Special Meeting of the Board of Directors

Finance/Compliance Education

Jan 26, 2015 at 01:30 PM - 04:30 PM

Eskridge Conference Room

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Meeting Book - 2015 Jan 26 Special Meeting of the Board of Directors - Finance/Compliance Education

Agenda Packet Contents

6.2 BREAK - meeting will reconvene at approximately 5:00 p.m.
The Board will take a break between the two education sessions.

[2 hours] 6.3 Compliance Education

A. Compliance Training - Speaker Diane Racicot Esq.

B. TFHD Corporate Compliance Program

7 - 13. See Agenda

14. MEETING EFFECTIVENESS ASSESSMENT

TAHOE FOREST HOSPITAL DISTRICT

SPECIAL MEETING OF THE BOARD OF DIRECTORS OF TAHOE FOREST HOSPITAL DISTRICT

AGENDA

Monday, January 26, 2015 at 1:30 p.m.

Eskridge Conference Room,
Tahoe Forest Hospital, 10121 Pine Avenue, Truckee, CA

1. CALL TO ORDER

2. ROLL CALL

3. CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA

4. INPUT – AUDIENCE

This is an opportunity for members of the public to address the Board on items which are not on the agenda. Please state your name for the record. Comments are limited to three minutes. Written comments should be submitted to the Board Clerk 24 hours prior to the meeting to allow for distribution. Under Government Code Section 54954.2 – Brown Act, the Board cannot take action on any item not on the agenda. The Board may choose to acknowledge the comment or, where appropriate, briefly answer a question, refer the matter to staff, or set the item for discussion at a future meeting.

5. INPUT FROM EMPLOYEE ASSOCIATIONS

This is an opportunity for members of the Employee Associations to address the Board on items which are not on the agenda. Comments are limited to three minutes.

6. ITEMS FOR BOARD DISCUSSION AND/OR ACTION

6.1. Finance Review *[3 hours]*

To ensure compliance with the Brown Act, the Board Finance Committee has been scheduled as an education opportunity during this Special Meeting of the Board of Directors in order to allow the full Board to participate in the discussion.

6.1.1. Financial statement orientation ..... *ATTACHMENT
6.1.2. Financial Report – November 2014 Package ..... ATTACHMENT
6.1.3. Financial Report – December 2015 Quarterly Package ..... ATTACHMENT
6.1.4. Review of Quarterly Payor Mix ..... ATTACHMENT
6.1.5. Review of Financial Status of Separate Entities
6.1.5.1. Separate Business Enterprises ..... ATTACHMENT
6.1.5.2. Center for Health and Sports Performance ..... ATTACHMENT
6.1.5.3. Cancer Program ..... ATTACHMENT
6.1.5.4. Tahoe Institute for Rural Health Research ..... ATTACHMENT
6.1.6. General Obligation Bond Refinancing Update
6.1.7. Revenue Cycle Project Update – Jacobus Presentation ..... ATTACHMENT
6.1.8. Approval of Revised Charity Care Financial Assistance Policy ..... ATTACHMENT
6.1.9. Agenda Input and Date for Next Finance Committee Meeting ..... ATTACHMENT

6.2. BREAK

APPROXIMATELY 5:00 P.M.

6.3. Compliance Education Session *[2 hours]*..... ATTACHMENT
Compliance attorney Diane Racicot will provide the Board training related to compliance programs' risks and obligations.

7. INPUT – AUDIENCE
This is an opportunity for members of the public to comment on any closed session item appearing before the Board on this agenda.

8. CLOSED SESSION:
8.1. Government Code Section 54956.9(d)(2): Exposure to Litigation (3 matters)

9. OPEN SESSION

10. REPORT OF ACTIONS TAKEN IN CLOSED SESSION

11. ITEMS FOR NEXT MEETING

12. BOARD MEMBERS' REPORTS/CLOSING REMARKS

13. NEXT MEETING DATE

14. MEETING EFFECTIVENESS ASSESSMENT..... ATTACHMENT
The Board will identify and discuss any occurrences during the meeting that impacted the effectiveness and value of the meeting.

15. ADJOURN

The next regularly scheduled meeting of the Board of Directors of Tahoe Forest Hospital District is January 27, 2015, 11603 Donner Pass Rd., Truckee, CA. A copy of the Board meeting agenda is posted on the District's web site (www.tfhd.com) at least 72 hours prior to the meeting or 24 hours prior to a Special Board Meeting.

*Denotes material (or a portion thereof) may be distributed later.

Note: It is the policy of Tahoe Forest Hospital District to not discriminate in admissions, provisions of services, hiring, training and employment practices on the basis of color, national origin, sex, religion, age or disability including AIDS and related conditions.

Equal Opportunity Employer. The meeting location is accessible to people with disabilities. Every reasonable effort will be made to accommodate participation of the disabled in all of the District's public meetings. If particular accommodations for the disabled are needed (i.e., disability-related aids or other services), please contact the Executive Assistant at 582-3481 at least 24 hours in advance of the meeting.

TAHOE FOREST HOSPITAL DISTRICT
BALANCE SHEET

	Jun-14	Jun-13	Jun-12	Jun-11	Jun-10	Jun-09
ASSETS						
CURRENT ASSETS						
* CASH	$ 10,315,543	$ 10,344,646	$ 16,832,278	$ 16,011,577	$ 16,316,900	$ 18,579,186
PATIENT ACCOUNTS RECEIVABLE - NET	17,493,626	21,966,814	16,052,562	15,296,304	12,981,902	14,865,441
OTHER RECEIVABLES	3,259,504	2,800,791	1,578,450	967,657	775,623	1,413,324
GO BOND RECEIVABLES	230,127	438,019	134,534	93,536	59,924	163,770
ASSETS LIMITED OR RESTRICTED	6,106,335	6,006,279	6,114,765	6,202,789	6,855,692	7,302,084
INVENTORIES	2,506,409	2,267,146	2,265,637	2,229,673	2,136,807	1,932,240
PREPAID EXPENSES & DEPOSITS	1,321,334	1,166,116	981,801	941,019	1,040,458	907,610
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	3,259,036	3,396,361	2,997,460	3,377,642	1,448,904	2,277,395
OTHER CURRENT ASSETS	-	-	1,105,338	1,105,338	1,105,338	1,105,338
TOTAL CURRENT ASSETS	44,491,913	48,386,172	48,062,825	46,225,535	42,721,548	48,546,388
NON CURRENT ASSETS						
ASSETS LIMITED OR RESTRICTED:						
* CASH RESERVE FUND	40,636,217	33,550,098	38,410,226	38,252,290	38,057,866	22,824,371
BANC OF AMERICA MUNICIPAL LEASE	2,290,125	3,030,427	-	-	-	-
TOTAL BOND TRUSTEE 1999	-	-	-	421,504	3,039,232	3,662,663
TOTAL BOND TRUSTEE 2002	2	2	2	2	2	2
TOTAL BOND TRUSTEE 2006	3,464,501	3,398,227	3,343,813	2,943,307	2,422,956	2,079,037
TOTAL BOND TRUSTEE GO BOND	-	-	-	-	-	-
GO BOND PROJECT FUND	19,832,145	31,004,454	14,809,655	45,363,022	20,814,540	28,907,904
GO BOND TAX REVENUE FUND	2,347,711	2,717,459	1,742,667	1,726,125	902,980	804,502
BOARD DESIGNATED FUND	2,297	2,297	2,297	2,297	2,291	2,300
DIAGNOSTIC IMAGING FUND	2,962	3,134	4,546	4,527	4,504	4,463
DONOR RESTRICTED FUND	753,931	646,074	534,412	105,664	44,039	42,757
WORKERS COMPENSATION FUND	19,026	1,325	11,295	7,008	11,859	10,069
TOTAL	69,348,918	74,353,497	58,858,913	88,825,746	65,300,269	58,338,068
LESS CURRENT PORTION	(6,106,335)	(6,006,279)	(6,114,765)	(6,202,789)	(6,855,692)	(7,302,084)
TOTAL ASSETS LIMITED OR RESTRICTED - NET	63,242,584	68,347,218	52,744,148	82,622,957	58,444,577	51,035,984
NONCURRENT ASSETS AND INVESTMENTS:						
INVESTMENT IN TSC, LLC	496,395	728,350	4,451,956	4,392,580	-	-
PROPERTY HELD FOR FUTURE EXPANSION	836,353	836,353	836,353	836,353	836,353	836,353
PROPERTY & EQUIPMENT NET	116,743,927	120,816,677	67,176,991	64,894,609	63,477,750	65,781,351
GO BOND CIP, PROPERTY & EQUIPMENT NET	27,305,201	16,414,365	57,869,177	24,207,966	10,828,847	1,645,063
TOTAL ASSETS	253,116,372	255,529,135	231,141,450	223,180,000	176,309,075	167,845,139
DEFERRED OUTFLOW OF RESOURCES:						
DEFERRED LOSS ON DEFEASANCE	620,616	659,404	1,069,859	1,005,430	1,643,490	1,720,062
ACCUMULATED DECREASE IN FAIR VALUE OF HEDGING DERIVATIVE	1,710,011	1,710,354	2,567,757	1,364,506	1,665,329	-
TOTAL DEFERRED OUTFLOW OF RESOURCES	$ 2,330,627	$ 2,369,758	$ 3,637,616	$ 2,369,936	$ 3,308,819	$ 1,720,062
LIABILITIES						
CURRENT LIABILITIES						
ACCOUNTS PAYABLE	$ 5,514,540	$ 6,127,626	$ 7,944,195	$ 6,250,178	$ 4,940,342	$ 5,248,675
ACCRUED PAYROLL & RELATED COSTS	8,302,902	7,668,235	7,728,182	6,920,778	6,490,964	5,713,935
INTEREST PAYABLE	612,279	627,679	642,299	655,787	940,629	977,901
INTEREST PAYABLE GO BOND	1,949,447	1,949,547	1,514,309	1,514,393	611,043	600,247
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	1,112,494	653,749	135,290	1,350,869	1,623,486	75,000
HEALTH INSURANCE PLAN	997,635	860,027	1,030,171	1,275,711	1,017,359	1,294,000
WORKERS COMPENSATION PLAN	1,006,475	1,392,606	1,438,552	1,532,207	1,532,207	1,736,405
COMPREHENSIVE LIABILITY INSURANCE PLAN	890,902	887,362	927,001	1,043,757	1,043,760	1,251,564
CURRENT MATURITIES OF GO BOND DEBT	50,000	-	-	-	-	-
CURRENT MATURITIES OF OTHER LONG TERM DEBT	2,245,193	2,572,776	1,454,475	1,361,987	1,696,088	2,490,252
TOTAL CURRENT LIABILITIES	22,681,867	22,739,607	22,814,474	21,905,667	19,895,878	19,387,979
NONCURRENT LIABILITIES						
OTHER LONG TERM DEBT NET OF CURRENT MATURITIES	35,346,645	37,704,876	35,558,214	36,988,214	41,588,440	43,339,691
GO BOND DEBT NET OF CURRENT MATURITIES	98,445,000	98,505,220	71,869,502	71,837,143	29,580,553	29,586,983
DERIVATIVE INSTRUMENT LIABILITY	1,710,011	1,710,354	2,567,757	1,364,506	1,665,329	-
TOTAL LIABILITIES	158,183,524	160,660,057	132,809,947	132,095,530	92,730,200	92,314,653
NET ASSETS						
NET INVESTMENT IN CAPITAL ASSETS	96,509,544	96,592,762	101,330,587	93,348,741	86,843,653	77,207,791
RESTRICTED	753,931	646,074	534,412	105,664	44,039	42,757
TOTAL NET POSITION	$ 97,263,475	$ 97,238,836	$ 101,864,999	$ 93,454,405	$ 86,887,692	$ 77,250,548

* Amounts included for Days Cash on Hand calculation

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TAHOE FOREST HOSPITAL DISTRICT
SUMMARY OF FINANCIAL STATEMENTS AND RATIO ANALYSIS (000's OMITTED)

	Fiscal Year Ended June 30											
	2003	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
Net Patient Revenue	$51,395	$56,467	$61,693	$71,552	$80,522	$87,501	$96,471	$92,423	$94,323	$99,795	$101,567	$107,664
District Tax Revenues	2,839	3,125	3,442	3,934	4,300	4,866	4,955	4,633	4,906	4,825	5,717	4,902
Other Operating Revenue	4,797	5,619	5,744	5,857	6,723	6,755	7,024	6,335	6,596	6,711	6,143	6,711
Total Operating Revenues	59,031	65,211	70,879	81,343	91,545	99,122	108,450	103,391	105,825	111,331	113,427	119,277
Total Operating Expenses	56,423	61,203	66,884	74,738	85,410	92,392	102,807	93,678	98,207	103,152	113,470	120,268
Income from Operations	2,608	4,008	3,995	6,605	6,135	6,730	5,643	9,713	7,618	8,179	(43)	(991)
Net Nonoperating Income	1,165	530	(295)	(68)	259	(329)	(350)	(76)	(1,052)	(37)	2,014	1,010
Excess of Revenue Over Expenses	**3,773**	**4,538**	**3,700**	**6,537**	**6,394**	**6,401**	**5,293**	**9,637**	**6,566**	**8,142**	**1,971**	**19**
Add Depreciation & Amortization Expense	3,204	3,692	4,158	4,764	5,901	6,275	5,696	5,304	5,372	4,966	7,239	8,642
Add Interest Expense on Revenue Debt	1,342	1,366	1,471	1,802	2,387	2,346	2,234	2,140	1,922	1,819	1,836	1,751
Add Interest Expense on GO Debt							1,307	1,217	2,945	2,665	2,612	3,639
Less GO Bond Ad Valorem Taxes							(1,600)	(1,590)	(2,918)	(3,223)	(4,987)	(4,744)
Less Capital Contributions	(1,547)	(991)	(546)	(308)	(141)	(65)	(1,141)	(131)	(158)	(145)	(396)	(668)
Net Available for Debt Service (EBIDA)	**$6,772**	**$8,605**	**$8,783**	**$12,795**	**$14,541**	**$14,957**	**$11,789**	**$16,577**	**$13,729**	**$14,224**	**$8,275**	**$8,639**
Existing Maximum Annual Debt Service	$3,343	$3,343	$3,618	$4,649	$5,109	$5,106	$5,030	$3,963	$3,921	$4,316	$4,305	$3,852
MADS Coverage Ratio	**2.03x**	**2.57x**	**2.43x**	**2.75x**	**2.85x**	**2.93x**	**2.34x**	**4.18x**	**3.50x**	**3.30x**	**1.92x**	**2.24x**
S&P Median Ratios (Good 2.60x / Better 3.10x / Best 5.50x)												
EBIDA Margin w/ Tax Revenues	**11.5%**	**13.2%**	**12.4%**	**15.7%**	**15.9%**	**15.1%**	**10.9%**	**16.0%**	**13.0%**	**12.8%**	**7.3%**	**7.2%**
EBIDA Margin w/o Tax Revenues	**7.0%**	**9.0%**	**8.0%**	**11.9%**	**12.0%**	**10.9%**	**6.6%**	**12.8%**	**9.0%**	**9.1%**	**2.3%**	**3.1%**
S&P Median Ratios (Good 10.7% / Better 12.8% / Best 17.0%)												
Cash and Cash Equivalents	$4,599	$6,434	$12,073	$12,490	$15,491	$20,223	$18,579	$16,324	$16,019	$16,839	$10,345	$10,316
Board Designated Assets	13,255	17,124	13,098	13,797	14,035	14,243	23,688	39,024	38,919	40,408	34,202	41,414
Total Unrestricted Cash	$17,854	$23,558	$25,171	$26,287	$29,526	$34,466	$42,267	$55,348	$54,938	57,247	44,547	51,730
Daily Cash Requirements	$149	$161	$176	$197	$224	$242	$272	$248	$260	$274	$296	$311
Days' Cash on Hand	**119**	**146**	**143**	**134**	**132**	**142**	**155**	**223**	**212**	**209**	**150**	**167**
S&P Median Ratios (Good 147 / Better 236 / Best 384)												
Net Long-term Debt	$30,840	$33,288	$33,380	$47,334	$47,852	$45,374	$43,094	$41,357	$36,771	$35,347	$37,592	$35,347
Unrestricted Net Assets	33,474	47,101	50,320	57,198	63,430	69,820	76,868	86,673	93,227	100,419	96,603	96,509
Total Capital	$64,314	$80,389	$83,700	$104,532	$111,282	$115,194	$119,962	$128,030	$129,998	$135,766	$134,195	$131,856
Unrestricted Cash to L-T Debt	**58%**	**71%**	**75%**	**56%**	**62%**	**76%**	**98%**	**134%**	**149%**	**162%**	**119%**	**146%**
S&P Median Ratios (Good 100% / Better 166% / Best 254%)												
L-T Debt to Capitalization	**48%**	**41%**	**40%**	**45%**	**43%**	**39%**	**36%**	**32%**	**28%**	**26%**	**28%**	**27%**
S&P Median Ratios (Good 39% / Better 31% / Best 21%)												
Net Accounts Receivable	$10,827	$10,338	$9,032	$12,066	$14,595	$16,699	$14,866	$12,975	$15,289	$16,045	$22,808	$21,125
Net Patient Revenue	$51,395	$56,467	$61,693	$71,552	$80,522	$87,501	$96,471	$92,423	$94,323	$99,795	$101,567	$107,664
Days in Accounts Receivable	**77**	**67**	**53**	**62**	**66**	**70**	**56**	**51**	**59**	**59**	**82**	**72**
S&P Median Ratios (Good 57 / Better 52 / Best 50)												

Outstanding Revenue Based Debt (as of December 31, 2014):	**Debt Serivce**	
2002 Revenue Bonds ($9,555,000 due 7/1/33 @ 3.54% swap rate)	$690	
2006 Revenue Bonds ($23,240,000 outstanding due 7/1/36 @ 4.85%)	1,920	(maximum annual debt service drops to $976,500 in 2030)
2012 BofA Muni Lease ($3,352,000 due 7/1/17 @ 1.42%)	1,243	
Revenue Debt Maximum Annual Debt Service	**$3,853**	

RATIOS & TERMS DEFINED

	Desired Position		
	Trend	Relative to Median	
MADS Coverage Ratio:	Up	Above	$\frac{\text{Net Available for Debt Service}}{\text{Maximum Annual Debt Service}}$
EBIDA Margin:	Up	Above	$\frac{\text{EBIDA}}{\text{Total Revenue}} \times 100$
Days' Cash On Hand:	Up	Above	$\frac{\text{Cash}}{\text{(Operating Expense - Depreciation Expense) / 365}}$
Unrestricted Cash to Long Term Debt:	Up	Above	$\frac{\text{Cash}}{\text{Long Term Debt}} \times 100$
Long Term Debt to Capitalization:	Down	Below	$\frac{\text{Long Term Debt}}{\text{Unrestricted Net Assets + Long Term Debt}}$
Days In Accounts Receivable:	Down	Below	$\frac{\text{Net Accounts Receivable x 365}}{\text{Net Patient Revenue}}$

Cash: Unrestricted Cash, investments and board designated funds.
EBIDA: Earnings (excess of revenues over expenses) before Interest, Depreciation and Amortization expense.
Long Term Debt: Long Term Debt net of current maturities.
MADS: Maximum Annual Debt Service.
Net Available for Debt Service: Same as EBIDA.

	Standard & Poor's and Moody's Median Ratios				Comparatives for Tahoe Forest Health System		
	BBB-/Baa3	BBB/Baa2	BBB+/Baa1	A-/A3	Good	Better	Best
MADS Coverage Ratio	2.6x / 3.0x	2.7x / 2.9x	3.1x / 3.7x	5.5x / 4.0x	2.6x	3.1x	5.5x
EBIDA Margin	10.7% / 8.4%	14.1% / 8.8%	12.8% / 7.9%	17.0% / 9.2%	10.7%	12.8%	17.0%
Days' Cash on Hand	147 / 109	205 / 125	236 / 133	384 / 169	147	236	384
Unrestricted Cash to Debt	101% / 93%	125% / 75%	166% / 92%	254% / 104%	101%	166%	254%
L-T Debt to Capital	39% / 49%	30% / 50%	31% / 48%	21% / 41%	39%	31%	21%
Days in Net Accounts Receivable	58 / 42	51 / 43	52 / 45	50 / 44	58	52	50

Source:

Standard & Poor's: RatingsDirect - U.S Not-For-Profit Small Hospitals Turn in Mixed 2012 Median Performance Ratios as the Industry Grapples With Changes
Report Dated: October 23, 2013

Moody's Investors Service: Median Reports - U.S. Not-for-Profit Hospital Medians Show Operating Stability Despite Flat Inpatient Volumes and Shift to Government Payers
Appendix 3: Freestanding Hospitals & Single-State Healthcare Systems, Medians by Numerical Rating Category, FY 2011
Report Dated: August 23, 2012

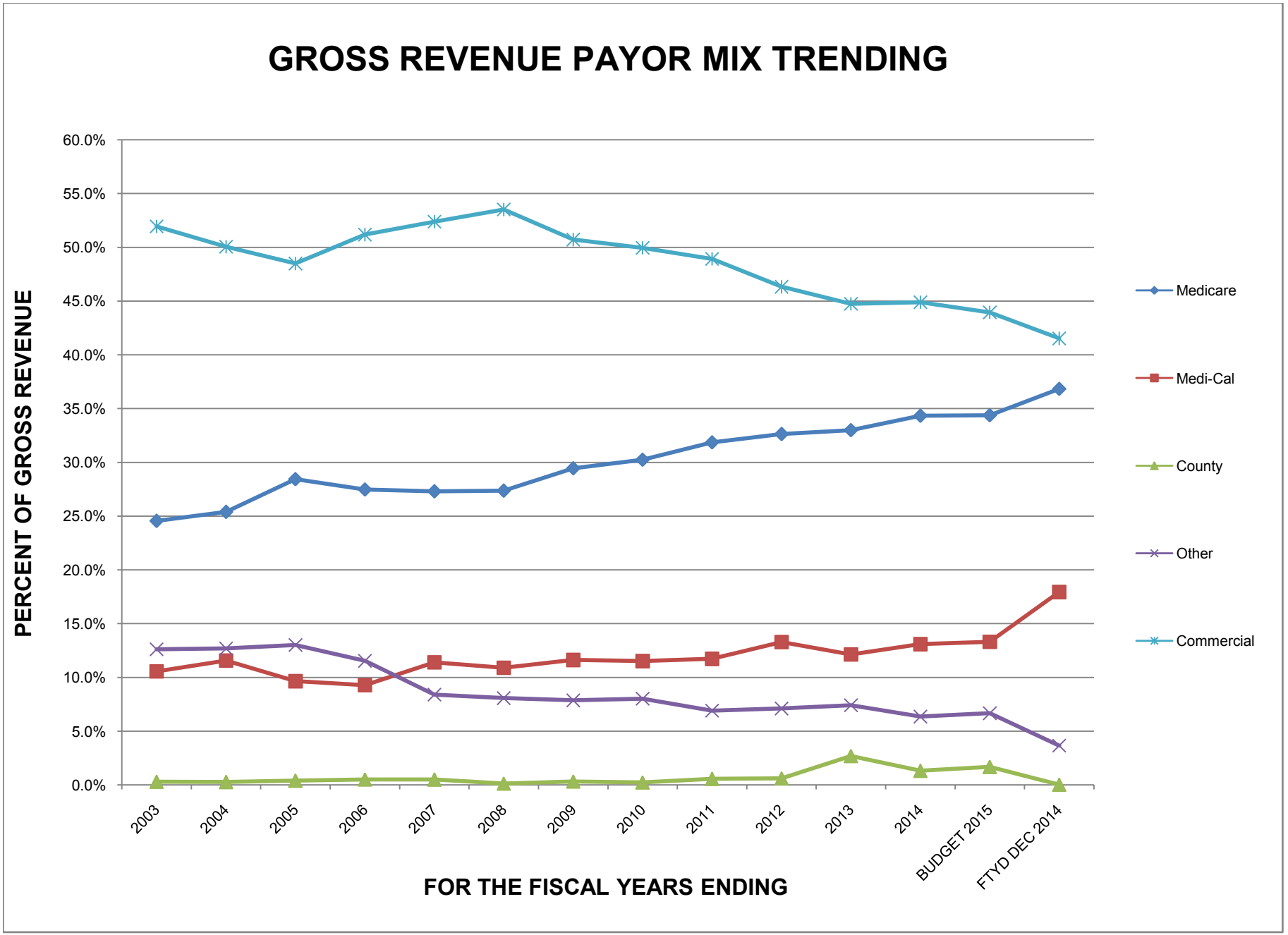
TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF REVENUE AND EXPENSE
FOR THE YEARS ENDED JUNE 30, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, and BUDGET 2015

	AUDITED FYE 6/30/02	AUDITED FYE 6/30/03	AUDITED FYE 6/30/04	AUDITED FYE 6/30/05	AUDITED FYE 6/30/06	AUDITED FYE 6/30/07	AUDITED FYE 6/30/08	AUDITED FYE 6/30/09	AUDITED FYE 6/30/10	AUDITED FYE 6/30/11	AUDITED FYE 6/30/12	AUDITED FYE 6/30/13	AUDITED FYE 6/30/14	BUDGET FYE 6/30/15
OPERATING REVENUE														
Total Gross Revenue	$ 66,860,832	$ 74,097,073	$ 79,527,406	$ 91,624,025	$ 103,713,126	$ 121,106,665	$ 132,808,469	$ 147,262,076	$ 153,249,520	$ 151,182,547	$ 158,223,647	$ 177,905,726	$ 188,378,523	$ 196,580,908
Gross Revenues - Inpatient														
Daily Hospital Service	9,409,497	9,961,237	10,325,317	11,514,857	12,311,639	12,825,999	14,392,149	14,482,511	15,627,369	15,580,655	17,992,179	19,232,255	19,155,747	19,233,943
Ancillary Service - Inpatient	22,095,397	23,718,092	25,849,316	32,830,038	36,682,542	39,139,078	38,430,087	42,608,370	44,412,594	42,753,101	42,675,528	43,399,664	43,242,323	46,598,586
Total Gross Revenue - Inpatient	31,504,894	33,679,329	36,174,633	44,344,894	48,994,180	51,965,077	52,822,235	57,090,880	60,039,963	58,333,756	60,667,707	62,631,919	62,398,070	65,832,529
Gross Revenue - Outpatient	35,355,938	40,417,744	43,352,773	47,279,130	54,718,946	69,141,588	79,986,234	90,171,196	93,209,558	92,848,791	97,555,940	115,273,807	125,980,453	130,748,379
Total Gross Revenue - Outpatient	35,355,938	40,417,744	43,352,773	47,279,130	54,718,946	69,141,588	79,986,234	90,171,196	93,209,558	92,848,791	97,555,940	115,273,807	125,980,453	130,748,379
Deductions from Revenue:														
Contractual Allowances	18,918,950	22,378,680	23,395,884	28,948,398	30,872,445	39,263,460	41,545,726	47,225,614	50,328,623	48,702,232	50,646,661	62,615,706	72,706,243	73,900,950
Managed Care Reserve/CAH Reserve	-	-	-	11,731	-	-	-	-	-	-	-	-	-	-
Charity Care	428,723	450,313	455,004	907,565	1,272,958	1,541,922	3,653,174	3,788,524	4,892,141	4,637,210	4,139,984	5,663,679	6,074,298	6,683,751
Bad Debt	5,806,942	4,147,547	4,784,654	4,452,731	5,353,188	6,830,144	6,258,966	6,853,240	6,337,718	5,606,617	6,727,911	8,110,057	2,995,454	7,863,237
Proposition 99	(74,853)	-	(2,633)	-	(703)	(1,703)	(3,650)	-	-	-	-	-	-	-
Prior Period Settlements	(482,111)	(127,284)	(790,799)	63,323	16,194	(220,363)	108,939	(222,629)	(731,585)	(2,143,456)	(3,129,373)	26,966	(1,061,758)	-
Total Deductions from Revenue	24,597,652	26,849,256	27,842,109	34,383,749	37,514,082	47,413,459	51,563,155	57,644,749	60,826,897	56,802,603	58,385,183	76,416,408	80,714,237	88,447,938
Other Operating Revenue	4,362,493	4,918,489	6,206,921	6,142,390	6,218,783	7,088,232	7,082,648	7,249,438	6,558,361	6,815,488	6,927,845	6,560,475	7,197,177	6,613,440
Wellness Neighborhood-RPT, Grants, Donations	-	-	-	-	-	-	-	-	-	-	-	94,038	636,620	1,102,265
TOTAL OPERATING REVENUE	46,625,673	52,166,306	57,892,218	63,382,666	72,417,827	80,781,438	88,327,963	96,866,765	98,980,984	101,195,432	106,766,309	108,143,831	115,498,083	115,848,675
OPERATING EXPENSES														
Salaries, Wages & Benefits	22,495,856	24,843,060	27,461,679	30,085,622	32,719,935	36,179,967	39,103,305	45,426,803	44,686,921	45,655,454	48,916,454	52,048,877	53,009,256	54,779,554
Benefits Workers Compensation	852,799	2,014,396	988,723	1,928,440	1,020,852	870,373	594,993	1,150,827	512,172	760,840	595,199	563,874	218,832	618,797
Benefits Medical Insurance	3,149,926	4,385,796	4,342,437	3,911,981	5,365,874	4,650,724	5,133,176	6,155,390	5,714,866	7,135,664	7,497,383	6,425,652	8,026,166	8,610,115
Professional Fees	3,867,154	4,715,034	5,536,984	6,231,241	7,526,802	9,320,882	11,610,230	12,044,583	12,230,428	12,688,270	15,142,691	18,147,762	19,209,522	18,761,537
Supplies	6,897,891	7,020,391	7,346,184	7,979,534	8,506,164	11,012,200	11,456,865	12,365,998	12,948,610	13,899,820	12,921,463	15,212,680	14,968,262	14,289,052
Purchased Services	3,930,286	3,588,293	3,596,725	4,147,471	4,422,562	5,465,996	5,926,855	6,505,784	6,737,293	7,107,036	7,366,626	7,683,361	10,235,914	10,008,734
Other	2,061,620	2,415,187	3,597,900	4,102,608	5,183,444	5,314,225	6,131,840	6,675,538	5,612,497	5,711,330	5,512,408	6,460,012	6,121,313	6,772,151
TOTAL OPERATING EXPENSE	43,255,532	48,982,158	52,870,632	58,386,897	64,745,633	72,814,367	79,957,263	90,324,923	88,442,787	92,958,414	97,952,224	106,542,218	111,789,267	113,839,940
NET OPERATING REV(EXP) EBIDA	**$ 3,370,141**	**$ 3,184,148**	**$ 5,021,586**	**$ 4,995,769**	**$ 7,672,194**	**$ 7,967,071**	**$ 8,370,700**	**$ 6,541,842**	**$ 10,538,196**	**$ 8,237,018**	**$ 8,814,085**	**$ 1,601,613**	**$ 3,708,816**	**$ 2,008,735**
NON-OPERATING REVENUE														
District and County Taxes	2,545,718	2,838,577	3,124,509	3,442,107	3,934,003	4,300,000	4,866,052	4,954,824	4,633,377	4,906,170	4,824,796	5,622,796	4,265,626	4,273,831
District and County Taxes - GO Bond	-	-	-	-	-	-	-	1,600,303	1,589,924	2,917,548	3,222,798	4,986,760	4,744,356	4,726,840
Interest Income	749,902	645,643	506,882	743,079	1,084,821	1,890,369	1,634,122	912,328	318,715	249,542	225,284	247,239	229,540	267,558
Interest Income - GO Bond	-	-	-	-	-	-	-	750,458	535,973	30,305	74,787	82,839	51,034	21,100
Donations	855,406	1,861,577	1,148,658	838,426	644,411	742,573	427,033	1,548,377	795,706	725,506	822,752	945,347	1,327,603	731,411
Gain/(Loss) on Joint Venture	-	-	-	-	-	-	-	-	-	30,747	59,376	(30,517)	(191,666)	(225,000)
Loss on Impairment of Asset	-	-	-	-	-	-	-	-	-	-	-	(1,066,498)	-	-
Gain/(Loss) on Sale of Equip/Property	(82,342)	(121,232)	8,262	(449,075)	(22,929)	293	(85,829)	-	31,772	(145,663)	24,125	(11,867)	1,000	-
Impairment Loss	-	-	-	-	-	-	-	-	-	-	-	(4,612,580)	-	-
Depreciation	(3,145,110)	(3,186,031)	(3,907,072)	(4,399,674)	(4,973,084)	(6,118,499)	(6,465,122)	(5,873,951)	(5,449,938)	(5,517,017)	(5,168,635)	(7,358,535)	(8,714,689)	(9,708,797)
Interest Expense	(1,266,170)	(1,449,271)	(1,365,716)	(1,470,787)	(1,801,965)	(2,387,500)	(2,345,795)	(2,234,752)	(2,139,911)	(1,922,283)	(1,818,981)	(1,822,655)	(1,751,126)	(1,675,418)
Interest Expense - GO Bond	-	-	-	-	-	-	-	(1,306,561)	(1,216,623)	(2,945,163)	(2,664,840)	(2,611,591)	(3,639,081)	(3,011,234)
TOTAL NON-OPERATING REVENUE	(342,596)	589,263	(484,477)	(1,295,922)	(1,134,743)	(1,572,763)	(1,969,539)	351,027	(901,005)	(1,670,308)	(398,538)	(5,629,262)	(3,677,404)	(4,599,709)
EXCESS REVENUE(EXPENSE)	**$ 3,027,544**	**$ 3,773,412**	**$ 4,537,109**	**$ 3,699,847**	**$ 6,537,451**	**$ 6,394,308**	**$ 6,401,160**	**$ 6,892,868**	**$ 9,637,191**	**$ 6,566,710**	**$ 8,415,547**	**$ (4,027,649)**	**$ 31,412**	**$ (2,590,974)**

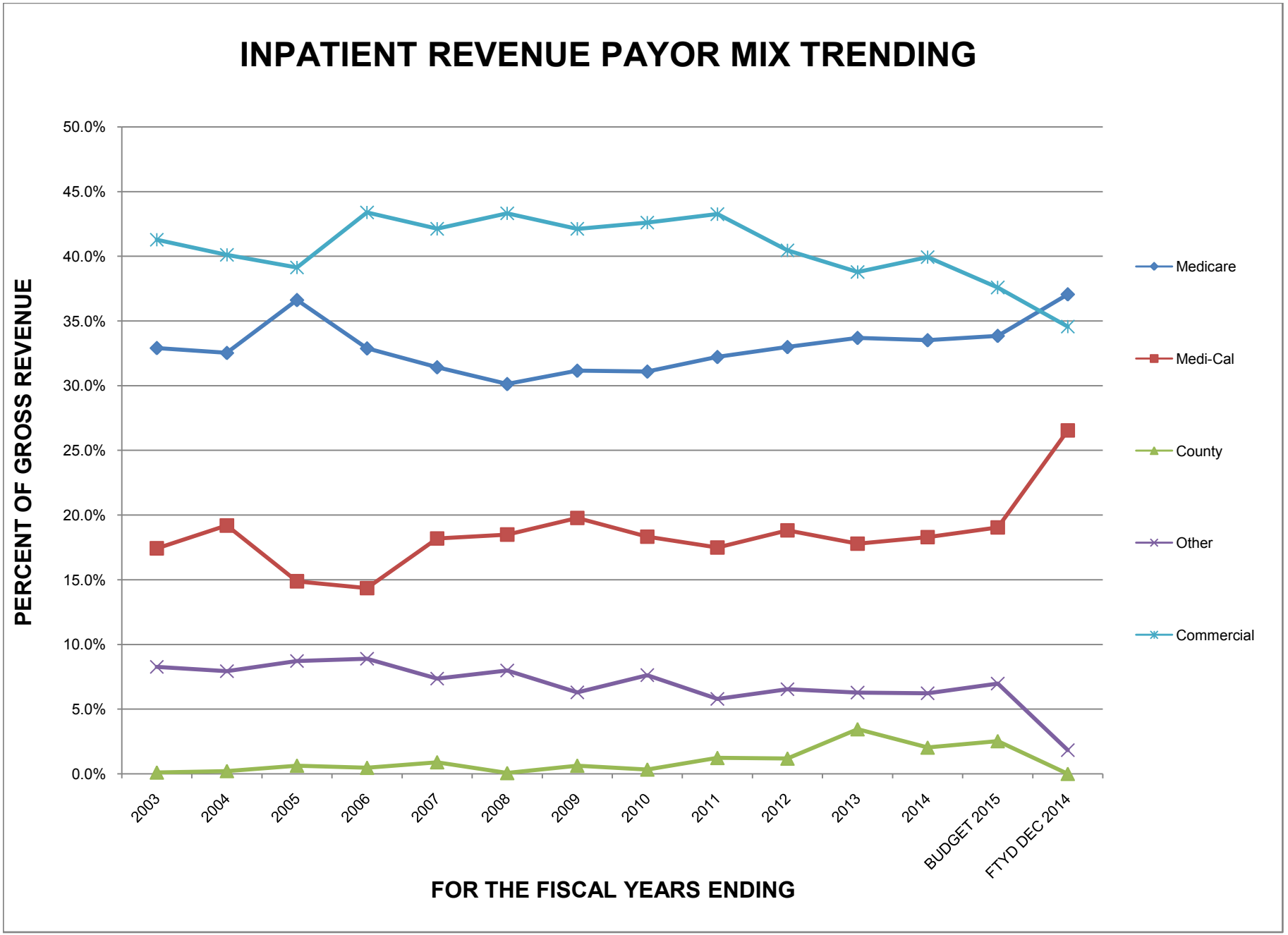
TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF REVENUE AND EXPENSE
FOR THE YEARS ENDED JUNE 30, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, and BUDGET 2015

