Agency for Health Care Administration

OFFICE OF INSPECTOR GENERAL

ANNUAL REPORT

FISCAL YEAR 2020-2021

RON DESANTIS
GOVERNOR

SIMONE MARSTILLER
SECRETARY

September 2021

On behalf of the Agency for Health Care Administration (Agency or AHCA) Office of Inspector General (OIG), once again I am pleased to present our annual report summarizing the OIG's accomplishments during the 2020-21 fiscal year.

The OIG remains committed to our work 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 and hard work 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
Inspector General

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OUR MISSION

Better Health Care for all Floridians.

OUR VISION

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

OUR VALUES

Accountability

We are responsible, efficient, and transparent.

Fairness

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

Responsiveness

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

Teamwork

We collaborate and share our ideas.

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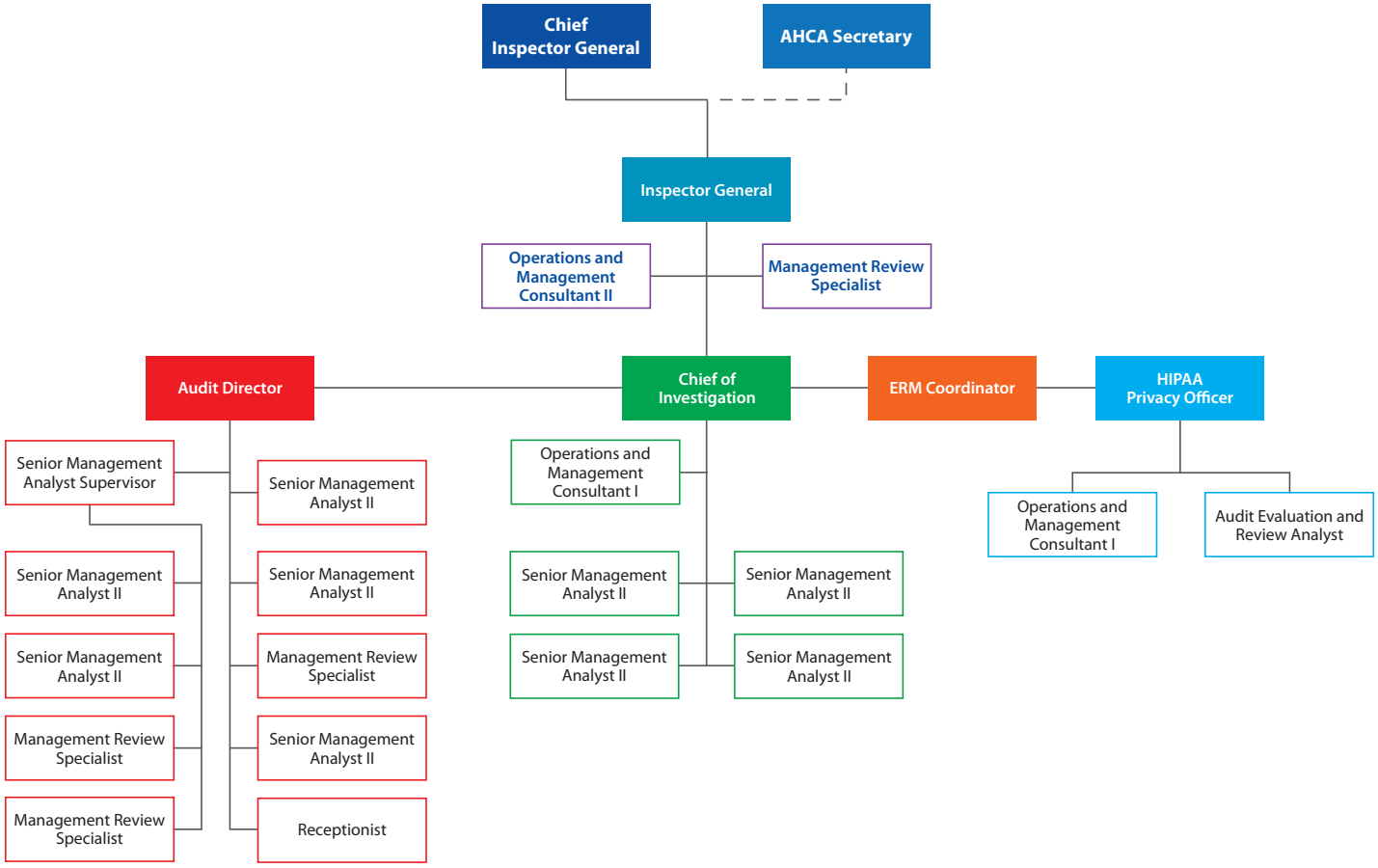
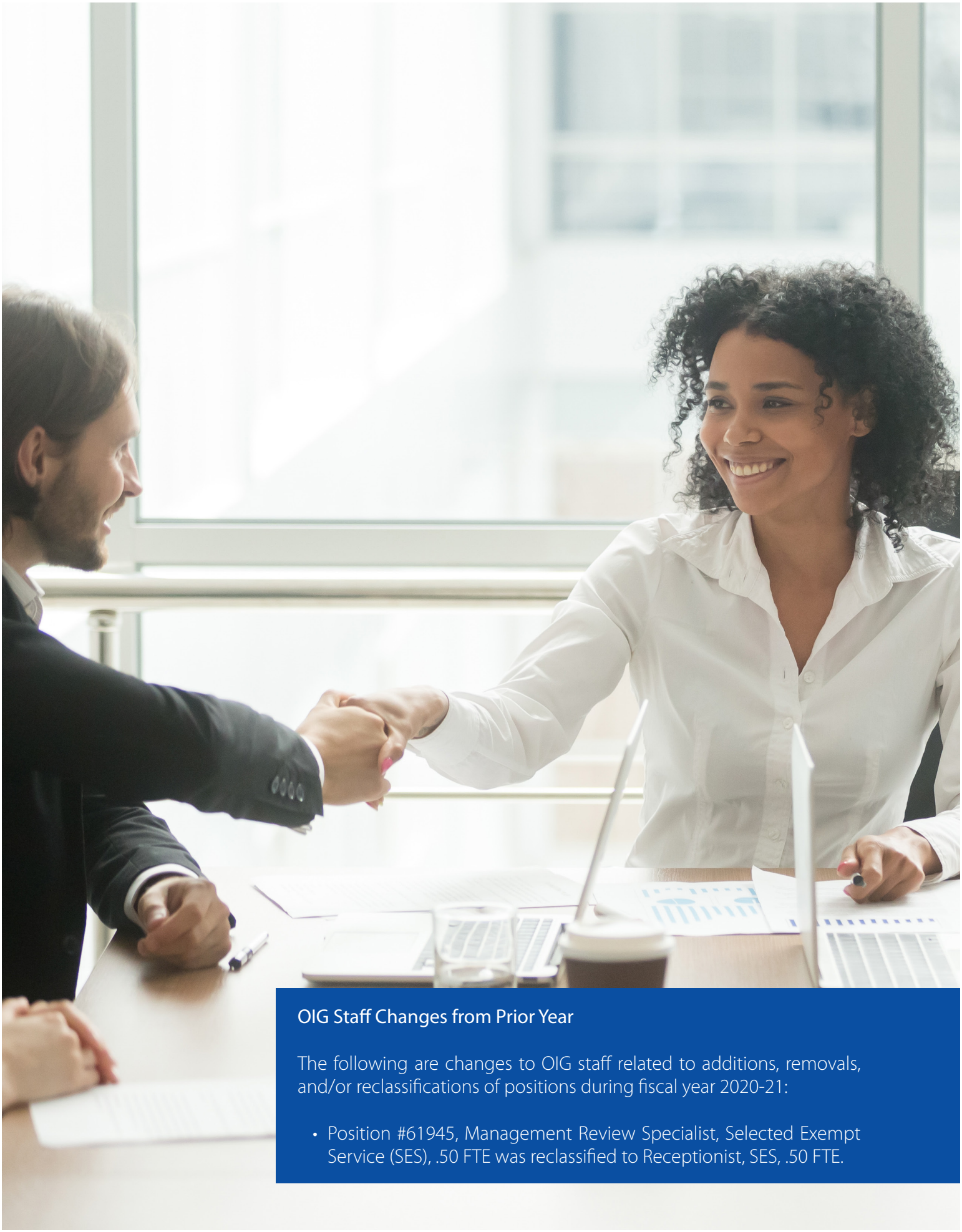
AHCA OIG ORGANIZATIONAL STRUCTURE



