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AHCA Reorganized to Enhance Managed Care Program Oversight and Continues to Recoup Fee-for-Service Overpayments

at a glance

As of December 2015, 80% of Florida's approximately 3.9 million Medicaid recipients received medical and long-term care services from managed care plans.

As part of 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, the Bureau of Medicaid Program Integrity (MPI) further reorganized to place greater emphasis on fraud and abuse in Medicaid managed care. MPI is establishing new policies and procedures for monitoring managed care program integrity efforts and has developed processes and systems to analyze managed care plan data. In implementing Statewide Medicaid Managed Care, AHCA reorganized the Medicaid Program including contract management processes and oversight of Medicaid managed care plans that support program integrity efforts.

MPI uses several methods to identify potential cases of Medicaid overpayment to fee-for-service providers. MPI has continued to recoup overpayments and sanction providers who overbill; during Fiscal Year 2013-14, AHCA levied $2.6 million in fines against 431 providers who had received $15.2 million in overpayments. AHCA also updated its case management system and implemented an advanced data analytics system to enhance detection and recovery efforts.

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 systems and processes for monitoring fraud and abuse and program integrity in Medicaid managed care and efforts to detect and recover overpayments from fee-for-service providers.

Background

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. Florida's Medicaid Program, administered by AHCA, is among the largest in the country, serving approximately 3.9 million persons each month. For Fiscal Year 2015-16, the Legislature appropriated $23.5 billion to operate the program. Of this amount, $5 billion is general revenue and $18.5 billion is derived from trust funds that include federal matching funds and state funds derived from drug rebates, hospital taxes, and county contributions.

[1] Prior reports related to Medicaid program integrity are available on OPPAGA's website.

The 2011 Legislature required that all Medicaid recipients who were not otherwise exempt receive services through managed care.[2] AHCA completed the transition to Statewide Medicaid Managed Care (SMMC) for Long-Term Care and the Managed Medical Assistance Program in August 2014. As of December 2015, 80% of Florida's Medicaid recipients received medical and long-term care services by enrolling in a managed care plan. Under managed care, Medicaid pays a plan a monthly contracted amount per recipient for health and support services, and the plan's medical and support staff work to ensure that recipients receive adequate care without unnecessary costs. Medicaid recipients who are exempt from mandatory managed care enrollment receive services from Medicaid providers paid on a fee-for-service basis.[3]

Health care programs, including Medicaid, are vulnerable to payment error, abuse, and fraud, which can occur in many forms.[4] Under managed care, providers may inflate or falsify the billing of services or the reporting of rendered services because this data is used to calculate providers' reimbursement rates. Higher billing claims may inflate providers' future reimbursement rates, and the reporting of services not rendered can distort the assessment of providers on their provision of, access to, and quality of care. Likewise, fee-for-service providers commit fraud and abuse by overbilling for services provided as well as deliberately billing for services that are not medically necessary or were not delivered.

AHCA requires managed care plans to establish program integrity functions and report on fraud and abuse.[5] The managed care contracts require plans to establish or contract for fraud investigative units and annually submit comprehensive compliance and anti-fraud plans to AHCA; establish internal controls, which include prior authorization, utilization management, and post review of claims; and provide employees with fraud and abuse prevention training. In addition, during the provider hiring, contracting, and re-credentialing processes 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 are also required to report quarterly and annually on their fraud and abuse activities and their experience in implementing their anti-fraud plans. The reporting requires detailed information on the number of referrals made to AHCA's Bureau of Medicaid Program Integrity (MPI), outcomes of investigations, and the dollar amount of vendor losses and recoveries attributable to fraud, abuse, and overpayment. Plans are also required to report each suspected or confirmed instance of provider or recipient fraud or abuse.

AHCA has the authority to impose fines or liquidated damages on plans that do not comply with contractual or statutory requirements and to require corrective action plans. For example, AHCA is authorized to fine plans $1,000 per calendar day for failing to report each suspected or confirmed instance of provider or recipient fraud or abuse within 15 days after detection.[6] In addition, AHCA is authorized to assess liquidated damages of $10,000 for each occurrence when plans fail to establish an investigative unit by the time the first recipient is enrolled or that fail to

[2] Chapter 2011-134, *Laws of Florida*.

[3] Exempt Medicaid recipients may choose to enroll voluntarily in Medicaid managed care plans. Exempt recipients include those who have other creditable health care coverage (excluding Medicare); reside in a Department of Juvenile Justice or mental health residential treatment 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.

[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] Federal regulations also require Medicaid managed care plans to have policies and procedures in place to guard against fraud and abuse.

[6] Section 409.91212(5), *F.S.*

implement an anti-fraud plan within 90 days of agency approval, as required by contract.[7, 8]

MPI has primary responsibility for administering and overseeing prevention and detection efforts for both managed care and fee-for-service. MPI, placed within AHCA's Office of Inspector General, is responsible for ensuring that managed care plans comply with contract requirements to have systems to prevent, detect, and deter abusive and fraudulent practices. The bureau is also responsible for identifying and investigating fee-for-service providers suspected of error and abuse. MPI refers providers suspected of fraud to the state's Medicaid Fraud Control Unit (MFCU) in the Office of the Attorney General. The unit is responsible for conducting fraud investigations and prosecuting providers who are accused of defrauding Medicaid.[9]

MPI's Fiscal Year 2015-16 approved operating budget to address fraud and abuse was $7.2 million, all of which is derived from the Medical Care Trust Fund. The trust fund includes funds recouped from past program integrity efforts and a 50% federal match for MPI functions. The program has 90.5 full-time equivalent positions and 27 other-personal-services positions. In addition to MPI's efforts, AHCA's Medicaid Program fulfills responsibilities and functions that ensure program integrity of the managed care plans.

Managed Care

AHCA reorganized MPI to place greater emphasis on managed care

With the implementation of Statewide Medicaid Managed Care (SMMC), MPI has further reorganized to place greater emphasis on managed care.[10] MPI is revising its policies and processes for monitoring managed care program integrity; in the interim, MPI reported that it is working collaboratively with plans to improve their anti-fraud capabilities. MPI conducts preliminary investigations before making referrals to MFCU.

MPI reorganized to place greater emphasis on managed care. Since our 2014 review, MPI divided its dedicated managed care unit into three functional areas—overseeing managed care plans' anti-fraud and compliance plans; monitoring managed care plans' compliance with reporting requirements; and investigating suspicious activities. By separating managed care investigations from oversight and monitoring functions, MPI reports that it will work collaboratively with plans on preventing and detecting fraud while maintaining the independence necessary for investigating potential managed care abuse. (See Appendix A for a summary of MPI's organization.)

MPI also centralized its complaint intake activities for both managed care and fee-for-service. All complaints of fraud and abuse, including suspected fraud and abuse reported by managed care plans, are reported to a central intake section; staff enters the complaints into the bureau's case management system. Once entered into the system, staff either opens the complaint as a case or the complaint is communicated to other relevant areas for follow-up, including the Medicaid Program, the Department of Health, and MFCU.[11]

MPI is revising its policies and processes for monitoring managed care program integrity. With the reorganization, MPI's focus has been to work collaboratively with plans' fraud investigative units to improve their anti-fraud oversight and enforcement capabilities. For example, MPI reviews the plans' individual

[7] Plans that fail to implement an MPI-approved anti-fraud plan within 90 days may incur liquidated damages. MPI may reassess the implementation of the anti-fraud plan every 90 days until it deems the plan to be in compliance.

