

# General Office of Compliance and Ethics Program Training

2016 JHS Annual Mandatory Education



# Introduction to Training

# General Compliance Training Instructions

- This presentation is an annual update of the Office of Compliance and Ethics training, which is designed for all employees, students, vendors, contractors and volunteers of the Public Health Trust/Jackson Health System (JHS) to complete using Jackson's Education Network (JEN)
- In order to complete this training and receive full credit you must:
  - Review the complete power point presentation materials
  - Complete the exam and pass with a score of 80% or better
  - Agree to abide by the Compliance Standards and Code of Conduct, by checking the appropriate acceptance box on the test

If you have any questions, please contact the JHS Compliance Office at (305) 585-2902

# Objectives of the Training

- Introduce the JHS Compliance and Ethics Program
- Understand the need for a Compliance Program
- Discuss the elements of JHS' Compliance and Ethics Program
- Overview of the Standards & Code of Conduct
- Use of Compliance Hotline
- Discuss fraud, abuse and laws that regulate health care

# Annual Compliance Training

- All new employees, agents, contractors and vendors must receive training **within 30-days of hire**
- Annual Training” means the General Compliance Training for all employees during the calendar year.
- Annual deadline – **September 30, 2016 (or 30 days after hire for those who were hired after September 12, 2016)**
- General Annual Compliance Training
  - Increase awareness through examples
  - Mandatory – All employees are required to participate in JHS’s General Compliance Training Program as a condition of employment.
- JHS Policy # 306-Mandatory Education
  - Employees who fail to complete annual mandatory education requirements as required may be suspended immediately and not permitted to work.

# Introduction to Compliance

# What is Compliance?

- Abiding by all applicable laws, regulations, and policies
  - We have laws from the FEDERAL, STATE & COUNTY levels. In addition, we have specific JHS Policies and Procedures.
- Recognizing areas of vulnerability
  - Your awareness of Compliance issues can help you do your job to the very best of your abilities
- Reporting suspicious and/or improper activities
  - Once aware of an issue, it is your duty, as a JHS employee, to report the issue
- Promoting ethical behavior throughout JHS
  - A culture of Compliance will allow us to meet the mission of our organization

# Compliance is a Core Part of Our Mission

- Compliance matters – it is not a detail, it is a core responsibility
- Jackson expects all employees and contractors to comply with the law when carrying out their duties
- There are no exceptions
- **Compliance is not a barrier to good clinical care, teaching and community service – it is an essential component**

# Why Be a Compliant Employee?

- **To Help ensure Jackson Health System (organization):**
  - Maintains its commitment to ethical behavior
  - *Improves* the quality of patient care
  - Continue to be a world-class health care system for the residents of Miami-Dade County
- **How does being Compliant help you (individual)?**
  - The mission of the organization is to provide *quality care* and your role, whether a clinician in direct patient care or not, serves that purpose. Being within the laws and regulations makes you better at your job.
  - Being Compliant helps you avoid disciplinary action.
  - Being Compliant keeps you with the *JHS values* you came to be a part of when you joined our organizational team

