Agency for Health Care Administration

Office of Inspector General

Annual Report FY 2018-19

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

A MESSAGE FROM THE INSPECTOR GENERAL

September 2019

On behalf of the Agency for Health Care Administration's (Agency or AHCA) Office of Inspector General (OIG), I am pleased to present our annual report summarizing the OIG's accomplishments during the 2018-19 fiscal year.

The OIG remains committed to our work 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. Our mission could not have been accomplished without the dedication and hard work of OIG management and staff.

The OIG includes Investigations, Internal Audit, and the HIPAA Compliance Office. The OIG ensures that complaints on Agency employees and contractors of alleged violations of policies, procedures, rules, or laws are properly investigated; audits and reviews add value by improving the efficiency and effectiveness of Agency operations, and that information held by AHCA is protected in accordance with state and federal privacy laws.

In addition, the OIG coordinates the Agency's process for adopting and implementing an Enterprise Risk Management (ERM) program. Although full implementation will likely span several years, the OIG is grateful for the support and recognition by Agency leadership on the importance of an enterprise-wide approach to addressing Agency risk.

The OIG looks forward to continuing our work with the Secretary, the Agency leadership team, and the management and staff of AHCA in meeting the challenges and opportunities that face the Agency in championing Better Health Care for all Floridians.

Respectfully,

Mary Beth Sheffield

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.

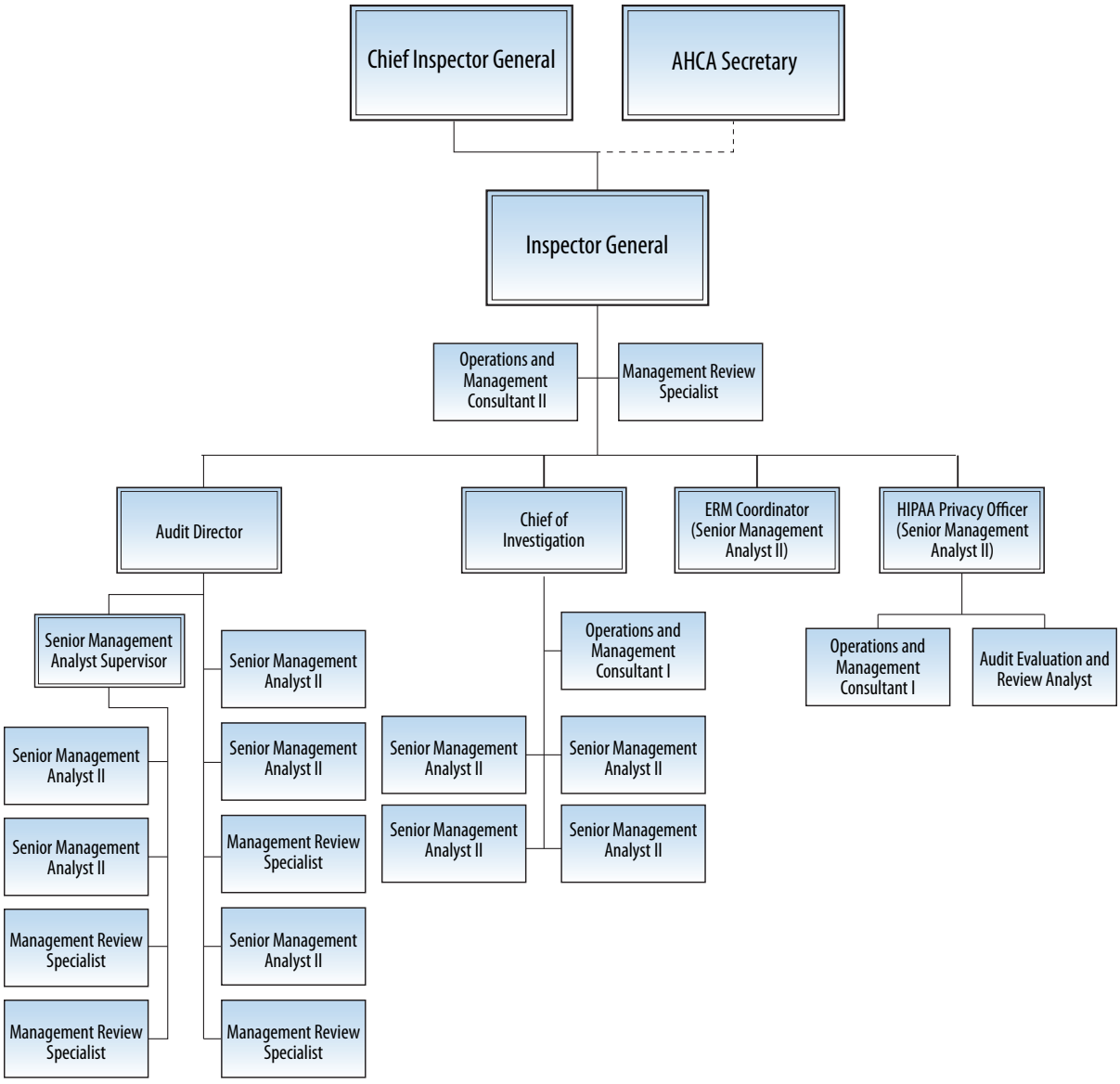
Teamwork

We collaborate and share our ideas.

TABLE OF CONTENTS

TABLE OF CONTENTS

AHCA OIG ORGANIZATIONAL STRUCTURE



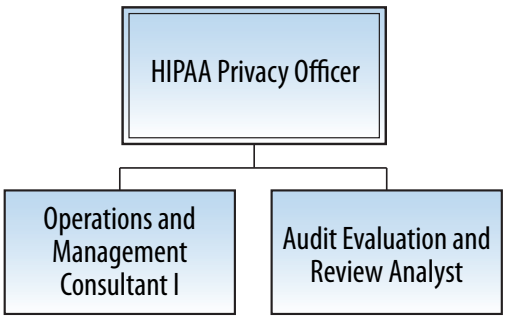
OIG STAFF CHANGES FROM PRIOR YEAR

The following are changes to OIG staff related to additions, removals, and/or reclassifications of positions during fiscal year 2018-19.

- Three OIG positions were reclassified as follows:
    - #20348, Administrative Assistant I, Selected Exempt Service (SES) to Operations and Management Consultant I, SES
    - #64830, Senior Management Analyst II, SES transferred to the Investigations Unit from the Bureau of Medicaid Program Integrity (MPI) on 07/13/2018
    - #59482, Senior Management Analyst II, SES transferred to the Investigations Unit from MPI on 07/01/2018

HIPAA COMPLIANCE OFFICE

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 has the following qualifications/ certifications: Bachelor's Degree (2), Associate's Degree (3), Florida Certified in Contract Management (1), and Certified in HIPAA (1).

HIPAA COMPLIANCE OFFICE FUNCTIONS

The general purpose of the HIPAA Compliance Office is to assist the Agency in ensuring compliance with the federal HIPAA regulations and other various state privacy statutes. This assistance takes the form of training, advising, responding to Agency breaches, responding to federal HIPAA requests from Medicaid recipients and their authorized representatives, ensuring HIPAA rights of recipients are upheld, responding to any received HIPAA complaints against the Agency and its workforce members, reviewing Agency contracts and other agreements, policy review and creation, participating in workgroups, and other various functions.

