STATE OF FLORIDA AUDITOR GENERAL

Operational Audit

Report No. 2021-013
August 2020

AGENCY FOR HEALTH CARE ADMINISTRATION

Analysis of Selected Medicaid Claims Data

Sherrill F. Norman, CPA
Auditor General

Secretary of the Agency for Health Care Administration

The Agency for Health Care Administration is established by Section 20.42, Florida Statutes. The head of the Agency is the Secretary who is appointed by the Governor and subject to confirmation by the Senate. During the period of our audit, the following individuals served as Secretary:

Mary C. Mayhew	From January 22, 2019
Justin Senior	Through January 7, 2019

The team leader was Jon M. Bardin, CPA, and the audit was supervised by Lisa Norman, CPA.

Please address inquiries regarding this report to Lisa Norman, CPA, Audit Manager, by e-mail at lisanorman@aud.state.fl.us or by telephone at (850) 412-2831.

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AGENCY FOR HEALTH CARE ADMINISTRATION

Analysis of Selected Medicaid Claims Data

SUMMARY

This operational audit of the Agency for Health Care Administration (Agency) analyzed selected Medicaid claims data. As discussed in Finding 1, our audit found that Agency controls could be enhanced to better prevent or detect potential improper Medicaid claims payments.

BACKGROUND

State law[1] designates the Agency for Health Care Administration (Agency) as the chief health policy and planning entity for the State and provides that the Agency is responsible for administering the Medicaid program. The objective of the Medicaid program is to provide medical coverage to eligible low-income families and individuals. The Medicaid program also assists the elderly and persons with disabilities with the costs of nursing facility care and other medical and long-term care expenses. The Agency administers the State's Medicaid program utilizing two delivery models: fee-for-service (FFS) and the Statewide Medicaid Managed Care (SMMC) program. Under the FFS delivery model, health care providers are paid by the Agency for each service provided, such as an office visit, medical test, or procedure. The SMMC program provides Medicaid recipients with services through managed health care plans offered by a limited number of managed care organizations (MCOs). These MCOs provide Medicaid services to enrollees in exchange for a monthly payment (capitation payment) from the Agency. Among other things, the Agency utilizes encounter data[2] to establish capitation payment rates.

State law[3] authorizes the Agency to investigate, review, or analyze Medicaid provider FFS records up to 5 years after the date the Medicaid provider furnishes goods or services to a Medicaid recipient. For the SMMC program, MCOs are contractually required to establish controls to reduce the occurrences of fraud and abuse and to have adequate staffing and resources to investigate indications of fraud and abuse.

As of March 31, 2019, the State's Medicaid program included 3.8 million enrollees, of which approximately 3 million were enrolled in the SMMC program and the remainder were enrolled in the FFS model. During the period July 2017 through March 2019, SMMC program capitation payments totaled $27.2 billion and FFS payments totaled $12.5 billion.

FINDING AND RECOMMENDATION

Finding 1: Medicaid Claims Payments

Pre-payment edits and post-payment reviews of Medicaid program claims are essential elements of a robust fraud and abuse prevention and detection program. In administering the Medicaid program, the

[1] Section 20.42(3), Florida Statutes.

[2] Encounter data are electronic records of Medicaid-covered services provided to enrollees of an MCO and paid by the MCO.

[3] Section 409.913(9), Florida Statutes.

Agency establishes Medicaid policies and procedures that providers are responsible for following to obtain reimbursement for eligible services provided to Medicaid recipients. Under the SMMC program, an MCO is allowed to provide coverage in excess of the benefits established in the State's Medicaid Plan if the MCO's contract with the Agency specified the additional coverage benefits or with Agency approval. The Agency utilizes the Florida Medicaid Management Information System (FMMIS)[4] to enroll providers, process Medicaid claims, adjudicate claims, reimburse providers, and store encounter data provided by the MCOs. According to Agency management, FMMIS includes controls designed to detect FFS claims exceeding the allowable number of occurrences (e.g., physician visits) or payment limitations outlined in Medicaid policies and procedures.

As part of our audit, we analyzed selected FFS claims adjudicated during the period July 2017 through March 2019 and the encounter data for selected SMMC program claims billed during the period July 2017 through March 2019. The selected claim types included, but were not limited to, those for controlled substances prescriptions, human immunodeficiency virus (HIV) prescriptions, home health care visits, and dental services. Our analysis of the selected Medicaid claim types identified numerous claims, summarized in Table 1, that appeared to be contrary to State or Federal law, Agency rules, or other guidelines, and, in some instances, indicative of potential fraud or abuse.

