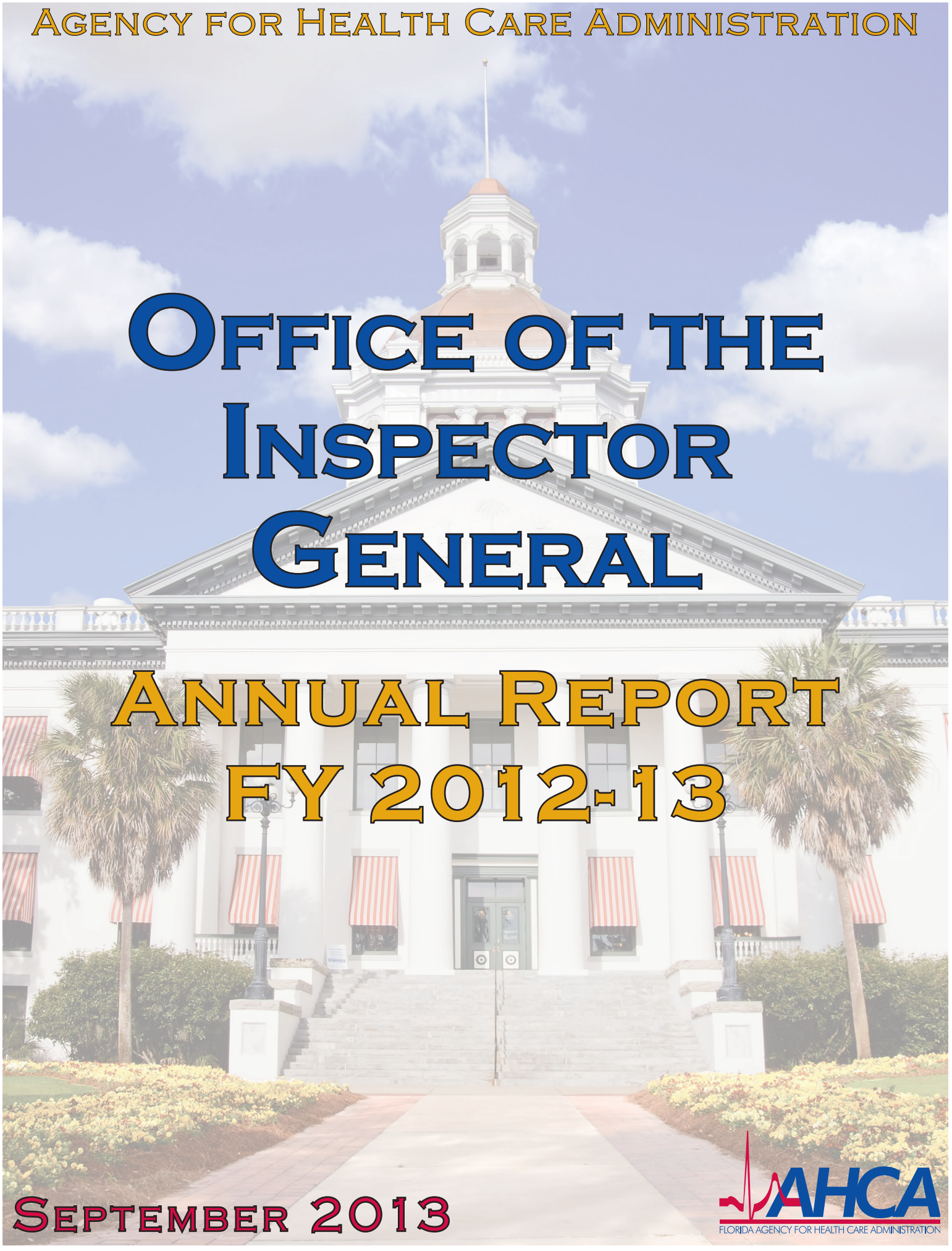
Agency for Health Care Administration

Office of the Inspector General

Annual Report FY 2012-13



September 2013

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

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Office of the Inspector General

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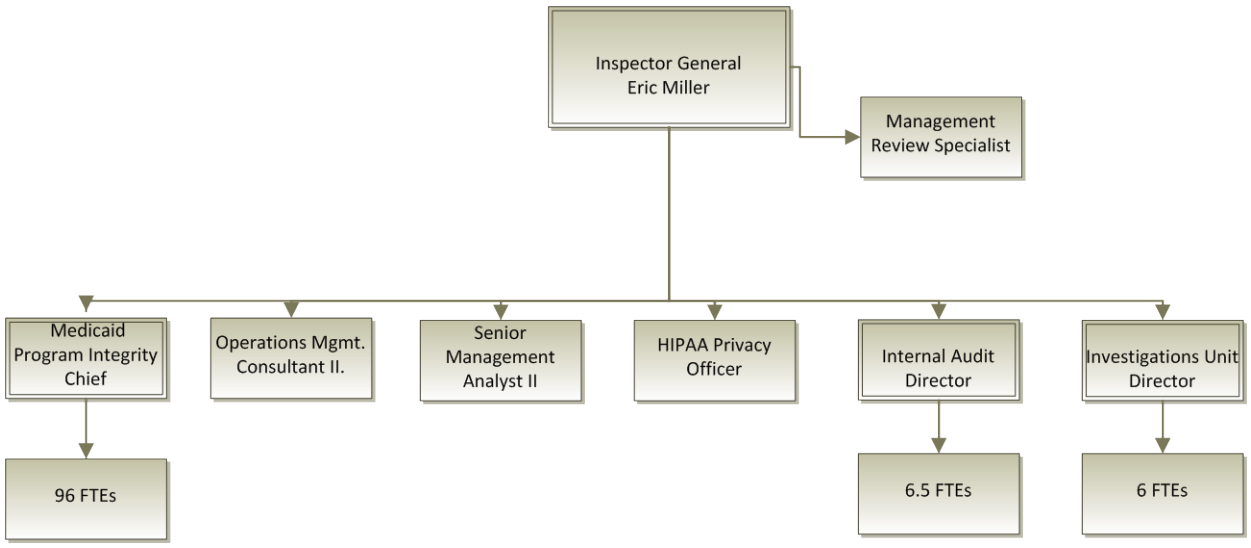


Background

The Office of the Inspector General (OIG) is an integral part of the Agency for Health Care Administration (Agency). The purpose of the OIG is to provide a central point for coordination of, and responsibility for, activities that promote accountability, integrity and efficiency in the Agency. Section 20.055, Florida Statutes (F. S.), defines the duties and responsibilities of each inspector general, with respect to the state agency or department in which the office is established.

The statute requires that the OIG submit to the Agency Secretary an annual report, not later than September 30 of each year, summarizing its activities during the preceding state fiscal year. This report includes but is not limited to:

- A description of significant abuses and deficiencies relating to the administration of programs and operations of the Agency disclosed by investigations, audits, reviews or other activities during the reporting period;
- A description of recommendations for corrective action made by the Inspector General during the reporting period with respect to significant problems, abuses or deficiencies identified;
- The identification of each significant recommendation described in previous annual reports on which corrective action has not been completed; and
- A summary of each audit and investigation completed during the reporting period.

This document is presented to the Secretary to comply with these statutory requirements and to provide information on the OIG's progress in completing its mission as defined by Florida law.

