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AHCA Continues to Expand Medicaid Program Integrity Efforts; Establishing Performance Criteria Would Be Beneficial

at a glance

Since OPPAGA's 2016 review, the Bureau of Medicaid Program Integrity (MPI) has developed two review checklists, reestablished on-site monitoring, and redesigned the managed care annual fraud and abuse activity report. From February to May 2017, MPI conducted annual monitoring reviews of all the managed care health plans using a new review checklist that considers health plan compliance with contractual, state, and federal guidelines. While MPI continues to identify and collect overpayments to fee-for-service providers, its data analytics vendor did not perform as expected and the contract was not renewed.

The Agency for Health Care Administration could further improve its program integrity efforts by establishing evaluation criteria and performance measures. MPI's review of managed care plans does not include performance standards. In addition, the agency has not identified useful measures to evaluate MPI's performance. Further, several recent state and federal reviews suggest the Bureau of Medicaid Program Integrity could improve its performance. The agency recently moved the bureau from the Office of the Inspector General to the Division of Health Quality Assurance, which may provide an opportunity to consider the bureau's current fee-for-service focus.

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. This is OPPAGA's eighth report in the series.[1]

Background

The Agency for Health Care Administration, through its Division of Medicaid, provides health care for low-income families and individuals and assists the elderly and people with disabilities with the costs of nursing facility care and other medical and long-term expenses.[2] Florida's Medicaid Program is among the largest in the country, serving approximately 3.9 million persons each month.[3] For Fiscal Year 2017-18, the Legislature appropriated $27.8 billion to operate the program.[4]

Historically, AHCA operated Florida's Medicaid Program using a fee-for-service payment system.[5] However, the 2011 Legislature directed AHCA to implement the Statewide Medicaid Managed

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

[2] Medicaid, a joint federal and state program, reimburses states a portion of expenditures according to a federal matching process.

[3] Participants must meet various federal and state eligibility guidelines including income and asset tests.

[4] Of the total Medicaid budget for Fiscal Year 2017-18, $6.4 billion is general revenue and $21.4 billion is from trust funds, including federal matching funds and state funds from drug rebates, hospital taxes, and county contributions.

[5] Under a fee-for-service system, providers deliver services to Medicaid recipients and bill the state on an individual or itemized basis, i.e., the state Medicaid Program reimburses the provider after he or she renders the service and bills the state.

Care (SMMC) Program.[6] SMMC provides for the delivery of services through contracts between AHCA and private health plans. As of December 2017, 81% of Florida's Medicaid recipients were enrolled in managed care.[7] While a much smaller portion of Medicaid recipients receive services through the fee-for-service system, the agency continues to process approximately 60 million fee-for-service claims each year.

Health services are vulnerable to waste, abuse, and fraud, which can occur in many forms. In both fee-for-service and managed care systems, providers may commit fraud and abuse by overbilling for services as well as deliberately billing for services that are not medically necessary or were not delivered. In terms of managed care, excessive provider billing or claims reporting may inflate future reimbursement rates, and the reporting of services not rendered can distort the assessment of providers' provision of, access to, and quality of care.[8]

In addition, according to the Medicaid and CHIP Payment and Access Commission, managed care delivery systems create new or different kinds of waste, fraud, and abuse risks that require program-specific safeguards, in particular, the payment and contracting arrangements.[9] In managed care, the state contracts with health plans and the health plans then subcontract for the delivery of services unlike a fee-for-service system, where the state oversees individual providers and contracts. According to the commission, managed care contracting arrangement can lead to a lack of access to subcontractor information or falsification of information as well as create opportunities for underutilization—when a provider shows a pattern of failing to provide patients with medically necessary health care services on a timely basis.

Federal rules require states to prevent, detect, and deter waste, fraud, and abuse in Medicaid. AHCA's Bureau of Medicaid Program Integrity (MPI) has primary responsibility for administering and overseeing waste, fraud, and abuse prevention and detection efforts for both managed care and fee-for-service.[10, 11, 12] MPI identifies and investigates fee-for-service providers suspected of fraud and abuse and ensures that SMMC contracted health plans comply with Medicaid requirements to prevent, detect, and deter abusive and fraudulent practices. The bureau has 108.5 positions and includes four primary units.[13] (See Exhibit 1.)

[6] Chapter 2011-134, *Laws of Florida*; SMMC was fully implemented statewide by August 2014.

[7] The remaining 19%, exempt from mandatory managed care enrollment, receive services from Medicaid providers on a fee-for-service basis; however, these recipients may still choose to enroll voluntarily in Medicaid managed care health 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.

