



Office of the Inspector General

Annual Report
July 1, 2024 – June 30, 2025



Agency Mission

Better health care for all Floridians.

Agency 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.

Agency Values

Accountability

We are responsible, efficient, and transparent.

Fairness

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

Responsiveness

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

Teamwork

We collaborate and share our ideas.

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RON DESANTIS
GOVERNOR

SHEVAUN L. HARRIS
SECRETARY

September 2025

In accordance with Section 20.055, Florida Statutes, it is my pleasure to present the Agency for Health Care Administration (AHCA) Office of Inspector General (OIG) Annual Report for Fiscal Year (FY) 2024-2025. The report details the accomplishments and efforts of staff within the Internal Audit and Investigations Sections during the fiscal year.

Our Internal Audit Unit provides assurance and consulting services to help ensure the efficiency and effectiveness of Agency programs and the Internal Investigative Unit works to protect the Agency's resources by deterring and detecting activities such as fraud and significant employee misconduct.

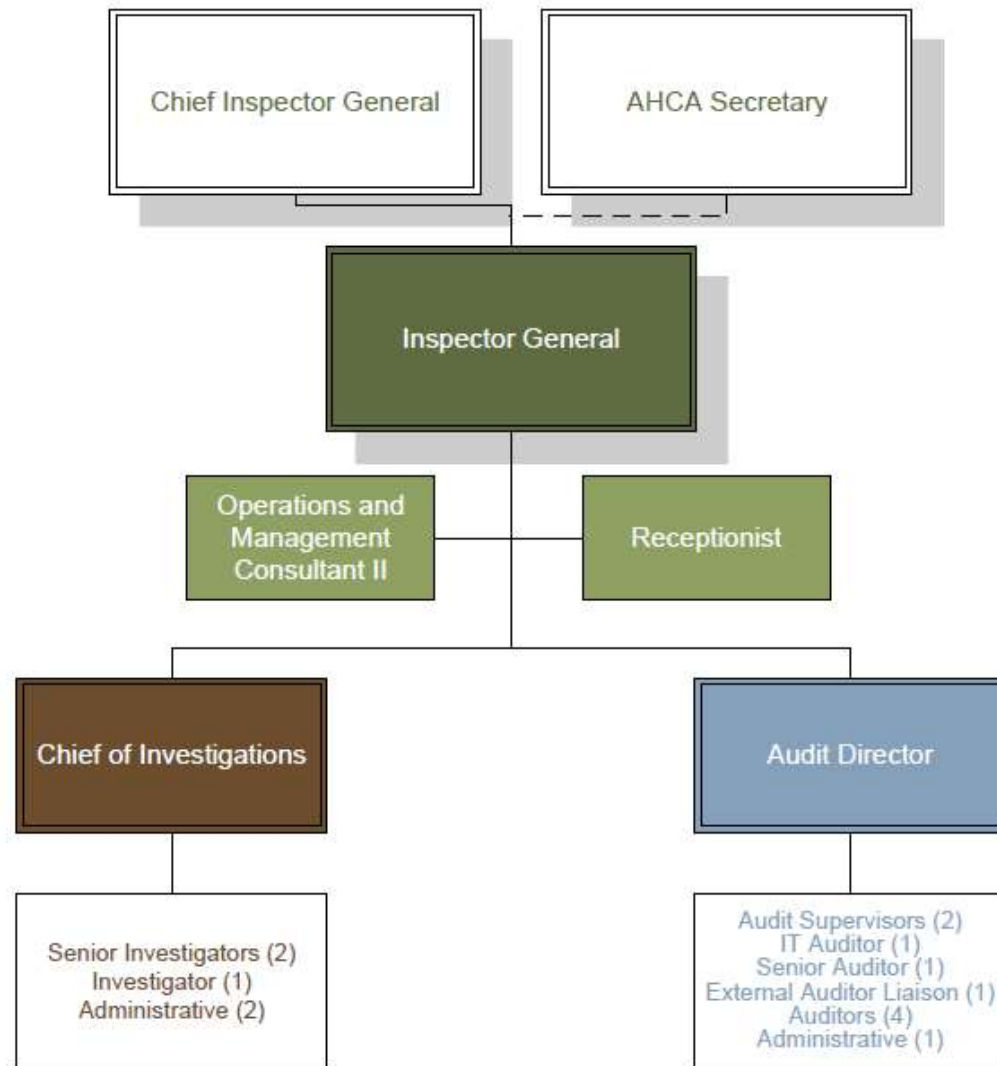
The OIG is committed to promoting accountability and integrity in a professional and timely manner. We look forward to continuing our work with the Agency leadership team, management, and staff of AHCA in meeting the challenges that face the Agency in championing Better Health Care for all Floridians.

