AGENCY FOR HEALTH CARE ADMINISTRATION

OFFICE OF THE INSPECTOR GENERAL

ANNUAL REPORT
FY 2013-14

SEPTEMBER 2014

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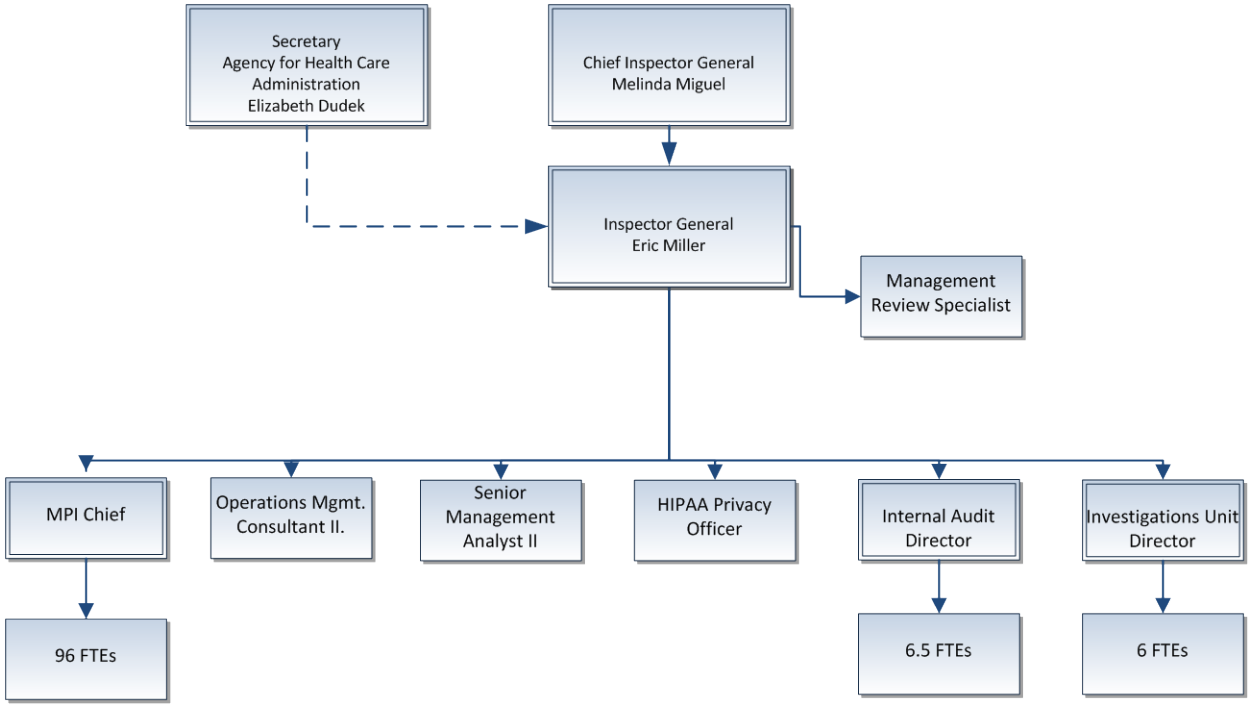
Office of the Inspector General

Organization and Staff



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 referenced statute requires that the OIG prepare an annual report, not later than September 30 of each year, summarizing the activities of the office during the preceding state fiscal year. The final report shall be provided to the Chief Inspector General and the head of the Agency. This report includes but is not limited to:

- A description of activities relating to the development, assessment, and validation of performance measures;
- 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 the 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.

2014 Legislative Changes

House Bill 1385, sponsored by Representative Daniel Raulerson, passed both houses during the 2014 Legislative Session, and became law on July 1, 2014. The intent of this bill evolved as a response to the findings and recommendations set forth in the *Nineteenth Statewide Grand Jury, First Interim Report: A Study of Public Corruption in Florida and Recommended Solutions*. This bill, as passed, amended how agency inspectors general are appointed, supervised, and removed.

As of July 1, 2014, the Chief Inspector General (CIG), rather than the agency head, will appoint an inspector general for a state agency under the jurisdiction of the Governor. Such inspector general shall remain under the general supervision of the agency head and may hire and remove staff within his or her office in consultation with the CIG, but independently of the agency.

An inspector general for a state agency under the jurisdiction of the Governor may only be removed from office by the CIG for cause. Cause includes concerns regarding performance, malfeasance, misfeasance, misconduct, or failure to carry out his or her duties. The CIG must notify the Governor in writing of his or her intention to remove the inspector general at least 21 days before removal, rather than seven days. If the inspector general disagrees with the removal, such inspector general may present objections in writing to the Governor within the 21-day period.

This independence from the individual agency is intended to allow the Inspector General and staff more independence to complete their audits, reviews, and investigations. The Agency head may request the Inspector General to perform an audit rather than direct the Inspector General to perform an audit.

In accordance with this new law, each inspector general in an agency under the jurisdiction of the Governor must keep the CIG informed concerning fraud, abuses, and deficiencies relating to programs and operations administered or financed by the state agency; recommend corrective action concerning fraud, abuses, and deficiencies; and report on the progress made in implementing corrective action in the inspector general's respective agency.

Mission Statement

The primary mission of the OIG is to assist the Chief Inspector General, the Agency 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 mission 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 the CIG and to appropriate Agency management. The OIG provides oversight for the Internal Audit Section, the Health Insurance Portability and Accountability Act (HIPAA) Compliance Office, the Investigations Unit and for the Office of Medicaid Program Integrity. The organizational chart on page 1 depicts 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 has responsibility for the Office of Medicaid Program Integrity (MPI), whose primary mission is to prevent, deter, detect, and recoup overpayments related to Medicaid fraud, waste, and abuse. Florida Medicaid is a $24 billion a year program serving 3.2 million Florida residents, so this oversight role, unique to state agency inspectors general offices ensures the Medicaid program complies with state and federal program accountability obligations. The AHCA OIG also has the responsibility for HIPAA Privacy Rule compliance within the agency. The purpose of the HIPAA Privacy Rule is to prevent inappropriate use and disclosure of individual health information, most commonly referred to as protected health information (PHI).

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 Agency programs , or preventing and detecting fraud and abuse in Agency programs and operations;
- Reporting to the Chief Inspector General and the Agency head concerning fraud, abuses and deficiencies, recommending related corrective Agency action, and reporting on the progress made in implementing corrective action associated with audit findings, investigations, and management reviews;
- 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.

HIPAA Compliance Office

The Health Insurance Portability and Accountability Act (HIPAA) Compliance Office coordinates Agency compliance with HIPAA Privacy Rule requirements, pursuant to Title 45, Code of Federal Regulations, Parts 160, 162, and 164 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).

The major responsibilities and activities undertaken by the HIPAA Compliance Office in FY 2013-14 were:

- Administered both the HIPAA and HITECH Privacy Training and Security Awareness Training online programs for all Agency employees;
- Provided in-person HIPAA and HITECH privacy training to all Agency employees as part of new employee orientation and annual employee refresher training;
- Responded to requests for protected health information (PHI), managed the responses to HIPAA-related complaints against the Agency or its employees, and answered other questions or requests involving HIPAA;
- Implemented process improvements to significantly reduce response timeframes for Medicaid recipient PHI access requests;
- Provided guidance to Agency staff regarding potential privacy incidents or breach situations and ensured Agency actions in such situations were in compliance with HIPAA rules;
- Initiated consultations with Agency staff and formal review of all interagency agreements to ensure such agreements complied with applicable HIPAA and HITECH regulations;
- Participated in the Agency-wide website re-facing project whereby Agency HIPAA web site content was revised and updated within newly established parameters; and
- Detected Agency legacy practices that presented elevated risk of HIPAA non-compliance and worked with Agency staff to alter practices thereby reducing the risk of HIPAA violation or information breach.

