



**Office of the Inspector General**  
*Internal Audit*

**Report No. 13-12**  
**March 2014**

**MCM Provider Enrollment Process Audit**  
Bureau of Medicaid Contract Management  
Provider Enrollment Unit

## **Executive Summary**

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As part of the Agency for Health Care Administration's (Agency) fiscal year 2012-2013 audit plan, we conducted an audit to determine the efficiency and effectiveness of the provider enrollment process for Health Practitioner Services (HPS) applications reviewed by the Provider Enrollment Unit (Unit) within the Bureau of Medicaid Contract Management (MCM).

Overall, MCM's provider enrollment process appears to have adequate internal controls and adheres to sound administrative practices. Ninety-four percent (94%) of HPS applications were processed in 60 days or less and forty-seven percent (47%) of HPS applications were processed in 14 days or less.<sup>1</sup>

However, we noted some weaknesses in the areas of monitoring and administration where improvement could be made by MCM to strengthen controls and increase efficiency. These weaknesses resulted in applications exceeding prescribed MCM review processing times due to background screening delays, change orders left in "MCM Review" status because no MCM analyst was assigned the task (i.e. "orphan" tasks), file mix-ups where an application is assigned to either the wrong analyst or linked to the wrong provider identification number, and delays in application reviews or file maintenance.

MCM has already strengthened some controls in the provider enrollment process. We recommend that the Unit continue to improve and strengthen controls that would enhance efficiency and prevent delays in the application review process by implementing the following:

- Require a monthly report or establish performance measures to track MCM review processing times.
- Establish a written policy for MCM review processing times.
- Continue to require all MCM analysts to utilize the reporting functions in iTRACE (Information Tracking Repository and Collaboration Exchange) to regularly track applications assigned to them.
- Continue to require the fiscal agent to conduct periodic monitoring to detect "orphan" tasks that are showing up under "MCM Review" status.

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<sup>1</sup> See Tables 1 and 2. There is a 60 day processing time for MCM reviews involving site surveys and 14 days for all other MCM reviews. We excluded anomalies (i.e. < 0 processing days).

- Require the fiscal agent to conduct periodic monitoring to detect applications in Return to Provider (RTP) status or have been sent to the wrong analyst for review, and are showing up under “MCM Review” status.
- Run a weekly report to identify tasks due within the week to alert both analysts and supervisors, and require monitoring of analysts at regular intervals to help ensure applications are handled appropriately and in accordance with processing time frames.

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

The scope of the audit covered an examination of HPS applications referred for MCM review<sup>2</sup> that resulted in enrollment or denial during the period July 1, 2012 through December 31, 2012. Our objectives were to determine the efficiency and effectiveness of the MCM review process utilized when a Medicaid enrollment application is referred for MCM review.

To accomplish our objectives, we reviewed applicable laws, rules, and regulations; interviewed staff of the MCM Provider Enrollment Unit; reviewed established or stated policies, processes, procedures, contracts, and related documents; observed and documented operations; reviewed records, reports, and other applicable documentation; and reviewed a sample of applications that exceeded the prescribed MCM review processing time.

## **Background**

The MCM Provider Enrollment Unit under the Division of Medicaid works in conjunction with the Medicaid fiscal agent to enroll Medicaid providers. The Florida Medicaid Management Information System (FMMIS) is the information system currently utilized to enroll providers, reimburse providers, and maintain eligibility and provider enrollment data. The FMMIS Provider functional area is used to research and maintain provider records and contains all relevant provider information, including provider identification numbers, owners, affiliations, billing agents, locations, specialties, addresses, contacts, email addresses and background screening status. Access to the Provider functional area is limited to the fiscal agent and Agency staff authorized to work with or view provider master files.

In order to receive Medicaid reimbursement, a provider must be enrolled into the Medicaid program and meet all the requirements and qualifications set forth in the Florida Medicaid Coverage and Limitations Handbooks incorporated by reference in Rule 59G-4, Florida Administrative Code (F.A.C.), Medicaid enrollment forms incorporated by reference in Rule 59G-5.010, F.A.C., and the legal requirements set forth in Section 409.907, Florida Statutes (F.S.).

