Agency for Health Care Administration
Office of the Inspector General
2014-15 Annual Report

September 2015

Message from the Inspector General

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

As a representative of the 133 members of the Agency for Health Care Administration's (AHCA) Office of Inspector General (OIG), I am proud to submit this summary report of our work and accomplishments during State Fiscal Year 2014-2015. The OIG's mission is to provide a central point for the coordination of activities and duties that promote accountability, integrity, and efficiency in AHCA and the programs that AHCA administers. This important mission could not be accomplished without the dedication and hard work of the auditors, analysts, administrators, investigators, pharmacists, review specialists, medical professionals, support personnel, and managers who comprise the OIG and its 4 component units.

The AHCA OIG is one of the largest inspectors general offices in Florida government, dedicated to combating fraud, waste and program abuse and to improving the efficiency of AHCA programs. A majority of our OIG's resource allocation is dedicated to the oversight of Medicaid payments to medical service providers, a crucial role since Medicaid dollars represent a significant part of the State of Florida's budget and the Medicaid program serves the State's most vulnerable citizens. The remaining OIG resources, also critical to the State's health care governance function, ensure that employee misconduct is properly investigated, program audits and reviews are coordinated and accomplished, and that information held by AHCA is protected in accordance with state and federal privacy laws.

I hope this report provides useful information on the OIG's work this past fiscal year. While the OIG's intangible deterrent impact cannot be fully represented in an annual report, the text and graphics that follow provide some understanding of the costs recovered and avoided as a result of the OIG's efforts, the investigations conducted, and the audits and reviews completed to ensure that the Agency for Health Care Administration is prepared to meet the needs of the public which it serves.

Eric W. Miller

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AHCA'S MISSION

Better Health Care for all Floridians.

VISION

A health care system that empowers consumers, that rewards personal responsibility and where patients, providers and payers work for better outcomes at the best price.

OUR VALUES

Accountability– We are responsible, efficient and transparent.

Fairness– We treat people in a respectful, consistent and objective manner.

Responsiveness– We address people's needs in a timely, effective, and courteous manner.

Teamwork– We collaborate and share our ideas.

Office of the Inspector General

The Office of the Inspector General is an integral part of the Agency for Health Care Administration (Agency). The purpose of the Office of the Inspector General 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, mandates the duties and responsibilities of each inspector general, with respect to the state agency/department in which the office is established.

The primary mission of the Office of the Inspector General 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 health care administration 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. Additionally, the Inspector General's mission is accomplished by investigating Medicaid providers suspected of fraud or abuse in the Medicaid program.

For an itemization of the specific duties and responsibilities of the Inspector General, and a summary of the Inspector General's activities for the latest complete fiscal year, please view the Office of the Inspector General Annual Report. [3MB, PDF]

Organization and Staff

The Inspector General is appointed by and reports to the Secretary. The Inspector General oversees four sections: Internal Audit, Investigations, HIPAA Compliance Office and Medicaid Program Integrity.

Internal Audit - Performs management consultation, management reviews, special projects, and independent audits. Internal Audit provides Agency management with an independent analysis of operations and controls within the Agency and recommends methods by which these functions may be improved in accordance with Sections 20.055(2)(d) and 20.055(5), Florida Statutes.

Investigations - Provides for the receiving, processing, investigation, and documentation of complaints of alleged violations of Agency policies, procedures, rules, or laws by the Agency or its employees. Conducts investigations pursuant to the Whistle-blower Act in accordance with Sections 112.3187 through 112.31895, Florida Statutes. Other investigations are conducted in accordance with the procedures and standards adopted by the Governor's Council on Integrity and Efficiency.

HIPAA Compliance Office - Advises and assists the agency in its HIPAA compliance efforts and in safeguarding the privacy of all Protected Health Information (PHI) in the Agency's custody. Assists Medicaid recipients in exercising their rights as provided by HIPAA.

Medicaid Program Integrity - Pursuant to Section 409.913, Florida Statutes, investigates providers suspected of fraud or abuse in the Medicaid program. Medicaid Program Integrity also recovers overpayments, issues administrative sanctions, and refers cases of suspected fraud for criminal investigation to the Office of the Attorney General. For more detailed information on MPI and their successes, please reference The State's Efforts to Combat Medicaid Fraud and Abuse FY 2013-14.

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). The HIPAA Compliance Office staff consists of two FTEs: a Senior Management Analyst II designated by the Secretary of the Agency for Health Care Administration as the Agency's Privacy Officer and an Operations and Management Consultant I. Responsibilities and activities undertaken by this two-person staff in FY 2014-15 included the following:

- Administered the HIPAA/Security Awareness Online Training program, which is a web-based course designed to orient new Agency staff to HIPAA requirements and heighten staff understanding of computer security procedures;
- Provided in-person HIPAA and HITECH privacy training to Agency employees as part of new employee orientation and annual refresher training;
- Responded to requests for protected health information (PHI) from Medicaid recipients or recipients' authorized representatives within an average of four business days and replied to emails and telephone inquiries from the public within an average of one business day;
- Provided guidance to Agency staff regarding potential privacy incidents or breach situations and ensured Agency actions in such situations were in compliance with HIPAA regulations;
- Detected and identified legacy Agency practices that presented a risk of HIPAA non-compliance and worked with Agency staff to alter such practices, thereby reducing risk of HIPAA violation or information breach;
- Contributed written recommendations for privacy and security related specifications for the upcoming procurement of a new Medicaid fiscal agent;
- Worked with staff on revising the Florida Center's *Data Security Manual* for policy and best practice compliance and provided written recommendations;
- Provided written guidance and training to Agency staff on compliance issues related to the 2014 Florida Information Protection Act (s. 501.171, Florida Statutes);
- Reviewed and provided written comments and recommendations on Agency contracts and agreements involving confidential data;

HIPAA Compliance Office

- Reviewed all new Agency forms or forms under revision for privacy policy compliance and provided written comments and recommendations;
- Issued formal “HIPAA Compliance Advisory Memoranda” as necessary to communicate major compliance concerns to Agency leadership; and
- The Privacy Officer was tapped by the Chief Inspector General to present HIPAA/Data Privacy training to Florida state government Inspectors General and Information Security Managers and, also, at the request of the Chief Inspector General, the Privacy Officer participated in an Inspectors General workgroup charged with reviewing a draft data security rule being developed by the Agency for State Technology.

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 Agency 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 AHCA's risk management, control, and governance processes. The scope and assignment of audits is determined by the Inspector General; however, the Agency Secretary may at any time request the Inspector General to perform an audit of a special program, function, or organizational unit.

Internal Audit operates within AHCA'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 AHCA records, data, and other information deemed necessary to carry out the Inspector General's duties. The Inspector General is authorized to request such information or assistance as may be necessary from AHCA or from any federal, state, or local government entity.

Risk Assessment

Internal Audit performs a risk assessment of AHCA's programs and activities near the end of each fiscal year to assist in the development of its annual audit plan. The risk assessment process includes the identification of activities or services performed by AHCA and an evaluation of various risk factors where conditions or events may occur that could adversely affect the Agency. Activities assessed consist of components of AHCA's critical functions that allow AHCA to achieve its mission. 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 AHCA.

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

Internal Audit also conducts assurance engagements for the Agency. These engagements 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 AHCA 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 subsequent 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 of process improvement between management and staff, or between AHCA units;
- Participating in process action teams;
- Reviewing planned or new processes to determine efficiency, effectiveness or adequacy of internal controls; and
- Preparing explanatory 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 examinations of Agency units, programs, or processes that do not require a comprehensive audit. These reviews may also include compliance reviews of contractors or entities under AHCA'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 AHCA 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 AHCA unit, the Governor's office, or the Legislature in researching an issue. Special projects also include atypical activities that are accomplished within Internal Audit, such as the installation of new audit tracking or training software, or revisions of policies and procedures.

