



Office of the Inspector General
Internal Audit

Report No. 13-10
November 2013

Provider Payment Suspension and Termination
Processes Review
Medicaid Fraud Prevention and Compliance Unit
Office of Medicaid Program Integrity

EXECUTIVE SUMMARY

At the request of the Communications Director, Internal Audit conducted a review of the Provider Payment Suspension and Termination Processes. The scope of this engagement covered the Office of Medicaid Program Integrity (MPI) and Medicaid's Fraud Prevention and Compliance Unit (FPCU) current provider payment suspension and provider termination processes and procedures. Our objectives were to review and identify inconsistencies in MPI's and FPCU's provider payment suspension and provider termination processes, evaluate their internal and external communications and information sharing processes, and make recommendations for improvement.

During this engagement, we interviewed the Deputy Secretary for the Division of Medicaid (Deputy Secretary) and senior management and staff from FPCU, Medicaid Contract Management (MCM), MPI, and Health Quality Assurance (HQA). We also reviewed state and federal laws as well as documents provided by management and staff.

To improve the efficiency and effectiveness of the provider payment suspension and termination processes, we recommend the implementation of the following:

1. All Agency for Health Care Administration (Agency) staff and external parties be instructed to refer any questionable or suspicious provider activity related to fraud or abuse to MPI.
2. The Agency continue to designate MPI as the Office tasked with detecting and investigating fraud and abuse pursuant to Section 409.913, Florida Statutes (F.S.).
3. As the Agency continues to review the organizational structure and duties related to implementing Statewide Medicaid Managed Care (SMMC), Agency management should review perceived areas of overlap between FPCU and MPI, taking into account MPI's statutory duties, to identify opportunities to realign unit functions and increase coordination.
4. FPCU establish written policies and procedures for processing contractual terminations¹ which address:
 - When to assign providers to pre-payment review (PPR), requiring all PPR requests associated with a contractual termination be reviewed and approved by the Fraud Liaison's immediate supervisor and if a provider is not assigned to PPR, documenting the reasons why.
 - Approvals for contractual termination, deactivation², and stacking³ requests.

¹ For the purposes of this report, a contractual termination is defined as an involuntary termination without cause initiated by the Agency and processed by FPCU via a contractual termination request memo.

² A deactivation request is defined as a request to add a termination code to the FMMIS profile of a registered treating Medicaid provider, done via a deactivation request memo processed by FPCU.

- Documenting communications with applicable Agency staff regarding proposed contractual termination requests and the resulting decision.
5. Medicaid adopt a communications policy (with input from MPI and in consultation with the Communications Director) to assist in the prevention of premature information disclosure to third parties regarding “with cause” and “without cause” terminations. Senior management and the Communications Director should approve the policy. Medicaid should also educate all employees on inappropriate information disclosure to third parties.
 6. The Prevention and Provider Focus Sub-committee of the Fraud Steering Committee develop written procedures to guide Medicaid in evaluating the enrollment of providers with previous contractual terminations.

Our concerns, recommendations, and management's responses can be found in the Concerns, Recommendations, and Management Responses section of this report on page 3. Also, though not required, MPI's response to the concerns and recommendations can be found in Exhibit I.

SCOPE, OBJECTIVES, AND METHODOLOGY

The scope of this engagement covered MPI's and FPCU's current provider payment suspension and provider termination processes. Our objectives were to review and identify inconsistencies in MPI's and FPCU's provider payment suspension and provider termination processes, evaluate their internal and external communications and information sharing processes, and make recommendations for improvement.

To accomplish our objectives, we interviewed senior management and appropriate FPCU, MCM, MPI, and HQA staff; reviewed state and federal laws; and documents provided by management and staff.

INDEPENDENCE

Pursuant to Section 20.055, F.S., this engagement was performed under the direction of the Audit Director and conducted in accordance with the *International Standards for the Professional Practice of Internal Auditing (Standards)* as established by the Institute of Internal Auditors. These *Standards* require us to be organizationally independent and objective in the performance of our work. However, since MPI and Internal Audit both report organizationally to the Office of Inspector General, we are required to disclose this potential impairment to our independence and objectivity. Except for the noted impairment, we have adhered to the *Standards* of our profession in conducting this engagement.

