Office of the Inspector General
Internal Audit

Report No. 16-14
November 2016

Review of Medicaid Aid Category Rate Assignments

EXECUTIVE SUMMARY

At the request of the Agency for Health Care Administration's (Agency) Secretary, the Agency's Office of the Inspector General (OIG) conducted a limited management review of the Division of Medicaid's Managed Care Aid Category Rate Assignment process. The review focused on the process and controls for assigning rates to the various Medicaid Managed Care Aid Categories in connection with the transition to Statewide Medicaid Managed Care (SMMC), and the communication and approval process for implementing Medicaid Managed Care financial and program changes in the Florida Medicaid Management Information System (FMMIS).

In February 2016, while reviewing the SMMC - Managed Medical Assistance (MMA) program data as an input source for the development of the 2016-2017 SMMC-MMA rates, Medicaid's contracted actuary discovered rate cell discrepancies and brought these discrepancies to the attention of the Bureau of Medicaid Data Analytics (MDA).[1] Further analysis showed that certain Medicaid aid categories were mapped to the wrong capitation rate cells in FMMIS. This improper mapping led to the Agency paying the health plans Temporary Assistance for Needy Families (TANF) capitation rates (a lower rate) instead of Supplemental Security Income (SSI) capitation rates for recipients belonging to certain Medicaid aid categories. In the course of this review, the Bureau of Medicaid Program Finance (MPF)[2] estimated that less than one percent of the managed care population was affected by the misalignment. In addition, during the course of our review, the Bureau of Medicaid Fiscal Agent Operations (MFAO)[3]

[1] MDA is responsible for the development of capitation rates for all contracted Medicaid health plans including the SMMC MMA and Long-term Care (LTC) Programs. MDA is also responsible for publishing quarterly reports focusing on the performance and evaluation of SMMC health plans, and creating data extracts for budgeting and forecasting uses.
[2] MPF is responsible for the fiscal planning of the State's Medicaid budget, sets reimbursements rates for facilities, and monitors the financial performance and health of Medicaid health plans. The Financial Monitoring unit within MPF oversees the financial reporting of contracted Medicaid health plans and reviews the reporting of plans' *medical loss ratio* and their *achieved savings*.
[3] MFAO has oversight responsibilities for the Fiscal Agent and is the contact bureau for all interaction and instruction given to the Fiscal Agent for all phases of operation from within the Medicaid Division, the Agency, and other state and federal agencies. MFAO's Systems Unit is responsible for monitoring the Fiscal Agent's System's Department; setting priorities and coordinating, developing, processing, and

corrected the rate misalignment issue in FMMIS. The Agency began reimbursing the health plans for resulting monies owed for the 2015-2016 fiscal year (FY) starting with the July and August 2016 SMMC capitation payments. The Agency is also seeking budget authority[4] to pay any monies owed for prior fiscal years. In addition, MFAO continues to work with the various Medicaid bureaus to create reports to improve and strengthen controls to avoid rate misalignment issues in the future. However, our review disclosed areas where improvements could still be made to strengthen controls and help prevent similar issues in the future. We recommend:

- Project management teams tasked with writing the business requirements for Customer Service Requests (CSRs) with large systems implications include representation, communication, or greater coordination from other bureaus impacted by the CSR.
- Project management teams more fully document discussions related to decisions with a systems or financial impact and document communication of decisions to project management teams tasked with writing business requirements for CSRs.
- MFAO work with the Fiscal Agent and Medicaid staff to clarify terminology and provide more detail for CSR specifications to avoid incorrect interpretation and assumptions of business requirements (as reportedly occurred in the assumptions regarding Benefit Plans).[5]
- MFAO continue to work with various Medicaid bureaus to develop reports for monitoring the SMMC capitation payment process, including working with MDA to create a report to analyze data to verify if the rates assigned are paid in accordance with appropriate aid categories.
- MPF's budgeting and forecasting process include periodic reviews of any significant changes to the per member per month (PMPM) expenditure amount for various budget categories.

SCOPE, OBJECTIVES, AND METHODOLOGY

The scope of the review included rate assignment-related activities at the Bureaus of Medicaid Program Finance, Medicaid Data Analytics, and Medicaid Fiscal Agent Operations as well as Medicaid Program Coordination from calendar year 2014 to the present.

