

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

MEDICAID FACILITY REIMBURSEMENT RATES

Operational Audit

For the Period July 2007 through February 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.

This report and other reports prepared by the Auditor General can be obtained on our Web site at www.myflorida.com/audgen; by telephone at (850) 487-9024; or by mail at G74 Claude Pepper Building, 111 West Madison Street, Tallahassee, Florida 32399-1450.

AGENCY FOR HEALTH CARE ADMINISTRATION

Medicaid Facility Reimbursement Rates

SUMMARY

This operational audit of the Agency for Health Care Administration (Agency) focused on Medicaid facility reimbursement rates during the period July 2007 through February 2009. Our audit disclosed the following deficiencies:

REIMBURSEMENT RATE CALCULATIONS

Finding No. 1: The Agency did not always calculate Medicaid reimbursement rates for hospitals and intermediate care facilities for the developmentally disabled (ICF-DDs) in accordance with established procedures and instructions.

RATES CALCULATED USING INCORRECT COST REPORT

Finding No. 2: The Agency calculated Medicaid reimbursement rates for hospitals and ICF-DDs using cost reports accepted after the deadline for cost report submission.

RATES NOT TIMELY ENTERED INTO FMMIS

Finding No. 3: The Agency did not always enter reimbursement rates into the Florida Medicaid Management Information System (FMMIS) prior to the effective date of the rate, resulting in claims being reimbursed at the previous rate. In addition, retroactive rate adjustments did not take into consideration required copayments, and overpayments were made.

COST REPORT SUBMISSION

Finding No. 4: Hospitals, ICF-DDs, and nursing homes did not always submit cost reports to the Agency within the required timeframes.

CONTRACT MONITORING

Finding No. 5: Agency monitoring of the contract with First Coast Service Options, Inc., for hospital cost report audits was not sufficient.

COST REPORT AUDIT ADJUSTMENTS

Finding No. 6: Facility reimbursement rate changes resulting from cost report audit adjustments were either not calculated or were calculated but not processed by the Agency.

BACKGROUND

Hospitals, nursing homes, and intermediate care facilities for the developmentally disabled (ICF-DDs) participating in the Medicaid Program were to be reimbursed on a per diem basis for services provided to Medicaid recipients. The per diem rates used were to be based on cost reports submitted to the Agency for Health Care Administration (Agency). Hospices were to be reimbursed room and board per diem rates based on 95 percent of the average Medicaid per diem rate of the nursing homes utilized by the hospice, weighted by actual recipient days. Rural health clinics and Federally Qualified Health Centers (FQHCs) were to be reimbursed at per diem rates based on inflation indices. As shown in Table 1, during the audit period, these facilities received total payments of \$9.4 billion in Medicaid funds.

Table 1
Medicaid Payments to Facilities by Type
July 2007 Through February 2009

Facility Type	Payment Amounts
Hospital	\$4,371,984,839.90
Nursing Home	3,877,022,129.28
ICF-DD	548,540,739.66
Hospice	466,433,127.41
FQHC	99,770,137.53
Rural Health Clinic	43,238,879.36
Total	<u>\$9,406,989,853.14</u>

Source: Medicaid Decision Support System.¹

FINDINGS AND RECOMMENDATIONS

Medicaid Facility Reimbursement Rates

The intent of Florida Law² and the Medicaid State Plan is to provide for the reimbursement of Medicaid services provided by hospitals, nursing homes, ICF-DDs, rural health clinics, and FQHCs. The amounts paid are to be based, ultimately, upon audited cost reports relating to each entity. The Agency has developed processes to collect from these facilities the information needed for the calculation of the applicable per diem rate. These processes generally include the submission of annual cost reports by the facility, Agency review of the cost reports, and then Agency calculation of the per diem rate. Lastly, the Agency contracts with entities to audit the cost reports, to determine the fairness of information included in the report, and adjusts amounts paid, as necessary, to reflect rates re-calculated based on the audited information.

