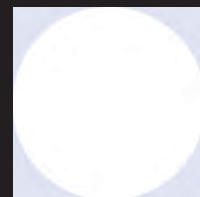


# OFFICE OF INSPECTOR GENERAL



ANNUAL REPORT FY 2016-17







RICK SCOTT  
GOVERNOR

JUSTIN M. SENIOR  
SECRETARY

A MESSAGE FROM THE INSPECTOR GENERAL

September 2017

As the Inspector General for the Agency for Health Care Administration (AHCA or Agency), I am honored to present the Office of Inspector General's (OIG) annual report summarizing the OIG's accomplishments during the 2016-17 fiscal year. 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 OIG management and staff who help deter and detect activities that could jeopardize the Agency's resources.

The AHCA OIG includes the Office of Medicaid Program Integrity (MPI), HIPAA Compliance Office, Investigations, and Internal Audit. The majority of the OIG's resources (MPI) are dedicated to combating fraud, waste and abuse in the Medicaid program. The remaining OIG resources, also critical to AHCA'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.

The OIG looks forward to continuing our work with the Secretary, the Agency leadership team, and the management and staff of AHCA in championing better health care for all Floridians.

Mary Beth Sheffield  
Inspector General

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## OUR MISSION

Better Health Care for all Floridians.

## OUR 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.

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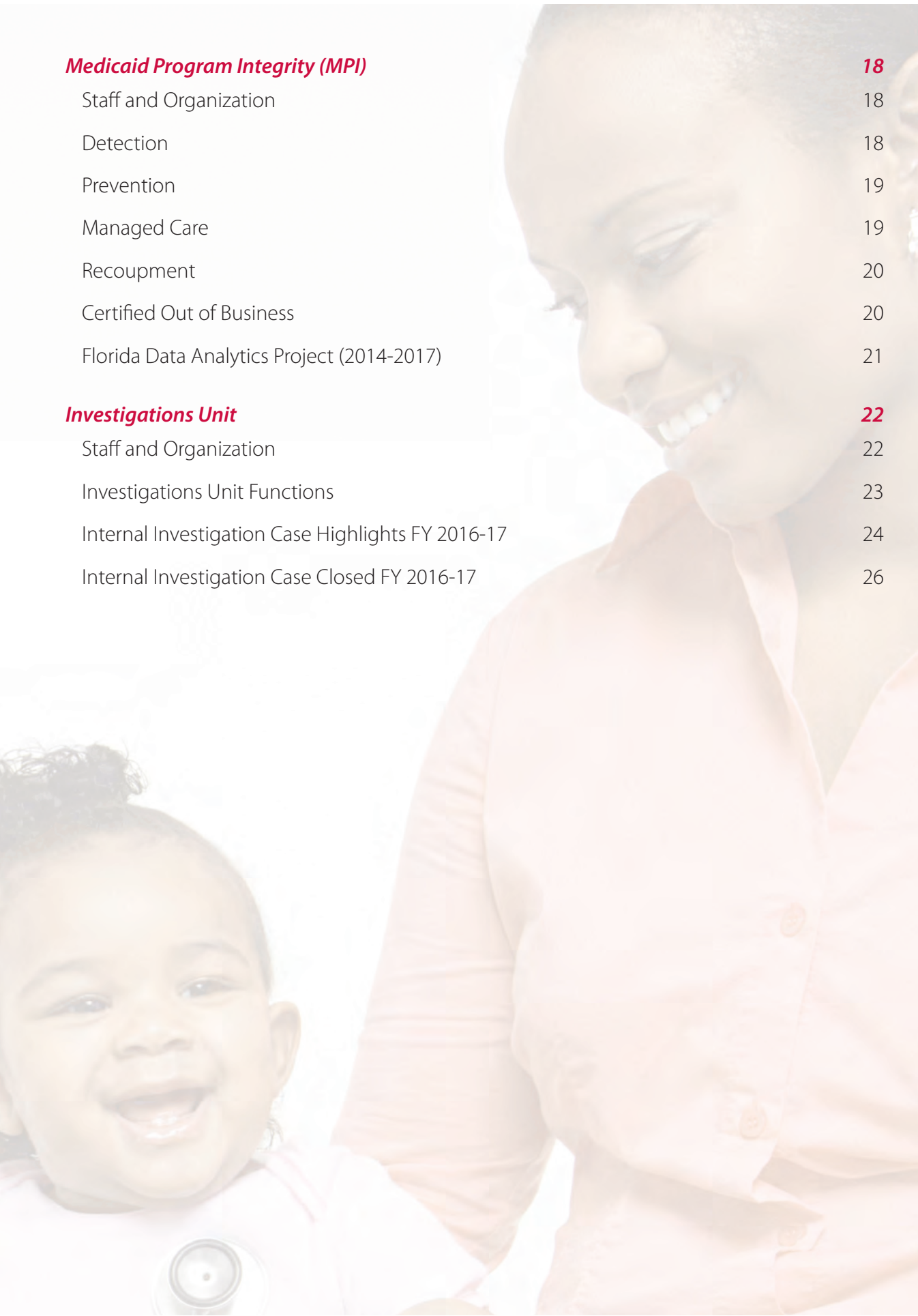
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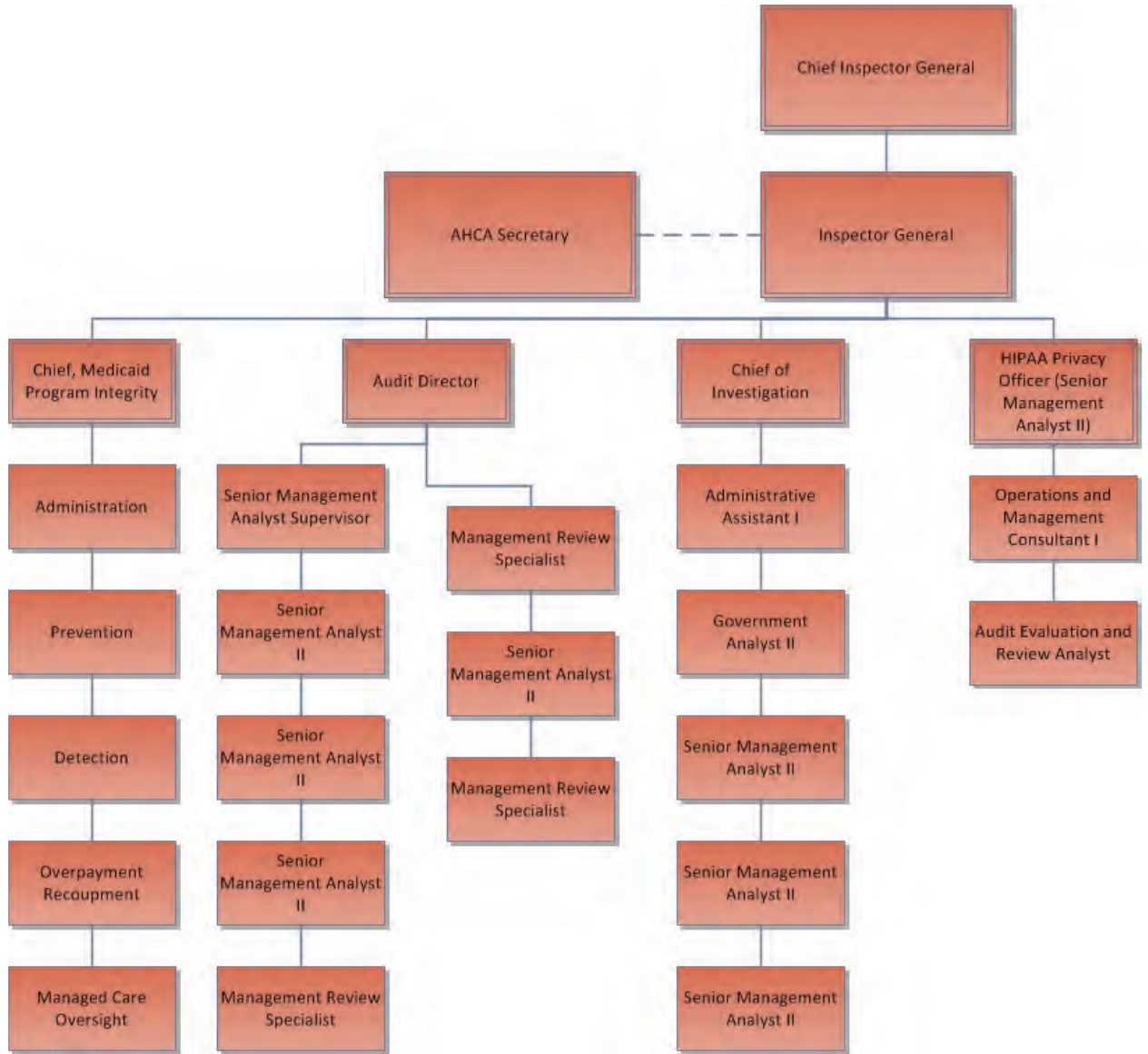
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# AHCA OIG ORGANIZATIONAL STRUCTURE