The objectives of our engagement were to review and evaluate:

- the process and controls over the Medicaid aid category rate assignments in FMMIS, and

---

approving systems maintenance and operational customer service requests; and coordinating the development of business requirements from end-users and the Fiscal Agent.

[4] The Agency's Legislative Budget Request for FY 2017-2018 totals $185,430,089 (State and Federal).

[5] "Benefit Plan" is a term used in FMMIS to define the scope of benefits an individual is eligible to receive. Although SSI and TANF receive full Medicaid benefits, under benefit plan hierarchy rules, when both are present concurrently for a date of service, the SSI benefit plan is designated over TANF.

- the communication and approval process for implementing Medicaid Managed Care financial and program changes in FMMIS.

To accomplish our objectives, we interviewed management and appropriate staff; reviewed state laws, contracts, SMMC Project Teams' decision points, agendas, and related documents; reviewed CSRs and Change Orders (COs) in FMMIS; and reviewed other applicable documentation.

BACKGROUND

In 2011, the Florida Legislature enacted Part IV of Chapter 409, Florida Statutes,[6] directing the Agency to create the SMMC program. The SMMC program has two key components: the MMA program and the LTC program. Capitation rate payments to SMMC health plans are made in accordance with rates outlined in the SMMC contract on a PMPM basis as determined by age, sex, region of the state, and other factors. For example, for the TANF population, a capitation rate cell was developed for all members age 55 and older (TANF 55+) and for the SSI Medicaid Only[7] population, another capitation rate cell was developed for all members age 14 and older (SSI No Medicare 14+). The TANF rates are less than 50% of the SSI Medicaid Only rates.[8]

SMMC Implementation

The Agency was tasked by the Florida Legislature with implementing the LTC component by October 1, 2013, and the MMA component by October 1, 2014. In order to accomplish this comprehensive statewide implementation within a relatively short time frame, the Medicaid Program Coordination's Projects and Process Improvement Unit (PPIU)[9] created several project management teams to focus on different aspects of the implementation. The Systems Readiness Team (SRT) and the Rates and Financial Monitoring Team (RFMT) were two of the teams responsible for systems and financial changes related to the SMMC implementation.

The SRT was responsible for implementing the requirements related to FMMIS for the SMMC. The team was tasked with overseeing the finalization and development of business requirements for systems related to the LTC and MMA program components. They were also tasked with coordinating and overseeing the planning and execution of systems analyses, testing, and monitoring of modifications and enhancements in advance of the transition into the SMMC programs. The objectives of the SRT were to ensure there was a process for reviewing, storing, and communicating systems

[6] Codified in 2011-134, Laws of Florida.
[7] Also designated as "SSI No Medicare."
[8] SMMC-MMA Base Rates September 1, 2015, through August 31, 2016.
[9] Medicaid Program Coordination's Projects and Process Improvement Unit designs, develops, and implements the infrastructure to support and document project management and process improvement efforts in the Division of Medicaid to assure that all projects are delivered on time and within the allocated budget. This unit was in charge of project management for the SMMC implementation.

information for SMMC implementation and mitigating conflicting areas that needed to be resolved.

For the MMA component, the SRT's MMA CSR team, which was comprised of four members from the Bureau of Health Systems Development and one member from the Bureau of Medicaid Contract Management,[10] worked on the technical and policy specifications for *CSR 2530 SMMC MMA Capitated Managed Care Plan,* including reviewing the test results prior to implementation*. Attachment A of CSR 2530* contained the overview for the CSR and specified the creation of 16 capitation rate cells for the SMMC-MMA health plans including the *TANF 55+* rate cell and the *SSI No Medicare 14+* rate cell. *Attachment B of CSR 2530* outlined the business requirements, and *Attachment C of CSR 2530* contained the SMMC eligibility category grid, which included a list of Assistance Categories, Eligibility Category Names, and Benefit Plans.

The RFMT's purpose was to identify critical milestones, activities, and deliverables necessary to ensure the financial integrity of the SMMC health plans. This team was tasked with coordinating and overseeing the development and approval of actuarially sound capitation rates and other payment mechanisms for the SMMC program. It was also tasked with coordinating and overseeing the planning and execution of ongoing financial monitoring processes and tools to ensure ongoing contract compliance throughout the transition and implementation process.