[8] The oversight of Medicaid managed care is increasing in importance as states' use of managed care plans to deliver services has been growing. A GAO report found that the estimated improper payment rate for managed care was less than 1%; however, this estimate was based on a review of the payments made to managed care organizations and did not review any underlying medical documentation. The report also noted that additional actions on the part of CMS and the states are critical to improving program integrity in Medicaid, particularly the reporting of encounter data which is used to track services received by beneficiaries. However, often managed care encounter data is incomplete and untimely. See *Medicaid: CMS Has Taken Steps, but Further Efforts Are Needed to Control Improper Payments,* U.S. Government Accountability Office, GAO-17-386T, January 2017.

[9] *Medicaid and CHIP Payment and Access Commission Report to Congress: Program Integrity in Medicaid Managed Care,* Medicaid and CHIP Payment and Access Commission, June 2017.

[10] As of August 25, 2017, MPI was organizationally relocated from AHCA's Office of Inspector General to the Division of Health Quality Assurance.

[11] MPI's Fiscal Year 2017-18 approved operating budget to address fraud and abuse was $8 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.

[12] During Fiscal Year 2016-17, the MPI budget was $15.1 million, including $7.5 million for contracted services.

[13] Of the 108.5 positions, 81.5 are full-time equivalent positions and 27 are other personal services positions.

Exhibit 1
The Bureau of Medicaid Program Integrity Has Four Units That Perform a Wide Range of Activities

Unit	Activities
Prevention	Develops strategies to support the larger Medicaid Program, e.g., to minimize the enrollment of fraudulent and high-risk providers
Detection	Identifies irregularities in Medicaid claims data and conducts preliminary investigations of providers, i.e., assesses relevant Medicaid claims, business associations, licensure status, complaints, etc.
Managed care	Reviews health plan program integrity efforts, e.g., whether health plans have sufficient expertise to pursue anti-fraud activities
Overpayment recoupment	Focuses on recovery of incorrect provider payments; the bureau continues its focus on recovering Medicaid fee-for-service overpayments

Source: OPPAGA analysis of Bureau of Medicaid Program Integrity information.

MPI refers cases of suspected provider fraud to the Florida Attorney General's Medicaid Fraud Control Unit for investigation and prosecution of providers suspected of defrauding Medicaid.

The agency's Division of Medicaid supports Medicaid program integrity through SMMC contracts that require health plans to establish program integrity functions and report on fraud and abuse.[14] Specifically, the managed care contracts require plans to

- establish or contract for fraud investigative units;
- annually submit comprehensive compliance and anti-fraud plans to MPI;
- report quarterly and annually on fraud and abuse activities and the results of implementing anti-fraud plans;
- establish internal controls, which include prior authorization, utilization management, and post review of claims; and
- provide employees with fraud and abuse prevention training.[15]

As part of hiring, contracting, and re-credentialing processes for health care providers, plans must check staff, subcontractors, and providers against AHCA's final order database of sanctioned providers and against a federal database that lists parties excluded from participating in publicly funded health care programs. Additionally, plans must report each suspected or confirmed instance of provider or recipient fraud or abuse. The division also has the authority to impose fines or liquidated damages on non-compliant plans and to require corrective action plans.[16, 17]

Prior Findings

In 2016, OPPAGA reported that as part of AHCA's efforts to prevent, detect, deter, and recover funds lost to fraud and abuse in the Medicaid Program, the Bureau of Medicaid Program Integrity had further reorganized to place greater emphasis on fraud and abuse in Medicaid managed care. With the reorganization, MPI reported it was focusing on working collaboratively with the managed care plans' fraud investigative units, with an aim toward improving its anti-fraud oversight and enforcement capabilities.

Because of MPI's focus on working collaboratively with the health plans, the bureau reported that it had temporarily discontinued on-site monitoring of managed care plans' anti-fraud and abuse activities. Agency staff was in the process of developing an on-site monitoring tool. We recommended that in developing the tool, MPI establish benchmarks or standards for assessing the plans' performance.

We found that MPI staff had not recommended health plan sanctions or liquidated damages for failure to report suspected fraud or abuse within 15 days. MPI reported that it had been working to educate plan officials on what constitutes fraud

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

[15] Plans must report detailed information on the number of fraud and abuse referrals made to MPI, investigation outcomes, and the dollar amount of vendor losses and recoveries attributable to fraud, abuse, and overpayment.

[16] For example, s. 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.

[17] 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.

and had no 15-day reporting violations for Fiscal Year 2014-15.

In addition, AHCA had reorganized the Division of Medicaid into subject matter areas in an effort to improve contract management and oversight of Medicaid managed care plans. At the time of our review, while the processes were in place and the reorganization was primarily complete, there were limited data to comprehensively assess and report on the effectiveness of these efforts.

Finally, our prior review found that MPI was using several methods to identify potential cases of Medicaid overpayments for fee-for-service providers. AHCA had also implemented a vendor-hosted, advanced data analytics system to detect and identify suspicious provider activity; the system became operational in August 2015. MPI had also purchased a new fraud and abuse case management tracking system that assisted in appending documentation collected during investigations.

