July 31, 2020

Ms. Mary C. Mayhew, Secretary
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, FL 32308

Dear Secretary Mayhew,

Enclosed is a six-month status report on OPPAGA's *AHCA Continues to Improve Medicaid Program Data Quality and Oversight; Additional Improvements Needed in Use of Data,* Report No. 20-04, issued January 2020. This status report is issued in accordance with the statutory requirement to report on corrective actions resulting from the Auditor General's recommendations six months from the report date.

If you have any questions about this status report, please contact Pilar Zaki, Audit Director, at 412-3986.

Sincerely,

Mary Beth Sheffield

Mary Beth Sheffield
Inspector General

MBS/sgb
Enclosure: Six-Month Status Report of OPPAGA Report No. 20-04
cc/enc: Joint Legislative Auditing Committee
            Melinda Miguel, Chief Inspector General, EOG
            Toby Philpot, AHCA Chief of Staff
            Katie Strickland, AHCA Communications Director
            Beth Kidder, Deputy Secretary, Division of Medicaid
            Molly McKinstry, Deputy Secretary, Division of Health Quality Assurance
            James Miller, Chief Strategic Officer
            Pilar Zaki, Audit Director, Office of the Inspector General

2727 Mahan Drive • Mail Stop #4
Tallahassee, FL 32308
AHCA.MyFlorida.com

Facebook.com/AHCAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL

Agency for Health Care Administration
Six-Month Status Report on OPPAGA Report No. 20-04, Issued January 2020
AHCA Continues to Improve Medicaid Program Data Quality and
Oversight; Additional Improvements Needed in Use of Data

I. <u>Lack of Intra-Agency Coordination of Managed Care Plan Compliance Oversight</u>

1. *Formalize communication regarding oversight responsibilities.*

<u>*Status as of July 31, 2020*</u>
As previously noted, 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 continues to be on ensuring high quality monitoring.

<u>*Agency Response as of January 30, 2020*</u>
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.

2. *Reorganize the Medicaid Business Intelligence Unit.*

<u>*Status as of July 31, 2020*</u>
The Agency does not concur that moving the unit is necessary. 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.

<u>*Agency Response as of January 30, 2020*</u>
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.

Agency for Health Care Administration
Six-Month Status Report on OPPAGA Report No. 20-04, Issued January 2020
AHCA Continues to Improve Medicaid Program Data Quality and
Oversight; Additional Improvements Needed in Use of Data

II. Lack of Summarized Managed Care Plan Antifraud Activity Data, Lack of Data System Documentation, and Lack of Information on Data Analytics Activities by MPI

1. Develop reports that provide context for plan antifraud activities.

Status as of July 31, 2020 (MPI)
MPI has established preliminary benchmarks for managed care plan antifraud performance, specifically, MFCU referrals. These and other benchmarks are developed on an ongoing basis and the development process is incorporated into MPI business processes. As such, this recommendation is complete.

Agency Response as of January 30, 2020
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.

2. 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.

Status as of July 31, 2020 (MPI)
MPI has developed additional documentation for the FACTS system sufficient to meet MPI business needs. Further revisions and documentation are developed as needed. As such, this recommendation is complete.

Agency Response as of January 30, 2020
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.

3. 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.

Status as of July 31, 2020 (MPI)
MPI has and continues to develop innovative data analysis techniques and models often tailored toward identification of egregious billing practices. This is a process that is ongoing and would be expected to always be ongoing. As such, this recommendation is complete.

Agency Response as of January 30, 2020
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

Agency for Health Care Administration
Six-Month Status Report on OPPAGA Report No. 20-04, Issued January 2020
AHCA Continues to Improve Medicaid Program Data Quality and
Oversight; Additional Improvements Needed in Use of Data

---

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 modeling 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 will follow. Actions vary based upon the materiality, nature, and extent of the error.

