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NEW PERSPECTIVES

on Healthcare Risk Management, Control and Governance

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HEALTHCARE TOP RISKS FOR 2023

2023 Top Risks for Healthcare identified from new survey conducted by Protiviti and North Carolina State's Enterprise Risk Management Initiative

For the complete list of Top Risks for 2023 and 2032 facing the Healthcare Industry, download the results here:

Protiviti.com/us-en/top-risks-2023-healthcare-insights

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FROM THE EDITOR

Strengthen Your Data Analytics

By Mike Fabrizius, CHIAP®, CIA®, CPA

Whether people work in sales, marketing, project management, design or many other fields, employers expect them to manipulate and analyze data, and bundle it into slick presentations.

– Wall Street Journal[1]

The article cited above has data analysis on its short list of important skills. The broad spectrum of employees explicitly mentioned might be considered a little surprising, but the list is indicative of how pervasive the focus on data has become in organizations. While internal auditors are not mentioned, data analytics and the related presentation of results are unquestionably part of the contemporary professional practice of internal auditing.

The article went on to say that employers expect proficiency in technology tools, even for new employees. Proficiency in traditional tools such as Excel is still necessary, but employers want more. Obtaining a return on significant investments in databases and related tools is dependent on leveraging the accumulation of information to improve the organization.

This issue of *New Perspectives* covers data analytics and the use of its insights from multiple perspectives. David Sems, our Information Technology columnist, begins a two-part series on tools that produce and present data analytic results quicker and with less effort. The first installment covers tools for data preparation that make raw data suitable for analysis. In our next issue David will review a tool that produces and displays graphical representations of data in powerful interactive reports and visualizations.

The Infographic feature in this issue summarizes the state of data analytics. Especially noteworthy are the benefits of analytics for internal auditors and the reasons that data analytic projects fail. Benefits that you can realize include supporting the efficient execution of the audit lifecycle through comprehensive documentation and clear recommendations. To avoid the failure of an analytics project, have clear deliverables and defined ownership.

Sara James informs us that our reporting is fundamentally about an accessible exchange between and among human beings. She tells us that when reporting,

[1] https://www.wsj.com/articles/technology-skills-employees-should-have-fdc6c0ba?st=yfls36928ziuod7&reflink=article_email_share (Subscription required)

NEW PERSPECTIVES

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Strengthen Your Data Analytics

ask yourself: What will prompt my readers to act? Good supporting data for your recommendations is surely one of the answers.

The expectation for leveraging data has broadened from a limited number of specialists to many others, including internal auditors. Data analysis skills have become an important factor in considering candidates for open positions and in evaluating employee performance. You can differentiate yourself by becoming skilled in this area.

Do not be left behind. Be prepared to make sense of the data that you encounter in your audits. **NP**

About *New Perspectives*

New Perspectives (NP) is a refereed and peer-reviewed journal that focuses on up-to-date information, trends and issues in the healthcare industry and the internal auditing profession. Practical guidance is provided on risks and controls that can be applied by internal audit professionals in their jobs.

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More than ever, it's important to be a great listener and not think that you know all the answers. – Ann Harrison

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FEATURE

Reporting Before, During and After Covid

Build better reporting on better relationships

By Sara I. James, PhD, CIA

Since March 2020, most office-based professionals have experienced a revolution in working practices. First working from home, then hybrid working, and for some, returning to prepandemic office habits—all of these approaches required major shifts in thinking and practice. As organizations across the world changed their ways of working, the importance of effective communication became even clearer. We can all benefit from improving relationships, using plain language and exploring new media.

Whichever sector internal auditors work in, different ways of working have forced us to explore more concise, reader-friendly approaches to communicating results. The approaches can include presentations, one-page reports, even videos. Such media have long been available, but those of us in assurance functions are creatures of habit. Nothing stopped us from improving our written communications before the pandemic. However, as is often the case, crisis prompts change.

The technology many of us used during lockdown gave us greater access to our colleagues and clients. Because people were not traveling, virtual meetings were easier to arrange with audit clients and committee and board members. Since virtual meetings often meant seeing people in their home environments, participants saw a different side of each other. With people often leaving their backgrounds visible on screen, we saw each other's homes, families and even pets.

Relationships between assurance professionals and their clients can often be difficult. Anything that helps us see our clients, interlocutors or audience as people, rather than roles, helps. Better access to people, more open exchanges, and more time to discuss difficult audit topics often improve professional relationships.

Internal auditors working in healthcare have faced a double pressure—that of the pandemic, combined with the changed working practices almost all internal auditors experienced. Healthcare professionals also have unique insight into the necessary preventive controls behind the changed working practices—and therefore into any benefits.

Different ways of being

When relationships improve, communications improve. The change does not mean that fewer disagreements occur, or less conflict happens. The change does mean that people communicate these differences better when they understand and engage with their audience.

Although some people complain of Zoom fatigue, video-conferencing technology allows insights and interactions that traditional phone or conference calls do not. Being able to speak to colleagues at all levels of the organization, in a more personal virtual setting, can break down barriers and lessen power distance (within certain cultural constraints).

Seeing others working from home, sometimes at kitchen tables alongside home-schooled children, created a profound change in workplace relationships. Seeing someone extremely senior distracted by their cat walking across their desk in the middle of a meeting is bound to create rapport.

Appreciating the context in which someone is working helps us ask better questions and better understand the answers.

We confuse what is interesting to us with what our readers need or want.

When relationships improve, communications improve.

Even if interactions with a senior person remain visually neutral, from using a false background or filter, technology allows greater access. During lockdowns, senior people were not conducting negotiations out of town or traveling to conferences—they were at home, like everyone else. The accessibility and equality of circumstances can create excellent conditions for building better relationships.

Relationships—understanding ourselves and our audience—are at the heart of effective communication. If we think about our most visible form of written communication—reports—they are a message from us to readers. Understanding our own motives and impulses and readers' probable reactions will help us communicate more effectively.

All too often, reports become all about what the writers think, rather than about readers and the wider organization. The question you must ask with every word, line, and sentence is this: What will prompt my readers to act?

A common failing in reports is writing what we want people to know about what we have done—not what they need to know to act. These perspectives are two separate things.

We are all human; we all do this. We confuse what is important or interesting to us with what our readers or listeners need or want. Now, often what they want and need may be two different things—maybe they want to hear that they are doing a great job, but what they need to hear is that they must improve. To convey that to them effectively, you must understand what will prompt and motivate them to take the necessary action.

Of course, doing this takes us back to understanding ourselves and our readers. Understanding takes us to culture—national, regional, professional, sectoral, and organizational—as well as individual context.

Even within your organization, and within your team, you can find yourself communicating at cross purposes. What is important to us is not necessarily important to the reader or listener. Being aware of the gap between your priorities and others' is the first step to bridging it.

The role of language

Since we usually communicate through reports, we must think about the language we use. As language reflects thought, choosing our words carefully can happen only once we have thought carefully. Yet language can hinder as well as help us in our thinking.

Whatever language or languages you work in, common terms and phrases exist. Some of them are necessary, such as legal terms or, for the readers of *New Perspectives*, medical jargon. In most organizations, though, the most common terms and phrases are often meaningless and become mocked as buzzwords or management speak.

The problem is that people and organizations become too reliant on this clichéd language, which George Orwell called *prefabricated*. They get out of the habit of choosing the fewest, best words to communicate. In doing so, they effectively abdicate responsibility for articulating their messages as clearly and precisely as possible. And, as Orwell said, they then have only limited, clichéd language in which to think—which will obviously harm the rigor of their analysis.

Furthermore, poor thinking and poor work is harder to detect when people communicate in this language. Long, vague sentences may bore readers—but more importantly, they often obscure gaps in knowledge and understanding. As an internal audit quality assurance reviewer, I was amazed how often people could not answer one simple question: What does this sentence mean?

They may have written it, but they could not say exactly what they had done or found during the audit. Did they

skimp on fieldwork? Did they understand management's answers to their questions? Did they analyze the test results thoroughly? All of these were possible—none of them clear.

Often a conscious decision to mislead did not exist. The convoluted corporate style they were used to seeing led to misunderstandings without anyone realizing it. The style had become a habit no one questioned; the result was reports that masked flaws in logic. Unless you can analyze your own work rigorously and articulate it clearly, you will not be able to persuade anyone how useful it is.

Even if you have conducted a thorough, well-reasoned piece of work, corporate communication habits can be hard to break. Sometimes people who care about good communication and clear reports fall into familiar traps.

Maybe they are nervous about delivering an unwelcome but necessary message. Maybe they think long, wordy sentences are impressive. They are not—they just bore and irritate readers. Maybe they are worried that if they do not use the latest buzzwords, people will not take them seriously. The flaw in all of these scenarios is the writer thinking only of themselves—not of the reader.

How to overcome these barriers? Put the reader first, obviously—imagine how you would feel if you had to read pages of convoluted prose. Plain language—simple words, short sentences and active rather than passive voice—is hard to write but easy to read. Rigorous critical thinking, expressed in plain language, should be the norm, but is not. Making the effort to understand your readers and communicate with them more effectively benefits your work, your readers, and, of course, the organization as a whole.

Different ways of reporting

As internal auditors, you mean to analyze rigorously and write clearly; however, this takes time and effort, which does not stop with the writing. Choosing a medium or format that does your work justice can be an almost pleasant experience after the hard work of critical thinking and plain language writing.

Ruthlessly interrogating your own understanding of your readers, your audience, their needs and what you actually have to convey is hard work. Learning how to do so clearly and concisely is not easy, either.

Once you have worked out these elements, how you transmit them depends on your audience, the organization and your colleagues' views. You may see your readers as a group: healthcare professionals. But this group can vary widely, with credentials, specializations and terminology creating subcultures, with differing communication preferences.

The different ways of working discussed earlier provide everyone—including internal auditors—with the opportunity to communicate results differently. Some people, who had long and rightly complained of poor reports, suggested abandoning them altogether. And yet, is this the only option?

Return to the basics of communication in the context of those changes to ways of working. People had to focus on dealing with crisis, which meant that business-as-usual content and format had to change. Producing lengthy, wordy, impenetrable reports—never a good way to communicate—became even less effective as readers' attention spans and energy levels were affected by change and often illness.

But having less time, energy and inclination to read lengthy reports led to innovative formats: one-pagers, email, PowerPoint and video. None of these approaches was impossible before, and a few teams had even used these media—but these modes were very much the exception to the deadly 30-pager. And remember—you can use any of these and still conform to the Institute of Internal Auditor's standards as long as you can prove you have communicated results.

The choice is up to you—and your readers or recipients. Some may want traditional reports, especially in healthcare, where documentation reassures and often legally protects. However, that does not mean drowning them in pages of verbiage. As stated before, more virtual access to colleagues often improved relationships. The exposure led in turn to less defensive writing because when you have had the opportunity to discuss things in depth, you may feel less obliged to document every detail. The change

Long, vague sentences may bore readers and obscure gaps in knowledge and understanding.

Use simple words, short sentences and active rather than passive voice.

is better for everyone involved and of course for the broader organization.

Conclusion

Whatever your team size or location, remember that you are communicating insight, not just data. The obligation has not changed, but the context has changed. Progress often arises from crisis, and in this case, changes to ways of working encourage positive changes in reporting.

Whatever format or medium you use to communicate results, the first step is to understand others, as well as yourself. Effective, transparent, constructive communication is fundamentally about an accessible exchange between and among human beings. Clear, concise communication means better service to your readers and ultimately to patients.

Better relationships lead to better communication, and reporting is no exception. The challenge is how you can adapt your practices, as assurance professionals elsewhere have. No limit exists to how you can improve. **NP**

*An earlier version of this article appeared in SIR*IUS, the journal of the Slovenian Institute of Auditors (Dr. Marjan Odar, Editor-in-Chief).*

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FEATURE

Postpandemic Regulatory Compliance

Recognize implications of PHE expired waivers and flexibilities

By Tynan Kugler, MBA/MPH, CVA, and Susan Thomas, CHIAP®, MHSA, CHC, CIA, CRMC, CPC, CCSFP

During the Covid-19 pandemic, temporary federal regulatory waivers and flexibilities allowed healthcare providers to increase access to care and streamline the delivery of services. Now, many waivers and flexibilities will expire because they were intended to respond to critical needs during the pandemic, not to permanently replace standing rules. Ensure that your organization resumes compliance when waivers and flexibilities expire.