Internal Audit

Internal Audit Functions

The purpose of Internal Audit 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. The scope and assignment of audits is determined by the inspector general; however, the Agency head may at any time request the inspector general to perform an audit of a special program, function, or organizational unit.

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 have access to any records, data, and other information of the Agency deemed necessary to carry out the IG's duties. The Inspector General is authorized to request such information or assistance as may be necessary from the Agency or from any federal, state, or local government entity.

Risk Assessment

Internal Audit performs a risk assessment of the Agency's programs and activities near the end of each fiscal year to assist in the development of the annual audit plan. The risk assessment process 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 components of the Agency's critical functions that allow the Agency 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 controls;
- Changes in the operations, programs, systems, or controls;
- Changes in personnel;
- Maintenance of confidential information;
- Dependency on internal systems;
- Complexity of operations; and
- Dependency on other programs or systems external to the Agency.

Audit Plan

Based on the risk assessment, Internal Audit develops an annual Audit Plan, which includes planned projects for the upcoming fiscal year and potential projects for the next two fiscal years. The plan,

approved by the Agency Secretary, includes activities to be audited or reviewed, budgeted hours, and assignment of staff.

Assurance Engagements

These engagements undertaken by Internal Audit consist of an objective examination of evidence to provide an independent assessment on governance, risk management, and control processes. Such engagements assess the adequacy of internal controls to ensure:

- 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.

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. The final reports include responses from management and are distributed to the Agency Secretary, affected program managers, the Chief Inspector General, and to the Auditor General.

Consulting Engagements

Internal Audit's consulting engagements provide assistance to Agency management or staff for improving specific program operations or processes. In performing consulting engagements, Internal Audit's objective is to assist management or staff to add value to Agency programs by streamlining operations, enhancing controls, and implementing best practices. Since these engagements are generally performed at the specific request of management, the nature and scope are agreed upon by Internal Audit and Agency management before commencing the requested engagement. Some examples of consulting engagements include:

- Reviewing processes and interviewing staff within specific areas to identify process weaknesses and making recommendations for improvement;
- Facilitating meetings and coordinating with staff of affected units to propose recommendations for process improvements, seeking alternative solutions, and determining 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's use.

If appropriate, consulting engagements are performed in accordance with the Standards published by the IIA.

Management Reviews

Internal Audit's 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 the Agency's direct oversight. Management reviews result in written reports or letters of findings and recommendations, including responses by management. The IIA *Standards* are not cited in these particular reviews. These reports are distributed internally to the Agency Secretary and affected program managers. In addition, certain reports are sent to the Chief Inspector General and to the Auditor General.

Special Projects and Other Projects

Services other than assurance engagements, consulting engagements, and management reviews performed by Internal Audit for Agency management or for external entities are considered special projects. Special projects may include 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 the Internal Audit Unit, such as installation of new software or revisions of policies and procedures.

Internal Audit Staff

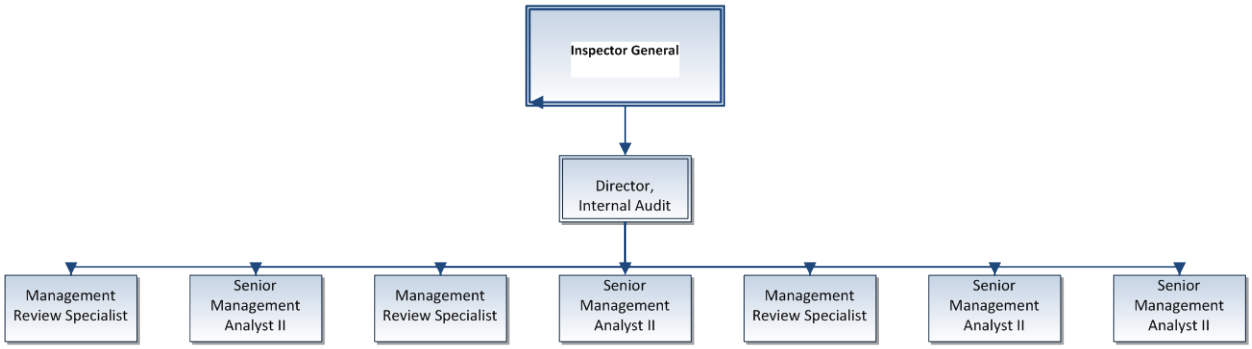
Internal Audit staff brings various backgrounds and expertise to the Agency. Certifications or advanced degrees collectively held by members of Internal Audit include:

- Certified Public Accountant
- Certified Internal Auditor
- Certified Fraud Examiner (2)
- Certified Information Systems Auditor
- Certified Inspector General
- Certified Inspector General Auditor (2)
- Master of Public Administration
- Master of Business Administration
- Juris Doctorate

The *Standards (also known as Red Book Standards)* and the Association of Inspectors General's *Principles and Standards for Offices of Inspector General (also known as Green Book Standards)* require Internal Audit 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. Staff members attend courses, conferences, seminars, and webinars throughout the year. Internal Audit staff attended trainings sponsored by national and local chapters of the Association of Inspectors

General, the Institute of Internal Auditors, the Association of Certified Fraud Examiners, and the Information Systems Audit and Control Association. Staff 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 nine assurance engagements, consulting engagements or reviews during FY 2013-14. The following is a list of engagements completed and a list of engagements in progress as of June 30, 2014:

Table 1: Internal Audit Engagements

Report No.	Engagement	Type	Month Issued
14-05	ARRA Data Quality Review, Quarter Ending June 30, 2013	Review	July 2013
14-09	ARRA Data Quality Review, Quarter Ending September 30, 2013	Review	October 2013
13-10	Provider Payment Suspension and Termination Processes Review	Assurance	November 2013
13-15	Review of the Agency's Data Exchange MOU with DHSMV	Assurance	November 2013
14-14	ARRA Data Quality Review, Quarter Ending December 31, 2013	Review	January 2014
13-06	Adverse Incident Report Process	Assurance	February 2014
13-12	MCM Provider Enrollment Process Audit	Assurance	March 2014
13-02	Review of Accurint Use (Data Aggregator Services)	Review	May 2014

Table 2: Internal Audit Engagements in Progress

Report No.	Engagement	Type	Planned Issue Month
14-06	Medicaid Treating Provider Registration Process	Assurance	October 2014
14-17	Review of TLO Use (Data Aggregator Services)	Review	September 2014
15-08	Background Screening Clearinghouse	Assurance	April 2015
13-14	Medicaid Recipient File Management	Assurance	November 2014

Engagement Summaries

The following summaries describe the results of the assurance engagements, consulting engagements, and reviews completed by Internal Audit during FY 2013-14:

ARRA Data Quality Reviews

In 2010, the Agency received an American Recovery and Reinvestment Act of 2009 (ARRA) award for $20,738,582 for the Florida Health Information Exchange Cooperative Agreement Program. Section 1512(c) of ARRA required recipients of ARRA funds to report quarterly on the use of the funds. Florida's quarterly reporting process for ARRA awards was centralized through the FlaReporting System. This system facilitated the collection, review, and submission of award data to the federal government. Internal Audit completed quarterly data quality reviews of the Agency's ARRA award data reported in the FlaReporting System for the quarters ending 6/30/13, 9/30/13, and 12/31/13. None of the reviews disclosed any material omissions or significant errors in the data submitted to the federal government. The award money was expended and the Florida Health Information Exchange Cooperative Agreement Program award is now closed.

13-10 Provider Payment Suspension and Termination Processes Review

At the request of Agency senior management, Internal Audit conducted a review of the Provider Payment Suspension and Termination Processes within the Office of Medicaid Program Integrity (MPI) and Medicaid's Fraud Prevention and Compliance Unit (FPCU). The objectives were to review and identify inconsistencies in MPI's and FPCU's separate provider payment suspension and provider termination processes, evaluate internal and external communications and information sharing processes, and make recommendations for improvement. The review identified concerns related to overlap of job functions; procedures for contractual terminations and payments suspensions; policies on approving certain types of requests; review and communication of proposed contractual terminations; communication with third parties; and the enrollment process. Internal Audit recommended the following:

- All Agency staff and external parties should be instructed to refer any questionable or suspicious provider activity related to fraud or abuse to MPI and the Agency should continue to designate MPI as the office tasked with detecting and investigating fraud and abuse.
- Agency management should review perceived areas of overlap between FPCU and MPI.

