Biennial Review of AHCA's Oversight of Fraud and Abuse in Florida's Medicaid Program

Report 24-03

January 2024

OPPAGA

Office of Program Policy Analysis and Government Accountability

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EXECUTIVE SUMMARY

REPORT SCOPE

Section 409.913(35), *Florida Statutes*, directs OPPAGA to biennially review AHCA's efforts to prevent, detect, deter, and recover funds lost to fraud and abuse in the Medicaid program. This is OPPAGA's 11th report.

The Agency for Health Care Administration's (AHCA) Division of Medicaid provides health care for low-income families and individuals and assists the elderly and people with disabilities with nursing facility care costs and other medical and long-term expenses.[1,2]

Statewide Medicaid Managed Care accounts for the majority of state Medicaid expenditures. In Fiscal Year 2022-23 it accounted for 65% of total expenditures, while the fee-for-service program accounted for the remaining 35%.

Florida's Medicaid enrollment grew substantially in the wake of the COVID-19 pandemic. Federal legislation resulted in enrollment increases in Florida and across the nation. When new congressional legislation ended these changes and decreased federal funding, states were required to return to normal eligibility and enrollment operations and to conduct eligibility redeterminations. Florida began redeterminations in April 2023. As of October 2, 2023, AHCA reported that Florida is estimated to have the ninth lowest procedural termination of coverage rate among states.[3]

AHCA's Office of Medicaid Program Integrity has primary responsibility for administering and overseeing fraud and abuse prevention and detection efforts throughout the state's Medicaid program. In this role, AHCA collaborates with federal and state agencies and managed care organizations (MCOs).

AHCA has established annual performance targets for program integrity, with specific emphasis on identifying and preventing overpayments within the Medicaid program. AHCA does not have agency performance targets for the detection and prevention of fraud and abuse. Over the past five fiscal years, the agency has failed to meet its targets for identifying overpayments. During Fiscal Year 2021-22, MCOs identified $187.8 million in overpayments, which was a 23% decrease from the previous fiscal year. In recent years, AHCA has shifted primary responsibility for fraud prevention and detection activities to MCOs. Although these organizations have met AHCA's contractually obligated

[1] Prior Medicaid program integrity reports are available on OPPAGA's website.
[2] Section 409.913, *F.S.*
[3] Procedural terminations occur when recipients have not provided required information to complete the redetermination process. AHCA based this conclusion on analyses of federal and state Medicaid renewal and disenrollment data conducted by the Kaiser Family Foundation.

performance targets for fraud referrals for Fiscal Year 2022-23, the quality and utility of these referrals is unknown.

A U.S. Department of Health and Human Services, Office of Inspector General report estimated that in August 2020, AHCA made capitation payments on behalf of over 55,000 Medicaid enrollees concurrently enrolled in another state, resulting in $15.8 million in total program costs.[4] An estimated $6.9 million of these payments were made on behalf of recipients no longer residing in Florida.

In recent years, AHCA has reportedly made efforts to enhance Medicaid program integrity by improving data quality, data analytics, and program oversight. Consistent with prior reports, OPPAGA recommends that AHCA consider taking steps to improve data analytics and program oversight, with particular emphasis on the utility of internal and external performance measures and inter-agency communication.

[4] Capitation payments are fixed monthly payments per beneficiary enrolled in a managed care organization.

INTRODUCTION

The Agency for Health Care Administration (AHCA) is divided into several divisions with numerous responsibilities. One of these responsibilities is administration and oversight of Florida's Medicaid program. AHCA operates the Medicaid program using the Statewide Medicaid Managed Care (SMMC) and fee-for-service (FFS) delivery systems. During 2020, the Medicaid program was impacted by the public health emergency caused by the COVID-19 pandemic. This resulted in federal legislation that substantially increased Medicaid enrollment. However, recent federal legislation has initiated a return to pre-pandemic enrollment and eligibility requirements. The Office of Medicaid Program Integrity (MPI) is responsible for fraud and abuse monitoring within the Medicaid program and collaborates with federal and state entities to support prevention, detection, and deterrence activities.

AHCA is Florida's chief health care policy and planning entity and administers the state's Medicaid program

As the state's chief health policy and planning entity, AHCA has numerous responsibilities pertaining to all aspects of health care. These responsibilities include

- administering the Medicaid program;
- licensing, inspecting, and regulating health facilities;
- certifying health maintenance organizations and prepaid health clinics;
- investigating consumer complaints related to health care facilities and managed care organizations (MCOs);
- implementing the certificate of need program;
- administering contracts with the Florida Healthy Kids Corporation; and
- operating the Florida Center for Health Information and Transparency.

The agency has 1,543.5 approved employee positions, and its total operating budget for Fiscal Year 2023-24 is $41.1 billion.

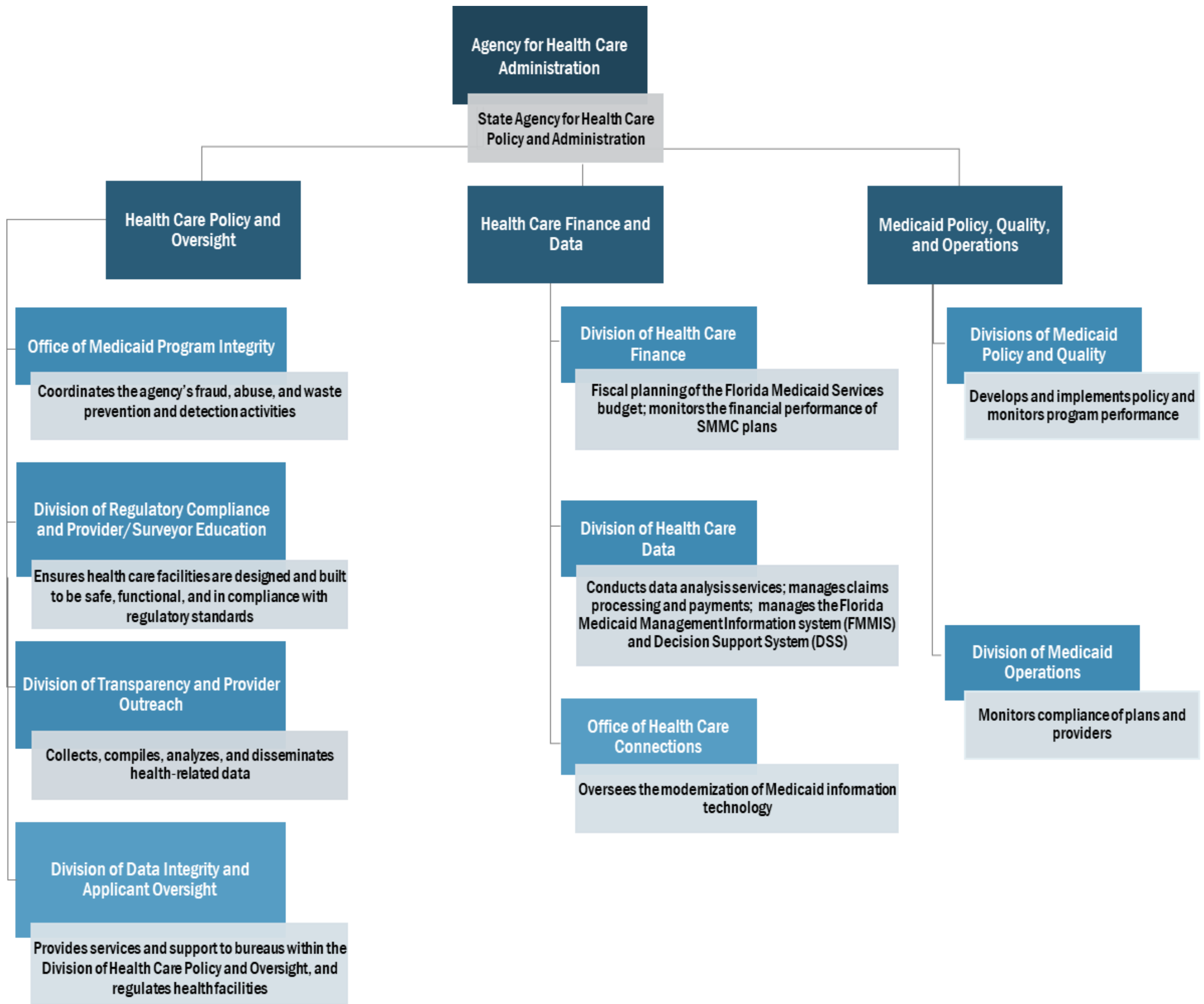
Florida's Medicaid program facilitates health care for low-income families and individuals and assists the elderly and people with disabilities with nursing facility care costs and other medical and long-term expenses.[5] The program is among the largest in the country, serving approximately 4.4 million persons each month as of October 2023. For Fiscal Year 2023-24, the Legislature appropriated $41 billion to operate the Medicaid program.[6,7]

AHCA is comprised of several divisions, many of which have units with Medicaid-related responsibilities and functions. (See Exhibit 1.) Health care policy and oversight is provided by the Office of Medicaid Program Integrity and the divisions of Regulatory Compliance and Provider/Surveyor Education, Transparency and Provider Outreach, and Data Integrity and Applicant Oversight. Health care finance and data is comprised of the divisions of Health Care Finance and Health Care Data and the Office of Health Care Connections. Lastly, Medicaid policy, quality, and operations

[5] Medicaid is a joint federal and state program where the federal government reimburses states a portion of expenditures according to a federal matching process.
[6] Of the total Medicaid budget for Fiscal Year 2023-2024, $9.9 billion is from general revenue and $31.1 billion is from trust funds.
[7] The remaining $124.9 million are appropriated for operation, administration, and support and health care regulation.

includes the divisions of Medicaid Policy and Quality and Medicaid Operations. Additionally, the Florida Department of Children and Families is responsible for determining Medicaid eligibility for recipients in Florida.

Exhibit 1
AHCA Fulfills Medicaid Responsibilities via Multiple Divisions[1]



[1] This is a general overview of the divisions within AHCA. The offices of the general counsel, inspector general, and chief of staff are not represented in this exhibit.

Source: OPPAGA analysis of AHCA organizational chart and website.

AHCA operates Florida's Medicaid program using the Statewide Medicaid Managed Care and fee-for-service delivery systems. Under the SMMC payment system, AHCA contracts with private MCOs for the coordination and payment of services for Medicaid recipients. The state pays the MCOs a capitation payment, which is a fixed monthly payment per beneficiary enrolled in the MCO. In return for the capitated payment, each MCO is required to arrange for and pay providers for all covered services delivered to Medicaid beneficiaries. Under the FFS payment system, providers first deliver services to Medicaid recipients, then bill the state on an individual or itemized basis, and the state Medicaid program subsequently reimburses the providers.[8] Individuals may qualify for full-scope

[8] Certain services provided to SMMC enrollees are reimbursed under FFS, including behavior analysis, organ transplants, and obstetrical care.