Some additional functions, duties, and continuing projects of the HIPAA Compliance Office for FY 2018-19 were:

- Reviewed and provided written comments/recommendations on Agency contractual templates involving confidential data.
- 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 and adheres to the HIPAA Minimum Necessary Standard.
- Continued a project to convert certain documentation to Laserfiche storage and automate HIPAA office workflows and processes where feasible.
- Participated in the Agency Computer Security Incident Response Team (C-SIRT) as a member representing the OIG.
- Advised on the Agency-wide Florida Healthcare Connections project.
- Participated on review of procured State Medicaid Managed Care (SMMC) health plans HIPAA policies and procedures.
- Created an Agency-wide inventory of all Agency databases containing protected health information (PHI), personally identifiable information (PII), and protected financial information (PFI).
- Continued an Agency-wide HIPAA risk assessment.

Training

The HIPAA Compliance Office has a robust presence in the training of Agency staff on issues related to redaction and disclosure of PHI, handling of printed and electronic protected documents, and general HIPAA and security information. In fiscal year (FY) 2018-19, the HIPAA Compliance Office provided or administered the following trainings:

- Administered the HIPAA Online Training program, which is a web-based course designed to orient new Agency workforce members 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.
    - In FY 2018-19, the HIPAA Compliance Office transitioned this online training to a new software platform.
- Provided in-person HIPAA and HITECH privacy training to Agency employees as part of new employee orientation as well as a web-based version of annual employee training.
- A recorded web-based redaction training available any time to Agency employees through the HIPAA Employee Resource SharePoint site. This training focuses on redaction requirements of federal HIPAA regulations as well as section 501.171, Florida Statutes (F.S.).
- Provided in-person HIPAA and HITECH privacy training to Agency OIG staff at the request of the Agency IG.
- Provided in-person HIPAA and HITECH privacy training to newly hired contractor staff.
- Provided in-person HIPAA and HITECH privacy training to newly hired field surveyors at the request of the Health Quality Assurance (HQA) Field Offices bureau chief.
- Provided in-person HIPAA and HITECH privacy training to the Agency Field Offices of Alachua, Jacksonville, and Pensacola.
    - Physical security walkthroughs were also performed by the HIPAA Compliance Office staff during these visits.

The HIPAA Compliance Office revised the presentations for New Employee Orientation and the annual Keep Informed Training as well as created a HIPAA and privacy law history-focused training for the Office of General Counsel, and a specific Field Office HIPAA training.

Additional training and education efforts of the HIPAA Compliance Office included the maintenance of a HIPAA Employee Resource page located on the OIG HIPAA Compliance Office's SharePoint site. Copies of all current trainings are posted here along with copies of legal references and redaction resources. Employees are encouraged to contact the HIPAA Compliance Office to request any new resources be created or posted.

PHI Requests

One of the biggest responsibilities of the HIPAA Compliance Office is to respond to all requests for PHI from Medicaid recipients or their authorized representatives within HIPAA required time frames and reply to emails and telephone inquiries from the public.

In FY 2018-19 the HIPAA Compliance Office responded to 438 received written requests. The average response time to all written correspondence was 3.3 business days. In FY 2018-19, the HIPAA Compliance Office received and responded to 576 telephone inquiries. These calls were addressed in an average response time of 0.6 business days.

Privacy Compliance with Breach Reporting Protocols

HIPAA and Florida Statutes require specific actions in response to a breach of PHI. In the event of a breach, it is the responsibility of the HIPAA Compliance Office to ensure the Agency responds as these laws and regulations dictate. In FY 2018-19, the Agency had one breach of printed PHI due to a loss, which involved less than 200 individuals. Several meetings were held throughout the course of this breach with the responsible business unit and the HIPAA Compliance Office staff regarding compliance, reporting, and mitigating efforts.

In response to this breach, the HIPAA Compliance Office provided guidance to Agency staff and ensured Agency actions were in compliance with federal HIPAA regulations. Such actions included timely notification to affected individuals and to the Secretary of Health and Human Services, Office for Civil Rights (HHS/OCR), the federal HIPAA enforcement agency.

To ensure that Agency Business Associates are compliant with HIPAA incident and breach reporting, the HIPAA Compliance Office staff track Medicaid managed care health plans' reports of HIPAA privacy and security incidents and breaches to the Agency and recommended compliance actions resulting in the potential imposition of fines on SMMC health plans for non-compliance with contractual reporting requirements. This tracking is required in the HIPAA regulations.

HIPAA Liaisons and Agency Physical Security

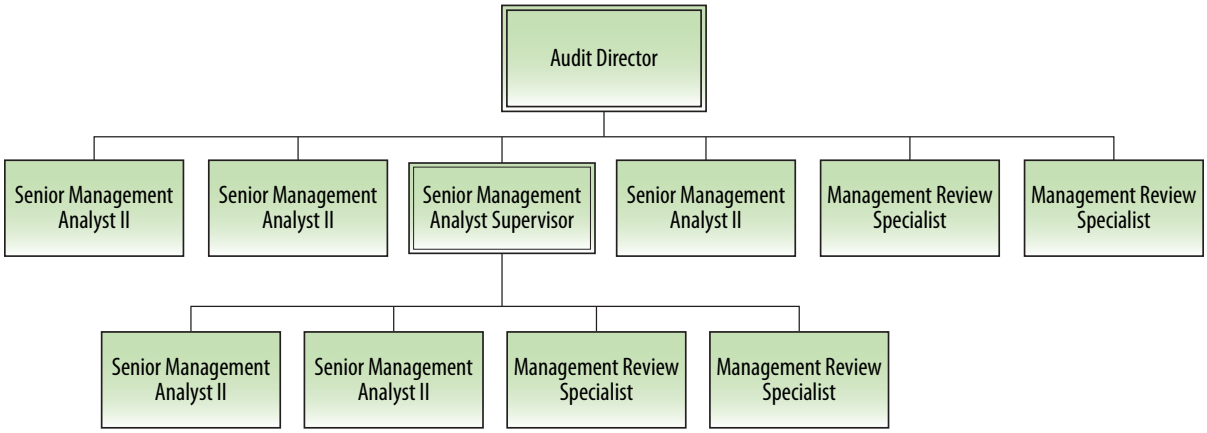
The use of Field Office HIPAA liaisons was reestablished in FY 2017-18 and continued throughout FY 2018-19. These HIPAA liaisons serve as a point of contact at each of the Agency Field Offices for any related HIPAA issues and increase compliance of the HIPAA prescribed physical safeguards by performing office walkthroughs and reporting any observed instances of unsecured PHI and any other related physical safety concerns to Agency PHI security. A monthly report is received from each Field Office HIPAA liaison to document these efforts. The HIPAA Compliance Office is currently revising the Agency HIPAA/HITECH Policies and Procedures Manual on physical security walkthroughs to better codify this procedure.

HIPAA Privacy Risk Assessment

The HIPAA Compliance Office 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.

