

CAPITOL ASSOCIATES

**Moderator: Bill Finerfrock
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Operator: Good day ladies and gentlemen and welcome to today's Establishing a Compliance Program for your Rural Health Plan conference call.

Today's conference is being recorded.

At this time it is my pleasure to turn the conference over to your host Mr. Bill Finerfrock. Please go ahead sir.

Bill Finerfrock: Thank you Operator and I want to welcome everyone to today's Rural Health Clinic teleconference call on Establishing a Compliance Program for your RHC.

My name is Bill Finerfrock and I'm the Executive Director of the National Association of Rural Health Clinics and I'm the moderator for today's call.

Our speaker today is Holly Louie. Holly is a Certified Healthcare Billing Management Executive and she serves as the Corporate Compliance Officer with Practice Management, Incorporated out of Boise, Idaho and she's also on the Board of Directors of the Healthcare Billing and Management Association and she's a former Chair of their Compliance Committee.

She's a nationally recognized expert on compliance programs. And today she's going to talk with you about - for about 45 minutes and then we're going to open it up for questions at the end on Establishing a Compliance Program for your RHC.

I want to remind everyone that this series is sponsored by the Health Resources and Services Administration, Federal Office of Rural Health Policy in conjunction with the national Association of Rural Health Clinics. And the purpose of this series is to provide RHC staff with valuable technical assistance and RHC specific information.

Today's call is the 49th in the series which began in late 2004 and during that time we've been - had over 13,000 combined participants on these bimonthly national teleconference calls. As you all know there's no charge to participate. We encourage you to refer others who might benefit from the information to sign up to receive the announcements regarding dates, topics and speaker presentations. You can get that information at the web site www.hrsa.gov/ruralhealth/policy/confcall/index.html.

And then during the Q&A period today we do ask that you identify yourself by name, city and the state that you're calling from.

In the future if you have some ideas for topics please send those to info@nrhc.org and put RHCTA topic or if you have questions in the future put RHCTA question in the subject line.

Again I want to thank you for all joining us today. And at this point I'd like to turn over control of our presentation to our speaker, Holly Louie. Holly the time is yours.

Holly Louie: Thank you Bill. I do have one question for you before we start. If any of our listeners are having a difficult time hearing is there any way for them to let us know that so I'm sure I'm speaking loudly enough?

Bill Finerfrock: I think the Operator can control that. You're coming through here loud and clear and I'm hearing with everybody else so...

Holly Louie: Okay.

Bill Finerfrock: ...if you and I - we can alert you if there's a problem. But I think everything sounds good.

Holly Louie: Awesome, thank you. Thank you for the opportunity to speak with all of you today.

What I really want to try to focus on is what is an effective Compliance Plan and the reason for that is it's a very mature environment now from an enforcement and an analysis perspective.

And that seems to be the area where many plans fall a little short and so we're going to focus on how to make sure your plan is effective and some tools and tips to help you with that.

So if we wanted to start right on Slide 3, the things we're going to cover today are the history of compliance, the Federal Sentencing Guidelines and the changes and how those impact all of our plans, what are today's expectations for mature plans and accountability and when things go wrong why do they go wrong.

And then some best practices that the industry is learning and continuing to expand upon that will help you.

On Slide 4 I wanted to mention this just because it is a very important change. The Patient Protection and Affordable Care Act actually makes Compliance Plans mandatory. They've always historically been referred to as guidelines by the OIG, best practices or other terminology but they are now absolutely required.

In addition some states are requiring Compliance Plans in order to participate with the Medicaid Programs. New York is a specific example of that.

So it really behooves us to understand what our states are doing and what the federal government is doing and also to understand it does not just apply to Medicare and Medicaid plans. The commercial payers are to be treated just as diligently in our compliance efforts as the federal programs are.

And the other thing that's become more and more obvious is "knew or should have known" That threshold bar we've always heard about has been very much lowered. It is almost impossible now to defend a failure by saying I didn't know about it or there was no way I knew about it because the perspective now is everybody knows or should know. And there's no excuse for not.

On Slide 5 I just started a very brief recap of the Federal Sentencing Guidelines and the core chapter for that, Chapter 8 is in your handouts that you can review at your convenience.

But basically Congress passed the Sentencing Reform Act in 1984 and the purpose was just to establish policies and standards to enlist organizations in the fight against fraud and abuse. Although they're called guidelines, again that's sort of a misnomer because they really are what are used in any sentencing for someone who has been convicted under the Civil False Claims Act.

So although they're called guidelines they mandate exactly what the federal judges will determine if there is a failure in a compliance effort.

On Slide 6 how do they affect you and why should you care is a common question we get but basically it outlines exactly how fines and sentencing occur linked one-to-one with Compliance Program requirements.

So there is a very close correlation between what we do and what the seven required elements are that we will talk about in just a moment. And if you do not have those things in place, how you will be judged in a worst case scenario.

On Slide 7, I wanted to remind everybody what the seven basic elements are and I want to stress that these are not unique to rural health, to hospitals, to physicians, to laboratories. The same seven core elements appear in every compliance guidance.

