

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

**MEDICAID PAYMENTS AND RELATED
CONTROLS**

Operational Audit

For the Period July 2007 through February 2009,
and Selected Actions through June 2009



SECRETARY OF THE AGENCY FOR HEALTH CARE ADMINISTRATION

The Agency of Health Care Administration is created by Section 20.42, Florida Statutes. The head of the Agency is the Secretary who is appointed by the Governor subject to confirmation by the Senate. During the audit period the following individuals served as Secretary:

Holly Benson	February 2008 to October 2009
Andrew Agwunobi, M.D.	July 2007 to February 2008

The audit team leader was Brian Meyer, CPA, and the audit was supervised by Gary Campbell, CPA. Please address inquiries regarding this report to Jane Flowers, CPA, Audit Manager, by e-mail at janeflowers@aud.state.fl.us or by telephone at (850) 487-9136.

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AGENCY FOR HEALTH CARE ADMINISTRATION

Medicaid Payments and Related Controls

SUMMARY

This operational audit of the Agency for Health Care Administration (Agency) focused on Medicaid payments and related controls during the period July 2007 through February 2009, and selected actions through June 2009. Our audit disclosed the following:

EMERGENCY PAYMENTS

Finding No. 1: 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 qualified, benefitting recipients were eligible, and the charges for the medical services provided were valid and allowable Medicaid expenditures.

Finding No. 2: The Agency had not developed policies or procedures specifically related to the calculation of the amount of emergency payments.

Finding No. 3: The responsibility for the final authorization and approval of emergency payments was assigned to the same Agency staff who initiated and calculated the payments. Also, large payments were not subjected to additional levels of review and approval.

Finding No. 4: 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 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.

MEDICAID FISCAL AGENT AND SUBCONTRACTOR MONITORING

Finding No. 5: 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.

Finding No. 6: Reporting requirements were not sufficient to allow the Agency to effectively monitor subcontractor performance.

MEDICAID CLAIMS PROCESSING

Finding No. 7: 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.

BACKGROUND

The Agency for Health Care Administration (Agency) is the chief health policy and planning entity for the State, and State law designates the Agency as the State government entity responsible for administering the Medicaid Program. State law also provides that the Agency is the single State agency authorized to make payments for medical assistance

and related services and provides that those payments shall be made only on behalf of eligible individuals and shall be made only to qualified providers in accordance with Title XIX of the Federal Social Security Act.¹

As indicated above, medical items and services are to be supplied by authorized (enrolled) providers. Providers include, but are not limited to, hospitals, doctors, health maintenance organizations, nursing homes, pharmacies, and intermediate care facilities for the developmentally disabled. State law authorizes the Agency to reimburse Medicaid providers in accordance with applicable State and Federal laws and according to methodologies set forth in Agency rules and in policy manuals and handbooks.² These methodologies include fee schedules, reimbursement methods based on cost reporting, negotiated fees, and other mechanisms. Additionally, the Agency submits a Medicaid State Plan to the Federal Centers for Medicare and Medicaid Services (CMS) for approval that specifies how the Agency will comply with Federal requirements.

Providers enrolled in the Medicaid Program are to receive compensation for services provided to Medicaid recipients by submitting a claim for payment, the vast majority of which are submitted electronically. The Agency contracts with private companies to serve as the Medicaid fiscal agent, and the fiscal agent's primary responsibility is to process medical claims submitted for reimbursement through the Florida Medicaid Management Information System (FMMIS). During the period July 2007 through December 2008, Medicaid claims totaling approximately \$18 billion were processed through FMMIS.

Effective June 26, 2008, Electronic Data Systems, Inc. (EDS) began operations as the Medicaid fiscal agent and FMMIS and Decision Support System (DSS)³ provider, replacing Affiliated Computer Systems, Inc. (ACS) which had previously held the contract. The contract between the Agency and EDS, effective May 16, 2006, through June 30, 2013, authorizes payments totaling \$309 million. Of the \$309 million, approximately \$38 million was for the planning, design, development, testing and implementation of the EDS versions of FMMIS and DSS. As of June 30, 2009, the Agency had made contract payments to EDS totaling \$116,669,304.

