MEMORIAL REGIONAL HOSPITAL • MEMORIAL REGIONAL HOSPITAL SOUTH • JOE DIMAGGIO CHILDREN'S HOSPITAL
MEMORIAL HOSPITAL WEST • MEMORIAL HOSPITAL MIRAMAR • MEMORIAL HOSPITAL PEMBROKE

DATE: January 31, 2024

TO: K. Scott Wester, President and Chief Executive Officer, MHS

SUBJECT: **AUDIT AND COMPLIANCE – THIRD QUARTERLY REPORT FISCAL YEAR 2024**

Attached is a copy of the third quarterly report of fiscal year 2024 summarizing the activities of the Internal Audit and Compliance Department from November 1, 2023, through January 31, 2024, for your records.

Please let me know if you have any questions regarding this report.

Denise (Denny) DiCesare

Chief Compliance and Internal Audit Officer

cc: Leah Carpenter, Executive Vice President and Chief Operations Officer, MHS
Matt Muhart, Executive Vice President and Chief Strategy Officer, MHS
Dave Smith, Executive Vice President and Chief Financial Officer, MHS
Frank Rainer, Senior Vice President and General Counsel, SBHD

I. WRITTEN STANDARDS AND PROCEDURES

The following policies and procedures were reviewed and/or revised during the quarter:

Reviewed:

- Patient Confidentiality, and
- Emergency Care

Revised:

- Cost Reports and Credit Balances,
- Reimbursement and Billing,
- DEA Compliance,
- Contractual Financial Arrangements with Physicians, and
- Rehabilitation Institute Code of Conduct.

II. COMPLIANCE LEADERSHIP AND OVERSIGHT

The Compliance Officer attended the following meetings during the quarter:

- Florida Compliance and Privacy Consortium: One Session,
- ACFE Government Anti-Fraud Summit: One Session,
- Compliance Officer Roundtable: One Session, and
- HCCA/SCCE Compliance Risk Assessment and Management: One Session.

III. TRAINING AND EDUCATION

The following compliance training was provided during the quarter:

- New Employee Orientation: Twelve Sessions,
- Leadership Essentials: One Session, and
- Compliance Working Committee: One Session.

IV. OPEN LINES OF COMMUNICATION

A. Hotline Calls

During the quarter, 29 calls, one of which was a callback, were placed to the System's Compliance Hotline covering 25 new topics. Four topics were compliance allegations (four calls). Two topics were HIPAA privacy allegations (two calls). One topic was a quality of care or service allegation (two calls). One topic was a workplace safety allegation (one call). All of the calls were investigated and three of the allegations were substantiated.

Finally, one topic was informational (one call), three topics (three calls) did not provide enough information to conduct an investigation, one call was a test call, and 12 topics (14 calls, one callback) were employee-management relations issues. The employee-management relations issues have been forwarded to the Employee Relations and Human Resources Departments.

V. ENFORCEMENT & DISCIPLINE

A. Sanctions Checks

Sanction checks were conducted of employees, physicians, vendors, volunteers, and students. There was one referring physician who was sanctioned during the quarter. Accounts Receivable Management was notified so appropriate action can be taken.

B. Conflicts of Interest

The Calendar Year (CY) 2024 Conflicts of Interest Questionnaire began during the quarter. To date, 3,555 employees completed CY 2024 Conflicts of Interest Questionnaire, of which 51 reported a possible or potential conflict of interest.

Conflicts of Interest Calendar Year 2023 Survey Results

Background

The Memorial Healthcare System (MHS) Standard Practice on "Business Ethics and Conflicts of Interest" states, "No Memorial Healthcare System officer or management or physician employee or any other employee who may be affected by a potential conflict of interest (as determined by Memorial Healthcare System) shall have an ownership or financial interest in, or permit his spouse or minor children to have an ownership or financial interest, direct or indirect, in any outside concerns, unless an exception applies and he is willing and able to report the full facts concerning such relations to the Board immediately upon learning of such relations or upon request." A conflict of interest can be considered to exist in any instance where the actions or activities of an individual on behalf of the Healthcare System also involve the obtaining of an improper gain or advantage, or an adverse effect on the Healthcare System's interest. Employees with outside employment may pose a conflict of interest if it appears that the employee is representing MHS, the services are like the services MHS provides or is considering providing, or employees perform services for individuals or entities who may refer patients to MHS or to whom MHS may refer patients. Annually, an accounting will be requested of MHS employees by means of a circularized questionnaire and all employees are required to disclose potential or possible conflicts of interest (COI). All disclosures of potential conflicts of interest are reported to the President and Chief Executive Officer (CEO), who determines whether each conflict is manageable. If MHS's appraisal determines that an outside interest may influence an employee's judgments or actions in the performance of his or her duties, the Board of Commissioners will require that the financial or other interest be terminated as a condition of continued employment.

The results of the questionnaire consist of "complete" status indicating all eight questions were answered, "incomplete" status indicating the questionnaire was started but not all questions were answered, "not me" status indicating the employee's name did not match the user identification verification upon initial review, and "not started" status indicating the employee did not respond to any of the questions.

Observations

MHS had a total of 17,112 employees at the end of calendar year (CY) 2023. The adjusted total of employees was 16,934 to account for individuals who were retiree status, off-boarding, or terminating. Of the adjusted total, 16,440 employees completed their questionnaires for a 97% completion rate. There were 35 employees of the 16,440 who answered "not me" for the user verification question but continued to complete the remaining questions and sign their name. These employees were contacted to update their information in order to move them into the calculated completion rate with no success. There were 165 employees who answered yes to one or more questions indicating a potential or possible conflict of interest, 58 of which were deemed to be made in error. The remaining 107 disclosures were reviewed, researched, and managed with requirements and restrictions to minimize risk. There were two employees who disclosed working a second job for Memorial vendors that created a conflict. The CEO decided that the employees could work for the vendor, but restrictions were placed on the employee providing vendor services at Memorial facilities. There were 100 employees who started but did not complete the

questionnaire and 359 employees did not start their assigned questionnaire.

Recommendations

Additional training and education will be developed to increase participation as well as decrease responses made in error to questions.

VI. RISK ASSESSMENT, AUDITING AND MONITORING

VII. RESPONSE & PREVENTION

A. Internal Audit

Recurring Quarterly Reports

South Broward Hospital District Construction Projects

Twenty-two payment vouchers for 11 construction projects were audited during the quarter, as shown on Exhibit A. No irregularities were found during these audits.

South Broward Hospital District Requests for Proposal and Competitive Quotes

Thirteen Requests for Proposal and 30 Competitive Quotes were audited during the quarter, as shown on Exhibit B. No irregularities were found during these audits.

Board Expenses

Board Expenses were audited during the quarter. The list of expenses audited for the quarter will be presented and discussed during the meeting.

Internal Audit of Controls Over Donations at Memorial and JDCH Foundations

Background

Established in 1981, the Memorial Foundation (MF) provides philanthropic support to Memorial Healthcare System (MHS). Joe DiMaggio Children's Hospital Foundation (JDCHF) established in 1994 provides philanthropic support to Joe DiMaggio Children's Hospital (JDCH). Both foundations have a Board of Directors comprised of volunteers from the community to oversee the operations. The Board members include business and community leaders and physicians. MF and JDCHF provide support to the community by raising funds through donations for programs and services, supporting initiatives, and providing emergency support for patients and their families. The Compliance & Internal Audit Department was asked to evaluate the financial operations of both foundations to ensure that the internal controls were appropriate and functioning. The purpose of this audit was to review the adequacy of controls over donations and expenditure at JDCH and Memorial Foundations to safeguard the integrity of donor funds and the financial statements.

We reviewed relevant MHS Standard Practice, MF and JDCHF Transaction Cycle and Control Narratives to gain an understanding of the control environment for both foundations. We performed walkthrough procedures of donations processing and check preparation procedures. We evaluated the bank reconciliation process for reasonableness, timeliness, and evidence of review by Corporate Finance. We selected a sample of 30 donations from various MF and JDCHF funds for testing. We verified that funds were deposited intact, that the documentation was appropriate, and donations received were properly reflected in the financial statements for each foundation. In addition, we selected a sample of 10 donations from the KISS Cares for Kids Radiothon fundraising event that was held in December 2023. Finally, we selected a sample of 15 checks paid by MF and JDCHF to ensure there was proper supporting documentation, approvals, and oversight by Corporate Finance prior to disbursement.

Observations

The policies and procedures reviewed provide comprehensive guidelines for MHS and Foundation staff on all matters concerning fund raising, solicitation, use of funds and procedures to safeguard those funds. The donation and check processing procedures observed conformed to MF and JDCHF Transaction Cycle and Control Narratives. We observed during the walkthrough procedures that a single individual opens the mail containing donations. There are adequate and appropriate separation of duties between the processing and deposit of donations and recording in the donor accounts. We suggested to MF and JDCHF management to consider a compensating control such as the placement of a camera in the area where mail is opened to provide greater security of incoming donations. All bank reconciliations reviewed were reconciled, reviewed, and approved on a timely basis by Corporate Finance. All KISS Cares for Kids donations were traced to the batch details, appropriately deposited, and posted to the bank and contribution accounts in the JDCHF general ledger. We verified with Foundation management that donation forms also function as 'thank you' letters. Copies of each are mailed to donors after each event to confirm the use of funds for the purpose intended by donors. All checks written contained the proper supporting documentation and approvals before disbursement.

