AGENCY FOR HEALTH CARE ADMINISTRATION

OFFICE OF INSPECTOR GENERAL

Annual Report Fiscal Year 2021-2022

OUR MISSION

Better Health Care for all Floridians.

OUR VISION

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

OUR VALUES

Accountability

We are responsible, efficient, and transparent.

Fairness

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

Responsiveness

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

Teamwork

We collaborate and share our ideas.

RON DESANTIS
GOVERNOR

SIMONE MARSTILLER
SECRETARY

September 2022

On behalf of the Agency for Health Care Administration (Agency or AHCA) Office of Inspector General (OIG), I am pleased to present our annual report summarizing the OIG's accomplishments during the 2021-22 fiscal year.

The OIG remains committed to our work providing a central point for the coordination of activities and duties that promote accountability, integrity, and efficiency in AHCA and the programs that AHCA administers. Our mission could not have been accomplished without the continued dedication and hard work of OIG management and staff.

The OIG includes Investigation, Internal Audit, and the HIPAA Compliance Office. The OIG ensures that complaints on Agency employees and contractors of alleged violations of policies, procedures, rules, or laws are properly investigated; audits and reviews add value by improving the efficiency and effectiveness of Agency operations; and information held by AHCA is protected in accordance with state and federal privacy laws. The OIG also coordinated the Agency's enterprise-wide approach to addressing risks.

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

Respectfully,

Brian P. Langston
Inspector General

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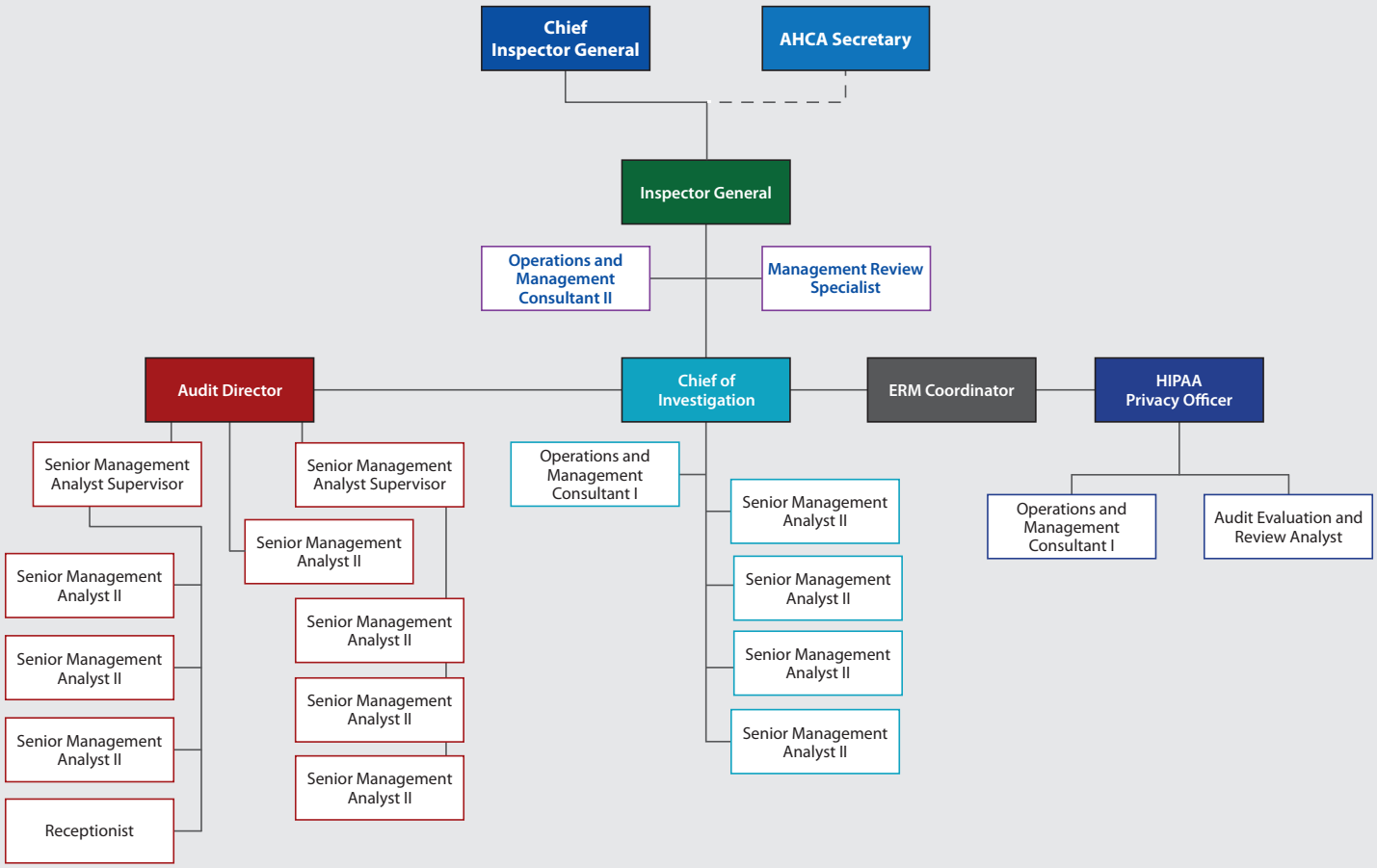
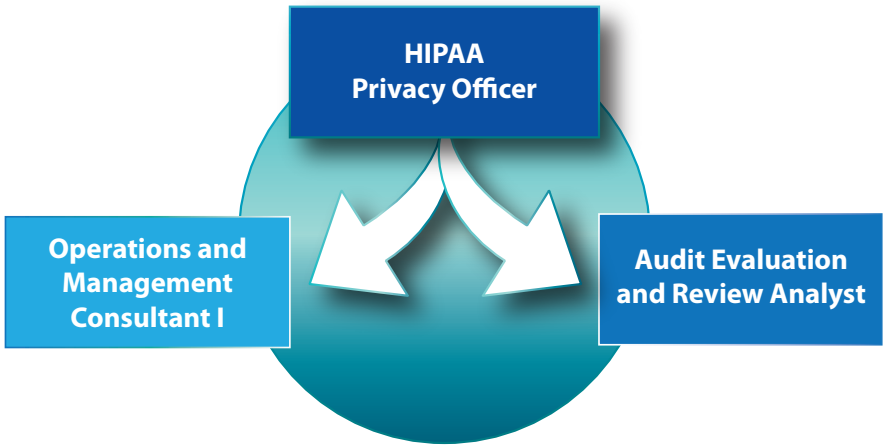


