FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

August 22, 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 *State of Florida Compliance and Internal Controls Over Financial Reporting and Federal Awards,* Report Number 2012-142, issued March 2012. 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,

Mary Beth Sheffield for
Eric W. Miller
Inspector General

EWM/szg
Enclosure

cc: Kathy DuBose, Joint Legislative Auditing Committee
Justin Senior, Deputy Secretary, Division of Medicaid
Tonya Kidd, Deputy Secretary, Division of Operations

Agency for Health Care Administration
AG 10-11 Federal Awards Audit (Report#2012-142)
Six-Month Status Report as of August 22, 2012

Finding# FA 11-039	Recommendation	Management Response as of February 28, 2012	Status as of August 22, 2012	Anticipated Completion Date and Agency Contact
FAHCA did not always maintain appropriate records to support salary and benefits charged to the Program.	We recommend that FAHCA ensure that salary charges reflect actual time worked as recorded in time and effort records.	FAHCA concurs with the finding. We have reviewed the relevant state time charging records and grant draw records and determined that an increasing adjustment to CHIP and a decreasing adjustment to the Medicaid Cluster, in the amount of $10,734.12 is required. FAHCA has made adjustments to the position description of the FAHCA staff member to remove all non-Title XXI duties, and clarified that the role and responsibilities of this staff member is dedicated to Title XXI.	Completed. The adjustment was made on the June 30, 2012 Federal reports.	Paula Shirley (850) 412-3820

Agency for Health Care Administration
AG 10-11 Federal Awards Audit (Report#2012-142)
Six-Month Status Report as of August 22, 2012

Finding# FA 11-041	Recommendation	Management Response as of February 28, 2012	Status as of August 22, 2012	Anticipated Completion Date and Agency Contact
Inadequate supervisory review and lack of written policies and procedures contributed to FAHCA incorrectly calculating cash draw amounts.	We recommend that FAHCA develop and implement written policies and procedures to ensure that the correct amounts and FMAP rates are used in the calculation of draw amounts to ensure that cash needs are appropriately met. Additionally, we recommend FAHCA ensure that cash draw calculations are reviewed before a cash draw is made.	FAHCA concurs with this finding. The two deposits that were incorrectly recorded as federal draws, GL code 000700, were subsequently adjusted to the correct GL on June 29, 2011. FAHCA has drafted and implemented procedures for completion of the Federal cash draws. Additionally, the section manager will review and confirm the accuracy of the draws on a weekly basis.	Completed.	Paula Shirley (850) 412-3820

Agency for Health Care Administration
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Finding# FA 11-042	Recommendation	Management Response as of February 28, 2012	Status as of August 22, 2012	Anticipated Completion Date and Agency Contact
FAHCA did not ensure that amounts were accurately reported on the Cash Management Improvement Act (CMIA) Annual Report to the Florida Department of Financial Services (FDFS).	We recommend FAHCA develop and implement written procedures for the preparation, review, and submission of CMIA data to FDFS, including procedures for ensuring that the amounts are accurate and complete. Additionally, we recommend FAHCA continue to perform reconciliations to ensure cash draws are correctly reported.	FAHCA concurs with the findings. Regarding the mis-classification of revenues, a reconciliation process was included in the procedure for completing the CMIA report for fiscal year 2010-11. Also, the cash draws for the ASC-HAI program were not included in the CMIA report for fiscal year 2010-11.	Completed.	Paula Shirley (850) 412-3820

Agency for Health Care Administration
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Six-Month Status Report as of August 22, 2012

Finding# FA 11-061	Recommendation	Management Response as of February 28, 2012	Status as of August 22, 2012	Anticipated Completion Date and Agency Contact
Payments were made to providers on behalf of CHIP recipients who were not eligible for the Program. Additionally, CHIP payments were made for a service type for which no fee schedule or policy had been developed.	We recommend that FAHCA establish a process to timely adjust payments when retroactive Medicaid eligibility determinations are made. We also recommend that FAHCA finalize the changes to the handbook to ensure that a fee schedule or policy has been established for the omitted service.	The nine MediKids enrollees reviewed with overlapping Medicaid eligibility spans were only MediKids eligible either at the beginning of the capitation month (for children enrolled in an HMO) or on the date of service (for the children in MediPass or fee for service). In all nine cases, Medicaid eligibility was established after the first of the month for the current and prior months. Therefore, at the time in question, MediKids coverage was correctly provided. Even though there were overlapping coverage months for the nine cases cited, there was no dual payment. There is no adjustment mechanism in FMMIS to adjust payments previously made if	A state plan amendment will be submitted to request provisional eligibility which CMS advises will eliminate this problem.	Anticipated Completion September 2012 Shevaun Harris (850) 412-4264