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<sup>2</sup> Due to background screening, site surveys, change of ownership, U.S. Department of Health and Human Services, Office of the Inspector General (HHS/OIG) exclusions, and previous terminations and denials.

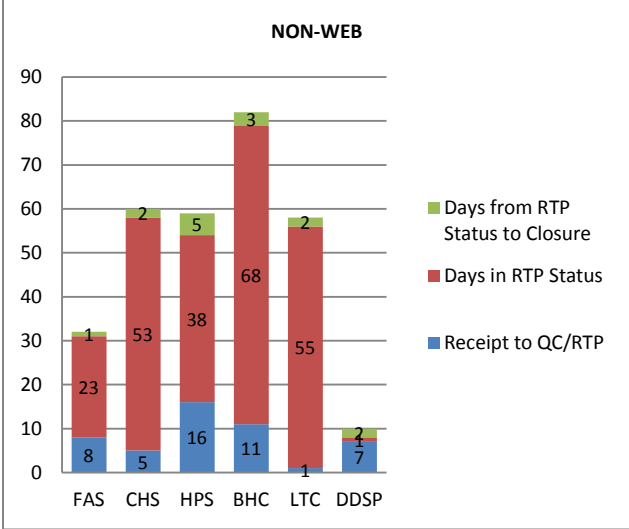
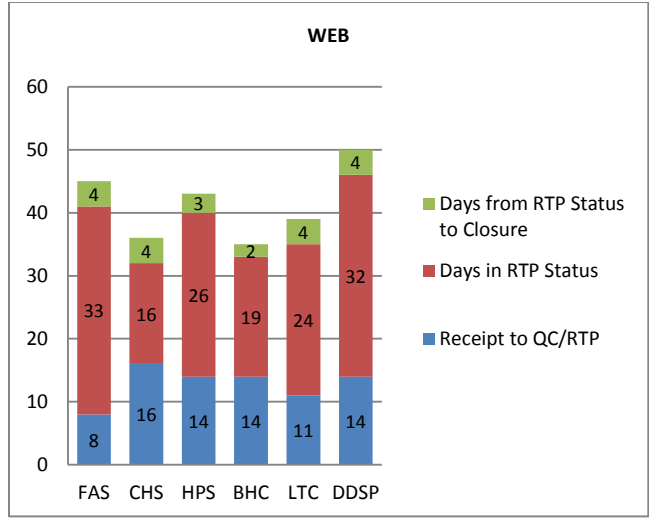
The Unit is responsible for reviewing Medicaid provider applicant eligibility for all applications that require state review before activation. These include all applicants with: previous terminations, HHS/OIG exclusions, changes of ownership, and suspended payments from Medicare. The Unit also reviews background screening and surety bonding, performs address verifications, and verifies Medicare and other certifications. In addition, the Unit obtains all court documents showing the dispensation of any criminal charges identified, and coordinates annual site surveys with the Medicaid area offices.

The fiscal agent is responsible for receiving and processing applications for provider participation in the Florida Medicaid program, processing file maintenance (FM) requests, maintaining electronic provider files, and answering provider queries regarding enrollment-related matters.

Currently, fiscal agent activity is monitored and measured through the report card process and performance measures posted on the Agency’s internal dashboard. The dashboard tracks the number of applications, web and non-web, that are received, processed, and result in approval or denial. It also tracks the fiscal agent’s monthly processing time for each of the following provider type categories: Health Practitioner Services (HPS), Health Facility and Ancillary Services (FAS), Child Health Services (CHS), Behavioral Health Care (BHC), Long Term Care (LTC), and Developmental Disabilities and Special Programs (DDSP). Examples of recently posted application processing dashboard measures follow:

