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Medicaid Program Integrity Recovers Overpayments in Fee-For-Service and Monitors Fraud and Abuse in Managed Care

at a glance

As of November 2013, 53% of Florida's Medicaid population was served by fee-for-service providers and 47% by managed care plans. As directed by law, the Agency for Health Care Administration (AHCA) is continuing to expand managed care statewide and expects that 85% of beneficiaries will be enrolled in managed care plans by October 2014.

For fee-for-service providers, AHCA has reduced the time it takes to recover overpayments and increased the fines and penalties imposed for provider overbilling. The agency also is procuring an advanced detection system and a case management system that will enhance fraud and abuse efforts for both fee-for-service and managed care plans.

To reflect the shift to managed care, AHCA is revising its organizational structure. It also requires managed care plans to establish program integrity functions and activities to reduce the incidence of fraud and abuse. In addition, AHCA is developing accountability systems that will enhance its ability to monitor managed care and identify program integrity concerns.

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] This report assesses AHCA's efforts to detect and recover overpayments from fee-for-service providers. The report also assesses the systems and processes AHCA has in place to oversee and monitor fraud and abuse and program integrity in Medicaid managed care.

Background

Florida's Medicaid Program, administered by AHCA, is among the largest in the country, serving over 3.3 million persons each month. Medicaid provides health care coverage to persons who meet state and federal eligibility requirements, including low-income families, elders who need long-term care services, and persons with disabilities.

Patients obtain Medicaid medical services in two ways: fee-for-service and managed care. Fee-for-service patients seek services from Medicaid providers, and Medicaid pays for each specific

[1] Prior OPPAGA reports released on Medicaid Program integrity efforts include: *Agency for Health Care Administration Continues Efforts to Control Medicaid Fraud and Abuse*, OPPAGA Report No. 11-22, December 2011; *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.

service rendered. Managed care patients participate in a plan, like a health maintenance organization (HMO), in which Medicaid pays the plan a monthly contracted amount per person for health services, and plan medical staff work to ensure that patients receive adequate care without unnecessary costs.

As of November 2013, 47% of Florida's Medicaid population was served through managed care. Chapter 2011-134, *Laws of Florida*, directed AHCA to expand enrollment in managed care by requiring all Medicaid recipients who are not otherwise exempt to enroll in a managed care plan.[2] The law directs AHCA to fully implement managed care statewide for Long-Term Care and the Managed Medical Assistance Program by October 2014.[3] AHCA anticipates that the percentage of beneficiaries served in managed care plans will increase to 85% upon full implementation.

Like all health care programs, Medicaid is vulnerable to payment error, abuse, and fraud, which can take many forms.[4] In fee-for-service, these include overbilling errors as well as deliberate efforts to bill for services that are not medically necessary or were not delivered. Fraud and abuse can also occur in managed care programs; providers may inflate or falsify billing for or reporting of rendered 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 Medicaid funds, the federal government requires Florida to identify and investigate fee-for-service providers suspected of error and abuse, which are functions conducted by AHCA's Bureau of Medicaid Program Integrity. The bureau refers providers suspected of fraud to the state's Medicaid Fraud Control Unit.[5]

Medicaid managed care plans assume primary responsibility for addressing payment error, fraud, and abuse within their provider networks. AHCA is responsible for ensuring that plans have systems in place to prevent, detect, and deter abusive and fraudulent practices in their organizations. Statewide expansion of Medicaid managed care will require AHCA to focus more of its program integrity efforts from fee-for-service to managed care. While managed care program integrity efforts must include preventing and detecting fraud and abuse, plans also must maintain accountability systems to ensure that beneficiaries have access to and receive appropriate and necessary medical services.

For Fiscal Year 2013-14, the Legislature appropriated $23.85 billion to operate the Medicaid Program. Of this amount, $5.36 billion is general revenue, while $18.47 billion comes from trust funds that include federal matching funds and other state funds derived from drug rebates, hospital taxes, and county contributions.

AHCA's Fiscal Year 2013-14 approved operating budget for addressing fraud and abuse is $8.0 million; none of these funds are from general revenue.[6] The program has 93.5 full-time equivalent (FTE) positions and 37 other-personal-services (OPS) positions.

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[2] Medicaid recipients who are exempt from mandatory enrollment in a managed care plan include those who have other creditable health care coverage, excluding Medicare; reside in a Department of Juvenile Justice or mental health treatment residential or commitment facility; are eligible for refugee assistance; reside in a developmental disability center; or have enrolled in a home and community-based services waiver or are waiting for waiver services. These recipients may voluntarily enroll in Medicaid managed care plans.

[3] The implementation of statewide managed care expansion occurred by region in two phases. The first phase began August 2013, in which AHCA began enrolling beneficiaries into Long Term Managed Care; this phase is scheduled to be completed March 2014. The second phase, in which AHCA will enroll beneficiaries into statewide Managed Medical Assistance, will be completed by October 2014.

[4] 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, reimbursement for goods and services that are not medically necessary, or 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.

[5] 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.

[6] The Bureau of Medicaid Program Integrity's entire budget 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.

