Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

FLORIDA GENERALLY ENSURED THAT PROVIDERS COMPLIED WITH SELECTED STATE DURABLE MEDICAL EQUIPMENT ENROLLMENT REQUIREMENTS

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Lori S. Pilcher
Regional Inspector General

May 2013
A-04-12-07034

Office of Inspector General

https://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC

at https://oig.hhs.gov

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

Florida generally ensured that providers complied with selected State durable medical equipment enrollment requirements. However, about $1.9 million in Medicaid DME program funds was vulnerable to fraud, waste, and abuse.

WHY WE DID THIS REVIEW

We chose to review durable medical equipment (DME) providers in Miami-Dade County, Florida because of the historically high level of fraud risk associated with DME and medical supply providers (DME providers) in South Florida. In March 2007, the Department of Health and Human Services and the Department of Justice formed a Medicare Fraud Strike Force consisting of Federal, State, and local investigators to combat the fraudulent activities of suppliers of DME, prosthetics, orthotics, and supplies in South Florida through the use of real-time analysis of Medicare billing data. During a 3-month period in 2007, 56 individuals were charged in South Florida with fraudulently billing Medicare more than $258 million (OEI-03-07-00540). In 2006, 31 percent of suppliers in three South Florida counties did not maintain a physical facility or were not open and staffed during unannounced site visits. Finally, another 14 percent of suppliers were open and staffed but did not meet at least 1 of 3 additional requirements for the standards that were reviewed (OEI-03-07-00150).

Our objective was to determine whether the Florida Agency for Health Care Administration (State agency) ensured that DME providers complied with selected Florida DME enrollment requirements.

BACKGROUND

DME is medically necessary equipment that can withstand repeated use, serves a medical purpose, and is appropriate for use in the recipient's home. The Medicaid DME program reimburses providers that sell or rent DME and medical supplies, including hospital beds, orthotic devices, diabetic testing strips, incontinence supplies, wheelchairs, walkers, oxygen equipment, and other home health care items.

WHAT WE FOUND

The State agency generally ensured that DME providers complied with selected Florida DME enrollment requirements. Of the 71 DME providers that we visited in Miami-Dade County and that received a total of about $15 million from Medicaid during the 13 months prior to our site visits, 61 providers complied with the selected enrollment requirements. However, 10 providers did not comply: 6 did not have the required signage to identify them as DME providers, 2 either did not meet the business-hour requirements or were not open during posted business hours, and 2 did not notify the State agency that their business addresses had changed.

These 10 providers did not comply with the enrollment requirements because the State agency did not maintain proper oversight through periodic monitoring. The State agency requires the

applicant's DME and medical services business to receive an unannounced site visit before the DME provider is approved for enrollment, unless it is exempt from a pre-enrollment site visit. However, followup site visits are not a State agency requirement for continued enrollment or re-enrollment as a DME provider. For these 10 providers, we were not able to find documentation of followup site visits in their provider files. As a result of the State agency's lack of periodic monitoring of DME providers, the Medicaid DME program in general and the $1,907,669 that the State agency claimed for these 10 providers were vulnerable to fraud, waste, and abuse.

WHAT WE RECOMMEND

We recommend that the State agency:

- terminate, sanction, or recoup Medicaid funds from the providers not in compliance with the State agency's DME enrollment requirements and

- strengthen enrollment procedures to include recurring site visits to ensure that DME providers comply with the State agency's enrollment requirements.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency generally did not concur with our findings. Of the 10 DME providers that we identified as not being in compliance with the selected enrollment standards, the State agency concurred with our findings for 4 providers. The State agency did not agree that six DME providers were not in compliance with requirements related to having adequate signage or meeting business hours. After our visits to the DME providers, the State agency said that it conducted onsite reviews of the providers who are currently active and found that, in most instances, the errors that we identified were not evident at the time of its visits.