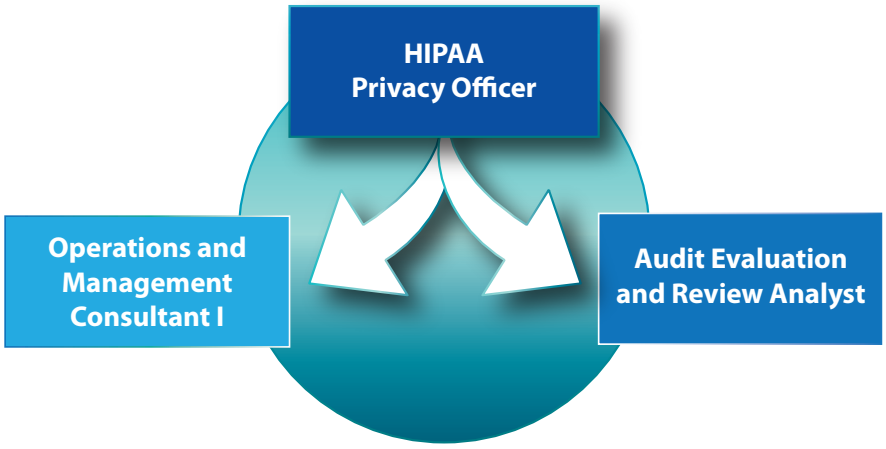


OIG Staff Changes from Prior Year

The following are changes to OIG staff related to additions, removals, and/or reclassifications of positions during fiscal year 2020-21:

- Position #61945, Management Review Specialist, Selected Exempt Service (SES), .50 FTE was reclassified to Receptionist, SES, .50 FTE.

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 (CFR), 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: Juris Doctorate (1), Master's Degree (1), Bachelor's Degree (3), Associate's Degree (2), Florida Certified in Contract Management (2), 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 is provided in the form of trainings, 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, and policy review and creation. Some additional functions, duties, and continuing projects of the HIPAA Compliance Office for Fiscal Year (FY) 2020-21 were:

- Published revisions to the Agency HIPAA-HITECH Policies and Procedures Manual.
- Reviewed and provided written comments/recommendations on Agency contractual templates involving confidential data.
- Provided comments to the federal Notice of Proposed Rule Making for the HIPAA regulations.
- Provided comments to the Resource Guide for Implementing the HIPAA Security Rule.
- Reviewed all new Agency forms or forms under revision for policy compliance and provided written comments/recommendations.
- Participated on multiple collaborative Agency work groups to ensure Agency HIPAA requirements were met.
- Continued a project to convert certain documentation to Laserfiche storage and automate HIPAA office workflows and processes where feasible.
- Updated and 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 survey and provided a report to the Agency's IG. This report included an overview of the survey results and updates to previously identified Agency HIPAA risks.
- Updated the Agency's Designated Record Set from which PHI requests are responded.
- Transitioned to a paperless routing system for HIPAA PHI requests in response to the COVID-19 pandemic and maintained this process upon return to the office.

