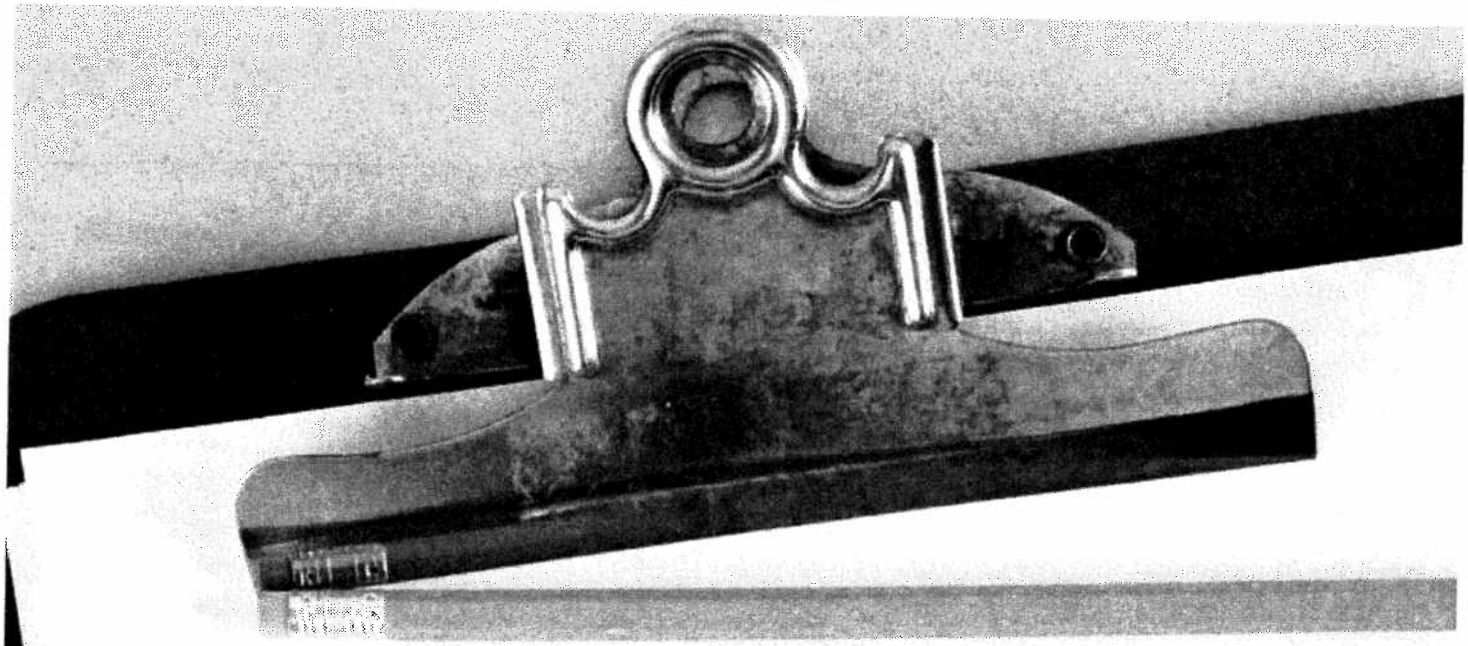


*Trustee Guide to Corporate Compliance*

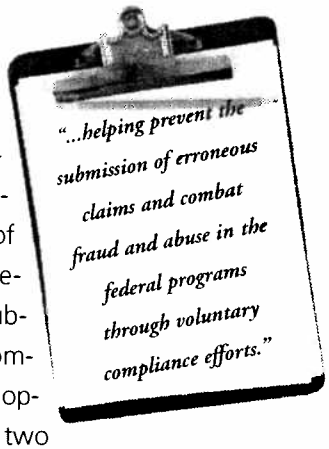
# CHECKLIST

HRET
HEALTH RESEARCH AND
EDUCATIONAL TRUST OF NEW JERSEY

TRUSTEE
*Institute*

# CORPORATE COMPLIANCE CHECKLIST

Several years ago the Office of the Inspector General (OIG) launched a major initiative to engage the health care community in helping prevent the submission of erroneous claims and combat fraud and abuse in the federal programs through voluntary compliance efforts. The OIG has developed a series of compliance program guidances (CPGs) directed at most provider segments. CPGs are intended to encourage the development and use of internal controls to monitor adherence to applicable statutes, regulations and program requirements. The OIG published the first hospital CPG in February 1998; then in January 2005 it published the "Supplemental Compliance Program Guidance for Hospitals" to update the recommendations and risk areas. The two documents collectively should be considered when developing, implementing or evaluating a hospital's compliance program. Below is a summary of the two hospital CPGs.




## I. INTRODUCTION

A. CPGs are not a "one-size-fits-all" guidance. CPGs are meant to assist hospitals in the development of a compliance program tailored to their particular circumstances. A compliance program is intended to encourage hospitals to identify and focus on the areas of potential concern or risk that are most relevant to their individual organization.

B. Benefits of a Compliance Program: a successful compliance program addresses the public and private sectors' mutual goals of reducing fraud and abuse; enhancing health care providers' operations; improving the quality of health care services; and reducing the overall cost of health care services.

C. Additional benefits with implementation of a compliance program will:

1. Demonstrate the hospital's commitment to honest and responsible corporate conduct;
2. Increase the likelihood of preventing, identifying, and correcting unlawful and unethical behavior at an early stage;
