RICK SCOTT
GOVERNOR

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

ELIZABETH DUDEK
SECRETARY

September 24, 2013

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

Dear Secretary Dudek,

Enclosed please find our six-month status report on the Auditor General's *State of Florida Compliance and Internal Controls Over Financial Reporting and Federal Awards,* Report Number 2013-161, issued March 2013. 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: Six-Month Status Report of AG Report# 2013-161
cc/enc: Kathy DuBose, Joint Legislative Auditing Committee
Justin Senior, Deputy Secretary, Division of Medicaid
Tonya Kidd, Deputy Secretary, Division of Operations
Molly McKinstry, Deputy Secretary, Division of Health Quality Assurance

Florida Agency for Health Care Administration
AG 11-12 Federal Awards Audit (Report# 2013-161)
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Finding# FS 12-001	Recommendation	Management Response as of March 18, 2013	Status of Finding as of September 24, 2013	Comments and Agency Contact
The FAHCA Bureau of Finance and Accounting (Bureau) did not follow established fiscal year-end procedures to record adjustments to Claims payable and Expenditures causing a material overstatement of these accounts in the General Fund.	We recommend that the Bureau enhance controls to provide additional assurance that fiscal year-end procedures for recording Medicaid claims payable and the related expenditures are followed.	Several key finance and accounting positions were vacated during the fiscal year closing timeframe which resulted in some oversights. The adjusting entries for Claims payable were completed for the trust funds but inadvertently overlooked for the General fund. Subsequently, the post-closing adjusting entries were completed for the General fund. The year-end checklist will be modified to identify each fund to be included in the process. **Estimated Corrective Action Date** Post-closing adjusting entry was completed December 10, 2012. Checklist will be completed by May 1, 2013.	Fully Corrected	The year-end checklist was modified to identify the adjusting entries for each agency trust fund. The checklist was updated prior to May 1, 2013. Anita Hicks (850) 412- 3815

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Finding# FS 12-002	Recommendation	Management Response as of March 18, 2013	Status of Finding as of September 24, 2013	Comments and Agency Contact
The FAHCA Bureau of Finance and Accounting (Bureau) incorrectly recorded deferred revenues for financial resources related to incurred-but-not-reported (IBNR) Medicaid claims liabilities as noncurrent deferred revenue rather than current deferred revenue. The Bureau also calculated the Federal share using an incorrect Federal Medical Assistance Percentage (FMAP).	We recommend that the Bureau establish a more thorough supervisory review of the work done in connection with the fiscal year-end close-out procedures related to the State's IBNR Medicaid claims.	Several key finance and accounting positions were vacated during the fiscal year closing timeframe which resulted in some oversights. The noncurrent deferred revenue code was inadvertently used instead of the current deferred revenue code. The financial statement checklist will be modified to specify that this entry should be considered current deferred. The incorrect FFP was used in the calculations. The checklist will be modified to include that the FFP should be the upcoming Federal Fiscal Year's FFP. **Estimated Corrective Action Date** The checklist will be completed by May 1, 2013.	Fully Corrected	The financial statement checklist was modified to ensure IBNR claims are reported correctly. The checklist was modified to include that the FFP should be the upcoming federal fiscal years' FFP. The checklist was updated prior to May 1, 2013. Anita Hicks (850) 412- 3815

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Finding# FS 12-009	Recommendation	Management Response as of March 18, 2013	Status of Finding as of September 24, 2013	Comments and Agency Contact
When determining the amount due from the Federal government at year-end, FAHCA did not take into consideration all post-closing adjustments. Also, FAHCA did not retain documentation supporting certain amounts recorded in accounts receivable and applied an incorrect Federal Medical Assistance Percentage (FMAP) to receivables, the allowance for doubtful accounts, and expenditures.	We recommend that FAHCA establish a more thorough supervisory review to ensure that all post-closing adjustments are considered when establishing net receivables, supporting documentation is retained for all refunds and changes in allowance for doubtful accounts, and the correct FMAP is applied.	Several key finance and accounting positions were vacated during the fiscal year closing timeframe which resulted in some oversights. Regarding the Third Party Liability differences noted above, it appears that information provided via a disk for Medicaid Program Integrity cases was not included thus resulting in a perceived understatement. The checklist includes the calculations for doubtful accounts, however, the specific calculations may vary based on a variety of factors including professional judgment and knowledge of specific situations related to uncertain ability to collect that may occur during the year. Specific factors considered when determining the allowance for doubtful accounts included the age and nature of the balances included in FMMIS, a large claim reprocessing effort that may result in unrecoverable balances recorded in FMMIS and unrecovered balances identified in previous Federal findings. The estimated unrecoverable balance associated with these last two items alone at fiscal year-end exceeded 5 percent of the outstanding balance in FMMIS thus the increase in the calculation for doubtful accounts. The checklist will be modified to identify that	Fully Corrected	The financial statement checklist was updated to ensure these activities are handled correctly. The checklist was updated prior to May 1, 2013. Anita Hicks (850) 412- 3815

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Finding# FS 12-009	Recommendation	Management Response as of March 18, 2013	Status of Finding as of September 24, 2013	Comments and Agency Contact
		the upcoming Federal Fiscal Year's FFP should be used in these calculations. **Estimated Corrective Action Date** Checklist will be completed by May 1, 2013.		

