AHCA Continues to Improve Medicaid Program Data Quality and Oversight; Additional Improvements Needed in Use of Data

Report No. 20-04

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OPPAGA

Office of Program Policy Analysis and Government Accountability

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EXECUTIVE SUMMARY

The Agency for Health Care Administration's (AHCA) Division of Medicaid provides health care for low-income families and individuals and assists the elderly and people with disabilities with nursing facility care costs and other medical and long-term expenses. Statewide Medicaid Managed Care accounts for the majority of state Medicaid expenditures, but fee-for-service payments still account for over one-third of total expenditures.

REPORT SCOPE

Section 409.913(35), *Florida Statutes*, directs OPPAGA to biennially review AHCA's efforts to prevent, detect, deter, and recover funds lost to fraud and abuse in the Medicaid program. This is the ninth report in the series.[1,2]

AHCA's Office of Medicaid Program Integrity (MPI) is primarily responsible for administering and overseeing waste, fraud, and abuse prevention and detection efforts for both managed care and fee-for-service. Other entities within AHCA, including the Division of Medicaid, assist the office in this effort.

Since OPPAGA's 2018 review, AHCA has made improvements to its centralized model for managed care oversight. Oversight would be further improved by AHCA formalizing communication regarding oversight responsibilities and reorganizing the Medicaid Business Intelligence Unit.

MPI has taken steps to monitor managed care plans but lacks specific benchmarks to assess plan antifraud performance and should develop reports that provide context for plan antifraud activities. MPI should also create documentation for its Fraud and Abuse Case Tracking System to ensure that all system users consistently enter investigative information and to assist in analyzing the information in the database.

Although AHCA continues efforts to improve data quality and oversight, it does not currently have a plan or a process in place to use encounter data or fee-for-service claims data to comprehensively monitor trends in the Medicaid program. Continuing issues with the quality of the encounter data reported to the Florida Medicaid Management Information System present barriers to agency efforts to ensure program integrity for managed care, and both fee-for-service and managed care program oversight are hindered by a lack of complete data.

[1] Prior Medicaid program integrity reports are available on OPPAGA's website.

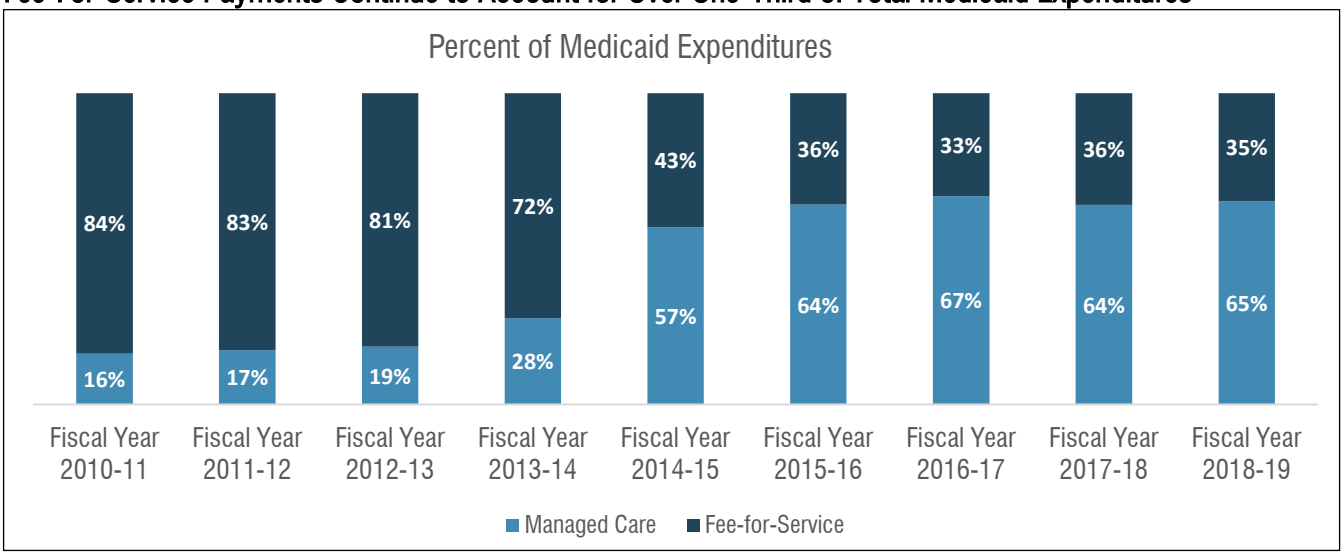
[2] Section 409.913, *F.S.*

BACKGROUND

The Agency for Health Care Administration's (AHCA) Division of Medicaid provides health care for low-income families and individuals and assists the elderly and people with disabilities with nursing facility care costs and other medical and long-term expenses.[3] Florida's Medicaid program is among the largest in the country, serving approximately 3.8 million persons each month.[4] For Fiscal Year 2019-20, the Legislature appropriated $28.6 billion to operate the program.[5]

Historically, AHCA operated Florida's Medicaid program using a fee-for-service payment system. However, with the passage of Ch. 2011-134, *Laws of Florida*, the state migrated to Statewide Medicaid Managed Care (SMMC), which was fully implemented statewide by August 2014.[6] The majority (78%) of Medicaid recipients receive services through SMMC, and 22% receive services through the fee-for-service system.[7] In addition, some services provided to SMMC enrollees are reimbursed under fee-for-service; these services include behavior analysis, organ transplants, and obstetrical care.[8] During Fiscal Year 2018-19, the SMMC system accounted for 65% ($18.1 billion) of Medicaid expenditures, and fee-for-service expenditures accounted for the remaining 35% ($9.65 billion). While SMMC continues to account for most Medicaid expenditures, fee-for-service payments have accounted for over one-third of total annual Medicaid expenditures during each of the past five fiscal years. (See Exhibit 1.)

Exhibit 1
Fee-For-Service Payments Continue to Account for Over One-Third of Total Medicaid Expenditures



Source: OPPAGA analysis of Agency for Health Care Administration data.

[3] Medicaid is a joint federal and state program where the federal government reimburses states a portion of expenditures according to a federal matching process.

[4] Participants must meet various federal and state eligibility guidelines, including income and asset tests.

[5] Of the total Medicaid budget for Fiscal Year 2019-20, $6.8 billion is general revenue and $21.8 billion is from trust funds, including federal matching funds and state funds from drug rebates, hospital taxes, and county contributions.

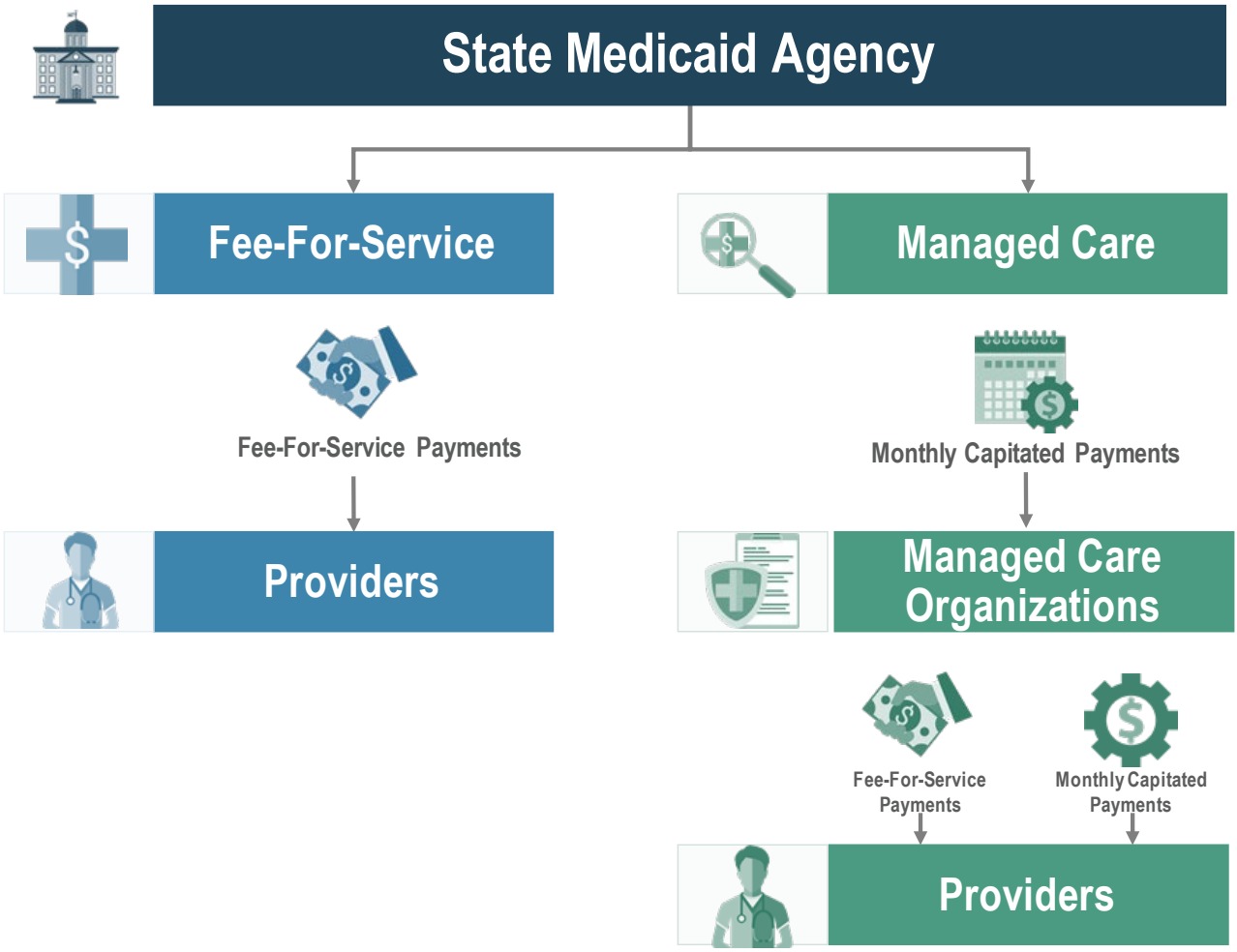
[6] Beginning in 2006, AHCA operated managed care pilot programs in several counties under a federal research and demonstration waiver.