Mission Statement

The primary mission of the OIG is to assist the Secretary and other Agency management in championing accessible, affordable, quality health care for all Floridians by assessing the efficiency and effectiveness of Agency resource management.

This is accomplished by providing an independent examination and evaluation of Agency programs, activities and resources and by conducting internal investigations of alleged violations of Agency policies, procedures, rules or laws. Reports of findings are prepared and distributed to appropriate management. Also, the OIG provides oversight for the Internal Audit Section, the Investigations Unit and for the Office of Medicaid Program Integrity. The organizational chart on page 1 provides the structure of the OIG. In addition to the typical audit and investigative functions of an Office of Inspector General, the OIG for the Agency for Health Care Administration has responsibility for the Office of Medicaid Program Integrity (MPI), whose primary mission is to prevent, deter, detect and recoup Medicaid fraud and abuse related overpayments and has responsibility for Health Insurance Portability and Accountability Act (HIPAA) compliance.

OIG Responsibilities

The specific duties and responsibilities of the Inspector General, according to Section 20.055(2), F. S., include:

- Reviewing actions taken by the Agency to improve program performance and meet program standards;
- Conducting, supervising or coordinating other activities to promote economy and efficiency in the administration of, or preventing and detecting fraud and abuse in its programs and operations;
- Reporting to the Agency head concerning fraud, abuses and deficiencies, recommending corrective action and reporting on the progress made in implementing corrective action;
- Ensuring effective coordination and cooperation between the Auditor General, federal auditors and other governmental bodies;
- Reviewing rules, as appropriate, relating to the programs and operations of the Agency; and
- Ensuring that an appropriate balance is maintained between audit, investigative and other accountability activities.

In addition, the Inspector General is required to initiate, conduct, supervise and coordinate investigations designed to detect, deter, prevent and eradicate fraud, waste, mismanagement, misconduct and other abuses in the Agency. The investigative duties and responsibilities of the Inspector General, pursuant to Section 20.055(6), F. S., include:

- Receiving complaints and coordinating activities of the Agency as required by the Whistle-blower's Act pursuant to Sections 112.3187 – 112.31895, F. S.;
- Receiving and considering the complaints which do not meet the criteria for an investigation under the Whistle-blower's Act and conducting, supervising or coordinating such inquiries, investigations or reviews as the Inspector General deems appropriate;
- Reporting expeditiously to the Department of Law Enforcement or other law enforcement agencies, as appropriate, whenever the Inspector General has reasonable grounds to believe there has been a violation of criminal law;
- Conducting investigations and other inquiries free of actual or perceived impairment to the independence of the Inspector General or the OIG. This includes freedom from any interference with investigations and timely access to records and other sources of information; and
- Submitting final reports on investigations conducted by the Inspector General to the Agency head, except for Whistle-blower's investigations, which are conducted and reported pursuant to Section 112.3189, F. S.

Internal Audit

Internal Audit Functions

The purpose of Internal Audit (IA) is to provide independent, objective assurance and consulting services designed to add value and improve the Agency's operations. Internal Audit's mission is to assist the Secretary and other Agency management in ensuring better health care for all Floridians by bringing a systematic, objective approach to evaluate and improve the effectiveness of Agency risk management, control and governance processes.

Internal Audit operates within the Agency's Office of the Inspector General (OIG) under the authority of Section 20.055, Florida Statutes (F.S.). In accordance with Section 20.055(5)(c), F.S., the Inspector General and staff shall have access to any records, data and other information of the Agency deemed necessary to carry out its duties. The Inspector General is also authorized to request such information or assistance as may be necessary from the Agency or from any federal, state or local government entity.

Assurance Engagements

These engagements are conducted to determine if a unit's system of internal controls is adequate to accomplish its business objectives and encompass:

- Reliability and integrity of information;
- Compliance with policies, procedures, laws and regulations;
- Safeguarding of assets;
- Economic and efficient use of resources; and
- Accomplishment of established objectives and goals for operations or programs.

The nature and scope of the assurance engagement are determined by Internal Audit. Assurance engagements are performed in accordance with the *International Standards for the Professional Practice of Internal Auditing (Standards)* published by the Institute of Internal Auditors (IIA).

Assurance engagements result in written reports of findings and recommendations, including responses by management. These reports are distributed internally to the Agency Secretary and affected program managers, to the Office of the Governor's Chief Inspector General and to the Office of the Auditor General.

Consulting Engagements

These engagements provide assistance to Agency management or staff for the purpose of improving specific program operations or processes. In performing consulting engagements, IA's objective is to assist management or staff to add value to Agency programs by streamlining

operations, enhancing controls and implementing best practices. These engagements are generally performed at the specific request of management, of which the nature and scope are agreed upon by IA and management. Some examples of consulting engagements include:

- Reviewing processes and interviewing staff within specific areas to identify process weaknesses and make recommendations for improvement;
- Facilitating meetings and coordinating with staff of affected units to propose recommendations for process improvements, seek alternative solutions and determine feasibility of implementation;
- Facilitating adoption and implementation between management and staff, or between agency units;
- Participating in process action teams;
- Reviewing planned or new processes to determine efficiency, effectiveness or adequacy of internal controls; and
- Preparing flow charts or narratives of processes for management.

Consulting engagements are performed in accordance with the *Standards* published by the IIA, where appropriate. Written reports may be issued to affected program managers.

Management Reviews

Management Reviews are reviews of Agency units, programs or processes that do not require a comprehensive audit. These reviews may also include compliance reviews of Agency contractors or entities under Agency oversight. Management reviews result in written reports or letters of findings and recommendations, including responses by management. The *Standards* are not cited. These reports are distributed internally to the Agency Secretary and affected program managers. In addition, certain reports are sent to the Executive Office of the Governor's Chief Inspector General and to the Office of the Auditor General.

Special Projects and Other Projects

Services other than assurance engagements, consulting engagements and management reviews performed by IA for Agency management or for entities outside of the Agency are considered special projects. Special projects may include: enterprise audits, participation in intra-agency and inter-agency workgroups; attendance at professional meetings; or assisting an Agency unit, the Governor's office or the Legislature in researching an issue. Special projects also include atypical activities that are accomplished within IA such as installation of new software or revision of IA's policies and procedures.

Internal Audit Staff

Internal Audit staff brings various backgrounds and expertise to the Agency. Certifications or advanced degrees collectively held by IA staff as of June 30, 2013 include:

- Certified Public Accountant
- Certified Internal Auditor
- Certified Fraud Examiner (3)
- Certified Information Systems Auditor
- Juris Doctorate
- Master of Public Administration
- Master of Business Administration
- Master of Accounting and Financial Management

The *Standards* and the Association of Inspectors General's *Principals and Standards for Offices of Inspector General* require IA staff members to maintain their professional proficiency through continuing education and training. Each auditor must receive at least 40 hours of continuing education every year. This is accomplished by staff attending courses, conferences, seminars and webinars throughout the year. IA staff has attended trainings sponsored by national and local chapters of the Association of Inspectors General, Institute of Internal Auditors, Association of Certified Fraud Examiners, Association of Government Accountants, Information Systems Audit and Control Association and the InfraGuard Members Alliance which deals with information technology security and criminal issues. Staff has also attended Agency employee training and Government and Nonprofit Accounting video training.

