

- Volume XV
- Issue 4
- Fall 2015  
Published  
10/5/2015

# Florida Medicaid

# Provider Bulletin

## AGENCY FOR HEALTH CARE ADMINISTRATION

### A Message from Secretary Elizabeth Dudek

Dear Medicaid Provider:

The Agency for Health Care Administration (AHCA) announced on September 22<sup>nd</sup> that health plans participating in the Statewide Medicaid Managed Care (SMMC) program are improving the quality of care families receive. Florida Medicaid health plans scored higher than the national average in more than half of the performance metrics measured by the National Committee for Quality Assurance. The HEDIS figures show we are making great strides in improving health outcomes and providing greater access to care. Medicaid recipients enrolled in Managed Medical Assistance plans now have access to the highest quality of care in the history of the Florida Medicaid program. For more information, please see the article on page 2 of this bulletin.

We also engaged in a healthy dialogue with health plans to develop the most appropriate reimbursement rates and ensure the continued success of the SMMC program. The new Medicaid health plan rates went into effect on September 1<sup>st</sup>.

In addition, the deadline for the ICD-10 transition is October 1<sup>st</sup> so if you haven't updated your code system, you will not be able to successfully bill for your services. For the latest news on the ICD-10 transition, visit the [CMS ICD-10](#) and the [Medicaid ICD-10](#) website.

Moving forward, the Agency will be transitioning its outpatient payment system from the current cost-based per visit rate methodology to an outpatient prospective payment system. We are in the process of hosting a series of public meetings on the new outpatient system. For more information about the implementation, please visit the [Hospital Outpatient Prospective Payment Reimbursement Methodology](#) web page.

As always, thank you for your commitment to serving the Florida Medicaid population.



Elizabeth Dudek  
Secretary

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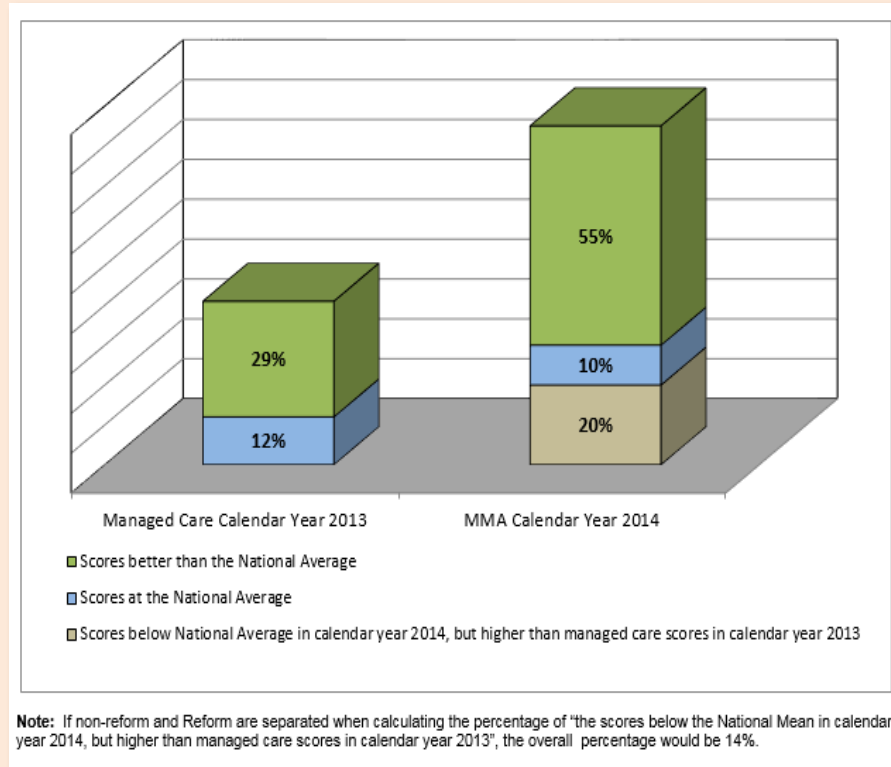
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# Florida Medicaid Health Plan Performance Continues to Improve with Implementation of Statewide Medicaid Managed Care Program

The Healthcare Effectiveness Data and Information Set, usually referred to as HEDIS, is a standardized set of performance measures that uses information reported by participating Medicaid health plans to compare individual Medicaid health plan performance and statewide performance to the national average. This tool is used by more than 90% of health plans to measure performance in key areas related to the provision of care and health outcomes.

Health plans participating in the Managed Medical Assistance (MMA) component of the SMMC program were required to report on 51 HEDIS measures for calendar year 2014. The chart below compares these 2014 HEDIS scores to the national average and to HEDIS scores for the Florida Medicaid program in 2013.