Our review of team documents (specifically, a system readiness question log and a decision log) disclosed an issue regarding one of the affected rate categories (MW A).[11] The decision log, dated September 2012, stated: "*MWA populations have traditionally been excluded from managed care, but they will be included in SMMC. Some MWA people also have a TANF or SSI designation in the system, but many do not. MWAs without an aid designation were included in the MMA data book as SSI, because their cost profile is more similar to SSI than TANF. However, the system currently defaults them to TANF. A decision was made to treat them as SSI for rate payment purposes and change the system to reflect this [sic].*" However, this Inspector General (IG) review did not locate and was not provided any other documentation related to this issue or documentation indicating whether any of the other SSI-like aid categories as listed in Table I were discussed. In addition, this September 2012 decision identified by RFMT, was not included in the business requirements for *CSR 2530.*

[10] The Bureau of Health Systems Development (HSD) was changed to the Bureau of Medicaid Plan Management Operations and the Bureau of Medicaid Contract Management has changed to MFAO after the Division of Medicaid's reorganization.

[11] MW A refers to Home and Community Based Services and is one of the affected aid categories listed in Table I.

Elderly and Disabled Budget Category

MDA provides enrollment, caseload, and expenditure data to the Budget and Fiscal Planning unit of MPF, which are used to estimate, implement, and track the Florida Medicaid budget and to also project and present caseload and expenditure estimates to the Social Services Estimating Conference (SSEC).

For the March 2015 SSEC, MPF included an MMA Supplemental Schedule[12] that contained Pre-MMA to Full-MMA data history from January 2013 to December 2014. The data showed a noticeable drop in the PMPM expenditure for the elderly and disabled budget category (*EL & DIS*). For example, from March 2014 (Pre-MMA) to September 2014 (Full-MMA), there was a drop of 61 percent.[13] There was no documentation located or provided in the course of this IG review to indicate that the drop in PMPM expenditures for the *EL & DIS* budget category was analyzed by MPF staff or the SSEC principals.

Prior to 2013, MPA performed both the budgeting and data analysis functions for Medicaid. These two functions were split during Medicaid's reorganization to accommodate statewide managed care and are currently divided between the MDA and MPF. Prior to SMMC implementation, MPA utilized a process whereby projected monthly budget category payments to health plans could be compared with the final capitation payment amounts prior to rate loading of the final payment to the health plans. MPA also looked at changes in the PMPM expenditure amount as part of the budgeting process. After the reorganization of MPA, the implementation of a new forecasting model, and the departure of some staff members with institutional knowledge, the analysis of variances between projected payments and final rate loading of capitation payments does not appear to have continued.

Medicaid Aid Categories Affected by Rate Mapping Errors

In February 2016, while reviewing the SMMC-MMA data for calculating the FY 2016-2017 SMMC-MMA rates, Medicaid's contracted actuary noticed the rate cell discrepancies and brought the discrepancies to the attention of MDA. Further analysis by MDA showed that certain Medicaid aid categories were mapped to the wrong capitation rate cells in FMMIS. This led to the Agency paying the SMMC health plans the lower TANF capitation rates instead of higher SSI capitation rates for recipients belonging to certain Medicaid aid categories. MDA's analysis also showed that prior to the statewide expansion of SMMC-MMA in May 2014, the affected categories were paying the correct SSI rates, and that the discrepancies did not affect the *dual eligible population*.[14]

[12] The *EL & DIS* budget category includes MM S and MH M, which were part of the affected rate categories.
[13] The March 2015, Supplemental Schedule showed a drop in *EL & DIS* PMPM expenditures from $1024.10 in March 2014 to $396.35 in September 2014.
[14] Recipients with both Medicaid and Medicare.

Table I lists the aid category codes affected. The MEDS-AD[15] aid category contained the most recipients affected by the rate mapping errors.