Furthering this effort, the HIPAA Compliance Office created a HIPAA-focused privacy risk assessment survey, which was sent to all business units within the Agency. Information collected from this survey was used to compile a thorough inventory of Agency PHI location and flow. This survey was also used to create a library of all policies, procedures, and associated contractual documents related to the creation, usage, maintenance, and reception and transmission of Agency PHI. The HIPAA Compliance Office is continuing to review unit responses, perform follow-up interviews, and conduct risk assessment activities to identify, document, and address any HIPAA risks related to Agency PHI.

STAFF AND ORGANIZATION



The purpose of Internal Audit (IA) 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 Inspector General determines the scope and assignment of audits; however, at any time, the Agency Secretary may 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.

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 Inspector General Auditor
- Certified Government Auditing Professional
- ITIL (Information Technology Infrastructure Library) V3 Foundation Certification
- Master of Arts in Teaching
- Master of Arts in Sociology
- Master of Business Administration
- Juris Doctor (JD)

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.

INTERNAL AUDIT FUNCTIONS

Risk Assessment

Internal Audit performs a risk assessment of the Agency's programs and activities 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 following:

- 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. Management's responses are included in the final reports, which are distributed to the Agency Secretary, affected program managers, the Chief Inspector General (CIG), and 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 CIG 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.

Completed and In Progress Engagements

The following is a summary list of completed and in progress engagements as of June 30, 2019:

REPORT NO.	ENGAGEMENT	TYPE	DATE ISSUED/PLANNED
AHCA-1617-07-A	Accounts Receivable Collection and Write Off Process	Assurance	Issued April 2019
AHCA-1617-05-A	Provider Eligibility Enrollment Process	Assurance	Issued June 2019
AHCA-1718-04-A	IT Help Desk Audit	Assurance	October 2019
AHCA-1718-03-A	SMMC Capitation Rate Setting Process	Assurance	October 2019
AHCA-1718-02-A	HQA Tracking of Final Orders	Assurance	November 2019
AHCA-1819-03-A	SMMC Detection and Investigation of Medicaid Fraud and Abuse	Assurance	December 2019
AHCA-1819-04-A	Medicaid Fair Hearing Process	Assurance	February 2020
AHCA-1819-02-A	Electronic Payment Audit	Assurance	March 2020
AHCA-1819-05-A	SMMC Health Plan Reporting	Assurance	August 2020

Engagement Summaries

The following summaries describe the results of the assurance engagements completed by Internal Audit during FY 2018-19:

AHCA-1617-07-A Accounts Receivable Collection and Write-Off Process

Internal Audit conducted an audit of the Division of Operations, Bureau of Financial Services (Financial Services) Accounts Receivable Collection and Write-Off Process. During our audit, we noted areas where improvements could be made to strengthen controls. Our audit disclosed the following:

- Financial Services and Office of Plans and Construction (OPC) did not actively monitor or collect on delinquent OPC accounts receivable;
- Financial Services did not assign delinquent accounts to the collection agency in accordance with statutory time requirements and the Department of Financial Services (DFS) exemption letter;
- Financial Services did not always report collection agency assignments to DFS as required by Florida Statutes (F.S.);
- Documentation provided by Financial Services showed that uncollectable accounts were not submitted for write-off consistently or within a reasonable amount of time;
- Financial Services did not maintain proper segregation of duties when processing OPC receivables; and
- Some collection agency documentation was not retained in accordance with the State of Florida General Records Schedule.

AHCA-1617-05-A Provider Eligibility Enrollment Process

Internal Audit conducted an audit of the Medicaid provider enrollment application review process within the Division of Medicaid, Bureau of Medicaid Fiscal Agent Operations (MFAO), Provider Enrollment Section.

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

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 guidance was provided to Agency staff regarding accuracy, validity, and reliability.

Internal Audit completed the following additional duties or projects during FY 2018-19:

- 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 Management Decision 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
- Updated Internal Audit Policies and Procedures Manual
- Auditor General Quality Assessment Review of Internal Audit
- Quarterly Audit Governance Reports and Meeting Preparation

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 2018-19, the following status reports for internal engagements were published:

- Employee Background Screening Process (Six-Month and 12-Month Status Reports)
- Cash Room Collection Process (12-Month and 18-Month Status Reports)
- Agency Agreements (Six-Month and 12-Month Status Reports)
- Single Sign On Application (12-Month and 18-Month Status Reports)

Corrective Actions Outstanding from Previous Annual Reports

As of June 30, 2019, the following corrective actions for significant recommendations described in previous annual reports were still outstanding:

AHCA Report No. 1516-08-A: Cash Room Collection Process, issued December 8, 2017

Recommendation: We recommend that each batch be recorded separately on the log. The log should include the change of custody date, revenue type, batch amount, and the name of the individual making the log entry. The log should document when the batches are placed into the safe at closing, removed from the safe at opening, and when batches transfer custody

Most Recent Management Response (June 2019): The Cash Room documentation and procedures have been the focus of significant review and improvement. Three of the former forms, used to establish possession, document possession and used for accounting for the processing of the negotiable instruments have been combined into a single form. Persons working in the cash room have been trained on the importance of complete and accurate documentation, the forms are reviewed by Revenue Managers daily, and corrective actions are taken to maintain effective, accurate, and efficient management of the negotiable instruments, processes and staffing in the cash room.

AHCA Report No. 1617-04-A: Agency Agreements, issued February 26, 2018

Recommendation: Internal Audit recommends that Procurement train Program Office staff when the Policy and Procedure has been updated.

Most Recent Management Response (February 2019): Procurement has begun the development of training materials. These materials are in the final stages of review. Trainings will begin in February 2019 and will be completed by March 31, 2019. Continuing education trainings will be held no less than quarterly thereafter.

Recommendation: For existing Agreements in the Contract Administration Tracking System (CATS), we recommend a review to identify and update inaccurate and missing information, including the following: the correct HIPAA Data indicator; the current Agreement Manager; the correct Expiration Date; the correct Effective Date; and adding a field to CATS for Agreements with costs in excess of $100,000 to ensure that a Florida Certified Contract Manager manages them.

Most Recent Management Response (February 2019): The Procurement Office continues the bi-weekly QA Process comparing the information in CATS, Florida Accountability Contract Tracking System, and My Florida Market Place systems to ensure the data is accurate for new agreements. The annual file review for existing agreements has been completed. The Procurement Office is currently working to correct inaccurate information in CATS. The Procurement Office is working with the Program Offices to update the agreements with no expiration date.

Recommendation: We recommend that current Agreements be reviewed and those which involve the use of Agency-owned HIPAA PHI be updated as needed with the appropriate Business Associate Agreement (BAA) or terms relating to the proper handling and security of PHI to meet federal compliance.

Most Recent Management Response (February 2019): The Procurement Office continues to review agreements to verify the accuracy of HIPAA which involve the use of Agency-owned HIPAA PHI. The Procurement Office is working with the Program Offices to review and update the agreements with no expiration date with the appropriate BAA or terms relating to the proper handling and security of PHI to meet federal compliance

Recommendation: We recommend that written procedures for monitoring Agreements be created to help ensure that all Agreements have documentation to show that Agreement Managers are monitoring the terms and conditions of the Agreement.

