

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

**PRIOR AUDIT FOLLOW-UP
AND SELECTED ADMINISTRATIVE ACTIVITIES**

Operational Audit



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. Elizabeth Dudek served as Secretary during the period of our audit.

The audit team leader was Barry Bell, CPA, and the audit was supervised by Karen Van Amburg, CPA. Please address inquiries regarding this report to Jane Flowers, CPA, Audit Manager, by e-mail at janeflowers@aud.state.fl.us or by telephone at (850) 412-2757.

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AGENCY FOR HEALTH CARE ADMINISTRATION

Prior Audit Follow-Up and Selected Administrative Activities

SUMMARY

This operational audit of the Agency for Health Care Administration (Agency) focused on evaluating the actions taken by the Agency to correct deficiencies disclosed in our report No. 2012-021, *FMMIS' Controls and the Prevention of Improper Medicaid Payments*. The audit also included an evaluation of selected Agency administrative activities. Our audit disclosed the following:

MEDICAID PAYMENTS AND FMMIS CONTROLS

Finding No. 1: The Agency should continue efforts to reprocess the estimated \$117.66 million in Medicare outpatient hospital crossover claims identified in our report No. 2012-021, finding No. 3, and recoup any payments made that were not consistent with State law.

Finding No. 2: Agency policies and procedures need strengthening to ensure that providers are timely suspended or terminated from Medicaid Program participation upon the Agency's discovery that the Federal Government or another state has excluded the provider from Federally funded health care program participation.

FISCAL AGENT OVERSIGHT

Finding No. 3: The Agency should revise the methodology used to monitor the performance of the Medicaid fiscal agent and, to encourage the timely correction of performance deficiencies, the Agency should consider increasing the monetary penalties (i.e., damages) in its contract with the fiscal agent.

SELECTED ADMINISTRATIVE ACTIVITIES

Finding No. 4: The Agency had not established policies and procedures for the collection and use of social security numbers or evaluated the collection and use of social security numbers to ensure and demonstrate compliance with State law.

Finding No. 5: Agency controls over employee access to the Florida Accounting Information Resource Subsystem (FLAIR) need improvement.

BACKGROUND

State law² designates the Agency for Health Care Administration (Agency) as the State's chief health policy and planning entity and government entity responsible for administering the State's Medicaid Program. The State's 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 Medicaid Program's eligibility criteria generally either enroll in a managed care plan³ or receive their services through a fee-for-service payment structure. As shown in Table 1, from July 1, 2011, through February 28, 2013, the Agency processed and paid Medicaid claims totaling approximately \$30.9 billion, with fee-for-service claims representing \$24.1 billion and managed care payments totaling approximately \$6.8 billion.

¹ Florida Medicaid Management Information System.

² Section 20.42(3), Florida Statutes.

³ Pursuant to Chapter 2011-134, Laws of Florida, in May 2011, the Agency began implementation of the Statewide Medicaid Managed Care Program (SMMCP) for all covered medical assistance and long-term care services. In August 2011, Agency management reported that, upon full SMMCP implementation, scheduled for October 2014, approximately 85 percent of the State's Medicaid population will be enrolled in managed care.

**Table 1
Medicaid Program Payments by Service Type
July 1, 2011, Through February 28, 2013**

Medicaid Service Type	Total Payments by Service Type	Percentage of Total
Fee-For-Service Claims		
Cost-Based Reimbursement Type Facilities (Hospitals, Intermediate Care Facilities for the Developmentally Disabled, and Nursing Homes)	\$15,132,308,175	49.02%
Home and Community-Based Waiver Services	1,858,087,912	6.02%
Other Facility Types (County Health Departments, Federally Qualified Health Centers, Hospices, Rural Health Clinics, etc.)	925,465,434	3.00%
Physician Services	1,779,231,426	5.76%
Prescription Drugs	2,252,138,949	7.30%
Remaining Service Types	2,143,789,340	6.94%
Total Fee-For-Service Payments	\$24,091,021,236	78.04%
Managed Care Payments	6,780,680,440	21.96%
Total Payments	\$30,871,701,676	100.00%

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

In a managed care delivery system, enrollees receive most or all of their Medicaid Program services from an organization under contract with the Agency. These managed care organizations provide Medicaid Program services to enrollees in exchange for a monthly payment from the Agency.

In the fee-for-service payment structure, Medicaid service providers must be approved and enrolled in the Medicaid Program. Once a service has been performed for a Medicaid recipient, 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 the State’s Medicaid fiscal agent.

The Agency contracted with HP Enterprise Services, LLP (HPES) to serve as the State’s Medicaid fiscal agent from July 1, 2008, through June 30, 2018.⁴ As part of this contract, HPES also enrolls providers in the Medicaid Program. During the period July 1, 2011, through February 28, 2013, Agency payments to HPES totaled approximately \$101 million.

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. Electronic audits are also to be utilized in the review of a recipient’s claim history to ensure that the claim submitted by the provider does not exceed

⁴ The contract, effective May 16, 2006, through June 30, 2018, authorized payments totaling \$645 million. The contract objectives addressed planning, designing, developing, testing, and implementing FMMIS prior to July 1, 2008, and fiscal agent responsibilities, including FMMIS administration, thereafter.

Medicaid Program limitations. These electronic edits and audits play a crucial role in ensuring that Medicaid claims are appropriately paid.

Finding No. 1: Medicare Outpatient Hospital Crossover Claims

The Medicare Program is the Federal health insurance program for individuals who are 65 or older, certain younger individuals with disabilities, and individuals with End-Stage Renal Disease. Among the features of the Medicare Program, Medicare Part B pays for outpatient medical services provided in hospitals, clinics, nursing homes, or other facilities. Individuals who receive Medicare benefits may also be eligible to receive certain levels of Medicaid benefits, the extent of which depends primarily upon the individual's income level. The levels of available Medicaid benefits range from payment of only the Medicare Part B premiums to full Medicaid benefits, including payment of Medicare Part A and Part B premiums, and for claims, Medicare coinsurance and deductibles. Since Medicaid is always the payor of last resort,⁵ each Medicare recipient claim must first be submitted to the Medicare Program for payment. Once the Medicare Program has paid the Medicare-covered portion of the claim, the claim can be submitted to the Medicaid Program for payment of any amounts due for Medicare coinsurance and deductibles. Such claims are referred to as crossover claims.