Internal Audit Staff

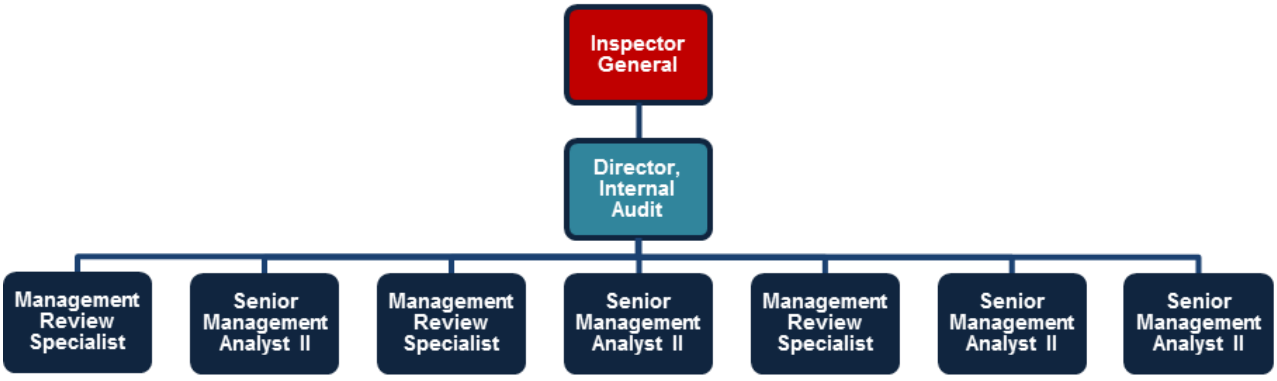
Internal Audit staff members bring various skills, expertise, and backgrounds to AHCA. Certifications or advanced degrees collectively held by members of Internal Audit include:

- Certified Public Accountant
- Certified Internal Auditor
- Certified Fraud Examiner (2)
- Certified Information Systems Auditor
- Certified Inspector General
- Certified Inspector General Auditor (4)
- Certified Government Auditing Professional
- Master of Arts in Teaching
- Master of Public Administration
- Master of Business Administration (2)
- Juris Doctorate in Law

The IIA *Standards (also known as Red Book Standards)* and the Association of Inspectors General *Principles and Standards for Offices of Inspectors 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. To meet this requirement, staff members attend courses, conferences, seminars, and webinars throughout the year.

During this fiscal year, Internal Audit staff attended trainings sponsored by national and/or local chapters of the Association of Inspectors General, the Institute of Internal Auditors, the Association of Certified Fraud Examiners, the Association of Government Accountants, and the Information Systems Audit and Control Association. Staff also attended AHCA employee training and completed Government and Nonprofit Accounting video training.

Internal Audit Organizational Chart



Internal Audit Activities

Assurance Engagements, Consulting Engagements, and Management Reviews

Internal Audit completed two reviews and one enterprise audit during fiscal year (FY) 2014-15. The following is a summary list of engagements completed and a summary list of engagements in progress as of June 30, 2015:

Table 1: Internal Audit Engagements

Report No.	Engagement	Type	Month Issued
14-17	Review of TLO	Assurance	October 2014
CIG 2014-1	Assessment of Managed Care Organizations' Anti-Fraud Plans	Enterprise Audit	December 2014
15-18	Pre-Admission Screening and Resident Review Process	Review	May 2015

Table 2: Internal Audit Engagements in Progress

Report No.	Engagement	Type	Planned Issue Month
13-14	Medicaid Recipient File Management	Assurance	July 2015
15-08	Background Screening Clearinghouse	Assurance	December 2015
15-09	Third Party Liability Process	Assurance	December 2015
15-11	HQA On-line Licensing Process	Assurance	February 2016
15-16	Single Sign-On Process	Assurance	February 2016

Engagement Summaries

The following summaries describe the results of the assurance engagements, consulting engagements, and reviews completed by Internal Audit during FY 2014-15:

14-17 Review of TLO

Internal Audit conducted a review to determine whether there were adequate internal controls in place to govern the use of TLO (a data aggregator service) by the Fraud Prevention and Compliance Unit (FPCU) within the Division of Medicaid and whether the use was appropriate and efficient. The scope of this engagement included the FPCU's use of TLO from July 2013 to May 2014. The review found that FPCU had inadequate controls in place to govern TLO software use and that TLO use was not always appropriate. On a positive note, FPCU updated their TLO agreement within the three-year requirement. Overall, Internal Audit identified opportunities for improvements in documentation, processes, policy/procedure, forms development, and training. Some of Internal Audit's recommendations to the Division of Medicaid were that the FPCU should:

- Develop written procedures to address user access and termination requests; user understanding of the confidentiality/security of data obtained from TLO; periodic monitoring of staff TLO usage; user documentation reason(s) for each search; and quarterly usage reviews.
- Maintain written documentation for no less than five years for each TLO licensed user addition or termination.
- Develop and implement a Confidentiality Acknowledgement form for all TLO users to sign when given access. These forms should be in a central file maintained by the Account Administrator for documentation and compliance assurance purposes.
- Periodically monitor TLO usage reports and determine how many user licenses are necessary to perform the intended function.
- Ensure reviews of TLO searches are performed by an independent party on a quarterly basis. All reviews should be documented and maintained for no less than five years.
- Ensure all staff are trained in the proper use of TLO, maintaining documentation of searches and any other procedures addressed in this report.

CIG 2014 -1 Assessment of Managed Care Organizations' Anti-Fraud Plans

The Office of the Chief Inspector General (CIG), Executive Office of the Governor, in consultation with various agency inspectors general, identified potential risks within Florida's Medicaid program, which was transitioning from a predominantly fee-for-service system to delivery of Medicaid services through multiple managed care providers. The CIG, pursuant to Section 14.32, F.S., initiated a review of Managed Care Organizations' (MCOs) anti-fraud plans and AHCA's process for reviewing and monitoring the implementation of these anti-fraud plans. AHCA's Internal Audit Unit led the team of auditors assigned to this engagement. The scope of the engagement included an assessment of anti-fraud plans submitted to AHCA under existing Medicaid managed care contracts for the 2010-11 and 2011-12 fiscal years. The objectives were to determine whether anti-fraud plan requirements sufficiently addressed or mitigated the potential fraud risks inherent in managed care organizations; to evaluate anti-fraud plans to identify best practices employed by MCOs to prevent fraud and abuse; and to evaluate AHCA's Office of Medicaid Program Integrity (MPI) processes for the review and monitoring of the MCOs' anti-fraud plans. Some of the recommendations made to MPI included recommendations that MPI:

- Develop suggested statutory language that will require MCOs to review a period beyond one year when conducting preliminary reviews of fraud, abuse and overpayments and to pursue statutory modifications to Section 409.91212(1)(a), F.S. and Section 409.91212(1)(f), F.S.;
- Propose Medicaid contract language which would require MCOs to provide detailed information about the personnel responsible for investigating and reporting possible overpayment, abuse, or fraud in their anti-fraud plans; periodically report on the effectiveness of their Special Investigative Unit's (SIU) performance in Florida's Medicaid program; provide more specific information on systems and analytical techniques that are or will be used in their detection efforts; and implement anti-fraud training that is customized to the various positions throughout their organizations;
- Require MCOs to report and describe their efforts taken to recover the identified overpayments and provide the reasons why remaining overpayments could not be recovered;
- Develop and establish written procedures for the review of the anti-fraud plans that will address the completeness of reviews, timeliness of the reviews, supervisory approval, and documenting correspondence between MPI and the MCOs;
- Develop a plan to provide MPI staff training on more insurance and public assistance fraud-related topics that will aid them in their review of the anti-fraud plans and in conducting field site visits;
- Establish a risk-based assessment to identify which MCOs require onsite visits;
- Develop procedures and checklists for desk reviews in addition to the review tool that is currently being used; develop a plan of utilizing MPI field office staff to aid in the monitoring of MCOs and conducting MCO onsite visits; and
- Develop a plan to conduct unannounced onsite visits of MCOs.

15-18 Pre-Admission Screening and Resident Review Process

At the request of the Agency Secretary, AHCA's OIG conducted a limited management review of the Pre-Admission Screening and Resident Review (PASRR) processes at both AHCA and the Department of Elder Affairs (DOEA). The review focused on DOEA's request for reimbursement at the enhanced Federal Financial Participation (FFP) rate of 75 percent. The review disclosed that DOEA was claiming cost reimbursement at the enhanced 75 percent rate for both PASRR and non-PASRR related activities (i.e. level of care assessments and determinations for individuals seeking services in the community). The review also found that a cost allocation plan was not available to identify and delineate reimbursement rates for PASRR and non-PASRR activities and AHCA did not adequately monitor DOEA's claiming of administrative and program costs, which allowed non-PASRR-related costs to be reimbursed to DOEA at the 75 percent rate. As a result of this review, Internal Audit recommended the following:

- AHCA should review DOEA's proposed cost allocation methodology to ensure it identifies PASRR and non-PASRR-related activities that qualify for different FFP funding rates and submit the approved plan to the United States (U.S.) Department of Health and Human Services (HHS) for federal approval;
- AHCA should update its Cooperative Agreement with DOEA to include, among other things, clearly addressing the monitoring and oversight responsibilities of AHCA in its predominant fiduciary duty related to Medicaid funding and the avoidance of payments for unallowable activities; and
- AHCA should consider combining the existing Cooperative Agreement and the Inter-agency PASRR Agreement as necessary to provide a comprehensive agreement that addresses all current responsibilities of each state agency concerning the administration of the Comprehensive Assessment and Review for Long-Term Care Services program.

