FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

STRATEGIC PLAN FOR DATA CONNECTIVITY:

HEALTH CARE FRAUD DATABASES
# TABLE OF CONTENTS

**Agency for Health Care Administration** ................................................................. 1
  - Our Mission ............................................................................................................. 1
  - Our Vision ............................................................................................................. 1
  - Our Values ........................................................................................................... 1

**Background and Overview** ...................................................................................... 2

**Project Oversight and Coordination** .................................................................... 3
  - Agency Fraud Steering Committee ................................................................. 3
  - Prevention Subcommittee ................................................................................. 4
  - Detection Subcommittee ................................................................................... 4
  - Recoupment Subcommittee ............................................................................... 4
  - Managed Care Fraud and Abuse Subcommittee ............................................. 4
  - Interagency Coordination ................................................................................ 5
  - Medicaid and Public Assistance Fraud Strike Force ........................................ 5
  - Interagency Fraud and Abuse Meetings ........................................................... 5
  - Technology and Communications Workgroup ............................................... 5
  - Interagency Background Screening Workgroup .............................................. 6

**Agency Initiatives** ................................................................................................. 7
  - Phase 1: Create Data Standardization Methods ............................................... 8
  - Background Screening Initiative ...................................................................... 8
  - Automate DOH / AHCA Licensure Comparisons ........................................... 9
  - Provider Addresses ............................................................................................ 9
  - Expand Use of the National Provider Identifier ............................................. 10
  - Phase 2: Utilize a Common Technical Architecture ........................................ 10
  - Case Management / Advanced Detection System ......................................... 10
  - Background Screening ...................................................................................... 11
  - Online Licensing ............................................................................................... 12
  - Phase 3: Integrate Systems that House Health Care Fraud Information ............ 12
    - Automate Provider Network Verification ....................................................... 13
    - Automated Detection Analytics .................................................................. 13
    - Proposed Systems For Data Connectivity .................................................. 15

**Medicaid Information Technology Architecture** .................................................. 16
**Database Summary** ............................................................................................... 19
AGENCY FOR HEALTH CARE ADMINISTRATION

OUR MISSION

Better health care for all Floridians

OUR VISION

A health care system that empowers consumers, that rewards personal responsibility and where patients, providers and payers work for better outcomes at the best price.

OUR VALUES

- Accountability: We are responsible, efficient and transparent.
- Fairness: We treat people in a respectful, consistent and objective manner.
- Responsiveness: We address people’s needs in a timely, effective and courteous manner.
- Teamwork: We collaborate and share our ideas.
The Agency for Health Care Administration (Agency) is committed to its mission of better health care for all Floridians. As the State Medicaid Agency, part of achieving that goal is to protect the use of public funds from fraud and abuse in the Medicaid system. In order to ensure that taxpayers’ dollars are being used efficiently, the Agency is continually looking for ways to prevent and detect fraud and abuse in the Medicaid program, as well as recover improper payments to Medicaid providers.  

Section 409.913(38)(b), Florida Statutes, requires the Agency to develop a Strategic Plan (Plan) to connect all databases that contain health care fraud information between the Agency, the Department of Health, the Department of Law Enforcement, and the Office of the Attorney General. The purpose of this Plan, originally published December 2010, is to serve as a roadmap for facilitating the electronic exchange of health information used to identify and prevent fraud and abuse in the Florida Medicaid program.

This revised Plan updates the status of projects in progress and outlines the projects the Agency will undertake in the future to continue to connect federal and state databases that contain data relevant to the Agency’s continued fight against health care fraud.

The objectives, priorities, and goals contained within this plan are designed to improve administrative efficiency, facilitate coordination and communication between multiple agencies and programs, and enhance efforts to prevent and detect fraud and abuse in the Medicaid program. The Plan will assist in achieving the Agency’s goal to reduce and/or eliminate fraud, waste, and abuse in the Medicaid program.

---


The following sections detail the Agency’s plan to achieve these objectives, priorities, and goals through oversight and coordination, long-term strategies for achieving full data connectivity, short-term solutions for identified issues, objectives for implementation, and the Agency’s intent to work in concert with Medicaid Information Technology Architecture.

PROJECT OVERSIGHT AND COORDINATION

Following the passage of SB 1986 during the 2009 legislative session, the Agency established project oversight and coordination activities. The following outlines the Agency’s Fraud Steering Committee as well as interagency coordination efforts.

AGENCY FRAUD STEERING COMMITTEE

In fall 2009, the Agency developed a project management team to coordinate efforts in fighting fraud and abuse in the Medicaid program. This group established a formal governance process. Oversight of the process is provided by the Fraud Steering Committee, which consists of the following executive management personnel:

The purpose of this Steering Committee is to ensure that all Agency resources are utilized in the fight against fraud, abuse, and improper payments by improving communication and coordination efforts, ensuring that all efforts are in line with Agency goals, and working with senior management to prioritize and implement policies quickly and consistently. To facilitate these activities, the Steering Committee oversees several teams that address specific fraud and abuse activities. These teams consist of leaders and participants throughout the Agency, along with representatives from the Medicaid Fraud Control Unit within the Office of the Attorney General.
PREVENTION SUBCOMMITTEE

This subcommittee is responsible for identifying existing fraud and abuse prevention methods and making recommendations for improvements to these activities and creating new methodologies where none currently exist. Prevention efforts enhance the efficiency of the Medicaid Program by reducing the amount of resources necessary for detecting, auditing and recovering overpayments. Stopping overpayments before they happen avoids recovery costs and allows those funds to be used as intended. Examples of prevention activities include provider enrollment, provider education, policies and handbook development, claim edits and reviews, oversight and control and background screening.

