

**Department of Health and Human Services
Centers for Medicare & Medicaid Services**

Medicaid Integrity Program

Florida Comprehensive Program Integrity Review

Final Report

July 2012

Reviewers:

Lauren Reinertsen, Review Team Leader

Richard Colangelo

Barbara Davidson

Eddie Newman IV

Joel Truman, Review Manager

Table of Contents

| | |
|--|----|
| Introduction..... | 1 |
| The Review..... | 1 |
| Objectives of the Review | 1 |
| Overview of Florida’s Medicaid Program | 1 |
| Bureau of Medicaid Program Integrity | 1 |
| Methodology of the Review | 2 |
| Scope and Limitations of the Review..... | 2 |
| Results of the Review | 3 |
| Noteworthy Practice..... | 3 |
| Effective Practices | 4 |
| Regulatory Compliance Issues | 8 |
| Vulnerabilities | 11 |
| Conclusion..... | 13 |
| Official Response from Florida | A1 |

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 conducted the onsite portion of the review at the Florida Agency for Health Care Administration (AHCA) offices. The review team also visited the office of the Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the Bureau of Medicaid Program Integrity (MPI) within AHCA which has primary responsibility for implementing program integrity activities. This report describes one noteworthy practice, six effective practices, three regulatory compliance issues, and three vulnerabilities in the State's program integrity operations.

The CMS is concerned that the review identified one repeat finding and one repeat vulnerability from its 2009 review of Florida. The CMS plans on working closely with the State to ensure that all issues, particularly those that remain from the previous review, are resolved as soon as possible.

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 January 1, 2011, the program served 2,920,498 beneficiaries. Florida has a managed care program which operates in many parts of the State and served 1,300,457 beneficiaries, or 45 percent of Florida's Medicaid population as of January 1, 2011.

At the time of the review, the Florida Medicaid program had 110,654 participating fee-for-service (FFS) providers. As of February 25, 2011, Florida had 51 managed care entities (MCEs). These included full-risk health maintenance organizations, provider service networks, and prepaid dental plans, with a total of 55,344 providers enrolled in the State's managed care program. According to the State, Medicaid expenditures for the State fiscal year (SFY) ending June 30, 2011 totaled \$19,246,159,917. This figure includes expenditures of \$3,501,771,740 for capitated payments to MCEs.

Bureau of Medicaid Program Integrity

The MPI is located within AHCA's Office of Inspector General. Although integrity functions

**Florida Comprehensive PI Review Final Report
July 2012**

are performed by other AHCA divisions, such as the Divisions of Medicaid, Health Quality Assurance, and Operations, MPI has the overall responsibility for the prevention and detection of fraud, abuse and improper payments within the Medicaid program. At the time of the review, MPI had 96 full-time equivalent staff, including 26 investigators, 8 nurses, 34.5 data analysts, and 27.5 management and support personnel. There were no vacant positions.

The table below represents the total number of preliminary and full investigations and the amount of identified and recouped overpayments in the past four SFYs as a result of program integrity activities. The numbers do not reflect data on managed care program integrity activities, but the figures on overpayments collected include dollars recouped from global settlements.

Table 1

| SFY | Number of Preliminary Investigations* | Number of Full Investigations** | Amount of Overpayments Identified*** | Amount of Overpayments Collected*** |
|-----------|---------------------------------------|---------------------------------|--------------------------------------|-------------------------------------|
| 2007-2008 | 1,126 | 725 | \$15,628,918 | \$12,663,327 |
| 2008-2009 | 1,614 | 1,270 | \$15,625,437 | \$13,286,976 |
| 2009-2010 | 2,366 | 1,476 | \$18,800,058 | \$14,370,072 |
| 2010-2011 | 3,172 | 1,361 | \$20,916,266 | \$18,199,795 |

*Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation.

**Full investigations are conducted when preliminary investigations provide reason to believe fraud or abuse has occurred. They are resolved through administrative action, a referral to the MFCU or other legal disposition.

***These figures reflect overpayments identified and recovered through MPI program integrity activities. They do not include collections from audit, law enforcement and other program integrity activities occurring outside MPI.

