Agency For Health Care Administration

OFFICE OF INSPECTOR GENERAL








ANNUAL REPORT

FISCAL YEAR

2019-2020

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

September 2020

On behalf of the Agency for Health Care Administration (Agency or AHCA) Office of Inspector General (OIG), I am proud to present our annual report summarizing our work and accomplishments during the 2019-20 fiscal year.

The Agency and OIG faced unprecedented challenges this year due to the Coronavirus. To keep our employees safe, the majority transitioned to working from home. The OIG adapted our business processes and used new tools to continue our work in providing 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 continued dedication of OIG management and staff.

The OIG includes Investigations, Internal Audit, HIPAA Compliance Office, and Enterprise Risk Management. 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 information held by AHCA is protected in accordance with state and federal privacy laws. The OIG also coordinates the Agency's enterprise-wide approach to addressing risks.

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.

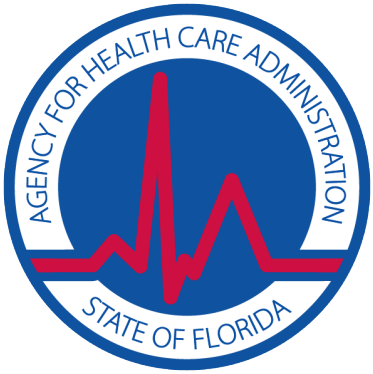
Respectfully,

Mary Beth Sheffield

Mary Beth Sheffield
Inspector General

2727 Mahan Drive • Mail Stop #4
Tallahassee, FL 32308
AHCA.MyFlorida.com

Facebook.com/AHCAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL



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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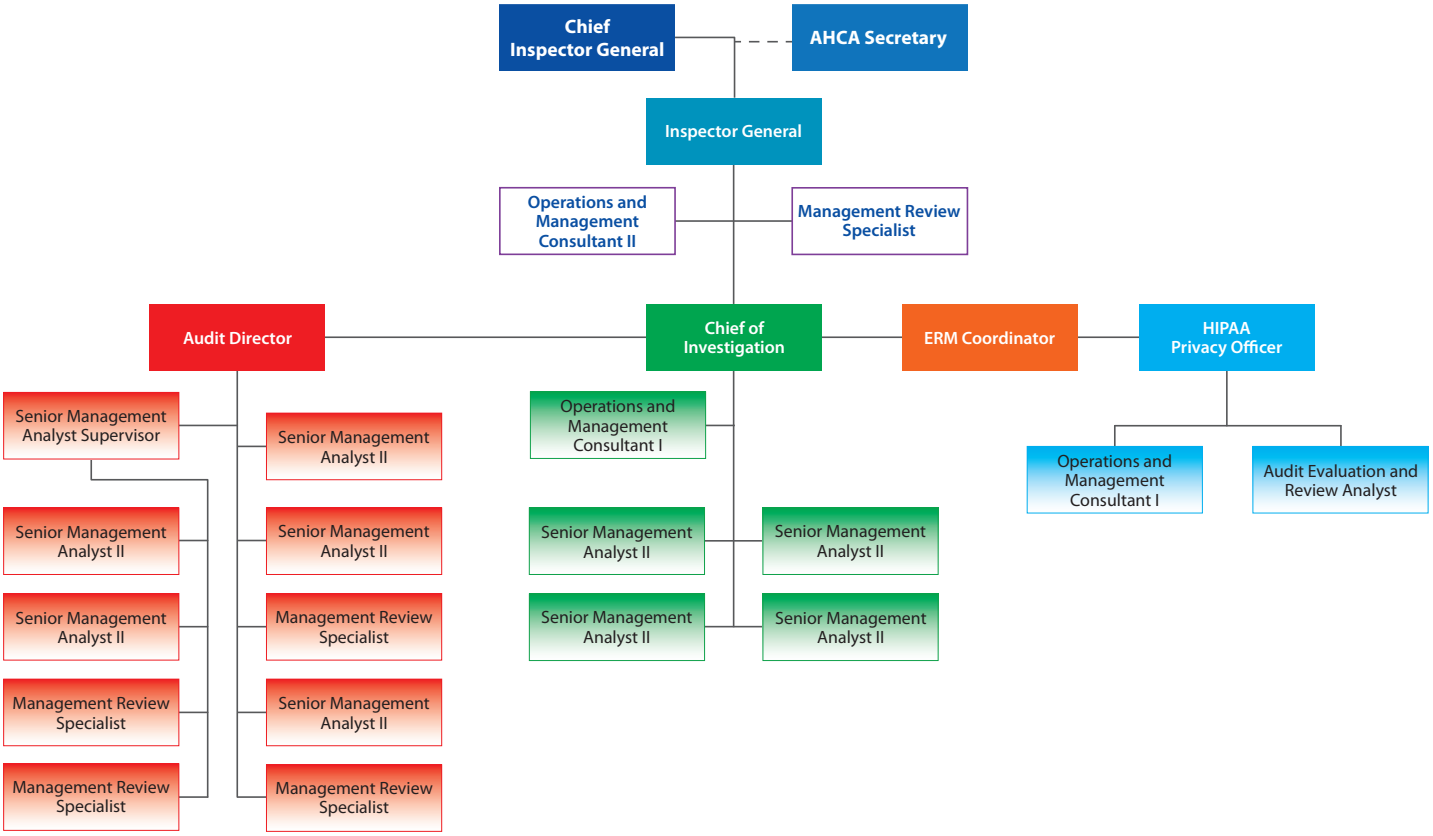
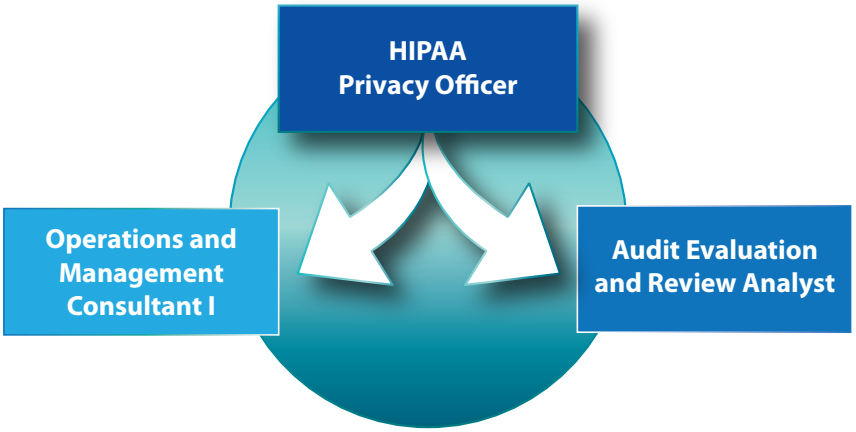
AHCA OIG
ORGANIZATIONAL STRUCTURE



OIG Staff Changes from Prior Year

There were no additions, removals, or reclassifications to OIG staff positions during fiscal year 2019-20.