	AUDITED FYE 6/30/02	AUDITED FYE 6/30/03	AUDITED FYE 6/30/04	AUDITED FYE 6/30/05	AUDITED FYE 6/30/06	AUDITED FYE 6/30/07	AUDITED FYE 6/30/08	AUDITED FYE 6/30/09	AUDITED FYE 6/30/10	AUDITED FYE 6/30/11	AUDITED FYE 6/30/12	AUDITED FYE 6/30/13	AUDITED FYE 6/30/14	BUDGET FYE 6/30/15
RETURN ON GROSS REVENUE EBIDA	5.0%	4.3%	6.3%	5.5%	7.4%	6.6%	6.3%	4.4%	6.9%	5.4%	5.6%	0.9%	2.0%	1.0%
RETURN ON EQUITY	8.4%	9.7%	10.6%	7.8%	12.8%	11.1%	10.0%	9.8%	12.5%	7.6%	9.1%	-4.0%	0.0%	-2.7%
RETURN ON EQUITY (excluding donations)	6.0%	4.9%	7.9%	6.0%	11.5%	9.8%	9.3%	7.6%	11.4%	6.7%	8.2%	-4.9%	-1.3%	-3.4%
INPATIENT REV AS A % OF GROSS REV	47.1%	45.5%	45.5%	48.4%	47.2%	42.9%	39.8%	38.8%	39.2%	38.6%	38.3%	35.2%	33.1%	33.5%
OUTPATIENT REV AS A % OF GROSS REV	52.9%	54.5%	54.5%	51.6%	52.8%	57.1%	60.2%	61.2%	60.8%	61.4%	61.7%	64.8%	66.9%	66.5%
CONTRACTUAL ADJ AS A % OF GROSS REV	28.3%	30.2%	29.4%	31.6%	29.8%	32.4%	31.3%	32.1%	32.8%	32.2%	32.0%	35.2%	38.6%	37.6%
CHARITY CARE AS A % OF GROSS REV	0.6%	0.6%	0.6%	1.0%	1.2%	1.3%	2.8%	2.6%	3.2%	3.1%	2.6%	3.2%	3.2%	3.4%
BAD DEBT AS A % OF GROSS REV	8.7%	5.6%	6.0%	4.9%	5.2%	5.6%	4.7%	4.7%	4.1%	3.7%	4.3%	4.6%	1.6%	4.0%
SALARIES, WAGES & BEN AS A % OF NET REV	48.2%	47.6%	47.4%	47.5%	45.2%	44.8%	44.3%	46.9%	45.1%	45.1%	45.8%	48.1%	45.9%	47.3%
WORKERS COMP AS A % OF NET REV	1.8%	3.9%	1.7%	3.0%	1.4%	1.1%	0.7%	1.2%	0.5%	0.8%	0.6%	0.5%	0.2%	0.5%
MEDICAL INSURANCE AS A % OF NET REV	6.8%	8.4%	7.5%	6.2%	7.4%	5.8%	5.8%	6.4%	5.8%	7.1%	7.0%	5.9%	6.9%	7.4%
PROFESSIONAL FEES AS A % OF NET REV	8.3%	9.0%	9.6%	9.8%	10.4%	11.5%	13.1%	12.4%	12.4%	12.5%	14.2%	16.8%	16.6%	16.2%
SUPPLIES AS A % OF NET REV	14.8%	13.5%	12.7%	12.6%	11.7%	13.6%	13.0%	12.8%	13.1%	13.7%	12.1%	14.1%	13.0%	12.3%
PURCHASED SVCS AS A % OF NET REV	8.4%	6.9%	6.2%	6.5%	6.1%	6.8%	6.7%	6.7%	6.8%	7.0%	6.9%	7.1%	8.9%	8.6%
OTHER AS A % OF NET REV	4.4%	4.6%	6.2%	6.5%	7.2%	6.6%	6.9%	6.9%	5.7%	5.6%	5.2%	6.0%	5.3%	5.8%

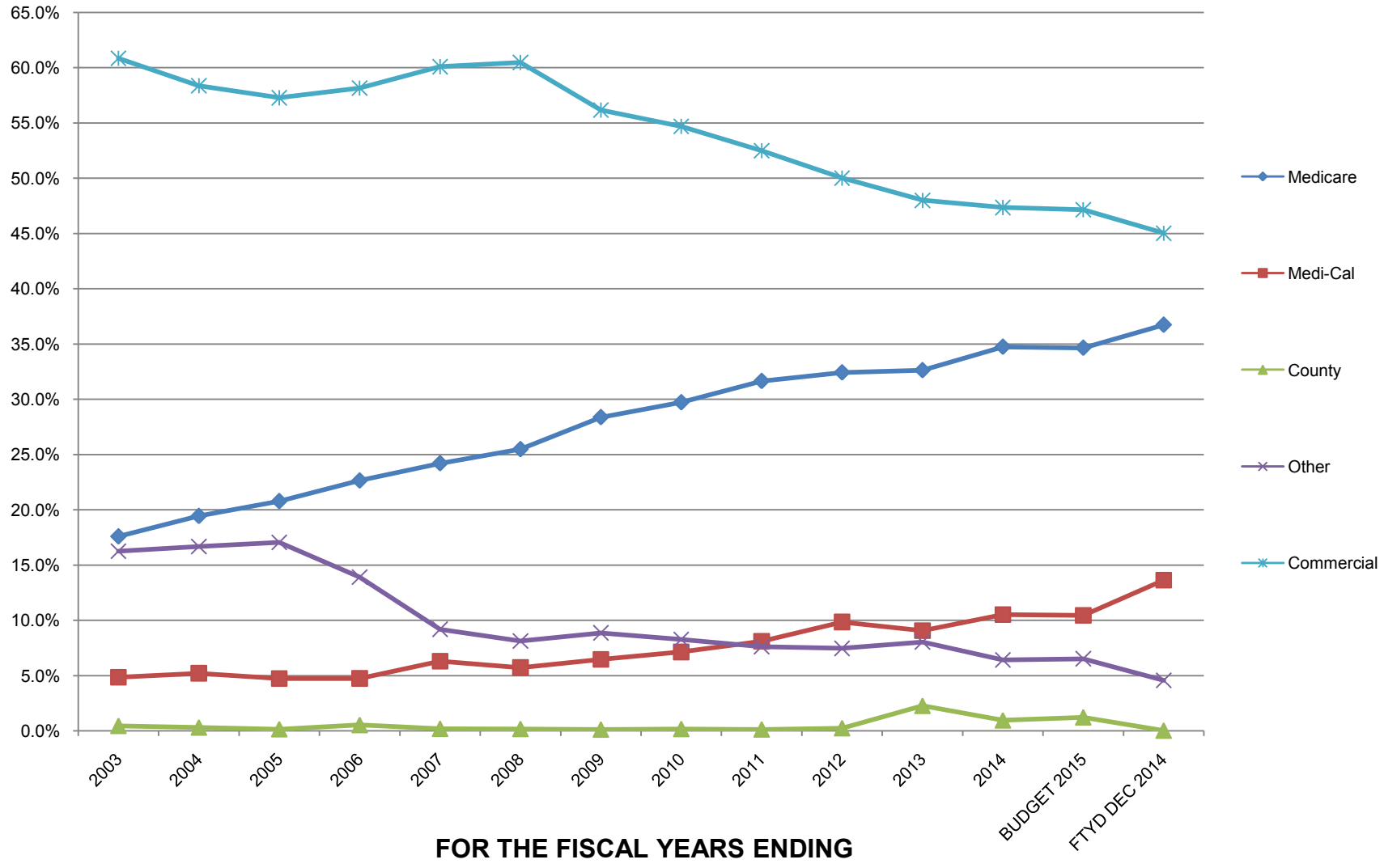
GROSS REVENUE PAYOR MIX TRENDING



INPATIENT REVENUE PAYOR MIX TRENDING



OUTPATIENT REVENUE PAYOR MIX TRENDING



TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF CASH FLOWS

	PROJECTED FYE 2014		BUDGET FYE 2015	BUDGET 1ST QTR	BUDGET 2ND QTR	BUDGET 3RD QTR	BUDGET 4TH QTR
Net Operating Rev/(Exp) - EBIDA	$ 2,671,717		$ 2,008,740	$ 534,681	$ 137,147	$ 1,794,461	$ (457,549)
Interest Income	90,129		96,542	19,653	25,816	25,794	25,279
Property Tax Revenue	5,056,116		5,376,000	415,000	70,000	2,790,000	2,101,000
Donations	731,373		600,300	241,200	26,100	256,000	77,000
Debt Service Payments	(4,363,655)		(3,926,699)	(1,311,692)	(815,474)	(984,061)	(815,474)
Bank of America - 2012 Muni Lease	(1,243,647)		(1,243,644)	(310,911)	(310,911)	(310,911)	(310,911)
Bank of America - 2007 Muni Lease	(421,850)		-	-	-	-	-
Copier	(100,439)		(105,000)	(26,250)	(26,250)	(26,250)	(26,250)
2002 Revenue Bond	(688,619)		(664,805)	(496,218)	-	(168,587)	-
2006 Revenue Bond	(1,909,100)		(1,913,250)	(478,313)	(478,313)	(478,313)	(478,313)
Physician Recruitment	(129,886)		(150,000)	(37,500)	(37,500)	(37,500)	(37,500)
Investment in Capital							
Equipment	(2,102,338)		(1,748,150)	(1,223,750)	(273,900)	(126,350)	(124,150)
Municipal Lease Reimbursement	1,250,000		1,250,000	-	1,024,950	177,900	47,150
GO Bond Project Personal Property	(755,894)		(747,761)	(129,275)	-	(309,243)	(309,243)
IT	(413,368)		(2,804,763)	(1,103,591)	(1,111,954)	(444,051)	(145,167)
Building Projects	(1,297,751)		(3,557,916)	(959,729)	(941,729)	(828,229)	(828,229)
Health Information/Business System	(349,125)		(1,105,000)	(765,000)	-	(340,000)	-
Change in Accounts Receivable	4,329,692	N1	1,989,042	375,255	1,238,379	(756,290)	1,131,698
Change in Settlement Accounts	1,681,901	N2	(900,000)	(1,200,000)	(300,000)	-	600,000
Change in Other Assets	51,893	N3	(548,326)	(149,636)	(530,799)	(538,676)	670,785
Change in Other Liabilities	(1,084,560)	N4	805,000	(300,000)	350,000	65,000	690,000
Change in Cash Balance	5,366,244		(3,362,991)	(5,594,384)	(1,138,964)	744,756	2,625,601
Beginning Unrestricted Cash	43,894,743		49,260,987	49,260,987	43,666,604	42,527,640	43,272,396
Ending Unrestricted Cash	49,260,987		45,897,996	43,666,604	42,527,640	43,272,396	45,897,996
Expense Per Day	313,227		316,480	327,160	319,853	318,724	316,480
Days Cash On Hand	157		145	133	133	136	145

Footnotes:
N1 - Change in Accounts Receivable reflects the 60 day delay in collections. For example, in July 2014 we are collecting May 2014.
N2 - Change in Settlement Accounts reflect cash flows in and out related to prior year and current year Medicare and Medi-Cal settlement accounts.
N3 - Change in Other Assets reflect fluctuations in asset accounts on the Balance Sheet that effect cash. For example, an increase in prepaid expense immediately effects cash but not EBIDA.
N4 - Change in Other Liabilities reflect fluctuations in liability accounts on the Balance Sheet that effect cash. For example, an increase in accounts payable effects EBIDA but not cash.

TAHOE FOREST HOSPITAL DISTRICT
NOVEMBER 2014 FINANCIAL REPORT
INDEX

Board of Directors
Of Tahoe Forest Hospital District

NOVEMBER 2014 FINANCIAL NARRATIVE

The following is a financial narrative analyzing financial and statistical trends for the five months ended November 30, 2014.

Activity Statistics

- TFH acute patient days were 269 for the current month compared to budget of 355. This equates to an average daily census of 9.0 compared to budget of 11.8.
- TFH Outpatient volumes were above budget in the following departments by at least 5%: Laboratory tests, Oncology Lab, Oncology procedures, MRI exams, Ultrasounds, PET CT, Pharmacy units, and Occupational Therapy.
- TFH Outpatient volumes were below budget in the following departments by at least 5%: Home Health visits, Surgical cases, Endoscopy procedures, Mammography, Radiation Oncology, Oncology Drugs, and Speech Therapy.

Financial Indicators

- Net Patient Revenue as a percentage of Gross Patient Revenue was 47.7% in the current month compared to budget of 54.9% and to last month's 52.6%. Current year's Net Patient Revenue as a percentage of Gross Patient Revenue is 54.1%, compared to budget of 54.9% and prior year's 57.4%.
- EBIDA was $(2,079,504) (-15.1%) for the current month compared to budget of $(503,769) (-3.4%), or $(1,575,735) (-11.7%) under budget. Year-to-date EBIDA was $254,084 (.3%) compared to budget of $192,975 (.2%) or $61,109 (.1%) above budget.
- Cash Collections for the current month were $7,414,016 which is 84% of targeted Net Patient Revenue.
- Gross Days in Accounts Receivable were 66.1, compared to the prior month of 63.8. Gross Accounts Receivables are $30,897,913 compared to the prior month of $33,530,676. The percent of Gross Accounts Receivable over 120 days old is 32.4%, compared to the prior month of 29.9%.

Balance Sheet

- Working Capital Days Cash on Hand is 24.3 days. S&P Days Cash on Hand is 147.2. Working Capital cash decreased $2,286,000 due to cash collections falling short of target by 16% and a decrease in Accounts Payable of $623,000.
- Net Patients Accounts Receivable decreased approximately $930,000. Cash collections were at 84% of target and days in accounts receivable were 66.1 days, a 2.3 day increase.
- Estimated Settlements, Medi-Cal and Medicare decreased $310,000 after truing up the FY2014 Medicare program settlements based on the As Filed cost reports.
- GO Bond Project Fund decreased $1,071,789 after reimbursing the District for funds advanced on Measure C projects.
- The District booked its 51% share of losses in the Truckee Surgery Center through October 2014.
- Accounts Payable decreased $623,000 due to the timing of the final check run in November.
- Estimated Settlements, Medi-Cal and Medicare decreased $443,000 after remitting payment due to the State for the As Filed FY2013 cost report and truing up the payable due to the Medi-Cal program based on the As Filed FY2014 cost report.

Operating Revenue

- Current month's Total Gross Revenue was $13,784,216, compared to budget of $14,927,751 or $1,143,535 below budget.
- Current month's Gross Inpatient Revenue was $4,342,604, compared to budget of $5,018,039 or $675,434 under budget.
- Current month's Gross Outpatient Revenue was $9,441,612, compared to budget of $9,909,713 or $468,101 below budget. Volumes were up in some departments and down in others. See TFH Outpatient Activity Statistics above.
- Current month's Gross Revenue Mix was 32.5% Medicare, 18.9% Medi-Cal, .2% County, 4.5% Other, and 43.9% Insurance compared to budget of 34.4% Medicare, 13.7% Medi-Cal, 1.7% County, 6.4% Other, and 43.8% Insurance. Last month's mix was 41.3% Medicare, 15.8% Medi-Cal, .0% County, 4.7% Other, and 38.2% Insurance.
- Current month's Deductions from Revenue were $7,215,837 compared to budget of $6,732,489 or $483,348 over budget. Variance is attributed to the following reasons: 1) Payor mix varied from budget with a 1.90% decrease in Medicare, a 5.13% increase to Medi-Cal, a 1.48% decrease in County, a 1.86% decrease in Other, and Commercial was above budget .12%, and 2) adjustments were made to the Medicare program Receivable and Medi-Cal payable based on the FY2014 As Filed cost reports.

Operating Expenses

DESCRIPTION	November 2014 Actual	November 2014 Budget	Variance	BRIEF COMMENTS
Salaries & Wages	3,324,352	3,333,474	9,122	
Employee Benefits	1,029,559	1,190,752	161,193	Paid leave budgeted for the Thanksgiving holiday season came in below budget estimations.
Benefits – Workers Compensation	39,352	51,566	12,214	
Benefits – Medical Insurance	629,002	717,510	88,508	
Professional Fees	1,913,854	1,528,387	(385,467)	Legal services provided to the Corporate Compliance department, services provided to Financial Administration for the updated Cancer Center proforma and development of an Integrated Strategic Financial plan, an increase in Outpatient Therapy revenues, and Revenue Cycle consulting fees created a negative variance in Professional Fees.
Supplies	995,878	1,125,082	129,204	Medical Supplies Sold to Patients and Surgery revenues fell short of budget, creating a positive variance in Patient & Other Medical Supplies.
Purchased Services	826,159	811,803	(14,356)	Locum coverage for IP Pharmacy, outsourced laboratory testing, and deposits for the Holiday party created a negative variance in Purchased Services.
Other Expenses	567,965	576,780	8,815	Negative variances in Outside Training & Travel for Jacobus consultants, physician continuing medical education, locums travel in the Emergency department and a Radiology conference were offset by positive variances in most of the Other Expenses categories.
Total Expenses	9,326,121	9,335,353	9,232	

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF NET POSITION
NOVEMBER 2014

	Nov-14	Oct-14	Nov-13	
ASSETS				
CURRENT ASSETS				
* CASH	$ 8,055,162	$ 10,341,175	$ 8,045,512	1
PATIENT ACCOUNTS RECEIVABLE - NET	14,100,599	15,030,260	20,528,481	2
OTHER RECEIVABLES	4,974,308	4,423,938	4,343,786	
GO BOND RECEIVABLES	1,927,777	1,530,438	2,153,832	
ASSETS LIMITED OR RESTRICTED	5,737,007	6,506,061	5,991,451	
INVENTORIES	2,529,539	2,530,283	2,310,675	
PREPAID EXPENSES & DEPOSITS	1,712,682	1,908,925	1,402,847	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	3,103,349	3,412,998	3,654,568	3
OTHER CURRENT ASSETS	-	-	-	
TOTAL CURRENT ASSETS	42,140,423	45,684,077	48,431,152	
NON CURRENT ASSETS				
ASSETS LIMITED OR RESTRICTED:				
* CASH RESERVE FUND	40,679,741	40,679,741	33,592,537	1
BANC OF AMERICA MUNICIPAL LEASE	2,292,784	2,291,388	3,035,151	
TOTAL BOND TRUSTEE 2002	2	2	2	
TOTAL BOND TRUSTEE 2006	3,097,001	2,937,724	2,888,826	
TOTAL BOND TRUSTEE GO BOND	-	-	-	
GO BOND PROJECT FUND	17,335,958	18,407,747	25,138,633	4
GO BOND TAX REVENUE FUND	44,944	44,944	373,022	
BOARD DESIGNATED FUND	2,297	2,297	2,297	
DIAGNOSTIC IMAGING FUND	2,965	2,965	3,138	
DONOR RESTRICTED FUND	889,680	855,443	717,332	
WORKERS COMPENSATION FUND	17,782	13,942	10,789	
TOTAL	64,363,154	65,236,192	65,761,727	
LESS CURRENT PORTION	(5,737,007)	(6,506,061)	(5,991,451)	
TOTAL ASSETS LIMITED OR RESTRICTED - NET	58,626,147	58,730,131	59,770,276	
NONCURRENT ASSETS AND INVESTMENTS:				
INVESTMENT IN TSC, LLC	428,977	496,395	714,274	5
PROPERTY HELD FOR FUTURE EXPANSION	836,353	836,353	836,353	
PROPERTY & EQUIPMENT NET	131,467,634	131,808,106	118,776,639	
GO BOND CIP, PROPERTY & EQUIPMENT NET	15,610,482	14,939,726	23,896,980	
TOTAL ASSETS	249,110,015	252,494,787	252,425,674	
DEFERRED OUTFLOW OF RESOURCES:				
DEFERRED LOSS ON DEFEASANCE	604,454	607,686	643,242	
ACCUMULATED DECREASE IN FAIR VALUE OF HEDGING DERIVATIVE	1,608,135	1,608,135	1,522,861	
TOTAL DEFERRED OUTFLOW OF RESOURCES	$ 2,212,589	$ 2,215,821	$ 2,166,103	
LIABILITIES				
CURRENT LIABILITIES				
ACCOUNTS PAYABLE	$ 6,172,568	$ 6,796,039	$ 4,718,549	6
ACCRUED PAYROLL & RELATED COSTS	7,656,403	7,750,526	7,353,912	
INTEREST PAYABLE	640,136	517,032	655,545	
INTEREST PAYABLE GO BOND	1,558,947	1,169,210	1,559,558	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	483,349	926,480	328,709	7
HEALTH INSURANCE PLAN	997,635	997,635	860,027	
WORKERS COMPENSATION PLAN	1,006,475	1,006,475	1,392,606	
COMPREHENSIVE LIABILITY INSURANCE PLAN	890,902	890,902	887,362	
CURRENT MATURITIES OF GO BOND DEBT	315,000	315,000	50,000	
CURRENT MATURITIES OF OTHER LONG TERM DEBT	2,300,830	2,300,830	2,531,925	
TOTAL CURRENT LIABILITIES	22,022,244	22,670,129	20,338,193	
NONCURRENT LIABILITIES				
OTHER LONG TERM DEBT NET OF CURRENT MATURITIES	33,785,064	33,885,341	35,939,611	
GO BOND DEBT NET OF CURRENT MATURITIES	98,130,000	98,130,000	98,450,220	
DERIVATIVE INSTRUMENT LIABILITY	1,608,135	1,608,135	1,522,861	
TOTAL LIABILITIES	155,545,443	156,293,605	156,250,885	
NET ASSETS				
NET INVESTMENT IN CAPITAL ASSETS	94,887,481	97,561,560	97,623,560	
RESTRICTED	889,680	855,443	717,332	
TOTAL NET POSITION	$ 95,777,161	$ 98,417,003	$ 98,340,892	

* Amounts included for Days Cash on Hand calculation

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF NET POSITION
NOVEMBER 2014

1. Working Capital is at 24.3 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 147.2 days. Working Capital cash decreased $2,286,000. Cash collections fell short of target by 16% and Accounts Payable decreased $623,000 See Note 5).

2. Net Patient Accounts Receivable decreased approximately $930,000. Cash collections were 84% of target. Days in Accounts Receivable are at 66.1 days compared to prior months 63.8 days, a 2.30 days increase.

3. Estimated Settlements, Medi-Cal & Medicare decreased $310,000 after truing up the FY2014 program settlements based on the As Filed Cost Reports.

4. GO Bond Project Fund decreased $1,071,789 after reimbursing the District for funds advanced on Measure C projects.

5. The District booked its 51% share in the losses of the Truckee Surgery Center through October 2014.

6. Accounts Payable decreased approximately $623,000 due to the timing of the final check run in November.

7. Estimated Settlements, Medi-Cal & Medicare decreased $443,000 after remitting payment to the State of California for payment due on the FY2013 As Filed Medi-Cal Cost Report and truing up the FY2014 Medi-Cal payable based on the As Filed Cost Report.

Tahoe Forest Hospital District
Cash Investment
November 30, 2014

WORKING CAPITAL				
US Bank	$ 7,903,844			
Tri Counties/US Bank	42,321			
Tri Counties/US Bank	108,998			
Wells Fargo Bank	-			
Local Agency Investment Fund	-	0.261%		
Total			$	8,055,162
BOARD DESIGNATED FUNDS				
US Bank Savings	$ 2,297	0.03%		
Capital Equipment Fund	-			
Total			$	2,297
Building Fund	$ -			
Cash Reserve Fund	40,679,741	0.261%		
Local Agency Investment Fund			$	40,679,741
Banc of America Muni Lease			$	2,292,784
Bonds Cash 1999			$	2
Bonds Cash 2002			$	-
Bonds Cash 2006			$	3,097,001
Bonds Cash 2008			$	17,380,902
DX Imaging Education	$ 2,965	0.261%		
Workers Comp Fund - B of A	17,782			
Insurance				
Health Insurance LAIF	-	0.261%		
Comprehensive Liability Insurance LAIF	-	0.261%		
Total			$	20,747
TOTAL FUNDS			$	71,528,636
RESTRICTED FUNDS				
Gift Fund				
US Bank Money Market	$ 8,367	0.03%		
Foundation Restricted Donations	$ 118,722			
Local Agency Investment Fund	762,591	0.261%		
TOTAL RESTRICTED FUNDS			$	889,680
TOTAL ALL FUNDS			$	72,418,316

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
NOVEMBER 2014

CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VAR$	CURRENT MONTH VAR%	Note		YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	YEAR TO DATE VAR$	YEAR TO DATE VAR%	Note	PRIOR YTD NOV 2013
					OPERATING REVENUE						
$ 13,784,216	$ 14,927,751	$ (1,143,535)	-7.7%		Total Gross Revenue	$ 86,400,290	$ 82,680,290	$ 3,720,000	4.5%	1	$ 79,488,377
					Gross Revenues - Inpatient						
$ 1,232,815	$ 1,496,019	$ (263,203)	-17.6%		Daily Hospital Service	$ 8,496,269	$ 7,918,928	$ 577,341	7.3%		$ 7,825,359
3,109,789	3,522,020	(412,231)	-11.7%		Ancillary Service - Inpatient	20,286,750	19,128,305	1,158,445	6.1%		18,365,936
4,342,604	5,018,039	(675,434)	-13.5%		Total Gross Revenue - Inpatient	28,783,018	27,047,233	1,735,786	6.4%	1	26,191,295
9,441,612	9,909,713	(468,101)	-4.7%		Gross Revenue - Outpatient	57,617,272	55,633,058	1,984,214	3.6%		53,297,082
9,441,612	9,909,713	(468,101)	-4.7%		Total Gross Revenue - Outpatient	57,617,272	55,633,058	1,984,214	3.6%	1	53,297,082
					Deductions from Revenue:						
6,088,043	5,627,834	(460,209)	-8.2%		Contractual Allowances	34,814,473	31,156,293	(3,658,180)	-11.7%	2	31,343,827
412,711	507,544	94,833	18.7%		Charity Care	2,710,718	2,811,129	100,411	3.6%	2	2,470,447
-	-	-	0.0%		Charity Care - Catastrophic Events	-	-	-	0.0%	2	-
416,159	597,111	180,952	30.3%		Bad Debt	1,808,209	3,307,214	1,499,005	45.3%	2	861,753
298,924	-	(298,924)	0.0%		Prior Period Settlements	298,924	-	(298,924)	0.0%	2	(829,615)
7,215,837	6,732,489	(483,348)	-7.2%		Total Deductions from Revenue	39,632,324	37,274,636	(2,357,688)	-6.3%		33,846,412
99,052	82,383	16,669	20.2%		Property Tax Revenue- Wellness Neighborhood	409,139	417,180	(8,041)	-1.9%		196,256
579,186	553,939	25,247	4.6%		Other Operating Revenue	3,046,351	2,831,927	214,423	7.6%	3	2,954,818
7,246,617	8,831,584	(1,584,967)	-17.9%		TOTAL OPERATING REVENUE	50,223,456	48,654,762	1,568,694	3.2%		48,793,039
					OPERATING EXPENSES						
3,324,352	3,333,474	9,122	0.3%		Salaries and Wages	17,014,059	17,193,286	179,226	1.0%	4	16,491,487
1,029,559	1,190,752	161,193	13.5%		Benefits	5,596,613	5,729,870	133,257	2.3%	4	5,495,106
39,352	51,566	12,214	23.7%		Benefits Workers Compensation	232,275	257,832	25,557	9.9%	4	258,139
629,002	717,510	88,508	12.3%		Benefits Medical Insurance	3,360,605	3,587,548	226,943	6.3%	4	3,519,121
1,913,854	1,528,387	(385,467)	-25.2%		Professional Fees	9,375,192	8,616,689	(758,503)	-8.8%	5	7,777,628
995,878	1,125,082	129,204	11.5%		Supplies	6,975,848	6,019,053	(956,795)	-15.9%	6	7,011,658
826,159	811,803	(14,356)	-1.8%		Purchased Services	4,667,895	4,177,938	(489,958)	-11.7%	7	3,758,756
567,965	576,780	8,815	1.5%		Other	2,746,884	2,879,571	132,687	4.6%	8	2,393,315
9,326,121	9,335,353	9,232	0.1%		TOTAL OPERATING EXPENSE	49,969,372	48,461,786	(1,507,585)	-3.1%		46,705,210
(2,079,504)	**(503,769)**	**(1,575,735)**	**312.8%**		**NET OPERATING REVENUE (EXPENSE) EBIDA**	**254,084**	**192,975**	**61,109**	**31.7%**		**2,087,829**
					NON-OPERATING REVENUE/(EXPENSE)						
348,956	365,625	(16,669)	-4.6%		District and County Taxes	1,830,901	1,822,860	8,041	0.4%	9	1,932,362
393,903	393,903	-	0.0%		District and County Taxes - GO Bond	1,969,517	1,969,517	-	0.0%		1,976,801
24,016	21,720	2,296	10.6%		Interest Income	114,935	108,764	6,171	5.7%	10	96,644
3,453	1,987	1,466	73.8%		Interest Income-GO Bond	16,866	12,465	4,401	35.3%		28,558
75,418	60,951	14,467	23.7%		Donations	174,781	304,754	(129,973)	-42.6%	11	146,262
(67,418)	-	(67,418)	0.0%		Gain/ (Loss) on Joint Investment	(67,418)	(56,250)	(11,168)	0.0%	12	-
-	-	-	0.0%		Loss on Impairment of Asset	-	-	-	0.0%	12	-
-	-	-	0.0%		Gain/ (Loss) on Sale of Equipment	-	-	-	0.0%	13	-
-	-	-	0.0%		Impairment Loss	-	-	-	0.0%	14	-
(809,066)	(809,066)	0	0.0%		Depreciation	(3,881,090)	(4,045,332)	164,242	4.1%	15	(3,491,480)
(139,863)	(139,415)	(448)	-0.3%		Interest Expense	(703,925)	(701,422)	(2,503)	-0.4%	16	(738,984)
(389,737)	(389,723)	(14)	0.0%		Interest Expense-GO Bond	(1,194,959)	(458,272)	(736,687)	-160.8%		(1,041,461)
(560,338)	(494,018)	(66,320)	-13.4%		TOTAL NON-OPERATING REVENUE/(EXPENSE)	(1,740,392)	(1,042,916)	(697,477)	-66.9%		(1,091,298)
$ (2,639,842)	**$ (997,787)**	**$ (1,642,055)**	**-164.6%**		**INCREASE (DECREASE) IN NET POSITION**	**$ (1,486,308)**	**$ (849,940)**	**$ (636,368)**	**-74.9%**		**$ 996,531**
					NET POSITION - BEGINNING OF YEAR	**97,263,468**					
					NET POSITION - AS OF NOVEMBER 30, 2014	**$ 95,777,161**					
-15.1%	**-3.4%**	**-11.7%**			**RETURN ON GROSS REVENUE EBIDA**	**0.3%**	**0.2%**	**0.1%**			**2.6%**

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
NOVEMBER 2014

		Variance from Budget Fav / <Unfav> NOV 2014	YTD 2015
1) Gross Revenues			
Acute Patient Days were below budget 24.2% or 86 days. Swing bed days were below budget 100% or 30 days. Daily Hospital and Ancillary Service revenues fell short of budget by 13.5% due to the decrease in patient days.	Gross Revenue -- Inpatient	$ (675,434)	$ 1,735,786
	Gross Revenue -- Outpatient	(468,101)	1,984,214
	Gross Revenue -- Total	$ (1,143,535)	$ 3,720,000
Outpatient volumes were below budget in the following departments: Emergency Department visits, Home Health visits, Surgical cases, Endoscopy procedures, Mammography, Radiation Oncology, Nuclear Medicine, Oncology Drugs, Physical Therapy, and Speech Therapy.			
2) Total Deductions from Revenue			
The payor mix for November shows a 1.90% decrease to Medicare, a 5.13% increase to Medi-Cal, 1.86% decrease to Other, a 1.48% decrease to County, and a .12% increase to Commercial when compared to budget. Contractual Allowances exceeded budget as a result of shifting in our payor mix to Medi-Cal and a shift from Bad Debt to Contractual Allowances as more of the self-pay population is qualifying for the Medi-Cal and Medicaid programs.	Contractual Allowances	$ (460,209)	$ (3,658,180)
	Managed Care Reserve	-	-
	Charity Care	94,833	100,411
	Charity Care - Catastrophic	-	-
	Bad Debt	180,952	1,499,005
	Prior Period Settlement	(298,924)	(298,924)
	Total	$ (483,348)	$ (2,357,688)
Negative variance in Prior Period Settlement related to the true up of the FY2014 Medicare receivable and Medi-Cal payable based on the As Filed cost reports.			
3) Other Operating Revenue			
Retail Pharmacy revenues exceeded budget by 5.70%.	Retail Pharmacy	$ 10,853	$ 142,946
	Hospice Thrift Stores	4,146	2,541
	The Center (non-therapy)	5,250	(3,114)
	IVCH ER Physician Guarantee	(3,515)	63,922
	Children's Center	(47)	(5,580)
	Miscellaneous	(5,641)	27,438
	Oncology Drug Replacement	-	-
Positive variance in Grants related to HRSA grant funds awarded to the Wellness Neighborhood.	Grants	14,201	(13,730)
	Total	$ 25,247	$ 214,423
4) Salaries and Wages	Total	$ 9,122	$ 179,226
Employee Benefits			
Long-Term Sick came in below budget estimations and we saw a reduction in estimated Paid Leave used during the Thanksgiving Holiday season.	PL/SL	$ 195,849	$ 271,851
	Nonproductive	(5,540)	(94,659)
	Pension/Deferred Comp	316	388
	Standby	(7,852)	(31,516)
	Other	(21,581)	(12,807)
	Total	$ 161,193	$ 133,257
Employee Benefits - Workers Compensation	Total	$ 12,214	$ 25,557
Employee Benefits - Medical Insurance	Total	$ 88,508	$ 226,943
5) Professional Fees			
Negative variance in Corporate Compliance attributed to legal services provided to the department.	Corporate Compliance	$ (37,988)	$ (575,632)
	Miscellaneous	(251,929)	(233,506)
Negative variance in Miscellaneous associated with Jacobus Consulting services provided to the Health Information Management, Case Management, Utilization Review, and Revenue Cycle departments.	Patient Accounting/Admitting	(137,900)	(168,870)
	Financial Administration	(17,084)	(87,081)
	The Center (includes OP Therapy)	(12,301)	(80,350)
	TFH/IVCH Therapy Services	3,588	(34,433)
	Oncology	22,275	(20,282)
	Business Performance	-	-
Patient Accounting/Admitting exceeded budget due to services provided by Jacobus Consulting.	Marketing	1,000	4,875
	Home Health/Hospice	4,300	6,100
	Multi-Specialty Clinics Admin	(3,272)	6,449
Financial Administration was over budget for the month for services provided by KaufmanHall for the updated Cancer Center proforma and the development of an Integrated Strategic Financial plan.	Information Technology	7,348	6,894
	Medical Staff Services	(6,219)	18,520
	Human Resources	7,220	22,344
	Sleep Clinic	515	23,653
	Managed Care	2,504	24,985
Outpatient Therapy revenues exceeded budget by 9.72%, creating a negative variance in The Center (includes OP Therapy).	IVCH ER Physicians	(20,000)	28,312
	Multi-Specialty Clinics	2,696	60,434
	Respiratory Therapy	15,959	72,764
IVCH ER Physicians exceeded budget due to overlap coverage.	TFH Locums	(4,863)	81,184
	Administration	38,684	85,139
Positive variance in Administration associated with lessened use of Legal Counsel.	Total	$ (385,467)	$ (758,503)

6) Supplies

Pharmacy Supplies exceeded budget as a result of restocking inventory at the end of the month.

Medical Supplies Sold to Patients and Surgery revenues fell short of budget, creating a positive variance in Patient & Other Medical Supplies.

Positive variance in Food related to the decrease in patient days.

Pharmacy Supplies	$ (44,876)	$ (533,969)
Patient & Other Medical Supplies	152,352	(415,288)
Minor Equipment	247	(43,154)
Other Non-Medical Supplies	1,862	(6,214)
Imaging Film	274	4,499
Office Supplies	3,435	17,267
Food	15,909	20,062
Total	$ 129,204	$ (956,795)

7) Purchased Services

Locums coverage created a negative variance in Pharmacy IP.

Negative variance in Laboratory associated with outsourced lab testing.

Payments for the Employee Holiday party created a negative variance in Human Resources.

Miscellaneous	$ (3,684)	$ (433,013)
Pharmacy IP	(14,608)	(132,325)
Patient Accounting	7,062	(58,225)
Laboratory	(10,847)	(29,901)
Community Development	109	(3,045)
Multi-Specialty Clinics	(1,090)	(369)
Medical Records	1,579	(282)
Hospice	5,520	4,319
Department Repairs	7,824	14,234
Human Resources	(14,499)	19,809
The Center	4,441	20,092
Diagnostic Imaging Services - All	11,198	52,239
Information Technology	(7,361)	56,508
Total	$ (14,356)	$ (489,958)

8) Other Expenses

Negative variance in Outside Training & Travel associated with Jacobus Consultants lodging and travel, physician continuing medical education, locums travel in the Emergency Department, and a Radiology conference.

Other Expenses budgeted for TIRHR came in below budget, creating a negative variance in Miscellaneous. In this instance the negative variance is a benefit to the District.

Controllable expenses continue to be monitored, creating a positive variance in the remainder of the Other Expenses categories.

Outside Training & Travel	$ (33,756)	$ (82,796)
Human Resources Recruitment	3,542	(3,294)
Multi-Specialty Clinics Equip Rent	9	(798)
Physician Services	-	(91)
Innovation Fund	-	-
Miscellaneous	(13,435)	7,448
Utilities	7,327	10,127
Multi-Specialty Clinics Bldg Rent	1,489	11,898
Other Building Rent	5,373	16,904
Dues and Subscriptions	2,468	18,845
Insurance	4,781	23,904
Equipment Rent	4,053	33,850
Marketing	26,964	96,691
Total	$ 8,815	$ 132,687

9) District and County Taxes

Total	$ (16,669)	$ 8,041

10) Interest Income

Total	$ 2,296	$ 6,171

11) Donations

IVCH	$ (4,200)	$ (14,239)
Operational	18,667	(115,734)
Capital Campaign	-	-
Total	14,467	(129,973)

12) Gain/(Loss) on Joint Investment

The District booked its 51% share in losses of the Truckee Surgery Center through October 2014.

