

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**FLORIDA MADE SOME PAYMENTS FOR  
PHARMACY ITEMS THAT EXCLUDED  
PROVIDERS HAD PRESCRIBED**

*Inquiries about this report may be addressed to the Office of Public Affairs at  
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Lori S. Pilcher  
Regional Inspector General  
for Audit Services

June 2014  
A-04-11-07024

# *Office of Inspector General*

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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

*The State agency made some payments for pharmacy items that excluded providers had prescribed, resulting in overpayments totaling \$180,416 (\$99,568 Federal share). Furthermore, it may have paid up to \$2.7 million to providers for pharmacy items prescribed by excluded providers because invalid information was included in the prescribing provider ID field.*

### WHY WE DID THIS REVIEW

We chose to review Florida Medicaid payments for pharmacy items because an Office of Inspector General (OIG) review determined that Centers for Medicare & Medicaid Services (CMS) did not have edits in place to check the validity of the prescribing provider identifier (ID) field on the Prescription Drug Event (PDE) record. Specifically, the report (A-14-09-00302) revealed that, for calendar year (CY) 2007, certain types of drug costs for approximately 228,000 PDE records had invalid prescribing provider IDs totaling approximately \$20.6 million.

The objective of our audit was to determine whether the State agency made payments for pharmacy items that excluded providers had prescribed for CYs 2009 and 2010.

### BACKGROUND

The U.S. Department of Health and Human Services, OIG, under Congressional mandate, established a program to exclude providers affected by various legal authorities contained in sections 1128 and 1156 of the Social Security Act. Under the exclusions program, Medicare and Medicaid should not pay for items or services furnished, ordered, or prescribed by an excluded provider.

In Florida, the Agency for Health Care Administration (State agency) is designated to administer the Florida Medicaid program. The Medicaid program in Florida made reimbursements for pharmacy claims totaling approximately \$2.3 billion for CYs 2009 and 2010 (audit period).

### WHAT WE FOUND

The State agency made some payments for pharmacy items that excluded providers had prescribed. Specifically, the State agency made payments, totaling \$180,416 (\$99,568 Federal share), for pharmacy items that excluded providers had prescribed during the audit period. These overpayments occurred because the State agency had inadequate policies and procedures to ensure that no payments were made for pharmacy items excluded providers had prescribed.

In addition, we were unable to test 904,022 pharmacy claims, totaling approximately \$28.6 million, to determine whether the State agency made payments for pharmacy items that excluded providers had prescribed. Furthermore, the State agency determined that, of those pharmacy claims, 260,220 claims, totaling approximately \$2.7 million, had invalid information in the prescribing provider ID field. This invalid information occurred because the State agency had

inadequate policies and procedures to ensure that valid prescribing provider IDs were included on submitted pharmacy claims before it paid them. As a result, the State agency may have paid up to \$2.7 million to providers for pharmacy items that excluded providers had prescribed.

## **WHAT WE RECOMMEND**

We recommend that the State agency:

- refund \$99,568 to the Federal Government for the improper Medicaid payments for pharmacy items prescribed by excluded providers and
- improve policies and procedures to ensure that excluded providers do not receive Medicaid payments for pharmacy items they prescribed and that all pharmacy claims have valid information in the prescribing provider ID field.

## **STATE AGENCY COMMENTS**

In written comments on our draft report, the State agency concurred with our first recommendation. Regarding our second recommendation, it stated that it reviewed the issues surrounding this finding and researched options that it could implement to increase program integrity over pharmacy claims.

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## INTRODUCTION

### WHY WE DID THIS REVIEW

We chose to review Florida Medicaid payments for pharmacy items because an Office of Inspector General (OIG) review determined that Centers for Medicare & Medicaid Services (CMS) did not have edits in place to check the validity of the prescribing provider identifier (ID) field on the Prescription Drug Event (PDE) record. Specifically, the report<sup>1</sup> revealed that, for calendar year (CY) 2007, certain types of drug costs for approximately 228,000 PDE records had invalid prescribing provider IDs totaling approximately \$20.6 million.

### OBJECTIVE

Our objective was to determine whether the State agency made payments for pharmacy items that excluded providers had prescribed for CYs 2009 and 2010.

