RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

September 30, 2015

Ms. Elizabeth Dudek, Secretary
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, FL 32308

Dear Secretary Dudek,

Enclosed is a six-month status report on the Auditor General's *State of Florida Compliance and Internal Controls Over Financial Reporting and Federal Awards*, Report Number 2015-166, issued March 2015. This status report is issued in accordance with the statutory requirement to report on corrective actions resulting from the Auditor General's recommendations six months from the report date.

If you have any questions about this status report, please contact Mary Beth Sheffield at 412-3978.

Sincerely,

Eric W. Miller
Inspector General

EWM/szg
Enclosure: Six-Month Status Report of AG Report# 2015-166
cc/enc: Kathy DuBose, Joint Legislative Auditing Committee
Melinda Miguel, Chief Inspector General, EOG
Justin Senior, Deputy Secretary, Division of Medicaid
Tonya Kidd, Deputy Secretary, Division of Operations
Molly McKinstry, Deputy Secretary, Division of Health Quality Assurance

Florida Agency for Health Care Administration
Auditor General 2013-14 FY Federal Awards Audit (Report# 2015-166)
Six-Month Status Report as of September 30, 2015

Finding# 2014-001	Recommendation	Previous Management Response(s)	Status of Finding as of September 30, 2015	Management Response as of September 30, 2015 and Agency Contact
During the FAHCA Bureau of Finance and Accounting (Bureau) supervisory review, various errors, which had a direct and material effect on the calculated year-end receivable balance due from the Federal Government, were inadvertently overlooked. ***NOTE:*** *The Bureau of Finance and Accounting is now Bureau of Financial Services.*	We recommend that the Bureau perform a more rigorous supervisory review of fiscal year-end receivable balance calculations to ensure that all errors are identified and appropriately corrected.	**Status as of June 30, 2015** Partially Corrected. The Bureau has implemented its new policy for titling OCAs to better distinguish between OCAs used to capture state and federal share of expenditures and rolled out the new structure as part of its FY 2015-2016 approved operating budget on July 1, 2015. Implementation of the new OCAs has given the involved supervisors a better understanding of the OCA structure which will strengthen the review process. The Bureau can now update its OCA Matrix (data element table), which identifies critical data elements such as the federal participation rate (FFP), CFDA number, and source of the state share. Anticipated completion date for the data element table update is December 31, 2015. The Bureau is on target to start its quarterly reviews of the FLAIR data with the quarter ending September 2015. **Status as of March 30, 2015** The calculation for the receivable balance due from federal government is prepared manually using FLAIR data. To enhance reporting capabilities of the receivable, the Bureau of Financial	Fully Corrected	The Bureau is now able to distinguish between the state and federal share of expenditures due to the implementation of a new OCA titling structure. As a process improvement measure, the Bureau is creating a data element table using a FoxPro application that will allow data to be readily available and easy to update. This table will be completed in December 31, 2015. Anita Hicks - Financial Services (850) 412-3815

Finding# 2014-001	Recommendation	Previous Management Response(s)	Status of Finding as of September 30, 2015	Management Response as of September 30, 2015 and Agency Contact
		Services (Bureau) is updating its OCA Matrix (data element table) which identifies the federal participation rate (FFP), where the state match is charged, and other critical data elements. The work on the OCA Matrix will aid in the accurate capture of financial information and analysis. The policy for titling OCAs is being changed to better distinguish between state and federal share; which will allow better use of the FLAIR reporting tools available. The new structure will be implemented by July 1, 2015. The Bureau will implement a quarterly review of the FLAIR data in September, December, March, and June, which will validate how we capture and identify state and federal share. The receivable balance due to the federal government will be prepared within the Grants Unit and the secondary review will be conducted by the Policy and Systems Unit Finance and Accounting Director. In preparation for 2014-2015 year-end, the Bureau will begin the analysis of data quarterly as of March and June to alert staff of any abnormalities prior to the Bureau's year-end submission timeline. *Estimated Corrective Action Date:* 7/1/15		

Florida Agency for Health Care Administration
Auditor General 2013-14 FY Federal Awards Audit (Report# 2015-166)
Six-Month Status Report as of September 30, 2015

Finding# 2014-002	Recommendation	Previous Management Response(s)	Status of Finding as of September 30, 2015	Management Response as of September 30, 2015 and Agency Contact
The FAHCA Bureau of Finance and Accounting (Bureau) did not reclassify drug rebates (refunds) from Other Revenue to a reduction of the corresponding expenditure account. ***NOTE:*** *The Bureau of Finance and Accounting is now Bureau of Financial Services.*	We recommend that the Bureau follow the refunds guidance provided by the FDFS to ensure that current year refunds are identified and appropriately reclassified at fiscal year-end to reduce the applicable expenditures.	**Status as of June 30, 2015** Fully Corrected. After discussion with the Auditor General, it was determined that the portion of refunds from Drug Rebates which could be tied to current year expenditures should have been reclassified for financial statements. The required financial statement adjustments forms were submitted. The agency will ensure that all future Drug Rebates received for current year expenditures will be reclassified at fiscal year-end to reduce the applicable expenditures. **Status as of March 30, 2015** The Agency sought guidance from FDFS regarding the reclassification of all refunds in General Ledger Code (GLC) 61800 for financial statements. Per our conversation, we were advised that reclassifying was not a requirement but a preference among agencies. After further discussion with the Auditor General, it was determined that the portion of refunds from Drug Rebates which could be tied to current year expenditures should have been reclassified for financial statements.	Fully Corrected	Anita Hicks - Financial Services (850) 412-3815