While State law⁶ authorizes the Agency to pay Medicare coinsurance and deductibles on behalf of Medicaid-eligible individuals, the law also provides 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. State law also provides that the combined payments from Medicare and Medicaid shall not exceed what Medicaid would have paid if Medicaid were the sole payor.

In our report No. 2012-021, finding No. 3, we disclosed that FMMIS was not programmed to ensure the proper payment of Medicare outpatient hospital crossover claims. Specifically, our audit found that FMMIS was not calculating the Medicaid payment as if Medicaid were the sole payor and then comparing that amount to the amount paid by Medicare to determine whether additional amounts were due from Medicaid. Additionally, our audit noted that the FMMIS methodology did not ensure that the combined payment of Medicare and Medicaid did not exceed the Medicaid 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. Our review of the *Florida Medicaid Provider General Handbook* disclosed that this payment methodology for Medicare outpatient hospital crossover claims had been in effect since July 1, 2001.

In our report No. 2012-021, finding No. 3, we also reported projected Medicare outpatient hospital crossover claim overpayments totaling approximately \$117.66 million⁷ for the 2007-08, 2008-09, and 2009-10 fiscal years. We recommended that the Agency ensure that FMMIS was programmed with the correct methodology for the payment of outpatient hospital crossover claims and that the Agency review outpatient hospital crossover claims and initiate recoupment efforts for any payments made that were not consistent with State law.

As part of our audit follow-up procedures, we performed inquiries of Agency personnel and inspected documents and records to determine whether Agency management had corrected, or was in the process of correcting, the deficiencies noted in our prior report. According to Agency management, as of May 30, 2014, FMMIS programming changes had been completed and the Agency was working with the fiscal agent to establish the necessary system edits to begin

⁵ Section 409.910(1), Florida Statutes.

⁶ Section 409.908(13), Florida Statutes.

⁷ The \$117.66 million includes both the State and Federal share.

reprocessing the identified claims. Reprocessing the claims will allow the Agency to begin recouping any payments made that were not consistent with State law.

In response to our audit inquiry, Agency management indicated that the delays in implementing FMMIS programming changes and initiating overpayment recoupment efforts were due to Agency staff awaiting updates to the *Florida Medicaid Provider General Handbook* made via the rule promulgation process which was completed effective June 13, 2013. Delays in making necessary FMMIS programming changes increased the likelihood that overpayments continued to be made for outpatient hospital crossover claims. Also, delays in initiating recoupment efforts may frustrate and reduce the effectiveness of the collection process.

Recommendation: We recommend that Agency management review the Medicare outpatient hospital crossover claims identified in our report No. 2012-021, finding No. 3, as well as outpatient hospital crossover claims processed subsequent to the 2009-10 fiscal year, and initiate recoupment efforts for any payments made that were not consistent with State law.

Finding No. 2: Provider Participation

State law⁸ requires the Agency to immediately suspend or terminate a provider's participation in the State's Medicaid Program if the provider has been suspended or terminated from participation in the Medicaid or Medicare Programs by the Federal Government or any state. State law⁹ also requires that the Agency deny payment, or require repayment, for services that were provided by a person who had been suspended or terminated from the Medicaid or Medicare Programs by the Federal Government or any state. The United States Department of Health and Human Services, Office of Inspector General (USDHHS-OIG), maintains a List of Excluded Individuals and Entities (LEIE) database. The LEIE database lists those individuals and entities that have been excluded by the Federal Government from participating in Federally funded health care programs, including the Medicaid Program. The database is updated monthly and may be downloaded from the USDHHS-OIG Web site.

In a June 12, 2008, letter addressed to the State Medicaid Directors, the Centers for Medicare and Medicaid Services (CMS) recommended that states search the LEIE database on a monthly basis to determine whether any new individuals or entities had been added or removed since the previous month. In the letter, the CMS also reminded states that any payments made to excluded individuals or entities are considered an overpayment and are unallowable for claiming matching Federal funds.

In our report No. 2012-021, finding No. 8, we noted that the Agency did not perform comparisons of the Medicaid providers in FMMIS with those individuals and entities in the LEIE database until June 2011. At that time, the Agency's Bureau of Medicaid Program Integrity (Bureau) began performing manual monthly matches between actively enrolled Medicaid providers in FMMIS and individuals and entities listed in the LEIE database. The Agency also subsequently established written procedures¹⁰ addressing Medicaid Program participation termination or suspension for excluded providers identified during the monthly matches.

As part of our audit follow-up procedures, we evaluated the Agency's procedures for suspending or terminating Medicaid Program providers listed in the LEIE database, and examined documentation for the monthly matches completed by the Bureau in January 2012, October 2012, and March 2014. We found that:

⁸ Section 409.913(14), Florida Statutes.

⁹ Section 409.913(25)(b), Florida Statutes.

¹⁰ Agency, Bureau of Medicaid Program Integrity, Internal Operating Procedure D-5, *Federal or State Exclusion*.

- Agency procedures did not require, although prescribed by State law, that a provider’s participation in the Medicaid Program be immediately suspended or terminated upon exclusion by the Federal Government or another state. Instead, the procedures provided that the Agency could determine the action warranted based on the type of exclusion.¹¹ Additionally, Agency procedures did not require that, as of the date a provider is terminated from the Medicaid Program, the Agency suspend the provider’s claims or remove the provider from active status in FMMIS. Instead, our audit procedures found that the Agency did not remove providers from active status until after final orders for termination were filed by the Agency.
- During the selected monthly matches, the Bureau identified 18 providers in FMMIS that were listed in the LEIE database. However, the Agency had not timely terminated 4 of the 18 providers from participation in the Medicaid Program, or suspended or removed the providers’ active status in FMMIS, upon discovery that the providers were listed in the LEIE database. Although the 4 providers had been excluded from participating in Federally funded health care programs, as shown in Table 2, the Agency did not timely terminate the providers from the Medicaid Program or timely remove the provider’s active status in FMMIS.

