Agency for Health Care Administration

Office of the Inspector General

Annual Report FY 2011-12

September 2012

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

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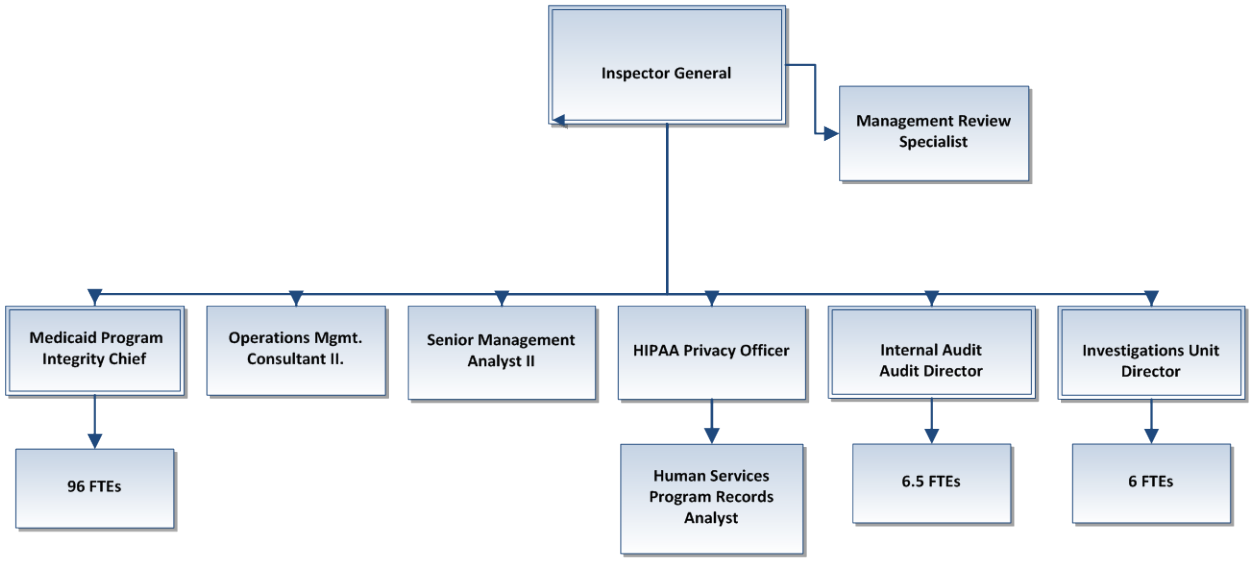
OIG Organization and Staff



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 Agency 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. Also, the OIG provides oversight for the Internal Audit Section, the Investigations Unit and for the Bureau of Medicaid Program Integrity. The organizational chart on page 1 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, deter, detect and recoup Medicaid fraud and abuse related overpayments.

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

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. Internal Audit's mission is to assist the Secretary and other Agency management in ensuring better health care for all Floridians by bringing a systematic, objective approach to evaluate and improve the effectiveness of risk management, control, and governance processes.

The Bureau operates within the Agency's Office of the Inspector General under the authority of section 20.055, Florida Statutes (F.S.). In accordance with subsection 20.055, (5)(c) F.S., the Inspector General and staff shall have access to any records, data and other information of the Agency that is deemed necessary to carry out his or her duties. The Inspector General is also authorized to request such information or assistance as may be necessary from the state agency or from any federal, state or local government entity.

Internal Audit Staff

Internal Audit (IA) staff brings various backgrounds and expertise to the Agency. Certifications or advanced degrees collectively held by IA staff as of June 30, 2012 include:

- Certified Public Accountant
- Certified Internal Auditor
- Certified Fraud Examiner
- Certified Information Systems Auditor

The *International Standards for the Professional Practice of Internal Auditing* and *Government Auditing Standards* require IA staff members 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 staff attending courses, conferences, seminars and webinars throughout the year. IA staff has attended trainings sponsored by national and local chapters of the Association of Inspectors General, Institute of Internal Auditors (IIA), Association of Certified Fraud Examiners, Information Systems Audit and Control Association (ISACA) and the InfraGuard Members Alliance which deals with information technology security and criminal issues. Staff has also attended Agency employee training and Government and Nonprofit Accounting video training.

Internal Audit Organizational Chart

Internal Audit Activities

Assurance Engagements, Consulting Engagements, and Management Reviews

IA completed a total of seven assurance engagements, consulting engagements and reviews during FY 2011-12. 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, 2012 are below.

Internal Audit Engagements Completed as of June 30, 2012

Report No.	Engagements	Type	Date Issued
11-Nov	Agency Data Consolidation	Consulting	8/23/2011
25-Nov	ARRA Data Quality Review, QE 6/30/11	Review	7/20/2011
5-Dec	Enterprise Wide Audit of Contract Monitoring	Assurance	3/15/2012
6-Dec	ARRA Data Quality Review, QE 9/30/11	Review	11/7/2011
7-Dec	IT Mobile Technology Survey	Consulting	3/6/2012
9-Dec	ARRA Data Quality Review, QE 12/31/11	Review	1/13/2012
13-Dec	ARRA Data Quality Review, QE 3/31/12	Review	4/25/2012

Internal Audit Engagements in Progress as of June 30, 2012

Report No.	Engagements	Type	Planned Completion Date
4-Dec	Agency Accounts Receivable Process	Assurance	October, 2012
10-Dec	Medicaid's Risk Management Process	Review	October, 2012
13-03	ARRA Data Quality Review, QE 6/30/12	Review	July, 2012

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

11-11 Agency Data Consolidation

As part of the Agency's FY 2010-11 audit plan, IA conducted a consulting engagement of the Division of Health Quality Assurance (HQA) data sharing needs. The initial focus of the engagement was to evaluate the data sharing capabilities between the information systems utilized by HQA. Later the focus expanded to include information systems throughout the Agency.

As a result of interviews with HQA staff and research throughout the Agency, it was discovered that the Agency was already in the process of reviewing solutions to allow systems to connect to one another. The Agency had developed a plan for data connectivity which is outlined in the Agency's *Strategic Plan for Data Connectivity: Health Care Fraud Databases, December 2010*. The IA recommended that the Agency continue its efforts to identify a universal data element that can be used to link systems together, develop/implement defined system controls to validate data, and improve the coordination and communication between the Divisions in its attempt to develop data connectivity and system integration.

