Report on
Medicare Compliance

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Weekly News and Compliance Strategies on CMS/OIG Regulations, Enforcement Actions and Audits

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Nosy Questions, Informal Chats Are Signs The Board Is Engaged With Compliance

After Wells Fargo Bank was fined $100 million by the Consumer Financial Protection Bureau in September for allegedly opening up 2 million phony deposit and credit card accounts in their customers' names despite hotline complaints, board members in some other organizations wondered about the effectiveness of their own hotlines. How would they know when trouble was brewing? Sure, board members get high-level reports from compliance officers about their organizations' hotlines, but what was really going on in the trenches? The Wells Fargo scandal, like other events in the wider business world, pulled back the curtain on hotline reports in some quarters.

It was a factor in the thinking at Dignity Health in California, says Margaret Hambleton, vice president and chief compliance officer. "My board committee has been asking me how we know we're getting full information related to hotlines that will ensure we are doing a full, credible investigation on matters than may be of some significance," she notes. Although Hambleton reports quarterly to the chair of the board audit and compliance committee, explaining in general terms how many calls the hotline received, the nature of the allegations and the response time — and describes "significant matters" in written reports to the full board — "they generally don't know which ones to be concerned about," Hambleton says. How do you distinguish between "my supervisor doesn't like me" and "we potentially have a serious problem"? After Wells Fargo, board members wanted to know. "That was an excellent question from them," she says.

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Misconceptions About Two-Midnight Rule Persist; 'No Code for Physician Discomfort'

When an elderly patient comes to the emergency room with significant cellulitis, the physician is inclined to hospitalize her. Treating the patient with the oral antibiotic Keflex may do the trick — with some time spent in observation — but the physician is aware there's no family to look after the patient and suspects she needs to be in a nursing home. Putting the patient on IV antibiotics instead seems like a way to nudge her into an inpatient admission, which moves her closer to qualifying for Medicare's skilled nursing facility benefit, and the physician figures he can find a way to justify it.

But that's not how the two-midnight rule works, says Todd Butz, M.D., physician adviser at WellSpan Health in York, Pa. It's a myth that it's appropriate for physicians to massage treatment to fit a higher level of care, he says. It's one of a number of misconceptions about the two-midnight rule that linger more than three years after it took effect.

"You don't change the treatment to justify the level of care," Butz says. "That kind of thought process needs to be corrected." Otherwise, "it's a gaming type of thing." If the patient has an "unsafe disposition," as was the case with the cellulitis patient, the physician may treat her with oral Keflex, assuming that's indicated, but accept that the

patient will be a kind of social admission *(RMC 2/16/15, p. 1)* — "outpatient in a bed" — and will remain hospitalized while other arrangements are made. "We don't get [paid] room and board, but we take care of our community," Butz says. Meanwhile, the hospital is improving its relationships with social services in the community to arrange care for patients with unsafe dispositions.

Here are some other myths of the two-midnight rule:

◆ ***Myth:*** Medicare Advantage plans have to follow the two-midnight rule. ***Reality:*** "They are free to develop their own inpatient admission policies," says Ronald Hirsch, M.D., vice president of education and regulations at Accretive Physician Advisory Services.

◆ ***Myth:*** Observation patients who are coming up on the second midnight must meet InterQual or MCG inpatient criteria to be admitted. ***Reality:*** That's not the case, Hirsch explains. "The patient must require continued hospital care and if that standard is met, inpatient admission is appropriate," he says.

◆ ***Myth:*** hospice patients are never inpatients. ***Reality:*** When a hospital stay begins with a presenting condition that satisfies the two-midnight presumption, inpatient level of care should be ordered for that patient, assuming "treatment will ensue," Butz says. On the second day, if the physician determines care is futile and the family opts for hospice/comfort care, the level of care should remain inpatient because the hospice selection was unforeseen when the hospital stay began, he says. However, "if the decision for hospice is made at the time of admission, it is appropriate to start the hospital encounter as observation level of care," he says. "This is the case no matter what the presenting diagnosis is." Even if it's the grim diagnosis of septic shock, which always meets the two-midnight presumption, it's not necessarily expected that the patient will require a two-midnight stay. "As soon as arrangements can be made, the patient can be discharged to home with hospice," Butz says.

