FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

*Better Health Care for all Floridians*

ELIZABETH DUDEK
SECRETARY

April 18, 2012

Elizabeth Dudek, Secretary
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, FL 32308

Dear Secretary Dudek,

Please find enclosed our six-month status report on the Auditor General's *FMMIS Controls and the Prevention of Improper Medicaid Payments,* Report Number 2012-021, issued October 2011. This status report is issued in accordance with the statutory requirement to report on corrective actions resulting from the Auditor General's recommendations six months from the report date.

If you have any questions about this status report, please contact Mary Beth Sheffield at 412-3978.

Sincerely,

Eric W. Miller
Inspector General

EWM/szg
Enclosure

cc: Kathy DuBose, Legislative Auditing Committee
Justin Senior, Deputy Secretary, Division of Medicaid

**Florida Agency for Health Care Administration**
**AHCA - FMMIS Controls and the Prevention of Improper Medicaid Payments**
**Six-Month Status Report on the Auditor General's Report# 2012-021**

| Finding# 1 | Recommendation | Management Response as of October 21, 2011 | Status as of April 18, 2012 | Anticipated Completion Date and Agency Contact |
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| Risk Assessment. The Agency's ineffective risk assessment processes contributed to the disbursement of improper payments. | We recommend that the Agency review its internal controls, including its risk assessment processes, as related to the prevention of improper payments for Medicaid services, and implement effective controls designed to ensure that improper payments are minimized to the greatest extent possible. | The Agency concurs with this finding. To enhance the internal controls within the FMMIS system, AHCA's Office of Inspector General will review the risk management processes within the Division of Medicaid to ensure that risks are correctly evaluated. This review will consist of the following:<br>• Evaluating risk management processes.<br>• Evaluating the reporting of key risks.<br>• Reviewing the management of key risks.<br><br>Additionally, the Office of Inspector General, in concert with the Division of Medicaid's management, will support the establishment and implementation of a risk management component within the Division of Medicaid to facilitate the identification and evaluation of risks, coach management in responding to risks, consolidate the reporting of risks, and develop a risk management framework. The Division of Medicaid will implement the risk management program.<br><br>Estimated completion date: February 2012. | The Bureau of Internal Audit is currently performing a review of Medicaid's risk management processes as they pertain to the prevention of improper payments for Medicaid services. Staff have been interviewing senior management, and other applicable staff to document Medicaid's risk governance process for identifying, assessing and controlling risks associated with improper Medicaid payments. We anticipate issuing the report in May 2012. | Eric Miller<br>(850) 412- 3965<br><br>May 2012 |

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| Finding# 2 | Recommendation | Management Response as of October 21, 2011 | Status as of April 18, 2012 | Anticipated Completion Date and Agency Contact |
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| Payment for Medicaid Services. To ensure that FMMIS includes the necessary audits, the Agency should have a process in place to periodically review FMMIS to determine that audits are in place and operating as intended and that they are based on current Medicaid limitations. Our examination disclosed that a comprehensive review of procedure codes and applicable audits had not been performed for all service types within the last several years. Additionally, when the Agency changed fiscal agents effective June 26, 2008, a review of procedure codes and audits was not performed as part of the two-year design, development, and implementation phase. Absent the Agency's periodic review of the effectiveness of FMMIS audits, deficiencies in the audits will not be identified and improper payments will be made and escape detection. For example, our analysis of selected service types and | **(1)** During fieldwork for this audit, the Agency's Bureau of Medicaid Program Integrity began a review of Medicaid services and applicable edits and audits in January 2011. We recommend that the Agency continue its review of Medicaid services and applicable edits and audits to ensure that FMMIS contains all controls necessary to prevent payment of claims for services in excess of policy limitations. This review should extend to all Medicaid services. We also recommend that the Agency give this project a high priority considering the likelihood that overpayments have and will be made until project completion.<br><br>**(2)** After project completion, the Agency should attempt to recover overpayments that were made in excess of program | **(1)** The Agency concurs with this finding and will continue its review of Medicaid services and applicable edits and audits within the FMMIS system. The Edits and Audits Task Force, created in January 2011by AHCA, is a multi-bureau task force with members from Medicaid Program Integrity (MPI), Medicaid Services and Medicaid Contract Management. The progress made by the Task Force is reported to the Agency's senior management as part of the AHCA Fraud and Abuse governance process. To date, the Edits and Audits Task Force has reviewed 7 provider types (5 are within our Waiver category of service) and has submitted 29 policy recommendations, 10 file maintenance requests to bring the FMMIS audits in line with policy. Additionally, 2 recoupment actions have been initiated by the Edits and Audits Task Force via referrals to MPI. These two recoupment referrals have a recovery potential of $2.4 Million.<br><br>**(2)** The Task Force will continue to report potential overpayments to MPI along with the supporting documentation identifying the | **(1)** The Edits and Audits Task Force continues to meet on a bi-weekly basis. The team continues to explore new areas on which to focus, having completed the review of the waiver services.<br><br>**(2)** MPI has received the referrals and will conduct Generalized Analysis projects to attempt to recoup the | **(1)** Mike Blackburn (850) 412- 3977<br><br>Implemented and On-going<br><br>**(2)** Mike Blackburn (850) 412- 3977<br><br>Implemented and |