DETECTION SUBCOMMITTEE

This subcommittee works with the detection or investigation of fraud and abuse during the claims payment process or after payment has occurred. This includes claim system payment methodologies, algorithms that identify outlier claims, analyzing data for aberrant billing practices such as up-coding and unbundling, provider audits and enhancing fraud and abuse requirements within Agency contracts. Fraud can be detected through site visits and audits, data mining and detection and investigations and case management.

RECOUPMENT SUBCOMMITTEE

This subcommittee addresses efforts regarding the recoupment and recovery of Medicaid funds paid out for inappropriate or fraudulent claims. The goal is to improve the collection of Medicaid overpayments or other money due to the Agency by increasing overpayment collections and reducing the length of time to recover funds. Examples of recoupment activities include voiding claims, collecting fines and overpayments, litigation support and identification of accounts receivable.

MANAGED CARE FRAUD AND ABUSE SUBCOMMITTEE

The Managed Care Fraud and Abuse Subcommittee was established in April 2011. The subcommittee’s charge is to provide Agency coordination and oversight for Medicaid managed care fraud and abuse issues through:

- Increasing the effectiveness of program integrity functions including, but not limited to, prevention, detection and recoupment processes;
- Promoting the sharing of information across bureaus, divisions, and agencies as needed in order to reduce workload and eliminate duplicative processes; and,
- Serving as the Agency’s central coordinating point for managed care fraud and abuse issues requiring elevation to the Fraud Steering Committee for informational and decision purposes.

The Managed Care Fraud and Abuse Subcommittee set several goals to be pursued through fiscal year 2011-2012. These goals include the following:

- Analyzing Agency information systems relevant in preventing and detecting corporate-level fraud and abuse;
- Developing new, and streamlining existing, processes to prevent and detect corporate-level fraud and abuse;
- Ensuring managed care organizations maintain robust anti-fraud programs; and,
- Staying abreast of industry standards applicable to Florida’s efforts in auditing and monitoring fraudulent activity in managed care organizations.
INTERAGENCY COORDINATION

All subcommittees of the Agency’s Fraud Steering Committee have participants representing other agencies. The following describes some high-level workgroups that are dedicated to interagency coordination.

MEDICAID AND PUBLIC ASSISTANCE FRAUD STRIKE FORCE

The Medicaid and Public Assistance Fraud Strike Force (Strike Force) was created during the 2010 Legislative Session to increase the effectiveness of programs and initiatives that work to prevent, detect and prosecute Medicaid and public assistance fraud. Members of the Strike Force include the following:

The Chief Financial Officer, Chair
The Attorney General, Vice Chair
The executive director of the Department of Law Enforcement
The Secretary of Health Care Administration
The Secretary of Children and Family Services
The State Surgeon General

The quarterly meetings have resulted in the creation of four committees focused on technology, legislation, planning, and funding. The Strike Force and committees work to improve coordination and communication, including the expansion of data sharing capabilities and creation of data standards.

INTERAGENCY FRAUD AND ABUSE MEETINGS

The purpose of the Interagency Fraud and Abuse Meetings is to share ideas and communicate high-level information to decision makers working within each agency. The meetings are held bimonthly at Agency headquarters and participants include the following:

Agency for Health Care Administration  Department of Health
Agency for Persons with Disabilities  Department of Financial Services
Department of Children and Families  Department of Law Enforcement
Department of Elder Affairs  Medicaid Fraud Control Unit

TECHNOLOGY AND COMMUNICATIONS WORKGROUP

During summer 2011, the members of the Interagency Fraud and Abuse Meetings established the Technology and Communications Workgroup (Workgroup). The Workgroup was established to create a technology focused workgroup to implement some of the high-level strategies developed by the Interagency Fraud and Abuse Meetings. The goals of the Workgroup are as follows:

- To implement the strategies and objectives outlined in the Strategic Plan for Data Connectivity: Health Care Fraud Databases (Plan);
- Work to develop new ideas to streamline the sharing of health care fraud information;
- Develop or enhance referral tracking policies and procedures; and,
- Develop specifications for standard data formats and the technical interface between state and federal health care fraud databases (where possible).

These goals will be accomplished by reaching out to both internal and external stakeholders, identifying existing health care fraud databases, and coordinating interagency communication. Because technology advances are
continual, this Workgroup will stay abreast of new trends and make recommendations for changes to the Plan. The Workgroup also monitors the activities of other agencies and their efforts to fight fraud and abuse. A liaison from each stakeholder agency or entity is a member of the Technology and Communications Workgroup.