With the end of the Covid-19 public health emergency (PHE) on May 11, 2023, numerous federal regulatory waivers and flexibilities were terminated, greatly affecting patients, hospitals, health systems, physicians and other providers. Returning to normal requires organizations to roll back policies and practices that were in place for more than three years. This article addresses several of the expired waivers relating to the Medicare and Medicaid programs and identifies key areas for audit and remediation consideration.

Implications for hospitals

Hospitals and health systems are making significant operational changes as the healthcare regulatory environment returns to a prepandemic state. They are assessing existing procedures, policies and relationships that were shaped by the waivers and flexibilities granted under the PHE. During this process, they are realizing that managing the effect on operations and finances may prove challenging.

Medicaid continuous enrollment stops – One of the biggest ongoing changes is the end of Medicaid's continuous enrollment requirement, which prevented states from terminating an individual's Medicaid coverage. As a result of the change, a significant number of beneficiaries who gained coverage during the PHE now are at risk of losing it.

During 2024, states must complete a redetermination process that terminates coverage for any person who no longer qualifies for Medicaid or who fails to submit information required for such redetermination. Healthcare organizations in states that have not expanded Medicaid may see a higher number of individuals lose coverage compared to states that have expanded the program.

An increase in the number of uninsured patients will probably hurt hospital financial performance. Even if these individuals secure other coverage, a rise in bad debt may still occur, given the cost of required co-pays, premiums or high deductible health plans.

Operational waivers end – Another sizable challenge for hospitals and health systems of all sizes is the end of the operational waivers. Medicare has reverted to requiring a three-day inpatient stay before covering skilled nursing facility (SNF) care; the same is true for critical access hospital (CAH) swing beds.

To manage surges during the pandemic, the Centers for Medicare and Medicaid Services (CMS) waived certain requirements, such as location (e.g., rural area), size (25-bed limit) and average length of stay (96 hours) for CAHs. Additionally, hospitals can no longer place acute care patients in excluded distinct part unit beds (i.e., inpatient psychiatric or inpatient rehabilitation units) or place distinct part unit patients in acute care beds. A hospital also must now satisfy all eligibility requirements to maintain its status as a sole community or Medicare-dependent hospital.

Teaching hospital waivers stop – Teaching hospitals receiving graduate medical education payments from CMS also benefited from the Covid-19 waivers. Specifically, during

the PHE, a hospital's bed count for determining the indirect medical education (IME) calculation was based on what it was the day before the PHE was declared on January 31, 2020. A hospital, therefore, was not penalized if beds were temporarily added during the PHE, which could have reduced the IME payment.

If student medical residents of a teaching hospital were sent to other hospitals on an emergency basis as a result of the PHE and spent time training there, the originating hospital was able to claim the residents' time in its IME and direct graduate medical education (DGME) calculations. Further, if a resident performed duties at his/her home or at the patient's home during the PHE (that were within the scope of the approved residency program and that met the appropriate supervision requirements), the teaching hospital could consider that time for IME or DGME payment purposes. These benefits and others impacting teaching facilities ceased with the end of the PHE.

340B program flexibilities expire – Certain PHE flexibilities to the 340B drug pricing program have also expired with the end of the PHE, including:

- Exempting 340B site registration requirements on a case-by-case basis
- Allowing remote audits of covered entities
- Allowing some hospitals not normally qualified to buy drugs through a group purchasing organization (GPO) to purchase through a GPO if they could not get the 340B price or wholesale acquisition cost price

During the PHE, hospitals that were terminated from 340B because their Medicare disproportionate share adjustment fell below requirements were allowed to apply for readmission. That law has now expired.

Effects on physicians

The flexibilities and waivers under the PHE touched nearly every part of physicians' practices, from patients' ability to access care to the payment physicians receive. Now, physician practices must evaluate necessary changes as these policies unwind. While access to Covid-19 vaccinations and certain treatments generally will not be affected, a transition to a more traditional model of insurance coverage for vaccines and therapeutics will occur.

Vaccine payment rate reduction – CMS will discontinue higher Medicare payment rates for Covid-19 vaccinations at the end of 2023, and, starting January 1, 2024, the payment rate will align with the rate for other Medicare Part B preventive vaccines (approximately $30 per dose[1]). For practices with a higher number of traditional Medicare beneficiaries, this change could be beneficial.

Physician supervision requirements reestablished – During the PHE, services that were required to be directly supervised (e.g., the physician is physically present in the same suite of offices and immediately available to assist and direct) were allowed to be virtually supervised via real-time audio and video technology. In the 2024 Medicare Physician Fee Schedule Proposed Rule, CMS states it intends to extend this practice through the end of 2024 with the flexibility set to return to pre-PHE rules on January 1, 2025.

Substitute billing arrangements flexibility ended – Prior to the PHE, a physician could use a substitute physician (i.e., locum tenens) to provide services for no more than 60 continuous days, At the end of 60 days, he/she either needed to find another substitute or return to work for at least one day to reset the 60-day period.

The waiver allowed a physician to use a substitute for the entirety of the PHE and for an additional 60 continuous days upon expiration of the PHE.[2] The substitution flexibility enacted during the PHE has ended, and physicians must now return to pre-PHE rules for substitution coverage.

Telehealth flexibilities to end – Unlike many other flexibilities, most Medicare telehealth flexibilities originally implemented under the PHE will not be immediately affected. Congress authorized Medicare coverage and policies that have

[1] https://www.cms.gov/files/document/physicians-and-other-clinicians-cms-flexibilities-fight-covid-19.pdf, page 2
[2] Ibid, page 14.

facilitated access and payment for telehealth services, including audio-only services, to continue through December 31, 2024. Certain telehealth flexibilities, however, were discontinued at the end of the PHE, such as the use of telehealth in place of face-to-face visits required for some services.

Merit-based Incentive Payment System exemptions continue – CMS granted automatic exemptions to reporting requirements associated with the Merit-based Incentive Payment System (MIPS) for the 2020 and 2021 performance years. CMS required entities seeking an exemption due to Covid-19 to apply for the exemption using the Extreme and Uncontrollable Circumstances (EUC) application for 2022. For the 2023 performance year, CMS will continue to use the EUC application to allow providers to request reweighting of one or more MIPS performance categories due to the impact of Covid-19 on their practices (e.g., labor shortages).

Stark Law waivers

On March 30, 2020, CMS issued blanket waivers of sanctions under the physician self-referral law (i.e., Stark Law) to protect financial relationships and resulting referrals identified by CMS as pertaining to at least one Covid-19 purpose:

- Securing the services of healthcare professionals
- Ensuring the ability and capacity of healthcare providers to address patient and community need
- Addressing business interruption in order to maintain the availability of medical care for patients and the community
- Diagnosing or treating Covid-19
- Shifting the diagnosis/patient care to an appropriate alternative setting

The blanket waivers were given a retroactive effective date of March 1, 2020, and remained in place through May 11, 2023. The waivers outlined 19 different types of financial relationships including remuneration from an entity to a physician (or an immediate family member of a physician) that is above or below the fair market value (FMV) for services personally performed by the physician (or the immediate family member of the physician) to the entity.[3]

Many of the blanket waivers permitted compensation greater or less than FMV. Also, many waivers were bidirectional, meaning they addressed payment from an entity to a physician or the physician to the entity (as in the case of space, equipment, or purchased services). Several waivers permitted loans at less than FMV.

The blanket waivers did not require the submission of specific documentation or notice to CMS in advance of their use. Instead, CMS encouraged the development and maintenance of records in a timely manner and indicated that parties using the blanket waivers would be required to make records relating to their use available to CMS upon request.

Given the potential for post-PHE scrutiny and perhaps for years to come, a critical audit priority should be identifying and documenting any financial relationships that relied on the blanket waivers. Such relationships should also be terminated by the end of the PHE. Practically speaking, the more time that goes by, the more difficult it will become to document these items.

To begin the documentation process, hospitals and health systems should identify whether they entered into any financial relationships that relied on the blanket waivers. To assist the identification process, providers should consider the examples of the arrangements identified by CMS in its blanket waiver publication[4] and then stratify the arrangements for which blanket waivers were utilized based on risk level. For example, if your organization increased compensation to a physician during the PHE, ensure that documentation for the stated increase is complete and available upon request.

Many of the arrangements that used the blanket waivers had a stated business purpose of helping to cope with Covid-19 during the PHE. Consequently, the arrangements may also need to be evaluated from a commercial reasonableness perspective.

While FMV often deals with the amount of money to be exchanged between two parties, commercial reasonableness examines the business purpose of the arrangement. If the business purpose that was primarily related to Covid-19 has not been adjusted post-PHE, documentation should exist as to ongoing need.

Exhibit 1 summarizes key waivers and flexibilities, including areas that may need audit and remediation.

[3]https://www.cms.gov/files/document/covid-19-blanket-waivers-section-1877g.pdf, page 8.
[4]Ibid, page 6.

Exhibit 1 – Summary of key waivers

Waiver and flexibility	Audit and remediation
1. Medicaid continuous enrollment provision	• Encourage Medicaid patients to respond to state requests for information relating to redetermination in a timely manner. • If coverage is terminated, assist patients in identifying alternative coverage or payment options.
2. SNF admission – Three-day prior hospitalization[5]	• Address policies and procedures for ensuring a Medicare beneficiary has a qualifying three-day prior hospitalization to qualify for SNF coverage.
3. Swing bed utilization[6]	• Address policies and procedures for ensuring a Medicare beneficiary has a qualifying three-day prior hospitalization to qualify for swing bed coverage.
4. Critical access hospitals[7]	• Discontinue use of more than 25 beds. • Adhere to 96-hour average length-of-stay requirements. • Discontinue use of any offsite nonrural locations.
5. Distinct part units[8]	• Ensure patients are treated in their dedicated units in order to receive payment for services.
6. Provider supervision[9]	• Identify any service requiring direct supervision and ensure that virtual supervision currently being used transitions back to direct supervision by January 1, 2025, in accordance with the 2024 Medicare Physician Fee Schedule proposed rule.
7. Teaching facilities	• Plan for any added beds to be considered in determining the hospital's IME payments.[10] • Discontinue claiming residents sent to other hospitals in IME and DGME full-time equivalent resident counts.[11] • Discontinue counting resident's time for activities at his/her home or a patient's home for purposes of Medicare IME or DGME payments.[12]
8. Telehealth exceptions[13]	• Discontinue use of telehealth for specific services no longer permitted under waivers.
9. Covid-19 vaccination payment[14]	• Assess the financial implication of a payment decrease starting in 2024.
10. Locum tenens billing arrangements[15]	• Comply with the requirement that locum tenens physicians provide services to Medicare patients over a continuous period of time no longer than 60 days.
11. Merit-based Incentive Payment System participation	• Evaluate need for EUC application and file for requested reweighting of one or more categories by January 2, 2024.[16] • Prepare to implement 2024 Quality Payment Program requirements.[17]
12. Stark Law waivers[18]	• Determine if a blanket waiver was used. • Stratify affected arrangements based on risk (e.g., low, medium, high). • Review documentation for affected arrangements to ensure appropriate support exists for reliance on the blanket waiver. • Consider the commercial reasonableness of the applicable arrangement.

[5]https://www.cms.gov/files/document/long-term-care-facilities-cms-flexibilities-fight-covid-19.pdf, page 5.
[6]https://www.cms.gov/files/document/hospitals-and-cahs-ascs-and-cmhcs-cms-flexibilities-fight-covid-19.pdf, page 12.
[7]Ibid, page 13.
[8]Ibid, page 14.
[9]Ibid, page 4.
[10]https://www.cms.gov/files/document/teaching-hospitals-physicians-medical-residents-cms-flexibilities-fight-covid-19.pdf, page 6.
[11]Ibid.
[12]Ibid, page 5.
[13]Ibid, page 4.
[14]https://www.cms.gov/files/document/hospitals-and-cahs-ascs-and-cmhcs-cms-flexibilities-fight-covid-19.pdf, page 2.
[15]https://www.cms.gov/files/document/covid-19-emergency-declaration-waivers.pdf, page 37.
[16]https://qpp.cms.gov/resources/covid19
[17]https://qpp.cms.gov/
[18]https://www.cms.gov/files/document/covid-19-blanket-waivers-section-1877g.pdf

Resources

- PYA
  - End of the PHE Compliance Checklist
  - Stark Law Blanket Waiver Documentation Checklist
- Centers for Medicare and Medicaid Services - Frequently Asked Questions: CMS Waivers, Flexibilities, and the End of the COVID-19 Public Health Emergency

Conclusion

The provision of various waivers and flexibilities afforded significant relief to hospitals, health systems and physicians while they treated patients during the PHE. As your organization moves forward, review and transition practices and policies that were used from March 2020 to May 2023.