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 Contract Manager (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 2019-20 were:

- Revised the Agency HIPAA-HITECH Policies and Procedures Manual.
- 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.
- Participated in multiple collaborative Agency work groups to ensure Agency HIPAA requirements are met.
- Continued a project to convert certain documentation to Laserfiche storage and automate HIPAA office workflows and processes where feasible.
- Maintained an Agency-wide inventory of all Agency databases containing

protected health information (PHI), personally identifiable information (PII), and protected financial information (PFI).

- Reviewed all Public Records requests containing PHI for appropriate and valid HIPAA access and authorization forms.
- Reviewed all Agency contracts and agreements prior to execution to ensure appropriateness and adequate contractual protections in place.
- Completed an Agency-wide HIPAA risk assessment and provided it to the Agency Management Team (AMT) for response.
- Updated all internal Agency HIPAA forms to ensure compliance with Agency Forms policy.
- Revised the Agency's Business Associate Agreement.
- Transitioned to a paperless routing system for HIPAA PHI requests in response to the COVID-19 pandemic.
    - This process will be reviewed for retention.

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) 2019-20, the HIPAA Compliance Office provided or administered the following trainings:

- Created and provided an Agency-wide HIPAA safeguards and telework training in response to the COVID-19 pandemic.
- 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.
- 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 newly hired field surveyors at the request of the Health Quality Assurance (HQA) Field Offices bureau chief.

The HIPAA Compliance Office revised the presentations for New Employee Orientation and the annual Keep Informed Training as well as maintained 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.

HIPAA COMPLIANCE OFFICE

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 2019-20, the HIPAA Compliance Office responded to 613 received written requests; this is an increase of 175 requests from the previous fiscal year. The average response time to all written correspondence was 3.9 business days. In FY 2019-20, the HIPAA Compliance Office received and responded to 553 telephone inquiries. These calls were addressed in an average response time of 0.7 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.

When an impermissible disclosure of PHI occurs, Agency staff contacts the HIPAA Compliance Office for assistance and reporting. HIPAA Compliance Office staff will instruct the Agency business unit to complete and submit a reporting form to provide a general overview of the details surrounding the disclosure and provide various instructions as to how to stop the disclosure or correct it. A four-factor breach risk assessment is then performed by the HIPAA Compliance Office in accordance with 45 CFR 164.402 to determine the level of compromise to the PHI. The four factors are: the nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification; the unauthorized person who used the protected health information or to whom the disclosure was made; whether the protected health information was actually acquired or viewed; and the extent to which the risk to the protected health information has been mitigated.

If a low level of compromise to the disclosed PHI is assessed, then no further actions are required, and the associated documents are retained. If a breach is assessed, the HIPAA Office will meet with the Agency supervisor to discuss possible mitigation strategies, including personnel actions and purchasing of credit monitoring for affected individuals. The HIPAA Compliance Office will then compose and provide notification letters to those affected individuals to the Secretary of Health and Human Services, Office for Civil Rights (HHS/OCR), the federal HIPAA enforcement agency. Depending on the nature and extent of the breach, other required notifications may include the media, an online posting on the Agency's webpage, the Social Security Administration, the Florida Attorney General, credit monitoring bureaus, and applicable law enforcement agencies. Oversight agencies can open an investigation at their discretion for any report of a breach.

The HIPAA Compliance Office is also tasked with monitoring Agency Business Associates for compliance with HIPAA incident and breach reporting. The HIPAA Compliance Office staff tracks 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 2019-20. 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 revised the Agency HIPAA/HITECH Policies and Procedures Manual on physical security walkthroughs to better codify this procedure.

In FY 2019-20, the Agency saw a consolidation of their headquarter buildings. Agency staff located in Building 1 of the John Knox office complex and in offices at the Koger Center were moved into Buildings 2 and 3 at John Knox. The HIPAA Compliance Office staff performed multiple walkthroughs and provided direction to ensure that no Agency PHI was unsecured or abandoned during the moving process.

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 completed 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 reviewed unit responses, performed follow-up interviews, and conducted risk assessment activities to identify, document, and address any HIPAA risks related to Agency PHI.

An Agency-wide HIPAA risk assessment was delivered to AMT in June of 2020. This report contained a description and assessment of all identified HIPAA risks along with mitigation recommendations. The HIPAA Compliance Office is now waiting on Agency response to this report for further action.

HIPAA Compliance Office Collaboration

The HIPAA Compliance Office is often approached to join or lead various work groups and teams at the Agency to ensure HIPAA compliance is adhered from the start of an effort. One such project is working with the Agency's Enterprise Risk Management Office (ERM) on several identified risks. These workgroups involved collaboration and coordination with the ERM Office and the Agency's IT department. Some of the risks addressed by this team were previously identified and included on the Agency HIPAA Risk Assessment and some were newly identified by the ERM Office. This effort is ongoing.

The Statement of Deficiency work group is comprised of the HIPAA Compliance Office, HQA Field Office staff, and members of IT. This work group has considered and proposed various solutions for how the Agency can provide facility documents to the public and remain compliant with HIPAA regulations. This group will present a decision memorandum to AMT in the upcoming fiscal year.

The Florida Medicaid Management Information System (FMMIS) Roles work group is headed by the HIPAA Compliance Office and has members from several Medicaid business units. This workgroup reviews FMMIS 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. A decision memorandum was produced last fiscal year resulting in a collaborative pilot project between the Agency and Florida Department of Health to shift certain users from FMMIS to an existing online solution.

Required under Florida Administrative Code 60-GG, the Computer Security Incident Response Team (CSIRT) is comprised of multiple business units throughout the Agency to respond to and discuss various IT security incidents. This work group meets quarterly to discuss any current or upcoming trends in the industry and the Agency's efforts at increasing its security procedures. It is crucial that the HIPAA Compliance Office and IT department maintain a close working relationship.

The Agency is embarking on a full-scale systems shift to create a more collective approach to its inner workings. This effort resulted in the creation of the Florida Healthcare Connections (FX) unit. This unit evaluates current Agency operating procedures, proposes various solutions, creates procurement documents, evaluates vendor proposals, and supervises implementation. The HIPAA Compliance Office serves as a critical consultant on multiple aspects of this endeavor to ensure that the resulting solutions will meet the Agency's HIPAA needs and requirements.

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 Business Administration
- Juris Doctor (JD)

The Institute of Internal Auditors (IIA) 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 the 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

In accordance with the annual Audit Plan, Internal Audit 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.

