanctions, and Managed Care Oversight Needed* OPPAGA Report No. 08-08, February 2008; *Enhanced Detection and Stronger Use of Sanctions Could Improve AHCA's Ability to Detect and Deter Overpayments to Providers*, OPPAGA Report No. 06-23, March 2006; *AHCA Takes Steps to Improve Medicaid Program Integrity, But Further Actions Are Needed,* OPPAGA Report No. 04-77, November 2004 and *Medicaid Program Integrity Efforts Recover Minimal Dollars, Sanctions Rarely Imposed, Stronger Accountability Needed*, OPPAGA Report No. 01-39, September 2001.

[2] Chapter 2002-400, *Laws of Florida* also required AHCA to annually report key statistics including the number of cases opened and investigated each year, the disposition of closed cases, and the average time (in days) to collect overpayments. See Appendix A for information required by law for Fiscal Years 2001-02 through 2008-09.

Like other health care programs, Medicaid is vulnerable to both abuse and fraud, which can take on many forms.[3] These include overbilling due to errors as well as deliberate efforts to bill for services that are not medically necessary or are never delivered. Providers may also illegally pay kickbacks for client referrals and operate 'hit and run' schemes in which they file a large volume of false claims and close their businesses after they are paid but before they are identified by fraud detection methods.

Fraud and abuse can occur at both the individual provider and the corporate levels. In corporate fraud cases, funds are diverted from health care services in order to increase profits. For example, managed care plans may withhold or delay payments to providers, pay excessive salaries or administrative fees, deny medically necessary treatment, or falsify provider networks.

Because of the complexity of Medicaid billing practices and the elusive nature of fraud and abuse, there is no firm estimate of the amount of funds lost to Medicaid due to waste, abuse, and fraud, although the amount can be considerable. However, some services and geographic areas are recognized as having a higher risk of fraud and abuse. For example, home health care services are considered to pose an increased risk of abusive billing practices, as these services are provided outside a structured medical facility. Miami-Dade County has been noted as a high-risk area for fraud and abuse by recent federal and state reports that have found disproportionate incidents of healthcare fraud compared to other parts of the country with similarly large populations of Medicare and Medicaid beneficiaries.

As a condition for receiving federal Medicaid funds, the federal government requires Florida to identify and investigate providers suspected of error and abuse and to refer providers suspected of fraud to the state's Medicaid Fraud Control Unit.[4] 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 ensure that managed care plans have systems in place to detect and deter abusive and fraudulent practices in their organizations. For Fiscal Year 2009-10, AHCA allotted $8,166,210 for program integrity functions, of which only $122,079 is from general revenue.[5] The program also has 100 full-time equivalent positions.

Over the past 10 years, the Legislature has made several changes to state law to curtail Medicaid fraud and abuse. These include requiring AHCA to increase efforts to ensure that only legitimate providers enroll in the program and giving the agency authority to review patient records, conduct prepayment reviews, and deny payments for prescriptions or services by non-Medicaid providers except in emergency or other limited circumstances. (See Appendix B for further information.)

Findings

Since our 2008 review, AHCA has taken some steps to better safeguard Medicaid funds. However, it has not implemented steps recommended by our prior reports to expand its use of advanced detection methodologies, increase fines by basing them on a percentage of provider overpayments, and ensure that managed care plans provide needed services to Medicaid beneficiaries. We continue to believe these steps are necessary to improve AHCA's ability to safeguard Medicaid funds while ensuring that beneficiaries receive needed services.

[3] 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.

[4] Located in the Office of the Attorney General, the Medicaid Fraud Control Unit is responsible for conducting fraud investigations and prosecuting providers who have defrauded Medicaid.

[5] The remainder of funds, $8,044,131, comes from the Medical Care Trust Fund, which includes funds recouped from past program integrity efforts and a 50% federal match for Office of Medicaid Program Integrity functions.

AHCA recently established the Fraud Steering Committee to promote an agency-wide focus on safeguarding Medicaid funds. The agency should direct this committee to develop a strategic plan to identify areas at high risk for fraud and abuse and develop interventions to reduce these risks.

While AHCA has strengthened its ability to safeguard Medicaid funds, it has not taken several recommended steps

Since our 2008 review, AHCA has taken steps to better safeguard Medicaid funds by amending its sanctioning guidelines and requiring managed care plans to report more information on their internal fraud and abuse investigations. However, AHCA has not taken other steps that we have recommended in our prior reports. Specifically, the agency has not implemented our recommendations to use advanced detection technologies such as neural networking to detect abusive patterns and potential fraud, to impose higher fines on providers with overpayments, and to develop ways to ensure that managed care plans appropriately use public funds. We continue to believe these steps are necessary to improve AHCA's ability to safeguard Medicaid funds while ensuring that beneficiaries receive needed services.

AHCA has not expanded its use of advanced technologies to detect funds lost to error, abuse, and fraud. As Medicaid billing is highly complex and services are delivered by a wide range of providers, it is important for AHCA to use an array of detection methods to identify billing errors, abuse, and potential fraud. AHCA uses several techniques, which include routine and ad hoc statistical analyses, to identify providers that have violated Medicaid payment policies while others try to identify providers with aberrant billing patterns when compared to peers.

However, AHCA has not implemented our recommendation to supplement these methods with advanced techniques that have been successfully used by other states. For example, California and Texas use neural networking, a form of artificial intelligence, to help detect potential fraud.[6] This technique and other predictive analytics learn from data and build models and complex computer algorithms that identify aberrations that may indicate new fraud or abuse schemes. AHCA formerly contracted with a company to conduct such analyses but discontinued this contract in 2004.[7] While AHCA's current fiscal agent provides some services to support program integrity efforts, it does not routinely conduct these types of complex analyses.

We continue to recommend that AHCA expand the types of detection tools it uses to include advanced technologies such as neural networking and other predictive analytics to analyze billing patterns and identity areas at risk of fraud. To do so, AHCA may need to contract with a vendor with specialized experience in mining Medicaid claims data and developing algorithms that detect anomalies not easily identified by more traditional techniques.