Respectfully submitted,

Brian P. Langston
Inspector General



ORGANIZATIONAL CHART



DEGREES AND PROFESSIONAL CERTIFICATIONS

In addition to the educational degrees and experience required for their respective positions, OIG staff members held the following professional certifications and licenses as of June 30, 2025:

- Master's Degree (6)
- Certified Equal Employment Opportunity Investigator (4)
- Certified Fraud Examiner (1)
- Certified Information Systems Auditor (1)
- Certified Inspector General (2)
- Certified Inspector General Auditor (9)
- Certified Inspector General Investigator (5)
- Certified Internal Auditor (2)
- Certified Public Accountant (1)
- Commission for Florida Law Enforcement Accreditation Assessor (4)
- COMPTIA CySA+ (1)
- COMPTIA Network+ (1)
- COMPTIA Security+ (1)
- COMPTIA Server+ (1)
- Florida Certified Contract Manager (1)
- Florida Notary Public (6)
- Medical Transcription Certificate (1)

INVESTIGATIONS UNIT

PURPOSE

The Office of Inspector General’s Investigations Unit (IU) is responsible for initiating, conducting, and coordinating investigations. These investigations 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 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 Florida 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 IU achieved accreditation status for a three-year term, and in February 2020 and 2023, the IU received re-accreditation status from the Commission for Florida Law Enforcement Accreditation, Inc. Accreditation demonstrates that the IU has met specific requirements and prescribed standards. Accreditation resulted in established standards and directives for the IU staff on (1)



Organization and Governing Principles; (2) Personnel Practices; (3) Training; (4) Investigation Process; (5) Case Supporting Materials and Evidence; (6) Whistle-blower’s Act; (7) Notification Process; (8) Case Management; and (9) Final Reporting Processes. Accreditation provides the IU with a means for maintaining the highest standards of professionalism and accountability.

COMPLAINT REVIEW

During FY 2024-25, the IU opened 544 new complaints and closed 538 complaints, some of which were ongoing from FY 2023-24. 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.

The 544 complaints received by the AHCA OIG for FY 2024-25 were assessed and assigned as follows:

429	Referred to other AHCA bureaus or outside agencies for proper assessment
67	Assigned for informational purposes only
27	Assigned for analysis to determine if the complaints met the criteria for Whistle-blower status as defined in Section 112.3187, F.S.
15	Assigned for preliminary investigation
6	Assigned as full administrative investigations

For this report, the complaints were generally categorized as follows:

Employee Misconduct	Allegations associated with employee misconduct reported 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 reported 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.

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

CASE HIGHLIGHTS FY 2024-25

The following are examples of the IU cases closed during FY 2024-25:

AHCA OIG CASE #24-10-010

This investigation was initiated upon the filing of a complaint by an AHCA employee alleging the unauthorized disclosure of Protected Health Information by an AHCA employee. The AHCA OIG's investigation found evidence to support the allegation and referred the complaint to AHCA Management and Human Resource (HR) for disciplinary action deemed appropriate. Our Office recommended Agency management continue to review and update their internal procedures to ensure employees are following HIPAA and IT Security laws, rules and regulations. Additionally, our Office recommended HR coordination with IT to provide in-person HIPAA compliance training and IT security awareness training every three years for all AHCA employees.