Additional Projects

Section 20.055(2), F.S., requires the OIG 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 AHCA's annual Long Range Program Plan (LRPP). Current measures and proposed new measures were reviewed and advice was provided to AHCA components regarding accuracy, validity, and reliability.

Internal Audit completed the following additional duties or projects during FY 2014-15:

- Chief Inspector General Quarterly Activity Reports;
- Schedule IX of the Legislative Budget Request;
- Summary Schedule of Prior Audit Findings;
- Department of Health and Human Services Audit Resolution Letter;
- Updating Audit Report Templates;
- OIG Annual Report;
- Engagements in Progress Report;
- Preparation for an upcoming Auditor General Quality Assurance Review;
- 2015 Enterprise Information Security Risk Assessment;
- Tracking of all HHS Demand Letters and Documentation Requests for Resolution of Audit Findings;
- Annual Risk Assessment; and
- Annual Audit Plan

Internal Engagement Status Reports

The IIA *Standards* require auditors to follow-up on reported findings and recommendations from previous engagements to determine whether AHCA management has taken prompt and appropriate corrective action. The OIG provides status reports on internal engagement findings and recommendations to AHCA management at six-month intervals after publication of an engagement report.

During FY 2014-15, the following status reports for internal engagements were published:

- 15-01 Medicaid Risk Management Processes Review (18-Month Status Update)
- 15-02 Adverse Incidents Report Process (6-Month Status Update)
- 15-03 MCM Provider Enrollment Process Audit (6-Month Status Update)
- 15-04 Review of Accurint (6-Month Status Update)
- 15-05 Review of the Agency's Data Exchange MOU with DHSMV (12-Month Status Update)
- 15-06 Provider Payment Suspension and Termination Processes Review (12-Month Status Update)
- 15-07 Agency Accounts Receivable Process (18-Month Status Update)
- 15-12 Medicaid Risk Management Processes Review (24-Month Status Update)
- 15-13 MCM Provider Enrollment Process Audit (12-Month Status Update)
- 15-14 Adverse Incidents Report Process (12-Month Status Update)
- 15-15 Review of TLO (6- Month Status Update)
- 15-17 Provider Payment Suspension and Termination Processes Review (18-Month Status Update)
- 15-19 CIG Report No. 2014-01 – Assessment of Managed Care Organizations' Anti-Fraud Plans (6-Month Status Update)

Corrective Actions Outstanding From Previous Annual Reports

As of June 30, 2015, the following corrective actions for significant recommendations described in previous annual reports were still outstanding:

12-04 Agency Accounts Receivable Process, issued June 2013

Recommendation: The new accounts receivable system should include the following:

1. The ability to maintain identified accounts and generate reports that allow monitoring for payment timeliness. Reports should include information that shows the chronology of AHCA action taken (i.e. Final Order, Final Audit Report, or notification letter), the date of that action, the date(s) the provider is overdue, the number of days an amount is overdue, and if an amount paid complies with the amount owed.
2. An interface that would automatically populate fields from FMMIS to improve efficiency and expedite data entry.
3. The ability to accommodate all accounts receivable types so that AHCA can discontinue the use of maintaining accounts receivable in Microsoft Excel to improve efficiency and information security.

Most Recent Management Response (dated December 2014): The Bureau of Financial Services executed a Direct Order through My Florida Marketplace on July 1, 2014, for consultant services to document and fix existing errors/breaks/issues for all systems and applications used by them. An Accounts Receivable Team was organized to develop a list of functionalities for a new system. In addition, AHCA included a funding request in its Legislative Budget Request for FY 2015-2016 for the development and implementation of an enterprise system. Progress for fully addressing the recommendation is contingent on the Legislature approving funds for this project. If the Legislature approves funding, it is anticipated the project will take at least three years to complete.

13-12 Provider Enrollment Process Audit issued March 2014

Recommendation: The MCM Provider Enrollment Unit should develop a monthly report, or establish performance measures, to track MCM review processing times.

Most Recent Management Response (dated March 2015): Analysis was completed regarding the impact of additional status codes on applications in MCM review. As expected, new status tracking codes will not shorten the time required for outside review of applications so the solution was not pursued. Instead, processors will enter expanded comments on the pending application records to better describe the reasons the applications were forwarded to the state for review. The entire Medicaid Public Portal is under a major redesign. The enrollment status page will be uploaded as part of that project.

13-10 Provider Payment Suspension and Termination Processes Review issued November 2013

Recommendation: The Prevention and Provider Focus Sub-committee of the Fraud Steering Committee should develop written procedures to guide Medicaid in evaluating the enrollment of providers with previous contractual terminations.

Most Recent Management Response (April 2015): The Provider Eligibility and Compliance Unit will be submitting written recommendations for Medicaid management's approval regarding procedures for evaluating the enrollment of providers with previous contractual terminations.

13-06 Adverse Incident Reporting Process issued February 2014

Recommendation: The Risk Management and Patient Safety Unit (RMPS) should develop policies and procedures to monitor the timely submission of reports.

Most Recent Management Response (dated February 2015): It has been determined the fining process for late submissions of Adverse Incident reports will be handled by the Enforcement Unit of HQA. The Enforcement Unit will develop policies and procedures to monitor the timely submission of reports. The procedures will be drafted by June 30, 2015 for approval.

Recommendation: AHCA should modify the Adverse Incident Data Collection system by including modifications designed to decrease security risks and increase RMPS staff efficiency such as changes to policies related to log-on and passwords, encryption, and documentation and form entries.

Most Recent Management Response (dated February 2015): Efforts to implement the Adverse Incident Reporting system (AIRS) and Single Sign On (SSO) system continue. The completion timeframe is contingent upon available resources for this information technology project. Adverse Incident Report data is compiled and reported for each calendar year. Implementing the new system at the end of the calendar year will reduce the scope of work by eliminating the need to migrate data to the new database. The system design will be complete by November 15, 2015.

Recommendation: AHCA should work with DOH to update the Memorandum of Understanding (MOU) to address the security, method, and frequency of report transfer to DOH.

Most Recent Management Response (February 2015): A legislative proposal related to the referral of Litigation Notices to AHCA was submitted to leadership for consideration in the 2016 session.

Recommendation: Further, if it is determined that RMPS should continue to receive and review Litigation Notices, we recommended that the Florida Center finalize a policy that includes how staff should record, at a minimum, from whom they received the document, the date received by RMPS, the date of review by RMPS, and the action taken by RMPS such as a referral.

Most Recent Management Response (February 2015): Submitted PSR 598 requesting electronic filing (e-File system) for submitting Litigation Notices to AHCA. This system will accommodate the current need to receive and review the Litigation Notices. It will allow the documents to be scanned directly into Laserfiche and generate a report for tracking purposes.

Recommendation: AHCA management should determine the benefit of requiring facilities to submit annual reports. If AHCA management determines that the annual report requirement is not useful or cost beneficial to either AHCA or facilities, we recommend that the law be revisited.

Most Recent Management Response (February 2015): A legislative proposal recommending deleting the requirement for facilities to send the annual reports to AHCA was submitted to leadership for consideration in the 2016 session.

Recommendation: The Florida Center should continue to update and align the rules, policies, and forms with current statutory provisions regarding Adverse Incidents and ensure congruence among these documents.

Most Recent Management Response (February 2015): RMPS is currently in the process of updating and aligning rules, policies, and forms with current statutory provisions regarding Adverse Incidents to ensure congruence among these documents.

External Engagement Status Reports

Pursuant to Section 20.055(5)(h), F.S., the OIG monitors the implementation of AHCA'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 by these entities. Copies of such response are 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 AHCA to provide data and other information describing specifically what AHCA has done to respond to recommendations contained in OPPAGA reports. The OIG is responsible for coordinating these status reports and ensuring that they are submitted within the established timeframes.

During FY 2014-15, status reports were submitted on the following external reports:

- Auditor General – State of Florida Compliance and Internal Controls Over Financial Reporting and Federal Awards (Report No. 2014-173)
- Auditor General - Operational Audit of AHCA - Statewide Medicaid Managed Care Program Implementation (Report No. 2014-193)
- Auditor General - Operational Audit of AHCA - Prior Audit Follow-up and Selected Administrative Activities (Report No. 2015-011)
- Auditor General - Operational Audit of AHCA - Financial Management (Report No. 2015-045)
- OPPAGA – Medicaid Program Integrity Recovers Overpayments in Fee-for-Service and Monitors Fraud and Abuse in Managed Care (Report No. 14-05)

Coordination with Other Audit and Investigative Functions

The OIG acts as AHCA'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, U.S. Department of Health and Human Services, the U.S. Social Security Administration, and the U.S. Government Accountability Office (GAO). The OIG coordinates AHCA's responses to all audits, reviews, and information requests from these entities.

