**Board of Trustees Audit & Compliance Committee**

Tuesday, May 24, 2022
10:30-11:15am (or upon adjournment of previous committee meeting)
Microsoft Teams Virtual Meeting

*Trustees:* Sandra Callahan, Chair; Oscar Horton, Lauran Monbarren

**A G E N D A**

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|---|---|---|
| I. | Call to Order and Comments | Chair Sandra Callahan |
| II. | Public Comments Subject to USF Procedure | Chair Callahan |
| III. | New Business – Action Items | |
| | a. Approval of February 21, 2022 Meeting Notes | Chair Callahan |
| | b. 5-Year Independent Peer Review of USF Compliance & Ethics Program | Chief Compliance Officer Caroline Fultz-Carver |
| IV. | New Business – Information Items | |
| | a. Update – Review of Financial Internal Controls University Support Organizations | Exec Director/Chief Internal Auditor Virginia Kalil |
| | b. Healthcare Compliance Program Overview | Healthcare Compliance Officer Jamie Sotelo |
| | c. Privacy Compliance Program Overview | Privacy Compliance Officer Barbara Wolodzko |
| | d. Healthcare and Privacy Compliance Programs Effectiveness Review and Validation | Jamie Sotelo Barbara Wolodzko |
| V. | Adjournment | Chair Callahan |

**USF Board of Trustees**
**Audit & Compliance Committee**
**NOTES**
**February 21, 2022**
**Microsoft Teams Virtual Meeting**

## I. Call to Order and Comments

The meeting of the Audit & Compliance Committee was called to order by Chair Sandra Callahan at 9:32am. Chair Callahan asked Kiara Guzzo to call roll. Ms. Guzzo called roll with the following committee members present: Sandra Callahan and Oscar Horton. A quorum was established.

## II. Public Comments Subject to USF Procedure

No requests for public comments were received.

## III. New Business – Action Items

### a. Approval of November 16, 2021 Meeting Notes

Upon request and receiving no changes to the meeting notes, Chair Callahan requested a motion for approval, it was seconded and the November 16th meeting notes were unanimously approved as written.

### b. Acceptance of Performance-Based Funding (PBF) and Preeminence Data Integrity Audits & Approval of Data Integrity Certification

Virginia Kalil, Executive Director and Chief Internal Auditor, presented the results of the Performance-Based Funding (PBF) and Preeminence Data Integrity Audits. These audits must be conducted annually pursuant to Board of Governors (BOG) request. These audits were conducted by the USF Office of Internal Audit (IA). Ms. Kalil provided some background on PBF and Preeminence funding and described the annual audit process. This is the eighth year conducting the PBF data integrity audit (the BOG approved the PBF funding model in 2014). The Preeminence audit is newer; this is the third year (USF reached full Preeminence in 2018). The primary audit objectives were to determine whether the processes and internal controls established by the University ensure the completeness, accuracy, and timeliness of data submissions which support PBF and preeminence; and to provide an objective basis of support for the President and BOT Chair to sign the representations included in the BOG Data Integrity Certification. The BOG requires the acceptance of the audit results and the approval of the Data Integrity Certification by the Board of Trustees, with submittal to the BOG by March 1. It is key for the BOG to rely on data submitted by the universities. The audit scope was to identify and evaluate any material changes to the controls and processes, including prior year recommendations, BOG data definition changes, and data element, key personnel, and/or file submission changes; review data resubmissions (why they were resubmitted); update risk assessments, including fraud risks; and verify accuracy, completeness, and consistency with BOG expectations of data components, data metric methodologies, and data submitted through detailed testing. As required by the BOG,

the scope and objectives of both audits were set jointly and agreed to by the University's President, Board of Trustees Chair, Board of Trustees Audit and Compliance Committee Chair, and chief audit executive. IA followed its standard risk assessment, audit program, and reporting protocols. The overall conclusion for both audits was that there was an adequate system of internal controls in place, with no reportable risks identified. Ms. Kalil congratulated the University on these results. This is the second consecutive year PBF has had a clean audit and the first year Preeminence has had a clean audit.

The Data Integrity Certification combines/covers both audits. All the questions on the certification can be answered in the affirmative for both audits.

A motion was made to recommend to the BOT acceptance of the Performance-Based Funding (PBF) and Preeminence Data Integrity Audits and approval of the Data Integrity Certification. The motion was seconded and approved by all Committee members present.

A brief, full BOT meeting will be called after this morning's committee meetings to approve this item in order to meet the BOG deadline of March 1.

## IV. New Business – Information Items

### a. USF Regulation 5.001 Revision

Ms. Kalil presented the revisions to USF Regulation 5.001. In response to the BOG new Regulation 3.003: Fraud Prevention and Detection, technical changes were made to USF Regulation 5.001: Waste, Fraud, or Financial Mismanagement. In addition to renaming the USF regulation as Fraud Prevention and Detection, revisions were made to define the University's fraud framework and its component parts, align language with that of the BOG, add a zero-tolerance statement, add more specific language to the applicability statement, reference retaliation, retribution and reprisal policy (USF 0-020), rename disciplinary section to remediation, and add a periodic review.

### b. USF/DSO Independent Audit Findings Report

Fell Stubbs, University Treasurer, presented the University and Direct Support Organizations (DSOs) Independent Audit Findings Report which describes audit findings and auditor recommendations, and management's responses and correction status. This is an annual oversight and reporting process. The University and DSOs will receive 16 audits from independent external auditors for the fiscal year ended June 30, 2021. Since June 30, 2021, 15 audits have been received with the following results: 2 findings in the University Operational Audit – IT June 30, 2021 Audited Financial Statements Received to Date; 5 findings in the 8 DSO June 30, 2021 Audited Financial Statements; and 1 finding in the USF Health Services Support Organization, Inc.'s June 30, 2021 Audited Financial Statements. One audit report for the fiscal year ended June 30, 2021 has not yet been issued: State of Florida Federal Awards Audit (Formerly A-133).

Mr. Stubbs briefly reviewed the eight new findings and their corrective actions and current status, as well as the two findings from the prior year.

### c. Annual Compliance Certifications of DSOs

Mr. Stubbs presented the Annual Compliance Certifications of DSOs. Each DSO and related entity under the control and direction of the BOT is expected to implement an

internal control, reporting, and governance structure consistent with best practices of USF, the DSO or related entity, as well as those detailed within National Association of College and University Business Officer's Advisory Report on the Sarbanes-Oxley Act of 2002.

During 2021, the University amended USF Regulation 13.002 to require all DSOs, beginning in FY 2022, to engage the USF Office of Internal Audit to perform independent and objective internal audit and investigative services in accordance with professional standards.

The University received all 8 Annual Compliance Certification Statements from the 10 DSOs (2 are reported on a consolidated basis), signed by the DSO Board Chair, CEO and CFO, for the fiscal year ended June 30, 2021, consistent with the Annual Reporting Requirements for DSOs. There were no instances of non-compliance with the 23 requirements from five categories of compliance (compliance with laws, regulations, policies and professional standards; system of internal controls; external audit; internal audit; and governance) cited in the Annual DSO Compliance Certification Statements.

The Compliance Certification process is an important element of DSO oversight and governance.

**d. Review of Financial Internal Controls – University Support Organizations**

Ms. Kalil gave a brief update on the review process of financial internal control for university support organizations. During the June 23, 2021 BOG meeting, each university board of trustees' chair was directed to develop a plan to evaluate the financial internal controls at their institution's support organizations. The review is expected be conducted by an entity not routinely or directly connected with the operations or internal oversight of the support organization. Additionally, the review will assess whether financial controls are reasonable over each support organization's financial processes and records to protect the organization from theft or malfeasance and that duties are properly segregated among employees with proper oversight and monitoring activities. Furthermore, the BOG encouraged all universities to work together on a shared contract with one outside entity to complete the reviews. As a result, Crowe, LLP, was selected to conduct these reviews at the 12 universities.

At USF, the scope of the review will include 14 support organizations. The review consists of four phases: 1) planning; 2) risk controls assessment and key control identification; 3) key control testing; and 4) reporting. Phase 1 has been completed and we are now in Phase 2. USF testing and reporting is expected to occur in April and May of 2022. Each DSO will receive their own report; USF will receive a summary of all 14 DSOs; and the SUS will receive a summary report of all universities. The project and reporting are expected to be completed no later than June 30, 2022.

Ms. Kalil noted that this review will inform Internal Audit's risk assessment and work plan.

## V. Adjournment

Having no further business, Chair Callahan adjourned the Audit & Compliance Committee meeting at 10:18am.

**Agenda Item:** IIIb

# USF Board of Trustees

June 15, 2022

**Issue:** Five-Year Independent Peer Review of the USF Compliance & Ethics Program

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**Proposed action:** Approval of the Five-Year Independent Peer Review of the USF Compliance & Ethics Program

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**Executive Summary:**

In accordance with Board of Governors Regulation 4.003(7)(c) “At least once every five (5) years, the president and board of trustees shall be provided with an external review of the Program's design and effectiveness and any recommendations for improvement, as appropriate. The first external review shall be initiated within five (5) years from the effective date of this regulation. The assessment shall be approved by the board of trustees and a copy provided to the Board of Governors.”

The Five-Year Independent Peer Review included an evaluation of the Compliance & Ethics Program planning processes, compliance tools and methodologies, engagement, staff management processes, evaluation of USF regulations, risk management, and a representative sample of the Program work and reports.

**Financial Impact: N/A**

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**Strategic Goal(s) Item Supports: N/A**
**BOT Committee Review Date: Audit & Compliance - 5/24/22**
**Supporting Documentation Online (*please circle*): Yes No**

5-Year Independent Peer Review of University of South Florida Compliance and Ethics Program-20220202-FINAL

**Prepared by:** Caroline Fultz-Carver, Chief Compliance Officer, Office of Compliance & Ethics

# 5-Year Independent Peer Review of University of South Florida Compliance and Ethics Program

Report Date: February 2, 2022

## *EXECUTIVE SUMMARY*

An independent external review of the University of South Florida's (USF) Compliance and Ethics Program was performed by the peer review (PR) team of Alexander Tzoumas, Chief Compliance Officer and Chief Audit Executive at New College of Florida and Joann Campbell, AVP and Chief Compliance and Ethics Officer at University of North Florida at the request of Caroline Fultz-Carver, Chief Compliance Officer, USF. The objective of the PR was to determine the effectiveness of the program and extent to which the USF Compliance and Ethics Program adhered to the requirements previously set forth in accordance with Board of Governors Regulation 4.003, State University System Compliance and Ethics Programs.

In order to effectively and faithfully execute the PR in accordance with Board of Governors Regulation 4.003 and subsequent guidance provided by the Florida Board of Governors Office of the Inspector General / Director of Compliance, the PR was performed using the State University System Compliance and Ethics Consortium Effectiveness Tool[1] (QAR-28), which was utilized as the basis for this review.

## *OPINION AS TO EFFECTIVENESS*

In acting as qualified independent external assessors from outside the organization, we are fully independent of USF and have the necessary background and skills to perform the assessment. After evaluating the documentation supporting the USF's self-assessment and conducting interviews with the President, Board Audit and Compliance Committee Chairperson, General Counsel, Chief Audit Executive, Senior Vice Provost, Provost, and other members of senior management, it is our overall opinion that the USF Compliance and Ethics Program is operating in a "Highly Effective" manner and in compliance with Board of Governors Regulation 4.003. Additionally, the evaluation identified opportunities for further improvement, details of which are provided in this report.

Ratings Scale:

- "Highly Effective" means the assessor has concluded that the relevant structures, policies and procedure of the activity, as well as the processes by which they are applied, promote ethical conduct and maximize compliance with applicable laws, regulations, rules, policies, and procedures as well as the requirements of the Board of Governors Regulation 4.003 *State University System Compliance and Ethics Programs* in all material aspects.
- "Generally Effective" means deficiencies in practice are noted that are judged to deviate from authoritative sources, but these deficiencies did not preclude the compliance activity from performing its responsibilities in an acceptable manner.

[1] The Effectiveness Tool was developed by a subgroup of the State University System Compliance and Ethics Consortium (SUSCEC) for the purpose of self-assessment and program evaluation against the regulatory requirements established in Board of Governors Regulation 4.003, SUS Compliance and Ethics Programs.

- "Not Currently Effective" means deficiencies in practice are judged to be so significant as to seriously impair or preclude the compliance activity from performing adequately in significant areas of its responsibilities.

## *SCOPE AND METHODOLOGY*

The scope of the PR included the last five years; however, the focus was on activities within the last two years. The work performed was guided by the SUS Evaluation Tool (QAR-28), which provides a detailed framework for compliance with the requirements set forth in Board of Governors Regulation 4.003. This includes the evaluation of the Compliance and Ethics Program planning processes, compliance tools and methodologies, engagement, staff management processes, evaluation of USF regulations, risk management, and a representative sample of the Program work and reports. The evaluation also included interviews from a cross section of a university Board Audit and Compliance Committee member, university executives, and senior leadership.

## *COMPLIANCE PROGRAM AREAS ASSESSED*

The peer review included areas in the Compliance and Ethics Program Required Questions outline as previously referenced. After each section heading, a compliance rating is provided.

1. Board of Trustees - Highly Effective
2. Audit and Compliance Committee - Highly Effective
3. Chief Compliance Officer - Highly Effective
4. Senior Leadership Team Compliance Partners – Highly Effective (However, it was noted several Compliance partners were not entirely familiar with the Office Compliance and Ethics activities or had never read a Compliance Report.)
5. Compliance Program Effectiveness – Generally Effective (The Office of Compliance and Ethics coordinates and facilitates an enterprise-wide risk assessment for the university every three years. The last assessment was completed in 2017. A new risk assessment is underway and is forecast to be completed in 2022; however, the university is exposed until the assessment is completed and ensuing mitigation activities occur. Additionally, in today's fast paced environment of constant change and innovation, new risks can quickly emerge and materially impede the achievement of the university's strategic plans. As such, risk assessments should occur more frequently.)
6. Code of Conduct - Highly Effective
7. Open Lines of Communication - Policies, Regulations, and Laws - Highly Effective (Some university policies have not been updated for an extended period of time.)
8. Reporting Expectations, Hotline, Non-Retaliation Policy – Highly Effective
9. Board of Trustee Training - Highly Effective
10. Compliance Training/New Employee Orientation - Highly Effective (While extensive training is offered for new employees and new regulations and compliance requirements are well communicated, a periodic employee compliance refresher training program is not in place.)