Recommendations

None.

The results of the audit were communicated to Kevin Janser, Senior Vice President MHS & President MF and JDCHF. Since there were no findings or recommendations in this audit, an action plan was not required.

B. Special Investigation

Internal Audit Investigation of Government Affairs at MHS

Background

On January 11, 2024, Memorial Healthcare System (MHS) learned that law enforcement arrested Lubby Navarro, Vice President of Government Affairs, MHS for allegedly making unauthorized purchases while a member of the Miami-Dade County School Board. South Broward Hospital District Board Chair Elizabeth Justen was immediately notified, and an executive team was assembled to address any adverse effects. Ms. Navarro's Information Technology access was removed, office was secured, and Memorial assigned credit card de-activated. MHS Office of General Counsel contacted Miami-Dade State Attorney's Office to fully comprehend the charges and offer full cooperation. Human Resources placed Ms. Navarro on unpaid administrative leave and advised her attorney. MHS Corporate Communications monitored the media and consulted with national strategic healthcare communications firm and consultant to field media inquiries. Internal Audit and Compliance Office began this investigation of the Government Affairs Department. Coincidentally, the regular Audit and Compliance Committee for the second quarter fiscal year (FY) 2024 was held on January 15, 2024, at which the results of the Internal Audit of Memorial Healthcare System Credit Cards noted that Government Affairs provided receipts for credit card expenditures after Audit requested them and several of the hotel folios did not have details for meals as required by the Standard Practice on Reimbursement of Travel, Mileage, and Expense Guidance (Travel). We recommended that Government Affairs submit receipts for all charges to substantiate that purchases were legitimate business expenses.

Observations

Ms. Navarro completed a Conflicts of Interest Questionnaire every year since hire, but she did not disclose a second job with the Miami-Dade County School Board, nor her association with Jorge Mas Canosa Freedom Foundation, NALEO, and MASTEC Network Solutions. Matthew Monica, Director of Government Affairs, emailed Ms. Navarro his job interview questions and answers prior to his formal interview. From Ms. Navarro's receipts found submitted with the Employee Travel and Reimbursement Form (ETR), we noted travel receipts totaling $3,877.71 with the last four-digits matching that of the Miami-Dade County School Board credit card. We identified 77 Memorial authorized trips from which $15,238.10 was paid to the MHS credit card however itemized receipts were not included with the check request, as required by the Travel Standard Practice. There were 20 trips that had no documentation indicating that Ms. Navarro traveled, but Memorial paid all or portions of the travel expenses without receipts. We noted six trips that Ms. Navarro traveled on behalf of another organization, of which Memorial paid expenses totaling $679.31 and Ms. Navarro did not take paid time off (PTO) for nine days. We noted Government Affairs' cost center charges were MHS related activities and followed the proper approval process, but many vendor invoices were not paid timely due to Ms. Navarro delaying the payment approval.

Recommendations

We recommended workforce training and education on disclosing conflicts of interest. After HR interviews, Mr. Monica resigned. We recommended that Memorial Healthcare System continue to cooperate with the State Attorney's Office. We recommended that MHS utilize Ms. Navarro's paid time off PTO bank to reimburse MHS for reimbursing Ms. Navarro for travel expenses paid with the school board's credit card, the ground transportation with no receipts, and to recover the paid days not worked. We recommended that MHS pay any potential outstanding Government Affairs invoices for the consultants and purchased outside vendors.

B. Compliance

Compliance Audit of the 340B Program at Memorial Healthcare System - FY 2024 Third Quarter

Background

The 340B Program is administered and overseen by the Health Resources and Services Administration (HRSA). The 340B Drug Pricing Program requires drug manufacturers to provide outpatient drugs to eligible healthcare organizations/covered entities at significantly reduced prices. To participate, eligible organizations must register and be enrolled with the 340B Program and maintain an up to date 340B database, recertify eligibility yearly, and prevent duplicate discounts by having mechanisms in place to prevent receiving a 340B price and a Medicaid drug rebate for the same drug. Any covered entity that fails to comply with the program requirements may be liable to manufacturers for refunds of the discounts obtained. To be eligible for the 340B program, patients must have an eligible medication order or prescription, and receive health care services other than drugs from the covered entity, such as treatment in a hospital-based mixed-use area, a location serving patient type of both inpatient and outpatient and classified as an outpatient in the electronic health record (EHR) at the time of medication administration.

Memorial Healthcare System (MHS) participates in the 340B Program for Memorial Regional Hospital (MRH) which includes Memorial Regional Hospital South (MRHS) and Joe DiMaggio Children's Hospital (JDCH); Memorial Hospital Pembroke (MHP); Memorial Hospital West (MHW); and Memorial Hospital Miramar (MHM). In order to manage the 340B Program, MHS uses split-billing software from Verity Solutions Group (Verity) to determine what each pharmacy

needs to purchase at the 340B price. Replenishment is accumulated each time a drug is administered as outpatient and meets all the program requirements. As the previous audit had findings related to the Automated Dispensing Cabinet (ADC), our medication dispensing system, overrides and eligibility of medication orders, this parameter was subsequently included in the 340B audits.

Observations

Of the 300 pharmacy claims reviewed, there were three claims with ADC overrides for which we were unable to find the original provider order in Epic. An ADC override occurs when a clinician pulls medication from the ADC without the pharmacy verifying the order or during emergent situations when the provider may give a verbal order and medication is taken out as an override. In response to previous audit recommendations, work is ongoing to develop Epic Clarity report so pharmacy management can link ADC overrides with the provider order and resolve the overrides within 48 hours. There was one claim with the patient classified as an inpatient status, but the account remained as observation when the drug was administered, thus making the claim 340B ineligible. Subsequently, the account was corrected, reversing the 340B claims and charges. There was one claim with the order written by a provider who was not listed on the credentialed provider's file at the time of drug administration. The patient was seen at our facility for a continuing issue and plan of care included the medication. Hence, this claim is still 340B eligible as per federal requirements but deviated from the MHS 340B Program Policy.

Recommendations

We recommended the identified 340B ineligible claims be reversed and charges corrected. We recommended pharmacy management together with the 340B management, continue to work in developing a system to review the claims missing the original order in Epic. We recommended pharmacy management continue to work with nursing management in reeducating nurses on the medication overrides policy to ensure provider orders are obtained and documented in Epic. We recommended the claim that deviated from the MHS 340B Program Policy be amended to reflect the currently approved provider and include the reason for the change.

Dorinda Segovia, Vice President, Pharmacy Services, MHS and Scott Davis, Vice President, Reimbursement and Revenue Integrity, MHS agreed with the findings and recommendations and have provided an action plan.

Compliance Audit of the 340B Program at Memorial Healthcare System Contract Pharmacies - FY 2024 Third Quarter

Background

The 340B Program is administered and overseen by the Health Resources and Services Administration (HRSA) which is within the Department of Health and Human Services (HHS). The 340B Drug Pricing Program requires drug manufacturers to provide outpatient drugs to eligible health care organizations/covered entities at significantly reduced prices. To participate in the 340B Program, eligible organizations must register and be enrolled with the 340B Program and comply with all the requirements, that include maintaining an up to date 340B database; recertifying eligibility every year; and preventing duplicate discounts by having mechanisms in place to prevent receiving a 340B price and a Medicaid drug rebate for the same drug. To prevent duplicate discounts, Memorial Healthcare System (MHS) bills Medicaid for 340B purchased medications, meaning it carves-in Medicaid which is approved by HRSA/ Office of Pharmacy Affairs (OPA). Covered entities are subject to audit by the manufacturers and/or the federal government. Any covered entity that fails to comply with 340B Program requirements may be

liable to the manufacturers for refunds of the discounts obtained. To be eligible to receive 340B-purchased drugs, patients must have an established relationship with the covered entity such that the entity maintains records of the individual's care; and must receive health care services from a health care professional employed by the covered entity or under contract or other arrangement with the covered entity such that responsibility for the care remains with the covered entity. Under the guidelines, an individual is not considered a patient of the covered entity if the only health care service received by the individual from the entity is the dispensing of a drug for subsequent self-administration or administration in the home setting. An individual may receive a 340B drug in connection with treatment rendered outside the covered entity if the treatment is proximate in type and time to prior services provided by the covered entity. A non-hospital prescription is proximate in type and time to hospital-based services if the prescription or refill is presented within an appropriate time frame of the MHS encounter and the prescriber's services are part of the same continuum of care as the prior hospital encounter. A continuum of care exists if MHS makes a referral to the outside provider for follow-up care and there is an established patient care relationship with MHS. The only exception is patients of state-operated or -funded acquired immunodeficiency syndrome (AIDS) drug purchasing assistance programs. The Ryan White Clinic provides Human Immunodeficiency Virus (HIV)/AIDS treatment and related services to low-income people living with HIV/AIDS. All prescriptions written in this location and prescriptions of continuum care for Ryan White patients are 340B eligible. MHS participates in the 340B Program for Memorial Regional Hospital (MRH) which includes Memorial Regional Hospital South (MRHS) and Joe DiMaggio Children's Hospital (JDCH); Memorial Hospital Pembroke (MHP); Memorial Hospital West (MHW); and Memorial Hospital Miramar (MHM).