HIPAA COMPLIANCE OFFICE



ORGANIZATION AND STAFF

The Health Insurance Portability and Accountability Act (HIPAA) Compliance Office coordinates Agency compliance with HIPAA requirements, pursuant to Title 45, Code of Federal Regulations (CFR), Parts 160, 162 and 164 (Public Law 104-191) and the Health Information Technology Economic and Clinical Health (HITECH) Act (Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), Public Law 111-5).

Current HIPAA staff consists of three full-time employees: the Senior Management Analyst Supervisor who serves as the Agency's HIPAA Privacy Officer (designated by the Secretary), an Operations and Management Consultant I, and an Audit Evaluation and Review Analyst.

Collectively, the HIPAA Compliance Office staff has the following qualifications/certifications: Master's Degree (1), Bachelor's Degree (2), Associates Degree (2), Florida Certified in Contract Management (2), and Certified in HIPAA (1).

HIPAA COMPLIANCE OFFICE RESPONSIBILITIES

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

PHI Requests

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

In FY 2021-22, the HIPAA Compliance Office responded to 542 received written requests; this is a decrease of 224 requests from the previous fiscal year. The average response time to all written correspondence was 1.6 business days, half the response time of the previous fiscal year. In FY 2021-22, the HIPAA Compliance Office received and responded to 684 telephone inquiries, an increase of 255 calls from the previous fiscal year. These calls were addressed in an average response time of 0.17 business days, more than a full day quicker response time than the previous fiscal year.

HIPAA Breach Procedures

HIPAA and Florida Statutes require specific actions in response to a breach of PHI. In the event of a breach, it is the responsibility of the HIPAA Compliance Office to ensure the Agency responds as these laws and regulations dictate.

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

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

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

HIPAA Liaisons and Agency Physical Security

The use of Field Office HIPAA liaisons was reestablished in FY 2017-18 and continued throughout FY 2021-22. These HIPAA liaisons serve as a point of contact at each of the Agency Field Offices for any related HIPAA issues and increases compliance of the HIPAA prescribed physical safeguards by performing field office walk-throughs and reporting any observed instances of unsecured PHI and any other related physical safety concerns to Agency PHI privacy and security. A monthly report is received from each Field Office HIPAA liaison to document these efforts. The HIPAA Compliance Office staff perform weekly walk-throughs at Agency headquarter buildings and provide direction to ensure that no Agency PHI is unsecured. The HIPAA Compliance Office published revisions to the Agency HIPAA/HITECH Policies and Procedures Manual on physical security walk-through to better codify this procedure. Additionally, the HIPAA Compliance Office created and delivered a report to the Bureau Chief of General Services with recommendations on unsecured trash and recycling receptacles at Agency headquarters to reduce the risk of improper destruction of Agency PHI.

HIPAA Privacy Risk Assessment

The HIPAA Compliance Office continued review of Agency practices and policies presenting risk of HIPAA non-compliance and worked with Agency staff to determine root causes, such as inadequate policies, training, or management oversight, and to assist management in implementing correction thereby reducing risk of HIPAA violation or information breach.

Furthering this effort, the HIPAA Compliance Office completed a HIPAA-focused privacy risk assessment survey, which was sent to all business units within the Agency. Information collected from this survey was used to update and refine a thorough inventory of Agency PHI location and flow. This survey was also used to add to a library of all policies, procedures, and associated contractual documents related to the creation, usage, maintenance, and reception and transmission of Agency PHI. The HIPAA Compliance Office reviewed unit responses, performed follow-up interviews, and conducted risk assessment activities to identify, document, and address any HIPAA risks related to Agency PHI. General HIPAA reminders of policy requirements and best practices were sent to all Agency units based on patterns seen in survey responses.

An Agency-wide HIPAA risk assessment was delivered to the Agency Inspector General and Agency Management Team (AMT) in May and July of 2022, respectively. This report contained a description of the survey activities, newly identified Agency HIPAA risks, updates and assessments of all identified HIPAA risks, and risk mitigation recommendations. The HIPAA Compliance Office is now waiting on Agency response to this report for further action.

HIPAA Compliance Office Collaboration

The HIPAA Compliance Office is often approached to join or lead various work groups and teams at the Agency to ensure HIPAA compliance is adhered from the start of an effort. One such project is working with the Agency's Enterprise Risk Management (ERM) on several identified risks. These workgroups involved collaboration and Coordination with the ERM Coordinator and the Agency's Information Technology (IT) department. Some of the risks addressed by this team were previously identified and included on both the 2019 and FY 2021-22 Agency HIPAA Risk Assessment and some were newly identified by the ERM Coordinator.

The Statement of Deficiency work group is comprised of the HIPAA Compliance Office, Healthcare of Quality Assurance (HQA) Field Office staff, and members of IT. This work group has considered and proposed various solutions for how the Agency can provide facility documents to the public and remain compliant with HIPAA regulations. This group presented a decision memorandum to the Agency Management Team (AMT) in FY 2021-22.