Total	$ (67,418)	$ (11,168)

12) Gain/(Loss) on Impairment of Asset

Total	$ -	$ -

13) Gain/(Loss) on Sale

Total	$ -	$ -

14) Impairment Loss

Total	$ -	$ -

15) Depreciation Expense

Total	$ -	$ 164,242

16) Interest Expense

Total	$ (448)	$ (2,503)

INCLINE VILLAGE COMMUNITY HOSPITAL
STATEMENT OF REVENUE AND EXPENSE
NOVEMBER 2014

CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VAR$	CURRENT MONTH VAR%	Note		YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	YEAR TO DATE VAR$	YEAR TO DATE VAR%	Note	PRIOR YTD NOV 2013
					OPERATING REVENUE						
$ 939,410	$ 982,848	$ (43,438)	-4.4%		Total Gross Revenue	$ 6,132,559	$ 6,018,041	$ 114,518	1.9%	1	$ 5,991,304
					Gross Revenues - Inpatient						
$ -	$ -	$ -	0.0%		Daily Hospital Service	$ 15,190	$ 13,976	$ 1,214	8.7%		$ 26,035
-	3,586	(3,586)	-100.0%		Ancillary Service - Inpatient	13,083	26,834	(13,751)	-51.2%		31,035
-	3,586	(3,586)	-100.0%		Total Gross Revenue - Inpatient	28,273	40,810	(12,537)	-30.7%	1	57,070
939,410	979,262	(39,852)	-4.1%		Gross Revenue - Outpatient	6,104,286	5,977,231	127,055	2.1%		5,934,234
939,410	979,262	(39,852)	-4.1%		Total Gross Revenue - Outpatient	6,104,286	5,977,231	127,055	2.1%	1	5,934,234
					Deductions from Revenue:						
238,682	299,782	61,100	20.4%		Contractual Allowances	1,731,956	1,819,426	87,470	4.8%	2	1,888,926
28,819	33,417	4,598	13.8%		Charity Care	198,317	204,613	6,296	3.1%	2	188,605
-	-	-	0.0%		Charity Care - Catastrophic Events	-	-	-	0.0%	2	-
200,011	39,314	(160,697)	-408.8%		Bad Debt	566,452	240,723	(325,729)	-135.3%	2	474,517
43,278	-	(43,278)	0.0%		Prior Period Settlements	43,278	-	(43,278)	0.0%	2	18,147
510,790	372,513	(138,277)	-37.1%		Total Deductions from Revenue	2,540,003	2,264,762	(275,241)	-12.2%	2	2,570,195
71,799	76,209	(4,410)	-5.8%		Other Operating Revenue	374,135	306,995	67,140	21.9%	3	323,937
500,418	686,544	(186,125)	-27.1%		TOTAL OPERATING REVENUE	3,966,691	4,060,273	(93,582)	-2.3%		3,745,046
					OPERATING EXPENSES						
225,986	239,903	13,917	5.8%		Salaries and Wages	1,208,026	1,271,354	63,328	5.0%	4	1,208,601
87,622	100,607	12,985	12.9%		Benefits	461,926	463,658	1,731	0.4%	4	453,976
3,075	2,717	(359)	-13.2%		Benefits Workers Compensation	15,539	13,583	(1,957)	-14.4%	4	11,873
42,418	48,049	5,631	11.7%		Benefits Medical Insurance	226,676	240,247	13,570	5.6%	4	225,175
196,731	185,930	(10,801)	-5.8%		Professional Fees	996,592	1,124,686	128,094	11.4%	5	1,071,017
25,450	37,489	12,039	32.1%		Supplies	235,492	235,860	368	0.2%	6	233,469
32,246	34,038	1,792	5.3%		Purchased Services	222,451	185,650	(36,801)	-19.8%	7	184,595
42,510	51,258	8,748	17.1%		Other	238,767	256,491	17,724	6.9%	8	233,882
656,039	699,990	43,951	6.3%		TOTAL OPERATING EXPENSE	3,605,470	3,791,528	186,058	4.9%		3,622,588
(155,621)	**(13,446)**	**(142,174)**	**1057.3%**		**NET OPERATING REV(EXP) EBIDA**	**361,221**	**268,745**	**92,476**	**34.4%**		**122,458**
					NON-OPERATING REVENUE/(EXPENSE)						
-	4,200	(4,200)	-100.0%		Donations-IVCH	6,761	21,000	(14,239)	-67.8%	9	70,385
-	-	-	0.0%		Gain/ (Loss) on Sale	-	-	-	0.0%	10	-
(53,601)	(53,601)	0	0.0%		Depreciation	(266,321)	(268,007)	1,686	-0.6%	11	(192,064)
(53,601)	(49,401)	(4,200)	-8.5%		TOTAL NON-OPERATING REVENUE/(EXP)	(259,561)	(247,007)	(12,554)	-5.1%		(121,679)
$ (209,222)	**$ (62,848)**	**$ (146,374)**	**232.9%**		**EXCESS REVENUE(EXPENSE)**	**$ 101,660**	**$ 21,738**	**$ 79,922**	**367.7%**		**$ 779**
-16.6%	**-1.4%**	**-15.2%**			**RETURN ON GROSS REVENUE EBIDA**	**5.9%**	**4.5%**	**1.4%**			**2.0%**

INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
NOVEMBER 2014

		Variance from Budget Fav<Unfav> NOV 2014	YTD 2015
1) Gross Revenues			
Acute Patient Days were at budget at 0 and Observation Days were below budget by 2 at 0.	Gross Revenue -- Inpatient	$ (3,586)	$ (12,537)
	Gross Revenue -- Outpatient	(39,852)	127,055
		$ (43,438)	$ 114,518
Outpatient volumes were under budget in Emergency visits, Surgical cases, Radiology exams, Pharmacy units, Sleep Clinic visits, and Physical Therapy.			
2) Total Deductions from Revenue			
We saw a shift in our payor mix with a 6.37% decrease in Commercial, Insurance, a 4.18% increase in Medicare, a 6.25% increase in Medicaid, a 3.69% decrease in Other, and a .37% decrease in County. Positive variance in Contractual Allowances related to revenues falling short of budget. Older, Self-pay accounts continue to be written off as they are turned over to collections, creating a negative variance in Bad Debt.	Contractual Allowances	$ 61,100	$ 87,470
	Charity Care	4,598	6,296
	Charity Care-Catastrophic Event	-	-
	Bad Debt	(160,697)	(325,729)
	Prior Period Settlement	(43,278)	(43,278)
	Total	$ (138,277)	$ (275,241)
Negative variance in Prior Period Settlement associated with the true-up of FY2014 Medicare receivable based on the As Filed cost report.			
3) Other Operating Revenue			
IVCH ER Physician Guarantee is tied to collections which fell short of budget estimations in November.	IVCH ER Physician Guarantee	$ (3,515)	$ 63,922
	Miscellaneous	(895)	3,218
	Total	$ (4,410)	$ 67,140
4) Salaries and Wages	Total	$ 13,917	$ 63,328
Employee Benefits	PL/SL	$ 14,225	$ 3,240
	Standby	3,705	998
	Other	(5,146)	(3,332)
	Nonproductive	(114)	(915)
	Pension/Deferred Comp	316	1,739
	Total	$ 12,985	$ 1,731
Employee Benefits - Workers Compensation	Total	$ (359)	$ (1,957)
Employee Benefits - Medical Insurance	Total	$ 5,631	$ 13,570
5) Professional Fees	Foundation	$ (1,020)	$ (6,269)
Negative variance in IVCH ER Physicians primarily related to overlap coverage.	Miscellaneous	(1,578)	117
	Administration	150	750
	Sleep Clinic	515	23,653
	IVCH ER Physicians	(20,000)	28,312
	Therapy Services	3,040	38,636
	Multi-Specialty Clinics	8,092	42,895
	Total	$ (10,801)	$ 128,094
6) Supplies	Patient & Other Medical Supplies	$ 7,250	$ (5,204)
Medical Supplies Sold to Patients and Surgical Services revenues fell short of budget by 21.38%, creating a positive variance in Patient & Other Medical Supplies.	Pharmacy Supplies	2,483	(917)
	Food	(85)	(110)
	Imaging Film	277	1,046
	Non-Medical Supplies	829	1,672
Drugs Sold to Patients revenues came in below budget by 29.02%, creative a positive variance in Pharmacy Supplies.	Office Supplies	(50)	1,930
	Minor Equipment	1,334	1,952
	Total	$ 12,039	$ 368

INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
NOVEMBER 2014

		Variance from Budget Fav<Unfav>	
		NOV 2014	YTD 2015
7) Purchased Services	Miscellaneous	$ (436)	$ (20,162)
Positive variance in Engineering/Plant/Communications associated with facility maintenance coming in below budget.	Engineering/Plant/Communications	1,494	(16,441)
	EVS/Laundry	162	(6,097)
	Pharmacy	(207)	(2,178)
	Department Repairs	1,097	(1,598)
	Surgical Services	-	-
	Multi-Specialty Clinics	108	458
	Laboratory	696	1,378
	Foundation	(321)	3,094
	Diagnostic Imaging Services - All	(800)	4,744
	Total	$ 1,792	$ (36,801)
8) Other Expenses	Outside Training & Travel	$ 68	$ (13,849)
Controllable expenses are being monitored closely, creating positive variances in all of the Other Expense categories.	Other Building Rent	-	-
	Multi-Specialty Clinics Equip Rent	-	-
	Physician Services	-	-
	Multi-Specialty Clinics Bldg Rent	-	-
	Insurance	213	1,067
	Dues and Subscriptions	1,087	1,483
	Miscellaneous	688	2,339
	Equipment Rent	157	3,108
	Marketing	2,996	11,087
	Utilities	3,537	12,490
	Total	$ 8,748	$ 17,724
9) Donations	Total	$ (4,200)	$ (14,239)
10) Gain/(Loss) on Sale	Total	$ -	$ -
11) Depreciation Expense	Total	$ -	$ 1,686

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF CASH FLOWS

	AUDITED FYE 2014		BUDGET FYE 2015		PROJECTED FYE 2015	ACTUAL NOV 2014	BUDGET NOV 2014	DIFFERENCE	ACTUAL 1ST QTR	PROJECTED 2ND QTR	PROJECTED 3RD QTR	PROJECTED 4TH QTR
Net Operating Rev/(Exp) - EBIDA	$ 3,742,843		$ 2,008,740		$ 2,075,247	**$ (2,079,504)**	**$ (503,769)**	**$ (1,575,735)**	$ 3,469,494	$ (2,731,159)	$ 1,794,461	$ (457,549)
Interest Income	90,129		96,542		95,696	-	-	-	19,503	25,120	25,794	25,279
Property Tax Revenue	5,285,587		5,376,000		5,201,289	-	-	-	237,157	73,132	2,790,000	2,101,000
Donations	1,132,315		600,300		598,430	**32,555**	**9,100**	**23,455**	221,165	44,266	256,000	77,000
Debt Service Payments	(4,308,075)		(3,926,699)		(3,722,478)	**(263,644)**	**(271,825)**	**8,180**	(1,123,831)	(799,113)	(984,061)	(815,474)
Bank of America - 2012 Muni Lease	(1,243,647)		(1,243,644)		(1,243,528)	**(103,637)**	**(103,637)**	**(0)**	(310,795)	(310,911)	(310,911)	(310,911)
Bank of America - 2007 Muni Lease	(421,721)		-		-		-	-	-	-	-	-
Copier	(100,214)		(105,000)		(65,103)	**(730)**	**(8,750)**	**8,020**	(2,393)	(10,210)	(26,250)	(26,250)
2002 Revenue Bond	(633,393)		(664,805)		(501,398)	-	-	-	(332,811)	-	(168,587)	-
2006 Revenue Bond	(1,909,100)		(1,913,250)		(1,912,448)	**(159,277)**	**(159,438)**	**160**	(477,831)	(477,992)	(478,313)	(478,313)
Physician Recruitment	(129,886)		(150,000)		(125,716)	**(5,530)**	**(12,500)**	**6,970**	(27,246)	(23,470)	(37,500)	(37,500)
Investment in Capital					-							
Equipment	(2,157,004)		(1,748,150)		(1,748,150)	**(101,201)**	**(287,188)**	**185,987**	(270,964)	(640,699)	(712,338)	(124,149)
Municipal Lease Reimbursement	748,489		1,250,000		1,250,000	-	-	-	-	-	1,202,850	47,150
GO Bond Project Personal Property	(703,327)		(747,761)		(747,761)	**(24,333)**	**(91,419)**	**67,086**	(24,369)	(104,906)	(309,243)	(309,243)
IT	(339,004)		(2,804,763)		(2,804,763)	**(104,787)**	**(388,160)**	**283,373**	(113,054)	(1,519,118)	(827,424)	(345,167)
Building Projects	(1,339,652)		(3,557,916)		(3,557,916)	**(172,598)**	**(427,053)**	**254,455**	(617,090)	(829,915)	(1,082,683)	(1,028,228)
Health Information/Business System	(349,125)		(1,105,000)		(1,100,852)	-	**(404,148)**	**404,148**	(30,303)	(260,549)	(410,000)	(400,000)
Change in Accounts Receivable	3,825,683		1,989,042	N1	2,629,258	**929,661**	**370,441**	**559,220**	1,214,891	1,788,959	(756,290)	381,698
Change in Settlement Accounts	1,070,839		(900,000)	N2	(978,678)	**(368,631)**	**(300,000)**	**(68,631)**	(310,047)	(368,631)	(300,000)	-
Change in Other Assets	527,205		(548,326)	N3	(630,755)	**466,490**	**428,373**	**38,117**	(997,401)	84,537	(438,676)	720,785
Change in Other Liabilities	(40,000)		805,000	N4	894,379	**(594,490)**	**(500,000)**	**(94,490)**	547,692	(8,313)	65,000	290,000
Change in Cash Balance	7,057,017		(3,362,991)		(2,672,769)	**(2,286,013)**	**(2,378,148)**	**92,135**	2,195,597	(5,269,859)	275,891	125,603
Beginning Unrestricted Cash	43,894,743		50,951,760	N5	50,951,760	**51,020,916**	**51,020,916**	-	50,951,760	53,147,357	47,877,498	48,153,388
Ending Unrestricted Cash	50,951,760		47,588,769		48,278,991	**48,734,903**	**48,642,769**	**92,135**	53,147,357	47,877,498	48,153,388	48,278,991
Expense Per Day	311,010		316,480		320,579	**331,290**	**321,511**	**9,778**	328,735	327,984	324,184	320,579
Days Cash On Hand	164		150		151	**147**	**151**	**(4)**	162	146	149	151

Footnotes:
N1 - Change in Accounts Receivable reflects the 60 day delay in collections. For example, in July 2014 we are collecting May 2014.
N2 - Change in Settlement Accounts reflect cash flows in and out related to prior year and current year Medicare and Medi-Cal settlement accounts.
N3 - Change in Other Assets reflect fluctuations in asset accounts on the Balance Sheet that effect cash. For example, an increase in prepaid expense immediately effects cash but not EBIDA.
N4 - Change in Other Liabilities reflect fluctuations in liability accounts on the Balance Sheet that effect cash. For example, an increase in accounts payable effects EBIDA but not cash.
N5 - Change in Beginning Unrestricted Cash is different than as presented in budget package due to final adjustments for fiscal year end 2014.

TAHOE FOREST HOSPITAL DISTRICT
DECEMBER 2014 FINANCIAL REPORT
INDEX

Board of Directors
Of Tahoe Forest Hospital District

DECEMBER 2014 FINANCIAL NARRATIVE

The following is a financial narrative analyzing financial and statistical trends for the six months ended December 31, 2014.

Activity Statistics

- TFH acute patient days were 392 for the current month compared to budget of 384. This equates to an average daily census of 12.7 compared to budget of 12.4.
- TFH Outpatient volumes were above budget in the following departments by at least 5%: Emergency visits, Laboratory testing, Oncology Lab, Diagnostic Imaging, Oncology procedures, Nuclear Medicine, Ultrasounds, Pharmacy units, Physical Therapy, Speech Therapy, and Occupational Therapy.
- TFH Outpatient volumes were below budget in the following departments by at least 5%: Surgical cases, MRI exams, and Respiratory Therapy.

Financial Indicators

- Net Patient Revenue as a percentage of Gross Patient Revenue was 60.0% in the current month compared to budget of 55.2% and to last month's 47.7%. Current year's Net Patient Revenue as a percentage of Gross Patient Revenue is 55.1%, compared to budget of 55.0% and prior year's 58.2%.
- EBIDA was $1,899,075 (10.6%) for the current month compared to budget of $529,044 (3.1%), or $1,370,031 (7.5%) above budget. Year-to-date EBIDA was $2,152,846 (2.1%) compared to budget of $722,019 (.7%) or $1,430,827 (1.3%) over budget.
- Cash Collections for the current month were $7,433,641 which is 83% of targeted Net Patient Revenue.
- Gross Days in Accounts Receivable were 70.4, compared to the prior month of 66.1. Gross Accounts Receivables are $33,745,535 compared to the prior month of $30,897,913. The percent of Gross Accounts Receivable over 120 days old is 29.5%, compared to the prior month of 32.4%.

Balance Sheet

- Working Capital Days Cash on Hand is 17.9 days. S&P Days Cash on Hand is 141.6. Working Capital cash decreased $2,154,000 due to cash collections falling short of target by 17%, a decrease in Accounts Payable of $1,245,000 and funds advanced on Measure C projects in the amount of $661,834.
- Net Patients Accounts Receivable increased approximately $1,314,000. Cash collections were at 83% of target and days in accounts receivable were 70.4 days, a 4.3 day increase.
- Estimated Settlements, Medi-Cal and Medicare increased $613,000. The District received notification from the Medicare program of underpayment on FY15 Inpatient revenues and booked a conservative receivable pending the completion of our third party payor analysis with outside consultants.
- An adjustments to the asset and offsetting liability reflecting the fair value of the Piper Jaffray swap transaction was made at the close of December to comply with GASB No. 63.
- Accounts Payable decreased $1,245,000 due to the timing of the final check run in December.
- Accrued Payroll & Related Costs increased $564,000 as a result of accruing additional payroll days at the end of the month.

Operating Revenue

- Current month's Total Gross Revenue was $17,837,183, compared to budget of $16,923,782 or $913,401 above budget.
- Current month's Gross Inpatient Revenue was $6,043,393, compared to budget of $5,527,351 or $516,042 over budget.
- Current month's Gross Outpatient Revenue was $11,793,790, compared to budget of $11,396,431 or $397,359 above budget. Volumes were up in some departments and down in others. See TFH Outpatient Activity Statistics above.
- Current month's Gross Revenue Mix was 32.5% Medicare, 20.9% Medi-Cal, .0% County, 3.6% Other, and 43.0% Insurance compared to budget of 34.0% Medicare, 13.3% Medi-Cal, 1.7% County, 6.8% Other, and 44.2% Insurance. Last month's mix was 32.5% Medicare, 18.9% Medi-Cal, .2% County, 4.5% Other, and 43.9% Insurance.
- Current month's Deductions from Revenue were $7,137,657 compared to budget of $7,589,510 or $451,853 below budget. Variance is attributed to the following reasons: 1) Payor mix varied from budget with a 1.53% decrease in Medicare, a 7.67% increase to Medi-Cal, a 1.68% decrease in County, a 3.24% decrease in Other, and Commercial was below budget 1.22%, 2) revenues exceeded budget by 5.4%, 3) the District booked a conservative receivable in the amount of $575,000 due from the Medicare program, and 4) we are seeing increased activity on the collection of outsourced, older patient accounts creating a positive variance in Bad Debt.

Operating Expenses

DESCRIPTION	December 2014 Actual	December 2014 Budget	Variance	BRIEF COMMENTS
Salaries & Wages	3,437,306	3,517,472	80,166	
Employee Benefits	1,007,657	1,020,734	13,078	
Benefits – Workers Compensation	45,082	51,566	6,485	
Benefits – Medical Insurance	650,852	717,510	66,658	
Professional Fees	1,605,152	1,562,128	(43,025)	Legal services provided to the Corporate Compliance department, services provided to Patient Accounting/Admitting by Jacobus Consulting, an increase in Inpatient and Outpatient Therapy revenues, and consulting services provided to Administration for Meaningful Use attestation created a negative variance in Professional Fees.
Supplies	1,470,934	1,197,144	(273,789)	Medical Supplies Sold to Patients, Surgery, and Pharmacy revenues exceeded budget, creating a negative variance in Patient & Other Medical Supplies and Pharmacy Supplies.
Purchased Services	921,180	825,847	(95,333)	Services provided to the Wellness Neighborhood, Press Ganey surveys, Patient Accounting collection agency fees, Locum coverage for IP Pharmacy, outsourced laboratory and genetic testing, annual employee Wellness screenings, and management fees over the retail operations of The Center created a negative variance in Purchased Services.
Other Expenses	596,909	596,669	(241)	Negative variance in Outside Training & Travel for Jacobus consultants, and locums travel in the Emergency and Surgery departments were mostly offset by positive variances in the remainder of the Other Expenses categories.
Total Expenses	9,735,071	9,489,070	(246,001)	

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF NET POSITION
DECEMBER 2014

	Dec-14	Nov-14	Dec-13	
ASSETS				
CURRENT ASSETS				
* CASH	$ 5,900,870	$ 8,055,162	$ 7,175,019	1
PATIENT ACCOUNTS RECEIVABLE - NET	15,414,102	14,100,599	21,845,033	2
OTHER RECEIVABLES	5,643,912	4,974,308	4,994,917	
GO BOND RECEIVABLES	2,325,313	1,927,777	2,548,163	
ASSETS LIMITED OR RESTRICTED	5,746,515	5,737,007	6,073,586	
INVENTORIES	2,471,541	2,529,539	2,281,959	
PREPAID EXPENSES & DEPOSITS	1,494,112	1,712,682	1,728,749	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	3,715,994	3,103,349	3,703,613	3
OTHER CURRENT ASSETS	-	-	-	
TOTAL CURRENT ASSETS	42,712,360	42,140,423	50,351,039	
NON CURRENT ASSETS				
ASSETS LIMITED OR RESTRICTED:				
* CASH RESERVE FUND	40,679,741	40,679,741	33,592,537	1
BANC OF AMERICA MUNICIPAL LEASE	2,292,784	2,292,784	3,035,151	
TOTAL BOND TRUSTEE 2002	2	2	2	
TOTAL BOND TRUSTEE 2006	3,121,382	3,097,001	3,072,484	
TOTAL BOND TRUSTEE GO BOND	-	-	-	
GO BOND PROJECT FUND	17,335,843	17,335,958	24,239,047	
GO BOND TAX REVENUE FUND	44,944	44,944	-	
BOARD DESIGNATED FUND	2,297	2,297	2,297	
DIAGNOSTIC IMAGING FUND	2,965	2,965	3,138	
DONOR RESTRICTED FUND	1,116,061	889,680	731,622	
WORKERS COMPENSATION FUND	17,540	17,782	14,259	
TOTAL	64,613,559	64,363,154	64,690,537	
LESS CURRENT PORTION	(5,746,515)	(5,737,007)	(6,073,586)	
TOTAL ASSETS LIMITED OR RESTRICTED - NET	58,867,044	58,626,147	58,616,951	
NONCURRENT ASSETS AND INVESTMENTS:				
INVESTMENT IN TSC, LLC	428,977	428,977	592,497	
PROPERTY HELD FOR FUTURE EXPANSION	836,353	836,353	836,353	
PROPERTY & EQUIPMENT NET	131,027,820	131,467,634	118,847,072	
GO BOND CIP, PROPERTY & EQUIPMENT NET	16,474,457	15,610,482	24,772,581	
TOTAL ASSETS	250,347,010	249,110,015	254,016,493	
DEFERRED OUTFLOW OF RESOURCES:				
DEFERRED LOSS ON DEFEASANCE	601,222	604,454	640,010	
ACCUMULATED DECREASE IN FAIR VALUE OF HEDGING DERIVATIVE	1,936,176	1,608,135	1,389,291	4
TOTAL DEFERRED OUTFLOW OF RESOURCES	$ 2,537,398	$ 2,212,589	$ 2,029,301	
LIABILITIES				
CURRENT LIABILITIES				
ACCOUNTS PAYABLE	$ 4,927,929	$ 6,172,568	$ 5,533,957	5
ACCRUED PAYROLL & RELATED COSTS	8,220,465	7,656,403	7,981,546	6
INTEREST PAYABLE	759,806	640,136	612,279	
INTEREST PAYABLE GO BOND	1,948,683	1,558,947	1,949,447	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	483,349	483,349	328,709	
HEALTH INSURANCE PLAN	997,635	997,635	860,027	
WORKERS COMPENSATION PLAN	1,006,475	1,006,475	1,392,606	
COMPREHENSIVE LIABILITY INSURANCE PLAN	890,902	890,902	887,362	
CURRENT MATURITIES OF GO BOND DEBT	315,000	315,000	50,000	
CURRENT MATURITIES OF OTHER LONG TERM DEBT	2,300,830	2,300,830	2,485,996	
TOTAL CURRENT LIABILITIES	21,851,075	22,022,244	22,081,929	
NONCURRENT LIABILITIES				
OTHER LONG TERM DEBT NET OF CURRENT MATURITIES	33,684,667	33,785,064	35,841,209	
GO BOND DEBT NET OF CURRENT MATURITIES	98,130,000	98,130,000	98,450,220	
DERIVATIVE INSTRUMENT LIABILITY	1,936,176	1,608,135	1,389,291	4
TOTAL LIABILITIES	155,601,918	155,545,443	157,762,649	
NET ASSETS				
NET INVESTMENT IN CAPITAL ASSETS	96,166,429	94,887,481	97,551,523	
RESTRICTED	1,116,061	889,680	731,622	
TOTAL NET POSITION	$ 97,282,490	$ 95,777,161	$ 98,283,145	

* Amounts included for Days Cash on Hand calculation

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF NET POSITION
DECEMBER 2014

1. Working Capital is at 17.9 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 141.6 days. Working Capital cash decreased $2,154,000. Cash collections fell short of target by 17%, Accounts Payable decreased $1,245,000 See Note 5), and the District advanced funds on the November Measure C billings in the amount of $661,834.

2. Net Patient Accounts Receivable increased approximately $1,314,000. Cash collections were 83% of target. Days in Accounts Receivable are at 70.4 days compared to prior months 66.1 days, a 4.30 days increase.

3. Estimated Settlements, Medi-Cal & Medicare increased $613,000. The District received notification from the Medicare program of underpayment on FY2015 inpatient revenues based on projected activity through December. A conservative receivable was booked pending the completion of our third party payor analysis.

4. To comply with GASB No. 63, the District has booked an adjustment to the asset and offsetting liability to reflect the fair value of the Piper Jaffray swap transaction at the close of December.

5. Accounts Payable decreased approximately $1,245,000 due to the timing of the final check run in December.

6. Accrued Payroll & Related Costs increased $564,000 as a result of accruing additional payroll days in December.

Tahoe Forest Hospital District
Cash Investment
December 31, 2014

WORKING CAPITAL				
US Bank	$ 5,617,730			
Tri Counties/US Bank	89,365			
Tri Counties/US Bank	193,776			
Wells Fargo Bank				
Local Agency Investment Fund	-	0.267%		
Total			$	5,900,870
BOARD DESIGNATED FUNDS				
US Bank Savings	$ 2,297	0.03%		
Capital Equipment Fund	-			
Total			$	2,297
Building Fund	$ -			
Cash Reserve Fund	40,679,741	0.267%		
Local Agency Investment Fund			$	40,679,741
Banc of America Muni Lease			$	2,292,784
Bonds Cash 1999			$	2
Bonds Cash 2002			$	-
Bonds Cash 2006			$	3,121,382
Bonds Cash 2008			$	17,380,787
DX Imaging Education	$ 2,965	0.267%		
Workers Comp Fund - B of A	17,540			
Insurance				
Health Insurance LAIF	-	0.267%		
Comprehensive Liability Insurance LAIF	-	0.267%		
Total			$	20,506
TOTAL FUNDS			$	69,398,369
RESTRICTED FUNDS				
Gift Fund				
US Bank Money Market	$ 8,367	0.03%		
Foundation Restricted Donations	$ 322,242			
Local Agency Investment Fund	785,452	0.267%		
TOTAL RESTRICTED FUNDS			$	1,116,061
TOTAL ALL FUNDS			$	70,514,430

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF NET POSITION
KEY FINANCIAL INDICATORS
DECEMBER 2014

	Current Status	Desired Position	Target	Bond Covenants	FY 2015 Jul 14 to Dec 14	FY 2014 Jul 13 to June 14	FY 2013 Jul 12 to June 13	FY 2012 Jul 11 to June 12	FY 2011 Jul 10 to June 11	FY 2010 Jul 09 to June 10	FY 2009 Jul 08 to June 09
Return On Equity: Increase (Decrease) in Net Position / Net Position			-2.7% (1)		.0%	.001%	-4.0%	8.7%	6.3%	12.4%	9.8%
Days in Accounts Receivable (excludes SNF & MSC) Gross Accounts Receivable / 90 Days			FYE 63 Days		70	75	97	64	59	60	58
Gross Accounts Receivable / 365 Days					70	75	93	64	59	59	66
Days Cash on Hand Excludes Restricted: Cash + Short-Term Investments / (Total Expenses - Depreciation Expense)/ by 365			Budget FYE 150 Days Budget 2nd Qtr 133 Days Projected 2nd Qtr 150 Days	60 Days BBB- 119 Days	142	164	148	203	209	219	163
Accounts Receivable over 120 days (excludes payment plan, legal and charitable balances)			13%		23%	22%	29%	15%	11%	13%	13%
Accounts Receivable over 120 days (includes payment plan, legal and charitable balances)			18%		30%	25%	34%	19%	16%	18%	20%
Cash Receipts Per Day (based on 90 day lag on Patient Net Revenue) excludes managed care reserve			FYE Budget $294,122 End 2nd Qtr Budget $291,229 End 2nd Qtr Actual $310,669		$286,120	$286,394	$255,901	$254,806	$240,383	$256,059	$258,654
											
Debt Service Coverage: Excess Revenue over Exp + Interest Exp + Depreciation / Debt Principal Payments + Interest Expense			Without GO Bond 1.83 With GO Bond 1.07	1.95	2.58 1.33	2.18 1.29	.66 .89	4.83 2.70	4.35 2.45	3.48 3.00	3.23 2.71

Footnotes:

(1) Target Return on Equity was established during the FY15 budgeting process. Fiscal year 2014 ended with a higher net income than projected. Based upon the actual fiscal year end net asset number, our Target Return on Equity was .001%.

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
DECEMBER 2014

CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VAR$	CURRENT MONTH VAR%	Note		YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	YEAR TO DATE VAR$	YEAR TO DATE VAR%	Note	PRIOR YTD DEC 2013
					OPERATING REVENUE						
$ 17,837,183	$ 16,923,782	$ 913,401	5.4%		Total Gross Revenue	$ 104,237,473	$ 99,604,072	$ 4,633,401	4.7%	1	$ 94,939,447
					Gross Revenues - Inpatient						
$ 1,748,250	$ 1,573,574	$ 174,676	11.1%		Daily Hospital Service	$ 10,244,519	$ 9,492,502	$ 752,017	7.9%		$ 9,479,788
4,295,143	3,953,777	341,366	8.6%		Ancillary Service - Inpatient	24,581,893	23,082,082	1,499,811	6.5%		22,193,812
6,043,393	5,527,351	516,042	9.3%		Total Gross Revenue - Inpatient	34,826,411	32,574,584	2,251,828	6.9%	1	31,673,600
11,793,790	11,396,431	397,359	3.5%		Gross Revenue - Outpatient	69,411,062	67,029,489	2,381,573	3.6%		63,265,847
11,793,790	11,396,431	397,359	3.5%		Total Gross Revenue - Outpatient	69,411,062	67,029,489	2,381,573	3.6%	1	63,265,847
					Deductions from Revenue:						
6,618,925	6,337,150	(281,775)	-4.4%		Contractual Allowances	41,433,398	37,493,443	(3,939,955)	-10.5%	2	36,058,142
545,163	575,409	30,246	5.3%		Charity Care	3,255,881	3,386,538	130,657	3.9%	2	3,029,754
-	-	-	0.0%		Charity Care - Catastrophic Events	-	-	-	0.0%	2	-
(26,431)	676,951	703,382	103.9%		Bad Debt	1,781,778	3,984,165	2,202,387	55.3%	2	1,391,581
-	-	-	0.0%		Prior Period Settlements	298,924	-	(298,924)	0.0%	2	(829,615)
7,137,657	7,589,510	451,853	6.0%		Total Deductions from Revenue	46,769,981	44,864,146	(1,905,835)	-4.2%		39,649,862
67,566	86,944	(19,378)	-22.3%		Property Tax Revenue- Wellness Neighborhood	476,705	504,124	(27,419)	-5.4%		231,619
867,054	596,898	270,156	45.3%		Other Operating Revenue	3,913,405	3,428,825	484,579	14.1%	3	3,578,480
11,634,146	10,018,114	1,616,032	16.1%		TOTAL OPERATING REVENUE	61,857,602	58,672,875	3,184,726	5.4%		59,099,684
					OPERATING EXPENSES						
3,437,306	3,517,472	80,166	2.3%		Salaries and Wages	20,451,366	20,710,758	259,392	1.3%	4	20,148,382
1,007,657	1,020,734	13,078	1.3%		Benefits	6,604,270	6,750,604	146,335	2.2%	4	6,640,628
45,082	51,566	6,485	12.6%		Benefits Workers Compensation	277,356	309,398	32,042	10.4%	4	317,721
650,852	717,510	66,658	9.3%		Benefits Medical Insurance	4,011,457	4,305,058	293,601	6.8%	4	4,230,760
1,605,152	1,562,128	(43,025)	-2.8%		Professional Fees	10,980,344	10,178,817	(801,528)	-7.9%	5	9,447,738
1,470,934	1,197,144	(273,789)	-22.9%		Supplies	8,447,095	7,216,198	(1,230,898)	-17.1%	6	8,171,917
921,180	825,847	(95,333)	-11.5%		Purchased Services	5,589,075	5,003,785	(585,290)	-11.7%	7	4,646,502
596,909	596,669	(241)	0.0%		Other	3,343,793	3,476,240	132,446	3.8%	8	2,913,474
9,735,071	9,489,070	(246,001)	-2.6%		TOTAL OPERATING EXPENSE	59,704,755	57,950,856	(1,753,899)	-3.0%		56,517,122
1,899,075	**529,044**	**1,370,031**	**259.0%**		**NET OPERATING REVENUE (EXPENSE) EBIDA**	**2,152,846**	**722,019**	**1,430,827**	**198.2%**		**2,582,562**
					NON-OPERATING REVENUE/(EXPENSE)						
380,442	361,064	19,378	5.4%		District and County Taxes	2,211,343	2,183,924	27,419	1.3%	9	2,545,563
393,903	393,903	-	0.0%		District and County Taxes - GO Bond	2,363,420	2,363,420	-	0.0%		2,367,250
22,888	22,543	345	1.5%		Interest Income	137,823	131,307	6,516	5.0%	10	113,337
3,643	1,840	1,803	98.0%		Interest Income-GO Bond	20,509	14,305	6,204	43.4%		32,473
64,692	60,951	3,742	6.1%		Donations	239,474	365,705	(126,232)	-34.5%	11	190,757
-	(56,250)	56,250	0.0%		Gain/ (Loss) on Joint Investment	(67,418)	(112,500)	45,082	0.0%	12	(95,564)
-	-	-	0.0%		Loss on Impairment of Asset	-	-	-	0.0%	12	-
-	-	-	0.0%		Gain/ (Loss) on Sale of Equipment	-	-	-	0.0%	13	-
-	-	-	0.0%		Impairment Loss	-	-	-	0.0%	14	-
(809,066)	(809,066)	0	0.0%		Depreciation	(4,690,156)	(4,854,399)	164,243	3.4%	15	(4,462,285)
(136,447)	(140,228)	3,781	2.7%		Interest Expense	(840,372)	(841,649)	1,277	0.2%	16	(886,308)
(313,489)	(288,972)	(24,517)	-8.5%		Interest Expense-GO Bond	(1,508,448)	(747,244)	(761,204)	-101.9%		(1,336,636)
(393,433)	(454,215)	60,782	13.4%		TOTAL NON-OPERATING REVENUE/(EXPENSE)	(2,133,825)	(1,497,130)	(636,695)	-42.5%		(1,531,413)
$ 1,505,642	**$ 74,829**	**$ 1,430,813**	**-1912.1%**		**INCREASE (DECREASE) IN NET POSITION**	**$ 19,021**	**$ (775,111)**	**$ 794,133**	**102.5%**		**$ 1,051,149**
					NET POSITION - BEGINNING OF YEAR	**97,263,468**					
					NET POSITION - AS OF DECEMBER 31, 2014	**$ 97,282,490**					
10.6%	**3.1%**	**7.5%**			**RETURN ON GROSS REVENUE EBIDA**	**2.1%**	**0.7%**	**1.3%**			**2.7%**

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
DECEMBER 2014

		Variance from Budget Fav / <Unfav> DEC 2014	YTD 2015
1) Gross Revenues			
Acute Patient Days were above budget 2.08% or 8 days. Swing bed days were below budget 88.89% or 24 days. Daily Hospital and Ancillary Service revenues exceeded budget by 8.6% due to the increase in Acute patient days.	Gross Revenue -- Inpatient	$ 516,042	$ 2,251,828
	Gross Revenue -- Outpatient	397,359	2,381,573
	Gross Revenue -- Total	$ 913,401	$ 4,633,401
Outpatient volumes were over budget in the following departments: Emergency Department visits, Laboratory tests, Oncology Lab, Diagnostic Imaging, Oncology procedures, Nuclear Medicine, Ultrasounds, Cat Scans, Pharmacy units, Physical Therapy, Speech Therapy, and Occupational Therapy.			
2) Total Deductions from Revenue			
The payor mix for December shows a 1.53% decrease to Medicare, a 7.67% increase to Medi-Cal, 3.24% decrease to Other, a 1.68% decrease to County, and a 1.22% decrease to Commercial when compared to budget. Contractual Allowances were over budget due to revenues exceeding budget by 5.4% along with the continued shift to Medi-Cal from Commercial and Other payor categories, however, the negative variance was mostly offset after booking a conservative estimate of $575,000 due from the Medicare program through December 2014.	Contractual Allowances	$ (281,775)	$ (3,939,955)
	Managed Care Reserve	-	-
	Charity Care	30,246	130,657
	Charity Care - Catastrophic	-	-
	Bad Debt	703,382	2,202,387
	Prior Period Settlement	-	(298,924)
	Total	$ 451,853	$ (1,905,835)
We saw a large pick up in Bad Debt write-off as an increasing patient population retrocatively qualifies and becomes part of the Medi-Cal Managed payor mix as well as seeing increased activity on the collection of older patient accounts through outsourced collection agencies.			
3) Other Operating Revenue			
Retail Pharmacy revenues fell short of budget by 5.75%.	Retail Pharmacy	$ (13,704)	$ 129,242
	Hospice Thrift Stores	(9,046)	(6,505)
	The Center (non-therapy)	27,670	24,556
Wellness at Work assessments and consults exceeded budget creating a positive variance in The Center (non-therapy).	IVCH ER Physician Guarantee	(4,949)	58,974
	Children's Center	2,735	(2,845)
	Miscellaneous	11,455	38,893
The District booked the final monies due from the HRSA Grant - Year 3, creating a positive variance in Grants.	Oncology Drug Replacement	-	-
	Grants	255,994	242,264
	Total	$ 270,156	$ 484,579
4) Salaries and Wages	Total	$ 80,166	$ 259,392
Employee Benefits	PL/SL	$ 51,029	$ 322,880
The quarterly adjustment to the Long-Term Sick liability created a positive variance in PL/SL.	Nonproductive	(23,703)	(118,362)
	Pension/Deferred Comp	298	686
	Standby	21,337	(10,179)
A negative variance in Non-Productive primarily related to Longevity Retention Bonuses not expected during the budgeting process.	Other	(35,883)	(48,690)
	Total	$ 13,078	$ 146,335
Employee Benefits - Workers Compensation	Total	$ 6,485	$ 32,042
Employee Benefits - Medical Insurance	Total	$ 66,658	$ 293,601
5) Professional Fees	Corporate Compliance	$ (14,806)	$ (590,438)
Negative variance in Corporate Compliance attributed to legal services provided to the department.	Patient Accounting/Admitting	(52,195)	(221,065)
	Miscellaneous	39,837	(193,668)
	The Center (includes OP Therapy)	(19,752)	(100,101)
Patient Accounting/Admitting exceeded budget due to services provided by Jacobus Consulting.	Financial Administration	(6,713)	(93,795)
	TFH/IVCH Therapy Services	(25,054)	(59,487)
	Oncology	(3,163)	(23,445)
Outpatient Therapy revenues exceeded budget by 21.98%, creating a negative variance in The Center (includes OP Therapy).	Business Performance	-	-
	Multi-Specialty Clinics	(650)	5,799
	Marketing	1,000	5,875
TFH Inpatient Therapy revenues and IVCH Outpatient Therapy revenues exceeded budget by 23.07%, creating a negative variance in TFH/IVCH Therapy Services.	Home Health/Hospice	200	6,300
	Information Technology	7,438	14,331
	Human Resources	514	22,858
Negative variance in Administration related to services provided to the District for Meaningful Use attestation.	Medical Staff Services	6,024	24,544
	Sleep Clinic	3,104	26,757
	Managed Care	3,092	28,077
	IVCH ER Physicians	16,255	44,566
	Administration	(29,939)	55,201
	Multi-Specialty Clinics Admin	(5,106)	55,328
	Respiratory Therapy	16,944	89,708
	TFH Locums	19,946	101,130
	Total	$ (43,025)	$ (801,528)

6) Supplies

Medical Supplies Sold to Patients and Surgery revenues exceeded budget by 5.92%, creating a negative variance in Patient & Other Medical Supplies.