Current Status

AHCA has taken numerous steps to enhance fraud detection and prevention activities

MPI has developed review checklists, reestablished on-site monitoring, and redesigned managed care annual fraud and abuse reports. To facilitate MPI's oversight of fraud and abuse prevention and detection efforts in managed care, MPI's Managed Care Unit created two review checklists to compare the health plans' anti-fraud and compliance plans for compliance with all required contractual provisions, including but not limited to

- ensuring that anti-fraud plans for each health plan include a written description of the procedures for detecting and investigating possible acts of fraud, abuse, and overpayment and
- verifying that compliance plans for each health plan include written policies, procedures, and standards of conduct that express the health plan's commitment to comply with all applicable federal and state standards.

From February 2017 through May 2017, MPI conducted annual monitoring reviews for 16 managed care health plans.[18] MPI's annual monitoring process consisted of three phases: (1) desk reviews of documents requested from the health plans, (2) on-site monitoring reviews, and (3) post-monitoring follow up.[19] MPI staff used another new checklist as part of its on-site monitoring reviews. Like the anti-fraud and compliance plans' checklists, the on-site monitoring checklist includes contractual, statutory, federal, and other guidelines related to the health plans' program integrity obligations. Following phases 1 and 2, MPI staff prepared the findings, provided the written results to the health plans, and conducted follow-up as necessary.[20]

To have a better understanding of the health plans' anti-fraud activities, MPI also redesigned its Annual Fraud and Abuse Activity Report in April 2016. The report captures detailed information on each health plan's fraud and abuse prevention and recovery activities and includes the number of fraud and abuse referrals the plans made to MPI, investigation outcomes, and the dollar amount of vendor losses and recoveries attributable to fraud, abuse, and overpayment. The plans' first submission using the new format was on September 1, 2016; the report captures additional information not collected in previous annual reports.[21] As of

[18] SMMC consists of 17 contracted health plans. One plan serves two different populations; MPI conducted one monitoring review of this plan.

[19] To conduct its desk reviews, MPI requests information from the health plans that may include plan policies and procedures, a written description of plan fraud prevention efforts, data that is not part of contractually required reporting, plan internal training curriculum, and documentation of training that staff completed.

[20] In addition to the annual monitoring of the health plans, MPI also conducts reviews of the plans' oversight efforts for specific areas of risk. These activities are best understood as compliance reviews of policies, procedures, documents, and claims data; MPI reported that it has not audited or reviewed health plans' fraud investigative units or compliance offices. Since our 2016 report, MPI has reviewed plans' oversight efforts for specific areas of risk including: (1) transportation vendor oversight; (2) ineligible provider use; and (3) suspended provider payment. During Fiscal Year 2016-17, MPI continued its review of transportation providers and also reviewed plans' oversight regarding health plan use of ineligible providers as well as plans' hospital rates as required by s. 409.975 (6), *F.S.*

[21] Additional information includes the number of providers referred to various state and federal entities; number and types of

January 2018, MPI has not validated fraud and abuse information reported by the health plans for 2016 and 2017, which limits our ability to draw conclusions based on this information.

While MPI continues to identify and collect overpayments to fee-for-service providers, its data analytics vendor did not perform as expected. MPI uses various methods to identify potential cases of Medicaid overpayments to fee-for-service providers, including conducting routine and ad hoc statistical analysis.[22] MPI investigators review the initial information generated through these methods to determine whether to open a complaint. If MPI opens an overpayment recovery audit, the provider has an opportunity to submit documentation. The investigator reviews the provider documentation for compliance with Medicaid policies. If necessary, the investigator develops audit findings and AHCA issues a final order that establishes the overpayments that the provider must repay, including the agency's investigative costs and payment for any sanctions assessed.[23, 24]

MPI applies punitive and monetary sanctions for providers failing to comply with Medicaid policies and requirements as a way to deter fraud and abuse.[25] During Fiscal Year 2016-17, MPI levied $1.8 million in fines for 118 cases against 114 providers that had received $18.5 million in overpayments.[26, 27, 28]

Some overpayment cases do not result in sanctions because of Medicaid amnesty programs. Pursuant to statute, MPI grants amnesty from sanctions when a fee-for-service provider performs a self-audit and voluntarily repays the overpayment.[29] In Fiscal Year 2016-17, sanctions were not levied in 88 cases (25.3%) because the provider performed a self-audit; in 142 cases (40.8%) sanctions were not applied because the provider qualified for amnesty or for other reasons. (See Exhibit 2.) Overpayments totaled $15.3 million for all cases where sanctions were not applied.

Exhibit 2
AHCA Sanctioned 34% of Fee-for-Service Provider Cases Identified With Overpayments in Fiscal Year 2016-17

Case Resolution	Fiscal Year 2016-17	
	Provider Cases	Percentage
No Sanction Applied	**230**	**66.1%**
Amnesty for Self-Audit	88	25.3%
Amnesty for Other Reasons	142	40.8%
Sanction Applied	**118**	**33.9%**
Fine	118	33.9%
Total	**348**	

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

providers terminated from the plan's network for fraud and abuse; number and type of providers prevented from participating as network providers as a result of fraud and abuse; number of cases the plans investigated; number of cases with overpayments identified, dollar amount of overpayments identified, and dollar amount of overpayments recovered; and length of time to recover overpayments.

