



RON DESANTIS
GOVERNOR

SIMONE MARSTILLER
SECRETARY

July 29, 2022

Ms. Simone Marsteller, Secretary
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, FL 32308

Dear Secretary Marsteller,

Enclosed is a six-month status report on OPPAGA's *Biennial Review of AHCA's Oversight of Fraud, Waste, and Abuse in Florida's Medicaid Program*, Report No. 22-03, issued January 2022. This status report is issued in accordance with the statutory requirement to report on corrective actions resulting from OPPAGA's recommendations six months from the report date.

If you have any questions about this status report, please contact Karen Preacher, Audit Director, at (850) 412-3968.

Sincerely,

Brian P. Langston
Inspector General

BL/sgb

Enclosure: Six-Month Status Report of OPPAGA Report No. 22-03

cc/enc: Joint Legislative Auditing Committee
Melinda Miguel, Chief Inspector General, EOG
Cody Farrill, AHCA Chief of Staff
Tom Wallace, Deputy Secretary, Division of Medicaid
Kim Smoak, Deputy Secretary, Division of Health Quality Assurance
Karen Preacher, Audit Director, Office of the Inspector General



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Biennial Review of AHCA's Oversight of Fraud, Waste,
and Abuse in Florida's Medicaid Program

I. Lack of Additional Oversight of Potential Fraud, Waste, and Abuse in Medicaid Funded Services Affected by Temporary Flexibilities Related to the COVID-19 Pandemic

- 1. *Implement increased monitoring of temporary changes made to Medicaid-funded services such as home- and community-based care and telemedicine during the COVID-19 public health emergency. AHCA should evaluate changes after the emergency to address opportunities for improvement.***

Status as of July 29, 2022

The Agency still does not concur that there is a need for additional or new procedures as this recommendation presumes that the existing oversight efforts would not have already considered the increased vulnerability due to the temporary changes. However, the Agency continues to complete existing oversight efforts with a sense of heightened scrutiny in areas with increased vulnerability due to the temporary changes.

Agency Response as of January 31, 2022

This recommendation presumes that the existing oversight efforts would not have already considered the increased vulnerability due to the temporary changes. As such, we do not concur that there is a need for additional or new procedures.

- 2. *Improve use of data analytics to focus on patterns or changes in Medicaid claims for services that may be particularly vulnerable to fraud in light of the recent policy changes made in response to the COVID-19 pandemic, such as home- and community-based services and telemedicine.***

Status as of July 29, 2022

The Agency has continued to use data to evaluate our processes and practices as the Federal public health emergency continues. This data has continued to inform the Agency, however, as the federal PHE is still in place, the Agency must continue to take into consideration all federal guidelines and requirements regarding COVID-19 flexibilities.

Agency Response as of January 31, 2022

As the Federal public health emergency continues, the Agency is continually evaluating our processes and practices to ensure our robust oversight is maintained at the highest level. The Agency has routinely pulled data for analysis specific to flexibilities implemented in response to the COVID-19 pandemic. This data has continued to inform the Agency, however, as the federal PHE is still in place, the Agency must continue to take into consideration all federal guidelines and requirements regarding COVID-19 flexibilities.

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The Agency will continue to develop data analytic reviews of the Medicaid services that have been changed in response to COVID-19. These analytics focus on service utilization trends and patterns.

II. Lack of Intra-Agency Coordination of Managed Care Plan Compliance Oversight

- 1. *Ensure that each unit with a role in program integrity efforts develops a unit-specific contract monitoring plan that explains how each unit will conduct oversight of the managed care entities and includes guidance on how subject matter experts will review and monitor plan reports or other data for contractual compliance.***

Status as of July 29, 2022

The Medicaid division uses a distributed compliance model approach for Statewide Medicaid Managed Care program. Managed care plan contract compliance and performance monitoring is a responsibility across all Medicaid functional units (e.g. Encounter Data Oversight, Provider Network Oversight, Financial Oversight, Marketing Oversight, etc.). Functional units contain subject matter experts needed to monitor and improve plan/program performance.

Agency Response as of January 31, 2022

While one contract monitoring plan was initially uploaded to the OPPAGA secure site, seven additional monitoring plans were uploaded on 8/31/2021 and again on 1/3/2022. Further, we do not agree that there is a lack of coordination or that there is a need to adjust the current strategy regarding these efforts.

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

- 1. *Develop summary reports of the plans' program integrity efforts using data from the Annual Fraud and Abuse Reports (AFAARs) to provide additional information to help the agency assess managed care plan antifraud performance.***

Status as of July 29, 2022

The Agency did not concur that corrective action was required and therefore there is no status update to provide.

Agency Response as of January 31, 2022

The AFAAR is, in itself, a summary report. While we concur with the sentiment that processes can be improved and that additional analytical techniques should be explored, we do not concur a recommendation to create a summary report of summary reports. We will continue to consider it for future efforts and planning.

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- 2. Continue to improve data system documentation by describing the structure of the data and adding a description of all possible values for each data element in the FACTS data dictionary.**

Status as of July 29, 2022

The Agency did not concur that corrective action was required and therefore there is no status update to provide.

Agency Response as of January 31, 2022

The recommendation does not identify deficiencies in the data that was prepared in response to the previous recommendation. While we concur with the concept of continuing to improve, we are unable to concur with implementing changes that were not well described by the report.

