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Florida Fines Medicaid HMO for Failing to Report Suspected Fraud by Providers

The Florida Agency for Health Care Administration ("AHCA") in August 2011 fined Humana $3.4 million for failing to promptly report suspected cases of Medicaid fraud and abuse by others, as required by statute and Humana's Medicaid HMO contract. Though many states have similar laws or regulations, this appears to be the first enforcement action of its kind in the nation. These laws and regulations impose substantial requirements on managed care companies to engage in anti-fraud investigative activities of their providers and promptly report the results of those investigations to the appropriate state agencies. Given the current budgetary constraints throughout the country, many states could begin to enforce these investigation and reporting requirements more stringently.

The Florida Action

Under Florida law, managed care organizations ("MCOs") that participate in the state Medicaid program have substantial statutory and contractual obligations to conduct robust and comprehensive investigative activities designed to detect and prevent overpayments, abuse and fraud. Additionally, MCOs must report all suspected or confirmed instances of provider or recipient fraud and abuse within 15 calendar days after detection to the Florida Office of Medicaid Program Integrity. Failure to report will result in a fine of $1,000 per day. In the situation with Humana, AHCA alleged that it failed to report suspected cases of provider fraud within the 15-day reporting period, stemming as far back as August 2009. For these statutory violations, AHCA imposed a $2.7 million fine

AHCA also found that Humana violated its Medicaid HMO contract by failing to report suspected or confirmed instances of fraud and abuse by Medicaid providers within 15 days. Pursuant to the contract terms, the AHCA imposed a second fine for $660,000.

Beyond Florida

Florida is not alone in imposing stringent anti-fraud mandates on Medicaid MCOs. In fact, nearly all states have substantially similar requirements, a development that stems back to the late 1990s, when the U.S. Health and Human Services Office of Inspector General released its Draft Compliance Guidance for Managed Care Organizations. In Texas, Medicaid MCOs must conduct preliminary investigations "within 15 working days of the identification and/or reporting of suspected fraud and/or potential waste, abuse, or fraud." Other states, including Kentucky, Maryland, New York, and California, impose similar requirements. Though nearly all states have similar reporting requirements on the books, the recent Florida sanctions appear to be the first enforcement action of its kind. With budgetary constraints affecting states across the country, this could signal a new era of enforcement activity. An MCO could easily fail to comply with such a statute, regulation or contractual obligation, and be faced with similar multi-million dollar fines for failing to detect or report fraud by others.

In addition, these regulations go beyond reporting suspected fraud. MCOs also have a duty to adopt robust fraud detection procedures. In Texas, for example, MCOs must adopt a plan to prevent and reduce fraud, abuse, and waste and must submit the plan to the Health and Human Services Commission on an annual basis. The plan must outline procedures for detecting, investigating, and referring possible fraud and abuse to the state Medicaid agency, as well as training personnel to prevent fraud and abuse. Similarly, California requires every health care service plan licensed to do business in the state to establish an antifraud plan. In New York, MCOs must establish a full-time special investigation unit "responsible for investigation of cases of suspected fraudulent and abusive activity."

Potential Future Enforcement

Going forward, it is important that all Medicaid MCOs adopt robust and effective anti-fraud investigation plans and become familiar with reporting regulations and contractual obligations in the states in which they operate. As a potentially lucrative and relatively easy activity to target, states may begin to enforce these regulations and contractual obligations more stringently. As the Humana action is the first of its kind, it will be important to monitor whether other states follow suit.