[22] MPI may also identify potential cases from complaints to the Medicaid hotline, newspaper articles, or referrals from other providers, state, or federal agencies. MPI cases may also be investigator initiated.

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

[24] Prior to issuing the Final Order, 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.

[25] Severity and conditions for sanctions are specified in the agency's administrative rule (see 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.

[26] During the same period, 94 providers were suspended and 64 were terminated from participating in the Medicaid Program for overpayments and other violations.

[27] In addition to applying punitive and monetary sanctions, MPI places providers on prepayment reviews and suspends payments to providers that have a credible fraud allegation. Section 409.913(25), *F.S.*, grants MPI the authority to withhold Medicaid payments to a provider upon receipt of reliable evidence that the circumstances giving rise to the need for a withholding of payments involve fraud, willful misrepresentation or abuse under the Medicaid Program, or a crime committed while rendering goods or services to Medicaid recipients.

[28] The number of providers that are placed on prepayment reviews or providers that had a credible allegation of fraud and had their Medicaid payments suspended are not available. However, in its annual report, MPI does report on the number and dollar amount of claims reviewed and denied as a result of placing providers on prepayment reviews. Additionally, MPI reports the number of claims and the dollar amount of claims that were withheld or suspended from providers that had a credible allegation of fraud.

[29] Section 409.913(25)(e), *F.S.*, allows AHCA to suspend sanctions and investigative expenses when it grants amnesty.

In December 2014, the agency signed a contract for a vendor-hosted advanced data analytics system that would use predictive abuse detection algorithms to detect and identify suspicious provider activity. The total cost for the three-year contract was $5,514,075, including $1,629,407 in state funds and $3,884,667 in federal funds. However, MPI officials reported that after three years the contract deliverables did not achieve the quality expected and did not result in viable leads for MPI to pursue. The contract term expired on June 30, 2017 and funding was not continued.

Other agency entities also participate in identifying, preventing, and deterring waste, fraud, and abuse in the Medicaid Program. To ensure fee-for-service providers deliver quality and necessary medical services to recipients in a timely and cost-effective manner, the Division of Medicaid screens and enrolls fee-for-service providers to prevent problem or abusive providers from participating in Medicaid and also monitors providers for compliance with Medicaid policy. The division works to ensure that managed care plans credential and screen providers participating in Medicaid managed care plans. The division also uses its achieved savings rebate incentives to encourage efficiencies and high performance; reviews managed care plans' contracted provider networks; tracks grievances and complaint resolution to ensure access to care for needed health care services; and evaluates plan performance to ensure continuous improvement.[30]

Complete and accurate encounter data is essential to the state's oversight of managed care, which includes supporting MPI's oversight of health plan fraud prevention activities.[31] During Fiscal Year 2015-16, AHCA contracted with Health Services Advisory Group, Inc. for an encounter data validation study to examine health plan encounter information submitted to the Florida Medicaid Management Information System during Fiscal Year 2015-16 and determine if data were complete and accurate.[32, 33] Based on validation study findings, the division's Bureau of Medicaid Fiscal Agent Operations worked to improve the collection of health plans' encounter data during Fiscal Year 2016-17.

The agency also reported a number of additional monitoring and oversight efforts for both managed care and fee-for-service.

- The Bureau of Medicaid Fiscal Agent Operations implemented a Streamlined Provider Enrollment application to provide a process by which the health plans' non-Medicaid network providers can enroll with the Medicaid Program.[34] According to division staff, the new process includes disclosure and screening of entities and persons with controlling interest in a managed care plan as well as all managing employees.
- The Bureau of Medicaid Quality procured a new vendor for its electronic visit verification efforts to deter fraud and abuse in home health services (e.g., private duty nursing, home health visits, and personal care services).

[30] The U.S. Centers for Medicare and Medicaid Services' managed care rule was finalized in December 2015. According to agency officials, in early 2017 a special contract amendment was completed so that the new rule requirements for the health plans' grievance and appeal systems could be added to the contracts to coincide with other changes being made at the state level.

[31] Encounter data is used by the agency to monitor health plans' quality, utilization, costs, performance, and compliance. Encounter data are similar to fee-for-service claims data, but encounter data (1) are not tied to per-service payment from the state to the managed care organization because the state is not paying for individual services and (2) do not necessarily include a Medicaid-paid amount.

[32] The system's fiscal agent is responsible for maintaining data quality and processing encounter and provider enrollment data. The Bureau of Medicaid Fiscal Agent Operations is responsible for planning, coordinating, and overseeing all activities related to the fiscal agent.