Table 1
Summary of Potential Medicaid Claims Irregularities

Claim Type	Number of Claims Analyzed	Amount Billed or Reimbursed [a]	Claims with Identified Potential Irregularities	
			Number of Claims	Amount Billed or Reimbursed
Controlled Substances:				
Encounter Claims	6,551,242	$ 716,111,297	27,316	$3,072,796
FFS Claims	1,062,581	156,105,847	7,445	643,980
HIV Prescriptions:				
Encounter Claims	200,313	320,346,957	268	434,831
FFS Claims	42,375	48,775,723	243	326,634
Home Health Visits:				
Encounter Claims	325,140	55,685,778	826	222,732
FFS Claims	90,552	16,536,209	24	3,489
Dental Services:				
Encounter Claims	1,721,743	118,935,498	287	747,261
FFS Claims	5,801	167,674	2	1,540
Totals	**9,999,747**	**$1,432,664,983**	**36,411**	**$5,453,263**

[a] For encounter claims, the amounts shown represent the total amounts billed by providers to the MCOs, as reported to the Agency. For FFS claims, the amounts shown represent the total amounts paid to providers by the Agency.

Source: Auditor analysis of FMMIS claims records.

[4] FMMIS is the State's Medicaid claims processing and information management system.

Specifically, our analyses found the following:

Controlled Substances The Federal Controlled Substances Act[5] places regulated substances into one of five schedules based on the substance's medical use, potential for abuse, and safety or dependency liability. Opioids are classified as a Schedule II drug that, while currently having an acceptable medical use, has a high potential for abuse which may lead to severe psychological or physical dependence.

Recognizing this guidance, State law[6] for example specifies that patients suffering from chronic nonmalignant pain[7] are to be seen by a physician at regular intervals, not to exceed 3 months, to assess the efficacy of the treatment and to ensure that controlled substance therapy remains indicated. Understanding that controlled substances such as opioids have a high risk of abuse and a high propensity for illicit sales, we analyzed Medicaid claims data to identify recipients with controlled substances[8] prescription claims who did not appear to have any recent associated hospital or physician visit claims. Our analysis of the Medicaid claims data identified 34,761 claims for 2,672 recipients who potentially received controlled substances prescriptions with costs totaling $3,716,776 for 5 months or more without an associated hospital or physician's visit. We examined claims records for 30 of these recipients to determine whether there were valid Medicaid hospital or physician visit claims for the recipients during the time frame they were receiving controlled substances prescriptions. Our examination disclosed that 24 recipients, receiving controlled substances prescriptions with costs totaling $110,294, had no associated Medicaid provider hospital or physician visit claims within the period of the controlled substances prescriptions. For example:

- One recipient received 900 days of OxyContin[9] during the period April 2017 through February 2019 for which the Agency reimbursed the pharmacy $18,124; however, Agency records for the recipient did not evidence a Medicaid hospital or physician's visit claim within that period. In response to our audit inquiry, Agency management indicated that the prescriptions were written by a physician who was not a Medicaid program provider and that 3 other recipients included in our testing for which the Agency provided information also received prescriptions from non-Medicaid providers. Notwithstanding this response, Federal regulations[10] specify that prescribing physicians must be enrolled in the Medicaid program. Additionally, State law[11] provides that the Agency is not to reimburse for any prescription written by a physician or other prescribing practitioner not enrolled in the Medicaid program.
- Beginning July 2017, another recipient received 660 days of fentanyl[12] over a period of 21 months and 360 days of oxycodone over a period of 12 months without a recorded Medicaid hospital or physician's visit claim. For this recipient, Medicaid also paid a claim in January 2018 for a Narcan[13] prescription.

[5] Title 21, Section 812, United States Code.

[6] Section 456.44(3)(d), Florida Statutes.

[7] Section 456.44(1)(f), Florida Statutes, defines chronic nonmalignant pain as pain unrelated to cancer which persists beyond the usual course of disease or the injury that is the cause of the pain or more than 90 days after surgery.

[8] Our analysis included controlled substances such as hydrocodone, oxycodone, morphine, amphetamine, and fentanyl.

[9] OxyContin is a brand name for oxycodone.

[10] Title 42, Section 455.410(b), Code of Federal Regulations, effective March 25, 2011.

[11] Section 409.913(8), Florida Statutes.

[12] Fentanyl is a potent synthetic opioid drug used for pain relief and anesthetic purposes. It is approximately 100 times more potent than morphine and 50 times more potent than heroin for pain relief.

[13] Narcan is a fast-acting medication used to reverse the effects of opioid emergencies which can cause severe injury or death.

Additionally, we noted that another of the 24 recipients was prescribed Narcan during the period of noted opioid prescriptions.

