AGENCY FOR HEALTH CARE ADMINISTRATION
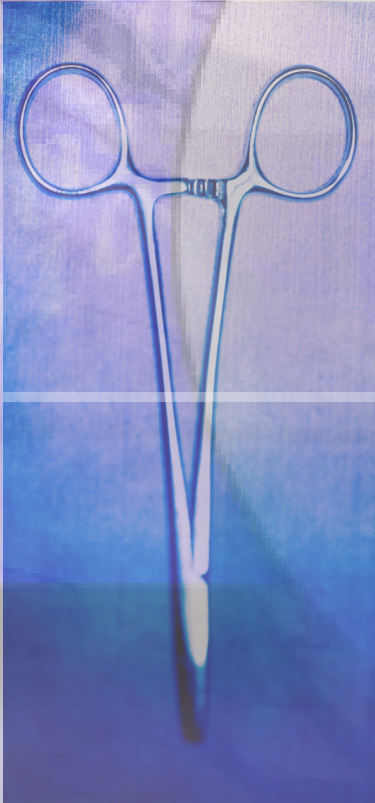
OFFICE OF THE INSPECTOR GENERAL

ANNUAL REPORT FY 2008-2009

SEPTEMBER 2009

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

AHCA
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Better Health Care for all Floridians

September 30, 2009

Holly Benson, Secretary
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, FL 32308

Dear Secretary Benson:

In accordance with Section 20.055(7), Florida Statutes, I am pleased to submit the Office of the Inspector General's Annual Report for the fiscal year ending June 30, 2009. This report reflects the major work activities of the Internal Audit Unit, the Internal Investigations Unit and the Bureau of Medicaid Program Integrity.

We look forward to continuing our work with you and all Agency for Health Care Administration staff in championing better health care for all Floridians.

Respectfully submitted,

Peter Williams
Inspector General

PW/sb

Enclosure

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Background

The Office of the Inspector General (OIG) is an integral part of the Agency for Health Care Administration (Agency). The purpose of the OIG is to provide a central point for coordination of, and responsibility for, activities that promote accountability, integrity and efficiency in the Agency. Section 20.055, Florida Statutes (F. S.), defines the duties and responsibilities of each inspector general, with respect to the state agency or department in which the office is established.

The statute requires that the OIG submit to the Agency Secretary an annual report, not later than September 30 of each year, summarizing its activities during the preceding state fiscal year. This report includes but is not limited to:

- A description of significant abuses and deficiencies relating to the administration of programs and operations of the Agency disclosed by investigations, audits, reviews or other activities during the reporting period;
- A description of recommendations for corrective action made by the Inspector General during the reporting period with respect to significant problems, abuses or deficiencies identified;
- The identification of each significant recommendation described in previous annual reports on which corrective action has not been completed; and
- A summary of each audit and investigation completed during the reporting period.

This document is presented to the Secretary to comply with these statutory requirements and to provide information on the OIG's progress in completing its mission as defined by Florida law.

Mission Statement

The primary mission of the OIG is to assist the Secretary and other Agency management in championing accessible, affordable, quality health care for all Floridians by assessing the efficiency and effectiveness of health care administration resource management.

This is accomplished by providing an independent examination and evaluation of Agency programs, activities and resources and by conducting internal investigations of alleged violations of Agency policies, procedures, rules or laws. Reports of findings are prepared and distributed to appropriate management. Additionally, the Inspector General's mission is accomplished by providing oversight to the Bureau of Internal Audit, the Internal Investigations Unit and to the Bureau of Medicaid Program Integrity. The organizational chart below provides the structure of the OIG. In addition to the typical audit and investigative functions of an Office of Inspector General, the OIG for

the Agency for Health Care Administration has responsibility for the Bureau of Medicaid Program Integrity (MPI), whose primary mission is to prevent, detect and recoup Medicaid fraud, abuse or overpayments.

OIG Organizational Chart
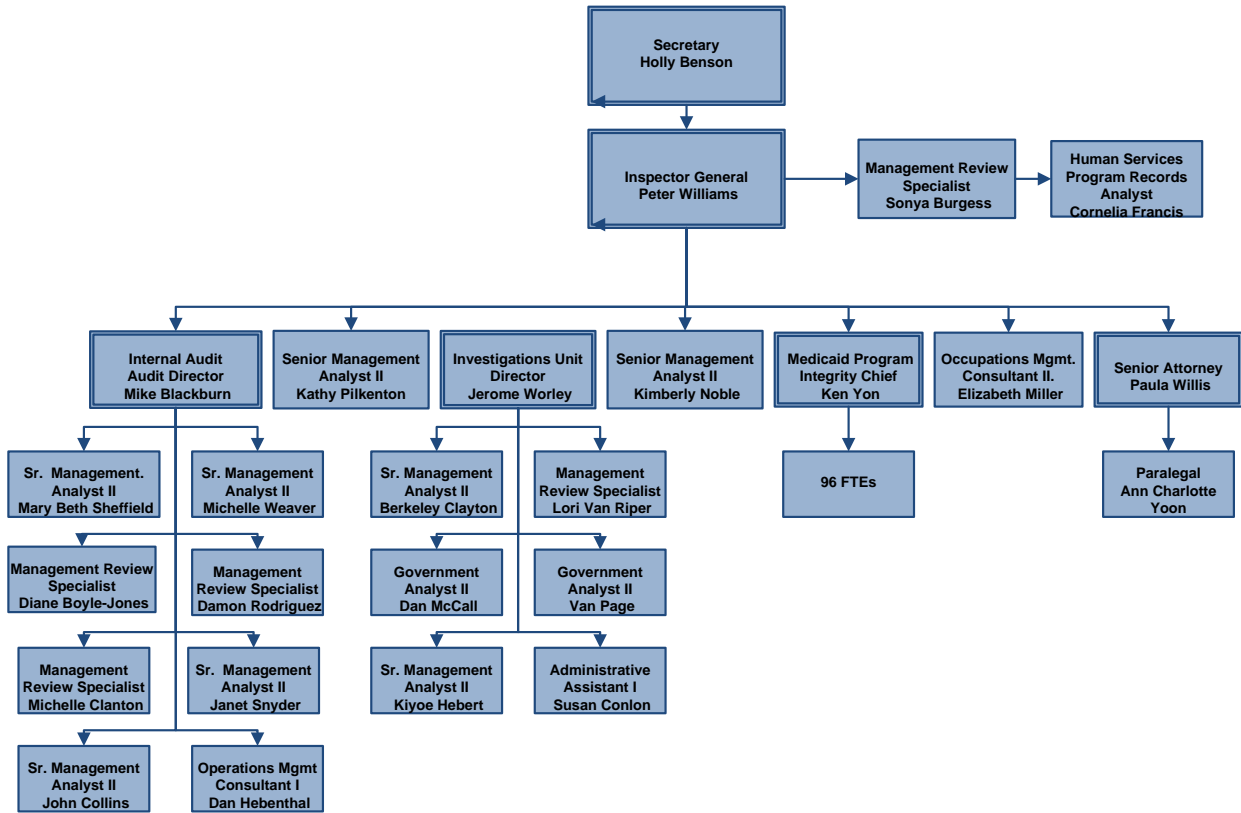
OIG Responsibilities

The specific duties and responsibilities of the Inspector General, according to Section 20.055(2), F. S., include:

- Reviewing actions taken by the Agency to improve program performance and meet program standards;
- Conducting, supervising or coordinating other activities to promote economy and efficiency in the administration of, or preventing and detecting fraud and abuse in its programs and operations;
- Reporting to the Agency head concerning fraud, abuses and deficiencies, recommending corrective action and reporting on the progress made in implementing corrective action;
- Ensuring effective coordination and cooperation between the Auditor General, federal auditors and other governmental bodies;

- Reviewing rules, as appropriate, relating to the programs and operations of the Agency; and
- Ensuring that an appropriate balance is maintained between audit, investigative and other accountability activities.

In addition, the Inspector General is required to initiate, conduct, supervise and coordinate investigations designed to detect, deter, prevent and eradicate fraud, waste, mismanagement, misconduct and other abuses in the Agency. The investigative duties and responsibilities of the Inspector General, pursuant to Section 20.055(6), F. S., include:

- Receiving complaints and coordinating activities of the Agency as required by the Whistle-blower's Act pursuant to Sections 112.3187 – 112.31895, F. S.;
- Receiving and considering the complaints which do not meet the criteria for an investigation under the Whistle-blower's Act and conducting, supervising or coordinating such inquiries, investigations or reviews as the Inspector General deems appropriate;
- Reporting expeditiously to the Department of Law Enforcement or other law enforcement agencies, as appropriate, whenever the Inspector General has reasonable grounds to believe there has been a violation of criminal law;
- Conducting investigations and other inquiries free of actual or perceived impairment to the independence of the Inspector General or the OIG. This includes freedom from any interference with investigations and timely access to records and other sources of information; and
- Submitting final reports on investigations conducted by the Inspector General to the Agency head, except for Whistle-blower's investigations, which are conducted and reported pursuant to Section 112.3189, F. S.

Internal Audit

Internal Audit Functions

The purpose of the Bureau of Internal Audit (IA) is to provide independent, objective assurance and consulting services designed to add value and improve the Agency's operations. Our mission is to assist the Secretary and other Agency management in ensuring better health care for all Floridians by bringing a systematic, objective approach to evaluate and improve the effectiveness of risk management, control and governance processes.

Assurance Engagements

These engagements are conducted to determine if a unit's system of internal controls is adequate to accomplish its business objectives and encompass:

- Reliability and integrity of information;
- Compliance with policies, procedures, laws and regulations;
- Safeguarding of assets;
- Economic and efficient use of resources; and
- Accomplishment of established objectives and goals for operations or programs.

Assurance engagements are performed in accordance with the *International Standards for the Professional Practice of Internal Auditing (Standards)* (i.e., "red book") published by the Institute of Internal Auditors (IIA). Where appropriate, the OIG adheres to the standards developed by the Comptroller General of the United States codified in *Government Auditing Standards* (i.e., "yellow book").

Assurance engagements result in written reports of findings and recommendations, including responses by management. These reports are distributed internally to the Agency Secretary and affected program managers, to the Office of the Governor's Chief Inspector General (Chief IG) and to the Office of the Auditor General.

Consulting Engagements

These engagements provide assistance to Agency management or staff for the purpose of improving specific program operations or processes. In performing consulting engagements, IA's objective is to assist management or staff to add value to agency programs by streamlining operations, enhancing controls and implementing best practices. Some examples of consulting engagements include:

- Reviewing processes and interviewing staff within specific areas to identify process weaknesses and make recommendations for improvement;
- Determining how a specific process or activity affects other units of the agency;
- Facilitating meetings and coordinating with staff of affected units to propose recommendations for process improvements, seek alternative solutions and determine feasibility of implementation;
- Facilitating adoption and implementation between management and staff, or between agency units;
- Participating in process action teams;
- Reviewing planned or new processes to determine efficiency, effectiveness or adequacy of internal controls; and
- Preparing flow charts or narratives of processes for management.

Where appropriate consulting engagements will be performed in accordance with the *Standards* published by the IIA. Written reports may be issued to affected program managers.

Management Reviews

Management Reviews are reviews of Agency units, programs or processes to assess efficiency, effectiveness, compliance with laws and regulations or adequacy of internal controls. These reviews may also include compliance reviews of Agency contractors or entities under Agency oversight. Management reviews result in written reports or letters of findings and recommendations, including responses by management. These reports are distributed internally to the Agency Secretary and affected program managers. In addition, certain reports are sent to the Office of the Governor's Chief Inspector General and to the Office of the Auditor General.

Special Projects and Other Projects

Services other than assurance engagements, consulting engagements and management reviews performed by IA for Agency management or for entities outside of the Agency are considered special projects. Special projects may include: participation in intra-agency and inter-agency workgroups; attendance at professional meeting; 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 IA such as installation of new software or revision of unit policies and procedures.

HIPAA Compliance Office Functions

The Health Insurance Portability and Accountability Act (HIPAA) Compliance Office, located within IA, 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). Responsibilities of the HIPAA Compliance Office include:

- Administering both the HIPAA and HITECH Privacy Training and Security Awareness Training online programs for all Agency employees;
- Providing in-person HIPAA and HITECH privacy training to all new Agency employees as part of their orientation and advanced HIPAA privacy training to all Health Quality Assurance surveyors;
- Responding to requests for protected health information (PHI), HIPAA-related complaints against the Agency or its employees and other questions or requests regarding HIPAA;
- Developing and implementing Agency policies and procedures to comply with HIPAA and HITECH implementation specifications;
- Maintaining web sites, both internal and external to the Agency, containing general HIPAA and HITECH information for use by Agency employees and the general public;

- Reviewing Agency contracts to ensure compliance with HIPAA and HITECH requirements; and
- Updating and distributing the Agency's Notices of Privacy Practices to all Medicaid recipients.

Internal Audit Staff

Staff of IA brings various backgrounds of expertise to the Agency. Certifications or advanced degrees held by IA staff as of June 30, 2009 include:

- Certified Public Accountant
- Certified Internal Auditor (3)
- Certified Information System Auditor (4)
- Certified Government Auditing Professional (2)
- Certified Public Manager
- Project Management Professional

The *International Standards for the Professional Practice of Internal Auditing* and *Government Auditing Standards* require IA staff to maintain their professional proficiency through continuing education and training. Each auditor must receive at least 80 hours of continuing education every two years. This is accomplished by the professional staff attending courses or conferences throughout the year. Staff has attended Association of Inspectors General chapter meetings and conferences, Tallahassee Chapter of the IIA and Auditor General Association luncheon meetings, Information Systems Audit and Control Association (ISACA) e-symposiums, federally sponsored InfraGuard seminars dealing with Information Technology security and criminal issues, Association of Certified Fraud Examiners seminars, Agency employee training, and Government and Nonprofit Accounting video training.

Staff members have also participated in numerous IIA and Association of Government Accountants (AGA) sponsored training programs which included Whistle-blower Act training, Implementing Risk-Based Auditing for the Government Auditing Professional, and Key IA Considerations in this Current Economic Environment.

