Corporate Compliance

METHODIST

Why Do I Need This Training?

For our compliance program to continue to be successful, every MHS employee and agent needs to understand their serious responsibility to report any suspected compliance issues.

It’s crucial that we do not personally, or as an organization, engage in any inappropriate or illegal behavior.

Examples of inappropriate and/or illegal behavior include:

- Falsifying, forging or altering records, bills, or other documents
- Stealing or misusing funds, supplies, property or other MHS resources
- Accessing or altering computer files or patient records without authority
- Falsifying reports to management or external agencies
- Violating the MHS Conflict of Interest policy
- Storing patient information on unsecured mobile devices
- Failing to comply with OSHA guidelines
- Accessing or sharing confidential information without a need-to-know

METHODIST

Corporate Compliance

There are six key areas that all MHS employees are required to review for annual compliance education:

1. Corporate Compliance Plan
2. False Claims Act
3. Conflict of Interest
4. HIPAA & Privacy
5. Monitoring & Reporting
6. Discipline for Non-Compliance

Corporate Compliance Plan

The **Corporate Compliance Plan** is applicable to all employees, agents, and affiliates of MHS. It is comprised of seven (7) key elements:

1. Standards, Policies, and Procedures
2. Compliance Program Oversight
3. Training and Education
4. Open Communication and Reporting Systems
5. Monitoring and Auditing
6. Corrective Action Plans
7. Discipline for Noncompliance

Key Contacts:

Shari Flowers, VP Compliance

Jen Anderson, Chief Compliance Officer

Anita Patterson, HIPAA Privacy Officer

Paula Pittman, VP Human Resources

Michael Kearns, Director Information Security

False Claims Act

The False Claims Act is a federal law that allows a civil lawsuit to be brought against a healthcare provider who does any of the following:

- Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval to the government or a government agency.
- Knowingly conceals or retains an over-payment made by the government or a government agency.
- Knowingly makes, uses or causes to be made or used a false record or statement material to a false or fraudulent claim.
- Conspires to defraud the government by getting a false or fraudulent claim allowed or paid.

METHODIST

So what is a false claim? Examples include…

- Billing for procedures not performed, or billing for 3 units when only 2 units were administered
- Incorrectly describing services or goods provided to a patient
- Retaining an over-payment made by Medicare or Medicaid
- Violating another law. For example, submitting a claim appropriately but the service involves an illegal kick-back to the physician for referrals.

And what's at stake?

The next page highlights a few examples of healthcare organizations that violated the False Claims Act (FCA) in 2019 and the extensive penalties they were required to pay….

METHODIST

January 28, 2019:

Avanti Hospitals LLC and six of its owners agreed to pay the federal government **$8.1 million** to settle claims that it violated the FCA by submitting false claims to Medicare and Medicaid programs. [link]

May 6, 2019:

Acadia Healthcare Company agreed to pay **$17 million** to resolve allegations of a billing scheme that allegedly defrauded Medicaid of $8.5 million. [link]

June 30, 2019:

Encompass Health Corporation, the nation's largest operator of inpatient rehabilitation centers, agreed to pay **$48 million** to resolve allegations that its centers provided medically unnecessary treatment, and submitted false information to Medicare for greater reimbursement. [link]

METHODIST

False Claims Act

If you see something that is not right, or looks like one of the examples of a false claim discussed earlier we encourage you to report it to your supervisor for further investigation. If you are not comfortable doing this or do not see action in response to your report, you have several options:

- Call the MHS Compliance Reporting Hotline: 877-640-0005 for English, 800-216-1288 for Spanish
- Submit a report online using the MHS Compliance Reporting link:
  - mhsintranet > Resources > Compliance
- Report directly to the federal Department of Justice: 202-514-2000 or AskDOJ@usdoj.gov

Both federal and state laws prohibit an employer from disciplining or terminating an employee because the employee reported or otherwise assisted in a false claims action.

METHODIST

Conflict of Interest

Legal issues can arise when employees mix personal interests with job duties. Specifically when there is a financial component. An employee may have a potential **conflict of interest** if they, or a member of their family, have a financial interest in a company that:

- Provides goods or services to MHS or an Affiliate
- Purchases goods or services for MHS or an Affiliate
- Engages in any other business or financial transaction with MHS or an Affiliate
- Directly competes with MHS or an Affiliate

Conflict of Interest

If a potential conflict exists, the Compliance team will assess the business transaction between the parties to ensure it's at fair market value as well as document how that decision was made.

To avoid any potential issues:

- Don't participate in activities that conflict with your position at MHS
- Don't accept personal gifts or favors from a patient, physician, contractor, supplier, customer, or anyone who does business with MHS (limited exceptions are detailed in the policy linked below).

If you have any questions about a potential conflict, talk with your Supervisor or the VP of Compliance.

METHODIST

HIPAA & Privacy

The HIPAA Privacy Rule was created to **protect patient privacy**; it includes a set of standards for how protected health information (PHI) can be used and disclosed.

Keep in mind that the HIPAA rules apply to our entire workforce: employees, physicians, students, temporary staff, and volunteers.

There are two facets that we need to take into consideration:

- Patient rights
- Our responsibilities as a “covered entity”

METHODIST

HIPAA & Privacy

Under HIPAA, patients have certain specific rights including:

- Receive a Privacy Notice
- Access their health record
- Amend (clarify or challenge) their medical record
- Request a list of when and why their confidential information was released
- Request restrictions on the use and disclosure of their confidential information
- File a complaint if they believe their rights were violated

METHODIST

Our responsibilities as a covered entity under HIPAA are many. To start, we must **ensure that we have written permission to disclose a patients PHI or confidential information** which includes, but is not limited to...

