



## Reasonable Compliance Needed

***Florida ARF and its members encourage the Florida Legislature to pursue revisions in law and practice that support “reasonable compliance” with Medicaid law rather than a punitive “perfect compliance” approach.***

State and federal interest in Medicaid fraud and abuse continues to rise and has been accompanied by legislation strengthening the Agency for Health Care Administration’s (AHCA) capability to deal with such concerns. In general, the Florida ARF membership views this action as necessary and appropriate; however, we believe some actions taken by Medicaid Program Integrity related to services provided under the Medicaid iBudget Waiver exceed what is necessary. The result is a system that does not allow for reasonable correction to remediate provider errors in performance, but relies upon punitive measures when errors are noted. There is an important difference between program integrity concerns regarding fraud and abuse and issues involving simple non-compliance with the Medicaid requirements found in the iBudget Handbook.

### Background

The Agency for Health Care Administration (AHCA) has taken the approach that any evidence of non-compliance with the DD Medicaid Waiver Handbooks is cause for disallowing an entire claim as “overpayment.” However, no specific legislative direction exists for this position and it is unlike the approach taken with other major areas of Medicaid spending such as hospitals, nursing homes, ICF/IIDs, community health centers, health departments, and physician services. In these programs, non-conformance with an Agency rule, including “conditions of participation,” may result in a corrective action plan, “down-coding” of a claim, a sanction, or even termination of the program. In all of these cases, the Agency acknowledges a service was provided and pays all or most of the claim.

The difference in treatment of Medicaid Waiver service providers compared to other provider types is heightened by the fact that the referenced handbooks are voluminous, sometimes inconsistent, and contain statements intended as “best practice” or “philosophical direction” the Agency for Persons with Disabilities (APD) hopes to see at the provider level. However, this philosophical direction has turned into absolute requirements and often without notice or training. Additionally, provider agencies indicate the State has adopted differing interpretations regarding documentation requirements and other standards that have not been communicated from APD to the provider community. We also note the criteria used to conduct quality assurance reviews are greatly different (or lead to greatly different results) than the standards applied by Medicaid Program Integrity.

The above is further complicated by the fact the involved agencies that provide services to recipients of the “iBudget” Medicaid Waiver often have no other business customers but Medicaid. They cannot turn to another source of funding and if they are not-for-profit agencies must rely on fundraising to cover the cost of care. These agencies are the very ones that the State of Florida encouraged to develop in order to reduce State reliance on large, entirely state-funded institutions. Some of the huge recoupments alleged by AHCA are not mere overpayment notices, if they become final agency action they are essentially termination notices.

## **Compliance with Chapter 120 F.S.: Perfect versus Substantial Compliance**

The focus solely on recoupment rather than an allowance for remediation is inconsistent with Chapter 120.695, F.S., which reads as follows:

“(1) It is the policy of the state that the purpose of regulation is to protect the public by attaining compliance with the policies established by the Legislature. Fines and other penalties may be provided in order to assure compliance; however, the collection of fines and the imposition of penalties are intended to be secondary to the primary goal of attaining compliance with an agency’s rules. It is the intent of the Legislature that an agency charged with enforcing rules shall issue a notice of noncompliance as its first response to a minor violation of a rule in any instance in which it is reasonable to assume that the violator was unaware of the rule or unclear as to how to comply with it.”

Florida ARF does not dispute the need for the Agency (AHCA) to provide firm oversight and correction for services provided and reimbursed. However, requirements for complete repayment for minor imperfections are not consistent with ordinary contractual duties in the private market. In cases we are aware of, the state received the basis for its bargain, yet provider agencies were penalized for failure to adhere to cumbersome documentation requirements. The cases we are referencing have nothing to do with quality of care and there was no dispute services were provided; yet, if the documentation is not in 100% compliance with the voluminous handbook, substantial payback provisions are being applied. We believe AHCA should develop a system of corrective actions and lesser penalties for infractions that violate requirements, but do not impact on service delivery for the iBudget Waiver similar to those implemented in other Medicaid programs.

### **Issue**

In most instances, community provider agencies are providing the essence of the service required by the iBudget Waiver handbook, and APD and AHCA are receiving the basis of their bargain with the provider. For example, provider agencies are supplying Residential Habilitation services, Adult Day Training, or Transportation services via Medicaid contracts. The fact that the Adult Day Training was provided in an unconventional site, or a support plan (though approved by the APD Regional Office) was not signed by a guardian who could not be found, or a transportation log was filled out incorrectly, does not mean the service contracted for was not provided. These are but a handful of examples where the Agency is seeking to deny all payment for the service as an “overpayment.”

While there may be technical non-conformity with Medicaid requirements, this does not justify considering such claims as “overpayments” to support 100 percent recoupment of the paid amount. We maintain “over-payment” did not occur. The provider was paid the amount specified in the handbook, no more and no less. Where there is adequate documentation that the service was provided, the fact that there were certain technical issues demanding compliance does not automatically turn the claim into a 100 percent “over-payment.” Florida ARF seeks correction of this problem and believes that legislative relief is critical so that qualified providers are not forced out of business. We offer that few business entities perform at the 100 percent accuracy level relative to documentation practices and that to treat such errors as “overpayment” is an unrealistic expectation.