Many CMS flexibilities have expired, but healthcare providers should recognize that several flexibilities, including those related to telehealth, are extended for a period of time. Although extended, the flexibilities do have deadlines. Your providers should be aware of these and prepare for their future expiration. CMS provides various sources on its website to ensure compliance with the deadlines.

An audit of your organization's compliance with end-of-PHE requirements can identify overlooked items and facilitate remediation. Regular check-ups and any required adjustments should be part of your organization's ongoing practices. **NP**

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When Revenue Models Collide with Ethics

Recognize the conflict in healthcare

By Marianne M. Jennings, JD

Ethics and compliance are approached as if we are automatons: create checklists, tweak processes, perform audits, take samples, and look for red flags. All is in place. We are prepared to tackle to the ground any breach that manages to infiltrate this impenetrable fortress of ethics and compliance tools. Sometimes, however, the root of all evil is the business revenue model.

How do you ensure compliance when the revenue model itself is the problem? How some organizations make money is the root cause of their ethical lapses.

A former student, hired by a defense contractor, called and said, "The job is great. But are you aware that the company that pays me makes weapons used in wars?" Although I was not immediately clear in what other types of skirmishes one could use M777 howitzers, I responded that I was aware of the product lines of defense contractors.

The former student then added, "Well, I am against war, and I am not sure how to raise my ethical concerns." I explained to my former student that whistleblowers generally report things not known to the public. Also, finding a different job at a company not involved in missile production might be the best avenue.

While the former student offered a comical perspective, the experience with the student raised a head-turner issue: What if the company's revenue model is the ethical issue? Several current examples in business news illustrate the question: What if how the company makes money is the overarching ethical issue?

Coinbase and its clientele

Coinbase, a publicly traded cryptocurrency exchange, was recently required to pay a $50 million fine to the New York State Department of Financial Services. In addition, during that department's investigation, Coinbase was ordered to hire an outside compliance consultant to vet customers until the department could get its arms around the scope of the problem.

Once the investigation was finished and the fine assessed, part of the settlement was that Coinbase would keep the compliance consultant on for at least another year. Coinbase grew so quickly—to a market cap of nearly $8 billion and 100 million users—that the organization

How a company makes money can be the overarching ethical issue.

Do not let the revenue model prevail over ethics and compliance controls.

lacked the compliance staff to vet money launderers from around the world.

Thinking through this one: Are you aware that some of the people who use cryptocurrency exchanges are drug traffickers and sellers of pornography? When the customers using your services are doing so to facilitate ongoing violations of the law, your revenue model may be the source of all compliance problems. Most crypto firms got away with their customers of the underworld by being based in countries that use the underworld as a tourist attraction, by lighter, if not favorable, regulation.

As you review this scenario you realize that the ethical and compliance issues in this company cannot be fixed because of the revenue model. Cryptocurrency firms thrive because of those looking for a way to make payments that they do not want to be detected. Nefarious is as nefarious does.

Wirecard – The PayPal of the iffy

Wirecard, sort of the PayPal of Germany, was founded in the early 2000s to process both credit and debit card transactions. Their revenue model was based on client recruitment. Client recruitment involved, shall we say, perks above and beyond a lunch or dinner.[1]

The old saying, "You get what you pay for," held true in a different way for Wirecard. The money spent on client perks brought in clients who ran live-stream pornography sessions. And those working at Wirecard tested the client's product in the office to determine if these truly were live sessions. The company then moved into processing payments for online gambling companies, something that was illegal in most countries at the time.

When the United States outlawed online betting in 2006, Wirecard took the novel approach of latching on to an exception: betting was allowed online for games of skill. Wirecard decided that poker was a game of skill, not one of chance. Wirecard's purchase of an Irish online poker company resulted in a 62 percent increase in revenue.[2]

The nature of the Wirecard clientele again demanded privacy and a means of skirting regulatory monitoring. The Irish poker acquisition was part of a global structure strategy that Wirecard created for routing payments. Wirecard continued to purchase companies in other countries where payments for clients were routed.

Using these companies around the world, Wirecard clients were not named on the Visa or MasterCard statements and thus could not be implicated in any illegal activity. For example, instead of "Bert's Online Strategic Poker House," the consumer Visa bill would be for "Satellite Cellular Phones." Come to think of it, Wirecard provided a service to spouses everywhere. Bills showing you are spending time at Bert's site might cause some friction. A benign cellular service could pass scrutiny even with the most suspicious.

Because of the nature of Wirecard clientele, with their limited options for obtaining payments due to regulators breathing down their necks, the circuitous Wirecard model was attractive. Wirecard knew that and charged mightily for its discreet (at least in the regulatory sense) payment system. And because of the transactions being run through other companies in other countries, Wirecard was able to say to regulators who might come calling, "Who knew?"

In fact, when the online poker thing slowed down, Wirecard moved into what is known as nutraceuticals. These over-the-counter (or in this case, over-the-internet) products are derived from food sources that provide both nutrition and medicinal benefits for weight loss, memory loss, fat loss, and all the other losses that come with age.

The thread the companies always have in common is a "free trial period" with "cancel any time" or "return what you don't use for a full refund." However, in the small print were conditions that presented hurdles for the nutraceutical purchasers to end their subscriptions and/or get their money back.

Wirecard's role was to help the nutraceuticals sellers spread their charges across many companies. The reason? To keep consumer complaints to a minimum at those companies so that the sales could just keep going without the Federal Trade Commission or Food and Drug Administration stepping in to shut down consumer fraud.

[1]Ben Taub, "How the Biggest Fraud in German History Unraveled," *The New Yorker*, February 27, 2023, https://www.newyorker.com/magazine/2023/03/06/how-the-biggest-fraud-in-german-history-unravelled (subscription may be required)
[2]Ibid.

The ethical obligation is to provide healthcare to the weakest among us.

Again, to summarize, Wirecard's revenue model was selling disguised payment processing. Where would ethics and compliance fit in such an operation?

Jeffrey Epstein and the banks

Over the first half of 2023, a slow trickle of information about relationships of banks with Jeffrey Epstein emerged. Mr. Epstein was convicted in Florida of soliciting a minor for prostitution in 2008 and sentenced to 11 months in jail. In 2019, the federal government charged him with sex trafficking. He died in jail awaiting trial on those charges.

Mr. Epstein, also known as a crackerjack investment adviser, was a client of JPMorgan, a subsidiary of JPMorgan Chase (Chase), both before and after his Florida conviction. Jes Staley, then in charge of Chase's private banking arm, worked closely with Mr. Epstein on developing key relationships with foreign leaders, recruiting new investment clients, and even using Epstein's clout to persuade Columbia's doctorate program to accept Mr. Staley's daughter.[3]

Chase settled a lawsuit brought by one of Mr. Epstein's victims for $290 million in June 2023. The suit alleged that the bank ignored red flags about Mr. Epstein.[4] Chase is currently dealing with a different suit brought by the U.S. Virgin Islands for ignoring red flags about Mr. Epstein's conduct. Depositions and filings in the case indicate that Chase employees had filed many Suspicious Activity Reports about Mr. Epstein's large and routine cash withdrawals. Chase approved at least 20 payments by Epstein to young women.[5]

In a 2010 email, the Chase compliance department wrote: "See below new allegations of an investigation related to child trafficking—are you still comfortable with this client who is now a registered sex offender?"[6] Chase's anti-money laundering compliance director asked the bank's general counsel to re-approve the relationship.[7] Even the compliance folks were seeking cover.

In 2006, Chase labeled Mr. Epstein a "high risk" client but the bank kept him as a client even as media reports of sexual abuse of minors continued. After Mr. Epstein was registered as a sex offender in 2008, the bank still kept him as a client because he had access to wealthy individuals.[8] Compliance officers provided repeated warnings about Mr. Epstein, but even after the warnings, the bank authorized loans to Mr. Epstein secured by his accounts.

Chase did not "fire" Mr. Epstein as a client until 2013, when Jes Staley left Chase to become CEO of Barclays. Meanwhile, across the pond, Jes Staley ended his tenure at Barclays under the ever-percolating information about the Epstein-Staley relationships and inconsistent statements to British authorities about that relationship.

While Mr. Epstein was completing his sentence for the Florida charges, Mr. Staley sent an email in 2009, "I owe you much. And I deeply appreciate our friendship. I have few so profound."[9]

In a sort of bizarre firing squad, the women sued Chase for facilitating Mr. Epstein's business. The U.S. Virgin Islands is suing Chase for its failure to act. Chase is suing Staley for his failure to disclose what he knew about Mr. Epstein. Some of the findings of an investigation by British regulators of Mr. Staley for his ties to Mr. Epstein became public in 2021 with Mr. Staley stepping down as CEO of Barclays.[10]

The revenue model here is more like the revenue model that is dangerous for any business. What would you do to close a sale? How far would you go to retain a client? How much would you suppress to keep a customer or client? At Chase, the goal was to gain and maintain large-wealth clients. Somehow the revenue model overrode the compliance controls in the bank. Wealthy clients matter; their baggage does not.

Wells Fargo and fictitious accounts

At Wells Fargo the revenue model was new accounts and eight products per customer. How employees achieved the goals was of little concern, as long as the gaming allegations by employees remained around one percent. What the revenue model overrode was looking at the

[3]Khadeeja Safdar and David Benoit, "JPMorgan Revealed Epstein Ties," *Wall Street Journal*, June 20, 2023, p. B1
[4]Ibid
[5]David Benoit, "Epstein Emails Show Ties to Bank Ex-CEO," *Wall Street Journal*, February 17, 2023, p. B1
[6]Khadeeja Safdar and David Benoit, "JP Morgan's Epstein Ties Were Deeper Than Bank Has Said," *Wall Street Journal*, April 22–23, 2023, p. A1, at A14
[7]Ibid
[8]Ibid
[9]David Benoit, "Epstein Emails Show Ties to Bank Ex-CEO," *Wall Street Journal*, February 17, 2023, p. B1.
[10]Michael J. de la Merced and Matthew Goldstein, "C.E.O. Out at Barclay's Over Ties to Epstein," *New York Times*, November 2, 2021, p. B1.

A callous revenue model will likely produce a callous culture.

turnover rate at the bank—employees leaving because they were unable to martial compliance efforts to stop the madness of fake accounts.

That revenue model ultimately resulted in a $3 billion settlement by Wells Fargo to resolve investigations into sales practices that produced millions of accounts without customer authorization.

Revenue models in healthcare

Consider revenue models in healthcare that trump ethics and compliance.

No-Medicare model

Recently, several doctors have decided to drop me as a patient. I am not an unwieldy patient and I am covered by Medicare and secondary insurance. The doctors want nothing to do with Medicare and, since I have Medicare, I am out. I also carry secondary insurance and tried to reason with these longstanding doctors. Secondary insurance is a plus, but the staff insisted that they would not treat anyone who has Medicare.

Because of the low reimbursement rate and the high costs of dealing with the federal government and its Medicare bureaucracy, this revenue model wants nothing to do with Medicare patients. The ethical issue of providing healthcare is overridden by healthcare providers seeking revenue models to maximize returns.

Profitable patient model: No pediatric patients need apply

Around the country, everything from regional hospitals to small town facilities are closing their pediatric units. Adult patients bring in more revenue. A quote from a pediatric doctor explains why hospitals are closing their pediatric units: "They're asking: 'Should we take care of kids we don't make any money off of, or use the bed for an adult who needs a bunch of tests?' If you're a hospital, that's a no-brainer."[11] Low Medicaid reimbursements and the disappearing Covid-19 subsidies have made revenue models shift.

Even if Medicaid rates are increased, pediatric care cannot compare with the revenue hospitals can make from adult patients. Even Medicare adult patients provide higher revenue than Medicaid patients.

As the number of pediatric beds declines in hospitals, doctors are treating children in emergency rooms (ER). One doctor in a Boston hospital, overwhelmed by seriously ill children sent a text to his chief medical officer that was filled with expletives and this demand, "Picu kids don't belong here."[12]

In the Phoenix area during the flu and respiratory syncytial virus season in 2022–2023, children who were intubated were being sent to hospitals in California because no beds were available in Arizona. My grandson spent two nights in the ER before he was assigned a bed in a pediatric unit.

