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AGENCY FOR HEALTH CARE ADMINISTRATION

MEDICAID PROGRAM
FRAUD PREVENTION AND DETECTION
POLICIES AND PROCEDURES
FACILITY COST REPORTS

Operational Audit

STATE OF FLORIDA
AUDITOR GENERAL
DAVID W. MARTIN, CPA

SECRETARY FOR 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
Holly Benson	From July 2009 to October 2009

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AGENCY FOR HEALTH CARE ADMINISTRATION

Medicaid Program

Fraud Prevention and Detection Policies and Procedures

Facility Cost Reports

SUMMARY

More than half of the amounts expended annually by Florida's Medicaid program are paid to facilities, such as hospitals, nursing homes, and intermediate care facilities for the developmentally disabled. The amounts paid to these facilities are based on per diem rates derived from annual cost reports submitted by the facilities to the Agency, and to ensure the accuracy and completeness of the amounts shown by the annual cost reports, the Agency engages independent contractors to conduct audits and reviews of selected annual reports of selected facilities. The focus of this audit was to determine the effectiveness of the Agency's cost report audit and review process in timely identifying improper payments, including errors that may be caused by fraud. This audit is the second of two examinations made by the Auditor General in response to the requirements of Chapter 2010-144, Laws of Florida. That law requires a review and evaluation of the Agency for Health Care Administration's Medicaid fraud and abuse prevention and detection systems. A previous report of the Auditor General addressed in its scope controls within the Florida Medicaid Management Information System related to the prevention and detection of improper Medicaid payments made through the fee-for-service payment structure for providers.

As summarized below, our audit of the controls over the cost report audit and review process disclosed several issues that should be corrected to strengthen the Agency's ability to prevent and timely detect improper payments, including those that may be caused by fraud.

COST REPORT AUDIT COVERAGE

Finding No. 1: The Agency did not select for audit facility cost reports at a frequency sufficient to reasonably ensure that improper payments were not made to facilities due to overstated or inaccurate cost reports.

COST REPORT AUDIT TIMELINESS

Finding No. 2: The Agency did not release cost report audits in a timely manner. The failure to timely release audit reports limited the Agency's ability to timely correct errors in per diem rates.

COST REPORT AUDIT APPEALS PROCESS

Finding No. 3: The Agency should consider revising the process used by facilities to appeal the results of cost report audits. A reduction in the number of appeals would reduce the time and resources needed by the Agency to process the appeals and may increase the frequency or timeliness with which the Agency can release cost report audits and finalize and apply corrected per diem rates.

CONSIDERATION OF COST REPORT FRAUD

Finding No. 4: The Agency had not developed written policies and procedures requiring further scrutiny or inquiry into the cost reports of facilities that may contain indications of fraudulent preparation.

HOSPITAL COST REPORT OVERSIGHT

Finding No. 5: The level of oversight provided by the Agency over the hospital cost report audit process was not sufficient. Increased Agency involvement in the hospital cost report audit process could provide additional assurance that hospital cost reports are accurate, complete, and free of material error.

BACKGROUND

The Agency for Health Care Administration (Agency) is the chief health policy and planning entity for the State, and State law designates the Agency as the State government entity responsible for administering the Medicaid program.[1] Consistent with this authority, State law also authorizes the Agency to compensate Medicaid providers for services rendered to Medicaid recipients, in accordance with State and Federal law, according to methodologies set forth in the rules of the Agency and in policy manuals and handbooks.[2]

Medicaid Program compensation paid to providers, such as hospitals, nursing homes, and intermediate care facilities for the developmentally disabled (ICF-DDs) was based upon per diem reimbursement rates calculated by the Agency using data included in cost reports submitted by each of the applicable facilities. The cost reports submitted by these facilities covered the facility's fiscal year and were required to be submitted on an annual basis. As shown by Table 1, the Agency disbursed to hospitals, nursing homes, and ICF-DDs $9.7 billion during the 2009-10 State fiscal year, which represented 54 percent of the approximately $18.1 billion in Medicaid payments made during that period.

Table 1
Medicaid Program
Cost Report-Based
Payments to Facilities

2009-10 Fiscal Year

Provider Type	Medicaid Payments	Number of Facilities
Hospital	$5,851,114,834	241
Nursing Home	3,557,020,050	733
ICF-DD	341,214,226	101
Total	**$9,749,349,110**	

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

The Medicaid State Plan includes for hospitals, nursing homes, and ICF-DDs reimbursement provisions that list allowable costs that may be claimed in annual cost reports and that specify timeframes within which the facilities must submit their reports to the Agency. Federal regulations[3] require that the Agency provide for periodic audits of facility financial and statistical records, such as annual cost reports and supporting facility documentation. The objective of the audits is to provide reasonable assurance that the reports are accurately prepared and that the costs and other data reported comply with the governing reimbursement plan requirements and other agency instructions. Florida law[4] provides authority to the Agency to suspend or terminate a medical provider's participation in Medicaid or to impose monetary sanctions against the provider for a variety of offenses, including the submission of a cost report to the Agency that contains materially false or incorrect information.