AHCA OIG CASE #25-03-014

This investigation was initiated upon the receipt of a complaint alleging discrimination by treating an employee differently than other staff based on race. Based on the documentary and testimonial evidence obtained and reviewed during the investigation, we found there was no evidence to support the allegation. Our Office recommended appropriate attendance and time management training for the complainant, as well as communication and supervisory training for the subject. Additionally, our Office recommended Agency management address potential security and HIPPA risk and re-evaluate visitor badge access controls.

AHCA OIG CASE #25-04-042

This investigation was initiated upon the filing of a complaint by an AHCA employee alleging an AHCA employee engaged in activities that constituted misuse of state resources. The AHCA OIG's investigation found evidence to support the allegation and referred the complaint to AHCA Management and HR for disciplinary action deemed appropriate. Additionally, our Office recommended Agency management provide training regarding Acceptable Use of Information Technology and Code of Ethics for state employees.

INTERNAL AUDIT

PURPOSE

The purpose of Internal Audit (IA) is to provide independent, objective assurance and advisory services designed to add value and improve Agency operations. Internal Audit's mission is to assist the Secretary and 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.

Internal Audit 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.

The Institute of Internal Auditors *Global Internal Audit Standards* (IIA Standards) and the Association of Inspectors General *Principles and Standards for Offices of Inspectors General* require IA 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.

RESPONSIBILITIES

Risk Assessment and Audit Plan

Internal Audit performs a risk assessment of the Agency's programs and activities each FY 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, IA 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, advisory services to be conducted, and budgeted hours for the projects.

Types of Engagements

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

INTERNAL AUDIT ACTIVITIES

Completed and In-Progress Engagements

The following is a summary list of completed engagements from July 1, 2024, to June 30, 2025:

REPORT NO.	ENGAGEMENT	TYPE	DATE ISSUED
AHCA-2324-00005-A	Online Licensure Renewal Process Audit	Assurance	December 2024
AHCA-2324-00002-A	Contract Monitoring Audit of Select Gainwell Technology LLC Contracts	Assurance	January 2025
AHCA-2324-00008-A	Audit of Laserfiche Records Retention and Storage	Compliance	January 2025
AHCA-2324-00012-A	Agency Audit of Date Use Agreements	Assurance	February 2025
AHCA-2425-00006-A	Physical Security - Homeland Security Assessment	Assessment	May 2025
AHCA-2425-00005-A	Enterprise Triennial Procurement Audit	Compliance	June 2025

The following is a list of engagements in progress as of June 30, 2025:

REPORT NO.	ENGAGEMENT	TYPE	PLANNED ISSUE DATE
AHCA-2324-00001-A	Review of Agency Compliance with Prompt Payment Requirements	Compliance	Issued July 2025
AHCA-2324-00030-A	Audit of Agency ePAR Process	Assurance	August 2025
AHCA-2324-00031-AS	Health Quality Assurance – Health Facility Regulation Productivity Analysis	Advisory Service	February 2026
AHCA-2425-00003-A	Enterprise Audit of Agency Cybersecurity Controls for Asset Management	Assurance	August 2025
AHCA-2425-00009-A	Medicaid Fair Hearing Intake Process	Assurance	September 2025
AHCA-2425-00019-A	Audit of the Bureau of Financial Services' Revenue Management Process for Central Services' Accounts	Assurance	November 2025
AHCA-2425-00026-A	Highway Safety Motor Vehicle Data Exchange Security Audit	Compliance	January 2026
AHCA-2425-00029-A	Contract Monitoring – Staff Aug Contracts	Compliance	March 2026
AHCA-2425-00023-A	Provider Enrollment Audit	Assurance	On Hold Pending FX Process Implementation

Engagement Summaries

The following summaries describe the results of the engagements completed by IA during FY 2024-25:

AHCA-2324-00005-A: Online Licensure Renewal Process Audit

Internal Audit conducted an audit of the Agency's online licensure renewal process. During the audit, we noted where improvements could strengthen controls in the following areas:

- The manual application entry process had a high error rate in VERSA (the licensure system); and
- Statutory time requirements were not being met.

