Office of Inspector General

Internal Audit

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June 2020

SMMC Capitation Rate Process

EXECUTIVE SUMMARY

As part of the Agency for Health Care Administration (Agency or AHCA) Audit Plan, Internal Audit conducted an audit of the Statewide Medicaid Managed Care (SMMC) capitation rate process within the Division of Medicaid, Medicaid Finance and Analytics, Bureau of Medicaid Data Analytics (MDA).

During our audit, we noted that, in general, the capitation rate process appears to follow established procedures. We noted that staff are committed to accuracy, timeliness, and compliance. However, we also noted areas where improvements are needed to strengthen controls and reduce risks. Our audit disclosed the following:

- The capitation rate process to determine and load capitation rates was not automated, increasing the potential for manual errors and the time needed for calculations, data entry, and formatting; and
- Certain activities performed within the capitation rate process, such as Long Term Care (LTC) *flagging* and *Blended Rates* calculation, lack adequate segregation of duties and insufficient compensating controls.

OBJECTIVES, SCOPE, AND METHODOLOGY

The objectives of this audit were to review the efficiency, effectiveness, and adequacy of controls over the SMMC capitation rate process.

The scope of the engagement includes the SMMC Managed Medical Assistance (MMA) and LTC capitation processing, approval, and rate loading into Florida Medicaid Management Information System (FMMIS) for the period from April 2018 through April 2019, and related activities through the conclusion of fieldwork in August 2019.

The methodology for this engagement included a review of relevant laws, rules, regulations, and policies and procedures associated with the managed care plan rate capitation process; interviews with Agency staff involved in the capitation rate loading

process; observations of capitation rate building and loading processes; data analytics of the accuracy of information loaded into FMMIS; and a review of calculated rates for managed care plans.

BACKGROUND

The Agency administers the Medicaid program which provides access to health care for low-income individuals and families in Florida. Authority for the Florida Medicaid Managed Care program is established under 42 CFR 438 and in Chapter 409, Florida Statutes, and Rule 59G, Florida Administrative Code. The Florida Medicaid budget for Fiscal Year 2019-2020 is approximately $29 billion.

The Agency historically operated Florida's Medicaid program using a fee-for-service payment system. However, in August 2014, the state implemented a Statewide Medicaid Managed Care (SMMC) program. Under the SMMC program, most Medicaid recipients were required to enroll with a Medicaid managed care plan. As of January 2020, approximately 2.9 million or 77.5 % of the Medicaid population were enrolled in the SMMC program. During Fiscal Year 2018-19, the SMMC program accounted for 65% ($18.1 billion) of Medicaid expenditures. The SMMC Program consists of two components: 1) Integrated MMA and LTC and 2) Dental. This audit focused on the Integrated MMA and LTC component.

As part of the SMMC payment system, the Agency 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, or fixed monthly payment, per recipient enrolled in the managed care plan. The managed care plan is responsible for contracting with providers and paying providers for Medicaid covered services provided to enrollees. As required by Section 409.967(2)(m), Florida Statutes, and Rule 59G-1.054, Florida Administrative Code, managed care plans are required to report to the Agency the recipients' encounters on services provided.

The Division of Medicaid's MDA is responsible for setting managed care capitation rates. Specific Units within MDA that participate in setting rates include the Medicaid Actuarial Services Unit (ASU) and the Medicaid Data Solutions Unit (DSU).

ASU's responsibilities include:

- Managed care payment methodology and analysis;
- Support of capitation rate development and risk adjustment; and
- The contract with Medicaid's external actuarial firm, Milliman.

DSU's responsibilities include:

- Calculation of plan payments;
- Identification of recipients with HIV/AIDS and other Serious Medical Illness;
- Management of data transfer to the external actuary;
- Calculation of risk scores and rates for all MMA plans;

- Calculation of blended LTC rates based on plan's case-mix; and
- Verification of the external actuary's calculation of risk scores.[1]

The Agency contracts with the actuarial firm, Milliman, for initial rate setting activities which includes setting base rates and quarterly risk scores. The capitation rate setting process combines the actuarially approved rates and the risk calculated rates which are sent to ASU. After ASU validates the rates, the file is sent to DSU to produce the *Build Rates* file that is uploaded to FMMIS.