3. Encourage employees to report potential problems to allow for appropriate internal inquiry and corrective action; and
4. Minimize any financial loss to government and taxpayers, as well as any corresponding financial loss to the hospital, through early detection and reporting.

## II. AREAS OF SUGGESTED FOCUS

A. Compliance Program Elements — General

1. Develop and distribute written standards of conduct, as well as written policies and procedures that promote the hospital's commitment to compliance;
2. Designate a chief compliance officer who reports directly to the CEO and the governing body;
3. Develop and annually provide, effective educational training programs on the compliance program and compliance issues for all employees;
4. Develop open lines of communication for the reporting of compliance issues;
5. Use audits and/or other evaluation techniques to monitor compliance and assist in the reduction of identified problem areas;
6. Develop a system to respond to allegations of improper/illegal activities, including investigating allegations and initiating remediation of identified problems; and
7. Take appropriate disciplinary action against employees who have violated internal compliance policies, and applicable statutes and regulations.

B. Written Policies and Procedures: every compliance program should include the development and distribution of both: (i) Standards of Conduct, which is a general organizational statement of ethical and compliance principles to guide the hospital's operations; and (ii) compliance policies, which identify specific areas of risk to the hospital. Examples of risk areas the OIG has highlighted include:

1. The submission of accurate claims information;
2. Arrangements in violation of the Physician Self-Referral (Stark) Law and the Federal Anti-Kickback Statute;
3. Gainsharing arrangements;
4. EMTALA;
5. Substandard care;
6. Relationships with federal health care beneficiaries;
7. HIPAA; and
8. Medicare Part D administration