HRSA has developed guidelines to allow covered entities to contract with one or more outside pharmacies to act as dispensing agents. The covered entity and contract pharmacy must establish and maintain a tracking system to prevent diversion of drugs to individuals who are not patients of the covered entity. MHS uses Verity Solutions Group, Inc.'s (Verity) application to help manage its contract pharmacy arrangements. There are seven contract pharmacies and a Ryan White Clinic. The purpose of this audit was to determine if MHS contract pharmacies are in compliance with the HRSA 340B Program requirements.

Observations

We examined 240 340B eligible contract pharmacy claims, 30 for each of the seven outpatient pharmacies and Ryan White clinic, of which 20 were specific targeted areas. All 240 340B contract pharmacy claims met the 340B eligibility requirements.

Recommendations

None.

Dorinda Segovia, Vice President & Chief Pharmacy Officer, MHS and Scott Davis, Vice President, Reimbursement and Revenue Integrity, Corporate Finance, MHS agreed with this audit and since there were no recommendations, an action plan was not required.

Compliance Audit of the Adult Inpatient Rehabilitative Services at Memorial Rehabilitation Institute in Memorial Regional Hospital South

Background

The Center for Medicare and Medicaid Services (CMS) covers inpatient rehabilitation facility (IRF) services when submitted documentation sufficiently demonstrates that a beneficiary's admission to an IRF was reasonable and necessary. Documentation for reasonable and necessary

admission is met based on the individual's need for multiple therapy disciplines [physical therapy (PT), occupational therapy (OT), speech-language pathology (SLP), or prosthetics and orthotics] one of which must be PT or OT, the intensity of therapy services, the individual's ability to actively participate in, and significantly benefit from the intensive therapy program, the need for close physician supervision or medical management, and the need for an intensive and coordinated interdisciplinary team approach.

The Memorial Rehabilitation Institute (MRI) established the Adult Inpatient Rehabilitation Program within Memorial Regional Hospital South (MRHS). The purpose of this audit is to determine if documentation supports medical necessity and compliance with requirements based on Medicare guidelines and determine if services are charged, coded, and billed correctly for the Adult Inpatient Rehabilitative Services at Memorial Rehabilitation Institute-MRHS.

Observations

We reviewed a total of 30 accounts with 462 dates of service. All 30 accounts had physician referrals and admission orders for IRF admission, and a comprehensive pre-admission screening with reasonable and necessary elements within 48 hours immediately preceding the IRF admission. All accounts had completed history and physical examination (H&P), and an individualized overall plan of care (POC) developed by the rehabilitation physician with input from the interdisciplinary team within four days of admission, documentation of the interdisciplinary team conference per week and documentation of the face-to-face visits from the rehabilitation physician at least three times per week throughout the IRF stay. All accounts had IRF patient assessment instrument (IRF-PAI) scanned into Epic, our electronic health records (EHRs). The IRF-PAI is required in order to collect and transmit patient information for quality measure calculations and payment determinations. The start date of therapy for all accounts were within 36 hours from midnight of the day of admission.

We noted seven out of 462 dates of service claims had no GO modifier reported with Current Procedural Terminology (CPT) codes as required to indicate that the service was performed under a therapy plan of care. One out of 462 dates of service claims had the incorrect modifier reported. Modifiers are appended to the claim in the background when the therapist documents the charge for the procedure. Subsequently, rehabilitation leadership requested for the appropriate modifier be appended for the appropriate revenue code. Additionally, there were two dates of service claims with missing documentation of the itemized and total treatment time on the OT charges for procedures. This affected the total time reported for the therapy discipline (total OT time) in the IRF-PAI as documentation is automatically derived from the documentation in Epic. There was one account that was denied payment as the patient did not meet insurance eligibility coverage criteria (citizenship status). As per Electronic eligibility verification (E-coverage), the patient was eligible on the date of service. Beginning in November 2023, an Epic update went live and now will identify the Medicare eligibility discrepancies for coverage and should prevent this issue from occurring in the future.

Recommendations

We recommended rehabilitation management reeducate staff therapist on confirming charges for therapy procedures.

Phil A. Wright, II, Chief Executive Officer, MRHS, and David Webb, Chief Financial Officer, MRHS, agreed with the findings and recommendation and have provided an action plan.

Compliance Audit of Documentation and Billing of Controlled Substances in the Hematology Oncology Inpatient Department at Joe DiMaggio Children's Hospital

Background

Controlled substances are medications that have the potential for abuse or dependence. Federal regulations require detailed documentation of the disposition of all controlled substances which includes the documentation of the persons' names who are administering to the patient, wasting and witnessing the wastage. Memorial Healthcare System (MHS) uses an automated dispensing cabinet (ADC), an advanced point-of-use system that automates the distribution, management, and control of medications, including controlled substances. According to the "Controlled Substances Waste" policy, controlled substances should be wasted in a timely fashion and prior to administration for safety purposes. If not feasible, then waste shall occur immediately after administration. The personnel authorized to witness waste must visually verify and document the amount of drug wasted. We regularly monitor for waste discrepancies and when discrepancies are identified, an investigation is completed. Patients admitted to a Hematology Oncology Department often requires the use of controlled substances for pain management. There must be an appropriate physician order to accompany all administration of medications. The purpose of this audit was to determine if documentation supports medical necessity and compliance with Federal Guidelines and MHS Policies and Procedures of Controlled Substances; and to determine the accuracy of charging in the Hematology Oncology Inpatient Department at Joe DiMaggio Children's Hospital (JDCH).

Observations

We selected 30 patient accounts to audit. We noted three of 30 patients did not receive a controlled substance for pain control. Twenty-seven accounts with 331 ADC transactions of controlled substances were reviewed. There were appropriate provider orders for all controlled substances documented as administered. We noted four accounts with seven discrepancies on documentation for medications administration and waste. One account had an ADC transaction with removal and waste of the total dose but there is no supporting documentation on the medication administration record (MAR) for reason the dose was not administered. One account had two separate ADC transaction of the same medication within seven minutes. The first dose removed was appropriately wasted in ADC but there is no indication on the MAR why the dose was not administered. The second dose removed was documented as administered according to the physician order, with the remaining dose appropriately documented in ADC as wasted. In one account, an error in documentation on the MAR indicated the total dose removed from ADC was administered but the ADC transaction of partial waste was documented for same medication. We noted the total dose of the documented amount given and amount wasted was more than the total amount removed from ADC. According to management, medication was used for a bedside procedure administered by a physician. The registered nurse (RN) pulled the medication from the ADC via cabinet override and was scanned at patient's bedside pre-procedure. This override generated an automatic administration of full dose on the MAR. The RN did not go back and revise the linked order to reflect the dose ordered and administered. One of the accounts with discrepancies had documentation which showed evidence that three transactions of same medication was not wasted immediately upon withdrawal and prior to or immediately after administration, and one transaction was missing documentation of waste as per the MHS Nursing/Pharmacy Departmental Policy and Procedure titled, "Controlled Substances Waste" policy. According to management, the three transactions were a departmental finding prior to this audit and an appropriate action and reeducation was provided to all RNs. All medications including

controlled substances were charged when ordered dose is scanned and administration is documented on MAR. All controlled substances were charged appropriately.

Recommendations

We recommended reeducating the RN the “ADC Nursing/Pharmacy Responsibilities” policy. We recommended reeducating RN on the “Medication Administration - Policy Statement” policy and that controlled substances medications are always administered as ordered and wasted as per the “Controlled Substances Waste” policy.

Caitlin Stella, Chief Executive Officer and Administrator, JDCH and Ananda Rampat, Chief Financial Officer, JDCH agreed with the findings and recommendations of this audit and have provided an action plan which is attached.

Compliance Audit of Documentation and Billing of Physician and Hospital Services for Psychiatric Inpatient Hospitalization at Memorial Regional Hospital

Background

Inpatient psychiatric hospitalization provides 24-hours of daily care in a structured, intensive, comprehensive, and secure setting for patients with a psychiatric principal diagnosis who cannot be safely and/or adequately managed at a lower level of care. The physician must certify and recertify the need for inpatient psychiatric hospitalization. The patient or a legal guardian must provide written informed consent for inpatient psychiatric hospitalization in accordance with state law. If the patient is subject to involuntary (Baker Act) or court-ordered commitment, the services must still meet the requirements for medical necessity and may not be held for involuntary examination longer than 72 hours. First Coast Service Options, Inc. (FCSO), our Medicare Administrative Contractor (MAC) has a Local Coverage Determination (LCD) titled, “Psychiatric Inpatient Hospitalization”, which outlines the indications and limitations of coverage and medical necessity criteria. Inpatient psychiatric facility services are reimbursed by Medicare under the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) based on appropriate weighting factors assigned to each medical severity diagnosis-related groups (MS-DRGs). Physician services are the professional services that include diagnosis, care plan, an evaluation and management (E/M) visit and medical decisions. Billing requires a Current Procedural Terminology (CPT) code that best represents a patient type, place of service, and level of E/M service performed. E/M visit provided as a teaching physician involving a resident physician must follow the Teaching Physician Guidelines.