As indicated in succeeding paragraphs, certain providers and provider types were unable to electronically file and receive payment for claims. This inability has been attributed to various FMMIS functionality issues. Our audit's scope did not include an identification of the causes of these functionality problems; however, it is likely that project management issues identified by the Agency's Inspector General contributed to the lack of full functionality. The Agency's Office of the Inspector General, Bureau of Internal Audit, conducted a review of the Agency's FMMIS/DSS implementation project and, in report No. 08-13, dated June 25, 2009, identified the following risks to project outcomes:

- The FMMIS/DSS User Acceptance Testing was not fully completed prior to the implementation of the system. Incomplete user acceptance testing could result in unidentified system defects and negative operational outcomes.
- Documentation of agency approval of EDS' deliverables was not well maintained during the project.

The report also disclosed that:

- During the design, development, and implementation phase, the Agency did not have a process in place to facilitate independent project monitoring and project status communication with the Agency Management Team.
- Rather than being broken down into smaller deliverables by system modules or development phases, the system development phase of the FMMIS/DSS project plan was considered to be one deliverable.

¹ Section 409.902, Florida Statutes.

² Section 409.908, Florida Statutes.

³ DSS is a data warehouse that provides users with access to FMMIS data.

FINDINGS AND RECOMMENDATIONS**Finding No. 1: Preaudit of Emergency Payments**

When a provider submits a claim to FMMIS for payment, the claim is to pass through numerous FMMIS edits to ensure that the provider is enrolled, the recipient is eligible, and the charge for the medical service is a valid and allowable Medicaid expenditure. Medicaid claims processed by FMMIS are also subject to review by the Bureau of Medicaid Program Integrity and the Medicaid Fraud Control Unit within the Attorney General's Office. The objective of these controls is to prevent and detect the payment of unallowable claims. The controls are also to provide assurance of compliance with requirements of Florida law which provide that payments shall be made only on behalf of eligible individuals and shall be made only to qualified providers in accordance with Title XIX of the Federal Social Security Act.

Due to functionality issues with the implementation of EDS' FMMIS, effective June 26, 2008, certain providers and provider types were unable to obtain payment for Medicaid claims electronically submitted to FMMIS. As this problem persisted, the Agency began issuing emergency payments to these providers. Emergency payments were intended to be essentially the Agency's estimate of what the provider would have received had the provider not experienced FMMIS billing difficulties. These emergency payments were intended to be issued temporarily until EDS resolved the billing issues that prevented certain provider types from receiving payment through FMMIS. However, one year after EDS began fiscal agent operations on June 26, 2008, the Agency continued to issue emergency payments to providers. For the 2008-09 fiscal year, the Agency issued 6,692 emergency payments totaling \$791,971,564 with approximately \$120,000,000 being issued to providers for the quarter ended June 30, 2009. A comparison of emergency payments issued to total payments issued, by provider type, is included at the end of this report as EXHIBIT A.

The Agency used two types of emergency payments: Automated Interim Payments (AIPs) and Emergency Assistance Payments (EAPs). The Agency issued AIPs primarily to providers in July 2008 through August 2008 in amounts calculated by FMMIS based on the provider's historical average payment for a given time period. The Agency issued AIPs either for an entire provider type population (for example, nursing homes), if it was determined that the type of provider was having difficulty obtaining payments, or based on a provider's request. For instances in which the Agency issued AIPs to an entire provider type population, the payments were issued without a provider request for payment or any provider-submitted documentation. The Agency issued EAPs on a case-by-case basis, following the Agency's receipt of a request from a provider for an emergency payment.

When the Agency issued an emergency payment to a provider, a receivable in the amount of the payment was to be established in FMMIS. In addition, a recoupment schedule was to be created under which a certain percentage of each claim submitted by the provider was to be held back and applied to the receivable until the balance was offset. The Agency directed providers to resubmit claims that may have been inappropriately denied.

As discussed above and in succeeding findings, emergency payments, consisting of AIPs and EAPs, 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 qualified, benefitting recipients were eligible, and the charges for the medical services provided were valid and allowable Medicaid expenditures. While we understand that these providers were of necessity continuing to provide medical items and services to clients and were deserving of timely payment, it was not clear that the Agency's solution involving AIPs and EAPs

allowed the Agency to demonstrate and document that the payments, when made, met the requirements of law. As indicated above, State law provides that payments shall be made only on behalf of eligible individuals and shall be made only to qualified providers in accordance with Title XIX of the Federal Social Security Act.

