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AGENCY FOR HEALTH CARE ADMINISTRATION

FMMIS CONTROLS AND THE PREVENTION OF IMPROPER MEDICAID PAYMENTS

Operational Audit

STATE OF FLORIDA
AUDITOR GENERAL
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SECRETARY OF THE AGENCY FOR HEALTH CARE ADMINISTRATION

The Agency for 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 period of our audit, the following individuals served as Secretary:

Elizabeth Dudek	From August 2010
Tom Arnold	From October 2009 to August 2010
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AGENCY FOR HEALTH CARE ADMINISTRATION

FMMIS Controls and the Prevention of Improper Medicaid Payments

SUMMARY

Chapter 2010-144, Laws of Florida, requires a review and evaluation of the Agency for Health Care Administration's Medicaid fraud and abuse prevention and detection systems. This operational audit focused on controls within the Florida Medicaid Management Information System (FMMIS) related to the prevention and detection of improper Medicaid payments made through the fee-for-service payment structure for providers. A subsequent report of the Auditor General will address in its scope additional controls relevant primarily to fee-for-service payments to facilities, such as hospitals and nursing homes.

Medicaid Payments and FMMIS Controls

FMMIS allows the use of numerous electronic edits and audits to ensure that each submitted claim is from a valid Medicaid provider, for a valid Medicaid recipient, and for a valid Medicaid service. The electronic audits are also to be employed in the review of a recipient's claim history to ensure that the claim submitted by the provider does not exceed Medicaid Program limitations. As the vast majority of claims processed by FMMIS are not subject to any type of manual preaudit or pre-payment review, the electronic edits and audits in FMMIS are critical in ensuring claims are paid appropriately. Not only are these edits and audits in FMMIS essential to ensure that claims are paid appropriately, but they also serve as a first line of defense in preventing and detecting fraud and abuse in the Medicaid Program. Since it is more cost-beneficial to prevent payment of improper claims than to employ what is known as a "pay and chase" approach, under which claims initially paid without sufficient scrutiny must be followed by attempts to identify and recover unallowable, erroneous, or fraudulent payments, it is incumbent upon the Agency for Health Care Administration (Agency) to ensure that FMMIS contains cost-effective electronic edits and audits. As summarized below, our audit found that processes that would reasonably ensure the timely implementation of edits and audits had not been established by the Agency.

Finding No. 1: The Agency's ineffective risk assessment processes contributed to the disbursement of improper payments.

Finding No. 2: To ensure that FMMIS includes the necessary audits, the Agency should have a process in place to periodically review FMMIS to determine that audits are in place and operating as intended and that they are based on current Medicaid limitations. Our examination disclosed that a comprehensive review of procedure codes and applicable audits had not been performed for all service types within the last several years. Additionally, when the Agency changed fiscal agents effective June 26, 2008, a review of procedure codes and audits was not performed as part of the two-year design, development, and implementation phase. Absent the Agency's periodic review of the effectiveness of FMMIS audits, deficiencies in the audits will not be identified and improper payments will be made and escape detection. For example, our analysis of selected service types and procedure codes identified claim payment errors totaling $17,274,230 made to durable medical equipment and other service providers. For some of these claims the absence of accurate claim information precluded reliable estimates as to the extent these payments represented overpayments.

Finding No. 3: FMMIS was not programmed to ensure the proper payment of outpatient Medicare crossover claims. Our review of 286 claims disclosed that 182, or 63.6 percent, had been paid amounts in excess of authorized amounts. When the errors identified by our audit are projected to the total of the amounts paid for outpatient hospital crossover claims during the three fiscal years tested, the total overpayment is estimated to be $117,659,683.

Finding No. 4: FMMIS was not programmed to correctly calculate the amounts due for some professional Medicare crossover claims. Our audit tests disclosed related overpayments totaling $14,053,660.

Finding No. 5: **Medicare crossover claims were paid on behalf of recipients without consideration of whether the recipient was eligible for the assistance. Related overpayments disclosed by our audit tests totaled $26,071,070.**

Finding No. 6: **Programming changes to FMMIS electronic edits and audits were not made in a timely manner. Our review of 28 FMMIS change orders to determine whether the changes were implemented by the effective date of the policy change disclosed that for 21 of the 28 change orders reviewed, the program change to FMMIS was not timely implemented. The period of time between the effective date of the policy change and the date the change was implemented in FMMIS ranged from 20 to 2,542 days and averaged 541 days.**

Finding No. 7: **The Agency should strengthen the process by which the Bureau of Medicaid Program Integrity's recommendations are reviewed and tracked.**

Finding No. 8: **The Agency should automate processes for the screening of new and currently enrolled Medicaid providers. Automating these processes would also improve the timeliness with which Medicaid providers are terminated from the Medicaid Program due to adverse actions.**

Fiscal Agent Oversight

Finding No. 9: **To enhance its effectiveness as a deterrent to unacceptable performance, should such occur, the methodology used to periodically monitor the performance of the Medicaid fiscal agent and assess related penalties should be modified.**

BACKGROUND

The 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 Florida Medicaid Program.[1] The Florida Medicaid Program is a joint Federal and State-funded program that pays for health care services provided to recipients who meet the Program's eligibility criteria. Recipients who meet the Program's eligibility criteria generally either enroll in a managed care plan or receive their services through a fee-for-service payment structure.[2] As shown by Table 1, during the 2009-10 fiscal year, the Agency processed Medicaid claims totaling approximately $18.1 billion, with fee-for-service claims representing $14.8 billion and managed care payments totaling approximately $3.3 billion.

[1] Sections 20.42, and 409.902, Florida Statutes.
[2] Medicaid Reform managed care plans were operating in Broward, Duval, Clay, Baker and Nassau counties.

Table 1
Medicaid Payments, By Service Type
2009-10 Fiscal Year

Medicaid Service Type	Payment Amount	Percentage of Total
Fee-For-Service Payments		
Cost-Based Reimbursement Type Facilities (Hospitals, Nursing Homes, Intermediate Care Facilities for the Developmentally Disabled)	$ 9,749,349,110	53.96%
Other Facility Types (Hospices, County Health Departments, Federally Qualified Health Centers, Rural Health Clinics, etc.)	646,477,808	3.58%
Prescription Drugs	1,168,779,989	6.47%
Physician Services	983,832,776	5.45%
Durable Medical Equipment	131,350,701	0.73%
Therapy Services	109,215,601	0.60%
Independent Laboratory Services	81,374,675	0.45%
All Other Service Types	757,734,949	4.19%
Aged and Disabled Adult Waiver	107,263,409	0.59%
Family and Supported Living Waiver	99,135,456	0.55%
Traumatic Brain and Spinal Cord Injury Waiver	9,369,727	0.05%
All Other Waiver Services	948,925,290	5.25%
Total Fee-For-Service Payments	14,792,809,491	81.88%
Managed Care Payments	3,274,632,829	18.12%
Total Payments	**$18,067,442,321**	**100.00%**

Source: Medicaid Decision Support System (DSS). Medicaid DSS is a data warehouse of Medicaid data, including payments for services, provider information, and recipient information.

In the fee-for-service payment structure, Medicaid service providers must be approved and enrolled in the Medicaid Program. Once the service has been performed, the provider is to submit a claim for monetary compensation. These claims are generally in electronic format and are submitted through the Florida Medicaid Management Information System (FMMIS), which is administered by a fiscal agent. Approximately 50 million fee-for-service claims were processed during the 2009-10 fiscal year.

The Agency currently has a contract with HP Enterprise Services (HPES) to serve as the Medicaid fiscal agent through June 2013.[3] Additionally, HPES enrolls providers in the Medicaid Program as part of this contract. HPES began operations as the fiscal agent on June 26, 2008. Prior to HPES, ACS State Healthcare, LLC, (ACS) served as

[3] The contract is effective May 16, 2006, through June 30, 2013, and authorized payments totaling $327 million. Prior to June 26, 2008, the contract objectives addressed planning, design, development, testing and implementation.

the Medicaid fiscal agent. During the 2009-10 fiscal year, Agency payments to HPES for fiscal agent services totaled $71 million.

The scope of this audit included controls relating to Medicaid payments to providers. A subsequent report of the Auditor General will address in its scope additional controls relevant to payments to facilities, such as hospitals and nursing homes. Since FMMIS did not adjudicate prescription drug claims, electronic controls related to prescription drugs were not included in the scope of this audit. Prescription drugs were processed through the Pharmacy Benefits System provided by Magellan Medicaid Administration, Inc. (formerly First Health, Inc.), through a subcontract with HPES. (Auditor General Report No. 2010-139, *Medicaid Payments and Related Controls*, includes a finding related to our review of prescription drug claims processed by the Pharmacy Benefits System.) Finally, certain FMMIS controls (edits and audits) were not reviewed for physician services claims, as many of the services performed by physicians were limited only by medical necessity.

As of the date of this report, the Office of Program Policy Analysis and Government Accountability had in progress a review of the efficiency and effectiveness of fraud and abuse prevention and detection procedures for managed care programs.