◆ ***Myth:*** Physician discomfort with discharging the patient is grounds for inpatient admission. ***Reality:*** When physicians ask whether they should sign admission orders because they are uncomfortable discharging patients, Hirsch says no. "I explain that there is an ICD-10 code for physical discomfort experienced by the patient but there is no ICD-10 code for 'physician discomfort,'" he says. "If the doctor can explain the patient's discomfort and that reason is rational and documented, such as concern about a fluctuating blood pressure and close monitoring in the hospital is clinically appropriate, that warrants admission."

◆ ***Myth:*** Physician certification of all inpatient admissions is required. ***Reality:*** Although certification was required by the first incarnation of the two-midnight rule in 2013, CMS eliminated certification in 2015 except when it comes to inpatient stays of 20 days *(RMC 11/10/14, p. 1)*, Hirsch says.

◆ ***Myth:*** If patients are approaching the second midnight and the physician plans to discharge them the next morning, they should stay in observation. ***Reality:*** "No. If that second midnight is medically necessary, the patient should be admitted," Hirsch notes. However, just because patients cross two midnights doesn't mean they should be admitted. "There must be medical necessity for both midnights."

◆ ***Myth:*** When admission orders are written at the second midnight, they're retroactive to the time care started in the hospital. ***Reality:*** "CMS doesn't allow retroactive orders," Hirsch says. "The inpatient admission begins with the order for the admission."

◆ ***Myth:*** When physicians document "I expect two midnights," they are home free on admissions. ***Reality:*** "The statement itself carries no presumptive weight. There must be documented clinical evidence to support that expectation," Hirsch says.

Contact Butz at tbutz@wellspan.org and Hirsch at RHirsch@accretivehealth.com. ✧

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21st Century Cures Act Protects Mid-Build Provider-Based Space

The sweeping health reform bill that passed the House of Representatives Dec. 1 would welcome back some off-campus provider-based departments to the outpatient prospective payment system (OPPS). The 21st Century Cures Act (H.R. 6) would allow OPPS billing by off-campus provider-based departments that had a binding written agreement for construction when Sec. 603 of the 2015 Bipartisan Budget Act cracked down on all off-campus provider-based space. But there would be hoops to jump through, including CMS attestation.

A lot of hospitals would benefit from the measure, but it's still a limited exception, says Washington, D.C., attorney Christopher Kenny, with King & Spalding. "We have clients who will be left out in the cold because they are still under construction and can't submit a complete attestation within the required time frame," he says.

The 21st Century Cures Act, which also would provide billions more for the National Institutes of Health and revamp the way the Food and Drug Administration approves drugs and devices, stands a good chance of winning Senate approval in early December and the signature of President Obama. And, of course, there's more. "A lot of other health care provisions that didn't have to do with the Cures Act got attached," Kenny says. That includes the Helping Hospitals Improve Patient Care Act of 2016, which authorized "providers that were already building new off-campus outpatient facilities to be grandfathered into the outpatient payment rates" *(RMC 5/23/16, p. 8)*.

The provision that was tucked into the 21st Century Cures Act was a response to complaints about provider-based space that was "mid-build" when Sec. 603 was enacted. Sec. 603 said goodbye to OPPS billing by new off-campus provider-based space starting Nov. 2, 2015 *(RMC 11/2/15, p. 1; 11/23/15, p. 1)*, and CMS emphasized in OPPS regulations that provider-based departments under construction at the time are out of luck. But Sec. 603 gave shelter to off-campus provider-based departments that were billing OPPS before Nov. 2, 2015, which

CMS Transmittals and *Federal Register* Regulations
Nov. 18 – Dec. 1

Live links to the following documents are included on *RMC*'s subscriber-only Web page at www.AISHealth.com. Please click on "CMS Transmittals and Regulations" in the right column.

Transmittals

(R) indicates a replacement transmittal.

Pub. 15-2, The Provider Reimbursement Manual - Part 2

- Provider Reimbursement Manual, Trans. 10P240 (Nov. 18; eff. for cost reporting periods on or after Sept. 30, 2016)