As more fully described in the **OBJECTIVES, SCOPE AND METHODOLOGY** section of this report, we tested various records and transactions to determine whether the per diem rates paid to selected facilities were calculated in accordance with the Medicaid State Plan, as well as Agency policies and procedures. As discussed in succeeding findings, we noted procedural deficiencies resulting in overpayments to Medicaid providers and payments to providers that were not consistent with the rates allowed by law.

Finding No. 1: Reimbursement Rate Calculations

To calculate the reimbursement rates for hospitals, nursing homes, and ICF-DDs, the Agency developed cost reimbursement plans that have been incorporated into the Medicaid State Plan. The cost reimbursement plans detail the types of costs to be included in the calculation of reimbursement rates, as well as the methods to be used to calculate the reimbursement rates.

The Agency also developed detailed written instructions for the calculation of hospital and ICF-DD reimbursement rates that indicate which amounts should be included in the reimbursement rate calculations and where to find these amounts in the cost reports submitted by the facilities. The instructions specify the cost report schedule, line, or column needed and describe necessary calculations. Agency staff were to use the instructions to prepare from the facility cost reports manual profile sheets. The instructions developed for calculating hospital reimbursement rates

¹ The Medicaid Decision Support System (DSS) is a data warehouse that provides users with access to Florida Medicaid Management Information System data.

² Section 409.908, Florida Statutes.

indicated that the manual profile sheet calculations were to be reviewed by a second person to ensure that the calculations had been performed correctly. Data from the reviewed manual profile sheets were then to be entered into the appropriate rate calculation system, and the system was then to be used to calculate the reimbursement rate.

Our audit disclosed the following deficiencies in the procedures employed in the calculation of hospital and ICF-DD per diem rates:

- The manual profile sheets provided to us for 7 of the 20 hospital rate calculations tested did not contain evidence of review by a second person. Specifically:
 - For two instances, there was no evidence of review by a second person.
 - For one instance, the manual profile sheet was completed and reviewed by the same person.
 - For four instances, the manual profile sheet contained tick marks that may have indicated review, but the sheets were not initialed or dated by a reviewer.

These procedural deficiencies contributed to errors in the calculation of rates and in the inconsistent application of procedures. Our audit of 20 hospital outpatient and inpatient per diem rates, ranging from \$38.01 to \$1,847.35, revealed that for all 20 rates tested, there were instances in which the calculations used to determine the rate were not performed or reviewed in accordance with Agency instructions. Had the rates been calculated and reviewed in accordance with the instructions, a different hospital reimbursement rate likely would have been calculated. In some instances the error appeared to be minor in amount, while in others we were not able to determine an amount because accurate and complete reports were not available for review.

- The policies and procedures provided to us for ICF-DD rate calculations did not require that manual profile sheets be reviewed by a second person, and the 19 profile sheets reviewed by us did not have any evidence of a second review. Such reviews would better ensure the detection of instances in which Agency instructions were not followed. Our audit of 20 ICF-DD rates disclosed two instances in which the rates were not calculated in accordance with Agency instructions. In both instances, there was a discrepancy between a summary schedule and a supporting schedule prepared by the ICF-DD. The instructions indicate that the supporting schedule is the master schedule and, for any differences noted between the two schedules, the summary schedule should be adjusted to agree with the supporting schedule. However, in these two instances, the amounts reported on the summary schedule totaling \$80,543 and \$81,668, respectively, were not adjusted to agree with the \$0 amount reported on the master supporting schedules. Had the summary schedules been adjusted as specified in the instructions, the facilities' per diem reimbursement rates would have been lower by \$4.66 and \$9.95, respectively, which would have resulted in the facilities receiving a total of \$63,905 less in reimbursement for the April 2008 rate semester.

The accurate calculation of Medicaid facility reimbursement rates is imperative to the proper payment of participating facilities and the appropriate use of Federal and State funds. Considering the significant amount of funds paid to these facilities, a thorough documented review of the rate calculations would provide the Agency with additional assurances that facilities are reimbursed at correct rates.

