Bartlett Regional Hospital

Board Compliance & Audit Committee Agenda
Date: November 15, 2021 Time: 12:00 PM

Public may follow the meeting via the following link https://bartletthospital.zoom.us/j/92867456249
or call
1-877-853-5247 **and enter webinar ID** 928 6745 6249

Mission Statement
Bartlett Regional Hospital provides its community with quality, patient-centered care in a sustainable manner.

CALL TO ORDER
APPROVAL OF AGENDA
APPROVAL OF THE MINUTES – August 5th BOD Compliance & Audit Committee Meeting
INFORMATIONAL – October 26th draft meeting minutes and agenda from Hospital Compliance Committee

TRAINING

340B for the C-Suite	15 minutes
(Apexus 340B University online training module)	Nathan Overson, CO

TRAINING DISCUSSION

340B Contract Pharmacy Q&A	10 minutes
	Committee Discussion

OLD BUSINESS

A. 340B Contract Pharmacy - Eide Bailly audit recommendations	20 minutes
B. Compliance Program Evaluation – 3rd Party Review & Risk Assessment	Committee Discussion

a. Full Report
b. Risk Assessment Recommendations
c. Program Recommendations

NEW BUSINESS

A. Compliance Officer Report	10 minutes
1. Current and new Compliance Program initiatives/involvement	Committee Discussion

a. Creation of new service line policy and Committee
b. Contracts process work-flow – with Beth Mow and Barbra Nault
c. Creation of 340B Oversite Committee – Kevin Benson, CFO as Committee Chair

2. Requesting input from the Committee for dashboard reporting elements and other priorities moving forward (PYA report gives a sample dashboard template in Appendix E)
3. Annual Board Compliance Training for 2021

EXECUTIVE SESSION
A. None planned

FUTURE AGENDA ITEMS — 5 minutes
A. Next Committee Education and Training
COMMITTEE MEMBER COMMENTS
ADJOURN - Next scheduled meeting: February

CITY/BOROUGH OF JUNEAU
ALASKA'S CAPITAL CITY

Bartlett Regional Hospital

3260 Hospital Drive, Juneau, Alaska 99801 907.796.8900 www.bartletthospital.org

Board Compliance & Audit Committee Meeting
Draft Minutes
August 05, 2021

Called to order at 12:05 PM., by Board Compliance Committee Chair, Iola Young

COMPLIANCE COMMITTEE AND BOARD MEMBERS:
Board Members: *Iola Young, Committee Chair; *Deborah Johnston; Rosemary Hagevig;

Absent: *Hal Geiger

Staff/Other: Nathan Overson, Compliance Officer; Rose Lawhorne, CEO; Bradley Grigg, CBHO; Vlad Toca, COO; Kim McDowell, CNO; Kevin Benson, CFO

PREVIOUS BOARD COMPLIANCE MEETING MINUTES APPROVAL:
Ms. Johnston made a motion to approve the May 18th 2021 Board Compliance and Audit Committee Meeting minutes as submitted. Ms. Young seconded the motion, and hearing no objection, Ms. Young approved the meeting minutes without change.

INFORMATIONAL:
Mr. Overson gave a verbal update from the last Hospital Compliance Meeting, which was that the Hospital Compliance Committee discussed the PYA Compliance Program Review & Risk Assessment report; including future prioritization of recommendations, and possible strategies for completing the action items that come from the priority list.

EXECUTIVE SESSION:
A motion was made by Ms. Johnston, to recess into executive session to discuss matters: Those which by law, municipal charter, or ordinance are required to be confidential or involve consideration of records that are not subject to public disclosure, specifically the Compliance Program Review & Risk Assessment Report and corresponding program recommendations and risk assessment recommendations.
The committee went into executive session at 12:10 PM and returned at 12:45 PM

POST EXECUTIVE SESSION:
A motion was made by Ms. Johnston to forward the PYA Compliance Program Review & Risk Assessment report to the full Board for its acceptance. Ms. Young seconded the motion, and hearing no objection, Ms. Young approved the motion.

COMMITTEE MEMBER COMMENTS:
Ms. Young asked for input from the meeting attendees for possible meeting times, and possible training topics for the next Compliance & Audit Committee meeting.

Meeting Adjourned: 12:50 PM
Next Meeting: Tentatively scheduled for November 4th at 12:00 PM

DRAFT

Hospital Compliance Committee Meeting
Draft Minutes
October 26, 2021

Called to order at 2:01 PM., by Compliance Committee Chair, Nathan Overson, CO

Hospital Compliance Committee Members in attendance: Nathan Overson, Beth Mow, Scott Chille, Rachael Stark, Angelita Rivera, Jeanette Lacey, Jerel Humphrey, Karen Forrest, Vlad Toca, Gail Moorehead, Debbie Kesselring, Dallas Hargrave, Kevin Benson, Sara Dodd

Compliance Committee Recent Activities:
Mr. Overson provided the Hospital Compliance Committee (HCC) with an update on the recent activities regarding a compliance workgroup that met on 9-27-2021. The workgroup met to review and discuss the Eide Bailly 340B Contract Pharmacy Report received on 9-24-2021. The outcome of the meeting was that the workgroup unanimously agreed to recommend that the HCC adopt all of the recommendations of the Eide Bailly report. Mr. Overson also provided an update regarding an ad hoc HCC meeting that met on 9-28-2021. The outcome of this meeting was that the HCC would follow the recommendation of the compliance workgroup by adopting all of the recommendations of the Eide Bailly report into the hospital's Compliance Work Plan.

Education and Training:
Mr. Overson provided the HCC an overview of BRH's 340B program including the added component of the contract pharmacy rules as they relate to 340B.

Compliance Work Plan Review:
The committee discussed the PYA report after having a chance to review it since the last regularly scheduled meeting on July 29th; when the report was introduced to the HCC for the first time. Ms. Lacy commented on the benefits of having departmental compliance plans hospital wide, especially if included in the education process of onboarding new managers. Mr. Humphrey stated that we couldn't assume that all directors know, and completely understand their role in compliance. Mr. Humphrey, Ms. Lawson-Churchill, and Mr. Benson agreed that the compliance risk would be reduced, and awareness would increase by having departmental compliance plans hospital wide. It was suggested that the information from the different plans be housed in a centralized document, or location for all of the department directors to view, and update. They could also see what other departments are doing as part of their plans. Ms. Lacy asked for the committee's support in several topics of risk that affects some of her areas regarding physician queries and documentation. Ms. Stark also noted that she, and Mr. Benson were engaging an outside auditor to perform regular coding audits, including use of modifiers, to address documentation and coding risks identified in the PYA risk assessment. Mr. Benson noted that he, and Ms. Dodd was doing something similar.

Compliance Officer Report:
Mr. Overson gave updates on the PYA program recommendations, and possible strategies for implementation of some. The committee also heard a verbal update from the HIPAA Privacy Officer, Ms. Stark, and a verbal update from Mr. Chille the HIPAA Security Officer.

Executive Session: The meeting did not go into executive session.

Meeting Adjourned: 3:03 PM
Next Meeting Scheduled: January 19th at 2:00 PM

DRAFT

Bartlett Regional Hospital

Hospital Compliance Committee Agenda
Date: October 26, 2021
Time: 2:00 PM

Mission Statement
Bartlett Regional Hospital provides its community with quality, patient-centered care in a sustainable manner.

CALL TO ORDER
APPROVAL OF AGENDA

APPROVAL OF THE MINUTES -- July 29th Hospital Compliance Committee Meeting

OLD BUSINESS

A. PYA Compliance Program Review and Risk Assessment
B. A 340B Contract Pharmacy Compliance workgroup met on 9-27-2021 (under ACP) to review the Eide Bailly 340B Contract Pharmacy Compliance Audit Report received by BRH on 9-24-2021 (Report also under ACP).
C. Ad hoc Compliance Committee Meeting met on 9-28-2021 and adopted all of the compliance workgroup recommendations, which were to adopt all recommendations from the Eide Bailly report based on how BRH's 340B program would move forward.

NEW BUSINESS

A. Committee Education and Training — 10 minutes
   1) BRH 340B Program overview — Nathan Overson, CO

B. Review of the *dynamic* Compliance Work Plan — 20 minutes
   1) Ongoing risk assessment feedback and prioritization from the committee — Committee Discussion
      a. PYA Risk Assessment integration into the Work Plan

C. Program Updates — 20 minutes
   1) 340B Oversite Committee – 340B Eide Bailly recommendations — Committee Discussion
   2) PYA Compliance Program recommendations
   3) HIPAA Privacy Officer update
   4) HIPAA Security Officer update

FUTURE AGENDA ITEMS &
COMMITTEE MEMBER COMMENTS — 5 minutes

ADJOURN - Next meeting: January 19th 2:00 PM

Bartlett Regional Hospital — A City and Borough of Juneau Enterprise Fund

Owner(s)		***340B Program Recommendations Assignment Summary*** 09-27-2021
Kevin Ursula	**1)**	***Management Recommendation:*** We recommend the Hospital establish a 340B Oversight Committee.
	b.	We would also recommend that one or two people become experts at the Verity products used for the in-house pharmacy as well as the contract pharmacies.
Kevin	**2)**	***Enrollment Recommendation:*** Management should continue to monitor the disproportionate share percentage on the cost report each year to ensure it is at least 11.75%.
Ursula Jordan	**3)**	***Policy and Procedures Manual Recommendation:*** We recommend the policies and procedure manual be updated.
Dallas	**4)**	***Human Resources Recommendation:*** We recommend the development of appropriate job descriptions as necessary for those individuals who work with the 340B Program.
Nathan Ursula Jordan Kevin	**5)**	***Audits Recommendation:*** The Contract Pharmacy program needs to be evaluated to determine whether these findings meets the Hospital's definition of a material breach.
	b.	We recommend that the internal audit process documentation be revised to ensure that the resolution of the prescriptions identified as either Risk of Diversion or Diversion is evident.
	c.	We also recommend that for those prescriptions where the Patient Status and Patient Location are Inpatient, the audit documentation needs to be expanded to explain why these are considered 340B eligible and how that eligibility was determined.
Ursula	**6)**	***Contracts Recommendation:*** We recommend adding the specific store number, and address to the Fred Meyer contract pharmacy information on the 340 OPAIS database.
Kevin Beth	b.	If it is decided to discontinue the contract pharmacy program, the contracts will need to be termed appropriately.
Ursula Nathan	**7)**	***Orientation and Training Recommendation:*** We recommend that a 340B Orientation and Training Program be developed
	b.	We recommend that the 340B specific training be included in the orientation process along with annual training/updates.
	c.	In addition, management may want to consider more formalized training for the 340B Oversight Committee, or those individuals more heavily involved with the 340B Program, on a periodic basis.
N/A	**8)**	***Inventory Recommendation:*** None
Ursula Jordan Nathan	**9)**	***Patient Eligibility Recommendation:*** We recommend that the 340B Oversight Committee review these reports and become familiar with the reports and the processes for transferring the information to Verity.
Debbie	**10)**	***Providers Recommendation:*** We recommend that the Hospital implement policies and procedures around the tracking of eligible providers and providing timely updates to Verity.
Nathan Ursula Jordan	**11)**	***Compliance Recommendation:*** We would recommend that the Compliance Officer obtain all audits being completed over in-house and contract pharmacies and review them as they are being completed.
	b.	Contract pharmacy agreements should also be reviewed on an annual basis to ensure that the contract is beneficial for the Hospital as the primary purpose of the 340B Program is to stretch scarce federal dollars.
	c.	We would suggest that the self-reporting policy be included in the 340B Policies and Procedures for the material breach to ensure that the appropriate steps are taken if a material breach were to occur.
Rachael Ursula Jordan Scott	**12)**	***340B Transaction Review Recommendation:*** We recommend ensuring that all 12 elements required by HRSA can be easily obtained from the Transaction Reports.
	b.	We also recommend that the Hospital review the 365-lookback period for claims to ensure that scripts written from the Hospital are appropriately matching with eligible visit dates from Bartlett.

Compliance Program and Risk Assessment Executive Summary Report and Detailed Findings

Prepared for ***Bartlett Regional Hospital***

June 3, 2021

BRIDGING BUSINESS & HEALTHCARE

PYA, P.C.
215 Centerview Drive, Suite 330
Brentwood, Tennessee 37027
p: (800) 270-9629
pyapc.com

June 3, 2021

Mr. Nathan Overson
Compliance and Risk Management Director
Bartlett Regional Hospital
3260 Hospital Dr.
Juneau, AK 99801

Dear Mr. Overson:

PYA, P.C. (PYA) is pleased to submit this report to Bartlett Regional Hospital (Bartlett) which details our methodology, findings, and recommendations from conducting a compliance program and risk assessment of Bartlett's compliance program.

We appreciate the opportunity to assist Bartlett with its compliance initiatives, and to serving Bartlett in the future. We look forward to speaking with you soon.

Respectfully,

PYA, P.C.

PYA, P.C.

Via Email Only: noverson@bartletthospital.org

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COMPLIANCE PROGRAM AND RISK ASSESSMENT EXECUTIVE SUMMARY

PROJECT BACKGROUND AND ENGAGEMENT APPROACH

BACKGROUND

Bartlett Regional Hospital (Bartlett) is a not-for-profit community hospital serving a 15,000-square-mile region in Southeast Alaska. Bartlett is owned by the City and Borough of Juneau and is the only hospital and emergency department in the Juneau community. Bartlett is Joint Commission Accredited and includes 57 inpatient beds, and 16 residential substance abuse treatment facility beds.

PYA, P.C. (PYA) was engaged by Bartlett, to perform an independent, third-party assessment of the effectiveness of Bartlett's compliance program (Program). In addition to the assessment of Program infrastructure (Program Assessment), Bartlett also requested an assessment of key compliance risk areas (Risk Assessment), which will enable Bartlett to continue to develop and execute a comprehensive compliance work plan.

TIMELINE AND APPROACH

A kick-off conference call was held on January 29, 2021 to discuss the project scope, goals, interviewees, remote interview scheduling, and PYA's Request for Information (RFI) with Bartlett's Compliance and Risk Management Director (CRMD) and Interim Chief Executive Officer (CEO). PYA conducted remote video interviews in March 2021. Interviews encompassed 16 sessions with over 30 key members of Bartlett's staff, management, and leadership. The list of interviewed Bartlett key personnel is located in ***Appendix C***.

Additionally, risk assessment questionnaires were distributed to selected members of leadership, as identified by the CRMD. A total of 17 questionnaires from various departments were completed and returned by leadership for use in this evaluation. Additional information related to each risk area was obtained during interviews and through document review.

ASSESSMENT METHODOLOGY

PYA utilized the Department of Health and Human Services' (HHS) Office of Inspector General (OIG) Compliance Program Guidance, the Federal Sentencing Guidelines, the OIG's Current Work Plan, the U.S. Department of Justice's (DOJ) "Evaluation of Corporate Compliance Programs," and the Health Care Compliance Association's (HCCA) and OIG's "HCCA-OIG Compliance Effectiveness Roundtable's Measuring Compliance Program Effectiveness: A Resource Guide"[1] (collectively referred to as "Guidance") as the foundation for PYA's review.

[1] HCCA-OIG Compliance Effectiveness Roundtable. *Measuring Compliance Program Effectiveness: A Resource Guide*. Roundtable Meeting: January 17, 2017, Washington DC. Retrieved from https://oig.hhs.gov/compliance/compliance-resource-portal/files/HCCA-OIG-Resource-Guide.pdf

Additionally, PYA's experience in regulatory compliance matters, along with serving as an Independent Review Organization (IRO) for entities under a Corporate Integrity Agreement (CIA), facilitates our understanding of key compliance risk areas. A comprehensive compliance program incorporates the following seven elements as recommended by the Guidance: (1) high-level oversight; (2) integration of compliance into standards, policies and procedures (P&Ps); (3) consistent enforcement; (4) training and education; (5) open lines of communication; (6) response to detected deficiencies; and (7) monitoring and auditing.

ENGAGEMENT SCOPE

The scope of PYA's Program and Risk Assessment included an evaluation of the structure of Bartlett's Program as it relates to the Guidance, interviews with key Bartlett personnel, a review of compliance documents provided[2], and risk assessment questionnaire responses received. This multi-level evaluation of the Program specifically assessed the Program's design, implementation progress, and the organizational impact as it relates to the Guidance's seven elements. The information provided from interviews, document reviews and risk assessment questionnaires were aggregated and analyzed using PYA's proprietary risk ranking methodology.

As with the Program Assessment, PYA's risk methodology also utilizes the Guidance to identify potential compliance risks which may impact Bartlett and provides the basic framework for the compliance work plan with the identification and prioritization of risk. Using a formal risk assessment methodology assures Bartlett's executive leadership team and the Board that thorough consideration has been given to the organization's risks, and that the resulting compliance work plan will be relevant and valuable to Bartlett's operational strategy.