In addition, the State agency suggested that we revise the title of our audit report because it implied a greater rate of noncompliance than the review actually determined. The State agency also suggested that we clarify that the instances of noncompliance fell on only 5 days after the 13-month period of time for which we reported total payments to the noncompliant DME providers.

The State agency also stated that it has instituted a vigorous pre-enrollment process and also conducts regular and unannounced monitoring site visits to verify compliance with Medicaid policy.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments, we revised the title of this report; however, we maintain that our findings are valid. When we made our onsite visits, 10 DME providers were not in compliance with the selected enrollment requirements, as evidenced by the pictures we have from our onsite visits. We also maintain that, because the DME providers were not in

compliance with the selected enrollment requirements, payments made to these providers during the period preceding the site visits were vulnerable to fraud, waste, and abuse.

TABLE OF CONTENTS

INTRODUCTION 1

Why We Did This Review 1

Objective 1

Background 1
The Medicaid Program 1
Florida's Durable Medical Equipment Program 2

How We Conducted This Review 2

FINDINGS 3

Durable Medical Equipment Providers Did Not Have Adequate Business Signage 4

Durable Medical Equipment Providers Failed To Meet Business-Hour Requirements 4

Durable Medical Equipment Providers Failed To Notify the State Agency Upon Changing Physical Location or Discontinuing Operations 4

RECOMMENDATIONS 4

STATE AGENCY COMMENTS 5

OFFICE OF INSPECTOR GENERAL RESPONSE 5

APPENDIXES

A: State Requirements for Durable Medical Equipment And Medical Supply Providers 6

B: Audit Scope and Methodology 7

C: Related Office of Inspector General Reports 9

D: State Agency Comments 10

INTRODUCTION

WHY WE DID THIS REVIEW

We chose to review durable medical equipment (DME) providers in Miami-Dade County, Florida, because of the historically high level of fraud risk associated with DME and medical supply providers (DME providers) in South Florida. In March 2007, the Department of Health and Human Services and the Department of Justice formed a Medicare Fraud Strike Force consisting of Federal, State, and local investigators to combat the fraudulent activities of suppliers of DME, prosthetics, orthotics, and supplies in South Florida through the use of real-time analysis of Medicare billing data. During a 3-month period in 2007, 56 individuals were charged in South Florida with fraudulently billing Medicare more than $258 million.[1] In 2006, 31 percent of suppliers in three South Florida counties did not maintain a physical facility or were not open and staffed during unannounced site visits. Finally, another 14 percent of suppliers were open and staffed but did not meet at least 1 of 3 additional requirements for the standards that were reviewed.[2]

OBJECTIVE

Our objective was to determine whether the Florida Agency for Health Care Administration (State agency) ensured that DME providers complied with selected Florida DME enrollment requirements.

BACKGROUND

The Medicaid Program

How Is It Administered?

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities and, along with the Medicare program, represents one of the largest areas of spending in the Federal Government. In contrast to the Medicare program, both the Federal and State Governments jointly fund and administer the Medicaid program.

At the Federal level, the Centers for Medicare & Medicaid Services (CMS), an agency with the Department of Health and Human Services, administers the Medicaid program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. The State plan establishes which services the Medicaid program will cover. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

---

[1] *South Florida Durable Medical Equipment Suppliers: Results of Appeals*, report number OEI-03-07-00540.

[2] *South Florida Suppliers' Compliance With Medicare Standards: Results From Unannounced Visits*, report number OEI-03-07-00150.

Florida's Durable Medical Equipment Program

What is Durable Medical Equipment?

DME is medically necessary equipment that can withstand repeated use, serves a medical purpose, and is appropriate for use in the recipient's home. The Medicaid DME program reimburses providers that sell or rent DME and medical supplies, including hospital beds, orthotic devices, diabetic testing strips, incontinence supplies, wheelchairs, walkers, oxygen equipment, and other home health care items.

Who Administers the Medicaid Durable Medical Equipment Program in Florida?