Pub. 100-04, Medicare Claims Processing Manual

- Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Competitive Bidding Program – January 2017 (R), Trans. 3668CP, CR 9792 (Nov. 25; eff. Jan. 1; impl. Jan. 3, 2017)
- New Revenue Code 0815 for Allogeneic Stem Cell Acquisition Services, Trans. 3571CP, CR 9674 (Nov. 25; eff. Jan. 1; impl. Jan. 3, 2017)
- Implement Operating Rules – Phase III Electronic Remittance Advice Electronic Funds Transfer: Committee on Operating Rules for Information Exchange 360 Uniform Use of Claim Adjustment Reason Codes, Remittance Advice Remark Codes and Claim Adjustment Group Code Rule – Update from Council for Affordable Quality Healthcare CORE, Trans. 3665CP, CR 9767 (Nov. 23; eff. April 1; impl. April 3, 2017)
- New Waived Tests, Trans. 3666CP, CR 9797 (Nov. 23; eff. Jan. 1; impl. Jan. 3, 2017)
- Claims Status Category and Claims Status Codes Update, Trans. 3661CP, CR 9769 (Nov. 18; eff. April 1; impl. April 3, 2017)
- Remittance Advice Remark Code, Claims Adjustment Reason Code, Medicare Remit Easy Print and PC Print Update, Trans. 3660CP, CR 9774 (Nov. 18; eff. April 1; impl. April 3, 2017)

Pub. 100-06, Medicare Financial Management

- New Physician Specialty Code for Hospitalist (R), Trans. 276FM, CR 9716 (Nov. 25; eff. April 1; impl. April 3, 2017)
- Chapter 3, Section 90 (Provider Liability) Revision, Trans. 275FM, CR 9708 (Nov. 18; eff./impl. Feb. 21, 2017)

Pub. 100-20, One-Time Notification

- ICD-10 Coding Revisions to National Coverage Determination, Trans. 1755OTN, CR 9861 (Nov. 18; eff. Oct. 1, 2016; impl. April 3, 2017)
- Issuing Compliance Letters to Specific Providers and Suppliers Regarding Inappropriate Billing of Qualified Medicare Beneficiaries for Medicare Cost-Sharing (R), Trans. 1757OTN, CR 9817 (Nov. 18; eff. Dec. 16; impl. March 8, 2017)
- Coding Revisions to National Coverage Determination (R), Trans. 1753OTN, CR 9751 (Nov. 17; eff. Jan. 1; impl. Jan. 3, 2017)
- Implementing Provider File Updates and PECOS to FISS Interface Via Extract File Updates to Accommodate Section 603 Bipartisan Budget Act of 2015, Trans. 1704OTN, CR 9613 (Nov. 25; eff. Jan. 1; impl. Jan. 3, 2017)

Federal Register Regulations

Final Rule

- Medicaid and Children's Health Insurance Programs: Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Other Provisions Related to Eligibility and Enrollment for Medicaid and CHIP, 81 Fed. Reg. 86382 (Nov. 30, 2016)

Proposed Rules

- Medicaid and Children's Health Insurance Programs: Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Other Provisions Related to Eligibility and Enrollment for Medicaid and CHIP, 81 Fed. Reg. 86467 (Nov. 30, 2016)
- The Use of New or Increased Pass-Through Payments in Medicaid Managed Care Delivery Systems, 81 Fed. Reg. 83777 (Nov. 22, 2016)

means they were grandfathered in, or, to use CMS parlance, "excepted." Outside that deadline, they will instead bill 50% of the OPPS rate *(RMC 11/7/16, p. 1)*.

And now the 21st Century Cures Act would expand the grandfathering "to include not just those existing and operational outpatient departments billing as of Nov. 2, but those departments that were nearly operational but had not yet dropped a bill" if they signed a written agreement for construction, says Kenny.

The catch: Hospitals' CEOs or COOs must submit to CMS a letter stating that the provider-based department meets the definition of mid-build, and hospitals must submit an attestation of compliance with provider-based status within 60 days of the bill becoming law, Kenny says. Normally, attestations are voluntary. "Then CMS will review the attestations in 2017, and if you were to qualify as a mid-build department, you only get the full OPPS payment beginning in 2018," he says. Because there will be a gap, mid-build provider-based departments would be paid the 50% rate in 2017, Kenny notes.

Contact Kenny at CKenny@KSLAW.com. ✧

Doctor and His Third-Party Biller Are Excluded From Medicare and Fined

Exclusion and fines awaited both a New Jersey physician who allegedly charged Medicare and Medicaid for pelvic floor therapy (PFT) he didn't perform and the owner of a third-party billing company who allegedly billed Medicare and Medicaid for the services, the HHS Office of Inspector General (OIG) said. Obstetrician-gynecologist Labib E. Riachi, owner of the Center for Advanced Pelvic Surgery, agreed to a 20-year exclusion from federal health care programs eight months after his $5.25 million false claims settlement, and Susan Toy, the owner of Millennium Billing in New Jersey, is excluded for five years and will pay $100,000 in a civil monetary penalty (CMP) law settlement.