The difference in the quality of care between the ER and the PICU was stunning. In the ER physicians, nurses and therapists either lose or do not have the skills to treat children. When pediatric units are closed, treatment on an emergency basis becomes challenging because the right sizes of equipment are no longer available.

At what point does the revenue model recognize the underlying and overarching ethical issue? That singular issue is the obligation to provide healthcare to the weakest among us.

Profitable patient model: High-dollar care model

Following being dropped by a specialist due to my Medicare cooties, I called three different specialists to find a replacement. One specialist was no longer taking new patients.

Another specialist indicated that an appointment could be scheduled in six to eight months. I had been dumped just weeks before my already scheduled annual visit, and with my prescriptions running out as they do, this one was not a viable option. Another office kept me on hold for 45 minutes three days in a row. I figured that was 8 to 12 months for an appointment.

When I finally reached a fourth option, I was told that I needed to send my records to be evaluated as to whether they would take me as a patient. Harking back to my college application days, I put my best package together.

[11]Emily Baumgaertner, "As Hospitals Chase Profitable Patients, Beds for Children Vanish," *New York Times*, October 12, 2022, p. A1, at A17.
[12]"Picu" is the converted word for PICU (Pediatric Intensive Care Unit).

The right to healthcare should not be a qualified right.

The response was, "You have been rejected as a patient because you do not qualify for our level of care." The reality was that the practice handles only those patients whose problems cannot be solved with a routine exam and a prescription. I just was not sick enough.

Through research I discovered that indeed this is a revenue model—taking only the specialty cases that require much testing, more follow-up, and complex solutions, preferably incurable but with great hope for more testing. The productivity studies in hospitals and practices may be fueling this revenue model. Healthcare providers are evaluated by the dollars they bring in per patient. Hence, they do not want to take routine patients because they take up time but are not revenue generators.

Just typing the description of this model is emotional while thinking of all the noble physicians in our country's history and throughout the ages. How does a profession become callous to the concept of service? How are ethical cultures lost? Look to the revenue model.

Dun the patients revenue model

Many media stories have covered hospitals and their aggressive collection tactics.[13] As noted in a previous column, sometimes the collection is undertaken even when not authorized.[14] In fact, some revenue models have moved beyond dunning into refusal to provide care. While all hospitals are obligated to provide emergency treatment, they do have the option of rejecting patients.[15]

An additional question arrives with this revenue model: At what point does an organization lose the ability to provide quality care when its revenue model has a callous attitude about patients?

Healthcare providers do have a natural sense of service. Is that instinct being chipped away by the revenue models being pursued with a result of less care for fewer patients and, in some cases, patients doing without non-emergency necessary care? Building a culture on a callous revenue model will probably produce a callous culture.

Where is healthcare now?

In a conversation with one of my physicians, she mentioned that she needs to retire as she turned 70. But retirement is not in the cards until she is able to hire physicians who could take over her practice and she could trust them with her patients.

She said, "Between patients being rejected because they simply need routine care and doctors refusing to accept Medicaid, I have quadrupled the number of patients I have in the past two years." She also noted that she sometimes feels that she is the only doctor in town who takes Medicare and provides routine healthcare.

This fine physician, who has provided me with quality routine care for 31 years, is unique and, apparently, part of a dying breed. Her revenue model is inclusive, not restrictive nor discriminatory.

That is quite a summary of our healthcare system that has touted healthcare as a right. What is not understood is that the right is now a qualified one: You must fit into someone's revenue model. Somehow, the entire debate on providing healthcare for everyone has moved to revenue models.

The revenue model of healthcare has handed us the additional problem of trying to create an ethical culture that still supports reporting breaches and harm in an organization that callously screens out those who are not revenue maximizers. In such business models, as the examples illustrate, ethics does not have a chance. **NP**

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[13]Jessica Silver-Greenberg and Katie Thomas, "Entitled to Free Treatment But Hounded by Hospitals," *New York Times*, September 25, 2022, p. A1
[14]Jessica Silver-Greenberg and Katie Thomas, "Patients Due Health Care Get Refunds," *New York Times*, October 5, 2022, p. B1; Marianne M. Jennings, "Ethics and the Nonprofit Organization," *New Perspectives*, 42-1, p. 11-15 (2023), https://ahia.org/wp-content/usploads/2023/02/Ethics-and-Nonprofit-Organizations-Marianne-M-Jennings.pdf (membership required)
[15]Sarah Kliff and Jessica Silver-Greenberg, "Medical Group Cuts Off Those Carrying Debt," *New York Times*, June 3, 2023, p. A1

FEATURE

Emergency E/M Code Leveling

Ensure resources align to billed service levels

By Amy Lee Smith, CHIAP®, CIA, CPC, CPMA, and Caroline Znaniec, MBA, MS-HCA, CRIP

The Centers for Medicare and Medicaid Services (CMS) typically provides strict guidance for what and how hospitals and other facilities are allowed to charge for services rendered. However, no national standard or specific methodology is required for facility evaluation and management (E/M) code leveling. Code levels should be consistently applied and correspond to the level of resources/effort provided in treating patients. Payers will attempt to downcode or deny charges, and your facility's coding guidelines can help you defend against those attempts.

Since 2000, CMS has held that each facility may use a unique system for E/M level assignment and that each facility must follow their system consistently to demonstrate compliance..

In 65 FR 18451 (page 18), published April 7, 2000, CMS states:

> We will hold each facility accountable for following its own system for assigning the different levels of Healthcare Common Procedure Coding System (HCPCS) codes. As long as the services furnished are documented and medically necessary and the facility is following its own system, which reasonably relates the intensity of hospital resources to the different levels of HCPCS codes, we will assume that it is in compliance with these reporting requirements as they relate to the clinic/emergency department visit code reported on the bill. Therefore, we would not expect to see a high degree of correlation between the code reported by the physician and that reported by the facility.

Because separate Common Procedural Terminology (CPT) and HCPCS codes have yet to be established to describe emergency E/M services provided within a facility, hospitals are permitted to use physician E/M CPT codes to capture charges for emergency services provided (e.g., 99281–99285).

Subsequent CMS deliberation and guidance

2002 proposal

In 2002, four types of E/M coding standards were proposed to CMS by an independent expert panel for adoption to standardize leveling methodology.

Staff time – The time staff spend with each patient could be the basis. Higher levels would be reported based on time increments beyond baseline care.

Staff intervention – The number or type of staff interventions performed by nursing or ancillary staff could be the basis. Higher levels would be reported based on the number and/or complexity of staff interventions.

Resource intensity point – Scoring could be based on points assigned to each staff intervention based on time, intensity and staff type required. The service level would be determined by the sum of the points for all services provided.

Severity acuity point scoring – Diagnosis codes, complexity of medical decision-making, or severity or acuity of a patient's presenting complaint or medical problem could be the basis.

CMS evaluated the options and commented with pros and cons of each method. Ultimately, CMS decided to not establish a national standard. Exhibit 1 provides the highlights of CMS' comments. Consider the pros and cons when evaluating the coding guidelines in use at your facility.

CMS requires each hospital to establish its own facility billing guidelines.

Exhibit 1 – Proposed E/M national coding guidelines (2002)

Methodology	Pros	Cons
Staff time	• Simple to understand • Correlates with total facility resource use • Provides an objective standard	• Burdensome documentation • Incentive to work slowly or use inefficient workflow • Potential for upcoding or gaming
Staff intervention (ACEP guidelines)	• Simple to understand • Reflects the care given to the patient • Does not require additional facility documentation	• Incentive for unnecessary services • High variability amongst hospitals • Susceptible for upcoding or gaming
Resource intensity point scoring	• Correlates with total facility resource use • Provides an objective standard	• Extra/unnecessary clinical documentation • High level of complexity to monitor and maintain • Susceptible for upcoding or gaming
Severity acuity point scoring	• Alignment of clinical protocols based on patients presenting complaints and diagnoses	• Extremely complex • Demands interpretive work • High variability amongst hospitals • Significant potential for upcoding or gaming

2008 standards

In the 2008 OPPS Final Rule (page 226), CMS outlined 11 standards that should be included in a facility's guidelines for E/M level management:

1. Follow CPT code descriptor intent and reasonably relate to the intensity of the hospital services
2. Base coding on hospital resources not physician resources
3. Clearly facilitate accurate payment and are usable for compliance purposes and audits
4. Meet Health Insurance Portability and Accountability Act requirements
5. Require documentation that is clinically necessary for patient care
6. Do not facilitate upcoding or gaming
7. Written or recorded, well-documented and provide the basis for selection of a specific code
8. Applied consistently
9. Not changed frequently
10. Readily available for Fiscal Intermediary and Medicare Administrative Contractor reviews
11. Result in coding decisions that can be verified by hospital staff and outside resources

Consider the standards when evaluating the coding guidelines in use at your facility.

Variations in practices

In the absence of a national standard, hospitals are varied in their methodologies. For facilities in Maryland, the state's rate-setting commission has required hospitals to assign levels based on clinical care time. In other states, staff

Staff intervention and point-based systems are the most commonly used methodologies.

intervention and point-based systems are the most common methodologies used.

However, the payer community uses methodologies more closely related to the severity acuity point score methodologies, which look at visits from a data perspective and assume that the level of care provided aligns to a defined visit level for billing and reimbursement.

Stakeholder differences

Regarding emergency services, the perspectives and goals of the patient, the provider and the payer often differ.

Patients

According to a 2017 Academy of Emergency Medicine (AAEM) study, patients are primarily concerned with access to and confidence in their care. When a patient is anxious and feels as if care is needed urgently, the value of reassurance from emergency-based services is paramount. They also depend on the views of family, friends and other healthcare professionals; seek convenience (location, operating hours, not having to make appointments); and are concerned about out-of-pocket costs.

Providers

Emergency physicians have an obligation to diagnose and treat patients in a cost-effective manner and must be knowledgeable about cost-effective strategies. However, they should not allow cost containment to impede proper medical treatment of the patient as required by the Code of Ethics for Emergency Physicians of the American College of Emergency Physicians.

Payers

The payer's perspective is to provide better care and health at lower overall costs. Consequently, payers maintain and revise their policies to address inconsistencies seen in coding accuracy and to relate facility E/M guidelines to hospital resource use.

The risk to your facility is that many payers, such as United Healthcare, are downcoding emergency visits, or initially denying services pending medical record documentation. The effect on your facility's revenue can be severe.

Audit coding and supporting processes

To ensure that your facility's policies and practices are compliant, begin by using a combination of data collection, interviews, testing and data analytics to:

- Understand the current methodology for visit level determination.
- Assess the general quality of documentation.
- Audit charge capture and coding.
- Test internal coding guidelines to actual encounters.
- Analyze trends in billing, denials and reimbursement.

When you review your facility's leveling methodology, ensure that it meets the 11 standards from CMS. Determine whether medical record documentation and workflows support the chosen methodology and whether clinical protocols are up to date.

Ensure that documentation is clear and thorough enough to provide for the capture of services and to facilitate efficient coding, especially for diagnosis specificity, service levels and procedures performed. Consider the following questions:

- Are presenting problems, complicating conditions, external causes and co-morbidities being captured appropriately?
- Are separately reportable services and procedures (such as injections, infusions, point-of-care lab tests, respiratory treatments) and diagnostic services (labs, radiology, EKGs) being captured consistently?

An opportunity for data analytics includes predicting the potential for payer downcoding by comparing data elements such as avoidable diagnoses in Level 4 or 5 visits, or non-avoidable diagnoses in Levels 4 or 5 in the absence of diagnostic services. Compare expected versus actual payments to understand when downcoding or denials are occurring.

You should ensure that the billing office is aggressively appealing downcoding and denials, sharing the facility E/M internal guidelines, providing medical record documentation to payers, and, if necessary, elevating concerns to higher levels of appeal.

Coding should reflect the volume and intensity of facility resources utilized to provide care.

Exhibit 2 is a tool to assess the current leveling methodology to clinical and billing processes, regulatory requirements and payer expectations. Identify opportunities to improve alignment of resources to the levels that are captured and billed.

Summary

Your facility must consistently apply established E/M leveling guidelines that align with the 11 CMS standards and maintain medical record documentation that is complete and accurate to support the levels billed. With these practices in place, you may not win every appeal of a payer denial or downcoding, but you should have a valid argument in support of your coding.