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Finding# FS 12-013	Recommendation	Management Response as of March 18, 2013	Status of Finding as of September 24, 2013	Comments and Agency Contact
The FAHCA prepared the Schedule of Expenditures of Federal Awards (SEFA) data file using the cash basis of accounting, contrary to instructions from the Florida Department of Financial Services (FDFS). Additionally, the SEFA data file submitted to the FDFS did not include all American Recovery and Reinvestment Act (ARRA) expenditures or amounts subgranted to other entities.	To ensure that information reported on the SEFA is accurate and complete, the FAHCA should develop and implement policies and procedures specific to their records and processes and update those procedures annually to reflect the FDFS' SEFA instructions.	Several key finance and accounting positions were vacated during the fiscal year closing timeframe which resulted in some oversights. The original submission used the accrual basis for revenues, but inadvertently used cash basis for expenditures. Additionally, the ARRA was omitted on the original submission but included in the revised submission. The report was revised using the accrual basis for expenditures and was resubmitted on December 12th. **Estimated Corrective Action Date** The staff has had several training sessions with bureau management and desk top procedures have been drafted and will be reviewed by the section manager and finalized by the end of January 2013.	Fully Corrected	A revised report was submitted on December 12, 2012. Staff has attended a training session and desk procedures have been developed. Anita Hicks (850) 412- 3815

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Finding# FA 12-035	Recommendation	Management Response as of March 18, 2013	Status of Finding as of September 24, 2013	Comments and Agency Contact
The FAHCA did not ensure that amounts were accurately reported on the Cash Management Improvement Act (CMIA) Annual Report to the Florida Department of Financial Services (FDFS).	We recommend that the FAHCA enhance its policies and procedures to ensure that cash draws are accurately recorded, and reported on the CMIA report. In addition, the FAHCA should use the Federally approved FMAP rates when determining the Federal portion of the balances in the MAP and SPIA bank accounts. We also recommend that more care be taken during the supervisory review of the CMIA report prior to its submission to the FDFS.	FAHCA concurs with the finding in that there were errors in how the amounts were classified on the Cash Management Improvement Act Report for State Fiscal Year 2010-11, and the first level of review should have been more detailed. However, in qualifying the conditions represented in this finding, and in order to formulate an accurate response, our review disclosed the impact of the report errors. Specifically, we found that the impact of the classification of the cash draws and refund classifications as reported to the FDFS reveals that the FAHCA incurred an overstated liability of $64.43. **Estimated Corrective Action Date** Procedures were improved and put in place to ensure that amounts, rates, methodologies and calculations will be accurate in future reports as well as performing additional managerial reviews - October 31, 2012.	Fully Corrected	Procedures were improved and put in place to ensure amounts, rates, methodologies and calculations will be accurate in futures reports, along with additional managerial reviews. Completed October 31, 2012. Anita Hicks (850) 412- 3815

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Finding# 12-045	Recommendation	Management Response as of March 18, 2013	Status of Finding as of September 24, 2013	Comments and Agency Contact
Refugee Medical Assistance (RMA) claim payments made to providers were not always paid in accordance with established Medicaid policy.	We recommend that the FAHCA ensure that appropriate electronic or manual controls are in place and operating effectively to ensure RMA claims are accurately and properly processed.	For the payments charged against a terminated provider number, this provider also had an active provider Medicaid ID, an active NPI and an active Tax ID. They also had an inactive FSS ID that was used inadvertently in the claims processing. Since our financial system pays off of Tax ID, they went through and paid with what appeared to be a 'bad' provider ID. This pharmacy was legitimately paid and provided covered services. After discussion between AHCA MCM, HP, and Magellan, we determined to leave the claims "as is" since attempting to make any adjustments would leave negative balances out against inactive numbers and be more confusing than leaving them alone. This provider was also closed out retroactively back to 7/20/09 but this update did not occur until mid-last year. There were no one cent overpayments on claims. Fee schedules are manually prepared separate from rate methodologies that are loaded into the system. Florida Medicaid considers that the fees that are loaded into FMMIS are carefully considered when incorporated into FMMIS and are correct. Rounding errors on the fee schedules result from attempts to duplicate claim	Fully Corrected Partially Corrected	**One cent over max**: Claim paid amount calculated by FMMIS is correct. Fee schedules are corrected and procedures are in place to prevent future occurrences. **Copayment:** Programming request (CSR 2250) submitted July 9, 2012, has not been implemented. Once the correction to FMMIS has been implemented, claims will be reprocessed. Monty McCullough (850) 412- 4003