OIG alleged Riachi charged for services that were never provided or were performed by medical assistants and billed incident to the physician, although the medical assistants weren't qualified and Riachi didn't provide direct supervision, as required by Medicare. The OB/GYN allegedly was out of the state or country at the time some of the claims were submitted, according to OIG's notice of proposed exclusion.

"The amount of money from a single provider is significant," David Blank, a senior counsel with OIG, tells *RMC*. "And 20 years is a significant period of exclusion, especially when somebody agrees to it."

The Center for Advanced Pelvic Surgery in Westfield treated female incontinence, prolapse and other pelvic floor dysfunction, and Riachi often recommended pelvic floor therapy (PFT), according to the OIG notice of proposed exclusion. PFT included an evaluation and management (E/M) service; two diagnostic tests (anorectal manometry and electromyography); and four physical therapy services.

Riachi didn't personally perform any of the PFT services, the notice of proposed exclusion alleged. Instead, medical assistants provided the services, including anorectal manometry, which involves inserting a balloon and a pressure sensor in the rectum to assess the sphincter reflex.

OIG: Supervision Was a Problem

"None of the individuals Riachi employed to perform the invasive procedure satisfied Medicare requirements or qualifications [for the procedure]," Blank says. "That particular issue was serious and can lead to adverse patient outcomes." Medicare pays for anorectal manometry performed by a physician or a physical therapist in the physician practice incident to the physician, but Riachi didn't employ a PT, Blank says.

The claims were submitted under Riachi's provider number even though he allegedly didn't provide direct supervision of the medical assistants, which requires the physician to be immediately available and able to provide assistance somewhere in the office suite to intervene if necessary, the notice of proposed exclusion alleges. But Riachi either wasn't around or the services weren't provided, according to the notice of proposed exclusion. Sometimes he wasn't in town when the services were provided. The OB/GYN took 32 trips outside New Jersey, and 21 of them were outside the United States, the notice of proposed exclusion alleged.

According to OIG, Riachi didn't pull off the alleged fraud by himself. He had help from the owner of the third-party billing company. According to OIG's demand letter to Toy, Riachi hired Millennium in 2007 to submit claims to various insurers. Toy received superbills from the Center for Advanced Pelvic Surgery, which indicated procedures performed and billed for PFT.

But there was a problem. She regularly submitted Medicare claims for anorectal manometry that wasn't provided, at $250 a pop, from July 1, 2010, through June 7, 2011, according to the demand letter. Toy allegedly listed Riachi as the rendering physician even when he wasn't in New Jersey. OIG sought a $250,000 CMP and five-year exclusion, and settled the case with the exclusion time intact but a $100,000 fine.

Riachi was pursued by the U.S. Attorney's Office for the District of New Jersey after its data mining brought the physician to its attention. In a false claims settlement, Riachi and the Center for Advanced Pelvic Surgery

agreed to pay $5.25 million to resolve allegations that they billed Medicare and Medicaid for anorectal manometry and electromyography although allegedly most tests were never performed. Claims also were submitted for physical therapy services that shouldn't have been paid because they weren't provided by a qualified therapist, the U.S. attorney's office said.

But OIG also pursued the exclusion — which is unusually long — independently of the U.S. attorney's false claims case, and that's rare, Blank says. "We took the position that our beneficiaries and programs needed to be protected from Dr. Riachi and integrity obligations would not protect the program to our satisfaction."

It's also unusual to see a physician and third-party biller in the same case. "Coders are usually anxious about situations where they may be asked to bill something, but the documentation isn't clear," says Minneapolis attorney David Glaser, with Fredrikson & Byron. In this case, the OIG alleged the biller added the service on her own. There's no reason to infer that a biller is liable for mistakes made by the practitioner, Glaser says. "The allegations here involved knowing improper conduct by a biller," he explains, adding that "it goes without saying this is a demand letter" and Toy's response is not included. She did not admit liability in the settlement.

Riachi did not admit liability in the settlement, and his attorney didn't respond to *RMC*'s request for comment.

