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

Report 22-03

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OPPAGA

Office of Program Policy Analysis and Government Accountability

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EXECUTIVE SUMMARY

> **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 OPPAGA's 10th report.[1,2]

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.[1,2] 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.

AHCA's Office of Medicaid Program Integrity is primarily responsible for administering and overseeing fraud, waste, 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.

Due to the COVID-19 pandemic, AHCA has implemented a number of Medicaid flexibilities since March 2020 to ensure access to health care services during a public health emergency. According to recent federal reports, changes in rules and regulatory processes increase risks of fraud, waste, and abuse during public health emergencies; however, AHCA has not developed additional oversight procedures in response to flexibilities implemented by the agency.

Consistent with several recommendations from OPPAGA's 2020 report, AHCA enhanced oversight and monitoring of Medicaid systems in several areas. The agency improved intra-agency coordination of managed care plan oversight, enhanced data system documentation, developed a performance target for fraud reporting, enhanced provider screening processes, implemented policies to refine service categories and procedure codes, and continued conducting validation studies. Improvements are still needed in several areas, including documentation of contract monitoring methods and data documentation, antifraud activity tracking and data analysis, and data quality and use of encounter 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 facilitates 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 5 million persons each month as of November 2021.[4] For Fiscal Year 2021-22, the Legislature appropriated $35 billion to operate the program.[5]

AHCA operates Florida's Medicaid program using the Statewide Medicaid Managed Care (SMMC) and fee-for-service (FFS) delivery systems. Under the 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. In return for the capitated payment, each managed care plan is responsible for arranging for and paying providers for all covered services delivered to Medicaid beneficiaries.[6] Under the FFS payment system, providers deliver services to Medicaid recipients and bill the state on an individual or itemized basis, and the state Medicaid program reimburses after providers render the service and bill the state.

The majority (78%) of Medicaid recipients receive services through SMMC, and 22% receive services through FFS as of August 2021.[7] Some services provided to SMMC enrollees are reimbursed under FFS, including behavior analysis, organ transplants, and obstetrical care.[8] Total Medicaid expenditures during Fiscal Year 2020-21 were $25.6 billion. SMMC expenditures accounted for 71% ($18.3 billion) and FFS expenditures accounted for 29% ($7.3 billion). While SMMC continues to account for most Medicaid expenditures, FFS payments have accounted for approximately 30% of Medicaid expenditures during each of the past six fiscal years.[9] (See Exhibit 1.)

[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] As of June 2021, Florida ranks fourth for Medicaid enrollment after California, New York, and Texas.

[5] Of the total Medicaid budget for Fiscal Year 2021-22, $8.5 billion is general revenue and $26.4 billion is from trust funds.

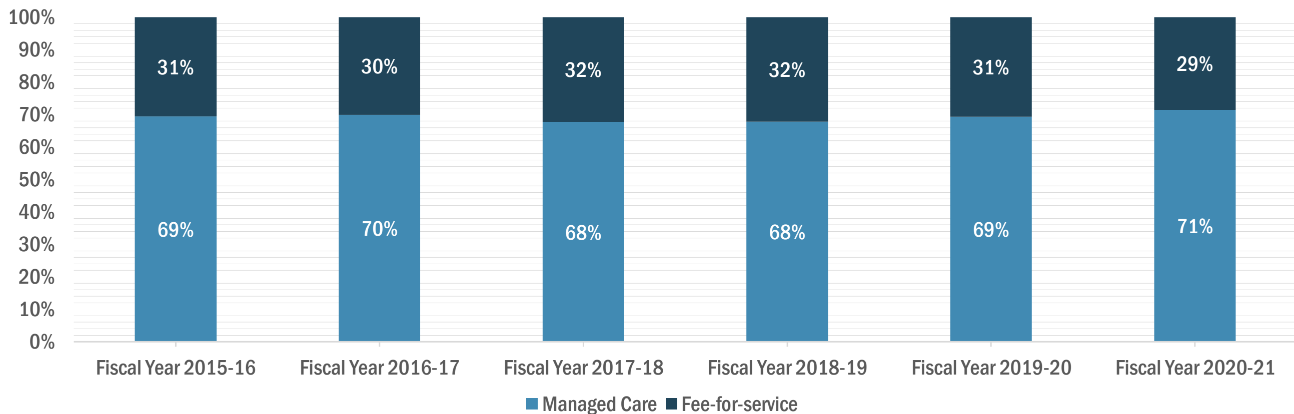
[6] Managed care plans may pay providers on a fee-for-service basis, a monthly capitation payment per beneficiary, or through some other payment approach in which the provider assumes some risk for delivering covered services.

[7] Some of 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. Voluntary 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.

[9] Some recipients in the FFS program are limited benefit eligible, and FFS expenditures also include non-claim supplemental payments that are distributed based on fixed formulas such as low income pool, disproportionate share hospital, and graduate medical education.

Exhibit 1
Statewide Medicaid Managed Care Payments Accounted for Approximately 70% of Total Medicaid Expenditures in Each of the Past Six Fiscal Years



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

Multiple AHCA units are responsible for meeting federal and state Medicaid fraud, waste, and abuse oversight requirements. Federal regulations include requirements for states regarding Medicaid program integrity, including identifying, investigating, and referring suspected fraud cases to law enforcement officials, cooperating with the state's Medicaid fraud control unit, and imposing payment suspensions on providers.[10] Several units within AHCA have various responsibilities to meet these requirements.

AHCA's Office of Medicaid Program Integrity (MPI) in the Division of Health Quality Assurance has primary responsibility for administering and overseeing fraud, waste, and abuse prevention and detection efforts for both managed care and fee-for-service systems.[11,12] MPI identifies and investigates providers suspected of fraud, waste, and abuse and ensures that SMMC contracted health plans comply with Medicaid requirements to prevent, detect, and deter abusive and fraudulent practices. MPI also refers cases of suspected provider fraud to the Florida Attorney General's Medicaid Fraud Control Unit (MFCU) for investigation and prosecution. MPI's Fiscal Year 2020-21 operating budget included funding for 81.5 FTE positions for MPI's Tallahassee central office and Miami office.

