



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

November 27, 2012

Elizabeth Dudek, Secretary
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, FL 32308

Dear Secretary Dudek,

Please find enclosed our status report on OPPAGA's *Agency for Health Care Administration Continues Efforts to Control Medicaid Fraud and Abuse*, Report Number 11-22, issued December 2011. This report provides the status of corrective actions taken in response to findings and recommendations contained within OPPAGA's report.

If you have any questions about this status report, please contact Mary Beth Sheffield at 412-3978.

Sincerely,

Eric W. Miller
Inspector General

EWM/szg
Enclosure

cc: Kathy DuBose, Joint Legislative Auditing Committee
Jennifer Johnson, Staff Director, OPPAGA



**Agency for Health Care Administration
AHCA Continues Efforts to Control Medicaid Fraud and Abuse
Status Report on OPPAGA Report#11-22 Issued December 2011**

Develop a Strategic Plan

Recommendation# 1

We continue to recommend that the Fraud Steering Committee develop a strategic plan to identify areas at high risk for fraud and abuse and develop interventions to reduce these risks. The plan should identify priorities, timelines for addressing priorities, and the primary agency personnel responsible for specific priorities. The plan also should include short-term and long-term components. While short-term priorities should focus on both fee-for-service and managed care, long-term priorities should emphasize managed care.

Agency Response as of November 30, 2011

As mentioned in the report, the Agency continues to coordinate with external entities to enhance efforts to combat Medicaid fraud and abuse. One of the primary outcomes of these efforts is the identification of high risk providers, provider types and services. The Agency has implemented a Fraud Steering Committee and several subcommittees dedicated to identifying high risk areas and making recommendations to reduce those risks. Last year, the Agency developed a Strategic Plan to connect various health care fraud databases, and we are working to implement the strategies outlined in that document. As recommended in the report, the Agency will continue its efforts to combat fraud and abuse in the Medicaid program and will develop a fraud and abuse strategic plan to assist in those efforts. As recommended in OPPAGA's report, the short-term priorities of our plan will focus on solutions and interventions for fraud and abuse within both fee-for-service and managed care programs. However, long-term priorities of the plan will emphasize curtailing managed care fraud and abuse.

Agency Status Update

OPPAGA recommended that the Fraud Steering Committee lead an effort to create a long range plan addressing Medicaid fraud and abuse. Similarly, the Medicaid and Public Assistance Strike Force, chaired by Chief Financial Officer Jeff Atwater, recommended that the Agency bring forth some immediate tasks to combat fraud and abuse. To comport with these demands for short-term and long range plans, the Agency updated and published a data connectivity plan in March 2012, which constituted a strategic plan to connect health care fraud databases between the Agency for Health Care Administration, the Department of Health, the Department of Law Enforcement, and the Office of the Attorney General. The purpose of this Plan is to serve as a roadmap for facilitating the electronic exchange of health information used to identify and prevent fraud and abuse in the Florida Medicaid program. This plan was presented to the Medicaid and Public Assistance Strike Force in early 2012 and approved, contingent upon appropriation of funds and resources necessary for implementation. The Agency is implementing the connectivity plan, – which also guides other components and initiatives of the Fraud Steering Committee.

Medicaid Program Integrity was granted an \$800,000 re-appropriation in the 2012 Legislative session for “enhanced detection technology” that was initially appropriated in the 2011 legislative session. The Agency also applied for a federal grant to develop and implement a Program Integrity Network to facilitate the secure exchange of information used to prevent and detect health care fraud and abuse within state health care administration agencies, state agencies maintaining fraud databases, other states, and federal entities. The proposed pilot project’s concept involves three phases: creation of data standardization methods, development and utilization of common technical architecture, and integration of systems that house health care fraud information (case management systems, background screening systems, online licensing systems).

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Managed Care Expansion

Recommendation# 2

Implementing Medicaid managed care statewide will require AHCA to continue focusing on this oversight system to ensure that plans comply with requirements and that monitoring processes continue to support an effective process for preventing and detecting fraud and abuse. In doing so, the agency should continue to use feedback from the managed care plans to identify modifications or enhancements that would further ensure the prevention and detection of fraud and abuse. In addition, because the number of managed care plans will increase, the agency should determine how it needs to shift resources currently committed to identifying and investigating fraud and abuse by fee-for-service providers to overseeing managed care plans. Further, agency integrity efforts in the past have primarily focused on identifying Medicaid fee-for-service overpayments. However, with the expansion of managed care, the agency will need to also focus efforts on identifying underutilization to help ensure beneficiaries receive medically necessary services.

