FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

CHARLIE CRIST
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
INTERIM SECRETARY

September 13, 2010

Elizabeth Dudek, Interim 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 Audit of *Agency for Health Care Administration Medicaid Payments and Related Controls* Report Number 2010-139, issued March 2010. 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 Damon Rodriguez at 412-3980.

Sincerely,

Pete Williams
Inspector General

PW/dr
Enclosure

cc: Kathy DuBose, Legislative Auditing Committee
Roberta Bradford, Secretary, Division of Medicaid

Agency For Health Care Administration
Bureau of Internal Audit
6th Month Follow Up Table
Auditor General Report #2010-139, Agency Operational – Medicaid Payments and Related Controls

Finding #1	Recommendation	Management Response as of February 19, 2010	Status as of August 19, 2010	Anticipated Completion Date & Contact
Because of claim payment system functionality issues, emergency payments totaling approximately $792 million were made to providers. These payments were made based on estimates rather than specific claims information submitted by the provider. Absent specific claims information and the Agency's preaudit of that information, whether by electronic or other means, the Agency was unable to demonstrate at the time of payment, on a claim-by-claim basis, that the providers were	The Agency should continue efforts to ensure that FMMIS payment issues are resolved so that Medicaid claims can be processed by FMMIS and subjected to the controls designed to prevent payment of unallowable claims. Additionally, the Agency should hold the contractor accountable for the timely resolution of the payment issues that are preventing providers from submitting claims through FMMIS. The Agency should also consider inclusion in future State Plans submitted for Federal review and approval,	The Agency has always pursued efforts to ensure that FMMIS payment issues are resolved as quickly and appropriately as possible. The Agency monitors and works with the contractor on a daily basis to hold the contractor accountable to timely resolutions of claims payment. The Agency has authority to make emergency payments through Florida statute. No additional provision to the State Plan is necessary. The Agency used several methodologies and analytical means to assess that the interim payments were legitimate, were to valid providers and would address provider claims that, at a point in time, the FMMIS was not capable of processing on a claim by claim basis, because of System processing errors occurring at transition. At present, the Agency has collected 99.2% of all the interim payments made through February 2010.	At present, the Agency has collected 99.33% of all the interim payments made since July 2008. As noted in #4 below, 217 of the Accounts Receivable (AR) balances were turned over to the Agency's Finance and Accounting Bureau for follow-up/ collection. Since February of 2010, the Agency has created only 13 ARs, and collected on all of them as of 7/31/2010, except the AR created 6/24/2010.	Complete Alan Strowd

Agency For Health Care Administration
Bureau of Internal Audit
6th Month Follow Up Table
Auditor General Report #2010-139, Agency Operational – Medicaid Payments and Related Controls

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qualified, benefitting recipients were eligible, and the charges for the medical services provided were valid and allowable Medicaid expenditures.	provisions to allow emergency payments to providers on a limited basis under specified circumstances.			

Agency For Health Care Administration
Bureau of Internal Audit
6th Month Follow Up Table
Auditor General Report #2010-139, Agency Operational – Medicaid Payments and Related Controls

Finding #2	Recommendation	Management Response as of February 19, 2010	Status as of August 19, 2010	Anticipated Completion Date & Contact
The Agency had not developed policies or procedures specifically related to the calculation of the amount of emergency payments.	The Agency should develop written policies and procedures for the calculation of emergency payments. In developing these policies and procedures, the Agency's policies and procedures should detail the methodology to be employed when calculating the payment amount as well as the types of Agency and provider documentation required.	In addition to responses to Auditor General "Memos of Understanding," the Agency provided documents that addressed both in general terms and specific circumstances, the procedures used to derive interim payments. The Agency has since formalized the general procedures used since July 2008 with a set of guidelines for subsequent use.		Complete (as of 2/19/2010) Alan Strowd

Agency For Health Care Administration
Bureau of Internal Audit
6th Month Follow Up Table
Auditor General Report #2010-139, Agency Operational – Medicaid Payments and Related Controls