In the absence of any national standard, facilities must understand the importance of establishing and complying

Exhibit 2 – Facility leveling assessment tool

A. General	Validation
1. Is the leveling methodology written or recorded?	Review policies
2. Is the methodology based on hospital resource utilization and intervention?	Review policies
3. Can the methodology be easily explained and replicated?	Test claims
4. Does the methodology provide for consistency in similar clinical situations?	Test claims; analyze data
5. Are all chargeable items and services captured in addition to the visit level?	Test claims
6. Are all complicating diagnoses and external cause diagnoses captured, coded and billed?	Test claims
B. Point-based methodology	
1. Are the weights/points translatable to resource time/effort (e.g., one point = one minute)?	Review policies; verify logic and consistency
2. Are weights/points assigned for items/services that are separately captured and billed (e.g., inhalation treatment, infusion)?	Review policies; review logic; review mapping
3. Are items/services that are not separately captured and billed not assigned a weight/points (e.g., oral medication administration, repeat vital signs)?	Review policies; review logic; review mapping
4. Are additional weight/points given when a billed item/service may need to be repeated (e.g., vital signs, reassessment), require additional resources (e.g., sitter, translator) or address a special population (e.g., pediatric)?	Review policies; interview staff
5. In the identification of items/services assigned a weight/points, were clinical operations staff involved in their identification and value assignment?	Review policies; interview staff
6. Are weights/points assigned driven by the performance of tasks and automated in the documentation workflow?	Review policies; review logic; review mapping
C. Intervention-based methodology	
1. Are the interventions, driving the final visit level, consistent with clinical protocols for patient presentation to the emergency department?	Review policies; review logic
2. Have the clinical protocols related to interventions been reviewed in the past two years?	Review policies; interview staff
3. Is the final visit determination based on automation through documentation, or is a manual review required?	Review policies; interview staff
4. Does the methodology provide for exceptions when an intervention may be more difficult or address a specific population (e.g., pediatric, mental status)?	Review policies; interview staff

with their own unique leveling methodology. You should partner with the emergency department to perform periodic workflow reviews as well as billing, coding and denials audits. **NP**

Resources

- American College of Emergency Physicians®
  - ED Facility Level Coding Guidelines
  - Approach to Emergency Department Coding FAQ
  - A Worthy Investment: What Every EM Resident Needs to Know About Reimbursement In 2023
- MRA – E/M Leveling: Compliance, Correct Coding and Best Practices

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Tools for Data Analytics – Part One

Use advanced tools

David E. Sems, CPA, CITP, CFF

Data analysis by auditors has become a routine and productive practice. For example, Grant Thornton's survey of 200 chief audit executives shows that 94 percent of their teams have prioritized analytics and 85 percent reported that analytics and automation add value to internal audit. Learn how advanced tools can help you increase your efficiency with data analytics.

The power of any tool for a user comes from awareness of its capabilities. In Part One of the series, learn how to prepare data for analysis. Part Two reviews a tool that produces and displays graphical representations of data.

Auditors can make use of numerous analytics tools. Certain industry leading auditing tools are considered gold standards, such as Diligent Analytics, formerly known as ACL for Windows, and Caseware's IDEA, which are renowned for their exceptional quality and comprehensiveness. The tools stand out as fantastic options by providing many powerful features and functionalities that streamline the audit process and enhance data analysis capabilities. You might be using one of those solutions today, which is terrific.

In this article, two tools are introduced that can significantly increase your efficiency. The examples—Altair Monarch and OpenRefine—are ones that I use and, consequently, am intimately familiar with their capabilities. But you should make your purchase decisions based on your own research and judgement.

Naturally, the written media that you are currently reading is static and not the most effective medium for software demonstrations. Therefore, links are provided to videos showcasing these tools. The videos should give you a more comprehensive understanding of their capabilities. Hopefully, your curiosity will be sparked and their value will be apparent, which will encourage you to delve further.

Preparation of data

Having data you can use to conduct tests with an analytics tool is the starting point with any analytics project. If the data you have is stuck in legacy systems or PDF file formats, you may believe analysis, let alone finding control weaknesses or fraud, will be impossible.

The power of analytics often comes from matching data between systems that generally do not interface with

Data preparation should ensure the accuracy and reliability of the analysis.

each other. By matching data, you may be able to uncover relationships that would not otherwise be obvious. Your challenge is to obtain good, readable data that is stuck in noncolumnar or nonspreadsheet formats.

Data preparation is a critical and indispensable step in the data analytics workflow, playing a pivotal role in any analytical project's overall success and accuracy. Raw data is often messy, incomplete, and comes from various sources, which makes it unsuitable for direct analysis. The primary objective of data preparation is to transform and clean the data to a consistent and reliable format to ensure that it is ready for further analysis.

Various tasks are undertaken during data preparation, including cleaning, integration, transformation and enrichment.

Cleaning – Cleaning involves identifying and correcting errors, removing duplicates and handling missing values.

Integration – Integration merges data from multiple sources into a unified format, allowing analysts to view the data comprehensively.

Transformation – Transformation involves converting data into a suitable representation through scaling, normalization or encoding categorical variables.

Enrichment – Enrichment supplements a dataset with relevant external information to enhance its analytical potential.

By working with good clean data, you can focus on extracting meaningful patterns and relationships from the data rather than dealing with avoidable data-related issues. Ultimately, a robust data preparation phase guarantees the accuracy and reliability of the analysis, leading to more informed decisions and valuable insights that can improve performance and drive business growth and innovation.

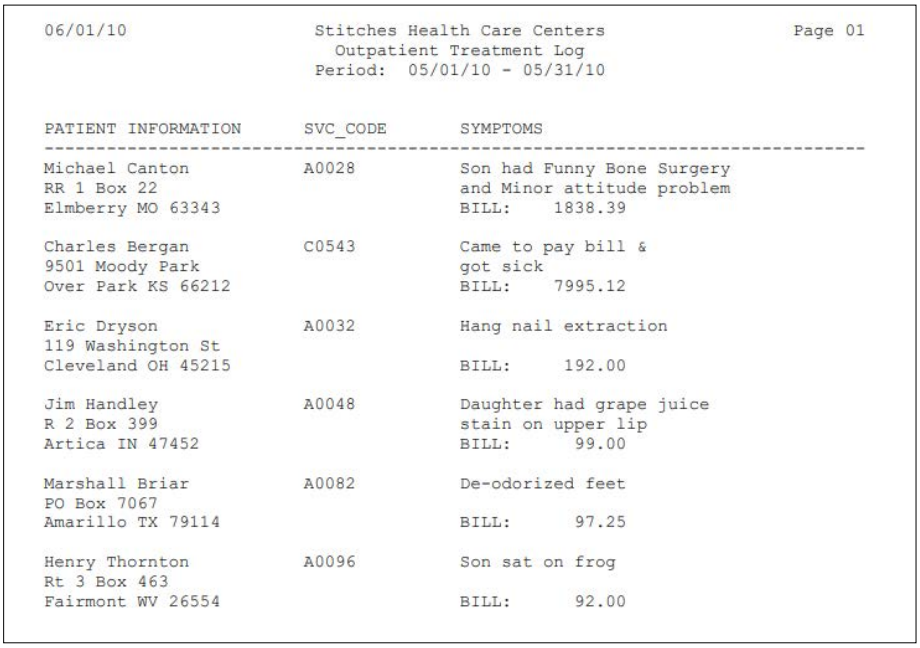
Data conversion

Altair Monarch (Monarch) can convert data and prepare it for analysis. The tool converts data locked in PDFs and semi-structured data, such as reports from legacy mainframe systems. Monarch can also open data from various databases, including DB2, Informix, Microsoft Access, MySQL, PostgreSQL, SQL Azure and SQL Server. Monarch can connect to SAP Business Objects, cloud-stored data, NetSuite, and SharePoint. For this article, the focus will be on the power that the tool has to extract clean data from a PDF report or other document.

Have you ever been presented with a multi-page report in a PDF or text file and tried to convert it to Excel for analysis? The conversion can be difficult. The following example demonstrates Monarch's power.

Start with a PDF report as illustrated in Exhibit 1.

Exhibit 1 – PDF report



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06/01/10                Stitches Health Care Centers                Page 01
                          Outpatient Treatment Log
                        Period:  05/01/10 - 05/31/10


PATIENT INFORMATION     SVC_CODE       SYMPTOMS
-------------------------------------------------------------------------------
Michael Canton          A0028          Son had Funny Bone Surgery
RR 1 Box 22                            and Minor attitude problem
Elmberry MO 63343                      BILL:    1838.39

Charles Bergan          C0543          Came to pay bill &
9501 Moody Park                        got sick
Over Park KS 66212                     BILL:    7995.12

Eric Dryson             A0032          Hang nail extraction
119 Washington St
Cleveland OH 45215                     BILL:     192.00

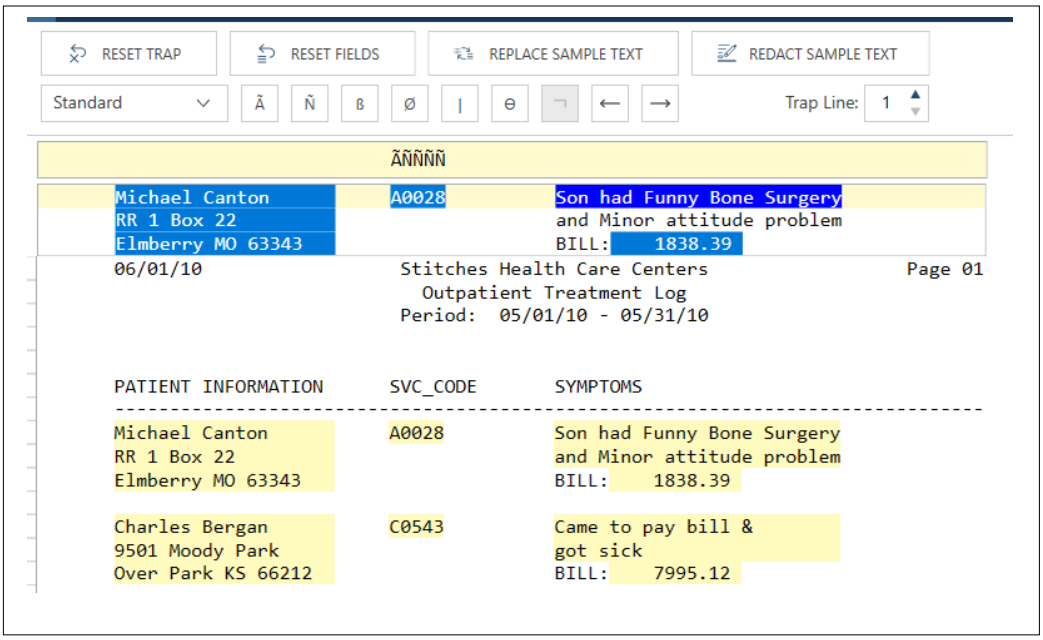
Jim Handley             A0048          Daughter had grape juice
R 2 Box 399                            stain on upper lip
Artica IN 47452                        BILL:      99.00

Marshall Briar          A0082          De-odorized feet
PO Box 7067
Amarillo TX 79114                      BILL:      97.25