[8] Section 409.91212(5), *F.S.*, directs AHCA to impose an administrative fine of $2,000 per calendar day to plans that fail to submit an acceptable anti-fraud plan and up to a $10,000 fine for plans that fail to implement an anti-fraud plan or investigations unit.

[9] To receive federal funds, Florida must identify and investigate fee-for-service providers suspected of fraud and abuse.

[10] As we reported in our January 2014 report, ACHA reorganized the bureau to increase managed care oversight in August 2013.

[11] Cases that originate as the result of managed care plan required reporting are forwarded to the MPI managed care unit for further analysis. For complaints from the public, the MPI intake section will identify whether the provider is a Medicaid provider or is serving in one or more of the managed care plan networks. If the complaint is not abuse or fraud related, it will be forwarded to the appropriate Medicaid Program unit.

reports of suspected fraud and abuse and conducts supplemental investigations to ensure identification of all potential violations and that all information is gathered and triaged. It also works with plans to enhance their anti-fraud activities, which may involve coordinating assistance from designated subject matter experts in other AHCA units. For example, MPI may request that the Bureau of Medicaid Policy staff or the Division of Health Quality Assurance's Bureau of Health Facility Regulation help a plan better understand how a provider is violating policy or licensing requirements applicable to a specific provider type. MPI also assists plans in identifying potential problem providers to audit and gather useful information on suspected abusive or fraudulent providers. In addition, MPI conducts quarterly meetings with plans' anti-fraud investigative units that serve as open forums to educate and communicate on anti-fraud activities amongst the plans.

Because of its focus on working with plans, MPI has temporarily discontinued some of its prior monitoring efforts. Since the implementation of SMMC, MPI has temporarily discontinued on-site monitoring of plans' anti-fraud and abuse activities. Prior to MPI's reorganization, AHCA conducted desk and on-site reviews to monitor plans' anti-fraud activities. Program integrity staff reported that since SMMC implementation, it had not conducted on-site monitoring of the managed care plans' anti-fraud and compliance plan activities and was still developing a monitoring tool.

MPI staff reported that plans have not been sanctioned or assessed liquidated damages, as authorized in the managed care plan contracts, for plan failure to report suspected fraud or abuse within 15 days. MPI staff reported that they are hesitant to recommend fining or assessing liquidated damages against plans for late reporting because plans have varying interpretations of what constitutes suspected fraud, and plans have difficulty generating timely reports if the source of originating information is a subcontractor.[12]

Moreover, MPI no longer routinely compiles summary information about managed care plans' fraud and abuse activities. Previously, MPI compiled individual plan data on the annual number of providers suspected of fraud and abuse, the amount of overpayments, the amount of monies lost to fraud, and the amount of monies lost to fraud that were recovered. MPI used this type of information to identify the magnitude of plan efforts and compare plans' efforts. AHCA officials report that they will strengthen the reporting requirements in April 2016.

With a full year of SMMC implementation complete in October 2015, MPI should finalize tools and procedures to ensure compliance with anti-fraud contract requirements and to determine the effectiveness of plans' anti-fraud activities.[13] MPI should determine the type of monitoring tool to use and decide if and how often to conduct site visits.[14] AHCA also should resume assessing fines or liquidated damages when plans do not comply with the anti-fraud activities or requirements specified in the contract.

As part of its efforts to assess plans, MPI should also identify the most useful information necessary to monitor the plans and should use such information to establish benchmarks or standards for assessing plans.[15] For example, it could establish a benchmark for the expected number of suspected fraud referrals. Finally, with the transition to SMMC, AHCA should include aggregate information on each

[12] Program staff uses plans' 15-day suspected and confirmed fraud and abuse reports as a comparison with fee-for-service claims and reviews the Florida Medicaid Management Information System (FMMIS) to determine if the provider was enrolled as a fee-for-service provider and also determines if the provider was serving in other managed care plan networks. The results of the preliminary analysis may be forwarded to other areas in the agency to assist in MPI's monitoring of the provider and the provider network activities.

[13] AHCA staff reported that they had planned to begin monitoring efforts during the first quarter of 2016 but have been delayed.

[14] AHCA could continue to utilize the monitoring tool used for assessing anti-fraud plan compliance under Medicaid Reform and modify it to include updates that have been made to the plan contracts.

[15] As part of its strengthened reporting requirements, effective April 2016, AHCA officials said that this information could be used for establishing benchmarks. It should be noted that it will be 2017 before AHCA has a year of data to establish benchmarks.

managed care plan's fraud and abuse prevention, detection, and recovery of overpayments in its Annual Medicaid Fraud and Abuse Activities Report.[16]

MPI conducts preliminary investigations before making referrals to MFCU. Section 409.913(4), *Florida Statutes*, requires that AHCA refer any suspected criminal violations that it identifies to MFCU for investigation. A 2013 memorandum of understanding (MOU) between MFCU and AHCA requires AHCA to promptly refer suspected cases of civil or criminal fraud or a violation of the Federal False Claims Act or Florida False Claims Act and provide all relevant information for civil or criminal prosecution, without regard to the origination of the referral. During the course of our review, MPI and MFCU reported that they were working to revise the MOU.

The current MOU was executed prior to the full implementation of SMMC with managed care contract requirements for plans' fraud investigative units to report suspected fraud and abuse to MPI. Currently, MPI refers managed care reports of suspected fraud to MFCU following its own preliminary investigation.[17] While MPI staff reported that they work with the plans to acquire additional information to assess the need to refer a case, MFCU staff reported that having contemporaneous access to all managed care plans' reports of suspected fraud enhances its ability to adequately investigate and enforce fraud control and could increase its ability to build a more robust prosecution for both state and federal cases. AHCA officials do not believe that simultaneous or instantaneous reporting will be helpful.

The National Association of Medicaid Fraud Control Units recommends that managed care plans simultaneously report suspected fraud and abuse to both MPI and MFCU. A U.S. Department of Health and Human Services Report review of Medicaid Fraud Control Units found that nationwide Medicaid managed care plans have been responsible for fewer referrals to MFCUs than expected.[18]

In Fiscal Year 2013-14, 21 Florida Medicaid managed care plans identified $34.8 million in overpayments, $27.9 million of which were recovered.[19] In addition, the plans referred 1,013 cases of suspected fraud to MPI with $1.8 million identified that had been lost to abusive activities; $875,793 was recovered. Between August 2014 and August 2015, MPI had forwarded 26 incidents of suspected fraud and abuse reported by managed care plans to MFCU. To increase both MPI's and MFCU's abilities to fulfill their respective oversight and law enforcement responsibilities, AHCA should explore options to expedite the sharing of information and referral of cases of suspected fraud to MFCU.

AHCA has continued to develop accountability systems that support program integrity

In addition to MPI's efforts, the Medicaid Program has processes and systems to analyze managed care plan data that support program integrity initiatives. AHCA also reorganized the Medicaid Program into subject matter areas in an effort to improve contract management and oversight of Medicaid managed care plans. As part of this oversight process, Medicaid staff reported that they would refer issues that appear to be abusive or fraudulent to MPI.[20] At the time of our review, while the processes were in place and the reorganization was

[16] Chapter 2002-400, *Laws of Florida*, requires AHCA to annually report key statistics on MPI activities, including the number of cases opened and investigated, disposition of closed cases, and average time (in days) to collect overpayments. See Appendix B for information required by law for Fiscal Years 2002-03 through 2014-15.

[17] Federal regulation 42 CFR 455.14 requires that the state Medicaid agency conduct a preliminary investigation before making a referral to MFCU. AHCA acknowledges that plans need better training about effective fraud reporting.