Most Recent Management Response (February 2019): The desk reference was distributed to all Agreement Managers on April 27, 2018. An initial request for Agreement Managers to complete the Contract Monitoring Plan was sent on March 30, 2018. Full compliance with this recommendation will be completed with the second Clean-Up Project.

AHCA Report No. 16-17-02-A: Employee Background Screening Process, issued April 5, 2018

Recommendation: Prospective hires should complete level 2 background screening before being hired and granted access to facilities, information systems, and confidential data. Implementation of this recommendation should eliminate the issues related to monitoring fingerprint registration delays for new hires addressed in Finding 2.

Most Recent Management Response (April 2019): Partially Completed. The BGS Unit is still working on implementing a level 2 background screening process prior to prospective hires being hired. On January 29, 2019, the BGS Unit began piloting this process within the General Counsel's Office and the Division of Information Technology.

Recommendation: Amend the Background Screening Policy to add the requirement that prospective hires should complete level 2 background screening before being hired and granted access to facilities, information systems, and confidential data.

Most Recent Management Response (April 2019): Partially Completed. The Background Screening Policy is currently being updated. While a draft version of the new policy and manual has been generated, it is still being amended based on feedback that is being received during the piloting phase.

AHCA Report No. 15-08: Background Screening Clearinghouse Program, issued June 6, 2016

Recommendation: Management continue to work with IT to develop appropriate reports to monitor the number of days to make eligibility determinations.

Most Recent Management Response (May 2019): The Background Screening Unit currently has the ability to track the turnaround times for an initial eligibility decision on a screening result.

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 timeframes.

During FY 2018-19, status reports were submitted on the following external reports:

- Auditor General – Operational Audit - Medicaid Enterprise System Procurement Project and Selected Administrative Activities Six-Month Status Report (Report No. 2019-015)

- Auditor General - State of Florida Compliance and Internal Controls Over Financial Reporting and Federal Awards Six-Month Status Report (Report No. 2018-189)
- Auditor General – Operational Audit - Collection and Use of Medicaid Managed Care Encounter Data and Selected Administrative Activities (Report No. 2018-172)
- OPPAGA – AHCA Continues to Expand Medicaid Program Integrity Efforts; Establishing Performance Criteria Would Be Beneficial Six-Month Status Report (Report No. 18-03)

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), the Florida Department of Law Enforcement, 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 2018-19, the following reports were issued by external entities:

Office of the Auditor General

- Medicaid Enterprise System Procurement Project and Selected Administrative Activities (Report No. 2019-015)
- State of Florida Compliance and Internal Controls Over Financial Reporting and Federal Awards, (Report No. 2019-186)

OPPAGA

- Selected State Agencies Provide Language Access Services to Non-English Speakers and Vary in Monitoring Effectiveness (Research Memorandum dated February 11, 2019)

GAO

- Medicaid Managed Care – Improvements Needed to Better Oversee Payment Risks (Report No. GAO-18-528)

HHS

- States Follow a Common Framework in Responding to Breaches of Medicaid Data (Report No. OEI-09-16-00210)
- Hospitals Reported Improved Preparedness for Emerging Infectious Diseases After the Ebola Outbreak (Report No. OEI-06-15-00230)

AST

- 2018 Information Technology Standards and Guidelines Assessment Report (Report No. AST-ED-RP-0002 issued December 1, 2018)

FBI

- 2018 Non- Criminal Justice Information Technology Security Audit (issued 2018)

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

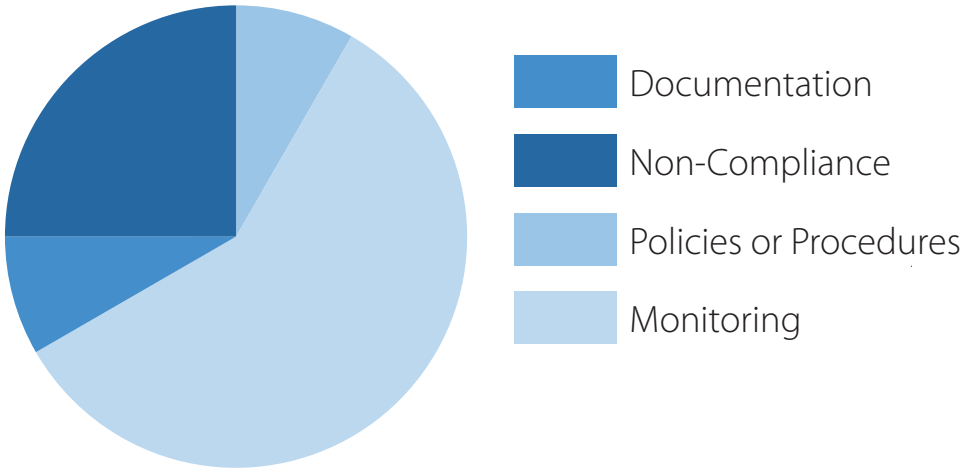
Single Audit Act) and Chapters 10.650 or 10.550 of the Rules of the Auditor General for state awards.

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. The OIG is responsible for reviewing submitted financial reporting packages to determine compliance with applicable submission requirements and reporting the results of the reviews to the program/bureau and the Agency's Contract Manager.

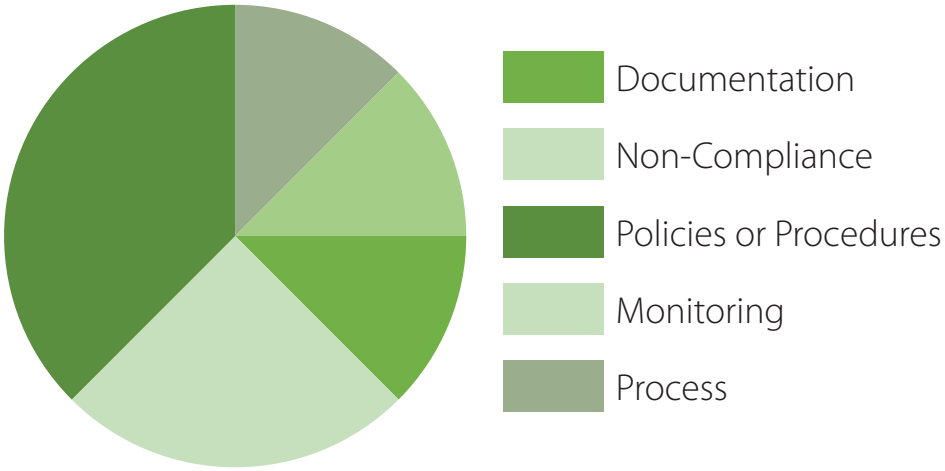
During FY 2018-19, Internal Audit continued to provide guidance to the Bureau of Financial Services and the applicable program areas to develop compliance supplement(s) for the Catalog of State Financial Assistance. Internal Audit provided assistance on the establishment of the Civil Money Penalty program as a new State Project in the Catalog of State Financial Assistance.

During the fiscal year, Internal Audit reviewed three audits that met the minimum threshold for compliance with single audit submission requirements. The contract managers were notified of the review results and were provided guidance on resolving any issues noted in the reporting package.