Negative variance in Pharmacy Supplies is a result of revenues exceeded budget by 10.58%.

Positive variance in Food related to the decrease in Swing patient days.

Patient & Other Medical Supplies	$ (228,900)	$ (644,501)
Pharmacy Supplies	(77,943)	(611,912)
Minor Equipment	1,870	(41,284)
Other Non-Medical Supplies	5,548	(665)
Imaging Film	1,232	5,731
Office Supplies	11,166	28,433
Food	13,239	33,301
Total	$ (273,789)	$ (1,230,898)

7) Purchased Services

Services provided to the Wellness Neighborhood and Press Ganey surveys created a negative variance in Miscellaneous.

Locums coverage created a negative variance in Pharmacy IP.

Negative variance in Patient Accounting related to outsourced collection agency fees.

Outsourced laboratory testing and genetic testing created a negative variance in Laboratory.

Annual employee wellness screenings attributed to the negative variance in Human Resources.

Outsourced management over the retail operations of the Center for Health and Sports Performance are tied to revenues generated, which exceeded budget in December and created a negative variance in The Center.

Diagnostic Imaging Services - All realized a positive variance after the contract for imaging reads was renegotiated and a credit was issued to the facility.

Miscellaneous	$ (40,155)	$ (473,168)
Pharmacy IP	(12,608)	(144,934)
Patient Accounting	(21,465)	(79,690)
Laboratory	(36,805)	(66,706)
Human Resources	(25,207)	(5,397)
Community Development	234	(2,811)
Multi-Specialty Clinics	(2,239)	(2,608)
Medical Records	2,230	1,948
The Center	(15,842)	4,251
Hospice	38	4,357
Department Repairs	15,180	29,414
Information Technology	(5,008)	51,501
Diagnostic Imaging Services - All	46,314	98,553
Total	$ (95,333)	$ (585,290)

8) Other Expenses

Negative variance in Outside Training & Travel associated with Jacobus Consultants lodging and travel and locums travel in the Emergency and Surgical departments.

Measure C Labor came in below budget estimates, creating a positive variance in Miscellaneous.

Natural Gas, Electricity, and Water/Sewer costs fell below budget, creating a positive variance in Utilities.

Controllable expenses continue to be monitored, creating a positive variance in most of the Other Expenses categories.

Outside Training & Travel	$ (29,300)	$ (112,096)
Miscellaneous	(16,151)	(8,703)
Human Resources Recruitment	(1,658)	(4,952)
Physician Services	0	(91)
Innovation Fund	-	-
Multi-Specialty Clinics Equip Rent	1,148	350
Other Building Rent	(3,552)	13,352
Multi-Specialty Clinics Bldg Rent	1,581	13,479
Dues and Subscriptions	6,014	24,859
Insurance	5,824	29,728
Utilities	20,275	30,402
Equipment Rent	4,779	38,628
Marketing	10,799	107,490
Total	$ (241)	$ 132,446

9) District and County Taxes	Total	$ 19,378 $ 27,419
10) Interest Income	Total	$ 345 $ 6,516
11) Donations	IVCH	$ 1,513 $ (12,726)
	Operational	2,229 (113,506)
	Capital Campaign	- -
	Total	3,742 (126,232)
12) Gain/(Loss) on Joint Investment	Total	$ 56,250 $ 45,082

The District received financial information on the Truckee Surgery Center through October 2014 and booked these numbers during the November close. We budgeted a loss on operations through December which has fallen short of budget estimations.

12) Gain/(Loss) on Impairment of Asset	Total	$ - $ -
13) Gain/(Loss) on Sale	Total	$ - $ -
14) Impairment Loss	Total	$ - $ -
15) Depreciation Expense	Total	$ - $ 164,243
16) Interest Expense	Total	$ 3,781 $ 1,277

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
KEY FINANCIAL INDICATORS
DECEMBER 2014

	Current Status	Desired Position	Target	FY 2015 Jul 14 to Dec 14	FY 2014 Jul 13 to June 14	FY 2013 Jul 12 to June 13	FY 2012 Jul 11 to June 12	FY 2011 Jul 10 to June 11	FY 2010 Jul 09 to June 10	FY 2009 Jul 08 to June 09
Total Margin: Increase (Decrease) In Net Position / Total Gross Revenue		⇧	FYE -1.3% 2nd Qtr -.01%	.0%	.0%	-2.2%	5.3%	3.6%	5.8%	4.6%
Charity Care: Charity Care Expense / Gross Patient Revenue		⇩	FYE 3.4% 2nd Qtr 3.4%	3.1%	3.2%	3.2%	2.6%	3.0%	3.1%	2.5%
Bad Debt Expense: Bad Debt Expense / Gross Patient Revenue		⇩	FYE 4.0% 2nd Qtr 4.0%	1.7%	1.6%	4.6%	4.3%	3.8%	4.1%	4.6%
Incline Village Community Hospital: EBIDA: Earnings before interest, Depreciation, amortization / Net Operating Revenue <Expense> / Gross Revenue		⇧	FYE 4.0% 2nd Qtr 4.8%	6.8%	4.9%	11.5%	10.8%	12.3%	6.7%	5.0%
Operating Expense Variance to Budget (Under<Over>)		⇧	-0-	$(1,753,899)	$2,129,279	$(1,498,683)	$790,439	$15,188	$2,662,695	<$1,292,399>
EBIDA: Earnings before interest, Depreciation, amortization / Net Operating Revenue <Expense> / Gross Revenue		⇧	FYE 1.0% 2nd Qtr .72%	2.1%	2.0%	.9%	5.6%	5.1%	6.6%	4.4%

INCLINE VILLAGE COMMUNITY HOSPITAL
STATEMENT OF REVENUE AND EXPENSE
DECEMBER 2014

CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VAR$	CURRENT MONTH VAR%	Note		YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	YEAR TO DATE VAR$	YEAR TO DATE VAR%	Note	PRIOR YTD DEC 2013
					OPERATING REVENUE						
$ 1,341,018	$ 1,246,256	$ 94,762	7.6%		Total Gross Revenue	$ 7,473,577	$ 7,264,297	$ 209,280	2.9%	1	$ 7,180,880
					Gross Revenues - Inpatient						
$ -	$ -	$ -	0.0%		Daily Hospital Service	$ 15,190	$ 13,976	$ 1,214	8.7%		$ 23,785
7,933	4,090	3,843	94.0%		Ancillary Service - Inpatient	21,016	30,924	(9,908)	-32.0%		31,035
7,933	4,090	3,843	94.0%		Total Gross Revenue - Inpatient	36,206	44,900	(8,694)	-19.4%	1	54,820
1,333,086	1,242,166	90,920	7.3%		Gross Revenue - Outpatient	7,437,371	7,219,397	217,975	3.0%		7,126,060
1,333,086	1,242,166	90,920	7.3%		Total Gross Revenue - Outpatient	7,437,371	7,219,397	217,975	3.0%	1	7,126,060
					Deductions from Revenue:						
439,193	372,319	(66,874)	-18.0%		Contractual Allowances	2,171,149	2,191,745	20,596	0.9%	2	2,213,895
43,026	42,373	(653)	-1.5%		Charity Care	241,343	246,986	5,643	2.3%	2	245,856
-	-	-	0.0%		Charity Care - Catastrophic Events	-	-	-	0.0%	2	-
47,523	49,850	2,327	4.7%		Bad Debt	613,975	290,573	(323,402)	-111.3%	2	522,346
-	-	-	0.0%		Prior Period Settlements	43,278	-	(43,278)	0.0%	2	18,147
529,742	464,542	(65,200)	-14.0%		Total Deductions from Revenue	3,069,745	2,729,304	(340,441)	-12.5%	2	3,000,244
50,748	56,685	(5,937)	-10.5%		Other Operating Revenue	424,883	363,679	61,204	16.8%	3	371,857
862,025	838,399	23,626	2.8%		TOTAL OPERATING REVENUE	4,828,716	4,898,672	(69,957)	-1.4%		4,552,493
					OPERATING EXPENSES						
263,984	261,181	(2,803)	-1.1%		Salaries and Wages	1,472,009	1,532,534	60,525	3.9%	4	1,481,330
62,297	76,483	14,186	18.5%		Benefits	524,223	540,141	15,918	2.9%	4	529,472
3,075	2,717	(359)	-13.2%		Benefits Workers Compensation	18,615	16,299	(2,315)	-14.2%	4	17,044
43,881	48,049	4,168	8.7%		Benefits Medical Insurance	270,558	288,296	17,738	6.2%	4	257,807
206,875	228,487	21,612	9.5%		Professional Fees	1,203,468	1,353,173	149,706	11.1%	5	1,288,155
55,474	52,345	(3,129)	-6.0%		Supplies	290,966	288,205	(2,761)	-1.0%	6	294,112
25,003	36,608	11,604	31.7%		Purchased Services	247,454	222,257	(25,197)	-11.3%	7	223,562
53,144	50,465	(2,679)	-5.3%		Other	291,911	306,956	15,045	4.9%	8	283,398
713,733	756,334	42,601	5.6%		TOTAL OPERATING EXPENSE	4,319,203	4,547,862	228,658	5.0%		4,374,880
148,291	**82,065**	**66,226**	**80.7%**		**NET OPERATING REV(EXP) EBIDA**	**509,512**	**350,810**	**158,702**	**45.2%**		**177,613**
					NON-OPERATING REVENUE/(EXPENSE)						
5,713	4,200	1,513	36.0%		Donations-IVCH	12,474	25,200	(12,726)	-50.5%	9	70,385
-	-	-	0.0%		Gain/ (Loss) on Sale	-	-	-	0.0%	10	-
(53,601)	(53,601)	0	0.0%		Depreciation	(319,922)	(321,608)	1,686	-0.5%	11	(311,450)
(47,888)	(49,401)	1,513	3.1%		TOTAL NON-OPERATING REVENUE/(EXP)	(307,449)	(296,408)	(11,040)	-3.7%		(241,065)
$ 100,403	**$ 32,664**	**$ 67,740**	**207.4%**		**EXCESS REVENUE(EXPENSE)**	**$ 202,064**	**$ 54,402**	**$ 147,662**	**271.4%**		**$ (63,452)**
11.1%	**6.6%**	**4.5%**			**RETURN ON GROSS REVENUE EBIDA**	**6.8%**	**4.8%**	**2.0%**			**2.5%**

INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
DECEMBER 2014

		Variance from Budget Fav<Unfav> DEC 2014	YTD 2015
1) Gross Revenues			
Acute Patient Days were over budget by 1 at 1 and Observation Days were below budget by 3 at 0.	Gross Revenue -- Inpatient	$ 3,843	$ (8,694)
	Gross Revenue -- Outpatient	90,920	217,975
		$ 94,762	$ 209,280
Outpatient volumes were above budget in Emergency visits, Surgical cases, Laboratory tests, Radiology exams, Pharmacy units, and Occupational Therapy.			
2) Total Deductions from Revenue			
We saw a shift in our payor mix with a 4.97% increase in Commercial, Insurance, a 5.04% decrease in Medicare, a 6.03% increase in Medicaid, a 5.55% decrease in Other, and a .40% decrease in County. Negative variance in contractual allowances attributed to revenues exceeding budget by 7.6% coupled with the shift to Medicaid from Medicare.	Contractual Allowances	$ (66,874)	$ 20,596
	Charity Care	(653)	5,643
	Charity Care-Catastrophic Event	-	-
	Bad Debt	2,327	(323,402)
	Prior Period Settlement	-	(43,278)
	Total	$ (65,200)	$ (340,441)
3) Other Operating Revenue			
IVCH ER Physician Guarantee is tied to collections which fell short of budget.	IVCH ER Physician Guarantee	$ (4,949)	$ 58,974
	Miscellaneous	(988)	2,230
	Total	$ (5,937)	$ 61,204
4) Salaries and Wages	Total	$ (2,803)	$ 60,525
Employee Benefits	PL/SL	$ 17,171	$ 20,412
	Standby	2,391	3,389
	Other	(5,592)	(8,923)
	Nonproductive	(100)	(1,015)
	Pension/Deferred Comp	316	2,055
	Total	$ 14,186	$ 15,918
Employee Benefits - Workers Compensation	Total	$ (359)	$ (2,315)
Employee Benefits - Medical Insurance	Total	$ 4,168	$ 17,738
5) Professional Fees	Foundation	$ (3,630)	$ (9,898)
Negative variance in Foundation related to services provided for philanthropy and fundraising.	Administration	150	900
	Miscellaneous	825	942
	Sleep Clinic	3,104	26,757
IVCH Physical Therapy volumes were slightly lower than budget, however, revenues exceeded budget by 4.01% creating a negative variance in Therapy Services.	Therapy Services	(2,945)	35,691
	IVCH ER Physicians	16,255	44,566
	Multi-Specialty Clinics	7,853	50,748
	Total	$ 21,612	$ 149,706
6) Supplies	Patient & Other Medical Supplies	$ (11,905)	$ (17,109)
Medical Supplies Sold to Patients and Surgical Services revenues exceeded budget by 38.33%, creating a negative variance in Patient & Other Medical Supplies.	Food	(422)	(532)
	Non-Medical Supplies	(1,211)	460
	Imaging Film	361	1,407
	Office Supplies	(237)	1,693
Drugs Sold to Patients revenues came in below budget by 5.55% creative a positive variance in Pharmacy Supplies.	Minor Equipment	1,880	3,832
	Pharmacy Supplies	8,406	7,489
	Total	$ (3,129)	$ (2,761)

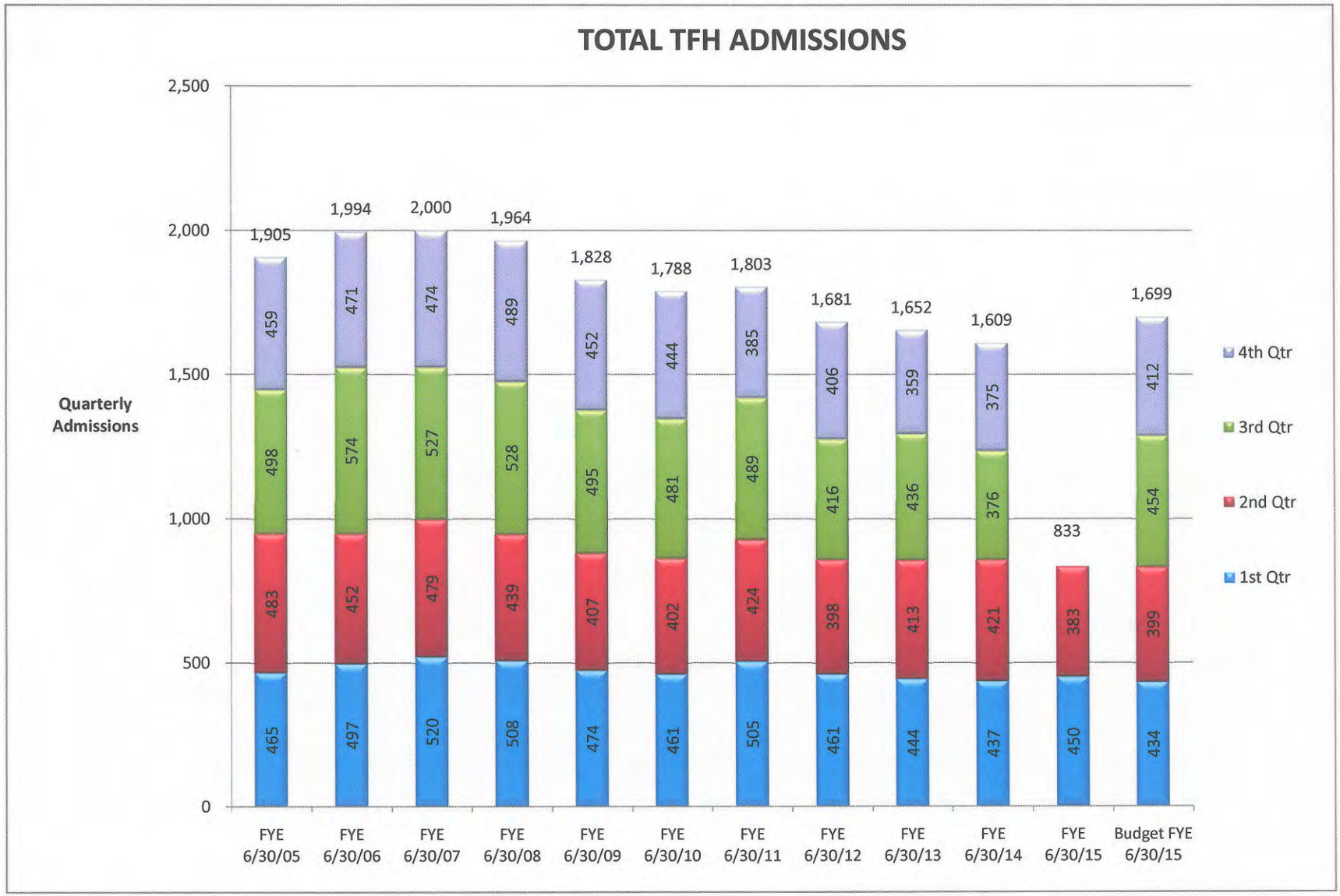
INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
DECEMBER 2014

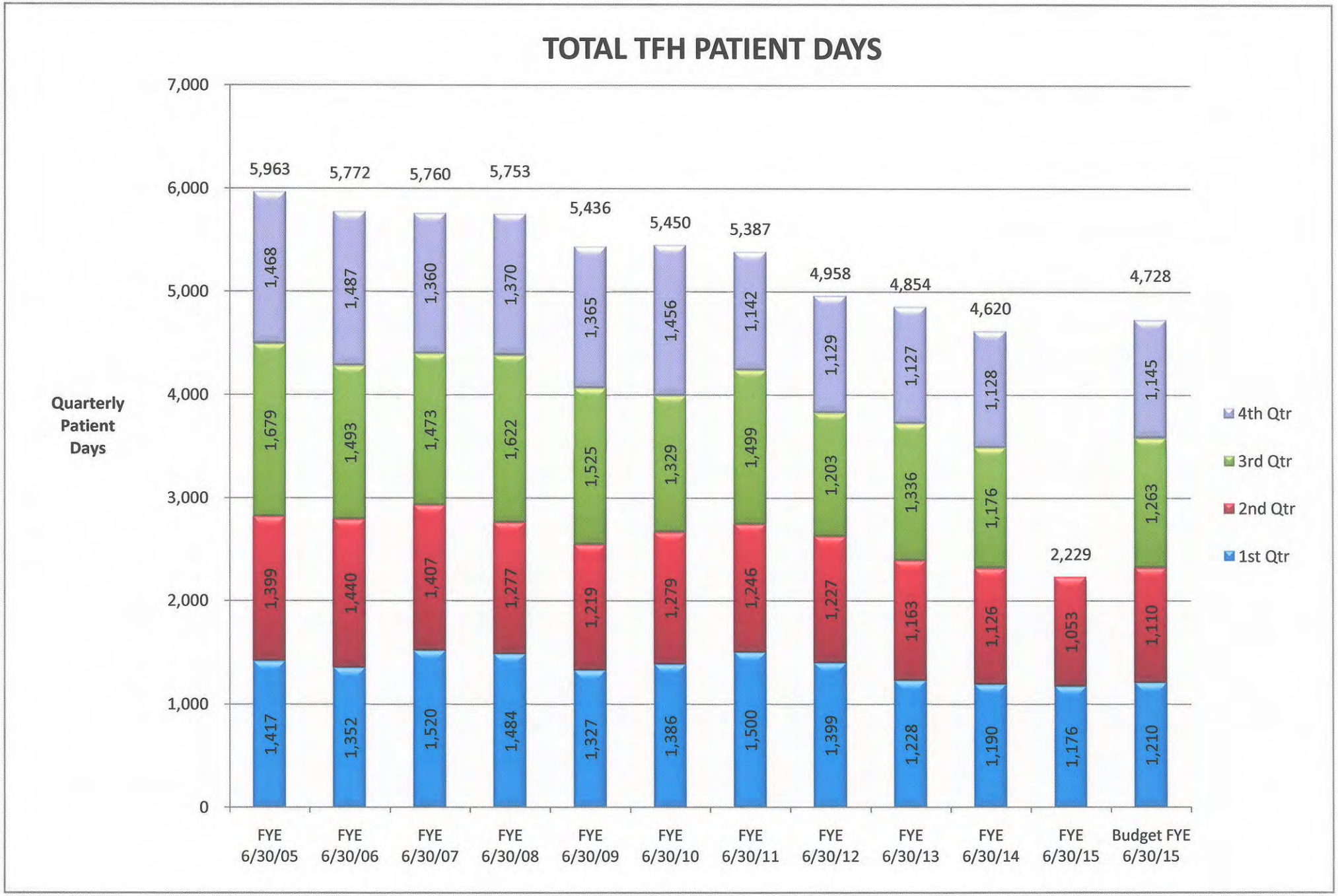
		Variance from Budget Fav<Unfav>	
		DEC 2014	YTD 2015
7) Purchased Services	Miscellaneous	$ (167)	$ (20,328)
Positive variance in Engineering/Plant/Communications associated with facility maintenance coming in below budget.	Engineering/Plant/Communications	3,930	(12,511)
	EVS/Laundry	(444)	(6,541)
	Pharmacy	(207)	(2,385)
Diagnostic Imaging Services - All realized a positive variance after the contract for imaging reads was renegotiated and a credit issued to the facility.	Surgical Services	-	-
	Multi-Specialty Clinics	326	785
	Laboratory	(345)	1,033
	Department Repairs	3,060	1,463
	Foundation	333	3,427
	Diagnostic Imaging Services - All	5,117	9,861
	Total	$ 11,604	$ (25,197)
8) Other Expenses	Outside Training & Travel	$ (68)	$ (13,918)
Negative variance in Equipment Rent related to oxygen tank rentals.	Other Building Rent	-	-
	Multi-Specialty Clinics Equip Rent	-	-
Electricity, Water, and Sewer costs came in over budget creating a negative variance in Utilities.	Physician Services	-	-
	Multi-Specialty Clinics Bldg Rent	-	-
	Miscellaneous	(1,560)	779
Controllable expenses continue to be monitored closely.	Equipment Rent	(2,313)	795
	Insurance	213	1,280
	Dues and Subscriptions	931	2,414
	Utilities	(2,186)	10,304
	Marketing	2,305	13,391
	Total	$ (2,679)	$ 15,045
9) Donations	Total	$ 1,513	$ (12,726)
10) Gain/(Loss) on Sale	Total	$ -	$ -
11) Depreciation Expense	Total	$ -	$ 1,686

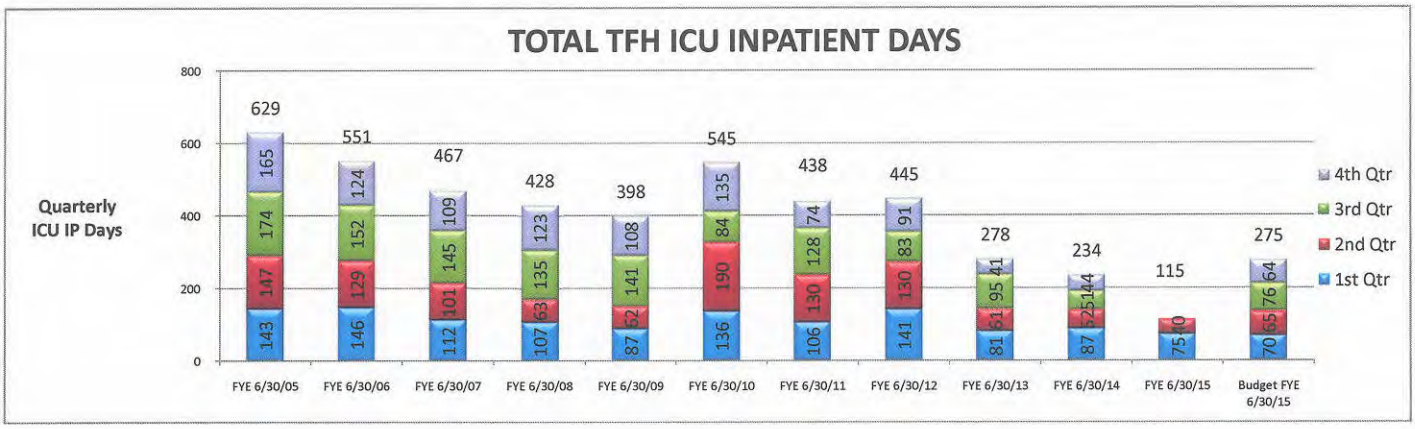
TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF CASH FLOWS

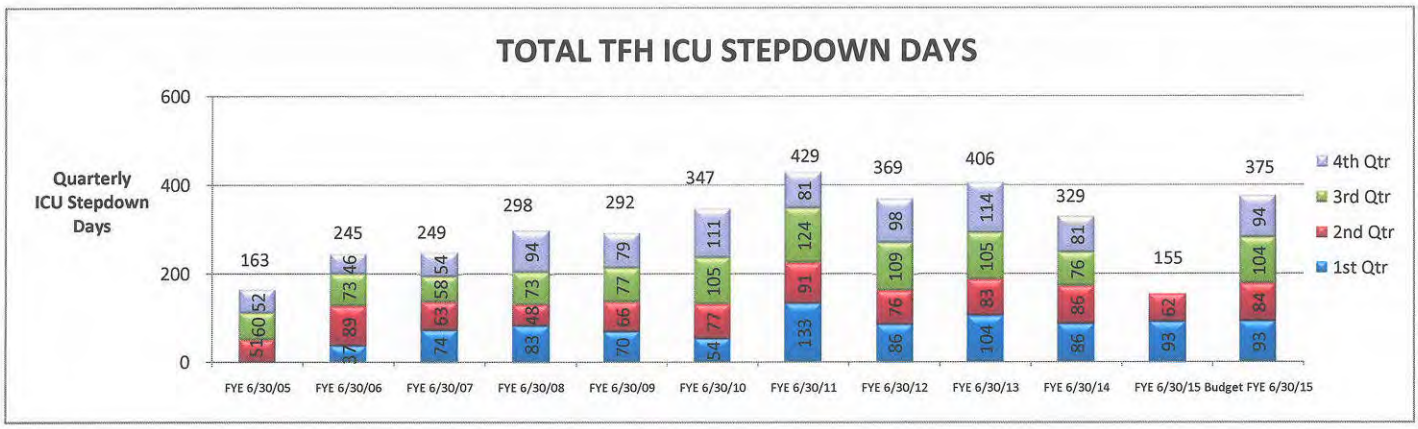
	AUDITED FYE 2014		BUDGET FYE 2015		PROJECTED FYE 2015	**ACTUAL DEC 2014**	**BUDGET DEC 2014**	**DIFFERENCE**	ACTUAL 1ST QTR	ACTUAL 2ND QTR	PROJECTED 3RD QTR	PROJECTED 4TH QTR
Net Operating Rev/(Exp) - EBIDA	$ 3,742,843		$ 2,008,740		$ 3,476,060	**$ 1,899,075**	**$ 529,044**	**$ 1,370,031**	$ 3,469,494	$ (1,330,346)	$ 1,794,461	$ (457,549)
Interest Income	90,129		96,542		95,696	-	-	-	19,503	25,120	25,794	25,279
Property Tax Revenue	5,285,587		5,376,000		5,201,289	-	-	-	237,157	73,132	2,790,000	2,101,000
Donations	1,132,315		600,300		600,412	**101,982**	-	**101,982**	221,165	146,247	156,000	77,000
Debt Service Payments	(4,308,075)		(3,926,699)		(3,714,305)	**(263,652)**	**(271,825)**	**8,173**	(1,123,831)	(790,940)	(984,061)	(815,474)
Bank of America - 2012 Muni Lease	(1,243,647)		(1,243,644)		(1,243,529)	**(103,637)**	**(103,637)**	**(0)**	(310,795)	(310,912)	(310,911)	(310,911)
Bank of America - 2007 Muni Lease	(421,721)		-		-		-	-	-	-	-	-
Copier	(100,214)		(105,000)		(57,090)	**(737)**	**(8,750)**	**8,013**	(2,393)	(2,197)	(26,250)	(26,250)
2002 Revenue Bond	(633,393)		(664,805)		(501,398)	-	-	-	(332,811)	-	(168,587)	-
2006 Revenue Bond	(1,909,100)		(1,913,250)		(1,912,287)	**(159,277)**	**(159,438)**	**160**	(477,831)	(477,831)	(478,313)	(478,313)
Physician Recruitment	(129,886)		(150,000)		(118,359)	**(5,143)**	**(12,500)**	**7,357**	(27,246)	(16,112)	(37,500)	(37,500)
Investment in Capital					-							
Equipment	(2,157,004)		(1,748,150)		(1,748,150)	**(137,994)**	**(444,086)**	**306,092**	(270,964)	(334,607)	(1,018,430)	(124,149)
Municipal Lease Reimbursement	748,489		1,250,000		1,250,000	-	-	-	-	-	1,202,850	47,150
GO Bond Project Personal Property	(703,327)		(747,761)		(747,761)	**(1,103)**	**(67,086)**	**65,983**	(24,369)	(38,923)	(375,226)	(309,243)
IT	(339,004)		(2,804,763)		(2,804,763)	**(35,004)**	**(461,189)**	**426,185**	(113,054)	(1,092,933)	(953,609)	(645,167)
Building Projects	(1,339,652)		(3,557,916)		(3,557,916)	**(195,152)**	**(428,123)**	**232,971**	(617,090)	(596,944)	(1,315,654)	(1,028,228)
Health Information/Business System	(349,125)		(1,105,000)		(1,040,852)	-	**(60,000)**	**60,000**	(30,303)	(200,549)	(410,000)	(400,000)
Change in Accounts Receivable	3,825,683		1,989,042	N1	2,614,922	**(1,303,513)**	**(389,177)**	**(914,336)**	1,214,891	874,623	443,710	81,698
Change in Settlement Accounts	1,070,839		(900,000)	N2	(978,678)	-	-	-	(310,047)	(368,631)	(300,000)	-
Change in Other Assets	527,205		(548,326)	N3	(1,036,146)	**(1,652,882)**	**278,318**	**(1,931,200)**	(997,401)	(1,846,663)	1,087,133	720,785
Change in Other Liabilities	(40,000)		805,000	N4	833,473	**(560,906)**	**500,000**	**(1,060,906)**	547,692	(1,069,219)	1,065,000	290,000
Change in Cash Balance	7,057,017		(3,362,991)		(1,675,078)	**(2,154,292)**	**(826,624)**	**(1,327,668)**	2,195,597	(6,566,746)	3,170,469	(474,398)
Beginning Unrestricted Cash	43,894,743		50,951,760	N5	50,951,760	**48,734,903**	**48,734,903**	-	50,951,760	53,147,357	46,580,611	49,751,080
Ending Unrestricted Cash	50,951,760		47,588,769		49,276,682	**46,580,611**	**47,908,280**	**(1,327,668)**	53,147,357	46,580,611	49,751,080	49,276,682
Expense Per Day	311,010		316,480		321,154	**329,124**	**319,853**	**9,271**	328,735	329,124	324,949	321,154
Days Cash On Hand	164		150		153	**142**	**150**	**(9)**	162	142	153	153

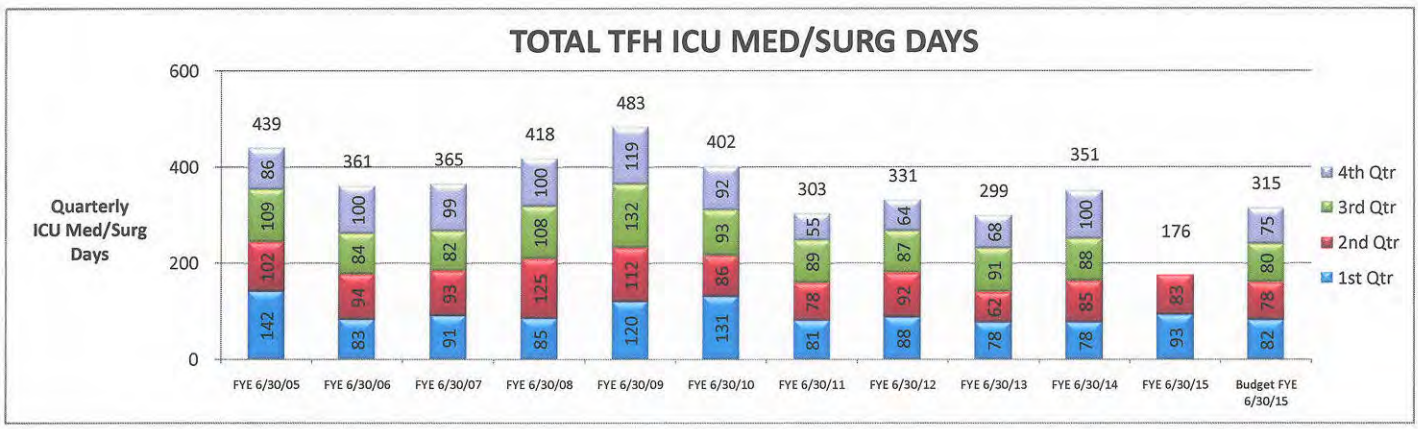
Footnotes:
N1 - Change in Accounts Receivable reflects the 60 day delay in collections. For example, in July 2014 we are collecting May 2014.
N2 - Change in Settlement Accounts reflect cash flows in and out related to prior year and current year Medicare and Medi-Cal settlement accounts.
N3 - Change in Other Assets reflect fluctuations in asset accounts on the Balance Sheet that effect cash. For example, an increase in prepaid expense immediately effects cash but not EBIDA.
N4 - Change in Other Liabilities reflect fluctuations in liability accounts on the Balance Sheet that effect cash. For example, an increase in accounts payable effects EBIDA but not cash.
N5 - Change in Beginning Unrestricted Cash is different than as presented in budget package due to final adjustments for fiscal year end 2014.