AHCA does not sanction most providers with identified overpayments, and it has not implemented our recommendation to increase fines for providers with overpayments. When AHCA identifies providers that have overbilled for services and the providers agree to repay the funds before the agency issues a final order, it typically does not sanction them. A final order describes the violation, the action taken, including repayment agreements, and grants an opportunity to appeal. As shown in Exhibit 1, the percentage of providers that AHCA has sanctioned has declined in recent years; AHCA sanctioned only 39% of providers with identified overpayments in Fiscal Year 2008-09 compared to 46% of such providers in Fiscal Year 2006-07.[8]

[6] Washington and Wisconsin have begun to develop advanced techniques that include neural networking to detect potential fraud.

[7] In 2001, AHCA entered into a three-year contract with a company 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 proprietary software owned by its Medicaid fiscal agent which used some advanced techniques but did not include artificial intelligence technology. In 2007, AHCA applied for a federal grant to develop advanced detection techniques but did not receive the grant.

[8] AHCA also does not sanction providers that overbilled Medicaid prior to implementing the sanction rule in July 2005 or providers that agree to repay overpayments that were discovered during an AHCA-initiated amnesty program.

Exhibit 1
AHCA Has Sanctioned a Lower Percentage of Providers With Overpayments Over Time

Case Resolution	Fiscal Year 2006-07		Fiscal Year 2007-08		Fiscal Year 2008-09	
	Providers	Percentage	Providers	Percentage	Providers	Percentage
No Sanction Applied	**438[1]**	**54.0%**	**431**	**54.5%**	**782[2]**	**60.7%**
Repay Prior to Final Order	247	30.5%	269	34.0%	750	58.2%
Self-Audit or Amnesty	103	12.7%	140	17.7%	26	2.0%
Audit Before Rule Implementation June 2005	88	10.9%	22	2.8%	6	0.5%
Sanction Applied	**372**	**45.9%**	**360**	**45.5%**	**505**	**39.2%**
Provider acknowledgement statement only	259	31.9%	151	19.1%	112	8.7%
Fines	113	13.9%	209	26.4%	393	30.5%

[1] Excludes one case that did not meet these categories; the final order indicated that no sanction would be applied.
[2] Excludes one case that the agency subsequently combined with another investigation.

Source: OPPAGA analysis of Agency for Health Care Administration data. Due to rounding, percentages may not total to 100%.

In addition, the fines that AHCA imposes represent a small percentage of the identified overpayments. During Fiscal Years 2006-07 through 2008-09, AHCA levied $776,822 in fines against 715 providers that had received $21.3 million in overpayments; these fines represented 3.6% of the overpayment amounts.

It is questionable whether these practices deter providers from overbilling. While it may be appropriate to waive fines for some providers that quickly repay funds billed in error, the agency applies this policy to providers with large overbillings as well as those with repeated violations. Imposing fines that represent only a small percentage of overbillings, particularly for repeat violations, weakens these penalties' deterrent value. Providers may consider these repayments as simply a cost of doing business and may not be dissuaded from repeating abusive behavior or continuing poor billing practices.[9]

AHCA amended its sanction rule in 2008 but did not address our prior recommendation to base fines on a percentage of providers' overpayments.[10] The rule provides that when imposing sanctions AHCA is to use a matrix which lists fines that may be levied for specified violations. We believe that when imposing fines, AHCA should consider the size of a provider's overpayment and impose either the fine listed in the matrix for the violation or a set percentage, such as 10% of the overpayment, whichever is higher. Instead, when AHCA considers the amount of a provider's overpayment in relation to the fine listed in the sanction matrix, it uses this information to lower the fines imposed on the providers. For example, the sanction rule provides that AHCA may lower the fine specified in the sanction matrix so that the fine will not exceed 30% of the provider's overpayment for a first agency action.[11]

We continue to recommend that AHCA amend its sanction rule to impose fines on providers with overpayments that are the higher of the fines listed in the sanction matrix for the violation or a set percentage of the provider's overpayment. AHCA also should modify its policy to ensure that it fines providers with large overpayments or that

[9] While the percentage of providers with overpayments that AHCA sanctioned has declined, it has increased the proportion of sanctioned providers who were fined rather than imposing an alternate disciplinary technique such as requiring the provider to write a letter acknowledging their violations. Of the 372 providers that were sanctioned in Fiscal Year 2006-07, AHCA only fined 31% compared to fining 78% of the 505 sanctioned providers in Fiscal Year 2008-09. Program integrity staff believe that a provider's failure to appeal a final order is an implicit acknowledgement of the violation and that an additional signed letter is not needed.

[10] Under the revised sanction rule, the agency increased some minimum monetary fines and increased the maximum cap for violations from $20,000 to $40,000; however, it did not revise its policy to lower a provider's fine when the fine amount exceeds a certain percentage of the provider's overpayment for certain violations.

[11] Further, the rule allows AHCA to make similar adjustments for subsequent agency actions against providers. Fines are not to exceed 50% of the overpayment for a second agency action and may not exceed 100% of the overpayment for providers with subsequent agency actions.

repeat violations even when they agree to repay funds prior to the agency issuing a final order.

AHCA has changed its managed care contracts to increase reporting on internal fraud and abuse investigations but needs to develop medical loss ratios to better monitor minimum standards of care. AHCA's new managed care contracts require plans to submit, beginning January 15, 2010, quarterly reports on their activities related to on-going and completed internal fraud and abuse investigations of their providers.[12,13] Program integrity staff expect to use these reports to ensure that plans are actively investigating fraud and abuse. Staff will provide technical assistance to plans that report few instances of potential provider abuse or fraud and can fine plans that do not comply with this reporting requirement.[14]

To increase the usefulness of reported information, AHCA should improve its case tracking system and take steps to better share investigation outcomes across plans.[15] Currently, the agency's case tracking system only can designate a single case identifier (either an individual provider or a managed care plan), which hinders staff's ability to track providers that may have overpayments in multiple plans.[16] Further, once plans report the outcomes of their provider investigations, AHCA should alert other plans that include these providers in their networks to determine if they have also overbilled those plans.

