



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

**Report No. AHCA-1617-05-A**  
**June 2019**

## **Provider Eligibility Enrollment Process**

### **EXECUTIVE SUMMARY**

As part of the Agency for Health Care Administration (Agency) Audit Plan, our office conducted an audit of the Medicaid provider enrollment application review process within the Division of Medicaid, Bureau of Medicaid Fiscal Agent Operations (MFAO), Provider Enrollment Section.

During our audit, we noted that, in general, applicable laws, rules, policies, and procedures were being followed. We noted areas where improvements could be made to strengthen controls and increase efficiencies. Our audit disclosed that the process for referring provider enrollment applications to MFAO for additional processing could be improved by reducing the type of applications requiring MFAO review. Our audit also disclosed that efficiencies could be improved by requiring the Provider Eligibility and Compliance Unit's (PECU) review of Targeted Case Management applications prior to scheduling site visits.

The Background section of this report provides details of our audit results.

### **OBJECTIVES, SCOPE, AND METHODOLOGY**

The objective of this audit was to determine the effectiveness and efficiency of controls in place for the Medicaid provider enrollment approval process. Our audit focused on application review activities conducted by four Provider Enrollment analysts who were primarily responsible for approval and denial of provider enrollment applications referred by the Fiscal Agent to MFAO for further review. Specific audit objectives included the process for referring applications for further review, the documentation of review processes, and referral to PECU within the Provider Enrollment Section as needed for additional review.

The scope of the engagement included applications requiring MFAO review and approval for the period of December 2017 through May 2018, and related activities through the conclusion of audit fieldwork in December 2018. The methodology included a review of relevant laws, rules, regulations, policies, and procedures; interviews with

Agency staff; observations of approval processes; and testing of a sample of electronic change orders used in the Medicaid provider enrollment process.

For the period of December 1, 2017 through May 31, 2018, the four Provider Enrollment analysts primarily responsible for MFAO provider enrollment application review received 7,343 change orders. Of the 7,343 change orders, our office selected a judgmental sample of 550 for testing and conducted detailed testing on a judgmental sample of 50 of these 550 change orders.

## BACKGROUND

To receive payment for rendering Medicaid-covered services, providers must be enrolled in the Medicaid program and must meet qualifications specified in federal laws and regulations, Florida Statutes (F.S.), Florida Administrative Code (F.A.C.), the Florida Medicaid Provider General Handbook, and Service-Specific Policies at the time services are rendered.

To enroll in the Medicaid program, providers must submit a completed enrollment application, a Medicaid Provider Agreement, copies of required licenses and/or certifications, a complete set of fingerprints for purposes of obtaining criminal history, and other information as required for the specific provider type. If the provider is a corporation, partnership, association, or other business entity, the provider is also required to submit identifying and background information of partners or shareholders with an ownership interest of five percent or more, officers and directors, financial records custodians, billing agents, managing employees or affiliated persons, and individuals authorized to sign on the account used for electronic funds transfer.

The Agency's contracted Medicaid Fiscal Agent, DXC Technology Services, LLC, (DXC) is responsible for receiving and processing provider enrollment applications, maintaining electronic provider files, performing provider and other stakeholder trainings, and answering provider queries regarding enrollment.

Applications and supporting documents are submitted via the Provider Enrollment Wizard located on the Agency's provider Web Portal and are entered into the Florida Medicaid Management Information System (FMMIS) through an automated process. FMMIS is the Agency's Medicaid information system used to maintain recipient eligibility data, process provider enrollment, maintain provider enrollment data, produce and maintain reports, and process provider reimbursement claims.

The Fiscal Agent initially reviews Medicaid provider enrollment applications for completeness based on automated checklists within FMMIS. If an application is incomplete, or if errors are identified, the application is returned to the provider for correction and resubmission. If the Fiscal Agent determines the application is complete and error-free, the Fiscal Agent further screens and processes the application to ensure that requirements have been met. The Wizard uses an automated rules engine to enforce edits on applications based upon provider type and specialty and assigns a

screening category of “High,” “Moderate,” or “Limited.” These edits ensure that all portions of the application are completed prior to submission and that the appropriate screening activities are applied to each application.