### ***OIG Staff Changes from Prior Year***

The following are changes to OIG staff related to additions, removals, and reclassification of positions during FY 2016-17.

- Position #48273, Government Analyst II, was removed from the Investigation Unit, reclassified and added to Internal Audit as a Senior Management Analyst Supervisor.
- Medicaid Program Integrity had three positions removed due to legislative action.
  - #24163, Government Operations Consultant I
  - #46733, Secretary
  - #46736, Secretary



**Staff and Organization**



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).

Current HIPAA staff consists of three full-time employees: the Senior Management Analyst II who serves as the Agency’s HIPAA Privacy Officer (designated by the Secretary), an Operations and Management Consultant I, and an Audit Evaluation and Review Analyst.

Collectively, the HIPAA Compliance Office staff have the following qualifications/certifications: Bachelor’s Degree (1); Master’s Degree (1); Certified Inspector General Investigator (1); Certified in Health Care Compliance (1); Certified in Health Care Privacy (2).

**HIPAA Office Functions**

- 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. HIPAA staff continued to emphasize an expedited time frame for workforce member completion

of this critical training and to alert Agency management regarding non-compliance where necessary.

- Provided in-person HIPAA and HITECH privacy training to Agency employees as part of new employee orientation. This was the second year for implementation by the Agency’s Bureau of Human Resources of a webinar version of annual employee training which includes HIPAA training resulting in a documented increase in compliance.
- Responded to all requests for protected health information (PHI) from Medicaid recipients or their authorized representatives within the HIPAA required time frames 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 are in compliance with HIPAA regulations.
- Reviewed and provided written comments/recommendations on Agency Memorandum of Understanding involving confidential data and on Medicaid Data Use Agreements.
- Reviewed all new Agency forms or forms under revision for policy compliance and provided written comments/recommendations.
- Continued leadership of an Agency workgroup for review of Medicaid Management Information System access by entities external to the Agency. The purpose of this endeavor is to ensure such access continues to be appropriate for the Medicaid program’s business needs.

- Continued a project to convert certain documentation to Laserfiche storage and automate HIPAA office workflows and processes where feasible.
- Enhanced/updated a comparison of Agency HIPAA-related policies and practices with the federal audit protocols released in 2014 and 2015 by the Department of Health and Human Services, Office for Civil Rights, which is the federal HIPAA enforcement agency.
- Participated in the Agency Computer Security Incident Response Team as a member representing HIPAA compliance issues per Chapter 74.2, F.A.C., Information Technology Security, effective March 2016.
- Tracked Medicaid managed care plans' reports of HIPAA privacy and security incidents and breaches to the Agency



and initiated compliance actions resulting in the potential imposition of fines on health plans for non-compliance with contractual reporting requirements.

- Continued review of Agency practices and policies presenting risk of HIPAA non-compliance and worked with Agency staff to determine root causes, such as inadequate policies, training, or management oversight, and to assist management in implementing correction thereby reducing risk of HIPAA violation or information breach.
- At the request of the Chief Inspector General, initiated a project to collect information regarding the HIPAA covered entity status of other Florida State agencies.

# INTERNAL AUDIT



## Staff and Organization



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

- Certified Public Accountant
- Certified Internal Auditor
- Certified Fraud Examiner
- Certified Information Systems Auditor
- Certified Information Systems Security Professional
- Certified ISO 20000 Internal Auditor
- Certified Inspector General
- Certified Inspector General Auditor
- Certified Government Auditing Professional
- Master of Arts in Teaching
- Master of Arts in Sociology
- Master of Business Administration
- Juris Doctorate in Law

The Institute of Internal Auditors  
International Standards for the Professional

Practice of Internal Auditing (IIA Standards) and the Association of Inspectors General Principles and Standards for Offices of Inspectors General 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 Agency employee training and completed Government and Nonprofit Accounting video training.