While increasing reporting requirements may improve AHCA's oversight of managed care plans' investigations of provider billing errors, abuse, and fraud, it needs to also develop medical loss ratio standards and use this information to enforce minimum standards for delivery of medical care. Medical loss ratios represent the percentage of funds spent on medical care compared to the percentage spent on other activities such as general administration, marketing, and profit. Although AHCA receives monthly revenue and expense (or medical loss ratio) reports from Medicaid managed care plans, it has not established mandatory medical loss ratio standards, which help ensure that Medicaid managed care plans provide a minimal level of services to their beneficiaries. Several other states, including Arizona, Tennessee, Texas, Washington, and Wisconsin, use minimum medical loss ratios in their quality assurance monitoring. These states' monitoring efforts can include verifying service expenditures and requiring plans to return revenues to the state when they do not meet loss ratio standards.[17] In addition, Florida requires minimum medical loss ratios for behavioral health care providers that contract with Medicaid and for managed care providers that contract with The Florida Healthy Kids Corporation.[18]

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[12] To address managed care plans' concerns about providing sensitive or confidential information, the agency has established a secure on-line reporting system for these quarterly reports.

[13] AHCA also requires managed care plans to report instances of suspected fraud and abuse within 15 calendar days to Medicaid Program Integrity. The number of referrals from managed care plans increased from 13 instances of suspicious provider behavior reported in Fiscal Year 2006-07 to 41 in Fiscal Year 2007-08 and 146 in Fiscal Year 2008-09.

[14] Plans must report specific case-level information such as provider identification, type of violation, estimated preliminary overpayment, and final overpayment.

[15] AHCA developed the Fraud and Abuse Case Tracking System (FACTS) in 2003 to track investigations from their preliminary stages through the legal process and through collections.

[16] In addition, some managed care plan providers are not enrolled in the Medicaid program and thus, do not have a Medicaid provider number, making it difficult to enter and track these providers in the agency's fraud and abuse data system. As we have recommended in previous OPPAGA reports, the agency must ensure that all managed care plan providers have a national provider identifier so that the agency has a unique identifier it can use to track all referred providers. See OPPAGA reports *Medicaid Reform: Legislature Should Delay Expansion Until More Information Is Available to Evaluate Success*, Report No. 09-29, June 2009 and *Medicaid Reform: Reform Provider Network Requirements Same as Traditional Medicaid; Improvements Needed to Ensure Beneficiaries Have Access to Specialty Providers*, Report No. 08 64, November 2008.

[17] Arizona and Tennessee review managed care plans' reported medical loss ratios to verify the amount of services provided to beneficiaries. One of Arizona's reviews discovered that one of its Medicaid managed care plans had inflated the value of the services it provided to beneficiaries. Texas has a tiered rebate schedule that requires managed care plans to return an increasing percentage of funds to the state when the pre-tax income exceeds revenues by more than 3%. For example, if pretax income is more than 3% but less than or equal to 7% of revenues, the managed care plan retains 75% of these funds and returns 25% to the state. If the plan's pretax income is more than 7% but less than or equal to 10% of revenues, the plan and state share these funds equally. However, if pretax income is more than 15% greater than revenues, the plan must return 100% of these funds to the state.

[18] 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. 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.

We continue to recommend that AHCA establish a minimum medical loss ratio for Medicaid managed care plans.[19] AHCA should review the financial information submitted by managed care plans to verify service expenditures and identify irregularities that may indicate health plans are not providing appropriate care to beneficiaries.[20]

AHCA has taken steps to better coordinate efforts to safeguard Medicaid funds and should develop a risk-based strategic plan

AHCA has taken steps to improve coordination between its internal units in its efforts to safeguard Medicaid funds. Staff in the agency's Program Integrity unit routinely meet with staff in the Medicaid units who oversee fee-for-service and managed care programs, as well as staff in the General Counsel's office. To promote coordination among these units, AHCA has a full-time Medicaid liaison that reports directly to the Medicaid director and facilitates communication between the offices and assists with identifying and implementing policy revisions. The liaison also focuses on preventing potential fraud and abuse by supporting efforts to enroll legitimate Medicaid providers and educating new providers on policies and procedures during the enrollment process.

AHCA also coordinates with the federal Centers for Medicare and Medicaid Services on investigative efforts and participates in discussions with other state's Medicaid program integrity offices to keep informed of best practices and national trends.[21] AHCA staff also meet with the Attorney General's Medicaid Fraud Control Unit as well as staff from other state agencies. (See Appendix C for a detailed description of these coordination activities.)

More recently, in July 2009, AHCA established the Fraud Steering Committee to increase agency-wide awareness and coordination of efforts to prevent, detect, and recover misspent funds. The Fraud Steering Committee, comprised of agency leadership, directs and oversees projects implemented by three subcommittees. The subcommittees include the Prevention Subcommittee that will address provider education and fiscal agent payment edits used to determine whether each claim meets the criteria for payment; the Detection Subcommittee that will focus on direct data mining, prepayment review practices, and provider termination; and the Recoupment Subcommittee that will explore methods of increasing recoupment efforts. The subcommittees include mid-level managers that supervise program staff specifically responsible for carrying out functions and activities throughout the agency. To date, the subcommittees have identified specific tasks related to assessing prevention, detection, and recovery efforts as well as focusing on tasks required by Ch. 2009-223, *Laws of Florida.*

To support these efforts, the Fraud Steering Committee should develop a strategic plan to identify areas at high risk for fraud and abuse and develop interventions to reduce these risks. A model for such planning is Texas' Medicaid integrity program, which periodically meets with state leaders inside and external to the agency to conduct a strategic risk assessment that identifies the areas of greatest financial risk. Texas staff use this information to develop a strategic risk reduction plan and prioritize resources to address the areas of highest risk.

Recommendations

To improve the state's ability to safeguard Medicaid funds, OPPAGA recommends that the Legislature direct AHCA to implement the actions described below.