11. Audits, Reviews, and other Monitoring Efforts - Generally Effective (Compliance function has operated with limited personnel for an extended period. Recent hires have improved the ability of the department to achieve its mission and responsibilities; however, the success of the Compliance program may continue to be constrained absent sufficient resources.)
12. Issue Investigation - Highly Effective
13. Remediation Corrective Action – Highly Effective
14. Enforcement - Highly Effective
15. Incentives and Disciplinary Measures – Highly Effective
16. Background Checks/Exclusion Screening – Generally Effective (During the review period, a manager of the University's Medical Service Association embezzled a material amount of funds. While the employee was hired prior to the university's a background check policy and the Board of Governor's fraud prevention and detection regulations; the manager was known to have a previously conviction for committing fraud and the associated risk was not being mitigated by an appropriate control environment.)

*Table 1. Summary of Section Ratings*

| RATING CATEGORY | RATING |
|---|---|
| **HIGHLY EFFECTIVE** | 13 |
| **GENERALLY EFFECTIVE** | 3 |
| **NOT CURRENTLY EFFECTIVE** | 0 |
| **TOTAL** | 16 |

## *OBSERVATIONS AND POSITIVE ATTRIBUTIONS*

The program evaluation shows the Office of Compliance and Ethics and the USF Compliance Program is well-structured and meets the regulatory requirements of the Board of Governors Regulation 4.003, SUS Compliance and Ethics Programs. Management is striving to apply compliance and ethics training, active compliance partnering, website information, and university policies to achieve a sound compliance environment. Some successful practices observed were:

- Strong and well-respected relationship between the CCO and USF Board and Senior leaders. CCO Caroline Fultz-Carver was repeatedly praised for her effective communication, professionalism, and leadership in advancing the mission and goals of the Compliance Program;
- New employee and Board member compliance training including Foreign Influence, Ethics, and Procurement;
- Policies on Waste, Fraud, and Financial Mismanagement; Progressive Discipline; Criminal History Background Check; and Discrimination and Harassment;
- Well experienced and credentialled Compliance and Ethics Program leadership;
- Maintenance of a Report a Concern, Code of Conduct and Compliance & Ethics Resources websites where compliance guidance can be found;
- Keeping the Compliance and Ethics Program up to date;

- Conducting investigations to ensure appropriate discipline for non-compliant activities; and,
- USF utilizes the Ethicspoint online service for anonymous reporting of suspected unethical activity and policy violations. A link to the EthicsPoint anonymous reporting hotline is included on the Compliance Department webpage. Additionally, in order to promote awareness of the Ethicspoint hotline, a campus-wide notification of the EthicsPoint hotline is sent to the campus community.

## *RECOMMENDATIONS*

The comments and recommendations that follow intended to build on this foundation already in place in the USF Compliance Program.

Recommendations are divided into two groups:

### PART I: MATTERS FOR CONSIDERATION FOR EXECUTIVE MANAGEMENT AND BOARD OF TRUSTEE'S AUDIT AND COMPLIANCE COMMITTEE

1. The USF Board of Trustees, and its Audit & Compliance Committee in particular, would benefit from a timelier update of the Enterprise Risk Assessment and Management Plan (ERM). The present plan has not been updated since 2017. We recommend the Enterprise Risk Assessment and Management Plan be updated annually to assure material unmitigated risks to the strategic plan have not arisen.
2. We recommend sufficient resources be allocated to the Office of Compliance and Ethics to enable the Compliance Program to achieve all the goals of the Compliance and Ethics Program Plan.
3. We recommend the background check policy be updated to include a requirement that in those instances where an employee was previously convicted of fraud or misconduct, the control environment must be sufficient to mitigate the commensurately higher risk.

### PART II: MATTERS FOR CONSIDERATION FOR CHIEF COMPLIANCE OFFICER

1. Consider monitoring university policies to assure their periodic evaluation and update.
2. Consider sending the Annual USF System Compliance and Ethics Program Plan report to all USF managers and conducting a meeting with the USF executive team and Leadership Counsel to walk through the results of the report and areas where there further compliance assistance or emphasis would be beneficial.

*Respectfully submitted by:*

Alexander G. Tzoumas, CIA, CISA, CFE, CRMA, CDPSE
Chief Compliance Officer and Chief Audit Executive

Joann Campbell, Ph.D.
Chief Compliance and Ethics Officer

# Five-Year Independent Peer Review

## Office of Compliance & Ethics

Caroline Fultz-Carver, PhD, CCEP I May 24, 2022

UNIVERSITY of SOUTH FLORIDA

# Five-Year Independent Peer Review

*At least once every five (5) years, the USF President and Board of Trustees (BOT) shall be provided with an external review of the design and effectiveness of the USF Compliance & Ethics Program and any recommendations for improvement.*

*The assessment shall be approved by the BOT and a copy provided to the Board of Governors (BOG).*

*BOG Regulation 4.003 (7)(c)*
*State University Compliance and Ethics Programs*

# Executive Summary

- Independent, external peer review of last five years activity with focus on past two years
- Assessed Compliance & Ethics Program effectiveness in meeting the Federal Sentencing Guidelines (FSG) and BOG Regulation 4.003
- Utilized *State University System Compliance and Ethics Consortium Effectiveness Tool*, based on regulatory requirements and guidance provided by the BOG Inspector General and Director of Compliance

# Observations and Positive Attributes

- Strong working relationship between leadership of our University, Board, and Compliance Program
- Experienced, credentialled compliance leadership
- Assuring consistent, appropriate progressive discipline for noncompliance
- Policies reflecting successful practices:
  - Waste, Fraud, & Financial Mismanagement
  - Progressive Discipline
  - Criminal History Background Check
  - Discrimination and Harassment
- EthicsPoint anonymous reporting hotline widely advertised
- New Employee Orientation and Board Compliance Training

# Overall Rating: Highly Effective

**GOVERNANCE AND HIGH LEVEL OVERSIGHT**

- ✓ Board of Trustees
- ✓ Audit and Compliance Committee
- ✓ Chief Compliance Officer
- ✓ Senior Leadership Team Compliance Partners
- ✓ Compliance Program Effectiveness

**POLICIES AND STANDARDS OF CONDUCT and OPEN COMMUNICATION AND REPORTING**

- ✓ Code of Conduct
- ✓ Open Lines of Communication-Policies, Regulations, and Laws
- ✓ Reporting Expectations, Hotline, Non-Retaliation Policy

**TRAINING AND EDUCATION**

- ✓ Board of Trustees Training
- ✓ Compliance Training/New Employee Orientation

**AUDITING AND MONITORING**

- ✓ Audits, Reviews, and Other Monitoring Efforts

**ADDRESSING KNOWN OR POTENTIAL ISSUES**

- ✓ Issue Investigation
- ✓ Remediation Corrective Action

**ENFORCING STANDARDS**

- ✓ Enforcement
- ✓ Incentives and Disciplinary Measures
- ✓ Background Checks/Exclusion Screening

**Ratings Scale**

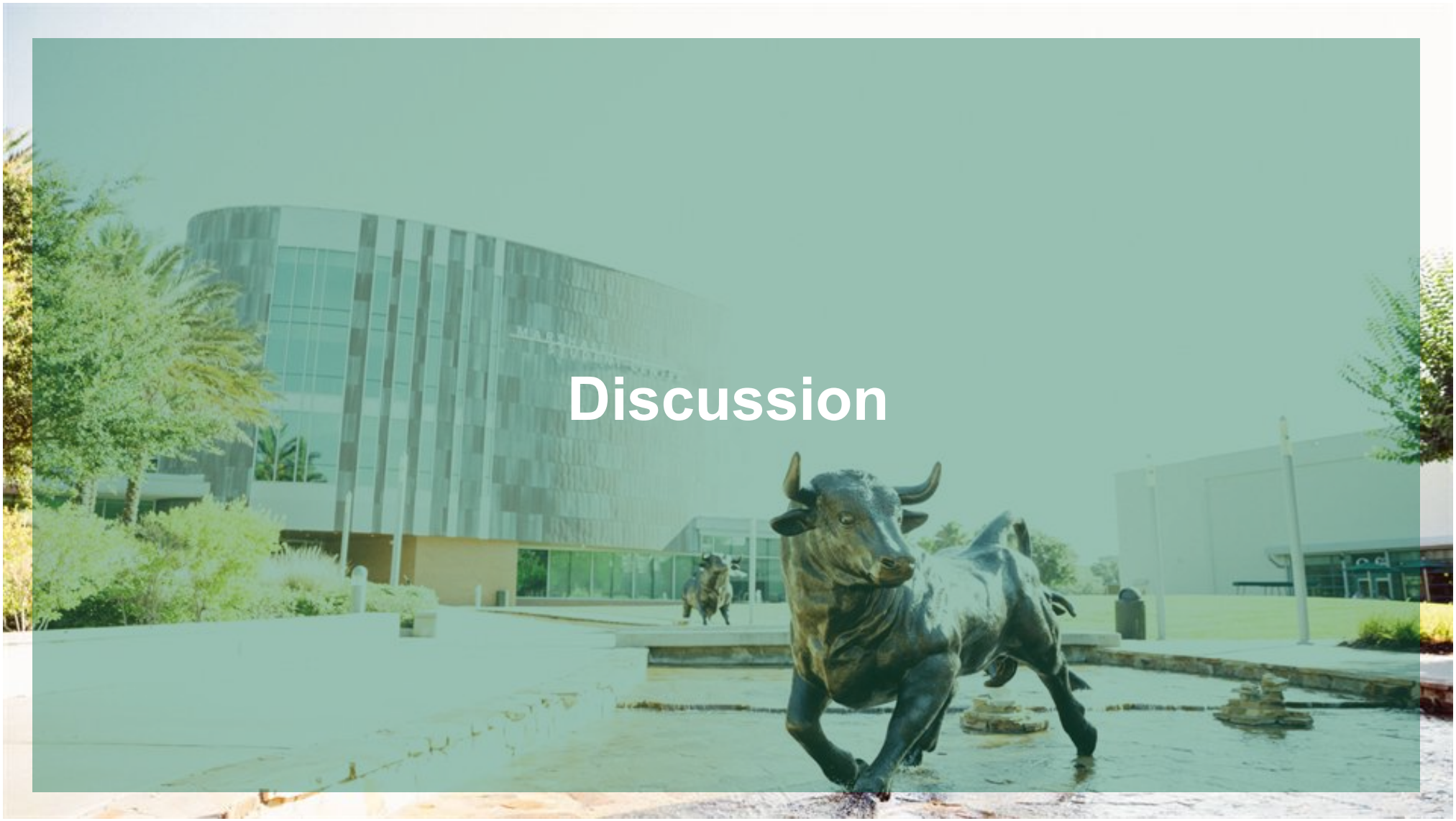
- ✓ Highly Effective
- ✓ Generally Effective
- ✗ Not Currently Effective

# Reviewer Recommendations for Executive Management and BOT ACC

| | Recommendations | Action Plan |
|---|---|---|
| 01 | Annually update Enterprise Risk Assessment and Management Plan (ERM) | Adapt ERM process to accommodate increased frequency, including establishing an ERM Coordinator |
| 02 | Allocate sufficient resources to enable the achievement of goals | Establish a Foreign Influence Officer to assure compliance with new foreign influence laws |
| 03 | Update background check policy | Ensure background check policy addresses control environment requirement |

# Reviewer Recommendations for Chief Compliance Officer

| | Recommendations | Action Plan |
|---|---|---|
| 01 | Monitor university policies to assure their periodic evaluation and update | Collaborate with Office of the General Counsel to assure USF policies are periodically evaluated and updated |
| 02 | Send the Compliance and Ethics Annual Report to all USF employees and confer with leadership | Annually notify USF employees of the availability of Annual Report and continue leadership briefings |


Discussion

**Agenda Item:** IVa

# USF Board of Trustees
# Audit & Compliance Committee
May 24, 2022

**Issue:** Review of Financial Internal Controls – University Support Organizations

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**Proposed action:** Informational

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**Executive Summary:** During the June 23, 2021 Board of Governors (BOG) meeting, former Chair Kitson directed each university board of trustees chair to develop a plan to evaluate the financial internal controls at their institution's support organizations. The review is expected be conducted by an entity not routinely or directly connected with the operations or internal oversight of the support organization. Additionally, the review will assess whether financial controls are reasonable over each support organization's financial processes and records to protect the organization from theft or malfeasance and that duties are properly segregated among employees with proper oversight and monitoring activities. Upon completion of the review, each university is required to submit a summary report to the BOG no later than June 30, 2022.

Furthermore, the BOG, through its Chief Financial Officer, Tim Jones, encouraged all universities to work together on a shared contract with one outside entity to complete the reviews. As a result, Crowe, LLP (Crowe), was selected to conduct these reviews at the 12 universities.

At the University of South Florida (USF), the scope of the review includes 14 support organizations which began on or about April 11, 2022. Crowe estimates completing review of the USF support organizations on or about May 27, 2022.

As a result of the overall project delay, the BOG has extended Crowe's reporting deadline to July 29, 2022.

**Financial Impact:** Support organizations represent approximately 22% of overall university expenditures.

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**Strategic Goal(s) Item Supports:** To practice continuous visionary planning and sound stewardship throughout USF to ensure a strong and sustainable financial base, and to adapt proactively to emerging opportunities in a dynamic environment.
**BOT Committee Review Date:** 05/24/2022
**Supporting Documentation Online (*please circle*):** (Yes) **No**
*Support Org Financial IC Review Presentation.pptx*
**Prepared by:** Virginia Kalil, Executive Director/Chief Internal Auditor, USF Office of Internal Audit

# Financial Internal Controls – USF Support Organizations

**Virginia L. Kalil**
**Executive Director/Chief Internal Auditor**

Audit & Compliance Committee | May 24, 2022

UNIVERSITY of SOUTH FLORIDA

UNIVERSITY of SOUTH FLORIDA

| SUPPORT ORGANIZATIONS | |
|---|---|
| State University System | 90 |
| University of South Florida | 14 |
| | |
| Phase 1: Planning | ✓ |
| Phase 2: Risk-Controls Assessment & Key Control Identification | *In progress* |
| Phase 3: Key Control Testing | *In progress* |
| Phase 4: Reporting | |
| | |
| Timeline for USF Testing & Reporting | Apr-May |

**Agenda Item:** IVb

# USF Board of Trustees
Audit & Compliance Committee
May 24, 2022

**Issue:** Healthcare Compliance Program Overview

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**Proposed action:** Informational

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**Executive Summary:**

The Healthcare Compliance Program assures an effective program measured by regulations that govern the provision and billing of healthcare services. This overview serves to educate the BOT Audit & Compliance Committee regarding this critical compliance program.