Internal Audit Activities:

Assurance Engagements, Consulting Engagements, and Management Reviews

IA completed a total of 13 assurance engagements, consulting engagements or management reviews during FY 2008-09. IA continues to monitor progress of management actions taken to correct significant abuses or deficiencies noted in the administration of Agency programs and operations disclosed by these engagements. A listing of the engagements completed and in progress as of June 30, 2008 are below:

Engagements Completed During FY 2008–09

Engagement Number	Topic	Engagement Type	Date Issued
08-06	Enhanced Benefits Program	Assurance	3/20/09
08-13	EDS MMIS/DSS Implementation	Review	6/25/09
08-14	MPA Data Center General Controls	Assurance	3/5/09
08-18	Wireless Network Security	Assurance	6/29/09
08-19	Medicaid Drug Rebate Program	Assurance	4/15/09
08-23	Business Impact Analysis	Consulting	7/18/08
08-24	Complaint and Information Call Center Evaluation	Consulting	12/16/08
09-01	MCO Application Process	Consulting	5/8/09
09-02	Chief IG's OFR Background Screening Project	Review	9/16/08
09-05	IT Risk Assessment	Review	12/16/08
09-06	2009 Disaster Recovery	Consulting	4/8/09
09-13	Long-Term Care Ombudsman Program Complaint Resolution Process	Assurance	6/12/09
09-15	SharePoint Security Consulting Engagement	Consulting	5/21/09

The following summaries describe the results of the assurance engagements, consulting engagements and management reviews completed by IA during the past fiscal year:

08–06 Enhanced Benefits Program

The Enhanced Benefits program, a component of Medicaid Reform, is designed as an incentive program to promote and reward participation in healthy behaviors. Our audit disclosed that, in general, management and system controls were effective in safeguarding program funds. In addition, program transactions were generally processed by the Enhanced Benefits Information System (EBIS) and the Prescription

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Drug Claims System in accordance with program policies and procedures. However, there were some controls and activities within the program that could be improved. Specifically:

- The Agency has not developed a process to identify individuals who lose their Medicaid eligibility and restrict them from accessing their Enhanced Benefits account if their income exceeds 200 percent of the Federal Poverty Level, and
- EBIS edits have not caught questionable drug transactions submitted for healthy behavior credit by the health plans.

We also noted a potential fraud risk associated with the use of the Enhanced Benefits universal form. This form is used to report healthy behavior activities not associated with paid claims; for example, participation in smoking cessation or alcohol/drug treatment programs. Agency policy does not require health plans to verify the beneficiaries' participation in the program with the provider or sponsor of the activity since this would impose an additional administrative burden for the health plans. Currently, there is minimal fraud risk due to low or no participation in healthy behavior activities that require the submission of the universal form. However, the potential for fraud will increase as the activities reported on the universal form increase unless the Agency requires the health plans to verify beneficiary participation with the provider or sponsor of the activity.

08-13 EDS MMIS/DSS Implementation

As part of our fiscal year 2008-2009 audit plan, IA conducted a review of the Agency's Florida Medicaid Management Information System / Decision Support System (FMMIS/DSS) implementation project (project).

The scope of this audit included the Agency's FMMIS/DSS project management procedures, project status, project deliverables, potential recoupment of funds, and outstanding project milestones as related to the implementation of the project. The audit focused on evaluating the project planning and management processes. This audit did not review the fiscal agent procurement or business operation implementation.

We established the following objectives for this audit:

- Evaluate the Electronic Data Systems (EDS) FMMIS/DSS project management strategy, procedures, and performance;
- Evaluate project deliverables to determine probability of a satisfactory system implementation by the agreed upon date; and
- Review the contract and determine the status of fund recoveries attributed to unmet deliverables.

During our review, we noted that the Agency did not have a process in place to facilitate independent project monitoring and project status communications with the Agency Management Team (AMT). We recommended the Agency continue to develop and

refine processes to ensure adequate reporting to the AMT when planning and developing future systems projects. We also noted that the "System Development" phase of the project plan was considered one deliverable rather than being broken down into smaller deliverables by system modules and development phases. Although there were many milestones within the "System Development" deliverable, there were no associated penalties for failing to meet a milestone as there would have been if the project plan required deliverables throughout the development process.

08-14 MPA Data Center General Controls

IA conducted an assurance engagement to determine if the Bureau of Medicaid Program Analysis (MPA), System Support Unit (SSU) has established adequate internal controls to ensure the confidentiality, integrity and availability of the data and information technology (IT) systems within its computing facility. We noted improvements since two prior external risk assessments, but areas remain where controls should be strengthened.

The scope of our audit included the IT general controls implemented by MPA's SSU designed to ensure the confidentiality, integrity and availability of Medicaid data. These controls include security and access controls, patch management, database administration controls and back-up and recovery procedures. Our assessment included controls in place during the audit period of April 8, 2008 through November 14, 2008.

We established the following objectives for this audit:

- Determine if internal controls implemented by the SSU were in compliance with the HIPAA Security rule and the Agency's Information Technology Security Plan (ITSP); and
- Ensure that SSU maintains the integrity and reliability of all IT related activities in support of the Division of Medicaid.

To accomplish our objectives, we reviewed applicable laws, rules, and regulations; interviewed appropriate Agency staff; reviewed policies, procedures, contracts, agreements, and related documents; observed and documented operations; and performed tests of internal controls.

The audit disclosed significant internal control weaknesses regarding security access controls, security program functions, network controls and business continuity planning within MPA's computing facility. We also found that the MPA computing facility does not have adequate measures or controls in place to protect systems against threats associated with their physical environment such as high temperatures, water leaks or unauthorized access. Collectively, these deficiencies constitute a material internal control weakness under the Agency ITSP and the final HIPAA Security Rule.

08-18 Wireless Network Security

As part of the Agency's fiscal year 2008-2009 audit plan, we conducted an audit of the Agency's wireless network security. The purpose of this audit was to assess IT's associated policies and procedures, monitoring efforts, and security controls.

The scope of this engagement included the Agency's wireless network and associated policies, procedures, and controls currently deployed.

We established the following objectives for this audit:

- Determine if there are adequate policies and procedures in place for the utilization and administration of the Agency's wireless network technology;
- Determine if IT's approach to monitoring the wireless network is sufficient to help ensure policy and security breaches are quickly identified and mitigated; and
- Assess the wireless technology, and determine if there are sufficient controls in place to protect the Agency's assets.

Overall, we noted the IT staff is very knowledgeable and capable of supporting the Agency's wireless local area network (WLAN) infrastructure. We did not identify any material security weaknesses in the supporting hardware architecture. Access point security and setup, personal firewall configurations on Agency laptops, guest user access controls, guest wireless password expirations, and wireless configuration on laptops were all evaluated without exceptions. However, the audit disclosed some controls designed to manage the security risks associated with maintaining a WLAN environment that were not implemented consistently. Specifically, monitoring efforts to identify rogue access and other suspicious activities are not performed or reviewed pursuant to policy. In addition, we identified instances where improvements could be made to strengthen the associated procedure documentation and business processes.

Of the three deficiencies noted, two are business process improvements and one is procedural. We recommended IT's network manager assign monitoring responsibilities to staff and review the results. Additionally, the Agency's Information Security staff and other appropriate personnel should review the monitoring results and assess whether implemented controls are working correctly and whether they are sufficient in mitigating security risks. We recommended IT enhance the change management procedures. Finally, we recommended IT formalize several procedures by incorporating these procedures into IT's established procedure template, submitting and acquiring Chief Information Officer approval, and communicating changes as necessary. Though not within the scope of this engagement, it is advised that IT perform a gap analysis of all current procedures and identify all appropriate revisions and formalizations.

08-19 Medicaid Drug Rebate Process

The purpose of this audit was to determine if the Agency and its contracted providers have sufficient internal controls in place to govern the Medicaid drug rebate process.

The scope of this audit included rebates invoiced and payments collected through the Medicaid drug rebate process during the period of January 1, 2006 through December 31, 2007. We established the following objectives for this audit:

- Ensure compliance with Federal regulations and Agency policies and procedures.
- Determine if the Agency is adequately monitoring the performance of the providers for compliance with contract terms.
- Determine if the Agency is successfully collecting rebate monies from pharmaceutical manufacturers.

During this audit we noted that, in general, the Agency and its contracted providers have sufficient internal controls. We specifically found Unisys to be committed to the tracking and successful collection of Medicaid drug rebates and to identifying improvements to the rebate process. However, there were some controls and activities within the drug rebate process that could be improved in order to strengthen effectiveness and efficiency. We found there were numerous J-Code claims that were not invoiced for rebate, and the Agency has approved claims without the required national drug code (NDC). We found a lack of written procedures surrounding the drug rebate process within the Bureau of Pharmacy Services. We also noted deficiencies in the management and monitoring of contracts.

In order to address these deficiencies, we recommended the Bureau of Pharmacy Services continue to work collaboratively with Unisys and the Bureau of Medicaid Program Integrity to develop methods for ensuring maximum rebate invoicing and collections. We recommended the Agency enforce the requirement for the NDC to be included on all claims and work cooperatively with the fiscal agent to ensure the appropriate edits are in place in FMMIS. We further recommended the Bureau of Pharmacy Services develop formal written procedures, to include procedures to ensure coordination between the contract manager and liaisons and promotion of more effective management and monitoring of the contracts.

08-23 Business Impact Analysis

IA conducted a Business Impact Analysis (BIA) to help the Agency identify which business units, operations and processes are crucial to the survival and continuity of the Agency's mission critical business objectives. We identified the time frames in which essential business operations must be restored to full functionality following a disruptive event and the resources required to resume business operations to a functioning level. We further defined the business impact of not performing critical business operations based on a worst-case scenario.

The analysis was accomplished through the completion of a BIA Assessment questionnaire and an interview with representatives of each of the Agency's bureaus. Participants were instructed to respond as though the event occurred at the worst possible time (i.e., prior to a known period of heavy transactions or during legislative

session) given the functionality of their business area. It was also assumed that a sufficient number of personnel survived to accomplish a recovery and re-establish business processes.

The core objective of the BIA was to identify critical processes and quantify the operational impact of a major disruption to those processes. During the course of the analysis, Recovery Time Objectives (RTO's) were established representing the timeframe in which these processes must be recovered. Additionally, preliminary estimates of the minimum infrastructure resources required to support identified functions were established.

Specifically, the BIA would allow Agency management to:

- Estimate the operational impacts of an interruption to the Agency's business operations and associated information systems;
- Identify and prioritize critical business functions for development or enhancement of Continuity of Operation Plans (COOP) for the identified divisions;
- Identify business dependencies for the individual business functions;
- Estimate minimum infrastructure resource requirements and personnel needed for the initial stages of recovery planning (including critical applications);
- Identify vital records and data that support individual business functions; and
- Document recommendations for recovery strategies to address requirements identified within the BIA.

We recommended the AMT, after reviewing the BIA documentation, establish or affirm RTO requirements based on their Business Plan for the Agency. Detailed Agency-wide department-based COOP would need to be reviewed and updated as changes are made to the approved recovery strategies. Current plans must be enhanced (or in some cases created) to ensure necessary elements are incorporated. The Agency must evaluate realistic options for alternate work space to accommodate requirements associated with business area strategies. Once internal facilities are identified, business strategies can be crafted to adhere to more realistic expectations and the information necessary to evaluate costs associated with resource requirements can be obtained and evaluated. A governance program should be developed and instituted to ensure that all plan elements are routinely tested and maintained. Coordinated testing involving representatives from IT, COOP representatives and representatives from the business units should be conducted to validate alternate work area preparations and associated connectivity.

08–24 Complaint and Information Call Center Evaluation

At the request of Agency management, IA conducted a consulting engagement to determine if it is more feasible to bring the Agency's Complaint and Information Call Center in-house or to rebid the contract once the current contract ends on June 30, 2009. The Call Center provides services primarily for the Agency's Bureau of Field

Operations and Bureau of Managed Health Care within the Division of Health Quality Assurance (HQA), the Division of Medicaid and the Department of Health (DOH). During our evaluation, we identified the following three options regarding the Complaint and Information Call Center:

- Let the existing contract end and develop an internal Agency call center either centralized like the current Affiliated Computer Services (ACS) Call Center or with a central phone number that routes the calls to staff within each Bureau through an Automated Voice Response (AVR) system;
- Rebid the contract with language and procedural input from all parties covered by the external call center providing an opportunity to improve upon the previous contract based on lessons learned during the current contract period as well as new technological advances; or
- A combination of the previous two options calling for the Agency to rebid the external contract for all parties other than the Bureau of Field Operations and developing a separate internal call center staffed by the Bureau of Field Operations to receive and process their complaint calls.

If the Agency had chosen to submit a Legislative Budget Request (LBR) to bring all or part of the call center in-house, the funding would not have been received until after the current contract with ACS had expired, and there would have been no internal call center ready to take over. Therefore, we recommended the Agency rebid the external call center contract with updated language and requirements and, during the contract term, determine the requirements of an internal call center and redevelop the LBR based on those new requirements. If the Agency then decided to bring the call center in-house, they would be prepared to have it up and running by the time the new contract expires.

We evaluated the cost allocation of the current contract and found that costs are not allocated based on call volume or call duration. When we calculated the allotment for fiscal years 2006-07 and 2007-08 based on call volume and call duration, we determined the Agency would have been entitled to at least $72,000 per year, and as much as $240,000 per year, more from DOH and Federal Medicaid reimbursements than it actually received. We recommended the Agency determine each party's share of the contract cost based on call volume or call duration to more appropriately assign costs.

We also recommended the Agency develop an online complaint submission system which would reduce the number of calls coming into the call center and provide a more efficient and accurate system for complaint submission.

09–01 MCO Application Process

At the request of Agency management, a team was formed and assigned the task of reviewing the contracts and application process executed by entities in order to become

a Medicaid managed care organization (MCO). This was a coordinated effort, with participation from each of the Agency bureaus involved in the application process. The team consisted of personnel from the Bureaus of Health Systems Development, Managed Health Care, Medicaid Program Integrity and Medicaid Contract Management. The Bureau of Medicaid Quality Management also joined the team to assist in providing structure and ensuring the team met established goals.

The primary objective of the team was to reduce the amount of time required to approve an MCO application, beginning with the moment an MCO contacts the Agency and ending with first enrollment. The team mapped out the current process and identified opportunities for improvement. Recommendations were developed based on the following criteria:

- All application steps and requested documentation should be tied to an existing law, rule or public health objective.
- The application process should allow for concurrent review where feasible.
- Duplicative steps should be eliminated.
- The application package should provide a clear picture of the steps to be taken to complete the application process, including points of contact, reference documents and appropriate timeframes.

In addition, select team members conducted a concurrent review of the Medicaid managed care model contracts to identify areas of opportunity as bulleted above.

As a result of this cooperative effort, the total time for processing an application is expected to be reduced to approximately 100 days. This will be accomplished by the establishment of time requirements for the Agency and MCO applicants and the performance of concurrent reviews by Agency personnel. The Agency is additionally revising the contract and application package and will enhance its website to ensure all application information is available to potential MCO applicants. The Agency will increase its focus on technical assistance by creating workshops designed to prepare the applicants for the application process.

