Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Florida Focused Program Integrity Review

Final Report

January 2018

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Objective of the Review

The Centers for Medicare & Medicaid Services (CMS) conducted a focused review of Florida to determine the extent of program integrity oversight of the managed care program at the state level and to assess the program integrity activities performed by selected managed care organizations (MCOs) under contract with the state Medicaid agency. The review also included a follow up on the state's progress in implementing corrective actions related to CMS's previous comprehensive program integrity review conducted in calendar year 2011.

Background: State Medicaid Program Overview

The Agency for Healthcare Administration (AHCA) administers the Florida Medicaid program. As of January 1, 2017, the program served approximately 4.0 million beneficiaries. Florida has a managed care program which operates statewide and serves approximately 3.2 million beneficiaries, or 82 percent of Florida's Medicaid population, as of January 1, 2017.

At the time of the review, the Florida Medicaid program had 75,147 participating fee-for-service (FFS) providers. As of May, 2017, Florida had 16 managed care entities (MCEs) and a total of 182,117 providers were enrolled in the state's managed care program. These MCEs included full-risk health maintenance organizations (HMOs) and provider service networks. Therefore, all MCOs will be referred to as MCEs throughout this report. Total Medicaid expenditures for federal fiscal year (FFY) 2016 were approximately $24.0 billion. Total capitated payments to MCEs during FFY 2016 were approximately $15.6 billion or 65 percent of the total Medicaid expenditures.

The Bureau of Medicaid Program Integrity (MPI) is located within AHCA's Office of the Inspector General (OIG). The MPI has the overall responsibility for the prevention and detection of fraud, abuse, and improper payments within the Medicaid program, and is tasked with conducting all program integrity, audit, and fraud investigation activities; however, integrity functions are also performed by other AHCA divisions, such as the Divisions of Medicaid, Health Quality Assurance, and Operations. At the time of the review, MPI had 82 full-time equivalent (FTE) staff; some of those FTEs include: 36 investigators, seven nurses, four data analysts, and 27 management and support personnel. In addition, the MPI utilizes 27 Other Personnel Services (OPS) staff. The OPS employment arrangement is a temporary employer/employee relationship used only for the completion of short term or intermittent tasks. These OPS employees do not fill established positions and may not be assigned the duties of any vacant authorized position. During the onsite review, it was noted that MPI had 13 vacant FTEs.

Methodology of the Review

In advance of the onsite visit, CMS requested that Florida and the MCEs selected for the focused review complete a review guide that provided the CMS review team with detailed insight into the operational activities of the areas that were subject to the focused review. A four-person review team has reviewed these responses and materials in advance of the onsite visit.

During the week of June 12, 2017, the CMS review team visited AHCA, which also included staff from the MPI bureau. It conducted interviews with numerous state staff involved in program integrity and managed care. The CMS review team also conducted interviews with four MCEs and their special investigations units (SIUs). In addition, the CMS review team conducted sampling of program integrity cases and other primary data to validate the state and the selected MCEs' program integrity practices.

Results of the Review

The CMS review team identified areas of concern with the state's managed care program integrity oversight, thereby creating risk to the Medicaid program. CMS will work closely with the state to ensure that all of the identified issues are satisfactorily resolved as soon as possible, particularly those that remain from the earlier review. These issues and CMS's recommendations for improvement are described in detail in this report.

Section 1: Managed Care Program Integrity

Overview of the State's Managed Care Program

As mentioned earlier, approximately 3.2 million beneficiaries, or 82 percent of the state's Medicaid population, were enrolled in 16 MCEs during FFY 2016. The state spent approximately $24.0 billion on managed care contracts in FFY 2016.

Summary Information on the Plans Reviewed

The CMS review team interviewed four MCEs as part of its review.

Amerigroup Florida (Amerigroup) is an HMO that has provided health care coverage in the state of Florida since 2003. Currently, they serve approximately 382,981 members who participate in Florida's Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance (MMA), SMMC Long-term Care, and Florida Healthy Kids programs. Amerigroup is a subsidiary of its parent, Amerigroup Inc., and serves members in five separate Florida regions and 14 counties. As of July 2012, Amerigroup became a part of the Anthem Inc.'s (Anthem) Government Business Division (GBD), after being acquired by WellPoint which provides insurance under the Blue Cross and Blue Shield brands. Through its GBD, Anthem serves approximately 5.8 million seniors, people with disabilities, low-income families, other state and federally sponsored beneficiaries, and National Government Services and Federal Employee Program beneficiaries in 19 states. Anthem is one of the largest health benefits companies in the United States. Program integrity resources are also available through Anthem's corporate SIU which has 209 associates dedicated to the detection and prevention of fraud, waste, and abuse, including 14 associates performing various functions for Florida's local plan. This team includes five dedicated SIU Investigators (four located in Florida), an Investigative Assistant, and a Certified Professional Coder. Full-time employees receive support from the SIU Manager, three Data Analysts, and a Regulatory Compliance Consultant. The total expenditures for FFY 2016 was approximately $1.3 billion.

