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Using Board Committees Effectively to Manage the Board’s Workload
By: Dianne K. Pledgie, Esq., Feldesman Tucker Leifer Fidell LLP

Committees can help or hinder a board. When working well, they support the work of the board and provide board members with a way to dive more deeply into the strategic issues affecting the organization. On the other hand, when there is a lack of board member participation, committees become ineffective and frustrating for staff to support.¹

Does the board of your community behavioral health organization (CBHO) run out of time at its board meetings? Do some important matters never seem to make it onto the board’s agenda? Do one or two members of the board monopolize meeting time? If so, your board may not be effectively using board committees to manage the workload of the board.

Given the number of issues facing boards and their organizations today, having effective board committees is critically important. Board committees can make boards more efficient by allocating issues to a smaller group of board members with the expertise, skills and time to handle complicated and important issues.

How can you create, support and enhance board committees so that they are a help and not a hindrance? This article provides an overview of board committee structure, responsibility, membership, and evaluation and includes helpful tips to increase the effectiveness of board committees and board meetings.

Types of Board Committees

Two types of committees are common for CBHOs: standing committees and ad hoc committees:

Standing committees: Standing committees should be included in the CBHO’s by-laws. These committees function on a permanent basis and they address ongoing, major activities. Common standing committees include:

- Executive: This committee is typically comprised of the board chair and officers (treasurer, secretary, vice chair, etc.). It may also include committee chairs. As defined in the bylaws, the executive committee can act as a smaller body that can convene quickly to coordinate the board’s priorities and to address urgent, administrative decisions between regularly

scheduled meetings of the full board. Actions taken by the executive committee should be confirmed at the next meeting of the full board.

- **Board development/governance:** This committee works to ensure effective board processes, structures and roles (including committee development) and orientation and training. This committee may also be responsible for board member recruitment or that task may be delegated to a nominating committee. This committee may also be responsible for investigating and addressing inappropriate board member conduct.

- **Finance:** This committee, often chaired by the board treasurer, oversees the development of the organizational budget; ensures accurate monitoring of funds, and ensures adequate financial controls are in place. The committee works closely with the Chief Financial Officer. The finance committee may also serve as the audit committee; however, separating the audit and finance committees provides greater fiscal oversight.

- **Fundraising/Development:** This committee oversees the development of the fundraising plans. Members help to identify and solicit funds from external sources of support. The full committee may be involved in major fundraising events or campaigns or such tasks may be delegated to a fundraising subcommittee.

- **Quality/Evaluation:** This committee oversees the evaluation of the organization’s programs and services, include tracking of quality measures. The committee works closely with clinical leadership.

- **Compliance:** This committee is responsible for developing and implementing internal controls and policies and procedures that promote adherence to all laws, regulations and requirements that apply to the organization. The committee oversees the development and implementation of the compliance program and the work plan.

Organizations may divide the work of the board into different committees with different titles but the board responsibilities in these areas remains. In the past 30 years, board committee structures have been streamlined. In 1994, boards had an average of 6.6 committees and today they have an average of 4.8 committees. This change may be related to growing organizations with more professional staff, busier board members, or greater use of ad hoc committees.

*Ad hoc committees:* Ad hoc committees address short-term activities or priorities. Once the activity is complete, these committees cease to exist. Common ad hoc committees include:

- **Campaign/event:** Responsible for planning and coordinating a major fundraising event.
- **Program/event:** Responsible for planning and coordinating a major event, such as a strategic plan, retreat, staff appreciation, or community engagement event.

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2 The role of the executive committee may be changing based on technology: “In the past, one role of the executive committee was to act as a smaller body that could convene quickly when needed. Today, technology allows the board to easily communicate, making that particular need less critical” (BoardSource, 17).

3 BoardSource, 16.
• Audit: Responsible for planning and supporting an audit of major functions, e.g. finances, programs or organization.
• Legislative: Responsible for coordinating response to legislative actions affecting the organization’s finances, operations or programs.
• Succession: Responsible for succession planning including manager development, recruitment and hiring.

**TIP:** Just because an ad hoc committee still exists, doesn’t mean that it still brings value to the board. The board development committee should annually evaluate the committee structure, including both standing and ad hoc committees. If it is unclear whether your board will need a particular ad hoc committee in the future, list its status as “inactive.” It can be reconvened if necessary or it can be

**Board reports**

Board committees are directly responsible to the full board and make recommendations to the full board. As such, the chair of each committee (discussed below) typically reports to the full board during the regular meetings. Such reports should summarize the committee’s work since the past board meeting. While the reports should be concise, they should also reflect that the committee had a full discussion and all options were considered. Other board members should be encouraged to ask questions to be sure that the committee has not failed to consider all options.

The committee should present specific recommendations for action by the full board. Typically, a committee brings ideas, actions or recommendations to the full board members through their report.

**TIP:** Got a committee chair that can’t seem to keep their report to the full board concise and on topic? Include time limits for each committee chair’s report (for example, five minutes per committee report). Ask that the committee chair submit a brief written report prior to the meeting and reference the written report during the meeting. If a topic raised by a committee chair warrants greater discussion and decision-making by the full board, the board chair should adjust the meeting agenda or suggest the topic be taken up in greater depth at the

**Chairs and members**

The individual selected to chair a committee of the board does not need to be a technical expert in the topic though they should have experience in the area through their employment, personal interest or involvement on the committee in the past. The chair must be able to work well with the other committee members to assure that the work of the committee is completed in a timely fashion. It is also important that the chair be organized, have strong communication skills, and encourage other committee members to stay motivated and focused.
In general, the responsibilities of the chair include:

1. Prepare and present the committee report to the full board
2. Set agendas, call meetings and assure committee minutes are recorded (if required)
3. Ensure that all committee members have the opportunity to contribute

Committee chairs are often appointed by the board chair. The board development committee may also be involved in the selection process or committee members may be asked to volunteer for the position.