Internal Audit Activities

Completed and In Progress Engagements

The following is a summary list of completed and in progress engagements as of June 30, 2020:

Report No.	Engagement	Type	Date Issued/Planned
AHCA-1718-04-A	IT Help Desk Audit	Assurance	January 2020
AHCA-1718-03-A	SMMC Capitation Rate Process	Assurance	June 2020
AHCA-1718-02-A	HQA Tracking of Final Orders	Assurance	November 2020
AHCA-1819-03-A	SMMC Detection and Investigation of Medicaid Fraud and Abuse (Prestige)	Assurance	November 2020
AHCA-1920-01-A	SMMC Detection and Investigation of Medicaid Fraud and Abuse (Humana)	Assurance	December 2020
AHCA-1819-04-A	Medicaid Fair Hearing Process	Assurance	January 2021
AHCA-1819-02-A	Electronic Payment Audit	Assurance	February 2021
AHCA-1920-03-A	SMMC Detection and Investigation of Medicaid Fraud and Abuse (United)	Assurance	March 2021
AHCA-1819-05-A	SMMC Health Plan Reporting	Assurance	May 2021
AHCA-1920-04-A	Specialty Plan Algorithm Process	Assurance	September 2021

Engagement Summaries

The following summaries describe the results of the assurance engagements completed by Internal Audit during FY 2019-20:

AHCA-1718-04-A IT Help Desk

Internal Audit conducted an audit of the Division of Information Technology (IT), Bureau of Customer Service and Support's Help Desk. The objectives of the audit were to determine the efficiency and effectiveness of the Help Desk's processes, controls, and compliance with standard procedures for managing service requests. This audit has been classified as exempt and/or confidential in accordance with Section 282.318(4)(g), F.S. and thus is not available for public distribution.

AHCA-1718-03-A SMMC Capitation Rate Process

Internal Audit conducted an audit of the Statewide Medicaid Managed Care (SMMC)

capitation rate process within the Division of Medicaid, Medicaid Finance and Analytics, Bureau of Medicaid Data Analytics (MDA). During our audit, we noted that, in general, the capitation rate process appears to follow established procedures. We noted that staff are committed to accuracy, timeliness, and compliance. However, we also noted areas where improvements are needed to strengthen controls and reduce risks. Our audit disclosed the following:

- The capitation rate process to determine and load capitation rates was not automated, increasing the potential for manual errors and the time needed for calculations, data entry, and formatting; and
- Certain activities performed within the capitation rate process, such as Long-Term Care (LTC) flagging and Blended Rates calculation, lack adequate segregation of duties and insufficient compensating controls.

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 2019-20:

- 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
- Quarterly Audit Governance Reports and Meeting Preparation
- CARES Act Agency Response Meetings
- Triennial IT Risk Assessment Review
- CIG Project - EO 20-44 – Coalition Against Domestic Violence Agency Response

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 2019-20, the following status reports for internal engagements were published:

- Cash Room Collection Process (Final Status Report)
- Employee Background Screening (18-Month and 24-Month Status Reports)
- Agency Agreements (18-Month and 24-Month Status Reports)
- Provider Eligibility Enrollment Process (Six-Month and 12-Month Status Reports)
- Accounts Receivable Collection and Write-Off Process (Six-Month and 12-Month Status Reports)
- IT Help Desk (Six-Month Status Report)
- Single Sign On Application (24-Month Status Report)

Corrective Actions Outstanding from Previous Annual Reports

As of June 30, 2020, the following corrective actions for significant recommendations described in previous annual reports were still outstanding:

AHCA Report No. 1617-07-S12: Accounts Receivable Collection and Write-Off Process, issued April 10, 2019

Recommendation: Internal Audit recommends that Financial Services coordinate with Facility Regulation in an effort to collect unpaid Office of Plans and Construction past due balances during the license renewal period, or during any other type of licensure change in which the Agency has leverage over the facility.

Most Recent Management Response (March 2020): The Bureau of Financial Services and the Division of Health Quality Assurance is in the process of implementing this recommendation. Anticipated Completion: On or before October 10, 2020.

Recommendation: Internal Audit recommends that Financial Services provide Facility Regulation periodic outstanding accounts receivable aging reports or view only access to Financial Services accounts receivable computer systems so that unpaid balances are known by Facility Regulation at the time of licensure renewal or change in ownership.

Most Recent Management Response (March 2020): The Bureau of Financial Services and the Division of Health Quality Assurance is in the process of implementing this recommendation. Anticipated Completion: On or before October 10, 2020.

Recommendation: Internal Audit recommends that Financial Services abide by Section 17.20(3)(a), F.S., to assign all delinquent accounts receivable to the collection agency according to statutory requirements, or approved Department of Financial Services (DFS) exemptions.

Most Recent Management Response (March 2020): The Bureau of Financial Services is in the process of implementing this recommendation. Anticipated Completion: On or before October 10, 2020.

Recommendation: Internal Audit recommends that Financial Services monitor account receivables by creating and utilizing an aging analysis report to determine when uncollectible debts should be referred to the collection agency.

Most Recent Management Response (March 2020): The Bureau of Financial Services is in the process of implementing this recommendation. Anticipated Completion: On or before October 10, 2020.

Recommendation: Internal Audit recommends that Financial Services update and finalize their draft collection agency referral procedures to include referrals for non-Medicaid receivables such as returned checks and facility assessments.

Most Recent Management Response (March 2020): The Bureau of Financial Services is in the process of implementing this recommendation. Anticipated Completion: On or before October 10, 2020.

AHCA Report No. 1617-05-S12: Provider Eligibility Enrollment Process, issued June 21, 2019

Recommendation: Internal Audit recommends that Medicaid Fiscal Agent Operations (MFAO) adopt a formalized quality assurance process to ensure MFAO application reviews are conducted accurately, efficiently, and timely. This process should sample a portion of reviewed applications to ensure that Provider Enrollment analysts' reviews were conducted consistently and appropriately. This process could also help identify relevant standardized practices for analysts to use in their application review process and identify applications that may have unnecessary processing delays.

Most Recent Management Response (June 2020): The Provider Enrollment supervisor has continued to pull a list of open Change Orders (CO) assigned to provider enrollment staff. The Provider Enrollment supervisor then disseminates the list of open COs based on ownership for the staff member to take appropriate action on (follow-up, closure, etc.).

The final piece to this multi-step approach in adopting a formalized quality assurance process to ensure MFAO application reviews are conducted accurately, efficiently, and timely is the sampling and review of COs closed the previous week for quality.

This has been occurring informally on a regular basis. The ultimate goal, however, is to automate the CO selection portion of process so a random sample can be pulled. The eligible sample would consist of all the COs identified in the initial pull. And, after reviewing historical volumes, a yet to be determined percentage of COs would then be reviewed for quality. Additionally, a method to track both the initial CO pull as well as those selected for follow up quality review needs to be developed. Discussions revolving around the creation of this were halted by the recent COVID-19 crisis, as priorities have temporarily shifted.

AHCA Report No. 15-08: Background Screening Clearinghouse Program issued May 5, 2016

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

Most Recent Management Response (March 2020): The Background Screening Unit currently has the ability to track the turnaround times for an initial eligibility decision on a screening result (initial review of background screening results). This covers the vast majority of criminal history results but does not include time associated with results that require additional information from the person being screened. The Clearinghouse system will be updated by October 1, 2020, and will include the ability to monitor turnaround times for analysts under all scenarios.