FINDINGS AND RECOMMENDATIONS

Medicaid Payments and FMMIS Controls

FMMIS allows the use of numerous electronic edits and audits to ensure that each submitted claim is from a valid Medicaid provider, for a valid Medicaid recipient, and for a valid Medicaid service. The electronic audits are also to be employed in the review of a recipient's claim history to ensure that the claim submitted by the provider does not exceed Medicaid Program limitations. As the vast majority of claims processed by FMMIS are not subject to any type of manual preaudit or pre-payment review, the electronic edits and audits in FMMIS are critical in ensuring claims are paid appropriately. Not only are these edits and audits in FMMIS essential to ensure that claims are paid appropriately, but they also serve as a first line of defense in preventing and detecting fraud and abuse in the Medicaid Program. Since it is more cost-beneficial to prevent payment of improper claims than to employ what is known as a "pay and chase" approach, under which claims initially paid without sufficient scrutiny must be followed by attempts to identify and recover unallowable, erroneous, or fraudulent payments, it is incumbent upon the Agency to ensure that FMMIS contains cost-effective electronic edits and audits.[4] As detailed in the audit findings which follow, our audit found that processes that would reasonably ensure the timely implementation of edits and audits had not been established by the Agency.

Finding No. 1: Risk Assessment

Efficient and effective management of a program, such as Medicaid, requires the ongoing and effective operation of internal control. Internal control can be defined as a process, effected by an entity's management, designed to provide

[4] The *Improper Payments Information Act of 2002, Public Law 107-300,(d)(2.),* defines an improper payment as any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. Improper payments include any payment to an ineligible recipient, any payment for an ineligible service, any duplicate payment, payments for services not received, and any payment that does not account for credit for applicable discounts.

reasonable assurance of the achievement of management's objectives relating to the effectiveness and efficiency of operations; the reliability of financial reporting; and compliance with applicable laws and regulations. A key component of effective internal control is risk assessment and management.

More specifically, all entities face risks from internal and external sources that must be identified, assessed, and controlled in order to effectively achieve management's objectives. A successful risk assessment process provides for the identification and analysis of risks and a determination as to how to effectively manage them through the implementation of mitigating internal controls. As these risks may change over time, a risk assessment process should also include mechanisms to identify and address risks associated with change.[5] As related to the Agency's efforts to prevent improper payments, including fraud and abuse, a risk assessment that addresses which edits and audits are necessary to safeguard State and Federal funds is an essential component of the Agency's internal controls.

During our audit, it became evident that the Agency had not implemented an effective risk assessment process whereby risks to the Agency's objectives are identified and controls are implemented to mitigate identified risks. The control deficiencies and improper payments noted in finding Nos. 2 through 6, can be attributed, in part, to an ineffective risk assessment process within the Agency's Division of Medicaid.

Recommendation: We recommend that the Agency review its internal controls, including its risk assessment processes, as related to the prevention of improper payments for Medicaid services, and implement effective controls designed to ensure that improper payments are minimized to the greatest extent possible.

Finding No. 2: Payment for Medicaid Services

As indicated under the heading **MEDICAID PAYMENTS AND FMMIS CONTROLS**, FMMIS allows the use of electronic controls designed to ensure that only claims submitted by valid Medicaid providers, on behalf of valid Medicaid recipients, for valid Medicaid services are paid. The electronic controls include audits that compare submitted claim data against other claims in a recipient's history. If an audit determines that the recipient has already met Medicaid's limitation for the type of service, the claim is to be denied payment.

To ensure that FMMIS includes the necessary audits, the Agency should have a process in place to periodically review FMMIS to determine that audits are in place and operating as intended and that they are based on current Medicaid limitations. Our examination disclosed that a comprehensive review of procedure codes and applicable audits had not been performed for all service types within the last several years. Additionally, when the Agency changed fiscal agents effective June 26, 2008, a review of procedure codes and audits was not performed as part of the two-year design, development, and implementation phase.

Agency staff did indicate that a project to compare Durable Medical Equipment procedure codes with applicable audits was started in February 2010. However, by the time of our review in October 2010, as indicated in the finding below, there were still 897 of 1,432 procedure codes that did not have an audit assigned to prevent the payment of claims in excess of policy limitations. Inquiry of agency staff indicated that this project was not completed until May 2011, more than one year after the project began.

[5] Committee of Sponsoring Organizations of the Treadway Commission (COSO), Internal Control – Integrated Framework (1992).

Absent the Agency's periodic review of the effectiveness of FMMIS audits, deficiencies in the audits will not be identified and improper payments will be made and escape detection. As part of this operational audit, we selected various Medicaid service types and the associated procedure codes and determined whether FMMIS contained audits reasonably necessary to ensure that claims were not paid for services that exceeded Medicaid's program limitations.[6] Our review of ten Medicaid services and their applicable audits in FMMIS disclosed that for seven of the ten service types reviewed, FMMIS either did not contain audits as needed, or the audits assigned to the service type were not programmed for current program limitations. For the seven service types that did not have an audit assigned or the audit was programmed for an incorrect policy limitation, our audit tests disclosed six service types with instances in which claims had been paid in excess of Medicaid service limitations.

For the six service types, our tests disclosed payment errors totaling $17,274,230. Specifically:

- For Durable Medical Equipment (DME) services, 897 of 1,432 procedure codes (62.6 percent), the majority of which had service limitations, did not have a limitation audit in place to prevent the payment of claims in excess of program limitations. From the 897 procedure codes that did not have an audit in place, we selected 18 procedure codes with payments totaling $18,771,346 to determine whether claims had been paid in excess of Medicaid Program limitations. Our analysis of the claims for 18 procedure codes disclosed that for all the procedure codes selected, payments had been made for services that exceeded program limitations for the service. The amount of the overpayments totaled $868,962 (4.6 percent of total payments for the selected procedure codes). For one procedure code, payments in excess of policy limitations accounted for 18.4 percent ($152,480) of the total amount expended for the procedure code. The detected payments in excess of service limitations were made over the last one to four years, depending upon the corresponding service limitation for the procedure code reviewed. As not all of the procedure codes without an audit in place were tested by us, it is likely that additional overpayments have been made for procedures codes that were not reviewed. While many of the overpayments were made simply for services in excess of policy limitations, our tests disclosed some patterns in payments that should be subjected to further investigation by the Agency:

  - For 4 of the 18 procedure codes reviewed, instances were noted in which providers submitted multiple claims for reimbursement for the same recipient, same medical procedure, and for the same service date. For 3 of the 4 procedure codes, instances were noted in which the same provider submitted the same claim from multiple locations. For the remaining procedure code, an instance was noted in which 2 different providers submitted claims for the same recipient, same service, and for the same service date. Payments identified for these instances totaled $8,552. An expanded analysis of one of these provider's claims identified additional instances where the same claim was submitted from different locations for nine additional procedure codes with claims paid totaling $5,472.

  - For 5 of the 18 procedure codes reviewed, we noted instances in which a payment was made for the same medical procedure, for the same recipient, on the same date of service, multiple times due to the submission of multiple claims for the same medical procedure. In some instances, the same procedure codes were included on multiple claims and paid on different payment dates, indicating that the claim had been resubmitted by the provider. An example of this situation occurred for a procedure code that had a service limitation of two units per year. In this instance, the recipient was provided two units (meeting the service limitation) on October 23, 2009. However, payments for the same two units were made multiple times pursuant to other claims for the same recipient, same service date, and from the same

[6] Previous audits of Federal Awards, including the Medicaid Program, have identified control weaknesses and resulting overpayments for additional service types. Auditor General report No. 2011-167, Finding No. FA 10-057; report No. 2010-165, Finding No. FA 09-055; and report No. 2009-144, Finding No. FA 08-056 provide information related to control deficiencies and potential overpayments for service types such as home health services, chiropractic services, dental services, and Developmental Disabilities Waiver services.

provider on November 25, 2009, December 2, 2009, September 1, 2010, and September 8, 2010, resulting in overpayments totaling $2,182.

- For Family and Supported Living (FSL) Waiver services, instances were noted in which programming in FMMIS for 4 of the 24 procedure codes was not set for the correct policy limitations. In these instances, FMMIS allowed a month's worth of services to be billed for a patient as if the services had been provided on one day, rather than requiring an itemized claim showing for each patient the days on which the services were provided. The total paid for these four procedure codes amounted to $48.9 million during the period July 1, 2009, through September 30, 2010. Our audit tests disclosed claim errors totaling $3,261,515. However, the absence of complete daily claim information precluded reliable estimates of the extent to which these errors represented overpayments.

- For Aged and Disabled Adult (ADA) Waiver services, claims were paid in excess of policy limitations for 6 of the 38 associated procedure codes. These codes either did not have an audit in place or the audit was programmed for an incorrect service limitation. For four of the six procedure codes, there were minimal overpayments noted, with $11,850 paid in excess of policy limitations. This represented less than one percent of the total $46,702,464 paid for the procedure codes during the period July 1, 2009, through September 30, 2010.