09–02 Chief IG's Office of Financial Regulation Background Screening Project

IA assisted the Chief IG, in a multi-agency task force at the request of Florida's Cabinet. The scope of this engagement is the licensing and enforcement activities of the mortgage industry by the Office of Financial Regulation (OFR) from 1/1/2000 through 8/1/2008.

We established the following objectives for this audit:

- Determine the level of compliance with Chapter 494, Florida Statutes, Florida Administrative Code, and Office of Financial Regulation policies and procedures; and
- Determine the sufficiency of Chapter 494, Florida Statutes, Florida Administrative Code, and Office of Financial Regulation policies and procedures.

For most of the review period OFR used a mainframe system called the Departmental Licensing System (DLS) to track and maintain licensure information. The DLS captured basic licensing data sufficient to allow OFR to manage the licensing process; however, some key fields that would have allowed OFR to better track its performance were missing from the legacy system. In March of 2008 OFR implemented the Regulatory Licensing (REAL) system which is a web-based system developed by Accenture. OFR converted all of their historical data into the REAL system, but also retained a copy of the data in the old mainframe system. The queries used to obtain our data were pulled from the DLS system.

An emergency rule proposed by OFR and adopted by the Financial Services Commission on August 12, 2008 assigns certain criminal convictions into classes. The rule further assigns associated periods of ineligibility for each crime class. Any individual applying for a license in the mortgage industry who was convicted of a crime listed in the rule within the associated period of ineligibility would not be granted a license.

We recommended the OFR, to better protect the citizens of the State of Florida from unscrupulous mortgage professionals, take the necessary steps to ensure that the proposed rule is adopted. Once the rule has been permanently adopted we recommend that OFR automate the screening process.

Licensed mortgage brokers are required by law to report to OFR any criminal convictions that occur subsequent to licensure. OFR can revoke their license if they fail to report any convictions.

We recommended OFR evaluate the risk of licensed mortgage brokers committing crimes subsequent to licensure and determine if a process to perform periodic rescreening of licensees should be developed. We further recommended OFR research the active mortgage brokers who have subsequently been convicted of crimes and determine if they self reported those convictions as required by law.

Florida Stature 494 requires that OFR license mortgage brokers, mortgage broker businesses, and mortgage lenders. There is no statutory requirement for loan originators to be licensed. Therefore, there is no background screening performed for loan originators as part of a licensure process. We recommended OFR consider licensing or screening loan originators.

09-05 IT Risk Assessment

At the request of the Agency's Information Security Manager (ISM), we reviewed and evaluated the Agency's completed 2008 Florida Risk Assessment Survey with supporting documentation as required by the Agency of Enterprise Information Technology. Florida Statutes require each agency to "conduct, and update every 3 years, a comprehensive risk analysis to determine the security threats to the data, information, and information technology resources of the agency," and to "ensure that

periodic internal audits and evaluations of the agency's security program for the data, information, and information technology resources of the agency are conducted." During this engagement, we provided comments to the ISM on the completeness and accuracy of the Agency's response to ensure that the requirements of the risk assessment were met and the Agency's submission fairly represented current practices.

09-06 2009 Disaster Recovery

The focus of this consulting engagement was to provide recommendations for improvement within the disaster recovery (DR) process and to add value to the disaster recovery function by assessing its alignment with the Agency's Continuity of Operations Plan (COOP).

The scope of this engagement included the 2009 DR test planning process, the information technology disaster recovery plan (ITDRP), and the DR test exercise.

We established the following objectives for this engagement:

- Evaluate the adequacy of backup and restore provisions to ensure the availability of information required to resume critical operations;
- Evaluate the organization's DR plan to ensure that it is in compliance with the Agency for Enterprise Information Technology's (AEIT's) ITDRP Guidelines and Checklist and enables the recovery of information technology processing capabilities in the event of a disaster; and
- Determine if problems encountered are addressed and that appropriate updates are made to the Agency's ITDRP based on lessons learned.

During this engagement, we noted the IT staff is very knowledgeable and capable of restoring the Agency's IT resources in the event of a disaster. We did not identify any issues or deficiencies in the DR team's technical capabilities. In addition, the process for requesting and restoring back-up data from the offsite location was completed successfully. However, we identified instances where improvements could be made to strengthen the processes and associated documentation. IT has not completed drafting the ITDRP. In addition, neither a disaster activation or deactivation exercise was included in the 2009 DR test.

We recommended IT finalize and implement an approved ITDRP, develop disaster activation and deactivation procedures, and meet with the appropriate Agency personnel to ensure alignment with the Agency's COOP.

09-13 Long-Term Care Ombudsman Program Complaint Resolution Process

The Department fo Elder Affairs (DOEA) requested our participation, along with the Deparment of Children and Families, for an audit of the Long-Term Care Ombudsman program (LTCOP). Volunteer ombudsmen are Florida citizens who advocate on behalf of others to resolve specific issues and concerns. They respond to concerns raised by

long-term care residents. This is accomplished by providing free services such as investigating complaints and aiding the development of family and resident councils, educating long-term care residents about their rights and performing annual assessments of long-term care facilities.

The objective of the audit was to determine the level of resolution to unresolved LTCOP investigations forwarded both internally and externally for further action. The audit found that follow-up on LTCOP complaint referrals to external partners is inconsistent or does not occur, communication with external partners is weak and inconsistent, LTCOP does not fully utilize its enforcement authority under section 400.0075, F.S., data consistency continues to be a problem within the LTCOP web-based application system, an outcome-based performance metric is needed for tracking resolution of complaints referred to external partners, and the state complaint resolution rate remains below the national average.

The following recommendations to the LTCOP were made:

- Program adequate data fields within the web-based application system to track final resolution of complaints referred to external partners and update LTCOP procedures to clarify the necessity of tracking external referrals and usage of any new fields created in the system,
- Establish a workgroup with representatives from external partner agencies, ombudsman, and District Ombudsman Management to establish enhanced tools for communication and complaint referral management,
- Institute measures to utilize its authority under section 400.0075, F.S.,
- Continue working with DOEA's Application Support Group to ensure all required fields are populated with appropriate information before a case or complaint is closed,
- Establish an outcome-based performance metric tracking the level of resolution for referred cases, and
- Emphasize ongoing training with district staff and ombudsman with respect to resolution of complaints. This training should target those districts based on data analysis, which have high variances from the state and national averages in the usage of particular codes.

09–15 SharePoint Security Consulting Engagement

At the request of the Agency's Information Security Manager (ISM), we conducted a consulting engagement to review Microsoft SharePoint security concerns. When discussing client expectations, the ISM indicated uncertainties in the current security program and whether it is sufficient in addressing new risks introduced through the deployment of SharePoint.

The scope of this engagement included the Agency's implementation of SharePoint Server and the associated security risks. The objective of this engagement was to

evaluate the potential security risks resulting from the Agency's deployment of SharePoint and recommend actions and controls for mitigation.

During this engagement, we noted the SharePoint Administrator is very knowledgeable in deploying SharePoint. Additionally, the Agency has hired one additional full time employee dedicated to SharePoint support. However, IT has not performed a risk or security assessment to identify the potential risks associated with implementing SharePoint in the current Agency environment.

We recommended IT perform a security assessment. IA has extended an offer to IT to discuss guidance material and other related assessment issues once the process has been initiated.

In addition we recommended IT:

- Create and implement approved written procedures for requesting maintenance once the collaboration effort has come to a close;
- Consider the impacts SharePoint deployment will have on the Agency's current BIA and DR efforts and modify as appropriate; and
- Ensure detailed training is provided for all web content developers, and develop and provide basic SharePoint training for Agency users.

Internal Audit Engagements in Progress as of June 30, 2009

Engagement Number	Topic	Engagement Type	Planned Completion Date
08-07	Physician Files at EDS	Assurance	September 2009
09-10	DME Prior Authorization and Information System	Assurance	September 2009
09-09	Florida Center Data Intake Process Evaluation	Consulting	October 2009
09-12	Homecare Unit Efficiency	Consulting	August 2009

Other Projects

The Bureau of Internal Audit worked with the Bureau of Medicaid Quality Management to perform an extensive review of the Agency's fraud and abuse efforts. This analysis allowed the Agency to identify the business units and processes that are currently in place to combat fraud and abuse in order to improve communication and coordination of these efforts. By identifying the efforts currently in place to combat Medicaid fraud and

abuse, the Agency can ensure that coordination of these efforts is enhanced in order to spend taxpayer dollars on legitimate services. Preventing, detection and recovering fraudulent payments will ensure that more Medicaid funds are available to provide needed services to our recipients.

The Bureau of Internal Audit led an initiative to enhance the Agency's dashboard measures. This included revising some of the existing measures as well as creating measures for some bureaus that had not previously reported. Establishing performance goals and working to ensure meeting these goals is an important management tool to make certain that we are providing the best service possible to our customers. Determining each bureau's core function and creating measurements of those core functions will help the Agency improve processes and identify areas where additional improvements or resources are needed.

The Bureau of Internal Audit worked on the Agency's AHCA-celerate initiative during this past fiscal year. The AHCA-celerate initiative is an Agency-wide project designed to reduce the regulatory costs to licensees and Medicaid providers by using business process evaluation and, ultimately, utilizing web-based technologies to improve the Agency's interactions with customers. Eliminating duplication of effort in the Agency's work processes and data management is imperative in this endeavor. To that end, IA personnel worked with various subcommittees to assist them in mapping their business processes and indentifying unproductive steps in the process. AHCA-celerate is an ongoing process and IA participation will continue into next fiscal year.

Other projects completed by IA during the fiscal year included: IA Policy and Procedures Update; Inspector General Activity Reports for the Governor's Office; Schedule IX of the Legislative Budget Request; Summary Schedule of Prior Audit Findings; Agency Fraud and Abuse Review; 2-CSFA Number Request Reviews; 2007-08 Annual Report; Risk Assessment/Audit Plan and Health and Human Services (HHS) Audit Resolution.

Prior Engagement Recommendation Follow-up

The *International Standards for the Professional Practice of Internal Auditing* and *Government Auditing Standards* require auditors to follow-up on reported findings and recommendations from previous assurance engagements and management reviews 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.

Pursuant to Section 20.055(5)(h), F. S., the OIG monitors the implementation of the Agency's response to external audit reports issued by the Auditor General and by the Office of Program Policy Analysis and Government Accountability (OPPAGA). The OIG is also 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. A copy of the

response is also provided to the Legislative Auditing Committee. Additionally, pursuant to Section 11.51(6), 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 their reports. The OIG is responsible for coordinating these status reports and ensuring that they are submitted within the established time frames.

During FY 2008-09, status reports were submitted on the following external reports:

- Auditor General – State of Florida – Contract Management (Report No. 2008-091, Dated February 2008)
- Auditor General – State of Florida – Compliance and Internal Controls Over Financial Reporting and Federal Awards, FYE 6/30/2007 (Report No. 2008-141)

Corrective Actions Outstanding From Previous Annual Reports

As of June 30, 2009 the following corrective actions for significant recommendations described in previous annual reports were still outstanding:

Medicaid Rate Setting, Report 07–01 issued November 20, 2006

Recommendation: The Bureau of Medicaid Program Analysis:

- Establish deadlines for the transfer of nursing home cost reports from the Audit Services Unit to the Cost Reimbursement Section.
- Ensure that only nursing home cost reports received and deemed as "acceptable" prior to the deadlines established in the Plan and in recommendation 2.1 above are utilized during each rate setting semester.
- Consider amending the Plan to alter cost report submission deadlines for nursing homes to allow ample time for all review and resubmissions (when necessary) to take place prior to forwarding the cost reports to the Cost Reimbursement Section.
- Include specific language regarding all deadlines and requirements of the providers to submit acceptable cost reports in the first section of the Plan.

Most Recent Management Response: Version XXI of the Plan, effective February 20, 2002, changed the submission dates of cost reports from March 31 and September 30 to April 30 and October 31 to accommodate the legislative change for the split of Patient Care into Direct and Indirect components. The Agency's policy is to allow providers to submit cost reports to the deadline, with 50-65% of the cost reports submitted for the upcoming rate setting submitted within the two weeks prior to the deadline. The cost reports are reviewed and accepted for rate setting.

Discussions on changing the cost report deadline back to March 31 and September 30 and whether cost reports that had not been accepted prior to the deadline would be used in rate setting were held as a result of the recommendation in the report.

The situation was monitored and reviewed by the Bureau Chief over a period of a year. Cost reports were forwarded for rate setting, and rates were set, and issued within acceptable timeframes for Medicaid management. The decision was made to leave the deadline and process in its current form.

Recommendation: The Audit Services Unit:

- Develop formal written time schedules for the review, acceptance and approval of cost reports. Some activities the unit should consider assigning time schedules to include: the amount of time from receipt of a cost report to assignment to an analyst; amount of time required for an analyst to review a cost report; amount of time allotted to the provider to submit missing or amended documentation; and amount of time required for the administrator to approve the cost report.
- Re-evaluate the design and use of the tracking system utilized in the acceptance and approval of nursing home cost reports to ensure it adequately reflects those activities for which time schedules were developed.
- Develop a standardized letter to be sent to providers upon determination that a submitted cost report is not acceptable. The letter should include established timeframes for submission of missing or amended documentation and a reminder that the cost report will not be used for the current rate setting semester if an acceptable version is not submitted by the deadline date.

Most Recent Management Response:

- Audit Services continues to use the tracking spreadsheet for cost report reviews. This spreadsheet, in conjunction with Hyperion, has provided the Bureau and section management with information that support the cost report review and acceptance process. Cost reports have been forwarded for rate setting, and rates were set, and issued within acceptable timeframes for Medicaid management. Further changes are not planned at this time.
- The purpose of the Hyperion database and the recommended changes were reviewed within the Bureau. Hyperion meets the current need effectively. No changes to the Hyperion database regarding the acceptance and approval of nursing home cost reports are planned at this time.
- Given the current timeframe to review and accept cost reports for rate setting, Audit Services contacts the provider to inform them to the specific problem with the cost report. The provider is informed of the deadline to get the issues resolved, and resubmitted if necessary, for the cost report to be forwarded for rate setting. The current process is working effectively and meets Bureau deadlines. Changes that would disrupt the timing of this process are not under consideration at this time, so the Bureau has decided not to propose a standardized letter at this time.

Nursing Home Diversion Waiver Program, Report #08-01 issued August 24, 2007

Recommendation: Attempt to recoup overpaid funds.

Most Recent Management Response: The Customer Service Request (CSR) creating the manual segment update functionality is completed. However, system generated payments for periods prior to June 30, 2008 are inconsistent. Use of financial expenditure transactions is being considered to complete these incorrect payments and recoupments. Revised target after 18month follow-up: 08/01/2009

Inappropriate Software and Licensing Violations, Report #08-03 issued October 5, 2007

Recommendation: We recommend the Division establish a sound IT asset management process for the Agency, eventually working towards a centralized repository as advised in COBIT 4.0 Detail Control Objective, DS9.1 Configuration Repository and Baseline.