[18] *Medicaid Fraud Control Units Fiscal Year 2013 Annual Report*, Department of Health and Human Services' Office of Inspector General Report OEI-06-13-00340, March 2014; *Medicaid Fraud Control Units Fiscal Year 2014 Annual Report*, Department of Health and Human Services' Office of Inspector General Report OEI-06-15-00010, April 2015.

[19] During our review, summary information on overpayments, recoveries, and the number of (and amount identified and recovered by) providers suspected of fraud from managed care plans was not available for Fiscal Year 2014-15.

[20] Other AHCA divisions and offices also support MPI functions. See Appendix A for a summary of these entities.

primarily complete, there was limited data to comprehensively assess and report on the effectiveness of these efforts.

AHCA has processes and systems to hold managed care plans accountable for providing appropriate and necessary health care services. In addition to the specific program integrity requirements that MPI oversees, AHCA is responsible for ensuring that managed care plans provide appropriate and necessary medical services to recipients in a timely and quality manner. To do this, AHCA

- evaluates plan performance to ensure continuous improvement;
- assesses provider network adequacy and tracking grievance and complaint resolution to ensure access to care for needed health care services;
- uses achieved savings rebate incentives to encourage efficiencies and high performance; and
- screens providers to prevent problem or abusive providers from participating in Medicaid managed care plans. (See Exhibit 1.)

Exhibit 1
To Support Program Integrity Initiatives, AHCA Developed Accountability Systems to Monitor Managed Care Plans

Accountability System	Agency Activities
Continuous Performance Improvement	AHCA monitors and evaluates performance by requiring plans to annually report measures from the federal Health Care Effectiveness Data and Information Set and agency-defined measures. The measures allow AHCA to assess provision of services and quality of care. The agency has established minimum performance thresholds that plans are required to meet or exceed and issues sanctions for not meeting these thresholds. AHCA may require plans identified as having poor performance to develop performance measure action plans and/or assess sanctions or liquidated damages. Plans' performance measure data will be reviewed by the Bureau of Medicaid Policy and Quality's Performance, Research, and Evaluation Unit, and, if necessary, be forwarded to MPI.[1]
Access to and Provision of 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 its 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 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 also must verify that enrollees received billed services by providers.
Achieved Savings Rebate	AHCA implemented the Achieved Savings Rebate Program as an incentive for proper use of state funds. The program monitors plans' premium revenues, medical and administrative costs, and income or losses in a uniform manner. Plans' detailed financial reports are audited by an independent public accountant. AHCA is promulgating program rules to ensure the independence of the public accountant and establishing criteria for the independent auditor. The program is tied to plan performance; when a plan exceeds agency-defined quality measures in the reporting period, it may retain an additional 1% of revenue.
Provider Background Screenings	AHCA has integrated many state agencies and Medicaid managed care plans into the Care Provider Background Screening Clearinghouse, which provides a single data source for state and national fingerprint-based criminal history screening results of persons required to be screened by law for employment in positions that provide services to children, the elderly, and disabled individuals. By providing a single data source, Medicaid and managed care plans can more efficiently screen out problem providers.[2]

[1] AHCA requires that the plans collect and report performance measures certified by a qualified auditor. AHCA publishes plans' performance measures in a comparative table for consumers at FloridaHealthFinder.gov. Plan enrollees have access to an online provider directory. AHCA incorporated initial Healthcare Effectiveness Data and Information Set (HEDIS) information for online report cards for each managed care plan in December 2015.

[2] As of fall 2015, all agencies have been incorporated into the clearinghouse database. Clearinghouse database agency users include: AHCA, AHCA Medicaid Program, AHCA Medicaid managed care plans, the Department of Health, the Division of Vocational Rehabilitation, the Department of Children and Families, the Agency for Persons with Disabilities, the Department of Elder Affairs, and the Department of Juvenile Justice.

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

With implementation of SMMC, AHCA developed systems to carry out these responsibilities. For example, to ensure continuous performance improvement, AHCA requires plans to report data on national performance measures, child core measures, and state-defined measures. AHCA is using these measures to create consumer report cards; the agency released these report cards with initial Healthcare Effectiveness Data and Information Set (HEDIS) measures in December 2015.[21]

To assist managed care plans in screening out problem providers, AHCA streamlined provider background screenings by developing the Care Provider Background Screening Clearinghouse. The clearinghouse is a secure website that provides a single data source for the registry of state and national fingerprint-based criminal history screening and results of persons required to be screened by law for positions that provide services to children, the elderly, and disabled individuals. Specified state agencies and Medicaid managed care plans have access to the clearinghouse for both reporting and research functions.[22]

To assess provider network adequacy, AHCA uses both the clearinghouse and commercial software to compare plans' capacity and the geographic availability of their enrolled network providers to plans' enrolled recipient data to create capacity ratios; the ratios are then compared to contractually prescribed access standards.[23]

Since our 2014 review, AHCA has improved the managed care encounter data. In July 2014, the Florida Medicaid Management Information System (FMMIS) was modified to identify duplicate encounters resubmitted with corrections. Furthermore, the agency developed a process to enroll, register, and link providers that registered in multiple plan networks to a unique provider number. Uniquely identifying providers is necessary to analyze encounters by provider.

AHCA developed these accountability systems prior to and during SMMC implementation. However, the agency should continually assess these systems to identify modifications that would improve plan oversight. For example, AHCA's automated provider network verification system uses Medicare's network adequacy standards. In August 2015, the U.S. Government Accountability Office (GAO) released its evaluation of the federal CMS's oversight of Medicare Advantage provider networks.[24] GAO recommended that CMS augment oversight of provider networks to include, for example, verification of provider information submitted by managed care organizations and periodic reviews of managed care organization network information.

AHCA officials report that managed care standards incorporate all of the GAO recommendations. AHCA should continue to seek similar opportunities to augment all of its accountability systems for ongoing improvement of plan monitoring and oversight.

AHCA's reorganization of the Medicaid Program included modifying contract management and monitoring. In 2014, we reported that AHCA was revising its organizational structure to reflect the shift to managed care. Since that time, AHCA has reorganized the Medicaid Program into three sections—Operations, Policy and Quality, and Finance and Analytics.[25] In an effort to more

[21] HEDIS measures are calculated using calendar year data and require six months of activity to evaluate outcomes. AHCA reported the agency did not have complete data to evaluate plans that began enrollment near or at the end of SMMC implementation in August 2014. Thus, AHCA will not be able to release a formal HEDIS report card until summer 2016.

[22] The 2012 Legislature directed AHCA to create the Care Provider Background Screening Clearinghouse.

[23] AHCA uses Quest Analytics, a commercially available software used by health plans. The software calculates capacity ratios for each plan's primary and specialty care providers using provider network data submitted by the plans. Applying geo-access mapping, the software uses on provider and plan recipient locations to generate county-level average time and distance.

[24] *Report to Congressional Requesters, Medicare Advantage Actions Needed to Enhance CMS Oversight of Provider Network Adequacy*, Government Accountability Office Report GAO-15-710, August 2015.