External Audits Root Cause Analysis



Internal Audits Root Cause Analysis



Root Cause Analysis

Both internal and external audits issued during FY 2018-19 showed audit findings had recurring themes or deficiencies in the following areas:

- 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 doc uments;
- Monitoring – Inadequate monitoring, supervisory review, or reporting of compliance with policies, procedures, contracts, or other established standards; and
- Noncompliance– Nonconformity with federal guidance, legislative appropriations state statutes, or Agency policy.

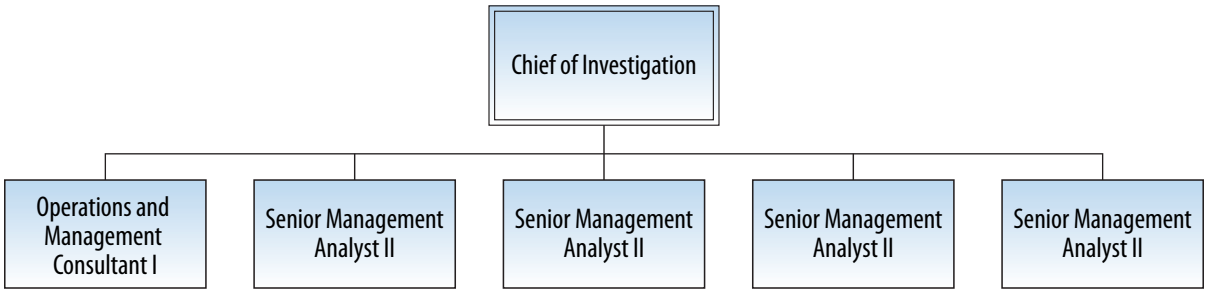
AUDIT MANAGEMENT SYSTEM

Internal Audit purchased and implemented MKinsight, an audit management system, in FY 2015-16. 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.

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.

In FY 2018-19, Internal Audit continued to configure MKinsight to improve the tracking of work performed on audits. In addition, the MKinsight policies and procedures were updated to improve processes and increase efficiency.

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, State, and Federal laws. Complaints may originate from the Office of the CIG, 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 2017, the AHCA OIG Investigations Unit achieved accreditation status for a three-year term from the Commission for Florida Law Enforcement Accreditation, Inc. Accreditation demonstrates that the IU has met specific requirements and prescribed standards. Accreditation resulted in established standards and directives for IU staff on (1) Organization and Governing Principles; (2) Personnel Practices; (3) Training; (4) Investigation Process; (5) Case Supporting Materials and Evidence; (6) Whistle-blowers Act; (7) Notification Process; (8) Case Management; and, (9) Final Reporting Processes. Accreditation provides the IU a means for maintaining the highest standards of professionalism and accountability.

The IU staff brings various backgrounds and expertise to the Agency. Certifications, in addition to advanced degrees, collectively held by IU staff as of June 30, 2019, include:

- Certified Fraud Examiner (2)
- Certified Inspector General Investigator (4)
- Certified Inspector General Auditor (2)
- Certified Equal Employment Opportunity Investigator (4)
- Certified Law Enforcement Officer (2)
- Certified Contract Manager (1)

INVESTIGATIONS UNIT FUNCTIONS

During FY 2018-19, the IU opened 180 new complaints and closed 178 complaints some of which were ongoing from previous fiscal years. 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.
- Facility - Regulated and licensed facility violations reported included but were not limited to allegations associated with substandard care, patients' rights violations, public safety concerns, facility licensing issues, and unlicensed activity.
- 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. Other allegations related to fraud included Medicare and private billing fraud.
- Equal Employment Opportunity (EEO) Violations - EEO violations reported included but were not limited to allegations associated with hostile work environments, 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.
- Other – Allegations not within the OIG's jurisdiction (e.g. theft); information provided wherein no investigative review, referral, or engagement was required.

The 180 complaints received by the AHCA OIG for FY 2018-19 were assessed and assigned as follows:

- Eleven were assigned for analysis to determine if the complaints met the criteria for Whistle-blower status as defined in §112.3187, F. S.
- Forty-three were assigned for Preliminary Investigation.
- Ten were assigned for Full Internal Investigation. The IU's analysis of the complaints received and investigated disclosed the majority of these cases involved disparaging remarks and unprofessional conduct directed toward employees and persons outside the agency.
- Ninety-seven were referred to other AHCA Bureaus or outside agencies for proper assessment.
- One was assigned to provide investigative assistance to management.
- Eighteen were assigned for informational purposes only.
- Additionally, the OIG IU closed the investigation of one active legacy Whistle-blower complaint that was referred to an external agency.

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.

The following are examples of Investigation Unit cases closed during FY 2018-2019. An index of complaint type received during this reporting period is included at the end of this section.

CASE HIGHLIGHTS FY 2018-19

AHCA OIG #18-07-003

This investigation was initiated by a complaint filed by an employee of the Agency that alleged AHCA employees were engaged in discriminatory behavior and created a hostile work environment during conversations, and was referred to IU by the AHCA Human Resources. The AHCA OIG's investigation determined there was sufficient evidence to support the allegation of a hostile work environment and discriminatory behavior.

AHCA OIG #18-10-004

This investigation was initiated by a complaint filed by an AHCA employee that alleged a hostile work environment due to the use of profanity in the workplace by a supervisor. The AHCA OIG's investigation determined there was sufficient evidence to support the allegation of an AHCA employee using or having used profane language in the workplace.

AHCA OIG #18-10-013

This investigation was initiated upon the filing of a complaint by an AHCA employee that alleged discrimination during the hiring process. The AHCA OIG's investigation determined there was insufficient evidence to support the allegation of discrimination; however, the OIG made recommendations to management regarding the Agency hiring policy.

AHCA OIG #18-12-001

This investigation was initiated upon the filing of a complaint by an employee of a facility regulated by AHCA's HQA division that alleged an AHCA employee was engaged in unprofessional and/or inappropriate conduct during a AHCA November 2018 survey. The AHCA OIG's investigation determined there was sufficient evidence to support the allegation that the AHCA employee's conduct was unbecoming a public employee.

AHCA OIG #18-12-009

This preliminary investigation was initiated upon the filing of a complaint that alleged possible misuse of resources by an AHCA employee. The AHCA OIG's preliminary investigation found the incident to be isolated and not a deliberate misuse of Agency resources. The case was referred to the Deputy Secretary for any action deemed appropriate.

AHCA OIG #19-01-015

This investigation was initiated by two similar complaints filed by two separate AHCA employees within AHCA's Health Quality Assurance (HQA) division, Area 4 office, which alleged an unknown AHCA employee(s) disclosed confidential survey information. The AHCA OIG's investigation determined there was insufficient evidence to support the allegations that an AHCA employee(s) disclosed confidential survey information.

AHCA OIG #19-02-003

This preliminary investigation was initiated upon the filing of a complaint referred by the AHCA Bureau of Human Resources that alleged a former AHCA employee was subjected to unfair treatment and worked in an unpleasant environment. The AHCA OIG's preliminary investigation found insufficient evidence to support the allegations of unfair treatment and hostile work environment

AHCA OIG #19-03-012

This preliminary investigation was initiated upon the filing of a complaint referred from the AHCA Bureau of Human Resources, in which an exit interview form submitted by a former employee stated they were subjected to discrimination by coworkers, and ridiculed and intimidated during their employment. The AHCA OIG's preliminary investigation

found there was insufficient evidence to support the allegations of discrimination and hostile work environment.