[1] Sections 20.42, Florida Statutes, and 409.902, Florida Statutes.
[2] Section 409.908, Florida Statutes.
[3] Code of Federal Regulations, Title 42, Section 447.253(g).
[4] Section 409.913(15)(i), (k), Florida Statutes.

The Agency contracted with independent certified public accounting (CPA) firms to perform on-site nursing home and ICF-DD cost report audits, and the Agency contracted with First Coast Service Options (FCSO), Inc., to perform hospital cost report audits. During the 2009-10 State fiscal year, the Agency paid CPA firms approximately $1.2 million to perform nursing home and ICF-DD cost report audits and FCSO approximately $1.8 million to perform hospital cost report audits.

We have previously audited the Agency's processing of the cost reports, including the calculation and application of the derived per diem rates. The results of that audit are presented in report No. 2010-189, *Medicaid Facility Reimbursement Rates – Operational Audit*. In that report we discussed the Agency's failure to timely enter new rates into the Florida Medicaid Management Information System, the failure of facilities to submit their cost reports within specified timeframes, and the Agency's failure to calculate new reimbursement rates resulting from cost report audit adjustments.

FINDINGS AND RECOMMENDATIONS

Medicaid cost reporting, the primary source of the information relied upon to calculate and make billions of dollars in Medicaid payments, is susceptible to fraud. In the 2007 and 2008 Health Care Fraud and Abuse Control Program Annual Reports, the United States Department of Health and Human Services (USDHHS) and the Department of Justice have included descriptions of provider settlements totaling millions of dollars in cases involving cost report fraud in a similarly administered program, the Medicare Program. The examples of fraud cited in the Annual Reports involve provider misrepresentations, such as the inclusion of unallowable costs, inflating the costs claimed, inflating counts of medical residents, and artificially inflating cost-to-charge ratios.[5] The USDHHS, Office of the Inspector General, has also issued a Special Fraud Alert that addresses cost report fraud.[6]

Notwithstanding the apparent prevalence of cost report fraud in other jurisdictions, the Agency was able to identify only one instance in which a Florida hospital, nursing home, or ICF-DD had ever been referred by the Agency for further investigation of fraudulent Medicaid cost reporting. Inquiries of the Agency's Medicaid Program Integrity (MPI) personnel also indicated that MPI did not investigate cost report fraud. Agency staff also stated that FCSO, which performs hospital cost report audits, has its own mechanism for addressing potential fraud. However, the contract between the Agency and FCSO did not address Medicaid cost report fraud or FCSO's obligation to investigate potential fraud, and no instances of cost report fraud had ever been reported to the Agency.

The focus of our operational audit was to identify opportunities for the improvement of the Agency's processes for the prevention and detection of improper payments, including those that may be attributable to the fraudulent preparation of Medicaid cost reports.

Finding No. 1: Cost Report Audit Coverage

As indicated in the **BACKGROUND** section above, Federal regulations require that the Agency provide for periodic audits of financial and statistical records of facilities. As also indicated in the **BACKGROUND** section of this report, the Agency contracted with CPA firms to perform nursing home and ICF-DD cost report audits and FCSO to perform hospital cost report audits. For these cost report examinations to both provide a reasonable degree of

[5] The Department of Health and Human Services and The Department of Justice, Health Care Fraud and Abuse Control Program, Annual Reports, FY 2007 and FY 2008.

[6] Publication of OIG Special Fraud Alerts: Home Health Fraud, and Fraud and Abuse in the Provision of Medical Supplies to Nursing Facilities, *Federal Register,* August 10, 1995.

assurance as to the timely detection of cost report errors and serve as an effective fraud deterrent and detection device, the examinations must be performed at each facility at a reasonable frequency.

To determine how often a facility's cost report was selected for audit we reviewed a selection of 40 nursing homes, 25 ICF-DDs, and 25 hospitals that received Medicaid payments during the period July 1, 2009, through September 30, 2010, to determine how often the facility's cost report had been selected for audit during the last ten State fiscal years. An audit conducted at least once every three years was considered reasonable audit coverage, with the understanding that some facilities may be selected at a higher frequency and some at a lower frequency. Our audit disclosed that for the 25 hospitals selected, only 9 (36 percent) had an annual cost report selected for audit at a frequency of less than once every three years. It was noted that the average rate at which a hospital's cost report was selected for audit was once every two and half years. (However, as noted in Finding No. 5, below, the scope of hospital cost report audits was often limited as to scope.) With respect to the nursing home and ICF-DDs selected by us for testing, our audit disclosed that the time elapsing between audits was excessive and not conducive to the timely detection of errors, including those that may be indicative of fraud. Specifically:

- Of 40 nursing homes selected, 34 (85 percent) had an annual cost report selected for audit at a frequency of less than once every three years. For the 40 nursing homes, the average rate at which a nursing home's cost report was selected for audit over the last ten State fiscal years was once every five years. Further, we found that for the 2009-10 fiscal year, only 67 nursing homes were selected for cost report audits. At that rate, it will take approximately 11 years for all nursing homes participating in the Medicaid Program to have one annual cost report selected for audit.
- Of 25 ICF-DDs selected, 17 (68 percent) had an annual cost report selected for audit at a frequency of less than once every three years.[7] The average rate at which an ICF-DD's cost report was selected for audit during the last six State fiscal years was once every six years. We also found that six ICF-DDs were selected for audits for the 2009-10 fiscal year. At that rate, it will take approximately 17 years for all ICF-DDs participating in the Medicaid Program to have one annual cost report selected for audit.