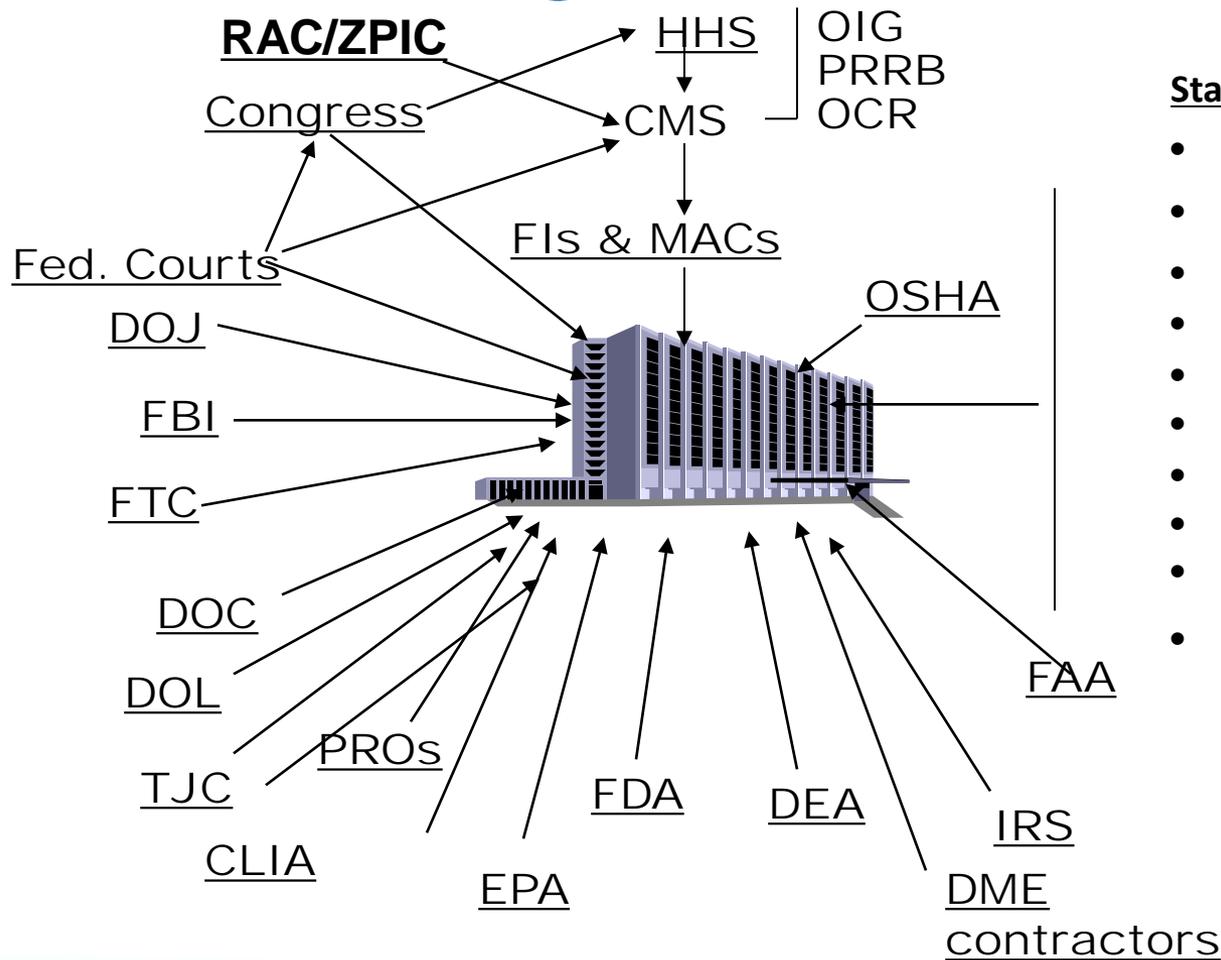
# JHS Values

- Service Excellence & Quality
- Commitment
- Compassion
- Teamwork & Communication
- Respect
- Confidentiality
- Integrity and Stewardship
- Inclusion



# Health Care Industry Compliance Environment

# The Compliance Environment: Regulators of JHS



# Who are Some of our Regulators?

- CLIA – Clinical Laboratory Improvement Act
- CMS – Centers for Medicare & Medicaid Services
- DCF – Department of Children and Families
- DEA – Drug Enforcement Agency
- DOC – Department of Corrections
- DOJ – Department of Justice
- DOL – Department of Labor
- EPA – Environmental Protection Agency
- FAA – Federal Aviation Administration
- FBI – Federal Bureau of Investigation
- FI – Fiscal Intermediary
- FDA – Food & Drug Administration
- FTC – Federal Trade Commission
- HHS – Health and Human Services
- IRS – Internal Revenue Service
- MAC – Medicare Administrative Contractors
- NIOSH – National Institute for Occupational Safety
- OCR – Office for Civil Rights
- OIG – Office of Inspector General
- OSHA – Occupational Safety & Health Administration
- PROs – Professional Review Organizations
- PRRB – Provider Reimbursement Review Board
- RAC – Recovery Audit Contractor
- TJC – The Joint Commission
- ZPIC – Zone Program Integrity Contractor