Finding# 12-045	Recommendation	Management Response as of March 18, 2013	Status of Finding as of September 24, 2013	Comments and Agency Contact
		adjudication with formulas that may have been previously built into the rate schedules when they are updated. Florida Medicaid continues to work on processes that most accurately reflect the rates on the fee schedules with the rate loaded in FMMIS. The Agency is working to ensure that fee schedules have the accurate rates reflected and that incorrect formulas that are carried over on fee schedules are removed. For claims with multiple dates of service, and the recipient is not in a category for exemption, one copayment was deducted for multiple dates of service. AHCA has written a Customer Services Request (CSR) to research the way copays are applied and to correct any logic where necessary, including this known issue. **Estimated Corrective Action Date** Research for the copayment issue should be completed October 13, 2013.		

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Finding# 12-053	Recommendation	Management Response as of March 18, 2013	Status of Finding as of September 24, 2013	Comments and Agency Contact
The FAHCA made payments to providers on behalf of ineligible CHIP recipients.	We recommend that the FAHCA continue its efforts to amend the State Plan and, once amended, invoke the provisional CHIP eligibility as proposed.	At the time the MediKids CHIP payments were made for the three recipient payments cited, each child only had MediKids coverage and the payment was made appropriately. Each child later became eligible for Medicaid, and Medicaid coverage was made retroactive to the month previously covered by MediKids. The children ended up dually enrolled in both programs, but payment was only made by CHIP. It is noted that for two of the three errors cited, the child was not dually enrolled for the audit month, but was dually enrolled in a subsequent month. The state sought guidance from CMS and has been engaged in discussions with CMS to resolve this issue. CMS suggested the state submit a State Plan Amendment requesting the authority to consider the dual enrollment months as CHIP provisional coverage, which allows the CHIP payment to remain a valid CHIP expenditure. State Plan Amendment (SPA) #23 was submitted to CMS on October 5, 2012, with an effective date of October 1, 2012. Subsequently, CMS issued a stop the clock letter with clarifying questions. Staff of FAHCA submitted a draft response to CMS, and on February 14, 2013, they	Fully Corrected	CHIP State Plan Amendment (SPA) #23 was approved by CMS on 4/1/2013 with an effective date of 10/1/2013. Through this SPA, the state adopted the policy of provisional CHIP eligibility for up to 60 days for children identified as potentially Medicaid eligible during the eligibility redetermination process. The audit finding involved CHIP MediKids recipients who were referred to Medicaid due to a decrease in income. At the time the CHIP MediKids payments were made for the recipient payments cited, each child only had MediKids coverage and the payment was made appropriately. When the Medicaid eligibility determination was made, Medicaid coverage was made retroactive to the month previously covered by MediKids. The children were dually enrolled in both programs, but payment was only made by CHIP. SPA #23 allows the child to be provisionally CHIP eligible from the time a referral is made to Medicaid until the Medicaid eligibility determination is made, up to 60 days. This makes the CHIP payments allowable that were made during this period. Gail Hansen

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		provided a few recommendations for our official response. Our official response to the stop the clock letter is routing for the Deputy Secretary for Medicaid's signature, and will then be submitted to CMS for final consideration. It is expected that SPA #23 will be approved soon. **Estimated Corrective Action Date** March 2013 - Anticipated date of State Plan Amendment #23 approval.		(850) 412-4195

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Finding# 12-056	Recommendation	Management Response as of March 18, 2013	Status of Finding as of September 24, 2013	Comments and Agency Contact
The FAHCA and the FDOH did not report applicable CHIP subaward data in the Federal Funding Accountability and Transparency Act (FFATA) Subaward Reporting System (FSRS) pursuant to Federal regulations.	We recommend that the FAHCA and the FDOH ensure that all key data elements are timely reported in the FSRS.	FAHCA concurs with the findings. The interpretation upon initial review of the Federal guidance at the original point of reporting, by the Medicaid Program Office Contract Manager and Finance and Accounting staff, was that reporting would not be required based on not meeting all of the criteria in the guidance. **Estimated Corrective Action Date** Grant reporting procedures will be amended to include the requirement to report data identified in FFATA regulations. The data that should have been reported will be entered on the FFATA on-line reporting site. Any new data, covered in FFATA regulations, will also be updated. Data required for reporting by FFATA regulations will be monitored on an on-going basis and updated as required. Corrective action should be completed by March 30, 2013.	Fully Corrected	Corrective action was taken and completed by March 30, 2013. The Florida Department of Health also now has a process to access the FSRS system to ensure compliance with FFATA. Anita Hicks (850) 412- 3815