- Name, birthdate, or SSN
- Medical Record Number (MRN)
- Diagnosis
- Test results
- Social history
- Insurance and financial information

There are important exceptions to this rule, however...

METHODIST

We **do <u>not</u> require written authorization** to use or share a patient's PHI for the following purposes:

- Treatment
- Payment
- Health Care Operations

These exceptions allow us to work efficiently when providing care to our patients, billing for the services we provide, and doing various other activities needed to support our business.

Because state laws and our own policies may be stricter than HIPAA, always check with your Supervisor or the Privacy Officer if you are unsure if we need patient authorization.

METHODIST

What can be shared in the Hospital Directory, as allowed by HIPAA?

- Patient's Name
- Personal Information
- Location in Facility
- Medical Condition
- Religious Affiliation

If a patient requests to be No Info or VIP, the information above cannot be disclosed. The patient can make this request verbally or in writing.

METHODIST

As a covered entity we are also required to report any breaches and personally notify the affected patients in a timely manner. Because the notification must be made within a very short time, prompt reporting is critical.

Notify the HIPAA Privacy Officer immediately if you know or suspect that a patient's information has been inappropriately accessed or shared, even if it was simply an accident. Time is of the essence!

Remember, the principles of Just Culture are equitable and non-punitive. Timely reporting of breaches protects not only our patients, but also yourself and our organization.

METHODIST

There are simple but impactful ways to **help prevent the inappropriate access of PHI**...

- Log out of computer applications when they aren't being used, lock your computer when you step away, even just to refill your coffee.
- Speak quietly and avoid conversations about patients in public areas.
- Do not share confidential information unless the person you are sharing it with has a legitimate need-to-know; snooping is grounds for termination.
- Be a smart social media user; a patient can be identified even if you don't include their name.
- Do not access a family member's electronic health record unless there is a signed release of information on file with the Medical Records Department.

METHODIST

Monitoring & Reporting

There are numerous software applications in place that record and monitor activity in systems like email and Cerner, and look for information security incidents and weaknesses. Logs are regularly reviewed and analyzed for evidence of inappropriate or unusual activity.

MHS reserves the right to monitor and record the usage of all computing resources as necessary to evaluate and maintain system efficiency, ensure compliance with MHS policies and applicable laws and regulations, and monitor employee productivity.

MHS may use information obtained in disciplinary or criminal proceedings.

METHODIST

Every compliance concern, regardless of whether it is received via telephone, e-mail, or through the electronic compliance reporting system, is promptly and fully investigated.

Although we encourage you to provide your name when making a report, you can do so on an anonymous basis. All reports are investigated and handled in a strictly confidential manner.

To review your options for reporting visit the mhsintranet > Resources > Compliance.

Following the investigation, we take whatever corrective action is necessary and appropriate to make sure we are in full compliance with all applicable laws and regulations. Corrective action may include staff re-education, disciplinary action, system and/or process redesign.

METHODIST

Discipline for Non-Compliance

Anyone who knowingly violates MHS policy may face disciplinary action. This may include verbal or written warning, suspension, termination, suspension of the right to access the MHS IT Network, and/or termination of other privileges.

Depending on the circumstances and severity of the issue, MHS may also notify law enforcement officials, and regulatory, accreditation, and licensure organizations.

Medicare Parts C & D

General Compliance Training

METHODIST

Why Do I Need This Training?

Every year **billions** of dollars are improperly spent because of Fraud, Waste, and Abuse (FWA). It affects everyone – **including you**. This training helps you detect, correct, and prevent FWA. **You** are part of the solution.

Compliance is everyone's responsibility. As an individual who provides health or administrative services for Medicare enrollees, your every action potentially affects Medicare enrollees, the Medicare Program, or the Medicare Trust Fund.

About: Medicare Parts C & D

Medicare Part C, also known as Medicare Advantage (MA), is a health plan choice available to Medicare beneficiaries. Private, Medicare-approved insurance companies run MA programs. These companies arrange for, or directly provide, health care services to the beneficiaries who elect to enroll in an MA plan.

MA plans must cover all services Medicare covers with the exception of hospice care. They provide Part A and Part B benefits and may also include prescription drug coverage and other supplemental benefits.

METHODIST

About: Medicare Parts C & D

Medicare Part D, the Prescription Drug Benefit, provides prescription drug coverage to all beneficiaries enrolled in Part A and/or Part B who elect to enroll in a Medicare Prescription Drug Plan (PDP) or an MA Prescription Drug (MA-PD) plan.

Medicare approved insurance and other companies provide prescription drug coverage to individuals who live in a plan's service area.

METHODIST

Effective Compliance Program Requirements

The Centers for Medicare & Medicaid Services (CMS) requires Sponsors to implement and maintain an **effective compliance program** for its Medicare Parts C and D plans.

An effective compliance program must:

- Articulate and demonstrate an organization's commitment to legal and ethical conduct;
- Provide guidance on how to handle compliance questions and concerns; and
- Provide guidance on how to identify and report compliance violations.

Effective Compliance Program Requirements

An effective compliance program must:

Foster a culture of compliance within an organization and, at a minimum:

- Prevents, detects, and corrects non-compliance;
- Is fully implemented and is tailored to an organization's unique operations and circumstances;
- Has adequate resources;
- Promotes the organization's Standards of Conduct; and
- Establishes clear lines of communication for reporting non-compliance.