BACKGROUND

The Agency has a duty to uphold the integrity of the Medicaid program by admitting providers with the highest quality and ethical standards into the program. Providers that violate any

³ A stacking request is defined as a request to add a termination code to the Florida Medicaid Management Information System (FMMIS) profile of an inactive Medicaid provider, done via a request memo processed by FPCU.

provision of Section 409.913(15), F.S., can be subjected to sanctions⁴ ranging from monetary penalties to termination (termination with cause) from the Medicaid program. Also, the Agency has a right to cancel the Medicaid contract with providers at any time (contractual termination).

Terminations with cause may be based upon fraud, integrity, or quality of services. A termination with cause does not include a termination as a result of provider inactivity. In addition, it does not include any voluntary action by a provider to end participation in the Medicaid program, except where the action is taken to avoid a sanction. With cause terminations results in a final order with administrative hearing rights.

The Agency reports all providers who were terminated with cause from the Medicaid program to the United States Department of Health and Human Services (HHS) Office of Inspector General (OIG). A termination with cause from the Medicaid program lasts for 20 years. The following parties are copied on terminations with cause sent to providers:

- Chief of MPI
- Finance and Accounting
- MCM AHC Administrator for Provider Services
- HQA
- Medicaid Health Systems Development
- Applicable License Regulating Agency
- HHS OIG

In addition, the Agency or the provider can end their written agreement with one another without cause. According to the "Termination for Convenience" clause of the Medicaid Provider Agreement, either party may terminate the agreement without cause upon thirty (30) days written notice to the other party. The following parties are copied on contractual termination letters sent to providers:

- Applicable Medicaid Area Office (AO)
- General Counsel
- Chief of MPI
- Accounting Services Supervisor II, Finance and Accounting, Medicaid Accounts Receivable Unit
- Senior Management Analyst Supervisor, MCM Financial/Audit Unit

With cause and without cause terminations can be accompanied by a provider payment suspension. There are two methods which the Agency can prevent a provider from receiving timely payments for services rendered: 1) PPR⁵ and 2) 25(a) pend⁶.

⁴ Sanction is any monetary or non-monetary disincentive imposed pursuant to Administrative Rule 59G-9.

⁵ Section 409.913(3), F.S. provides for prepayment review of provider claims "...to ensure that billing by a provider to the agency is in accordance with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accordance with federal, state, and local law; and to ensure that appropriate care is rendered to Medicaid recipients."

CONCERNS, RECOMMENDATIONS, AND MANAGEMENT RESPONSES

Concern 1: Overlap of Job Functions

As outlined in the Long Range Program Plan for FY2012-13 through FY2016-17, the Agency's goals by priority are:

1. To operate an efficient and effective government;
2. To reduce and/or eliminate waste, fraud, and abuse (MPI is primarily designated as the Agency program associated with achieving this goal); and
3. To assure access to quality, and reasonably priced health services.

During our review of the duties and objectives of FPCU and MPI, we noted instances where there appears to be a duplication of objectives and job functions. For example, two of FPCU's program oversight and compliance objectives, as listed in the *FPCU FY 12-13 Summary Workplan*, are to detect and prevent fraud; and recover overpayments. To help detect and prevent fraud, FPCU conducts provider pre-enrollment and monitoring reviews and on-site reviews throughout the State regarding high-risk programs/provider types. However, MPI is also tasked with combatting fraud and abuse in the Medicaid program by addressing detection and prevention activities, as well as recovering improper payments to Medicaid providers in accordance with Section 409.913(2), F.S. To accomplish its objectives, MPI utilizes detection analyses, fraud and abuse prevention activities, audits and investigations, imposition of sanctions and referrals to the Medicaid Fraud Control Unit (MFCU) of the Office of the Attorney General, the Department of Health and other regulatory and investigative agencies.

To assist in the recovery of overpayments, FPCU's workplan identified a goal of increasing the number of voluntary self-audits by providers and increasing referrals to MPI (e.g. self-audits, overpayments, coverage limitation projects). However, MPI has a Generalized Analysis/Self-audit unit responsible for conducting computer-assisted reviews of potential Medicaid policy abuse by providers. The unit assists providers conducting self-audits by pulling sample claims, reviewing supporting documentation (medical records) of the sample claims, and validating the overpayment amount submitted by providers.

