Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Florida Focused Program Integrity Review

Medicaid Managed Care Oversight

May 2025

Final Report

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Executive Summary

Objectives

The Centers for Medicare & Medicaid Services' (CMS) conducted a focused program integrity review to assess Florida's program integrity oversight efforts for Fiscal Years (FYs) 2019 – 2021. This focused review specifically assessed the state's compliance with CMS regulatory requirements at 42 CFR Part 438, Subpart H. A secondary objective of this review was to provide the state with feedback, technical assistance, and educational resources that may be used to enhance program integrity in Medicaid managed care.

To meet the objectives of this focused review, CMS reviewed information and documents provided in response to questions posed by CMS in a managed care review tool provided at the initiation of the review. CMS also conducted in-depth interviews with the State Medicaid Agency (SMA) and evaluated program integrity activities performed by selected managed care organizations (MCOs) under contract with the SMA.

This report includes CMS' findings and resulting recommendations, as well as observations, that were identified during the focused review.

Findings and Recommendations

Findings represent areas of non-compliance with federal and/or state Medicaid statutory, regulatory, sub-regulatory, or contractual requirements. CMS identified **two** findings that create risk to the Florida Medicaid program related to managed care program integrity oversight. In response to the findings, CMS identified **two** recommendations that will enable the state to come into compliance with federal and/or state Medicaid requirements related to managed care program integrity oversight. These recommendations include the following:

Interagency and MCO Program Integrity Coordination

> **Recommendation #1:** The state should outline in its MFCU Memorandum of Understanding (MOU) the procedures by which the MFCU will receive referrals of potential fraud from MCOs, either directly or through the agency, as required by § 455.21(c)(3)(iv).
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> **Recommendation #2:** The SMA should ensure that their agreement with the MFCU is updated no less frequently than every five years in accordance with § 455.21(c)(3)(v).

Observations

Observations represent operational or policy suggestions that may be useful to the state in the oversight of its Medicaid managed care program. CMS identified **six** observations related to Florida's managed care program integrity oversight. While observations do not represent areas of non-compliance with federal and/or state requirements, observations identify areas that may pose a vulnerability or could be improved by the implementation of leading

practices. The observations identified during this review include the following:

MCO Contract Compliance

Observation #1: Although all MCOs meet the MCO general contract requirement to verify beneficiary services, CMS encourages Florida to require the MCOs to regularly report on service verification results to the state. Additional oversight of this requirement can help the state ensure MCOs remain in compliance and improve future verification processes by tracking return on investment.

Observation #2: CMS encourages Florida to revise its payment suspension procedures to ensure compliance with all aspects of the payment suspension regulations at §§ 438.608(a)(8) and 455.23. Specifically, the following requirements should be addressed by the state: documenting and retaining payment suspension termination notices for a minimum of five years, in accordance with § 455.23(g)(1)(iv); certifying on a quarterly basis with the MFCU that there is an ongoing investigation for which a payment suspension was implemented, in accordance with §§ 455.23(d)(3)(ii); documenting and retaining such certifications for a minimum of five years, in accordance with § 455.23(g)(1)(iii); establishing and relying on the required legal burden of proof for credible allegations of fraud, in accordance with § 455.2; and establishing good cause exception criteria, in accordance with § 455.23(e) – (f).

Interagency and MCO Program Integrity Coordination

Observation #3: CMS encourages the SMA and MFCU to share case information on a quarterly basis in accordance with their MOU, including reconciling the number of referrals between the entities and evaluating the status of MFCU investigations.

Observation #4: CMS encourages the state to resume regular meetings or communication with the MFCU in accordance with the MOU.

MCO Investigations of Fraud, Waste, and Abuse

Observation #5: CMS encourages Florida to develop procedures for MCOs to implement corrective actions for providers who are sanctioned or face administrative actions.

Encounter Data

Observation #6: CMS encourages Florida to create a standard process to regularly analyze MCO encounter data for program integrity purposes.

Background

Focused Program Integrity Reviews

In the Comprehensive Medicaid Integrity Plan for Fiscal Years (FYs) 2019-2023, CMS set forth its strategy to safeguard the integrity of the Medicaid program.[1] This plan encompasses efforts to ensure that states are adhering to key program integrity principles, including the requirement that state Medicaid programs have effective oversight and monitoring strategies that meet federal standards.

As a part of these efforts, CMS conducts focused program integrity reviews on high-risk areas in the Medicaid program, such as managed care, new statutory and regulatory provisions, non-emergency medical transportation, telehealth, and personal care services. These reviews include onsite or virtual state visits to assess the effectiveness of each state's program integrity oversight functions and to identify areas of regulatory non-compliance and program vulnerabilities. Through these reviews, CMS also provides states with feedback, technical assistance, and educational resources that may be used to enhance program integrity in Medicaid.