**Agency Dashboard Performance Measures  
Medicaid Provider Enrollment Application Processing Time  
October 2013**

Program	WEB			NON-WEB		
	Receipt to QC/RTP	Days in RTP Status	Days from RTP Status to Closure	Receipt to QC/RTP	Days in RTP Status	Days from RTP Status to Closure
FAS	8	33	4	8	23	1
CHS	16	16	4	5	53	2
HPS	14	26	3	16	38	5
BHC	14	19	2	11	68	3
LTC	11	24	4	1	55	2
DDSP	14	32	4	7	1	2



The fiscal agent report card developed by the Agency and tested by the fiscal agent monitors and measures the success of the fiscal agent’s performance on a monthly basis and results in a numeric score. The report card methodology utilizes sampling to determine if the fiscal agent has met standards outlined in the contract. The outcomes are reviewed by MCM and are approved or sent for corrective action.

### Provider Management Report Card Areas Measured:

#### Provider Enrollment Processing

- I. Enter provider's application into FMMIS within two (2) workdays of receipt.
- II. Process provider applications within seven (7) workdays of logging application in FMMIS. Measurement should start the next business day after item 1 is complete.
- III. Enroll and activate providers within two (2) workdays of the date the applications meet all requirements for enrollment including background screening and any state review.
- IV. Ensure all provider enrollment requirements were enforced and all data entry is accurate for applications activated during the audit month.
- V. Ensure entire application and supporting documentation are accurately imaged and viewable.
- VI. Document enrollments and send notice of enrollment to enrolled providers within five (5) workdays of completion of enrollment.

#### Provider Communications

- I. Respond to written provider inquiries in writing within five (5) workdays.
- II. Monitor calls for adherence to procedures and policy, noting quality and accuracy.

#### Provider Maintenance

- I. Complete accurately all provider file updates received from providers or the State within one (1) workday of receipt unless the State grants another time frame.

*Source: 2012 Fiscal Agent Report Card*

Since the fiscal agent application processing activity is tracked by both the report card and the dashboard measures, we focused our audit on the review process conducted by the Unit when the fiscal agent refers an application for MCM review. Neither the report card nor dashboard measures capture the Unit's processing time. MCM review is required for the following reasons:

- Approval for specific provider types
- Site surveys
- Change of ownership
- Previous background screening
- Reviews of applicants with previous adverse terminations

In addition an application is sent for MCM review if any of the individuals listed in the application have ever:

- Been convicted of a felony, had adjudication withheld on a felony, pled nolo contendere to a felony, or entered into a pre-trial agreement for a felony;
- Had any disciplinary action taken against any business or professional license held in this or any other state or surrendered a license in this or any state;
- Been denied enrollment, been suspended or excluded from Medicare or Medicaid in any state, or been employed by a corporation, business or professional association that has ever been suspended or excluded from Medicare or Medicaid in any state;
- Had suspended payments from Medicare or Medicaid in any state, or been employed by a corporation, business or professional association that ever had suspended payments from Medicare or Medicaid in any state;

- Owed money to Medicaid or Medicare that has not been paid; or
- Had ownership in any other Medicaid enrolled business.

We examined the MCM review process for the HPS provider category, which has the largest number of provider applications for non-institutional providers. Between July 1, 2012, and December 31, 2012, the Unit reviewed a total of 1,064 applications in the HPS category out of a total 2,451 applications which were enrolled or denied. The HPS category is comprised of physicians, podiatrists, chiropractors, physician assistants, nurse practitioners, registered nurses/registered nurse first assistants, medical assistants, hearing aid specialists, licensed midwives, dentists, audiologists, optometrists, opticians and birth centers.

Tables 1 and 2 stratify the 1,064 HPS applications into 14 and 30 day increments. Nine applications which show up as < 0 days in “MCM Review” status represent an anomaly in the MCM review dates entered into FMMIS and were therefore excluded from our test sample.