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Finding# 12-057	Recommendation	Management Response as of March 18, 2013	Status of Finding as of September 24, 2013	Comments and Agency Contact
Medical service claim payments made to providers of Medicaid services were not always paid in accordance with established Medicaid policy and fee schedules. Specifically, some payments were for improper amounts or for unallowable services.	We recommend that the FAHCA ensure that appropriate electronic or manual controls are in place and operating effectively to ensure that Medicaid claims are accurately and properly processed.	Incorrect payments for certain crossover claims are a known issue and FAHCA is working on a system solution and a plan for correcting overpayments. For recipients who are not exempt from the copayment requirements, AHCA has written a Customer Services Request (CSR) to research this known issue and will correct any incorrect logic where necessary. There were no one cent overpayments on claims. Fee schedules are manually prepared separate from rate methodologies that are loaded into the system. Florida Medicaid considers that the fees that are loaded into FMMIS are carefully considered when incorporated into FMMIS and are correct. Rounding errors on the fee schedules result from attempts to duplicate claim adjudication with formulas that may have been previously built into the rate schedules when they are updated. Florida Medicaid continues to work on processes that most accurately reflect the rates on the fee schedules with the rate loaded in FMMIS. FAHCA is working to ensure that fee	Fully Corrected Partially Corrected Fully Corrected Fully Corrected	**Finding 1: Crossover :** The Provider General Handbook has been promulgated by rule, and the Agency continues to identify crossover claims which may have been paid inappropriately. Monty McCullough (850) 412-4234 **Finding 2: Copayment:** Programming request (CSR 2250) submitted July 9, 2012, has not been implemented. Once the correction to FMMIS has been implemented, claims will be reprocessed. Monty McCullough (850) 412-4234 **Finding 3: Fee schedules - one cent over max:** Claim paid amount calculated by FMMIS is correct. Fee schedules are corrected and procedures are in place to prevent future occurrences. Monty McCullough (850) 412-4234 **Finding 4: Capitation payments:**

Finding# 12-057	Recommendation	Management Response as of March 18, 2013	Status of Finding as of September 24, 2013	Comments and Agency Contact
		schedules have the accurate rates reflected and that incorrect formulas that are carried over on fee schedules are removed. In regard to FMMIS processing one capitation payment for one cent over and three payments for one cent less than the approved Medicaid capitation rate, these differences were caused by a rounding error that has been addressed in the system. For Home Health Services: We performed a random sampling of claims. Our findings indicated that the claims paid appropriately. The services approved through the Quality Improvement Organization (QIO) must have a prior authorization (PA) on the claim. The only exception is the claims for Home Health Services that are approved for personal care services by the Agency for Persons with Disabilities (APD) for recipients on the Developmental Disabilities Waivers. They do not have to have a PA number on the submitted claim. Services approved via the QIO are processed based on the number of units	Fully Corrected	In regard to FMMIS processing one capitation payment for one cent over and three payments for one cent less than the approved Medicaid capitation rate, these differences were caused by a rounding error that has been addressed in the system to prevent future occurrences. Melanie Brown –Woofter (850) 412-4028 **Finding 5: Home Health Services:** Our findings indicated that the claims were paid appropriately. Although the prior authorization (PA) number was not on the claim for some of these services, the paper claims included the PA numbers for the following: 1. The one hour issue (11pm – midnight) which was force paid by AHCA's area offices through paper claims. 2. Provider Service Network claims which were authorized by the PSN. 3. Children's Medical Services (CMS)-PSN claims which were authorized and processed through the CMS-PSN. 4. PSN-Reform health plan claims manually processed through the Agency's fiscal agent.

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		and the Max Fee assigned to that procedure code. The edit to require prior authorization for the personal care services procedure codes was enabled on July 28, 2011. MPI initiated recoupment efforts on the claims that were already submitted. This project's recoupment was not being accomplished through voiding of claims; therefore, all of the claims that were originally identified as being without the required prior authorization number would still appear in claims history – unless the provider voided the claims themselves. We did not instruct the providers to void the claims. Although the PA number was not on the claim for some of these services, the paper claims had PA numbers on them: ☐ Providers with the recipients that were authorized for services but were unable to bill related to the one hour issue, submitted paper claims that were force paid. The PA number was on the paper claim. ☐ The FMMIS does not track home health services prior authorization numbers for the Provider Service Network claims, which are billed fee for	Fully Corrected	This finding does not warrant further action for Home Health Services. The Home Health Services Coverage and Limitations Handbook has been updated to remove the 2 hour minimum for personal care and private duty nursing services (to allow the one hour billing) and was effective on June 25, 2013. Claire Anthony-Davis (850) 412-4266 **Finding 6: Hospital Services:** A programming request (CSR 2052) was submitted on March 21, 2011, to remedy the issue of inpatient claims being paid in excess of 45 days. As a result of this CSR, 15 CO's were created, with the last CO installed on July 12, 2013. System programming has been completed, and the issue has been fully corrected. Ronique Scorsone (850) 412-4281