Observations

We reviewed 30 patient accounts with inpatient psychiatric hospitalization. All 30 patients were admitted from the Emergency Department (ED) with a chief complaint of mental disorder, and documentation for evaluations and assessments by the ED provider. All 30 patients received medical clearance prior to being admitted by the psychiatrist to the Behavioral Health Unit. All 30 accounts had documentation that supported medically reasonable and necessary admission. Involuntary examination and admission were initiated with the required legal documentation for 19 patients. Petition for involuntary placement were filed with the court for four of the 19 patients as required by Florida law. All had informed consent to receive inpatient behavioral health treatment. All 30 accounts had an initial psychiatric evaluation documented by psychiatrist within 24 hours of admission and an admission certification. Recertification was not completed for one account. All 30 patient accounts had an individual treatment plan developed, documentation of individual or group psychotherapy, and patient education and training notes. All 30 patient accounts were assigned the appropriate MS-DRG. Five of the patient accounts had the principal

International Classification of Diseases, Tenth Revision, Clinical Modification System (ICD-10-CM) diagnosis codes that did not concur with the physician's documentation. Subsequently, Health Information Management (HIM) corrected these accounts and Accounts Receivable Management (ARM) rebilled them. There was no impact on reimbursement. One account was not billed because Medicare does not cover services with discharge disposition to court/law enforcement. The account without the physician recertification was reimbursed for the entire stay and ARM refunded and rebilled for the length of stay with certification. One account was denied payment appropriately by Medicare and subsequently was billed to commercial insurance.

For physician services, we reviewed the same 30 accounts. There were 149 hospital inpatient E/M visits. Six visits supported a different CPT code or were not separately reportable and 15 visits had insufficient documentation to support billing for services. We noted 91 of the 101 visits met CMS teaching physician guidelines and 55 of the 74 required modifiers were appropriately applied. Reimbursement was not affected. We noted 35 visits had ICD-10 codes that were supported by documentation. The remaining visits had medical record documentation supporting additional or different ICD-10 codes.

Recommendations

We recommended Behavioral Health management reeducate psychiatrists on the LCD hospital inpatient recertification requirements and implement a process to ensure compliance. We recommended that HIM management reeducate inpatient coders to code to the highest specificity concurring with physician documentation and perform regular audits to ensure accuracy of coding. We recommended that MPG Business Office correct and rebill or refund accounts for physician services identified with errors. We recommended to reeducate providers on medical necessity documentation, coding, and billing.

Peter Powers, Administrator and Chief Executive Officer, MRH, Walter Bussell, Chief Financial Officer, MRH, Mario Salceda-Cruz, Chief Operating Officer, MPG and Esther Surujon, Chief Financial Officer agreed with the findings and recommendations and have provided the attached detailed action plan.

D. Services Provided by Protiviti

A list of Services Provided by Protiviti for the quarter will be discussed during the meeting.

E. Other Reports

Investor Log

The Investor Contact Log for the quarter is attached for your review. See Exhibit C.

Non-Audit Engagements

A list of RSM and Zomma Group Non-Audit Engagements for the quarter is attached for your review. See Exhibit D.

Compliance Environment

A discussion of Nationwide Audit and Investigation Activities for the quarter will be held during the meeting.

SBHD Construction Projects
Period Ending 1/31/2024

Exhibit A

	Ambulatory Surgery Center ANF Group, Inc. #450218ASC MHM	Urgent Care Center Miami Gardens Gerrits Construction Inc. #650322 MHS	Family Birthplace Turner Construction Co. #400121 MHS	Wind Retrofit Turner Construction Co. #409020 MRH	Family Birthplace Turner Constuction Co., Inc. #400622 MRH
	Amount	Amount	Amount	Amount	Amount
Original Contract Sum	$ 5,589,844	$ 1,929,942	$ 3,658,618	$ 4,924,483	$ 43,850,159
Prior Change Orders	(1,340,949)				
Budget Transfer			44,248.00		
Current Change Orders	(124,622)				
Prior Owner Purchase Orders		(146,641)	(306,220)	(270,947)	(9,703,000)
Current Owner Purchase Orders		(33,981)	55,512		
Current Contract Sum to Date	$ 4,124,272	$ 1,749,321	$ 3,452,159	$ 4,653,537	$ 34,147,159
Previous Payments	4,124,271	1,632,849	3,144,395	4,548,849	9,246,246
	25 -	11 72,955	21 24,413		9 1,547,935
		12 19,371	22 283,351		10 1,318,835
					11 1,269,532
Total Payments	4,124,271	1,725,175	3,452,158	4,548,849	13,382,548
Balance	$ 0	$ 24,146	$ 0	$ 104,688	$ 20,764,611
Owner Purchased Materials					
Retainage			25,374		502,526
Payments	4,124,271	1,725,175	3,452,158	4,548,849	13,382,548
Work completed	$ 4,124,271	$ 1,725,175	$ 3,477,532	$ 4,548,849	$ 13,885,074
Status	Active	Active	Active	Active	Active

SBHD Construction Projects
Period Ending 1/31/2024

Exhibit A

	Main Electrical Panel Upgrade Turner Construction Co., Inc. #410222 MRHS	MOB II Second Floor Pediatric Fit Out Thornton Construction Co. Inc. #800122 MHM	MOB Women Center ANF Group, Inc. #450218 MHM	Memorial Cancer Center Expansion DPR Construction #431019 MHW	Hurricane Hardening Thornton Construction Co. #410121 MRHS
	Amount	Amount	Amount	Amount	Amount
Original Contract Sum	$ 1,120,307	$ 10,650,417	$ 35,067,236	$ 86,165,924	$ 13,613,113
Prior Change Orders			(5,101,409)	(15,603,724)	
Budget Transfer					
Current Change Orders				31,819	
Prior Owner Purchase Orders		(2,591,108)	(750,000)	81,964	(2,984,941)
Current Owner Purchase Orders	(75,607)			80,666	180,509
Current Contract Sum to Date	$ 1,044,700	$ 8,059,309	$ 29,215,826	$ 70,756,649	$ 10,808,680
Previous Payments		6,593,614	27,790,363	59,505,367	9,335,485
	1 175,523	9 354,174	27 840	25 455,762	17 123,419
	2 113,185			26 1,417,879	
				27 294,875	
Total Payments	288,708	6,947,788	27,791,202	61,673,884	9,458,904
Balance	$ 755,992	$ 1,111,521	$ 1,424,624	$ 9,082,764	$ 1,349,777
Owner Purchased Materials					
Retainage	13,063	142,201		1,796,751	497,837
Payments	288,708	6,947,788	27,791,202	61,673,884	9,458,904
Work completed	$ 301,771	$ 7,089,990	$ 27,791,202	$ 63,470,635	$ 9,956,741
Status	Active	Active	Active	Active	Active

SBHD Construction Projects
Period Ending 1/31/2024

Exhibit A

	Family Birthplace Replacement Thornton Construction Co. #430321 MHW		JDCH ER Room Finishes Engel Construction, Inc. #460120 JDCH		Memorial Cancer Institute ANF Group, Inc. #401820 MHS		Emergency Department Trauma Center Turner Construction Company #400222 MRH		JDCH Vertical Expansion Robins & Morton Group #460117 JDCH	
	Amount		Amount		Amount				Amount	
Original Contract Sum	$	2,110,655	$	1,920,630	$	3,318,035	$	16,401,716	$	108,993,259
Prior Change Orders						(578,606)				
Budget Transfer										
Current Change Orders										
Prior Owner Purchase Orders		261,019		(189,663)		182,424		(3,300,002)		(15,093,946)
Current Owner Purchase Orders		(41,567)		(28,501)						
Current Contract Sum to Date	$	2,330,107	$	1,702,466	$	2,921,853	$	13,101,714	$	93,899,313
Previous Payments		2,330,107		47,816		2,808,328		3,973,721		86,963,071
		-	4	23,074			9	236,477	27	437,391
			5	117,505			10	360,999		
			6	128,049			11	358,631		
Total Payments		2,330,107		316,444		2,808,328		4,929,828		87,400,462
Balance	$	0	$	1,386,022	$	113,525	$	8,171,886	$	6,498,850
Owner Purchased Materials										
Retainage				16,655				146,342		
Payments		2,330,107		316,444		2,808,328		4,929,828		87,400,462
Work completed	$	2,330,107	$	333,099	$	2,808,328	$	5,076,170	$	87,400,462
Status	Active		Active		Active		Active		Active	