### **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, disciplined, and risk-based approach to evaluate and contribute to improvement of the Agency's governance, risk management, and control 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 perform an audit of a special program, function, or organizational unit.

Internal Audit operates within the OIG under the authority of Section 20.055, Florida Statutes (F.S.). In accordance with Section 20.055(6)(c), F.S., the Inspector General and staff have access to any Agency 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 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 its annual audit plan. The risk assessment process includes the identification of activities or services performed by the Agency 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 the Agency's critical functions that allow the Agency 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;
- Maintenance of confidential information;

- Complexity of operations;
- Assessment of data and information systems; and
- Management's concerns.

#### *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 IIA Standards. 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 (AG).

### *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 the Agency's 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 the Agency 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 IIA Standards.

### *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 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 AG.

### *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 Internal Audit, such as the installation of new audit tracking or training software, or revising policies and procedures.

## Internal Audit Activities

### Assurance & Consulting Engagements, and Management Reviews

Internal Audit completed one management review during FY 2016-17. The following is a summary list of completed and in progress engagements as of June 30, 2017:

Table 1: Internal Audit Engagements Completed and In Progress

Report No.	Engagement	Type	Date Issued/Planned
16-14	Medicaid Aid Category Rate Assignment	Review	November 3, 2016
AHCA-1415-16-A	Single Sign-On Process	Assurance	August 31, 2017
AHCA-1516-08-A	Cash Room Collection Process	Assurance	October 2017
AHCA-1617-02-A	Employee Background Screening Process	Assurance	January 2018
AHCA-1617-04-A	Agency Agreements	Assurance	January 2018
AHCA-1617-05-A	Provider Eligibility Enrollment Process	Assurance	March 2018
AHCA-1617-07-A	Accounts Receivable Collection and Write-off Process	Assurance	January 2018

### Engagement Summaries

The following summary describes the results of the review completed by Internal Audit during FY 2016-17:

#### 16-14 Medicaid Aid Category Rate Assignment

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

program changes in the Florida Medicaid Management Information System (FMMIS).

In February 2016, while reviewing the SMMC - Managed Medical Assistance (MMA) program data as an input source for the development of the 2016-2017 SMMC-MMA rates, Medicaid's contracted actuary discovered rate cell discrepancies and brought these discrepancies to the attention of the Bureau of Medicaid Data Analytics (MDA). Further analysis showed that certain Medicaid aid categories were mapped to the wrong capitation rate cells in FMMIS. This improper mapping led to the Agency paying the health plans Temporary Assistance for Needy Families (TANF) capitation rates (a lower rate) instead of Supplemental Security Income (SSI) capitation rates for recipients belonging to certain Medicaid aid categories.



The Bureau of Medicaid Program Finance (MPF) estimated that less than one percent of the managed care population was affected by the misalignment. In addition, during the course of the review, the Bureau of Medicaid Fiscal Agent Operations (MFAO) corrected the rate misalignment issue in FMMIS. The Agency began reimbursing the health plans for resulting monies owed for the FY 2015-2016 starting with the July and August 2016 SMMC capitation payments. The Agency also sought budget authority to pay any monies owed for prior fiscal years and MFAO is continuing to work with various Medicaid bureaus to create reports to improve and strengthen controls to avoid rate misalignment issues in the future. Internal Audit's recommendations to the Division of Medicaid include:

- Project management teams tasked with writing the business requirements for Customer Service Requests (CSRs) with large systems implications include representation, communication, or greater coordination from other bureaus impacted by the CSR.
- Project management teams more fully document discussions related to decisions with a systems or financial impact and document communication of decisions to project management teams tasked with writing business requirements for CSRs.
- MFAO work with the Fiscal Agent and Medicaid staff to clarify terminology and provide more detail for CSR specifications to avoid incorrect interpretation and assumptions of business requirements (as reportedly occurred in the assumptions regarding Benefit Plans).<sup>1</sup>

<sup>1</sup> "Benefit Plan" is a term used in FMMIS to define the scope of benefits an individual is eligible to receive. Although SSI and TANF receive full Medicaid benefits, under benefit plan hierarchy rules, when both are present concurrently for a date of service, the SSI benefit plan is designated over TANF.

- MFAO continue to work with various Medicaid bureaus to develop reports for monitoring the SMMC capitation payment process, including working with MDA to create a report to analyze data to verify if the rates assigned are paid in accordance with appropriate aid categories.
- MPF's budgeting and forecasting process include periodic reviews of any significant changes to the per member per month expenditure amount for various budget categories.

#### *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 included in the Agency's annual Long Range Program Plan. Current measures and proposed new measures were reviewed and advice was provided to the Agency staff regarding accuracy, validity, and reliability.

Internal Audit completed the following additional duties or projects during FY 2016-17:

- Chief Inspector General Quarterly Activity Reports;
- Assisted with Chief Inspector General Enterprise Projects;
- Executive Office of the Governor Weekly Activity Reports;
- Schedule IX of the Legislative Budget Request;

- Summary Schedule of Prior Audit Findings;
- Department of Health and Human Services Audit Resolution Letter;
- Contributed to OIG Annual Report;
- Engagements in Progress Report;
- Auditor General Information Technology Survey;
- 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 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 2016-17, the following status reports for internal engagements were published:

- 16-13 Medicaid Recipient File Management (12-Month Status Report);
- AHCA-1213-14-S18 Medicaid Recipient File Management (Final Status Report);



### *Corrective Actions Outstanding from Previous Annual Reports*

- As of June 30, 2017, there were no corrective actions for significant recommendations described in previous annual reports that were still outstanding.

### *External Engagement Status Reports*

Pursuant to s.

20.055(6)(h), F.S., the OIG monitors the implementation of the Agency's response to external reports issued by the AG 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 responses are also provided to the Legislative Auditing Committee. Additionally, pursuant to s. 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 OPPAGA reports. The OIG is responsible for coordinating these status reports and ensuring that they are submitted within the established time frames.

During FY 2016-17, status reports were submitted on the following external reports:

- Auditor General – Comprehensive Risk Assessments at Selected State Agencies 6-Month Status Report (Report No. 2017-004);
- Auditor General - State of Florida Compliance and Internal Controls Over Financial Reporting and Federal Awards 6-Month Status Report (Report No. 2016-159); and
- OPPAGA – AHCA Reorganized to Enhance Managed Care Program Oversight and Continues to Recoup Fee-for-Service Overpayments 6-Month Status Report (Report No. 16-03).

