



*Office of the Inspector General  
Bureau of Internal Audit*

**Report No. 12-04  
June 2013**

## **Agency Accounts Receivable Process**

### **Executive Summary**

As part of the Agency for Health Care Administration's (Agency) fiscal year 2011-2012 audit plan, we conducted an audit of the accounts receivable processes within the Bureau of Finance and Accounting (F&A) and other areas of the Agency. The focus of this audit was to identify the main business processes, assess the adequacy of their internal control structures, and identify areas that could improve efficiency and effectiveness. We reviewed accounts receivable systems that included MAR, HAR, RARA, and OPC Track Billing<sup>1</sup>. We also reviewed the accounts receivables originating from HQA and maintained in Versa (a licensure enforcement tracking system).

Overall, the accounts receivable processes appear to have adequate internal controls and adhere to sound business practices. However, we noted areas where improvement could be made by F&A to strengthen controls and improve efficiency.

- In the new accounts receivable system, include a means of identifying MAR late payment dates and automatically generating notices if payments are not received by set deadlines.
- In the new accounts receivable system, include the ability to generate MAR reports that allow monitoring for payment timeliness. The reports should include information such as action taken, date of the action, date(s) the provider is overdue, the number of days an amount is overdue, and if the amount paid is in compliance with the amount owed.
- Clarify circumstances that are acceptable exceptions to the policy of sending MAR late payment notifications every 30 days.
- Consider an interface between MAR and the Florida Medicaid Management Information System (FMMIS) that would automatically populate provider information from FMMIS to create a more efficient case set-up process.
- Develop a written policy specifying how frequently the list of referrals should be sent to the collection agency.
- Reconcile information on the collection agencies' reports to the information on receivables in the MAR system.
- Finalize MAR payment plans in a timely manner by adopting a policy or guidelines that meets the approval of the Office of General Counsel limiting the number of negotiations allowed or setting deadlines for finalizing payment plan agreements.
- Expand the current Memorandum of Understanding with the Office of Attorney General's Medicaid Fraud Control Unit (MFCU) to clarify the roles and responsibilities between MFCU and F&A when handling restitution cases.

<sup>1</sup> OPC Track Billing was replaced by a new accounts receivable system as of March 1, 2013.

- In the new accounts receivable system, include accurate and relevant queries needed to produce reliable reports for OPC Track Billing and a way to ensure that appropriate and relevant data from previous billings are accessible for collections.
- In the new accounts receivable system, accommodate all receivable types so that various Agency units can discontinue the use of maintaining accounts receivables in Microsoft Excel (MS Excel).
- Maintain all Versa receivables in the new accounts receivable system, or include an interface between Versa and the new accounts receivable system, that would create an accounts receivable and record payments.

## **Scope, Objectives, and Methodology**

The scope of this engagement covered various accounts receivable processes within the Agency in effect during the 2011-12 fiscal year. Our objectives were to map out the current business processes, determine if proper internal controls are in place to govern the process, and determine if the processes utilized are efficient and effective. To accomplish our objectives, we reviewed applicable laws, rules, and regulations; interviewed appropriate Agency staff; reviewed policies, procedures, and related documents; observed and documented operations; and performed limited tests of internal controls. We reviewed accounts receivable systems that included MAR, HAR, RARA, and OPC Track Billing. We also reviewed the accounts receivables originating from HQA and maintained in Versa (a licensure enforcement tracking system).

We did not review the Medicaid County Billing process due to the changes being implemented by the Agency as a result of House Bill 5301, signed into law March 29, 2012. Detailed information on these process improvements may be found under the County Billing section of the report. In addition, we did not review processes of other receivables housed in FMMIS.

## **Background**

F&A is responsible for maintaining the Agency's accounts receivable accounts, which can be generated from various areas within the Agency. These areas include Medicaid, Medicaid Program Integrity (MPI) housed under the Office of the Inspector General, Office of General Counsel (OGC), and HQA. F&A utilizes four systems to maintain the accounts receivable accounts: MAR, HAR, RARA, and OPC Track Billing. HQA staff utilizes Versa to maintain other accounts receivables. The table below lists the accounts receivable type, its description, followed authority, responsible bureau and system used to maintain the accounts receivable type.

