The Florida Senate

Interim Project Report 2006-133 *November 2005*

Committee on Health Care Senator Durell Peaden, Jr., Chair

IDENTIFICATION AND PREVENTION OF FRAUD AND ABUSE IN MEDICAID MANAGED CARE

SUMMARY

Florida's Medicaid program is one of the largest in the nation, with a total budget of over $15.5 billion in FY 2005-06. As of June 2005, there were approximately 2.2 million Medicaid recipients in Florida.

Fraud and abuse in the overall health care system is a serious concern. The National Health Care Anti-Fraud Association (NHCAA) estimates that for all private and public health expenditures in 2003, between 3 percent and 10 percent of these expenditures were lost to fraud alone. Like the overall health care system, Florida's Medicaid program is subject to the threats of fraud and abuse.

Medicaid fraud and abuse can be committed by any of the stakeholders in the Medicaid system including physicians, health plans, providers of ancillary services, or recipients. Over the years, the state has committed significant resources to the prevention, detection, and recovery of Medicaid funds lost to fraud and abuse.

In general, the state's anti-fraud and abuse efforts have focused on the fee-for-service aspects of the Medicaid program. This policy is based on the assumption that capitated managed care plans have a financial incentive to identify and prevent fraud and abuse. However, as Florida contemplates moving forward with Medicaid reform activities that concentrate recipients in various forms of capitated managed care plans, the question becomes whether there is sufficient evidence to support the assumption that capitated managed care plans are better able to reduce fraud and abuse.

Based on the findings in this review, staff has determined that the ability of managed care plans to adequately prevent fraud and abuse is not supported. Under managed care, fraud and abuse activities change form-requiring changes in how the state conducts its anti-fraud and abuse activities. Based on these findings, staff provides the following recommendations.

- All Medicaid managed care plans, even under the Governor's proposed reform initiative, should be required to have a comprehensive fraud and abuse prevention and identification system within their corporate structure as a condition of participating in Florida's Medicaid program. These systems should work in partnership with the state's anti-fraud and abuse activities.

- The state should develop a system of information sharing between Medicaid program management and the managed care plans that allows each to become aware of providers with suspicious practice/billing patterns. This system should include a method of providing protections for managed care plans from civil liability if they are reporting suspicious provider practice/billing patterns in good faith.

- The Agency for Health Care Administration should be required to develop a system to validate the information collected through the encounter data system currently being developed to collect utilization information from providers (in lieu of claims data).

- The Agency for Health Care Administration should evaluate how its internal anti-fraud and abuse prevention and detection systems are coordinating in regards to managed care plans and develop a more systematic method to obtain and share fraud and abuse referrals from managed care plans.

BACKGROUND

Florida's Medicaid Program

Florida's Medicaid program was established in 1970 and is administered by the Agency for Health Care Administration (AHCA). Florida's program provides health care coverage to certain low-income persons who meet federal and state eligibility requirements. Medicaid serves mainly low-income families and children, elderly persons who need long-term care services, and persons with disabilities.

Florida's Medicaid program is one of the largest in the nation, with a total budget of over $15.5 billion in FY 2005-06. As of June 2005, there were approximately 2.2 million Medicaid recipients in Florida.[1]

Florida Medicaid Program's Service Delivery Systems

Florida law requires that, to the extent possible, Medicaid recipients must enroll in a managed care delivery system.[2] There are three main types of managed care delivery systems: 1) MediPass; 2) Medicaid Health Maintenance Organizations (HMOs); and 3) Provider Service Networks (PSNs). Medicaid recipients not enrolled in one of these managed care systems are usually in certain institutional settings. The following is a description of each of these Medicaid managed care options.

- **MediPass.** The MediPass system is available statewide and is a primary care case management program. MediPass recipients select or are assigned a primary care physician (PCP) who is responsible for providing primary care and referring patients for specialized services. The state pays each PCP a $3 monthly case management fee for each recipient for which the PCP is responsible, in addition to fee-for-service reimbursement for each service the PCP provides to recipients.