**Table 2
Excluded Providers Not Timely Terminated From Medicaid Participation**

Excluded Provider	Month Excluded From Federally Funded Health Care Program Participation	Month Agency Terminated Medicaid Program Participation	Month Agency Removed Active FMMIS Status
1	August 1996	November 2011	June 2013 ^a
2	June 2012	November 2012	June 2013 ^a
3	July 2012	November 2012	June 2013 ^a
4	November 2013	June 2014 ^b	N/A ^c

- ^a Provider’s active FMMIS status removed in June 2013, subsequent to audit inquiry.
- ^b Provider terminated from Medicaid Program participation in June 2014, subsequent to audit inquiry.
- ^c Provider’s active FMMIS status had not been removed as of June 2014.

By remaining active in FMMIS, the four excluded providers could potentially have received payments for services provided after termination from the Medicaid Program; however, our analysis of FMMIS Medicaid payment data indicated that, as of the dates of our audit field work, providers 2 through 4 did not receive any Medicaid payments after they were excluded by the Federal Government or another state and provider 1 had not received Medicaid payments since at least July 2011.

In response to our audit inquiry, Agency staff indicated that delays in Medicaid participation termination sometimes occurred when notification letters had to be redelivered because of an incorrect provider address. Additionally, Agency staff indicated that, upon discovering an LEIE match, Agency staff checked the matched provider’s billing history in FMMIS and, if the provider had not filed a Florida Medicaid claim in the past 2 fiscal years, the Agency considered it unlikely that the provider would file a claim before the termination process was complete. Therefore, it was unnecessary to suspend the provider in FMMIS to prevent payments during the termination process. Notwithstanding these Agency staff explanations, absent actions taken to timely suspend or terminate a provider’s participation in the Medicaid Program upon discovery of exclusion by the Federal Government or another state, the Agency cannot demonstrate compliance with State law. Also, by not timely terminating excluded Medicaid Program providers and timely updating FMMIS to reflect the actions taken, the risk that excluded providers may continue to receive Medicaid payments is increased.

¹¹ 42 USC 1320a-7, *Exclusion of certain individuals and entities from participation in Medicare and State health care programs*, provides a list of mandatory and permissive exclusions.

Recommendation: We recommend that Agency management revise procedures to require that, upon discovering that a provider has been excluded from participation by the Federal Government or another state, Agency staff take immediate actions to suspend or terminate the provider's participation in the Medicaid Program and timely remove the provider's active status in FMMIS.

Fiscal Agent Contract Monitoring

As noted in the **BACKGROUND** section of this report, the Agency entered into a \$645 million contract with HPES to serve as the State's Medicaid fiscal agent through June 2018. As the State's Medicaid fiscal agent, HPES' primary responsibility is to administer FMMIS to process the claims submitted by Medicaid providers. In order to monitor fiscal agent performance, each month HPES is scored¹² on 93 individual performance measures, organized into nine separate performance measure areas. A report card is prepared for each of the nine separate performance measure areas. Pursuant to the contract provisions, monetary penalties can be assessed by the Agency should HPES not achieve satisfactory performance levels in each performance measure area. Monetary penalties assessed and paid by HPES for unsatisfactory performance during the period July 1, 2011, through February 28, 2013, totaled \$15,000, while total contract payments made by the Agency to HPES during that period totaled approximately \$101 million.

Finding No. 3: Performance Measures and Monetary Sanctions

According to the provisions of the HPES contract, for each of the nine performance measure area report cards, the Agency can assess HPES a penalty (i.e., damages) of \$5,000 for scores below 77 and \$10,000 for scores below 70. To arrive at the final overall score for each report card, the performance measures included on each report card are scored individually and then averaged together.

In our report No. 2012-021, finding No. 9, we identified areas in which the Agency's scoring methodology for the HPES report cards needed modification to enhance its effectiveness as a deterrent to unacceptable performance. Specifically, we found that:

- While many of the individual performance measures could receive a score of 100, 65 was the lowest possible score that could be recorded for 84 of the performance measures. By setting 65 as the lowest possible score, we noted that the report card's overall score was artificially inflated which may have resulted in the assessment of fewer, or lower, monetary penalties.
- By considering the report card's overall score when assessing monetary penalties, the Agency may not assess monetary penalties for unsatisfactory performance levels on a critical performance measure should HPES achieve a high score for a less critical measure on the same report card. Accordingly, subjecting each individual performance measure to a monetary penalty, or assigning a greater weight to the more critical performance measures, would enhance the Agency's ability to objectively evaluate and assess meaningful penalties for unsatisfactory performance.
- The contract between the Agency and HPES provided for the assessment of monetary penalties that were relatively small in amount and the Agency did not always fully utilize the penalty provisions available in the contract.

To address these areas, we recommended that the Agency revise its scoring methodology to subject each performance measure to a monetary penalty or to allow scores of less than 65, should they be warranted. We also recommended that the Agency amend its contract with HPES to provide for an escalation of monetary penalties for continued

¹² The scoring process involves numerous steps whereby HPES initially scores itself and submits the scores to Agency Medicaid Contract Management (MCM) staff. Agency MCM staff review the HPES-submitted scores, discuss scoring changes with HPES, and then revise and provide the final scores to HPES.

failure to achieve satisfactory levels of performance, and that the penalties increase to an amount sufficient to encourage the timely correction of performance deficiencies.

As part of our audit follow-up procedures, we performed inquiries and inspected Agency documents and records to evaluate the extent to which Agency management had addressed the issues we noted regarding the scoring methodology and penalty assessments. We found that:

- The Agency had revised the scoring methodology for only two (Provider Management and Recipient Management) of the nine performance measure areas. As shown in Table 3, for the January 2014 report cards, the Agency had established a lowest possible score of 65 for 48 of the 93 performance measures and the lowest possible score for 16 other performance measures was 75 or 77. Only 4 performance areas had individual performance measures that could be scored below 65.