[7] The remaining 22% that receive services on a fee-for-service basis are exempt from mandatory managed care enrollment but may still choose to enroll voluntarily. Exempt recipients include those who have other creditable health care coverage (excluding Medicare); reside in a Department of Juvenile Justice or mental health residential treatment or commitment facility; are eligible for refugee assistance; reside in a developmental disability center; or have enrolled in a home and community-based services waiver or are awaiting waiver services.

[8] While obstetrical care is covered by the SMMC plan, AHCA provides an additional payment to plans for labor and delivery services.

Medicaid fee-for-service and managed care systems have different service delivery and payment processes. Under the fee-for-service system, providers deliver services to Medicaid recipients and bill the state on an individual or itemized basis, and the state Medicaid program reimburses providers after they render the service and bill the state. Under Florida's SMMC payment system, AHCA contracts with private managed care plans for the coordination and payment of services for Medicaid recipients. The state pays the managed care plans a capitation payment, which is a fixed monthly payment per beneficiary enrolled in the managed care plan.[9] In return for the capitated payment, each managed care plan is responsible for arranging for and paying providers' claims for all covered services provided to Medicaid beneficiaries.[10] Managed care plans may pay providers on a fee-for-service basis, a monthly capitation payment per beneficiary, or through some other payment approach in which the provider assumes some risk for providing covered services. Managed care plans are required to report to AHCA the beneficiaries' encounters on services provided.[11] (See Exhibit 2.)

Exhibit 2
Medicaid Fee-for-Service and Managed Care Systems Have Different Payment Processes



Source: U.S. Government Accountability Office, GAO-18-528.

[9] Medicaid contracts with Milliman, Inc., for actuarial services for rate setting by utilizing validated cost and utilization data and adjusting for program changes.

[10] Claims are bills submitted to health insurance providers for services rendered to patients by providers of care.

[11] Section 409.967(2)(m), *F.S.*, and Rule 59G-1.054, *F.A.C.*

Federal rules require states to prevent, detect, and deter waste, fraud, and abuse in Medicaid; AHCA meets these requirements through efforts and coordination among many agency units. Program monitoring involves examining key elements of the Medicaid program to ensure services are being provided and to identify aberrant trends that may signal a problem. For monitoring to be effective, it must occur frequently enough to allow anomalies to be identified quickly, involve a comprehensive review of all key program elements to ensure the integrity of services, and coordinate efforts of differing functional units to ensure all program elements are being monitored.

AHCA's Office of Medicaid Program Integrity is primarily responsible for administering and overseeing waste, fraud, and abuse prevention and detection efforts for both managed care and fee-for-service systems.[12,13] MPI identifies and investigates fee-for-service providers suspected of fraud and abuse and ensures that SMMC contracted health plans comply with Medicaid requirements to prevent, detect, and deter abusive and fraudulent practices. The office has 99.5 positions.[14] MPI refers cases of suspected provider fraud to the Florida Attorney General's Medicaid Fraud Control Unit for investigation and prosecution of providers suspected of defrauding Medicaid.

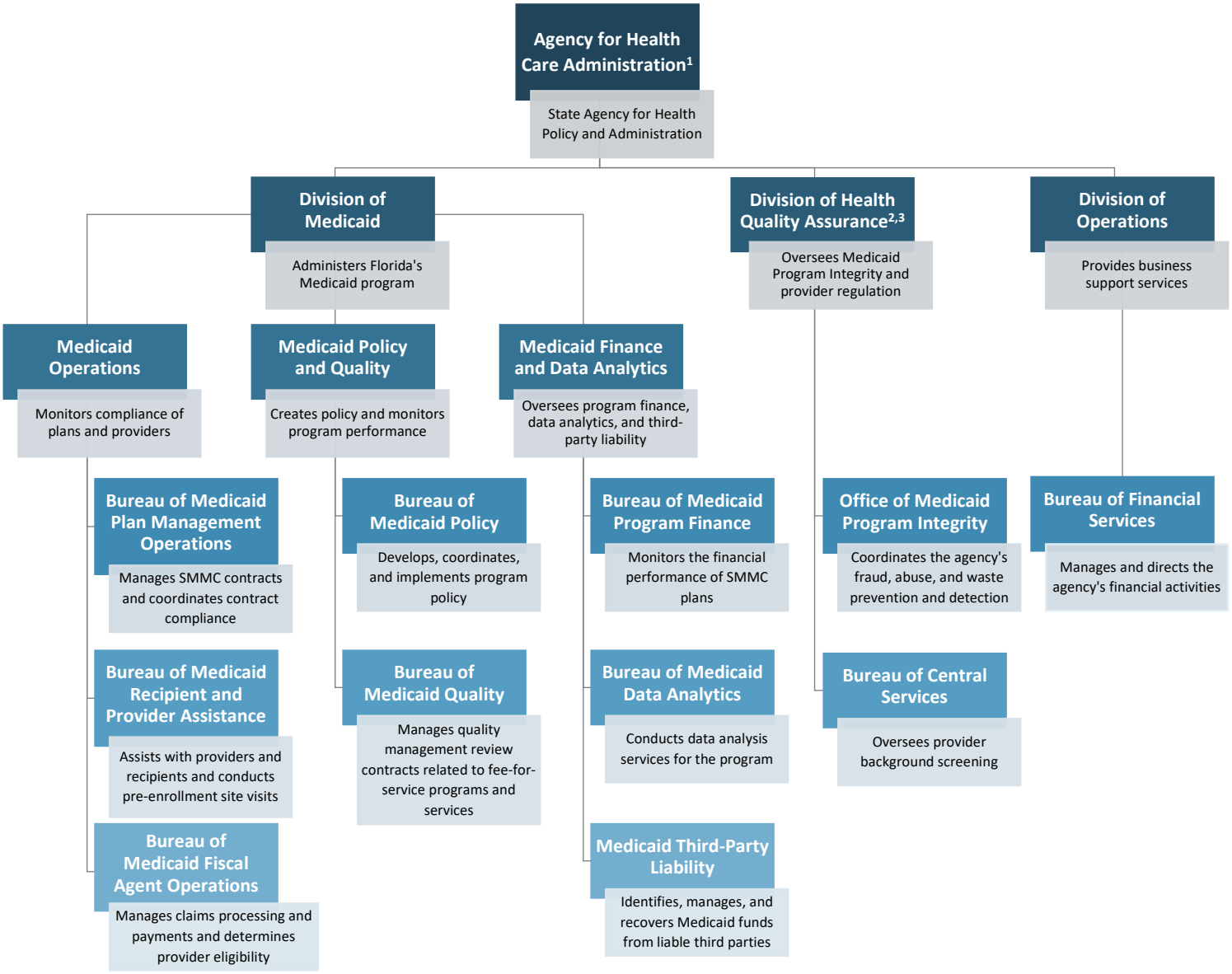
In addition to MPI, several other bureaus and units within AHCA play a role in the state's efforts to ensure the integrity of the Medicaid program. Most reside within AHCA's Division of Medicaid, while others are located within the Division of Health Quality Assurance, the Division of Operations, and the agency's Office of General Counsel. Each unit has specific roles and responsibilities related to oversight of both the fee-for-service and managed care systems. (See Exhibit 3 and Appendix A.)

[12] Since August 25, 2017, MPI is organizationally located within the Division of Health Quality Assurance.

[13] MPI's Fiscal Year 2019-20 approved operating budget to address fraud and abuse is $6.7 million, all of which is derived from the Medical Care Trust Fund; the trust fund includes funds recouped from past program integrity efforts and a 50% federal match for MPI functions.

[14] Of the 99.5 positions, 81.5 are full-time equivalent positions and 18 are other personal services positions.

Exhibit 3
Oversight Activities That Support Medicaid Program Integrity Efforts Are Coordinated Among Many AHCA Entities



[1] The General Counsel Office provides legal advice and representation for the agency on all legal matters, including the recovery of Medicaid overpayments due to abuse.
[2] The Bureau of Health Facility Regulation, in the Division of Health Quality Assurance, licenses and regulates health care facilities. The bureau's program integrity activities include initiating sanctions and managing the Statewide Provider and Health Plan Claim Dispute Resolution Program.
[3] The Bureau of Field Operations, in the Division of Health Quality Assurance, oversees facility and service inspections, conducts provider surveys, provides training for staff and providers, and oversees the agency's Complaint and Information Call Center.
Source: OPPAGA analysis of information from the Agency for Health Care Administration.

For a state to fulfill its fiduciary responsibility for Medicaid program oversight and integrity, it is essential to collect complete and accurate data.[15] State agencies and managed care plans use claims data to analyze costs, utilization, and trends; evaluate benefits; and determine service quality. Under fee-for-service systems, this data is available through a state's own claims payment system. Under managed care, states receive this information using health plan encounter data reported to the state.[16] Encounter data are records of the health care services for which managed care organizations (MCO) pay the providers of those services. Encounter data are conceptually equivalent to the paid claims records that state Medicaid agencies create when they pay providers on a fee-for-service basis. Claims from managed care plans must be accompanied by an itemized accounting of the individual claims included in the payment, including enrollee name, date of service, procedure code, amount of reimbursement, and identification of the plan on whose behalf the payment is made. Providers are required to document information for each service visit or encounter with a Florida Medicaid recipient, including date of service, diagnosis, description of services rendered, and prescribed or provided medications and supplies, among other items. States use managed care encounter data for three primary purposes, which are

- financial monitoring, including budget forecasting and capitation rate development;
- program oversight, including achievement of quality benchmark requirements, policy analyses to assess issues such as carving benefits into or out of managed care and adding or eliminating optional services; consistency of services with the state plan; cost-effectiveness of managed care service substitutes; and general oversight of managed care administration and interaction with providers; and
- managed care contract monitoring, including ensuring delivery of services; timely payment of claims; achievement of quality benchmark requirements; and provider network access and adequacy.