According to Agency management, Medicaid policy does not require a medical visit as a prerequisite for a prescription claim adjudication. Notwithstanding the Agency's response, adequate monitoring of patients receiving controlled substances prescriptions, particularly for substances such as opioids, would better ensure that the prescriptions are working as intended and risks for dependency and overdose are appropriately monitored and mitigated.

HIV Prescriptions According to the U.S. Department of Health and Human Services,[14] patients on human immunodeficiency virus (HIV) medications should have regular medical visits to monitor the amount of virus in their blood and to ensure that they are responding positively to the treatment plan. We analyzed Medicaid claims data to identify recipients receiving HIV medications who did not have associated hospital or physician visit claims. Our analysis identified 511 claims associated with 35 recipients who appeared to have received HIV prescriptions, with costs totaling $761,465, for 5 months or more without a hospital or physician visit. We examined claims records for 5 of these recipients to determine whether there were valid Medicaid hospital or physician claims for the recipients during the time frame they were receiving HIV prescriptions with costs totaling $236,002. Our examination disclosed that all 5 recipients had no associated Medicaid provider hospital or physician visit claims during the time frame they received the HIV prescriptions.

For example, one recipient received monthly HIV medications during the period April 2017 through February 2019 without a recorded hospital or physician visit in FMMIS for that period. As shown in Table 2, the Agency reimbursed the recipient's pharmacy $102,068 for the recipient's HIV medications.

Table 2
Example of HIV Prescriptions with no Hospital or Physician Visits

Medicine	Earliest Prescription	Latest Prescription	Count of Prescriptions	Total Supply Days	Amount Reimbursed
Tivicay	4/24/2017	2/26/2019	32	960	$ 50,695
Truvada	4/24/2017	5/29/2018	23	690	36,675
Descovy	6/29/2018	2/26/2019	9	270	14,698
Totals			**64**		**$102,068**

Source: Auditor analysis of FMMIS claims records.

As previously noted, according to Agency management, Medicaid policy does not require a medical visit as a prerequisite for a prescription claim adjudication. Notwithstanding the Agency's response, without periodic visits it is unclear how physicians can appropriately monitor the amount of virus in the recipient's blood and properly adjust prescriptions.

Home Health Visits According to Agency rules,[15] home health visits are not to be duplicative of services received from other providers, such as those occurring in a hospital or nursing facility. We compared the dates of service for home health visit claims to dates of service for inpatient hospital or nursing facility

[14] *Tips on Taking Your HIV Medication Every Day*, U.S. Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy.

[15] Agency Rule 59G-4.130, Florida Administrative Code.

claims to determine whether home health visit claims were potentially duplicative of other services. Our analysis identified 541 home health visit claims totaling $56,374 where an inpatient hospital or nursing facility claim was also paid for the same date of service. We examined claims records for 32 of the 541 claims (21 encounter claims and 11 FFS claims), totaling $3,842, to determine whether the home health visit claims were for days in which the recipient was in a hospital or nursing facility according to the claims information. Our examination identified 30 home health visit claims (20 encounter claims and 10 FFS claims), totaling $3,809, paid for recipients for whom an inpatient hospital or nursing facility claim was paid for the same date of service.

For example, a hospital provider submitted an inpatient claim and was reimbursed for a recipient's hospital stay with an admittance date of May 9, 2018, and a discharge date of May 15, 2018. However, a home health service provider submitted and was paid $48 for services listed as being provided to the same recipient at their home on May 11 and 12.

According to Agency management, since home health visits had been previously authorized for the encounter claim recipients, claims would be paid as submitted and a retro-payment review would be required to identify claims paid while the recipient was in a hospital or nursing facility. Agency management also indicated that the FFS claims payments were likely made in error and that they were working to correct the FFS issue and recover funds, as appropriate.

Agency rules[16] specify that the Medicaid program is to cover no more than three intermittent home health visits per day for nonpregnant recipients age 21 years or older. As previously noted, an MCO may provide additional coverage benefits (e.g., visits) as contractually authorized or otherwise permitted by the Agency. All home health visits are to be rendered intermittently, at least 1 hour apart. We analyzed Medicaid claims data to determine whether more than seven home health visit claims were made for a recipient on the same day. Our analysis identified 309 home health visit encounter claims, totaling $169,847, where it appeared that there were more than seven home health visits in a single day. We examined claims records for 4 of the claims, totaling $2,712, to determine whether the number of home health visit claims exceeded the allowed number of visits. Our examination disclosed that each of the 4 claims examined exceeded seven visits in a day. For example, a provider submitted claims for 102 home health visits, totaling $1,781, for a single recipient over the course of 4 days (an average of 25.5 visits per day). Although we requested, Agency management was unable to provide explanations for these issues.