**Financial Impact: N/A**

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**Strategic Goal(s) Item Supports: N/A**
**BOT Committee Review Date: 5/24/22**
**Supporting Documentation Online (*please circle*): Yes No**
**Prepared by:** Jamie Sotelo, Healthcare Compliance Officer

# Healthcare Compliance Program Overview

Jamie Sotelo | May 24, 2022

UNIVERSITY of SOUTH FLORIDA

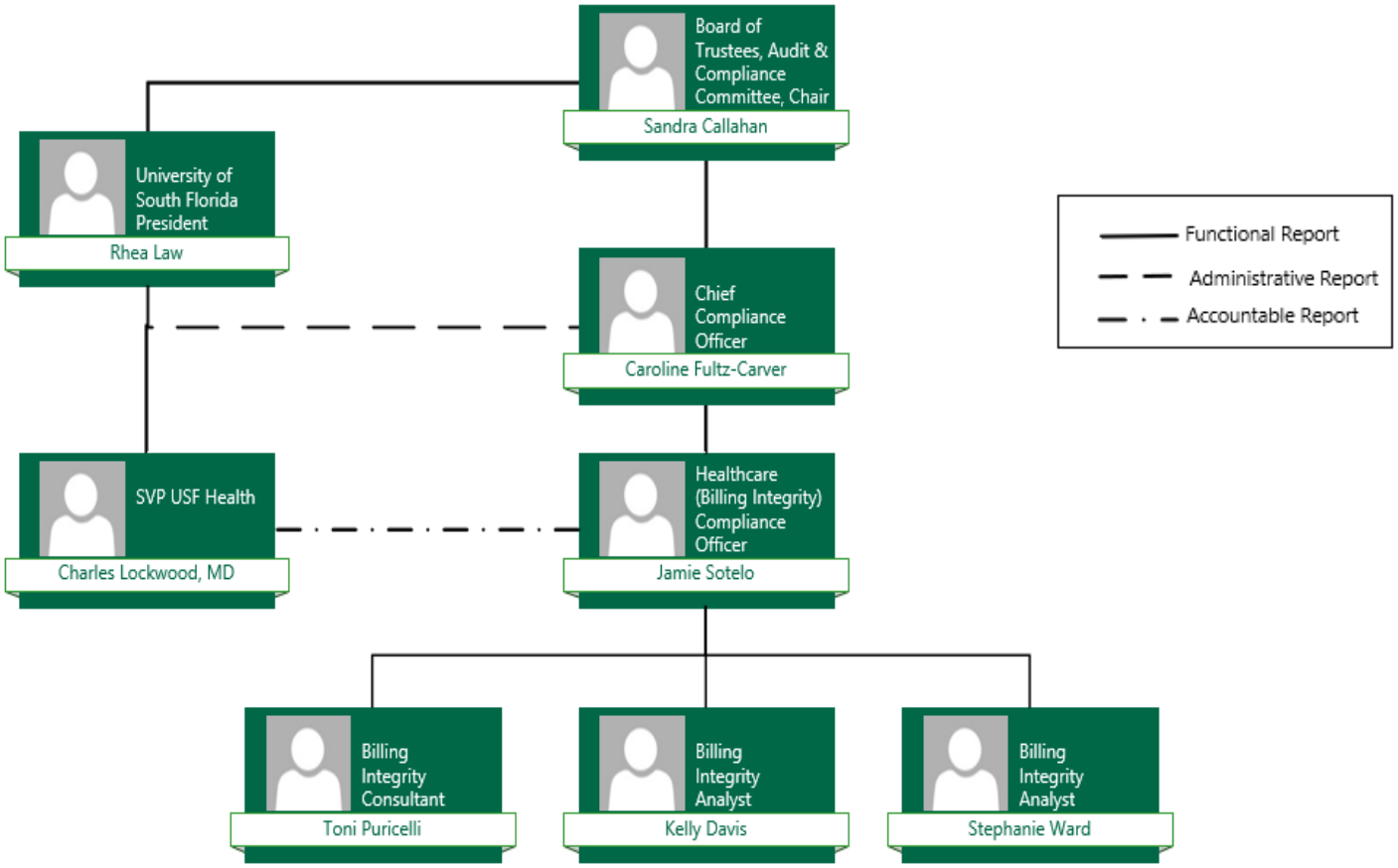
# Mission


*Assure an effective compliance program measured by state and federal regulations that govern provision and billing of healthcare services that includes due diligence to ensure understanding of standards of conduct and policies to prevent, detect, and correct criminal conduct or other violations of standards.*

Affordable Care Act

Medicare Managed Care Manual, Chapter 21

# Reporting and Oversight



# Scope

USF practitioners and those supporting the provision of care at over 30 bay area locations:

- 900+ credentialed providers across 23+ clinical subspecialties
- 400+ leadership, administrators and staff

*College of Medicine*

*Student Health Services*

*Infant Family Center*

*Communication Sciences & Disorders*

*School of Physical Therapy*

# University Medical Services Association (UMSA)

**Contracting, Credentialing & Provider Enrollment**

**Bill average 2.5 million claims per year**

**Practice Management Services contracted from USFTGP**

Scheduling

Revenue Cycle

Clinical IT systems


Policy
Disciplinary Action
Education
Fraud Waste Abuse Prevention
Responding to concerns
Monitoring

# Noncompliance Risks

| Financial Implications | Regulatory | Reputational |
| --- | --- | --- |
| • $10K - $50K in Civil Monetary Penalties *plus 3x* damages (overpayments) per violation, per claim<br>• Exclusion from participation with third party payers | • Harsh penalties and corrective actions<br>• Criminal prosecution | • Mistrust within the community<br>• Negative impact on new patient referrals |

# Healthcare Compliance Resources

**** funded by Contracts & Grants (UMSA)***

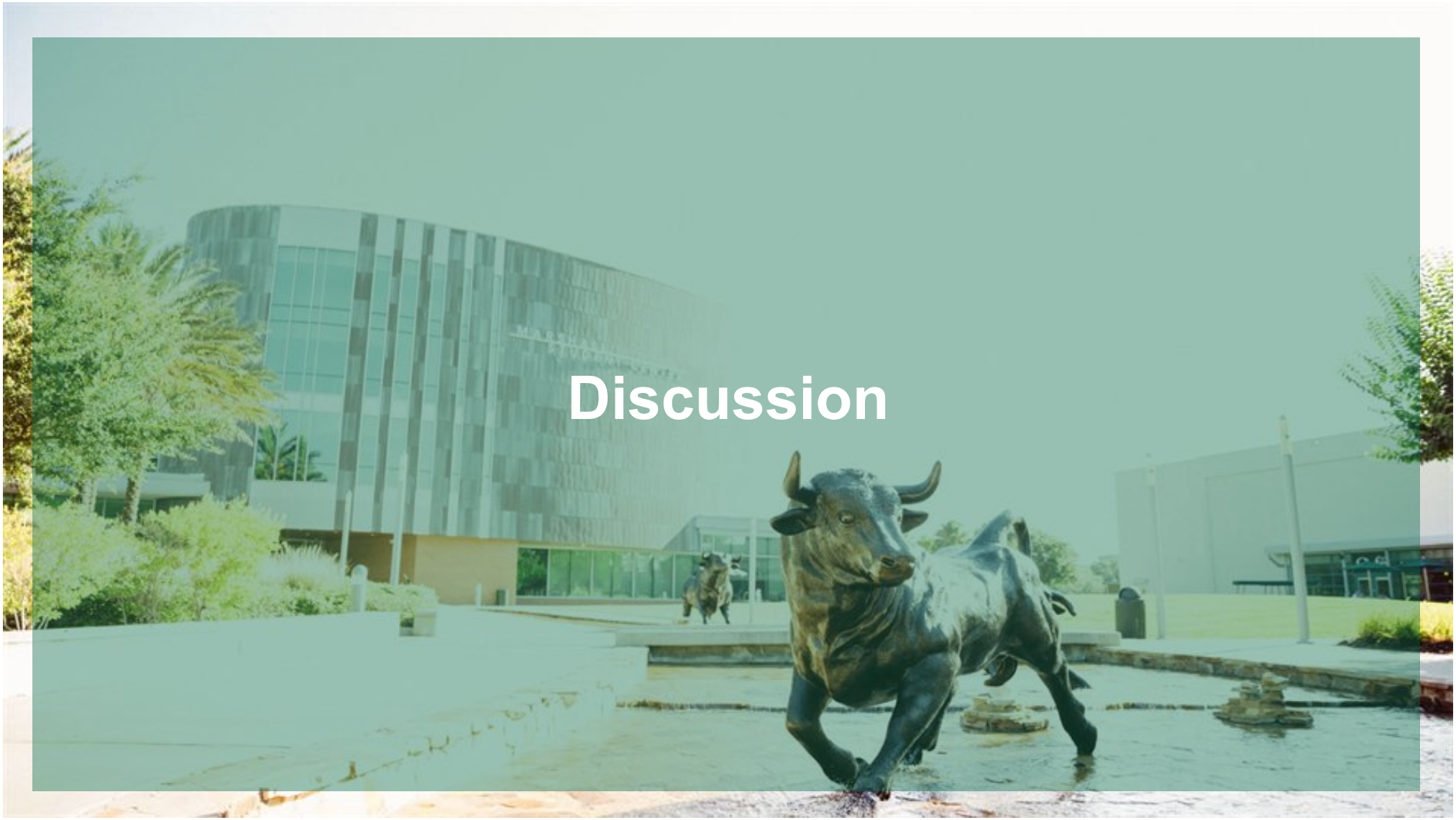
- FY22 budget - $530,935
- Advanced specialized skill set
  - *Certified Professional Coder (CPC)*
  - *Certified Professional Medical Auditor (CPMA)*
- Each team member has minimum 15 years expertise in professional fee compliance

***Analyst***

- Education (25%)
- Internal Risk Monitoring (75%)

***Consultant***

- Education (40%)
- External review response & Internal Investigations (60%)


Discussion

**Agenda Item: IVc**

# USF Board of Trustees
# Audit & Compliance Committee
May 24, 2022

**Issue:** Privacy Compliance Program Overview

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**Proposed action:** Informational

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**Executive Summary:**

The Privacy Compliance Program Overview provides the historical development of the privacy program, its scope of responsibility within our university, and the program's reporting structure. This overview highlights federal and state laws governing privacy, ongoing compliance monitoring efforts, and how the program contributes to a culture of compliance. This overview serves to educate the BOT Audit & Compliance Committee regarding this critical compliance program.

**Financial Impact:** N/A

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**Strategic Goal(s) Item Supports:** N/A
**BOT Committee Review Date: 5/24/2022**
**Supporting Documentation Online (*please circle*):** Yes **No**
**Prepared by:** Barbara Wolodzko, USF Health Privacy Officer & Civil Rights Coordinator

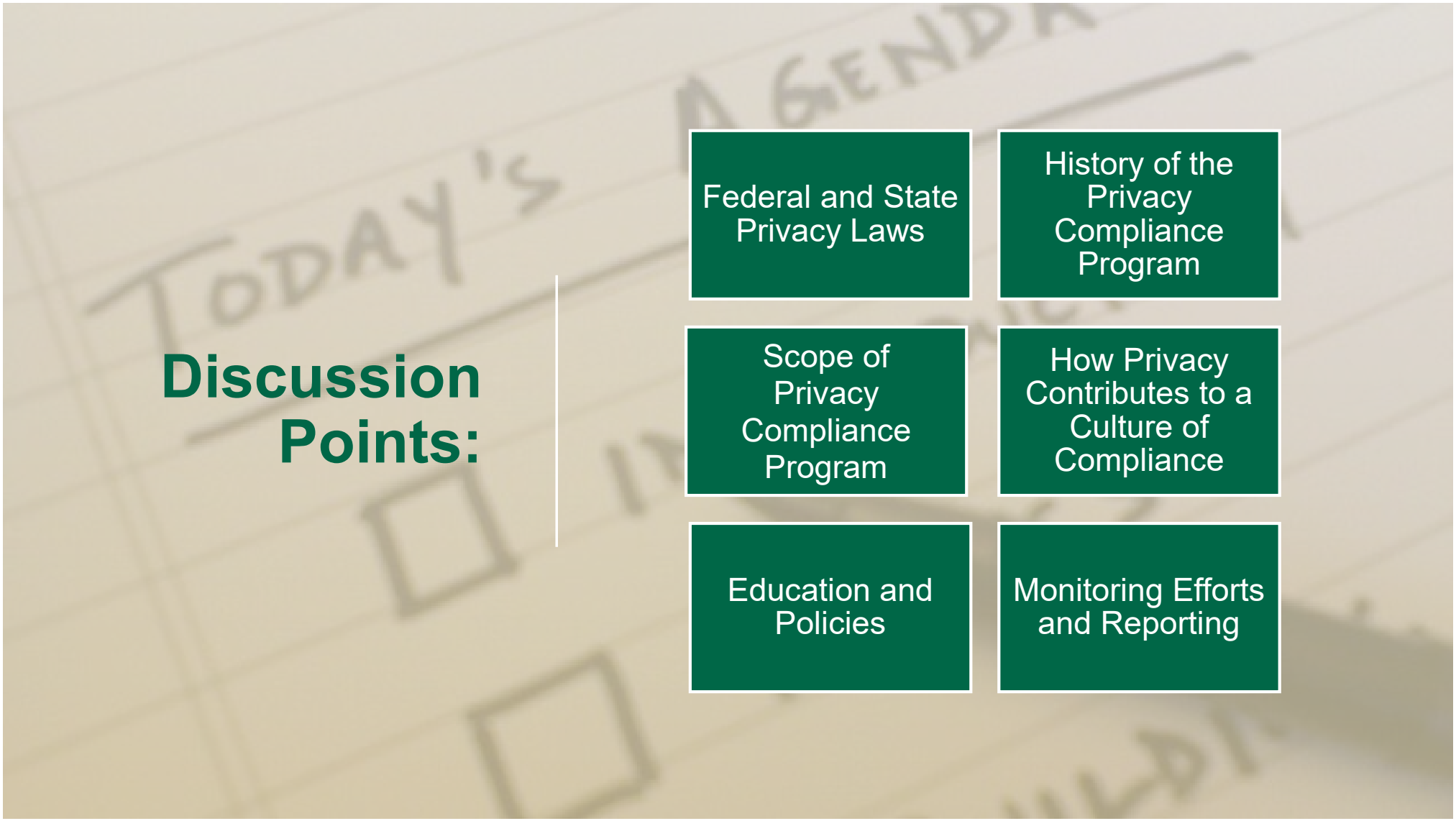
# Privacy Compliance Program Overview

Barbara Wolodzko, JD, LL.M, LL.M., CHC | May 24, 2022

UNIVERSITY of SOUTH FLORIDA

# Privacy & Healthcare Civil Rights Compliance Program ("Privacy Compliance Program")

*The mission of the Privacy Compliance Program is to ensure that individuals' health information is properly protected in compliance with federal and state laws, while allowing the flow of health information needed to provide and promote high quality health care.*


Discussion Points:
Federal and State Privacy Laws
History of the Privacy Compliance Program
Scope of Privacy Compliance Program
How Privacy Contributes to a Culture of Compliance
Education and Policies
Monitoring Efforts and Reporting

**Federal Laws:**

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Section 1557 of the Affordable Care Act (Section 1557)