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 2019-20, status reports were submitted on the following external reports:

- Auditor General - State of Florida Compliance and Internal Controls Over Financial Reporting and Federal Awards Six-Month Status Report (Report No. 2019-186)

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), Florida Digital Service (FDS), 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 2019-20, the following reports were issued by external entities:

Office of the Auditor General

- Florida Retirement System and Retiree Health Insurance Subsidy Program Cost-Sharing Multiple Employer Defined Benefit Plans Deferred Outflows for Contributions Subsequent to the June 30, 2018, Measurement Date by Employer Fiscal Year Ended June 30, 2019 (Report No. 2020-019)
- State of Florida Compliance and Internal Controls Over Financial Reporting and Federal Awards (Report No. 2020-170)

OPPAGA

- OPPAGA Review of Tertiary Health Services Licensing Standards (Report No. 19-11)
- AHCA Continues to Improve Medicaid Program Data Quality and Oversight; Additional Improvements Needed in Use of Data (Report No. 20-04)
- OPPAGA Review of Florida's Organ Donation and Transplantation System (Research Memorandum dated January 22, 2020)

GAO

- Medicaid Payment: CMS Has Not Overseen States' Implementation of Changes to Third- Party Liability (Report No. GAO-19-601)

HHS

- Many Medicaid-Enrolled Children Who Were Treated for ADHD Did Not Receive Recommended Follow-up Care (Report No. OEI-07-17-00170)
- Florida Medicaid Paid Hundreds of Millions in Unallowable Payments to Jackson Memorial Hospital Under Its Low Income Pool Program (Report No. A-04-17-04058)
- CMS 2019 Medicaid Program Integrity Opioid Desk Review Report for Florida
- Florida's Refugee Medical Assistance Payments Were Generally Allowable (Report No. A-04-18-02010)
- Florida Should Improve Its Oversight of Selected Nursing Homes' Compliance With Federal Requirements For Life Safety and Emergency Preparedness (Report No. A-04-18-08065)

- Florida Made Almost $4 Million in Unallowable Capitation Payments for Beneficiaries Assigned Multiple Medicaid ID Numbers (Report No. A-04-18-07080)
- Twenty-Three States Reported Allowing Unenrolled Providers To Serve Medicaid Beneficiaries (Report No. OEI-05-19-00060)
- States Could Do More To Prevent Terminated Providers From Serving Medicaid Beneficiaries (Report No. OEI-03-19-00070)

SSA

- Social Security Administration Compliance Review Report (Report No. 2019-FL)

DMS

- DMS Florida Retirement System Audit (Summary Letter October 23, 2019)

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 2019-20, 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 COVID-19 Communicative Technology 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.

Root Cause Analysis

Both internal and external audits, including status reports on previous audit reports, showed 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 documents;

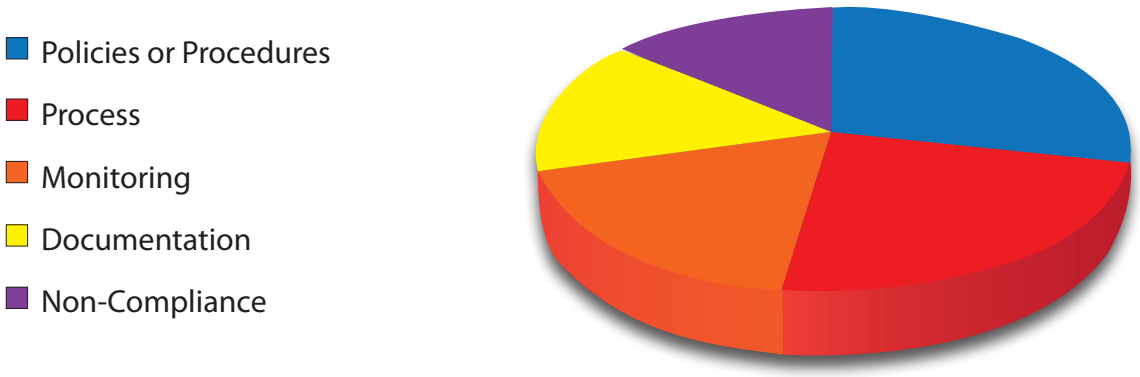
- Monitoring – Inadequate monitoring, supervisory review, or reporting of compliance with policies, procedures, contracts, or other established standards;
- Noncompliance– Nonconformity with federal guidance, legislative appropriations, state statutes, or Agency policy.

Audit Management System

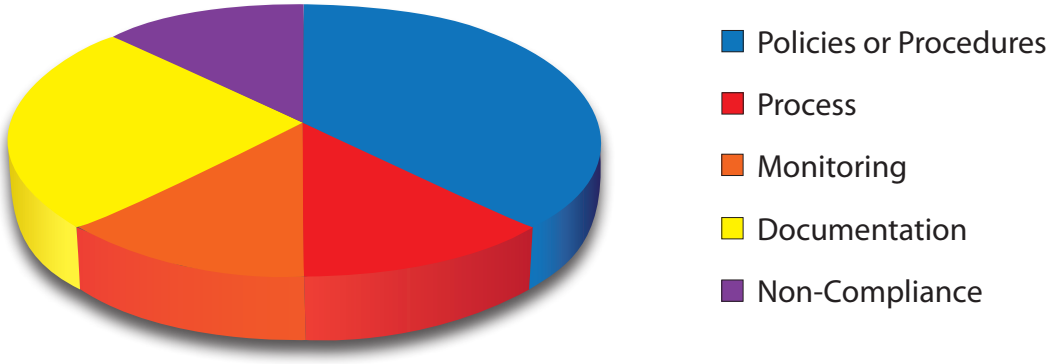
Internal Audit purchased and implemented MKinsight, an audit management system, in FY 2015-16. MKinsight tracks work performed on audits, management reviews, consulting projects, special assignments, follow-up activities, and risk assessments. The system assists with ensuring compliance with s. 20.055, F.S., IIA Standards, and other requirements by embedding such standards into its configuration.

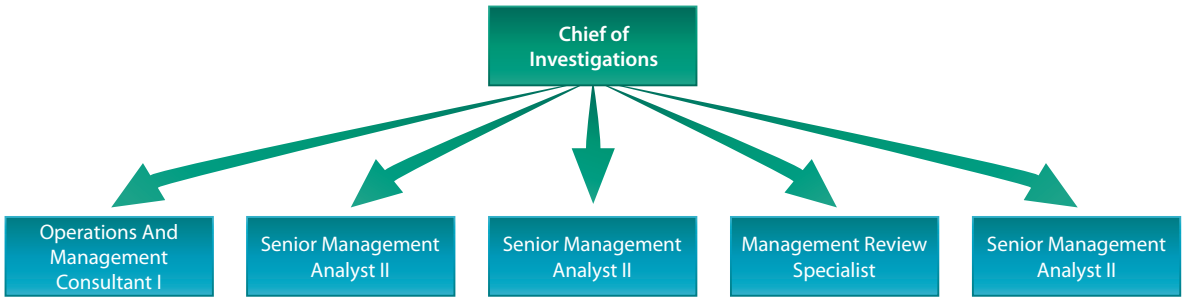
MKinsight allows Internal Audit to maintain and improve productivity, to continue to ensure standards are met, and efficiently accomplish its mission to bring a systematic, disciplined, and risk-based approach to evaluate and contribute to the improvement of the Agency's governance, risk management,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

External Audits Root Cause Analysis



Internal Audits Root Cause Analysis





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 State and Federal 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 2017, the AHCA OIG IU achieved accreditation status for a three-year term and in February 2020, the AHCA OIG IU received our first Re-accreditation status 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, 2020, include:

- Certified Inspector General Investigator (5)
- Certified Inspector General Auditor (1)
- Certified Equal Employment Opportunity Investigator (2)
- Certified Law Enforcement Officer (1)
- Certified Contract Manager (2)

Investigations Unit Functions

During FY 2019-20, the IU opened 208 new complaints and closed 214 complaints, some of which were ongoing from the previous fiscal year. For this report, the complaints were generally categorized as follows:

INVESTIGATIONS UNIT

- 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 208 complaints received by the AHCA OIG for FY 2019-20 were assessed and assigned as follows:

- 153 were referred to other AHCA Bureaus or outside agencies for proper assessment.
- 22 were assigned for Full/Preliminary 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.
- 16 were assigned for analysis to determine if the complaints met the criteria for Whistle-blower status as defined in §112.3187, F. S.
- 14 were assigned for informational purposes only.
- One was assigned to provide investigative assistance to management.
- One Initiative was opened.
- One complaint was opened in error.