Finding# 2014-002	Recommendation	Previous Management Response(s)	Status of Finding as of September 30, 2015	Management Response as of September 30, 2015 and Agency Contact
		The agency will ensure that all future Drug Rebates received for current year expenditures will be reclassified at fiscal year-end to reduce the applicable expenditures. *Estimated Corrective Action Date:* February 11, 2015		

Finding# 2014-005	Recommendation	Previous Management Response(s)	Status of Finding as of September 30, 2015	Management Response as of September 30, 2015 and Agency Contact
FAHCA procedures for preparing the Schedule of Expenditures of Federal Awards (SEFA) data form were not sufficient to ensure the accuracy of reported amounts. As a result, amounts reported on the State's SEFA were materially misstated before adjustment. ***NOTE:*** *The Bureau of Finance and Accounting is now Bureau of Financial Services.*	We recommend that the FAHCA enhance its procedures to ensure that amounts reported on the SEFA data form are complete and accurate and provided in accordance with FDFS instructions.	**Status as of June 30, 2015** Fully Corrected. The Bureau held several meetings to discuss, review, and modify our procedures on Schedule of Expenditures of Federal Awards (SEFA). As a result, the Bureau utilized the Florida Department of Financial Services' (FDFS') SEFA template to identify and define the specific data required for this report as it relates to FAHCA. In addition, the Bureau has implemented its new policy for titling OCAs to better distinguish between OCAs used to capture state and federal share of	Fully Corrected	Anita Hicks - Financial Services (850) 412-3815

Finding# 2014-005	Recommendation	Previous Management Response(s)	Status of Finding as of September 30, 2015	Management Response as of September 30, 2015 and Agency Contact
		expenditures and rolled out the new structure as part of its FY 2015-2016 approved operating budget on July 1, 2015. Implementation of the new OCAs has given the involved supervisors a better understanding of the OCA structure which will strengthen the review process. **Status as of March 30, 2015** The Schedule of Expenditures of Federal Awards (SEFA) is prepared manually using FLAIR data. The Bureau of Financial Services (Bureau) has consulted with other state agencies on their SEFA process. The Bureau plans to implement a similar process to the Florida Department of Health (FDOH). Updating its OCA Matrix (data element table), which identifies the federal participation rate (FFP); where the state match is charged; and other critical data elements will assist in the Bureau's reporting responsibilities. Changing the policy for titling OCAs will allow better use of the FLAIR reporting tools available. The new structure will be implemented by July 1, 2015. The SEFA will be prepared within the Grants Unit and the secondary review will be conducted by the Policy and Systems Unit.		

Finding# 2014-005	Recommendation	Previous Management Response(s)	Status of Finding as of September 30, 2015	Management Response as of September 30, 2015 and Agency Contact
		Estimated Corrective Action Date: July 1, 2015		

Finding# 2014-033	Recommendation	Previous Management Response(s)	Status of Finding as of September 30, 2015	Management Response as of September 30, 2015 and Agency Contact
The FAHCA did not ensure that payments made to the Florida Healthy Kids Corporation (FHKC) for Florida Healthy Kids Program dental services were accurate.	We recommend that the FAHCA ensure that Florida Healthy Kids Program dental service payments do not exceed the established per member per month rate.	**Status as of June 30, 2015** Fully Corrected. Proviso language in the SFY 2013-2014 legislative appropriations limited Healthy Kids dental payments to $12.57 per member per month. Florida Healthy Kids Corporation (FHKC) projected their dental plan rates would average $12.57 or less for the year based on 50,000 Healthy Kids enrollees transitioning to Medicaid in January 2014, to comply with the Affordable Care Act requirements. Most of the children transitioning were enrolled in dental plans with a higher rate, so when they transitioned to Medicaid the average rate would be reduced. The FAHCA delayed the transition to coincide with the implementation of the Medicaid Managed Medical Assistance Program.	Fully Corrected	Gail Hansen - Medicaid (850) 412-4195