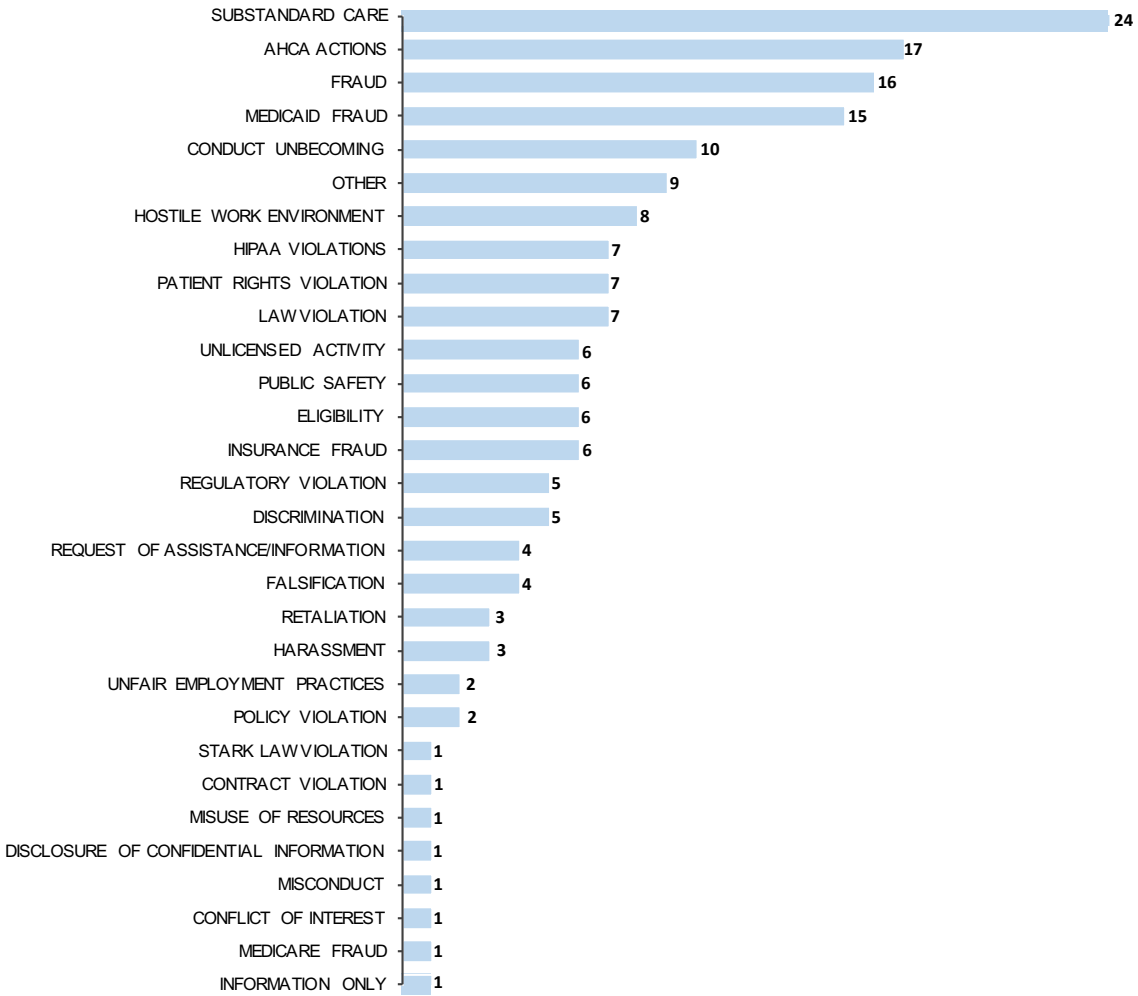
AHCA OIG #19-05-015

This preliminary investigation was initiated upon the filing of a complaint that alleged an AHCA employee was experiencing abusive language and a hostile work environment. The AHCA OIG's preliminary investigation found there was insufficient evidence to support the allegation of a hostile work environment.