Findings

AHCA continues its detection and recovery efforts in Medicaid fee-for-service

AHCA uses several methods, including statistical analyses, to identify potential cases of Medicaid overpayment to fee-for-service providers. The agency has continued to reduce the time it takes to recoup overpayments and has increased the number of sanctions imposed on providers who overbill. To enhance detection and recovery efforts, AHCA is updating its case management system and procuring advanced detection technology.

AHCA takes several steps to identify and resolve overbilling cases. The agency uses several methods to identify potential fee-for-service providers who have overbilled the Medicaid Program, including routine and ad hoc statistical analysis. In addition, providers are encouraged to perform self-audits and repay any overpayments identified.

Medicaid Program Integrity investigators review initial information on potential overbillings to determine whether to open a case. If AHCA opens a case, it requests supporting documentation, such as patient medical files, to conduct a more thorough review of the claims in question.[7] The provider has two periods to submit documentation.[8, 9, 10] AHCA reviews the documentation for compliance with Medicaid policies, develops final audit findings, and issues a final order, which sets forth the overpayments the provider must repay, agency costs for conducting the investigation, and the sanctions assessed.[11]

The provider may appeal AHCA's findings by requesting an informal hearing with the agency's general counsel or a formal hearing with the Division of Administrative Hearings.[12] The Bureau of Medicaid Program Integrity closes cases once it has recouped the overpayment in full. In Fiscal Years 2011-12 and 2012-13, AHCA closed 4,368 cases, with 2,826 identified as having an overpayment.[13]

AHCA continues to reduce the time it takes to recoup overpayments from fee-for-service providers. AHCA has been working to reduce recovery time for overpayments and has significantly reduced the average time it takes to collect overpayments in full. In Fiscal Year 2012-13, the average collection time was 228 days, compared to 780 days in Fiscal Year 2003-04, a decrease of 64%.[14]

Some of the protections built into the process can extend the time required to collect overpayments. For example, providers may request an extension to the deadlines 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.

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[7] Providers may repay overpayments identified at any time during AHCA's audit process.

[8] When Bureau of Medicaid Program Integrity staff opens a case, they send the provider a letter requesting documentation to support the claim. The provider has 21 days to submit such supporting documentation. If the provider does not submit supporting documentation or AHCA is not satisfied that the supporting documentation justifies the claim, the agency will issue a preliminary audit report; the provider has to submit necessary supporting documentation within 15 days of receiving the report.

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

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

[11] As part of its review of provider records, AHCA contracts on an hourly rate with actively licensed medical professionals to review supporting documentation to determine if procedures were medically necessary and if the level of care was appropriate. These medical professionals are practicing providers but not necessarily Medicaid providers.

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

[13] AHCA may investigate a provider for multiple violations and opens a case for each suspected violation. For example, if the agency investigated a provider for offering services that were medically unnecessary and for failing to make records available for review, it would open two cases.

[14] 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 2012-13.

The formal hearing process for providers who appeal audit findings also lengthens the process, taking from several months to several years due to providers requesting extensions in order to submit additional documentation. The 2013 Legislature addressed this issue by restricting providers presenting records to contest an overpayment or sanction to only those records that are contemporaneous.[15]

AHCA has increased the number of sanctions imposed on fee-for-service providers who overbill the system. To deter fraud and abuse, AHCA amended Rule 59G-9.070, *Florida Administrative Code*, in 2010 to increase the severity of punitive and monetary sanctions for failing to comply with Medicaid policies and requirements.[16] During Fiscal Years 2011-12 and 2012-13, AHCA levied $8.2 million in fines against 2,467 providers who had received $58.8 million in overpayments.[17] This was more than four times the amount in fines that AHCA levied in the prior five years combined.[18] AHCA also has increased the number of providers terminated by sanction from 33 in Fiscal Year 2009-10 to 91 in Fiscal Year 2012-13. Historically, many providers voluntarily relinquished Medicaid participation after receiving written notice of an audit. However, 2013 legislation addressed this issue by requiring AHCA to sanction with termination for cause when providers take such action.[19]

Many overpayment cases are not sanctioned due to amnesty policies. AHCA grants amnesty when a fee-for-service provider performs a self-audit and when overpayments are less than a specified amount.[20] AHCA'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 still must repay identified overpayments.[21] In Fiscal Year 2012-13, of the 1,340 cases, 11% were not sanctioned because the provider performed a self-audit, and 56% were not sanctioned because the provider qualified for an amnesty program or for other reasons. (See Exhibit 1.)

[15] Chapter 2013-150, *Laws of Florida.*

[16] In 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.

[17] In Fiscal Years 2011-12 and 2012-13, 145 providers were suspended and 194 providers were terminated from participation in the Medicaid Program. In addition, 433 providers with no identified overpayments were fined $4.9 million when they failed to provide documentation requested by AHCA.

[18] In the past five years, AHCA levied $2.0 million in fines against 3,495 providers who had received $78.4 million in overpayments.

[19] When providers are sanctioned with termination, they are no longer permitted to participate in Medicaid as enrolled providers or as Medicaid managed care network providers.

[20] Investigators determine if cases are eligible for amnesty when issuing the preliminary audit report. If the provider's total paid claims for the audit period are less than $50,000 and the overpayment is less than $5,000, or the total paid claims for the audit period are $50,000 or more and the overpayment is less than $10,000, the provider is eligible for amnesty. However, if an overpayment is $10,000 or more, regardless of the total claims paid to the provider, sanctions will be applied.