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| procedure codes identified claim payment errors totaling $17,275,263 made to durable medical equipment and other service providers. For some of these claims the absence of accurate claim information precluded reliable estimates as to the extent these payments represented overpayments. | limitations, including the amounts identified by this audit.<br><br>**(3)** We also recommend that the Agency implement procedures to ensure that whenever an existing policy is modified or a new policy is added, all applicable edits and audits are reviewed to determine whether programming changes are needed. | specifics of the overpayment. Referrals of potential overpayments will be submitted to MPI at the conclusion of each audit.<br><br>**(3)** Both Medicaid Contract Management and the fiscal agent (FMMIS contractor) will be participants in future policy implementation teams to ensure they are involved in the planning process to determine whether programming changes are needed and to prepare for such changes. The Bureau of Medicaid Services will develop and implement a checklist to be used throughout the Division of Medicaid for employment whenever an existing policy is modified or when policy additions or changes are required by legislation, judicial or executive orders, or other mandates. The checklist will be routed with the Notices of Proposed Rule (or other order or revision of law necessitating policy changes) and will document for each new or modified policy in the proposed rule that all applicable edits and audits have been reviewed to determine whether programming changes are needed. If programming changes are identified, the checklist will detail the plan for ensuring the | overpayments identified.<br><br>**(3)** The checklist is developed and is being reviewed. Staff will be trained in its use by the end of May 2012. | On-going<br><br>**(3)** Beth Kidder (850) 412-4003<br><br>Spring 2012 |

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| | | programming changes are completed. This plan will be used by bureau managers, contract management and the fiscal agent (FMMIS contractor) to track and monitor the programming changes.<br><br>Estimated Completion Date: December 15, 2011 | | |
| | **(4)** Additionally, procedures should be implemented to provide for the periodic review of edits and audits for each service type to ensure that all cost-effective edits and audits are in place and programmed for the correct policy. | **(4)** The Agency has undertaken a systematic review of edits and audits, starting with the most expensive and heavily utilized codes. The review team is carefully documenting its work to determine the most cost-effective way to continue to review and update the system edits and audits. Once the team gains experience with the review process, we will determine how best to implement a permanent process.<br><br>Estimated Completion Date: October 2012 | **(4)** The team is continuing its work as planned. | **(4)** Beth Kidder (850) 412-4003<br><br>October 2012 |