In response to our audit inquiries regarding the authority relied upon in making the emergency payments, the Agency cited several statutes and Federal directives that address the Agency's authority, including:

- Section 409.907, Florida Statutes, related to Medicaid provider agreements. The Agency response indicated that emergency payments were made only to Medicaid-enrolled providers. However, as indicated by finding No. 7, during our audit, we noted that emergency payments were issued to providers that were operating with expired Medicaid provider agreements at the time payment was issued.
- Section 409.908, Florida Statutes, related to reimbursement of Medicaid providers. This statute indicates that the Agency shall reimburse providers in accordance with State and Federal law, according to the methodologies set forth in the Agency rules, policy manuals, and handbooks. Section 409.908, Florida Statutes, also provides that these methodologies may include fee schedules, methods based on cost reporting, negotiated fees, competitive bidding, and other mechanisms the Agency considers efficient and effective for purchasing services or goods on behalf of recipients. The Agency indicated that the provision of emergency payments falls within the "other mechanisms" reimbursement method.

Our review of the Medicaid State Plan, Agency policy manuals, and handbooks did not disclose any provisions pertaining to the issuance of these payments. Additionally, it was not clear that the intent of this statutory reference to "other mechanisms" was to authorize emergency payments on the scale in which they were made.

- Section 409.912, Florida Statutes, related to the purchase of goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. The Agency response indicated these provisions are deemed applicable to emergency payments as well as to the claims that were submitted to FMMIS by providers related to the emergency payments. However, as these payments were issued to providers without a review of applicable medical claims to determine allowability, the Agency is unable to demonstrate that these payment methods were effective in ensuring compliance with Medicaid Program legal requirements. Further, the possibility that some payments may not be successfully recouped from the provider also does not support the argument that these payments represented the most cost-effective method of purchase.
- Section 409.919, Florida Statutes, related to Agency adoption of rules necessary to comply with or administer Sections 409.901 through 409.920, Florida Statutes, and all rules necessary to comply with Federal requirements. The Agency response indicated that Agency Rule 59G-6.010, Florida Administrative Code (FAC), related to nursing homes, incorporates CMS Publication 15-1. This publication indicates that accelerated payments can be issued to providers and prescribes eligibility criteria and a specific methodology to be followed when calculating the payment amount. The publication also provides that such payments must be approved by CMS and that the applicable CMS regional office will review each request to assure that payment provisions are being correctly and consistently applied. We noted that Agency Rule 59G-6.010, FAC, only pertains to nursing homes and that the Agency did not demonstrate that the required eligibility criteria had been met, payments were calculated in accordance with the methodology established in CMS Publication 15-1, or CMS approval had been obtained for the payments issued.

It is not clear that the statutes and Federal directives cited by the Agency provide the Agency with the authority to make emergency payments for claims that had not been processed in a manner to ensure that the provider was qualified, the recipient was eligible, and the charge for the medical service was a valid and allowable Medicaid expense.

Recommendation: 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, provisions to allow emergency payments to providers on a limited basis under specified circumstances.

In response to this finding, the Agency indicated that it had the authority to make emergency payments through Florida Statute. The Agency did not cite a specific statute in its response; however, the provisions of law and directive that were identified by the Agency during the course of our audit work are listed in the finding. We continue to question whether these provisions of law provide the Agency with clear on-point authorization to make payments to Medicaid providers in advance of the receipt and processing of proper claims.

Finding No. 2: Emergency Payment Calculations

Our evaluation of the Agency's process for issuing EAPs to providers during the period July 2008 through February 2009, revealed that the Agency had not developed policies and procedures specifically related to the calculation of the amounts of EAPs. As a result, the methodology used to calculate EAPs varied from payment to payment. Specifically, for the 12 EAPs reviewed, we noted:

- Five instances in which payments were issued to providers based on the provider's requested amount. The provider's request generally included, for example, a letter requesting payment in a particular amount. In these instances, an Agency-prepared analysis as to the reasonableness or necessity of the requested amount was not documented. Payments in these instances were for \$40,000, \$225,000, \$6,500,000, \$21,745,977, and \$35,000,000.
- One instance in which the Agency calculated and issued the payment based on the provider's assertion that denied claims totaled \$155,000. In response to our audit inquiry, Agency staff provided us with an analysis of denied claims that totaled only \$15,933 for this provider.
- Five instances in which the Agency used varied time periods ranging from 3 to 6 months to compute the average payment amount for the EAP. Payments in these instances ranged from \$8,200 to \$947,000.

Without established policies and procedures that detail the methodology to be used by Agency staff when calculating and documenting the basis for EAPs, the Agency is unable to demonstrate that it has considered and taken steps to reduce the added risk of noncompliance and loss associated with the EAPs to as low a level as practicable.