Medicaid Managed Care

Medicaid managed care is a health care delivery system organized to manage cost, utilization, and quality. Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care. This approach provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between SMAs and MCOs that receive a set per member per month (capitation) payment for these services. By contracting with various types of MCOs to deliver Medicaid program health care services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health services.

Overview of the Florida Managed Care Program and the Focused Program Integrity Review

The Florida Agency for Health Care Administration (AHCA) is responsible for the administration of the Florida Medicaid program, the Statewide Medicaid Managed Care (SMMC) program. Within AHCA, the Office of Medicaid Program Integrity (MPI) is the organizational unit tasked with oversight of program integrity-related functions for the managed care program. During the review period, Florida contracted with sixteen MCOs[2] to provide health services to the Medicaid population. As part of this review, three of these MCOs were interviewed: Community Care Plan, Humana, and UnitedHealthcare Community Plan. Appendix C provides enrollment and expenditure data for each of the selected MCOs.

[1] https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf
[2] https://www.kff.org/medicaid/state-indicator/total-medicaid-mcos/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

In June 2022, CMS conducted a focused program integrity review of Florida's managed care program. This focused review assessed the state's compliance with CMS regulatory requirements at 42 CFR Part 438, Subpart H. As a part of this review, CMS also evaluated program integrity activities performed by selected MCOs under contract with the SMA. CMS interviewed key staff and reviewed other primary data. CMS also evaluated the status of Florida's previous corrective action plan that was developed in response to a previous focused program integrity review of Florida's managed care program conducted by CMS in 2017, the results of which can be found in Appendix A.

During this review, CMS identified a total of **two** recommendations and six observations. CMS also included technical assistance and educational resources for the state, which can be found in Appendix B. The state's response to CMS' draft report can be found in Appendix D, and the final report reflects changes CMS made based on the state's response.

This review encompasses the following five areas:

A. **State Oversight of Managed Care Program Integrity Activities** - CMS established requirements at §§ 438.66 and 438.602 that require the SMA to have a monitoring system that includes mechanisms for the evaluation of MCO performance in several program integrity areas. These areas include, but are not limited to: data, information, and documentation that must be submitted under §§ 438.604 – 606, as well as compliance with contractual program integrity requirements under §§ 438.608.
B. **MCO Contract Compliance** - Regulations at § 438.608 require the state, through its contracts with the MCOs, to ensure that MCOs implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse, such as implementing compliance plans, payment suspensions based on credible allegations of fraud, and overpayment reporting.
C. **Interagency and MCO Program Integrity Coordination** - Within a Medicaid managed care delivery system, MCO SIUs, the SMA, and the state MFCU play important roles in facilitating efforts to prevent, detect, and reduce fraud and abuse to safeguard taxpayer dollars. Under § 455.21, the SMA is required to cooperate with the state MFCU by entering into a written agreement with the MFCU. The agreement must provide a process for the referral of suspected provider fraud to the MFCU and establish certain parameters for the relationship between the MFCU and the SMA.
D. **MCO Investigations of Fraud, Waste, and Abuse** - Regulations at § 438.608(a)(7) require states to ensure that MCOs promptly refer any potential fraud, waste, and abuse that the MCO identifies to the state Program Integrity Unit (PIU) or any potential fraud directly to the state's MFCU. Similarly, as required by § 455.13-17, states must have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and MCOs.
E. **Encounter Data** - In accordance with § 438.242, the state must ensure, through its contracts, that each MCO maintains a health information system that collects, analyzes, integrates, and reports encounter data. In addition, in accordance with § 438.602(e), the state must periodically, but no less frequently than once every 3 years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and

completeness of the encounter data submitted by, or on behalf of, each MCO.

Results of the Review

A. State Oversight of Managed Care Program Integrity Activities

State oversight of managed care program integrity activities is critical to ensuring that MCOs are meeting all CMS requirements and state contractual requirements. CMS established state monitoring requirements at §§ 438.66 and 438.602 that require the SMA to have a monitoring system that includes mechanisms for the evaluation of MCO performance in several program integrity areas, including but not limited to, data, information, and documentation that must be submitted under §§ 438.604 – 606, as well as compliance with contractual program integrity requirements under §§ 438.608.

In Florida, these oversight and monitoring requirements are met through a hub-and-spoke model that governs intra-agency interactions for plan oversight and monitoring, wherein Medicaid Plan Management Operations within AHCA serves as the "hub," with ultimate programmatic oversight of managed care. The MPI is the functional unit within the Division of Health Quality Assurance that solely performs compliance activities relating to MCO fraud, waste, and abuse. The state confirmed that it does not have formal operational guidelines or written interagency agreements that outline the specific program integrity responsibilities of each unit within the SMA. Instead, AHCA uses the hub-and-spoke model and an internal Distributed Compliance Model to outline potential plan performance issues and points of contact.