- Expand detection tools to include neural networking or other advanced techniques capable of identifying emerging patterns of abuse and fraud. As OPPAGA previously recommended in 2006 and 2008, AHCA should expand the detection tools it uses to identify Medicaid fraud and abuse and adopt

[19] Florida's 2010 Legislature will be considering this requirement. Two bills (SB1002 and HB703) propose a medical loss ratio of 0.85 for Medicaid managed care plans.

[20] Verifying service expenditures will also require that plans submit encounter data to AHCA. As of January 2010, most managed care plans were submitting current encounter information to AHCA. The agency is working with managed care plans to ensure that the data are complete and accurate.

[21] Collaboration with the federal Centers for Medicare and Medicaid Services includes joint investigative efforts of providers that are suspected of Medicare and Medicaid fraud and abuse as well as working with the federal contractor that conducts Florida Medicaid investigations, which is required by federal law.

advanced methods capable of identifying patterns of abuse and fraud that other techniques can miss. Such predictive analytic tools, including neural networking, examine billing patterns and identify problems that may be otherwise missed given the complexity and extent of healthcare fraud.

- Strengthen the sanctioning process to increase fines for overbilling. As we recommended in 2006 and 2008, AHCA should amend its sanction rule to impose fines based on the higher of the amount designated in the sanction matrix for specified violations or a set percentage of providers' identified overpayments. AHCA also should modify its policy to ensure that it fines providers with large overpayments or repeat violations even when they agree to repay funds prior to the agency issuing a final order. Implementing these changes would better deter future overbillings.
- Increase fiscal oversight of managed care plans and establish a minimum medical loss ratio to ensure that beneficiaries receive needed services. As OPPAGA recommended in 2008, AHCA should develop minimum medical loss ratio requirements for Medicaid managed care plans, similar to Medicaid programs in other states, and use this information to verify the amount of services provided to beneficiaries. Such controls are particularly important as the state moves towards requiring more beneficiaries to enroll in managed care.
- Require AHCA to develop a risk-based fraud and abuse strategic plan to guide the efforts of its Fraud Steering Committee. To help ensure that the committee achieves its purpose, agency leadership should direct the committee to develop a strategic plan to guide its work. This plan should identify areas at high risk for fraud and abuse and identify strategies to reduce these risks. This process could also assist program integrity to direct its resources to these high-risk areas.

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 to review and respond. The Secretary's written response has been reproduced in Appendix D.

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 2008-09.

Table A-1
AHCA Has Reported the Program Integrity Information Required by State Law

	Fiscal Year							
	2001-02[1]	2002-03[2]	2003-04[3]	2004-05[4]	2005-06[5]	2006-07[6]	2007-08[7]	2008-09[8]
Cases: Investigated	5,783	4,731	3,145	2,556	1,694	1,860	2,402	2,619
Cases: Opened New During Fiscal Year	2,598	1,516	658	1,497	612	1,406	1,679	1,438
Cases: Sources of Opened Cases (sources defined by agency)								
Medicaid Program Integrity	2,162	1,372	550	1,316	526	1,337	1,520	1,203
Other AHCA	42	120	44	12	14	18	22	28
Services (Health Systems Development)	285	0	0	77	0	0	0	0
Public	19	9	23	70	49	31	110	139
Other State Agencies	20	2	0	2	2	3	7	10
Federal Agencies	8	7	20	7	12	16	18	41
Law Enforcement	5	4	21	13	9	1	2	11
Other	57	2	0	0	0	0	0	6
Cases: Disposition of Closed Cases (disposition defined by agency)								
Total	3,087[9]	2,270	1,953	1,459	1,228	1,018	1,126	1,614
No Finding of Overpayment	1,447	568	905	566	199	177	331	309
Provider Education Letter	263	99	104	44	27	30	4	17
Overpayment Identified	1,150	1,603	944	849	1,002	811	791	1,288
Amount of Overpayments Alleged in Preliminary Action Letters/Reports	$80,980,180	$56,541,435	$75,300,070	$63,256,733	$50,927,504	$41,612,084	$32,678,926	$25,019,516
Amount of Overpayments Alleged in Final Action Letters/Reports	$42,214,700	$36,162,432	$40,747,041	$26,871,573	$31,117,205	$20,114,948	$21,456,858	$14,872,291
Reduction in Overpayments Negotiated in Settlement Agreements, etc.	Not Available	$139,454	$856,746	$116,059	$236,970	$0	$0	$0
Amount of Final Agency Determinations of Overpayments[10]	Not Available	$36,795,546	$30,368,463	$25,384,338	$25,427,878	$19,973,393	$15,628,918	$15,625,438
Amount of Overpayments Recovered	$26,097,172	$20,482,607	$16,674,923	$20,468,894	$28,049,039	$34,527,935	$14,900,000	$15,400,000
Average Time to Collect from Case Opened Until Paid in Full	Not Available	603 days	780 days	500 days	452 days	328 days	328 days	311 days
Amount of Cost of Investigations Recovered	Not Available	$45,587	$119,648	$67,295	$187,282	$113,917	$72,156	$49,850
Number of Fines/Penalties Imposed[11]	0	0	3	1	153	222	155	501
Amount of Fines/Penalties Imposed	0	0	$20,500	$2,000	$289,000	$373,073	$150,000	$481,228
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	$19,300,000	$12,100,000
Amount Determined as Uncollectible	$21,169,765	$34,290,850	$11,518,098	$4,008,607	$5,600,000	$11,600,000	$5,500,000	$411,286
Portion of Uncollectible Amount Reclaimed from Federal Government	$11,840,303	$19,225,633	$5,749,373	$2,095,662	$25,000	$0	$0	$0