### 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, CMS, an agency within the U.S. Department of Health and Human Services (HHS), 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.

#### **Florida's Medicaid Program**

##### *Who Administers the Medicaid Program in Florida?*

In Florida, the Agency for Health Care Administration (State agency) is responsible for administering the Medicaid program. The State agency contracts with HP Enterprise Services (formerly Electronic Data Systems) to maintain its Medicaid Management Information System, a computerized payment and information reporting system that processes and pays Medicaid claims. The Medicaid program in Florida made reimbursements for pharmacy items, totaling approximately \$2.3 billion, for the period January 1, 2009, through December 31, 2010.

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<sup>1</sup> See report number A-14-09-00302.

## **Exclusions Program**

HHS, OIG, has the authority to exclude providers from federally funded health care programs (sections 1128 and 1156 of the Social Security Act).<sup>2</sup> Under the exclusion program, Medicare and Medicaid should not pay for items or services furnished, ordered, or prescribed by an excluded provider. The exclusion applies regardless of who submits the claims and applies to all administrative and management services furnished by the excluded provider.

To administer the exclusion program, OIG maintains a database of all currently excluded parties, called the *List of Excluded Individuals/Entities* (LEIE).<sup>3</sup> In addition, CMS maintains a database, called the *Medicare Exclusion Database* (MED), to collect and convey information that is used to help prevent payments to excluded providers for services furnished during the exclusion period.

The State agency uses the LEIE and the MED to identify which providers OIG has excluded from the Medicare or Medicaid programs. The State agency conducts periodic searches for excluded providers by matching names and social security numbers (SSNs), if available, in the LEIE and MED to the Florida Medicaid provider file. CMS provides the MED files to State Medicaid agencies every month. The CMS *State Medicaid Director Letter* #08-003, dated June 12, 2008, directed States to conduct monthly searches via the LEIE or MED to capture recent exclusions and reinstatements. See Appendix A for details on the Federal requirements and guidance to States regarding excluded providers.

OIG also periodically sends exclusion letters to the State agencies identifying providers who have been excluded from participation in Medicare, Medicaid, and all Federal health care programs. The letters instruct the State agencies to exclude the providers from participation in the Medicaid program. The letters identify the applicable sanction authority, as well as the excluded individual's name, address, SSN, and date of birth.

## **HOW WE CONDUCTED THIS REVIEW**

For CYs 2009 and 2010 (audit period), the State agency paid almost 41 million pharmacy claims totaling approximately \$2.3 billion. From these pharmacy claims, we removed about 38.6 million claims, totaling approximately \$2.2 billion, because of low-dollar thresholds,<sup>4</sup> Medicaid

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<sup>2</sup> Some examples of reasons individuals and entities may be excluded are: (1) conviction relating to fraud, patient abuse, or felony or misdemeanor possession of controlled substances; (2) license revocation or suspension; (3) failure to supply payment information; (4) default on health education loan or scholarship obligations; or (4) making false statements or misrepresentation of material facts.

<sup>3</sup> This database, which is available on the OIG Web site ([https://oig.hhs.gov/exclusions/exclusions\\_list.asp](https://oig.hhs.gov/exclusions/exclusions_list.asp)), lists parties that are excluded from participation in Medicare, Medicaid, and all other Federal health care programs.

<sup>4</sup> We removed the claims in which the aggregate amount paid each year for each prescribing provider was less than \$1,000.

enhanced benefits not requiring a prescription,<sup>5</sup> or no exact name or similar name matches after comparing the prescribing provider's name to the MED. In addition, we identified and separated from the population 904,022 pharmacy claims, totaling approximately \$28.6 million, that had atypical IDs in the prescribing provider field that did not match either the National Provider Identification (NPI) table or the Florida license database.<sup>6</sup> From the remaining 1,480,146 pharmacy claims, totaling approximately \$131.9 million,<sup>7</sup> we judgmentally selected for review 368,356 claims, which totaled about \$45 million.

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 scope and methodology, and Appendix C contains related OIG reports.