**Table 1: List of Accounts Receivable Types Reviewed by Internal Audit**

Accounts Receivable Type	Description	Authority	Bureau	System
MPI Abuse/Sanction Cases	Overpayments, fines and sanctions identified by MPI	Section 409.913, F.S.	F&A	MAR
Nursing Home Retro Cases	Overpayments to nursing homes based on rate adjustments	Chapter 409, F.S.	F&A	MAR
Fraud Restitution Cases	Payments owed by persons convicted or sentenced to pay restitution for Medicaid fraud	Section 409.920, F.S.	F&A	MAR
Third Party Liability (TPL) Cases	Payment plans for payments owed by certain providers as identified by vendor	Section 409.910, F.S.	F&A	MAR
Nursing Home Facility Quality Assessment Fee	Assessment fee collected from nursing home facilities	Section 409.9082, F.S.	F&A	RARA
Intermediate Care Facility for the Developmentally Disabled Quality Assessment Fee	Assessment fee collected from intermediate care facilities for the developmentally disabled	Section 409.9083, F.S.	F&A	RARA
Public Medical Assistance Trust Fund In Patient Assessment Fee	An annual assessment based on the hospital revenue for inpatient services	Section 395.701, F.S.	F&A	HAR
Public Medical Assistance Trust Fund Out Patient Assessment Fee	An annual assessment based on the hospital revenue for outpatient services	Section 395.701, F.S.	F&A	HAR
Hospital Data Collection Assessment	An annual assessment to finance data collection activities	Section 408.20, F.S.	F&A	HAR
OPC Review Fee	A fee assessed to review the plans for new facility construction	Section 395.0163, F.S.	OPC	OPC Track Billing MS Excel
Annual Facility Assessment Fee	An assessment on selected health care facilities to fund local health councils	Section 408.033, F.S.	F&A	HAR
HQA Final Orders	Sanctions for regulatory violations and infractions	Section 408.805, F.S.	F&A	HAR
Managed Health Care (MHC) Fines	The Bureau of MHC assesses fines due to late filing of reports and non-compliance with the contract.	Chapter 409, F.S.	F&A HQA – MHC	HAR Versa (to record the sanction) MS Excel
Hospital Surveys	Hospitals not accredited by an approved hospital accrediting organization are subject to a scheduled annual licensure survey.  Ambulatory surgical centers (ASCs) not accredited by TJC or AAAHC are subjected to a scheduled annual licensure survey by the Agency.  Birth Centers not accredited are subject to a scheduled annual licensure survey and a life safety survey by the Agency.	Section 395.0161, F.S. Rule 59A-3.253, F.A.C.  Ambulatory Surgical Centers: Rule 59A-5.004, F.A.C.  Birth Centers: Rule 59A-11.004(3), F.A.C.	HQA – Health Facility Regulation (HFR) – Hospital & Outpatient Unit	Versa
MHC Regulatory Assessments	The Bureau of MHC receives premium data from the Office of Insurance Regulation for Health Maintenance Organizations (HMO), Pre-Paid Health Clinics (PHC), and Exclusive Provider Organizations (EPO).	Sections 641.58(1) and 627.6472(14), F.S.	HQA-MHC	Versa MS Excel

**Table 1: List of Accounts Receivable Types Reviewed by Internal Audit**

Accounts Receivable Type	Description	Authority	Bureau	System
	AHCA collects up to .1% of premiums collected by the HMOs, PHC, EPOs, only collects on the state portion for Medicaid premiums, none for Medicare premiums, and 100% for commercial premiums.			
Organ, Tissue, and Eye Assessments	Fees specifically collected from organ procurement organizations, tissue and eye donor banks	Sections 408.805 and 765.544, F.S.	HQA - HFR - Laboratory License Unit	Versa MS Excel
Behavioral Health 80/20 Refunds	Health plans that provide Behavioral Health Services in non-reform counties must complete an Agency supplied template calculating whether or not the health plan expensed at least 80% of the capitation paid to it by AHCA for certain codes (targeted case management and community mental health services). Any plan not expending 80%, must refund the difference between actual expenditure and 80%.	Section 409.912(4)(b), F.S.	HQA - MHC	MS Excel
Debit Memorandums	Debit Memorandums are received from the State Treasurer's Office for returned checks due to non-sufficient funds, stop payments, or other issues noted by the bank.	Section 215.34, F.S.	F&A	MS Excel