21st Century Cures Act (Cures Act)

Chapter 8 of the United States Sentencing Guidelines (Chapter 8)

**State Law:**

Florida Information Protection Act of 2014 (FIPA)

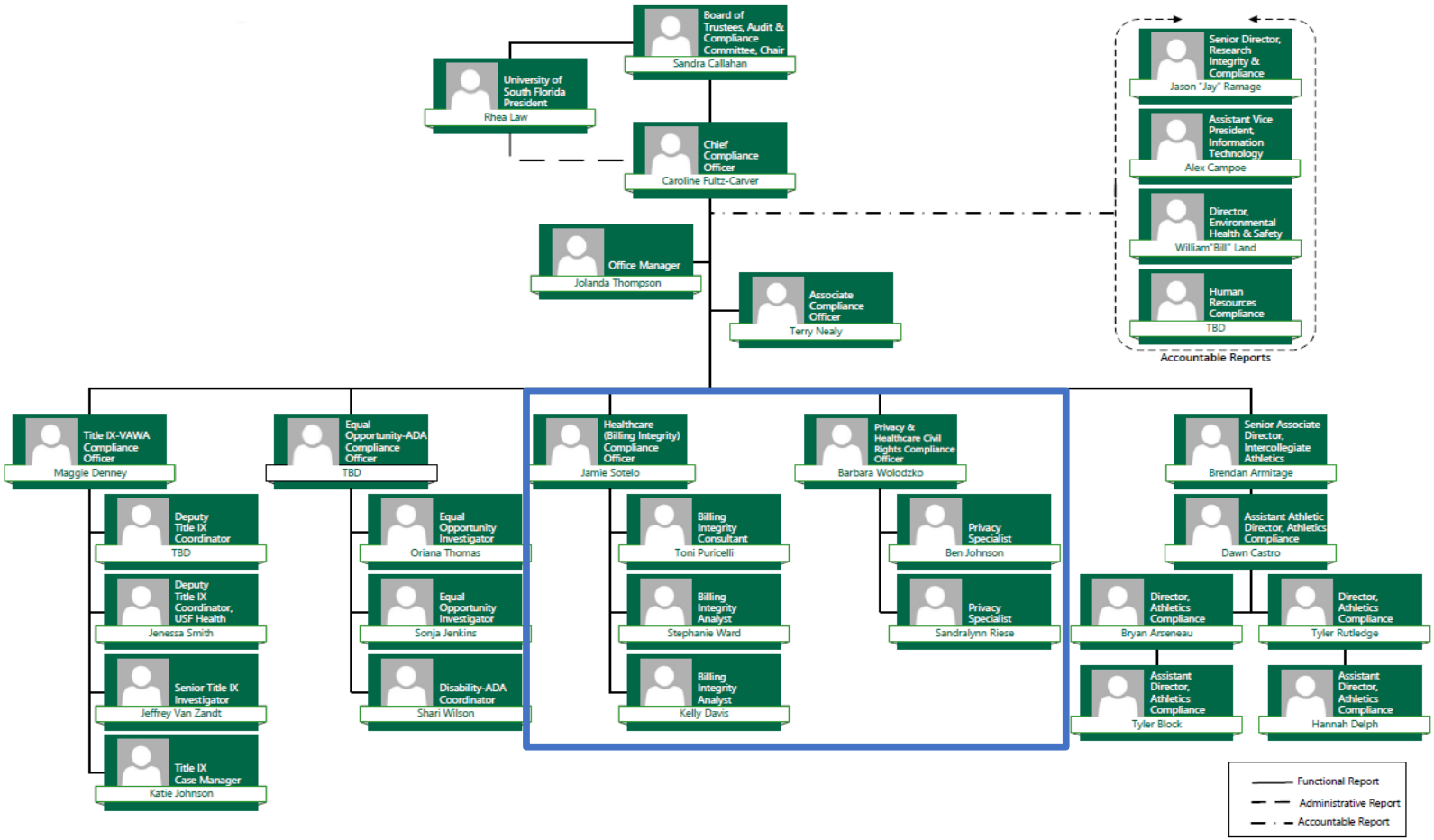
# Privacy Compliance Program History

**1997**
USF College of Medicine Faculty Practice Plan Compliance Plan was established. Privacy was not included.

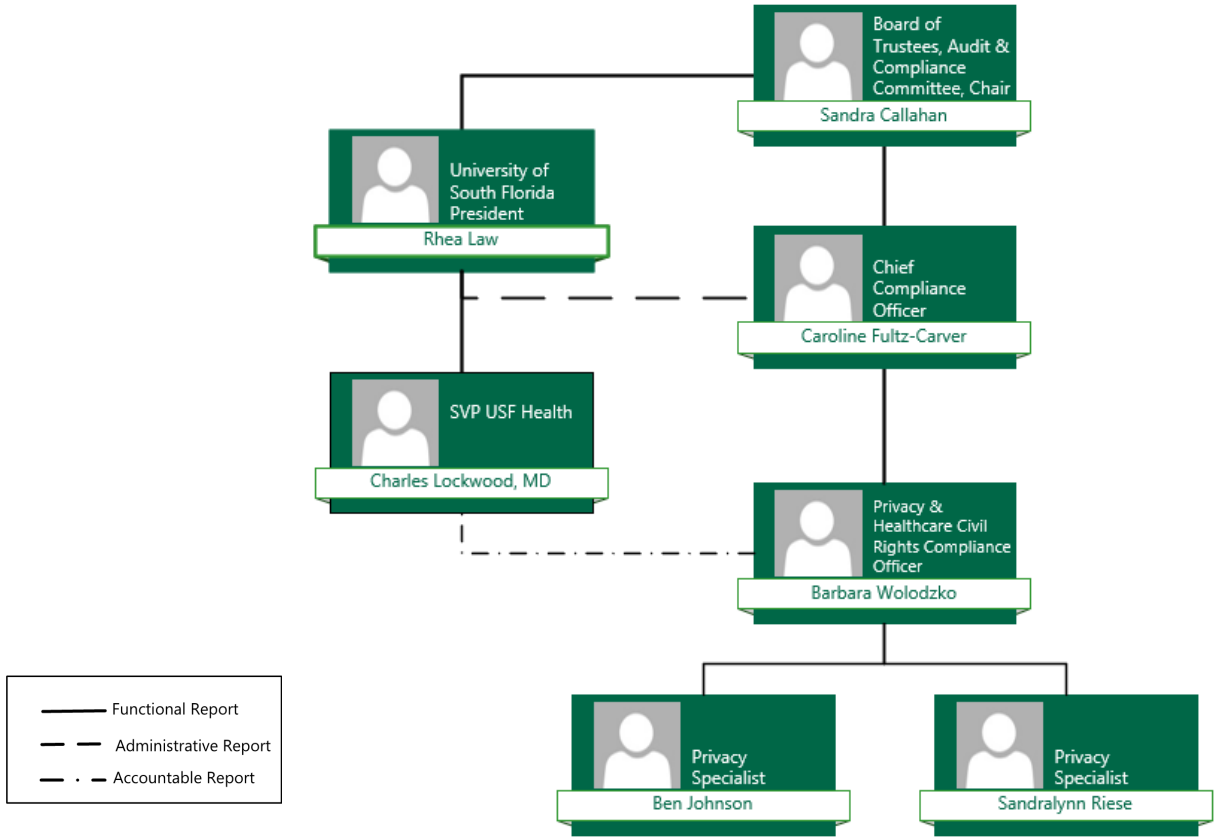
**2003**
USF Health Professional Integrity Office (PIO) was formally established. HIPAA privacy was now part of PIO.

**2021**
Effective August 1st, the privacy compliance functions began reporting to the USF Chief Compliance Officer under the Office of Compliance & Ethics as the Privacy & Healthcare Civil Rights Compliance program, “Privacy Compliance Program”.

# Office of Compliance & Ethics



# Privacy & Healthcare Civil Rights Compliance Program



# Program Scope

## In scope:

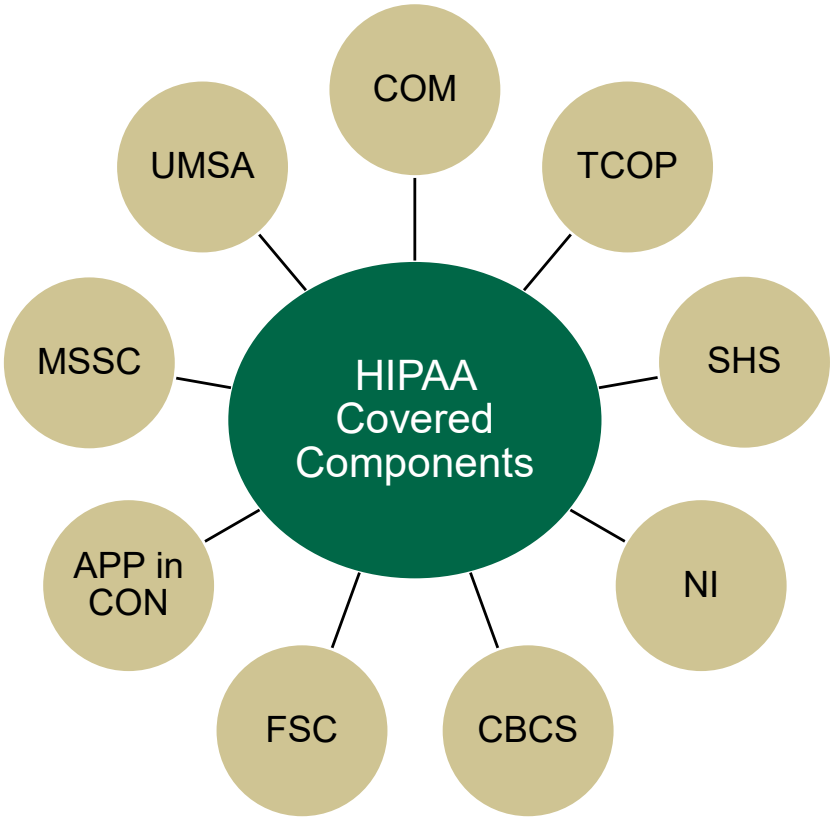
- **USF Health**
  - Hybrid Entity
  - Covered vs. Noncovered Component
- **Organized Health Care Arrangement**
  - USF and TGH
- **USF Tampa General Physicians**
  - Responsible for all privacy services

## Out of scope:

All noncovered components

- State and Federal Laws:
  - Family Educational Rights Act (FERPA)
  - General Data Protection Regulation (GDPR)
  - Other federal and state laws
  - Gramm Leach Bliley Act of 199 (GLBA)
  - Fair and Accurate Credit Transaction Act of 2003 (FACTA)
  - Florida Information Protection Act (FIPA)

# HIPAA Covered Components




| | |
|---|---|
| COM | USFH Morsani College of Medicine |
| TCOP | Taneja College of Pharmacy |
| SHS | USF Student Health Services |
| NI | USFH Neuroscience Institute |
| CBCS | USF College of Behavioral & Community Sciences |
| FSC | USF St. Petersburg Family Study Center |
| APP in CON | Advanced Practice Providers under USF College of Nursing |
| MSSC | USF Medical Services Support Corporation |
| UMSA | University Medical Service Association |

# How we contribute to our culture of compliance

- Leadership buy-in
- Anonymous reporting
- Anti-retaliation policy enforcement
- Team visibility in the clinical space
- Helpline responsiveness
- Trusted privacy advisors
- Assure consistent progressive discipline

# HIPAA Education and Policies

## Education

- Online HIPAA education
  - 10 days of hire
  - Annually thereafter
  - Progressive sanctions
- HIPAA privacy tips
- In person topic training
- Helpline for assistance
- Updates at established meetings

## Policies and Procedures

Based on HIPAA requirements and best practices in collaboration with the following:

- Privacy and Security Advisory Committee
- Practice Leadership Team
- USF Health Leadership

# Monitoring Efforts and Reporting

## Monitoring Efforts:

- FairWarning / Imprivata
- Epic audits
- Privacy helpline
- CompliancePro
- Anonymous reporting / EthicsPoint
- Clinical area walkthroughs
- Privacy liaisons

## Reporting:

External

Office for Civil Rights, Department of Health and Human Services

Internal

- Privacy & Security Advisory Committee
- USF Health Leadership
- Chief Compliance Officer

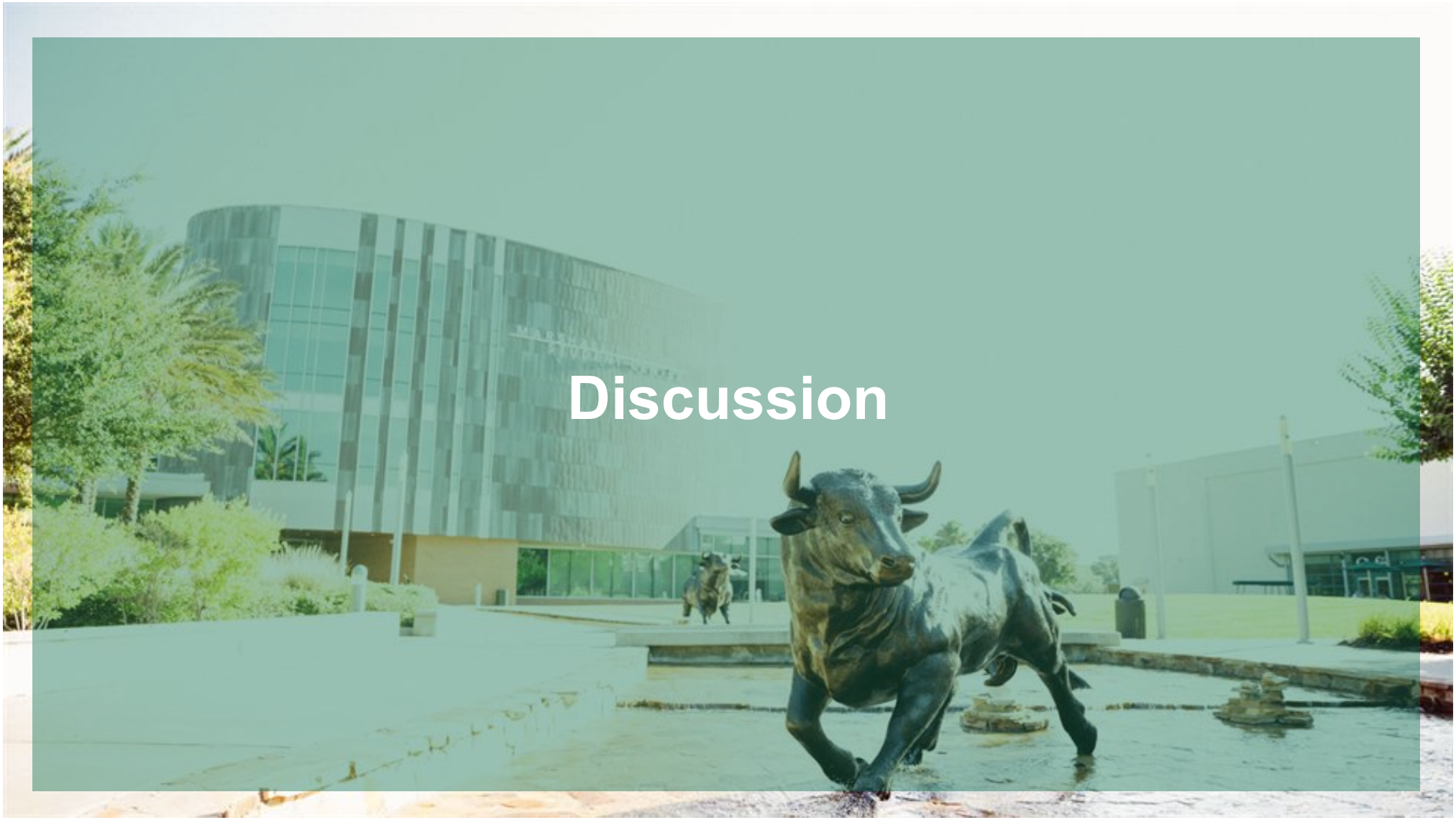
# Risks and Priorities

### *Noncompliance Risks*

- HHS/Office of Civil Rights (OCR) financial penalties up to $1.8M per calendar year
- 5-year corrective action plan and oversight expenses
- Increased HHS/OCR scrutiny
- Criminal prosecution expenses and penalties (incarceration)
- Civil claim exposure
- Reputational damage