Medicaid benefits or limited benefits. Individuals who qualify for full-scope benefits are entitled to all mandatory and optional benefits covered under the Medicaid state plan.[9] Individuals who do not qualify for full-scope benefits may receive limited benefits, also referred to as restricted or partial benefits. These include the Medically Needy Program and the Medicare Savings Program. In 2021, 94% of the FFS population received limited benefits, 78% of whom were eligible for both Medicare and Medicaid.[10]

The SMMC program currently operates via an 11-region structure through contracts with multiple health plans providing a range of services. There are nine SMMC health plans, some of which also offer long-term care services; five specialty plans provide coverage for children with chronic conditions, children in the child welfare system, individuals living with HIV/AIDS, and individuals with serious mental illness; and three dental plans provide services.[11,12,13] Of these, three SMMC health plans, four specialty plans, and all three dental plans are available in all regions. The 2022 Legislature amended Florida statutes to revise the regional structure for plan selection to 9 lettered regions rather than 11 numbered regions in anticipation of the competitive procurement process for the 2025 plan year.[14] (See Appendix A for additional information about the plans and services provided in each region and the current and revised regional structures.)

From Fiscal Year 2017-18 to Fiscal Year 2022-23, total Medicaid expenditures increased $10.5 billion, from $22.9 billion to $33.4 billion. (See Exhibit 2.) Historically the SMMC program has accounted for the majority of total Medicaid expenditures, accounting for approximately two-thirds of total Medicaid expenditures. AHCA reported that in Fiscal Year 2022-23, 65% of Medicaid expenditures were related to SMMC and 35% were for FFS.

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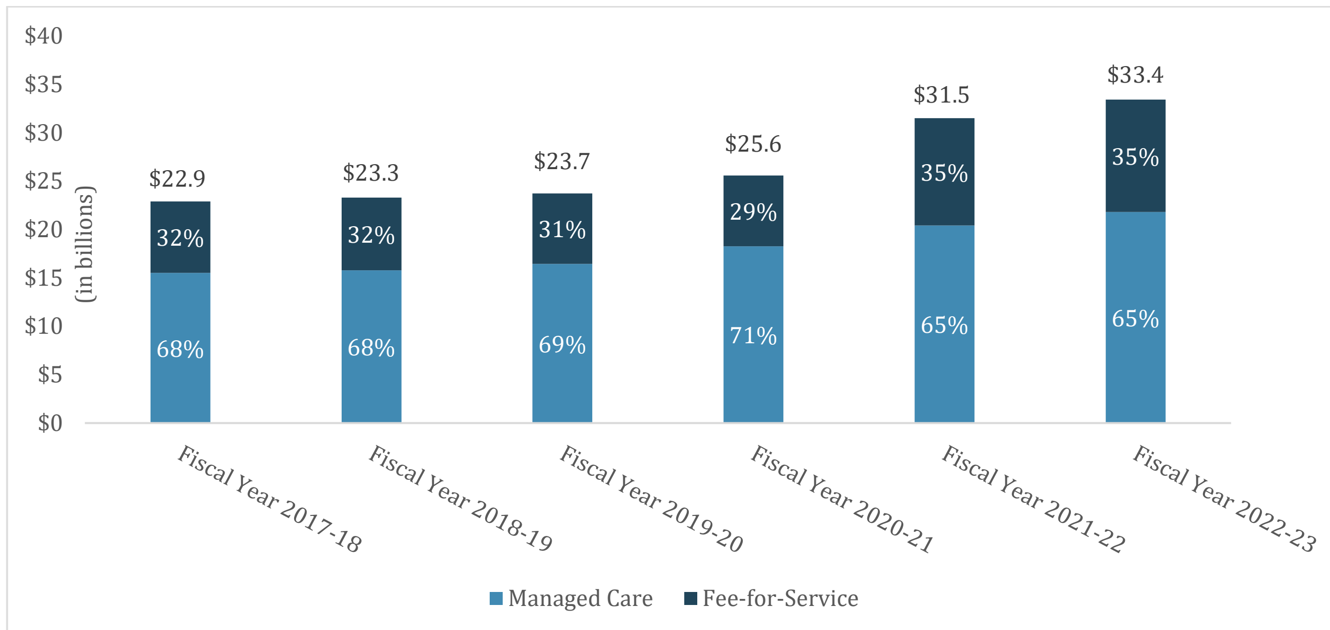
[9] Medicaid coverage groups that have full benefits in Florida are Medicaid for aged and disabled individuals; Modified Project Aids Care; Institutional Care Program; hospice; Home and Community Based Services waiver; and Program of All-Inclusive Care for the Elderly.
[10] Depending on the Medicare eligibility category, Medicaid may cover all or part of the cost-sharing obligations or may cover the cost of services that are not covered by Medicare, such as long-term care, eyeglasses, dentures, and hearing aids.
[11] SMMC health plans are Aetna Better Health, Amerihealth, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine Health, and United-Healthcare. Amerihealth and Community Care Plan do not offer long-term care services and Simply Healthcare offers long-term care in five of the nine regions it serves.
[12] The SMMC specialty plans are Children's Medical Services Plan for children with chronic conditions, Sunshine Health Child Welfare, Clear Health Alliance – HIV/AIDS, Molina Healthcare Serious Mental Illness, and Sunshine Serious Mental Illness.
[13] The SMMC dental plans are DentaQuest, Liberty, and MCNA Dental.
[14] See Ch. 2022-42, *Laws of Florida.*

Exhibit 2
From Fiscal Year 2017-18 to Fiscal Year 2022-23, Total Medicaid Expenditures Increased From $22.9 Billion to $33.4 Billion



Source: OPPAGA analysis of AHCA data.

The Florida Medicaid Management Information System is AHCA's central system for service claims processing and information retrieval. FFS providers submit claims to Gainwell Technologies, the fiscal agent for the Medicaid program, while SMMC providers submit claims to MCOs. Providers and MCOs submit claims and encounter data to the Florida Medicaid Management Information System (FMMIS).[15,16] AHCA has begun the multi-year Florida Health Care Connections (FX)/FMMIS Transition Program to modernize the agency's Medicaid technology. The transition program will help ensure that Florida complies with federal Centers for Medicare and Medicaid Services (CMS) rule changes, which were intended to increase the use of CMS Medicaid Information Technology Architecture, and other CMS conditions and standards.[17] The project also will enable additional U.S. Department of Health and Human Services data to be incorporated into the system. According to AHCA documents, the transition is expected to be completed in Fiscal Year 2026-27 and will result in a unified and interoperable system that complies with federal regulations.

[15] Encounter data captures individual services provided by a capitated managed care entity.
[16] The fiscal agent is responsible for financial duties for the Medicaid program, which includes enrolling providers in the Medicaid program, processing claims, issuing payments, and providing technical support.
[17] The transition program includes replacing the current fiscal agent services, FMMIS, the decision support system, and upgrading other related functions.

Florida's Medicaid enrollment grew due to COVID-19 and related federal legislation; over two million Medicaid eligibility redeterminations were completed from April 2023 through August 2023

In March 2020, Congress enacted the Families First Coronavirus Response Act, requiring state Medicaid programs to keep recipients continuously enrolled through the end of the public health emergency in exchange for enhanced federal funding.[18] Under the act, states received an additional 6.2% in Federal Medical Assistance Percentage (FMAP) funds during the public health emergency.[19] To receive FMAP funding, CMS prohibited states from disenrolling Medicaid recipients unless individuals moved out of state, requested to be disenrolled, or died. Due to the continuous enrollment provision, Medicaid enrollment increased substantially compared to previous years. Nationally, Medicaid enrollment rates grew from 64.8 million in March 2020 to over 87 million in March 2023 (a 34% increase in enrollment). During a similar period (March 2020 to April 2023), Florida's Medicaid program also experienced a significant increase in the number of recipients, from 3.8 million to almost 5.8 million (a 54% increase in enrollment).

In December 2022, Congress enacted the Consolidated Appropriations Act ending the continuous enrollment provision and allowing states to terminate enrollment for ineligible recipients following a redetermination. States were required to return to normal eligibility and enrollment operations and conduct redeterminations in accordance with federal requirements. Further, the enhanced federal funding gradually decreased as states processed applications and renewals and returned to normal redetermination procedures.[20] States were eligible for a gradual reduction of the enhanced federal funding if states comply with certain rules outlined under the act.[21] As of April 2023, states may conduct redeterminations for all Medicaid enrollees and disenroll recipients who are no longer eligible for Medicaid according to applicable federal requirements. States have 12 to 14 months to initiate and complete renewals for all recipients currently enrolled in Medicaid.

Florida began redeterminations in April 2023.[22] According to AHCA, 4.6 million recipients will have their cases redetermined by the Department of Children and Families (DCF) over a 12-month period. Prior to redetermination (March 2020 to April 2023), total Medicaid enrollment increased by 54% (from 3.8 million to 5.8 million; managed care enrollments increased by more than 1.6 million and fee-for-service enrollments increased by 372,944. (See Exhibit 3.) Since redetermination began in April

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[18] The Secretary of the U.S. Department of Health and Human Services may declare a public health emergency when they determine that (1) a disease or disorder presents a public health emergency, or (2) a public health emergency, including significant outbreaks of infectious diseases or bioterrorist attacks, otherwise exists. [42 U.S.C. § 247d](2024).

[19] Beginning in January 2020, the FMAP was increased by 6.2%, thereby bringing Florida's FMAP to 67.67%. Since the enactment of the Consolidation Appropriation Act, 2023, Florida's FMAP decreased slightly from 67.67% in FY 2020 to 66.25% in FY 2023.

