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Agency for Health Care Administration Continues Efforts to Control Medicaid Fraud and Abuse

at a glance

The Agency for Health Care Administration continues to coordinate efforts to prevent and detect fraud and abuse in its Medicaid fee-for-service and managed care programs. It oversees fraud and abuse prevention and detection in Medicaid managed care by requiring plans to perform specific fraud and abuse activities and by monitoring to ensure that plans comply with these requirements. For fee-for-service, the agency follows a systematic process to identify and investigate providers who are suspected of overbilling.

The agency has reduced the time it takes to recover overpayments from providers and has increased the fines and penalties imposed for provider overbilling.

Scope

Section 409.913(35), *Florida Statutes,* 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.[1] In addition, Ch. 2010-144, s. 13, *Laws of Florida*, directs the Auditor General and OPPAGA to review and evaluate specific aspects of AHCA's Medicaid fraud and abuse prevention and detection systems. The Auditor General's review focuses on AHCA's data system that processes Medicaid bills to identify improper payments; OPPAGA's review focuses on fraud and abuse in Medicaid managed care.[2]

This report assesses AHCA's efforts to prevent, detect, and recover overpayments from fee-for-service providers as well as oversee and assist managed care plans' efforts to identify and prevent abusive and fraudulent activities.[3]

Background

Florida's Medicaid Program, administered by AHCA, is among the largest in the country, serving over three million persons each month. Medicaid provides health care coverage to persons who meet federal and state eligibility

[1] Prior OPPAGA reports released on Medicaid program integrity efforts include: *Enhanced Detection, Stronger Sanctions, Managed Care Fiscal Safeguards, and a Fraud and Abuse Strategic Plan Are Needed to Further Protect Medicaid Funds*, OPPAGA Report No. 10-32, March 2010; *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] The Auditor General evaluated Medicaid fraud and abuse detection processes, databases, and internal controls. See reports *Agency for Health Care Administration, FMMIS Controls and the Prevention of Improper Medicaid Payments*, Auditor General Report 2012-021 and *Agency for Health Care Administration, Medicaid Program Fraud Prevention and Detection Policies and Procedures Facility Costs Report*, Auditor General Report 2012-035.

[3] As part of this review, OPPAGA interviewed officials from states with the largest Medicaid population expenditures and states with the largest proportion in managed care.

requirements, including low-income families, elders who need long-term care services, and persons with disabilities.

Patients obtain Medicaid medical services in two primary ways: fee-for-service and managed care. Fee-for-service patients seek services from Medicaid providers and Medicaid pays for each specific service rendered. Managed care patients participate in a plan, like an HMO, in which Medicaid pays the plan a contracted amount per person for health services, and plan medical staff work to ensure that patients get appropriate care without unnecessary costs.

As of November 2011, 44.1% of Florida's Medicaid population was served through managed care. Chapter 2011-134, *Laws of Florida*, directs AHCA to expand enrollment in managed care starting in January 2013 by requiring all Medicaid recipients, who are not otherwise exempt, to enroll in a managed care plan.[4, 5] The law directs AHCA to fully implement managed care statewide by October 2014.

Like all health care programs, Medicaid is vulnerable to payment error, abuse, and fraud, which can take many forms.[6] In fee-for-service, these include overbilling errors as well as deliberate efforts to bill for services that are not medically necessary or are never delivered. Providers may also 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 also occur in managed care programs; providers may inflate billing for services since this data is used to calculate their reimbursement rate and assess the provider on access to and quality of care.

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.[7] AHCA's Bureau of Medicaid Program Integrity is primarily responsible for these functions. The bureau has traditionally focused its efforts on detecting and deterring error, abuse, and fraud from providers paid on a fee-for-service basis.

Florida's Medicaid managed care plans assume primary responsibility for managing payment error, fraud, and abuse concerns within their provider network. AHCA is responsible for ensuring that plans have systems in place to detect and deter abusive and fraudulent practices within their networks.

For Fiscal Year 2011-12, the Legislature appropriated $21.94 billion to operate the Medicaid Program. Of this amount, $4.38 billion is general revenue while $17.56 billion comes from trust funds that include federal matching funds and other state funds derived from drug rebates, hospital taxes, and county contributions.

AHCA allotted $8,077,338 of its budget to address fraud and abuse, of which $50,646 is from general revenue.[8] The program also has 98.5 full-time equivalent positions, with 3.75 positions dedicated to oversight of managed care plans.[9]

[4] Medicaid recipients who are excluded from enrollment in a managed care plan include those who have other creditable health care coverage, excluding Medicare, or reside in a Department of Juvenile Justice or mental health treatment residential or commitment facility. Individuals who are enrolled in most Medicaid Home and Community-Based Services waivers or are waiting for waiver services may voluntarily enroll in a managed care plan.

[5] Recipients that are exempt from mandatory enrollment may voluntarily choose to participate in the managed medical assistance program.

[6] Abuse refers to provider practices that are inconsistent with generally accepted business and/or medical practices and that result in unnecessary cost to the Medicaid Program. This includes reimbursement for goods and services that are not medically necessary or providing services that 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.

[7] 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.

