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STATE OF FLORIDA AUDITOR GENERAL

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Summary

Report Number: **2012-021**

Report Title: **Agency for Health Care Administration – FMMIS Controls and the Prevention of Improper Medicaid Payments - Operational Audit**

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Chapter 2010-144, Laws of Florida, requires a review and evaluation of the Agency for Health Care Administration's Medicaid fraud and abuse prevention and detection systems. This operational audit focused on controls within the Florida Medicaid Management Information System (FMMIS) related to the prevention and detection of improper Medicaid payments made through the fee-for-service payment structure for providers. A subsequent report of the Auditor General will address in its scope additional controls relevant primarily to fee-for-service payments to facilities, such as hospitals and nursing homes.

MEDICAID PAYMENTS AND FMMIS CONTROLS

FMMIS allows the use of numerous electronic edits and audits to ensure that each submitted claim is from a valid Medicaid provider, for a valid Medicaid recipient, and for a valid Medicaid service. The electronic audits are also to be employed in the review of a recipient's claim history to ensure that the claim submitted by the provider does not exceed Medicaid Program limitations. As the vast majority of claims processed by FMMIS are not subject to any type of manual preaudit or pre-payment review, the electronic edits and audits in FMMIS are critical in ensuring claims are paid appropriately. Not only are these edits and audits in FMMIS essential to ensure that claims are paid appropriately, but they also serve as a first line of defense in preventing and detecting fraud and abuse in the Medicaid Program. Since it is more cost-beneficial to prevent payment of improper claims than to employ what is known as a "pay and chase" approach, under which claims initially paid without sufficient scrutiny must be followed by attempts to identify and recover unallowable, erroneous, or fraudulent payments, it is incumbent upon the Agency for Health Care Administration (Agency) to ensure that FMMIS contains cost-effective electronic edits and audits. As summarized below, our audit found that processes that would reasonably ensure the timely implementation of edits and audits had not been established by the Agency.

Finding No. 1: The Agency's ineffective risk assessment processes contributed to the disbursement of improper payments.

Finding No. 2: To ensure that FMMIS includes the necessary audits, the Agency should have a process in place to periodically review FMMIS to determine that audits are in place and operating as intended and that they are based on current Medicaid limitations. Our examination disclosed that a comprehensive review of procedure codes and applicable audits had not been performed for all service types within the last several years. Additionally, when the Agency changed fiscal agents effective June 26, 2008, a review of procedure codes and audits was not performed as part of the two-year design, development, and implementation phase. Absent the Agency's periodic review of the effectiveness of FMMIS audits, deficiencies in the audits will not be identified and improper payments will be made and escape detection. For example, our analysis of selected service types and procedure codes identified claim payment errors totaling $17,274,230 made to durable medical equipment and other service providers. For some of these claims the absence of accurate claim information precluded reliable estimates as to the extent these payments represented overpayments.

Finding No. 3: FMMIS was not programmed to ensure the proper payment of outpatient Medicare crossover claims. Our review of 286 claims disclosed that 182, or 63.6 percent, had been paid amounts in excess of authorized amounts. When the errors identified by our audit are projected to the total of the amounts paid for outpatient hospital crossover claims during the three fiscal years tested, the total overpayment is estimated to be $117,659,683.

Finding No. 4: FMMIS was not programmed to correctly calculate the amounts due for some professional Medicare crossover claims. Our audit tests disclosed related overpayments totaling $14,053,660.

Finding No. 5: Medicare crossover claims were paid on behalf of recipients without consideration of whether the recipient was eligible for the assistance. Related overpayments disclosed by our audit tests totaled $26,071,070.

Finding No. 6: Programming changes to FMMIS electronic edits and audits were not made in a timely manner. Our review of 28 FMMIS change orders to determine whether the changes were implemented by the effective date of the policy change disclosed that for 21 of the 28 change orders reviewed, the program change to FMMIS was not timely implemented. The period of time between the effective date of the policy change and the date the change was implemented in FMMIS ranged from 20 to 2,542 days and averaged 541 days.

Finding No. 7: The Agency should strengthen the process by which the Bureau of Medicaid Program Integrity's recommendations are reviewed and tracked.

Finding No. 8: The Agency should automate processes for the screening of new and currently enrolled Medicaid providers. Automating these processes would also improve the timeliness with which Medicaid providers are terminated from the Medicaid Program due to adverse actions.

FISCAL AGENT OVERSIGHT

Finding No. 9: To enhance its effectiveness as a deterrent to unacceptable performance, should such occur, the methodology used to periodically monitor the performance of the Medicaid fiscal agent and assess related penalties should be modified.

Management's response is included in the audit report as Exhibit A.

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