MPI uses various methods to identify potential cases of Medicaid overpayments to providers, including conducting routine and ad hoc statistical analysis.[13] MPI investigators review the information generated through these methods to determine whether to open a complaint. If MPI subsequently decides to open an overpayment recovery audit, the provider has an opportunity to submit documentation. The investigator then reviews the provider documentation for compliance with Medicaid policies. If necessary, the investigator develops audit findings and AHCA issues a final order that establishes the overpayments that the provider must repay, including the agency's investigative costs and payment for any sanctions assessed.[14,15] MPI applies punitive and monetary sanctions for

[10] 42 C.F.R. § 455.
[11] MPI's Fiscal Year 2020-21 approved operating budget to address fraud, waste, and abuse is $6.5 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.
[12] Section 409.913, *F.S.*
[13] MPI may also identify potential cases from complaints to the Medicaid online complaint form, the media, or referrals from other providers or from other state agencies. MPI cases may also be investigator initiated.
[14] Section 409.913(23), *F.S.*, grants AHCA the authority to recover investigative, legal, and expert witness costs.
[15] Prior to issuing the final order, the provider may appeal MPI's findings by requesting an informal hearing with the agency's general counsel or a formal hearing with the Division of Administrative Hearings.

providers failing to comply with Medicaid policies as a way to deter fraud, waste, and abuse.[16,17] Some overpayment cases do not result in sanctions because of Medicaid amnesty programs. Pursuant to statute, MPI grants amnesty from sanctions when a Medicaid provider performs a self-audit and voluntarily repays the overpayment.[18]

In Fiscal Year 2019-20, there were 60,692 Medicaid providers with billed services in Florida, among which MPI identified 547 provider cases with $27.7 million in overpayments, the majority of which were for fee-for-service expenditures.[19] These overpayments accounted for approximately 0.4% of FFS expenditures during this time period. MPI applied sanctions that amounted to $2.3 million in fines for 123 (22.5%) cases that had received $19.0 million in overpayments.[20] MPI did not apply sanctions for 424 (77.5%) cases that had received $8.7 million in overpayments because the providers performed self-audits (193 cases) or qualified for amnesty for other reasons (231 cases). (See Exhibit 2.) AHCA staff reported that the Bureau of Financial Services collected $23.7 million of Fiscal Year 2019-20 overpayments. During the same period, 50 providers were suspended and 33 were terminated from participating in the Medicaid program for overpayments and other violations.

Exhibit 2
During Fiscal Year 2019-20, MPI Identified $27.7 Million in Medicaid Overpayments and Applied Sanctions to 22.5% of Cases That Had Received $19 Million in Overpayments

MPI Case Resolution	Number of Provider Cases with Overpayments Identified	Percentage of All Cases with Overpayments Identified	Amount of Overpayments Identified	Fine Amount
No Sanction Applied	424	77.5%	$8.7 million	n/a
Amnesty for Self-Audit	*193*	*35.3%*		
Amnesty for Other Reasons	*231*	*42.2%*		
Sanction Applied	123	22.5%	$19 million	$2.3 million[1]
Total Cases with Overpayments Identified	**547**	**100%**	**$27.7 million**	**$2.3 million**

[1] An additional $950,000 in fines were levied in cases for actions other than overpayment (e.g., failure to renew a required license or failure to provide Medicaid-related records for review).
Source: OPPAGA analysis of Agency for Health Care Administration sanctioning data.

In addition to MPI, several other units within AHCA play a role in the state's efforts to ensure the integrity of the Medicaid program. Most of these units 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. For example, the Division of Medicaid administers the state's Medicaid program, the Division of Health Quality Assurance oversees the Medicaid Program Integrity Office and facility licensure, and the Division of Operations provides business support services.[21]

[16] Sanctions include fines, provider terminations, and provider suspensions.
[17] Severity and conditions for sanctions are specified in the agency's administrative rule (see rule 59G-9.070, *F.A.C.*).
[18] Section 409.913(25)(e), *F.S.*, allows AHCA to suspend these costs when it grants amnesty.
[19] Fiscal Year 2019-20 fraud, waste, and abuse case numbers are presented because OPPAGA validated MPI's numbers for this fiscal year using MPI FACTS data. Fiscal Year 2020-21 numbers are not presented because FACTS data was extracted near the end of the fiscal year and OPPAGA was unable to validate the information.
[20] The sanctions for these cases were levied against 113 individual providers. Pursuant to s. 409.913, F.S., MPI levied an additional $95,000 in fines for cases without an overpayment, which could be for other violations of Medicaid laws such as failure to renew a required license or failure to provide Medicaid-related records for review.
[21] For additional information on the roles and responsibilities of these units in AHCA's Medicaid program integrity efforts, see AHCA Continues to Improve Medicaid Program Data Quality and Oversight; Additional Improvements Needed in Use of Data, OPPAGA Report 20-04, January 2020.

Managed care plans must meet federal requirements to guard against fraud, waste, and abuse, and AHCA holds plans accountable through contract management; antifraud activities continue to vary widely across plans. Managed care plans are responsible for administering and overseeing fraud, waste, and abuse prevention and detection efforts within plan provider networks, and AHCA is responsible for ensuring that plans have proper systems in place to conduct these activities. AHCA's contract with each managed care plan must meet several statutory requirements related to antifraud activities, including having program integrity functions, reporting encounter data to AHCA, and making continuous improvements to health care quality performance.[22] AHCA uses a centralized managed care oversight process in which the Division of Medicaid coordinates oversight by using subject matter experts across multiple agency units to communicate with managed care contract managers responsible for overall contract compliance.

During Fiscal Year 2019-20, the health plans reported recovering 52% of overpayments ($146.7 million of $281.7 million) and 12% of funds lost to fraud, waste, and abuse ($2.0 million of $17.1 million). Consistent with OPPAGA's 2020 report findings, the managed care plans continue to vary widely in size and level of antifraud activity. For example, average monthly enrollment among plans in Fiscal Year 2019-20 ranged from 10,502 to 864,838 enrollees. The number of cases opened by each plan during the same period ranged from 1 to 2,976, cases with overpayments recovered ranged from 0 to 198, and recovered dollars from overpayments ranged from $0 to $55.7 million. While this variation may correspond to plan size, there may not always be a direct correlation between level of antifraud activity and plan size. OPPAGA's 2020 report showed that program integrity efforts can vary among plans of similar size. (See Appendix A for additional information on individual plans' antifraud activities.)

AHCA is undergoing a multi-year and phased-in process to update and integrate the Medicaid management information system that is used to administer Medicaid business functions. States use mechanized claims processing and information retrieval systems called Medicaid management information systems (MMIS). These systems support program integrity activities, such as provider screening, claims processing, and utilization reviews.[23] Currently, Florida's MMIS functions as a single, integrated system for claims processing and information retrieval.[24] AHCA is undergoing a multi-year, phased-in process to modernize and integrate Florida's MMIS and decision support system with other state agency databases and migrating to a modular approach to Medicaid information technology acquisition, as encouraged by the Centers for Medicare and Medicaid Services (CMS).[25] The new system will be called Florida Health Care Connections (FX), and AHCA plans to replace the existing system by Fiscal Year 2024-25. The objective of the modernization is to enhance the provider and recipient experience, improve access to health care data, and enhance data integration between state agencies.[26] AHCA has executed contracts with two vendors to begin implementing the first two of six FX system development modules—the Integration Services/Integration Platform and Enterprise Data Warehouse modules; the other four modules are in various stages of procurement planning or solicitation.[27]

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[22] Section 409.967 (2), *F.S.*

[23] The federal government requires all states to have a MMIS to manage Title XIX program control and administrative costs; manage services to recipients, providers, and inquiries; operate claims control and computer capabilities; and perform management reporting for planning and control.

