Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Florida Comprehensive Program Integrity Review

Final Report

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INTRODUCTION

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Florida Medicaid Program. The MIG review team conducted the onsite portion of the review at the offices of the Agency for Health Care Administration (AHCA). The review team also visited the offices of the Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the Bureau of Medicaid Program Integrity (MPI) which is responsible for Medicaid program integrity. This report describes 10 effective practices, 6 regulatory compliance issues, and 2 vulnerabilities in the State's program integrity operations.

THE REVIEW

Objectives of the Review

1. Determine compliance with Federal program integrity laws and regulations;
2. Identify program vulnerabilities and effective practices;
3. Help Florida improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of Florida's Medicaid Program

The AHCA administers the Florida Medicaid program. As of the State fiscal year (SFY) ending June 30, 2008, the program served 2.1 million recipients, with Medicaid expenditures totaling $14,131,095,733. Approximately 1.3 million recipients were enrolled in 13 managed care organizations (MCOs) and 8 provider service networks. The remaining 800,000 recipients were served on a fee-for-service (FFS) basis. The State had approximately 80,000 FFS enrolled providers and 40,000 MCO providers. During Federal fiscal year 2008, the Federal medical assistance percentage for Florida was 56.83 percent.

Program Integrity Section

The MPI, within the AHCA Office of Inspector General, is the organizational component dedicated to the prevention and detection of provider fraud and abuse. At the time of the review, MPI had approximately 96 full-time equivalent staff. Twenty of those staff are located in MPI's field offices around the state. A key component of MPI's Tallahassee operations is the Data Detection Unit (DDU), which maintains an array of mechanisms in support of its work to prevent, detect, and monitor fraud and abuse. The DDU consists of one full-time administrator and six full-time staff. The recoveries generated by MPI for the past four SFYs as a result of program integrity activities exceed $112 million.

Methodology of the Review

In advance of the onsite visit, the review team requested that Florida complete a comprehensive review guide and supply documentation in support of its answers. The review guide included

such areas as program integrity, provider enrollment/disclosure, managed care, and the MFCU. A four-person review team reviewed the responses and materials that the State provided in advance of the onsite visit.

During the week of February 2, 2009, the MIG review team visited the offices of MPI, AHCA's Medicaid Contract Management Office, and the MFCU. The team conducted interviews with numerous AHCA officials and the MFCU Director. Finally, to determine whether the MCOs were complying with contract provisions and other Federal regulations relating to program integrity, the MIG team interviewed State staff from the Bureau of Managed Health Care (BMHC). The team also reviewed the managed care contract provisions and gathered information through interviews with representatives of three MCOs. In addition, the team conducted sampling of provider enrollment applications, case files, selected claims, and other primary data to validate the State's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of the MPI, but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment, managed care and non-emergency medical transportation. Florida's Children's Health Insurance Program operates as a stand alone program under Title XXI of the Social Security Act and was, therefore, excluded from this review.

Unless otherwise noted, Florida provided the program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing or financial information that AHCA provided.

RESULTS OF THE REVIEW

Effective Practices

The State has highlighted several practices that demonstrate its commitment to program integrity. These include a comprehensive case tracking system, a wide range of surveillance and utilization review tools, an innovative drug rebate initiative, verification of billed services with all Medicaid recipients, the use of criminal background checks, required surety bonds for providers at higher risk of fraud and abuse, and frequent communication with the MFCU.

Flexible and comprehensive case tracking system

Florida's MPI utilizes a fraud and abuse case tracking system called the Fraud and Abuse Case Tracking System (FACTS). The FACTS is a web-based, event-driven system that has document scanning, workflow tracking, and querying capabilities. It can be easily modified to fit the needs of MPI management by changing system parameters and incorporating information from accounts receivable and the Office of the General Counsel. The MPI staff have the ability to add activities and documents applicable to those activities. The FACTS is used for case management and reporting purposes. It is a

comprehensive system that compiles all information needed to track a case over time. It allows for the addition of notes and attachments and serves as the electronic case record.