  For one procedure code, with a service limitation of two units per day, and a total of $10,740,917 paid during the period July 1, 2009, through September 30, 2010, programming was not set for the policy limitation. Similar to an issue identified with the Family and Supported Living Waiver services claims and noted above, FMMIS allowed a month's worth of services to be billed for a patient as if the services had been provided on one day, rather than requiring an itemized claim showing for each patient the days on which the services were provided. Our audit tests disclosed claim errors totaling $7,666,627. However, the absence of complete daily claim information precluded reliable estimates of the extent to which these errors represented overpayments. Further, instances were noted in which providers billed for and were paid for providing 62 units of service for months in which, at most, only 56 or 60 units of service were eligible for payment.

  For the sixth procedure code (Attendant Care Services) that did not have an audit in place, we found that $4,905,174 (41.2 percent) of the payments totaling $11,911,622 had been paid in excess of policy limitations. Agency staff indicated that the Agency allowed a group of recipients to exceed the established program limitations for this procedure code.[7] As Section 409.908, Florida Statutes, authorizes the Agency to reimburse providers in accordance with limitations established in rules of the Agency and in policy manuals and handbooks, the Agency was not authorized by Florida law to exceed established program limitations for this service. Additionally, instances were noted in which claims were paid in excess of the service limitations for some other recipients.

- For the remaining three service types with procedure codes with no audit in place or with an audit programmed for an incorrect limitation (that is, Therapy Services, Traumatic Brain and Spinal Cord Injury (TBSCI) Waiver services, and Independent Laboratory Services), payments made in excess of policy limitations totaled $513,002, $46,911, and $189, respectively.

Details of the potential overpayments discussed above have been provided to the Agency's Bureau of Medicaid Program Integrity for further investigation.

Recommendation: During fieldwork for this audit, the Agency's Bureau of Medicaid Program Integrity began a review of Medicaid services and applicable edits and audits in January 2011. We recommend that the Agency continue its review of Medicaid services and applicable edits and audits to ensure that FMMIS contains all controls necessary to prevent payment of claims for services in excess of policy limitations. This

[7] The Agency allowed recipients enrolled in the Aging Out Program, under the Aged and Disabled Adult Waiver, to exceed established program limits. The Aging Out Program provides services to individuals who had been receiving medical services in the home through the Department of Health, Children's Medical Services, but no longer qualify once reaching age 21.

review should extend to all Medicaid services. We also recommend that the Agency give this project a high priority considering the likelihood that overpayments have and will be made until project completion. After project completion, the Agency should attempt to recover overpayments that were made in excess of program limitations, including the amounts identified by this audit.

We also recommend that the Agency implement procedures to ensure that whenever an existing policy is modified or a new policy is added, all applicable edits and audits are reviewed to determine whether programming changes are needed. Additionally, procedures should be implemented to provide for the periodic review of edits and audits for each service type to ensure that all cost-effective edits and audits are in place and programmed for the correct policy.

Finding No. 3: Medicare Outpatient Crossover Claims

Individuals who receive Medicare benefits may also be entitled to receive certain levels of Medicaid benefits, the extent of which depends primarily upon income level, with benefits ranging from Medicaid payment of only the Medicare Part B premiums to full Medicaid benefits pursuant to which Medicaid also pays the Medicare Part A premiums, Medicare Part B premiums, and for claims, Medicare coinsurance and deductibles. Since Medicaid is always the payor of last resort, claims for Medicaid recipients who are also receiving Medicare benefits must first be submitted to the Medicare program for payment. Once the Medicare program has paid the covered portion of the claim, the claim can be submitted to the Medicaid Program for payment of any amounts due for Medicare coinsurance and deductible amounts. Such claims are referred to as crossover claims.

While Section 409.908(13), Florida Statutes, authorizes the Agency to pay Medicare coinsurance and deductibles on behalf of Medicaid-eligible individuals, the law also states that Medicaid will not pay any portion of Medicare coinsurance or deductible amounts when Medicare has already paid amounts that equal or exceed what Medicaid would have paid if Medicaid were the sole payor. Florida law also states that the combined payments from Medicare and Medicaid shall not exceed what Medicaid would have paid if Medicaid were the sole payor.[8]

We reviewed Medicare Part B outpatient hospital crossover claims to determine whether they were calculated and paid properly by the Medicaid Program. Medicare Part B pays for outpatient medical services provided in hospitals, clinics, nursing homes, or other facilities. We initially reviewed a sample of 40 such claims, totaling $20,303, paid during the 2009-10 fiscal year and noted that 30 of the 40 claim payments, or 75 percent, had been calculated improperly, resulting in overpayments of $19,487. As a result of this high rate of error, we expanded our sample to test an additional 286 claims paid by the Medicaid Program during the 2007-08, 2008-09, and 2009-10 fiscal years. The 2007-08 fiscal year was included to determine whether this type of error predated the change in fiscal agents effective June 26, 2008. The total amount expended by the Medicaid Program for outpatient hospital crossover claims for the three fiscal years tested was $172,649,765. Our review of 286 claims, totaling $101,164, disclosed that 182, or 63.6 percent of the number of claims reviewed, had been paid in excess of authorized amounts, with errors noted in all three fiscal years tested. Specifically, we noted:

- Of the 182 claims that were overpaid, 141 had already been paid by Medicare in an amount that exceeded what Medicaid would have paid if Medicaid were the sole payor. As a result, Medicaid should have paid $0 for these 141 sample items, but paid to providers amounts ranging from $2.09 to $3,174.99. Additionally, for

[8] Section 409.908(13)(b), Florida Statutes.

28 of the 141 claims, the Medicare coinsurance amount paid by Medicaid on the crossover claim was more than the payment Medicaid would have made if Medicaid were the sole payor.

- For 25 of the 182 claims paid improperly, while Medicare's payment did not exceed what Medicaid would have paid if Medicaid were the sole payor, the combined payment of Medicare and Medicaid did exceed the amount that would have been due from Medicaid had Medicaid been the sole payor.
- For 16 of the 182 claims, there was insufficient detail on the crossover claim to determine what Medicaid's payment would have been if Medicaid were the sole payor. As the claim did not contain sufficient information to accurately determine Medicaid's rate, these 16 sample items should have been denied for payment by FMMIS. Instead, Medicaid funds were expended for all 16 sample items.

The total overpayment identified during our testing for the 182 sample items paid in error was $87,784. When the errors identified by our testing are projected to the population of $172,649,765, the total overpayment for outpatient hospital crossover claims paid during the three fiscal years tested was estimated to be $117,659,683.[9]

Due to the high error rates disclosed by our testing, we reviewed the related FMMIS methodology and determined that FMMIS was not calculating Medicaid's payment as if Medicaid were the sole payor and comparing that amount to the amount paid by Medicare to determine whether additional amounts were due from Medicaid. Nor did the methodology ensure that the combined payment of Medicare and Medicaid did not exceed Medicaid's rate. Rather, FMMIS was programmed to pay the lesser of 20 percent of the recalculated Medicare allowed amount or the coinsurance and deductible amounts submitted by Medicare. A review of Provider General Handbooks disclosed that this payment methodology for outpatient hospital crossover claims had been in effect since July 1, 2001. As a result, overpayments of outpatient hospital crossover claims likely extend beyond the three years tested by us.

Recommendation: We recommend that the Agency ensure that FMMIS is programmed with the correct methodology for the payment of outpatient crossover claims. Appropriate priority should be given to these programming changes considering the likelihood that overpayments will continue until the changes have been implemented. We also recommend the Agency review outpatient crossover claims and initiate recovery efforts for any payments made that were not consistent with Florida law.

Finding No. 4: Medicare Professional Crossover Claims

Medicare Part B also pays for services provided by medical professionals, such as physicians, chiropractors, audiologists, and podiatrists. Similar to the benefits described in Finding No. 3 for outpatient services, if the Medicare recipient meets certain Medicaid eligibility criteria, then the recipient may be eligible to have Medicaid pay for all or a portion of the Medicare coinsurance and deductible amounts. The payments of coinsurance and deductible amounts for professional Medicare Part B crossover claims are also subject to the limits provided in Section 409.908(13)(b), Florida Statutes. Specifically, Medicaid is not to pay any coinsurance or deductible amounts when Medicare has already paid the claim in an amount that equals or exceeds Medicaid's rate had Medicaid been the sole payor.

[9] The projected amount of the overpayments is estimated based upon our evaluation of a stratified random sample of 286 claims, with a 90 percent confidence level and a confidence interval ranging from $102,963,413 to $132,355,953. As discussed further in Finding No. 5, approximately five percent of the dollar value of the population includes crossover claims that should not have been paid for SLMB and QI1 recipients. Because of their relatively minimal impact on our estimate, no adjustment for these potentially unallowable claims has been made to the population or the amount of the estimated overpayments.

Additionally, the combined payment amounts from Medicare and Medicaid cannot exceed Medicaid's rate if Medicaid were the sole payor.[10]

Due to the high payment error rates disclosed by tests of outpatient hospital crossover claims, we obtained the FMMIS methodology used to process professional crossover claims and found that while the methodology was generally consistent with Florida law, we noted a discrepancy that resulted in FMMIS paying a rate that differed from Medicaid's established rate for the service and that was often higher than Medicaid's rate. Specifically, we found that if the professional crossover claim submitted to FMMIS contained any one of five different procedure code modifiers[11] (modifiers), then FMMIS was programmed to calculate Medicaid's payment at 50 percent of Medicare's rate (80 percent of Medicare's rate for Durable Medicaid Equipment providers), rather than calculating Medicaid's payment using the established Medicaid rate.