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

Exhibit 1
AHCA Sanctioned 32.7% of Provider Cases Identified with Overpayments in Fiscal Year 2012-13

Case Resolution	FY 2008-09 Provider Cases/ Percentage		FY 2009-10 Provider Cases/ Percentage		FY 2010-11 Provider Cases/ Percentage		FY 2011-12 Provider Cases/ Percentage		FY 2012-13 Provider Cases/ Percentage	
No Sanction Applied	783	60.80%	1,534	85.90%	1,161	71.70%	1,063	72%	901	67%
Amnesty or Other Reason	758	58.80%	1,179	66.00%	1,011	62.40%	935	63%	752	56%
Self-Audit	25	1.90%	355	19.90%	150	9.30%	128	9%	149	11%
Sanction Applied	505	39.20%	252	14.10%	458	28.30%	423	28.47%	439	32.76%
Corrective Action Plan only	112	8.70%	2	0.01%	0	0%	0	0%	0	0%
Fine	393	30.50%	250	14.00%	458	28.30%	423	28%	439	33%
Total	**1,288**		**1,786**		**1,619**		**1,486**		**1,340**	

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

AHCA is updating its case management system and procuring advanced detection technology. The 2013 Legislature appropriated $3 million in non-recurring funds to AHCA for the Public Benefits Integrity Data Analytics and Information Sharing Initiative to detect and deter fraud, waste, and abuse in Medicaid and other public benefit programs. Since 2011, the agency has attempted to replace its existing case management system with one that includes features similar to the old system, as well as additional features, such as the ability to track investigative costs and automate tasks that staff manually perform. The system was to have incorporated advanced detection tools and have been built on a software platform that AHCA could support.[22] However, after not receiving satisfactory responses to three invitations to negotiate for the procurement of a new case tracking and advanced detection system, AHCA separated the procurement of advanced analytics technology from the procurement of a case management system. The agency released its fourth invitation to negotiate for a case management system in December 2013.

AHCA should ensure that the new case tracking system enhances the existing capabilities of the old system and automates features such as merging hard copy reports into case files and generating required provider notification letters and agency alerts. The new system also should allow management to track the time and costs required to complete each phase of the investigation process and to improve aspects of the investigation, such as automating collection of documentation and standardizing agency notifications and letters. In addition, the new system should allow the bureau to reduce the time and errors inherent to manual processes with it current system.

In October 2013, AHCA released its invitation to negotiate for the procurement of a subscription-based advanced data analytics service that incorporates advanced detection tools and builds interfaces to agency systems. According to agency staff, the advanced detection system will analyze encounter data as well as fee-for-service claims data. In implementing this advanced detection system that uses pattern recognition technology, AHCA should ensure that the procurement is sustainable and that it enhances the agency's current detection of abuse and fraud and recoupment of overpayments.

AHCA is refocusing program integrity and accountability efforts as it implements statewide managed care

Since OPPAGA's 2011 biennial review, AHCA has continued to expand and enhance Medicaid managed care. (See Appendix B for legislative changes made to support Medicaid Program Integrity efforts.) AHCA is revising its organizational structure to reflect Florida's shift from fee-for-service to managed care. AHCA contracts require managed care plans to conduct activities to reduce fraud and abuse, and the

[22] The existing case management system, called Fraud and Abuse Case Tracking System (FACTS), was developed by AHCA in 2003 to track investigations from their preliminary stages through the legal process and collections. The system is built on a software platform that AHCA no longer supports.

agency is developing accountability systems to enhance its ability to monitor plans and identify program integrity concerns.

AHCA is shifting program integrity resources from fee-for-services activities to managed care and revising its organizational structure. In August 2013, AHCA reorganized the Bureau of Medicaid Program Integrity to increase the number of staff dedicated to managed care program integrity oversight. Prior to that time, the bureau dedicated 12 positions (4 FTE and 8 OPS) to managed care integrity activities. The agency now has 19 positions (9 FTE and 10 OPS) dedicated to managed care.[23]

AHCA also is assessing its organizational structure to revise the way it will manage plan contract compliance and oversight. AHCA plans to streamline job functions and increase its focus on managed care monitoring, quality, and data analytics. Medicaid staff previously dedicated to analyzing fee-for-service provider claims now analyze managed care performance, utilization, and quality of care. In addition, AHCA created an actuarial position that will assist in capitation rate setting and risk adjustment activities.[24] AHCA intends to coordinate all oversight and monitoring activities through the Medicaid contract manager. By centralizing plan contract compliance and accountability with the contract manager, AHCA should be positioned to better identify and compile anomalies and trends that might signal abusive behavior by plans that should be referred to the Bureau of Medicaid Program Integrity. AHCA anticipates releasing a restructuring plan in mid - 2014.

In centralizing its approach to monitoring plan compliance, AHCA should include coordinating communication among all agency staff involved in managed care plan oversight. In addition, AHCA should consider developing a plan tracking system that would allow managers to identify potential program integrity concerns. For example, such a system could provide trend data on grievances and complaints, plan performance measures, and provider network changes. It also could alert contract managers when plans fail to submit required reports to the agency.