Individual managed care plans are responsible for arranging for and paying providers' claims for all covered services provided to Medicaid beneficiaries. This includes ensuring that beneficiaries receive quality services in the least restrictive setting with treatment and recovery capabilities that address the needs of the beneficiary for all Medicaid covered services. Similar to the state, managed care plans use provider claims and encounter data to analyze costs, utilizations, and trends; evaluate benefits; and determine service quality.

[15] Gerstorff, J. L., Gibson, S., Medicaid Encounter Data: the Next National Data Set, *In the Public Interest*, Social Insurance & Public Finance Section Council, Society of Actuaries, 13, September 2016: 6-14.

[16] Section 1903 (m)(2)(A)(xi) of the Social Security Act specifies that in order to receive federal funding for their Medicaid programs, states must include in their MCO contracts a provision that the MCO must report "patient encounter data" for physician claims to the state in a timeframe and level of detail specified by the secretary. This was strengthened under sections 6402(c)(3) and 6504(b)(l) of the Patient Protection and Affordable Care Act to mandate that states collect and routinely report accurate, complete, and timely encounter data in order to receive federal funding for managed care payments under their Medicaid programs.

FINDINGS

AHCA generally improved its centralized model for managed care oversight; multiple agency units continue efforts to enhance program monitoring

In 2014, the Agency for Health Care Administration reorganized Medicaid to centralize managed care oversight with the belief that it would facilitate more effective communication among agency staff involved in managed care plan oversight and program integrity issues. As a result, Medicaid coordinates its oversight by using subject matter experts in each bureau who communicate with Bureau for Plan Management Operations managed care contract managers who are responsible for overall plan contract compliance.[17] AHCA staff reported that they have completed a Comprehensive Contract Monitoring Plan that establishes each unit's managed care oversight responsibilities, but staff also reported that this plan does not include instructions for how reports and data should be used. Not including these instructions could impede the effectiveness of program integrity activities if there are staffing or management changes within the respective units. However, several units within AHCA continue to improve data quality and oversight.

AHCA's intended centralized approach for managed care oversight relies on multiple units within the agency. (See Exhibit 4.) The agency's Division of Medicaid, Medicaid Plan Management Operations is the core unit of the centralized model and is responsible for coordinating Statewide Medicaid Managed Care plan contract compliance using data that the plans are required to report.[18,19] Each bureau identified is a functional unit of the model and contributes subject matter experts to assist with compliance efforts.

[17] Entities outside of AHCA coordinate with bureaus to conduct compliance monitoring, including the Attorney General's Medicaid Fraud Control Unit (MFCU), the Department of Health, and the Department of Children and Families.

[18] For example, plans that fail to implement an MPI-approved anti-fraud plan within 90 days may incur liquidated damages. MPI may reassess the implementation of the anti-fraud plan every 90 days until it deems the plan to be in compliance.

[19] Section 409.91212(5), *F.S.*, directs AHCA to impose an administrative fine of $2,000 per calendar day to plans that fail to submit an acceptable anti-fraud plan and up to a $10,000 fine for plans that fail to implement an anti-fraud plan or investigations unit.

Exhibit 4
AHCA Uses a Centralized Approach to Monitoring Managed Care Plans Where Contract Managers Coordinate Oversight With Subject Matter Experts in Key Bureaus Within the Agency

Source: OPPAGA analysis of information from the Agency for Health Care Administration.

In 2018, the Centers for Medicare and Medicaid Services found that AHCA had no formal intra-agency agreements detailing how each unit conducts managed care plan oversight, including which unit is responsible for each specific activity.[20] In October 2019, the Bureau of Medicaid Plan Management Operations provided staff training on intra-agency coordination of managed care plan compliance

[20] Centers for Medicare and Medicaid Services, Center for Program Integrity, *Florida Focused Program Integrity Review*, Final Report, January 2018.

oversight. The bureau developed training materials, including functional organizational charts that detailed each units' major responsibilities. These materials were intended to help staff across the agency better coordinate plan oversight and clarify staff responsibilities and roles related to each contractually required managed care plan report. AHCA also now maintains lists of assigned subject matter experts by unit, a flowchart for handling provider complaints, and spreadsheets for contract managers to track plan reporting and communications. The bureau reported that staff is finalizing a contract monitoring plan to ensure that agency staff are prioritizing monitoring efforts.

Additional clarification of staff roles and moving the Bureau of Medicaid Data Analytics would provide better communications regarding the centralized approach to managed care oversight. The training materials the Bureau of Medicaid Plan Management Operations provided to improve intra-agency coordination on managed care plan oversight did not include guidelines for how staff should use the plans' reports or other data to review and monitor plans for contractual compliance. Because Medicaid managed care oversight is a collaborative effort, continuity of oversight must include formal communications and unit responsibilities, including directions for how those units must perform their oversight. The bureau reported that such guides are maintained by each individual bureau or functional unit.

The Bureau of Medicaid Data Analytics' Business Intelligence Unit performs statistical analyses to evaluate the SMMC program and communicates results to stakeholders and the public via the Quarterly Statewide Medicaid Managed Care Report. Agency staff and external users review these reports to monitor and evaluate the performance of the SMMC program. The reports contain information such as the health of the Medicaid population and top illnesses by plan, age, sex, and health statuses. However, this unit does not seem to be functionally integrated into the centralized approach for managed care oversight. Agency staff reported that the Division of Medicaid has encountered shifting priorities, which resulted in changing program oversight functions with at least one unit responsible for program oversight; this included suspending production of the Quarterly Statewide Medicaid Managed Care Report. If the Business Intelligence Unit were more integrated with plan management's centralized oversight process, it could assist other Medicaid areas with analyzing encounter and fee-for-service data.

Several units within AHCA continue to improve data quality, which will help ensure more effective oversight. AHCA's Bureau of Medicaid Fiscal Agent Operations (MFAO) assesses the quality and usefulness of encounter and fee-for-service claims data and assists with identification of potential fraud, abuse, and overpayments. In 2018, MFAO modified the claims data reporting for behavior analysis (BA) services and improved provider screening and credentialing. For example, MFAO created system modifications for BA services to ensure rendering providers are identifiable on claims and that diagnosis codes identify medical necessity. The bureau implemented edits to prevent BA services from being reimbursed if delivered on the same day as therapeutic behavior on-site services. MFAO required that all BA service providers, not just the billing provider, be enrolled with Medicaid and modified provider enrollment requirements by changing the BA provider risk category to high-risk.[21] MFAO also implemented data checks on information from three federal government information systems to help identify potentially problematic providers or applicants for Medicaid claims in general.[22]

[21] In addition, the Bureau of Data Analytics monitors the payments to BA providers.

[22] These federal information systems include the Provider Enrollment, Chain, and Ownership System; the Social Security Administration Death Master File; and the States Medicaid Termination File.

In addition, the Division of Medicaid's Bureau of Medicaid Data Analytics uses plan encounter data reported to FMMIS to create a service profile for dental services, which it posts on its Medicaid Data Visualization Series webpage. The bureau also created dashboards for potentially preventable events and birth outcomes and is developing a dashboard report for substance use disorders.[23] The bureau's monitoring activities also include tracking monthly trends in payments to managed care plans and looking for large changes in payments to plans.

Moreover, the Bureau of Medicaid Program Finance uses encounter data and fee-for-service claims data to track enrollment and expenditure changes throughout the year.[24] As part of managed care plan provider networks oversight, the Bureau of Medicaid Plan Management Operations uses the FMMIS encounter data to create heat maps of where behavioral health services are being rendered to identify potential issues. For example, the heat maps can depict the concentration of behavioral health services by provider by geographic area and reveal abnormal utilization patterns.

Finally, the Division of Health Quality Assurance's Bureau of Central Services manages the Care Provider Background Screening Clearinghouse website, which is used by managed care plans to efficiently screen out potential providers. This bureau is in the process of implementing updates to reduce the risk of unauthorized users' ability to access provider demographic information and background screening eligibility information if there is no professional relationship between the employer and provider. Eligibility information does not contain confidential elements, but limiting access to relevant employees will reduce the potential for inappropriate use of the system.[25]

MPI has taken steps to monitor managed care plans, but other priorities delayed some oversight activities; the office lacks certain information on plan antifraud efforts

Since OPPAGA's 2018 review, MPI has taken additional steps to monitor managed care plans. However, the office has experienced shifting priorities over the past two years, and this has delayed some oversight activities. For example, the office's primary focus during Fiscal Year 2017-18 was on fraud identified among behavior analysis providers. MPI has not developed benchmarks for evaluating managed care plans' anti-fraud efforts. In lieu of such benchmarks, summarized data on managed care plan antifraud activities could help improve program oversight and monitoring. MPI also lacks documentation for the Fraud and Abuse Case Tracking System (FACTS), which limits the system's usefulness for examining antifraud activities and trends and could result in inconsistent data entry.

MPI has taken steps to monitor managed care plans. The Office of Medicaid Program Integrity reconciles information that managed care plans submit in 15-day reports and Quarterly Fraud and Abuse Reports (QFAAR) to their Annual Fraud and Abuse Report (AFAAR) and requires plans to correct erroneous data.[26] MPI summarizes each plan's reports and identifies additional action needed

[23] Potentially preventable events are indicators of the extent to which Medicaid recipients use hospital services for conditions that might have been addressed in a primary care setting. The birth outcomes dashboard indicates the extent of Florida births resulting in a cesarean section, pre-term delivery, or neonatal abstinence syndrome. The agency reported that it would add more metrics to dashboards at the end of January 2020.