We ran queries in the Medicaid DSS for professional crossover claims paid during 2007-08, 2008-09, and 2009-10 fiscal years to identify claims paid with these five modifiers so that we could determine whether any overpayments had occurred as a result of the programming error. For the three fiscal years, payments for professional crossover claims paid with these five modifiers totaled $24,261,214.[12] We selected for testing 10 of the approximately 350 procedure codes, each with payments made in each fiscal year, and found that the Agency's practice of calculating Medicaid's payment using 50 percent of the Medicare rate resulted in total overpayments to providers of $14,053,660, as summarized in Table 2, below.

Table 2
Professional Crossover Claims Summary
For 10 Selected Procedure Codes

Fiscal Year	Overpayment	Total Payment	Overpayment as % of Total
2009-10	$ 7,306,576	$ 8,133,701	89.8%
2008-09	5,753,643	6,423,175	89.6%
2007-08	993,441	1,557,396	63.8%
Total	**$14,053,660**	**$16,114,272**	**87.2%**

Source: Audit analysis of FMMIS data.

For the majority of instances in which an overpayment occurred, Medicare had already paid the claim in an amount that exceeded Medicaid's established rate. As a result, Medicaid should have paid $0. Other instances were noted where the combined payment of Medicare and Medicaid exceeded Medicaid's established rate for the service.

Inquiry of Agency personnel indicated that the methodology used in FMMIS to calculate the Medicaid amount due for these five modifiers was incorrect and that the presence of these five modifiers on a claim should not result in a different rate. A programming change request had been submitted to correct this error, but as of April 1, 2011, the programming change had not been implemented. Further inquiry of Agency personnel indicated that this payment

[10] Section 409.902(13)(b), Florida Statutes.
[11] A procedure code modifier is a two digit alpha or numeric code indicating that a service or procedure was altered in some way from the standard description.
[12] As discussed further in Finding No. 5, approximately three percent of the dollar value of the population includes crossover claims that should not have been paid for SLMB and QI1 recipients. Because of their relatively minimal impact on our analysis, no adjustment for these potentially unallowable claims has been made to the amount of the estimated overpayments.

methodology had likely been in effect for the last ten years. As a result, it is likely that additional overpayments may have been made.

Recommendation: We recommend that the Agency correct the payment methodology used by FMMIS to pay professional Part B Medicare crossover claims. Any programming changes should be given an appropriate priority considering the likelihood that overpayments will continue to occur until the changes have been implemented. We also recommend the Agency review professional crossover claims and initiate recovery efforts for any payments made that were not consistent with Medicaid policy or Florida law.

Finding No. 5: Crossover Claims and Medicaid Assistance Category

Medicaid-eligible Medicare beneficiaries are categorized according to Medicaid Program income-based criteria and are eligible to receive the medical benefits associated with the category. Table 3, below, identifies the categories and the respective benefits available to each.

Table 3

Medicaid Coverage of Medicare Beneficiaries

Medicaid Assistance Category	Medicare Part A Premium	Medicare Part B Premium	Medicare Coinsurance & Deductible	Non-Medicaid Covered Services	Full Medicaid Benefits
Qualified Medicare Beneficiary (QMB)	Yes	Yes	Yes	Yes	No
Qualified Medicare Beneficiary (QMB) Plus	Yes	Yes	Yes	Yes	Yes
Specified Low-Income Medicare Beneficiary (SLMB)	No	Yes	No	No	No
Qualifying Individual (QI1)	No	Yes	No	No	No
Full Medicaid Only (no QMB; with or without SLMB or QI1 Coverage)	Yes	Yes	Yes	No	Yes

Source: Agency personnel and Centers for Medicare and Medicaid Services Guidance, *"List and Definition of Dual Eligibles."*

As different assistance categories entitled Medicare beneficiaries to differing levels of services, we reviewed Medicare crossover claims paid by Medicaid to determine whether the claims were paid in accordance with policy. Our tests disclosed:

- Recipients enrolled in Medicaid as an SLMB or QI1 beneficiary are only eligible for payment of their Medicare Part B premiums and should not have any amounts paid on their behalf for Medicare coinsurance and deductibles. To determine the extent that unallowed payments may have been made, we ran queries in the Medicaid DSS and noted that $17,466,971 had been paid for crossover claims for individuals enrolled as SLMB or QI1 beneficiaries during the period July 1, 2009, through September 30, 2010. Additional queries disclosed that $7,799,926 had been paid for crossover claims submitted on behalf of SLMB or QI1 beneficiaries for the 2008-09 fiscal year, resulting in $25,266,897 in overpayments to providers during the period July 1, 2008, through September 30, 2010.
- Individuals eligible for Medicaid as a QMB or QMB Plus beneficiary are eligible for Medicaid payment of Medicare coinsurance and deductibles for both services covered by Medicaid and services not covered by

Medicaid, but covered by Medicare. Medicare beneficiaries who are not eligible as a QMB or QMB Plus beneficiary, but meet the eligibility criteria for full Medicaid, are eligible for Medicaid payment of Medicare coinsurance and deductibles for only Medicaid-covered services within Medicaid Program limits. As only QMB or QMB Plus beneficiaries are eligible to have Medicaid pay their Medicare coinsurance and deductibles for non-Medicaid covered services, we selected a sample of 80 recipients who had $922,446 in crossover claims paid on their behalf to Durable Medical Equipment providers for non-Medicaid covered services. Our tests disclosed that for 43 of the 80 sample items tested, or 53.8 percent, the recipient was not enrolled as a QMB or QMB Plus beneficiary at the time the crossover claims for the non-Medicaid covered services were paid. Overpayments made to providers during the period July 1, 2009, through September 30, 2010, for the 43 sample items totaled $801,130. A limited review of nursing home outpatient crossover claims also disclosed instances where outpatient crossover claims for non-Medicaid covered services were erroneously paid on behalf of recipients who were not enrolled as QMB or QMB Plus beneficiaries at the time the crossover claim was paid. These overpayments totaled $3,043.

- As Medicare beneficiaries who are not eligible as QMB or QMB Plus beneficiaries, but meet the eligibility criteria for full Medicaid, are eligible for Medicaid payment of their Medicare coinsurance and deductibles only for Medicaid-covered services within Medicaid Program limits, amounts should not be paid for crossover claims in excess of Medicaid Program limitations. However, inquiry of Agency personnel indicated that limitation audits, necessary to ensure Medicaid Program limitations are not exceeded, are not applied by FMMIS when processing Medicare crossover claims. Absent the FMMIS audits, it is likely that crossover claim payments have been made for services in excess of Medicaid Program limitations.

Recommendation: We recommend that the Agency ensure that Medicare crossover claims are calculated and paid with consideration of the recipient's assistance category. Any programming changes required to FMMIS should be given a high priority due to the likelihood that overpayments will continue until the changes have been implemented. We also recommend the Agency review crossover claims and initiate recovery efforts for any payments made on behalf of recipients who were not eligible for Medicaid payment of coinsurance and deductible amounts.

Finding No. 6: Timeliness of FMMIS Programing Changes

Within the Agency, the Bureau of Medicaid Services (Medicaid Services) was responsible for identifying Medicaid Program changes and requesting that applicable changes to edits and audits be established in FMMIS. Once the related programming change orders were documented in writing by Medicaid Services, the Bureau of Medicaid Contract Management (MCM) was responsible for ensuring that the changes requested by Medicaid Services were effectively prioritized, programmed, and implemented in a timely manner.

During the period July 1, 2009, through September 30, 2010, 748 FMMIS change orders related to edits and audits for Medicaid claims processing were initiated and implemented. Our review of 28 FMMIS change orders to determine whether the changes were implemented by the effective date of the policy change disclosed that for 21 of the 28 change orders reviewed, the program change to FMMIS was not timely implemented. In determining the interval between the effective date of the policy change and the date the program change was implemented in FMMIS, we compared the effective date of the policy change to system-generated logs or to an Agency-provided date in the instances in which a system-generated log was not available. The period of time between the effective date of the policy change and the date the change was implemented in FMMIS ranged from 20 to 2,542 days and averaged 541 days.

Further analysis indicated that for 19 of the 21 program change orders discussed above, Medicaid Services did not identify and request that MCM implement the programming change in a timely manner. The period of time between the effective date of the policy change and the date that Medicaid Services requested a change ranged from 22 to

2,519 days and averaged 547 days. Additionally, for 11 of the 21 change orders, MCM did not always timely implement the requested changes. The period of time between the date Medicaid Services requested a change and the date the change was implemented in FMMIS ranged from 15 to 266 days and averaged 82 days.

Without timely incorporation of edits and audits programmed for current policy, it is likely that improper payments will be made.

Recommendation: We recommend the Agency strengthen procedures to ensure that Medicaid policy changes are identified and any FMMIS programming changes required are timely communicated to Medicaid Contract Management for timely implementation in FMMIS.