## FINDINGS

The State agency made some payments for pharmacy items that excluded providers had prescribed. Specifically, the State agency made payments, totaling \$180,416 (\$99,568 Federal share), for pharmacy items that excluded providers had prescribed during the audit period. These overpayments occurred because the State agency had inadequate policies and procedures to ensure that no payments were made for pharmacy items excluded providers had prescribed.

In addition, we were unable to test 904,022 pharmacy claims, totaling approximately \$28.6 million, to determine whether the State agency made payments for pharmacy items that excluded providers had prescribed. Furthermore, the State agency determined that, of those pharmacy claims, 260,220 claims, totaling approximately \$2.7 million, had invalid information in the prescribing provider ID field. This invalid information occurred because the State agency had inadequate policies and procedures to ensure that valid prescribing provider IDs were included on submitted pharmacy claims before it paid them. As a result, the State agency may have paid up to \$2.7 million to providers for items that excluded providers had prescribed.

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<sup>5</sup> These are claims under the Medicaid Enhanced Benefits Rewards program. A generic code is used in the prescribing provider ID field for nonprescription, point-of-sale items purchased at the pharmacy (e.g., an over-the-counter medicine).

<sup>6</sup> Many of the prescribing provider IDs in the claims data obtained from the State agency lacked information (name, address, etc.) but fit the pattern of either NPI numbers or Medicaid IDs. Therefore, we compared the NPI and Medicaid IDs, when possible, with the CMS NPI table and the Florida license database, respectively. This comparison was one of the procedures we performed to determine the validity of the prescribing provider ID.

<sup>7</sup> Because we are rounding such large figures, the resulting amount pertaining to the remaining 1,480,146 pharmacy claims may seem greatly understated; however, the actual amount is \$131,879,556.

## **IMPROPER PAYMENTS MADE TO PROVIDERS FOR PHARMACY ITEMS PRESCRIBED BY EXCLUDED PROVIDERS**

Federal regulations prohibit payments for items prescribed by providers that have been excluded from participation in Medicare and Medicaid. However, the State agency made improper payments to providers for pharmacy items prescribed by excluded providers totaling \$180,416 (\$99,568 Federal share) during the audit period. These overpayments occurred because the State agency had inadequate policies and procedures to ensure that it did not make payments for pharmacy items that excluded providers had prescribed.

## **INVALID INFORMATION IN THE PRESCRIBING PROVIDER IDENTIFIER FIELD ON SOME PHARMACY CLAIMS**

Requiring a valid prescribing provider ID on a pharmacy claim is a valuable program integrity safeguard. Without this information, it is extremely difficult for the State agency to determine whether items are being prescribed by providers that have been excluded from the Medicare or Medicaid programs.

Of the nearly 41 million pharmacy claims that the State agency reimbursed during the audit period, we were unable to test 904,022 (approximately 2 percent) claims, totaling approximately \$28.6 million, because the information in the prescribing provider ID field either was not recorded (a blank field) or did not match the NPI table or Florida license database.

We requested that the State agency determine whether the prescribing provider IDs on these claims were valid because invalid prescribing providers increase the probability of Medicaid fraud, waste, and abuse. The State agency limited its review to determining whether the prescribing provider ID was valid and not whether the prescribing providers associated with those claims had been excluded from the Medicare or Medicaid programs. After conducting its own review, the State agency concluded that \$25.9 million of the \$28.6 million in pharmacy claims that it reviewed included a valid prescribing provider ID.<sup>8</sup> However, it was unable to determine whether the prescribing provider IDs were valid for 260,220 pharmacy claims totaling \$2.7 million. Therefore, the State agency could not properly monitor, detect, prevent, or control fraud, waste, and abuse for these claims.

The State agency had some policies and procedures to identify excluded providers, which included conducting a search of the LEIE. In addition, the State identified excluded providers when it received a letter from OIG notifying it when a provider had been excluded from participation in Medicare and Medicaid. However, during our audit period, the State agency did not have sufficient prepayment controls in place to ensure that, before paying a pharmacy claim, it verified that a valid prescribing provider ID was on the claim. As a result of the State agency's insufficient review of the information in the prescribing provider ID field, it may have paid up to \$2.7 million to providers for pharmacy items that excluded providers had prescribed.

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<sup>8</sup> Because the State agency required so much time to conduct its review, we were unable to verify whether the prescribing providers had been excluded.

