

FRAUD, WASTE AND ABUSE IN FLORIDA MEDICAID MANAGED CARE

Medicaid Program Integrity

Agency for Health Care Administration

February 23, 2011

Tallahassee, FL

Medicaid Program Integrity

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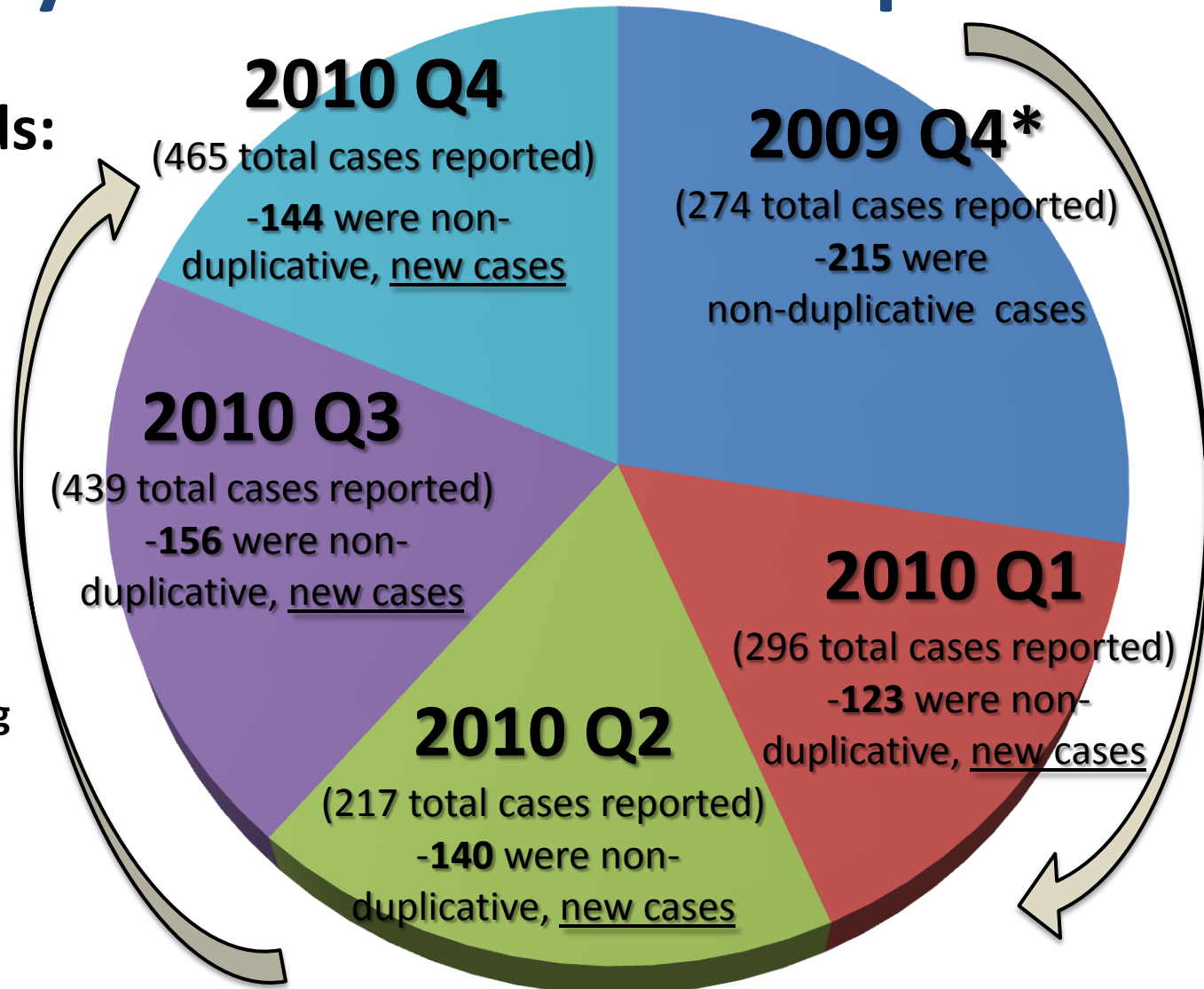
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Quarterly Fraud and Abuse Report