[24] The bureau makes projections for the Social Services Estimating Conferences. The conferences use laws, policies, caseload and expenditure trend data from Medicaid, and other information to estimate the projected costs for the state's social services. These conferences include estimating the cost and caseload for Medicaid services.

[25] The clearinghouse provides a single data source for state and national fingerprint-based criminal history screening results of persons required to be screened by law for employment in positions that provide services to children, the elderly, and disabled individuals.

[26] As of April 1, 2018, MPI implemented the two new federally required reports for plans on identified waste and provider disciplinary actions.

based on review of the plan's 15-day, QFAAR, and AFAAR data; the office also uses the information to monitor plans' special investigations unit activities. For example, MPI may require plans to correct reporting dates of detected fraud and abuse to match the reporting period or to add internal tracking identification. MPI reconciled some aspects of the plans' Fiscal Year 2017-18 AFAAR reports but has not validated the reports. Based on the plans' AFAAR reports, during Fiscal Year 2017-18, plans reported recovering 43% of overpayments ($81.7 million of $188.6 million) and 37% of funds lost to fraud and abuse ($3.2 million of $8.75 million).

In lieu of establishing benchmarks or standards for assessing plans' performance, MPI staff reported that they are developing a risk-based model to incorporate risk assessment when selecting plans for on-site monitoring and audits. The risk-based model has seven baseline factors that staff identified as being indicators of high risk for managed care plans; these factors include a plan's program integrity policies and implementing tools.[27] Staff reported that the model will continue to evolve and might include additional risk factors in the future. While the risk-based modeling efforts may provide useful information for identifying high-risk plans, determining a plan's compliance with effectively recovering overpayments is difficult without annual plan performance benchmarks. These benchmarks, relative to the plan's size and special investigations unit capability, should include expected

- numbers of cases identified and investigated internally;
- amount of overpayment dollars identified and recovered within in a specified period;
- numbers of suspected/confirmed fraud and abuse providers that the plan identified and referred to MPI; and
- number of providers prevented from joining the plan's networks.

Such benchmarks would provide consistent measures by which to evaluate a plan's program integrity efforts and identify plans that may be high risk or may require assistance in their anti-fraud efforts. MPI should develop these expectations to guide its staff as they monitor managed care plan antifraud and abuse activities and conduct on-site visits.

Faced with shifting priorities, MPI's primary focus during Fiscal Year 2017-18 was on fraud identified among behavior analysis providers. In 2017, MPI identified fraudulent activity among providers of behavior analysis (BA) services. According to MPI staff, they continue to spend significant time on analysis and investigations relating to BA providers, which has limited the time available for other oversight activities. Upon the creation of a specific provider code for BA services, MPI was able to identify signs of potential fraud and initiated several projects to detect fraud, including a statewide review of provider credentials, billing and utilization assessments to determine potential overpayments, and fraud investigations of rendering and group providers.[28] MPI staff reported that they also began developing in-house advanced data analytics and structured a model for use with BA providers. They created non-claims based reports that examine prospective providers and any history or relationship they may have with existing risky providers to identify problem providers during the

These reports are the Suspected/Confirmed Waste Report and the Denied/Suspended/Terminated Provider Report. MPI received its first modified and additional reports but is modifying plan reporting requirements because report instructions did not include terminology or definitions to provide consistent reporting among the plans. Without consistent data, the information cannot be used for quality fraud detection.

[27] The seven criteria that MPI will use to identify plans' risk for readiness reviews and risk-based audits are the following: organization/plan's overall plan to combat fraud, abuse, and waste; network provider enrollment/provider network controls; detection/detection resources; application, successes, prevention/prevention tools and outcomes; audits and overpayments/auditing for compliance issues and overpayment; record maintenance; and measurements for program integrity activities/plan's tools used to measure the success of the plan's program to combat fraud, abuse, and waste.

[28] While efforts to detect fraudulent activity for BA services is ongoing, the Office of Medicaid Program Integrity has contributed to MFCU referrals, provider sanctions, and overpayment identification.

screening process prior to enrolling as a Medicaid provider. MPI anticipates that this process can be applied to other provider types. In addition, AHCA implemented an electronic visit verification (EVV) system for BA providers in select counties.[29] AHCA also implemented an EVV system in December 2017 for home health providers, to verify the utilization and delivery of services using technology that deters fraudulent or abusive billing for the service.

Federal requirements have also caused MPI to shift priorities. For example, instead of conducting on-site monitoring of managed care plans during Fiscal Year 2018-19, MPI participated in a federally-required managed care plan readiness process intended to ensure that the health plans entering into new contracts were ready to provide services. These shifts in unit priorities have resulted in delays in validating managed care plan reports, developing the risk-based analysis, providing oversight of managed care plans' activities in the form of managed care plan site visits, and developing data analytics. MPI staff reported using fee-for-service claims and encounter data for advanced data analytics and provided examples. These examples demonstrate that MPI staff have analyzed fee-for-service data; however, we did not see evidence of advanced data analytics in the examples that were provided.

Aggregated data on managed care plan antifraud activities could help improve program oversight and monitoring; MPI does not currently summarize such data. While MPI staff has the ability to create reports that summarize and compare plans' antifraud activities, they do not currently do so. In the absence of performance benchmarks, a comparative summary of plans' reported program integrity data could help evaluate whether plans are conducting fraud and abuse activities as expected given plan size in relation to similar plans. Such information could also be used to identify outliers. For example, a plan that has 4% or fewer of the Medicaid enrollees opening proportionately more investigative cases than plans with more than 11% of the Medicaid enrollees may be an indication of an outlier. However, according to MPI staff, comparing AFAAR data based solely on plan size does not take into account important factors such as the geographic region or managed care plan type.[30,31]

A number of factors may influence the effectiveness of plan antifraud activities, including plan size and the size and staff capabilities of a plan's special investigation unit. Florida's managed care plans vary widely in size and level of antifraud activity. For example, average monthly enrollment among plans in Fiscal Year 2017-18 ranged from 118 to 642,333 enrollees, representing 0.004% and 20% of total managed care enrollment, respectively. Managed care plans reported a wide range of program integrity efforts in their AFAARS for Fiscal Year 2017-18. For example, the number of cases opened by each plan ranged from 2 to 3,355; cases with overpayments recovered ranged from 0 to 147; and recovered dollars from fraud or abuse ranged from $0 to $1,285,510. Only one plan reported assessing fines or penalties to providers (representing four fines or penalties totaling $152,500).

OPPAGA analyzed AFAAR data for Fiscal Year 2017-18 and determined that plan program integrity efforts also vary among plans with similar market share (i.e., each plan's percentage of the total state managed care enrollment). For example, plans with market share between 5% and 11% varied widely in their reported program integrity efforts. They reported opening between 11 and 3,355 cases; recovering between $2,406 and $772,767 in funds lost to fraud and abuse; preventing between 0 and 430 providers from participating due to fraud and abuse; recovering between $2,406 and $12.5 million

[29] The agency is piloting the electronic visit verification system for behavior analysis providers in Broward, Indian River, Martin, Miami-Dade, Okeechobee, Palm Beach, and St. Lucie counties.

[30] Florida has 11 service regions; not all plans serve all regions in the state.

[31] Florida Medicaid has five types of managed care: managed medical assistance; long-term care plus; comprehensive (managed medical assistance and long-term care services); specialty care (children with chronic conditions, HIV/AIDS, serious mental illness, etc.); and dental.

in overpayments; and determining that between $0 and $442,367 was uncollectible. Although the two plans with more than 11% in market share opened a similar number of cases (368 and 433), they varied in their reported program integrity activities. Specifically, funds lost to fraud and abuse were $1.4 million versus $3.0 million and providers prevented from participating due to fraud and abuse were 0 versus 208. (See Exhibit 5.)

Exhibit 5
Florida's Managed Care Plans Vary Widely in Size and Level of Antifraud Activity[1]

Managed Care Plan Fiscal Year 2017-18 AFAAR Activities	All Plans	Plans With Market Share <1%[2]	Plans With Market Share 1% ≤ 4%[2]	Plans With Market Share 5% ≤ 11%[2]	Plans With Market Share >11%[2]
	16	3	6	5	2
Market Share	<0.1 to 20%	<0.1 to <0.3%	1 to 3%	9 to 11%	17 vs. 20%
Average Monthly Enrollments	118 to 642,333	118 to 9,237	42,581 to 96,500	281,342 to 347,700	548,662 vs. 642,333
Number of Cases Opened	2 to 3,355	2 to 275	9 to 818	11 to 3,355	368 vs. 433
Number of Cases With Overpayments Recovered	0 to 147	0 to 1	3 to 49	1 to 77	56 vs. 147
Dollar Amount of Fines/Penalties	$0 to $152,500[3]	$0 to $0	$0 to $0[3]	$0 to $0	$0 vs. $152,500
Providers Prevented From Participation Due to Fraud and Abuse	0 to 430[3]	0 to 0	0 to 0[3]	0 to 430	0 vs. 208
Overpayments Recovered	$0 to $41.4 million	$0 to $890	$13,686 to $165,609	$2,406 to $12.5 million	$26.0 million vs. $41.4 million
Amount Determined as Uncollectable	$0 to $40.9 million[3]	$0 to $0	$0 to $100,718[3]	$0 to $442,367	$490,383 vs. $40.9 million
Total Lost to Fraud and Abuse	$0 to $3.0 million[3]	$0 to $104,435	$0 to $374,488[3]	$65,808 to $2.3 million	$1.4 million vs. $3.0 million
Total Lost to Fraud and Abuse Recovered	$0 to $1.3 million[3]	$0 to $0	$0 to $154,175[3]	$2,406 to $772,767	$872,623 vs. $1.3 million

[1] Ranges represent the minimum and maximum for each activity.

[2] OPPAGA determined the market share ranges based on natural breaks in the plans' market share.

[3] One plan did not report data for this category.

