CHARLIE CRIST
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

HOLLY BENSON
SECRETARY

September 14, 2008

Ms. Holly Benson, Secretary
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, FL 32308

Dear Secretary Benson:

Please find enclosed our six-month status report on the Office of Program Policy Analysis and Government Accountability's (OPPAGA) report entitled *AHCA Making Progress But Stronger Detection, Sanctions, and Managed Care Oversight Needed*, Report #08-08, issued February 2008. This status report is provided in accordance with a statutory requirement that the Agency report on corrective actions taken as a result of OPPAGA's recommendations six months from the report date.

If you have any questions about this status report, please contact me at 921-0633 or Michael Blackburn at 414-5419.

Sincerely,

D. Kenneth Yon
Interim Inspector General

KY/dh
Enclosure

cc: Terry Shoffstall, Legislative Auditing Committee

Finding #1	Recommendation	Management Response as of February 14, 2008	Status as of August 14, 2008	Anticipated Completion Date & Contact
AHCA has not developed a sustainable advanced detection system using artificial intelligence.	Expand Florida's capabilities to detect Medicaid fraud, abuse, and overbillings by developing advanced detection models.	We agree that enhanced detection methods are needed; however, implementation of a new detection system is an expensive and time consuming process. Our previous efforts to obtain funding for an enhanced detection system were not successful, but additional attempts to secure funding will be made. As well, we will continue to request funds from the Legislature to add positions in the Bureau of Medicaid Program Integrity (MPI) for both statisticians and computer programmers. This will add consistency in long term data analysis and will meet the current demands required by the Medicaid Fraud Control Unit (MFCU) and AHCA for detecting fraud and abuse.	The development of advanced detection methods requires the assistance of specialized firms that have the personnel trained to do that and attendant other resources. Such methods involve sophisticated statistical and computer science applications. They might include artificial intelligence such as pattern recognition, multivariate discriminant analysis, complex mathematical algorithms and advanced data mining queries. The development of advanced and truly effective methods represents a major project. Advanced detection methods would be very helpful to the Office of the Inspector General, Medicaid Program Integrity. In 2007, the Agency for Health Care Administration applied to the Centers for Medicare & Medicaid Services for a two-year Transformation Grant in the amount of $12.8 million beginning October 1, 2007 to develop Medicaid overpayment detection and evaluation software. The Agency was not successful in this endeavor. The	

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			Agency will seek to locate and contract with a firm that has a demonstrated capability to analyze health care claims and find aberrant claims if funds are available. The new fiscal agent contractor, Electronic Data Systems, is providing in the Florida Medicaid Management Information System innovative fraud and abuse detection capabilities that will be used by the Agency. The Data Unit of Medicaid Program Integrity has been working extensively with EDS to ensure optimum utilization of these new capabilities.	

Finding #2	Recommendation	Management Response as of February 21, 2008	Status as of August 21, 2008	Anticipated Completion Date & Contact
AHCA has not strengthened its sanctioning process by setting minimum fines.	Establish minimum fine amounts based on the amount of a provider's overpayments.	We agree with this finding and, as reported, have begun imposing fines for providers who overbill Medicaid. For those who intentionally overbill, we continue to make every effort to remove the provider from the Medicaid program in addition to imposing fines. For the remainder of the overbillings deemed not intentional, we understand that these still represent a cost to the Agency in both personnel costs to identify and recoup the overbilling and interest lost on the improperly claimed Medicaid dollars. We submit however, that the revised sanction rule has been in effect for a short period of time and additional time is needed to critique the effectiveness of the rule before making recommended amendments.	The Office of the Inspector General has been reviewing Medicaid fraud and abuse administrative sanction policies. One current project is to simplify these policies that presently seem unduly complex. While it might seem appropriate to increase fine amounts with the magnitude of overpayments, it is important to bear in mind the fundamental purpose of administrative fines. If the purpose of fines were predominantly to punish the transgressor, then it would appear appropriate to scale fine with overpayments. The primary purpose of administrative is, however, to encourage compliance of providers with Medicaid policies. It has been found that providers are very sensitive to fines, which reflect on the reputation and integrity of the organizations receiving them. It has been found that a fine of a given amount will usually get the attention of a provider to about the same degree as a larger one. The Agency is in the process of updating its sanctions, and fine amounts have been increased in certain situations. The Agency will continue to review sanction policies including the application of administrative fines.	

Finding #3	Recommendation(s)	Management Response as of February 21, 2008	Status as of August 21, 2008	Anticipated Completion Date & Contact
AHCA has expanded its role in preventing fraud and abuse in the Medicaid managed care program but needs to take additional steps.	Expand oversight of Medicaid managed care organizations to detect and deter corporate fraud and abuse.	We agree with this finding and, at my direction, the Office of the Inspector General conducted a review of the Medicaid Reform Pilot project, which has been the template effort for potential statewide rollout of managed care. This review highlighted issues with the pilot program that bear directly on the State's ability to deter and detect fraud and abuse in the managed care arena. Subsequent to the report being issued, the Agency did not recommend expansion of the pilot this year. An additional OIG/MPI effort currently underway involves reviewing the Agency's standard managed care contracts, policies and practices for potential fraud and abuse vulnerabilities. As part of this project we are examining how other states conduct program integrity	Detailed information was given in September and October of 2007 to OPPAGA concerning reviews by the Agency of Medicaid managed care plans. This information included the names of plans reviewed, copies of review tools, and findings. Follow-up reviews have been conducted in 2008. Of the managed care plans surveyed in 2007, all required some corrective action. Year two of the contract period (and also of the survey process) has involved MPI returning to each plan, conducting follow-up reviews, and assessing implementation of the corrective actions prescribed. Preliminary findings of follow-up reviews for managed care plans' corrective actions indicate varying levels of performance. Some plans require further strengthening of their efforts to implement agency-approved corrective actions. MPI has also been involved in Phase III of new health plans' fraud prevention compliance reviews in order to assess their readiness prior to contract execution. MPI will be supplying monthly reports to	

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		functions with managed care organizations, giving particular focus to corporate level fraud and abuse. This effort is expected to assist MPI to better deal with fraud and abuse in a capitated environment. This effort is in addition to the managed care review the Division of Medicaid is conducting.	the Agency managed care contract manager concerning the status of activity regarding fraud prevention contract compliance of each plan. In addition, MPI has established a work group to meet monthly with the Medicaid Fraud Control Unit and Bureau of Managed Health Care on managed care fraud and abuse issues.	