REPORT NO. 2014-057
DECEMBER 2013

AGENCY FOR HEALTH CARE ADMINISTRATION

HEALTH CARE FACILITY LICENSING FUNCTION AND INFORMATION TECHNOLOGY CONTROLS

Operational Audit

STATE OF FLORIDA
AUDITOR GENERAL
DAVID W. MARTIN, CPA

SECRETARY OF THE AGENCY FOR HEALTH CARE ADMINISTRATION

The Agency for Health Care Administration is created by Section 20.42, Florida Statutes. The head of the Agency is the Secretary who is appointed by the Governor, subject to confirmation by the Senate. During the period of our audit, the following individuals served as Secretary:

Elizabeth Dudek	From August 2010
Tom Arnold	Through August 2010

The audit team leader was Jacqueline Joyner, CPA. Please address inquiries regarding this report to Jane Flowers, CPA, Audit Manager, by e-mail at janeflowers@aud.state.fl.us or by telephone at (850) 412-2757.

This report and other reports prepared by the Auditor General can be obtained on our Web site at www.myflorida.com/audgen; by telephone at (850) 412-2722; or by mail at G74 Claude Pepper Building, 111 West Madison Street, Tallahassee, Florida 32399-1450.

AGENCY FOR HEALTH CARE ADMINISTRATION

Health Care Facility Licensing Function and Information Technology Controls

SUMMARY

This operational audit of the Agency for Health Care Administration (Agency) focused on the Division of Health Quality Assurance's (Division's) administration of the health care facility licensing function as well as selected Agency information technology controls. Our audit disclosed the following:

HEALTH CARE FACILITY LICENSING FUNCTION

Finding No. 1: The Agency's health care facilities licensing processes did not always ensure that required background screenings were timely performed for health care facility employees or document Agency efforts to verify that nursing home applicants reported civil verdicts or judgments.

Finding No. 2: The Agency did not always verify that required health care facility licensure due dates were met or ensure that all applicable fees were assessed.

Finding No. 3: The Agency could not always demonstrate that health care facility license fee deposits recorded in the Agency's licensing system were timely and appropriately reconciled to those deposits in the State's accounting records.

INFORMATION TECHNOLOGY CONTROLS

Finding No. 4: Agency network authentication controls need improvement.

Finding No. 5: The Agency could not always demonstrate that system and application changes were properly authorized, tested, and approved.

BACKGROUND

The Agency for Health Care Administration (Agency) is the chief health policy and planning entity for the State. The Agency is responsible for administration of the Medicaid Program, which is a Federally subsidized program that provides medical assistance to certain low-income persons. The Agency is also responsible for health care facility licensure, inspection, and regulatory enforcement; investigation of consumer complaints related to health care facilities and managed care plans; the certification of health maintenance organizations and prepaid health clinics; and other duties as prescribed by State law.[1]

FINDINGS AND RECOMMENDATIONS

Health Care Facility Licensing Function

The Agency for Health Care Administration (Agency), Division of Health Quality Assurance (Division), is responsible for licensing and regulating 40 different types of health care facilities. The Division utilizes the Versa: Regulation (VR) system to manage all phases of health care facility licensing, including complaint tracking, inspections, legal cases, and revenue management. As shown in Table 1, during the period July 2010 through February 2012, the Division processed initial, renewal, or change of ownership applications for 19,814 health care facility licenses, and collected related application fees totaling approximately $28.7 million. Of this amount, approximately $19.3 million (67 percent) pertained to nursing home, health care clinic, assisted living facility, and clinical laboratory licenses.

[1] Section 20.42(3), Florida Statutes.

Table 1
Health Care Facility License Applications
Processed and Fees Collected
For the period July 2010 through February 2012

Health Care Facility Type	Applications Processed	Application Fees Collected
Nursing Home	611	$ 8,322,844
Health Care Clinic	2,020	4,081,811
Assisted Living Facility	2,473	5,180,462
Clinical Laboratory	3,468	1,734,383
Other	11,242	9,398,193
Totals	**19,814**	**$28,717,693**

Source: VR system.

Our audit of the Agency's health care facilities licensing function focused on the Division's licensing activities for nursing homes, health care clinics, assisted living facilities, and clinical laboratories and identified areas in which Agency controls and processes needed improvement.