And so those are considered to be the benchmarks that everybody should have in place and then you expand upon them and customize them.

So written policies and procedures and standards of conduct, having somebody in a high level authority position who is charged with the overall oversight, implementation and monitoring of the Compliance Program, education and training. And that is for every single person in the organization from the Board of Directors all the way down to the lowest level employee in your facility. Every single one of them must have compliance training.

How you communicate compliance things is very important. There needs to be an effective means to share that information with again every single person in the organization. Enforcement and discipline is also required. That does not mean it all has to be punitive in the sense some people think about it. But it needs to be effective to educate people, do remedial training, and in some cases termination. But it must fit the crime so to speak.

Auditing and monitoring are really the hallmarks of your compliance plan. It's your benchmark. It's your measuring stick. It's how you know what you're doing is working.

And then the other thing that became very important with the changes in the Federal Sentencing Guidelines is the culture of ethical behavior is now considered required. That's sort of a squishy thing to define sometimes but they are really looking to see do all of your employees and does your organization focus on ethical proper behavior or is it just trying to find a way to circumvent the rules it doesn't like.

And the last thing that is now becoming much more prevalent is accountability of the people in charge. We saw that with Sarbanes-Oxley. The OIG has published a document for Boards of Directors and their responsibilities.

But certainly the fact that you - the higher level position you have in the organization the more you're personally accountable.

So we're going to talk more about that in detail later in this program today.

On Slide 8 I just gave a very brief recap under the Federal Sentencing Guidelines. It's a mathematical formula as we talked about to calculate fines or penalties. Even if you're perfect you don't get a zero to start with under these guidelines. You have points against you right from the outset.

Then if you have effective Compliance Program components or efforts you can have points taken away to lower your culpability score. If you have failures it will definitely raise your culpability score.

So that is where these astronomical fines come into play because you can have double damages, trouble damages, etcetera. And depending on how many points you accumulate will determine the final outcome there.

In addition the Federal Sentencing Guideline changes looked at the size of the organization. So the bigger the organization the more risk you have. The more that management were involved or knew or should have known or were willfully ignorant of a problem the more liability you have.

So they've made it very, very clear that the people in charge do have personal as well as corporate accountability to make sure that things are done correctly.

So on Slide 9 let's talk a little bit about your risk areas. And one of the things I want to stress today is I know before we started this call we had 100 plus listeners.

And none of you are going to have the same compliance plan. And I think that's an important concept. Although there are common risk areas some of which we'll discuss, your individual organizations are all unique. Therefore your risks are unique and your problems are unique and how you solve them is unique.

So it is just absolutely critically important that your plans and your programs are customized to you. You can't really borrow from each other or just pick an off the shelf product online and think you're going to have an effective program.

As we've said it about hospitals, physicians, we'll say the same thing about Rural Health Clinics. If you've seen one you've seen one.

So please keep that in mind and make sure as we talk about this today and as you go back and reassess where you are that you're looking for that customization. It means it really fits your particular organization or clinic.

On Slide 10 I just went through the OIG guidance's and pulled out some of the common risk areas that appear in virtually every publication there is.

Failure to timely refund credit balances is always on the list. Obviously federal law is changing. There's a 60 day window for some things. Cost reporting I understand is very different than that.

But depending on how you're doing your reporting you just need to make sure your credit balances are handled for all payers promptly and correctly.

System integrity, not only from the concept of the security and protection under HIPAA-HITECH but also just that the system is protected from other errors that could cause Compliance Program problems; incorrect programming that automatically codes that aren't correct. Improper provider numbers, things like that should be vetted and carefully reassessed to make sure that they're all accurate.

Coding of course is always on the hit parade. I don't think a day goes by we don't see something about somebody's coding being incorrect.

So what mechanism you use to verify your coding is very important.

Obviously provider numbers and one of the things that are seen - excuse me, is seen and periodically that crops up is a particular provider, physician for example doesn't have their enrollment completed yet. They don't have numbers set up yet. They haven't been approved yet. So you just bill under somebody else who does and that's the path to disaster.

Place of service, again it says there's payment differentials attached to that. That's a big deal.

And one of the newest things I think that we're experiencing more and more, if any of you saw the article in the New York Times this week it discussed it. But it's electronic health records which most institutions have adopted or are in the process of doing so. Many, many physicians have adopted or in the process of doing so.

And some of them create an incredible amount of risk. They - the software will let you prepopulate notes before the patient is there. And we're actually seeing issues where entire records are created and the patient never came or they copy and carry forward what are supposed to be normal templates and there's no proper modifications made to those to customize them to the patient in the visit, in the encounter.

So EHRs while on the one hand they are believed to be something that eventually will help patient care and interoperability and lower costs, right now that's really not the

case. And so if you have or are implementing EHR products it would behoove you to scrutinize those with extreme care and due diligence to make sure that they don't cause you to incorrectly bill for services not provided through the reliance on the EHR to solve your problems in coding and billing.