Table 3
Performance Measure Area Scoring Scale
for the January 2014 Report Cards

Performance Measure Area	Individual Performance Measures				
	Total Number	Lowest Possible Score			
		77	75	65	0
Call Center	8	-	-	6	2
General Functions	12	10	1	1	-
Interfaces	8	-	-	8	-
Magellan Medicaid Administration	11	2	-	7	2
Payment Management I	7	-	-	7	-
Payment Management II	8	1	1	6	-
Provider Management	9	-	-	-	9
Recipient Management	17	-	-	1	16
Systems	13	1	-	12	-
Totals	<u>93</u>	<u>14</u>	<u>2</u>	<u>48</u>	<u>29</u>

Source: Auditor analysis of January 2014 performance report cards.

- The HPES contract had not been amended, as of May 2014, to provide for an escalation of penalties for continued failure to achieve satisfactory levels of performance.

In response to our audit inquiry, Agency staff indicated that further changes to the scoring methodology had not been made due to Agency staff turnover. Agency staff also indicated that changes to the monetary penalties would require negotiations between the Agency and HPES as the contract terms were already in effect, and that future changes to the monetary penalties could be incorporated into a request for proposal soliciting a new fiscal agent contract upon expiration of the current HPES contract in 2018. Notwithstanding the changes to the monetary penalties that can be made in connection with a future fiscal agent solicitation, changes to the scoring methodology and a contract amendment for the assessment of penalties in amounts sufficient to encourage performance would enhance the Agency’s ability to ensure that the current fiscal agent consistently performs at a satisfactory level.

Recommendation: We again recommend that Agency management take the steps necessary to revise the Medicaid fiscal agent performance scoring methodology. The revised methodology should subject each individual performance measure to a monetary penalty, or assign a greater weight to the more critical performance measures, and allow scores below the lowest established scores when warranted. We also recommend that Agency management continue to consider amending the contract with HPES to provide for an escalation of monetary penalties for continued failure to achieve satisfactory levels of performance. The escalation of penalties should increase to an amount sufficient to encourage the timely correction of any performance deficiencies.

Selected Administrative Activities

Finding No. 4: Collection of Social Security Numbers

The Legislature has acknowledged in State law¹³ that a person's social security number (SSN) was never intended to be used for business purposes. However, over time the SSN has been used extensively for identity verification and other legitimate business purposes.

Recognizing that an SSN can be used to perpetrate fraud against an individual and acquire sensitive personal, financial, medical, and familial information, the Legislature specified¹⁴ that State agencies may not collect an individual's SSN unless the agency is authorized by law to do so or it is imperative for the performance of that agency's duties and responsibilities as prescribed by law. Additionally, State agencies are required to provide each individual whose SSN is collected written notification regarding the purpose for collecting the number. The SSNs collected may not be used by the agency for any purpose other than the purposes provided in the written notification. State law further provides that SSNs held by an agency are confidential and exempt from public inspection and requires each agency to review its SSN collection activities to ensure the agency's compliance with the requirements of State law and to immediately discontinue SSN collection upon discovery of noncompliance.

We noted that the Agency had established policies and procedures¹⁵ that required, upon creation of a new form or revision to an existing form, the form be approved by the Office of the General Counsel and the HIPAA¹⁶ Compliance Officer before receiving final approval from the Agency Forms Administrator. To document the form approvals, the policies and procedures required the Agency Forms Coordinator to prepare a Form Number Request (Request) which included spaces for the applicable signatures and dates of approval. The Request also contained a space to describe the statutory authority relevant to the accompanying form, and a space to indicate whether the form would require the collection of personal health information. However, we noted that the Request did not contain a space to identify whether the form would be used to collect individuals' SSNs and, if so, to reference the Agency's statutory authority for collecting the SSNs.

Additionally, our audit procedures disclosed that the Agency had not established written policies and procedures relating to the collection and use of SSNs, including the periodic review of its SSN collection activities. We also noted that the Agency could not demonstrate the statutorily required review of its SSN collection activities, or provide a complete listing of all forms and information systems used by the Agency to collect SSNs. In response to our audit inquiry, Agency staff indicated that a listing of SSN collection points had last been compiled in 2005 and that the listing was no longer valid due to changes in the Agency's forms and business processes. Although the Agency could not identify all forms used to collect SSNs, Agency staff did identify five forms which collected individuals' SSNs. Our examination of the five forms disclosed that one of the forms did not identify the purpose for collecting the SSN and the Agency was unable to provide documentation to evidence that another means of written notification was provided to the individuals completing the form. For this form and one other, Agency staff indicated that the collection of SSNs was not necessary and the Agency subsequently revised the two forms to remove the request for SSNs.

Agency management indicated, in response to our audit inquiry, that they considered the identification of personal health information on the Request to include SSNs, and that it was routine for the Office of the General Counsel staff

¹³ Section 119.071(5), Florida Statutes.

¹⁴ Section 119.071(5)(a)2., Florida Statutes.

¹⁵ Agency, Division of Operations, Bureau of Support Services, Policy and Procedure Number 4016, *Forms Management*.

¹⁶ Health Insurance Portability and Accountability Act of 1996.

to verify each form's compliance with the law before approving Requests. Notwithstanding this response, effective controls, including written policies and procedures addressing the Agency's collection and use of individuals' SSNs, a means to properly notify each individual regarding the purpose for collecting his or her SSN, and periodic assessments of SSN collection activities, would better ensure and demonstrate Agency compliance with statutory requirements and reduce the risk that SSNs may be unnecessarily collected or utilized for unauthorized purposes.

Recommendation: To demonstrate compliance with applicable statutory requirements, we recommend that Agency management establish written policies and procedures regarding the collection and use of individuals' SSNs, develop a means to properly notify each individual regarding the purpose for collecting his or her SSN, and conduct periodic assessments of the Agency's SSN collection activities. Additionally, we recommend that Agency management enhance the Form Number Request to address whether the Agency form subject to approval will be used to collect individuals' SSNs and, if so, express the Agency's statutory authority to do so.