During FY 2014-15, the following reports were issued by external entities through Internal Audit's coordination of activities and responses:

Office of the Auditor General

- Operational Audit of AHCA – Prior Audit Follow-up and Selected Administrative Activities (Report No. 2015-011)
- Operational Audit of AHCA – Financial Management (Report No. 2015-045)
- State of Florida Compliance and Internal Controls Over Financial Reporting and Federal Awards (Report No. 2015-166)

OPPAGA

Long-Term Care Waitlist, Enrollment, and Budget Processes and Procedures Continue to Evolve (Research Memorandum)

GAO

- Medicaid Financing: States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection (GAO-14-627)
- Transportation Disadvantaged Populations: Nonemergency Medical Transportation Not Well Coordinated, and Additional Federal Leadership Needed (GAO-15-110)
- Transportation for Older Adults: Measuring Results Could Help Determine If Coordination Efforts Improve Mobility (GAO-15-158)

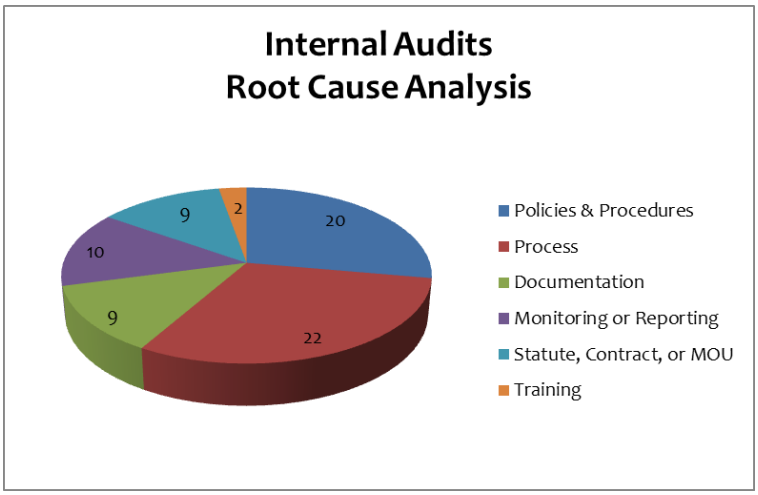
HHS

- Florida Made Medicaid Electronic Health Record Payments to Hospitals in Accordance With Federal and State Requirements (Report No. A-04-13-06164)

Root Cause Analysis

Both internal and external audits showed recurring themes or deficiencies in the following areas:

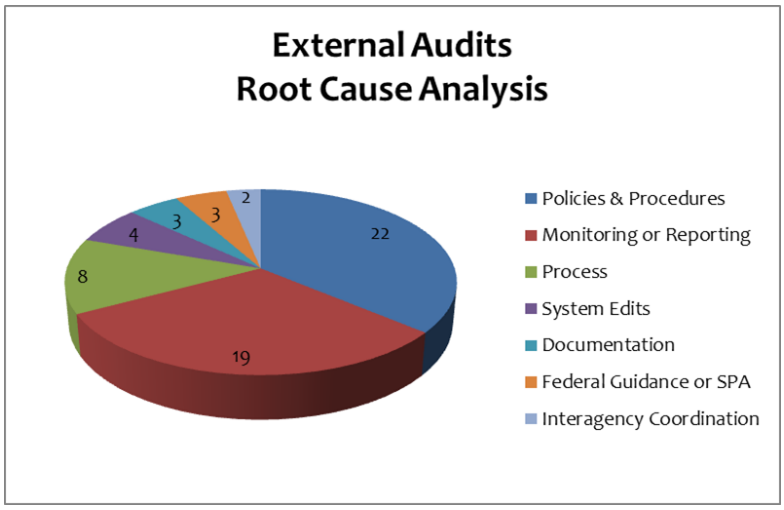
- **Policies and Procedures** – One of the main root causes for external audits and internal audits was the absence of written policies/procedures, or inadequate and outdated policies/procedures.
- **Process** – Inadequate process or failure in the process to address risk was another common root cause for both internal and external audits.
- **Documentation** – Lack of supporting documentation or failure to maintain documentation to show compliance with procedures, laws, contracts, statutes, MOUs, or other governing documents.



- **Monitoring or Reporting** – Inadequate monitoring, supervisory review, reporting or oversight of compliance with policies, procedures, contracts, statutorily imposed controls, or other established standards.

Other Areas showing recurring themes or deficiencies are as follows:

- **Statute, Contract, or MOU Deficiency** – In some instances, the root cause for deficiencies was an obsolete provision or interpretation of a contract, statute, or MOU between agencies.
- **Federal Guidance or State Plan Amendment (SPA) Noncompliance** –Inadequate controls over compliance with procedures, policies or governing documents existed which resulted in non-compliance with federal CMS guidance or the State Medicaid Plan.
- **System Edits** –Programming changes to the Florida Medicaid Management Information System (FMMIS) and electronic edits to FMMIS were required and were not timely implemented, resulting in improper Medicaid payments.
- **Inter-agency Coordination** –State agencies concerned did not adequately coordinate to prevent Medicaid overpayments for non-eligible beneficiaries or prevent concurrent enrollment and dual Medicaid payments for Medicaid recipients in accordance with Federal and State requirements.
- **Training -** Inadequate employee training on certain aspects of their job duties contributed to the disclosure of protective information to third parties.



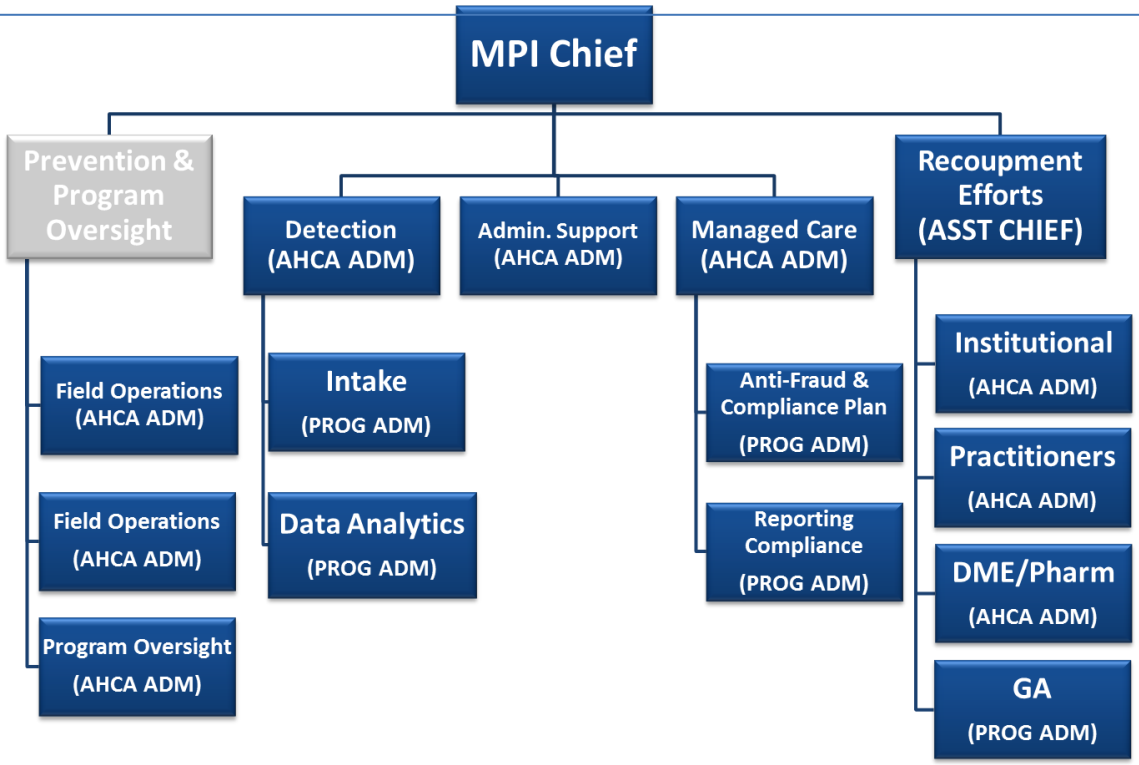
New Capabilities, Staff Certification, and Training Highlights

The Internal Audit Charter and Policy and Procedure Manual underwent major revisions in FY 2014-15 based on changes in the IIA's *Standards* and Practice Advisories, and revisions to Section 20.055, F.S., the statute controlling inspectors general. These changes also prompted an overhaul of Internal Audit's audit program templates.