The information received as a result of the Bartlett interviews, document reviews and the questionnaire respondents has been aggregated and reported in this assessment as it was communicated to PYA by key Bartlett leadership and personnel. The information itself was not validated or tested for accuracy. The scope of the assessment also did not include a financial analysis or an effectiveness review of Bartlett's financial reporting process. PYA did not conduct testing that would provide assurance of effective controls to mitigate risk areas identified.

[2] In response to PYA's request for copies of compliance program P&Ps, PYA was provided with a table of the Program's P&Ps, but did not receive copies of the P&Ps referenced within the table. As such, many of PYA's findings reflect the fact that a detailed review of the context of these P&Ps was not performed. Bartlett should ensure that its Program P&Ps address control requirements and the findings and recommendations provided within this report.

COMPLIANCE PROGRAM KEY OBSERVATIONS

TONE AT THE TOP

The success of an effective compliance program is highly dependent upon the support provided by the organization's governance and management (the Tone at the Top). The Tone at the Top is the foundation of an effective compliance program and begins with the Board of Directors' (Board) oversight responsibility[3], followed by the CEO's commendation of the program, support by a senior leadership team, and a Chief Compliance Officer (CCO) that facilitates organization-wide accountability for compliance issues. Furthermore, "*The Individual Accountability for Corporate Wrongdoing*" guidance issued September 9, 2015, informally known as the Yates Memo[4], has increased emphasis on individual accountability regarding ethics and compliance issues.

Bartlett's executive leadership team and the Board have verbalized their commitment to, and support of, the compliance function; however, the organization is undergoing a leadership change, with the current CEO's retirement, leading to the hiring of a new CEO. While executive leadership and the Board recognize the importance of a culture of compliance and of modeling those expectations across the entire organization, it is imperative that Bartlett continues to build the current Program's infrastructure in order for the Program to continue to grow. Implementing an optimized compliance program conveys the importance of compliance publicly and demonstrates to the staff that Bartlett is committed to making the right decisions.

COMPLIANCE FUNCTION

Compliance is complex, and successfully managing compliance is a challenge in the best of circumstances. Expectations of compliance, encompassing both external regulatory requirements and internal policies, must be clearly communicated to the workforce in order to assign responsibility and create accountability. It is the responsibility of the CCO and other senior leaders to establish ethical values, solidify company policies, and communicate clearly with the workforce by relaying information updates, reminders, and feedback. Additionally, the compliance officer must cultivate an environment that rewards the workforce for communicating openly about violations they have witnessed or concerns they have. In accordance with the OIG's Compliance Program Guidance for Hospitals, "Every hospital should designate a compliance officer to serve as the focal point for compliance activities." [5] Therefore, PYA recommends that the CRMD position be modified to recognize the distinct responsibilities of the organization's CCO. Further, the inclusion of additional compliance activities, including implementation of a formal, documented organizational risk assessment process,

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[3] OIG, Association of Healthcare Internal Auditors, American Health Lawyers Association, et al. (OIG, et al.). *Practical Guidance for Health Care Governing Boards on Compliance Oversight.* April 20, 2015. Retrieved from http://oig.hhs.gov/compliance/compliance-guidance/docs/Practical-Guidance-for-Health-Care-Boards-on-Compliance-Oversight.pdf [hereinafter, *Practical Guidance*]

[4] Memorandum from Sally Quillian Yates, Deputy Attorney General, U.S. Department of Justice to All U.S. Attorneys et al., *Individual Accountability for Corporate Wrongdoing*. Sept. 9, 2015. Retrieved from https://www.justice.gov/dag/file/769036/download

[5] Department of Health and Human Services. Office of Inspector General. Publication of the OIG Compliance Program Guidance for Hospitals. Federal Register. Vol. 63. Number 35. Monday, February 23, 1998.

systematic auditing and monitoring, and innovative training with measurable outcomes would serve to further strengthen Bartlett's compliance function. In addition, it best serves an organization to include the compliance officer as a key stakeholder in due diligence activities and strategic initiatives.

Compliance-Related Functions

The Compliance, Quality, and Risk Management functions and the associated interrelationships should be defined within Bartlett's organizational structure. Pursuant to the *Practical Guidance for Healthcare Governing Boards on Compliance Oversight*[6], the purpose, reporting relationships, and interaction of correlated functions should be integrated in the organizational structure as roles and responsibilities are defined. Additionally, by defining these interrelationships, reasonable expectations are clarified. The *Practical Guidance for Healthcare Governing Boards on Compliance Oversight* defines the compliance and quality functions as follows:

> *"The **compliance function** promotes the prevention, detection, and resolution of actions that do not conform to legal, policy, or business standards. This responsibility includes the obligation to develop policies and procedures that provide employees guidance, the creation of incentives to promote employee compliance, the development of plans to improve or sustain compliance, the development of metrics to measure execution (particularly by management) of the program and implementation of corrective actions, and the development of reports and dashboards that help management and the Board evaluate the effectiveness of the Program.*
>
> *The **quality improvement function** promotes consistent, safe, and high-quality practices within health care organizations. This function improves efficiency and health outcomes by measuring and reporting on quality outcomes and recommends necessary changes to clinical processes to management and the Board. Quality improvement is critical to maintaining patient-centered care and helping the organization minimize the risk of patient harm."*

Currently the CRMD is responsible for both the compliance and risk management functions. The compliance function guides the organization in meeting regulatory and policy requirements, while the risk management function is the set of processes by which adverse operational risks are analyzed, managed, and resolved effectively. As such, risk management is considered to be a distinct competence function that protects the organization from risk; correspondingly, compliance is achieved by leadership's ethical commitment to do the right thing. Therefore, it is important to note that, while the risk management and compliance functions must collaborate with one another to prevent, detect and mitigate organizational compliance risks, organizational separation of these functions as distinct, but collaborative roles would allow the autonomy necessary for effective compliance and risk management throughout the organization.

[6] https://oig.hhs.gov/compliance/compliance-guidance/docs/Practical-Guidance-for-Health-Care-Boards-on-Compliance-Oversight.pdf

DEDICATED COMPLIANCE RESOURCES

Compliance Management includes development and implementation of the seven elements of an effective compliance program as described by the HHS-OIG[7]. Specifically, Compliance Management activity may include, but is not limited to, conducting a compliance risk assessment and developing a corresponding work plan, reporting auditing and monitoring results to the Board, performing investigations, and managing an organization's compliance P&P repository.

Bartlett employs approximately 600 individuals. The CRMD is currently responsible for all compliance program and risk management activities. The ability to achieve Bartlett's goals of a high-performing compliance team and Program is currently limited by Program staffing constraints. Notably, under the direction of the CRMD, interviews revealed that Bartlett has continued to strengthen the Program's infrastructure through development of P&Ps and compliance-related training. Additionally, in response to the identification of the need for reporting metrics and information to the Compliance and Audit Committee of the Board (CAC), the CRMD is supported by both a Hospital Compliance Committee (HCC) and a Revenue Cycle Committee (RCC), which have served to further strengthen the Program's foundation. The CRMD plans to utilize the results of this assessment report to continue to build upon the foundation for Bartlett's 2021/2022 compliance work plan.

For healthcare organizations comparable to Bartlett, PYA recommends the compliance function be supported by two full-time equivalent employees (FTEs)[8], including a dedicated FTE CCO, to support the operational structure and maintain the continuous process of abiding by legal, ethical, and professional healthcare standards. Given Bartlett's growth, PYA also recommends re-evaluating compliance staffing needs on an annual basis, at minimum, with immediate re-evaluation for significant compliance needs that may arise throughout the year.

Recommended Corporate Compliance Staff

PYA recommends the following staffing structure for Bartlett's compliance department:

- 1.0 FTE CCO with responsibilities for oversight of the organizational Bartlett compliance function
- 1.0 FTE, Compliance Specialist, dedicated to compliance P&Ps and addressing regulatory compliance issues such as exclusion screening, vendor management, conflicts of interest, etc.

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[7] Health Care Fraud Prevention and Enforcement Action Team (HEAT). OIG. *Operating an Effective Compliance Program*. Retrieved from https://oig.hhs.gov/compliance/provider-compliance-training/files/OperatinganEffectiveComplianceProgramFinalBR508.pdf

[8] HCCA. *Healthcare Industry Compliance Staffing and Budget Benchmarking and Guidance Survey*. February 2018. Retrieved from https://assets.hccainfo.org/Portals/0/PDFs/Resources/Surveys/hcca-2017-benchmarking-guidance-survey.pdf?ver=2018-02-14-125509-590

Additionally, PYA recommends the following:

- To acknowledge and support the separate, but collaborative roles of Compliance and Risk Management while facilitating a valuable and productive collaboration, 1.0 FTE should be dedicated to the Risk Management function and should report to the CRMD.
- The Health Information (HIM) HIM Director's job description should be updated to include the HIPAA Privacy duties being performed in conjunction with HIM responsibilities.
- The Information Systems Director's job description should be updated to include the HIPAA Security duties being performed in conjunction with Information System Security responsibilities.

DEPARTMENTAL COMPLIANCE PLANS

In accordance with industry standards and regulatory requirements, healthcare organizations must develop a compliance work plan that addresses high-risk areas related to federal health care program requirements, as well as the OIG's compliance guidance, work plan, special advisory bulletins, and fraud alerts. High-risk areas include, but are not limited to, arrangements with physicians that may implicate the Anti-Kickback Statute, and the Stark Law, Emergency Medical Treatment & Labor Act (EMTALA); cost reports; claims development and submission; laboratory services; HIPAA privacy and security; bad debts; credit balances; outpatient services; and most recently, COVID-19 waivers, exceptions, and relief funding.

While the compliance department is accountable for facilitating that internal controls are in place to effectively mitigate compliance risk, operational departments must verify that they have engaged in ongoing monitoring of their areas of compliance-related responsibility. These responsibilities include ensuring all regulatory changes have been translated into written guidance, all staff have been effectively trained on these policies, and that these policies are being followed properly.

An effective method for establishing an organization-wide compliance plan process is to implement departmental-specific compliance plans (Plans). Such Plans will be the responsibility of the departmental compliance champion and must include risk areas identified by the department which are to be regularly monitored and evaluated. The Plans should be submitted quarterly to the CCO or compliance department designee for review.

Additionally, Plans should also include departmental-specific compliance education and communication requirements. By working closely and regularly with departmental compliance champions, the compliance department will be positioned to not only demonstrate the value of the Plans, but also obtain buy-in from departmental employees and strengthen the current sense of accountability for compliance throughout the organization. Finally, by reporting the results of the Plans to the compliance department, compliance will be able to provide effective feedback to the department as well as determine relevant information to be reported to the HCC. To assist with Plan development, PYA has included a sample departmental compliance plan in ***Appendix F***.

REPORTING COMPLIANCE CONCERNS

Interviews revealed that the compliance hotline is administered internally via the use of a Bartlett telephone number wherein employees may leave an anonymous voicemail message which is reviewed by the CRMD. Interviewees indicated that, while the hotline is technically anonymous, it may be perceived that, as it is an internal Bartlett phone number, anonymity is not guaranteed. Information reported through use of the hotline number is routed through the CRMD who in turn forwards the information to the appropriate department for review and response. Notably, there does not appear to be a confidential method for employees or non-employees (e.g., non-employed physicians, vendors, patients, family members, etc.) to report concerns and receive appropriate follow-up.

PROGRAM STRENGTHS

PYA identified the following compliance program strengths as part of the interview and risk assessment questionnaire responses:

Compliance Element	Strengths
High-Level Oversight and Tone at the Top	• Senior leadership support of compliance • Organizational commitment to mission, vision, and values • Sense of accountability for compliance among staff • Bartlett's CRMD's experience, leadership skills, credibility, and respect within the organization • Engaged HCC • CRMD/Compliance reporting structure • Compliance visibility • Engagement of independent assessment of Program and key risks
Integration of Compliance into Policies and Procedures	• Policy Tech utilized for maintaining and managing P&Ps • An actively engaged Policy Review Committee • The CRMD updates the Code of Conduct (CoC) on an annual basis • Employees receive the CoC at hire and can access at any time within Policy Tech
Open Lines of Communication	• Employees feel comfortable reporting concerns to their direct supervisor or to the CRMD
Auditing and Monitoring	• The RCC and oversight of associated revenue cycle processes and procedures

OPPORTUNITIES FOR PROGRAM IMPROVEMENT

The objective of the Program is to create a process for identifying and reducing risk and improving internal controls. Accordingly, focusing on key program improvement opportunities will strengthen the effectiveness of the Program by promoting a culture of compliance, protecting corporate reputation, and enhancing workforce engagement. Development and implementation of the following compliance-related internal controls will assist Bartlett with strengthening and improving its current Program.

Detailed information regarding these controls and the associated requirements can be found in ***Appendix A***. Additionally, PYA has developed a proposed Program improvement plan based on a priority ranking of these internal controls for Bartlett to utilize when determining the steps necessary to further integrate compliance elements into its Program.

Compliance Element	Opportunities for Program Improvement
High-Level Oversight	• An internal compliance risk assessment is performed annually to identify compliance risks and resulting work plans for Board approval. • The compliance department is adequately and appropriately staffed. • Formalize the use of compliance program benchmarks and measurable goals to allow for an ongoing evaluation of the Program's performance, the results of which are reported to the HCC, CAC, executive management, and the Board. As demonstrated by the sample compliance dashboard provided in ***Appendix E***, such measurable goals and benchmarks may include: – New and updated P&Ps – Exclusion screening results – Compliance training and education completion – Compliance investigations and hotline calls – Departmental monitoring and auditing – Regulatory updates – Overpayments/repayments • The CCO is a key stakeholder in the strategic initiatives of the organization, including strategic planning and due diligence processes
Training	• Develop and implement a consolidated compliance training plan to ensure consistency across the Bartlett organization • All employees, vendors, and physicians receive annual compliance training and training completion is tracked • Define positions in high risk areas (i.e., revenue cycle, physician contracting, physician recruitment, behavioral health, etc.) and provide focused compliance training and regulatory updates on a regular basis • Promotion of compliance through activities such as Compliance Awareness Week, compliance fairs/other employee involvement activities occurs • Inclusion of specific risks identified through the risk assessment process in the compliance training plan
Open Lines of Communication	• Existence of a hotline which allows for the workforce, patients, and vendors to report concerns and remain anonymous

Compliance Element	Opportunities for Program Improvement
Consistent Enforcement	• Conflict of Interest (COI) awareness and process to report both upon hire and annually • COI auditing and evaluation of Open Payments database • Formal process for corrective action when an issue is identified regarding exclusion screening • In-person exit interviews for all senior leadership and high-risk positions with feedback communicated regularly to the former employee's manager, division/departmental leader, and HR
Monitoring and Auditing	• The compliance work plan reflects the most significant compliance risks identified through an annual risk assessment • Enhance the compliance function throughout the organization with implementation of departmental compliance work plans.
Vendor Management	• There is a vendor management process inclusive of requirements for vendor training, expectations for compliance, and exclusion screening

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APPENDIX A: COMPLIANCE PROGRAM ASSESSMENT SUMMARY AND DETAILED FINDINGS

COMPLIANCE PROGRAM ASSESSMENT SUMMARY

For each of the Guidance's seven elements, PYA provides a priority ranking as defined below.

PRIORITY RANKING DEFINITIONS

HIGH PRIORITY: Expected controls that present a ***fundamental program priority*** that should be evaluated by management as quickly as possible (within one to three months).

MODERATE PRIORITY: Presents a ***significant program priority*** that should be evaluated by management as a priority (within three to six months).

LOW PRIORITY: Expected controls where either no issue has been identified, or the issue noted presents ***a standard program priority*** that should be evaluated by management in the normal course of business (within one year).

SUMMARY OF FINDINGS

As illustrated below, PYA has provided a summary priority ranking for each of the Guidance's seven elements, as well as strengths and opportunities for each element. The detailed findings list the controls that are expected to exist in an effective compliance program as well as PYA's assessment of the current state of controls. A detailed priority ranking has been assigned for identified issues and recommendations provided to address the priority(s) identified.

Compliance Plan Elements	Priority Ranking
1. High-Level Oversight	**HIGH**
2. Integration of Compliance into Policies and Procedures	**LOW**
3. Consistent Enforcement of Standards	**HIGH**
4. Training and Education	**MODERATE**
5. Open Lines of Communication	**MODERATE**
6. Response to Detected Deficiencies	**LOW**
7. Monitoring and Auditing	**HIGH**

COMPLIANCE PROGRAM IMPROVEMENT PLAN

In order to strengthen its compliance function, Bartlett should work to implement the high priority control items listed below into its compliance work plan. PYA has ordered the below list in accordance with suggested precedence for Bartlett's review and consideration.