Finding# 2014-033	Recommendation	Previous Management Response(s)	Status of Finding as of September 30, 2015	Management Response as of September 30, 2015 and Agency Contact
		As a result of the enrollees remaining in the Healthy Kids dental plans longer than expected, the Healthy Kids average dental rate was $12.58; $0.01 higher than specified. FHKC repaid the overage by including an adjustment of $19,095.71 in their February 2015 total invoice, received by the FAHCA on February 11, 2015. This represents the questioned costs of $19,978.93 minus $883.22, an amount previously adjusted. Due to the uniqueness of events in SFY 2013-2014, this problem should not recur. **Status as of March 30, 2015** Proviso language in the SFY 2013-14 General Appropriations Act limited Healthy Kids dental plan payments to $12.57 per member per month. Florida Healthy Kids Corporation (FHKC) negotiates a dental rate with each plan and projects that the average rate at the end of the fiscal year will be within the allocated amount. FHKC contracted with three dental plans during SFY 2013-14. Previously, FHKC had only contracted with two dental plans. The negotiated rate for the new plan was $12.32 per member, less than the $12.59 rate paid to the two older plans. The new plan has		

Finding# 2014-033	Recommendation	Previous Management Response(s)	Status of Finding as of September 30, 2015	Management Response as of September 30, 2015 and Agency Contact
		fewer members, but FHKC projected the growth of enrollment in the new plan, coupled with the Affordable Care Act (ACA) requirement that children 6 through 18 with income under 133% FPL would transition to Medicaid effective January 1, 2014. The projection was that approximately 50,000 Healthy Kids enrollees would transfer to Medicaid and most of these children would have been enrolled in the more costly plans. If the ACA transition had progressed as projected; the average dental rate should have been $12.57 or less. Due in large part to the Agency's roll out of the Medicaid Managed Medical Assistance Program, the transition of the 50,000 Healthy Kids enrollees identified for transition to Medicaid was delayed, with federal approval, until after July 2014. As a result, these children remained in their more costly dental plans for the entire fiscal year, and the average dental rate at the end of the year was $12.58 per member per month, or $0.01 higher than allowed. The total Healthy Kids dental expenditures were within the Healthy Kids dental appropriations. FHKC has repaid the dental overage of		

Finding# 2014-033	Recommendation	Previous Management Response(s)	Status of Finding as of September 30, 2015	Management Response as of September 30, 2015 and Agency Contact
		$19,095.71. This represents the questioned costs of $19,978.93 less the $883.22 adjustment to dental service payments. A repayment adjustment was included in the FHKC February 2015 Total invoice received on February 11, 2015. Due to the uniqueness of events in SFY 2013-14, this overage should not recur. *Estimated Corrective Action Date:* February 11, 2015 - FHKC invoice submitted February 11, 2015 includes a $19,095.71 repayment adjustment.		

Finding# 2014-036	Recommendation	Previous Management Response(s)	Status of Finding as of September 30, 2015	Management Response as of September 30, 2015 and Agency Contact
Medical service claim payments made to providers of Medicaid services were not always paid in accordance with established Medicaid policy and fee schedules. Specifically, some payments were for improper amounts or for unallowable services.	We recommend that the FAHCA ensure that appropriate electronic and manual controls are in place and operating effectively to ensure that Medicaid claims are accurately and properly processed.	**Status as of June 30, 2015** Partially Corrected. Physician Claims - The initial request for the Affordable Care Act (ACA) rate change provided to FAHCA from the Centers for Medicare and Medicaid Services (CMS) on March 4, 2014, was incomplete and required further clarification. Final clarification was	Partially Corrected	Physician Claims – Fully Corrected Nurse Practitioner Claim – Fully Corrected Physician Medicare Crossover Claim – Fully Corrected. Date of Death Claims – The FAHCA Plan Managers are currently developing a recoupment plan for years prior to 2015.

Finding# 2014-036	Recommendation	Previous Management Response(s)	Status of Finding as of September 30, 2015	Management Response as of September 30, 2015 and Agency Contact
		received on June 2, 2014. Change Order (CO) #64164 implemented the new ACA rates on July 2, 2014. All Medicaid claims reprocessing for the ACA rate change between the dates of January 1, 2014, and July 2, 2014, were identified and processed under CO #64165 which was completed on January 13, 2015. Nurse Practitioner Claim – CO #59553 was generated to complete the coding for the rate segment update for the Child Health Check-Up program (CHCUP) and created a new rate type specific to CHCUP. CO #59553 was implemented on July 24, 2014. Reprocessing of the Nurse Practitioner underpayment was performed under change order #65758 and was completed on November 11, 2014. Physician Medicare Crossover Claim – CO #73223 was created to modify the FL MMIS to exclude the Qualified Medicare Beneficiaries (QMB) benefit plan from copay processing logic. CO #73223 was implemented on January 13, 2015. CO #74982 is currently in an "open" status and once implemented will identify the physician Medicare crossover claims that need to be reprocessed. CO #81184 was created, coded and implemented to		This plan is expected to be completed around the end of September 2015. Durable Medical Equipment (DME) – CSR #2889 has been written to address this issue. It is currently in analysis and, due to the scope of this project, should be completed by December 2015. At that time, a project plan and timeline for the system updates will be created. Cheryl Travis - Medicaid (850) 412-3416