**Table 1: Stratification of HPS Applications in MCM Review Days by 14 day increments**

Number of Days in MCM Status	Number of Applications	% of Total Applications
< 0	9	1%
0-14	504	47%
15-28	303	28%
29-42	137	13%
43-56	47	4%
57-90	39	4%
91-104	7	1%
105-118	10	1%
119-132	5	1%
133-147	1	0%
>147	2	0%
	<b>1,064</b>	<b>100.00 %</b>

**Table 2: Stratification of HPS Applications in MCM Review Days by 30 day increments**

Number of Days in MCM Status	Number of Applications	% of Total Applications
< 0	9	1%
0-30	834	78%
31-60	169	16%
61-90	27	3%
91-120	18	2%
121-150	5	0%
151-180	1	0%
181-210	1	0%
	<b>1,064</b>	<b>100.00 %</b>

As shown in the tables above, ninety-four percent (94%) of the 1064 HPS applications were processed in 60 days or less and forty-seven percent (47%) of HPS applications were processed in 14 days or less.<sup>3</sup> From this population, we identified 221 applications that had the longest interval period from the first date it was sent to MCM review to the last date it left MCM review. We then selected 35 applications for review which we subdivided into Group A and Group B. Group A consisted of HPS providers that required mandatory MCM review for site surveys. Group B consisted of HPS providers that did not require mandatory site surveys.

<sup>3</sup> This excludes the < 0 anomalies.

## Findings, Recommendations, and Management Responses

MCM reviews involving site surveys have a 60 day processing time after receipt of a complete provider application. Prior to July 1, 2013, the statutory requirement was that “The agency shall perform a random onsite inspection, within 60 days after receipt of a fully complete new provider application...” The Unit also applied the 60 day processing standard for mandatory site surveys. On July 1, 2013, Section 409.907(7), F.S., was modified to do away with the time requirement. The Unit Administrator stated that this was to give the Agency broader discretion to perform site surveys as needed to protect the Medicaid program; however, the Agency still adheres to the 60 day processing time for site surveys.

All other MCM reviews have a 14 day processing time. Once a new application is reviewed, it may be RTP for additional information, forwarded to the field office for survey, or sent to the fiscal agent for activation or denial. If an application is resubmitted to MCM for additional review the “clock restarts.”

The communications function regarding provider applications between the fiscal agent and MCM is managed through the Florida Interactive Portal (FIP) file maintenance system. FIP is utilized for tracking tasks communicated between MCM, the fiscal agent, and vice-versa. The FIP File Maintenance Procedures document outlines the procedure for entering change orders (CO) into iTRACE or requesting file maintenance (FM). A Change Order is one of several delivery methods for file maintenance. File Maintenance is a request from the provider or the Medicaid Program to alter a provider’s record. Due dates are assigned based on the priority of the task as indicated below:

<u>Priority</u>	<u>Description</u>
0 = Emergency	<b>URGENT</b> – Immediate response needed
1 = High	<b>RUSH</b> – By close of business
2 = Medium	<b>STANDARD</b> – 24 hours
3 = Low	<b>NON-STANDARD</b> – 48 hours, unless otherwise noted.

The FIP document does not capture the amount of time required for site surveys, CHOW reviews, and other MCM reviews. It only captures when a task has been identified for review or a FM is requested. A delay in requesting a FM or initiating a CO is not captured within the FIP system.

Using the information obtained from the FMMIS “Comments” field, iTRACE notes, and supplemental iTRACE information, we accounted for the time period when our 35 sample applications went in and out of MCM review and compressed it to the time period when the applications were actually in “MCM Review” status.<sup>4</sup> We then analyzed the timeliness of application review and identified the primary reasons for processing delays. These were broken down into the following categories: “Timely,” “Background Screening,” “Non-Institutional Subunit / File Maintenance,” “Fiscal Agent,” and “File Mix-ups.”