1. Adequately staff and budget for the Program.
    - The CRMD is responsible for Compliance and Risk Management and, therefore time available to administer the Program is limited by inadequate staffing.
    - PYA recommends the compliance function be supported by two full-time equivalent employees (FTEs), to include a dedicated FTE CCO.
    - The Risk Management functions should be supported by an FTE independent of the compliance program.
2. Develop and implement a formal risk assessment methodology to evaluate and assess organizational risk.
3. Develop and implement departmental compliance work plans in order to disseminate the compliance function throughout the organization.
4. Evaluate and monitor exclusion checks, with documentation of appropriate action.
    - The compliance department should evaluate the organization's compliance with performing exclusion checks at on-boarding and monthly thereafter. This process should be monitored on a monthly basis to prevent engagement with excluded individuals or entities.
    - The compliance department should assist with ensuring that vendors are included as part of both the initial and monthly exclusion screening process.
5. Develop and implement a process to monitor claims for improper payments, as well as for reporting results to the HCC.
6. Develop and implement an Anonymous Hotline for Reporting Compliance Concerns to allow for consistent documentation, tracking, and confidential reporting.
7. Develop and implement a procedure to regularly audit the organization's COI disclosure process to assure consistency of execution, and that the Open Payments database[9] is regularly reviewed.

[9] https://openpaymentsdata.cms.gov/

8. Develop and provide compliance training.
    a. Develop and implement a process to ensure that new Board members receive formal compliance training within 90 days of joining the Board. Board compliance responsibility training should be provided annually thereafter and should include Board oversight responsibilities as referenced in the HHS OIG Practical Guidance[10].
    b. Define positions in high-risk areas and provide focused compliance training and regulatory updates on a regular basis.

HIGH-LEVEL OVERSIGHT

SUMMARY PRIORITY RANKING: HIGH

Board of Directors		
Priority: High	**Expected Control**	**Current State**
Board Oversight and Training	New Board members are provided compliance oversight responsibility training within 90 days of joining the Board.	Annual compliance training is provided by the CRMD to Board members and new Board members receive compliance responsibility training within 90 days of joining the Board. Interviews revealed that all board members execute annual attestations confirming completion of annual training and acknowledging that they understand the compliance program and their associated responsibilities.
Board Engagement	The CAC charter includes approval and oversight of the compliance work plan and annual compliance budget. The compliance work plan is reviewed annually and is updated as appropriate. The Board supports sufficient compliance program resources to support the compliance program and work plan. Compliance is a topic discussed at each meeting and there is a demonstrated commitment from the top.	Interviews revealed that the Controller and CFO review the compliance budget. The CAC is provided the annual compliance work plan for review and approval but is not provided the annual compliance budget to validate whether the work plan can be completed with the available resources.
Compliance Committee Charter	The HCC Charter should be reviewed annually by the CAC and updated as necessary. Additionally, an annual report of the achievement of program objectives, as described in the HCC charter, should be reported to the Board.	The HCC structure was discussed during interviews for this evaluation. Interviewees reported that activities carried out by the HCC are reported to the CAC.

[10] https://oig.hhs.gov/compliance/compliance-guidance/docs/practical-guidance-for-health-care-boards-on-compliance-oversight.pdf

Code of Conduct	The CoC is reviewed annually by the CCO and approved by the HCC and Board. Documentation is present of its distribution to employees (e.g., test score, attestations, etc.).	The CoC is reviewed and updated annually by the CRMD. Interviews and documentation revealed the CoC is not reviewed and approved by the Board on an annual basis.
CCO Access to the Board	The CCO should have direct access to the Board through executive sessions (at least annually).	The CRMD has a dotted line reporting structure to the Board. Interviews revealed the CRMD does not have executive sessions without the CEO present.

Board of Directors (cont.)	
Recommendations	1. The CAC should receive and approve the Compliance budget on an annual basis. 2. The HCC Charter should be reviewed annually by the CAC and updated as necessary. Additionally, an annual report of the achievement of program objectives, as described in the charter, should be reported to the Board. 3. The CoC should be reviewed and receive approval by the Board on an annual basis. 4. The CCO should have direct access to the Board through executive sessions without the CEO present, at least annually.

Compliance Management		
Priority: High	**Expected Control**	**Current State**
Compliance Department	The compliance department is adequately and appropriately staffed to ensure significant risks are managed appropriately. Requests/needs that have been communicated by the compliance department to the CEO/Board have been addressed appropriately.	At the time of this review, the Compliance function was performed solely by the CRMD. The primary compliance activities currently performed by the department are limited to investigations of regulatory issues, management of hotline calls, management of compliance related P&Ps, and basic annual employee training. Bartlett budgeted in 2021 for a third-party compliance program and risk assessment which is recommended on a regular basis for operating an effective compliance program. The CRMD has developed and utilizes a compliance work plan, inclusive of monitoring and auditing activities. Additionally, an annual compliance review is conducted by the CRMD, which serves as an informal organization-wide risk assessment as part of departmental compliance auditing activities. Information received as a result of the annual review is reported to the HCC and added to the compliance work plan as appropriate.

<table>
<tr><th colspan="3">Compliance Management (cont.)</th></tr>
<tr><th>Priority: High</th><th>Expected Control</th><th>Current State</th></tr>
<tr><td>Measurable Goals</td><td>The compliance program has measurable goals and benchmarks, including key performance measures such as high-risk work plan items and item status, compliance dashboards, and trending of auditing and monitoring over time.

This information is communicated regularly to the Board and compliance presentations are made at least annually to the Board by the CCO with evidence of the presentations maintained.</td><td>As reported in interviews, the CRMD reports information to the Board regarding the Program’s effectiveness. Additionally, as evidenced by Board meeting minutes and the training material received, the CRMD provides annual Compliance training to the board.</td></tr>
<tr><td>Recommendations</td><td colspan="2">1. The compliance department should be appropriately staffed in order to strengthen the Program as necessary to support an organization the size of Bartlett. According to the national benchmark for healthcare organizations with total Full-Time Equivalent (FTE) employees and revenue comparable to Bartlett, the compliance management function is typically supported by two employees[11], including a dedicated FTE CCO, dedicated to core compliance activities.

PYA recommends that the CCO position be increased to 1.0 FTE and an additional 1.0 FTE be added to the compliance department to oversee and assist with compliance program operations.

2. PYA supports Bartlett’s use of a Program plan and the informal organization-wide risk assessment to identify organizational risks for consideration and prioritization in the compliance work plan. Bartlett should work towards formalization of the organizational risk-assessment process and continue to report the results to the HCC, whereupon approval by the CAC is obtained for items to be included in the compliance work plan.

3. In order to continue to strengthen the Program, PYA recommends that the compliance department formalize the use of measurable goals, benchmarks, and the extent of compliance program activity as demonstrated by the sample compliance dashboard in Appendix E. Such goals and benchmarks for the Program should be approved by the CAC.</td></tr>
</table>

[11] https://www.hcca-info.org/Portals/0/PDFs/Resources/Surveys/hcca-2017-benchmarking-guidance-survey.pdf?ver=2018-02-14-125509-590

Strategic and Operational Planning		
Priority: High	**Expected Control**	**Current State**
Strategic Initiatives	The CCO is a key stakeholder in the strategic initiatives of the organization, including strategic planning and due diligence processes.	The committee to discuss new service lines no longer assembles, but when it did, the prior compliance officer was a standing member. The CRMD plans to reactivate this committee following this assessment This committee was responsible for discussing due diligence and strategic planning for the organization. Interviews revealed that a BOD Strategic Planning Committee is active and meets regularly; however, the CRMD does not attend these meetings.
Performance Evaluation Criteria	The organization aligns incentives and performance evaluation criteria with ethics and compliance objectives. The incentive program is consistent with the compliance program. Performance evaluations have compliance as a performance appraisal element.	It was noted during interviews that performance evaluations do not contain a question related to compliance.
Recommendations	1. PYA supports the reactivation of the New Service Line Committee in order to incorporate compliance considerations into organizational initiatives. 2. It is recommended that the CCO be a standing member if the committee to discuss new strategic initiatives reconvenes. 3. Performance evaluations should include compliance as an appraisal element and compliance should be considered for incentives and promotion decisions. These expectations should be clearly communicated during orientation and annual education.	

Risk Assessment and Work Plan		
Priority: High	**Expected Control**	**Current State**
Annual Risk Assessment	An annual risk assessment is conducted by the compliance department. The compliance work plan is derived from the annual risk assessment and is reviewed and approved by the Board annually. The Board is updated regularly regarding progress of completed work plan items.	Bartlett requested that PYA perform a compliance risk assessment, the findings of which may be found in ***Appendix B***. The risk assessment findings include guidance for a prioritized compliance work plan for CY 2021/2022.
Recommendations	1. A formal risk assessment methodology should be developed and implemented consistently throughout the organization to assure a systematic way of evaluating and assessing risks in the organization. The consistent approach of the risk assessment should drive the development of the compliance work plan. 2. The compliance work plan should be approved by the CAC on an annual basis, with regular updates of work plan items provided thereafter. Challenges to appropriately execute work plan items should be communicated and documented accordingly.	

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STANDARDS, POLICIES, AND PROCEDURES

SUMMARY PRIORITY RANKING: LOW

COMPLIANCE POLICIES		
Priority: Moderate	**Expected Control**	**Current State**
Maintenance and Storage of P&Ps	The organization should have a central repository for all P&Ps which are accessible to all employees. P&Ps should be regularly updated and maintained by the appropriate business owner.	Interviews revealed that Bartlett maintains P&Ps in the policy management system, Policy Tech; however, some P&Ps are maintained in various locations and departments throughout the organization.
P&Ps	There is a specified process outlining the responsibility for preparing and maintaining a comprehensive set of P&Ps related to the OIG's specific risk areas, including: a) Associate/medical staff/vendor screening b) Regulatory aspects of billing, coding, cost reporting c) Kickbacks, gifts, and gratuities d) Inducements, self-referrals e) Vendor relationships f) Self-disclosure g) Documentation, record-keeping	PYA was provided a listing of compliance P&Ps, and the content and application of the P&Ps was discussed during interviews with management. In order to fully evaluate adherence with specific controls, a more detailed P&P review would be beneficial.
Recommendations	1. Bartlett should ensure departments utilize the central policy management system, Policy Tech, for maintaining and storing all P&Ps throughout the organization. Utilizing a central P&P repository will ensure all employees have access to P&Ps, overlapping P&Ps don't exist, and P&Ps are appropriately updated and maintained.	

CONSISTENT ENFORCEMENT

SUMMARY PRIORITY RANKING: HIGH

EXCLUSION SCREENING AND BACKGROUND CHECKS		
Priority: High	**Expected Control**	**Current State**
Exclusion Screening Process	There is a process to ensure that exclusion screenings are performed for new employees prior to hire, physicians, contractors, vendors, and others. Monthly exclusion screenings are conducted. Individuals are screened against the OIG's List of Excluded Individuals/Entities (LEIE), the System for Award Management (SAM), and state Medicaid exclusion lists. While there is not a formal regulation that mandates monthly exclusion screening, OIG issued guidance in May 2013, which recommended that providers check their employees and contractors against the OIG-LEIE each month because the LEIE is updated on a monthly basis.[12] Healthcare organizations that engage and receive reimbursement for an excluded individual is subject to fines, treble damages, and the right to bill CMS. The organization has an established process for investigation and resolution of positive "hits".	Bartlett has a Sanctioned Individuals P&P. Interviews revealed that the exclusion screening process is fragmented throughout the organization and the compliance department is not involved. Pre-employment and monthly exclusion screenings are performed for the Human Resource department by a third-party vendor. The Medical Staff Office is responsible for screening medical staff prior to appointment, and monthly thereafter. Vendors are not screened for exclusions.
Vendor Management	A P&P exists so that new vendors contracted are screened against the LEIE, the SAM, and state Medicaid exclusion lists, if applicable, prior to being contracted. Evidence of screening should be retained. A process exists for exclusion screenings to be performed on a monthly basis. The organization has established a process to ensure vendor and other third-party agreements are managed and consistent with the terms of the agreement, and an inventory of all outsourced vendors (e.g., Revenue Cycle, Rehabilitation Services, etc.) should be regularly monitored.	It was reported in interviews that vendors are required to register with RepTrax, a third-party vendor management system utilized by Bartlett. Interviewees were not sure if RepTrax performs vendor exclusion checks. It is not known if the Sanctioned Individuals P&P addresses excluded entities. PYA requested an interview with Bartlett's Legal department regarding, in part, the organization's process for managing vendor and other third-party agreements; however, the legal team was unavailable at the time of PYA's assessment.

[12] U.S. Department of Health and Human Services Office of Inspector General. "Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs." May 8, 2013: 15.

EXCLUSION SCREENING AND BACKGROUND CHECKS (cont.)		
Priority: High	**Expected Control**	**Current State**
Background Checks and Licensure Verification	There is a process to ensure that background checks and licensure verification are performed for new employees prior to hire, physicians, contractors, vendors, and others.	The Human Resource department conducts a State of Alaska background check, fingerprint, and licensure/credentials verification prior to hiring an employee. Interviews revealed exclusion screenings are part of the background check process but interviewees were not aware of which databases are screened. Exclusion screenings are performed but background checks are not for non-employed providers, vendors, contractors, and agents, etc.
Recommendations	1. PYA recommends the overall exclusion screening process be centrally managed, preferably by the compliance department. The act of conducting the initial and monthly exclusion checks for employees, providers, vendors, and contractors may be performed by a third-party vendor; however, the compliance department should evaluate its compliance with performing exclusion checks throughout the system with regular monthly monitoring. Employees, providers, vendors, and contractors should be screened against LEIE, SAM, and state Medicaid exclusion lists. 2. PYA recommends Bartlett develop a background screening and licensure verification P&P, and the process should be centrally managed within the organization. Background checks should be performed for all employees, physicians, contractors, and vendors. 3. PYA recommends developing an administrative vendor management P&P that clearly outlines the procurement process and responsibility of all vendors. Bartlett should regularly monitor this process to assure the screening and tracking of vendors is consistent for all vendors throughout the organization. 4. If not already in place, a formal process should be developed and implemented to evaluate third-party payer reimbursement to ensure such payment is in accordance with the contractual obligations.	

CONFLICT OF INTEREST		
Priority: Moderate	**Expected Control**	**Current State**
Conflict of Interest	There is a policy regarding who in the organization is required to complete a COI Disclosure statement. Disclosed conflicts are brought to the attention of the CAC and the Board. Board resolution of the conflict is documented and retained. Education is provided to all employees regarding COI.	The city of Juneau has a COI process, which Bartlett Board members are required to follow. Bartlett has a COI policy in place for vendors; however, the P&P was not available for review. The CoC references the need for employees to submit COI upon hire and annually, however, a standalone policy does not exist that details the requirements and process.
Recommendations	1. Bartlett should ensure that the COI P&P includes monitoring procedures that are specific for every area in the organization that manages COI. 2. Bartlett should regularly audit its COI disclosure process to assure consistency of execution and that the CMS Open Payments database is regularly reviewed to assess the accuracy and completeness of disclosures to monitor for financial conflicts.	

EXIT INTERVIEWS		
Priority: Moderate	**Expected Control**	**Current State**
Exit Interviews	The organization has established a P&P for conducting exit interviews with employees leaving the organization. The exit interview process includes questions related to compliance obligations and any known violations of law, policies, or procedures. All executives and high-risk employees should have an exit interview, along with questions regarding the Compliance Program and any concerns, risks, violations, or failures of the Compliance Program.	It was noted during interviews that Human Resources sends an exit interview through Survey Monkey to all termed employees and offers an in-person exit interview. The exit interview contains questions related to unethical conduct, illegal activity, manager honesty, safety, and orientation and training. The exit interview process was discussed during this evaluation.
Recommendations	1. PYA recommends in-person exit interviews be provided for termed Directors and above. All exit interviews should include questions related to compliance and retaliation (e.g., “Did you ever witness someone doing something illegal or unethical in the workplace?”).	

CONSISTENT ENFORCEMENT		
Priority: Moderate	**Expected Control**	**Current State**
Discipline for Non-Compliance	Discipline is consistent throughout the organization and documentation is present that supports disciplinary actions. Transparency exists regarding lessons learned.	Bartlett has a Corrective Action P&P but does not have a policy to specifically address disciplinary action for non-compliance.
Recommendations	1. A Discipline for Non-Compliance P&P should be developed and include progressive discipline for non-compliance, as well as follow-up education.	