### *Strategic Priorities*

- Establishing adequate staffing levels to meet compliance obligations per Federal Sentencing Guidelines
- Ensure market rate to retain current and recruit new team members


Discussion

**Agenda Item:** IVd

# USF Board of Trustees
## Audit & Compliance Committee
May 24, 2022

**Issue:** Healthcare and Privacy Compliance Programs Effectiveness Review and Validation

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**Proposed action:** Informational

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**Executive Summary:**

A self-assessment was performed of the Healthcare Compliance and Privacy Compliance programs to evaluate the programs' design, effectiveness, and, as appropriate, provide recommendations for improvement. An overview of the self-assessment and the Office of Internal Audit's independent validation is being provided to the BOT Audit & Compliance Committee for awareness of program effectiveness.

**Financial Impact: N/A**

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**Strategic Goal(s) Item Supports: N/A**
**BOT Committee Review Date: 5/24/22**
**Supporting Documentation Online (*please circle*):** **Yes** **No**

21-007_USFH_Compliance_Self_Assessment_20220203_FR-Signed
Self-Assessment for Privacy November 2020
USFH Compliance Effectiveness Self-Assessment

**Prepared by:** Jamie Sotelo, Healthcare Compliance Officer and Barbara Wolodzko, USF Health Privacy Officer and Civil Rights Coordinator

UNIVERSITY of SOUTH FLORIDA
Office of Internal Audit

# MEMORANDUM

TO: Jamie Sotelo, Compliance Officer, Healthcare & Billing Integrity Compliance
Barbara Wolodzko, Privacy Officer, Privacy & Healthcare Civil Rights Compliance

FROM: Virginia L. Kalil, CIA, CISA, CFE, CRISC
Executive Director/Chief Internal Auditor

DocuSigned by: Virginia Kalil 0D6C38EF9E6641E...

DATE: February 3, 2022

SUBJECT: 21-007 USF Health Professional Integrity Office Compliance Self-Assessment Validation

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Internal Audit (IA) performed a review of the USF Health Professional Integrity Office (PIO) Compliance Self-Assessment as part of the IA 2020-21 Work Plan. The focus of this consulting engagement was validation of the self-assessment performed by the PIO during the fall of 2020. The specific audit scope and objectives are described at Appendix A.

Overall, IA determined the compliance program components and identified opportunities/gaps listed by PIO on their self-assessment document were accurate and supported, and that the PIO has measured the effectiveness of their compliance program in good faith as recommended by applicable authorities, and in a manner that was consistent with the Measuring Compliance Program Effectiveness: A Resource Guide (HCCA-OIG Resource Guide) published by the Health Care Compliance Association (HCCA) and the Department of Health and Human Services (HHS) Office of Inspector General (OIG).

Based on our review, IA agreed with PIO's identified opportunities/gaps, and that resolution of these identified opportunities/gaps will improve the compliance program's effectiveness. These identified opportunities/gaps were primarily related to the need for updates to the Compliance Plan, the Professional Integrity Program Handbook, various policies and procedures, and job descriptions so that they would more accurately reflect recent organizational changes within the University. IA also feels that PIO's holistic higher-level approach in performing their self-assessment, whereby overall program components were inventoried and reviewed for sufficiency, was a reasonable and logical methodology to use for this initial self-assessment under the HCCA-OIG Resource Guide.

IA recommends in future self-assessment activities the PIO consider incorporating additional steps such as sample testing, surveys or questionnaires, etc. to determine whether individual program components, which we recommend be selected using a risk-based approach, are functioning as intended.

Please contact us at 974-2705 if you have any questions.

4202 E. Fowler Ave., Suite 200 • Tampa, FL 33617
Office: (813) 974-2705 • www.usf.edu/audit

cc: Dr. Charles Lockwood, Senior Vice President, USF Health
Richard Sobieray, Senior Associate Vice President and Chief Financial Officer, USF Health
Dr. Caroline Fultz-Carver, Chief Compliance Officer

# APPENDIX A

## BACKGROUND

### USF Health Compliance Program

The USF Health College of Medicine (COM) Faculty Practice Plan Compliance Plan (Compliance Plan) was established in 1997, and included a Code of Conduct and a focus on healthcare billing integrity.

The USF Health Professional Integrity Program (PIP) was formally adopted in 2003 to build upon the Compliance Plan by creating an overall compliance and quality improvement program to include HIPAA (Health Insurance Portability and Accountability Act of 1996), with the focus on HIPAA Privacy compliance related to patient care activities. The PIP applies to all USF Health physicians, other healthcare providers, faculty, employees, trainees, students, volunteers and other workforce members and personnel.

The USF Health (USFH) Professional Integrity Office (PIO) consists of two distinct functional programs 1) Healthcare & Billing Integrity Compliance and 2) Privacy & Healthcare Civil Rights Compliance. The Healthcare & Billing Integrity Compliance Program is led by an Associate Director/USFH Compliance Officer, and the Privacy & Healthcare Civil Rights Compliance Program is led by an Associate Director/USFH Privacy Officer. Effective August 1, 2021, both report to the University Compliance Officer under the Office of Compliance & Ethics. Previously the PIO reported to USFH leadership. The PIO is collectively responsible for development and delivery of education on billing integrity and privacy, monitoring of billing accuracy and privacy compliance, development of billing integrity and privacy standards, and sanctions checks. In addition, PIO operates a Help Line to assist USF Health community members with questions about Professional Integrity topics and allow for reporting of potential compliance/privacy problems, and responds to issues reported through the USF EthicsPoint Hotline, which also allows for anonymous reporting of compliance concerns.

### Measuring Compliance Program Effectiveness

Measuring health care compliance program effectiveness is recommended by several authorities, including the United States Sentencing Commission (Chapter 8 of the United States Sentencing Guidelines) §8B2.1.

In January 2017, the Health Care Compliance Association (HCCA) and Department of Health and Human Services (HHS) Office of Inspector General (OIG) met to discuss methods to measure the effectiveness of compliance programs. As a result of this meeting the Measuring Compliance Program Effectiveness: A Resource Guide (HCCA-OIG Resource Guide) was published in March 2017. HCCA-OIG Resource Guide lists many individual compliance program metrics from which organizations may choose to best suit their needs. To ensure that all elements of a compliance program were covered, HCCA-OIG Resource Guide and its metrics were based on the Health Care Compliance Association's CHC Candidate Handbook: Detailed Content Outline which identifies Compliance Program Elements as:

1. Standards, Policies, and Procedures
2. Compliance Program Administration
3. Screening and Evaluation of Employees, Physicians, Vendors and other Agents
4. Communication, Education, and Training on Compliance Issues
5. Monitoring, Auditing, and Internal Reporting Systems
6. Discipline for Non-Compliance
7. Investigations and Remedial Measures

During the fall of 2020, the PIO performed a self-assessment of the USFH Compliance program based on the HCCA-OIG Resource Guide. The PIO took a holistic approach by listing and describing all enacted program components in place across the seven generally-accepted program elements, along with opportunities/gaps that PIO Leadership identified while compiling and reviewing this information.

Internal Audit (IA) was asked to perform an independent evaluation of the self-assessment performed by the PIO.

## SCOPE AND OBJECTIVES

IA's review focused on validation of the self-assessment performed by the PIO to provide management with an objective assessment of whether the information contained therein was accurate and supported, and whether the self-assessment was conducted in a manner that was consistent with the HCCA-OIG Resource Guide.

IA validated the work of the PIO's self-assessment by conducting walkthroughs and reviewing available documentation of enacted program components that the PIO compiled for their review in order to determine if the program components and identified opportunities/gaps listed by the PIO on the Self-Assessment Document were accurate and supported.

IA's audit scope did not include detailed testing of the PIO's listed and described controls and program elements to determine if they were functioning effectively.

In conducting the review, IA followed a disciplined, systematic approach using the International Standards for the Professional Practice of Internal Auditing. The COSO (Committee of Sponsoring Organizations of the Treadway Commission) control framework was used to assess control structure effectiveness.

## CONCLUSION

Overall, IA determined the program components and identified opportunities/gaps listed by the PIO on the Self-Assessment Document were accurate and supported, and that the PIO has measured the effectiveness of their compliance program in good faith as recommended by applicable authorities, and in a manner that was consistent with the HCCA-OIG Resource Guide.

IA agreed with the PIO's identified opportunities/gaps, and that resolution of these identified opportunities/gaps will improve the compliance program's effectiveness. These identified opportunities/gaps were primarily related to the need for updates to the Compliance Plan, the

Professional Integrity Program Handbook, various policies and procedures, and job descriptions so that they would more accurately reflect recent organizational changes within the University. IA also believes the PIO's holistic higher-level approach, whereby overall program components were inventoried and reviewed for sufficiency, was a reasonable and logical methodology for this initial self-assessment.

IA recommends in future self-assessment activities the PIO consider incorporating additional steps such as sample testing, surveys or questionnaires, etc. to determine whether individual program components, which should be selected using a risk-based approach, are functioning as intended.

**USF Health Professional Integrity Office**

To: Berina Fazlic-Frljak, MBA, CIA, CRMA, Sr. Audit Consultant, Office of Internal Audit
Kethessa Carpenter, CPA, CIA, Audit Consultant, Office of Internal Audit
From: Barbara Wolodzko, J.D., LL.M., LL.M., Privacy Officer and Civil Rights Coordinator
Date: November 2020
RE: **Self-Assessment of the HIPAA Privacy Program as of November 2020**

# The Seven Fundamental Elements of an Effective Compliance Program

I have used the seven fundamental elements of an effective compliance program coupled with a review of the HCCA-OIG Compliance Effectiveness Roundtable issued on March 27, 2017 entitled "Measuring Compliance Program Effectiveness: A Resource Guide" to prepare my self-assessment. I have addressed each element below and then identified areas of risk or opportunities to be addressed under each element.

## Element 1: Standards, Policies, and Procedures

Our privacy policies are available through our website and can be found linked to the confluence site: https://confluence.usf.edu/display/MCOM/Professional+Integrity+Office. I have uploaded our policies to the Team Folder under the "Privacy Policies" tab for easy review. In accordance with Flesch Kincaid measuring standard, I have tried to draft all of the policies and standard operating procedures at a 10th grade reading comprehension level.

The privacy policies I have uploaded for your review in Teams are as follows:

Joint Notice of Privacy Practices and Notice of Organized Health Care Arrangement:

- Notice of Privacy Practices Provision policy
- To Our Patients Joint NPP effective November 1, 2020
- Joint Notice of Privacy Practices Brochure in English
- Joint Notice of Privacy Practices Brochure in Spanish
- Joint Notice of Privacy Practices Poster
- Joint Notice of Privacy Practices Web version
- Acknowledgment or Best Effort form for Joint Notice effective 110120

Definitions and General Provisions:

- Workforce – USF HIPAA Covered Component
- HIPAA and Same Sex Marriage
- USF HIPAA Designated Record Set

Uses and Disclosures of Protected Health Information (PHI):

- Minimum Necessary Uses & Disclosures of PHI
- HIPAA Business Associate Agreement Process
- Photography, Videos, and Audio Recordings of Patients
- Photograph, Videos, and Audio Recordings by Patients or Guests
- HIPAA Privacy in Emergency Situations
- Email Communications Containing PHI
- Permitted Uses and Disclosures of PHI
- Uses and Disclosures of PHI that Require Authorization
- Uses and Disclosures of PHI for which an Authorization or Opportunity to Agree or Object is Not Required
- Uses and Disclosures of PHI Requiring an Opportunity to Agree or Object
- Access to Inspect Own PHI within EHR
- HIPAA and Social Media Use

Patient Rights:

- Fundraising and Right to Opt Out
- Request Access to Inspect and Obtain a Copy of PHI
- Request Amendment of PHI
- Accounting of Disclosures Requests
- Request Restriction of Uses and Disclosures of PHI
- Request for Alternative Communications
- Authorization for Verbal or Written Communication of PHI

Administrative and Monitoring:

- Privacy Incident Reporting, Investigation and Corrective Actions
- Privacy Monitoring – FairWarning
- Privacy Monitoring – Walkthroughs
- HIPAA Privacy Record Retention

- HIPAA Privacy Administrative Requirements
- USF HIPAA Personnel Designations
- Training Requirements for Workforce Members with Access to PHI
- Safeguarding PHI
- HIPAA Privacy Complaint Management
- HIPAA Privacy Sanctions
- Retaliation Prohibited
- Waiver of Rights

Standard Operating Procedures

- Incident Response Plan

The privacy policies are vetted at the quarterly Privacy & Security Advisory Committee meetings. They are then submitted, discussed and approved at the monthly Practice Leadership Team meetings. Once approved, our privacy policies will also be available with all the other USF Health policies on the webpage that Betsy Willard is preparing under the direction of Dr. Moseley. They are also available on our PIO website as I have discussed. I am currently reformatting the Privacy section of the website from a drop-down list of options to a landing page that will be easier to navigate.

When a new policy is adopted or a current policy is updated for an internal or legally required change, I communicate such at our Clinical department Administrators meetings that are held monthly. This month I am discussing and sharing our new Joint Notice of Privacy Practices and Organized Health Care Arrangement that became effective November 1, 2020. Copies of such are already in all clinical sites, located on posters within each clinic and posted on the USF Health website as required by HIPAA; however, discussing such at the Administrator's meeting will provide an opportunity for them to ask questions.