Most Recent Management Response: IT will research IT Asset Management a little further (3 months - March) for affordable IT tools to leverage. And will also review the Department of Health's Policy on like issues to try and leverage another State agency's solution.

Recommendation: We recommend Agency management:

- Evaluate the risk of users installing software on their computers;
- Assess current policy;
- Implement controls to mitigate the risk identified as a result of the risk evaluation and policy assessment.

Most Recent Management Response: IT will address the issue regarding "sufficient controls to help ensure compliance with Agency policy regarding software installations" by approaching the controls needed by network group policy.

IT General Controls, Report #08-08 issued April 21, 2008

Recommendation: Select a control framework and develop a strategic plan that identifies the goals and objectives of the Agency, aligns the goals and objectives of IT with those of the Agency and sets a direction for the bureau that outlines how they will accomplish their objectives.

Most Recent Management Response: An IT Strategic Plan is currently being used but has not been formally approved by the Secretary. The Technical Advisory Group (TAG) has met since Feb 2009 to have input and assist in finalizing the IT Governance Model that will consist of 3-4 Tiers in an approval process. The TAG group represents all

Divisions and Internal Audit. The AMT is planned to resolve larger IT decisions when needed in the current version of AHCA's Strategic Plan.

Recommendation: Develop, implement and document controls over the process of identifying, evaluating, and developing or acquiring new technology solutions within the Agency.

Most Recent Management Response: A new IT Governance Model is currently beginning to be used as of February 2009. The TAG (see above) is meeting on a scheduled monthly basis.

Recommendation: Develop a monitoring and measurement process that defines relevant performance indicators and compliance requirements, ensures systematic and timely reporting of performance and compliance and promptly acts upon identified deviations.

Most Recent Management Response: Since February 2009, IT has been asked to develop some key performance indicators for "Dashboard" metrics. The Agency's 2009 "Climate Survey" also indicated performance indicators the Chief Information Officer will adopt and has already provided in "Action Plan" in response. Microsoft Project Server (as reported in the 6 month response is close to deployment on a full-team basis but our move from a Bureau to a Division has put-off our deployment by approximately 60 days. As indicated in our 6 month response; Project Server can give reporting analysis that will give performance measures. This process has not been mapped until the reporting is customized and finalized.

Recommendation: Develop and implement and maintain formally written information technology policies and procedures that should be reviewed and updated on an annual basis.

Most Recent Management Response: A new IT tool, Microsoft SharePoint, is allowing for greater access to IT policies and any written procedures since the last response relying on C1dm3 shared drive access. The process is not yet finalized.

Coordination with Other Audit and Investigative Functions

The OIG acts as the Agency's liaison on audits and reviews conducted by outside organizations such as the Office of the Auditor General, OPPAGA and the federal Department of Health and Human Services. The OIG also coordinates the Agency's responses.

Office of the Auditor General

During FY 2008-09 the Office of the Auditor General issued the following report: *State of Florida – Compliance and Internal Controls Over Financial Reporting and Federal Awards, FYE 6/30/2008* (Report No. 2009-144, Dated March 2009)

Office of Program Policy Analysis and Government Accountability

The following reports were issued by OPPAGA during FY 2008-09:

- Early Steps Has Revised Reimbursement Rates but Needs to Assess Impact of Expanded Outreach on Child Participation (Report No. 08-44, Release date: July 2008)
- Medicaid Reform: Beneficiaries Earn Enhanced Benefits Credits But Spend Only a Small Proportion (Report No. 08-45, Release date: July 2008)
- Medicaid Reform: Choice Counseling Goal Met, But Some Beneficiaries Experience Difficulties Selecting a Health Plan That Best Meets Their Needs (Report No. 08-46, Release date: July 2008)
- Medicaid Reform: Risk-Adjusted Rates Used to Pay Medicaid Reform Health Plans Could Be Used to Pay All Medicaid Capitated Plans (Report No. 08-54, Release date: September 2008)
- Medicaid Reform: Oversight to Ensure Beneficiaries Receive Needed Prescription Drugs Can Be Improved; Information Difficult for Beneficiaries to Locate and Compare (Report No. 08-55, Release date: September 2008)
- Medicaid Reform: Reform Provider Network Requirements Same as Traditional Medicaid; Improvements Needed to Ensure Beneficiaries Have Access to Specialty Providers (Report No. 08-64, Release date: November 2008)
- Increased Public Awareness of the Long-Term Care Insurance Partnership Program Would Contribute to the Program's Success (Report No. 09-08, Release date: February 2009)
- Medicaid Reform: Legislature Should Delay Expansion Until More Information Is Available to Evaluate Success (Report No. 09-29, Release date: June 2009)

Department of Health and Human Services

During FY 2008-09 the Department of Health and Human Services issued no reports on Agency operations.

Risk Assessment

IA performs a Risk Assessment of the Agency's programs and activities each year to assist in the development of the Annual Audit Plan. The Risk Assessment is a formal process that includes identification of activities or services performed by the Agency and evaluation of various "risk factors" where conditions or events may occur that could adversely affect the Agency. Activities assessed consist of each Bureau's critical functions that allow the Bureau to achieve its mission. Risk factors used to assess the overall risk of each core function include but are not limited to:

- The adequacy and effectiveness of internal control;
- Changes in the operations, programs, systems, or controls;
- Changes in personnel;

- Maintenance of confidential information;
- Dependency on systems maintained by the Bureau;
- Complexity of operations; and
- Dependency on other programs or systems, both internal and external to the Agency.

The assessment of the overall risk of each activity is accomplished by appropriate management and IA ranking the areas of concern in importance using the risk factors. The ranking of the activities is reviewed and evaluated. Meetings are held with management to discuss the ranking and to identify any additional areas of concern.

In addition to the Agency-wide risk assessment, IA conducted an American Recovery and Reinvestment Act of 2009 (ARRA) specific risk assessment to determine if any ARRA related activities warranted additional engagement activities during the 2009-10 fiscal year. Staff interviewed Division of Medicaid and Florida Center personnel for this assessment and used the results when completing the Audit Plan. The Health Information Technology grants that will be distributed by the Florida Center were added to the 2009-10 Audit Plan as a result of this assessment.

Audit Plan

IA has developed an Annual Audit Plan for the fiscal year 2009-10. This plan also includes audit issues that will be addressed in subsequent years, 2010-2011 and 2011-2012. The audit plan includes activities that are to be audited or reviewed, audit and review schedules, budgeted hours and assignment of staff. Steps taken in developing the audit plan include:

- Performing a Risk Assessment to identify auditable activities and ranking each activity using established criteria to determine the relative significance of, and likelihood that, conditions or events may occur that could adversely affect the Agency;
- Reviewing and evaluating the auditable activities that rank the highest in risk and that could potentially adversely affect the Agency, its providers, or health care recipients; and
- Meeting with Agency management and the Secretary to obtain feedback on these auditable activities and on any additional areas of concern.

The audit plan was approved by the Agency Secretary and provides the most effective coverage of the Agency's programs and processes while optimizing the use of internal audit resources.

Internal Investigations Unit

Investigations Function

The OIG 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 for Health Care Administration (Agency). To that effort, the AHCA OIG conducts internal investigations of Agency employees, as well as contractors of alleged violations of policies, procedures, rules and Florida laws. Complaints may originate from the Office of Chief Inspector General, the Whistle-blower Hotline, the Chief Financial Officer's "Get Lean" Hotline, Agency employees, health care facilities, practitioners or the general public. Investigations conducted by the OIG may include alleged violations of Agency standards such as unprofessional conduct; unauthorized disclosure of confidential information; theft or misuse of property, records or documents; violation of the nepotism policy and falsification of records, to name a few. Allegations of a criminal nature are referred to the appropriate law enforcement entity, as required by Section 20.055(6)(c), F.S. When necessary or requested, the IU section works closely with the local police, the Florida Department of Law Enforcement, the Attorney General's Office and the State Attorney's Office. The Investigations Unit members include a nationally certified inspector general, four nationally certified inspector general investigators, five federally certified Equal Employment Opportunity investigators, one current auxiliary police officer, four former law enforcement officers, a veteran data analyst and an administrative assistant. The following are some examples of internal investigative reports published this period. A complete list of cases for this reporting period is included at the end of this section.

Internal Investigation – 08–096

An employee alleged management suspended her without cause - Unfounded

An employee alleged that she was suspended with leave without pay for ten days without explanation, was the only staff member disciplined for similar violations and office supervisors improperly discussed the employee's work issues in front of other staff. Investigation determined that the employee was directed by the supervisor to email him when she arrived at work because of tardiness issues for which she had been counseled. Investigation revealed that the employee, in an effort to conceal her continued tardiness, shared her password and username with a co-worker in violation of Agency policies and asked the employee to log into her computer and email the supervisor, to mislead the supervisor into believing that she was at work at her scheduled time. The employee's allegation that she has been disciplined for violations that other employees had committed without discipline was unfounded. No other employee in the unit had tardiness issues. The employee's allegation that the unit

supervisors openly discussed her issues in front of other staff was also not substantiated.

Internal Investigation – 08–099

Alleged Race Discrimination and Hostile work environment - Unfounded

An Agency employee alleged she was the victim of race discrimination and a hostile work environment. The employee alleged that because of her race, supervisors addressed her requests for flex time and leave differently and that the two supervisors in the unit were argumentative and raised their voices at her. The OIG interviewed all parties involved and found no evidence that the two supervisors ever denied the complainant any leave requests, changed her flex schedule or were argumentative or raised their voices at her. The case was closed with no recommendations.

Internal Investigation – 08–124

Allegation that an Agency Surveyor accepted gifts during an HQA Annual Survey – Unfounded

Conflict of Interest – Founded

A complaint alleged an Agency employee, who was participating in the annual survey of a facility, accepted a free fishing trip from the facility's Director after work hours during the same time period of the annual survey. The investigation determined that the surveyor met with the Director of the facility at his home and accompanied the Director and the Director of Nursing on the Director's personal boat. The surveyor admitted to the allegation and the OIG determined that the surveyor's actions were a conflict of interest. The OIG recommended appropriate disciplinary action against the surveyor.

Internal Investigation – 08–125

Allegation that an Agency employee abused sick leave and submitted an altered physician note – Unfounded

A complaint was received from a field office supervisor who suspected that an employee was abusing sick leave and submitted a counterfeit or altered note from a physician. The OIG interviewed the employee and received permission to contact the physician. It was determined that the employee had two children and the physician had written the wrong child's name on the note. The employee was cleared of any wrongdoing.

Internal Investigation – 08-130

Provider alleged a Health Quality Assurance (HQA) employee falsified survey reports - Founded

A complaint alleged that an Agency HQA nurse consultant, in the Nurse Monitoring Program responsible for Quality Improvement visits in nursing homes, may not have been performing her duties as required. A corporate nurse from a Veterans Home called the manager of the Nurse Monitoring Program and requested copies of the facility's reports. After review, the Veteran Home's corporate nurse reported that the Director of Nursing's (DON) name on the current survey report was actually the former DON who left in June 2008. The current DON did not remember a monitoring visit for the quarter. The Agency manager randomly called three facilities and was told that the nurse monitor had not visited the facilities since the spring. When interviewed, the HQA nurse consultant admitted to OIG staff that she falsified at least fifteen reports for facilities she never actually visited. OIG recommended appropriate disciplinary action.

Internal Investigation – 08-131

Provider alleged Agency employee of misconduct and Conduct Unbecoming a State Employee- Founded

A written complaint from a South Florida physician alleged an Agency Architect represented himself as a private consultant (working alongside a private architect), offering to assist the physician with her project to build a surgical center. The physician said it was not until she met the Agency architect at the Agency Plans and Construction offices that she realized he was also employed by Agency. The physician alleged after the Agency architect and his partner were turned down for her project, all following reviews completed by the ACHA architect were unfair and held to a higher standard than the regular process. The Agency architect declined to be interviewed after requesting union representation and then submitted his resignation. Evidence independent of the complaint indicated that a personal business relationship existed between the Agency employee and the private architect.

Internal Investigation – 09-012

Alleged Employee Misconduct, Misuse of Computer Resources - Founded

It was alleged that an Agency employee misused computer resources by accessing pornographic or other inappropriate material or websites. The scope of the investigation was limited to a search for evidence of pornography or other inappropriate material on the employee's computer hard drive and other misuse of the computer. Forensic examination of the computer hard drive revealed no pornographic or other inappropriate material. However, further examination exposed the employee's computer contained a bookmark for a website which contained pornographic images, in violation of Agency

Office of the Inspector General

Policy 99-HR-52. The OIG recommended that management take appropriate disciplinary action.

Internal Investigation – 09–053

Alleged violations of: Agency Travel and Ethics Policy, and Poor Performance- Founded

Additional Findings: Conduct Unbecoming a State Employee and Computer Policy violations - Founded

A Bureau Chief advised after she reviewed travel documents produced for a public records request, it was discovered that a Program Manager approved her own travel while delegated temporary signature authority. The Bureau Chief also reported her concerns about a possible conflict of interest because the Program Manager was also working as a paid consultant to a waiver program under her supervision. Investigation determined:

- The Program Manager tried to approve her own travel, failed to complete pre-authorization forms required for conference travel, approved her subordinate employee's conference travel without authorization, submitted incorrect or false travel reimbursement forms, rented vehicles and lodging rooms for extra days, received reimbursement for expenses in violation of travel policy, failed to travel by the most economical means possible as required, and finally, advised management some conference travel was a contract requirement when in fact, it was not.
- The Program Manager's outside employment as a consultant with Agency created the appearance of or an actual conflict with her Agency duties. The Commission on Ethics opinion allowing the Program Manger to consult with Agency may not have been rendered with full knowledge of the employees actual duties. The Program Manager failed to include her entire position description, or disclose she had a supervisory role over the program for which the Program Manager was a paid consultant for, or that the employee had a supervisory role over the consultant reviewers. Additionally, she did not disclose she had terminated the previous consultant reviewer and suggested herself for that position, or that a subordinate approved the Program Manager's invoices for payment as the outside consultant, or that she was listed on the purchase order for the consulting services of the other physician consultant. The Program Manager's outside employment as a consultant with the Agency created a clear and continued appearance of or an actual conflict under Florida Statute and Agency policy.
- The Program Manager failed to properly supervise an employee resulting in years of unprocessed disbursements to Medicaid providers.
- The Program Manager improperly shared test and quiz answers for an on-line certification course with subordinate employees.
- The Program Manager's improper use of the Internet and state email account was found to be in violation of Agency's Use of Internet, Email and Computer Resources Policy. The Program Manager visited unauthorized Internet sites in violation of the Agency

Internet use policy and received in excess of 1000 personal and unsolicited emails from Internet sites where she had used her state email account to make purchases, view materials or sign up for dating services. The Internet Activity Report demonstrated she spent many hours on the Internet for personal reasons on state time.