[25] The Operations section is responsible for managed care contract management, managing fiscal agent activities, managing the call center and choice counseling, and assisting recipients and providers. The Policy and Quality section is responsible for developing Medicaid Program policies and monitoring quality, while the Finance and Analytics section is responsible for reviewing managed care plan financial statements and

effectively oversee managed care plans, rather than assigning all oversight responsibilities to one contract manager, each section has oversight responsibilities. Subject matter experts in each section communicate potential issues to the contract manager responsible for each plan's contract compliance. For example, financial specialists in the Finance and Analytics section monitor plans' financial performance and are responsible for the achieved savings rebates and medical loss ratio calculations. In the Policy and Quality section, licensed health professionals with clinical expertise monitor data to assess and review quality of care. Within the Operations section, the FMMIS fiscal agent is responsible for maintaining data quality and processing encounter and provider enrollment data.[26] Subject matter experts report information to contract managers in the Operations section, who then manage coordinating and enforcing contract compliance.

Medicaid's reorganization was gradually implemented beginning in the fourth quarter of 2014. By centralizing its approach to monitoring contract compliance, AHCA believes it is more effectively coordinating communications among agency staff involved in managed care plan oversight and issues regarding program integrity. Utilizing agency subject matter experts should allow AHCA to better identify and compile anomalies and trends that might signal abusive behavior that should be referred to MPI. While the reorganization is nearly complete, there is limited data at this time to comprehensively report on the activities that Medicaid uses to oversee managed care compliance under the new structure.[27]

conducting managed care plan data analysis. (See Appendix A for a summary of Medicaid's organization.)

[26] The fiscal agent's duties include processing and editing encounter data, enrolling and terminating Medicaid providers, and communicating with plans on encounter data and provider enrollment issues. Data analysts generate encounter data and utilization reports, which are matched against the plan's financial data. Staff specializing in recipient and provider assistance analyzes grievances and complaints that are used to track plans' contract compliance and identify trends and recurring issues.

[27] While the agency's reorganization was approved in March 2015, staff continue to assess specific activities for better alignment and consolidation of functions.

Fee-for-Service

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

MPI uses several methods, including statistical analyses, to identify potential cases of Medicaid overpayment made to fee-for-service providers. The agency has continued to recoup overpayments and sanction providers who overbill. MPI updated its case management system and is implementing an advanced data analytics system to enhance detection and recovery efforts.

MPI has a formal process to recoup overpayments, including issuing a final order that identifies sanctions and costs.[28] The agency uses several methods to identify fee-for-service providers who have potentially 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.[29]

MPI investigators review initial information on potential overbillings to determine whether to open a case. If MPI opens a case, it requests supporting documentation, such as patient medical files, to conduct a more thorough review of the claims in question.[30] The provider has two opportunities to submit documentation.[31, 32, 33] MPI reviews the documentation for compliance with Medicaid policies, develops final audit findings, and

[28] Section 409.913(23), *F.S.*, grants AHCA the authority to recover investigative, legal, and expert witness costs.

[29] Section 409.913(25)(e), *F.S.*, allows AHCA to suspend these costs when it grants amnesty.

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

[31] When MPI 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.

[32] If the investigator suspects fraud, the case is referred to MFCU and the audit is suspended. However, the case remains open until MFCU completes its investigation and prosecution.

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

issues a final order, which sets forth the overpayments the provider must repay, agency costs for conducting the investigation, and the sanctions assessed.[34] The provider may appeal MPI's findings by requesting an informal hearing with the agency's general counsel or a formal hearing with the Division of Administrative Hearings.[35] MPI closes cases once it has recouped the overpayment in full. (See Appendix C for a diagram of MPI's investigatory process.)

MPI has made efforts to reduce the time it takes to recover overpayments. For example, the agency revised its approach to conducting preliminary investigations of fee-for-service providers by using risk assessment technology. Staff utilizes modeling that includes quantitative and qualitative analyses of providers. The modeling assesses the provider's professional associates and financial stability and generates a risk factor that represents the provider's likelihood to commit abuse or fraud. By strategically targeting preliminary investigations, MPI hopes to more effectively prevent, identify, and recover overpayments from fee-for-service providers. In addition, the 2013 Legislature placed greater restrictions on providers' documentation used for contesting an overpayment or sanction to only those records that are contemporaneous.[36, 37]

In Fiscal Year 2014-15, the average time from the date that MPI opened the case to the date the case was paid in full increased slightly to 234 days, compared to 228 days in Fiscal Year 2012-13, an increase of 2.6%.[38]

MPI sanctions fee-for-service providers who overbill the system; it also has an amnesty policy. To deter fraud and abuse, MPI amended agency rules in 2010 to increase the severity of punitive and monetary sanctions for failing to comply with Medicaid policies and requirements.[39] During Fiscal Year 2013-14, MPI levied $2.6 million in fines against 431 providers who had received $15.2 million in overpayments.[40] This was less than the amount of fines that MPI levied in the prior two years.[41] MPI continues to terminate providers by sanction; in Fiscal Year 2013-14, the agency terminated 73 providers.[42, 43] This was fewer terminations than in the prior two years.

However, many overpayment cases are not sanctioned due to amnesty policies. MPI grants amnesty when a fee-for-service provider performs a self-audit and when overpayments are less than a specified amount; providers still must repay identified overpayments.[44] MPI's amnesty policies reduce the burden placed on providers whose billing errors are minimal or who are proactive in identifying their own billing errors. In Fiscal Year 2013-14, 129 cases (8%) were not sanctioned because the provider

[34] As part of its review of provider records, AHCA contracts with 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.

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

[36] Since 2000, the Legislature has taken steps to prevent, detect, and recover misspent Medicaid funds. See Appendix D for legislative changes made to support Medicaid program integrity.

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

[38] MPI reported that in Fiscal Year 2013-14, the average collection time was 69 days, a decrease of 70% from the previous fiscal year. Staff speculated that this drop was inaccurately reported because the formal hearing process for providers who appeal audit findings lasts longer than 69 days.

[39] Rule 59G-9.070, *F.A.C.* 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.

[40] In Fiscal Year 2013-14, 47 providers were suspended and 73 were terminated from participation in the Medicaid Program.

[41] In Fiscal Years 2011-12 and 2012-13, AHCA levied $8.2 million in fines against 2,467 providers who received $58.8 million in overpayments.

[42] In Fiscal Years 2011-12 and 2012-13, AHCA terminated 103 and 91 providers, respectively.

[43] 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. 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.

[44] 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.

performed a self-audit, and 1,062 cases (65.5%) were not sanctioned because the provider qualified for amnesty or for other reasons. The cases that were granted amnesty amounted to $13.4 million in overpayments. (See Exhibit 2.)

Exhibit 2
During Fiscal Year 2013-14, MPI Sanctioned 27% of Provider Cases With Identified Overpayments

Case Resolution	FY 2008-09		FY 2009-10		FY 2010-11		FY 2011-12		FY 2012-13		FY 2013-14	
	Provider Cases/	Percentage	Provider Cases/	Percentage	Provider Cases/	Percentage	Provider Cases/	Percentage	Provider Cases/	Percentage	Provider Cases/	Percentage
No Sanction Applied	**783**	**60.8%**	**1,534**	**85.9%**	**1,161**	**71.7%**	**1,063**	**71.5%**	**901**	**67.2%**	**1,191**	**73.4%**
Amnesty or Other Reason	758	58.8%	1,179	66.0%	1,011	62.4%	935	62.9%	752	56.1%	1,062	65.5%
Self-Audit	25	1.9%	355	19.9%	150	9.3%	128	8.6%	149	11.1%	129	8.0%
Sanction Applied	**505**	**39.2%**	**252**	**14.1%**	**458**	**28.3%**	**423**	**28.5%**	**439**	**32.8%**	**431**	**26.6%**
CAP Only[1]	112	8.7%	2	0.1%	0	0.0%	0	0%	0	0	0	0.0%
Fine	393	30.5%	250	14.0%	458	28.3%	423	28%	439	32.8%	431	26.6%
Total	1,288		1,786		1,619		1,486		1,340		1,622	

[1] CAP stands for Corrective Action Plan.