Key findings from the data set include:

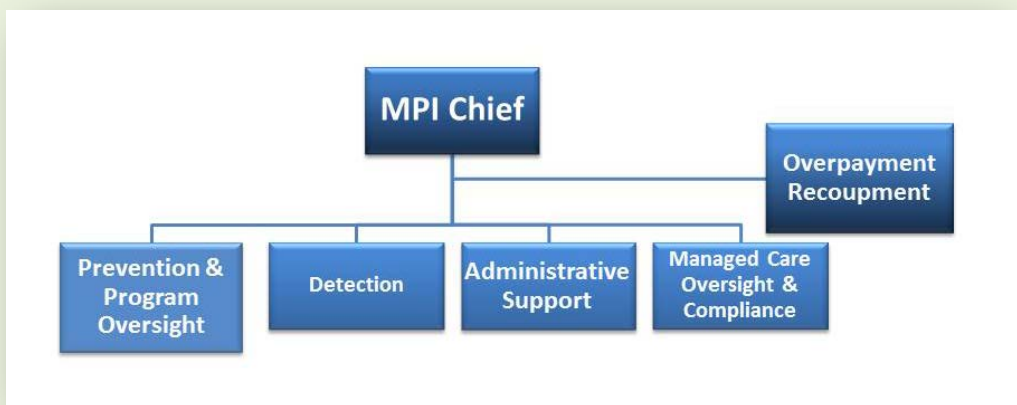
- In 2014, Florida's Medicaid plans performed as well as or better than the national Medicaid average on 65% of HEDIS measures.
- Compared to HEDIS scores for 2013 (prior to SMMC implementation), the critical areas of prenatal care, diabetes management and breast cancer screenings show substantial improvements.

To learn more about how the Healthcare Effectiveness Data and Information Set (HEDIS) is used in evaluating Medicaid health plan performance visit [www.ncqa.org](http://www.ncqa.org).

To access the 2014 HEDIS measure data for Florida Medicaid health plans, please visit <http://ahca.media/2014HEDISMeasures>.

## Medicaid Program Integrity (MPI)

Medicaid Program Integrity (MPI) reports to the Agency's Inspector General and is charged under state law with preventing, detecting, and auditing fraud and abuse, and initiating the recovery of overpayments in the Medicaid program. MPI also serves as the primary office within the Agency to fulfill the federal law requirements to operate a fraud and abuse prevention and detection program. MPI has five operational/organizational units. The Assistant Bureau Chief manages units responsible for *recoupment* activities; an AHCA Administrator manages the unit responsible for *managed care oversight* activities; an AHCA Administrator manages *administrative support* activities; an AHCA Administrator manages *detection* activities; and, there is a unit responsible for *prevention* of fraud, waste, and abuse (presently managed directly by the Bureau Chief). This MPI update will focus on **detection** activities. Subsequent articles will focus on other functional areas within MPI.



Detection efforts, along with other MPI activities, are further described in the Agency's annual report on fraud and abuse activities. [The State's Efforts to Control Medicaid Fraud and Abuse](#) is published each year by January 1 and is available on the Agency's website.

While there have been few organizational changes over the years in the Detection Unit (continuing to have a sub-unit for the *intake* of complaints and a sub-unit for *data analysis*), the activities performed within the unit have changed. The Data Analysis team is comprised of very experienced data analysts with knowledge in statistical programming and modeling, database coding, and health data analysis. Additionally, the team has experience visualizing complex datasets, including the mapping of social networks and geospatial mapping and analysis. The experience this team brings to MPI helps the Agency's fraud fighting efforts grow with changes in technology, including the transition to advanced data analytics.

The Intake team is the sub-unit for the intake of complaints, which includes receiving complaints through the [Medicaid Fraud and Abuse Complaint Form](#) on the Agency's website. Additionally, the Intake unit conducts a preliminary investigation of all leads before referring the matter to other MPI units or external organizations. The preliminary investigation process varies depending on several factors. Therefore, prior to conducting a preliminary investigation, to ensure proper assignment of the preliminary investigation, the complaints are triaged.

The complaint triage process is geared toward comprehending who is the subject of the complaint, the nature of the allegations, the subject's enrollment status, the potential complexity of the preliminary investigation based upon the perceived nature of the allegations and issues involved, and the level of potential risk associated with the subject.

# Medicaid Program Integrity (MPI)

## (continued)

This initial triage is a necessary process to ensure that preliminary investigations are properly assigned. Preliminary investigations may be assigned to Prevention Unit staff (if the triage process indicates a potential termination or suspension is warranted, or suggests a potential MFCU referral), Managed Care Unit staff (when the subject is a managed care plan), and Case Management Unit staff when there is an extensive need for a subject matter expert to review the allegations).