Dental Services According to the American Association of Endodontists (AAE), the expected procedural time for a root canal appointment is 90 minutes. Most root canals are done in two or three appointments, where the first appointment is the procedure itself and the second (potentially third) is when the root canal is cleaned and filled with a crown or other filling to prevent infections.

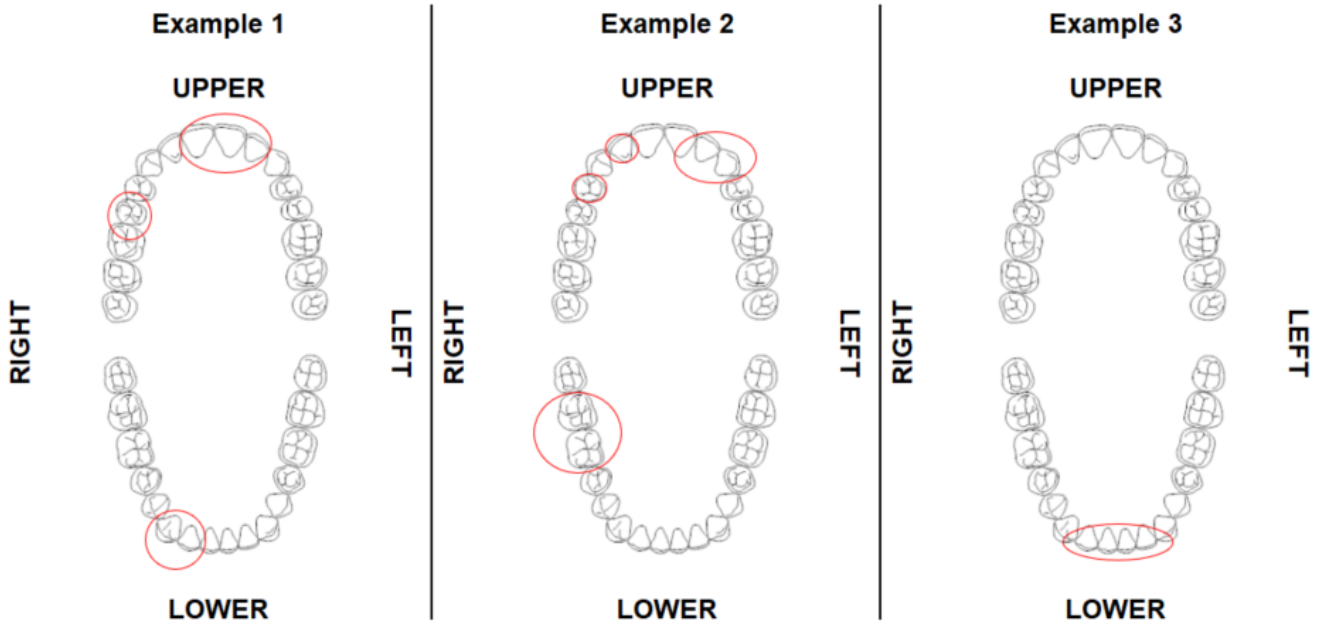
We searched Medicaid claims data for indications that an excessive number of root canals were performed for a single recipient on the same service day. Our analysis found 289 claims, totaling $748,801, in which the recipient appeared to have had at least three root canals performed on the same day, and at least one root canal was performed on each side of the recipient's mouth. We examined claims records for 13 claims (11 encounter claims and 2 FFS claims), totaling $28,917, to determine

[16] Agency Rule 59G-4.130, Florida Administrative Code.

whether the records indicated that the recipients had, in fact, received at least 3 root canals on the same day and that a root canal was performed on both sides of the recipient's mouth that day. Our examination disclosed that for 13 claims totaling $28,917 (11 encounter claims and 2 FFS claims) billing records indicated that 3 to 9 root canals were performed on a recipient on the same day and root canals were performed on both the left and right side of the recipient's mouth.

Our examination also disclosed that, while the root canals for 7 of the 13 claims were performed by a provider at a hospital or ambulatory surgical center or received prior authorization from the MCO, the root canals for the other 6 claims were not performed in either setting nor was prior authorization received. The number of root canals for the 6 claims ranged from 3 to 6. Examples for 3 of the 6 claims are illustrated below. Specifically:

- As shown in **Example 1**, a provider claimed 6 root canals for a recipient on a single day (2 in the upper right quadrant, 2 in the upper left quadrant, and 2 in the lower right quadrant). Using the AAE expected procedure time of 90 minutes, this would equate to the recipient undergoing an estimated 9 hours of root canal procedures during that day.
- As shown in **Example 2**, a recipient received 6 root canals (2 in the lower right quadrant, 2 in the upper right quadrant, and 2 in the upper left quadrant) in a single day, which would equate to an estimated 9 hours of root canal procedures.
- As shown in **Example 3**, a 12-year-old recipient received 4 root canals (2 in the lower right quadrant and 2 in the lower left quadrant) in a single day, indicating that the recipient underwent an estimated 6 hours of root canal procedures.