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

The Agency is embarking on a full-scale systems shift to create a more collective approach to its inner workings. This effort resulted in the creation of the Florida Health Care Connections (FX) unit. This unit evaluates current Agency operating procedures, proposes various solutions, creates procurement documents, evaluates vendor proposals, and supervises implementation. The HIPAA Compliance Office serves as a critical consultant on multiple aspects of this endeavor to ensure that the resulting solutions will meet the Agency's HIPAA needs and requirements. Additionally, the HIPAA Compliance Office, in partnership with the Agency's Information Security Manager, co-created an FX Role-Based Access workgroup to ensure the functionality is built into the system to provide access on a much more granular level and provide better compliance to HIPAA's Minimum Necessary Standard than is currently available. Efforts are ongoing and likely will continue into the foreseeable future.

Training

The HIPAA Compliance Office has a robust presence in the training of Agency staff on issues related to redaction and disclosure of PHI, handling of printed and electronic protected documents, and general HIPAA and security information. In FY 2021-22, the HIPAA Compliance Office provided or administered the following trainings:

- Administered the HIPAA Online Training program, which is a web-based course designed to orient new Agency workforce members to HIPAA requirements and heighten staff understanding of computer security procedures.
  - HIPAA staff continued to emphasize an expedited time frame for workforce member completion of this critical training and to alert Agency management regarding non-compliance where necessary.
- Provided live HIPAA and HITECH privacy training to Agency employees as part of new employee orientation as well as a web-based version of annual employee training.
- A recorded web-based redaction training available any time to Agency employees through the HIPAA Employee Resource SharePoint site. This training focuses on redaction requirements of federal HIPAA regulations as well as section 501.171, Florida Statutes (F.S.).
- Provided live HIPAA and HITECH privacy training to newly hired field surveyors at the request of the Health Quality Assurance (HQA) Field Offices bureau chief. Additionally, this training was recorded by HQA for future training sessions.

The HIPAA Compliance Office revised the presentations for New Employee Orientation and the annual Keep Informed Training, as well as maintained a HIPAA and privacy law history-focused training for the Office of General Counsel, provided specific Field Office HIPAA training, and provided individual redaction guidance as requested by various Agency business units.

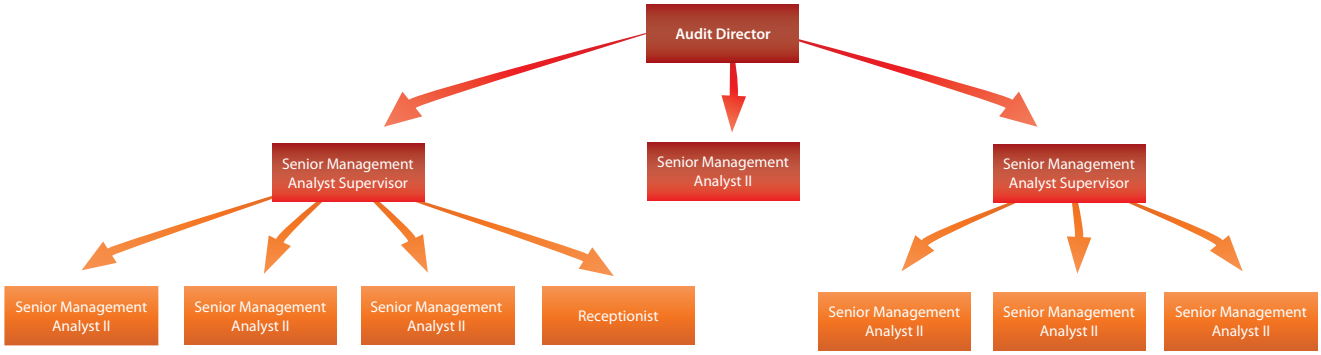
Additional training and education efforts of the HIPAA Compliance Office included the maintenance of a HIPAA Employee Resource page located on the OIG HIPAA Compliance Office's SharePoint site. Copies of all current trainings are posted here along with copies of legal references and redaction resources.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

Some additional functions, duties, and continuing projects of the HIPAA Compliance Office for fiscal year (FY) 2021-22 were:

- Published revisions to the Agency HIPAA-HITECH Policies and Procedures Manual.
- Reviewed and provided written comments/recommendations on Agency contractual templates involving confidential data.
- Provided comments to the federal Notice of Proposed Rule Making for the HIPAA regulations.
- Provided comments to the Resource Guide for Implementing the HIPAA Security Rule.
- Reviewed all new Agency forms or forms under revision for policy compliance and provided written comments/recommendations.
- Participated on multiple collaborative Agency work groups to ensure Agency HIPAA requirements are met.
- Updated and maintained an Agency-wide inventory of all Agency databases containing protected health information (PHI), personally identifiable information (PII), and protected financial information (PFI).
- Reviewed all Public Records requests containing PHI for appropriate and valid HIPAA access and authorization forms.
- Reviewed all Agency contracts and agreements prior to execution to ensure appropriateness and adequate contractual protections in place.
  - Including revisions made to Agency Purchase Order template to include additional protections.
- Completed the Agency-wide HIPAA Risk Assessment report and provided the report to the Agency Management Team (AMT) for response. This report included an overview of the survey results and updates

to previously identified Agency HIPAA risks.

- Maintained a paperless routing system for HIPAA PHI requests, originally created in response to the COVID-19 pandemic.
- Provided a report to General Services containing recommendations on unsecured trash and recycling receptables located at headquarters offices.
- Reviewed and discussed various types of Agency access badges with Information Technology (IT) Security, the Agency's Enterprise Risk Management (ERM) Coordinator, and General Services.
- Created and co-owned an Agency workgroup to refine access to Agency data based on roles to ensure more granularity and better compliance with the Minimum Necessary Standard within the Agency's future Florida Health Care Connections (FX) system.
- Created a new report for monthly delivery to AMT regarding Agency and health plan breaches and incidents.