In setting the frequency with which the audits are conducted, there should be a consideration of the results of any prior audits, as the existence of significant errors in the cost reports of previous years may be indicative of a high risk of future error. Further, the Agency has a responsibility to enforce the provisions of Florida law which provide that sanctions can be sought against a provider who has included in a cost report costs that are not allowable under the facility's cost reimbursement plan, after the provider had been advised in an audit exit conference or audit report that the costs were not allowable. Given these risks and responsibilities, audits which disclose errors should often be followed by an audit of a succeeding cost report.

We found that the Agency generally did not request audits of succeeding periods for nursing home or ICF-DD providers, including those whose cost report audits had resulted in rate decreases after correction of report errors. Our analysis of a selection of facilities for which audits were finalized during the 2008-09 and 2009-10 fiscal years disclosed that for 20 of 21 (95.2 percent) nursing homes that had a rate decrease, the facility's subsequent cost report was not selected for audit. Additionally, for 4 of 4 (100 percent) ICF-DDs that had a rate decrease, the facility's subsequent cost report was not selected for audit.

While the Agency's Audit Services Section had adopted guidelines for selecting facilities for audit, neither the guidelines nor Agency policies or procedures required that cost report audits be conducted with reasonable frequency. By requiring the audit of facility cost reports more frequently, the Agency would reduce the risk that the cost reports contain errors or fraud that will lead to improper payments.

[7] The Agency began conducting ICF-DD cost report audits during the 2003-04 FY. As a result, our analysis could only extend back six years to audits selected during the 2003-04 FY.

Recommendation: The Agency should develop policies specifying the frequency with which each facility's cost report shall be audited. The policy should include provisions requiring the scheduling of follow-up audits for those facilities whose previous cost reports have contained significant error and the imposition of sanctions when errors in the costs reported are knowingly repeated by the provider in subsequent cost reports.

Finding No. 2: Cost Report Audit Timeliness

To ensure that the CPA firm followed the audit program and that the Agency agreed with the adjustments made by the CPA firm, the Agency's Audit Services section, within the Division of Medicaid, was to review the audit report, adjustments, and supporting documentation before releasing the audit report. Should the provider elect to appeal the audit report adjustments, Agency practice was to not apply the audited rates until the appeals process was complete. If the provider did not appeal the audit, Audit Services forwarded the audit report to the Cost Reimbursement Section, within the Division of Medicaid, for calculation of new reimbursement rates based on the audited cost report. Conversely, when the Agency received a hospital cost report audit, no review of the audit report or adjustments was performed by Audit Services as the audit report was routed directly to the Cost Reimbursement Section. Finding No. 5, below, provides additional information concerning the differences in how the Agency processed cost report audits received for nursing homes and ICF-DDs and the cost report audits of hospitals.

To maximize their effectiveness as a means of detecting errors and detecting and deterring fraud, the audits should be completed, reviewed, and issued in a timely manner. We would consider the issuance of an audit report to be timely and the most useful when issued within two years after the close of the year-end of the provider. To determine the timeliness with which the cost reports were issued, we reviewed Agency files relating to nursing home, ICF-DD, and hospital cost report audits released by the Agency during the period July 1, 2009, through September 30, 2010. Our review disclosed that oftentimes the cost report audits had not been performed and released in a timely manner. Specifically, our audit disclosed:

- For the 242 nursing home cost report audits released, the average length of time to release an audit, from the facility's cost report fiscal year end, to the release date, was 4.15 years.
- For 12 ICF-DD cost report audits released during this period, the average length of time to release a report, from the facility's cost report fiscal year end, to the release date, was 7.34 years.
- For 80 hospital cost report audits the average length of time to process a hospital cost report audit, from the facility's cost report fiscal year end, to the release date, was 5.58 years.

Several factors contributed to the delays in performing and processing cost report audits. We found that the Agency had not developed policies or procedures specifying timeframes for the timely processing of the cost report audits upon their receipt. We noted that an extensive period of time often elapsed while the Agency reviewed the audit report and supporting working papers for nursing home and ICF-DD cost report audits and sent to the firms multiple sets of review notes. In explanation of the delays, Agency personnel also advised us that the large percentage of nursing homes and ICF-DDs that appeal the results of a cost report audit further contributed to the delay as Agency staff indicated that Agency resources that could be used to review and process the reports were needed to review and prepare for appeals. Agency staff further indicated that the delays in the processing of cost report audits can be partially attributed to nursing home, ICF-DD, and hospitals not timely submitting their cost reports.

The failure to timely conduct and release cost report audits increases the risk that facilities will be paid rates based on overstated or fraudulent cost reports. Additionally, the failure to timely release and calculate reimbursement rates based on audit reports may limit the Agency's ability to successfully recoup overpayments made to the provider, as the

likelihood that a provider may terminate its participation in the Medicaid program, declare bankruptcy, or terminate its business operations increases over time.