Recommendation: 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.

Finding No. 3: Emergency Payment Issuance

Emergency payment amounts were identified and calculated by Bureau of Medicaid Contract Management staff and approved by the Bureau Chief. Once an emergency payment amount was calculated and approved, an approval memorandum was sent to EDS and the Bureau of Finance and Accounting for payment.

Due to the large dollar amount of some emergency payments, the responsibility for the final authorization and approval of these payments should not be assigned to Agency staff who initiate and calculate the payments. Also, an

additional level of review and approval would provide further assurances regarding the accuracy of the payments. We noted deficiencies in the Agency's controls over the approval of emergency payments as discussed below.

Our tests disclosed six instances in which emergency payments, ranging in value from \$796,449 to \$35,000,000, were approved only by the Bureau Chief of Medicaid Contract Management. These payments were not reviewed by any staff independent of the Bureau of Medicaid Contract Management and were not subjected to additional levels of review and approval by upper management.

In response to our audit inquiry, Agency staff responded that a \$500,000 threshold had been established in emergency payment procedures (2003 procedures) followed under the previous contractor. Amounts above the threshold amount required approval by the Deputy Secretary for Medicaid. However, Agency staff further indicated these procedures were outdated and no dollar threshold regarding the approval of emergency payments had been established since the transition to EDS. Also, Agency staff responded that the Assistant Deputy Secretary had reviewed the larger payments (ranging from \$6,500,000 to \$35,000,000); however, this process was not documented.

Without an adequate separation of duties and appropriate levels of review and approval to serve as controls over the issuance of emergency payments, the Agency's ability to detect and prevent errors in emergency payments was significantly reduced.

Recommendation: 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.

Finding No. 4: Emergency Payment Recoupment

As stated above, after an emergency payment had been issued to a provider, an account receivable was to be established in FMMIS 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 balance was offset. For emergency payments issued in July 2008 and August 2008, the recoupment schedule generally lasted from October 16, 2008, through January 31, 2009, with either 33 or 50 percent held back from each claim. If the account receivable was not offset by January 31, 2009, 100 percent of each claim submitted was to be held back until the receivable balance was satisfied. As of March 20, 2009, there were 723 providers with a total outstanding accounts receivable balance for emergency payments of \$194,274,056, or 30 percent of the total payment amount. As of June 30, 2009, the Agency indicated the outstanding receivable balance for emergency payments totaled \$147,793,262.

Our audit disclosed that the Agency process for recouping emergency payments did not include provisions to timely identify and collect the balances due from those providers which did not file claims during the recoupment period. For example, we tested Agency documentation related to 53 emergency payments with outstanding balances. We noted that 37 providers that had received an emergency payment in July 2008 or August 2008 had either subsequently terminated from the Medicaid Program or remained enrolled but had not submitted a claim for reimbursement during the recoupment period. As a result, these providers still had a large portion of the emergency payment receivable balance outstanding at the time of our audit field work. Specifically, we noted the following:

- Nine providers were enrolled providers that had received an emergency payment in July 2008 but had not submitted any claims for reimbursement during the scheduled recoupment period to offset the related accounts receivable. Emergency payments to these 9 providers totaled \$135,774. Subsequent to our audit

inquiry, Agency staff indicated that 70 percent of the accounts receivable balance totaling \$11,885 for one provider had been recouped.

- Twenty-eight providers that had received an emergency payment in July 2008 or August 2008 had terminated participation in the Medicaid Program subsequent to the issuance of the emergency payment. Relative to these 28 providers:
 - The terminations from the Medicaid Program for 20 providers were due to voluntary termination, an expired license, or notification from another agency. In 7 of these instances, the provider was retroactively terminated as of a date preceding the date on which the Agency issued an emergency payment. The outstanding receivable balance for these 20 providers totaled \$482,759.
 - The emergency payments for the remaining 8 providers were issued after the effective date of the provider’s termination from the Medicaid Program. In all 8 instances, the Agency processed the provider’s termination subsequent to the emergency payment issuance date. In 6 of the 8 instances, the provider’s retroactive date of termination, effective December 20, 2007, was well before the date the Agency issued the emergency payment. In these 8 instances, there had been a change in provider ownership, and the Medicaid identification number (ID) associated with the former owner was canceled and a new ID was issued for the new owner. However, in all 8 instances, the outstanding receivable balance associated with the terminated provider ID was not transferred to the new provider ID. The outstanding receivable balance for these providers totaled \$1,222,715.
- Of the 28 terminated providers that had outstanding receivable balances, 9 received payments for claims submitted between the time FMMIS was updated with termination information and the recoupment schedule began. As these payments were issued before the recoupment schedule began, none of these payments were withheld and applied to the provider’s receivable balance. These claim payments totaled \$140,304.