Finding No. 5: Information Technology Access Controls

The Agency utilizes the Florida Accounting Information Resource Subsystem (FLAIR) to authorize payment of Agency obligations and to record and report financial transactions. Controls over employee access to FLAIR are necessary to help prevent and detect any improper or unauthorized use of FLAIR. Accordingly, FLAIR access should be: (1) limited to properly authorized employees, (2) appropriate for the employee's assigned duties and responsibilities, and (3) promptly revoked when employees separate from the Agency or are reassigned to positions no longer requiring FLAIR access.

Effective access controls also include a process for ensuring appropriate separation of duties and the unique identification and authentication of users. To ensure security over State agency information technology systems and data, minimum security standards were established in Agency for Enterprise Information Technology (AEIT) rules.¹⁷ Those rules require that each user of a multiple-user information resource be assigned a unique user identification to allow management to affix responsibility for system activity to an individual person. The rules also provide for the adequate separation of duties to minimize the opportunity for any one person to subvert or damage information resources.

We noted that, as of March 2013, the Agency had not established policies and procedures requiring the periodic review of employees' FLAIR access to identify and resolve any instances where excess or incompatible privileges had been granted or where access was no longer needed, and our audit procedures disclosed that no FLAIR access privilege reviews had been performed. Subsequent to our audit inquiry, the Agency developed policies and procedures¹⁸ in March 2013 for granting, reviewing, and terminating FLAIR access. The policies and procedures required Access Control Custodians to periodically review user access privileges but did not prescribe how frequently the reviews were to occur. In July 2014, the Agency provided updated policies and procedures that prescribed the frequency of user access reviews.

Additionally, we reviewed FLAIR access privileges associated with 201 Agency user accounts as of April 2014 and found that:

¹⁷ AEIT Rules 71A-1.013(5), 71A-2.004, and 71A-2.005, Florida Administrative Code. Effective July 1, 2014, Chapter 2014-221, Laws of Florida, created the Agency for State Technology (AST) within the Department of Management Services and authorized a type two transfer of all records; property; administrative authority; administrative rules in Chapters 71A-1 and 71A-2, Florida Administrative Code; and existing contracts of the AEIT to the AST.

¹⁸ Agency, Division of Operations, Bureau of Finance and Accounting, Policy and Procedure Number 12-FA-02, *Granting, Reviewing, and Terminating FLAIR Access*.

- Employees performing financial management functions had been granted update capabilities to incompatible functions in FLAIR. For example, 10 user accounts had update access to both disbursement and cash receipts functions, 9 user accounts had update access to both the vendor file function and the disbursement function, and 11 user accounts had update access to both the fixed assets accounting and fixed assets custodial functions. Subsequent to our audit inquiry, the Agency deleted inappropriate update capabilities for some users. However, as of June 2014, 7 user accounts retained update access to both disbursement and cash receipts functions, 3 user accounts retained update access to both the vendor file function and the disbursement function, and 9 user accounts retained update access to both the fixed assets accounting and fixed assets custodial function. These incompatible access privileges heighten the risk that errors or fraud may occur and not be timely detected.
- Four employees shared a single user ID to an account with update capabilities to the FLAIR access control function that allowed them to grant user access to FLAIR. Subsequent to our audit inquiry, the Agency assigned two employees each a unique user ID and deleted the shared user ID.
- Four employees shared a single user ID to an account with update capabilities to multiple financial management functions in FLAIR including, but not limited to accounts receivable, cash receipts, disbursements and disbursement corrections, fixed asset accounting, and fixed asset custodial functions. Subsequent to our audit inquiry, the Agency deleted the shared user ID.

Without periodic and timely reviews of user access, the Agency cannot be assured that FLAIR access privileges remain appropriate and provided only to authorized employees. Additionally, the sharing of user IDs and passwords increases the risk that Agency management will be unable to timely identify the persons responsible for inappropriate system actions, should they occur.

Recommendation: We recommend that Agency management limit FLAIR user access privileges to only those functions needed for the performance of the user's job duties, and ensure that each user is assigned a unique FLAIR user ID. We also recommend that Agency management ensure that reviews of FLAIR access privileges are routinely performed to aid in the identification and resolution of any instances where excess or incompatible access privileges have been granted or FLAIR access is no longer needed.

PRIOR AUDIT FOLLOW-UP

Except as discussed in the preceding paragraphs, the Agency had taken corrective actions for the findings included in our report No. 2012-021.

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 February 2013 through September 2013, and selected actions taken through June 2014, 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 evaluating actions taken by the Agency to correct the deficiencies disclosed in our report No. 2012-021, *FMMIS Controls and the Prevention of Improper Medicaid Payments*, as well as selected administrative activities. The overall objectives of the audit were:

- To evaluate management's performance in establishing and maintaining internal controls, including controls designed to prevent and detect fraud, waste, and abuse, and in administering assigned responsibilities in accordance with applicable laws, administrative rules, contracts, grant agreements, and guidelines.
- To examine internal controls designed and placed in operation to promote and encourage the achievement of management's control objectives in the categories of compliance, economic and efficient operations, the reliability of records and reports, and the safeguarding of assets, and identify weaknesses in those internal controls.
- To determine whether management had corrected, or was in the process of correcting, all deficiencies disclosed in our report No. 2012-021.
- To identify statutory and fiscal changes that may be recommended to the Legislature pursuant to Section 11.45(7)(h), Florida Statutes.

This audit was designed to identify, for those programs, activities, or functions included within the scope of the audit, deficiencies in management's internal controls, instances of noncompliance with applicable governing laws, rules, or contracts, and instances of inefficient or ineffective operational policies, procedures, or practices. The focus of this audit was to identify problems so that they may be corrected in such a way as to improve government accountability and efficiency and the stewardship of management. Professional judgment has been used in determining significance and audit risk and in selecting the particular transactions, legal compliance matters, records, and controls considered.

As described in more detail below, for those programs, activities, and functions included within the scope of our audit, our audit work included, but was not limited to, communicating to management and those charged with governance the scope, objectives, timing, overall methodology, and reporting of our audit; obtaining an understanding of the program, activity, or function; exercising professional judgment in considering significance and audit risk in the design and execution of the research, interviews, tests, analyses, and other procedures included in the audit methodology; obtaining reasonable assurance of the overall sufficiency and appropriateness of the evidence gathered in support of our audit's findings and conclusions; and reporting on the results of the audit as required by governing laws and auditing standards.