[33] The study included validating enrollment data from Managed Medical Assistance, Specialty, and Long-Term Care plans.

[34] Streamlined Provider Enrollment is a limited enrollment application for providers who are not Medicaid enrolled and need to complete basic credentialing, which is a prerequisite to seeking a contract with a Medicaid health plan. The system allows the provider to complete the process faster than the traditional provider enrollment process. Upon receipt of a streamlined provider enrollment application, AHCA performs several basic credentialing functions, including licensure verification and review of background screening history, which includes criminal history and federal exclusion database checks. This process eliminates the need for providers to undergo the basic required credentialing with each plan for which they contract.

- As directed by the Legislature, the agency evaluated whether cost savings could be achieved by contracting for plan oversight and monitoring. In September 2017, AHCA issued a request for information from entities with experience monitoring managed care plans, including analysis of encounter data, assessment of performance metrics, provider credentialing/onboarding, clinical/service delivery oversight, and provider network oversight as required by s. 409.967(2)(f)4, *Florida Statues*. After meeting with responding vendors in November 2017, the agency reported that it was not moving forward with contracts with either vendor.
- The Bureau of Medicaid Policy, in collaboration with MPI, enhanced core provisions of the 2018 through 2023 SMMC contract to include a retention policy for the treatment of recoveries for Medicaid fraud, abuse, and waste overpayments.[35] This policy allows MPI to recover Medicaid overpayments made by managed care plans to network providers that might otherwise have been prevented because of the time limits placed on commercial health plans to claim overpayments from providers.[36, 37]

AHCA's Office of the General Counsel provides legal representation and counsel to MPI in matters relating to the agency's Medicaid fee-for-service and managed care programs. For example, with the general counsel's support, MPI sanctioned 277 providers for inappropriate practices related to Medicaid fee-for-service participation during Fiscal Year 2016-17.[38, 39]

The agency could further improve its efforts by establishing evaluation criteria and performance measures

MPI has no formal criteria to evaluate managed care plans' program integrity efforts. MPI's review of contractually required documents and on-site monitoring of managed care plans do not include performance benchmarks. MPI uses review checklists to compare the managed care plans' anti-fraud and compliance plans with contractual requirements. Bureau staff reported that while these reviews assess plan contract compliance, they do not address whether the plans' efforts are effective. Staff further reported that because state law does not define the term "effective," they do not have the authority to establish minimum criteria to use in determining the effectiveness of required provisions in the plans' anti-fraud and compliance plans. Such provisions include effective training and education of managed care plan employees and compliance officers and effective pre-payment and post-payment review processes.[40]

In lieu of standards, MPI staff reported that they handle issues related to these items informally. Specifically, MPI staff brings any shortcomings they identify to the plans' attention. For example, MPI staff reported an instance where a managed care plan described a specific anti-fraud and abuse process but had not sufficiently outlined

[35] This contract revision is in response to changes made to 42 CFR 438 in 2016.

[36] MPI may investigate, review, analyze, and seek recovery of overpayments to any Medicaid provider up to five years after the date that the service was provided (s. 409.913(9), *F.S.*). However, s. 641.3155(16), *F.S.*, requires that all claims for overpayments submitted from health maintenance organizations to most licensed health care providers must be submitted to the provider within 12 months of the payment of the claim, except that claims for overpayments may be sought beyond that time from providers convicted of fraud.

[37] The plans' retention policies identify the terms for how Medicaid overpayments made to health plan network providers that are recovered by MPI will be shared with the managed care plans. It creates incentives for plans to identify overpayments made and report accurately to MPI. At the time of our review, AHCA was in the process of negotiating SMMC contracts for the 2018 through 2023 contract period.

[38] This is a unique count of providers that were sanctioned; however, a provider can have more than one sanction assessed.

[39] Other entities within AHCA also perform functions that support Medicaid program integrity efforts. AHCA's Division of Operations collects the remittance of overpayments and fines, including program integrity sanctions; identifies and manages the recovery of funds for claims paid by Florida Medicaid for which a third party was liable; and officiates the coordination of procurement for all AHCA purchasing. AHCA's Division of Health Quality Assurance maintains the required background screening results of individuals who work with children, the elderly, and the disabled in a single data source that provides the Medicaid Program and managed care plans the ability to more efficiently screen out problem providers.

[40] See the Statewide Medicaid Managed Care contract, Attachment II – Core Contract Provisions, Section VIII – Administration and Management, Paragraph F – Fraud and Abuse Prevention.

the process. MPI told the managed care plan to provide more details and the plan complied.

As previously discussed, MPI conducted on-site monitoring reviews of the managed care plans from February 2017 through May 2017. MPI's checklist for these reviews allows staff to determine plan compliance with program integrity requirements using four categories: (1) in-compliance, (2) not in compliance, (3) under internal corrective action, or (4) under internal development. The checklist examines whether plans have written policies and procedures but, in the absence of established criteria or benchmarks, the checklists provide little to no evaluative information about whether policies and procedures are effective.