Source: Analysis of Medicaid Managed Care Annual Fraud and Abuse Reports and AHCA market share data for Fiscal Year 2017-18.

MPI lacks documentation for the FACTS data system, which limits the system's usefulness for examining antifraud activities and trends and could result in inconsistent data entry. MPI investigators, managers, and others use the FACTS system to track the status of complaints and cases that are being investigated or audited for overpayments and abuse. The system was designed to allow investigators to append necessary documentation, including communications with providers such as preliminary audit reports, final audit reports, final orders, and documentation providers submit.

MPI staff log complaints or cases of suspected overpayments into the system. Once a case is opened, investigators track the status of the case as they investigate it, and managers review and edit the case before closing it. In addition, after closing, staff reviews the case for quality and consistency of coding and makes changes as needed. At each stage, multiple people have access to modifying the data. However, MPI lacks a user guide, data dictionary, or other documentation to explain field definitions, field value definitions, data structure, and appropriate use of data fields for analyses.

MPI's Fiscal Year 2017-18 Annual Fraud and Abuse Report to the Legislature indicated that the office investigated 4,069 cases, identified $18.2 million in overpayments, and imposed $1.9 million in fines

and penalties for 294 cases.[32,33,34,35] MPI and the Medicaid Fraud Control Unit terminated 649 providers, including 387 behavior analysis providers.[36] MPI was unable to provide a detailed description of the methodology AHCA uses to address statutory reporting requirements via the annual Medicaid fraud and abuse report or to explain how OPPAGA could use the data to replicate MPI's results or generate additional statistics for our biennial review.[37] As a result, OPPAGA was unable to create summary statistics that could be used to examine antifraud activities and trends.

AHCA's current uses of FMMIS claims and encounter data have limitations and are not guided by a comprehensive plan to effectively monitor Medicaid program trends

According to actuarial research, Medicaid claims and encounter data are the most important analytical tools for health plans and health programs.[38] Encounter data sets are large and complex, and there are many challenges associated with collecting this type of data in a standardized format, including file format problems, rejected encounters, and data system hardware and software issues. These challenges have been recognized by the U.S. Government Accountability Office (GAO), the U.S. Department of Health and Human Services Office of Inspector General, and other states around the country.[39] While multiple units within AHCA continue to improve data quality and oversight efforts, these units do not consistently use encounter data or fee-for-service claims data to fully support program integrity functions across the agency. Using claims and encounter data is necessary to analyze trends in Medicaid service utilization and costs, evaluate Medicaid benefits, and assess service quality.

Uses of Encounter Data in Managed Care Oversight

Managed care program integrity oversight has four main components: program monitoring and oversight, program quality improvement, fraud and abuse oversight, and Medicaid payments. AHCA uses encounter data to support two of these functions and relies on other data sources and information to support all four program integrity functions. There are limitations associated with the current use of data within all four oversight components. (See Exhibit 6.)

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[32] Severity and conditions for sanctions are specified in AHCA's administrative rule 59G-9.070, *F.A.C.* Under the rule, a provider who fails to comply with any of the terms of a previously agreed-upon repayment schedule will be fined $5,000 for the first offense and suspended until the violation is corrected. If the provider remains noncompliant with the repayment schedule after 30 days, the provider will be terminated.

[33] In addition to applying punitive and monetary sanctions, MPI places providers on prepayment reviews and suspends payments to providers that have a credible fraud allegation. Section 409.913(25), *F.S.*, grants MPI the authority to withhold Medicaid payments to a provider upon receipt of reliable evidence that the circumstances giving rise to the need for a withholding of payments involve fraud, willful misrepresentation or abuse under the Medicaid program, or a crime committed while rendering goods or services to Medicaid recipients.

[34] The number of providers placed on prepayment reviews or providers that had a credible allegation of fraud and had their Medicaid payments suspended is not available. However, in its annual report, MPI does report on the number and dollar amount of claims reviewed and denied as a result of placing providers on prepayment reviews. MPI also reports the number of claims and the dollar amount of claims withheld or suspended from providers that had a credible allegation of fraud.

[35] Some overpayment cases do not result in sanctions because of Medicaid amnesty programs. Section 409.913(25)(e), *F.S.*, allows AHCA to suspend sanctions and investigative expenses when it grants amnesty.

[36] Of cases that were closed during Fiscal Year 2017-18, 55 providers were suspended and 100 were terminated from participating in the Medicaid program for overpayments and other violations.

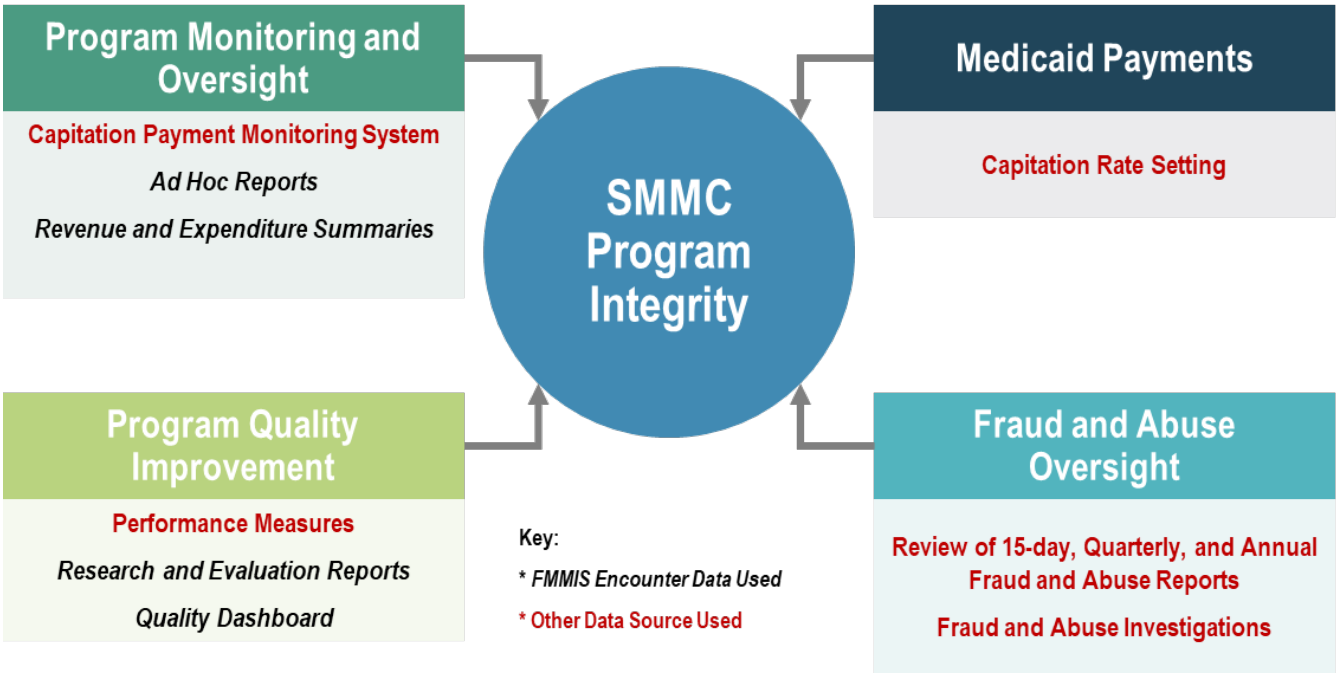
[37] Section 409.913, *F.S.*

[38] Gerstorff, J. L., Gibson, S., Medicaid Encounter Data: the Next National Data Set, *In the Public Interest*, Social Insurance & Public Finance Section Council, Society of Actuaries, 13, September 2016: 6-14.

[39] U.S. Department of Health and Human Services, Office of Inspector General, *Weaknesses Exist in Medicaid Managed Care Organizations' Efforts to Identify and Address Fraud and Abuse*, OEI-02-15-00260, July 2018.

Exhibit 6

AHCA's Use of Encounter Data to Support Managed Care Program Integrity Functions Is Limited



Source: OPPAGA analysis of information provided by AHCA staff.

Use of FMMIS encounter data for program monitoring and oversight is limited, and frequent monitoring either relies on alternative data sources or summarized FMMIS financial information. AHCA staff described relying on ad hoc reports for oversight and monitoring of the fee-for-service and managed care programs. The Bureau of Data Analytics generates ad hoc reports using FMMIS fee-for-service claims or encounter data in response to requests submitted by internal Medicaid staff and external stakeholders. However, the agency does not have a comprehensive plan in place to coordinate the requests to ensure all aspects of program oversight were covered by the ad hoc reports. For example, AHCA began tracking trends in behavior analysis service utilization in its fee-for-service program only after issues occurred in the BA program and does not currently do this for all services, including managed care. Agency staff reported that since July 2019, the agency has been conducting monthly reviews that summarize Medicaid expenditures, revenues, and appropriations by service category and fund type over time. These reports are reviewed by agency leadership each month to identify potential areas of concern, including any changes in trends and outliers. While these reports summarize fee-for-service and encounter data, they are limited to financial information reported in aggregate categories, some of which appear to be strictly financial (rather than service categories), and they lack utilization information on number of recipients and providers for services. A comprehensive monitoring plan might include using FMMIS data to examine trends in health care for specific vulnerable populations, as well as general utilization trends. Agency staff also reported monitoring trends in the managed care program to detect over and underpayments using the capitation payment monitoring system. Instead of using encounter data, this system uses records of electronic financial transactions of the agency's payments to plans to monitor payment trends in the program.

Some program quality improvement activities are supported by information other than encounter data, and the frequency of encounter data use is insufficient for comprehensive monitoring. The Division of Medicaid requires health plans to meet specific requirements for an extensive set of quality performance measures based on Health Effectiveness Data and Information Sets (HEDIS), Centers for Medicare and Medicaid Services Adult and Child Core Set measures, and AHCA-defined measures. However, performance measure scores are calculated by the health plans using encounter data from each plan's system rather than using the encounter data they report to FMMIS.[40] While the agency reports that it is appropriate and valid for plans to calculate their own HEDIS measures, this is an example of use of data other than FMMIS encounter data for program quality improvement.