Internal Audit Organizational Chart

Internal Audit Activities

Assurance Engagements, Consulting Engagements, and Management Reviews

Internal Audit completed a total of seven assurance engagements, consulting engagements or reviews during FY 2012-13. IA continues to monitor progress of management actions taken to correct significant abuses or deficiencies noted in the administration of Agency programs and operations disclosed by these engagements. A listing of the engagements completed and in progress as of June 30, 2013 follows:

Internal Audit Engagements Completed as of June 30, 2013

Report No.	Engagements	Type	Date Issued
12-04	Agency Accounts Receivable Process	Assurance	June 2013
12-10	Medicaid Risk Management Processes Review	Review	February 2013
13-03	ARRA Data Quality Review, QE 6/30/2012	Review	July 2012
13-08	Review of FMMIS and DSS Assessment Project Procurement	Review	February 2013
13-09	ARRA Data Quality Review, QE 9/30/12	Review	October 2012
13-13	ARRA Data Quality Review, QE 12/31/12	Review	January 2013
13-17	ARRA Data Quality Review, QE 3/31/13	Review	April 2013

Internal Audit Engagements in Progress as of June 30, 2013

Report No.	Engagements	Type	Planned Issue Date
13-02	Review of Agency's Use of Accurint and TLO Software	Review	November 2013
13-06	Adverse Incident Reporting	Assurance	October 2013
13-10	Medicaid Provider Payment Suspension and Termination Processes	Review	October 2013
13-12	Medicaid Provider Enrollment Process	Assurance	November 2013
13-14	Medicaid Recipient File Maintenance	Assurance	January 2014
13-15	Agency Compliance with Data Exchange Memorandum of Understanding with Highway Safety and Motor Vehicles	Assurance	October 2013
13-18	Managed Care Organizations' Anti-Fraud Plans	Enterprise Audit/Special Project	December 2013
14-05	ARRA Data Quality Review, QE 6/30/13	Review	July 2013

The following summaries describe the results of the assurance engagements, consulting engagements and reviews completed by IA during the past fiscal year.

12-04 Agency Accounts Receivable Process

Internal Audit conducted an assurance engagement of the Agency's accounts receivable processes within the Bureau of Finance and Accounting (F&A) and other areas of the Agency. The focus of this audit was to identify the main business processes, assess the adequacy of their internal control structures and identify areas that could improve efficiency and effectiveness. The accounts receivable systems were reviewed that included MAR, HAR, RARA, and OPC Track Billing. Staff also reviewed the accounts receivables originating from the Division of Health Quality Assurance and maintained in Versa (a licensure enforcement tracking system).

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

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

Medicaid Risk Management Processes Review

At the request of the Secretary and to assist in correcting deficiencies noted in Auditor General Report No. 2012-021, *FMMIS Controls and the Prevention of Improper Medicaid Payments*, the IA reviewed the Division of Medicaid's (Medicaid) risk management processes. The scope of this engagement covered the risk management processes currently conducted by Medicaid that pertain to the prevention of improper payments for Medicaid services. IA's objectives were to evaluate current risk management processes, evaluate the reporting of key risks and review the management of key risks. The review disclosed that Medicaid management identified and addressed a number of risks that could possibly impact Medicaid as well as the Agency.

However, the review identified items that could improve Medicaid's risk management processes:

- An Enterprise Risk Management (ERM) Steering Committee needs to be established to oversee efforts to identify, assess, measure, respond, monitor and report risks. Also, a core team should be established to adopt the ERM framework and an ERM Officer should be appointed.
- A comprehensive ERM policy needs to be formally developed and documented.
- The process of setting objectives, identifying events, assessing risks and responding to the identified risk needs to be formalized and documented.
- The compilation of risk assessments completed by the various business units should be the responsibility of the ERM Officer and one business unit.
- Formal communication protocols and procedures to share risk information should be established.
- Information systems should be reviewed to determine if they house useful and relevant data in order for management to implement an effective ERM process.
- The effectiveness of the ERM process should be periodically assessed and deficiencies reported to the appropriate senior managers.

ARRA Data Quality Reviews
(13-03, 13-09, 13-13, and 13-17 for quarters ending 6/30/12, 9/30/12, 12/31/12, and 3/31/13)

The purpose of the American Recovery and Reinvestment Act of 2009 (ARRA) is to provide federal assistance designed to create and preserve jobs, stimulate economic development and provide help for people affected by the national economic recession. Staff reviewed the following ARRA award:

Florida Health Information Exchange Cooperative Agreement Program in the amount of $20,738,582. The purpose of this project is to implement a statewide health information exchange (HIE) plan that will facilitate and expand the secure, electronic movement and use of HIE among organizations according to nationally recognized standards.

Internal Audit completed four data quality reviews of the ARRA award data reported by the Agency in the FlaReporting System for the quarters ending June 30, 2012, September 30, 2012, December 31, 2012 and March 31, 2013. IA's objective was to determine if there were any material omissions or significant errors in the data. The reviews did not disclose any material omissions or significant errors in the data submitted to the federal government.

Review of FMMIS and DSS Assessment Project Procurement (13-08)

At the request of the Chief Inspector General, IA reviewed the Agency's procurement process for the Florida Medicaid Management Information System (FMMIS) and Decision Support System (DSS) Assessment Project. The focus of this review was the procurement indexed as AHCA RFP 008-11/12.

The 2012-13 General Appropriations Act included an appropriation of $1.5 million for the Agency to competitively procure a private consultant to evaluate FMMIS as a result of the State transitioning to managed care for most Medicaid recipients. The consultant was tasked with performing environmental scans of Florida and other comparable states' MMIS and Decision Support Systems to develop recommendations for a "Best in Class" model to support Florida's Statewide Medicaid Managed Care program. Based on the review, the procurement's project scope of services addressed the basic requirements of this Act. The report also noted that the Agency complied with 85% of the applicable statutory, administrative code and Agency policy requirements. However, it appeared Agency personnel were more concerned with the timeliness of the procurement rather than obtaining high quality services at the "best value" to the state.

The review identified the following items for improvement:

- The Agency should ensure only an Agency Certified Contract Manager is assigned to manage a contractual project.
- The Agency should comply with its procurement language, "Failure to submit" any mandatory requirement "will result in the rejection of a prospective vendor's response," or not include those requirements in the procurement package.
- The Mandatory Criteria sheet should have a place to identify the vendor whose information is recorded on the Mandatory Criteria sheet.
- The Agency should post timely advertisements on VBS. All advertisements should have an adequate description of the purpose of the advertisement. Addendums should be attached with additional information.
- The Agency should document in writing all major decision points in the procurement process. Any communication with the Office of General Counsel should also be documented with specific detail.
- All changes should be explained in writing, initialed and dated. Evaluators should sign and date their score sheets. In the future, the Agency may want to consider asking the Evaluators to provide a brief narrative to sum up their evaluation and identify any issues/problems that requires a discussion.
- Procurement staff should sign and date questionnaires, as required.
- The Agency should consider requiring the addition of the project dates and a detailed description of provided services on the questionnaires.
- The Agency should consider how scores and weights reflect what is important to the accomplishment of the project. If a category is important for the project, that category should reflect a higher weight and require detailed verification and/or evaluation of criteria. The Agency should consider requiring audited financial statements for projects over a certain dollar threshold (example, $1 million).
- To ensure contracts are awarded in the best interest of the State, the Agency should identify required minimum total scores. Minimum scores can be separated into different categories; for example, financial and technical. If multiple categories are defined, the proposals must meet each category's minimum score. Proposals that fail to attain minimum scores in any category should not be considered.