METHODIST

Effective Compliance Program Requirements

An effective compliance program is essential to **prevent, detect, and correct Medicare non-compliance and Fraud, Waste, and Abuse** (FWA).

It must, at a minimum, include the seven core compliance program requirements:

1. Written Policies, Procedures, and Standards of Conduct
2. Compliance Officer, Compliance Committee, and High-Level Oversight
3. Effective Training and Education
4. Effective Lines of Communication
5. Well-Publicized Disciplinary Standards
6. Effective System for Routine Monitoring, Auditing, and Identifying Compliance Risks
7. Procedures and System for Prompt Response to Compliance Issues

METHODIST

Effective Compliance Program Requirements

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7. Procedures and System for Prompt Response to Compliance Issues

METHODIST

Written Policies, Procedures, and Standards of Conduct

These articulate the Sponsor's commitment to comply with all applicable Federal and State standards and describe compliance expectations according to the Standards of Conduct.

Compliance Officer, Compliance Committee, and High-Level Oversight

The Sponsor must designate a compliance officer and a compliance committee that will be accountable and responsible for the activities and status of the compliance program, including issues identified, investigated, and resolved by the compliance program. The Sponsor's senior management and governing body must be engaged and exercise reasonable oversight of the Sponsor's compliance program.

METHODIST

Effective Training and Education

This covers the elements of the compliance plan as well as preventing, detecting, and reporting of FWA. Tailor this training and education to the different employees and their responsibilities and job functions.

Effective Lines of Communication

Make effective lines of communication accessible to all, ensure confidentiality, and provide methods for anonymous and good-faith reporting of compliance issues at Sponsor and First-Tier, Downstream, or Related Entity (FDR) levels.

METHODIST

Well-Publicized Disciplinary Standards

Sponsor must enforce standards through well-publicized disciplinary guidelines.

Effective System for Routine Monitoring, Auditing, and Identifying Compliance Risks

Conduct routine monitoring and auditing of Sponsor's and FDR's operations to evaluate compliance with CMS requirements as well as the overall effectiveness of the compliance program.

> **NOTE**: Sponsors must ensure that FDRs performing delegated administrative or health care service functions concerning the Sponsor's Medicare Parts C and D program comply with Medicare Program requirements.

Procedures and System for Prompt Response to Compliance Issues

The Sponsor must use effective measures to respond promptly to non-compliance and undertake appropriate corrective action.

Sponsors and Their FDRs

CMS expects all Sponsors will apply their training requirements and effective lines of communication to their FDRs (First-Tier, Downstream, or Related Entity).

Having effective lines of communication means employees of the Sponsor and the Sponsor's FDRs **have several avenues to report compliance concerns**.

Ethical Guidelines

As part of the Medicare Program, you must conduct yourself in an ethical and legal manner. **It's about doing the right thing!**

General Ethical Guidelines:

- Act fairly and honestly
- Adhere to high ethical standards in all you do
- Comply with all applicable laws, regulations, and CMS requirements
- Report suspected violations

METHODIST

Ethical Guidelines

Now that you've read the general ethical guidelines on the previous page, how do you know what is expected of you in a specific situation?

> **Standards of Conduct** (or Code of Conduct) state organization's compliance expectations and the principles and values. Contents will vary as Standards of Conduct should be tailored to each individual organization's culture and business operations. The MHS Code of Conduct is available on the Compliance page of the intranet.

Everyone has a responsibility to report Violations of Standards of Conduct and suspected non-compliance. An organization's Standards of Conduct and Policies and Procedures should identify this obligation and tell you how to report suspected non-compliance.

METHODIST

Non-Compliance

Non-compliance is conduct that does not conform to the law, Federal health care program requirements, or an organization's ethical and business policies. CMS has identified the following Medicare Parts C and D high risk areas:

- Agent/broker misrepresentation
- Appeals and grievance review (for example, coverage and organization determinations)
- Beneficiary notices
- Conflicts of interest
- Claims processing
- Credentialing and provider networks
- Documentation and Timeliness requirements
- Ethics
- FDR oversight and monitoring
- Health Insurance Portability and Accountability Act (HIPAA)
- Marketing and enrollment
- Pharmacy, formulary, and benefit administration
- Quality of care

METHODIST

Non-Compliance

Failure to follow Medicare Program requirements and CMS guidance can lead to serious consequences including **contract termination, criminal penalties, exclusion from participation in all Federal health care programs and civil monetary penalties**.

Additionally, your organization must have disciplinary standards for non-compliant behavior. Those who engage in non-compliant behavior may be subject to any of the following:

- Mandatory training or re-training
- Disciplinary action
- Termination

Non-Compliance

Without programs to prevent, detect, and correct non-compliance, we all risk the following:

Harm to beneficiaries, such as:

- Delayed services
- Denial of benefits
- Difficulty in using providers of choice
- Other hurdles to care

Less money for everyone, due to:

- High insurance copayments
- Higher premiums
- Lower benefits for individuals and employers
- Lower Star ratings
- Lower profits

METHODIST

How to Report Potential Non-Compliance:

Employees of a Sponsor: Call the Medicare Compliance Officer, make a report through your organization's website, or call the Compliance Hotline.

First-Tier, Downstream, or Related Entity (FDR) Employees: Talk to a Manager or Supervisor, call your Ethics/Compliance Help Line, or report to the Sponsor.