Table I: Medicaid Aid Categories Affected by Rate Mapping Errors				
Aid Category Codes	**Description**	**Benefit Plan**	**Post MMA Rate Cell Configuration**	**Corrected Rate Cell Configuration**
MH A	Hospice Medicaid - Supplemental to LIF Medicaid	TXIX	TANF	SSI
MH H	Stand Alone Hospice Medicaid	TXIX	TANF	SSI
MH M	**Hospice Medicaid - Supplemental to MEDS-AD (MM S)**	**TXIX**	**TANF**	**SSI**
MH S	Hospice Medicaid Supplemental to SSI Medicaid (MS)	TXIX	TANF	SSI
MM S	**MEDS for Aged and Disabled**	**TXIX**	**TANF**	**SSI**
MT C	Regular Protected Medicaid (COLA)	TXIX	TANF	SSI
MT D	Protected Medicaid for Disabled Adult Children	TXIX	TANF	SSI
MT W	Protected Medicaid for Widows II	TXIX	TANF	SSI
MW A	Home and Community Based Services	TXIX	TANF	SSI
MX	Continuous Coverage for SSI child who loses SSI eligibility	TXIX	TANF	SSI
* MH M and MM S are included in the *EL & DIS* budget category				

CSR 2530 – SMMC-MMA Capitated Managed Care Plan

MFAO was notified of the rate misalignment issue in March 2016. MFAO, in consultation with the Fiscal Agent, narrowed the mismatch to assumptions regarding Benefit Plans in *Attachment C - the SMMC Eligibility Categories Grid* of CSR 2530 and the rate cell configuration based on these assumptions.

Generally, recipients with aid category codes whose eligibility is determined by the Florida Department of Children and Families (DCF) were linked to the Title XIX[16] Benefit Plan and the related PMPM capitation payments to SMMC plans were paid TANF rates. For recipients whose eligibility was determined by the United States Social Security Administration (SSA) the related PMPM capitation payments to SMMC plans were paid SSI rates. DCF, however, also determines eligibility for "SSI-related" groups like MEDS-AD, and PMPM capitation payments for these groups are aligned with SSI capitation rates. Recipients with the affected aid category codes have cost profiles that more closely match SSI; therefore, not all DCF-determined categories should have been assigned the lower TANF rates.

[15] MM S or MEDS-AD – Sixth Omnibus Budget Reconciliation Act (SOBRA) for aged and disabled or Medicaid for Aged or Disabled for persons without Medicare; or if they have Medicare, must be receiving institutional care, hospice, assistive care, or home and community based services.
[16] Title XIX of the Social Security Act, 42 U.S.C. §1396 et seq., established regulations for the Medicaid program, which provides funding for medical and health-related services for persons with limited income.

CSR 2530's test results appear to have matched the documented specifications. However, insufficient detail provided by the specifications led to incorrect interpretations and assumptions for testing. The assumption that assistance categories assigned to Title XIX or SSI Benefit Plans would be aligned with TANF or SSI rate cells respectively, does not appear to have been questioned, thus test documentation related to rate cells consisted of test cases to verify functionality and did not include testing to verify rate cell alignment.

In addition, the tight timeline for SMMC implementation and the number of system changes in FMMIS, including the creation of over 27,000 new rate cells, increased the risk of errors. Reports produced after the SMMC-MMA rollout focused on reviewing and verifying capitation cycle results and processing of enrollment and disenrollment files by MMA implementation phases and, therefore, the small percentage change in the expenditure amounts related to affected categories was not readily apparent to Medicaid management. MPF estimated that less than one percent of the managed care population was affected by the rate misalignment, and this factor may have contributed to the errors' latency.

In April 2016, the Agency met with applicable SMMC health plans to discuss the identified rate mapping errors, the number of recipients affected in each plan, and the estimated dollar amounts involved in potential underpayments. The Agency sent a letter to the health plans in June 2016 with the estimated amounts involved and the Agency conveyed a commitment to match all aid categories and rate cells correctly going forward and to pay all monies owed from underpayments. The Agency started reimbursing the SMMC health plans for FY 2015-2016 underpayments with the July and August 2016 SMMC capitation payments. The Agency is also seeking budget authority in FY 2017-2018 to pay any monies owed for prior fiscal years that may be attributable to rate mapping errors.

Rate Mapping Configuration and Managed Care Reconciliation Reporting CSRs

In April 2016, CSR 2580 was completed to correct the rate mapping issue that led to the previously described underpayments. This corrective action was effected in time for the May 2016 SMMC capitation payments. In addition, MFAO created *CSR 2992 – Managed Care Reconciliation Reporting* for the current and future development of rate monitoring reports. At the time of our review, the following two reports were in development:

- the *New Capitation and Final Payment Variance Report,* which will compare the projected total capitation payment to the actual payments in the financial process to flag variances at a macro level; and
- the *Capitation Sample QA Report*, which will pull a random sample of capitation payments for the coming month which could be analyzed at an aid category level.