**Findings and Recommendations**

**Finding 1: MAR Collection Efforts Are Impeded by Manual Monitoring of Receivables for Payment Activity**

To collect an accounts receivable, the MAR unit's procedures outline a series of escalating steps depending on the type of case. In cases where MPI identifies that a provider owes the Agency money due to an overpayment, fine, and/or other assessed cost, the provider is given 30 days from the date of receipt of a Final Audit Report<sup>2</sup> to make payment or payment arrangements. In the event of non-payment after 30 days, MAR staff can impose a lien (for the overpayment amount only) through FMMIS to deduct amounts from Medicaid claims scheduled to be paid. Next, the provider is sent a Final Order<sup>3</sup> by the Office of General Counsel which reflects the official amount owed; this includes overpayment, as well as any fine and assessed cost. In cases where an amount is due as a result of a nursing home overpayment, the MAR staff notifies the provider of the amount due with a letter. Interest may be assessed after 30 days of receipt of a nursing home overpayment notice. After 30 days, if a payment has not been received or payment arrangements made, the MAR staff will attempt to impose a lien against current claims if they have not already done so. If a lien cannot be successfully imposed, the MAR staff then sends collection letters to the provider. Written policy states that after three notification letters, the case may then be referred to a collection agency.

We determined that sometimes collection letters were sent less frequently than 30 days in our review of six cases that were ultimately referred to a collection agency. Our review identified instances where collection

<sup>2</sup> A Final Audit Report is sent to the provider by MPI outlining the amount of overpayment due as well as any sanctions and assessed costs.

<sup>3</sup> A Final Order is issued after a Final Audit Report. It becomes an official document when filed by the Agency Clerk. Interest can be assessed 30 days from the date of the Final Order.

letters were not sent every 30 days. F&A provided the following reasons why collection letters were not always sent within 30 days:

- Provider was involved in bankruptcy proceedings;
- Provider stopped payment and then restarted thus interrupting the late notification cycle;
- First collection notice was returned undeliverable requiring staff to take additional measures to track down a current address;
- Case was reassigned within MAR;
- Provider made a verbal repayment agreement which was later not honored;
- Provider requested a payment plan which was ultimately not successful; and
- Provider was not on a payment plan but still paid a portion of the payment due; thus staff was reluctant to send a collection letter since the provider paid some amount.

Although these circumstances result in reasons why a notice is not promptly sent every 30 days, we also determined that the lack of a more progressive monitoring system hindered collection efforts. To identify past due amounts, MAR staff periodically review their manual case files or, in some instances, spreadsheets developed to track the dates the collection letters are sent. MAR staff stated that “manual” monitoring of case payment information slows staff down in identifying when to send a notice. MAR staff may have case loads of over 150 cases that they must monitor for payment activity. The MAR system currently does not have the capability of notifying MAR staff when a payment is late or when they should send late payment notices. The system cannot flag cases where 30 days has passed from the last date a late payment notice was sent. Thus, the collection of payment is delayed.

Additionally, reports generated from MAR are limited in their ability to provide management with information about overdue cases. For example, the Aging Collections report will show a case status, such as “F&A Collection Notice to Provider,” and the date of last payment. It does not show the date the notices were sent to determine if a notice was sent timely or when the next notice is due. The report also has a field “FAL/FO Date” to show the date the Final Audit Report (FAR) or Final Order was sent. A Final Order generally follows a FAR. It is the official notice that yields the final amount owed by the provider. However, MAR staff cannot determine by looking at the field which event the report refers to, thus its use as a monitoring tool is limited. Finally, the report may show the date of last payment but it does not indicate if the required minimum amount is the amount paid. For example, a provider in a payment plan may owe \$500 every month on a payment plan but only pay \$200 a month.

## **Recommendations**

1. In order to send notification letters timely, we recommend the MAR unit clarify circumstances that are acceptable exceptions to their policy of sending late payment notification every 30 days.
2. We also recommend the new accounts receivable system include a means of identifying late payment dates and automatically generating notices if a payment has not been received by set deadlines.
3. We further recommend that the new accounts receivable system include the ability to generate reports that allow monitoring for payment timeliness. Such reports should include information that shows the chronology of Agency action taken (i.e. Final Order, FAR, notification letter), the date of that action, the date(s) the provider is overdue, the number of days an amount is overdue, and if an amount paid is in compliance with the amount owed.