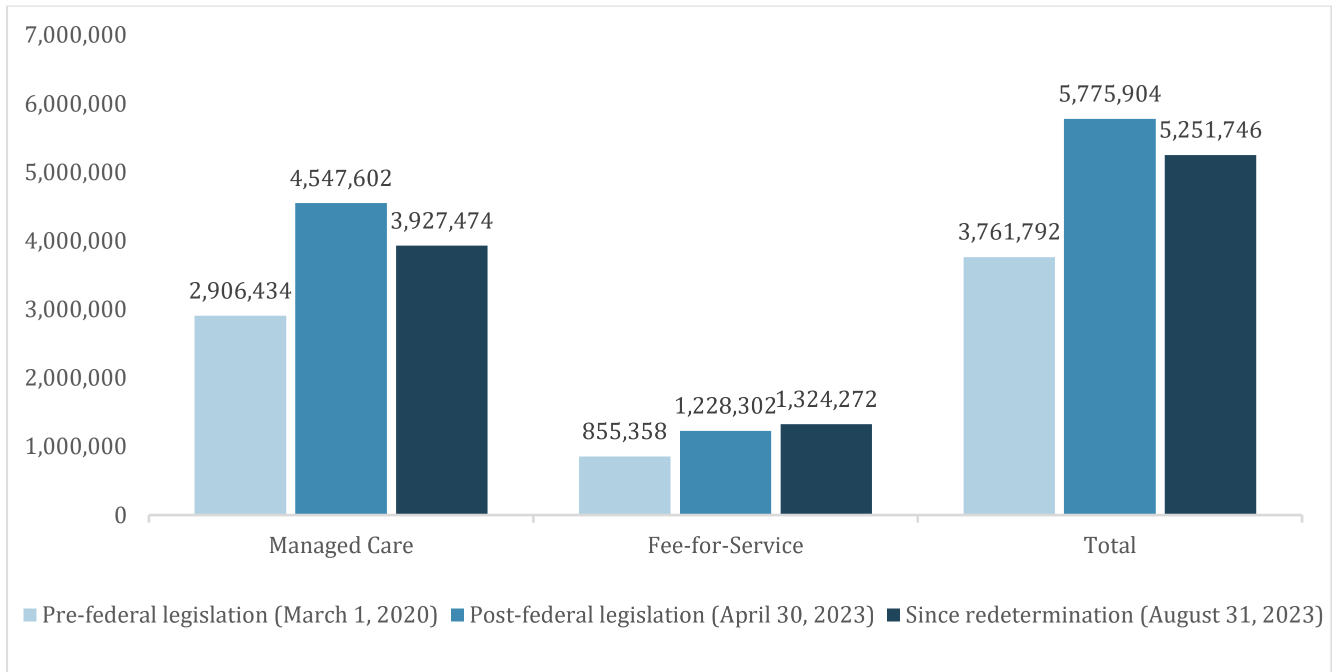
[20] The act provided a 6.2 percentage point increase in FMAP funds. The percentage point increase reduced in each subsequent quarter to 5.0 as of April 1, 2023; 2.5 as of July 1, 2023; and 1.5 as of October 1, 2023.

[21] To qualify for the phase-down of the enhanced federal funding, states could not restrict eligibility standards, methodologies, or procedures and increase premiums as prohibited in the act. Additionally, states had to comply with federal renewal rules, maintain the most up-to-date contact information, and attempt to contact enrollees before disenrollment. States also had to adhere to certain reporting requirements to maintain the federal funding enhancement through December 2023.

[22] Redetermination refers to the process of renewing enrollees' eligibility for Medicaid and Children's Health Insurance Program benefits through an *ex-parte* basis or renewal form.

2023, total Medicaid enrollment has decreased by 9% (from 5.8 million to 5.3 million) while managed care enrollment decreased by 620,128 (14%) and fee-for-service increased by 95,970 (8%).

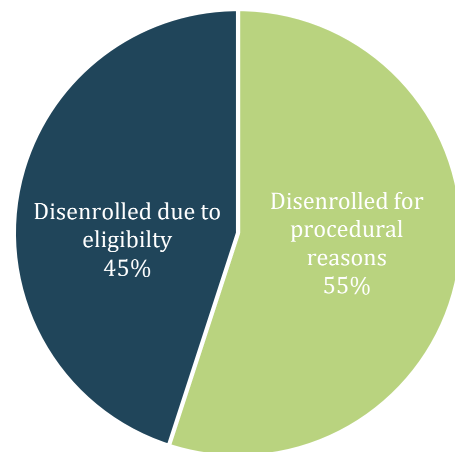
Exhibit 3
Florida Medicaid Enrollment Decreased Due to Redeterminations



Source: OPPAGA analysis of AHCA data.

DCF completed over 2.2 million redeterminations of Medicaid enrollees from April 2023 through August 2023. Of these enrollees, 1.5 million (67%) recipients were determined eligible, while over 746,000 recipients (32%) were determined ineligible and subsequently disenrolled. Of the recipients who were disenrolled, 55% were terminated for procedural reasons by DCF and 45% were terminated due to eligibility. (See Exhibit 4.) Procedural terminations include recipients who did not provide necessary information in a timely manner to complete the renewal process. Florida has the ninth lowest procedural termination rate in the nation. AHCA reported using a comprehensive outreach communication plan.[23] DCF will continue redeterminations for the remaining 2.4 million Medicaid recipients through March 2024.

Exhibit 4
Most Ineligible Recipients Were Disenrolled for Procedural Reasons



Source: Kaiser Family Foundation, *Medicaid Enrollment and Unwinding Tracker.*

[23] DCF created a robust outreach initiative consisting of emails, text messages, and automated calls to Medicaid recipients. On average, enrollees received 5 to 13 contact attempts from DCF. As a result of an extensive communication plan, 87% of recipients in Florida responded to Medicaid redetermination notices, higher than the national average.

MPI is primarily responsible for Medicaid fraud and abuse prevention and detection, which includes contracting with and monitoring MCOs and overseeing the FFS system

As required by statute, AHCA's MPI has primary responsibility for administering and overseeing fraud and abuse prevention and detection efforts for both managed care and fee-for-service systems.[24,25] MPI identifies and investigates providers suspected of fraud and abuse; ensures that SMMC contracted health plans comply with Medicaid requirements to prevent, detect, and deter abusive and fraudulent practices; acts as the lead coordinator for all integrity efforts; and collaborates with federal and state agencies and entities to support activities in these areas.[26]

Fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to themselves or another person. The term includes any act that constitutes fraud under applicable federal or state law.

Abuse is either

- provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care; or
- recipient practices that result in unnecessary cost to the Medicaid program.

MPI uses various methods to identify potential cases of fraud, abuse, or overpayment. These methods include conducting ad hoc statistical analysis of Medicaid overpayments to providers and reviewing complaints submitted to the Medicaid online complaint form, media inquiries, or referrals from other providers or state agencies.[27] MPI cases may also be investigator initiated (e.g., in the course of routine record reviews or provider audits).

MPI reviews program-integrity related aspects of MCO contracts, within the SMMC program. MCOs are required to comply with both state and federal requirements to prevent, detect, and deter abusive and fraudulent practices. MCOs are responsible for monitoring and reporting potential and verified instances of fraud and abuse. Both MCOs and MPI refer cases of suspected fraud to the Florida Office of the Attorney General's Medicaid Fraud Control Unit (MFCU) for criminal and civil investigation and prosecution.[28] MPI works closely with MFCU to develop and implement data mining activities, conduct statistical analyses, and educate all relevant parties about fraud and abuse.

[24] Section 409.913, *F.S.*
[25] MPI's Fiscal Year 2022-23 approved operating budget is $7.3 million, all of which is derived from the Medical Care Trust Fund; trust fund includes funds recouped from past program integrity efforts and a 50% federal match for MPI functions. The operating budget includes funding for 81.5 FTE positions.
[26] More generally, AHCA, MCOs, and other stakeholders also rely on resources from the federal government, such as data from the U.S. Department of Health and Human Services Office of Inspector General's list of excluded individuals/entities, which details providers and entities that are not permitted to receive payment from federal health care programs.
[27] Section 409.913(2)(b), *F.S.*, defines a complaint as an allegation that fraud, abuse, or an overpayment has occurred.
[28] MFCU submits data about individuals convicted of Medicaid fraud to the National Practitioner Data Bank exclusions list.

> **Overpayments** include any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake.

One way fraud and abuse may present is through overpayments to providers. MPI may initiate an investigation of a MCO or provider's payment records for several reasons, including when MPI conducts routine reviews, random auditing, formal investigations, and statistical analyses. If MPI opens an overpayment recovery audit, the MCOs and providers are required to submit documentation. The investigator then reviews the documentation for compliance with Medicaid policies. When appropriate, the investigator develops audit findings and AHCA issues a final order that establishes the overpayments that the provider must repay, including the agency's investigative costs and payment for any sanctions assessed.[29,30] MPI applies punitive and monetary sanctions for providers failing to comply with Medicaid policies as a deterrent.[31,32] Some overpayment cases do not result in sanctions because of Medicaid amnesty programs. Pursuant to statute, MPI grants amnesty from sanctions when a Medicaid provider performs a self-audit and voluntarily repays the overpayment.[33]

AHCA uses the Fraud and Abuse Case Tracking System (FACTS) to document complaints about Medicaid providers, plans, and recipients, and to track investigations related to Medicaid fraud and abuse. MPI updated FACTS software in May 2023. The purpose of the update was to replace the system platform because the previous platform was no longer supported.

FINDINGS

As part of its Medicaid oversight responsibilities, the Agency for Health Care Administration continues efforts to detect, prevent, and deter fraud, abuse, and overpayment within the Medicaid program. AHCA also continues to prioritize efforts to identify and prevent overpayments. The agency has set annual performance targets for identifying and preventing overpayments, though the agency does not set performance targets for other agencies' fraud and abuse prevention activities. AHCA also ensures that Statewide Medicaid Managed Care contracted health plans use performance targets for fraud referrals to comply with Medicaid requirements to prevent, detect, and deter abusive and fraudulent practices. The agency uses data analytics to identify potential fraud and improve Medicaid Program Integrity's Fraud and Abuse Case Tracking System.

[29] Section 409.913(23), *F.S.*, grants AHCA the authority to recover investigative, legal, and expert witness costs.
[30] Prior to issuing the final order, the provider may appeal MPI's findings by requesting an informal hearing with the agency's general counsel or a formal hearing with the Division of Administrative Hearings.
[31] Sanctions include fines, provider terminations, and provider suspensions.
[32] Severity and conditions for sanctions are specified in r. 59G-9.070, *F.A.C.*
[33] Section 409.913(25)(e), *F.S.*, allows AHCA to suspend these sanctions when it grants amnesty.

AHCA continues to identify cases of fraud, abuse, and overpayment; use of self-audits to identify overpayments has increased, but recoupment amounts have remained stable

Over a five-year period, MPI initiated or reviewed over 13,000 fraud and abuse complaints. MPI most often identified overpayment cases through special projects, although increasingly, providers have used self-auditing processes to identify overpayments. For Fiscal Year 2021-22, MPI did not meet the established goal for identifying overpayments. During the same period, SMMC health plans reported recovering three-quarters of overpayments and one-third of funds lost to fraud and abuse. The U.S. Department of Health and Human Services Office of Inspector General (OIG) identified instances of Medicaid recipients simultaneously enrolled in Florida and another state. In Florida, DCF is responsible for Medicaid eligibility determinations. Although instances of simultaneous enrollment are not defined as overpayment, these enrollments resulted in the Florida Medicaid program incurring nearly $7 million in costs.