Methodology of the Review

In advance of the onsite visit, CMS requested that Florida complete a comprehensive review guide and supply documentation in support of its answers to the review guide. The review guide included such areas as provider enrollment, program integrity, managed care and the MFCU. A four-person team reviewed State responses and documents provided in advance of the onsite visit.

During the week of October 17, 2011, the MIG review team visited AHCA offices and also met with the MFCU director. The review team conducted interviews with officials from AHCA as well as the MFCU. To assess whether MCEs were complying with the contract provisions and other Federal regulations relating to program integrity, the MIG team reviewed the State-MCE contracts and interviewed representatives from five of the MCEs. In addition, the review team met with staff from the AHCA division that oversees MCE contracting and program performance. The team also 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 AHCA as they relate to program integrity but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment, managed care, personal care services, waiver programs and non-emergency medical transportation.

Florida Comprehensive PI Review Final Report July 2012

Florida operates its Children's Health Insurance Program (CHIP) both as a stand alone Title XXI program and a Title XIX Medicaid expansion program. The expansion program operates under the same billing and provider enrollment policies as Florida's Title XIX program. The same effective practices, findings and vulnerabilities found in the Medicaid program integrity review also apply to the CHIP expansion program. The stand alone program operates under the authority of Title XXI and is beyond the scope of 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 provided by the State.

Results of the Review

Noteworthy Practice

As part of its comprehensive review process, the CMS review team identified one practice that merits consideration as a noteworthy or "best" practice. The CMS recommends that other States consider emulating this activity.

Improved statutory and regulatory controls against fraud and abuse

Florida has strengthened its efforts to combat Medicaid fraud and abuse by enhancing its regulatory authority and controls. A series of amended State rules have allowed the State to impose fines of up to 40 percent of provider overpayments and to more than double the fines for providers who do not furnish records in a timely manner.

In March 2010, the Office of Program Policy Analysis and Government Accountability (OPPAGA) released a report outlining several recommendations that MPI could implement to strengthen Florida's Medicaid fraud and abuse program. One of the OPPAGA recommendations directed MPI to strengthen the sanctioning process by imposing higher fines based on the provider's identified overpayment. The enactment of Senate Bill 1986, which was introduced in the 2009 Legislative Session, paved the way for this statutorily, but amendments to several rules in the Florida Administrative Code (F.A.C.) were required to fully implement the new fraud fighting authority.

One such rule was the Administrative Sanction Rule, Rule 59G-9.070, F.A.C. Recent amendments to the rule became effective September 7, 2010 and significantly increased the sanctions, monetary and otherwise, available to AHCA as a deterrent against egregious billing practices and repeated misbillings. For example, the penalty for a first time failure to furnish Medicaid-related records increased from \$1,000 to \$2,500 per record request and included a suspension until the records were made available. After 10 days, the fine increases by another \$1,000 per record request, and if all records are not provided within 30 days, the provider is terminated. For second offenders, the fine is \$5,000 per record request, increasing by \$2,500 per record after 10 days and including an imposed termination after 30 days. The F.A.C. also provides for the immediate

termination of third time offenders.

Under paragraph (7)(e) of the same rule, failure to comply with Medicaid laws likewise subjects the provider to a fine that has increased from \$500 to \$1,000 per claim, with a maximum penalty of up to 20 percent of the overpayment amount for first-time offenders. For second-time violators, the fines increase to \$2,500 per claim up to 40 percent of the overpayment amount, and upon a third violation, they rise to \$5,000 per claim up to 50 percent of the overpayment amount. Termination from the program may occur as early as the first violation and generally takes place by the second or third violation.

During SFY 2009-2010, 453 Medicaid providers received 525 sanctions for violations based on the above rule. The sanctions included program suspensions and terminations from the Medicaid program as well as fines totaling \$666,740 and the imposition of corrective action plans on providers who were permitted to remain in the program.

Effective Practices

As part of its comprehensive review process, CMS also invites each State to self-report practices that it believes are effective and demonstrate its commitment to program integrity. The CMS does not conduct a detailed assessment of each State-reported effective practice. Florida reported a proactive data detection unit with a wide range of surveillance and utilization tools and having regular communication about program integrity issues with multiple Medicaid stakeholders. Florida also reported the use of an electronic web-portal provider enrollment system, an automated provider license verification process, use of a fraud and abuse tool kit to help MCEs maintain compliance with program integrity contract provisions, and use of a physician credentialing and recredentialing checklist for MCE providers.