#### *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 U.S. Government Accountability Office (GAO), U.S. Department of Health and Human Services (HHS), the Agency for State Technology (AST), and the Social Security Administration (SSA). The OIG coordinates the Agency's responses to all audits, reviews, and information requests from these entities. During FY 2016-17, the following reports were issued by external entities:

Office of the Auditor General

- Auditor General – State of Florida Compliance and Internal Controls Over Financial Reporting and Federal Awards (Report No. 2017-180)

- Auditor General – AHCA Fraud and Abuse Case Tracking System (Report No. 2017-093)
- Auditor General – Comprehensive Risk Assessments at Selected State Agencies (Report No. 2017-004)

OPPAGA

- Review of Medicaid Dental Services (Report No. 16-07)

GAO

- Medicaid Managed Care: Compensation of Medicaid Directors and Managed Care Organization Executives (Report No. GAO-17-427R)
- Medicaid Program Integrity – CMS Should Build on Current Oversight Efforts by Further Enhancing Collaboration with States (Report No. GAO-17-277)

HHS

- Florida Managed Care Organizations Received Medicaid Capitation Payments After Beneficiary's Death (Report No. A-04-15-06182)
- Florida Did Not Suspend Medicaid Payments To Some Providers That Had Credible Fraud Allegation Cases (Report No. A-04-14-07046)

AST

- 2016 Agency Compliance Assessment with Rule Chapter 74-1, Florida Administrative Code (F.A.C.)

SSA

- Compliance Review 2016 Closeout Letter

#### *Single Audit Act Activities*

Entities that receive federal or state funds are subject to audit and accountability

requirements commonly referred to as “single audits.” The Federal Office of Management and Budget (OMB) Uniform Guidance and the Florida Single Audit Act require certain recipients that expend federal or state funds, grants or awards to submit single audit reporting packages in accordance with federal regulations Title 2 Code of Federal Regulations §200 Subpart F, (Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards), or s. 215.97, F.S. (the Florida Single Audit Act) and Chapters 10.650 of the Rules of the Auditor General for state awards.

As a pass-through entity of federal and state financial assistance, the Agency is required to determine whether timely and appropriate corrective action has been taken with respect to audit findings and recommendations subject to the single audit requirements. Internal Audit is charged with reviewing the single audit reporting packages submitted to determine that the reporting package complies with submission requirements.

In 2017, Internal Audit requested a list of contracts and grants from the Bureau of Support Services for FY 2015-2016. Contract managers were contacted to request reporting packages from the recipients.

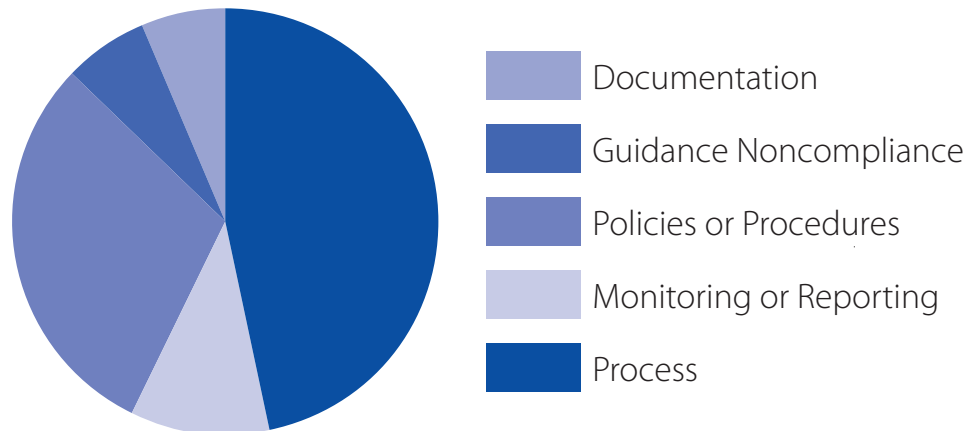
Internal Audit received and reviewed 37 audits and compilation reports. Of this total, 16 were examined for compliance with single audit submission requirements. The contract managers were notified of our review results and were provided guidance on resolving any issues noted in the reporting package.

In addition, Internal Audit worked with the Bureau of Financial Services and the Bureau of Support Services in developing policies and procedures to address single audit compliance and in updating contract language related to “special audit requirements” to reflect current federal and state terms and conditions. The draft revisions also included a requirement to submit reports to the contract manager and provided for electronic copy submission to the OIG. The revised language is expected to be added via amendment to all applicable FY 2017-18 contracts, agreements, and grants.

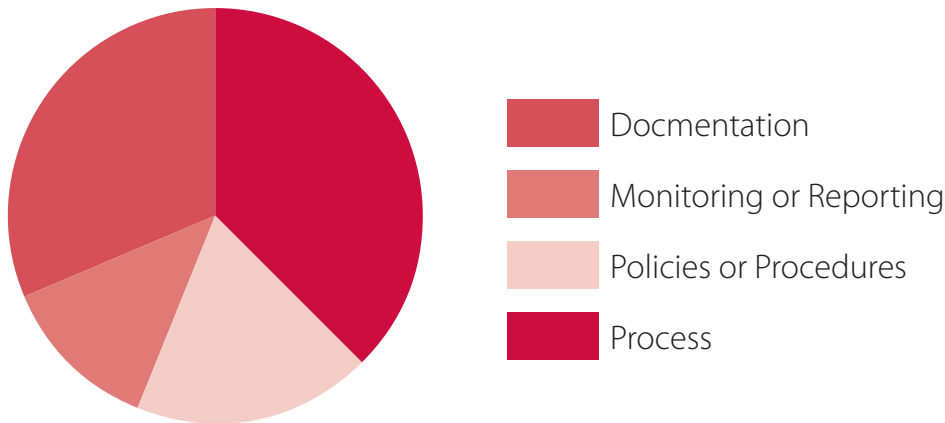
*Root Cause Analysis*

Both internal and external audits, including status reports on previous audit reports, showed recurring themes or deficiencies in the following areas:

*Chart 1: External Audits Root Cause Analysis*



*Chart 2: Internal Audits Root Cause Analysis*



- Policies or Procedures – Nonexistent, outdated, or inadequate policies or procedures;
- Process – Inadequate process or failure to address risk in a process;
- Documentation – Lack of supporting documentation or failure to maintain documentation to show compliance with procedures, laws, contracts, statutes, interagency agreements, or other governing documents; and
- Monitoring or Reporting – Inadequate monitoring, supervisory review, or reporting of compliance with policies, procedures, contracts, or other established standards.