Recommendation: We recommend:

- **The Agency develop policies and procedures to provide for the timely release of cost report audits. These procedures should provide timeframes within which cost report audits are to be reviewed and released.**
- **With respect to delays attributable to facilities failing to submit their cost report in a timely manner, the Agency finalize a rule, in development at the time of this audit, that subjects facilities to monetary penalties for failing to submit their cost reports within specified timeframes.**

Finding No. 3: Cost Report Audit Appeals Process

Following the Agency's review of submitted cost report audits and the Agency's release of the report, facilities had, pursuant to Federal regulations,[8] the opportunity to participate in an appeals or exception procedure that allowed providers to submit additional evidence and receive an administrative review. To meet these requirements, the Cost Reimbursement Plans, incorporated into the Medicaid State Plan, for nursing homes, ICF-DDs, and hospitals provided facilities the right to appeal the results of a cost report audit by requesting a hearing in accordance with Section 120.57, Florida Statutes, and Administration Commission Rule 28-106, Florida Administrative Code. Federal regulations also provide authority to States to limit appeals to issues the agency determines appropriate.

We found that nursing homes and ICF-DDs frequently appealed the results of cost report audits. Our analysis of nursing home and ICF-DD cost report audits released by the Agency during the 2007-08, 2008-09, and 2009-10 fiscal years found that 201 of 344 (58 percent) nursing home audit reports released and 19 of 42 (45 percent) ICF-DD audit reports released were appealed by the facility. Agency staff could not recall any instances in which a hospital had appealed the results of its cost report audit.

The Agency indicated that there was a backlog of nursing home and ICF-DD appeals. Specifically, there were a total of 291 nursing home and ICF-DD appeals that had been opened but not been finalized as of December 2010, with 24 of the open appeals dating to audits assigned during the 2002-03 fiscal year and pertaining to cost report fiscal year ends as old as August 31, 2000. Table 2, below, provides an analysis of pending cost report audit appeals.

[8] Code of Federal Regulations, Title 42, Section 447.253.

Table 2

Pending Cost Report Audit Appeals

Fiscal Year in Which Assigned	Nursing Homes	ICF-DDs	Total	% of Total
2002-03	24	0	24	8.2%
2003-04	15	14	29	10.0%
2004-05	5	5	10	3.4%
2005-06	121	0	121	41.6%
2006-07	56	0	56	19.2%
2007-08	49	0	49	16.8%
2008-09	1	0	1	0.3%
2009-10	1	0	1	0.3%
Total	**272**	**19**	**291**	**100.0%**

Source: Audit analysis of Agency-provided listing. As of December 20, 2010.

To ensure that improper reimbursement rates are identified and corrected as timely as possible, the time required to dispose of appeals should be minimized. To obtain a better understanding of the appeals process, we reviewed 25 of the 67 nursing home appeals that had been finalized during the period July 1, 2009, through September 30, 2010. There were no ICF-DD or hospital appeals that had been finalized during this period. Our review disclosed:

- The length of time to finalize an appeal, from the date the nursing home cost report audit was released to the date of settlement, was excessive, averaging approximately three years. Agency staff indicated the length of time to finalize an appeal was partially attributable to the amount of time Agency staff needed to prepare for the appeal. Another factor contributing to the delay in finalizing appeals was the large number of released audit reports that were appealed by providers. As indicated above, 58 percent of nursing homes reports released were appealed and 45 percent of ICF-DD reports released were appealed, contributing to a backlog of 291 open appeals dating back to audits assigned during the 2002-03 fiscal year.
- The results of the appeals indicated that the adjustments identified by the audits, and accepted by the Agency after its review, were often reversed during the appeals process. For 19 of 25 (76 percent) of the appealed nursing home cost report audits, the Agency either removed or revised audit adjustments as result of the provider's appeal. The 25 appealed cost report audits contained a total of 961 audit adjustments, with 634, or 66 percent, related to inadequate documentation to support costs claimed by the facility. Of the 634 adjustments, 146 related to lack of supporting documentation and 488 were made to adjust costs to an amount supported by the facility. Upon review of the finalized appeal, it was noted, as shown in Table 3, that 96 of 146 (66 percent) adjustments related to lack of supporting documentation were either removed or revised by the Agency, and 51 of 488 (10.5 percent) adjustments to adjust costs to amounts supported by the provider were either removed or revised by the Agency.