ORGANIZATION AND STAFF

The purpose of Internal Audit (IA) is to provide independent, objective assurance and consulting services designed to add value and improve Agency operations. Internal Audit's mission is to assist the Secretary and other Agency management in ensuring better health care for all Floridians by bringing a systematic, disciplined, and risk-based approach to evaluate and contribute to the improvement of the Agency's governance, risk management, and control processes. The Inspector General determines the scope and assignment of audits; however, at any time, the Agency Secretary may request the Inspector General to perform an audit of a special program, function, or organizational unit.

IA operates within the OIG under the authority of Section 20.055, F.S. In accordance with Section 20.055(6)(c), F.S., the Inspector General and staff have access to any Agency records, data, and other information deemed necessary to carry out the Inspector General's duties. The Inspector General is authorized to request such information or assistance as may be necessary from the Agency or from any federal, state, or local government entity.

IA staff members bring various skills, expertise, and backgrounds to the Agency. Certifications or advanced degrees collectively held by members of Internal Audit include:

- Certified Internal Auditor
- Certified Inspector General Auditor
- Florida Certified Contract Manager
- Master of Arts in Teaching
- Master of Business Administration
- Certified Fraud Examiner
- Certified Evaluation and Management Auditor
- Certified Crime Intelligence Analyst

The Institute of Internal Auditors International Standards for the Professional Practice of Internal Auditing (IIA Standards) and the Association of Inspectors General Principles and Standards for Offices of Inspectors General require Internal Audit staff members to maintain their professional proficiency through continuing education and training. Each auditor must receive at least 40 hours of continuing education every year.

INTERNAL AUDIT RESPONSIBILITIES

Risk Assessment and Audit Plan

Internal Audit performs a risk assessment of the Agency's programs and activities each fiscal year to develop an annual audit plan. The risk assessment process includes the identification of activities or services performed by the Agency and an evaluation of various risk factors where conditions or events may occur that could adversely affect the Agency. Based on the risk assessment, Internal Audit develops an annual Audit Plan, which includes planned projects for the upcoming fiscal year and potential projects for the next two fiscal years. The plan, approved by the Agency Secretary, includes activities to be audited or reviewed, consulting engagements and budgeted hours.

Types of Engagements

In accordance with the annual Audit Plan, Internal Audit conducts various types of engagements for the Agency. These engagements include assurance or compliance audits, consulting, management reviews, or other special projects. These engagements are undertaken to provide an independent and objective analysis of process and provide information for improving Agency operations.

INTERNAL AUDIT ACTIVITIES

Completed and In-Progress Engagements

The following is a summary list of completed and in progress engagements as of June 30, 2022:

REPORT NO.	ENGAGEMENT	TYPE	DATE ISSUED/ PLANNED
AHCA-2122-03-A	Agency for Health Care Administration, Enterprise Audit for House Bill 1079	Compliance	April 2022
AHCA-2122-04-A	CIG Cybersecurity	Compliance	June 2022
AHCA 2122-01-A	P-Card Program Administration Audit	Compliance	October 2022
AHCA -2122-02-A	Public Records Process	Assurance	November 2022
AHCA-2122-05-A	P-Card Program Transaction Audit	Compliance	November 2022
AHCA-2122-06-A	Specialty Plan Algorithm Process	Assurance	February 2022

Engagement Summaries

The following summaries describe the results of the engagements completed by Internal Audit during Fiscal Year (FY) 2021-22:

AHCA-2122-03-A, Agency for Health Care Administration, Enterprise Audit for House Bill 1079

Internal audit conducted an audit of the contract procurement process. This audit satisfied the requirements of House Bill 1079, passed during the 2020-21 Legislative Session, which amended Section 287-136, F.S., to require a periodic risk-based compliance audit of all contracts executed by Florida State Agencies to identify any trends in vendor preferences.

During our audit there were no trends in vendor preference identified. However, we did note areas where improvements could be made to strengthen controls in the following areas:

- Agency contracts were not always entered timely (within 30-days) or accurately into the Florida Accountability Contract Tracking System (FACTS), as required by Section 215-985 (14)(a), F.S.
- Agency procurement policies, procedures and quality assurance processes need to be updated and revised.
- Agency procurement processes relevant to conflict-of-interest documentation need improvement.

Our office made the following recommendations:

- The Agency should ensure contract data and documents are accurately entered into FACTS within the statutory 30-day deadline, and ensure contracts/grant disbursements with inactive vendors and past end dates are identified and corrected;
- The Agency should revise and update relevant internal procurement policies and procedures, and institute additional quality assurance processes over the entry of contracts into FACTS to ensure greater accuracy of the data in FACTS; and
- The Agency's procurement office should implement quality assurance processes to ensure that conflict of interest forms are completed and included for all executed contracts, and update the conflict of interest form to include the five-year previous vendor employment prohibition for Agency contract managers.

AHCA-2122-04-A, Agency for Health Care Administration Enterprise Audit of Cybersecurity Continuous Monitoring

Internal Audit conducted an audit of the Division of Information Technology (IT). The audit focused on the Agency's controls and compliance with Chapter 60GG-2.004(2), F.A.C., Security Continuous Monitoring, regarding IT resource monitoring to identify cybersecurity events.

This audit has been classified as exempt and/or confidential in accordance with Section 282.318(4)(g), F.S. and thus is not available for public distribution.

Additional Projects

Section 20.055(2), F.S., requires the OIG in each state agency to "advise in the development of performance measures, standards, and procedures for the evaluation of state agency programs" and to "assess the reliability and validity of the information provided by the state agency on performance measures and standards, and make recommendations for improvement, if necessary."