Committee members may be assigned in a variety of ways. As with selecting the committee chair, the board chair or board development committee may select committee members. Many boards ask members to volunteer for committees of interest to them. Be aware that board members are often looking to broaden their experiences and skills by volunteering for committees outside their areas of expertise. For example, the lawyer you recruited may be willing to serve on the governance committee but may also want to serve on the quality committee to better understand your organization’s clients or patients.

New board members should be assigned to committees as soon as possible. This will encourage them to get involved and invested from the start. It will also help them to understand board culture and acclimate to their role on the full board.

TIP: Not getting enough board members volunteering for certain committees? Have members submit their top choices for committee membership and then have the board chair or board development committee assign members so that talent, time and experience are shared among the committees.

**Doing the work**

Committees exist in order to make better use of board member expertise, time and commitment. Depending on the workload of each committee, meeting schedules will vary. Committees that are likely to meet more frequently/monthly include finance and quality. The board development committee may meet frequently during board recruitment and may have limited meetings during the rest of the year.

Whether standing or ad hoc, committees work best when they have a clear purpose. The committee should annually review its description and/or charter to assure that it reflects the needs of the full board and the work that it does. Each member should understand the responsibilities of the committee and of committee membership.
TIP: Committees that struggle to find a time to meet should consider meeting either immediately before or after the full board meeting. It is often the only time to meet face-to-face with all (or most) committee members. While it can make for a long haul for members, there is less follow-up between meetings and it may be easier to discuss issues while they are still fresh in member’s minds.

Evaluation

The committee structure and each committee should be periodically evaluated. A natural time for such evaluation is prior to the board recruitment process or prior to making annual committee assignments. Some items to keep in mind include:

- Do committees meet enough? Too much?
- How are committee meetings structured? Is there a clear agenda? Does the meeting start and end on time? What can committees learn from each other in terms of structure?
- How are decisions made by the committee? Are all members involved? Is the chair effective in allowing discussion?
- What are the gaps in knowledge, skills or time on the committee? Has this information been communicated to the board development committee or board chair?
- Has the committee achieved its goals for the year?
- How do other board members view the committee?

Conclusion

In a play on the well-known proverb, it could be said that “a board is only as effective as its committees.” Given the pace and number of changes in the health care environment, each committee of a CBHO’s board must function effectively in order for the board to be successful.

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Training the Board of Directors: Advice for Compliance Officers
By: Dianne K. Pledgie, Esq., Feldesman Tucker Leifer Fidell LLP

Perhaps it is buried on page four of your organization’s compliance work plan. Maybe the Executive Director keeps mentioning it. Or, more likely, you worry about it periodically...until the next crisis hits your “to do” list.
Training the Board of Directors can be challenging because there are so many other priorities for both board members and the compliance officer. The Office of Inspector General ("OIG") for the U.S. Department of Health and Human Services has identified training and education as an integral piece of an effective compliance program.

This article reviews the components of compliance training and education and provides advice for compliance officers on training both new and veteran Board members.

All aboard: Training for everyone

Over the past seventeen years, the OIG has issued a series of Compliance Program Guidances for different sectors of the health care industry. Each describes how to develop and implement a comprehensive compliance program in order to detect fraud, waste and abuse.

Among the seven elements that the OIG identifies for inclusion in every Compliance Program is conducting appropriate training and education. While some individuals affiliated with the Community Behavioral Health Organization (CBHO) should receive specialized training to address specific risks associated with their positions (such as coders), all employees and Board members should receive general compliance training.

General compliance training should describe the CBHO's Compliance Program and its various components, as well as the organization's commitment to compliance with all applicable laws and regulations. Additional topics to be covered include:

- The importance and operation of the Compliance Program
- The consequences of violating the policies and procedures
- The role of each individual in the operation of the Compliance Program.

Training should explain why the Compliance Program has been implemented and should provide a summary of applicable laws and regulations. For example, to address the importance of preventing improper claims submission, compliance training should explain the relevant fraud and abuse statutes and regulations, government and private payor program requirements, and coding and billing standards and procedures.

Training should be conducted by or under the direction of the Compliance Officer. Different training techniques can be used. The OIG suggests disseminating publications that explain requirements in a practical manner. CBHOs should use publicly available compliance information, such as the information published by the OIG on its website, to supplement its training and education efforts. Training and education can also be implemented by using outside sources, such as professional associations, consultants, and other community partners.

What is compliance and why should I care? On-boarding new board members
Compliance training and education create an important opportunity to formally introduce the Compliance Program to new board members and to communicate the CBHO’s commitment to conducting business in a manner consistent with the highest ethical principles and in accordance with all applicable laws and regulations.

The on-boarding process for new board members differs at each organization. Some tips for compliance officers include:

- If there is a formal board orientation for new members, be sure that the Compliance Program is included. Introduce yourself and the Compliance Program. Offer to answer questions during your presentation and at a later date and time.

- If there is no formal board orientation, send new board members a letter to welcome them and to introduce the Compliance Program. If possible, have the chair of the compliance committee sign the letter as well. Encourage new board members to contact you with any questions or concerns. Inform them of the next time you are scheduled to attend the Board meeting.

- If there is no formal board orientation, schedule the annual Board compliance training as soon as possible after new board members start their service. If new board members are elected during the December Board meeting, schedule Board compliance training for the first quarter of the year.

- Provide new board members with relevant Compliance Program documents, including:
  - Standards of Conduct
  - Compliance Program Policies and Procedures
  - Compliance Program Description
  - Current Compliance Program Work Plan

- For new board members assigned to the corporate compliance committee, also include:
  - Board of Directors Compliance Committee Charter
  - Board of Directors Compliance Committee Member List
  - Board of Directors Compliance Committee Meeting Minutes

Yeah, yeah, yeah...didn’t you tell us this last year? Keeping board training interesting

Board members are busy people. With packed board meeting agendas, they don’t want to waste their time and you don’t want to waste your time.