Beneficiaries: Call the Sponsor's Compliance Hotline or Customer Service, make a report through the Sponsor's website, or call 1-800-Medicare.

METHODIST

How to Report Potential Non-Compliance:

When you report suspected non-compliance in good faith, **the Sponsor cannot retaliate** against you. Each Sponsor must offer reporting methods that are:

Anonymous, Confidential and Non-Retaliatory

Sponsor's website, or call 1-800-Medicare.

METHODIST

Non-Compliance

In the event that non-compliance is detected it must be investigated immediately and promptly corrected.

Internal monitoring should continue to ensure:

- There is no recurrence of the same non-compliance
- Ongoing compliance with CMS requirements
- Efficient and effective internal controls
- Enrollees are protected

Internal Monitoring and Audits

Internal monitoring activities are regular reviews that confirm ongoing compliance and ensure that corrective actions are undertaken and effective.

Internal auditing is a formal review of compliance with a particular set of standards (for example, policies and procedures, laws, and regulations) used as base measures.

Summary

Compliance Is Everyone's Responsibility!

Prevent: Operate within your organization's ethical expectations to prevent non-compliance!

Detect & Report: If you detect potential non-compliance, report it!

Correct: Correct non-compliance to protect beneficiaries and save money!

Organizations must create and maintain compliance programs that, at a minimum, meet the seven core requirements. An effective compliance program fosters a culture of compliance.

METHODIST

Summary

Compliance Is Everyone's Responsibility!

To help ensure compliance, behave ethically and follow your organization's Standards of Conduct.

Watch for common instances of non-compliance, and report suspected non-compliance.

Know the consequences of non-compliance, and help correct any non-compliance with a corrective action plan that includes ongoing monitoring and auditing.

METHODIST

Fraud, Waste, and Abuse

Combating FWA in Medicare Parts C & D

METHODIST

Why Do I Need This Training?

As an individual who provides health or administrative services for Medicare enrollees, your every action potentially affects Medicare enrollees, the Medicare Program, or the Medicare Trust Fund. Every year **billions** of dollars are improperly spent because of Fraud, Waste, and Abuse (FWA). It affects everyone – **including you**.

This training helps you detect, correct, and prevent FWA. **You** are part of the solution. Combating FWA is everyone's responsibility.

Exception to FWA Training Requirement

FDRs meet the FWA training and education requirements if they met the FWA certification requirement through either:

- Accreditation as a supplier of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)
- Enrollment in Medicare Part A (hospital) or B (medical) Program

If you are unsure if this exception applies to you, contact your management team for more information.

Course Objectives

When you complete this course, you should be able to correctly:

- Recognize FWA in the Medicare Program
- Identify the major laws and regulations pertaining to FWA
- Recognize potential consequences and penalties associated with violations

Fraud Definition

Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program, or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program.

The Health Care Fraud Statute makes it a criminal offense to knowingly and willfully execute a scheme to defraud a health care benefit program. Health care fraud is punishable by imprisonment for up to 10 years. It is also subject to criminal fines of up to $250,000.

In other words, fraud is intentionally submitting false information to the government or a government contractor to get money or a benefit.

METHODIST

Waste & Abuse Definition

Waste includes practices that, directly or indirectly, result in unnecessary costs to the Medicare Program, such as overusing services. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.

Abuse includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

METHODIST

Differences Among FWA

There are differences among fraud, waste, and abuse. One of the primary differences is *intent* and *knowledge*.

Fraud requires intent to obtain payment **and the knowledge** that the actions are wrong.

Waste and abuse may involve obtaining an improper payment or creating an unnecessary cost to the Medicare Program, but **does not require the same intent and knowledge**.

METHODIST

To detect FWA, you need to know about the follow laws:

- Civil False Claims Act, Health Care Fraud Statute, and Criminal Fraud
- Anti-Kickback Statute
- Stark Statute (Physician Self-Referral Law);
- Exclusion
- Civil Monetary Penalties
- Health Insurance Portability and Accountability Act (HIPAA)

The next page will give an overview of these laws but for specific details, such as safe harbor provisions, consult the applicable statute and regulations.

METHODIST

Civil False Claim Act (FCA)

The civil provisions of the FCA make a person liable to pay damages to the Government if he or she knowingly:

- Conspires to violate the FCA
- Carries out other acts to obtain property from the Government by misrepresentation
- Conceals or improperly avoids or decreases an obligation to pay the Government
- Makes or uses a false record or statement supporting a false claim
- Presents a false claim for payment or approval.

For more information, refer to 31 United States Code (USC) Sections 3729-3733

METHODIST

Civil False Claim Act (FCA)

- Damages and Penalties: Any person who knowingly submits false claims to the Government is liable for three times the Government's damages caused by the violator plus a penalty.
- Whistleblower: is a person who exposes information or activity that is deemed illegal, dishonest, or violates professional or clinical standards.
- Protected: Persons who report false claims or bring legal actions to recover money paid on false claims are protected from retaliation.
- Rewarded: Persons who bring a successful whistleblower lawsuit receive at least 15 percent but not more than 30 percent of the money collected.

METHODIST

Health Care Fraud Statute

The Health Care Fraud Statute states, “Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice to defraud any health care benefit program … shall be fined under this title or imprisoned not more than 10 years, or both.” Conviction under the statute does not require proof the violator had knowledge of the law or specific intent to violate the law.

For more information, refer to 18 USC Sections 1346–1347.

Criminal Fraud

Persons who knowingly make a false claim may be subject to:

- Criminal fines up to $250,000
- Imprisonment for up to 20 years

If the violations resulted in death, the individual may be imprisoned for any term of years or for life.