Recommendation: The Agency should ensure that rates are calculated in accordance with established policy. The Agency should also enhance controls to ensure that calculations are performed correctly and based on complete cost reports submitted by the facility. Furthermore, the Agency should ensure that all manual profile sheets are reviewed by a second person to ensure that reimbursement rates are calculated using accurate information. Any corrections needed should be verified by the reviewer.

Finding No. 2: Rates Calculated Using Incorrect Cost Report

The Medicaid State Plan indicates that, for hospitals, nursing homes, and ICF-DDs, reimbursement rates will be set twice a year, and the Plan specifies a due date for the receipt of acceptable annual cost reports to be used in the rate

semester's calculation. For the next semester, the rate is adjusted for inflation and other authorized factors. If an acceptable cost report was not received by the Agency prior to the rate semester's applicable due date, then the facility's previous cost report was to be used in the calculation of reimbursement rates. As health care costs have increased each year, these provisions serve as an incentive for facilities to timely submit their cost reports to the Agency. State law provides that, if a provider submits a cost report late and the use of the cost report would have resulted in a lower rate, then the late cost report is to be used in rate setting.³

During our testing of 40 cost reports, 20 submitted by hospitals and 20 submitted by ICF-DDs, we noted that one hospital cost report and two ICF-DD cost reports received by the Agency after the applicable due date were used to set the current reimbursement rate. These three facilities received reimbursement totaling \$28,216,508 for services performed during the rate semester for which the late cost reports were used to calculate the reimbursement rate. For the two ICF-DD cost reports, the Agency indicated that the reports were revised cost reports and the originals had been submitted before the deadline. However, the Medicaid State Plan states that only acceptable cost reports received by the Agency by the applicable due dates are to be used in the rate-setting process. In accordance with State law and the Medicaid State Plan, the facilities' previously submitted cost reports should have been used to calculate the reimbursement rates, as the Agency did not provide documentation evidencing that the use of the late reports would have resulted in lower reimbursement rates.

The Agency's use of cost reports received after established deadlines reduced the incentive for facilities to timely submit cost reports and could result in the use of rates in excess of those authorized by law.

Recommendation: The Agency should enhance controls to ensure that Medicaid reimbursement rates are calculated using the correct cost report, in accordance with Medicaid policy and Florida law.

The Agency disagreed that the ICF/DD facility cost reports had been accepted after the filing deadline. As noted in our finding, we agree that the original cost reports were received before the filing deadline. However, the rates authorized were based on the revised cost reports rather than the most current acceptable cost report received by the applicable due date.

Finding No. 3: Rates Not Timely Entered Into FMMIS

Reimbursement rates for hospitals and hospices are set twice each year, on January 1 and July 1. Rural health clinics and FQHCs receive reimbursement at rates adjusted for inflation factors effective each October 1. Once reimbursement rates have been calculated, the new rates are to be entered into the Florida Medicaid Management Information System (FMMIS) so that claims submitted for payment will be paid using the correct rate. When rates were entered into FMMIS after the effective dates (January 1, July 1, or October 1, as applicable), the Agency's practice was to retroactively adjust any claims already paid at the previous rate. Net overpayments were withheld from the provider's weekly payment and net underpayments were added to the provider's weekly payment.

We noted during our testing that rates were not always timely entered into FMMIS, resulting in claims being reimbursed to providers at the previous rates. Specifically, we noted that for 17 of 20 hospital rates, 3 of 10 hospice rates, 8 of 10 rural health clinic rates, and 6 of 10 FQHC rates tested, the new rates were entered into FMMIS subsequent to the effective dates. For example, Medicaid claims for 7 hospital rates with an effective date of January 1, 2008, were not paid at the January 1, 2008, rate until February 27, 2008, 57 days later.

³ Section 409.908, Florida Statutes.