- FPCU should establish written policies and procedures for processing contractual terminations and assigning Medicaid providers for pre-payment review (PPR) when terminating them.
- Medicaid should develop a written policy for approving contractual termination, deactivation, and stacking (compounding action) requests.
- FPCU should develop written policies and procedures for communicating with applicable Agency staff regarding proposed contractual termination requests.
- FPCU should document the decision making process for contractual terminations.
- Medicaid should adopt a communications policy, in consultation with MPI and the AHCA Communications Director, to assist in the prevention of premature information disclosure to third parties regarding terminations.
- Medicaid should educate all employees on inappropriate information disclosure to third parties.
- The Prevention and Provider Focus Sub-Committee of the Fraud Steering Committee should develop written procedures to guide Medicaid in evaluating enrollment of providers with previous contractual terminations.

13-15 Review of the Agency's Data Exchange MOU with DHSMV

At the request of the Florida Department of Highway Safety and Motor Vehicles (DHSMV), Internal Audit conducted a review of the Agency's compliance with the Memorandum of Understanding (MOU) identified as MOU-HSMV 180-12, which established the conditions under which DHSMV provided electronic access to driver license and motor vehicle data to the Agency. The review focused on the OIG's Investigations Unit and the Division of Operations, Bureau of Support Services and these units' use of DHSMV's Driver and Vehicle Express (DAVE) system. The review identified and examined issues related to policies and procedures; the MOU's purpose; supporting documentation; confidentiality and security; access terminations and reviews; sharing of confidential information; user acknowledgements; monitoring and annual affirmation statements required by the MOU; the MOU's authorization, and accountability provisions. As a result of this review, Internal Audit recommended the following:

The Investigations Unit should be responsible for the development of policies and procedures to address the use of DAVE and the MOU compliance requirements.

- Investigations should amend the Agency's MOU with DHSMV to include the purpose for the Division of Operations' Bureau of Support Services' access.
- Investigations should formally document its log process in written procedures and the Bureau of Support Services should create a log to document its access to DAVE.
- Investigations should document and implement procedures to ensure DAVE users and any associated personnel understand the confidentiality/security of data obtained from DAVE.
- DAVE-related information in Investigations should be contained where it is not accessible to unauthorized persons and the Bureau of Support Services should ensure any DAVE-related information stored electronically is accessible only to DAVE-authorized staff.
- Investigations should document and ensure user access permissions are terminated in compliance with MOU requirements. A staff person independent of the DAVE process

should be appointed to conduct and document quarterly reviews and to develop desk procedures.
- The Bureau of Human Resources should modify the "Employee Separation Checklist" to include termination of employees' DAVE access permissions and all other pertinent systems or applications.
- Investigations should document and implement procedures addressing public records requests regarding DAVE information and staff should receive training on handling such requests.
- All current DAVE users and any authorized staff with access to DAVE information should sign DHSMV's Confidentiality Acknowledgement and Criminal Sanctions Acknowledgement forms and these forms should be maintained in a central file.
- An annual report should be completed and an Annual Affirmation Statement should be submitted to DHSMV.
- The Secretary should sign the MOU with DHSMV that authorizes DAVE access.
- Investigations should request DHSMV remove the Bureau of Support Services' user access to the legacy DHSMV system not currently covered by the MOU.

13-06 Adverse Incident Report Process

Based on the annual audit plan, Internal Audit conducted an audit of the adverse incident reporting process within the Florida Center for Health Information and Policy Analysis (Florida Center) in the Division of Health Quality Assurance (HQA). The focus of the audit was to determine compliance with applicable state laws and rules, if proper internal controls were in place to govern the reporting process, and if the reporting process was efficient and effective. The audit identified and examined issues with monitoring the timeliness of report submission from facilities; regulatory action taken against facilities for late reports; controls over the reporting systems; required report referrals within and outside the Agency; review of litigation notices; the receipt and review of annual reports; and outdated rules, policies, and procedures. As a result of this audit, Internal Audit recommended the following:

- HQA should develop policies, procedures, and forms to monitor the timely submission of adverse incident reports.
- HQA should consult with the AHCA Office of the General Counsel (OGC) regarding fines for facilities that submit adverse incident reports after the applicable statutory deadlines.
- The Agency should improve reporting system controls;
- The Florida Center's Risk Management and Patient Safety (RMPS) office and the HQA Complaint Administration Unit should periodically reconcile report referrals to ensure that all incidents referred by RMPS are actually received.
- The Florida Center should improve policies, procedures, and forms regarding report referral and reconciliation.
- The Agency should update the existing Memorandum of Understanding with the Florida Department of Health (DOH).
- HQA should address issues in the VERSA data system regarding the ability of DOH to review certain reports.
- HQA should determine the purpose of review of litigation notices and develop a policy, if applicable.

- The Agency should review the purpose of requiring facilities to submit annual reports.
- The Agency should publish malpractice statistics from hospitals and ambulatory surgical centers.
- The Florida Center should update and align the rules, policies, and forms with current statutory provisions regarding adverse incidents and ensure congruence among these documents.

13-12 MCM Provider Enrollment Process Audit

Based on the annual audit plan, Internal Audit conducted an audit to determine the efficiency and effectiveness of the provider enrollment process for Health Practitioner Services (HPS) applications reviewed by the Provider Enrollment Unit within the Bureau of Medicaid Contract Management (MCM). The objectives were to determine the efficiency and effectiveness of the MCM review process used when a Medicaid enrollment application is referred for MCM review. The review identified weaknesses in monitoring and administration. Internal Audit recommended the following:

- Require a monthly report or establish performance measures to track MCM review processing times.
- Establish a written policy for MCM review processing times.
- Continue to require all MCM analysts to use the reporting functions in the existing Information Tracking Repository and Collaboration Exchange (iTRACE) data system.
- Continue to require the Medicaid fiscal agent to conduct periodic monitoring to detect "orphan" tasks.
- Require the Medicaid fiscal agent to conduct periodic monitoring.
- Run a weekly report to identify tasks due and require monitoring of analysts at regular intervals.

13-02 Review of Accurint

Based on the annual audit plan and a prior request from the AHCA Inspector General, Internal Audit conducted a review to determine whether there were adequate internal controls in place to govern the use of Accurint by OIG staff and whether the use was appropriate and efficient. Accurint is an electronic data aggregator investigative tool offered by LexisNexis. The scope of the engagement included the OIG's Investigations Unit and the Office of Medicaid Program Integrity's (MPI) use of Accurint from July 2012 to January 2014. The objectives were to determine whether adequate internal controls were in place to govern the OIG's use of Accurint and whether the use of Accurint was appropriate and efficient. The review found that weak controls were in place governing Accurint use and determined that Accurint use had not been efficient or always appropriate. Internal Audit recommended the following:

- Investigations and MPI should review and update their current applications/agreements with LexisNexis.
- Procedures should be implemented to ensure all Accurint users and any associated personnel understand the consequences if users do not comply with requirements of the Accurint agreement for any misuse, including the Fair Credit Reporting Act.

