



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

May 16, 2012

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

Dear Secretary Dudek,

Please find enclosed our six-month status report on the Auditor General's *Medicaid Program Fraud Prevention and Detection Policies and Procedures Facility Cost Reports*, Report Number 2012-035, issued November 2011. 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

cc: Kathy DuBose, Legislative Auditing Committee
Justin Senior, Deputy Secretary, Division of Medicaid



**Florida Agency for Health Care Administration
 AHCA Medicaid Program Fraud Prevention and Detection Policies and Procedures, Facility Cost Reports
 Six-Month Status Report on the Auditor General's Report# 2012-035**

Finding# 1	Recommendation	Management Response as of November 9, 2011	Status as of May 16, 2012	Anticipated Completion Date and Agency Contact
<p>Cost Report Audit Coverage. The Agency did not select for audit facility cost reports at a frequency sufficient to reasonably ensure that improper payments were not made to facilities due to overstated or inaccurate cost reports.</p>	<p>The Agency should develop policies specifying the frequency with which each facility's cost report shall be audited. The policy should include provisions requiring the scheduling of follow-up audits for those facilities whose previous cost reports have contained significant error and the imposition of sanctions when errors in the costs reported are knowingly repeated by the provider in subsequent cost reports.</p>	<p>The Agency does consider the number of years since last examination as one of the risk factors used when determining whether to include a cost report on the examination list, although this is a lower risk than other issues and not specifically stated. The number of years since last examination will be added to the risk criteria.</p> <p>The current policy includes cost reports where issues or concerns were noted during the performance of examinations as a risk factor. Management judgment is used in making the final determination of whether the issues in examinations and cost report acceptance review necessitate the inclusion of future cost reports on the examination list.</p> <p>The current policy will be updated to include a section related to the potential imposition of sanctions when errors in the costs are knowingly repeated by the provider in subsequent cost reports.</p> <p>Estimated completion date: March 31, 2012</p>	<p>The Agency has added "number of years since last examination" to the risk criteria to the written policy. The Agency has also added Medicaid utilization to the written risk criteria. Both of these have been used in the past when considering cost reports to be added to the examination list, although not specifically stated.</p> <p>The current policy has been updated to include a section related to the potential imposition of sanctions when errors in the costs are knowingly repeated by the provider in subsequent cost reports.</p>	<p>Completed January 13, 2012</p> <p>Mercedes Bosque (850) 412-4083</p>

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Finding# 2	Recommendation	Management Response as of November 9, 2011	Status as of May 16, 2012	Anticipated Completion Date and Agency Contact
<p>Cost Report Audit Timeliness. The Agency did not release cost report audits in a timely manner. The failure to timely release audit reports limited the Agency's ability to timely correct errors in per diem rates.</p>	<p>We recommend:</p> <p>(1) The Agency develop policies and procedures to provide for the timely release of cost report audits. These procedures should provide timeframes within which cost report audits are to be reviewed and released.</p> <p>(2) With respect to delays attributable to facilities failing to submit their cost report in a timely manner, the Agency finalize a rule, in development at the time of this audit, that subjects facilities to monetary penalties for failing to submit their cost reports within specified timeframes.</p>	<p>(1) The Agency policy describes the approach from determining the selection of cost reports through the release of the reports and the appeal process. The Agency strives to issue initial reports and conclude legal challenges as soon as processes allow, so that applicable rate changes can be determined. The Agency resources are managed to include both review and release of reports, as well as the detail work in handling a legal challenge.</p> <p>(2) The Agency has updated the Title XIX Long-Term Care Reimbursement Plan to include the ability to apply monetary penalties for cost report submissions that do not comply with required timeframes. This change was effective for the July 1, 2011 Plan.</p>	<p>The Agency strives to issue reports and conclude legal challenges as soon as processes allow. The Agency will be including a timeline requirement in future nursing home and ICF/DD cost report examination contracts.</p> <p>CMS approved the State Plan change to all sanctions for late cost reports on May 23, 2011.</p>	<p>Completed November 9, 2011 Mercedes Bosque (850) 412-4083</p> <p>Completed May 23, 2011 Mercedes Bosque (850) 412-4083</p>

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Finding# 3	Recommendation	Management Response as of November 9, 2011	Status as of May 16, 2012	Anticipated Completion Date and Agency Contact
<p>Cost Report Audit Appeals Process. The Agency should consider revising the process used by facilities to appeal the results of cost report audits. A reduction in the number of appeals would reduce the time and resources needed by the Agency to process the appeals and may increase the frequency or timeliness with which the Agency can release cost report audits and finalize and apply corrected per diem rates.</p>	<p>We recommend that the Agency pursue steps to reduce the number of appeals and the length of time involved in closing appeals. Steps to reduce the number of appeals should include the disallowance of those appeals that seek to extend consideration of audit adjustments made in response to facility documentation deficiencies.</p>	<p>The Agency cannot prevent the facilities from pursuing their Chapter 120 hearing rights for each report issued. Each challenge filed, if meeting the legal requirements, has to be addressed through the legal process.</p> <p>The Agency requested the advice of our General Counsel regarding the recommendation to limit appeals that seek to extend consideration of adjustments made in response to facility documentation deficiencies. Per Counsel, the Title XIX Long-Term Care Reimbursement Plan references the examination process. The filing of a petition for the Chapter 120 hearing is a separate process from the examination. The Agency will further discuss our processes with our General Counsel to determine options that may be available.</p> <p>Estimated completion date: June 30, 2012</p>	<p>The AHCA General Counsel's Office has been consulted on this issue. The recommendation from the General Counsel's Office is to expedite the timeline for the exchange of documents once an appeal is filed. This suggestion will be taken up with Medicaid management to determine further action to reduce the length of time involved in closing appeals.</p>	<p>June 30, 2012</p> <p>Mercedes Bosque (850) 412-4083</p>