The board compliance training program will vary by organization based upon each CBHO’s risk areas, past compliance issues and the maturity of the Compliance Program. Some tips for compliance officers include:
• Turn reports to the board into training sessions: If you are reporting regularly to the Board, there may be opportunities to combine reports with shorter training sessions. Here are some examples:
  o When presenting the compliance work plan for approval, include a section on compliance 101 that covers the seven elements of an effective compliance program and identifies the laws and requirements related to your CBHO’s top risk areas. This training will help put the compliance work plan in context for board members.
  o When discussing the outcome of any audit (whether internal or external), provide an initial training on the topic area. For example, if your organization recently hired an audit to assess HIPAA compliance, preface the audit report with details about what HIPAA requires and top enforcement trends. Again, this provides board members with background information before hearing audit results and it creates a training opportunity.

• Propose a series of trainings: Instead of trying to cover everything in one session, break up compliance related content over several board meetings. Consider having others help with the presentations as well. For example, a presentation on HIPAA could include the Privacy Officer, Security Officer and Compliance Officer. The Chief Financial Officer and Compliance Officer could present on billing compliance.

• Partner with other board committees: General compliance training can also be combined with other trainings such as quality improvement.

• Change the training method: If your CBHO invested in an on-line training system for staff members, show Board members how the system works by going through the Compliance 101 curriculum. Instead of creating another set of slides, find relevant videos on the OIG’s website or use recent news stories to kick-off a training.

• Include board members on compliance program reminders: Sending an email to staff members about the compliance program? Forward it to Board members or include a copy in your next report to the Board.

• Invite board members to participate in staff compliance training: Want to role-play some common compliance scenarios in your next staff compliance training? Board members make great guest stars! Having them participate in staff training sends a strong message about the organization’s commitment to compliance. The board members will also learn more about the Compliance Program. Ask the board members that participate to report back to the full Board.

*If you don’t document it, it didn’t happen: Documentation matters in compliance, too*

It is important for a CBHO to document all of its training and education efforts. Documentation should include:

• The board meeting minutes with the date, attendance, description of the compliance training, and name of the trainer
• Copy of training slides and materials, including introduction letters, bulletins or emails on compliance
• The signed statement of each board member acknowledging understanding of the CBHO’s Standards of Conduct and commitment to compliance.

The Compliance Officer should maintain this documentation to record the CBHO’s compliance efforts and the participation of the board.

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Sample Compliance Training Agenda

Target Audience: Members of the Board of Directors

Title: The Board’s Role in Compliance

1. Overview of Corporate Compliance and Corporate Responsibility
   • Enforcement trends
   • Sarbane-Oxley
   • Office of Inspector General

2. The Board’s Role in Compliance
   • Fiduciary duties
   • Legal requirements
   • Governance-management roles and responsibilities
   • Members of Compliance Committee of the Board
   • Oversight and Evaluation of Compliance Program – OIG / AHLA Guidances
   • Board member “Do’s and Don’t’s”

3. Overview of CBHO’s Compliance Program
   • Compliance Officer
   • Written Policies
   • Training and education
   • Audits and monitoring
   • Open Communication
   • Responding to detecting issues
   • Disciplinary standards

4. High Risk Areas
   • Fraud (billing and coding; documentation; cost-reporting; false claims)
Compliance and Enforcement Briefs

**CMS**

- **RAC program to expand reviews, enhance oversight, and increase transparency**: On December 30, 2014, the Centers for Medicare & Medicaid Services (CMS) announced changes to the Recovery Audit Contractor (RAC) Program. Recovery Auditors will broaden their reviews to include all claim and provider types and will review topics based on referral, such as an OIG report. Providers will have more immediate feedback on the outcome of reviews and CMS will limit document requests based on a provider's compliance with Medicare rules and the types of claims at a facility. For more information, see: [http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/RAC-Program-Improvements.pdf](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/RAC-Program-Improvements.pdf).

**Enforcement**

- **LCSW sentenced to 21 months in prison for role in Medicare fraud scheme**: A Licensed Clinical Social Worker (LCSW) was sentenced to 21 months in prison and 2 years of supervised release for her role in a health care fraud scheme. She was also ordered to pay over $400,000 in restitution. The LCSW created false and misleading medical records that indicated Medicare beneficiaries had received face-to-face psychotherapy when, in fact, no such services had been provided. The owner of the company then prepared false claims for the services and submitted them to Medicare for reimbursement. For more information, see: [http://www.justice.gov/usao-mdla/pr/licensed-clinical-social-worker-sentenced-prison-health-care-fraud-0](http://www.justice.gov/usao-mdla/pr/licensed-clinical-social-worker-sentenced-prison-health-care-fraud-0)

- **Former owner of psychotherapy clinic sentenced for role in $3.3 million Medicare fraud scheme**: The former owner of a psychotherapy clinic in Michigan was sentenced to 87 months in prison and ordered to pay $1.4 million in restitution for submitting false claims to Medicare for purported psychotherapy services. He admitted to causing over $3.3 million in fraudulent claims to be submitted and Medicare paid $1,453,064 for those claims.
The former clinic owner admitted to using the Medicare information and identities of hundreds of Medicare beneficiaries without their consent to submit claims for psychotherapy services that were not actually provided. In addition, he also used personal information of licensed social workers without their consent to obtain Medicare provider numbers in their names, which he then used to submit false claims to Medicare for services purportedly provided by the same social workers. The social workers, however, did not provide the care which was billed. For more information, see: http://www.justice.gov/opa/pr/michigan-psychotherapy-clinic-owner-sentenced-87-months-prison-his-role-33-million-medicare.

• Additional Fraud Convictions Handed Down to Operators of Partial Hospitalization Program: The May/June 2013 and July/August 2013 edition of Compliance Watch reported on the sentencing of several individuals for their roles in a health care fraud scheme at a company that operated four community mental health centers at which partial hospitalization program (PHP) services were available. Additional sentences have recently been handed down in that health care fraud scheme.

Two Miami residents were sentenced to serve 72 months in prison after a November 2014 trial in which both were convicted of conspiracy to commit health care fraud and one was also convicted of two counts of health care fraud. Evidence at trial showed the individuals oversaw the alteration, fabrication and forgery of thousands of documents, including patient medical records, to support the fraudulent claims submitted to Medicare and Medicaid. Many of these medical records were created weeks or months after the patients were admitted to facilities for purported treatment. In addition, the individuals knew that many of the referred patients were ineligible for PHP services because they suffered from mental retardation, dementia and Alzheimer’s disease. For more information, see: http://www.justice.gov/opa/pr/two-miami-residents-sentenced-72-months-prison-their-roles-63-million-medicare-fraud-scheme.