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

MPI updated its case management system and is implementing advanced data analytics technology. The 2012 Legislature appropriated $800,000 in non-recurring funds for MPI to replace its case management system with one that includes features from the legacy system as well as additional features, such as the ability to track investigative costs and automate tasks that staff manually performed. The system was to incorporate advanced detection tools and be built on a software platform that AHCA could support.[45] However, after three unsuccessful procurement attempts, the 2013 Legislature appropriated an additional $3 million in non-recurring funds for a separate procurement of a data analytics system.[46] MPI purchased its new Fraud and Abuse Case Tracking System (FACTS) in April 2014.[47] In December 2014, AHCA signed a separate contract for a vendor-hosted, advanced data analytics system that uses predictive abuse detection algorithms to detect and identify suspicious provider activity.[48]

FACTS became operational in May 2015 and allows staff to track and manage the MPI work process, from the time the complaint is entered into the system to the time that the case is closed. Staff can create a case history by automating the process for initiating correspondence and append documentation including correspondence, evidence, audits, and analyses necessary to validate overpayments or create evidence to support administrative or legal challenges. The system includes standard templates to generate notices to providers and is capable of linking associated providers to current cases for ease of developing and investigating potential cases.

However, staff reported that AHCA still needs to develop the management functionality available in the previous case management system. For example, standardized reports that assist management in assessing performance are yet to

[45] The system is intended to track and manage the work process of MPI; track events, documents, and staff hours; interface with other commercially available applications from case intake through the legal process; and provide management with the tools to assess workloads and performance.

[46] The 2015 Legislature appropriated $3,045,000 in additional funding to continue the Public Benefits Integrity Data Analytics and Information Sharing Initiative.

[47] The $800,000 non-recurring contract for FACTS was awarded to Imager Software, Inc.

[48] The agency released its invitation to negotiate for the procurement of the advanced data analytics system in October 2013. The contract was awarded to SAS Institute, Inc.

be developed, and reminders for staff to complete certain fields before beginning the next step are either not available or may be circumvented, which may result in incomplete case documentation. To address these issues, the system should be modified to include reports that summarize the status of cases, including completion time, for various phases of the process as well as the case and the outcome. This will assist management in assessing performance and identifying areas to improve upon. In addition, the system should incorporate notices to remind staff to complete necessary tasks or to document activities.

AHCA anticipates that the new advanced data analytics system will provide pattern analysis that will include mapping social and entity relationships, conducting active pattern and fraud scheme analyses, and identifying investigation-ready leads based on suspicious behavior patterns using analyses of private business data. The software will score providers' financial risk, profile provider business transactions, and cross match provider demographic data to Medicaid enrollment and state licensure data.

At the time of our review, the agency and the vendor were working to integrate, modify, and test each of the more than 800 pre-defined fraud and abuse detecting scenarios and algorithms for compatibility with Florida's Medicaid and provider data system and state Medicaid policies and requirements. According to MPI, program integrity staff will also apply the algorithms to analyze encounter data. The initial implementation of the system became operational in August 2015. As new scenarios occur, MPI plans to write its own abuse detection algorithms.

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 E.

Appendix A

The Agency for Health Care Administration Reorganized to Administer Statewide Medicaid Managed Care and Support Program Integrity Functions

The Agency for Health Care Administration (AHCA) reorganized the Division of Medicaid and the Bureau of Medicaid Program Integrity (MPI) to implement and administer Statewide Medicaid Managed Care (SMMC). Exhibit A-1 summarizes MPI's organization to oversee Medicaid program integrity in both managed care and fee-for-service. Exhibit A-2 details other areas within Medicaid that also support program integrity activities. Exhibit A-3 summarizes other areas within AHCA that also support program integrity functions both directly and indirectly including legal, administrative, and provider background screening functions.

Exhibit A-1
As Part of Statewide Medicaid Managed Care Implementation, MPI Further Reorganized to Oversee Program Integrity

Office of Inspector General, Bureau of Medicaid Program Integrity		
Unit	**Section**	**Responsibilities**
Prevention and Program Oversight	Prevention Strategy and Oversight	▪ Coordinates program integrity activities with other Medicaid areas and state agencies ▪ Sends referrals to MFCU ▪ Creates a statewide strategic plan for conducting and coordinating field operations ▪ Analyzes data to direct field office investigations towards providers at highest risk for committing fraud and abuse ▪ Educates providers on Medicaid policy and proper billing practices ▪ Conducts on-site audits/preliminary investigations of providers in the Florida Panhandle
	Field Operations—Two Sections (Miami and Jacksonville/Orlando/Tampa)	▪ Conducts on-site audits/preliminary investigations of providers according to assigned regions (may also cover other regions) ▪ Educates providers on Medicaid policy and billing practices
Detection	Intake	▪ Receives and enters all complaints (from the public and managed care plans) into the case management tracking system ▪ Runs preliminary data queries to develop background information on provider(s) identified in the complaint ▪ Refers complaints to other divisions and agencies as appropriate (including Medicaid, DOH, DCF, and MFCU and the federal CMS) ▪ Distributes and reviews the recipients' explanation of medical benefits
	Data Analytics	▪ Conducts standard data mining and statistical analyses to identify fee-for-service providers whose billings practices appear to be outside the normal parameters of Medicaid policy ▪ Analyzes encounter data to identify problem providers serving in one or more plans to strengthen plans' identification and oversight of network providers and enhance MPI's investigations of providers

Office of Inspector General, Bureau of Medicaid Program Integrity		
Unit	**Section**	**Responsibilities**
Managed Care	Anti-Fraud and Compliance Plan	▪ Conducts desk reviews for contractual compliance of plans' anti-fraud and compliance plans (annually and when revisions are made by the plans) ▪ Conducts on-site monitoring of plans to ensure that plans are operating according to their anti-fraud and compliance plans ▪ Works collaboratively with plans to train and strengthen plans' anti-fraud activities At the time of our review, on-site monitoring had not occurred since SMMC implementation.
Managed Care (continued)	Reporting Compliance	▪ Ensures that plans comply with the mandatory reporting of suspected or confirmed fraud and abuse within 15 days of detection (15-Day Report), as well as Quarterly and Annual Fraud and Abuse Reports (QFAAR and AFAAR) ▪ Reconciles the 15-Day Reports to the QFAAR and AFAAR ▪ Assists plans in completing the 15-day reports ▪ Educates plans on how to strengthen the identification and reporting of suspicious providers and communicates with other plans and agency bureaus about plan reported provider information ▪ Assists the MPI Anti-Fraud and Compliance Plan section in reviewing plans' annual anti-fraud and compliance plans
	Investigations	▪ Investigates complaints received against plans ▪ Conducts investigations when a plan is conducting an internal investigation
Recoupment Efforts	Fee-for-Service Recoupment by Provider Type—Durable Medical Equipment and Pharmacy Providers, Institutional Providers (e.g., hospitals and nursing homes), Individual Practitioners (e.g., physicians, ARNPs, and Physician's Assistants)	▪ Audits and investigates fee-for-service providers to identify and recoup overpayments
	Generalized Analysis	▪ Audits and investigates single issues aggregated across many providers or provider types to identify and recoup overpayments paid to Medicaid fee-for-service providers

Source: OPPAGA analysis of the Agency for Health Care Administration's Bureau of Medicaid Program Integrity organization.