Memorial Healthcare System
RFP and Competitive Quote Audits

	RFPs	Current Phase - 3rd Quarter FY 2024	Audited Through	Exceptions
1	Investment Advisory	Selection	Selection	None
2	Disaster Debris Removal and Disposal	Selection	Selection	None
3	Call Center Outsourcing	Cancelled	Advertising/Mailing	None
4	Building Automation and Fire Alarm Vendor RFP	Analysis	Selection	None
5	Employee Survey Tool	Analysis	Analysis	None
6	Talent Acquisition Center Exterior Painting RFQ	Analysis	Analysis	None
7	Surgical and Critical Care Tower Addition RFQ at MRH	Analysis	Analysis	None
8	Retail Food Service RFQ at JDCH	On Hold	Analysis	None
9	Valet Parking Service, Booth Attendant and Shuttle Services	Selection	Oral Presentation	None
10	Clinical Engineering Computerized Maintenance Management System	Selection	Oral Presentation	None
11	Audit Management Software RFQ	Selection	Oral Presentation	None
12	Compliance Program Evaluation RFP	Oral Presentation	Oral Presentation	None
13	Merchant Services Processor RFP	Selection	Receipt	None

Memorial Healthcare System
RFP and Competitive Quote Audits

	Completed Competitive Quotes	Amount $	Exceptions
1	Oncology Medication for MHW Patient	462,000	None
2	Three Year Software Subscription for Neonatology Intensive Care Unit Nutrition System for JDCH	153,129	None
3	Workday Consultant for Corporate Finance	110,160	None
4	Computed Tomography Scanner for Red Road Emergency Department	695,000	None
5	Radiology Equipment for Red Road Emergency Department	239,884	None
6	Three Year Software Subscription for Neurology Equipment at MRH	161,137	None
7	Interventional Radiology Room Renovation at MHM	600,712	None
8	Memorial Cancer Institute Media Advertisement	249,798	None
9	Elevator Maintenance for MHW	331,540	None
10	Neurovascular Intervention Equipment for MHW	229,800	None
11	Citrix Netscaler Load Balancer Replacements & Implementation	159,017	None
12	Year One of Electronic Signature Subscription Service for MHS	149,232	None
13	Microbiology Laboratory Diagnostic Equipment Replacement at MRH	300,937	None
14	Hardware & Software Maintenance Renewal for Physical & Virtual Servers at MHS Datacenters	285,762	None
15	Three Year Subscription for Radiology Software at MHS	157,985	None
16	Software Subscription for Clinical Documentation at MHS	744,600	None
17	Three Year Patient Safety During Disasters Cloud Service Solution at MHS	366,523	None
18	Three Year Clinical Documentation Cloud Service Solution at MHS	344,878	None
19	Five Year Service Agreement for IMRIS Surgical Theatre at JDCH	1,600,000	None
20	Employee Health Plan Service Agreement	139,722	None
21	Three Year Agreement for Operating Room Equipment at JDCH	283,718	None
22	Clinical Documenation Software for MHS	501,059	None
23	Hybrid Cloud Based Facsimile Software Solution for MHS	320,166	None
24	Cardiac Imaging Software Solution for JDCH	267,600	None
25	Permit Processing Services for Dania Beach Primary Care Center	103,060	None
26	Ultrasound Equipment Upgrade for JDCH	182,751	None
27	Standing Order of Disposable Supplies for Radiometer Instruments in Respiratory Care at MRH	143,616	None
28	Airconditioning System Upgrade at Medical Office Building MRH	155,714	None
29	Medical Equipment Support and Maintenance for MRH	105,478	None
30	Supply Chain Management Pricing Consultant	219,408	None

Exhibit C

Memorial Healthcare System
Investor Contact Log
Fiscal Year 2024

Quarter: Ended	Contact:	Representing:	Discussion:
July 31,2023	Beth Wexler	Moody's Investor Service	Post-ratings discussion
October 31, 2023	None.		
January 31, 2024	None.		
April 30, 2024			

Exhibit D

Memorial Healthcare System
Non Audit Engagement Report
Q3 FY 2024

Quarter Ended	RSM US LLP Engagement:		
Q3 FY2024	For professional services rendered and expenses incurred in connection with due diligence for Sega Project.	$	97,000
	For professional services rendered and expenses incurred in connection with Memorial Healthcare System's IRS Audit for tax year ending 4/30/2020.	$	3,600
	Total	$	100,600
Q3 FY2023	Total spend, provided for comparative purpose	$	64,089

Quarter Ended	Zomma Group LLP Engagement:		
Q3 FY2024	For professional services rendered and expenses incurred in connection with Non Audit Engagements.	$	-
Q3 FY2023	Total spend, provided for comparative purpose	$	-

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To: Denise DiCesare, Chief Compliance and Internal Audit Officer, MHS

Date: March 4, 2024

From: Dorinda Segovia, Vice President, Pharmacy Services, MHS
Scott Davis, Vice President, Reimbursement and Revenue Integrity, MHS

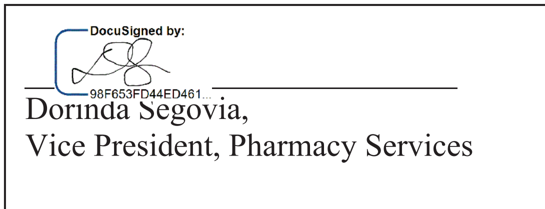
Subject: **Action Plan: COMPLIANCE AUDIT OF THE 340B PROGRAM AT MEMORIAL HEALTHCARE SYSTEM - FY 2024 THIRD QUARTER**

Attached is our Action Plan, which identifies the steps which will be taken to address the recommendations made in the above referenced audit.

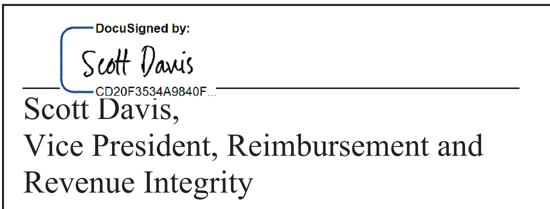
Recommendations	Response/Action Plan	Estimated Completion Date
We recommend the identified 340B ineligible dispensations be reversed and charges corrected.	340B team will work with the billing team to reverse the three identified dispensations without respective provider orders in EPIC.	4/15/2024
We recommend pharmacy management together with the 340B management continue to work in developing a system to review the claims missing the original order in Epic.	Pharmacy has developed a real time report to identify unlinked cabinet overrides. Report is being tested prior to finalizing. Nursing pharmacy policy procedure recently revised to include nursing responsibility to obtain orders for overrides and follow up by linking orders.	4/30/24
We recommend pharmacy management continue to work with nursing management in reeducating nurses on the medication overrides policy to ensure provider orders are obtained and documented in Epic.	Nursing has been provided education tip sheets on how to link overrides in the MAR. DOPs and Medication Safety coordinators to evaluate the need of non-profiled cabinets. Override education included in system wide pharmacy nursing orientation.	Completed

We recommend the dispensation that deviated from the MHS 340B Program Policy be amended to reflect the currently approved provider and include the reason for the change.	Orders revised by respective sites and amended when warranted. The 340B Team will educate sites and work with billing team to reverse the identified dispensations. VP/CPO seeking process with CMIO and Informatics VP	4/30/2024

cc: K. Scott Wester, President and Chief Executive Officer, MHS



Dorinda Segovia,
Vice President, Pharmacy Services



Scott Davis,
Vice President, Reimbursement and Revenue Integrity

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To: Denise DiCesare, Chief Compliance and Internal Audit Officer, MHS

Date: March 5, 2024

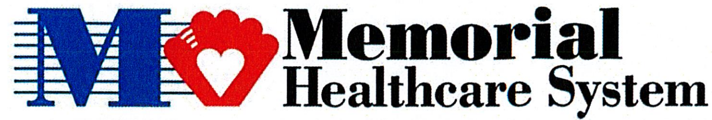
From: Philoron A. Wright, II, Chief Executive Officer, MRHS
David Webb, Chief Financial Officer, MRHS

Subject: **Action Plan: COMPLIANCE AUDIT OF THE ADULT INPATIENT REHABILITATIVE SERVICES AT MEMORIAL REHABILITATION INSTITUTE IN MEMORIAL REGIONAL HOSPITAL SOUTH**

Attached is our Action Plan, which identifies the steps which will be taken to address the recommendations made in the above referenced audit.

Recommendations	Response/Action Plan	Estimated Completion Date
We recommend that rehabilitation management reeducate staff therapist on confirming charges for therapy procedures.	Therapists will continue to validate the charges on the revenue and usage report. Will have random audits on a weekly basis to monitor charges are entered correctly.	Initiated, April 1, 2024

cc: K. Scott Wester, President and Chief Executive Officer, MHS



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To: Denise DiCesare, Chief Compliance and Internal Audit Officer, MHS

Date: March 15, 2024

From: Caitlin Stella, Chief Executive Officer and Administrator, JDCH
Ananda Rampat, Chief Financial Officer, JDCH

Subject: **Action Plan: COMPLIANCE AUDIT OF DOCUMENTATION OF CONTROLLED SUBSTANCES IN THE HEMATOLOGY ONCOLOGY INPATIENT DEPARTMENT AT JOE DIMAGGIO CHILDREN'S HOSPITAL**

Attached is our Action Plan, which identifies the steps which will be taken to address the recommendations made in the above referenced audit.