Finding# 12-057	Recommendation	Management Response as of March 18, 2013	Status of Finding as of September 24, 2013	Comments and Agency Contact
		service if the plan is non-capitated, which most of them are. ☐ Private duty nursing services provided to a recipient enrolled in a CMS-PSN are authorized and processed through the CMS-PSN. These claims do not require approval by the QIO reviewer contracted with the Agency. ☐ For the recipients enrolled in a PSN-Reform health plan, paper claims were manually processed for payment by the Agency's fiscal agent. There is sufficient evidence that the services were prior approved by the PSN Reform plan. There was a prior authorization number on the claim and the PSN's "stamp" of approval. Because the claim had a PSN stamp of approval, it is likely that the fiscal agent staff assumed that it was appropriate for payment. We do not recommend that these claims be reprocessed because they were prior approved by the PSN. INPATIENT CLAIMS PAID IN EXCESS OF 45 DAYS: The Agency will investigate the QIO and MMIS systems to determine where the error may be occurring: provider billing error, limit calculation, or prior authorization		

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		programming. The 162 claims will be carefully reviewed to determine an appropriate claim status and reimbursement. System corrections will be made where appropriate. **Estimated Corrective Action Date** Home Health services: April 2013 INPATIENT CLAIMS PAID IN EXCESS OF 45 DAYS: June 1, 2013 60 days for QIO and Agency to review processing of BBA claims in systems 30 days for thorough review of the 162 claims in question		

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Finding# 12-058	Recommendation	Management Response as of March 18, 2013	Status of Finding as of September 24, 2013	Comments and Agency Contact
Controls were not sufficient to ensure that amounts paid by the FAHCA to the Commission for the Transportation Disadvantaged (CTD), or amounts paid by the CTD to transportation providers under a Medicaid transportation program, were reasonable.	We again recommend that current transportation costs be summarized and used to evaluate the reasonableness of the total NET Program contract amount, as well as the amounts to be allocated to the to the CTD and STPs for administrative costs. We also recommend that the FAHCA establish adequate monitoring procedures that include the performance of periodic monitoring of the CTD, timely provision of the results of the monitoring activities, and follow-up on any deficiencies noted during monitoring. In addition, the CTD should establish monitoring procedures to require the periodic review of STP operations, provision of the monitoring results to the STPs, and follow-up on any deficiencies noted during monitoring.	Section 427.013(8)(a), Florida Statute requires FAHCA to contract with the CTD for NET services without negotiating with other providers unless the FAHCA and the CTD mutually agree that the CTD is unable to provide those services. Therefore, the FAHCA does not have competitive data to compare to the CTD contract to determine cost effectiveness. FAHCA conducted onsite contract monitoring at the CTD office on July 18-19, 2012. The monitoring tool was organized into 11 performance components to evaluate vendor contract compliance. The CTD has been encouraged to engage in the same monitoring activities. **Estimated Corrective Action Date** March 2013 - follow-up CTD onsite contract monitoring.	Fully Corrected	The CTD provided financial statements which indicate the amounts paid by the CTD to transportation providers were reasonable. The Agency has updated the contract monitoring tool as a control to ensure the amount paid to the CTD was appropriate. Ronique Scorsone (850) 412-4281

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Finding# 12-059	Recommendation	Management Response as of March 18, 2013	Status of Finding as of September 24, 2013	Comments and Agency Contact
The FAHCA could not provide documentation to support all Disproportionate Share Hospital (DSH) payments.	We recommend that the FAHCA maintain supporting documentation for all DSH payments.	The LIP/ DSH unit does keep copies of payments processed through our unit and will continue the practice as part of our checks and balances for each program. One DSH payment was not located during the AG audit. We believe the paper work was misfiled during our unit relocation from the second floor to the third floor. **Estimated Corrective Action Date** Please note that currently we keep paper copies of all payments processed from our unit. We will continue this practice and it is currently ongoing.	Fully Corrected	This issue has been fully corrected. We keep copies of all payments. Lecia Behenna (850) 412-4130

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Finding# 12-060	Recommendation	Management Response as of March 18, 2013	Status of Finding as of September 24, 2013	Comments and Agency Contact
The FAHCA did not have effective procedures in place to prevent duplicate processing of Low Income Pool (LIP) payments.	We recommend that the FAHCA continue to ensure that the correct amounts are paid to the LIP providers and take actions to recoup the outstanding overpayments.	Concur. Once Agency staff became aware of the duplicate entries, actions were taken to either recoup the duplicate payments within the same financial cycle or to void and reissue the payments in the correct amounts for the vast majority of this amount, thereby preventing the issuance of the duplicate payments to the providers. The Agency entered into an agreement with the Florida Department of Health in which the remaining $234,513 will be recouped from their next LIP payment. The Agency requested a Corrective Action Plan from the contractor in January 2012 in which procedures were revised to eliminate e-mail requests, as noted above. **Estimated Corrective Action Date** Completed.	Fully Corrected	The unrecouped payments identified in the finding have been fully recouped in accordance with the agreement between the Agency and the Florida Department of Health. Brian Meyer (850) 412-3446