Recommendations made by the OIG report included in part:

- An agency-wide review to identify all Agency employees who are currently dual employed to insure policy is being correctly and consistently enforced.
- Finance and Accounting should review travel policy violations uncovered in this report and seek reimbursement where appropriate.
- Finance and Accounting should review procedures to ensure that all suspected travel policy violations are returned to the employee for justification.
- The Agency take appropriate disciplinary action.

Internal Investigation – 08-068

Whistle-blower complaint alleging public health violations at a Medicaid facility - Founded

This investigation was based upon a complaint alleging that a Medicaid provider failed to repair a faulty generator, used unlicensed personnel to repair plumbing, failed to repair contaminated seals on refrigeration equipment housing food and nourishments' for the residents, failed to provide medications to patients during the night shift, failed to report an alleged rape of a patient, failed to use capital outlay funds to make needed improvements and finally terminated the whistle-blower for reporting the alleged violations. AHCA OIG staff worked with Health Quality Assurance (HQA) staff and the State Fire Marshall to investigate these allegations.

After a site visit by HQA staff, the facility was found to be in violation of Agency policy, Florida Statute and federal rules.

In addition, a Federal Complaint Investigation survey was conducted with AHCA Inspector General's staff found deficiencies in violation of National Fire Protection Association Standards.

The report recommended in part:

- Medicaid review HQA and OIG reports for any appropriate action.
- The report be provided to the Florida Department of Health, Board of Nursing to evaluate for possible violation of the Nurse Practice Act.
- AHCA consider termination of the facility license based upon the severity of the findings or other action as deemed appropriate.

- Copies of the report be forwarded to the Florida Department of Health, Florida Department of Elder Affairs and the Department of Children and Families for additional review.
- All "sister" facilities be evaluated by immediate unannounced survey teams from HQA to insure compliance with state and federal regulations.

Internal Investigation – 09-072

Alleged Race discrimination by an Agency Supervisor - Unfounded

A complainant alleged that the supervisor was attempting to force him into retirement and that his race and age were the motivating factors. Investigation determined that there was no evidence of discrimination. There was evidence that the complainant and the supervisor had discussed his retirement in the past, however, no evidence suggested that the conversations were threatening, racial or hostile toward the complainant.

Internet Monitoring

During this reporting period, the Investigations Unit became responsible for the monitoring of Internet activity for the Agency. The Investigations Unit only monitors employee Internet activity when requested by management or for the collection of evidence during an internal investigation, and has instituted procedures to ensure that monitoring of Internet activity is not misused.

In-house Fingerprinting

Agency employees are required to be fingerprinted when they are hired and every five years thereafter for background screening. The investigations Unit has implemented an in-house fingerprinting station, managed by an IU Investigator who is an auxiliary police officer, enabling employees to be fingerprinted at headquarters without having to travel to a local law enforcement agency during working hours. In some instances, this will save the Agency fingerprinting fees and lost employee travel time. This new program, utilizing current OIG staff, is not only convenient, but demonstrates an innovative effort to provide another cost savings for the State of Florida.

Agency's Hiring Policy Workgroup

An IU member was chosen to participate this year on AHCA's Hiring Policy Workgroup. The workgroup was charged by the Agency Secretary to review, revise as appropriate, all Agency hiring practices, including recruitment, selection and background screening. The goal is to ensure that Agency actively seek, hire and retain the best employees.

The IU staff member is specifically charged with participating in the development of:

- Clear policy on obtaining the details and disposition of non-adjudicated arrests discovered during employment screening
- Policy on offering employment to ex-offenders and persons with non-adjudicated arrests

Fraud and Abuse Efforts

The Investigations Unit's fraud and abuse efforts this fiscal year included assisting the Bureau of Medicaid Program Integrity as well as generating cases from data examined and citizen complaints. The IU utilized the strengths of investigators with law enforcement experience, coupled with the skill set of a veteran data analyst, to design and implement a number of field initiatives. These focused investigations have included the use of data analyses, witness interviews, records review and, in some cases, the collection of physical evidence for review. During this fiscal year, the IU closed 62 fraud and abuse files and made 55 referrals. Thirty-three of these referrals were to MFCU for potential criminal investigation. Several of these field investigations are described below.

Diagnostic and Radiological Test Project

The IU reviewed 99 procedure codes with a total Medicaid reimbursement of more than $24 million during a 12-month period. These procedure codes included all diagnostic and radiological provider specialties and all recipient ages. Miami-Dade County was the highest billing county in Florida with a reimbursed total of $7,956,987.

Accordingly, the IU designed and led the Diagnostic and Radiological test project conducted in Miami-Dade County, in January 2009. The IU reviewed claims to identify waste, fraud and abuse in Radiological and Diagnostic Procedures. Fifty Medicaid providers were selected for on-site visits. Five teams of four investigators, consisting of two IU/MPI members, one DOH member and one MFCU member, visited these provider locations.

The initiative resulted in 14 referrals to MFCU, 22 referrals to DOH and 23 referrals to MPI for comprehensive audits. Additionally, 8 referrals to other agencies were made for administrative review. As a result of this initiative, there are ongoing criminal investigations and pending plea agreements that include criminal convictions, restitution and the surrendering of a physician's medical license.

DME (oxygen related equipment) Bay County

Two Durable Medical Equipment (DME) providers and ten recipient records from each provider were selected and reviewed. Collectively, the two DME's billed Medicaid $105,698 for oxygen concentrators and related equipment from January 2008 through February 2009. This helped rand Bay County as the eighth highest billing county for oxygen concentrators in Florida. Each recipient was interviewed to verify the provider billing records and for a visual inspection of the medical equipment. Agency for Persons with Disabilities (APD) staff made recipient visits to recipients who received

Medicaid waiver services. This effort identified one provider with numerous documented violations who closed after the on-site visit. The other provider was found to be in compliance. A recommendation for a comprehensive audit was forwarded to MPI.

DME (oxygen related equipment) Escambia County

Medicaid billing for oxygen concentrators by DME's in Escambia County from January 2007 through April 2009 was analyzed and the two top billing providers were selected for review. These two providers collectively billed Medicaid $245,614 for the review period. Fifteen recipients for each provider were selected and the billing records were compared with the recipient interviews and site visits. One provider was determined to be in compliance with Medicaid policy. The second provider was found to be in violation of numerous Medicaid policies and the findings were forwarded to MFCU. This same provider was also a provider in Alabama and the IU findings were forwarded to the Alabama Medicaid Agency Investigations Unit for their consideration. The final disposition of this investigation is still pending.

At the conclusion of field initiatives, the OIG staff used the findings to determine where additional Medicaid policy controls were needed. As a result of the Escambia and Bay county initiatives, the following policy recommendations were made to Agency Medicaid Services related to oxygen related equipment:

- Reduce the monthly Medicaid reimbursement rate for oxygen concentrators or gradually reduce the per-month payment. Even when considering labor, time and gas for quarterly maintenance visits, $170.48 per month appears excessive, especially when compared to the purchase cost. Medicaid may consider this item as a rent-to-purchase item after a certain number of payments.
- Require a Medicaid recipient's or legal guardian's signature and date on the quarterly home visit documentation.
- Require oxygen usage meter hours to be recorded at the time of each quarterly home visit for the oxygen concentrator, instead of only at the time of delivery.
- Require DME providers to adhere a small sticker to the oxygen concentrator in the recipients' residences at the time of the quarterly visit containing the following information: visit date, DME provider staff person who completed the visit, oxygen output and oxygen meter reading.
- At the time of each quarterly visit by the DME provider, as required by Medicaid policy, require the DME company to promptly report Medicaid recipients' non-compliance with the prescribed use of oxygen related equipment to the prescribing physician. Non-compliance and non-use should be apparent to the DME provider from either the oxygen meter or from the interviews. DME providers must document their contacts with ordering physicians and determine if the continued use of oxygen related equipment remains medically necessary.

- Prohibit DME providers from billing and receiving Medicaid reimbursement for oxygen concentrators when the provider is not able to document in-person, home visits as required by Medicaid policy.
- Require DME providers to provide newer oxygen concentrator models. Older machines consume more energy to run and burden Medicaid recipients with higher electric bills, therefore promoting non-compliance.
- Require a physician's order to justify medical necessity when specifically prescribing portable oxygen.
- If portable oxygen use is not for a Medicaid recipient who requires oxygen 24 hours per day, then the prescribing physician should clearly define detailed therapeutic activities or exercise requiring the use of portable oxygen. The DME provider must keep a copy of the physician prescription detailing this information.

Internal Investigation Cases FY 2008–09

Case Number	Case Type	Allegation	Disposition
08-081	PI	Alleged sexual harassment and conduct unbecoming a supervisor	No action required
08-082	RF	Alleged inadequate patient care	Referred to DOH, CSU
08-083	RF	Alleged inadequate patient care	Referred to DOH, CSU
08-084	RF	Alleged violation of patient's rights	Referred to AHCA CAU
08-085	RF	Alleged Medicaid coverage cancelled	Referred to DCF IG
08-086	PI	New FMMIS Program alleges to be revision of old system	No action required
08-087	RF	Allegation of battery and medical negligence	Referred to CAU
08-088	NF	Alleged paying off the State	No actual information
08-089	RF	Alleged inappropriate services to people	Referred to CAU
08-090	RF	Alleged patient abuse and retaliation to employee for reporting it	Referred to DOH, CSU
08-091	PI	Alleged conflict of interest with private counseling services and AHCA position	Referred to Management
08-092	IN	Alleged employee misconduct	Unfounded
08-093	RF	Allegations against a physician	Referred to DOH
08-094	RF	Alleged of poor quality of care and abuse	Referred to CAU
08-095	RF	Alleged poor quality of care / neglect	Referred to CAU
08-096	IN	Alleged discrimination in the workplace	Unfounded
08-097	PI	Alleged fraudulent billing / kickbacks	Referred to CMS
08-098	IN	Alleged conduct unbecoming of a public employee	Founded
08-099	IN	Alleged racial discrimination	Unsubstantiated
08-100	RF	Alleged Medicaid fraud	Referred to FDLE
08-101	PI	Alleged patient abuse	Referred to APD
08-102	PI	Alleged fraud	Insufficient information
08-103	PI	Alleged improper billing	Referred to HQA

08-104	PI	Alleged patient abuse / neglect and fraudulent billing	Referred to MFCU
08-105	PI	Alleged closing clients accounts	Reviewed and Resolved
08-106	PI	Alleged falsifying patient records for Medicaid reimbursement	Referred to HHS IG, Washington, DC
08-107	RF	Alleged conduct Unbecoming a public employee	Referred to HQA
08-108	RF	Alleged improper billing	Referred to HHS
08-109	IN	Alleged inaccurate facility functions	Unfounded
08-110	PI	Alleged fraud and abuse	Referred to DCF
08-111	PI	Alleged fraud	Referred to MFCU
08-112	PI	Alleged non-compliance with HIPAA	Unfounded
08-113	PI	Alleged abuse to mentally challenged adult	Referred to AHCA LA
08-114	PI	Alleged sending Medicaid benefits out of state	Resolved
08-115	IN	Alleged employee abuse	Unfounded
08-116	PI	Alleges that sick child has not received Medicaid card	Resolved
08-117	RF	Alleged fraud	Referred to DOH
08-118	RF	Alleged fraud	Referred to Medicare
08-119	PI	Alleged fraud	Referred to HQA
08-120	PI	Alleged poor patient care	Unfounded
08-121	PI	Alleged poor quality patient care	Founded
08-122	RF	Alleged improper patient care	Referred to AHCA HQA and DOH MQA
08-123	PI	Alleged improper patient care	Referred to DOH and DCF
08-124	IN	Alleged attempt to pay-off surveyors	Unfounded
08-125	IN *	Alleged misuse sick leave	Unfounded
08-126	PI	Alleged fraud	Referred to HQA
08-127	RF	Alleged discrimination	Referred to HQA
08-128	IN	Alleged patient abuse	Founded
08-129	IN	Alleged fraudulent billing	Founded
08-130	IN	Alleged false reporting	Founded

08-131	IN	Alleged conflict of interest and conduct unbecoming	Founded
08-132	IN	Alleged identity theft	Reviewed and Resolved
08-133	PI	Alleged inadequate billing	Referred to DCF
09-001	PI	Alleged billing fraud	Referred to DOH
09-002	PI	Alleged fraud	Unfounded
09-003	PI	Alleged Medicaid services not attainable	Resolved
09-004	PI	Alleged identity theft	Unfounded
09-005	IN	Alleged misuse of Provider number	Founded
09-006	PI	Alleged HIPAA violation	Reviewed and Resolved
09-007	PI	Alleged lack of patient care	Reviewed and Resolved
09-008	PI	Alleged conduct unbecoming a Medicaid employee	Reviewed and Resolved
09-009	PI	Alleged Medicaid fraud	Referred to FDLE
09-010	NF	Medicaid client requests surgeon contact	Reviewed and Resolved
09-011	PI	Alleged lack of Medicaid service	Reviewed and Resolved
09-012	IN	Alleged misuse of employee's computer	Founded
09-013	RF	Alleged DCF poor child care service provided	Referred to DCF
09-014	PI	Alleged lack of care	Reviewed and Resolved
09-015	PI	Alleged that hospice care not being provided	Reviewed and Resolved
09-016	PI	Alleged poor patient care	Referred to BFO
09-017	PI	Alleged Quality Indicator Survey (QIS) lacks effectiveness and efficiency	Unfounded
09-018	IN	Alleged employee conduct unbecoming	Founded
09-019	IN	Alleged failed to review facility properly	Founded
09-020	IN	Alleged billing for services not rendered	Referred to BFO
09-021	PI	Alleged inadequate patient care	Referred to BFO
09-022	PI	Alleged inadequate patient care	Referred to FMQA and DOH
09-023	PI	Alleged overbilling	Referred to MFCU
09-024	RF	Alleged HIPAA violation	Referred to