Our audit included the selection and examination of transactions and records. Unless otherwise indicated in this report, these transactions and records were not selected with the intent of statistically projecting the results, although we have presented for perspective, where practicable, information concerning relevant population value or size and quantifications relative to the items selected for examination.

An audit by its nature, does not include a review of all records and actions of agency management, staff, and vendors, and as a consequence, cannot be relied upon to identify all instances of noncompliance, fraud, abuse, or inefficiency.

In conducting our audit we:

- Evaluated Agency actions taken to correct the deficiencies noted in our report No. 2012-021. Specifically, we:
 - Reviewed the Agency's 6-month report on the status of corrective actions taken, and obtained confirmation from Agency staff regarding the current status of corrective actions taken for each finding disclosed in our report No. 2012-021.
 - Performed inquiries of Agency staff, inspected documents and records, and reviewed internal audit reports related to the Agency's Medicaid risk management process to determine whether the Agency had established an effective risk assessment process providing for the identification of risks and the implementation of controls to mitigate the identified risks.

- Inspected documents and records to determine whether FMMIS contained electronic edits to ensure that only active and valid providers were to be paid for services provided to active and valid Medicaid recipients.
- Examined documentation related to five Medicaid service types that had service limitations to determine whether FMMIS contained edits and audits to prevent the payment of claims in excess of service limitations.
- Performed inquiries of Agency staff and inspected documents and records to determine whether programming changes in FMMIS and promulgated revisions to the *Florida Medicaid Provider General Handbook* were sufficient to ensure that Medicare outpatient hospital crossover claims were paid in the correct amounts and in accordance with Medicaid policy and State law.
- Examined documentation for 15 Medicare professional crossover claims, with reimbursed Medicaid expenditures totaling \$358, paid during the period November 1, 2012, through February 28, 2013, to determine whether the claims were paid in accordance with Medicaid policy and State law. Additionally, analyzed Agency records for 5 procedure codes for which payments totaling \$1,948,434 for professional Medicare crossover claims were made during the period July 1, 2011, through February 28, 2013, to determine whether the claims were paid in accordance with Medicaid policy and State law.
- Analyzed Medicare professional crossover claims, totaling \$937,288, paid to Durable Medical Equipment providers on behalf of 22 recipients during the period July 1, 2011, through February 28, 2013, to determine whether each recipient was eligible for Medicaid payment of these services.
- Analyzed Medicare professional and outpatient hospital crossover claims with Medicare payments totaling \$42,276,085 during the period November 1, 2012, through February 28, 2013, for recipients enrolled in the Medicaid Program as a Special Low Income Beneficiary or as a Qualifying Individual to determine whether Medicaid had also paid on the claims.
- Performed inquiries and inspected documents and records to determine whether the Agency took action to reprocess and recoup the overpayments of Medicare crossover claims identified in our report No. 2012-021, finding Nos. 2, 3, 4, and 5.
- Reviewed and evaluated the Agency's process for conducting periodic reviews of FMMIS edits and audits to determine whether the Agency conducted reviews, and whether the reviews were sufficient to ensure that cost-effective edits and audits were in place and programmed for the correct Medicaid policy.
- Reviewed and evaluated the effectiveness of Agency procedures designed to ensure that Medicaid policy changes are identified and that necessary FMMIS programming changes are timely implemented.
- Evaluated, for 10 FMMIS change orders for edits and audits implemented during the period April 18, 2012, through February 28, 2013, whether the Agency's checklist for the change order was properly completed and whether the changes were programmed into FMMIS and moved into production in a timely manner.
- Evaluated Agency policies and procedures for issuing and tracking the Bureau of Medicaid Program Integrity's (Bureau) policy and edit recommendations to determine whether Bureau recommendations were appropriately communicated, that acceptance or rejection of the recommendations was appropriately documented, and that accepted recommendations were tracked to ensure that they were properly implemented.
- Reviewed documentation for the three Bureau recommendations made during the period July 1, 2011, through February 28, 2013, to determine whether the Agency adequately communicated the recommendations, documented the acceptance or rejection of the recommendations, and tracked the accepted recommendations to verify that they were implemented.
- Examined documentation for 20 providers terminated from the Medicaid Program by the Agency during the period April 18, 2012, through February 28, 2013, to determine whether the Agency timely notified the United States Department of Health and Human Services, Office of Inspector General.

- Performed inquiries and inspected documents and records to evaluate the effectiveness of the Agency's process for communicating to providers their responsibility for screening employees against the LEIE database.
- Performed inquiries and inspected documents and records to evaluate the effectiveness of the Agency's process for matching the individuals and entities in the LEIE database to the FMMIS listing of actively enrolled Medicaid providers.
- Examined documentation for the January 2012, October 2012, and March 2014 monthly matches performed by Bureau staff between the LEIE database and actively enrolled Medicaid providers in FMMIS. For excluded Medicaid providers identified, we performed inquiries and inspected documents and records to determine whether the Agency immediately suspended or terminated the provider's participation in the Medicaid Program and timely removed the provider's active status in FMMIS.
- Performed inquiries and inspected documents and records to evaluate the effectiveness of the Agency's process for monitoring the performance of the Medicaid fiscal agent.
- Reviewed the Agency's contract with the Medicaid fiscal agent to determine whether the contract had been amended to provide for increased monetary penalties for continued failure to achieve satisfactory levels of performance.
- Tested five monthly performance measure area report cards for the Medicaid fiscal agent submitted during the period October 1, 2011, through February 28, 2013, to determine whether:
 - The report cards were accurately and appropriately completed.
 - The report card scoring methodology provided for an accurate assessment of fiscal agent performance.
 - Appropriate monetary penalties were assessed, as applicable.
- Evaluated Agency policies, procedures, and processes for collecting and utilizing individuals' social security numbers to determine the extent of Agency compliance with the applicable requirements of State law.
- Performed inquiries, observations, inspections of documents and records to determine whether the Agency had established procedures that required periodic verification that employee FLAIR access was appropriate and necessary for assigned job duties, ensured that FLAIR access was timely updated or canceled based on changes in employee responsibilities and status, and provided an appropriate separation of accounting responsibilities.
- Examined FLAIR access control records for 201 Agency user accounts with FLAIR access privileges as of April 2014 to determine whether the access privileges were reasonable given the employees' job duties and whether any of the employees had incompatible or excessive FLAIR access privileges.
- Observed, documented, and evaluated the effectiveness of selected processes and procedures for the management of Agency budgetary and Florida Single Audit Act activities.
- Performed inquiries, observations, inspections of documents and records, and analytical procedures related to Agency travel expenditures incurred during period July 2009 through January 2013 and totaling \$10,972,680, to determine whether the Agency had established appropriate controls for the approval, payment, documentation, and recording of travel expenditures.
- Observed, documented, and evaluated the effectiveness of selected processes and procedures for the management of Agency settlement agreements.
- Communicated on an interim basis with applicable officials to ensure the timely resolution of issues involving controls and noncompliance.
- Performed various other auditing procedures, including analytical procedures, as necessary, to accomplish the objectives of the audit.