Wide range of surveillance and utilization review tools
The DDU uses effective review tools such as the 1.5, Chi Square, and Early Warning System reports, Decision Support Systems (DSS) profiler, and Ad Hoc and pharmacy detection reports in support of its efforts to prevent, detect, and monitor fraud and abuse. A DDU staff member is assigned to each report and detection tool. One DSS profiler query of particular interest involves personal care attendants (PCAs). The daily and weekly reports provide detailed claims information on PCAs with hours greater than 48 units (12 hours) for a single day or 240 units (60 hours) for a week.

Innovative drug rebate initiative
The DDU undertook an innovative Drug Rebate Program initiative which focused on the dispensing of certain drugs to specific doctors. The investigation involved requests for medical records and a review of written prescriptions. Where applicable, rebate amounts were determined, and the drug manufacturers were formally notified in writing of the findings. The manufacturers had to pay the delinquent rebate amounts without appeal or litigation. Florida plans to conduct additional investigations, as large dollar amounts continue to be lost within the Drug Rebate Program.

Verification of billed services with all Medicaid recipients
Florida sends Explanations of Medical Benefits (EOMBs) on a quarterly basis to all recipients for whom providers have billed services. The State reports a return rate of 2 percent, or 16,000 EOMBs per quarter. Three AHCA staff review the returned EOMBs, which have given the State substantive leads on program integrity issues. In SFY 2008, for example, 22 cases of overpayment identified by EOMBs supported a total of $447,758.55 in recoveries.

Criminal background checks on all non-licensed providers and their principals
The AHCA requires criminal background checks, including fingerprinting, for each provider or principal of a provider that is a corporation, partnership, association or other entity. Principals are defined as those with an ownership interest of 5 percent or more, partners, subcontractors, officers, directors, managers, financial records custodians, and all individuals who hold signing privileges on the provider's depository account. The State allows for some exemptions, such as individuals with prior criminal background checks that meet State standards. Also exempt are licensed facilities, publicly traded companies and any medical, osteopathic, podiatric and chiropractic physician, advanced practice nurse, or registered nurse who is actively licensed. Non-profit organizations must submit affidavits to obtain exemptions for their volunteer board members.

Surety bonds for providers at higher risk of fraud and abuse
The AHCA has the discretionary authority to require a $50,000 surety bond for selected providers for the first 12 months of enrollment and for each provider location up to a maximum of 5 bonds. Provider categories that are required to post surety bonds include

physician groups with over 50% non-physician owners, selected transportation providers, independent labs, durable medical equipment (DME) providers, home health agencies (HHAs) with history of sanctions/terminations in last five years, and home and community based services waiver providers when owned by a DME provider or HHA that is not Medicaid enrolled. Many providers must renew such bonds annually (e.g., selected DME providers).

Frequent and regular communications with the MFCU
The MPI has biweekly meetings with the MFCU to discuss how to handle individual case referrals. The MFCU branch offices from around the State are involved in these meetings, whether in person or by audio conferencing.

Additionally, the MIG review team identified three practices that are particularly noteworthy. The CMS recognizes efforts to enroll all billing agents as Medicaid providers, perform onsite checks of high risk providers prior to enrollment, and establish effective communication between MPI, BMHC, and contracted MCOs.

Billing agents are enrolled as Medicaid providers
By independently enrolling all billing agents as Medicaid providers, the State effectively vets billing agents in order to reduce the likelihood of fraud and abuse. Billing agents are also linked in the enrollment database to all providers whom they represent. When problems with a billing agent are identified, all related providers can be quickly identified, the existence of aberrant patterns can more easily be identified, and the State can act quickly in addressing problems.

Site visits for providers at higher risk for fraud and abuse
The State conducts unannounced site visits, as a condition of enrollment, to oxygen suppliers and DME providers who supply orthotic and prosthetic supplies, diabetic monitors and disposable supplies. Community mental health service providers, certain transportation providers and physician group practices that are more than 50 percent owned by non-physicians (except for groups owned by nonprofit hospitals) are likewise subject to mandatory site visits before enrollment. Other provider types may also be subject to random onsite inspections before enrollment.

Effective communication among MPI, BMHC, and the State's contracted MCOs
The MPI, BMHC and Medicaid MCOs communicate and cooperate with each other to an unusual extent. The BMHC seeks guidance from MPI staff on the fraud and abuse provisions in the managed care contract to ensure that the provisions are meaningful and that MCOs have adequate staff to carry out required functions. The BMHC includes MPI staff in the onsite visits to each MCO health plan at initial certification and during onsite reviews at the end of the first contract year. The MPI staff also attend monthly BMHC meetings with each health plan to discuss and receive information on fraud and abuse issues.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations related to provider attestations, disclosures, and notification activities.