• Physician owners of mental health clinic sentenced in $97 million Medicare fraud scheme: Two physician owners of a Houston-area mental health clinic have been sentenced to 148 months and 120 months respectively for their roles in a $97 million Medicare fraud scheme. They were ordered to pay $8 million in restitution. A group home owner who sent residents to the clinic in exchange for kickbacks was also sentenced to 54 months in prison and was ordered to pay $1.8 million in restitution.

Evidence presented at trial showed that the physician owners signed admission documents and progress notes certifying that patients qualified for PHPs when they did not qualify for or need such services. The physician owners paid kickbacks to group care home operators and patient recruiters for delivering ineligible Medicare beneficiaries to the clinic. In some cases, patients also received a portion of the kickbacks.
The clinic billed Medicare for approximately $97 million in services that were not medically necessary and, in some cases, not provided. For more information, see: [http://www.justice.gov/opa/pr/physician-owners-mental-health-clinic-sentenced-97-million-medicare-fraud-scheme](http://www.justice.gov/opa/pr/physician-owners-mental-health-clinic-sentenced-97-million-medicare-fraud-scheme)

- **Former mental health clinic owner sentenced for role in $3.4 million Medicaid fraud scheme:** The former owner for a purported non-profit Medicaid-approved company providing mental health and mentoring services was sentenced to 30 months in prison for his role in a $3.4 million Medicaid fraud scheme. In addition he will serve three years under court supervision and was ordered to pay $3,153,074 in restitution to Medicaid.

  From in 2007 to 2011, the former owner defrauded Medicaid by submitting false reimbursements to the government program for mental health services that were either provided by unlicensed, non-Medicaid approved individuals, or were never provided at all. The fraudulent claims were submitted using Medicaid provider numbers of at least three licensed clinicians who had performed some work for the clinic. Court records indicate that these clinicians never provided the claimed services and were not aware of the false claims using their provider numbers. The former owner also obtained Medicaid beneficiary information from other organizations and used that information to submit claims for the made-up services.

  Two social workers, formerly employed by the County Department of Social Services, who provided the Medicaid beneficiary information, plead guilty to health care fraud charges and await sentencing. For more information, see: [http://www.fbi.gov/charlotte/press-releases/2015/former-clinic-owner-sentenced-for-role-in-3.4-million-medicaid-fraud-scheme](http://www.fbi.gov/charlotte/press-releases/2015/former-clinic-owner-sentenced-for-role-in-3.4-million-medicaid-fraud-scheme).

- **COO of nonprofit pleads guilty to stealing more than $34,000:** The Chief Operation Officer (COO) of a substance abuse education nonprofit funded primarily by state grants and member dues pled guilty to stealing $34,492 from the organization. She received 10 years of suspended jail time. During her four years with the organization, the COO was the sole monitor of accounts. She opened a debit card linked to the organizational account and drained it over time.

  According to the Board treasurer, the COO reported to the board on the account balance from 2010 to 2013 “and no one questioned her.” In December 2013 the COO reported that there was no money in the account which prompted an audit which uncovered the theft. For more information, see: [http://www.adn.com/article/20150223/former-head-alaska-nonprofit-pleads-guilty-stealing-more-34000](http://www.adn.com/article/20150223/former-head-alaska-nonprofit-pleads-guilty-stealing-more-34000).
• **Updated portal poses heightened risks for reporting HIPAA breaches:** The Office for Civil Rights (OCR) has updated its breach reporting web portal, requesting additional information from entities reporting a HIPAA breach.

Whereas the previous version of the portal was a single web page, the new portal takes users through a series of pages with questions that adapt based upon the type of organization (covered entity, business associate) and the information entered. In the previous version of the portal entering a "breach end date" and a "discovery end date" was optional; those fields are now mandatory.

New questions in the portal now focus more on the actions taken after a breach. Instead of selecting from a list of five general actions taken after a breach (Security and/or Privacy safeguards, mitigation, sanctions and policies and procedures)--the new portal contains 15 more specific options. The additional information will likely make it easier for the Federal Government to identify entities that fail to quickly discover the breach, have insufficient safeguards in place, or take insufficient action to prevent subsequent breaches.

The development of a web portal is also a step toward the start of Phase 2 of the HIPAA Audit Program. Implementation of a web portal through which entities can submit information to OCR was cited as a reason for delaying the scheduled Phase 2 audits in the fall of 2014.

CBHOs should familiarize themselves with the new portal (available here: [https://ocrportal.hhs.gov/ocr/breach/wizard_breach.jsf?faces-redirect=true](https://ocrportal.hhs.gov/ocr/breach/wizard_breach.jsf?faces-redirect=true)) and should update their breach reporting procedures to reflect the new level of detail required when reporting through the portal.

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**Q&A for Compliance**

*Compliance Watch* is pleased to introduce readers to “Q&A for Compliance,” a new, regularly appearing column aimed at answering questions from our readers, identifying available resources and supporting compliance professionals at Community Behavioral Health Organizations (CBHOs) throughout the country.

This first column is aimed at answering reader questions about how and when to screen board members and when to report board composition changes.