INTERAGENCY BACKGROUND SCREENING WORKGROUP

During the 2011 Legislative Session, the Florida House of Representatives and the Florida Senate passed Senate Bill 1992, relating to Background Screening. Governor Rick Scott subsequently vetoed the legislation and noted his concerns with the legislation. In the veto message, the Governor agreed with the importance of creating a workgroup to look at the background screening process. Accordingly, under the direction of the Executive Office of the Governor, in coordination with the Governor’s Office of Policy and Budget for Health and Human Services, a statewide Interagency Background Screening Workgroup (BGS Workgroup) was created. This workgroup was tasked with developing a strategy for the criminal background screening of professionals, lay persons and volunteers that serve vulnerable populations within the State and recommending potential legislative changes to implement this strategy.\(^3\)

In a report published October 14, 2011, the BGS Workgroup identified 11 issues with recommendations for improvement. The first issue identified is the need to share criminal history information. Currently, a person who works or volunteers at more than one agency may be screened multiple times at a cost to the applicant or provider. The Florida Department of Law Enforcement is working with the Federal Bureau of Investigations to find a possible solution that will allow agencies to share criminal history information while maintaining compliance with federal guidelines.\(^4\)

While there are several requirements the State will need to incorporate into such a solution, the BGS Workgroup identified the following regarding data connectivity:

> A shared database will exist consisting of criminal history record information that agencies use to screen applicants. This shared database shall include the photograph of the applicant, the waiver (or acknowledgement), the state and national criminal history information and any subsequent arrest information on the applicant. The database shall keep a record of all dissemination of criminal history information to other agencies. The database shall allow providers, day care employers and other similar employers to access whether the applicant is qualified to work or volunteer under the screening(s) that the agencies have conducted using the criminal history record information that is available in the centralized database. The database shall be housed at the Agency for Health Care Administration. The Agency for Health Care Administration shall work with the FDLE to ensure that all state and federal standards are met and with the other agencies to ensure that the needs of these agencies are met.\(^5\)

---


\(^4\) Ibid.

\(^5\) Ibid.
Planning for data connectivity began by examining data and processes within the Agency, the Department of Health, the Department of Law Enforcement, and the Medicaid Fraud Control Unit within the Attorney General’s Office. As communication efforts increased through interagency workgroups, additional opportunities for connectivity were identified. The Agency has worked to implement interim solutions to address identified issues. However, these are often manual and resource intensive processes.

In order to effectively prevent and detect fraud and abuse in the Medicaid program, the agencies regulating Medicaid providers must have the ability to identify inappropriate providers in a timely manner. Ensuring the availability of consistent provider information to all affected entities will save countless hours in manually hunting for information located across multiple databases.

The Agency plans to integrate provider-centric data by developing a Program Integrity Network (PIN). This PIN will facilitate the secure exchange of information used to prevent and detect health care fraud and abuse within the Agency, other Florida agencies, other states, and federal entities. As of December 2011, the list of directly affected programs includes, but is not limited to, the following:

- Agency for Health Care Administration
- Florida Office of the Attorney General, Medicaid Fraud Control Unit
- Federal Health & Human Services, Office of the Inspector General
- Department of Law Enforcement
- Department of Health
- Department of Financial Services
- Department of Elder Affairs
- Agency for Persons with Disabilities
- Department of Children and Families
- Department of Corrections
- Department of State
- Clerks of Court
- Centers for Medicare & Medicaid Services
- General Services Administration

Implementation of the proposed PIN will occur in three phases and includes federal, state, and local programs and their respective data systems. The pilot project proposes that states:

1. Create data standardization methods;
2. Utilize a common technical architecture; and,
3. Integrate systems that house health care fraud information (case management systems, background screening systems, online licensing systems).

The following details the purpose of each phase, along with current and planned Agency initiatives.
PHASE 1: CREATE DATA STANDARDIZATION METHODS

The goal of Phase 1 is to standardize data structures or formats that will enable and support interoperability among health care fraud databases as they interact with state and federal networks. As the Agency has continued to identify additional data sources containing possible health care fraud information, the need for common data elements has become clear.

At this time, agencies within the State of Florida are collecting many of the data elements necessary to identify fraudulent providers. However, the antiquated data collection and data storage methods are not capable of bridging the gaps between the databases. The Agency is working to identify all data sources containing health care fraud information. This list is changing continuously as new systems are identified or existing systems are consolidated. Over the past decade, as operational processes have changed and new technologies emerged, the Agency implemented disparate information technology solutions. This resulted in the creation of separate data silos that contain vast amounts of data. These data silos, created within various parts of the Agency, make it difficult to locate information and deliver it to those who need it to safeguard the Medicaid program. Before the Agency, and its stakeholders, can develop and use a Program Integrity Network, standard data formats must be developed and implemented. These standard data formats must be applied to new data collected, as well as existing data in the various databases. Before a common technical architecture can be developed, these standards must be in place. The Agency has made changes where possible and is continuously working towards connecting databases.

During the first phase of this project, an as-is assessment of directly affected programs should be completed. Phases 1 and 2 could be completed in approximately 18 months. However, each of these projects has its own implementation schedule. The projects and phases will be implemented concurrently as resources allow. The Agency has started collaborating with affected programs to determine common data elements and make changes when possible. One major barrier to full integration is resource availability, both financial and physical.