Finding No. 1: Health Care Facility Licensing Requirements

State laws and rules define the licensure requirements applicable to nursing homes, health care clinics, assisted living facilities, and clinical laboratories.[2] These licensure requirements include a level 2 background screening[3] every 5 years for the licensee (if an individual), facility administrator and financial officer, licensed health care practitioners employed by or contracted to a health care clinic, and any person seeking employment with a licensee or facility who is expected to, or whose responsibilities may require him or her to, provide personal care or services directly to clients or have access to client funds, personal property, or living areas.[4] During the review of the health care facility's application for licensure, Division staff are to verify the performance of required background screenings.

In addition to the required background screenings for health care facility employees, State law[5] requires that nursing home license applications contain copies of any civil verdicts or judgments involving the applicant rendered within the 10 years preceding the application that relate to medical negligence, violation of residents' rights, or wrongful death. State law also requires applicants to provide the Agency with documentation of any new verdict or judgment within 30 days after the county clerk of court filing.

We evaluated Agency licensing procedures and examined documentation related to 100 health care facility license applications (25 nursing home applications, 25 assisted living facility applications, 25 health care clinic applications, and 25 clinical laboratory applications), and identified instances in which the Agency had not ensured that the applicable health care facility licensing requirements related to background screenings and documentation of civil verdicts or judgments had been met. Specifically, we found that:

- The Agency's licensing procedures did not require Division staff to track and identify background screenings required during license periods. Our audit tests disclosed that seven employees (a Medical Director, an

[2] Chapter 408, Florida Statutes, Agency Rules, Chapter 59A, Florida Administrative Code, and Department of Elder Affairs Rules, Chapter 58A, Florida Administrative Code.
[3] As defined in Section 435.04, Florida Statutes, a level 2 background screening includes, but need not be limited to, fingerprinting for Statewide criminal history records checks through the Department of Law Enforcement, national criminal history records checks through the Federal Bureau of Investigation, and may include local criminal records checks through local law enforcement agencies.
[4] Section 408.809(1) and (2), Florida Statutes, and Agency Rule 59A-33.002(1)(e)1, Florida Administrative Code.
[5] Section 400.071(1)(e), Florida Statutes.

owner, four physicians, and an MRI technician) related to 3 health care clinics had not received a level 2 background screening in more than 5 years. While a background screening had been performed for these employees within 5 years prior to the dates the facilities were licensed by the Agency, a subsequent background screening was required during the 2-year license period. As of July 2, 2012, the number of days that had elapsed in excess of 5 years since the dates of the employees' prior background screenings ranged from 274 to 368 days. Level 2 background screenings were subsequently obtained for the individuals who were still employed at the health care clinics as of October 31, 2012.

- For 22 nursing home applications, documentation was not available to evidence that the nursing homes had notified the Agency of any, or that Division staff had verified there were no, civil verdicts or judgments rendered involving the applicant in the previous 10 years. Although the Agency's instructions for completing the application stated that the information on civil verdicts or judgments should be provided by the nursing homes, the Agency's standard application form did not contain a space for the nursing home to provide this information. Subsequent to our audit inquiry, the Agency updated the standard application, as of October 2013, to include a space for nursing homes to provide information related to civil verdicts. In addition, although the checklist used by Division staff for the review of nursing home change of ownership license applications contained a step requiring Division staff to check the application documentation for the inclusion of any civil verdicts or judgments, the checklists used for the review of initial and renewal nursing home license applications did not include a similar step.

Absent a process to track health care facility compliance that includes documentation of Division efforts to verify that health care facilities timely completed required employee background screenings and that nursing homes notified the Agency of any applicable civil verdicts or judgments, the Agency may be limited in its ability to demonstrate that the Division's efforts were adequate to ensure compliance with State laws and rules established to promote the safety and well-being of individuals receiving services from Agency-licensed health care facilities.

Recommendation: We recommend that Agency management enhance the licensing procedures to require that Division staff track and verify the timely performance of required background screenings by health care facilities. In addition, Agency management should revise the nursing home licensing procedures and associated checklists to better ensure that nursing homes timely notify the Agency of any civil verdicts or judgments related to medical negligence, violation of residents' rights, or wrongful death.