Wide range of surveillance and utilization tools for detecting fraud

The MPI Data Detection Unit uses a number of valuable tools to proactively search for potential fraud and abuse in the Medicaid program and to detect aberrant behaviors, over-utilization patterns, upcoding, unbundling, and double billing. These tools allow MPI to focus on claim areas that would benefit from prepayment reviews or comprehensive reviews and to identify providers for audits or MFCU referral.

The MPI has developed three detection tools and is willing to share the algorithms which provide the foundation for these tools with other State program integrity operations. They include:

- A 1.5 Report which is generated weekly and identifies, by provider type, provider payments exceeding 150 percent of the provider's running average for the prior 26 weeks.
- A Chi-Square analysis, run quarterly, which compares a provider's billing pattern to that of his/her peers for several evaluation and management procedure codes.
- An Early Warning Report which identifies the rates of increase in payments to providers for 29 different provider types.

Other tools which MPI uses are proprietary to Florida's fiscal agent. They include a

profiler tool which gives Florida's surveillance and utilization review subsystem five quarters of data from which to perform risk adjusted peer group comparisons and generate targeted queries. In addition, one of Florida's contractors regularly produces reports that identify outliers and highlight current trends in the prescribing, consumption, and dispensing of prescription drugs. Such reports include prescriber ranking by volume, quarterly doctor shopper lists, and lists of the most utilized pharmacies.

With the help of these tools, Florida recovered \$43.8 million in SFY 2009-10. An additional savings of \$3.8 million in denied claims was gained through Florida's prepayment review process, which uses the detection and ad hoc reporting systems to find outlying providers for the review program.

Notwithstanding the value of the previously mentioned analytic tools which Florida uses, a report issued by the State of Florida Auditor General (No. 2012-021, October 2011) found significant shortcomings in the day-to-day operation of Florida's Medicaid Management Information System (MMIS). When the identified vulnerabilities are corrected, Florida's Medicaid payment process will be strengthened.

Regular communication on program integrity issues and efforts with key internal and external stakeholders

The Bureau of Health Systems Development (BHSD) organizes and establishes regular communications with the key components within AHCA that are responsible for Florida's managed care programs. These components include the BHSD which is responsible for contracting with and general oversight of MCEs, the Bureau of Medicaid Services (BMS), which develops policies, procedures and programs for medical, behavioral, therapeutic and transportation services, and the Bureau of Medicaid Quality Management which sets performance measures for MCEs, analyzes encounter data, and oversees the external quality review organization contract. The MPI participates in quarterly meetings with these bureaus to discuss program integrity issues and fraud and abuse referrals.

The MPI also participates in monthly meetings with BMS to discuss fraud and abuse requirements outlined in the managed care contract. With the aid of MPI feedback, BHSD conducts technical assistance calls and quarterly meetings to educate MCEs regarding the State's program integrity expectations, best practices, and suspected fraud cases. The BHSD has also conducted a webinar on quarterly fraud and abuse reporting.

The MPI's Case Management Unit is also active in an Edits and Audits Task Force, led by BMS and initiated in January 2011. The work of this task force, which checks that edits which are programmed into the State's MMIS reflect current policy, has led to additional MMIS edits and prior authorization requirements.

The MPI also takes part in bi-weekly Medicare-Medicaid Data Sharing Initiative coordination meetings which focus on computerized matching of Medicaid and Medicare claims data in order to identify fraud and abuse by providers serving the dual eligible population.

The MPI also meets bi-weekly with Florida's MFCU to share ideas for data mining and fraud detection projects and discuss potential referrals. Florida's MFCU has a temporary waiver from CMS to allow independent data mining using the Medicaid data warehouse. All data mining projects are coordinated and thoroughly discussed to ensure that no duplication of efforts occurs. Good communication with other components and stakeholders on program integrity issues was also found to be an effective practice during MIG's 2009 review.

Electronic web portal provider enrollment system

Florida has established a complete web portal provider enrollment system which supplements its paper-based enrollment processes with an electronic platform and interface. Although not mandatory, it was used by 43 percent of providers at the time of the review.