Our Office made the following recommendations:

- The Bureau of Health Facility Regulation (HFR) should create and implement a written quality control process which should include a methodology for locating and correcting manual data entries;
- HFR should create and implement a written re-training program that identifies when error rates require additional staff training and a methodology for providing additional training to identified staff as necessary;
- HFR should develop a written and consistent process for reassigning applications across the units, taking into consideration the age of the application to ensure compliance with statutory date requirements;
- HFR should create and implement the development of a written training program for all staff who use the AppKeyDate report; and
- All supervisors and managers in HFR should review the AppKeyDate report often for potential out of compliance applications and other anomalies, including written documentation of the results of reviews and corrective action plans, as necessary.

AHCA-2324-00002-A Contract Monitoring Audit of Select Gainwell Technology LLC Contracts

Internal Audit conducted an audit of selected contracts and the contract monitoring process. During the audit, we noted where improvements could strengthen controls in the following areas:

- Gainwell did not adequately monitor the Knowli Data Science subcontractor as outlined in the contract;
- Gainwell did not assess liquidated damages as prescribed in the subcontract agreement with Knowli Data Science;
- The Agency does not have documentation supporting review and approval of Knowli Data Science subcontractor staff qualifications;
- The Agency does not have an established process for documenting validation of the approval of contract manager qualifications outlined in Section 287.057(15), F.S.;
- The Agency did not ensure the supervisors of contract managers timely took training required by Section 287.057(18), F.S.; and
- The MED037 contract does not contain the updated language required by Section 20.055(5), F.S.

Our Office made the following recommendations:

- The Gainwell Technologies LLC contract (MED037) should be amended to state the Agency is responsible for monitoring Knowli Data Science subcontractor staff, including but not limited to verifying time worked by Knowli subcontractor staff;
- Gainwell should assess the liquidated damages related to the vacancy over 30 days;
- The Agency should improve their process for monitoring Knowli subcontractor staffing levels, including but not limited to ensuring staff vacancies are filled in a timely manner;
- Gainwell should update their subcontractor agreement with Knowli to include a specific methodology for calculating staff vacancy percentages;

- The Division of Health Care Finance and Data should strengthen the process for review and approval of qualifications of subcontractor staff and documentation thereof;
- The Bureau of Purchasing and Contract Administration (BPCA) should establish a process for documenting validation of the approval of contract manager qualifications prior to appointment to ensure only qualified contract managers are appointed to contracts;
- BPCA should develop and implement a process for notifying newly appointed supervisors over contract managers of the required training, which is to be completed within 12 months of appointment;
- BPCA should develop and implement a process for verifying completion of the training;
- The Gainwell Technologies LLC contract manager (MED037) should execute an amendment to include the updated language required by Section 20.055(5), F.S.; and
- BPCA should follow through with their intent to review contracts executed prior to July 1, 2015, to identify any active contracts that need the Section 20.055(5), F.S., updated language added by amendment. The contract managers should be notified if their contract needs to be amended to include this updated language.

AHCA-2324-00008-A Audit of Laserfiche Records Retention and Storage

Internal Audit conducted an Agency-wide audit of Laserfiche Records Retention and Storage. During the audit, we noted where improvements could strengthen controls in the following areas:

- Agency processes related to notification of applicable Records Custodians for new active legal holds need improvement;
- Formalized Agency-wide procedures are needed for preservation of electronic records during active legal holds;
- Agency timeliness in destroying (deleting) electronic records stored in Laserfiche needs improvement;
- Specific process instructions for the destruction (deletion) of electronic records will help improve clarity within Agency Policy/Procedure 4004, Records Management;
- Elimination of all unnecessary duplicate copies of electronic records from Laserfiche storage will help reduce storage costs; and
- Laserfiche system improvements related to separation of duties and change management processes will help facilitate improved user experiences and system owner inputs.