The MPI and Plan Management Operations conducted readiness reviews for all MCOs in FY 2019. Site visits were conducted for MCOs that did not meet the requirements of the desk review. In FY 2020, MPI moved to a risk-based review focused on prevention factors, such as untimely provider termination or insufficient provider enrollment processes. In FY 2021, MPI and Plan Management Operations held joint virtual reviews focused on subcontractor oversight and program-integrity related data analytics. The state also investigates providers with managed care exposure but does not differentiate their investigations by payor type.

Florida does not contractually require MCOs to maintain specific staffing ratios. However, Section X.F. of the state's MCO general contract requires the MCO to have adequate Florida-based staffing resources to enable the Compliance Officer to investigate fraud, waste, and abuse. The state confirmed during the virtual review that they do not have a numerical metric or benchmark for staffing ratios.

AHCA reported that MCOs undergo review with the state's contracted external quality review organization (EQRO), Health Services Advisory Group (HSAG), every three years. A review of the state's MCO contracts showed compliance with conflict-of-interest safeguards required by §§ 438.58 and 438.602(h). The state's MCO general contracts and amendments are also posted publicly on the SMA's website, in accordance with § 438.602(g)(1).

CMS did not identify any findings or observations related to these requirements.

B. MCO Contract Compliance

Regulations at § 438.608 require the state, through its contracts with the MCOs, ensure that MCOs implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. These requirements extend to any subcontractor that is delegated responsibility for coverage of services and payment of claims under the contract between the state and the MCO. As part of this review, the MCO general contract was evaluated for compliance with several of these requirements, which are described in greater detail below.

The MCO general contract for Florida is developed by the Managed Care Policy and Contract Development Section in the Bureau of Medicaid Policy. The MPI submits draft contract language on fraud and abuse using the state's standard Contract Amendment Request Template. The AHCA utilizes their hub-and-spoke model to delegate managed care contract compliance monitoring to multiple functional units within the agency. The MPI serves as a functional unit that monitors MCO fraud, waste, and abuse activities within the contract. The state reported that any identified performance and compliance issues are escalated to SMA plan-specific contract managers.

Compliance Plans

In accordance with §§ 438.608(a)(1)(i)-(vii), states must require MCOs to implement compliance programs that meet certain minimal standards, which include the following:

1. Written policies, procedures, and standards of conduct that articulate the MCO's commitment to comply with all applicable requirements and standards under the contract, and all applicable federal and state requirements.
2. Designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the Chief Executive Officer and the board of directors.
3. Establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the MCO's compliance program and its compliance with the requirements under the contract.
4. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the federal and state standards and requirements under the contract.
5. Effective lines of communication between the Compliance Officer and employees.
6. Enforcement of standards through well-publicized disciplinary guidelines.
7. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law

enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract.

Section X.F.4. of Florida's MCO general contract explicitly addresses the requirement that all seven compliance plan elements listed above be addressed. A review of the MCOs' compliance plans and programs found them to be in compliance with the requirements at § 438.608. As required by § 438.608, MPI reviews compliance plans annually, uses an internal tool for tracking, and communicates approval with the MCOs at least 45 days before implementation. CMS found that the state's requirements for MCO anti-fraud plans included strong elements, which can be found in Section X.F.4. of Florida's MCO general contract.

CMS did not identify any findings or observations related to these requirements.

Beneficiary Verification of Services

In accordance with § 438.608(a)(5), the state, through its contract with the MCO, must require a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis.

In Florida, this requirement is met through MCO general contract Section X.F.4. which stipulates that MCOs must include provisions to verify, by sampling or other methods, delivery of services by network providers to enrollees. During the review, CMS observed that all three MCOs utilized Explanation of Medical Benefits letters (EOMBs) or phone calls to beneficiaries to verify services. The general contract does not require MCOs to report the results of beneficiary verification monitoring to AHCA, and the MCOs confirmed they do not submit this information to the state.

Observation #1: Although all MCOs meet the MCO general contract requirement to verify beneficiary services, CMS encourages Florida to require the MCOs to regularly report on service verification results to the state. Additional oversight of this requirement can help the state ensure MCOs remain in compliance and improve future verification processes by tracking return on investment.

False Claims Act Information

In accordance with § 438.608(a)(6), the state, through its contract with the MCO, must require that, in the case of MCOs that make or receive annual payments under the contract of at least $5,000,000, there are written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other federal and state laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.

In Florida, this requirement is met. A review of the state's general contract Section X.F.4. includes contract language that requires false claims education for MCOs and subcontractors as

described in § 438.608(a)(6).

CMS did not identify any findings or observations related to these requirements.

Payment Suspensions Based on Credible Allegations of Fraud

Pursuant to § 438.608(a)(8), states must ensure that MCOs suspend payments to a network provider for which the state determines there is a credible allegation of fraud in accordance with § 455.23.