In August 2014, the Agency entered into a contract with an advanced data analytics vendor to work cooperatively with MPI's Detection Unit. Advanced data analytics is the integration of multiple business intelligence tools, including claims-based outlier algorithms, customizable fraud and abuse risk indicators, human resources, and statistical models, utilizing a variety of data sources to identify and deter emerging trends of fraud, abuse, and waste. Through the vendor's tools, MPI will have the ability to review far more investigative-ready leads than previously available through manual detection methods. Through statistical and other analytical processes, the analytics system will identify aberrant billing patterns for further review by MPI staff. This will result in an increase of overpayment audits for Medicaid providers. MPI will begin issuing further educational alerts (provider alerts or subsequent provider bulletin articles) with additional information about data analytics in the coming months.

MPI encourages providers to incorporate internal quality control and auditing functions in their business practices. The routine review of Medicaid claims and reimbursements often assists providers in identifying instances of both underbilling and overbilling. When a provider identifies an instance of overbilling, the claim(s) can be voided or adjusted. Taking this proactive approach minimizes a provider's risk for future audit by MPI, and minimizes the risk of sanctions associated with non-compliances identified from an MPI audit.

When the provider wishes to submit a check to repay overpayments in lieu of voiding or adjusting claims, MPI requests that the provider submit documentation of the self-disclosure that is sufficient to allow for a review and validation of the overpayment. MPI refers to this process as a self-audit.

Information about conducting self-audits is available on the [Agency's website](#), on the [MPI landing page](#). Please see the below screen-shot which demonstrates how to navigate from the Agency's home page to the MPI landing page.



## Payment Error Rate Measure Project (2014) Update

This article is the final in a series on the 2014 Payment Error Rate Measurement (PERM) program. The Improper Payments Information Act of 2002 (HR 4878) requires federal government agencies to estimate their improper payments annually. The Agency for Health Care Administration (the Agency) is Florida's single state agency that administers the state's Medicaid program; this includes the administration and management of funding for the Children's Health Insurance Program (CHIP), also known as Florida KidCare. The Agency is cooperating with the Centers for Medicare and Medicaid Services (CMS) in this effort. These updates provide additional information on PERM as the program evolves, and program requirements are refined by CMS.

The 2014 PERM cycle has officially ended. Over 99% of the medical records requested by the CMS medical review contractor were submitted by Medicaid providers within the 75 day deadline. Florida Medicaid wants to thank all providers that participated in the 2014 PERM project for their prompt assistance in submitting the requested records. Our high percentage of completed record requests would not have been possible without your cooperation.

Out of 769 Medicaid claims reviewed, 16 state-specific errors were found during the review for the following root causes:

- Medical records could not be located from a Medicaid provider that closed its business;
- Insufficient medical documentation was submitted by providers to support paid claims as required in Medicaid policy;
- A Medicaid provider voided or reversed an incorrect claim more than 60 days after the claim was billed;
- The incorrect number of units was billed for the services provided;
- The patient was not seen on the date of service billed for;
- The services provided were not in accordance with Medicaid policy.

For more information on PERM, please visit the CMS PERM website at <http://www.cms.hhs.gov/perm/>. All documentation specific to 2014 participating states will be located under **Cycle 3**. General state provider information will be located under **Providers**.

The next Payment Error Rate Measurement cycle (2017) for Florida Medicaid will begin in October 2016.

We appreciate your continued cooperation with Florida Medicaid.

If you have questions about PERM, please contact Jason Ottinger, Bureau of Medicaid Quality at (850) 412-4695 or [Jason.Ottinger@ahca.myflorida.com](mailto:Jason.Ottinger@ahca.myflorida.com).



# Medicaid Provider Background Screening Overview

Providers seeking to enroll or renew an existing enrollment in Florida Medicaid must submit to background screening prior to entering into an agreement with the Agency, in compliance with 42 CFR §455.434 and 409.907, F.S.

All entities and individual persons with five percent or greater controlling interest in the provider, plus all managing employees, must be disclosed on the provider enrollment application and must be fingerprinted for purposes of obtaining criminal history, unless they meet one of the exceptions as defined in 409.907, F.S.

All screenings must be initiated through the Care Provider Background Screening Clearinghouse (Clearinghouse), available through the AHCA Web Portal (Portal), prior to sending an applicant to a Livescan Service Vendor (Vendor) for fingerprinting.

If you are not enrolled on the Portal, you will need to create a Portal account. Once your Portal user account is successfully created, you can request access to the Clearinghouse results website. When prompted to select a program, be sure to select Florida Medicaid in order for any screenings to be associated with your provider application.