Additionally, we noted that the Agency's practice of adjusting claims paid at the previous rates and either adding to or holding back the net difference between the old and new rates from the provider's weekly payment, which the Agency did in the instances described above, resulted in overpayments for some claims. For certain types of Medicaid services, some Medicaid recipients were responsible for copayments that ranged from \$1 to \$3. Normally, when a recipient was responsible for a copayment, FMMIS paid the claim by deducting the copayment amount from the amount due pursuant to the reimbursement rate. For example, a claim submitted for a service with a \$100 reimbursement amount and subject to a \$3 copayment would be paid by FMMIS at \$97. Our testing disclosed instances for hospitals, rural health clinics, and FQHCs where claims paid at a previous rate, net of the copayment amount, were subsequently adjusted and paid based on the full amount of the new rate, rather than the full amount less the copayment amount. In all of these instances, the facilities were overpaid by the amount of the copayment. In response to our audit inquiry, the Agency stated that FMMIS did not consider copayments when applying retroactive rate adjustments and that a programming change to FMMIS had been requested to correct this error.

Absent timely entry of the reimbursement rates into FMMIS, the Agency is unable to ensure that certain claims submitted by Medicaid providers are reimbursed at the correct rate. Additionally, the Agency's practice of adjusting claims paid at the previous rates, without consideration of the copayments required of the Medicaid recipient, resulted in overpayments to Medicaid providers.

Recommendation: The Agency should enhance controls to ensure that reimbursement rates are entered into FMMIS prior to the rates' effective dates. The Agency should also ensure that claims adjusted for a new rate are paid in the correct amount, considering any copayments required from the recipient. In addition, the Agency should identify overpayments related to copayments that resulted from retroactive rate adjustments and initiate actions to recoup the applicable amounts from providers.

Finding No. 4: Cost Report Submission

The Medicaid State Plan specifies that hospitals and nursing homes are to submit a cost report to the Agency within 5 months of the end of their cost reporting year, while ICF-DDs are to submit a cost report within 3 months of the close of their cost reporting year. The Medicaid Provider Agreement that all Medicaid providers are required to sign states that the provider agrees, by signing, to comply with all laws, rules, and regulations applicable to the Medicaid Program.

Our audit disclosed that 9 of the 20 nursing home cost reports and 9 of the 20 hospital cost reports tested were not submitted to the Agency within 5 months of the close of the cost reporting year. Additionally, we noted that 12 of 20 ICF-DD cost reports tested were not submitted within 3 months of the close of the cost reporting year.

The Medicaid State Plan also states that ICF-DDs that do not submit their cost reports within 180 days of the end of the cost reporting year shall have their Medicaid provider contracts canceled. Although 9 of the 12 ICF-DDs that submitted their cost reports after the 3 month time period had submitted their cost reports more than 180 days after the end of the cost reporting year, the Agency had not canceled any of the providers' contracts.

Our testing also disclosed that a total of 19 nursing homes that had become active Medicaid providers prior to July 1, 2007, had never submitted a cost report to the Agency. Since these nursing homes had not submitted a cost report to the Agency, they were reimbursed for Medicaid claims based on budgeted cost reports prepared by the Agency, rather than actual cost data submitted by the provider. The amounts paid to these 19 nursing homes totaled

\$40,620,387, during the 2008-09 fiscal year. Because these providers had not submitted cost reports, their reimbursement rates were not calculated from cost reports that were subject to Federally required cost report audits.⁴

By not enforcing Medicaid State Plan contractual provisions concerning the submission of nursing home cost reports, the Agency is unable to ensure that nursing homes were paid the amounts legally authorized by law. In addition, the Agency's failure to enforce Medicaid State Plan provisions requiring the submission of cost reports within required timeframes precludes efforts to timely calculate and apply current rates.

Recommendation: The Agency should revise the Medicaid State Plan to either develop new punitive measures, such as rate reductions, or enforce existing measures to ensure the timely submission of cost reports to the Agency.