The initial data entry captures demographic information and generates a unique tracking number which allows the applicant to save and subsequently complete the application. Varying questions are asked based on the requested provider type and specialty and the applicant is prevented from moving forward with the application until all required questions are answered. This process dramatically reduces the number of applications rejected for missing data. After the online data entry is complete, the web portal provider enrollment system prompts for the submission of all supporting documentation, which may be uploaded or faxed directly to the MMIS.

As of September 2011, State data has shown that providers using the web portal are able to finalize applications 43 percent faster than paper-based submissions, reducing the enrollment process by an average of 60 days. Notwithstanding these improvements, the review team found certain problems in the State's collection of required provider disclosures which are discussed in the Findings section of this report.

Automated provider license verification process

Since the previous MIG review in 2009, Florida Medicaid has automated its manual license verification process to allow daily checking of provider licensure information and weekly checking of facility licensure data. This process, which includes an interface with the MMIS, allows Florida to suspend providers whose licensure data on file does not match new information and to notify a provider proactively that an upcoming suspension will occur if a license due to expire in 60 days is not renewed.

Data related to licensed practitioners and pharmacies is received on a daily basis from the Florida Department of Health and data related to facility licensure arrives on a weekly basis from AHCA. The license data is stored as an MMIS table and all initial and renewal provider applications are verified against this data prior to approval.

During interviews, the State indicated it will expand the type and amount of data in the license table and further automate the verification process with automated suspension letters and automated renewal letters for providers with licenses due to expire. The automated verification process frees the State agency from a manual labor intensive

paper-based process that was historically challenged with untimely receipt of notifications and State exposure to potential overpayments and costly recoupment efforts.

Required MCE use of a “Fraud and Abuse Tool Kit” during the contracting process

Through a process which specifies program integrity standards, Florida ensures that all MCEs within its Medicaid program are complying with certain core program integrity provisions in their managed care contracts at the start of each contracting period. Florida also checks for compliance with these standards during the contract period.

The MPI has developed a “Fraud and Abuse Tool Kit” which is available to MCEs online and which the MCEs must use during the contracting process. Using the tool kit, MPI checks on MCE compliance by conducting an onsite survey at least once during each MCE’s contract period. If an MCE is found out of compliance with the standards, the MCE is placed on a corrective action plan. The MPI generally performs such monitoring reviews independent of other AHCA bureaus but it will undertake collaborative or joint reviews with another component if a review is required prior to a contracting cycle or if another bureau specifically requests MPI participation in a concurrent review.

The program integrity standards in the tool kit include such areas as compliance plans and committees, anti-fraud and abuse training programs, policies and procedures for fraud and abuse prevention, documentation, and submission of suspected fraud activity reports.

Physician credentialing and recredentialing checklist for MCE providers

Florida MCE providers are credentialed at enrollment and re-credentialed every three years thereafter and Florida uses a checklist, known as the “Physician Credentialing and Recredentialing File Review Tool”, during onsite credentialing or recredentialing reviews to monitor these efforts. This checklist captures licensure and certification provisions and assists the State in assessing whether MCE network providers are submitting disclosure information comparable to what FFS providers must furnish under 42 CFR §§ 455.104-106.

The checklist also allows the State to assess whether criminal background checks have been completed, if MCE providers have disclosed any sanctions imposed by Medicare or Medicaid, and to pinpoint other items such as gaps in work history, hospital privileges, patient load attestation, onsite assessment of the facility, and records and file documentation. There is also a requirement that the medical director or another qualified individual attest to the review and approval (as complete) of the credentialing or recredentialing files.

Notwithstanding the State’s efforts to monitor MCE network providers more closely, the review team found certain problems in the collection of MCE network provider disclosures using State-approved forms. These are discussed in the Findings section of the report.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations related to the MFCU referral process, the collection of ownership and control disclosures, and the performance of complete searches for individuals and entities excluded from participating in Medicaid.

The State does not suspend payments in cases of credible allegations of fraud, and its MFCU referrals do not meet the minimum fraud referral performance standards.