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 FY 2020-21, the HIPAA Compliance Office provided or administered the following trainings:

- Updated 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 live 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.
- Provided a recorded web-based redaction training that's available 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 live HIPAA and HITECH privacy training to newly hired field surveyors at the request of the Health Quality Assurance (HQA) Field Offices bureau chief. This training was recorded by HQA for future training sessions.

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 provided 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 the creation or posting of any new resources.

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 2020-21, the HIPAA Compliance Office responded to 766 received written requests; this is an increase of 153 requests from the previous fiscal year. The average response time to all written correspondence was 3 business days. In FY 2020-21, the HIPAA Compliance Office received and responded to 429 telephone inquiries. These calls were addressed in an average response time of 1.5 business days.

HIPAA Breach Procedures

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 contact 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 to 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 track Medicaid managed care health plans' reports to the Agency of HIPAA privacy and security incidents and breaches and recommend Agency compliance actions resulting in the potential imposition of fines on Statewide Medicaid Managed Care (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 2020-21. These HIPAA liaisons serve as a point of contact at each of the Agency Field Offices for any related HIPAA issues and increases compliance of the HIPAA prescribed physical safeguards by performing office walkthroughs and reporting of 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 2020-21, the Agency experienced mass transition to telework in response to the COVID-19 pandemic and Agency buildings were largely unoccupied. Building walkthroughs were put on hold with an emphasis placed on self-reporting of any impermissible PHI disclosures to household members or home visitors.

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 update and refine a thorough inventory of Agency PHI location and flow. This survey was also used to add to 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. General HIPAA reminders of policy requirements and best practices were sent to all Agency units based on patterns seen in survey responses.

An associated report on the survey efforts was delivered to the Agency IG in April of 2021. This report contained a description of the survey activities, newly identified Agency HIPAA risks, and updates to existing Agency HIPAA risks since the 2019 HIPAA Risk Assessment.

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 Information Technology (IT) division. Some of the risks addressed by this team were previously identified and included on the 2019 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 the Agency Management Team (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 requests 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 and resulted in a collaborative evaluation between the Agency and Florida Department of Health for an in-depth look at access and available options. This project concluded in a final determination that current access practices are appropriate and necessary.

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 maintain a close working relationship.

The Agency is embarking on 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) office. This office 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 the 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 Inspector General Auditor
- Certified Government Auditing Professional
- Certified Internal Controls Auditor
- ITIL (Information Technology Infrastructure Library) V3 Foundation Certification
- Florida Certified Contract Manager
- Master of Arts in Teaching
- 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 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 (IIA), 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 maintenance and upgrade of audit tracking 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, 2021:

REPORT NO.	ENGAGEMENT	TYPE	DATE ISSUED/PLANNED
AHCA-1718-02-A	Tracking of HQA Final Orders	Assurance	June 2021
AHCA-1819-03-A	SMMC Detection and Investigation of Medicaid Fraud and Abuse (Prestige)	Assurance	December 2021
AHCA-1920-01-A	SMMC Detection and Investigation of Medicaid Fraud and Abuse (Humana)	Assurance	December 2021
AHCA-1920-03-A	SMMC Detection and Investigation of Medicaid Fraud and Abuse (United)	Assurance	December 2021
AHCA-1819-04-A	Medicaid Fair Hearing Process	Assurance	February 2022
AHCA-1819-02-A	Online Payment Audit	Assurance	February 2022
AHCA-1819-05-A	SMMC Health Plan Reporting	Assurance	February 2022
AHCA-2122-03-A	CIG Enterprise-wide Procurement	Compliance	March 2022
AHCA-2122-02-A	Public Records Process	Assurance	April 2022
AHCA-2122-01-A	Purchasing Card Program	Compliance	June 2022

Engagement Summaries

The following summaries describe the results of the assurance engagement completed by Internal Audit during FY 2020-21:

AHCA-1718-02-A, Tracking of HQA Final Orders

Internal Audit conducted an audit of the process for tracking and monitoring compliance with the Division of Health Quality Assurance (HQA) final orders. This audit also encompassed activities performed by the Division of Operations, Bureau of Financial Services (Financial Services) and the Office of General Counsel (OGC).

During our audit, we noted areas where improvements could be made to strengthen controls in the following areas:

- HQA staff did not consistently monitor and track final order non-monetary compliance penalties as required;
- Financial Services manual process steps for the intake of final orders and the collection of final order monetary penalties did not always properly identify final order monetary penalties;
- Different entry points in processing final order monetary penalties in Financial Services and HQA resulted in some delays in posting payment information into VERSA Regulation (VERSA;)
- Final Order monetary compliance penalties were not always updated or closed appropriately in VERSA;
- Financial Services staff sometimes misidentified and misclassified HQA final order payments; and
- HQA final orders with certain obsolete compliance requirements were issued by OGC.

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 also completed the following additional duties or projects during FY 2020-21:

- Schedule IX of the Legislative Budget Request
- Summary Schedule of Prior Audit Findings
- Department of Health and Human Services (HHS) 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 Report and Meeting Preparation
- CARES Act Agency Response Meetings – This additional duty required weekly interaction with the Executive Office of the Governor, Office of Planning and Budget, regarding appropriate reporting provisions for CARES Act funds and expenditures.
- Coronavirus Relief Funds Risk Readiness Review – The objective of this review was to assess the status of the implementation of internal controls in programs expending CARES Act funds. This review encompassed a review focused on the internal controls of the Agency's Procurement/ Acquisition, Budget, Legal, and Finance and Accounting functions, as well as a review of program areas within the Agency expending CARES Act funds.
- IT Risk Assessment Review -a review of the 2021 AHCA Cybersecurity Compliance Risk Assessment, which provided a high-level overview of compliance with the Florida Cybersecurity Standards as of March 2021.
- CIG Project: Office of the Governor Executive Order Number 20-44, Section 4 - Attestation Request – Internal Audit provided consulting assistance in reviewing the procedures and amendments to all applicable contracts and grant agreements requiring the submission of an annual report which includes compensation information for entities named in statute with which a state agency must form a sole-source, public-private agreement or an entity that, through contract or other agreement with the state, annually receives 50% or more of their budget from the State or from a combination of State and Federal funds.
- CIG House Bill (HB) 1079 Workgroup on the CIG Enterprise Procurement Compliance Audit – Internal Audit participated in a workgroup providing feedback on the implementation guidance for HB 1079 effective July 1, 2021. The legislation requires each agency inspector general to complete a risk-based compliance audit of all contracts executed by the agency for the preceding three fiscal years.