BACKGROUND SCREENING INITIATIVE

In 2010 the Florida Legislature significantly amended background screening requirements. The background screening requirements for health care providers regulated by the Agency’s Division of Health Quality Assurance or enrolled in the Medicaid program were expanded to include the following:

- Level 2 fingerprint screenings for state and national offenses;
- A 5 year rescreening requirement; and,
- Increased position types that require screening.

The new requirements created an increased volume in annual screenings from 60,000 to over 200,000. All screening results from requests processed through the Agency are reviewed by Agency staff to determine if the person being screened is eligible to work or be enrolled in Medicaid pursuant to the requirements of Chapter 435 and additional disqualifying offenses in section 408.809, F.S. Upon making a determination of eligibility of a screening result, Agency staff post the results in a database that licensed health care providers may access through a secure web site with an assigned user ID and password.
In examining the processes used to determine eligibility, the Agency recognized a need to standardize data collected. This need became more apparent as the workload increased. To accommodate the increased volume without additional resources, major changes were needed to the data systems and processes in order to create efficiencies and maintain an average turnaround time of screening results of 5-7 business days.

In October 2010, The Agency was awarded a $3 Million Federal Grant to expand background screening of long term care staff through the Centers for Medicare and Medicaid Services National Background Screening Program. The goals of this 2 year project are to enhance systems, reduce duplicative screenings, foster coordination between state agencies and implement a retained fingerprint program.

AUTOMATE DOH / AHCA LICENSURE COMPARISONS

In Florida, the Department of Health (DOH) licenses practitioners and the Agency for Health Care Administration (Agency) licenses health care facilities. As the Agency improves prevention efforts, it is important to coordinate with other regulating entities, such as the DOH. One key prevention activity is to ensure that only actively-licensed providers are allowed to provide services to Medicaid recipients. Currently, the Agency uses the DOH Practitioner Database and the Agency’s licensure database to look up all licensed Medicaid provider applicants. This is done to ensure that each applicant has a clear and active license prior to enrolling them in the Medicaid program. In addition, the DOH provides the Agency with a weekly file that contains licensure information for the five profiled professions: Medical Doctors, Osteopathic, Chiropractic and Podiatric Physicians and Advanced Registered Nurse Practitioners. This file allows the Agency to compare all active Medicaid providers to the licensure file to ensure that each provider maintains a clear and active license for the duration of their Medicaid contract.

Until fall 2011, this was a manual comparison. Different file formats for provider license fields prevented an automated comparison between the FMMIS provider file and the licensure databases. The license field within FMMIS was updated, allowing for a more automated comparison. The Agency is currently working to standardize fields within facility licensure database. However, the Agency is striving for a real-time comparison of these databases containing information on Medicaid providers, facilities regulated by the Agency, and practitioners licensed by the Florida Department of Health.

PROVIDER ADDRESSES

Addresses for providers are not consistent in databases within the Agency and throughout the state. It is proposed that the Agency adopt standards established by the United States Postal Service for all data fields containing addresses. Access and consistent availability of provider addresses is a key component in the regulation and oversight of Medicaid providers. Having accurate contact information significantly improves the Agency’s ability to identify owner/controlling interest relationships, enhance social/link analysis capabilities, and centralize provider identifiers for investigative purposes. The Agency will be working towards this standardization under the guidance of the Fraud Steering Committee’s Managed Care Fraud and Abuse Subcommittee.

EXPAND USE OF THE NATIONAL PROVIDER IDENTIFIER

The National Provider Identifier (NPI) is a standard mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This ten-digit unique identification number must be used in all administrative and financial transactions. Health plans, health care clearinghouses and those health care providers who transmit any health information in electronic form, known as covered health care providers, must use the identifier. As of January 1, 2011, Medicaid requires covered health care providers to include their NPI on all claims submitted to Medicaid, including fee-for-service claims. The use of the NPI simplifies the administration of the health care system and enables the efficient electronic transmission of certain health information. This unique identifier may prove to be a more reliable identification standard than either the license number or Tax ID/SSN, since license numbers are useful only within the state, and Tax IDs/SSNs are not universally collected and are difficult to share with external partners.

PHASE 2: UTILIZE A COMMON TECHNICAL ARCHITECTURE

The goal of Phase 2 is to use standardized data to develop a common infrastructure called the Program Integrity Network (PIN). Once developed, the PIN will include a master provider directory designed to enable quality and coordinated care for Medicaid recipients by ensuring that only qualified providers are permitted to participate in the Medicaid program. The information housed within the master provider directory will store unique provider identifiers and demographic information allowing for consistent identification and cross-referencing of health care providers. The core function of this directory is the ability to find and retrieve provider information within and between Agency divisions.

While planning for this common technical architecture, the Agency realized the potential for integration between three other Agency systems. Because of this unique opportunity to simultaneously plan for integration, the Agency has increased collaboration efforts across bureaus.

CASE MANAGEMENT / ADVANCED DETECTION SYSTEM

Authorized by Section 409.913, Florida Statutes, the primary goal of the Bureau of Medicaid Program Integrity (MPI) is to combat fraud and abuse in the Florida Medicaid program by addressing detection and prevention activities, as well as methods to recover improper payments to Medicaid providers. The Bureau of MPI audits and investigates providers suspected of overbilling or defrauding Florida's Medicaid program, recovers overpayments, issues administrative sanctions, and refers cases of suspected fraud for criminal investigation. To enhance the Bureau’s ability to track and report, the Agency utilizes a custom case tracking system called the Fraud and Abuse Case Tracking System (FACTS). FACTS has been operational since 2003 and was written with software that is no longer fully supported by the Agency. The Agency must maintain separate application and database servers for the development and production processes. FACTS is approaching ten (10) years of age.