- Evaluation score sheets should not contain questions for non-required options, without a weighted score for those vendors that did not choose that option. This could appear to unfairly reward vendors. The Agency should not delete criteria on any vendor's evaluation when the criteria do not apply to that specific vendor.
- To ensure consistency in how Agency competitive procurements are evaluated, the Agency should develop and implement Evaluator training. Each Evaluator should be required to attend the training before participating in any procurement process.
- In Evaluator training, the Procurement Office should stress the importance of reviewing and bringing a copy of the Request for Proposal to the evaluation. This would ensure consistency in what the Evaluators use in their assessment.
- The Procurement Office should update their procedures to address any gaps in the procurement process.

Additional Projects

Additional projects completed by IA during the fiscal year included Enterprise Wide Background Screening; Schedule IX of the Legislative Budget Request; review of performance measures in the Agency's Long Range Program Plan; Summary Schedule of Prior Audit Findings; U. S. Department of Health and Human Services Audit Resolution Letter; Chief IG Quarterly Activity Reports; OIG Annual Report and the annual Risk Assessment and Audit Plan.

Internal Engagement Recommendations Status Reports

The *International Standards for the Professional Practice of Internal Auditing* require auditors to follow-up on reported findings and recommendations from previous assurance engagements and reviews to determine whether Agency management has taken prompt and appropriate corrective action. The OIG provides status reports on internal engagement findings and recommendations to Agency management at six-month intervals after publication of an engagement report.

During FY 2012-13, the following status reports for internal engagements were published:

- 13-01 Contract Monitoring 6 Month Status Update
- 13-05 Enterprise Wide Audit of Organizational Ethics 18 Month Status Update
- 13-11 Contract Monitoring 12 Month Status Update

Corrective Actions Outstanding From Previous Annual Reports

As of June 30, 2013 the following corrective actions for significant recommendations described in previous annual reports were still outstanding:

Enterprise Wide Audit of Organizational Ethics, Report 11-18 issued May 5, 2011 (Most Recent Management Response as of 10/24/12)

Recommendation: IA recommended that the subjects of public records, open meetings, records retention, equal opportunity and the related proper personnel procedures be incorporated into the Agency's required *New Employee Orientation* and *Keep Informed* training classes.

Most Recent Management Response: The Agency Records Retention Policy is still under review. The Division of Operations is waiting for the results of a work committee to update the records retention policy.

Recommendation: The Bureau of Human Resources should continue to track and send email reminders to employees that have not yet fulfilled their annual training requirements.

Most Recent Management Response: The Bureau tracks employee training and is developing a database to more efficiently track this training with the assistance of the Division of Information Technology staff.

Due to the length of time the remaining corrective actions have been in progress and the need to focus IA's resources on other projects, IA is no longer monitoring these issues. The responsibility for ensuring corrective action is taken lies with the Division of Operations.

Enterprise Wide Audit of Contract Monitoring, Report 12-05 issued March 15, 2012 (Most Recent Management Response as of 3/13/2013)

Recommendation: The Procurement Office, in concert with General Counsel (to ensure compliance with Section 112.24, F.S. and Section 215.971, F.S.) develop policies and procedures for Agency agreements to help ensure consistency in the development, execution, and monitoring of Agency agreements.

Most Recent Management Response: The Procurement Office has completed a revised draft Agency Agreement policy which is currently being routed for approval through the Agency.

Recommendation: Update appropriate policies and procedures, specifically the Procurement Policy and the Contract Manager Desk Reference, to include the requirements specified in Section 287.057(14), Section 287.057(16)(a)&(b), and Section 287.133(3)(b), F.S.

Most Recent Management Response: The Procurement Office is reviewing its policies and procedures to ensure policies are current and forms are updated as appropriate. The Department of Management Services recently published the *Florida Procurement Guidebook*. The Procurement Office is utilizing this Guidebook in updating its policies and procedures.

External Engagement Recommendations Status Reports

Pursuant to Section 20.055(5)(h), F.S., the OIG monitors the implementation of the Agency's response to external audit reports issued by the Auditor General and by the Office of Program Policy Analysis and Government Accountability (OPPAGA). The OIG is also required to provide a written response to the Secretary on the status of corrective actions taken no later than

six months after a report is published. A copy of the response is also provided to the Legislative Auditing Committee. Additionally, pursuant to Section 11.51(3), F.S., OPPAGA submits requests (no later than 18 months after the release of a report) to the Agency to provide data and other information describing specifically what the Agency has done to respond to recommendations contained in their reports. The OIG is responsible for coordinating these status reports and ensuring that they are submitted within the established time frames.

During FY 2012-13, status reports were submitted on the following external reports:

- Auditor General - State of Florida Compliance and Internal Controls Over Financial Reporting and Federal Awards, FYE June 30, 2011 (Report No. 2012-142)
- OPPAGA – Agency for Health Care Administration Continues Efforts to Control Medicaid Fraud and Abuse (Report No. 11-22)
- Coordination with Other Audit and Investigative Functions

The OIG acts as the Agency's liaison on audits and reviews conducted by outside organizations such as the Office of the Auditor General, OPPAGA, the U. S. Department of Health and Human Services, the Social Security Administration, the United States Government Accountability Office and the Department of Financial Services. The OIG also coordinates the Agency's responses.

During FY 2012-13, the following reports were issued:

Office of the Auditor General

- Office of Inspector General's Internal Audit Activity Quality Assessment Review (Report No. 2013-062)
- Public Assistance Eligibility Determination Processes At Selected State Agencies (Report No. 2013-133)
- Compliance and Internal Controls Over Financial Reporting and Federal Rewards (Report No. 2013-161)

Office of Program Policy Analysis and Government Accountability

- OPPAGA Analysis of Rates for Florida's Program of All- Inclusive Care for the Elderly (PACE) (Research Memorandum dated January 2013)
- OPPAGA Research on Assisted Living Facilities (ALFs) (PowerPoint presentation)
- Profile of Florida's Medicaid Home and Community-Based Services Waivers (Report No. 13-07)

United States Government Accountability Office (GAO)

- Medicaid – Enhancements Needed for Improper Payments Reporting and Related Corrective Action Monitoring (GAO-13-229)

U. S. Department of Health and Human Services

- Florida Comprehensive Program Integrity Review Final Report (dated July 2012)
- Florida Claimed Some Medicaid Administrative Costs That Did Not Comply With Program Requirements (Report No. A-04-10-00076)
- Florida Medicaid: Millions in Overpayments Not Refunded (Report No. A-04-11-08007)
- Florida Generally Ensured That Providers Complied With Selected State Durable Medical Equipment Enrollment Requirements (Report No. 04-12-07034)

Risk Assessment

Internal Audit performs a risk assessment of the Agency's programs and activities each year to assist in the development of the Annual Audit Plan. The Risk Assessment is a formal process that includes identification of activities or services performed by the Agency and evaluation of various "risk factors" where conditions or events may occur that could adversely affect the Agency. Activities assessed consist of each Bureau's critical functions that allow the Bureau to achieve its mission. Risk factors used to assess the overall risk of each core function include but are not limited to:

- The adequacy and effectiveness of internal control;
- Changes in the operations, programs, systems, or controls;
- Changes in personnel;
- Maintenance of confidential information;
- Dependency on systems maintained by the Bureau;
- Complexity of operations; and
- Dependency on other programs or systems external to the Bureau (both within and outside the Agency.)
- The assessment of the overall risk of each activity is accomplished by appropriate management and IA ranking the areas of concern in importance using the risk factors. The ranking of the activities is reviewed and evaluated. Meetings are held with management to discuss the ranking and to identify any additional areas of concern.

