COMPLIANCE AND ETHICS TRAINING

2019

AMERICAN HEALTH COMMUNITIES
SENIOR LIVING • REHABILITATION

Message from our Chief Compliance and Ethics Officer

This Compliance and Ethics Awareness Training will give you a better understanding of our Code of Conduct, as well as your role in the corporate compliance program. The Code of Conduct documents the basic principles that we must follow to perform our job in a legal and ethical manner.

I want to emphasize the importance of this training. Our organization takes the obligation to comply with laws, regulations, and standards that govern our business very seriously. This commitment to compliance starts with the Board of Directors and is needed at every level of the organization.

It is not only your duty to follow the Code of Conduct, you are also expected to take action if you see these standards are not being met. This training will inform you about the resources available when you need to report a concern or if you just want to ask a question.

Thank you for your attention to this important information and for joining me and the Board of Directors in the effort to ensure that we maintain an organization that we can all be proud of.

Kelly Thomas, J.D, CHC
Chief Compliance and Ethics Officer

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What Is Compliance & Ethics?

- Following the rules and regulations
- Conducting business in an ethical manner
- Values
- Integrity
- Honesty
- Abiding by good conduct
- Doing the right thing every time, all the time

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Compliance Program Goals

Do we need this slide?

- Protect the organization, our employees, our patients, and the community by providing clear guidelines to ensure honest and responsible behavior;
- Identify and correct violations of the law, rules, and regulations, and the organization's Code of Conduct;
- Fulfill our legal duty to payers by submitting accurate claims for reimbursement;
- Limit the risk of violating the law; and
- Improve the quality of care provided to our patients.

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Why Do We Need a Compliance & Ethics Program?

- Demonstrate our commitment to good corporate conduct
- Prevent and detect potential criminal and/or unethical conduct
- Improve the quality of patient care
- Encourage employees to report potential misconduct
- Process for prompt, thorough investigation of alleged misconduct
- Process to ensure fair and consistent disciplinary actions
- Process to ensure non-retaliation for reporting known or suspected misconduct
- Reduce the corporation's exposure to civil damages, penalties, criminal sanctions, etc.
- A mechanism to improve internal communications
- Mandated by regulations

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Compliance Program Focus

Quality of Care – to ensure that our organization provides the highest possible quality of care

Confidentiality – to protect the privacy of patients' and employees' personal identifying information and health information

Conditions of Participation – to ensure compliance with federal regulatory standards

Complaints – to ensure that patient/resident/employee complaints are investigated timely and thoroughly and to identify any compliance issues that may be included in the complaint

Excluded Persons/Entities – to ensure that we do not employ or contract with individuals or entities that have been excluded from participation in federal programs

Compliance Program Focus

- **Coding & Billing** – to ensure all claims for reimbursement are accurate & consistent with the applicable laws, regulations, and program requirements
- **Medical Record Documentation** – to ensure medical records are timely, accurate, and complete
- **Cost Reporting** – to ensure the accuracy of these reports
- **Patient Referrals** – to ensure patient referrals do not violate the anti-kickback law
- **Financial Arrangements** – to ensure these arrangements do not violate laws

Compliance Program Focus

- **Training & Education** – to ensure every person affiliated with American Health Communities are trained on the compliance program and Code of Conduct
- **Federal/State Rules and Regulations** – to ensure we are in compliance with all federal and state regulations governing the organization and subsidiaries
- **Code of Conduct –** to ensure all persons associated with American Health Communities abide by the Code of Conduct.
- **Vendor Relationships –** to ensure relationships with vendors do not create a conflict of interest

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Risk Areas That affect the entire organization

- Substandard Care
- Resident/Patient Rights
- Employee Screening
- Vendor Relationships
- Billing/Cost Reports
- Kickbacks/Inducements
- Medical Record Documentation
- Inaccurate Coding
- Confidentiality/Privacy/Security

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Fraud & Abuse Laws: False Claims

- **Federal False Claim Act**
  Creates penalties for submitting false materials to the federal government

- **State False Claims Acts**
  - Tennessee, Oklahoma, Kansas, and Missouri also have similar State False Claims Acts. These include financial penalties and in certain states whistleblower protections.
  - Alabama has Medicaid fraud statutes, but does not have a state Medicaid false claims act.

Federal False Claims Act

- Prohibited actions under the False Claims Act include:
  1. Submitting a false or fraudulent claim
  2. Creating or using a false document to get a claim paid
  3. Conspiring to get a false claim paid
  4. Creating a false record to avoid returning some or all of what is owed to the federal or state government

- The federal government may impose penalties, plus treble (triple) damages for violations of the False Claims Act

State False Claims Acts

Tennessee

- Tennessee has a Medicaid False Claims Act with qui tam provisions
- Imposes financial penalties of a minimum of $5,000 but not more than $10,000 per violation; not less than 2 times up to 3 times the amount of all payments fraudulently obtained.
- Whistleblowers potentially receive between 10% and 50% of recovery plus reasonable attorney fees and costs.