Although we requested, Agency management was unable to provide explanations for these issues.

While there may be reasonable explanations for performing multiple root canals for a Medicaid recipient on a single day, FMMIS did not contain edits to identify claims with such occurrences and Agency procedures did not require investigation of claims for multiple single-day root canals, even when such procedures were performed in a setting other than a hospital or ambulatory surgical center or without prior authorization.

Absent effective controls to detect improper claims, the risk is increased that claims will be paid in excess of established limitations or for services not rendered.

Recommendation: We recommend that Agency management enhance FMMIS and MCO oversight controls to better prevent or detect potential improper Medicaid claims payments.

Follow-Up to Management's Response

Agency management indicated in their written response that FMMIS paid the claim payments in question in accordance with Agency policies and that many of the claims were either subject to prior authorization or were in accordance with MCO coverage policy allowances. Notwithstanding Agency management's response, although requested, the Agency did not provide documentation evidencing that the claims in question, such as for controlled substances, were appropriate as suggested. Additionally, while Agency management cited statutory exemptions to controlled substances prescriber enrollment requirements, as noted in the finding, Federal regulations promulgated in 2011 require prescribing physicians to be enrolled in the Medicaid program. As the statutory exemptions cited by the Agency were established in 2004 prior to the promulgation of the Federal regulations, the more restrictive Federal regulations must be followed by the Agency regardless of what may be authorized by the earlier-established State law. Lastly, the point of our finding was not that the identified claims were paid contrary to Agency policies or MCO coverage policy requirements, but rather, that the claims were indicative of potential improper payments that warranted further investigation. Consequently, the finding and related recommendation stand as presented.

OBJECTIVES, SCOPE, AND METHODOLOGY

The Auditor General conducts operational audits of governmental entities to provide the Legislature, Florida's citizens, public entity management, and other stakeholders unbiased, timely, and relevant information for use in promoting government accountability and stewardship and improving government operations.

We conducted this operational audit from February 2019 through March 2020 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

This operational audit of the Agency for Health Care Administration (Agency) analyzed selected Medicaid claims data. The overall objectives of the audit were:

- To evaluate management's performance in establishing and maintaining internal controls, including controls designed to prevent and detect fraud, waste, and abuse, and in administering assigned responsibilities in accordance with applicable laws, administrative rules, contracts, grant agreements, and other guidelines.
- To examine internal controls designed and placed in operation to promote and encourage the achievement of management's control objectives in the categories of compliance, economic and efficient operations, the reliability of records and reports, and the safeguarding of assets, and identify weaknesses in those internal controls.

- To identify statutory and fiscal changes that may be recommended to the Legislature pursuant to Section 11.45(7)(h), Florida Statutes.

This audit was designed to identify, for those programs, activities, or functions included within the scope of the audit, deficiencies in management's internal controls, instances of noncompliance with applicable governing laws, rules, or contracts, and instances of inefficient or ineffective operational policies, procedures, or practices. The focus of this audit was to identify problems so that they may be corrected in such a way as to improve government accountability and efficiency and the stewardship of management. Professional judgment has been used in determining significance and audit risk and in selecting the particular transactions, legal compliance matters, records, and controls considered.

As described in more detail below, for those programs, activities, and functions included within the scope of our audit, our audit work included, but was not limited to, communicating to management and those charged with governance the scope, objectives, timing, overall methodology, and reporting of our audit; obtaining an understanding of the program, activity, or function; exercising professional judgment in considering significance and audit risk in the design and execution of the research, interviews, tests, analyses, and other procedures included in the audit methodology; obtaining reasonable assurance of the overall sufficiency and appropriateness of the evidence gathered in support of our audit's findings and conclusions; and reporting on the results of the audit as required by governing laws and auditing standards.

Our audit included the selection and examination of transactions and records. Unless otherwise indicated in this report, these transactions and records were not selected with the intent of statistically projecting the results, although we have presented for perspective, where practicable, information concerning relevant population value or size and quantifications relative to the items selected for examination.

An audit by its nature, does not include a review of all records and actions of agency management, staff, and vendors, and as a consequence, cannot be relied upon to identify all instances of noncompliance, fraud, abuse, or inefficiency.