Contact Blank through OIG spokeswoman Katherine Harris at Katherine.Harris@oig.hhs.gov and Glaser at dglaser@fredlaw.com. ✧

CMS Says Audit Findings, CIA Void Provider-Liability Waiver

Providers probably shouldn't count on the provider-liability provision in the Social Security Act to deflect claim denials, although occasionally it's a life-saver. But the scope of the provider-liability waiver is very broad, according to a new *MLN Matters* (MM9708), so it shouldn't be considered the first line of defense in appeals, lawyers say.

The provider-liability provision (Sec. 1395pp) lets providers off the hook for billing errors when they don't know, or couldn't be expected to know, that Medicare wouldn't reimburse them for the services they provided. Patients are also excused from coinsurance if they couldn't have known the services weren't covered.

What does it mean to know services aren't covered? It's spelled out in the *MLN Matters*. For example, CMS says Medicare administrative contractors (MACs) will "assume" providers knew about the policy or rule from an audit and investigation.

The audit part is a little disconcerting, says Atlanta attorney Ross Burris, with Polsinelli. "Audit results or denials aren't always that informative," he says. "Just because you get a denial doesn't always explain why you were denied," beyond stock language about the services being medically unnecessary or lacking documentation. Auditors may not explain how the patient supposedly didn't meet medical-necessary criteria or what pieces of documentation were missing, and without the details, it's hard to appeal based on a waiver of provider liability, Burris says.

Sometimes Waiver Argument Triumphs

The *MLN Matters* cites other reasons MACs will assume providers knew about a policy or rule, including:

◆ The policy or rule appeared in the Medicare manual or regulations;

◆ CMS or a MAC issued a general notice;

◆ The specific provider received a written notice from CMS, a MAC or the HHS Office of Inspector General; and

◆ "The provider, physician, or supplier previously agreed to a Corporate Integrity Agreement [CIA] as a result of not following the policy or rule."

While providers routinely use the provider-liability waiver in appeals of claim denials, they rarely succeed with this argument, Burris says. But once in a while it's a winning strategy. For example, Burris recently represented a client that argued provider liability on appeal and prevailed. The provider dropped a claim because the billing system indicated the patient appeared to be discharged, but it later turned out that wasn't the case. "It was a unique set of circumstances," he says. The provider-liability argument succeeded, Burris speculated, "because the provider had very good documentation and they had reason to believe the claim was valid when they dropped the bill."

Provider liability also won the day in a recent appeal of a home health company's claim denial before the U.S. Court of Appeals for the 10th Circuit. *(RMC 6/13/16, p. 1)*.

Contact Burris at rburris@polsinelli.com. View the *MLN Matters* at http://tinyurl.com/hmvc29a. ✧

Taking Stock: Board Committee Self-Assessment Tool

Brian Kozik, chief compliance officer at Lawrence General Hospital, developed this checklist to help board members determine their effectiveness at compliance oversight. Contact him at Brian.Kozik@lawrencegeneral.org.

LAWRENCE GENERAL HOSPITAL COMPLIANCE, AUDIT & RISK COMMITTEE: SELF-ASSESSMENT GUIDE		
PRINICPAL COMPONENTS OF EFFECTIVE AUDIT COMMITTEES	**RATING Y/N**	**FOLLOW UP ACTIONS**
Risk, Control, Compliance:		
The Compliance, Audit and Risk (CAR) Committee clearly understands and agrees with the LGH Board of Trustees on which elements of internal control – financial reporting, operational effectiveness and efficiency, and compliance with laws and regulations – it oversees on behalf of the Lawrence General Hospital (LGH) Board		
Reviews the extent of control testing by LGH internal and external, Feeley & Driscoll (F&D) auditors, understanding the degree to which it can be relied on to detect internal control problems or fraud		
Discusses with LGH internal and external (F&D) auditors their observations on internal control effectiveness and any significant weaknesses or issues found		
Sees that management addresses, on a timely basis, significant control exposures, relying on LGH internal and external auditors as required to assess adequacy of corrective actions taken		
Through the Chief Compliance Officer (CCO), monitors compliance with laws and regulations in areas in which it has oversight responsibility, through periodic briefings from the CCO		
Reviews periodically the program management established to communicate LGH's Code of Ethical Conduct and monitor compliance, understanding systemic issues and management's plans to address them		
Retains the authority to conduct, through the CCO, special investigations		
Is comfortable with the nature and extent of responsibilities delegated to the committee by the LGH Board of Trustees, and has sufficient time and resources to carry them out effectively		
Interaction with Management, Auditors:		
The committee maintains a productive relationship with management, with open lines of communication and ongoing dialogue		
Meets periodically in executive session to assess management's effectiveness		
Reviews and concurs in the appointment, replacement or dismissal of the CCO, ensuring continued objectivity		
Reviews compliance/audit annual plan, ensuring adequate coverage of key risk areas		
Reviews the adequacy of Corporate Compliance Departments staffing and budget		
Discusses significant audit and compliance findings reported to the committee in appropriate detail, as well as the status of past audit recommendations		
Is satisfied through discussions with management and the CCO that the function is operationally independent of the areas it assesses, and by its support, assists in preserving such independence		
In conjunction with the Finance Committee, reviews the external audit scope and related fees, ensuring members understand and are comfortable with the extent of audit work anticipated		
Receives information required to be communicated under auditing standards		
Instructs both the COO and F&D auditors that the committee expects to be advised of any areas requiring its attention		
Committee Composition:		
The Committee has its new members selected by designated independent directors, identifying needed skills/ attributes		
Members possess characteristics such as integrity, judgment, credibility, trustworthiness, intuition, industry knowledge, ability to handle conflict, and communication, decision-making and interpersonal skills		
Members possess requisite level of financial reporting knowledge, or acquire such knowledge soon after joining the committee, ensuring any applicable rules are met		
Is satisfied it has a sufficiently independent voice		
Considers, with the LGH Board of Trustees, a need for balancing continuity with fresh perspective when considering members' terms of service		
Is the right size, bringing requisite knowledge, abilities and skills to the table in a group small enough to act cohesively		
Training and Resources:		
The committee ensures new members have the robust orientation required to understand the committee's responsibilities and the compliance function they oversee		