Our Office made the following recommendations:

- The Office of General Counsel (OGC) Litigation Unit should timely update the Current (Active) Legal Hold list on the Agency portal at the time each new active legal hold is determined;
- Timely notification and instructions should be provided to all relevant Agency Records Custodians at the time of each new legal hold;
- The OGC should formalize the "Process" section of the Legal Hold Procedure for Electronically Stored Documents as an approved Agency procedure and distribute this procedure to all areas of the Agency; and
- Each Bureau Chief or designated Records Custodian should destroy all electronic records stores by its respective Bureau or area of responsibility that have met retention requirements and are no longer needed. Destruction should be documented on a signed Records Disposition Document, in accordance with Agency policy.

AHCA-2324-00012-A Audit of Agency Data Use Agreements

Internal Audit conducted an audit of Data Use Agreements. During the audit, we noted where improvements could strengthen controls in the following area:

- Data Use Agreements (DUA) do not contain consistent language across all Agency divisions.

Our Office made the following recommendations:

- BPCA should collaborate with HQA, the Division of Medicaid, and the Information Security Manager/HIPAA Privacy Officer to develop and implement a standardized Agency DUA template that includes all required HIPAA and Information Technology data elements; and
- BPCA should enhance its verification process to ensure all Agency DUAs contain the necessary language in compliance with HIPAA, Rule 60GG-2, Florida Administrative Code (F.A.C.), Information Technology (IT) Standards, and all applicable Agency IT security policies.

AHCA-2425-00006-A Physical Security - Homeland Security Assessment

Internal Audit, with collaboration from the Department of Homeland Security, conducted an assessment of physical security controls at 10 of AHCA's locations.

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

AHCA-2425-00005-A Enterprise Triennial Procurement Audit

Internal Audit conducted an audit of the Agency's contract procurement process. During the audit, we noted where improvements could strengthen controls in the following areas:

- The Agency did not complete or retain all conflict of interest questionnaires required by Section 287.057(21), F.S.;
- The Agency did not establish continuing oversight teams for a contract as required by Section 287.057(26)(a), F.S., or document that a continuing oversight team was not required;
- The Agency did not have documentation demonstrating the evaluators and negotiators collectively had experience and knowledge required by Section 287.057(17)(a), F.S.;
- The Agency has not revised and updated Agency policies and procedures, as noted in a previous audit (AHCA-2122-03-A); and
- The Agency did not ensure the Justification for Use of Statutory Exemption form was completed for one contract as required Agency Policy #4006.

Our Office made the following recommendations:

- BPCA should work with the OGC and program areas to develop and document a process to ensure that conflict of interest questionnaires are completed by all Agency staff taking part in the evaluation and selection process for noncompetitively procured contracts in accordance with State law. The conflict of interest questionnaires should be maintained in the contract file;
- BPCA should work with the program area to establish a continuing oversight team for the MED215 Milliman Inc. contract;
- BPCA should ensure the reason the Agency is not responsible for establishing a continuing oversight team is retained in the MED233 contract file;
- BPCA should collaborate with program areas to determine which active contracts would require teams and to determine whether the requirement for a continuing oversight team would be applicable. In collaboration with program areas, these teams should be established;
- BPCA should develop a process to ensure that if the requirement to establish a continuing oversight team is not applicable for a contract, documentation supporting the determination is retained in the contract file;
- BPCA should establish and document a process to retain documentation in the procurement file showing the validation of the requisite experience and knowledge for the appointed evaluators and negotiators;
- BPCA should acquire approval of the draft Policy #4006 with the requisite language from HB 1079 and disseminate the policy;
- BPCA should develop and document a process to ensure that Agency staff are provided with updated policies and procedures related to the procurement process. This process should

allow for timely updates as changes to laws and rules occur, ensuring Agency staff have the most current information while keeping the Agency's overall procurement policies and procedures up to date;

- BPCA should work with OGC to develop and document a process to ensure the Justification

for Use of Statutory Exemption form is utilized, completed, and retained for each contract procured through statutory exemption; and

- BPCA should update Policy #4006 to reflect the actual process for completion of the Justification for Use of Statutory Exemption form.