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TRAINING AND EDUCATION

SUMMARY PRIORITY RANKING: MODERATE

COMPLIANCE TRAINING AND EDUCATION		
Priority: Moderate	**Expected Control**	**Current State**
Annual Compliance Training and Plan	The organization has an established compliance training plan that is regularly reviewed and updated (e.g., annually) to include identified topics via the annual risk assessment, OIG work plan updates, investigative findings, etc. Compliance training should be tracked, and a process should be developed regarding follow-up and sanctions for employees who fail to complete training.	PYA requested and received Bartlett's new hire compliance training to review for content. Interviews with the CRMD revealed that the CRMD presents compliance training at new employee orientation, which is held in-person. Interviews revealed that department leaders are responsible for ensuring employees complete annual compliance training, and employee training completion is tracked by the organization's education department.
Focused Compliance Training for Clinicians and High-Risk Positions	The organization integrates specific risks identified through the risk assessment process into compliance training, as well as solicits feedback from employees on training needs. Compliance education specifically addressing the Stark Law, Anti-Kickback Statute, and Civil Monetary Penalties is provided to all employees within 90 days of hire. Compliance training is offered for non-employed physicians and non-physician providers. Focused departmental/job related training is provided for individuals in high-risk positions (e.g., physician recruitment, coding, billing). Evidence of all training is maintained.	Based upon information collected at interviews and via questionnaire responses, compliance training is limited to new hire and basic annual training and does not integrate specific risks or solicit feedback from employees on training needs. Limited compliance resources restrict the ability to perform this expected control. The P&P which defines appropriate compliance training for job-specific education was discussed during the assessment.
Vendor Compliance Training	The organization has established training requirements for vendors and maintains evidence of completion. Compliance training is offered for vendors and third parties, and compliance language is included in vendor contracts.	An interview was requested, but Legal was not available to discuss whether vendor agreements contain compliance language.

COMPLIANCE TRAINING AND EDUCATION (cont.)	
Recommendations	1. PYA recommends the development of an administrative P&P related to job-specific education provided at the departmental level upon hire or transfer that focuses on department-specific compliance educational programs. Staff education on appropriate training topics will aide in the discernment between standards of care and service and compliance (i.e., legal and risk mitigation). 2. Further, PYA recommends that the CRMD or his/her designee review compliance-related education developed for these high-risk positions to assure that information on regulatory requirements, sanctions, and reporting is included, accurate and up to date. 3. Bartlett should ensure that all vendor agreements include compliance language and vendors have access to Bartlett's compliance P&P's and agree to abide by them.

ORGANIZATIONAL COMPLIANCE AWARENESS		
Priority: Low	**Expected Control**	**Current State**
Compliance Awareness	The organization promotes compliance through activities such as Compliance Awareness Week, Compliance Fairs, or other employee involvement activities.	As evidenced in interviews and questionnaire responses, compliance awareness is provided primarily through new hire training. Formal employee involvement activities have not been developed and implemented.
Recommendations	1. Upon adequate staffing in the compliance department, PYA recommends that Bartlett promote compliance activities through employee involvement activities, such as celebrating Compliance Awareness Week, regular newsletters, or other employee communication, etc. Promotion of compliance for such events assists with building a culture of compliance throughout the organization and keeps compliance "top of mind" and relevant for all employees.	

OPEN LINES OF COMMUNICATION

SUMMARY PRIORITY RANKING: MODERATE

INTERNAL REPORTING SYSTEM		
Priority: Moderate	**Expected Control**	**Current State**
Internal Reporting System/Hotline	An internal reporting system/hotline exists, is accessible, and is promoted so that team members can report compliance concerns anonymously, if desired, and without fear of retaliation. The hotline is well-publicized throughout the organization.	A compliance hotline exists which allows employees to use an internal Bartlett phone number and leave an anonymous voicemail message with concerns. It was noted during interviews, that Bartlett utilizes posters throughout the organization advertising the compliance hotline number.
	Business partners, contractors, etc. are aware of an internal reporting system/hotline.	Interviews revealed that non-employees (e.g., non-employed physicians, vendors, patients, family members, etc.) may use the compliance hotline to report concerns. Interviewees stated that this information is listed on the organization's website and in its patient education documents.
	A policy exists, and staff are aware of the reporting and investigation process for how a concern is handled.	Bartlett should ensure that the Reporting Violations P&P addresses the compliance hotline including reporting procedures for workforce members, business partners, contractors, etc. Leadership indicated during interviews that employees are knowledgeable of the compliance hotline and how to report concerns to the CRMD.
Recommendations	1. PYA recommends that an administrative, standalone P&P for the internal reporting process be developed to include all affected persons (e.g., vendors, business partners, contractors, etc.) that work and/or provide services within Bartlett. 2. PYA recommends that Bartlett utilize a hotline number through a third-party vendor to allow for consistent documentation, tracking, and anonymous reporting. Education should be provided regarding reporting requirements, including detailed information regarding the various methods for reporting. The hotline number should be well-publicized throughout the organization utilizing posters, communications with patients, and the website.	

RESPONSE TO DETECTED DEFICIENCIES

SUMMARY PRIORITY RANKING: LOW

INVESTIGATION PROCESS		
Priority: Low	**Expected Control**	**Current State**
Investigation Communication	The organization has guidelines established to ensure thorough, credible, and complete investigations are done in a consistent, timely manner, inclusive of individual accountability, and resolutions are documented and monitored accordingly, including discipline for non-compliance. Education on the investigative process is provided at hire and annually so employees know what to expect.	It was reported during interviews that when a compliance matter is received, the CRMD is responsible for investigating the matter and determining remedial measures. The investigation process is documented in an Excel spreadsheet maintained by the CRMD. Privacy matters are sent to the HIM Director for investigation. Interviews also revealed that education regarding the investigative process is not provided during initial or annual training.
	The outcome of an investigation is communicated appropriately to the reporting individual, as well as senior leadership and the governing board, promoting an active and responsible compliance culture. The long-term effectiveness of remedial measures is evaluated and used as education for "lessons learned" to the organization.	It was reported during interviews, that the outcome of compliance investigations is provided to the reporter when the reporter does not choose to remain anonymous. A Compliance Internal Investigations P&P exists, but was not provided for content review to determine whether there is a formal process for reporting compliance matters and investigations to senior leadership and the CAC.
	When appropriate, investigations are coordinated with legal counsel.	Interviews revealed that investigations are coordinated with outside legal counsel, as necessary.
Recommendations	1. Bartlett should ensure that the status of the investigation (e.g., underway, closed, resolved), is reported to administrative leadership, the governing body, and the relator of the concern, if they are not anonymous. Documentation should be maintained that includes details regarding follow-up provided to the reporting individual. Utilizing a third-party hotline would provide a case number for each report and allow the investigator to follow-up with anonymous reporters. 2. The effectiveness of remedial measures taken for compliance and privacy investigations should be evaluated for organizational improvement purposes. 3. PYA recommends that, upon adequate staffing of the compliance department, reports and concerns should be evaluated and education of such should be incorporated into Bartlett's Compliance Training Plan.	

AUDITING AND MONITORING

SUMMARY PRIORITY RANKING: HIGH

Risk Assessment		
Priority: High	**Expected Control**	**Current State**
Risk Assessment	An enterprise-wide risk assessment is conducted annually (frequency) and the information is used to create the auditing and monitoring plan or work plan. The resulting work plan is risk-based and identifies participants (interviews), prioritized topics, mitigation steps, education, and reported results. Follow-up risk assessments are performed, and their effectiveness is monitored by the HCC and reported to leadership.	Interviews revealed that the HCC reviews active OIG and state work plan items as they are added, as well as internal tracking of compliance activity to determine applicability to the organization for inclusion in the current compliance work plan. Items added to the work plan as a result include a risk ranking for mitigation and reporting purposes. While the CRMD completes an annual compliance review across the organization, a formal enterprise-wide risk assessment which includes compliance risk feedback and input from leadership across the organization has not yet been conducted for Bartlett. Bartlett plans to utilize the results from the risk assessment included in this review as the basis for its 2021 risk assessment.
Recommendations	1. Bartlett should formalize the organizational risk-assessment process, including a process for inclusion of feedback and input received from across the organization. Items added to the work plan as a result of the risk assessment process should be detailed and prioritized pursuant to specific risk assessment findings. Additionally, Bartlett should utilize the recommendations contained herein to assist with work plan development. 2. Upon completion of the enterprise-wide risk assessment, follow-up risk assessments should be performed for areas identified in the risk assessment. Ongoing monitoring of those areas and effectiveness should be regularly communicated to the HCC.	

Annual Compliance Work Plan		
Priority: High	**Expected Control**	**Current State**
Audit Work Plan	At minimum, the compliance work plan is updated annually and reflects the most significant compliance risks. The scope of auditing and monitoring is based on the risk areas identified in the compliance risk assessment. There are periodic reviews of the monitoring and auditing plan and completion rates are documented for the compliance work plan.	The CRMD and HCC members are responsible for identifying work plan items on a quarterly basis. The work plan is presented to the CAC for review and approval. Bartlett will utilize the results from the risk assessment included in PYA's review to formulate a risk-based work plan.

Annual Compliance Work Plan (cont.)		
Priority: High	**Expected Control**	**Current State**
Audit Processes	There is evidence that the organization is conducting audits and the results are reported to the CAC and Board.	Interviews indicated there is evidence of departmental compliance auditing and monitoring (e.g., monthly chart audits, outlier log). Interviews revealed that results from audits conducted as part of the compliance work plan are reported to the HCC and in summary to CAC, as appropriate.
EMR Audits and Access to ePHI	Audits of electronic patient information access are regularly performed.	At the time of PYA's assessment, Fair Warning was being implemented within the organization to be used to identify inappropriate patient information access.
Audit the Auditor Process	A process is in place to periodically "audit the auditors" that includes independent, third-party auditors who evaluate the current coding auditors process, competency/skillset, and guidelines.	Interviews did not indicate "audit the auditor" activities are being conducted.
Internal or External Assessments	An evaluation of billing and coding processes is performed by external or internal parties, and results are shared as appropriate to improve performance (e.g., education).	As represented in interviews, there is evidence of departmental compliance auditing and monitoring; however, in review of the HCC minutes, discussions of the results were not noted. It was noted during interviews that the RCC conducted internal coding and billing audits; however, internal audits were paused as a result of external self-auditing activities, which were reviewed by the RCC.
Claims Trending	Trending is performed on claims data to identify patterns that may indicate errors and merit investigations, including denials, misuse of modifiers, unbundling, credit balances and others.	Interviews revealed that every 30 days, credit balances are reviewed by Revenue Cycle. In addition, report data is run on outlier payments and condition codes on a quarterly basis. Other claims data trending was not noted during interviews.

Annual Compliance Work Plan (cont.)	
Recommendations	1. Bartlett should utilize PYA's compliance program and risk assessment findings to develop a risk based focused work plan for CY 2021/2022. The work plan should be presented to and approved by the CAC. 2. Departments should conduct regular internal auditing and monitoring activities, the results of which should be reported the HCC for review and approval. Action Plans for remedial measures should be developed when findings of non-compliance are identified. 3. Bartlett should implement a process for "auditing the auditor" to determine whether Coders have adequate competencies and skillsets. 4. PYA recommends the re-instatement of regularly performed coding and billing auditing and monitoring activities by the RCC. Results should be reported to the HCC and the CAC. Action Plans should be developed when there are findings of non-compliance. 5. Departmental monitoring and auditing activity results should be reported to the HCC on a scheduled and as needed basis. Further, ad hoc reporting of issues requiring additional monitoring or auditing should be reported to the HCC. 6. Bartlett should utilize internal or external resources to conduct regular claims data trending to identify errors or areas of non-compliance. Examples of claims data trending could include denial patterns, modifier usage, unbundling of services, E/M up-coding, etc.

Risk Assessment		
Priority: High	**Expected Control**	**Current State**
Overpayments	To adhere to the 60-day payback rule, incorrect claims identified through retrospective reviews/audits are repaid no later than 60 days following the date the overpayment was identified.	The Overpayments P&P outlining the issuance of refunds and overpayments within 60 days following the date of identification was discussed during the assessment. It was noted in interviews that a credit balance report is run regularly to identify potential overpayments.
Recommendations	1. PYA recommends Bartlett develop an overpayments P&P to ensure that the Overpayment Rule requirements are met, including that incorrect claims identified through retrospective reviews/audits be repaid no later than 60 days following the date the overpayment was identified, with regard to refunding overpayments to governmental payers, including, Medicare, Medicare Advantage and state Medicaid. Consequences for failing to timely report and return any identified overpayments may subject supported practices to liability under the False Claims Act. 2. PYA recommends that Patient Financial Services reviews information related to billing errors, claims re-payments, payer audits, and patient billing complaints to identify potential overpayments and take appropriate action to refund.	

APPENDIX B: COMPLIANCE RISK ASSESSMENT SUMMARY AND DETAILED FINDINGS

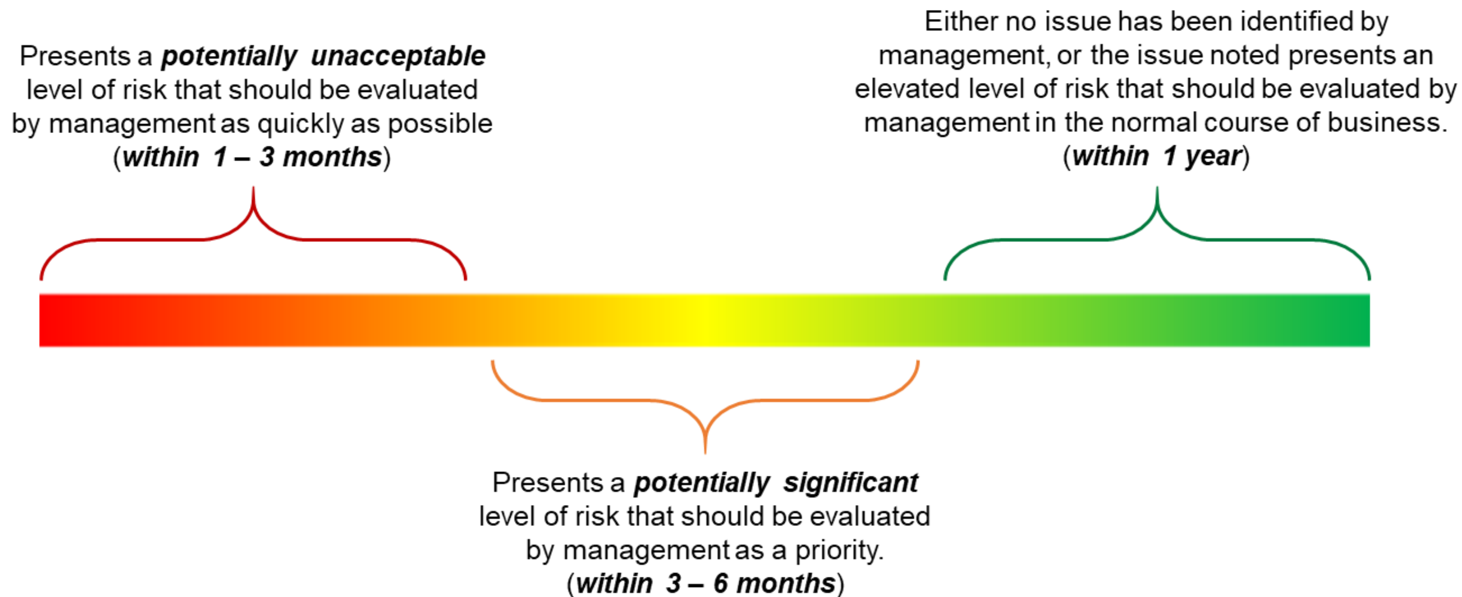
COMPLIANCE RISK ASSESSMENT SUMMARY

"Compliance Risk" is a risk of loss resulting from failure to follow an internal policy or requirement, or the failure to follow an external legal requirement, such as a law or regulation, including contractual requirements. Effective compliance programs engage in the regular and systematic identification and assessment of key risk areas. To identity key risk areas, PYA completed a review of documents provided by Bartlett, including P&Ps and reports received; completed virtual interviews with a cross-section of leaders in the organization; and incorporated Bartlett's responses to the PYA Risk Assessment questionnaires.

To manage identified organizational risks, it is essential to create a process that prioritizes and assigns accountability for existing or potential threats related to legal or policy non-compliance or ethical misconduct to avoid possible fines/penalties, reputational damage, and/or the inability to operate in key markets.

RISK RANKING DEFINITIONS

A graded system of organizational exposure has been established based on the following definitions:



COMPLIANCE RISK RANKING SUMMARY RESULTS

PYA offers the following results, incorporating virtual interviews with management of Bartlett and members of the Board. The key risk areas ranked in this report are those that potentially expose the organization to a substantive level of exposure or loss. The identified risk items should be evaluated and prioritized for inclusion in Bartlett's compliance work plan based on institutional knowledge of the operational areas. PYA's recommendations are provided in accordance with healthcare industry best practices; however, Bartlett may choose to accept certain risks in order to allow for operational strategies, as well as the accepted level of risk tolerance.

The graph below represents the total score for the risk ranking of key organizational risk categories. The detailed findings associated with each risk ranking are also included herein.