MPI initiated or reviewed over 2,000 fraud and abuse complaints each fiscal year between Fiscal Year 2017-18 and Fiscal Year 2021-22. The intake and assessment of fraud and abuse complaints is one of MPIs core detection activities.[34,35] Between Fiscal Year 2017-18 and Fiscal Year 2021-22, new reports of fraud and abuse complaints ranged from 2,328 to 3,040 per fiscal year, 68% of which were received through MPI's online complaint form. In Fiscal Year 2021-22, AHCA opened 2,584 distinct complaints against Medicaid providers, non-Medicaid providers, and Medicaid recipients; during the same period, the agency closed 3,062 complaints, some of which were opened in previous fiscal years.

Complaints are closed by being accepted as a case for further investigation, referred to other units or agencies, or declined with an indication that no further action is needed. Of the 3,062 complaints closed in Fiscal Year 2021-22, 53.4% (1,634) were referred to another AHCA unit or another agency, 42.1% (1,289) were declined with an indication that no further action was needed, and 4.4% (135) were elevated to a case for further investigation. (See Exhibit 5.) Of those that MPI referred to another AHCA unit or another agency, 55.9% were MCO submissions of individual complaints about fraud and abuse that were referred for instances that are also included in aggregate MCO-provided Quarterly Fraud and Abuse Activity Reports (QFAAR).[36]

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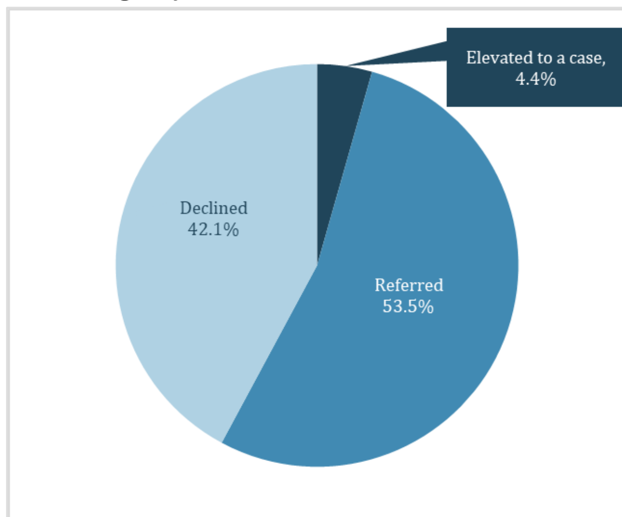
[34] AHCA's FACTS categorizes initial investigations as complaints; however, complaint records include, but are not limited to, referrals from other agencies, internal AHCA referrals, submissions via the MPI web portal, and federal CMS referrals.
[35] Other core detection activities include data analysis, preliminary investigations, and MCO program integrity-related oversight.
[36] MCOs submit individual complaints about fraud and abuse to MPI for inclusion in FACTS. MCOs also submit summarized referral counts in aggregate reports to MPI on an annual basis.

Exhibit 5
More Than Half of Complaints That MPI Closed in Fiscal Year 2021-22 Were Referred to Another AHCA Unit or Another Agency[1,2,3]



[1] OPPAGA summarized Fiscal Year 2021-22 data because it was the last full fiscal year with complete data in the current FACTS system.
[2] Four closed complaints had no recommendation recorded and are excluded from these figures.
[3] Percentages do not total to 100% due to rounding.
Source: OPPAGA analysis of AHCA data.

MPI most often identified overpayment cases through special projects, although increasingly, overpayments are identified through self-auditing processes. One of MPI's primary functions is overpayment recoupment. Overpayments include any amount that is not authorized to be paid by the Medicaid program whether paid because of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or an error. From Fiscal Year 2017-18 through Fiscal Year 2020-21, the majority of overpayment dollars identified in closed cases was associated with an AHCA special project.[37] However, in Fiscal Year 2021-22, the share of overpayment cases associated with special projects was lower than in most of the previous four fiscal years. AHCA's recent emphasis on provider self-audits may partially explain this decline.[38] Consistent with AHCA's emphasis, both the total number of self-audits and the number of cases with overpayments identified through self-audits increased substantially; overpayment cases with self-audits increased from 163 in Fiscal Year 2017-18 to 439 in Fiscal Year 2021-22. However, during the same period, the overpayment dollar amount associated with self-audits decreased from $2.3 million to $2.1 million.[39]

In Fiscal Year 2021-22, AHCA closed 1,397 fraud and abuse cases, 682 (48.8%) of which identified overpayments to providers. The overpayments identified amounted to $22.5 million, the majority of which were for fee-for-service expenditures.[40,41]

From Fiscal Year 2017-18 through Fiscal Year 2021-22, MPI closed 3,363 cases with overpayments totaling $119.7 million. During the five year period, the number and percentage of overpayment cases with sanctions applied declined from 104 (24% of 436 cases) in Fiscal Year 2017-

[37] Special projects are focused, data-driven, field initiatives designed to address identified program needs and vulnerabilities. This includes projects that aim to identify and examine fraud and abuse, and the overutilization of Medicaid services (e.g., the Comprehensive Care Management pilot project and Telephonic Home Health Services Delivery Monitoring and Verification (DMV) Program).
[38] Self-audits can assist providers in identifying problems, may allow providers to avoid an external audit, and can allow states to focus resources more on recovering improper payments.
[39] The dollar amount associated with self-audits, as with other types of cases, fluctuates from year to year and these differences do not indicate a linear trend.
[40] OPPAGA summarized Fiscal Year 2021-22 data because it was the last full fiscal year with complete data in the current FACTS system.
[41] These overpayments represent approximately 0.4% of estimated FFS expenditures during the same period.

18 to 44 (6% of 682 cases) in Fiscal Year 2021-22.[42] (See Exhibit 6.) Total fines MPI imposed on providers for overpayments ranged from $3.2 million in Fiscal Year 2018-19 to $364,000 in Fiscal Year 2020-21.[43] MPI offers a reprieve from the imposition of a sanction when a provider voluntarily repays an overpayment without the agency pursuing an administrative remedy. In Fiscal Year 2021-22, MPI did not apply sanctions in 638 of the 682 cases (94%), primarily because providers performed self-audits (439 cases; 69% of non-sanctioned cases). In 199 cases (31%), MPI did not apply sanctions because providers voluntarily repaid identified overpayments.

Exhibit 6

Although the Number of Overpayment Cases Increased From Fiscal Year 2017-18 to Fiscal Year 2021-22, the Share of Overpayment Cases With Fines Applied Declined During the Same Period

Fiscal Year	Number of Cases with Overpayments Identified[1]	Dollar Amount of Overpayments Identified (in millions)	Number of Overpayment Cases With Fines Applied[2]	Percentage of Overpayment Cases With Fines Applied	Amount of Overpayments Associated With Cases With Fines (in millions)	Total Amount of Fines Levied/ Imposed (in millions)[3]
2017-18	436	$18.1	104	24%	$10.9	$1.9
2018-19	491	$32.6	114	23%	$24.7	$3.2
2019-20	547	$27.7	121	22%	$18.9	$2.3
2020-21	1,207	$18.8	69	6%	$3.0	$0.4
2021-22	682	$22.5	44	6%	$1.9	$0.7
Total	**3,363**	**$119.7**	**452**	**13%**	**$59.4**	**$8.4**

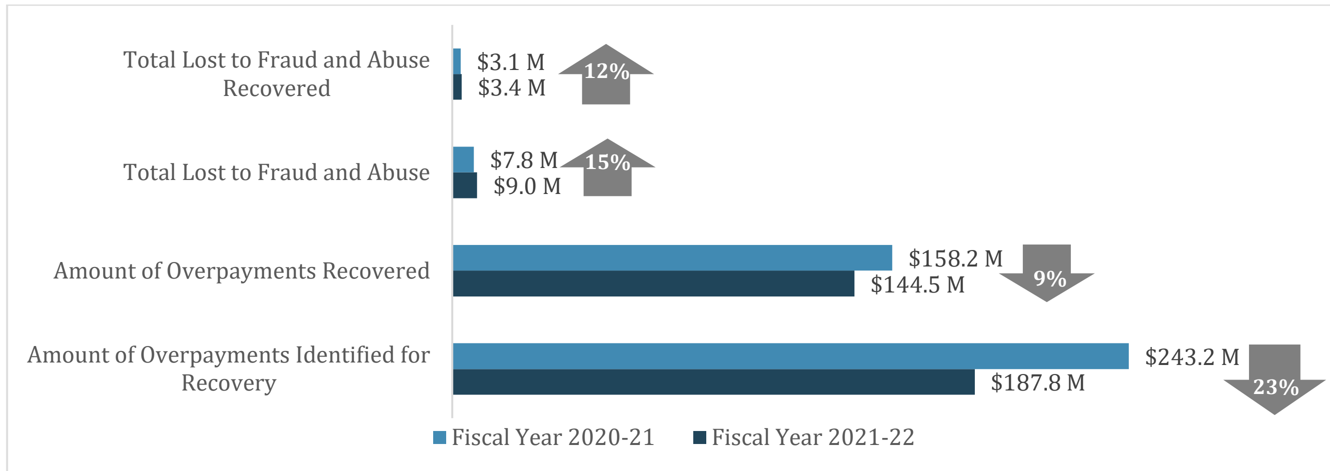
[1] Providers may be associated with more than one case. For example, in Fiscal Year 2021-22, 401 providers were associated with 682 cases.
[2] With the exception of two cases, the only sanctions applied in overpayment cases were fines; one provider with an overpayment case had a suspension and another had a termination, both in Fiscal Year 2018-19. In all years except Fiscal Year 2021-22, the number of providers with fines was the same as the number of cases; in Fiscal Year 2021-22, two providers had more than one overpayment case with fines.
[3] OPPAGA classified cases with fines as those that were closed and were either included in AHCA's public final order database or had an indication in FACTS that the case had a final order that was sustained. Data in the table include four cases with $557,564 in fines that were in FACTS but not in the public final order database.

Source: OPPAGA analysis of AHCA data.

During Fiscal Year 2021-22, MCOs identified fewer dollars in overpayments than in Fiscal Year 2020-21, but had relatively high recovery rates of these funds. From Fiscal Year 2020-21 to Fiscal Year 2021-22, the total dollar amount in overpayments that MCOs identified decreased by 23% and the total amount in overpayments recovered decreased by 9%. In contrast, during the same two-year period, MCOs identified 15% more dollars lost to fraud and abuse and recovered 12% more of these funds compared to the previous year. (See Exhibit 7.) However, a further analysis of the data shows that MCOs are more successful in recovering overpayments than funds identified as lost to fraud and abuse. MCOs recovered 77% ($144.5 million of $187.8 million) of overpayments identified in Fiscal Year 2021-22 and 65% of overpayments identified in Fiscal Year 2020-21 ($158.2 million of $243.2 million). During the same period, MCOs recovered 38% of funds identified as lost to fraud and abuse (38% in Fiscal 2021-22 and 39% in Fiscal Year 2020-21). (See Appendix B for additional information on MCOs' anti-fraud activities.)