Audit Plan

Internal Audit has developed an Annual Audit Plan for the FY 2013-14. This plan also includes audit issues that will be addressed in FY 2014-15 and FY 2015-16. The audit plan includes activities that are to be audited or reviewed, audit and review schedules, budgeted hours and assignment of staff. Steps taken in developing the audit plan include:

- Performing a Risk Assessment to identify auditable activities and ranking each activity using established criteria to determine the relative significance of, and likelihood that, conditions or events may occur that could adversely affect the Agency;
- Reviewing and evaluating the auditable activities that rank the highest in risk and that could potentially adversely affect the Agency, its providers or health care recipients; and
- Meeting with Agency management and the Secretary to obtain feedback on these auditable activities and on any additional areas of concern.

The audit plan was approved by the Agency Secretary and provides the most effective coverage of the Agency's programs and processes while optimizing the use of internal audit resources.

HIPAA Compliance Office

The Health Insurance Portability and Accountability Act (HIPAA) Compliance Office coordinates Agency compliance with HIPAA requirements, pursuant to Title 45, Code of Federal Regulations, Parts 160, 162 and 164 (Public Law 104-191) and the Health Information Technology Economic and Clinical Health (HITECH) Act (Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), Public Law 111-5).

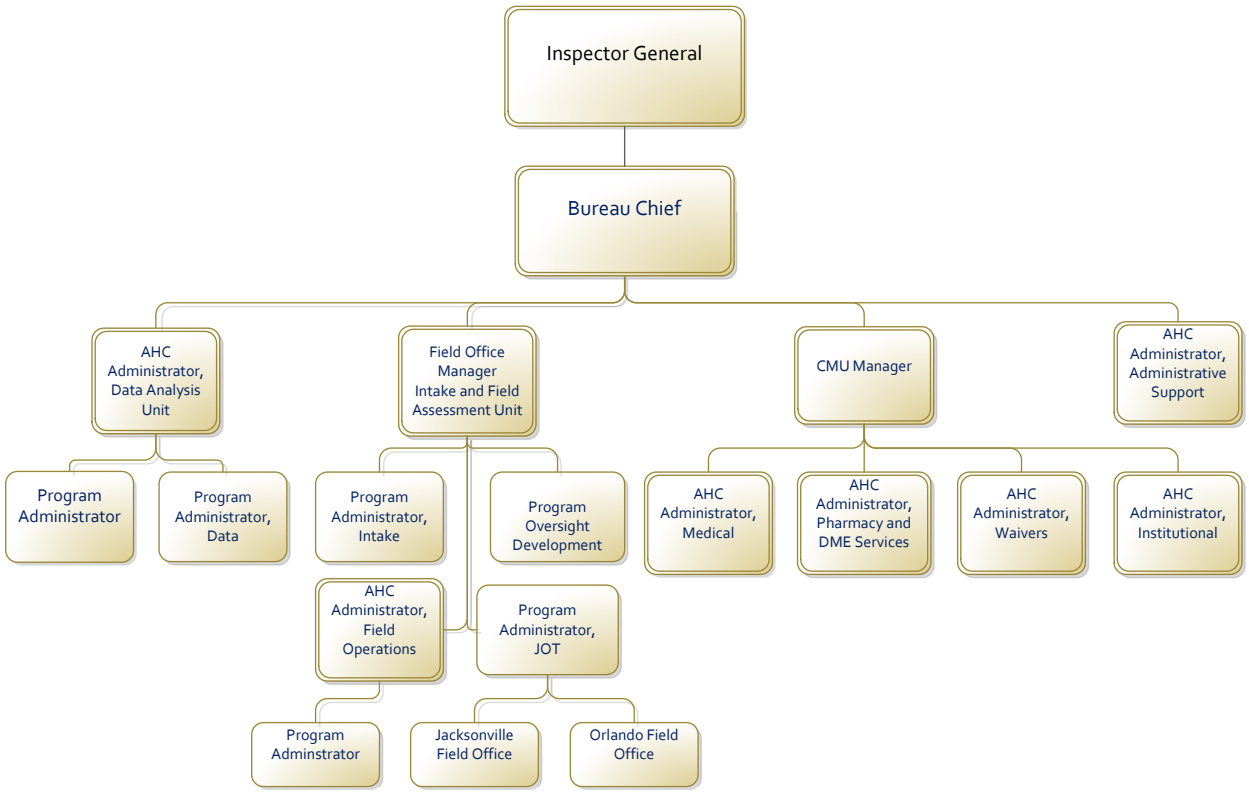
Responsibilities and activities undertaken by the HIPAA Compliance Office in FY 2012-13 included:

- Administering both the HIPAA and HITECH Privacy Training and Security Awareness Training online programs for all Agency employees;
- Providing in-person HIPAA and HITECH privacy training to all Agency employees as part of their new employee orientation and annual refresher training;
- Responding to requests for protected health information (PHI), HIPAA-related complaints against the Agency or its employees and other questions or requests involving HIPAA;
- Providing guidance to Agency staff regarding potential privacy incidents or breach situations and ensuring Agency actions in such situations are in compliance with HIPAA rules.
- Developing and implementing Agency policies and procedures to comply with HIPAA and HITECH regulations;
- Ensuring Agency HIPAA web site content is up to date and contains relevant information for use by Agency employees, Medicaid recipients, and the general public;
- Reviewing Agency contracts to ensure compliance with HIPAA and HITECH requirements;
- Updating the Agency's Notice of Privacy Practices and ensuring its distribution to all Medicaid recipients; and
- Coordinating with the Agency's Office of General Counsel on revising the Agency's Business Associate Agreement and implementing other changes brought about by the 2013 Omnibus HIPAA Rule.

Medicaid Program Integrity

As an integral part of the Office of the Inspector General, the Office of Medicaid Program Integrity (MPI) is responsible for ensuring that Medicaid payments are made to appropriate providers for eligible services provided to eligible Medicaid recipients. MPI also ensures that fraudulent and abusive behavior occurs to the minimum extent possible; recovering overpayments and imposing sanctions as appropriate. MPI accomplishes this mission through fraud and abuse prevention activities, detection analyses, audits and investigations, imposition of sanctions and referrals to the Medicaid Fraud Control Unit (MFCU) of the Office of the Attorney General and to other regulatory and investigative agencies.