The capitation rates reflect historical utilization and spending for covered services projected forward and are adjusted to reflect the level of care profile, or risk, for enrollees in each health plan. Rates must be actuarially sound, as required by federal law. The rates are developed by a qualified actuary and provide for all reasonable, appropriate, and attainable costs of providing the required care and administering the contract including benefit costs, administrative expenses, fees and taxes, and cost of capital.

The capitation rate is paid regardless of the level of claims of the recipient. Any changes to the rates must be accompanied by documentation from the actuary and must be approved by the Federal Center for Medicare and Medicaid Services (CMS).

Information used in the Rate Setting process include elements such as:

- Historical capitated plan data;
- Demographic data;
- Provider fee schedules;
- Delivery system changes;
- Utilization and unit cost trends;
- Pharmacy and medical practice innovation;
- Program changes;
- Capitated plan input;
- CMS input; and
- Actuarial standards of practice.

MMA Rate Setting:

The MMA rate setting process begins with an analysis of validated historical utilization and cost data. This data is then adjusted for any changes to the program such as benefit changes, significant fee changes for hospitals, etc. The rates are then trended or revised to reflect the new rate period, and allowance is made for the managed care plan's administrative costs and profit margin.

MMA rates vary by region, age, and eligibility. For instance, for a healthy child in the Temporary Assistance for Needy Families (TANF) eligibility group, a plan will receive

[1] Risk scoring is adjusting for the severity or case mix of a population. Risk scores in this context means using indicators of health status such as diagnoses, pharmaceuticals, etc. in estimating the likelihood of illness burden.

a capitation payment of approximately $230 per month. In contrast, for a child with a disability in the Supplemental Security Income (SSI) eligibility group, the plan may receive a monthly $6,300 capitation payment.

Risk Adjustment
MMA capitation rates are then risk-adjusted. In a managed care setting, risk adjustment of capitation payments is the process used to distribute capitation payments across managed care plans based on the expected health risk of the members enrolled in each plan. The purpose of this process is to adjust capitation payments for expected expenditures based on health status of recipients enrolled in the health plan. The goal is to minimize the incentives for plans to selectively enroll healthier recipients and to allow the health plan to focus on quality of care rather than recipient risk. MMA risk scores are calculated on a quarterly basis or whenever there are changes in rates.

The risk adjustment process contains two distinct elements of data validation:

- AHCA provides each plan with a data set of recipient encounter data from FMMIS. The plan reviews this data for completeness and rectifies any data errors or omissions within one month.
- AHCA provides the revised data set to Milliman for additional validation. Milliman produces a set of data summaries within three weeks and shares this information with the plans. However, plans are not given any additional time to rectify data errors or omissions. MMA risk scores are thus changed quarterly.

LTC Rate Setting:
Similar to the MMA rate setting process, the LTC rate setting process begins with an analysis of validated historical utilization and cost data. This data is adjusted for any changes to the program such as benefit changes, nursing facility and hospice fee schedule changes, etc. The rates are then trended and allowance made for the LTC plan's administrative costs and profit margin. LTC plans are required to pay nursing facilities an amount equal to, or greater than, the nursing facility-specific payment rates set by AHCA and to pay hospice providers through a prospective system for each enrollee an amount equal to the per diem rate set by AHCA.

LTC *Flagging* and *Blended Rates*
A recipient enrolled in the LTC component of the SMMC program can reside either in a Nursing Facility (NF) or in a home and community-based setting (HCBS) which includes the recipients own home or family home, assisted living facility, or adult family care home. A distinct base rate is set for each setting and region. At the beginning of the rate year, eligible recipients are flagged as being either NF or HCBS. The flag comes from the prior rate year. The rate paid to each plan is a blended rate to include the NF rates based on the Health Plans enrolled population after applying a transition percentage. The transition percentage requires that base rates be adjusted to provide an incentive for plans to transition enrollees from NF with a higher base rate to HCBS with a lower rate.

The *Blended Rate* is the payment model where two rates are blended to include one for the nursing home population and one for the community-based population. LTC *blended rates* are updated monthly, which differs from the quarterly update of MMA risk scores.