In addition, the AHCA OIG IU closed 5 investigations from the previous fiscal year during the 2019-2020 fiscal year.

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 2019-2020. An index of complaints received during this reporting period is included at the end of this section.

Internal Investigation Case Highlight FY 2019-20

AHCA OIG CASE #19-04-003

This investigation was initiated upon a complaint filed by a private citizen that alleged an AHCA employee was stalking/harassing the citizen during the AHCA employees normal working hours. The AHCA OIG's investigation determined there was insufficient evidence to support the allegation of a conduct unbecoming and the case was unsubstantiated.

AHCA OIG CASE #19-04-019

This investigation was initiated upon the filing of a complaint by AHCA management alleging an AHCA employee misused AHCA resources for personal financial gain. The AHCA OIG's investigation determined there was no evidence to support the allegation of misuse and the case was unfounded.

AHCA OIG CASE #19-06-004

This investigation was initiated upon the filing of a complaint by an employee of a facility regulated by AHCA's Health Quality Assurance (HQA) division that alleged an AHCA employee engaged in conduct unbecoming a state employee by displaying aggressive behavior and using unprofessional techniques during an AHCA HQA survey. The AHCA OIG's investigation determined there was insufficient evidence to support the allegation that the AHCA employee's conduct was unbecoming of a public employee and was unsubstantiated.

AHCA OIG CASE #19-06-019

This investigation was initiated upon the filing of a complaint by AHCA management alleging an AHCA employee engaged in conduct unbecoming of a state employee by attempting to use her official position for personal gain. The AHCA OIG's investigation determined there was insufficient evidence to support the allegation that the AHCA employee misused her position for personal gain and the case was unsubstantiated.

AHCA OIG CASE #19-09-008

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 engaged in conduct unbecoming of a state employee by misusing his authority while conducting an onsite survey. The AHCA OIG's investigation determined there was insufficient evidence to support the allegation that the AHCA employee's conduct was unbecoming of a public employee and was unsubstantiated.

AHCA OIG CASE #20-01-021

This investigation was initiated upon information provided by the Tallahassee Police Department, which was found during a search warrant execution. The AHCA OIG's investigation determined there was sufficient evidence to support the allegations that an AHCA employee was failing to protect state property from loss or abuse and was negligent by failing to exercise due care and reasonable diligence in the performance of their job duties and the case was substantiated.

AHCA OIG CASE #19-09-05

This preliminary investigation was initiated upon the filing of a complaint by an employee of a facility regulated by the AHCA's HQA division that alleged misuse of funding. The AHCA OIG's preliminary investigation found the facility did not have an active Medicaid Provider agreement in place and the clients were not Medicaid recipients; therefore, the AHCA OIG did not have jurisdiction to investigate the complaint. The complainant was referred to the appropriate entity to further investigate the complaint.

AHCA OIG CASE #19-10-010

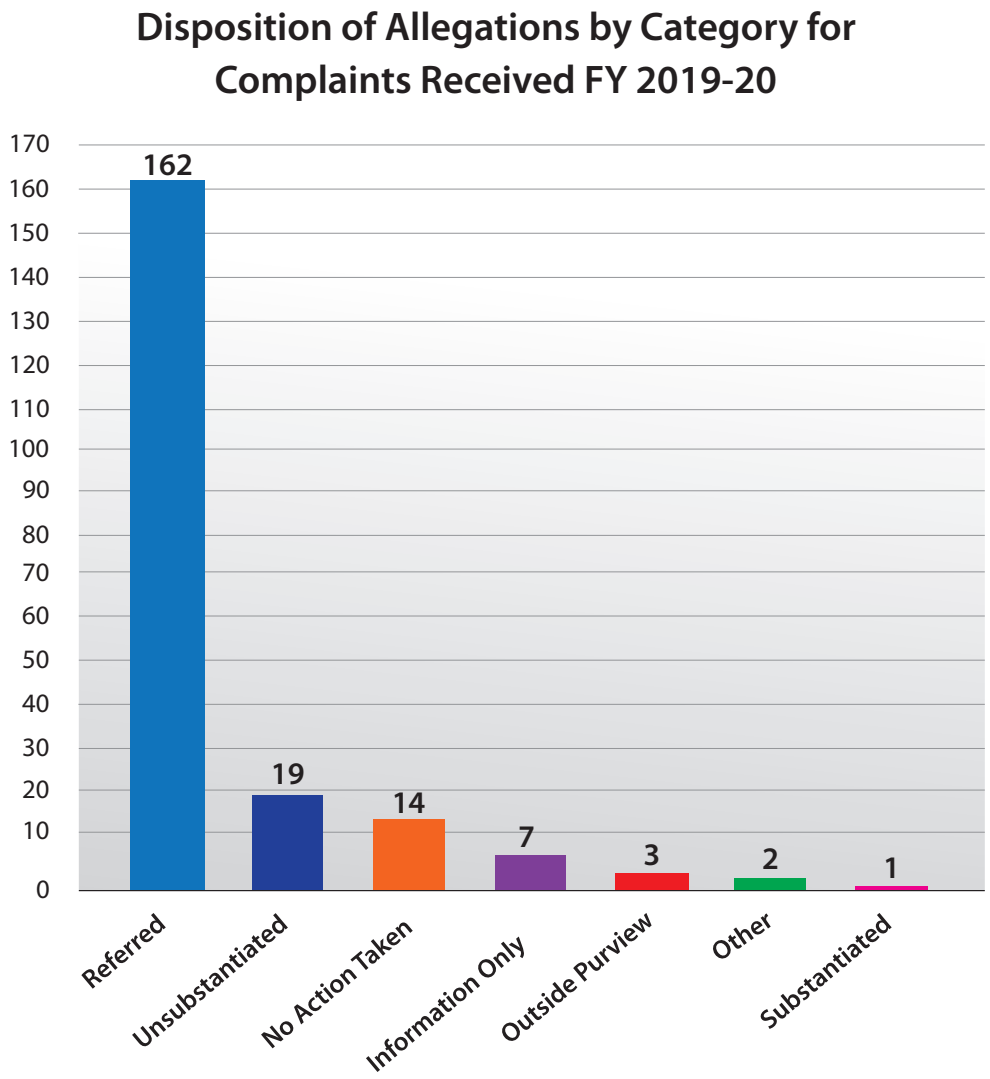
This preliminary investigation was initiated upon the filing of a complaint by an AHCA employee alleging hostile work environment caused by another AHCA employee. The AHCA OIG's preliminary investigation found there was insufficient evidence to meet the requirements for hostile work environment; however, the complaint was referred to the Deputy Secretary and Bureau of Human Resources for handling as they deemed appropriate.