- Prepared and submitted for management response the findings and recommendations that are included in this report and which describe the matters requiring corrective actions.

AUTHORITY

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



David W. Martin, CPA
Auditor General

MANAGEMENT'S RESPONSE

In a letter dated August 27, 2014, the Secretary of the Agency provided responses to our audit findings and recommendations. The Secretary's letter is included as **EXHIBIT A**.

**EXHIBIT A
MANAGEMENT'S RESPONSE**



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

August 27, 2014

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 from your operational audit of the Agency for Health Care Administration, Prior Audit Follow-up and Selected Administrative Activities. 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, Audit Director at 412-3978.

Sincerely,



Elizabeth Dudek
Secretary

ED/szg
Enclosure



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

**Agency for Health Care Administration
Prior Audit Follow-up and Selected Administrative Activities – Operational Audit
Response to Auditor General's P&T Audit Findings and Recommendations**

Medicaid Payments and FMMIS Controls

Finding 1:

Medicare Outpatient Hospital Crossover Claims. The Agency should continue efforts to reprocess the estimated \$117.66 million in Medicare outpatient hospital crossover claims identified in our report No. 2012-021, finding No. 3, and recoup any payments made that were not consistent with State law.

Recommendation:

We recommend that Agency management review the Medicare outpatient hospital crossover claims identified in our report No. 2012-021, finding No. 3, as well as outpatient hospital crossover claims processed subsequent to the 2009-10 fiscal year, and initiate recoupment efforts for any payments made that were not consistent with State law.

Agency Response:

Programming Changes

The Agency completed a review of Medicaid claims reimbursed for fiscal years 2007/2008, 2008/2009 and 2009/2010 for Medicare outpatient crossover claims. The Agency worked with its fiscal agent to correct the programming for payment of Medicare outpatient crossover claims. These system corrections have been implemented over the past year, through Customer Service Request 2642 and Change Order 55328, with all system modifications completed on March 14, 2014. Consequently, claim payments are processing correctly.

Recoupment of Monies

The Agency's Bureau of Medicaid Policy reviewed the estimated take-back results and has developed a communication plan for provider notification and a recoupment of monies schedule. We anticipate that reprocessing efforts will be completed by the end of this calendar year.

Agency Contact:

Cheryl Travis
(850) 412-3416

Finding 2:

Provider Participation. Agency policies and procedures need strengthening to ensure that providers are timely suspended or terminated from Medicaid Program participation upon the Agency's discovery that the Federal Government or another state has excluded the provider from Federally funded health care program participation.

Recommendation:

We recommend that Agency management revise procedures to require that, upon discovering that a provider has been excluded from participation by the Federal Government or another state, Agency staff take immediate actions to suspend or terminate the provider's participation in the Medicaid Program and timely remove the provider's active status in FMMIS.

Agency Response:

Upon discovering that a provider has been excluded from participation by the federal government or another state, the Agency will take the following actions:

- *Utilize the automated data match currently under construction and compare the HHS/OIG List of Excluded Individuals and Entities (LEIE) and the System for Award Management (SAM) entries with the Florida Medicaid providers in FMMIS at initial enrollment, at renewal, and monthly thereafter at the direction of Medicaid Contract Management.*

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

**Agency for Health Care Administration
Prior Audit Follow-up and Selected Administrative Activities – Operational Audit
Response to Auditor General's P&T Audit Findings and Recommendations**

- *For potential matches, the automated process will immediately place payment restrictions on all Florida Medicaid providers matched on the LEIE or SAM databases and report the action for review by Agency analysts at the direction of Medicaid Contract Management.*
- *For all matched but previously terminated or denied Florida Medicaid providers, Medicaid Contract Management will document the provider enrollment file as being excluded by the federal government or another state and will share the results of the monthly match with Medicaid Program Integrity.*
- *Medicaid Program Integrity will evaluate monthly the matched Florida Medicaid providers currently "not yet terminated," verify payment restrictions have been placed on these providers, and immediately pursue program suspension or termination "with-cause" procedures as well as monitor the process for timely completion.*
- *The Agency acknowledges the need for immediate action when entities or individuals become excluded, in keeping with Florida law. However, it should be noted that the State of Florida's program suspension or termination "with-cause" procedures include provider hearing and appeal rights for state administrative action. Execution of these rights may delay the conclusion of the action, issuance of the Final Order and the recording of the final action in FMMIS. Nevertheless, the Agency will ensure compliance with the requirement for immediate action by restricting payments to the provider upon notification of the exclusion until confirmation of the exclusion and any subsequent legal action by the Agency is finalized.*

Agency Contact:

Shawn McCauley - MPI
(850) 412-3428

Ken Yon - MPI
(850) 412-4637

Fiscal Agent Oversight

Finding 3:

Performance Measures and Monetary Sanctions. The Agency should revise the methodology used to monitor the performance of the Medicaid fiscal agent and, to encourage the timely correction of performance deficiencies; the Agency should consider increasing the monetary penalties in its contract with the fiscal agent.