# Why is the Compliance Environment important?

- **Evolution of Compliance:** in the last 25 years has transitioned to nearly every aspect of Health Care Operations having Government oversight and enforcement
  - Examples: Documentation, Billing, Quality, etc.
- **From the Government's perspective:**
  - Government oversight and enforcement leads to, as an example, \$8 for every \$1 they spend sending an investigator or performing oversight duties
- **Combination** = A highly incentivized Government will be looking into what we are doing closer than ever

# 2014 Health Care Fraud Recovery Statistics

- In 2014:
  - 4,017 Individual and entity exclusions
  - 971 criminal actions; 533 civil actions
  - Nearly \$1 billion in audit recoveries
  - Over \$4 billion through investigations
  - \$3.8 billion in settlements and judgments for civil cases; over \$17 billion since January 2009.
- ROI for 2011-2013 is \$8.01 for every \$1.00 expended.
- IOM Report: 30 cents for every dollar spent in healthcare service organizations in the U.S. is wasted, up to \$750 billion every year.
  - 10% is due to fraudulent activity

# JHS Response to Compliance Environment

- A Compliance Program aimed at specific “Compliance Blocks” (see visual on next slide) of operational areas the Compliance team positively affects
- A Compliance Program intended to serve as more than just oversight, but also a resource to operations
- Adding Value to the Organization through a culture of Compliance

# Compliance Blocks



# How the Compliance Program Works

# Compliance Program Framework

- **Designated Chief Compliance Officer** – monitors compliance efforts and enforce practice standards throughout the organization
- **Written Standards of Conduct** – policies, procedures and other operating guidelines that promote JHS' commitment to compliance and address specific areas of potential fraud
- **Effective Compliance Education and Training** – development and implementation of regular and effective training
- **Internal Monitoring and Auditing** – use of risk evaluation and audits to monitor compliance and reduce problems (annual Compliance Audit Plan)
- **Effective Lines of Communication** – including a system to receive, record and respond to compliance questions or reports of potential non-compliance (Compliance HOTLINE)
- **Procedures for Responding to Detected Offenses** – mechanism to respond and initiate a timely and reasonable inquiry
- **Corrective Action Process** – remediation of identified issues to consistently enforce standards (including non-hiring of sanctioned persons)

# Standards & Code of Conduct

- JHS is committed to conducting its business lawfully and ethically
- JHS' reputation is the sum of the reputation of its employees, so it is critical that all employees perform their duties in accordance with the legal and ethical standards
- All employees/vendors must review and abide by the JHS Compliance Standards and Code of Conduct
- **Together, we must have increased awareness to detect and ultimately prevent violations!**

# Standards & Code of Conduct

- Non-Discrimination
- Non-Retaliation
- Quality of Service to our Patients
- Contract Negotiations
- Marketing and Advertising Activities
- Anti-Trust and Trade Laws
- Fraud and Abuse Issues
- Charging Cost/Time Card Reporting
- Billing and Reimbursement
- Emergency Care
- Advance Directives and Patient and Resident Rights
- Receipt of Business Courtesies

# Auditing and Monitoring: Office of Compliance and Ethics Annual Work Plan

- Items included in the work plan are based on:
  - Internal Risk Assessments
  - Office of Inspector General (OIG) Annual Work Plan
  - OIG Fraud Alerts
  - Government Investigations and Settlements
  - Medicaid Fraud Control Unit investigations
  - CMS/OIG reports
  - Health Care Industry Issues

# CMS Program Recovery Audit Contractor (RAC)

- **RAC Detects and corrects past improper payments**
  - To deter providers from submitting improper claims to Medicare
    - DRG coding based on incomplete or poorly documented medical records
    - Medical necessity/appropriate level of care for patients who did not meet guidelines for admission
  - Reduce Medicare improper payments through:
    - Efficient detection and collection of overpayments
    - The identification of underpayments
- **JHS' Current Process:**
  - Identifying where improper payments have been persistent by reviewing and identifying any patterns of denied claims within our own facilities
  - Identifying and implementing specific corrective actions to ensure compliance with Medicare's requirements and to avoid submitting incorrect claims in the future