- A Civil/Criminal Sanctions Acknowledgement form and a Confidentiality Acknowledgement form should be developed, which address consequences of any misuse of Accurint. Signed forms should be in a central file maintained by the Accurint Administrator.
- The Accurint Administrator should train all staff that has access to Accurint information regarding the requirements of the Accurint agreement, including adherence to the Fair Credit Reporting Act, data security, confidentiality, and employ the use of all applicable Accurint services, including the Healthcare option menu within Accurint.
- The Accurint Administrator should develop procedures, with the Inspector General's approval, to address user access and termination requests, use of the system, and to ensure users understand requirements for maintaining confidentiality and security of data.
- A person independent of both Investigations and MPI should be appointed to perform reviews of Accurint searches on a quarterly basis. Desk procedures should be developed for such reviews and documentation of completed reviews should be maintained for no less than five years.
- The OIG should designate specific individuals responsible for approving Accurint access and termination.
- The Accurint Administrator should maintain written documentation for no less than five years for each Accurint addition or termination.
- The Accurint Administrator should terminate the Division of Operations' Bureau of Financial Services staff's access and discontinue payment for that access.
- The OIG should reevaluate its need for Accurint and determine whether it is the appropriate tool for MPI.
- MPI should determine how many licenses are necessary to perform the intended function and consider limiting the licenses accordingly.

Additional Projects

Section 20.055(2), Florida Statutes requires the Office of Inspector General in each state agency to "advise in the development of performance measures, standards, and procedures for the evaluation of state agency programs" and to "assess the reliability and validity of the information provided by the state agency on performance measures and standards, and make recommendations for improvement, if necessary." Internal Audit participated in the review of performance measures for the Agency's annual Long Range Program Plan (LRPP). Current measures and proposed new measures were reviewed and advice was provided regarding accuracy, validity, and reliability.

Internal Audit completed the following additional duties or projects during FY 2013-14:

- Participation in the Office of the Chief Inspector General's Enterprise Assessment of the State of Florida's Background Screening Process;
- Chief Inspector General Quarterly Activity Reports;
- Review of the Agency's Disaster Recovery Exercise;
- Review of Office of Medicaid Program Integrity Other Personal Services Positions;
- 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;
- Auditor General Information Technology Survey;

- Department of Health and Human Services Audit Resolution Letter;
- OIG Annual Report;
- Annual Risk Assessment; and
- Annual Audit Plan.

Internal Engagement Status Reports

The *Standards* require auditors to follow-up on reported findings and recommendations from previous engagements 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 2013-14, the following status reports for internal engagements were published:

- 14-01 Medicaid Risk Management Processes Review (Six-Month Status Update)
- 14-02 Review of FMMIS and DSS Assessment Project Procurement (Six-Month Status Update)
- 14-03 Enterprise Wide Audit of Contract Monitoring (18-Month Status Update)
- 14-04 Agency Accounts Receivable Process (Six-Month Status Update)
- 14-08 Medicaid Risk Management Processes Review (12-Month Status Update)
- 14-10 Enterprise Wide Audit of Contract Monitoring (24-Month Status Update)
- 14-11 Review of FMMIS and DSS Assessment Project Procurement (12-Month Status Update)
- 14-12 Provider Payment Suspension and Termination Processes Review (Six-Month Status Update)
- 14-13 Review of the Agency's Data Exchange MOU with DHSMV (Six-Month Status Update)
- 14-15 Agency Accounts Receivable Process (12-Month Status Update)

Corrective Actions Outstanding From Previous Annual Reports

As of June 30, 2014, the following corrective actions for significant recommendations described in previous annual reports were still outstanding:

12-10 Medicaid Risk Management Processes Review, issued February 2013

The Division of Medicaid has not made substantive progress in establishing an enterprise risk management framework due to the workload associated with the transition to Statewide Medicaid Managed Care. However, the Office of Inspector General's Health Insurance Portability and Accountability Act (HIPAA) Compliance Office, at the direction of the Agency Secretary, will be developing an enterprise risk management framework, assessment, reporting, and monitoring function for the Agency.

12-04 Agency Accounts Receivable Process, issued June 2013

Recommendation: The new accounts receivable system include a means of identifying late payment dates, automatically generating notices if a payment has not been received by set deadlines, and the ability to generate reports that allow monitoring for payment timeliness.

Most Recent Management Response (June 2014): The Bureau of Financial Services plans to have a draft Request For Quotes (RFQ) by late September or early October 2014.

Recommendation: To improve efficiency and expedite data entry, the new accounts receivable system should consider an interface that would automatically populate fields from FMMIS.

Most Recent Management Response (June 2014): The Bureau of Financial Services plans to have a draft RFQ by late September or early October 2014.

Recommendation: To clarify the roles and responsibilities between the Medicaid Fraud Control Unit (MFCU) and the Bureau of Financial Services, the current Memorandum of Understanding (MOU) should be revised.

Most Recent Management Response (June 2014): The Bureau of Financial Services submitted recommendations regarding defendant probationary terms, case information, and collections. It was determined that reconciliations would be completed each month on all payments received from MFCU. The Agency is currently receiving a spreadsheet of all cases processed each month by MFCU and this spreadsheet is used for reconciliations. An MOU will be drafted and approved to implement the collection procedural change at the beginning of the fiscal year.

Recommendation: To improve efficiency and information security, the new accounts receivable system [should] accommodate all accounts receivable types so that the Agency can discontinue the use of maintaining accounts receivable in Microsoft Excel and Versa.

Most Recent Management Response (June 2014): The Bureau of Financial Services plans to have a draft Request For Quote (RFQ) by late September or early October 2014. Prior to Financial Services staff turnover, HQA worked closely with Financial Services on system requirements related to HQA receivables. HQA currently works closely with Financial Services on online payment issues for the Online Licensing and Background Screening Clearinghouse and has a bi-weekly stakeholder meeting on Online Payment and Single Sign-On issues. The Agency also has monthly strategic planning meetings attended by HQA and Financial Services that discusses, among other things, automation.

Recommendation: Financial Services evaluate current processes and written procedures to identify process improvements such as updating and/or removing unnecessary forms.

Most Recent Management Response (June 2014): Financial Services had its kickoff meeting on January 17, 2014, to discuss the functional assessment of the bureau. Meetings are held on Fridays. Phase I

and Phase II were completed, which included listing all tasks and determining where the task should be assigned.

External Engagement Status Reports

Pursuant to Section 20.055(5)(h), F. S., the OIG monitors the implementation of the Agency's response to external reports issued by the Auditor General and by the Office of Program Policy Analysis and Government Accountability (OPPAGA). The OIG is 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 timeframes.

During FY 2013-14, status reports were submitted on the following external reports:

- Auditor General - Public Assistance Eligibility Determination Processes At Selected State Agencies (Report No. 2013-133)
- Auditor General - State of Florida Compliance and Internal Controls Over Financial Reporting and Federal Awards, Fiscal Year End (FYE) June 30, 2012 (Report No. 2013-161)
- Auditor General - Operational Audit - Prior Audit Follow-up (Report No. 2014-001)
- Auditor General - Operational Audit - Health Care Facility Licensing Function and Information Technology Controls (Report No. 2014-057)

Coordination with Other Audit and Investigative Functions

The OIG acts as the Agency's liaison on audits, reviews, and information requests conducted by external state and federal organizations such as the Florida Office of the Auditor General, the Florida Department of Financial Services, OPPAGA, the United States (U. S.) Department of Health and Human Services (HHS), the U. S. Social Security Administration, and the U. S. Government Accountability Office (GAO). The OIG coordinates the Agency's responses to all audits, reviews, and information requests from these entities.