AHCA OIG # 20-03-010

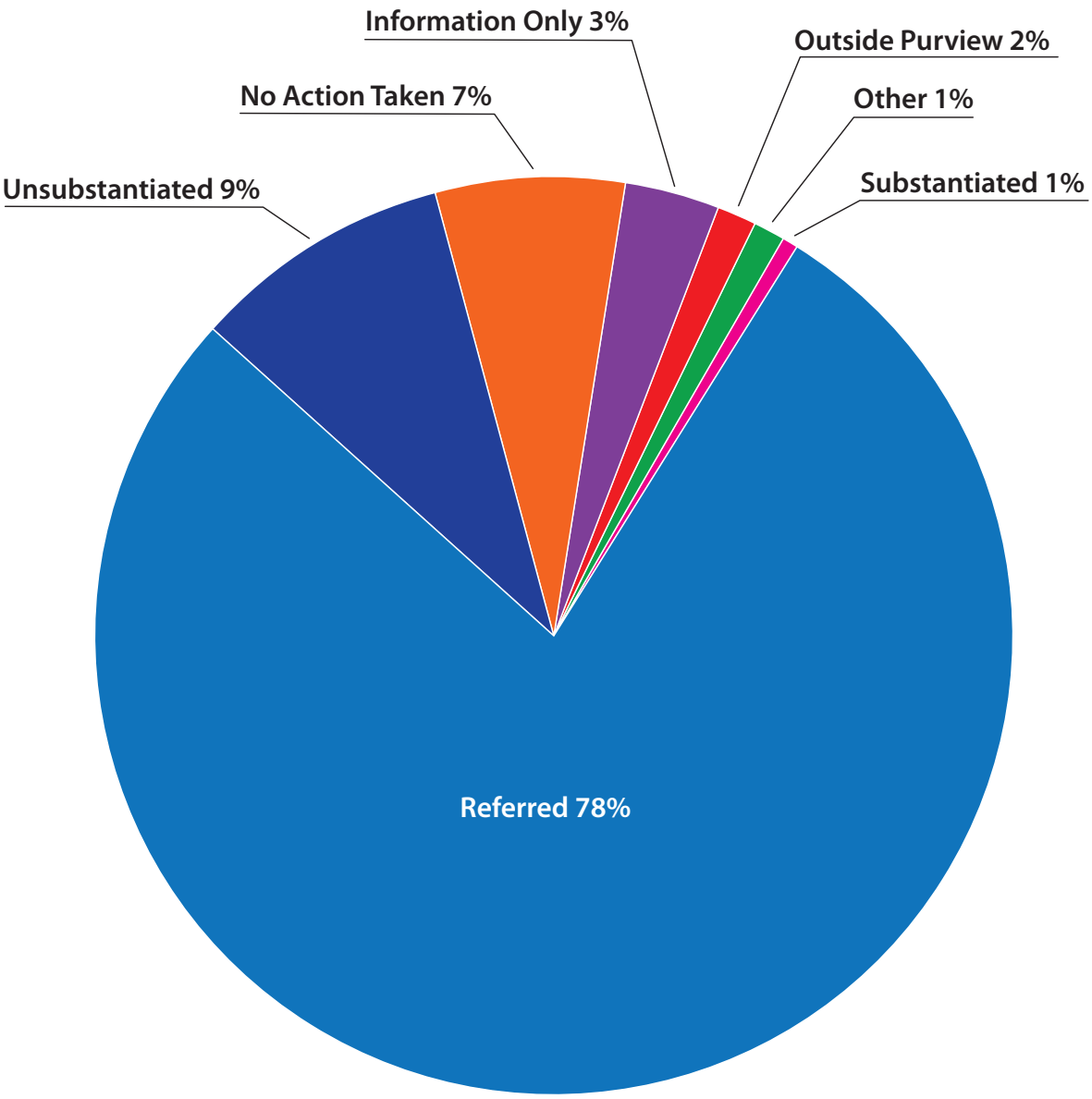
This preliminary investigation was initiated upon the filing of a complaint by a private company that alleged AHCA did not follow proper protocol during the Notice of Intent to Award during a Request for Proposal (RFP). The AHCA OIG's preliminary investigation found the Agency appropriately followed protocols in the notification of vendors; therefore, no further action was warranted.

AHCA OIG # 20-05-016

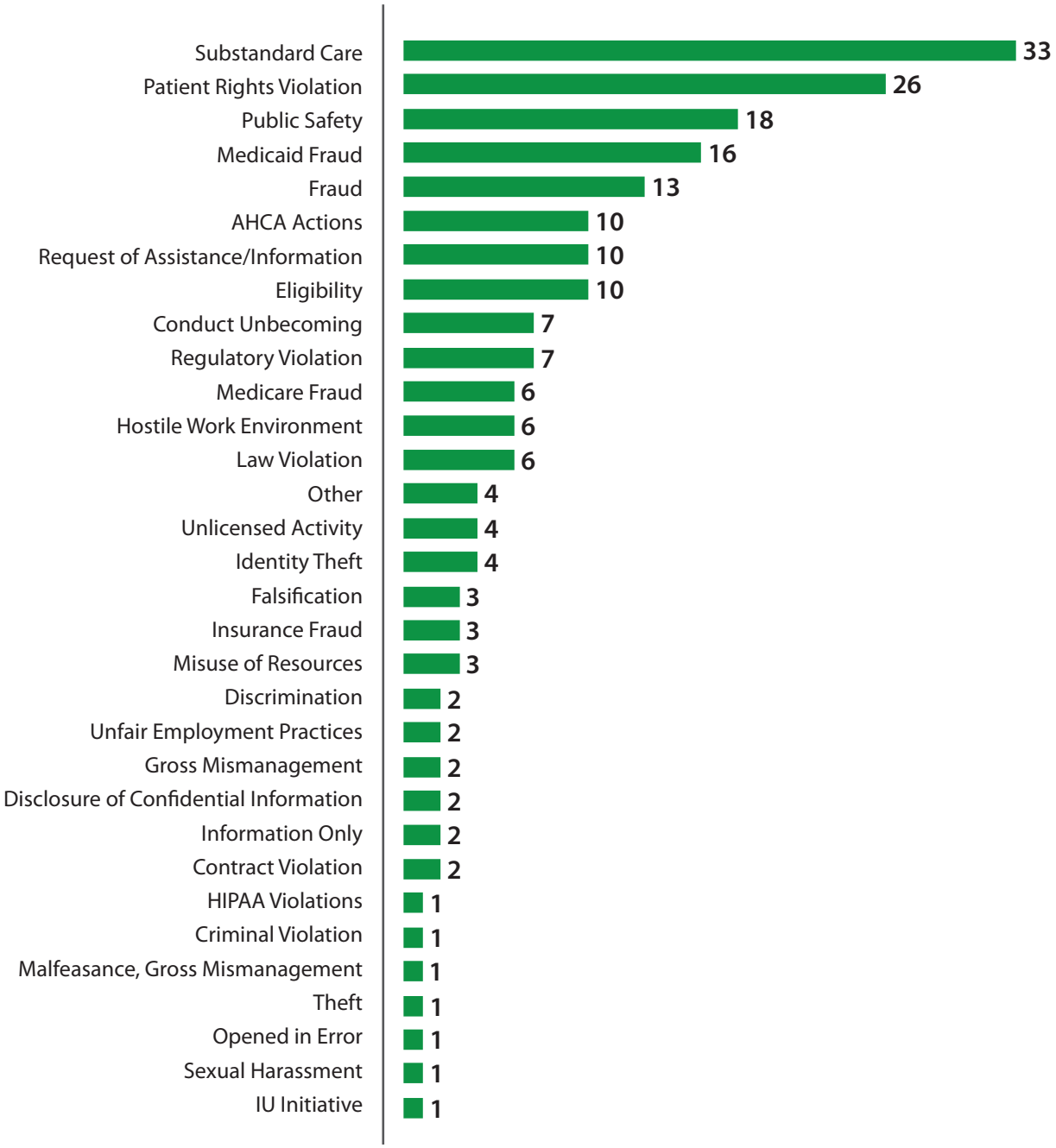
This preliminary investigation was initiated upon the filing of a complaint by an AHCA supervisor that alleged one of her direct reports forged a medical excuse and utilized another AHCA employee to submit the documents. The AHCA OIG's preliminary investigation found the forms submitted by the AHCA employee were valid and no information was obtained regarding the misuse of AHCA computers. No further action was taken by the AHCA OIG.