Finding# FA 11-061	Recommendation	Management Response as of February 28, 2012	Status as of August 22, 2012	Anticipated Completion Date and Agency Contact
		subsequent eligibility periods appear with different funding sources attached to the new eligibility. The federal Office of the Inspector General conducted an audit of Title XXI reviewing the dual enrollment issue. As reported to OIG, both Medicaid and CHIP are following their respective State Plans. In addition, the Agency and the Florida Healthy Kids Corporation have implemented a second Medicaid match later in the month to identify CHIP children newly eligible for Medicaid coverage. The State requested federal guidance on 6/30/2010 and 6/24/2011 to assist with minimizing dual enrollment. The Agency received a letter from CMS		

Finding# FA 11-061	Recommendation	Management Response as of February 28, 2012	Status as of August 22, 2012	Anticipated Completion Date and Agency Contact
		dated 12/29/2011 offering possible alternatives. A conference call was held with the federal Centers for Medicare and Medicaid Services on February 7, 2012 to discuss the viability of the suggested options. Even though the Agency has made gains in minimizing dual coverage, the audit was conducted prior to receiving the most recent CMS guidance. Children's Health Services Targeted Case Management Services is authorized and implemented through Section 409.906, F.S., and Case Management Services, Supplemental 1 to Attachment 3/1-A of the State Plan under Title XIX of the Social Security Act. Both the Florida Statute and Medicaid State Plan allow for services and	The Child Health Services Targeted Case Management Coverage and Limitations Handbook and rule number 59G-8.700, F.A.C., was adopted on July 19, 2012.	Completed Shevaun Harris (850) 412-4264

Finding# FA 11-061	Recommendation	Management Response as of February 28, 2012	Status as of August 22, 2012	Anticipated Completion Date and Agency Contact
		reimbursement. The Child Health Services Targeted Case Management Coverage and Limitations Handbook is in the proposed rule phase of the rule promulgations process. The rule number is 59G-8.700, F.A.C., and the proposed rule hearing date is scheduled for February 21, 2012.		

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Finding# FA 11-064	Recommendation	Management Response as of February 28, 2012	Status as of August 22, 2012	Anticipated Completion Date 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, the payments were for improper amounts or for unallowable services.	We recommend that FAHCA ensure that appropriate electronic or manual controls are in place and operating effectively to ensure that Medicaid claims are accurately and properly processed.	Medicare Crossover Claim: There were known system issues with professional Medicare crossover claims. Change orders were completed in October 2011 to correct overpayment on these claims. A query to establish a recoupment process is currently underway. Aged/Disabled Adult: Waiver procedure code (S5170U2) – FMMIS has an edit in place to limit the maximum number of meals per month to 62 (31 days x 2 meals). However, the problem with this particular procedure code is that at the time of the system review, there was no policy/legal guidance regarding providers that might deliver a week or two weeks of frozen meals at one time. This is	The claims reprocessing task is complete. However, the Agency is developing re-payment plans for providers and anticipates that collections will begin in September 2012. Aged/Disabled – System changes were installed through file maintenance CS02201201 on May 1, 2012, to limit provider billing to 2 meals per day, and the provider bills a separate line item for each day's services.	Medicare Crossover - Anticipated Completion June 2013 Shevaun Harris (850) 412-4264 Aged/Disabled Adult - Completed Shevaun Harris (850) 412-4264

Finding# FA 11-064	Recommendation	Management Response as of February 28, 2012	Status as of August 22, 2012	Anticipated Completion Date and Agency Contact
		permissible per Medicaid policy. Under that circumstance, the provider would need to bill for 14 or 28 meals on one day, so limiting billing to a literal two meals per day would inappropriately cause payment to deny. FMMIS currently matches policy and until policy determines how to limit multiple days' worth of deliveries at one time, further restriction placed in FMMIS would violate policy. Due to the above issues, the Agency has determined that the current edits in place in the FMMIS are not adequate to ensure correct payment according to the days of the month. File maintenance will be developed to limit billing to 2 meals per day (maximum of 2 units per		