**Question:** Our new board members seemed upset and confused about providing the necessary personal information (birth dates, Social Security numbers, etc.) for our payor enrollment applications (Medicare, Medicaid, etc.). How can we best explain why we need this information and how can we collect it in a pain-free fashion?
Answer: If your board members are new to the health care industry, they may not realize that enrollment in Medicare, Medicaid, and CHIP programs requires personal information about the organization’s board members. Consider your board members’ reaction to this request as a learning opportunity for them and a chance for you to talk about compliance at your organization. Some points to consider:

- **Context:** Put the request for personal information in context. Explain to your board members that, as part of the Affordable Care Act, the Centers for Medicare and Medicaid Services (CMS) enacted regulations aimed at the detection and prevention of fraud and abuse in federal and state health care programs. In order to bill Medicare and Medicaid for services provided, your organization must complete enrollment applications that request specific information about the organization. Such information may include:
  - Basic and identifying information about the behavioral health organization (such as the type of providers, type of business entity, licensing information);
  - Adverse legal history;
  - Sites of service; and
  - Information regarding the individuals who manage and control the CBHO, including officers and directors and managing employees, such as the Chief Executive Officer or Executive Director. This information includes, but is not limited to, Social Security numbers, dates and places of birth, and adverse legal history for each director, officer, and managing employee, as well as the date the individual assumed the position of management and control.\(^4\)

As part of revisions made in July 2011, CMS Form 855A requires Medicare enrollment applicants to identify when each director, officer, and managing employee assumed their position of control and provide a description of any services the director, officer, or managing employee renders to the organization under contract.

- **The Messenger:** Consider who delivers the message that board members’ personal information is required for payor enrollment applications. Did they receive an out-of-the-blue email from the Executive Director’s assistant who they have never met? Or, was it explained during the recruitment process that providing such information is a requirement of joining the board and that they should expect to hear from the Compliance Officer? Reactions to requests (especially ones that require the recipient to do or provide something) often go over better when individuals are prepared for the request.

- **Control the Information:** To ensure that the personal information for each director is kept accurate, we recommend that CBHOs maintain an up-to-date file on each director. We recommend that the organization collect the identifying

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\(^4\) CBHOs should review the specific enrollment requirements of their state Medicaid program.
information required for the new directors, in writing, upon their joining the board and on a regular basis (at least annually) thereafter. This task can be carried out by creating a personal information collection form and integrating the information request into another request for information from directors that is collected on a similar schedule, such as a conflict of interest disclosure statement.

The personal information collection forms should state the purpose for collecting the requested information and should inform the directors that the collected information will be stored securely and in a confidential manner. The CBHO then should store the documentation in a secure location.

If your CBHO integrates this process with a conflicts of interest reporting process, be sure to separate the personal information collection form from the conflicts of interest statement. That is because personal identifying information need not be accessible to the board, while conflicts of interest information should be made available to the board as necessary to analyze any potential conflicts. Only the individuals who will require access to the information for the purposes disclosed to the directors (i.e., payor enrollment applications) should have access to the personal identifying information. This will help to ensure that the directors’ information is kept confidential.

**Question:** We just held our board elections and are delighted to have four new directors join our board. Are we required to update the list of board members for Medicaid billing as well as Medicare billing? If so, what are the deadlines for making such updates?

**Answer:** For Medicare, a change of ownership or control must be reported within 30 days of the reportable event.

Medicaid reporting requirements differ by state. CBHOs should check their state requirements about when to report any changes in ownership or control. Any questions should be addressed by qualified legal counsel.

**Question:** Are we required to check our board members against the OIG exclusion lists? If we do screen our board members and find out that they have been excluded, may they still serve on the board?

**Answer:** The OIG has not issued guidance for non-profit health care providers related to checking board members against the exclusion lists. While the OIG’s Special Advisory Bulletin from May 8, 2013\(^5\) includes some discussion about excluded individuals who own a provider and are involved in furnishing billing or administrative services to the provider, there is no discussion of screening volunteer board members at a non-profit organization.

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Under certain provisions of the Social Security Act, an excluded person who "is an officer or managing employee" may be subject to a civil monetary penalty (CMP). A member of a board of directors may also be construed as a managing employee for purposes or as performing administrative functions for which penalties may be assessed against the organization. We recommend that you review the functions and requirements for members of the board of directors and determine whether including an excluded person in the board would violate these sections. Payment prohibition and penalties apply regardless of whether an entity is a for-profit or nonprofit organization.

If your CBHO decides to screen board members against the OIG exclusion lists, remember that the OIG recommends screening on a monthly basis to minimize potential overpayment and CMP liability. The OIG also recommends that providers maintain documentation of the initial name search performed (such as a printed screen-shot showing the results of the name search) and any additional searches conducted. All names used by an individual, including maiden names, should be searched.

For CBHOs that rely on screening conducted by a contractor (vendor, staffing agency, physician group), the OIG recommends validating that the contractor conducting such screenings is not excluded. It is important to note that CBHOs opting for this arrangement remain responsible with regard to CMP liability. Because CBHOs are ultimately liable for overpayments if the CBHO bills for the services furnished by an employee of a contracted entity, the OIG recommends that the provider validate that the contractor is conducting such screening on its behalf. In addition, CBHOs should ensure there are provisions in its contracts with vendors obligating the vendors to perform screening checks of its employees or contractors, maintain documentation of such checks, and that the vendor be liable for any overpayments and fines related to its failure to identify an excluded employee or contractor.

We encourage you to send your questions to Compliance Watch by submitting them to kirstenr@thenationalcouncil.org.

Compliance Matters for Board Members

By: Laura G. Hoffman, Esq., Feldesman Tucker Leifer Fidell LLP

As discussed in previous Compliance Watch articles, the Office of Inspector General (OIG) for the U.S. Department of Health and Human Services expects Boards of Directors of health care entities to play a role in their organization's compliance program. To this end, the OIG

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6 Section 1128A(a)(4)(b).
7 Section 1128a(a)(4).
8 Section 1128a(a)(6).
maintains a Compliance 101 web page, http://oig.hhs.gov/compliance/101, which centralizes many of the OIG’s free educational resources designed to help health care providers and board members understand the health care fraud and abuse laws, as well as the consequences of violating them.

Many of the OIG’s resources aimed at Boards of Directors, however, focus on a board’s fiduciary duties – the duties of care, loyalty, and obedience – to protect the organizations they serve from liabilities and financial loss through the establishment and oversight of a compliance program. While these resources provide valuable guidance to board members regarding the questions of what board members should do and how they should participate in a compliance program, they sometimes gloss over the basic question of why compliance programs matter in the first place.9

Designed for board members of Community Behavioral Health Organizations (CBHOs), this article explains in clear language the need for an effective compliance program. Our hope is that by answering this fundamental question, it will serve as a useful resource for your organization’s board members to review before their annual compliance training or for members of your board’s compliance committee.