On Slide 11 just talk a bit about the OIG guidance which CMS, OIG, DOJ, most of the organizations say are the best practices that we all should be following and be familiar with.

1998 was the first hospital guidance. It was revised in 2005. For Billing Services, their guidance came in '98, and Physicians in 2000. There's many more, as I articulated. And the fact that there may not be one specific to Rural Health really is okay, because all of the guidances, as we said, have the same basic elements and all of them cover issues that have arisen and give you very good instructions on how to deal with it.

In particular, the revised Hospital guidance that was published in 2005 has excellent recommendations on effective auditing and monitoring, effective program implementation, and anyone can use any of the guidances to help in their own programs and requirements. And I would really encourage you to use the footnotes, because that's where all the meat of these programs lies.

So on slide 12, what are the expectations of effective Compliance in today's environment? Well, obviously prevention. Prevention is absolutely - the number one goal is to avoid having a problem to begin with.

If you do have a problem, you want it to be rapidly identified through your auditing and monitoring processes so that it is not a pattern and it does not continue for any period of time before it's discovered and can be promptly dealt with.

If you do find a problem, it obviously needs to be corrected right away. And what steps should be given due care? Well, you know, you may need to involve your Legal counsel. The - are there overpayments involved? Your situation may be different than if there aren't any overpayments affiliated with an error. How long has it been going on? Was it intentional? Was it not intentional? But each of those things need to be dealt with carefully.

The other thing that always needs to be given due care in consultation with qualified legal counsel is if you have had an overpayment, you must be very careful about, "We're just going to fix it and go forward," rather than make the appropriate repayments or corrections retrospectively.

That could be deemed an effort to deliberately mislead or be non-compliant. So again, you just need to be very careful in the decisions you make if a problem is identified.

Compliance now is specific that it means all laws, rules, regulations and statutes, not simply the Federal ones. And depending on your particular jurisdiction, in some cases, courts have ruled that payer policy also carries the weight of law. So you need to be very familiar with your payer coverage policies and what they expect from those.

Again, Compliance should be embedded in every single job description, and it should be particularly heavily embedded in your management role job descriptions and require knowledge and expertise of them.

Slide 13 is just a few more expectations -- that the education is done for every single level in the organization. So you don't want to fall under the category of some organizations who have said, "Well, we only need to educate this group of people. We don't need to educate this other group of people."

And that's not acceptable. Every single person needs to be educated. And it can be different, because your managers don't need exactly the same education as a nurse and a nurse doesn't need exactly the same education as the board. So it needs to be customized to fit their role in your organization or clinic and what their responsibilities are, but it does need to include every single person.

Most of the Compliance guidance does spell out that this should be at least annual, it should be for all new hires within X days of hire, and it should be ongoing if problems are discovered.

So it's not a once a year thing where everybody gets together and sits there with glazed over eyes for a full day and call it 'Compliance Education.' It should be something that's happening every day all day.

The other change is back at the infancy of Compliance programs. People did a risk assessment generally at the start and then moved on. And that's no longer okay. Risk assessments are to be repeated on a recurrent basis at least annually.

And that really does make sense, because things are changing so rapidly in every organization, in every clinic, in every practice. But something that was done two years/three years/ten years ago is clearly not going to be relevant now.

So that is the other thing, that if you don't have ongoing risk assessments, that's something that you should investigate how you can implement that effectively as soon as you can, so you can get a reassessment of where you are.

We talked a bit about knew or should have known, but the other thing I want to talk about is false claims. Historically a false claim meant exactly that -- it was a claim for payment that was submitted incorrectly.

It doesn't necessarily mean that anymore under the changes in the Federal guidelines. It is actually any misrepresentation that leads to a payment. So it could be an enrollment error, it could be any number of things. You don't have to receive payment to have had a false claim.

So it just expands the definition greatly of what could be considered a false claim, and it doesn't require a claim and it doesn't require a payment. So just keep that in mind as you look at your risk areas.

On slide 14, this - I wanted to include this about bonus points for a Compliance plan in the mature environment. This was a presentation for the Healthcare Compliance

Association by an AUSA attorney who was talking about what he is investigating now, what he is bringing charges for now, what he's referring other cases to other agencies for now.

And this is just sort of the perspective across the board of -- there is so much out there now. Compliance has been known for so long that they really are looking at you to have a very complex and effective plan and procedures in place now, much more so than they did several years ago.

The other thing he stressed is, it is not a book. It's not some document you can whip off a shelf. Of course there is documentation and most of us have a documented Compliance plan.

Most of us have documented policies and procedures. And those are still necessary, but that isn't your plan. That is merely documenting what you're doing and gives you a benchmark to measure against.

It's also not a check-off list. So you can't say, "Yes, I checked my policies and procedures this year. I'm done." It's - that's just another tool to help you make your plan effective. But one of the things that I think is important to know is a Compliance plan does not equal an effective Compliance plan.

And so if you sort of viewed it as, "Well, it's that document, or that binder, or that person," I would just encourage you to reassess that. Your Compliance plan is every one of your people doing their job every day and how they do it.