For more information, refer to 18 U.S.C. Section 1347 on the Internet.

Stark Statute

The Stark Statute prohibits a physician from making referrals for certain designated health services to an entity when the physician (or a member of his or her family) has:

- An ownership/investment interest or
- A compensation arrangement

Exceptions may apply. For more information, refer to 42 USC Section 1395nn.

Civil Monetary Penalties

The Office of Inspector General (OIG) may impose Civil penalties for several reasons, including:

- Arranging for services or items from an excluded individual or entity
- Providing services or items while excluded
- Failing to grant OIG timely access to records
- Knowing of and failing to report and return an overpayment
- Making false claims
- Paying to influence referrals

METHODIST

Civil Monetary Penalties

The penalties range from $15,000 to $70,000 depending on the specific violation.

Violators are also subject to three times the amount:

- Claimed for each service or item or
- Of remuneration offered, paid, solicited, or received.

For more information, refer to the Act, Section 1128A(a).

Exclusion

No Federal health care program payment may be made for any item or service furnished, ordered, or prescribed by an individual or entity excluded by the OIG.

The OIG has authority to exclude individuals and entities from federally funded health care programs and maintains the List of Excluded Individuals and Entities (LEIE).

METHODIST

Exclusion

The U.S. General Services Administration (GSA) administers the Excluded Parties List System (EPLS), which contains debarment actions taken by various Federal agencies, including the OIG. You may access the EPLS on the System for Award Management (SAM) website.

When looking for excluded individuals or entities, check both the LEIE and the EPLS since the lists are not the same.

For more information, refer to 42 USC Section 1320a-7 and 42 Code of Federal Regulations (CFR) Section 1001.1901.

METHODIST

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA created greater access to health care insurance, strengthened the protection of privacy of health care data, and promoted standardization and efficiency in the health care industry.

HIPAA safeguards deter unauthorized access to protected health care information. As an individual with access to protected health care information, you must comply with HIPAA.

Damages and Penalties Violations may result in Civil Monetary Penalties. In some cases, criminal penalties may apply.

For more information, visit http://www.hhs.gov/ocr/privacy.

METHODIST

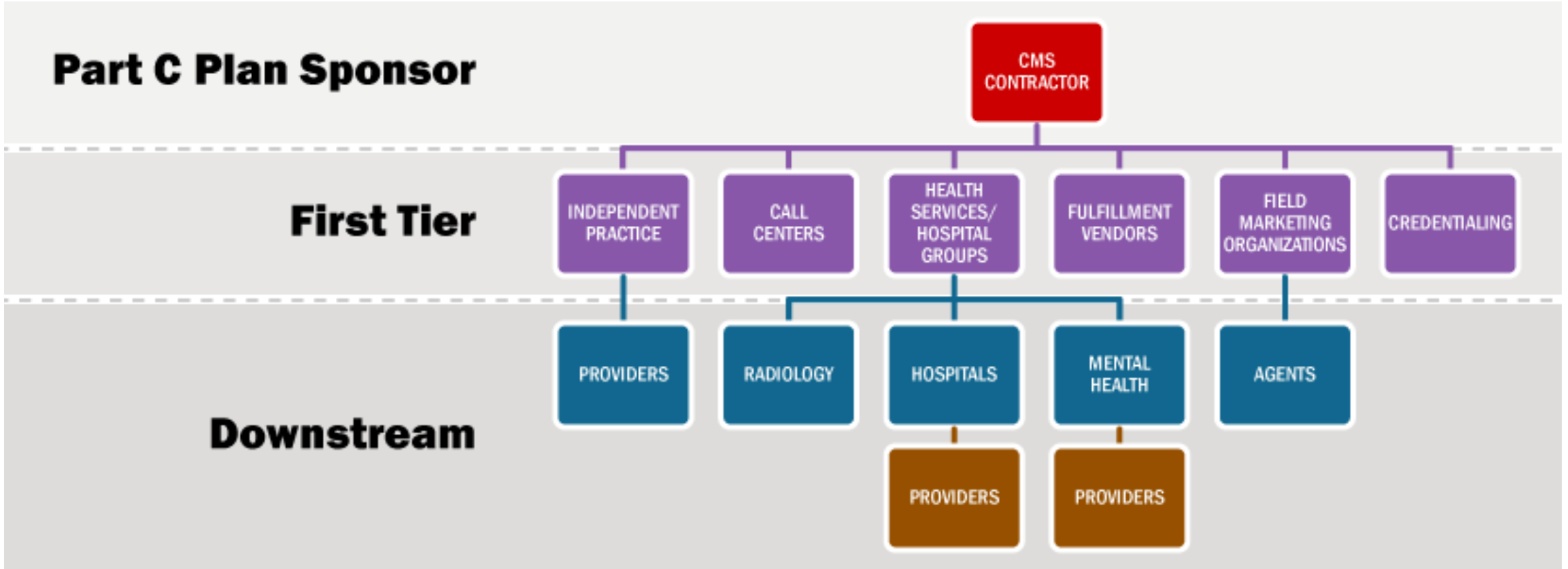
Where Do I Fit In?

