HOSPICE OF THE WESTERN RESERVE

CORPORATE COMPLIANCE PLAN

ABBREVIATIONS

Agency	Hospice of the Western Reserve
CMS	Centers for Medicare and Medicaid
CoPs	Medicare Conditions of Participation
MAPC	Medical Advisory, Program, and Compliance Committee of the Board of Directors
Plan	The Corporate Compliance Plan (this document)

PURPOSE

This Plan describes the policies, procedures, and monitoring systems in place in the Agency to help ensure compliance with all legal, professional, and ethical obligations, and to provide instruction for reporting potential violations. It also helps to guide all Agency employees, volunteers, and agents to fulfill their legal, professional, and ethical obligations.

STANDARDS OF CONDUCT

Accordant with its mission, the Agency operates in an ethical and conscientious manner by adhering to laws and regulations in the provision of hospice care and services to the people and communities it serves. The following standards of conduct have been adopted by the Board of Directors of the Agency to ensure compliance with all laws and regulations applicable to hospice operations. All staff must review and acknowledge these standards of conduct annually:

1. Staff will perform their duties in accordance with all laws and regulations applicable to hospices, including provisions of the Deficit Reduction Act of 2005, which require the organization to provide information and about certain Federal and State fraud and abuse laws and whistleblower protection laws to all employees, contractors, and agents.
2. Staff have knowledge of and act in accordance with the prohibitions against fraud and abuse, including, but not limited to, thorough assessment and evaluation of patients' medically necessary needs and services; timely and accurate documentation of clinical services; actual and precise time and expense reporting; and immediate reporting of any suspected or real offer of a bribe, kickback, or disguised payment for service that may result in illegal referrals.
3. Staff must report any direct or indirect act, which may place the Agency at risk of violation of the CoPs, or reimbursement practices by CMS, a third-party payor, or a private pay arrangement.
4. Staff will perform duties free from personal gain, profit, or advantage, including but not limited to, receipt of gifts or gratuities from patients and vendors.
5. Staff will protect the Agency's property and assets.
6. The senior leadership and governing body will uphold the standards of conduct to promote integrity, support objectivity, and foster trust to guide staff in conducting business professionally and ethically.

a. No staff member will knowingly mislead a patient, family member, or caregiver about services, charges, or use of equipment.
b. No staff member will misuse or appropriate any property (real or personal) belonging to any patient, family member, or caregiver.
c. The Agency will accept patient referrals without remuneration to the referral source.
d. Patient clinical records, administrative records, daily visit records, and financial records will not be falsified by anyone for any reason.

ROLE OF CHIEF COMPLIANCE OFFICER AND CORPORATE COMPLIANCE COMMITTEE

It is the responsibility of the Chief Compliance Officer and Corporate Compliance Committee to monitor activities for fraud and abuse; to recommend policies and procedures that decrease the likelihood or occurrence of illegal or improper activity in the Agency; to investigate complaints of alleged violations; and if verified, recommend corrective action to the Board of Directors.

1. The Vice President of Quality will serve as the Chief Compliance Officer. In the absence of the Chief Compliance Officer, the Director of Quality will serve. Duties include to:
    a. Distribute written compliance policies and standards
    b. Oversee and monitor the Agency's compliance activities
    c. Review staff Plan review, indicating receipt, review and understanding of the Plan
    d. Develop, coordinate and participate in education related to the Plan
    e. Coordinate personnel issues with Human Resources staff to ensure that appropriate databases have been reviewed, including The National Practitioner Data Bank and The List of Excluded Individuals/Entities, as appropriate
    f. Receive reports/inquiries about potential fraud, abuse or regulatory noncompliance
    g. Investigate potential fraud, abuse and regulatory noncompliance issues
    h. Maintain a log of all reports/inquiries, including notes on investigations and the results
    i. Ensure a process in place to discipline individuals who do not comply
    j. Monitor reporting process to ensure reporting without fear of retaliation and to ensure the reporting mechanism is adequately publicized
    k. Any other duties requested or specified by the Board of Directors and/or the Chief Executive Officer