The Division of Medicaid contracts with several external organizations to evaluate different facets of the Medicaid program. While many of these evaluations utilize claims and encounter data to examine important aspects of the Medicaid program (e.g., long-term care program, maternal and child health measures, etc.), reports are submitted annually and cannot be effectively used for more frequent monitoring of program trends or to evaluate plan service delivery.[41,42] The evaluations focus on specific program subsets and do not provide a comprehensive examination of all program elements. Reports submitted under these contracts are primarily used to direct quality improvement of Medicaid services. In addition, the Division of Medicaid has a public dashboard that displays several quality metrics pertaining to birth outcomes and potentially preventable events that are based on FMMIS encounter data. The metrics are part of Medicaid's quality initiatives. However, since the metrics are measured annually, they cannot be effectively used for more frequent program monitoring.[43]

Incomplete and inaccurate data limits the use of encounter data for fraud and abuse oversight; AHCA staff reported that they are taking steps to improve encounter data. Data for services such as home health care and some waiver services lack information necessary to link rendering providers to the services they provided, which prevents AHCA from effectively monitoring service providers. Inaccurate or missing provider information is a problem for managed care encounter data as well. Both MPI and the Attorney General's Medicaid Fraud Control Unit staff reported that the inability to link the direct care provider to a service in the managed care encounter data and the lack of a rendering provider in the managed care encounter data hinders their oversight responsibilities. For example, it may make it more difficult for MFCU to prosecute fraudulent providers. MFCU staff reported that referring physician, rendering provider, and doctor prescribing for pharmacy prescriptions should be mandatory fields to ensure complete and accurate encounter data.

Agency staff reported that currently, requirements for rendering provider numbers must be based on the current Medicaid service policies, and as new policies are developed to require rendering provider numbers, the agency can program these requirements into the FMMIS system. In the meantime, for services that currently do not identify the rendering provider, such as home health, the agency is looking at other ways to identify the caregiver. For example, agency staff reported that rendering care giver

[40] Plans are required to use National Committee for Quality Assurance-approved software and to have the calculations audited by a committee-approved vendor.

[41] Reports submitted under these contracts are primarily utilized by the Bureau of Medicaid Quality to drive quality improvement of Medicaid services.

[42] The Bureau of Medicaid Quality also has a public dashboard that displays several quality metrics pertaining to birth outcomes and potentially preventable events that are part of Medicaid's quality initiatives and are produced using FMMIS encounter data and anticipates releasing another metric on substance use disorders.

[43] AHCA staff reported that the agency has developed and will launch a Florida Medicaid Plan Performance Dashboard in early 2020, which will include more real-time data and be updated on a quarterly basis.

information is captured by the fee-for-service and managed care plans' home health EVV vendors, and the agency is exploring options for capturing the EVV vendors' home health rendering provider data and submitting that information to the agency to aid in monitoring providers. In addition, the agency initiated the Referring, Ordering, Prescribing, and Attending (ROPA) enrollment solution project to require all ROPA providers to enroll as a Florida Medicaid provider. The agency anticipates that by the end of 2020, these providers will be visible in FMMIS. The ability to link the direct care provider to a service in claims or encounter data, including the rendering provider in the managed care encounter data, would enhance MPI and the Attorney General's Medicaid Fraud Control Unit's oversight responsibilities and potentially aid in the detection and prosecution of fraudulent providers.

While AHCA is phasing out the use of supplemental encounter data, AHCA's ability to use FMMIS encounter data for capitation rate setting is hindered by ongoing issues with data quality. Evaluating the accuracy of the process for setting capitation rates is of fundamental importance in ensuring program integrity for managed care programs since capitation rates that are unrealistically high contribute to waste in health care spending and run the risk of rewarding providers and managed care organizations for inefficient care. Encounter data that are inaccurate, unreliable, or not sufficiently assessed for accuracy affect the capitation rate-setting process, even when using actuarially sound rate-setting standards. A 2018 GAO review identified inaccurate data and inclusion of costs that should have been excluded in rate setting as important risks associated with states' Medicaid payments to MCOs.[44] Quality of data and technology was one of the three most common challenges cited by GAO for effective oversight of program integrity in managed care programs.[45] (See Appendix B for a summary of the six payment risks GAO identified as being associated with managed care.)

AHCA is required by s. 409.967(2)(e)(2), *Florida Statutes*, to validate the data submitted by plans. External reviews of the encounter data managed care plans reported to Florida's Medicaid program have identified problems with data accuracy. AHCA's external quality review organization has completed several reviews of AHCA's encounter data using a small subset of encounter data, including six months of dental, long-term care, and children's therapy encounters from 2015 and six months of dental encounters from 2016. Both reviews identified issues with the accuracy of FMMIS encounter data.[46]

The agency has collected managed care encounter data since 2006, but the Bureau of Medicaid Data Analytics still uses a supplemental encounter data feed from managed care plans rather than Florida Medicaid Management Information System encounter data for rate setting because not all of the encounter data reported to FMMIS is complete or accurate enough to use for this purpose. Supplemental encounter data differs from the encounter data in FMMIS in that it has not been through the FMMIS edits and checks. Instead, AHCA engages in a reconciliation process with managed care plans to address discrepancies between the supplemental encounter data and information from AHCA's Achieved Savings Rebates Financial Reports from plans.[47] Given the accuracy concerns and AHCA's need to reconcile the supplemental encounter data with plans, it is unclear how data quality issues affect capitation rate setting. AHCA staff reported that as they work with plans to improve

[44] *Medicaid Managed Care: Improvements Needed to Better Oversee Payment Risks,* U.S. Government Accountability Office, GAO-18-528, July 2018.

[45] The other two most commonly cited challenges to effective Medicaid managed care program integrity oversight were allocation of resources and adequacy of state policies and practices.

[46] Health Services Advisory Group, Inc., is AHCA's external quality review organization, which conducted the encounter data validation studies to examine the extent to which encounters submitted to AHCA by its contracted managed care plans are complete and accurate. The Fiscal Year 2016-17 study focused its review on all dental procedure codes for children under the age of 21.

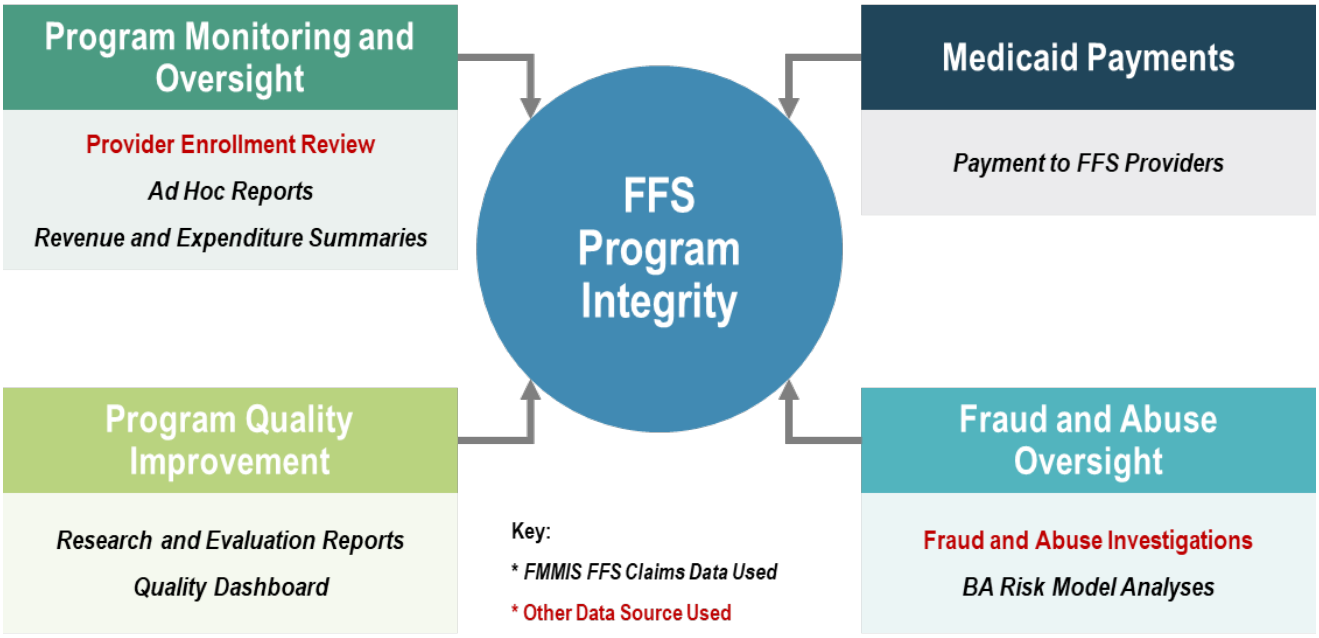
[47] Achieved Savings Rebate (ASR) Financial Reports are submitted by each MCO to AHCA on a quarterly and annual basis and provide the agency with unaudited information about MCOs' financial operations and performance. Agency staff explained that ASR reports are independently audited each year.

encounter data quality, they plan to use FMMIS encounter data to set capitated rates in the future. For the 2020 rate year (October 2020 to September 2021), AHCA staff reported that they will use FMMIS-reported hospital inpatient and outpatient and pharmacy encounter data from 2018 and the supplemental encounter data for all other claims. AHCA anticipates no longer using supplemental encounter data by the 2021 rate year.

Use of Claims Data in Fee-for-Service Oversight

Fee-for-service program integrity oversight has four main components: program monitoring and oversight, program quality improvement, fraud and abuse oversight, and payments to fee-for-service providers. AHCA uses claims data to support all of these program integrity functions and relies on other data sources and information to support two program integrity functions. Similar to the use of encounter data, there are limitations associated with the use of claims data. (See Exhibit 7.)

