



# ***Fraud and Abuse Prevention in Medicaid Managed Care Organizations***

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## *Fraud and Abuse*

- 42 CFR 455.1 (Program Integrity: Medicaid) defines “fraud” and “abuse”:
- *Fraud* means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law related to Medicaid.
- *Abuse* means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professional recognized standards for health care. It also includes recipient practices that result in unnecessary costs to the Medicaid program.

## *Licensure, Management and Monitoring of Medicaid Health Maintenance Organizations*

- Agency for Health Care Administration:
  - Division of Medicaid/ Bureau of Health Systems Development.
  - Division of Health Quality Assurance/ Bureau of Managed Health Care.
  - Office of the Inspector General.
- Office of the Attorney General/ Medicaid Fraud Control Unit.
- Office of Insurance Regulation.

## *Agency for Health Care Administration Division of Medicaid*

- Agency for Health Care Administration, Division of Medicaid/ Bureau of Health Systems Development:
  - Responsible for the development and oversight of Medicaid's managed care programs and policy including managing contracts with Medicaid HMOs.
  - Work closely with the Bureau of Managed Health Care in the Division of Health Quality Assurance to oversee the health care delivery provided by Medicaid HMOs.
  - Execute contracts, and provide oversight of all aspects of care provided to Medicaid beneficiaries through managed care organizations.
  - Work to develop managed care plan policy and responsible for managed care contract interpretation.

## *Agency for Health Care Administration Division of Health Quality Assurance*

- Agency for Health Care Administration, Division of Health Quality Assurance/ Bureau of Managed Health Care:
  - Regulatory control over both commercial and Medicaid HMOs.
  - Shares responsibility with Medicaid Health Systems Development for approval of all Medicaid HMO contracts in the state.
  - Responsible for monitoring of all Medicaid HMO contracts in the state.
  - Bureau staff conduct desk and on-site reviews throughout the year to ensure contract compliance.
  - Sanctions/ fines can be levied for:
    - Reporting violations
    - Marketing/ outreach violations
    - Failure to provide services

## *Agency for Health Care Administration Office of the Inspector General*

### ➤ Medicaid Program Integrity:

- Responsible for overseeing the activities of Medicaid recipients, Medicaid providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and for recovering overpayments and imposing sanctions as appropriate.
- Specifically responsible for monitoring and compliance with contract provisions relating to Fraud and Abuse prevention and reporting.
- Actions taken can include:
  - Prepayment review
  - Recommendations for termination
  - Site visits
  - Sanctions
  - Referrals (560 referrals made during SFY 08-09)

## *Office of the Attorney General Medicaid Fraud Control Unit*

- The Office of the Attorney General, through its Medicaid Fraud Control Unit (MFCU), has two primary areas of enforcement responsibility – fraud perpetrated against the Medicaid program by service providers, and abuse, neglect and exploitation of patients residing in a Medicaid-funded facility.
- Enforcement in these areas, which includes both criminal and civil actions, is designed to prevent, detect and **prosecute** these types of misconduct in order to protect the integrity of the Medicaid program as well as the health and safety of Florida citizens.
- Maintain fraud hotline. Under Florida's False Claims Act (F.S. 68.081) , persons who blow the whistle on Medicaid fraud may be entitled to share in any funds recovered by the state. Florida Statutes Chapter 409.9203 provides that persons reporting Medicaid Fraud may be entitled to a reward for their information.

## *Fraud and Abuse Oversight and Prevention in the Managed Care Setting*

- Medicaid experience and data indicate that fraud and abuse is primarily a fee-for-service (FFS) system problem.
- Reducing that marketplace through increased managed care, including increased participation of health maintenance organizations (HMOs), provider service networks (PSNs) and other managed care organizations, will result in cost avoidance and expenditure predictability through additional fraud and abuse prevention.

## *Fraud and Abuse Oversight and Prevention in the Managed Care Setting*

- Medicaid funds paid to a managed care organization are still Medicaid funds from a fraud and abuse perspective.
- Medicaid Managed Care Organizations (MCOs) are paid a monthly capitation rate and have financial incentive to be vigilant about preventing, identifying, and combating fraud and abuse.
- Medicaid Managed Care Organizations must comply with all contract requirements relating to fraud and abuse prevention and reporting.

## *Fraud and Abuse Oversight and Prevention in the Managed Care Setting*

- In 1999, federal Centers for Medicaid and Medicare Services (CMS), Office of the Inspector General, published a report of guidelines for addressing fraud and abuse in Medicaid managed care, which identified potential fraud and abuse risk areas.
  - Procurement of the Managed Care Contract
  - Marketing and Enrollment
  - Underutilization
  - Claims submission and billing procedures
  - Fee-for-service fraud in managed care (network providers)
  - Embezzlement, theft and related fee-for-services fraud.
- The report suggested that states can promote program integrity in Medicaid managed care programs by incorporating language with explicit fraud and abuse measures into contracts, programs, and waivers.

## *Evolution of Contract Requirements*

- As Managed Care expanded within the Florida Medicaid program, requirements regarding fraud and abuse prevention and reporting for plans strengthened along with the increased concentration on issues relating to fraud and abuse throughout the fee-for-services program:
  - 2002: Plans required to develop and maintain written policies and procedures for fraud prevention.
  - 2005: Joint discussions with Florida Association of Health Plans and the Medicaid Fraud Control Unit – develop best practice models and enhanced fraud detection measures.
  - 2006 Contracts: Incorporate additional requirements regarding policies and procedures, compliance officer.
  - 2009 Contracts: New reporting requirements and additional documentation required; FTP site created for monthly reporting.