2. The Corporate Compliance Committee is chaired by the Vice President of Quality and is composed of the following staff positions: Chief Financial Officer, Chief Clinical Officer, Director of Access to Care, Director of Home Care, Vice President of Human Resources, Director of Residential Services, and two other staff. The committee's functions to:
    a. Analyze legal requirements and specific areas with which the Agency must comply and to also identify specific risk areas
    b. Assess existing policies and procedures that address these risk areas for possible incorporation into the compliance program
    c. Develop standards of conduct, policies and procedures to promote compliance with legal, regulatory, professional and ethical requirements
    d. Determine ways to promote compliance with the Plan and to detect violations

e. Monitor internal and external audits and investigations to identify problem areas and implement corrective and preventive measures
f. Meet at least quarterly to review compliance activities
g. Provide advice to the Vice President of Quality when requested
h. Direct investigations of alleged violations

PLAN EVALUATION AND UPDATE

The Plan will be reviewed annually by the Corporate Compliance Committee and any changes will be submitted to MAPC.

REPORTING TO BOARD OF DIRECTORS

The activities of the Corporate Compliance Committee will be reported to the Chief Executive Officer and MAPC of the Board of Directors on a quarterly basis. Any matters requiring urgent attention will be immediately communicated to the Chief Executive Officer and MAPC.

RECORDKEEPING AND RETENTION

Reports of investigations, committee activities and audits will be maintained in the office of the Chief Compliance Officer for as long as the existing regulations prescribe.

STANDARDS AND PROCEDURES

CONFLICT OF INTEREST

Agency employees, volunteers, directors, and agents must avoid any personal interest, gain, or association, which may be inconsistent with their responsibilities and in the best interest of the organization. The Agency maintains specific policies on conflict of interest with respect to its trustees, volunteers, and employees.

The Agency's policy and Federal regulations require employees, directors, and volunteers who encounter an actual or potential conflict to follow the Agency's policy to resolve the conflict.

BRIBES/KICKBACKS

This section is commensurate with 42 U.S.C §1320a-7b, also known as the Stark Law. Violations are punishable by a $25,000 fine, five years in jail, and exclusion from all CMS programs.

1. The Agency will not offer or accept any bribe, kickback, or disguised payment for goods or services that is intended to result in referrals.

2. The Agency's employees will not accept or provide gifts, gratuity, favor, service, or compensation to or from any referral source to induce referrals to The Agency or to provide referrals to the referral source.
3. The Agency will accept patient referrals in a professional manner. Under no circumstances will the Agency offer any form of remuneration to the referring agency in exchange for such referrals.
4. Each Agency employee will perform duties free from personal gain, profit, or advantage from patients and families, including but not limited to the receipt of tips, gifts, or gratuities.
5. No Agency employee, patient or family will be coerced into participating in Agency fundraising activities. Patients and family members will be told how to opt out of fundraising solicitations.
6. The Agency will not offer services for free or below fair market value to induce patient referrals to any potential referral source, including any nursing home or other facility.
7. The Agency will not pay room and board to a nursing home in excess of CMS reimbursement that the facility would have received from CMS, if the patient not been enrolled in hospice.
8. The Agency will not pay above fair market value for additional non-core services, which CMS does not include in its room and board payments to the nursing home.
9. The Agency will not refer its patients to a nursing home to induce the nursing home to refer its residents to the Agency.
10. The Agency will not provide either free or below fair market value care to nursing home patients, for whom the nursing home is receiving CMS payment under the CMS Skilled Nursing Facility benefit, expecting that, after the patient exhausts the skilled nursing facility benefit, the patient will receive hospice services from The Agency .
11. The Agency will not provide staff at its expense to a nursing home to perform duties that are the responsibility of the nursing home.