Also, external audits showed a recurring theme as follows:

- Noncompliance with Federal Guidance or Legislative Appropriations – Noncompliance with federal CMS guidance or legislative appropriation payment limitations.

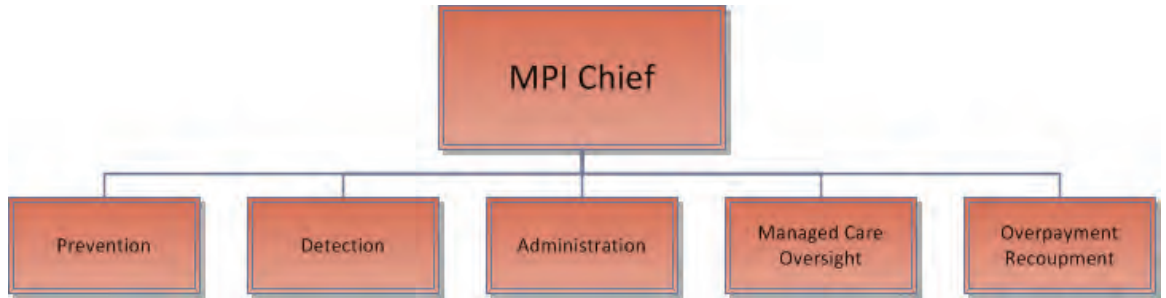
**Audit Management System**

Internal Audit purchased and implemented MKinsight, an audit management system, in FY 2015-16. During FY 2016-17, Internal Audit continued to work with the vendor to configure MKinsight so that it would mirror Internal Audit’s audit methodology. MKinsight tracks work performed on audits, management reviews, consulting projects, special assignments, follow-up activities, and risk assessments. The system assists with ensuring compliance with s. 20.055, F.S., IIA Standards, and other requirements by embedding such standards into its configuration. All new audits started in FY 2016-17 were performed using MKinsight.

Internal Audit also worked with the vendor to develop and configure an auto-generated audit report. This new report exports the audit information from MKinsight and creates a formatted Word document.

MKinsight allows Internal Audit to maintain and improve productivity, to continue to ensure standards are met, and efficiently accomplish its mission to bring a systematic, disciplined, and risk-based approach to evaluate and contribute to the improvement of the Agency’s governance, risk management, and controls processes.

**Staff and Organization**



The Bureau of Medicaid Program Integrity<sup>2</sup> (MPI) is located within the OIG. MPI 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. In addition to s. 20.055, F.S., MPI derives its authority from ss. 409.913 and 409.91212, F.S., laws relating to the integrity of the Medicaid program. 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.

Pursuant to s. 409.913, F.S., MPI’s accomplishments are presented annually in a report entitled, The State’s Efforts to Control Medicaid Fraud and Abuse (Fraud and Abuse report). Published by January 1 of each year, this report is a joint endeavor, detailing the combined efforts of the Medicaid Fraud Control Unit (MFCU) of the Office of Attorney General and AHCA.

MPI’s efforts to prevent, detect, and audit fraud, abuse, and waste, align with the organizational units within MPI, depicted in the above organizational chart. For FY 2016-17, since there were no significant organizational or operational changes and MPI’s accomplishments will be described at length in the Fraud and Abuse report to be published on or before January 1, 2018, those accomplishments will not be described in detail in this report. Some of the accomplishments that will be

described in the Fraud and Abuse report include provider sanction actions regarding Medicaid participation (suspensions and terminations), referrals to the MFCU and to other external entities, payment restrictions and other cost savings, overpayment recovery actions and other audits and reviews, including those related to managed care plans.

**Detection**

Detection efforts are a key factor in a program integrity unit’s success. Without efforts to identify anomalies and conduct preliminary investigations, other efforts would decrease in effectiveness. Florida’s MPI detection activities include a complaint review process which consists of complaint assessment, determination of predication, and (where there is sufficient predication) investigation planning, and preliminary investigation. Florida MPI preliminary investigation processes involve extensive research about the provider, including the history with Medicaid, MPI audits, and MFCU investigations. The investigation also involves an assessment of Medicaid claims reimbursement, business associations, licensure status, known complaints about the provider, and as much history about the provider’s business and owners as can be readily obtained. Further details about MPI’s detection efforts will be published in the annual Fraud and Abuse report.

<sup>2</sup> Also referred to as the Office of Medicaid Program Integrity in s. 409.91212, Florida Statutes.

### Prevention

Most program integrity organizations will implement fraud prevention strategies through guidance, research, and support to the operational aspects of the larger organization. For example, MPI will collaborate with the Medicaid Provider Enrollment division to implement processes designed to minimize enrollment of fraudulent and high-risk providers. MPI also has a role in fraud fighting efforts through Medicaid policy and training activities that minimize unintentional provider errors. Additionally, program integrity units coordinate efforts with other regulatory offices (such as practitioner and facility licensure) to investigate and monitor compliance through large-scale investigation and enforcement projects. Efforts also include sharing information regarding Medicaid providers who may be engaging in abusive conduct by referring the information to parties within and outside of the organization, as appropriate.

Referrals are among the highest priorities within most program integrity organizations, second only to recoupment of overpayments. The development of mechanisms to ensure a high-volume of quality referrals to MFCU is typically the highest prevention priority within a state program integrity operation. However, most states have not mastered this task to a satisfactory level due to the sophistication and complexity of fraud-related issues. A referral must not only be well written, but must also carefully and thoroughly detail the issues of fraud so that referral can readily be assessed by MFCU. Prevention activities typically also include strategic planning, data analysis for deterrence efforts, and programmatic oversight of a very broad nature (different from the focused reviews that are carried out for detection purposes). Further details about MPI's prevention efforts will be published in the annual Fraud and Abuse report.

### Managed Care

Nationally, many state Medicaid programs are moving toward increased managed care delivery systems. Some states are exclusively managed care. In Florida, with an increasing shift to managed care, a reliance on retrospective claims data analysis to develop leads is simply an antiquated detection (and thus prevention) method that will become obsolete or of minimal value. A successful data analytics system will be able to present leads without any reliance on claims data. Some of the schemes that Florida has identified and investigated by way of internally developed detection efforts include: alleged kickbacks; a health plans' failure to comply with legal requirements for a program integrity (or special investigative) unit regarding functions to pursue fraud and abuse; inefficient auditing processes; a lack of special investigative unit expertise sufficient to diligently pursue anti-fraud activities; and the health plans' contracting practices including mandatory exclusion checks. Other Managed Care investigative topics include whether any health plans have submitted false or erroneous encounters to circumvent mandatory medical expenditures for services as well as investigations surrounding the many business arrangements that arise in a managed care environment, and overall contract compliance.