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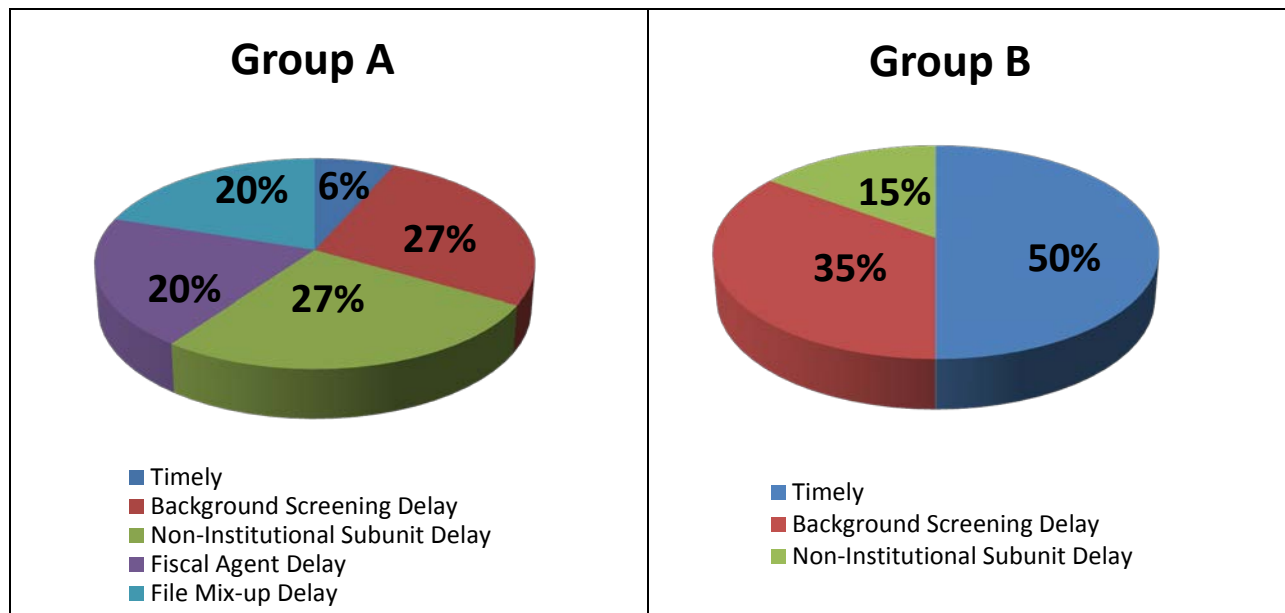
<sup>4</sup> If an application was in MCM Status several times, only the actual number of days in MCM Status was counted.

All of the applications sampled met the 60 day processing time for site surveys, and as shown in Table 3, thirty one percent (31%) of applications were reviewed timely which is 60 days for site surveys and 14 days for other reviews. The other areas in which MCM review processing times were exceeded are shown and discussed further in Findings 1-4.

**Table 3: Summary of Results for Aging Applications Tested**

Timeliness or Primary Reasons for Delay	Age in MCM Status	Group A	Group B	Combined Totals	% Distribution
Timely	n/a	1	10	11	31%
Background Screening	33 - 139 days	4*	7	11	31%
Non-Institutional Subunit / File Maintenance	30 - 162 days	4	3	7	20%
Fiscal Agent	78 - 122 days	3	0	3	9%
File Mix-ups	121 - 190 days	3	0	3	9%
<b>TOTAL</b>		<b>15</b>	<b>20</b>	<b>35</b>	<b>100%</b>

*\*1 application tested involved a Background Screening processing of 111 days and a Fiscal Agent delay of 13 days. The total number of days in "MCM Review" Status was 139 days.*



**Group A** - HPS providers that **do** require mandatory site surveys.

**Group B** – HPS providers that **do not** require mandatory site surveys.



### **Finding 1: Delay in Background Screening Review**

Thirty-one percent (31%) of the sampled aging applications reviewed or a combined total of 11 out of the 35 applications involved a delay in a background screening review. The applications were in “MCM Review” status from 33 to 139 days. One application was delayed as a result of a background screening delay of 111 days and a fiscal agent referral delay of 13 days.