If you already have a Portal account with access to monitor and submit screening requests for licensure or employment purposes, you still must add Florida Medicaid as one of your programs and select Florida Medicaid each time you login to the Clearinghouse when ordering screenings to be applied to Medicaid provider enrollment eligibility.

Once access is granted, you will be prompted to generate a User Registration Agreement. The agreement for new accounts must be received and approved by Florida Medicaid staff before accessing the site. An email will be sent to notify you when your request has been approved.

The following tips can aid you in a successful registration.

1. New provider applicants must create their online Florida Medicaid Provider Enrollment Application and obtain the Application Tracking Number (ATN) before registering as a user in the Clearinghouse. Once the ATN is created, allow 24-48 hours before attempting to register. Existing providers can register at any time.
2. User Registration Agreements are usually approved within five business days. An email will be sent to the email address on file once your request has been approved. Upon approval, you can request screenings and schedule appointments with a Vendor through the Clearinghouse.
3. Once the screening request is submitted, a Livescan Request Form will be generated which the applicant takes to their screening appointment. The request form contains important information, including the following:
  - a. The ORI (originating agency identifier) number, the Florida Medicaid account number with the Florida Department of Law Enforcement, is required for electronic fingerprint submission.
  - b. The Screening Request ID used by Vendor to link the screening results to your screening request in the Clearinghouse.
  - c. The applicant's personal information

# Medicaid Provider Background Screening Overview (continued)

The Vendor will take your picture and transmit your information along with the fingerprints. To avoid delays in processing your results, it is critical that the Vendor transmits all of your personal information including your Social Security Number and home address.

4. Screening results are generally available in five to seven business days. An email notification will be sent to the email address on record when there is a status change.
5. If you have an eligible screening status for a program other than Florida Medicaid, you can request an Agency review of the screening for Medicaid at no cost and without the need to visit a Vendor and submit new fingerprints. Be sure to choose Florida Medicaid as your program when you login to request the Agency Review for enrollment in Florida Medicaid.

Clearinghouse User Guides and training videos are available on the [Care Provider Background Screening Clearinghouse \(Clearinghouse\)](#) web page.

For further assistance with background screening or other provider enrollment questions, please call the Medicaid Provider Enrollment Call Center at 1-800-289-7799, Option 4.

The screenshot displays the Agency for Health Care Administration website. The header includes the agency logo and name, a search bar, and a navigation menu with links for HOME, ABOUT US, MEDICAID, LICENSURE & REGULATION, FIND A FACILITY, and REPORT FRAUD. The main content area is titled "Care Provider Background Screening Clearinghouse (Clearinghouse)" and features a "Clearinghouse Results Website" section. This section provides information about the Clearinghouse implementation and includes a link to the results website. Below this, there is a "To All Health Care Providers:" section with a recommendation to frequently review employee eligibility. The page also includes "Instruction Guides" and "Training Videos" sections, with links to "SSO Portal User Registration Training Videos" and "Clearinghouse Results Training Videos". A left sidebar contains "Local Navigation" links for various services, including Clearinghouse, Screening, Live Scan, and Additional Information.

# Are You Signed Up for Florida Medicaid Health Care Alerts?

The Florida Medicaid program has an email alert system that notifies registered providers or other interested parties of "late-breaking" health care information. An email will be delivered to your mailbox when Medicaid policy clarifications or other health care information is available that is appropriate for your selected provider type.

Here's how you sign up:

Go to the [Agency for Health Care website](#).

Click on **Sign Up for Medicaid Health Care Alerts**.

On the Florida Medicaid Health Care Alerts page complete the form with your email address (required), first name and last name (optional). You can then choose to receive all areas and all messages/provider types, or as many individual provider types and areas as you wish. Once you have completed the form, click **Submit**.

A confirmation email will be sent to your mailbox to avoid fraudulent subscription

requests. You must click on the link **Confirm to list: Medicaid Alerts** in the confirmation email to complete your subscription. If you do not wish to be added, do not click on the link.

You can unsubscribe or add/change email addresses at any time by clicking on the **Manage Your Subscription** link located at the bottom of any health care alert email you receive.

To see previous health care alerts please visit the [Provider Message Archive](#) page and follow the instructions on how to search for an alert.

\*Email

First Name

Last Name

\*Region

All Regions  
 Region 1  
 Region 2  
 Region 3

\*Provider Type

00 - All Messages/Provider Types  
 01 - General Hospital  
 04 - State Mental Hospital  
 05 - Community Behavioral Health Services  
 06 - Ambulatory Surgical Center  
 07 - Mental Health Practitioner  
 08 - District Schools  
 09 - Skilled Nursing Unit

\* = Required Field