FINANCIAL ARRANGEMENTS WITH OTHERS

Employees will report any direct or indirect act which may place the Agency at risk of violating the CoPs or reimbursement practices required by CMS, any other payor, or private pay arrangement. The Agency's contracts and agreements with referral sources will be in compliance with the applicable laws and regulations.

1. The Agency will not knowingly enter into agreements with other providers who are submitting claims for services that are covered by the CMS Hospice Benefit. The Agency will not provide services to patients who are accessing their skilled nursing benefits for their terminal diagnosis, unless the patient/family elects to self-pay for services.
2. The Agency will not provide incentives in violation of State or Federal law.
3. The Agency will not participate in improper patient solicitation activities.
4. The Agency will not offer financial incentive compensation for referrals.
5. The Agency will bill payors the appropriate rate for the level of care provided to the patient; will notify payors if reimbursement exceeds the contractual agreement; and return excess funds.
6. The Agency will purchase durable medical equipment (DME), pharmaceuticals, and other services from vendors at a fair market value.
7. No federal funding disbursed to the Agency will be used in connection with lobbying activities at the State or Federal level by any agent, employee, or other designee of the Agency.

ANTITRUST

Pursuant to Section 5 of the Federal Trade Commission Act, under no circumstances will the Agency or any employee of the Agency enter into any anti-competitive agreement or arrangement with another hospice or other entity which would violate the antitrust restrictions under State or Federal law, including but not limited to:

1. Agreements not to compete in any service area
2. Exchange competitively sensitive information with current or potential competitors
3. Coordinate or agreement on fees or charges or other competitive terms with competitors
4. Coordinate or agreement on bids to payors with competitors
5. Allocate existing or future services or patients among competitors

BILLING

The Agency will not permit misrepresentation of any information relating to a claim for reimbursement for hospice services, and will maintain billing practices in accordance with the law and regulations.

The Agency's employees and agents will not knowingly:

1. Bill for services not provided
2. Bill for inadequate or substandard services
3. Submit false claims for services provided to ineligible persons
4. Improperly bill for dually eligible patients
5. Duplicate bill to obtain double payments from the same of different payors
6. Bill a patient or payor for services that are normally covered by a hospice benefit
7. Submit incomplete or inaccurate CMS cost reports
8. Fail to refund credit or prepaid balances to patients and payor sources
9. Bill for a higher level of care than was necessary
10. Bill for hospice care provided by unqualified or unlicensed clinical personnel or personnel excluded from federal health care programs
11. Bill based on improper location where hospice care was delivered
12. Improperly bill due to inadequate management and oversight of subcontracted services
13. Fail to return overpayments made by Federal and/or State health care programs and/or commercial pay sources
14. Bill knowingly using incorrect provider certification numbers

MARKETING

1. The Agency will provide honest straightforward, fully informative marketing without deception. Patients' freedom of choice to select their own providers of choice will at all times be respected.
2. The Agency will fully inform patients and families about hospice benefits for which they are eligible and which are the patient/family financial responsibility.

ELIGIBILITY AND SERVICE

1. To be eligible for hospice care individuals need to be terminally ill. Persons will be evaluated for eligibility for hospice care at the time of admission and at defined intervals thereafter.
2. The Agency is responsible for discharging individuals who do not meet the criteria for eligibility for hospice services.
3. The Agency will maintain complete and timely documentation of specific clinical factors that qualify a patient for the hospice benefit.
4. The Agency is responsible for providing the appropriate level and intensity of hospice services to individuals. Services to patients will be provided in accordance with CMS hospice regulations, CoPs, and Ohio hospice licensure laws.
5. The Agency's staff will not encourage eligible beneficiaries to revoke the hospice benefit when their care becomes costly to deliver, or discourage the election of the hospice benefit by patients with costly diagnoses.

COMMUNICATION OF STANDARDS (EDUCATION AND TRAINING)

The Agency will communicate the Plan to staff upon employment and periodically thereafter. Staff may also be required to participate in training programs about specific legal and ethical standards related to their job responsibilities. Staff members who feel they need additional information about the Plan, in general or about a specific matter, may contact their supervisors or a member of the Corporate Compliance Committee.