Finding# FA 11-064	Recommendation	Management Response as of February 28, 2012	Status as of August 22, 2012	Anticipated Completion Date and Agency Contact
		day) and the provider will then file for reimbursement using a separate line item for each day. As home-delivered meal providers throughout the state will need to be notified by the waivers' operational partner, the Florida Department of Elder Affairs, an effective date for the reimbursement change will be May 1, 2012. Assisted Living Waiver: FMMIS cannot limit units of service based upon the length of specific months. There is an edit in place to limit billing to 31 units per calendar month. If a limit is put in place to limit to 30 units per month, providers' payments will be denied for legitimate claims on day 31 of longer months. Likewise if the system was limited to 28 days for	Assisted Living – System changes were installed through file maintenance CS02201201 on May 1, 2012, to 1 unit per day, and the provider will file for reimbursement using a separate line item for each day.	Assisted Living – Completed Shevaun Harris (850) 412-4264

Finding# FA 11-064	Recommendation	Management Response as of February 28, 2012	Status as of August 22, 2012	Anticipated Completion Date and Agency Contact
		February, the other 11 months and leap year would deny for days 29 through 31. What appears to be incorrect is that programming for procedure code T1020U3TS still allows billing for all units on one date of service. The one unit per day limit combined with the existing edit limiting to 31 units per month effectively limit the service to the number of days in the month. In order to prevent any future billing issues, the Agency has determined, for the sake of consistency, that the current edit in place in the FMMIS will be changed. File maintenance will be developed to limit billing to 1 unit per day and the provider will then file for reimbursement using a		

Finding# FA 11-064	Recommendation	Management Response as of February 28, 2012	Status as of August 22, 2012	Anticipated Completion Date and Agency Contact
		separate line item for each day. As Assisted Living Waiver providers throughout the state will need to be notified by the waivers' operational partner, the Florida Department of Elder Affairs, an effective date for the reimbursement change will be May 1, 2012. Chiropractic: It was determined that a new edit number was not necessary re: 99201-99203 and 98940-98942, because 5129 already existed. FM #KS09201001 was implemented on October 14, 2010, limiting chiropractic visits to 24 per year. The 24-visit limit may be exceeded when medically necessary for beneficiaries who are under the age of 21. Previous editing did not	Reprocessing and recoupment of claims for outside the chiropractic visit limits is expected to be completed in November 2012.	Chiropractic - Anticipated Completion November 2012 Shevaun Harris 850-412-4264

Finding# FA 11-064	Recommendation	Management Response as of February 28, 2012	Status as of August 22, 2012	Anticipated Completion Date and Agency Contact
		combine all possible procedure codes for visits for chiropractic services. Reprocessing of claims has not taken place yet due to an issue discovered during testing relating to copayments. A change order has been submitted to require a referring provider identification number for claims in exceptional places of service described in policy. File maintenance has also been requested to remove places of service that are not allowed in policy; this was completed on December 9, 2011. Dental: The procedure codes that are not allowed to be billed on the same date of service, same quadrant were updated to	Dental - Rule 59G-4.060 Dental Services was adopted May 3, 2012. Certain procedure codes may not be billed for the same quadrant	Dental – Completed Shevaun Harris (850) 412-4264

Finding# FA 11-064	Recommendation	Management Response as of February 28, 2012	Status as of August 22, 2012	Anticipated Completion Date and Agency Contact
		restrict these codes to be paid with quadrant indicators. It is permissible to bill these code combinations if they are in different quadrants. Policy has been updated to reflect this clarification in our Dental Services Coverage and Limitations Handbook, and is pending rule adoption. The claims submitted for consideration of overpayment all have quadrant indicators that are permissible according to our policy clarification. Inpatient: AHCA headquarters staff have worked with AHCA Area offices and providers to adjust two claims that resulted in overpayments. One provider processed a payback and the other provider voided the claim and will resubmit for the	on the same date of service, same recipient, or the same provider. The quadrant indicator must be on the claim form. Inpatient – Completed	Inpatient – Completed Shevaun Harris (850) 412-4264