## **Management Response**

1. The Medicaid Accounts Receivable (MAR) procedure manual has been updated with guidelines for sending notices to providers. Additionally, this has been discussed with MAR unit staff.  
*Anticipated date of completion: Completed*
2. Upon integration into the new accounts receivable system (AR), the MAR unit will be able to receive alert notifications, to review cases for past due notices, and be able to print electronically generated invoices. In the interim, the MAR staff is using Microsoft Outlook to set up automatic reminder alerts. *Anticipated date of completion: June 30, 2014*
3. The AR system currently has an account balance functionality that shows all outstanding receivables for a given entity. The AR system incorporates Change Data Capture (CDC) functionality in all SQL server database tables. The CDC stores the original state of a given record or records, changes made to those records and the state of the records after the changes. Once the project is developed to the point for MAR integration, this functionality will be available to MAR staff. *Anticipated date of completion: June 30, 2014*

## **Finding 2: MAR Case Set-up Could Be More Efficient by Importing Provider Information from FMMIS**

The MAR Unit tracks Medicaid receivables resulting from abuse, fraud, and overpayment. Abuse is defined as an unnecessary cost to the Medicaid program or reimbursement for goods or services not medically necessary. Fraud is the intentional misrepresentation by a person with knowledge that the action results in unauthorized benefit to that person or another person. Overpayment is any amount not authorized to be paid by Medicaid whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake.

To set up a receivable in MAR, staff enters provider information into the MAR system such as phone number, provider tax identification number, and provider type. This provider information is obtained from FMMIS. The amount of time to set up a case in MAR could be reduced if the system could automatically retrieve basic provider information from FMMIS. Currently, MAR staff must navigate between the two systems to enter information. Additionally, the possibility for error in inputting information exists when navigating between the two systems.

## **Recommendation**

To improve efficiency and expedite data entry, the new accounts receivable system should consider an interface that would automatically populate these fields from FMMIS.

## **Management Response**

When MAR is integrated into the new AR system the need for interfaces with other systems (FMMIS, FACTS, etc.) will be considered and addressed accordingly. *Anticipated date of completion: June 30, 2014*

### **Finding 3: Cases Designated for Referral to a Collection Agency May Be Delayed**

During our fieldwork, the Agency's policy was to send three collections letters to the provider and if no payment had been received, the MAR staff referred the case to the collections liaison within F&A. Section 17.20, Florida Statutes (F.S.) requires state agencies to refer unpaid cases within 120 days of the due date. However, during FY 2010-11, the Department of Financial Services granted the Agency an exemption from the 120-day requirement with regards to Medicaid cases. The Agency is allowed 365 days from the date a payment is initially due before the case should be referred to a collection agency. Even with this extension, it is still important to promptly refer cases to a collection agency to recoup owed monies.

Once cases were designated for referral to a collection agency, there were at times further delays until the actual referral. The liaison waited until there were several cases before referring the group of cases to the collection agency. In the past, cases have waited two to three months after they have been designated for referral before they were sent to a collection agency. As of October 2012, MAR staff are responsible for sending cases directly to the collection agencies. However, a written policy still does not exist specifying how frequently a case, once determined for referral, should be sent to the collection agency. A written policy would standardize and improve the efficiency of referrals.

#### **Recommendation**

In order to enhance prompt collection, we recommend F&A develop a written policy or guidelines that meet the approval of the Office of General Counsel specifying how frequently the list of referrals should be sent to the collection agency.

#### **Management Response**

The MAR unit has written procedures for cases to be referred to a collection agency. However, the procedures will be updated to better define the timeframes and frequency. *Anticipated date of completion: Completed*

### **Finding 4: Collection Agency Report Balances Did Not Agree with the Account Balances in the MAR System**

To ensure that the collection agencies have recorded and are collecting the correct amount owed to the Agency, F&A staff need to routinely check and compare the balances on the collection agencies' reports to the case balances in the MAR system. We selected nine cases to compare balances between the MAR system and the most recent collections agencies' reports. We found that the balances for all nine cases on the collection agencies' reports differed from the balances in the MAR system. We notified F&A staff of the discrepancy. Staff stated that they do not reconcile the balances and were not aware of the differences. During our review, they worked with the collection agencies to correct this problem. Incorrect balance information could result in collecting either more or less of the correct amount of money.

#### **Recommendation**

To ensure that cases referred to collection agencies are correctly recorded and their balances are accurate, we recommend MAR staff periodically reconcile the information on the collection agencies' reports with the receivables identified in MAR.