## *Current MCO Contract Requirements Information for Enrollees*

- Provide enrollees with information about Fraud and Abuse reporting:
  - Provide information on how to report suspected fraud and abuse
  - Handbook must contain procedures for reporting fraud, abuse and overpayment- specifically:
    - *To report suspected fraud and/or abuse in Florida Medicaid, call the Consumer Complaint Hotline toll-free at 1-888-419-3456 or complete a Medicaid Fraud and Abuse Complaint Form, which is available online at*
    - [https://ahcaxnet.fdhc.state.fl.us/InspectorGeneral/fraud\\_complaintform.aspx](https://ahcaxnet.fdhc.state.fl.us/InspectorGeneral/fraud_complaintform.aspx)

## *Current MCO Contract Requirements Compliance Office/ Policies and Procedures*

- Have functions and activities governing program integrity:
  - Utilization management must include reporting fraud and abuse information through the UM program.
  - Maintain adequate staffing and resources to enable the compliance officer to investigate unusual incidents and develop and implement corrective action plans relating to fraud and abuse.
  - Have internal controls and policies and procedures in plan that are designed to prevent, reduce, detect, correct and report know or suspected fraud and abuse activities.
  - Specific controls required include, but are not limited to:
    - Claims edits
    - Post-processing review of claims
    - Prior authorization
    - Utilization management
    - Provider profiling, credentialing, an recredentialing, including a review process for claims and encounters for providers who are suspected of potential fraud and abuse activities

## *Current MCO Contract Requirements Reporting and Data*

- Responsible for reporting suspected fraud and abuse for both participating providers and non-participating providers.
- Report all suspected or confirmed instances of provider or enrollee fraud and abuse under state and/or federal law to MPI within fifteen calendar days of detection.
- For the 2009-2012 MCO contract, a new quarterly reporting requirements was included and a secure FTP site created to provide a mechanism for additional documents, data and report transmittal.
  - This is an increase over prior reporting periods.
  - Result of increased MPI compliance monitoring process.
  - And/or result of SB 1986 (provided immunity to plans reporting providers for fraud and abuse).

## *Other MCO Contract Requirements*

- In addition to the contract requirements specific to fraud and abuse reporting and prevention, other contract and statutory requirements work to ensure that plans are appropriately enrolling and providing services to enrollees:
  - Florida's competitive procurement laws.
  - Marketing restrictions.
  - Performance measure reporting.
  - Encounter data reporting.

## *Detection Using Encounter Data*

- Encounter data are one tool used to detect MCO fraud and abuse.
- Use of encounter data is dependent upon the accuracy and validity of the data elements needed for fraud and abuse pattern detection:
  - Service provider and recipient identifiers.
  - Procedure codes.
  - Product and service descriptions.
  - Provider payment on capitated vs. FFS basis.
- Encounter data validation is proceeding steadily; however, sufficiently validated data are not available for all detection / prevention activities.

## *Program Integrity*

- The Agency's Bureau of Medicaid Program Integrity Increased Oversight.
- 2006-2009 Contract Period:
  - Assessing capabilities of health plans through on-site and desk review
    - Participate in on-site contract monitoring (all plans)
    - Issuing and monitoring corrective action plans
  - Increased MPI involvement in review and approval of required contract elements.
  - Increased communication to and with health plans.
  - Special projects and Generalized and Specific Audits.

## *Program Integrity*

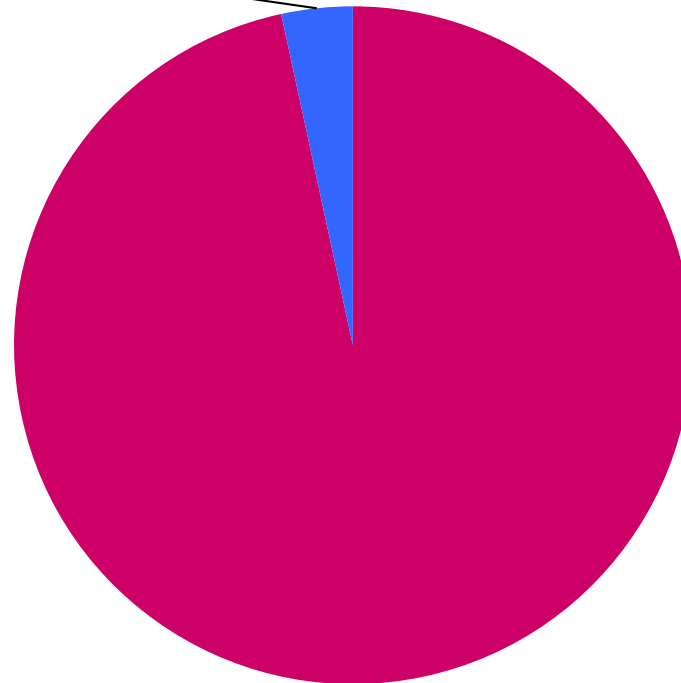
- The Agency's Bureau of Medicaid Program Integrity recently conducted a review of cases conducted from July 1, 2005 through November 30, 2009, and concluded that 97% of those cases were fee-for-service related and 3% were MCO related.
- The chart on the following slide categorizes cases MPI opened for fee-for-services vs. manage care organizations that were initiated as a result of Agency detection efforts.
- The chart does not purport to represent the level of fraud and abuse in any particular arena, but does indicate that with our current detection methodologies used, 97 out of 100 cases opened fell within the fee-for-service arena.
- Stated another way, fee-for-service carries a higher area of concern at this juncture than managed care.

# Medicaid Program Integrity Cases

The chart below categorizes cases MPI opened for fee-for-services vs. manage care organizations that were initiated as a result of our detection efforts.

## 7,418 MPI Cases 7-1-05 thru 11-30-09

HMO, 252 Cases, 3%



Non-HMO, 7166 Cases,  
97%



*Questions?*