Finding# FA 11-064	Recommendation	Management Response as of February 28, 2012	Status as of August 22, 2012	Anticipated Completion Date and Agency Contact
		correct number of days. Home Health: The systems edits have been fixed and are working according to policy. The AHCA Bureau of Medicaid Program Integrity is handling recoupment of these overpayments. The Bureau of Medicaid Services is continuing the process of promulgating updates to the Home Health Services Coverage and Limitations Handbook, which is incorporated by reference in Rule 59G-4.130. The modifications to the handbook will offer better guidance to providers on the reimbursement requirements for private duty nursing and personal care services.	Home Health - The Rule Development workshop for the update to the Home Health Services Coverage and Limitations Handbook was held on August 15, 2012, to eliminate the 2 hour minimum requirement for personal care services and private duty nursing. The projected promulgation date for the handbook is November 2012. The prior authorization edits in the FMMIS have been fixed and Medicaid Program Integrity is handling the recoupment of any over-payments that occurred prior to the policy change.	Home Health – Anticipated Completion November 2012 Shevaun Harris (850) 412-4264

Finding# FA 11-065	Recommendation	Management Response as of February 28, 2012	Status as of August 22, 2012	Anticipated Completion Date and Agency Contact
Controls were not sufficient to ensure that amounts paid by FAHCA to CTD or amounts paid by CTD to transportation providers under a Medicaid transportation program were reasonable.	We recommend that current transportation costs be summarized and used to evaluate the reasonableness of the total contract amount as well as the amounts allocated to STPs and to CTD for administrative costs. FAHCA should also conduct appropriate monitoring to evaluate CTD and STP compliance with governing laws, regulations, and contract terms and communicate the results of the monitoring to CTD and STPs.	The Commission for the Transportation Disadvantaged (CTD) submitted a new allocation methodology that took effect January 1, 2012. The allocation is based on a formula that takes into account recent data relating to the Medicaid Non-Emergency Transportation program. By May 2012, the Agency intends to conduct an onsite review of the CTD's compliance with the contract. A formal report of findings will be supplied to the CTD, along with a requirement to correct any deficiencies that may be found during that review. The CTD has contracted with an audit firm to conduct its reviews for FY 2008-2009, FY 2009-2010, and FY 2010-2011	The CTD submitted audit reports for each Fiscal Year (FY) 08/09, 09/10, and 10/11. The Florida Agency for Health Care Administration (FAHCA) issued a corrective action plan to the CTD relating to the untimely submission of these reports, and to address what steps will be taken to prevent the non-compliance in FY 11/12. The independent auditors reported the expenditures conformed to generally accepted auditing standards in the United States, in Government Auditing Standards, and OMB Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations. Based upon these criteria, FAHCA determined the CTD expenditures to be reasonable; however, the audit reports found that the schedule of expenditures provided by the CTD was not	Anticipated Completion August 31, 2012 Shevaun Harris (850)412-4264

Finding# FA 11-065	Recommendation	Management Response as of February 28, 2012	Status as of August 22, 2012	Anticipated Completion Date and Agency Contact
		budgets in compliance with OMB Circular A-133 and expects to have the reviews completely by June 30, 2012.	reconciled to the financial statement spreadsheet numbers provided by the CTD. CTD remarked the difference was due to administrative charges allowable per the grant, not included on the spreadsheet numbers. FAHCA has requested that the CTD submit a corrective action plan to reconcile the schedules to the state's FLAIR system. The corrective action plan is due August 31, 2012.	

Finding# FA 11-067	Recommendation	Management Response as of February 28, 2012	Status as of August 22, 2012	Anticipated Completion Date and Agency Contact
As noted in the prior year audit, FAHCA continued to record expenditures to incorrect appropriation categories in the State's	We recommend that FAHCA ensure that expenditures are accurately recorded in the State's accounting records. We also	FAHCA's procedure is to pay the weekly Medicaid claims payment in as few categories as possible that have the largest amount of budget released, and then	Not Corrected. FAHCA has made and continues to make efforts to secure the needed legislative authority to move budget between categories to align with expenditures at	Paula Shirley (850) 412-3820

Finding# FA 11-067	Recommendation	Management Response as of February 28, 2012	Status as of August 22, 2012	Anticipated Completion Date and Agency Contact
accounting records.	recommend that FAHCA continue to pursue the necessary changes to the budget amendment process to ensure that funds are available in the appropriate categories.	do an adjusting journal transfer to move the expenditures to the correct categories. The adjusting journal transfers are generally completed within the same week. There may be occasions at fiscal year-end or at the conclusion of carry forward processing that the FLAIR Medical Services appropriation categories may not agree with the FMMIS appropriation categories due to insufficient FLAIR budget. Additionally, expenditures for the Title XXI are included in the FMMIS report under the specific appropriation category. These are identified as category type 8 (Title XXI) expenditures on the weekly report and are moved to the FLAIR appropriation category 102340 (Medikids), which is used for Title XXI. The amounts for Title XXI are	year end.	