In addition to developing the various checklists, MPI staff reported that they plan to use the new information captured in the revised Annual Fraud and Abuse Activity Report template to create an electronic dashboard of plan activities. However, staff reported that they have not yet identified which elements of the report they could use as performance indicators to measure managed care plan program integrity performance.

Moreover, as of January 2018, MPI had not validated the 2016 and 2017 data reported by the health plans. According to MPI staff, they are still refining the validation process and adapting it to the new Annual Fraud and Abuse Activity Report format. During Fiscal Year 2016-17, the health plans reported recovering 58% of overpayments ($105.3 million of $182.9 million) and 30% of funds lost to fraud and abuse ($2.3 million of $7.6 million). However, since MPI had not validated this information, we could not determine the reliability or accuracy of the reported data.

While Florida does not have minimum standards or expectations for health plans' fraud and abuse activities, some states have implemented minimum standards or expectations for Medicaid managed care plans. States including New Jersey, New York, South Carolina, and Texas conduct regular oversight reviews of their Medicaid managed care plans' special investigative units (SIU) and anti-fraud plan compliance. In addition, New Jersey contractually established credential standards for SIU staff as well as staffing ratios that require a certain number of SIU staff per plan enrollees.[41] MPI staff reported that they considered establishing similar staffing ratios but do not have statutory authority to implement ratios and are interested in plan outcomes rather than the number of people assigned to different tasks. However, without performance standards, it is difficult to assess plan outcomes and evaluate the adequacy of program integrity staffing and resources.[42]

AHCA has not identified useful measures to evaluate MPI's performance. Florida law requires that the annual Medicaid fraud and abuse report, published jointly by the agency and the Office of the Attorney General, include detailed, unit-specific performance standards and metrics, including projected cost savings to the state.[43] MPI staff reported that the agency satisfies these statutory requirements through its reporting on the bureau's annual achievements. However, the report does not identify metrics, baseline standards, or ongoing benchmarks that can be used to assess bureau performance, identify areas of improvement, or inform the Legislature regarding appropriate performance expectations. Instead, the annual report includes information on various activities (e.g., number of cases opened and investigated each year, dollar amount of overpayments recovered each year, and return on investment for overpayments recovered).

Similarly, AHCA's long-range program plan includes two MPI performance measures: (1) amount of overpayments to Medicaid providers directly identified by MPI staff and (2) amount of overpayments to Medicaid providers prevented by MPI staff oversight. However, these measures

[41] New Jersey's Medicaid managed care contracts require plan SIUs to have an investigator-to-beneficiary ratio of at least one investigator per 60,000 or fewer enrollees. Plans can achieve this ratio by using full-time equivalent employees rather than dedicated investigators.

[42] The Statewide Medicaid Managed Care contract requires the plans to have adequate Florida-based staffing and resources to enable their compliance officers to investigate possible fraud and abuse.

[43] Section 409.913, *F.S.*

appear to combine both fee-for-service and managed care, which may not be helpful given the differences in the programs and the distribution of MPI staff, which is weighted toward fee-for-service.

Several recent reviews of MPI suggest the bureau could improve its performance. A U.S. Centers for Medicare and Medicaid Services review of program integrity oversight for Florida's managed care program conducted in 2017 suggested that the number of Medicaid provider investigations and referrals by the state's managed care plans were low compared to plan size.[44, 45] AHCA disagreed with this finding and raised concerns about the appropriate benchmark for such a conclusion. The agency's final response is currently pending. However, this finding may suggest that there is value to the bureau establishing standards for the managed care plans' program integrity efforts.

The agency continues to challenge a review conducted in 2014 by the U.S. Department of Health and Human Services' Office of Inspector General. The study found that between March 25, 2011 and December 31, 2013, MPI did not suspend Medicaid payments to providers with pending credible allegations of fraud or did not provide documentation to support the return of federal funds in 54 of the 95 cases reviewed.[46, 47] AHCA contended that 53 of the 54 cases involved providers whose activities were suspicious or otherwise did not rise to the level of credible fraud allegations. At the time of our review, discussions between AHCA and the U.S. Department of Health and Human Services were ongoing.

Most recently, the Florida Auditor General published the results of its review of AHCA's administration of SMMC. The review found that the agency's on-site monitoring reviews of managed care plans did not adequately encompass certain contract provisions and that the agency had not established sufficient procedures to fully assess the accuracy or completeness of managed care plans' reports used as the basis for certain monitoring conclusions.[48] According to the agency's response, whether a health plan is appropriately detecting and then investigating fraud and abuse is not necessarily a topic for all health plans' annual monitoring. AHCA also reported that assessing whether the plans appropriately investigated a matter requires an assessment of the health plans' detection efforts and a duplicate investigation to assess errors in the health plans' investigations.