AHCA requires managed care plans to establish program integrity functions and activities to reduce the incidence of fraud and abuse. Per provisions in managed care contracts, plans submit comprehensive compliance and anti-fraud plans to AHCA that establish, or contract for, a fraud investigative unit; establish internal controls, which include prior authorization, utilization management, and post review of claims; and provide employees with fraud and abuse training. In addition, during the provider hiring, contracting, and re-credentialing process and at least monthly thereafter, plans must check staff, subcontractors, and providers against both federal databases and AHCA's listing of parties that have been excluded from participating in publicly funded health care programs.

Plans also report quarterly and annually on their fraud and abuse activities and their experience in implementing anti-fraud plans. The reports include details on the number of referrals made to the Bureau of Medicaid Program Integrity, outcomes of investigations, and the dollar amount of vendor losses and recoveries attributable to fraud, abuse, and overpayment. Plans also are required to report each suspected or confirmed instance of provider or recipient fraud or abuse within 15 days after detection or receive an administrative fine of $1,000 per calendar day.[25]

Due to these requirements and monitoring activities, plans have identified and recovered overpayments and funds associated with fraudulent behavior. In Fiscal Years 2011-12 and

[23] Over the next three to five years, the bureau expects to transition more staff to managed care fraud and abuse oversight.

[24] For statewide Medicaid managed care, Florida will be risk adjusting capitated payments utilizing CDPS + Rx (Version 5.0), a combined diagnosis and pharmacy-based risk-adjustment model. The risk weights will be calibrated to Florida's Medicaid experience. This model includes the latest version of the Chronic Disability and Illness Payment System (CDPS) diagnostic classification system used by Medicaid programs to make capitated payments. It also incorporates 15 risk adjustment categories from the Medicaid Rx (MRX) model. The MRX model is used to identify a large number of Medicaid beneficiaries who receive pharmacotherapy but do not have an ICD9 diagnosis.

[25] For the 2011 biennial review, OPPAGA surveyed plans regarding the reasonableness of the fraud and abuse reporting requirements. More than half reported that the requirement to report all suspected and confirmed fraud and abuse within 15 days was unreasonable because information often changed upon further investigation.

2012-13, the plans identified more than $50.9 million in overpayments, of which they recovered $35.7 million. In addition, the plans identified that $5.9 million had been lost to abusive activities and recovered $482,305 of these funds.

The Bureau of Medicaid Program Integrity oversees plans' program integrity functions and activities. It uses a comprehensive monitoring tool and conducts desk reviews, field visits, and investigations to monitor plans' anti-fraud activities.[26] When AHCA determines that plans do not comply with contract or statutory requirements, it imposes fines or liquidated damages for noncompliance.[27, 28] The agency may also require a corrective action plan.

Between November 2011 and March 2013, AHCA conducted on-site reviews of 13 managed care plans, including 2 dental plans. The on-site reviews included readiness reviews, on-site contract monitoring, and comprehensive surveys for fraud and abuse. As of December 2013, one plan's review had not been finalized because of federal intervention, one plan withdrew its application from consideration as a Medicaid health plan after deficiencies were identified during the on-site readiness review, and the remaining plans corrected identified deficiencies.[29]

AHCA is developing accountability systems that will enhance its ability to monitor managed care and identify program integrity concerns. AHCA is developing systems in managed care fraud and detection to broaden its monitoring to other aspects of plan compliance. This includes

- evaluating plan performance to ensure continuous improvement;
- assessing provider network adequacy and tracking grievance and complaint resolution to ensure access to care for needed health care services;
- analyzing encounter data for abusive and fraudulent activities and adequate utilization of service; and
- using achieved savings rebate incentives to encourage efficiencies and high performance.

Continuous Performance Improvement. To ensure continuous improvement, AHCA will monitor and evaluate plan performance by requiring plans to annually report measures from the Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS) satisfaction and experience survey measures, agency-defined measures, and other sources.[30] The measures will allow AHCA to assess provision of services and quality of care. The agency has established minimum performance thresholds that plans are required to achieve or exceed and sanctions for not meeting these thresholds.

AHCA may require plans identified as having poor performance to develop performance measure action plans and/or apply sanctions or liquidated damages.[31] Plans' submissions of incomplete or inaccurate performance measure data will be reviewed by the Performance, Evaluation, and Research Unit, or its successor and, if necessary, forwarded to the Bureau of Medicaid Program Integrity.

As part of performance improvement, plans will participate in projects that focus on prenatal care

[26] The bureau uses the compliance monitoring tool to assess plan readiness and for on-going monitoring.

[27] AHCA has begun to assess liquidated damages as a means to compensate the agency for financial losses and damages resulting from plans' non-performance.

[28] The federal Centers for Medicare and Medicaid Services (CMS) conducts a triennial review of AHCA's Medicaid Program integrity efforts. As part of this review, CMS evaluates AHCA's oversight of Medicaid managed care plans. The last federal evaluation report for Florida was released July 2012.

[29] Universal Health Care, Inc., was a Florida Medicaid and Medicare HMO. AHCA staff stated that due to a federal investigation, the agency reassigned Universal Health Care, Inc.'s beneficiaries to other plans in March 2013. At the time the agency began reassigning beneficiaries, the company had 57,276 Medicaid enrollees.