## **Management Response**

The MAR unit will identify and reconcile all cases referred to the collection agencies to ensure accurate balances. We are currently working with the collection agencies to provide us with data on our accounts, in the Collections Inventory Report. *Anticipated date of completion: June 28, 2013*

## **Finding 5: Payment Plan Finalization May Be Delayed**

The Agency conducts audits, investigations and other types of reviews of the Medicaid claims paid to providers in accordance with Section 409.913, Florida Statutes. In some cases when an overpayment is discovered a provider may be unable to pay the full amount of the Medicaid overpayment at one time. In these cases, the provider may request a payment plan. Section 409.913(25)(d), F.S. states that the agency, upon entry of a final agency order, a judgment or order of a court of competent jurisdiction, or a stipulation or settlement, may collect the monies owed by all means allowable by law. At the time of our fieldwork, a committee comprised of the Bureau Chief of F&A, the F&A Director, and applicable MAR staff reviewed the provider's request and if the repayment period was not acceptable, the committee provided a counter-offer. However, the committee did not document the reasons for their determinations. Now, a case summary form is prepared by MAR staff and reviewed by the MAR supervisor, the F&A Director, and the Bureau Chief of F&A for approval.

There are written procedures for payment plan agreements that outline how payment plans are to be established. These procedures specify the factors to be considered in approving the repayment period including the length of the audit period, the amounts of monthly claim payments, and the amount of the overpayment. Usually payment plans cannot exceed one year; however, exceptions are provided for cases of financial hardship. Providers requesting a payment plan that exceeds one year must submit copies of their tax returns to document the financial hardship.

Providers may choose to enter into either a payment plan or a lien agreement. Both options are formalized with a written agreement and amortization schedule detailing the amounts of principal and interest for each month. With a payment plan, the provider sends the Agency a check each month. In a lien agreement, the provider agrees to have a lien placed on their prospective Medicaid payments. The agreement will either establish a percentage to recoup (between 10 and 100%, provided that a minimum monthly payment is maintained) or set an amount to be recouped each week or month. The plans are reviewed by the committee members and signed by the Deputy Secretary of Operations.

Payment plan finalization, especially for Third Party Liability cases, may take several months from the initial request to the final plan document. The reasons payment plans may take time to finalize include:

- The payment plan request may not be timely;
- The provider may not provide requested documents such as tax records timely;
- Other communication may not be timely; and
- The provider and the Agency differ on the amount to be paid. Proposed payment plans, especially involving Third Party Liability providers, appear to go back and forth between F&A staff and providers numerous times before determining the weekly or monthly amount to be paid.

The MAR unit will impose a lien 30 days after the FAR is issued regardless of the time taken for negotiations.



While written procedures outline the factors considered in approving the payment plan, they may not be specific enough. Providers often want to repay the amount owed over a longer period of time than MAR staff deem acceptable. The MAR unit currently does not have a written policy for the number of days permitted or number of counter offers allowed before a payment plan agreement is approved which could result in extended negotiations. Payment plans should be finalized in a timely manner. Staff resources which are expended on lengthy plan negotiations could be put to better use.

### **Recommendation**

We recommend that F&A consider adopting a policy limiting the number of negotiations allowed or setting a deadline so that payment plans can be finalized more timely.

### **Management Response**

MAR has implemented processing limits at three attempts to secure a payment plan, before placing a lien or referring the case to collections. *Anticipated date of completion: Completed*

### **Finding 6: The Coordination of Restitution Cases Could be Improved between MFCU and F&A**

Restitution payments are made by persons convicted of Medicaid fraud or otherwise determined to owe restitution. The State of Florida's Attorney General's MFCU is involved in these cases. After the court determines the amount owed, MFCU sends the MAR unit a probation order, restitution order, or another court document or agreement that outlines the case information including the amount owed to the Agency due to Medicaid fraud. MAR staff set up a receivable in the MAR system using this information. If the payer is on court-ordered probation, monies are collected through the Department of Corrections' probation officers and sent to MFCU. Payment to the Agency is generally sent through a Journal Transfer from MFCU. If the defendant is sentenced to prison, MFCU may not receive any payments until the person is released. Both MFCU and the Agency maintain records of case balances and receipt of payment for these cases.

It is important to periodically reconcile balances between MFCU and the Agency to ensure that the case information is congruent between the two agencies. Additionally, responsibilities regarding collection efforts should be written and clearly defined between the two entities. We observed that coordination efforts between the two units could be improved. For example, at the time of our review, MAR staff and MFCU staff did not routinely review and compare lists of open MFCU case balances. While balances of certain cases may be discussed between the two units, there is no periodic reconciliation of all case balances involving restitution.

Additionally, both the Agency and MFCU staff told us that they make efforts to collect and refer delinquent restitution cases to a collection agency in the event of non-payment; however, this effort does not appear to be coordinated. When payments stop, MAR staff stated that they attempt to contact the person owing money. If payment is more than one year overdue, the Agency refers the case to a collection agency. However, MFCU staff also stated that they refer delinquent accounts to a collection agency. It does not appear that either unit communicates to the other when they refer a case to a collection agency. The possibility exists that both the Agency and MFCU could refer the same case to a collection agency and ultimately to DFS for write-off. MAR staff agreed that they need to meet with MFCU staff to clarify responsibilities of both units.