ARRA Data Quality Reviews for 11-25, 12-06, 12-09 and 12-13

(For quarters ending 6/30/11, 9/30/11, 12/31/11, and 3/31/12)

The purpose of the American Recovery and Reinvestment Act of 2009 (ARRA) is to provide federal assistance designed to create and preserve jobs, stimulate economic development and provide help for people affected by the recession. The Agency received the following ARRA awards:

1. *Ambulatory Surgical Center – Healthcare Associated Infection Prevention Initiative* for 2009 and 2010 in the amounts of $16,250 and $659,273 respectively. The awards funded federal ambulatory surgical center surveys that utilized a new infection control survey tool.
2. *Florida Health Information Exchange Cooperative Agreement Program* in the amount of $20,738,582. The purpose of this project is to implement a statewide health information

exchange (HIE) plan that will facilitate and expand the secure, electronic movement and use of HIE among organizations according to nationally recognized standards.

IA completed four data quality reviews of the ARRA award data reported by the Agency in the FlaReporting System for the quarters ending June 30, 2011; September 30, 2011; December 31, 201; and March 31, 2012. The objective was to determine if there were any material omissions or significant errors in the data. Throughout the reviews, staff worked closely with Agency staff to help ensure that reported data was accurate and complete. The reviews did not disclose any material omissions or significant errors in the data submitted to the federal government.

12-05 Enterprise Wide Audit of Contract Monitoring

Pursuant to Section 14.32, Florida Statutes (F.S.), the Executive Office of the Governor, Office of Chief Inspector General (IG) initiated an enterprise audit of the Contract Monitoring Process to evaluate agencies' current policies, procedures and processes for contract monitoring. The Agency's IG participated on this project along with 14 other agencies. Enterprise audit steps were developed by a team of auditors brought together by the Chief IG's Office. The purpose of the audit was to evaluate the Agency's contract policies, procedures, and processes, as well as evaluate contract manager training.

During the engagement, IA reviewed the Agency's contract policies and procedures (specifically the *Procurement Policy* and *Contract Manager Desk Reference*) and contract manager training materials. The Agency's contract policies and procedures, in general, were in compliance with state laws and requirements. However, the review identified a few items that needed to be addressed:

- The Agency Contract Manager training needed to be expanded to detail all aspects of contract management.
- Contract closeout procedures were not specifically defined and documented.
- The Agency's *Agency Agreements Policy* needed to be modified to include procedures for the development, use, and monitoring of such agreements.
- The Agency *Procurement Policy* (Policy #4006) and *Contract Manager Desk Reference* needed to be updated.

12-07 IT Mobile Technology Survey

The Executive Office of the Governor, Office of Chief IG and agency Offices of Inspectors General conducted an enterprise engagement of Information Technology (IT) Mobile Technology and distributed two separate surveys in November 2011 - one to the Chief Information Officer and the other to Agency employees. The surveys were designed to determine how agency employees use mobile technology; what areas of potential risk exist in

regards to confidentiality, integrity and availability and to identify and summarize best practices and employee opinions on the impact of mobile technology on security.

IA reviewed the Agency's specific survey results which included some of the following:

- Almost 17% of the respondents stated that they use personally-owned mobile devices for work-related purposes and many have stored confidential or exempt information on such devices.
- These personally-owned mobile devices included laptops, notebooks, tablets, smartphones, cellphones, etc.
- Employees stated that these personally-owned mobile devices were used to access work information systems, document/spreadsheet software, email, phone calls, etc.
- 17% of the respondents stated that they have never been trained on the risks of storing confidential or exempt information on personally-owned mobile devices.
- Many of the respondents were unclear of the types of guidance (e.g. policies, procedures, training, usage agreements) that address mobile technology security risks for personally-owned mobile devices.

Based on the assessment of the survey results, the following recommendations were made:

- Further develop and refine specific policies and procedures for personally-owned mobile devices.
- Revise the Information Technology and Security sections of the Agency's *New Employee Orientation* and *Keep Informed* trainings to cover the acceptable use and security over personally-owned mobile devices when used for work related purposes.
- Request current and new employees read and acknowledge their understanding of IT policies relating to mobile technology. Specifically the *Acceptable Use Policy* (#10-IT-01), *IT Mobile Computing Policy* (#06-IT-04) and *Portable Storage Policy* (#06-IT-05).

Other Projects

MPI Advanced Detection Consultation

IA assisted MPI in researching and analyzing Advanced Detection software to replace the current Fraud and Abuse Case Tracking System (FACTS). The improved case tracking system will incorporate advanced detection tools. These tools such as predictive analytics and neural networking will enhance MPI's ability to target investigations and audits by assigning resources to high-risk areas.

2011 IT Risk Assessment Survey

Section 282.318(4)(c) and (f), F. S. requires each agency to "conduct, and update every three 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." The Agency for Enterprise

Information Technology (AEIT) developed the *2011 State of Florida Information Security Risk Assessment Survey* to help agencies satisfy this statutory requirement. Each agency Information Security Manager (ISM) was responsible for completing this risk assessment. IA reviewed the completed assessment and supporting documentation provided by the Agency ISM and verified the reasonableness of the responses. The Agency submitted the completed assessment to AEIT by the March 31, 2012 deadline.

Additional Projects

Additional projects completed by IA during the fiscal year included: Schedule IX of the Legislative Budget Request; Summary Schedule of Prior Audit Findings; Department of Health and Human Services Audit Resolution Letter; Chief IG Quarterly Activity Reports; OIG Annual Report; and the annual Risk Assessment and Audit Plan.

Internal Engagement Recommendations Status Reports

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 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.

During FY 2011-12, the following status reports for internal engagements were published:

- 11-15 Aging Out Program, Aged and Disabled Adult Waiver Six Month Status Update
- 11-21 Durable Medical Equipment 18 Month Status Update
- 12-01 Durable Medical Equipment Final Status Update
- 12-03 Enterprise Wide Audit of Organizational Ethics Six Month Status Update
- 12-11 Aging Out Program, Aged and Disabled Adult Waiver 12 Month Status Update
- 12-14 Enterprise Wide Audit of Organizational Ethics 12 Month Status Update

Corrective Actions Outstanding From Previous Annual Reports

As of June 30, 2012 the following corrective actions for significant recommendations described in previous annual reports were still outstanding:

Enterprise Wide Audit of Organizational Ethics, Report 11-18 issued May 5, 2011 (Most Recent Management Response as of 5/1/12)

Recommendation: IA recommended that the subjects of public records, open meetings, records retention, equal opportunity and the related proper personnel procedures be incorporated into the Agency's required New Employee Orientation and Keep Informed training classes.