---

and is both expensive and difficult to update for enhancements due to outdated technology. FACTS is a "stand-alone" system and does not benefit from many of the enhancements that are incorporated in the software solutions that are more widely used and accepted in the industry today.

The Agency is in the process of procuring a replacement to this system, with the added functionality of an enhanced detection component to include neural networking or other advanced detection techniques.

The new system will:

- Incorporate improved trending capabilities for complaint and case management, Explanation of Medicaid Benefits analysis, and audit resolutions;
- Provide advanced detection that employs predictive analytics to further enhance MPI’s ability to target investigations and audits to increase the Agency’s Return on Investment (ROI); and
- Provide detection and trending tools that will alert the Agency to procedure codes and providers that are exhibiting fraud or abuse indicators.

BACKGROUND SCREENING

The background screening system mentioned in Phase 1 has also completed work towards utilizing a common technical architecture. The federal funding supporting this work has also been applied to the centralization of screening functions and data connectivity. The Agency plans to centralize the background screening process to incorporate provider licensure and employment screening with Medicaid enrollment screening. The feasibility of centralizing background screening between state agencies was researched by the Interagency Background Screening Workgroup (BGS Workgroup).

The BGS Workgroup has proposed the creation of a “Care Provider Background Screening Clearinghouse” (See Senate Bill 310, 2012 Legislative Session). The purpose of this Clearinghouse is to provide a single data source to house the background screening results processed through specific state agencies as required.

To be entered into the Clearinghouse, the person must:

- Undergo Level 2 fingerprint screening;
- Have fingerprints retained by the Florida Department of Law Enforcement; and,
- Have a photograph taken at the time of printing.

Specific state agencies that would have access to the Clearinghouse include the following:

- Agency for Health Care Administration;
- Department of Children and Families;
- Department of Health;
- Department of Elder Affairs;
- Department of Juvenile Justice;
- Agency for Persons with Disabilities; and,
- Department of Education - Vocational Rehabilitation.

Because of work completed on this project, the BGS Workgroup decided that the shared database (the “Clearinghouse”) will be housed at the Agency for Health Care Administration. The Agency is working with the Florida Department of Law Enforcement to ensure compliance with all state and federal standards. In addition, the Agency continues to communicate with other agencies to ensure their needs are met. The Agency has the infrastructure of an external site that allows health care providers to:
- Initiate screenings;
- Select a LiveScan service provider;
- Track the screening request;
- Receive email notification of eligibility status changes;
- Access the screening result; and,
- Maintain an employee roster.

The Agency also has an internal data system that

- Downloads screening results from the Florida Department of Law Enforcement;
- Analyzes criminal history data eliminating the need for most data entry;
- Uses a workflow concept to review and make eligibility determinations, review applications for Exemption from Disqualification, generate correspondence, track screening processes based on system timers, and provide instant status reporting.

---

ONLINE LICENSING

The Agency is developing an online licensing system for 29 provider types. The system will include online payments and integration with the following:

- Florida Department of State;
- The Florida Medicaid Management Information System;
- Background screening system; and,
- Agency accounts receivable system

By providing online payment capabilities and integrating with other data sources, the Agency expects to enhance tracking efforts for fraud and abuse, reduce costs related to mail and collection, and stay abreast of corporate changes within the health care industry.

To accomplish this, the Agency will develop a Web portal allowing providers to submit application, check their status, and update license information between renewals. The Web portal will also have a “single sign-on” feature, where providers will only have one user account with access to multiple online systems and email notification capabilities.

---

PHASE 3: INTEGRATE SYSTEMS THAT HOUSE HEALTH CARE FRAUD INFORMATION

The goal of Phase 3 is to integrate state and federal databases that house health care fraud information. As previously outlined, the Agency currently shares data with other state agencies. However, the data that is shared between and among agencies relies heavily on manual processes. Phase 3 proposes fully automated integration between programs and participants regarding health care fraud. Real-time use of a Program Integrity Network will speed up the eligibility process, enhance detection capabilities, utilize and enhance existing background screening efforts, and improve the coordination and communication among state agencies. The proposed outcome of the PIN is to improve the quality of care given to the state’s most vulnerable citizens.
This can be accomplished, in part, by ensuring only qualified providers are enrolled in the Medicaid program and Medicaid managed care organizations.

AUTOMATE PROVIDER NETWORK VERIFICATION

Managed care organizations are required to submit network files to the Agency to obtain approval of their Health Care Provider Certificate and Medicaid Managed Care Contract Application. These files are submitted with geographic locations for each provider so the Agency is able to evaluate networks against drive-time requirements. Currently, analysts perform a manual comparison using the geographic location list, Department of Health licensure files, or other publicly available information.