## **Recommendation**

To clarify the roles and responsibilities between MFCU and F&A, we recommend that the current Memorandum of Understanding be revised and signed specifying:

1. How often periodic reconciliations of open case balances should be performed and documented; and
2. A clarification of responsibilities for monitoring delinquent cases, contacting probation officers in cases of delinquent payment by probationers and referral to a collections agency for non-payment.

## **Management Response**

F&A will schedule a meeting with MFCU staff to discuss roles and responsibilities between MFCU and F&A staff. When integrating MAR into the new AR system, we will coordinate with MFCU staff to ensure both their needs and F&A needs are taken into consideration. *Anticipated date of completion: June 28, 2013*

## **Finding 7: Queries Used to Run Reports in OPC Track Billing Are Ineffective**

According to F&A staff, there is a lack of confidence in the accuracy of data in the reports run from the OPC Track Billing system due to outdated queries used to run reports. OPC Track Billing system does not have the capability to generate second notices and receipts cannot be tied to a specific invoice. In addition, fines have never been assessed on facilities that have not paid monthly bills or submitted late payments.

The Agency is establishing a new accounts receivable system and as of March 1, 2013, OPC billings and payments are processed in the new accounts receivable system. OPC houses data and F&A has access to the data to bill the facilities and produce reports. F&A is currently conducting a comprehensive data analysis and conversion process to identify and convert all outstanding receivables from respective legacy systems to the new accounts receivable system.

In order to effectively collect on past due accounts, the system must house accurate and reliable data. Inaccurate reports due to incorrect queries can lead to ineffective collections on accounts and loss of revenue. An effective accounting system should be able to: 1) Collect and store data about organizational activities, resources, and personnel; 2) Transform data into information that is useful for making decisions so management can plan, execute, control, and evaluate activities, resources, and personnel; and 3) Provide adequate controls to safeguard the organization's assets, including its data, to ensure that the assets and data are available when needed and the data is accurate and reliable.

## **Recommendations:**

We recommend:

1. The new accounts receivable system include accurate and relevant queries needed to produce reliable reports for OPC Track Billing.
2. The new accounts receivable system includes a way to ensure that appropriate and relevant data from previous billings be accessible for collections.

## Management Response

1. **F&A:** The new AR system uses modern technology to create, store and track data for accounts receivables and the capacity to write queries to produce accurate and relevant results, including reports, is an inherent feature of this technology. *Anticipated date of completion: Completed*

**HQA:** As of March 1, 2013, OPC Track Billing was replaced by the new AR system. The new AR system has access to the data in OPC Track and can produce accurate and relevant queries as well as reports from OPC Track; OPC staff has access to the queries and reports. *Anticipated date of completion: Completed*

2. **F&A:** The logic within the new AR system generates accounts receivables in a manner that ensures these items can be tracked throughout their lifecycle. *Anticipated date of completion: Completed*

**HQA:** The new AR system has access to the data in OPC Track and includes a way for the data from previous billings to be retrieved for collections. *Anticipated date of completion: Completed*

## Finding 8: Manual Processes

Some of the accounts receivable processes are very manual. Some processes include using Microsoft Word (MS Word) to bill for monies due to the Agency and MS Excel as the mechanism to track receivables. Other processes include both recording amounts due and payments in the software programs in addition to utilizing an information system to perform the same function. For example, because generated report data in the OPC Track Billing system is unreliable, F&A performs reconciliations using MS Excel by entering all payments made throughout the month, which is in addition to posting payments into the OPC Track Billing system. Below is a table identifying manual components of the accounts receivable processes.

**Table 2: Accounts Receivable Types with Manual Processes**

Receivable Type	Billing			Collections
	Invoice Type	Calculation Method	System	System Used to Record Payment
Debit Memos	Letter MS Word	MS Excel	None	MS Excel
Organ, Tissue, and Eye Assessments	Letter MS Word	Manual (calculator)	Versa Assessment Transaction	Versa Cash Module MS Excel
Behavioral Health 80/20 Refunds	Email Template	MS Excel	None	MS Excel
MHC Regulatory Assessments	Letter MS Word	Adobe Acrobat (PDF)	None	Versa Cash Module MS Excel
MHC Fines	Letter MS Word	Manual (calculator)	HAR Versa Complaint Module (to record the sanction)	HAR MS Excel
OPC	System generated invoice	System calculated	OPC Track Billing	OPC Track Billing MS Excel

There is no standard system to accommodate billing for all receivable types. The current systems include MAR, HAR, OPC Track Billing, and RARA. Versa, an enforcement tracking system, is also used to bill for certain accounts receivable accounts.