Freedom Health, Inc., is an MMA HMO designed specifically for providing services to Medicaid/Medicare dually eligible enrollees with diabetes, chronic obstructive pulmonary disorder, congestive heart failure, and cardiovascular disease. This plan was designed to meet the specific needs of the members who comprise its specialty population. Freedom has been providing MMA specialty services in the state since January 2015 and currently delivers care in 42 Florida counties. The local plan's Medicaid SIU is comprised of four employees: a compliance officer, a manager, and two investigators. In addition, there is also a corporate compliance team of 12 FTEs which also conducts program integrity activities. The total expenditures for FFY 2016 was approximately $105,000.

Molina Healthcare of Florida (Molina) is a subsidiary of Molina Healthcare. Molina's parent company operates as a multi-state health care organization that arranges the delivery of health care services and offers health information management solutions to nearly five million individuals and families who receive care through Medicaid, Medicare, and other government-funded programs in 15 states. Molina's SIU is comprised of 22 employees which include an associate vice president, clinician manager, manager, supervisor, investigators, coding analysts, data analyst, analysts, administrative assistant, and clerk. The total expenditures for FFY 2016 was approximately $1.1 billion.

Simply Healthcare Plans, Inc., (Simply)[1] is a Florida licensed HMO with health plans for individuals enrolled in Medicaid and/or Medicare programs. Simply and its affiliates, Better Health and Clear Health Alliance (CHA), serve over 200,000 Medicare and Medicaid members in 60 Florida counties. CHA is a subsidiary/b/a of Simply and has offices in both Miami and Tampa, Florida. Clear Health Alliance is a unique for-profit local HIV/AIDS Medicaid Specialty Plan that serves Florida Medicaid beneficiaries living with HIV/AIDS. Clear Health Alliance Simply has been in existence since 2009 and its d/b/a CHA has been in existence since 2012. Anthem acquired Simply and its sister companies in February of 2015. The Clear Health Alliance plan has medical directors who have experience working in the HIV/AIDS community, as well as a network of primary care physicians, specialists, hospitals, and facilities experienced in caring for persons diagnosed with HIV/AIDS. The plan has managed care coordinators, dedicated provider relations representatives and community outreach specialists to ensure their members with HIV/AIDS receive medically necessary services. Through its Government Business Division, Anthem serves approximately 5.8 million seniors, people with disabilities, low-income families, other state and federally sponsored beneficiaries, and National Government Services and Federal Employee Program beneficiaries in 19 states. Anthem is one of the largest health benefits companies in the United States. Program integrity resources are also available through Anthem's corporate SIU which has 209 associates dedicated to the detection and prevention of fraud, waste, and abuse, including 14 associates performing various functions for Florida's local plan. This team includes five dedicated SIU Investigators (four located in Florida), an Investigative Assistant, and a Certified Professional Coder. Full-time employees receive support from the SIU Manager, three Data Analysts, and a Regulatory Compliance

[1] The review and all information contained in the report, including the tables, focuses on Clear Health Alliance and does not include data for Simply Healthcare Plan.

Consultant. Clear Health Alliance. The total expenditures for FFY 2016 was approximately $242.6 million.

Enrollment information for each MCE as of May 2017 is summarized below:

Table 1.

	Amerigroup	**Freedom**	**Molina**	**Clear Health Alliance**
Beneficiary enrollment total	382,981	122	721,236	9,623
Provider enrollment total	28,289	15,993	45,445	10,465
Year originally contracted	2014*	2015*	2008	2012
Size and composition of SIU	209.0 FTEs	16.0 FTEs	22.0 FTEs	209.0 FTEs
Number of SIU FTEs dedicated to state's plan	5.0 FTEs/9.0 PTEs	4.0 FTEs	2.0 FTEs	5.0 FTEs/9.0 PTEs
National/local plan	National/Local	Local	National	National/Local

*The MCE was contracted to provide services to SMMC-MMA beneficiaries during this year.

Table 2.

MCEs	**FFY 2014**	**FFY 2015**	**FFY 2016**
Amerigroup	$702.8 million	$1.2 billion	$1.3 billion
Freedom	$41.2 million*	$98,072*	$105,000
Molina Healthcare	$348.5 million	$671.0 million	$1.1 billion
Clear Health Alliance	$101.8 million	$$239.3 million	$242.6 million

*Decrease in expenditures from FFY 2014 to FFY 2015 attributed to entering into a new contract with AHCA to provide only specialized services to dual eligible recipients with specific chronic health conditions.

State Oversight of MCE Program Integrity Activities

The MPI is the state unit responsible for program integrity oversight. The state reported that oversight of the Medicaid system in Florida is a collaborative effort between AHCA and the Program Integrity Unit (PIU), the MCEs, and the Medicaid Fraud Control Unit (MFCU). However, no formal intra-agency agreements are in place detailing how each area will conduct oversight of the MCEs, including which unit within the state Medicaid agency is responsible for each specific activity. The PIU is responsible for all program integrity, audit, and fraud investigation activities.