Consistent with CMS regulations, Florida's Medicaid MCOs are contractually required to suspend payments to providers at the state's request. The MCO general contract requires that MCOs suspend payments to individuals or entities for which a credible allegation of fraud has been identified, according to Section VIII.E.1. If AHCA conducts an independent investigation and determines a credible allegation of fraud exists, MPI notifies the MCOs in writing to suspend payments to the provider. The state reported that MPI audits managed care encounters for providers with credible allegations of fraud to ensure no payments have been made. If payments were erroneously made to providers under a payment suspension, AHCA may take contract actions against the MCO, including sanctions and liquidated damages. While MPI is the only entity that can impose a credible allegation of fraud payment suspension across the state's Medicaid program, the state reported that MCOs are allowed to implement their own payment restrictions within their networks at their own discretion. The MCOs interviewed confirmed that any additional payment restrictions initiated by the MCO are regularly reported to MPI.

During our review, we observed several areas of Florida's payment suspension process under § 455.23 that we believe could lead to program risk. First, Florida does not have a process in place to ensure all notices documenting the termination of a payment suspension are maintained for a minimum of five years, in accordance with § 455.23(g)(1)(iv). Second, Florida's current MOU with its MFCU does not contain procedures by which the state and MFCU will certify on a quarterly basis the ongoing investigation for which a payment suspension was implemented, as required by §§ 455.23(d)(3)(ii), and that such certification is documented and retained for a minimum of five years, as required by § 455.23(g)(1)(iii). Third, the classification of suspected fraud in Florida relies on a lower legal burden of proof (called "reliable evidence") than the "credible allegation" standard required for a fraud payment suspension under § 455.2. Thus, fraud referrals in Florida are not equivalent to traditional fraud referrals to the MFCU that utilize the federal credible allegation of fraud standard. Specifically, Florida's MOU requires its MFCU to provide written request for a good cause exception from implementing a payment suspension based on a credible allegation of fraud; however, the state reported receiving very few requests for good cause exceptions. The AHCA confirmed that this is due to the state utilizing payment withholds with a lower legal burden of proof as the default payment restriction, instead of payment suspensions due to credible allegations of fraud as defined in § 455.23. The AHCA also stated they have no policy or procedure to determine what may constitute a good cause exception, as described in §§ 455.23(e) - (f).

Observation #2: CMS encourages Florida to revise its payment suspension procedures to

ensure compliance with all aspects of the payment suspension regulations at §§ 438.608(a)(8) and 455.23. Specifically, the following requirements should be addressed by the state: documenting and retaining payment suspension termination notices for a minimum of five years, in accordance with § 455.23(g)(1)(iv); certifying on a quarterly basis with the MFCU that there is an ongoing investigation for which a payment suspension was implemented, in accordance with §§ 455.23(d)(3)(ii); documenting and retaining such certifications for a minimum of five years, in accordance with § 455.23(g)(1)(iii); establishing and relying on the required legal burden of proof for credible allegations of fraud, in accordance with § 455.2; and establishing good cause exception criteria, in accordance with § 455.23(e) – (f).

Overpayments

Regulations at §§ 438.608(a)(2) and (d) require states to maintain oversight of MCOs' overpayment recoveries. Specifically, § 438.608(a)(2) requires states to ensure that MCOs promptly report all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the state. In addition, § 438.608(d) requires states to specify in MCOs' contracts how the MCOs should treat overpayment recoveries. This must include retention policies for recoveries of all overpayments, including overpayments due to fraud, waste, and abuse; the process, timeframes, and documentation requirements for reporting the recovery of all overpayments; and the process, timeframes, and documentation requirements for payment of recoveries to the state in situations where the MCO is not permitted to retain some or all of the recoveries. States must also ensure that MCOs have a process for network providers to report to the MCO when it has received an overpayment (including the reason for the overpayment), and to return the overpayment to the MCO within 60 calendar days. Each MCO must report annually to the state on their recoveries of overpayments, and the state must use the results of the information in setting actuarially sound capitation rates, consistent with the requirements in § 438.4.

CMS found that the state adequately addressed the requirements at §§ 438.608(a)(2) and (d). Section X.F.6. of the state's MCO general contract states that the MCO shall "…report on a quarterly basis a comprehensive fraud and abuse prevention activity report" and shall "…comply with all reporting requirements in § 438.608." The MCOs are provided with a standardized fraud and abuse activity template to report identified overpayments and recoveries to MPI on a quarterly basis, in accordance with § 438.608(a)(2).

Annual reporting of overpayments is required as part of the MCOs' annual anti-fraud plan submission to MPI. This reporting includes the total amount of overpayments identified as fraud or abuse and the amount of overpayments actually recovered, as required by § 438.608(d)(3). The state audits Achieved Savings Rebate (ASR) financial reports from the MCOs annually and works with Milliman, the state's contracted actuarial services, to reduce base claim costs and assist in rate-setting. The MPI confirmed that MCO ASR financial reports include verified overpayment data and additional recovery efforts due to third-party liability or other efforts.