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

The findings and conclusions of this engagement are as follows:

1. The SRT's MMA CSR team did not appear to include representation, input, or coordination from other units or bureaus like MDA (previously MPA) in writing the business requirements and testing the MMA CSR. Four out of the five members of the SRT's MMA CSR team were from one Medicaid bureau. There were no team members from MDA or other bureaus that could have provided input about the aid categories and related rate cell configuration.

2. Limited documentation was available regarding actions related to making a systems change for one of the affected aid categories (MW A) found in a decision log dated September 2012. Although there was a recognition that one of the aid categories defaulted to TANF for rate payment purposes and should have been changed to SSI, there appears to be no documentation of discussions related to the matter in the decision log, whether other similarly affected aid categories were part of the discussion, or whether system changes in FMMIS were pursued by the SRT.

3. The tight timeline for SMMC implementation and the number of system changes in FMMIS, including the creation of over 27,000 new rate cells, increased the risk of errors. Reports produced after the SMMC-MMA rollout focused on reviewing and verifying capitation cycle results and processing of enrollment and disenrollment files by MMA implementation phases and, therefore, the small percentage change in the affected categories was not readily apparent to Medicaid management.

4. CSR 2530's test results appear to have matched the documented specifications. However, insufficient detail provided by the specifications led to incorrect interpretations and assumptions for testing. The assumption that assistance categories assigned to Title XIX or SSI Benefit Plans would be aligned with TANF or SSI rate cells, respectively, does not appear to have been questioned and thus test documentation related to rate cells consisted of test cases to verify functionality and did not include testing to verify rate cell alignment.

5. Documentation was not available to indicate that MPF analyzed the drop in PMPM for the *EL & DIS* budget category from pre-MMA implementation to Full-MMA implementation.

Recommendations

As noted earlier, during the course of our review, MFAO corrected the rate misalignment issue and the Agency started reimbursing the health plans for resulting monies owed with the July 2016 capitation payments. MFAO continues to work with the various Medicaid bureaus to create reports to improve monitoring over the capitation payment process to help avoid rate misalignment issues in the future. However, our review disclosed areas where further improvements could be made to strengthen controls and help prevent similar issues in the future. We recommend:

1. Project management teams tasked with writing the business requirements for CSRs with large systems implications include representation, communication, or greater coordination from other bureaus impacted by the CSR.

   PPIU's Management Response:
   Although the larger Systems Readiness Team did include members from various bureaus within Medicaid, including Medicaid Data Analytics, it appears that the sub-team for the CSR creation did not. The Projects and Process Improvement Unit has updated its program policies and processes accordingly to make sure that every project- managed team has members from every appropriate Medicaid bureau.
   Anticipated Date of Completion: Complete

   MFAO's Management Response:
   MFAO will request that for each FMMIS project, a representative from each bureau within Medicaid be included in the project meetings. In addition, a sign-off form from the impacted business will require the Bureau Chief's signature. The Fiscal Agent's Project Management Office will record action items, issues, and decisions and report them to MFAO during each project meeting.
   Anticipated Date of Completion: December 31, 2016.

2. Project management teams more fully document discussions related to decisions with a systems or financial impact and document communication of decisions to project management teams tasked with writing business requirements for CSRs.

   PPIU Management Response:
   A project schedule template was created for systems changes and includes a task for the project team to work together to develop CSR business requirements. Decisions made within project-managed teams are documented in meeting summaries and posted on the team's SharePoint site. Decisions requiring review and approval from Medicaid leadership are brought forth as formal Decision Points to Medicaid Steering and advanced to Executive Leadership as appropriate. Decision Points are logged on SharePoint with the final date of a decision, the deciding body, and the decision made. Project Managers individually meet with the PPIU Supervisor and Agency for Health Care Administrator on a weekly basis to review their assigned project schedules and receive feedback and instruction to communicate with their project teams as

appropriate regarding decisions made at Medicaid Steering and/or the Executive Leadership level. Project Managers and Project Administrators have been reminded to upload all relevant project team documentation to the project's SharePoint site.
Anticipated Date of Completion: Complete

MFAO Management Response:
MFAO will continue to document projects with the Fiscal Agent's Project Management Office for each FMMIS project. The Fiscal Agent's Project Management Office will record and report decisions to MFAO during each project meeting. MFAO will identify stakeholders and encourage cross-functional team participation from Agency staff for the FMMIS projects.
Anticipated Date of Completion: December 31, 2016.