In Florida, the State agency administers the Medicaid program. Within the State agency, the Provider Enrollment office is responsible for processing all initial and renewal applications for enrollment made by DME providers and for checking their qualifications and compliance with all applicable enrollment requirements.

What Are the Requirements to Enroll as a Durable Medical Equipment Provider in Florida?

To meet requirements for enrollment as a Medicaid DME provider, each provider must: (1) be licensed by the Florida Department of Health, if applicable, and various agencies; (2) comply with applicable laws relating to qualifications or licensure; and (3) have an in-State business location or be located not more than 50 miles from the Florida State line.

Once they meet these requirements, the types of entities that may enroll in the DME program include: (1) businesses and pharmacies that supply DME and medical supplies; (2) home health agencies; (3) orthopedic physicians' groups that supply orthotic and prosthetic devices, which are not otherwise included in the physician's office visit charge; and (4) optometrists and opticians who supply prosthetic eyes.

To become eligible for initial enrollment, continued enrollment, or re-enrollment as a Medicaid DME provider, each applicant must meet the enrollment requirements, unless otherwise exempt. For details on the State requirements related to DME providers, see Appendix A.

The State agency requires the applicant's DME and medical services business to receive an unannounced site visit before the DME provider is approved for enrollment, unless it is exempt from a pre-enrollment site visit. However, followup site visits are not a State agency requirement for continued enrollment or re-enrollment as a DME provider.

HOW WE CONDUCTED THIS REVIEW

For the period March 1, 2011, through March 31, 2012, the State agency paid claims for DME providers totaling about $152 million, to 4,066 DME providers throughout Florida. We limited our review to Medicaid DME providers within Miami-Dade County, Florida. We did not review DME providers that were: (1) entities operated by and within a pharmacy that is currently

enrolled as a Medical pharmacy provider, (2) individuals who were licensed Medicaid-enrolled orthotists or prosthetists who provide only orthotic or prosthetic devices, (3) under Federal investigation, or (4) reimbursed less than $5,000 by the State agency during the audit period. We reviewed 71 DME providers that received a total of $15,389,164 in Medicaid reimbursements to determine whether they complied with 5 judgmentally selected DME enrollment requirements relating to (1) physical location,[3] (2) business hours, (3) signage, (4) functional land-line business phone, and (5) proof of current accreditation that were identifiable during onsite inspections.

We conducted this performance audit 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.

Appendix B contains the details of our audit scope and methodology and Appendix C contains the related OIG reports.

FINDINGS

The State agency generally ensured that DME providers complied with selected Florida DME enrollment requirements. Of the 71 DME providers that we visited in Miami-Dade County and that received a total of about $15 million from Medicaid during the 13 months prior to our site visits, 61 providers complied with the selected enrollment requirements. However, 10 providers did not comply:

- Six providers did not have the required signage to identify them as DME providers.
- Two providers either did not meet the business-hour requirements or were not open during posted business hours.
- Two providers did not notify the State agency that their business addresses had changed.

These 10 providers did not comply with the enrollment requirements because the State agency did not maintain proper oversight through periodic monitoring. The State agency requires the applicant's DME and medical services business to receive an unannounced site visit before the DME provider is approved for enrollment, unless it is exempt from a pre-enrollment site visit. However, followup site visits are not a State agency requirement for continued enrollment or re-enrollment as a DME provider. For these 10 providers, we were not able to find documentation of followup site visits in their provider files. As a result of the State agency's lack of periodic monitoring of DME providers, the Medicaid DME program in general and the $1,907,669 that the State agency claimed for these 10 providers were vulnerable to fraud, waste, and abuse.

[3] In addition to checking whether the DME provider has a physical location with DME and medical supplies on site, we also verified that the provider was at the current location identified by the State.

DURABLE MEDICAL EQUIPMENT PROVIDERS DID NOT HAVE ADEQUATE BUSINESS SIGNAGE

Chapter 1 of the *DME and Medical Supply Services Coverage and Limitations Handbook* (the *Handbook*) says that a provider must have signage that readily identifies the business location as a business that furnishes DME, medical supplies, or both. Six providers did not comply with this requirement.