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| Finding# 3 | Recommendation | Management Response as of October 21, 2011 | Status as of April 18, 2012 | Anticipated Completion Date and Agency Contact |
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| Medicare Outpatient Crossover Claims. FMMIS was not programmed to ensure the proper payment of outpatient Medicare crossover claims. Our review of 286 claims disclosed that 182, or 63.6 percent, had been paid amounts in excess of authorized amounts. When the errors identified by our audit are projected to the total of the amounts paid for outpatient hospital crossover claims during the three fiscal years tested, the total overpayment is estimated to be $117,659,683. | **(1)** We recommend that the Agency ensure that FMMIS is programmed with the correct methodology for the payment of outpatient crossover claims. Appropriate priority should be given to these programming changes considering the likelihood that overpayments will continue until the changes have been implemented.<br><br>**(2)** We also recommend the Agency review outpatient crossover claims and initiate recovery efforts for any payments made that were not consistent with Florida law. | **(1)** & **(2)** Agency staff has logged reports of overpayments or underpayments since the System transitioned from the prior fiscal agent in July 2008, and at this time, all known issues have been logged. Those issues that have identified claims as processing incorrectly have already been addressed with associated Customer Service Requests (CSRs) and Change Orders (COs). For most issues that were identified as over or underpayments, the CSRs and COs have been installed into production and any recovery efforts that were identified have also been logged as tasks for reprocessing/ recoupment. Within the next 90 days, the MCM Bureau will coordinate with the Bureau of Medicaid Services to create provider announcements that will advise the provider community of the upcoming reprocessing tasks, an explanation of the identified System processing errors, the total dollars to be recouped, and the methodology for recovery.<br><br>**(1)** & **(2)** Estimated Completion Date: December 2011 for final CSR implementation for FMMIS corrections, and initiation of recoupment. | Medicaid Services bureau staff, with MCM bureau staff, reviewed the statute language, State Plan language, and Handbook (Rule/ Administrative Code) language, and FMMIS logic, and identified conflicting perspectives among the three legal readings. The Handbook is the guiding documentation for the provider community, and has not appropriately reflected the intent of the statute. The Agency's guidance and directive is to always hold providers accountable to the Handbook's instructions. At present, because the Handbook is not in line with statute and the State Plan, Medicaid Services is promulgating revised Handbook language to properly align it with statute and the State Plan. Once this revision is made, a reprocessing of past paid claims would be inappropriate because doing so would be contrary to previous Handbook direction and instruction. However, going forward claims should adjudicate appropriately. The rule promulgation should be completed in the next several months. | **(1)** & **(2)**<br>Alan Strowd and David Powers<br>(850) 412-3400<br><br>Reprocessing will be complete in April 2012 |

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| Finding# 4 | Recommendation | Management Response as of October 21, 2011 | Status as of April 18, 2012 | Anticipated Completion Date and Agency Contact |
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| Medicare Professional Crossover Claims. FMMIS was not programmed to correctly calculate the amounts due for some professional Medicare crossover claims. Our audit tests disclosed related overpayments totaling $14,053,660. | **(1)** We recommend that the Agency correct the payment methodology used by FMMIS to pay professional Part B Medicare crossover claims. Any programming changes should be given an appropriate priority considering the likelihood that overpayments will continue to occur until the changes have been implemented. | **(1)** The Agency does not disagree with the finding that various types of Medicare professional crossover claims have adjudicated inappropriately over the 3 year audit period, which resulted in overpayments in some instances. Staff has logged into the System documentation records issues of reports of overpayments (or underpayments) since the System transition in July 2008, and at this time, all known issues have been logged, and those issues that have identified claims as processing incorrectly have already been addressed with associated CSRs and Change Orders (COs). For most issues that were identified as legitimate over/underpayments, the CSRs and COs have been installed into production and any recovery efforts that were identified have also been logged as tasks for reprocessing/recoupment. | **(1)** Completed | **(1)** Alan Strowd and David Powers (850) 412-3400<br><br>Completed |
| | **(2)** We also recommend the Agency review professional crossover claims and initiate recovery efforts for any payments made that were not consistent with Medicaid policy or Florida law. | **(2)** Within the next 90 days, the MCM Bureau will coordinate with the Medicaid Services Bureau to create provider announcements that will advise the provider community of the upcoming reprocessing tasks, an explanation of the identified System processing errors, the total dollars to be recouped, and | **(2)** Reprocessing/ recoupment start date for the associated CSR "fixes" (above), began in February/March 2012. The MCM Bureau will present recoupment amounts for this issue to Medicaid Services in April and implement a takeback plan in May 2012. | **(2)** Alan Strowd and David Powers (850) 412-3400<br><br>April 2012 |