Finding No. 2: Timely Receipt and Review of Licensing Applications

State law[6] requires that health care facility renewal licenses or change of ownership licenses be received by the Agency at least 60 days prior to the date of expiration of the current license or the date of the change of ownership. State law[7] also requires the Agency to assess a $50 per day late fee, not to exceed 50 percent of the license fee or $500, whichever was less, for failure to timely submit a renewal application and license fee. Additionally, State law[8] requires the Agency to review each application within 30 days of receipt and to notify the applicant, in writing, of any apparent errors or omissions and request any additional required information. Pursuant to State law,[9] the Agency cannot deny a license for failure to correct an error or omission or to supply additional information unless the Agency timely notified the applicant of the error or omission within the 30-day period. To notify applicants of any apparent errors or omissions and to request additional information, the Agency utilizes an "omissions letter" that requires applicants to respond within 21 days after the Agency's notification or request for information.

[6] Section 408.806(2), Florida Statutes.
[7] Section 408.806(2)(d), Florida Statutes.
[8] Section 408.806(3)(a), Florida Statutes.
[9] Section 120.60(1), Florida Statutes.

As part of our audit, we examined 100 Agency application files, including 20 files for initial licensure, 60 files for license renewals, and 20 files for change of ownership to determine whether the applications included the required information and to verify that Division staff had timely received and reviewed the applications, assessed and collected the proper fees, and timely sent omissions letters, if appropriate. The application files selected for examination related to 25 nursing homes, 25 assisted living facilities, 25 health care clinics, and 25 clinical laboratories. We found that:

- Although 1 assisted living facility submitted a license renewal application to the Agency 43 days before expiration of the license, or 17 days late, the Division did not assess the facility a $500 late fee. In response to our audit inquiry, Division staff indicated that the facility application was not identified as late due to an employee error.
- Four facility applications were incomplete (1 assisted living facility initial license application, 1 assisted living facility renewal license application, 1 assisted living facility change of ownership application, and 1 health care clinic initial license application) and the Division had not timely mailed omission letters within 30 days after the receipt of the applications. The Division mailed omission letters for these facilities 1, 13, 26, and 6 days late, respectively.

Agency management lacks assurance that statutorily required fees are assessed in the appropriate amounts when late renewal applications are not properly identified. In addition, when omission letters are not sent within 30 days of application receipt, the Agency loses the ability to deny a license for an applicant's failure to correct an application error or omission or to supply additional required information.

Recommendation: We recommend that Agency management ensure that applicable fees are assessed for late applications. In addition, the Agency should ensure that applications are subject to timely review and, as applicable, appropriate follow-up procedures that include the timely mailing of omission letters.

Finding No. 3: Reconciliation of License Fees Received

Division staff receive health care facility license applications and the associated moneys (i.e., fees, fines, and penalties) and, upon receipt, input the relevant information into the VR system. Division staff are then to transfer the moneys received to the Agency's Bureau of Finance and Accounting (Bureau) for deposit. Bureau staff are then to record the revenue in the State's accounting records, the Florida Accounting Information Resource Subsystem (FLAIR).

Agency procedures required Bureau staff to perform a monthly license fee reconciliation between the VR system and FLAIR to identify, research, and correct any discrepancies. If timely and properly completed, reconciliation procedures, including the investigation of any noted discrepancies, provide assurance that moneys collected were deposited and recorded correctly.

As part of our audit, we evaluated the Bureau's reconciliation process and reviewed documentation related to selected monthly comparisons of health care facility license fee deposits recorded in the VR system to those deposits recorded in FLAIR during the period December 2011 through March 2013, as well as documentation of a year-to-date comparison for the period July 2012 through April 2013. We found that the Bureau's reconciliation process needed improvement. Specifically, we found that:

- The Bureau's year-to-date comparison of health care facility license fee deposits recorded in the VR system to those deposits recorded in FLAIR during the period July 2012 through April 2013 identified differences totaling $228,433. However, documentation was not available to evidence that Bureau staff had timely researched or, as applicable, corrected the differences. In response to our audit inquiry, Bureau staff indicated that any differences noted in the comparisons are researched, but the research results are not documented.

- Documentation of the Agency's monthly deposit comparisons did not contain evidence, such as tick marks or reviewer initials, indicating supervisory review.

Absent a process that ensures that reconciliations of health care facility license fee deposits recorded in the VR system to those recorded in FLAIR are timely and properly completed, documented, and reviewed, the Agency has limited assurance and cannot readily demonstrate that all moneys collected have been deposited and recorded correctly.

Recommendation: We recommend that Agency management enhance the health care facility license fee deposits procedures to ensure that appropriate reconciliations of fee collections are timely and properly completed, documented, and reviewed by appropriate supervisory staff.