As a person who provides health or administrative services to a Medicare Part C or Part D enrollee, you are likely an employee of a:

- Sponsor (Medicare Advantage Organization [MAO] or a Prescription Drug Plan [PDP])
- First-tier Entity (ex: Pharmacy Benefit Management [PBM]; hospital or health care facility; provider group; doctor's office; clinical laboratory; customer service provider; claims processing and adjudication company; a company that handles enrollment, disenrollment, and membership functions; and contracted sales agents)
- Downstream Entity (ex: pharmacies, doctor's office, firms providing agent/broker services, marketing firms, and call centers)
- Related Entity (ex: Entity with common ownership or control of a Sponsor, health promotion provider, or SilverSneakers®)

METHODIST

Where Do I Fit In?



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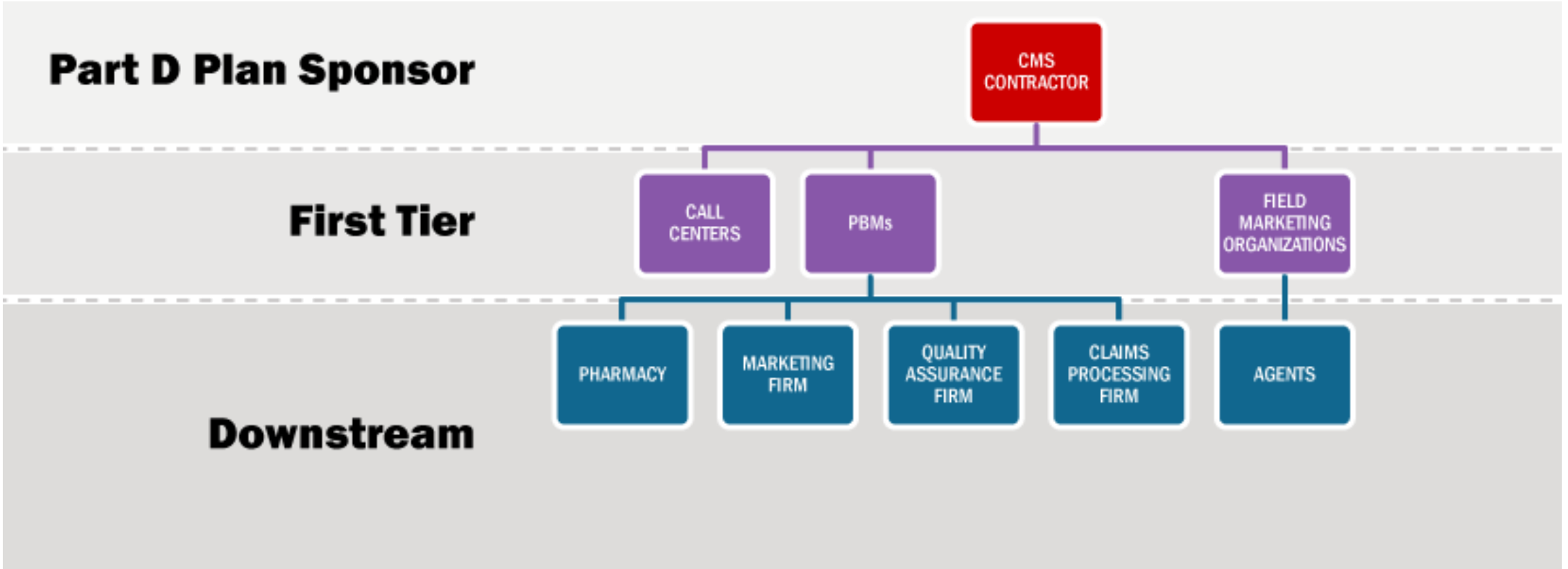

METHODIST

Responsibilities

You play a vital part in preventing, detecting, and reporting potential FWA, as well as Medicare non-compliance.

FIRST, you must comply with all applicable statutory, regulatory, and other Medicare Part C or Part D requirements, including adopting and using an effective compliance program.

SECOND, you have a duty to the Medicare Program to report any compliance concerns, and suspected or actual violations that you may be aware of.

THIRD, you have a duty to follow your organization's Code of Conduct that articulates your and your organization's commitment to standards of conduct and ethical rules of behavior.

METHODIST

Preventing FWA

- Look for suspicious activity
- Conduct yourself in an ethical manner
- Ensure accurate and timely data/billing
- Ensure you coordinate with other payers
- Know FWA policies and procedures, standards of conduct, laws, regulations, and CMS guidance
- Verify all received information
- Know your entity's policies and procedures.
  - Every Sponsor and FDR must have policies and procedures that address FWA. These procedures should help you detect, prevent, report, and correct FWA.

Preventing FWA

Standards of Conduct should describe the Sponsor's expectations that:

- All employees conduct themselves in an ethical manner
- Appropriate mechanisms are in place for anyone to report noncompliance and potential FWA
- Reported issues will be addressed and corrected

Standards of Conduct communicate to employees and FDRs compliance is everyone's responsibility, from the top of the organization to the bottom

METHODIST

Reporting FWA

Every Sponsor must have a mechanism for reporting potential FWA by employees and FDRs. Each Sponsor must accept anonymous reports and cannot retaliate against you for reporting. Review your organization's materials for the ways to report FWA. When in doubt, call your Compliance Department or FWA Hotline.

Everyone must report suspected instances of FWA. Your Sponsor's Code of Conduct should clearly state this obligation. Sponsors may not retaliate against you for making a good faith effort in reporting. Report any potential FWA concerns you have to your compliance department or your Sponsor's compliance department. Your Sponsor's compliance department will investigate and make the proper determination. Often, Sponsors have a Special Investigations Unit (SIU) dedicated to investigating FWA. They may also maintain an FWA Hotline.