[30] AHCA requires that the plans collect and report performance measures that are certified by a qualified auditor. AHCA will eventually grade plans using a consumer report card.

[31] AHCA currently publishes plans' performance measures in a comparative table for consumers on its website located at FloridaHealthFinder.gov. Plan enrollees will have access to an online provider directory with performance indicators, and AHCA will use the data to develop online report cards for each managed care plan.

and well-child visits; dental care for children; population health issues within geographic areas that need improvement; primary care and behavioral health; and reducing preventable readmissions.

Access to and Provision of Services. To ensure that beneficiaries have access to care and receive needed services, AHCA developed an automated provider network verification system that has enhanced the agency's ability to regularly monitor adequacy, accuracy, and quality of provider networks. AHCA designed the system using Medicare's network adequacy standards, and it has the ability to match files with the Florida Medicaid Management Information System, the Department of Health's health care practitioner licensure database, the Medicaid prescription drug database, excluded provider lists, and criminal databases. Plans will be required to submit an annual network development and management plan that describes how enrollees access the system, timeliness of services, relationships among parties, approaches to addressing network gaps, and ongoing activities for network development. Plans must also verify if enrollees received billed services by providers.

To monitor beneficiary and provider grievances, AHCA developed a system that tracks complaints made to the complaint center hotline and provides routine reports. Plans also are required to document and report all grievances and appeals to AHCA, which the agency will use to monitor trends and report anomalies to the Bureau of Medicaid Program Integrity.

Encounter Data Analysis. AHCA also plans to use encounter data to monitor fraud and abuse in managed care. It anticipates analyzing encounter data on network providers much like it analyzes Medicaid fee-for-service provider claims data to identify abusive or fraudulent activities. The Bureau of Medicaid Program Integrity will use encounter data to make comparisons about service provision over time and across plans. It will also use encounter data to identify under and over utilization, determine misrepresentation and medical necessity, and assist with oversight and investigations. In addition, the data from the encounter data system will have the capacity to be integrated into the advanced detection system that AHCA is currently procuring.[32]

Achieved Savings Rebates. As an incentive for proper use of state funds, AHCA is implementing the Achieved Savings Rebate Program. The program will monitor plan premium revenues, medical and administrative costs, and income or losses in a uniform manner. Plans' detailed financial reports will be audited by an independent public accountant. AHCA is promulgating program rules to ensure the independence of the public accountant and establish criteria for the independent auditor.[33] The Achieved Saving Rebate Program will be tied to plan performance; when a plan exceeds agency-defined quality measures in the reporting period, it may retain an additional 1% of revenue.

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 AHCA to review and respond. The secretary's written response has been reproduced in Appendix C.

[32] At the time of this review, AHCA was using inpatient pharmacy and mental health encounter data for capitation rate setting and will add outpatient encounter data for the September 2012 through August 2013 rate-setting process. It also was assessing appropriateness of care and services for specific populations with targeted conditions, such as chronic obstructive pulmonary disease and asthma; evaluating health plans on the select performance measures; and created baseline statistics for three types of specialty care—orthopedics, neurology, and dermatology, which will be used to assess plans' specialty to care access.

[33] Section 59G-8.800, *F.A.C.*

Appendix A

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

The 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.[34] Exhibit A-1 details the information provided by AHCA's annual reports for Fiscal Years 2001-02 through 2011-12.

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

	Fiscal Year											
	2001-02[1]	2002-03[1]	2003-04[1]	2004-05[1]	2005-06[1]	2006-07[1]	2007-08[1]	2008-09[1]	2009-10[1]	2010-11[1]	2011-12[1]	2012-13[1]
Cases: Investigated	5,783	4,731	3,145	2,556	1,694	1,860	2,402	2,619	3,839	5,368	3,980	3,393
Cases: Opened New During Fiscal Year	2,598	1,516	658	1,497	612	1,406	1,679	1,438	2,922	4,119	2,301	2,108
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	3,048	1,401	1,502
Other AHCA	42	120	44	12	14	18	22	28	258	894	500	271
Services (Health Systems Development)	285	0	0	77	0	0	0	0	0	0	0	0
Public	19	9	23	70	49	31	110	139	342	20	154	148
Other State Agencies	20	2	0	2	2	3	7	10	12	24	75	20
Federal Agencies	8	7	20	7	12	16	18	41	14	107	91	129
Law Enforcement	5	4	21	13	9	1	2	11	16	19	3	0
HMO Investigative Unit[2]	–	–	–	–	–	–	–	6	8	2	18	14
Other	57	2	0	0	0	0	0	0	3	5	59	24
Cases: Disposition of Closed Cases (disposition defined by agency)												
Total	3,087[3]	2,270	1,953	1,459	1,228	1,018	1,126	1,614	2,366	3,841	2,842	2,203
No Finding of Overpayment	1,447	568	905	566	199	177	331	309	401	1,006	229	136
Provider Education Letter	263	99	104	44	27	30	4	17	158	513	248	7
Overpayment Identified	1,150	1,603	944	849	1,002	811	791	1,288	1,807	1,907	1,987	1,562

