Compliance Round-Up

October 13, 2015

NBHD, Adventist Health, Stone County Hospital, Pediatric Services of America, Columbus Regional Healthcare System, and Yates Memo

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Faculty

Brian Annulis, JD, CHC
Managing Director, Aegis Compliance & Ethics Center, LLP
773.697.3881
bannulis@aegis-compliance.com

Ryan D. Meade, JD, CHC-F, CHRC
Managing Director, Aegis Compliance & Ethics Center, LLP
773.697.3882
rmeade@aegis-compliance.com

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Continuing Goals

The goals of the Compliance Round-Up Webinars:

- Teaching/knowledge transfer
- Keep you up to date on compliance rules
- Practical points
- Assist organizations to develop in-house methods of managing
- Please share your thoughts, suggestions (and criticisms)

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Compliance Round-Up: Webinar Overview

Administrative Matters

- Monthly on the 2nd Tuesday of the month
- No charge! (feel free to spread the word….)
- Each session will be 60-75 minutes in duration
- Each session will begin at 12:00 PM CT
- If you are unable to participate in the live discussion, each session will be recorded and made available in MP3 format

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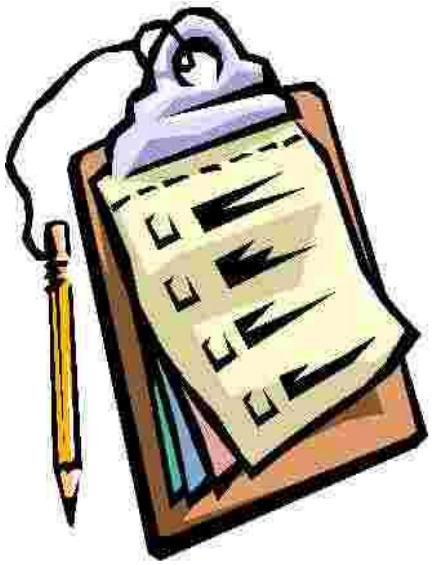
Today's Topics/Agenda

a) NBHD
b) Adventist Health
c) Stone County Hospital
d) Pediatric Services of America
e) Columbus Regional Healthcare System
f) Yates Memo



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North Broward Hospital District

- September 15, 2015
- http://www.justice.gov/usao-sdfl/pr/florida-hospital-district-agrees-pay-united-states-695-million-settle-false-claims-act
- North Broward Hospital District (NBHD) agreed to pay the United States $69.5 million to settle allegations that it violated the federal FCA by engaging in improper financial relationships with referring physicians

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North Broward Hospital District

- The settlement resolved allegations that the hospital district provided compensation to nine employed physicians that exceeded the fair market value (FMV) of their services.

- The United States contended that these agreements violated the Stark Statute and the FCA.

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North Broward Hospital District

- The allegations settled arose from a lawsuit filed by a whistleblower, Dr. Michael Reilly, under the qui tam provisions of the FCA. Dr. Reilly was a physician on staff at one of the NBHD facilities.
- Dr. Reilly will receive $12,045,655.51 from the recovery.
- According to the complaint, the plaintiff claimed that the district maintained secret compensation records called “Contribution Margin Reports” for cardiologists, oncologists, and orthopedic surgeons, who collected salaries of $1 million or more.

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North Broward Hospital District

- Specifically, Reilly contended that employed physicians, and particularly orthopedic surgeons, cardiologists, and the primary care, hematology/oncology, and orthopedics groups, were compensated at levels that were above FMV, not commercially reasonable, and based in part on the volume and value of inpatient and outpatient referrals.
- The complaint alleged that the excessive nature of the compensation and lack of commercial reasonableness was demonstrated by the substantial losses generated by the employed physicians when the profits from such physicians' referrals to NBHD were not considered.

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North Broward Hospital District

- According to the Second Amended Complaint, NBHD's internal pro formas reflect that the hiring and compensation of these physicians was based in part on the value of their anticipated referrals by the inclusion of **ancillary revenue** in the pro formas.
- Absent the inclusion of this revenue, the pro formas would show losses in the millions of dollars over the term of the employment agreements, some of which were for nine years.

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North Broward Hospital District

- The complaint also alleged that compensation paid to employed physicians substantially exceeded the 90th percentile for such physicians in the region, and that the compensation to collections ratio (which exceeded a 1:1 ratio) was double that of the 90th percentile.
- The complaint also alleged that NBHD internally tracked the inpatient and outpatient contribution margins from referrals of the subject-employed physicians, and pressured the employees to make certain referrals internally, despite questions they had raised about the quality of the services.