The Agency's Plan education activities include:

1. New staff will be informed about the Plan in detail during orientation. All new staff will take a post-test during orientation the test results will be sent to the Chief Compliance Officer.
2. All staff will be required to review the Plan annually and results will be sent to the Chief Compliance Officer.

MONITORING AND REPORTING MECHANISMS

The Agency requires any staff, vendor, independent contractor, patient or family member who believes he/she has witnessed or has knowledge of any unethical or illegal act to report his/her concerns to the Chief Compliance Officer. Anyone who makes a good faith report about a compliance issue will be protected by the Agency from harassment and/or retribution. However, reports of incidents or concerns which are knowingly false or are made for reasons of personal animosity or gain will result in disciplinary action.

The Agency will strive to maintain the confidentiality of the person making the report; however, the reporting person's identity may become known or may have to be revealed if needed. No promises can be made to staff making a report regarding their liability or what steps the Agency may take in response to the matter.

The Agency's staff, vendors, independent contractors, patients and families can report matters to the Chief Compliance Officer at:

Mary Kay Tyler, Chief Compliance Officer
Hospice of the Western Reserve
17876 St. Clair Avenue
Cleveland, OH 44110
Telephone: 216-486-6007
Email: mktyler@hospicewr.org
Compliance Hotline Voicemail (Confidential): 216-383-6688
Compliance Mailbox: compliance@hospicewr.org

Upon termination of employment, all staff will be provided the opportunity to disclose any violations of Federal, State, or local regulations they may be aware of, but have not previously reported.

AUDITING AND AUDIT TEAMS

The Agency will take reasonable steps to achieve compliance with standards by using monitoring and auditing systems designed to detect criminal conduct. The Agency will also publicize a reporting system for staff and other agents to report criminal conduct without fear of retribution.

Depending on the focus of the audit, each team will include one or more persons with the background or experience in one of the following areas, including, as necessary outside consultants:

1. Claims documentation and submission processes
2. Sales and/or marketing practices
3. Admission, discharge, and clinical care processes
4. Familiarity with Federal and State statutes and regulations and CoPs

AUDIT AREAS

The audit types listed below have been identified by the Office of the Inspector General in its Compliance Program Guide for Hospices (Federal Register, October 5, 1999) as areas of specific concern in hospice operations, and these types will be the core of audit activities:

- Uninformed consent to elect the CMS Hospice Benefit
- Admission of patients to hospice care who are not terminally ill
- Arrangement with another provider who the Agency knows is submitting claims for services already covered by the CMS Hospice Benefit
- Underutilization
- Falsified medical records of plans of care
- Untimely and/or forged physician certifications on plans of care
- Inadequate or incomplete services rendered by the transdisciplinary group

- Insufficient oversight of patients, in particular, those patients receiving more than six consecutive months of hospice care
- Hospice incentives to actual or potential referral sources (e.g. physicians, nursing homes, hospitals, patients, etc.) that may violate the Stark Law similar Federal or State regulation, including improper arrangements with nursing homes
- Overlap in nursing home services that result in insufficient care provided by a hospice to a nursing home resident
- Improper relinquishment of core services and professional management responsibilities to nursing homes, volunteers, and privately paid professionals
- Provide hospice services in a nursing home before a written agreement has been finalized, if required
- Bill for a higher level of care than was necessary
- Knowingly billing for inadequate or substandard care
- Pressure a patient to revoke the CMS Hospice Benefit when the patient is still eligible and desires care, but the care has become too expensive for the hospice to deliver
- Bill for hospice care provided by unqualified or unlicensed personnel
- Falsify any aspect of the medical record, including dates, locations, service provided, etc.
- Use high-pressure marketing of hospice care to ineligible beneficiaries
- Improper patient solicitation activities
- Inadequate management and oversight of subcontracted services
- Provide commissions based upon length of stay
- Deficient coordination of volunteers
- Fail to comply with applicable requirements for verbal orders for hospice services
- Non-response to late referrals by physicians
- Any other action that would violated Federal or State laws or regulations
- Other areas may be subject to monitoring as determined by the Corporate Compliance Committee