Risk Scale

Compliance Management
COVID-19
Documentation & Coding
HIPAA Privacy
Human Resources
Information Technology
Medical Staff Office Credentialing
Pharmacy
Physician Financial Arrangements
Physician Practices
Patient Billing
Quality Reporting
Revenue Cycle
Strategic Planning/New Service Lines
Vendor Contract Management

ESTABLISHING INTERNAL CONTROLS TO ADDRESS ORGANIZATIONAL RISK

Risk is inherent in healthcare operations, and while each organization has specific areas of risk that must be considered in strategic initiatives and day-to-day functions, there are risks that are prevalent throughout the industry. Robust internal controls are effective tools for preventing losses, safeguarding operations, and achieving organizational goals and strategic objectives.

As healthcare organizations continue to face increased legislative and regulatory scrutiny, the implementation of strong internal controls aimed at addressing organizational risk is more important than ever. Accordingly, as detailed in the table on the following page, PYA noted several areas in which Bartlett has communicated that they have robust internal controls in place which are operating effectively to reduce the industry risk associated with that area and provide for effective operational processes.

PYA did not verify the existence nor test whether these identified controls are effective; however, based upon our experience, these reported controls appear to be in line with industry requirements and/or best practices.

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Risk Area	Internal Controls Communicated to Be in Place to Mitigate Risk
Information Technology	• The organization has a process in place to assure that all workstations, laptops, and tablets are updated with anti-virus and/or endpoint security and critical security patches per industry standards. • The organization completes an annual HIPAA Security Risk Analysis (HSRA) that includes an assessment of data at rest. • The organization has a plan in place to manage the enterprise in the event of a cyber-attack that includes the ability to detect attackers, efficiently respond to events, and restore operations. • The organization has a well-defined IT project management process. • A process is in place to protect biomedical devices from cybersecurity threats, including product procurement security standards, device testing prior to implementation, and regularly scheduled biomedical device functional assessments.
Physician Financial Arrangements	• The types of physician arrangements are defined and approved contract templates are in place for each., e.g., Employment, Independent Contractor, Medical Director, On-call, etc. • Arrangements for physician services are monitored for compliance with the Stark Law and the Anti-Kickback Statute. • All physician contracts are audited for appropriate execution (terms, signatures, dates/timeframes, etc.), implementation, and reconciliation. • The physician compensation arrangement represents fair market value in an arm's-length transaction for the items and services.
Physician Practices	• The practice reviews claims and medical records for compliance with applicable coding, billing, and documentation requirements. • An appropriate protocol is in place to respond to issues detected during audits. • All practice employees receive compliance training and understand that compliance is a condition of employment.
Revenue Cycle and Patient Billing	• Denials are managed on a daily basis. • Third-party audit requests that result in refunds of overpayments are analyzed for system and human errors, and appropriate action plans are implemented. • The organization follows the 'payment window' rules applicable to each payer in combining outpatient services with inpatient claims. • Remittance information is appropriately updated and routinely monitored against claims data.

Compliance risks identified by weak or absent internal controls during PYA's risk assessment review are provided in the Risk Assessment Detailed Findings and include the expected internal control, the current state of implementation at Bartlett, and recommendations for identified gaps. Bartlett should incorporate the prioritized items contained below into its compliance work plan and develop a strategy for developing and/or strengthening the associated internal control(s) as part of its risk mitigation processes.

COMPLIANCE RISK ASSESSMENT DETAILED FINDINGS

COMPLIANCE MANAGEMENT

<table>
<tr><th colspan="2">COMPLIANCE MANAGEMENT: CONFLICT OF INTEREST</th></tr>
<tr><th>Expected Control</th><th>Current State</th></tr>
<tr><td>COI statements are obtained initially and annually for board members, community committee members, management, staff, physicians, and vendors.

Disclosed conflicts are brought to the attention of the CAC and Board. Resolution of conflicts are documented and retained.</td><td>As reported in interviews with management, the organization's COI process is described within the CoC; however, there is not a defined and documented procedure for reporting of potential or actual conflicts for vendors. Interviewees stated that Bartlett has implemented the following processes for obtaining COI disclosures from board members, committee members, management, staff, and physicians:

• Medical Staff: Initial COI disclosures are obtained initially as part of credentialing. Annual attestations for medical staff members are not currently required.

• Management and Staff: Initial COI disclosures are obtained initially as part of the hiring process by Human Resources. Annually, Human Resources is responsible for obtaining and maintaining documentation of annual COI attestations.

• Board Members: As the Board is a City of Juneau entity, and not a Bartlett entity, Board members are required to submit potential conflicts of interest directly to the City of Juneau pursuant to the City's COI policies and procedures. Additionally, while there does not appear to be a formalized process in place for Board members to disclose potential or actual conflicts to Bartlett's HCC, Board members are asked to recuse themselves from conversations and decisions where a conflict exists.</td></tr>
<tr><td colspan="2">Recommendations

1. Develop and implement a COI management plan that includes auditing and monitoring of disclosure attestations followed with periodic education, enforcement guidelines, and mitigation steps to reduce the risk of COI non-compliance.

2. Utilize the CMS Open Payments database to validate COI disclosures and evaluate providers' financial relationships.

3. Establish COI control metrics with disclosures reported to the CAC and the Board as appropriate.

4. Evaluate physician financial relationships and vendor process/product reviews to identify potential conflicts. Compliance should follow through to identify and report cases which pose a COI risk.

5. Obtain confirmation from the City of Juneau that Bartlett Board members have provided COI disclosures and that all disclosures received have been reviewed by the City's legal department. Additionally, Bartlett should ensure that all conflicts determined to exist are reported to the CRMD for inclusion as part of the COI management plan.</td></tr>
</table>

COMPLIANCE MANAGEMENT: AUDITING AND MONITORING	
Expected Control	**Current State**
Departments are educated on the types of compliance audits that are essential to organizational operations, as well as how to participate in compliance monitoring and auditing. Operational compliance related audits are reported to Compliance.	As determined by interviews with management, several organizational departments are performing departmental monitoring. The results are largely utilized within the department and shared with the HCC and the CAC, as appropriate. Bartlett has a strong RCC that carries out regular auditing of the revenue cycle function, including chart audits, outlier review, observation stays, registration process, overpayments, etc. While members of the revenue cycle team are on the HCC, information from the RCC is not regularly shared with the HCC. This is due in part to the overlap of membership between the two committees. PYA requested and received copies of HCC agendas and minutes to review for evidence of departmental compliance activity.

Recommendations:

1. Develop and implement a compliance work plan which incorporates structured compliance auditing processes to address high-priority organizational risks. PYA supports Bartlett's assignment of responsibility to the department directly involved in the identified risk. Additionally, Bartlett should ensure that auditing and monitoring processes include expected controls, findings/observations, appropriate follow-up activities, and corrective actions indicated to mitigate risk.
2. Compliance risks should be identified by applying consistent auditing and monitoring techniques and benchmarks throughout the entire organization. Internal departmental auditing practices and processes should be established through the use of departmental compliance work plans. A sample departmental compliance work plan template has been provided in ***Appendix F***. Reporting of departmental audit findings and compliance controls should continue to occur through the HCC and be documented in the committee meeting minutes. Further, Bartlett should ensure that the RCC continues to provide regular RCM reports to the HCC.
3. Develop and implement a comprehensive internal and external audit schedule, including quality thresholds, required education, consequences, and disciplinary actions for failure to meet required thresholds.
4. Compliance metrics which measure the effectiveness of key performance improvement areas should be established and implemented.
5. As part of the annual risk assessment, coding, billing, medically necessary audits, and findings should be listed in the compliance work plan with detailed expectations, thresholds, corrective actions, and education metrics. The results should be reported to affected members of Bartlett management for corrective and improvement actions. A comprehensive summary result of the audits should also be reported to the CAC.
6. PYA supports the RCC and the important role they play in organizational compliance. However, a formal and regular reporting of information from the RCC needs to be brought to the HCC to show the strong controls that are in place for the Revenue Cycle function as part of organizational compliance.

COMPLIANCE MANAGEMENT: OIG EXCLUSION SCREENING	
Expected Control	**Current State**
All providers, employees and vendors are screened for OIG exclusion prior to hiring or contracting with an individual or entity and monthly thereafter.	Interviews revealed that initial exclusion checks for employees are completed by Human Resources. Initial exclusion checks for physicians are completed by the Medical Staff Office. As reported in interviews, initial exclusion checks are not performed for vendors; however, monthly exclusion checks are completed for employees, physicians, and vendors. The Exclusion Checks P&P was discussed for purposes of this review.
The organization searches the available state Medicaid exclusion lists in addition to the OIG's LEIE.	Interviews revealed that exclusion checks are performed for "the big five databases"; however, state Medicaid databases outside of Alaska are not included as part of the exclusion check process.

Recommendations

1. As recommended within the Compliance Program Assessment Detailed Findings section of this report, Bartlett should develop and implement a vendor management P&P. The processes detailed therein should be reviewed and assessed periodically to ensure that the controls and oversight processes support the regulations outlined in federal and state requirements. The P&P should include processes associated with the identification and exclusion of vendors who are found to be excluded through sanctions and exclusion checks, as well as the process to reinstate vendors after an exclusion period has expired. Education regarding a revised P&P, and the associated requirements and expectations, should be provided.
2. Regular audits of the vendor management P&P should be conducted to ensure compliance with Bartlett's sanction screening and reinstatement processes.
3. Sanction screening should include a nationwide search of all state licensing boards as a best practice.
4. Consider utilization of a third-party solution to assist in performing initial and monthly exclusion screenings. Such a solution will check federal databases, such as OIG, SAM, the Office of Foreign Assets Control of the U.S. Treasury Specifically Designated Nationals and Blocked Persons list, as well as state Medicaid exclusion databases.

COMPLIANCE MANAGEMENT: ADEQUATE RESOURCES	
Expected Control	**Current State**
The compliance department is adequately staffed to provide adequate regulatory oversight.	Currently, the compliance department is staffed by the CRMD, who represents a 0.5 FTE for the Compliance function. The CRMD is also responsible for the Risk Management function. While compliance efforts and resulting expenditures should be scaled to Bartlett's operations and resources should be focused on addressing risks, the budget for the Program, excluding the CRMD's and Contract Administrator's salaries, is $20,000 – $30,000.
The organization has a designated Privacy Officer.	During interviews with management, it was reported that the HIM director functions as the Privacy Officer for the organization; however, the position description for the director does not include Privacy Program responsibilities.

Recommendations

1. PYA recommends that the compliance function be supported by two FTEs, inclusive of a dedicated FTE CCO. Given Bartlett's growth of services in recent years, evaluating necessary resources at a minimum, annually, will be a critical component to developing and maintaining a robust Program. Please refer to the "Dedicated Compliance Resources" section of this report, found in the Executive Summary, for specific recommendations related to proposed staffing levels and infrastructure.
2. Understanding the distinct roles and responsibilities associated with Compliance and Risk Management, Bartlett should consider establishing a separate Risk Management Director role to carry out the responsibilities associated with the Risk Management function. Risk Management should continue to report to the CCO to continue to ensure optimal collaboration and value to the organization.
3. In order to have an effective Program to identify and mitigate risks, PYA recommends that Bartlett establish a compliance budget that will allow the Program to operate efficiently, demonstrate support and commitment from leadership, and reinforce the independence of the compliance department.[13]
4. PYA recommends that the position description for the HIM Director be revised to include specific responsibilities for the HIPAA Privacy Program. Additionally, the position description for the Information Systems Director should be revised to include specific responsibilities for the HIPAA Security Program. The organization should be made aware of both the Privacy and Security Officer roles.

[13] Budgeted activities may include, but are limited to compliance and other healthcare industry training, compliance certifications, professional association memberships, subscriptions, compliance and regulatory update materials, software applications, legal services, outsourced audits, compliance program evaluation, compliance risk assessment, compliance program awareness activities, etc.

COVID-19

COVID-19: WAIVERS	
Expected Control	**Current State**
The organization has developed policies for documenting use of waivers when changing established operations in response to the PHE, including tracking provider relief funding. The organization has a process in place for unwinding arrangements dependent upon waivers and flexibilities following the end of the COVID-19 PHE.	As noted in interviews with management, tracking of PHE-related expenses is the responsibility of each department and a centralized process for Provider Relief Funding (PRF) reporting has not been developed. From a clinical perspective, the organization has invested substantial resources to ensure patients have access to testing and treatment. The Emergency Department (ED) is involved with facility requirements and readiness maneuvers to ensure staff and patient safety when providing care to COVID-positive patients. Further, the Quality department has a dedicated resource to stay up to date on COVID information, including regulatory requirements.
The organization routinely audits use of the blanket waivers to ensure the provisions are appropriately implemented.	During interviews with management, concerns were voiced regarding circumstances when the PHE waivers are lifted and ensuring that proper processes are implemented in response thereto. Additionally, it was reported that many of the waiver allowances are still in use despite changes in PHE circumstances.

Recommendations

1. Ensure that a centralized process to report and document the use of PRF is developed and implemented immediately to ensure compliance with the conditions imposed. The process should include detailed information regarding reporting the use of any PRF, including any monies returned that were provided but not utilized.
2. Ensure that a detailed process is in place that allows for appropriate notification regarding waiver expirations. Upon notification of expiration, a process must be developed and implemented that allows the organization to immediately revert to prior requirements.

COVID-19: TELEHEALTH	
Expected Control	**Current State**
The organization has processes in place to meet the expanded use of telehealth, including appropriate documentation and the accurate use of procedure codes, modifiers, and place of service. The organization understands and has incorporated the current CMS regulatory requirements into their telehealth processes during the PHE.	As evidenced by information shared in interviews, the organization does not have one individual or workgroup responsible for telehealth. Each department involved in providing telehealth has their own processes. In order to implement telehealth to a wide panel of patients, it was reported in interviews that the organization had to quickly establish the necessary processes including technology, documentation, coding, and billing in response to the PHE. Interviewees stated that an external billing/coding audit for these services has been approved, but not yet completed. Management reports that due to the decentralized processes, tracking PHE waivers and policy changes has been challenging in order to ensure compliance with regulatory requirements. As reported in interviews with management, the organization is planning to complete a third-party audit of telehealth services.

Recommendations

1. PYA recommends that one individual at Bartlett be responsible for telehealth throughout the organization to ensure consistency of use and compliance with regulatory requirements.
2. Bartlett should complete the external billing/coding audit of telehealth services to ensure that appropriate revenue cycle processes are developed and implemented to meet the expanded use of telehealth, including appropriate documentation and the accurate use of procedure codes, modifiers, and place of service. The process should also include detailed information regarding the CMS requirements to post charges to COVID-19 testing.
3. Given the expanded use of telehealth, Bartlett should review the OIG Work Plan item "Medicare Part B Telehealth Services During the PHE"[14] to ensure that such services meeting the Medicare requirements, for example the use of telehealth for Evaluation and Management, Psychotherapy, Opioid Use, Site Locations, Remote Patient Monitoring, Virtual Check-in Services, and Annual Wellness Visits.
4. Bartlett should review the financial assistance policies to assure that any adjustments made during the PHE are clearly delineated both as to their application and the time period for the adjustment to be in place.
5. PYA supports Bartlett's plan to complete a third-party audit of telehealth services. Upon completion of the audit, issues identified should be included in the compliance work plan.

[14] https://www.oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000556.asp

DOCUMENTATION AND CODING

DOCUMENTATION AND CODING: CODING AUDITS	
Expected Control	**Current State**
The accuracy of coding is independently audited on a regular basis and reported to oversight committees.	As reported in interviews with Bartlett leadership, a formal process to independently audit organization coders has not been developed or implemented. Interviewees stated that consideration is being given to completing an audit in the future; however, a final decision has not been made.

Recommendations

1. Evaluate the necessary competency of coders, particularly those in specialized areas, and mitigate those risks accordingly to minimize lost revenues and maintain compliance with regulatory requirements.
2. PYA recommends that Bartlett develop a formal coding review P&P that clearly defines quality thresholds, required education, and action plan documentation.
3. Defined timelines for follow up audits should be developed and required quality thresholds enforced. Results should be communicated to appropriate leadership.
4. An external review of a sample of claims should be conducted annually, as a best practice.

DOCUMENTATION AND CODING: USE OF MODIFIERS	
Expected Control	**Current State**
Coding modifiers are applied by coding staff, rather than billing staff, and regular audits are completed to review high-risk modifiers.	Management reports the billing staff apply coding modifiers in response to claim edits for surgery and other procedures.

Recommendations

1. Coding professionals should verify the clinical circumstances and accuracy of any modifier applied to a code for claims submission. Modifiers for CPT and HCPCS codes should be supported by documentation and applied in accordance with CMS National Correct Coding Initiative (NCCI) coding or billing requirements.