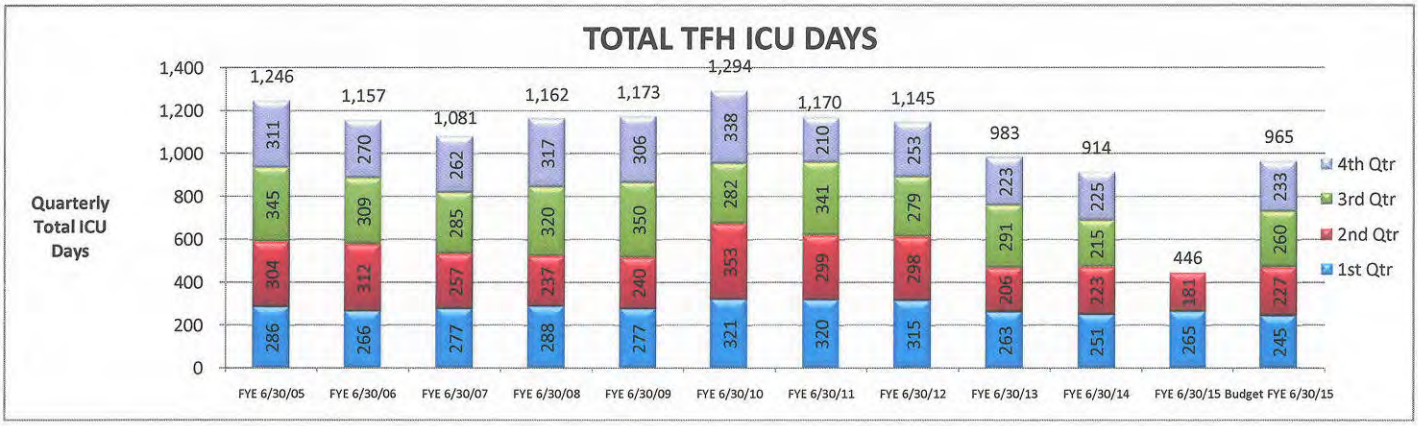

TOTAL TFH ADMISSIONS
Quarterly Admissions
2,500
2,000
1,500
1,000
500
0
1,905
1,994
2,000
1,964
1,828
1,788
1,803
1,681
1,652
1,609
833
1,699
459
471
474
489
452
444
385
406
359
375
412
498
574
527
528
495
481
489
416
436
376
454
483
452
479
439
407
402
424
398
413
421
383
399
465
497
520
508
474
461
505
461
444
437
450
434
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

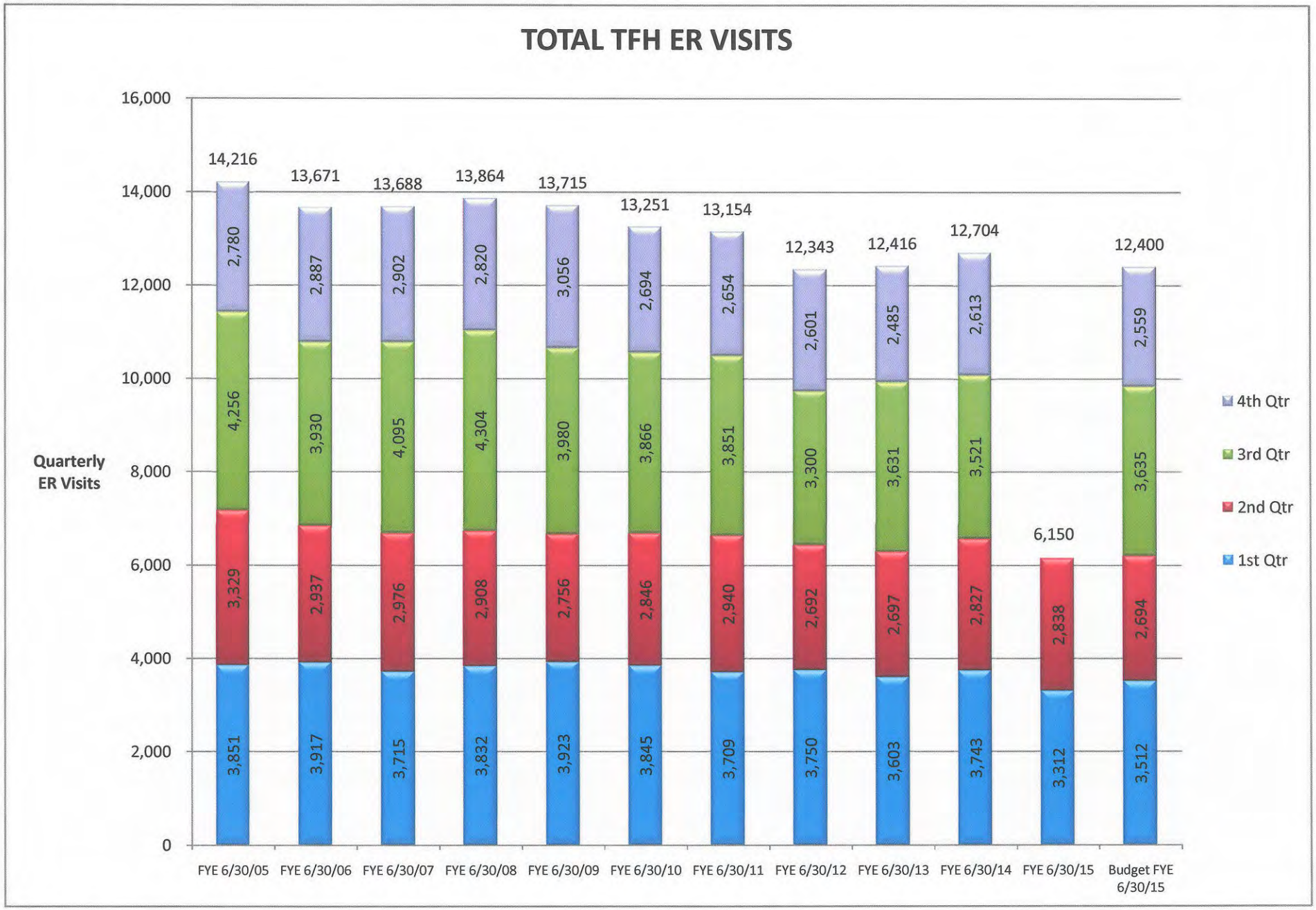

TOTAL TFH PATIENT DAYS
Quarterly Patient Days
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
5,963
5,772
5,760
5,753
5,436
5,450
5,387
4,958
4,854
4,620
2,229
4,728
1,468
1,487
1,360
1,370
1,365
1,456
1,142
1,129
1,127
1,128
1,145
1,679
1,493
1,473
1,622
1,525
1,329
1,499
1,203
1,336
1,176
1,263
1,399
1,440
1,407
1,277
1,219
1,279
1,246
1,227
1,163
1,126
1,053
1,110
1,417
1,352
1,520
1,484
1,327
1,386
1,500
1,399
1,228
1,190
1,176
1,210
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

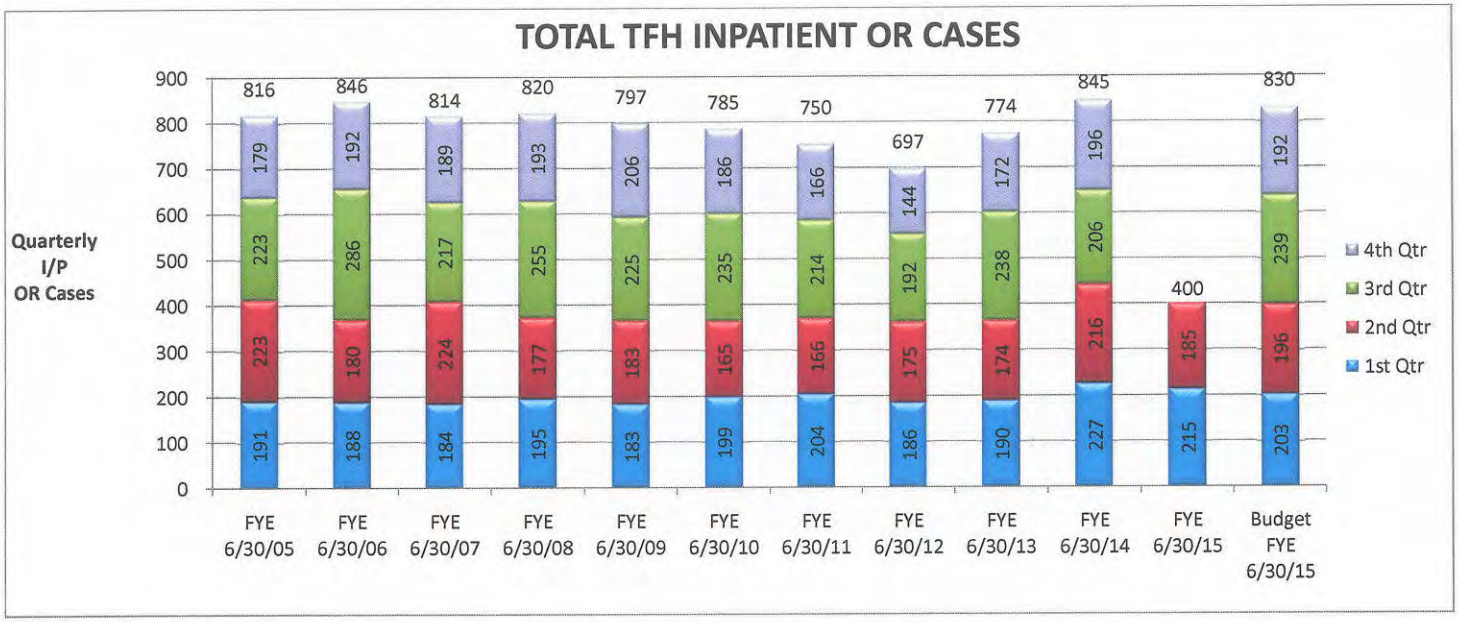

TOTAL TFH ICU INPATIENT DAYS
Quarterly ICU IP Days
800
600
400
200
0
629
551
467
428
398
545
438
445
278
234
115
275
143 147 174 165
146 129 152 124
112 101 145 109
107 63 135 123
87 52 141 108
136 190 84 135
106 130 128 74
141 130 83 91
81 51 95 41
87 25 44
75 10
70 65 76 64
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

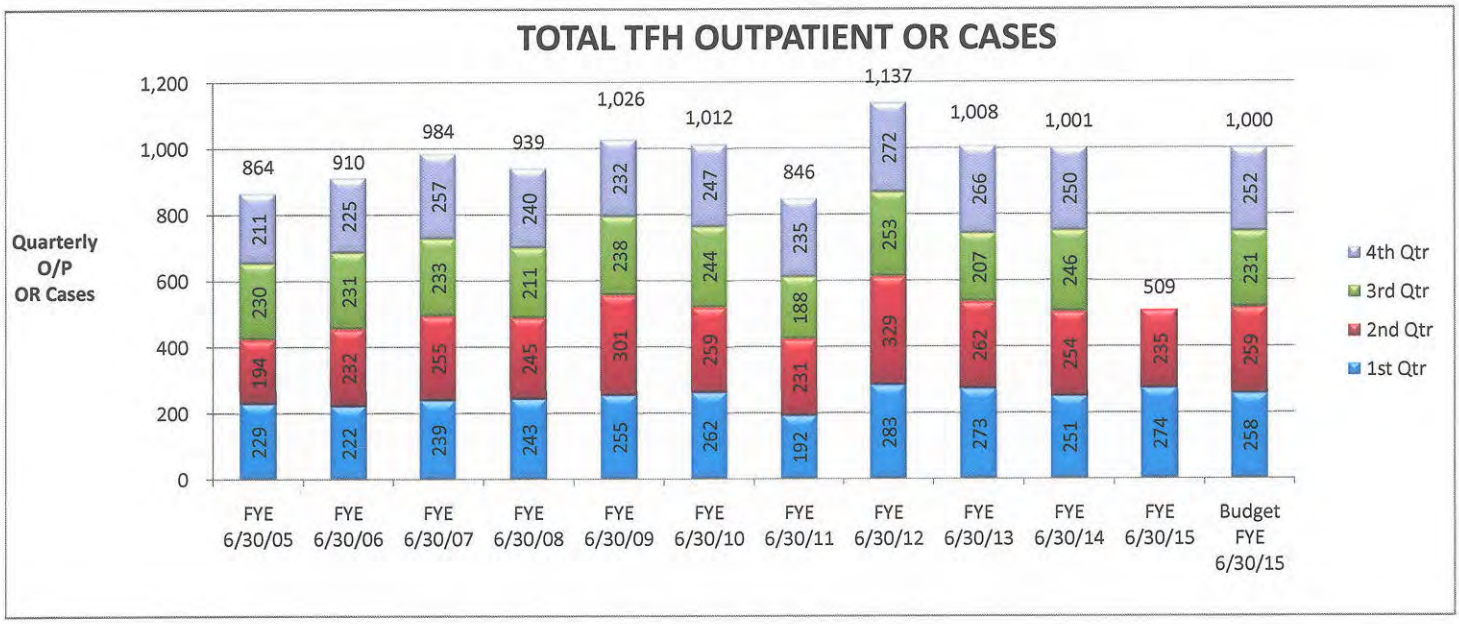

TOTAL TFH ICU STEPDOWN DAYS
Quarterly ICU Stepdown Days
600
400
200
0
163
245
249
298
292
347
429
369
406
329
155
375
51 60 52
37 89 73 46
74 63 58 54
83 48 73 94
70 66 77 79
54 77 105 111
133 91 124 81
86 76 109 98
104 83 105 114
86 86 76 81
93 62
93 84 104 94
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

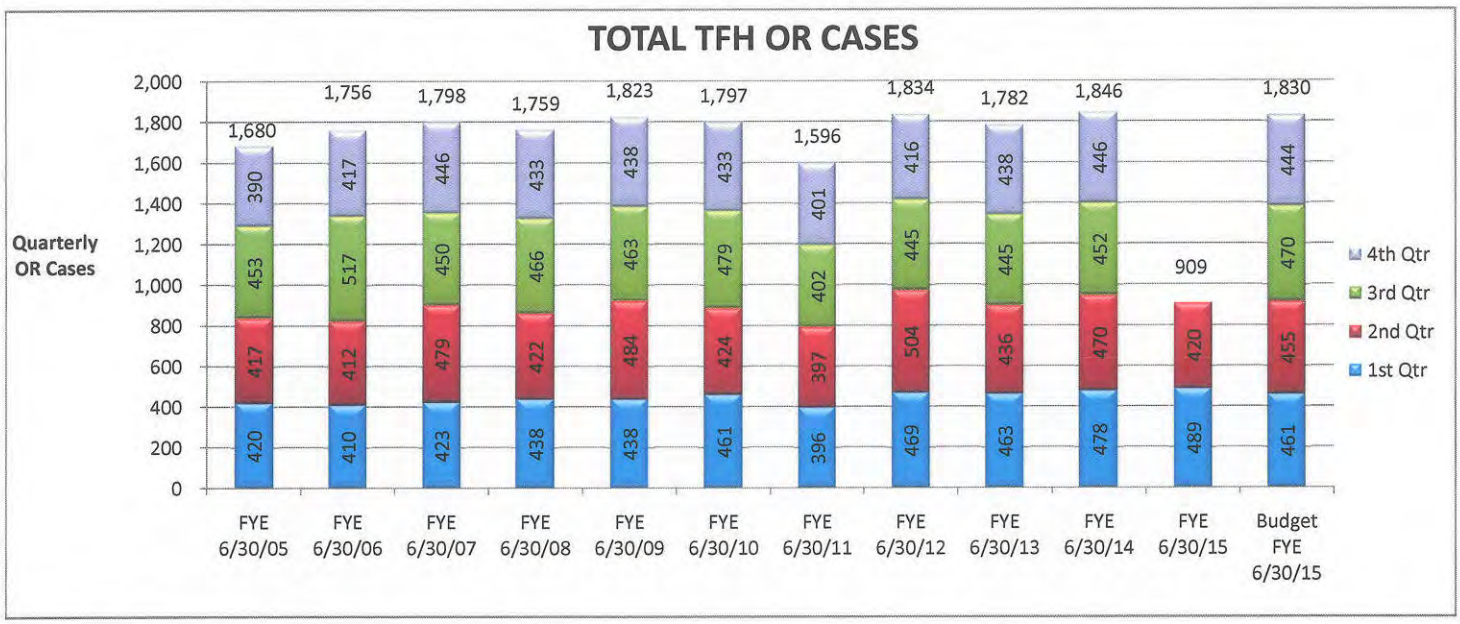

TOTAL TFH ICU MED/SURG DAYS
Quarterly ICU Med/Surg Days
600
400
200
0
439
361
365
418
483
402
303
331
299
351
176
315
142 102 109 86
83 94 84 100
91 93 82 99
85 125 108 100
120 112 132 119
131 86 93 92
81 78 89 55
88 92 87 64
78 62 91 68
78 85 88 100
93 83
82 78 80 75
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

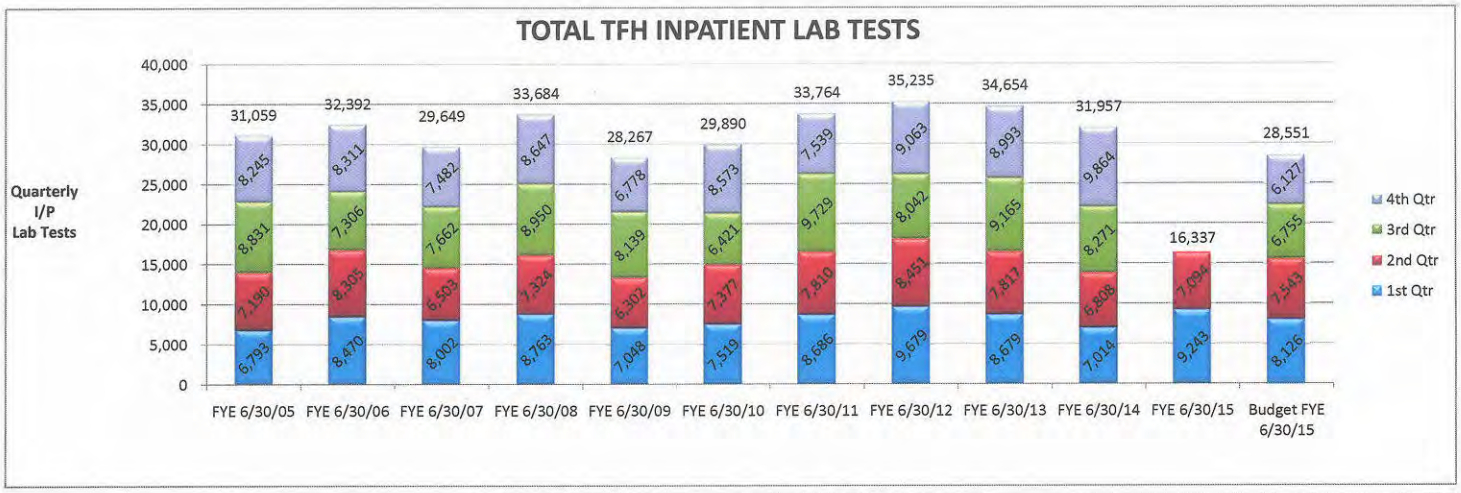

TOTAL TFH ICU DAYS
Quarterly Total ICU Days
1,400
1,200
1,000
800
600
400
200
0
1,246
1,157
1,081
1,162
1,173
1,294
1,170
1,145
983
914
446
965
286 304 345 311
266 312 309 270
277 257 285 262
288 237 320 317
277 240 350 306
321 353 282 338
320 299 341 210
315 298 279 253
263 206 291 223
251 223 215 225
265 181
245 227 260 233
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

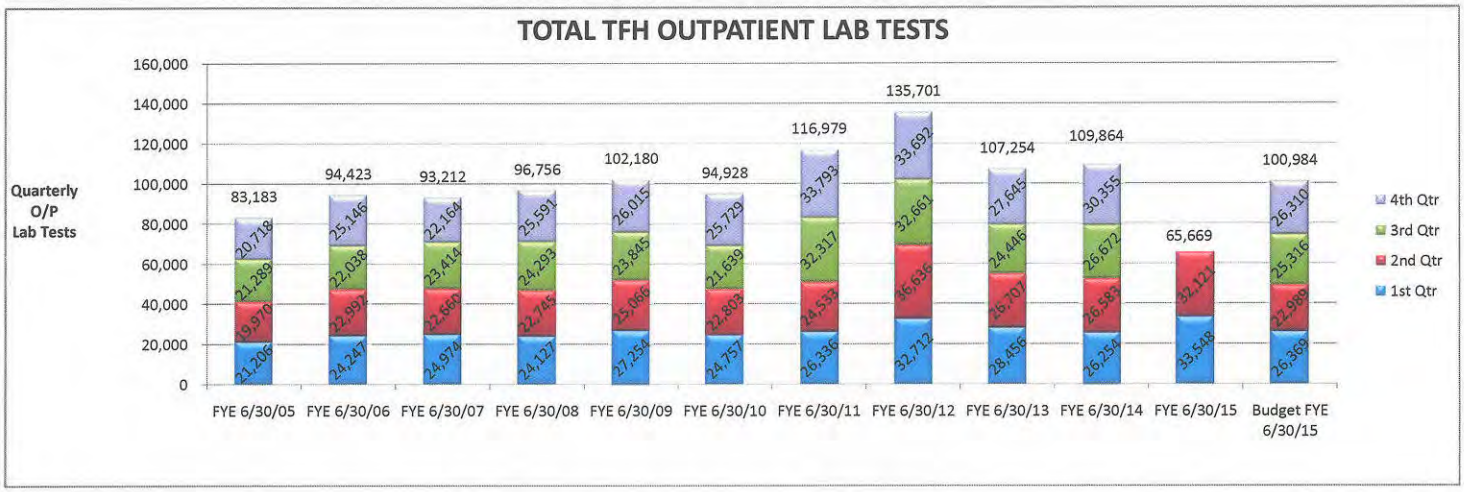

TOTAL TFH ER VISITS
Quarterly ER Visits
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
14,216
13,671
13,688
13,864
13,715
13,251
13,154
12,343
12,416
12,704
6,150
12,400
2,780
2,887
2,902
2,820
3,056
2,694
2,654
2,601
2,485
2,613
2,559
4,256
3,930
4,095
4,304
3,980
3,866
3,851
3,300
3,631
3,521
3,635
3,329
2,937
2,976
2,908
2,756
2,846
2,940
2,692
2,697
2,827
2,838
2,694
3,851
3,917
3,715
3,832
3,923
3,845
3,709
3,750
3,603
3,743
3,312
3,512
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

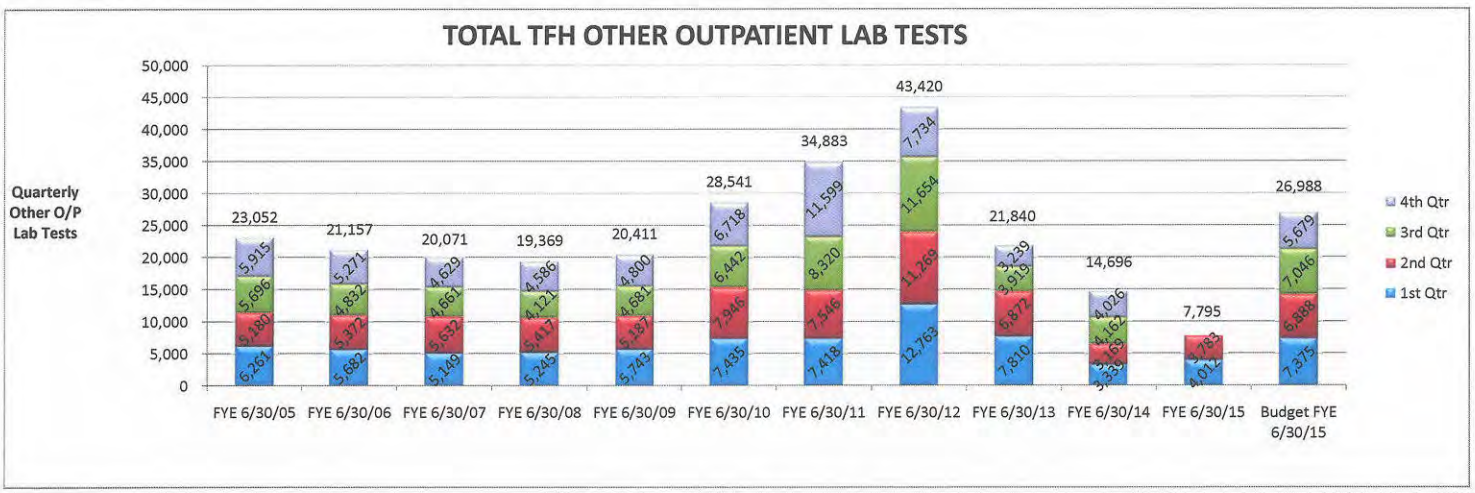

TOTAL TFH INPATIENT OR CASES
Quarterly I/P OR Cases
900
800
700
600
500
400
300
200
100
0
816 846 814 820 797 785 750 697 774 845 400 830
191 223 223 179
188 180 286 192
184 224 217 189
195 177 255 193
183 183 225 206
199 165 235 186
204 166 214 166
186 175 192 144
190 174 238 172
227 216 206 196
215 185
203 196 239 192
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

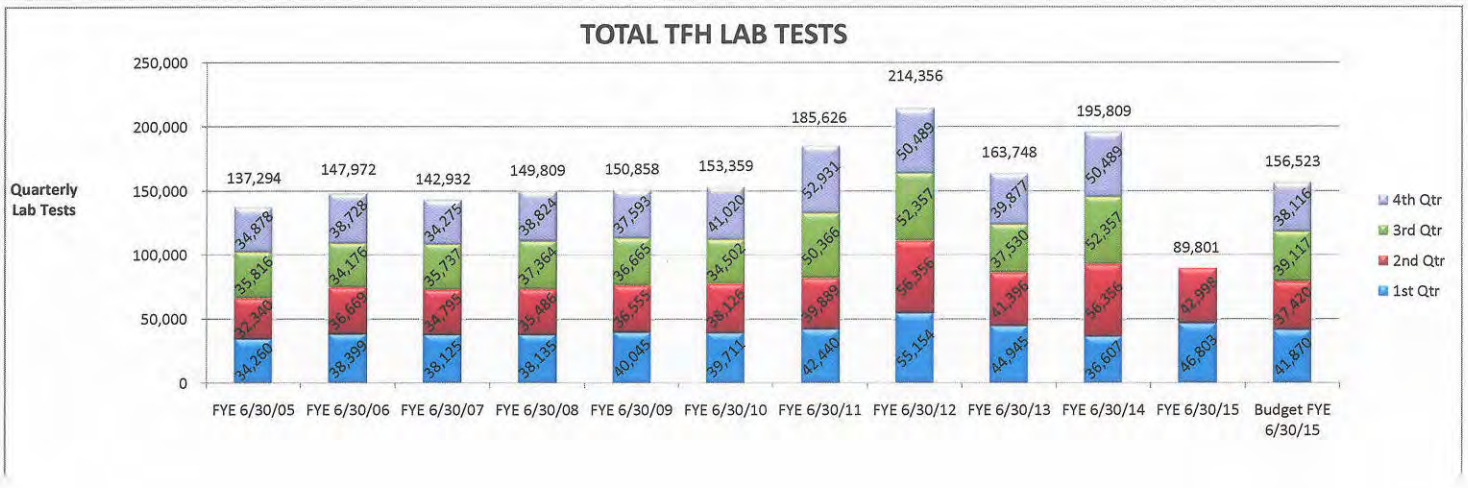

TOTAL TFH OUTPATIENT OR CASES
Quarterly O/P OR Cases
1,200
1,000
800
600
400
200
0
864 910 984 939 1,026 1,012 846 1,137 1,008 1,001 509 1,000
229 194 230 211
222 232 231 225
239 255 233 257
243 245 211 240
255 301 238 232
262 259 244 247
192 231 188 235
283 329 253 272
273 262 207 266
251 254 246 250
274 235
258 259 231 252
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr


TOTAL TFH OR CASES
Quarterly OR Cases
2,000
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0
1,680 1,756 1,798 1,759 1,823 1,797 1,596 1,834 1,782 1,846 909 1,830
420 417 453 390
410 412 517 417
423 479 450 446
438 422 466 433
438 484 463 438
461 424 479 433
396 397 402 401
469 504 445 416
463 436 445 438
478 470 452 446
489 420
461 455 470 444
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

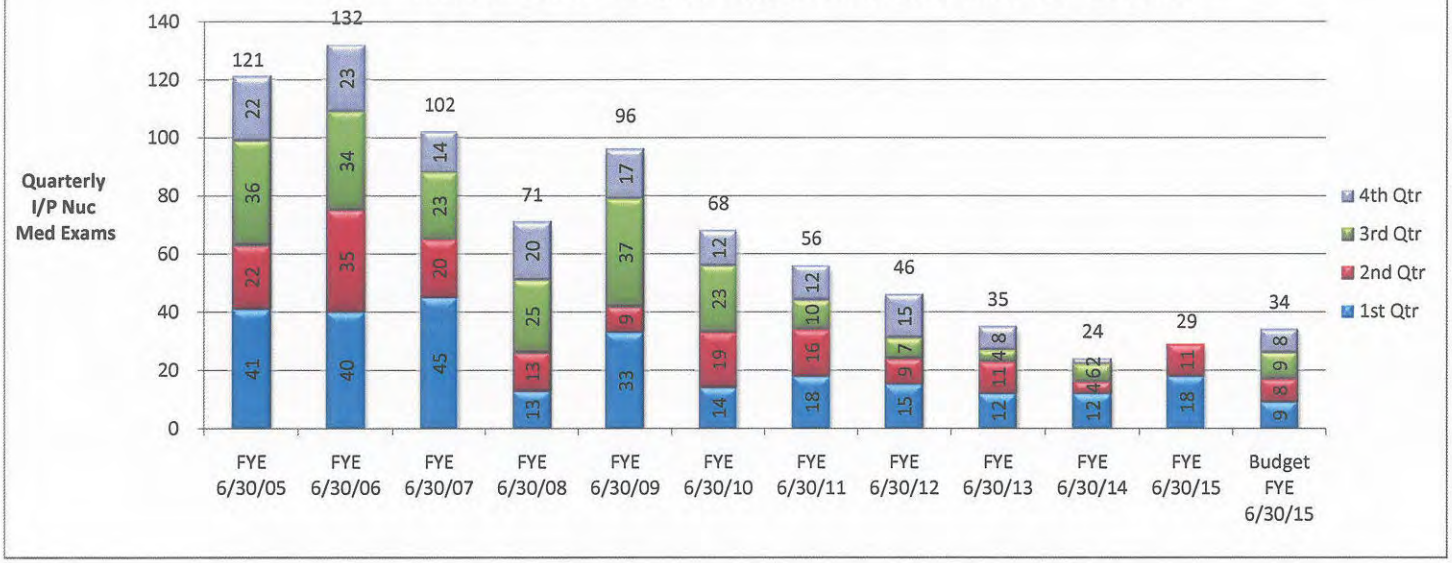

TOTAL TFH INPATIENT LAB TESTS
Quarterly I/P Lab Tests
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
31,059
32,392
29,649
33,684
28,267
29,890
33,764
35,235
34,654
31,957
16,337
28,551
8,245
8,831
7,190
6,793
8,311
7,306
8,305
8,470
7,482
7,662
6,503
8,002
8,647
8,950
7,324
8,763
6,778
8,139
6,302
7,048
8,573
6,421
7,371
7,519
7,539
9,729
7,510
8,686
9,063
8,042
8,451
9,679
8,993
9,165
7,811
8,679
9,864
8,271
6,808
7,014
7,094
9,243
6,127
6,755
7,543
8,126
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr


TOTAL TFH OUTPATIENT LAB TESTS
Quarterly O/P Lab Tests
160,000
140,000
120,000
100,000
80,000
60,000
40,000
20,000
0
83,183
94,423
93,212
96,756
102,180
94,928
116,979
135,701
107,254
109,864
65,669
100,984
20,718
21,289
19,970
21,205
25,146
22,038
22,897
24,247
22,164
23,414
22,660
24,974
25,591
24,293
22,745
24,127
26,015
23,845
25,066
27,254
25,729
21,639
22,803
24,757
33,793
32,317
24,533
26,336
33,692
32,661
36,636
32,712
27,645
24,446
25,701
28,456
30,355
26,672
26,583
26,254
32,121
33,548
26,310
25,316
22,989
26,369
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

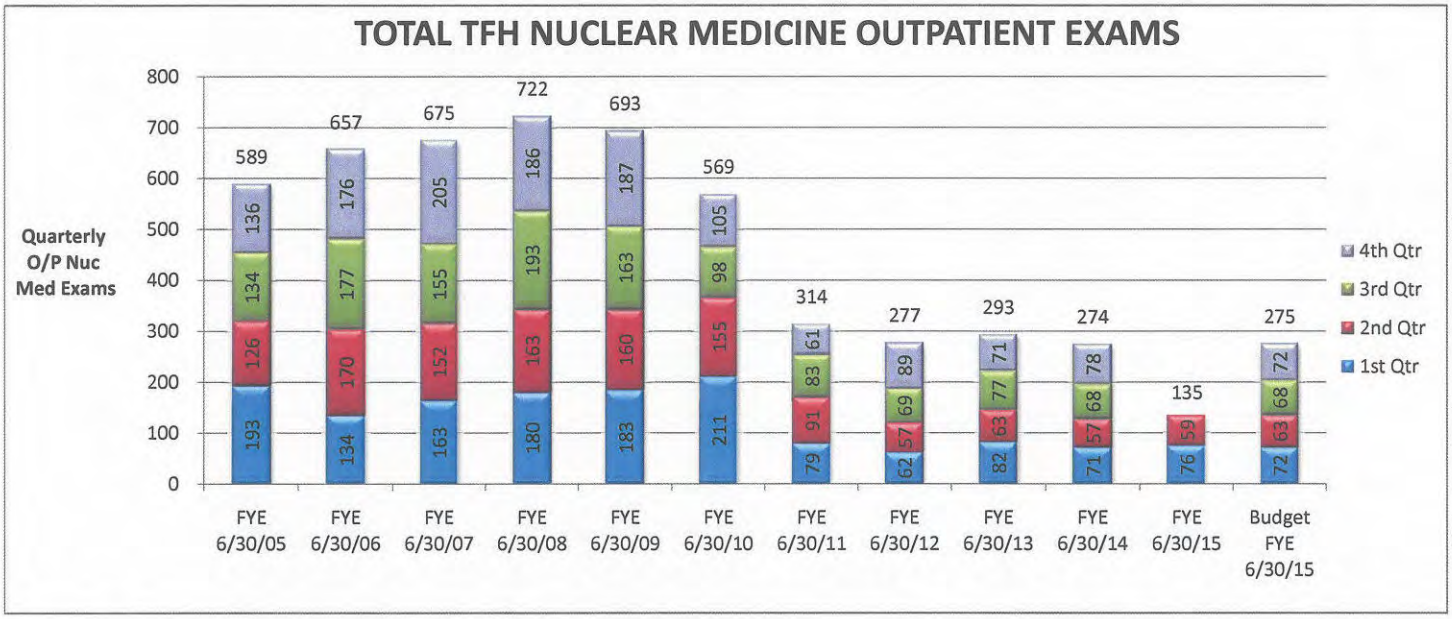

TOTAL TFH OTHER OUTPATIENT LAB TESTS
Quarterly Other O/P Lab Tests
50,000
45,000
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
23,052
21,157
20,071
19,369
20,411
28,541
34,883
43,420
21,840
14,696
7,795
26,988
5,915
5,696
5,180
6,261
5,271
4,832
5,172
5,682
4,629
4,651
5,632
5,149
4,586
4,121
5,417
5,245
4,800
4,681
5,187
5,743
6,718
6,442
7,946
7,435
11,599
8,320
7,546
7,418
7,734
11,654
11,289
12,763
3,239
3,915
6,872
7,610
4,026
4,162
3,163
3,331
3,783
4,012
5,679
7,046
6,888
7,375
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr


TOTAL TFH LAB TESTS
Quarterly Lab Tests
250,000
200,000
150,000
100,000
50,000
0
137,294
147,972
142,932
149,809
150,858
153,359
185,626
214,356
163,748
195,809
89,801
156,523
34,878
35,816
32,340
34,260
38,728
34,176
36,669
38,399
34,275
35,737
34,795
38,125
38,824
37,364
35,486
38,135
37,593
36,665
36,555
40,045
41,020
34,502
38,126
39,711
52,931
50,366
39,889
42,440
50,489
52,357
56,356
55,154
39,877
37,530
41,396
44,945
50,489
52,357
56,356
36,607
42,998
46,803
38,115
39,117
37,420
41,870
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

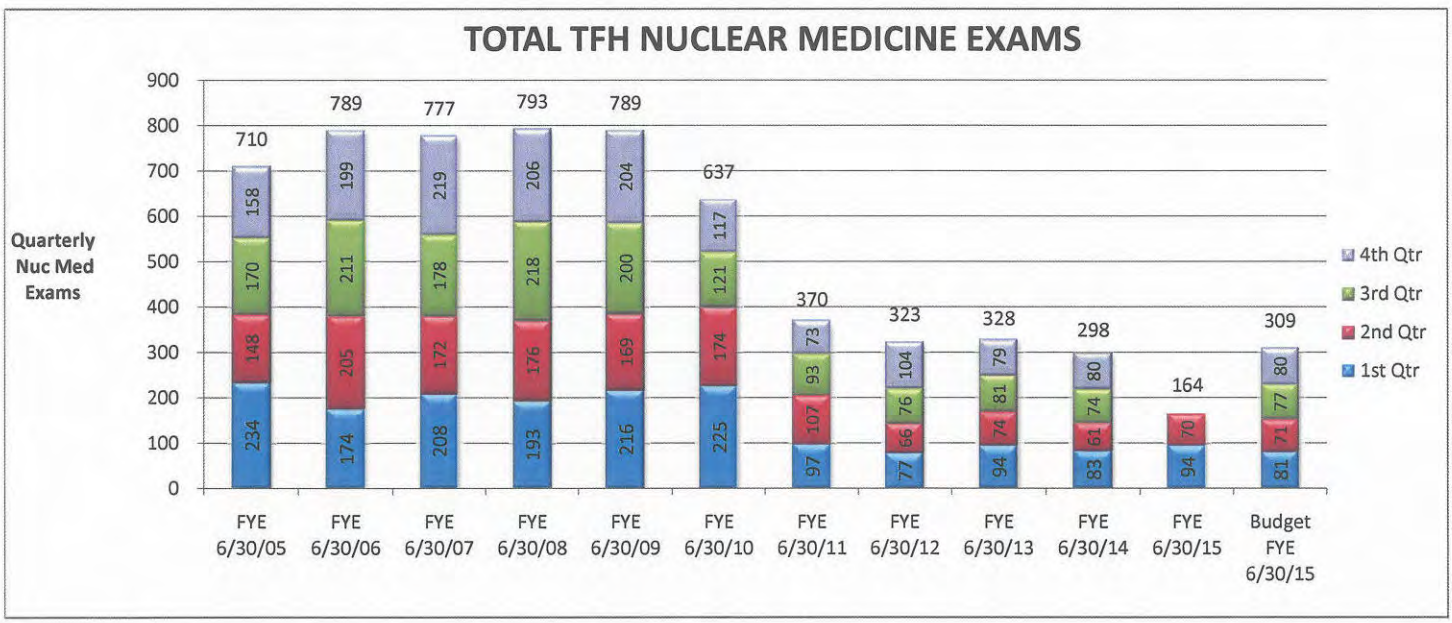
TOTAL TFH NUCLEAR MEDICINE INPATIENT EXAMS