We have begun monitoring the number of hits to our website https://health.usf.edu/pio. We just received a report regarding the number of actual hits on our Professional Integrity website. See Website Hits Report under the Privacy Effectiveness Review in Teams.

Risk Identification or Opportunities for Improvement under Element 1:

On my workplan for the remainder of the 2020/2021 is to better communicate the location and the content of the HIPAA privacy policies. Having the policies available on our PIO website is a good start however I am going to include in my upcoming HIPAA

Privacy Tip emails a link to our HIPAA policies and additional information highlighting the contents of those policies. UMSA, under Dr. Moseley's direction is also establishing an internal site for all of the policies to be available to Workforce Members.

An area of risk is that Information Technology (IT) does not have a adequate set of HIPAA related security policies. While HIPAA security does not fall under my purview, as the Privacy Officer I do not believe they have the HIPAA security policies in place that are required under HIPAA. I have reviewed past third party audits of IT and this weakness was identified. If an IT Workforce Member is identified as a policy drafter, I would be willing to work with him/her to make sure they are compliant with the necessary HIPAA security policies. However, I do not have the technical computer expertise to draft these on my own nor is it within my job function or role.

## Element 2: Compliance Program Administration

The Professional Integrity Office (PIO) was established back in 1997 and HIPAA privacy was incorporated within the PIO in 2003. Patsy Bickel was the first Compliance Officer named and then became the Compliance and Privacy Officer in 2003. I was then named the Privacy Officer in 2018 as addressed below. I was also appointed as the Civil Right Coordinator in compliance with Section 1557.

I report to the USF Chief Compliance Officer, Dr. Caroline Fultz-Carver, and the Compliance & Ethics department. I file an annual report with their office. I also report weekly to Robert Pelaia, Deputy General Counsel and I have a standing monthly meeting with Dr. Mark Moseley, Chief Clinical Officer, USF Health and Associate Dean for Clinical Affairs. I also can meet directly with Dr. Lockwood should I feel the need to alert him to any HIPAA privacy issues. I also share any large HIPAA privacy breaches with leadership and keep them informed of the process. Our PIO budget it also vetted and approved by committee through USF Health as is our requests for staffing needs (budgetary staffing requests).

The formal announcement of being appointment as Privacy Officer came from Dr. Moseley on September 14, 2018:

> **From:** Willard, Betsy **On Behalf Of** Moseley, Mark
> **Sent:** Friday, September 14, 2018 1:57 PM
> **To:** clinical_master
> **Subject:** Professional Integrity Office Promotions
>
> Pleased join me in congratulating Jamie Sotelo and Barbara Wolodzko on their recent promotions to Associate Director positions in the USF Health Professional Integrity Office ("PIO"). Specifically, Jamie has been appointed as the USF Health Compliance Officer and Barbara has been appointed as the USF Health Privacy Officer.

**Jamie Sotelo**

Jamie has been a key member of our compliance team since its inception in 1997, most recently serving as Interim Compliance Officer. After earning her Bachelors of Science from the University of Central Florida in Health Information Management (HIM), Jamie started her career in physician practice management. A Registered Health Information Administrator (RHIA) since 1994, she brings a comprehensive knowledge of medical, administrative, ethical and legal requirements related to patient care. Jamie is also proficient in the management and analysis of patient data/classification systems.

As Compliance Officer, Jamie has delegated authority and responsibility for leading, monitoring and evaluating the compliance program and activities of the practice plan. The Billing Integrity team provides guidance to USF Health clinicians, staff and trainees on supervision, documentation and coding regulations; conducts internal compliance risk assessments and related monitoring; drafts standard practices and procedures for compliance/billing integrity; and investigates reports of potential billing problems. Jamie can be reached at 813-974-8091 or jsotelo@health.usf.edu.

**Barbara Wolodzko**

Prior to this promotion, Barbara served as the Interim Privacy Officer from November 2017. Barbara joined the PIO back in early 2014 and has earned progressively more responsible positions including being named the USF Health Civil Rights Coordinator back in 2016 to address nondiscrimination under the Affordable Care Act.

Barbara earned her Bachelor of Arts degree from the University of South Florida, her Juris Doctor from Rutgers School of Law – Camden, her Master of Laws in Estate Planning from the University of Miami School of Law, and a Master of Laws degree in Health Law from Loyola University Chicago School of Law. She is a licensed attorney in the state of Florida with 20 years of experience and a member of the Florida Bar Association.

Barbara will continue to utilize her legal knowledge in her new role through drafting HIPAA standard practices and procedures, investigating and reporting privacy breaches, advising on privacy related issues or questions, assessing privacy risks, drafting and negotiating Business Associate Agreements, and monitoring access to the electronic health record through FairWarning. Barbara can be reached at 813-974-7413 or bwolodzko@health.usf.edu.

The Professional Integrity Office is located off campus in the University Professional Center Building, 3500 E. Fletcher Avenue. https://health.usf.edu/pio/

Mark G. Moseley, MD, MHA, FACEP
Chief Clinical Officer
USF Health

Professor and Associate Dean for Clinical Affairs
Morsani College of Medicine

University of South Florida

Assisted by Betsy Willard
Phone: 813-974-8486 | Fax: 813-974-8487
Mailing Address: 12901 Bruce B. Downs Blvd. | MDC 62 | Tampa, FL 33612
Street Address: USF Health Faculty Office Building, 13220 USF Laurel Drive, Room 4169, Tampa FL 33612

The advisory committee for HIPAA privacy reporting and monitoring is the Privacy and Security Advisory Committee (PSAC). I lead the PSAC and appointed committee members from the following areas: Clinical members (providers from different practice areas), College of Nursing members, Information Security members, IT Clinical Systems member, Legal member, Pharmacy member, Research member, Clinical Operations member, Access member, and Health Information Management member. Here is a current breakdown of the members of the PSAC:

| | **Clinical Members:** | | **Information Security Members:** | | **Clinical Operations Member:** |
|---|---|---|---|---|---|
| | Dr. Heather Agazzi | | Tim Bulu | | Kim Clifford |
| | Dr. Terri Ashmeade | | Alex Campoe | | **Access Member:** |
| | Dr. Bryan A. Bognar | | Dennis Guillette | | Dan Gregg |
| | Dr. Paul Kuo | | Olu Abiose | | **Privacy Officer Member:** |
| | Dr. Joe Lezama | | **IT Clinical Systems Member:** | | Barbara Wolodzko |
| | Dr. Cuc Mai | | Andy Wineinger | | **PSAC Secretary:** |
| | Dr. Mark Moseley | | **Legal Member:** | | Ben Johnson |
| | Dr. Cory Pollard | | Robert Pelaia | | **HIM Member:** |
| | **CON Member** (and guests)**:** | | **Pharmacy Member:** | | Dina Orihuela |
| | Dr. Marcia Johansson | | Dr. Kevin Sneed (or delegate) | | |
| | Dr. Susan Perry | | **Research Member:** | | |
| | Dr. Tracey Taylor | | Anna Sladky | | |

The PSAC meets quarterly for an hour to discuss privacy incidents/breaches, monitoring, Business Associate Agreements, Security issues regarding HIPAA requirements, HIPAA and research issues, our annual report, and other key topics and concerns. The PSAC also reviews all privacy policies prior to them being submitted to the Practice Leadership Team for final approval. I have attached a

copy of the PSAC Agenda from September 24, 2020 (with meeting minutes) and a copy of the PSAC Agenda for our November 19, 2020 meeting in Teams under the tab "Privacy & Security Advisory Committee."

Risk Identification or Opportunities for Improvement under Element 2:

I am currently tracking my time spent on HIPAA issues outside the HIPAA Covered Component. I work with certain departments such as the College of Public Health or Research that fall outside the HIPAA Covered Component but still need HIPAA guidance and support. I believe my defined role is the HIPAA Covered Component however, my job function/description and/or my title may need to reflect my expanded role that I have assumed. We have also expanded the HIPAA Covered Component this fiscal year to include the Infant Family Center and the advance practitioners within the College of Nursing; thankfully, I was part of that formation process to make sure they were named as part of our hybrid entity under the covered components. An area of opportunity exists when a department's functions change and fall under part of our hybrid entity.

## Element 3: Screening and Evaluation of Employees, Physicians, Vendors and other Agents

As the Privacy Officer in compliance with HIPAA, I have to maintain a list of all of our Business Associate Agreements (BAA) along with certain other information such as their address, website and contact information. I have provided this list within Teams under the OCR Business Associate Spreadsheet. This list is maintained within our software called CompliancePro Solutions (from a third party vendor). Workforce members can request my review of a vendor's BAA or that I draft a BAA within ComplaincePro Solutions.

The Compliance Officer and our assistant handle all sanctions screening for our employees, physicians, vendors and agents via a third party vendor. She has discussed this process in her self assessment.

Risk Identification or Opportunities for Improvement under Element 3:

At this time, I have not identified any risks other than the ongoing risk of not being informed of a new contract that requires a BAA. However, this risk has been mitigated by linking CompliancePro to the contract submission site so if there is a question on whether a BAA is required, the Workforce Member has to submit it through CompliancePro for my review prior to the underlying agreement being processed or signed.

## Element 4: Communication, Education, and Training on HIPAA Privacy Issues

All of our Workforce Members under the HIPAA covered component (and/or who have access to PHI) must complete annual HIPAA training within the first 10 days of hire and annually thereafter within our learning management system called SABA. My HIPAA training within SABA has an overview of HIPAA requirements, information about our privacy program including the contact information for our office, and my name as the Privacy Officer. At the end of the HIPAA training, there are a number of hypothetical real-life scenarios that provide the viewer with an opportunity to apply what they have just learned. They must answer whether they witnessed a HIPAA violation or the behavior was compliant. If they answer incorrectly, they must go back and answer again

until they are correct. Additionally, I have explained why or why not there was a HIPAA violation for each question to provide additional insight. I have uploaded a copy of our current HIPAA Privacy Training under the "HIPAA Annual Training" Tab in Teams. This module was developed by Patsy Bickel and I a few years ago and I am currently revising it for the 2020/2021 fiscal year to shorten the module and focus more on the HIPAA information our workforce members need in their daily lives to keep our patients' PHI safe and USF Health compliant under HIPAA. This new module will feature more HIPAA scenarios to help viewers reinforce the HIPAA information they have just learned.

Here is a link to the required HPAA privacy training within Saba on our website at: https://health.usf.edu/pio/required-training. The SABA learning management system will allow Workforce Members to sign up for the required courses (if they have not already been assigned) and the Workforce Member will be able to see a list of completed or pending courses and will also be able to print out certificates for each course completed. Here are the instructions on our website:

## Purpose

To ensure that all USF Health credentialed providers, fellows, residents, students, staff, and all employees of the USF HIPAA covered health care components (collectively, "Workforce Members") with access to protected health information (PHI) receive HIPAA Privacy training and are familiar with HIPAA regulations and USF Health policies related to security and confidentiality of patient information. See 45 C.F.R. § 164.530

## Standard Practices

Workforce Members shall complete the USF Health online HIPAA Privacy training prior to having access to Protected Health Information ("PHI"). Workforce members are to receive pertinent role-specific training as part of their orientation/onboarding in accordance with departmental/unit procedures.

## Procedures

1. The hiring manager/supervisor is responsible for ensuring that the Workforce Member completes the USF Health online HIPAA training.
2. Access to the electronic medical record and/or the patient management system is contingent upon completion by the Workforce Member of the required online HIPAA training.
3. Training will be completed within a reasonable time, **but no later than within 10 days, after the Workforce Member joins the USF Health HIPAA Covered Entity**. **Training then must occur every fiscal year thereafter (deadline date is June 30 for annual training.)**
4. Role-based training is to be provided to Workforce Members involved in performing duties related to the USF HIPAA Covered Component's responsibilities, including those addressed in the Joint Notice of Privacy Practices and Notice of Organized Health Care Arrangement. This includes Health Information Management; QSR Patient Advocate; and

USFPG Call Center and Revenue Performance staff. Such training is to be provided as part of new Workforce Member orientation and as part of the required annual HIPAA training.

5. The **annual training** includes HIPAA Privacy and Computer & Information online modules via SABA and any applicable role-based training.
6. Additional training within a reasonable time will be required of each Workforce Member whose functions are affected by a material change in the applicable regulations.
7. The online training data shall be maintained within the USF Health Learning Management System, with reports available to management within all units.

One of the key factors of this Element is also to establish effective lines of communication. I do this by providing posters in each USF Health clinic informing all Workforce Members how to report a privacy breach through CompliancePro Solutions and how to contact our office with questions. I also provide Privacy Tips on timely topics to keep them informed of privacy issues. These Privacy Tips are emailed to all Workforce Members under the listserv. Some of my past Privacy Tips can be viewed on our website: https://health.usf.edu/pio/privacy-tips.

The Professional Integrity Office has a helpline we have established for concerns, questions, or other general inquiries and can be reached via email at piohelp@usf.edu or via phone at (813) 931-9755. Our website has this information listed and all my posters and HIPAA topic emails also list this contact information.

I have also listed my work number (813) 974-7413 and my cell phone number (941) 704-9176 on my signature line and all of my out of office messages so all Workforce Members know I am available after hours in case of a HIPAA emergency, breach or other concern.

Workforce Members may also report concerns via USF's Ethics Point. This is a reporting system that can be anonymous should the user wish to remain anonymous. Once a privacy/HIPAA concern is reported, it is sent to me to investigate and respond. We have referenced Ethics Point on our website and have it included in our annual training.

Additionally, we have a nonretaliation policy under the HIPAA policies to remind all Workforce Members that retaliation of any kind will not be tolerated whether it is for reporting a concern or a violation internally or externally. I have had a workforce member report a HIPAA violation to HHS/OCR prior to reporting the violation to me. I worked with the Workforce Member to investigate the matter, listen to his/her concerns, send a breach notification letter and report the breach to HHS all while thanking this Member and assuring them that we do not retaliate in any way.

As I stated above, we also draft and distribute posters on varying HIPAA topics and remind Workforce Members to reach out to us via email or phone to discuss any concerns. I have noticed the volume of HIPAA privacy questions via phone and email have increased significantly in the last 2-3 years (we track all inquiries). I think this can be credited to our privacy teams' quick and friendly response. Our Members are not intimidated to ask a question.

Risk Identification or Opportunities for Improvement under Element 4:
I have identified some of the high-risk areas that are in need of specialized HIPAA training. A few years ago, Health and Human Services (HHS) opened an investigation against our Health Information Management department for failing to timely respond to a patient's repeated requests for amendments to their medical record. As part of our negotiation and mitigation plan with HHS, I agreed to specific training for our call center, health information management and the patient advocate (see the "Role Based Training" under the "Privacy Policies" section within Teams. Additionally, in my 2021 HIPAA training module in SABA, I plan to address role-based training and risks associated with conducting those everyday roles. For example, our most common privacy incident is clinical employees handing a patient the After Visit Summary of another patient. I will provide examples for some of our Work Force members to caution them about common privacy incidents in their job roles or functions.