[24] Since 1978, Florida has had six Medicaid Systems vendors and two new systems.

[25] The Decision Support System, Florida Medicaid's data warehouse, is a relational database and suite of software tools.

[26] Other outside systems include the Department of Health, Department of Elder Affairs, Agency for Persons with Disabilities, Department of Financial Services, Florida Department of Law Enforcement, and Department of Juvenile Justice.

[27] AHCA executed a contract with Accenture in November 2019 to conduct the Integration Services/Integration Platform module of FX development, and it executed a second contract with Deloitte in December 2020 to conduct the Enterprise Data Warehouse module.

FINDINGS

AHCA implemented flexibilities to increase access to health care in response to the COVID-19 pandemic but has not implemented any additional program integrity oversight procedures

Consistent with national and state trends, Florida's monthly Medicaid enrollment increased by 29% from February 2020 to July 2021 and was largely attributable to the COVID-19 pandemic. During this period, AHCA implemented a number of flexibilities to ensure access to health care services. According to recent federal reports, changes in rules and regulatory processes increase risks of fraud, waste, and abuse during public health emergencies; however, AHCA has not developed additional oversight procedures in response to flexibilities implemented by the agency.

Consistent with national and state trends, Florida's monthly Medicaid enrollment increased by 29% from February 2020 to July 2021; during this period, AHCA implemented a number of flexibilities to ensure access to health care services. Florida's total monthly Medicaid enrollment increased from 3.8 million in February 2020 to 4.9 million in July 2021. This increase is consistent with trends seen in other states and nationally during the same period, and the increases are largely attributable to the COVID-19 pandemic. To address public health emergencies, states may apply for waivers or amendments to the state plans as part of federal disaster relief. Florida and many other states took advantage of such strategies to ensure continued access to health care services in response to the COVID-19 pandemic. AHCA implemented several flexibilities during Fiscal Year 2019-20, including

- waiving prior authorization requirements;
- allowing out-of-state Medicaid or Medicare enrolled providers to be reimbursed for services;
- implementing provisional enrollment processes, including temporarily waiving nursing facility pre-admission screening and resident review;
- removing all limits for COVID-related testing and services;
- expanding long-term care home- and community-based services;
- waiving requirements for face-to-face services; and
- expanding allowable services to be provided by telehealth, including behavior analysis caregiver training and supervision, early intervention service sessions, therapy services, and medical services.

According to recent federal reports, changes in rules and regulatory processes increase risks of fraud, waste, and abuse during public health emergencies; however, AHCA has not developed additional oversight procedures in response to flexibilities implemented by the agency. Several recent federal reports cite the increased risks of fraud associated with flexibilities states have implemented in the Medicaid program that were intended to expand access to services during a public health emergency. In September 2021, the U.S. Department of Health and Human Services Office of

Inspector General reported on the increased risks for fraud, waste, and abuse as a result of expanding the use of telemedicine during the pandemic.[28] Telemedicine has been cited by several other reports as an area of health care that is highly susceptible to fraud, particularly during a public health emergency.[29,30,31,32] The inspector general reported that most states' program integrity efforts lacked activities that specifically targeted telehealth. The report suggests that the telehealth flexibilities implemented during the COVID-19 pandemic provide opportunities for states to improve processes and protect against fraud, waste, and abuse and recommends that CMS work with states to ensure that telehealth is distinguished from in-person services; conduct evaluations of effects of telehealth on access, cost, and quality of behavioral health services; and monitor for fraud, waste, and abuse in these services.

The U.S. Government Accountability Office also reported in September 2021 on the challenges to beneficiary health and welfare associated with flexibility measures in states' Medicaid programs and noted that CMS relied on states to monitor changes during the public health emergency.[33] The report focused on risks to the Medicaid home- and community-based services (HCBS) program and examined implementation of COVID-19 related temporary changes to HBCS in six states. The report found that the selected states used a variety of information sources and approaches to examine the effects of temporary policy changes, including monitoring program data before and during the pandemic and regularly communicating with stakeholders (e.g., managed care organizations, providers, and beneficiary groups) to monitor service provision and effects of COVID-19 on those services. The office recommended that CMS develop procedures to monitor temporary changes to Medicaid HCBS programs during public health emergencies and evaluate such changes after emergencies to identify opportunities for improvement.

Many federal and state criminal investigations of COVID-19 related fraud have occurred during the past two years. A February 2, 2021 advisory issued by the U.S. Department of the Treasury's Financial Crimes Enforcement Network observed a wide range of COVID-19 related fraud in the health care industry, including Medicaid fraud.[34] The U.S. Department of Justice's 2020 report of the Fraud Section's Health Care Fraud Unit included a focus on investigations into telemedicine and COVID-19 related fraud schemes.[35] Data analytics are an important aspect of efforts to target fraudulent schemes that are more complex and higher in value than in past years. The National Health Care Fraud Enforcement Action reported $29 million in COVID-19 health care fraud charges nationwide as of

[28] U.S. Department of Health and Human Services, Office of Inspector General. "Opportunities Exist to Strengthen Evaluation and Oversight of Telehealth for Behavioral Health in Medicaid, Data Brief." September 2021. https://oig.hhs.gov/oei/reports/OEI-02-19-00401.pdf.

[29] U.S. Department of Justice, U.S. Attorney's Office, Southern District of Florida. "National Health Care Fraud Enforcement Action Results in Charges of Over $308 Million in Intended Loss Against 52 Defendants in the Southern District of Florida." September 17, 2021. https://www.justice.gov/usao-sdfl/pr/national-health-care-fraud-enforcement-action-results-charges-over-308-million-intended.

[30] Bittinger, Stephen D. et al. "Qui Tam Quarterly: COVID-19 and the Big-Data Revolution of Health Care False Claims Act Litigation." National Law Review 10, no. 365 (December 2020): 1-13. https://www.natlawreview.com/article/qui-tam-quarterly-covid-19-and-big-data-revolution-health-care-false-claims-act#google_vignette.

