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And Government Accountability

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# FOLLOW-UP REVIEW ON EFFORTS TO IDENTIFY AND DETER PROVIDER FRAUD AND ABUSE IN FLORIDA'S MEDICAID PROGRAM

## *Report Abstract*

**Although the Agency for Health Care Administration has taken some of the actions we recommended, it has not:**

- **Fully implemented our recommendation that the Agency monitor the billings of providers that have abused Medicaid to ensure that abusive patterns are corrected; or**
- **Developed performance measures for judging the success of Agency efforts to identify and deter Medicaid providers from abusing Medicaid policy.**

## *Purpose of Review*

Section 11.45(7)(f), F.S., requires agencies to inform us of the actions they have taken in response to our recommendations within 18 months of the release of our reports. This follow-up report presents our assessment of the status of recommendations we made to the Agency for Health Care Administration in our Report No. 12287, a Performance Audit of Efforts to Identify and Deter Provider Fraud and Abuse in Florida's Medicaid Program, dated April 28, 1994.

## *Background*

The Agency for Health Care Administration is responsible for administering Florida's Medicaid Program authorized by Title XIX of the United States Social Security Act, as amended. To receive federal Medicaid funds, the Agency must develop methods and criteria for identifying and investigating Medicaid providers suspected of abuse and procedures for referring cases of suspected provider fraud to the Medicaid Fraud Control Unit (MFCU), located in the Department of Legal Affairs.

The Agency's Office of Medicaid Program Integrity is responsible for identifying and deterring Medicaid fraud and abuse. To meet its responsibilities, Program Integrity staff develop and use statistical methodologies to identify providers who exhibit aberrant billing patterns, conduct investigations and audits of these providers, calculate provider overpayments, initiate the recovery of overpayments for instances of provider abuse, recommend administrative sanctions for providers who have abused or defrauded Medicaid, and refer cases of suspected Medicaid provider fraud to the MFCU. The MFCU conducts investigations of suspected fraud and, when warranted, provides its findings to the various State Attorneys for possible criminal prosecution.

## *Prior Findings*

Although the Agency's efforts to identify provider fraud and to recover money from providers who have abused Medicaid compares favorably with other states in the Southeast region, we found that the Agency could strengthen its ability to deter Medicaid provider fraud and abuse if it improved some of its procedures. Specifically, we noted the following:

- Because clearly distinguishing between fraud and abuse can be difficult, staff from both the Office of Program Integrity and MFCU should participate in determining which cases to refer to MFCU for fraud investigation. For example, over-billings may sometimes be the result of simple errors or represent a departure from acceptable medical practice with no intent on the part of the provider to increase income. In other instances, providers may intentionally manipulate service codes or require excessive patient visits as a means of increasing their income. Towards the end of our audit, staff from Program Integrity and MFCU began meeting bi-weekly to discuss cases that might warrant fraud investigation.

- The Agency was imposing administrative sanctions on only a small proportion of providers that abused Medicaid. We noted that Program Integrity staff frequently did not document their use of the violation and sanction matrix (prescribed by rule) to support their decisions as to whether or not to sanction providers. We also found that staff who completed these matrices, often did not recommend the sanctions prescribed by rule.

- While the Agency did seek to recover overpayments and sometimes sanctioned providers, it did not have procedures requiring Program Integrity staff to identify and monitor the billings of providers that have abused Medicaid. Routine monitoring of such providers is needed to ensure that abusive practices are corrected. Otherwise, providers could continue their abusive practices which can add unnecessary costs to the Medicaid Program or affect the well-being of Medicaid clients.

In addition, we noted that the Agency had not established performance standards and benchmarks to evaluate the effectiveness of its efforts to identify and deter Medicaid fraud and abuse.

## *Current Status*

The Agency has taken some steps that we recommended. However, additional steps are needed to ensure that providers that have abused Medicaid policy discontinue the practices that led to the identified abuse as well as to deter other providers from abusing Medicaid policy. To ensure that the Agency takes these actions, the Legislature may wish to require periodic reviews of the Agency's Medicaid Program Integrity function. These reviews could be done either by our Office or the Office of the Auditor General (OAG).

## *Actions Taken*

**Meetings of Program Integrity and MFCU Staff.** As we recommended, Medicaid Program Integirty and MFCU staff have continued to meet on a regular basis to discuss cases of potential fraud. In addition, Agency staff have participated in several special task forces with staff from other state and federal entities that focus on Medicaid and Medicare fraud and abuse.

**Documenting Decisions to Sanction Providers.** As recommended in our prior report, the Agency now requires Program Integrity staff to complete violation and sanction matrices in cases where overpayments are identified. The Chief of Medicaid Program Integrity is responsible for reviewing and approving sanctions recommended by staff.

**Agency Review of Violation and Sanction Matrix.** As we recommended, the Agency reviewed the violation and sanction matrix. As a result of this review, the Agency proposed legislation that enhances its sanction authority. These proposals are contained in Ch. 96-387, Laws of Florida.

However, as noted in our prior report, OAG Report No. 12679, dated April 3, 1996, also found that the Agency sometimes does not recommend the sanction prescribed by rule or document its rationale for not imposing the prescribed sanction.

## *Actions Taken*

While the Agency has taken some of the steps we recommended, it has not implemented our recommendations in the following areas:

**Monitoring of Providers.** The Agency has not implemented procedures for conducting follow-up reviews of selected providers that have abused Medicaid to determine whether these providers have corrected their abusive practices. Program Integrity staff should purposely identify and monitor the billings of selected providers who meet criteria related to the magnitude of the abuse or the potential effect of continued abuse on Medicaid costs. Legislative support for this recommendation is reflected in Ch. 96-387, Laws of Florida, which requires the Agency to establish a process for conducting follow-up reviews of providers that have a history of Medicaid overpayments.

**Performance Measures and Benchmarks.** While the Agency reports that it will continue to work towards improving its overall performance in identifying health care fraud and abuse and in recovering misspent funds, it has not yet developed performance objectives and measurable targets for its Program Integrity function. The Agency should continue its efforts to develop measures that will assist the Legislature in assessing its performance and funding needs.

This project was conducted in accordance with applicable evaluation standards. Copies of this report may be obtained by telephone (904/488-1023 or 800/531-2477), by FAX (904/487-3804), in person (Claude Pepper Building, Room 312, 111 W. Madison St.), or by mail (OPPAGA Report Production, P.O. Box 1735, Tallahassee, FL 32302). Web site: http://www.state.fl.us/oppaga/

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