Information Technology Controls

Effective information technology (IT) controls ensure the confidentiality, integrity, and availability of data and are essential to the overall management of IT resources. The Agency utilizes various IT resources during the performance of its statutory duties. Two such resources are the VR system which Agency staff are to use for the management of all phases of health care facility licensing and the Agency's documentation management system, Laserfiche. Agency staff are able to access the VR system, Laserfiche, and other IT resources, via the Agency's network.

Finding No. 4: Security Controls - Network Authentication

Security controls are intended to minimize the risk of unauthorized access to data and IT resources. Our audit procedures disclosed that certain Agency security controls related to network authentication need improvement. We are not disclosing specific details of the issues in this report to avoid the possibility of compromising Agency data and IT resources. However, we have notified appropriate Agency management of the specific issues. Without adequate security controls related to network authentication, the risk is increased that the confidentiality, integrity, and availability of Agency data and IT resources may be compromised.

Recommendation: The Agency should strengthen network authentication controls to ensure the confidentiality, integrity, and availability of Agency data and IT resources.

Finding No. 5: Change Management Controls

Effective change management processes should ensure that system and application changes are properly authorized, tested, approved, and tracked. To ensure that changes are authorized and appropriate, Agency change management processes should appropriately separate between employees the responsibility for programming changes and the responsibility for moving approved changes into production. In addition, the Agency's change management records should clearly document and track the change management process from initial authorization to the final approval of the change.

The Agency utilizes the VR system to manage all health care facility licensing data, including complaint, inspection, legal case, and revenue management data. The Agency uses the document management system, Laserfiche, to look up, correct, organize, and store scanned documents. Generally, the Agency's change management process for both systems began in the business unit, flowed through the IT Division, and concluded in the business unit with user acceptance. According to Agency personnel, the Agency communicated approval for changes made to the VR system and Laserfiche verbally and electronically through e-mail and the Agency's change management system. The Agency

used the change management system to track the change management process from the movement of the change into production to the final approval of the change.

As part of our audit, we tested the Agency's change management controls over the VR system and Laserfiche. Specifically, we selected 12 programming changes made to the VR system and 3 programming changes made to Laserfiche during the period July 2010 through February 2012 and reviewed available Agency documentation supporting the changes. We found that:

- For 8 VR system programming changes, Agency documentation did not provide sufficient detail to demonstrate that an authorized individual gave final approval for the change.
- For 1 VR system programming change, the Agency could not provide documentation to evidence the initial authorization or user testing and acceptance.
- For 7 VR system programming changes, Agency documentation was not sufficient to demonstrate that there was appropriate separation of duties between change programming and the movement of the change to production.
- For 1 VR system programming change, documentation from the Agency's change management system indicated that the change was approved; however, Agency staff indicated that the change was never promoted to production and, therefore, no change was implemented in the VR system. Agency staff also indicated that the change management system identified when a change was approved but did not indicate when a change was implemented.
- For 1 VR system programming change, documentation from the Agency's change management system indicated that the approval status of the change was pending; however, the change had been implemented and the change management system should have indicated that the change had been approved. Agency staff indicated that an anomaly in the change management system had allowed approved changes to be marked as pending and that the anomaly had since been corrected.
- For 3 Laserfiche programming changes, Agency documentation did not provide sufficient detail to demonstrate that an authorized individual gave final approval for the change and, for 2 of these programming changes, the Agency could not provide documentation to evidence initial authorization, user testing and acceptance, independent programming, and appropriate separation of duties between change programming and the movement of the change to production.

The Agency's entire change management process was not always documented as, according to Agency management, some steps of the change management process were verbally performed. In addition, the Agency's change management system did not document the change management process steps occurring prior to the movement of a change into production and approvals after the change was moved into production were deleted from the change management system after 60 days. Further, we noted that the Agency's written procedures did not address the maintenance of documentation for system and application change authorizations.

Absent records that clearly document and track the entire change management process, the Agency cannot demonstrate that only properly authorized, tested, and approved system and application changes were made.

Recommendation: We recommend that Agency management enhance the change management procedures to require that sufficient documentation of any changes to Agency systems and applications be maintained to demonstrate that only those changes that are properly authorized, tested, and approved are made.

OBJECTIVES, SCOPE, AND METHODOLOGY

The Auditor General conducts operational audits of governmental entities to provide the Legislature, Florida's citizens, public entity management, and other stakeholders unbiased, timely, and relevant information for use in promoting government accountability and stewardship and improving government operations.