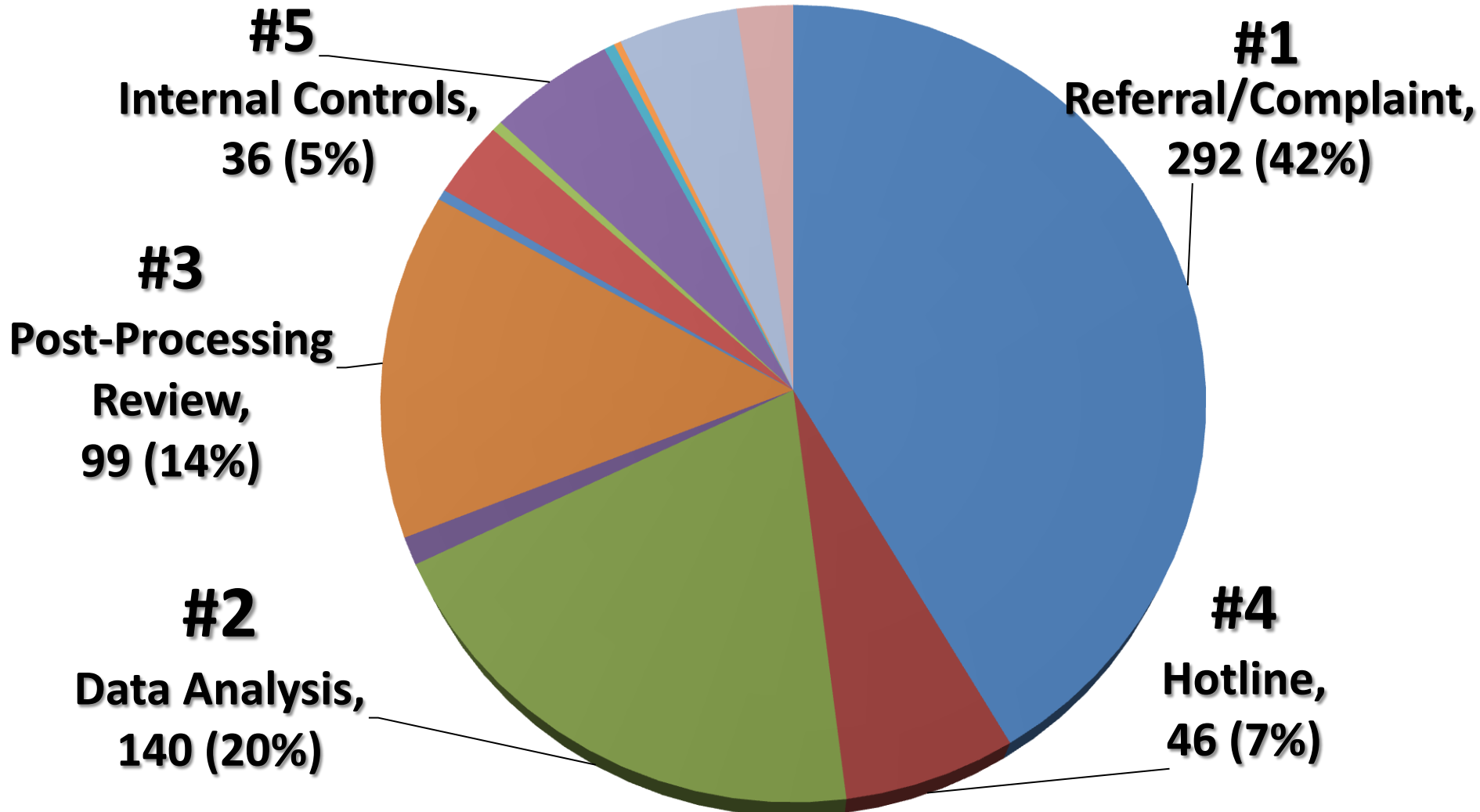
Reporting Trends: New Records

Across the 5 quarter reporting periods –
778
Total new cases

*First quarter of reporting – not required



QFAAR - Top 5 Detection Tools in New Cases Reported from 2009 Q4 – 2010 Q4



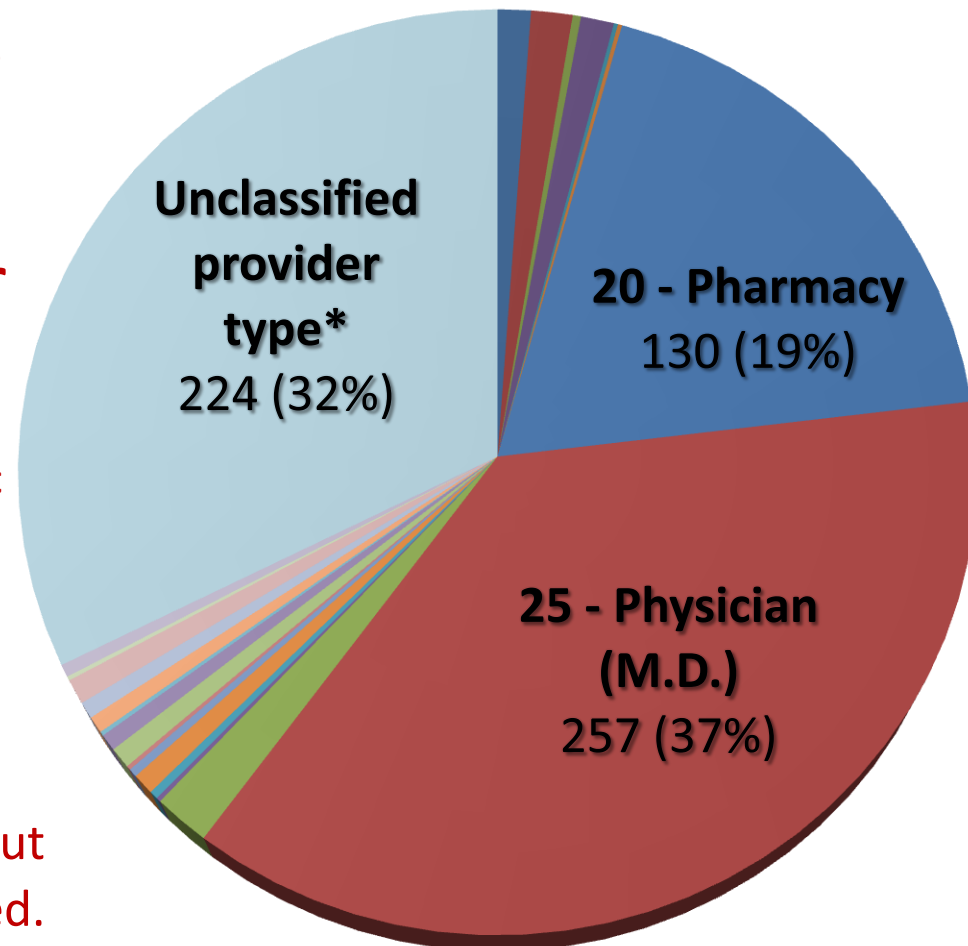
Top 3 Most Reported Provider Types from 2009 Q4 – 2010 Q4

1. 25 – Physician (M.D.)

2. Unclassified Provider Type*

- Need to give feedback – be specific

3. 20 – Pharmacy



*Signifies that a case was reported but no provider type was specified.

QFAAR – Top 3 Primary Allegations

- 1. Provider - Billing for services not rendered**
- 2. Provider - Pattern of overstated reports
(Upcoding)**
- 3. Other:**
 - 1) Pharmacy abuse/Doctor shopping/Narcotic drug seeking
 - 2) Narcotic/Controlled Substance Abuse
 - 3) High/Unusual Provider claims activity

Annual Fraud and Abuse Report

- Submit by Sept. 1 prior to SFY period

Data Reported for: July 1, 2009 – June 30, 2010)

HMO

Total Overpayments Identified for Recovery	Total Overpayments Recovered	Total Dollars Identified as Lost to Fraud and Abuse	Total Dollars Lost to Fraud and Abuse That Were Recovered
\$9,505,113.39	\$4,624,358.21	\$5,104,677.26	\$248,560.58

PSN

Total Overpayments Identified for Recovery	Total Overpayments Recovered	Total Dollars Identified as Lost to Fraud and Abuse	Total Dollars Lost to Fraud and Abuse That Were Recovered
\$120,915.82	\$0.00	\$120,495.98	\$0.00

TOTAL: \$9,626,029.21 \$4,624,358.21 \$5,225,173.24 \$248,560.58

WHAT HAS IMPROVED

- Report Attestations – demonstrating proper signatory authority for certifying QFAAR report
- Timeliness of Reporting
- Reporting is more detailed
- Providing supplemental information via MPI SFTP Site