Contract Monitoring and Cost Report Audit Adjustments
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Finding No. 5: Contract Monitoring

The cost reports of hospitals are subject to periodic audits. For the performance of hospital cost report audits, the Agency entered into an annual contract totaling approximately \$1.8 million with First Coast Service Options, Inc. (FCSO). If a cost report audit indicates that adjustments are necessary to a facility's cost report, then new reimbursement rates are to be calculated and claims paid at the old, unadjusted rate are to be reimbursed at the new rate. Overpayments resulting from the rate changes are to be recouped by the Agency and any underpayments are to be paid to the facility.

We evaluated the Agency's monitoring of FCSO and noted several areas in which monitoring was insufficient to ensure adherence to contractual terms. Specifically, we noted:

- The contracts with FCSO for the 2007-08 and 2008-09 fiscal years contained a provision under which FCSO was to submit to the Agency quarterly status reports of all audits in process. During the audit period, FCSO did not submit any quarterly status reports to the Agency. Additionally, a monitoring report prepared by the Agency for the 2007-08 fiscal year contract did not disclose FCSO's failure to submit the contractually required status reports. By failing to enforce contractual provisions requiring the submission of quarterly status reports, the Agency's ability to effectively monitor FCSO's progress was reduced.
- Agency monitoring reports for both the 2006-07 and 2007-08 fiscal years' FCSO contracts were released on October 14, 2008. The reported monitoring procedures consisted of billing analyses and a working paper review of audits released by FCSO to determine whether the audits were conducted in accordance with the audit program. As the review was conducted simultaneously for both fiscal years, it appears that the contract with FCSO was renewed for the 2007-08 fiscal year absent a documented Agency review of FCSO performance. In addition, the review that was completed was of limited scope. The Agency's review included 12 audits selected from the 2006-07 fiscal year and 10 audits pertaining to the 2007-08 fiscal year; however, only 4 audits and 2 audits, respectively, involved a full working paper review. The other selected audits included only a limited review of the report and applicable time summary. In comparison, FCSO's proposal for the 2007-08 fiscal year listed 284 audits scheduled for the year.
- The audit contract was not awarded competitively, and no agency cost analysis was prepared to evaluate the competitiveness of proposed increased rates. The hourly rate paid to FCSO for the 2007-08 fiscal year increased from the \$82 rate for the 2006-07 fiscal year to \$90, an increase of 9.8 percent. For the 2008-09 fiscal year, the hourly rate paid to FCSO increased from \$90 to \$130, or by 44.4 percent over the 2007-08 fiscal year rate. While the contract amount remained constant at approximately \$1.8 million, the number of hours allocated in the contract and, consequently, the number of audits to be performed, decreased as a result

⁴ Title 42, Section 447.253(g), Code of Federal Regulations.

of the higher hourly rate. Specifically, the number of audits included in FCSO's 2008-09 fiscal year proposal decreased to 247 from the 284 listed in the 2007-08 fiscal year proposal.

In response to our audit inquiry, Agency staff indicated that the hourly rate increase was due to FCSO's implementation of a new accounting system that was necessary for it to successfully bid on a Medicare contract. Agency staff further indicated that the new system provided a more refined allocation of all indirect costs based on direct labor costs and increased the cost of operations allocated to the Medicaid contract. It is not clear to us that the accounting system was necessary for the execution of the Medicaid cost report audit contract.

Although audit services are exempt from the competitive procurement requirements of State law,⁵ due to the substantial increase in the hourly rate, the Agency should have considered competitively procuring this contract or, alternatively, performing a cost analysis to determine whether the same services could have been procured at a more cost-effective rate.

Recommendation: The Agency should require that FCSO adhere to all contract provisions, including the submission of all required reports. In addition, to gain increased assurance that the audits are performed in accordance with the contract, the Agency should consider increasing the level of detail review employed during annual contract monitoring. Also, prior to entering into another hospital cost reports audit contract, the Agency should consider performing a cost analysis to evaluate the competitiveness of proposed rates or competitively procuring the services.