- **Medicaid HMOs.** Medicaid HMOs are available in 34 of the state's 67 counties and provide medical services to Medicaid recipients on a prepaid basis, based on a discount off of fee-for-service costs for a similar population.

- **PSNs.** The state's only PSN is currently available in two counties, Broward and Miami-Dade. Generally, PSNs provide medical services through an integrated health care delivery system owned and operated by Florida hospitals and physician groups.

As of June 2005, almost 1.5 million (or 68%) of the state's Medicaid recipients were enrolled in one of these managed care options, including 727,287 recipients enrolled in MediPass, 781,521 in Medicaid HMOs, and 18,179 in the PSN. All other recipients are considered fee-for-service.[3]

Medicaid Fraud and Abuse

Fraud and abuse in the overall health care system is a serious concern. The National Health Care Anti-Fraud Association (NHCAA) estimates that for all private and public health expenditures in 2003, between 3 percent and 10 percent of these expenditures were lost to fraud alone. With total national health care expenditures exceeding $1 trillion in 2003, this would equal loses of between $51 billion and $170 billion to fraud.[4]

Like the overall health care system, Florida's Medicaid program is subject to the threats of fraud and abuse. Medicaid fraud and abuse can be committed by any of the stakeholders in the Medicaid system including physicians, health plans, providers of ancillary services, or recipients.

Over the years, the state has committed significant resources to the prevention, detection, and recovery of Medicaid funds lost to fraud and abuse. These prevention, detection, and recovery activities are primarily conducted by AHCA's Medicaid Program Integrity Office (MPI) in cooperation with the Attorney General's Medicaid Fraud Control Unit (MFCU) and the Florida Department of Law Enforcement (FDLE). Each of these units has a specific role in the system depending on whether the suspected activity is considered fraud or abuse.

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[1] Florida Government Accountability Report. (2005). *Agency for Health Care Administration Medicaid Health Care Services*. Office of Program Policy and Government Accountability.

[2] S. 409.9121, F.S.

[3] Florida Government Accountability Report. (2005). *Agency for Health Care Administration Medicaid Health Care Services*. Office of Program Policy and Government Accountability.

[4] National Health Care Anti-Fraud Association. (2005). *Health Care Fraud: A Serious and Costly Reality For All Americans.* http://www.nhcaa.org/pdf/all_about_hcf.pdf

AHCA's MPI office is responsible for identifying and recovering Medicaid funds lost to abuse and simple billing error. Medicaid abuse is defined in statute as "provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care."[5] If MPI determines a provider has committed abuse, the office has a wide range of actions that it may take, from providing education and training to assigning fines.

However, if a provider is suspected of committing Medicaid fraud, the case is required to be referred to the MFCU in the Attorney General's Office for investigation. Medicaid fraud is defined as "an intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to herself or himself or another person. The term includes any act that constitutes fraud under applicable federal or state law."[6] A Medicaid provider convicted of fraud may face both criminal and/or civil fines and penalties.

Regarding Medicaid fraud or abuse by recipients, the FDLE's Public Assistance Fraud Unit is responsible for investigating and prosecuting such cases. Florida Statutes define Medicaid recipient abuse as "practices that result in unnecessary cost to the Medicaid program."[7]

Florida's Medicaid Reform Initiative: Moving Toward More Managed Care

In general, the state's anti-fraud and abuse efforts have focused on the fee-for-service aspects of the Medicaid program. This policy is based on the assumption that capitated managed care plans have a financial incentive to identify and prevent fraud and abuse. It is also assumed that managed care plans are better able to control fraud and abuse through contract arrangements and other techniques used in the private sector. However, as Florida contemplates moving forward with Medicaid reform activities that concentrate recipients in various forms of capitated managed care plans, the question becomes whether there is sufficient evidence to support the assumption that capitated managed care plans are better able to reduce fraud and abuse or if the state needs to re-design its own efforts to meet the "challenge to develop a process to oversee the activities of Medicaid managed care organization enrollees, health care providers, managed care organization networks, and their representatives in order to prevent fraud or abuse [under the reform system]."[8]