[31] U.S. Treasury, Financial Crimes Enforcement Network. "Advisory on COVID-19 Health Insurance- and Health Care-Related Fraud." February 2, 2021. https://www.fincen.gov/sites/default/files/advisory/2021-02-02/COVID-19%20Health%20Care%20508%20Final.pdf.

[32] U.S. Department of Justice, Criminal Division, Fraud Section. "Year in Review 2020." February 2021. https://www.justice.gov/criminal-fraud/file/1370171/download.

[33] U.S. Government Accountability Office. "Medicaid Home- and Community-Based Services – Evaluating COVID-19 Response Could Help CMS Prepare for Future Emergencies." September 2021. https://www.gao.gov/assets/gao-21-104401.pdf.

[34] U.S. Treasury, Financial Crimes Enforcement Network. "Advisory on COVID-19 Health Insurance- and Health Care-Related Fraud." February 2, 2021. https://www.fincen.gov/sites/default/files/advisory/2021-02-02/COVID-19%20Health%20Care%20508%20Final.pdf.

[35] U.S. Department of Justice, Criminal Division, Fraud Section. "Year in Review 2020." February 2021. https://www.justice.gov/criminal-fraud/file/1370171/download.

September 2021.[36] In addition, the Florida Attorney General's office and its Medicaid Fraud Control Unit work with local, state, and federal agencies to identify emerging COVID-19 related fraud schemes.

Finally, a recent National Law Review article emphasized the importance of being able to distinguish good actors from those engaging in fraudulent activities and that the use of data analytics to identify and predict fraud will involve challenges because of the public health emergency. The authors reported that these changes will require regulators, prosecutors, and providers to increase use of and competencies in data analytics to evaluate impacts of these policy changes.[37]

While AHCA recognizes that the flexibilities implemented in response to the COVID-19 pandemic have affected Medicaid programs and quality monitoring efforts, agency staff reported that the agency has not created any new program oversight procedures to enhance monitoring and oversight of Medicaid programs affected by these policy changes. AHCA Division of Medicaid staff reported that the flexibilities were incorporated into the agency's standard business processes and practices and did not impede the division's ability to ensure appropriate delivery of health care services or to detect and prevent fraud, waste, and abuse. MPI staff reported that they initially endeavored to monitor COVID-specific claims but determined that most of the known fraudulent schemes (e.g., fraudulent COVID testing) were not billed to Medicaid, and therefore they did not continue such monitoring.

Consistent with prior OPPAGA recommendations, AHCA enhanced oversight and monitoring of Medicaid systems; improvements are still needed in several areas

Consistent with several recommendations from OPPAGA's 2020 report, AHCA enhanced its oversight and monitoring of Medicaid systems in several areas. AHCA made improvements to intra-agency coordination of managed care plan oversight, enhanced data system documentation, developed a performance target for fraud reporting, enhanced provider screening processes, implemented policies to refine service categories and procedure codes, and continued conducting validation studies. Improvements are still needed in several areas, including documentation of contract monitoring methods and data documentation, antifraud activity tracking and data analysis, and data quality and use of encounter data.

AHCA improved intra-agency coordination of managed care plan compliance oversight; some improvements may still be needed. According to OPPAGA's 2020 report, AHCA staff noted that they had completed a Comprehensive Contract Monitoring Plan that established each unit's managed care oversight responsibilities. However, staff also reported that at the time, the plan did not include instructions for how reports and data should be used.

Prior OPPAGA Recommendation: AHCA should formalize communication regarding oversight responsibilities, including incorporating language in the Comprehensive Contract Monitoring Plan to explain how each unit will conduct oversight of the managed care entities and developing guidance on

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[36] U.S. Department of Justice, U.S. Attorney's Office, Southern District of Florida. "National Health Care Fraud Enforcement Action Results in Charges of Over $308 Million in Intended Loss Against 52 Defendants in the Southern District of Florida." September 17, 2021. *National Health Care Fraud Enforcement Action Results in Charges of Over $308 Million in Intended Loss Against 52 Defendants in the Southern District of Florida.*

[37] Bittinger, Stephen D. et al. "Qui Tam Quarterly: COVID-19 and the Big-Data Revolution of Health Care False Claims Act Litigation." National Law Review 10, no. 365 (December 2020): 1-13. https://www.natlawreview.com/article/qui-tam-quarterly-covid-19-and-big-data-revolution-health-care-false-claims-act#google_vignette.

how subject matter experts will review and monitor plan reports or other data for contractual compliance.

Since OPPAGA's 2020 report, AHCA completed the Comprehensive Contract Monitoring Plan and identified which business unit is responsible for each element of the state's SMMC contract. AHCA reported that each unit of subject matter experts is responsible for housing its monitoring tools and instructions, and the agency provided an example of a contract monitoring plan for the Bureau of Medicaid Fiscal Agent Operations. The bureau's plan provides information on how the unit will conduct its contract monitoring activities, including the types of agency review tools, information sources, and monitoring methods.

Because the oversight of Medicaid managed care is a collaborative effort across multiple agency units, formalized communications and unit responsibilities and directions for how to perform oversight are critical for ensuring continuity of oversight. In the absence of the formal establishment of each unit's oversight responsibilities, turnover in staff and changes in management may impede the effectiveness of program integrity activities. OPPAGA requested that AHCA provide contract monitoring plans for all agency units with SMMC monitoring roles. However, because the agency only provided such a plan for one business unit, OPPAGA cannot evaluate whether this improvement has occurred across all units that have SMMC contract monitoring roles.

AHCA enhanced data system documentation and developed a performance target for fraud reporting; improvements are still needed for antifraud activity data and data analysis activities.

Prior OPPAGA Recommendation: MPI should develop reports that provide context for their widely varying antifraud activities to help evaluate whether plans are conducting fraud and abuse activities as expected given plan size in relation to similar plans.

These reports could assist MPI's managed care plan oversight and would provide standard data regarding the effectiveness of each plan's program integrity efforts and how plans compare to each other on measures like sources of opened cases, disposition of closed cases, providers prevented from enrolling and providers terminated. While AHCA did not develop summary reports of the plans' program integrity efforts, MPI staff reported that they created a performance target for plans' antifraud activities. The performance target requires plans to report provider fraud to the Attorney General's Medicaid Fraud Control Unit.[38] If a plan does not comply with the performance target requirement, MPI staff refers the issue to Medicaid for a contractual remedy based upon the facts and circumstances of the particular situation. While this target provides some additional information on plan antifraud activities, its effectiveness may be limited because there is no penalty for non-compliance.

Prior OPPAGA Recommendation: AHCA should develop documentation for the Fraud and Abuse Case Tracking System (FACTS) database to ensure that all system users consistently enter investigative information and to assist MPI staff and external reviewers in analyzing system data.

