Advanced Data Analytics and Detection Services

Issue Summary:

- This issue provides $5 million in non-recurring funds for the first year of analytical subscription services in order to better identify fraud, waste, and abuse within the Florida Medicaid system.
- Identifying fraud, waste, and abuse in the Medicaid program has become a complex undertaking in Florida. Schemes, trends, and fraud are increasingly difficult to detect as perpetrators use elaborate schemes, hidden relationships, and straw owners to shield their activities.
- The Centers for Medicare and Medicaid Services (CMS) has identified the need for states to modernize their detection abilities by using advanced statistical methods and graph-pattern analysis methods to identify aberrant billing patterns, whether due to fraud or errors.
- The CMS provides a 90% federal funding match amount.
- In Fiscal Year 2013-2014, the Legislature appropriated $3 million to the Agency for Health Care Administration (AHCA) in non-recurring funds for the procurement of enhanced data analytical services.
- Services procured with this non-recurring funding will cease June 30, 2014 thereby creating the need to fund the subscription of analytical services in Fiscal Year 2014-2015 and beyond.

- The analytical subscription services will enable the AHCA to:
  - Create a design plan;
  - Migrate the data;
  - Utilize Acceptance Testing (UAT);
  - Provide access to users through training;
  - Add reports; and
  - Include additional functionality and data sources.

- These subscription services operate in a self-hosted environment and require only data uploads from state agencies thereby minimizing the network impact and requiring no infrastructure or hardware changes.
  - The use of these services will also provide for faster and more efficient referrals to other Medicaid related agencies, such as the Medicaid Fraud Control Unit (MFCU), the Department of Children and Families (DCF), and the Department of Health (DOH). The sooner aberrant billing practices are identified and discontinued, the greater the realized savings to the program.
  - DCF and MFCU will each have direct access to the system for their own case development purposes.

- The <u>return on investment</u> for appropriating funds for the analytical subscription services will be realized in:
  - cost savings by keeping unqualified recipients and providers out of the system and
  - actual recoveries of overpayments and fraud as a result of the investigative leads generated by system analysts.
  - Per AHCA, other states that have implemented these subscription services have seen returns on investment of up to ten to one (for every $1 spent on the effort, $10 is recovered or prevented from being paid out)

- The AHCA has performed extensive research and conducted interviews with other states including the CMS regarding their implementation and usage of these types of analyses and services to derive the cost of this service.
  - While the AHCA will be delivering Medicaid services predominantly through contracted managed care organizations (MCO) beginning in 2014, approximately 15 percent of Medicaid recipients (the churn population and those receiving Medicaid Waiver services) will equate to about $1 billion in Medicaid expenditures.
  - Further, the AHCA will continue to conduct retrospective fee-for-service audits for a period of five years after full implementation of Statewide Medicaid Managed Care

(SMMC), which will extend to 2019 and allow these proposed data analytics services to enhance overpayment recoveries before the recovery opportunities have expired.
- Advanced data analytics services are also applicable in the analysis of MCOs, encounter data, and MCO business relationships, which will assist the AHCA in conducting MCO oversight.
  - The use of these services will allow maximum efficiency of staff by targeting reviews and audits to those cases most likely to result in higher recovery amounts.
- The AHCA will implement the project in phases and will add other data sources as migration and testing is accepted.
- The project will be implemented by starting the analyses of Medicaid claim data for providers, adding other provider data information such as licensing from the Division of Health Quality Assurance (HQA), and moving into eligibility data for recipients/enrollees.

CITS Information:

1. Description: This issue requests funding for the purchase of analytical subscription services to identify fraud, waste and abuse in the Medicaid Program.

2. Importance & Impact: This issue was included in Governor Scott's recommended budget for FY 2013-14 and was funded by the Legislature in the annualized (3 months) amount of $3 million. Federal matching funds are available at 90 percent federal financial participation.

Per AHCA, other states that have implemented these subscription services have seen returns on investment of up to ten to one (for every $1 spent on the effort, $10 is recovered or prevented from being paid out).