Finding# 2014-036	Recommendation	Previous Management Response(s)	Status of Finding as of September 30, 2015	Management Response as of September 30, 2015 and Agency Contact
		exclude copay for crossover claims when the provider bills using an emergency diagnosis code. CO #81184 was implemented June 26, 2015. The affected claims are currently being identified and pulled for reprocessing. Date of Death Claims – CO #65743 was generated to synchronize the enrollment dates with the Date of Death (DOD). These modifications will cause capitation payments to be recouped and aligned with the DOD. The auto recoupment processing for DOD reasons will take place for all ongoing DOD updates. CO #65743 was implemented on March 5, 2015. CO # 77842 was generated to handle DOD recoupments for previous time periods. At present, the first quarter of 2015 has been processed. Additional modifications are needed after the first recoupment process to identify these recoupments as DOD type recoupments. The FAHCA Plan Managers are currently developing a recoupment plan for years prior to 2015. This plan is expected to be completed around September 2015. Durable Medical Equipment (DME) – CSR #2889 has been written to address this issue. It is currently in analysis and, due to the scope of this project, should		

Finding# 2014-036	Recommendation	Previous Management Response(s)	Status of Finding as of September 30, 2015	Management Response as of September 30, 2015 and Agency Contact
		be completed by December 2015. At that time, a project plan and timeline for the system updates will be created. **<u>Status as of March 30, 2015</u>** Physician Claims – The initial request for the ACA rate change provided to FAHCA from the Centers for Medicare and Medicaid Services (CMS) on March 4, 2014, was incomplete and required further clarification. Final clarification was received on June 2, 2014. Change Order (CO) #64164 implemented the new ACA rates on July 2, 2014. All Medicaid claims reprocessing for the ACA rate change between the dates of January 1, 2014, and July 2, 2014, were identified and processed under CO #64165 which was completed on January 13, 2015. Nurse Practitioner Claim – CO #59553 was generated to complete the coding for the rate segment update for Child Health Check-Up program (CHCUP) and created a new rate type specific to CHCUP. CO #59553 was implemented on July 24, 2014. Reprocessing of the Nurse Practitioner underpayment was performed under change order #65758 and was completed on November 11, 2014. Physician Medicare Crossover Claim –		

Finding# 2014-036	Recommendation	Previous Management Response(s)	Status of Finding as of September 30, 2015	Management Response as of September 30, 2015 and Agency Contact
		CO #73223 was created to exclude the QMB benefit plan from copay processing logic. CO #73223 was implemented on January 13, 2015. CO #74982 is currently in an "open" status and will identify and complete the reprocessing of the claims. Date of Death Claims - In response to the 245 paid claims for services claimed to have been rendered after the recipient's date of death, the Agency's TPL vendor identifies potential claims for recovery under the date of death project on a monthly basis for institutional and physician claims, while pharmacy claims are analyzed quarterly. The project compares recipient dates of death in FLMMIS to claim dates of service in order to identify overpayments. Once an individual provider's total overpayment amount for all recovery projects exceeds $750.00, the results are forwarded to the Bureau of Medicaid Program Integrity (MPI) where a tracking match is performed to exclude any providers or claims that may be under MPI review. Upon receipt of the tracking match results, an audit letter is generated. Provider audit letters are mailed monthly. Regarding the 89 claims that had		

Finding# 2014-036	Recommendation	Previous Management Response(s)	Status of Finding as of September 30, 2015	Management Response as of September 30, 2015 and Agency Contact
		previously been identified with audit letters mailed to the providers, $1,805.33 has been recovered and providers are appealing eight (8) claims totaling $2,515.36. For the remaining 156 claims where audit letters had not been mailed to date, once the claims thresholds are reached and tracking matches have been completed, audit letters will also be mailed to those providers. DME - It appears as though the referenced DME payments may have not been made in accordance with section 409.908(13), Florida Statutes. The Agency for Health Care Administration will further research and take appropriate action to correct these DME payments, if necessary. *Estimated Corrective Action Date:* Physician Claims - Corrected July 2, 2014. Claims reprocessing completed January 13, 2015. Nurse Practitioner Claim - Corrected July 24, 2014. Claims reprocessing completed November 11, 2014. Physician Medicare Crossover Claims - Corrected January 13, 2015. Claims		

Finding# 2014-036	Recommendation	Previous Management Response(s)	Status of Finding as of September 30, 2015	Management Response as of September 30, 2015 and Agency Contact
		reprocessing is currently underway, and expected to be complete by April 30, 2015. Date of Death Claims - Ongoing process. DME - To be determined once research is complete.		