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| | | the methodology for recovery.<br><br>**(1)** & **(2)** Estimated Completion Date: December 2011 for final CSR implementation for MMIS corrections, and initiation of Recoupment Plans | | |

| Finding# 5 | Recommendation | Management Response as of October 21, 2011 | Status as of April 18, 2012 | Anticipated Completion Date and Agency Contact |
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| Crossover Claims and Medicaid Assistance Category. Medicare crossover claims were paid on behalf of recipients without consideration of whether the recipient was eligible for the assistance. Related overpayments disclosed by our audit tests totaled $26,071,070. | **(1)** We recommend that the Agency ensure that Medicare crossover claims are calculated and paid with consideration of the recipient's assistance category. Any programming changes required to FMMIS should be given a high priority due to the likelihood that overpayments will continue until the changes have been implemented.<br><br>**(2)** We also recommend the | **(1)** & **(2)** The Agency has acted on and completed the system corrections as recommended. The claims have been reprocessed awaiting release. Provider letters have been mailed to the overpaid providers for this System processing error. The reprocessed claims will be released into the System's financial cycle starting the weekend of November 7, 2011, to initiate the recoupment of those overpaid dollars associated with this finding.<br><br>**(2)** Recoupment will begin | **(1)** Completed – February 2012.<br><br>**(2)** Recoupment is at 91% thru | **(1)** Michael Bolin and (850) 412-4003<br><br>Alan Strowd (850) 412-3400<br><br>Completed<br><br>**(2)** Alan Strowd and |

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| Finding# 5 | Recommendation | Management Response as of October 21, 2011 | Status as of April 18, 2012 | Anticipated Completion Date and Agency Contact |
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| | Agency review crossover claims and initiate recovery efforts for any payments made on behalf of recipients who were not eligible for Medicaid payment of coinsurance and deductible amounts. | November 7, 2011 | the March 24 financial cycle. The Agency has identified terminated providers to whom demand letters will be sent to attempt to recoup outstanding dollars not collected prior to their termination; all other providers with outstanding balances will have their recoupment plans modified to collect outstanding balances by end of the fiscal year. | David Powers (850) 412-3400<br><br>Spring 2012. |

| Finding# 6 | Recommendation | Management Response as of October 21, 2011 | Status as of April 18, 2012 | Anticipated Completion Date and Agency Contact |
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| Timeliness of FMMIS Programing Changes. Programming changes to FMMIS electronic edits and audits were not made in a timely manner. Our review of 28 FMMIS change orders to determine whether the changes were implemented by the effective date of the policy change disclosed that for 21 of the 28 change | We recommend the Agency strengthen procedures to ensure that Medicaid policy changes are identified and any FMMIS programming changes required are timely communicated to Medicaid Contract Management for timely implementation in FMMIS. | Medicaid Contract Management acknowledges the time span from the date a change was submitted by Medicaid Services to the date of implementation by MCM/HP. Both Medicaid Contract Management and the fiscal agent (FMMIS contractor) will be participants in future policy implementation teams to ensure they are involved in the planning process to determine whether programming changes are needed and to prepare for | The checklist is developed and is being reviewed by Agency management. Staff will be trained in its use by the end of May 2012.<br><br>The Bureaus of Medicaid Contract Management and Medicaid Services have worked together to develop streamlined approaches to communicating policy and system changes. This item is complete. | Beth Kidder (850) 412-4003<br><br>Spring 2012<br><br>Alan Strowd and David Powers (850) 412-3400<br><br>Completed |

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| orders reviewed, the program change to FMMIS was not timely implemented. The period of time between the effective date of the policy change and the date the change was implemented in FMMIS ranged from 20 to 2,542 days and averaged 541 days. | | such changes. The Bureau of Medicaid Services will develop and implement a checklist to be used throughout the Division of Medicaid for employment whenever an existing policy is modified or when policy additions or changes are required by legislation, judicial or executive orders, or other mandates. The checklist will be routed with the Notices of Proposed Rule (or other order or revision of law necessitating policy changes) and will document for each new or modified policy that all applicable edits and audits have been reviewed to determine whether programming changes are needed. If programming changes are identified, the checklist will detail the plan for ensuring the programming changes are completed. This plan will be used by bureau managers, contract management and the fiscal agent (FMMIS contractor) to track and monitor the programming changes.<br><br>Our procedures for addressing submitted changes require all such modifications be assigned and then prioritized among the available system engineers and business analysts with HP Systems (fiscal agent). Some changes are minimal and require | | |