[34] 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[1]	2003-04[1]	2004-05[1]	2005-06[1]	2006-07[1]	2007-08[1]	2008-09[1]	2009-10[1]	2010-11[1]	2011-12[1]	2012-13[1]
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	$29,485,094	$40,099,191	$36,550,414
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	$15,424,288	$25,201,196	$23,387,961
Reduction in Overpayments Negotiated in Settlement Agreements, etc.	Not Available	$139,454	$856,746	$116,059	$236,970	$0	$0	$0	$0	$0	$0	$0
Amount of Final Agency Determinations of Overpayments[4]	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	$14,168,854	$29,187,799	$22,099,877
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	$21,500,000	$18,400,000	$31,400,000
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	332 days	284 days	228 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	$1,500,000	$200,000	$212,000
Number of Fines/Penalties Imposed[5]	0	0	3	1	153	222	155	501	507	717	781	839
Amount of Fines/Penalties Imposed	$0	$0	$20,500	$2,000	$289,000	$373,073	$150,000	$481,228	$666,740	$957,609	$2,643,713	$3,505,686
Number of Managed Care Assessments Imposed[5]	–	–	–	–	–	–	–	–	–	–	7	0
Amount of Managed Care Assessments[6]	–	–	–	–	–	–	–	–	–	–	$3,555,600	$0
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	$31,000,000	$36,000,000	$0
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	$390,990	$13,800,000	$3,700,000
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	$0	$0	$0
Number of Providers by Type Terminated Due to Fraud/Abuse	129	28	160	224	194	194	59	78	85	131	217	361
Community Alcohol, Drug Abuse, or Mental Health	2	0	0	0		0	0	0	0	5	8	15
Pharmacy	13	3	35	29	24	11	3	1	1	8	2	30
Physicians	63	15	74	114	85	60	4	15	7	31	88	102
Physician Assistants	1	0	3	0	2	0	0	0	0	1	1	1
Chiropractors	1	0	0	0	1	4	0	3	0	2	0	2
Podiatry Services	1	0	0	0	3	0	1	0	0	1	0	2
Nurses	1	0	2	0	1	0	0	0	1	1	5	2
Dental	27	2	4	5	1	2	1	1	0	2	0	6
Laboratory	5	3	3	0	1	1	0	0	0	0	0	3
Home Health Care	2	0	0	5	31	46	7	7	2	14	14	39
Home and Community-Based	3	0	9	13	30	47	27	42	44	42	56	64
Therapy	2	0	0	1	1	9	4	3	5	9	2	6

	Fiscal Year											
	2001-02[1]	2002-03[1]	2003-04[1]	2004-05[1]	2005-06[1]	2006-07[1]	2007-08[1]	2008-09[1]	2009-10[1]	2010-11[1]	2011-12[1]	2012-13[1]
Durable Medical Equipment Suppliers/ Medical Supplies	8	4	22	49	0	0	6	2	16	0	2	7
Public Health Provider	0	1	0	0	0	0	0	0	0	0	0	0
Assistive Care Services	0	0	5	3	9	7	4	4	2	9	28	44
Skilled Nursing Provider	0	0	0	0	0	0	0	0	0	0	0	4
Transportation	0	0	0	2	0	0	0	0	0	0	0	0
Managed Care Organization	–	–	–	–	–	–	–	0	0	0	1	0
Non- Medicaid Managed Care Provider	–	–	–	–	–	–	–	0	0	0	3	22
Other	0	0	3	3	5	7	2	0	7	6	7	12
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[7]	$12,420,695[8]	$15,105,407[9]	$15,092,040[10]	$14,199,749	$9,665,863	Not Available
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	$8,558,901	$8,516,519	$13,200,000	$10,400,000
Office of General Counsel, 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	$1,373,866	$1,173,384	Not Available
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	$1,384,342	$1,156,304	$1,111,031
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	78	229	255
Document Actions Taken to Prevent Overpayments	Annual Report	Annual Report	Annual Report	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	Annual Report	Annual Report	Annual Report

[1] Annual reports on the state's efforts to control Medicaid fraud and abuse, Agency for Health Care Administration and Department of Legal Affairs.

[2] In Fiscal Years 2001-02 through 2007-08, cases referred from the HMO Investigative Unit were included in the "Other" category.

[3] 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.

[4] 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.

[5] 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.

[6] This category was added to the annual reports beginning in Fiscal Year 2011-12.

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

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

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

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

Source: Agency for Health Care Administration Medicaid Fraud Control Unit and Department of Legal Affairs annual reports required by Ch. 2002-400, *Laws of Florida*.

Appendix B

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

The Legislature has revised state law substantively since 2000 to increase efforts to prevent, deter, and recover Medicaid funds lost to fraud and abuse. (See Exhibit B-1.)