We conducted this operational audit from January 2012 to July 2013 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

This operational audit focused on the Agency, Division of Health Quality Assurance's, licensing function. The audit also included a review of selected IT controls and Health Care Trust Fund activities. The overall objectives of the audit were:

- To evaluate management's performance in establishing and maintaining internal controls, including controls designed to prevent and detect fraud, waste, and abuse, and in administering assigned responsibilities in accordance with applicable laws, administrative rules, contracts, grant agreements, and guidelines.
- To examine internal controls designed and placed in operation to promote and encourage the achievement of management's control objectives in the categories of compliance, economic and efficient operations, the reliability of records and reports, and the safeguarding of assets, and identify weaknesses in those internal controls.
- To identify statutory and fiscal changes that may be recommended to the Legislature pursuant to Section 11.45(7)(h), Florida Statutes.

This audit was designed to identify, for those programs, activities, or functions included within the scope of the audit, deficiencies in management's internal controls, instances of noncompliance with applicable governing laws, rules, or contracts, and instances of inefficient or ineffective operational policies, procedures, or practices. The focus of this audit was to identify problems so that they may be corrected in such a way as to improve government accountability and efficiency and the stewardship of management. Professional judgment has been used in determining significance and audit risk and in selecting the particular transactions, legal compliance matters, records, and controls considered.

As described in more detail below, for those programs, activities, and functions included within the scope of our audit, our audit work included, but was not limited to, communicating to management and those charged with governance the scope, objectives, timing, overall methodology, and reporting of our audit; obtaining an understanding of the program, activity, or function; exercising professional judgment in considering significance and audit risk in the design and execution of the research, interviews, tests, analyses, and other procedures included in the audit methodology; obtaining reasonable assurance of the overall sufficiency and appropriateness of the evidence gathered in support of our audit's findings and conclusions; and reporting on the results of the audit as required by governing laws and auditing standards.

Our audit included the selection and examination of transactions and records. Unless otherwise indicated in this report, these transactions and records were not selected with the intent of statistically projecting the results, although we have presented for perspective, where practicable, information concerning relevant population value or size and quantifications relative to the items selected for examination.

An audit by its nature, does not include a review of all records and actions of agency management, staff, and vendors, and as a consequence, cannot be relied upon to identify all instances of noncompliance, fraud, abuse, or inefficiency.

In conducting our audit we:

- Reviewed applicable laws, rules, regulations, and Agency policies and procedures, and interviewed Agency personnel to gain an understanding of the Agency's operations within the scope of the audit.
- Obtained an understanding of internal controls and evaluated the effectiveness of processes, policies, and procedures related to areas within the scope of the audit.
- Obtained an understanding of VR system and Laserfiche IT controls, assessed the related control risks, determined whether selected general and application IT controls were in place, and tested the effectiveness of the controls.
- Reviewed Agency heath care facility licensing procedures and evaluated whether the procedures were sufficient to detect unlicensed activity.
- Examined Agency documentation for 100 health care facility license applications related to 25 nursing homes, 25 assisted living facilities, 25 health care clinics, and 25 clinical laboratories selected from the 8,344 initial, renewal, and change of ownership applications received by the Agency during the period July 2010 through February 2012 and recorded in the VR system, to verify that the application included all the statutorily required elements and to determine whether the Agency had assessed and collected the proper fees, timely received and reviewed each application, and timely notified the applicant of any apparent errors or omissions and requested any additional required information.
- Examined Agency documentation related to 25 license applications selected from the 1,484 exempt health care clinic applications received and recorded in the VR system during the period July 2010 through February 2012, to verify that the Agency had ensured that the health care clinic applying for exempt status met the statutory requirements for exemption and to determine whether the Agency had collected the proper fees and timely received and reviewed each application.
- Interviewed Agency personnel regarding the coordination of the Agency's health care facility survey efforts with the survey efforts of other regulatory entities.
- Examined Agency documentation related to 10 nursing home surveys selected from the 1,592 nursing home surveys performed by the Agency during the period July 2010 through February 2012, to determine whether the Agency surveyed the nursing homes at least once every 15 months, documented evidence of supervisory review, ensured any noted deficiencies were timely corrected, and updated the licensing records to properly reflect the survey results.
- Examined Agency documentation related to 25 assisted living facility surveys selected from the 3,043 assisted living facility surveys performed by the Agency during the period July 2010 through February 2012, to determine whether the Agency reported and timely resolved any noted deficiencies.
- Examined Agency documentation related to 10 assisted living facility surveys selected from the 3,043 assisted living facility surveys performed by the Agency during the period July 2010 through February 2012, to determine whether the Agency surveyed the assisted living facilities biennially, documented evidence of supervisory review, and updated the licensing records to properly reflect the survey results.
- Examined Agency documentation related to 25 health care clinic surveys selected from the 1,898 health care clinic surveys performed by the Agency during the period July 2010 through February 2012, to verify that an adequate number of Medicaid patient files were sampled during the survey and to determine whether the Agency surveyed the health care clinics biennially, reported and timely resolved any noted deficiencies, and updated the licensing records to properly reflect the survey results.
- Examined Agency documentation related to 25 clinical laboratory surveys selected from the 1,017 clinical laboratory surveys performed by the Agency during the period July 2010 through February 2012, to determine whether the Agency performed the clinical laboratory surveys biennially and reported and timely resolved any noted deficiencies.
- Examined Agency documentation related to 10 clinical laboratory surveys selected from the 1,017 clinical laboratory surveys performed by the Agency during the period July 2010 through February 2012, to