AHCA has implemented a "hub & spoke" model for intra-agency interactions that governs managed care plan contract compliance and performance monitoring. This is a responsibility that reaches all functional units within the agency, and communication between these different units is vital to managing plan performance. Agency contract managers serve as the primary point of contact with plans and are often the coordinating point of contact, both internally and externally, on specific issues. Additionally, the functional units contain subject matter experts who are needed to monitor and improve plan performance. Various units throughout the agency

monitor plan performance and compliance; as issues are identified, they are presented to the plan-specific contract manager, vetted through management, and appropriate action is taken. The state confirmed that it does have operational guidelines, as well as the contract with the MCEs, that govern the interaction between the state's program integrity efforts and programmatic oversight for each managed care plan. As it relates to Fraud, Waste, and Abuse, the state conducts annual onsite, desk-level, and ad-hoc reviews of the MCEs, in addition to its contractual program integrity provisions for conducting fraud and abuse-related activities.

MCE Investigations of Fraud, Waste, and Abuse

As required by 42 CFR 455.13, 455.14, 455.15, 455.16, and 455.17, the state does have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and MCEs.

Florida's MCE contract states that the MCE "shall establish functions and activities governing program integrity in order to reduce the incidence of fraud and abuse and shall comply with all state and federal program integrity requirements."

The MCEs must submit evidence of fraud, waste, and abuse allegations to MPI within 15 days of detection of activity. Also, the MCEs must submit the comprehensive *Quarterly Fraud and Abuse Activity Report* to AHCA and the MPI for review. In addition, the contract includes language that requires the MCE to report suspected provider fraud to the MFCU. Incidents of suspected provider waste and abuse are reported to MPI.

Amerigroup's national *Fraud, Waste and Abuse Detection and Prevention in Health Plan Operations* policy and procedure specifies that the Medicaid Business Unit (MBU), "its associates and contractors, and the Company's shared services departments, which support the MBU in the operation of its government-sponsored business, have an obligation to participate in efforts to prevent, detect, and mitigate fraud, waste and abuse in the health care system. This also includes an obligation to report instances of suspected fraud, waste or abuse to government authorities, where appropriate." The reporting requirements are also outlined by policy. Amerigroup's Fraud, Waste and Abuse Plan, including the Florida Addendum, specifies that when "the documents and evidence gathered during the course of an investigation indicate a potential fraud, waste or abuse, the SIU will make referrals to the appropriate agency in accordance with contractual and/or regulatory guidelines."

In addition, Amerigroup's SIU stated that it does not conduct preliminary investigations; all cases are considered full investigations from inception through resolution. All cases that are opened are considered "full" and undergo a preliminary stage to validate the allegation. For the purposes of the CMS audit, Amerigroup provided numbers of their investigations including those investigations resulting from tips or leads. The tips/leads were noted as the preliminary investigations. Not all tips/leads become a full investigation case. Therefore the number of preliminary investigations (tips/leads) is higher than the number of full investigations since both the tips/leads not resulting in an investigation and tips/leads that do become full investigations are included within the preliminary investigations numbers.

Freedom requires the immediate reporting of suspected incidents of fraud, waste, and abuse through established policies and procedures, and as specified in local, state, and federal guidelines. Freedom's SIU has developed and implemented a comprehensive anti-fraud program designed to prevent, detect, investigate, resolve, correct, and report incidents of suspected fraud, waste, and abuse. While the SIU is the primary investigative unit responsible for handling instances of suspected fraud, waste, and abuse, the staff is not solely dedicated to conducting program integrity activities. The SIU will also assist management in meeting compliance standards regarding fraud, waste, and abuse. In addition, the SIU serves as a liaison between the plan, providers, contractors, federal and state agencies, and other constituents in the prevention, detection, and reporting of any suspected fraud, waste, and abuse. As a component of Freedom's compliance program, the SIU utilizes a multi-faceted approach to prevent and detect suspected or potential fraud, waste, and abuse involving both prepayment and post-payment claims edits/strategies. The SIU utilizes a combination of analytical tools, clinical expertise, investigative knowledge, and internal and external referrals. The SIU also depends on an effective education and awareness training program to maximize employee, business partner, and downstream entity referrals.