Ensuring Boards Get Compliance

continued from p. 1

When the board and/or the board's audit and compliance committee pose meaningful questions about hotlines and other important matters, it telegraphs their engagement in compliance, according to compliance officers.

"I knew they got it because of questions they asked," says Cassandra Andrews Jackson, compliance and HIPAA privacy officer at SBH Health System in New York City. Sometimes questions come in formal meetings with the full board, and sometimes they call her when they're troubled by something they see at another organization because they serve on multiple boards. "That lets me know they're not thinking about compliance just when I stand in a board meeting giving my report," Jackson says. She also assumes more pointed questions will come her way if new executive sessions with the board — out of earshot of senior leadership — come to fruition. The executive sessions were a recent recommendation in the New York state Office of Medicaid Inspector General's compliance-review guidance, and they empowered Jackson to seek that authority.

continued

Taking Stock: Board Committee Self-Assessment Tool (continued)

LAWRENCE GENERAL HOSPITAL COMPLIANCE, AUDIT & RISK COMMITTEE: SELF-ASSESSMENT GUIDE (continued)		
PRINICPAL COMPONENTS OF EFFECTIVE AUDIT COMMITTEES	**RATING Y/N**	**FOLLOW UP ACTIONS**
Sees that all members are provided continuing information and training on business, compliance and accounting developments		
Makes sure it commands adequate resources to support it in accomplishing its objectives		
Charter, Evaluation, Reporting:		
The committee operates pursuant to a written charter that has been approved by the LGH Board of Trustees		
The Charter clearly articulates the committee's: purpose, responsibilities, composition, authority and reporting responsibilities		
Assess the Charter annually, suggesting required updates to the LGH Board of Trustees for its approval		
Ensures annually that it carries out all the responsibilities outlined in its Charter		
Regularly evaluates performance of the committee as a whole, and takes decisive corrective action		
Regularly evaluates individual members' performance, and takes decisive corrective action		
Operates in an atmosphere of openness and trust, where members feel free to speak their minds and pursue issues to conclusion		
Reports regularly on its activities, key issues and major recommendations to the LGH Board of Trustees		
Holds sufficient number of meetings, scheduled at appropriate points to address its responsibilities on a timely basis		
Meetings are adequate length to allow the committee to accomplish its agenda, with time to fully discuss issues		
Meetings are effective, with advance buy-in on the agenda, and the right amount of quality advance material distributed in a timely manner, which members review before meetings		
Makes sure the right individuals attend, particularly those with meaningful input on the agenda items		
Members regularly meet in private sessions with both the CCO and external auditors, to allow full and frank discussion of potentially sensitive matters		
Members regularly meet in executive session, allowing confidential discussion of financial reporting reliability and auditor and management performance		
The committee considers whether there are emerging issues that will demand its attention going forward, and is proactive in positioning itself to deal with them		
Financial Statements:		
The committee, in conjunction with the Finance Committee is satisfied that F&D adequately addresses the risk that the financial statements may be materially misstated, intentionally or unintentionally		
The committee, in conjunction with the Finance Committee is comfortable, through discussions with management and external auditors, that accounting principles followed by LGH and any changes in accounting principles are appropriate		
In conjunction with the Finance Committee, thoroughly reviews the reasons for any changes in accounting principles made at management's discretion, understanding potential regulator and market reactions, before granting approval		
In conjunction with the Finance Committee, scrutinizes areas involving management judgment – significant accounting accruals, reserves or other estimates – that have a material impact on the financial statements		