DOCUMENTATION AND CODING: PHYSICIAN QUERIES AND DOCUMENTATION	
Expected Control	**Current State**
Clinical Documentation queries are done in compliance with industry standards and regulatory requirements in order to produce legible, consistent, complete, precise, nonconflicting, and clinically valid documentation.	As evidenced in interviews with management, certain physicians do not respond to clinical documentation queries. Further, there are no sanctions imposed for non-response to these queries. As reported during interviews with management, certain physicians in the organization do not follow the policy requirements for documentation and there is a lack of authority for behavioral health management to level enforcement actions, such as suspension of privileges.

Recommendations

1. PYA recommends that Bartlett implement enforceable clinical documentation policies that are in accordance with medical staff by-laws and industry best practices. Examples include chart completion, query retention, and query escalation.
2. Non-compliance with processes for query response and clinical documentation requirements should be reported to the Chief of Staff and executive management for disciplinary actions and resolution.
3. Documentation should be completed as soon as possible after the service is rendered to assure patient documentation is accurate and complete. In addition, thorough and complete documentation is required for reimbursement by third-party payers.

DOCUMENTATION AND CODING: RELEASE OF INFORMATION (ROI)	
Expected Control	**Current State**
Processing of requests of information is consistent across the organization, inclusive of verifying the completeness of the request, the authority of the requestor, the identity of the patient, and the appropriateness of the information requested.	It was noted in interviews that, while a consistent ROI process has been implemented and is utilized by the HIM Department, there are concerns regarding the inconsistent, informal processes utilized by other departments to release records, particularly relating to the release of Bartlett records.

Recommendations

1. PYA recommends that Bartlett consider implementation of a centralized ROI process which would allow for streamlined processes and would provide direction to staff who receive records requests. Further, all staff impacted by ROI should receive education on the proper procedure to release patient information.

PHARMACY

PHARMACY: 340B COMPLIANCE	
Expected Control	**Current State**
For the 340B program, child sites included in the organization's cost report are reimbursable cost centers.	Interviews with Bartlett management revealed that there are concerns regarding the designation of the Bartlett Outpatient Psychiatric Services as an eligible location for 340B medication dispensation. Interviewees stated that, in response to this concern, Bartlett has requested guidance on eligible locations from a third-party firm utilized to prepare its Medicare Cost Report.
There is an audit process in place to ensure the 340B requirements are being met.	340B Programs can be a high-risk area for organizations due to vulnerabilities to waste, abuse, and mismanagement. Government oversight agencies, such as HRSA, OIG, and GAO, have placed emphasis on increasing oversight of hospitals who participate in 340B. While controls have been implemented in response to regulatory standards, including inclusion of the Pharmacy Director on the organization's HCC in an effort to address issues and concerns proactively, currently, there is no formal internal audit process in place to evaluate 340B program compliance. Interviews revealed that an external audit is underway, with results pending as of the time of PYA's review.
The organization is able to articulate how the savings realized through the participation of the 340B program allows the organization to reach more eligible patients and provide more comprehensive services.	Interviews revealed that, while the organization has recognized significant savings from participation in the 340B Program, Bartlett has been unable to quantify the specific services benefitting from the savings achieved by participating in the Program.

PHARMACY: 340B COMPLIANCE (cont.)

Recommendations

1. Develop, educate, and implement P&Ps regarding the organization's 340B Program and the requirements associated therewith. PYA supports the inclusion of the Pharmacy Director as a member of the organization's HCC; however, Bartlett should develop and implement a formal ongoing monitoring and auditing process and results should be regularly reported to the HCC.
2. PYA recommends that an annual review of the 340B Program be included as part of the compliance work plan. The review should include a review of database accuracy, compliance with eligibility requirements, maintenance of required records, review of contract pharmacy arrangements, the process for material breach, and performance of appropriate program monitoring. An external, independent review should be conducted every 2 – 3 years and more often if Bartlett expands its contract pharmacy program.
3. Issues identified pursuant to the recent external 340B Program audit should be included as part of the compliance work plan.
4. As a 340B covered entity, Bartlett should develop a process that allows the organization to articulate the value of 340B program and document the use of savings realized from participation in the program. This will allow Bartlett to demonstrate how the 340B program expands access to underserved patient populations. A publicly posted tool[15] can assist in determining and documenting the program savings.

[15] https://docs.340bpvp.com/documents/public/resourcecenter/calculating-340b-program-value-and-use-of-savings.docx

STRATEGIC PLANNING

STRATEGIC PLANNING: RISKS AND OPPORTUNITIES	
Expected Control	**Current State**
When developing the organization's vision and strategic plan, leaders assess organizational risks for the organization. Regulatory requirements are included in the organization's strategic planning process. The CCO is a key stakeholder in the strategic initiatives of the organization, including strategic planning and due diligence processes.	Interviews revealed that organizational risks are not formally included in the strategic planning development process; however, interviewees stated that Bartlett has implemented a program entitled "Focus and Execute" in order to assist with the operationalization of strategic objectives, organization wide. Further, interviews found that the CRMD is not a key stakeholder in the development of organizational strategic objectives and proactive consideration of regulatory requirements and potential for organizational risk is not always considered prior to the implementation of strategic planning objectives.

Recommendations

1. Strategic goals and initiatives need to align with regulatory requirements, accreditation standards, and industry events. Bartlett should establish an alliance between corporate strategy and the compliance program to mitigate potential compliance risk associated with key organizational initiatives.
2. With involvement of the CRMD, the risk environment and appetite of the organization can be taken into consideration with strategic initiatives to ensure that the initiative planning is carried out with integrity and includes risk mitigation.

STRATEGIC PLANNING: NEW SERVICE LINES	
Expected Control	**Current State**
Compliance risks are defined and understood for all proposed new service lines.	It was reported in interviews with management that there was a "New Service Line Committee" in place in the past, but this group is not currently functional. Decisions for new service line development and changes to service lines are accomplished by the department leader. The CRMD plans to reactivate the committee following this assessment. Additionally, interviews revealed that certain recent new services have been established in response to the PHE in order to provide necessary services to patients. While patient care delivery has been a primary consideration, compliance risks, such as ensuring adequate knowledge of and ability to meet associated regulatory and payer policy requirements, are not always proactively addressed.
A legal review has been completed for all contracts for the new service line including physicians, vendors, third party billing companies, and any other contracted services.	As determined during this assessment, contracts are reviewed by the Bartlett contract administrator. Additionally, legal services are provided by outside counsel and the city attorney as necessary. The level of involvement of legal services in review of contracts for new service lines is not clear.
Federal and state requirements (including program licensing and accreditation) have been assessed/reviewed for this program/service.	Members of management expressed concern that the organization could be exposed to risk due to dynamic rules and waivers associated with the PHE. As previously mentioned, certain new service lines were reactively established to address organizational limitations in order to meet patient needs and during the PHE without a firm understanding of the underlying regulatory implications.

Recommendations

1. PYA supports the CRMD's efforts to revive the New Service Line Committee in order to define and understand risks associated with new services.
2. Any contractual arrangements associated with new service lines should be analyzed by legal counsel prior to execution.
3. New service offerings initiated in response to the PHE should be carefully scrutinized to determine the regulatory implications on both the state and federal level. A third-party review by an industry expert with knowledge of state and federal PHE regulations is advised.

VENDOR MANAGEMENT

VENDOR MANAGEMENT: STANDARDIZED PROCESSES	
Expected Control	**Current State**
Controls exist to ensure that contractors with which the organization does business are aware of the compliance program and their obligations to comply with state and federal regulations. Policies are in place regarding: • The organization's contract procurement and approval process. • Guidelines for receipt of gifts. • Process for providing vendors with information on false claims and whistleblower protection according to the Deficit Reduction Act.	Interviews revealed that vendor contracts are managed by the organization's Contract Administrator; however, a formal vendor management process has not been established. Interviewees stated that there is not a clearly identified process which outlines specifically requirements for the vendor procurement process and responsibility of vendors.
All providers, employees and vendors are screened for OIG exclusion prior to hiring or contracting with an individual or entity and monthly thereafter. Excluded persons and entities are prohibited from furnishing administrative and management services that are payable by federal health care programs.	Bartlett utilizes RepTrax as a vendor management solution and it was noted during interviews that vendor representatives who visit the organization are required to check-in via RepTrax prior to being granted access to departmental areas. Additionally, interviewees stated that the majority of vendors are established, and new vendors are rarely utilized. Therefore, it was reported that a process to screen vendors both initially upon procurement as well as monthly is not utilized.

Recommendations

1. PYA recommends that, upon development of an administrative vendor management P&P as recommended in the *Compliance Program Detailed Findings* section of this report, Bartlett should conduct regular audits of the P&P to ensure compliance with the processes contained therein.
2. A vendor contract monitoring plan should be implemented to assess compliance with contract terms and conditions, as well as performance metrics.
3. As part of the vendor management program, vendor COI controls should be developed, implemented, and enforced to diminish and prevent vendors and contractors, particularly referral sources, from influencing decisions to review or acquire products that pose potential or actual COI. Additionally, vendor product and services usage should be audited for possible conflicts.

APPENDIX C: COMPLIANCE PROGRAM AND RISK ASSESSMENT INTERVIEW LIST

COMPLIANCE PROGRAM AND RISK ASSESSMENT INTERVIEW LIST

DEPARTMENT NAME	PERSONNEL IN ATTENDANCE	DEPARTMENT NAME	PERSONNEL IN ATTENDANCE
HIPAA Privacy and Security	• Rachel Stark • Scott Chille	**Ancillary Services**	• Ursula Iha • John Fortin • Paul Hawkins • Robert Follett • James Reed
Organizational Leadership	• Kevin Benson • William Gardner	**Information Technology**	• Scott Chille • Max Salassi
Health Information Management	• Rachel Stark	**Medical Staff Office**	• Debbie Kesselring
Quality Management	• Gail Moorhead • Debbie Kesselring	**Finance, Contracting, Physician Services**	• Kevin Benson • Kathryn Callahan • Beth Mow
Materials Management	• Ethan Sawyer	**Compliance**	• Nathan Overson
Behavioral Health/ Mental Health	• Bradley Grigg • Ariel Thorsteinson • Rachel Wasserman	**Board of Directors**	• Kenny Solomon • Lola Young
Nursing Services	• Rose Lawhorne • Audrey Rasmussen • Lauren Beason • Liz Bishop	**Human Resources**	• Dallas Hargrave • Cindy Carte
Emergency Department	• Kimberly McDowell	**Revenue Cycle**	• Rachel Stark • Tami Lawson • Angelita Rivera

APPENDIX D: REQUEST FOR INFORMATION

REQUEST FOR INFORMATION (RFI)

PYA, P.C. (PYA) will depend upon Bartlett Regional Hospital (BRH) for assistance in gathering relevant information to complete our compliance program and risk assessment engagement. The information requested on the following pages will facilitate our field work. PYA has provided this Request for Information (RFI) in a format to assist with communicating the status of each requested document. If these requested documents do not currently exist or are in development, please communicate this information accordingly.

PYA requests that all information be **submitted electronically** via our secure ShareFile portal (ShareFile). Do not email any reports or documentation containing protected health information. PYA has established a ShareFile folder titled "***Bartlett Regional 2021 Program and Risk Assess***". Within this folder, you will find **subfolders** that reflect each section of the RFI.

To expedite identification and review, please upload documents into the correct corresponding subfolder, as categorized below. Additionally, please reference the name of the document in the file title. For example, if uploading the organizational chart of the compliance department, please name the document "Org chart – comp. dept.," or similar.

We request that this information be uploaded by **Friday February 12, 2021** prior to our field work, to allow adequate time for review and preparation. If you have questions regarding this RFI, please contact Susan Thomas at sthomas@pyapc.com, Katie Croswell at kcroswell@pyapc.com or Erin Walker At ewalker@pyapc.com. Additional data may be requested at a later date as the information below is reviewed and analyzed.

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Materials Requested *Please upload requested documents into the corresponding ShareFile subfolder identified for each section.*	**Document Available? Y/N**
ShareFile Subfolder: Administrative and Operational (e.g., demographic information, organizational charts)	
1. Contact distribution list for the program and risk assessment interviews, to include anticipated participant names, direct numbers, and email addresses.	
2. Organizational chart(s) to include structure and reporting relationships for the following: a. Health system/corporate b. Individual entity(ies) c. Compliance department	
3. Strategic Plan for current fiscal year (FY).	
4. List of hospital committees, membership, and reporting structure.	
5. The Board of Directors (Board) Listing, Executive Leadership Team Listing, Audit and Compliance Committee, etc. Include any reporting relationships, reporting structures and roles and responsibilities between management and Compliance.	

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Materials Requested *Please upload requested documents into the corresponding ShareFile subfolder identified for each section.*	**Document Available? Y/N**
ShareFile Subfolder: Compliance Program Documents (e.g., compliance plan, work plan, risk methodology, job descriptions)	
1. Compliance department employee listing, credentials of each employee, position title, and corresponding job descriptions, including the CCO and all direct reports.	
2. Most recent FY budget documentation for the Compliance Department including budget approval process.	
3. Compliance plan document describing program, to include structure (including budget, operations, and FTEs), and Board involvement.	
4. Compliance risk assessment methodology, risk assessments, *and the resulting compliance work plans* for the two most recent FYs.	
5. A sample compliance work plan audit report	
6. Compliance program dashboard illustrating metrics regularly monitored and reported	
7. Compliance Committee charter, meeting agendas and meeting minutes for the 2020 FY.	
8. Reports provided by the Chief Compliance Officer (CCO) to the Board for FY 2020, including investigative findings.	
9. Agendas and/or meeting notes between CEO and the CCO for the FY 2020.	
10. Board meeting agendas and minutes where compliance-related matters were presented and discussed for the two most recent FYs, to include any compliance program reports presented.	
11. Board Charter.	

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Materials Requested *Please upload requested documents into the corresponding ShareFile subfolder identified for each section.*	**Document Available? Y/N**
ShareFile Subfolder: Audits, Investigations & Hotline Reporting (e.g., hotline reports and investigations)	
1. Policy regarding employee reporting of any issues of non-compliance as well as any awareness materials publicizing the company hotline.	
2. Tracking of reported compliance concerns for the FY 2020, to include hotline reports and other means to report compliance issues.	
3. Hotline and/or investigation log, showing the type of allegation, the status of the investigation, and any corrective action taken ***(PYA may request a representative sample of internal investigation files as part of the on-site review)***	
4. Reports from compliance department site visits for FY 2020.	
5. HIPAA security risk analysis (privacy, security, and breach notification) for FY 2020 or most recent analysis with remediation action plan documentation.	
6. Summary results from network vulnerability and penetration testing for FY 2020 or most recent testing.	
7. A listing of internal and external audits and reports conducted in FY 2020 (e.g. government payer audits, HRSA, etc.)	
8. External financial audit management letter comments for FY 2020 (or most recent) related to topics that may reveal issues with billing and reimbursement compliance, fair market value, physician compensation, accounting for lease arrangements, etc.	

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Materials Requested *Please upload requested documents into the corresponding ShareFile subfolder identified for each section.*	**Document Available?** **Y/N**
ShareFile Subfolder: Vendor Management (e.g., hotline reports and investigations)	
1. List of significant contractual arrangements (e.g., outsourced services such as billing, copying, release of information, medical records/imaging storage, IT, education, etc.) ***(PYA may request a sample of these agreements as part of the on-site review)***	
2. List of current relationships between the healthcare system and other organizations (e.g. joint ventures, etc.).	
3. List of any third-party vendors engaged to help administer the compliance program (auditors, hotline operators, etc.)	
4. Results of employee/culture surveys sent within last two years (if applicable) including survey questions.	
5. Policy describing the vendor management process, including check-in and access to employees and patient care areas.	
6. Policy describing vendor/equipment/item approval process.	