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 2020-21, the following status reports for internal engagements were published:

- Provider Eligibility Enrollment Process (18-Month and 24-Month Status Reports)
- Accounts Receivable Collection and Write-Off Process (18-Month and 24-Month Status Reports)
- IT Help Desk (12-Month Status Report)
- SMMC Capitation Rate Process (6-Month Status Report)

Corrective Actions Outstanding from Previous Annual Reports

As of June 30, 2021, except for two outstanding findings in the Confidential IT Help Desk Report which were completed on July 14, 2021, there were no corrective actions for significant recommendations described in previous annual reports that were still outstanding.

External Engagement Status Reports

Pursuant to Section 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 Section 11.51(3), F.S., OPPAGA submits requests (no later than 18 months after the release of a report) to the Agency to provide data and other information describing specifically what the Agency has done to respond to recommendations contained in OPPAGA reports. The OIG is responsible for coordinating these status reports and ensuring that they are submitted within the established timeframes.

During FY 2020-21, six-month status reports were submitted on the following external reports:

- OPPAGA - AHCA Continues to Improve Medicaid Program Data Quality and Oversight; Additional Improvements Needed in Use of Data (Report No. 20-04)
- Auditor General - State of Florida Compliance and Internal Controls Over Financial Reporting and Federal Awards (Report No. 2020-170)
- Auditor General - Analysis of Selected Medicaid Claims Data (Report No. 2021-013)
- Auditor General – Surplus Computer Hard Drive Disposal Processes at Selected State Agencies (Report No. 2021-028)

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 2020-21, the following reports were issued by external entities:

Florida Office of the Auditor General

- Analysis of Selected Medicaid Claims Data (Report No. 2021-013, August 2020)
- 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, 2019, Measurement Date by Employer Fiscal Year Ended June 30, 2020 (Report No. 2021-014, August 2020)
- Surplus Computer Hard Drive Disposal Processes at Selected State Agencies (Report No. 2021-

028, September 2020)
- State of Florida Compliance and Internal Controls Over Financial Reporting and Federal Awards (Report No. 2021-182, March 2021)
- MediKids Program Funding and Selected Administrative Activities (Report No. 2021-198, April 2021)

U.S. Government Accountability Office
- Medicaid Long-Term Services and Supports - Access and Quality Problems in Managed Care Demand Improved Oversight (Report No. GAO-21-49, November 2020)
- Medicaid - CMS Needs More Information on States' Financing and Payment Arrangements to Improve Oversight (Report No. GAO-21-98, December 2020)

U.S. Department of Health and Human Services
- Florida Received Unallowable Medicaid Reimbursement for School-Based Services (Report No. A-04-18-07075, November 2020)
- Florida Did Not Ensure That Nursing Facilities Always Reported Allegations of Potential Abuse or Neglect of Medicaid Beneficiaries and Did Not Always Assess, Prioritize, or Investigate Reported Incidents (Report No. A-04-17-08058, March 2021)

Florida Department of Financial Services
- Cash Management Improvement Act (CMIA) Consultation Report (Report No. 2019-004, November 2020)

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 Title 2 Code of Federal Regulations §200 Subpart F (Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards), or Section 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 these reviews to the program/bureau and the Agency's Contract Manager.

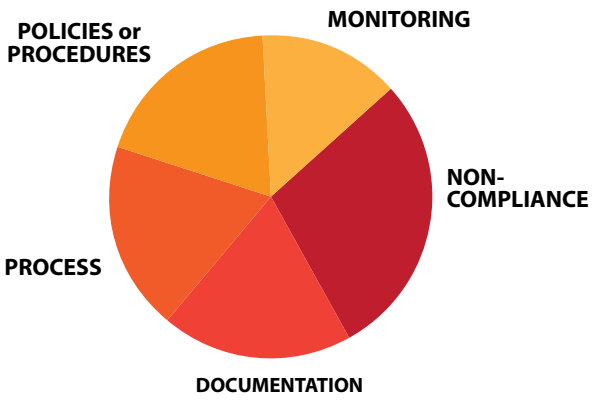
During FY 2020-21, Internal Audit continued to provide guidance to the Bureau of Financial Services and the applicable program areas to develop compliance supplement(s) for the Catalog of State Financial Assistance. Internal Audit provided assistance on the establishment of the COVID-19 Communicative Technology Program as a new State Project in the Catalog of State Financial Assistance. Internal Audit reviewed two 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

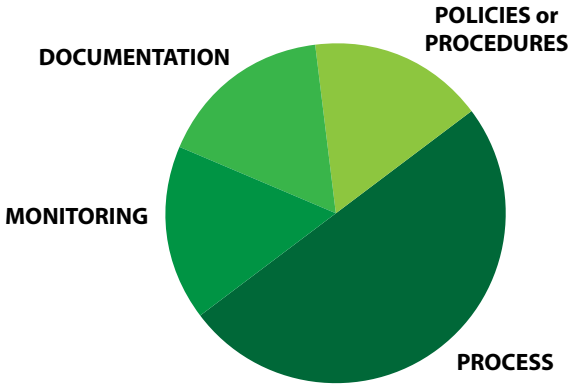
An analysis of both internal and external audit reports issued during FY 2020-21, showed audit findings with recurring themes or deficiencies in the following areas:

- 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; and
- Noncompliance– Nonconformity with federal guidance, legislative appropriations, state statutes, or Agency policy.

