DEPARTMENT OF HEALTH & HUMAN SERVICES **OFFICE OF INSPECTOR GENERAL**

Office of Audit Services, Region IV
61 Forsyth Street, SW, Suite 3T41
Atlanta, GA 30303

December 13, 2011

Report Number: A-04-11-07020

Ms. Elizabeth Dudek
Secretary
Florida Agency for Healthcare Administration
2727 Mahan Drive, MS#1
Tallahassee, FL 32308

Dear Ms. Dudek:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Medicaid Payments to Excluded or Terminated Durable Medical Equipment Suppliers in Florida*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Denise R. Novak, Audit Manager, at (305) 536-5309, extension 10, or through email at Denise.Novak@oig.hhs.gov. Please refer to report number A-04-11-07020 in all correspondence.

Sincerely,

/Lori S. Pilcher/
Regional Inspector General
for Audit Services

Enclosure

cc: Mary Beth Sheffield
Audit Director, Office of the Inspector General
Florida Agency for Healthcare Administration
2727 Mahan Drive, MS#5
Tallahassee, FL 32308

Direct Reply to HHS Action Official:

Ms. Jackie Garner, Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICAID PAYMENTS TO EXCLUDED OR TERMINATED DURABLE MEDICAL EQUIPMENT SUPPLIERS IN FLORIDA

Daniel R. Levinson
Inspector General

December 2011
A-04-11-07020

Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administer the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

CMS reimburses State Medicaid agencies based on the Federal medical assistance percentage for claimed Medicaid expenditures, including Medicaid expenditures for items and services furnished, ordered, or prescribed by providers enrolled in the State's Medicaid program.

In Florida, the Agency for Health Care Administration (State agency) is the single State agency designated to administer the Florida Medicaid program. The Medicaid program in Florida reimbursed durable medical equipment (DME) suppliers approximately $120 million in calendar year 2009.

The U.S. Department of Health and Human Services, Office of Inspector General, under Congressional mandate, established a program to exclude individuals and entities affected by various legal authorities contained in sections 1128 and 1128A of the Act. The effect of an exclusion (not being able to participate) is that no payment will be made by the Medicare or Medicaid programs for any items and services furnished, ordered, or prescribed by an excluded individual or entity.

CMS established the National Supplier Clearinghouse (Clearinghouse), which is responsible for enrolling suppliers in Medicare, issuing all DME supplier numbers nationwide, and ensuring that suppliers comply with federally mandated supplier standards. The Clearinghouse can revoke a supplier number for failure to comply with these federally mandated supplier standards. A supplier with a revoked supplier number is automatically considered terminated from the Medicare program, and Florida law prohibits Medicaid payments to suppliers terminated from the Medicare program.

OBJECTIVE

Our objective was to determine whether the State agency made payments to DME suppliers that had been excluded or terminated from the Medicare or Medicaid programs for calendar year 2009.

SUMMARY OF FINDINGS

The State agency did not make payments to DME suppliers that had been excluded from the Medicare or Medicaid programs. However, it made payments totaling $230,992 ($127,407 Federal share) to 31 DME suppliers that were terminated from the Medicare program during

2009. The State agency made improper payments to these 31 suppliers because it did not have procedures to validate DME suppliers' billing privileges through the Clearinghouse to ensure that they were not terminated from the Medicare program.

RECOMMENDATIONS

We recommend that the State agency:

- refund $127,407 to the Federal Government for the improper Medicaid payments made to terminated DME suppliers and

- improve controls to ensure that the State agency validates DME suppliers' billing privileges before paying them.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our findings and provided information on actions that it planned to take to address them. The State agency's comments are included in their entirety as the Appendix.

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INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

CMS reimburses State Medicaid agencies based on the Federal medical assistance percentage (FMAP) for claimed Medicaid expenditures, including Medicaid expenditures for items and services furnished, ordered, or prescribed by providers enrolled in the State's Medicaid program. The FMAP during our audit period was approximately 55 percent.

State of Florida Medicaid Program

In Florida, the Agency for Health Care Administration (State agency) is responsible for administering the Medicaid program. The State agency contracts with HP Enterprise Services (formerly Electronic Data Systems) to maintain its Medicaid Management Information System, a computerized payment and information reporting system that processes and pays Medicaid claims. The Medicaid program in Florida reimbursed durable medical equipment (DME) suppliers approximately $120 million in calendar year (CY) 2009.

Federal and State Criteria

Federal Criteria - Excluded Providers

The U.S. Department of Health and Human Services, Office of Inspector General (OIG), under Congressional mandate, established a program to exclude individuals and entities affected by various legal authorities contained in sections 1128 and 1128A of the Act. Medicare and Medicaid will not pay excluded individuals and entities for any items or services furnished, ordered, or prescribed. The exclusion applies regardless of who submits the claims and applies to all administrative and management services furnished by the excluded entity.

