FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

CHARLIE CRIST
GOVERNOR

HOLLY BENSON
SECRETARY

September 24, 2008

Holly Benson, Secretary
Agency for Heath Care Administration
2727 Mahan Drive
Tallahassee, FL 32308

Dear Secretary Benson,

Please find enclosed our six-month status report on the *State of Florida Compliance and Internal Controls over Financial Reporting and Federal Awards*, Report Number 2008-141, issued February 21, 2007. 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 Mike Blackburn at 414-5419.

Sincerely,

D. Kenneth Yon
Interim Inspector General

KY/mb
Enclosure

cc: Terry L. Shoffstall, Legislative Auditing Committee
Dyke Snipes, Deputy Secretary, Division of Medicaid

JLAC
Rec 9/26/08

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Six-Month Status on Auditor General Report:
State of Florida Compliance and Internal Controls Over Financial Reporting and Federal Awards
Report #2008-141 Issued: March 24, 2008
Six-Month Status as of: September 24, 2008

Issue #07-059	Recommendation	Management Response as of March 24, 2008	Management Response as of September 24, 2008	Anticipated Completion Date & Contact
FAHCA expended administrative costs at a rate higher than the established threshold.	In order to reduce the amount of nonprimary expenditures, FAHCA provided an analysis of SCHIP expenditures to the Social Services Estimating Conference in March 2007. The analysis projected that 2006-07 fiscal year primary expenditures would be $311,620,201 and administrative expenditures would be $52,409,909 or $17,785,442 over the threshold. The Legislature authorized $7 million from another funding source for the school health initiative for the 2007-08 fiscal year. FAHCA should continue efforts to ensure that nonprimary expenditures do not exceed the ten percent limit. We also recommend that FAHCA seek written approval from USDHHS to draw Federal funds for the excess administrative expenditures.	The cause was threefold. In March 2003 the Department of Health began claiming comprehensive school health services under title XXI, which increased administrative costs. Also, enrollment in the children's insurance program dropped from 284,948 in July 2004 to 178,997 in June 2005, which caused primary expenditures to decrease. At the same time, Department of Health was approved for random moment sampling, which allowed them a higher level of administrative claiming. Additionally, a system glitch was discovered in 2003 in which 15 to 19 year olds that were to be phased out of Title XXI were continuing to be included. The retroactive adjustment resulted in approximately $189 Million reduction in primary services charges.	Based on the current projections this issue should be resolved in the Federal fiscal year ending September 30, 2009. The procedures currently being used were presented verbally in a CMS training session by a CMS staff member. We have asked for written procedures, but have not received them.	September 30, 2009 Paula Shirley, Chief, Finance and Accounting (850) 922-8452.

Six-Month Status on Auditor General Report:
State of Florida Compliance and Internal Controls Over Financial Reporting and Federal Awards
Report #2008-141 Issued: March 24, 2008
Six-Month Status as of: September 24, 2008

Issue #07-060	Recommendation	Management Response as of March 24, 2008	Management Response as of September 24, 2008	Anticipated Completion Date & Contact
FAHCA procedures did not effectively ensure the timely recoupment of overpayments made to HMOs on behalf of deceased clients.	We recommend that FAHCA take steps to ensure that all capitation overpayments are timely recouped.	The Agency will make every effort to recoup erroneous capitation payments on a timely basis. The following is the current process for recouping the capitation payments: The Third Party Liability (TPL) Vendor is responsible for identifying and recouping overpayments made to HMOs on behalf of deceased Medicaid recipients. The Date of Death project is conducted on a quarterly basis. The Vendor identifies full-month capitation payments that were made on behalf of deceased Medicaid recipients. The Vendor conducts a five-year look back on all Medicaid paid claims each time the project is conducted. The Vendor submits provider notices signed by the Agency to HMOs advising them of any Medicaid overpayments. Providers are provided 45 days in which to review its records and submit refuting documentation	The Agency continues to make every effort to recoup erroneous capitation payments on a timely basis. The TPL Vendor continues to conduct the date of death project on a quarterly basis. A new Third Party Liability contract is scheduled to begin November 1, 2008. After execution of the new contract, the Agency will work with the TPL Vendor to review the above procedure to determine if there is a method to identify and recoup the capitation payments in a timelier manner. The Agency will continue to monitor the recoupment process through the MMIS to ensure claims are identified by the TPL Vendor and recouped from providers.	September 1, 2008 Jennifer Barrett (850) 487-0925

Six-Month Status on Auditor General Report:
State of Florida Compliance and Internal Controls Over Financial Reporting and Federal Awards
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Six-Month Status as of: September 24, 2008