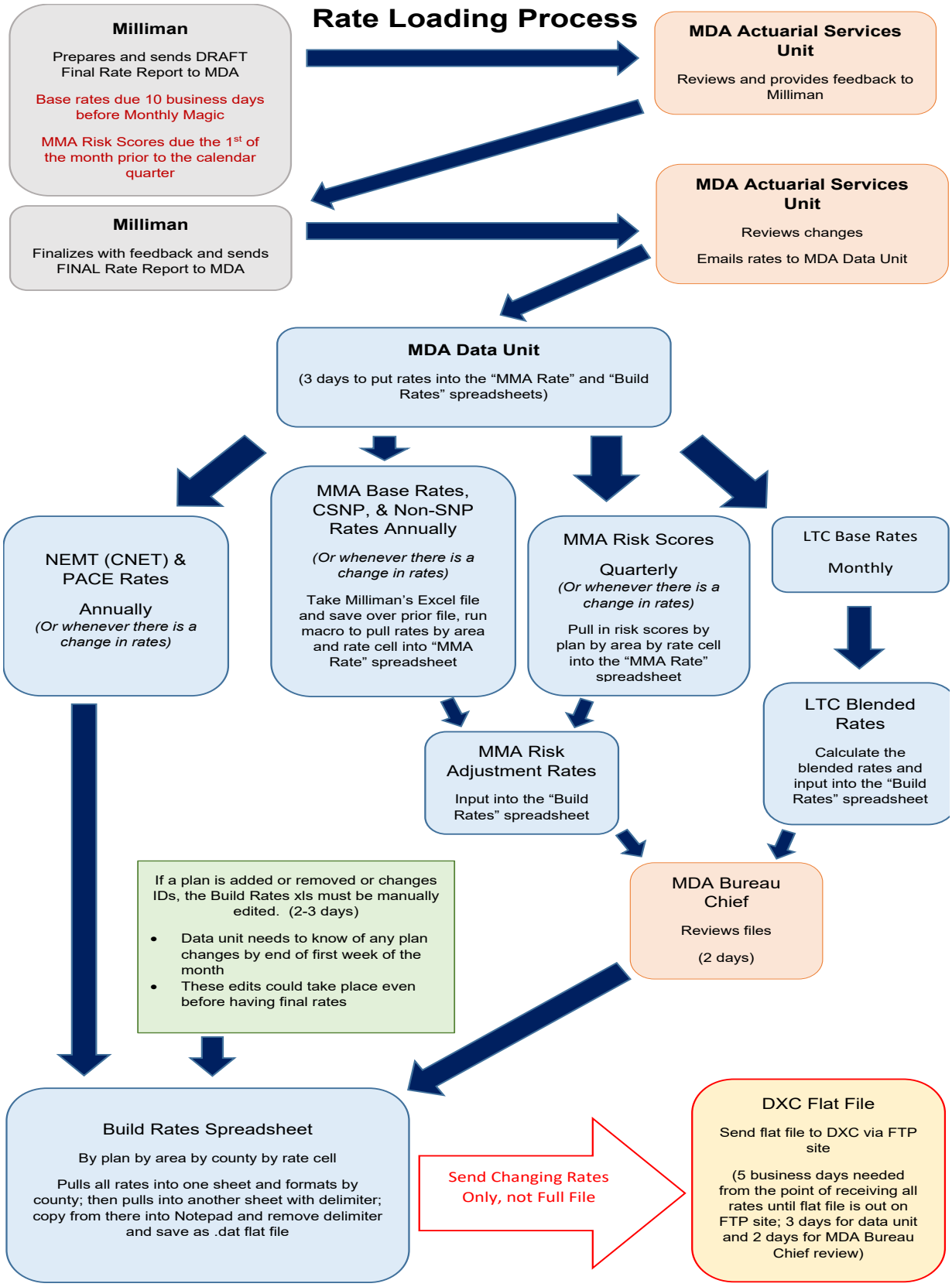
Build Rates

After ASU reviews the base rates and the MMA risk scores from the actuary, it is sent to MDA. MDA is given three days to enter the approved rates into the *MMA Rate* and the *Build Rates* spreadsheet. The *Build Rates* spreadsheet incorporates all the rate tables into one spreadsheet and formats the rates by the following key categories: *enrollment type, plan ID, region*, *rate cell, effective date, and end date*. This is converted into a *flat* file. This *flat* file database stores data in a single table formatted in plain text format, to match the fiscal agent's (DXC) process input and is uploaded to DXC via the secure FTP site on a monthly basis. There are five days needed from the point of receiving all rates including file review to when the rates are uploaded to DXC. This is done prior to "monthly magic," which is the penultimate or the second to last Saturday of each month.