The Federal regulation at 42 CFR § 455.23(a) requires that upon the State Medicaid agency determining that an allegation of fraud is credible, the State Medicaid agency must suspend all Medicaid payments to a provider, unless the agency has good cause to not suspend payments or to suspend payment only in part. Under 42 CFR § 455.23(d) the State Medicaid agency must make a fraud referral to either a MFCU or to an appropriate law enforcement agency in States with no certified MFCU. The referral to the MFCU must be made in writing and conform to the fraud referral performance standards issued by the Secretary.

At the time of the review, Florida was not suspending Medicaid payments upon referral to the MFCU as required by the revised regulation at 42 CFR § 455.23(a) that went into effect on March 25, 2011. The MPI stated that at times it places providers on pre-payment review which results in an automatic payment suspension. However, this process is only a temporary suspension while a review is conducted and documents are gathered.

According to the State, MPI referred 22 cases to the MFCU from March 25, 2011 until the week of the program integrity review. A total of \$29,490,119 was paid to these providers after their referral to the MFCU. These cases should have been suspended after the case was referred to the MFCU, unless the MFCU requested a good cause exception in writing or the MPI exercised one of the other good cause exceptions not to suspend payments in whole or in part. The team found no evidence that either party had justified the continuation of payments on the basis of written good cause exception requests.

The team also observed that MFCU referrals being made by MPI did not fully meet current performance standards. In September 2008, CMS issued a document entitled “*CMS-MIG Performance Standards for Referrals of Suspected Fraud from a Single State Agency to a Medicaid Fraud Control Unit*,” which became part of the § 455.23 regulation on March 25, 2011. A MFCU referral should contain at least the minimum elements set forth in this guidance document. In reviewing the fraud referral letter submitted to the MFCU, the team noticed that the State agency did not provide the following required categories of information: amount paid to the provider for the last three years or during the period of alleged misconduct, all communication between the State Medicaid agency and the provider, and the dollar amount of Medicaid’s financial exposure, when available.

In addition, the MFCU does not provide the State with written notification of case acceptance, although acceptance is communicated verbally during the bi-weekly meetings.

Recommendation: Develop and implement policies and procedures to meet the fraud referral standards for MFCU referrals and the requirements of 42 CFR § 455.23 concerning the suspension of payments to providers upon MFCU referral.

The State does not capture all required ownership and control disclosures from disclosing entities. (Uncorrected Repeat Finding)

Under 42 CFR § 455.104(b)(1), a provider (or “disclosing entity”), fiscal agent, or MCE, must disclose to the State Medicaid agency the name, address, date of birth (DOB), and SSN of each person or entity 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. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address. Additionally, under § 455.104(b)(2), a disclosing entity, fiscal agent, or MCE must disclose whether any of the named persons is related to another disclosing entity, fiscal agent, or MCE as spouse, parent, child, or sibling. Moreover, under § 455.104(b)(3), there must be disclosure of the name of any other disclosing entity, fiscal agent, or MCE in which a person with an ownership or controlling interest in the disclosing entity, fiscal agent, or MCE has an ownership or controlling interest. In addition, under § 455.104(b)(4), the disclosing entity must provide the name, address, DOB, and SSN of any managing employee of the disclosing entity, fiscal agent, or MCE. As set forth under § 455.104(c), the State agency must collect the disclosures from disclosing entities, fiscal agents, and MCEs prior to entering into the provider agreement or contract with such disclosing entity, fiscal agent, or MCE.

Florida’s Medicaid Contract Management Unit uses two types of enrollment application forms for all provider enrollments. The forms are mandatory for FFS providers, MCE contractors, dental providers, and personal care service agencies, as well as certain MCE physicians who submit FFS billings. There is a 12-page paper enrollment application and an online enrollment application. In addition, the State uses a 2-page registration form to enroll physicians who will only perform services under contract to a capitated Medicaid MCE. Florida refers to these physicians as managed care treating providers. None of these forms capture all the ownership and control disclosure information required by the regulation.

The 12-page paper enrollment application (used by 57 percent of providers) has not been revised since the 2009 CMS review when CMS found it did not clearly ask for information on persons with ownership and control interests of 5 percent or greater who also have ownership and control interests in subcontractors. Additionally, the 12-page application does not capture the information now required under the revised regulation related to managing employees, DOB, and enhanced address information. Because Florida enrolls a portion of MCE physicians using the 12-page application, this finding also applies to these MCE network providers.