It's also a "marker" of an engaged board when board members ask whether there are other issues the compliance officer wants to bring to their attention, Jackson says. After her last meeting, where she was laser-focused on training, a board member "who listened intently" asked about other potential problems. "That was an open door for me," she says. "It lets me know if I did have some issue they would be willing to hear it."

To ensure board members are savvy about compliance, some compliance officers use tools to objectively determine members' engagement with the compliance program (see box, p. 6). Assessment is a smart move because board members probably come from diverse backgrounds, says Florie Munroe, chief compliance and privacy officer at Care New England in Providence, R.I. She surveys the members of her audit and compliance committee annually. To work effectively with board members, "you have to evaluate and understand your board," Munroe says.

But it always seems to come back to the questions asked by board members. "You should have members familiar enough with health care to challenge me and say, for example, 'what are the risks with cybersecurity?'" says Brian Kozik, chief compliance officer at Lawrence General Hospital in Massachusetts.

Recently the board's compliance, audit and risk committee questioned Kozik and senior leaders about a compliance problem in an operational department. "The CFO said, 'there is a plan to address it,'" but the board wanted a firm date for resolution. "There was an exchange and finally the CFO said, 'OK, we will give you a date.'"

Less formal contact with board members also can be a game changer. Every quarter, Kozik has lunch with his compliance committee chair. "Face time is essential," he says. If they have any questions or concerns, this is a good time, especially if they are worried about something they have heard while serving on another board (e.g., the Yates memo).

Munroe also has had valuable feedback from informal contact. When she was compliance liaison at Yale New Haven Health System, the chair of the audit committee — a high-finance sort — also volunteered at the hospital's front desk. "I couldn't walk past him without his questioning me about [accounting standards]," she recalls. "He saw a lot of interactions between patients, visitors and staff" and shared them. "You can only do so much in formal board meetings. You need to develop relationships."

Hambleton cautions against the conversation being one-sided. "One of the problems that lead to a lack of engagement is just giving them information without asking them to engage in the information," she says. Board members should ask questions about the material in the report presented at meetings with the compliance officer. "Where folks tend to fall down a little is where it is all one-way information," she says. "It's incumbent on the compliance officer to engage them to ask questions to get them to think about the material."

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NEWS BRIEFS

◆ **It's *déjà vu* all over again with the infamous implied certification case.** The U.S. Court of Appeals for the First Circuit ruled Nov. 16 that the plaintiffs in *United States ex rel. Escobar v. Universal Health Services* (No. 14-1423) sufficiently alleged that the regulatory violations in question were material to the government's payment decision, a requirement for an actionable False Claims Act (FCA) claim. In 2015, the First Circuit held that Universal Health Services (UHS) had violated Massachusetts Medicaid regulations on licensing and certification of mental health workers that "clearly impose conditions of payment" even though the conditions were not expressly stated. The defendant, UHS, had appealed the First Circuit's decision to the U.S. Supreme Court. In a landmark June decision, the court endorsed the theory of implied certification in FCA cases, but remanded the case to the First Circuit to determine whether the case met the implied certification standards articulated in its decision *(RMC 6/20/16, p. 1)*. The Supreme Court crafted a "holistic approach to determining materiality" and suggested several factors to consider. Applying these standards, the First Circuit "had little difficulty in concluding that [plaintiffs] have sufficiently alleged that UHS's misrepresentations were material." The First Circuit then remanded the case to the district court for additional proceedings. Visit http://tinyurl.com/j4r6nuq.

◆ **The HHS Office of Inspector General has posted its Semiannual Report to Congress for the half year ending Sept. 30, 2016.** The report describes "significant problems, abuses, deficiencies, remedies and investigative outcomes." Visit http://go.usa.gov/x8Qxr.

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