For February 2019, the applicable rate amounts were plugged into 211 Medicaid ***plan IDs***, 158 ***rate cells,*** and 11 ***regions*****.** There were more than 38,000 records in the spreadsheet for February 2019. The seven enrollment types are shown below:

ENROLLMENT TYPE	DEFINITION	EFFECTIVE DATE	END DATE
MMAC	Managed Medical Assistance Care	2/1/19	3/31/19
MMASC	Managed Medical Assistance Specialty Care	2/1/19	3/31/19
MMACC	Managed Medical Assistance Children's Care	2/1/19	3/31/19
LTCC	Capitated Long-Term Care	2/1/19	2/28/19
SWDEN	State-wide Dental	1/1/19	9/30/19
PACE	Program for All-Inclusive Care for the Elderly	1/1/19	12/31/19
CNET	Capitated Non-Emergency Transportation	1/1/19	12/31/19

A diagram of the rate loading process provided by DSU is shown below:


Rate Loading Process
Milliman
Prepares and sends DRAFT Final Rate Report to MDA
Base rates due 10 business days before Monthly Magic
MMA Risk Scores due the 1st of the month prior to the calendar quarter
MDA Actuarial Services Unit
Reviews and provides feedback to Milliman
Milliman
Finalizes with feedback and sends FINAL Rate Report to MDA
MDA Actuarial Services Unit
Reviews changes
Emails rates to MDA Data Unit
MDA Data Unit
(3 days to put rates into the "MMA Rate" and "Build Rates" spreadsheets)
NEMT (CNET) & PACE Rates
Annually
(Or whenever there is a change in rates)
MMA Base Rates, CSNP, & Non-SNP Rates Annually
(Or whenever there is a change in rates)
Take Milliman's Excel file and save over prior file, run macro to pull rates by area and rate cell into "MMA Rate" spreadsheet
MMA Risk Scores
Quarterly
(Or whenever there is a change in rates)
Pull in risk scores by plan by area by rate cell into the "MMA Rate" spreadsheet
LTC Base Rates
Monthly
LTC Blended Rates
Calculate the blended rates and input into the "Build Rates" spreadsheet
MMA Risk Adjustment Rates
Input into the "Build Rates" spreadsheet
If a plan is added or removed or changes IDs, the Build Rates xls must be manually edited. (2-3 days)
Data unit needs to know of any plan changes by end of first week of the month
These edits could take place even before having final rates
MDA Bureau Chief
Reviews files
(2 days)
Build Rates Spreadsheet
By plan by area by county by rate cell
Pulls all rates into one sheet and formats by county; then pulls into another sheet with delimiter; copy from there into Notepad and remove delimiter and save as .dat flat file
Send Changing Rates Only, not Full File
DXC Flat File
Send flat file to DXC via FTP site
(5 business days needed from the point of receiving all rates until flat file is out on FTP site; 3 days for data unit and 2 days for MDA Bureau Chief review)

FINDINGS AND RECOMMENDATIONS

Finding 1: Manual Nature of the Capitation Rate Process	
Finding Statement	The Capitation Rate process to determine and load capitation rates was not automated, increasing the potential for manual errors and the time needed for calculations, data entry, and formatting.
Criteria	In accordance with the United States Government Accountability Office Standards for Internal Control in the Federal Government Principle 11, management should design the entity's information system and related control activities to achieve objectives and respond to risks. Application controls are those controls that are incorporated directly into computer applications to achieve validity, completeness, and accuracy of data during application processing. Application controls include controls over input, processing, output, and data management. Application controls are more reliable than manual controls when evaluating the potential for control errors due to human intervention. Once an application control is established, and there is little change to the application, database, or supporting technology, the organization can rely on the application control until a change occurs.
Condition	During the audit, the process to determine and load capitation rates was not automated and relied heavily on manual calculations, manual data interaction by separate analysts, and reformatting of rate information to conform to FMMIS compatible format. The DSU analyst responsible for the *Build Rates* process, which was the final step prior to rate loading, used an Excel process to retrieve the MMA base rates and the quarterly MMA risk scores received from the actuary and approved by ASU. Risk-adjusted rates are then calculated and formatted by region, managed care plan ID, rate cell, and rate. The rates are then copied into separate worksheets where the PACE, CNET, SWDEN, and LTC rates are then reformatted as managed care plan ID, Medicaid rate cell, and rate. If a Health Plan was added, removed, or changed Medicaid Provider IDs, the *Build Rates* file had to be manually edited.