Both the State’s online and 12-page paper enrollment applications do not capture enhanced address information as required under the revised 42 CFR § 455.104 regulation. The State indicated that it is in the process of drafting a new provider enrollment application form for both paper and online submissions and it will add information pertaining to managing employees, DOBs, and enhanced addresses. In addition, the State is encouraging all Medicaid providers to use the online enrollment application form in an attempt to streamline the enrollment process.

The two page MCO Treating Provider Registration form, which Florida uses to register physicians that only provide Medicaid services within capitated MCEs, also does not collect the

information required under the revised regulation. It does not collect information on managing employees, and it does not collect the name, address, DOB, and SSN of each person or entity with an ownership or controlling interest in the disclosing entity. It likewise solicits none of the above information on persons or entities with ownership or control interests in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more.

Recommendations: Develop and implement policies and procedures for the appropriate collection of disclosures from disclosing entities and MCEs regarding persons with an ownership or control interest, or who are managing employees of the disclosing entities or of the MCEs and their network providers. Modify disclosure forms as necessary to capture all disclosures required under the regulation. This recommendation applies to one element that was not corrected from the 2009 review (the requirement that disclosing entities furnish information on persons with 5 percent or more ownership or control interests in both the disclosing entity and subcontractors). The recommendation also applies to the post-March 25, 2011 regulatory requirements that Florida has not implemented.

The State does not conduct complete searches for individuals and entities excluded from participating in Medicaid.

The Federal regulation at 42 CFR § 455.436 requires that the State Medicaid agency must check the exclusion status of the provider, persons with an ownership or control interest in the provider, and agents and managing employees of the provider on the HHS-OIG's LEIE and the General Services Administration's Excluded Parties List System (EPLS) no less frequently than monthly.

During the October 2011 review, the team found that Florida had an automated process in place to check provider names against the LEIE. However, MPI stated it had not received an LEIE data feed since June 2011. According to the MPI bureau chief, the LEIE checks were conducted by MPI only on a quarterly basis until June 2011 because the State agency did not believe there was enough of a risk to warrant doing monthly checks. Since June 2011, MPI was no longer able to get data feeds from the LEIE, which meant that MPI needed to download the data to conduct its LEIE checking. However, MPI reported that it had been unsuccessful since June in its attempts to download the data from the LEIE website and therefore was unable to perform automated monthly checks against the LEIE.

Florida stated that when information on provider names is supplied, it is manually checked against the LEIE at the time of initial enrollment and re-enrollment. However, if information on persons with ownership and control interests, agents and managing employees is supplied during the time of initial enrollment or re-enrollment, it is not checked against the LEIE. In addition, the names of providers, persons with ownership and control interests, agents and managing employees are not checked against the LEIE on a monthly basis.

Also, the names of providers and all of the above types of affiliated parties are not checked against the EPLS at any time during initial enrollment, re-enrollment or on a monthly basis. This leaves the State open to the risk that Medicaid monies are being paid to providers who are affiliated with excluded parties, persons or entities debarred from Federal contracting.

Recommendations: Develop and implement policies and procedures for appropriate collection

and maintenance of disclosure information about the provider, any person with an ownership or control interest, or who is an agent or managing employee of the provider. Search the LEIE (or the Medicare Exclusion Database [MED]) and the EPLS upon enrollment, reenrollment, and at least monthly thereafter, by the names of the above persons and entities, to ensure that the State does not pay Federal funds to excluded persons or entities.

Vulnerabilities

The review team identified three areas of vulnerability in Florida's Medicaid practices. These include not adequately addressing business transaction disclosures in dental plan network provider contracts, not verifying with managed care enrollees whether services billed were received, and not conducting complete searches for MCE individuals and entities excluded from participating in Medicaid.

Not adequately addressing business transaction disclosures in dental plan network provider contracts.

Two of Florida's prepaid dental plans are currently operating under an older contract that does not require providers to supply, upon request, the business transaction information that would otherwise be required from FFS providers under 42 CFR § 455.105(b)(2). Florida stated that these two contracts expire in February 2012, at which time these two dental plans will operate under Florida's new standard MCE contract. The new standard MCE contract does contain the required disclosure language.