**Do You Know the Speed Limit?**

Many board members wonder why compliance programs are needed. To help explain this, let’s imagine three scenarios in which you are driving.

1. First, let’s say you are driving your car around town. Speed limit signs are posted on the side of the road for you to follow. As you drive, the speed limit changes, and you adjust your speed to comply with the law. Should you ignore or fail to notice the speed limit, you may exceed the lawful speed and violate the law. If law enforcement were to see you violate the speed limit, you could be subject to speeding fines or even arrest.

   In this case, the speed limit signs provide you with sufficient information and preparation to ensure that you drive with minimal risk of unknowingly going over the speed limit or suffering the consequences of noncompliance. Moreover, you are familiar with the locations where the police closely monitor traffic speed, so you can pay special attention to your speed in those locations.

2. Now imagine a scenario in which the speed limit signs are not posted on the side of the road, but rather, they are contained in a large atlas. The atlas contains maps for each road, accompanied by the applicable speed limit. If you want to know the speed limit, you must consult the atlas.

9 More information on how a board member should participate in their CBHO’s compliance program may be found in “The Board’s Role in Compliance: Sample Bylaw Provisions Related to Corporate Compliance” from the November/December 2013 issue of Compliance Watch.
How would this impact your driving? No doubt, it would slow you down as you would need to check the atlas before you drove anywhere to determine the lawful speed limit. Hopefully, you would have someone with you who could help check the atlas as you drove. But even with someone to help you, it would be challenging to drive always in compliance with the lawful speed limit and there would be plenty of opportunities for you or your driving companion to inadvertently and unknowingly miss a change in the speed limit.

3. In the last scenario, you are responsible for ensuring that eight of your friends comply with the speed limits as they drive across the country, each of whom is taking a different route. Again, there are no speed limit signs and you must consult the atlas to determine speed limits as in the previous scenario.

To ensure your friends comply with the speed limit laws, you would need to constantly monitor your friends’ specific locations, check the atlas for the applicable speed limit at specific locations, and then communicate changes in the speed limit in a timely manner to each of your friends. This presents many complications and opportunities for noncompliance with the speed limits. Additionally, both you and your friends will be responsible for any speeding violations your friends commit as a result of your instructions.

For CBHOs, operating in compliance with all applicable legal requirements is akin to the third scenario since they are heavily regulated and subject to state, federal, and local laws. This is in part because CBHOs often receive funding from the Federal Government through grants and insurance programs like Medicare and Medicaid, each of which have their own rules for how services may be charged.

Just as in the third scenario described above, CBHOs must exercise a high degree of diligence to ensure that they remain knowledgeable of the various legal requirements, communicate those requirements to the appropriate staff, and ensure that those rules are being followed. Such a level of diligence is the reason that a CBHO needs to implement a compliance program.

What is a Compliance Program?

Let’s take a step back and discuss what compliance really means. “Compliance” is commonly defined as the act or process of complying with a set of laws, rules, and requirements. While almost every health care entity must follow some form of compliance, many have compliance programs in place that are tailored to their organization’s specific needs.

A compliance program formalizes a CBHO’s efforts to comply with laws, rules, and other applicable requirements. It is both proactive – informing staff of the applicable legal requirements and monitoring compliance, and reactive – taking corrective action when required to return the CBHO to compliance and preventing future noncompliance.
To formalize efforts to ensure compliance, a CBHO should adopt a compliance program with the following seven elements:

1. A designated compliance officer
2. Written standards and policies to ensure compliance with all of the applicable legal requirements
3. Effective, clear, open lines of communication to allow for internal reporting of potential compliance issues to the compliance officer
4. Internal monitoring and regular audits to ensure the CBHO’s compliance
5. Training and education programs to ensure that all staff understand the rules that they must follow when performing their job
6. Responsiveness to detected issues through appropriate investigation and corrective action
7. Publicized and enforced disciplinary standards for individuals who do not abide by the CBHO’s established policies, procedures, and other applicable requirements

So, how do CBHOs benefit from maintaining an effective compliance program? In large part, a compliance program helps to avoid serious problems by preventing and detecting issues early and correcting them quickly and effectively.

What are the Rules?

One way to think about a compliance program is as a system designed to ensure that the CBHO plays by the “rules.” But, you may ask, what exactly are the rules? There are many specific legal requirements to consider when developing a compliance program. Below are a few examples, along with how the compliance program benefits patients of CBHOs.

Publicly-Funded Insurance Programs

A compliance program helps a CBHO furnish services to recipients of publicly-funded insurance programs, such as Medicare and Medicaid. For example, claims submitted to government insurance programs for payment must be correctly coded and documented. To be eligible to receive payments on those claims, the CBHO must agree to comply with a complex array of coding and documentation rules.

Grant Funded Programs

A compliance program helps CBHOs participate in a variety of grant-funded health and human service programs administered by municipalities, counties, states, and the Federal Government. For instance, such grants typically impose both programmatic and administrative record-keeping requirements. CBHOs that do not comply with grant requirements can lose the grant funding and forfeit their eligibility for future grant opportunities.
**Patient Privacy**

Having a compliance program helps protect patient privacy by ensuring that the confidentiality of patient records is maintained, except where authorized or required by law. Federal and state laws establish when CBHOs may disclose patient health information to third parties, with limitations for sensitive information such as mental health and substance use disorder services. CBHOs that do not comply with these requirements can be assessed financial penalties and lose the trust of their patients.

**Consequences of Noncompliance**

There are a range of consequences for noncompliance, which can be imposed on the CBHO as a whole or on an individual. Consequences of noncompliance for employees may include warnings, being placed on probation, or termination of employment. In appropriate situations, the CBHO can make referrals to government entities for criminal prosecution. As noted above, the consequences of noncompliance for a CBHO can include the loss of federal funding, loss of licensure, financial penalties, and even criminal prosecution.