- 3. Develop advanced data analysis using fee-for-service claims data and encounter data to identify baseline trends in Medicaid services and monitor trends for anomalous or unexpected changes**

Status as of July 29, 2022

The Agency continues to develop and utilize advanced data analyses to review data trends in Medicaid service data. As the Agency transitions to the use of the FX's Enterprise Data Warehouse (EDW), additional reports and analysis are being developed to monitor trends for anomalous or unexpected changes in claims and encounter data.

Agency Response as of January 31, 2022

The Agency continues to conduct and develop advanced data analyses to review data trends in Medicaid service data. These analyses inform the Agency of program trends and help identify unexpected changes and anomalies.

IV. Limitations to Use of Encounter and Fee-for-Service Claims Data and Lack of a Comprehensive Plan to Monitor Trends Effectively in Medicaid

- 1. Continue to conduct encounter data validation studies and implement recommendations from such studies.**

Status as of July 29, 2022

The Agency takes our charge to prevent and reduce fraud, waste, and abuse in the Medicaid program seriously. As part of our robust, ongoing integrity program, the Agency contracted with an External Quality Control (EQR) vendor to complete encounter validation studies. Two are complete related to Managed Medical Assistance plan, specialty plan, and dental plan encounter data. A third study is underway and is focused on Long-Term Care plan encounter data. While the EQR vendor suggested ways we could continue to improve, the findings overall indicate

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the encounter data demonstrates a high level of completeness and very low omission discrepancies. The Agency will continue to actively monitor encounter data, as well as continue to evaluate recommendations from such studies and implement strategies as appropriate for the State of Florida.

Agency Response as of January 31, 2022

The Agency takes seriously our charge to prevent and reduce fraud, waste, and abuse in the Medicaid program. As part of our robust, ongoing program integrity program, the Agency contracted with an External Quality Control (EQR) vendor to complete encounter validation studies. Two are complete related to Managed Medical Assistance plan, specialty plan, and dental plan encounter data. A third study is underway and is focused on Long-Term Care plan encounter data. While the EQR vendor suggested ways we could continue to improve, the findings overall indicate the encounter data demonstrate a high level of completeness and very low omission discrepancies. The Agency will continue to actively monitor encounter data, as well as continue to evaluate recommendations from such studies and implement strategies as appropriate for the State of Florida.

- 2. Continue to expand the use of managed care encounter data reported to FMMIS for program oversight including using data for regular and frequent monitoring of Medicaid recipients to ensure services are of appropriate quality and provided when needed, for setting capitation rates, and for analyzing utilization trends.**

Status as of July 29, 2022

The Agency continues to expand the use of managed care encounter data. Starting with Rate Year (RY) 2020/2021, the Agency began transitioning the base data used to develop the SMMC capitation rates to the FMMIS data. Effective in RY 2020/2021, the SMMC Dental program has been set using FMMIS data and Achieved Savings Rebate (ASR) financial data. The SMMC MMA program began using hospital and pharmacy data from the FMMIS for RY 2020/2021 and expanded to use the FMMIS data for all encounter data in RY 2021/2022. The SMMC LTC program is expected to transition to the FMMIS data in RY 2023/2024.

Agency Response as of January 31, 2022

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- 3. Use results of the actuarial validation process to improve FMMIS encounter data quality with the goal that adjustments to encounter data during the process of rate setting be reduced and eventually eliminated.**

Status as of July 29, 2022

The Agency continues to work with its actuarial vendor and the SMMC health plans to improve the FMMIS encounter data quality.

Agency Response as of January 31, 2022

The Agency continues to work with its actuarial vendor and the SMMC health plans to improve the FMMIS encounter data quality.

- 4. Identify ways to improve the quality of encounter data for subcapitated encounters so that the data can be reliably used for rate setting rather than relying on managed care plan financial transaction data.**

Status as of July 29, 2022

For rate setting purposes the Agency and its actuarial vendor do not intend to use subcapitated encounters for rate setting purposes. The Agency's actuarial vendor will continue to rely on financial transaction data for subcapitated encounters. Using financial data for subcapitated expenses is a common occurrence across the health care industry since the financial data reflects the actual cost incurred by the managed care plan. Additionally, subcapitated encounters do not always reflect the subcapitation arrangement that is in place between the managed care plan and the subcapitated provider.

In an effort to continue to improve the overall quality of the encounter data, the Medicaid Fiscal Agent Operations (MFAO) Bureau and Medicaid Data Analytics (MDA) Bureau continue to work with plans to improve the quality of the encounter data they submit.

Agency Response as of January 31, 2022

For rate setting purposes the Agency and its actuarial vendor do not intend to use subcapitated encounters for rate setting purposes. The Agency's actuarial vendor will continue to rely on financial transaction data for subcapitated encounters. Using financial data for subcapitated expenses is a common occurrence across the health care industry since the financial data reflects the actual cost incurred by the managed care plan. Additionally, subcapitated encounters do not always reflect the subcapitation arrangement that is in place between the managed care plan and the subcapitated provider.

The Medicaid Fiscal Agent Operations (MFAO) Bureau now has a staffed position for this purpose. They have started meeting with MDA to identify critical fields needed for data quality improvement. They will set up ongoing meetings with the plans to improve the quality of the encounter data the plans submit.