Exhibit 7
AHCA's Use of Claims Data to Support Fee-for-Service Program Integrity Functions Is Limited



Source: OPPAGA analysis of information provided by AHCA staff.

Use of fee-for-service claims data for program monitoring and oversight is limited, and monitoring relies on information other than claims data. Although the fee-for-service program accounted for 35% of Medicaid program expenditures in Fiscal Year 2018-19, AHCA reported that it relies heavily on the provider enrollment process for fee-for-service program oversight because of the relatively small size of the program as compared to managed care. Thus, fee-for-service oversight relies on AHCA's review of providers' applications to enroll as Medicaid providers rather than on a comprehensive analysis of fee-for-service claims data to monitor services provided. As reported above, the use of ad hoc reports for oversight and monitoring of the fee-for-service program lacks a comprehensive plan to coordinate the requests to ensure oversight of all aspects of the program were covered.

Program quality improvement efforts do not utilize fee-for-service claims data frequently enough to facilitate comprehensive monitoring. As reported above for the use of encounter data for managed care oversight, evaluations conducted by external organizations of different facets of the Medicaid program utilize claims and encounter data to examine important aspects of the Medicaid program but are submitted annually. Similarly, the quality dashboard reports' metrics are generated annually. Therefore, this information cannot be effectively used for more frequent monitoring of program trends or to evaluate plan service delivery.

Fraud and abuse oversight is hindered by a lack of complete fee-for-service claims data. As reported above, there is a lack of information to link rendering providers to the services they provided among certain types of health care services, such as home health and some waiver services. This prevents AHCA from effectively monitoring service providers.

RECOMMENDATIONS

Due to concerns about intra-agency coordination, lack of managed care plans' antifraud performance benchmarks for managed care plans, lack of data system documentation, and limitations to the use and quality of encounter and fee-for-service claims data, we recommend that the Agency for Health Care Administration consider several actions. (See Exhibit 8.)

Exhibit 8
OPPAGA Recommendations for AHCA's Oversight and Monitoring of Medicaid Fee-for-Service and Managed Care Systems

Concern	Recommendation
Lack of Intra-Agency Coordination of Managed Care Plan Compliance Oversight	▪ **Formalize communication regarding oversight responsibilities.** This would include incorporating language in the Comprehensive Contract Monitoring Plan that AHCA is developing to explain how each area will conduct oversight of the managed care entities, including guidance on how subject matter experts will review and monitor plan reports or other data for contractual compliance. ▪ **Reorganize the Medicaid Business Intelligence Unit.** AHCA should consider moving the Medicaid Business Intelligence Unit, currently within the Bureau of Medicaid Data Analytics, to Medicaid Operations. Since the unit is responsible for performing statistical analyses to evaluate the Statewide Medicaid Managed Care program and this function is central to managed care oversight, the unit would be better positioned if it were functionally located within Medicaid Operations. Within this division, it could become an integral part of improving the quality of encounter data reported to FMMIS and coordinating assistance in the development of analyses needed by the subject matter experts for their managed care oversight functions, as well as identifying improvements needed for fee-for-service claims.
Lack of Summarized Managed Care Plan Antifraud Activity Data, Lack of Data System Documentation, and Lack of Information on Data Analytics Activities by MPI	▪ **Develop reports that provide context for plan antifraud activities.** In the absence of plan-specific benchmarks to assess managed care plan antifraud performance, MPI should develop a summary report of all plans' annual activities included in Annual Fraud and Abuse Report submissions and include information that would provide context for plan anti-fraud performance. Information from the AFAAR reports should include an overview of each plan's activities, sources of opened cases, disposition of closed cases, providers prevented from enrolling, and providers terminated. Contextual information could include descriptive information about each plan's Special Investigations Unit, including the number of staff dedicated to the plan's Florida-based unit and the size of the plan in terms of Florida Medicaid enrollment, which is available from the agency's monthly enrollment reports. This report could be included in the annual MFCU-MPI Fraud and Abuse report and could assist the Legislature in its review of managed care program integrity activities and effectiveness by plan. These summary reports could assist MPI in its managed care plan oversight and would provide the office with standard data regarding the effectiveness of each plan's SIU as well as how plans compare to each other. ▪ **Create documentation for the FACTS database to ensure that all system users consistently enter investigative information and to assist MPI staff and external reviewers in analyzing system data.** Documenting the FACTS database would enable MPI to use the system as a management tool for assessing the effectiveness of processes to identify and recover overpayments and manage staff resources, as well as respond to external information requests. This would also help ensure that all MPI staff enters information consistently according to the same rules and allow the FACTS system to quickly generate reliable statistics. This effort should include creating a data dictionary and user guide for defining fields and field values to help ensure consistency of data entry and use.

Concern	Recommendation
	▪ **Develop advanced data analysis using fee-for-service claims data and encounter data. MPI should be using fee-for-service claims and encounter data to identify baseline trends in Medicaid services and monitor those trends for anomalous or** unexpected changes. Developing techniques to identify fraud and abuse using advanced analytics on encounter data ensures that managed care organizations are actively analyzing their own data for fraud and abuse. MPI should describe its use of advanced analytics for the Legislature in its annual Medicaid fraud and abuse report. The description of the advanced data analytic techniques should include the data sources utilized for each technique, samples of output from the advanced analytics that highlight the role the technique plays in monitoring and identifying fraud and abuse, and a summary of the past effectiveness of the advanced analytic techniques in identifying fraud and abuse.
Limitations to Use of Encounter and Fee-for-Service Claims Data and Lack of a Comprehensive Plan to Monitor Trends Effectively in Medicaid	▪ **Establish a process to identify high-risk services and ensure that critical data fields are complete and accurate.** For example, for high-risk services where the rendering provider is not currently reported in data submissions, develop provider policies and rules to identify direct care providers to avoid enrollment of problem providers and clarify approved services and the claims reimbursement process. Once the process is established, AHCA should identify how many provider and service types lack direct care provider and billing information in fee-for-service and encounter data so that the agency can update policies to incorporate requirements and direct care rendering providers can be linked to billing providers and services rendered. Likewise, Medicaid should require that managed care plans include rendering provider information in encounter data submissions. ▪ **Update policies to refine service categories and define specific service procedure codes and provider types.** Starting with high-risk services, the agency should track the refined service categories by developing ongoing reports using claims data to monitor services by provider, number of claims, and amount of claims. As with behavior analysis services, doing so may help MPI detect unusual patterns in program service utilization and billing and identify problems. This could also assist the agency in monitoring services delivered by the managed care plans. ▪ **Use claims and encounter data for regular and frequent monitoring of specific groups of Medicaid recipients that could provide insight into program functioning.** For instance, monitoring trends in service use and cost for recipients with chronic diseases such as diabetes or HIV, recipients with mental health diagnoses, or dually eligible recipients has the potential to provide useful information about the status of the Medicaid program. For example, mapping the constellation of services received by specific recipient groups and following trends over time would facilitate an understanding of how well different aspects of the Medicaid program are functioning and would provide a tool for identifying areas that may benefit from improvement. ▪ **Continue encounter data validation studies to examine the extent to which encounters submitted to AHCA by contracted SMMC plans are complete and accurate.** The studies should incorporate a broader range of data types and key data fields. Data types could include inpatient, outpatient, and professional claims. Additional data fields could include all diagnosis codes (not just the primary diagnosis code), provider type, provider county, quantity of service, amount billed, and place of service. ▪ **Continue to expand the use of managed care encounter data reported to FMMIS for program oversight, including using data to set capitation rates, analyze utilization trends, and determine service quality.** To the extent that plans are not accountable for the encounter data they submit, data quality issues will likely persist. There are two primary ways that plans are held accountable financially: capitation rate setting and liquidated damages for performance on quality performance measures. At the time of our review, neither of these used FMMIS encounter data.

Source: OPPAGA analysis.

APPENDIX A

Program Integrity Monitoring

Numerous entities perform functions to support the Agency for Health Care Administration's Medicaid program integrity efforts. Exhibit A-1 identifies the specific Medicaid program integrity activities performed by each unit.

Exhibit A-1
Agency for Health Care Administration Medicaid Program Integrity Monitoring Activities

AHCA Bureaus/Units[1,2]	Provider Enrollment	Provider Oversight[2]	Plan Communication	Plan Oversight	Data Monitoring	Data Utilization	Payments	Complaints[3]	Investigations[4]	Sanctions	Overpayment Recovery
Division of Medicaid											
Medicaid Operations											
Bureau of Medicaid Plan Management Operations			√	√		√		√	√	√	
Bureau of Medicaid Fiscal Agent Operations	√	√	√		√	√	√				
Bureau of Recipient and Provider Assistance	√	√	√	√				√			
Medicaid Finance and Analytics											
Bureau of Medicaid Program Finance			√	√	√	√					
Bureau of Data Analytics		√	√	√	√	√					
Medicaid Third Party Liability						√					√
Medicaid Policy and Quality											
Bureau of Medicaid Policy			√	√							
Bureau of Medicaid Quality			√	√	√						
Division of Health Quality Assurance											
Medicaid Program Integrity		√	√	√	√	√		√	√	√	√
Bureau of Central Services	√	√									
Division of Operations											
Bureau of Financial Services							√				√

[1] In addition to the bureaus listed, the General Counsel's Office provides legal advice and representation on all agency legal matters, including the recovery of Medicaid overpayments due to abuse.
[2] Health plans are expected to contribute to program integrity activities through prior authorization, utilization management, and program and provider monitoring.
[3] The Bureau of Field Operations oversees AHCA's Complaint and Information system and receives public grievances.
[4] Resulting actions of investigations may include sanctions, referrals to other units, contract actions, referrals for prosecution, warrants for arrests, or financial recovery.
Source: OPPAGA analysis of information from the Agency for Health Care Administration.