Exhibit 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 clarified 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 made 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 authorized AHCA 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 authorized AHCA 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 addressed provider participation, including requiring providers to notify AHCA of pending bankruptcies and allowing AHCA to deny participation if additional providers are not needed. It also authorized AHCA to withhold provider payments even for providers who 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 prescribed on-site inspections for provider enrollment, required AHCA to deny provider applications based on certain financial circumstances, required imposition of sanctions or disincentives except in certain circumstances, expands circumstances where AHCA can withhold payments or terminate a provider from the Medicaid program, and required AHCA 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 eliminated Medicaid eligibility for any person found to have committed fraud twice within five years and requires AHCA to seek a federal waiver to terminate eligibility in certain circumstances. This law also allowed AHCA to limit the provider network using credentialing criteria, service need, past program integrity history, and compliance with billing and record keeping. Further, this law allowed AHCA 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, it directed AHCA to use peer reviews to assess medical necessity, required providers to acknowledge in writing their understanding of Medicaid laws and regulations, further clarified the criteria AHCA must use when auditing pharmacies, and eliminated 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 stipulated that at least 5% of all audits conducted to determine fraud, abuse, and overpayment must be conducted on a random basis. It also required AHCA 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 stated 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 required AHCA to submit policy recommendations to the Legislature with its annual report. It also required AHCA to identify and monitor patterns of Medicaid services overutilization. This law extended 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 required AHCA to report any imposed administrative sanction on a provider to any other state entity which regulates that provider within five business days. In addition, it required AHCA to mail an explanation of benefits to each Medicaid recipient at least three times annually; to publish on its website, and update monthly, a searchable list of Medicaid providers who have been terminated or subjected to sanctions; and to compile and update biannually a list of all state and federal databases containing health care fraud information. Furthermore, it directed AHCA 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 directed AHCA 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 required that all home health services be medically necessary and written on a prescription that is signed and dated by an ordering physician. It stipulated 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 directed AHCA 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 required AHCA 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 designated Miami-Dade County as a health care fraud crisis area. In addition, this law imposed 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 AHCA. The law stipulated 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 directed AHCA 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 revised 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 required 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 established 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 established 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 required 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 allowed AHCA 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.
Chapter 2011-61, Laws of Florida (Sections 1 and 2)	***Medicaid.*** This law revised the minimum staffing requirements for nursing homes. It also required AHCA to deny an applicant for a license or license renewal if the controlling interest of the applicant or any entity in which a controlling interest of the applicant was an owner or officer during the occurrence of certain actions. This law also repealed the sunset of provisions authorizing the federal waiver for certain persons age 65 and older or who have a disability.

State Law	Topic(s) Addressed
Chapter 2011-134, *Laws of Florida* (Sections 1, 5, 8, 10, 13, and 16)	***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. It establishes provider services network requirements, effective prepayment and post-payment review processes, and monitoring and reporting performance measures. It provides a grievance resolution process, quality criteria for plan selection and achieved savings rebates, 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 AHCA to impose fines when a plan fails to comply with the encounter data reporting requirements.
Chapter 2011-135, *Laws of Florida* (Section 1, 2, and 30)	***Medicaid.*** This law required the Agency for Persons with Disabilities to collect premiums or cost sharing for home and community-based delivery systems; required the agency to establish corrective action plans; provided that implementation of Medicaid waiver programs and services authorized under Ch. 393, *Florida Statutes*, are subject to certain funding limitations; prohibited the agency from imposing sanctions related to patient day utilization by patients eligible for care under Title XIX of Social Security Act for nursing home, effective on specified date; and extended certificate-of-need moratorium for additional community nursing home beds. The law also required AHCA to develop a reorganization plan for realigning the Medicaid Program's administrative resources.
Chapter 2012-44, *Laws of Florida* (Sections 1, 2, 3, and 4)	***Medicaid managed care.*** This law specified which health plan entities are subject to the subscriber assistance program. It authorized AHCA to extend or modify certain contracts with behavioral health care providers under specified circumstances, and set enrollment requirements. It also directed AHCA to calculate a medical loss ratio for managed care plans under specified circumstances and provided a method for calculating the medical loss ratio. In addition, it clarified that Medicaid contracts are not rules and are not subject to the Administrative Procedure Act, Ch. 120, *Florida Statutes*.
Chapter 2012-64, *Laws of Florida* (Sections 1 and 2)	***Health care fraud***. This law revised the grounds under which the Department of Health or corresponding board is required to refuse to admit a candidate to an examination and refuse to issue or renew a license, certificate, or registration of a health care practitioner. It also provided conditions for persons who were denied renewal of licensure, certification, or registration to regain licensure, certification, or registration only by completing the application process for initial licensure.
Chapter 2012-73, *Laws of Florida* (Sections 1, 4, 6, and 11)	***Background screening.*** This law exempted from the fingerprinting and screening requirements certain mental health personnel who work on an intermittent basis for less than 15 hours per week of direct, face-to-face contact with patients; required background screening and rescreening of certain persons who have contact with vulnerable persons; authorized an employer to hire an employee to a position that otherwise requires background screening before the completion of the screening process for the purpose of training the employee; and prohibited the employee from having direct contact with vulnerable persons until the screening process is complete.
Chapter 2013-48, *Laws of Florida* (Section 6)	***Medicaid recoveries.*** This law established the requirements and timeframe for a recipient to contest the amount designated as recovered medical damages payable to AHCA and required that the recipient prove that a lesser portion of the total recovery should be allocated as reimbursement for past and future medical expenses. In addition, the law required that all administrative proceedings be located in Leon County and appeals arising from administrative proceedings be heard in the First District Court of Appeals in Leon County. It also required that the party bear its own attorney fees and costs for any administrative proceedings.
Chapter 2013-150, *Laws of Florida* (Sections 1 through 6)	***Modifies provisions for enrolling providers and conducting background checks; conducting audits; and settling claims and contesting and appealing agency findings.*** This law required that a change in principal be reported by the Medicaid provider to AHCA. It revised the provisions relating to AHCA's on-site inspection responsibilities; revises provisions relating to background screening; authorized AHCA to enroll a provider who is licensed in this state and provides diagnostic services through telecommunications technology; and revised provisions relating to settlements of Medicaid claims. In addition, it provided procedures for contesting the amount of medical expense damages; established the conditions regarding what is admissible as evidence, the venue for administrative proceedings and appeals, and attorney fees and costs; revised the grounds for terminating a provider from the program, for seeking certain remedies for violations, and for imposing certain sanctions; provided limitation on the information AHCA may consider when making a determination of overpayment. It also specified the records a provider must present to contest overpayment; clarified a provision regarding accrued interest on certain payments withheld from a provider; deleted the requirement that AHCA place payments withheld from a provider in a suspended account and revised when a provider must reimburse overpayments. In addition, it revised the membership requirements for the Medicaid and Public Assistance Fraud Strike Force within the Department of Financial Services and provided for future review and repeal of the strike force and interagency agreements to detect and deter Medicaid and public assistance fraud unless reenacted by the Legislature.
Chapter 2013-242, *Laws of Florida* (Section 1)	***Personal identification theft.*** This law defined illegal possession of personal identification and establishes criminal penalties for possession of personal identification.