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North Broward Hospital District

- The records supposedly rewarded the physicians for referrals for hospital services and penalized the physicians for providing services to low paying charity cases.
- Additionally, an instance of free rent to a non-employed physician was cited in the complaint.

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North Broward Hospital District

- NBHD agreed to enter into a five-year CIA.
- CIA included (standard) provisions, requiring all owners, officers, directors, commissioners, employees, members of the medical staff, contractors, subcontractors, commissioners, and employees of NBHD to be provided with its AKS and Stark Law policies and Code of Conduct, and to be trained on the requirements of those policies, as well as of the CIA, Compliance Program, and Code of Conduct.
- The CIA also requires implementation of a regimen for entering into, tracking, monitoring, and review of each arrangement that implicates the Stark Law and AKS. An IRO is required to be engaged to test compliance with these aspects of the CIA.

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Adventist Health

- September 21, 2015
- http://www.justice.gov/opa/pr/adventist-health-system-agrees-pay-115-million-settle-false-claims-act-allegations#sthash.xuHiF1x8.dpuf
- Adventist Health System agreed to pay $**115 million** to settle allegations that it violated the FCA by maintaining improper compensation arrangements with referring physicians and by miscoding claims.

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Adventist Health

- Adventist is a non-profit healthcare organization that operates hospitals and other health care facilities in 10 states.
- The settlement resolves allegations that Adventist submitted false claims to the Medicare and Medicaid programs for services rendered to patients referred by employed physicians who received bonuses based on a formula that improperly took into account the value of the physicians' referrals to Adventist hospitals.

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Adventist Health

- The settlement also resolves allegations that Adventist submitted bills to Medicare for its employed physicians' professional services containing certain improper coding modifiers, and thereby obtained greater reimbursement for these services than entitled
- The allegations arose from two lawsuits filed respectively by whistleblowers Michael Payne, Melissa Church and Gloria Pryor, who worked at Adventist's hospital in Hendersonville, North Carolina, and Sherry Dorsey, who worked at Adventist's corporate office, under the qui tam provisions of the FCA. According to published reports several of the relators had "compliance" position the organization/hospitals

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Adventist Health

- The complainants alleged that compensation offered to physicians, mid-level practitioners such as nurse practitioners, and physician assistants was above fair market value (FMV), as evidenced by Adventist's substantial and consistent losses on their physician practices.

- In the qui tam complaints, the plaintiffs contended that for a period in excess of ten years employed physicians and mid-level practitioners were compensated at levels that were above FMV, were not commercially reasonable, and were based in substantial part on the volume and value of inpatient and outpatient referrals of designated health services (DHS) to their hospital employers.

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Adventist Health

- The complaint further alleged that the defendants paid above FMV compensation for part-time or non-productive work; that excessive bonuses were based upon inflated work relative value unit values; that compensation formulas consistent with applicable law were often not followed; and that incentives were based upon hospital revenue from DHS referrals rather than personally performed services.

- The relators claimed that despite contractual provisions designed to reduce salaries to address practice losses, these provisions were never implemented, although the practices experienced substantial losses.

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Adventist Health

- The allegations included claims that employed physicians were provided with perks such as car payments, private office staff, equipment, and supplies without charge.
- In some cases, it is alleged, direct payments for ancillary services or expensive drugs provided by the hospital were made to physicians whose referrals generated the revenue.
- Finally, the complaints allege that Adventist tolerated known overbilling and upcoding by employed as well as contracted physicians.

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Adventist Health

- The complainant claimed that underlying the excessive compensation paid to its employed physicians was Adventist's strategy to purchase physician practices and employ physicians in order to control their referrals.

- Excessive compensation was allegedly required to attract physicians from independent practice and keep them from working for competitor hospitals.

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Adventist Health

- Also alleged was that inpatient and ancillary contribution margins from referrals of the employed physicians were internally tracked, and included in the methodology for calculating physician bonuses.
- The complaints contend that senior managers internally admitted to knowing that the compensation practices were illegal, but did not correct them.
- Adventist was NOT required to enter into a CIA as part of the settlement

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Stone County Hospital

- On September 18, DOJ filed a FCA complaint intervening in a qui tam action filed against Stone County Hospital Inc. (Hospital), the hospital's owner, Ted Cain, and his wife, Julie Cain, who is also the hospital administrator.
- Relator was the former COO of the Hospital
- The government alleges the defendants funneled millions of dollars in federal reimbursements to a management company (also owned by Ted Cain) in fraudulent cost reports filed through Medicare's payment system for CAHs.

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Stone County Hospital

- The government alleges that in each year from 2002 to the present, the defendants knowingly misrepresented the hospital's costs on its cost report by including costs associated with compensation and luxury items paid to Ted and Julie Cain.