METHODIST

Reporting FWA Outside MHS

If warranted, Sponsors and FDRs must report potentially fraudulent conduct to Government authorities, such as the Office of Inspector General, the Department of Justice, or CMS.

Individuals or entities who wish to voluntarily disclose self-discovered potential fraud to OIG may do so under the Self-Disclosure Protocol (SDP).

Self-disclosure gives providers the opportunity to avoid the costs and disruptions associated with a Government directed investigation and civil or administrative litigation.

METHODIST

Reporting FWA Outside MHS

When reporting suspected FWA, you should include:

- Contact information for the information source, suspects, and witnesses
- Alleged FWA details
- Alleged Medicare rules violated
- The suspect's history of compliance, education, training, and communication with your organization or other entities

Correction

Once fraud, waste, or abuse has been detected, promptly correct it. Correcting the problem saves the Government money and ensures you are in compliance with CMS requirements.

Develop a plan to correct the issue. Ask your organization's compliance officer about the development process for the corrective action plan. The actual plan is going to vary, depending on the specific circumstances.

Correction

In General:

- Design the corrective action to correct the underlying problem that results in FWA program violations and to prevent future noncompliance.
- Tailor the corrective action to address the particular FWA, problem, or deficiency identified. Include timeframes for specific actions.
- Document corrective actions addressing noncompliance or FWA committed by a Sponsor's employee or FDR's employee, and include consequences for failure to satisfactorily complete the corrective action.
- Monitor corrective actions continuously to ensure effectiveness.

METHODIST

Potential **Beneficiary** Issues

- Does the prescription, medical record, or laboratory test look altered or possibly forged?
- Does the beneficiary's medical history support the services requested?
- Have you filled numerous identical prescriptions for this beneficiary, possibly from different doctors?
- Is the person receiving the medical service the actual beneficiary (identity theft)?
- Is the prescription appropriate based on the beneficiary's other prescriptions?

METHODIST

Key Indicators

Potential **Provider** Issues

- Are the provider's prescriptions appropriate for the member's health condition (medically necessary)?
- Does the provider bill the Sponsor for services not provided?
- Does the provider write prescriptions for diverse drugs or primarily for controlled substances?
- Is the provider performing medically unnecessary services for the member?
- Is the provider prescribing a higher quantity than medically necessary for the condition?
- Is the provider's diagnosis for the member supported in the medical record?

Potential **Pharmacy** Issues

- Are drugs being diverted (drugs meant for nursing homes, hospice, and other entities being sent elsewhere)?
- Are the dispensed drugs expired, fake, diluted, or illegal?
- Are generic drugs provided when the prescription requires that brand drugs be dispensed?
- Are PBMs being billed for prescriptions that are not filled or picked up?
- Are proper provisions made if the entire prescription cannot be filled (no additional dispensing fees for split prescriptions)?
- Do you see prescriptions being altered (changing quantities or Dispense As Written)?

Potential **Wholesaler** Issues

- Is the wholesaler distributing fake, diluted, expired, or illegally imported drugs?
- Is the wholesaler diverting drugs meant for nursing homes, hospices, and Acquired Immune Deficiency Syndrome (AIDS) clinics and then marking up the prices and sending to other smaller wholesalers or pharmacies?

Potential **Manufacturer** Issues

- Does the manufacturer promote off-label drug usage?
- Does the manufacturer provide samples, knowing that the samples will be billed to a Federal health care program?

METHODIST

Potential **Sponsor** Issues

- Does the Sponsor encourage/support inappropriate risk adjustment submissions?
- Does the Sponsor lead the beneficiary to believe that the cost of benefits is one price, only for the beneficiary to find out that the actual cost is higher?
- Does the Sponsor offer cash inducements for beneficiaries to join the plan?
- Does the Sponsor use unlicensed agents?

METHODIST

Summary

As a person providing health or administrative services to a Medicare Part C or D enrollee, **you play a vital role in preventing fraud, waste, and abuse (FWA).** Conduct yourself ethically, stay informed of your organization's policies and procedures, and keep an eye out for key indicators of potential FWA.

Report potential FWA. Every Sponsor must have a mechanism for reporting potential FWA. Each Sponsor must accept anonymous reports and cannot retaliate against you for reporting.

Promptly correct identified FWA with an effective corrective action plan.

METHODIST

Patient Rights & Responsibilities

Our Meaning of Care culture calls for a posture and environment committed to safety and minimizing risk. Safety of our patients, customers, visitors, and employees is our first priority.

Continuous monitoring and evaluation of our processes is vital. **Each person has accountability for safe practices and initiating actions to resolve the unsafe behavior.**

METHODIST

Patient Rights & Responsibilities

Our patients expect the following:

- Provide a clean and quiet environment
- Communicate clearly about our role by introducing ourselves and telling them about our skills
- Provide the right procedure/medication/diagnostic test/meal, every time
- Protect them from harm (hospital acquired infections, falls, med errors)
- Communicate clearly the plan for the visit/day/stay
- Educate about self-care after discharge

A patient has the right to personal dignity, to express their needs, and to be involved in making decisions regarding their care.

METHODIST

Patient Rights & Responsibilities

Specific **patient rights** include...

- Access to medical services
- Respect and dignity
- To know the identity and professional status of care provider
- Privacy and confidentiality
- Personal safety
- To communicate with people outside the facility, unless physician determines this will hinder treatment
- To participate in healthcare decisions
- Be included in the information on the treatment plan

METHODIST

Patient Rights & Responsibilities

Specific **patient rights** include...