During the three FYs reviewed, there were no returned overpayments from the MCOs to the state. The MPI confirmed that the state does not require MCOs to return overpayments recovered

from providers. The AHCA's retention policy in Section X.F.5. of the MCO general contract stipulates that the entity that identifies and reports the overpayment and engages in recovery efforts may retain the amount. The MCOs may also retain recoveries related to fraud reports evaluated by MFCU if the report was initiated by the MCO. Section VIII.C.5. of the general contract also requires that MCOs have a process for network providers to report and return overpayments to the MCO within 60 days of identification, in accordance with § 438.608(d)(2).

CMS did not identify any findings or observations related to these requirements.

C. Interagency and MCO Program Integrity Coordination

Within a Medicaid managed care delivery system, MCO SIUs, the SMA, and the state MFCU play important roles in facilitating efforts to prevent, detect, and reduce fraud and abuse to safeguard taxpayer dollars and beneficiaries. Each of these entities performs unique functions that are critical to providing effective oversight of the Medicaid program. The ability to reduce fraud in Medicaid managed care will be greatly enhanced as these entities develop methods and strategies to coordinate efforts. Ineffective collaboration can adversely affect oversight efforts, putting taxpayer dollars and beneficiaries at risk.

Under § 455.21, the SMA is required to cooperate with the state MFCU by entering into a written agreement with the MFCU. The agreement must provide a process for the referral of suspected provider fraud to the MFCU and establish certain parameters for the relationship between the MFCU and the SMA. The state does have an MOU in place with the MFCU; however, it does not meet all of the regulatory criteria. Section V. Case Referrals of the state's MOU contains procedures by which the MFCU will receive referrals of suspected or confirmed fraud from MPI and the MCOs. In Florida's current case referral process, MCOs are contractually required to submit advance notice of suspected provider fraud to MPI within 5 days of detection, according to Section X.F.6.b. of the MCO general contract. Within 15 days of detection, MCOs must submit a standardized report on all suspected or confirmed instances of internal and external fraud and abuse to MPI. After further MCO investigation, if the case is found to be Medicaid provider fraud, the MCO has an additional 10 days to submit a fraud referral directly to the MFCU; in total, MCOs must submit a fraud referral to the MFCU within 25 days from detection. The MCOs do not take further case action for 45 days after the fraud referral to the MFCU, unless otherwise directed. **While Florida's referral process is outlined in the state's MCO general contract, procedures for MCO case referrals to the MFCU, either directly or through the SMA, are not included in the state's MOU with the MFCU, as required by § 455.21(c)(3)(iv).**

After receiving notice of suspected fraud from the MCO, MPI is responsible for conducting an investigation. The state reported there is no distinction between preliminary and full investigations for managed care. The MPI makes their own case referral to the MFCU or appropriate law enforcement agencies in tandem with the MCO case referral to the MFCU. During the review, MPI informed CMS that they are unable to identify the number of cases accepted or denied by the MFCU. While MPI believes all case referrals are accepted by the MFCU, the state reported difficulties obtaining official case status information and establishing

regular communication with the MFCU. Cases that are referred back to the SMA for administrative action are listed in closing reports from the MFCU to MPI; however, MPI indicated inconsistencies in the closing reports that compromise accurate case information. The state reported that until they know if the MFCU is accepting or denying the investigation, MPI cannot assess the case for corrective action plan (CAP) development at the same time.

As such, the state does not meet with the MFCU regularly to discuss case referrals, as required in the MOU. The state's MOU with the MFCU states that referrals should be made during scheduled monthly case referral meetings, and during these case referral meetings, the MFCU will advise the SMA whether the matter is accepted as a referral to the MFCU. However, MPI confirmed that regular meetings were discontinued due to the aforementioned difficulty obtaining official case status information and establishing regular communication with the MFCU. In addition, both the MOU and MCO general contract include language that MPI and the MFCU will evaluate the number of referrals and status of investigations no less frequently than quarterly, according to Section V.D. of the MCO general contract. Section X.6. 4b of the MCO general contract states the MFCU will provide routine investigative updates to the MCO and MPI. However, the MPI confirmed that case and investigation information is not communicated regularly or clearly from the MFCU to the SMA.

During the review, MPI reported that there have been no recent revisions on the MOU with the MFCU, despite the federal requirement to review the MOU no less frequently than every five years as directed in § 455.21(c)(3)(v). While Section XI. Amendment and Renewal, number 4 of the MOU states that the SMA and MFCU will meet to update the MOU during the fourth quarter of each state fiscal year, the state clarified that they had not met with the MFCU to evaluate the agreement as of the time of this review. However, since this review, CMS verified that the MOU has been reviewed on several occasions, including several iterations of proposed changes and discussions of processes between the MFCU and MPI.