C. Designation of a Compliance Officer and a Compliance Committee

1. A Compliance Officer should be designated for every hospital to serve as a focal point for compliance activities, and be given enough funding and authority to carry out the requisite responsibilities. A Compliance Officer's responsibilities include the following:
   a. Oversee and monitor the implementation of the program;
   b. Periodically revise the program to meet changes in the organization, new laws and new government enforcement priorities;
   c. Develop, coordinate and participate in multifaceted educational and training program that focuses on the elements of the compliance program;
   d. Ensure that independent contractors and agents who furnish medical services to the hospital are aware of the requirements of the hospital's compliance program;
   e. Coordinate personnel issues with the Human Resources office;
   f. Assist in the hospital's financial management in coordinating internal compliance review and monitoring activities;
   g. Independently investigate and act on matters related to compliance, including the flexibility to design and coordinate internal investigation and any corrective actions;
   h. Develop policies that encourage managers and employees to report suspected fraud and other improprieties without fear of retaliation; and
   i. Interact directly with the hospital's governing board and the CEO with respect to compliance issues.
2. A Compliance Committee should be established which consists of a broad cross-section of disciplines/departments. The Compliance Committee should:
   a. Advise the compliance officer and assist in the implementation of the compliance program;
   b. Analyze the organization's industry environment, legal requirements and specific risk areas;
   c. Assess existing policies and procedures to address these areas for incorporation into the compliance program;
   d. Work with appropriate hospital departments to develop standards of conduct and polices and procedures to promote compliance;
   e. Recommend and monitor, in conjunction with appropriate departments, internal systems and controls to carry out the organization's standards, policies and procedures.

D. Training and Education

1. Require training for all personnel including all management and trustees, upon commencement of employment/affiliation, and annually thereafter;
2. All personnel should receive general training that includes highlights of the organization's compliance program and a summary of the applicable fraud and abuse laws;
3. Personnel should also receive specific training tailored to their particular responsibilities, such as coding requirements and marketing practices;
4. Completion of training by personnel should be documented; and
5. The training program should be regularly evaluated, modified and updated.

E. Develop Effective Lines of Communication

1. Encourage open communication without the fear of retaliation;
2. Provide personnel easy access to the Compliance Officer;
3. Establish hotlines and other means of anonymously reporting issues; and
4. The Compliance Officer should regularly report to and share the results of internal investigations with the governing body and affected departments.

F. Audits and Investigations

1. Several annual audits of risk areas should be conducted both internally (by the Compliance Officer or other hospital staff) and by third party contractors;
2. All reports of noncompliance received from any source should be fully investigated;
3. All employees, vendors and contractors should be checked both initially and annually thereafter against the various government exclusion/sanctions lists;

4. Also, conduct criminal background checks on certain categories of employees, to the extent necessary or desirable;

5. The "effectiveness" of the compliance program should itself be audited annually, and changes should be made as necessary to update and improve the program.

G. Respond to Deficiencies; Corrective Action

1. Respond appropriately to detected offenses and develop corrective action initiatives (e.g., new/modified policies, repayment, discipline, etc.);

2. Review past problem areas to verify that the corrective action plan was fully implemented, and continues to be implemented so that the same or related problems do not recur; and

3. If credible evidence of misconduct is found, the hospital must promptly report the existence of the misconduct to the appropriate governmental authority (not more than 60 days after determination of misconduct); reporting such conduct will be considered a mitigating factor by the OIG in determining administrative sanctions.

H. Enforce Standards Through Well-Publicized Disciplinary Guidelines

1. Provide a written policy statement setting forth the degrees of disciplinary actions that may be imposed upon corporate officers, managers, employees, physicians and other health care professionals for failing to comply with hospital standards.

2. Publish and disseminate the range of disciplinary standards for improper conduct and educate officers and other hospital staff regarding these standards.

Special areas of focus were determined by the OIG in the January 2005 issuance. Those are listed below.

## III. FRAUD AND ABUSE RISK AREAS

A. Submission of accurate claims and information is possibly the single biggest risk area for hospitals:

1. Outpatient Procedure Coding: Medicare's Hospital Outpatient Prospective Payment System (OPPS) increased the importance of accurate procedure coding for hospital outpatient services;

2. Admissions and Discharges: policies regarding the time of admission or discharge should be updated to reflect current CMS rules;

3. Supplemental Payment Considerations: policies should be in place to ensure supplemental payments such as DRG outlier payments and payments for clinical trials are accurate;

4. Use of Information Technology: hospitals must pay particular attention to their computerized billing, coding and information systems to ensure programs are accurate and updated to reflect changes in the law.