Finding No. 6: Cost Report Audit Adjustments

As indicated in finding No. 5, the Agency contracted with FCSO to perform hospital cost report audits. For nursing home and ICF-DD cost report audits, the Agency engaged independent certified public accounting (CPA) firms. The Agency then reviewed the audit reports submitted by the CPA firms and released the reports subsequent to review. Once the audit report was released by the Agency, new rates were to be calculated based on the audited cost report and applied to claims submitted during the period of time covered by the audited cost report. In our reports on the Federal Awards audit of the Medicaid Program for the 2004-05 through 2007-08 fiscal years, we have commented on the extensive length of time the Agency takes to release audit reports submitted by CPA firms.⁶

We tested cost report audit reports released by the Agency during the audit period and noted that, for all 15 of the ICF-DD audits selected, the Agency had received the audit report from the CPA firm and released the audit report, but had not calculated new rates based on the audited cost report. Furthermore, the Agency indicated that 6 of the 15 ICF-DDs had undergone a change of ownership and that new rates would not be calculated. For all 6 ICF-DDs, the audited cost report pertained to the fiscal year ending in 2002, with \$12,323,732 paid to these facilities for services performed during the period of time for which rates would not be recalculated. In all 6 instances, the audit report was dated prior to the change of ownership date. In one instance, the audit report was dated 628 days before the change of ownership occurred. Because new rates were not calculated, potential overpayments or underpayments to these ICF-DDs may not be subject to proper correction by the Agency.

We also noted that 9 of the 15 hospital audits and 2 of the 15 nursing home audits selected for testing had resulted in a rate change, but the Agency had not adjusted previous claims for reimbursement at the new rate. In response to our audit inquiry, the Agency processed adjustments for claims paid at the previous rate for five of the nine hospitals and both nursing homes.

⁵ Section 287.057, Florida Statutes.

⁶ Audit report No. 2009-144, finding No. FA 08-061; report No. 2008-141, finding No. FA 07-062; report No. 2007-146, finding No. FA 06-066; and report No. 2006-152, finding No. FA 05-053.

Recommendation: The Agency should implement procedures to ensure that new ICF-DD rates are calculated when audit reports on ICF-DD cost reports are released. Furthermore, the Agency should enhance policies and procedures to ensure that cost report audits procured by the Agency are timely processed and that any rate changes resulting from cost report audits are timely calculated, entered into FMMIS, and retroactively applied.

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 facility reimbursement rates. 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 determine whether facilities serving Medicaid recipients were reimbursed at rates authorized by Medicaid policy and applicable laws, rules, and regulations.
- To determine whether selected disproportionate share (DSH) payments to hospitals were calculated in accordance with applicable laws, rules, and regulations.
- To determine whether the Agency sufficiently monitored the contract with First Coast Service Options, Inc. to ensure that hospitals providing Medicaid services are reimbursed at the appropriate rate. Also, to determine whether the Agency recorded the necessary retroactive rate adjustments in FMMIS for any adjusted cost reports for hospitals, nursing homes, and ICF-DD facilities.
- 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. In conducting our audit we:

- Obtained an understanding of selected Information Technology (IT) controls, assessed the risks of those controls, evaluated whether selected general and application IT controls were in place, and tested the effectiveness of the controls.
- Reviewed 20 hospital reimbursement rates to determine whether the rates were calculated in accordance with Medicaid policy and applicable laws, rules, and regulations.
- Reviewed 20 nursing home reimbursement rates to determine whether the rates were calculated in accordance with Medicaid policy and applicable laws, rules, and regulations.