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Materials Requested *Please upload requested documents into the corresponding ShareFile subfolder identified for each section.*	**Document Available? Y/N**
ShareFile Subfolder: Training and Education (e.g., compliance training, onboarding, interview forms, etc.)	
1. Compliance training plan for the most recent two FYs.	
2. List of compliance education and training sessions provided in FY 2020 and examples of educational content (e.g., PowerPoint, handout materials, etc.), to include topics covered during both annual and periodic orientation, including grants compliance, if applicable	
a. Include specialty training for high-risk areas (i.e. revenue cycle positions such as patient access, business office, and coders).	
3. Sign-in sheets and/or documented percentage of employee completion of annual compliance education and training for the two most recent FYs	
4. New employee onboarding compliance training sign-in sheet and/or documented percentage for the two most recent FYs	
5. Medical Staff onboarding compliance training and sign-in sheet and/or documented percentage for the two most recent FYs	
6. Vendor compliance training and documentation of completion	
7. Code/Standards of conduct	
8. Governance	
9. Employee handbook	
10. Exit interview form and summary of exit interviews conducted within last two FYs (if maintained)	
11. Performance evaluation template	
12. Medical staff and employee job applications	
13. Bonus/incentive compensation plan document	

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Materials Requested *Please upload requested documents into the corresponding ShareFile subfolder identified for each section.*	**Document Available? Y/N**
ShareFile Subfolder: Policies and Procedures (e.g., retaliation policy, overpayment policy, etc.)	
1. Index of all compliance policies and procedures, including table of contents of the system policy and procedure manual	
2. Specifically, please upload copies of all policies, procedures, guidelines, or informal guidance documents that address the following topics:	
a. Policy on policy management	
b. Compliance event reporting/Hotline	
c. **List** of HIPAA-related policies and procedures (e.g., privacy, security & breach notification, etc.). *PYA may request certain policies for review.*	
d. Fraud and Abuse (including Anti-kickback and Stark Law, payments to physicians and relationships with other referral sources)	
e. Interactions with healthcare industry stakeholders (vendors, pharma/device reps, etc.)	
f. Screening for excluded providers, employees, and vendors	
g. Revenue cycle related policies to include patient registration/admissions, health information management, and business office/billing departments. *(*Can be a list of revenue cycle policies; however, please include specific policies addressing credit balances, account write-offs, up-front collections, waiver of copay or deductibles, and charity/financial assistance*)	
h. Overpayments (to include identification measures and process), including policies for repayment	
i. Coding and billing accuracy auditing and monitoring	
j. Gifts, gratuities, and physician non-monetary compensation	
k. Notice of privacy and confidentiality practices	
l. Non-retribution/non-retaliation	
m. Disciplinary and escalation process	
n. Confidentiality	
o. Provider credentialing	
p. Conflict of interest (to include acknowledgement and disclosure form)	
q. Contract approval and initiation process	
r. Compliance investigation	
s. Escalation process to governing body or government agency	

Materials Requested *Please upload requested documents into the corresponding ShareFile subfolder identified for each section.*	**Document Uploaded**	**Document in Development**	**Document Not Present**
ShareFile Subfolder: Other Information			
1. List of management's compliance concerns the organization believes would be helpful in PYA's execution of the compliance program and risk assessment			
2. Any other compliance-related documents the organization believes would be helpful in PYA's execution of the compliance program and risk assessment			

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APPENDIX E: SAMPLE COMPLIANCE DASHBOARD TEMPLATE

COMPLIANCE DASHBOARD

Location	
Compliance Leader	
Prepared By	
As of Date	
Date Reviewed with Administrative Leader	
Date Reviewed with Compliance Committee	
Date Reviewed with Board	

Element/Metric	Q1	Q2	Q3	Q4	Annual
Oversight					
% Completion of Board members compliance training					
% Quarterly reports to Board (*Compliance Plan = 1 per quarter*)					
Compliance issues addressed as an outcome of education					
Code of Conduct/Policies and Procedures					
% Completion of CoC attestation: physicians					
% Completion of CoC attestation: employees					
% Policy and procedure receipt sign-off: new employees					
% Compliance policies and procedures reviewed per schedule					
Exclusion Screening					
% OIG/SAM physician screening: prior to hire/contract					
% OIG/SAM vendor screening: prior to hire/contract					
% OIG/SAM employee screening: prior to hire/contract					
% OIG/SAM physician screening: monthly					
% OIG/SAM vendor screening: monthly					
% Open screening/requires additional documentation					
Education					
% Completion of compliance training within 30 days of hire					
% Completion of HIPAA training					
% Completion of role-specific training					
Annual re-training					
Compliance Investigations					
Number of hotline calls					
Number of issues reported **other** than hotline					
Total					
Number of issues requiring compliance investigation					
Number of issues closed					
Number of issues pending					
Number of compliance surveys returned					
Average time to initiate compliance investigation					
Average time to complete compliance investigation					
Top three concerns reported: #1					
Top three concerns reported: #2					
Top three concerns reported: #3					

Sample

COMPLIANCE DASHBOARD

Element/Metric	Q1	Q2	Q3	Q4	Annual
Departmental Monitoring and Auditing					
% Denied claims requiring resubmission					
Average % of billing accuracy					
Number of inappropriate IS access or logins					
Number of employees disciplined for compliance violations					
Regulatory/Policy Updates					
Regulatory requirements: new or revised					
Follow-up required					
Policies: new or revised					
Follow-up required					
Repayments/Overpayments					
Discovered by auditing and monitoring					
Number of claims					
Repayment amount					
Paid within 60 days					
Discovered by internal investigation					
Number of claims					
Repayment amount					
Paid within 60 days					
Government audits					
Number of claims					
Repayment amount					
Paid within 60 days					
Systemic/Repeat Issues					
Comments/Suggested Action Items					

Sample

APPENDIX F: SAMPLE DEPARTMENTAL WORK PLAN TEMPLATE

Original Approval Date by ICC: **Prior Review:** **Review / Revised**

Department Compliance Champion:
Department:
DIV/RC:
Location:

INTRODUCTION
Department Compliance Work Plans will be presented to the Compliance Committee for approval and oversight.

Each department is responsible to designate a **management level staff member**, described as a Department Compliance Champion, who is responsible for executing the departmental compliance activities, including completion of the Departmental Compliance Work Plan and reporting the Work Plan information to the **Bartlett Compliance Officer**.
The Department Compliance Work Plan will include those items that have been identified by the department as potential risks considering industry standards and operational activities. Additional risks will be included in the Departmental Compliance Work Plan pursuant to the organizational risk assessment process.

Departmental Compliance Risk Assessment and Risk Identification Process

1. Determine and evaluate vulnerable risk areas specific to [INSERT DEPARTMENT], including risks identified pursuant to the organizational risk assessment
2. Utilize a weighted risk factor system to evaluate and rank each identified risk
3. Evaluate prioritized risks for inclusion in the Compliance Work Plan

Departmental Work Plan Development and Approval Process

1. Submit a Department Compliance Work Plan to the Compliance Officer for approval and subsequent revision approvals. Annual review/revision required.
2. Adjust the Department Compliance Plan to integrate measures that will address any new risk areas identified by the Annual OIG Work Plan and/or any other regulatory agency.
3. Notify the Compliance Officer of any scheduled and/or unannounced accreditation or regulatory inspection on-site visits.
4. Develop and implement:
   a. A departmental program of monitoring for compliance risk areas as identified by the Annual OIG Work Plan, any other regulatory agency and/or in the organizational compliance risk assessment
   b. A reporting schedule detailing reporting frequency, to whom the information should be reported and the reporting method (e.g., format, etc.)
   c. A method for receiving feedback from the Compliance Director regarding monitoring activities/information
   d. A process for development and implementation of remediation/corrective action
   e. A process for determining if follow-up audits are necessary
   f. A process for planning annual audits

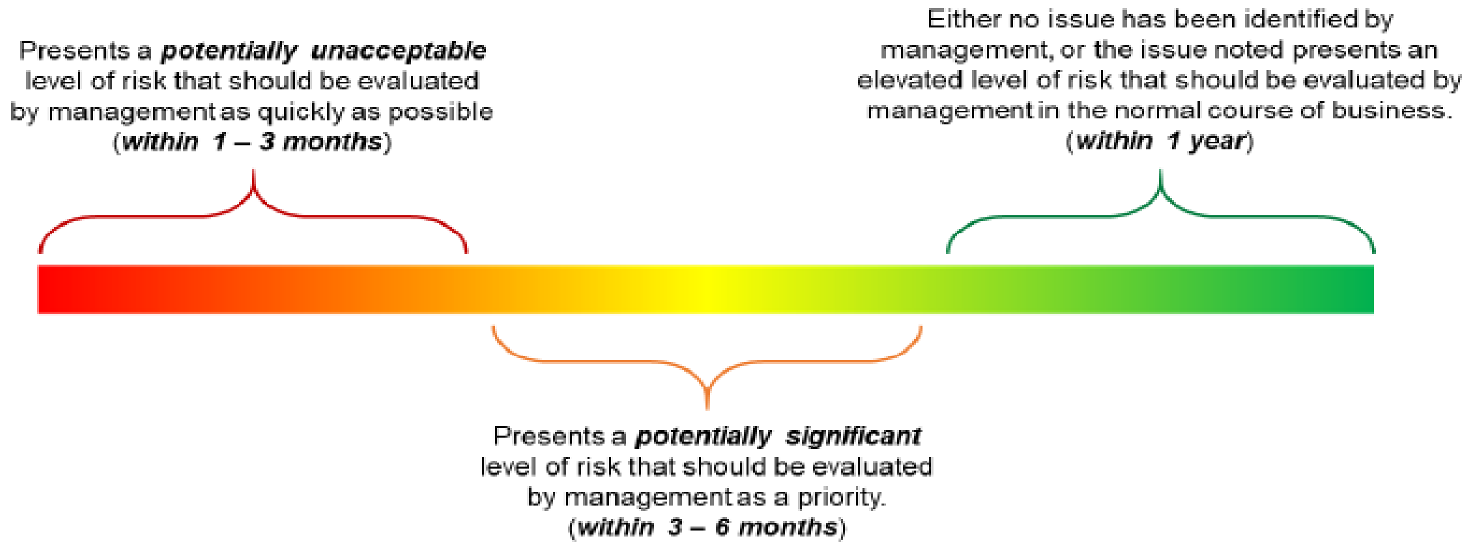
Risk Area	Risk Category	Risk Impact to Department (H-M-L) Likelihood of Risk to Become a Reality (H-M-L)	Regulatory Requirement	Associated Hospital and Department Policies and Procedures	Associated Education	Monitor/Audit Metrics	Monitor/Audit Frequency	Responsible Individual (s) w/Titles	Results	Target	Realization of Target	Reported to Compliance Department Y|N w/Date	Reported to Compliance Committee Y | N w/Date	Follow-Up
EXAMPLE: Revenue Cycle	Medicare overpayments	H-H	Section 6402(a) of the Affordable Care Act	Overpayments, Revenue Cycle Processes, Auditing & Monitoring	Annual compliance training; Fraud, Waste, and Abuse updates	Credit balances, billing accuracy audits	Monthly	J. Smith, Revenue Cycle Manager	Credit balances worked by Rev Cycle Specialist on a daily basis. February audit identified 12 accounts with credit balances.	100% of overpayments are identified, researched, and rebilled/repaid appropriately	10/12 accounts researched and rebilled accordingly. 2 encounters in appeal process.	Y - March 15, 2020	Y - Part of Revenue Cycle Quarterly Report - March 25, 2020	Continue monthly monitoring.

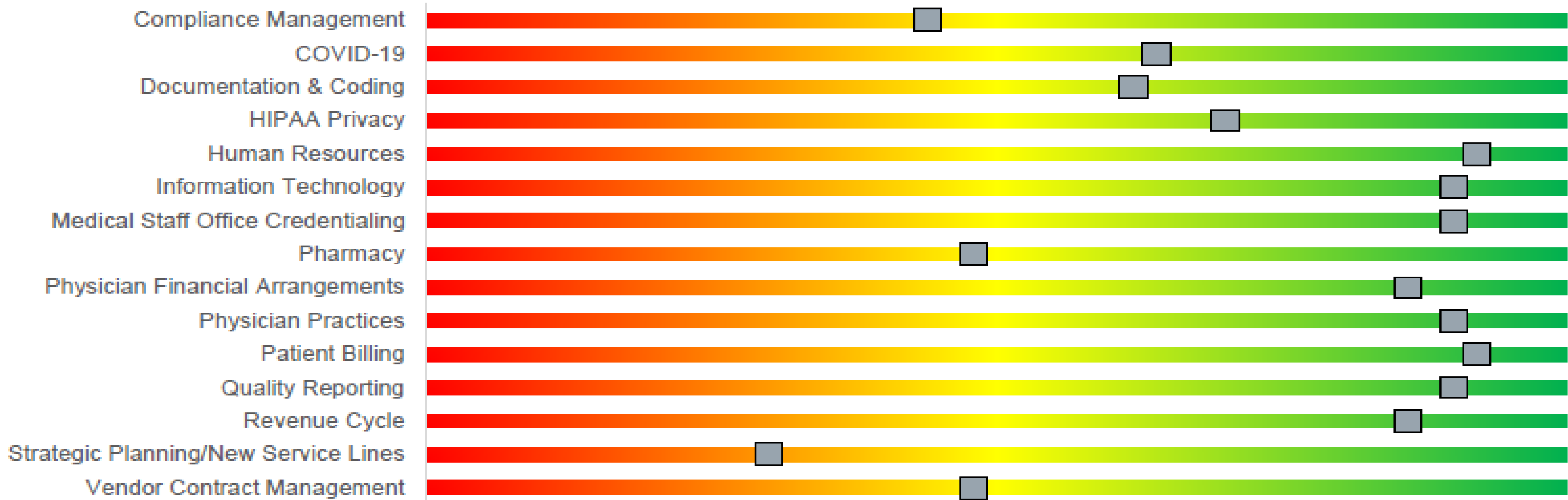
Sample

RISK ASSESSMENT RECOMMENDATIONS

RISK RANKING DEFINITIONS

A graded system of organizational exposure has been established based on the following definitions:





RISK ASSESSMENT RECOMMENDATIONS

		Compliance Management: CONFLICT OF INTEREST
1	1	Develop and implement a COI management plan that includes auditing and monitoring of disclosure attestations followed with periodic education, enforcement guidelines, and mitigation steps to reduce the risk of COI non-compliance.
2	2	Utilize the CMS Open Payments database to validate COI disclosures and evaluate providers' financial relationships.
3	3	Establish COI control metrics with disclosures reported to the CAC and the Board as appropriate.
4	4	Evaluate physician financial relationships and vendor process/product reviews to identify potential conflicts. Compliance should follow through to identify and report cases which pose a COI risk.
5	5	Obtain confirmation from the City of Juneau that Bartlett Board members have provided COI disclosures and that all disclosures received have been reviewed by the City's legal department. Additionally, Bartlett should ensure that all conflicts determined to exist are reported to the CRMD for inclusion as part of the COI management plan.
		Compliance Management: AUDITING AND MONITORING
6	1	Develop and implement a compliance work plan which incorporates structured compliance auditing processes to address high-priority organizational risks. PYA supports Bartlett's assignment of responsibility to the department directly involved in the identified risk. Additionally, Bartlett should ensure that auditing and monitoring processes include expected controls, findings/observations, appropriate follow-up activities, and corrective actions indicated to mitigate risk.
7	2	Compliance risks should be identified by applying consistent auditing and monitoring techniques and benchmarks throughout the entire organization. Internal departmental auditing practices and processes should be established through the use of departmental compliance work plans. A sample departmental compliance work plan template has been provided in Appendix F. Reporting of departmental audit findings and compliance controls should continue to occur through the HCC and be documented in the committee meeting minutes. Further, Bartlett should ensure that the RCC continues to provide regular RCM reports to the HCC.
8	3	Develop and implement a comprehensive internal and external audit schedule, including quality thresholds, required education, consequences, and disciplinary actions for failure to meet required thresholds.
9	4	Compliance metrics which measure the effectiveness of key performance improvement areas should be established and implemented.
10	5	As part of the annual risk assessment, coding, billing, medically necessary audits, and findings should be listed in the compliance work plan with detailed expectations, thresholds, corrective actions, and education metrics. The results should be reported to affected members of Bartlett management for corrective and improvement actions. A comprehensive summary result of the audits should also be reported to the CAC.
11	6	PYA supports the RCC and the important role they play in organizational compliance. However, a formal and regular reporting of information from the RCC needs to be brought to the HCC to show the strong controls that are in place for the Revenue Cycle function as part of organizational compliance.
		Compliance Management: OIG EXCLUSION SCREENING

12	1	As recommended within the Compliance Program Assessment Detailed Findings section of this report, Bartlett should develop and implement a vendor management P&P. The processes detailed therein should be reviewed and assessed periodically to ensure that the controls and oversight processes support the regulations outlined in federal and state requirements. The P&P should include processes associated with the identification and exclusion of vendors who are found to be excluded through sanctions and exclusion checks, as well as the process to reinstate vendors after an exclusion period has expired. Education regarding a revised P&P, and the associated requirements and expectations, should be provided.
13	2	Regular audits of the vendor management P&P should be conducted to ensure compliance with Bartlett's sanction screening and reinstatement processes.
14	3	Sanction screening should include a nationwide search of all state licensing boards as a best practice.
15	4	Consider utilization of a third-party solution to assist in performing initial and monthly exclusion screenings. Such a solution will check federal databases, such as OIG, SAM, the Office of Foreign Assets Control of the U.S. Treasury Specifically Designated Nationals and Blocked Persons list, as well as state Medicaid exclusion databases.
		Compliance Management: ADEQUATE RESOURCES
16	1	PYA recommends that the compliance function be supported by two FTEs, inclusive of a dedicated FTE CCO. Given Bartlett's growth of services in recent years, evaluating necessary resources at a minimum, annually, will be a critical component to developing and maintaining a robust Program. Please refer to the "Dedicated Compliance Resources" section of this report, found in the Executive Summary, for specific recommendations related to proposed staffing levels and infrastructure.
17	2	Understanding the distinct roles and responsibilities associated with Compliance and Risk Management, Bartlett should consider establishing a separate Risk Management Director role to carry out the responsibilities associated with the Risk Management function. Risk Management should continue to report to the CCO to continue to ensure optimal collaboration and value to the organization.
18	3	In order to have an effective Program to identify and mitigate risks, PYA recommends that Bartlett establish a compliance budget that will allow the Program to operate efficiently, demonstrate support and commitment from leadership, and reinforce the independence of the compliance department.
19	4	PYA recommends that the position description for the HIM Director be revised to include specific responsibilities for the HIPAA Privacy Program. Additionally, the position description for the Information Systems Director should be revised to include specific responsibilities for the HIPAA Security Program. The organization should be made aware of both the Privacy and Security Officer roles.
		COVID-19: WAIVERS
20	1	Ensure that a centralized process to report and document the use of PRF is developed and implemented immediately to ensure compliance with the conditions imposed. The process should include detailed information regarding reporting the use of any PRF, including any monies returned that were provided but not utilized.
21	2	Ensure that a detailed process is in place that allows for appropriate notification regarding waiver expirations. Upon notification of expiration, a process must be developed and implemented that allows the organization to immediately revert to prior requirements.
		COVID-19: TELEHEALTH
22	1	PYA recommends that one individual at Bartlett be responsible for telehealth throughout the organization to ensure consistency of use and compliance with regulatory requirements.