Recommendations	Response/Action Plan	Estimated Completion Date
We recommend reeducating Registered Nurses on the ADC Nursing/Pharmacy Responsibilities" policy	• Recommended education to be completed on the policy, including documentation in the EHR the rationale for any additional needed dose.	April 12th 2024
We recommend reeducating Registered nurses on the "Medication Administration - Policy Statement" policy and that controlled substances medications are always administered as ordered and wasted as per the "Controlled Substances Waste" policy.	• Recommended education to be completed on the policies, including expectations for controlled substances medication administration and waste.	April 12th 2024

cc: K. Scott Wester, President and Chief Executive Officer, MHS

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To: Denise DiCesare, Chief Compliance and Internal Audit Officer, MHS

Date: March 20, 2024

From: Peter Powers, Administrator and Chief Executive Officer, MRH
Walter Bussell, Chief Financial Officer, MRH

Subject: Action Plan: COMPLIANCE AUDIT OF DOCUMENTATION AND BILLING OF PHYSICIAN AND HOSPITAL SERVICES FOR PSYCHIATRIC INPATIENT HOSPITALIZATION AT MEMORIAL REGIONAL HOSPITAL

Attached is our Action Plan, which identifies the steps which will be taken to address the recommendations made in the above referenced audit.

Recommendations	Response/Action Plan	Estimated Completion Date
We recommend behavioral health management reeducate all psychiatrists about the LCD requirement of hospital inpatient recertification and implement a process to ensure compliance.	Management will provide education on certification/re-certification with a written letter to each psychiatrist that covers the adult inpatient units.	April 15, 2024
	We will present the information about certification and re-certification to the Department of Psychiatryy Meeting on May 7, 2024	May 7, 2024
	A request was submitted March 19, 2024 to the Best Practice Alert Governance Committee EPIC Physician Team to determine if a hard stop can be placed on the limited circumstances in which a re-certification is	May 3, 2024

	required in 12 days and 30 days thereafter. The Case Manager – RN staff will screen the Medicare Charts at the 12th day and 30 days thereafter to confirm that the physician has responded to the advisory alert. If the physician has not responded, the Case Manager – RN staff will have the physician complete a paper form certifying the patient and the form will be scanned into the chart.	April 1, 2024
We recommend that HIM management reeducate inpatient coders to code to the highest specificity concurring with physician documentation and perform regular audits to ensure accuracy of coding.	Re-educate coders to seek clarification when physician documentation is inconsistent and continue to perform regular audits to ensure accuracy of coding. We will coordinate with Behavioral Health to provide education to psychiatrists to document diagnoses with consistency and to the highest degree of specificity to ensure accurate coding.	5/31/2024

cc: K. Scott Wester, President and Chief Executive Officer, MHS

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To: Denise DiCesare, Chief Compliance and Internal Audit Officer, MHS

Date: February 6, 2024

From: Mario Salceda-Cruz, Chief Operating Officer, MPG
Esther Surujon, Chief Financial Officer, MPG

DocuSigned by: Mario Salceda E7994C622C204F9...
DocuSigned by: Esther Surujon 5B3194FFE1074E8...

Subject: **Action Plan: COMPLIANCE AUDIT OF DOCUMENTATION AND BILLING OF PHYSICIAN AND HOSPITAL SERVICES FOR PSYCHIATRIC INPATIENT HOSPITALIZATION AT MEMORIAL REGIONAL HOSPITAL**

Attached is our Action Plan, which identifies the steps which will be taken to address the recommendations made in the above referenced audit.

Recommendations	Response/Action Plan	Estimated Completion Date
We recommend that MPG Business Office correct and rebill or refund accounts for physician services identified with errors, as appropriate.	MPG Business Office will correct/rebill, and refund accounts identified with errors, as appropriate.	04/19/2024
We recommend that the Director of Billing and Compliance reeducate providers on medical record documentation, coding, and billing to support medical necessity and services billed, as MPG Business Office does not code E/M or ICD-10 codes.	The Director of Billing and Compliance will reeducate providers on medical record documentation, coding, and billing to support medical necessity and services billed.	05/20/2024

cc: K. Scott Wester, President and Chief Executive Officer, MHS

Exhibit E

MEMORIAL HEALTHCARE SYSTEM
AUDIT AND COMPLIANCE WORK PLAN
FISCAL YEAR 2025

SUMMARY

		HOURS		
		FY 2025 Budget	FY 2024 Budget	Mar 1, 2023 thru Feb 29, 2024 Actual
I.	INTERNAL AUDIT			
	RECURRING ANNUAL AUDITS	750	1,150	1,626
	RECURRING QUARTERLY AUDITS	860	1,160	1,450
	INFORMATION SYSTEMS AUDITS	1,100	950	1,091
	OTHER INTERNAL AUDITS	3,300	1,450	1,803
	INTERNAL AUDIT TOTAL	6,010	4,710	5,969
II.	COMPLIANCE			
	FACILITY BILLING AUDITS	4,700	4,150	4,175
	PROFESSIONAL BILLING AUDITS	2,400	1,810	1,814
	FACILITY AND PROFESSIONAL BILLING AUDITS	400	600	607
	OTHER COMPLIANCE AUDITS	730	800	886
	COMPLIANCE AUDIT TOTAL	8,230	7,360	7,482
III.	PRIVACY & SECURITY			
	PRIVACY AUDITS	550	450	462
	SECURITY AUDITS	1,000	910	935
	PRIVACY & SECURITY TOTAL	1,550	1,360	1,396
IV.	CONFLICTS OF INTEREST	1,810	1,400	1,413
V.	HOTLINE AND OTHER INVESTIGATIONS	1,400	1,400	1,412
VI.	ADMINISTRATIVE & OTHER	1,800	1,800	1,837
VI.	PAID LEAVE	2,860	1,890	1,490
	GRAND TOTAL	23,660	19,920	20,999

SUMMARY BY STAFFING	INTERNAL AUDIT	COMPLIANCE	PRIVACY & SECURITY	CONFLICTS OF INTEREST	HOTLINE & INVESTIGATIONS	ADMIN & OTHER	PAID LEAVE	TOTAL
CHIEF COMPLIANCE & INTERNAL AUDIT OFFICER	829	795	229	246	425	170	90	2,784
DIRECTOR OF COMPLIANCE	130	751	115	375	152	343	223	2,089
COMPLIANCE AUDITORS	102	3,830	0	143	143	460	214	4,891
COMPLIANCE AUDITOR - MPG	213	1,478	29	16	35	62	256	2,088
DIRECTOR OF INTERNAL AUDIT	1,457	28	267	0	122	122	210	2,204
SR DIRECTOR OF INTERNAL AUDIT	282	32	57	56	19	124	0	569
SENIOR INTERNAL AUDITOR	766	51	117	1	157	19	201	1,310
INTERNAL AUDITOR	1,476	54	279	70	76	245	176	2,375
SENIOR IT & PRIVACY AUDITOR	716	449	304	37	225	261	97	2,088
CONFLICTS OF INTEREST MANAGER	0	16	0	471	58	33	24	601
TOTALS	5,969	7,466	1,396	943	1,354	1,804	1,466	20,999

I. INTERNAL AUDIT

	Hours
A. RECURRING ANNUAL AUDITS	**750**
Pension Plan Annual audit of pension plan activity for compliance with plan document. Audit of Contributions.	200
RSM Annual Audit Assist RSM with annual financial audit.	550
B. RECURRING QUARTERLY AUDITS	**860**
Construction Audit of construction disbursements for all projects with an estimated cost of $1,000,000 or greater.	200
RFPs and Competitive Quotes Audit to determine that all Requests for Proposal (RFPs) and Competitive Quotes are conducted according to System policies.	200
Board, Executive Staff Travel & Administrative Team Travel Audit to determine that all travel and entertainment expenses incurred by Board members, President and CEO, and Government Affairs are consistent with System policies.	200
RSM Non Audit Engagements Identify and report to the Audit and Compliance Committee all RSM engagements that are not related to their main audit activities.	60
Executive and Administrative Staffs Travel Reimbursement Audit to determine that all travel and entertainment expenses incurred by members of the Executive and Administrative Staffs are consistent with System policies.	200
C. INFORMATION SYSTEMS AUDITS	**1,100**
Assistance Provided to Protiviti Coordinate and review services provided by Protiviti.	200
Audit Workpaper Software Maintenance of the Audit Department management system, including the development of automated reports and management response process, development of risk assessments, updates to project program steps, and create and maintain audit summary dashboard.	300
Hospital Price Transparency Assess the MHS cost of hospital items and services are appropriately available to the public and contains comprehensive machine-readable files with all items and services, and shoppable services are available in a consumer-friendly format to meet the CMS requirements.	200
Risk Management Framework Review the standards and guidelines for assessing and managing risks, which include setting objectives, establishing principles for corrective actions, identifying threats and vulnerabilities, analyzing the impact that PHI, PII and sensitive information losses may have and developing criteria for accepting risk levels.	200
Florida Off-Shore Storage of eHealth Records Review compliance of new Florida law requiring all patient data storage is phsicially held within the United States.	200