As of June 2009, the Agency had not taken steps to collect the outstanding receivable balances from these 37 providers.

Without sufficient controls to ensure that any outstanding balances for emergency payments issued to providers are properly collected, the risk that payments will not be successfully recouped by the Agency is significantly increased.

Recommendation: 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 Program.

Medicaid Fiscal Agent and Subcontractor Monitoring

Finding No. 5: Medicaid Fiscal Agent Monitoring

As previously stated in the BACKGROUND section of this report, the Agency and EDS have entered into a \$309 million contract for Medicaid fiscal agent services. EDS began fiscal agent operations on June 26, 2008, approximately 4 months after the scheduled date of March 1, 2008. The contract between the Agency and EDS required EDS to submit monthly performance assessments known as report cards, to the Agency within 14 days of the end of each month. The performance assessments that EDS submitted were organized into nine separate report cards, with each report card subject to liquidated damages. These report cards were independently scored by EDS and the Agency using a numerical scale ranging from 0 to 100. Report cards that received a score below 77 were to be assessed liquidated damages of \$5,000 and those with scores below 70 were to be assessed damages of \$10,000. Additionally, the Agency could assess damages of \$500 per day for report cards that were submitted more than 14 days after the end of the month.

Our audit disclosed that the Agency's Bureau of Medicaid Contract Management did not timely review and score the report cards to determine adherence with contractual terms. We noted that, as of May 2009, the Agency had reviewed and scored the EDS report cards for July 2008 through October 2008, but had not reviewed or scored the report cards for November 2008 through February 2009. We also noted that the contractually required report cards did not require an assessment of the accuracy of claims processed by FMMIS.

The contractually required report cards that were submitted during the audit period indicated that EDS had not met the performance measures specified in the contract. None of the four monthly report cards scored by the Agency reflected a score above that required to avoid liquidated damages (a minimum score of 77). In several instances, the individual report cards received a score of 0 from Agency staff. As a result of the continued poor scores shown by the contractually required report cards, the Agency assessed damages of \$80,000 for the October 2008 report card. However, the Agency did not assess damages for the July 2008, August 2008, or September 2008 report cards, which also reflected poor scores. Had the Agency assessed damages as stipulated in the contract, an additional \$265,000 could have been assessed as a penalty for underperformance. Further, although the contract also provided for the assessment of damages for poor performance relating to correctness of payments, system capacity, and the failure to correct deficiencies, the Agency did not assess damages in these areas. In response to our audit inquiry, the Agency indicated that it may take up to 18 months, or 30 percent of the contract term, before EDS is able to successfully meet some of the required performance measures.

The failure to enforce existing damage clauses may limit the Agency's ability to utilize the contract to ensure that EDS successfully meets all performance requirements.

Recommendation: 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.

Finding No. 6: Subcontractor Monitoring

EDS subcontracted with First Health, Inc. (First Health) to provide the pharmacy benefits system for processing prescription drug claims. Prescription drug claims were submitted directly to the First Health system, which processed the claim and then sent adjudicated claim information to FMMIS for payment. Conversely, FMMIS updated the First Health system with provider and recipient eligibility information. During the period July 2008 through February 2009, approximately \$704 million in prescription drug claims were paid to providers. One of the nine monthly report cards EDS was required to submit to the Agency regarding performance pertained to First Health operations.

The First Health operations report card included 12 performance measures: 8 pertaining to call center staffing and wait times, 2 relating to system capacity, and 2 concerning claim processing speed. None of the First Health performance measures addressed the accuracy of prescription drug claims processed by the First Health pharmacy benefits system. In response to our audit inquiry, Agency staff indicated that, since their inception in 2000, report cards have never addressed the accuracy of pharmacy claims processing.

Because the pharmacy benefits system is provided by First Health through a subcontract with EDS, rather than a contract with the Agency, performance measures addressing the accuracy of claims processed by the subcontractor would be helpful in allowing the Agency to effectively monitor subcontractor performance. Absent these reporting requirements, the potential for the payment of inaccurate claims is increased.

Recommendation: 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.