Finding No. 7: Bureau of Medicaid Program Integrity Recommendations

The Bureau of Medicaid Program Integrity (MPI), organizationally located within the Agency's Office of Inspector General, is responsible for assisting the Agency in preventing and detecting fraudulent and abusive behavior on the part of recipients and providers. MPI is also responsible for recovering overpayments that have been made to providers as well as imposing sanctions for violations of Medicaid policy. To assist in the identification of fraudulent or abusive billing practices, MPI conducts audits and investigations that may employ computer-based data analysis, sampling (statistical or non-statistical), or other methods deemed appropriate.[13]

As a result of MPI audits or investigations, MPI staff may identify instances in which a new edit or audit in FMMIS may be needed or an existing edit or audit may need modification. MPI staff may also identify areas in which Medicaid policy may need changes in order to address potential abusive billing practices. To ensure timely consideration and implementation of the corrective actions recommended by MPI, MPI should direct its recommendations to the Agency Secretary and thereafter monitor the implementation of the recommended corrective actions.

Our audit disclosed that MPI did not direct its recommendations to the Agency's Secretary. Rather, the recommendations were submitted to Medicaid Services. Further, we requested a listing of MPI recommendations made to Medicaid Services and noted that for the 58 recommendations made over the past three years, MPI was unable to determine which were actually forwarded to Medicaid Services and which were implemented. Medicaid Services also did not provide information as to which recommendations were implemented. By knowing which recommendations had been implemented, MPI staff could likely avoid duplicating projects from which the recommendations arose and focus Agency resources on different areas. Inquiry of Agency staff indicated that the lack of status information for the recommendations was partly due to limitations in the system used to track the information. A programming change to this system now allows MPI staff to track whether Medicaid Services has implemented a recommendation. Another contributing factor is that no formal process had been developed requiring Medicaid Services to respond to MPI's recommendations within a specified time.

A further review of several recommendations made to Medicaid Services for the implementation of edits in FMMIS found that while the recommendation included a dollar amount that could be saved per individual claim, the

[13] Chapter 2004-344, *Laws of Florida*, required the Office of Program Policy Analysis and Government Accountability (OPPAGA) to biennially review the Agency's efforts to prevent, detect, deter, and recover funds lost to fraud and abuse in the Medicaid Program. To satisfy this requirement, OPPAGA has released Report No. 10-32, Report No. 08-08, and Report No. 06-23.

recommendation did not include a projection of total cost savings based upon the volume of claims submitted which would be affected by the edit. Inclusion of the total projected cost savings could further assist the Agency in a determination of whether and when to implement a recommendation.

Absent submission of the recommended corrective actions to the Agency Secretary and the subsequent monitoring by MPI of the status of corrective actions, identified improvements to the internal controls of the Agency may not be prioritized appropriately and timely implemented.

Recommendation: We recommend that the Agency strengthen its procedures for tracking MPI recommendations. These procedures should include:

- **Submission of recommendations to both the Agency Secretary and Medicaid Services for consideration.**
- **A requirement that edit or policy recommendations submitted include annual projected cost savings, if subject to reasonable estimation.**
- **Provisions for more accurate tracking of recommendations, including dates and final disposition of the recommendation.**
- **To assist the Agency in consideration of the recommendation, a requirement that Medicaid Services provide a formal response within a specified timeframe concerning its views regarding the recommendation. If the recommendation will not be implemented, the reason(s) for the rejection should be included in the response.**

Finding No. 8: Provider Enrollment Functions

In order to be enrolled in and receive payments from the Medicaid Program, Florida law requires that providers have a valid professional license and that the license be maintained in good standing.[14] When a provider elects to enroll in the Medicaid Program, the provider's license information is to be verified by the Agency as part of the enrollment process. Upon enrollment, the licensee is entered into FMMIS as an authorized provider. Subsequently, the Florida Department of Health (DOH), as the State entity responsible for licensing many different health professionals in Florida, is to notify the Agency of any provider license changes or adverse actions taken against a provider's license so that the Agency may consider whether the provider's enrollment should be terminated. Table 4, below, provides a summary of provider enrollment activity for the 2009-10 fiscal year.

Table 4
Provider Enrollment Statistics, 2009-10 FY

Newly Enrolled Providers	Terminated Providers	Active Providers (1)
18,165	12,250	70,816

Source: Medicaid DSS.
Note (1): As of July 8, 2010.

[14] Section 409.907(3)(a), Florida Statutes.

DOH notification of licensure actions is provided through the mailing of a final order to the Agency. In addition, the Agency receives on a daily basis an electronic file showing the status of all individuals licensed by DOH that may be used by the Agency to automate the processes associated with monitoring the license status of enrolled providers. However, this electronic file is not loaded into FMMIS and electronically compared to existing providers to determine whether any providers have had a license status change that could preclude Medicaid participation. Inquiry of Agency staff indicated this is not done electronically because the process was initially developed incorrectly prior to the change in fiscal agents, effective June 26, 2008, and had not been implemented. The Agency has created several change orders to automate this process, but as of April 2011, the automated process had yet to be implemented. As a result, the Agency must continue to rely on the manual process.

As part of the enrollment process, the Agency also screens new providers against the Federal Government's List of Excluded Individuals/Entities (LEIE) to verify that the providers have not been excluded from participation by the Federal Government. Individuals or entities included on this listing are barred from participation in the Medicaid Program. The Agency also screens providers against the LEIE during the re-enrollment process, which occurs every three years for institutions and every ten years for non-institutional providers. This list is also available in a downloadable database that is updated monthly. This database is in a format that can be loaded into FMMIS and automatically run against currently enrolled Medicaid providers to determine whether any currently enrolled Medicaid providers have been added to the LEIE. However, as of April 2011 the Agency had not developed a process by which the database of excluded individuals and entities could be loaded into FMMIS and automatically compared to currently enrolled providers. As a result, the Agency must rely on receipt of a letter mailed from the United States Department of Health and Human Services, Office of Inspector General (USDHHS-OIG), for notification of an individual or entity operating in Florida that has been added to the list.

In a June 12, 2008, letter addressed to State Medicaid Directors, the Centers for Medicare and Medicaid Services (CMS) recommended that States search the LEIE on a monthly basis to determine whether any new individuals or entities have been added or removed from the previous month. This letter also reminded States that any payments made to excluded individuals or entities are considered an overpayment and are unallowable for claiming matching Federal funds. We found that the Agency had not performed a comparison of Medicaid providers with the LEIE until fieldwork for this audit was underway, with the initial comparison completed in February 2011. The Agency's Bureau of Medicaid Program Integrity (MPI) performed the comparison and found six active providers currently enrolled in the Medicaid Program who were included on the LEIE and who should have been barred from participation in the Medicaid Program, with two providers actively billing the Medicaid Program. Payments made to these providers while they were barred totaled $301,313. According to MPI staff, the Agency is in the process of recovering these payments. MPI staff also indicated that additional comparisons would be performed on a periodic basis.

In a January 16, 2009, letter from CMS addressed to State Medicaid Directors, CMS advised states of their obligation to direct providers to screen their own employees against the LEIE. This obligation extends to facilities who receive Medicaid reimbursement from cost reports that may have expenditures of excluded individuals included in the calculation of the facility's reimbursement rate. This letter also recommends States communicate this obligation to all providers at enrollment and reenrollment and to explicitly require the providers to agree to comply with this obligation as a condition of enrollment. Currently, the Agency does not advise providers of their obligation to screen all employees against the LEIE, nor do they obtain the provider's agreement to do so as a condition of enrollment.

The Agency's practice of waiting to receive letters from the DOH and the USDHHS-OIG contributes to delays in terminating unqualified providers and increases the likelihood that unallowable payments will be made. Additionally,

automating the process to compare the LEIE with current Medicaid providers, rather than having MPI staff perform this comparison, would enable the Agency to devote these resources to other areas.

Federal regulations also require states to notify the USDHHS-OIG of any action taken on a provider's application for participation in the Medicaid Program, as well as any actions taken by states to limit or exclude existing providers from participation in the Medicaid Program.[15] During our review of 20 provider applications for enrollment in the Medicaid Program, we noted 3 instances in which the Agency denied the application for participation in the Medicaid Program, but failed to notify the USDHHS–OIG of the Agency's decision to deny the application. In another review of 40 active providers who were terminated from the Medicaid Program, 26 of these providers were terminated due to an adverse action taken against them by either the Agency or another State of Florida entity. In all 26 of these instances, the Agency was unable to provide documentation that the USDHHS–OIG was notified of the Agency's decision to terminate these providers from the Medicaid Program. As license revocations or suspensions and exclusions from a Federal or State healthcare program are sufficient grounds for the USDHHS-OIG to exclude an individual or entity from participation in Federally-funded healthcare programs,[16] failure to notify the USDHHS-OIG of such actions taken by the State hinders efforts to combat fraud and abuse at both the state and national level.

Recommendation: We recommend the Agency implement automated processes by which electronic files of license information and the LEIE can be uploaded into FMMIS and compared against currently enrolled Medicaid providers. We also recommend the Agency modify the provider agreement to inform providers of their obligation to screen their employees against the LEIE and to explicitly require providers to agree to comply with this obligation as a condition of participation. Finally, we recommend the Agency strengthen procedures to ensure that timely notifications to the USDHHS–OIG occur in instances where the Agency chooses to deny or limit participation in the Medicaid Program.