Florida does not ensure that providers attest that information on claim forms is accurate.
The regulation at 42 CFR § 455.18 requires that providers attest to the accuracy of information on all claim forms. The regulation at 42 CFR § 455.19 permits an alternative to attestations on claim forms: the State may print attestation language above the claimant's endorsement on checks or warrants payable to providers.

Florida accepts the CMS 1500 and UB-04 forms for paper billings from providers. While the CMS 1500 is fully compliant with 42 CFR 455.18, the UB-04 is only partially compliant. The back side of the UB-04 contains the required attestation language; however, the UB-04 form does not provide an area for the provider to sign certifying that the information is true, accurate, and complete. The team also found that the remittance check did not contain the printed attestation statement on the back of the check.

***Recommendation*:** Develop and implement procedures to include the required signed provider attestation for all paper claims submitted to the Medicaid program. As an alternative, revise the checks and warrants payable to providers to include appropriate language pursuant to 42 CFR § 455.19.

Florida's provider enrollment forms do not capture complete ownership, control and relationship information. Florida did not obtain disclosures from its fiscal agent.
Under 42 CFR § 455.104(a)(1), a provider, or "disclosing entity," that is not subject to periodic survey under § 455.104(b)(2) must disclose to the Medicaid agency, prior to enrolling, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. Additionally, under § 455.104(a)(2), a disclosing entity must disclose whether any of the named persons is related to another as spouse, parent, child, or sibling. Moreover, under § 455.104(a)(3), there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity has an ownership or controlling interest. In addition, under § 455.104(c), the State agency may not contract with a fiscal agent that has not disclosed the ownership and control information required under this section.

Although Florida's FFS enrollment application asks providers to name owners and then to specify if they are subcontractors of the disclosing entity, the application does not precisely conform to the regulation by asking for the names of owners of those subcontractors in which the disclosing entity has a 5 percent or greater ownership interest. Moreover, when asked whether providers generally supply information about subcontractors, a Medicaid Contract Management Office administrator stated that providers do not typically disclose information about subcontractors. In addition, the enrollment application instructions about subcontractor

information are not sufficiently clear and consistent with § 455.104 to effectively promote compliance.

While Florida's fiscal agent Request for Proposals form and procurement process requests information about type of organization and corporate ownership, the State was not able to provide evidence that the identities of persons with ownership and control interests in the fiscal agent were ever disclosed.

***Recommendations*:** Modify the provider enrollment application and instructions to ask for the names of owners of those subcontractors in which the disclosing entity has a 5 percent or greater ownership interest. Modify the fiscal agent contract to require submission of the required ownership and control information and collect the required disclosures.

The State's provider enrollment agreement does not require the disclosure of business transactions.

The regulation at 42 CFR § 455.105(b)(2) requires that, upon request, providers furnish to the State or the U.S. Department of Health and Human Services (HHS) information about certain business transactions with wholly owned suppliers or any subcontractors. The provider agreements used in the FFS program do not obligate providers to provide the requisite business transaction information upon request by the State agency or the HHS Secretary.

***Recommendation*:** Modify provider agreements to require disclosure of the required business transaction information upon request.

Florida does not report health care-related criminal conviction disclosures in its FFS operations to HHS Office of Inspector General (HHS-OIG).

The regulation at 42 CFR § 455.106 stipulates that providers must disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request. The regulation further requires that the Medicaid agency notify HHS-OIG whenever such disclosures are made.

Florida does not have a routine procedure for reporting health care-related criminal convictions to HHS-OIG when providers disclose them as part of the provider enrollment or re-enrollment process. Convictions are only reported internally to the AHCA Inspector General.

***Recommendations*:** Develop and implement procedures to report all health care-related criminal conviction disclosures to HHS-OIG within the required time frames.