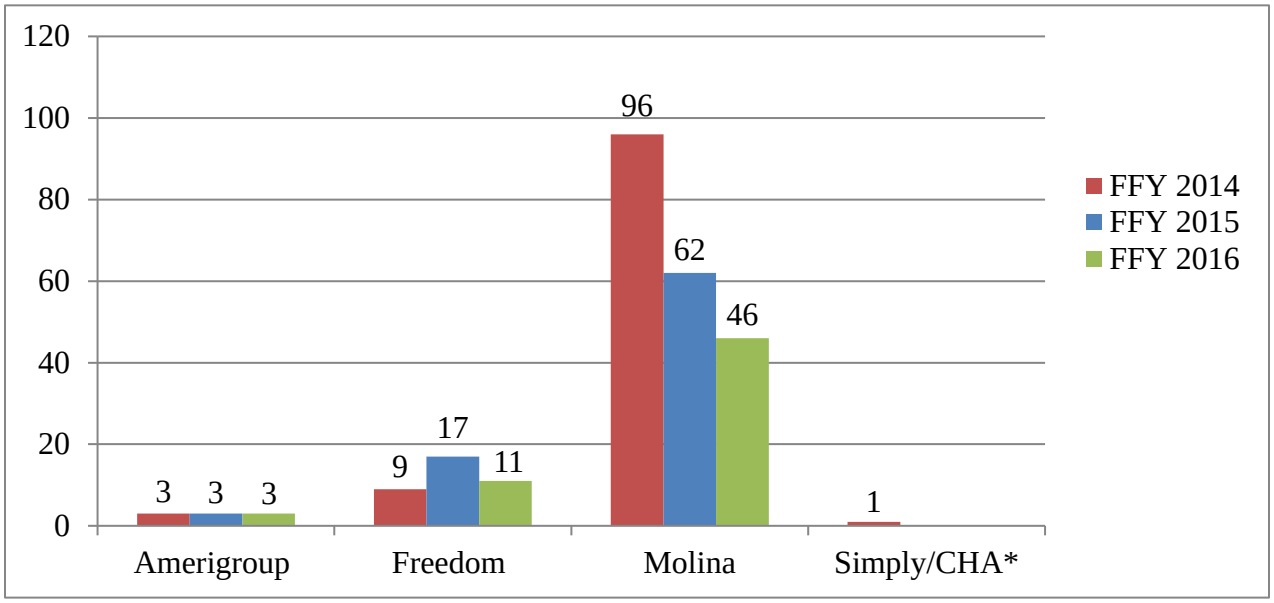
Molina's SIU conducts audits and investigations to determine the extent of all member and provider-related instances of fraud, waste, and abuse. The SIU will conduct a preliminary investigation on all matters referred to the SIU to determine if a full investigation is required. Molina's SIU will document the findings of the preliminary review and close the investigation if it has been determined that: the case was based on a misunderstanding between the complainant and the suspect of the alleged fraud; a claims processing/clerical error was identified; or another rational explanation based on fact was substantiated. However, if the SIU determines the allegation is sufficient to require further action, the matter is transitioned to an extensive investigation to determine if services were provided and/or appropriately rendered and/or billed. Policy and procedure states that any final resolution reached by the health plan shall include a written statement of notice to the provider or enrollee; the notice should stipulate that the resolution in no way binds the state nor precludes Florida from taking further action regarding the allegation.

As stated in AHCA's MCE contract and indicated during onsite interviews with Clear Health Alliance staff, the plan performs both preliminary and full investigations to identify and recover overpayments for collection by the AHCA OIG. Clear Health Alliance receives referrals from multiple sources including, but not limited to, beneficiaries, data analysis and algorithms, tips, internal staff, and other divisions. If any referrals or billing anomalies are identified, a preliminary investigation is opened. A full investigation is opened and current findings from the MCE are reviewed, along with any other program integrity activities required by the state, if there is further evidence of aberrant billing patterns; overpayments; or fraud, waste, and abuse. Furthermore, if Clear Health Alliance determines that there is potential credible allegation of fraud while the full investigation is in progress, the MCE will inform AHCA via email and await further instruction from the state. Clear Health Alliance may also terminate the provider. In addition, Clear Health Alliance's SIU is responsible for the identification of overpayments associated with investigative fraud, waste, and abuse activities. Both the SIU and the Audit & Recovery Division work on program integrity activities either in part or as a team. The Audit & Recovery Division is primarily responsible for collecting overpayments. Once a full

investigation is completed by the SIU, potential identified overpayments are passed on to Audit & Recovery Division for overpayment recovery or for further analysis to determine if an overpayment is due from the provider. The Audit & Recovery Division team performs ongoing monthly and quarterly audits to identify claim overpayments related to correct coding edits, processing rules, contract, and mandates. The Audit & Recovery Division also performs quality assurance audits on the claims processers responsible for reviewing payments and procedural accuracy. After a full investigation is completed, the MCE will determine the next steps that may include administrative actions, provider education, fraud referrals to the state or MFCU, or any other applicable actions necessary.

Table 3 lists the number of referrals that the Amerigroup, Freedom, Molina, and Clear Health Alliance SIUs made to the state in the last three FFYs. Overall, the number of Medicaid provider investigations and referrals by each of the MCEs is low, compared to the size of the plan, with the exception of Molina. However, Molina's referrals have declined approximately 48 percent from FFY 2014 to FFY 2016. The level of investigative activity has not significantly changed over time.

Table 3.



*No investigations were referred to the state by the MCE during FFYs 2015 and 2016.

During onsite interviews with Clear Health Alliance, the low volume of investigations referred to the state was attributed to the decline in membership. No other reason was provided to the CMS review team. Clear Health Alliance membership was comprised of approximately 9,100 beneficiaries in FFY 2014 and increased to 9,623 during FFY 2016.

The CMS review team selected samples of five MCE network provider investigations conducted by the state during the past four FFYs. Upon review of the case files, four provider investigations resulted in the conclusion that the allegations were unfounded, therefore, no action was taken by the MCE. The results of the remaining case sampled determined that the provider had contractual deficiencies, but no program integrity violations were evident.