Finding #3	Recommendation(s)	Management Response as of February 19, 2010	Status as of August 19, 2010	Anticipated Completion Date & Contact
The responsibility for the final authorization and approval of emergency payments was assigned to the same Agency staff that initiated and calculated the payments. Also, large payments were not subjected to additional levels of review and approval.	The Agency should establish policies and procedures regarding the identification, calculation, and authorization of emergency payments. These procedures should provide for adequate separation of duties between persons calculating, authorizing, and approving emergency payments.	Final authorization and approval was performed by the Medicaid Contract Management (MCM) Bureau Chief, with other MCM staff performing the calculations; large payments were reviewed and/or approved by the Assistant Deputy Secretary for Medicaid Finance or the Deputy Secretary for Medicaid.		Complete (as of 2/19/2010) Alan Strowd

Agency For Health Care Administration
Bureau of Internal Audit
6th Month Follow Up Table
Auditor General Report #2010-139, Agency Operational – Medicaid Payments and Related Controls

Finding #4	Recommendation(s)	Management Response as of February 19, 2019	Status as of August 19, 2010	Anticipated Completion Date & Contact
After an emergency payment had been issued to a provider, an account receivable was to be established and the provider was to be notified that recoupment of the emergency payment would occur in a recoupment period during which a certain percentage of each claim submitted by the provider would be held back and applied to the account receivable until	The Agency should enhance procedures to ensure that FMMIS is timely updated to record Medicaid Program provider terminations and that provider recoupment schedules are modified, as needed, to maximize the collection of outstanding receivable balances. Additionally, the Agency should initiate collection efforts for providers with an outstanding receivable balance that have either ceased billing the Medicaid Program or who have been terminated from the	The Agency, over the course of the months in which interim payments have been made, has reviewed the Accounts Receivables (AR) subsidiary accounts and sent out, on at least 3 occasions, various collection letters to providers identified as delinquent on repayment of their ARs to the State. This started on July 28, 2009.	The Agency has continued its collection efforts for these outstanding AR balances. In accordance with Agency policy, after attempting to collect these balances directly by issuing collection letters from the Bureau of Medicaid Contract Management, 217 ARs with uncollected balances that had no payments made were turned over to the Agency's Bureau of Finance & Accounting for collection pursuant to FAC Rule 69I-21.003.	Complete Alan Strowd

Agency For Health Care Administration
Bureau of Internal Audit
6th Month Follow Up Table
Auditor General Report #2010-139, Agency Operational – Medicaid Payments and Related Controls

Finding #4	Recommendation(s)	Management Response as of February 19, 2019	Status as of August 19, 2010	Anticipated Completion Date & Contact
the balance was offset. The Agency process for recouping emergency payments did not include provisions to timely identify and collect the balances due from those providers that did not file claims during the recoupment period.	Program.			

Agency For Health Care Administration
Bureau of Internal Audit
6th Month Follow Up Table
Auditor General Report #2010-139, Agency Operational – Medicaid Payments and Related Controls

Finding #5	Recommendation(s)	Management Response as of February 19, 2010	Status as of August 19, 2010	Anticipated Completion Date & Contact
According to the available performance reports, the Medicaid fiscal agent, Electronic Data Systems, Inc. (EDS), was not performing at contractually required levels. Additionally, the Agency was not timely reviewing and scoring levels of contractor performance.	In order to effectively monitor contractor performance, the Agency should timely review and score contractually required performance measures and take punitive actions, including the assessment of liquidated damages, for nonperformance. The Agency should also consider requiring the contractor to submit performance measures that address whether claims are accurately processed.	The Agency established a "Report Card" monitoring tool as a component of the Request for Proposal (Contract). Agency staff were involved with fiscal agent transition issues and very intensely monitored the change from the old, outdated FMMIS to the new architecture FMMIS, and the transition between fiscal agent operations and staff. Report card monitoring is an evolving activity, and at present the Agency is now "caught-up" with the monthly report cards.		Complete (as of 2/19/2010) Alan Strowd

Agency For Health Care Administration
Bureau of Internal Audit
6th Month Follow Up Table
Auditor General Report #2010-139, Agency Operational – Medicaid Payments and Related Controls