	In order to prepare the file for rate loading, another worksheet reformats the plan's ID, county code, rate cell code, and rate into the fixed length fields specified by DXC. Excel delimiters or character(s) specifying data boundaries were removed, and the *flat* file was submitted to DXC for processing. A final worksheet provided a summary of the rates to be processed in the payment cycle, including the percentage change from the previous month's rates. The *Build Rates* file process was complex, time-sensitive, required accurate manual input, and was dependent on one DSU analyst. The analyst noted that normal workplace interruptions throughout the day increased the risk that errors or data transpositions could occur in the data file. Although this process was dependent on one DSU analyst, we did note that all materials used to produce the rates, the final rate data file, and the projection of the next month's MMA and LTC payments were forwarded to members of the Rate Review Process team, who reviewed the rates for errors. This process included a review by a DSU supervisor or designated analyst, an ASU supervisor or designated analyst, and the MDA Bureau Chief. After all reviews were completed and edits made, the final approved *Build Rates* file was sent back to the DSU analyst for submission to DXC for processing and payment. Despite the review, the *Build Rates flat* file for February 2019 contained an incorrect effective date for State-wide Capitated Dental Plan rates for the month in question. Further, relevant documentation evidencing review and edits of the Build Rates file was not provided to our Office during the review period. The *Build Rates* file process has been revised since the period of our audit testing. MDA management identified and has taken proactive steps to update this process. Although this new process is still manual in nature, some specific Excel worksheet development steps, such as changing the format in which the file is initially received from the actuary to match the format in which it is sent for processing has been amended, thus eliminating the need to reformat the worksheet to match the processing file for FMMIS.

FINDINGS AND RECOMMENDATIONS

Cause	The capitation rate process specifically the *Build Rates* process is complex, deadline-driven, and relies on manual input of one analyst to produce. MDA management had previously identified concerns with the manual nature of this process and submitted a request for a technological solution in 2017. However, other information technology governance projects assumed precedence and this process has not yet had an automated solution that would lessen the risks inherent in this process, such as data entry or data transposition errors.
Effect	The total SMMC capitated rate payments for the month of February 2019 was $1.33 billion. As noted by the analyst responsible for the *Build Rates* process, risks such as staff interruptions or transposition of data could create errors in the *Build Rates* file. Given the volume of information in this file and the tight deadlines, it would be difficult for review efforts to detect and correct such errors. Errors in the *Build Rates* file increases the risk of over or under payments to managed care plans.
Recommendation	1. We recommend that the Capitation rate process be automated to the extent possible. This would streamline the process, eliminate manual steps and errors, and reduce the time needed for calculations and formatting. This would also facilitate and simplify the review process and provide enhanced reporting to highlight anomalies and errors. 2. We also recommend that review steps of the capitation rate process be designed to ensure revisions are valid and accurate and that proper documentation is maintained documenting the completion of the review and any file changes made.
Management Response	MDA acknowledges the incorrect dental effective date for the February 2019 file. February 2019 was the last rollout month of the new SMMC contracts, with regions 1-4 rolling out February 1st. Consequently, the dental plans in those regions were enrolled in FMMIS with an effective date of February 1, 2019. The February 2019 file contained an effective date of January 1, 2019 for these regions, which is when the prior month's regions, 5-8, rolled out. Because the effective date of the rate file for

	dental rates was before the effective date of the dental plan in regions 1-4, the rate file failed in processing and a revised file with an effective date of February 1, 2019 was submitted. It should be noted that the rate was exactly the same – it was a matter of aligning effective dates between the effective date of the plan enrollment and the rate. Dental rates typically have the same effective date across the State; now that SMMC rollout has completed, the scenario of different regions rolling out at different times should not occur until the next procurement. Recommendation 1: As of May 2019, the process used to create the capitation rate files for processing in FMMIS by MFAO no longer uses the Excel Build Rates file. Instead, the process uses files received directly from the Agency's contracted actuary, Milliman, and MDA's SQL server to generate the capitation rate file that is provided to MFAO. MDA believes that this new process is as automated as we can currently make it, and is essentially the same process that would be used if the capitation rates were to be calculated by FMMIS. Recommendation 2: Procedures will be enhanced to ensure that both the review process, and any changes occurring as a result of the review, are adequately documented.
Anticipated Completion Date	Recommendation 1: Complete. Recommendation 2: September 30, 2020