I. INTERNAL AUDIT

	Hours
D. OTHER INTERNAL AUDITS	**3,300**
Non-Monetary Compensation to Contracted Physicians Determine whether non-monetary compensation are provided to physicians for medical staff incidental benefits that can include meals, parking, and items or incidental services. Verify that an inventory of non-monetary compensation and benefits exists.	300
Supply Chain Evaluate the supply chain governance, risk management and control processes appropriately reduce operations costs, increase competitive advantage, and inventory sole source providers, and verify supplier selection process ensures that they provide quality goods and services, timely delivery and follow up on delays, have strong cybersecurity controls, have service level audits, and are held to ethical standards.	400
Construction Services Determine whether operational and financial internal controls are in place and operating properly. Review policies and procedures, evaluate RFP process, bid documentation and review payment application and close-out process.	400
Internal Audit Risk Assessment Partner with outside auditor to identify and assess the likelihood and potential impact of operational risks to the organization and evaluate how adequate controls are in reduing risk to ensure that residual risk is at a manageable level.	200
Business Intelligence Review and validate the financial data that is being used for business decisions by Executives. Assess the role this function plays in decision making.	300
Emergency Preparedness Assess emergency response procedures to mitigate environmental emergency situations related to geographic areas, care-related emergencies, equipment and power failures, communications interruptions, loss of all or a portion of the facility, loss of all or a portion of supplies. Evaluate management controls, business impact analysis, emergency plan for continued operations, and recovery plan. https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-emergency-preparedness/core-ep-rule-elements	400
Legal Functions and Contracts Review Review the charter for legal functions, evaluate the agreements and contracts review process, review the legal department processes and procedures for handling cases, quality assurance, and documentation.	400
Facilities Management That goods and services are ordered, received, approved and paid according to MHS policies. That conflicts of interest are identified, evaluated and mitigated. That the risks of purchase schemes, kickbacks, bid rigging, etc. are mitigated.	400
Food Services That goods and services are ordered, received, approved and paid according to MHS policies. That conflicts of interest are identified, evaluated and mitigated. That the risks of purchase schemes, kickbacks, bid rigging, etc. are mitigated.	400
District Labs Manage outside internal audit firm to assess the processes for supplies and availability, medication reconciliation, and capturing medication errors. Identify where in the process tests are charged, evaluate the timeliness and accuracy of the test and the need for retesting at all laboratory locations. Joint audit with the nurses for "medical necessity".	100
Property Management (off-site facilities/non-hospitals and MOBs) Manage outside internal audit firm to assess the management of general maintenance and special requests for items such as painting, mold mitigation, social distancing set up, etc. Perform minor maintenance such as changing light bulbs and AC filters. Hospital facility departments will have the same level of risk. The hospital facility departments report through the hospitals.	100
Health Information Management Assess the outsourced records release function to ensure the vendor follows Memorial procedures or policies, is compliant with contractual obligation, program coding from medical records requirements, and HIPAA. Focus would be on vendor compliance. Verify legal medical record custodians.	300
INTERNAL AUDIT TOTAL	**6,010**

II. COMPLIANCE

		Hours
A.	**FACILITY BILLING AUDITS**	**4,700**

DRG Coding — 300

Conduct coding audits of MS-DRGs that have been nationally identified as subject to manipulation. Determine whether the services provided were medically necessary. Audit the coding process to determine that the assignment of DRGs is appropriate and reasonable.

APCs & Outpatient Services — 300

Conduct coding audits that have been nationally identified as subject to manipulation. Determine whether the services provided were medically necessary. Audit to determine whether issues of medical necessity, diagnosis and procedure coding, and bundling and unbundling of services relating to the outpatient prospective payment system are properly handled.

Medicaid Services — 200

Determine whether the services are medically necessary. Determine whether the services are billed according to Medicaid guidelines.

340B Drug Pricing Program - Hospital — 400

Determine whether the patients are appropriate candidates. Determine if the provider is 340B eligible. Audit for potentially abusive practices, such as duplicate discounts. Audit to determine adequacy of documentation. Determine if the location is an eligible location.

340B Drug Pricing Program - Contract Pharmacies — 400

Determine whether the patients are appropriate candidates. Determine if the provider is 340B eligible. Audit for potentially abusive practices, such as duplicate discounts. Audit to determine adequacy of documentation. Determine if the location is an eligible location.

340B Drug Pricing Program - External Contract Pharmacies — 400

Determine whether the patients are appropriate candidates. Determine if the provider is 340B eligible. Audit for potentially abusive practices, such as duplicate discounts. Audit to determine adequacy of documentation. Determine if the location is an eligible location.

New Programs and Services — 800

Determine whether issues of medical necessity, diagnosis and procedure coding, and bundling and unbundling of services relating to new programs are properly handled. Includes OB Emergency Services at Regional and West, Comprehensive Stroke Designation at MHW, RN Fellowship Program,LDL Pheresis at JDCH; Outpatient Nutrition Program at Hwd OP Center by Target from JDCH, and Manor Insourcing Pharmacy Services.

Total Heart Center and Adult Congenital Heart Disease Program — 200

Audit for potentially abusive practices such as upcoding; examine for adequacy of patient record documentation.

Clinical Trials — 200

Audit to assess program safeguards related to clinical trial claim processing requirements. Audit to assess that payment only includes items and services that Medicare would otherwise have covered if they were not provided in the context of a clinical trial.

Memorial Cancer Institute Risk Assessment — 200

Identify and assess the likelihood and potential impact of operational risks to the organization and evaluate how adequate controls are in reduing risk to ensure that residual risk is at a manageable level.

Compliance Risk Assessment — 300

Identify areas lacking internal control, evaluate potential compliance risks to possible outcomes, and prioritize legal and regulatory risks based on the severity of possible operational, legal, and financial damage associated with each.

II. COMPLIANCE

	Hours
Memorial/Moffitt Cancer Program Audit to ensure all policies, care plans, and other documentation are in order, medication adherence rates are monitored; examine for adequacy of patient record documentation. Audit for potentially abusive practices such as upcoding; examine for adequacy of patient record documentation.	200
Regulatory Audits Conduct audits that determine whether we are following the rules which allow us to be Medicare and Medicaid providers, such as, the Medicare Outpatient Observation Notice, the Important Message from Medicare, the Detailed Notice of Discharge, signage, Pregnancy Termination after 15 weeks, etc.	200
Medicare Administrative Contractor Comparative Billing Reports Conduct audits to review First Coast Service Options, Inc. letters of utilization units and dollars paid, average number of units and dollars paid as compared to our peer group to identify opportunities to refine Medicare billing and utilization.	200
Partnerships and Outside Services Programs Conduct audits that determine whether we are following the rules which allow us to be Medicare and Medicaid providers with our partnerships and outside services, including Memorial Physical Therapy at Home with Luna Care, Inc., HOPCo, and Solis.	200
Spravato Antidepressant Treatment Spravato is an FDA-approved nasal spray for the treatment of depression in adults who have not benefited from antidepressant medicines. Determine whether issues of medical necessity, diagnosis and procedure coding, and bundling G Codes 2082 and 2083 that cover both drug and treatment visit and unbundling of services relating to new programs are properly handled as appropriate in guideline Article A59249 on billing and coding of Esketamine.	200
B. PROFESSIONAL BILLING AUDITS	**2,400**
Coding and Billing Practices of Employed Physicians Audit for potentially abusive practices such as upcoding; examine for adequacy of patient record documentation, include telehealth reviews and teach physician services for Hospitalists, Lung Cancer, Radiation Oncology, Oncologists, Pediatric GI Program, and Primary Care Physicians.	2,400
C. FACILITY AND PROFESSIONAL BILLING AUDITS	**400**
Medical Necessity, Coding and Billing Audits for Hospital and MPG Audit for compliance with Medicare and Medicaid requirements for medical record documentation of medical necessity, diagnosis and procedure coding, and medication adherence for both technical component and professional components in programs such as Bariatric/Weight-Loss Program, Chronic Care Pediatrics, and NICU III at MHM.	400
D. OTHER COMPLIANCE AUDITS	**730**
CCP Network Perform the function of compliance committee member at the Community Care Plan.	30
Excluded Party Searches Perform annual searches of all employees, physicians, non staff physicians, non physician practitioners, traveling nurses, students, volunteers, vendors and vendor principles to ensure that none have been excluded from participation in federal programs.	200
Compliance Policies and Procedures Update policies and procedures. Audit to determine whether the Compliance Program policies and procedures are being followed.	500
COMPLIANCE AUDIT TOTAL	**8,230**