Henry Thornton          A0096          Son sat on frog
Rt 3 Box 463
Fairmont WV 26554                      BILL:      92.00
```

The PDF report has some good information, but how do you transfer the data into Excel rows and columns? The information includes patient names, addresses, service codes, symptoms, and bill amounts. For data preparation in Monarch, you would set up a routine to capture (trap) what you define as the data that visually looks like a record. In this example, you would key off the SVC_CODE column, looking for a pattern of an alpha character and four numbers. Exhibit 2 shows how information looks in the program.

Exhibit 2 – Monarch fields



You can instantly start seeing the data being identified and highlighted in yellow. Headings from the PDF have been excluded from the highlighting. With a few clicks, Monarch is already providing excellent data to work with, as shown in Exhibit 3.

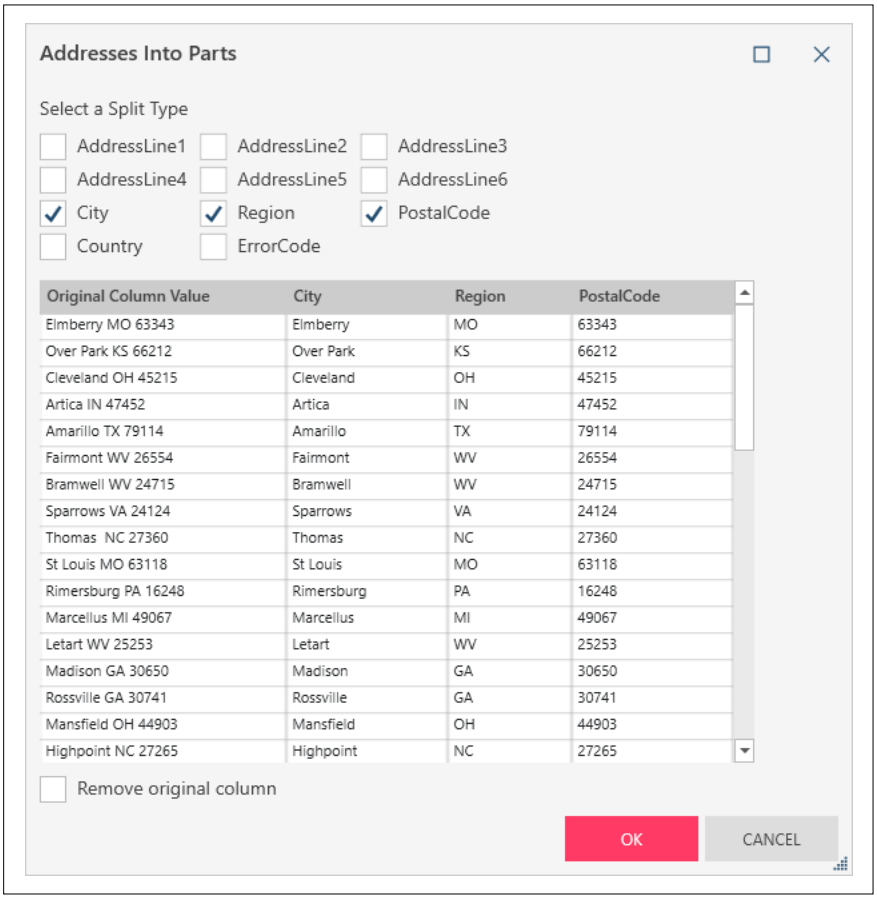
Exhibit 3 – Monarch data display

	PatientName	ServiceCode	Symptoms	Address	CityStateZip	BillAmount
1	Michael Canton	A0028	Son had Funny Bone Surgery and Minor attitude problem	RR 1 Box 22	Elmberry MO 63343	1838.39
2	Charles Bergan	C0543	Came to pay bill & got sick	9501 Moody Park	Over Park KS 66212	7995.12
3	Eric Dryson	A0032	Hang nail extraction	119 Washington St	Cleveland OH 45215	192.00
4	Jim Handley	A0048	Daughter had grape juice stain on upper lip	R 2 Box 399	Artica IN 47452	99.00
5	Marshall Briar	A0082	De-odorized feet	PO Box 7067	Amarillo TX 79114	97.25
6	Henry Thornton	A0096	Son sat on frog	Rt 3 Box 463	Fairmont WV 26554	92.00
7	Louis Mc Nally	C0440	Daughter has stomach full of Tootsie Rolls	PO Box 293	Bramwell WV 24715	238.80

Here is where your analysis begins. You can see in the Symptoms column that a line feed or carriage return is in that field. Monarch has a quick way of fixing the issue. By right-clicking on the column in the program, you can run a function called Collapse Spaces, and the data in the symptoms field becomes one sentence without the two lines.

A very powerful address conversion tool makes breaking up the CityStateZip into separate fields with just a click away after making the choices that are indicated in Exhibit 4.

Exhibit 4 – Breakup city, state and zip



Original Column Value	City	Region	PostalCode
Elmberry MO 63343	Elmberry	MO	63343
Over Park KS 66212	Over Park	KS	66212
Cleveland OH 45215	Cleveland	OH	45215
Artica IN 47452	Artica	IN	47452
Amarillo TX 79114	Amarillo	TX	79114
Fairmont WV 26554	Fairmont	WV	26554
Bramwell WV 24715	Bramwell	WV	24715
Sparrows VA 24124	Sparrows	VA	24124
Thomas NC 27360	Thomas	NC	27360
St Louis MO 63118	St Louis	MO	63118
Rimersburg PA 16248	Rimersburg	PA	16248
Marcellus MI 49067	Marcellus	MI	49067
Letart WV 25253	Letart	WV	25253
Madison GA 30650	Madison	GA	30650
Rossville GA 30741	Rossville	GA	30741
Mansfield OH 44903	Mansfield	OH	44903
Highpoint NC 27265	Highpoint	NC	27265

With just seconds of work, you have extracted the data from a PDF report into a usable rows and columns format that can be sent to Excel or another standard analytics tool. Exhibit 5 shows the resulting Excel file.

Exhibit 5 – Excel file ready for analysis

	PatientName	ServiceCode	Symptoms	Address	City	Region	PostalCode	BillAmount
1	Michael Canton	A0028	Son had Funny Bone Surgery and Minor attitude problem	RR 1 Box 22	Elmberry	MO	63343	1838.39
2	Charles Bergan	C0543	Came to pay bill & got sick	9501 Moody Park	Over Park	KS	66212	7995.12
3	Eric Dryson	A0032	Hang nail extraction	119 Washington St	Cleveland	OH	45215	192.00
4	Jim Handley	A0048	Daughter had grape juice stain on upper lip	R 2 Box 399	Artica	IN	47452	99.00
5	Marshall Briar	A0082	De-odorized feet	PO Box 7067	Amarillo	TX	79114	97.25
6	Henry Thornton	A0096	Son sat on frog	Rt 3 Box 463	Fairmont	WV	26554	92.00
7	Louis Mc Nally	C0440	Daughter has stomach full of Tootsie Rolls	PO Box 293	Bramwell	WV	24715	238.80
8	Kurt Grady	A0179	Dog was hysterical	Rt 1 Box 241	Sparrows	VA	24124	176.00
9	Leo Masterson	A0187	Tests for chest hair	8 Hickory Trail	Thomas	NC	27360	241.78
10	Richard Waite	A0195	Family had two needs food & money	3525 Halliday	St Louis	MO	63118	2400.07
11	Charles Arlo	A0228	Was studying for urine test	Rd #1 Box 739	Rimersburg	PA	16248	166.94
12	Derrick Thomas	A0243	Burping and burping and keeps burping	53026 Day Road	Marcellus	MI	49067	211.20

Monarch has other built-in functions to transform your data, including date conversion, numeric conversion, case conversion, and more. From an audit trail standpoint, Monarch also includes fields with the page number and original file from where the data was extracted, so you can always reference back to the original PDF or report that you received.

The feature is helpful when you have a report that only has the month and day in a column, but the file name has the year. You can extract the year from the file name and the month and day from their field and create a new field with the entire date.

After setting up the trap and transforming the data, you can save the progress made and apply it to the next month's PDF or a group of report files. Monarch will consolidate all the data into a large database, such as Excel, for easy access and organization.

Some analytics capabilities are built into Monarch. In our example, you are able, with a few clicks and no coding, to show that the top five producing states are MO, PA, IN, OH and GA. Exhibit 6 displays the results.

Exhibit 6 – Top five producing states

	Region	BillAmount	Count
1	MO	25550.60	6
2	PA	23503.53	11
3	IN	23500.48	10
4	OH	23126.66	19
5	GA	21528.26	7

A video covers the Monarch process to trap PDF data. More information about the product can be found on the Altair Monarch website.

Data cleaning

Messy data is the bane of every data analyst's existence, hindering the efficacy of data analytics processes. Messy data refers to inaccurate, incomplete or inconsistent information resulting from human errors during data entry, system glitches or disparate data sources. Such data poses significant challenges, requiring extensive cleaning, transformation, and normalization before any meaningful analysis occurs.

In data analytics, working with messy data can lead to skewed insights, erroneous conclusions, and unreliable predictions. Some tools can help clean up this data to make it more manageable and useful for analysis. One of those tools is a free tool called OpenRefine.

OpenRefine, formerly known as Google Refine, is a powerful tool designed to assist in cleaning and transforming messy data. It provides a user-friendly interface that allows you to efficiently perform various data-cleaning tasks.

Facet and cluster data – OpenRefine allows users to facet data, which means grouping similar values. Faceting makes identification of inconsistencies and errors in the data easier. OpenRefine can also cluster similar data entries, which helps to merge duplicates or identify potential matching records. An example of this is shown in Exhibit 8.

Text transformation and standardization – OpenRefine enables text transformation functions, such as changing the case (e.g., uppercase, lowercase), removing leading/trailing spaces, or replacing specific substrings. The changes to the data ensure uniformity in textual data, reducing variations that might hinder analysis.

Split and merge cells – Data often comes in formats unsuitable for analysis. OpenRefine allows users to split cells containing multiple values into separate rows or columns, making it easier to analyze individual data elements. Conversely, OpenRefine can merge cells to consolidate information when needed.

Data parsing – OpenRefine can parse complex data structures, like JSON or XML, extracting specific elements or attributes for analysis. Parsing capability is useful when dealing with nested or semistructured data.

Handling missing values – OpenRefine offers various options to handle missing data, such as filling empty cells with default values, using statistical measures (e.g., mean, median), or propagating values from other related records.

Remove duplicates and outliers – OpenRefine facilitates the identification and removal of duplicate records, reducing redundancy and ensuring data integrity. OpenRefine can also help identify and handle outliers, either by removing them or treating them specially.

Reconciliation with external datasets – OpenRefine allows users to match and reconcile data with external reference datasets, which can help standardize or enrich the existing data.

Undo/redo and auditing – The tool keeps track of all changes made during the data cleaning process, allowing users to undo or redo actions if necessary. The capability helps maintain transparency and ensure data auditability.

Export cleaned data – After data cleaning, OpenRefine enables users to export the cleaned data in various formats, such as CSV, JSON, or Excel, for further analysis using other tools.

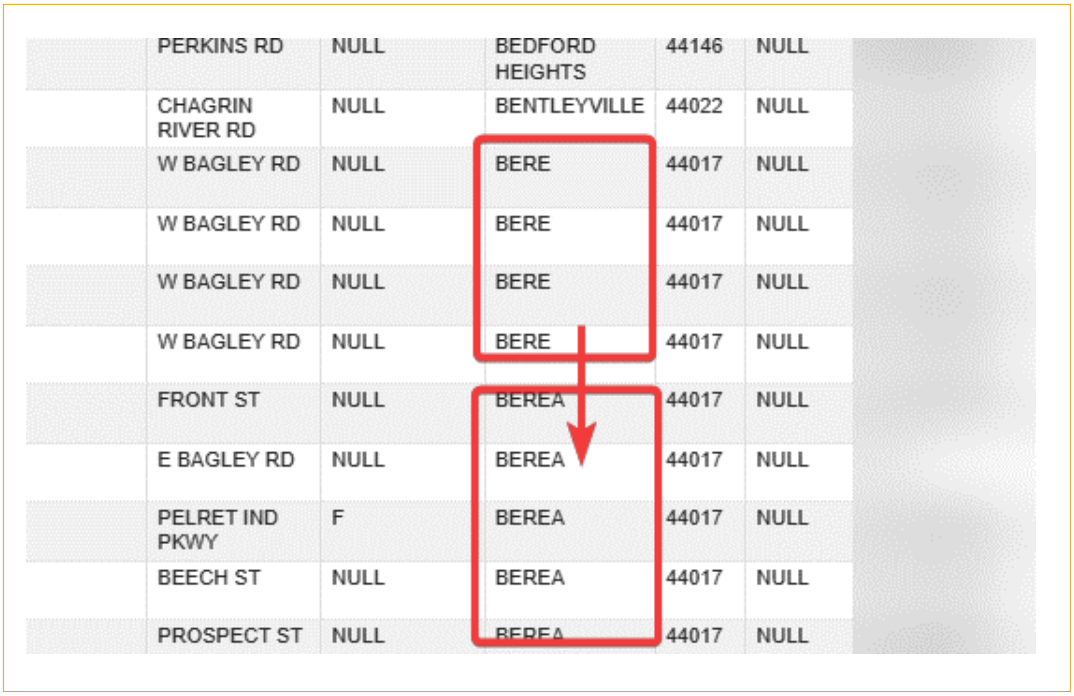
Overall, OpenRefine is a versatile and user-friendly data cleaning tool that can significantly expedite and streamline the data preparation process, leading to more accurate and reliable analyses in data analytics projects.

Let's walk through the basic process of using OpenRefine. First, download and follow the instructions at https://openrefine.org/ to start. While OpenRefine runs in a web browser, your data never leaves your network and your processing is done locally. The local feature is helpful with healthcare data for security and privacy purposes.

While OpenRefine can read data from various sources, I typically use it for CSV files. CSV stands for ***comma-separated values***. A CSV file organizes data into rows and columns like a table. Each piece of information (e.g., names, numbers, or dates) is separated by a comma. The format is an easy way for computers to read and understand the data, making it helpful in keeping lists or sharing information between different programs.

A CSV address file with about 15,000 records will be used for demonstration purposes. A quick sample of the data in Exhibit 7 shows that the City name in the third column is not right. Some misspellings look similar but are not exactly the same. The variations could cause issues when trying to summarize the data.

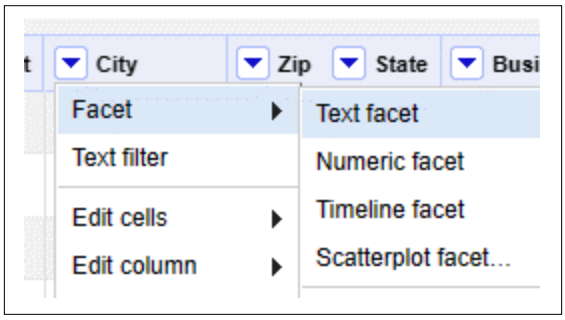
Exhibit 7 – CSV file with city names



	PERKINS RD	NULL	BEDFORD HEIGHTS	44146	NULL
	CHAGRIN RIVER RD	NULL	BENTLEYVILLE	44022	NULL
	W BAGLEY RD	NULL	BERE	44017	NULL
	W BAGLEY RD	NULL	BERE	44017	NULL
	W BAGLEY RD	NULL	BERE	44017	NULL
	W BAGLEY RD	NULL	BERE	44017	NULL
	FRONT ST	NULL	BEREA	44017	NULL
	E BAGLEY RD	NULL	BEREA	44017	NULL
	PELRET IND PKWY	F	BEREA	44017	NULL
	BEECH ST	NULL	BEREA	44017	NULL
	PROSPECT ST	NULL	BEREA	44017	NULL

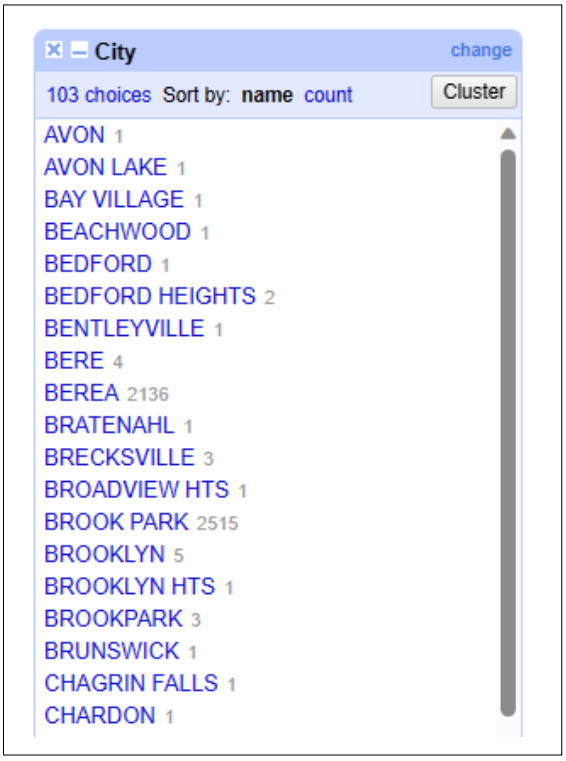
In this example, BERE should be BEREA. One option would be to load this in Excel and hope you manually corrected all the problems and did not accidentally overwrite fields with the wrong data. Or you could use OpenRefine's Facet feature. Click on the City column in Exhibit 8 and choose Text facet from the drop-down menu.

Exhibit 8 – Facet choice



A summary of each distinct spelling in the City column is created and displayed in Exhibit 9.

Exhibit 9 – Summary of City values



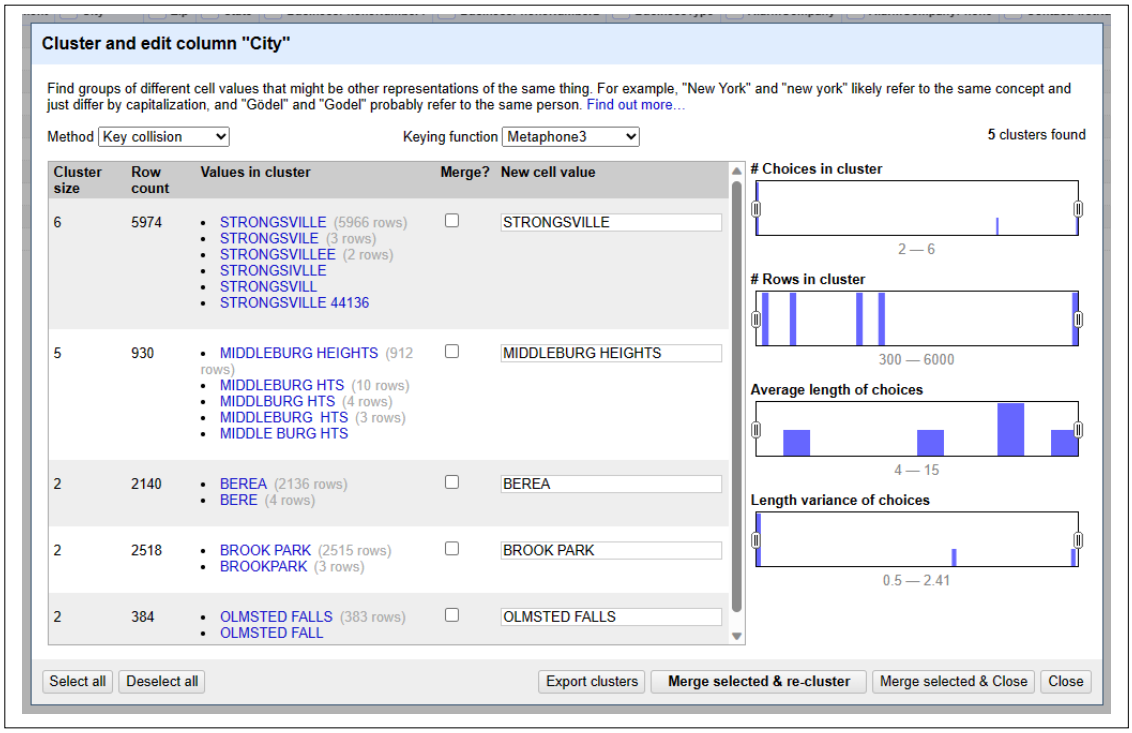
Click on the BERE in this list and choose Edit. You then can change it to the correct spelling—BEREA. That step changes all four records into the correct spelling. You can also click on a city, and the program will filter the records to those that match.