Internal Audit participated in the review of performance measures included in the Agency's annual Long Range Program Plan. Current measures and proposed new measures were reviewed and guidance was provided to Agency staff regarding accuracy, validity, and reliability.

Internal Audit also completed the following additional duties or projects during FY 2021-22:

- Schedule IX of the Legislative Budget Request.
- IT Risk Assessment Review - a review of the 2022 AHCA Cybersecurity Compliance Risk Assessment, which provided a high-level overview of compliance with the Florida Cybersecurity Standards as of May 2022.
- CIG Project: Office of the Governor Executive Order Number 20-44, Section 4 - Attestation Request – Internal Audit provided consulting assistance in reviewing the procedures and amendments to all applicable contracts and grant agreements requiring the submission of an annual report which includes compensation information for entities named in statute with which a state agency must form a sole-source, public-private agreement or an entity that, through contract or other agreement with the state, annually receives 50% or more of their budget from the State or from a combination of State and Federal funds.

Internal Engagement Status Reports

The IIA Standards require auditors to follow-up on reported findings and recommendations from previous engagements to determine whether Agency management has taken prompt and appropriate corrective action. The OIG provides status reports on internal engagement findings and recommendations to Agency management at six-month intervals after publication of an engagement report.

During FY 2021-22, the following status reports for internal engagements were published:

- Tracking of HQA Final Orders (6-Month and 12-Month Status Reports)
- IT Help Desk (18-month Status Report)

Corrective Actions Outstanding from Previous Annual Reports

As of June 30, 2022, the following significant recommendations described in previous annual reports were still outstanding.

- Financial Services manual process steps for the intake of final orders and the collection of final order monetary penalties did not always properly identify final order monetary penalties; and
- Final Order monetary compliance penalties were not always updated or closed appropriately in VERSA.

External Engagement Status Reports

Pursuant to Section 20.055(6)(h), F.S., the OIG monitors the implementation of the Agency's response to external reports issued by the AG and by the Office of Program Policy Analysis and Government Accountability (OPPAGA). The OIG is required to provide a written response to the Secretary on the status of corrective actions taken no later than six months after a report is published by these entities. Copies of such responses are also provided to the Legislative Auditing Committee. Additionally, pursuant to Section 11.51(3), F.S., OPPAGA submits requests (no later than 18 months after the release of a report) to the Agency to provide data and other information describing specifically what the Agency has done to respond to recommendations contained in OPPAGA reports. The OIG is responsible for coordinating these status reports and ensuring that they are submitted within the established timeframes.

During FY 2021-22, six-month status reports were submitted on the following external reports:

- Auditor General - State of Florida Compliance and Internal Controls Over Financial Reporting and Federal Awards (Report No. 2021-182) (September 30, 2021)
- Auditor General - MediKids Program Funding and Selected Administrative Activities (Report No. 2021-198) (October 12, 2021)

Coordination with Other Audit and Investigative Functions

The OIG acts as the Agency's liaison on audits, reviews, and information requests conducted by external state and federal organizations such as the Florida Office of the Auditor General, the Florida Department of Financial Services, OPPAGA, the U.S. Government Accountability Office (GAO), U.S. Department of Health and Human Services (HHS), Florida Digital Service (FDS), the Florida Department of Law Enforcement (FDLE), and the Social Security Administration (SSA). The OIG coordinates the Agency's responses to all audits, reviews, and information requests from these entities.

During FY 2021-22, the following reports were issued by external entities:

Florida Office of the Auditor General

- Auditor General - State of Florida Compliance and Internal Controls Over Financial Reporting and Federal Awards (Report No. 2022-189) (March 2022)
- Auditor General - COVID-19 Data Collection and Reporting (Report No. 2022-200) (June 2022)

U.S. Government Accountability Office

- GAO - COVID-19 HHS's Collection of Hospital Capacity. (Report No. GAO-21-600) (August 2021)
- GAO - Military Personnel - Opportunities Exist to Improve Access to Services Supporting Caregivers of Dependents with Special Needs. (Report No. GAO-22-105204) (June 2022)

U.S. Department of Health and Human Services

- HHS OEI-03-20-00230 - Nationwide, Almost All Medicaid Managed Care Plans Achieved Their Medical Loss Ratio Targets (August 2021)
- HHS A-09-20-02005 - CMS's COVID-19 Data Included Required Information From the Vast Majority of Nursing Homes, but CMS Could Take Actions To Improve Completeness and Accuracy of the Data (September 2021)

Office of Program Policy Analysis and Government Accountability

- OPPAGA - Annual Report on the Commercial Sexual Exploitation of Children in Florida, 2021. (Report No. 21-06) (July 2021)
- OPPAGA - Electrocardiograms for High School Student Athletes (Presentation) (December 2021)
- OPPAGA - Review of Services Provided to Medicaid - Eligible Pregnant Women, Infants, and Children by Florida Healthy Start and Medicaid Managed Care Plans. (Report No. 21-08) (December 2021)
- OPPAGA - Biennial Review of AHCA's Oversight of Fraud, Waste, and Abuse in Florida's Medicaid Program. (Report No. 22-03) (January 2022)