Most Recent Management Response: Public records, open meetings, equal opportunity and the proper personnel procedures were incorporated into the Agency's required New Employee Orientation and Keep Informed training classes in June 2011. The subject of records retention is currently being reviewed for updates to the Agency Policy and Procedures.

Recommendation: The Bureau of Human Resources should continue to track and send email reminders to employees that have not yet fulfilled their annual training requirements.

Most Recent Management Response: The Bureau of Human Resources continues to track and send email reminders to all employees who have not completed their annual training requirements. The Bureau also continues to notify the supervisor, via email, if an employee is non-compliant for inclusion on their evaluation. The Division of Information Technology is still developing the database to make tracking more efficient and effective.

External Engagement Recommendations Status Reports

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

During FY 2011-12, status reports were submitted on the following external reports:

- Auditor General - State of Florida - Compliance and Internal Controls Over Financial Reporting and Federal Awards, FYE 6/30/10 (Report #2011-167)
- Auditor General - FMMIS Controls and the Prevention of Improper Medicaid Payments (Report #2012-021)
- Auditor General - Medicaid Program Fraud Prevention and Detection Policies and Procedures Facility Cost Reports (Report #2012-035)

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, the U. S. Department of Health and Human Services, and the Department of Financial Services. The OIG also coordinates the Agency's responses to audits and reviews conducted by these entities.

Office of the Auditor General

During FY 2011-12 the Office of the Auditor General issued the following reports:

- FMMIS Controls and the Prevention of Improper Medicaid Payments (Report #2012-021 - Dated October 2011)
- Medicaid Program Fraud Prevention and Detection Policies and Procedures Facility Cost Reports (Report #2012-035 - Dated November 2011)
- State of Florida Compliance and Internal Controls Over Financial Reporting and Federal Awards (Report #2012-142 - Dated March 2012)

Office of Program Policy Analysis and Government Accountability

During FY 2011-12, OPPAGA issued the following reports:

- AHCA Has Issued an ITN for the Medicaid Statewide Managed Disposable Incontinence Medical Supply Program (Research Memorandum - Dated March 1, 2012)
- Agency for Health Care Administration Continues Efforts to Control Medicaid Fraud and Abuse (Report #11-22 - Dated December 2011)
- Profile of Florida's Medicaid Home and Community-Based Services Waivers (Report #12-03 - Dated January 2012)

U. S. Department of Health and Human Services

During FY 2011-12 the U. S. Department of Health and Human Services issued the following reports:

- Review of Medicaid Payments to Excluded or Terminated Durable Medical Equipment Suppliers in Florida (Report #A-04-11-07020 - Dated December 2011)
- Medicaid Payments for Therapy Services in Excess of State Limits (Report #OEI-07-10-00370 - Dated March 2012)

Department of Financial Services

During FY 2011-12, the Department of Financial Services issued the following report:

- Review of Selected Contract and Grant Agreements and Related Contract and Grant Management Activities for AHCA (Dated 11/29/11)

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.

Audit Plan

IA has developed an Annual Audit Plan for FY 2012-13. This plan also includes audit issues that will be addressed in FY 2013-14 and FY 2014-15. 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:

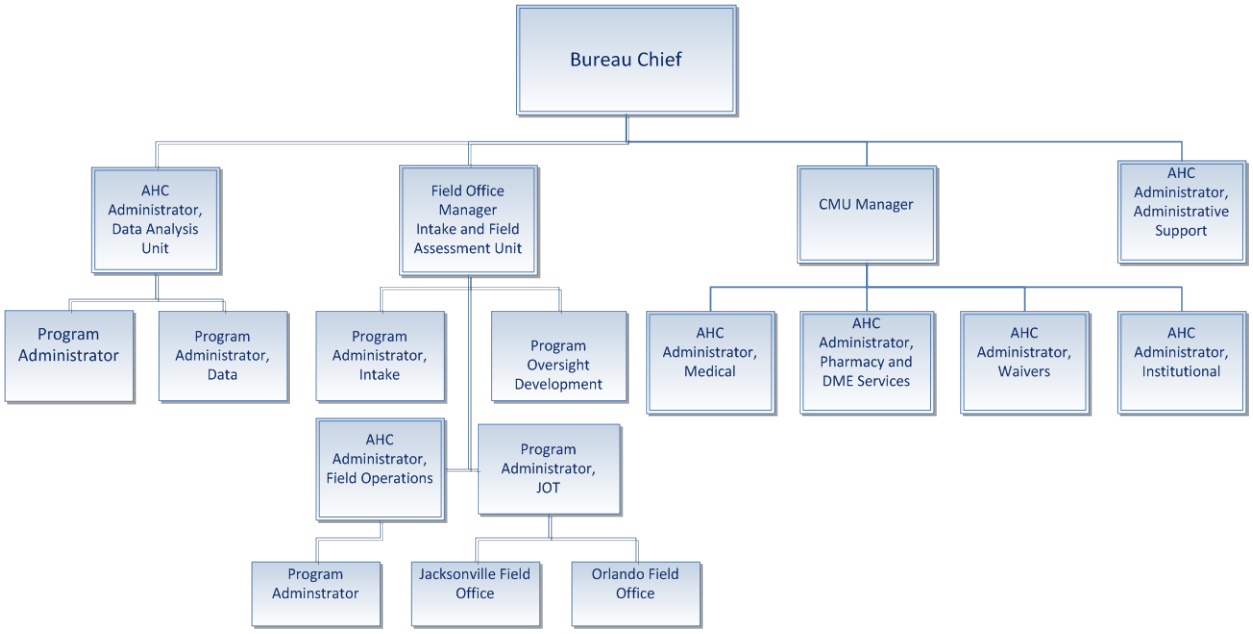
- Performing a Risk Assessment to identify auditable activities and ranking each activity using established criteria to determine the relative significance of, and likelihood that, conditions or events may occur that could adversely affect the Agency;
- Reviewing and evaluating the auditable activities 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.

Medicaid Program Integrity

As an integral part of the Office of the Inspector General, the Bureau of Medicaid Program Integrity (MPI) is responsible for ensuring that Medicaid payments are made to appropriate providers for eligible services provided to eligible Medicaid recipients. This bureau also ensures that fraudulent and abusive behavior occurs to the minimum extent possible; recovering overpayments and imposing sanctions as appropriate. MPI accomplishes this mission through fraud and abuse 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.