Medicaid Claims Processing

Finding No. 7: Payment of Claims

State law provides that the Agency may make payments for medical assistance only to an individual or entity that has a provider agreement in effect with the Agency.⁴ The provider agreement serves as a contract between the Agency and the provider, where, among other conditions, the provider agrees that the services billed to the Medicaid Program were medically necessary and had actually been provided to an eligible Medicaid recipient.

Following the performance of a medical service for a Medicaid recipient, the provider is to submit a claim for reimbursement. During the audit period, the vast majority of Medicaid claims were submitted electronically to FMMIS. As indicated by Finding No. 1, FMMIS had numerous automated edits to determine whether the claim was submitted by a valid Medicaid provider and was for an allowable Medicaid service provided to an eligible recipient and paid at the correct amount. These FMMIS edits were to be programmed to pay only valid Medicaid claims and were to be based on Coverage and Limitation Handbooks and fee schedules developed by the Agency's Bureau of Medicaid Services. Our tests of 40 selected claims processed by EDS' FMMIS and 40 pharmacy claims processed by the First Health pharmacy benefits system, disclosed indications of ineffective automated edits and related procedures. Specifically:

- For the 40 EDS FMMIS claims tested, we noted:
 - In 14 instances, the provider receiving payment for the claim had an expired provider agreement. During the audit period, these 14 providers received a total of \$21,511,094 for claims paid after their provider agreements had expired. Additionally, our review of 113 emergency payments, as discussed in finding Nos. 2 and 4 above, disclosed that 9 other providers had an expired provider agreement at the time the emergency payment was issued. Emergency payments to these providers totaled \$1,815,807.
 - One instance in which the recipient was responsible for a \$2 copayment for each service date. The claim in question consisted of three service dates, and should have had \$6 deducted from the claim paid amount. However, the \$2 copayment was only deducted from the first service date with the other two dates receiving full reimbursement. There was no evidence that this claim was exempt from a copayment.
 - For one instance pertaining to the service type Children's Medical Services – Targeted Case Management, the Agency could not demonstrate that the claim was paid in accordance with established policy or reimbursed at the correct rate because a Coverage and Limitation Handbook or fee schedule had not been developed by the Agency for this service type. Claims paid during our audit period for this service type totaled \$6,404,299.
- For the 40 pharmacy claims tested, we noted 7 instances in which prescription drug claims processed by the First Health pharmacy benefits system were reimbursed at an incorrect State Maximum Allowable Cost (SMAC) rate. In all 7 instances, the claims had service dates between July 1, 2008, and September 30, 2008, but were reimbursed at rates effective January 1, 2008, rather than July 1, 2008, resulting in a net overpayment of \$6.17. As of May 2009, these claims had not been reimbursed at the correct rate. Agency staff indicated that these errors occurred because the July 1, 2008, SMAC rate information was not timely entered into the

⁴ Section 409.907, Florida Statutes.

pharmacy benefits system. Since the SMAC pricing data was not timely entered into the system, this issue could have affected any claims submitted for the approximately 24,000 drugs that receive SMAC pricing.

Without sufficient controls to ensure that Medicaid claims are paid in accordance with applicable laws, rules, and regulations, the likelihood that unallowable claims will be paid and may remain undetected is increased. The failure to ensure that all Medicaid providers enrolled in the Medicaid Program have an active provider agreement in effect with the Agency may preclude efforts of enforcing provisions of the provider agreement.

Recommendation: 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.

OBJECTIVES, SCOPE, AND METHODOLOGY

The Auditor General conducts operational audits of governmental entities to provide the Legislature, Florida's citizens, public entity management, and other stakeholders unbiased, timely, and relevant information for use in promoting government accountability and stewardship and improving government operations.

We conducted this operational audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

This operational audit focused on Medicaid payments and related internal controls. The overall objectives of the audit were:

- To evaluate the effectiveness of established internal controls in achieving management's control objectives in the categories of compliance with controlling laws, administrative rules, and other guidelines; the economic, efficient, and effective operation of State government; the relevance and reliability of records and reports; and the safeguarding of assets.
- To evaluate management's performance in achieving compliance with controlling laws, administrative rules, and other guidelines; the economic, efficient, and effective operation of State government; the relevance and reliability of records and reports; and the safeguarding of assets.
- To identify statutory and fiscal changes that may be recommended to the Legislature pursuant to Section 11.45(7)(h), Florida Statutes.