MCE Compliance Plans

The state does require its MCEs to have a compliance plan to guard against fraud and abuse in accordance with the requirements at 42 CFR 438.608. The state does have a process to review the compliance plans and programs. At minimum, the MCEs shall submit the compliance plan to the state's Medicaid PIU annually; the deadline for submission is the first day of September of each year.

As required by 42 CFR 438.608, the state does review the MCE's compliance plan and communicates approval/disapproval with the MCEs. The compliance review is performed on specific key elements required of a compliance plan along with a file review of grievances and appeals. Those key elements include: 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; provisions for internal monitoring and auditing; provision for prompt response to detected offenses; and development of corrective action initiatives relating to the MCE's contract.

The review of the compliance plan revealed minimal issues. Each of the MCEs provided the review team with a copy of their compliance plans that have been submitted to the state. A review of these plans revealed they were in compliance with 42 CFR 438.608, with the exception of a fully-developed process for beneficiary verification of services.

Encounter Data

The MCE contract with the state requires the submission of an electronic record for every encounter between a network provider and an enrollee; these records should be forwarded no later than seven days following the date on which the managed care plan adjudicated the claim(s). The state does receive encounter data from the MCEs and reported that it does contractually require the MCEs to conduct data mining; the Agency has a unit within the MDA Bureau called Medicaid Data Analytics, therefore state-initiated data mining does occur on a regular basis.

The MCE contract states, "If the Managed Care Plan fails to comply with the encounter data reporting requirements as specified in this Contract for thirty (30) days, the Agency shall assess the Managed Care Plan a fine of five thousand dollars ($5,000) per day for each day of noncompliance beginning on the thirty-first (31st) day. On the thirty-first (31st) day, the Agency must notify the Managed Care Plan that the Agency will initiate contract termination procedures on the ninetieth (90th) day unless the Managed Care Plan comes into compliance before that date." During the onsite review, the state indicates that there is a process in place to ensure timely submission of encounter data occurs. The MCE contract states, "For all services rendered to its enrollees (excluding services paid directly by the Agency on a fee-for-service basis), the

Managed Care Plan shall submit encounter data no later than seven (7) days following the date on which the Managed Care Plan adjudicated the claims." Compliance with this provision of the contract is monitored on a weekly basis, and monthly actions are taken for non-compliance.

Overpayment Recoveries, Audit Activity, and Return on Investment

The state does not require MCEs to return to the state overpayments recovered from providers as a result of MCE fraud and abuse investigations or audits; however, it does require reporting of identified overpayments.

In addition, it is important to note that Florida regulation issued by the Office of Insurance Regulations (OIR) has a statute that indicates an MCE cannot look back at claims greater than 12 months. This prohibits MCEs from identifying and recovering additional monies for fraud, waste, and abuse.

The state Medicaid agency, in partnership with MPI, does conduct reviews, investigations, analyses, audits, or any combination thereof, to determine possible fraud, abuse, and overpayments; it also requires the MCE to report the findings of any overpayments in audit reports as appropriate.

The table below shows the respective amounts reported by Amerigroup for the past three FFYs.

Table 4-A.

FFY	Preliminary Investigations*	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2014	28	5	$352,900	$11,000
2015	98	59	$1.8 million	$297,600
2016	154	84	$3.3 million	$196,900

*The MCE's SIU stated that it does not conduct preliminary investigations; all cases are considered full investigations from inception through resolution.

During onsite interviews, Amerigroup's SIU stated that it does not conduct preliminary investigations; all cases are considered full investigations from inception through resolution. However, the numbers of preliminary/full investigations reported to the CMS review team were not identical, as would be expected where no case-type distinction is made. Upon request, the MCE confirmed that these numbers were correct as reported. Amerigroup stated the increase in full investigations during the FFYs reviewed was attributed to the plan expanding its coverage area to statewide in calendar year 2014; transitioning to a SMMC plan; and increases in enrollment levels. The increases in investigations were also attributed to changes in MCE management and AHCA's establishment of parameters related to their investigative expectations.

Amerigroup's increases in overpayment amounts identified and recovered during FFYs 2014 through 2016 were attributed to the carryover from previous years' overpayments identified and recovered in the following FFY and the increase in staffing levels. Overall, the recoveries for

Amerigroup were low due to the OIR which restricts the MCEs' SIUs to a look back period of only 12 months for recoveries.

The table below shows the respective amounts reported by Freedom for the past three FFYs.

Table 4-B.

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2014	9*	9	$0	$0
2015	17*	17	$0	0
2016	11*	11	$0	$0

*All preliminary investigations were developed into full investigations during the time period reviewed.

The preliminary and full investigations reported by Freedom originated from the plan's Medicare line of business. Since the Medicare investigations involved claims submitted on behalf of dual eligible recipients, the cases were also referred to the Freedom Medicaid SIU due to the Medicaid portion of the exposure in these crossover claims.