It is important to have an additional layer of security over information. Accounts should be maintained in a proper accounting information system to ensure proper maintenance and tracking. In addition, there is an

increased risk of human error, erroneous or intentional deletion of a payment and/or invoice, and accidental deletion of documents from the shared drive when accounts are maintained outside an accounting information system.

**Recommendation**

To improve efficiency and information security, we recommend the new accounts receivable system accommodate all accounts receivable types so that the areas can discontinue the use of maintaining accounts receivable in MS Excel.

**Management Response**

**F&A:** The goal is to incorporate all accounts receivable activity into the new system. *Anticipated date of completion: June 30, 2015*

**HQA:** HQA will work with F&A to address these issues as efficiently as possible within the existing resources. Within the resources available, the new AR system will exchange data electronically with Versa Regulation to capture accounts receivable. *Anticipated date of completion: December 31, 2013*

Receivable Type	HQA Action Plan
Organ, Tissue, and Eye Assessments	Adjust Versa to calculate assessment through a formula; AR system can pull assessment and generate an invoice and receivable.
Behavioral Health 80/20 Refunds	Adjust process to use Versa Cash module.
MHC Regulatory Assessments (Medical Loss Ratio)	Research similar processes like the submission of hospital financial data and assessments based on that data to potentially leverage existing systems to eliminate manual processing.
MHC Fines	Adjust process to use Versa Cash module.
OPC Track Billing	This has already been addressed.

**Finding 9: Use of Versa as an Accounts Receivable System**

Versa is a database management system used to assist the Agency in licensing facilities it regulates, inspecting the facilities, and tracking complaints filed against the facilities. Typically, units in HQA bear the responsibility of billing for receivables applicable to them. Versa is used as an enforcement vehicle for outstanding receivables because facilities cannot renew their licenses until all outstanding debts recorded in the system are settled. The following receivable types are tracked in the Versa:

- Hospital/Facility Surveys
- Organ Procurement Organization, Tissue Bank, and Eye Bank Assessments

Only payments are logged into the Versa Cash Module for the MHC Regulatory Assessments. The Complaint Module of Versa is used to record the sanction for MHC fines.

The invoicing and collections process for an accounts receivable should use an effective accounting information system which includes the following components:

- The people who operate the system and perform various functions;

- The procedures and instructions, both manual and automated, involved in collecting, processing, and storing data about the organization's activities;
- The data about the organization and its business processes;
- The software used to process the organization's data;
- The information technology infrastructure, including computers, peripheral devices, and network communications devices used to collect, store, process, and transmit data and information; and
- The internal controls and security measures that safeguard the data in the Accounting Information System.

Data should be collected and recorded only once wherever possible without the need for multiple systems. Not utilizing an effective accounting information system could result in an inadequate collections process because Versa is incapable of producing aging reports.

### **Recommendations**

We recommend:

1. The identified accounts be maintained in the new accounts receivable system instead of Versa.
2. As an alternative, F&A consider implementing an interface between Versa and the new accounts receivable system that would create an accounts receivable and record payments.

### **Management Response**

**F&A/HQA Response:** The two divisions will work together to address these issues as efficiently as possible within the existing resources to assure at a minimum that the Versa account receivable data is recorded in the new accounts receivable system. *Anticipated date of completion: June 30, 2014*

### **Finding 10: Revenue Management's Documentation Processes Are Inconsistent**

F&A's Revenue section has inconsistent verification practices in the collection procedures for the accounts receivable types. Policies and procedures are developed to manage certain risks and provide guidance, direction, and operational consistency. Without consistent policies and procedures, management creates a risk of non-compliance with reporting, inefficiencies due to the different amounts of time spent completing tasks various ways, and an increase in control gaps.

We noted the following:

- F&A's policies and procedures for revenue management differ depending upon the type of revenue received. The HAR Revenue procedures states, "Sign one copy of the Log Sheet and leave in Revenue Receiving Unit." However, the procedures for PMATF accounts, which are also entered in the HAR system, state "The Accountant I will sign and date both copies of the log sheets." The Debit Memo procedures do not state whether a check log should be signed. There is also no instruction on initialing or signing Returned Check FLAIR Code Sheets or separator pages.
- Our review of deposits from various accounts receivable types revealed that many forms were consistently missing required signatures/initials or were incomplete. Within the final deposit packet, we noted signatures/initials were missing from the Check Log Batch Report by Unit, the Transfer of

Cash Receipts sheet, and separator pages. We also noted that the Returned Check FLAIR Code Sheets found in the Debit Memorandum files were not filled out completely.