So bringing that perspective really helps you assess your effectiveness much better. The other thing I think it's critically important to stress is, if it is a problem in your organization you just really need to be incredibly aggressive about fixing it quickly and sharing the knowledge, sharing the education, sharing the information with your employees.

I wish I could see everybody on this call, because I'd like to ask everyone who employs anybody like slide 15 -- a long term employee, not a spring chicken, generally a recognized leader, a manager, a supervisor -- somebody who is just the backbone of your organization and considered very trustworthy.

The bad news about that is, that is a typical whistleblower. And these are the people who eventually -- because they could not successfully get resolution to concerns within the organization -- have decided to take it to an enforcement agency because nobody would deal with it in-house.

The magnitude of Qui Tam cases or whistleblower cases now is virtually almost every Federal case. The numbers are extremely large on slide 16, predominantly because of the Pharmaceutical industry problems.

But I think the statistics are more telling just that virtually everything the Federal government is going after now is low-hanging fruit because a Qui Tam Relator has brought the case to their attention.

The U.S. Attorney I mentioned a couple slides ago said that in the last two years, every - 100% of the cases that his office has handled have been whistleblower cases.

He also said that these are not retaliatory or false accusations or accusations without merit. These are people who really have significant issues they've identified and most of them have tried for at least one to two years to resolve it in-house before they went outside for help.

So I think it's important for us to recognize our employees do know what's going on in our organization, they know of things that concern them, and we need to have that open dialogue with them going all the time so that we're aware of what their concerns are and we can look at them and address them.

The other -- on slide 17, a couple of other points. If you go to the Federal Sentencing Commission Web site, they publish all kinds of statistics. And one of the things that leaps out at me every time are - it is rare that organizations who are sentenced under the Federal sentencing guidelines were given any culpability points off or deducted because they had an effective Compliance program.

So that seems to raise a big red flag. Why - how could that be, given the number of organizations they look at? And one might say, "Well, they're only seeing the really bad apples. They're only seeing the fraud factories." But I'm not convinced that is true.

Prosecutors have acknowledged in the vast majority of successful prosecutions the organizations and the entities did have a Compliance program and they had people designated, and they had spent time and they had spent money.

So what happened? Why did the wheels come off? Why did it fail? And that's what I'm going to move to now. I think it's always good to learn from what other people have experienced and the best practices that they're telling us.

So let's go to the next slide -- slide 18 -- and talk about the commonalities that both the prosecuting agencies, as well as the defense attorneys, have said are virtually guaranteed to be present when a problem arises.

One, which we talked about a little bit, is there is a plan, but it's just a document. It isn't executed, it is not living/breathing, the employees don't relate to it, and so it really is just a piece of paper. It isn't anything that's in the fabric of the organization.

The next problem is that we rely on what we build to happen the way we thought it should. But if we really look at that for any organization, or a clinic, or a hospital, or a physician practice, what all has changed since we developed our plan?

How many rules or regs have changed? How much employee turnover has there been, or employees now in different positions within the organization? Have we put in new systems? Have we added new services? Have we added new providers? What payer policies have been published since then?

All of those things have to be reviewed regularly. So relying upon what we thought was going to happen rarely will be successful. So we just need to re-look at everything from

ground zero and say, "Okay, here's what we said would happen. What all has changed? Therefore, what needs to change to match that?"

On slide 19, the next is Culture Overrides Intent. One of the things I do in part of my professional life is work for attorneys defending physicians, or institutions, or organizations, or hospitals, or clinics, who have been accused in fraud and abuse cases to try to defend them.

And I will tell you this is the number one problem, is culture. Everybody in Management and Leadership says, "Yes, here's what we do," but when you sit with the employees, that's not what they do.

They act differently, they follow different rules, they find workarounds -- many times, the employees will say, "Well yes I know what the plan says, but that's not really what my management wants me to do."

So you need to be very cognizant of the message that your employees believe they have received relative to your Compliance programs. Do they look at it that if they raise a concern or issue that you welcome that? Do you reward that if they raise things that come to your attention?

Whether they're right or whether they're wrong doesn't really matter. You want to reward the fact that they feel comfortable bringing concerns to you. And what do they really understand about Compliance related to their job?

One of the biggest things I've learned -- if nothing else -- is that sticky notes and cheat sheets need to be banned because they become out-of-date and employees live and die by them.

And the next thing you know, you've got a bunch of people doing something wrong because they're relying on a sticky note that's 10 years old. So how they contribute and how they understand is just critically important.

On slide 20, the next problem that seems pretty prevalent in organizations that have had a problem is employees and management are not on the same page at all.

Employees will say I've never had compliance training or I have to go once a go or no, I'm not going to my manager, they embarrass me, they yell at me, they humiliate me, they don't care.

And I think part of that is our fault as compliance people because we need to make the connection for employees between operations and compliance and we don't do that well. So when we're asking them to handle situations a specific way we need to explain to them, to educate them, that yes, this is operations, but this is compliance! So I think that is another really important facet to make.

Some other comments on Slide 21 that employees - they feel they haven't been taken seriously, that they're demeaned, that they're degraded and anytime you have a manager that makes employees feel that way you need to deal with your manager.