Fiscal Agent Contract Monitoring

As indicated in the **BACKGROUND** section of the report, the Agency has entered into a five-year, $327 million contract with HP Enterprise Services (HPES) to serve as the Medicaid fiscal agent. As the Medicaid fiscal agent, HPES' primary responsibility is to provide the FMMIS system which processes the millions of claims submitted by Medicaid service providers. In order to monitor fiscal agent performance, each month HPES is scored on 90 performance measures, organized into nine separate reporting areas. Monetary penalties can be assessed by the Agency should HPES fail to achieve satisfactory levels of performance for each reporting area. Monetary penalties paid by HPES for unsatisfactory performance during the 2009-10 fiscal year totaled $223,000. Total contract payments to HPES during the 2009-10 fiscal year totaled $71 million.

Finding No. 9: Performance Measures and Monetary Sanctions

Each month, a report card is prepared for each of the nine separate reporting areas. For each of the nine report cards, HPES can be assessed a penalty of $5,000 for scoring below a 77 and $10,000 for scoring below a 70. To arrive at the score for each report card, the performance measures included on each report card are scored individually and then averaged together for the final report card score.

[15] Title 42, Section 1002.3(2), Code of Federal Regulations.
[16] Title 42, Section 1320a-7(b), United States Code.

Upon reviewing the scoring methodology, we noted that while many of the performance measures could receive a score of 100, the lowest score that could be recorded for 84 of 90 performances measures was a 65, although the Agency has assessed a score of 0 for instances where HPES failed to provide sufficient documentation to score a measure. By setting 65 as the lowest score possible, the effect of averaging a 65 into the report card's final score, rather than a lower score, should it be warranted, is to artificially inflate the report card's overall score and may enable HPES to avoid monetary penalties. Additionally, by subjecting the total report card's score to monetary penalties, rather than subjecting each individual performance measure to a monetary penalty, HPES could avoid monetary penalties for failing to meet satisfactory performance levels for a critical performance measure as long as it achieved a high score for a less critical measure on the same report card.

For example, a score of 100 on a less critical measure could offset a score of 65 on a critical performance measure on the same report card, resulting in an average of 82.5 for the two measures and enabling HPES to avoid monetary penalties. As this scoring methodology enables HPES to avoid monetary penalties, HPES has little incentive to correct issues that led to a low score for a particular performance measure. The adjustment of the grading methodology to allow scores of less than 65 would allow a more accurate measure of the fiscal agent's performance and possibly allow assessment of additional monetary penalties. The prospect of additional monetary penalties could provide an incentive for HPES to achieve and maintain satisfactory performance levels.

Additionally, the contract between the Agency and HPES provided for the assessment of monetary penalties that were relatively small in amount. Under the contract, the agency could assess a penalty of $5,000 if a report card received a score of 77 or less and a penalty of $10,000 for receiving a score of 70 or less. A separate contract provision allowed for the assessment of $1,000 per day for failing to correct deficiencies. Again, the ability to assess meaningful penalties would enhance the Agency's ability to ensure the fiscal agent performs at a satisfactory level.

Further, we found that the Agency did not always fully utilize the penalty provisions available in the contract. Our review of ten monthly report cards submitted during the period July 2009 through September 2010 (90 report cards in total) indicated that the same two report cards submitted each month (20 report cards in total) identified a failure to achieve a level of performance necessary to avoid monetary penalties, with the most recent month reviewed being July 2010, two years after the fiscal agent began operations. While penalties were assessed for each of these months, ($5,000 or $10,000 depending upon the score), the Agency did not use contract provisions allowing the assessment of penalties for failing to correct the deficiencies that led to the continuing low scores.

The ability to assess meaningful penalties would enhance the Agency's ability to ensure the fiscal agent performs at a satisfactory level.

Recommendation: We recommend that the Agency take the steps necessary to revise its scoring methodology to subject each performance measure to a monetary penalty or allow scores of less than 65 should they be warranted. We also recommend that the Agency amend the contract with the fiscal agent to provide for an escalation of monetary penalties for a continued failure to achieve satisfactory levels of performance. The escalation of penalties should increase to an amount that encourages the contractor to timely correct performance deficiencies.

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 from September 2010 to May 2011 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 the Agency's efforts to prevent and detect improper payments, including fraud and abuse, with respect to services provided in the Medicaid fee-for-service payment structure. The overall objectives of the audit were:

- To evaluate the effectiveness of selected 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 evaluate the extent to which the Agency relies on edits to prevent improper payments, including whether FMMIS includes as many edits as practicable, per the Coverage and Limitations handbooks, fee schedules, and applicable policies, to prevent improper payments.
- To determine whether programming changes to FMMIS edits related to the prevention of improper payments are properly prioritized.
- To evaluate the Agency's process for updating FMMIS with new policy or fee information to ensure that claims are paid based on current policy and/or fees.
- To evaluate the effectiveness of the Agency's screening processes for new and existing Medicaid providers to ensure that fraudulent or abusive providers are not successfully enrolled in the Medicaid program.
- To evaluate the extent to which the fiscal agent complied with contractual provisions, and to determine whether the contract contained sufficient provisions to reasonably ensure the prevention or detection of improper payments.
- To identify statutory and fiscal changes that may be recommended to the Legislature pursuant to Section 11.45(7)(h), Florida Statutes.

In conducting our audit we:

- Obtained an understanding of selected 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.
- Determined whether FMMIS contained electronic edits to ensure that only active and valid providers were to be paid for services provided only to active and valid Medicaid recipients.
- Reviewed ten Medicaid service types that had service limitations to determine whether FMMIS contained edits and audits to prevent the payment of claims in excess of policy limitations. Our review was limited to Medicaid service types with defined service limitations for providers other than facilities. Electronic controls related to payments to facilities reimbursed by cost-based reporting (including hospitals, nursing homes, etc.) were not examined. (Auditor General Report No. 2010-189, *Medicaid Facility Reimbursement Rates*, addresses our review of controls related to payments to facilities. Also, an upcoming Auditor General report will address the cost-based claims process applicable to facilities.) Prescription drugs are processed through the Pharmacy Benefits System provided by Magellan Medicaid Administration, Inc. (formerly First Health, Inc.), through a subcontract with HPES. Since FMMIS did not adjudicate these claims, electronic controls related to prescription drugs also were not included in the scope of this audit. (Auditor General Report No. 2010-139, *Medicaid Payments and Related Controls*, includes a finding related to our review of prescription drug claims

processed by the Pharmacy Benefits System.) Finally, FMMIS edits and audits for physician services claims were not reviewed as many of the services performed by physicians were limited only by medical necessity.

- Reviewed a sample of 40 outpatient hospital Medicare crossover claims to determine whether the claims were paid in accordance with applicable policies and Florida law. Additionally, due to the high error rate disclosed by our examination of the initial sample of 40 claims, we expanded our tests to include a statistical sample of 286 outpatient hospital crossover claims.
- Reviewed professional Medicare crossover claims to determine whether the claims were paid in accordance with applicable policies and Florida law. As part of our audit, we reviewed a sample of 80 Medicaid recipients who had non-Medicaid covered services paid on their behalf to durable medical equipment providers to determine whether they were eligible for Medicaid's payment of these services.
- Reviewed a sample of 28 FMMIS programming changes related to edits or audits to determine whether the programming changes were timely implemented in FMMIS.
- Determined whether legislative mandates affecting the expenditure of Medicaid funds was timely and properly implemented by the Agency.
- Reviewed a sample of 20 Medicaid providers enrolled during the period July 2009 through September 2010 to determine whether they were properly screened and met all Medicaid eligibility criteria.
- Reviewed a sample of 40 Medicaid providers terminated during the period July 2009 through September 2010 to determine whether they were timely terminated from the Medicaid program, based on the date of the terminating action.
- Reviewed various aspects of the Agency's monitoring of the Medicaid fiscal agent to determine the extent to which the fiscal agent complied with contract provisions, including an analysis of contract provisions and a review of report cards submitted for ten months during the period July 2009 through September 2010.
- To determine whether risks and mitigating controls had been appropriately identified to prevent the processing of improper payments, we reviewed and evaluated the effectiveness of risk assessments completed by the Agency's Bureau of Medicaid Program Integrity (MPI) and other Bureaus.
- Obtained an understanding of the improper payment detection tools and procedures employed by MPI.
- Tested a sample of 25 leads identified by MPI as potential indicators of overpayments during the period July 2009 through September 2010 to determine whether MPI appropriately prioritized and investigated the case.
- Obtained MPI staff opinions concerning the effectiveness and functionality of the Medicaid DSS as a tool to identify and detect potential improper payments.
- Reviewed projects completed by an Agency contractor for the identification and recoupment of payments made on behalf of deceased clients to determine whether the contractor was effective in its performance.
- Reviewed the performance of contracted Quality Improvement Organizations (QIO), which perform prior authorization services, to determine whether the QIOs performed satisfactorily and whether Agency oversight of the contractors was sufficient to identify instances of contractual noncompliance.
- Performed various other auditing procedures, including analytical procedures, as necessary, to accomplish the objectives of the audit.
- Communicated on an interim basis with applicable Agency officials to ensure the timely resolution of issues involving controls and noncompliance.
- Prepared and submitted for management response the findings and recommendations that are included in this report and which describe those matters requiring corrective actions.