During FY 2013-2014, the following reports were issued by external entities:

Office of the Auditor General

- Operational Audit – Prior Audit Follow-up (Report No. 2014-001)
- Operational Audit – Health Care Facility Licensing Function and Information Technology Controls (Report No. 2014-057)
- Compliance and Internal Controls Over Financial Reporting and Federal Awards, FYE June 30, 2013 (Report No. 2014-173)
- Operational Audit - Statewide Medicaid Managed Care Program Implementation (Report No. 2014-193)

OPPAGA

- State Child Welfare Systems: Key Components and Performance Indicators (Research Memorandum dated March 10, 2014)
- iBudget Implementation Continues as the Agency for Persons with Disabilities Responds to Legal Challenges (Report No. 14-09)
- Medicaid Program Integrity Recovers Overpayments in Fee-For-Service and Monitors Fraud and Abuse in Managed Care (Report No. 14-05)
- Florida's Graduate Medical Education System (Report No. 14-08)

GAO

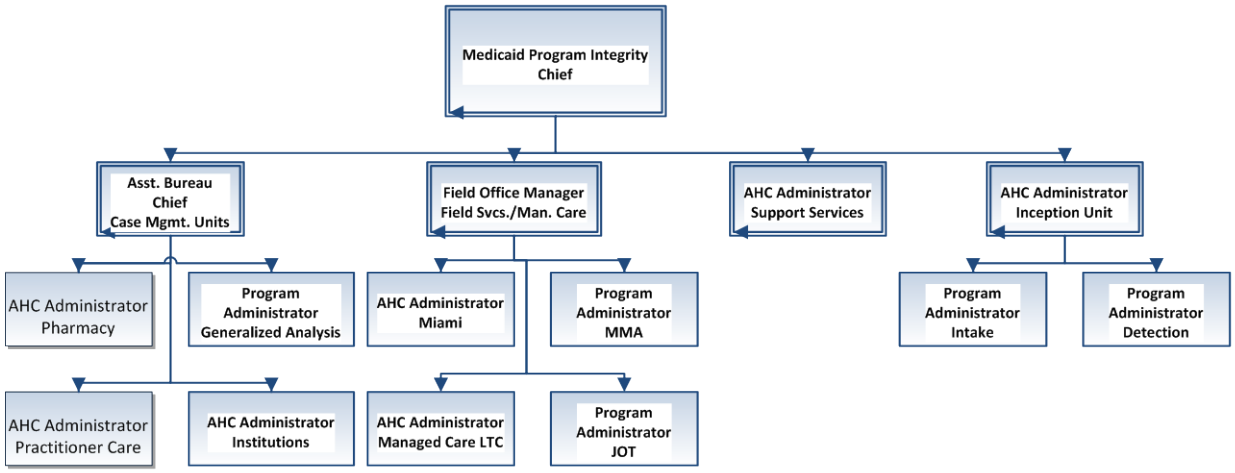
- Medicaid: CMS Should Ensure That States Clearly Report Overpayments (GAO-14-25)
- Foster Children: Additional Federal Guidance Could Help States Better Plan for Oversight of Psychotropic Medications Administered by Managed-Care Organizations (GAO-14-362)
- Medicaid Program Integrity: Increased Oversight Needed to Ensure Integrity of Growing Managed Care Expenditures (GAO-14-341)

HHS

- Inconsistencies in States' Reporting of the Federal Share of Medicaid Drug Rebates (Report No. A-06-13-00001)
- Florida Made Some Payments for Pharmacy Items That Excluded Providers Had Prescribed (Report No. A-04-11-07024)
- Florida Paid Hospitals for Some Inpatient Hospital Services That Medicare Paid (Report No. A-04-12-06158)
- State and CMS Oversight of the Medicaid Managed Care Credentialing Process (Report No. OEI-09-10-00270)
- Offshore Outsourcing of Administrative Functions by State Medicaid Agencies (Memorandum Report No. OEI-09-12-00530)

Medicaid Program Integrity

Staff and Organization



MPI strives to ensure that Medicaid payments are made to appropriate providers for eligible services rendered to eligible Medicaid recipients. This is accomplished through a number of operational functions ranging from the detection of misspent funds, the imposition of administrative actions and sanctions, and the coordination of activities that serve to deter or prevent fraud, abuse, and overpayments in the Medicaid program. In addition, as appropriate, MPI prepares referrals to the Medicaid Fraud Control Unit (MFCU) of the Office of the Attorney General and to other regulatory and criminal investigative agencies.

Detection

MPI activities begin with detection of a possible fraud, abuse, or overpayment within the Medicaid program. Detection is one of the most important and challenging aspects of the work due to the dynamic nature of fraud and abuse and the sheer volume of claims for payment received annually by the Florida Medicaid program (over 127,000,000 claims). While fee-for-service claims processed through the Medicaid program are subjected to system edits, edits are not able to detect all abusive claims, and certainly cannot discover the intent of the individual or entity submitting the claim. While edits catch some billing errors, they cannot detect when goods or services were not medically necessary or were not actually provided, and they cannot determine when the goods or services rendered were done so contrary to established Medicaid policy.

MPI detection efforts include both external sources (such as a complaint hotline) as well as internal tools. MPI utilizes software supplied by the Medicaid fiscal agent contractor, has developed its own software to detect the upcoding of claims (the billing of higher paying procedure codes than warranted for the services actually supplied), and is in the process of implementing advanced data

analytics through contracted services. Advanced data analytics is expected to significantly enhance the number and quality of investigation-ready leads for MPI through the analysis of internal and external data sets.

Investigation and Recovery

Once a suspect activity is identified, whether it is a suspicious claims submission by a Medicaid provider or some other complaint that suggests a Medicaid provider warrants closer review, MPI initiates a preliminary review of the activity to determine whether it should be referred to other entities, including MFCU, for investigation of potential fraud. When the activity appears to involve misbilling without rising to the level of fraud, MPI conducts comprehensive investigations with the intended outcome to be the recovery of Medicaid overpayments. By definition, an overpayment is any amount not authorized to be paid by the Medicaid program. Overpayments may arise from errors, abuse, or fraud. If fraud, an intentional action or inaction, is suspected, MPI will refer the suspected matter to MFCU. Overpayments as a result of abuse (practices that are inconsistent with generally accepted practices and that result in unnecessary costs, goods, or services to the Medicaid program that are not medically necessary, or the rendering of care in a fashion that fails to meet professionally recognized standards) or mistake are recovered 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 validated statistical analysis methods. Florida licensed pharmacists within MPI review pharmacy claims and identify apparent misbillings, conduct non-extrapolated pharmacy audits and perform paid-claims reversals. Vendor-assisted audits are conducted, under MPI supervision, by contracted firms who perform audit work for MPI that would otherwise not be possible due to staffing limitations.

Prevention

MPI's efforts are also intended to serve as a deterrent. To the extent possible, MPI also strives to assist the Agency in preventing improper Medicaid payments. The prevention of Medicaid fraud and abuse reduces the need for after-the-fact recovery efforts and is a high-priority activity of MPI. Prevention activities by MPI include the use of prepayment reviews to scrutinize pending Medicaid claims; initiating audit and review projects to address areas that are believed to be more susceptible to fraud and abuse; making referrals to other regulatory and law enforcement entities; assisting the Agency with provider education initiatives; and ensuring that MPI investigations include a conclusory evaluation as to whether Medicaid system edits or Medicaid policy amendments might have prevented or increased the likelihood of preventing the erroneous claims in the first place.

Annual Fraud and Abuse Report

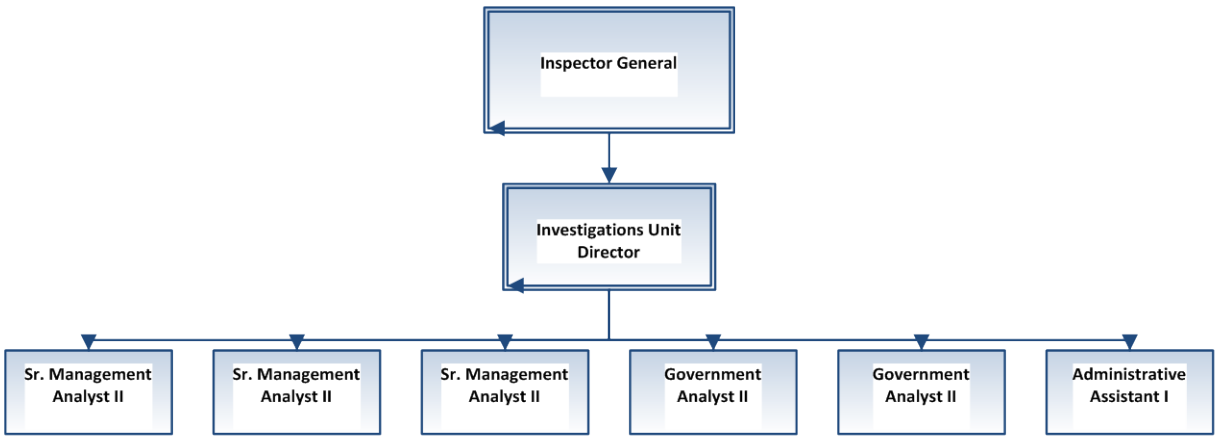
The results of these MPI activities are presented annually in a report entitled *The State's Efforts to Control Medicaid Fraud and Abuse*. This report is published by January 1 of each year to reflect the prior fiscal year efforts. It is a joint report, detailing the combined efforts of MFCU and AHCA, submitted to the Legislature pursuant to Section 409.913, F. S. The report is available on the Agency's internet site: http://ahca.myflorida.com/Executive/Inspector_General/docs/OIGAnnualReports/OIGAnnualReport2012-13.pdf.