In conducting our audit, we:

- Reviewed applicable laws, rules, Agency policies and procedures, and other guidelines and interviewed Agency personnel to gain an understanding of Medicaid claims limitations and restrictions.
- Analyzed Medicaid claims data:
    - For the 53,691 fee-for-service (FFS) medical foster care claims with reimbursements totaling $10,568,528 and the 153 medical foster care encounter claims with billed amounts totaling $88,679 during the period July 2017 through March 2019, to determine whether any providers were compensated for more days per recipient than possible.
    - For the 145 FFS dental assessment claims with reimbursements totaling $645 and the 138,029 dental assessment encounter claims with billed amounts totaling $1,801,852 during the period July 2017 through March 2019, to determine whether the claims were not in excess of established limitations.
    - For the 31 FFS dental screening claims with reimbursements totaling $281 and the 16,463 dental screening encounter claims with billed amounts totaling $366,277 during the period July 2017 through March 2019, to determine whether the claims were not in excess of established limitations.

- For the 382 FFS orthodontic service claims with reimbursements totaling $58,933 and the 108,948 orthodontic service encounter claims with billed amounts totaling $31,334,151 during the period July 2017 through March 2019, to determine whether the claims were not in excess of established limitations.
- For the 5,125 FFS dental bitewing radiograph claims with reimbursements totaling $66,129 and the 1,436,148 dental bitewing radiograph encounter claims with billed amounts totaling $62,623,159 during the period July 2017 through March 2019, to determine whether the claims were not in excess of established limitations.
- For the 29,382 FFS wheelchair claims with reimbursements totaling $6,990,479 and 183,571 wheelchair encounter claims with billed amounts totaling $49,304,889 during the period July 2017 through March 2019, to determine whether the Medicaid recipient was not provided more than one wheelchair every 5 years.

- Analyzed Medicaid claims data for the 118 FFS dental root canal claims with reimbursements totaling $41,686 and the 22,155 dental root canal encounter claims with billed amounts totaling $22,810,059 during the period July 2017 through March 2019, to identify claims indicating that the recipient had at least three root canals performed on the same day, with at least one root canal performed on each side of the recipient's mouth. From the 289 claims identified, totaling $748,801, we analyzed claims records for 13 selected claims, totaling $28,917, to determine whether the records indicated that the recipients had received, on the same day, at least 3 root canals and whether a root canal was performed on both sides of the recipient's mouth.
- Analyzed Medicaid claims data for the 90,552 FFS home health visit claims with reimbursements totaling $16,536,209 and the 325,140 home health visit encounter claims with billed amounts totaling $55,685,778 during the period July 2017 through March 2019, to determine whether the claims were for the same date as an inpatient hospital or nursing facility claim and whether recipients age 21 or older received more than three home health visits or recipients under 21 years of age received more than four home health visits in a day. From the 541 claims that appeared to be for the same date as an inpatient hospital or nursing facility claim, examined records for 32 selected claims, totaling $3,842, to determine whether detailed claims records evidenced that the claims were for the same date as inpatient hospital or nursing facility claims. Additionally, from the 309 home health visit encounter claims, totaling $169,847, we identified that appeared to include more than seven home health visits in a single day, we examined claims records for 4 selected claims, totaling $2,712, to determine whether the number of home health visit claims exceeded the allowed number of visits.
- Analyzed Medicaid claims data for:
  - The 42,375 FFS prescription claims for HIV medications with reimbursements totaling $48,775,723 and the 200,313 encounter claims for HIV medication prescriptions with billed amounts totaling $320,346,957 during the period July 2017 through March 2019, to determine whether the recipient had recent physician or hospital Medicaid claims which corresponded with the prescription or were indicative of continued medical supervision. From the 511 claims associated with 35 recipients who appeared to have received HIV prescriptions, totaling $761,465, for 5 months or more without a hospital or physician visit, we examined claims records for 5 selected recipients to determine whether valid Medicaid hospital or physician claims existed.
  - The 1,062,581 FFS prescription claims for controlled substances with reimbursements totaling $156,105,847 and the 6,551,242 encounter claims for controlled substances prescriptions with billed amounts totaling $716,111,297 during the period July 2017 through March 2019, to determine whether the recipient had recent physician or hospital Medicaid claims which corresponded to the prescriptions or were indicative of continued medical supervision. From the population of 34,761 claims for 2,672 recipients of controlled substances prescriptions

totaling $3,716,776 who appeared to have received the prescriptions for 5 months or more without a hospital or physician's visit, we examined claims records for 30 selected recipients, with controlled substances prescriptions totaling $141,802, to determine whether valid Medicaid hospital or physician visit claims for the recipients existed during the time frame they were receiving controlled substances prescriptions.