determine whether the Agency documented evidence of supervisory review and updated the licensing records to properly reflect the survey results.

- Examined documentation from 40 Agency complaint files (18 for assisted living facilities, 1 for a clinical laboratory, 1 for a health care clinic, and 20 for nursing homes) selected from the 7,809 assisted living facility, clinical laboratory, health care clinic, and nursing home complaints received by the Agency during the period July 2010 through February 2012 to determine whether the Agency had adequately captured, assessed, classified, tracked, reviewed, and timely surveyed the complaints.
- Compared an Agency-published listing of expired licenses to VR system records to determine whether the expired license list agreed with the VR system licensing records.
- Tested for unlicensed health care facilities by conducting Internet searches for 20 health care facilities operating in the State and then accessing the VR system to locate licensing data for those facilities.
- Analyzed 5 years of FLAIR data for the Health Care Trust Fund to identify any unexpected trends or variances that would require additional audit procedures.
- Inquired with Agency personnel regarding the recording of fines, penalties, and interest in FLAIR and reviewed FLAIR records to evaluate the associated Health Care Trust Fund transactions.
- Reviewed Agency documentation of monthly reconciliations comparing health care facility license deposits recorded in the VR system to those recorded in FLAIR for the months of December 2011, January 2012, February 2012, January 2013, February 2013, and March 2013, as well as a year-to-date comparison covering the period July 2012 through April 2013, to determine whether the reconciliations had been timely and properly completed, documented, and reviewed.
- Reviewed Agency FLAIR records for the transfer of funds, as directed by the Legislature, from the Health Care Trust Fund to the State General Revenue Fund to verify that no Federal grant funds had been included in the transfer.
- Selected 10 deposits from the 1,665 Hospital Accounts Receivable (HAR) system deposits recorded in FLAIR during the period July 2010 through February 2012 and, for the 10 deposits, compared the HAR system records to FLAIR records to verify that the records demonstrated that the moneys had been timely deposited and accurately recorded in FLAIR.
- Reviewed HAR system records to determine if the Agency had imposed fines or penalties on delinquent facility accounts, properly notified the facility of the outstanding balance, and updated the VR system licensing records to include the delinquent amounts.
- Communicated on an interim basis with applicable officials to ensure the timely resolution of issues involving controls and noncompliance.
- Performed various other auditing procedures, including analytical procedures, as necessary, to accomplish the objectives of the audit.
- Prepared and submitted for management response the findings and recommendations that are included in this report and which describe the matters requiring corrective actions.

AUTHORITY

Section 11.45, Florida Statutes, requires that the Auditor General conduct an operational audit of each State agency on a periodic basis. Pursuant to the provisions of Section 11.45, Florida Statutes, I have directed that this report be prepared to present the results of our operational audit.



David W. Martin, CPA
Auditor General

MANAGEMENT'S RESPONSE

In a letter dated December 5, 2013, the Secretary of the Agency provided responses to our audit findings and recommendations. The letter is included as **EXHIBIT A** of this report.