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Finding# 12-061	Recommendation	Management Response as of March 18, 2013	Status of Finding as of September 24, 2013	Comments and Agency Contact
The FAHCA did not always maintain appropriate records to support the salary and benefits costs charged to the Medicaid Program.	We recommend that the FAHCA strengthen its procedures to ensure that salary and benefits costs charged to Federal programs are supported by periodic certifications.	We concur that position certifications for two employees could not be located in the files. However we do believe that the positions supported the Medicaid program as we do have the certifications, for the employees in question, for the bi-annual period before and after the period of time tested. We are re-sending the missing certifications to the appropriate offices to be signed, returned and added to the applicable file. **Estimated Corrective Action Date** The procedures will be modified to include escalation steps when certifications are not received timely from the office managers, effective with the distribution of the April 2013 position certifications.	Fully Corrected	Procedures were modified to include escalation steps when certifications are not received timely from office managers. This procedure became effective April 2013. Anita Hicks (850) 412- 3815

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Finding# 12-062	Recommendation	Management Response as of March 18, 2013	Status of Finding as of September 24, 2013	Comments and Agency Contact
The FAHCA continued to record expenditures to incorrect appropriation categories in the State's accounting records.	We recommend that FAHCA ensure that expenditures are accurately recorded in the State's accounting records. We also recommend that FAHCA continue to pursue the necessary actions to ensure that funds are available in the appropriate categories.	As indicated above, the total amounts recorded in the Medical Services appropriations are correct. Our procedures are to make the initial disbursement from as few categories as possible and follow-up with an adjusting journal transfer. However, charges totaling $1,261,446.23 should have been moved out of Hospital Inpatient charges but were not. This charge will be moved as applicable. Our procedures had already been modified for the current fiscal year to ensure there is review and reconciliation of these transactions each week, to ensure all transactions are processed appropriately and timely. **Estimated Corrective Action Date** We will continue to pursue the necessary actions to ensure funds are available in the appropriate categories. Additionally, the review process by supervisors will continue to include verification that the full amount of the adjusting entry was completed.	Partially Corrected	Our procedures have been modified to ensure there is a review and reconciliation of these transactions each week to ensure transactions are processed appropriately. The Agency will have to pursue the necessary permission from the Florida Legislature to move appropriations around to where the expenditures occurred. Anita Hicks (850) 412- 3815

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Finding# 12-063	Recommendation	Management Response as of March 18, 2013	Status of Finding as of September 24, 2013	Comments and Agency Contact
The FAHCA did not maintain documentation evidencing that contract monitoring activities were performed for the contractor responsible for administering the State's Medicaid Drug Rebate Program.	We recommend that the FAHCA perform and document contract monitoring activities in accordance with the contract monitoring plan.	Although the Bureau of Pharmacy Services staff were able to produce documentation of receipt and approval of the reports according to the Contract Monitoring Plan, we understand that this documentation was not deemed sufficient by the auditors. The contract manager will work with the Agency's contracting professionals to devise documentation that will meet the audit requirements and implement use of the documentation on an ongoing basis. **Estimated Corrective Action Date** On-going.	Fully Corrected	The Monitoring Plan has been modified to show that monitoring activities are continuous throughout the term of the contract. All correspondence pertaining to monitoring is placed, as documentation, in a separate monitoring file. Michael Alsentzer (850) 412-4148

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Finding# 12-064	Recommendation	Management Response as of March 18, 2013	Status of Finding as of September 24, 2013	Comments and Agency Contact
The FAHCA had not resolved issues related to the determination and return of overpayments for Medicare outpatient hospital crossover claims as identified in the Florida Auditor General's report on Florida Medicaid Management Information System (FMMIS) Controls and the Prevention of Improper Medicaid Payments (report No. 2012-021). In our report No. 2012-021, finding No. 3, we identified improper payments for Medicare outpatient hospital crossover claims. The projected overpayments totaled $117,659,683 for the 2007-08, 2008-09, and 2009-10 State fiscal years. The United States Department of Health and Human Services (USDHHS) issued a resolution letter (CIN Number: A-04-12-18633, dated May 4, 2012) that identified $117,659,683 in questioned costs and recommended that the	We recommend that the FAHCA determine and return unallowable costs, as appropriate.	FAHCA is in the process of initiating recoupment efforts of improper payments for Medicare outpatient hospital claims. **Estimated Corrective Action Date** August 2013 (6 months), for resolution of the 2007-2010 State Fiscal Year Outpatient Hospital Crossover claim overpayments.	Partially Corrected	The Provider General Handbook has been promulgated in rule. The Agency will begin identifying overpayments and recouping reimbursement for those claims per handbook regulations. Claims will be reprocessed by December 31, 2013, with full recoupment by December 31, 2014. Ronique Scorsone (850) 412-4281

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Finding# 12-064	Recommendation	Management Response as of March 18, 2013	Status of Finding as of September 24, 2013	Comments and Agency Contact
FAHCA determine the amount of overpayments and return those amounts to USDHHS. As of January 23, 2013, the FAHCA had not determined the amounts or returned the overpayments.				