The Certified Inspector General Auditor program sponsored by the Association of Inspectors General was successfully completed by two senior auditors. This certification program covered the following ten core competency areas: the audit process, professional audit standards, ethics, working with investigators, internal control, forensic auditing, information technology auditing, the peer review process, identifying and reporting monetary benefits, and contract auditing.

Additionally, the AHCA Academy, a year-long supervisory certificate program comprising a total of fourteen classes pertinent to the administration and operations of the Agency and enhancement of leadership capabilities, was completed by the Audit Director and a senior auditor.

Medicaid Program Integrity (MPI)



The Office of Medicaid Program Integrity is a unique component of AHCA's Office of Inspector General in that most Florida inspectors general offices do not house an administrative enforcement arm within their structure. The Office of Medicaid Program Integrity derives its authority from ss. 409.913 and 409.91212, Florida Statutes, laws relating to the integrity of the Medicaid program, and s. 20.055, Florida Statutes, the inspectors general statute. Recognizing its unique and essential role, 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.

MPI activities and audits include comprehensive investigations involving the review 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 improper payments, 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 MPI's staffing limitations.

Detection

MPI activities begin with detection of possible fraud, program abuse, or Medicaid 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. 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 the analysis of information received from external sources (such as a complaint hotline) as well as the analysis of claims using internal tools developed and refined by MPI. Software supplied by the Medicaid fiscal agent contractor complements MPI's own software to detect the upcoding of claims (the billing of higher paying procedure codes than warranted for the services actually supplied). Additionally, MPI is implementing advanced data analytics through contracted services to significantly enhance the number and quality of investigation-ready leads for MPI through the analysis of both internal and external data sets.

Investigation and Recovery

Once a suspected overpayment or program abuse activity is identified, whether it is a suspicious claim 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. Program abuse involves Medicaid billings that are inconsistent with generally accepted practices and that result in unnecessary costs or unnecessary goods or services being provided by the Medicaid program that are not medically necessary, or the rendering of Medicaid-funded care in a manner that fails to meet professionally recognized standards. When 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.

Prevention

MPI's efforts are also intended to deter improper Medicaid payments. The prevention of Medicaid fraud and program abuse reduces the need for costly 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. To enhance MPI's prevention activities, MPI has created a unit to specifically, among other duties, address strategic planning for field initiatives. This is expected to increase the effectiveness of MPI fraud and program abuse prevention and detection activities by ensuring that compliance initiatives are conducted statewide, at locations and facilities where Medicaid services are actually delivered.

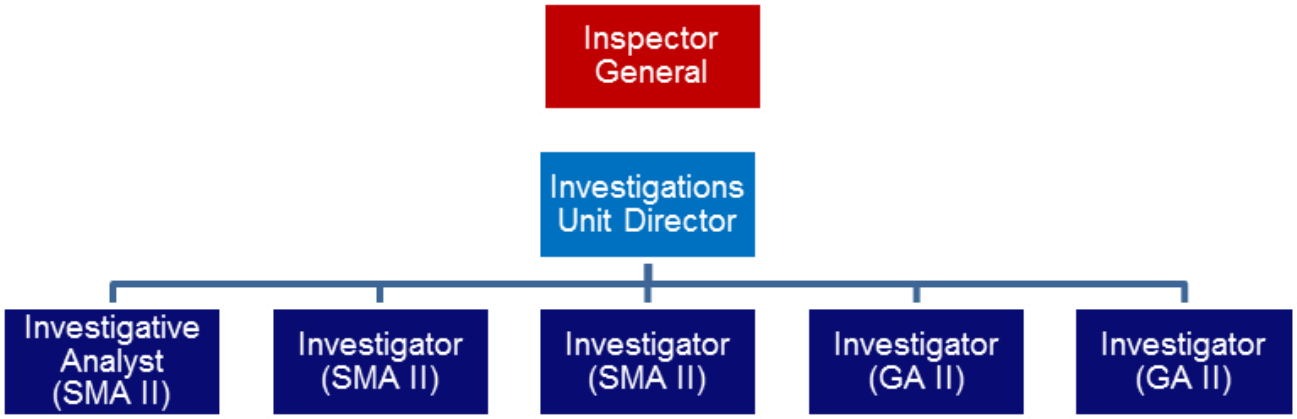
Annual Fraud and Abuse Report

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's 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 past several years' versions of the report are available on the Agency's internet site. The report to be published by January 1, 2016, will also be placed on the website and will include the most current published details about MPI activities.

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 for investigation. 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 on matters involving the accountability or integrity of Agency personnel.



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, 2015 include:

- Certified Compliance and Ethics Professional;
- Certified Fraud Examiners;
- Nationally Certified Inspector General Investigators;
- Certified Equal Employment Opportunity investigators;
- Certified Law Enforcement Analysts;
- Former law enforcement criminal intelligence/investigative analysts;
- Former law enforcement officers; and
- Current police reserve officer.

Investigations Unit Functions

During FY 2014-15, the Investigations Unit (IU) addressed 233 complaints, an increase of 24% from the prior fiscal year when the IU addressed 186 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 a public employee, ethics violations, misuse of Agency Resources, and unfair employment practices.
- Other – Allegations not within the OIG's jurisdiction; information provided wherein no investigative review, referral, or engagement was required.
- Facility - Regulated and licensed facility violations included but were not limited to allegations associated with substandard care, public safety concerns, facility licensing issues, and unlicensed activity.
- Medicaid Fraud - Medicaid fraud violations included but were not limited to allegations associated with Medicaid billing fraud and allegations related to patient brokering and physician self-referral (Stark Law) violations.
- Equal Employment Opportunity (EEO) Violations - EEO violations included but were not limited to allegations associated with discrimination, harassment, and retaliation for engaging in protected activity.
- Health Information Portability and Accountability Act (HIPAA) Violations –Allegations associated with violations of HIPAA's Privacy Rule.
- 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.

During FY 2013-14, 11 of the 186 complaints received required analyses to determine if the complaints met the criteria established under the Whistle-blower's Act, as defined in §112.3187 F. S. Four of the 11 complaints reviewed met the criteria and were designated as Whistle-blower complaints.

In comparison, during FY 2014-15, 17 of the 233 complaints received required analyses to determine if the complaints met the criteria for Whistle-blower status; however, only one of the 17 complaints met qualifying Whistle-blower criteria.

During FY 2014-15, the OIG IU closed 277 complaints and continued to investigate and/or monitor the investigation of three active legacy Whistle-blower complaints that were referred to external law enforcement agencies.

A comparison of the complaints received during FY 2013-14 and FY 2014-15 is in Table 1 (next page).

Table 1: FY 2013-14 and FY 2014–15 Complaint Comparison Summary

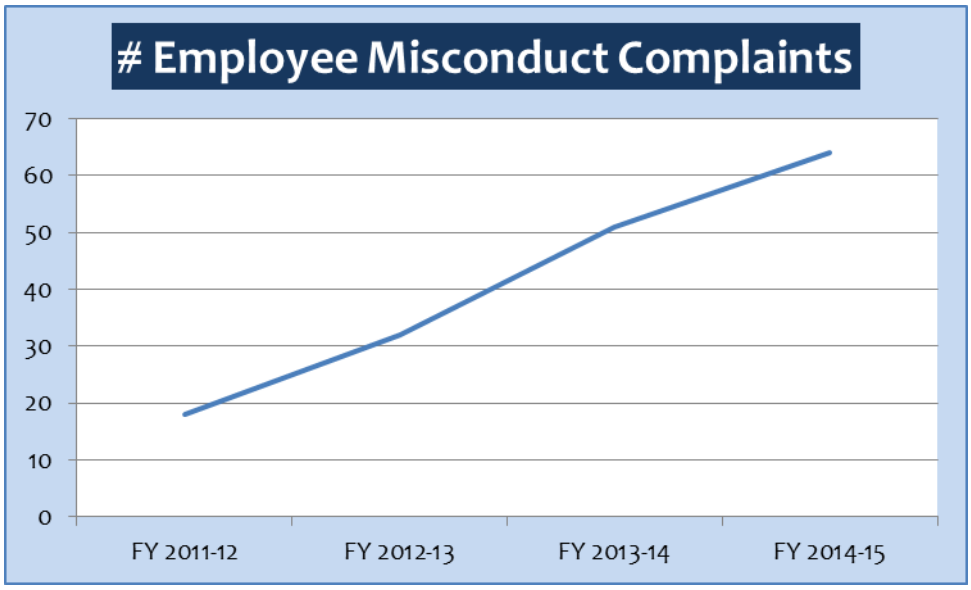
Category	2013-14 Number of Complaints	2013-14 Percentage of Complaints	2014-15 Number of Complaints	2014-15 Percentage of Complaints	Change in Number of Complaints	Change in %
Employee Misconduct	51	27%	63	27%	12	24%
Other	34	18%	68	30%	34	100%
Facility	32	17%	47	20%	15	47%
Medicaid Fraud	29	16%	36	16%	7	24%
EEO	27	15%	6	3%	-21	-78%
HIPAA	7	4%	1	<1%	-6	-86%
Medicaid Services	6	3%	12	5%	6	100%
Total	**186**	**100%**	**233**	**100%**	**47**	

A comparison of the categorized complaints received during FY 2013-14 and FY 2014-15 indicated an increase in non-employee related complaints as follows: Medicaid fraud complaints increased by 24%; facility regulations complaints increased by 47%; Medicaid services complaints increased by 100%, and complaints categorized as “Other” increased by 100%.