To screen provider enrollment applications, the Fiscal Agent primarily uses data available in FMMIS, such as licensure data from the Department of Health and the Agency’s Division of Health Quality Assurance (HQA), and criminal history data from HQA’s Care Provider Background Screening Clearinghouse. In addition, data from several federal database systems are loaded to tables in the FMMIS. These data files include information from the Social Security Administration’s Death Master File; the National Plan and Provider Enumeration System; the List of Excluded Individuals/Entities; the System for Award Management; and the Medicare provider enrollment database, the Provider Enrollment Chain and Ownership System (PECOS). FMMIS tracks the results of the automated screening and identifies potential eligibility issues that MFAO staff reviews.

The Fiscal Agent determines the need to refer applications to MFAO, based on automated processes in FMMIS and the following criteria:

- Provider type, including, but not limited to, the following:
  - Behavior Analysis;
  - Pharmacy, for Area 11, if privately owned and not a chain pharmacy;
  - Assisted Living Facility;
  - Community Mental Health Services;
  - Home Health Agency;
  - Case Management Agencies; and
  - School District.
- A requirement for an onsite review for certain provider types, including, but not limited to, the following:
  - Community Mental Health Services;
  - Durable Medical Equipment;
  - Non-physician owned Physician groups; and
  - Independent Diagnostic Testing Facilities.
- Change of ownership;
- Rate information needed;
- Background screening issues identified;
- Exclusion by the United States Department of Health and Human Services Office of Inspector General;
- Adverse history or previous termination or denial;

- Assignment of a screening category of “Moderate” or “High”;
- Provider license is not clear and active or there has been discipline action associated with the license; and
- History of sanctions, fines, or overpayments.

Provider enrollment applications referred by the Fiscal Agent to MFAO for further review are sent to three analysts in the Plan and Provider Enrollment and Outreach (PPEO) Unit, one analyst in the Provider Business Module Management Unit, and one analyst in the PECU.

Provider enrollment application review activities conducted by Provider Enrollment Section analysts vary based on the associated provider type, the application itself, and relevant supporting documents submitted by the provider. Review activities include, but are not limited to the following:

- Verification of the information submitted by the provider;
- Coordination of onsite reviews, if required;
- Background screening analysis;
- Research of previous adverse history or termination, if applicable;
- Referral to the PECU, for additional review, if appropriate; and
- Verification of provider eligibility.

The Fiscal Agent also refers applications directly to the PECU, primarily for review of applications from providers with a history of exclusion from a federal program, applications from providers with a history of previous termination, and applications for Case Management Agencies. The PECU also assists other analysts in the Provider Enrollment Section by conducting research that is more extensive for Behavior Analysis applicants, applicants with an adverse history, and applicants with background screening issues. The PECU reviews requests for Medicaid reinstatement, which are received from providers, Agency management, other analysts in the Provider Enrollment Section, and occasionally from the Fiscal Agent. The PECU also consults with the Bureau of Medicaid Program Integrity regarding issues of Medicaid overbilling and overpayments, suspected fraud, and administrative sanctions.

Fiscal Agent requests for provider enrollment application review by MFAO are processed using electronic change orders in the Information Tracking Repository and Collaboration Exchange (iTRACE) subsystem of FMMIS. Change orders for provider enrollment application reviews include the provider enrollment application and other supporting documents, as needed.

When Provider Enrollment Section analysts complete their review, the change orders are forwarded back to the Fiscal Agent with instructions for approval or denial. Approved applications are processed for enrollment. Applications to be denied are first reviewed by the Provider Enrollment AHCA Administrator and MFAO Bureau Chief, a denial notice is sent to the provider, and a copy of the letter is attached to the change order, which is then processed for denial by the Fiscal Agent.

The provider enrollment process is governed by the following federal and state laws, rules, and regulations:

- 42 Code of Federal Regulations (C.F.R.) 455.450, notes that state agencies are required to screen all applications for Medicaid provider enrollment.
- Section 409.907, F.S., requires the Agency to enroll Medicaid provider applicants upon approval of a completed, signed, and dated application, and after completion of any necessary background investigation and a criminal history check.
- Rule 59G-5, Florida Administrative Code (F.A.C.), which notes that to enroll a provider in the Medicaid program, providers must meet requirements of federal and state laws and regulations.