AHCA addressed the recommendation by creating documentation for the FACTS database, which includes some user training. However, AHCA could further improve FACTS documentation by

[38] The performance target is calculated by dividing the total number of plan enrollees from the July monthly enrollment report by the number of unique providers in the plan and multiplying the result by a suspected fraud multiplier. Each plan's suspected fraud multiplier is based on the size of the plan's capitated payments for July of the current fiscal year.

describing the content and organization of the data, including adding a definition of all values for each data element in the data dictionary.

Prior OPPAGA Recommendation: AHCA should develop advanced data analysis using fee-for-service claims and encounter data to identify baseline trends in Medicaid services and monitor those trends for anomalous or unexpected changes.

MPI staff reported that implementing this recommendation was hindered by staff turnover, and as a result, the unit lacks staff with the skills required to use encounter data to evaluate managed care plan compliance. Recent staff turnover issues resulted in four different administrators of the detection unit, two different administrators of the data unit, and eight staff changes across four positions in the systems project consultant positions during the past two years. MPI reported that while it developed a risk-based model for selecting plans for on-site monitoring and audits, it experienced data integrity issues and has been unable to fix the model in part because of the aforementioned staff turnover issues. MPI staff reported that recruiting and retaining qualified candidates with the appropriate expertise is challenging due to competition with the private sector and other state agencies. However, staff plans to continue to focus efforts on developing the risk-based model.

AHCA enhanced provider screening processes, policies to refine service categories and procedure codes, and validation studies; however, improvements are still needed in data quality and use of encounter data.

Prior OPPAGA Recommendation: AHCA should establish a process to identify high-risk services and ensure that critical data fields are complete and accurate.

AHCA engages in a number of activities to screen providers that participate in the Medicaid program. Typical screening activities include federal database checks, criminal history checks, previous termination reviews, enrollment application pre-screening questions, practitioner and facility license final order reviews, and data system checks between AHCA and Department of Health licensure systems and the Florida Medicaid Managed Information System (FMMIS). Consistent with OPPAGA's recommendation, AHCA improved existing processes and added several new processes for screening Medicaid providers.

AHCA implemented enhanced screenings on renewing high-risk behavior analysis groups and lead analysts that include a review of group members' location in comparison to the location of the group, a review of provider numbers for owners associated with group or lead analyst providers to identify adverse terminations or restrictions on owners, and a public records search of owners to identify issues of concern (e.g., financial problems), other businesses, or associated persons. Information resulting from the enhanced screenings was communicated to the Office of Medicaid Program Integrity along with pertinent information related to investigations, adverse findings, or risk to the Medicaid program. AHCA adjusted screening protocols on initial high-risk behavior analysis group and case management group applications to focus on shared owners, linked employees (group members), managing employees, credentialing specialists, and contact persons listed on applications.[39] AHCA also terminated multiple large batches of registered providers that were used for managed care plan

[39] AHCA reported that the application volume in South Florida for these two provider types has increased, and relatively few individuals appear to be facilitating the enrollment of high volumes of new behavioral health businesses.

encounter tracking, were not under a provider agreement with AHCA, and had been identified as a fraud vulnerability.[40]

In addition, AHCA reported adding a review process for new Referring, Ordering, Prescribing, and Attending (ROPA) provider types to identify previous adverse enrollment status.[41] AHCA's Bureau of Fiscal Agent Operations implemented a new process that utilizes CMS's Adverse Actions Report to identify providers that have been terminated for-cause by external state Medicaid agencies, revoked for-cause from Medicare, or listed on a federal exclusionary database. AHCA reported that the Medicaid fiscal agent's technical team automated the reconciliation of CMS's Adverse Actions Report within the FMMIS system to generate match reports for Medicaid providers, and started running the process monthly on October 1, 2021. Manual reconciliation was used until automation was complete. Finally, at the time of OPPAGA's review, AHCA's Division of Health Quality Assurance reported developing a new Care Provider Background Screening Clearinghouse. AHCA expects enhancements to be complete in September 2022.

Prior OPPAGA Recommendation: AHCA should update and refine its service coverage policies and procedure codes.

AHCA updated electronic visit verification (EVV) for behavior analysis and home health services and now requires fee-for-service ROPA providers to enroll with Medicaid. EVV is one of several methods AHCA uses to verify the utilization and delivery of services and ensure health care is necessary and appropriate for certain services. AHCA uses EVV to monitor and verify the delivery of home health and behavior analysis services. Behavioral analysis services were among the top five Medicaid provider types in fraud cases opened by the Florida Attorney General's Medicaid Fraud Control Unit in Fiscal Year 2018-19, and home health services were among the top six provider types in fraud cases opened by MFCU in Fiscal Year 2019-20. (See Appendix B for information on MFCU's top Medicaid provider types for Medicaid fraud cases.) Beginning January 1, 2021, home health providers contracted with a Medicaid managed care plan were required to verify home health and personal care service visits through the managed care plan's electronic visit verification system. AHCA also contracted with a vendor to provide EVV of home health services provided through the fee-for-service program. Behavior analysis providers in regions 9, 10, and 11 were required to bill through an EVV system beginning on February 1, 2021; these regions include Broward, Indian River, Martin, Miami-Dade, Monroe, Okeechobee, Palm Beach, and St. Lucie counties. AHCA is suspending EVV for behavior analysis services beginning February 5, 2022, and will transition to the American Medical Association Behavior Analysis Current Procedural Terminology code structure on July 1, 2022. (See Appendix C for a map of Medicaid regions.)

To protect beneficiaries and the state against fraudulent and abusive providers, state Medicaid agencies conduct risk-based screening activities when providers enroll and periodically throughout enrollment. Recent federal regulations require all providers that refer, order, prescribe, or attend to patients in conjunction with provision of services to Medicaid beneficiaries (ROPA providers) to enroll with their state Medicaid agency. ROPA providers are healthcare practitioners who do not bill claims directly to fee-for-service Medicaid or Medicaid health plans and are therefore not enrolled Medicaid providers. In accordance with the new federal regulations, AHCA now requires all ROPA providers for Florida Medicaid fee-for-service recipients to be enrolled with Florida Medicaid. The requirement went into effect October 1, 2021. As of this date, fee-for-service claims submitted for a provider not

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[40] AHCA reported that these providers historically received little to no screening against federal exclusionary databases or criminal history screening.

[41] Providers with a previous adverse enrollment status have had adverse terminations or denials from Florida Medicaid.

enrolled with Florida Medicaid, including claims listing an unenrolled ROPA provider, will be denied, and the provider will not receive reimbursement for services.