There was a decrease in employee-related complaints received during FY 2014-15 in comparison to complaints received during FY 2013-14. Allegations associated with EEO violations decreased 78% - a significant decrease from the previous year. Complaints logged for HIPAA violations decreased 86%. Overall, employee misconduct complaints increased by 24%.

A comparison of Employee Misconduct complaints received between FY 2011-12 through FY 2014-15 is depicted in Table 2.

Table 2: Employee Misconduct Complaints



During FY 2011-12, eighteen Employee Misconduct complaints were received. In FY 2012-13, there was a 78% increase (or 32) in Employee Misconduct complaints. The number of Employee Misconduct complaints continued to rise in FY 2012-13 by 59% (or 51), and increased another 25% (or 64) in FY 2014-15.

The IU's analysis of the Employee Misconduct complaints received and investigated disclosed that the misuse of agency resources was a common factor and that the lack of internal controls and/or monitoring of employees' use of Agency resources was lacking in some areas.

During FY 2014-15, the IU obtained computer forensic software and training which provided the IU with the ability to image hard-drives and perform forensic analyses to locate and view stored and deleted files on Agency-issued computers. The IU performed digital forensic analysis on six Agency-issued computers associated with IU investigations during FY 2014-15. The forensic analyses on four of these six computers disclosed images and documents that historically may not have otherwise been discovered by the IU.

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

The following are examples of closed internal investigative reports published during FY 2014-2015. An index of complaints received during this reporting period is included at the end of this section.

Internal Investigation Case Highlights– FY 2014-15

13-044

This investigation was predicated upon allegations received from an employee with a Medicaid provider who alleged the Medicaid provider was fraudulently billing for Medicaid and Medicare services. The complainant was awarded Whistle-blower status under the provisions of s. 112.3187, F.S.

The AHCA OIG, in conjunction with AHCA's Office of Medicaid Program Integrity, and SafeGuard Services (SGS), a contractor for the U.S. Department of Health and Human Services' Office of Inspector General, conducted an on-site investigation and review of the Medicaid (and Medicare) provider's billing records. Based on documentary evidence reviewed, there was insufficient evidence to support the allegations of Medicaid fraud; however, SGS documented findings associated with Medicare billing fraud.

13-051

This investigation was initiated following a complaint received from an employee of a Medicaid provider who alleged the facility failed to provide care and services to meet the needs of patients in a timely manner due to insufficient staffing. The complainant was awarded Whistle-blower status under the provisions of s. 112.3187, F.S.

The AHCA OIG coordinated with AHCA's Division of Health Quality Assurance (HQA), the entity responsible for licensing and regulation of medical facilities in Florida, to investigate the allegations presented. Through review of documentary evidence, witness interviews, and investigative observations, component allegations presented by the complainant were substantiated.

Following the investigation documenting these findings, the facility corrected the deficiencies found by HQA.

AHCA 14-03-009

This investigation was predicated upon an anonymous complaint alleging an AHCA employee had misused their AHCA-issued computer to store pornographic material and write a biography.

Documentary evidence collected by the AHCA OIG disclosed there was insufficient evidence to support the allegations that the employee viewed or stored pornographic images using their AHCA -issued computer. However, through evidence collected and statements provided by the AHCA employee, the AHCA OIG determined the AHCA employee used their AHCA-issued computer to create and store over 50 documents containing sexually explicit and inappropriate language. The AHCA OIG also determined that the AHCA employee misused AHCA resources to access unauthorized Internet sites that included but were not limited to chat rooms and social media sites. The AHCA OIG substantiated the allegations that the AHCA employee violated Agency polices addressing the use of Internet, e-mail, and Agency-owned computer resources.

AHCA OIG #14-06-002

This investigation, conducted jointly with assets from the OIG's Bureau of Internal Audit and Office of Medicaid Program Integrity, was initiated when information was presented to the AHCA OIG that indicated an AHCA employee and AHCA contractor failed to adequately manage and coordinate contracted litigation associated with "third party liability" (TPL) Medicaid recoveries. The AHCA OIG's investigation disclosed there were insufficient policies or procedures in place to provide sufficient guidance to AHCA personnel regarding the management of the associated contract with the AHCA TPL contractor and this lack of policies or procedures allowed deficiencies to exist in AHCA's management of the TPL contractor. As a result of this investigation, a full audit was requested by the Agency Secretary and included in the audit plan for FY 2015-16.

AHCA OIG #14-07-008

This investigation was initiated when the AHCA OIG discovered evidence that an AHCA employee may have accepted meals provided by a responder/competitive vendor for a pending Invitation to Negotiate (ITN).

The AHCA OIG's investigation disclosed the employee did not meet the definition of a procurement employee associated with the ITN. The vendor was not a contractor with the State of Florida and a contract between AHCA and the vendor never ensued. The AHCA OIG concluded the employee did not accept a gratuity from a vendor in violation of state law or Agency policy. However, documentary evidence collected during the course of this investigation disclosed the employee misused AHCA resources in furtherance of outside employment.

14-08-005

A complainant submitted a written complaint to the U.S. Equal Employment Opportunity Commission alleging racial discrimination. The complainant alleged they were told a vacancy would be filled at the position's base salary, affecting the employee's interest in the position, but instead the position was filled at a higher salary rate. The complainant also alleged that employees of another ethnicity were hired at a starting salary higher than the complainant's salary.

The AHCA OIG's investigation disclosed the complainant voluntarily withdrew from the applicant pool for the referenced vacancy and did not participate in the interview and selection process. The investigation also found that the complainant did not provide sufficient evidence in support of their allegation of racial discrimination.

14-09-003

A complainant alleged discrimination based on race, gender, national origin, and disability in a written complaint to the U.S. Equal Employment Opportunity Commission.

Based on the AHCA OIG's review of documentary evidence collected and statements provided through investigative interviews, the AHCA OIG determined the complainant provided insufficient information or evidence beyond their personal opinion to indicate the complainant was subjected to discrimination based on race, gender, national origin, or disability.

14-11-016

This investigation was initiated when the AHCA OIG received notification that an employee may have engaged in unauthorized outside employment.

The AHCA OIG's review of evidence collected and statements offered in investigative interviews disclosed the employee did not hold unauthorized outside employment; however, evidence was discovered to indicate the employee had provided false statements on their State of Florida Application for employment and failed to disclose a prior criminal history that was subject to mandatory disclosure.

14-11-017

This investigation was initiated when a complainant alleged discrimination based on race, gender, and harassment. The complainant also alleged subjection to adverse employment action in retaliation for submitting prior allegations of discrimination.

The AHCA OIG's review disclosed the complainant's allegations of discrimination based on race and gender were unsubstantiated. The AHCA OIG's investigation disclosed the complainant did not provide sufficient evidence in support of the allegation of harassment. Although documentary evidence disclosed the complainant was subjected to adverse employment actions through counseling and termination, there was insufficient evidence to support any temporal connection between the complainant's counseling/termination and their prior discrimination complaint. The complainant's allegations of discrimination and retaliation were unsubstantiated.

14-11-019

A complainant alleged discrimination when not promoted to position vacancy and instead placed in a "lower grade position."

The AHCA OIG's investigation disclosed the complainant had been promoted or reclassified to a higher pay grade three times following the complainant's initial hire date with AHCA, and was never subjected to placement in a lower pay grade. Based on documentary evidence and investigative interviews collected during the course of this investigation, the AHCA OIG determined that the complainant was not selected for a promotion when the complainant received the lowest interview score of all the applicants interviewed. The AHCA OIG's investigation did not substantiate the complainant's allegation of discrimination.