But what if more misspellings are in the file? Clusters in OpenRefine is a helpful feature that helps identify and group similar or potentially duplicate data entries together. When you use clusters, OpenRefine analyzes your dataset and

looks for similarities in the data, such as strings that look alike or have minor variations. It then groups these similar values into clusters, which you can review and act on.

You can click the Cluster button on the home screen to cluster on City. The resulting screen in Exhibit 10 shows the clustering of similar-looking city names. Click on the correct name and choose Merge. Merge will then correct all the variations of the city name to the correct name selected. All with a few clicks.

Exhibit 10 – Clustering on CITY

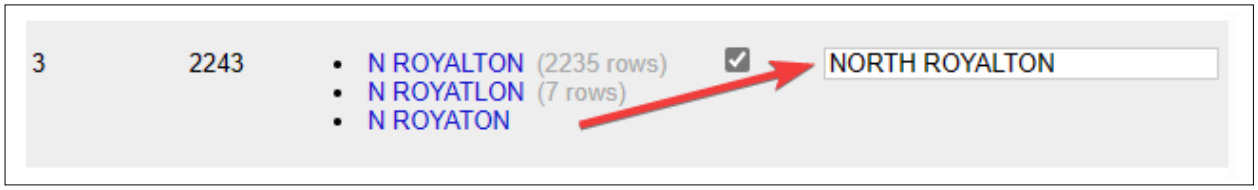


In the example, you can see that Strongsville is shown in six different ways. You can start the cluster of values in two ways: use the dropdown menu on your chosen column in the home screen, select Edit Cells, then Cluster and edit, or create a text facet and press the Cluster button in the Facet box on the home screen.

To apply clustering methods successfully to your data, you do not need to comprehend the specifics behind each technique. The clustering pop-up window provides two categories of clustering methods—six key collision clustering methods and two nearest-neighbor clustering methods. Try each of the methods to find the most matches. More details on the methods can be found on the OpenRefine website.

You can also completely change the names of all the related field data, which is illustrated in Exhibit 11. The variations of N ROYALTON were changed to North Royalton.

Exhibit 11 – Change data names



This tool is excellent for standardizing addresses when doing analysis that matches employees to vendors for accounts payable fraud detection analysis. Exhibit 12 shows slight misspellings that can be understood by a human but are problematic when trying to match with computer data.

Exhibit 12 – Misspellings

Cluster size	Row count	Values in cluster	Merge?	New cell value
2	149	• SHELDON RD (148 rows) • SHELDON RD.	☐	SHELDON RD
2	2	• WHEELER'S LN • WHEELERS LN	☐	WHEELER'S LN
2	100	• YORK ALPHA DR (96 rows) • YORK ALPHA DR. (4 rows)	☐	YORK ALPHA DR
2	57	• CORPORATE CIR (54 rows) • CORPORATE CIR. (3 rows)	☐	CORPORATE CIR
2	5	• SETTLERS WAY (3 rows) • SETTLER'S WAY (2 rows)	☐	SETTLERS WAY
2	9	• MARKS RD NORTH (7 rows) • MARKS RD NORTH (2 rows)	☐	MARKS RD NORTH

You can often detect fraudulent activities by comparing the addresses of employees and vendors. Employees and vendors sharing the same address could be a sign of fictitious vendors being used to siphon funds or engage in kickback schemes. Inconsistencies in addresses may also indicate unauthorized relationships or transactions. Identify these suspicious patterns to detect possible financial losses.

A video about OpenRefine reviews the main features.

Resources

- TechRepublic – Altair Monarch: Data preparation solution review
- Gartner – Competitors and Alternatives to Altair Monarch
- National Library of Medicine – OpenRefine (version 2.5)
- G2 – Top 10 OpenRefine Alternatives and Competitors

Conclusion

You can benefit from tools that produce data analytic results quicker and with less effort. Part One covered tools for data preparation that make raw data suitable for analysis. Look forward to Part Two in the next issue, which will cover a tool that produces and displays graphical representations of data in powerful interactive reports and visualizations. **NP**

AHIA does not endorse or recommend specific products. Any product references are for illustrative purposes only. Readers should make decisions based on their own research and judgement.

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FEATURE

Optimize the Three Lines Model

Add effectiveness elements to your compliance program

By Kenneth Zeko, JD, CHC, and Jerry Lear, CHIAP®, CIA®, CISA, CHC

Effective compliance management is crucial to safeguarding the resources and integrity of healthcare organizations. Internal audit, in collaboration with the compliance function, plays a vital role in identifying, assessing and helping mitigate risks. Use of the widely recognized Three Lines Risk Model and the foundational Seven Elements of an Effective Compliance Program in active collaboration by internal auditors and compliance professionals can contribute to establishing and maintaining a robust compliance program.

The task of effectively and efficiently identifying and mitigating regulatory and other compliance risks is daunting. Most healthcare entities in the United States have chosen to identify and mitigate risk in a decentralized fashion. In a decentralized model, operational departments are responsible for acting on the information they receive from the compliance department and adopting their practices to fit the compliance department's framework or workplan. Departments report the results of their compliance work to the compliance department for aggregation and analysis.

One of the most effective ways for compliance functions to educate and hold operational leadership accountable is through an operational compliance committee (OCC). The OCC is usually a working committee comprised of functional directors from across your organization that often meets monthly to discuss compliance issues. The OCC, with leadership from the Chief Compliance Officer, centralizes, coordinates and monitors the key elements of the compliance program.

However, operational department personnel are often not fully aware of their roles and responsibilities. In this situation the Three Lines Risk Model combined with the Seven Elements of an Effective Compliance Program can be of huge value to compliance programs.

Three lines

The Three Lines Risk Model, developed by the Institute of Internal Auditors (IIA), is a framework that delineates the roles and responsibilities of different stakeholders within an organization to effectively manage and mitigate risks. The model provides a concise structure for risk governance by defining the responsibilities for three lines of defense for risk identification, mitigation and accountability.

First line

The first line represents operational management, including individuals and teams directly responsible for executing business processes and managing risks on a day-to-day basis. They are accountable for identifying and managing the risks within their respective areas.

Second line

The second line is a function of management, but is comprised of risk management and monitoring departments, such as compliance, legal, quality, risk/insurance, information technology (IT), security and other key oversight functions. They support, facilitate and provide guidance to the first line, ensuring that risks are properly assessed, controls are in place, and regulatory requirements are met.

The Three Lines Risk Model informs personnel of their compliance roles and responsibilities.

The Three Lines Risk Model defines three lines of defense for managing risk.

Third line

The third line represents internal audit, which is a function of the Board, and operates independently of the first and second lines. Internal auditors provide objective assurance and evaluate the effectiveness of risk management, internal controls and governance processes. They offer insights and recommendations for improving controls and risk management practices.

A misconception sometimes exists that compliance is in the third line. The compliance function sometimes engages others to serve in the third line, such as using internal audit or contracting with external third parties to conduct independent auditing of specific risk areas.

However, compliance is still a second-line function as they are part of management with direct input to the development, implementation and oversight of controls and monitoring, like other second-line functions. The delineation further helps to enable activities and controls established and overseen by compliance to be included in the scope of independent assurance reviews performed by internal audit.

The Three Lines Model offers a comprehensive framework to enable operational departments to collaborate with the compliance department to identify and mitigate compliance risks. The model delineates the responsibilities among management, compliance functions, and internal auditors, fostering collaboration and ensuring risk oversight throughout the organization.

Internal auditors and compliance personnel should educate operational personnel regarding the model to maximize the effectiveness of their organization's compliance program. Another area where promotion and education on the Three Lines is beneficial is IT security programs to help emphasize responsibility for implementation of controls over cybersecurity.

Seven elements

Compliance departments should combine the Three Lines with the Seven Elements to embed compliance activities throughout healthcare entities. The Seven Elements, promoted by the Office of Inspector General of Health and Human Services, are a set of components that form the foundation for building and maintaining a robust compliance program within an organization. The elements are widely recognized and endorsed by regulatory bodies and industry standards.

The following narrative briefly summarizes each element and provides an example of where organizations can use the Three Lines Risk Model to improve compliance programs and organizational cultures.

Element 1 – Written policies and procedures

Documented policies and procedures outline the organization's commitment to compliance, as well as specify guidelines for employees to follow.

First line – Organizations should require operational departments to assist with the creation of organization-wide policies, which the compliance department and other oversight functions can support and facilitate. Additionally, operational departments should be responsible for formalizing their departmental risk identification and mitigation activities by creating departmental policies and procedures that describe their compliance activities.

Second line – In addition to having comprehensive and robust policies and procedures for the compliance function, compliance should also be involved in evaluating operational and clinical policies and procedures to ensure regulatory requirements and risks are considered.

Third line – Internal audit departments should audit to determine the extent employees are complying with organizational policies and procedures. Internal audit would

normally review and identify any potential gaps in policies and procedures for significant operations and projects, including those related to compliance and regulatory guidance.

Element 2 – Compliance oversight

Clear lines of authority and responsibility must be established for compliance, including the appointment of a compliance officer or team to effectively oversee and manage the compliance program.

First line – Operational departments should identify compliance liaisons who will be responsible for interacting with the compliance department and for participating in the organization's OCC. The OCC can also empanel subcommittees of operational employees, internal audit staff and oversight functions to address certain issues. The OCC should include leaders from second line functions who are also monitoring regulatory risk on a regular basis.

Second line – Establishing the oversight elements is important, including reporting structures to both leadership and governance, and should be documented in both a departmental and board or board committee charter. The board committee charter should also delineate the specific areas of oversight for the compliance function.