Disposition of Allegations by Category for Complaints Received FY 2019-20



Primary Allegations by Category for Complaints Received FY 2019-20



Complaints Received FY 2019-20

Case Number	Primary Allegation	Disposition
19-07-001	Medicaid Fraud	No Action Taken
19-07-002	Substandard Care	Referred
19-07-003	Substandard Care	Referred
19-07-004	Patient Rights Violation	Referred
19-07-005	HIPAA Violations	Referred
19-07-006	Medicaid Fraud	No Action Taken
19-07-007	Substandard Care	Referred
19-07-008	Medicaid Fraud	Referred
19-07-009	Medicaid Fraud	Referred
19-07-010	Patient Rights Violation	Referred
19-07-011	Fraud	Referred
19-07-012	Hostile Work Environment	No Action Taken
19-07-013	Insurance Fraud	Unsubstantiated
19-07-014	Other	Referred
19-07-015	Public Safety	No Action Taken
19-07-016	Fraud	Referred
19-07-017	Medicaid Fraud	Referred
19-07-018	Patient Rights Violation	Referred
19-07-019	Patient Rights Violation	Referred
19-07-020	Substandard Care	Referred
19-07-021	Medicaid Fraud	Referred
19-07-022	Substandard Care	Referred
19-07-023	Request of Assistance/Information	Referred
19-08-001	Patient Rights Violation	Referred
19-08-002	Eligibility	Referred
19-08-003	Medicaid Fraud	Referred
19-08-004	Substandard Care	Referred
19-08-005	Fraud	Outside Purview
19-08-006	Medicaid Fraud	No Action Taken
19-08-007	Patient Rights Violation	Referred
19-08-008	Law Violation	No Action Taken
19-08-009	Substandard Care	Referred
19-08-010	AHCA Actions	Referred
19-08-011	Fraud	Referred
19-08-012	Medicare Fraud	Referred
19-08-013	Regulatory Violation	Referred

Complaints Received FY 2019-20

Case Number	Primary Allegation	Disposition
19-08-014	Unlicensed Activity	Referred
19-08-015	Hostile Work Environment	Unsubstantiated
19-09-001	Fraud	No Action Taken
19-09-002	Regulatory Violation	Referred
19-09-003	Discrimination	Unsubstantiated
19-09-004	Falsification	Referred
19-09-005	Falsification	Outside Purview
19-09-006	Unlicensed Activity	Referred
19-09-007	Patient Rights Violation	Referred
19-09-008	Conduct Unbecoming	Unsubstantiated
19-09-009	AHCA Actions	No Action Taken
19-09-010	Disclosure of Confidential Information	Unsubstantiated
19-09-011	Regulatory Violation	Referred
19-09-012	Substandard Care	Referred
19-09-013	Law Violation	Referred
19-09-014	Patient Rights Violation	Referred
19-09-015	Substandard Care	Referred
19-09-016	Public Safety	No Action Taken
19-10-001	Request of Assistance/Information	Referred
19-10-002	Substandard Care	Referred
19-10-003	Medicaid Fraud	Referred
19-10-004	Patient Rights Violation	Referred
19-10-005	Regulatory Violation	Referred
19-10-006	Regulatory Violation	Referred
19-10-007	Hostile Work Environment	Unsubstantiated
19-10-008	Substandard Care	Referred
19-10-009	Conduct Unbecoming	Unsubstantiated
19-10-010	Hostile Work Environment	Unsubstantiated
19-10-011	Fraud	Referred
19-10-012	Hostile Work Environment	Unsubstantiated
19-10-013	Public Safety	Information Only
19-10-014	Public Safety	Referred
19-10-015	Substandard Care	Referred
19-10-016	Misuse of Resources	Referred
19-10-017	Public Safety	Information Only
19-10-018	Substandard Care	Referred

Complaints Received FY 2019-20

Case Number	Primary Allegation	Disposition
19-10-019	Gross Mismanagement	Referred
19-10-020	AHCA Actions	Unsubstantiated
19-10-021	Regulatory Violation	Referred
19-10-022	Hostile Work Environment	Referred
19-11-001	Public Safety	Referred
19-11-002	Conduct Unbecoming	Unsubstantiated
19-11-003	Eligibility	Referred
19-11-004	Substandard Care	Referred
19-11-005	Conduct Unbecoming	Referred
19-11-006	Patient Rights Violation	Referred
19-11-007	Patient Rights Violation	Referred
19-11-008	Identity Theft	Referred
19-11-009	AHCA Actions	Referred
19-12-001	Public Safety	Referred
19-12-002	Patient Rights Violation	Referred
19-12-003	Theft	Referred
19-12-004	Substandard Care	Referred
19-12-005	Public Safety	Referred
19-12-006	Identity Theft	No Action Taken
19-12-007	AHCA Actions	Unsubstantiated
19-12-008	Patient Rights Violation	Referred
19-12-009	Medicare Fraud	Referred
19-12-010	Substandard Care	Referred
20-01-001	Conduct Unbecoming	Unsubstantiated
20-01-002	Sexual Harassment	Referred
20-01-003	Other	Referred
20-01-004	Substandard Care	Referred
20-01-005	Substandard Care	Referred
20-01-006	Patient Rights Violation	Referred
20-01-007	Identity Theft	Referred
20-01-008	Other	Information Only
20-01-009	Medicare Fraud	Referred
20-01-010	Substandard Care	Referred
20-01-011	Eligibility	Referred
20-01-012	AHCA Actions	No Action Taken
20-01-013	Conduct Unbecoming	Unsubstantiated