III. <u>Limitations to Use of Encounter and Fee-for-Service Claims Data and Lack of a Comprehensive Plan to Monitor Trends Effectively in Medicaid</u>

*1. **Establish a process to identify high-risk services and ensure that critical data fields are complete and accurate.***

<u>*Status as of July 31, 2020*</u>
The Agency agrees that identifying high risk providers and having the rendering providers identified on a claim/encounter are useful tools for detecting fraud and abuse. Medicaid identifies high risk provider types as part of the Medicaid provider enrollment process. We have also identified the provider types for which we do not receive rendering providers on the claim/encounter. For services that currently do not identify the rendering caregiver, such as home health, the Agency is exploring other options to identify the caregiver, such as through the use of the electronic visit verification system. The Referring, Ordering, Prescribing, and Attending (ROPA) enrollment project to allow ROPA providers to enroll as a Florida Medicaid provider will help make such providers visible in FMMIS. However, due to the COVID-19 State of Emergency and the need for the Agency to prioritize system changes to respond to the public health emergency, the ROPA project has been delayed and will be rescheduled to complete once the emergency is over.

<u>*Agency Response as of January 30, 2020*</u>
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.

Agency for Health Care Administration
Six-Month Status Report on OPPAGA Report No. 20-04, Issued January 2020
AHCA Continues to Improve Medicaid Program Data Quality and
Oversight; Additional Improvements Needed in Use of Data

2. *Update policies to refine service categories and define specific service procedure codes and provider types.*

Status as of July 31, 2020
The Agency understands the need to have clear and concise coverage policies that are accessible to Medicaid providers, managed care plans, and stakeholders. This is necessary to ensure that providers, managed care plans, and stakeholders are clear on Florida Medicaid's service coverage. As part of this effort the Agency is in the process of reorganizing and updating its policies to make them more accessible, prevent duplication of language, and remove obsolete elements. During SFY 19-20, the Division of Medicaid adopted 14 rules and coverage policies, including the Provider Enrollment and Community Behavioral Health policies. The Agency continues its work on updating and restructuring the remaining coverage policies and has timeframes in place for their adoption.

Agency Response as of January 30, 2020
Not specifically addressed in the January 30, 2020, response document.

3. *Use claims and encounter data for regular and frequent monitoring of specific groups of Medicaid recipients that could provide insight into program functioning.*

Status as of July 31, 2020
The Agency continues to use encounter data as the primary data source for monitoring all aspects of service delivery and utilization with the program. The Agency's efforts to improve the accuracy and consistency of encounter data submitted from the health plans, including the imposition of liquidated damages and the use of FMMIS encounter data in capitation rate setting, will further support the use of encounter data to provide program oversight.

Agency Response as of January 30, 2020
Not specifically addressed in the January 30, 2020, response document.

4. *Continue encounter data validation studies to examine the extent to which encounters submitted to AHCA by contracted SMMC plans are complete and accurate.*

Status as of July 31, 2020
The Agency continues to monitor encounter data submissions by contracted SMMC plans to help ensure that the submissions are accurate and complete. Beginning in August, the Agency will impose liquidated damages on SMMC plans for failing to meet encounter data accuracy requirements. Additionally, the Agency continues to work on monitoring tools to ensure encounter data submissions are complete and intends to issue liquidated damages related to completeness in the future.

Agency for Health Care Administration
Six-Month Status Report on OPPAGA Report No. 20-04, Issued January 2020
AHCA Continues to Improve Medicaid Program Data Quality and
Oversight; Additional Improvements Needed in Use of Data

Agency Response as of January 30, 2020
Not specifically addressed in the January 30, 2020, response document.

5. ***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.***

Status as of July 31, 2020
Beginning in August, the Agency will impose liquidated damages on SMMC plans for failing to meet encounter data accuracy requirements. Additionally, the Agency continues to work on monitoring tools to ensure encounter data submissions are complete and intends to issue liquidated damages related to completeness in the future. The Agency is developing 2020-2021 Managed Medical Assistance (MMA) capitation rates using hospital and pharmacy managed care encounters reported to FMMIS and intends to use FMMIS encounters for all aspects of MMA rate setting beginning with rate year 2021-2022. In addition, the Agency is using managed care encounters reported to FMMIS to set 2020-2021 dental plan capitation rates and 2020-2021 non-emergency medical transportation capitation rates.

Agency Response as of January 30, 2020
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.