Finding# 2014-037	Recommendation	Previous Management Response(s)	Status of Finding as of September 30, 2015	Management Response as of September 30, 2015 and Agency Contact
General computer controls for the Florida Medicaid Management Information System (FMMIS) need improvement.	We recommend that the FAHCA ensure the State's Medicaid fiscal agent takes timely and appropriate corrective action to resolve the deficiencies noted in the SSAE 16 SOC 1 Type II report.	**Status as of June 30, 2015** Fully Corrected. The FAHCA has reviewed the issues surrounding this finding and concurs with HP Enterprise Services (HPES) management that there is a business need for the control exceptions noted in the SSAE 16 SOC 1 Type II report. CO #65277 - 2014 SSAE16 Audit Support was implemented on November 6, 2014, and identifies when authorized software developers switched to an HP Global ID. Daily system activity reports are generated showing the date, time, production system, HP Global ID and	Fully Corrected	Cheryl Travis - Medicaid (850) 412-3416

Finding# 2014-037	Recommendation	Previous Management Response(s)	Status of Finding as of September 30, 2015	Management Response as of September 30, 2015 and Agency Contact
		developer's name. The daily report is routed to all Technical Leads. All Oracle changes made while under HP Global ID access must be reviewed and verified to be completed. The individual Technical Leads must specify the reason for the HP Global ID access. The daily report and reasons for the HP Global ID access are kept in a log by the Cycle Monitors. Hardware and Software constraints limit the number of HP Global ID's that can be created within the FL MMIS and therefore these ID's must be "checked out" before a given software developer can gain access to the FL MMIS using the HP Global ID. Completed November 6, 2014. **Status as of March 30, 2015** The Agency has reviewed the issues surrounding this finding and concurs with HPES' management that there is a business need for the control exceptions noted in the SSAE 16 SOC 1 Type II report. CO #65277 - 2014 SSAE16 Audit Support was implemented on November 6, 2014, and identifies when authorized software developers switched to an HP Global ID. Daily system activity reports are generated showing the date, time, production system, HP Global ID and		

Finding# 2014-037	Recommendation	Previous Management Response(s)	Status of Finding as of September 30, 2015	Management Response as of September 30, 2015 and Agency Contact
		developer's name. The daily report is routed to all Technical Leads. All Oracle changes made while under HP Global ID access must be reviewed and verified to be completed. The individual Technical Leads must specify the reason for the HP Global ID access. The daily report and reasons for the HP Global ID access are kept in a log by the Cycle Monitors. Hardware and Software constraints limit the number of HP Global ID's that can be created within the FL MMIS and therefore these ID's must be "checked out" before a given software developer can gain access to the FL MMIS using the HP Global ID. *Estimated Corrective Action Date:* Completed November 6, 2014		

Finding# 2014-038	Recommendation	Previous Management Response(s)	Status of Finding as of September 30, 2015	Management Response as of September 30, 2015 and Agency Contact
The FAHCA continued to record medical assistance related payments to incorrect appropriation categories in	We recommend that the FAHCA strengthen procedures for the accurate recording of	**Status as of June 30, 2015** Fully Corrected. The FAHCA continues to make every	Fully Corrected	Anita Hicks - Financial Services (850) 412-3815

Finding# 2014-038	Recommendation	Previous Management Response(s)	Status of Finding as of September 30, 2015	Management Response as of September 30, 2015 and Agency Contact
the State's accounting records. ***NOTE:*** *The Bureau of Finance and Accounting is now Bureau of Financial Services.*	medical assistance related payments in the State's accounting records.	effort to ensure that medical assistance related payments are accurately recorded in the State's accounting records. The FAHCA implemented an Electronic Fund Transfer (EFT) process for the payment of the medical assistance related payments allowing payments to be posted against the correct category at the time of vouchering if release, budget, and cash are sufficient. If release or budget is not available for the posting of expenditures, a budget amendment approved by the Legislative Budget Commission is required. **Status as of March 30, 2015** The FAHCA has taken the following steps to ensure that medical assistance related payments are accurately recorded in the State's accounting records: 1. As a result of implementing Statewide Medicaid Managed Care, a budget amendment was submitted and approved on December 10, 2014, to establish new categories, realign budget between existing categories, and delete obsolete categories in order to properly capture expenditures. 2. The FAHCA discontinued its practice		

Finding# 2014-038	Recommendation	Previous Management Response(s)	Status of Finding as of September 30, 2015	Management Response as of September 30, 2015 and Agency Contact
		of recording medical assistance related payments to a few medical services appropriation categories and then journal transferring the expenditures to the correct appropriation categories in accordance with the weekly FMMIS appropriation reports. Effective February 23, 2015, the FAHCA implemented an Electronic Fund Transfer (EFT) process for the payment of the medical assistance related payments. Payments are now recorded in the correct category from the onset if release, budget, and cash are sufficient. 3. The FAHCA will submit a budget amendment, at least annually, to realign the Medicaid Services categories to reflect the results of the latest Medicaid Expenditures Social Services Estimating Conference (SSEC). *Estimated Corrective Action Date:* February 2015		