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Finding# 4	Recommendation	Management Response as of November 9, 2011	Status as of May 16, 2012	Anticipated Completion Date and Agency Contact
Consideration of Cost Report Fraud. The Agency had not developed written policies and procedures requiring further scrutiny or inquiry into the cost reports of facilities that may contain indications of fraudulent preparation.	We recommend that the Agency develop and communicate to relevant staff written policies and procedures describing the steps to be followed should the results of cost report audits contain indications of facility fraud.	The Agency will expand its current policy to include steps to be followed should the results of cost report examinations contain fraud indicators. Estimated completion date: March 31, 2012	The Agency has expanded its policy regarding how cost report examinations with fraud indicators are to be handled. This policy is adhered to by all analysts during the cost report review process.	Completed January 13, 2012 Mercedes Bosque (850) 412-4083

Finding# 5	Recommendation	Management Response as of November 9, 2011	Status as of May 16, 2012	Anticipated Completion Date and Agency Contact
Hospital Cost Report Oversight. The level of oversight provided by the Agency over the hospital cost report audit process was not sufficient. Increased Agency involvement in the hospital cost report audit process could provide additional assurance that hospital cost reports are accurate, complete, and free of material error.	The Agency should increase the level of oversight provided for the hospital cost report audit process. We recommend the Agency define and increase its role by: (1) Documenting an understanding of the relationship between FCSO's work as Medicare intermediary and FCSO's review of hospital Medicaid cost reports, as well as how that relationship impacts the prevention and detection of errors and fraud in the Medicaid cost reports of hospitals.	(1) The Agency will document the understanding of the relationship between FCSO's work as Medicare intermediary and FCSO's review of Medicaid hospital cost reports. Estimated completion date: June 30, 2012	Contract monitoring documents the relationship between FCSO's work as Medicare intermediary and FCSO's review of hospital cost reports. This documentation will become part of the file and will be updated during subsequent contract monitoring.	Completed May 2, 2012 Mercedes Bosque (850) 412-4083

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Finding# 5	Recommendation	Management Response as of November 9, 2011	Status as of May 16, 2012	Anticipated Completion Date and Agency Contact
	<p>(2) Documenting the extent of the Agency's participation in the hospital cost reports selected for audit.</p> <p>(3) Reviewing cost report audits as they are received to ensure that the Agency is in agreement with the adjustments made by FCSO.</p> <p>(4) Reviewing and approving of all adjustments made through the reopening process.</p>	<p>(2) The Agency will document the extent of the participation in the hospital cost reports selected for audit.</p> <p>Estimated completion date: June 30, 2012</p> <p>(3) The Agency does review the hospital cost report audits received for changes in costs, outlier information, transpositions, and other information that does not fit the situation. The Agency addresses any concerns during this process with FCSO.</p> <p>The Agency performs contract monitoring of the FCSO contract. A sample of audited hospital cost reports is selected for review. This review includes the supporting documentation of the work performed and adjustments made to the cost reports selected. The expansion of this activity is limited to the resources available.</p> <p>Estimated completion date: June 30, 2012</p> <p>(4) Reopenings occur for numerous reasons. Reopenings may be requested by the Agency, the provider, or initiated by FCSO. If obvious errors are noted by these parties, the error</p>	<p>Contract monitoring documents the participation of the Agency in the selection of hospital cost reports to be audited. This documentation will become part of the file and will be updated during subsequent monitoring.</p> <p>Contract monitoring reviews a sample of the audited hospital cost reports along with the supporting documentation of the work performed and adjustments to the cost reports.</p> <p>The Agency reviewed its process for (1) documentation of hospital cost reports received to indicate review for changes, outlier information, and transpositions, and (2) concerns addressed with FCSO.</p> <p>A tracking form has been created to record any outlier and transpositions with FCSO.</p> <p>Contract monitoring includes a review of a reopening. Future monitoring will also include a review of a reopening.</p>	<p>Completed May 2, 2012</p> <p>Mercedes Bosque (850) 412-4083</p> <p>Completed May 2, 2012</p> <p>Mercedes Bosque (850) 412-4083</p> <p>Completed May 2, 2012</p> <p>Rydell Samuel (850) 412-4093</p> <p>Completed May 2, 2012</p> <p>Mercedes Bosque (850) 412-4083</p>

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Finding# 5	Recommendation	Management Response as of November 9, 2011	Status as of May 16, 2012	Anticipated Completion Date and Agency Contact
		<p>is corrected and new schedules are prepared and submitted to the Agency. Reopenings of the Medicare cost report may also cause the reopening of a Medicaid cost report due to the flow of the information. Since reopening occurs after the release of rates based upon the audited cost reports, changes made during the reopening process may change rates. The Agency will include a reopening in the sample selected for review during contract monitoring.</p> <p>Estimated completion date: June 30, 2012</p>		