DURABLE MEDICAL EQUIPMENT PROVIDERS FAILED TO MEET BUSINESS-HOUR REQUIREMENTS

Chapter 1 of the *Handbook* requires that a provider must have posted business hours and that it operate no less than 5 hours per day, 5 days per week.

Two providers did not comply with these requirements. One provider did not have its business hours posted. The other provider was not open during its posted business hours.

DURABLE MEDICAL EQUIPMENT PROVIDERS FAILED TO NOTIFY THE STATE AGENCY UPON CHANGING PHYSICAL LOCATION OR DISCONTINUING OPERATIONS

Chapter 1 of the *Handbook* requires that a provider must have a current physical DME business location and that the State agency's Provider Enrollment office must be notified of any change in that location. The *Florida Medicaid Provider Enrollment Application* requires the provider to certify that it is its responsibility to notify Medicaid's fiscal agent of any change to the information on the application. In addition, Chapter 2 of the *Florida Medicaid Provider General Handbook* states that, if a provider's business is closed, abandoned, or nonoperational, the effective date of termination will be the date that the business was closed, abandoned, or became non-operational or that the State became aware of the change.

Two providers did not notify the State agency that their businesses were either no longer at the physical location provided to the State agency or closed, abandoned, or nonoperational. Specifically, one provider had a physical DME location with DME and medical supplies on site; however, the State agency did not know that it had relocated. During our site visit of the other provider, we found a vacant facility.

RECOMMENDATIONS

We recommend that the State agency:

- terminate, sanction, or recoup Medicaid funds from the providers not in compliance with the State agency's DME enrollment requirements and

- strengthen enrollment procedures to include recurring site visits to ensure that DME providers comply with the State agency's enrollment requirements.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency generally did not concur with our findings. Of the 10 DME providers that we identified as not being in compliance with the selected enrollment standards, the State agency concurred with our findings for 4 providers. The State agency did not agree that six DME providers were not in compliance with requirements related to having adequate signage or meeting business hours. After our visits to the DME providers, the State agency said that it conducted onsite reviews of the providers who are currently active and found that in most instances, the errors that we identified were not evident at the time of its visits.

In addition, the State agency suggested that we revise the title of our audit report because it implied a greater rate of noncompliance than the review actually determined. The State agency also suggested that we clarify that the instances of noncompliance fell on only 5 days after the 13-month period of time for which we reported total payments to the noncompliant DME providers.

The State agency also stated that it has instituted a vigorous pre-enrollment process and also conducts regular, unannounced monitoring site visits to verify compliance with Medicaid policy.

We attached the State agency's comments with certain information redacted for privacy/security reasons at Appendix D.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments, we revised the title of this report; however, we maintain that our findings are valid. When we made our onsite visits, 10 DME providers were not in compliance with the selected enrollment requirements, as evidenced by the pictures we have from our onsite visits. We also maintain that, because the DME providers were not in compliance with the selected enrollment requirements, payments made to these providers during the period preceding the site visits were vulnerable to fraud, waste, and abuse.

APPENDIX A: STATE REQUIREMENTS FOR DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLY PROVIDERS

Chapter 1 of the *DME and Medical Supply Services Coverage and Limitations Handbook* states: to become eligible for initial enrollment, continued enrollment, or re-enrollment as a Medicaid DME provider, each applicant must meet the enrollment requirements, unless otherwise exempt. Below are some of the enrollment requirements with which each applicant must comply. The applicant must:

- have a physical DME business location[4] with DME and medical supplies on site and readily available to the general public;
- be easily accessible to the local public served during its scheduled, posted business hours and must operate no less than 5 hours per day, 5 days per week;
- have signage that can be easily read from a distance of 20 feet that readily identifies the business location as a business that furnishes DME, medical supplies, or both;
- have a functional land-line business phone; and
- submit proof of current accreditation as a prerequisite for enrollment, continued enrollment, or reenrollment.