3. MFAO continue to work with various Medicaid bureaus to develop reports for monitoring the SMMC capitation payment process, including working with MDA to create a report to analyze data to verify if the rates assigned are paid in accordance with appropriate aid categories.

   Management Response:
   MFAO will assist Agency stakeholders to define financial monitoring reports for managed care and other financial projects. Reporting needs will be reviewed during the requirements and design sessions with the Fiscal Agent, and MFAO will document the financial balancing and reconciliation reports needed to monitor the new processing logic for enhancements to FMMIS.
   Anticipated Date of Completion: December 31, 2016.

4. MFAO work with the Fiscal Agent and Medicaid staff to clarify terminology and provide more detail for CSR specifications to avoid incorrect interpretations and assumptions of business requirements (as reportedly occurred in the assumptions regarding Benefit Plans).

   Management Response:
   MFAO, working with the Fiscal Agent, will generate a business requirements document and create expected results with stakeholders that will be reviewed and approved by the CSR initiator. MFAO will also create walkthrough requirements for User Acceptance testing with the Fiscal Agent and the stakeholders.

   MFAO will work with the Agency's Medicaid CSR requestor and the Fiscal Agent staff to clarify terminology and provide more specific details and requirements for CSR specifications to avoid incorrect interpretation and assumptions of business requirements (as occurred in the assumptions regarding Benefit Plans).
   Anticipated Date of Completion: December 31, 2016.

5. MPF's budgeting and forecasting process include periodic reviews of any significant changes to the PMPM expenditure amount for various budget categories.

Management Response:
Moving forward, the Agency, along with the SSEC Principals, have revised the methodology used to develop estimates for the conference. Previously the estimates were based on eligibility category; they are now based on rate cells. This change should allow the Agency to quickly identify this type of discrepancy and make corrections.

Reviewing the TANF and SSI rate cells was previously outside the scope of the estimates prepared by MPF for the Social Services Estimating Conference. In addition, the PMPM rate would have been expected to decrease due to the *dual eligible population* being captured in this category; this would have brought down the PMPM rate as the *dual eligible population* has a much lower PMPM rate.
Anticipated Date of Completion: Complete

ACRONYMS

Acronym	Description
AHCA	Agency for Health Care Administration
CO	Change Order
CSR	Customer Service Request
DCF	Florida Department of Children and Families
EL & DIS	Elderly and Disabled
FMMIS	Florida Medicaid Management Information System
F.S.	Florida Statutes
FY	Fiscal Year
HSD	Bureau of Health Systems Development
IG	Inspector General
LTC	Long-term Care
MDA	Bureau of Medicaid Data Analytics
MFAO	Bureau of Medicaid Fiscal Agent Operations
MMA	Managed Medical Assistance
MPA	Bureau of Medicaid Program Analysis
MPF	Bureau of Medicaid Program Finance
OIG	Office of Inspector General
PMPM	Per Member Per Month
PPIU	Projects and Process Improvement Unit
RFMT	Rates and Financial Monitoring Team
SMMC	Statewide Medicaid Managed Care
SSA	United States Social Security Administration
SSEC	Social Services Estimating Conference

SSI	Supplemental Security Income
SRT	Systems Readiness Team
TANF	Temporary Assistance for Needy Families

FINAL COMMENTS

Internal Audit would like to thank the management and staff of the Agency's Division of Medicaid for their assistance and cooperation extended to us during this engagement.

PROJECT TEAM

The review was conducted by Pilar C. Zaki, JD, CIGA, under the supervision of Mary Beth Sheffield, Audit Director, CPA, CIA, CFE, CIG.

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. Please address inquiries regarding this report to the AHCA Audit Director 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.

Copies may also be obtained by telephone (850) 412-3990, by FAX (850) 487-4108, in person, or by mail at Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop #5, Tallahassee, FL 32308.