Reducing fraud and abuse in public insurance programs is a major objective of health reform. Spending has increased for activities targeted at finding, exposing, and penalizing health care fraud. Among the enforcement laws that have been strengthened over the past few years is the federal False Claims Act. Penalties for violations of the False Claims Act can include fines of up to $11,000 per claim, triple damages, and possible exclusion from federal health care programs.

The OIG and the U.S. Department of Justice have increased enforcement authority to impose financial penalties. In other words, they can fine organizations – including CBHOs – more significantly and for more types of offenses. Finally, the Affordable Care Act established the requirement for providers to return and report overpayments within 60 days, which means that any money the CBHO owes to the government must be promptly returned or it could be considered a violation of the False Claims Act.

**Conclusion**

While investing in an effective compliance program does have its costs, the benefits extend beyond simple compliance with the law. For example, many enforcement agencies are willing to reduce financial penalties for organizations that can demonstrate the implementation of a compliance program, recognizing that even effective compliance programs cannot prevent all compliance issues from occurring.

Moreover, compliance programs help CBHOs to preserve access to behavioral health services. Think about it: if a CBHO loses governmental funding because of noncompliance, that loss of funding may jeopardize the CBHO's ability to provide those services in the future. Therefore, it is very important to the CBHO’s patients and community that the
CBHO has an active and effective compliance program and that everyone in the organization knows about – and participates in – the program.

Board members should bear in mind that their obligation to oversee and evaluate their CBHO’s compliance program does not mean that the board should run the day-to-day operations of the compliance program. Rather, board members should focus their attention on the structure, process, and outcome of the CBHO’s compliance program. This task becomes easier to perform – and perform well – once equipped with an understanding of a compliance program’s purpose.

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Updates in Legal Developments in Joint Recruitment and Retention-Part Two: Stark Law Exceptions

By: Laura G. Hoffman, Esq., Feldesman Tucker Leifer Fidell LLP

CBHOs are all too familiar with the challenges of attracting and retaining psychiatrists on their staff. For one thing, many CBHOs are located in regions of the country with documented psychiatry shortages. Both small, isolated, rural towns as well as crowded, poor, inner cities often face challenges in finding and keeping psychiatrists. These shortages can have a dramatic impact on meeting the behavioral health care needs in many communities.

Although compensation is but one factor of a multi-faceted approach to recruitment and retention, it is a factor with legal ramifications if not done in compliance with applicable federal law and regulations. For example, in some communities, local hospitals have contributed funds to allow a CBHO to make payments to a psychiatrist or to guarantee a certain level of income for a psychiatrist in order to attract or retain a psychiatrist within a community. If not structured properly, such payments could expose both the CBHO and the psychiatrist to liability.

This article is Part Two in Compliance Watch’s series on legal issues that arise in the context of recruitment and retention payment arrangements, including payments made to community behavioral health organizations (CBHOs) by tax-exempt hospitals, focusing on Stark Law exceptions for physician recruitment and retention payments. Part One discussed Internal Revenue Service (IRS) standards for physician recruitment and retention payments; Part Three in this series will discuss the federal Anti-Kickback Statute’s safe harbor for certain physician recruitment arrangements.

The Stark Law
The Stark Law prohibits a physician from making referrals for certain designated health services payable by Medicare or Medicaid to an entity with which the physician (or an immediate family member) has a direct or indirect financial relationship. Unless an exception applies, the physician cannot refer to the entity and the entity cannot bill for the referred services.

In other words, a financial relationship is established under the Stark Law when an entity, such as a hospital, pays recruitment or retention payments either directly to a physician, or indirectly to a CBHO that employs or contracts with a physician. If the physician makes a referral to the entity, such as the hospital, for services payable under Medicare or Medicaid, a violation occurs.

A. The Physician Recruitment Exception of the Stark Law

The Stark Law includes exceptions for employment relationships and personal services arrangements, thereby allowing hospitals to employ or contract with physicians. Those exceptions, however, do not cover payments made by a hospital to a physician who is, or will be, employed or contracted by another entity, such as a CBHO.

The Physician Recruitment Exception applies to payments by a hospital to a physician for the purpose of inducing the physician to relocate to the hospital’s geographic area and become a member of the hospital’s medical staff, and also to payments by a hospital to a physician either indirectly through payments to a CBHO, or directly to a physician employed by or contracted with a CBHO.

10 See 42 U.S.C. § 1395nn. Designated health services are defined to include:
• clinical laboratory services;
• physical, occupational, and speech therapy services;
• radiology and radiation therapy services;
• durable medical equipment and supplies;
• parenteral and enteral nutrients, equipment and supplies;
• prosthetics, orthotics, and prosthetic devices;
• home health services;
• outpatient prescription drugs; or
• inpatient and outpatient hospital services.

11 See 42 U.S.C. §1395nn(e)(2)-(3); 42 C.F.R. §411.357(c)-(d).

12 See 42 U.S.C. § 1395nn(e)(5); 42 C.F.R. § 411.357(e). A hospital’s geographic area is defined as the lowest number of contiguous postal zip codes from which the hospital draws at least 75 percent of its inpatients.

A physician will be deemed to have relocated to the hospital’s geographic area if: (i) the physician has relocated the site of his or her practice a minimum of 25 miles; or (ii) at least 75 percent of the physician’s revenues from services provided by the physician to patients (including services to hospital inpatients) are derived from services provided to new patients.