The *Florida Medicaid Provider Enrollment Application* requires the provider to certify that it is its responsibility to notify Medicaid's fiscal agent of any change to the information on the application. In addition, Chapter 2 of the *Florida Medicaid Provider General Handbook* states that, if a provider's business is closed, abandoned, or nonoperational, the effective date of termination will be the date that the business was closed, abandoned, or became non-operational or that the State became aware of the change.

[4] In addition to checking whether the DME provider has a physical location with DME and medical supplies on site, we also verified that the provider was at the current location identified by the State.

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

For the period March 1, 2011, through March 31, 2012, we limited our review to certain Medicaid DME providers within Miami-Dade County, Florida. We also excluded DME providers that were exempt from any of the selected enrollment requirements, which included:

- individuals licensed as orthotists or prosthetists who provide only orthotic or prosthetic devices as Medicaid DME providers and

- DME providers that operated by and within a pharmacy and were currently enrolled as Medicaid pharmacy providers.

After taking into account the exclusions above, we determined that the State agency claimed $15,389,164 ($8,574,068 Federal share) for DME and medical supply payments made to 71 DME providers during the audit period. We reviewed these DME providers.

We did not review the overall internal control structure of the State agency or the Medicaid program. Rather, we limited our internal control review to the objective of our audit.

We conducted our fieldwork at the State agency's offices in Tallahassee, Florida, and at 71 DME providers' offices throughout Miami-Dade County, Florida.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable State guidance;

- judgmentally selected five enrollment requirements relating to (1) physical location, (2) business hours, (3) signage, (4) functional land-line business phone, and (5) proof of current accreditation, that were identifiable during onsite inspections;

- interviewed the State agency officials to identify policies and procedures related to the DME enrollment requirements;

- obtained from the State agency a list of paid claims for all DME providers from March 1, 2011, through March 31, 2012;

- refined the list of DME providers to exclude from our review the DME providers that were:

    - entities operated by and within a pharmacy that is currently enrolled as a Medical pharmacy provider,

- individuals who were licensed Medicaid-enrolled orthotists or prosthetists that provide only orthotic or prosthetic devices,
- under Federal investigation, or
- reimbursed less than $5,000 by the State agency during the audit period; and

- conducted site visits at 71 DME providers in Miami-Dade County, Florida.

We conducted this performance audit 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.

APPENDIX C: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Review of Medicaid Payments to Excluded or Terminated Durable Medical Equipment Suppliers in Florida	A-04-11-07020	12/11
Review of Provider Compliance With the District of Columbia's Medicaid Durable Medical Equipment Program Standards for Physical Presence	A-03-11-00202	08/11
Review of Medicare Claims for Home Blood-Glucose Test Strips and Lancets — Durable Medical Equipment Medicare Administrative Contractor for Jurisdiction D	A-09-08-00046	02/11
South Florida Durable Medical Equipment Suppliers: Results of Appeals	OEI-03-07-00540	10/08
Medical Equipment Suppliers: Compliance With Medicare Enrollment Requirements	OEI-04-05-00380	03/07
South Florida Suppliers' Compliance With Medicare Standards: Results from Unannounced Visits	OEI-03-07-00150	03/07
Medicaid Provider Enrollment Standards: Medical Equipment Providers	OEI-04-05-00180	10/06

APPENDIX D: STATE AGENCY COMMENTS

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

April 12, 2013

Ms. Lori S. Pilcher
Regional Inspector General for Audit Services
Department of Health & Human Services
Office of Inspector General
Office of Audit Services, Region IV
61 Forsyth Street, SW, Suite 3T41
Atlanta, GA 30303

Dear Ms. Pilcher:

Thank you for your letter of March 13, 2013, requesting us to provide comments on the draft report number A-04-12-07034 entitled *Florida Did Not Always Ensure That Providers Complied With Selected State Durable Medical Equipment Enrollment Requirements.* In accordance with your request, we have emailed you our response.