[42] Sanctions can include fines, suspensions, and terminations. With two exceptions (one suspension and one termination, both in Fiscal Year 2018-19) the only sanctions for overpayment cases from Fiscal Year 2017-18 through Fiscal Year 2021-22 were fines. OPPAGA classified cases with fines as those that were closed and were either included in AHCA's public final order database or had an indication in FACTS that the case had a final order that was sustained. Data in the table include four cases with a total of $557,564 in fines were in the FACTS but not in the public final order database.
[43] An additional 16 cases with no overpayments identified had final orders indicating fines totaling $55,927 for actions other than overpayments.

Exhibit 7
MCOs Recovered More Dollars Lost to Fraud and Abuse and Fewer Dollars in Overpayments in Fiscal Year 2021-22 Than in Fiscal Year 2020-21



Source: OPPAGA analysis of AHCA data.

The U.S. Department of Health and Human Services OIG identified instances of Medicaid recipients simultaneously enrolled in Florida and another state, resulting in estimated costs of $6.9 million. In Florida, DCF is responsible for Medicaid eligibility determinations. In February 2023, OIG reported that AHCA made Medicaid capitation payments for recipients concurrently enrolled in a managed care program in another state.[44] Specifically, OIG found that AHCA made payments for over 55,000 enrollees who were concurrently enrolled in another state from July 2020 through September 2020, totaling $15.8 million. In an audit based on a stratified random sample of 100 Florida Medicaid recipients, OIG determined that 56 enrollees were residing in Florida and 44 were residing and concurrently enrolled in another state.[45] Of the 44 enrollees concurrently enrolled in another state, Florida made capitation payments totaling $22,624. Based on the sample results, OIG estimated that AHCA incurred costs of $6.9 million ($4.7 million federal share) for per-member, per-month payments on behalf of recipients no longer residing in Florida.[46,47]

The Public Assistance Reporting Information System (PARIS) provides states enrollee information quarterly by matching state and federal eligibility, including Medicaid data.[48] States use PARIS to identify possible concurrent enrollment and erroneous payments. States must have an eligibility system that provides data matching through the PARIS system to receive Medicaid funding. PARIS sends notifications of potential payments for recipients concurrently enrolled in another state. States must determine whether an enrollee should continue to receive services and must contact the recipient prior to terminating enrollment.

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[44] U.S. Department of Health and Human Services, Office of Inspector General. *Florida Made Capitation Payments for Enrollees Who Were Concurrently Enrolled in a Medicaid Managed Care Program in Another State*. February 2023. https://oig.hhs.gov/oas/reports/region5/52100028.pdf.

[45] OIG selected a stratified random sample of 100 Florida Medicaid managed care enrollees with capitation payments in August 2020 using validated data and other personal identifying information. OIG then reviewed supporting documents to determine which state the enrollee was residing in and whether they were receiving benefits in another state.

[46] Federal share refers to the federal government's portion of Medicaid service expenditures. The federal share is determined by the federal medical assistance percentage rate, which varies by state and depends on a formula set in statute.

[47] AHCA contracts with MCOs that subcontract with providers to deliver services to Medicaid recipients. MCOs provide fixed per-member, per-month capitation payments to providers for rendered services. The federal government pays a share of Florida's medical assistance expenditures under Medicaid based on the federal medical assistance percentage. Per federal law, states are required to render services to eligible recipients, including those who are absent from the state, unless an enrollee establishes residency in another state for Medicaid eligibility purposes.

[48] Prior to the 2023 OIG audit, Florida suspended the use of the PARIS interstate match data and temporarily stopped processing annual eligibility redeterminations during the COVID-19 pandemic. However, previous audits found that concurrent Medicaid enrollment was an issue in Florida before the public health emergency.

The 2023 OIG report noted that PARIS did not always notify AHCA about enrollees concurrently enrolled in another state. For example, AHCA did not receive notification for 30 of the 44 sampled enrollees who were residing in another state. OIG also determined that AHCA did not always identify and terminate enrollment for recipients concurrently enrolled in Medicaid in another state after PARIS alerts. For instance, AHCA failed to terminate enrollment for 14 of the 44 sampled enrollees after receiving notification of possible concurrent enrollment.

OIG recommended that AHCA resume and enhance procedures in accordance with federal requirements and the state's redetermination plan to identify and disenroll recipients concurrently enrolled in another state. Additionally, OIG recommended that AHCA collaborate with CMS to consider the potential use of Transformed Medicaid Statistical Information System (T-MSIS) data to help identify potential cases of concurrent enrollment. T-MSIS is a federal system, maintained by CMS, that collects state data on Medicaid enrollment, eligibility, and claims data as well as data from the Children's Health Insurance Program.

Agency staff reported meeting with CMS representatives in March 2023 to discuss a corrective action plan to address issues identified in the OIG audit, including the viability of using T-MSIS data to identify possible cases of concurrent enrollment. AHCA staff reported that they currently use the PARIS data match to identify simultaneous payments and enrollments. However, the data is only updated quarterly, which means that users do not always have the most current information available, and the underlying data provided by states may be incomplete or inaccurate. The limited information results in agency staff's inability to confirm concurrent capitation payments for recipients enrolled in a Medicaid program in another state. As of April 2023, CMS had recommended that AHCA use the PARIS system because federal restrictions prohibit sharing beneficiary protected health information stored in T-MSIS.

AHCA uses formal performance targets to evaluate overpayment identification and prevention efforts, but the targets' usefulness is unclear

AHCA annually establishes internal performance targets for identifying and preventing overpayments but has not established similar targets for fraud and abuse within the Medicaid program. Over the past five fiscal years, the agency has failed to meet its targets for identified overpayments. AHCA also has established external performance targets for managed care organizations; these targets focus specifically on cases of suspected fraud. Managed care organizations met contractually obligated referral performance targets for Fiscal Year 2022-23, but the quality and utility of these referrals are unknown.

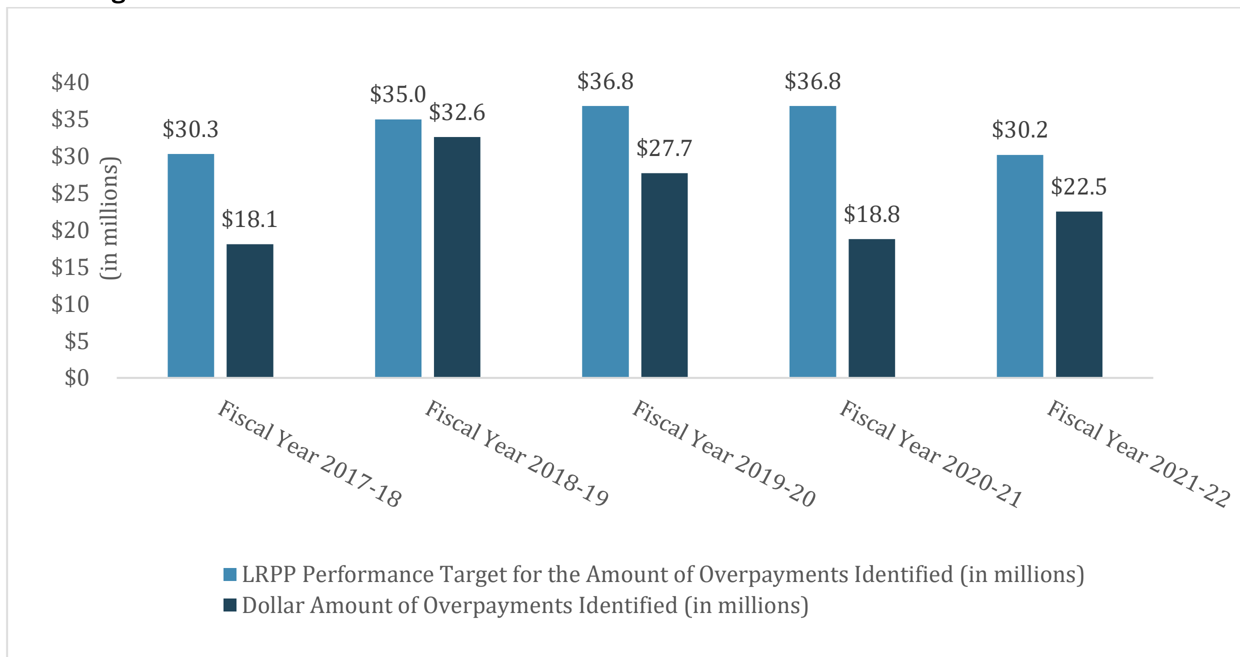
AHCA has set annual performance targets for the agency's effectiveness in identifying and preventing overpayments, but does not have explicit targets for agency efforts to detect fraud and abuse. AHCA establishes an annual goal to reduce and or eliminate fraud, waste, and abuse. However, the agency set only two internal performance targets related to overpayments within the Medicaid program: 1) total dollars in overpayments identified, and 2) total dollars in overpayment

prevented due to MPI oversight.[49] Although AHCA's annual performance target for overpayments captures instances of fraud and abuse, this target does not distinguish between fraud, abuse, mistakes, or other categories that count as overpayment. Consequently, the performance target for overpayments does not provide a complete picture of the agency's performance in detecting fraud and abuse. Without such targets, a comprehensive evaluation of the agency's oversight activities cannot be made.

Nevertheless, MPI reported referring at least 150 cases of potential fraud or abuse to MFCU annually from Fiscal Year 2015-16 to Fiscal Year 2020-21. Annual reports indicate a shift within AHCA towards the identification and prevention of overpayment. Accordingly, AHCA has prioritized special projects, which focus on specific programmatic vulnerabilities, and assigned primary fraud prevention and detection activities to MCOs.

AHCA did not meet annual performance targets for identified overpayments for any year from Fiscal Year 2017-18 through Fiscal Year 2021-22. AHCA establishes its performance targets each year in the agency's Long Range Performance Plan (LRPP). In the past five fiscal years, this target has ranged from $30.3 million to $36.8 million. (See Exhibit 8.) During the same period, the agency failed to meet any of these targets. For instance, in Fiscal Year 2021-22, AHCA identified $22.5 million in overpayments, which was $7.7 million less than the performance target of $30.2 million. Similarly, the agency failed to meet annual performance targets for identified overpayments in each of the previous four years.