METHODOLOGY

Staff reviewed state and federal laws related to Medicaid fraud and abuse prevention, detection, and recovery activities and federal guidelines specifically developed for addressing fraud and abuse in Medicaid managed care. Staff also reviewed other literature related to Medicaid fraud and abuse, including published and unpublished studies conducted by the Florida Legislature's Office of Program Policy Analysis and Government Accountability (OPPAGA) and other states' evaluation offices. Staff conducted interviews with Program Integrity, Inspector General, and Attorney General representatives in Arizona, Florida, Tennessee, and Texas because of their significant experience with Medicaid managed care systems. Staff also conducted a focus group with representatives of Florida's current Medicaid HMOs. Finally, staff attended a Medicaid Fraud and Abuse Summit hosted jointly by the Florida Association of Health Plans (FAHP), MPI, and MFCU, which was attended by AHCA and Attorney General personnel, as well as professionals from the various Medicaid HMOs currently operating in Florida.

FINDINGS

Medicaid Fraud and Abuse Still Occur in Capitated Managed Care Plans, They Simply Change Form

One of the core arguments for supporting a reform initiative that moves Medicaid recipients into capitated managed care plans is that the plans are fiscally at-risk, and not the state, if they fail to control fraud and abuse. Furthermore, proponents argue that these private plans have greater flexibility in addressing problem providers under federal and state Medicaid laws than AHCA. Experts in Medicaid and Medicare fraud disagree with these assumptions and the federal government has published guidelines for state Medicaid programs on how to identify and address Medicaid fraud and abuse in managed care systems.

[5] S. 409.913, F.S.
[6] Ibid.
[7] Ibid.

[8] Agency for Health Care Administration. (2005). *Medicaid Program Integrity Presentation*. Medicaid Fraud and Abuse Summit. September 23, 2005.

In *License to Steal*, Dr. Malcolm Sparrow, a nationally-recognized expert in health care fraud and abuse, argues that "payers make a major mistake if they leave the responsibility for fraud control in the hands of the contracting plans…The trap payers fall into looks like this: mindful only of the old forms of fraud, the payers recognize the contractors' financial incentives to control it. They relax their scrutiny of the plans, thinking that the plans are the ones who will suffer any consequences of fraud. What payers fail to realize is that *the locus for fraud control has now shifted to precisely the same place as the locus for fraud commission*: to the intervening corporate middle layers."[9]

This very point was articulated at the Medicaid Fraud and Abuse Summit attended by Senate staff and in interviews with investigators in other states. During a presentation by the Manager of Corporate Investigations of one of Florida's Medicaid HMOs, it was stated that the most difficult situation to identify and address is when internal staff cooperate with external providers to defraud a managed care plan. As a result, it was recommended that managed care plans should carefully design their fraud and abuse prevention units outside the main organizational structure so they can remain neutral in their investigations.[10]

Similarly, investigators in one state reported that the belief was so pervasive (that managed care plans have an inherent fiscal incentive to police themselves) that state leaders completely eliminated their Medicaid Program Integrity Unit as the state moved to a managed care system, only to reinstate the unit within three years. In another case, another state had to strengthen existing laws to mandate the creation of Special Investigative Units (SIUs) in their Medicaid managed care plans with specific corporate structures.[11]

The federal government also challenged the belief that capitated managed care plans inherently control fraud by stating, "The original thinking of many within the industry was that fraud did not exist in managed care. However, experience has proven that fraud does, in fact, exist in many ways within a managed care environment."[12] As a result, the Centers for Medicare and Medicaid Services (CMS) (formerly the Health Care Financing Administration) developed a set of national guidelines for states to help them in addressing fraud and abuse in Medicaid managed care.