Prior OPPAGA Recommendation: AHCA should continue encounter data validation studies to examine the extent to which encounters submitted to AHCA by managed care plans are complete and accurate.

Managed care contracts must meet statutory requirements to submit encounter data to AHCA for services provided to all Medicaid recipients enrolled in prepaid plans, and AHCA must maintain and use an encounter data system to collect, process, store, and report on covered services. Furthermore, AHCA is responsible for validating the data submitted by the plans and developing methods and protocols for ongoing analysis of the encounter data that adjusts for plan differences and allows for service utilization comparisons to identify inappropriate over and underutilization. AHCA continued to conduct encounter data validation (EDV) studies and implement recommendations from the studies; EDV study results indicate persisting problems with encounter data quality.

During Fiscal Year 2019-20, AHCA contracted with Health Services Advisory Group, Inc. for another EDV study to examine the extent to which encounters submitted to AHCA by its contracted Statewide Medicaid Managed Care plans are complete and accurate. The study focused on encounters submitted by AHCA's managed medical assistance and specialty plans. The study's analysis of record completeness indicated many discrepancies at the record level between AHCA encounter data and health plan encounter data. The medical record review comparing AHCA's encounter data to enrollees' medical records found that both data sources contained the same information for all data elements reviewed in slightly over half of records, which suggests that quality issues remain a problem for AHCA's encounter data.

The study made a number of recommendations to AHCA to improve encounter data quality including the development of a standardized process to track and identify the final adjudication record of an encounter, since there seems to be an issue identifying the final adjudication of resubmitted denied encounters. AHCA reported developing a standardized process to track and identify final adjudications of encounters and implemented the process on July 1, 2020.

To address issues with encounter data quality, the study also recommended that AHCA develop methods to

- assign internal control numbers that identify the type of encounter transaction;
- enhance submission requirements to ensure adjusted encounters are submitted appropriately;
- review standard quality controls for data extraction to verify accurate data extracts from agency systems;
- assist plans with addressing encounter data issues in plans' data systems;
- provide periodic provider education and training regarding encounter submissions, medical record documentation, and coding practices; and
- consider requiring health plans to conduct standardized validation of encounter data using medical record review.

While AHCA staff did not report specific strategies to address each of these recommendations, staff reported that the agency intends to improve encounter data accuracy through the procurement of a new claims and encounter processing module as part of the FX project, and that the agency engages in regular outreach to the health plans to assist with encounter data submissions.

Prior OPPAGA Recommendation: AHCA should continue to expand the use of managed care encounter data reported to the Florida Medicaid Managed Information System for program oversight, including using data to set capitation rates, analyze utilization trends, and determine service quality.

While AHCA's actuary expanded its use of FMMIS encounter data, the agency is still limited in its use of FMMIS-reported managed care plan encounter data for program oversight. While AHCA uses encounter data for contract compliance, this data is not currently used systematically and consistently to examine broader trends in service provision for program integrity oversight.

AHCA's use of FMMIS-reported encounter data for capitated rate setting continues to be limited, and the agency has extended the date to fully transition to using FMMIS encounter data to rate year 2022-23 (October 2022 through September 2023). AHCA's actuary currently uses all data from encounters paid by plans on a fee-for-service basis for calculating capitation rates but reported engaging in a validation process with plans for this data that resulted in the actuary receiving additional FMMIS encounter data, which suggests that quality issues with the encounter data remain a problem. AHCA staff reported that the agency anticipates the actuary will continue to validate encounter data that will be used as the base data for capitation rate setting. The actuary also reported excluding subcapitated FMMIS encounters from the rate setting process. AHCA staff reported that the actuary excludes this data because financial data paid to the plans' subcapitated vendor is used instead.

While AHCA has implemented a quality initiatives dashboard that uses encounter data for metrics that track potentially preventable events and birth outcomes, the metrics are calculated annually and therefore cannot be utilized for more frequent monitoring of program trends.

The Division of Medicaid does not currently have a plan or a process in place to use encounter data broadly to monitor trends in individual Medicaid services. External contracted evaluations are not consistently conducted by the same entities, are typically conducted annually, and do not provide an ongoing trend assessments for a broad range of Medicaid services. Therefore, these evaluations cannot be used to regularly (i.e., monthly or quarterly) assess service utilization for consistency with expectations and contractual obligations. For instance, monitoring trends in service use and cost for recipients with chronic diseases, recipients with mental health diagnoses, or dually eligible recipients could provide useful information about the status of the Medicaid program. While the Division of Medicaid uses encounter data to produce a few broad metrics and to answer questions on an ad-hoc basis, AHCA does not utilize encounter data to the fullest extent possible for monitoring managed care plans for fraud, waste, and abuse.

RECOMMENDATIONS

The Agency for Health Care Administration implemented a number of flexibilities to ensure access to health care services in the Medicaid program during the COVID-19 public health emergency. Changes in rules and regulatory processes increase risks of fraud, waste, and abuse during public health emergencies, but AHCA reports that it has not developed additional oversight procedures for the services affected by the flexibilities it has implemented. In addition, while AHCA has made several improvements to its oversight and monitoring of Medicaid systems as previously recommended by OPPAGA, there are several areas where improvements are still needed. (See Exhibit 3.)

Exhibit 3
Recommendations for AHCA's Oversight and Monitoring of Medicaid Fee-for-Service and Managed Care Systems

Concern	Recommendation
Lack of Additional Oversight of Potential Fraud, Waste, and Abuse in Medicaid Funded Services Affected by Temporary Flexibilities Related to the COVID-19 Pandemic	• 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. For example, the agency could monitor program data prior to the pandemic and compare to program data during the pandemic and communicate with stakeholders like managed care organizations, providers, and beneficiary groups to monitor service provision.[1] • 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.[1]
Lack of Intra-Agency Coordination of Managed Care Plan Compliance Oversight	• 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.[2]
Lack of Summarized Managed Care Plan Antifraud Activity Data, Data System Documentation, and Information on Data Analytic Activities by MPI	• 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.[3] • 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.[2] • 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.[3]
Limitations to Use of Encounter and Fee-for-Service Claims Data and Lack of a Comprehensive Plan to Monitor Trends Effectively in Medicaid	• Continue to conduct encounter data validation studies and implement recommendations from such studies.[3] • 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.[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.[1] • 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.[1]

[1] New OPPAGA recommendation.
[2] Modified recommendation from OPPAGA's 2020 report.
[3] Recommendation from OPPAGA's 2020 report.
Source: OPPAGA analysis.

AGENCY RESPONSE

In accordance with the provisions of s. 11.51(2), *Florida Statutes*, OPPAGA submitted a draft of this report to the Secretary of the Agency for Health Care Administration for review and response. The Secretary's written response is in Appendix D.