Exhibit A-2
Many of the Activities Performed by Medicaid's Newly Formed Functional Areas of Expertise Contribute to Program Integrity Efforts

Operations	
Bureau	**Responsibilities**
Medicaid Plan Management Operations	Manages and coordinates all SMMC contract compliance including coordinating intra- and inter-agency SMMC contract compliance actions and conducts on-site monitoring, complaint investigations, and oversight of plans reporting and marketing
Medicaid Fiscal Agent Operations	Plans, coordinates, and oversees all activities related to the Florida Medicaid Management Information System fiscal agent contract including processing claims and encounter data, provider enrollment and registration, management of the Medicaid Data Warehouse/Decision Support System, which is used by MPI to analyze Medicaid fee-for-service and encounter data
Enrollment Broker and Consolidated Call Center Operations	Oversees plans' network compliance and all parts of enrollment broker operations and choice counseling processes
Medicaid Recipient and Provider Assistance	Provides recipient support, including assessing complaints and grievances from both managed care providers and fee-for-service providers
Policy and Quality	
Bureau	**Responsibilities**
Medicaid Policy	Develops, coordinates, and implements all Medicaid program policies and ensures that all Medicaid program policies are expressed in contracts and provider guides; policies and contracts are fundamental to all areas of Medicaid accountability and program integrity; for example, this bureau develops all policies related to the SMMC program and provider enrollment; claims submission, and reimbursement.
Medicaid Quality	Manages fee-for-service prior authorization contracts and fee-for-service providers; monitors and evaluates plan quality performance measures; and monitors clinical oversight and contract requirements of plans by ensuring that plans' programs, care coordination, and case management serve patients appropriately and effectively and that gaps in plan care are communicated to improve outcomes
Finance and Analytics	
Bureau	**Responsibilities**
Medicaid Program Finance	Monitors all SMMC plans' financial statements and balance sheets and validates the plans' calculation of their achieved savings rebate and medical loss ratio calculation; manages nursing home audits
Medicaid Data Analytics	Conducts the plan performance analysis including comparing recipient complaints and plan-enrollment with utilization data and then compares that with the capitated payment paid to the plans; validates plan encounter data with the plans' expenditure reports to validate and deter plans from abusively misrepresenting their expenditures or encounters; also oversees actuarial calculation of capitated rates and risk adjustments.

Source: OPPAGA analysis of the Agency for Health Care Administration's Division of Medicaid organization as it relates to program integrity efforts of the Medicaid Program.

Exhibit A-3
Other Areas of AHCA Contributed to Program Integrity Efforts

Office of General Counsel	
Section	**Responsibilities**
Medicaid Managed Care	Provides legal counsel to the Medicaid division heads and bureau chiefs and their staff in all legal matters relating to managed care, including procurements, contract management, compliance with federal law and waivers, state plan amendments, and legislative bill analysis
Medicaid Fee-for-Service	Provides legal representation to AHCA's fee-for-service Medicaid programs including representing the agency in MPI administrative proceedings
Administrative Rules	Provides legal guidance and recommendations to AHCA's divisions regarding the rulemaking process
Division of Operations	
Bureau	**Responsibilities**
Financial Services	Receives payments from overpayments recovered, fines including program integrity sanctions, and investigatory, administrative and legal costs associated with MPI work; establishes a repayment schedule for providers and tracks payment compliance; distributes the AHCA's monthly financial reports and maintains accounting data.
Third Party Liability	Identifies, manages, and recovers funds for claims paid for by Florida Medicaid for which a third party was liable; updates third party insurance information to the Florida Medicaid Management Information System to avoid payment of claims that should by paid by a third party; and works in conjunction with MPI to recoup overpayments and duplicate payments and assists with provider audits and overutilization reviews
Health Quality Assurance	
Bureau	**Responsibilities**
Central Service	Determines eligibility for individuals required to be screened in order to operate a health care facility regulated by AHCA which includes determining applications for exemption; maintains the required background screening results of individuals who work with children, the elderly, and the disabled in a single data source—the Care Provider Background Screening Clearinghouse which provides Medicaid and managed care plans the ability to more efficiently screen out problem providers
Health Facility Regulation	Licenses, regulates, and certifies Medicare and Medicaid health care facilities including hospitals, ambulatory surgical centers, home health agencies, hospices, clinical laboratories, nursing homes, assisted living facilities, and other types of health care providers
Field Operations	Monitors the quality improvement/quality assurance indicators and processes complaints about the quality of care provided in health care facilities licensed by AHCA

Source: OPPAGA analysis of the Agency for Health Care Administration's Office of General Counsel, Division of Operations, and Division of Health Facilities Regulation organization as it relates to program integrity efforts of the Medicaid Program.

Appendix B

The Legislature Requires the Agency for Health Care Administration to Annually Report Fee-for-Service Program Integrity Information

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.[49] Exhibit B-1 details the information provided by AHCA's annual reports for Fiscal Years 2002-03 through 2014-15.

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

	Fiscal Year												
	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]	2013-14[1]	2014-15[1]
Cases Investigated	4,731	3,145	2,556	1,694	1,860	2,402	2,619	3,839	5,368	3,980	3,393	3,043	2,764
New Cases Opened	1,516	658	1,497	612	1,406	1,679	1,438	2,922	4,119	2,301	2,108	1,647	1,752
Sources of Opened Cases (as defined by agency)													
Medicaid Program Integrity	1,372	550	1,316	526	1,337	1,520	1,203	2,269	3,048	1,401	1,502	1,099	1,317
Other AHCA	120	44	12	14	18	22	28	258	894	500	271	264	250
Services (Health Systems Development)	0	0	77	0	0	0	0	0	0	0	0	0	0
Public	9	23	70	49	31	110	139	342	20	154	148	158	18
Other State Agencies	2	0	2	2	3	7	10	12	24	75	20	50	73
Federal Agencies	7	20	7	12	16	18	41	14	107	91	129	47	34
Law Enforcement	4	21	13	9	1	2	11	16	19	3	0	0	0
HMO Investigative Unit[2]	–	–	–	–	–	–	–	8	2	18	14	0	31
Other	2	0	0	0	0	0	6	3	5	59	24	29	29
Disposition of Closed Cases (as defined by agency)													
No Finding of Overpayment	568	905	566	199	177	331	309	401	1,006	229	136	126	151
Provider Education Letter	99	104	44	27	30	4	17	158	513	248	7	3	4
Overpayment Identified	1,603	944	849	1,002	811	791	1,288	1,807	1,907	1,987	1,562	1,622	1,319
Total	2,270	1,953	1,459	1,228	1,018	1,126	1,614	2,366	3,841	2,842	2,203	2,089	1,319
Amount of Overpayments Alleged in Preliminary Action Letters/Reports	$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	$45,300,753	$35,713,820
Amount of Overpayments Alleged in Final Action Letters/Reports	$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	$23,297,293	$21,638,399