### **Discussion**

We note that most states seem to use the term Medicaid overpayment to imply “the difference between what Medicaid paid and what the provider was rightly owed.” The same concept is used in other areas of state and federal law such as income payments for welfare assistance pertaining to cash assistance payments under TANF and SSI. The terms “over” and “under” payment are also found throughout various state tax codes and in the federal Internal Revenue Code. The practical construction of the term

“overpayment” to mean “any non-conformance with technical requirements” seems without precedence.

We have been unable to find any reference in Florida law to support the notion that identification of a non-conforming issue during the delivery of a service must necessarily result in full recoupment of all funds previously paid. The definition simply says an overpayment is any amount not authorized to be paid. The amount to be repaid, if any, and how it is calculated is left to agency discretion. Additionally, there is significant leeway in the statute for AHCA to use its discretion when imposing fines and sanctions. Section 409.913(17), F.S., specifically authorizes six different factors for AHCA to consider when determining an “appropriate administrative sanction.” (See Attachment 1)

A review of federal law regarding overpayment of Medicaid dollars revealed the following:

- **42 USC 1396u-6:** Contains one reference to the “Identification of overpayments.” However, the prime Congressional direction is “. . . to determine whether fraud, waste or abuse has occurred, [or] is likely to occur “and to cooperate “. . . in the investigation and deterrence of fraud and abuse.”
- **42 USC 1396a(d):** States are required to conduct utilization and quality control of the services they provide, either directly or by contract. The two agencies involved in this program (AHCA and APD) have jointly chosen the Delmarva Foundation to conduct these activities, but AHCA is actually the manager of this contract. Though often reviewing the same material, the agencies seem to use different standards and draw different conclusions. The Medicaid Integrity process even draws different conclusions than the Delmarva process.
- **42 USC 1396a(a)(11)A:** Federal law mandates use of existing state agencies such as AHCA and APD in the administration of Medicaid programs and requires States to “provide for entering into cooperative arrangements with State agencies responsible for administering or supervising the administration of health services and vocational rehabilitative services in the State looking toward maximum utilization of such services in the provision of medical assistance under the plan; . . .” Some of the recent proposed recoupments cast doubt about whether such cooperation and coordination is being carried out. While APD has developed policies for corrective action, sanctions, and fines (18-002) when noncompliance is identified, Medicaid Integrity seeks overpayment recoupment on the same issues.

From the state perspective, numerous references to stamping out “fraud and abuse” exist, but the Legislature’s directives about handling “overpayments” still appear to give considerable discretion to AHCA. In audit cases of which we are aware, there is generally no challenge to the basic fact that the State obtained what it intended to pay for (i.e., oversight, training, and care of Medicaid recipients who would otherwise be cared for in a state institution). However, virtually all the claims related to these services were denied for one (mostly) technical reason or another. In four audits, AHCA found 100%, 96.7%, 84% and 60% of all claims were denied as overpayments. This occurred despite the fact that these organizations earned high marks from Delmarva (the Agencies quality assurance review organization), for services provided during the same time period as the Program Integrity audit. We think the overpayment interpretation is being turned into a de-facto penalty not authorized by law.

The hyper-technical approach to regulation that is currently being implemented is not a satisfactory method for the State to implement its programs and policies. Indeed, the applicable statutes §120.695, F.S. and §409.913 (17), F.S., both give the Agency considerable leeway and direction to implement sensible penalties and sanctions. (See Attachment 1)

As a result of the manner in which Medicaid Program Integrity audits are being administered, iBudget waiver providers, who often are raising funds to supplement inadequate rates, will have to either close their doors or make a significant investment in attorneys’ fees to stay in the iBudget Medicaid Waiver

program. In cases we are aware of, if the Medicaid allegations were upheld, the provider agencies would have to raise 60 to 100 percent of their annual income to pay the State back for services already rendered. In addition, they must repay at a now usurious interest rate of 10 percent per year. A provider who cannot adhere to a repayment schedule, or misses a payment, can be terminated from the program. See §409.913 (25)(c), F.S.

Huge audit findings can be tantamount to termination from the program - this is uncalled for and not mandated by any legislative directive. Moreover, the effect of such declarations of huge overpayments and the inevitable result is directly at odds with both federal and state direction which require the Medicaid agency to cooperate with other State authorities and to look “toward maximum utilization of such services” of these agencies (42 USCA 1396a(a)(11)(A), Id.). Good regulation calls for clear standards and consistency in the application of those uniform requirements mixed with common sense.

## **Recommendations**

The Florida Legislature’s underlying interests remain quality of care, consistency, and cost effectiveness for Medicaid programs and services. Therefore, Florida ARF recommends the State adopt the following approaches when monitoring/reviewing iBudget Waiver providers.