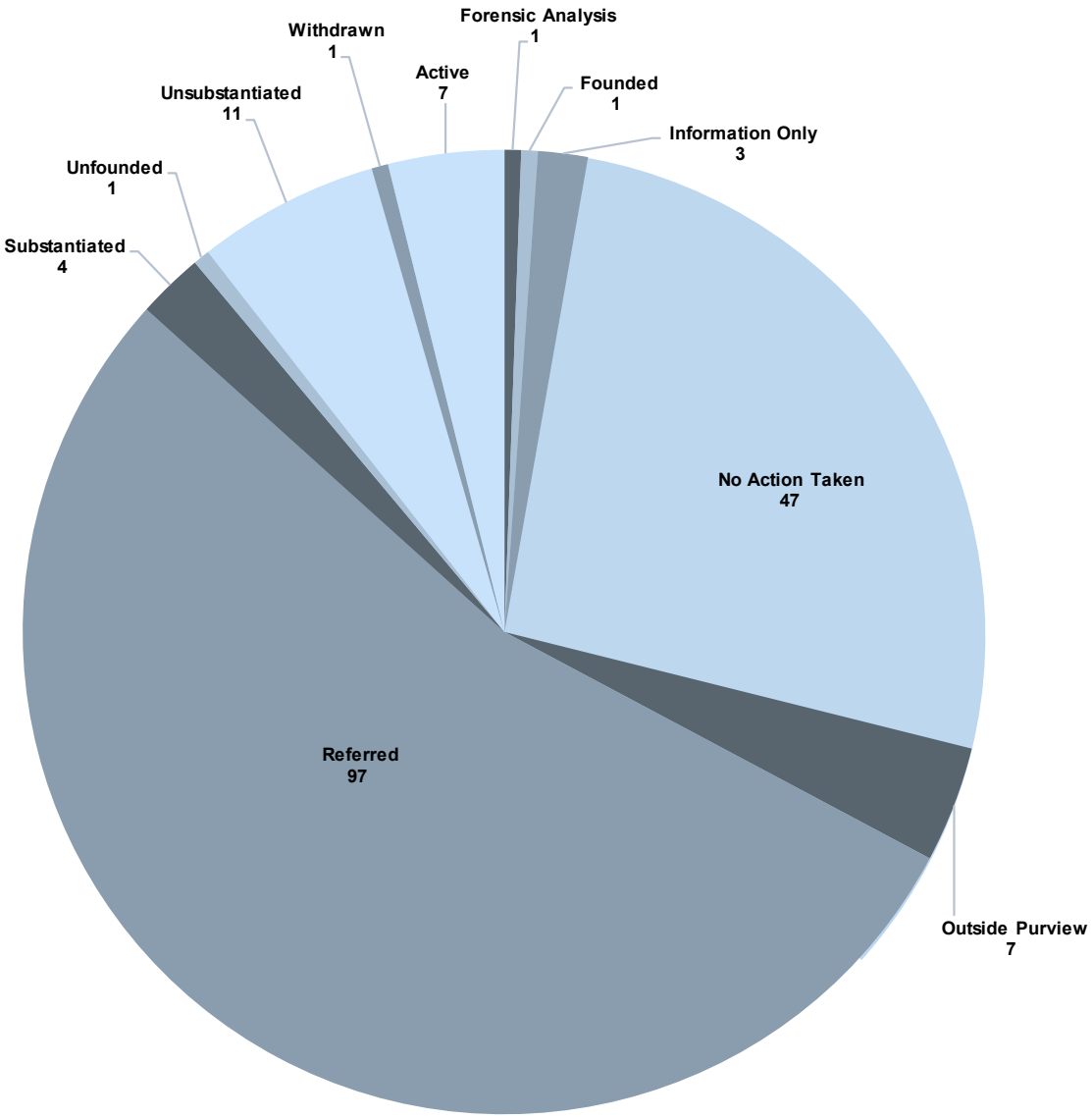
AHCA OIG #19-06-003

This preliminary investigation was initiated upon the filing of a complaint that alleged Agency management instructed an AHCA employee to deliberately violate law. During the AHCA OIG's preliminary investigation, the complainant withdrew the complaint due to additional information

Primary Allegations by Category for Complaints Received FY 2018-19



Disposition of Allegations by Category for Complaints Received FY 2018-19



COMPLAINTS RECEIVED FY 2018-19

CASE NUMBER	PRIMARY ALLEGATION	DISPOSITION
18-07-001	Medicaid Fraud	Referred
18-07-002	Fraud	Referred
18-07-003	Hostile Work Environment	Substantiated
18-07-004	AHCA Actions	Referred
18-07-005	Hostile Work Environment	Referred
18-07-006	Medicaid Fraud	Referred
18-07-007	Medicaid Fraud	No Action Taken
18-07-008	Law Violation	No Action Taken
18-07-009	Substandard Care	Outside Purview
18-07-010	Policy Violation	Referred
18-07-011	Substandard Care	Referred
18-07-012	Harassment	No Action Taken
18-07-013	Public Safety	No Action Taken
18-07-014	Medicaid Fraud	Referred
18-07-015	Substandard Care	No Action Taken
18-07-016	Fraud	No Action Taken
18-07-017	Medicaid Fraud	Referred
18-07-018	Retaliation	No Action Taken
18-08-001	Substandard Care	No Action Taken
18-08-002	Fraud	No Action Taken
18-08-003	Eligibility	No Action Taken
18-08-004	Unlicensed Activity	No Action Taken
18-08-005	Unlicensed Activity	No Action Taken
18-08-006	Conduct Unbecoming	No Action Taken
18-08-007	Unlicensed Activity	No Action Taken
18-08-008	Regulatory Violation	Unsubstantiated
18-08-009	AHCA Actions	Outside Purview
18-08-010	Substandard Care	No Action Taken
18-08-011	AHCA Actions	No Action Taken
18-09-001	Substandard Care	Information Only
18-09-002	Hostile Work Environment	No Action Taken
18-09-003	Falsification	No Action Taken
18-09-004	HIPAA Violations	Forensic Analysis
18-09-005	Eligibility	Referred
18-09-006	Falsification	Referred
18-09-007	AHCA Actions	Unsubstantiated
18-09-008	Medicaid Fraud	No Action Taken
18-09-009	Insurance Fraud	No Action Taken
18-09-010	Insurance Fraud	No Action Taken

COMPLAINTS RECEIVED FY 2018-19

CASE NUMBER	PRIMARY ALLEGATION	DISPOSITION
18-09-011	Medicaid Fraud	Unsubstantiated
18-09-012	Substandard Care	Referred
18-09-013	Retaliation	No Action Taken
18-09-014	Medicaid Fraud	Referred
18-09-015	Unfair Employment Practices	Referred
18-10-001	Substandard Care	Referred
18-10-002	AHCA Actions	Referred
18-10-003	Eligibility	Information Only
18-10-004	Hostile Work Environment	Substantiated
18-10-005	Discrimination	Unsubstantiated
18-10-006	Substandard Care	Referred
18-10-007	Fraud	Referred
18-10-008	Eligibility	Referred
18-10-009	Other	Referred
18-10-010	AHCA Actions	Referred
18-10-011	AHCA Actions	No Action Taken
18-10-012	Unlicensed Activity	Referred
18-10-013	Discrimination	Unsubstantiated
18-10-014	Substandard Care	Referred
18-11-001	Substandard Care	Referred
18-11-002	Discrimination	Unsubstantiated
18-11-003	Harassment	Referred
18-11-004	Eligibility	Referred
18-11-005	Fraud	Referred
18-11-006	Stark Law Violation	Referred
18-11-007	Substandard Care	Referred
18-11-008	Other	No Action Taken
18-11-009	Medicaid Fraud	No Action Taken
18-12-001	Conduct Unbecoming	Substantiated
18-12-003	Other	No Action Taken
18-12-005	Medicare Fraud	No Action Taken
18-12-006	Medicaid Fraud	Referred
18-12-007	HIPAA Violations	No Action Taken
18-12-008	Conduct Unbecoming	No Action Taken
18-12-009	Misuse of Resources	Substantiated
18-12-010	Other	Referred
18-12-011	Law Violation	No Action Taken
19-01-001	Other	Referred
19-01-002	Hostile Work Environment	Unsubstantiated

COMPLAINTS RECEIVED FY 2018-19

CASE NUMBER	PRIMARY ALLEGATION	DISPOSITION
19-01-003	Information Only	Referred
19-01-004	HIPAA Violations	Referred
19-01-005	HIPAA Violations	Referred
19-01-006	Regulatory Violation	Founded
19-01-007	Patient Rights Violation	Information Only
19-01-008	Patient Rights Violation	Referred
19-01-009	Other	Referred
19-01-010	Contract Violation	No Action Taken
19-01-011	Insurance Fraud	Referred
19-01-012	Regulatory Violation	Referred
19-01-013	Other	Referred
19-01-014	Patient Rights Violation	Referred
19-01-015	Disclosure of Confidential Information	Unsubstantiated
19-01-016	Substandard Care	Referred
19-01-017	Patient Rights Violation	Referred
19-02-001	Unfair Employment Practices	Referred
19-02-002	Substandard Care	Referred
19-02-003	Hostile Work Environment	Unsubstantiated
19-02-004	Conflict of Interest	No Action Taken
19-02-005	Substandard Care	Referred
19-02-006	Fraud	Referred
19-02-007	Fraud	Referred
19-02-008	Fraud	Referred
19-02-009	Unlicensed Activity	No Action Taken
19-02-010	Other	Outside Purview
19-02-011	Fraud	Referred
19-02-012	Medicaid Fraud	Referred
19-02-013	Substandard Care	Referred
19-02-014	Request of Assistance/ Information	Referred
19-03-001	AHCA Actions	Referred
19-03-002	Substandard Care	Referred
19-03-003	HIPAA Violations	Referred
19-03-004	Insurance Fraud	Referred
19-03-005	Public Safety	Referred
19-03-006	AHCA Actions	Referred
19-03-007	Substandard Care	Referred
19-03-008	Substandard Care	Referred