[8] The remainder of funds, $8,026,692, comes from the Medical Care Trust Fund, which includes funds recouped from past program integrity efforts and a 50% federal match for the Bureau of Medicaid Program Integrity functions.

[9] The agency also has five FTEs within its inspector general's office dedicated to program integrity functions.

Findings

AHCA continues to coordinate efforts to prevent and detect Medicaid fraud and abuse in both fee-for-service and managed care programs. As Florida moves to managed care statewide for Medicaid, AHCA has instituted several systems to address fraud and abuse. The agency also has reduced the time it takes to recoup overpayments from fee-for-service providers.

The agency continues to coordinate efforts to combat Medicaid fraud and abuse in both fee-for-service and managed care

Our 2010 report found that to enhance its efforts to safeguard Medicaid funds, AHCA had improved coordination among its internal units as well as with other state agencies and federal entities. Our current review found that the agency has continued its coordination efforts.

Coordination is important because a number of bureaus within the agency have responsibilities related to ensuring that legitimate providers participate in the Medicaid program and are reimbursed for providing medically necessary services to eligible Medicaid beneficiaries. Other state agencies have regulatory responsibilities over medical providers that participate in Medicaid or for combating fraud and abuse in the health care system. It is also important to coordinate with federal entities, as they provide guidance and support to states and conduct audits of state Medicaid program integrity efforts.

Several bureaus within AHCA routinely conduct coordination activities. For example, the Bureau of Medicaid Program Integrity participates in weekly conference calls with the Bureau of Medicaid Contract Management to discuss changes to the agency's billing system in order to prevent inappropriate provider payments. The Bureau of Managed Health Care, which regulates both commercial and Medicaid managed care organizations for access and quality of care, notifies the Bureau of Medicaid Program Integrity if it identifies excessive beneficiary complaints or grievances or atypical utilization. This bureau also is working with the Bureau of Medicaid Program Integrity and Information Technology Office staff to develop an electronic provider network validation system to ensure that plan providers are not listed as ineligible providers in the federal List of Excluded Individuals and Entities database.

To promote coordination, AHCA's full-time Medicaid liaison, who reports directly to the Medicaid director, facilitates communication among the offices and assists with identifying and implementing policy revisions. The liaison focuses on preventing potential fraud and abuse by supporting efforts to enroll legitimate Medicaid providers and educating new providers and managed care plans on policies and procedures during the enrollment process. The agency also has continued its Fraud Steering Committee, which is composed of agency leadership and directs and oversees projects implemented by four subcommittees.[10]

In addition, AHCA works with other state entities, such as the Attorney General's Medicaid Fraud Control Unit, to prepare evidence for fraud cases. The agency also participates in the Department of Financial Services' Medicaid and Public Assistance Fraud Strike Force, which was created to oversee and coordinate state and local agency, law enforcement, and investigative unit efforts to prevent, detect, and prosecute health care fraud and abuse.[11]

Finally, AHCA coordinates with the federal Centers for Medicare and Medicaid Services

[10] The subcommittees include the Prevention Subcommittee that addresses provider education and fiscal agent payment edits used to determine whether each claim meets the criteria for payment; the Detection Subcommittee that focuses on data mining and prepayment review practices, and provider termination; the Recoupment Subcommittee that explores methods of increasing recoupment efforts, and the recently created Managed Care Subcommittee that coordinates efforts to promote information sharing across bureaus relative to potential fraud and abuse issues in managed care.

[11] The Medicaid and Public Assistance Fraud Strike Force was created by Ch. 2010-144, *Laws of Florida*.

on investigative efforts and participates in discussions with other states' Medicaid program integrity offices to remain informed of best practices and national trends.[12] AHCA has coordinated with the federal Medicaid Integrity Group, which provides technical assistance and resources including global positioning system navigation applications and computers. The agency also has used the national Medicaid Integrity Institute for free monthly employee training and to develop contacts in and coordinate with other states. In addition, Florida participates in the Fraud and Abuse Technical Advisory Group, a group of 10 regional state representatives, in order to facilitate discussion of potential fraud and abuse threats and identify state training needs. (See Appendix A for a detailed description of AHCA's coordination activities.)

To better guide its coordination efforts, we continue to recommend that the Fraud Steering Committee develop a strategic plan to identify areas at high risk for fraud and abuse and develop interventions to reduce these risks.[13] In doing so, the agency should identify issues that need specific attention and identify areas where improved coordination is needed. For example, in its recent report, the Auditor General found that AHCA overpaid Medicaid providers more than $117 million over three fiscal years because it had not programmed its claims review system to ensure proper payment of outpatient Medicare crossover claims.

The plan should identify priorities, timelines for addressing priorities, and the primary agency personnel responsible for specific priorities. The plan also should include short- and long-term components. While short-term priorities should focus on both fee-for-service and managed care, long-term priorities should emphasize managed care.

AHCA has an oversight system to address fraud and abuse in Medicaid managed care

As Florida moves to statewide managed care for Medicaid, several systems have been established to address fraud and abuse by managed care plans. AHCA oversees fraud and abuse prevention and detection in Medicaid managed care by requiring managed care plans to perform specific fraud and abuse activities and monitoring to ensure that plans comply with these requirements.