	Fiscal Year							
	2001-02[1]	2002-03[2]	2003-04[3]	2004-05[4]	2005-06[5]	2006-07[6]	2007-08[7]	2008-09[8]
Number of Providers by Type Terminated Due to Fraud/Abuse	129	28	160	224	194	194	59	78
Community Alcohol, Drug Abuse or Mental Health	2	0	0	0		0	0	0
Pharmacy	13	3	35	29	24	11	3	1
Physicians	63	15	74	114	85	60	4	15
Physician Assistants	1	0	3	0	2	0	0	0
Chiropractors	1	0	0	0	1	4	0	3
Podiatry Services	1	0	0	0	3	0	1	0
Nurses	1	0	2	0	1	0	0	0
Dental	27	2	4	5	1	2	1	1
Laboratory	5	3	3	0	1	1	0	0
Home Health Care	2	0	0	5	31	46	7	7
Home and Community-Based	3	0	9	13	30	47	27	42
Therapy	2	0	0	1	1	9	4	3
Durable Medical Equipment Suppliers/Medical Supplies	8	4	22	49	0	0	6	2
Public Health Provider	0	1	0	0	0	0	0	0
Assisted Living Care	0	0	5	3	9	7	4	4
Transportation	0	0	0	2	0	0	0	0
Other	0	0	3	3	5	7	2	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[12]	$12,420,695[13]	$15,105,407[14]
Office of Medicaid Program Integrity	$8,944,480	$9,823,862	$7,063,566	$7,317,546	$6,801,325	$7,330,164	$8,769,746	$7,661,020
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	$1,348,526	$1,391,711
Indirect Costs	Not Available	$863,553	$777,080	$1,056,332	$1,254,691	$1,247,745	$1,266,091	$1,296,339
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	115	104
Document Actions Taken to Prevent Overpayments	Annual Report	Annual Report	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	Annual Report	Annual Report

[1] *Fighting Medicaid Fraud and Abuse FY 2001-02,* Agency for Health Care Administration and Department of Legal Affairs, January 2003.
[2] *Annual Report on the State's Efforts to Control Medicaid Fraud and Abuse FY 2002-03,* Agency for Health Care Administration and Department of Legal Affairs, January 2004.
[3] *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.
[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] *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.
[6] *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.
[7] *Annual Report on the State's Efforts to Control Medicaid Fraud and Abuse FY 2007-08,* Agency for Health Care Administration and Medicaid Fraud Control Unit Department of Legal Affairs, December 2008.
[8] *Annual Report on the State's Efforts to Control Medicaid Fraud and Abuse FY 2008-09,* Agency for Health Care Administration and Medicaid Fraud Control Unit Department of Legal Affairs, December 2009.
[9] 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.
[10] 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.
[11] 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.
[12] Does not include $1,184,627 for contractual services or $489,088 for ACS support services.
[13] Includes $1,036,332 in Medicaid costs incurred for services related to MPI activities.
[14] Includes $4,756,337 in Medicaid costs incurred for services related to MPI activities.
Source: Agency for Health Care Administration's annual reports.

Appendix B

The Legislature Has Revised State Law Substantively to Support Efforts to Prevent, Detect, and Recover Misspent Medicaid Funds Since 2000

As shown below, the Florida Legislature has revised state law substantively since 2000 to increase efforts to prevent, deter, and recover Medicaid funds lost to fraud and abuse.

Table B-1
The Legislature Has Revised State Law Substantively Since 2000

State Law	Topic(s) Addressed
Chapter 2000-163, *Laws of Florida* (sections 6-9, and 16)	***Access to medical records; MFCU processes; Medicaid provider agreements.*** This law clarifies the confidentiality of patient records, waiving that protection when records are needed for purposes of an investigation conducted by the Medicaid Fraud Control Unit. It also makes changes related to surety bonds, allowing the agency to require a surety bond based on the amount of a provider's total Medicaid payments during the most recent calendar year or $50,000, whichever is greater. The surety bond may be based on expected billings for new providers. In addition, this law authorizes the agency to consider factors including the availability of services in a particular geographic area when deciding whether to enroll a provider.
Chapter 2000-256, *Laws of Florida* (section 53)	***Medicaid provider agreements***. This law establishes that the agency may require providers to post a surety bond prior to enrolling them as Medicaid providers.
Chapter 2001-377, *Laws of Florida* (sections 6 and 12)	***Provider agreements; payment withholds.*** This law addresses provider participation, including requiring providers to notify the agency of pending bankruptcies and allowing the agency to deny participation if additional providers are not needed. It also authorizes the agency to withhold provider payments even for providers that have requested administrative hearings and prescribes additional sanctions that may be imposed on providers.
Chapter 2002-400, *Laws of Florida* (sections 21 and 30)	***Provider enrollment, disincentives, investigations, and agency reporting.*** This law prescribes on-site inspections for provider enrollment, requires the agency to deny provider applications based on certain financial circumstances, requires imposition of sanctions or disincentives except in certain circumstances, expands circumstances where the agency can withhold payments or terminate a provider from the Medicaid program, and requires the agency and the Medicaid Fraud Control Unit to submit a joint annual report to the Legislature.
Chapter 2004-344, *Laws of Florida* (sections 4-7,10, and 32)	***Medicaid eligibility, provider network, provider payments, overpayments, and pharmacy audits.*** This law eliminates Medicaid eligibility for any person found to have committed fraud twice within five years and requires the agency to seek a federal waiver to terminate eligibility in certain circumstances. This law also allows the agency to limit the provider network using credentialing criteria, service need, past program integrity history, and compliance with billing and record keeping. Further, this law allows the agency to conduct prepayment reviews of providers for up to one year, deny payments for prescriptions or services by non-Medicaid providers except in emergency or other limited circumstances, and to develop an amnesty program to collect overpayments. In addition, this law directs the agency to use peer reviews to assess medical necessity, requires providers to acknowledge, in writing, their understanding of Medicaid laws and regulations, further clarifies the criteria the agency must use when auditing pharmacies, and eliminates a requirement to provide advance notification of an audit.
Chapter 2005-133, *Laws of Florida* (section 7)	***Provider audits; recipient explanation of benefits.*** This law stipulates at least 5% of all audits conducted to determine fraud, abuse, and overpayment must be conducted on a random basis. It also requires the agency to mail an explanation of benefits to each Medicaid recipient.
Chapter 2008-143, *Laws of Florida* (section 14)	***Explanation of benefits for laboratory services and school-based services.*** This law states that explanations of benefits may not be mailed for independent laboratory services or school-based Medicaid services.