AUTHORITY

Chapter 2010-144, Laws of Florida, directs the Auditor General and Office of Program Policy Analysis and Government Accountability to review and evaluate the Agency for Health Care Administration's Medicaid fraud and abuse systems. Pursuant to the provisions of Section 11.45, Florida Statutes, I have directed that this report be prepared to present the results of the Auditor General's operational audit.

David W. Martin, CPA
Auditor General

MANAGEMENT'S RESPONSE

In a response letter dated October 21, 2011, the Secretary of the Agency provided responses to our audit findings and recommendations. The Secretary's response is included as **EXHIBIT A**.

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EXHIBIT A
MANAGEMENT'S RESPONSE

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

October 21, 2011

Mr. David W. Martin
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 findings and recommendations resulting from your audit of the Agency for Health Care Administration, FMMIS Controls and the Prevention of Improper Medicaid Payments. In accordance with your request, we have emailed you the preliminary and tentative audit findings document with our response incorporated therein.

If you have any questions regarding our response, please contact Mary Beth Sheffield at 412-3978.

Sincerely,

Elizabeth Dudek
Secretary

ED/szg
Enclosure

2727 Mahan Drive • Mail Stop #1
Tallahassee, FL 32308

Visit AHCA online at
AHCA.MyFlorida.com

EXHIBIT A
MANAGEMENT'S RESPONSE (CONTINUED)

Agency for Health Care Administration
AHCA-FMMIS Controls and the Prevention of Improper Medicaid Payments
Response to Auditor General's P&T Audit Findings and Recommendation
(July 1, 2009 to September 30, 2010)

Finding 1:
Risk Assessment. The Agency's ineffective risk assessment processes contributed to the disbursement of improper payments.

Recommendation:
We recommend that the Agency review its internal controls, including its risk assessment processes, as related to the prevention of improper payments for Medicaid services, and implement effective controls designed to ensure that improper payments are minimized to the greatest extent possible.

Agency Response:
The Agency concurs with this finding. To enhance the internal controls within the FMMIS system, AHCA's Office of Inspector General will review the risk management processes within the Division of Medicaid to ensure that risks are correctly evaluated. This review will consist of the following:

- *Evaluating risk management processes.*
- *Evaluating the reporting of key risks.*
- *Reviewing the management of key risks.*

Additionally, the Office of Inspector General, in concert with the Division of Medicaid's management, will support the establishment and implementation of a risk management component within the Division of Medicaid to facilitate the identification and evaluation of risks, coach management in responding to risks, consolidate the reporting of risks, and develop a risk management framework. The Division of Medicaid will implement the risk management program.

Finding 2:
Payment for Medicaid Services. To ensure that FMMIS includes the necessary audits, the Agency should have a process in place to periodically review FMMIS to determine that audits are in place and operating as intended and that they are based on current Medicaid limitations. Our examination disclosed that a comprehensive review of procedure codes and applicable audits had not been performed for all service types within the last several years. Additionally, when the Agency changed fiscal agents effective June 26, 2008, a review of procedure codes and audits was not performed as part of the two-year design, development, and implementation phase. Absent the Agency's periodic review of the effectiveness of FMMIS audits, deficiencies in the audits will not be identified and improper payments will be made and escape detection. For example, our analysis of selected service types and procedure codes identified claim payment errors totaling $17,275,263 made to durable medical equipment and other service providers. For some of these claims the absence of accurate claim information precluded reliable estimates as to the extent these payments represented overpayments.

Recommendation:
During fieldwork for this audit, the Agency's Bureau of Medicaid Program Integrity began a review of Medicaid services and applicable edits and audits in January 2011. We recommend that the Agency continue its review of Medicaid services and applicable edits and audits to ensure that FMMIS contains all controls necessary to prevent payment of claims for services in excess of policy limitations. This review should extend to all Medicaid services. We also recommend that the Agency give this project a high priority considering the likelihood that overpayments have and will be made until project completion. After project completion, the Agency should attempt to recover overpayments that were made in excess of program limitations, including the amounts identified by this audit.

We also recommend that the Agency implement procedures to ensure that whenever an existing policy is modified or a new policy is added, all applicable edits and audits are reviewed to determine whether

EXHIBIT A
MANAGEMENT'S RESPONSE (CONTINUED)

Agency for Health Care Administration
AHCA-FMMIS Controls and the Prevention of Improper Medicaid Payments
Response to Auditor General's P&T Audit Findings and Recommendation
(July 1, 2009 to September 30, 2010)

programming changes are needed. Additionally, procedures should be implemented to provide for the periodic review of edits and audits for each service type to ensure that all cost-effective edits and audits are in place and programmed for the correct policy.

Agency Response:
The Agency concurs with this finding and will continue its review of Medicaid services and applicable edits and audits within the FMMIS system. The Edits and Audits Task Force, created in January 2011by AHCA, is a multi-bureau task force with members from Medicaid Program Integrity (MPI), Medicaid Services and Medicaid Contract Management. The progress made by the Task Force is reported to the Agency's senior management as part of the AHCA Fraud and Abuse governance process. To date, the Edits and Audits Task Force has reviewed 7 provider types (5 are within our Waiver category of service) and has submitted 29 policy recommendations, 10 file maintenance requests to bring the FMMIS audits in line with policy. Additionally, 2 recoupment actions have been initiated by the Edits and Audits Task Force via referrals to MPI. These two recoupment referrals have a recovery potential of $2.4 Million.

The Task Force will continue to report potential overpayments to MPI along with the supporting documentation identifying the specifics of the overpayment. Referrals of potential overpayments will be submitted to MPI at the conclusion of each audit.

Both Medicaid Contract Management and the fiscal agent (FMMIS contractor) will be participants in future policy implementation teams to ensure they are involved in the planning process to determine whether programming changes are needed and to prepare for such changes. The Bureau of Medicaid Services will develop and implement a checklist to be used throughout the Division of Medicaid for employment whenever an existing policy is modified or when policy additions or changes are required by legislation, judicial or executive orders, or other mandates. The checklist will be routed with the Notices of Proposed Rule (or other order or revision of law necessitating policy changes) and will document for each new or modified policy in the proposed rule that all applicable edits and audits have been reviewed to determine whether programming changes are needed. If programming changes are identified, the checklist will detail the plan for ensuring the programming changes are completed. This plan will be used by bureau managers, contract management and the fiscal agent (FMMIS contractor) to track and monitor the programming changes.

The Agency has undertaken a systematic review of edits and audits, starting with the most expensive and heavily utilized codes. The review team is carefully documenting its work to determine the most cost-effective way to continue to review and update the system edits and audits. Once the team gains experience with the review process, we will determine how best to implement a permanent process.

Finding 3:
Medicare Outpatient Crossover Claims. FMMIS was not programmed to ensure the proper payment of outpatient Medicare crossover claims. Our review of 286 claims disclosed that 182, or 63.6 percent, had been paid amounts in excess of authorized amounts. When the errors identified by our audit are projected to the total of the amounts paid for outpatient hospital crossover claims during the three fiscal years tested, the total overpayment is estimated to be $117,659,683.

Recommendation:
We recommend that the Agency ensure that FMMIS is programmed with the correct methodology for the payment of outpatient crossover claims. Appropriate priority should be given to these programming changes considering the likelihood that overpayments will continue until the changes have been implemented. We also recommend the Agency review outpatient crossover claims and initiate recovery efforts for any payments made that were not consistent with Florida law.

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Agency Response:
Agency staff has logged reports of overpayments or underpayments since the System transitioned from the prior fiscal agent in July 2008, and at this time, all known issues have been logged. Those issues that have identified claims as processing incorrectly have already been addressed with associated Customer Service Requests (CSRs) and Change Orders (COs). For most issues that were identified as over or underpayments, the CSRs and COs have been installed into production and any recovery efforts that were identified have also been logged as tasks for reprocessing/ recoupment. Within the next 90 days, the MCM Bureau will coordinate with the Bureau of Medicaid Services to create provider announcements that will advise the provider community of the upcoming reprocessing tasks, an explanation of the identified System processing errors, the total dollars to be recouped, and the methodology for recovery.

Finding 4:
Medicare Professional Crossover Claims. FMMIS was not programmed to correctly calculate the amounts due for some professional Medicare crossover claims. Our audit tests disclosed related overpayments totaling $14,053,660.

Recommendation:
We recommend that the Agency correct the payment methodology used by FMMIS to pay professional Part B Medicare crossover claims. Any programming changes should be given an appropriate priority considering the likelihood that overpayments will continue to occur until the changes have been implemented. We also recommend the Agency review professional crossover claims and initiate recovery efforts for any payments made that were not consistent with Medicaid policy or Florida law.