			HIPAA
09-025	PI	Alleged failure to provide insurance service	Resolved
09-026	RF	Alleges infusion fraud scheme	Referred to MPI
09-027	PI	Alleged resident/patient neglect	Referred to BFO
09-028	NF	Alleged lack of children's customer services	Reviewed and Resolved
09-029	RF	Alleged defrauding Medicare, Medicaid and SSA	Referred to Miami-Dade Police, DCF and DOH
09-030	PI	Alleged fraudulent billing	Insufficient information
09-031	RF	Alleged lack of security	Referred to BFO
09-032	PI	Alleged fraud	Insufficient information
09-033	IN	Alleged patient abuse	Unfounded
09-034	PI	Alleges retaliation	Unfounded
09-035	PI	Alleged fraud Internet prescribing	Referred to FMCU
09-036	PI	Alleged falsification of records	Referred to DCF
09-037	PI	Alleged inadequate patient care	Unfounded
09-038	PI	Alleged child health insurance issues	Resolved
09-039	PI	Alleged credit card theft	Founded
09-040	IN	Alleged AHCA of illegal investigation	Unfounded
09-041	RF	Alleged Theft	Referred to County Sheriff office
09-042	PI	Alleged wrongful termination of child from Medicaid	Reviewed and Resolved
09-043	PI	Alleged fraud	Unfounded
09-044	PI	Review of Internet monitoring	Unfounded
09-045	IN	Alleged AHCA failed to respond to Public Records request	Unfounded
09-046	RF	Alleged of fraud	Referred to APD
09-047	PI	Alleged patient abuse	Referred to MFCU
09-048	PI	Alleged self referral violations	Insufficient information
09-049	PI	Alleged pharmacy / prescription issues	Insufficient information
09-050	IN	Alleged failure to properly investigate	Insufficient information

09-051	PI	Alleged fraud billing	Reviewed and Resolved
09-052	PI	Alleged fraud	Reviewed and Resolved
09-053	IN	Alleged improper travel arrangements	Founded
09-054	PI	Alleged unprofessional conduct	Reviewed and Resolved
09-055	RF	Alleged failure to honor directive / surrogate of patient	Referred to HQA
09-056	IN	Alleged fraud and patient abuse	Insufficient information
09-057	PI	Alleged fraud	Reviewed and Resolved
09-058	PI	Alleged lack of patient care	Reviewed and Resolved
09-059	IN	Alleged falsification of documents	Founded
09-060	PI	Alleged lack of customer service	Reviewed and Resolved
09-061	PI	Alleged inappropriate presentation	Handled by AHCA Secretary
09-062	PI	Alleged fraud	Referred to MPI
09-063	PI	Alleged fraud	Insufficient information
09-064	PI	Alleged Medicaid overpayment should be corrected	Referred to MPI
09-065	PI	Alleged fraud	Reviewed and Resolved
09-066	PI	Alleged misuse of Upper Payment Limit (UPL)	Referred to PPAGA
09-067	PI	Alleged fraud / overpayment	Insufficient information
09-068	IN	Alleged failure to honor directive / surrogate	Reviewed and Resolved
09-069	PI	Alleged inappropriately terminated from Florida KidCare	Reviewed and Resolved
09-070	IN	Alleged employee harassment	Unfounded
09-071	PI	Alleged unfair Medicaid monitoring	Reviewed and Resolved
09-072	IN	Alleged employee harassment	Unfounded
09-073	IN	Alleged discrimination	Unfounded

09-074	PI	Alleges inappropriately terminated from Florida KidCare	Reviewed and Resolved
09-075	PI	Alleged Medical Center conspiracy	Reviewed and Resolved
09-076	PI	Alleged financial strain on provider from pre payment review (MPI)	Referred to MPI
09-077	PI	Alleged Medicaid fraud	Referred to DOH
09-078	RF	Alleged lack of patient care	Referred to HQA
09-079	PI	Alleged Florida KidCare contact information not provided to public	Reviewed and Resolved
09-080	RF	Alleged poor customer service on decade old complaint	Referred to Health Facility Regulations
09-081	RF	Alleged fraud	Referred to DCF
09-082	PI	Alleged unethical practices	Referred to OSHA
09-083	RF	Alleged Medicaid fraud	Referred to DCF IG
09-084	IN	Alleged excessive Internet activity	Founded
09-085	PI	Alleged failure to enroll children in Kid Care Program	Reviewed and Resolved
09-086	PI	Alleged discrimination by Ombudsmen Program	Referred to OGC
09-087	RF	Alleged was terminated after reporting to AHCA facility hired unqualified staff	Referred to CSI
09-088	PI	Alleged patient care concerns	Referred to DEA IG
09-089	IN	Alleged sexual harassment	Founded
09-090	PI	Alleged fraud	Reviewed and Resolved
09-091	NF	Alleged discrimination	Information only
09-092	RF	Alleged DCF office unresponsive	Referred to DCF IG
09-093	RF	Alleged retaliation	Referred to CAU
09-094	RF	Alleged unsafe equipment	Referred to CAU
09-095	IN	Alleged falsification of report	Founded
09-096	PI	Alleged sleeping on the job	Referred to person at the facility
09-097	RF	Alleged Medicaid fraud	Referred to DCF IG
09-098	RF	Alleged fraud	Referred to DCF IG

| 09-099 | IN | Alleged telephone threat call in Medicaid office | Pending |
09-100	RF	Requested Background Screening requirements	Referred to HFR HCU
09-101	IN	Alleged lack of patient care	Reviewed and Resolved
09-102	IN	Alleged AHCA failed to support client in securing records requested of a facility under Section 395.0197 F.S.	Reviewed and Resolved
09-103	IN	Alleged that Medicaid will not provide his requested medicine	Reviewed and Resolved
09-104	PI	Alleged unlicensed home equipment provider	Referred to CAU
09-105	IN	Alleged advanced notification of an unannounced survey	Unfounded

Medicaid Program Integrity

The Bureau of Medicaid Program Integrity (MPI) combats fraud and abuse in the Medicaid program through prevention activities, detection analyses, audits and investigations, imposition of sanctions, and referrals to the Medicaid Fraud Control Unit (MFCU) of the Office of the Attorney General and to other regulatory and investigative agencies. Each year the results of these activities are presented in the *Annual Report on the State's Efforts to Control Medicaid Fraud and Abuse.* This report is submitted jointly by the Agency and MFCU to the Legislature pursuant to Section 409.913, Florida Statutes. The report can be found by underline clicking here[1]

Organization

The Bureau of Medicaid Program Integrity consists of approximately 100 full time staff members. MPI employees are located in Tallahassee, Miami, Tampa, Jacksonville and Orlando. The staff consists of investigators, data analysts, nurses, pharmacists, physicians, programmers and administrative support personnel.

The organizational structure is as follows:

Medicaid Program Integrity Organizational Chart

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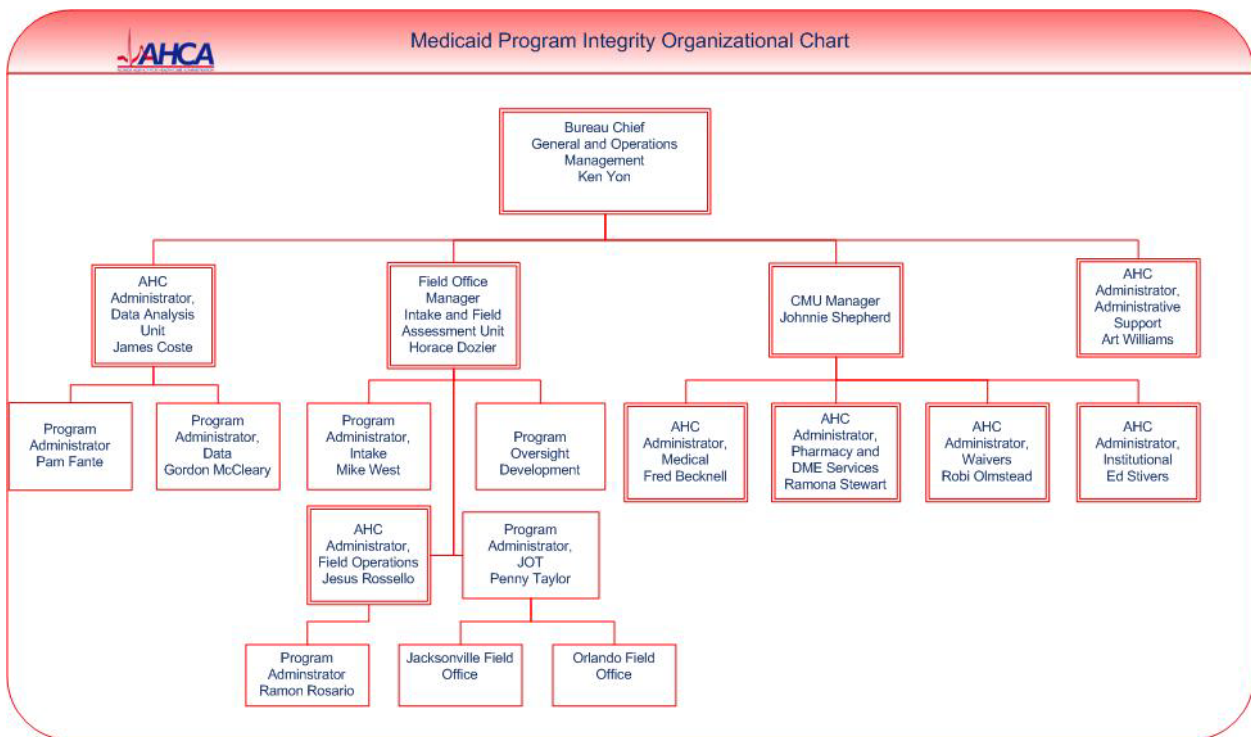
[1]http://www.fdhc.state.fl.us/Executive/Inspector_General/docs/2008_Fraud_and_%20Abuse%20Binder_signed.pdf.

Intake and Field Assessment Unit

The Intake Section is responsible for all incoming referrals, whether from complaints, the hotline or Explanation of Medicaid Benefits (EOMBs). The members of this section perform an initial review of each referral to validate the information and determine the course of action required. EOMBs are mailed quarterly to Medicaid recipients listing the services received during the previous quarter. The recipients are asked to report any services they did not receive. The Intake Section follows up on each discrepancy. If it is determined that the services were not provided, the provider will be requested to void the claim. If a pattern of services not provided is noted, the provider will be referred to the appropriate case management unit (CMU) or to MFCU. Complaints received over the telephone or via the Internet may or may not be Medicaid fraud or abuse related. Non-MPI issues are forwarded to the appropriate agency for action. Any information regarding possible fraud or abuse is evaluated and, if substantiated, referred to the appropriate MPI unit or to MFCU for further investigation.

The Intake Section also monitors press releases via the Internet for any news relating to an investigation, arrest or conviction of a Medicaid provider. Providers found to be under indictment for activity relating to health care practices will be suspended from participation in the Medicaid program for the duration of the legal proceedings, and a conviction will result in termination.

The Field Assessment section combats fraud and abuse throughout the state. Field offices are located in Jacksonville, Orlando, Tampa and Miami. This presence in the community is vital to our efforts in combating fraud, waste and abuse in the Medicaid program. Field office employees are responsible for conducting comprehensive onsite visits, performing recipient interviews to ascertain whether services were rendered, and if rendered, the appropriateness of those services. Based on observations at the visit and from review of records, a number of actions might be taken, including:

- Sanctioning
- Prepayment review
- Paid claims reversal
- Referral to MFCU
- Referral to an MPI case management unit
- Referral to other agencies
- Referral to self audit unit to initiate a provider self audit
- Termination recommendation

MPI field office employees also perform several field initiatives (focused projects) each year. These initiatives focus on simultaneous reviews of recipients, providers and prescribers and often include collaboration with state and federal partners such as the Division of Health Quality Assurance, the Medicaid Division, the Department of Health, the Agency for Persons with Disabilities, MFCU and the Centers for Medicare & Medicaid.

Field office personnel act as liaisons with Medicaid Area Offices, local governments and law enforcement entities. They participate in regularly scheduled meetings among federal, state and local health care regulators with the goal of improving interagency communication. They also conduct presentations on the roles of MPI for other agencies and providers.

Field office staff members participate in Operation Spot-check visits throughout the state, which are managed by MFCU. These unannounced visits are made to nursing homes, assisted living facilities and licensed group homes. MPI reviews the operations of these facilities to ensure that Medicaid policies and procedures are being met. If more action is needed, MPI pursues necessary remedies including prepayment reviews, records requests and referrals.

Data Analysis Unit

The Data Analysis Unit detects potential fraud and abuse in the Medicaid program. This unit is responsible for developing generalized analyses and providing programming support for other MPI units. They also facilitate provider self audits and coordinate Medicaid policy clarification requests. The Data Analysis Unit contains the Data Detection Section and the Special Projects, Research and Development and the Coordination Section (RDU).

The Data Detection Section is responsible for reviewing detection reports and analyzing claims data. They develop leads for the case management units. They work closely with our Medicare partners to identify fraud and abuse issues related to claims paid by both entities. They work with MFCU on data projects. Data detection efforts are geared to detect violations through several detection methods. On the basis of apparent violations, investigations are conducted to determine whether overpayments exist. Recoveries of any overpayments are initiated or referrals to outside agencies are recommended. The Data Detection section utilizes various tools, resources and reports in an effort to identify Medicaid fraud and abuse activities.

The RDU is the primary source for generalized analyses referrals. They review previously successful generalized analyses for possible reproduction or expansion, meet regularly to discuss leads from the CMUs and Data Analysis, analyze policy to identify possible violations and develop and monitor requests for generalized analyses programming. They also provide programming support to MPI and produce Generalized Analysis reports. The RDU guides providers in performing self-audits for inappropriate payments due to a misunderstanding of a policy interpretation or erroneous Medicaid billing and develops and refers self audits to the CMUs for execution. The RDU is responsible for coordinating all Medicaid policy clarifications for MPI.

Case Management Units

CMU recovers misspent Medicaid funds by performing standard, comprehensive audits and generalized analyses. Statistical methodology is used in the generation of a random sample of claims. After a review of provider documentation, if an overpayment is determined for the sampled claims, the sample findings are extrapolated or extended to the population of claims for the time period under review. The statistical methodology for determining the total overpayment utilizes the 95 percent confidence level and has been affirmed in administrative hearings involving MPI's sampling methods.

CMUs perform claim reviews, prepayment reviews, make policy or edit recommendations and assist with the litigation process. The CMUs are organized based primarily by the types of providers each investigates, as follows:

- Institutional Unit - Conducts audits of institutional types of providers such as hospitals, nursing facilities, health maintenance organizations and ambulatory surgical centers.
- Medical Unit - Conducts audits primarily of non-institutional types of providers such as physicians, independent laboratories, advanced registered nurse practitioners, and county health departments.
- Pharmacy and Durable Medical Equipment Unit - Conducts audits primarily of non-institutional types of providers such as pharmacies and durable medical equipment providers.
- Waiver Unit - Conducts audits related to the Home and Community Based Waiver Program and of providers such as dentists, audiologists, podiatrists and chiropractors.