APPENDIX A

Managed Care Plans' Anti-Fraud Activities in Fiscal Year 2019-20

Managed care plans are contractually required to establish and maintain a unit to investigate possible acts of fraud, waste, abuse, or overpayments. Each health plan must submit an anti-fraud plan to the Office of Medicaid Program Integrity (MPI), which includes a summary of the results of investigations of fraud, waste, abuse, or overpayments conducted during the previous fiscal year by the managed care plan's fraud investigative unit. MPI uses this information, which plans submit via Annual Fraud and Abuse Reports (AFAAR), to monitor plans' activities. Managed care plans' reported activity varied widely in AFAARs for Fiscal Year 2019-20. [See Exhibit A-1 for a summary of health plan activities (excluding dental plans).[42]

Exhibit A-1
Florida's Managed Care Plans Vary Widely in Level of Antifraud Activity for Fiscal Year 2019-20

Managed Care Plan	Average Monthly Enrollments[1]	Number of Cases Opened	Number of Cases Investigated[2]	Number of Cases With Overpayments Recovered	Amount of Overpayments Identified for Recovery	Amount of Overpayments Recovered	Total Lost to Fraud, Waste, and Abuse[3]	Total Lost to Fraud, Waste, and Abuse Recovered
Aetna Better Health	99,335	50	97	2	$3,960	$2,488	$0	$0
Children's Medical Services	60,681	74	83	9	1,401,509	430,933	883,512	248,125
Community Care Plan	39,227	23	22	4	952,567	466,143	214,868	15,859
Florida Community Care	16,063	46	46	0	1,770	0	1,770	0
Humana Medical Plan	474,001	2,976	1,079	42	447,978	361,251	44,194	11,608
Lighthouse Health Plan	31,052	2	3	1	2,375,663	891,360	223	73
Magellan Complete Care	20,912	592	782	198	633,300	453,727	36,114	36,095
Miami Children's Health Plan	18,058	2	2	0	526,841	104,546	372	0
Molina Health Care of Florida	96,648	58	58	0	17,584,996	0	623,529	0
Prestige Health Choice	79,691	87	66	28	87,371	74,785	87,371	14,651
Simply Health Care Plan	466,113	458	618	14	1,485,481	79,708	1,485,481	79,708
Staywell Health Plan	864,838	1,130	1,450	77	101,415,766	49,431,294	3,362,129	1,233,392
Sunshine State Health Plan	578,351	323	526	49	55,627,087	38,590,583	8,586,441	335,976
United Health Care Plan	252,696	66	66	24	98,885,636	55,726,120	1,746,779	35,210
Vivida Health	10,502	1	2	1	275,577	91,006	1,020	397
Totals	**3,108,057**[4]	**5,888**	**4,900**	**449**	**$281,705,501**	**$146,703,944**	**$17,073,804**	**$2,011,095**

[1] Averages for each managed care plan were calculated using a 12-month average from July 2019 through June 2020 for all Managed Medical Assistance and Long Term Care enrollees.
[2] Includes cases for which investigations were, at a minimum, started during the reporting period.
[3] Plans are directed to report the total amount lost to fraud, waste, and abuse as the portion of the total amount of overpayments identified for recovery that were identified as being lost only to fraud, waste, and abuse.
[4] The total average monthly enrollment is a 12-month average from July 2019 through June 2020 calculated for all Managed Care and Long Term Care enrollees.
Source: OPPAGA analysis of Medicaid Managed Care Annual Fraud and Abuse Reports for Fiscal Year 2019-20.

[42] Medicaid has three statewide dental plans. Statewide dental plans are available to every beneficiary enrolled in a managed care plan and provide specific carved out services, so OPPAGA removed them from this analysis.

APPENDIX B

Top Medicaid Provider Types for Medicaid Fraud Control Unit Fraud Cases

The Office of the Attorney General's Medicaid Fraud Control Unit (MFCU) is responsible for investigating fraud committed upon the Medicaid program by providers. MFCU investigates diverse providers, including doctors, dentists, psychologists, home health care companies, pharmacies, drug manufacturers, and laboratories. Case investigations focus on types of fraud, targets, and providers having a widespread impact on the Medicaid program or involving public safety. The top provider types for opened fraud cases vary from year to year. (See Exhibit B-1.)

Exhibit B-1
The Top Provider Types for MFCU Fraud Cases Vary From Year to Year; Physicians and Pharmaceutical Manufacturers Were in the Top Five in Fiscal Years 2018-19 and 2019-20[1]

	Fiscal Year 2018-19[2]	Fiscal Year 2019-20
1	Physician	Home- and Community-Based Services
2	Pharmaceutical Manufacturer	Pharmacy
3	Behavioral Analysis	Pharmaceutical Manufacturer
4	Community Alcohol/Drug/Mental Health	Physician
5	Home Health Agency	Independent Lab
6	–	Home Health Services