State Law	Topic(s) Addressed
Chapter 2009-223, *Laws of Florida* (section 18)	***Overutilization detection; provider sanction and termination; reporting requirements; information technology.*** This law requires the agency to submit policy recommendations to the legislature with its annual report. It also requires the agency to indentify and monitor patterns of Medicaid services overutilization. This law extends the application of provider termination and administrative sanctions to applicable offenses carried out by any officer, principal, director, agent, managing employee, or person affiliated with the provider, or any shareholder with ownership interest equal to 5% or greater. It also requires the agency to report any imposed administrative sanction on a provider to any other state entity which regulates that provider within five business days. This law requires the agency to mail an explanation of benefits to each Medicaid recipient at least three times annually. This law also requires the agency to publish, on its website, and update monthly a searchable list of Medicaid providers who have been terminated or subjected to sanctions. In addition, it requires the agency to compile and update biannually a list of all state and federal databases containing health care fraud information. Furthermore, it directs the agency to develop a strategic plan to link all state databases containing health care fraud information, monitor innovations in health information technology pertaining to Medicaid fraud prevention and detection, and periodically publish policy briefs highlighting available new technology used by other states, the private sector, or the federal government.
Chapter 2009-55, *Laws of Florida* (sections 5, 21, and 22)	***Home health care services prior authorization and pilot projects.*** This law directs the agency to require prior authorization for skilled nursing visits when a home health agency's billing rates exceed the state average by 50% or more. It requires that all home health services be medically necessary and written on a prescription that is signed and dated by an ordering physician. It stipulates the ordering physician cannot be employed by the home health agency and must have examined the recipient within 30 days preceding the initial request for services and biannually thereafter. This law also directs the agency to develop and implement a home health agency monitoring pilot project in Miami-Dade County to verify the utilization and the delivery of home health services, provide an electronic billing interface for such services by January 1, 2010, and submit a report evaluating the pilot project by February 1, 2011. In addition, this law requires the agency to implement a comprehensive care management pilot project in Miami-Dade County for home health services by January 1, 2010 which includes face-to-face assessments by a state-licensed nurse, consultation with physicians ordering services to substantiate the medical necessity for services, and on-site or desk reviews of recipients' medical records.
Chapter 2009-193, *Laws of Florida* (sections 1, 4, and 5)	***Designation of Miami-Dade as a fraud crisis area; home health care licensure requirements.*** This law designates Miami-Dade County as a health care fraud crisis area. In addition, this law imposes additional licensure requirements for home health agencies, home medical equipment providers, and home health care clinics, including demonstration of financial ability to operate, submission of pro forma financial statements, submission of a statement of the applicant's estimated start-up costs and funding sources, and the filing of a surety bond of at least $500,000 payable to the agency. The law stipulates that any unlicensed person offering skilled services or any person knowingly filing a false or misleading licensure application commits a third degree felony. Furthermore, this law directs the agency not to issue new home health care licenses until July 1, 2010.

Source: OPPAGA Analysis of Florida Laws.

Appendix C

AHCA Program Integrity Staff Coordinate Efforts to Safeguard Medicaid Funds with Multiple Internal and External Stakeholders

To facilitate efforts to prevent funds lost to error, fraud, and abuse, AHCA program integrity staff coordinate with multiple internal and external stakeholders. (See Table C-1.)

Within the agency, program integrity staff routinely meet with Medicaid program staff responsible for overseeing the traditional fee-for-service program to discuss planned and completed audits. These meetings can involve discussions of policies that could affect the audit and discussions of potential policy changes based on audit findings. Program integrity staff also meet routinely with staff that oversee the Medicaid managed care plans to ensure that plans are complying with specific contract requirements such as reporting management changes, meeting behavioral health service level standards, implementing integrity efforts, and to discuss agency processes such as contract amendments and scheduled audits and reviews. Program integrity staff also meet with General Counsel staff for legal guidance and assistance on upcoming cases.

External to the agency, program integrity staff participate in periodic meetings with the Medicaid Fraud Control Unit, other state agencies, and the federal government. For example, Medicaid Program Integrity staff meet biweekly with Medicaid Fraud Control Unit staff to discuss specific cases, refer suspected fraud cases, and identify services or providers in targeted areas that are at high risk for fraud and warrant further exploration, analysis, or data mining. Program integrity staff meet with other state agencies' staff to ensure that they correctly apply policies and billing practices for the Medicaid programs that they implement. Staff also participate in monthly telephone conferences with program integrity staff from the three other large states (California, New York, and Texas) to share best practices and discuss detection and investigative strategies. In addition, staff participate in telephone conferences with federal contractors.[22]

[22] The federal government expects states to collaborate with several contractors. For example, one contractor matches Medicare and Medicaid claims to identify potential overpayments abuse, and fraud. Another contractor coordinated with the agency to investigate Medicaid error, abuse and fraud in Florida as part of Section 6034 of the Deficit Reduction Act of 2005. This act established the Medicaid Integrity Program in section 1936 of the Social Security Act (Public Law 109-171), which directs the federal government to hire contractors to conduct state Medicaid program integrity investigations. This effort requires extensive coordination and collaboration between the contractor, the federal government, and the state to ensure that the investigations do not duplicate current state efforts, the contractor is interpreting state policies correctly, and the state approves the findings since it must manage any litigation from the audits.