An additional risk is that the reporting system within SABA is not as detailed nor accurate as it should be. To be clear, the data pull into SABA are not as accurate and detailed as they should be. There should be a clear indication the department and job role/function of each Workforce Member. The employee classifications with SABA are so vague they do not indication whether the individual has access to PHI.

## Element 5: Monitoring, Auditing, and Internal Reporting Systems

One of the ways in which I conduct internal monitoring and auditing is through the use of FairWarning. FairWarning is a program that monitors user behavioral trends and activity within Epic. FairWarning allows us to monitor Workforce Members' access and use within Epic. We look for unauthorized access to patient and/or other Workforce Members' Epic medical records. We can also drill down to determine whether a Workforce Members' access within Epic was in accordance with his or her job function. For example, a front desk staff is permitted to access scheduling within Epic, however, the front desk staff should not access a patient's test results. We then determine after an investigation whether such access violated internal policies and/or such access was a privacy breach.

We also monitor requests for access to Epic. We work closely with the IT staff members to review requests for Epic access and make sure the type of access permissions they are granted fit the job role/function they are assigned.

For internal reporting of privacy incidents or breaches is through the CompliancePro Solutions program. Once we receive a report through CompliancePro, we begin our investigation to determine if a breach occurred and/or if a violation of internal policy occurred. We reach out to the parties involved to learn more about what occurred, why it happened and we work with them to determine if there are procedures or other things we can change or put in place to prevent or lessen the chance of this occurring in the future. If a breach has occurred, we send a breach notification letter to the patient(s) whose PHI was involved and we also notify HHS as is required under HIPAA. We also work with the individual(s) who caused a breach and their supervisor to apply sanctions. We have a sanctions policy that we apply to every case making sure they are applied the same to every Workforce Member without regard to who the individual is or what level within the organization they are.

At a minimum, at the end of the fiscal year we report the number of incidents we investigated, the number of policy violations, the number of HIPAA breaches and the number of patients those breaches affected, and what corrective actions/mitigation occurred as well as the kind of sanctions applied.

We also monitor overlays to determine if a breach has occurred. As part of that monitoring program, I make sure the Workforce Member(s) that have mistakenly created an overlay attend retraining to decrease or eliminate overlays in the future. Once they complete retraining, they send me a certificate of completion.

We also monitor deleted communications (letters prepared through Epic that are not sent or sent in error) to make sure a breach did not occur.

We also have a HIPAA Liaison program within each clinic to increase HIPAA privacy knowledge and awareness within the clinics. The Liaisons are clinical employees who volunteer to assume the role of a Liaison. They are tasked with completing a list of HIPAA awareness questions each quarter and report those back to us. The questions involve reviewing the clinical space for potential HIPAA breaches (such as PHI being left unattended) and assisting their colleagues in learning more about HIPAA (such as making sure they know how to file a HIPAA incident report or contact myself or Ben).

Ben and I also conduct unannounced walkthroughs of our clinics to identify potential risk areas (such as monitors being left on while unattended) and assist the clinic in correcting these identified problems. We have noticed a decrease in these risks since we have been conducting these random walkthroughs.

The monitoring policies for your review are within Teams:

- Privacy Incident Reporting, Investigation and Corrective Actions
- Privacy Monitoring – FairWarning
- Privacy Monitoring – Walkthroughs
- HIPAA Privacy Record Retention
- HIPAA Privacy Administrative Requirements
- USF HIPAA Personnel Designations
- Training Requirements for Workforce Members with Access to PHI
- Safeguarding PHI
- HIPAA Privacy Complaint Management
- HIPAA Privacy Sanctions
- Retaliation Prohibited
- Waiver of Rights

Risk Identification or Opportunities for Improvement under Element 5:

The risk with monitoring is the lack of privacy employees within our department. There are only two of us working on HIPAA privacy issues. Ben Johnson is our full time Privacy Specialist and I am the full time Privacy Officer. There are no other employees working on any privacy issues. I believe adding a fulltime privacy employee to my department would greatly assist us in taking a more proactive approach to managing privacy issues. With only two of us, I feel like many times we are taking a reactive approach and struggling to find the time to put proactive measures in place. I understand budgetary restrictions at this time but hope to be able to hire an employee in the future to serve as a second privacy specialist.

## Element 6: Discipline for Non-Compliance

I have a policy for HIPAA violations with a chart for progressive discipline for such violations based on a number of factors. The policy is entitled HIPAA Privacy Sanctions and has been uploaded to Teams. Sanctions are applied consistently in accordance with our sanctions policy and table. Sanctions are also recorded and maintained in case of audit as required under HIPAA.

Risk Identification or Opportunities for Improvement under Element 6:

Sometimes it is difficult to apply the sanctions policy and table because there are so many variables for each situation. However, our policy and table have to have some flexibility in them to apply to each violation. I would recommend that I form a group (smaller than our current PSAC) to review the breach or policy violation and recommend the sanction based on the sanctions table.

This group of 4 or 5 individuals could also involve the manager of the person being sanctioned. Currently I seek out the advice of HR, legal and the individual's manager, as applicable, when talking about our sanctions policy and table.

## Element 7: Investigations and Remedial Measures

Ben Johnson, our Privacy Specialist, and I respond promptly to detected or suspected offenses and undertaking corrective actions as required under our policies and HIPAA. As soon as possible but no later than 60 days from the time we are aware, or should be aware, of a potential HIPAA violation, we begin our investigation, determine whether a breach has occurred, and prepare and mail a HIPAA breach notification letter to the patient. If it is a breach, the breach must then be reported to Health and Human Services Office of Civil Rights (HHS) no later than 60 days after the end of the year in which the breach occurred or if 500 or more patients' PHI was breached, then I have to report the breach to HHS as soon as possible but no later than 60 days from the date I learned of the incident or should have learned of it. Additionally, as part of the investigation of an alleged privacy incident, we also begin remedial measures to make sure such an event does not occur in the future. We analyze whether this was a human error or operational error and determine if we can reduce the risk. We document our remedial measures (report them to HHS) and maintain them in accordance with HIPPA.

Additionally, as discussed above, we also enforce reeducation of our Workforce Members when they make an overlay within Epic. Retraining assists in decreasing the number of overlay errors in Epic.

<u>Risk Identification or Opportunities for Improvement under Element 7:</u>

I have identified no risk areas under this Element. We are always striving to improve our investigation measures and our remedial measures.

**USF Health Faculty Practice Plan Compliance Plan Effectiveness**
**Self-Assessment October 2020**

The last independent effectiveness review was completed by a third-party health care consulting firm, Compliance Concepts Inc, in June 2013. This self-assessment was conducted by the USF Health Compliance Officer based on the Department of Health & Human Services (HHS) Office of Inspector General (OIG) and Health Care Compliance Association (HCCA) compliance program guidance, Accountable Care Organization requirements and Medicare Part C expectations.

Supporting documents for assessment tools, previous evaluations, and program elements are filed within the corresponding folders in the MS Teams "USFH PIO Effectiveness Review GRP". Other resources referenced in this assessment include:

PIO Website (public facing)
https://health.usf.edu/pio/billing-integrity

PIO Confluence site (internal to USF NET ID users) – in development
https://confluence.usf.edu/display/MCOM/Professional+Integrity+Office

SABA learning management system (access controlled by USFH clinical systems)
https://usf.sabacloud.com

Using the seven key elements of an effective program, the below table includes current state and identified opportunities for improvement for the respective element.

| **Compliance Program Element** | **Compliance @ USF Health** | **PIO identified opportunities/gaps** |
|---|---|---|
| 1. Program Structure & Compliance Oversight | A. Compliance Plan - Established in 1997; no official revision on file<br>B. Program expanded in 2003 to include HIPAA Privacy<br>C. Designation of Compliance Officer (CO) has been in place since 1997.<br>D. Current Reporting structure<br>a. Billing Integrity Committee – advisory role<br>b. Independent audit committee – oversight | A. Compliance Plan requires significant revision. Key items include:<br>1. Add language relative to non-COM entities that contract with UMSA for billing/compliance services (ie. Infant Family Center – St. Pete, USF Student Health services, Communications Sciences & Disorders) |

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| | c. USF Chief Compliance Officer - reporting accountability<br>d. Deputy General Counsel/UMSA CEO – weekly/monthly meetings, or as identified<br>E. FY21 approved PIO budget<br>F. FY21 PIO staffing model | 2. Revise section 3.3 to reflect membership changes & change in responsibilities.<br>3. Revise section 3.4 and references throughout document to reflect current reporting accountability.<br>4. Remove section 3.4.2 – Internal Audit is not part of the Professional Integrity Office.<br>5. Remove section 3.5 - billing functions and related policies/workflows are now centralized under UMSA management.<br>6. Revise section 6.5 to reflect periodic review of program<br>7. GAP: Section 6.6 – Need to access/review current organizational process regarding exit interviews and tie to compliance involvement<br>8. Revise section 7.3 relative to authority regarding corrective actions/discipline<br><br>C. With expansion of CO job scope to include work outside of the COMFPP (ie. assisting COP with compliance matters), clarification is needed for both duties and related funding (USF Health vs. COM DSO). GAPs: COM clinical research compliance – need clarification for compliance oversight/audit and reporting responsibilities<br><br>E/F. Limited funding for compliance program, which aligns with industry trends, has shifted compliance focus from annual audits to risk based. PIO scope of work extends beyond traditional compliance office that only performs audits. PIO spends a significant amount of FTE on billing specific education/training. |

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| 2. Establish Standards and Procedures & related effective communication | A. Code of Conduct – is included in new hire and annual online training course; also posted on PIO website<br>*(See PIP Handbook)*<br><br>B. Compliance/Billing Integrity Policies - Policies are vetted with appropriate committees/service areas and then reviewed/discussed at the UMSA Practice Leadership Team monthly meetings. Ultimately, policies are approved by UMSA CEO unless such requires submittal to the UMSA EMC (generally those with financial implications).<br><br>PIO is developing an internal site, via Confluence, that will host all compliance and privacy policies.<br><br>Billing Integrity related policy updates are currently communication at monthly Clinical Department Administrator meetings and/or Clinical Provider/Master email distribution groups. | A. Code of Conduct should be reviewed by senior leadership to ensure alignment with USFH Culture Campaign.<br><br>B. Employee awareness of and access to Standards, Policies and Procedures is a risk.<br>• UMSA practice plan began work on internal site to host P&P; however with migration from Health to USF domain, host site no longer functional. UMSA leadership is currently pursuing new platform for hosting. PIO internal site will host P&P until new platform is ready.<br>• Formal process to review/approve P&P has been established by UMSA leadership, but communication of such policies to workforce members is not yet established. Challenges include uncertainty of membership within IT email distribution groups. |
| 3. Education & Training | Required education is hosted in the SABA LMS and includes:<br>Code of conduct (Code & sources for policies)<br>Medicare Parts C & D (Compliance/Fraud, Waste & Abuse)<br>HIPAA Privacy at USFH<br>and other courses as defined by managed care contracts. Mandatory courses are to be completed within 10 days of hire and annually thereafter. Monitoring of completion is done by the PIO.<br><br>New provider billing integrity orientation is required prior to submission of claims and provided by PIO billing | Risk: PIO has been unable to successfully leverage the SABA system to monitor outstanding training due to LMS system reporting limitations stemming from unreliable source feeds to SABA.<br>• Currently, there is no discrete field within the USF GEMS system that would identify if a USF employee supports in any capacity the Faculty Practice Plan. This requires a significant amount of manual work to identify those who are required to complete certain trainings. There is currently an unknown number of USF employees that require training who may not be taking such. |

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| | integrity staff with content specific to the provider licensure, specialty, and practice.<br><br>Ad Hoc training is also provided by the PIO as requested by clinical providers/staff or as need is identified by the PIO.<br><br>All training records are maintained for 10 years. | • The employee's manager is not consistently imported into SABA which affects management's ability to view "their team" training status in SABA for appropriate follow up.<br>• SABA reports have not been made available to clinical departments to accomplished expected monitoring of employees.<br>• Terminated employees are not automatically updating in SABA which overstates report findings.<br>A performance improvement plan was established with UMSA clinical systems regarding these gaps in SABA, however corrective action is dependent upon main campus IT collaboration with MIMs which has been significantly delayed.<br><br>PIO recently received a corrective action plan from one of our managed care plans for negative findings on required training completion. Therefore it is critical to resolve the above risks. |
| 4. Sanctions Screening | USF Health conducts screening via a third-party vendor software for UMSA credentialed providers, UMSA employees/vendors and USFH/COM employees that are known to support the practice plan.<br><br>Screening includes the following databases:<br><br>SAM - System for Award Management<br>OIG - Office of Inspector General<br>SDN - US Treasury OFAC Specially Designated Nationals<br>OCSL - US Treasury OFAC Consolidated Sanctions<br>FLM - Florida Health Care Medicaid Sanctions | PIO performs screening for USFH units outside of the UMSA DSO, such as PharmacyPlus, CON and GME.<br><br>Identification of COM or other USFH employees that "support the practice plan" are not identifiable by a discrete field in any existing database. This creates risk for an incomplete universe to be screened.<br><br>Multiple points of source data (GEMS, USF department delegated hiring processes, Cyborg, CODA) create risk for an incomplete universe. Processes have been continually revised over past 18 mo to improve screening compliance. |

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| | *See USF Health Care Policy 15, Federal Health Care Exclusions Review Process.*<br><br>Clinical Faculty and staff new hire letters of offer include language that employment is contingent upon successful screening.<br><br>Contract for vendor software, SanctionsCheck5, between UMSA and vendor is included in the PIO operating budget ($ 10,162/yr) for population of 5,000 employees & 6,000 vendors. Current subscription is scheduled for renewal on Feb. 19, 2021. | Vendors contracted via USF funds are not included in the PIO screening. |
| 5. Auditing, Monitoring & Investigating with response to concerns | A. Monitoring - Internal reviews are identified by risk analysis or request. Risk analysis is a combination of provider/service billing trends/outliers, HHS OIG workplan items, local carrier focused reviews, payer utilization notices or new services or codes. PIO previously used MDAudit software for monitoring activities. This software contract was not renewed upon expiration in July 2020. PIO is now utilizing CRA for monitoring and completed a pilot project Mar – Aug 2020.<br><br>Contract for vendor software, Compliance Risk Analyzer (CRA), between DoctorsManagement, LLC and UMSA is included in the PIO operating budget at $10,500/quarter. UMSA claims data is electronically uploaded to CRA. The software enables the PIO to focus limited resources on billing trend analysis/outliers, sample identification/reporting.<br><br>The monitoring workplan is fluid and reviewed monthly relative to new billing risks/trends, additions to OIG workplan, etc. | A. Monitoring policy is under revision to reflect change to risk-based monitoring and elimination of MDAudit; estimated completion Dec 2020.<br><br>GAPs:<br>• RCO surgical monitoring – Surgical services are included in PIO reviews when identified as risk. PIO working with RCO to establish process of periodic review of surgical coders.<br><br>B. RPP policy is under review and revisions are scheduled for completion in Dec 2020. Revisions include procedural updates for responsibilities and changes in reporting.<br><br>C. Ability to pull activity data on charge correction activity was affected by the transition from GE to EPIC PB billing systems in July 2019. PIO has recently established with the EPIC team identifiers that should allow such reporting. Testing of this data is anticipated for Jan 2021. |