APPENDIX B

Six Types of Medicaid Managed Care Payment Risks

In 2018, the Government Accountability Office identified six payment risks associated with states' Medicaid program payment to managed care organizations resulting from using inaccurate data or including costs that should have been excluded in setting payment rates. According to GAO, quality of the data and technology, allocation of resources, and adequacy of state policies and practices were the three most common challenges to effective program integrity oversight in managed care programs. See Exhibit B-1 for a summary of all of the payment risks that GAO associated with Medicaid managed care.

Exhibit B-1
GAO Identified Six Types of Medicaid Managed Care Payment Risks

Payment Risks Related to Medicaid Managed Care Organization Payments to Providers	
Incorrect MCO fee-for-service payments	MCO pays providers for improper or false claims for services ▪ Not provided or provided by ineligible providers ▪ Represent inappropriate billing, such as billing individually for bundled services or for higher intensity of services than needed
Incorrect MCO capitation payments	MCO pays providers without assurances they have provided needed services
Payment Risks Related to State Medicaid Program Payments to Managed Care Organizations	
Improper state capitation payments	The state makes monthly capitated payments to an MCO for ineligible beneficiaries ▪ Ineligible for Medicaid ▪ Not enrolled in Medicaid ▪ Deceased
Inaccurate state capitation rates	The state establishes capitation rates that are inaccurate, primarily due to issues with the data used to set the rates ▪ Inaccurate encounter data ▪ MCOs reporting costs that were not allowable ▪ Overpayments were not adjusted ▪ Data do not reflect changes in care delivery practices that have affected MCO costs
State payments to noncompliant MCOs	The state makes monthly capitation payments to an MCO for beneficiaries even though the MCO has not fulfilled the state contract requirements ▪ Does not establish an adequate provider network ▪ Reports inaccurate encounter data for services ▪ Does not report the amount of overpayments made to providers
Duplicate state payments	The state makes duplicate payments, for example, when a health care provider submits a fee-for-service claim to the state Medicaid program for services that were covered by the MCO contract

Source: OPPAGA analysis of *Medicaid Managed Care: Improvements Needed to Better Oversee Payment Risks,* U.S. Government Accountability Office, GAO-18-528, July 2018.

APPENDIX C

Agency Response

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

January 30, 2020

Mr. R. Phillip Twogood, Coordinator
Office of Program Policy Analysis and Government Accountability
111 West Madison Street, Room 312
Claude Pepper Building
Tallahassee, Florida, 32399-1475

Dear Mr. Twogood:

The Agency for Health Care Administration (Agency) appreciates the opportunity to comment on the biennial review of the Agency's efforts to prevent, detect, deter, and recover funds lost to fraud, abuse and waste in the Medicaid program. This year's report, *AHCA Continues to improve Medicaid Program Data Quality and Oversight: Additional Improvements Needed in Use of Data* focuses on the Agency's monitoring of the managed care plans and the small remaining fee-for-service population through the use of data.

Governor DeSantis is committed to increasing transparency to demonstrate accountability in state programs and has established clear goals for our health care systems and health care experiences as Floridians: We must provide efficient, accountable health care that produces the best possible outcomes, and we must be transparent regarding how our health care facilities and programs are performing.

During the first year of Governor DeSantis' administration, the Agency has improved comprehensive monitoring of Florida Medicaid. In response the Agency has initiated an Agency-wide approach to managing program integrity matters, and used its extensive program data to enhance program monitoring, accountability, and outcomes. The following are key areas of focus.

Pilots to Improve Outcomes and Reduce Inappropriate Service Use: During 2019, the Agency launched intensive stakeholder workgroups based on data analysis conducted in the areas of potentially hospitalizations, re-hospitalizations, and emergency department use; hospital emergency room super utilizers; and birth outcomes. These workgroups are using data to select and measure the impact of evidence-based interventions that can be piloted and, if successful, applied program-wide to reduce inappropriate use of services and improve health outcomes.

Enhanced Internal Expenditures Monitoring and Reporting: Since July 2019 Agency leadership has conducted monthly reviews of Medicaid expenditures by service categories, fund types, revenues, and more, comparing these expenditures to the appropriations, past months and the same period in the prior year. The results are reviewed to identify potential areas of concern and determine real time indicators for on which management can take action. The intent of this monthly review is to rapidly identify any changes in trends or outliers, including utilization, fraud and integrity. Once identified, further research and analytics are employed to determine root cause for the abnormality or change in spending.

Medicaid Health Plan Performance Dashboard: The Agency has designed a groundbreaking Medicaid health plan performance dashboard, which is the most comprehensive performance dashboard of any state Medicaid program. It focuses on key areas of clinical and operational importance to those served by and responsible for administering the program. The dashboard will be published quarterly and give the Agency and the public greater insight to plan performance in a real time manner.

We believe that there are always opportunities for improvement in the efforts we make to monitor the Florida Medicaid program and will undertake a thorough review of the recommendations in the report. There are, however, some recommendations with which we have concerns and several issues that require clarification pertaining to the facts or conclusions specified within the report. In addition, we wish to submit several technical clarifications to the report, which are included in the attached document. Our comments below address those issues (OPPAGA recommendations in bold; Agency response follows each recommendation).

Formalize communication regarding oversight responsibilities (page 21).
The Agency has completed the Comprehensive Contract Monitoring Plan, and each unit maintains its procedures and tools for monitoring in the areas for which it is responsible. While creating a central repository for these tools may be desirable, the priority focus is on ensuring high quality monitoring.

Reorganize the Medicaid Business Intelligence Unit (page 21).
While the Agency concurs that the BI unit could be used to a greater extent in overall program monitoring, we do not concur that moving the unit is necessary to accomplish that goal. When the Agency extensively reorganized the Division of Medicaid to adjust to Statewide Medicaid Managed Care, it deliberately centralized all data functions in the newly established Bureau of Data Analytics and created the BI unit within it. The goal was to ensure that data produced about Medicaid was consistent and of high quality and that there were opportunities for cross-training of staff and other efficiencies gained by a centralized analytic group. Separating the BI unit from the other data analytic resources is not consistent with these goals.

Establish a process to identify high-risk services and ensure that critical data fields are complete and accurate (Page 22).
The Agency understands that identifying high risk providers and having rendering providers identified on a claim/encounter are useful tools for detecting fraud and abuse. To that end, high risk provider types are already identified by Medicaid as part of the provider enrollment process, and we know the provider types for which we do not receive rendering providers on the claim/encounter. As noted in the report, for services that currently do not identify the rendering caregiver, such as home health, the Agency is exploring other ways to identify the caregiver, such as though the electronic visit verification system. In addition, the Referring, Ordering, Prescribing, and Attending (ROPA) enrollment project to require all ROPA providers to enroll as a Florida Medicaid provider will ensure that all such providers are visible in FMMIS by the end of 2020.

Continue to expand the use of managed care encounter data reported to FMMIS for program oversight, including using data to set capitation rates, analyze utilization trends, and determine service quality (Page 22).

Plans are being held accountable for the quality of their encounter data. The Agency monitors monthly for timeliness and accuracy of encounter data submissions and imposes liquidated damages for timeliness. Beginning in March, the Agency will begin assessing liquidated damages to the plans for deficiencies in the accuracy of their encounter data. The Agency also monitors encounter data for completeness and is developing monitoring reports to begin assessing liquidated damages over the next year. In addition, the Agency will rely on hospital and pharmacy encounter data for capitation rate-setting for the 2020-2021 rate year. These service categories make up 53 percent of Medicaid spending. The following rate year, only encounters will be used for capitation rate-setting, further incentivizing accurate encounters.

Lack of Summarized Managed Care Plan Antifraud Activity Data, Lack of Data System Documentation, and Lack of Information on Data Analytics Activities by MPI (Page 21)

The recommendations from OPPAGA include three specific program integrity recommendations most closely aligned with the functions of the Agency's Bureau of Medicaid Program Integrity (MPI). The recommendations generally are that MPI should establish benchmarks for managed care plan antifraud performance, have greater documentation regarding the MPI case tracking system, and develop advanced data analysis. During the review the Agency explained how benchmarks are being developed using a risk-based model, also described in the Agency's annual fraud report. MPI will establish benchmarks for key performance indicators such as Medicaid health plan referrals to MFCU. In regard to FACTS, MPI will create additional documentation regarding the case tracking system and would welcome any specific examples of data integrity concerns identified during this review; such examples may assist the Agency in prioritizing these efforts.

MPI utilizes innovative data analysis techniques and models often tailored toward identification of egregious billing practices. These efforts were described during the review and in the annual fraud and abuse report. MPI processes infuse fee-for-service claims, encounter data, and other sources, in complaint intake, data detection, preliminary investigations, and overpayment recovery audits. MPI is currently developing managed care risk modelling that incorporates data elements from the Medicaid health plan reports and other sources. Health plans are required to attest to the accuracy of information submitted to the Agency. Risk models being developed include data elements from submitted reports and will be used to determine audit selection considering erroneous or outlier data. If a plan is identified as having submitted erroneous information, further MPI actions would follow. Actions vary based upon the materiality, nature, and extent of the error.

Thank you again for the opportunity to comment on the report. We will continue to make prevention and detection of fraud, waste, and abuse in the Medicaid program a priority as we work towards a more transparent and efficient system of care.

Sincerely,

Mary C. Mayhew
Secretary

MCM/ks
Enclosure

OPPAGA Comment

During Fiscal Year 2018-19, the SMMC system accounted for 65% ($18.1 billion) of Medicaid expenditures, and fee- for-service expenditures accounted for the remaining 35% ($9.65 billion).

Agency Clarification

Over 50% of the $9.65 billion of Medicaid expenditures the report classified as fee-for-service consists of Medicare premium/crossover payments over which the Agency exerts little control and non-claim supplemental payments such Low Income Pool, Disproportionate Share Hospital, and Graduate Medical Education which are distributed based on fixed formulas.

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OPPAGA

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