23	2	Bartlett should complete the external billing/coding audit of telehealth services to ensure that appropriate revenue cycle processes are developed and implemented to meet the expanded use of telehealth, including appropriate documentation and the accurate use of procedure codes, modifiers, and place of service. The process should also include detailed information regarding the CMS requirements to post charges to COVID-19 testing.
24	3	Given the expanded use of telehealth, Bartlett should review the OIG Work Plan item "Medicare Part B Telehealth Services During the PHE"14 to ensure that such services meeting the Medicare requirements, for example the use of telehealth for Evaluation and Management, Psychotherapy, Opioid Use, Site Locations, Remote Patient Monitoring, Virtual Check-in Services, and Annual Wellness Visits.
25	4	Bartlett should review the financial assistance policies to assure that any adjustments made during the PHE are clearly delineated both as to their application and the time period for the adjustment to be in place.
26	5	PYA supports Bartlett's plan to complete a third-party audit of telehealth services. Upon completion of the audit, issues identified should be included in the compliance work plan.
		Documentation and Coding: CODING AUDITS
27	1	Evaluate the necessary competency of coders, particularly those in specialized areas, and mitigate those risks accordingly to minimize lost revenues and maintain compliance with regulatory requirements.
28	2	PYA recommends that Bartlett develop a formal coding review P&P that clearly defines quality thresholds, required education, and action plan documentation.
29	3	Defined timelines for follow up audits should be developed and required quality thresholds enforced. Results should be communicated to appropriate leadership.
30	4	An external review of a sample of claims should be conducted annually, as a best practice.
		Documentation and Coding: USE OF MODIFIERS
31	1	Coding professionals should verify the clinical circumstances and accuracy of any modifier applied to a code for claims submission. Modifiers for CPT and HCPCS codes should be supported by documentation and applied in accordance with CMS National Correct Coding Initiative (NCCI) coding or billing requirements.
		Documentation and Coding: PHYSICIAN QUERIES AND DOCUMENTATION
32	1	PYA recommends that Bartlett implement enforceable clinical documentation policies that are in accordance with medical staff by-laws and industry best practices. Examples include chart completion, query retention, and query escalation.
33	2	Non-compliance with processes for query response and clinical documentation requirements should be reported to the Chief of Staff and executive management for disciplinary actions and resolution.
34	3	Documentation should be completed as soon as possible after the service is rendered to assure patient documentation is accurate and complete. In addition, thorough and complete documentation is required for reimbursement by third-party payers.
		Documentation and Coding: RELEASE OF INFORMATION (ROI)

35	1	PYA recommends that Bartlett consider implementation of a centralized ROI process which would allow for streamlined processes and would provide direction to staff who receive records requests. Further, all staff impacted by ROI should receive education on the proper procedure to release patient information.
		Pharmacy: 340B COMPLIANCE
36	1	Develop, educate, and implement P&Ps regarding the organization's 340B Program and the requirements associated therewith. PYA supports the inclusion of the Pharmacy Director as a member of the organization's HCC; however, Bartlett should develop and implement a formal ongoing monitoring and auditing process and results should be regularly reported to the HCC.
37	2	PYA recommends that an annual review of the 340B Program be included as part of the compliance work plan. The review should include a review of database accuracy, compliance with eligibility requirements, maintenance of required records, review of contract pharmacy arrangements, the process for material breach, and performance of appropriate program monitoring. An external, independent review should be conducted every 2 – 3 years and more often if Bartlett expands its contract pharmacy program.
38	3	Issues identified pursuant to the recent external 340B Program audit should be included as part of the compliance work plan.
39	4	As a 340B covered entity, Bartlett should develop a process that allows the organization to articulate the value of 340B program and document the use of savings realized from participation in the program. This will allow Bartlett to demonstrate how the 340B program expands access to underserved patient populations. A publicly posted tool15 can assist in determining and documenting the program savings.
		Strategic Planning: RISKS AND OPPORTUNITIES
40	1	Strategic goals and initiatives need to align with regulatory requirements, accreditation standards, and industry events. Bartlett should establish an alliance between corporate strategy and the compliance program to mitigate potential compliance risk associated with key organizational initiatives.
41	2	With involvement of the CRMD, the risk environment and appetite of the organization can be taken into consideration with strategic initiatives to ensure that the initiative planning is carried out with integrity and includes risk mitigation.
		Strategic Planning: NEW SERVICE LINES
42	1	PYA supports the CRMD's efforts to revive the New Service Line Committee in order to define and understand risks associated with new services.
43	2	Any contractual arrangements associated with new service lines should be analyzed by legal counsel prior to execution.
44	3	New service offerings initiated in response to the PHE should be carefully scrutinized to determine the regulatory implications on both the state and federal level. A third-party review by an industry expert with knowledge of state and federal PHE regulations is advised.
		Vendor Management: STANDARDIZED PROCESSES
45	1	PYA recommends that, upon development of an administrative vendor management P&P as recommended in the Compliance Program Detailed Findings section of this report, Bartlett should conduct regular audits of the P&P to ensure compliance with the processes contained therein.

46	2	A vendor contract monitoring plan should be implemented to assess compliance with contract terms and conditions, as well as performance metrics.
47	3	As part of the vendor management program, vendor COI controls should be developed, implemented, and enforced to diminish and prevent vendors and contractors, particularly referral sources, from influencing decisions to review or acquire products that pose potential or actual COI. Additionally, vendor product and services usage should be audited for possible conflicts.

PROGRAM ASSESSMENT RECOMMENDATIONS

PRIORITY RANKING DEFINITIONS

HIGH PRIORITY: Expected controls that present a ***fundamental program priority*** that should be evaluated by management as quickly as possible (within one to three months).

MODERATE PRIORITY: Presents a ***significant program priority*** that should be evaluated by management as a priority (within three to six months).

LOW PRIORITY: Expected controls where either no issue has been identified, or the issue noted presents ***a standard program priority*** that should be evaluated by management in the normal course of business (within one year).

Compliance Plan Elements	Priority Ranking
1. High-Level Oversight	HIGH
2. Integration of Compliance into Policies and Procedures	LOW
3. Consistent Enforcement of Standards	HIGH
4. Training and Education	MODERATE
5. Open Lines of Communication	MODERATE
6. Response to Detected Deficiencies	LOW
7. Monitoring and Auditing	HIGH

PROGRAM ASSESSMENT RECOMMENDATIONS

		Board of Directors
1	1	The CAC should receive and approve the Compliance budget on an annual basis.
2	2	The HCC Charter should be reviewed annually by the CAC and updated as necessary. Additionally, an annual report of the achievement of program objectives, as described in the charter, should be reported to the Board.
3	3	The CoC should be reviewed and receive approval by the Board on an annual basis.
4	4	The CCO should have direct access to the Board through executive sessions without the CEO present, at least annually.
		Compliance Management

5	1	The compliance department should be appropriately staffed in order to strengthen the Program as necessary to support an organization the size of Bartlett. According to the national benchmark for healthcare organizations with total Full-Time Equivalent (FTE) employees and revenue comparable to Bartlett, the compliance management function is typically supported by two employees11, including a dedicated FTE CCO, dedicated to core compliance activities. PYA recommends that the CCO position be increased to 1.0 FTE and an additional 1.0 FTE be added to the compliance department to oversee and assist with compliance program operations.
6	2	PYA supports Bartlett's use of a Program plan and the informal organization-wide risk assessment to identify organizational risks for consideration and prioritization in the compliance work plan. Bartlett should work towards formalization of the organizational risk-assessment process and continue to report the results to the HCC, whereupon approval by the CAC is obtained for items to be included in the compliance work plan.
7	3	In order to continue to strengthen the Program, PYA recommends that the compliance department formalize the use of measurable goals, benchmarks, and the extent of compliance program activity as demonstrated by the sample compliance dashboard in Appendix E. Such goals and benchmarks for the Program should be approved by the CAC.
		Strategic and Operational Planning
8	1	PYA supports the reactivation of the New Service Line Committee in order to incorporate compliance considerations into organizational initiatives.
9	2	It is recommended that the CCO be a standing member if the committee to discuss new strategic initiatives reconvenes.
10	3	Performance evaluations should include compliance as an appraisal element and compliance should be considered for incentives and promotion decisions. These expectations should be clearly communicated during orientation and annual education.
		Risk Assessment and Work Plan
11	1	A formal risk assessment methodology should be developed and implemented consistently throughout the organization to assure a systematic way of evaluating and assessing risks in the organization. The consistent approach of the risk assessment should drive the development of the compliance work plan.
12	2	The compliance work plan should be approved by the CAC on an annual basis, with regular updates of work plan items provided thereafter. Challenges to appropriately execute work plan items should be communicated and documented accordingly.
		COMPLIANCE POLICIES
13	1	Bartlett should ensure departments utilize the central policy management system, Policy Tech, for maintaining and storing all P&Ps throughout the organization. Utilizing a central P&P repository will ensure all employees have access to P&Ps, overlapping P&Ps don't exist, and P&Ps are appropriately updated and maintained.
		EXCLUSION SCREENING AND BACKGROUND CHECKS

14	1	PYA recommends the overall exclusion screening process be centrally managed, preferably by the compliance department. The act of conducting the initial and monthly exclusion checks for employees, providers, vendors, and contractors may be performed by a third-party vendor; however, the compliance department should evaluate its compliance with performing exclusion checks throughout the system with regular monthly monitoring. Employees, providers, vendors, and contractors should be screened against LEIE, SAM, and state Medicaid exclusion lists.
15	2	PYA recommends Bartlett develop a background screening and licensure verification P&P, and the process should be centrally managed within the organization. Background checks should be performed for all employees, physicians, contractors, and vendors.
16	3	PYA recommends developing an administrative vendor management P&P that clearly outlines the procurement process and responsibility of all vendors. Bartlett should regularly monitor this process to assure the screening and tracking of vendors is consistent for all vendors throughout the organization.
17	4	If not already in place, a formal process should be developed and implemented to evaluate third-party payer reimbursement to ensure such payment is in accordance with the contractual obligations.
		CONFLICT OF INTEREST
18	1	Bartlett should ensure that the COI P&P includes monitoring procedures that are specific for every area in the organization that manages COI.
19	2	Bartlett should regularly audit its COI disclosure process to assure consistency of execution and that the CMS Open Payments database is regularly reviewed to assess the accuracy and completeness of disclosures to monitor for financial conflicts.
		EXIT INTERVIEWS
20	1	PYA recommends in-person exit interviews be provided for termed Directors and above. All exit interviews should include questions related to compliance and retaliation (e.g., “Did you ever witness someone doing something illegal or unethical in the workplace?”).
		CONSISTENT ENFORCEMENT
21	1	A Discipline for Non-Compliance P&P should be developed and include progressive discipline for non-compliance, as well as follow-up education.
		COMPLIANCE TRAINING AND EDUCATION
22	1	PYA recommends the development of an administrative P&P related to job-specific education provided at the departmental level upon hire or transfer that focuses on department-specific compliance educational programs. Staff education on appropriate training topics will aide in the discernment between standards of care and service and compliance (i.e., legal and risk mitigation).
23	2	Further, PYA recommends that the CRMD or his/her designee review compliance-related education developed for these high-risk positions to assure that information on regulatory requirements, sanctions, and reporting is included, accurate and up to date.
24	3	Bartlett should ensure that all vendor agreements include compliance language and vendors have access to Bartlett’s compliance P&P’s and agree to abide by them.
		ORGANIZATIONAL COMPLIANCE AWARENESS

25	1	Upon adequate staffing in the compliance department, PYA recommends that Bartlett promote compliance activities through employee involvement activities, such as celebrating Compliance Awareness Week, regular newsletters, or other employee communication, etc. Promotion of compliance for such events assists with building a culture of compliance throughout the organization and keeps compliance "top of mind" and relevant for all employees.
		INTERNAL REPORTING SYSTEM
26	1	PYA recommends that an administrative, standalone P&P for the internal reporting process be developed to include all affected persons (e.g., vendors, business partners, contractors, etc.) that work and/or provide services within Bartlett.
27	2	PYA recommends that Bartlett utilize a hotline number through a third-party vendor to allow for consistent documentation, tracking, and anonymous reporting. Education should be provided regarding reporting requirements, including detailed information regarding the various methods for reporting. The hotline number should be well-publicized throughout the organization utilizing posters, communications with patients, and the website.
		INVESTIGATION PROCESS
28	1	Bartlett should ensure that the status of the investigation (e.g., underway, closed, resolved), is reported to administrative leadership, the governing body, and the relator of the concern, if they are not anonymous. Documentation should be maintained that includes details regarding follow-up provided to the reporting individual. Utilizing a third-party hotline would provide a case number for each report and allow the investigator to follow-up with anonymous reporters.
29	2	The effectiveness of remedial measures taken for compliance and privacy investigations should be evaluated for organizational improvement purposes.
30	3	PYA recommends that, upon adequate staffing of the compliance department, reports and concerns should be evaluated and education of such should be incorporated into Bartlett's Compliance Training Plan.
		Risk Assessment
31	1	Bartlett should formalize the organizational risk-assessment process, including a process for inclusion of feedback and input received from across the organization. Items added to the work plan as a result of the risk assessment process should be detailed and prioritized pursuant to specific risk assessment findings. Additionally, Bartlett should utilize the recommendations contained herein to assist with work plan development.
32	2	Upon completion of the enterprise-wide risk assessment, follow-up risk assessments should be performed for areas identified in the risk assessment. Ongoing monitoring of those areas and effectiveness should be regularly communicated to the HCC.
		Annual Compliance Work Plan
33	1	Bartlett should utilize PYA's compliance program and risk assessment findings to develop a risk based focused work plan for CY 2021/2022. The work plan should be presented to and approved by the CAC.
34	2	Departments should conduct regular internal auditing and monitoring activities, the results of which should be reported the HCC for review and approval. Action Plans for remedial measures should be developed when findings of non-compliance are identified.
35	3	Bartlett should implement a process for "auditing the auditor" to determine whether Coders have adequate competencies and skillsets.

36	4	PYA recommends the re-instatement of regularly performed coding and billing auditing and monitoring activities by the RCC. Results should be reported to the HCC and the CAC. Action Plans should be developed when there are findings of non-compliance.
37	5	Departmental monitoring and auditing activity results should be reported to the HCC on a scheduled and as needed basis. Further, ad hoc reporting of issues requiring additional monitoring or auditing should be reported to the HCC.
38	6	Bartlett should utilize internal or external resources to conduct regular claims data trending to identify errors or areas of non-compliance. Examples of claims data trending could include denial patterns, modifier usage, unbundling of services, E/M up-coding, etc.
		Risk Assessment
39	1	PYA recommends Bartlett develop an overpayments P&P to ensure that the Overpayment Rule requirements are met, including that incorrect claims identified through retrospective reviews/audits be repaid no later than 60 days following the date the overpayment was identified, with regard to refunding overpayments to governmental payers, including, Medicare, Medicare Advantage and state Medicaid. Consequences for failing to timely report and return any identified overpayments may subject supported practices to liability under the False Claims Act.
40	2	PYA recommends that Patient Financial Services reviews information related to billing errors, claims re-payments, payer audits, and patient billing complaints to identify potential overpayments and take appropriate action to refund.