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| | B. Reports of Potential Problems (RPPs) – PIO standards and procedures for receiving and following up on reports of concerns.<br><br>C. Charge correction policy – reflects obligation to return any federal overpayment within 60 days of identification as per Federal False Claims and Affordable Care Acts. | |
| 6. Incentive for Compliance & Discipline/corrective action for non-compliance | UMSA HR has included in annual performance evaluations a measure for meeting required training. UMSA CEO has established expectation of corrective action for noncompliance with compliance training. | In collaboration of respective department leaders, PIO is finalizing the corrective action progressive steps, based upon HR classification (UMSA, Residents/Fellows, USF staff, USF Faculty) for noncompliance with training. |
| 7. Open lines of Communication & Reporting Systems with related protection from relation | https://health.usf.edu/pio/report-concern<br><br>Helpline/inquiries<br>PIO hosts a "Helpline" for asking questions or reporting concerns. The helpline function offers both a phone and email POC. This contact info is published on the PIO website and all educational materials distributed by PIO.<br><br>PIO trends the quantity of inquiries received via the Helpline and direct team member contact.<br><br>Ethics Point | GAPs:<br>• need to identify methods other than email communication to promote awareness of these reporting systems<br>• need to provide workforce members vignettes on a periodic basis to bring awareness to scenarios/topics that should warrant reporting |

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| | PIO provides information relative to the University's anonymous reporting system in all new hire and annual training, as well as inclusion on the PIO website.<br><br>The Code of Conduct, Fraud, Waste & Abuse Prevention policy and the Nonretaliation policy each provide encouragement and protection for workforce members to report concerns. | |

# Healthcare and Privacy Compliance Programs Effectiveness Review and Validation

Jamie Sotelo & Barbara Wolodzko | May 24, 2022

UNIVERSITY of SOUTH FLORIDA

# Effectiveness Review

## Objectives

- Evaluate the effectiveness of program elements
- Identify gaps and opportunities for improvement

## Best practice

Every 5 years by an independent party

## Periodic

- Annual Attestations required for Medicare/Medicaid and shared savings programs
- Program audits by third party payers
- IT Security assessment

# Process

## Self-Assessment

Completed in June 2020

- Holistic higher-level approach
- Health Care Compliance Association (HCCA) and the Department of Health and Human Services (HHS) Office of Inspector General (OIG) Resource Guide

## Validation

Completed in January 2022 by Internal Audit (IA)

- Reasonable and logical methodology to use
- Identified opportunities/ gaps were accurate and supported
- Effectiveness of the program was measured in good faith

## Gaps and Opportunities

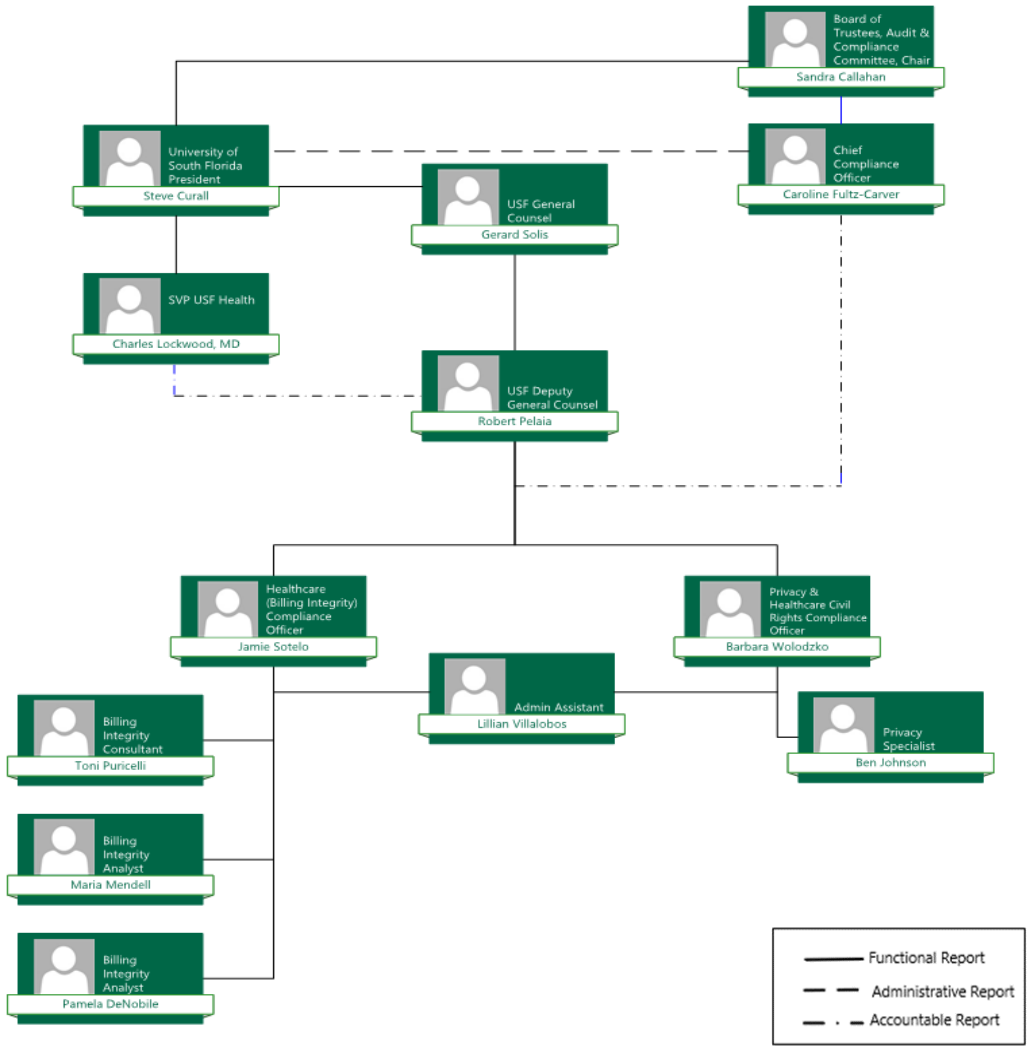
IA recommendations for next self assessment

- Awareness surveys
- Knowledge questionnaires
- Testing of program components to evaluate if functioning as intended

# Gaps/Opportunities

## Governance Structure

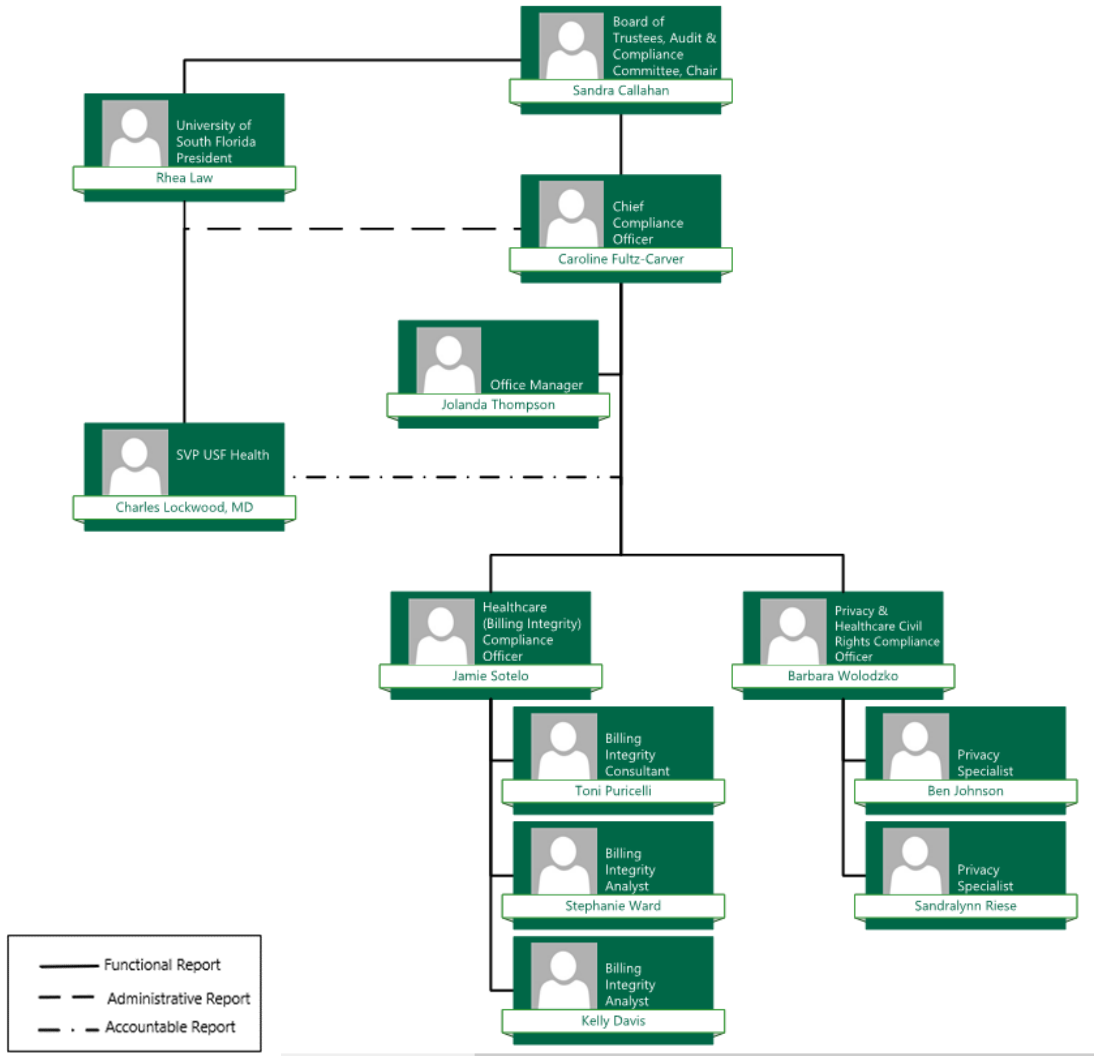
as of June 2020



# Gaps/Opportunities

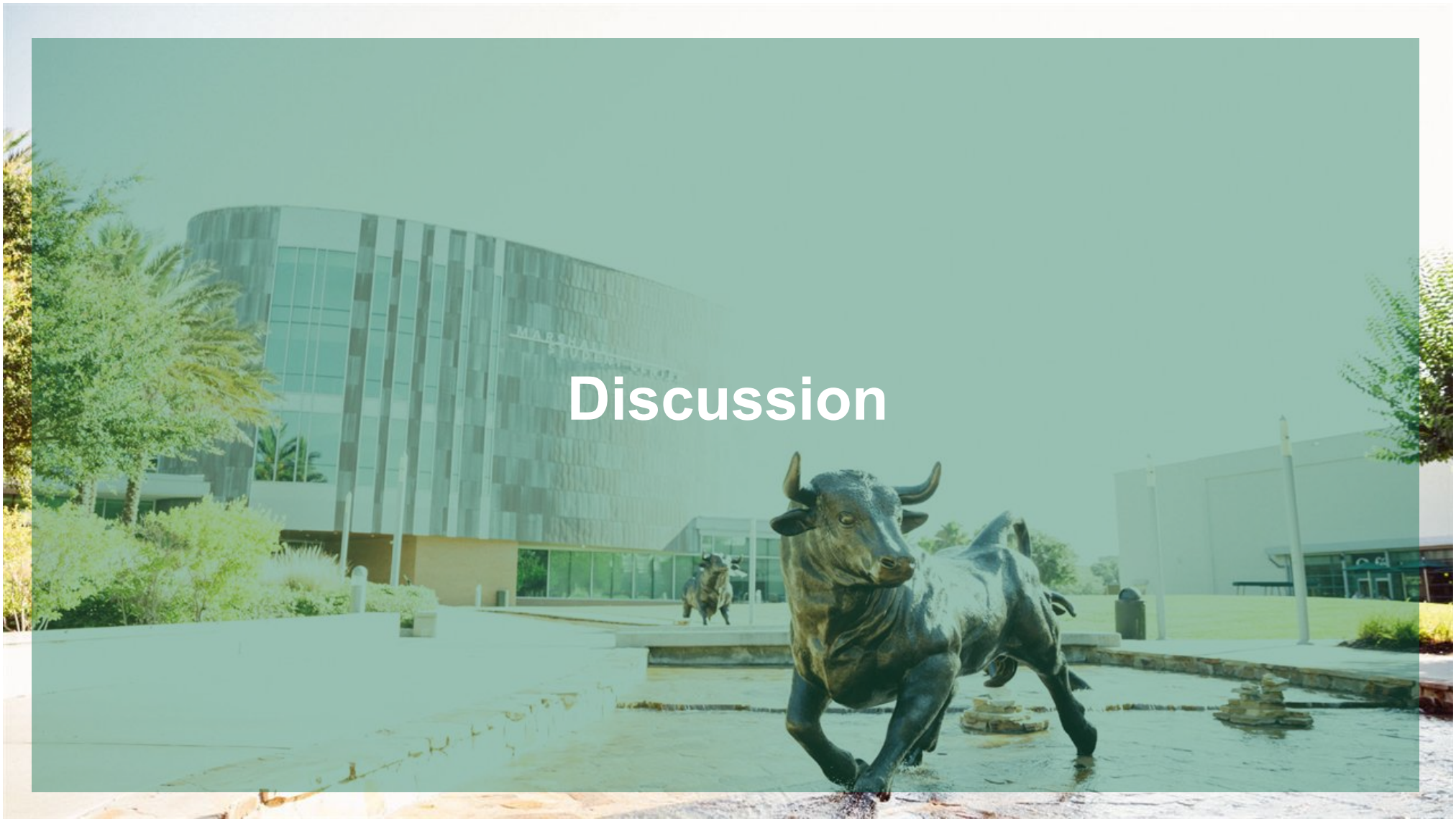
## Governance Structure

effective Aug 1, 2021



# Gaps and Opportunities: Action Items

- Ensure program policies and procedures and job descriptions accurately reflect current governance structure
- Address inadequate software support
  - Corporate LMS support/build
  - Role-based HR system data
- Address inadequate staffing and resources


Discussion