3. Other:

Agency Priority #4

Economic Development Strategy:

24 - Support and sustain statewide and regional partnerships to accomplish Florida's economic and quality of life goals;

25 - Improve the efficiency and effectiveness of government agencies at all levels; and

26 - Invest in strategic statewide and regional economic development priorities; and

27 - Create and sustain vibrant, safe, and healthy communities that attract workers, businesses, residents, and visitors.

The Agency’s original requested amount ($15 million/annually) corresponds to Texas' estimate of their yearly service cost ($15 million) which include access to third party private data, technology licenses, maintenance and support, data center operations, and professional analytic personnel services.

For the types of analyses and services needed, the Texas program was the model for the Agency's competitive procurement (ITN).

Medicaid Electronic Health Record Incentive Program

Issue Summary:

- This issue would provide $60,969,600 for the AHCA to continue the Medicaid Provider Incentive Payment program, which provides incentive payments to eligible Medicaid providers and hospitals for the adoption and meaningful use of electronic health records (EHRs).
- This allows the AHCA to continue the implementation of the EHR program and to provide incentives to the hospitals and eligible professionals as directed in 42 Code of Federal Regulations (CFR) 495. Section 4201 of the American Recovery and Reinstatement Act (ARRA) provides funding for certified EHRs through incentive payments to eligible Medicaid providers and hospitals.
    - The Centers for Medicare and Medicaid Services (CMS) provides 90 percent matching funds to the AHCA for planning and implementing this program.
    - The incentives paid to providers are 100 percent federal funds.
    - Providers include hospitals and eligible professionals defined as non-hospital-based physicians, dentists, nurse-midwives, nurse practitioners, and some physician assistants.
    - Eligible professionals can receive up to $63,750 over six years for adopting and meaningfully using EHR technology.
    - In order to be eligible for incentive payments:
        - Professionals must meet certain Medicaid patient volume thresholds.
        - Hospitals eligible for Medicaid incentive payments are acute care hospitals, critical access hospitals and children's hospitals.
            - Acute care and critical access hospitals must have a Medicaid patient volume of at least 10 percent to be eligible to receive payments.
            - Incentive payments to eligible hospitals are based on a complex formula in which a base incentive amount for all hospitals is modified by the number of Medicaid patient discharges as well as other factors.

- Initial incentive payments were made in September 2011.
- The program will continue to make incentive payments through 2021.
    - A system has been developed to administer the payments to providers and hospitals.
    - The administration of the program includes payment, eligibility verification, auditing, provider outreach, and technical assistance.

- An additional $150,000 will be used to contract to build a consent infrastructure in conjunction with the Florida Health Information Exchange that providers can use to confirm that patient consent has been obtained for release of information to other providers.
    - The consent infrastructure will add functionality for the health information exchange by enabling providers to exchange data in the Florida Health Information Exchange as well as to release and store documents for consent. This additional functionality will also enable participants to verify that patient consent has been received.

Budget Summary:

- This issue would provide $60,969,600 in budget authority, which includes:
    - $59,444,600 in incentive payments to providers and hospitals matched at 100 percent federal financial participation (FFP), and
    - $1,375,000 for Florida Medicaid Management Information System (FMMIS) activities related to this program matched at 90 percent FFP.

- FMMIS staff was augmented to implement the requirements of the EHR. System engineers and business analysts customize and maintain the registration and attestation system, and call center staff provides customer service dedicated to the program. This includes continued development, infrastructure, and support for the registration and attestation system.

- This issue also provides an additional $150,000 in funding to build a consent infrastructure in conjunction with the Florida Health Information Exchange that providers can use to confirm that patient consent has been obtained for release of information to other providers.

CITS Information:

3. Other:

Agency Priority #8

Economic Development Strategy:

19 - Ensure state, regional, and local agencies provide collaborative, seamless, consistent and timely customer service to businesses; and

25 - Improve the efficiency and effectiveness of government agencies at all levels.