Root Cause of Findings for External Audits



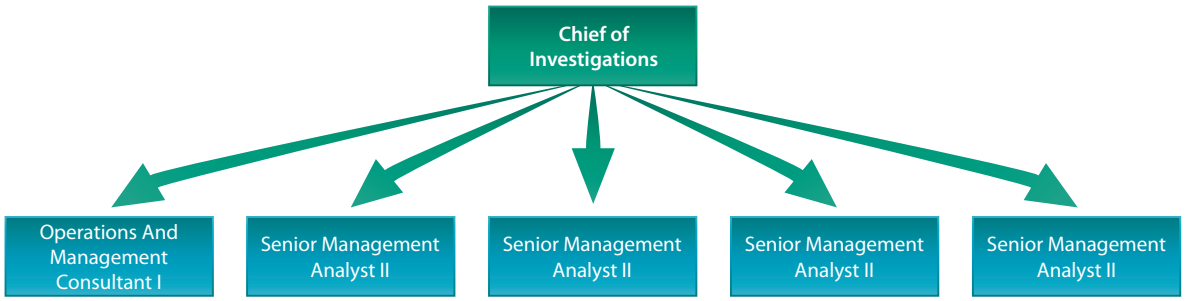
Root Cause of Findings for Internal Audits



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.



Staff and Organization

The Office of 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 their 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, 2021, 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 (3)

Investigations Unit Functions

During FY 2020-2021, the IU opened 162 new complaints and closed 160 complaints, some of which were ongoing from the previous fiscal year. For this report, the complaints were generally 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 162 complaints received by the AHCA OIG for FY 2020-2021 were assessed and assigned as follows:

- 118 were referred to other AHCA Bureaus or outside agencies for proper assessment.
- 21 were assigned for Full/Preliminary Investigation. The IU's analysis of the complaints received and investigated disclosed that most of the cases involved disparaging remarks and unprofessional conduct directed toward employees and persons outside the agency.
- 14 were assigned for analysis to determine if the complaints met the criteria for Whistle-blower status as defined in §112.3187, F.S.
- Eight were assigned for informational purposes only.
- One was assigned to provide investigative assistance to management.

In addition, two initiatives are ongoing from the previous fiscal year.

Investigations that resulted in published investigative reports were distributed to applicable Agency management responsible for remedial action (if appropriate) or to effect recommended policy changes.

The following are examples of Investigation Unit cases closed during FY 2020-2021. An index of complaints received during this reporting period is included at the end of this section.

Investigation Unit Case Highlights FY 2020-2021

AHCA OIG CASE #20-07-009

This preliminary investigation was initiated upon the receipt of information provided by the AHCA Bureau of Human Resources (HR) that alleged a policy violation of working a secondary job during normal work hours. The AHCA OIG's preliminary investigation found no evidence of any wrongdoing. No further action was taken, and the findings were referred to HR for any further action deemed appropriate.

AHCA OIG CASE #20-08-005

This preliminary investigation was initiated upon the receipt of a complaint forwarded by the Office of the Chief Inspector General that alleged a lack of impartiality by AHCA during the fair hearings process. The AHCA OIG's preliminary investigation found there was insufficient information to indicate that there was an AHCA policy violation committed by AHCA staff that would warrant further investigation. The findings were referred to AHCA's Office of General Counsel for review and any action deemed appropriate.

AHCA OIG CASE #20-08-014

This preliminary investigation was initiated upon the receipt of an email by an AHCA employee alleging hostile work environment. The AHCA OIG's preliminary investigation found there was insufficient evidence to meet the requirements for hostile work environment. The findings were referred to HR to provide communication and performance evaluation process training to staff.

AHCA OIG CASE #20-09-006

This preliminary investigation was initiated upon the filing of a complaint by an Agency for Persons with Disabilities (APD) supervisor that alleged potential misuse of computer resources by an AHCA provider. The AHCA OIG's preliminary investigation found that the AHCA provider did not have access to any AHCA systems. The findings were referred to the Bureau of Medicaid Fiscal Agent Operations for further review.

AHCA OIG CASE #20-09-008

This preliminary investigation was initiated upon the filing of an anonymous complaint that alleged an AHCA supervisor used profanity which placed the unit in a hostile work environment. The AHCA OIG's preliminary investigation found there was insufficient evidence to satisfy the elements of hostile work environment and it did not appear the AHCA supervisor was verbally abusive towards her direct reports. The findings were referred to HR for any further action deemed appropriate.

AHCA OIG CASE #20-10-012

This preliminary investigation was initiated upon the filing of a complaint forwarded to the AHCA OIG by AHCA's Office of Communications that alleged a recipient had issues with their insurance provider. The AHCA OIG's preliminary investigation found no evidence of employee misconduct and referred the complaint to the Bureau of Recipient and Provider Assistance.

AHCA OIG CASE #21-01-009

This preliminary investigation was initiated upon the filing of a complaint by an AHCA employee that alleged discrimination, retaliation, and unfair treatment by an AHCA supervisor. The AHCA OIG's preliminary investigation found that the complainant was not able to provide actions that rises to the level of discrimination under Equal Employment Opportunity Commission guidelines and the findings were referred to HR for any further action deemed appropriate.