They're either in the wrong role or you've put them in a position that they're not trained to fulfill.

On 22 we talked about ((inaudible)) and some of the things that I think we can do much better is when an employee does raise a concern, no matter what it is, we need to give them feedback, they were right and here's what we did about it. They were wrong and here's why they were wrong and we're going to change this and they're going to see it.

They need to understand that their concerns are taken seriously and they need to see what you did with it and I think that's an important step that's often overlooked especially if management decides the concern wasn't really valid and they don't need to deal with it, the employee doesn't get that education so they understand why it really wasn't a problem.

On Slide 23 I thought this quote was interesting from both defense attorneys and prosecutors. Middle managers "in particular" are the problem failures in organizations for compliance. I will tell you I think that is 100% accurate and I think sometimes the fault lies with administration because they promote up and they don't give the person that they promoted up the tools to succeed so they haven't given them education in what are compliance concerns, they haven't given them resources to know the rules and regulations that they're having to now assess and evaluate, they don't have the time to do the auditing and monitoring, nobody is reviewing their work to see if it's where they should be and nobody looks at it in a big picture perspective where different departments become very competitive with each other and they don't want to share information because there's a little power struggle going on.

So I think we need to focus a lot on our management team.

On Slide 24 business priorities are the next. I don't think any rural health clinic or organization, most hospitals, even most physician offices right now are rolling in cash that they can spend on things. So it is important now - there is cost to compliance and a lot of resources are really free, they're online, they're available, but you do have to dedicate the time and the people and the work to implement it effectively.

So that's something else to look at is if it always loses the resource battle, you can't have an effective compliance program.

Slide 25, we see this a lot of times. You're wearing ten hats and you're trying to be a manager and a supervisor and a working supervisor and doing payroll and, and, and... So just keep in mind that we need to have people who are doing compliance roles who have the time and the resources to do them effectively and nobody can be all things to all people. So if you've got inadequate resources allocated, that's an important time to relook at what you've done and how can you improve that or change that?

Slide 26, I think it never hurts to go back and look at what we've built, to relook at compliance as a blueprint or a game plan because if we look at it as a blueprint, blueprints don't change. You built - you've planned it and you've built it and you're done and that is not what compliance plans are. They're extremely dynamic and everyday is a new day and everyday you have to be tweaking things and everyday you have to be

able to prove what you changed, why you changed it and how it worked. So, if there's one takeaway here I think it's to think dynamic, not static, as far as our plans go.

Slide 27, the next issue that arose is failure to prevent violations. And if you have a problem and it's a pattern and it's gone on before you found it, why is that? Was auditing and monitoring not done at all? Was it not done correctly? Was it done at the wrong point in the process to find the problem? You don't really know what your risk areas are because you haven't done your ongoing risk assessments and therefore you're not looking at the right things that are your areas you should be addressing. And how do you monitor compliance with all of your policies and procedures? If you said you did it, are you doing it and how do you know you're doing it?

On Slide 28 education is always a challenge. You want it to be fresh, you want it to be new, you want it to be helpful, you want people to really learn and as I've gotten smarter in my old age, I've really moved away from monster annual training, we do annual training but its maybe four hours instead of eight and we do mini sessions all throughout the year and you can make it fun! There are things like Jeopardy games where you can write your own questions and divide people up in teams, they can compete with each other. There's just all kinds of creative ways to make education fun where people feel more engaged and hopefully will retain more of it.

Slide 29, what are your best practices? Some things that have been pointed out that all organizations should do to learn about best practices are read the OIG Guidance's. Look at some of the Corporate Integrity Agreements, see what they say, look at some of the settlements with the government and see what went wrong and what you said you should do to fix it. Read the OIG Annual Work Plan, what are they targeting?

Look at your payer Web sites they generally will publish their probe reviews, their audit reviews. Look at the (RAC) Web sites and what they're targeting and you can look at contractors outside of just your jurisdiction because sometimes another contractor may have far more valuable information published that you can learn from. So those are good ways to reassess where you are.

On Slide 30 the next problem is when you do find a problem you don't want to deal with it. It's going to be too big, it might cost too much, you don't have the resources. Maybe if you ignore it, it'll go away? But once you've known, identified, you should have known there was an issue, time is really of the essence that you can demonstrate that you were very aggressive about investigating it, correcting it and prevent it from reoccurring.

And an important step there too is to prevent it from reoccurring. What happened that allowed this to occur in the first place and how do you make sure that not only this problem but another similar problem won't happen again in the future?

Slide 31, I again just want to stress if you have the wrong people in charge of compliance your compliance plan is going to fail. So who are the right people? On the next slide you need people who pay attention all the time. You need people who can draw a line in the sand and hold it and I don't mean that they're ugly, they're adversarial, they're cruel but they have to be able to hold the line when it needs to be held. They need to be inclusive. Every person in the organization should feel comfortable going to

them, talking to them, asking questions of them and they should include all the people not try to hold it in their office and make it top secret.