# Zone Program Integrity Contractors (ZPIC)

- In 2003, The Medicare Modernization Act (MMA) was signed into law. § 911 of the MMA directed implementation of Medicare Fee-For –Service Contracting Reform which, required CMS to use competitive procedures to replace its current FIs and Carriers with a uniform type of administrative entity, referred to as Medicare Administrative Contractors (MACs)
- As a result, seven program integrity zones were created based on the newly established MAC jurisdictions. New entities entitled Zone Program Integrity Contractor (ZPICs) were created to perform program integrity functions in these zones for Medicare part A,B, Durable Medical Equipment Prosthetics, Orthotics, and supplies, Home Health and Hospice and Medicare-Medicaid data marching. ZPICs work under the direction of the Center for Program Integrity (CPI) in CMS
- Safeguard Services(SGS)=Florida

# JHS Administrative Corrective Action Policy # 306

## GENERAL GUIDELINES:

Employees are expected to understand and follow job and workplace performance standards and to take advantage of the many resources available to support successful performance. Supervisors may use coaching, feedback, performance improvement plans and corrective action to assist and guide them in resolving unsatisfactory job performance, misconduct or behavior that violates JHS policies, procedures or practices

- These resources include:
  - Organizational, department and job-specific orientations for new staff
  - Review and discussion of the JHS New Employee Orientation Handbook (located on JHS intranet)
  - Review and discussion of department and work unit expectations
  - Regular dialogue between supervisor and staff regarding performance and future expectations and goals
- Any employee may be **reprimanded, suspended, demoted or terminated** by a Vice President, Chief Nursing Officer, Division Director, or designee as approved in JHS Policy & Procedure Manual Code No. 100.07 Delegation of Authority for any good and sufficient reason

# Selected Laws, Regulations & Policies

# Certain Laws and Regulations

- Title XVIII of the Social Security Act
- Patient Protection and Affordable Care Act
- The Stark Law
- The Anti-Kickback Statute
- Deficit Reduction Act
- The False Claims Act
- Civil Monetary Penalties
- Florida Sunshine Law
- EMTALA
- Conflict of Interest



# Title XVIII of the Social Security Act

- Created the “Health Insurance for the Aged and Disabled” commonly known as **Medicare**
- Divided into Subparts:
  - **Part A:** helps pay for inpatient hospital, home health, skilled nursing facility, and hospice care. Part A is provided free of premiums to most eligible people; certain otherwise ineligible people may voluntarily pay a monthly premium for coverage
  - **Part B:** helps pay for physician, outpatient hospital, home health, and other services. To be covered by Part B, all eligible people must pay a monthly premium
  - **Part C:** Known as the Medicare Advantage program which expands beneficiaries’ options for participation in private-sector health care plans
  - **Part D:** provides subsidized access to prescription drug insurance coverage on a voluntary basis, upon payment of premium, for all beneficiaries, with premium and cost-sharing subsidies for low-income enrollees

# Patient Protection and Affordable Care Act (Pub. L. No. 111-148, 124 Stat. 119)

- Enacted with the goals of increasing the quality and affordability of health insurance, lowering the uninsured rate by expanding public and private insurance coverage, and reducing the costs of healthcare for individuals and the government
- Ends Pre-Existing Condition Exclusions for Children: Health plans can no longer limit or deny benefits to children under 19 due to a pre-existing condition
- Keeps Young Adults Covered: If patients are under 26, they may be eligible to be covered under their parent's health plan
- Removes Insurance Company Barriers to Emergency Services: patients can seek emergency care at a hospital outside of their health plan's network

# Medicare regulations governing Parts C and D found at 42 C.F.R. § § 422 and 423 respectively

- Part C and Part D sponsors must have an effective compliance program which includes measures to prevent, detect and correct Medicare non-compliance as well as measures to prevent, detect and correct fraud, waste, and abuse
- Sponsors must have an effective training for employees, managers and directors, as well as their first tier, downstream, and related entities

# Stark Law – 42 U.S.C. § 1395nn

- **Also Known as Self-Referral Law**
  - Physicians may not make referrals to an entity for inpatient or outpatient services, and certain other services (known as Designated Health Services) where the Physician (or their immediate family member) has a financial relationship with that entity
  - Hospital may not bill Medicare/Medicaid
  - Unless the relationship fits with an exception
    - If you are a Physician or work with Physicians in a way where you need a more detailed understanding of this complex regulation, please immediately contact the Compliance department