Source: OPPAGA analysis of Florida laws.

Appendix C

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

January 27, 2014

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 your preliminary report entitled *Medicaid Program Integrity Recovers Overpayments in Fee-For-Service and Monitors Fraud and Abuse in Managed Care*. Our response is enclosed.

If you have any questions regarding our response, please contact Mary Beth Sheffield, Audit Director, at 412-3978.

Sincerely,

Elizabeth Dudek
Secretary

ED/mbs
Enclosure

2727 Mahan Drive • Mail Stop #1
Tallahassee, FL 32308

Visit AHCA online at
AHCA.MyFlorida.com

Agency for Health Care Administration
Medicaid Program Integrity Recovers Overpayments in Fee-For-Service and Monitors Fraud and Abuse in Managed Care
Response to OPPAGA Draft Report, dated January 2014

AHCA is updating its case management system and procuring advanced detection technology.

Recommendation #1

a) AHCA should ensure that the new case tracking system enhances the existing capabilities of the old system and automates features such as merging hard copy reports into case files and generating required provider notification letters and agency alerts.
b) The new system also should allow management to track the time and costs required to complete each phase of the investigation process and to improve aspects of the investigation, such as automating collection of documentation and standardizing agency notifications and letters.
c) In addition, the new system should allow the bureau to reduce the time and errors inherent to manual processes with its current system.

Agency Response

The Agency agrees with this recommendation and these features will be specified to the vendors during the negotiation phase of the case management system procurement.

Recommendation #2

AHCA should ensure that the procurement is sustainable and that it enhances the agency's current detection of abuse and fraud and recoupment of overpayments.

Agency Response

The Agency agrees with this recommendation; however, sustainability of the advanced data analytics program is dependent upon continued legislative funding.

AHCA is shifting program integrity resources from fee-for-services activities to managed care and revising its organizational structure.

Recommendation #3

In centralizing its approach to monitoring plan compliance, AHCA should include coordinating communication among all agency staff involved in managed care plan oversight.

Agency Response

Coordinating communication among all agency staff involved in manage care plan oversight is indeed a fundamental role of contract managers. While contract managers will serve as the primary point of contact between the Agency and contracted managed care plans, other agency staff will interact directly with plans on compliance issues related to their respective functional areas. These areas include, but are not limited to, provider network oversight, complaints and grievances, encounter data reporting, and, of course, program integrity. Contract managers are expected to be aware of, involved in, or directing (as appropriate to the specific issue) all contract compliance activities across functional areas. This will provide for a more comprehensive perspective of plan performance and the ability to "connect the dots" broader contract compliance and program integrity issues and trends that may be less apparent from within a given functional area.

Agency for Health Care Administration
Medicaid Program Integrity Recovers Overpayments in Fee-For-Service and Monitors Fraud and Abuse in Managed Care
Response to OPPAGA Draft Report, dated January 2014

Recommendation #4
AHCA should consider developing a plan tracking system that would allow managers to identify potential program integrity concerns. For example, such a system could provide trend data on grievances and complaints, plan performance measures, and provider network changes. It could also alert contract managers when plans fail to submit required reports to the agency.

Agency Response
The Agency anticipates that a number of systems will be used by both contract managers and Agency staff involved in managed care plan oversight across different functional areas. These include, but are not limited to, the Complaints and Issues Tracking System (CIRTS) for enrollee and provider complaints, the Provider Network Verification (PNV) system for plan's provider network oversight, the Versa Regulation (VR) system for enforcement of liquidated damages and sanctions, as well as the new Medicaid Program Integrity Advanced Data Analytics System. Additionally, contract managers will have access to various analytical reports, such as Compliance Reports for measuring the completeness and timely submission of encounter data.

The Florida Legislature

Office of Program Policy Analysis and Government Accountability

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