Complaints Received FY 2019-20

Case Number	Primary Allegation	Disposition
20-01-014	Request of Assistance/Information	Referred
20-01-015	Eligibility	Referred
20-01-016	AHCA Actions	Referred
20-01-017	AHCA Actions	Referred
20-01-018	Patient Rights Violation	Referred
20-01-019	Eligibility	Referred
20-01-020	Patient Rights Violation	Referred
20-01-021	Conduct Unbecoming	Substantiated
20-01-022	Medicaid Fraud	Referred
20-02-001	Substandard Care	Referred
20-02-002	Discrimination	Referred
20-02-003	Substandard Care	Referred
20-02-004	Unlicensed Activity	Referred
20-02-005	Insurance Fraud	Referred
20-02-006	Regulatory Violation	Referred
20-02-007	Insurance Fraud	Referred
20-02-008	Request of Assistance/Information	Referred
20-02-009	Substandard Care	Referred
20-02-010	Law Violation	Referred
20-02-011	Substandard Care	Referred
20-03-001	Substandard Care	Referred
20-03-002	Malfeasance, Gross Mismanagement	Referred
20-03-003	Eligibility	Referred
20-03-004	Information Only	Information Only
20-03-005	Medicare Fraud	Referred
20-03-006	Criminal Violation	No Action Taken
20-03-007	Patient Rights Violation	Referred
20-03-008	Substandard Care	Referred
20-03-009	Substandard Care	Referred
20-03-010	Contract Violation	Unsubstantiated
20-03-011	Public Safety	Referred
20-03-012	Substandard Care	Referred
20-03-013	Substandard Care	Unsubstantiated
20-03-014	AHCA Actions	Referred
20-03-015	Disclosure of Confidential Information	Outside Purview
20-03-016	Eligibility	Unsubstantiated

Complaints Received FY 2019-20

Case Number	Primary Allegation	Disposition
20-03-017	Public Safety	Referred
20-03-018	Fraud	Referred
20-03-019	Gross Mismanagement	Referred
20-04-001	Substandard Care	Referred
20-04-002	Eligibility	Referred
20-04-003	Fraud	Referred
20-04-004	Request of Assistance/Information	Referred
20-04-005	Public Safety	Referred
20-04-006	Request of Assistance/Information	Referred
20-04-007	Substandard Care	Referred
20-04-008	Substandard Care	Referred
20-04-009	Unfair Employment Practices	Referred
20-04-010	Identity Theft	Referred
20-04-011	Request of Assistance/Information	Referred
20-04-012	Contract Violation	Unsubstantiated
20-04-013	Law Violation	Referred
20-04-014	Eligibility	Referred
20-04-015	Public Safety	Information Only
20-04-016	Public Safety	Referred
20-04-017	Public Safety	Referred
20-04-018	Medicaid Fraud	Referred
20-04-019	Patient Rights Violation	Referred
20-04-020	Public Safety	Referred
20-04-021	Public Safety	Referred
20-04-022	Request of Assistance/Information	Referred
20-05-001	Request of Assistance/Information	Referred
20-05-002	Medicaid Fraud	Referred
20-05-003	Patient Rights Violation	Referred
20-05-004	Patient Rights Violation	Referred
20-05-005	Fraud	Referred
20-05-006	Fraud	Referred
20-05-007	Patient Rights Violation	Referred
20-05-008	Public Safety	Referred
20-05-009	Fraud	Referred
20-05-010	Unlicensed Activity	Referred
20-05-011	Fraud	Referred

Complaints Received FY 2019-20

Case Number	Primary Allegation	Disposition
20-05-012	Medicaid Fraud	Referred
20-05-013	Medicare Fraud	Referred
20-05-014	Falsification	Referred
20-05-015	Patient Rights Violation	Referred
20-05-016	Misuse of Resources	Unsubstantiated
20-05-017	Medicaid Fraud	Referred
20-05-018	Substandard Care	Referred
20-05-019	Request of Assistance/Information	Referred
20-06-001	Medicaid Fraud	Referred
20-06-002	Patient Rights Violation	Referred
20-06-003	Law Violation	Information Only
20-06-004	Eligibility	Referred
20-06-005	Patient Rights Violation	Referred
20-06-006	Patient Rights Violation	Referred
20-06-007	Misuse of Resources	No Action Taken
20-06-008	Fraud	Referred
20-06-009	Unfair Employment Practices	No Action Taken
20-06-010	Law Violation	Referred
20-06-011	AHCA Actions	Referred
20-06-012	Medicare Fraud	Referred
20-06-013	Substandard Care	Referred
20-06-014	IU Initiative	Active
20-06-015	Public Safety	Referred
20-06-016	Information Only	Information Only
20-06-017	Other	Referred
20-06-018	Patient Rights Violation	Referred
20-06-019	Opened in Error	Opened in Error
20-06-020	Medicaid Fraud	Referred

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.

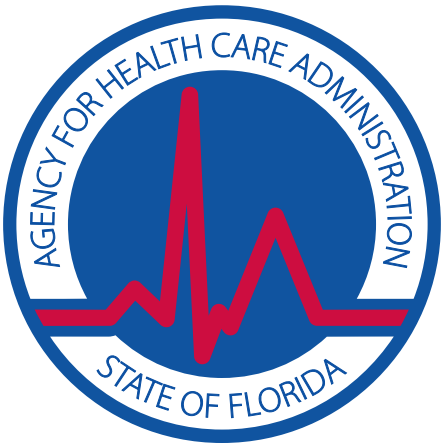
The OIG is tasked with coordinating the Agency's process for adopting and implementing an ERM program. During the summer of 2018, the Agency's Management Team received training and participated in planning and developing an ERM framework and process. Full implementation of the Agency's ERM program will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

During FY 2019-2020, Agency employees continued to receive training on the ERM process, both through the Introduction to Enterprise Risk Management and the ERM Risk Assessment training courses.

- Introduction to Enterprise Risk Management - four classes were conducted and 68 employees attended.
- ERM Risk Assessment Training – provided to 18 employees who participated in an ERM workgroup.

The ERM Coordinator has been working with the Agency Management Team in continuing to determine critical functional areas and processes and conducting risk assessments. Currently, several Agency functions are in various stages of the risk assessment process.

ERM Framework



Report Medicaid Billing Fraud at:

1-888-419-3456

or

Report Fraud Online at:

http://ahca.myflorida.com/Executive/Inspector_General/investigations.shtml

Agency for Health Care Administration

Office of the Inspector General

2727 Mahan Drive, MS4

Tallahassee, FL 32308

(850) 412-3990

(850) 921-6009 Fax

Http://AHCA.MyFlorida.com

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