MPI Organizational Chart



Prevention

The prevention of Medicaid fraud and abuse reduces the need for detection and investigation and is a high-priority activity of Medicaid Program Integrity, which has devoted approximately forty percent of its staff resources to prevention activities. These activities include the use of prepayment reviews to identify improper claims and deny such payments; making recommendations for the termination of providers suspected of misusing the Medicaid program; initiating projects to address areas that are believed to be more susceptible to fraud and abuse, creating a deterrent effect that results in cost savings for the Medicaid program;

making referrals to other regulatory and law enforcement entities that may result in restrictions on providers' ability to continue to participate in the Medicaid program, and the use of a provision of law that allows Medicaid to decline reimbursement for prescription drugs prescribed by practitioners who abused the program or were terminated from the Medicaid program.

Detection

The detection of possible Medicaid abuse through the misbilling of claims is one of the most important and challenging aspects of the work of Medicaid Program Integrity. More than 150,000,000 claims are received annually by the Florida Medicaid program. These are processed by the Florida Medicaid Management Information System, subjected to system edits, and are paid, pended or denied. The system edits are not able to detect all abusive claims, however. For example, edits can note duplicate claims and those claims for procedures that are inconsistent with the age or sex of the recipient, but cannot detect when goods or services were not medically necessary or actually provided. Accordingly, Medicaid Program Integrity has developed and used advanced detection software and has also used certain detection software supplied by the fiscal agent contractor. MPI has originated chi-square analysis software to detect upcoding of claims, i.e., the billing of higher paying procedure codes than warranted by the services actually supplied, and has developed early warning system software to detect sudden unwarranted increases in providers' billings. Still, many abusive claims go undetected and more sophisticated and effective detection software is required and being explored by AHCA.

Investigation and Recovery

Medicaid Program Integrity recovers overpayments, i.e., payments made in a manner inconsistent with Medicaid policy, through MPI-conducted audits, paid claims reversals and vendor-assisted audits. MPI audits include comprehensive investigations involving reviews of professional records, generalized analyses involving computer-assisted reviews of paid claims and focused audits involving reviews of certain types of providers in specific geographic areas. MPI audits utilize generally-accepted accounting principles and statistical analysis methods. Paid claims reversals are effected within MPI by Florida licensed pharmacists who review pharmacy paid claims and identify apparent misbillings. The pharmacies are notified and claims corrected, resulting in recoveries of Medicaid overpayments. Vendor-assisted audits are conducted, under MPI supervision, by contracted firms who perform work that would otherwise not be possible due to staffing limitations.

Annual Fraud and Abuse Report

Each year the results of these Medicaid Program Integrity activities are presented in the Annual Report on the State's Efforts to Control Medicaid Fraud and Abuse for the fiscal year. This report is published by January 1 and is submitted to the Legislature pursuant to the requirements found in Section 409.913, F. S. It presents the results of the combined efforts to control Medicaid fraud and abuse for the fiscal year by the Agency for Health Care Administration and the Medicaid Fraud Control Unit of the Office of Attorney General. The report is made available on the Agency's internet site: The State's Efforts to Control Medicaid Fraud and Abuse FY 2010-11.[1]

[1] http://ahca.myflorida.com/Executive/Inspector_General/docs/2010_11_Fraud_and_Abuse_Annual_Report.pdf

Investigations Unit

The Office of the Inspector General (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. To that effort, the IU conducts internal investigations of Agency employees and contractors related to alleged violations of policies, procedures, rules and Florida laws. Complaints may originate from the Office of the Chief Inspector General, the Whistleblower Hotline, the Chief Financial Officer's "Get Lean" Hotline, Agency employees, health care facilities, practitioners, Medicaid beneficiaries or the general public. Investigations conducted by the IU may include alleged violations of:

- Agency standards such as unprofessional conduct;
- Unauthorized disclosure of confidential information;
- Theft;
- Misuse of property, records or documents;
- Violation of the nepotism policy; and
- Falsification of records.

Allegations of a criminal nature are referred to the appropriate law enforcement entity. When necessary or requested, the IU works closely with the local police, the Florida Department of Law Enforcement, the Attorney General's Office, the Office of the Chief Inspector General and the appropriate State Attorney's Office.

Investigations staff brings various backgrounds and expertise to the Agency. Certifications or advanced degrees collectively held by IU staff as of June 30, 2012 include:

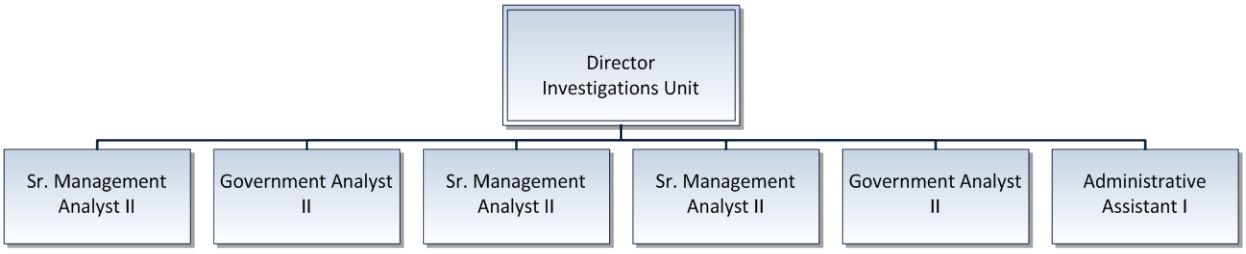
- Nationally certified inspector general investigators;
- Certified Equal Employment Opportunity investigators;
- Former law enforcement officers; and
- Current auxiliary police officer.

The IU also serves as support to the anti-fraud and abuse efforts of the Agency by addressing complaints of fraud and abuse, conducting field initiatives and assisting in the recoupment of Medicaid dollars. In FY 2011-12, the IU addressed 218 complaints or concerns that were reported or generated by the IU office. Fourteen of these cases required analysis to determine if the complaint met the Whistle-blower's Act, as defined in §112.3187 F.S. Three complaints met the criteria; two were referred to external partners and are active investigations and the third was addressed by the Agency with no substantiated findings.

Investigations that resulted in published investigative reports were distributed to the leadership responsible for the employee or program investigated for appropriate personnel action or

recommended policy changes. The published reports were presented to the Agency Secretary for resolution and action. The IU's performance is measured and presented to the Agency Management Team (AMT) in regular briefings.