They should focus on ethics. Ethical behavior will guide compliant practices and they have to be high level, one of the mistakes some organizations make is just appoint any one body to be the compliance person and if they hate people and they hate research and they hate speaking in front of somebody and they don't like detail work they're not the best person to put in this job. And if their personality is they want everybody to like them all the time, they're not the right person for this job.

On Slide 33 I thought this was an interesting quotation. It was (Kirk Ogrosky) who, for those of you who don't know him, did lead the HEAT Initiative, the Strike Forces, for CMS and FBI, that big taskforce, but his perspective now that he's on our side of goodness and light and defending physicians and hospitals and entities is that it's not a matter anymore of when, I mean, excuse me, if, it is a matter of how soon you're going to be involved in a false claims case and so you need to be very proactive to ensure that won't happen.

Other pearls of wisdom are what a defense attorney might be able to argue in a worst-case scenario should not be the crux of your compliance plan. You don't want to build something based on the premise that, well, if we absolutely had to I think we might be able to defend this.

So, we have seen that as a strategy at some institutions and it universally has led to failure. In other best practices - some of these are in your handout but I've also given you some Web sites, the OIG is doing a phenomenal job of uploading little clips, they're pretty short, five to ten minutes roughly, some different perspectives on effective compliance plans and educational material and tools. They're very, very good. I would encourage you to take a look at those Webinars.

CMS, if you weren't aware, also has certification now for Part A and Part B. It is free online and all of your employees can work through this at their own speed and print off the proof of completion and that's another excellent tool that keeps the dollar. Free is about as good as you can get and it is a good thing!

And as much as possible I would encourage you to take advantage of open door forums and some of the other calls that are relevant to your practices and your institutions. Again, they're free and they're good learning tools and I would subscribe to every contractor Web site. They have free emails, notifications, bulletins and you can glean a lot that will be helpful to use from that.

The next thing is I would say, set a clock! We all change our batteries in our smoke alarms or smoke detectors with Daylight Savings Time, I guess except for Arizona so you'll have to set a separate clock, but come back and visit your plan at least once a year, preferably more, so that it doesn't get stale and it's always up-to-date, all the time.

And then on Slide 37 you want to focus on your weak spots. Up the ante for management, if they want to be a manager they're going to have to step up and they're going to have to learn these things and they're going to have to make a time and a work investment to be your eyes and ears on the ground in the trenches, so to speak,

because you can't be everywhere and they're the ones that are responsible for how employees are doing their work everyday and making sure that compliance is embedded into the fabric of your organization.

I think we've covered pretty much Slide 38; just reminders that it is at the work level, it is not at the on-the-shelf level. So, I think this completes the presentation so, Bill, I guess we can take questions now or any points that need clarified.

Bill Finerfrock: Operator, do you want to give the instructions for people who want to ask questions?

Operator: Absolutely. If you would like to ask a question please signal by pressing Star 1 on your telephone keypad. If you are using a speakerphone please make sure your mute function is turned off to allow your signal to reach our equipment.

Please be aware that a voice prompt on your phone line will indicate when your line is open. At that point we ask that you please state your name and your city, state location before posing your questions.

Once again, that is star then 1 to be placed in the queue and we'll pause for just a moment.

Bill Finerfrock: While we're waiting for folks to line up we did get a question or two ahead of time and start out with those and in this particular case it's an individual who's with a provider-based Rural Health Clinic and they were wondering, they said they have three provider-based RHC's and that the compliance program for the Rural Health Clinic should be the same as the hospitals compliance program covering the clinics and the hospitals all under one program or should there be a separate compliance manual for the RHC's and one for the hospital rather than the entire system?

Holly Louie: Well, what I would say to that person is, you're going to hate this answer, but it depends. If the employees are all employed by one entity and if all the systems are identical and if all of the operational functions are identical then one plan is probably sufficient.

If there are differences though and nuances between the clinics and the hospital then they should have their own customized plans that fit exactly what they are doing. One of the biggest mistakes to make is to try to adopt a plan that isn't customized for you and make it work.

So for them I guess they would have to evaluate how much difference there is among the clinics and the hospital and then customize accordingly.

Bill Finerfrock: Okay. All right, one of the issues you addressed was the designation of a compliance officer and I think you spoke about it but could you talk a little bit more, should this be necessarily a dedicated individual? I think for a lot of our smaller Rural Health Clinics for example, they might find it difficult to justify having a compliance officer. Or is it someone who it can be one of several hats they might wear?

Or should they look to go outside and retain someone outside who might serve as their compliance officer?

Holly Louie: Well again I think customization is the key. I'll kind of go last first.

You can have an outside compliance expert maybe to assist you with specific questions. But in my experience typically that's not the ideal situation.

Because you need somebody who is there every day. You need somebody that the employees have access to every day.

You need somebody who knows that clinic or facility inside out, backwards and forwards. And usually that's not going to be an external person.

They're better serving in a specific question or specific issue capacity maybe to help you. As far as does it have to be full time?

No as long as however you structure it they are able to successfully do the things that are necessary to make an effective compliance plan operational. So it is scalable like many things.