In developing its oversight system, the agency addressed provisions of Ch. 2010-144, *Laws of Florida*, and guidelines established by the U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services.[14, 15] Based on these criteria, the agency established requirements to guide managed care plan efforts to prevent and detect fraud and abuse, and included these requirements in all managed care contracts. For example, plans must implement a comprehensive anti-fraud plan and establish or contract for a fraud investigative unit. Plans also must establish internal controls and policies, such as prior authorization, utilization management, and post review of claims, to ensure that providers supply necessary services to beneficiaries. In addition, plans must implement grievance reporting procedures for beneficiaries, provide employee fraud and abuse training, and report certified encounters to the state.

[12] Collaboration with the federal Centers for Medicare and Medicaid Services includes joint investigative reviews 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.

[13] This recommendation was also included in *Enhanced Detection, Stronger Sanctions, Managed Care Fiscal Safeguards, and a Fraud and Abuse Strategic Plan Are Needed to Further Protect Medicaid Funds*, OPPAGA Report No. 10-32, March 2010.

[14] See Appendix B for state laws that specifically support efforts to prevent, detect, and recover Medicaid provider overpayments.

[15] *Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care*, U.S. Health Care Financing Administration's National Medicaid Fraud and Abuse Initiative, August 2000; *Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and PrePaid Health Plans*, Medicaid Alliance for Program Safeguards, May 2002.

To monitor compliance with contract requirements, AHCA developed a monitoring tool that it uses for on-site visits of the plans.[16] Plans also are required to report quarterly and annually on their fraud and abuse activities, including information on the details and outcomes of investigations and the number of referrals made to the Bureau of Medicaid Program Integrity. Plans also are required to report each suspected or confirmed instance of provider or recipient fraud or abuse to the Bureau of Medicaid Program Integrity within 15 days after detection.

When AHCA determines that plans do not comply with contract requirements, it requires them to develop a corrective action plan and/or imposes fines for noncompliance.[17] During the period from April 2010 to November 2011, the agency required 12 of the 13 plans visited by its staff as part of a comprehensive survey to develop corrective action plans.[18] The reasons that plans were required to develop corrective action plans ranged from not having required documentation of fraud and abuse policies and procedures to needing significant enhancements in anti-fraud and abuse plans. In addition, the agency fined one plan approximately $3.4 million for not submitting suspected or confirmed instances of recipient or provider fraud and abuse within 15 days after detection.[19]

In addition to state monitoring activities, the federal Centers for Medicare and Medicaid Services (CMS) conducts a triennial review of the agency's Medicaid program integrity efforts. As part of this review, CMS evaluates the agency's oversight of Medicaid managed care plans. The federal evaluation report for Florida is due in 2012.

Due to these requirements and monitoring activities, plans have identified and recovered overpayments and funds associated with fraudulent behavior. In Fiscal Year 2010-11, the plans identified approximately $28.3 million in overpayments and the plans recovered $13.9 million in overpayments. Moreover, plans reported that fraud and abuse requirements also have resulted in improvements in their investigations units, communications, and data mining capabilities.[20]

Most plans responding to an OPPAGA questionnaire reported that the requirements to report fraud and abuse were reasonable. However, half reported that the requirement to report all suspected or confirmed fraud and abuse within 15 days was unreasonable or difficult to meet because information often changed upon further investigation. Several plans recommended that the time period for reporting suspected fraud and abuse be extended to 30 or 60 days.

Implementing Medicaid managed care statewide will require AHCA to continue focusing on this oversight system to ensure that plans comply with requirements and that monitoring processes continue to support an effective process for preventing and detecting

[16] Medicaid Program Integrity staff use the tool to monitor compliance with contract provisions including adequacy of staffing and resources for the investigations unit; adequacy of internal controls designed to prevent, reduce, detect, and correct suspected fraud and abuse; providing training and education to plan employees and compliance officer; debarring or reporting providers for health plan violations; adequacy of processes to edit claims to prevent or detect potential or suspected fraud and abuse, as well as credentialing and recredentialing of providers.

[17] Until AHCA deems the managed care plan or report to be in compliance, the agency can impose an administrative fine of $2,000 per calendar day for failure to submit an acceptable anti-fraud plan or report. AHCA can also impose a fine of not more than $10,000 for failure to implement an anti-fraud plan or investigative unit. In addition, the agency can impose an administrative fine of $1,000 per calendar day after the 15th day of detection for failure to report.

[18] The agency also conducted comprehensive site visits to six additional plans but had not issued its findings at the time of our review.

[19] This fine was the result of the agency's site visit to a plan to investigate noncompliance with the reporting requirements. The assessment of the fine was in litigation at the time of this report.

[20] Sixteen of the 28 managed care plans responded to an OPPAGA questionnaire about the agency's reporting requirements. Responses included seven capitated managed care plans, five Provider Service Networks (including two Children's Medical Services plans), and two specialty dental plans.

fraud and abuse. In doing so, the agency should continue to use feedback from the managed care plans to identify modifications or enhancements that would further ensure the prevention and detection of fraud and abuse. In addition, because the number of managed care plans will increase, the agency should determine how it needs to shift resources currently committed to identifying and investigating fraud and abuse by fee-for-service providers to overseeing managed care plans. Further, agency integrity efforts in the past have primarily focused on identifying Medicaid fee-for-service overpayments. However, with the expansion of managed care, the agency will need to also focus efforts on identifying underutilization to help ensure beneficiaries receive medically necessary services.