Exhibit 8
AHCA Did Not Meet Annual Performance Targets for Identified Overpayments for Any Year From Fiscal Year 2017-18 Through Fiscal Year 2021-22



Note: LRPP performance targets are from the LRPP that began with the related fiscal year. For example, the performance target included for Fiscal Year 2017-18 is published in the LRPP for 2017-18 through 2021-22.

Source: OPPAGA analysis of AHCA data.

[49] Overpayment detection includes the analysis of claims data to identify instances of overpayment. Overpayment prevention includes the suspension or withholding of payment to providers (e.g., due to ineligibility or credible allegations of fraudulent or abusive billing practices).

MCOs met AHCA's contractually obligated referral performance targets for Fiscal Year 2022-23; the quality and utility of these referrals are unknown. In Fiscal Year 2020-21, AHCA began using contractually required performance targets for each plan for the referral of cases to MFCU. The performance target is calculated by considering the size of the plan (i.e., ratio of enrollees to providers) and the plan's total capitation amount. In Fiscal Year 2021-22, the 14 plans with a performance target had 287 referrals to MFCU. This did not meet the total referral goal of 296 established by AHCA. For Fiscal Year 2022-23, 13 plans made 370 referrals (a 29% increase from Fiscal Year 2021-22), which exceeded the total referral goal of 343 set for that period.[50] Nine of 13 plans (69%) had an increase in the total number of referrals compared to Fiscal Year 2021-22. MPI staff stated that currently, there are no contractual consequences for plans that do not meet annual fraud referral performance targets.

MPI reported that the MFCU is the entity best positioned to provide MCOs with feedback on fraud referrals. While MFCU provides feedback on submitted referrals, the unit has not conducted formal, in-person meetings with MCOs to provide training or guidance on the referral process since 2020. MFCU reported that the quality of referral submissions from MCOs is inconsistent. MFCU staff reported that is it common for referrals to lack supporting documentation to verify fraud has occurred and that insufficiently supported referrals are returned back to the MCOs.

In addition, CMS reported that it does not have indicators for comparing Medicaid program integrity efforts across states. Interstate comparisons could be useful in understanding how well other states detect fraud and abuse as well as uncovering broader trends that may affect the interpretation of findings from year-to-year. Variation among state policies and program structure makes it difficult to compare Medicaid fraud and abuse prevention and detection data across states. For example, CMS computes state-specific improper payment rates by subtracting claims (both FFS and capitation payments to MCOs) from eligibility determinations. CMS cautions that these rates should not be compared because states have a different mix of FFS and managed care.[51] CMS reports that it is in the process of developing best practice benchmarks.

AHCA does not routinely perform automated fraud detection data queries; the agency's current fraud tracking data system has several limitations

Using data-driven methods for detecting fraud and abuse is common practice in the insurance industry, including the healthcare arena. AHCA reported using ad hoc data analysis and manual queries to identify potential fraud, but the agency does not use automated red flags or perform routine or automated statistical analysis as part of its fraud detection protocol. AHCA relies on FACTS to store investigation data related to Medicaid fraud and abuse. FACTS was updated in May 2023, but further system improvements could contribute to more efficient management of investigation data.

Data analytics are increasingly important for identifying fraud in the insurance industry, but AHCA does not routinely perform automated fraud detection queries. Data mining and data analysis of insurance claims are a common component of fraud detection in the insurance industry. In a 2021 Coalition Against Insurance Fraud survey, 100% of the 80 responding insurance companies

[50] Between Fiscal Year 2021-22 and Fiscal Year 2022-23, Vivida Health merged with Simply Healthcare Plan.
[51] Improper payments are less likely in managed care than in FFS systems based on differences in the review standards (each FFS claim undergoes a medical and data processing review while managed care payment claims undergo only a data processing review).

reported using automated red flags or business rules as part of a detection system to identify fraud. Moreover, federal agencies, the Florida Attorney General's Medicaid Fraud Control Unit, and AHCA have all reported on the importance of advanced analytic and data-mining activities for detecting fraud and abuse. Although data mining methods are not federally mandated as a program integrity approach, s. 409.913, *Florida Statutes,* states that AHCA "shall conduct reviews of provider exceptions to peer group norms and shall, using statistical methodologies, provider profiling, and analysis of billing patterns, detect and investigate abnormal or unusual increases in billing or payment of claims for Medicaid services and medically unnecessary provision of services."

AHCA reported using ad hoc data analysis and manual queries to identify potential fraud, but the agency does not use automated red flags or perform routine or automated statistical analysis as part of its fraud detection protocol. The agency described its data analysis efforts at a high level to ensure that suspected fraudsters do not become aware of the specific activities, which could potentially allow them to escape detection.[52] Specifically, in July 2023, MPI reported primarily using manual queries for detection. In addition, AHCA reported conducting ad hoc statistical queries, but such analyses have not been developed into more systematic routine reviews. The agency anticipates greater automation of risk-based tools in the future, once the new FX Enterprise Data Warehouse fully replaces the current data reporting system.[53] This statement is consistent with previous MPI goals, which have described the intended future use of more advanced data analytics and/or data mining efforts.

MPI receives additional analytic support from other state and federal agencies. Through the U.S. Department of Health and Human Services and in partnership with AHCA, MFCU conducts data mining activities to uncover potentially fraudulent activity in Medicaid claims data. In Fiscal Year 2021-22, MFCU submitted five data mining proposals to MPI to ensure that the projects did not duplicate any internal efforts by AHCA. All five proposals were approved, indicating no potential overlap with any AHCA data mining activities or plans.

AHCA acknowledges limitations in the data system used to track and manage fraud and abuse investigations. AHCA staff use the Fraud and Abuse Case Tracking System to document complaints about Medicaid providers, plans, and recipients, and to track investigations related to Medicaid fraud and abuse. AHCA acknowledged limitations of the data system that affect data entry and retrieval. These limitations have required certain information to be entered manually and have led to known issues with at least one reporting field. Manual data entry is less efficient and more prone to error than an automated process, and unreliable reporting fields can create additional work and the need for manual corrections. Furthermore, staff has developed workarounds to compensate for the fact that the system was not developed specifically for MPI processes. For example, staff may create separate cases in the system to document different activities associated with one case of potential fraud (e.g., create one case to document putting a provider on payment restriction, a complaint record to refer the potential fraud to MFCU, and another case record for the same issue to document the monetary value of the potential fraud). Using multiple case numbers for the same fraud case is inefficient and may add unnecessary challenges when using or updating case information.

In May 2023, AHCA began using a new version of FACTS; to update the system, the agency worked with the vendor that developed the initial version. In June and July 2023, MPI staff worked with the vendor to ensure a smooth transition to the updated version and conducted quality checks on the data that

[52] This practice is consistent with methods in the private sector, where such methods may be proprietary.
[53] In the December 14, 2023, Florida Health Care Connections Executive Steering Committee meeting, the committee agreed to delay work on the core FX module for 12 months, which may delay anticipated increases in the use of automated risk-based tools.

had been migrated to the new system. The system updates may improve system functionality, but the changes do not represent a substantial system overhaul for a fundamental change in system functionality, nor is the system designed to integrate or interface with AHCA's forthcoming FX Enterprise Data Warehouse.

CONCLUSIONS AND RECOMMENDATIONS

The Agency for Health Care Administration continues to update its data systems, has taken steps to enhance program integrity, and has modified oversight processes. Though AHCA has implemented internal performance targets for the prevention and identification of overpayments, it lacks standards for preventing and identifying fraud and abuse. Similarly, while managed care organizations now have an annual performance target for fraud referrals, the Attorney General's Medicaid Fraud Control Unit reported that the quality of these referrals is inconsistent. AHCA has also taken steps to improve data quality, but data analysis remains an inefficient manual process. In addition, while AHCA has routinely communicated with other key stakeholders, formal meetings with related state (e.g., MFCU) and federal (e.g., Centers for Medicare and Medicaid Services) agencies could enhance information sharing and promote feedback on the referral process. This may also promote access to key data sources used to verify enrollment eligibility. Accordingly, OPPAGA identified several areas where improvements are still needed to enhance AHCA's efforts to prevent, detect, and deter fraud and abuse in the Medicaid program. (See Exhibit 9.)

Exhibit 9
AHCA Could Further Improve the Agency's Fraud and Abuse Detection Activities in Several Key Areas

Topic	Concern	Recommendation
Performance Measures	AHCA's performance targets for overpayment identification are variable and could be enhanced.	AHCA should revise its method for projecting the identification and prevention of overpayments to enhance the utility of performance targets related to overpayment. The projection consideration could factor in the number of providers or services rendered within the Florida Medicaid program, rather than relying on past years' dollar amounts, which can be variable from year-to-year—depending on Medicaid trends.[1]
Performance Measures	AHCA does not have formal internal performance targets for fraud and abuse.	AHCA should create performance targets for agency investigations of fraud and abuse within the Medicaid program. This could include the number of investigations initiated (or convictions made) out of the total number of referrals made to MFCU.
Performance Measures	The overall utility of MCO referral performance targets could be enhanced.	AHCA should annually report on the total number of accepted referrals out of the total referrals submitted; and/or annually report on the number of investigations initiated (or convictions made) out of the total number of accepted referrals.[2]
Data Analytics	MPI investigators rely on manual search and data entry processes; increasing automation of data entry and analysis processes could potentially increase background investigation data reliability and reduce workload.	AHCA should continue to improve the reliability and efficiency of the Fraud and Abuse Case Tracking System by assuring that the system automates data entry to the greatest extent possible. For example, the system should automatically allow users to view all information related to a case, such as previously registered complaints and cases for the same provider or type of infraction.[1] MPI might consider incorporating a version of FACTS into the Florida Health Care Connections system, so that issues identified throughout the agency via data analysis can easily be flagged for MPI review.[1]
Performance Measures; Stakeholder Communication	AHCA and MFCU have not held formal, in-person meetings together or with MCOs, to provide training or guidance on the fraud referral process.	AHCA should improve stakeholder communication by resuming regular, formal, in-person meetings and trainings with both MFCU and MCOs. Formal meetings would provide an opportunity for MCOs to receive guidance on the referral process, receive feedback on the quality of past submissions, and share insights with AHCA/MFCU.[1]

Topic	Concern	Recommendation
Oversight; Program Integrity	Current federal reporting systems used to alert states of concurrent enrollments do not always provide timely data or notify Florida of recipients possibly enrolled in another state. A recent U.S. Department of Health and Human Services OIG report recommended that AHCA use a specific data system to identify cases of concurrent enrollment, but states are generally restricted from accessing the system.	AHCA should coordinate with both CMS and the U.S. Department of Health and Human Services OIG to determine whether and how the agency can improve its access to more accurate and timely data about Medicaid enrollees.[1]

[1] New OPPAGA recommendation.
[2] Modified recommendation from previous OPPAGA reports.
Source: OPPAGA analysis.