While there is no requirement for SMAs to meet on a regular basis with its MCOs for collaborative sessions to discuss pertinent program integrity issues regarding fraud, waste, and abuse and relevant contractual concerns, such collaborative sessions are an effective and important process to ensure open communication and strong partnerships. The SMA holds collaborative sessions with its MCOs every six to ten weeks to discuss program integrity issues. MPI meets with MCO SIU managers and Compliance Officers for a quarterly General Collaboration meeting and an additional quarterly meeting to discuss emerging schemes and cases of interest. MPI is also invited to biweekly "all-plan" calls for ad-hoc agenda items. All three MCOs interviewed confirmed meeting with AHCA MPI at least quarterly. While the MFCU is not present at these quarterly meetings, the MCOs reported communicating with MFCU investigators on an ad-hoc basis. The state and MFCU have not conducted formal program integrity training for the MCOs during the review period. However, the MCOs are contractually responsible for providing program integrity training to their staff as part of their annual anti-fraud plan, according to Section X.F.4. of the MCO general contract.

Recommendation #1: The state should outline in its MFCU MOU the procedures by which

the MFCU will receive referrals of potential fraud from MCOs, either directly or through the agency, as required by § 455.21(c)(3)(iv).

Recommendation #2: The SMA should ensure that their agreement with the MFCU is updated no less frequently than every five years, in accordance with § 455.21(c)(3)(v).

Observation #3: CMS encourages the SMA and MFCU to share case information on a quarterly basis in accordance with their MOU, including reconciling the number of referrals between the entities and evaluating the status of MFCU investigations.

Observation #4: CMS encourages the state to resume regular meetings or communication with the MFCU in accordance with the MOU.

D. MCO Investigations of Fraud, Waste, and Abuse

State Oversight of MCOs

Regulations at § 438.608(a)(7) require states to ensure that MCOs promptly refer any potential fraud, waste, and abuse that the MCO identifies to the state PIU or any potential fraud directly to the state's MFCU. Similarly, as required by §§ 455.13-17, states must have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and MCOs.

Florida has such a process in accordance with §§ 455.13-17 and 438.608(a)(7). Florida's MCO contract, Section X.F.6.b. requires MCOs to provide advance notice of suspected provider fraud to MPI within 5 days of detection. MCOs are also contractually required to submit a standardized report with additional information on "all suspected or confirmed instances of internal and external fraud and abuse" to MPI within 15 days of detection. After receiving notice of suspected fraud from the MCO, MPI is responsible for conducting their own investigation. Although MPI reported there is no distinction between preliminary and full investigations for managed care, CMS found the state to be in compliance with § 455.14-17 requiring the SMA to conduct their own investigation and refer the incident externally if necessary. The three MCOs interviewed confirmed receiving acknowledgment of receipt from MPI after submitting their notice of suspected fraud.

MCOs are contractually required to submit comprehensive quarterly and annual fraud, waste, and abuse reports to MPI, according to Section XVI.A.3. of the Florida general contract. During the review, MPI stated that the MCOs are also expected to provide quarterly updates until an investigation is closed. While the SMA and MCOs did not indicate that the required fraud, waste, and abuse reporting is being reviewed regularly, each of the three MCOs interviewed confirmed adhering to this process using SMA-provided reporting templates.

The state is continuously evaluating the adequacy of the cases referred from the MCOs. MPI reported they are cognizant of the multiple factors involved in open investigations and are working with the MCO SIUs to better understand their caseloads.

MCO Oversight of Network Providers

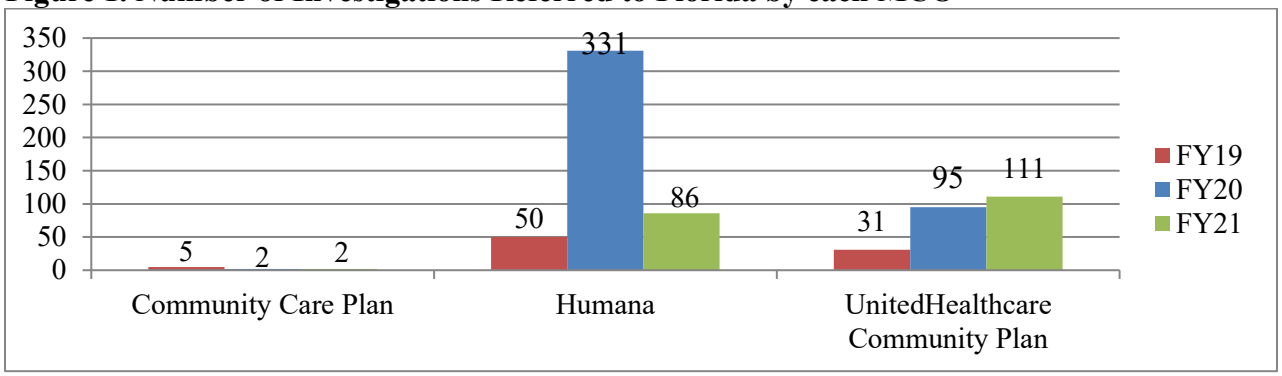
CMS verified whether each Florida MCO had an established process for conducting investigations and making referrals to the state, consistent with CMS requirements and the state's contract requirements.