Table 3
Analysis of Appeals Process on Audit Adjustments

	Adjustments Due to Documentation Deficiencies			
	Adjustments Due to Lack of Supporting Documentation	Adjustments to Adjust Costs to Amounts Documented	All Other Adjustments	Total
Initial Audit Adjustments	146	488	327	**961**
Audit Adjustments Revised Through Appeal	96	51	70	**217**
% of Initial Adjustments Revised Through Appeal	65.8%	10.5%	21.4%	**22.6%**

The Cost Reimbursement Plan for nursing homes states that following an exit conference between the provider and the CPA firm performing the audit, the provider has 60 calendar days to submit documentation to contest any audit adjustments. For adjustments made due to lack of adequate documentation or support, the Plan provides that any documentation received after the 60-day period shall not be considered when revising adjustments made due to lack of adequate documentation or support.[9] As the CPA firms submitted their final audit reports to the Agency after the 60-day period had passed, the Agency's subsequent acceptance of additional documentation, and relying upon it to revise the 147 audit adjustments, was in apparent conflict with this provision of the Medicaid State Plan. In explaining the extent to which adjustments related to inadequate documentation were subsequently removed or revised, Agency staff indicated that different CPA firms may have different standards governing the type of documentation that would be accepted to support costs. However, since the Agency had expended much time and effort in reviewing the adjustments and had agreed with them at the time the cost report audit was released, the extent to which such adjustments were removed or revised through the appeals process appeared unreasonable.

Absent the timely disposition of appeals, there is an extended delay in the correction of reimbursement rate errors, as Agency staff indicated that if a facility appealed a cost report audit, new rates were not calculated based on the audited cost report until the appeal had been finalized. The delay in closing appeals, combined with the issues discussed in Finding Nos. 1 and 2, results in conditions under which a nursing home, should it appeal a cost report audit, may avoid the calculation and application of a corrected reimbursement rate for periods of, on average, seven years after the fiscal year end of a cost report containing errors.[10] For some facilities, the length of time taken by the Agency to finalize an appeal and calculate new rates could provide an incentive to appeal an audit as it would delay State efforts to recover any overpayments by several years. Also, as providers may terminate Medicaid Program participation, file for bankruptcy, or cease business operations entirely, failing to timely finalize appeals could preclude Agency efforts to successfully recover any amounts due to the State.

[9] The 60-day limitation does not apply to providers that can adequately demonstrate that emergency circumstances prevented the provider from submitting documentation within the prescribed deadline. Emergency circumstances are limited to fire, wind, flood, or theft.
[10] As noted in Finding No. 2, above, for the nursing home cost report audits reviewed, the average time for the Agency to release a cost report audit was approximately 4.15 years after the facility's cost report fiscal year end, and on average the settlement of an appeal required 3 years.

Recommendation: We recommend that the Agency pursue steps to reduce the number of appeals and the length of time involved in closing appeals. Steps to reduce the number of appeals should include the disallowance of those appeals that seek to extend consideration of audit adjustments made in response to facility documentation deficiencies.

Finding No. 4: Consideration of Cost Report Fraud

Our review of selected cost report audits finalized during the 2008-09 and 2009-10 fiscal years disclosed that for 21 of 30 nursing homes (70 percent) and 4 of 5 ICF-DDs (80 percent), the cost report audit resulted in audit adjustments that reduced the facility's cost rate. For 20 of 30 hospitals (67 percent) a cost report audit resulted in audit adjustments that reduced either the facility's inpatient cost rate, outpatient cost rate, or both. While the existence of audit adjustments is not unusual or necessarily indicative of a facility's fraudulent preparation of a report, the Agency should consider the review of certain adjustments to determine whether they may be indicative of fraud. Audit adjustments that may be worthy of further investigation may include, for example, large audit adjustments that correct unsupported record or report entries initiated by facility management and the presence of a pattern, such as that reflected by numerous audit adjustments to a facility's cost report.

Our examination disclosed that the Agency had not developed written policies and procedures requiring further scrutiny or inquiry into the cost reports of facilities that may contain at least indications of fraudulent preparation and that the absence of written policies and procedures contributed to the lack of a routine consideration as to whether cost report audits contained indications of fraud on the part of facilities.

Our review of recently released audit reports disclosed, as indicated above, many reports were accompanied by audit adjustments. Although, in some instances, the audit adjustments were large in amount, and in some other instances, the audit resulted in a large number of adjustments, Agency staff indicated that during the 2010-11 fiscal year, only one provider had been referred to the Department of Legal Affairs' Medicaid Fraud Control Unit (MFCU). Absent a consideration of whether the results of cost report audits contain indications of fraud, the Agency may forego an opportunity to identify and prosecute facilities which have intentionally misrepresented material facts in their cost reports.

Recommendation: We recommend that the Agency develop and communicate to relevant staff written policies and procedures describing the steps to be followed should the results of cost report audits contain indications of facility fraud.

Finding No. 5: Hospital Cost Report Oversight

As indicated in the **BACKGROUND** section of this report, the Agency contracted with independent CPA firms to perform nursing home and ICF-DD cost report audits and the Agency contracted with FCSO to perform hospital cost report audits. As part of the hospital cost report audit contract, FCSO also performed a limited examination of certain cost report data elements related to uncompensated charity care, referred to as a Disproportionate Share Reimbursement (DSR) audit. FCSO also served as a Medicare intermediary for Florida and was responsible for processing hospital claims submitted to the Medicare Program and for desk reviews and audits of Medicare cost reports.