Additional Projects

Internal Audit also completed the following additional duties or projects during FY 2024-25:

- Schedule IX of the Legislative Budget Request; and
- Chief Inspector General (CIG) Project: Office of the Governor Executive Order Number 20-44, Section 4 - Attestation Request – IA provided advisory 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 Updates

The *I/A 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 2024-25, the following status updates for internal engagements were published:

- Health Care Policy and Oversight (HCPO) Responses to Federal Audits (6-Month and 12-Month Status Updates);
- Enterprise Audit of Cybersecurity Identity Management, Authentication, and Access Control (12-Month and 18-Month Status Updates);
- Public Records Process Audit (24-Month Status Update);
- Enterprise Audit of Cybersecurity Controls for Incident Response Reporting and Recovery (IRRR) (6-Month Status Update); and
- Agency Cash Collection Processes (12-Month and 18-Month Status Updates).

Corrective Actions Outstanding from Previous Annual Reports

As of June 30, 2025, the following significant recommendations described in previous annual reports were still outstanding:

Enterprise Audit of Cybersecurity Identity Management, Authentication, and Access Control

Outstanding findings from the annual cybersecurity audit are confidential and are not included in this report.

HCPO Responses to Federal Audits

Our Office recommended the Agency begin the process of updating 59-A-4, F.A.C., Minimum Standards for Nursing Homes regarding emergency plans.

- **Last management response:** The Comprehensive Emergency Management Plan for nursing homes has been drafted and serves as a template for the intermediate care facilities template. The final review is being completed and after appropriate notification and posting in the Florida Administrative Register, anticipate a rule workshop on both rules by late February. Anticipated Completion Date: If there are no challenges, it is anticipated that the rules will be completed by September 2025.

Enterprise Audit of Agency Cybersecurity Controls for Incident Response, Reporting, and Recovery (IRRR).

Outstanding findings from the annual cybersecurity audit are confidential and are not included in this report.

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 Auditor General (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 Joint 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 2024-25, six-month status reports were submitted on the following external reports:

- OPPAGA – Biennial Review of AHCA's Oversight of Fraud and Abuse in Florida's Medicaid Program (Report No. 24-03) (7/31/24); and
- Auditor General – State of Florida Compliance and Internal Controls Over Financial Reporting and Federal Awards (Report No. 2024-174) (9/24/24).

Single Audit 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 appropriate contract manager.

During FY 2024-25, IA continued to provide guidance to the Agency's 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, IA 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 with guidance on resolving any issues noted in the reporting package.

Coordination with Other Audit and Investigative Functions

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

During FY 2024-25, the following reports were issued by external entities:

Entity	Report Number	Report Name	Issue Date
Florida Office of the Auditor General	2025-162	State of Florida Compliance and Internal Controls Over Financial Reporting and Federal Awards	March 2025
U.S. Government Accountability Office	GAO-24-106883	Medicaid – Federal Oversight of State Eligibility Redeterminations Should Reflect Lessons Learned after COVID-19	July 2024
U.S. Department of Health and Human Services	A-06-23-09002	Twelve Selected States Did Not Accurately Calculate the Federal Share of Medicaid Collections Subject to the Increased COVID-19 Federal Medical Assistance Percentages	December 2024
U.S. Department of Health and Human Services	A-04-23-00135	Florida Did Not Comply With Federal Waiver and State Requirements at 18 of 20 Adult Day Care Facilities Reviewed	December 2024
U.S. Department of Health and Human Services	Control No. EC-FM-2022-FL-01-F	Financial Management Review – State of Florida – Medicaid Managed Care State Directed Payments for FY 2021	May 2025
Ohio Department of Medicaid	Auditor of State Report	The Cost of Concurrent Enrollment	March 2024



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