Our audit included examinations of various records and transactions (as well as events and conditions) occurring during the period July 2007 through February 2009, and selected actions through June 2009. In conducting our audit we:

- Obtained an understanding of selected IT controls, assessed the risks related to those controls, evaluated whether selected general and application IT controls were in place, and tested the effectiveness of the controls.
- Interviewed appropriate Agency personnel to gain an understanding of the topics included in this audit.
- Examined 60 emergency payments issued to providers to determine whether the payments were calculated and processed in accordance with governing laws, rules, and applicable policies and procedures.

- Reviewed 53 emergency payments to providers with outstanding accounts receivable balances to determine whether the payments were processed in accordance with applicable policies and procedures.
- Reviewed monitoring reports submitted by EDS to the Agency to evaluate the adequacy of contractor monitoring efforts.
- Reviewed the subcontract between EDS and First Health to gain an understanding of monitoring provisions. Also reviewed monitoring reports submitted by EDS to the Agency that pertained to First Health.
- Reviewed 40 nonpharmacy Medicaid claims processed by EDS' FMMIS to gain an understanding and to evaluate whether controls were sufficient to ensure that the claims tested were paid in accordance with Medicaid policy.
- Reviewed 40 pharmacy claims processed by First Health's pharmacy system to gain an understanding and to evaluate whether controls were sufficient to ensure that the claims tested were paid in accordance with Medicaid policy.
- Performed various other auditing procedures, including analytical procedures, as necessary, to accomplish the objectives of the audit.

AUTHORITY

Section 11.45, Florida Statutes, requires that the Auditor General conduct an operational audit of each State agency on a biennial basis. Pursuant to the provisions of Section 11.45, Florida Statutes, I have directed that this report be prepared to present the results of our operational audit.



David W. Martin, CPA
Auditor General

MANAGEMENT'S RESPONSE

In a response letter dated February 19, 2010, the Secretary of the Agency provided responses to our audit findings and recommendations. The Agency's response is included as EXHIBIT B.

EXHIBIT A
ANALYSIS OF EMERGENCY PAYMENTS

**Comparison of Emergency Payments to Total Payments by Provider Type
During the Period July 1, 2008, Through June 30, 2009**

Provider Type	Emergency Payments (in dollars)	Total Payments (in dollars)	Percent of Emergency Payments to Total Payments
01 – General Hospital	\$569,950,019	\$ 3,047,064,540	18.70%
05 – Community Behavioral Health	1,112,846	97,982,934	1.14%
06 – Ambulatory Surgery Center	43,821	18,331,782	.24%
07 – Specialized Mental Health	250,135	14,666,552	1.71%
10 – Skilled Nursing Facility	116,850,865	2,841,425,206	4.11%
12 – Private ICF/DD Facility	10,904,360	215,372,835	5.06%
14 – Assistive Care Services	241,635	24,459,684	.99%
15 – Hospice	18,059,204	285,079,124	6.33%
16 – Inpatient Psychiatric Program	1,181,054	52,101,131	2.27%
20 – Pharmacy	109,191	1,069,510,381	.01%
23 – Medical Foster Care	122,243	7,691,318	1.59%
24 – Prescribed Medical Rehab	652,855	29,711,352	2.20%
25 - Physician M.D.	5,326,109	793,505,006	.67%
26 – Physician D.O.	84,068	15,170,891	.55%
27 – Podiatrist	30,378	5,480,299	.55%
28 – Chiropractor	1,300	1,192,498	.11%
30 – Nurse Practitioner	1,264	2,210,250	.06%
31 – Registered Nurse	12,000	176,089	6.81%
34 – Licensed Midwife	15,966	662,723	2.41%
35 – Dentist	181,680	59,074,471	.31%
40 – Ambulance	15,597	46,638,146	.03%
41 – Non-Emergency Transport	18,822	21,521	87.46%
51 – Portable X-Ray Company	61,142	2,678,985	2.28%
63 – Optician	4,152	3,712,387	.11%
65 – Home Health Agency	3,340,000	218,451,356	1.53%
66 – Rural Health Clinic	389,127	28,534,059	1.36%
67 – Home & Community-Based Services	50,477,465	1,075,518,345	4.69%
68 – Federally Qualified Health Center	724,708	65,575,792	1.11%
69 – Birth Center	6,309	1,365,884	.46%
70 – HMO	750,000	2,279,949,475	.03%
72 – Prepaid Mental Health Services	3,783,655	215,595,245	1.75%
77 – County Health Department	183,087	117,755,964	.16%
78 – Children’s Medical Services	13,266	1,328,582	1.00%
81 – Early Intervention Services	10,188	5,164,392	.20%
83 – Therapist PT, OT, ST, RT	982,416	90,975,026	1.08%
89 – Dialysis Center	1,694,488	57,181,412	2.96%
90 – Durable Medical Equipment	1,542,681	109,764,074	1.41%
91 – Case Management Agency	2,843,468	24,338,206	11.68%
All Other Provider Types	-	304,524,555	-
Totals	<u>\$791,971,564</u>	<u>\$13,229,942,472</u>	<u>5.99%</u>

Sources: Emergency Payments – Agency-provided listing.
Total Payments – Medicaid DSS.