MPI's new organizational placement provides an opportunity for the bureau to consider its focus. In August 2017, the agency shifted oversight of MPI from the Office of the Inspector General to the Division of Health Quality Assurance (HQA), AHCA's division that licenses and regulates health care providers, many of whom are Medicaid providers. According to agency staff, the change in placement ensures that AHCA's internal audit staff will avoid conflicts of interest, in fact or in appearance, when performing their work; the move will also allow for greater collaboration of MPI and HQA activities. AHCA officials reported that the move would help the agency accomplish these objectives because the shift will remove any potential appearance of lack of independence in oversight of MPI by internal audit and allow HQA and MPI to streamline efforts and ensure integrity in the Medicaid Program under a single deputy secretary.

The new placement may also provide an opportunity to consider the bureau's current focus, which is primarily on fee-for-service activities. Although Medicaid still processes 60 million claims from fee-for-service providers each year, 81% of Medicaid recipients receive services through managed care. Excluding the bureau

[44] The Statewide Medicaid Managed Care contract requires the health plans to report all suspected or confirmed instances of fraud and abuse relating to the provision of, and payment for, Medicaid services to MPI within 15 days of detection.

[45] The federal report reviewed a sample of four of Florida's contracted Medicaid managed care plans.

[46] The Social Security Act requires a state Medicaid agency to suspend all Medicaid payments to providers when it determines that there is a credible fraud allegation.

[47] *Florida Did Not Suspend Medicaid Payments to Some Providers That Had Credible Fraud Allegation Cases in Accordance with the Social Security Act*, U.S. Department of Health and Human Services, Office of Inspector General, A-04-14-07046, April 2017.

[48] *Agency for Health Care Administration, Statewide Medicaid Managed Care Program and Prior Audit Follow-Up*, Florida Auditor General, Rpt. No. 2018-002, July 2017.

chief and its chief management analyst, MPI has 106.5 staff working directly on fraud and abuse, with 85% (90.75) of these positions primarily dedicated to fraud and abuse in fee-for-service.

Agency Response

In accordance with the provisions of s. 11.51(2), *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 A.

Appendix A

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

January 31, 2018

Mr. R. Phillip Twogood
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 (Agency or AHCA) has reviewed the draft of the preliminary report dated January 2018 and titled *AHCA Continues to Expand Medicaid Program Integrity Efforts.* We have worked diligently in recent years to ensure comprehensive program integrity efforts within the Medicaid program and appreciate the recognition of these efforts and the high standard of performance achieved by our personnel described in the report.

The following comments address the report, provided to the Agency on January 12, 2018, and again in updated format on January 24, 2018, referenced as both a preliminary report and a draft report. With regard to the findings, the Agency agrees that there are always opportunities for improvement in operational activities, including program integrity efforts, both as they relate to the Agency's Bureau of Medicaid Program Integrity (MPI) and oversight of the Medicaid managed care plans' program integrity efforts. We agree that the recent move of MPI from the Office of the Inspector General to the Division of Health Quality Assurance will assist the Agency in overall program integrity efforts.

We would like to elaborate on our current efforts, including evaluation criteria and performance measures for the Medicaid managed care plans and MPI, recent state and federal reviews referenced in the report, and organizational changes.

Current efforts:
Historical program integrity efforts nationally have focused on analytical review of Medicaid claims data as the sole means for fraud, abuse, and waste detection. Over the years, Florida began to develop advanced procedures which focus on other indicators of fraudulent and abusive behavior. While claims data continues to be relevant, the decrease in fee-for-service (FFS) claims has not resulted in a corresponding decrease in FFS program integrity results. In fact, since SMMC, MPI has increased its referrals and collaborative efforts with other entities, including law enforcement, and has continued to identify suspected fraud and abuse at increasing rates in FFS; identifying more intricate fraud schemes. As recognized in the OPPAGA report, managed care can create a layer of complexity to the program integrity efforts and we are fortunate to have systems and protocols in place to allow increased communication and collaboration to address these matters.

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MPI, in consultation with the Division of Medicaid, continues to create risk-based models, using data beyond claims to identify suspect providers and areas of vulnerability in managed care, which may include the managed care plans themselves. The majority of MPI personnel are focusing on these (non-claims-based) efforts. We appreciate the opportunity to discuss the genesis of 85% of MPI positions primarily dedicated to fee-for-service activities. As we shift our focus away from the method of reimbursement to examining overarching fraud schemes, we also move away from categorizing staff as devoted to fee-for-service versus managed care. We believe that MPI efforts are advanced and would point to other Agency publications which elaborate on innovative activities such as the Annual Fraud and Abuse Report. We are mindful, however, that the Florida Medicaid fee-for-service program continues to require program integrity attention and do not wish to hastily shift resources, leaving readily collectable overpayments unidentified. We will continue to develop more robust managed care-related compliance efforts but also remain dedicated to a comprehensive approach.