MPI Organizational Chart



Prevention

The prevention of Medicaid fraud and abuse reduces the need for detection and investigation and is a high-priority activity of Medicaid Program Integrity, which devotes approximately forty percent of its staff resources to prevention activities. These activities include the use of prepayment reviews to identify improper Medicaid claims and to deny such payments; providing information on providers suspected of misusing the Medicaid program; initiating projects to address areas that are believed to be more susceptible to fraud and abuse, creating a

deterrent effect that results in cost savings for the Medicaid program; making referrals to other regulatory and law enforcement entities that may result in restrictions on providers' ability to continue to participate in the Medicaid program, and the use of a provision of law that allows Medicaid to decline reimbursement for prescription drugs prescribed by practitioners who abused the program or were terminated from the Medicaid program.

Detection

The detection of possible Medicaid abuse through the misbilling of claims is one of the most important and challenging aspects of the work of Medicaid Program Integrity. More than 150,000,000 claims are received annually by the Florida Medicaid program. These are processed by the Florida Medicaid Management Information System, subjected to system edits, and are paid, pended or denied. The system edits are not able to detect all abusive claims, however. For example, edits can note duplicate claims and those claims for procedures that are inconsistent with the age or sex of the recipient, but cannot detect when goods or services were not medically necessary or actually provided. Accordingly, Medicaid Program Integrity has developed and used advanced detection software and has also used certain detection software supplied by the Medicaid fiscal agent contractor. MPI has originated chi-square analysis software to detect upcoding of claims, i.e., the billing of higher paying procedure codes than warranted by the services actually supplied, and has developed early warning system software to detect sudden unwarranted increases in providers' billings. Still, abusive claims go undetected and more sophisticated and effective detection software is required and being explored by the Agency for procurement in FY 2013-14.

Investigation and Recovery

Medicaid Program Integrity recovers overpayments, i.e., payments made in a manner inconsistent with Medicaid policy, through MPI-conducted audits, paid claims reversals and vendor-assisted audits. MPI audits include comprehensive investigations involving reviews of professional records, generalized analyses involving computer-assisted reviews of paid claims and focused audits involving reviews of certain types of providers in specific geographic areas. MPI audits utilize generally-accepted accounting principles and statistical analysis methods. Pharmacy paid-claims reversals are effected within MPI by Florida licensed pharmacists who review pharmacy paid claims and identify apparent misbillings. Vendor-assisted audits are conducted, under MPI supervision, by contracted firms who perform work that would otherwise not be possible due to staffing limitations.

Annual Fraud and Abuse Report

The results of these Medicaid Program Integrity activities are presented in the report entitled The State's Efforts to Control Medicaid Fraud and Abuse for the fiscal year. This report is published by January 1 and is submitted to the Legislature pursuant to the requirements found in Section 409.913, F. S. It details the results of the combined efforts to control Medicaid fraud and abuse for the fiscal year by the Agency for Health Care Administration and the Medicaid Fraud Control Unit of the Office of Attorney General. The report is available on the Agency's internet site: http://ahca.myflorida.com/Executive/Inspector_General/index.shtml.

Investigations Unit

The Office of the Inspector General (OIG), Investigations Unit (IU) is responsible for initiating, conducting and coordinating investigations that are designed to detect, deter, prevent and eradicate fraud, waste, mismanagement, misconduct and other abuses within the Agency. To that effort, the IU conducts internal investigations of Agency employees and contractors related to alleged violations of policies, procedures, rules and Florida laws. Complaints may originate from the Office of the Chief Inspector General, the Whistleblower Hotline, the Chief Financial Officer's "Get Lean" Hotline, Agency employees, health care facilities, practitioners, Medicaid beneficiaries or the general public. Investigations conducted by the IU may include alleged violations of:

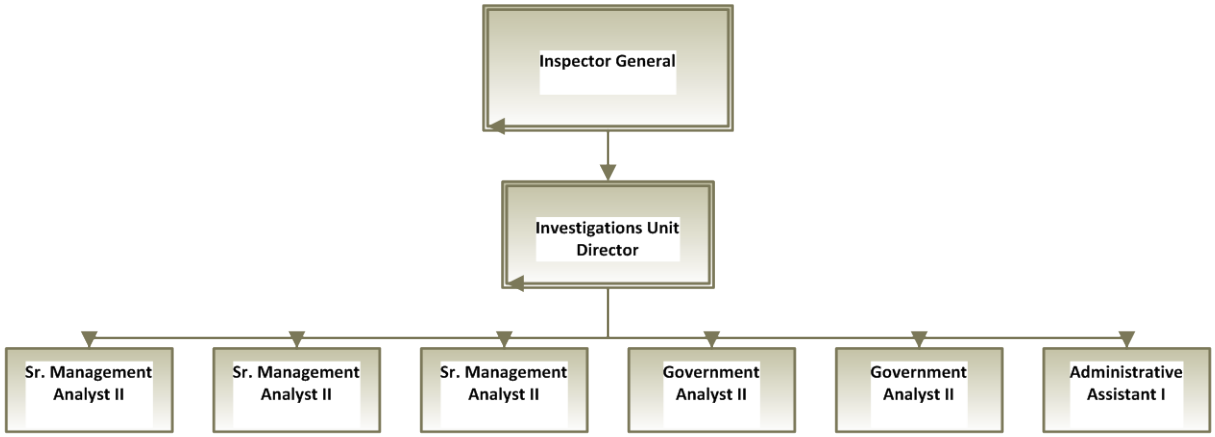
- Agency conduct standards;
- Unauthorized disclosure of confidential information;
- Theft;
- Misuse of property, records or documents;
- Violation of the nepotism policy; and
- Falsification of records.

Allegations of a criminal nature are referred to the appropriate law enforcement entity. When necessary or requested, the IU works closely with the local police, the Florida Department of Law Enforcement, the Office of the Chief Inspector General and the appropriate State Attorney's Office.

Investigations staff brings various backgrounds and expertise to the Agency. Certifications in addition to advanced degrees, collectively held by IU staff as of June 30, 2013 include:

- Certified Compliance and Ethics Professional;
- Certified Fraud Examiners;
- Nationally certified inspector general investigators;
- Certified Equal Employment Opportunity investigators;
- Former law enforcement officers; and
- Current reserve police officer.

Investigations Organizational Chart



In FY 2012-13, the IU addressed 201 complaints or concerns that were reported to or generated by the IU office. Twenty-two of these cases required analysis to determine if the complaint met the criteria for protection under the Whistle-blower's Act, as defined in §112.3187 F.S. Ten complaints met the criteria; two were referred to external partners and the remaining eight were addressed by the Agency.

Investigations that resulted in published investigative reports were distributed to the leadership responsible for the employee or program investigated for appropriate personnel action or recommended policy changes. The published reports were also presented to the Agency Secretary for review, resolution and action.

The following are examples of internal investigative reports published during FY 2012-13. An index of complaints received during this reporting period is included at the end of this section.

Investigation 12-028

Following a media report regarding questionable dental procedures for Medicaid patients, the Office of Inspector General investigated a random sample of Medicaid recipient records. The review disclosed a full mouth debridement was provided for all of the recipients reviewed. The investigation was inconclusive as to whether or not the treatment was necessary or a violation of Medicaid policy at that time. As a result of this review, Medicaid policy was revised to limit full debridements to patients between the ages of 16-20 years old.

Investigation 12-046

An AHCA employee alleged employment discrimination based on age and race and retaliation against an AHCA supervisor.