IMPROVEMENTS TO BE MADE

QFAAR

- For “Other” categories – be descriptive and **specify provider types** in your reporting
- Broaden scope of provider types under investigation
 - i.e. What’s going on with your inpatient claims? Home health? DME? IV Infusion?
- Include internal fraud risk assessments in your compliance/anti-fraud programs (occupational fraud – employee level and management level)

Education, Training, Provider Manual, and Enrollee Handbooks

- Publish and **educate all** regarding toll-free state hotline numbers
 - Agency Consumer Complaint Hotline, and for
 - the Florida Attorney General’s Office for reporting fraud and abuse

Overpayment Recoveries

- Improve your recoveries by being **more aggressive** in your acquisition of dollars to be recovered

Note: Significant Changes to Fraud and Abuse Section in Amendment

- **CHECK MONTHLY** the federal...
 - **List of Excluded Individuals and Entities (LEIE)**
and
 - **Excluded Parties List System (EPLS)** to identify excluded parties during the process of engaging services of new employees, subcontractors and providers during renewal of agreements and recredentialing.
- Report directly to HHS OIG and **copy MPI**

Subcontract Approvals for SIU functions

If a Health Plan subcontracts for the investigation of fraudulent claims and other types of program abuse by enrollees or service providers, the Health Plan shall file the following with the Bureau of Medicaid Program Integrity (MPI) for approval at least sixty **(60) calendar days** before subcontract execution:

- (1) The names, addresses, telephone numbers, e-mail addresses, and fax numbers of the principals of the entity with which the Health Plan wishes to subcontract;
- (2) A description of the qualifications of the principals of the entity with which the Health Plan wishes to subcontract; and
- (3) The proposed subcontract.

The Health Plan shall submit to MPI such executed subcontracts, attachments, exhibits, addendums or amendments thereto, within thirty **(30) calendar days** after execution.

Compliance vs. Anti-Fraud Plan

Compliance Plan required by
42 CFR 438.608

Anti-Fraud Plan is required by
F. S. 409.91212

COMPLIANCE PLAN:

The compliance plan is a broader scope and a federal requirement and is considered an overarching structure in the health plan's program which includes instilling company values, policies, procedures related to anti-fraud and abuse, deterrence to criminal activity, as well as to promote and instill ethics and the define the corporate culture, (e.g. tone from the top) dealing with but not limited to: possible acts of discrimination, misuse of proprietary information, recordkeeping errors, environmental violation, conflict between employees, and other potentially costly issues, standards of conduct (e.g. for fraud and abuse - reasonably capable of reducing the likelihood of criminal conduct; for HR issues – discrimination or cheating on time card), designation of a compliance officer and compliance committee accountable to senior management (these are the purse strings and have the duty to care), effective training of compliance officer and health plan employees, effective lines of communication between the compliance officer and health plan employees, enforcement of standards through well-publicized disciplinary guidelines, provisions for monitoring and auditing, and provisions for prompt response to detected offenses and for development of corrective action initiatives.

Each may share policies/procedures related to anti-fraud and abuse prevention i.e. to deter, detect, investigate, correct, and report. However, the compliance plan is broader in scope and contains other requirements not mentioned in the 409.91212, F.S. and vice versa.

ANTI-FRAUD PLAN:

The scope is narrower in the anti-fraud plan, aimed primarily and more focused on fraud, abuse, and overpayment. The anti-fraud plan must include several items, some of which include the arrangement of an SIU, procedures for detecting and investigation F&A, training personnel (including DRA), and summarizing results of investigations conducted the previous year and reporting to MPI its experience in the implementation with annual report requirements. It also includes the requirement for subcontracting (with MPI approval) if not implementing an SIU unit. HMOs also have a requirement to report their anti-fraud plan to OIR per 69D-2. Now 409.91212, F.S., is in the mix with specific reporting requirements to our MPI/Agency and includes both HMOs and PSNs. (per the legislature)

Reporting Deadlines

- **Anti-Fraud Plan annually – due July 1st**
- **Annual Fraud and Abuse Activity Report – due September 1st annually**
- **MPI Quarterly Fraud & Abuse Activity Report – due 15 calendar days after the end of each reporting quarter (Submit via new web based app)**
- **MPI – Suspected/Confirmed Fraud & Abuse Reporting – Online form due within 15 days of detection**

If you have any fraud and abuse questions or other concerns:

Please submit via email to

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