# The Anti-Kickback Statute – 42 U.S.C. § 1320a-7b

**Far broader reach than Stark Law and prohibits anyone (person or corporate entity) from:**

- Offering, paying, soliciting, or receiving remuneration
  - Directly or indirectly
  - In cash or in kind
- In exchange for
  - Referring an individual
  - Furnishing or arranging for a good or service
- For which payment may be made under any federal health care program

# Summary: AKS v. Stark

	AKS	Stark
Citation	42 USCA 1320a-7b(b)	42 USCA 1395nn
General Prohibition	Prohibits offering, paying, soliciting or receiving anything of value to induce or reward referrals or generate Federal healthcare program business	Prohibits a physician from referring Medicare patients for designated health services to an entity with which the physician (or an immediate family member) has a financial relationship, unless an exception applies
Referrals	Referrals from anyone	Referrals from a physician
Items/ Services	Any items or services	Designated health services
Intent	Intent must be proven (knowing and willful)	<ul style="list-style-type: none"> <li>▪ Strict liability statute (no intent required) for overpayments</li> <li>▪ Knowing violation for CMPs</li> </ul>

# Summary: AKS v. Stark

	AKS	Stark
Penalties	<p><u>Criminal:</u></p> <ul style="list-style-type: none"> <li>▪ Fines up to \$25,000 per violation</li> <li>▪ Up to a 5-year prison term per violation</li> </ul> <p><u>Civil/Administrative:</u></p> <ul style="list-style-type: none"> <li>▪ False Claims Act liability</li> <li>▪ CMP and program exclusion</li> <li>▪ Potential \$50,000 CMP per violation</li> <li>▪ Civil assessment of up to 3x the amount of the kickback</li> </ul>	<p><u>Civil:</u></p> <ul style="list-style-type: none"> <li>▪ Overpayment/refund obligation</li> <li>▪ False Claims Act liability - if knowing</li> <li>▪ CMP and program exclusion for knowing violations</li> <li>▪ Potential \$15,000 CMP for each service</li> <li>▪ Civil assessment of up to 3x the amount claimed</li> </ul>
Exceptions	Voluntary safe harbors (42 CFR 1001.952)	Mandatory exceptions (42 CFR Part 411, Subpart J)
Federal Healthcare Programs	All	Medicare and Medicaid*

# Deficit Reduction Act of 2005

- Established the Medicaid Integrity Program
  - Reviews activities, audit claims, identifies overpayments and education on integrity issues
  - Increased financial support and assistance to the OIG to aid states in fighting fraud and abuse
    - Mandates and provides funding for employee training on Whistleblower policies
- Expanded the False Claims Act to the states
  - Florida has established policies which provide information about the False Claims Act
- Ultimate Goal is to eliminate fraud, waste and abuse in federal health care programs

# False Claims Act (FCA)

## **Violation of FCA results in civil liabilities to anyone who:**

- Knowingly presents, or involved in presenting, soliciting or receiving a false or fraudulent claim record or statement for payment or approval
- Defrauds the government by getting a false or fraudulent claim allowed or paid
- Uses a false record or statement to avoid or decrease an obligation to pay the government
- And other fraudulent acts enumerated in the statute

# Penalties for Violating FCA

- A person who violates the FCA must repay:
  - Triple (3x) the amount of damages suffered by the government  
PLUS
  - A mandatory civil monetary penalty of at least \$5,500 and no more than \$11,000 per claim
- **Example:** A person who submits 50 false claims for \$50 each is liable for between \$282,500 and \$557,500 damages

# Fraud Waste & Abuse

- **Fraud** – An intentional deception to gain an unauthorized benefit
  - Examples: Billing for services not rendered, Billing separately for services that should be single service (unbundling), falsely reporting of diagnoses or procedures to maximize payments, duplicate billing
- **Waste** – Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources
  - Examples: Services conducted with insufficient medical necessity.
- **Abuse** – Unintentional practices that are inconsistent with sound fiscal, business, or medical practices resulting in an unnecessary cost to the government or health plan
  - Examples: Services with insufficient or no documentation, incorrectly coded claims

# The Beneficiary Inducement Statute [42 U.S.C. § 1320a-7a(a)(5)]

- Offers made to eligible individuals for benefits under subchapter XVIII (**Medicare**) of this chapter, or under a State health care program to influence such individual to receive services from a particular provider, practitioner, or supplier are impermissible
- **Examples of impermissible items would be:**
  - Tickets to a sporting event
  - Free medical equipment
  - Big Screen Television