15-02-001

This investigation was initiated when the AHCA OIG received notification that an AHCA employee may have engaged in activities associated with misconduct while engaged in a professional capacity at an AHCA licensed and regulated facility.

During the course of this investigation, the AHCA received two contradicting explanations of events from complainants, witnesses, and the subject. The allegations against the accused employee were not substantiated.

15-04-014

This investigation was initiated when the AHCA OIG received notification that an AHCA employee may have used AHCA resources to engage in activities associated with identity theft.

Based on the AHCA OIG's review of the employee's AHCA e-mail and a forensic review of the employee's AHCA-issued computer hard drive, coupled with the employee's own admission, the AHCA OIG determined the employee used AHCA resources and compensable time to apply for and open accounts for credit/service in names other than the employee's own; send and receive non-AHCA business e-mails, some of which included inappropriate, non-business language; offer public assistance benefits to other AHCA employees in exchange for cash; create a "promissory note" offering the use of the employee's minor child's identity to a co-worker for use on the co-worker's federal income tax return in exchange for an outstanding debt; create fictitious State of Florida earning statements and bank documents; store personal identification information associated with non-AHCA employees; create and disseminate flyers and programs associated with the employee's church activities; complete and store student financial aid documents; and store credit reports and tax returns for non-AHCA employees.

The AHCA OIG determined there was insufficient evidence to indicate that the employee may have obtained information through AHCA resources such as FMMIS, HealthTrack, or any other Agency database to engage in activities associated with identity theft.

In April 2015, the employee was arrested for "organized fraud," a felony codified in s. 817.034, F.S.

15-04-033

This investigation was initiated when evidence was discovered during the course of another inquiry that indicated an AHCA employee may have engaged in conduct and misused AHCA resources in violation of Agency policies and Florida Administrative Code.

Based on the AHCA OIG's review of the employee's AHCA e-mail and a forensic review of the employee's AHCA-issued computer hard drive, combined with the employee's own admission, the AHCA OIG determined the employee used compensable AHCA work time and AHCA resources to create, store, and/or disseminate homework assignments; e-mails associated with accounts applied for and/or opened in names other than the employee's own; loan modification referrals for non-AHCA employees; and to prepare and submit federal income tax returns for the employee and a relative of the employee.

Information obtained in the course of this investigation also disclosed tthe employee's misuse of AHCA resources may have also been directly or indirectly involved with another employee's arrest for organized fraud and activities associated with the trafficking of public assistance (food stamps and electronic benefit transfer funds) benefits in exchange for cash payments.

The AHCA OIG reported these findings to the appropriate law enforcement entities for their review and possible investigation.

15-05-027

During the course of another inquiry, the AHCA OIG discovered evidence indicating an employee may have misused AHCA resources to engage in public assistance fraud.

The AHCA OIG reported these findings to the Florida Department of Financial Services, Division of Public Assistance Fraud for their review and handling as they deemed appropriate.

Internal Investigation Cases Index – FY 2014-15

Case #	Primary Allegation	Disposition
14-07-001	Substandard Care	Referred to HQA
14-07-002	Medicaid Fraud	Referred to MPI
14-07-003	Other	Unsubstantiated
14-07-004	Medicaid Fraud	Referred to DOH
14-07-005	Stark Law Violation	Referred to HQA and MPI; referred complainant to OAG and HHS
14-07-006	Facility Regulation	Referred to AHCA Privacy Officer
14-07-007	Substandard Care	Referred to HQA and DOH
14-07-008	Misconduct	Substantiated
14-07-009	Misconduct	Unsubstantiated
14-07-010	Medicaid Fraud	Referred to MPI
14-07-011	Medicaid Fraud	Referred to MPI
14-07-012	Misconduct	Unsubstantiated
14-07-013	Other	Outside jurisdiction; referred complainant to law enforcement
14-07-014	Medicaid Services	Referred to MCM
14-07-015	Medicaid Fraud	Referred to HQA
14-07-016	Substandard Care	Referred to HQA
14-07-017	Substandard Care	Referred to HQA
14-07-018	Substandard Care	Referred to HQA
14-07-019	Other	Referred to HQA
14-07-020	Review of Current AHCA employees associated with active Medicaid Provider IDs	Report provided to AHCA management
14-08-001	Misconduct	Referred to HQA
14-08-002	Substandard Care	Referred complainant to Medicaid and health plan
14-08-003	Other	Referred complainant to FCHR
14-08-004	Substandard Care	Referred to HQA
14-08-005	EEO	Unsubstantiated
14-08-006	Substandard Care	Complainant referred to facility to obtain requested medical records
14-08-007	Medicaid Services	Complainant referred to Medicaid and health plan.
14-08-008	Medicaid Fraud	Complainant referred to DCF
14-08-009	Medicaid Services	Information Only; closed without investigation
14-08-010	Medicaid Fraud	Referred complainant to USDOL
14-08-011	Medicaid Fraud	Referred to HQA and MPI
14-08-012	EEO	Unsubstantiated

Case #	Primary Allegation	Disposition
14-08-013	Stark Law Violation	Referred to HQA and MPI; referred complainant to OAG and HHS
14-08-014	Other	Complainant referred to DCF
14-09-001	Conduct Unbecoming	Unsubstantiated
14-09-002	Other	Complainant referred to private insurance plan.
14-09-003	EEO	Unsubstantiated
14-09-004	Substandard Care	Unsubstantiated
14-09-005	Medicaid Fraud	Referred to MPI
14-09-006	Substandard Care	Referred to HQA
14-09-007	Other	Referred to MPI
14-09-008	Review of MPI employee productivity review	Report provided to AHCA management
14-09-009	Medicaid Fraud	Referred complainant to Medicaid
14-09-010	Substandard Care	Referred to HQA; referred complainant to DOH
14-09-011	Medicaid Fraud	Outside jurisdiction; referred complainant to county code enforcement
14-09-012	Substandard Care	Referred to HQA
14-09-013	Medicaid Fraud	Investigation deferred to HHS to avoid duplication
14-09-014	Medicaid Fraud	Referred to DCF
14-09-015	Other	Information Only; No Action Taken
14-09-016	Other	Information Only; No Action Taken
14-09-017	Medicaid Fraud	Referred to MCM and MPI
14-09-018	Other	Complainant referred to DCF
14-09-019	Theft	Information Only; No Action Taken
14-09-020	Substandard Care	Referred to Medicaid
14-10-001	Medicaid Services	Referred to Medicaid
14-10-002	Other	Referred to OGC
14-10-003	Substandard Care	Referred to HQA
14-10-004	Request for Assistance/Information	Assistance/Information provided
14-10-005	Substandard Care	Referred to HQA
14-10-006	Substandard Care	Referred to MPI
14-10-007	Medicaid Fraud	Referred to MPI
14-10-008	Other	Referred to HQA
14-10-009	Misconduct	Referred to Medicaid
14-10-010	Other	Outside jurisdiction; closed without investigation

Case #	Primary Allegation	Disposition
14-10-011	Other	Information Only; No Action Taken
14-10-012	Misconduct	Unsubstantiated
14-10-013	Other	Referred to DCF
14-10-014	Medicaid Services	Substantiated
14-10-015	Medicaid Fraud	Complainant denied making complaint; no action taken
14-10-016	Other	Complainant referred to DOC
14-10-017	Other	Referred to HQA
14-10-018	Substandard Care	Referred to HQA
14-10-019	Other	Referred to MPI
14-10-020	Other	Referred to AHCA Privacy Officer
14-10-021	Substandard Care	Referred to HQA
14-11-001	Other	Referred to MCM
14-11-002	Medicaid Fraud	Referred to MPI
14-11-003	Medicaid Fraud	Referred to MPI
14-11-004	Request for Assistance/Information	Assistance/Information provided
14-11-005	Other	Referred complainant to APD and SMMC
14-11-006	Substandard Care	Referred to HQA
14-11-007	Substandard Care	Referred to HQA
14-11-008	Substandard Care	Referred to HQA
14-11-009	Medicaid Fraud	Referred complainant to health plan
14-11-010	Other	Information Only; No Action Taken
14-11-011	Other	Referred to HQA
14-11-012	Substandard Care	Referred to HQA
14-11-013	Substandard Care	Information Only; No Action Taken
14-11-014	Substandard Care	Information Only; No Action Taken
14-11-015	Substandard Care	Referred to SMMC
14-11-016	Misconduct	Substantiated
14-11-017	EEO	Unsubstantiated
14-11-018	Misconduct	Unsubstantiated
14-11-019	EEO	Unsubstantiated
14-12-001	Facility Regulation	Referred to HQA
14-12-002	Substandard Care	Referred to HQA
14-12-003	Review of AHCA email archives associated keyword "iCloud."	Report provided to AHCA management
14-12-004	Conduct Unbecoming	Referred to TPL
14-12-005	Other	Complainant referred to DOH
14-12-006	Medicaid Fraud	Referred to MPI
14-12-007	Other	Referred complainant to HHS
14-12-008	Substandard Care	Referred to HQA
14-12-009	Other	Information Only; No Action Taken