Alabama

- Alabama does not have a False Claims Act
- Alabama has a criminal statute for Medicaid fraud and kickbacks
- Imposes a fine of not more than $10,000 and felonies if convicted
- There are no qui tam civil lawsuit / whistleblower provisions

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Key Provisions of False Claims Act

- The False Claims Act (FCA) protects the government from being overcharged or sold shoddy goods
- It is illegal to submit claims to Medicare or Medicaid that you know or should have known are false or fraudulent.
- The FCA defined knowingly to include not only actual knowledge but also instances in which the person acted in deliberate ignorance or reckless disregard of information.
- Any person who knowingly presents or causes to present a false or fraudulent claim to the U.S. Government for payment
- Any person who knowingly makes, uses or causes to be made or used a false record or statement to get a false or fraudulent claim paid
- Any person who conspires to get a false or fraudulent claim paid is in violation of the FCA

Examples of False Claims

- Services billed that were not rendered
- Upcoding & Unbundling
- Submitting claims that are a result of kickbacks
- Incorrect reporting of diagnosis
- Misrepresenting dates and descriptions of services
- Misrepresentation on coding
- False certification/documentation
- Credit balances not refunded
- Poor quality of care
- Substandard or non-existent care
- Forging another person’s signature

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Fraud & Abuse Laws: Anti-Kickback

Anti-kickback Law

- Strictly prohibits payments that are designed to induce the referral of patients or other healthcare business that go into patient care.
- Paying for referrals is a crime.

Our organization upholds two (2) primary rules for patient referrals:

1. **We do not pay or offer to pay for referrals.**
2. **We do not accept or ask for payments or anything of value for referrals that we make.**

Payment includes:

- Any form of compensation, not just money, i.e. free services, gifts, etc.

Our organization does not waive deductibles or co-insurance unless the patient is approved for financial hardship waiver.

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Fraud & Abuse Laws: Anti-Kickback

Kickbacks are illegal because they harm the Federal health care programs and program beneficiaries.

They can lead to:

- Overutilization of items or services,
- Increased program costs,
- Interference with medical decision making,
- Patient steering, and
- Unfair competition

Examples of Potential Kickbacks

- Routinely waiving coinsurance or deductible amounts without a good faith determination that the resident is in financial hardship
- Any arrangements between the facility and a hospital/home health/hospice to offer, solicit, pay, or receive anything of value (including referrals) in exchange for referring or transferring of a resident to or from the nursing home
- Soliciting, accepting or offering any gift or gratuity of more than nominal value to or from residents, potential referral sources, and other individuals or entities with which the facility has a business relationship
- Financial arrangements with physicians (including the facility Medical Director) that do not meet exceptions to the AKS (and Stark) statutes
- Soliciting or receiving items of value in exchange for providing supplier access to residents medical records and other information needed to bill Medicare
- Joint ventures with entities supplying goods or services

Stark Law

Stark Law: Self referral prohibits physicians from referring Medicare/Medicaid patients to an entity for the furnishing of designated health services if the physician or physician's immediate family member has a financial relationship with the facility.

"Designated health services" include:

- Lab Services
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Durable Medical Equipment (DME)
- Prosthetics
- Radiology
- Home Health
- Pharmaceuticals
- Inpatient and Outpatient Services

Quality of Care Concerns

- Absence of a comprehensive, accurate assessment of each resident's functional capacity and a comprehensive care plan that includes measurable objectives to meet the resident's medical, nursing, and mental/psychological needs
- Inappropriate/insufficient treatment and services to address residents' clinical conditions, including pressure ulcers, dehydration, malnutrition, incontinence, and mental/psychological problems
- Failure to accommodate individual resident needs and preferences
- Failure to properly prescribe, administer, and monitor prescription drug usage

Quality of Care Concerns

- Inadequate staffing levels or insufficiently trained or supervised staff to provide medical, nursing, and related services
- Failure to provide appropriate therapy services
- Failure to provide appropriate services to assist residents with ADLs
- Failure to provide an ongoing activities program
- Failure to report incidents of mistreatment, neglect or abuse
- Unnecessary antipsychotic medication administration

Resident Rights Concerns

- Discriminatory admission or improper denial of access to care
- Verbal, mental, or physical abuse, corporal punishment and involuntary seclusion
- Inappropriate use of physical or chemical restraints
- Failure to ensure that residents have personal privacy and confidentiality of records
- Denial of resident's right to participate in care and treatment decisions
- Failure to safeguard a residents' financial affairs