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Finding# 12-066	Recommendation	Management Response as of March 18, 2013	Status of Finding as of September 24, 2013	Comments and Agency Contact
The FAHCA had not documented that the State met the matching requirements of the Medicaid Program for the 2010-11 Federal fiscal year (FFY). Additionally, the FAHCA's matching requirement calculations were not adequately supported, accurately prepared, or properly reviewed and approved.	We recommend that the FAHCA implement policies and procedures detailing the method for calculating, documenting, and verifying the Medicaid Program State match. We also recommend that the FAHCA document the review and approval of the Medicaid State match calculations.	While there was supervisory review, we concur that it was not documented on the worksheet. We also concur that the procedures for preparing the State match calculations were not well documented. We are modifying the procedures to define how the match calculations are derived, sources of financial data, exhibits of screen shots and examples of presentation. Additionally, the spreadsheet will include documentation of management review and approval. The FLAIR reports are the basis of the calculations. FLAIR is the official State accounting system in which the cash disbursements and receipts are reconciled to the Department of Financial Services records. The review of the CMS-64, line 11 determined that the sum of the Federal expenditures was less than the amounts recorded in FLAIR. We will include the step to reconcile CMS-64 line 11 to the FLAIR data for future state match calculations. The back-up documentation for the FFY 2010-11 state match calculations was provided to the audit staff subsequent to the initial review. **Estimated Corrective Action Date**	Fully Corrected	Procedures were completed in March 2013. Supporting documentation will be filed and available for review when the match calculations are prepared. Anita Hicks (850) 412- 3815

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Finding# 12-066	Recommendation	Management Response as of March 18, 2013	Status of Finding as of September 24, 2013	Comments and Agency Contact
		Revised procedures will be completed by March 30, 2013. Supporting documentation will be filed and available for review when the match calculations are prepared.		

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Finding# 12-067	Recommendation	Management Response as of March 18, 2013	Status of Finding as of September 24, 2013	Comments and Agency Contact
The FAHCA made payments to an ineligible provider.	We recommend that the FAHCA ensure that payments are made only to providers with Medicaid Provider Agreements in effect.	The Agency traditionally re-enrolls providers every 5 years which typically coincides with fiscal agent contract renewals. For a variety of reasons, the most recent fiscal agent contract change was delayed and reenrollment efforts were suspended. Because of the delay surrounding reenrollment efforts, some agreements did expire between the last reenrollment tasks for the prior fiscal agent and the resumption of reenrollment tasks under the current fiscal agent. The reenrollment process was automated in 2011 with subsequent enhancements added to restrict claims for any provider whose agreement has expired prior to completion of the reenrollment process. This prevents payments from being issued to providers with expired agreements. **Estimated Corrective Action Date** This is a repeat finding on an issue that has already been corrected.	Fully Corrected	Significant FMMIS modification was completed in 2011 to automate the renewal process for Medicaid providers. Any provider who fails to complete a timely renewal is automatically restricted and all claims suspended pending completion of the renewal. This ensures no payments are issued to a provider without a valid agreement. After the coding was installed, the FAHCA completed a renewal for each active provider with an expired agreement. The example in this finding pre-dates completion of that renewal period. No further action is required of the FAHCA. Shawn McCauley (850) 412-3428

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Finding# 12-069	Recommendation	Management Response as of March 18, 2013	Status of Finding as of September 24, 2013	Comments and Agency Contact
The FAHCA did not always ensure that facilities receiving Medicaid payments met required health and safety standards.	We recommend that the FAHCA increase its efforts to ensure that Life Safety Surveys and follow-up surveys be conducted within the established time frames.	Regarding the hospitals, these were state-only visits that were delayed due to workload in federal programs. Additionally, the 45-day revisit on the state LSC Hospital visits is listed in the HQA Standard Operating Procedures as the standard timeframe for revisits. However, we are updating the Standard Operating Procedures Manual to expand the 45-day timeframe to accurately reflect an acceptable timeframe, of a minimum of 45 days but allow for flexibility and desk-review revisits as well. **Estimated Corrective Action Date** 7/1/2013 for updating the HQA Standard Operating Procedures Manuals.	Partially Corrected	The annual state hospital life safety code surveys are required in Rule 59A-3.253(5), F.A.C. Since March 1, 2011 the Bureau of Field Operations reassessed their workload and developed overall priority levels to assist Field Office Management in scheduling their workload. Level 1 includes the Centers for Medicare & Medicaid Services (CMS) Tier 1 and Tier 2, Priority 1 State complaints, state statutory required inspections and initial licensure surveys. Level 2 includes CMS Tier 3 work, Priority 2 State Complaints, state health follow-up inspections and Rule required inspections. As previously stated the Life Safety Code annual inspections referenced in this report are required under the hospital rule, therefore would thus fall under the Level 2 priority levels within the Field Operations Bureau of priority of onsite inspections. These Priority Levels will be included in the HQA Procedures Manual to respond fully to the current and future audits. NOTE: The HQA Standard Operating Procedures Manual is still being updated. This manual is an overall procedural manual for HQA processes, therefore it represents more than Life Safety Code Surveys.