To administer this exclusion program, OIG maintains a database of all currently excluded parties called the *List of Excluded Individuals/Entities* (LEIE). This database provides information about parties excluded from participation in Medicare, Medicaid, and all other Federal health care programs. In addition, CMS maintains a database called the Medicare Exclusion Database (MED). CMS developed the MED in 2002 to collect and retrieve information that aided in ensuring that no payments were made to excluded individuals or entities for services furnished during the exclusion period. CMS provides the MED files to State Medicaid agencies every

month. Pursuant to a CMS State Medicaid Directors Letter, dated June 12, 2008, States should conduct monthly searches via the LEIE or the MED to capture exclusions and reinstatements that have occurred since the previous search. The State agency uses the LEIE and the MED to determine which providers have been excluded from the Medicare or Medicaid programs.

Federal Criteria - Terminated Providers

The National Supplier Clearinghouse (Clearinghouse), which CMS established in 1993 by contract, is responsible for enrolling suppliers in Medicare, issuing all DME supplier numbers nationwide, and ensuring that suppliers comply with federally mandated supplier standards. The Clearinghouse can revoke Medicare DME supplier numbers for failure to comply with 1 or more of the 26 federally mandated supplier standards.[1] According to the *Medicare Program Integrity Manual* (the manual), chapter 15, section 1.1, "Revoke/revocation means that the provider [sic] or supplier's billing privileges are terminated." Therefore, revoked providers are considered terminated from the Medicare program during the time of revocation.

Office of Management and Budget (OMB) Circular A-87, attachment A, section C.1.c, provides that, to be allowable, costs must be "authorized or not prohibited under State or local laws or regulations." Thus, Medicaid costs incurred by Florida are not allowable (and, therefore, not federally reimbursable) if the costs are prohibited under Florida law.

State Criteria – Terminated Providers

Section 409.913 of the Florida Statutes also provides grounds for administrative sanctions against Medicaid DME suppliers that fail to meet standards required by Federal law and regulations. These sanctions include suspension or termination of the Medicaid DME suppliers from the program. Specifically, the State agency "shall deny payment, or require repayment, if the goods or services were furnished, supervised, or caused to be furnished by a person[2] who has been suspended or terminated from the Medicaid or Medicare programs by the Federal Government or any State" and shall not enroll such provider in the Florida Medicaid program while such suspension or termination remains in effect.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency made payments to DME suppliers that had been excluded or terminated from the Medicare or Medicaid programs for CY 2009.

[1] On January 1, 2009, Medicare had 25 DME supplier standards; it added a 26th standard on October 1, 2009.

[2] Pursuant to 409.913(1)(f) of the Florida Statutes, the term "person" means any natural person, corporation, partnership, association, clinic, group, or other entity, whether or not such person is enrolled in the Medicaid program or is a provider of health care.

Scope

Our audit covered all Medicaid DME suppliers that the State agency had reimbursed during CY 2009. The State agency paid $119.8 million to 3,880 DME suppliers.

We limited our review to DME suppliers that had received payment from Medicaid during CY 2009. We did not review the overall internal control structure of the State agency or the Medicaid or Medicare programs because our objective did not require us to do so. Instead, we reviewed only the State agency internal controls that pertained to our objective.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidance;
- interviewed State agency officials to understand its policies, procedures, guidance, and methodology for preventing payments to excluded or terminated DME suppliers;
- obtained the list of Medicaid DME suppliers that received Medicaid reimbursements (State agency's file) during the audit period;
- obtained the MED[3] from CMS as of December 31, 2009, and compared it to the State agency's file using the suppliers' social security numbers (SSNs), National Provider Identifiers (NPIs), business names, or addresses to determine whether the State agency made Medicaid payments to excluded suppliers;
- obtained the list of terminated suppliers from the Clearinghouse as of December 31, 2009, and:
    - compared it to the State agency's file using NPIs, Tax Identification Numbers, business names, and addresses to determine whether the State made Medicaid payments to terminated suppliers;
    - requested claims information from the State agency for those terminated suppliers identified as having received Medicaid payments; and
    - calculated the total payments that were made during each supplier's period of termination; and
- calculated the Federal share of the expenditures using the lowest FMAP (54.98 to 55.4 percent) applicable for each quarter.

[3] We used the MED in our analysis because it contained unique identifiers, such as SSNs or NPIs.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

The State agency did not make payments to DME suppliers that had been excluded from the Medicare or Medicaid programs. However, it paid $230,992 ($127,407 Federal share) to 31 DME suppliers that were terminated from the Medicare program during 2009. The State agency made improper payments to these 31 suppliers because it did not have procedures to validate DME suppliers' billing privileges through the Clearinghouse to ensure that they were not terminated from the Medicare program.

FEDERAL AND STATE REQUIREMENTS

Federal regulations (42 CFR § 424.57) outline 26 Medicare standards to which all DME suppliers must adhere to participate in the Medicare program. Through the Clearinghouse, CMS will revoke a supplier's billing privileges if it is found not to meet these standards. According to the manual, chapter 15, section 1.1, "Revoke/revocation means that the provider [sic] or supplier's billing privileges are terminated." Therefore, revoked suppliers are deemed terminated from the Medicare program during the time of revocation.