AHCA OIG CASE #21-02-002

This preliminary investigation was initiated upon the filing of a complaint by a Medicaid provider who alleged they were potentially scammed into sending money to an individual pretending to be an AHCA employee by using a similar looking work email address. The AHCA OIG's preliminary investigation determined the AHCA OIG does not have jurisdiction over this case. The provider contacted law enforcement and the case is being reviewed criminally.

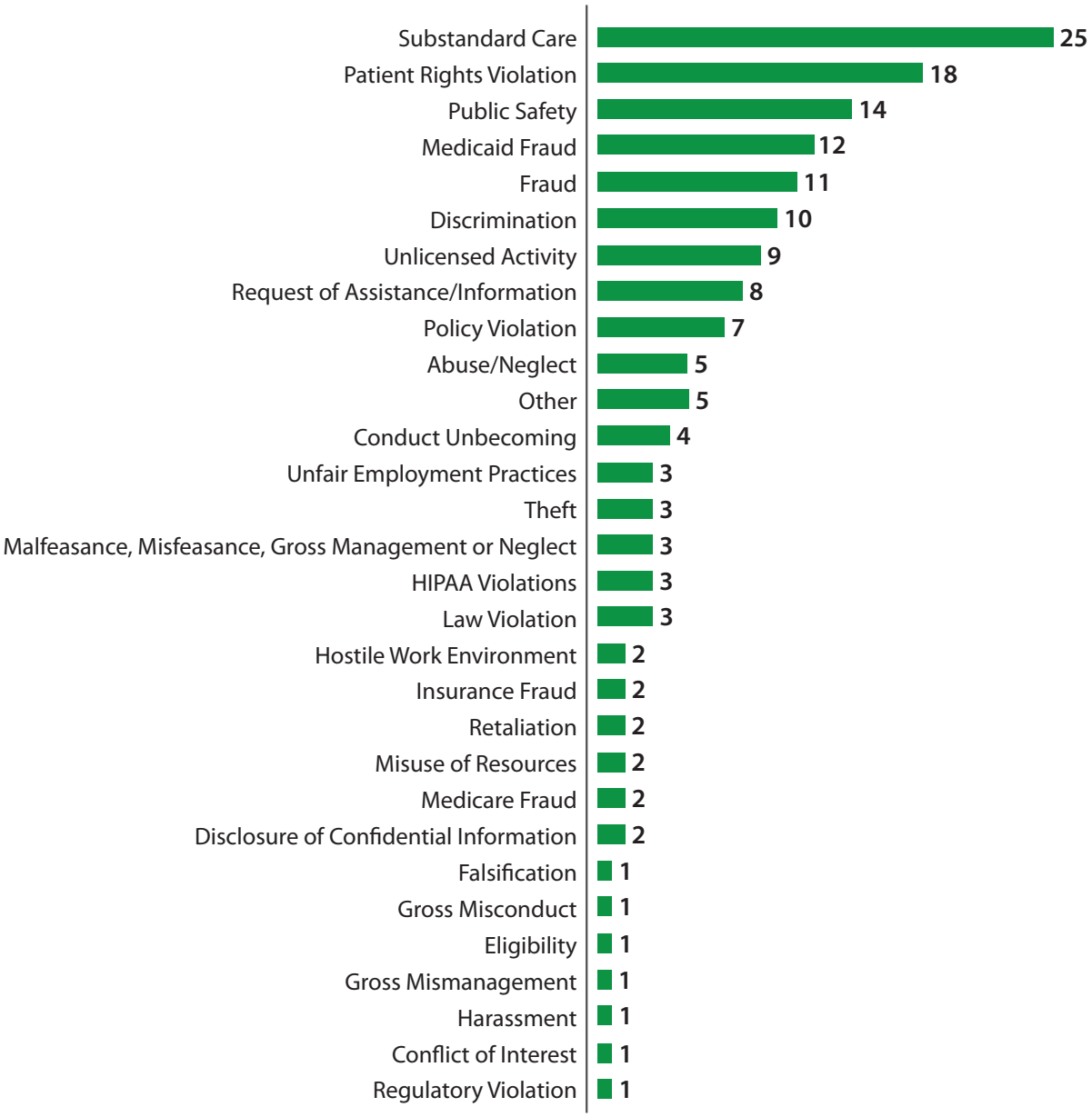
AHCA OIG CASE #21-03-014

This preliminary investigation was initiated upon receipt of information provided by the AHCA Bureau of Human Resources regarding an exit interview form from a former AHCA employee for alleged bullying, harassment, and discrimination by multiple AHCA supervisors. The AHCA OIG's preliminary investigation determined there was insufficient evidence to support the allegations. No further action was taken.