Investigations Organizational Chart



The following are examples of internal investigative reports published during FY 2011-12. An index of complaints received during this reporting period is included at the end of this section.

Investigation 12-039

An Agency employee was alleged to have been sexually harassed by a co-worker. This complaint was substantiated.

The IU received a written complaint from an Agency employee alleging that a co-worker entered her office on several separate occasions and physically touched her and attempted to engage in sexually explicit conversations with her. The investigation identified several additional employees who corroborated reporting a similar pattern of behavior by the subject employee. The subject employee admitted to the allegations and subsequently resigned prior to Agency action.

Investigation 11-059

An Agency employee allowed her adult son, a wanted fugitive, to enter the workplace and loiter on campus during working hours. This complaint was substantiated.

The IU initiated this investigation after local law enforcement located and arrested a suspect in the Agency's parking lot. The suspect was wanted by local police for attempted homicide. The investigation determined that the mother of the suspect was an Agency employee and had been bringing the son to the Agency during the day. Contrary to the employee's denial of having knowledge of her son's warrant, the IU determined that the employee used her state computer to search for news stories related to the attempted homicide. The employee retired during the pendency of the investigation.

Investigation 11-039

A former Agency employee alleged discrimination based on her disability. This complaint was unfounded.

The complainant was employed with the Agency from April 1993 through March 2010. For a period of time the complainant was on Family and Medical Leave Act (FMLA) / disability leave. Shortly after her return to work, she was terminated. Complainant alleged that the Agency terminated her because of her disability. Based on the evidence made available during this investigation, including emails, work evaluations and taped interviews, no evidence was discovered to substantiate the allegations.

Investigation 11-072

An employee of an Agency contractor was arrested for identity theft of a Medicaid client. This complaint was substantiated with recommendations.

The complaint alleged the identity and bank account information of a Florida resident was used to pay an automobile insurance premium for a person in Tallahassee, Florida. The automobile insurance company identified the policy holder's name and place of employment (Healthy Kids Florida) to law enforcement. The IU, assisting law enforcement, determined that the Healthy Kids Florida employee (subject) used the citizen's personal checking account information to pay his personal insurance premium. The Tallahassee Police Department arrested the subject employee for several offenses that included *Defrauding a Financial Institution*.

The Agency questioned how the subject passed his background screening for employment. Subsequent investigation determined that a subcontractor was used to screen Healthy Kids Florida applicants. The subject was originally notified that he did not pass the background screening process, challenged the findings and explained that he was not found guilty of the charges indicated in his record. The subcontractor asked for proof that the subject was found not guilty or exonerated. The subject provided the subcontractor with court documentation representing he was not convicted. The documentation was later determined to be fraudulent.

The investigation determined that the subject was able to collect the complainant's name and personal information from her income tax returns. As part of the IU findings, the Agency contractor now redacts the bank account information on documents before they are scanned into their computer system.

The subject's employment was terminated by the Agency contractor.

Investigation 12-007

An Agency employee used state resources to collect and transmit a citizen's personal information for nonbusiness related purposes. This complaint was substantiated.

A complainant alleged that his former girlfriend, an Agency employee, used State resources to generate a report that contained his personal records, disclosed this information to his current girlfriend and other unknown third parties with the intent to defame his character. The allegations made by the complainant were partially substantiated. The IU recommended that management take appropriate disciplinary action against the Agency employees involved. The Agency employees were subsequently terminated as a result of the IU's investigation.

Investigation 11-145

An Agency employee shared a Medicaid recipient's personal health information with the recipient's ex-spouse. This complaint was unfounded.

The Office of the Inspector General (OIG) received a written complaint filed by the U. S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR). The complainant, a Medicaid recipient, stated that she received a call regarding her prescription from the Agency's Bureau of Pharmacy Services. The complainant said that she recognized the voice as that of a friend of her ex-spouse, identified as a Senior Healthcare Specialist of AHCA. The complainant stated that the employee revealed knowledge of her protected health information (PHI), including the name of her physician and her prescription information. The IU found no violations of Health Insurance Portability and Accountability Act (HIPAA) Privacy or Security Rules and determined that the subject's actions were conducted in accordance with protocols established by the Agency's Bureau of Pharmacy Services. The IU discovered no evidence or collected any witness statements that indicated the subject acted inappropriately or outside of her position description. HHS OCR adopted the findings of this investigation and concurred that no violations of HIPAA Privacy and Security Rules occurred.

Investigation 11-068

An Agency employee alleged *Poor Performance* related to the investigation of Standard of Care Issues in a Long Term Care Facility. This complaint was substantiated.

The OIG received a written complaint from the daughter of a deceased long term care resident who alleged a facility failed to provide adequate care and as a result, her mother was injured and subsequently passed away. Two Health Quality Assurance (HQA) surveys were completed, including HQA management review of the surveys to ensure facility compliance.

The second HQA review survey by management determined the facility was out of compliance with respect to mandatory adverse incident reporting. The initial Agency surveyor was found to be in violation of performance standards for failing to properly review all the records relating to the complaint.

Investigation 11-096

A complainant alleged *Discrimination on the Basis of Sex*. This complaint was unfounded.

The IU received a written complaint from an Assistant General Counsel that alleged "*abuse, intimidation, defamation and discrimination on the basis of sex.*" The investigation determined there was no discrimination on the basis of sex. Additionally, the investigation revealed that the concerns noted by the complainant were management issues, not discrimination.

Investigation 12-003

A complainant alleged *Discrimination on the Basis of Race*. The complaint was unfounded.

The IU received a written complaint of discrimination filed with the U. S. Equal Employment Opportunity Commission (EEOC) and to the Florida Commission on Human Relations (FCHR), from a current state employee presently working in an OPS (Other Personal Services) position at the Florida Department of Revenue. The complainant alleged that he was discriminated against on the basis of his race after he was not selected for an Agency Information Technology (IT) position. The investigation revealed the highest scoring applicant in the application process was hired. There was no evidence found to support the allegation.

Investigation 12-010

A complainant alleged that an employee demonstrated *Unbecoming Conduct by a Health Quality Assurance Surveyor*. The complaint was substantiated.