In addition, MPI's Field Operations unit employees are responsible for conducting comprehensive on-site visits and performing recipient interviews to determine whether Medicaid services were appropriate and/or actually rendered. Based on observations during site visits and reviews of records, MPI can take any one of the following actions:

- Apply for an administrative sanction
- Place a provider on prepayment review
- Initiate a paid claims reversal
- Refer a case to MFCU
- Refer a case to the MPI case management unit

⁶ Section 409.913(25)(a), F.S. states that "The agency shall withhold Medicaid payments, in whole or in part, to a provider upon receipt of reliable evidence that the circumstances giving rise to the need for a withholding of payments involve fraud, willful misrepresentation, or abuse under the Medicaid program, or a crime committed while rendering goods or services to Medicaid recipients."

- Refer a case to another agency
- Refer a case to the self-audit unit to initiate a provider self-audit
- Recommend provider termination

Effective June 17, 2013, MPI no longer makes recommendations for contractual terminations to Medicaid. MPI forwards provider information to FPCU, which is responsible for determining the appropriate actions.

Finally, a FPCU workplan objective for Statewide Medicaid Managed Care (SMMC) is to identify and improve monitoring of the Managed Care Organizations (MCO) efforts to prevent and detect fraud. However, MPI has a Managed Care Unit also dedicated to ensuring and monitoring MCO compliance with fraud, waste and abuse contract requirements. MCOs are required by F.S.⁷ to submit an anti-fraud plan addressing the detection and prevention of overpayments, abuse, and fraud to MPI for approval. MCOs must also report all suspected or confirmed instances of provider or recipient fraud or abuse and the implementation of an anti-fraud plan to MPI.

Ensuring clear, specific, and non-overlapping job functions assists the Agency's goal of improving efficiency and effectiveness and avoids confusion among the MCOs regarding which unit to contact concerning fraud and abuse.

Recommendations:

1. We recommend that Agency staff and external parties be instructed to refer any questionable or suspicious provider activity related to fraud or abuse to MPI and the Agency continue to designate MPI as the Office tasked with detecting and investigating fraud and abuse pursuant to Section 409.913, F.S.
2. As the Agency continues to review the organizational structure and duties related to implementing SMMC, we recommend Agency management review perceived areas of overlap, taking into account MPI's statutory duties, to identify opportunities to realign unit functions and increase coordination between FPCU and MPI.

Management Response:

1. Agree but note that this is done on a routine basis through many methods and needn't be further tracked as it is ongoing. Furthermore, where it is not clear whether a matter is related to fraud and abuse (vs. non-compliance) Medicaid staff are encouraged to discuss the matter with the FPCU to assist. *Anticipated Completion Date: Completed and on-going.*

⁷ Section 409.91212(1), F.S. states that "Each managed care plan, as defined in s. 409.920(2)(e), shall adopt an anti-fraud plan addressing the detection and prevention of overpayments, abuse, and fraud relating to the provision of and payment for Medicaid services and submit the plan to the Office of Medicaid Program Integrity within the agency for approval."

Section 409.91212(4), F.S. states that "On or before September 1 or each year, each managed care plan shall report to the Office of Medicaid Program Integrity within the agency on its experience in implementing an anti-fraud plan, as provided under subsection (1), and, if applicable, conducting or contracting for investigations of possible fraudulent or abusive acts as provided under this section for the prior state fiscal year."

2. Agree but also state that the statutory duties referenced are Agency duties and the Division of Medicaid should continue to be mindful of fraud prevention as we implement SMMC. *Anticipated Completion Date: Completed and on-going.*

Concern 2: Procedures for Contractual Terminations and Payment Suspensions

FPCU does not have written procedures for terminating a Medicaid provider contract or suspending provider payments during a contractual termination.

The Fraud Liaison, however, has drafted a “Protocol Regarding Payment Suspensions (PPR or 25A) with Provider Terminations” document. This process relates only to sanction-based and contract terminations. The protocol states the following:

- “The purpose of this process is to ensure consistency of imposing payment suspensions with provider terminations...”
- Contract terminations are processed through the Fraud Liaison, routed to the Medicaid Director, and then to MCM for implementation in FMMIS. A termination notice letter, signed by the Chief of MCM, is issued.
- If not already in place, at the point of approval by the Medicaid Director, MPI or the Fraud Liaison (determined by the source of the recommendation - MPI or Medicaid) will initiate a payment suspension utilizing one of two statutory authorities⁸, considering the facts of the case and which statute is applicable.