- Reviewed 20 ICF-DD reimbursement rates to determine whether the rates were calculated in accordance with Medicaid policy and applicable laws, rules, and regulations.
- Reviewed 10 hospice, 10 rural health clinic, and 10 FQHC rates to determine whether the rates were calculated in accordance with Medicaid policy and applicable laws, rules, and regulations.
- Reviewed 15 DSH payments and determined that the rates were calculated in accordance with Medicaid policy and applicable laws, rules, and regulations.
- Reviewed Agency FCSO contract monitoring activities during the audit period to determine whether the level of monitoring was sufficient to ensure contract compliance.
- Reviewed 15 hospital, 15 nursing home, and 15 ICF-DD cost report audits issued during the audit period to determine whether adjusted rates had been calculated and that any adjustments had been retroactively applied in FMMIS.
- 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 March 22, 2010, the Secretary of the Agency provided responses to our audit findings and recommendations. The Agency's response is included as EXHIBIT A.

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EXHIBIT A
MANAGEMENT'S RESPONSE



Better Health Care for all Floridians

CHARLIE CRIST
GOVERNOR

THOMAS W. ARNOLD
SECRETARY

March 22, 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 Operational Audit on Medicaid Facility Reimbursement Rates. 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) 412-3977.

Sincerely,

Thomas W. Arnold
Secretary

TWA/mb
Enclosure: Response to the P&T for Medicaid Facility Reimbursement Rates
cc: James McFaddin, Chief of Staff



**EXHIBIT A
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 of Medicaid Facility Reimbursement Rates

Issue	Recommendation(s)	Management Response	Target Date	Contact Name
<p>1 The Agency did not always calculate Medicaid reimbursement rates for hospitals and intermediate care facilities for the developmentally disabled (ICF-DDs) in accordance with established procedures and instructions.</p>	<p>The Agency should ensure that rates are calculated in accordance with established policy. The Agency should also enhance controls to ensure that calculations are performed correctly and based on complete cost reports submitted by the facility. Furthermore, the Agency should ensure that all manual profile sheets are reviewed by a second person to ensure that reimbursement rates are calculated using accurate information. Any corrections needed should be verified by the reviewer.</p>	<p>The Agency has and is continuing to ensure that all providers' rates are calculated in accordance with State and Federal policy. The Medicaid Cost Reimbursement Planning Administrator (MCRP Administrator) conducts a review process and signs each rate letter prior to distributing them to the hospital, ICF/DD and the Medicaid Fiscal Intermediary. The review process includes reviewing the manual profile sheet, rate computations, rate letter and the cost report (which produces the manual profile sheet, rate computations and rate letter). The Agency will continue to calculate Medicaid reimbursement rates for hospitals and ICF/DDs in accordance with established procedures and instructions. The Agency will develop and implement a process to document in a form of a checklist that will provide the required information to demonstrate that the agency is in compliance with the rate setting procedures. The Agency feels that the policies and procedures as defined in the state plan are followed however, the detailed supplemental instructions will be updated to reflect the changes required under the more current state plan.</p>	<p>Updated instructions and process checklist will be developed and implemented by 11/1/10</p>	<p>Rydell Samuel</p>

**EXHIBIT A
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 of Medicaid Facility Reimbursement Rates

Issue	Recommendation(s)	Management Response	Target Date	Contact Name
2 The Agency calculated Medicaid reimbursement rates for hospitals and ICF-DDs using cost reports accepted after the deadline for cost report submission.	The Agency should enhance controls to ensure that Medicaid reimbursement rates are calculated using the correct cost report, in accordance with Medicaid policy and Florida law.	The Hospital Reimbursement Plan states each hospital shall submit a cost report 5 months after the close of its cost-reporting year; however, the Plan also states, all cost reports received by AHCA by April 15 and October 15 respectively shall be used to establish the reimbursement ceilings (rates). The Agency disagrees with the finding that ICF/DD cost reports were accepted after the filing deadline. The Agency has confirmed that the original cost reports were submitted prior to the established deadline. The Medicaid policy regarding amended/revised cost report is that the original cost report filing date is the factor for determining if a cost report is late.	NA	Rydell Samuel
3 The Agency did not always enter reimbursement rates into the Florida Medicaid Management Information System (FMMS) prior to the effective date of the rate, resulting in claims being reimbursed at the previous rate. In addition, retroactive rate adjustments did not take into consideration required copayments, and overpayments were made.	The Agency should enhance controls to ensure that reimbursement rates are entered into FMMS prior to the rates’ effective dates. The Agency should also ensure that claims adjusted for a new rate are paid in the correct amount, considering any copayments required from the recipient. In addition, the Agency should identify overpayments related to copayments that resulted from retroactive rate adjustments and initiate actions to recoup the applicable amounts from providers.	The Bureau of Medicaid Program Analysis (MPA) has and will continue to ensure that providers’ rates are submitted to MCM in a timely fashion in order to ensure that reimbursement rates are entered into FMMS prior to the rate effective dates. The Agency is aware of issues regarding the overpayment to providers of copayments when retroactive rate adjustments are generated and CSR 1236 was created on July 29, 2009 and implemented into production October 5, 2009. The CSR corrected the business rules used in FMMS to process retroactive claim adjustments for claims with copayments. The Agency will initiate actions to identify and recoup any overpayments made to providers due to this issue.	Ongoing	Rydell Samuel, Shannon Segers, Alan Strowd