Table C-1
AHCA Staff Coordinate Efforts to Safeguard Medicaid Funds With Multiple Internal and External Stakeholders

Meeting	Frequency	Purpose	Lead	Participants
Internal Agency Coordination				
Fraud Steering Committee	Biweekly	Oversees agency projects intended to reduce the amount of funds lost through error and abuse. Created in July 2009.	Secretary	Agency leadership including Secretary, Chief of Staff, Inspector General, General Counsel, Health Quality Assurance, and Medicaid Operations
Prevention Subcommittee	Biweekly	Address provider education and fiscal agent payment edits used to determine whether each claim meets the criteria for payment.	Medicaid Director's Office	Medicaid Director's Office, Medicaid Services, Contract Management, Program Analysis and Field Office Management, Program Integrity, and General Counsel
Detection Subcommittee	Biweekly	Address data mining, prepayment review practices, and provider termination issues.	Medicaid Program Integrity	Chief of staff, Medicaid Services, Medicaid Contract Management, Program Analysis, and Program Integrity
Recoupment Subcommittee	Biweekly	Explore methods to increase recoupment of misspent funds.	General Counsel's Office	Medicaid Operations, General Counsel, Program Integrity, Health Quality Assurance, Medicaid director, Medicaid Services, Medicaid Program Analysis, and Medicaid Contract Management
Fiscal Agent Coordination	Weekly	Allow bureau chiefs and their key staff to work with contract management staff on issues related to the fiscal agent. Topics include updates on the need for changes, the status of prior change requests, as well as new issues or questions on functionality.	Medicaid Operations	Medicaid leadership and all bureaus, finance and accounting, internal audit, operations, and agency leadership
Legal Coordination	Biweekly	Discuss cases.	Medicaid Program Integrity brings issues for discussion	Program Integrity and Office of General Counsel
Third Party Liability	Biweekly	Discuss contractor progress on overpayment data matching projects that supplement third party liability efforts.	Medicaid Contracts	Program Integrity and Medicaid Contract Management
Termination Staffing	Biweekly or less often	Discuss recommendations to end contracts with certain providers. Sometimes decisions are handled by email or there are no providers to discuss.	Medicaid Program Integrity /Office of Inspector General	Program Integrity, General Counsel, Medicaid Fraud Control Unit, Inspector General, Medicaid Long-Term Care and Health Quality Assurance
Managed Care Plans	Monthly for each plan	Review plan compliance on 34 measures and discuss related agency issues. For example, discuss upcoming contract amendments, enrollment issues (plan reaching capacity) ownership or management changes, upcoming reviews or audits, trends in complaints, HIPPA or other security violations, etc. Future discussions will include fraud and abuse reporting as well as issues related to provider file and encounter data submission, HEDIS reporting, and pharmacy.	Bureau of Health Systems Development	Bureau of Managed Health Care, Health Systems Development, Behavioral Health and Program Integrity
Policy Clarification Meetings	As needed	Discuss specific billing policies to ensure that MPI understands rules and limits prior to conducting an audit.	Medicaid Program Integrity	Program Integrity and Medicaid Services

Meeting	Frequency	Purpose	Lead	Participants
External Agency Coordination				
Federal Audit Contractor	Weekly at start, then biweekly	Coordinate with federal contractor for Florida Medicaid investigations into potential error, waste, and abuse.	Centers for Medicaid and Medicare Services	Centers for Medicare and Medicaid, Federal Contractor, and Program Integrity
Medicaid Fraud Control Unit	Biweekly	Coordinate MFCU investigations of Medicaid providers, make and discuss referrals and data needs.	Medicaid Program Integrity /Office of Inspector General	Medicaid Program Integrity and Medicaid Fraud Control Unit
Medi-Medi	Biweekly	Coordinate investigations and plan new investigations that arise from combining Medicaid and Medicare data.	Centers for Medicaid and Medicare Services	Centers for Medicare and Medicaid, Federal Contractor, and Program Integrity
Fraud and Abuse Technical Advisory Group	Monthly	Facilitate discussion of emerging issues of potential threats to the Medicaid programs and identify state's training needs.	National Association of Medicaid Program Integrity	Centers for Medicare and Medicaid and Medicaid Program Integrity representatives from other states
Quad State Meeting	Monthly	Discuss best practices and discuss issues among the four largest states.	Medicaid Program Integrity/Office of Inspector General	Medicaid Program Integrity staff of California, Florida, New York, and Texas
Meet with staff of other agencies	As needed	Educate on correct billing practices or address concerns regarding provider practice. For example, educate Department of Elder Affairs staff on items frequently billed to waivers, at a higher rate, but which should be billed at a lower cost through the Medicaid state plan. Also, meet with Department of Health staff to improve ensure agencies effectively share information that could affect provider licenses or participation in Medicaid.	Medicaid Program Integrity	Medicaid Program Integrity and appropriate agency staff

Source: OPPAGA analysis of AHCA activities.

Appendix D

CHARLIE CRIST
GOVERNOR

Better Health Care for all Floridians

THOMAS W. ARNOLD
SECRETARY

March 17, 2010

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

Reference: OPPAGA Follow-up Report: *AHCA Making Progress But Stronger Detection, Sanctions, and Managed Care Oversight Needed,* March 2010

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. Our appreciation of OPPAGA staff members' thorough analysis continues as we work through the issues raised in this follow-up report.

In response to this review we feel that it is important to discuss our recent accomplishments as well as to comment on your specific recommendations.

Accomplishments in Combating Fraud and Abuse:

The Agency established a Fraud Steering Committee and identified multiple segments within the Agency that collectively address prevention, detection and recoupment in the fight against combating fraud, abuse and waste in the Medicaid program.

MPI partnered with APD, CMS, and DOH to conduct field initiatives on Home Health Agencies, Durable Medical Equipment providers, Assisted Living Facilities, and Diagnostic and Radiology providers in known areas of high Medicaid fraud and abuse.

The Agency expanded it use of Explanation of Medicaid Benefits to quarterly mail-outs to all FFS recipients that received services during the inquiry period.

MPI initiated the use of the DSS Profiler, an advanced powerful detection tool.

MPI initiated quarterly meetings with New York, California, and Texas to share emerging issues and detection methodologies.

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MPI staff worked with Agency staff to enhance oversight provisions in the contract with managed care organizations, established compliance criteria, and conducted compliance reviews of all managed care organizations.