The protocol identified instances when a payment suspension would not be imposed such as when it would not be in the best interest of the Medicaid program. Considerations include the projected impact on recipients’ access to care and the availability of other providers to render the same or similar services. Although the protocols address contractual terminations and payment suspensions, they appear to be a summary of the process and not step-by-step written procedures for recommending contractual terminations and imposing payment suspensions.

The Fraud Liaison also drafted the “Protocol Regarding Payment Suspensions (25A) with MFCU referral” which describes MPI’s role and duties in referring cases to MFCU; however, these activities do not appear to be related to duties of FPCU.

Policies and procedures are developed to manage certain risks and provide guidance, direction, and operational consistency. Having written procedures prevents mistakes, saves time, ensures consistency, and improves quality. Clear and detailed written policies and procedures will avoid workplace communication problems before they begin. Other advantages of having procedures include a reduced learning curve for training for new employees, business continuity, standardized processes, and more efficient time management.

Recommendations:

We recommend the FPCU establish written policies and procedures for processing contractual terminations⁹ and assigning Medicaid providers for PPR when contractually terminating them. These policies and procedures should address when to assign providers to PPR, require review and approval by the Fraud Liaison’s immediate supervisor for all PPR requests, and require documentation of reasons why a provider is not assigned to PPR.

⁸ 25A Pend and PPR. See Footnote 5 and 6.

⁹ See Footnote 1.

Management Response:

Agree to written policies and procedures but do not agree that the policies and procedures should require approval of PPR assignment, rather, should require approval when PPR will not be assigned concurrent with a termination. *Anticipated Completion Date: January 1, 2014.*

Concern 3: Policies on Approving Contractual Termination, Deactivation, and Stacking Requests

Contractual terminations, deactivations, and stacking requests were requested through a memo addressed to the Medicaid Deputy Secretary. The memo requires the Medicaid Director's signature indicating approval/disapproval of the request. We reviewed FPCU's September 2012 spreadsheet that tracked contractual termination, deactivation, and stacking requests, as well as the corresponding request memos. We noted that the Deputy Secretary approved all contractual termination requests for active providers while the Fraud Liaison approved all deactivation and stacking requests on behalf of the Deputy Secretary (See Table 1). The Fraud Liaison stated that there is an unwritten policy that delegates the Fraud Liaison to approve deactivation and stacking requests.

The duties of initiating an action, approving an action, and recording an action should be separated. Risks include performance of unauthorized actions, and senior management not being fully informed of actions taken.

Table 1: Final Approval by Initiating Department and Type of Request

Requesting Department	Contractual Termination Request		Deactivation Requests		Stacking Requests	
	FPCU Approval	Deputy Secretary Approval	FPCU Approval	Deputy Secretary Approval	FPCU Approval	Deputy Secretary Approval
MPI	-	5	-	-	16 ¹⁰	-
FPCU	-	4	1	-	-	-

¹⁰ Includes one denial request (Deny-Best Interest). The previous status code in FMMIS was Deny-Incomplete Enrollment. MCM is responsible for denying provider enrollment applications.

Recommendation:

We recommend Medicaid develop a written policy for approving contractual termination, deactivation, and stacking requests.

Management Response:

The aforementioned policies and procedures will address, generally, when a termination, deactivation, and stacking recommendation will be processed. No further policy will be written. *Anticipated Completion Date: January 1, 2014.*

Concern 4: Review and Communication of Proposed Contractual Terminations

The Agency has a major responsibility in ensuring access to quality of care for all Floridians including Medicaid recipients. In fulfilling that responsibility, effort should be taken to make sure that unsuitable providers are banned from participation in the Medicaid program.

HQA and Medicaid hold a weekly facility actions meeting. Representatives from HQA Field Offices, FPCU, MPI, MCM, the Bureau of Health Facility Regulation, and the HQA Deputy Secretary's Office attend the meeting. Discussions during the meetings are focused on:

- Any issues with HQA-licensed facilities including facility closures;
- Any issues with Medicaid providers including sanctions and final order terminations;
- Updates/outcomes of any investigations and site visits; and
- Decisions made to suspend/terminate a provider or suspend/revoke a facility's license.

