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Better Health Care for all Floridians

THOMAS W. ARNOLD
SECRETARY

September 1, 2010

Thomas W. Arnold, Secretary
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, FL 32308

Dear Secretary Arnold,

Please find enclosed our six-month status report on the OPPAGA report entitled *Enhanced Detection, Stronger Sanctions, Managed Care Fiscal Safeguards, and a Fraud and Abuse Strategic Plan Are Needed to Further Protect Medicaid Funds*, Report Number 10-32, issued March 2010. This status report is issued in accordance with the statutory requirement to report on corrective actions resulting from the OPPAGA's recommendations six months from the report date.

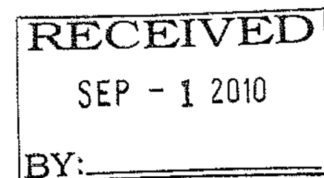
If you have any questions about this status report, please contact Damon Rodriguez at 412-3980.

Sincerely,

Peter Williams
Inspector General

PW/dr
Enclosure

cc: Kathy DuBose, Legislative Auditing Committee
Roberta Bradford, Deputy Secretary, Division of Medicaid



Agency for Health Care Administration
Office of the Inspector General - Internal Audit Unit
6th month Follow up Response Table for the OPPAGA Audit of Medicaid Program Integerty - 2010 - Report #10-32

	Issue	Recommendation(s)	Management Response as of March 16, 2010	Status as of August 16, 2010	Anticipated Completion Date & Contact
1	AHCA has not expanded its use of advanced technologies to detect funds lost to error, abuse, and fraud.	Expand detection tools to include neural networking or other advanced techniques capable of identifying emerging patterns of abuse and fraud.	We concur that enhanced detection tools are desirable. We have learned from other states that the use of advanced detection tools such as neural networking still requires staff support to analyze and follow-up the leads provided by the software. We have met with vendors that are offering various services to ensure the integrity of Medicaid payments prior to and after the payments are made and are in the process of evaluating these potential solutions. A selection will be made based on the best proposed return on investment coupled with available funding. We will continue to explore and develop sustainable advanced detection tools and to seek funding to not only provide for detection tool purchase, but staff to support successful implementation and utilization	The Bureau of Medicaid Program Integrity is completing a Legislative Budget Request to submit during the upcoming legislative session. The goal of this request will be to replace the current case tracking system with an improved case management system that incorporates advanced detection tools. The improved case tracking system will incorporate improved trending capabilities for complaint intake, EOMB analysis, and audit resolutions. Detection tools such as predictive analytics and neural networking will further enhance MPI's ability to target	7/1/2012 Mike Blackburn

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2	AHCA does not sanction most providers with identified overpayments, and it has not implemented our recommendation to increase fines for providers with overpayments.	Strengthen the sanctioning process to increase fines for overbilling.	The Agency is currently in the process of revising the Sanction Rule (Rule 59G-9.070, F.A.C.). Consideration will be given to your recommendations for significant increases in fine amounts and for possibly using a set percentage of providers' overpayments to calculate the fine. The Agency increased fines as part of the October 2008 rule amendment resulting in fine increases from $149,861 in FY 07-08 to $481,228 in FY 08-09. We are proposing additional increases with the current rule development.	MPI is in the final stages of adopting a revised Sanction Rule (Rule 59G-9.070, F.A.C.) that significantly strengthens sanctions and incorporates into rule statutory changes resulting from SB 1986. The revised rule was filed for adoption on August 16, 2010, and will become effective on September 7, 2010.	9/30/2010 Mike Blackburn

	Issue	Recommendation(s)	Management Response as of March 16, 2010	Status as of August 16, 2010	Anticipated Completion Date & Contact
3	AHCA has changed its managed care contracts to increase reporting on internal fraud and abuse investigations but needs to develop medical loss ratios to better monitor minimum standards of care.	Increase fiscal oversight of managed care plans and establish a minimum medical loss ratio to ensure that beneficiaries receive needed services.	Following up on the October 2009 report from the statutorily required Medicaid Managed Care Reimbursement Workgroup, the Medicaid program worked with its two contracted actuaries to develop financial reporting templates and instructions to be used by managed care entities to report to the Agency financial details regarding the plans' business activities in Florida. The financial data will be reported by area of the state, and by book of business (Medicaid pilot separate from non-pilot details). The draft templates were shared with plans and the Florida Association of Health Plans in January. Their input was incorporated and two conference calls/meetings were held with plans to further vet any questions or concerns they had. Final templates and instructions	The financial reporting was submitted by all HMOs in April 2010 and the data was shared with the Agency actuaries. Draft capitation rates have been developed that included the financial data reported. Final capitation rates are expected by September 1, 2010. Language was proposed in the 2010 Legislative session that would impose Medical Loss Ratios for managed care plan but no language was adopted that granted authority for the Agency to impose an MLR requirement for managed care plans.	9/1/2010 Phil Williams

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4	AHCA has taken steps to better coordinate efforts to safeguard Medicaid funds and should develop a risk-based strategic plan.	Require AHCA to develop a risk-based fraud and abuse strategic plan to guide the efforts of its Fraud Steering Committee.	We concur with your finding. The Office of the Inspector General drafted a strategic plan in 2008. We have used this plan to guide MPI's activities over the last two years. Although a formal risk assessment was not included in the strategic plan, the risk of fraud, waste and abuse in the Medicaid program was considered throughout its development. Additionally, the Fraud Steering Committee was established as an agency-wide tool to efficiently and cohesively combat fraud and abuse. The creation of focused sub-committees provides the basis for developing a strategic plan that identifies areas at high risk and formalizes strategies to reduce those risks. MPI will focus on the areas of highest risk to ensure the efficient and effective use of available resources.	Pursuant to SB 1986, the Agency is in the final stages of creating a fraud and abuse strategic plan. Per the bill language, we are focused on connecting databases that contain information related to Medicaid fraud and abuse, considering standardized data formats to facilitate the sharing of data, and researching improved methods for identifying health care fraud and abuse. An improved case management system that incorporates advanced detection tools will greatly assist the Agency in identifying high risk areas. The detection and trending tools will alert the	9/30/2010 Mike Blackburn