Despite the CPA firms and FCSO performing similar functions with respect to the audit of facility cost reports, the manner in which the Agency provided oversight of the audits performed by CPA firms and FCSO differed

considerably. We found that the oversight provided by the Agency for the hospital cost reports to be less rigorous than the oversight provided for the nursing home and ICF-DD cost report audits. Upon inquiry, Agency staff could not fully explain the rationale for the different approach used for hospital cost report audits. Specifically:

- The Agency selected the nursing home and ICF-DD facilities that were to be audited by the CPA firms, whereas the extent to which the Agency had participated in the selection of the particular hospital cost reports selected for audit was unclear. Documentation provided for our review included a scoping tool form and a work proposal prepared by FCSO listing hospital costs reports to be audited. The documents provided did not evidence the extent of the Agency's participation in the process or the Agency's approval of those hospital cost reports included in the work proposal.
- A review of 30 nursing home cost report audit reports received from CPA firms disclosed that all 30 were full scope audits in which the CPA firm performed on-site work and expressed an opinion as to whether the schedules within the cost report were in conformity with Federal and State Medicaid reimbursement principles. Conversely, for the cost report audits associated with the 11 hospital reopenings reviewed, discussed below, the initial audit reports received from FCSO were all limited scope desk reviews for which no opinion on compliance is required. Additionally, the annual work proposal submitted by FCSO for the 2009-10 fiscal year, disclosed that all 242 proposed audits were to be desk reviews of varying levels, with 31 reviews budgeted for only three hours. FCSO completed by the end of the contract term in June 2010, 155 Medicaid audits (desk reviews).
- The contracts between the Agency and the CPA firms which perform cost report audits of nursing homes and ICF-DDs required that the audits be conducted in accordance with standards established by the American Institute of Certified Public Accountants (AICPA). Based on the form of reports issued, the CPA firms conducted examinations under the AICPA's attestation standards, which require consideration of fraud risk factors in the planning and conduct of the examination. Such consideration includes the identification of areas in which errors caused by fraud are both likely and potentially significant and requires that the CPAs design and execute reasonable procedures to detect such errors. The contract between the Agency and FCSO did not specifically address FCSO's responsibility to consider and address fraud risks.
- The Agency performed an extensive review of the audit report, adjustments, and supporting working papers for all nursing home and ICF-DD cost report audits submitted by CPA firms. These cost report audits were received by the Agency's Audit Services section within the Division of Medicaid for review of the audit report and working papers. After the review and release of the audit report, the report was sent to the Agency's Cost Reimbursement Section for the calculation of new rates. Conversely, hospital cost report audits were routed directly to the Cost Reimbursement Section, and no review of the audit adjustments or supporting working papers was performed prior to calculating new hospital rates. The Agency performed a limited review of hospital cost report audit working papers during annual contract monitoring, and produced a report dated June, 24, 2010. However, as noted in an Auditor General operational audit report entitled *Medicaid Facility Reimbursement Rates*, this monitoring was limited in scope.[11]

In addition to the differences in Agency oversight provided for the cost report audits of nursing homes and ICF-DDs and the cost report audits of hospitals, we also found significant differences in the appeals process used for cost report audit adjustments. As discussed above in Finding No. 3, the cost reimbursement plans within the Medicaid State Plan for nursing homes, ICF-DDs, and hospitals all provide a facility the right to appeal the results of the audit before a hearing, in accordance with Florida law.[12] While an analysis of audit reports released during the last three fiscal years found that 58 percent of released nursing home audit reports were appealed by the provider and 45 percent of released ICF-DD audit reports were appealed by the provider, there were no instances in which a hospital appealed the results of a cost report audit performed by FCSO. Instead, hospitals utilized a process referred to as a reopening, which is allowed under the Hospital Cost Reimbursement Plan. The reopening process differed from the appeals process in several ways:

[11] Report No. 2010-189, Finding No. 5.
[12] Section 120.57, Florida Statutes.

- If a nursing home or ICF-DD wished to appeal the results of a cost report audit, the provider had to notify the Agency of the facility's intent to appeal the results of the audit within 21 days of receipt of the audit report. However, hospitals that request a reopening of a cost report audit had three years from the date of the audit report to request the reopening, rather than the 21-day period to request an appeal.
- In an appeal by a nursing home or ICF-DD, the Agency determined whether the appeal was timely filed and could be granted, and the Agency was involved in the appeals process, including the decision to revise adjustments and to what amount. However, if a hospital requested a reopening, the hospital notified FCSO of its request for a reopening, rather than the Agency, and FCSO decided whether to grant the reopening, not the Agency. Additionally, FCSO determined whether to adjust the cost report and by how much, rather than the Agency. At the conclusion of the reopening, FCSO was to send a revised cost report audit to the Agency and the provider, and the Agency was then to calculate new rates based on the revised cost report audit, as determined by FCSO. At no point was the Agency involved in the reopening process.
- For the 25 nursing home cost report audit appeals included in out tests, the appeals were initiated by the applicable facility. Our review of 11 hospital reopenings finalized during the period July 1, 2009, through September 30, 2010, found that 6 of the reopenings were initiated by FCSO, rather than the facility.

The hospital cost report audit process followed by the Agency was authorized in the Hospital Cost Reimbursement Plan; however, the Agency was unable to provide explanations as to how that approach, which essentially delegates the hospital Medicaid cost report audit process to a Medicare intermediary, sufficiently addressed the risks of error and fraud that may exist in the Medicaid cost reports of particular hospital facilities. Absent sufficient Agency oversight of the hospital cost report audit process, the Agency's ability to ensure that hospitals were not paid rates that are in excess of the amounts authorized by the Medicaid State Plan was reduced.