Investigations Unit

The Office of the Inspector General's 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 from the general public.

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

Staff and Organization



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, 2014 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 auxiliary police officer.

Investigation Unit Functions

During FY 2013-14, the IU addressed 186 complaints, a decrease of 7% from the prior fiscal year when the IU addressed 201 complaints. For the purpose of this report, the complaints were categorized as follows:

- Employee Misconduct - Allegations associated with Employee Misconduct included but were not limited to allegations associated with Conduct Unbecoming, Ethics Violations, Misuse of Agency Resources, and Unfair Employment Practices.
- Other: Regulated/Licensed Facility Violations - Regulated and Licensed Facility Violations included but were not limited to allegations associated with Substandard Care, Public Safety Concerns, Facility Licensing, and Unlicensed Activity.
- Medicaid Fraud - Medicaid Fraud violations included but were not limited to allegations associated with Medicaid Billing Fraud.
- Equal Employment Opportunity (EEO) Violations - EEO violations included but were not limited to allegations associated with Discrimination, Harassment, and Retaliation.
- HIPAA (Health Information Portability and Accountability Act) Violations - HIPAA Violations were associated with allegations of HIPAA Privacy Rule breaches.
- Medicaid Service Complaints - Medicaid Service Complaints included but were not limited to allegations associated with the Denials of Service, Denials of Eligibility, and Medicaid Provider contract violations.

A comparison of the categorized complaints received during FY 2012-13 and FY 2013 – 14 indicated a decrease in non-employee related complaints as follows: Medicaid Fraud complaints decreased by 49%; Facility Regulations complaints decreased by 42%; Medicaid Services complaints decreased by 33%, and complaints categorized as "Other" decreased by 6%.

However, Employee Misconduct complaints increased by 55% and allegations associated with EEO violations increased 145% - a significant increase from the previous year. Furthermore, there were no complaints logged for HIPAA violations in FY 2012-13, while there were seven complaints generated in FY 2013-14.

A comparison of the complaints received during FY 2012-13 and FY 2013-14 is in Table 3.

Table 3: FY 2012-13 and FY 2013–14 Complaint Comparison Summary

Category	2012-13 Number of Complaints	2012-13 Percentage of Complaints	2013-14 Number of Complaints	2013-14 Percentage of Complaints	Change in Number of Complaints	Change in %
Employee Misconduct	33	16%	51	27%	18	55%
Other	36	18%	34	18%	-3	-6%
Facility	55	27%	32	17%	-23	-42%
Medicaid Fraud	57	28%	29	16%	-28	-49%
EEO	11	5%	27	15%	16	145%
HIPAA	0	0%	7	4%	7	
Medicaid Services	9	4%	6	3%	-3	-33%
Total	201	100%	186	100%	-16	-7%

During FY 2012-13, 21 of the 201 complaints required analysis to determine if the complaint met the criteria established under the Whistle-blower's Act, as defined in §112.3187 F. S. Ten of the 21 complaints reviewed met the criteria and were designated as Whistle-blower complaints. Two of the ten complaints were referred to external partners for review and the remaining seven were handled by the IU in coordination with AHCA's Division of Health Quality Assurance (HQA) and the OIG's Office of Medicaid Program Integrity (MPI).

In comparison, during FY 2013-14, 21 of the 186 complaints received required analysis to determine if the complaint met the criteria for Whistle-blower status; however, only four of the 21 complaints met the criteria. The IU, in coordination with HQA and MPI, investigated each of these four complaints.

At the close of FY 2013-14, the OIG IU continued to investigate and/or monitor the investigation of seven active Whistle-blower complaints.

Investigations that resulted in published investigative reports were distributed to the leadership responsible for the employee or program investigated for subsequent personnel action (if appropriate) or recommended policy changes. In all instances, the published reports were presented to the Agency Secretary for review prior to management's resolution and action.

The following are examples of closed internal investigative reports published during FY 2013-2014. An index of complaints received during this reporting period is included at the end of this section.

Investigation 13-050

A complainant alleged harassment by an Agency employee.

A complaint was filed by an AHCA employee alleging another AHCA employee verbally threatened them. Documentary evidence alone provided inconclusive evidence that the AHCA employee acted in a threatening manner. However, in the course of the investigation, the subject admitted they had acted aggressively toward the complainant thereby violating AHCA's policy regarding Ethics and Political Activities and Rule 60L-36.005(3) – Disciplinary Standards, FAC.

Investigation 13-086

This complaint was initiated based on a report received by the AHCA OIG that an AHCA manager may have engaged in inappropriate workplace conduct and inappropriate interactions with AHCA employees.

Based on the IU's investigative research and an admission by the manager during the investigative interview, the IU concluded that the manager had accessed inappropriate, non-work-related websites portraying images, which could be considered inappropriate for the workplace and offensive by others.

Investigation 13-122

The IU received a complaint relayed from the Office of the Chief Inspector General (CIG), which conveyed a complainant's disagreement with the Division of Health Quality Assurance's (HQA) findings in an AHCA-regulated facility inspection. HQA conducted two unannounced inspections and documented no deficient practices at the time of their inspections related to the facility in question. The complaint was unsubstantiated.

Investigation 13- 131

A complainant alleged discrimination based on age and sex. The complaint was unsubstantiated.

The IU received a written complaint of discrimination filed with the U. S. Equal Employment Opportunity Commission (EEOC) from an AHCA employee alleging discrimination on the basis of age and gender after two other employees were allegedly hired at a higher rate of pay but shared the same job title and work responsibilities as the complainant. The complainant also alleged age discrimination when the complainant was denied the opportunity to work overtime. The investigation revealed that AHCA's hiring policies allowed managers to recommend starting salaries based on employees' education level, work experience, and AHCA's budget at the time of hire. There was insufficient evidence to support the complainant's allegations.

Investigation 13-177

The IU received a complaint filed with the Equal Employment Opportunity Commission (EEOC) alleging discrimination based on gender. The complaint was unsubstantiated.

The complainant alleged they were subjected to disparate treatment from their direct supervisor and another employee when they were required to meet different terms and conditions of employment and were allegedly held to a different standard than other employees in comparable positions. There was insufficient evidence to support the allegations.

Investigation 14-01-013

An Agency employee alleged retaliation for engaging in protected activity after filing a prior allegation of discrimination.

The complainant alleged that after filing a previous complaint of discrimination they received "impossible" performance evaluation measures, were evaluated on higher standards than employees in the same position were, were required to submit numerous reports, and were ordered to falsify work hours. The IU found that the complainant accepted their performance evaluation measures almost three months prior to the protected activity , their performance expectations were consistent with their job duties, all employees in the same position were required to submit the same reports within the same time period, and personnel were not ordered to falsify their work hours. The complaint was unsubstantiated.

Investigation 14-01-015

An Agency employee alleged discrimination and retaliation based on race and gender. The complaint was unsubstantiated.