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

	Fiscal Year												
	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]	2013-14[1]	2014-15[1]
Reduction in Overpayments Negotiated in Settlement Agreements, etc.	$139,454	$856,746	$116,059	$236,970	$0	$0	$0	$0	$0	$0	$0	$0	$0
Amount of Final Agency Determinations of Overpayments[3]	$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	$28,640,118	$30,380,115
Amount of Overpayments Recovered	$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	$21,301,711	$82,729,279[4]
Average Time to Collect from Case Opened Until Paid in Full	603 days	780 days	500 days	452 days	328 days	328 days	311 days	283 days	332 days	284 days	228 days	69 days[5]	234 days
Amount of Cost of Investigations Recovered	$45,587	$119,648	$67,295	$187,282	$113,917	$72,156	$49,850	$35,647	$1,500,000	$200,000	$212,000	$391,669	$124,524
Number of Fines/Penalties Imposed[6]	0	3	1	153	222	155	501	507	717	781	839	667	461
Amount of Fines/Penalties Imposed	$0	$20,500	$2,000	$289,000	$373,073	$150,000	$481,228	$666,740	$957,609	$2,643,713	$3,505,686	$2,810,147	$1,516,201
Number of Managed Care Assessments Imposed[6]	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	0	7	0	0	0
Amount of Managed Care Assessments[7]	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	$0	$3,555,600	$0	$0	0
Amount Deducted in Federal Claiming due to Overpayment	$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	$26,500,000	$34,500,000
Amount Determined as Uncollectible	$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	$4,500,000	$0
Portion of Uncollectible Amount Reclaimed from Federal Government	$19,225,633	$5,749,373	$2,095,662	$25,000	$0	$0	$0	$0	$0	$0	$0	$158,650	$0
Number of Providers by Type Terminated Due to Fraud/Abuse	28	160	224	194	194	59	78	85	131	217	361	269	125
Community Alcohol, Drug Abuse or Mental Health	0	0	0		0	0	0		5	8	15	12	2
Pharmacy	3	35	29	24	11	3	1	1	8	2	30	20	6
Physicians	15	74	114	85	60	4	15	7	31	88	102	94	28
Physician Assistants	0	3	0	2	0	0	0		1	1	1	6	0
Chiropractors	0	0	0	1	4	0	3		2	0	2	3	1
Podiatry Services	0	0	0	3	0	1	0		1	0	2	1	1
Nurses	0	2	0	1	0	0	0	1	1	5	2	4	1
Dental	2	4	5	1	2	1	1		2	0	6	8	2
Laboratory	3	3	0	1	1	0	0		0	0	3	2	0
Home Health Care	0	0	5	31	46	7	7	2	14	14	39	21	13
Home and Community-Based	0	9	13	30	47	27	42	44	42	56	64	28	30
Therapy	0	0	1	1	9	4	3	5	9	2	6	6	3
Durable Medical Equipment Suppliers/Medical Supplies	4	22	49	0	0	6	2	16	0	2	7	8	3
Public Health Provider	1	0	0	0	0	0	0	0	0	0	0	0	0
Assisted Living Care	0	5	3	9	7	4	4	2	9	28	0	0	0
Assistive Care Services											44	21	19
Skilled Nursing Provider											4	3	1

	Fiscal Year												
	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]	2013-14[1]	2014-15[1]
Transportation	0	0	2	0	0	0	0	0	0	0	0	0	0
Managed Care Organization[7]	–	–	–	–	–	–	–	–	–	1	0	0	0
Non-Medicaid Managed Care Provider	–	–	–	–	–	–	–	–	–	3	22	14	4
Other	0	3	3	5	7	2	0	7	6	7	12	18	11
All Costs Associated with Discovering, Prosecuting, and Recovering Overpayments: Total Reported Costs	$11,907,940	$9,143,570	$9,851,188	$10,754,917	$9,956,835[8]	$12,420,69[9]	$15,105,407[10]	$15,092,040[11]	$14,199,749	$9,665,863	Not Available	$14,972,558	$15,816,493
Bureau of Medicaid Program Integrity	$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	$12,028,969	Not Available
Office of General Counsel, Accounts Receivable, and Medicaid Contract Management	$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	$1,441,000	Not Available
Indirect Costs	$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	$1,069,027	$1,159,779
Number of Providers Prevented from Enrolling or Re-Enrolling Due to Documented Fraud/Abuse	Not Available	Not Available	Not Available	Not Available	Not Available	115	104	99	78	229	255	199	108
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	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	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 2002-03 through 2007-08, cases referred from the HMO Investigative Unit were included in the "Other" category.

[3] 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.

[4] This includes recoveries made by MPI and MPI-Third Party Liability and includes collections of overpayments, fines, costs, and paid claims reversals.

[5] Staff was unable to explain what contributed to the significant reduction in time and speculated that it was inaccurately reported as the formal hearing process for providers who appeal audit findings lasts longer than 69 days.

[6] 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.

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

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

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

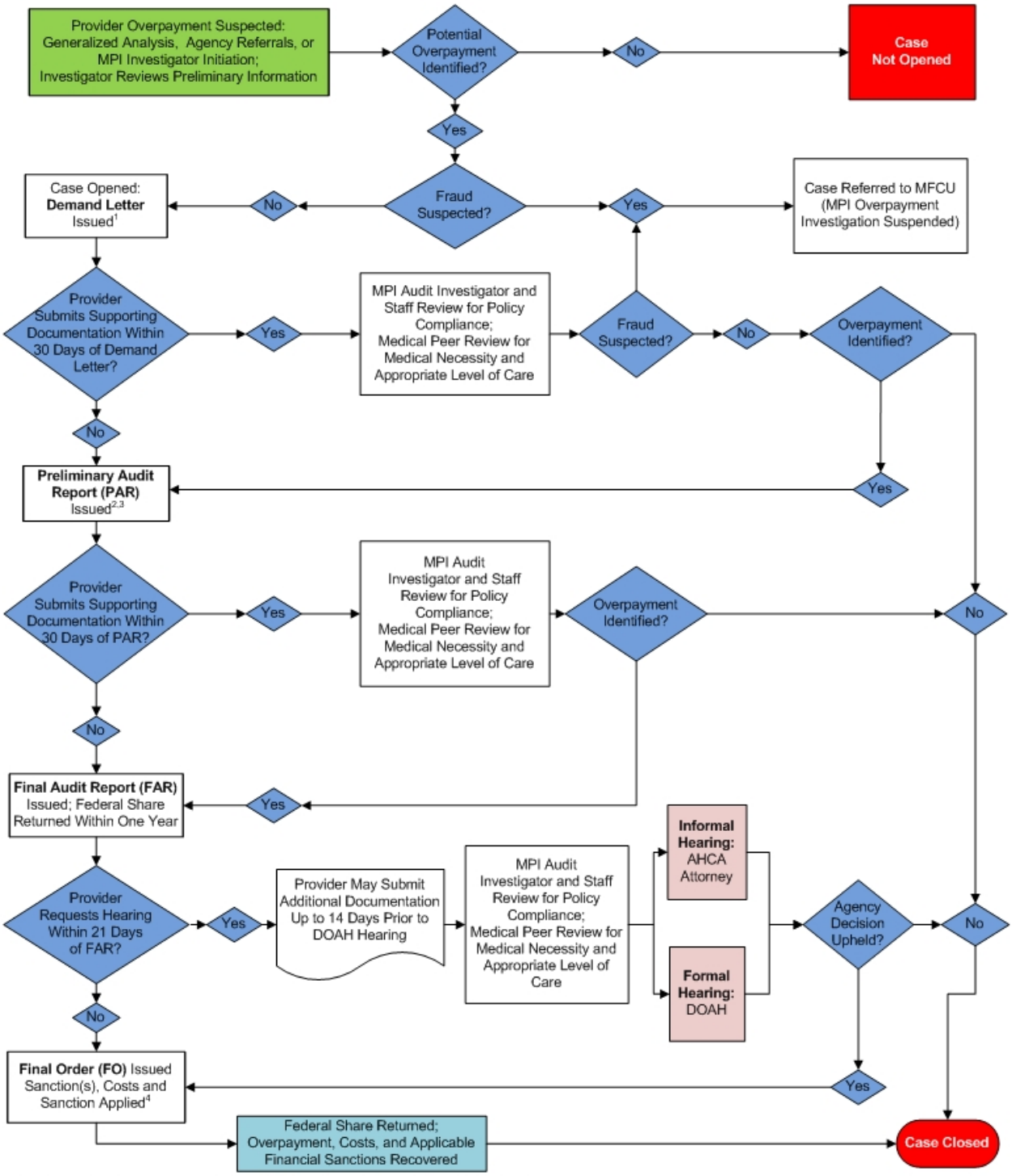
[10] Includes $4,756,337 in Medicaid costs incurred for services related to MPI activities.