Case #	Primary Allegation	Disposition
15-01-001	Other	Referred complainant to DCF
15-01-002	Medicaid Services	Referred to Medicaid
15-01-003	Misconduct	Open
15-01-004	Substandard Care	Referred to HQA
15-01-005	Threats	Referred to law enforcement
15-01-006	Review of AHCA Memoranda of Agreement (MOA) and Memorandum of Understanding (MOU) with other State of Florida agencies	Report provided to AHCA management
15-01-007	Substandard Care	Referred to HQA
15-01-008	Other	Outside jurisdiction; closed without investigation
15-01-009	Other	Referred to MPI
15-01-010	Other	Complainant referred to SSA
15-01-011	Medicaid Services	Information Only; No Action Taken
15-01-012	Other	Complaint withdrawn
15-01-013	Facility Regulation	Referred to HQA
15-01-014	Other	Information Only; No Action Taken
15-01-015	Misconduct	Unsubstantiated
15-01-016	Request for Assistance/Information	Assistance/Information provided
15-02-001	Misconduct	Unsubstantiated
15-02-002	Misconduct	Unsubstantiated
15-02-003	Misconduct	Unfounded
15-02-004	Misconduct	Referred to MPI
15-02-005	Other	Referred to HQA
15-02-006	Medicaid Services	Referred to Medicaid
15-02-007	Threats	Information Only; No Action Taken
15-02-008	Other	Referred complainant to DCF
15-02-009	Other	Referred to MPI; referred complainant to DOH and HHS
15-02-010	Theft	Outside jurisdiction; closed without investigation
15-02-011	Medicaid Services	Referred to Medicaid
15-02-012	Facility Regulation	Referred to HQA
15-02-013	Request for Assistance/Information	Assistance/Information provided
15-02-014	Other	Unsubstantiated
15-03-001	Other	Referred to HQA
15-03-002	Other	Referred complainant to HHS
15-03-003	Medicaid Fraud	Referred to MPI

Case #	Primary Allegation	Disposition
15-03-004	Medicaid Fraud	Referred to Medicaid
15-03-005	Theft	Referred to HQA
15-03-006	Facility Regulation	Referred to HQA and SMMC
15-03-007	Substandard Care	Referred to HQA and Provider Enrollment
15-03-008	Other	Referred to HQA
15-03-009	Substandard Care	Referred to HQA
15-03-010	Other	Referred complainant to FCHR
15-03-011	Review of information maintained by People First and Impromptu	Report provided to AHCA management
15-03-012	Medicaid Services	Referred to SMMC
15-03-013	Conduct Unbecoming	Open
15-03-014	Other	Information Only; No Action Taken
15-03-015	Medicaid Fraud	Referred to DCF
15-03-016	Misconduct	Referred to TPL
15-04-001	Other	Referred complainant to DOH
15-04-002	Review of Medicaid Enterprise User Provisioning System (MEUPS) accounts assigned to AHCA OIG employees	Report provided to AHCA management
15-04-003	Substandard Care	Referred to MPI
15-04-004	Facility Regulation	Referred to HQA
15-04-005	Medicaid Fraud	Referred to MPI
15-04-006	Misconduct	Unsubstantiated
15-04-007	Misconduct	Open
15-04-008	Medicaid Fraud	Referred to SMMC
15-04-009	Medicaid Fraud	Referred to SMMC
15-04-010	Medicaid Services	Referred to SMMC
15-04-011	Misconduct	Unsubstantiated
15-04-012	Substandard Care	Referred to HQA
15-04-013	Misuse of Agency Resources	Forensic analysis
15-04-014	Misconduct	Substantiated; Referred to law enforcement
15-04-015	Misuse of Agency Resources	Open
15-04-016	Misuse of Agency Resources	Open
15-04-017	Request for Assistance/Information	Assistance/Information provided
15-04-018	Misconduct	Unsubstantiated
15-04-019	Review of Level 2 Background Checks for AHCA employees	Open
15-04-020	Medicare Fraud	Outside jurisdiction; closed without investigation
15-04-021	Medicare Fraud	Outside jurisdiction; closed without investigation

Case #	Primary Allegation	Disposition
15-04-022	Medicare Fraud	Outside jurisdiction; closed without investigation
15-04-023	Medicare Fraud	Outside jurisdiction; closed without investigation
15-04-024	Substandard Care	Referred complainant to DOH and HHS
15-04-025	Medicaid Fraud	Referred to MPI
15-04-026	Case generated in error	N/A
15-04-027	Misconduct	Forensic analysis
15-04-028	Misuse of Agency Resources	Open
15-04-029	Misuse of Agency Resources	Forensic analysis
15-04-030	Misconduct	Forensic analysis
15-04-031	Misuse of Agency Resources	Referred to Management
15-04-032	Misuse of Agency Resources	Referred to Management
15-04-033	Misconduct	Substantiated
15-04-034	Other	Outside jurisdiction; closed without investigation
15-04-035	Other	Outside jurisdiction; closed without investigation
15-04-036	Other	Outside jurisdiction; closed without investigation
15-04-037	Request for Assistance/Information	Assistance/Information provided
15-04-038	Misconduct	Forensic analysis
15-04-039	HIPAA Violation	Substantiated
15-05-001	Conduct Unbecoming	Referred to Management
15-05-002	Misuse of Agency Resources	Referred to Management
15-05-003	Misuse of Agency Resources	Referred to Management
15-05-004	Misuse of Agency Resources	Referred to Management
15-05-005	Misuse of Agency Resources	Referred to Management
15-05-006	Misuse of Agency Resources	Referred to Management
15-05-007	Misuse of Agency Resources	Referred to Management
15-05-008	Misuse of Agency Resources	Referred to Management
15-05-009	Misuse of Agency Resources	Referred to Management
15-05-010	Misuse of Agency Resources	Referred to Management
15-05-011	Misuse of Agency Resources	Referred to Management
15-05-012	Misuse of Agency Resources	Referred to Management
15-05-013	Misuse of Agency Resources	Referred to Management
15-05-014	Misuse of Agency Resources	Referred to Management
15-05-015	Misuse of Agency Resources	Referred to Management
15-05-016	Misuse of Agency Resources	Referred to Management
15-05-017	Misuse of Agency Resources	Referred to Management

Case #	Primary Allegation	Disposition
15-05-018	Misuse of Agency Resources	Referred to Management
15-05-019	Misuse of Agency Resources	Referred to Management
15-05-020	Misuse of Agency Resources	Referred to Management
15-05-021	Misuse of Agency Resources	Referred to Management
15-05-022	Misuse of Agency Resources	Referred to Management
15-05-023	Misuse of Agency Resources	Referred to Management
15-05-024	Misuse of Agency Resources	Referred to Management
15-05-025	Misuse of Agency Resources	Referred to Management
15-05-026	Medicaid Services	Referred complainant to Medicaid
15-05-027	Misconduct	Referred to law enforcement
15-05-028	Medicaid Fraud	Referred complainant to HHS
15-05-029	Stark Law Violation	Referred to HQA and SMMC
15-05-030	Theft	Referred to HQA; referred complainant to DOH
15-05-031	Substandard Care	Referred to HQA; referred complainant to DOH
15-06-001	Other	Referred to DCF
15-06-002	Other	Referred to HQA
15-06-003	Misconduct	Open
15-06-004	Conduct Unbecoming	Referred to Management
15-06-005	Other	Referred to HQA
15-06-006	Other	Referred to HQA
15-06-007	Substandard Care	Referred to HQA
15-06-008	Substandard Care	Referred to HQA
15-06-009	Misconduct	Forensic analysis
15-06-010	Substandard Care	Referred to HQA
15-06-011	Substandard Care	Referred to HQA
15-06-012	EEO	Open
15-06-013	Facility Regulation	Referred to HQA
15-06-014	Medicaid Fraud	Open
15-06-015	Substandard Care	Open

Staffing Allocation Changes (FY 2014-15)

In FY 2014-15, the AHCA Office of Inspector General experienced the following changes to its staffing allocation:

- In the Office of Medicaid Program Integrity, three FTE positions were eliminated to comply with an agency-mandated budget reduction:

  Position #63476, Pay Grade 13, Consumer Services Analyst

  Position #63478, Pay Grade 18, Research Assistant

  Position #64700, Pay Grade 24, Medical Health Care Program Analyst