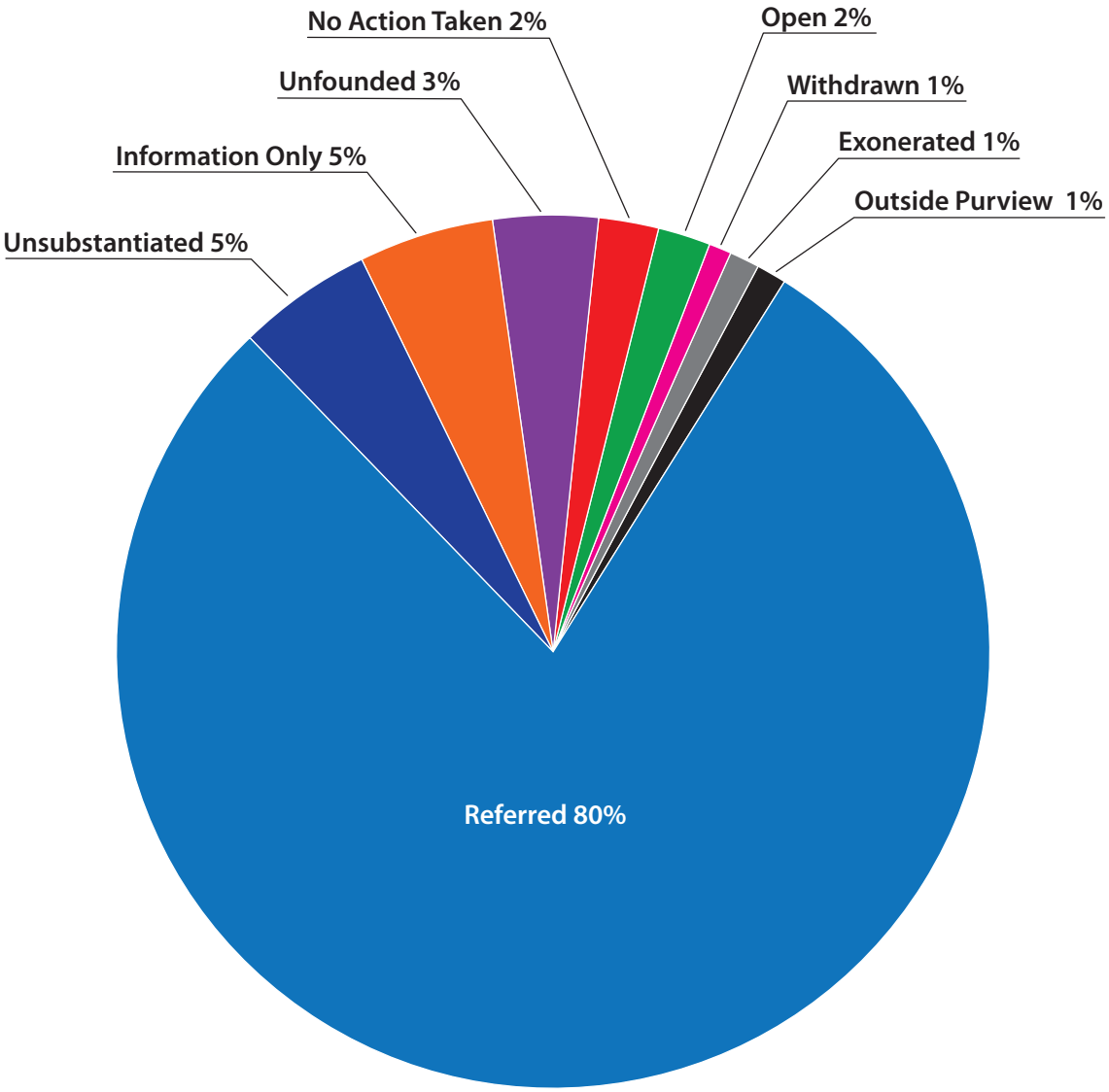
AHCA OIG CASE #21-02-008

This investigation was initiated upon the filing of a complaint by an AHCA employee alleging a policy violation regarding disciplinary action and violation of HQA procedures for investigating complaints on survey staff. The AHCA supervisor was exonerated regarding policy violation for disciplinary action and violating procedures for investigating complaints on survey staff. Policy recommendations were made and forwarded to management.

Primary Allegations by Category for Complaints Received FY 2020-21



Disposition of Allegations by Category for Complaints Received FY 2020-21



Complaints Received FY 2020-21

Case Number	Primary Allegation	Disposition
20-07-001	Unfair Employment Practices	Referred
20-07-002	Substandard Care	Referred
20-07-003	Law Violation	Referred
20-07-004	Substandard Care	Referred
20-07-005	Public Safety	Referred
20-07-006	Public Safety	Referred
20-07-007	Substandard Care	Referred
20-07-008	Discrimination	Referred
20-07-009	Conduct Unbecoming	Unfounded
20-07-010	Public Safety	Referred
20-07-011	Malfeasance, Misfeasance, Gross Management or Neglect	Referred
20-07-012	Fraud	Referred
20-07-013	Public Safety	Referred
20-07-014	Public Safety	Referred
20-07-015	Insurance Fraud	Referred
20-07-016	Policy Violation	Unfounded
20-07-017	Patient Rights Violation	Referred
20-07-018	Substandard Care	Referred
20-07-019	Fraud	Referred
20-07-020	Patient Rights Violation	Referred
20-07-021	Medicaid Fraud	Referred
20-08-001	Fraud	Referred
20-08-002	Abuse/Neglect	Referred
20-08-004	Public Safety	Referred
20-08-005	Conflict of Interest	Unsubstantiated
20-08-006	Substandard Care	Referred
20-08-007	Patient Rights Violation	Referred
20-08-008	Medicaid Fraud	Referred
20-08-009	Patient Rights Violation	Referred
20-08-010	Request of Assistance/Information	Referred
20-08-011	Substandard Care	Referred
20-08-012	Substandard Care	Referred
20-08-013	Substandard Care	Referred
20-08-014	Hostile Work Environment	Unsubstantiated
20-08-015	Substandard Care	Referred

Complaints Received FY 2020-21

Case Number	Primary Allegation	Disposition
20-08-016	Public Safety	Referred
20-08-017	Patient Rights Violation	Referred
20-08-018	Misuse of Resources	Referred
20-08-019	Patient Rights Violation	Referred
20-08-020	Discrimination	Referred
20-08-021	Patient Rights Violation	Referred
20-09-001	Substandard Care	Referred
20-09-002	Patient Rights Violation	Referred
20-09-003	Eligibility	Referred
20-09-004	Patient Rights Violation	Referred
20-09-005	Malfeasance, Misfeasance, Gross Management or Neglect	Referred
20-09-006	Misuse of Resources	Unsubstantiated
20-09-007	Public Safety	Referred
20-09-008	Hostile Work Environment	Unsubstantiated
20-09-009	Patient Rights Violation	Referred
20-09-010	Request of Assistance/Information	Referred
20-09-011	Abuse/Neglect	Referred
20-09-012	Fraud	Referred
20-10-001	Public Safety	Referred
20-10-002	Other	Referred
20-10-003	Medicaid Fraud	Referred
20-10-004	Harassment	Referred
20-10-005	Patient Rights Violation	Referred
20-10-006	Other	Referred
20-10-007	Substandard Care	Referred
20-10-009	Request of Assistance/Information	Referred
20-10-010	Regulatory Violation	Referred
20-10-011	Fraud	Referred
20-10-012	Request of Assistance/Information	Unfounded
20-10-013	Medicaid Fraud	Referred
20-11-001	Conduct Unbecoming	Unfounded
20-11-002	Substandard Care	Referred
20-11-003	Substandard Care	Referred
20-11-004	Substandard Care	Referred
20-11-005	Retaliation	Referred
20-11-006	Other	Referred