When the complainant applied for an internal job vacancy and was not selected in favor of another candidate, the complainant alleged age and racial discrimination and engaged in argumentative and hostile behavior with the selected applicant.

Investigative interviews and supporting documentation disclosed the methods used to select the initial applicant and then fill the position with a second applicant did not violate Agency policies or procedures. There was no evidence presented or discovered to substantiate the complainant's allegations of age and racial discrimination or retaliation.

Investigation 12-143

An AHCA employee was alleged to have falsified a State of Florida application for employment by omitting a prior arrest history.

Evidence disclosed the employee had entered a plea of nolo contendere for an arrest in 2002, but failed to report the plea by answering "No" to the question, "Have you ever pled nolo contendere or pled guilty to a crime which is a felony or first degree misdemeanor?" on a State of Florida application for employment in 2012. This allegation was substantiated.

Investigation 12-212

A complainant alleged sexual harassment by another AHCA employee.

Investigative evidence and interviews disclosed five AHCA employees had been subjected to inappropriate and offensive comments and improper behavior and physical touching by another AHCA employee. This complaint was substantiated as conduct unbecoming by the subject employee.

Investigation 12-230

After the Office of Inspector General received notification that unlicensed building contractors had provided Medicaid services through the Home Modification/Environmental Accessibility service in the Home Based Community Service (HBCS) waiver program, a review of all building contractors providing Home Modification/Environmental Accessibility services was conducted.

The results of the review disclosed some contractors were operating without proper building permits and other contractors were acting without licensure by the Florida Department of Business and Professional Regulation.

The results of these findings were referred to AHCA's Division of Medicaid Services for further review and any handling as deemed appropriate.

Investigation 12-238

An AHCA employee was alleged to have engaged in conduct unbecoming a public employee with a regulated entity. The allegation was substantiated.

Investigation 13-017

An AHCA employee was alleged to have engaged in conduct unbecoming a public employee and to have maintained simultaneous employment with a regulated entity

Investigative research disclosed while on Workers Compensation leave from the Agency, an AHCA employee applied for and obtained a full-time position with a regulated entity. Then, while employed with the regulated entity, the employee displayed their AHCA employee ID badge, without a legitimate business reason, and threatened to report the facility to AHCA for fraud. . Both allegations were substantiated.

Investigation 13-020

A former employee of a subcontractor of a facility alleged the facility was endangering patients and facility staff when they used broken or defective equipment. The complainant also alleged the facility failed to respond to grievances.

This complaint was referred to the Agency's Division of Health Quality Assurance (HQA) for review and investigation of the complainant's allegations. Evidence was collected and interviews were conducted by HQA during a site visit to the facility. Documentary evidence maintained by the facility disclosed grievances were documented and responses were provided. Investigative interviews with facility staff disclosed employees removed equipment in disrepair improperly; however, there was no evidence the broken equipment was used by patients before the broken equipment was returned. There was no evidence of equipment in disrepair found to be in use at the time of the site visit. The allegation regarding patient safety was substantiated; the allegation regarding the facility's failure to respond to grievances was unsubstantiated.

Investigation 13-067

An AHCA employee was alleged to have failed to notify AHCA of pending criminal charges and an arrest.

Investigative research and evidence disclosed an AHCA employee was arrested on an outstanding federal warrant for health care fraud, conspiracy to commit health care fraud and aggravated identity theft. In addition to the federal warrant, investigative research disclosed the employee had an outstanding county warrant for fraud/insufficient funds. Review of the employee's State of Florida application determined the employee did not properly complete the application and failed to disclose prior employment histories, job qualifications and business affiliations, a violation of Florida Statutes and the Florida Administrative Code. The allegations were substantiated.

Internal Investigations Cases FY 2012-13

Case Number	Allegation	Disposition
12-138	Medicaid Fraud	Referred to PAF
12-139	Medicaid Fraud	Referred to PAF
12-140	Medicaid Fraud	Referred to PAF
12-141	Request for Information	No Action Required
12-142	Discrimination	Unsubstantiated
12-143	Falsification of Information	Substantiated
12-144	Medicaid Fraud	Unsubstantiated
12-145	Medicaid Fraud	Referred to PAF
12-146	Medicaid Fraud	Referred to PAF
12-147	Medicaid Fraud	Referred to PAF
12-148	Medicaid Fraud	Referred to PAF
12-149	Dispute	Unsubstantiated
12-150	Harassment, Discrimination, & Retaliation	Referred to FCHR
12-151	Conflict of Interest	Substantiated
12-152	Medicaid Fraud	Referred to PAF
12-153	Medicaid Fraud	Referred to PAF
12-154	Medicaid Fraud	Referred to PAF
12-155	Medicaid Fraud	Referred to PAF
12-156	Medicaid Fraud	Referred to PAF
12-157	Medicaid Fraud	Referred to PAF
12-158	Medicaid Fraud	Referred to PAF
12-159	Medicaid Fraud	Referred to PAF
12-160	Medicaid Fraud	Referred to PAF
12-161	Medicaid Fraud	Referred to PAF
12-162	Substandard Care	Unsubstantiated
12-163	Unlicensed Activity	Closed in favor of 12-234
12-164	Unlicensed Activity	Closed in favor of 12-234
12-165	Unlicensed Activity	Closed in favor of 12-234
12-166	Patient Abuse	Referred to HQA
12-167	Other	Referred to HR
12-168	Conflict of Interest	Unsubstantiated
12-169	Theft and Sale of Prescription Drugs	Unsubstantiated
12-170	Disclosure of Confidential Information	Inconclusive
12-171	Medicaid Fraud	Unsubstantiated
12-172	Substandard Care	Substantiated

12-173	Medicaid Fraud	Referred to MFCU
12-174	Substandard Care	Unsubstantiated
12-175	Substandard Care	Unsubstantiated
12-176	Medicare Billing Fraud	Referred to HHS
12-177	Discrimination	Unsubstantiated
12-178	Medicaid Fraud	Unsubstantiated
12-179	Discrimination	Unsubstantiated
12-180	Conflict of Interest	Substantiated
12-181	Substandard Care	Referred to HQA
12-182	Unlawful Activity	Substantiated
12-183	Substandard Care	Substantiated
12-184	Unfair Employment Practices	Unsubstantiated
12-185	Medicaid Fraud	Referred to MPI
12-186	Unfair Employment Practices	Complaint Withdrawn
12-187	Substandard Care	Referred to HQA
12-188	Medicaid Fraud	Referred to MPI
12-189	HIPAA Violation	Referred to DOH
12-190	Contract Violation	No Action Required
12-191	Medicaid Identity Fraud	Inconclusive
12-192	Disclosure of Confidential Information	Inconclusive
12-193	Medicaid Fraud	Unsubstantiated
12-194	Falsification of Information	Referred to DOH
12-195	Substandard Care	Unsubstantiated
12-196	Information Only	No Action Required
12-197	Insurance Fraud	Referred to OIR
12-198	Information Only	No Action Required
12-199	Medicaid Fraud	Referred to MPI and BMHC
12-200	Conduct Unbecoming	Substantiated
12-201	Medicaid Fraud	Unsubstantiated
12-202	Discrimination	Unsubstantiated
12-203	Substandard Care	Referred to DOH
12-204	Substandard Care	Unsubstantiated
12-205	Substandard Care	Referred to HQA
12-206	Substandard Care	Referred to HQA
12-207	Substandard Care	Referred to HQA
12-208	Medicaid Fraud	Referred to MPI
12-209	Medicaid Fraud	Referred to MPI
12-210	Substandard Care	Referred to HQA
12-211	Eligibility Issue	Unsubstantiated
12-212	Sexual Harassment	Substantiated
12-213	Disclosure of Confidential	Unsubstantiated