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

Source: The 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 C

MPI Investigation Process



[1] Generalized Analysis initiated cases generally do not require the issuance of a Demand Letter.
[2] If the overpayment is less than $10,000 or it is a designated amnesty issue (e.g., provider self-audit), and the provider pays upon receipt of the PAR, then the case is closed with no further action or sanction.
[3] Providers failing to submit supporting documentation after the demand letter may be sanctioned for failing to submit information.
[4] Providers may appeal final orders within 30 days of Final Order issuance. Appeals of Final Order result in a second issuance of a Final Order based on the findings of the Appeals Court.
Source: OPPAGA analysis of AHCA's Medicaid Program Integrity Investigations process.

Appendix D

State Law Revisions Since 2000

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

Exhibit D-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.
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

State Law	Topic(s) Addressed
	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* (Sections 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, 4 and 7)	***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.

State Law	Topic(s) Addressed
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.
Chapter 2014-17, *Laws of Florida* (Section 101)	***Statutory revisions.*** This law is technical in nature; it removes redundancies, obsolete and repealed provisions, and unnecessary repetition from statutes; improves clarity; and corrects errors. The law revises the Medicaid provider agreements statute by correcting a reference to AHCA.
Chapter 2014-19, *Laws of Florida* (Section 210)	***Statutory revisions.*** This law is technical in nature; it removes redundancies, obsolete and repealed provisions, and unnecessary repetition from statutes; improves clarity; and corrects errors. The law revises the Oversight of Integrity of the Medicaid Program statute by correcting a reference to the Department of Children and Families.
Chapter 2014-57, *Laws of Florida* (Section 7)	***Medically Needy in Statewide Medicaid Managed Care.*** Repeals requirements for Medicaid managed care plans related to Medically Needy. Specifically, the law repeals the requirements for Medicaid managed care plans to accept any medically needy recipient who selects or is assigned to the plan and provide that recipient with continuous enrollment for 12 months; pay claims for medically needy patients for services provided before enrollment in the plans; and provide a grace period of at least 90 days before disenrolling recipients who fail to pay their shares of the premium.
Chapter 2014-89, *Laws of Florida* (Section 32)	***Prescription drug definition.*** Updates statutory references pertaining to the definition of prescription drug.

Source: OPPAGA analysis of the *Laws of Florida*.

Appendix E

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

January 25, 2016

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

Dear Mr. Twogood:

The Agency for Health Care Administration (AHCA or Agency) appreciates the opportunity to comment on the OPPAGA biennial review of the Agency's efforts to prevent, detect, deter, and recover funds lost to fraud, abuse, and waste in the Florida Medicaid Program. While the primary anti-fraud efforts rests with the Office of Medicaid Program Integrity (MPI), AHCA recognizes that program integrity efforts must be systemic and Agency-wide to be most effective.

Continued collaboration among the Agency's divisions, increased use of technology and integration of data from external sources, and a commitment to assessment and refinement of Agency processes, are among the extensive efforts underway since OPPAGA's previous review. The Agency has transitioned to a fully implemented managed care delivery system and the Division of Medicaid continues to streamline processes, improve assessment practices, and demonstrate a commitment to program integrity efforts. MPI continues to increase its overall efforts in the fee-for-service system, continues to evaluate, detect, deter and recover overpayments from fraud, abuse, and waste during the five-year retrospective audit period that remains, and continues to transition its efforts to address integrity assurance in the managed care environment. For the next several years, MPI will straddle both worlds, continuing to strive for excellence.

Overall, the Agency concurs with the findings of this report. While there are minor issues that require clarification pertaining to facts specified within the report, our comments and response in the attached document address those issues.

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

Sincerely,

Elizabeth Dudek
Secretary

ED/szg
Enclosure

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Agency for Health Care Administration
AHCA Reorganized to Enhance Managed Care Program Oversight and Continues to Recoup Fee-for-Service Overpayments
Response to OPPAGA's Draft Report, dated January 2016

Managed Care

MPI is revising its policies and processes for monitoring managed care program integrity.

Recommendation

- With a full year of SMMC implementation complete in October 2015, MPI should finalize tools and procedures to ensure compliance with anti-fraud contract requirements and to determine the effectiveness of plans' anti-fraud activities.
- MPI should determine the types of monitoring tool to use and decide if and how often to conduct site visits.
- AHCA also should resume assessing fines or liquidated damages when plans do not comply with the anti-fraud activities or requirements specified in the contract
- As part of its efforts to assess plans, MPI should also identify the most useful information necessary to monitor the plans and should use such information to establish benchmarks or standards for assessing plans.
- Finally, with the transition to SMMC, AHCA should include aggregate information on each managed care plan's fraud and abuse prevention, detection, and recovery of overpayments in its Annual Medicaid Fraud and Abuse Activities Report.

Agency Response

AHCA concurs with these recommendations and will continue with its planning and implementation. However, one recommendation could be interpreted to presume AHCA has ceased assessing fines or liquidated damages. In fact, AHCA continues to diligently monitor Medicaid managed care contract compliance specific to anti-fraud activities. Not having assessed liquidated damages for late-filed fraud reports during FY 2014-15 is a credit to the ongoing efforts to increase provider overall compliance with program requirements. It should not be construed to indicate that AHCA has not been monitoring the issue. It simply means that there were no violations related to untimely reporting of suspected fraud or abuse during FY 2014-15. MPI is focusing on education of providers (including health plans) and the public regarding the quality and type of information needed to turn a fraud, waste, or program abuse complaint into a viable lead.

Agency for Health Care Administration
AHCA Reorganized to Enhance Managed Care Program Oversight and Continues to Recoup Fee-for-Service Overpayments
Response to OPPAGA's Draft Report, dated January 2016

AHCA has processes and systems to hold managed care plans accountable for providing appropriate and necessary health care services.

Recommendation

- AHCA developed these accountability systems prior to and during SMMC implementation. However, the agency should continually assess these systems to identify modifications that would improve plan oversight.

- AHCA officials report that managed care standards incorporate all of the GAO recommendations. AHCA should continue to seek similar opportunities to augment all of its accountability systems for ongoing improvement of plan monitoring and oversight.

Agency Response

AHCA is doing a great deal with regard to program monitoring and oversight and will continue to seek opportunities for improvement. AHCA concurs with these recommendations and welcomes any specific recommendation from OPPAGA that would augment current accountability systems for managed care oversight developed for SMMC.

Fee-for Service

MPI updated its case management system and is implementing advanced data analytics technology.

Recommendation

- To address these issues, the system should be modified to include reports that summarize the status of cases, including completion time, for various phases of the process as well as the case and the outcome. This will assist management in assessing performance and identifying areas to improve upon.

- In addition, the system should incorporate notices to remind staff to complete necessary tasks or to document activities.

Agency Response

AHCA is committed to process improvement, including systems improvement, and concurs with these recommendations.

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The Florida Legislature

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