  - The 49,562 FFS claims for erythropoietin with reimbursements totaling $3,986,326 and the 45,997 encounter claims for erythropoietin with billed amounts totaling $160,547,373 during the period July 2017 through March 2019, to determine whether any recipient received more than 500 units of erythropoietin in a single month.

- Analyzed Medicaid data for the 3,871,112 recipients enrolled in managed care during the period July 2017 through June 2018 to determine whether the number of enrolled recipients without encounter claims during that period appeared reasonable.
- Communicated on an interim basis with applicable officials to ensure the timely resolution of issues involving controls and noncompliance.
- Performed various other auditing procedures, including analytical procedures, as necessary, to accomplish the objectives of the audit.
- Prepared and submitted for management response the finding and recommendation that is included in this report and which describe the matters requiring corrective actions. Management's response is included in this report under the heading ***MANAGEMENT'S RESPONSE***.

AUTHORITY

Section 11.45, Florida Statutes, requires that the Auditor General conduct an operational audit of each State agency on a periodic basis. Pursuant to the provisions of Section 11.45, Florida Statutes, I have directed that this report be prepared to present the results of our operational audit.

Sherrill F. Norman, CPA
Auditor General

MANAGEMENT'S RESPONSE

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

August 27, 2020

Ms. Sherrill F. Norman
Auditor General
Claude Denson Pepper Building, Suite G74
111 West Madison Street
Tallahassee, FL 32399-1450

Dear Ms. Norman:

Thank you for the opportunity to respond to the preliminary and tentative audit finding and recommendation from your operational audit of the Agency for Health Care Administration, Analysis of Selected Medicaid Claims Data. In accordance with your request, we have emailed you the preliminary and tentative audit findings document with our response incorporated therein.

If you have any questions regarding our response, please contact Pilar Zaki, Audit Director, at 412-3986.

Sincerely,

Mary C. Mayhew
Secretary

MCM/sgb
Enclosure

2727 Mahan Drive • Mail Stop #1
Tallahassee, FL 32308
AHCA.MyFlorida.com

Facebook.com/AHCAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida

Finding 1:

Our audit found that Agency controls could be enhanced to better prevent or detect potential improper Medicaid claims payments.

As part of our audit, we analyzed selected FFS claims adjudicated during the period July 2017 through March 2019 and the encounter data for selected SMMC program claims billed during the period July 2017 through March 2019. The selected claim types included, but were not limited to, those for controlled substances prescriptions, human immunodeficiency virus (HIV) prescriptions, home health care visits, and dental services. Our analysis of the selected Medicaid claim types identified numerous claims, summarized in Table 1, that appeared to be contrary to State or Federal law, Agency rules or policies, or other guidelines, and, in some instances, indicative of potential fraud or abuse.

Recommendation:

We recommend that Agency management enhance FMMIS and MCO oversight controls to better prevent or detect potential improper Medicaid claims payments.

Agency Response:

In response to the finding and recommendation above, the Agency for Health Care Administration provides the following information and analysis related to questioned claims associated with controlled substances, human immunodeficiency virus (HIV) prescriptions, home health visits, and dental services. Much of this information reiterates the Agency's previous response(s) to the AG detailing the appropriateness of the claim payments in question. Additionally, Agency review indicates that the FMMIS paid in accordance with Agency policies. However, should system/programmatic improvements be deemed necessary at any time, they will be made.

Controlled Substances

Statutory exemptions [s. 409.913(8), F.S.] to prescriber enrollment requirements are applied by Florida Medicaid to ensure reimbursement for medically necessary services. These services may include (but are not limited to) prescribing by a non-enrolled board-certified specialist, by a Medicare enrolled prescriber for a dually eligible Medicare beneficiary, or by a non-enrolled prescriber for medically necessary service not otherwise reasonably available from an enrolled physician.

In regard to the management of controlled substances, refills of OxyContin or any other control II substance is federally prohibited. Federal law requires a new prescription from the physician for OxyContin or oxycodone to be filled. Consultation with the prescriber is required in these instances.

In addition, Florida Medicaid maintains a number of other safeguards through the utilization management process which includes automated and manual prior authorizations, step-edit criteria, and other system edits (quantity limits, age limits, etc.) to ensure appropriate prescribing practices or use of medication.