The guidelines focused on risk-based, managed care systems and identified several ways in which fraud and abuse are most likely to occur, which are outlined in Table 1.

Table 1: Likely Areas for Fraud and Abuse in Medicaid Managed Care Plans

Potential Areas for Fraud and Abuse	Specific Activities
Procurement of the Managed Care Contract	• Falsification of provider credentials • Falsification of financial solvency • Falsified or an inadequate provider network • Fraudulent subcontract • Fraudulent subcontractor • Bid-rigging or self-dealing • Collusion among providers • Contracts with related parties • Illegal tying agreements
Marketing and Enrollment Fraud and Abuse	• Misrepresentation to beneficiaries (also known as "slamming") • Misrepresentation to beneficiaries by charging non-existing fees • Enrolling nonexistent individuals • Enrolling ineligible individuals • Enrolling nonexistent or ineligible family members • "Cherry-picking" or selecting the healthiest segment of the enrollment population • Kickbacks for referrals • Disenrolling undesirable members

[9] Sparrow, Malcolm. (1996). License to Steal: Why Fraud Plagues America's Health Care System. 2nd Edition. Oxford: Westview Press. Pg. 150.

[10] Runkle, Kathy. (2005). *Amerigroup: Fraud and Abuse Plan Overview*. Medicaid Fraud and Abuse Summit. September 23, 2005.

[11] In the second case, managed care plans fought the law and rule-making process arguing the requirements were over burdensome and bureaucratic. However, once in place, plans began working closely with the state as they realized the benefits of the SIUs and how successful they were in identifying fraud and abuse never considered possible by the plans' management.

[12] Health Care Financing Administration. (2000). *Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care*. National Medicaid Fraud & Abuse Initiative. October 2000.

	• Failing to notify the state of deceased members • Beneficiary enrollment fraud
Underutilization	• Untimely first contact with clients • Untimely assignment of a primary care physician (PCP) • Delay in reassigning PCP upon an individual's request • Discouragement of treatment using geographic or time barriers • Engagement in any federally-prohibited discrimination activities • Failure to make provisions to assist individuals with cultural or language barriers • Failure to provide educational services • Failure to provide outreach or follow-up care • Failure to provide court-ordered treatment • Defining "appropriateness of care" and/or "experimental procedures in a manner inconsistent with standards of care • Slow or nonexistent drug formulary updates • Strict utilization review standards • Cumbersome appeal process for enrollees • Ineffective grievance process • Inadequate/unreasonable prior authorization processes • Cumbersome appeals process for providers • Delay or failure of the PCP to perform necessary referrals for additional care • Incentives to PCPs and specialty providers to illegally limit services or referrals • Routine denial of claims
Claims Submission and Billing Procedures	• Balance billing • Inflating the bills for services and/or goods provided • Double-billing • Improper coding (upcoding or unbundling) • Billing for ineligible consumers or services never rendered • Inappropriate physician
Fee-For-Service Fraud in Managed Care (if the plan does not capitate its providers)	• Billing for unnecessary services or overutilization • Double billing • Unbundling • Upcoding • "Ghost billing" or billing for services not provided
Embezzlement, Theft, and Related Fee-For-Service Fraud	• Embezzlement and theft • Diversion of funds for medical services to unnecessary administrative costs • "Bust outs" or withholding payments and declaring bankruptcy

While this list contains a large number of possible fraud and abuse activities, Florida's Medicaid program and the state's general managed care regulations already address many of these areas. As the state pilot tests Medicaid reform, AHCA is required to include these and new credentialing requirements for the reform plans to avoid many of these problems.