## **RECOMMENDATIONS**

We recommend that the State agency:

- refund \$99,568 to the Federal Government for improper Medicaid payments for pharmacy items prescribed by excluded providers and
- improve policies and procedures to ensure that excluded providers do not receive Medicaid payments for pharmacy items they prescribe and that all pharmacy claims have valid information in the prescribing provider ID field.

## **STATE AGENCY COMMENTS**

In written comments on our draft report, the State agency concurred with our first recommendation. Regarding our second recommendation, it stated that it reviewed the issues surrounding this finding and researched options that it could implement to increase program integrity over pharmacy claims.

The State agency comments are included in their entirety as Appendix D.

## **APPENDIX A: FEDERAL REQUIREMENTS AND GUIDANCE FOR EXCLUDED PROVIDERS**

“*Exclusion* means that items and services furnished, ordered or prescribed by a specified individual or entity will not be reimbursed under Medicare, Medicaid and all other Federal health care programs until the individual or entity is reinstated by the OIG” (42 CFR § 1001.2).

With respect to these reimbursements, or payments, § 1002.211 (a) states:

[N]o payment may be made by the State agency for any item or service furnished on or after the effective date specified in the notice by an excluded individual or entity, or at the medical direction or on the prescription of a physician who is excluded when a person furnishing such item or service knew, or had reason to know, of the exclusion.

CMS’s *State Medicaid Director Letter #09-001*, dated January 16, 2009, clarifies Federal statutory and regulatory prohibitions regarding Medicaid payments for any items or services furnished or ordered by providers that have been excluded from participation in Federal health care programs.

Furthermore, the Exclusions Program on the OIG Web site states that “[n]o program payment will be made for anything that an excluded person furnishes, orders, or prescribes. This payment prohibition applies to the excluded person, anyone who employs or contracts with the excluded person, any hospital or other provider for which the excluded person provides services, and anyone else.”

## APPENDIX B: AUDIT SCOPE AND METHODOLOGY

### SCOPE

For CYs 2009 and 2010 (audit period), the State agency reimbursed 40,987,134 pharmacy claims totaling approximately \$2.3 billion. From these pharmacy claims, we removed 38,602,966 claims, totaling approximately \$2.2 billion, because of low dollar thresholds,<sup>9</sup> Medicaid enhanced benefits not requiring a prescription,<sup>10</sup> or no exact name or similar name matches after comparing the prescribing provider's name to the MED. In addition, we identified and separated from the population 904,022 pharmacy claims, totaling approximately \$28.6 million, that had atypical IDs in the prescribing provider field that did not match the NPI table or Florida license database. From the remaining 1,480,146 pharmacy claims, totaling approximately \$131.9 million,<sup>11</sup> we judgmentally selected for review 368,356 claims, which totaled about \$45 million.

In performing our review, we established reasonable assurance that the claims data were accurate. We compared the total claims paid data, obtained from the Medicaid Management Information System from the State agency, to the total claims paid data obtained from the Medicaid Statistical Information System. We did not, however, assess the completeness of the Florida paid claims file from which we obtained the data. Furthermore, we did not review the overall internal control structure of the State agency or the Medicaid or Medicare programs because our objective did not require us to do so. Instead, we limited our review to the State agency internal controls that pertained to our objective.

### METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws and State guidance;
- obtained from the State agency and reviewed written policies and procedures for preventing payments for any items furnished, ordered, or prescribed by an excluded provider;
- obtained from the State agency and reviewed a database of Medicaid pharmacy claims, totaling about \$2.3 billion, submitted during the audit period;
- removed pharmacy claims, totaling about \$2.2 billion, due to:

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<sup>9</sup> We removed the claims where the aggregate amount paid each year for each prescribing provider was less than \$1,000.

<sup>10</sup> These are claims under the Medicaid Enhanced Benefits Rewards program. A generic code is used in the prescribing provider ID field for non-prescription point-of-sale items purchased at the pharmacy (i.e., an over-the-counter medicine).

<sup>11</sup> Due to the rounding of such large figures, the resulting amount pertaining to the remaining 1,480,146 pharmacy claims may seem greatly understated; however, the actual amount is \$131,879,556.