However, we noted that FPCU does not hold weekly meetings with applicable Agency staff to discuss proposed contractual terminations and payment suspensions. The Medicaid Fraud Liaison stated that participating in periodic meetings to discuss Medicaid provider contractual terminations may become more burdensome than productive. Scheduling a weekly meeting to discuss numerous contractual terminations would require attendance from various policy experts within Medicaid Services, essentially pulling those employees away from their primary job functions. Currently, FPCU processes contractual terminations on a case by case basis by seeking individual guidance from policy experts in Medicaid Services as well as input from MPI and Medicaid AO. FPCU may obtain this guidance through telephone calls, emails and face-to-face discussions with appropriate staff. Communication between departments is essential to manage, create, and sustain organizational operations and avoid inefficiencies.

Recommendations:

1. We recommend that the FPCU develop written policies and procedures for communicating with applicable Agency staff regarding proposed contractual termination requests.
2. We recommend that FPCU document the decision making process for contractual terminations.

Management Response:

1. The aforementioned policies and procedures will address, generally, who will be involved in the communication regarding a termination recommendation. No further policy will be written. *Anticipated Completion Date: January 1, 2014.*
2. All contractual terminations are carried out through written memo. No further/additional documentation will be prepared unless requested by the Medicaid Director (or other Agency management) on a case by case basis. *Anticipated Completion Date: Completed.*

Concern 5: Communication with Third Parties

In carrying out job duties related to the Agency's mission, there is a risk that employees may erroneously or prematurely disclose sensitive information to third parties. An example includes furnishing health plans with information on investigations of fraud and abuse of providers applying to a health plan's network. The Fraud Liaison drafted, "Prohibited Communications Regarding Provider Enrollment Status and Investigations" document, which provides guidance on disclosing sensitive information.

The Florida Legislature passed an Anti-Fraud bill, HB939/SB844, in April 2013. The bill sought to enhance Medicaid provider controls and increase provider accountability. An important provision of the bill included issues related to information sharing. Section 409.920(8), F.S. will extend immunity from tort liability for persons reporting or sharing information on Medicaid fraud or program abuse. Section 409.920(8), F.S. will now state:

"Such immunity extends to reports of fraudulent acts or suspected fraudulent acts conveyed to or from the agency in any manner, including any forum and with any audience as directed by the agency, and includes all discussions subsequent to the report and subsequent inquiries from the agency, unless the person acted with knowledge that the information was false or with reckless disregard for the truth or falsity of the information."

All employees should take careful consideration in disclosing any information to third parties. In ensuring that providers are monitored in order to deter fraud and abuse, employees must be careful not to provide information about fraud or suspected fraudulent acts without regard for the truth. Disclosing sensitive information carelessly or inappropriately, even if it does not rise to a level of "reckless disregard for the truth or falsity of information", increases the risk of lawsuits to the Agency and clouds the Agency's reputation.

Recommendations:

1. We recommend that Medicaid (with input from MPI and in consultation with the Communications Director) adopt a communications policy to assist in the prevention of premature information disclosure to third parties regarding with cause and without cause terminations. This policy should be approved by senior management and the Communications Director.
2. We recommend that Medicaid educate all employees on inappropriate information disclosure to third parties.

Management Response:

FPCU will work with the OIG as we write a communication protocol. FPCU staff has already prepared a draft and is awaiting comments from MPI. *Anticipated Completion Date: January 1, 2014.*

Concern 6: Enrollment Process for Providers with Previous Contractual Terminations

A provider that has been terminated for reasons other than inactivity from the Medicaid program must:

1. Submit a new provider enrollment application (including a new fingerprint card);
2. Meet all provider qualifications; and
3. Include the prior name or tax identification (ID) number with the application if the provider is applying under a different name or different tax ID number.

During the enrollment process, the fiscal agent forwards applications of providers with previous contractual terminations (not including terminations due to inactivity) to MCM for approval. An analyst from MCM will consult with the original party that initiated the termination and subsequently make a determination on the provider's enrollment eligibility. Even though there is a specified duration for with cause terminations (20 years), the length of an involuntary contractual termination is indefinite. There are no guidelines or criteria to reference when considering the enrollment eligibility of providers with previous contractual terminations on file.