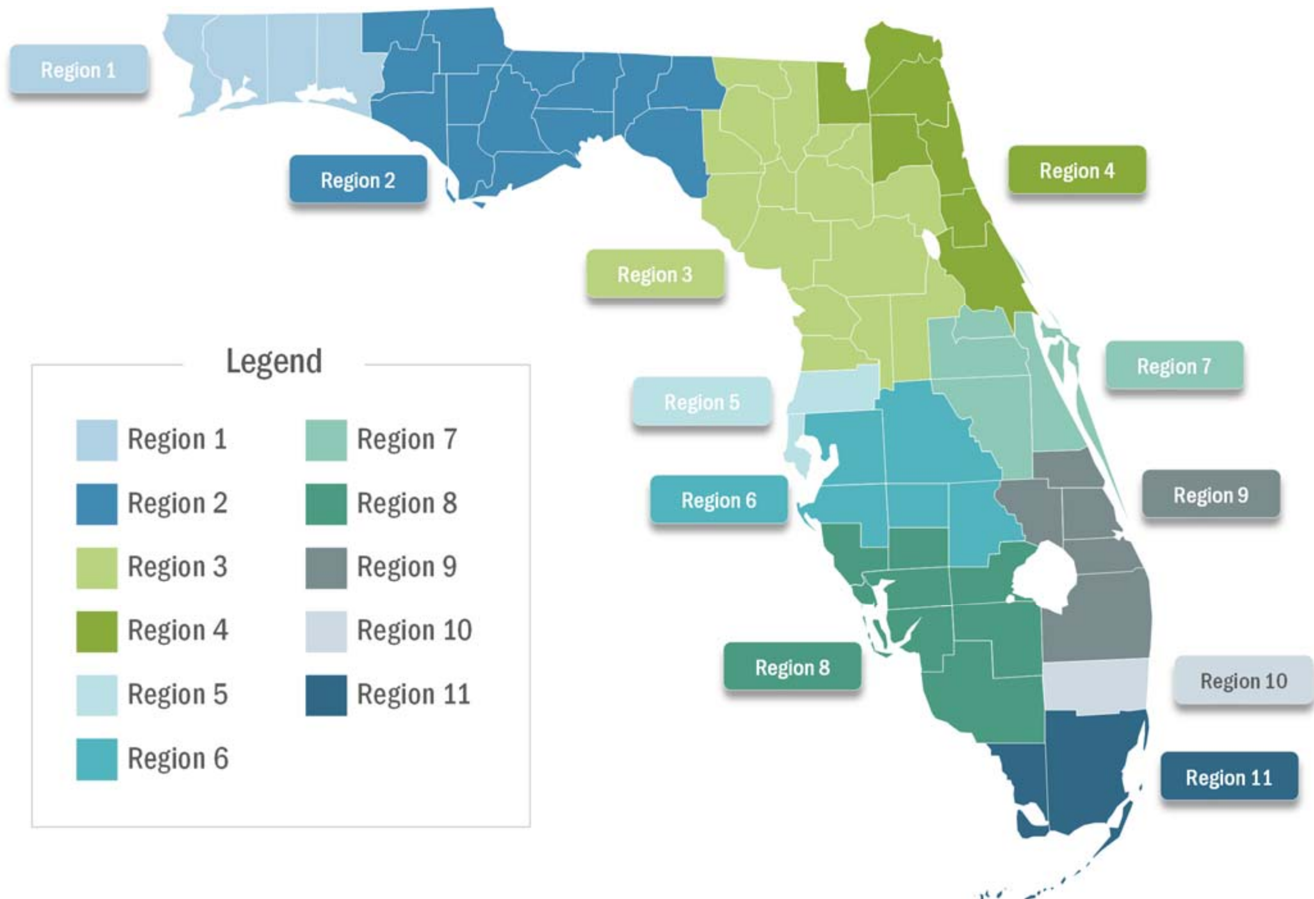
[1] Cases were opened in the Fiscal Year indicated.
[2] The Medicaid Fraud Control Unit prepared a list of the top five provider types for Fiscal Year 2018-19.
Source: Florida's Efforts to Control Medicaid Fraud and Abuse, Fiscal Year 2018-2019 and Fiscal Year 2019-2020.

APPENDIX C

Florida Medicaid Managed Care Plan Regions

The Agency for Health Care Administration contracts with private managed care health plans for the coordination of services for Medicaid recipients. These health plans operate on a regional basis throughout the state. Behavior analysis service providers are designated as high risk and were involved in previous cases of fraud, waste, and abuse. The agency has taken steps to address concerns related to the provision of behavior analysis services including piloting the utilization of an electronic visit verification system for behavior analysis service providers in Southeast Florida. The system tracks arrival and departures of health care providers who provide care at a recipient home or other non-office site. For dates of services on or after February 1, 2021, the agency required behavior analysis providers to bill through the electronic visit verification system in select regions—9, 10, and 11. These regions include Broward, Indian River, Martin, Miami-Dade, Monroe, Okeechobee, Palm Beach, and St. Lucie counties. AHCA is suspending EVV for behavior analysis services beginning February 5, 2022, and will transition to the American Medical Association Behavior Analysis Current Procedural Terminology code structure on July 1, 2022. (See Exhibit C-1.)

Exhibit C-1
Electronic Visit Verification Was Required for Behavior Analysis Providers in Regions 9, 10, and 11



Source: Agency for Health Care Administration.

APPENDIX D

Agency Response

RON DESANTIS
GOVERNOR

SIMONE MARSTILLER
SECRETARY

January 31, 2022

Ms. PK Jameson, Coordinator
Office of Program Policy Analysis and Government Accountability
111 West Madison Street, Room 312
Claude Pepper Building
Tallahassee, Florida 32399-1475

Dear Ms. Jameson:

The Agency for Health Care Administration (Agency) appreciates the opportunity to comment on OPPAGA's draft report titled: ***Biennial Review of AHCA's Oversight of Fraud, Waste, and Abuse in Florida's Medicaid Program.*** While OPPAGA has taken the Agency's comments into consideration and has made several of the edits requested, additional Agency concerns remain.

In addition to our preliminary review and comments, Agency responses to the recommendations identified in the report are as follows:

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.**

   Agency Response

   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.**

   Agency Response

   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

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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.

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.

Agency Response

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.

Agency Response

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.

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.

Agency Response

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**

   Agency Response

   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.**

   Agency Response

   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.**

   Agency Response

   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.

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.**

Agency Response

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.**

Agency Response

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.

Thank you again for the opportunity to comment on the MPI biennial report. The Agency will continue to make prevention and detection of fraud, waste and abuse in the Medicaid program a priority.

Sincerely,

Simone Marstiller
Secretary

SM/cs
cc: Tom Wallace, Deputy Secretary for Medicaid
Kim Smoak, Deputy Secretary for Health Quality Assurance.

OPPAGA Comments to Agency Response

OPPAGA Comment 1

Regarding agency comments:

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.**

   Agency Response

   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.

While AHCA reports that existing oversight efforts already consider the increased vulnerability due to the temporary changes related to the COVID-19 pandemic, OPPAGA identified several COVID-19 related flexibilities that, according to several federal reports, could introduce additional vulnerabilities to fraud, waste, and abuse. These flexibilities include expanding home- and community-based services and expanding allowable services to be provided by telehealth. As reported by OPPAGA, increased monitoring of the impacts of these flexibilities during and after a public health emergency can provide opportunities for states to improve processes and protect against fraud, waste, and abuse.

OPPAGA Comment 2

Regarding agency comments:

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.**

   Agency Response

   While one contract monitoring plan was initially uploaded to the OPAGGA 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.

As referenced by AHCA, OPPAGA received one document from the Medicaid Fiscal Agent Operations (MFAO) Bureau that OPPAGA considers to be a contract monitoring plan for that unit; the MFAO plan provides specific information on how the unit will conduct contract monitoring activities. The additional seven documents that AHCA provided outline the units responsible for each element of the Statewide Medicaid Managed Care contract. However, unlike the MFAO plan, these documents do not

specify the activities and methods that each unit will use to monitor assigned contract elements. In the absence of contract monitoring plans that are consistent with the content and structure of the MFAO plan, OPPAGA continues to recommend that AHCA ensure that each unit with program integrity responsibilities develops a unit-specific contract monitoring plan that describes unit oversight and monitoring methods.

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PK Jameson, Coordinator