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Finding# 12-069	Recommendation	Management Response as of March 18, 2013	Status of Finding as of September 24, 2013	Comments and Agency Contact
				Update as of September 16, 2013: The HQA Standard Operating Procedures continues to be updated. Currently adding licensure updates. Kimberly Smoak (850) 412-4516

Finding# 12-070	Recommendation	Management Response as of March 18, 2013	Status of Finding as of September 24, 2013	Comments and Agency Contact
The FAHCA's established policies and procedures did not provide for the timely review and issuance of cost report audits and desk reviews of nursing homes and Intermediate Care Facilities for the	We recommend that the FAHCA enhance its policies and procedures to provide for an adequate number of cost reports to be audited annually, as well as the timely review and issuance of cost report	On a yearly basis, each of the 650 nursing homes participating in the Medicaid program are to submit a cost report, five months after the close of the provider's fiscal year end, compliant with cost reporting requirements. Cost reports are not considered late until they have not been received to be used for the next	Fully Corrected	Effective April 2013, the Agency for Health Care Administration initiated a three year contract with a certified public accounting (CPA) firm to perform examination reviews of ICF-DD cost reports. There will be an average of 50 cost reports examined during this contract, an average

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Developmentally Disabled (ICF-DD).	audits and desk audits. To ensure the timeliness and usefulness of the information contained within the cost report audits and desk audits, these procedures should identify the time frames within which the audits and desk audits are to be reviewed and issued.	January or July rate setting following the due date of the cost report. If the costs submitted in the cost report result in an increased per diem, and the cost report is considered late, the provider would not receive the higher per diem until the next rate setting semester. Otherwise, any rate reductions would be applied immediately. Cost reports cannot be included in the audit selection pool until they have been submitted to the Agency and accepted for rate setting, regardless of the fiscal year end. Due to the previously described cost report process, setting a two year window from the close of the provider's fiscal year end would not be practical for the following reasons. FAHCA has reviewed the average length of time from cost report acceptance to audit assignment, and from audit assignments to report issuance. For the 134 audits issued during the 2011-12 fiscal year, these average lengths of time were 15.4 months and 21.6 months, respectively. Combining these timeframes, reports are issued on average within 37 months from cost report acceptance.		of 17 cost reports a year. To ensure timeliness and usefulness of the information contained within the cost report, the CPA will be submitting monthly reports displaying anticipated date of the examination review process. It is projected that assignments given in April 2013 will be finished by November-December 2013 as long as Audit Services staff remains unchanged. Mercedes Bosque (850) 412-4083

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Finding# 12-070	Recommendation	Management Response as of March 18, 2013	Status of Finding as of September 24, 2013	Comments and Agency Contact
		Of the 134 audits in the 2011-12 fiscal year, twenty nine audits were for fiscal year ending 2004 through 2008, based on assignments originally started by one contracted CPA firm which were still open when the firm's contract was not renewed. Six of these assignments with fiscal year ending 2004 and 2005 were completed by the Agency, rather than reassigning them to another CPA firm, saving the Agency an estimated $90,000 of contracted audit costs. However, due to limited Agency resources, the other twenty three assignments with fiscal years ending 2006, 2007 and 2008 were assigned to other contracted CPA firms. Reviewing supporting work papers for each report and preparing audit appeals are not considered hindrances, but necessary components of the process. Each report issued is considered an FAHCA action, and the FAHCA is required to provide administrative hearing or appeal rights. The FAHCA is responsible for all work necessary to conclude any appeals, including defending adjustments in the reports and performing additional audit steps, including any report revisions. Releasing		

Finding# 12-070	Recommendation	Management Response as of March 18, 2013	Status of Finding as of September 24, 2013	Comments and Agency Contact
		reports without having reviewed the adjustments and supporting work papers would put the FAHCA at a disadvantage in a legal challenge. Should the provider choose to appeal the adjustments, no further processing of the report is done until the administrative action is legally concluded. This includes any rate changes resulting from these audit reports. FAHCA's available resources have to be considered in the timing and completion of cost report audits or special projects, as well as selection of the cost reports considered to be the highest risk for audit. FAHCA personnel assigned to review reports and supporting work papers are also required to defend the adjustments, perform additional work for audit appeals, perform cost report acceptance reviews, and complete special projects. A balance of these required functions is necessary.		