EXHIBIT A
MANAGEMENT'S RESPONSE



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

December 5, 2013

Mr. David W. Martin
G74 Claude Pepper Building
111 West Madison Street
Tallahassee, FL 32399-1450

Dear Mr. Martin:

Thank you for the opportunity to respond to the preliminary and tentative findings and recommendations from your Operational Audit of the Agency for Health Care Administration, Health Care Facility Licensing Function and Information Technology Controls. In accordance with your request, we have emailed you the preliminary and tentative audit findings document with our response incorporated therein.

If you have any questions regarding our response, please contact Mary Beth Sheffield, Audit Director, at 412-3978.

Sincerely,

Elizabeth Dudek
Secretary

ED/szg
Enclosure

2727 Mahan Drive • Mail Stop #1
Tallahassee, FL 32308

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EXHIBIT A (CONTINUED)
MANAGEMENT'S RESPONSE

Agency for Health Care Administration
Health Care Facility Licensing Function and IT Controls
Response to Auditor General's P&T Audit Findings and Recommendations

Health Care Facility Licensing Function

Finding 1:
Health Care Facility Licensing Requirements. The Agency's health care facilities licensing processes did not always ensure that required background screenings were timely performed for health care facility employees or document Agency efforts to verify that nursing home applicants reported civil verdicts or judgments.

Recommendation:
We recommend that Agency management enhance the licensing procedures to require that Division staff track and verify the timely performance of required background screenings by health care facilities. In addition, Agency management should revise the nursing home licensing procedures and associated checklists to better ensure that nursing homes timely notify the Agency of any civil verdicts or judgments related to medical negligence, violation of residents' rights, or wrongful death.

Agency Response:
Background Screening
At the time of renewal, change of ownership, or other change during the licensure period, licensure staff reviews the background screening status of the relevant employees. During the licensure period, the Agency now runs reports for those individuals that require rescreening. As new screenings are conducted through the Agency's Background Screening Clearinghouse, the ability to manage rescreening and overall compliance with the criminal background standards will improve. Full implementation of the Clearinghouse is expected by July 31, 2015 (refer to s. 408-809(5), F.S.).

Anticipated Completion Date:
Review of background screening status during the licensing process is already in place.

Civil Verdicts
Section 400.071(1)(e) Florida Statutes provides that an application for a nursing home license must include copies of civil verdicts rendered during the previous 10 year period. As indicated in the P&T Audit Findings and Recommendations, it has been the practice of the Agency to rely on the nursing home applicant or licensee to submit this information with the application as directed by the application instructions. The Agency revised the nursing home application to require the provider to affirm whether or not there were any civil verdicts as prescribed by statute. In addition, the Agency has revised the internal checklists used by staff when evaluating Initial, Renewal and Change of Ownership applications to include an item regarding civil verdicts. The check list provides documentation that staff reviewed the civil verdict information. A copy of the revised application and internal application checklists have been provided separately.

Anticipated Completion Date:
The application was revised in October 2013 to reflect the civil verdict requirement and the checklists were revised in November of 2013.

Agency Contact:
Bernard Hudson
(850) 412-4456

EXHIBIT A (CONTINUED)
MANAGEMENT'S RESPONSE

Agency for Health Care Administration
Health Care Facility Licensing Function and IT Controls
Response to Auditor General's P&T Audit Findings and Recommendations

Finding 2:
Timely Receipt and Review of Licensing Applications. The Agency did not always verify that required health care facility licensure due dates were met or ensure that all applicable fees were assessed.

Recommendation:
We recommend that Agency management ensure that applicable fees are assessed for late applications. In addition, the Agency should ensure that applications are subject to timely review and, as applicable, appropriate follow-up procedures that include the timely mailing of omission letters.

Agency Response:
Application Timeframes
The statute requires that a specific fee be assessed on late-filed renewal applications. The Agency has had processes in place to track the time an application was open. Over the past year, the Agency has refined those procedures and implemented other measures, including regular reports to management, to ensure that applications are reviewed efficiently and within the statutorily-mandated timeframes.

Anticipated Completion Date:
The tracking of application timeframes and monitoring for assessment of applicable fees are currently in place.

Agency Contact:
David Oropallo
(850) 412-4340

Finding 3:
Reconciliation of License Fees Received. The Agency could not always demonstrate that health care facility license fee deposits recorded in the Agency's licensing system were timely and appropriately reconciled to those deposits in the State's accounting records.

Recommendation:
We recommend that Agency management enhance the health care facility license fee deposits procedures to ensure that appropriate reconciliations of fee collections are timely and properly completed, documented, and reviewed by appropriate supervisory staff.