Recommendation: The Agency should increase the level of oversight provided for the hospital cost report audit process. We recommend the Agency define and increase its role by:

- **Documenting an understanding of the relationship between FCSO's work as Medicare intermediary and FCSO's review of hospital Medicaid cost reports, as well as how that relationship impacts the prevention and detection of errors and fraud in the Medicaid cost reports of hospitals.**
- **Documenting the extent of the Agency's participation in the hospital cost reports selected for audit.**
- **Reviewing cost report audits as they are received to ensure that the Agency is in agreement with the adjustments made by FCSO.**
- **Reviewing and approving of all adjustments made through the reopening process.**

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 cost report audit process. The overall objectives of the audit were:

- To evaluate the effectiveness of established internal controls in achieving management's control objectives in the categories of compliance with controlling laws, administrative rules, and other guidelines; the economic, efficient, and effective operation of State government; the relevance and reliability of records and reports; and the safeguarding of assets.
- To evaluate management's performance in achieving compliance with controlling laws, administrative rules, and other guidelines; the economic, efficient, and effective operation of State government; the relevance and reliability of records and reports; and the safeguarding of assets.
- To review and evaluate the Agency's processes for performing facility cost report audits to ensure that facilities do not receive overpayments based on fraudulent or overstated cost reports.
- 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 relevant legal requirements, including applicable State statutes and rules, Federal regulations, Medicaid State Plan document, and contracts, and the controls established to reasonably ensure compliance therewith.
- Evaluated the efficiencies of selected controls, with a focus on those that may impact fraud prevention and detection.
- Reviewed 40 nursing homes, 25 ICF-DDs, and 25 hospitals that received Medicaid payments during the 2009-10 fiscal year to determine whether the facility had a cost report that was selected for audit during the period July 1, 2009, through September 30, 2010. We also performed an analysis as to the frequency with which the sampled facilities had a cost report selected within the preceding ten fiscal years.
- Reviewed 242 nursing home, 12 ICF-DD, and 80 hospital cost report audits released or processed by the Agency during the period July 1, 2009, through September 30, 2010, to determine whether the Agency timely released or processed the cost report audits. The entire population of ICF-DD cost report audits released during this period was tested.
- Reviewed 30 nursing home, 5 ICF-DD, and 30 hospital cost report audits finalized during the 2007-08 and 2009-10 fiscal years to determine the effect of the audit on the facility's reimbursement rate. Only five ICF-DD cost report audits released during the 2007-08 and 2009-10 fiscal years had new rates calculated. As a result, the entire population was tested.
- Reviewed 25 nursing home cost report audit appeals and 11 hospital reopenings finalized during the period July 1, 2009, through September 30, 2010, to determine whether the appeals and reopening were timely finalized and what the effect of the appeal was on the facility's reimbursement rate. There were no ICF-DD appeals finalized during this period to test.
- Reviewed 15 nursing homes with overpayments in excess of $10,000, as determined by a cost report audit, to determine whether the State had successfully recovered the overpayment.
- 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 November 9, 2011, the Agency provided responses to our audit findings and recommendations. The Agency's response is included as **EXHIBIT A**.

EXHIBIT A
MANAGEMENT'S RESPONSE

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

November 9, 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, Medicaid Program Fraud Prevention and Detection Policies and Procedures, Facility Cost Reports. In accordance with your request, we have emailed you the preliminary and tentative audit findings document and included our response.

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

Sincerely,

Elizabeth Dudek
Secretary

ED/szg
Enclosures

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-Medicaid Program Fraud Prevention and Detection Policies and Procedures, Facility Cost Reports
Response to Auditor General's P&T Audit Findings and Recommendations dated 10/21/11

Finding 1:
Cost Report Audit Coverage. The Agency did not select for audit facility cost reports at a frequency sufficient to reasonably ensure that improper payments were not made to facilities due to overstated or inaccurate cost reports.

Recommendation:
The Agency should develop policies specifying the frequency with which each facility's cost report shall be audited. The policy should include provisions requiring the scheduling of follow-up audits for those facilities whose previous cost reports have contained significant error and the imposition of sanctions when errors in the costs reported are knowingly repeated by the provider in subsequent cost reports.

Agency Response:
The Agency does consider the number of years since last examination as one of the risk factors used when determining whether to include a cost report on the examination list, although this is a lower risk than other issues and not specifically stated. The number of years since last examination will be added to the risk criteria.

The current policy includes cost reports where issues or concerns were noted during the performance of examinations as a risk factor. Management judgment is used in making the final determination of whether the issues in examinations and cost report acceptance review necessitate the inclusion of future cost reports on the examination list.

The current policy will be updated to include a section related to the potential imposition of sanctions when errors in the costs are knowingly repeated by the provider in subsequent cost reports.

Finding 2:
Cost Report Audit Timeliness. The Agency did not release cost report audits in a timely manner. The failure to timely release audit reports limited the Agency's ability to timely correct errors in per diem rates.