All MPI performance indicators for FY 08-09 were up from the previous year. For example,

- In FY 08-09, prevention and recovery efforts yielded $82.6 million with an overall return on investment of 5.5 to 1 compared to FY 07-08 results of $50.4 million with an overall return on investment of 4.1 to 1.
- In FY 08-09, the overpayment collection rate for MPI cases was 81.4 percent, up from 78.6 percent the previous FY.
- The total cases closed by MPI in FY 08-09 were 1614 compared to the previous FY of 1126.
- The average time from open case to paid in full in FY 08-09 decreased by 17 days from the previous FY 07-08.
- In FY 08-09, MPI applied fines totaling $481,228. In FY 07-08 the fine total was $149,861.
- In FY 08-09, MPI made 560 referrals to other entities such as DOH, FDLE, Health Quality Assurance and MFCU. In FY 07-08, the referrals totaled 535.

Comments regarding specific recommendations:

Detection Tools - We concur that enhanced detection tools are desirable. We have learned from other states that the use of advanced detection tools such as neural networking still requires staff support to analyze and follow-up the leads provided by the software. We have met with vendors that are offering various services to ensure the integrity of Medicaid payments prior to and after the payments are made and are in the process of evaluating these potential solutions. A selection will be made based on the best proposed return on investment coupled with available funding. We will continue to explore and develop sustainable advanced detection tools and, where appropriate, to seek funding to not only provide for detection tool purchase, but staff to support successful implementation and utilization of advanced tools.

Sanctioning Process – The Agency is currently in the process of revising the Sanction Rule (Rule 59G-9.070, F.A.C.). Consideration will be given to your recommendations for significant increases in fine amounts and for possibly using a set percentage of providers' overpayments to calculate the fine. The Agency increased fines as part of the October 2008 rule amendment resulting in fine increases from $149,861 in FY 07-08 to $481,228 in FY 08-09. We are proposing additional increases with the current rule development.

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Managed Care – Following up on the October 2009 report from the statutorily required Medicaid Managed Care Reimbursement Workgroup, the Medicaid program worked with its two contracted actuaries to develop financial reporting templates and instructions to be used by managed care entities to report to the Agency financial details regarding the plans' business activities in Florida. The financial data will be reported by area of the state, and by book of business (Medicaid pilot separate from non-pilot details). The draft templates were shared with plans and the Florida Association of Health Plans in January. Their input was incorporated and two conference calls/meetings were held with plans to further vet any questions or concerns they had. Final templates and instructions were sent to plans in early March, with an April 1, 2010, reporting deadline. Once the financial data is submitted to the Agency by the plans, the Agency will then share the data with the Agency contracted actuaries, who will assess the data and make a recommendation to the Agency as to whether to include the financial data as part of the data base for September 1, 2010, rate setting for managed care plans. The plan financial data can also be used for contract compliance management purposes, validation of plan encounter data, and for purposes related to fraud and abuse reviews.

Relevant to the medical loss ratio issue is a description of additional Agency action taken to prevent improper use of funds. The decision was made to audit HMO & Pre-Paid Mental Health Plans to determine whether the plans met the 80 percent fund expenditure requirement on approved and specified services. The 2006 calendar year was the year selected for review. For 2006, there were 13 HMOs and 2 Pre-Paid Plans covering four areas. Eight HMOs with expenditures greater than $1 million were selected. Four areas with Pre-Paid plans with expenditures greater than $1 million were also selected. Three of the four areas with Pre-Paid plans are under one Pre-Paid plan. The Agency did not include any of the HMOs related to Well Care for this project.

The Agency contracted with Buttner Hammock & Company to perform the audits. The selected entities were notified by the Agency of the audit and the company selected to perform the fieldwork. The HMOs submit a Financial Worksheet to the Agency noting the revenues and expenditures related to the Behavioral Mental Health Expenditures and whether a refund is necessary. Refunds are submitted along with the Financial Worksheets. The Pre-Paid Plans also file a similar report with the Agency noting the revenues and expenditures related to the program. The Agency provided the audit firm with these reports as the basis for the audits.

Prior to the completion of fieldwork, two HMOs refunded $157,573 and $373,815 to the Agency. These amounts were not included in the final estimated return. The Agency has issued the eight (8) HMO reports with estimated total overpayment of $2,930,642. The Agency has collected $2,214,188 from three (3) of the HMOs and one of these HMOs has also agreed to restate their 2007 Financial Worksheet. Three of the HMOs have appealed their audits.

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Audits of the four Pre-Paid Mental Health Plans are not ready for issuance. Issues have evolved regarding the internal pricing for encounters reported to the Agency. The Agency is working to resolve these issues in order to complete the audits. The estimated return to the Agency is dependent on the method used for the encounter valuation.

The establishment/requirement of medical loss ratios is a policy and contractual issue, or could be legislatively mandated. As footnoted in your report, legislative bills proposed to date in the current session contain language requiring implementation of your recommendation (SB1002 and HB703). Should a specific medical loss ratio be legislated, the Agency would use a medical loss ratio requirement as an additional tool to assist in assessing service provision to Medicaid beneficiaries. Also, given appropriate resources, medical loss ratio reporting would be used as an additional audit tool for detection of fraudulent or abusive practices such as underutilization or other corporate level fraud schemes.

Strategic Plan - We concur with your finding. The Office of the Inspector General drafted a strategic plan in 2008. We have used this plan to guide MPI's activities over the last two years. Although a formal risk assessment was not included in the strategic plan, the risk of fraud, waste and abuse in the Medicaid program was considered throughout its development. Additionally, the Fraud Steering Committee was established as an Agency-wide tool to efficiently and cohesively combat fraud and abuse. The creation of focused sub-committees provides the basis for developing a strategic plan that identifies areas at high risk and formalizes strategies to reduce those risks. MPI will focus on the areas of highest risk to ensure the efficient and effective use of available resources.

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 Peter Williams, Inspector General, at 412-3990.

Sincerely,

Thomas W. Arnold
Secretary

TWA/mb/cls

The Florida Legislature

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