Agency Response as of November 30, 2011

The Agency holds periodic discussions with the managed care plans regarding the prevention and detection of fraud and abuse. The Agency also reviews the managed care entities' anti-fraud and abuse plans and their annual reports on their experience and results in implementing such anti-fraud plans. As development of the core managed care contract continues to evolve, the Agency will continue to obtain feedback from the managed care plans and review their anti-fraud and abuse efforts to identify necessary modifications or enhancements.

As referenced in the report, the number of Medicaid enrollees in managed care plans will increase as Florida expands managed care statewide. In the 2011 legislative session, the Agency was directed to develop a reorganization plan for the realignment of resources that would assess the Agency's current capabilities, identify shifts in staffing and other resources necessary to strengthen managed care procurement and managed care contract monitoring functions, and establish an implementation timeline. Resources dedicated to identifying and investigating fraud and abuse in the Medicaid program's managed care environment were included in that assessment.

As the Agency continues to move forward with the expansion of managed care, there will be ongoing evaluation and realignment of resources dedicated to the prevention and detection of Medicaid fraud and abuse, including focusing on identifying underutilization practices and patterns.

Agency Status Update

Requests for authority to implement the Statewide Medicaid Managed Care (SMMC) program were submitted pursuant to Part IV of Chapter 409, Florida Statutes, and the Agency has been involved in ongoing discussions with Federal CMS relating to the SMMC program and continues to be in frequent regular communication with CMS. Waiver and state plan amendment approval is necessary prior to SMMC program enrollment, which is anticipated to begin in the fall of 2013 for the Long-term Care Managed Care program and the summer of 2014 for the Managed Medical Assistance (MMA) program.

The ITN for the Long-term care component of the SMMC program was released on June 29, 2012, and we anticipate that contracts will be awarded in January 2013. The Agency will release the MMA ITN by no later than January 1, 2013.

MPI recently shifted and will continue to expand infrastructure to increase staff dedicated to managed care oversight and implemented an official MPI Managed Care Unit. The MPI Managed Care Unit staff review materials submitted by the health plans related to fraud and abuse prevention. The Managed Care Organizations report the progression of casework quarterly via MPI's web-based application that allows tracking statewide of all cases reported to MPI. Health Plans are also required to submit an Annual Fraud

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and Abuse Activity Report citing their respective identified overpayments and recoveries as required by Section 409.91212, Florida Statutes.

Collaborative efforts with other bureaus and with MFCU resulted in the development of a better reporting mechanism for tracking of the health plan subcontractors and affiliates. The Agency is better able to identify with whom the health plans are contracting for administrative services to Medicaid recipients, thus this is a first step in the detection of underutilization schemes involving inflated or inaccurate medical loss ratio reporting. This new contract reporting requirement was implemented in contract amendments earlier this summer (2012) and is now incorporated into the 2012-2015 contracts with the managed care plans.

Identify Options to Further Shorten the Audit Process

Recommendation# 3

To further decrease the length of the investigation process, the agency should identify the areas that consume a significant amount of time and identify potential options to address these areas.

Agency Response as of November 30, 2011

The Agency will continue its efforts to conduct audits of Medicaid providers as efficiently as possible. Identifying areas that consume a significant amount of time and proposing solutions to reduce or eliminate those delays will be a part of that process. To that end, the Agency has submitted proposed legislation that will assist in further reducing the amount of time it takes to complete an audit.

Agency Status Update

The Agency continues its efforts to conduct audits of Medicaid providers as efficiently as possible. With implementation of SB 1986, the Agency now initiates the collection process when overpayments are identified at the time a Final Agency Audit Report is issued rather than beginning that process at the end of a case which may be extended as hearing rights are exercised. Therefore, identified overpayments are recovered prior to the final conclusion of the case. This recovery process appears to have contributed to a decline in the number of days a case remains open.

Also, proposed legislative changes to Section 409.913, Florida Statutes, will be resubmitted this session. One change proposed requires that the providers submit all documentation early in the auditing process and limits piecemeal submission of requested documents. This would shorten the audit process.