During onsite interviews, Freedom was unsure what caused the increase in investigations from FFY 2014 to FFY 2015, and the decrease in investigations from FFY 2015 to FFY 2016. The plan told the CMS onsite review team that they were provided with consistent instructions regarding what is required for acceptance of case referrals by AHCA. Freedom's lack of any monies recovered was also attributed to low exposure to the Medicaid line of business. The recipient population is both small and dually eligible.

The table below shows the respective amounts reported by Molina for the past three FFYs.

Table 4-C.

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2014	28	*	$117,083	$38,559
2015	58	*	$81,269	$46,024
2016	28	*	$268,158	$38,076

*Full investigations are not tracked; all cases are worked until reconciled.

Once reported, Molina investigates all cases from inception through reconciliation. During FFY 2014, the MCE recovered approximately 33 percent of the monies identified as overpaid to providers. During FFY 2015, Molina monies recovered from identified overpayments increased to 57 percent. However, the recoveries in FFY 2016 decreased to 14 percent of the overpayments identified during the same time period, which is low in comparison to the recovery results from prior years reviewed. Molina attributed the lower recoveries in FFY 2016 to the

increase in enrollment and the state's required look back period being limited to a 12 month time frame.

The table below shows the respective amounts reported by Clear Health Alliance for the past three FFYs.

Table 4-D.

FFY	Preliminary Investigations*	Full Investigations**	Total Overpayments Identified	Total Overpayments Recovered
2014	1	6	$0	$0
2015	8	8	$6,107	$5,941
2016	1	1	$56,422	$4,888

*The MCE defines preliminary investigations as investigative leads it has received. Leads may or may not develop into full investigations.
**All investigations are considered full investigations. The MCE does not conduct preliminary investigations.

Clear Health Alliance considers all investigations to be full investigations. The number of preliminary investigations reported by the MCE represents investigative leads. A lead may not always result in an investigation, therefore, the relationship between leads (reported here as preliminary investigations) and full investigations can be mutually exclusive or independent of each other. During onsite interviews, Clear Health Alliance attributed the overall reason for little to no collection on identified overpayments in FFY 2014 to low membership.

Overall, collections of identified overpayments is very low for the MCEs reviewed. As previously mentioned, Florida regulation issued by the OIR has a statute specifying that health plans may not look back more than 12 months when initiating collection efforts. This significantly limits plans in their collection efforts regarding monies overpaid to providers.

Payment Suspensions

In Florida, Medicaid MCEs are contractually required to suspend payments to providers at the state's request. The state confirmed that there is no contractual language mirroring the payment suspension regulation at 42 CFR 455.23; however, AHCA does allow a payment hold in cases with a credible allegation of fraud. Credible allegations of fraud must be verified by AHCA.

The *Statewide Medicaid Managed Care Contract* requires that "the Managed Care Plan shall not pay for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) for the following:

> Items or services furnished by an individual or entity during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the state determines there is good cause not to suspend payments."

Currently, a compliance review is being developed to evaluate the issue regarding the payment of claims by the MCEs to providers with pending investigations related to credible allegations of

fraud. When MPI identifies potential violations, each instance is evaluated and, when appropriate, MPI forwards recommendations to ACHA for contract actions; these actions may include sanctions and liquidated damages against the MCE.

The state does not request a payment suspension, rather they impose it when a credible allegation of fraud is identified and an exception does not apply. These payment suspensions are imposed by the state across all of the MCEs. The payment suspension is imposed against a provider when the facts and circumstances of each case indicate a need for the payment suspension. These payment suspensions are not identified or tracked based upon specific network participation. For the past three FFYs, MPI has not received any requests for a good cause exception from the MCEs. In addition, there is a high level of communication between the MCEs, AHCA, and the MFCU, which occurs at a minimum on monthly basis.

Terminated Providers and Adverse Action Reporting

The state MCE contract states, "In addition to any other right to terminate the provider contract, and notwithstanding any other provision of this Contract, the Agency or the Managed Care Plan may request immediate termination of a provider contract if, as determined by the Agency, a provider fails to abide by the terms and conditions of the provider contract, or in the sole discretion of the Agency, the provider fails to come into compliance with the provider contract within fifteen (15) days after receipt of notice from the Managed Care Plan specifying such failure and requesting such provider abide by the terms and conditions thereof."

There are no contractual requirements that address instances in which a plan shall terminate a provider for cause. The MCEs are contractually required to report all terminations to the state Medicaid agency, but their report does not identify whether the termination was for cause or not for cause. However, all plans are statutorily required to inform the state of all suspected or confirmed instances of provider fraud or abuse within 15 days of detection or suspicion.

Table 5:

MCEs	Total # of Providers Disenrolled or Terminated in Last 3 Completed FFYs		Total # of Providers Terminated For Cause in Last 3 Completed FFYs	
Amerigroup	2014 2015 2016	2,393 2,547 2,699	2014 2015 2016	687 651 567
Freedom *	2014 2015 2016	1,193 710 209	2014 2015 2016	1,193 710 209
Molina	2014 2015 2016	561 995 1,274	2014 2015 2016	18 45 62
Clear Health Alliance	2014 2015 2016	2,146 3,089 0	2014 2015 2016	8 56 0

* All providers are removed from the MCE's network, regardless of the reason for their termination.