Recommendation:

We again recommend that Agency management take the steps necessary to revise the Medicaid fiscal agent performance scoring methodology. The revised methodology should subject each individual performance measure to a monetary penalty, or assign a greater weight to the more critical performance measures, and allow scores below the lowest established scores when warranted. We also recommend that Agency management continue to consider amending the contract with HPES to provide for an escalation of monetary penalties for continued failure to achieve satisfactory levels of performance. The escalation of penalties should increase to an amount sufficient to encourage the timely correction of any performance deficiencies.

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

**Agency for Health Care Administration
Prior Audit Follow-up and Selected Administrative Activities – Operational Audit
Response to Auditor General’s P&T Audit Findings and Recommendations**

Agency Response:

Performance Scoring Methodology

The current scoring methodology used by the Agency for performance measures and monetary sanctions was originally proposed by the Agency in the pertinent section of the competitive procurement document, "RFP, Section 30.29 (8) Performance Monitoring," and was agreed to by the Medicaid fiscal agent in its Proposal. Since this is a contractual agreement, the Medicaid fiscal agent and the Agency would have to mutually agree on any changes to the contract.

The Agency is currently working with the Medicaid fiscal agent to revise the performance scoring methodology. The Medicaid fiscal agent has submitted a draft project plan for the performance scoring reports with the following anticipated start and completion task dates. The collaboration process started July 2014.

- Payment Management 1 07/15/2014 - 10/08/2014
- General Functions 07/15/2014 - 10/08/2014
- Systems 07/14/2014 - 10/08/2014
- Magellan 07/17/2014 - 12/15/2014
- Call Center 07/17/2014 - 12/10/2014
- Payment Management 2 07/17/2014 - 02/15/2015
- Interfaces 07/17/2014 - 01/25/2015
- Recipient 11/28/2014 - 01/28/2015
- Provider 11/28/2014 - 01/28/2015

Contract Revision

Actual and Liquidated Damages were proposed in the RFP, Section 30, and agreed to by the Medicaid fiscal agent in its Proposal. Since this is a contractual agreement, any change has to be mutually agreed upon by the Medicaid fiscal agent and the Agency. At this time the Medicaid fiscal agent has not agreed to the escalation of monetary damages for failure to achieve satisfactory levels of performance. The Agency will include an escalation of monetary damages when planning and developing the next fiscal agent contract.

Agency Contact:

Cheryl Travis
(850) 412-3416

Selected Administrative Activities

Finding 4:

Collection of Social Security Numbers. The Agency had not established policies and procedures for the collection and use of social security numbers or evaluated the collection and use of social security numbers to ensure and demonstrate compliance with State law.

Recommendation:

To demonstrate compliance with applicable statutory requirements, we recommend that Agency management establish written policies and procedures regarding the collection and use of individuals' SSNs, develop a means to properly notify each individual regarding the purpose for collecting his or her SSN, and conduct periodic assessments of the Agency's SSN collection activities. Additionally, we recommend that Agency management enhance the Form Number Request to address whether the Agency form subject to approval will be used to collect individuals' SSNs and, if so, express the Agency's statutory authority to do so.

EXHIBIT A (CONTINUED)
MANAGEMENT'S RESPONSE

Agency for Health Care Administration
Prior Audit Follow-up and Selected Administrative Activities – Operational Audit
Response to Auditor General's P&T Audit Findings and Recommendations

Agency Response:

The Agency currently has procedures in place to ensure that: (i) social security numbers (SSN) are collected only when legally appropriate; (ii) it properly notifies individuals regarding the purpose for collecting their SSNs; and (iii) SSN collection activities are periodically monitored. All forms by which the Agency requests SSNs are reviewed by the General Counsel's Office to assure compliance with applicable statutory requirements prior to the form being implemented. The forms must contain the necessary notifications to the individuals before they are approved for use. By means of this process, the Agency's collection activities are monitored on a continuous basis. The Agency is amending its Forms Management Policy, No. 4016, to specifically address the collection of SSNs. Any unit of the Agency requesting approval of a form that requires a SSN must explain in writing the statutory authority for collection or why collection is necessary for the performance of the Agency's duties as prescribed by law; the Office of the General Counsel will then review the form request, staff justifications and basis for SSN collection, and decide whether it meets applicable federal and state law applicable to same prior to the form being authorized for use. The form that is eventually generated must also contain the explanation for why the collection of the SSN is needed.

Agency Contact:

William Roberts
(850) 412-3664

Finding 5:

Information Technology Access Controls. Agency controls over employee access to the Florida Accounting Information Resource Subsystem (FLAIR) need improvement.

Recommendation:

We recommend that Agency management limit FLAIR user access privileges to only those functions needed for the performance of the user's job duties, and ensure that each user is assigned a unique FLAIR user ID. We also recommend that Agency management ensure that reviews of FLAIR access privileges are routinely performed to aid in the identification and resolution of any instances where excess or incompatible access privileges have been granted or FLAIR access is no longer needed.

Agency Response:

The Bureau of Financial Services amended its procedure in October 2013 (and updated it again in July 2014) to address granting, reviewing, and terminating FLAIR access. We conduct reviews bi-annually and as staff changes; to ensure access is compatible with the employee's duties and responsibilities. The Bureau receives Personnel Action Request (PAR) forms to alert us of staffing changes. Based upon the action of the PAR, all applicable FLAIR updates are completed by 4:00 p.m. the day the action becomes effective. We are in the process of developing a profile matrix based upon user type as another method of ensuring access privileges are compatible with the employee's duties and responsibilities. We anticipate that the profiles will be developed and in effect by December 31, 2014.

The Bureau uses the Agency's password policy #06-IT-02 to make users aware of the importance of unique passwords. Every new employee is required to take the online computer security awareness training, an Agency mandate. This training covers creating unique passwords and outlines the importance of not sharing passwords. In addition, the user ID must be unique as the FLAIR system will not allow duplications and passwords must be changed at specific intervals in accordance with the Department of Financial Services' requirements.

Agency Contact:

Anita B. Hicks
(850) 412-3815