If you have any questions regarding our response, please contact Mary Beth Sheffield, Audit Director, at 850-412-3978.

Sincerely,

Elizabeth Dudek
Secretary

ED/szg
Enclosure

Summary of Findings

The State agency did not always ensure that DME providers complied with selected Florida DME enrollment requirements. Of the 71 DME providers that we visited in Miami-Dade County and that received a total of about $15 million from Medicaid during the 13 months that we reviewed, 60 providers complied with the selected enrollment requirements. However, 10 providers did not comply: 6 did not have the required signage to identify them as DME providers, 2 either did not meet the business-hour requirements or were not open during posted business hours, and 2 did not notify the State agency that their business addresses had changed.

These 10 providers did not comply with the enrollment requirements because the State agency did not maintain proper oversight through periodic monitoring. The State agency requires the applicant's DME and medical services business to receive an unannounced site visit before the DME provider is approved for enrollment, unless it is exempt from a pre-enrollment site visit. However, follow up site visits are not a State agency requirement for continued enrollment or reenrollment as a DME provider. For these 10 providers, we were not able to find follow up site visits in their provider files. As a result of the State agency's lack of periodic monitoring of DME providers, the Medicaid DME program in general and the $1,907,669 that the State agency claimed for these 10 providers were vulnerable to fraud, waste, and abuse.

Recommendation#1

Terminate, sanction, or recoup Medicaid funds from the providers not in compliance with the State agency's DME enrollment requirements.

Agency Response and Corrective Action Plan:

Florida Medicaid is statutorily required to conduct pre-enrollment site visits for every DME applicant statewide to ensure compliance with current state and federal requirements prior to issuing a Medicaid provider number; when an applicant is found not to be compliant, the application is denied and no provider number is issued. While the Florida Medicaid program is very strict in its enforcement at pre-enrollment, obviously a provider cannot be reviewed every day for non-compliance. Detection and enforcement protocols have to be employed to ensure that priority is given to the higher risk providers. While AHCA agrees that DME providers are, generally, among the higher-risk provider types, providers have to be reviewed based upon their individual characteristics and subjected to onsite follow up reviews as indicated by claims analysis and other factors. In fact, as described further below, the identified providers have been subjected to follow-up reviews since enrollment. Furthermore, while AHCA will accept evidence from any source regarding provider non-compliance, and will take appropriate action as a result of that evidence, this particular report suggests that the issues are more significant than AHCA can agree with.

There are nearly 500 active Medicaid DME providers presently in Miami-Dade County. The title of this report implies a much greater rate of non-compliance than the review actually determined and we would recommend that title be amended to appropriately reflect that fact, perhaps to describe that Florida has Minor Deficiencies with regard to Selected Provider Enrollment Standards for Durable Medicaid Equipment Providers. Additionally, the report implies that nearly $2 Million has been identified as potential overpayment. However, the figure is based upon reimbursements over a 13-month period of time. The alleged non-compliances were on a specific date (presumably one day each), and as such, any sanction or overpayment potential is based solely upon the specific date that there is evidence to suggest that non-compliance.

State law would not allow recovery of overpayments or sanctions for any non-compliance that is unknown or speculative, therefore, the potential vulnerability addressed in the report should also be amended to reflect the amount of reimbursement to each of the 10 DME providers on the single date that the reviewers have evidence of potential non-compliance. The report should also be amended to clarify that while the review encompassed a 13-month period of time, the non-compliances noted fell on only five days during that period of time. It is simply inaccurate to suggest that the entire 13-month period of time revealed non-compliances since the findings were based upon a single instance of a subjective event. The precise

date that each of the 10 DME provider locations were reviewed and the non-compliance found should be noted in the report. AHCA will review the documentation provided by HHS, and consistent with state law, appropriate action will be taken. If the policy violations are documented, Medicaid will consult with the Office of Medicaid Program Integrity (MPI) regarding the appropriate sanction to be levied for that single date of violation.