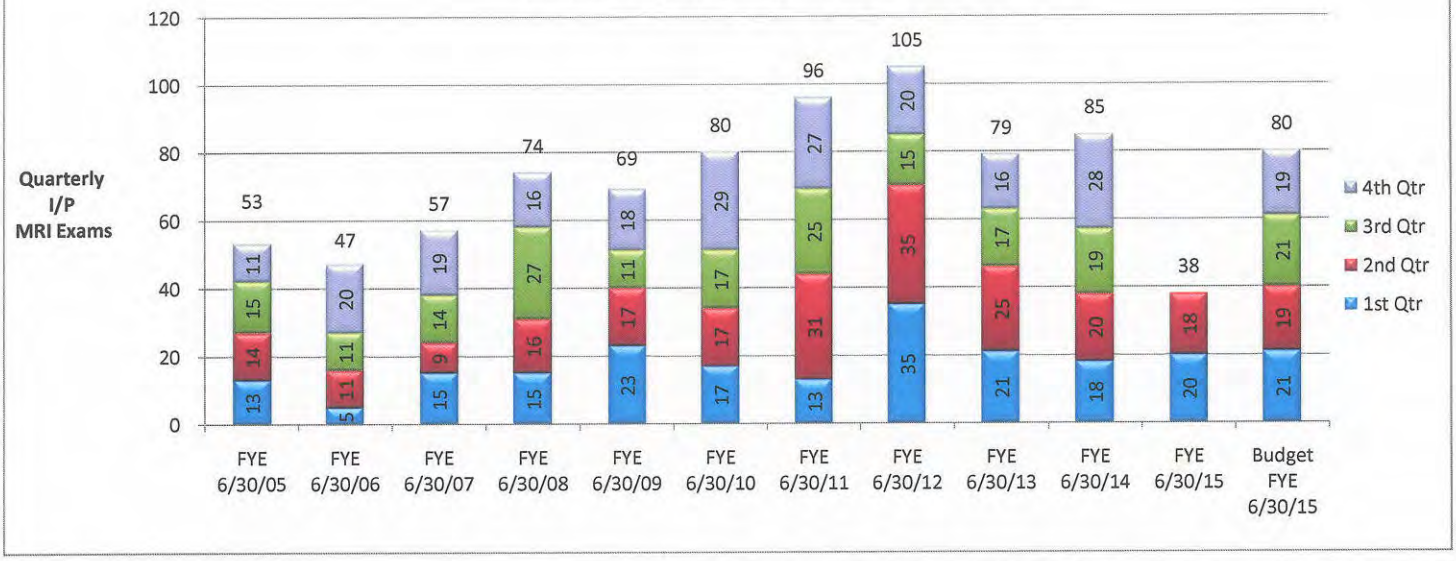
TOTAL TFH NUCLEAR MEDICINE OUTPATIENT EXAMS



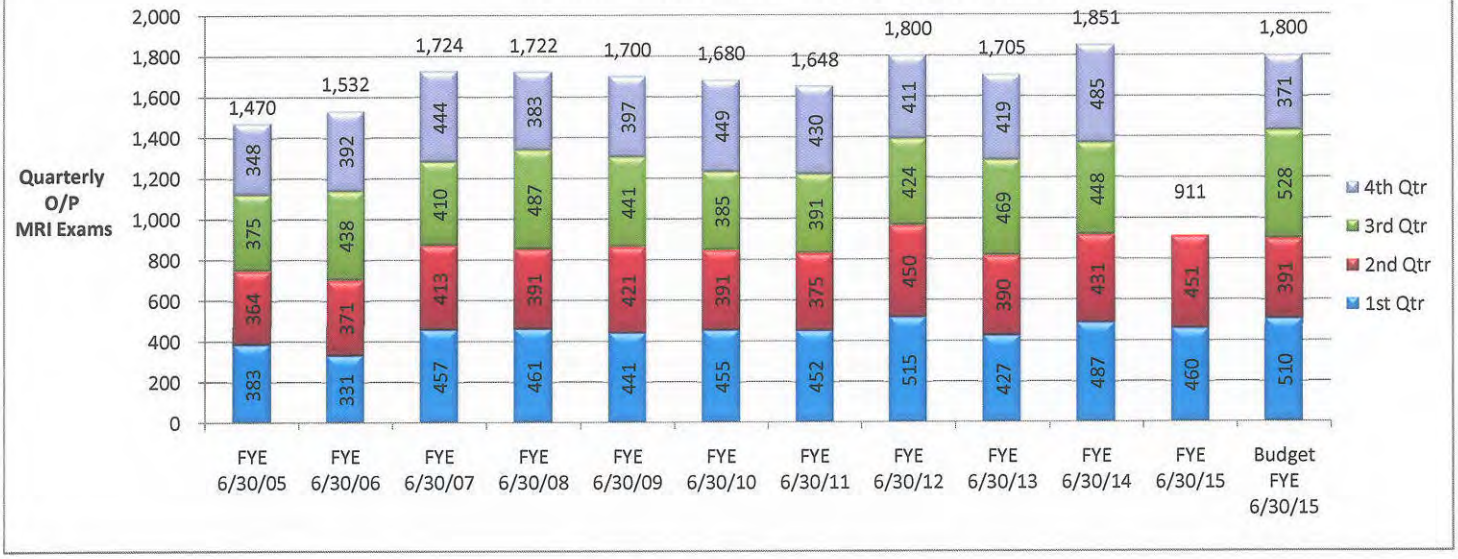
TOTAL TFH NUCLEAR MEDICINE EXAMS



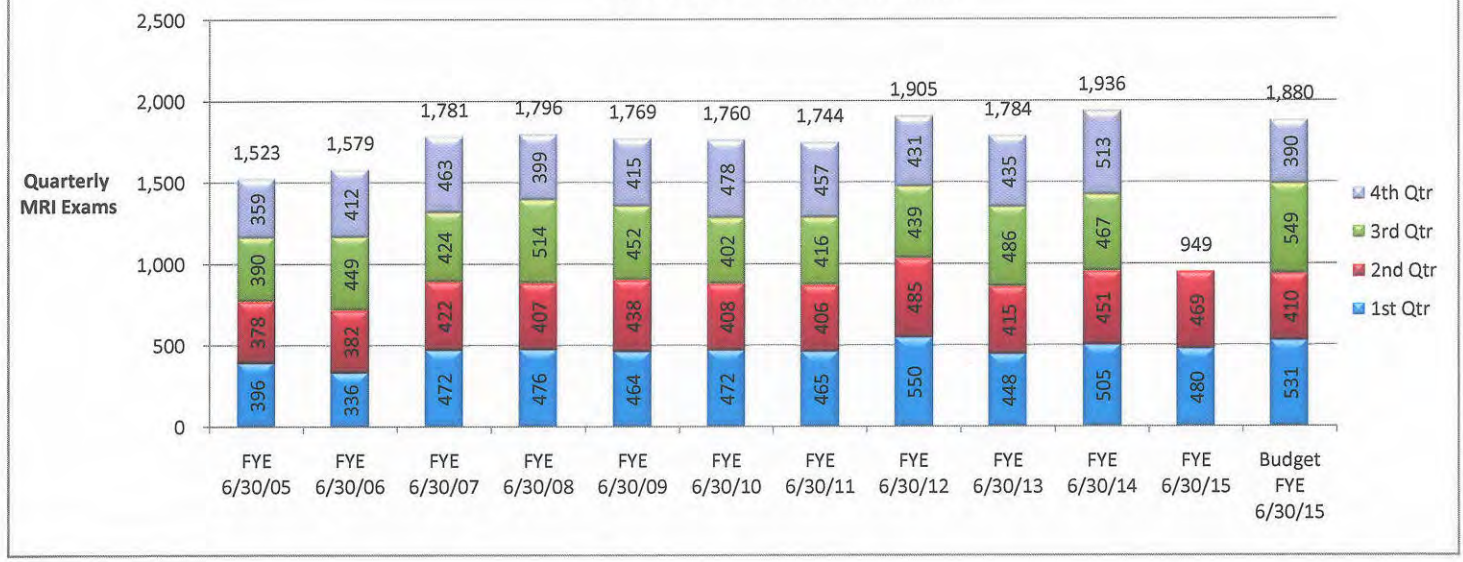
TOTAL TFH MRI INPATIENT EXAMS

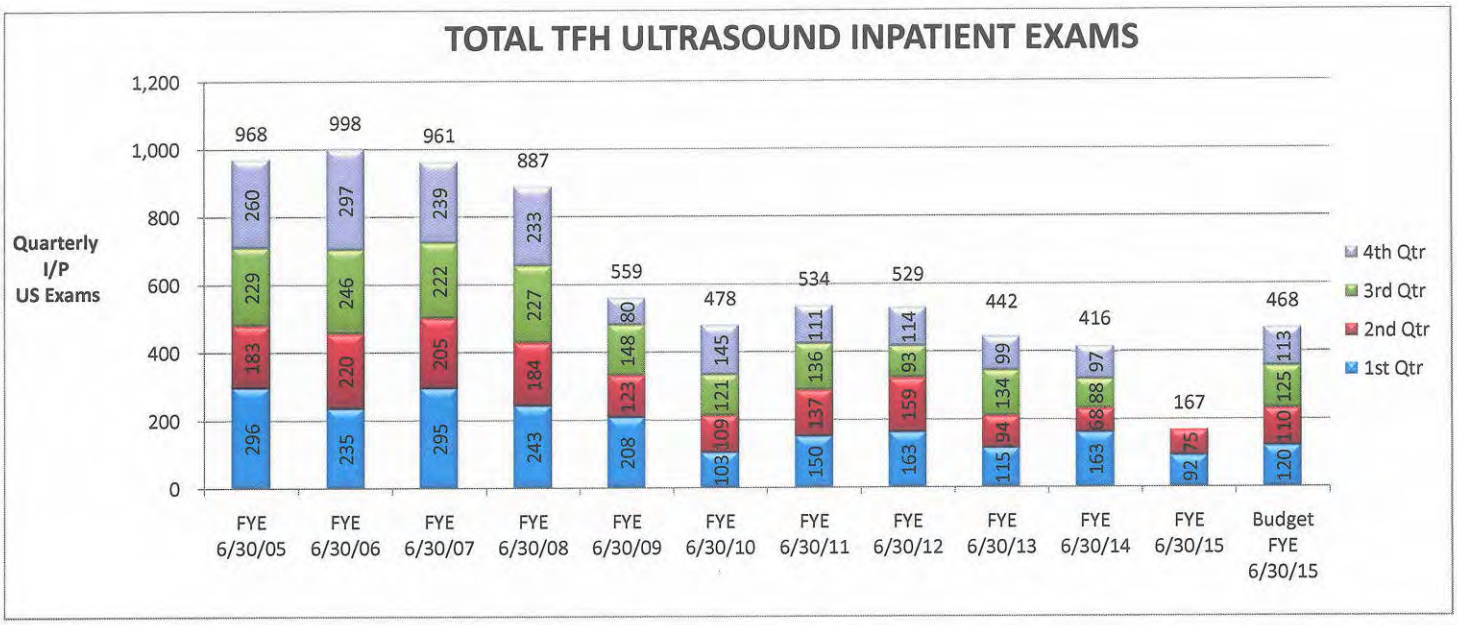


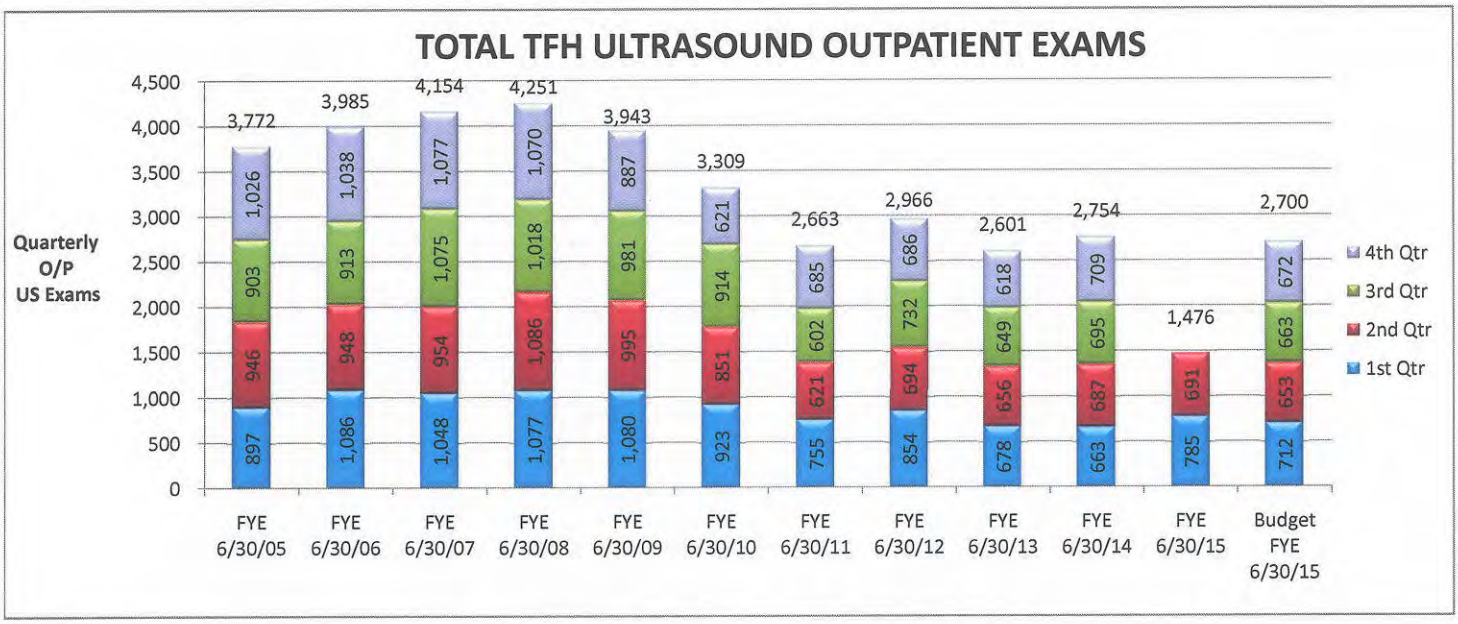
TOTAL TFH MRI OUTPATIENT EXAMS

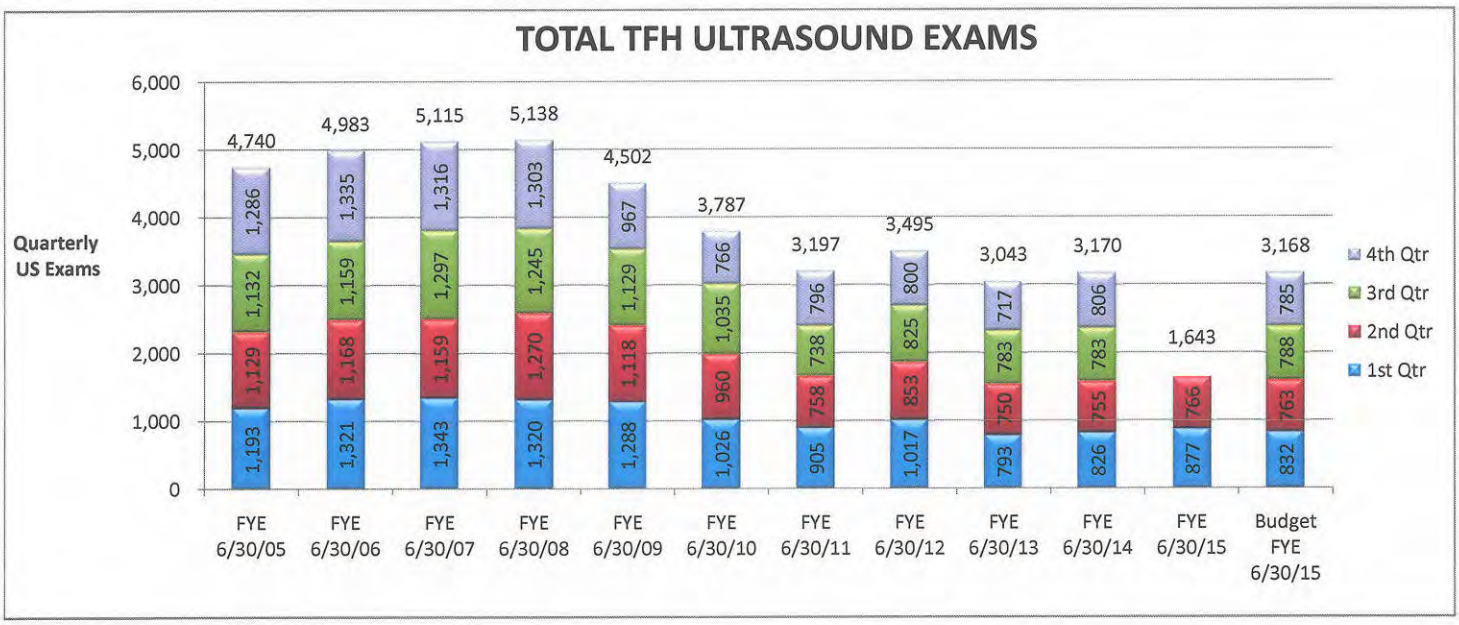


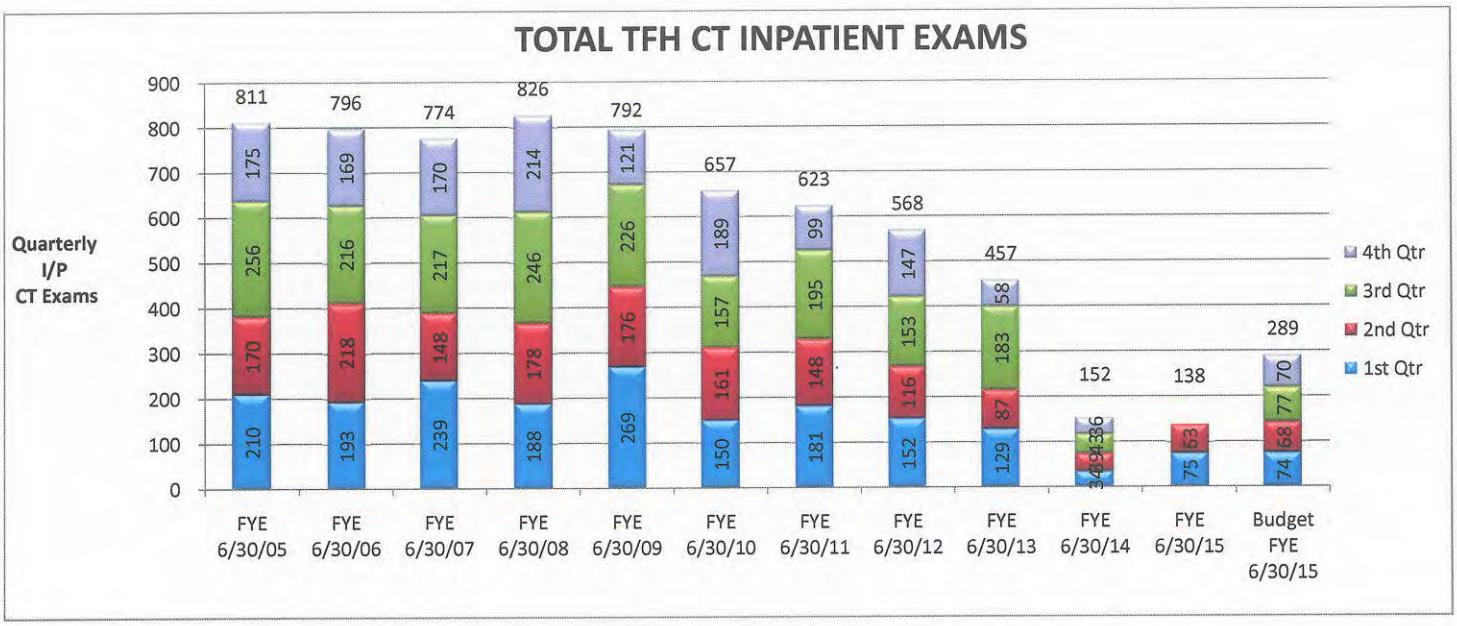
TOTAL TFH MRI EXAMS

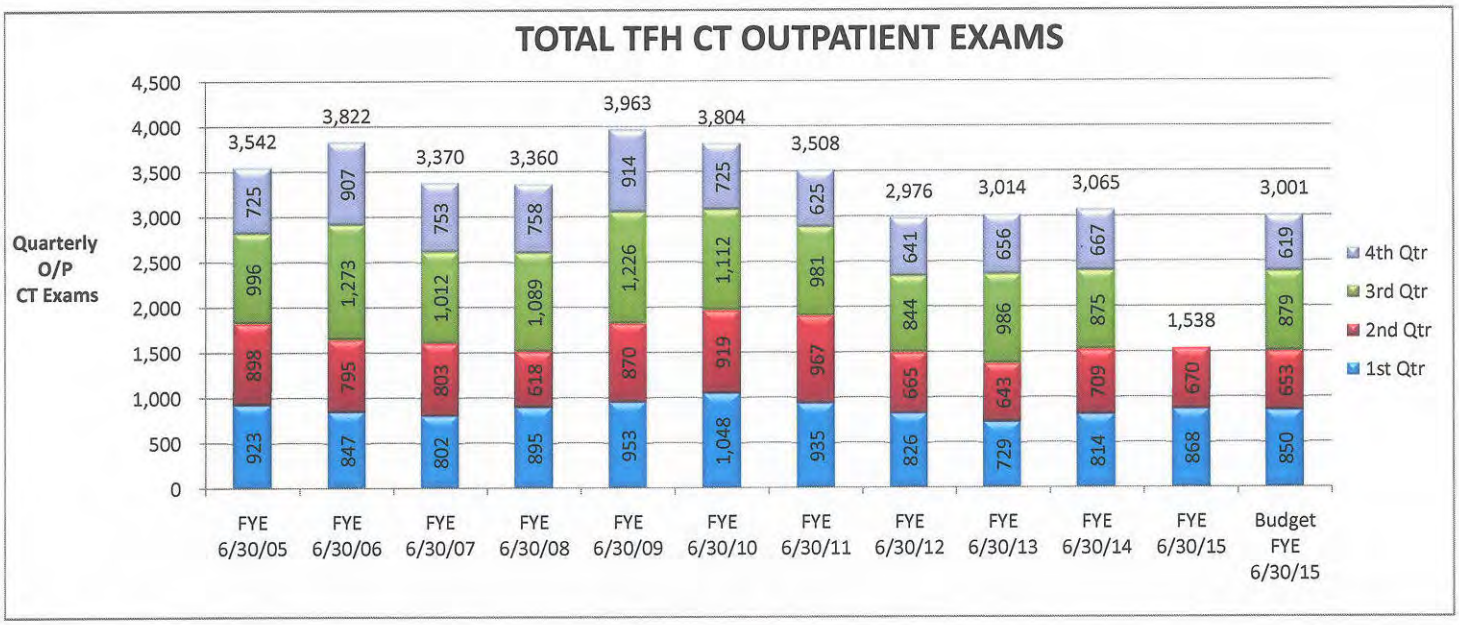


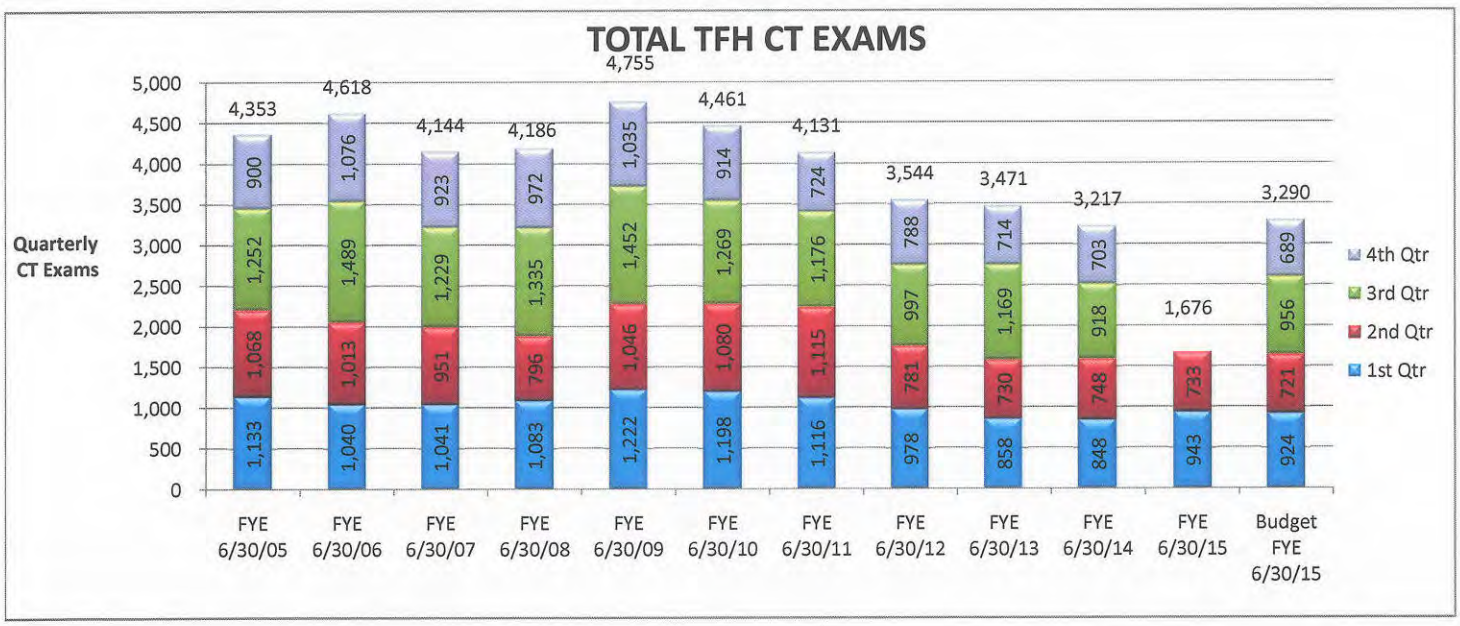

TOTAL TFH ULTRASOUND INPATIENT EXAMS
Quarterly I/P US Exams
1,200
1,000
800
600
400
200
0
968
998
961
887
559
478
534
529
442
416
167
468
296 183 229 260
235 220 246 297
295 205 222 239
243 184 227 233
208 123 148 80
103 109 121 145
150 137 136 111
163 159 93 114
115 94 134 99
163 68 88 97
92 75
120 110 125 113
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr


TOTAL TFH ULTRASOUND OUTPATIENT EXAMS
Quarterly O/P US Exams
4,500
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
3,772
3,985
4,154
4,251
3,943
3,309
2,663
2,966
2,601
2,754
1,476
2,700
897 946 903 1,026
1,086 948 913 1,038
1,048 954 1,075 1,077
1,077 1,086 1,018 1,070
1,080 995 981 887
923 851 914 621
755 621 602 685
854 694 732 686
678 656 649 618
663 687 695 709
785 691
712 653 663 672
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

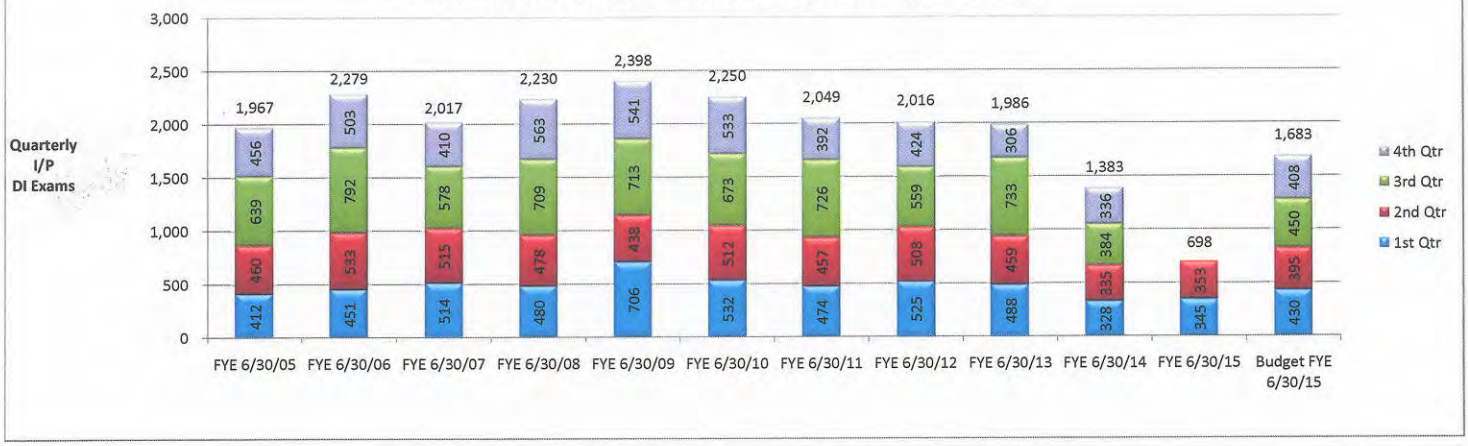

TOTAL TFH ULTRASOUND EXAMS
Quarterly US Exams
6,000
5,000
4,000
3,000
2,000
1,000
0
4,740
4,983
5,115
5,138
4,502
3,787
3,197
3,495
3,043
3,170
1,643
3,168
1,193 1,129 1,132 1,286
1,321 1,168 1,159 1,335
1,343 1,159 1,297 1,316
1,320 1,270 1,245 1,303
1,288 1,118 1,129 967
1,026 960 1,035 766
905 758 738 796
1,017 853 825 800
793 750 783 717
826 755 783 806
877 766
832 763 788 785
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr


TOTAL TFH CT INPATIENT EXAMS
Quarterly I/P CT Exams
900
800
700
600
500
400
300
200
100
0
811
796
774
826
792
657
623
568
457
152
138
289
210 170 256 175
193 218 216 169
239 148 217 170
188 178 246 214
269 176 226 121
150 161 157 189
181 148 195 99
152 116 153 147
129 87 183 58
34 49 36
75 63
74 68 77 70
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

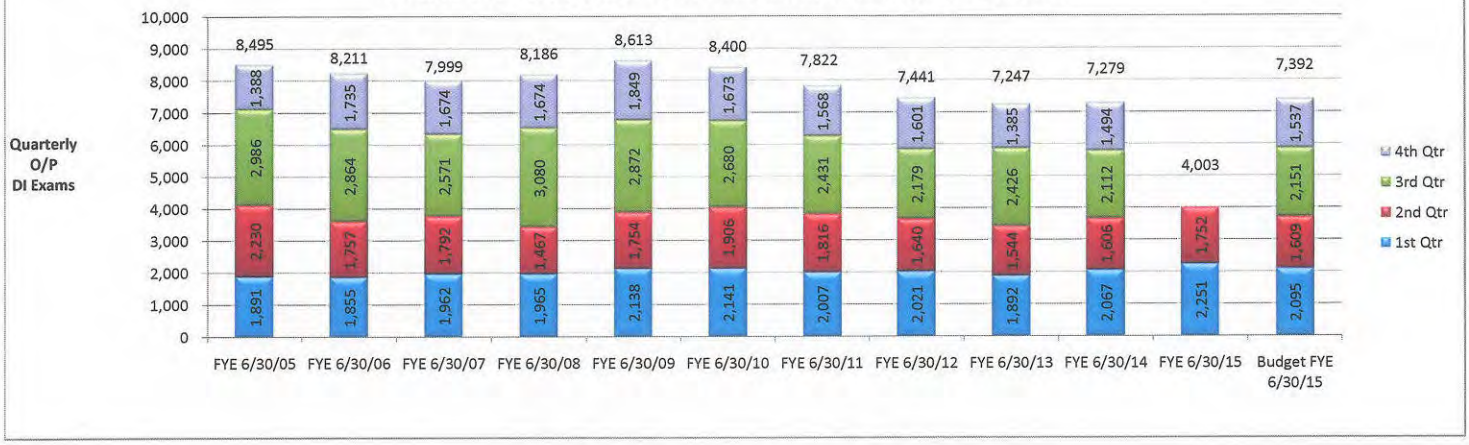

TOTAL TFH CT OUTPATIENT EXAMS
Quarterly O/P CT Exams
4,500
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
3,542
3,822
3,370
3,360
3,963
3,804
3,508
2,976
3,014
3,065
1,538
3,001
923 898 996 725
847 795 1,273 907
802 803 1,012 753
895 618 1,089 758
953 870 1,226 914
1,048 919 1,112 725
935 967 981 625
826 665 844 641
729 643 986 656
814 709 875 667
868 670
850 653 879 619
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr


TOTAL TFH CT EXAMS
Quarterly CT Exams
5,000
4,500
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
4,353
4,618
4,144
4,186
4,755
4,461
4,131
3,544
3,471
3,217
1,676
3,290
1,133 1,068 1,252 900
1,040 1,013 1,489 1,076
1,041 951 1,229 923
1,083 796 1,335 972
1,222 1,046 1,452 1,035
1,198 1,080 1,269 914
1,116 1,115 1,176 724
978 781 997 788
858 730 1,169 714
848 748 918 703
943 733
924 721 956 689
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

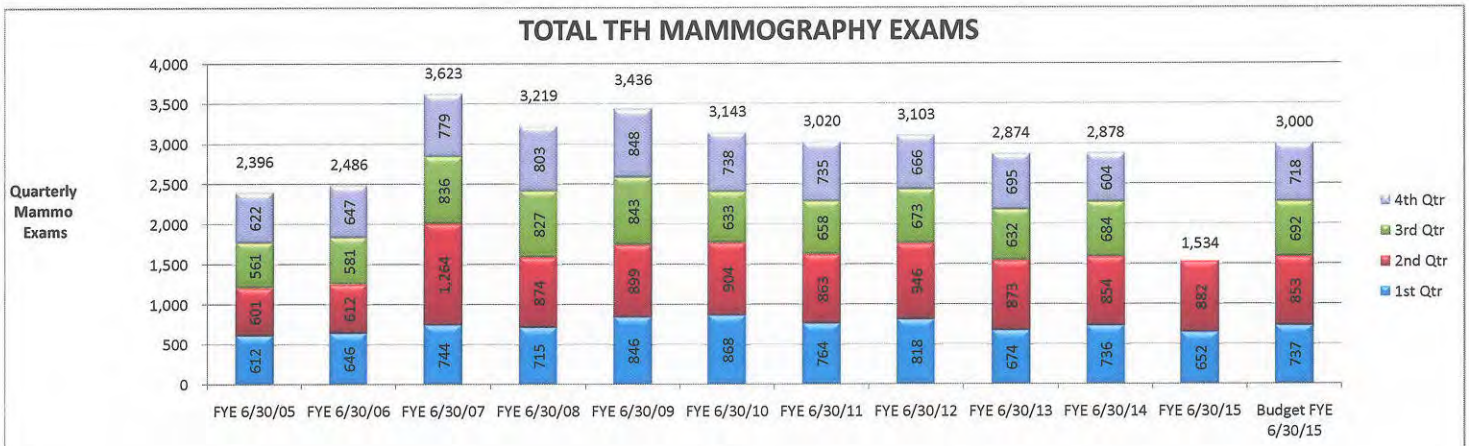
TOTAL TFH INPATIENT DIAGNOSTIC IMAGING EXAMS



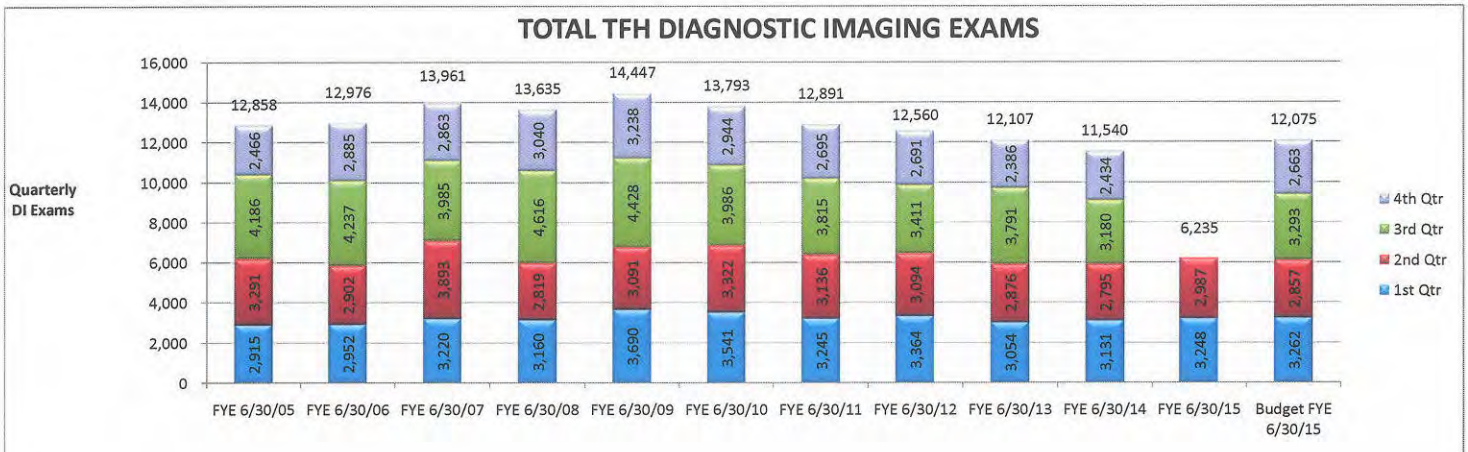
TOTAL TFH OUTPATIENT DIAGNOSTIC IMAGING EXAMS