At this time, the Agency conducts manual comparisons of the provider network files and the HHS/OIG excluded provider database, the Agency’s licensure database, and the Florida Medicaid Management Information System. An automated verification system could provide the Agency with the tools to ensure that managed care network reviews are complete, thorough, and timely. Multiple bureaus within the Agency will have the ability to perform regular and specific monitoring and oversight of the adequacy, accuracy, and quality of provider networks.

Features of the desired system are as follows:

- Compare subsequent provider network submissions to initials (for monitoring % change)
- Compare network file submissions to the plan’s directory on the web (to verify accuracy of information provided to consumers)
- Compare network files of all health plans to determine primary care providers in multiple health plans (for monitoring caseload access standards)
- Compare network files to encounter data (to confirm active participation and patient load)
- Compare network files to address (location) verification system (USPS)
- Compare network provider location against recipient location to confirm access standards
- Compare network providers to Florida Sunbiz corporate files

AUTOMATED DETECTION ANALYTICS

The Agency is in the process of procuring a new case management system which will have an enhanced detection component to include neural networking or other advanced detection techniques capable of identifying emerging patterns of fraud and abuse in the Medicaid program. However, this is only one small aspect of enhanced detection capabilities. In addition to predictive analytics, the Agency also plans to use the PIN and related databases to examine the relationships between providers and facilities. The process to be used is called Social Network Analysis, which provides a visual representation of these relationships and detects data patterns.

Currently, the Agency is analyzing potential relationships between Medicaid providers by comparing provider identifiers with those listed on external databases. Each provider type/group listed is compared to each database.
<table>
<thead>
<tr>
<th>Providers Analyzed</th>
<th>Database Comparison / Relationships</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid treating providers</td>
<td>Federal List of Excluded Individuals and Entities</td>
</tr>
<tr>
<td>Owners</td>
<td>Other states’ exclusions lists</td>
</tr>
<tr>
<td>Provider groups</td>
<td>Department of Health’s adverse actions and previous terminations</td>
</tr>
<tr>
<td>Prescribing physicians</td>
<td>Other criminal databases</td>
</tr>
<tr>
<td>Providers in managed care networks</td>
<td>Florida corporate records</td>
</tr>
<tr>
<td>Providers in licensure files</td>
<td>Medicaid prescribing database</td>
</tr>
<tr>
<td></td>
<td>FMMIS ownership records</td>
</tr>
<tr>
<td></td>
<td>National Provider and Plan Enumeration System</td>
</tr>
<tr>
<td></td>
<td>Tax records</td>
</tr>
<tr>
<td></td>
<td>Property records</td>
</tr>
<tr>
<td></td>
<td>Familial and social records</td>
</tr>
</tbody>
</table>

Potential relationships with excluded/criminal entities and providers are identified using different parts of the name, abbreviations, and/or social security numbers. These analytical methodologies are used to identify the following:

- Providers who submit false social security numbers to evade exclusion matching
- People using their immediate relatives to reopen new companies or continue existing companies often at the same business address;
- People using their partners to continue doing business or open related businesses;
- People using multiple electronic funds transfer accounts; and,
- Prescribing/referring services in states which either do not require them to be enrolled for these referrals or do not check valid referral National Provider Identifiers (NPI) on claims.

The Agency is currently conducting this analysis via a no-cost contract pilot project. In order to continue this work, funding will be needed. The project began March 2011. In ten months of analysis, 175 providers have been identified for further action. The Agency is no longer receiving vendor assistance. However, the work has continued on a smaller scale. The Agency will continue to work on this as resources allow.

The Agency has taken action against these providers, resulting in the following:

- 11 providers terminated from the program (Reason: Exclusion from other states)
- 77 prescribers sent to Medicaid Contract Management for termination from the prescription drug management system (Reason: Federal exclusion)
- 4 providers placed on prepayment review
- 15 referred to Managed Care Organization for further investigation
- $407,000 in potential improper payments

Many case management systems have a social network analysis component, as this has become a widely accepted method of detecting fraud. In order to integrate this component, the Agency would need to obtain funds via legislative appropriation or federal grant.
The proposed Program Integrity Network will be aimed at providing oversight for the integrity of the Medicaid program and the providers serving Medicaid recipients. The development of this Network will include a master provider directory designed to enable quality and coordinated care for Medicaid recipients by ensuring that only approved providers are allowed to participate in the Medicaid program. The figure below represents the databases that will feed information into the Program Integrity Network, along with the relevant outputs of information. Like this strategic plan, the figure represented here is being updated continually.
The Medicaid Information Technology Architecture (MITA) is an initiative of the Center for Medicaid and State Operations, a division of the Centers for Medicare and Medicaid Services. The MITA Framework is a blueprint for business integration and IT transformation to improve the administration of the Medicaid program. The Agency intends to use the MITA development process to meet the two statutory objectives for creating standard data formats and developing specifications for the technical interface between state and federal health care fraud databases. States are required to meet certain MITA milestones to obtain enhanced federal funding for operational costs associated with the Medicaid Management Information System. The State is conducting a self-assessment to review its current business processes and to chart the course for improving Medicaid operations.

The processes and planning guidelines within the MITA framework are designed to provide structured approaches for states to use in planning and implementing their transition to improved business processes and system maturity. Florida’s Medicaid Management Information Systems (FMMIS) will evolve to optimize adaptability, flexibility, interoperability and data sharing in a service-oriented, enterprise-wide architecture.