Current Medicaid Managed Care Fraud and Abuse Oversight in Florida is Primarily a Contract Management Activity

Federal law and regulations require specific anti-fraud and abuse policies and procedures for managed care plans participating in Medicare and Medicaid. Since Florida has not codified most of these requirements in Florida Statutes, the federal regulations are the governing authority. These regulations are primarily enforced through the Medicaid HMO contract approval and monitoring process conducted by AHCA's Bureau of Managed Health Care. Specifically, these requirements include:

- The managed care organization (MCO) must have administrative and management arrangements or procedures, and a mandatory compliance plan, that are designed to guard against fraud and abuse (42 CFR 438.608). The arrangements or procedures must include the following elements:
    - Written policies, procedures, and standards of conduct that articulate the organization's

commitment to comply with all applicable federal and state standards.
  - The designation of a compliance officer and a compliance committee that are accountable to senior management.
  - Effective training and education for the compliance officer and the organization's employees.
  - Effective lines of communication between the compliance officer and the organization's employees.
  - Enforcement of standards through well-publicized disciplinary guidelines.
  - Provision for internal monitoring and auditing.
  - Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the MCO's contract.

- The MCO cannot use Medicaid funds to pay for services from providers who have been excluded from Medicare, Medicaid, or the State Children's Health Insurance Program (SCHIP), except for emergency services.

- The MCO must report suspected fraud and abuse to the state (42 CFR 455.1). The report must contain (42 CFR 455.17):

  - The number of complaints of fraud and abuse made to the state that warrant preliminary investigations; and
  - For each compliant which warrants investigation, the MCO must provide the name/ID number, source of complaint, type of provider, nature of complaint, approximate dollars involved, and legal and administrative disposition of the case.

- The MCO must have a system to verify that services are actually provided (42 CFR 455.1).

In addition to these federal regulations, Florida's Medicaid HMO contracts include other fraud prevention policies and procedures that have additional reporting and credentialing requirements.

The agency's Bureau of Managed Care uses these criteria to approve new Medicaid HMOs and in their annual monitoring of current Medicaid HMOs. In meetings with agency staff, they report that these activities constitute most of the oversight activity regarding fraud and abuse in managed care plans. In interviews, all parties reported limited involvement of MPI or MFCU. This is a concern because during the course of this review, and in previous work conducted by OPPAGA, staff found limited examples of current Medicaid HMOs reporting suspected fraud and/or abuse.

In response to a request for the number of cases referred to AHCA by the current Medicaid HMOs over the last five years, the agency identified 47 cases, of which, most had only been received over the past few months almost exclusively from two HMOs. In comparison, MPI investigated 4,731 cases of potential overpayments due to fraud, abuse, or error in the MediPass and fee-for-service system in a single year (FY 2002-03, the last year complete information was available). Of these cases, over 1,600 resulted in findings of overpayments.[13]

Florida's Medicaid HMOs, AHCA Staff, and Experiences Collected from Other States Provide Opportunities to Improve Fraud and Abuse Oversight of Managed Care Plans

In interviews and focus groups with representatives of the Medicaid HMO industry, AHCA staff, and Medicaid administrators in other states, several ideas were provided to Senate staff to improve the fraud and abuse oversight of managed care entities, especially under the Governor's proposed reform initiative.

The Medicaid HMO Industry

Representatives of the current Medicaid HMOs met individually and in a focus group with Senate staff. Through these discussions, the industry provided several recommendations for improving the current system. Their recommendations include:

- Improve the sharing of information between AHCA and the HMOs, especially regarding providers who are being dropped from plans because of inappropriate practices or that have been identified by the state for suspicious practice/billing behavior in the fee-for-service and MediPass systems;
- Ensure new types of managed care plans that may develop under the reform initiative undergo similar credentialing requirements;

[13] Office of Program Policy Analysis and Government Accountability. (2004). "AHCA Takes Steps to Improve Medicaid Program Integrity, But Further Actions Are Needed." Report No. 04-77.