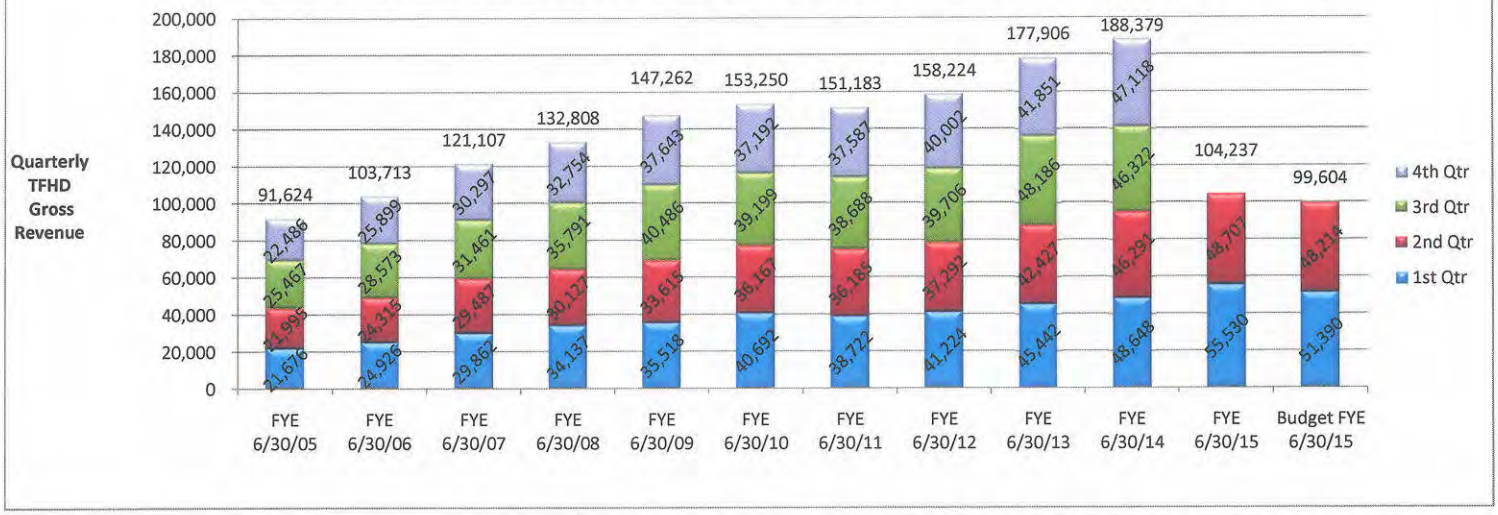
TOTAL TFH MAMMOGRAPHY EXAMS



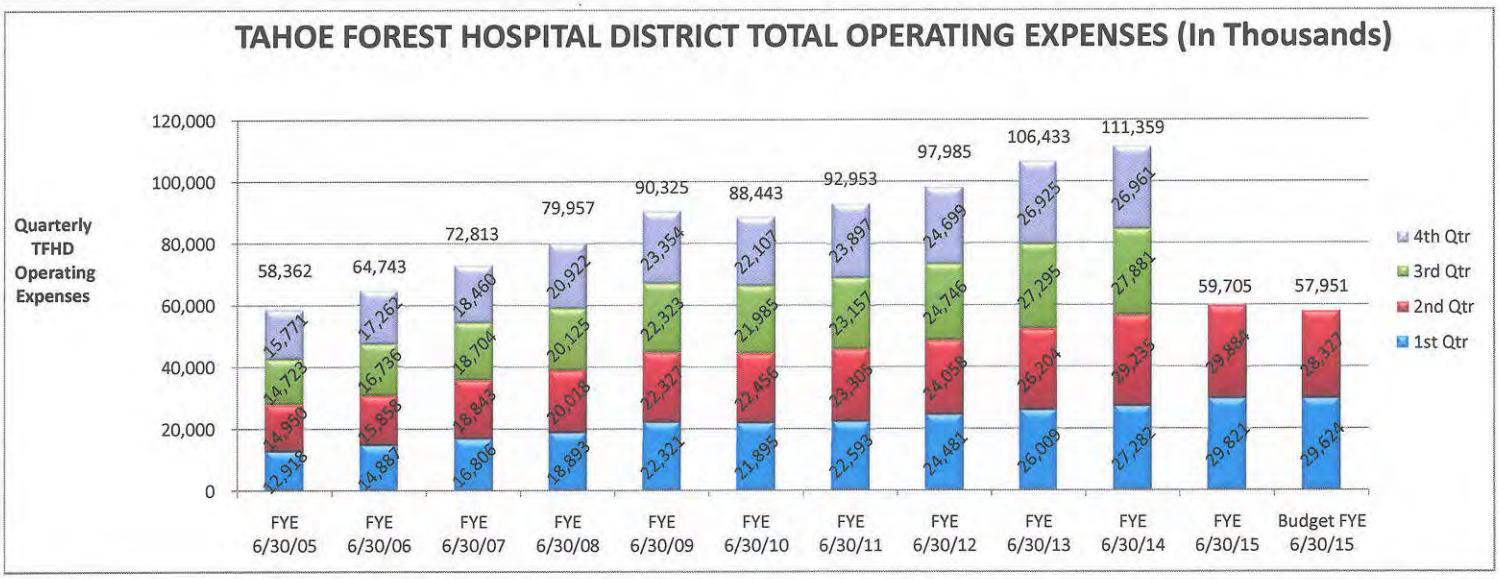
TOTAL TFH DIAGNOSTIC IMAGING EXAMS



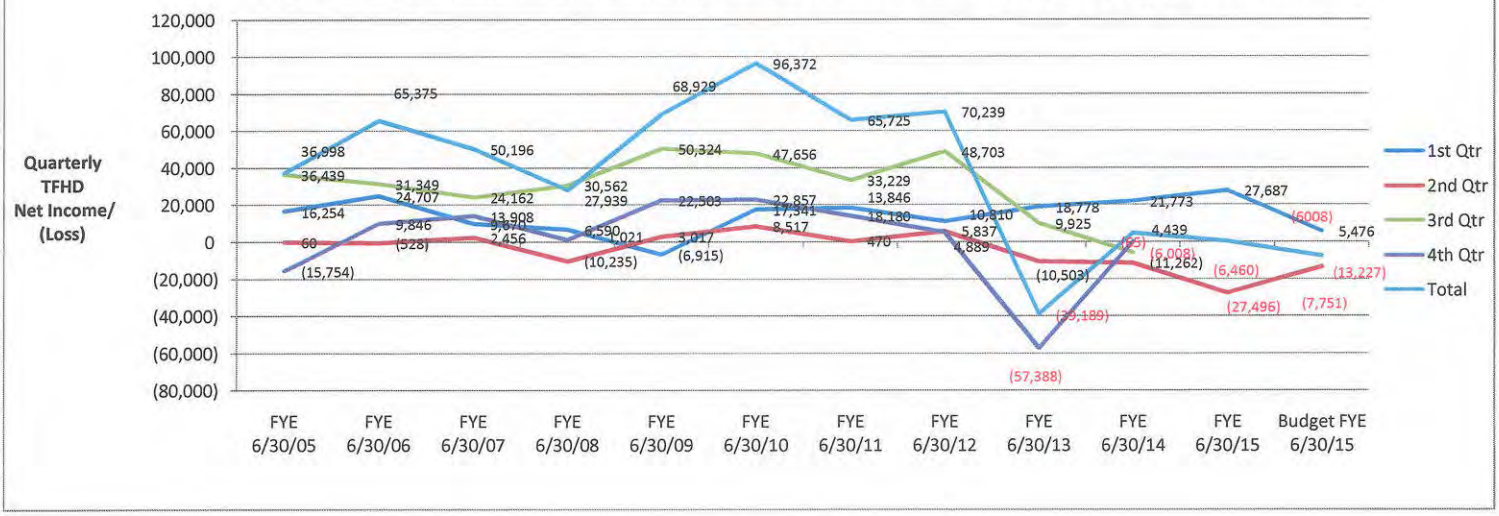
TAHOE FOREST HOSPITAL DISTRICT TOTAL GROSS REVENUE (In Thousands)



TAHOE FOREST HOSPITAL DISTRICT TOTAL OPERATING EXPENSES (In Thousands)



TAHOE FOREST HOSPITAL DISTRICT TOTAL NET INCOME/(LOSS) (In Hundreds)



Tahoe Forest Hospital
Operating Indicators
Inpatient Volumes
Month & YTD June 2015
December 31, 2014

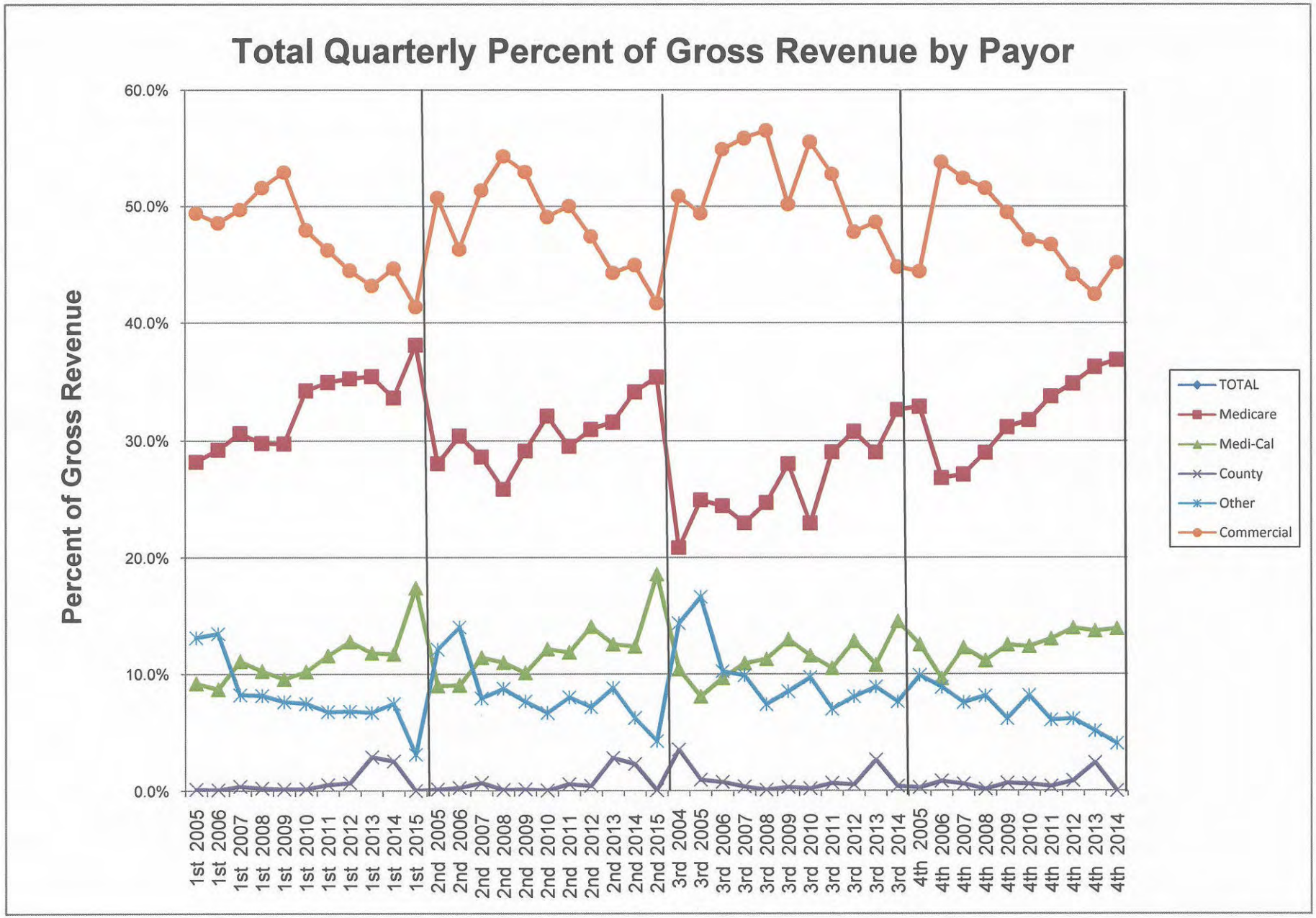
Acute	Dec-13 Actual	Dec-13 YTD Actual	Jul-14 Actual	Aug-14 Actual	Sep-14 Actual	Oct-14 Actual	Nov-14 Actual	Dec-14 Actual	Dec-14 Budget	Dec-14 Variance	Dec-14 % Variance	Dec-14 YTD Actual	Dec-14 YTD Budget	YTD Variance	YTD % Variance
Admissions - (Excludes Swing)	155	856	167	151	132	131	101	151	138	13.00	9.42%	833	834	(1)	-0.12%
Swing Admits	1	18	2	5	1	5	0	1	3	(2.00)	-66.67%	14	21	(7)	-33.33%
Total Admissions	156	874	169	156	133	136	101	152	141	11.00	7.80%	847	855	(8)	-0.94%
Length of Stay - Acute	2.64	2.70	2.77	2.72	2.84	2.56	2.77	2.72	2.78	(0.06)	-2.16%	2.73	2.78	(0.05)	-1.80%
Length of Stay - Swing	17.00	10.14	16.00	5.50	4.50	5.20	0.00	3.00	9.00	(6.00)	-66.67%	5.85	7.90	(2.05)	-25.95%
Length of Stay - Acute & Swing	2.93	2.85	2.85	2.79	2.87	2.65	2.77	2.72	2.91	(0.19)	-6.53%	2.78	2.91	(0.13)	-4.47%
LOS - Acute & Swing - Medicare	4.18	3.48	3.06	2.95	2.72	2.98	2.35	2.61	N/A	N/A	N/A	2.83	N/A	N/A	N/A
LOS - Acute & Swing - MediCal	2.76	2.84	2.62	3.12	3.00	2.65	2.48	3.69	N/A	N/A	N/A	2.96	N/A	N/A	N/A
LOS - Acute & Swing - Self Pay	1.82	2.57	1.17	1.50	3.67	2.43	1.75	1.83	N/A	N/A	N/A	1.94	N/A	N/A	N/A
LOS - Acute & Swing - Commercial	1.72	2.13	3.75	2.27	2.25	2.00	3.89	1.45	N/A	N/A	N/A	2.55	N/A	N/A	N/A
LOS - Acute & Swing - Contract	2.77	2.59	2.68	2.67	3.13	2.48	3.29	2.52	N/A	N/A	N/A	2.74	N/A	N/A	N/A
Average Daily Census - Acute	12.6	12.6	14.9	13.3	11.6	11.7	9.0	12.8	12.4	0.20	1.61%	12.1	12.5	(0.4)	-3.20%
Average Daily Census - Swing	1.6	1.0	0.5	0.7	0.3	0.8	0.0	0.1	0.9	(0.80)	-88.89%	0.4	0.1	0.3	300.00%
Avg Daily Census - Acute & Swing	14.2	13.6	15.4	14.0	11.9	12.5	9.0	12.7	13.3	(0.60)	-4.51%	12.5	12.6	(0.1)	-0.79%
Occupancy Percentage - Acute	50.8%	50.3%	59.4%	53.4%	46.3%	46.8%	35.9%	50.6%	49.5%	0.01	2.22%	48.8%	50.5%	-1.7%	-3.37%
Occupancy Percentage - Swing	6.6%	4.0%	2.1%	2.8%	1.2%	3.4%	0.0%	0.4%	3.5%	(0.03)	-88.57%	1.7%	3.6%	-1.9%	-52.78%
Occupancy % - Acute & Swing	57.4%	54.3%	61.4%	56.3%	47.5%	50.2%	35.9%	51.0%	53.0%	(0.02)	-3.77%	50.5%	54.1%	-3.6%	-6.65%
Patient Days (excludes swings)	394	2,316	460	414	347	363	269	392	384	8.00	2.08%	2,245	2,322	(77)	-3.32%
Swing Days (inc swings)	51	182	16	22	9	26	0	3	27	(24.00)	-88.89%	76	166	(90)	-54.22%
Total Patient Days	445	2,498	476	436	356	389	269	395	411	(16.00)	-3.89%	2,321	2,488	(167)	-6.71%
ICU I/P Days	26	139	34	19	22	6	8	26	24	2.00	8.33%	115	135	(20)	-14.81%
ICU Stepdown Days	37	172	30	29	34	25	16	21	27	(6.00)	-22.22%	155	177	(22)	-12.43%
ICU Med/Surg Days	16	163	33	29	35	26	19	34	27	7.00	25.93%	176	160	16	10.00%
Medical/Surgical Days	237	1,346	272	253	185	216	152	251	229	22.00	9.61%	1,329	1,343	(14)	-1.04%
Medical/Surgical In OB Days	0	1	0	0	0	0	0	0	1	(1.00)	-100.00%	0	5	(5)	-100.00%
Obstetrics Days	78	495	91	84	71	88	74	60	73	(13.00)	-17.81%	468	484	(16)	-3.31%
Nursery Re-Admits	0	0	0	0	0	2	0	0	1	(1.00)	-100.00%	2	4	(2)	-50.00%
Total Acute Patient Days (excludes sv	394	2316	460	414	347	363	269	392	382	10.00	2.62%	2,245	2,308	(63)	-2.73%
M/S Swing Days	51	182	16	22	9	26	0	3	27	(24.00)	-88.89%	76	166	(90)	-54.22%
Total Patient Days (includes swings)	445	2498	476	436	356	389	269	395	409	(14.00)	-3.42%	2,321	2,474	(153)	-6.18%
Nursery Days	74	459	90	74	57	92	60	53	56	(3.00)	-5.36%	426	446	(20)	-4.48%
Deliveries	36	202	33	38	25	35	29	28	32	(4.00)	-12.50%	188	204	(16)	-7.84%
ICU (Med/Surg) Days	16	163	33	29	35	26	19	34	27	7.00	25.93%	176	160	16	10.00%
I/P Medical / Surgical Days	237	1,346	272	253	185	216	152	251	229	22.00	9.61%	1,329	1,343	(14)	-1.04%
Medical / Surgical Days in OB	0	1	0	0	0	0	0	0	1	(1.00)	-100.00%	0	5	(5)	-100.00%
Total Medical / Surgical Days	253	1510	305	282	220	242	171	285	257	28.00	10.89%	1,505	1,508	(3)	-0.20%
Medical / Surgical Swings Days	51	182	16	22	9	26	0	3	27	(24.00)	-88.89%	76	166	(90)	-54.22%
Total Med/Surg Days (inc Swings)	304	1692	321	304	229	268	171	288	284	4.00	1.41%	1,581	1,674	(93)	-5.56%
Average Daily Census															
ICU I/P Days	0.8	0.8	1.1	0.6	0.7	0.2	0.3	0.8	0.8	0.00	0.00%	0.6	0.7	(0.1)	-14.29%
ICU Stepdown Days	1.2	0.9	1.0	0.9	1.1	0.8	0.5	0.7	0.9	(0.20)	-22.22%	0.8	1.0	(0.2)	-20.00%
ICU Boarder Days	0.5	0.9	1.1	0.9	1.2	0.8	0.6	1.1	0.9	0.20	22.22%	1.0	0.9	0.1	11.11%
I/P Medical / Surgical Days	7.6	7.3	8.8	8.2	6.2	7.0	5.1	8.1	7.4	0.70	9.46%	7.2	7.3	(0.1)	-1.37%
Medical / Surgical Days in OB	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.00	0.00%	0.0	0.0	0.0	0.00%
Obstetrics Days	2.5	2.7	2.9	2.7	2.4	2.8	2.5	1.9	2.4	(0.50)	-20.83%	2.5	2.6	(0.1)	-3.85%
Newborn Re-Admits	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.00	0.00%	0.0	0.0	0.0	0.00%
Acute Patient Average Daily Census	12.6	12.6	14.9	13.3	11.6	11.7	9.0	12.6	12.4	0.20	1.61%	12.1	12.5	(0.4)	-3.20%
Medical / Surgical - Swing	1.6	1.0	0.5	0.7	0.3	0.8	0.0	0.1	0.9	(0.80)	-88.89%	0.4	0.1	0.3	300.00%
Patient Avg Daily Census (Inc swing)	14.2	13.6	15.4	14.0	11.9	12.5	9.0	12.7	13.3	(0.60)	-4.51%	12.5	12.6	(0.1)	-0.79%
Skilled Nursing Unit															
Patient Days	1,045	6,206	1,056	1,090	1,030	1,108	1,030	1,051	1,054	(3.00)	-0.28%	6,365	6,256	109	1.74%
Average Daily Census	34	34	34	35	34	36	34	34	34	0.00	0.00%	35	34	1	2.94%
Occupancy Percentage	96.3%	96.4%	97.3%	100.5%	98.1%	102.1%	98.1%	96.9%	97.1%	0.00	-0.21%	98.8%	97.1%	1.7%	1.75%
Operating Room															
Cases	76	443	79	74	56	67	73	76	74	2.00	2.70%	400	399	1	0.25%
Minutes	8,151	22,856	7,685	8,948	7,908	7,244	6,993	8,151	8,178	(27.00)	-0.33%	41,040	43,986	(2,946)	-6.70%

Tahoe Forest Hospital
Operating Indicators
Outpatient Volumes
Month & YTD June 2015

Outpatient	Dec-13 Actual	Dec-13 YTD Actual	Jul-14 Actual	Aug-14 Actual	Sep-14 Actual	Oct-14 Actual	Nov-14 Actual	Dec-14 Actual	Dec-14 Budget	Dec-14 Variance	Dec-14 % Variance	YTD Actual	YTD Budget	YTD Variance	YTD % Variance
E/R Visits	1,216	6,570	1,059	1,375	878	816	749	1,273	1,155	(277.00)	-23.98%	6,150	6,206	(56)	-0.90%
TF Laboratory Tests	6,244	38,783	9,215	8,924	8,358	8,161	7,259	8,572	5,917	2,441.00	41.25%	50,489	38,378	12,111	31.56%
TC Laboratory Tests	725	4,866	1,102	1,120	933	1,158	910	895	709	224.00	31.59%	6,118	4,789	1,329	27.75%
IVCH Laboratory Tests	405	2,434	451	372	398	362	336	368	343	55.00	16.03%	2,287	2,407	(120)	-4.99%
MOB Tests	339	2,242	493	339	464	542	420	502	327	137.00	41.90%	2,760	2,246	514	22.89%
Clinic Accounts Tests	458	4,458	367	406	606	1,238	942	458	628	(22.00)	-3.50%	4,015	4,353	(338)	-7.76%
Send Outs O/P Tests	824	6,508	1,324	1,278	1,410	1,521	1,208	1,054	2,387	(977.00)	-40.93%	7,795	14,263	(6,468)	-45.35%
Total O/P Tests	8,995	59,291	12,952	12,439	12,169	12,980	11,075	11,849	10,311	1,858.00	18.02%	73,464	66,436	7,028	10.58%
Home Health Visits	277	2,036	266	277	260	322	305	318	320	(60.00)	-18.75%	1,748	2,024	(276)	-13.64%
Radiology Exams	723	3,673	902	828	521	507	465	780	684	(163.00)	-23.83%	4,003	3,704	299	8.07%
Ultrasound Exams (excludes Breast U	222	1,350	294	282	199	219	242	230	214	(15.00)	-7.01%	1,476	1,365	111	8.13%
Cat Scan Exams	308	1,523	345	302	221	198	191	281	280	(59.00)	-21.07%	1,538	1,503	35	2.33%
MRI Scan Exams	122	918	171	153	136	151	142	158	168	(32.00)	-19.05%	911	901	10	1.11%
Operating Room															
Cases	93	505	110	93	71	98	62	77	91	(20.00)	-21.98%	509	517	(8)	-1.55%
Minutes	6,675	35,980	7,205	6,725	4,740	5,877	4,504	5,198	6,326	(1,586.00)	-25.07%	34,249	35,574	(1,325)	-3.72%

Incline Village Community Hospital
Operating Indicators
Month & YTD June 2015
December 31, 2014

	Dec-13 Actual	Dec-13 YTD Actual	Jul-14 Actual	Aug-14 Actual	Sep-14 Actual	Oct-14 Actual	Nov-14 Actual	Dec-14 Actual	Dec-14 Budget	Dec-14 Variance	Dec-14 % Variance	YTD Actual	YTD Budget	YTD Variance	YTD % Variance
Admissions	0	4	4	0	0	0	0	1	0	1.00	0.00%	5	4	1	25.00%
Registrations	777	5,134	989	885	795	765	622	791	809	(18.00)	-2.22%	4,847	5,090	(243)	-4.77%
I/P Days	0	8	5	0	0	0	0	1	0	1.00	0.00%	6	4	2	50.00%
Observation Days	1	13	2	1	0	2	0	0	3	(3.00)	-100.00%	5	17	(12)	-70.59%
Total Days	1	21	7	1	0	2	0	1	3	(2.00)	-66.67%	11	21	(10)	-47.62%
Emergency Visits	403	1,975	431	382	317	260	227	367	359	8.00	2.23%	1,984	1,915	69	3.60%
Surgical Services:															
Cases - Inpatient	0	0	0	0	0	0	0	0	0	0.00	0.00%	0	0	0	0.00%
Cases - Outpatient	7	47	9	10	5	8	5	9	8	1.00	12.50%	46	48	(2)	-4.17%
Total Cases	7	47	9	10	5	8	5	9	8	1.00	12.50%	46	48	(2)	-4.17%
Minutes	2,194	14,938	2,668	3,087	1,400	2,024	1,188	2,568	2,286	282.00	12.34%	12,935	14,326	(1,391)	-9.71%
Laboratory Tests (inc EKG's)	1,930	13,066	3,090	2,624	2,644	2,438	2,021	2,233	1,868	365.00	19.54%	15,050	12,761	2,289	17.94%
Radiology - I / P Exams	0	1	0	0	0	0	0	0	0	0.00	0.00%	0	1	(1)	-100.00%
Radiology - O / P Exams	79	454	82	71	57	66	55	65	68	(3.00)	-4.41%	396	450	(54)	-12.00%
Radiology - ER Exams	160	753	181	172	128	104	59	156	139	17.00	12.23%	800	743	57	7.67%
Radiology (inc mammos) Totals	239	1,208	263	243	185	170	114	221	207	14.00	6.76%	1,196	1,194	2	0.17%
CT - I / P Exams	0	1	0	0	0	0	0	0	0	0.00	0.00%	0	0	0	0.00%
CT - O / P Exams (Inc. U/S)	16	80	23	12	16	8	17	14	15	(1.00)	-6.67%	90	81	9	11.11%
CT - ER Exams	47	274	46	47	33	30	48	43	49	(6.00)	-12.24%	247	264	(17)	-6.44%
Total Cat Scan Exams	63	355	69	59	49	38	65	57	64	(7.00)	-10.94%	337	345	(8)	-2.32%
Pharmacy - I/P units	147	284	87	0	0	0	0	23	0	23.00	0.00%	110	95	15	15.79%
Pharmacy - O/P units	816	4,261	1,043	840	584	521	475	892	786	106.00	13.49%	4,335	4,203	132	3.14%
Pharmacy Totals	963	4,545	1,130	840	584	521	475	915	786	129.00	16.41%	4,445	4,298	147	3.42%
IV's - Inpatient	14	36	2	0	0	0	0	0	0	0.00	0.00%	2	14	(12)	-85.71%
IV's - Outpatient	104	629	12	3	12	2	2	8	117	(109.00)	-93.16%	39	626	(587)	-93.77%
Total IV's	118	665	14	3	12	2	2	8	117	(109.00)	-93.16%	41	640	(599)	-93.59%
RT - I/P Procedures	46	85	17	0	0	0	0	19	0	19.00	0.00%	36	0	36	0.00%
RT - O/P Procedures	133	798	159	150	91	94	67	153	0	153.00	0.00%	714	0	714	0.00%
R/T Totals	179	863	176	150	91	94	67	172	0	172.00	0.00%	750	0	750	0.00%
Sleep Clinic Visits	9	95	9	13	18	14	7	8	17	(9.00)	-52.94%	69	106	(37)	-34.91%
Perioperative Services Minutes															
OR - Inpatients	0	0	0	0	0	0	0	0	0	0.00	0.00%	0	0	0	0.00%
OR - Outpatients	705	4,236	804	868	332	619	329	720	577	143.00	24.78%	3,672	3,617	55	1.52%
OR - Total	705	4,236	804	868	332	619	329	720	577	143.00	24.78%	3,672	3,617	55	1.52%
Total ASD	1,271	9,181	1,564	1,878	897	1,270	623	1,524	1,501	23.00	1.53%	7,976	9,406	(1,430)	-15.20%
I/P Recovery	0	0	0	0	0	0	0	0	0	0.00	0.00%	0	0	0	0.00%
O/P Recovery	218	1,521	280	286	171	135	36	324	208	116.00	55.77%	1,232	1,303	-71	-5.45%
Total Recovery	218	1,521	280	286	171	135	36	324	208	116.00	55.77%	1,232	1,303	(71)	-5.45%
Pain Clinic	0	0	0	0	0	0	0	0	0	0.00	0.00%	0	0	0	0.00%
Procedure Room	0	0	0	55	0	0	0	0	0	0.00	0.00%	55	0	55	0.00%
Total Surgicenter Minutes	2,194	14,938	2,668	3,087	1,400	2,024	1,188	2,568	2,286	282.00	12.34%	12,935	14,326	(1,391)	-9.71%
Anesthesia - Minutes															
Inpatient	0	0	0	0	0	0	0	0	0	0.00	0.00%	0	0	0	0.00%
Out Patient	725	4,366	848	926	357	586	342	739	601	138.00	22.96%	3,798	3,763	35	0.93%
Elsewhere	0	0	0	0	0	0	0	0	0	0.00	0.00%	0	0	0	0.00%
Total Anesthesia - Minutes	725	4,366	848	926	357	586	342	739	601	138.00	22.96%	3,798	3,763	35	0.93%
Dietary															
Patient Meals	66	429	96	75	61	62	62	70	101	(31.00)	-30.69%	426	600	(174)	-29.00%
Pantries	201	1,227	228	201	230	166	155	188	74	94.00	127.03%	1,148	448	702	157.40%
Non-patient Meals	0	0	0	0	0	0	0	0	0	0.00	0.00%	0	0	0	0.00%
Total Meals	267	1,656	324	276	291	228	217	258	175	63.00	36.00%	1,574	1,046	528	50.48%
Flu Shots	18	396	0	0	74	317	46	8	32	(24.00)	-75.00%	445	385	60	15.58%
P/T - 42 076	2,309	16,020	2,463	2,292	2,211	2,547	2,095	2,353	2,372	(19.00)	-0.80%	13,961	16,262	(2301)	-14.15%
OT - 42 080	75	619	108	153	175	151	116	87	85	2.00	2.35%	790	612	178	29.08%
Diamond Peak - Patients Seen	113	113	0	0	0	0	0	84	91	(7.00)	-7.69%	84	91	(7)	-7.69%
Incline Village Health Clinic	61	346	65	115	109	128	108	110	47	63.00	134.04%	655	282	373	132.27%


Total Quarterly Percent of Gross Revenue by Payor
Percent of Gross Revenue
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
1st 2005
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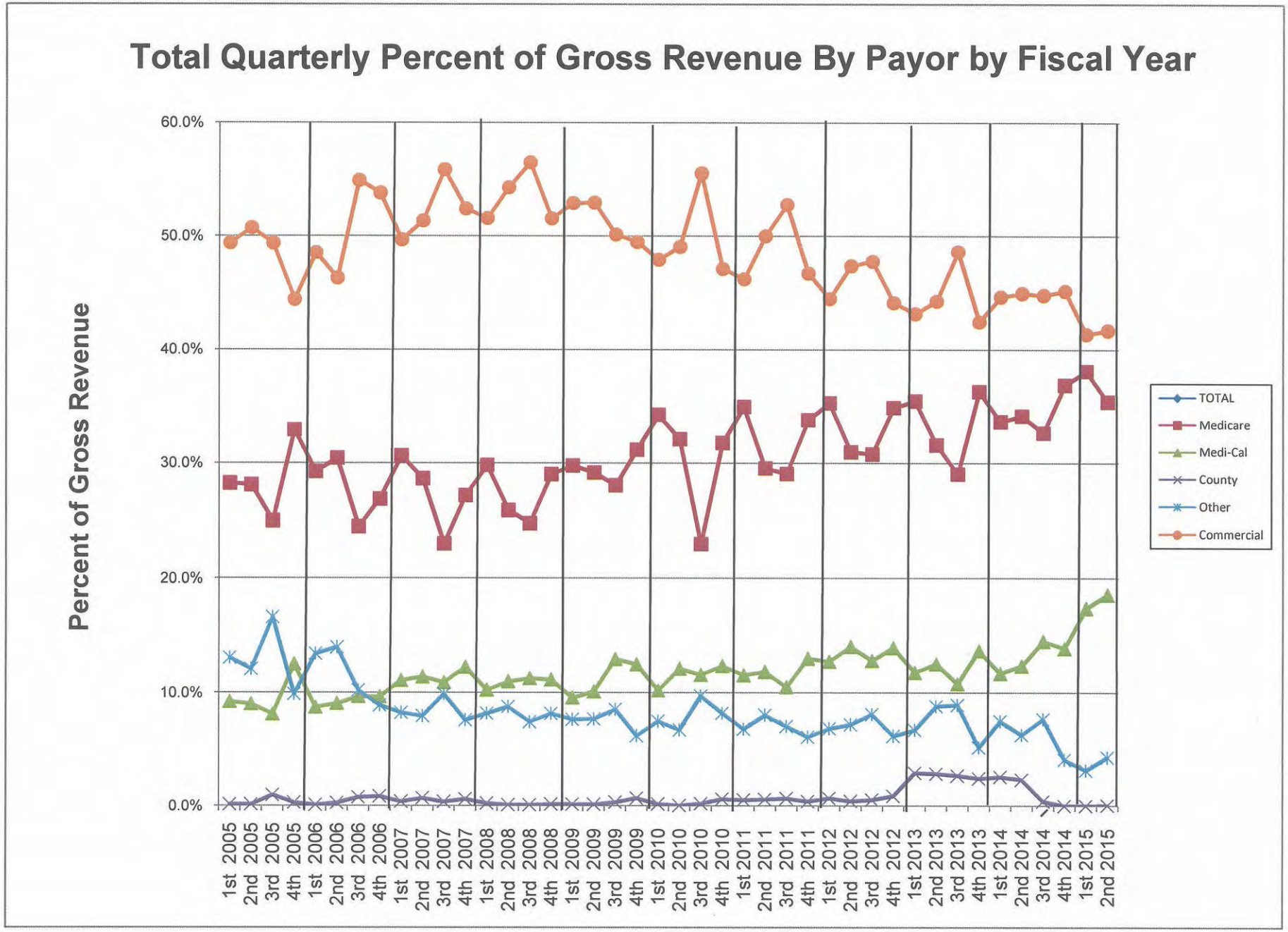
4th 2014
TOTAL
Medicare
Medi-Cal
County
Other
Commercial

Total Quarterly Percent of Gross Revenue By Payor by Fiscal Year



TAHOE FOREST HOSPITAL DISTRICT
SEPARATE BUSINESS ENTERPRISES
FOR THE SIX MONTHS ENDING DECEMBER 31, 2014

	HOME HEALTH				HOSPICE			
	ACTUAL	BUDGET	$ VARIANCE FAVORABLE/ (UNFAVORABLE) BUDGET	PRIOR YTD DEC 2013	ACTUAL	BUDGET	$ VARIANCE FAVORABLE/ (UNFAVORABLE) BUDGET	PRIOR YTD DEC 2013
Gross Operating Revenue	837,615	985,340	(147,725)	966,023	801,050	1,053,092	(252,043)	831,810
Deduction From Rev	408,863	480,972	72,109	541,283	463,609	609,479	145,870	330,740
Other Operating Revenue	-	-	-	-	-	-	-	-
Total Operating Revenue	428,752	504,368	(75,617)	424,740	337,440	443,613	(106,173)	501,070
Operating Expense:								
Salaries	296,159	299,060	2,901	302,447	166,378	253,182	86,804	263,238
Benefits	141,022	130,806	(10,216)	135,181	141,896	173,099	31,203	140,879
Professional Fees	100	200	100	200	6,400	12,600	6,200	12,455
Supplies	8,509	5,396	(3,114)	5,698	39,281	34,107	(5,174)	28,475
Purchased Services	26,143	28,638	2,495	21,890	33,111	37,468	4,357	25,540
Other Expenses	15,422	14,434	(988)	16,926	31,191	26,631	(4,560)	31,808
Total Operating Expenses	487,356	478,534	(8,822)	482,342	418,257	537,086	118,830	502,395
Net Operating Rev (Exp)	(58,604)	25,834	(84,438)	(57,602)	(80,816)	(93,473)	12,657	(1,325)
Non - Operating Rev / (Exp)								
Donations	-	-	-	100	20,155	20,000	155	13,018
Thrift Store Net Income	-	-	-	-	267,702	280,163	(12,460)	262,696
Employee Benefit - EE Discounts	-	-	-	-	-	-	-	-
Depreciation	(4,687)	(4,687)	-	(21,537)	(3,732)	(3,732)	-	(3,673)
Total Non-Operating Rev/(Exp)	(4,687)	(4,687)	-	(21,437)	284,125	296,431	(12,305)	272,041
Net Income/(Loss)	(63,291)	21,147	(84,438)	(79,039)	203,309	202,957	352	270,716
Units	1,748	2,024	(276)	2,036	2,022	2,394	(372)	2,244
Gross Revenue/Unit	479.18	486.83	(7.64)	474.47	396.17	439.89	(43.72)	370.68
Total Operating Expense/Unit	278.81	236.43	(42.38)	236.91	206.85	224.35	17.49	223.88