Recommendation: Revise the dental plan network provider agreement to require disclosure upon request of the information identified in 42 CFR § 455.105(b).

Not verifying with managed care enrollees whether services billed were received. (Uncorrected Repeat Vulnerability)

The regulation at 42 CFR § 455.20 requires the State Medicaid agency to have a method for verifying with beneficiaries whether services billed by providers were received.

The AHCA uses Explanations of Medical Benefits to verify with all FFS Medicaid beneficiaries whether services billed by providers were actually received. However, neither the State nor its contracted MCEs performs any service verifications with managed care enrollees. There is also no contract language requiring MCEs to do so. This is a repeat vulnerability from the 2009 review.

Recommendation: Develop and implement procedures to verify with MCE enrollees whether services billed by providers were received. The same recommendation was issued following the 2009 review.

Not conducting complete searches for individuals and entities excluded from participating in Medicaid.

The regulations at 42 CFR § 455.104 through 455.106 require States to solicit disclosure

Florida Comprehensive PI Review Final Report July 2012

information from disclosing entities, including providers, and require that provider agreements contain language by which the provider agrees to supply disclosures upon request. If the State neither collects nor maintains complete information on owners, officers, and managing employees in the MMIS, then the State cannot conduct adequate searches of the LEIE or the MED.

The CMS issued a State Medicaid Director Letter (SMDL) #08-003 dated June 16, 2008 providing guidance to States on checking providers and contractors for excluded individuals. That SMDL recommended that States check either the LEIE or the MED upon enrollment of providers and monthly thereafter. States should check for providers' exclusions and those of persons with ownership or control interests in the providers. A follow-up SMDL (#09-001) dated January 16, 2009 provided further guidance to States on how to instruct providers and contractors to screen their own employees and subcontractors for excluded parties, including owners, agents, and managing employees. A new regulation at 42 CFR § 455.436, effective March 25, 2011, now requires States to check enrolled providers, persons with ownership and control interests, and managing employees for exclusions in both the LEIE and the EPLS on a monthly basis.

Florida's MCEs do not conduct exclusion searches of network providers and contractors that are fully consistent with this guidance. The provider enrollment process used for some MCE network providers does not fully adhere to the requirements at 42 CFR § 455.104, as noted previously. Because the State does not collect information on all persons with ownership or control interest, agents and managing employees relating to MCE network providers, such parties cannot be searched for exclusions. Furthermore, MCE providers do not conduct monthly screening of their own employees and subcontractors using both the LEIE and EPLS.

Recommendations: Amend the contract to require the appropriate collection and maintenance of disclosure information about disclosing entities, and about any person with a direct or indirect ownership interest of 5 percent or more, or who is an agent or managing employee of the disclosing entity, or who exercises operational or managerial control over the disclosing entity. Require the contractor to search the LEIE and the EPLS upon enrollment, reenrollment, credentialing or recredentialing of network providers, and at least monthly thereafter, by the names of the above persons and entities, to ensure that the State does not pay Federal funds to excluded persons or entities.

Conclusion

The State of Florida applies some noteworthy and effective practices that demonstrate program strengths and the State's commitment to program integrity. The CMS supports the State's efforts and encourages it to look for additional opportunities to improve overall program integrity.

However, the identification of three areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, three areas of vulnerability were identified. The CMS is particularly concerned over the uncorrected repeat finding and vulnerability. The CMS expects the State to correct them as soon as possible.

To that end, we will require Florida 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.



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

August 6, 2012

Angela Brice-Smith
Director, Medicaid Integrity Group
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Ms. Brice-Smith:

Thank you for the opportunity to respond to the findings and recommendations resulting from your comprehensive review of the Florida Medicaid program integrity procedures and processes. In accordance with your request, we have emailed you the corrective action plan document.

If you have any questions regarding our response, please contact Mary Beth Sheffield, Audit Director, at (850) 412-3978.

Sincerely,

Elizabeth Budek
Secretary

ED/szg

Enclosures: Attachments A, B, C, and D

cc: Rob Miller, Director of the Division of Field Operations
Justin Senior, Deputy Secretary for Medicaid
Eric Miller, Inspector General
Mike Blackburn, Bureau of Program Integrity Chief