Florida Agency for Health Care Administration
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Finding# 2014-039	Recommendation	Previous Management Response(s)	Status of Finding as of September 30, 2015	Management Response as of September 30, 2015 and Agency Contact
The FAHCA did not always limit Federal funds draws to amounts needed for immediate cash needs. ***NOTE:*** *The Bureau of Finance and Accounting is now Bureau of Financial Services.*	We recommend that the FAHCA ensure draw amounts are only for immediate cash needs.	**Status as of June 30, 2015** Fully Corrected. New policy fully implemented: 1. The draw request responsibility has been reassigned to the Accountant IV from the Revenue Unit Supervisor. 2. The Revenue Unit Supervisor performs a secondary review to ensure that the request is entered into the Federal Payment Management System (PMS) and in our State's accounting records accurately. Once approved by the Revenue Unit Supervisor, the entry is then transmitted to the State Treasury. 3. The Accountant Supervisor II performs a daily audit of all draw requests entered in PMS and our State's accounting records to ensure that all entries in PMS and our State's accounting records match the backup documentation and that all notifications are transmitted. **Status as of March 30, 2015** The overdraw/double draw of funds was caused when a computer program froze in the middle of the transaction. Attempts were made to cancel and resubmit the request; however, the efforts taken inadvertently caused the request to be	Fully Corrected	Anita Hicks - Financial Services (850) 412-3815

Finding# 2014-039	Recommendation	Previous Management Response(s)	Status of Finding as of September 30, 2015	Management Response as of September 30, 2015 and Agency Contact
		submitted twice. Staff immediately identified the duplication in the draw request and implemented a plan to offset the overdraw of funds by reducing the draws for two subsequent weeks. In addition, the FAHCA has taken the following steps to ensure that draw amounts are only for the immediate cash needs: 1. The draw request responsibility has been reassigned to the Accountant IV from the Revenue Unit Supervisor. 2. The Revenue Unit Supervisor performs a secondary review to ensure that the request is entered into the Federal Payment Management System (PMS) and in our State's accounting records accurately. Once approved by the Revenue Unit Supervisor, the entry is then transmitted to the State Treasury. 3. The Accountant Supervisor II performs a daily audit of all draw requests entered in PMS and our State's accounting records to ensure that all entries in PMS and our State's accounting records match the backup documentation and that all notifications are transmitted. *Estimated Corrective Action Date:* 5/1/14		

Finding# 2014-040	Recommendation	Previous Management Response(s)	Status of Finding as of September 30, 2015	Management Response as of September 30, 2015 and Agency Contact
The FAHCA did not always ensure that facilities receiving Medicaid payments met required health and safety standards.	We recommend that the FAHCA increase efforts to ensure Life Safety Surveys and the follow-up surveys for Life Safety and Health/Standard Surveys with noted deficiencies are conducted within the established time frames.	**Status as of June 30, 2015** Partially Corrected. The Health Quality Assurance Licensure and Certification Procedures Manual was fully updated and implemented June 2015. Within this manual the Bureau of Field Operations has incorporated the timeframes for conducting the annual licensure Fire Life Safety Survey along with the revisit. The timeframes state that annual licensure surveys must be completed no later than 15.9 months from the previous annual licensure survey. Additionally, revisits must be conducted within 90-days from the date of exit, unless the facility has an approved State or Federal Waiver. Exception to the scheduling timeframes may be approved by the Chief of Field Operations and documentation of the approval maintained by the field office. The Bureau of Field Operations continues to monitor compliance with the survey timeframes. In February 2015, we developed a new report, which supplements existing Fire Life Safety scheduling reports to better capture relicensure timeframes based on initial	Partially Corrected	As noted in the response from June 30, 2015, the Bureau of Field Operations developed a new report in February 2015 to supplement the existing Fire Life Safety scheduling reports to better capture relicensure timeframes based on initial licensure completion. Additionally, in February, the Bureau of Field Operations was fully responsible for conducting all initial licensure Life Safety Code (LSC) surveys. Since March 1, 2015, the Bureau of Field Operations has conducted ten initial State Licensure LSC surveys, three with revisits. During review and monitoring of the new Life Safety Survey Reports (developed in February), data quality issues were identified in the coding of survey properties within the ASPEN Event ID. In order to trigger the next survey due date, the survey needs to reflect both “K-State Licensure” AND either a “1-Initial Licensure” or “2-Relicensure”. The absence of a “1” or “2” resulted in inaccurate survey interval calculations. This occurred approximately 10% of the time. Quality Assurance audits were implemented to improve data quality and fix data outliers. This has been

Finding# 2014-040	Recommendation	Previous Management Response(s)	Status of Finding as of September 30, 2015	Management Response as of September 30, 2015 and Agency Contact
		licensure completion. During the creation of this additional report, we discovered several instances in which some initial Fire Life Safety Surveys were conducted by staff in the Bureau of Plans and Construction, in conjunction with the 100% construction survey reviews, but were not entered into our survey database (ASPEN). Entry into the ASPEN system is required in order for the surveys to appear on scheduling reports. Although these outlier initial licensure surveys were conducted timely, since the initial survey dates were not entered into the ASPEN system, they were inadvertently excluded from scheduling reports. This report will assist in providing additional oversight to ensure all Fire Life Safety Surveys are completed within the required timeframes. Effective February 2015, the Bureau of Field Operations is now conducting all initial licensure Fire Life Safety Surveys. This will facilitate oversight of the data entry system since the initial Fire Life Safety Survey is now coupled with the health survey so that all requisite processes follow a consistent protocol as with other survey activities.		addressed with the Field Office Managers and Survey Schedulers in each of the eight Field Offices. All Life Safety Surveys conducted after March 1, 2015 for Nursing Homes, ICFs, Birth Centers, and ASCs were completed timely. However, of the 158 hospital surveys conducted after March 1, 2015, two were not done timely (1%). Additionally, reconciliation of the new Hospital Providers Not Surveyed Report against the Schedulers LSC Tickler Report identified four more hospital surveys that were late and needed to be scheduled. Further data analysis for this discrepancy between the reports revealed intervening complaint or monitoring surveys were erroneously counted as an annual relicensure survey on the LSC Tickler Report. The report was fixed and the responsible Field Offices will be completing these surveys by September 30, 2015. In light of the conflicting information, the Bureau of Field Operations has improved the Life Safety Survey reports and will only be utilizing one report to capture the specific timeframe for conducting the surveys. Kim Smoak - HQA (850) 412-4516