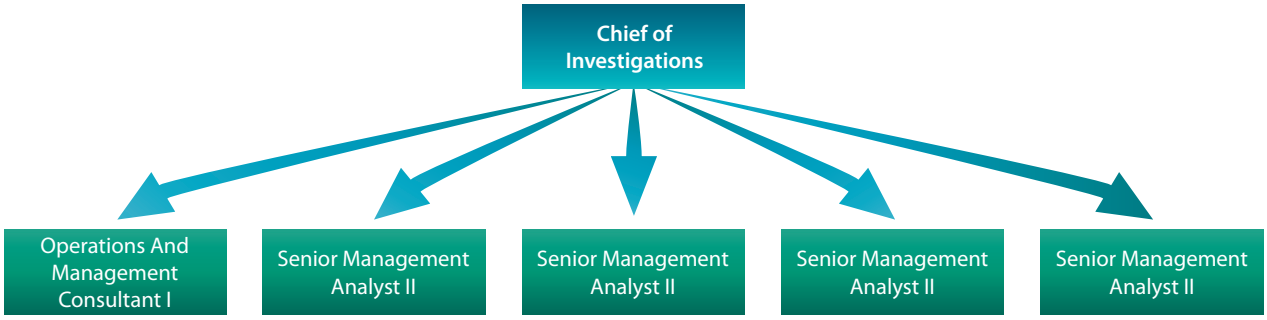
Single Audit Act Activities

Entities that receive federal or state funds are subject to audit and accountability requirements commonly referred to as "single audits." The Federal Office of Management and Budget (OMB) Uniform Guidance and the Florida Single Audit Act require certain recipients that expend federal or state funds, grants or awards to submit single audit reporting packages in accordance with Title 2 Code of Federal Regulations §200 Subpart F (Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards), or Section 215.97, F.S. (the Florida Single Audit Act) and Chapters 10.650 or 10.550 of the Rules of the Auditor General for state awards.

As a pass-through entity of federal and state financial assistance, the Agency is required to determine whether timely and appropriate corrective action has been taken with respect to audit findings and recommendations subject to the single audit requirements. The OIG is responsible for reviewing submitted financial reporting packages to determine compliance with applicable submission requirements and reporting the results of these reviews to the program/bureau and the Agency's Contract Manager.

During FY 2021-22, Internal Audit continued to provide guidance to the Bureau of Financial Services and the applicable program areas to develop compliance supplement(s) for the Catalog of State Financial Assistance. During the fiscal year, Internal Audit reviewed two audits that met the minimum threshold for compliance with single audit submission requirements. The contract managers were notified of the review results and were provided guidance on resolving any issues noted in the reporting package.

INVESTIGATION UNIT



ORGANIZATION AND STAFF

The Office of Inspector General's Investigation Unit (IU) is responsible for initiating, conducting, and coordinating investigations that are designed to detect, deter, prevent, and eradicate fraud, waste, mismanagement, misconduct, and other abuses within the Agency. To that effort, the IU conducts internal investigations of Agency employees and contractors related to alleged violations of policies, procedures, rules, and State and Federal laws. Complaints may originate from the Office of the Chief Inspector General, the Whistle-blower Hotline, the Chief Financial Officer's "Get Lean" Hotline, Agency employees, health care facilities, practitioners, Medicaid beneficiaries, or from the general public.

Allegations of a criminal nature are immediately referred to the appropriate law enforcement entity for investigation. When necessary or requested, the IU works closely with local police, the Florida Department of Law Enforcement, the Office of the Attorney General, and the appropriate State Attorney's Office on matters involving the accountability or integrity of Agency personnel.

In February 2017, the AHCA OIG IU achieved accreditation status for a three-year term and in February 2020, the AHCA OIG IU received their first Re-accreditation status from the Commission for Florida Law Enforcement Accreditation, Inc. Accreditation demonstrates the IU has met specific requirements and prescribed standards. Accreditation resulted in established standards and directives for IU staff on (1) Organization and Governing Principles; (2) Personnel Practices; (3) Training; (4) Investigation Process; (5) Case Supporting Materials and Evidence; (6) Whistle-blowers Act; (7) Notification Process; (8) Case Management; and (9) Final Reporting Processes. Accreditation provides the IU a means for maintaining the highest standards of professionalism and accountability.

The IU staff brings various backgrounds and expertise to the Agency. Certifications, in addition to advanced degrees, collectively held by IU staff as of June 30, 2022, include:

- Certified Inspector General Investigator (6)
- Certified Inspector General Auditor (1)
- Certified Equal Employment Opportunity Investigator (2)
- Certified Contract Manager (3)
- Certified Compliance and Ethics Professional (1)
- Certified Fraud Examiner (1)
- COSO Enterprise Risk Management Certificate Program (1)
- Masters Degrees (2)

INVESTIGATION UNIT COMPLAINT REVIEW

During FY 2021-2022, the IU opened 260 new complaints and closed 263 complaints, some of which were ongoing from the previous fiscal year. The IU's analysis of the complaints received and investigated disclosed that most of the cases involved disparaging remarks and unprofessional conduct directed toward employees and persons outside the agency. For this report, the complaints were generally categorized as follows:

- **Employee Misconduct** - Allegations associated with employee misconduct included but were not limited to allegations associated with conduct unbecoming a public employee, ethics violations, misuse of Agency resources, and unfair employment practices.
- **Facility** - Regulated and licensed facility violations reported included but were not limited to allegations associated with substandard care, patients' rights violations, public safety concerns, facility licensing issues, and unlicensed activity.
- **Fraud** - Medicaid fraud violations reported included but were not limited to allegations associated with Medicaid billing fraud, allegations related to patient brokering, and allegations of physician self-referral (Stark Law) violations. Other allegations related to fraud included Medicare and private billing fraud.
- **Equal Employment Opportunity (EEO) Violations** - EEO violations reported included but were not limited to allegations associated with hostile work environments, discrimination, harassment, and retaliation for engaging in protected activity.
- **Health Insurance Portability and Accountability Act (HIPAA) Violations** - Allegations associated with violations of HIPAA's Privacy Rule or records access rule.
- **Medicaid Service Complaints** - Medicaid service complaints included but were not limited to allegations associated with reported denials of service, denials of eligibility, and Medicaid provider contract violations.
- **Other** - Allegations not within the OIG's jurisdiction (e.g., theft); information provided wherein no investigative review, referral, or engagement was required.