In addition, MFAO policies, procedures, and practices provide additional guidance, as follows:

- The Florida Medicaid Provider General Handbook includes general information for providers regarding provider enrollment requirements.
- The FMMIS/Decision Support System/Fiscal Agent Operations: Provider Enrollment Processing Procedures Manual provides specific enrollment requirements for individual provider types.
- Provider Enrollment Analysts' performance standards include an expectation that requires change orders for new enrollment applications received from the Fiscal Agent to be completed and returned to the Fiscal Agent within five business days of receipt. This expectation does not include time waiting on results from reviews by other Agency staff (e.g., onsite reviews, referrals to the PECU, legal reviews, etc.).

## **Provider Enrollment Application Reviews**

Our audit determined that provider enrollment applications could be processed more efficiently by reducing the number of change orders sent to MFAO for further review.

For the period of December 1, 2017 through May 31, 2018, there were 7,343 change orders forwarded to four MFAO Provider Enrollment analysts who were primarily responsible for MFAO provider enrollment application review and approval or denial. Internal Audit selected 550 of these change orders for review and determined that overall, applications were appropriately referred to the Provider Enrollment analysts. Only eight out of the 550 change orders or 1.5% appeared to have been sent to Provider Enrollment analysts in error.

Our testing of change orders identified an imbalanced workload for the four Provider Enrollment analysts. During the six month period tested, of the 7,343 change orders processed, one analyst processed 5,286 change orders, or approximately 72% of the total; another analyst processed 1,557 change orders, or approximately 21%; and the remaining two analysts processed 308 and 192 change orders, respectively. At the time of audit testing, change orders were assigned to the Provider Enrollment analyst based on provider type, which unintentionally contributed to an imbalanced workload, particularly when there was an influx of applications for a specific provider type.

In June 2018, a new process was implemented to normalize workload. This involved assigning applications for MFAO review through "MFAOATN, FMMIS" in iTRACE instead of to the individual Provider Enrollment analyst. According to MFAO, the assigned application change orders assigned to "MFAOATN, FMMIS" are checked each morning and distributed equally among the Provider Enrollment analysts for review rather than by provider type. In addition, according to MFAO, in May 2018, a new naming convention was added to files assigned to MFAO staff to help track files internally, such as the addition of the letters "PQ" for a file referred to PECU or "XS" for a file that is referred for site visit. This allows files to be flagged and identified for internal tracking purposes. MFAO is able to download a report of change orders and identify where each application is in the review process.

Internal Audit noted that controls are in place requiring the Provider Enrollment AHCA Administrator and the MFAO Bureau Chief to review denied applications before a denial notice is sent to the provider. Conversely, MFAO approved applications are generally processed for enrollment without further supervisory review. Provider Enrollment supervisors may at times review change orders, individual application documents, and analysts' work, when there is an issue, to assess workload or to determine the reasons for delays. However, supervisory monitoring is not done consistently for applications approved by Provider Enrollment analysts giving them final approval authority. This creates a heightened risk that an application might be approved improperly.

Our testing also determined that certain supporting documents were not consistently included in change orders for approved applications. For instance, detailed testing of

50 change orders determined that some of the change orders did not include documentation of National Provider Identifier numbers, results of background screenings, proof of tax identification numbers, evidence of a current license as required by the provider type, required Medicare certification letters, and signed Medicaid Provider Agreements. Although supporting documents required by the Provider Enrollment Processing Procedures Manual can be accessed on various FMMIS subsystems, Florida Health Finder, and federal database systems, accessing various systems can be time-consuming for Provider Enrollment analysts especially when the Fiscal Agent has already checked this information and normally would have attached this documentation to the change order.

Internal Audit also determined that for applications requiring a review of United States Employment Authorizations and Permanent Resident documents to verify whether the documents have expired could be transferred to the Fiscal Agent instead of referring it to MFAO for review since this information can be confirmed by Fiscal Agent staff.