So I think you just need to be careful about having them wear so many hats that compliance always takes a backseat and those things don't get done.

Bill Finerfrock: Right.

Holly Louie: You can have more than one compliance designated person. Or they could have a compliance committee where they delegate specific tasks to other people to help with.

Any of those ways of doing it are completely okay.

Bill Finerfrock: Right. Operator do we have some questions?

Operator: We do. We'll go to our first caller.

Bill Finerfrock: Go ahead caller if you would identify your name and where you're calling from?

(Diane Condin): My name is (Diane Condin). I'm calling from Osage, Iowa. Holly if you were to put together a new compliance committee what departments would sit around the table or what positions would sit around the table?

Holly Louie: Okay well I'm going to shoot from the hip here since I don't know your organization exactly. But first of all whoever's in charge -- overall in charge has to be high level enough that they can act independently with authority and that they have the ability if they say stop billing claims or I'm going to external counsel that they have the ability to do that.

They have to have that latitude. After that, you know, I would look at how you are structured.

You want finance involved, you want nursing involved, you want - whether it's your business office or however coding occurs in your facility involved. You - if you have an electronic health record you need that to be evaluated.

So I would say you look at your core business areas -- whatever those may be and how your particular clinic is structured. And you want representation from all of those people.

You sort of want their brains to do a SWOT (strength, weaknesses, opportunities and threats) analysis basically. What are your strengths, what are your weaknesses, what are your different departments concerned about so that you're sure you're getting the big picture. Does that help?

(Diane Condin): Yes thank you. We are a critical access hospital with rural health clinic. So small, many employees wearing different hats, multiple hats. So a lot of the leaders and management are involved in a lot of teams. So want to make sure we have the right people around the table in that.

Holly Louie: Sure.

(Diane Condin): Not that we waste their time but there's other things they could be doing if it's not effective so.

Holly Louie: Exactly. And so, you know, and it can change. What you build doesn't again have to be that way.

So you may start off with a lot of people involved at the table and kind of weed through well we need these three people but not those six people. And that's okay too as long as you've covered all your bases.

(Diane Condin): Sure. Thank you.

Bill Finerfrock: Okay. Next caller operator?

Operator: Yes. Please go ahead.

Bill Finerfrock: Caller?

(Teri Vall): Hi. This is (Teri Vall) from Jasper, Indiana. And you had referenced the policies - or the first question actually referenced the policies of a hospital and rural health clinic combined. We have that same situation.

Wondering if we need to actually print a manual because the hospital and the clinics have all gone to electronic policy and procedures where it's all electronic. Do we have to have an actual manual?

Holly Louie: No. That's fine.

(Teri Vall): Okay.

Holly Louie: I'm not for killing forests. I think that's fine if they're electronic.

I think it's important that however they put them on your - in your facility that they're accessible to all employees all the time.

(Teri Vall): Okay. Okay. Thank you.

Bill Finerfrock: Next caller? Next question?

Operator: And at this time we have no further questions. But once again that is star 1.

Bill Finerfrock: Okay. The - you talked about rapid identification. Let me - and then rapid correction of a - of problems.

If a - even if a clinic has that process -- rapid identification, rapid correction -- but they're continuing to have the same problems would that be looked upon as you're not really doing anything to fix it? You're just dealing with a, you know, problem occurs, you address it but they're not doing the structural things?

Holly Louie: Yes it would be. One of my favorite quotes by one of the attorneys is, "pattern and practice determine intent".

So it's okay if it happened the first time maybe. But effective compliance means not only did you find it and correct it but you have reevaluated your processes, your policies, your procedures, your people, everything that went into creating that problem.

And you should be able to take remedial action so that it doesn't occur again. That's part of why compliance works is once you've identified it - you don't only identify the problem, you identify the antecedents and you identify the reasons and you fix those two.

It would certainly be viewed skeptically by any enforcement agency if you keep having the same kinds of issues over and over and over.

Bill Finerfrock: You were just trying to keep getting away with it until you got caught. And then you go oh, yeah sorry about that.

Holly Louie: Either that or you haven't made the appropriate investment to really fix the issues.

Bill Finerfrock: Right. Right. Operator do we have any questions?

Operator: We do have a few more questions. First caller please go ahead?

(Mary): Hi. I'm sorry. My name is (Mary) and we're a critical access and a rural health center as well. And we wear many hats. Who should...

Bill Finerfrock: Where are you Mary?

(Mary): We're in Arizona. And I'm wondering who should a compliance officer report to?

Holly Louie: Well...

(Mary): Is there a thread?

Holly Louie: The compliance officer ideally -- famous last words -- would report to the board of Directors if you have one.

(Mary): Okay.

Holly Louie: There is no absolute mandate. But it is viewed skeptically if for example they report to the CFO.

Because they are potentially perceived as having a conflict of interest. So if it's a difference between fixing a compliance problem and getting money they may choose money.

So ideally the board, possibly external counsel. It would depend on how you're structured.

It's not required. They could report to the President or the CEO.