HIV Prescriptions

The Agency has implemented an automatic prior authorization (Auto-PA) process to ensure Medicaid recipients obtaining HIV medications have an HIV medical claims diagnosis in their history. The Auto-PA process has been in effect since prior to the 2014 implementation of Statewide Medicaid Managed Care. If the policy rules established by the automatic prior authorization criteria are not met, the submitted claim will deny and trigger a manual prior authorization review process for verification of consultation with a prescriber. This is to prevent delays in access to medication determined necessary to control the HIV infectious disease process by promoting 100% adherence to the prescription. This strategy prevents HIV transmission, slows or halts progression of disease, and reduces occurrence of comorbid complications.

Home Health Visits

The Agency reviewed claim examples across the two topics identified by the auditors. The below details information for each instance for which claims were provided. The Agency does not recommend system changes in the fee-for-service delivery system nor through the health plans. The health plans have provided justification on their system edits and specific claim examples in question by the auditor.

More than Three Home Health Visits - Per the Home Health Visits Coverage policy, Florida Medicaid reimburses for up to three intermittent home health visits per day for non- pregnant recipients age 21 and older. It was asked that the Agency review four claims in which it appears that payments were made in excess of this policy.

Response after Agency review:

All four of the claims submitted for Agency review are encounter claims. This means that these recipients are enrolled in a managed care plan. In accordance with the Home Health Visit Services Coverage Policy, managed care plans must comply with the coverage requirements outlined in the policy, unless otherwise stated in the contract with the Agency. The plans are not allowed to be more restrictive than the coverage policy. Plans are permitted to be more expansive in coverage than the Agency. These claims were encounter claims; as such the managed care plans may exceed the limits of the coverage policy.

Recipients under Inpatient Care - ***Thirty claims were identified having had a home health visit paid for while the recipient was under inpatient care at a hospital or nursing home/facility. It was asked that a detailed explanation along with any applicable supporting documentation be provided.***

Response after Agency review:

The Agency was asked to review thirty claims. Please see the detailed review below:

Encounter Claims:

Twenty of the claims were encounter claims from a recipient enrolled in a managed care plan. The plans' coverage may be more expansive than the coverage policy. Seven health plans were contacted about the 20 encounter claims. Because prior authorization was in place for the home health services, clean claims did pay. Identifying home health claims that were paid for dates of service when a member was inpatient must be done

as retro-payment review. For the claims identified by the AG, the plans will be reaching out to the home health providers to request documentation and then take appropriate action.

These claims were encounter claims and as such health plans may exceed the limits of the coverage policy. Additionally, it is likely the home health visit claim was made prior to the hospital or nursing facility claim was filed with the health plan.

Fee-for-Service Claims:

Ten claims are fee-for-service claims. Prior authorization is required for home health visits. This is one of the mechanisms the state uses to apply utilization management of home health services. Providers obtain authorization every 60 days. However, when the prior authorization is approved it is not possible to predict health emergencies or natural disasters that may result in an inpatient stay.

One of the 10 claims coincides with the disaster grace period for Hurricane Irma (9/7/17 – 9/21/17). During the disaster grace period, all prior authorization requirements were waived. Reimbursement was provided for services provided in good faith to eligible Florida Medicaid Recipients.

The remaining nine out of ten fee-for-service claims were paid prior to the implementation of electronic visit verification (EVV). With the implementation of EVV the Agency has greater controls over the location in which services are delivered. The vendor now has more detailed claims information which helps contribute to the management of home health visit claims.

Dental Services

The Agency provided the auditors with a plan review of each dental claim in question, as well as health plan contract details to describe the flexibilities health plans have. The Agency asserts that multiple root canals on one date of service is not in conflict with the Agency's policies or any conflict with scope of practice/standards of care.

The Agency reimburses for medically necessary services for children in accordance with the coverage policy and fee schedule. Additionally, the Agency complies with the National Correct Coding Initiative which details when billing for specific procedure codes are prohibited. In regard to the number of procedures performed in a single day, that would need to be determined by the healthcare practitioner who has knowledge of the impact of the services to the recipient. For instance, where the recipient requires anesthesia, it is common practice to perform as many procedures as can be safely administered in order to avoid having to anesthetize the patient again at a later date.

It is not appropriate for the Agency to limit the number of root canals a recipient under the age of 21 years may receive on one date of service due to multiple factors:

- The Agency follows national correct coding system edits and limitations in accordance with federal guidance and the dental code book.
- The Agency does not regulate scope of practice nor standards of care.

- Parental consent, parental choice (e.g., due to need to take time off or work or to arrange transportation), and medical necessity may dictate multiple services to be performed on the same date of service, including evidence-based quadrant dentistry by specific local anesthetic area.
- The majority of dental services are managed by dental plans, with their own utilization management and review practices.

Agency Contact:

Carla Sims – Medicaid
Carla.sims@ahca.myflorida.com
(850) 412-4013