Florida does not report to HHS-OIG adverse actions taken on provider applications for participation in the program.
The regulation at 42 CFR § 1002.3(b) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program. The AHCA does not report to HHS-OIG adverse actions taken against provider applications or actions taken to limit the ability of providers to participate in FFS Medicaid based on permissive State authority. State staff indicated that they also do not report to HHS-OIG adverse actions taken against MCO providers. The three MCO plans interviewed said they notify the State of adverse actions taken during the re-credentialing process but do not notify the State when a provider is denied initial entry into the MCO network.

Recommendations: Develop and implement procedures to report to HHS-OIG all adverse actions taken against and limits placed on provider participation in the program. Require MCOs to notify the State when the MCO denies provider credentialing for program integrity-related reasons or otherwise limits the ability of providers to participate in the program.

The State does not notify all required parties when there is a State-initiated exclusion.
The regulation at 42 CFR § 1002.212 requires a State agency that has initiated an exclusion to notify the individual or entity subject to an exclusion, as well as other State agencies, the State medical licensing board, the public, recipients, and other interested parties.

When AHCA initiates an exclusion for any reason, its current procedures include notification to the provider, certain internal components within the State agency (such as Finance & Accounting, the Inspector General, Medicaid Operations and Services, and the Area Medicaid Offices), and the sister agencies that administer waiver programs, if appropriate. The AHCA does not notify the relevant State licensing boards, Medicaid recipients, or the general public. It was not clear to the review team whether the State agency customarily notifies entities in which an excluded individual may have been serving as an employee.

***Recommendation*:** Develop and implement policies and procedures to provide notification about exclusions to all required parties.

Vulnerabilities
The review team identified two areas of vulnerability relating to recipient verification of managed care services and the non-reporting of criminal conviction disclosures in the managed care program.

Not verifying with managed care recipients whether services billed by providers were received.
While the State meets the requirements of 42 CFR § 455.20 by sending EOMBs to FFS recipients, one of the managed care plans interviewed does not verify receipt of services. Instead it uses aggregate data from the Healthcare Effectiveness Data and Information Set to look for general patterns of underutilization.

***Recommendations*:** Modify the State's MCO contract to require that MCOs verify with recipients the receipt of services billed by providers. Develop and implement procedures to confirm plan compliance with this provision.

Not reporting health care-related criminal conviction disclosures in the managed care programs to HHS-OIG.

Florida's Medicaid managed care contract does not require MCOs to inform the State or HHS-OIG directly when health care-related convictions are disclosed as part of the provider credentialing process. Consequently, disclosures that may occur in the managed care programs go unreported.

***Recommendations*:** Modify the managed care credentialing packages and MCO contracts to require that all health care-related criminal convictions be reported to the State or to HHS-OIG directly within the specified time frames. Develop and implement procedures to monitor MCO compliance with this provision.

CONCLUSION

The State of Florida applies some effective practices that demonstrate program strengths and the State's commitment to program integrity. These effective practices include:

- a flexible and comprehensive case tracking system,
- a wide range of useful surveillance and utilization review tools,
- an innovative drug rebate initiative,
- verification of billed services with all FFS Medicaid recipients,
- criminal background checks on all non-licensed providers and their principals,
- surety bonds for providers at higher risk of fraud and abuse prior to enrollment,
- frequent and regular communications on cases with the MFCU,
- mandatory enrollment of all billing agents as Medicaid providers,
- required site visits for providers at higher risk for fraud and abuse prior to enrollment, and
- effective communication and coordination among MPI, BMHC, and contracted Medicaid MCOs

The CMS supports the State's efforts and encourages it to look for additional opportunities to improve overall program integrity.

However, the identification of six areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, two areas of vulnerability were identified. The CMS encourages AHCA to closely examine each area of vulnerability that was identified in this review.

It is important that these issues be rectified as soon as possible. To that end, we will require AHCA to provide a corrective action plan for each area of non-compliance within 30 calendar days from the date of the final report letter. Further, we will request the State include in that plan a description of how it will address the vulnerabilities identified in this report.

The corrective action plan should address how the State of Florida will ensure that the deficiencies will not recur. It should include the timeframes for each correction along with the specific steps the State expects will occur. Please provide an explanation if correcting any of the regulatory compliance issues or vulnerabilities will take more than 90 calendar days from the date of the letter. If Florida has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

The Medicaid Integrity Group looks forward to working with the State of Florida on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.