FINDINGS AND RECOMMENDATIONS

Finding 2: Segregation of duties	
Finding Statement	Certain activities performed within the capitation rate process, such as LTC *flagging* and *Blended Rates* calculation, lack adequate segregation of duties and insufficient compensating controls.
Criteria	According to the American Institute of Certified Public Accountants, segregation of duties "is a basic building block of sustainable risk management and internal controls." The principle is based on shared responsibilities of a key process that disperses the critical functions of that process to more than one person or organizational unit. Without this separation in key processes, fraud and error risks are more likely.
Condition	During the audit, several of the activities in the capitation rate process had only one key analyst responsible for the process. For the LTC *flagging process*, one DSU analyst was responsible for extracting data from FMMIS Decision Support System (DSS,) which contained recipient eligibility information each month. This was used to flag recipients for LTC. Editing and updating the data analysis tool and approving changes to the file were also made by the same analyst. For the LTC *Blended Rates* calculation process, a second DSU analyst calculated the LTC *Blended* rates paid to each plan on a monthly basis. The rates were blended to include the NF rates based on the Health Plan's enrolled population after applying a transition percentage to provide an incentive for plans to transition enrollees from NF with a higher base rate to HCBS with a lower rate. MDA management noted that the recipients identified as NF or HCBS and the LTC *Blended Rates* file were reviewed by the Health Plans each month and that changes made to these files are tested internally before being placed into production. However, the analyst responsible for this process noted that testing of these changes and documentation approving such changes were not maintained by MDA.

FINDINGS AND RECOMMENDATIONS

Cause	DSU analysts make programming changes and approve the changes for certain key activities in the capitation rate process, such as the LTC *flagging* and *Blended Rates* calculation process. The Unit has relied on certain analysts due to their institutional knowledge of the specific process. Further, DSU did not have detailed desktop procedures and guidelines necessary for cross-training staff to prevent one analyst from performing these multiple activities in the input and production of these files.
Effect	The lack of segregation of duties in the input and production of the LTC *flagging* and the *Blended Rates* file increases the risk of errors. Errors in the development of these files increase the risk of over or under payments to SMMC managed care plans.
Recommendation	1. We recommend that the LTC *flagging* and *Blended Rates* calculation file be revised to include more than one analyst in the process. Where not practical, separate employees should monitor and perform monthly reviews and document performance of these activities. 2. We recommend that DSU staff document all programming changes, testing, and approvals made during the LTC *flagging* and *Blended Rates* calculation files.
Management Response	Recommendation 1: MDA considers the monthly process of assigning LTC flags and calculating the blended LTC rates to be part of the same process. Due to this, combined with staffing limitations, MDA does not consider it practical to divide this process across multiple analysts. The current process includes supervisory review of the blended rates file each month by a Data Solutions supervisor along with a monthly review performed by the Actuarial Services unit. This review is in addition to the review of Capitation Rate file described in Finding No.1. As noted in the finding, the health plans are provided a monthly file that includes the flag assignment of each recipient, along with the calculation of the blended rate. MDA will enhance procedures to ensure that the monthly process of assigning flags and calculating blended rates, along with the review of these activities, is documented.

	Recommendation 2: MDA notes that documentation can take many forms; oftentimes the programming code itself serves as documentation that would allow another analyst to perform the task. MDA will enhance procedures to ensure that any programming changes to the LTC flagging process and/or calculation of the LTC blended rates is sufficiently documented.
Anticipated Completion Date	Recommendation 1: September 30, 2020 Recommendation 2: September 30, 2020

PROJECT TEAM

Beth Jones, CPA, conducted the audit under the supervision of Steven Henry, Senior Management Analyst Supervisor, JD, CGAP, CIGA; and Pilar Zaki, Audit Director, JD, CIGA.

FINAL COMMENTS

Internal Audit would like to thank the management and staff of the Agency's Division of Medicaid, Bureau of Medicaid Data Analytics Data Solutions Unit, and the Bureau of Medicaid Fiscal Agent Operations for their assistance and cooperation extended to us during this engagement.

The Agency for Health Care Administration's mission is
Better Health Care for All Floridians.

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This engagement was conducted pursuant to Section 20.055, Florida Statutes, and in accordance with the *International Standards for the Professional Practice of Internal Auditing* as established by the Institute of Internal Auditors. Please address inquiries regarding this report to the AHCA Audit Director at (850) 412-3990.

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