The background screening analyst reviews the following:

- previously approved background screening in the past 12 months
- “not eligible” background screenings
- “previously termed or denied” background screenings (D3 or T1)
- Question 30 A reviews

There is only one analyst tasked to review background screenings. She stated that she performed a lot of manual processing and reviewed approximately 300 to 400 background screening inquiries from providers and the fiscal agent per week during the audit period between June 1, 2012, and December 31, 2012. In addition, she was primarily utilizing emails from the fiscal agent, and not the FIP system iTRACE reports, to monitor MCM reviews assigned to her. The emails were “hit or miss” since initially there were problems in adding her to the FIP system. According to the Unit Administrator, staff now run reports to ensure they see everything sent to them instead of just relying on email alerts. He also pointed out that due to the confidential nature of the background screening inquiry, delays may be caused by applications sent back to a provider for further information without going through the fiscal agent and being put into RTP status, or applications awaiting further information from Medicaid Program Integrity (MPI) or Medicaid Fraud Control Unit (MFCU). Since applications are still under “MCM Review” status during the time that further information is being sought this shows up as a longer processing time under MCM review.

According to Unit staff, in June 2013 the BGS system has started to automatically upload information into FMMIS on a daily file. This has freed much of the manual processing and reduced the number of background screening inquiries.

### **Finding 2: Non-Institutional Subunit Review or FM Delay**

Twenty percent (20%) of the sampled aging applications reviewed, or a combined total of 7 out of the 35 applications, involved a delay in the application review or file maintenance in the Non-Institutional subunit. Site survey documentation attached to COs reviewed reflects that site surveys were completed within 60 days, often less than 30 days, from the time assigned. The FMMIS and iTRACE comments did not indicate the reasons for a delay in the review or FM. The applications in this category were under “MCM Review” status from 30 to 162 days.

**Finding 3: Fiscal Agent Referral Delay/ “Orphan” Tasks**

Nine percent (9%) of the sampled aging applications reviewed, or a combined total of 3 out of the 35 applications, involved a delay on the part of the Fiscal Agent by either a delayed referral to a specific MCM analyst whereby an application is placed into “MCM Review” status but no analyst was assigned to review (i.e. “orphan” tasks) or a delay in task completion even after a file maintenance is entered by an MCM analyst. The applications in this category were under “MCM Review” status from 78 to 122 days.

A procedure which would require all applications that are placed in MCM review be assigned to a specific MCM analyst would help to manage delays. This did not exist at the time of the review.

In the spring of 2013, the fiscal agent started running a weekly report that identifies “orphan” tasks by pulling all open COs with no state participant (MCM analyst) from the previous seven days. This enables the fiscal agent to identify applications under “MCM Review” status that have not been assigned to a specific analyst. MCM analysts now also run reports to help ensure they see all their assigned COs and not just rely on email alerts.

Delays in task completion after an MCM analyst requests a file maintenance, can be prevented and detected by regularly running reports that would indicate aging applications, doing quality checks, and tracking applications that are aging in “MCM Review” status.

**Finding 4: File Mix-ups**

Nine percent (9%) of the sampled aging applications reviewed, or a combined total of 3 out of the 35 applications, involved a file mix-up delay. The FMMIS and iTRACE comments indicate the delays were caused by linking the wrong provider ID or name to an application or referring the application to the wrong MCM analyst for review. The applications in this category were under “MCM Review” status for the longest period, from 121 to 190 days.

The mix-ups can be prevented and detected by regularly running reports that would indicate aging applications, doing quality checks, and tracking applications that are aging in “MCM Review” status.

## **RECOMMENDATIONS:**

As noted earlier, the vast majority of provider enrollment applications reviewed by the Unit were processed timely. In addition, during the course of our review, the Unit was already strengthening some controls over the provider enrollment process. We recommend that the Unit continue to improve and strengthen controls that would enhance efficiency and prevent delays in the application review process by implementing the following:

### **Recommendation 1:**

Require a monthly report or establish performance measures to track the MCM review processing times.