## **Recoupment**

The recovery of overpayments is, typically, the cornerstone of Medicaid program integrity units' operations. In Florida, MPI historically has had a high overall return on investment (typically approximately 7:1).

During FY 2016-17, anticipated recovery amounts (validation of figures remains underway) are expected to exceed all previous years for which MPI has maintained such statistics. Although there has been a decrease in fee-for-service (FFS) reimbursements, MPI continues to conduct retrospective

audits, improve processes to increase audit effectiveness, and improve detection methodologies. Despite the remaining FFS population being approximately 15 percent of the overall program expenditures, the FFS amount remains in excess of seven billion dollars, a figure that exceeds the total program expenditures for more than 20 other states. This remaining FFS population continues to be rich with opportunities for MPI recoupment activities. Further, pursuant to s. 641.3155, F.S., the Medicaid managed care plans are not permitted to recoup overpayments as far back as MPI is pursuant to its authority in s. 409.913, F.S. As such, MPI recoupment efforts will continue. Further details about the recovery amounts for FY 2016-17 will be published in the annual Fraud and Abuse report.



## **Certified Out of Business**

During the 2016 Legislative Session, a law (Chapter 2016-103, Laws of Florida) was passed to address the treatment of Medicaid overpayments when a Medicaid provider is out of business and the overpayments

cannot be collected under state law. The law allows the Agency to certify a Medicaid provider "out-of-business" and that any overpayments made to the provider cannot be collected under state law and procedures. This law allows the State of Florida to retain the federal share of funds that otherwise would have been required to

be remitted back to the Centers for Medicare and Medicaid Services. During FY 2016-17, MPI developed a process for coordination with the Bureau of Financial Services and the Division of Medicaid to identify potential out-of-business instances and to evaluate whether the matter met the legal parameters for treatment under the state and federal law. Immediately after development and implementation of the new processes, the Bureau of Financial Services and MPI identified more than a dozen instances for review. The validation of the FY 2016-17 cost savings due to the certified out-of-business processes is ongoing and the final amounts will be published in the annual Fraud and Abuse report.



**Florida Data Analytics Project (2014-2017)**

In August 2014, a contract was executed with an external vendor to develop and implement an advanced data analytics system. In addition to provider and claims data, the project required the integration of other state and third party data to increase the overall value of the system. The initial contract period (August 2014 through September 2015) is considered year one for purposes of Agency discussions about expectations, outcomes, and lessons learned discussions. Subsequent contract period(s) are referenced as year two (October 2015 through October 2016), and year three (November 2016 through June 2017). Year one included development of system requirements, data connectivity solutions, data integration solutions, algorithm assessment and refinement, new algorithm creation, and testing. The contract was refined for year two to provide detail about the expectations for the underlying user interface for purposes of presenting the leads to the Agency.

Also during year two, additional data sources were integrated and thousands of leads were generated. While many people involved in contracting may believe that thousands of leads will increase the likelihood of successful outcomes (more opportunities to find actionable leads), the volume of “false positives” is typically staggering at initial implementation. A vendor may also want to generate the high-volume of leads to allow for the greatest amount of information to be analyzed for system refinement (both accepted and rejected leads can inform the vendor as to how to adjust the algorithms



scoring and weighting). However, just as the program integrity unit can be inundated with false positives and have resource concerns, the vendor likely will be unable to analyze thousands of rejected leads to meaningfully adjust the system in a timely fashion.

During year three, the system refinement continued, and recognizing the short year three period, the parties amended the contract to have reimbursements be based solely upon the analysis of a sample of the leads. This allowed for a faster deliverable schedule, with more timely refinement.

While a final return on investment for the project has not been calculated for purposes of this report, the project is expected to at least break even. Ongoing cases resulting from the project will continue and will affect the overall return. While the project has not had the level of success that is believed to be possible with a data analytics system, the project team: (1) believes data analytics can enhance a state’s program integrity efforts, (2) with adjustments based upon “lessons learned” greater success can be realized earlier, and (3) the public-private partnership with a data analytics vendor is the future for program integrity efforts in many programs and many systems. Additional information, including lessons learned, as perceived by members of the project team, related to the procurement processes, contract development, data analytics system design, development and implementation, technical issues related to data acquisition and integration, and prioritization and utilization of resources will be published in the annual Fraud and Abuse report.

**Staff and Organization**

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 Whistle blower 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.

In February of FY 2016-17 the AHCA OIG Investigations Unit achieved accreditation status from the Commission for Florida Law Enforcement Accreditation, Inc. (CFA). Accreditation

is recognized as a means of maintaining the highest standards of professionalism. Accreditation is the certification by an independent reviewing authority that demonstrates an entity has met specific requirements and prescribed standards.

Some benefits of accreditation include the following:

- Increases cooperation and coordination with other Offices of Inspectors General;
- Standards provide norms against which Agency performance can be measured and monitored over time;
- Provides the Agency with a continuous flow of CFA distributed information about exemplary policies, procedures and practices;
- Provides objective measures to justify decisions related to budget requests and personnel policies; and
  - Streamlines operations by providing more consistency and more effective deployment of Agency resources.

Accreditation requires that Agency policies and procedures are in written form and are available to all Agency personnel at all time.

The Investigations Unit staff brings various backgrounds and expertise to the Agency.



Certifications, in addition to advanced degrees, collectively held by IU staff as of June 30, 2017 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
- Current deputy sheriff reserve officer
- Current police reserve officer

**Investigations Unit Functions**

During FY 2016-17, the IU addressed 142 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 reported 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 reported included but were not limited to allegations associated with Medicaid billing fraud, allegations related to patient brokering, and allegations of physician self-referral (Stark Law) violations.
- Equal Employment Opportunity (EEO) Violations - EEO violations reported included but were not limited to allegations associated with discrimination, harassment, and retaliation for engaging in protected activity.
- Health Insurance Portability and Accountability Act (HIPAA) Violations – Allegations associated with violations of HIPAA’s Privacy Rule or records access rule.
- Medicaid Service Complaints - Medicaid service complaints included but were not limited to allegations associated with reported denials of service, denials of eligibility, and Medicaid provider contract violations.