A previously contractually terminated provider may improve prior deficiencies and meet the requirements and standards of becoming a Medicaid provider in the future. The Agency should establish guidelines for evaluating these providers and determining the level of risk for enrollment into the program.

Recommendations:

We recommend the Prevention and Provider Focus Sub-committee of the Fraud Steering Committee develop written procedures to guide Medicaid in evaluating the enrollment of providers with previous contractual terminations.

Management Response:

The Sub-committee is working on this. *Anticipated Completion Date: July 1, 2014.*

FINAL COMMENTS

Internal Audit would like to thank the management and staff of the Medicaid Fraud Prevention and Compliance Unit, Office of Medicaid Program Integrity, Bureau of Medicaid Contract Management, and Health Quality Assurance Bureau of Field Operations for their assistance and cooperation extended to us during this review.

Exhibit I: MPI's Response to Concerns and Recommendations




RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

MEMORANDUM

TO: Lillian Spell, Office of Internal Audit

FROM: Rick Zenuch, Chief, MPI 

DATE: 10/11/2013

SUBJECT: Report No. 13-10 Provider Payment Suspension Termination Process Review

Ms. Spell,

Thank you for the preliminary report briefing provided by you to members of my staff on this review. MPI would like to offer the following observations on pertinent findings, which are related to MPI.

Concern 1: Overlap of Job Functions

Recommendations:

1. We recommend that Agency staff and external parties be instructed to refer any questionable or suspicious provider activity related to fraud or abuse to MPI and the Agency continue to designate MPI as the Office tasked with detecting and investigating fraud and abuse pursuant to Section 409.913, F.S.

We agree with this finding and would offer that the existence of any unit within the Agency other than MPI which has "Fraud" within their unit title or any part of their defined duties creates confusion, both internally and externally. We find that to be the case even with formal relationships with other agencies such as the MFCU. Even though the MOU designates MPI as the Agency liaison between the two, it appears that members of the FPCU communicate directly with the MFCU, without consultation or coordination with MPI.

2. As the Agency continues to review the organizational structure and duties related to implementing SMMC, we recommend Agency management review perceived areas of overlap, taking into account MPI's statutory duties, to identify opportunities to realign unit functions and increase coordination between FPCU and MPI.

We agree with this finding and believe that any appropriate duties related to fraud, waste and abuse within the Medicaid system should be relegated to MPI.

Concern 4: Review and Communication of Proposed Contractual Terminations

Recommendations:

1. We recommend that the FPCU develop written policies and procedures for communicating with applicable Agency staff regarding proposed contractual termination requests.
2. We recommend that FPCU document the decision making process for contractual terminations.

We agree with these findings and would suggest that any process for a contractual termination of a provider include consultation with MPI so as to not jeopardize an on-going audit or investigation.

Concern 5: Communication with Third Parties

Recommendations:

1. We recommend that Medicaid (with input from MPI and in consultation with the Communications Director) adopt a communications policy to assist in the prevention of premature information disclosure to third parties regarding with cause and without cause terminations. This policy should be approved by senior management and the Communications Director.
2. We recommend that Medicaid educate all employees on inappropriate information disclosure to third parties.

We agree with these findings. The FPCU currently holds a quarterly information exchange meeting with the MCO anti-fraud units. This meeting, in and of itself supports Concern #1 and leads to confusion among the plans as to whom to report fraud related information. MPI has concerns over the solicitation of MCO fraud case activity and the ultimate dissemination of that information by the FPCU during these meetings, without clear policy and protocols. We suggest that MPI assume responsibility for conducting these quarterly anti-fraud meetings with the MCOs, for the purpose of establishing strong relationships between the MCO anti-fraud units and MPI, as well as eliminating multiple points of contact within the Agency for fraud related issues among the plans.



The Agency for Health Care Administration's mission is Better 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 review was conducted pursuant to Section 20.055, Florida Statutes and in accordance with the *International Standards for the Professional Practice of Internal Auditing* as established by the Institute of Internal Auditors. The review was conducted by Lillian Faye Spell, CFE, CIGA under the supervision of Mary Beth Sheffield, Audit Director, CPA, CIA, CFE, CIG. Please address inquiries regarding this report to the AHCA Audit Director by telephone at (850) 412-3978.

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