AHCA has reduced the time it takes to recover overpayments from fee-for-service providers

The agency follows a systematic process to identify and investigate providers who are suspected of overbilling and has reduced the time it takes to recover overpayments from providers. The agency also has increased the fines and penalties in its sanctioning process.

AHCA identifies and investigates fee-for-service providers who overbill Medicaid. The agency uses several methods, including routine and ad hoc statistical analysis, to identify potential fee-for-service providers who have overbilled the Medicaid Program. Medicaid Program Integrity investigators review initial information on potential overbillings to determine whether to open a case. If a case is opened, the agency requests supporting documentation, such as patient medical files, to do a more thorough review of the claims in question. The provider has two 30-day periods to provide this documentation.[21, 22] The agency reviews the documentation for compliance with Medicaid policies, develops final audit findings, and issues a final order, which sets forth the overpayments that the provider must repay, agency costs for conducting the investigation, and the sanctions assessed.[23] The provider may appeal the agency's findings by requesting an informal hearing with the agency's general counsel or a formal hearing with the Division of Administrative Hearings.[24] The Bureau of Medicaid Program Integrity closes cases once it has recouped the overpayment in full.

The agency has reduced the time it takes to recoup overpayments from fee-for-service providers. AHCA has reduced the average time it takes to collect overpayments in full from 780 days in Fiscal Year 2003-04 to 332 in Fiscal Year 2010-11.[25] To recover overspent monies more quickly, providers are encouraged to perform self-audits and repay any overpayments identified. In addition, providers may repay overpayments identified at any time during the agency's audit process. Further, ss. 409.913(27) and 409.913 (30), *Florida Statutes*, direct AHCA to recover overpayments from providers while waiting for a formal hearing and issuance of the final order, and terminate providers from Medicaid within 35 days after the final order for failing to repay overpayments or enter into a repayment agreement.

There are factors that can extend the length of the investigative process. For example, providers may request an extension

[21] If the investigator suspects fraud, the case is referred to the Attorney General's Medicaid Fraud Control Unit (MFCU) and the audit is suspended. However, the case remains open until the unit completes its investigation and prosecution.

[22] Providers may agree to repay the overpayment rather than submit supporting documentation.

[23] As part of reviewing records, AHCA contracts on an hourly rate with actively licensed medical professionals with specialties in all areas to review supporting documentation to determine whether procedures were medically necessary and whether the level of care was appropriate. These medical professionals are practicing providers but not necessarily Medicaid providers.

[24] Providers are allowed to submit additional supporting documentation up to 14 days prior to the formal hearing.

[25] Section 409.913, *F.S.*, requires 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 C for information required by law for Fiscal Years 2001-02 through 2009-10.

to the deadline for submitting requested documentation. AHCA tries to limit extensions to 15 days; however, it grants extensions based on the volume of records the provider must submit to the agency. In addition, the formal hearing process for providers who appeal audit findings may take from several months to several years to complete, in part, because providers may request extensions in order to submit additional documentation. To expedite the process, the agency is proposing changes to the investigative process that would require providers to submit all supporting documentation prior to requesting a hearing.

To further decrease the length of the investigation process, the agency should identify the areas that consume a significant amount of time and identify potential options to address these areas. The agency recently completed a needs assessment and is in the process of issuing an invitation to negotiate for the development of a new case tracking system that will allow it to better track the time staff spends on various stages of the investigative process. The agency expects that the new system will help it reduce the time it takes to recoup overpayments.

The agency increased sanctions for fee-for-service provider overbilling. The agency has increased the sanctions imposed for service provider overbilling. During Fiscal Years 2009-10 and 2010-11, AHCA levied $1.2 million in fines against 2,779 providers that had received $57.1 million in overpayments.[26, 27] During the three prior fiscal years, the agency levied $776,822 in fines against 715 providers that had received $21.3 million in overpayments.

AHCA may investigate a provider for multiple violations and will open a case for each suspected violation. For example, if the agency investigated a provider for providing services that were medically unnecessary and for failing to make records available for review, it would open two cases. As shown in Exhibit 1, of the 3,556 cases closed in Fiscal Year 2010-11, 1,619 had an overpayment.[28]

Many overpayment cases are not sanctioned due to amnesty policies. AHCA grants amnesty when a provider performs a self-audit and when overpayments are less than a specified amount or less than a given amount of total paid claims for the audit period.[29] The agency's amnesty policy reduces the burden placed on providers whose billing errors are minimal or who are proactive in identifying their own billing errors. However, the provider must still repay identified overpayments.[30] In Fiscal Year 2010-11, of the cases having an overpayment, 9.3% were not sanctioned because the provider performed a self-audit and 62.4% were not sanctioned because the provider qualified for an amnesty program or for other reasons.[31]

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[26] In Fiscal Years 2009-10 and 2010-11, 115 providers were suspended and 81 providers were terminated from participation in the Medicaid Program. In addition, 407 providers with no identified overpayments were fined $578,923 when they failed to provide documentation requested by the agency.