- While compensation for services provided by the owner of a Medicare provider are allowable costs, owner compensation is only a proper Medicare cost to the extent that the services are actually performed in a necessary function directly related to patient care and only to the extent that the compensation is in an amount that would ordinarily be paid for comparable services by comparable institutions.

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- However, the government alleges that any costs "flowing from the provision of luxurious items or services" are not allowable. 42 C.F.R. 413.9(c)(3).

- The government alleges an "ongoing fraudulent scheme" wherein the Hospital would include costs relating to Ted Cain's "exorbitant, multi-million dollar salary" as CEO of the management company, costs for Julie Cain's "quarter-million dollar annual salary" as hospital administrator, costs for the Cains' two luxury BMWs, and additional costs associated with the management company's extensive network of closely held businesses.

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Stone County Hospital

- The government alleges that over the past ten years, the Hospital reported costs in fees to its management company ranging from $1.2 million to $3 million per year.
- During the same time span, Ted Cain received an annual salary as CEO of the management company ranging from $1 million to $3.3 million per year.
- While Ted Cain purportedly spent 80% of his time managing hospital operations, the 25-bed Hospital also directly employed a COO, CFO, HR Director, Nursing Director, Quality Director, and Chief of Staff, all of whom had duties overlapping with or duplicative to the duties of Ted Cain's management company.

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Stone County Hospital

- The complaint also alleges that Ted Cain represented to Medicare that he worked more than 50 hours per week on Hospital matters, but represented to the IRS on his tax returns that he worked over 500 hours each year for other entities he owned.
- The combined hours Ted Cain claimed through his representations to Medicare and the IRS, according to the complaint, exceeded 10.5 hours per day for 365 days per year.
- The government further alleges that, at his investigative deposition, Ted Cain could not articulate any specific work that he performed for the Hospital that his company purportedly managed.

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Stone County Hospital

- The complaint alleged further that Julie Cain, although she had no formal education or training in hospital management, had an annual salary which, at times, exceeded a quarter million dollars and was largely reimbursed by Medicare.
- Like Ted Cain, the government alleges that Julie Cain did not perform any meaningful work for the Hospital, or at best performed services that were duplicative to Hospital staff and lacked substantial value.
- The complaint also alleges that the defendants knowingly inflated the hospital's cost reports and the management company's home office costs statements and that these false certifications and reports were material to Medicare's decision to provide reimbursement to the Hospital.

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Stone County Hospital

- The government seeks treble damages on the actual Medicare losses based on false records and failure to refund payments based on those false claims.

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Pediatric Services Of America

- http://www.justice.gov/usao-sdga/pr/pediatric-services-america-and-related-entities-pay-688-million-resolve-false-claims#sthash.bxek4ftE.dpuf
- August 4, 2015
- Pediatric Services of America Healthcare, Pediatric Services of America, Inc., Pediatric Healthcare, Inc., Pediatric Home Nursing Services (collectively, “PSA”), and Portfolio Logic, LLC agreed to pay $6.88 million ($6,882,387) to resolve allegations that PSA, a provider of home nursing services to medically fragile children, knowingly (1) failed to **disclose and return overpayments** that it received from federal health care programs such as Medicare and Medicaid, (2) submitted claims under the Georgia Pediatric Program for home nursing care without documenting the requisite monthly supervisory visits by a registered nurse, and (3) submitted claims to federal health care programs that overstated the length of time their staff had provided services, which resulted in PSA being overpaid.

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Pediatric Services Of America

- “Participants in federal health care programs are required to actively investigate whether they have received overpayments and, if so, promptly return the overpayments,” said United States Attorney for the Northern District of Georgia John Horn. “This settlement is the first of its kind and reflects the serious obligations of health care providers to be responsible stewards of public health funds.”

- This is the first settlement under the FCA involving a health care provider’s failure to investigate credit balances on its books to determine whether they resulted from overpayments made by a federal health care program. Under section 6402 of the Affordable Care Act, health care providers must report and return any overpayments by the later of (i) 60 days after the overpayment was identified or (ii) the date any corresponding cost report is due (if applicable).

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Pediatric Services Of America

- PSA had been maintaining numerous credit balances on its books that related to claims it had submitted to various federal health care programs, some of which had been on PSA's books for several years. Additionally PSA wrote off and absorbed credit balances that had resulted from overpayments into their revenue because they had not investigated the reason for the credit balances before doing so. At the government's request, PSA cooperated with a joint audit of the credit balances on its books in order to identify all outstanding overpayments.

- As part of the settlement, PSA has agreed to enter into a CIA, which will require PSA to put in place procedures and reviews to avoid and promptly detect conduct similar to that which gave rise to the settlement.