	Information	
12-214	Medicare Fraud	No Action Required
12-215	Medicaid Fraud	Referred to PAF
12-216	Falsification of Information	Substantiated
12-217	Review of Provider Termination Process	No Action Required
12-218	Substandard Care	Unsubstantiated
12-219	Information Only	No Action Taken due to insufficient information from anonymous complainant.
12-220	Medicaid Fraud	Substantiated
12-221	Substandard Care	Referred to HQA
12-222	Medicaid Fraud	Unsubstantiated
12-223	Misuse of Resources	Substantiated
12-224	Identity Theft	Unsubstantiated
12-225	Employee Safety	Unsubstantiated
12-226	Violation of Patient's Rights	Unsubstantiated
12-227	Substandard Care	Substantiated
12-228	Discrimination	No Action Taken
12-229	Discrimination	Unsubstantiated
12-230	Unlicensed Activity	Referred to Medicaid
12-231	Medicaid Fraud	Referred to MPI
12-232	Substandard Care	Unsubstantiated
12-233	Medicaid Fraud	Inconclusive
12-234	Unlicensed Activity	Referred to Division of Medicaid
12-235	Safety	Referred to HQA
12-236	Medicaid Fraud	Referred to HQA
12-237	Medicaid Fraud	Referred to MPI
12-238	Conduct Unbecoming	Substantiated
12-239	Inequitable treatment	Open
12-240	Substandard Care	Substantiated
12-241	Substandard Care	Unsubstantiated
12-242	Information Only	No Action Taken
13-001	Medicaid Fraud	Referred to MPI
13-002	Substandard Care	Unsubstantiated
13-003	Medicaid Fraud	Unsubstantiated
13-004	Medicaid Fraud	Referred to MPI
13-005	Regulatory Violations	Referred to DOH
13-006	Substandard Care	Unsubstantiated
13-007	Conduct Unbecoming	Substantiated
13-008	Substandard Care	No Action Taken
13-009	Request for Information	Referred to Medicaid Field Office

13-010	Information Only	No Action Taken
13-011	Medicaid Fraud	Referred to Medicaid Field Office
13-012	Substandard Care	Referred to HQA
13-013	Medicaid fraud; Falsification of Records	Referred to MFCU
13-014	Information Only	No Action Taken
13-015	Unfair Employment Practices; Unprofessional Conduct	Complaint Withdrawn
13-016	Information Only	No Action Taken
13-017	Conflict of Interest; Conduct Unbecoming	Substantiated
13-018	Misuse of Resources	Substantiated
13-019	Substandard Care	
13-020	Public Safety	Unsubstantiated
13-021	Conflict of Interest	Substantiated
13-022	Medicaid fraud; Substandard Care	Referred to HQA and DOH
13-023	Conduct Unbecoming	Unsubstantiated
13-024	Substandard Care	Open
13-025	Conflict of Interest	Unsubstantiated
13-026	Safety	Referred to DOC
13-027	Discrimination	Referred
13-028	Medicaid Fraud	Open
13-029	Other	
13-030	Dispute	Referred to HQA
13-031	Substandard Care	No Action Taken
13-032	Request for Information	No Action Taken
13-033	Medicaid Fraud	Referred to MPI
13-034	Other	Referred to DOH
13-035	Medicaid Fraud; Medicare Fraud	Referred to HHS and HQA
13-036	Medicare Fraud	Referred to HHS
13-037	Security	Referred to MPI
13-038	Medicaid Fraud	Referred to MPI
13-039	Substandard Care	Referred to HQA
13-040	License denial	Referred to HQA
13-041	Misuse of IT Resources	Unsubstantiated
13-042	Other	Unsubstantiated
13-043	Unfair Employment Practices	Open
13-044	Medicaid Fraud	Open
13-045	Other	Referred to HQA
13-046	Other	No Action Taken
13-047	Substandard Care	Referred to DOH

13-048	Substandard Care	Referred to HQA and MPI
13-049	Substandard Care	Referred to HQA and MPI
13-050	Unprofessional Conduct	Open
13-051	Substandard Care	Open
13-052	Public Safety	Open
13-053	Other	Referred to HQA
13-054	Medicaid Fraud	Referred to MPI
13-055	Request for Assistance	No Action Taken
13-056	Medicaid Fraud	Referred to MPI
13-057	Substandard Service	Referred to Medicaid Field Office
13-058	Conflict of Interest	Open
13-059	Violation of IT Security	Unsubstantiated
13-060	Conflict of Interest	Substantiated
13-061	Medicare Fraud	Referred to HHS
13-062	Medicaid Fraud	Referred to MPI
13-063	Request for Assistance	Referred
13-064	Unprofessional Conduct	Referred to Management
13-065	Denial of Eligibility	Referred to Medicaid Field Office
13-066	Request for Assistance	Referred to Medicaid Field Office
13-067	Conduct Unbecoming	Substantiated
13-068	Safety	Referred to Legal
13-069	Unprofessional Conduct	Unsubstantiated
13-070	Medicaid Fraud; Falsification of Information	Referred to DOT
13-071	Information Only	No Action Taken
13-072	Misuse of Resources	Substantiated
13-073	Discrimination; Intimidation	Unsubstantiated
13-074	Substandard Care	Open
13-075	Vandalism	Referred to FDLE
13-076	Medicaid Fraud	Referred to Pharmacy Services
13-077	Safety	Unsubstantiated
13-078	Unlawful Activity	Open
13-079	Substandard Care	Referred to HQA
13-080	Information Only	No Action Taken
13-081	Medicaid Fraud	Referred to MPI and APD
13-082	Dispute	Referred to MPI
13-083	Substandard Care	Referred to DOT
13-084	Identity Theft	Unsubstantiated
13-085	Request for Information	No Action Taken
13-086	Misuse of Agency Resources	Substantiated
13-087	Substandard Care	Referred to HQA
13-088	Information Only	No Action Taken

13-089	Information Only	No Action Taken
13-090	Substandard Care	No Action Taken
13-091	Violation of Florida	Referred to DOH
13-092	Medicaid Fraud	Referred to Florida Healthy Kids
13-093	Substandard Care	Referred to HQA
13-094	Medicaid Fraud	Referred to MPI
13-095	Contract Violation	Unsubstantiated
13-096	Substandard Care	Open
13-097	Information Only	No Action Taken

This report was published by the Office of Inspector General at the Agency for Health Care Administration, in compliance with Florida Statutes, 20.055(7)(a) which states: *Except as provided in paragraph (b), each inspector general shall, not later than September 30 of each year, prepare an annual report summarizing the activities of the office during the immediately preceding state fiscal year.* If you have any questions or comments regarding this report, please contact Kimberly Noble, Office of the Inspector General, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, Florida 32309, or email: Kimberly.Noble@ahca.myflorida.com.

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