Overall, the number of providers terminated for cause by Molina and Clear Health Alliance appears to be low, compared to the number of providers in each of the MCE's networks and compared to the number of providers disenrolled or terminated for any reason. Both Amerigroup and Freedom demonstrated higher numbers of providers terminated for cause, compared to the other MCEs reviewed during the same three FFYs. In addition, Freedom removes all providers from their network, regardless of the reason for termination.

The four MCEs interviewed by CMS reported that they submit providers terminated either with or without cause to AHCA on a weekly basis via their provider network reports. Additionally, they submit these providers on both a monthly basis and on a quarterly basis during the MPI meetings. During the monthly MPI meetings, the state does provide notification regarding the providers terminated from other plans or who have lost Florida Medicaid eligibility, so that all of the MCEs may ensure that these terminated providers are not operating in their plans. The state confirmed there is a process to ensure that the MCEs are terminating providers with and without cause. During the onsite review, the TIBCO process for reviewing provider terminations was discussed and determined to be followed in a timely manner.

Federal Database Checks

The regulation at 42 CFR 455.436 requires that the state Medicaid agency must check the exclusion status of the provider or persons with an ownership or control interest in the provider, and agents and managing employees of the provider on the U.S. Department of Health and Human Services-OIG's (HHS-OIG) List of Excluded Individuals and Entities (LEIE); the Excluded Parties List System (EPLS) on the System for Award Management (SAM); the Social Security Administration's Death Master File (SSA-DMF); the National Plan and Provider

Enumeration System upon enrollment and reenrollment, and check the LEIE and EPLS no less frequently than monthly.

Florida Medicaid has matched all persons and entities on initial and renewing applications to the LEIE since 2002. During January 2015, the match process was automated and expanded to include the monthly match. The monthly match occurs when the state Medicaid agency downloads the LEIE to the Florida Medicaid Management Information System (MMIS) on a monthly basis and stores the data to a searchable table. An automated process matches all individuals/entities to the LEIE data table upon submission of an initial or renewing application, and monthly for enrolled providers. Potential matches between Florida Medicaid providers and the LEIE are included in a report and loaded to the provider's record. State staff works with the potential match reports to verify the identity of the excluded individual/entity to the Florida Medicaid provider. State staff directs the Medicaid fiscal agent to update the provider's record to reflect the results and the date of the match verification. Confirmed positive matches are referred to MPI to activate the for cause termination process.

The Medicaid State Terminations match (TIBCO) is currently manual and has produced negligible results. There is a project underway to automate that process similar to the LEIE solution previously outlined.

The state of Florida does screen MCE providers. It is also the responsibility of each plan to screen all applications, including initial enrollment, relocation, and re-enrollment or revalidation. It is the responsibility of each MCE to perform all required federal database checks for the managed care providers as well as collect and store all required disclosure information.

The state confirmed they do have written policies and procedures for overseeing the screening and enrollment process for both FFS providers and MCE providers, and has contractual language requiring the MCEs to have written policies and procedures for credentialing and recredentialing, as well as monitoring and disciplining providers who are found to be noncompliant. The policy and procedure has been reviewed for appropriateness and inclusion of the above cited language.

Recommendations for Improvement

- Develop written policies and procedures or an interagency agreement that outlines which state unit will be responsible for various program integrity related oversight functions.
- The state should continue to work with the MCEs to develop and routinely provide specific program integrity training related to developing and enhancing the quantity of case referrals from the MCEs. The state should provide more frequent feedback to the plans regarding the quality and quantity of MCE case referrals forwarded to the state. The state should also ensure that MCE staff is receiving adequate training in identifying, investigating, and referring potential fraudulent billing practices by providers.
- Contractually include language and require a detailed plan of action to review and approve the MCEs compliance plans based on fulfilling all elements of the compliance requirements, including a fully-developed process for the beneficiary verification of services.
- Continue efforts to improve the state's ability to analyze encounter data reported by MCEs and perform state-initiated data mining activities in order to identify fraud, waste, and abuse issues with MCE network providers.
- Verify that identified and collected overpayments are fully reported by the MCEs and that they are incorporated into the rate-setting process along with the overpayments determined by state-initiated reviews.
- Contractually include language and require MCEs to collect identified overpayments in accordance with regulations issued by Florida OIR.
- Contractually require MCEs to suspend payment to providers against whom an MCE or the state can document a credible allegation of fraud. The payment suspension requirements in the federal regulation at 42 CFR 455.23 should be consulted in designing this provision. The state should provide training to its contracted MCEs on the circumstances in which payment suspensions are appropriate pursuant to 42 CFR 455.23, and should further require the reporting of plan-initiated payment suspensions based on credible allegations of fraud.
- The state should develop contractual requirements that specify the instances under which a plan shall terminate a provider for cause. The state should also contractually require the MCEs to identify providers terminated for cause in their reporting.