- Billed only for services provided
- Pain management needs met
- Be protected and respected during research, experimentation, or clinical trials
- Consult with a specialist upon request
- Consent, refuse, or limit treatment
- Transfer to another facility with a complete explanation for reason of transfer, and to be informed of continuing care following discharge
- Receive information in a manner they can understand
- Freedom from neglect, exploitation; and verbal, mental, sexual, and physical abuse, or unnecessary restraints, unless clinically necessary, and to have access to protective and advocacy services

METHODIST

Patient Rights & Responsibilities

Specific **patient responsibilities** include the following:

- Provide correct and complete information about their current health complaints, prior illnesses, hospitalizations, medications, and changes in matters relating to their health
- Comply with hospital or clinic rules
- Cooperate with staff as they implement the ordered plan of care
- Provide copies of their Advance Directives (Living Will or Durable Power of Attorney for Healthcare)

Patient Rights & Responsibilities

Specific **patient responsibilities** include the following:

- Be responsible for their actions if treatment or instructions refused
- Assure financial obligations are fulfilled as promptly as possible
- Be considerate of the rights of other patients, staff, assist in noise control of their visitors, and respect the property of others
- Responsible for any property/valuables kept in their possession

Advance Directive

An advance directive is any written instrument which documents a patient's healthcare choices, or which appoints/designates another individual to make healthcare choices on behalf of the patient, only when patient is incapable of making their own decisions.

A patient's Advance Directive status is documented on the patient's medical record. Methodist Health System understands adult patients generally have the right to agree, to refuse, or otherwise limit, the medical care they receive. We will respect this right in accordance with state law.

It is the responsibility of the patient or family member to provide a copy of the Advance Directive to healthcare providers. The patient keeps the original.

METHODIST

Advance Directive

There are two types of Advance Directives recognized under NE and IA law:

- Living Will Declaration of the Rights of the Terminally Ill Act
- Durable Power of Attorney for Healthcare

A Power of Attorney for Health Care designates an agent to make health care decisions for you. A Living Will provides specific instructions about treatments desired and not desired.

Both documents come into effect at any point in your health care when you are unable to make or communicate your own decisions.

METHODIST

Advance Directive

Internal Resources

- Chaplin
- Social Worker
- Administrative Coordinator or House Supervisor

External Resources

- Nebraska Emergency Treatment Order (NETO)
- Iowa Physician Order for Scope of Treatment (IPOST)

NETO & IPOST combine a clear & succinct living will with actionable orders for Emergency Medical Services regarding CPR, intubation & transport.

METHODIST

Matters of Conscience

Working in the healthcare industry, there may come a time when you're uncomfortable performing certain tasks or procedures due to personal beliefs. Examples may include: termination of pregnancy, termination of life support systems, administering certain medications, and treating patients with communicable diseases.

If this happens, take the following action:

- Express your objections to your supervisor in writing, in advance
- Ask not to be assigned to that type of duty in the future

METHODIST

The care of the patient is the top priority.

Every reasonable attempt will be made to accommodate such requests, however, if a reasonable accommodation is not possible, patient care will not be compromised. You will be required to complete the care of the patient.

For ongoing concerns, talk to your supervisor.

Ethics in Healthcare Decisions

We have processes in place for the ethical dispute resolution that provides assistance to clinical staff, patients, and their families in managing ethical issues and disputes. These services are available 24/7.

In the event of an issue, concerns should be directed toward the following:

MH & MWH: Service Leader or Administrative Coordinator (after hours)

MJE: Director, House Supervisor, Vice President of Medical Affairs

MPC: Direct Supervisor

MFH: Supervisor, Chair & Co-Chair of Ethics Committee

METHODIST

Do you know about the **benefits of providing culturally competent care and service**?

Social Benefits: Fosters mutual respect between patient and provider and organization, increases trust, promotes patient and family responsibility for health, promotes inclusion of all community members.

Health Benefits: Improves patient data collection, increases preventative care, reduces care disparities between different populations, decreases number of missed medical visits, reduces medical errors and overtreatment.

Business Benefits: Incorporates different perspectives, ideas, and strategies into the decision-making process. Decreases barriers that slow progress. Improves efficiency of services. Increases market share of the organization.

METHODIST

Cultural Competence

Use this self-assessment to heighten awareness and sensitivity to culture and language differences:

- When interacting with individuals who speak limited English, do I utilize my translation resources appropriately? Am I patient and respectful?
- While at work, do I impose values and opinions that might conflict with those I'm serving?
- Would I intervene in a situation where others are behaving in ways that show cultural insensitivity, racial bias, or prejudice of any kind?
- Do I accept that family and gender roles are defined differently among different cultures?
- Do I make an effort to continue educating myself and sharpening my skills so that I'm able to provide culturally competent care and service?

Adapted from Tawara D. Goode ▪ National Center for Cultural Competence ▪ Georgetown University Center for Child & Human Development

METHODIST

Interpreter Services / Resources

MHS and its clinical business units identify patients with limited English language skills, or a hearing impairment, and provide resources to ensure effective communication with these individuals. MHS utilizes an interpreting service called MARTTI – “My Actual Real-Time Trusted Interpreter”. If MARTTI is not available in your area, reference the Interpreter tab under Resources on the mhsintranet.

Signs are posted at patient entry points explaining that interpreter services are offered at no cost to the patient. Keep in mind, children and family members are not to be used for interpreting services.

If an employee has questions they should contact their supervisor for assistance.

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