Issue #07-060	Recommendation	Management Response as of March 24, 2008	Management Response as of September 24, 2008	Anticipated Completion Date & Contact
		regarding the date of death of a Medicaid recipient. The Vendor's provider service center contacts the HMOs seven to ten days after the notice is mailed to ensure the HMOs have received the notice. In addition, seven to ten days prior to the closing of the project, the Vendor's provider service center contacts the HMOs again to advise the recoupment is about to occur. After the project closes, the Vendor prepares the claims for recoupment. Claims that are to be voided are submitted electronically directly to the Agency's fiscal agent. Claims that are more than 22 months old are submitted on paper. The electronic claims processing takes approximately two to three weeks for completion. The paper claims processing takes approximately thirty days. After the claims processing, the recovery is indicated on the HMO's remittance voucher. Below is a summary of the claims		

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Issue #07-060	Recommendation	Management Response as of March 24, 2008	Management Response as of September 24, 2008	Anticipated Completion Date & Contact
		identified through the audit. ITEM ISSUE AMOUNT 1. Claim/Provider Threshold $34,381.58 2. Claim Date More Than 180 Days After Date of Death $22,944.95 3. Posted After Audit Results Provided $523,398.19 4. Claims in Suspense – MMIS System $1,681,193.96 5. Vendor System Issue $521,084.96 6. Provider Type (72) Reviewed on an Annual Basis $89,539.59 TOTAL $2,872,543.23 1. Recovery thresholds have been established between the Agency and the Vendor. There is a threshold of $50.00 per claim for identification for recoupment and a provider level threshold of $500.00 for identification for		

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Issue #07-060	Recommendation	Management Response as of March 24, 2008	Management Response as of September 24, 2008	Anticipated Completion Date & Contact
		recoupment. 2. An assumption that the date of death is inaccurate is made for claims that are paid more than 180 days after the date of death. This is done to help ensure claims are not included for recipients where the date of death is inaccurate. 3. These claims have been posted to the MMIS system since identification during the audit. 4. Some claims identified by the Vendor were placed in suspense in the MMIS system during the recoupment process. This issue has been corrected and recoupment is in process. 5. A system issue was discovered by the Vendor where claims were not identified that should have been included in the recoupment process. The Vendor has corrected its system and these claims will be reviewed and recouped accordingly during the next cycle of the project. 6. On an annual basis, the Vendor reviews all provider types for		

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Issue #07-060	Recommendation	Management Response as of March 24, 2008	Management Response as of September 24, 2008	Anticipated Completion Date & Contact
		claims paid after the date of death. This provider type will be included when the review is done for fiscal year 07-08. A new Third Party Liability contract is scheduled to begin May 1, 2008. After execution of the new contract, the Agency will work with the TPL Vendor to review the above procedure to determine if there is a method to identify and recoup the capitation payments in a timelier manner. In addition, the Agency will review capitation payments on a periodic basis to ensure claims are identified and recouped. Due to the Agency's fiscal agent implementation, the Agency will also monitor the recoupment process through the MMIS to ensure claims identified by the TPL Vendor are recouped from providers.		

Six-Month Status on Auditor General Report:
State of Florida Compliance and Internal Controls Over Financial Reporting and Federal Awards
Report #2008-141 Issued: March 24, 2008
Six-Month Status as of: September 24, 2008

Issue #07-062	Recommendation	Management Response as of March 24, 2008	Management Response as of September 28, 2007	Anticipated Completion Date & Contact
FAHCA did not review and release certain audits of Intermediate Care Facilities for the Developmentally Disabled (ICF-DD) cost reports on a timely basis. Additionally, FAHCA had not resolved issues relating to ICF-DD facilities for which the independent auditors disclaimed an opinion on the cost reports.	We recommend that FAHCA devote the necessary efforts to ensure the timely completion and release of ICF-DD cost report audits and the resolution of the issues associated with the cost reports on which opinions had been disclaimed.	AHCA staff will continue to focus audit resources to complete the review and issuance of the older audits. From December 21, 2007 through February 19, 2008, 16 ICF-DD facility audits have been issued from the 2003-04 and 2004-05 fiscal years. Newer ICF-DD audits are being incorporated into the review process for nursing home audits. Medicaid management will continue to support audit efforts to attempt completion of the 19 disclaimed audits. A second information request was sent to the provider on January 25, 2008. Receipt of the requested information will begin the process to complete the disclaimed audits.	AHCA staff has continued to incorporate ICF-DD audits into the review process for nursing home audits. AHCA staff has reviewed additional information and plan to issue Schedule of Proposed Audit Adjustments for the nine disclaimed 6/30/2002 audits. The provider will be given 60 days to provide any additional information related to the proposed adjustments. Any additional information will be reviewed and final audits issued.	September 30, 2008 Lisa Milton (850) 487-1242