Billing/Cost Report Concerns

- Billing for services/items not rendered or provided as claimed
- Submitting claims for equipment, supplies and/or services that are not medically necessary
- Submitting claims to Medicare Part A for residents that are not eligible
- Duplicate billing
- Failing to identify and refund credit balances
- Billing for items/services not ordered by MD
- Billing for inadequate or substandard care

Billing/Cost Report Concerns

- Providing misleading information about a residents condition on MDS or providing inaccurate information used to determine the RUG
- Upcoding the level of service provided
- Unbundling
- Billing residents for items/services that are included in the per diem rate or is covered by another payor
- Altering documentation or forging MD signatures on documents
- Failing to maintain sufficient documentation to support the claim

Why is Documentation So Important?

- Supports the diagnosis
- Justifies treatment/services
- Documents course of treatment
- Documents result of treatment
- Promotes continuity of care
- Supports the claim billed

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Non-retaliatiation

- THM has a strict non-retaliation policy to protect employees who report actual or suspected concerns in good faith and/or employees who cooperate in compliance investigations

- Additionally, federal and some state False Claims Acts protect employees from retaliation for reporting violations and/or concerns.

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Corporate Integrity Agreement

Tennessee Health Management, Inc. (THM) entered into a five (5) year Corporate Integrity Agreement ("CIA") with the Office of Inspector General, Department of Health and Human Services ("OIG") in February 2019 to resolve allegations by the United States and the State of Tennessee that THM submitted pre-admission evaluations with photocopied or pre-signed physician signatures on the required certifications for claims rendered to TennCare beneficiaries at its associated Tennessee skilled nursing and rehabilitation facilities.

- All employees are expected to support the CIA obligations, including adherence to all compliance policies and procedures and completion of all compliance training and education within required timeframes.
- These obligations are a component of employee evaluations. Failure to support the CIA will result in disciplinary action up to and including termination.

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Code of Conduct

- The Code of Conduct serves as the foundation for the Corporate Compliance and Ethics program

- The information contained in the Code of Conduct summaries the Compliance Program Policies and Procedures

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Policies and procedures

- The Compliance and Ethics policies and procedures contain specific information related to the Compliance Program and are accessible by employees on PolicyStat at: www.ahc.policystat.com

- Each employee reviews and acknowledges the Code of Conduct that summarizes those policies and procedures within the first 30 days of employment

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Compliance Committees

- There are multiple Compliance Committees within the Company
- The Compliance Committees meet at least quarterly
- All Compliance Committees are charged with assisting the Chief Compliance and Ethics Officer in promoting compliance with the statutes, regulations, requirements and written directives of Medicare, Medicaid, and all other Federal health care programs

THM / American Health Communities Compliance Committee

- The THM/American Health Communities (SNF) Compliance Committee has been designated to assist with compliance efforts, the prevention and detection of possible fraud and abuse, and the implementation of the Compliance Program.

- This Committee meets at least quarterly and is compromised of the Chief Compliance and Ethics Officer, the Regional Compliance Directors, and other members of senior management deemed necessary, including senior executives of relevant departments such as billing, clinical, human resources, operations and internal audit.

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EMPLOYEE RESPONSIBILITY

- Who is responsible for Compliance?

  EVERY EMPLOYEE, regardless of role

- Employees have the responsibility to report, in good faith, concerns about actual, potential or suspected wrongdoing

- Failure to report a known compliance violation could result in disciplinary action

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Reporting Suspected Misconduct

- It is every employees' duty to report known or suspected inappropriate, illegal, or unethical conduct to protect the organization and the community it serves.
- The purpose of such reporting is to allow the organization to correct problems before they get out of hand.
- This helps avoid fines and penalties, damage to the public's trust, and helps ensure that we act with honesty & integrity by doing the right thing.
- Our organization prohibits retaliation against any employee for reporting misconduct in good faith.

Reporting Suspected Misconduct

There are several avenues that you can take if you suspect misconduct or fraud:

- First, if you feel comfortable doing so, discuss your concerns with your supervisor
- Report your concerns to any member of Senior Management
- Call or email the Chief Compliance and Ethics Officer, or the Compliance Department
- Report your concerns via the Compliance Hotline

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Compliance Hotline

- 24 hours a day, 7 days a week, you may call:
  (800) 570-0219
- You may identify yourself or choose to remain anonymous
- A confidential report based on the information you provide will be forwarded to the Compliance Department for review, investigation, and appropriate corrective action.
- You will be provided with a date to call back to receive the results of the investigation.

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Chief Compliance and Ethics Officer

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