AGENCY RESPONSE

In accordance with the provisions of s. 11.51(2), *Florida Statutes*, OPPAGA submitted a draft of this report to the Secretary of the Agency for Health Care Administration for review and response. The Secretary's written response is in Appendix C.

APPENDIX A

Florida Medicaid Managed Care Organization Regions

The Statewide Medicaid Managed Care (SMMC) program enrolls Medicaid recipients in health care plans through an 11-region structure. The Agency for Health Care Administration contracts with private managed care health plans to coordinate services for Medicaid recipients. These health plans operate on a regional basis throughout the state. (See Exhibits A-1 and A-2 for details on health plans in each region.)

Recent legislation amended Florida statute to adjust the regional structure of the health plans within the SMMC. In 2025, the law will reduce the number of regions from 11 to 9. The structural change aims to increase provider networks for Medicaid recipients by widening the region size. The law also establishes requirements for the minimum and maximum number of health plans in each area.[54] Additionally, the legislation changes the regions' labels from numbers to letters. (See Exhibit A-3 for details on the region changes.)

[54] Chapter 2022-42, *Laws of Florida*, specifies requirements for minimum numbers of plans for each region. For example, in Regions A and F, AHCA must procure at least 3 plans and may procure up to 4 plans. In Regions B and E, AHCA must procure at least 3 plans and may procure up to 6 plans. In Regions C, G, and H, AHCA must procure at least 3 plans and may procure up to 5 plans may. In Region D, AHCA must procure at least 4 plans and may procure up to 7 plans. In Region I, AHCA must procure at least 5 plans and may procure up to 10 plans may.

Exhibit A-1
The Number of Health Plans in Each Region Varies Under the Current SMMC Regional Structure

SMMC Health Plans[1]									
	Aetna Better Health	Amerihealth	Community Care Plan	Florida Community Care	Humana Medicial Plan	Molina Healthcare	Simply Healthcare	Sunshine Health	United Healthcare
Region 1				✓	✓		✓	✓	
Region 2				✓	✓		✓	✓	
Region 3				✓	✓			✓	✓
Region 4				✓	✓			✓	✓
Region 5				✓	✓		✓	✓	
Region 6	✓			✓	✓		✓	✓	✓
Region 7	✓			✓	✓		✓	✓	
Region 8				✓	✓	✓	✓	✓	
Region 9		✓		✓	✓		✓	✓	
Region 10			✓	✓	✓		✓	✓	
Region 11	✓	✓		✓	✓	✓	✓	✓	✓

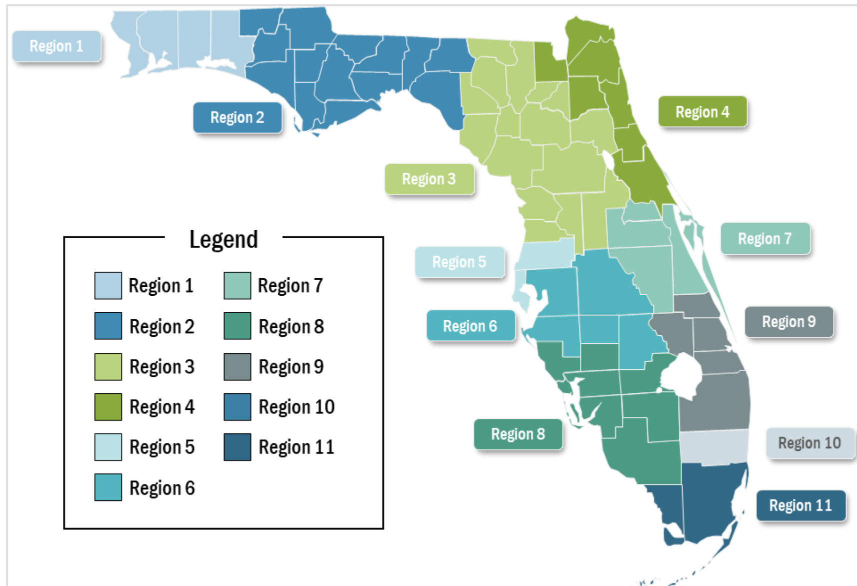
[1] The private managed care health plans provide a variety of options, such as comprehensive, managed medical assistance, or long-term care health plans.
Source: OPPAGA analysis of AHCA SMMC health plan information.

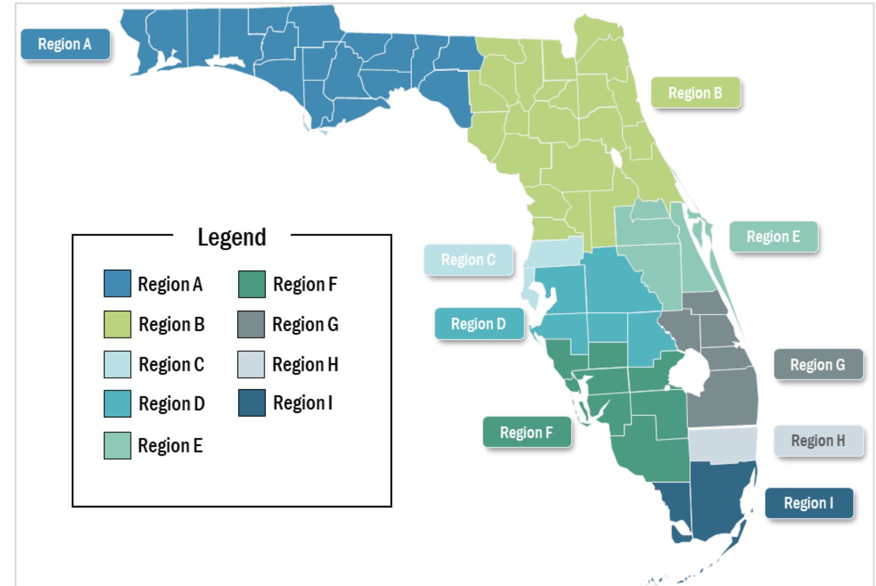
Exhibit A-2
Most Specialty Plans and All Dental Plans Provide Services in All Regions

	SMMC Specialty Plans					SMMC Dental Plans		
	Children's Medical Services Plan – Children with Chronic Conditions	Clear Health Alliance – HIV/AIDS	Molina Healthcare Serious Mental Illness (SMI)	Sunshine Serious Mental Illness (SMI)	Sunshine Health Child Welfare (CW)	Dentaquest	Liberty	MCNA Dental
Region 1	✓	✓		✓	✓	✓	✓	✓
Region 2	✓	✓		✓	✓	✓	✓	✓
Region 3	✓	✓		✓	✓	✓	✓	✓
Region 4	✓	✓	✓	✓	✓	✓	✓	✓
Region 5	✓	✓	✓	✓	✓	✓	✓	✓
Region 6	✓	✓		✓	✓	✓	✓	✓
Region 7	✓	✓	✓	✓	✓	✓	✓	✓
Region 8	✓	✓		✓	✓	✓	✓	✓
Region 9	✓	✓		✓	✓	✓	✓	✓
Region 10	✓	✓		✓	✓	✓	✓	✓
Region 11	✓	✓		✓	✓	✓	✓	✓

Source: OPPAGA analysis of AHCA SMMC health plan information.

Exhibit A-3
Recent Legislation Amended Florida Statute to Reduce the Number of Regions Within the Florida Medicaid Program[1]





[1]The consolidation of regions will go into effect in 2025.
Source: AHCA SMMC region maps.

APPENDIX B

Managed Care Organizations' Anti-Fraud Activities in Fiscal Years 2020-21 and 2021-22

Managed Care Organizations are contractually required to establish and maintain a unit to investigate possible acts of fraud, abuse, waste, or overpayment. Each health plan must submit to the Office of Medicaid Program Integrity (MPI) an anti-fraud plan that includes a summary of the results of the managed care organizations' fraud investigations conducted during the previous fiscal year. MPI uses this information, which plans submit via Annual Fraud and Abuse Activity Reports (AFAARs), to monitor plans' activities. Reported activity varied widely in managed care plans' AFAARs for Fiscal Years 2020-21 and 2021-22. (See Exhibits B-1 and B-2 for summaries of health plan activities; the exhibits exclude dental plans.)[55]

During these two fiscal years, managed care plans identified fewer total dollars in overpayments and also recovered fewer dollars. In Fiscal Year 2021-22, the total dollars in overpayments identified by managed care plans decreased by 23% ($55.4 million) from $243.2 million in Fiscal Year 2020-21 to $187.8 million in Fiscal Year 2021-22. In Fiscal Year 2021-22, the total dollars in overpayments recovered by managed care plans decreased by 9% ($13.6 million) from $158.2 million in Fiscal Year 2020-21 to $144.5 million in Fiscal Year 2021-22. During the same period, managed care plans both lost and recovered more total dollars. In Fiscal Year 2021-22, managed care plans lost $1.2 million more to fraud and abuse than in the prior fiscal year and recovered $352,672 more of the funds lost to fraud and abuse. The latter figure represents a 12% increase (from $3.1 million to $3.4 million) from the prior fiscal year.

[55] Medicaid has three statewide dental plans. Statewide dental plans are available to every beneficiary enrolled in a managed care plan and provide specific carved out services, so OPPAGA removed the plans from this analysis.