- low dollar thresholds,
  - Medicaid Enhanced Benefits not requiring a prescription, and
  - no exact name or similar name matches after comparing the prescribing provider's name to the MED;<sup>12</sup>
- identified and separated from the population 904,022 pharmacy claims, totaling approximately \$28.6 million, that had atypical<sup>13</sup> prescribing provider IDs that did not match the NPI table or Florida license database;
  - requested that the State agency determine whether the prescribing provider IDs from the 904,022 claims were valid;
  - analyzed the remaining pharmacy claims that we compared to the MED, reviewed the matching results, and judgmentally selected 368,356 claims in which the prescribing providers' names were the same or similar to excluded prescribing providers' names on the MED;
  - contacted the Florida Department of Health and CMS to obtain SSNs and DOBs for the prescribing providers found on the selected claims to determine whether they were the same individuals found on the MED;
  - obtained claim details for selected prescribing providers during the audit period to determine whether they were excluded during the time that the services were provided;
  - calculated the total amount paid for pharmacy items prescribed by excluded providers; and
  - calculated the Federal share of the expenditures using the lowest Federal Medical Assistance Percentages (54.98 to 55.45 percent) applicable for each quarter.

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.

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<sup>12</sup> We used the MED in our analysis because it contained unique IDs, such as SSNs or dates of birth (DOBs). We obtained the MED, as of June 2011, from CMS and compared it to the pharmacy claims using exact name and similar name matching to determine whether we identified any excluded prescribing providers of pharmacy items. We removed those claims that did not have exact name or similar name matches after comparing the prescribing provider's name to the MED and further analyzed the remaining claims.

<sup>13</sup> For example, some of the information in the prescribing provider ID field was blank; contained identical digits (i.e. 999999999); or contained numbers, such as tax identification, or Drug Enforcement Agency numbers. We were unable to match such IDs, because they were not contained within the MED.

**APPENDIX C: RELATED OFFICE OF INSPECTOR GENERAL REPORTS**

<b>Report Title</b>	<b>Report Number</b>	<b>Date Issued</b>
<i>Review of Medicaid Excluded Providers in Iowa</i>	<a href="#">A-07-10-03149</a>	2/2011
<i>Review of Medicaid Excluded Providers in Missouri</i>	<a href="#">A-07-10-03153</a>	2/2011
<i>Oversight of the Prescriber Identifier Field in Prescription Drug Event Data for Schedule II Drugs</i>	<a href="#">A-14-09-00302</a>	2/2011

APPENDIX D: STATE AGENCY COMMENTS



RICK SCOTT  
GOVERNOR

ELIZABETH DUDEK  
SECRETARY

May 27, 2014

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  
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Dear Ms. Pilcher:

Thank you for your letter of April 25, 2014, requesting us to provide comments on the draft report number A-04-11-07024 entitled *Florida Made Some Payments for Pharmacy Items That Excluded Providers Had Prescribed*. 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



**Agency for Health Care Administration**  
**Florida Made Some Payments for Pharmacy Items That**  
**Excluded Providers Had Prescribed**  
**Response to HHS/OIG Draft Report Number A-04-11-07024 dated April 25, 2014**

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**Summary of Findings**

The State agency made some payments for pharmacy items that excluded providers had prescribed. Specifically, the State agency made payments, totaling \$180,416 (\$99,568 Federal share), for pharmacy items that excluded providers had prescribed during the audit period. These overpayments occurred because the State agency had inadequate policies and procedures to ensure that no payments were made for pharmacy items excluded providers had prescribed.

In addition, we were unable to test 904,022 pharmacy claims, totaling approximately \$28.6 million, to determine whether the State agency made payments for pharmacy items that excluded providers had prescribed. Furthermore, the State agency determined that, of those pharmacy claims, 260,220 claims, totaling approximately \$2.7 million, had invalid information in the prescribing provider ID field. This invalid information occurred because the State agency had inadequate policies and procedures to ensure that valid prescribing provider IDs were included on submitted pharmacy claims before it paid them. As a result, the State agency may have paid up to \$2.7 million to providers for pharmacy items that excluded providers had prescribed.