The OIG received a written complaint from a Nursing Home Administrator who wrote to a State Representative and voiced concerns about the conduct of, and citations documented, by an Agency surveyor. The complaint alleged that during the biennial survey of the facility, an Agency surveyor examined a resident without cause, had a hostile adversarial attitude toward facility staff and issued unwarranted citations to the facility. A Quality Assurance (QA) review of the survey was completed by Health Quality Assurance (HQA) Management and found the survey team failed to follow the revised AHCA survey process. The investigation revealed the surveyor was new in her position and her conduct was strained at times with facility staff. Based upon the preponderance of evidence, including interviews with additional surveyors,

violations of conduct unbecoming a public employee and poor performance were substantiated. The IU recommended HQA management take action as outlined in their QA review and provide additional training for HQA field staff. Those corrective actions were taken.

In-house Fingerprinting

Agency employees are required to be fingerprinted when they are hired and then every five years thereafter for background screening. The IU established an in-house fingerprinting station that is managed by an IU investigator who is an auxiliary police officer. In-house fingerprinting enables employees to be fingerprinted at headquarters without having to travel to a local law enforcement agency during working hours. This program produces an annual cost savings to the Agency of approximately $32,000. The IU fingerprinted 172 employees in FY 2011-12.

Fraud, Abuse and Compliance Efforts

The IU assisted the Bureau of Medicaid Program Integrity in generating cases from data claims and citizen complaints.

During FY 2011-12, the IU opened 56 fraud and abuse files. The IU participated in the identification and recovery of overpayments and supported MPI in larger field initiatives.

Anti-Psychotic Medicaid Prescribers

In FY 2009-10, the IU initiated the review of Florida's top anti-psychotic prescribers. These prescribers were identified and ranked based on the total dollars paid by Medicaid for pharmacy claims. The highest ranked prescriber of 2009 was terminated from the Medicaid program after the initial IU investigation. The IU continued its review of Florida's top antipsychotic prescribers during this reporting period. Due to the efforts of the IU's investigative staff, the Agency's Bureau of Medicaid Program Integrity and the Bureau of Medicaid Pharmacy Services, total paid claims for antipsychotics of the top 25 prescribers declined by 15% in three years, saving approximately $4 million dollars. In the "top 25" prescribers identified in the initial review, three have been terminated by AHCA after the findings of the IU team. In addition, four other prescribers discontinued prescribing antipsychotic medications to Medicaid recipients as of 2011.

Licensed Healthcare Clinic Initiative

The IU led a multi-agency onsite investigation of 63 healthcare clinics with current or pending license applications at the Agency. The clinics were identified as having "cookie cutter"

applications primarily utilizing the same Certified Public Accountant (CPA) firms and presenting a business model only existing in South Florida. The IU organized the multi-state agency investigation that included: The Florida Department of Health (DOH), Divisions of Medical Quality Assurance and Bureau of Radiation Control; The Office of the Chief Financial Officer, Division of Insurance Fraud; and the Agency's Office of the General Counsel, Bureau of Health Quality Assurance (HQA) and Health Facility Regulation (HFR). Nearly all of the clinic business models employed an owner, medical director, secretary, physician and a licensed massage therapist. Further investigation revealed nearly all the clinics were exclusively billing insurance companies under Florida Personal Injury Protection (PIP) laws for medical claims associated with vehicle crashes. The investigation included the following:

a) Verification that the clinics were operational and providing services within the scope of the licenses;
b) Verification of the Medical Directors and the number of clinics each Medical Director supervised;
c) Documentation of any changes in ownership;
d) Verification of the presence of radiological and diagnostic equipment and that the equipment was properly functioning and registered;
e) Verification that clinic staff was licensed or certified to operate the equipment onsite, and
f) Documentation of "red flag" indicators of insurance fraud.

During the onsite investigation, 14 clinics were found to be out of business without notification to the Agency. Investigators only observed 17 patients in the 49 existing clinics and some clinic staff reported never having seen a patient in their clinic.

The investigation revealed regulatory violations in 43 of the 49 clinics, to include, but not limited to:

- A healthcare provider maintaining employment after failing his background screening;
- Failing to report change of ownership or changes in clinic staff as required, and
- Failing to post required licensing and numerous instances of clinic employees employed without Level 2 background screening.

Additionally, suspected criminal activity was observed regarding falsification of medical billing and suspected unlicensed activity by medical providers. One clinic operator immediately surrendered their clinic license to the IU due to the violations uncovered by IU investigators. Several referrals resulted in additional investigations which are still pending.

The IU referred 36 clinics to HQA with regulatory violations regarding missing Level 2 background screenings on their providers or staff. To date, two referred clinics have closed, one license was revoked, one sanction of $500 was imposed and one is pending disciplinary action.

Twenty-four clinics referred to HQA rapidly completed and submitted the required Level 2 background screenings and the 24 clinics are now in regulatory compliance.

Internal Investigation Cases – FY 2011-12

Case Number	Allegation	Disposition
11-077	Facility Mismanagement	Reviewed
11-078	Theft	Resolved
11-079	Poor Customer Service	Resolved
11-080	Unlicensed Activity	Unfounded
11-081	Fraudulent Licensing	Referred to FDLE
11-082	Fraud	Referred to MPI
11-083	Sexual Harassment	Unsubstantiated
11-084	Poor Performance	Substantiated
11-085	Sexual Harassment	Unsubstantiated
11-086	Inadequate Service	Referred to Medicaid Area Office 10
11-087	Fraud	Closed
11-088	Harassment	Unfounded
11-089	Wrongful Denial to Services	Resolved
11-090	Employee Complaint	Closed
11-091	Fraud	Referred to MPI
11-092	Public Records Request	Referred to OGC
11-093	Inadequate Patient Care	Referred to HQA
11-094	Billing Dispute	Referred to Medicaid Area Office 3
11-095	Mismanagement	Closed
11-096	Discrimination Based on Sex	Unfounded
11-097	Fraud	Referred to MPI
11-098	Medicaid and Medicare Fraud	Referred to MPI
11-099	Violation of Patient's Rights	Referred to DCF
11-100	Unethical Behavior	Information only
11-101	Breach of Confidential Information	Unsubstantiated
11-102	Lack of Patient Care	Resolved
11-103	Medicaid and SSDI fraud	Referred to Agency of for Persons with Disabilities
11-104	Suspected DME Fraud	Closed
11-105	Conduct Unbecoming	Unsubstantiated
11-106	Poor Performance	Referred to Medicaid Area Office 6
11-107	Unauthorized Medical Services	Information only