In addition, for Targeted Case Management Applications that are sent to PECU for further handling, site visits are conducted prior to PECU review despite the high denial rate, which is close to 50 percent in some areas within the State according to PECU staff. Approval or denial could have been determined by PECU prior to the site visit being scheduled. This is contrary to how site visits are conducted for all other provider types. This results in time inefficiencies for field office staff and PECU staff and raises the expectations of the Providers whose site visit may have initially been approved but upon further review by PECU result in a determination of denial.

## **CONCLUSIONS AND RECOMMENDATIONS**

### **Conclusions**

The conclusions of this engagement are as follows:

1. The process for referring provider enrollment applications to MFAO for additional processing could be improved by reducing the type of applications requiring MFAO review.
2. Efficiencies could be improved by requiring PECU review for Targeted Case Management applications prior to scheduling site visits.

### **Recommendations**

We noted that during the course of our engagement, the Provider Enrollment Section improved the process for assigning provider enrollment application reviews to analysts. This process change resulted in a more evenly distributed workload among the Provider Enrollment analysts. In addition, MFAO added two-letter acronyms for identifying certain files for tracking and expedited processing and according to MFAO, new procedures are in development to better align with current application processing.

However, our audit disclosed areas where further improvements could be made to strengthen controls and increase efficiencies. We recommend that MFAO:

1. Identify additional provider enrollment application review activities that could be transferred to the Fiscal Agent such as PECOS verification and the process for reviewing work authorizations and legal residency.

***Management Response:***

This recommendation will be reviewed and prioritized by the Provider Enrollment Process Team. This team has been tasked with identifying and initiating solutions that will streamline the provider enrollment process to more efficiently handle the growing volume of provider applications and improve provider satisfaction with the process. The team is also tasked with development of a standardized process for monitoring and reporting provider enrollment metrics by provider type. All team recommendations and deliverables will be reviewed and approved by the team sponsor and key stakeholders.

*Anticipated Date of Completion: December 1, 2019*

2. Adopt a formalized quality assurance process to ensure MFAO application reviews are conducted accurately, efficiently, and timely. This process should sample a portion of reviewed applications to ensure that Provider Enrollment analysts' reviews were conducted consistently and appropriately. This process could also help identify relevant standardized practices for analysts to use in their application review process and identify applications that may have unnecessary processing delays.

***Management Response:***

The provider enrollment supervisors will begin pulling weekly Change Order (CO) reports. The reports will list the COs that are completed, pending, and overdue. They will use these reports to determine if the analysts are completing the assigned COs in a timely manner.

One of the enrollment analysts is currently monitoring the COs from DXC for accuracy of submissions to MFAO. Through this monitoring a Corrective Action Plan was requested from DXC, which resulted in errors dropping by 65% from February to May 2019.

In addition, the Provider Enrollment Process team has appointed a sub-team to review the number of applications being sent to MFAO and make recommendations to reduce the number of applications coming to MFAO. The Provider Enrollment Process Team is being tasked with identifying and initiating solutions that will streamline the provider enrollment process to more efficiently handle the growing volume of provider applications and improve provider satisfaction with the process. The team is also tasked with development of a standardized process for monitoring and reporting provider enrollment metrics by



provider type. All team recommendations and deliverables will be reviewed and approved by the team sponsor and key stakeholders.

*Anticipated Date of Completion: December 1, 2019*

3. For Targeted Case Management provider applications referred to PECU for further processing, consider conducting site visits after PECU review to increase efficiency and reduce unnecessary site visits for applications with high denial rates and other concerns.

***Management Response:***

MFAO agrees with this recommendation and will start the operational changes for DXC, MFAO, and the Bureau of Recipient and Provider Assistance staff to have this process in place by August 1, 2019.

*Anticipated Date of Completion: December 1, 2019*

## **PROJECT TEAM**

The audit was conducted by Theresa Skipper, CGAP, CIGA, under the supervision of Steven Henry, Senior Management Analyst Supervisor, JD, CGAP, CIGA and Pilar Zaki, Audit Director, JD, CIGA.

## **FINAL COMMENTS**

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

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