The dates of non-compliance covered five days, however, based upon the 13-month reimbursements, the total amount of potential vulnerability is presumed to be less than $5,000 (combined for all 10 providers). This figure much more accurately describes the significant efforts that Florida makes to ensure that participating providers are compliant with governing laws. Furthermore, the report fails to include any reference to AHCA's efforts to monitor compliance subsequent to enrollment. In fact, all 10 of the providers identified by HHS have been reviewed[1] by AHCA since their respective enrollment dates and on the date of the AHCA reviews they were not found to be non-compliant in the areas noted by HHS.

Furthermore, subsequent to the HHS review, AHCA conducted a brief onsite review of each of the providers who are currently active ([redacted] is no longer an active provider) and found that in most instances, any errors perceived by HHS were not evident at the time of the AHCA visit.

- *HHS indicated that six of the provider's did not have the required signage to identify them as DME providers – AHCA concurs with regard to two of the providers and will refer those two providers ([redacted]) to MPI for sanction.*

- *HHS said that two DME providers either did not meet the business-hour requirements or were not open during posted business hours – AHCA does not concur with that assessment as both providers were open during posted hours and had hours properly posted.*

- *HHS said that two providers did not notify the State agency that their business addresses had changed – one was the provider whose business closed (AHCA will terminate that provider number as closed) and the other ([redacted]) has either closed or relocated without advising AHCA; we will recommend that the Medicaid Director terminate the contract for this provider.*

The findings of this report demonstrate the Florida Medicaid program's aggressive stance regarding provider compliance, particularly with regard to DME providers. Florida Medicaid takes advantage of all current administrative tools at its disposal when an actively enrolled provider is found to have violated any of the policies promulgated into rule. We believe the aforementioned recommended changes will more accurately describe those efforts and do not believe further action is warranted.

Recommendation#2

Strengthen enrollment procedures to include recurring site visits to ensure that DME providers comply with the State agency's enrollment requirements.

Agency Response and Corrective Action Plan:

The Florida Medicaid Program requires every participating provider to sign a provider agreement as required by Section 409.907, Florida Statutes. The provider agreement requires ongoing compliance with the provisions of Medicaid policy that are considered at the time of enrollment. Furthermore, the agreement at paragraph (5) subsection (p) states: "A Medicaid provider shall agree to notify the Agency of any changes to the information furnished on the Florida Medicaid Provider Enrollment Application including changes of address, tax identification number, group affiliation, depository bank account, and principals..." Also, the Agency for Health Care Administration under Rule 59G-9.070, Florida Administrative Code,

[1] The nature of the review varied for each provider and they may not have all had an onsite review.

sanctions violators under the authority as stated on paragraph 7, subsection (o) "For failure to comply with the notice and reporting requirements of Section 409.907, F.S." or under paragraph 7, subsection (e) for other policy violations such as signage or office hours violations. The Agency is also authorized to terminate the contract with any participating provider, as specified in the provider agreement at paragraph (7), with 30 days' notice to the provider. Had any of the violations noted by HHS been evident during subsequent reviews which were conducted regarding these providers, the providers would have been sanctioned or terminated for the violations.

As previously stated, the Florida Medicaid program recognized early on the importance of maintaining a compliant DME provider network in order to avoid and suppress instances of fraud and abuse. Towards that goal, the state of Florida has instituted a vigorous and proactive pre-enrollment process. In addition, Florida Medicaid also conducts regular and unannounced monitoring site visits within their networks to verify compliance with Medicaid policy. Furthermore, MPI conducts regular DME projects, the objectives being to verify compliance with all applicable laws and policies. In cases where non-compliance issues are uncovered, the Florida Medicaid program and its regulatory partners will apply all administrative sanctions allowed by law including fines, recoupment of inappropriate reimbursements and termination from the Medicaid program. The Florida Medicaid program will continue to conduct random monitoring visits to DME providers and will work closely with MPI and our licensing partner within the Agency for Health Care Administration to ensure compliance with all DME enrollment requirements.