Agency Response:
The Agency does not disagree with the finding that various types of Medicare professional crossover claims have adjudicated inappropriately over the 3 year audit period, which resulted in overpayments in some instances. Staff has logged into the System documentation records issues of reports of overpayments (or underpayments) since the System transition in July 2008, and at this time, all known issues have been logged, and those issues that have identified claims as processing incorrectly have already been addressed with associated CSRs and Change Orders (COs). For most issues that were identified as legitimate over/underpayments, the CSRs and COs have been installed into production and any recovery efforts that were identified have also been logged as tasks for reprocessing/recoupment.

Within the next 90 days, the MCM Bureau will coordinate with the Medicaid Services Bureau to create provider announcements that will advise the provider community of the upcoming reprocessing tasks, an explanation of the identified System processing errors, the total dollars to be recouped, and the methodology for recovery.

Finding 5:
Crossover Claims and Medicaid Assistance Category. Medicare crossover claims were paid on behalf of recipients without consideration of whether the recipient was eligible for the assistance. Related overpayments disclosed by our audit tests totaled $26,071,070.

Recommendation:
We recommend that the Agency ensure that Medicare crossover claims are calculated and paid with consideration of the recipient's assistance category. Any programming changes required to FMMIS should be given a high priority due to the likelihood that overpayments will continue until the changes have been implemented. We also recommend the Agency review crossover claims and initiate recovery efforts for any

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payments made on behalf of recipients who were not eligible for Medicaid payment of coinsurance and deductible amounts.

Agency Response:
The Agency has acted on and completed the system corrections as recommended. The claims have been reprocessed awaiting release. Provider letters have been mailed to the overpaid providers for this System processing error. The reprocessed claims will be released into the System's financial cycle starting the weekend of November 7, 2011, to initiate the recoupment of those overpaid dollars associated with this finding.

Finding 6:
Timeliness of FMMIS Programming Changes. Programming changes to FMMIS electronic edits and audits were not made in a timely manner. Our review of 28 FMMIS change orders to determine whether the changes were implemented by the effective date of the policy change disclosed that for 21 of the 28 change orders reviewed, the program change to FMMIS was not timely implemented. The period of time between the effective date of the policy change and the date the change was implemented in FMMIS ranged from 20 to 2,542 days and averaged 541 days.

Recommendation:
We recommend the Agency strengthen procedures to ensure that Medicaid policy changes are identified and any FMMIS programming changes required are timely communicated to Medicaid Contract Management for timely implementation in FMMIS.

Agency Response:
Medicaid Contract Management acknowledges the time span from the date a change was submitted by Medicaid Services to the date of implementation by MCM/HP. Both Medicaid Contract Management and the fiscal agent (FMMIS contractor) will be participants in future policy implementation teams to ensure they are involved in the planning process to determine whether programming changes are needed and to prepare for such changes. The Bureau of Medicaid Services will develop and implement a checklist to be used throughout the Division of Medicaid for employment whenever an existing policy is modified or when policy additions or changes are required by legislation, judicial or executive orders, or other mandates. The checklist will be routed with the Notices of Proposed Rule (or other order or revision of law necessitating policy changes) and will document for each new or modified policy that all applicable edits and audits have been reviewed to determine whether programming changes are needed. If programming changes are identified, the checklist will detail the plan for ensuring the programming changes are completed. This plan will be used by bureau managers, contract management and the fiscal agent (FMMIS contractor) to track and monitor the programming changes.

Our procedures for addressing submitted changes require all such modifications be assigned and then prioritized among the available system engineers and business analysts with HP Systems (fiscal agent). Some changes are minimal and require hours to complete, others can require hundreds of hours. Regardless, we prioritize based on the impact to recipients, providers, claim volumes and claim dollars. The averages for hours from start to finish (the period extending from the date of requested change by Medicaid Services to the date of the CSR's implementation) averaged 82 days, as referenced in the AG finding. This was within acceptable expectations of the FMMIS certification process conducted by the Centers for Medicare and Medicaid Services. Medicaid Contract Management acts on all policy changes and many of such changes are submitted via File Maintenance and are completed within 2 to 10 working days of receipt with the fiscal agent, depending on the type of File Maintenance. For the File Maintenance changes, Medicaid Contract Management, with the support of Medicaid Services, has implemented a File

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Maintenance tracking process requiring the requester to assign a tracking ID that the requester can use to check, on-line, the status of their File Maintenance request after it has been submitted to the fiscal agent. In so doing, no changes are missed and they are completed in a timely fashion.

Finding 7:
Bureau of Medicaid Program Integrity Recommendations. The Agency should strengthen the process by which the Bureau of Medicaid Program Integrity's recommendations are reviewed and tracked.

Recommendation:
We recommend that the Agency strengthen its procedures for tracking MPI recommendations. These procedures should include:

- Submission of recommendations to both the Agency Secretary and Medicaid Services for consideration.
- A requirement that edit or policy recommendations submitted include annual projected cost savings, if subject to reasonable estimation.
- Provisions for more accurate tracking of recommendations, including dates and final disposition of the recommendation.
- To assist the Agency in consideration of the recommendation, a requirement that Medicaid Services provide a formal response within a specified timeframe concerning its views regarding the recommendation. If the recommendation will not be implemented, the reason(s) for the rejection should be included in the response.

Agency Response:
The Agency concurs with this finding. MPI has already made changes to this process to better track recommendations resulting from provider audits. We will further revise the Operating Procedures to include the recommendations made in the audit report. MPI will continue to work with the Division of Medicaid to enhance communication and ensure implementation of audit recommendations.

MCM and Medicaid Services will work with MPI to strengthen the MPI procedures for tracking its recommendations to the Medicaid Services Bureau and Bureau of Medicaid Contract Management with regard to issues surrounding the System edits and audits relative to Medicaid policy and business rules. Such procedures will require the approval of the Deputy Secretary for Medicaid and the Inspector General.

Finding 8:
Provider Enrollment Functions. The Agency should automate processes for the screening of new and currently enrolled Medicaid providers. Automating these processes would also improve the timeliness with which Medicaid providers are terminated from the Medicaid Program due to adverse actions.

Recommendation:
We recommend the Agency implement automated processes by which electronic files of license information and the LEIE can be uploaded into FMMIS and compared against currently enrolled Medicaid providers. We also recommend the Agency modify the provider agreement to inform providers of their obligation to screen their employees against the LEIE and to explicitly require providers to agree to comply with this obligation as a condition of participation. Finally, we recommend the Agency strengthen procedures to ensure that timely notifications to the USDHHS–OIG occur in instances where the Agency chooses to deny or limit participation in the Medicaid Program.

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Agency Response:
The Agency currently has processes/procedures in place to access the federal LEIE database of excluded providers. Access occurs for each new provider enrollment as well as during provider reenrollment. Recently, the MCM Bureau and MPI were jointly involved in a matching/review effort of excluded providers, with a full upload of the LEIE data, and such review identified less than a dozen providers who were on the excluded list, but were not on such list at the time of their initial enrollment or reenrollment. We agree that fully automating the LEIE screening procedure will further aid in identifying providers who should be excluded in the current time period, but were not earlier identified as excluded providers during enrollment or reenrollment. Medicaid Contract Management will evaluate the cost-benefit ratio of making System changes to accommodate an automated upload of the LEIE database into the FMMIS, and subsequent matching of FMMIS records with the LEIE database to identify newly excluded providers. Their recommendations will be provided to the Deputy Secretary for Medicaid and the Agency Head.

The AG recommendation of modifying the provider agreement (PA) to address a provider/applicant's obligation to screen their employees against the LEIE database has merit. While the current provider agreement already mandates adherence to CMS rules on the fiscal agent, we will modify our provider agreement to specifically address the notification requirement.

The Agency understands the AG's recommendation to strengthen procedures to ensure timely notification to the USDHHS-OIG regarding the Agency's denial or limitations to participation in the Medicaid program. Medicaid Contract Management will review the costs and benefits to moving to such an approach, which extends beyond the procedures that are in place today to notice the USDHHS of such restrictions to our providers. Their recommendations will be presented to the Deputy Secretary for Medicaid.

Finding 9:
Performance Measures and Monetary Sanctions. To enhance its effectiveness as a deterrent to unacceptable performance, should such occur, the methodology used to periodically monitor the performance of the Medicaid fiscal agent and assess related penalties should be modified.

Recommendation:
We recommend that the Agency take the steps necessary to revise its scoring methodology to subject each performance measure to a monetary penalty or allow scores of less than 65 should they be warranted. We also recommend that the Agency amend the contract with the fiscal agent to provide for an escalation of monetary penalties for a continued failure to achieve satisfactory levels of performance. The escalation of penalties should increase to an amount that encourages the contractor to timely correct performance deficiencies.

Agency Response:
The Agency follows the RFP/contract requirements/references with regard to the grading methodologies associated with the fiscal agent report cards. The contracted fiscal agent receives a monetary penalty when a report card is assessed a score below 77. The performance of the fiscal agent continues to be monitored closely and the Agency has, when necessary, added additional penalties when a scored area has remained static or failed to improve. This escalated penalty application was applied as recently as May 2011, after corrective action plans imposed failed to achieve improvement. AHCA is also considering placement of an associated performance dashboard on the Internet.