Agency Response:
The Bureau of Financial Services worked with the appropriate staff in the Division of Health Quality Assurance to develop various reports in Versa Regulation to better identify from the onset the revenue by provider type. These reports have eliminated some of the manual research associated with identifying the correct revenue type. When the revenue type is unknown the revenues are deposited as miscellaneous revenue until the correct revenue type can be ascertained. To address the review by appropriate supervisory staff, the Bureau has re-implemented the use of an existing monthly reconciliation report that is prepared by the Accountant and submitted to the Revenue Manager for review and approval. This monthly report will be provided to the Agency's Chief Financial Officer. The process will be ongoing for updating reports each month.

Anticipated Completion Date:
The Bureau re-implemented the report in July 2013.

Agency Contact:
Michael Murphy
(850) 412-3829

EXHIBIT A (CONTINUED)
MANAGEMENT'S RESPONSE

Agency for Health Care Administration
Health Care Facility Licensing Function and IT Controls
Response to Auditor General's P&T Audit Findings and Recommendations

Information Technology Controls

Finding 4:
Security Controls - Network Authentication. Agency network authentication controls need improvement.

Recommendation:
The Agency should strengthen network authentication controls to ensure the confidentiality, integrity, and availability of Agency data and IT resources.

Agency Response:
Regarding network passwords and requirements associated with the former Agency for Enterprise Information Technology requirements, the AHCA Division of Information Technology is considering the more stringent computer access and network access that were cited in the audit. We are also awaiting Florida Department of Law Enforcement (FDLE) policy decisions regarding Criminal Justice information Services (CJIS) standards for password standards for e-mail cloud solutions which will affect our password policies in a more stringent way as well.

Anticipated Completion Date:
There will be a resolution by June 2014.

Agency Contact:
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Finding 5:
Change Management Controls. The Agency could not always demonstrate that system and application changes were properly authorized, tested, and approved.

Recommendation:
We recommend that Agency management enhance the change management procedures to require that sufficient documentation of any changes to Agency systems and applications be maintained to demonstrate that only those changes that are properly authorized, tested, and approved are made.

Agency Response:
Change Control/Management Process
By June 2013 we made the following changes due to the audit consultations and findings (see screen shot from AHCA's virtualized AHCA IT Change Control process below):

- *The Request for Change (RFC) number was added, as well as the Central Systems Management Unit (CSMU) number which ties the change control issue to a project or specific application.*
- *Since the person listed cannot be the implementor, the sponsor's name from the business unit or the user-acceptance name are now listed as well.*
- *We have added an actual "Start" and "Complete" date for completion of any changes to a system which requires verification of a test from the requesting business unit before "Actual Complete" date is finalized and submitted.*
- *Further documentation indicating any logistics and actual scripts etc.is now attached as well.*

EXHIBIT A (CONTINUED)
MANAGEMENT'S RESPONSE

Agency for Health Care Administration
Health Care Facility Licensing Function and IT Controls
Response to Auditor General's P&T Audit Findings and Recommendations

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Title	RFC2092 - VR add ins agent, reopen app, new city/st combo
Description of Change	CSMU 5660 - Requests to add insurance agent "Professional Insurance Services". CSMU 5682 - Requests to reopen the appl #23678 for client 56. CSMU 5699 - Requests to add new city state combination SALEM/VA.
Implementor	Doerr, Joshua Nomula, Swetha Ernst, Zack dba
Implementation Start	10/22/2013 4:30 PM
Implementation Complete	10/22/2013 4:45 PM
Actual Start	10/22/2013 4:30 PM
Actual Complete	10/22/2013 5:00 PM
Risk/Impact Analysis	none.
Outage Required	No
Delta	0.00
Sensitive Data	No
Back-Out Plan	5660 - Keanna Green will verify the added insurance agent 'professional Insurance Services'. 5682 - Keanna will verify the reopened app #23678 for client 56. 5699 - Keanna will verify the added SALEM/VA city/State combination.
field1	
Approval Status	Approved Approval after final completion
Attachments	20131022_5660_add_insurance_agent.sql 20131022_5682_reopen_appl.sql 20131022_5699_add_city_state.sql

IT Policy and Procedure Enhancements
The following AHCA IT policy and procedure were updated as well:

- *Information Technology Change Management Policy (Policy 09-IT-03)*
- *Change Management Procedure (Policy Reference 09-IT-03)*

Anticipated Completion Date:
Findings resolved.

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