11-108	Non-Compliance by Hospital	Referred to HQA
11-109	Questionable Financials Provided by a Medical Center	Reviewed
11-110	Patient Brokering / Ethics Violation	Resolved
11-111	Request review of previous investigation	Responded/Closed
11-112	Patient Neglect / Abuse	Referred to Medicaid Area 8
11-113	Incomplete Survey	Unsubstantiated
11-114	Medicaid fraud	Closed
11-115	Medicaid licensing Error	Referred to Medicaid Area Office 11
11-116	Over Prescribing	Referred to MFCU
11-117	Violation of Employee Rights	Closed
11-118	Kickbacks for Medicare Referrals	Referred to Medicare
11-119	Overbilling for Pharmacy Services	Resolved
11-120	Employee Misconduct	Referred to Medicaid management
11-121	Healthcare Clinics Fraud	Reviewed
11-122	Unsanitary Medical Facility	Referred to DOH
11-123	Payment Dispute	Reviewed
11-124	Home Health Fraud	Referred to MPI
11-125	Age Discrimination [EEOC]	Unfounded
11-126	Discrimination based on National Origin	Reviewed
11-127	Medicaid Fraud	Referred to HQA
11-128	Fraudulent Employment Records	Referred to Long Term Care
11-129	Medicaid and Medicare Fraud	Reviewed
11-130	Medicaid Fraud	Referred to MPI
11-131	Exploitation/Abuse of Elderly Patient	Referred to HQA
11-132	Discrimination	Reviewed
11-133	HIPAA Violation	Referred to HQA
11-134	Exploitation of the Elderly	Referred to HQA
11-135	Conduct Unbecoming	Reviewed
11-136	Improper Patient Care	Referred to Ombudsman
11-137	Fraud	Reviewed
11-138	Exploitation of Patient	Referred to HQA
11-139	Medicaid Fraud	Reviewed by MFCU
11-140	Overbilling	Referred to DOH
11-141	Medicaid Fraud	Referred to HQA
11-142	Violation of Nursing Home Regulations	Referred to HQA
11-143	Medicaid Fraud	Resolved
11-144	Harassment	Referred to HQA

11-145	HIPAA Violation	Unsubstantiated
11-146	Medical Billing Concerns	Information only
11-147	Medicaid Fraud	Closed
11-148	Lack of Patient Care	Referred to HQA
11-149	Lack of Patient Care	Closed
11-150	Order of Insolvency Dispute	Referred to OGC
11-151	Lack of Medicaid Services	Referred to Medicaid Area Office 6
11-152	Fraud and Abuse	Closed
11-153	Inappropriate Care	Closed
11-154	Prescription Fraud	Closed
11-155	Unlicensed Activity	Referred to HQA
11-156	Inadequate Survey	Closed
11-157	Inadequate Employee Pay	Closed
12-001	Misconduct	Reviewed
12-002	Failure to provide facility maintenance	Referred to HQA
12-003	Discrimination (EEOC)	Unfounded
12-004	Inadequate patient care	Referred to HQA
12-005	Fraudulent Prescribing	Reviewed
12-006	Conflict of Interest	Unfounded
12-007	Misuse of Position	Founded
12-008	Provider Payment Dispute	Referred to MPI
12-009	Dental Fraud	Reviewed
12-010	Conduct Unbecoming a Public Employee	Substantiated
12-011	Retaliation for Reporting Abuse	Closed
12-012	Fraud	Closed
12-013	Misconduct	Resolved
12-014	Fraudulent Medicaid Claims	Resolved
12-015	Fraud	Referred to Medicaid Area Office 8
12-016	Discrimination (EEOC)	Partially Substantiated
12-017	Fraud	Closed
12-018	Abuse	Referred to HQA
12-019	Abuse	Referred to DOH
12-020	Mismanagement	Referred to HQA
12-021	Fraud	Closed
12-022	Medicaid Fraud	Referred to DCF IU
12-023	Fraud	Referred to HQA
12-024	Medicaid Fraud	Referred to Managed Health Care

12-025	Coding Violation	Closed
12-026	Lack of Patient Care	Referred to HQA
12-027	Stark Law Violation	Closed
12-028	Dental Fraud	Under review
12-029	Sexual Harassment	Reviewed
12-030	Theft	Referred to HQA
12-031	Fraud	Closed
12-032	Lack of Medicaid services	Resolved
12-033	Conduct Unbecoming	Unsubstantiated
12-034	Threats to Employee	Resolved
12-035	Medicaid Fraud	Closed
12-036	Misuse of Medicaid Data	Closed
12-037	Lack of Patient Care	Closed
12-038	Medicaid Fraud	Closed
12-039	Sexual Harassment	Substantiated
12-040	Medicaid Fraud	Closed
12-041	Lack of Patient Care	Referred to Medicaid
12-042	Dental Fraud	Closed
12-043	Theft	Substantiated with mitigating circumstances
12-044	Discrimination	Closed
12-045	Theft	Closed
12-046	Discrimination	Unfounded
12-047	Violation of Agency Policies	Unsubstantiated
12-048	Conduct Unbecoming	Referred HQA
12-049	Harassment	Referred to Medicaid
12-050	Conduct Unbecoming	Closed
12-051	Theft	Active
12-052	Discrimination Based on Disability and Retaliation	Unfounded
12-053	Harassment	Active
12-054	Fraud	Referred to TPL and DFS
12-055	Harassment	Closed
12-056	Recipient Dispute Regarding Quantity of Care	Closed
12-057	Lack of Service	Referred to MPI
12-058	Medicaid Fraud	Referred to DFS
12-059	Fraud	Unsubstantiated
12-060	Misconduct	Closed
12-061	Fraud	Referred to HQA

12-062	Background Screening	Referred to Background Screening Unit
12-063	Public Assistance Fraud	Referred to DCF
12-064	Overbilling	Closed
12-065	Employment Qualifications	Referred to HQA
12-066	Medicaid Fraud	Referred DCF
12-067	Public Assistance Fraud	Referred to Public Assistance Fraud
12-068	Medicaid Fraud	Closed
12-069	Harassment	Closed
12-070	Prescription Fraud	Active
12-071	Prescription Fraud	Active
12-072	Prescription Fraud	Active
12-073	Fraud	Closed
12-074	Public Assistance Fraud	Referred to Dept. of Financial Services
12-075	Misconduct	Information only
12-076	Harassment	Closed
12-077	Suspicious Package	Closed
12-078	Neglect and Abuse	Closed
12-079	Poor Service	Closed
12-080	Medicaid Fraud and Physical Abuse	Closed
12-081	Medicaid Fraud	Referred to DCF
12-082	Lack of Service	Closed
12-083	Medicaid Fraud	Closed
12-084	Medicaid Fraud	Closed
12-085	Medicaid Fraud	Closed
12-086	Medicaid Fraud	Closed
12-087	Medicaid Fraud	Closed
12-088	Medicaid Fraud	Closed
12-089	Medicaid Fraud	Closed
12-090	Medicaid Fraud	Closed
12-091	Medicaid Fraud	Closed
12-092	Recoupment Error	Closed
12-093	Death Certificate Concerns	Referred to Bureau of Vital Statistics
12-094	Study of Home Health Requirements	Closed
12-095	Medicaid Fraud	Closed
12-096	Medicaid Fraud	Closed
12-097	Medicaid Fraud	Closed
12-098	Sexual Harassment	Closed