But you just have to be cognizant that whoever they report to can't be conflicted in receipt of that information from the compliance officer or say well if it's going to cost us \$1 to do what we need to do we're not going to do it.

(Mary): Okay. Thank you. And I just have one more quick one. How - now I've done compliance in other states and other types of organizations. But how do you get small rural health critical access facilities from a well we never had one, it wasn't that important, we've never gotten into trouble to we're vested in yes we need a compliance program and it's important for us to do this because it's the right thing to have kind of thing?

So how do I get that buy in from leadership and move them in that direction?

Holly Louie: Well you've got a cultural problem.

(Mary): Yeah.

Bill Finerfrock: Ask them how they look in prison stripes.

Holly Louie: Well, you know, sometimes -- and I don't obviously know your personal situation. But sometimes the very fact that it's now required under federal law is a good starting point.

And, you know, I think the other thing that I have found that works is most of the time what's good for compliance is good for operations. And sometimes taking that approach because it's going to be really hard to find anybody credible who's going to look you in the eye and say I don't care if we do it right or not. I don't care if we commit fraud or not.

And so sometimes taking that spin on it is we're just wanting to do what's right for our patients in our facility and here's some things we need to implement. Sometimes that will help.

(Mary): Okay thank you.

Bill Finerfrock: And I was somewhat facetious. But I mean I do think that one of the things that some folks have been trying to do is publicize some of the cases and the consequences of the cases -- whether it's a QUI TAM or whatever it may be to make people realize that just because you're in a - perhaps a critical access hospital, rural health clinic and you think that well we're just a small guy or small clinic out here in the middle of nowhere, no one's really paying attention.

That isn't always the case. And so you're not always going to be able to fly under the radar screen.

Holly Louie: No and, you know, sometimes it's an eye opener if you go onto the OIG website. You can pull up by your state all the people or institutions or organizations that have been excluded.

And you can also look under the OIG website for corporate integrity agreements. And you could maybe for example search for some specific to rural health.

And, you know, sometimes seeing that - as Bill said, no we're not exempt and we're not bulletproof just because we're small and we're rural -- sometimes that's an eye opener.

Bill Finerfrock: Any other questions operator?

Operator: Yes we do have another question.

Bill Finerfrock: Okay.

Operator: Please go ahead caller.

Bill Finerfrock: Have to be our last one but go ahead.

(Mary Jo): Hi my name is...

Bill Finerfrock: Go ahead caller.

(Mary Jo): My name is Mary Jo and I'm calling from Montgomery, Indiana.

Bill Finerfrock: Hey (Mary Jo).

(Mary Jo): I have a question. What does a good risk assessment look like? Sometimes I - we work in a small office and I can't see the forest for the trees. Are there any templates out there that could give me kind of a guideline to make sure that I am covering the broad scope that I need to?

Holly Louie: Well again they have to be customized to you. But if you go to the OIG guidance it gives you a good starting point.

Some of the things we talked about in here -- credit balances, accuracy in coding and billing, employee knowledge -- for example. Just some things I'm shooting from the hip here.

Some of the other things is you could look at the OIG work plan and say okay do any - does anything on this work plan apply to my institution or my organization or my clinic?

(Mary Jo): Okay.

Holly Louie: You could go to your contractor websites and look at what they've published on probe reviews or problems. Same with the RAC program because they all have to publish what they're investigating.

And sometimes that's a good place to get started is it's just okay, here's things everybody's looking at. I'll look at them.

If your organization or clinic has ever had a problem you have found ever what was it? Is it still occurring?

Is it not occurring anymore? What caused it -- maybe that's a place to go dive a little deeper.

(Mary Jo): Okay. All right thank you.

Bill Finerfrock: Well thank you. We're going to have to cut it off here.

And I want to thank everyone who participated in today's call for the time you took. I want to particularly thank our speaker Holly Louie for what a great presentation.

You got a lot of stuff covered in the time that we had. And I think it was extremely helpful for our audience.

And I want to thank you for the time you spent on the presentation. A transcript of today's call will be made available along with a recording as soon as we've been able to go through and get the editing done.

And it will be posted on the OHRP website. I gave you that address earlier.

I want to also remind folks to encourage you to get others to sign up and participate in this series if they are interested or you think it would be helpful. Please also share your thoughts about this, topics, questions, future topics, things you might like us to try and cover in these calls and send those to info@narhc.org.

Finally I just want to remind everybody that this is a project supported by the Federal Office of Rural Health Policy. We are probably looking to have our next call in November.

We are under the same fiscal year funding as everyone else. And we have been approved to continue this project for another year.

So we will be continuing on into 2012. We were very pleased to be able to continue and gain that support from the Office of Rural Health Policy.

So we're probably looking at some time in November will be our next call. And we will announce the topic for that sometime prior.

Again thanks everyone for participating and look forward to your future participation. And thanks again Holly Louie for the time and effort you put in for what a wonderful presentation.

Holly Louie: Thank you.

Operator: Thank you. Ladies and gentlemen this does conclude today's presentation. You may now disconnect.

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