Exhibit B-1

Florida's Managed Care Organizations Varied Widely in Level of Antifraud Activity for Fiscal Year 2020-21

Managed Care Organization	Average Monthly Enrollments[1]	Number of Cases Opened	Number of Cases Investigated[2]	Number of Cases With Overpayments Recovered	Amount of Overpayments Identified for Recovery	Amount of Overpayments Recovered	Total Lost to Fraud and Abuse[3]	Total Lost to Fraud and Abuse Recovered
Aetna Better Health	135,732	90	121	11	$1,026,064	$199,876	$375,021	$199,876
AmeriHealth Caritas	97,208	81	140	11	$75,115	$33,186	$86,996	$38,647
Best Care Assurance/Molina	No data provided	2	2	0	$483,759	$142,290	$0	$0
Children's Medical Services	74,589	53	105	8	$50,470,808	$20,031,812	$2,823,461	$963,564
Community Care Plan	48,739	22	19	1	$1,244,805	$803,212	$324,244	$62,720
Florida Community Care	23,753	26	3	0	$1,639	$0	$1,639	$0
Humana Medical Plan	597,395	2,223	524	55	$814,847	$783,596	$9,931	$11,519
Lighthouse Health Plan, LLC	38,131[4]	No data provided	No data provided	No data provided	No data provided	No data provided	No data provided	No data provided
Miami Children's Health Plan	29,594[5]	No data provided	No data provided	No data provided	No data provided	No data provided	No data provided	No data provided
Molina Healthcare of Florida	135,337	23	43	30,597[6]	$14,977,788	$15,272,335[6]	$689,941	$264,283
Simply Healthcare Plan	558,381	367	564	31	$1,522,719	$508,517	$1,522,719	$508,517
Staywell of Florida	875,063	No data provided	No data provided	No data provided	No data provided	No data provided	No data provided	No data provided
Sunshine State Health Plan	759,136	408	590	63	$49,483,715	$38,601,308	$644,473	$789,448
United-HealthCare (URA)	297,497	154	154	14	$123,081,563	$81,795,586	$1,327,639	$224,177
Vivida Health	17,817	No data provided	No data provided	No data provided	No data provided	No data provided	No data provided	No data provided
Total	**N/A**	**3,449**	**2,265**	**30,791**	**$ 243,182,822**	**$142,899,382**	**$7,806,064**	**$3,062,752**

[1] Averages for each managed care plan were calculated using a 12-month average from July 2020 through June 2021 for the all Managed Medical Assistance and Long-Term Care enrollees.
[2] Includes cases for which investigations were, at a minimum, started during the reporting period. This number may also include cases opened during a prior fiscal year.
[3] Plans are directed to report the total amount lost to fraud and abuse as the portion of the total amount of overpayments identified for recovery which were identified as being lost only to fraud and abuse.
[4] Lighthouse Health Plan did not have enrollments for the entire fiscal year. Data provided reflects the average enrollment from July 2020 through March 2021. Simply Healthcare Plan acquired Lighthouse Health Plan effective February 1, 2021.
[5] Simply Healthcare Plan acquired Miami Children's Health Plan effective May 1, 2021. Data provided reflects the average enrollment from July 2020 through April 2021.
[6] Molina noted that it was instructed to include waste figures in categories that spoke to recoveries.

Source: OPPAGA analysis of Medicaid Managed Care Annual Fraud and Abuse Activity Reports for Fiscal Year 2020-21 and AHCA's Medicaid Monthly Enrollment Report.

Exhibit B-2
Florida's Managed Care Organizations Varied Widely in Level of Antifraud Activity for Fiscal Year 2021-22

Managed Care Organization	Average Monthly Enrollments[1]	Number of Cases Opened	Number of Cases Investigated[2]	Number of Cases With Overpayments Recovered	Amount of Overpayments Identified for Recovery	Amount of Overpayments Recovered	Total Lost to Fraud and Abuse[3]	Total Lost to Fraud and Abuse Recovered
Aetna Better Health	168,051	75	135	31	$1,718,400	$312,241	$1,718,400	$312,241
AmeriHealth Caritas	111,978	62	58	4	$62,241	$40,270	$62,241	$40,270
Best Care Assurance/Molina	No data provided	2	2	0	$137,725	$0	$0	$0
Children's Medical Services	87,114	69	98	25	$8,306,944	$8,157,174	$389,822	$419,539
Community Care Plan	54,919	32	13	3	$628,162	$730,771	$56,995	$54,572
Florida Community Care	31,078	22	22	1	$2,540	$1,889	No data provided	No data provided
Humana Medical Plan	703,638	2,000	432	33	$2,887,241	$2,731,480	$79,839	$20,584
Molina Healthcare of Florida	154,591	146	197	10	$12,954,404	$10,415,183	$288,819	$746,155
Simply Healthcare Plan	685,169	350	598	21	$3,578,460	$950,902	$3,578,460	$950,902
Staywell of Florida	914,266[4]	No data provided	No data provided	No data provided	No data provided	No data provided	No data provided	No data provided
Sunshine State Health Plan	1,527,992	388	611	47	$37,001,921	$27,530,960	$1,251,139	$621,448
United-HealthCare (URA)	344,715	53	53	15	$120,486,847	$93,661,350	$1,539,648	$249,714
Vivida Health	24,018	No data provided	No data provided	No data provided	No data provided	No data provided	No data provided	No data provided
Total	**N/A**	**3,199**	**2,219**	**190**	**$187,764,885**	**$144,532,219**	**$8,965,363**	**$3,415,424**

[1] Averages for each managed care plan were calculated using a 12-month average from July 2021 through June 2022 for the all Managed Medical Assistance and Long-Term Care enrollees.
[2] Includes cases for which investigations were, at a minimum, started during the reporting period.
[3] Plans are directed to report the total amount lost to fraud and abuse as the portion of the total amount of overpayments identified for recovery which were identified as being lost only to fraud and abuse.
[4] Staywell of Florida did not have enrollments for the entire fiscal year. Data provided reflects the average enrollment from July 2020 through September 2021. Centene, the parent company of Sunshine State Health Plan, purchased Staywell of Florida and brought the health plans together on October 1, 2021.

Source: OPPAGA analysis of Medicaid Managed Care Annual Fraud and Abuse Activity Reports for Fiscal Year 2021-22 and AHCA's Medicaid Monthly Enrollment Report.

APPENDIX C

Agency Response

RON DESANTIS
GOVERNOR

JASON WEIDA
SECRETARY

AHCA Response to:

January 2024 Biennial Review of AHCA's Oversight of Fraud and Abuse in Florida's Medicaid Program

There are several projections about identified and prevented overpayments that the Agency may develop for a variety of purposes. The long range program plan (LRPP) is intended to memorialize the Agency's prioritization of resources dedicated to identify and prevent overpayments, and that by prioritizing the efforts, MPI will strive to attain an increasing value each year. We do recognize that while all potential fraud and abuse may not result in overpayments, for purposes of the LRPP, the Agency considers the totality of the fraud and abuse detection and prevention efforts in MPI. These are projections that are intended to demonstrate that fraud-fighting remains a priority and that MPI is expected to continue to work toward as much as possible and are not intended as the measure by which Agency leaderhips assesses MPI's performance. By all measures, as reported in the Annual Fraud Report (Florida's Efforts to Control Medicaid Fraud & Abuse), MPI continues to far exceed the LRPP amounts. See "Prevention of Overpayments" which includes a variety of program integrity interventions. Furthermore, in previous years' OPPAGA reviews the discussions related to the Agency's Annual Fraud Report resulted in the additional trend data (typically showing three years of efforts for comparison). For purposes of performance planning, however, the Agency does not oppose further review of the measures and consideration of efforts to enhance fraud and abuse mitigation. Additionally, the Agency does not oppose further clarification or modification of the LRPP amounts for future iterations.

OPPAGA's recommendations to pursue more automated fraud and abuse detection is well-founded. The Agency does recognize that developing these types of systems is extraordinarily resource intensive (both from a fiscal standpoint and as it relates to the human resources that have to be dedicated to its development) and has, and will continue to, explore the options that will best serve the Medicaid program and the citizens of Florida.

Finally, the Agency does not disagree that routine communication with partners can enhance efforts, and the Agency will continue to seek out these opportunities. MPI and Medicaid hold many numerous and ad hoc meetings with key stakeholders, including the MCOs, CMS and MFCU. Often these meetings are not in person due to the location of the individuals, however, MPI has several meetings each year with the MCOs in person and is routinely engaged with HHS-OIG, MFCU, and others for many in-person meetings. We agree that we continue to work to improve communication and will strive to do so.

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	Concern	Recommendation	AHCA Response
Performance Measures	AHCA's performance targets for overpayment identification are variable and could be enhanced	AHCA should revise its method for projecting the identification and prevention of overpayments to enhance the utility of performance targets related to overpayment. The projection consideration could factor in the number of providers or services rendered within the Florida Medicaid program, rather than relying on past years' dollar amounts, which can be variable from year-to-year—depending on Medicaid trends.	The Agency will evaluate the manner in which the LRPP items are developed as it relates to MPI, and as determined appropriate, adjustments will be made.
Performance Measures	AHCA does not have formal internal performance targets for fraud and abuse	AHCA should create performance targets for agency investigations of fraud and abuse within the Medicaid program. This could include the number of investigations initiated (or convictions made) out of the total number of referrals made to MFCU.	The Agency will evaluate the manner in which the LRPP items are developed as it relates to MPI, and as determined appropriate, adjustments will be made.
Performance Measures	The overall utility of MCO referral performance targets could be enhanced	AHCA should annually report on the total number of accepted referrals out of the total referrals submitted; and/or annually report on the number of investigations initiated (or convictions made) out of the total number of accepted referrals.	In 2016, a federal rule change mandated that MFCU referrals go directly to MFCU. This reduced MPI's ability to positively impact the preparation of the referrals and acceptance/conviction rate. However, this concern is noted, and MPI will continue to work toward improvements in the processes regarding MCO performance targets. Please see the Annual Fraud Report for more comments on this issue.
Data Analytics	MPI investigators rely on manual search and data entry processes; increasing automation of data entry and analysis processes could potentially increase background investigation data reliability and reduce workload	AHCA should continue to improve the reliability and efficiency of the Fraud and Abuse Case Tracking System by assuring that the system automates data entry to the greatest extent possible. For example, the system should automatically allow users to view all information related to a case, such as previously registered complaints and cases for the same provider or type of infraction. MPI might consider incorporating a version of FACTS into the Florida Health Care Connections system, so that issues identified throughout the agency via data analysis can easily be flagged for MPI review.	We do not disagree that systems can be improved. However, personnel resources which would be required to perform many of the recommended enhancements are already actively engaged with the Agency FX project and a separate effort toward automation may not be the most effective use of resources. That said, *after* critical FX systems and tools are in use by MPI, the Agency will consider incorporating a case tracking system.
Performance Measures; Stakeholder Communication	AHCA and MFCU have not held formal, in-person meetings together or with MCOs, to provide training or guidance on the fraud referral process	AHCA should improve stakeholder communication by resuming regular, formal, in-person meetings and trainings with both MFCU and MCOs. Formal meetings would provide an opportunity for MCOs to receive guidance on the referral process, receive feedback on the quality of past submissions, and share insights with AHCA/MFCU.	This has already been completed to the extent reasonably practical. Most MFCU meetings and trainings are performed via MS Teams simply due to the location of personnel. MPI has continued to offer to facilitate further meetings with MFCU and the MCOS.

Oversight; Program Integrity	Current reporting systems used to alert states of concurrent enrollments do not always provide timely data or notify Florida of recipients possibly enrolled in another state	AHCA should coordinate with CMS and the U.S. Department of Health and Human Services OIG to determine whether and how the agency can improve its access to more accurate and timely data about Medicaid enrollees	AHCA has met with our CMS Regional Director and discussed the possibility of States using National TMSIS data. Currently, states are not allowed access to the PHI needed to perform this match for residents not in their state. Our CMS Regional director said he would make note of the request.

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OPPAGA provides performance and accountability information about Florida government in several ways.

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