Finding# 2014-040	Recommendation	Previous Management Response(s)	Status of Finding as of September 30, 2015	Management Response as of September 30, 2015 and Agency Contact
		Status as of March 30, 2015 HQA Bureau of Field Operations continues to ensure Life Safety Code (LSC) surveys are conducted annually, but no later than 15.9 months from the previous annual licensure and/or recertification survey. Also, if it is determined an onsite revisit is necessary, the onsite revisit will be conducted no later than 90 days following the survey for which noncompliance was determined. Revisits can be conducted by desk review; however, the same timeframe of no more than 90 days must be followed. There are times in which exceptions to the revisit timeframes may be appropriate, such as a waiver (which is a process to waive the correction of noncompliance for an established timeframe but no more than one year from the original approval) or if a provider fails to submit a timely plan of correction. The field offices would maintain the documentation in these instances. In October 2013, the Bureau of Field Operations implemented the timeframes as noted above and incorporated into the Life Safety Code section of the HQA-Licensure and Certification Procedures Manual. Although the entire Licensure		

Finding# 2014-040	Recommendation	Previous Management Response(s)	Status of Finding as of September 30, 2015	Management Response as of September 30, 2015 and Agency Contact
		and Certification Procedures Manual has not been fully updated and approved, this section has been updated and should be considered the official process for LSC survey completion. This is the timeframe currently followed by HQA's eight field offices. While reviewing our process for monitoring LSC survey activity, we identified errors in the “Tickler” Report used by the field offices to schedule LSC surveys. Therefore, Field Operations has re-built the reports used for scheduling, monitoring, and tracking the completion of LSC surveys within the established timeframes for both annual and revisit surveys. Additionally, Field Operations has revised the Performance Standards for the Field Office Managers to expand the standard of completion of survey activity to include, specifically, Agency audit reviews, such as Fire Safety surveys, which must be completed within the timeframes noted in audit responses and as mandated in Agency Protocols. Staff within the Bureau’s Survey and Certification Support Branch (SCSB) continue to monitor compliance. The specific staff within SCSB who are responsible for tracking timely survey		

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		completion conduct monthly conference calls with the Field Office Manager and Field Office Scheduler. The purpose of these calls is to discuss the specific offices' survey activity to ensure that not only LSC surveys are conducted within the established timeframes, but all other state and federal survey activities are conducted within the required timeframes as mandated by the federal government through the Mission and Priority Document and/or State statues or rules. Performance Standards for these Quality Assurance staff will also include specific reference to monitoring survey activity related to audit responses in addition to other mandated workload. *Estimated Corrective Action Date:* Ongoing		

Finding# 2014-041	Recommendation	Previous Management Response(s)	Status of Finding as of September 30, 2015	Management Response as of September 30, 2015 and Agency Contact
The FAHCA's established policies and procedures did not provide for the timely assignment and issuance of cost report audits of nursing homes or the timely assignment of cost report audits of Intermediate Care Facilities for the Developmentally Disabled (ICF-DD). Additionally, FAHCA had not performed monitoring of the vendor contracted to perform hospital cost report audits.	We recommend that the FAHCA enhance policies and procedures to specify an adequate number of cost reports to be audited annually, as well as to address the timely issuance of cost report audits. We also recommend that the FAHCA ensure that the performance of the hospital cost report auditor be timely monitored.	**Status as of June 30, 2015** Partially Corrected. In regards to cost report audits and audits on appeal, an interagency contract has been obtained with the Office of the Attorney General to assist with the backlog of audits on appeal. This should lead to audits being settled in a timelier manner. Cost reports are also being selected for audit as timely as possible. Between July 1, 2014 and June 30, 2015, 157 audits were assigned to various CPA firms. During that time 121 final audits were issued to the providers. In addition, 170 audit appeal cases were closed by FAHCA and Attorney General Staff. Under the contract with Myers and Stauffer, LLC the on-line website allows FAHCA to review the on-going status of audit work for each hospital's cost report. This website allows a real time report. For the past SFY 2014-2015, the vendor completed 270 audits which are in accordance to the current contract requirement. We receive a monthly status report and have bi-weekly conference calls to review the current	Partially Corrected	During Fiscal Year 14-15, the Agency assigned 156 nursing home cost reports for audit. Of these cost reports, 34 had a fiscal year end of 2014 and an additional 110 had a fiscal year end of 2013. The Agency is taking steps to ensure that cost reports are being selected as timely as possible. In order to maintain timeliness and monitoring procedures, the contracted CPA firms continue to submit monthly reports to update the status of the audits. With regard to the number of audits done in any fiscal year, the Agency assigns as many audits as budgeted funds allow. The Agency continues to work with the Office of the Attorney General to work through audit appeals which will free resources to work on current year audits to ensure more timely completion. Additional ICF audits will continue to be assigned, as limited by budget, by end of October 2015. The current policies and procedures that are in place provide for an adequate number of cost reports to be audited annually. The cost report is a combination of Medicare Title XVIII & V and Medicaid