# Civil Monetary Penalties (CMPs)

CMPs may be imposed, in pertinent part, when a person:

- Gives or causes to be given false or misleading information reasonably expected to influence the decision to discharge a patient
- Offers or gives remuneration to any beneficiary of a federal health care program likely to influence the receipt of reimbursable items or services
- Arranges for reimbursable services with an entity which is excluded from participation from a federal health care program

# Florida “Sunshine” Law

- Florida places a high priority on the public’s right to access governmental **meetings** and **records** unless there is an exemption
  - **Meetings:** any formal or casual gathering of two or more members of the same governing board or commission to discuss some matter on which foreseeable action will be taken by the public board or commission
    - Meetings must be open to the public
    - Notice must be given
    - Minutes of the meeting must be taken
  - **Records:** all materials made or received by an agency in connection with official business; these include personnel records and emails
- Violation of the Sunshine Law may be prosecuted by the State Attorney!

# What is EMTALA?

- The Emergency Medical Treatment and Labor Act applies to any hospital with an operating emergency room that participates in a federal health program:
  - **Any individual who comes to any hospital's emergency room must be screened and treated regardless of the patient's insurance status or ability to pay for the care (=increased access to Emergency Care Services!)**
    - Requires the hospital to screen the patient's condition to determine if the patient has an emergency medical condition
    - If the patient is found to have an emergency medical condition, the hospital must treat the patient to stabilize them
    - Ensures patients who request medical treatment receive appropriate care as quickly as possible

# Conflict of Interest (COI)

**COI exists when the private interests of an employee (or close relation/associate) prevent the employee from acting or making decisions in the best interest of JHS**

- The purpose of this policy is to promote disclosure from JHS employees regarding COI
  - Business, financial or any other relationship that influences the employee/employer relationship
- COI is necessary to prevent fraud, corruption and questionable associations and behaviors
- **Some Examples:**
  - Competing with the employer
  - Having a financial interest in a company that works with the employer
  - Outside employment with a company that conducts business with JHS
  - Using information or position for direct or indirect personal gain

# Gratuities and Gifts

- JHS Policy 329
  - “Prohibits any employee from accepting, soliciting or receiving any gift having a value of fifty dollars (\$50.00) or more from patients, relatives or friends of patients, or from firms or individuals doing business with or soliciting business from JHS”

**Compliance as  
a resource to you:  
How to communicate or report  
issues**

# Examples of reportable noncompliance that an employee might observe

- HIPAA (Health Insurance Portability and Accountability Act) or patient privacy issues
- Receipt of kickbacks and/or billing company incentives that violate the anti-kickback statute or other similar Federal or State statute or regulations
- Billing for items or services not actually documented
- Inappropriate gifts and entertainment from contractors and/or vendors
- Duplicate billing in an attempt to gain duplicate payment
- Altered prescriptions(changing quantities or Dispense As Written)

# Reporting Potential Compliance Issues

- JHS Administrative, Section 600 – Compliance; Policy 631-  
DUTY TO REPORT SUSPECTED MISCONDUCT
  - Each JHS employee is required, as a condition of employment, to report any practice that the employee, in good faith, believes violates, or may violate, JHS' Standards and Code of Conduct, JHS' Compliance Policies and Procedures, or any applicable rules, laws, or regulations

# How to report issues

## Reporting Compliance Issues (Mandatory per JHS Policy)

- Issues can be reported: to your Supervisor/Manager, Compliance Dept., or the Hotline
- Provide as many details possible
- Duty to report
- Follow up on your Hotline Call
- Employee Obligation to report suspicious or improper behavior
- **Office of Compliance & Ethics # 305-585-2902**

## Compliance Hotline Reporting

- SECURE, ACCEPTS ANONYMOUS CALLS, CONFIDENTIAL
- Live Operator (independent vendor)
- NO retaliation/retribution policy
- 24-hours a day/seven (7) days a week
- **Compliance Hotline number is 1-800-684-6457**





**Jackson Medical Towers (JMT)**  
**1500 NW 12th Ave, Suite 102**  
**Main Number: (305) 585-2902**

**Compliance Hotline: (800) 684-6457**

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