Overall, CMS found the reported MCO processes for the investigation of suspected fraud, waste, and abuse to adequately meet CMS requirements and state contract requirements. All three MCOs reported the use of an internal or contracted SIU tasked with identifying and conducting investigations of potential fraud, waste, and abuse. Indicators of potential issues were identified through different sources, including but not limited to claims, hotline calls, referrals from subcontractors, referrals from the SMA, algorithms, and data mining. A preliminary investigation is completed to see if the case should be opened by the SIU. When a case is opened as a result of the preliminary investigation, a referral is sent to the state and a full investigation is conducted.

However, CMS observed that some MCOs appear to have minimal corrective actions in place when a provider is sanctioned or faces administrative action. Overall, the number of corrective CAPs issued for providers by Community Care Plan and UnitedHealthcare Community Plan appear to be low compared to the number of providers in each of the MCO's networks. Several MCOs reported that their internal SIUs and compliance panels are responsible for developing and issuing CAPs. While there is no statutory requirement for the SMA to implement CAPs for non-compliant providers, it is advised that the state develop written processes wherein MPI can provide subject matter expertise on the proposed CAP to improve the appropriateness and effectiveness of the corrective actions. The MCO general contract includes language in Section XIII.B. that requires the SMA to formally approve a CAP developed by the MCO if the SMA determines one is necessary; however, interviews with the MCOs revealed that the CAP development process is generally handled internally at the MCO-level.

Figure 1 below describes the number of investigations referred to Florida by each MCO, as reported by AHCA. As discussed in the review, the number of referrals in Figure 1 are referrals of suspected fraud to AHCA MPI and the MFCU as outlined in state policy, not traditional referrals based on a credible allegation of fraud. While reviewing MCO documentation, CMS observed that the number of cases referred to the state reported by the MCOs did not match the number reported by the state. Humana reported a large increase in preliminary investigations in FY 19 due to an influx in leads that year.

Figure 1. Number of Investigations Referred to Florida by each MCO



Tables 1-A, 1-B, and 1-C, below, describe each MCO's recoveries from program integrity activities. The state must obtain a clear accounting of any recoupments for these dollars to be accounted for in the annual rate-setting process (§ 438.608(d)(4)). Without these adjustments, MCOs could be receiving inflated rates per member per month. The state reported that recoupment amounts are accounted for in the ASR Financial Reports used for rate-setting. ASR reports are audited annually.

Table 1-A Community Care Plan's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2019	--	25	$567,818.00	$32,188.87
2020	--	12	$176,496.29	$8,247.00
2021	14	11	$2,126.80	$57,226.00

Table 1-B Humana's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2019	2583	282	$320,397.51	$174,835.91
2020	813	261	$442,898.18	$248,312.52
2021	853	238	$320,397.51	$332,512.20

Table 1-C UnitedHealthcare Community Plan's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2019	195	355	$47,054.66	$13,049.82
2020	252	302	$1,746,779.41	$35,210.02
2021	328	417	$1,327,638.62	$224,176.82

Observation #4: CMS encourages Florida to develop procedures for MCOs to implement corrective actions for providers who are sanctioned or face administrative actions.

E. Encounter Data

In accordance with § 438.242, the state must ensure, through its contracts, that each MCO maintains a health information system that collects, analyzes, integrates, and reports encounter data. Additionally, § 438.242 further outlines that state MCO contracts must specify the frequency and level of detail of beneficiary encounter data, including allowed amount and paid amount, that the state is required to report to CMS under § 438.818. The systems must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility.

Through a review of the Florida MCO general contract and interviews with the MCOs, CMS determined that Florida was in compliance with § 438.242. Specifically, contract language in Section X.E.1. includes all the necessary provisions in accordance with § 438.242. Interviews with the MCOs revealed that the state provides report templates to the MCOs to standardize encounter data submissions. MCOs are contractually required to submit encounter data weekly. The MCOs were observed to be compliant this requirement. The MCOs also indicated that AHCA provides a weekly encounter accuracy and timeliness report based on data submitted by the MCO. UnitedHealthcare Community Plan reported meeting with AHCA and fiscal agent Gainwell monthly to review the top encounter rejections; Humana reported having quarterly meetings with AHCA and Gainwell. The SMA also works with vendor Milliman to validate encounter data, create plan-specific data summaries, and compare ASR financial data against encounter data.

In addition, in accordance with § 438.602(e), the state must periodically, but no less frequently than once every 3 years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter data submitted by, or on behalf of, each MCO. Florida was in compliance with § 438.602(e). Specifically, the MCOs undergo an external quality review process with the state's EQRO every three years, in accordance with the state monitoring requirements at § 438.66. While this process is not contractually-required, CMS found this to be sufficient in ensuring that the independent audit requirement at § 438.602(e) is met.