[27] In September 2010, AHCA amended Rule 59G-9.070, *F.A.C.*, to increase the severity of punitive and monetary sanctions for failing to comply with Medicaid policies and requirements. Under the rule, a provider who fails to comply with any of the terms of a previously agreed-upon repayment schedule will be fined $5,000 for the first offense and suspended until the violation is corrected. If the provider remains noncompliant with the repayment schedule after 30 days, the provider will be terminated. Prior to the rule's implementation, providers were fined $1,000 for the first offense, suspended after 30 days of noncompliance, and terminated after 90 days of noncompliance.

[28] In Fiscal Years 2009-10 and 2010-11, the agency closed cases for 4,800 providers. These providers represented 6.4% of the approximately 75,000 providers currently active in the Medicaid Program's fee-for-service system.

[29] Cases may be eligible for amnesty if a provider's total claims paid for the audit period are less than $50,000 and the overpayment is less than $5,000 or if a provider's total claims paid is $50,000 or more and the overpayment is less than $10,000. However, if an overpayment is $10,000 or more, then sanctions will be applied regardless of amount of the total claims paid to the provider.

[30] Section 409.913(23), *F.S.*, grants the agency the authority to recover investigative, legal, and expert witness costs. Section 409.913(25)(e), *F.S.*, allows the agency to suspend these costs when it grants amnesty.

[31] Some cases were not sanctioned because the preliminary audit report or the final audit report was issued prior to implementation of sanctioning rules or because the provider repaid the agency prior to the final order being issued.

Exhibit 1
AHCA Sanctioned 28.3% of Provider Cases Identified with Overpayments in FY 2010-11

	FY 2006-07		FY 2007-08		FY 2008-09		FY 2009-10		FY 2010-11	
Case Resolution	Cases	Percentage	Cases	Percentage	Cases	Percentage	Cases	Percentage	Cases	Percentage
No Sanction Applied	439	54.1%	431	54.5%	783	60.8%	1,534	85.9%	1,161	71.7%
Amnesty or Other Reason	405	49.9%	320	40.5%	758	58.8%	1,179	66.0%	1,011	62.4%
Self-Audit	34	4.2%	111	14.0%	25	1.9%	355	19.9%	150	9.3%
Sanction Applied	372	45.9%	360	45.5%	505	39.2%	252	14.1%	458	28.3%
CAP Only[1]	259	31.9%	151	19.1%	112	8.7%	2	.01%	0	0.0%
Fine	113	13.9%	209	26.4%	393	30.5%	250	14.0%	458	28.3%
Total	**811**		**791**		**1,288**		**1,786**		**1,619**	

[1] CAP stands for Corrective Action Plan.

Source: OPPAGA analysis of Agency for Health Care Administration (AHCA) sanctioning data.

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 Medicaid Program Integrity Staff Coordinate Efforts to Safeguard Medicaid Funds with Multiple Stakeholders

To facilitate efforts to prevent funds lost to error, fraud, and abuse, AHCA Program Integrity staff coordinate with multiple internal and external stakeholders.

Table A-1
AHCA Coordinates Program Integrity Efforts Internally and with Other State and Federal Agencies

Meeting/Activity	Frequency	Purpose	Lead	Participants
Internal Agency Coordination				
Fraud Steering Committee	Biweekly	Oversee 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 and Provider Enrollment Issues Subcommittee	Monthly	Address issues to prevent improper payments from being made and to ensure the integrity of enrolled providers	Office of the Inspector General, Medicaid Contract Management	Inspector General, Office of Finance and Accounting, Medicaid Operations, General Counsel, Medicaid Program Integrity, Health Quality Assurance, Medicaid Director, Medicaid Services, Medicaid Program Analysis, and Medicaid Contract Management
• Detection Subcommittee	Biweekly	Address data mining initiatives and projects, new detection tools, current detection tool usage prepayment review practices and payment edits used to determine whether each claim meets the criteria for payment.	Bureau of Medicaid Program Integrity	Chief of Staff, Medicaid Services, Medicaid Contract Management, Medicaid Program Analysis, and Medicaid Program Integrity
• Edits and Audits Task Force – under the Detection Committee	Biweekly	Evaluate billing codes individually to assure that all audits and edits represent the current Medicaid handbook policy and ensure that claims are being paid properly. Operational since January 2011.	Bureau of Medicaid Program Integrity	Medicaid Program Integrity, Medicaid Services, and Medicaid Contract Management
• Recoupment Subcommittee	Monthly	Explore methods to increase recoupment of misspent funds and to recoup funds more expeditiously.	Office of Finance and Accounting	Inspector General, Office of Finance and Accounting, Medicaid Operations, General Counsel, Medicaid Program Integrity, Health Quality Assurance, Medicaid Director, Medicaid Services, Medicaid Program Analysis, and Medicaid Contract Management
• Managed Care Fraud and Abuse Subcommittee	Biweekly	Provide agency coordination and oversight for Medicaid Managed Care Fraud and Abuse issues. Created in April 2011.	Office of the Inspector General	Medicaid Director, Medicaid Health Systems Development, Medicaid Contract Management, Medicaid Quality Management, Medicaid Program Analysis, Medicaid Field Offices, Medicaid Program Integrity, Health Quality Assurance/Bureau of Managed Health Care, and General Counsel
Medicaid's Fraud Prevention and Compliance Unit	Ongoing	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, Medicaid Services, Medicaid Contract Management, Medicaid Program Analysis, Medicaid Field Offices, Medicaid Program Integrity, and General Counsel