Complaints Received FY 2020-21

Case Number	Primary Allegation	Disposition
20-11-007	Discrimination	Referred
20-11-009	Request of Assistance/Information	Information Only
20-11-010	Substandard Care	Referred
20-11-011	Substandard Care	Referred
20-12-001	Fraud	Referred
20-12-002	Policy Violation	Information Only
20-12-003	Other	Referred
20-12-004	Medicaid Fraud	Referred
20-12-005	Medicaid Fraud	Referred
21-01-001	Retaliation	Referred
21-01-002	Substandard Care	Referred
21-01-003	Unlicensed Activity	Referred
21-01-004	Substandard Care	Referred
21-01-005	Theft	Referred
21-01-006	Medicaid Fraud	Referred
21-01-007	Public Safety	Referred
21-01-008	Patient Rights Violation	Referred
21-01-009	Discrimination	Unsubstantiated
21-01-010	Request of Assistance/Information	Referred
21-01-011	Gross Mismanagement	Referred
21-02-001	Disclosure of Confidential Information	Referred
21-02-002	Fraud	Outside Purview
21-02-003	Theft	Referred
21-02-004	Abuse/Neglect	Referred
21-02-005	Policy Violation	Referred
21-02-006	Unfair Employment Practices	Referred
21-02-007	Disclosure of Confidential Information	Referred
21-02-008	Policy Violation	Exonerated
21-02-009	HIPAA Violations	Referred
21-02-010	Policy Violation	Referred
21-02-011	Medicaid Fraud	Referred
21-03-001	Substandard Care	Referred
21-03-002	Discrimination	Unsubstantiated
21-03-003	Discrimination	Withdrawn
21-03-004	Insurance Fraud	Referred
21-03-005	Substandard Care	Referred
21-03-006	Medicare Fraud	Information Only

Complaints Received FY 2020-21

Case Number	Primary Allegation	Disposition
21-03-007	Patient Rights Violation	Referred
21-03-008	Medicaid Fraud	Referred
21-03-009	Fraud	Referred
21-03-010	Public Safety	Information Only
21-03-011	Medicaid Fraud	Referred
21-03-012	Policy Violation	Unfounded
21-03-013	Medicaid Fraud	Referred
21-03-014	Discrimination	Unsubstantiated
21-03-015	Discrimination	Referred
21-04-001	Policy Violation	Referred
21-04-002	Patient Rights Violation	Referred
21-04-003	Discrimination	Withdrawn
21-04-004	HIPAA Violations	Information Only
21-04-005	Substandard Care	Referred
21-04-006	Substandard Care	Referred
21-04-007	Patient Rights Violation	Referred
21-04-008	Falsification	Open
21-04-009	Substandard Care	Referred
21-04-010	Patient Rights Violation	Referred
21-04-011	Unlicensed Activity	Referred
21-04-012	Discrimination	No Action Taken
21-05-001	Unlicensed Activity	Referred
21-05-002	Unlicensed Activity	Referred
21-05-003	Other	Referred
21-05-004	Law Violation	No Action Taken
21-05-005	Fraud	Referred
21-05-006	Substandard Care	Referred
21-05-007	Unlicensed Activity	Referred
21-05-008	Fraud	Referred
21-05-009	HIPAA Violations	Referred
21-05-010	Patient Rights Violation	Referred
21-05-011	Malfeasance, Misfeasance, Gross Management or Neglect	Referred
21-05-012	Conduct Unbecoming	Unsubstantiated
21-05-013	Unlicensed Activity	Referred
21-05-014	Abuse/Neglect	Referred
21-05-015	Public Safety	Information Only

Complaints Received FY 2020-21

Case Number	Primary Allegation	Disposition
21-05-016	Medicare Fraud	Referred
21-05-017	Unlicensed Activity	Referred
21-05-018	Unlicensed Activity	Referred
21-05-019	Abuse/Neglect	Referred
21-06-001	Request of Assistance/Information	Referred
21-06-002	Theft	Referred
21-06-003	Patient Rights Violation	Referred
21-06-004	Conduct Unbecoming	Unfounded
21-06-005	Public Safety	Information Only
21-06-006	Request of Assistance/Information	Referred
21-06-007	Unlicensed Activity	Referred
21-06-008	Fraud	Referred
21-06-009	Medicaid Fraud	Referred
21-06-010	Gross Misconduct	Open
21-06-011	Substandard Care	Information Only
21-06-012	Unfair Employment Practices	No Action Taken
21-06-013	Public Safety	Referred
21-06-014	Law Violation	Open

Case numbers 20-08-003, 20-10-008, and 20-11-008 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 2020-2021, the Agency moved the Introduction to Enterprise Risk Management course to an on-line format to encourage more employees to take the course. A total of 96 employees participated in the training during FY 2020-2021.

A risk survey was conducted for all areas of the Agency to determine areas of concern and to aid the ERM Coordinator in planning future risk assessments. The ERM Coordinator continues to work 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.

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