Finding# FA 11-067	Recommendation	Management Response as of February 28, 2012	Status as of August 22, 2012	Anticipated Completion Date and Agency Contact
		$59,499.29 and $2,475,025.24 for Inpatient Services and Prepaid Health Plan, respectively. The FMMIS expenditures, less Title XXI, were $60,389,925.43 for Inpatient Services and $243,561,314.48 for Prepaid Health Plans. On the FMMIS report, there are three appropriation categories for prepaid health plans: 102671, 102672 and 102674. The sum of these three categories is paid from FLAIR category 102673. FAHCA has made and continues to make efforts to secure the needed legislative authority to move budget between categories to align with expenditures at year end.		

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Finding# FA 11-069	Recommendation	Management Response as of February 28, 2012	Status as of August 22, 2012	Anticipated Completion Date and Agency Contact
FAHCA had not documented that the State met the matching requirements of the Medicaid Program for the 2009-10 Federal fiscal year (FFY). Additionally, FAHCA did not have a process in place to monitor compliance with matching requirements.	We recommend FAHCA implement policies and procedures detailing the method for calculating, documenting, and verifying the Medicaid Program State match. To allow timely identification of deficiencies, those policies and procedures should require periodic verifications of State matching contributions.	FAHCA concurs with the findings. FAHCA has implemented procedures to calculate and document the Medicaid Program State match. FAHCA has modified its methodology to verify the other entities' actual expenditure reports representing the State match contributions.	Completed.	Paula Shirley (850) 412-3820

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Finding# FA 11-070	Recommendation	Management Response as of February 28, 2012	Status as of August 22, 2012	Anticipated Completion Date and Agency Contact
FAHCA procedures were not sufficient to ensure that Medicaid providers receiving payments had a current Medicaid Provider Agreement in effect. Additionally, FAHCA did not always maintain Medicaid provider files containing applications, agreements, and other required documentation evidencing the provider's eligibility to participate in the Medicaid program.	We recommend that FAHCA ensure that payments are made only to providers with current Medicaid Provider Agreements in effect. FAHCA should continue to work with the fiscal agent to ensure that providers have current Medicaid Provider Agreements in place, or assess appropriate penalties for nonperformance against the fiscal agent. Additionally, FAHCA should work with the fiscal agent to ensure provider files are maintained and accessible.	The Agency is completing the process of reenrolling providers whose agreements expired prior to the launch of the automated reenrollment process in January 2010. The Agency installed an additional automated job in November 2010 to identify providers with agreement end dates less than the current date; flag the file as needing to reenroll; create a report for tracking purposes; and send the reenrollment packet to the provider. The provider had 90-days from that date to return the completed reenrollment packet in order to remain active in Florida Medicaid. Providers who failed to respond within the 90-day window were restricted in the system to prevent claims with dates of	The "expired provider agreement" identification and subsequent provider termination steps addressed in the February 2012 management response have been completed.	Completed March 2012 Alan Strowd (850) 412-3450

Finding# FA 11-070	Recommendation	Management Response as of February 28, 2012	Status as of August 22, 2012	Anticipated Completion Date and Agency Contact
		services after the deadline from processing. This process of identifying and notifying providers with expired agreements, and then applying the restriction status and finally the termination status (for the providers failing to comply), covered several quarters of work (> 20,000 affected providers), with final completion staged for January/ February 2012. This job is onetime cleanup of older provider files and encompasses the providers who were not reenrolled during the fiscal agent transition (May 2005 – July 2009). Completion of this job will result in a fully corrected status for this finding.		