Meeting/Activity	Frequency	Purpose	Lead	Participants
Fiscal Agent Coordination	Weekly	Work on issues related to the fiscal agent, including updates on the need for changes, the status of prior change requests, as well as new issues or questions on functionality.	Bureau of Medicaid Operations	Medicaid leadership and all bureaus in Medicaid (including Operations and Contact Management), Finance and Accounting, Internal Audit, and Medicaid Program Integrity
Legal Coordination	Biweekly	Discuss cases.	Bureau of Medicaid Program Integrity brings issues for discussion	Medicaid Program Integrity and General Counsel
Third Party Liability	Biweekly	Discuss contractor progress on overpayment data matching projects that supplement third party liability efforts.	Bureau of Medicaid Program Integrity/Medicaid Third Party Liability	Medicaid Program Integrity and Medicaid Third Party Liability
Managed Care Plans	Quarterly for each plan	Review plan compliance on 31 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, fraud and abuse reporting, provider file issues, encounter data submission, Healthcare Effectiveness Data and Information Set reporting, and pharmacy issues.	Bureau of Medicaid Health Systems Development	Bureau of Managed Health Care, Medicaid Health Systems Development, Behavioral Health, Medicaid Director's Fraud Prevention and Compliance Unit, and Medicaid Program Integrity
Policy Clarification Meetings	As needed	Discuss specific billing policies to ensure that Medicaid Program Integrity understands rules and limits prior to conducting an audit, and to discuss possible handbook revision recommendations from Medicaid Program Integrity.	Bureau of Medicaid Program Integrity	Medicaid Program Integrity and Medicaid Services
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.	U.S. Centers for Medicaid and Medicare Services	U.S. Centers for Medicare and Medicaid Services, Federal Contractor, and Medicaid Program Integrity
Medicaid Fraud Control Unit	Biweekly	Coordinate Medicaid Fraud Control Unit investigations of Medicaid providers, make and discuss referrals and data needs. Coordinate the new waiver application that allows MFCU to directly mine data.	Bureau of Medicaid Program Integrity /Office of the Inspector General	AHCA Medicaid Program Integrity and Office of Attorney General Medicaid Fraud Control Unit. Also expanded to include AHCA Health Quality Assurance, Medicaid Operations, and Medi-Medi contractor
Medi-Medi	Biweekly	Coordinate data mining projects and investigations and plan new investigations that arise from combining Medicaid and Medicare data.	U.S. Centers for Medicaid and Medicare Services	U.S. Centers for Medicare and Medicaid Services, Federal Contractor, and Medicaid Program Integrity

Meeting/Activity	Frequency	Purpose	Lead	Participants
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	U.S. Centers for Medicare and Medicaid Services and Medicaid Program Integrity representatives from other states
Quad State Meeting	Monthly	Discuss best practices and discuss issues among the four largest Medicaid states.	Bureau of Medicaid Program Integrity/Office of the Inspector General	Medicaid Program Integrity staff from California, Florida, New York, and Texas
Termination Staffing	On an as-needed basis	Discuss recommendations to end contracts with certain providers.	Bureau of Medicaid Program Integrity/Office of the Inspector General	Medicaid Program Integrity, General Counsel, Office of Attorney General Medicaid Fraud Control Unit, Inspector General, Medicaid Long-Term Care, and Health Quality Assurance
Interagency Fraud and Abuse Meetings	Bimonthly	Educate on correct billing practices or address concerns regarding provider practice. For example, educate staff from Department of Elder Affairs 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 ensure agencies effectively share information that could affect provider licenses or participation in Medicaid.	Bureau of Medicaid Program Integrity	AHCA, Department of Health, Office of Attorney General Medicaid Fraud Control Unit, Department of Financial Services, Department of Elder Affairs, Department of Children and Families, Agency for Persons with Disabilities, and Office of Insurance Regulation
Technology and Communications Workgroup	As needed	Implement the Strategic Plan for Health Care Fraud Database Connectivity, including coordinating inter- and intra-agency communications, reaching out to stakeholders, identifying and developing standards to interface with state and federal health care fraud databases where possible.	Bureau of Medicaid Program Integrity	AHCA, Department of Financial Services, Office of Attorney General Medicaid Fraud Control Unit, and Department of Health
Medicaid and Public Assistance Fraud Strike Force	At least four times per year or as requested of the Chair	Oversee and coordinate state and local agencies, law enforcement entities, and investigative units in order to increase the effectiveness of programs and initiatives dealing with the prevention, detection, and prosecution of Medicaid and public assistance fraud. Created by the 2010 Legislature. Subcommittees include the Grants Subcommittee, the Technology Subcommittee, the Legislative Subcommittee, and the Mapping Subcommittee.	Department of Financial Services	Department of Financial Services, Office of Attorney General Medicaid Fraud Control Unit, Florida Department of Law Enforcement, AHCA, Department of Children and Families, Department of Health, County Sheriffs, Chiefs of Police, and State Attorneys

Source: OPPAGA analysis of AHCA activities.