Florida law prohibits Medicaid payments for items furnished by suppliers that have been terminated from the Medicare program by the Federal government. Section 409.913 (14) of the *Florida Statutes* provides that:

> If the provider has been suspended or terminated from participation in the Medicaid program or the Medicare program by the Federal Government or any state, the agency must immediately suspend or terminate, as appropriate, the provider's participation in this state's Medicaid program for a period no less than that imposed by the Federal Government or any other state, and may not enroll such provider in this state's Medicaid program while such foreign suspension or termination remains in effect.

Furthermore, section 409.913(25)(b) of the *Florida Statutes* provides that "[t]he agency shall deny payment, or require repayment, if the goods or services were furnished, supervised, or caused to be furnished by a person who has been suspended or terminated from the Medicaid program or Medicare program by the Federal Government or any state."

OMB Circular A-87, attachment A, section C.1.c, provides that to be allowable, costs must be "authorized or not prohibited under State or local laws or regulations." Thus, Medicaid costs incurred by Florida are not allowable (and, therefore, not federally reimbursable) if the costs are prohibited under Florida law.

IMPROPER PAYMENTS MADE TO TERMINATED PROVIDERS

The State agency did not make improper payments to DME suppliers that had been excluded from the Medicare or Medicaid programs. However, it made improper payments totaling $230,992 ($127,407 Federal share) to 31 DME suppliers that the Clearinghouse had terminated from the Medicare program during 2009. The Clearinghouse had revoked 31 DME suppliers' billing privileges, and, thus, these providers were deemed terminated from the Medicare program and should not have received payment.

NO PROCEDURES TO IDENTIFY TERMINATED PROVIDERS

Although the State agency had policies and procedures to identify excluded DME providers, which included conducting a search of the LEIE, it did not have controls to ensure that improper payments were not made to terminated DME suppliers. Specifically, the State agency did not have procedures to validate DME suppliers' billing privileges through the Clearinghouse to verify that they were not terminated from the Medicare program.

As a result, it improperly paid $230,992 ($127,407 Federal share) to 31 DME suppliers that the Clearinghouse had terminated from the Medicare program during 2009.

RECOMMENDATIONS

We recommend that the State agency:

- refund $127,407 to the Federal Government for the improper Medicaid payments made to terminated DME suppliers and

- improve controls to ensure that the State agency validates DME suppliers' billing privileges before paying them.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our findings and provided information on actions that it planned to take to address them. The State agency's comments are included in their entirety as the Appendix.

APPENDIX

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

November 8, 2011

Ms. Lori S. Pilcher
Regional Inspector General for Audit Services
Department of Health & Human Services
Office of Inspector General
Office of Audit Services, Region IV
61 Forsyth Street, SW, Suite 3T41
Atlanta, GA 30303

Dear Ms. Pilcher:

Thank you for your letter of October 19, 2011, requesting us to provide comments on the draft report number A-04-11-07020, *Review of Medicaid Payments to Excluded or Terminated DME Suppliers in Florida*. In accordance with your request, we have mailed you a paper copy of our response and we also sent our response by email.

If you have any questions regarding our response, please contact Mary Beth Sheffield, Audit Director, at 850-412-3978.

Sincerely,

for Sonya Kidd

Elizabeth Dudek
Secretary

ED/szg
Enclosure

Florida Agency for Health Care Administration
Report# A-04-11-07020
Review of Medicaid Payments to Excluded or Terminated DME Suppliers in Florida
Response to HHS OIG's Request for Written Comments on the Draft Report

Findings	Recommendations	State Agency Response and Corrective Action Plan	Estimated Corrective Action Date and Agency Contact
The State agency did not make payments to DME suppliers that had been excluded from the Medicare or Medicaid programs. However, it made payments totaling $230,992 ($127,407 Federal share) to 31 DME suppliers that were terminated from the Medicare program during 2009. The State agency made improper payments to these 31 suppliers because it did not have procedures to validate DME suppliers' billing privileges through the Clearinghouse to ensure that they were not terminated from the Medicare program.	**(1)** Refund $127,407 to the Federal Government for the improper Medicaid payments made to terminated DME suppliers and **(2)** Improve controls to ensure that the State agency validates DME suppliers' billing privileges before paying them.	We concur with this finding. The Agency will initiate recoupment activities on the 31 providers identified during the audit. The Agency will also implement processes to identify DME providers terminated by CMS and take appropriate action. Over the past year, our MPI field offices have reviewed the weekly terminations list to try and identify terminated DME providers in their area. However, with only a business name and city/state data to go on, locating the providers has proven difficult. If staff is able to confirm that the business identified on the termination list is an active Medicaid provider, then payment review actions would be initiated. The state is currently working with CMS to identify a database that contains sufficient identifying information to enable the application of administrative action.	March 1, 2012 Mike Blackburn (850) 412- 3977