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Pediatric Services Of America

- The settlement resolves allegations filed by Yvette Odumosu and Sheila McCray, former employees of PSA, under the qui tam or whistleblower provisions of the FCA.

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Columbus Regional Healthcare System

- September 4, 2015
- http://www.justice.gov/opa/pr/georgia-hospital-system-and-physician-pay-more-25-million-settle-alleged-false-claims-act-and
- U.S. Attorney's Office for the Middle District of Georgia reached a settlement with Columbus Regional Healthcare System ("Columbus Regional") and Dr. Andrew Pippas, a medical oncologist employed by Columbus Regional's cancer center ("Cancer Center").
- The settlement resolved alleged FCA violations based on upcoded claims and AKS and Stark Law violations. Columbus Regional settled for $25 million, plus up to $10 million in contingency payments.

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Columbus Regional Healthcare System

- The relator (Richard Barker, the Cancer Center's former administrative director) alleged violations of the federal and Georgia FCAs.

- In the first complaint, Barker alleged that the Cancer Center had a long-standing practice of billing for evaluation and management (E/M) services at levels that were not supported by the documentation in the medical record, and billing separately for E/M services that should have been included in the reimbursement for administration of chemotherapy provided on the same day.

- The relator alleged that the medical oncologists employed by the Cancer Center were paid on a per-relative-value-unit (RVU) basis that encouraged the upcoding of services, and that the medical record documentation was lacking, or non-existent, for certain claims

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Columbus Regional Healthcare System

- In the second complaint, the relator alleged that Columbus compensation failed the Stark employment exception's fair market value, "volume or value" and commercial reasonableness tests.

- Relator alleged this because it was more than what Columbus Regional collected from Dr. Pippas' personally performed professional services; took into account the value of his chemotherapy and other referrals to Columbus; and was based in significant part on productivity that was allegedly artificially inflated by the productivity of other practitioners and his own upcoding of patient visits.

- The complaint noted that CRHS obtained outside valuation opinions in 2008 and 2009, but these opinions assumed that Pippas was paid only for services he personally performed.

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Columbus Regional Healthcare System

- The complaint alleges that the payment of Pippas for services he did not personally perform continued until at least 2013, when CRHS obtained a subsequent valuation opinion concluding that Pippas' total wRVU production could not be solely attributed to Pippas' personally performed services and instead took into account services provided by another physician and midlevel. According to the complaint, the 2013 valuation opinion concluded that Pippas' compensation was in excess of FMV.

- Settlement resolves billing and Stark law concerns, but CIA only contains provisions for oversight of financial arrangements with physicians and no billing/claims review.

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Columbus Regional Healthcare System

- The settlement agreement also resolves claims that were self-disclosed by CRHS under the CMS Self-Referral Disclosure in 2013 related to specialty clinic, ophthalmology, call coverage, surgical services, and other services arrangements
- Dr. Pippas also agreed to pay $425,000
- As part of the settlement, Columbus Regional also agreed to enter into a CIA.

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Individual Accountability for Corporate Wrongdoing

- Announcing a new policy on white-collar crime, Deputy U.S. Attorney General Sally Yates recently vowed to pursue “not just corporate entities, but also the individuals through which these corporations act.”

- Federal prosecutors would no longer enter into settlement agreements with companies whose internal investigations do not disclose the “culpable individuals.”

- “No more picking and choosing what gets disclosed. No more partial credit for cooperation that doesn’t include information about individuals,” Yates said.

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DOJ Memo (Sept. 9, 2015)

The guidance in the memo reflects six key steps to strengthen DOJ's pursuit of individual corporate wrongdoing, some of which reflect policy shifts:

(1) in order to qualify for any cooperation credit, corporations **must** provide to DOJ all relevant facts relating to the individuals responsible for the misconduct;

(2) criminal and civil corporate investigations should focus on individuals from the inception of the investigation;

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DOJ Memo (Sept. 9, 2015)

(3) criminal and civil attorneys handling corporate investigations should be in routine communication with one another;

(4) absent extraordinary circumstances or approved departmental policy, **DOJ will not release culpable individuals from civil or criminal liability when resolving a matter with a corporation**;

(5) Department attorneys should not resolve matters with a corporation without a clear plan to resolve related individual cases, and should memorialize any declinations as to individuals in such cases; and

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DOJ Memo (Sept. 9, 2015)

(6) civil attorneys should consistently focus on individuals as well as the company and evaluate whether to bring suit against an individual based on considerations beyond that individual's ability to pay.

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Follow-Up

Questions?

questions@aegis-compliance.com

audiocourses@aegis-compliance.com

Next Lecture:

Tuesday, November 10, 2015

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