Appendix B

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

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 Substantially Since 2000

State Law	Topic(s) Addressed
Chapter 2000-163, *Laws of Florida* (Sections 6 through 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 (MFCU). It also makes changes related to surety bonds, allowing AHCA 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 authorizes the agency to 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 AHCA 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 AHCA 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 through 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 AHCA 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.
Chapter 2010-114, *Laws of Florida* (Sections 1 and 4 through 58)	***Medicaid and other provider personnel screening.*** This law revises background screening requirements for various types of patient care including, but not limited to: mental health personnel, personnel of nursing homes, home health agencies, hospices, intermediate care providers, medical equipment providers, intermediate care facilities for developmentally disabled, providers of consumer-directed care, and Medicaid providers. The law also requires Medicaid providers to obtain a level 2 background screening for each provider employee in direct contact with or providing direct services to Medicaid recipients. The law also establishes screening requirements and minimum standards for medical equipment providers.
Chapter 2010-144, *Laws of Florida* (Sections 4, 12, and 13)	***Medicaid and Public Assistance Fraud Strike Force; Medicaid managed care fraud and abuse requirements.*** This law establishes the Medicaid and Public Assistance Fraud Strike Force to oversee and coordinate state and local efforts to eliminate Medicaid and public assistance fraud and to recover state and federal funds. In addition, this law requires additional anti-fraud procedures for Medicaid managed care organizations, including requiring that organizations adopt an anti-fraud plan, have a fraud and investigations unit or contract for such services, produce an annual report on the plan's experience in implementing an anti-fraud plan, and report suspected or confirmed instances of provider or recipient fraud and abuse within 15 calendar days after detection. The law also allows the agency to impose administrative fines on organizations that fail to comply with the requirements. Furthermore, this law directs the Auditor General and OPPAGA to review and evaluate specific aspects of AHCA's Medicaid fraud and abuse systems.

State Law	Topic(s) Addressed
Chapter 2011-134, *Laws of Florida* (Sections 1, 5, 8, 10, and 13)	***Statewide integrated Medicaid managed care expansion; Medicaid managed care plan accountability requirements***. This law expands integrated Medicaid Managed Care Statewide for all covered services, including long term care. In addition, it establishes Medicaid managed care plan accountability requirements, including requiring a provider credentialing system and ongoing monitoring for plan providers, effective prepayment and post-payment review processes, and designation of a program integrity compliance officer. Furthermore, it requires managed care plans to maintain and operate a Medicaid Encounter Data System to collect, process, store, and report on covered services provided to all Medicaid recipients enrolled in prepaid plans and requires the agency to impose fines when a plan fails to comply with the encounter data reporting requirements.

Source: OPPAGA analysis of Florida law.

Appendix C

AHCA Reports Annually on Information Required by the Legislature to Document Its Program Integrity Efforts in Its Fee-for-Service Program

The Florida Legislature requires the Agency for Health Care Administration (AHCA) to annually report specific information related to its efforts to prevent, detect, deter, and recover misspent Medicaid funds.[32] Table C-1 details the information provided by AHCA's annual reports for Fiscal Years 2001-02 through 2009-10.

Table C-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]	2009-10[9]
Cases: Investigated	5,783	4,731	3,145	2,556	1,694	1,860	2,402	2,619	3,839
Cases: Opened New During Fiscal Year	2,598	1,516	658	1,497	612	1,406	1,679	1,438	2,922
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	2,269
Other AHCA	42	120	44	12	14	18	22	28	258
Services (Health Systems Development)	285	0	0	77	0	0	0	0	0
Public	19	9	23	70	49	31	110	139	342
Other State Agencies	20	2	0	2	2	3	7	10	12
Federal Agencies	8	7	20	7	12	16	18	41	14
Law Enforcement	5	4	21	13	9	1	2	11	16
Other	57	2	0	0	0	0	0	6	11
Cases: Disposition of Closed Cases (disposition defined by agency)									
Total	3,087[10]	2,270	1,953	1,459	1,228	1,018	1,126	1,614	2,366
No Finding of Overpayment	1,447	568	905	566	199	177	331	309	401
Provider Education Letter	263	99	104	44	27	30	4	17	158
Overpayment Identified	1,150	1,603	944	849	1,002	811	791	1,288	1,807
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	$38,000,000

[32] Chapter 2002-400, *Laws of Florida,* 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.