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Finding# FA 11-072	Recommendation	Management Response as of February 28, 2012	Status as of August 22, 2012	Anticipated Completion Date and Agency Contact
FAHCA's established policies and procedures did not provide for the timely review and release of cost report audits of nursing home and Intermediate Care Facilities for the Developmentally Disabled (ICF-DD).	We recommend FAHCA enhance its policies and procedures to specify the frequency with which each facility's cost report should be audited and to provider for the timely release of cost report audits. These procedures should identify time frames within which cost reports audits are to be reviewed and released to ensure the timeliness and usefulness of the information contained within the audits.	Each of the 649 nursing homes participating in the Medicaid program are to submit a cost report, compliant with cost reporting requirements, each year five months after the close of the provider's fiscal year end. Cost reports are not considered late until they have not been received to be used for the next January or July rate setting following the due date of the cost report. The consequence of submitting a late cost report was the provider would not receive a per diem increase based upon the costs submitted until the next rate setting. Any rate reductions would be immediately applied. On May 23, 2011, the Centers for Medicare and Medicaid (CMS) approved	The Audit Services policy (updated January 2012) states that cost reports selected for audit are generally assigned within three (3) years of receipt, regardless of the fiscal year end. To address audits beyond the policy timelines, we will evaluate each step of the process to determine if new policies or procedures need to be incorporated in order to streamline the overall timeliness of the entire audit process. Currently all audits performed are reviewed by Agency staff to ensure that we can defend any adjustments in case of legal challenges. As such, we do not recommend limiting the reviews of the audits performed. The Agency may be able to assign fewer audits to be performed by our independent CPA vendors.	Evaluation process to be completed by December 2012 Karen Chang (850) 412-4075

Finding# FA 11-072	Recommendation	Management Response as of February 28, 2012	Status as of August 22, 2012	Anticipated Completion Date and Agency Contact
		a change to the Long-Term Care Reimbursement Plan (Plan) allowing the Agency the ability to impose sanctions on those providers with late cost reports. The result of advertising the requested Plan change to the nursing home industry reduced the number of providers with late cost reports from sixty-one to less than five. The submission of cost reports to avoid possible sanctions will have older cost reports in the pool for possible selection that could show up in audit assignments in future fiscal years. Cost reports cannot be included in the audit selection pool until they have been submitted to the Agency and accepted for rate setting, regardless	In addition to evaluating our current audit policy, we will be evaluating the need for additional qualified staff to review the audits in a timely and efficient manner.	

Finding# FA 11-072	Recommendation	Management Response as of February 28, 2012	Status as of August 22, 2012	Anticipated Completion Date and Agency Contact
		of fiscal year end. Due to the previously described cost report process, setting a two year window from the close of the provider's fiscal year end would not be practical. The Agency has reviewed the average length of time from cost report acceptance to audit assignment and from audit assignment to report issuance. For the 102 audits issued during the 2010-11 fiscal year, the averages are 14.9 months and 23.6 months, respectively. Combining these timeframes, reports are issued on average within 38.5 months from cost report acceptance. Included in the reports released are six reports, with fiscal years ending 2003, 2006, and 2007,		

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		based on assignments originally started by contract CPA firms. These assignments were open at the time the firm's contract was not renewed. The Agency completed these audits rather than reassigning them to another CPA for re-audit, saving the Agency an estimated $90,000 of contracted audit costs. Reviewing supporting work papers for each report and preparing audit appeals are note considered hindrances, but necessary components of the process. Each report issued is considered an Agency action, and the Agency is required to provide administrative hearing (appeal) rights. The Agency is responsible defending the adjustments included in the reports and		

Finding# FA 11-072	Recommendation	Management Response as of February 28, 2012	Status as of August 22, 2012	Anticipated Completion Date and Agency Contact
		performing additional audit steps, including any report revisions, necessary to conclude the appeals. Releasing reports without having reviewed the adjustments and supporting work papers would put the Agency at a disadvantage in the legal challenge and the allowance of costs that should be removed. Should the provider choose to appeal the adjustments, all further processing of the report is ceased until the administrative action is legally concluded. This includes any rate changes resulting from these reports. The Agency's available resources have to be considered in the timing and completion of cost		

Finding# FA 11-072	Recommendation	Management Response as of February 28, 2012	Status as of August 22, 2012	Anticipated Completion Date and Agency Contact
		report audits or special projects, as well as selection of the cost reports considered the highest risk for audit. Agency personnel assigned to review reports and supporting work papers are also required to defend the adjustments, perform additional work for audit appeals, perform cost report acceptance reviews, and complete special projects. A balance of these required functions is necessary.		