The 260 complaints received by the AHCA OIG for FY 2021-2022 were assessed and assigned as follows:

- 194 were referred to other AHCA Bureaus or outside agencies for proper assessment.
- 20 were assigned for informational purposes only.
- 19 were assigned for Preliminary Investigation *(Two of which were initially assigned for Whistle-blower determination)*.
- 18 were assigned for analysis to determine if the complaints met the criteria for Whistle-blower status as defined in §112.3187, F.S.
- Six were assigned as full Administrative Investigations.
- Five were assigned to provide investigative assistance to management.

Investigation Unit Case Highlights

Investigations that resulted in published investigative reports were distributed to applicable Agency management responsible for remedial action (if appropriate) or to effect recommended policy changes. The following are examples of Investigation Unit cases closed during FY 2021-2022:

AHCA OIG CASE #21-04-008

This investigation was initiated upon the receipt of a complaint which alleged falsification of documentation and mishandling of a survey by an AHCA employee. The AHCA OIG's investigation found evidence to support the allegation the AHCA employee failed to follow HQA internal procedures for complaint investigations. The findings were provided to HR with a recommendation to provide re-training on complaint survey procedures and any other action deemed appropriate.

AHCA OIG CASE #21-10-002
This investigation was initiated upon the receipt of a complaint that alleged conduct unbecoming a public employee, and a conflict of interest by an AHCA employee. The AHCA OIG's investigation found there was no evidence to support that there was an AHCA policy violation committed by AHCA staff. The findings were provided to AHCA Management and HR for review and any action deemed appropriate.

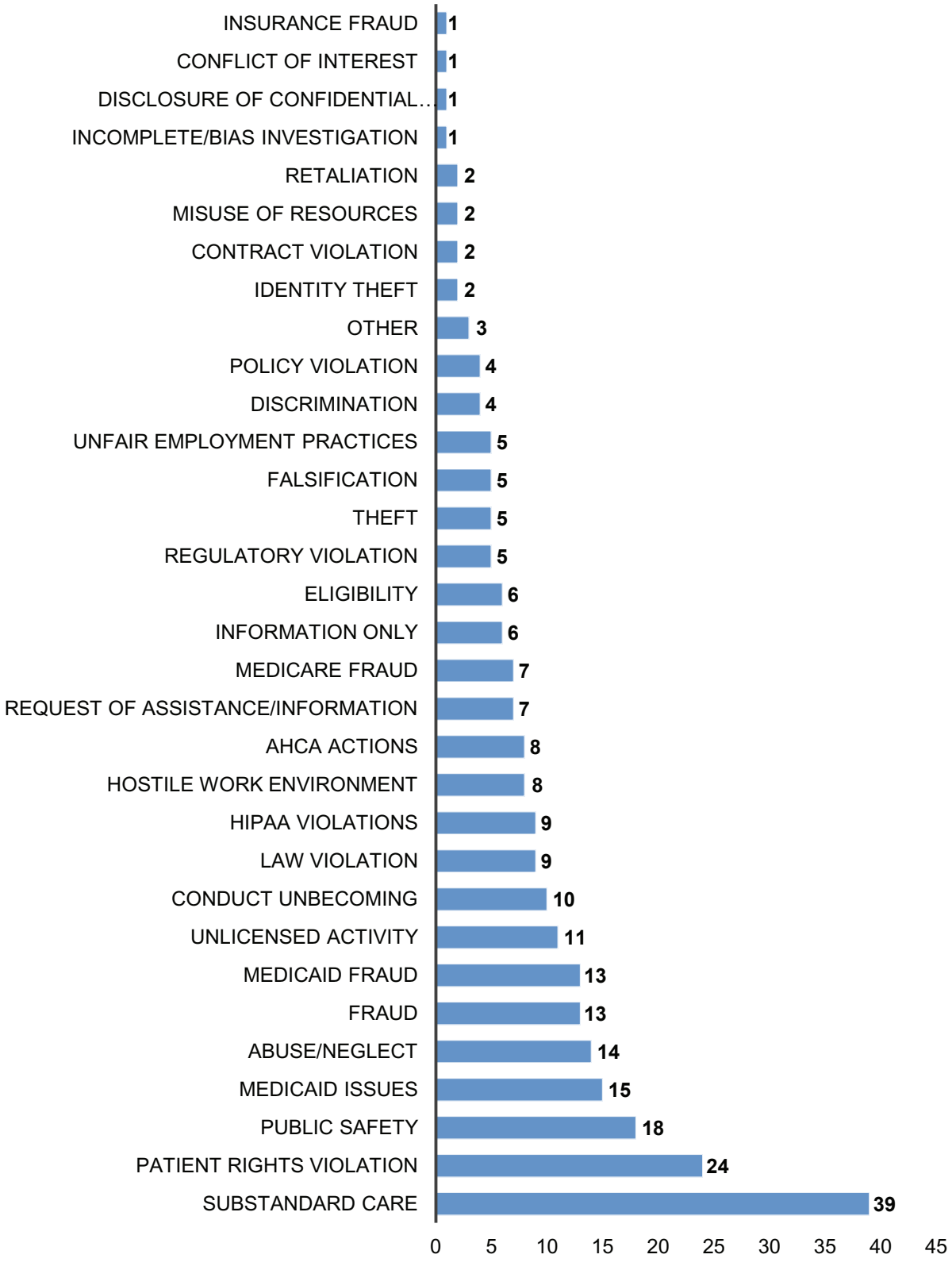
AHCA OIG CASE #21-10-027
This investigation was initiated upon the receipt of an email alleging an AHCA employee failed to report a conflict of interest. The AHCA OIG's investigation found the AHCA employee was exonerated of the allegation. The findings were provided to HQA Management with recommendations to provide training to all HQA staff on Conflict of Interest, update the current HQA Bureau of Field Operations Conflict of Interest Form to include all HQA staff and management, and to create an internal HQA policy that specifically addresses the HQA Conflict of Interest Form.