AUDIT PROCESS

The cornerstone of the audit process includes sampling protocols that permit the Chief Compliance Officer to identify and review variations from an established baseline and to identify trends. The audit process monitoring techniques may include, but are not limited to:

- On-site visits
- Interviews of patients at their residences
- Interviews of focus groups with personnel involved in management, operations, billing, marketing, patient referrals, and referral source development
- Tests of clinical staff on their knowledge of reimbursement coverage criteria
- Chart reviews
- Document reviews (including policies and procedures)
- Unannounced mock audits and investigations
- Contract review

- Assessment of existing relationships with physicians, nursing homes, hospitals, and other referral sources
- Personnel chart reviews to verify applicable State license renewals and certifications of non-licensed professionals

AUDIT FINDINGS

1. The audit team will report its findings to the Corporate Compliance Committee and those reports will be shared with MAPC.
2. If a lack of compliance is found, a corrective action plan will be implemented within 30 days.
3. The audit team will assess the adequacy of the plan within six months of its implementation.
4. The audit team may request future audits to ensure continued compliance.
5. Findings of the audits may lead to an investigation.

AUDIT OF THE CORPORATE COMPLIANCE PLAN

The Plan will be regularly audited to ensure its effectiveness. The audit may include:

1. Spot checks of compliance issues that were resolved to ensure the problem has not recurred
2. Post-compliance audits
3. Analyze results of audits performed by contracted entities and organizations
4. Assess effectiveness and frequency or education

INVESTIGATION

The Chief Compliance Officer will begin an investigation of complaints or allegations within one business day of receipt of a report, and will also decide if the investigation requires consultation with outside counsel. If the Chief Compliance Officer believes the integrity of the investigation may be at stake because the staff under investigation is present, that staff member may be removed from work until the investigation is complete. The Chief Compliance Officer will take appropriate steps to secure or prevent the destruction of documents and other evidence relevant to the investigation.

REPORTING

If the Chief Compliance Officer or designee receives credible evidence of misconduct from any source and if, after investigation has reason to conclude the misconduct may violate criminal, civil, or administrative law, the Chief Compliance Officer will report the incident to the appropriate governmental authorities, after the Agency consults with legal counsel.

Working with legal counsel, the Chief Compliance Officer or designee will furnish to appropriate government officials information about any violation within sixty days after receipt of the credible evidence of misconduct. The Agency will cooperate fully with any government investigation of a violation.

CORRECTING PROBLEMS

If the investigation reveals that misconduct did occur, the Agency will initiate corrective actions, and may include:

- Immediate restitution to the appropriate agency, company or person
- Disciplinary action
    - Staff members will be disciplined in accordance with the Agency's policies and procedures
    - Agents, contractors or any other person or company engaging in business with the Agency may have their relationship with the Agency terminated
- Correction of any problems or processes identified by the investigation

EMPLOYEE SCREENING AND RETENTION

Criminal background and reference checks will be done on hire for all staff. Applicants must disclose any criminal conviction. New staff found to have been convicted of criminal offenses as outlined in the Ohio Department of Health regulations pertaining to hospice care, or who are listed as disbarred, excluded, or otherwise ineligible for participation in federal healthcare programs, will not be employed

All Agency-employees and contracted physicians will be checked using the National Practitioner Databank. The List of Excluded Individuals/Entities will be checked for all staff, referring physicians, and contracted personnel.

RECORDS RETENTION

The Agency will ensure that all records and reports pertaining to the compliance plan are maintained in a secure and confidential manner for a period of seven years.

REVISION HISTORY

October 2011
June 2012
July 2013
July 2014
May 2015
January 2016
January 2017