- Better define and help plans identify the "trigger point" at which a plan must report suspected fraud and abuse;
- Provide statutory protection for the plans from civil liability for acting in good faith in reporting suspected fraud or abuse;
- Move forward with the introduction of a well-designed encounter data system to monitor services provided through HMOs and other MCOs;[14]
- Ensure that providers and patients understand the grievance procedures for inappropriate denials of care.

AHCA Personnel

Senate staff met with AHCA representatives from MPI, the Inspector General's Office, the Bureau of Managed Care, Medicaid, and the administration regarding current fraud and abuse prevention and detection practices for managed care plans, as well as their vision for how fraud and abuse oversight may need to be modified under the Governor's Medicaid reform proposal.

In general, agency staff characterized the current credentialing and monitoring activities for managed care plans as effective. They believe that current reporting levels by managed care plans are low because most plans have the ability to address suspected fraud and abuse by limiting access to their networks, a quicker and more efficient method than an in-depth investigation similar to those conducted by MPI in MediPass and fee-for-service.

There was an acknowledgment that current fraud and abuse prevention and detection techniques will need to evolve as Medicaid reform expands, although the administration assured Senate staff that they were not considering eliminating MPI or other programs as occurred in other states that moved toward a greater reliance on managed care. However, the administration stressed that they believe the managed care plans under reform will have a strong financial incentive to aggressively pursue and eliminate fraud and abuse, beyond their contractual requirements, an issue that has come under question by earlier findings in this review.

Experiences from Other States

Senate staff conducted interviews with Program Integrity and Inspector General representatives in three states with significant Medicaid managed care experience: Arizona, Tennessee, and Texas. All interviews produced the same conclusion, that managed care does not eliminate Medicaid fraud and abuse, but simply changes its form, requiring the state to change its tactics for preventing and identifying fraud and abuse.

These states provided three recommendations, among many, that are consistent with those identified by the current Medicaid HMOs and agency personnel. These recommendations include:

- Developing a credentialing system that requires the managed care plans to be active partners with the state in preventing and identifying fraud and abuse. This includes mandatory reporting by plans of suspected fraud and abuse (sometimes on a quarterly basis), while providing incentives for cooperation (including protection from civil liability for good faith reporting).

- Improving information sharing between the state and the managed care plans regarding providers with suspicious practice/billing patterns. One state goes as far as to send out a broadcast email to all Medicaid HMOs if a provider is terminated from a particular network. This way other plans can check their panels to see if they may have the same provider (and potentially the same problem) and the state uses the information to check its fee-for-service network.

- Developing a high quality encounter data system with the ability to validate the information provided by managed care plans.

RECOMMENDATIONS

Based on the findings in this review, staff has determined that the ability of managed care plans to adequately prevent fraud and abuse is not supported. Under managed care, fraud and abuse activities change form requiring changes in how the state conducts its anti-fraud and abuse activities.

Based on these findings, staff provides the following recommendations.

[14] An encounter data system is an electronic method of tracking services provided in a capitated managed care setting. Since no billing occurs in these systems, there are no claims filed with the health plan or AHCA. Under this system, visits and procedures are reported and can be analyzed for suspicious activity, among other uses.

- All Medicaid managed care plans, even under the Governor's proposed reform initiative, should be required to have a comprehensive fraud and abuse prevention and identification system within their corporate structure as a condition of participating in Florida's Medicaid program. These systems should work in partnership with the state's anti-fraud and abuse activities.

- The state should develop a system of information sharing between Medicaid program management and the managed care plans that allows each to become aware of providers with suspicious practice/billing patterns. This system should include a method of providing protections for managed care plans from civil liability if they are reporting suspicious provider practice/billing patterns in good faith.

- AHCA should be required to develop a system to validate the information collected through the encounter data system currently being developed to collect utilization information from providers (in lieu of claims data).

- AHCA should evaluate how its internal anti-fraud and abuse prevention and detection systems are coordinating in regards to managed care plans and develop a more systematic method to obtain and share fraud and abuse referrals from managed care plans.