#### **Management Response:**

- Designing, building, testing, implementing, and supporting new reports in production is more costly than the risk. MCM will table new reporting until procurement of new FMMIS. Preliminary work toward that goal began in 2013 with final product in place July 1, 2018.

Ultimately, there are several factors, outside of the control of MCM analysts, which may cause an application to take longer than the average time to process. Activities that can increase MCM processing times include: site surveys, pre-certification reviews, changes of ownership for facility licensure, and rate setting.

*Anticipated date of completion:* **Accept risk.**

- MCM will pursue the feasibility of adding new application status tracking codes, which will be used to show in the FMMIS whenever an application has been forwarded for an action outside of MCM. The status tracking codes will not shorten the time these outside actions take for completion. It will however aid applicants in understanding the exact whereabouts of their application and avoid the impression the application has stalled.

As part of the implementation of the new status tracking codes, MCM will also revise the Enrollment Status page on the Medicaid public portal to better display expected processing times and to supply contact points for questions regarding an application at any given stage of processing.

*Anticipated date of completion:* June 1, 2014.

### **Recommendation 2:**

Establish a written policy for MCM review processing times.

#### **Management Response:**

Agree, but cannot mitigate risk. MCM has begun design sessions for documenting desk level procedures. Completion of the documentation will be impacted by several high priority projects, including the Statewide Medicaid Manage Care rollout, the Affordable Care Act provider screening implementation, and the 2014 Legislative Session. While MCM agrees with the need for desk level procedures, those procedures can only impact the processes directly under the control of MCM analysts. They cannot mitigate the risk of longer review times as the result of waiting for results of site surveys, pre-certification reviews, changes of ownership for facility licensure, and rate setting.

*Anticipated date of completion:* September 1, 2014.

**Recommendation 3:**

Continue to require all MCM analysts to utilize the reporting functions in iTRACE to regularly track applications assigned to them. This will help ensure that applications do not “fall through the cracks” and do not exceed processing times unnecessarily.

**Management Response:**

MCM analysts currently utilize the reporting functions in iTRACE.

*Anticipated date of completion: Completed.*

**Recommendation 4:**

Continue to require the fiscal agent to conduct periodic monitoring to detect “orphan” tasks that are showing up under “MCM Review” status.

**Management Response:**

The Medicaid fiscal agent runs weekly reports and verifies all open Change Orders and there are specific monitoring roles assigned to both state and fiscal agent analysts.

*Anticipated date of completion: Completed.*

**Recommendation 5:**

Require the fiscal agent to conduct periodic monitoring to detect applications in RTP status or have been sent to the wrong analyst for review, and are showing up under “MCM Review” status.

**Management Response:**

Design session held with Medicaid fiscal agent for creation of a new report which will identify all applications in any status other than RTP which have an RTP letter generated for a later date. Fiscal agent staff will work the report weekly and will correct any application status that is in error. The issue of tasks being assigned to the wrong analyst was corrected under response 6 below.

*Anticipated date of completion: June 1, 2014.*

**Recommendation 6:**

Run a weekly report to identify tasks due within the week to alert both analysts and supervisors and require monitoring of analysts at regular intervals to help ensure applications are handled appropriately and in accordance with processing time frames.

**Management Response:**

MCM analysts run daily reports to capture their current workload. Supervisors run weekly reports to identify outliers and work with the analysts to resolve. The daily reports also correct the issue of tasks being assigned to the wrong analyst. These are able to be reassigned in a timely manner.

*Anticipated date of completion: Completed.*

## **Final Comments**

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Internal Audit would like to thank the management and staff of the Division of Medicaid, Bureau of Contract Management, Provider Enrollment Unit for their assistance and cooperation extended to us during this engagement.



**The Agency for Health Care Administration's mission is Better Health Care for All Floridians.**

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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 Pilar C. Alsiro, J.D. and Shushan Gemora 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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