However, residents and physicians who have been in medical practice less than one year, as well as physicians employed on a full-time basis for at least 2 years immediately prior to the recruitment by (a) a Federal or State bureau of prisons (or similar entity operating at least one correctional facility) to serve a prison population, the Department of Defense or Department of Veterans Affairs to serve active or veteran military personnel and their families, or a facility of the Indian Health Service to serve patients receiving medical care exclusively through the Indian Health Service; and (b) did not maintain a private practice in addition to such full-time employment, will not be considered to have an established practice and will therefore be eligible under the physicians’ recruitment exception regardless of whether the physician actually moved his or her practice location.
**Hospital Recruitment Payments to CBHO Physician**

In the context of CBHOs that employ or contract physicians, the Physician Recruitment Exception requires all nine of the following conditions\(^{13}\) to be met in order to allow hospital-funded recruitment payments to a CBHO’s employed or contracted physician:

1. The arrangement must be in writing, signed by all of the parties – the CBHO, the recruited physician, and the hospital;
2. The arrangement may not be conditioned on the recruited physician referring to the hospital;
3. The recruitment payment must not be based on the value or volume of referrals, or expected referrals, from the recruited physician or CBHO, or other business generated between the parties;
4. The recruited physician must be allowed to establish privileges at other hospitals and refer to other facilities;
5. All of the recruitment payment must remain with or pass through to the recruited physician except for the actual costs incurred by the CBHO in recruiting the new physician;
6. In the case of income guarantees, only the actual incremental costs attributable to the recruited physician may be allocated by the CBHO to the new physician;
7. Records of the costs, and passed through amounts, must be kept for five years, and made available to the U.S. Department of Health and Human Services upon request;
8. The CBHO may not impose any additional practice restrictions on the recruited physician, other than those relating to quality of care; and
9. The arrangement may not violate the Federal Anti-Kickback Statute, or any federal or state law or regulation governing billing or claims submission.

If *all* of the above conditions have been met, then a hospital may:

- Make an indirect payment to a physician, by way of the CBHO passing payment from the hospital to the recruited physician, or
- Make a direct payment to a recruited physician who contracts with, or is employed by, a CBHO.

**B. The Physician Retention Exception of the Stark Law**

When determining the geographic service area of rural hospitals, (1) zip codes may in some cases be noncontiguous and (2) at least 90 percent of inpatients must be drawn from this area. The Secretary of the U.S. Department of Health and Human Services (HHS) may also issue an advisory opinion under 42 U.S.C. §1395nn(g)(6) deeming that the physician does not have an established medical practice that serves or could serve a significant number of patients who are or could become patients of the recruiting hospital, thereby exempting the recruited physician from the relocation requirement.

\(^{13}\) See 42 C.F.R. § 411.357(e). Note that the exception applies to federally-qualified health centers (FQHCs) and rural health centers in the same way as it does to hospitals provided that the arrangement does not violate the anti-kickback statute or any Federal or State law or regulation governing billing or claims submission.
To assist hospitals and other entities in certain rural and inner city areas in retaining sufficient numbers of qualified physicians in the community, the Stark Law regulations also include an exception for retention payments made by hospitals to physicians who practice in a rural area or Health Professional Shortage Area (“HPSA”), or where at least 75 percent of the physician’s patients reside in a medically underserved area or are members of a medically underserved population.  

*Hospital Retention Payments to Physicians*

To qualify for this exception, a physician must have a bona fide written recruitment or employment offer or must provide a written certification that he or she has received a bona fide opportunity for future employment, as explained below.

**Bona Fide Written Offer.** A physician must first have a bona fide firm written recruitment offer from another hospital, FQHC, rural health clinic, academic medical center, or physician organization. The offer must specify the amount of remuneration, and require the physician to relocate from a location that is at least 25 miles outside of the geographic location served by the hospital making the retention payment and outside of the geographic area serviced by the hospital making the retention payment. The retention payment is subject to the same obligations and restrictions on repayment or forgiveness as contained in the offer. Finally, the retention payment may not exceed the lower of (a) the amount obtained by subtracting the physician’s current income from the offer, or (b) the reasonable costs the hospital would have to expend to recruit a new physician to replace the retained physician.

**Written Certification from Physician.** A physician must provide a written certification of bona fide employment from another hospital, FQHC, rural health clinic, academic medical center, or physician organization that would require the physician to move his or her practice at least 25 miles and outside of the geographic area served by the hospital making the retention payment. The certification must contain the following information:

- **Details regarding the steps taken by the physician to effectuate the opportunity;**
- **Details of the physician’s employment opportunity, including the identity and location of the physician’s future employer or employment location or both, and the anticipated income and benefits (or a range thereof);**
- **A statement that the future employer is not related to the hospital making the payment;**
- **The date on which the physician anticipates relocating his or her medical practice outside of the geographic area serviced by the hospital; and**
- **Information sufficient for the hospital to verify the information included in the written certification.**

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14 See 42 C.F.R. § 411.357(t). This exception applies to FQHCs and rural health centers in the same way as it does to hospitals.
In addition, the hospital must take reasonable steps to verify the physician’s opportunity.

Finally, the retention payment made by the hospital may not exceed the lower of (a) 25 percent of the physician’s current income,\textsuperscript{15} or (b) the reasonable costs the hospital would have to expend to recruit a new physician.

If the physician qualifies for a retention payment under this exception, the retention payment must meet the same first four requirements of the physician recruitment exception, namely:

- The retention payment arrangement must be in writing and signed by the parties;
- The payment may not be conditioned on the retained physician referring to the hospital;
- The payment may not be based on the value or volume of referrals; and
- The retained physician must be allowed to establish privileges and refer to other hospitals.

Further, a hospital providing the remuneration may not enter into a retention arrangement with a physician any more frequently than once every five years and the terms of the retention payment may not be altered during the term of the arrangement in any manner that takes into account the volume or value of referrals or other business generated by the physician for the hospital. In addition, the arrangement may not violate the Federal Anti-Kickback Statute or any federal or state law or regulation governing billing or claims submission.

**Conclusion**

Recruitment and retention payments can be an effective tool to successfully recruit and retain physicians to practice within a geographic community served by a CBHO. However, when a hospital funds the recruitment or retention payment, it can raise legal issues under the Stark Law. As a guard against placing the hospital, CBHO, and/or physician in violation of applicable federal laws and regulations, CBHOs should:

- Instruct legal counsel to review recruitment or retention payment arrangements for compliance with the Stark Law.
- Ensure that its recruitment and retention payments to physicians (in addition to other staff) are reasonable and comply with the CBHO’s own compensation policies and procedures.

\textsuperscript{15} The amount must be measured over no more than a 24-month period using a reasonable and consistent methodology that is calculated uniformly.
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