COMPLAINTS RECEIVED FY 2018-19

CASE NUMBER	PRIMARY ALLEGATION	DISPOSITION
19-03-009	Other	Referred
19-03-010	Conduct Unbecoming	Referred
19-03-011	HIPAA Violations	Outside Purview
19-03-012	Discrimination	Unfounded
19-03-013	Medicaid Fraud	Outside Purview
19-03-014	Medicaid Fraud	Referred
19-04-001	Discrimination	No Action Taken
19-04-002	Fraud	Referred
19-04-003	Conduct Unbecoming	Active
19-04-004	AHCA Actions	Outside Purview
19-04-005	Eligibility	No Action Taken
19-04-006	Public Safety	Referred
19-04-007	AHCA Actions	No Action Taken
19-04-008	Policy Violation	Referred
19-04-009	Public Safety	Referred
19-04-010	AHCA Actions	No Action Taken
19-04-011	Conduct Unbecoming	No Action Taken
19-04-012	AHCA Actions	Referred
19-04-013	Substandard Care	No Action Taken
19-04-014	Falsification	Referred
19-04-015	Insurance Fraud	No Action Taken
19-04-016	Falsification	Referred
19-04-017	Public Safety	No Action Taken
19-04-018	AHCA Actions	Unsubstantiated
19-04-019	Law Violation	Active
19-05-001	Request of Assistance/ Information	Referred
19-05-002	Law Violation	Referred
19-05-003	Substandard Care	Referred
19-05-004	Conduct Unbecoming	No Action Taken
19-05-005	Patient Rights Violation	Referred
19-05-006	HIPAA Violations	Referred
19-05-007	Retaliation	Referred
19-05-008	AHCA Actions	Referred
19-05-009	Fraud	Referred
19-05-010	Law Violation	No Action Taken
19-05-011	Harassment	Referred
19-05-012	Law Violation	Referred
19-05-013	Patient Rights Violation	Referred

COMPLAINTS RECEIVED FY 2018-19

CASE NUMBER	PRIMARY ALLEGATION	DISPOSITION
19-05-014	Hostile Work Environment	Unsubstantiated
19-05-015	Hostile Work Environment	No Action Taken
19-05-016	Regulatory Violation	Referred
19-05-017	Substandard Care	Referred
19-06-001	Request of Assistance/ Information	Referred
19-06-002	Medicaid Fraud	Referred
19-06-003	AHCA Actions	Withdrawn
19-06-004	Conduct Unbecoming	Active
19-06-005	Substandard Care	Referred
19-06-006	Law Violation	Outside Purview
19-06-007	Fraud	Referred
19-06-009	AHCA Actions	No Action Taken
19-06-010	Conduct Unbecoming	Active
19-06-011	Fraud	Referred
19-06-012	Fraud	No Action Taken
19-06-013	Regulatory Violation	Referred
19-06-014	Medicaid Fraud	Referred
19-06-015	Insurance Fraud	Referred
19-06-016	Public Safety	Referred
19-06-017	Fraud	Referred
19-06-018	Substandard Care	Referred
19-06-019	Misconduct	Active
19-06-020	Request of Assistance/ Information	No Action Taken
19-06-021	Fraud	Referred
19-06-022	Patient Rights Violation	Referred
19-06-023	Conduct Unbecoming	Active
19-06-024	Unlicensed Activity	Referred

Note: Case numbers 18-12-002, 18-12-004, and 19-06-008 were opened in error.

ENTERPRISE RISK MANAGEMENT

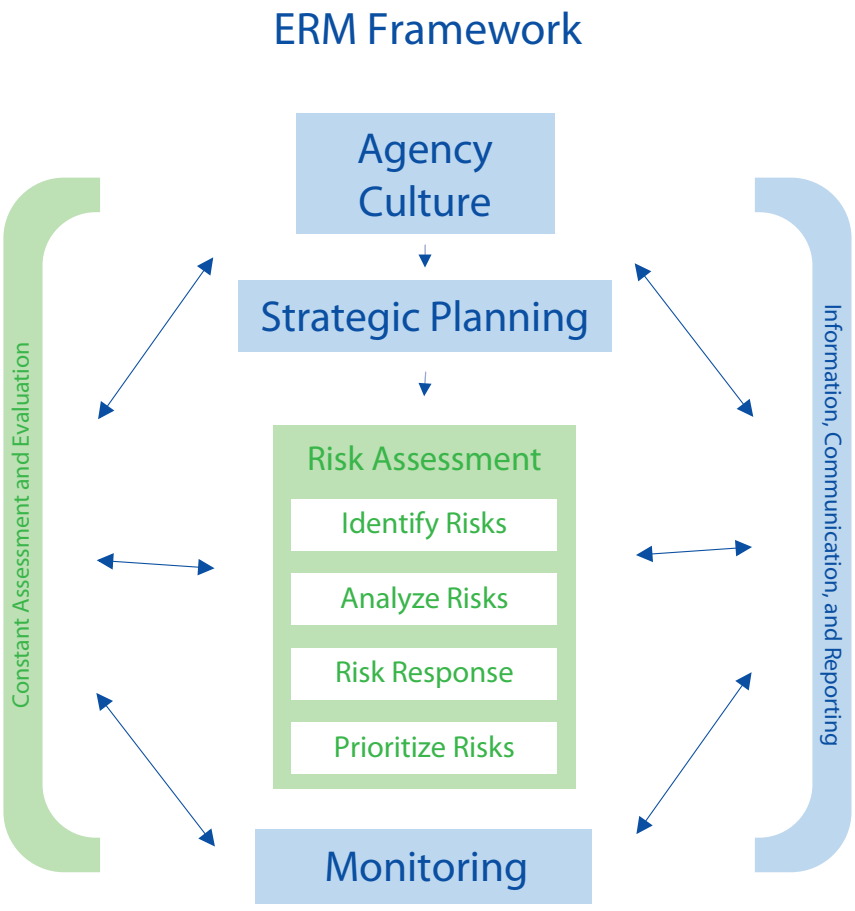
Enterprise Risk Management (ERM) is an enterprise-wide approach for addressing the full spectrum of an entity's risks by considering these risks as an entity-level portfolio, instead of addressing risks within individual divisions, bureaus, or units. ERM provides a structured methodology for understanding risks by identifying, analyzing, quantifying, managing, and monitoring these risks and determining how these risks affect the achievement of an entity's objectives.

The OIG is tasked with coordinating the Agency's process for adopting and implementing an ERM program. During the summer of 2018, the Agency's Management Team received training and participated in planning and developing an ERM framework and process. Full implementation of the Agency's ERM program will likely span several years.

During FY 2018-2019, two training courses were developed and the training of Agency employees began.

- Introduction to Enterprise Risk Management - four classes were conducted and 93 employees attended.
- ERM Risk Assessment Training – a more in-depth training was provided to 34 employees who participated in an ERM workgroup.

The ERM Coordinator has been working with the Agency Management Team in determining the order in which functional areas and processes will be involved in the risk assessment process. Currently, several Agency functions are in the process of a risk assessment.



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