B. Referral Statutes: The Physician Self-Referral Law (Stark Law) and the Federal Anti-Kickback Statute:

1. Physician Self-Referral Law: as part of its compliance program, the hospital should have a procedure to carefully review its financial relationships with physicians;

2. The Federal Anti-Kickback Statute: as part of its compliance program, the hospital should have a procedure to carefully review its business relationships with other entities, especially those entities that are in a position to generate Federal health care program business for the hospital, including ambulances, nursing facilities, and physicians. Areas of particular concern include:

a. Joint ventures;

b. Compensation arrangements with physicians;

c. Relationships with other health care entities;

d. Recruitment arrangements;

e. Discounts;

f. Medical staff credentialing;

g. Malpractice insurance subsidies.

C. Payments to Reduce of Limit Services, in particular, gainsharing arrangements

D. Emergency Medical Treatment and Labor Act (EMTALA)

E. Substandard Care

F. Relationships with Federal Health Care Beneficiaries

1. Gifts and gratuities

2. Cost-sharing waivers

3. Free transportation

G. HIPAA Privacy and Security Rules

H. Billing Medicare or Medicaid substantially in excess of usual charges

I. Medicare Part D issues

J. Areas of General Interest

1. Discounts to uninsured patients

2. Preventive care services

3. Professional courtesy

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# IRS Compliance Check Questionnaire for Tax Exempt Hopitals

In addition to the corporate compliance programs you must establish, the Internal Revenue Service (IRS) is also increasing its surveys of tax-exempt hospitals with a new Compliance Check Questionnaire (Form 13790 May 2006). This wide ranging investigation of nonprofit hospitals will determine whether they are flouting standards for tax-exempt status, whether they deny care to people without insurance and whether they provide significant amounts of charity care.

More than 550 hospitals (less than 10 percent of the registered nonprofits) already have received the questionnaire from the IRS seeking detailed information about their operations, billing practices and compensation for top hospital executives. It is considered a contact by the IRS and verifies the information supplied on the 990 tax filing. It is not considered an audit, but after review of the questionnaires the agency may decide on a full scale examination of the hospital's records.

Prior to 1969, the IRS required hospitals to provide charity care to qualify for tax-exempt status. Since then, the agency has not specifically required such care, as long as hospitals provide benefits to the community in other ways - like health fairs, screening for cancer and cholesterol, providing emergency care, training doctors and conducting medical research. There is some question among lawmakers that hospitals have too much leeway under this "community benefits standard" and there should be more accountability to retain nonprofit status.

The questionnaire is composed of 80 detailed questions covering the following areas:

### Organization

- Identifiers and recent tax period

### Operations

- Types of services offered in the facility (i.e., surgical, psychiatric, cancer, heart, OB/GYN, chronic disease)
- Patients (i.e., how many, inpatient, outpatient, emergency room, insurance, Medicare, Medicaid)
- Any denied services to patients
- Emergency room status and level of trauma services as well as if any services were denied
- Board of directors (i.e., number, employment focus, number of meetings)
- Medical staff privileges (i.e., qualifications and denial of privileges)
- Medical research (i.e., how much of your funding is from research projects, medical trials, limited public access to trials)
- Professional medical education and training (i.e., did you train professional staff, where did the funding come from)
- Uncompensated care (policies, how much, what did you write off as uncompensated)
- Billing practices (payment policies, billing schedule, installment agreements, classification of bad debt, same fee for all patients)
- Community programs (screening programs, immunization programs, community education, newsletters/ publications, any fees charged for programs)

### Compensation practices

- Listing of hospital officers, directors, trustees and key employees and amounts of salary and other compensation (this is more extensive than the 990 filing information which is usually the top three salaries)
- Responsibility for compensation decisions
- This comprehensive section asks for compensation policy; how compensation is determined; any business relationships with the compensation decision makers

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