The MITA Framework emphasizes a common business and technology vision for state Medicaid organizations. Programs, technology and vision will guide the way to a patient-centric view not constrained by organizational barriers. Interoperability between state Medicaid organizations within and across states, as well as with other agencies involved in healthcare, will be achieved by Web-based access and integration, software reusability, use of commercial off-the-shelf software and the integration of public health data as outlined in the MITA Framework. The MITA Framework defines a five-level Maturity Model that relies on:

1. Supported information sharing;
2. Use of MITA standard data and technical solutions; and,

The five levels represent progression from simple compliance with regulations (Level One) to progressively higher levels of performance (Levels Four and Five). Please note that Levels Four and Five have not yet been fully defined by the Centers for Medicare and Medicaid Services.

---

The MITA Maturity Model projects a timeline of ten years or more. The assumptions for the timeline include dependencies on technology advances, state and federal policies and enactment of legislation that would support the improvement of state Medicaid programs. Figure 2 below illustrates the planned progress for state Medicaid agencies over the next 10+ years.

MITA is intended to align state Medicaid and CMS goals and objectives for the Medicaid program. The alignment results will benefit the Medicaid community as a whole, with particular benefits to the public, the state and the federal government. The goals for the MITA initiative are directed toward the environment, the enterprise view and the coordination of systems that adhere to performance measures.

Specific MITA goals:

1. Develop seamless and integrated systems that communicate effectively to achieve common Medicaid goals through interoperability and the use of common standards;
2. Promote an environment that is flexible, adaptable and that responds rapidly to changes in programs and technology;
3. Promote an enterprise view that supports enabling technologies that are aligned with Medicaid business processes and technologies;
4. Provide data that is timely, accurate, usable and easily accessible in order to support analysis and decision making for healthcare management and program administration;
5. Provide performance measurement for accountability and planning; and,
6. Coordinate with public health and other partners and integrate health outcomes within the Medicaid community.

MITA goals translate into the following objectives:

1. Adopt data and industry standards;
2. Promote reusable components, modularity;
3. Promote efficient and effective data sharing to meet stakeholder needs;
4. Provide a beneficiary-centric focus;
5. Support interoperability, integration and an open architecture; and,

---

6. Promote secure data exchange:
   a. Promote good practices;
   b. Support integration of clinical and administrative data; and,
   c. Break down artificial boundaries between systems, geography and funding\textsuperscript{11}

In June 2010, Florida Medicaid completed the “As-Is” analysis of MITA maturity and is, as anticipated, at an overall Level 2, consistent with most state Medicaid programs. The process of completing the “To-Be” analysis is underway and will chart the course for Florida to achieve full MITA maturity. This “To-Be” assessment is the second portion of the state self-assessment required by the Centers for Medicare & Medicaid Services and will be used to develop capabilities to transform the Medicaid program into one consistent with MITA principles. A vendor was hired in 2011 to assist the Agency in completing the state self-assessment. The vendor will be expected to build a road map to a more mature business model.

More information on this federal initiative can be found at CMS.gov/MedicaidInfoTechArch.

\textsuperscript{11} Agency for Health Care Administration (AHCA) and HP Enterprise Services (HP). June 4, 2010. MITA state self-assessment consulting services project: Florida MITA as-is state self-assessment. Version 1.0.
## DATABASE SUMMARY