In addition, while it is not a requirement, regularly analyzing the encounter data submitted by

MCOs will allow the state to conduct additional program integrity activities, such as identifying outlier billing patterns, payments for non-covered services, and fraudulent billing. Florida does not have a process to regularly analyze MCO encounter data for program integrity purposes. Specifically, the state reported that there is no standard process to reconcile encounter data for investigations or to review encounter data related to overpayments.

> **Observation #6:** CMS encourages Florida to create a standard process to regularly analyze MCO encounter data for program integrity purposes.

Conclusion

CMS supports Florida's efforts and encourages the state to look for additional opportunities to improve overall program integrity. CMS' focused review identified two recommendations and six observations that require the state's attention.

We require the state to provide a CAP for each of the recommendations within 30 calendar days from the date of issuance of the final report. The CAP should explain how the state will ensure that the recommendations have been addressed and will not reoccur. The CAP should include the timeframes for each corrective action along with the specific steps the state expects will take place and identify which area of the SMA is responsible for correcting the issue. We are also requesting that the state provide any supporting documentation associated with the CAP, such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. The state should provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of issuance of the final report. If the state has already acted to correct compliance deficiencies or vulnerabilities, the CAP should identify those corrections as well.

The state is not required to develop a CAP for any observations included in this report. However, CMS encourages the state to take the observations into account when evaluating its program integrity operations going forward.

CMS looks forward to working with Florida to build an effective and strengthened program integrity function.

Appendices

Appendix A: Status of Prior Review

Florida's last CMS program integrity review was in June 2017, and the report for that review was issued in January 2018. The report contained eight recommendations. During the virtual review in June 2022, the CMS review team conducted a thorough review of the corrective actions taken by Florida to address all recommendations reported in calendar year 2018. The findings from the 2017 focused PI review report have all been satisfied by the state.

Appendix B: Technical Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance and educational resources for the SMA.

- Access the Resources for State Medicaid Agencies website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Resources-for-SMAs to address techniques for collaborating with MFCUs.
- Access the Medicaid Payment Suspension Toolkit at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/medicaid-paymentsuspension-toolkit-0914.pdf, to address overpayment and recoveries.
- Use the program integrity review guides posted in the Regional Information Sharing Systems (RISS) as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the RISS for information provided by other states including best practices and managed care contracts. https://www.riss.net/
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute. More information can be found at https://www.cms.gov/medicaid-integrity-institute
- Regularly attend the Fraud, Waste, and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Participate in Healthcare Fraud Prevention Partnership studies and information-sharing activities. More information can be found at https://www.cms.gov/hfpp.
- Consult with other states that have Medicaid managed care programs regarding the development of policies and procedures that provide for effective program integrity oversight, models of appropriate program integrity contract language, and training of managed care staff in program integrity issues. Use the Medicaid PI Promising Practices information posted in the RISS as a tool to identify effective program integrity practices.

Appendix C: Enrollment and Expenditure Data

Table C-1 and Table C-2 below provide enrollment and expenditure data for each of the selected MCOs.

Table C-1. Summary Data for Florida MCOs

Florida MCO Data	Community Care Plan	Humana	UnitedHealthcare Community Plan
Beneficiary enrollment total	48,052	574,269	331,184
Provider enrollment total	3,958	22,171	25,561
Year originally contracted	2000	1997	1996
Size and composition of SIU	4 FTEs	28 FTEs (6 dedicated Florida SIU investigators)	70+ FTEs; 14 FTEs for Optum Behavioral Health SIU; 32 FTEs for Optum Investigations SIU
National/local plan	Local	National	National

Table C-2. Medicaid Expenditure Data for Florida MCOs

MCOs	FY 2019	FY 2020	FY 2021
Community Care Plan	$168,088,386.29	$418,572,005.89	$596,319,263.08
Humana	$2,590,310,245.69	$2,932,079,423.21	$3,357,412,879.82
UnitedHealthcare Community Plan	$1,583,195,544.73	$1,454,939,321.21	$1,594,550,258.94
Total MCO Expenditures	**$4,341,594,177.71**	**$4,805,590,750.31**	**$5,548,282,401.84**

Appendix D: State Response

State PI Review Response Form

INSTRUCTIONS:

For each draft recommendation listed below, please indicate your agreement or disagreement by placing an "X" in the appropriate column. For any disagreements, please provide a detailed explanation and supporting documentation.

Classification	Issue Description	Agree	Disagree
Recommendation #1	The state should outline in its MFCU MOU the procedures by which the MFCU will receive referrals of potential fraud from MCOs, either directly or through the agency, as required by § 455.21(c)(3)(iv).	**X**	
Recommendation #2	The SMA should ensure that their agreement with the MFCU is updated no less frequently than every five years, in accordance with § 455.21(c)(3)(v).	**X**	

Acknowledged by:

_____
[Name], [Title]

_____
Date (MM/DD/YYYY)