EXHIBIT A
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 of Medicaid Facility Reimbursement Rates

Issue	Recommendation(s)	Management Response	Target Date	Contact Name
4 Hospitals, ICF-DDs, and nursing homes did not always submit cost reports to the Agency within the required timeframes.	The Agency should revise the Medicaid State Plan to either develop new punitive measures, such as rate reductions, or enforce existing measures to ensure the timely submission of cost reports to the Agency.	The Bureau of Medicaid Program Analysis (MPA) is currently working with the Bureau of Medicaid Program Integrity and Office of the Inspector General to make a rule change to 59G-9.070 to establish punitive fines for providers who are not filing a timely cost report for rate setting.	Expected rule change - 7/1/2010	Rydell Samuel
5 Agency monitoring of the contract with First Coast Service Options, Inc., for hospital cost report audits was not sufficient.	The Agency should require that FCSO adhere to all contract provisions, including the submission of all required reports. In addition, to gain increased assurance that the audits are performed in accordance with the contract, the Agency should consider increasing the level of detail review employed during annual contract monitoring. Also, prior to entering into another hospital cost reports audit contract, the Agency should consider performing a cost analysis to evaluate the competitiveness of proposed rates or competitively procuring the services.	The Agency is amending the FCSO contract to more accurately reflect the status reports being employed. FCSO is submitting monthly reports of work submitted and an updated status of the budget to actual work completed. The contract monitoring for 2009-10 fiscal year will be completed during the contract period. The Agency will consider increasing the number of audits for a full working paper review. The Agency is currently exploring options to lower the hourly rate for the hospital cost report audit contract that will allow for increased audit hours when the contract is renewed.	6/30/2010	Rydell Samuel

**EXHIBIT A
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 of Medicaid Facility Reimbursement Rates

Issue	Recommendation(s)	Management Response	Target Date	Contact Name
6 Facility reimbursement rate changes resulting from cost report audit adjustments were either not calculated or were calculated but not processed by the Agency.	The Agency should implement procedures to ensure that new ICF-DD rates are calculated when audit reports on ICF-DD cost reports are released. Furthermore, the Agency should enhance policies and procedures to ensure that cost report audits procured by the Agency are timely processed and that any rate changes resulting from cost report audits are timely calculated, entered into FMMIS, and retroactively applied.	Currently, there are procedures in place to ensure that new ICF/DD rates are calculated when audit reports on ICF/DD cost reports are released; however, the delay in processing the current audit is based solely on staff turnover within the unit. We are currently at full staff and the pending audits have been assigned to an analyst. In addition, procedures have been put in place regarding facilities undergoing a change of ownership. For an ICF-DD undergoing a change of ownership, the Licensure process consists of verifying outstanding audits and/or pending rate adjustments based on cost reports. A facility license will not be issued until these outstanding issues have been resolved with the old owner and new owner, with regard to repayment of any outstanding Medicaid liens.	NA	Rydell Samuel