<table>
<thead>
<tr>
<th>Database Name</th>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Florida Medicaid Management Information System (FMMIS)</td>
<td>Maintains all Medicaid billing and utilization information. This provider-based system is maintained and supported by the Agency's contracted Fiscal Agent, Hewlett Packard. Select information is downloaded periodically into the Decision Support System (DSS) data warehouse for use in other applications and reports. Limited interface with Versa Regulation and COMPAS.</td>
</tr>
<tr>
<td>Fraud and Abuse Case Tracking System (FACTS)</td>
<td>An activity driven system used to track and manage Medicaid Program Integrity (MPI) cases and associated activities. This system is designed to manage MPI investigations related to fraud and abuse, sanctions, and overpayments. It can also provide advanced information of potential money due for collections prior to changes of ownership or in bankruptcy filings. This system only provides information on cases administered through Medicaid Program Integrity. Aligning legal case tracking with Versa Regulation, or using one system, would increase efficiency.</td>
</tr>
<tr>
<td>Customer Oriented Medical Practitioner Administration System (COMPAS)</td>
<td>A regulatory system used by Department of Health to license health care practitioners. The system manages licensure applications, legal sanctions, and consumer complaint information. The system specifies the expiration dates of licenses and the process for tracking compliance with continuing education requirements, financial responsibility requirements, and any other conditions of renewal set forth in statute or rule.</td>
</tr>
<tr>
<td>List of Excluded Individuals / Entities (LEIE)</td>
<td>The Office of the Inspector General (OIG) established a program to exclude individuals and entities affected by the various legal authorities contained in §§ 1128 and 1156 of the Social Security Act and maintains a list of all currently excluded parties called the List of Excluded Individuals/Entities. Criteria for exclusions include convictions for program-related fraud and patient abuse, licensing board actions, and default on Health Education Assistance Loans.</td>
</tr>
<tr>
<td>National Crime Information Center (NCIC)</td>
<td>A computerized index of criminal justice information (i.e. criminal record history information, fugitives, stolen properties, and missing persons). It is available to Federal, state, and local law enforcement and other criminal justice agencies.</td>
</tr>
<tr>
<td>Medicaid Case Tracking Software</td>
<td>This application is specifically designed to create the Office of the Inspector General (OIG) Quarterly Statistical Report on demand as well as manage all aspects (even non-reporting related) of active Medicaid Fraud Control Unit (MFCU) cases. By using this application you establish records for each referral and case. Once the referral or case is completed or closed the unit enters outcome results which are utilized to produce statistical reports. The application has over 60 detailed reports including the OIG Quarterly report and the OIG Annual report built in. Any form customization or additional custom reports are included in the cost the annual support contract.</td>
</tr>
<tr>
<td>Comprehensive Case Information System (CCIS)</td>
<td>Offered by the Florida Association of Court Clerks and Comptrollers, the CCIS is a secured single point of search for statewide court case information. This system allows authorized users to search for and subscribe to receive information from any Florida Court Clerk on filed actions including criminal arrests, dispositions, warrants, and civil cases. The subscription option is very limited and not able to handle large scale data sharing without additional programming.</td>
</tr>
<tr>
<td>Database Name</td>
<td>Function</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Versa Regulation (VR)</td>
<td>A regulatory system used to license health care facilities and providers. The system manages licensure applications, legal cases, and consumer complaint information. The system includes fees and fine amounts due and paid, facility/provider demographic information, nursing home and assisted living facility adverse incident data, and other conditions of licensure. Information regarding inspections and federal sanctions is downloaded into Versa Regulation from the Automated Survey Processing Environment data mart.</td>
</tr>
<tr>
<td>Automated Survey Processing Environment (ASPEN)</td>
<td>The federal system used by the Agency to manage provider information for federal certification including demographic information, inspections, and consumer complaints, and certain federal sanctions.</td>
</tr>
<tr>
<td>Med-Tel Track</td>
<td>A Web-based telephone call tracking system accessible through the Agency’s Intranet. Phone call data is entered and shared by Medicaid Headquarters and the eleven Field Offices.</td>
</tr>
<tr>
<td>Fraud Investigation Database (FID)</td>
<td>The FID is a comprehensive nationwide system devoted solely to the accumulation of Medicare fraud and abuse data and is currently accessible by CMS program integrity staff and its contractors, MFCU, and Federal law enforcement agencies.</td>
</tr>
<tr>
<td>Florida Crime Information Center (FCIC)</td>
<td>The FCIC database contains Florida conviction, arrest, and warrant information as reported to the Florida Department of Law Enforcement by law enforcement agencies throughout the state and authorized for release to the public.</td>
</tr>
<tr>
<td>Medicaid Accounts Receivable</td>
<td>A FoxPro application used to track Medicaid overpayments due and received by the Agency. This excludes some overpayments collected through Medicaid claims recoupment.</td>
</tr>
<tr>
<td>Web Document Management</td>
<td>Integrates with the Agency’s document management system, Laser Fiche, to post documents online for consumers and the public. Documents include provider inspection reports and all legal final orders for sanctions including licensure and legal actions. The system is used to provide copies of final orders of Medicaid sanctions and to the Department of Health or others as needed.</td>
</tr>
<tr>
<td>Comprehensive Case Information System (CCIS)</td>
<td>The Comprehensive Case Information System (CCIS), developed and implemented by the Florida Clerks of the Court, is a secured internet portal providing a single point of search for statewide court case information. CCIS users are comprised of the judicial community, state and local law enforcement, state agencies, and the Florida Legislature.</td>
</tr>
<tr>
<td>Medicaid &amp; CHIP State Information System (MCSIS)</td>
<td>Secure, web-based application developed to allow States to share information regarding terminated providers.</td>
</tr>
<tr>
<td>National Plan and Provider Enumeration System (NPPES)</td>
<td>Created by the Centers for Medicare &amp; Medicaid Services (CMS), the National Plan and Provider Enumeration System (NPPES) to assigns the National Provider Identifier.</td>
</tr>
<tr>
<td>Database Name</td>
<td>Function</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Excluded Parties List System (EPLS)</td>
<td>The Excluded Parties List System (EPLS) includes information regarding entities debarred, suspended, proposed for debarment, excluded or disqualified under the non-procurement common rule, or otherwise declared ineligible from receiving Federal contracts, certain subcontracts, and certain Federal assistance and benefits.</td>
</tr>
<tr>
<td>Sunbiz (Department of State, Division of Corporations)</td>
<td>Online database with information for corporations, limited liability companies, limited partnerships, general partnerships, trademarks, fictitious name registrations and liens.</td>
</tr>
<tr>
<td>Public Assistance Reporting Information system (PARIS)</td>
<td>A computer matching process by which the Social Security Numbers of public assistance recipients are matched against various Federal databases and participating States.</td>
</tr>
<tr>
<td>Palmetto (DME)</td>
<td>Medicare Administrative Contractor (MAC) that administers claims for DME benefits.</td>
</tr>
</tbody>
</table>
2727 Mahan Drive, MS #6
Tallahassee, Florida 32308
AHCA.MyFlorida.com
850-412-4600