During FY 2016-17, six of the 142 complaints received required analyses to determine if the complaints met the criteria for Whistle-blower status as defined in §112.3187 F.S.

During FY 2016-17, the OIG IU closed 137 complaints and continued to investigate and/or monitor the investigation of one active legacy Whistle-blower complaint that was referred to an external agency.

During FY 2016-17, eight Employee Misconduct complaints were received. The IU’s analysis of the Employee Misconduct complaints received and investigated disclosed the majority of these cases involved disparaging remarks and unprofessional conduct directed toward employees and persons outside the Agency.

The IU referred 61 complaints to other AHCA bureaus or outside agencies during FY 2016-17 for proper assessment.

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 internal investigation cases closed during FY 2016-2017. An index of investigations closed during this reporting period is included at the end of this section.

**Internal Investigation Case Highlights FY 2016-17**

*AHCA OIG #16-08-007*

This investigation was predicated by an anonymous complaint that alleged an AHCA employee was engaged in inappropriate behavior in the workplace.

The AHCA OIG's investigation determined there was sufficient evidence to support conduct unbecoming a public employee in the workplace.

*AHCA OIG #16-09-009*

This investigation was initiated when the AHCA OIG received notification that an AHCA employee may have engaged in inappropriate behavior with a co-worker.

The AHCA OIG's investigation found sufficient evidence that the actions of the employee did not meet the criteria for a finding of sexual harassment. The AHCA OIG did not issue an investigative conclusion relative to whether or not the employee engaged in conduct unbecoming a public employee due to the employee's voluntary separation from the Agency.

*AHCA OIG #16-10-005*

This investigation was initiated by a complaint filed with the Equal Employment Opportunity Commission (EEOC) and the Florida Commission on Human Relations (FCHR) alleging discrimination by AHCA based on the employee's age.

The OIG AHCA investigation found that the Agency supplied legitimate, non-discriminatory reasons for the adverse employment actions (not hiring the complainant) of the Agency. The employee was offered the opportunity to provide evidence or information that the Agency's stated reasons were a mere pretext to hide discrimination but the employee failed to provide sufficient evidence that the reasons supplied by the Agency were a mere pretext to hide unlawful discrimination.

*AHCA OIG #16-10-007*

This investigation was initiated by an anonymous email complaint forwarded to the AHCA Office of Inspector General OIG COMPLAINT email address. The complaint alleged AHCA employees were engaged in inappropriate behaviors to include sending inappropriate emails, leaving the office and not claiming leave time, using vulgar language in the workplace and making sexual advances.

The AHCA OIG's review of applicable personnel rules and statutes along with interviews of AHCA employees provided sufficient evidence to support the conclusion that some employees were engaged in behavior inappropriate for the workplace or behavior rising to the level of conduct unbecoming a public employee.

*AHCA OIG #16- 11-001*

This investigation was initiated following a complaint received from a job applicant alleging his scheduled job interview with AHCA was canceled with no legal reason and that AHCA employees had conspired with

other state agencies regarding the decision not to interview the complainant.

The AHCA OIG compiled documentary evidence and conducted interviews as part of the investigation. The analysis of evidence did not disclose sufficient information supporting the allegations of improper, immoral, inappropriate behavior or conduct unbecoming a public employee by any of the AHCA personnel mentioned in the complaint. The complainant's allegations were unsubstantiated.

*AHCA OIG #16-11-015*

This investigation was predicated on the filing of a complaint of discrimination on the bases of race and age with the FCHR and cross-filed with the U.S. EEOC. The complainant stated that AHCA consistently practiced unfair hiring procedures and, that in the last year, there were three employment opportunities, all promotional, which she did not receive.

The AHCA OIG's review of documentary and testimonial evidence associated with the AHCA employee's discrimination allegations based on age and race found the employee failed to provide sufficient evidence to support how her race was a motivating factor with regard to the alleged adverse employment action. Accordingly, based on the OIG's review of this matter, the OIG found insufficient evidence to support the allegation that AHCA discriminated against the employee based on her race.

Also, by the employee's own admission, she believed the adverse employment action was based on her age, race, and a lack of proper training. The employee's admission in this regard failed to provide sufficient evidence that age was the "but-for" cause for the alleged adverse employment action, and moreover, actually refuted that her age was the sole cause for the adverse employment action.

*AHCA OIG #16-11-016*

This investigation was predicated on alleged discrimination on the basis of race and unfair treatment. The complainant stated salary increases were given to those who took on additional duties but only certain individuals were allowed to take on additional duties. The complainant also stated that when asking for a salary increase was told that when funds became available. Shortly thereafter, three Caucasian females received salary increases while the complainant did not.

The AHCA OIG's investigation disclosed that the complainant, failed to present the AHCA OIG with a prima facie case of discrimination. The complainant's allegation that she had been discriminated against based on her race and had treated her unfairly was unsubstantiated.

*AHCA OIG #17-02-005*

This investigation was predicated upon the filing of a complaint alleging that an unknown Agency employee had violated state statute and AHCA policy when they informed management at a regulated facility of the date an AHCA survey was to be initiated.

While the AHCA OIG's review of emails between AHCA staff and the managerial staff at the facility disclosed that numerous emails were sent between AHCA staff and the facility, the AHCA OIG found no evidence in these emails and in emails provided by the management of the facility that any AHCA staff member informed the facility management of a pending AHCA site visit. This allegation was unfounded.