AHCA OIG CASE #21-11-014
This investigation was initiated upon the filing of a complaint by an AHCA supervisor that alleged a Disclosure of Confidential Information and Conduct Unbecoming by an AHCA employee. The AHCA OIG's investigation found evidence to support the allegations of a Disclosure of Confidential Information and Conduct Unbecoming. The findings were provided to AHCA's HQA Management and HR with recommendations for them to consider having all supervisory positions attend all AHCA Academy classes specific for supervisors, include a supervisor refresher training component to be completed as part of the AHCA yearly Keep Informed Training, and to provide additional hands-on training concerning team dynamics and professionalism in the workplace.

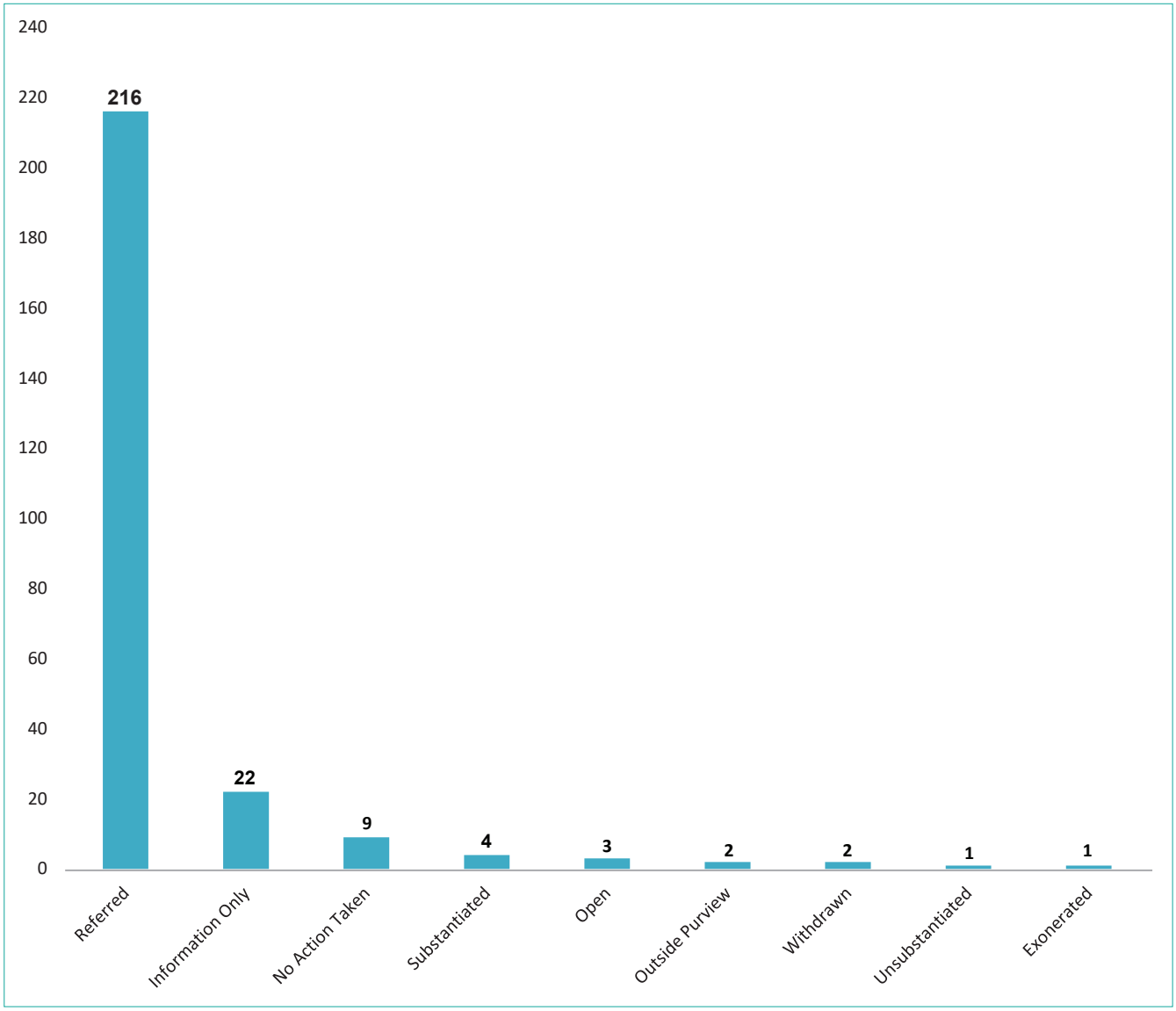
AHCA OIG CASE #22-03-008
This investigation was initiated upon the filing of a complaint forwarded to the AHCA OIG by AHCA HR alleging an AHCA employee submitted falsified work release forms. The AHCA OIG's investigation found evidence to support the allegation. The employee resigned during the investigation and the findings were provided to AHCA Management and HR for any further action deemed appropriate.

AHCA OIG CASE #22-04-001
This investigation was initiated upon the filing of a complaint by a Medicaid Provider and forwarded by AHCA's HR to the AHCA OIG alleging an AHCA Surveyor made racial, discriminatory, and unprofessional comments while conducting a survey. The AHCA OIG's investigation found evidence to support the allegation of Conduct Unbecoming and provided the findings to AHCA HQA Management for any action deemed appropriate.

Primary Allegations by Category for Complaints Received FY 2021-22



Disposition of Allegations by Category for Complaints Received FY 2021-22



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