Evaluation and performance measures:
The Agency has criteria and measures in place and constantly works to refine processes and increase standards. We agree with the recommendations that the Agency establish evaluation criteria and performance measures for the managed care plans which is consistent with current initiatives.

At present, MPI personnel are simultaneously gathering results of current managed care plan program integrity activities for purposes of both recommending base-line benchmarks and to compare to the similar activities of MPI related to current and historical efforts. MPI also has been developing risk-based models to identify suspected fraud and abuse. A managed care specific risk assessment tool is in development and is anticipated to assist the Agency in determining which plans are at greater risk for fraud or abuse committed by the plan (or plan personnel).

With regard to the recommendation that the Agency identify useful measures to evaluate MPI's performance, we understand that OPPAGA would like to see more detail about how current measures are used. The Agency uses statutorily defined measures and other figures on a routine basis (some weekly, monthly, and quarterly) to ensure management intervenes as needed to maintain the high level of performance routinely demonstrated by MPI. However, the Agency is not opposed to increasing the side-by-side reporting of these metrics over multiple years (much as is done at present for return on investment; see page 37 of the FY 2016-17 report titled *The State's Efforts to Control Medicaid Fraud and Abuse).*

Recent state and federal reviews:
In 2017 the Centers for Medicare and Medicaid Services initiated a review of the Agency which has not yet been finalized. The review did include a number of recommendations, but did not recognize the numerous best-practices established in Florida, relied on a non-representative sample of managed care plans to base many of the findings, and misstated or mischaracterized some information. The review is not final until the Agency response, which is due next month.

In 2014 the Department of Health and Human Services (HHS), Office of Inspector General conducted a review that evaluated the imposition of payment restrictions pursuant to a federal

law regarding the Agency's determination of "credible allegations of fraud." The review evaluated the then policies and procedures and investigations which had culminated into a referral to the state's Medicaid Fraud Control Unit (MFCU). Florida has state law obligations to make referrals to MFCU at an earlier point in the preliminary investigation (state law compels a referral when there is a suspicion of criminal activity, even where such activity is not yet known to constitute Medicaid fraud; the "suspicion" standard also compels a referral before a point where the allegations may be "credible"). Some referrals to MFCU will subsequently become investigations that yield credible allegations of fraud, which will trigger the payment restriction. The Agency has demonstrated to HHS that in all but two instances, there is no finding of non-compliance. With regard to the remaining two instances, MPI has furnished information to HHS that we anticipate will result in a determination that there were no instances during the 2014 review period where the Agency was non-compliant.

OPPAGA points out that an Auditor General report found that the Agency's on-site monitoring did not encompass certain contract provisions. While the Agency did not object to the findings that we can do more to ensure the plans are effective with their program integrity activities, throughout the Auditor General audit and other reviews of Agency processes, MPI has contended that the on-site monitoring of the managed care plans is not always the proper approach for some aspects of the managed care plans' special investigative units (SIU) activities.

The Auditor General specifically found that, while on-site, MPI personnel did not evaluates SIU investigations to determine the appropriateness of the managed care plans' actions with regard to investigations of fraud, abuse, or overpayments. This finding would involve MPI conducting a look-behind review of the path and progress of a managed care plan's SIU to evaluate whether the investigation was proper. The Agency continues to contend that onsite review is not the most effective means to evaluate this SIU effectiveness. Rather, MPI personnel evaluate SIU effectiveness based on the ability to appropriately detect fraud or abuse, even prior to initiating an investigation. Current MPI activities are geared toward driving the plans to robust detection activities, faster assessment and reporting (as required) of investigative subjects, and more effectively and efficiently investigating and auditing providers.

Organizational changes:
Finally, the report comments on the move of MPI to the Division of Health Quality Assurance and suggests that the move will allow a greater focus on managed care and less focus on fee-for-service activities. While we do not agree that the current focus within MPI is inappropriately geared toward fee-for-service, we do concur that the decision to move MPI was a sound decision that will assist with the continued efforts.

The Agency supports the spirit of the report, which is intended to increase efficiencies and optimize Agency efforts. We apply an evolutionary approach to program integrity efforts and are cognizant of the balance between fee-for-service and managed care oversight. MPI is also developing methodologies for identifying audit candidates for the managed care plans, increasing its documentation processes to more formally capture referral (to managed care plans) information, and incorporating managed care-related processes into the current (fee-for-

service) recovery processes. These and other activities serve to continually inform the Agency's managed care program integrity efforts.

Sincerely,

Justin M. Senior
Secretary

cc: Molly McKinstry, Deputy Secretary, Division of Health Quality Assurance
Beth Kidder, Deputy Secretary, Division of Medicaid
Mary Beth Sheffield, Inspector General
Eric Miller, Chief Inspector General, Executive Office of the Governor
Kelly Bennett, Chief, Medicaid Program Integrity

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The Florida Legislature

Office of Program Policy Analysis and Government Accountability

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