Finding #6	Recommendation(s)	Management Response as of February 19, 2010	Status as of August 19, 2010	Anticipated Completion Date & Contact
Reporting requirements were not sufficient to allow the Agency to effectively monitor subcontractor performance.	The Agency should enhance subcontractor monitoring by requiring that data pertaining to the accuracy of claims processed by the subcontractor's pharmacy benefits system be reported to the Agency at required intervals.	The Agency receives a variety of reporting tools from the contractor and subcontractor regarding the pharmacy benefits management (PBM) component of operation. The Agency's Pharmacy Bureau reviews those reports on a daily and weekly basis. The Agency will review the possibility of adding a unique Report Card to the existing 10+ cards in use today that addresses the PBM operations separately.	MCM has continuously maintained a Report Card for the Pharmacy Area. MCM staff monitor the statistics for the calls, average speed of answer, blockage, etc., for all the pharmacy call centers; MCM also monitors system down time and listens to calls for accuracy. While there is not an item on the Report Card that monitors accuracy of claims processing, per se, there are many reports generated through On-Base that address the processing results for pharmacy claims. Staff in the Pharmacy, Program Analysis and MPI Bureaus have access to these reports, from "Pay/Deny" reports to a variety of trend reports that would indentify claims accuracy processing questions. Staff in these bureaus also have access to DSS to create unique queries that fine-tune trending issues and examine any anomalies identified on trending reports.	Complete Alan Strowd

Agency For Health Care Administration
Bureau of Internal Audit
6th Month Follow Up Table
Auditor General Report #2010-139, Agency Operational – Medicaid Payments and Related Controls

Finding #7	Recommendation(s)	Management Response as of February 19, 2010	Status as of August 19, 2010	Anticipated Completion Date & Contact
Controls were not sufficient to ensure that Medicaid claims submitted to the Florida Medicaid Management Information System (FMMIS) were paid in accordance with applicable laws, rules, and regulations.	The Agency should ensure that, in accordance with State law, Medicaid claims are paid only to providers with valid provider agreements in place. Additionally, the Agency should develop Coverage and Limitation Handbooks for all Medicaid service types and improve automated edits and related procedures to ensure that claims are processed in accordance with applicable Medicaid policies and fee schedules.	The new FMMIS was installed effective June/July 2008. A large component of the transition, which includes design, development, and implementation (DDI) also, includes conversion--the transfer of coding and logic from the old MMIS architecture to the new architecture. The DDI effort was designed to review that conversion, all 16 billion records, to assess the success of that effort. Multiple forms of testing were created and the Agency, as well as other entities, set parameters of test completion and success prior to a go-live date for transition. Under all these circumstances the Agency made the transition, and while a small percentage of the thousands of controls were found to not perform as expected, the vast majority were sufficient and replicated the controls in the old FMMIS--all designed to ensure claims are paid in accordance with	The Agency has worked with providers of Targeted Case Management for Children At Risk of Abuse and Neglect to revise policy in preparation for promulgating a Coverage and Limitations Handbook for this service. The draft handbook will soon be routed within the Agency in anticipation of entering the Rule Development phase. We expect a promulgation date in early 2011. The Child Health Services Targeted Case Management handbook is entering the Proposed Rule phase and is expected to be promulgated by the end of 2010. Familial Dysautonomia Waiver handbook is under development. It has been delayed by staff turnover. We project it will be promulgated in Spring 2011.	In Progress Beth Kidder

Agency For Health Care Administration
Bureau of Internal Audit
6th Month Follow Up Table
Auditor General Report #2010-139, Agency Operational – Medicaid Payments and Related Controls

Finding #7	Recommendation(s)	Management Response as of February 19, 2010	Status as of August 19, 2010	Anticipated Completion Date & Contact
		applicable laws, rules, and regulations. The Agency has now resumed its provider re-enrollment efforts with the contractor (delayed because of several previous contract extensions with the prior contractor, due to legal protests associated with the contract award, etc), and the new automated approach will ensure valid, current provider agreements are in place. Coverage and Limitations handbooks are promulgated for all but three applicable Medicaid services. Each of the three are already in development and are expected to begin rule promulgation by the dates in the next column. These handbooks will always continue to address edits, audits and controls applicable to appropriate claims processing.		