Finding# 2014-041	Recommendation	Previous Management Response(s)	Status of Finding as of September 30, 2015	Management Response as of September 30, 2015 and Agency Contact
		status of audits. **<u>Status as of March 30, 2015</u>** According to the Florida Title XIX Long-term Care Reimbursement Plan, Section I., cost reports are to be submitted to the Agency by the cost report due date, which is five months after the fiscal year end of the cost report. To be considered timely for rate setting purposes, a cost report must be received by April 30th. A cost report with a fiscal year end of September 30th is not due until February of the following calendar year, and is not late for rate setting purposes until April 30th of that year. By the time the cost report is received by the Agency, it has been over seven months since the cost report fiscal year end. After the cost report is received, it is reviewed for rate setting acceptance before the audit review can begin. Currently, the Audit Services unit is attempting to select cost reports for audit within two years of the fiscal year end in order to expedite the audit process. Several steps have been taken by the Agency to shorten the timeline associated with cost report audits. The Agency has revised the Long Term-care		Title XIX. The Medicaid portion of the audit process cannot begin until the audit is completed for the Medicare program. The completion of the Medicare audit may take more than a year depending on the scope of the audit. In addition, the scope of the Medicaid audit may take a year or longer to finalize. At the beginning of each federal fiscal year, the Agency and the Medicaid contractor perform a reconciliation of pending audits to ensure audits are completed within a reasonable timeframe. Also, there are legislative budget restraints which only allow for a certain number of audit hours to be performed each state fiscal year. Hospital Audits The Agency's current contract with a CPA vendor to perform the hospitals audits, effective January 2014, calls for a monthly status report of all examinations that are current and ongoing. The Agency has weekly status update calls with the vendor in which an agenda and the previous weekly meeting minutes are provided. The Agency is taking steps to ensure that cost reports are being selected as timely as possible. In order to maintain timeliness and monitoring procedures, the CPA vendor (Myers & Stauffer) continues to

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		Reimbursement Plan to begin sanctioning providers for failure to submit timely cost reports. Effective July 1, 2014 providers are subject to sanctions for cost reports not submitted within 60 days after the cost report due date. A cost report with a fiscal year end of June 30th is due to the Agency by November 30th, and if not received by January 29th the provider would be subject to sanctions. This should have the desired effect of causing cost reports to be submitted more timely, allowing the audit process to begin sooner. The Audit Services unit also cleared a backlog of 400 audits during calendar year 2014 which should free resources to work towards completing current period audits more timely. The Agency also contracted with the Office of the Attorney General to assist in closing the backlog of audit appeals. The Office of the Attorney General began working on audit appeals in October 2013. Again, cleaning up this backlog should free resources to work on current period audits. Going forward, the Audit Services unit will attempt to identify cost reports to audit and assign them in a more timely fashion, and in accordance with State and Federal guidelines. Hospital Audits		submit monthly reports to update the status of the audits. With regards to the number of audits done in any fiscal year, the Agency assigns as many audits as budgeted funds allow which is 270 per year. Tom Parker - Medicaid (850) 412-4110 Rydell Samuel - Medicaid (850) 412-4093

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		The current policies and procedures that are in place do provide for an adequate number of cost reports to be audited annually. The cost report is a combination of Medicare Title XVIII & V and Medicaid Title XIX. The Medicaid portion of the audit process cannot begin until the audit is completed for the Medicare program. The completion of the Medicare audit may take more than a year depending on the scope of the audit. In addition, the scope of the Medicaid audit may take a year or longer to finalize. At the beginning of each federal fiscal year, the Agency and the Medicaid contractor perform a reconciliation of pending audits to ensure audits are completed within a reasonable timeframe. Also, there are legislative budget restraints which only allow for a certain number of audit hours to be performed each state fiscal year. The Agency's current contract with a CPA vendor to perform the hospitals audits, effective January 2014, calls for a monthly status report of all examinations that are current and ongoing. The Agency has weekly status update calls with the vendor in which an agenda and the previous weekly meeting minutes are		

Finding# 2014-041	Recommendation	Previous Management Response(s)	Status of Finding as of September 30, 2015	Management Response as of September 30, 2015 and Agency Contact
		provided. *Estimated Corrective Action Date:* July 1, 2015		