The complainant alleged they were assigned additional duties without a pay raise, were subjected to adverse terms and conditions of employment, and passed over for promotion when they submitted a written statement describing their concerns. The investigation did not disclose sufficient evidence to corroborate allegations of adverse employment action against the complainant and did not disclose sufficient evidence in support of the allegations that the complainant was not awarded promotions due to the complainant's race or gender. The investigation indicated the complainant was not awarded promotions due to management's assessment that the complainant lacked the necessary qualifications and level of experience. The allegations were unsubstantiated.

Review of AHCA Employees Associated with Active Medicaid Provider Numbers

This review was undertaken at the request of the Agency Secretary after another state agency's employee was found to have overbilled the Medicaid program by over $500,000 while the employee was actively employed at the state agency. The review required gathering of Florida Medicaid Management Information System (FMMIS) data, AHCA personnel file documents, and Medicaid

provider enrollment applications. The findings of this review highlighted possible deficiencies or areas of concern associated with AHCA's Ethics Policy, #01-HR-55; Rule 60L-36.003, Florida Administrative Code; and s. 112.313 (3) and (7), Florida Statutes.

OPS Productivity Review

The IU performed productivity reviews of Other Personal Service (OPS) status employees based on email and Internet usage. The completed reviews included OPS personnel in the following AHCA divisions: Executive Offices (Chief of Staff, Office of General Counsel), Division of Operations, Health Quality Assurance (HQA), and Medicaid Program Integrity (MPI). A productivity review of OPS personnel in Medicaid Services is ongoing.

Internal Investigation Cases – FY 2013-14

Case Number	Allegation	Disposition
13-098	Patient Rights Violation	Referred to HHS
13-099	Medicaid Fraud	Referred to MPI
13-100	Fraud	Referred to MPI
13-101	Conduct Unbecoming	Referred to HQA
13-102	Request for PHI	Complaint Withdrawn
13-103	Other	Open
13-104	Medicaid Fraud	Referred to MPI
13-105	Other	Referred to Law Enforcement
13-106	Discrimination	Unsubstantiated
13-107	Theft	Inconclusive
13-108	Violation of Agency Policy	Substantiated
13-109	Medicaid Fraud	Referred to MPI
13-110	Hostile Work Environment	Complaint Withdrawn
13-111	Substandard Care	Open
13-112	Violation of State Regulations	Referred to HQA/MPI
13-113	HIPAA Violation	Referred to HIPAA
13-114	Misconduct	Open
13-115	HIPAA Violation	Referred to HIPAA
13-116	Discrimination	Open
13-117	Conduct Unbecoming	Referred to DOH
13-118	Request for Information	Referred to HQA/DOH
13-119	HIPAA Violation	Inconclusive
13-120	Improper Counseling	Referred to HR
13-121	Medicaid Fraud	Referred to DFS
13-122	Substandard Care	Referred to HQA
13-123	Conduct Unbecoming	Referred to DOH
13-124	Public Safety	Referred to HQA/APD
13-125	Medicaid Fraud	Referred to HQA/MPI
13-126	Retaliation	Insufficient information provided by complainant to warrant investigative activity
13-127	Other	Insufficient information provided by complainant to warrant investigative activity
13-128	Request for Information from DOEA	Data provided to DOEA

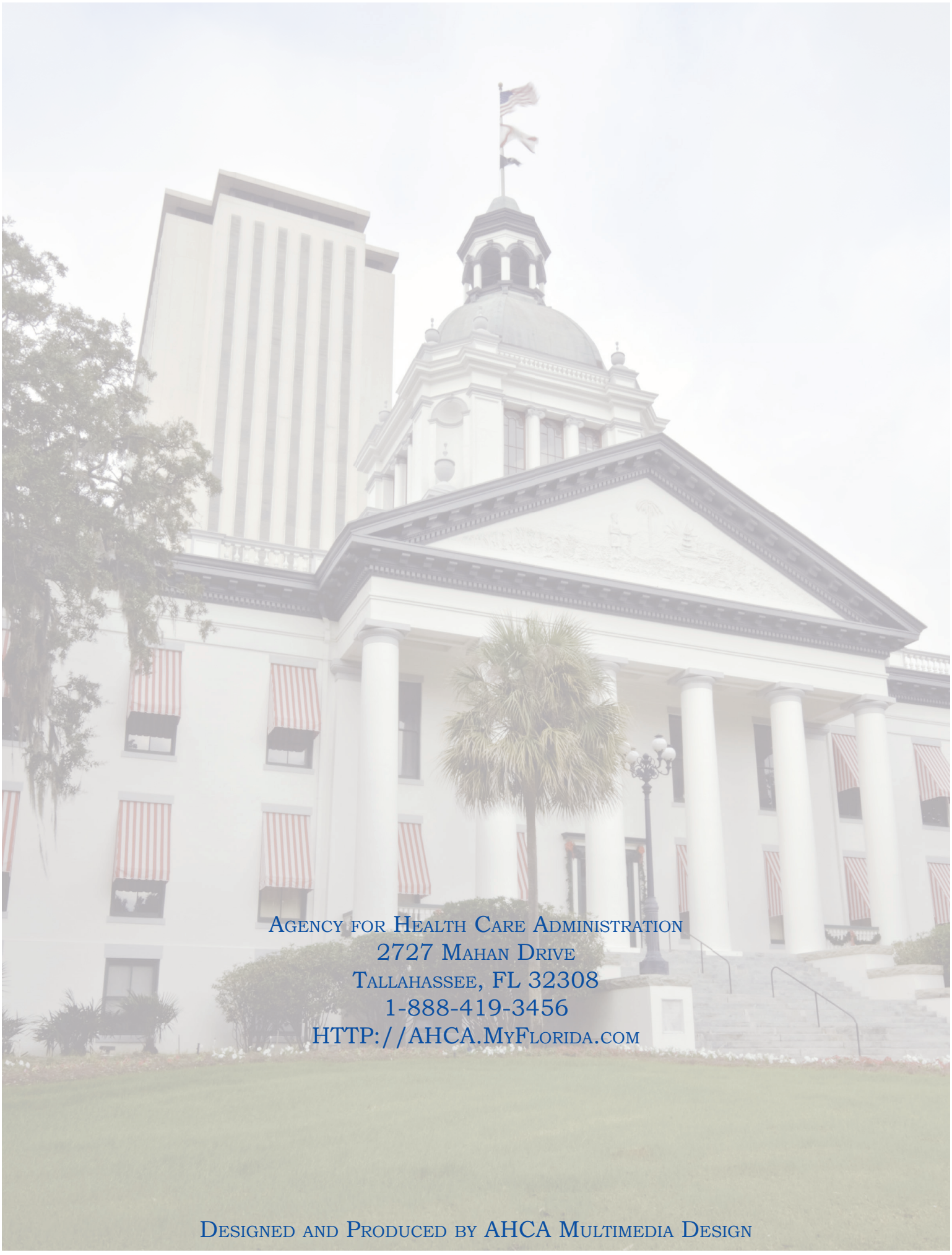
Case Number	Allegation	Disposition
13-129	OPS Employee Productivity Review	Data provided to AHCA MPI Management
13-130	Violation of Agency Policy	Substantiated
13-131	Discrimination	Complaint Withdrawn
13-132	Substandard Care	Referred to HQA
13-133	HIPAA Violation	Referred to HQA
13-134	Medicaid Fraud	Referred to HQA
13-135	Conduct Unbecoming	Referred to HQA
13-136	AHCA Employee Failed to Report to Work	Referred to MPI / HR
13-137	Conflict of Interest	Unsubstantiated
13-138	Contract Violation	Referred to MPI
13-139	Substandard Care	Referred to HQA/MPI
13-140	Retaliation	Insufficient information provided by complainant to warrant investigative activity
13-141	Medicaid Fraud	Referred to MPI
13-142	Substandard Care	Referred to HQA
13-143	Substandard Care	Referred to DOH
13-144	Substandard Care	Referred to HQA
13-145	Substandard Care	Referred to DOH
13-146	Medicaid Fraud	Referred to MPI
13-147	Identity Theft	OIG lacks oversight of the circumstances presented
13-148	Misuse of Resources	Open
13-149	Medicaid Fraud	Referred to MPI
13-150	Conduct Unbecoming	Unsubstantiated
13-151	Medicaid Fraud	Referred to DOH
13-152	Substandard Care	Referred to HQA
13-153	Substandard Care	Referred to HQA
13-154	Other	OIG lacks oversight of the circumstances presented
13-155	Denial Without Cause	Referred to Medicaid
13-156	Discrimination	Unsubstantiated
13-157	Medicaid Fraud	Open
13-158	Discrimination	Unsubstantiated
13-159	Other	OIG lacks oversight of the circumstances presented