- Require AHCA and APD come together to develop practical and uniform standards for regulation of iBudget Waiver providers. These standards must allow for reasonable correction of errors by the provider as specified in Section 120.695 F.S. Some progress has been made in this regard with the Delmarva monitoring process.
- Mandate the two agencies focus on bringing all provider agencies into “substantial compliance” as is currently done in the facilities regulation arm of AHCA’s health care quality assurance division.
- Mandate the Agencies develop a single approach to regulation of iBudget waiver providers. This means the standards expected by the Agencies (written and in practice) will be the same.
- Require the two agencies to develop standards that distinguish between technical, inadvertent and non-essential requirements which should call for a “corrective action plan” and those that threaten the life, health, or safety of waiver recipients or result in economic damage to the State. We support the policy that life, health, or safety problems may call for sanctions up to and including termination.
- End the notion that technical non-compliance results in an overpayment which justifies the recoupment of all funds even though AHCA and APD received the essential benefit which they contracted for and the provider is in “substantial compliance” with the Handbooks.
- Amend Florida Statutes, Subsection 409.913(1)(e) to require more uniform and reliable regulation and provide for relief from disproportionate penalties when providers do not meet administrative requirements of the Agency. (See Attachment 2 for suggested text.)

## **Conclusion**

Florida ARF is not requesting an exemption from proper medical record-keeping or from requirements pertaining to inappropriate, unnecessary or excessive goods or services, or any relief at all in the areas of abuse or fraud. Rather, the Association is presenting and supporting a common sense approach that protects the interests of the State, the individuals served, and the Medicaid provider community.

## Attachment 1: Statutory References

### **120.695 Notice of noncompliance. ---**

- (1) It is the policy of the state that the purpose of regulation is to protect the public by attaining compliance with the policies established by the Legislature. Fines and other penalties may be provided in order to assure compliance; however, the collection of fines and the imposition of penalties are intended to be secondary to the primary goal of attaining compliance with an agency's rules. It is the intent of the Legislature that an agency charged with enforcing rules shall issue a notice of non-compliance as its first response to a minor violation of a rule in any instance in which it is reasonable to assume that the violator was unaware of the rule or unclear as to how to comply with it.
- (2) (a) Each agency shall issue a notice of non-compliance as a first response to a minor violation of a rule. . . . A notice of non-compliance may not be accompanied with a fine or other disciplinary penalty. . . .  
(b) . . . A violation of a rule is a minor violation if it does not result in economic or physical harm to a person or adversely affect the public health, safety or welfare or create a significant threat of such harm. . . .  
(c) . . . [Requires each agency to compile a list of rules which are considered "minor" violations. Note that the designation was to be accomplished by December 1, 1995.]

### **409.913 (17) Oversight of the integrity of the Medicaid program**

- (17) In determining the appropriate administrative sanction to be applied, or the duration of any suspension or termination, the agency shall consider:
  - (a) The seriousness and extent of the violation or violations.
  - (b) Any prior history of violations by the provider relating to the delivery of health care programs which resulted in either a criminal conviction or in administrative sanction or penalty.
  - (c) Evidence of continued violation within the provider's management control of Medicaid statutes, rules, regulations, or policies after written notification to the provider of improper practice or instance of violation.
  - (d) The effect, if any, on the quality of medical care provided to Medicaid recipients as a result of the acts of the provider.
  - (e) Any action by a licensing agency respecting the provider in any state in which the provider operates or has operated.
  - (f) The apparent impact on access by recipients to Medicaid services if the provider is suspended or terminated, in the best judgment of the agency.

The agency shall document the basis for all sanctioning actions and recommendations.

## Attachment 2: Suggested Amendments to Chapter 409.913

(Proposed amendments are noted as underlines for additions and strikethroughs for deletions.)

**409.913 Oversight of the integrity of the Medicaid program.** --- The agency shall operate a program to oversee the activities of Florida Medicaid recipients and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate. . . .

(1) For purposes of this section, the term:

(a) – (d)

(e) ““Overpayment” includes 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. However, when used in the context of home and community-based waiver providers, “overpayment” does not mean or imply that the Agency has the authority to reclaim all funds paid for a particular good or service when a non-essential requirement of that good or service is not supplied by the provider in accordance with Medicaid rules or Handbook requirements. In these cases, the Agency shall follow the guidance set forth in §120.695, Florida Statutes, unless the Agency determines that there is probable cause to believe that fraud or abuse is involved in the claims being investigated.

**409.913 (7)** When presenting a claim for payment under the Medicaid program, a provider has an affirmative duty . . . to present a claim that is true and accurate and that is for goods and services that:

(e) Are provided in substantial compliance ~~accord~~ with applicable provisions of all Medicaid rules, regulations, handbooks, and policies in accordance with federal, state, and local law.

**409.913 (15)** The agency shall seek a remedy provided by law, including, but not limited to, any remedy provided in subsections (13) and (16) and s. 812.035, if: . . .

(e) The provider is not in substantial compliance with provisions of Medicaid provider publications that have been adopted by reference as rules in the Florida Administrative Code; with provisions of state or federal laws, rules, or regulations; with provisions of the provider agreement between the agency and the provider; or with certifications found on claim forms or on transmittal forms for electronically submitted claims that are submitted by the provider or authorized representative, as such provisions apply to the Medicaid program.