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| | | hours to complete, others can require hundreds of hours. Regardless, we prioritize based on the impact to recipients, providers, claim volumes and claim dollars. The averages for hours from start to finish (the period extending from the date of requested change by Medicaid Services to the date of the CSR's implementation) averaged 82 days, as referenced in the AG finding. This was within acceptable expectations of the FMMIS certification process conducted by the Centers for Medicare and Medicaid Services. Medicaid Contract Management acts on all policy changes and many of such changes are submitted via File Maintenance and are completed within 2 to 10 working days of receipt with the fiscal agent, depending on the type of File Maintenance. For the File Maintenance changes, Medicaid Contract Management, with the support of Medicaid Services, has implemented a File Maintenance tracking process requiring the requester to assign a tracking ID that the requester can use to check, on-line, the status of their File Maintenance request after it has been submitted to the fiscal agent. In so doing, no changes are missed and they are completed in a | | |

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| | | timely fashion.<br><br>Estimated Completion Date: December 2011 for finalizing guidelines for streamlining the communication between the two bureaus on policy changes. | | |

| Finding# 7 | Recommendation | Management Response as of October 21, 2011 | Status as of April 18, 2012 | Anticipated Completion Date and Agency Contact |
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| Bureau of Medicaid Program Integrity Recommendations. The Agency should strengthen the process by which the Bureau of Medicaid Program Integrity's recommendations are reviewed and tracked. | We recommend that the Agency strengthen its procedures for tracking MPI recommendations. These procedures should include:<br>☐ Submission of recommendations to both the Agency Secretary and Medicaid Services for consideration.<br>☐ A requirement that edit or policy recommendations submitted include annual projected cost savings, if subject to reasonable estimation.<br>☐ Provisions for more accurate tracking of recommendations, including dates and final disposition of the recommendation.<br>☐ To assist the Agency in consideration of the | The Agency concurs with this finding. MPI has already made changes to this process to better track recommendations resulting from provider audits. We will further revise the Operating Procedures to include the recommendations made in the audit report. MPI will continue to work with the Division of Medicaid to enhance communication and ensure implementation of audit recommendations.<br><br>Estimated completion date: December 31, 2011<br><br>MCM and Medicaid Services will work with MPI to strengthen | MPI amended its existing procedures for issuing and tracking Policy and Edit Recommendations to include the Auditor General's recommendations. The revised procedures were issued and implemented in January 2012.<br><br>MCM and Medicaid Services have collaborated with MPI on a | Mike Blackburn<br>(850) 412- 3977<br><br>Completed<br><br>Beth Kidder<br>(850 412-4003 |

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| | recommendation, a requirement that Medicaid Services provide a formal response within a specified timeframe concerning its views regarding the recommendation. If the recommendation will not be implemented, the reason(s) for the rejection should be included in the response. | the MPI procedures for tracking its recommendations to the Medicaid Services Bureau and Bureau of Medicaid Contract Management with regard to issues surrounding the System edits and audits relative to Medicaid policy and business rules. Such procedures will require the approval of the Deputy Secretary for Medicaid and the Inspector General.<br><br>Estimated Completion Date: April 2012 | revised set of procedures for tracking recommendations. This is closed. | Alan Strowd and David Powers (850) 412-3400<br><br>April 2012 |

| Finding# 8 | Recommendation | Management Response as of October 21, 2011 | Status as of April 18, 2012 | Anticipated Completion Date and Agency Contact |
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| Provider Enrollment Functions. The Agency should automate processes for the screening of new and currently enrolled Medicaid providers. Automating these processes would also improve the timeliness with which Medicaid providers are terminated | **(1)** We recommend the Agency implement automated processes by which electronic files of license information and the LEIE can be uploaded into FMMIS and compared against currently enrolled Medicaid providers. | **(1)** The Agency currently has processes/procedures in place to access the federal LEIE database of excluded providers. Access occurs for each new provider enrollment as well as during provider reenrollment. Recently, the MCM Bureau and MPI were jointly involved in a matching/review effort of excluded providers, with a full upload of the LEIE data, and | **(1)** The LEIE match has been fully incorporated into the central background screening system at HQA. The central background screening system receives an upload of all providers from the MMIS and performs a match against the LEIE. If the provider is excluded on the LEIE, the provider's status in the screening system changes to Not Eligible. MCM receives a data | **(1)** Alan Strowd and Shawn McCauley (850) 412-3400<br><br>Spring 2012 |