**Internal Investigation Cases Closed FY 2016-17**

Substandard Care	Referred	Allegations Substantiated
16-07-001	Medicaid Fraud	Referred
16-07-002	Substandard Care	Referred
16-07-003	Substandard Care	Referred
16-07-004	Conduct Unbecoming	No Action Taken
16-07-005	Substandard Care	Referred
16-07-006	Insurance Fraud	No Action Taken
16-07-007	Breach of Confidential Information	Referred
16-07-008	HIPAA Violation	Substantiated
16-07-009	Medicaid Fraud	No Action Taken
16-07-010	Request for Assistance/Information	Referred
16-07-011	Substandard Care	Referred
16-07-012	Facility Regulation	Referred
16-08-001	Misconduct	Referred
16-08-002	Misconduct	Referred
16-08-003	Conduct Unbecoming	No Action Taken
16-08-004	Substandard Care	No Action Taken
16-08-005	Fraud	No Action Taken
16-08-006	Substandard Care	Referred
16-08-007	Sexual Harassment	Substantiated
16-08-008	Medicaid Fraud	Information Only
16-08-009	Unlicensed Activity	No Action Taken
16-08-010	Unlicensed Activity	Referred
16-08-011	Substandard Care	Referred
16-08-012	Substandard Care	Referred
16-08-013	Eligibility	No Action Taken
16-08-014	Unlicensed Activity	No Action Taken
16-09-001	Medicaid Fraud	Outside Purview
16-09-002	Fraud	Referred
16-09-003	Eligibility	Unfounded
16-09-004	Substandard Care	Referred
16-09-005	Conflict of Interest	No Action Taken
16-09-006	AHCA Actions	Referred
16-09-007	Violation of Agency Policy	No Action Taken
16-09-008	Substandard Care	Referred
16-09-009	Sexual Harassment	Unsubstantiated
16-09-010	Substandard Care	Referred
16-09-011	Other	No Action Taken
16-09-012	Unlicensed Activity	Referred
16-10-001	Discrimination	Unsubstantiated

Substandard Care	Referred	Allegations Substantiated
16-10-002	Substandard Care	Referred
16-10-003	Substandard Care	No Action Taken
16-10-004	Conflict of Interest	No Action Taken
16-10-005	Discrimination	Unsubstantiated
16-10-006	Substandard Care	Referred
16-10-007	Sexual Harassment	Substantiated
16-10-008	HIPAA Violation	Forensic Analysis
16-10-009	Criminal Mischief	Unfounded
16-10-010	Suspicious Activity	No Action Taken
16-10-011	Substandard Care	Referred
16-10-012	AHCA Actions	Referred
16-10-013	Conduct Unbecoming	Referred
16-10-014	Substandard Care	Referred
16-11-001	Misconduct	Unsubstantiated
16-11-002	Fraud	Referred
16-11-003	Stark Law Violation	No Action Taken
16-11-004	Eligibility	Referred
16-11-005	Substandard Care	Referred
16-11-006	Substandard Care	Referred
16-11-008	Other	Referred
16-11-009	Substandard Care	Referred
16-11-010	Unjustified Termination	No Action Taken
16-11-011	Substandard Care	Referred
16-11-013	Misconduct	Unsubstantiated
16-11-014	Theft	No Action Taken
16-11-015	Discrimination	Unsubstantiated
16-11-016	Discrimination	Unsubstantiated
16-11-017	Substandard Care	Referred
16-11-018	Hostile Work Environment	No Action Taken
16-12-001	Fraud	Referred
16-12-002	Identity Theft	Referred
16-12-003	Fraud	Referred
16-12-004	Substandard Care	Referred
16-12-005	Request for Assistance/Information	No Action Taken
16-12-006	Disclosure of Confidential Information	No Action Taken
16-12-007	Request for Assistance/Information	No Action Taken
16-12-008	Substandard Care	Referred
16-12-009	Substandard Care	Referred
16-12-010	Public Safety	Referred

# INVESTIGATIONS UNIT

Substandard Care	Referred	Allegations Substantiated
17-01-001	Substandard Care	Referred
17-01-003	Falsification	Referred
17-01-004	Substandard Care	No Action Taken
17-01-005	Substandard Care	Referred
17-01-006	Disclosure of Confidential Information	No Action Taken
17-01-007	Substandard Care	No Action Taken
17-01-008	Substandard Care	Referred
17-01-009	Harassment	No Action Taken
17-01-010	Substandard Care	No Action Taken
17-01-011	Medicaid Fraud	Referred to DOH
17-01-012	Unlicensed Activity	No Action Taken
17-01-013	Hostile Work Environment	No Action Taken
17-01-014	Medicaid Fraud	No Action Taken
17-02-001	Eligibility	No Action Taken
17-02-002	Substandard Care	Referred
17-02-003	Unfair Employment Practices	No Action Taken
17-02-004	Medicaid Fraud	No Action Taken
17-02-005	Disclosure of Confidential Information	Unfounded
17-02-006	Eligibility	No Action Taken
17-02-007	Substandard Care	Referred
17-03-001	Disclosure of Confidential Information	No Action Taken
17-03-002	Stark Law Violation	Referred
17-03-003	Fraud	Referred
17-03-004	Substandard Care	Referred
17-03-005	Initiative	IU Initiative
17-03-006	Initiative	To be Reassigned
17-03-007	Medicaid Fraud	No Action Taken
17-03-008	Medicaid Fraud	Referred
17-03-009	Discrimination	No Action Taken
17-03-010	Discrimination	Referred
17-03-011	Substandard Care	No Action Taken
17-03-012	Unfair Employment Practices	No Action Taken
17-03-013	Substandard Care	No Action Taken
17-03-014	Fraud	No Action Taken
17-03-015	Conduct Unbecoming	Unfounded
17-04-001	Conduct Unbecoming	Referred
17-04-002	Disclosure of Confidential Information	No Action Taken
17-04-003	Fraud	Unfounded
17-04-004	Fraud	Referred
17-04-005	Substandard Care	Referred



Substandard Care	Referred	Allegations Substantiated
17-05-002	Conduct Unbecoming	No Action Taken
17-05-003	Disclosure of Confidential Information	No Action Taken
17-05-004	Unlicensed Activity	Insufficient information
17-05-005	Stark Law Violation	Referred
17-05-006	Medicaid Fraud	Referred
17-05-007	Substandard Care	No Action Taken
17-05-008	Eligibility	No Action Taken
17-05-009	Theft	Referred
17-05-010	Fraud	Referred
17-05-011	Discrimination	Outside purview
17-05-012	Disclosure of Confidential Information	No Action Taken
17-05-013	Disclosure of Confidential Information	Outside purview
17-06-001	Fraud	Referred
17-06-002	Substandard Care	Outside purview
17-06-003	Substandard Care	Outside purview
17-06-004	Conduct Unbecoming	Referred
17-06-006	Request for Assistance/Information	Outside purview
17-06-007	Misconduct	No Action Taken
17-06-008	Misconduct	Referred







REPORT MEDICAID BILLING FRAUD AT:  
1-888-419-3456

OR

REPORT FRAUD ONLINE AT:  
[HTTP://AHCA.MYFLORIDA.COM/EXECUTIVE/INSPECTOR\\_GENERAL/COMPLAINTS.SHTML](http://ahca.myflorida.com/executive/inspector_general/complaints.shtml)

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