### **Recommendation**

We recommend F&A management and staff evaluate current processes and written procedures to identify process improvements such as updating and/or removing unnecessary forms.

### **Management Response**

Several policies, procedures and processes have been evaluated and updated. Processes and forms are being reviewed to insure consistency. Process improvement is continuously evaluated and is one of the most material determining factors in how F&A's current technology development projects are designed.

*Anticipated date of completion: June 30, 2014*

### **County Billing**

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Section 409.915, Florida Statutes, states that "Although the state is responsible for the full portion of the state share of the matching funds required for the Medicaid program, in order to acquire a certain portion of these funds, the state shall charge the counties for certain items of care and services as provided in this section." The County Billing Unit within F&A is responsible for invoicing and collecting payments from the 67 Florida counties for their share of Medicaid payments for inpatient hospital stays and nursing home charges.

Due to issues in the county billing process, disputes over determining the correct county of residence for Medicaid recipients and unpaid billings from all counties exceeding \$325 million as of December 31, 2011, the Florida Legislature passed House Bill (HB) 5301 which was signed into law by Governor Scott on March 29, 2012.

In collaboration with the Department of Children and Families, Department of Revenue (DOR), the Florida Association of Counties, and officials and staff from the 67 Florida counties, the Agency implemented the provisions in House Bill 5301 in two parts:

- A review and certification process of all outstanding claims from November 2001 through March 31, 2012 (retrospective claims); and
- A prospective claims process for certification, withholdings by the DOR and refund requests by the counties.

Agency management visited each county to conduct meetings to discuss the current Medicaid County Billing process and the new changes to the process as a result of HB 5301. These meetings included discussions on the process for certifying outstanding county billings.

For counties that had an unpaid invoice from November 2001 to March 2012, the counties either paid the full certified balance or entered into a five-year payment plan agreement with the Agency. The frequency of payments ranged from monthly to annually depending on the stipulation of the payment plan agreement.

HB 5301 also revised the methodology for determining a county's eligible recipients for the purpose of county contributions to Medicaid, the methodology of collecting those funds, and established guidelines for

counties to request refunds. The Agency implemented a process whereby counties could request an Advanced Refund Request (ARR) for disputed charges on a current bill. Current invoice amounts less the ARR amount and credits are certified by the Agency to DOR. Counties can also request a Back End Refund Request (BERR) for charges on the current invoice that were paid. Beginning June 2013, with May 2013 invoices, ARRs will no longer be accepted. Counties will be required to pay their invoices in full and continue to follow the BERR process to dispute charges. Counties can either pay their invoices directly to the Agency or DOR can withhold the invoice amount from their ½ cent sales tax.

F&A has established a good working relationship with DOR in the certification process and anticipates many improvements to the County Billing process with the implementation of HB 5301.

### **Final Comments**

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The Office of the Inspector General, Bureau of Internal Audit would like to thank the Agency's management and staff for their assistance and cooperation extended to us during this engagement.



**The Agency for Health Care Administration champions accessible, affordable, quality health care for all Floridians. The Inspector General's Office conducts audits and reviews of Agency programs to assist the Secretary and other agency management and staff in fulfilling this mission.**

This engagement was conducted pursuant to Section 20.055, F.S., in accordance with *International Standards for the Professional Practice of Internal Auditing* as established by the Institute of Internal Auditors. The engagement was conducted by Lillian Spell, CFE and Kathryn Voigt, CFE under the supervision of Mary Beth Sheffield, Audit Director, CPA, CIA, CFE. Please address inquiries regarding this report to the AHCA Audit Director by telephone at (850) 412-3978.

Copies of final reports may be viewed and downloaded via the internet at:  
[ahca.myflorida.com/Executive/Inspector\\_General/Internal\\_Audit/audit.shtml](http://ahca.myflorida.com/Executive/Inspector_General/Internal_Audit/audit.shtml)

Copies may also be obtained by telephone (850) 412-3978, by FAX (850) 487-4108, in person, or by mail at Agency for Health Care Administration, Fort Knox Center, 2727 Mahan Drive, Mail Stop #5, Tallahassee, FL 32308.