III. PRIVACY & SECURITY

	Hours
A. PRIVACY AUDITS	550
Privacy Technical Issues Participation in the management of Privacy Technical issues including log management and development, remote and system access, software application privacy compliance, investigation tools, and privacy monitoring.	100
Population Health Services Assess the current policies and procedures for this program to determine whether it meets the objectives and is consistent with the privacy and security standards. Audit approach would be validating any key indicators, reportable statistics on productivity, efficiency, and resource allocation, etc. Source - www.CDC.gov/POPhealthtraining/what is Population Health	150
General Data Protection Regulation Review patients and employees for residence in the European Union and evaluate privacy requirements are met to ensure data protections at rest and transit, use and disclosure, and data retention meet the requirements of GDPR.	150
Break the Glass Evaluate a sample of the break the glass report for escalated access to ePHI for appropriateness.	150
B. SECURITY AUDITS	1,000
Ransomware Readiness Evaluate effectiveness of controls to mitigate ransomware attacks at the Memorial Healthcare System network perimeter.	150
Artificial Intellgence Risk Tolerance Evaluate the organization's artifical intelligence risk tolerance and the influence of the policies and norms established by AI system owners, organizations, industries, communities, or policy makers, legal or regulatory requirements. See https://www.nist.gov/itl/ai-risk-management-framework	150
Identity and Access Management Evaluate access controls as employees and vendors change roles within Memorial Healthcare System.	150
Transmission Security Review electronic transmission of ePHI, verify a mechanism to encrypt the ePHI was implemented appropriately, to include email, texting, application sessions, FTP, remote backups, remote access and support sessions (VPN) and web conferencing.	250
Epic Slicer/Dicer Level 2 Monitoring Review Epic Slicer/Dicer default Level 2 access to all MHS users, which is unmonitored, does not present an elevated risk.	150
Privacy and Security of Voice Recognition Drives Available in Patient Rooms Review Opt In/Opt Out procedures of voice recognition devices available in patient rooms along with the data retention/activation of conversations held within range of such devices.	150
PRIVACY & SECURITY TOTAL	1,550

IV. CONFLICTS OF INTEREST	**Hours**
C. CONFLICTS MANAGEMENT	1,810
Distribution and Analysis Review and evaluate system to determine that conflicts of interest are identified, evaluated and mitigated. Determine that the risks of purchase schemes, kickbacks, bid rigging, etc. are mitigated. Determine that related party transactions are identified, evaluated and mitigated. Determine that second jobs and outside activities are identified, evaluated, and mitigated.	900
Training Program Develop training program for the organization about conflicts, how and when to disclose potential conflicts, and make available on the MHS LMS Aspire.	200
Policies Develolpment Develop compliance policies for identification, evaluations and mitigation of potential and possible conflicts of interest.	200
Development of Subcommittee with Conflicts Evaluation and Risk Instrument Establish a conflict decision-tree flowchart, invite members to participate on the COI Subcommittee. Develop a package for the Subcommittee members that includes the disclosed potential conflict, the applicable laws and regulations related to the disclosed conflict, standardize tools and processes to mitigate conflicts, fielding questions and requests for additional information, coordination of Subcommittee votes and mitigation requirements. Implement updated and new software, including contracting, roll-out, training, and maintenance.	510
CONFLICTS OF INTEREST TOTAL	**1,810**

V. HOTLINE AND OTHER INVESTIGATIONS	
Hotline Investigate and respond to compliance hotline calls.	700
Internal Reports Investigate and respond to Internal Reports of suspected noncompliance.	700
INVESTIGATIONS TOTAL	**1,400**

VI. ADMINISTRATIVE & OTHER	
Compliance and Internal Audit Training and Development Includes New Employee Orientation, Leadership Essentials, Management Updates, Compliance Working Committee, Physician Compliance Training and other sessions as needed.	1,200
Administrative and Other Includes special projects, meetings, etc. Includes Credit Union	600
TRAINING, STAFF DEVELOPMENT & OTHER TOTAL	**1,800**

VII. WORK PERFORMED BY OUTSIDE AUDIT FIRMS

A.	ANNUAL IT SECURITY AUDITS	Firm

External Penetration Testing — Protiviti

Conduct an annual scan to identify and evaluate the security posture and risk exposures of external MHS environments (Internet perimeter) and to identify information security system issues. Conduct scans of new, outward facing features such as ePrescribing and Patient Medical Records.

Internal Penetration Test — Protiviti

Internal Penetration Test, with a focus on Ransomware attack vectors, would be performed to evaluate the risk the organization faces if an attacker, malicious code, or internal employee were to attempt to perpetrate an attack on the network from the inside, otherwise bypassing external network controls that would prevent an external attacker.

Internal Vulnerability Assessment — Protiviti

Conduct an annual scan to identify and evaluate the security posture and risk exposures of internal MHS environments and to identify information security system issues.

B.	NEW IT SECURITY AUDITS	Firm

Cloud Strategy, Governance, and Security Configuration Review — Protiviti

Protiviti will perform evaluation of rules and policies adopted to run services in the cloud, cloud governance that facilitates effective and efficient security management and operations in the cloud environment, review the application's supporting cloud infrastructure for effective cloud application using a cloud provider's security controls to protect workloads, data security, and manage risk.

Workday Post Implementation Assessment — Protiviti

This review will include follow up on control deficiencies identified during the Workday Pre-Implementation Assessment. Any remedial action items will be reviewed for compliance with agreed upon resolution.

Application Review (i.e. Epic, Infor, Population Health) — Protiviti

Protiviti will assist MHS to evaluate the system and security controls of Epic, Infor, and Population Health, including an evaluation of the databases, servers, and infrastructure that support the applications, access management, and data governance.

Incident Response Program Assessment — Protiviti

Assess Information Technology Incident Response Program against industry best practices and standards to identify potential risks and vulnerabilities, measure maturity, forensic capabilities, and lessons learned process.

Digital Identity and Access Management Assessment — Protiviti

Assess the business processes, policies and technologies that facilitates the management of electronic or digital identities, including products, processes, and policies used to manage user identities and regulate user access within an organization..

HIPAA Gap Assessment — Protiviti

Measure against current privacy and security requirements and the risk analysis where existing controls are insufficient and action required to reduce risk to an acceptable level.

IT Asset Management — Protiviti

Evaluate the IT assets, licenses, and audit the process of ensuring an organization's assets are accounted for, deployed, maintained, upgraded, and disposed of to ensure that the valuable items, tangible and intangible, are tracked and being useds.

Revenue Cycle — Protiviti

Analysis of the process that follows to generate revenue, from initial customer interaction to the collection of payments. When CHCBC conducts an assessment, we evaluate the efficiency and effectiveness of each stage in the revenue cycle. This assessment is crucial for your business to identify bottlenecks, streamline processes, and optimize financial performance. It helps in maximizing revenue, reducing operational costs, and enhancing overall financial health

IT Security Program Assessment — Protiviti

Evaluate the management, operational, and technical security controls in an information system to determine the extent to which the controls are implemented correctly, operating as intended, and producing the desired outcome with respect to meeting the security requirements for the system.

C.	INTERNAL & COMPLIANCE AUDITS	Firm

VII. WORK PERFORMED BY OUTSIDE AUDIT FIRMS

Audit Area	Firm
Internal Audit Risk Assessment Identify and assess the likelihood and potential impact of operational risks to the organization and evaluate existing controls to identify residual risk areas which will populate the continuous internal audit workplan.	Elevate
District Labs Assess the processes for supplies and availabilty, medication reconciliation, and capturing medication errors. Identify where in the process tests are charged, evaluate the timeliness and accuracy of the test and the need for retesting at all laboratory locations. Maybe a joint audit with the nurses for "medically necessary". In Hallandale and is the same as the individual labs in regards to risk	TBD
Property Management (off-site facilities/non-hospitals and MOBs) Managing general maintenance and special requests for items such as painting, mold mitigation, social distancing set up, etc. Perform minor maintenance such as changing light bulbs and AC filters. Hospital facility departments will have the same level of risk. The hospital facility departments report through the hospitals.	TBD
Cancer Institute Risk Assessment Identify and assess the likelihood and potential impact of operational risks to the organization and evaluate how adequate controls are in reduing risk to ensure that residual risk is at a manageable level.	Elevate
Pharmacy Regular quarterly audits to determine medication adherence	PPP
Physician Agreements Determine whether Physician Agreements, including lease agreements, are in compliance with federal regulations. Verify that the work being performed and the payments being made are in accordance with an executed and current contract.	Nelson Mullins Broad & Cassel
Evaluation of Corporate Compliance Programs Determine that the Compliance Program effectively articulates and demonstrates the organization's commitment to the compliance process and ethical business practices, a culture that promotes prevention, detection and resolution of conduct that does not conform to Federal and State laws.	RFP Process
Price Transparency Assess the MHS cost of hospital items and services are appropriately available to the public and contains comprehensive machine-readable files with all items and services, and shoppable services are available in a consumer-friendly format to meet the CMS requirements.	TBD
Transplant Program Determine transplant program policies and procedures align with regulatory requirements and data reporting, and coding and billing are appropriate.	TBD
Compliance Risk Assessment Identify areas lacking internal control, evaluate potential compliance risks to possible outcomes, and prioritize legal and regulatory risks based on the severity of possible operational, legal, and financial damage associated with each.	TBD