The CMU also serves as the Bureau's point of contact for the Federal Audit Program. CMS created the Medicaid Integrity Group (MIG) to carry out the program. CMS has established contracts with private firms referred to as Medicaid Integrity Contractors (MICs) to carry out the program. The three primary MIC functions are:

- The "review MIC," which analyzes Medicaid claims data to determine whether provider fraud, waste, or abuse has occurred or may have occurred;
- The "audit MIC," which audits provider claims and identifies overpayments; and
- The "education MIC," which provides education to providers and others on payment integrity and quality-of-care issues.

Florida was one of four states in the Federal Audit Pilot Program which has resulted in six audits being completed by the audit MIC. Currently, 20 Florida Medicaid providers are being audited.

Administrative Support Unit

The Administrative Support Unit monitors the budget and manages all of MPI's contracts and purchases. Its members are responsible for staff training, workplace

safety and security, and personnel functions. The unit also assists with the litigation process, records storage and other support functions.
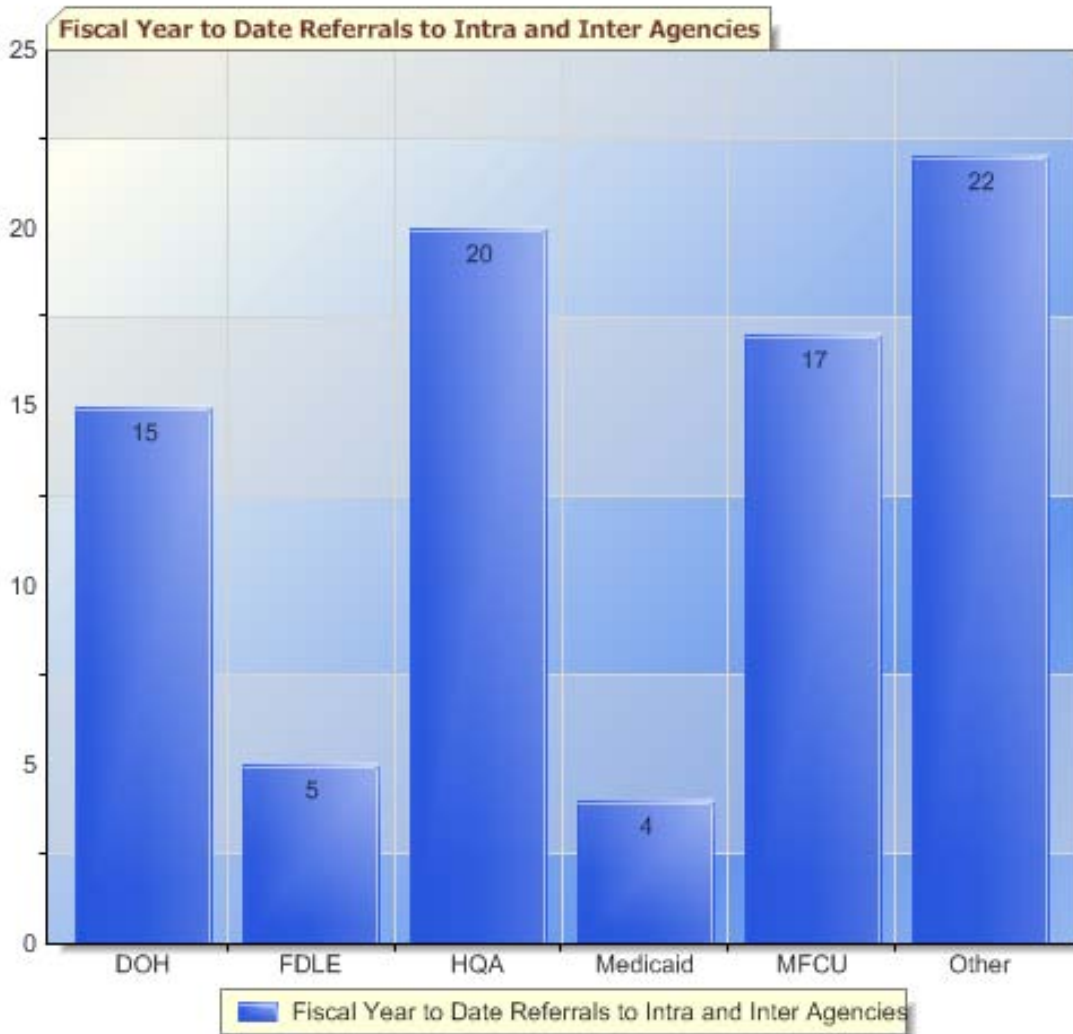
Challenges

Four significant factors influenced MPI operations during FY 2008-09:

1. FY 2008-09 continued to be impacted by the Agency's transition to the new Florida Medicaid Management Information System and Decision Support System (FLMMIS/DSS) and the final certification of the Surveillance and Utilization Review System (SURS). MPI extensively involved in the development and testing of the systems since they are critical to the fraud and abuse detection and investigation activities of the Bureau.
2. The Agency's Third Party Liability contract ended during FY 2007-08. That contractor provided vital fraud and abuse detection services to MPI, including retrospective computer-based analyses of paid claims to determine overpayments. These services were not fully available to MPI during FY 2008-09 and the current fiscal year. Transition to a new contractor will adversely affect MPI's efforts to detect irregular claims and to recoup overpayments during FY 2009-10.
3. MPI continues to actively assist the CMS in the development of provider audit protocols involved in their oversight of state Medicaid programs. The Federal Audit Program requires MPI staff members to review draft audits during the audit process. MPI will take ownership of the CMS MIC produced Final Audit Reports and notify Florida providers of the findings. MPI will then coordinate the collection of identified overpayments and support litigation requirements. The number of audits is expected to increase during the upcoming fiscal year.
4. A provider has challenged the use by the Agency of statistical sampling in audits on the basis that a certain formula had not been incorporated in an Agency Administrative Rule, notwithstanding that this formula and other pertinent formulas are published in many textbooks referenced by the Agency. A legal proceeding culminated in a court decision upholding the Agency's practices in this regard, but not before the Agency was precluded for more than a year from issuing binding audit reports incorporating statistical sampling. This litigation encumbered the processing of approximately 250 cases with estimated overpayments of $18 million identified either preliminarily or in final reports. Working the backlog of these cases in litigation has impacted MPI's efforts to develop new cases.

Performance Measures

MPI performance measures are posted monthly on the Agency's Internet site and include claims denied, the identification and collection of overpayments on closed

cases, and referrals. (*Click here to go to Agency Dashboard*)[1] Below is an example of the type of information available on the dashboard.

Fiscal Year to Date Referrals to Intra and Inter Agencies

Agency	Referrals
DOH	15
FDLE	5
HQA	20
Medicaid	4
MFCU	17
Other	22

Fiscal Year to Date Referrals to Intra and Inter Agencies

Detection

MPI detection efforts include development of advanced detection software as well as use of software supplied by the fiscal agent contractor. Primary detection tools include DSS Profiler, First Health Pharmacy reports, Business Objects ad hoc reports, 1.5 reports, Chi-square upcoding reports, Early Warning System reports and the Medi-Medi project. These tools provide a means for analyzing Medicaid claims data and for detecting over-utilization and aberrant behavior. They result in referrals to MFCU and other regulatory agencies. Investigative leads are also produced for investigation by MPI's field staff and the CMU.

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[1] http://ahcaxnet.fdhc.state.fl.us/dashboard

Office of the Inspector General

Medi–Medi Project

The Medi-Medi project was established to detect and prevent fraud, waste and abuse in the Medicare and Medicaid programs by performing computerized matching and analysis of both Medicare and Medicaid data. This matching is to detect claims paid by Medicaid that should have been paid only by Medicare. Through this program, statistical analysis, trending activities and the development of valuable potential fraud cases for referral to appropriate health care and law enforcement agencies can be completed. Information is provided to MPI and other entities in the areas of excessive billing patterns, duplicate payments, services billed in both programs with no cross-over in place, and various other abuses. Medi-Medi complements MPI's efforts not only by matching Medicare and Medicaid data, but also by developing enhanced coordination between agencies and with law enforcement to prevent, identify, analyze, and investigate Medicaid fraud and abuse.

Prevention

Prevention efforts enhance the efficiency of the Medicaid program. Ensuring Medicaid claims are proper prior to issuing payments prevents unnecessary expenditure on recovery efforts and allows Medicaid funds to be used as intended. Prevention efforts by MPI include prepayment reviews, site visits, focused projects, denial of reimbursement for prescription drugs, policy change recommendations and field initiatives.
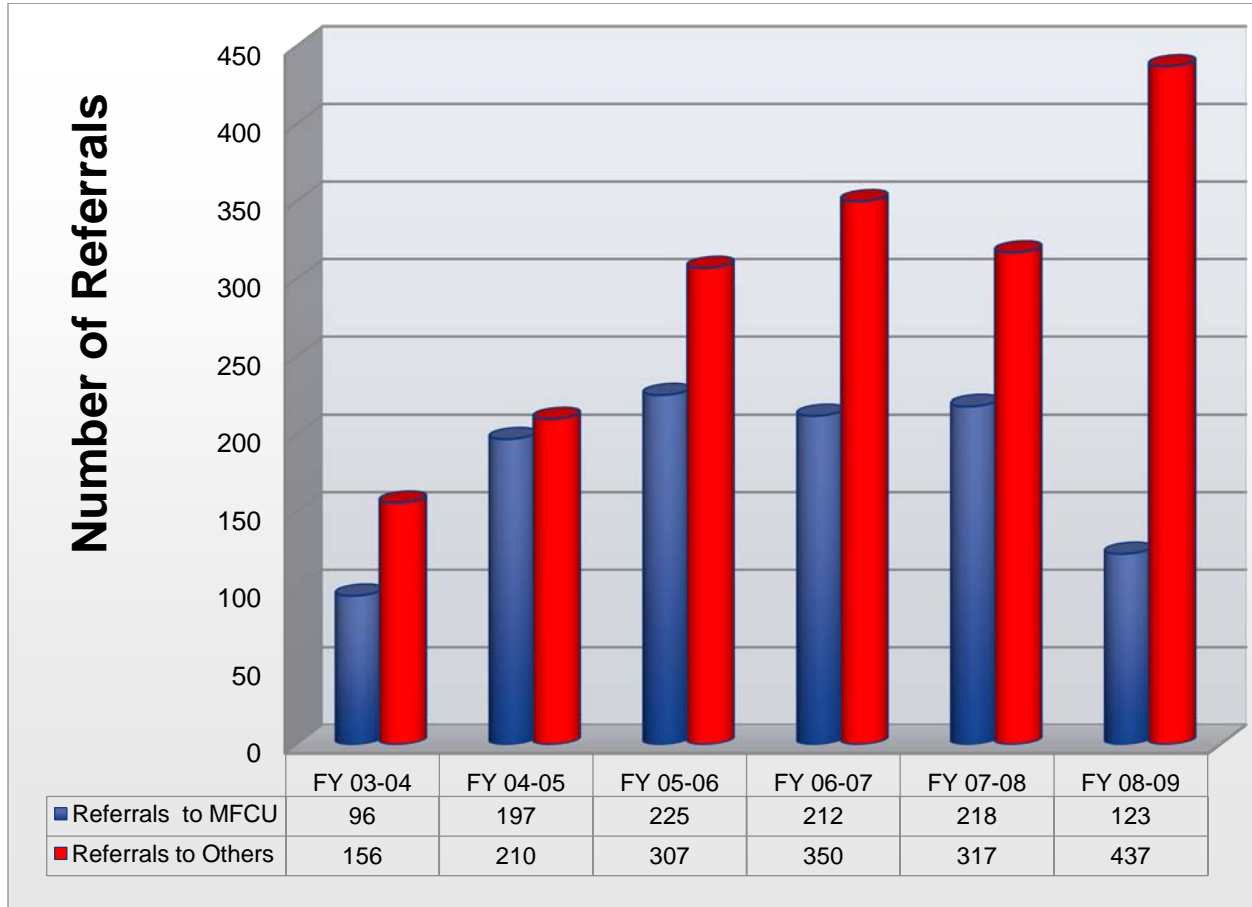
Referrals

The Agency for Health Care Administration and the Medicaid Fraud Control Unit of the Attorney General's Office have continued their joint efforts to prevent, reduce, and mitigate health care fraud, waste, and abuse in Florida. Staff members from the Agency and MFCU, as well as the Department of Health, meet regularly to discuss major issues, strategies, joint projects and other matters concerning health care.

Any suspected fraud is referred to MFCU for full investigation and prosecution. The Agency and MFCU continue to refine that referral process and continue to collaborate closely with each other and with DOH, Florida Department of Law Enforcement, Department of Children & Families, and Center for Medicare & Medicaid Services to assure that Medicaid funds are utilized for those most vulnerable, as intended.

Referrals

Number of Referrals

	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08	FY 08-09
■ Referrals to MFCU	96	197	225	212	218	123
■ Referrals to Others	156	210	307	350	317	437

Referrals made by MPI to MFCU and other agencies

Prepayment Reviews

Prepayment Reviews encompass the examination of claims associated with intercepted payments and the evaluation of pended claims. The intercepted payments are payments for Medicaid claims that have been processed for payment but the payment has not yet been sent to the provider. Pended claims have not yet been processed for payment. Both types of claims may undergo a prepayment review. A provider must submit supporting documentation for claims under prepayment review so MPI can determine whether to pay or deny the claim.

In a prepayment review, claims not having proper documentation are denied. MPI may place a provider on prepayment review for such reasons as:

- suspicion of fraudulent or abusive behavior;
- suspicion of neglect of a recipient;
- suspected overpayment;

- receipt of a complaint against the provider;
- suspicion of rendering goods or services that are not medically necessary, are of inferior quality, or have not been provided in accordance with applicable provisions of all Medicaid or professional requirements;
- suspicion of billing for goods or services that have not actually been furnished;
- suspicion of billing for goods or services for which appropriate documentation is not made at the time the goods or services were provided;
- random selection based upon a fraud or abuse prevention initiative;
- suspicion of any of the violations set forth in Section 409.913(15), F.S.; or
- standard oversight evaluations.

Cost savings for prepayment reviews are calculated based on funds that would have been paid had the prepayment review not occurred. For intercepted payments, the amount avoided is the amount of the reduction in the payment to the provider. The full amount of the reduction is considered cost avoided, because the claim has been through the Medicaid system edits. For pended claims denied, the cost-avoided amount is the billed amount less the proportion of the billed amount that would have been denied due to system edits.

The chart below provides a historical look at dollars associated with prepayment reviews over the last four years.