Third line – The board committee that oversees compliance and internal audit should also delineate responsibilities in its charter for oversight of corrective action plans and their resolution, which could include compliance controls and monitoring.

Element 3 – Train and educate

Ensure that employees receive appropriate training and education on compliance-related matters. The education element focuses on providing regular training sessions to raise awareness, enhance knowledge, and promote a culture of compliance within the organization.

First line – Operational departments should create training for the compliance risks that reside in their functions, which the compliance department and other second-line functions can assist with and facilitate. For example, the emergency department, with the assistance of the compliance department, can create Emergency Medical Treatment and Labor Act training, the health information management function can create False Claims Act training, and the pharmacy can create training that describes the organization's drug diversion prevention and detection processes. Departmental compliance training presentations can be vetted and tracked by the OCC.

Second line – Training is a staple responsibility for the compliance function and is an important preventive control for any organization. To be effective, compliance functions should go beyond general training. Specific training programs should be implemented in high-risk areas identified by the Office of Inspector General of the Centers for Medicare and Medicaid Services, or for issues that are critically pertinent to your organization based on circumstances, such as adverse events, audit issues and self-monitoring results.

Third line – Internal audit should identify training needs that may be required based on the results of audits. For example, an internal audit in a revenue cycle area could result in an action plan that includes enhancement of current training. More emphasis may be needed for some of the issues identified for coders and department staff, as well as the implementation of self-audit and monitoring procedures.

Element 4 – Communicate effectively

The communication element requires maintaining open and effective communication channels and operating anonymous reporting methods, such as hotlines, to promote confidential communication and foster a culture of compliance.

First line – Operational departments should promote and raise awareness of your organization's hotline and create a commitment to nonretaliation.

Second line – The compliance department typically oversees administration of the hotline and triaging of calls but can also conduct surveys to assess employees' perceptions of your organization's culture. The existence and use of the various communication channels should be advertised and promoted through posters, newsletters and training.

Third line – Internal audit may review controls over the hotline. However, internal audit is more commonly used for certain types of investigations that are reported and triaged by compliance through the hotline. The investigations may

An operational compliance committee can effectively educate and hold operational management accountable.

The Seven Elements of an Effective Compliance Program are essential to an effective compliance and ethics program.

include alleged financial fraud or other issues that require an independent review.

Element 5 – Monitor and audit

Regular monitoring and auditing activities are crucial to assess the effectiveness of the compliance program. Monitoring and auditing involve implementing procedures to proactively identify and address compliance issues and conduct periodic internal audits to evaluate compliance performance.

First line – Operational departments should conduct monitoring activities of their compliance risk areas. The outcomes from their regulatory monitoring activities in high-risk areas should be reported to the OCC.

Second line – The compliance department should conduct or delegate ongoing monitoring activities in select regulatory areas, as identified during the compliance risk assessment process. Many compliance departments have limited resources and rely on a delegated approach to ongoing monitoring and auditing projects.

The delegated approach is acceptable, as the OIG guidance states the organization should perform compliance monitoring and auditing, but does not require the individuals within the compliance department to actually perform the work. Some compliance functions may also employ or contract coding compliance professionals to conduct compliance reviews of coding and billing risks.

Third line – Internal audit should conduct audits of the risk areas that are being monitored by the operational departments and oversight departments. Ongoing regulatory-focused audits should be natural outcomes of the internal audit risk assessment and planning process. The audits would assess controls established and monitored by the compliance function and/or management.

Element 6 – Report, investigate and promptly respond to issues

Reports of potential compliance violations should be promptly investigated and corrective action taken if reported violations are substantiated.

First line – Operational departments should be involved in implementing compliance fixes in their departments. Additionally, operational departments can potentially assist with investigations into alleged wrongdoing and should actively report potential regulatory issues to the compliance or internal audit teams. Promoting a culture of open communication and encouraging staff to identify and report potential issues should be an ongoing part of departmental meetings.

Second line – The compliance, legal and human resources departments oversee and guide regulatory investigations. The compliance department should be the central reporting and triage mechanism for potential regulatory issues, including tracking and resolution.

Third line – Internal audit is the primary function for investigations of regulatory issues and fraud. Internal audit should be engaged by other departments, such as compliance, legal and finance, when structured, formal, independent investigations are required.

Element 7 – Enforce and discipline

Consistent and equitable enforcement of compliance standards and appropriate disciplinary actions for violations should be emphasized at all levels. This element involves implementing mechanisms to enforce compliance policies, address noncompliance and apply disciplinary measures as necessary. Additionally, organizations should establish processes to recognize and reward positive compliance behavior.

First line – Operational departments should raise awareness at department meetings or huddles regarding your organization's corrective action policies and procedures.

Second line – The compliance department can use organizational outlets, such as newsletters, lunch and learns, and town halls to raise awareness of anonymized reports of violations and the corrective action taken. Compliance department input and oversight should be provided to ensure disciplinary policies and procedures are in place and applied consistently when events occur.

Third line – Internal audit can ensure that enforcement and disciplinary policies and procedures exist and are complete

ERM can be enhanced by the implementation of the Three Lines Risk Model and the Seven Elements.

from an internal control perspective, and can provide advisory input. However, to maintain their independence, Internal audit should not get involved from an administration and action perspective.

Contribution to ERM

An approach that combines the Three Lines Risk Model and the Seven Elements of an Effective Compliance Program in a thoughtful way can have a positive, material effect on your organization's enterprise risk management (ERM) program. The ERM program can be a central conduit for focusing, combining and communicating key risk management efforts up to senior leadership and the board.

Summarize the risk mitigation and monitoring activities of all three lines for each of the key strategic ERM risk areas. The summary should provide your board with a clear line of sight to where and how these risks are being managed or where gaps may exist.

Resources

- The Institute of Internal Auditors – The IIA's Three Lines Model
- Health and Human Services, Office of Inspector General
  - Compliance Program Basics
  - The Seven Fundamental Elements of an Effective Compliance Program

Conclusion

By combining the Seven Elements of an Effective Compliance Program with the Three Lines Risk Model, your organization can integrate compliance risk management into the overall risk governance structure, ensuring a comprehensive and coordinated approach to risk identification and mitigation. Although all lines should be working collaboratively with the goal of risk reduction, their ultimate understanding and adhering to the spirit of the guidance will greatly affect your organization's culture of risk management. **NP**

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Don't allow missed opportunities of the past interfere with the opportunities that are right before you.
– Ryan Robbins

Data Analytics

Usage by internal audit teams:

- Have prioritized analytics through dedicated analytic resources and/or training – **94%**
- Report that analytics and automation add value to internal audit – **85%**

Grant Thornton

Demand for internal audit analytics is driven by:

1. Pressure on internal audit to audit closer to the business and develop an informed position on risks
2. Increasing regulatory expectations to monitor business activities
3. Data is growing exponentially and the technologies to analyze it are maturing rapidly
4. Organizations need to do more with less to manage risk and compliance issues

PwC

Maturity model stages:

1. Traditional model
2. Ad hoc integrated analytics
3. Continuous auditing
4. Continuous monitoring
5. Continuous assurance and predictive analysis

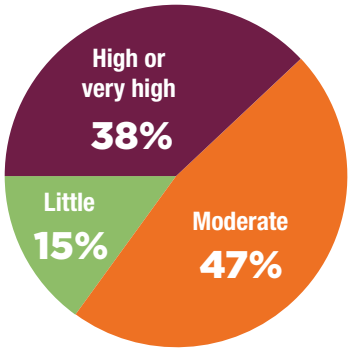
KPMG

Benefits of data analytics:

1. Improves data quality
2. Empowers auditors to analyze and audit large amounts of data, including testing the entire population
3. Helps auditors to prioritize risks based on likelihood and impact
4. Allows risks to be viewed in the context of broader organizational objectives, operations and priorities
5. Enables the audit plan to align with capacity, risk potential and risk tolerance
6. Supports the execution of the audit process through comprehensive documentation and clear recommendations.
7. Delivers usable insights
8. Provides a clear picture of compliance
9. Drives greater efficiency throughout the audit lifecycle

Diligent

Level of value created by internal audit data analytics:



Grant Thornton

Rules of the road:

1. Tie stakeholder goals to their wants and key performance indicators.
2. Build high-performance analytics teams.
3. Build data literacy by focusing on descriptive analytics and key performance indicators.
4. Make compliance an integral part of analytics.
5. Refine analytics models continuously.
6. Support analytics with governance.
7. Use data storytelling to promote insights.

MIT

Reasons why analytics projects fail:

1. Ambiguous deliverables and conflicting interests
2. Actionable insights are not the focal end goal
3. Lack of leadership and ownership
4. Lack of an agile approach
5. Poor data integration
6. No plan for ongoing development

Salesforce

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