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| from the Medicaid Program due to adverse actions. | | such review identified less than a dozen providers who were on the excluded list, but were not on such list at the time of their initial enrollment or reenrollment. We agree that fully automating the LEIE screening procedure will further aid in identifying providers who should be excluded in the current time period, but were not earlier identified as excluded providers during enrollment or reenrollment. Medicaid Contract Management will evaluate the cost-benefit ratio of making System changes to accommodate an automated upload of the LEIE database into the FMMIS, and subsequent matching of FMMIS records with the LEIE database to identify newly excluded providers. Their recommendations will be provided to the Deputy Secretary for Medicaid and the Agency Head.<br>Estimated completion date: April 2012 | file with all providers with a change of status. The data file is used to update the MMIS provider records. | |
| | **(2)** We also recommend the Agency modify the provider agreement to inform providers of their obligation to screen their employees against the LEIE and to explicitly require providers to agree to comply with this obligation as a condition of | **(2)** The AG recommendation of modifying the provider agreement (PA) to address a provider/ applicant's obligation to screen their employees against the LEIE database has merit. While the current provider agreement already mandates | **(2)** Completed | **(2)** Alan Strowd and Shawn McCauley (850) 412-3400<br><br>Completed |

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| | participation.<br><br>**(3)** Finally, we recommend the Agency strengthen procedures to ensure that timely notifications to the USDHHS–OIG occur in instances where the Agency chooses to deny or limit participation in the Medicaid Program. | adherence to CMS rules on the fiscal agent, we will modify our provider agreement to specifically address the notification requirement.<br><br>**(3)** The Agency understands the AG's recommendation to strengthen procedures to ensure timely notification to the USDHHS-OIG regarding the Agency's denial or limitations to participation in the Medicaid program. Medicaid Contract Management will review the costs and benefits to moving to such an approach, which extends beyond the procedures that are in place today to notice the USDHHS of such restrictions to our providers. Their recommendations will be presented to the Deputy Secretary for Medicaid.<br><br>Estimated completion date: April 2012 | **(3)** Five Agency employees were granted access to load lists of excluded providers to the LEIE. This was established with federal CMS in compliance with federal law. To date, the staff at MPI have successfully loaded a report. MCM is working with Agency IT staff to gain the reporting access, which is expected in April, 2012. | **(3)** Alan Strowd and Shawn McCauley (850) 412-3400<br><br>April 2012 |

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| Finding# 9 | Recommendation | Management Response as of October 21, 2011 | Status as of April 18, 2012 | Anticipated Completion Date and Agency Contact |
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| Performance Measures and Monetary Sanctions. To enhance its effectiveness as a deterrent to unacceptable performance, should such occur, the methodology used to periodically monitor the performance of the Medicaid fiscal agent and assess related penalties should be modified. | **(1)** We recommend that the Agency take the steps necessary to revise its scoring methodology to subject each performance measure to a monetary penalty or allow scores of less than 65 should they be warranted.<br><br>**(2)** We also recommend that the Agency amend the contract with the fiscal agent to provide for an escalation of monetary penalties for a continued failure to achieve satisfactory levels of performance. The escalation of penalties should increase to an amount that encourages the contractor to timely correct performance deficiencies. | **(1)** & **(2)** The Agency follows the RFP/contract requirements/ references with regard to the grading methodologies associated with the fiscal agent report cards. The contracted fiscal agent receives a monetary penalty when a report card is assessed a score below 77. The performance of the fiscal agent continues to be monitored closely and the Agency has, when necessary, added additional penalties when a scored area has remained static or failed to improve. This escalated penalty application was applied as recently as May 2011, after corrective action plans imposed failed to achieve improvement. AHCA is also considering placement of an associated performance dashboard on the Internet. | **(1)** & **(2)** Completed | **(1)** & **(2)**<br>Alan Strowd and<br>Brian Meyer<br>(850) 412-3400<br><br>Completed |