Recommendation:
We recommend:

- The Agency develop policies and procedures to provide for the timely release of cost report audits. These procedures should provide timeframes within which cost report audits are to be reviewed and released.

- With respect to delays attributable to facilities failing to submit their cost report in a timely manner, the Agency finalize a rule, in development at the time of this audit, that subjects facilities to monetary penalties for failing to submit their cost reports within specified timeframes.

Agency Response:
The Agency policy describes the approach from determining the selection of cost reports through the release of the reports and the appeal process. The Agency strives to issue initial reports and conclude legal challenges as soon as processes allow, so that applicable rate changes can be determined. The Agency resources are managed to include both review and release of reports, as well as the detail work in handling a legal challenge.

EXHIBIT A
MANAGEMENT'S RESPONSE (CONTINUED)

Agency for Health Care Administration
AHCA-Medicaid Program Fraud Prevention and Detection Policies and Procedures, Facility Cost Reports
Response to Auditor General's P&T Audit Findings and Recommendations dated 10/21/11

The Agency has updated the Title XIX Long-Term Care Reimbursement Plan to include the ability to apply monetary penalties for cost report submissions that do not comply with required timeframes. This change was effective for the July 1, 2011 Plan.

Finding 3:
Cost Report Audit Appeals Process. The Agency should consider revising the process used by facilities to appeal the results of cost report audits. A reduction in the number of appeals would reduce the time and resources needed by the Agency to process the appeals and may increase the frequency or timeliness with which the Agency can release cost report audits and finalize and apply corrected per diem rates.

Recommendation:
We recommend that the Agency pursue steps to reduce the number of appeals and the length of time involved in closing appeals. Steps to reduce the number of appeals should include the disallowance of those appeals that seek to extend consideration of audit adjustments made in response to facility documentation deficiencies.

Agency Response:
The Agency cannot prevent the facilities from pursuing their Chapter 120 hearing rights for each report issued. Each challenge filed, if meeting the legal requirements, has to be addressed through the legal process.

The Agency requested the advice of our General Counsel regarding the recommendation to limit appeals that seek to extend consideration of adjustments made in response to facility documentation deficiencies. Per Counsel, the Title XIX Long-Term Care Reimbursement Plan references the examination process. The filing of a petition for the Chapter 120 hearing is a separate process from the examination. The Agency will further discuss our processes with our General Counsel to determine options that may be available.

Finding 4:
Consideration of Cost Report Fraud. The Agency had not developed written policies and procedures requiring further scrutiny or inquiry into the cost reports of facilities that may contain indications of fraudulent preparation.

Recommendation:
We recommend that the Agency develop and communicate to relevant staff written policies and procedures describing the steps to be followed should the results of cost report audits contain indications of facility fraud.

Agency Response:
The Agency will expand its current policy to include steps to be followed should the results of cost report examinations contain fraud indicators.

EXHIBIT A
MANAGEMENT'S RESPONSE (CONTINUED)

Agency for Health Care Administration
AHCA-Medicaid Program Fraud Prevention and Detection Policies and Procedures, Facility Cost Reports
Response to Auditor General's P&T Audit Findings and Recommendations dated 10/21/11

Finding 5:
Hospital Cost Report Oversight. The level of oversight provided by the Agency over the hospital cost report audit process was not sufficient. Increased Agency involvement in the hospital cost report audit process could provide additional assurance that hospital cost reports are accurate, complete, and free of material error.

Recommendation:
The Agency should increase the level of oversight provided for the hospital cost report audit process. We recommend the Agency define and increase its role by:

- Documenting an understanding of the relationship between FCSO's work as Medicare intermediary and FCSO's review of hospital Medicaid cost reports, as well as how that relationship impacts the prevention and detection of errors and fraud in the Medicaid cost reports of hospitals.
- Documenting the extent of the Agency's participation in the hospital cost reports selected for audit.
- Reviewing cost report audits as they are received to ensure that the Agency is in agreement with the adjustments made by FCSO.
- Reviewing and approving of all adjustments made through the reopening process.

Agency Response:
The Agency will document the understanding of the relationship between FCSO's work as Medicare intermediary and FCSO's review of Medicaid hospital cost reports.

The Agency will document the extent of the participation in the hospital cost reports selected for audit.

The Agency does review the hospital cost report audits received for changes in costs, outlier information, transpositions, and other information that does not fit the situation. The Agency addresses any concerns during this process with FCSO.

The Agency performs contract monitoring of the FCSO contract. A sample of audited hospital cost reports is selected for review. This review includes the supporting documentation of the work performed and adjustments made to the cost reports selected. The expansion of this activity is limited to the resources available.

Reopenings occur for numerous reasons. Reopenings may be requested by the Agency, the provider, or initiated by FCSO. If obvious errors are noted by these parties, the error is corrected and new schedules are prepared and submitted to the Agency. Reopenings of the Medicare cost report may also cause the reopening of a Medicaid cost report due to the flow of the information. Since reopening occurs after the release of rates based upon the audited cost reports, changes made during the reopening process may change rates. The Agency will include a reopening in the sample selected for review during contract monitoring.