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**EXHIBIT B
MANAGEMENT'S RESPONSE**



Better Health Care for all Floridians

CHARLIE CRIST
GOVERNOR

THOMAS W. ARNOLD
SECRETARY

February 19, 2010

David W. Martin, CPA
Auditor General
G74 Claude Pepper Building
111 West Madison Street
Tallahassee, FL 32399-1450

Dear Mr. Martin:

Thank you for the opportunity to respond to the preliminary and tentative audit findings and recommendations from your audit of the Agency for Health Care Administration, Medicaid Payments and Related Controls, for the period of July 2007 through February 2009. We appreciate the efforts of your staff and have included our response to the recommendations noted in your report. The Agency for Health Care Administration continuously looks for opportunities to improve operations and is committed to providing cost-effective and efficient health care services to the citizens of Florida.

In accordance with your request, we have emailed you the preliminary and tentative findings document with our response incorporated therein. If you have any questions regarding our response, please contact Mike Blackburn, Audit Director, at (850) 414-5419.

Sincerely,

Thomas W. Arnold
Secretary

TWA/mb
Enclosure: Response to the P&T for Federal Awards
cc: James McFaddin, Chief of Staff



**EXHIBIT B
MANAGEMENT’S RESPONSE (CONTINUED)**

Agency for Health Care Administration
Office of the Inspector General - Internal Audit Unit
Response Table for the Auditor General Operational Audit P&T Medicaid Payments and Related Controls - Audit Period of 7/2007 - 02/2009

Issue	Recommendation(s)	Management Response	Target Date	Contact Name
<p>1 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 qualified, benefitting recipients were eligible, and the charges for the medical services provided were valid and allowable Medicaid expenditures.</p>	<p>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, provisions to allow emergency payments to providers on a limited basis under specified circumstances.</p>	<p>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.</p>	<p>Ongoing</p>	<p>Alan Strowd</p>
<p>2 The Agency had not developed policies or procedures specifically related to the calculation of the amount of emergency payments.</p>	<p>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.</p>	<p>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.</p>	<p>Complete</p>	<p>Alan Strowd</p>

**EXHIBIT B
MANAGEMENT’S RESPONSE (CONTINUED)**

Agency for Health Care Administration
Office of the Inspector General - Internal Audit Unit
Response Table for the Auditor General Operational Audit P&T Medicaid Payments and Related Controls - Audit Period of 7/2007 - 02/2009

Issue	Recommendation(s)	Management Response	Target Date	Contact Name
<p>3 The responsibility for the final authorization and approval of emergency payments was assigned to the same Agency staff who initiated and calculated the payments. Also, large payments were not subjected to additional levels of review and approval.</p>	<p>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.</p>	<p>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.</p>	<p>Complete</p>	<p>Alan Strowd</p>
<p>4 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 certain percentage of each claim submitted by the provider would be held back and applied to the account receivable until 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.</p>	<p>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 Program.</p>	<p>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.</p>	<p>Ongoing</p>	<p>Alan Strowd</p>
<p>5 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.</p>	<p>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.</p>	<p>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.</p>	<p>Complete</p>	<p>Alan Strowd</p>

**EXHIBIT B
MANAGEMENT'S RESPONSE (CONTINUED)**

Agency for Health Care Administration
Office of the Inspector General - Internal Audit Unit
Response Table for the Auditor General Operational Audit P&T Medicaid Payments and Related Controls - Audit Period of 7/2007 - 02/2009

Issue	Recommendation(s)	Management Response	Target Date	Contact Name
6 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.	Ongoing	Alan Strowd
7 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 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 date in parentheses in the next column. These handbooks will always continue to address edits, audits and controls applicable to appropriate claims processing.	At Risk Targeted Case Management (June 2010); Child Health Targeted Case Management (May 2010); Familial Dysautonomia Waiver (June 2010).	Alan Strowd and Beth Kidder