Section 2: Status of Corrective Action Plan

Florida's last CMS program integrity review was in October 2011, and the report for this review was issued in July 2012. The report contained three findings and three vulnerabilities. During the onsite review in June 2017, the CMS review team conducted a thorough review of the corrective actions taken by Florida to address all issues reported in calendar year 2012. The findings of this review are described below.

Findings –

1. 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.

   Status at time of the review: Corrected

   The state has procedures in place to suspend provider payments upon reliable evidence of fraud, pursuant to Florida Statute 409.913(25)(a).
   - The state suspends payments when there is credible evidence of fraud and has imposed over 75 payment suspensions in the last two FFYs. In the past, however, the state has suspended payments subsequent to the referral to the MFCU, rather than upon the referral to MFCU.
   - The state revised the memorandum of understanding (MOU) between the agency and MFCU to initiate the payment suspensions at the time MPI makes the referral to MFCU. Once the MOU has been completed and signed by both agencies, MPI will update their procedures and begin imposing payment suspensions upon referral to MFCU.
   - The state amended the MFCU referral templates, during the course of the previous Medicaid Integrity Group review, to be in full compliance with the fraud referral performance standards.

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

   Status at time of the review: Corrected

   - Both the web-based and paper versions of the *Medicaid Provider Enrollment Application* currently require applicants to disclose ownership of five percent or more in the disclosing entity and subcontractors.
   - The date of birth is now captured during the provider fingerprinting process and is loaded to the MMIS.
   - The MCE *Treating Provider Registration Form* does not capture ownership information. However, the agency decided four years ago to avoid duplication and to streamline this MCE provider registration process. It decided not to capture this data, since the MCEs would already perform their credentialing in compliance with all regulations. The "Enrollment and Screening of Providers" section of the State Plan Agreement and approval letter each address this issue. Per CMS, risk-based MCEs are exempt from this

regulation. The exemption for risk-based MCEs was also outlined in guidance provided to the state by CMS.

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

   Status at time of the review: Corrected

   - All business and personal names disclosed on the application are searched against the LEIE. Medicaid Contract Management supplied a desk-level procedure document to illustrate this process.
   - After the technical difficulties experienced with the Medicare Exclusion Database file were corrected, MPI initiated monthly checks against the exclusions file. The state is currently matching the EPLS database to their provider file and is also conducting this match on a monthly basis as well.

Vulnerabilities –

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

   Status at time of the review: Corrected

   The May 2011 model MCE contract, which is the basis of the new dental contract that went into effect March 1, 2012, specifically requires all provider contracts to comply with 42 CFR 438.230, 42 CFR 455.104, 42 CFR 455.105, and 42 CFR 455.106. CFR 455.105, and 42 CFR 455.106.

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

   Status at time of the review: Not Corrected

   After the 2009 audit, the state Medicaid agency discussed resending the explanations of benefits to recipients with the MCEs, and encouraged them to use a method of their own choosing. With the implementation of the 2012-2015 MCE contracts on September 1, 2012, plans will be required to include in their fraud and abuse plans a description of their method for verifying with members whether services billed by providers were received, as specified in the requirements at 42 CFR 455.20.

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

   Status at time of the review: Corrected

   The current model contract requires compliance with 42 CFR 455.105, in terms of provider disclosures, credentialing and recredentialing, and health plan ownership. The 2012-2015

MCE contracts (which will went into effect September 1, 2012) specified that plans must, on at least a monthly basis, check current staff, subcontractors, and providers against the LEIE and the EPLS (or their equivalents) to identify excluded parties.

The 2012-2015 MCE contract further states that the health plans shall also conduct these checks during the process of engaging the services of new employees, subcontractors, and providers, and during renewal of agreements and recredentialing. The MCE shall not engage the services of an entity that is in nonpayment status or is excluded from participation in federal health care programs under sections 1128 and 1128A of the Social Security Act.

Technical Assistance Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for Florida to consider utilizing:

- Use the program integrity review guides posted in the Regional Information Sharing Systems as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the Regional Information Sharing Systems for information provided by other states including best practices and managed care contracts.
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute which can help address the risk areas identified in this report. Courses that may be helpful to (Select State) are based on its identified risks include those related to managed care. More information can be found at http://www.justice.gov/usao/training/mii/.
- Regularly attend the Fraud and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Consult CMS's Medicaid Payment Suspension Toolkit at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/MedicaidGuidance.html to develop a payment suspension process for MCEs that is consistent with federal regulations and guidance.
- Access the Toolkits to Address Frequent Findings: 42 CFR 455.436 Federal Database Checks website at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/fftoolkit-federal-database-checks.pdf.

Conclusion

The CMS focused review identified areas of concern and instances of non-compliance with federal regulations which should be addressed immediately.

We require the state to provide a CAP for each of the recommendations within 30 calendar days from the date of the final report letter. The CAP should address all specific risk areas identified in this report and explain how the state will ensure that the deficiencies will not recur. The CAP should include the timeframes for each correction along with the specific steps the state expects will take place, and identify which area of the state Medicaid agency 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 that will take more than 90 calendar days from the date of the letter. If the state has already taken action to correct compliance deficiencies or vulnerabilities, the CAP should identify those corrections as well.

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