**Recommendation#1**

Refund \$99,568 to the Federal Government for the improper Medicaid payments for pharmacy items prescribed by excluded providers.

**Agency Response and Corrective Action Plan:**

*The Agency concurs. To mitigate future Medicaid Pharmacy payments being made to excluded providers, the Agency is implementing the actions listed below in the response to Recommendation #2.*

**Recommendation#2**

Improve policies and procedures to ensure that excluded providers do not receive Medicaid payments for pharmacy items they prescribed and that all pharmacy claims have valid information in the prescribing provider ID field.

**Agency Response and Corrective Action Plan:**

*The Agency has reviewed the issues surrounding this finding and researched options that can be implemented to increase program integrity over pharmacy claims.*

*In 2010, the Agency, in conjunction with its Medicaid fiscal agent, Hewlett Packard Enterprise Services, LLC, and the Medicaid pharmacy vendor, Magellan, installed new system edits to ensure all pharmacy claims contain valid data in the prescriber field. Pharmacy claims submitted by prescribers licensed in Florida are validated against the Florida Department of Health license data file to ensure only practitioners with valid prescribing licenses are allowed to submit pharmacy claims for processing.*

*In 2014, the Agency installed an enhancement to the FL MMIS which created the Suspended Prescriber Table. Any prescriber's license that is prohibited by the Agency from writing prescriptions or from causing prescriptions to be written or claims to be submitted is loaded into this table. The prohibition may be the result of several types of adverse actions including exclusion from Medicare or Medicaid. The Suspended Prescriber License Table is delivered daily to the FL MMIS pharmacy system and is used to deny any claims containing the suspended prescriber's license.*

*Beginning in November of 2013 and continuing through 2014, the Agency is overseeing an enhancement project designed to bring the FL MMIS into compliance with the Affordable Care Act (ACA) Provider Screening requirements. New interfaces with federal provider screening and eligibility databases are under construction and are planned for implementation by year's end. Data from the List of Excluded Individuals*

**Agency for Health Care Administration**  
**Florida Made Some Payments for Pharmacy Items That**  
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**Response to HHS/OIG Draft Report Number A-04-11-07024 dated April 25, 2014**

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*and Entities (LEIE), Provider Enrollment, Chain and Ownership System (PECOS), National Plan and Provider Enumeration System (NPPES), Social Security Administration's Death Master File, as well as Medicare terminations will be loaded to tables in the FL MMIS. All new and renewing applicants will be compared to the data upon FL Medicaid provider enrollment application. All enrolled providers will be compared on a daily basis to ensure that no excluded person or entity is enrolled in or paid by Medicaid.*

*Also, the Agency acknowledges that challenges remain in meeting this audit finding and will continue to pursue permanent solutions, with the goal of gaining greater oversight and control regarding pharmacy claims.*

1. *FL Medicaid policy currently allows licensed providers practicing in the two border states of Alabama and Georgia to enroll in Florida Medicaid.*

*For those border providers who hold a practitioner license issued by Florida, the comparison of the license on a pharmacy claim with the practitioner license database as described above will ensure no unlicensed person is able to submit a claim for payment.*

*However, for those border providers who hold a practitioner license issued by Alabama or Georgia, there is no comparable validation to ensure that the licenses are unencumbered. The Agency will pursue a data sharing agreement with the two Border States with the goal of obtaining access to their practitioner license data which would be incorporated into the existing license match coding in the pharmacy system.*

2. *FL Medicaid policy currently allows unenrolled licensed prescribers to issue prescriptions to Medicaid eligible recipients.*

*For the unenrolled prescribers, there is no comparison to the national databases to prevent an excluded person from successfully submitting a Medicaid pharmacy claim. The comparison to the practitioner license database will prevent anyone without a valid license from successfully submitting pharmacy claims but it will not guarantee excluded practitioners are not paid for pharmacy claims.*

*The Agency will investigate possible solutions to eliminate this vulnerability once the full implementation of Statewide Medicaid Managed Care is accomplished. If the preferred solution is to require the non-Medicaid prescribing practitioners to obtain Medicaid IDs prior to submitting pharmacy claims, the Agency will exercise its existing authority for rulemaking to modify Florida Administrative Code and, if needed, will pursue additional authority through Legislative action.*