12-099	Fraud, Abuse and Nepotism	Referred to HQA
12-100	Lack of Care	Closed
12-101	Medicaid Fraud	Closed
12-102	Medicaid Fraud	Closed
12-103	Medicaid Fraud	Closed
12-104	Lack of Patient Care	Referred to HQA
12-105	Lack of Patient Care	Referred to HQA
12-106	Lack of Patient Care	Active
12-107	Sexual Harassment	Closed
12-108	Medicaid Fraud	Closed
12-109	Medicaid Fraud	Closed
12-110	Medicaid Fraud	Closed
12-111	Medicaid Fraud	Closed
12-112	Mismanagement	Closed
12-113	Patient Neglect	Active
12-114	Medicaid Fraud	Closed
12-115	Medicaid Fraud	Closed
12-116	Medicaid Fraud	Closed
12-117	Discrimination	Unfounded
12-118	Medicaid Fraud	Active
12-119	Patient Abuse	Referred to HQA
12-120	Lack of Services	Referred to Area 7
12-121	Retaliation	Active
12-122	Active Provider's Website Review	Closed
12-123	Medicaid Fraud	Closed
12-124	Medicaid Fraud	Closed
12-125	Medicaid Fraud	Closed
12-126	Lack of Patient Care	Active
12-127	Medicaid Fraud	Closed
12-128	Fraud	Active
12-129	Fraud	Active
12-130	Lack of Patient Care	Referred to Medicaid Area Office7
12-131	Lack of Medical Services	Closed
12-132	HIPAA violation	Active
12-133	Lack of Service	Referred to FL KidCare
12-134	Fraud [home modifications services]	Closed
12-135	ACCESS CENTER Review	Active
12-136	Anti-Psychotic Drug Query	Active
12-137	Patient Abuse and Neglect	Referred to HQA

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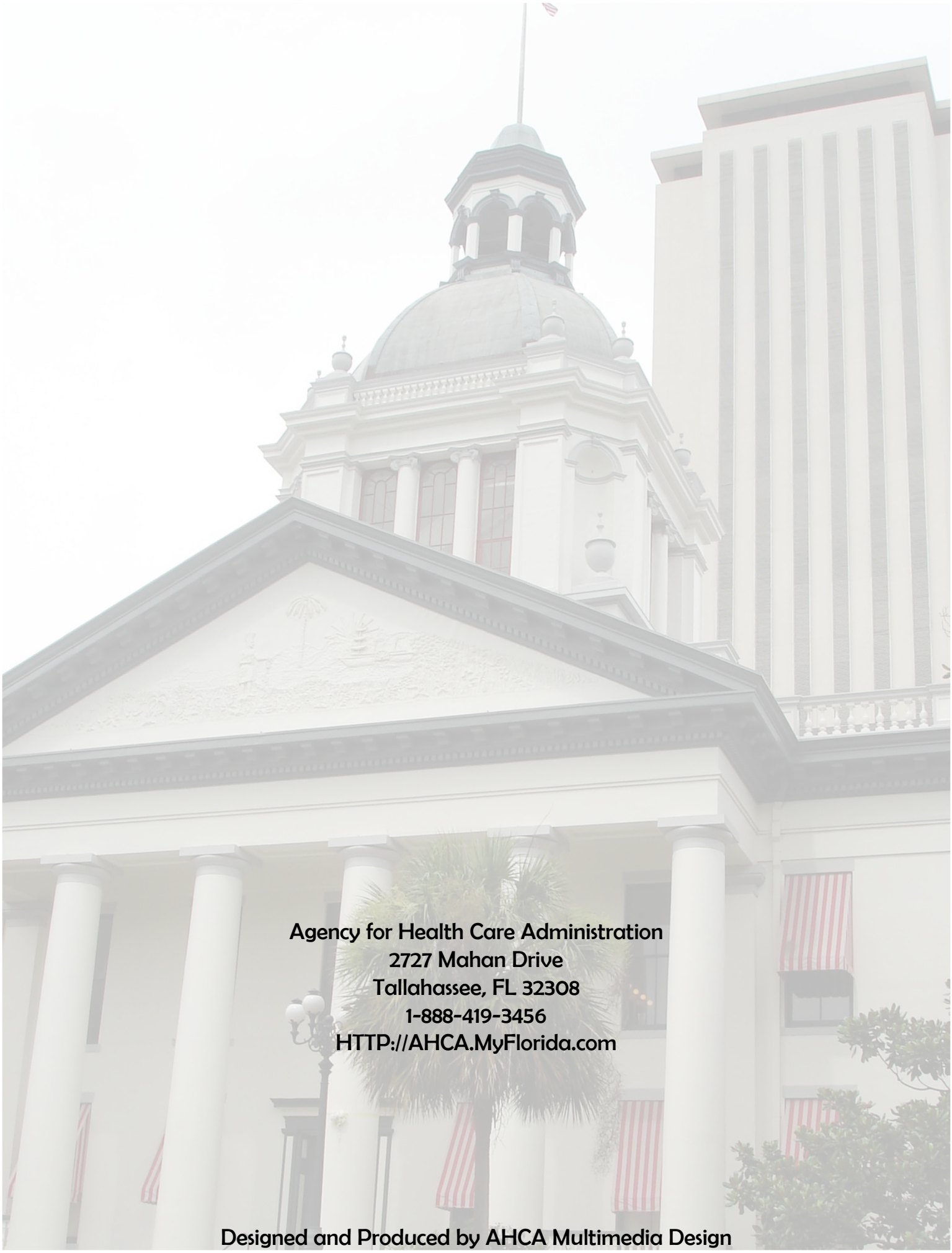

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