Case Number	Allegation	Disposition
13-160	Denied Treatment	Referred to CIG
13-161	Medicaid Fraud	Referred to MPI
13-162	Substandard Care	Referred to HQA
13-163	Conduct Unbecoming	Substantiated
13-164	Misconduct	Unsubstantiated
13-165	Substandard Care	Open
13-166	Retaliation	Unsubstantiated
13-167	Other	Referred to HQA
13-168	Conduct Unbecoming	Open
13-169	Discrimination	Open
13-170	Discrimination	Open
13-171	Discrimination	Open
13-172	Other	OIG data collection and review
13-173	Discrimination	Unsubstantiated
13-174	Retaliation	Open
13-175	Conduct Unbecoming	Referred to HQA
13-176	Medicaid Fraud	Referred to HQA
13-177	Discrimination	Unsubstantiated
13-178	Substandard Care	Open
13-179	Discrimination	Unsubstantiated
13-180	Discrimination	Unsubstantiated
13-181	Misconduct	Unsubstantiated
13-182	Medicare Fraud	Referred to MPI
13-183	OPS Employee Productivity Review	Data provided to HQA Management
13-184	Harassment	Unsubstantiated
13-185	Misconduct	Open
13-186	Substandard Care	Complainants allegations previously addressed by HQA
13-187	Medicaid Fraud	Referred to MPI
13-188	Misconduct	Inconclusive
13-189	Theft	Referred to Law Enforcement
13-191	Request for Information	Referred to Law Enforcement
14-01-001	Misconduct	Unsubstantiated
14-01-002	Substandard Care	Insufficient information provided by complainant to warrant investigative activity

Case Number	Allegation	Disposition
14-01-003	Unfair Employment Practices by a physician	Complainant referred to DOH
14-01-004	Unfair Employment Practices	Referred to FCHR
14-01-005	Violation of Civil Rights	Referred to DOC
14-01-006	Substandard Care	Referred to HQA
14-01-007	Identity Theft	Inconclusive
14-01-008	HIPAA Violation	Unsubstantiated
14-01-009	Other	Referred to HQA
14-01-010	Medicaid Fraud	Referred to HQA/MPI
14-01-011	Substandard Care	Referred to HQA
14-01-012	Unfair Employment Practices	Unsubstantiated
14-01-013	Retaliation	Unsubstantiated
14-01-014	Substandard Care	Unsubstantiated
14-01-015	Unfair Employment Practices	Unsubstantiated
14-01-016	Hostile Work Environment	Open
14-02-001	Misconduct	Unsubstantiated
14-02-002	Request for Assistance	Data provided to law enforcement
14-02-003	HIPAA Violation	Unsubstantiated
14-02-004	Unfair Employment Practices	Referred to CIG
14-02-005	Other	Unsubstantiated
14-02-006	Other	Referred to MPI
14-02-007	Unsafe Working Conditions	OIG lacks oversight of the circumstances presented
14-02-008	Misconduct	Open
14-02-009	HIPAA Violation	Data provided to HIPAA Management
14-02-010	Discrimination	Unsubstantiated
14-02-011	Discrimination	Open
14-02-012	Medicaid Fraud	Open
14-02-013	Misconduct/Substandard Care	Open
14-02-014	Medicaid Fraud	Referred to MPI
14-02-015	Conflict of Interest	Referred to MPI
14-02-016	Substandard Care	Closed in favor of AHCA OIG #13-074
14-02-017	Conduct Unbecoming	Open
14-03-001	Other	Insufficient information provided by complainant to warrant investigative activity
14-03-002	Discrimination	Unsubstantiated

Case Number	Allegation	Disposition
14-03-003	Substandard Care	Referred to HQA
14-03-004	Violation of Agency Policy	Unsubstantiated
14-03-005	Medicaid Fraud	Referred to MPI
14-03-006	Fraud	OIG lacks oversight of the circumstances presented
14-03-007	Cyber Stalking	Referred to Law Enforcement
14-03-008	Misconduct	OIG lacks oversight of the circumstances presented
14-03-009	Conduct Unbecoming	Open
14-03-010	Medicaid Fraud	Insufficient information provided by complainant to warrant investigative activity
14-03-011	Fraud	OIG lacks oversight of the circumstances presented
14-03-012	Disparate Treatment	Open
14-03-013	Fraud	Insufficient information provided by complainant to warrant investigative activity
14-03-014	Denial of License	Insufficient information provided by complainant to warrant investigative activity
14-03-015	OPS Employee Productivity Review	Data provided to Office of General Counsel for review
14-03-016	Medicaid Fraud	Referred to MPI
14-03-017	Medicaid Fraud	OIG lacks oversight of the circumstances presented
14-03-018	Medicaid Fraud	Open
14-03-019	OPS Employee Productivity Review	Data provided to Chief of Staff for review
14-03-020	OPS Employee Productivity Review	Data provided to Operations Management for review
14-04-001	Conflict of Interest	Substantiated
14-04-002	Unfair Employment Practices	Open
14-04-003	Conduct Unbecoming	Open
14-04-004	Medicaid Fraud	Unsubstantiated
14-04-005	Suspicious Call	Referred to Law Enforcement
14-04-006	Conduct Unbecoming	Unsubstantiated
14-04-007	Substandard Care	Referred to HQA
14-04-008	Medicaid Fraud	Referred to MPI

Case Number	Allegation	Disposition
14-04-009	Other	Referred to Medicaid Area 8
14-04-010	Substandard Care	Referred to HQA
14-04-011	Wrongful Termination	Referred to APD
14-04-012	Change of Benefits	Referred Area 11
14-04-013	Substandard Care	Referred to HQA
14-04-014	Inaccurate Charges	Referred to HQA
14-05-001	Misuse of Agency Resources	Open
14-05-002	Substandard Care	Referred to HQA
14-05-003	Substandard Care	Referred to HQA
14-05-004	Denied Access	Referred to HIPAA
14-05-005	Hostile Work Environment	Open
14-05-006	Unfair Employment Practices	Unsubstantiated
14-05-007	Unfair Employment Practices	Unsubstantiated
14-05-008	Misconduct	Open
14-05-009	Substandard Care	Insufficient information provided by complainant to warrant investigative activity
14-06-001	Fraud	Referred to DMS
14-06-002	Misconduct	Unsubstantiated
14-06-003	Release of PHI	Referred DCF/Area10
14-06-004	Fraud	Referred to HQA
14-06-005	Medicaid Fraud	Open
14-06-006	Hostile Work Environment	Insufficient information provided by complainant to warrant investigative activity
14-06-007	Medicaid Fraud	Open
14-06-008	Denied Access	Insufficient information provided by complainant to warrant investigative activity
14-06-009	Misconduct	Unsubstantiated
14-06-010	Misconduct	Unsubstantiated
14-06-011	Substandard Care	Referred to HQA
14-06-012	Safety	Unsubstantiated
14-06-013	Medicaid Fraud	Referred to HQA
14-06-014	Discrimination	Open
14-06-015	Substandard Care	Open
14-06-016	Eligibility	Referred to DFS
14-06-017	Eligibility	Referred to Medicaid Area 10
14-06-018	Denied Access	Open



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