	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]	2009-10[9]
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	$14,000,000
Reduction in Overpayments Negotiated in Settlement Agreements, etc.	Not Available	$139,454	$856,746	$116,059	$236,970	$0	$0	$0	$0
Amount of Final Agency Determinations of Overpayments[11]	Not Available	$36,795,546	$30,368,463	$25,384,338	$25,427,878	$19,973,393	$15,628,918	$15,625,438	$18,800,000
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	$16,400,000
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	283 days
Amount of Cost of Investigations Recovered	Not Available	$45,587	$119,648	$67,295	$187,282	$113,917	$72,156	$49,850	$35,647
Number of Fines/Penalties Imposed[12]	0	0	3	1	153	222	155	501	507
Amount of Fines/Penalties Imposed	0	0	$20,500	$2,000	$289,000	$373,073	$150,000	$481,228	$666,740
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	$11,900,000
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	$4,100,000
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	$0
Number of Providers by Type Terminated Due to Fraud/Abuse	129	28	160	224	194	194	59	78	85
Community Alcohol, Drug Abuse, or Mental Health	2	0	0	0		0	0	0	
Pharmacy	13	3	35	29	24	11	3	1	1
Physicians	63	15	74	114	85	60	4	15	7
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	1
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	2
Home and Community-Based	3	0	9	13	30	47	27	42	44
Therapy	2	0	0	1	1	9	4	3	5
Durable Medical Equipment Suppliers/Medical Supplies	8	4	22	49	0	0	6	2	16
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	9

	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]	2009-10[9]
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[13]	$12,420,695[14]	$15,105,407[15]	$15,092,040[16]
Bureau 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	$8,558,901
Office of General Council, Accounts Receivable, and Bureau of 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	$1,494,555
Indirect Costs	Not Available	$863,553	$777,080	$1,056,332	$1,254,691	$1,247,745	$1,266,091	$1,296,339	$1,425,541
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	99
Document Actions Taken to Prevent Overpayments	Annual Report	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	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] *Annual Report on the State's Efforts to Control Medicaid Fraud and Abuse FY 2009-10,* Agency for Health Care Administration and Medicaid Fraud Control Unit Department of Legal Affairs, December 2010. This report provided only round numbers for certain reported information.

[10] 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.

[11] 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.

[12] 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.

[13] Does not include $1,184,627 for contractual services or $489,088 for ACS support services.

[14] Includes $1,036,332 in Medicaid costs incurred for services related to MPI activities.

[15] Includes $4,756,337 in Medicaid costs incurred for services related to MPI activities.

[16] Includes $3,613,043 in Medicaid costs incurred for services related to MPI activities.

Source: Agency for Health Care Administration and Medicaid Fraud Control Unit Department of Legal Affairs annual reports.

Appendix D

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

November 30, 2011

Mr. R. Philip Twogood
Coordinator, Office of Program Policy Analysis
and Government Accountability
Claude Pepper Building
111 West Madison Street, Room 312
Tallahassee, Florida 32399-1475

Dear Mr. Twogood:

Thank you for the opportunity to respond to the draft report: "*Agency for Health Care Administration Continues Efforts to Control Medicaid Fraud and Abuse*."

Please review our comments in response to your specific findings and recommendations.

Develop a Strategic Plan – As mentioned in the report, the Agency continues to coordinate with external entities to enhance efforts to combat Medicaid fraud and abuse. One of the primary outcomes of these efforts is the identification of high risk providers, provider types and services. The Agency has implemented a Fraud Steering Committee and several subcommittees dedicated to identifying high risk areas and making recommendations to reduce those risks. Last year, the Agency developed a Strategic Plan to connect various health care fraud databases, and we are working to implement the strategies outlined in that document. As recommended in the report, the Agency will continue its efforts to combat fraud and abuse in the Medicaid program and will develop a fraud and abuse strategic plan to assist in those efforts. As recommended in OPPAGA's report, the short-term priorities of our plan will focus on solutions and interventions for fraud and abuse within both fee-for-service and managed care programs. However, long-term priorities of the plan will emphasize curtailing managed care fraud and abuse.

Managed Care Expansion – The Agency holds periodic discussions with the managed care plans regarding the prevention and detection of fraud and abuse. The Agency also reviews the managed care entities' anti-fraud and abuse plans and their annual reports on their experience and results in implementing such anti-fraud plans. As development of the core managed care contract continues to evolve, the Agency will continue to obtain feedback from the managed care plans and review their anti-fraud and abuse efforts to identify necessary modifications or enhancements.

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Mr. R. Philip Twogood
November 30, 2011
Page Two

As referenced in the report, the number of Medicaid enrollees in managed care plans will increase as Florida expands managed care statewide. In the 2011 legislative session, the Agency was directed to develop a reorganization plan for the realignment of resources that would assess the Agency's current capabilities, identify shifts in staffing and other resources necessary to strengthen managed care procurement and managed care contract monitoring functions, and establish an implementation timeline. Resources dedicated to identifying and investigating fraud and abuse in the Medicaid program's managed care environment were included in that assessment.

As the Agency continues to move forward with the expansion of managed care, there will be ongoing evaluation and realignment of resources dedicated to the prevention and detection of Medicaid fraud and abuse, including focusing on identifying underutilization practices and patterns.

Identify Options to Further Shorten the Audit Process – The Agency will continue its efforts to conduct audits of Medicaid providers as efficiently as possible. Identifying areas that consume a significant amount of time and proposing solutions to reduce or eliminate those delays will be a part of that process. To that end, the Agency has submitted proposed legislation that will assist in further reducing the amount of time it takes to complete an audit.

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 contact Mary Beth Sheffield, Audit Director, at 412-3978.

Sincerely,

Elizabeth Dudek
Secretary

ED/szg

The Florida Legislature

Office of Program Policy Analysis and Government Accountability

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R. Philip Twogood, Coordinator