Prepayment Reviews

	FY 05-06	FY 06-07	FY 07-08	FY 08-09
Prepayment Reviews	$5,478,787	$4,806,913	$4,168,821	$5,791,425
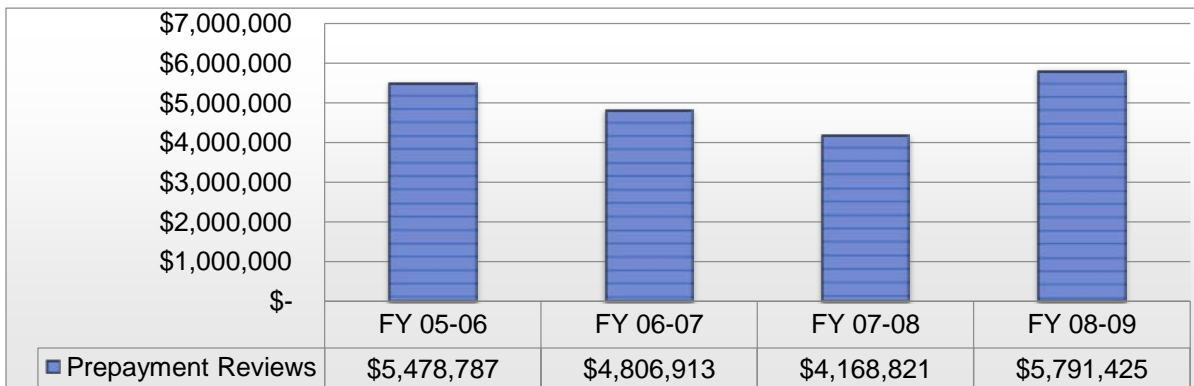
Medicaid costs avoided as a result of MPI prepayment reviews

Field Office Initiatives

Field office personnel conduct site visits to certain newly-enrolled Medicaid providers in specified geographic areas in an effort to control Medicaid provider fraud and abuse and to prevent the misuse of State funds. These visits ensure that the provider is still at the address given, appears to have the assets required to perform the services that will purportedly be furnished, has necessary Medicaid manuals and forms, is generally

familiar with Medicaid policies, and knows how to obtain Medicaid information. Following the site visits, MPI sends education letters to the providers advising them of any issues identified during the visits, including those found in the review of records. A follow-up visit to the provider may be conducted to ensure that the provider has corrected any deficiencies and is in compliance with Medicaid policy.

Four major field initiatives were conducted between January and June 2009 addressing diagnostic and radiological testing services in Miami, home health agency services in Miami and Jacksonville and durable medical equipment services in Miami. These focused projects included site visits to more than 150 providers and more than 200 recipients. CMS, DOH and MFCU participated in some of the projects. As a result of these projects MPI made referrals to internal and external agencies, imposed sanctions and terminated certain providers.
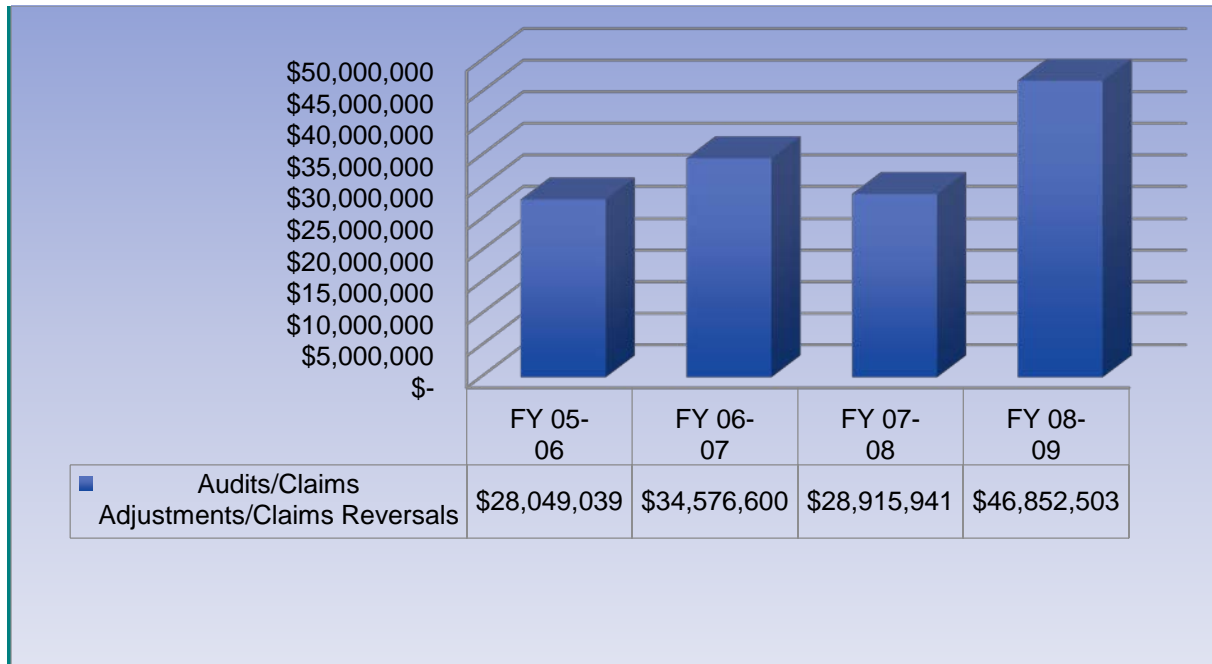
Investigations and Recovery

Investigation and recovery efforts by MPI include comprehensive reviews of professional records, generalized analyses involving computer-assisted reviews of paid claims, paid claim reversals involving adjustments to incorrectly billed claims, focused audits involving reviews of certain providers in specific geographic areas, and referrals to MFCU and other regulatory and enforcement agencies.

Allegations and indications of Medicaid policy violations could result in an MPI-conducted audit, a paid claim reversal, or a vendor-assisted audit. MPI's recovery efforts concentrate on conducting comprehensive investigations and generalized analyses of Medicaid providers. MPI uses Florida licensed pharmacists to review claims paid to pharmacies and works with Medicaid Third Party Liability to augment its recovery efforts.

There are two types of MPI audits. Comprehensive audits evaluate all aspects of a single provider's billings and generalized analyses evaluate specific aspects of numerous providers' billings. Comprehensive audits typically involve identifying all of the provider's paid claims (the population) for a specific period of time and taking a random sample of claims from the population. The sampled claims are carefully reviewed with respect to Medicaid policy and any overpayments found in the sample are extrapolated by generally accepted statistical methods to the population of claims in order to determine the total overpayment in the population.

Office of the Inspector General

Identified Overpayments

Overpayments identified by Medicaid Program Integrity

	FY 05-06	FY 06-07	FY 07-08	FY 08-09
Audits/Claims Adjustments/Claims Reversals	$28,049,039	$34,576,600	$28,915,941	$46,852,503

Pharmacies submit claims to Medicaid as the pharmaceuticals are dispensed. Occasionally, pharmacies overstate the amount of the drug that is dispensed creating an overpayment. If an atypical claim is identified, the provider is contacted and given the opportunity to submit supporting documentation justifying the paid claim amount or is requested to reverse the claim in the electronic claims submission system. When the claim is reversed, the Medicaid program is credited with the original amount paid to the provider. The provider may resubmit the claim with the corrected quantity and then is paid the correct, reduced amount. The difference between the original payment and the reduced payment is recorded by Medicaid as recovered overpayments. Providers who do not adjust or reverse the incorrect payment are subject to further audit or other administrative action by the Agency.

MPI contracts with the Third Party Liability vendor for assistance in several fraud and abuse recovery efforts. The vendor is able to focus on projects involving large volumes of data, which allows the Agency to process claims adjustments on projects involving numerous providers. The vendor works closely with MPI to ensure that the policy basis for the project is sound and that there are no conflicts between providers under investigation by MPI or MFCU and those reviewed by the vendor.

The Date of Death project involves reviewing the FLMMIS paid claims file and comparing the date of service to the date of death on the recipient file. If claims were paid for dates of service after the date of death, the provider is notified of the amount of

overpayments that are to be recouped. The providers are given the opportunity to review the claims in question and submit documentation refuting the date of death, such as a copy of a death certificate or a doctor's note. If the provider's documentation is acceptable, those claims are removed from the recoupment listing. In order to recover the funds, adjustments are submitted to the fiscal agent for posting to the FLMMIS.

On-Site Facility Audits involve reviewing the credit balance reports of hospitals and nursing homes in order to identify overpayments by Medicaid. A credit balance appears on a provider's accounts payable ledger as an amount owed to another entity, such as Medicaid.

Provider Self Audits can occur when providers having credit balances are mailed letters requesting that they review their credit balances and voluntarily refund any overpayments to Medicaid.

Duplicate Billing reviews identify Medicaid payments to hospitals for inpatient services that are for overlapping periods or are duplicates.

Managed Care

MPI and OIG staff was heavily involved this year in developing standard contract language for the fraud and abuse sections of the Agency's new managed care organization (MCO) contract, effective September 1, 2009. Development of fraud and abuse related language for this three-year contract was seen as a critical endeavor requiring establishment of a workgroup to review all aspects of the contract where language enhancements or additions could improve MCO accountability as well as aid in the prevention, detection and reporting of suspected fraud and abuse. The workgroup aligned this effort with the broader Agency contract development team, while coordinating with MFCU and Agency General Counsel staff. Many of the OIG/MPI workgroup's recommended contract language changes were adopted, resulting in a core managed care contract with strengthened reporting requirements and an emphasis on encouraging MCOs to establish effective fraud and abuse compliance programs.

OIG/MPI staff began strategic planning for re-tooling MPI to better address the unique characteristics of fraud and abuse oversight in managed care. This included identifying key Agency MCO oversight activities and processes that produced information indicative of fraud or abuse at the plan, provider, subcontractor, or enrollee level. Progress was also made on implementing necessary MPI managed care fraud and abuse oversight infrastructure. For example, MPI staff established a casework system and assigned case tracking responsibility for MCO referrals of suspected fraud or abuse. A secure FTP site was also established by MPI for MCOs to report case activity and status on a quarterly basis as well as to provide a secure electronic means for MCOs to submit supplemental investigative information. OIG and MPI staff collaborated on development of a report template to be included in the new Agency Managed Care Report Guide, which is part of the 2009-2012 contract. The data reported by MCOs will be used to track statewide MCO fraud and abuse detection and prevention activity, to

assist MCOs in enhancing their fraud and abuse related activities, and in demonstrating MCO due diligence regarding their oversight of providers. The data will also assist in detecting fraud and abuse patterns among MCO providers and in coordinating with the MFCU on active investigations.

Referrals of suspected fraudulent or abusive providers from MCO Special Investigative Units to MPI have increased significantly over last year. The Fraud and Abuse Tracking System reports 41 referrals were received from MCOs in FY 2007-08, while 146 were received in FY 08-09, an almost four-fold increase. MPI staff assigned to the managed care area continued to monitor and track these referrals, as well as participate in MCO application reviews and on-site reviews as a means of educating the MCOs about the referral process and to ensure that MCOs have strong fraud and abuse compliance programs in place. Specifically, MPI staff conducted managed care oversight through participation in the following activities:

1) Review of MCO application materials related to fraud and abuse prevention contract provisions, as a means of assessing MCO readiness prior to contract execution;
2) On-site contract compliance reviews and staff interviews to assure MCOs have active and effective compliance programs in place, including viable communication pathways for reporting fraud and abuse;
3) Assigning corrective action to MCOs when required as a result of MPI fraud and abuse compliance review findings, and providing follow-up assessment of MCO corrective action implementation;
4) Attending monthly managed care contract oversight meetings with the Bureau of Health Systems Development and the Bureau of Managed Health Care;
5) Hosting monthly to bi-monthly meetings with the Medicaid Fraud Control Unit on managed care issues;
6) Staffing managed care casework with MPI's Intake Unit, including coordinating referral of any complaint not involving a fraud or abuse issue to the appropriate Agency bureau;
7) Conference calling with MCOs on an as needed basis;
8) Authoring MPI internal operating procedures related to managed care; and
9) Responding to information requests and serving on Agency workgroups related to managed care such as:
   a. The Agency task force for the Managed Care Application Process;
   b. Focused reviews conducted by the External Quality Review vendor;
   c. The Centers for Medicare & Medicaid Services review of Florida's Medicaid Integrity Program; and
   d. Technical and Operations Conference Calls with managed care plans hosted by the Bureau of Health Systems Development.

MPI staff also conducted two major managed care audit projects this year. One involved HMO use of the unborn activation process (a process to pre-register babies before they are born so that their HMO coverage and related capitation payments can begin at birth). The other project related to HMO members who received hospice services. The findings of both projects are currently under Agency review at the MCOs' request and per contract stipulations. Both projects demonstrated an Agency need to review the functionality of preventative systems edits.

2008–09 Highlights

Noteworthy accomplishments by MPI during FY 2008-09 include the following:

- The Third Party Liability vendor identified overpayments to institutions for simultaneously billing for mother and newborn, overpayments to nursing homes for costs covered by patients, and overpayments to nursing homes for errors in reported bed occupancy. These efforts produced over $30 million dollars in contractor recoveries.
- A Medicaid recipient may choose hospice services when they have a medical condition that is expected to reduce their life expectancy to less than six months. While the person is in hospice, the range of non-hospice services for which Medicaid will pay is reduced. MPI identified and recovered approximately $690,000 for non-hospice related services that were not covered by the Medicaid Program.
- For uncomplicated pregnancies, Medicaid will pay for a limited number Fetal Biophysical Profiles. Many instances were identified in which Medicaid paid for services beyond the stated limit. After examination of medical records to confirm that the limit was appropriate for each pregnancy, MPI recovered approximately $393,000 from 148 providers for prenatal services that exceeded the number allowed.
- MPI's Pharmacy Case Management Unit developed and successfully implemented audits for 340B-covered entities. Covered 340B entities may not bill Florida Medicaid more than the 340B acquisition cost plus the state's dispensing fee for pharmaceuticals. Pharmacies were required to submit documentation showing their purchases in the 340B program. Approximately $245,000 was recovered in 5 audits. As of October 2008, Florida was one of only three states to investigate 340B covered pharmacies' Medicaid billing practices, and one of only two states that had collected overpayments in 340B covered entity investigations.
- MPI worked closely with Pharmacy Services in resolving disputes over pharmacy rebates and our direct participation resulted in collections of over $13 million.

Summary

MPI's current results for FY 2008-09 are as follows:

Number of Investigative Files Completed or Closed	2,188
Number of Cases Completed or Closed	1,615
Overpayments Identified	$ 46,852,503
Fine Sanctions Imposed	481,228
Number of Referrals (HQA, DOH, Div. of Medicaid, FDLE, MFCU, etc.)	560
Claims Denied based on Prepayment Reviews	$ 5,791,425

These results display a considerable increase over FY 2007-08, and represent a return on investment of over 5:1.

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