TAHOE FOREST HOSPITAL DISTRICT
SEPARATE BUSINESS ENTERPRISES
FOR THE SIX MONTHS ENDING DECEMBER 31, 2014

	CHILDRENS CENTER				OCCUPATIONAL HEALTH			
	ACTUAL	BUDGET	$ VARIANCE FAVORABLE/ (UNFAVORABLE) BUDGET	PRIOR YTD DEC 2013	ACTUAL	BUDGET	$ VARIANCE FAVORABLE/ (UNFAVORABLE) BUDGET	PRIOR YTD DEC 2013
Gross Operating Revenue	405,042	407,886	(2,845)	399,330	299,867	232,346	67,521	241,506
Deduction From Rev	-	-	-	-	66,713	51,692	(15,022)	51,924
Other Operating Revenue	-	-	-	-	50	600	(550)	550
Total Operating Revenue	405,042	407,886	(2,845)	399,330	233,203	181,255	51,949	190,132
Operating Expense:								
Salaries	202,418	200,146	(2,272)	201,253	84,481	71,952	(12,529)	68,258
Benefits	142,980	162,759	19,779	147,086	27,960	34,992	7,032	49,375
Professional Fees	-	-	-		3,600	3,960	360	3,518
Supplies	13,275	6,946	(6,329)	6,649	20,962	19,110	(1,852)	23,821
Purchased Services	10,871	9,240	(1,631)	10,865	96,973	76,215	(20,758)	91,435
Other Expenses	15,467	16,858	1,391	16,731	23,915	16,398	(7,517)	32,758
Total Operating Expenses	385,011	395,949	10,938	382,584	257,890	222,626	(35,264)	269,165
Net Operating Rev (Exp)	20,031	11,937	8,093	16,746	(24,687)	(41,372)	16,685	(79,033)
Non - Operating Rev / (Exp)								
Donations	14,285	10,000	4,285	1,285	-	-	-	-
Thrift Store Net Income	-	-	-	-	-	-	-	-
Employee Benefit - EE Discounts	(107,718)	(105,000)	(2,718)	(103,419)	-	-	-	-
Depreciation	(18,645)	(19,211)	566	(18,885)	(12)	(12)	-	(201)
Total Non-Operating Rev/(Exp)	(112,079)	(114,211)	2,132	(121,019)	(12)	(12)	-	(201)
Net Income/(Loss)	(92,048)	(102,274)	10,226	(104,273)	(24,698)	(41,383)	16,685	(79,234)
Units	9,357	9,199	158	9,367	1,425	1,305	120	1,352
Gross Revenue/Unit	43.29	44.34	(1.05)	42.63	210.43	178.04	32.39	178.63
Total Operating Expense/Unit	41.15	43.04	1.90	40.84	180.98	170.59	(10.38)	199.09

TAHOE FOREST HOSPITAL DISTRICT
SEPARATE BUSINESS ENTERPRISES
FOR THE SIX MONTHS ENDING DECEMBER 31, 2014

	HEALTH CLINIC				RETAIL PHARMACY			
	ACTUAL	BUDGET	$ VARIANCE FAVORABLE/ (UNFAVORABLE) BUDGET	PRIOR YTD DEC 2013	ACTUAL	BUDGET	$ VARIANCE FAVORABLE/ (UNFAVORABLE) BUDGET	PRIOR YTD DEC 2013
Gross Operating Revenue	261,183	243,169	18,014	227,952	1,385,201	1,255,959	129,242	1,226,244
Deduction From Rev	167,942	156,359	(11,583)	132,212	564,379	427,028	(137,351)	349,948
Other Operating Revenue	-	-	-	-	-	-	-	-
Total Operating Revenue	93,241	86,811	6,431	95,740	820,822	828,931	(8,109)	876,296
Operating Expense:								
Salaries	163,833	145,036	(18,797)	143,343	172,811	178,001	5,191	190,143
Benefits	69,481	71,318	1,836	85,788	91,490	93,309	1,819	95,001
Professional Fees	6,300	4,800	(1,500)	4,800	-	-	-	3,861
Supplies	11,206	9,837	(1,369)	12,553	705,708	655,594	(50,114)	698,588
Purchased Services	9,056	6,722	(2,334)	7,528	16,019	16,240	221	17,533
Other Expenses	6,690	12,045	5,355	11,862	33,047	33,369	322	33,626
Total Operating Expenses	266,567	249,758	(16,809)	265,874	1,019,075	976,513	(42,562)	1,038,752
Net Operating Rev (Exp)	(173,326)	(162,947)	(10,378)	(170,134)	(198,254)	(147,582)	(50,671)	(162,456)
Non - Operating Rev / (Exp)								
Donations	-	-	-	-	-	-	-	-
Thrift Store Net Income	-	-	-	-	-	-	-	-
Employee Benefit - EE Discounts	-	-	-	-	-	-	-	-
Depreciation	(315)	(315)	-	(141)	-	-	-	
Total Non-Operating Rev/(Exp)	(315)	(315)	-	(141)	-	-	-	-
Net Income/(Loss)	(173,641)	(163,263)	(10,378)	(170,275)	(198,254)	(147,582)	(50,671)	(162,456)
Units	1,633	1,582	51	1,575	13,452	13,719	(267)	13,759
Gross Revenue/Unit	159.94	153.71	6.23	144.73	102.97	91.55	11.42	89.12
Total Operating Expense/Unit	163.24	157.87	(5.36)	168.81	75.76	71.18	(4.58)	75.50

Employee Drug Plan

Plan Costs	(473,662)
Captured through Retail Rx	258,042
Net Plan Costs	(215,620)
Net Operating Income	(198,254)
Net Employee Drug Plan Costs	(215,620)
Net Financial Position	(413,874)

TAHOE FOREST HOSPITAL DISTRICT
SEPARATE BUSINESS ENTERPRISES
FOR THE SIX MONTHS ENDING DECEMBER 31, 2014

	TOTAL SEPARATE BUSINESS ENTITIES			
	ACTUAL	BUDGET	$ VARIANCE FAVORABLE/ (UNFAVORABLE) BUDGET	PRIOR YTD DEC 2013
Gross Operating Revenue	3,989,956	4,177,793	(187,837)	3,892,865
Deduction From Rev	1,671,506	1,725,530	54,024	1,406,107
Other Operating Revenue	50	600	(550)	550
Total Operating Revenue	2,318,500	2,452,864	(134,363)	2,487,308
Operating Expense:				
Salaries	1,086,080	1,147,377	61,297	1,168,682
Benefits	614,829	666,283	51,454	653,310
Professional Fees	16,400	21,560	5,160	24,834
Supplies	798,942	730,990	(67,952)	775,784
Purchased Services	192,173	174,522	(17,651)	174,791
Other Expenses	125,732	119,734	(5,998)	143,711
Total Operating Expenses	2,834,156	2,860,467	26,311	2,941,112
Net Operating Rev (Exp)	(515,656)	(407,603)	(108,052)	(453,804)
Non - Operating Rev / (Exp)				
Donations	34,440	30,000	4,440	14,403
Thrift Store Net Income	267,702	280,163	(12,460)	262,696
Employee Benefit - EE Discounts	(107,718)	(105,000)	(2,718)	(103,419)
Depreciation	(27,391)	(27,956)	566	(44,436)
Total Non-Operating Rev/(Exp)	167,033	177,206	(10,173)	129,244
Net Income/(Loss)	(348,623)	(230,397)	(118,225)	(324,560)
Units	29,637	30,223	(586)	30,333
Gross Revenue/Unit	134.63	138.23	(3.60)	128.34
Total Operating Expense/Unit	95.63	94.65	0.98	96.96

TAHOE FOREST HOSPITAL DISTRICT
CENTER FOR HEALTH AND SPORTS PERFORMANCE
FOR THE SIX MONTHS ENDING DECEMBER 31, 2014

	THERAPY SERVICES				SPORTS PERFORMANCE LAB			
	ACTUAL	BUDGET	$ VARIANCE FAVORABLE/ (UNFAVORABLE) BUDGET	PRIOR YTD DEC 13	ACTUAL	BUDGET	$ VARIANCE FAVORABLE/ (UNFAVORABLE) BUDGET	PRIOR YTD DEC 13
Gross Operating Revenue	$ 2,033,389	$ 1,681,551	$ 351,838	$ 1,526,808	$ 5,649	$ 420	$ 5,229	$ 300
Deduction From Rev	673,052	556,593	(116,458)	505,373	-	-	-	-
Other Operating Revenue	562	840	(278)	1,028	-	-	-	-
Total Operating Revenue	$ 1,360,900	$ 1,125,798	$ 235,102	$ 1,022,463	$ 5,649	$ 420	$ 5,229	$ 300
Operating Expense:								
Salaries	$ -	$ -	$ -	$ -	$ 1,554	$ 1,727	$ 173	$ 1,668
Benefits	-	-	-	-	996	632	(364)	701
Professional Fees	790,930	685,829	(105,101)	675,895	-	-	-	-
Supplies	17,805	18,120	316	20,626	4,036	-	(4,036)	-
Purchased Services	31,722	34,287	2,565	36,468	4,868	-	(4,868)	-
Other Expenses	941	2,900	1,960	2,112	-	-	-	-
Total Operating Expenses	$ 841,398	$ 741,137	$ (100,261)	$ 735,101	$ 11,453	$ 2,359	$ (9,094)	$ 2,369
Net Operating Rev (Exp)	$ 519,502	$ 384,660	$ 134,841	$ 287,362	$ (5,804)	$ (1,939)	$ (3,865)	$ (2,069)
Non - Operating Rev / (Exp)								
Donations	-	-	-	-	-	-	-	-
Depreciation	(4,147)	(4,147)	-	(3,989)	-	-	-	-
Total Non-Operating Rev/(Exp)	(4,147)	(4,147)	-	(3,989)	-	-	-	-
Net Income/(Loss)	$ 515,355	$ 380,513	$ 134,841	$ 283,373	$ (5,804)	$ (1,939)	$ (3,865)	$ (2,069)
Overhead Allocation Based on Sq Ft	$ (105,333)	$ (108,372)	3,040	$ (104,357)	$ (29,016)	$ (29,854)	837	$ (28,747)
Adjusted Net Income/(Loss)	$ 410,022	$ 272,141	$ 137,881	$ 179,017	$ (34,821)	$ (31,793)	$ (3,028)	$ (30,816)
Units	27,395	24,497	2,898	23,847	180	5	$ 175	3
Gross Revenue/Unit	$ 74.22	$ 68.64	$ 5.58	$ 64.03	$ 31.38	$ 84.00	$ (52.62)	$ 100.00
Total Operating Expense/Unit	$ 34.56	$ 34.68	$ 0.12	$ 35.20	$ 224.83	$ 6,442.57	$ 6,217.74	$ 10,372.16

TAHOE FOREST HOSPITAL DISTRICT
CENTER FOR HEALTH AND SPORTS PERFORMANCE
FOR THE SIX MONTHS ENDING DECEMBER 31, 2014

	FITNESS CENTER				HP/EDUCATION/WELLNESS			
	ACTUAL	BUDGET	$ VARIANCE FAVORABLE/ (UNFAVORABLE) BUDGET	PRIOR YTD DEC 13	ACTUAL	BUDGET	$ VARIANCE FAVORABLE/ (UNFAVORABLE) BUDGET	PRIOR YTD DEC 13
Gross Operating Revenue	$ 82,945	$ 84,388	$ (1,443)	$ 84,929	$ 8,439	$ 5,654	$ 2,785	$ 6,363
Deduction From Rev	-	-	-	-	-	-	-	-
Other Operating Revenue	-	-	-	-	-	-	-	-
Total Operating Revenue	$ 82,945	$ 84,388	$ (1,443)	$ 84,929	$ 8,439	$ 5,654	$ 2,785	$ 6,363
Operating Expense:								
Salaries	$ -	$ -	$ -	$ -	$ 12,310	$ 5,399	$ (6,912)	$ 7,479
Benefits	-	-	-	-	4,367	3,160	(1,207)	3,172
Professional Fees	-	-	-	-	-	-	-	-
Supplies	2,721	2,013	(708)	2,564	3,346	2,921	(426)	2,623
Purchased Services	90,539	93,391	2,852	96,837	10,424	11,412	989	12,004
Other Expenses	-	-	-	-	1,523	1,907	384	1,542
Total Operating Expenses	$ 93,260	$ 95,404	$ 2,144	$ 99,401	$ 31,970	$ 24,798	$ (7,171)	$ 26,820
Net Operating Rev (Exp)	$ (10,316)	$ (11,016)	$ 701	$ (14,472)	$ (23,531)	$ (19,144)	$ (4,386)	$ (20,457)
Non - Operating Rev / (Exp)								
Donations	-	-	-	-	-	-	-	-
Depreciation	(421)	(421)	-	(1,798)	-	-	-	-
Total Non-Operating Rev/(Exp)	(421)	(421)	-	(1,798)	-	-	-	-
Net Income/(Loss)	$ (10,737)	$ (11,437)	$ 701	$ (16,270)	$ (23,531)	$ (19,144)	$ (4,386)	$ (20,457)
Overhead Allocation Based on Sq Ft	$ (55,847)	$ (57,459)	1,612	$ (55,330)	$ (80,687)	$ (83,015)	2,328	$ (79,939)
Adjusted Net Income/(Loss)	$ (66,584)	$ (68,896)	$ 2,312	$ (71,600)	$ (104,218)	$ (102,159)	$ (2,058)	$ (100,396)
Units	1,261	1,275	(14)	1,231	1,019	672	347	857
Gross Revenue/Unit	$ 65.78	$ 66.19	$ (0.41)	$ 68.99	$ 8.28	$ 8.41	$ (0.13)	$ 7.42
Total Operating Expense/Unit	$ 118.25	$ 119.89	$ 1.65	$ 125.70	$ 110.56	$ 160.44	$ 49.88	$ 124.57

TAHOE FOREST HOSPITAL DISTRICT
CENTER FOR HEALTH AND SPORTS PERFORMANCE
FOR THE SIX MONTHS ENDING DECEMBER 31, 2014

	OCCUPATIONAL HEALTH TESTING				CENTER OPERATIONS			
	ACTUAL	BUDGET	$ VARIANCE FAVORABLE/ (UNFAVORABLE) BUDGET	PRIOR YTD DEC 13	ACTUAL	BUDGET	$ VARIANCE FAVORABLE/ (UNFAVORABLE) BUDGET	PRIOR YTD DEC 13
Gross Operating Revenue	$ 85,375	$ 67,112	$ 18,263	$ 79,914	$ -	$ -	$ -	$ -
Deduction From Rev	-	-	-	-	-	-	-	-
Other Operating Revenue	-	-	-	-	-	-	-	-
Total Operating Revenue	$ 85,375	$ 67,112	$ 18,263	$ 79,914	$ -	$ -	$ -	$ -
Operating Expense:								
Salaries	$ 7,237	$ 6,366	$ (871)	$ 8,634	$ -	$ -	$ -	$ -
Benefits	3,042	4,150	1,108	3,641	-	-	-	-
Professional Fees	-	-	-	-	13,600	18,600	5,000	20,450
Supplies	145	183	38	390	184	771	587	626
Purchased Services	13,240	14,057	817	10,803	10,718	11,916	1,198	10,083
Other Expenses	187	200	13	127	186,859	188,317	1,458	185,490
Total Operating Expenses	$ 23,851	$ 24,956	$ 1,105	$ 23,595	$ 211,361	$ 219,604	$ 8,243	$ 216,649
Net Operating Rev (Exp)	$ 61,524	$ 42,156	$ 19,368	$ 56,319	$ (211,361)	$ (219,604)	$ 8,243	$ (216,649)
Non - Operating Rev / (Exp)								
Donations	-	-	-	-	-	-	-	-
Depreciation	-	-	-	-	(79,354)	(79,500)	146	(71,373)
Total Non-Operating Rev/(Exp)	-	-	-	-	(79,354)	(79,500)	146	(71,373)
Net Income/(Loss)	$ 61,524	$ 42,156	$ 19,368	$ 56,319	$ (290,715)	$ (299,104)	$ 8,389	$ (288,022)
Overhead Allocation Based on Sq Ft	$ -	$ -	-	$ -	$ 270,883	$ 278,699	(7,817)	$ 268,373
Adjusted Net Income/(Loss)	$ 61,524	$ 42,156	$ 19,368	$ 56,319	$ (19,833)	$ (20,405)	572	$ (19,649)
Units	951	913	38	1,005				
Gross Revenue/Unit	$ 89.77	$ 73.51	$ 16.27	$ 79.52				
Total Operating Expense/Unit	$ 25.08	$ 27.33	$ 2.25	$ 23.48				

TAHOE FOREST HOSPITAL DISTRICT
CENTER FOR HEALTH AND SPORTS PERFORMANCE
FOR THE SIX MONTHS ENDING DECEMBER 31, 2014

	TOTAL CENTER FOR HEALTH & SPORTS PERFORMANCE			
	ACTUAL	BUDGET	$ VARIANCE FAVORABLE/ (UNFAVORABLE) BUDGET	PRIOR YTD DEC 13
Gross Operating Revenue	$ 2,215,797	$ 1,839,125	$ 376,672	$ 1,698,314
Deduction From Rev	673,052	556,593	(116,458)	505,373
Other Operating Revenue	562	840	(278)	1,028
Total Operating Revenue	$ 1,543,307	$ 1,283,372	$ 259,936	$ 1,193,969
Operating Expense:				
Salaries	$ 21,101	$ 13,492	$ (7,609)	$ 17,781
Benefits	8,405	7,942	(462)	7,514
Professional Fees	804,530	704,429	(100,101)	696,345
Supplies	28,238	24,008	(4,230)	26,829
Purchased Services	161,511	165,064	3,553	166,195
Other Expenses	189,510	193,325	3,815	189,271
Total Operating Expenses	$ 1,213,294	$ 1,108,259	$ (105,034)	$ 1,103,935
Net Operating Rev (Exp)	$ 330,014	$ 175,112	$ 154,901	$ 90,034
Non - Operating Rev / (Exp)				
Donations	-	-	-	-
Depreciation	(83,922)	(84,068)	146	(77,160)
Total Non-Operating Rev/(Exp)	(83,922)	(84,068)	146	(77,160)
Net Income/(Loss)	$ 246,091	$ 91,044	$ 155,047	$ 12,874
Overhead Allocation Based on Sq Ft	-	-	-	-
Adjusted Net Income/(Loss)	$ 246,091	$ 91,044	$ 155,047	$ 12,874
Units	30,806	27,362	3,444	26,943
Gross Revenue/Unit	$ 71.93	$ 67.21	$ 4.71	$ 63.03
Total Operating Expense/Unit	$ 39.38	$ 40.50	$ 1.12	$ 40.97

TAHOE FOREST HOSPITAL DISTRICT
CANCER PROGRAM
FOR THE SIX MONTHS ENDED DECEMBER 31, 2014

	MEDICAL ONCOLOGY				MSC MEDICAL ONCOLOGY			
	ACTUAL	BUDGET	$ VARIANCE FAVORABLE/ (UNFAVORABLE) BUDGET	PRIOR YTD DEC 2013	ACTUAL	BUDGET	$ VARIANCE FAVORABLE/ (UNFAVORABLE) BUDGET	PRIOR YTD DEC 2013
Gross Operating Revenue	1,059,267	776,072	283,195	738,683	440,767	602,205	(161,437)	519,119
Deduction From Rev	399,684	292,828	(106,855)	312,937	225,948	308,705	82,757	268,133
Other Operating Revenue	-	-	-	-	-	-	-	-
Total Operating Revenue	659,583	483,244	176,340	425,746	214,819	293,500	(78,681)	250,986
Operating Expense:								
Salaries	699,661	630,045	(69,616)	724,969	-	-	-	-
Benefits	293,734	297,206	3,473	370,293	-	-	-	-
Professional Fees	154,382	134,349	(20,032)	114,726	420,247	412,500	(7,747)	412,500
Supplies	42,688	34,563	(8,126)	30,030	4,920	1,076	(3,844)	1,024
Purchased Services	54,072	51,927	(2,145)	54,644	8,842	3,060	(5,782)	3,917
Other Expenses	112,750	113,708	959	83,356	-	-	-	-
Total Operating Expenses	1,357,287	1,261,799	(95,488)	1,378,018	434,009	416,636	(17,372)	417,441
Net Operating Rev (Exp)	(697,704)	(778,555)	80,852	(952,272)	(219,190)	(123,137)	(96,053)	(166,455)
Non - Operating Rev / (Exp)								
Donations	151,197	82,000	69,197	78,789	-	-	-	-
Depreciation	(59,593)	(59,593)	-	(73,778)	-	-	-	-
Total Non-Operating Rev/(Exp)	91,604	22,407	69,197	5,011	-	-	-	-
Net Income/(Loss)	(606,099)	(756,148)	150,049	(947,260)	(219,190)	(123,137)	(96,053)	(166,455)
Units	3,843	2,645	1,198	2,638	2,255	3,100	(845)	2,975
Gross Revenue/Unit	275.64	293.41	(17.78)	280.02	195.46	194.26	1.20	174.49
Total Operating Expense/Unit	353.18	477.05	123.87	522.37	192.47	134.40	(58.07)	140.32

TAHOE FOREST HOSPITAL DISTRICT
CANCER PROGRAM
FOR THE SIX MONTHS ENDED DECEMBER 31, 2014

	RADIATION ONCOLOGY				MSC RADIATION ONCOLOGY			
	ACTUAL	BUDGET	$ VARIANCE FAVORABLE/ (UNFAVORABLE) BUDGET	PRIOR YTD DEC 2013	ACTUAL	BUDGET	$ VARIANCE FAVORABLE/ (UNFAVORABLE) BUDGET	PRIOR YTD DEC 2013
Gross Operating Revenue	2,015,677	2,013,911	1,766	1,851,270	390,699	395,182	(4,483)	393,606
Deduction From Rev	806,814	806,107	(707)	799,040	206,249	208,616	2,367	186,746
Other Operating Revenue	-	-	-	-	-	-	-	-
Total Operating Revenue	1,208,863	1,207,803	1,059	1,052,230	184,450	186,567	(2,117)	206,860
Operating Expense:								
Salaries	218,143	306,776	88,632	199,570	-	-	-	-
Benefits	134,369	162,265	27,896	102,894	-	-	-	-
Professional Fees	89,788	86,375	(3,413)	99,272	260,758	256,000	(4,758)	256,000
Supplies	2,123	2,110	(13)	1,525	-	-	-	-
Purchased Services	170,895	173,724	2,829	157,060	-	-	-	-
Other Expenses	8,362	6,811	(1,552)	4,457	-	-	-	-
Total Operating Expenses	623,681	738,060	114,379	564,778	260,758	256,000	(4,758)	256,000
Net Operating Rev (Exp)	585,182	469,743	115,439	487,452	(76,307)	(69,433)	(6,874)	(49,140)
Non - Operating Rev / (Exp)								
Donations	-	-	-	-	-	-	-	-
Depreciation	(519,764)	(519,764)	-	(517,929)	-	-	-	-
Total Non-Operating Rev/(Exp)	(519,764)	(519,764)	-	(517,929)	-	-	-	-
Net Income/(Loss)	65,418	(50,021)	115,439	(30,477)	(76,307)	(69,433)	(6,874)	(49,140)
Units	1,837	1,893	(56)	1,709	828	1,007	(179)	1,072
Gross Revenue/Unit	1,097.27	1,063.87	33.39	1,083.25	471.86	392.44	79.42	367.17
Total Operating Expense/Unit	339.51	389.89	50.38	330.47	314.92	254.22	(60.70)	238.81

TAHOE FOREST HOSPITAL DISTRICT
CANCER PROGRAM
FOR THE SIX MONTHS ENDED DECEMBER 31, 2014

	ONCOLOGY LAB				ONCOLOGY DRUGS			
	ACTUAL	BUDGET	$ VARIANCE FAVORABLE/ (UNFAVORABLE) BUDGET	PRIOR YTD DEC 2013	ACTUAL	BUDGET	$ VARIANCE FAVORABLE/ (UNFAVORABLE) BUDGET	PRIOR YTD DEC 2013
Gross Operating Revenue	136,200	115,329	20,871	115,120	9,810,023	9,742,436	67,587	9,417,661
Deduction From Rev	55,356	46,873	(8,483)	47,142	4,015,768	3,988,101	(27,667)	3,763,665
Other Operating Revenue	-	-	-	-	-	-	-	-
Total Operating Revenue	80,844	68,456	12,388	67,978	5,794,255	5,754,335	39,920	5,653,996
Operating Expense:								
Salaries	56,835	47,615	(9,220)	52,193	-	-	-	-
Benefits	22,375	22,002	(373)	24,405	-	-	-	-
Professional Fees	-	-	-	-	-	-	-	-
Supplies	1,426	4,043	2,617	2,837	2,020,379	1,695,687	(324,693)	1,840,737
Purchased Services	-	500	500	135	-	-	-	-
Other Expenses	549	-	(549)	-	-	-	-	-
Total Operating Expenses	81,185	74,160	(7,025)	79,570	2,020,379	1,695,687	(324,693)	1,840,737
Net Operating Rev (Exp)	(341)	(5,704)	5,363	(11,592)	3,773,876	4,058,648	(284,772)	3,813,259
Non - Operating Rev / (Exp)								
Donations	-	-	-	-	-	-	-	-
Depreciation	(388)	(388)	-	(388)		-	-	
Total Non-Operating Rev/(Exp)	(388)	(388)	-	(388)	-	-	-	-
Net Income/(Loss)	(729)	(6,092)	5,363	(11,980)	3,773,876	4,058,648	(284,772)	3,813,259
Units	1,847	1,386	461	1,448	21,732	50,161	(28,429)	49,295
Gross Revenue/Unit	73.74	83.21	(9.47)	79.50	451.41	194.22	257.19	191.05
Total Operating Expense/Unit	43.96	53.51	9.55	54.95	92.97	33.80	(59.16)	37.34

TAHOE FOREST HOSPITAL DISTRICT
CANCER PROGRAM
FOR THE SIX MONTHS ENDED DECEMBER 31, 2014

	PET CT				TOTAL CANCER PROGRAM			
	ACTUAL	BUDGET	$ VARIANCE FAVORABLE/ (UNFAVORABLE) BUDGET	PRIOR YTD DEC 2013	ACTUAL	BUDGET	$ VARIANCE FAVORABLE/ (UNFAVORABLE) BUDGET	PRIOR YTD DEC 2013
Gross Operating Revenue	700,216	575,916	124,300	477,009	14,552,850	14,221,051	331,799	13,512,468
Deduction From Rev	272,245	223,917	(48,328)	209,099	5,982,065	5,875,148	106,917	5,586,762
Other Operating Revenue	-	-	-	-	-	-	-	-
Total Operating Revenue	427,971	351,999	75,972	267,910	8,570,785	8,345,903	224,882	7,925,706
Operating Expense:								
Salaries	18,037	24,622	6,586	-	992,676	1,009,058	(16,382)	976,732
Benefits	7,446	7,148	(297)	-	457,923	488,621	(30,698)	497,592
Professional Fees	-	-	-	-	925,174	889,224	35,949	882,498
Supplies	36,417	23,538	(12,878)	17,495	2,107,954	1,761,018	346,937	1,893,648
Purchased Services	88,768	88,095	(673)	91,601	322,577	317,306	5,271	307,357
Other Expenses	107	88	(19)	71	121,768	120,607	1,162	87,884
Total Operating Expenses	150,775	143,492	(7,282)	109,167	4,928,073	4,585,834	(342,238)	4,645,711
Net Operating Rev (Exp)	277,196	208,507	68,689	158,743	3,642,712	3,760,069	(117,356)	3,279,995
Non - Operating Rev / (Exp)								
Donations	-	-	-	-	151,197	82,000	69,197	78,789
Depreciation		-	-		(928,641)	(928,641)	-	(941,596)
Total Non-Operating Rev/(Exp)	-	-	-	-	(777,444)	(846,641)	69,197	(862,807)
Net Income/(Loss)	277,196	208,507	68,689	158,743	2,865,268	2,913,427	(48,159)	2,417,188
Units	153	131	22	112	32,495	60,323	(27,828)	59,249
Gross Revenue/Unit	4,576.58	4,396.31	180.27	4,259.01	447.85	235.75	212.10	228.06
Total Operating Expense/Unit	985.45	1,095.36	109.91	974.71	151.66	76.02	(75.64)	78.41

TAHOE INSTITUTE FOR RURAL HEALTH RESEARCH
EXPENDITURE REPORT

	AS OF DECEMBER 31, 2014				ACTUAL FY2014	ACTUAL FY2013	ACTUAL FY2012	ACTUAL FY2011
	ACTUAL	BUDGET	VAR$	VAR%				
OPERATING EXPENSES								
Salaries and Wages	$ -	$ -	$ -	0.0%	$ -	$ 16,518	$ 22,142	$ 20,860
Benefits	-	-	-	0.0%	-	7,550	5,586	5,372
Benefits Workers Compensation	-	-	-	0.0%	-	551	350	531
Benefits Medical Insurance	-	-	-	0.0%	-	3,662	4,317	2,752
Professional Fees	186,576	155,000	(31,576)	-20.4%	524,544	297,311	161,339	78,688
Supplies	1,875	10,082	8,207	81.4%	28,462	5,806	1,059	1,961
Purchased Services	12,345	25,000	12,655	50.6%	18,868	2,600	1,500	-
Other	14,871	2,900	(11,971)	-412.8%	160,597	230,932	104,828	4,730
Interest Expense	43,508	44,290	782	1.8%	61,147	32,059	13,351	2,490
TOTAL OPERATING EXPENSE	$ 259,175	$ 237,272	$ (21,903)	-9.2%	$ 793,618	$ 596,989	$ 314,471	$ 117,384
GRANT REIMBURSEMENT FOR TBI EXPENSES	$ (55,049)				$ (112,424)	$ (21,987)	$ (23,624)	$ (1,250)
TOTAL FUNDS ADVANCED TO TIRHR	(204,126)	(237,272)	21,903	-9.2%	(681,194)	(575,002)	(290,847)	(116,134)
	-	-	-		-	-	-	-

CUMULATIVE:

Letter of Credit	$ 2,000,000 **N1**
FY2011 Actual Draw Against Letter of Credit	(113,644)
FY2012 Actual Draw Against Letter of Credit	(277,496)
FY2013 Actual Draw Against Letter of Credit	(542,943)
FY2014 Actual Draw Against Letter of Credit	(620,047)
FY2015 Actual Draw Against Letter of Credit	(160,618)
Balance on Letter of Credit	$ 285,252

N1: Draws against the Letter of Credit are exclusive of Accrued Interest Expense

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FINANCE COMMITTEE BOARD PRESENTATION

1/27/15

TAHOE FOREST HEALTH SYSTEM

ACHIEVE WHAT MATTERS MOST

AGENDA

- Industry Trends Driving Revenue Cycle Optimization
- Jacobus Service and Strategy
- Project Goals and Comparisons
- Revenue Cycle Pillar Project Status, Gap Analysis
- Conclusion

INDUSTRY PRESSURE FOR REVENUE CYCLE EXCELLENCE AND RE-ENGINEERING

Hospitals, physicians, and health systems are under tremendous pressure from multiple factors impacting healthcare

- **ACA** (Affordable Care Act) – More covered lives by private insurance, insurance exchanges, increased Medicaid (MediCal)
- **CMS** (Centers for Medicare and Medicaid) changing the way providers of care are paid; pay for performance versus fee for service
- **CMS bundled payments**; hospital, physician, anesthesiologist, radiologist, etc., all paid from one payment
- **ARRA** (America Recovery and Reinvestment Act) – Part of the ARRA money went to "digitize" healthcare, implement EHR (Electronic Health Records) and Advanced Clinical Systems
- **MU** (Meaningful Use 1 &2) – Proof that advanced systems are improving quality of care; awards for getting it done, penalties if not met, imperative to have clinical and financial systems optimized
- **ACA and ARRA** – Increased direct consumer financial responsibility, increased consumer expectations for technology and quality care; Higher deductibles, more out of pocket, higher scrutiny of charges, more choices
- **ICD 10 PCS** – World Health Organization and CMS imperative – Predicted to reduce productivity by 50% for 6 months to 1 year, delayed payments, increased denials

INDUSTRY TRENDS DRIVING REVENUE CYCLE OPTIMIZATION

40% of CFOs surveyed indicated spending for RC IT improvements or replacements for 2015 and 2016 to meet needs and radical payment changes. Financial resources are scarce, of course, and properly allocating them is critical to having a robust suite of revenue cycle tools.

–TFHD Executive Team – Foresight in 2011, strategy in 2012 to know this was coming, new technologies needed and selected

41% of CFOs surveyed believe Next generation RC IT needed to weather the storm.

–TFHD Executive Team – Foresight to know, not only will this impact clinical advanced technologies, but it will have a major impact on the revenue cycle, 2012/2013 – Strategies to optimize new technologies and reengineer processes – PMO Office, IT Optimization, RC Expertise

94% of the surveyed hospital CFOs self-identified as "struggling" report that delayed or failed implementations in other IT systems, particularly EHR, have drastically impacted the organization's financial position.

–All providers who have implemented new technologies know they will see financial impact – Vendors implement disruptive technology, providers must then optimize after implementation

–TFHD ahead of the curve with optimization in 2013/2014 – sustainability and knowledge transfer to TFHD staff and leadership major factor in choice of firms to assist

INDUSTRY EXPERTS WEIGH IN

—"It will be the major platform or strategy for advancing organizations in the new payment and delivery world. Truly progressive organizations make integral use of data to develop and provide evidence-based care, to build data warehouses and analytic capabilities to predict health care outcomes, and to manage population health. However, significant resources and financial investments are necessary to realize the advancements"

– ***American Hospital Association (AHA)*** – 2015 Healthcare Trends Environmental Scan

INDUSTRY EXPERTS WEIGH IN

"Revenue cycle tools built for fee for service, not ready for payment reform. Providers know the era of getting reimbursed for volume is in its gloaming, technologies deployed to manage revenue streams must evolve"

- ***John Hoyt*** – EVP HIMSS Analytics –industry leaders / healthcare technology think tank

"EHR implementation is a financially and time-consuming process but it offers long-term benefits for overall revenue cycle integrity, with streamlined processes to improve the bottom line. By developing a unified Revenue Cycle Team, and proactively improving departmental processes, the experience can be successful and positively impact the facility's long-term revenue"

- ***Shawn Armbruster*** – Manager - Data Integrity and Compliance Department with The Rybar Group – Healthcare Industry IT experts / think tank

INDUSTRY EXPERTS WEIGH IN

—Starting now, CFOs should vigorously pursue strategies to enhance cash on hand. These strategies should include decreasing days in accounts receivable (A/R) as well as assessing all processes for obtaining and recording patient information required for the revenue cycle that can potentially restrict the flow of revenue. Also, clinical documentation improvement, utilization management, denials management, and improved coding efforts all can contribute to accelerating net revenue and cash on hand."

– ***HFMA (Hospital Financial Management Association)*** – Dollars and Sense– Mitigating the Financial Risks for ICD 10 Implementation

REV CYCLE ISSUES ARE NOT UNIQUE

"No industry today is facing quite as much disruption as the US healthcare industry. In addition to obvious economic and regulatory disruption, the healthcare industry is undergoing a paradigm shift towards true consumerism."

- ***Stuart Hanson,*** *Director Healthcare Business Development, HIMSS*

TFHD Executive Team foresaw that consumers will need more information, more choice, and more say in how their healthcare is delivered – the RC project is "patient centric"

"EHR deployment isn't an end point. It's an important step in an organization's journey to automate the clinical functions within the hospital or health system (physicians) and improvement to quality and patient safety as well as fiscal sustainability. There needs to be continued focus on resourcing and having the correct sponsorship and commitment to deploy an EHR and to continue to support and use it."

- ***Jerry Howell,*** *principal with KPMG Healthcare*

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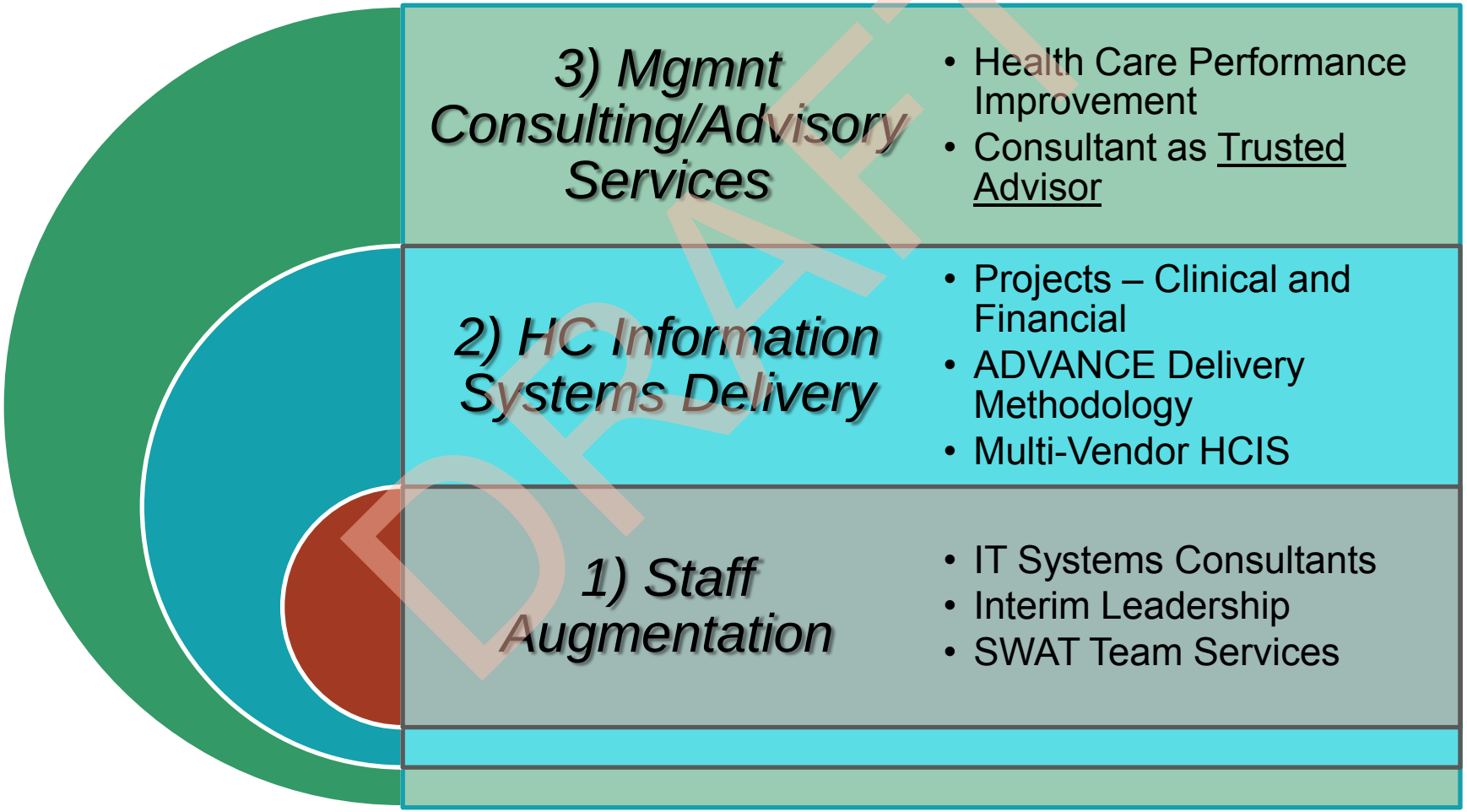
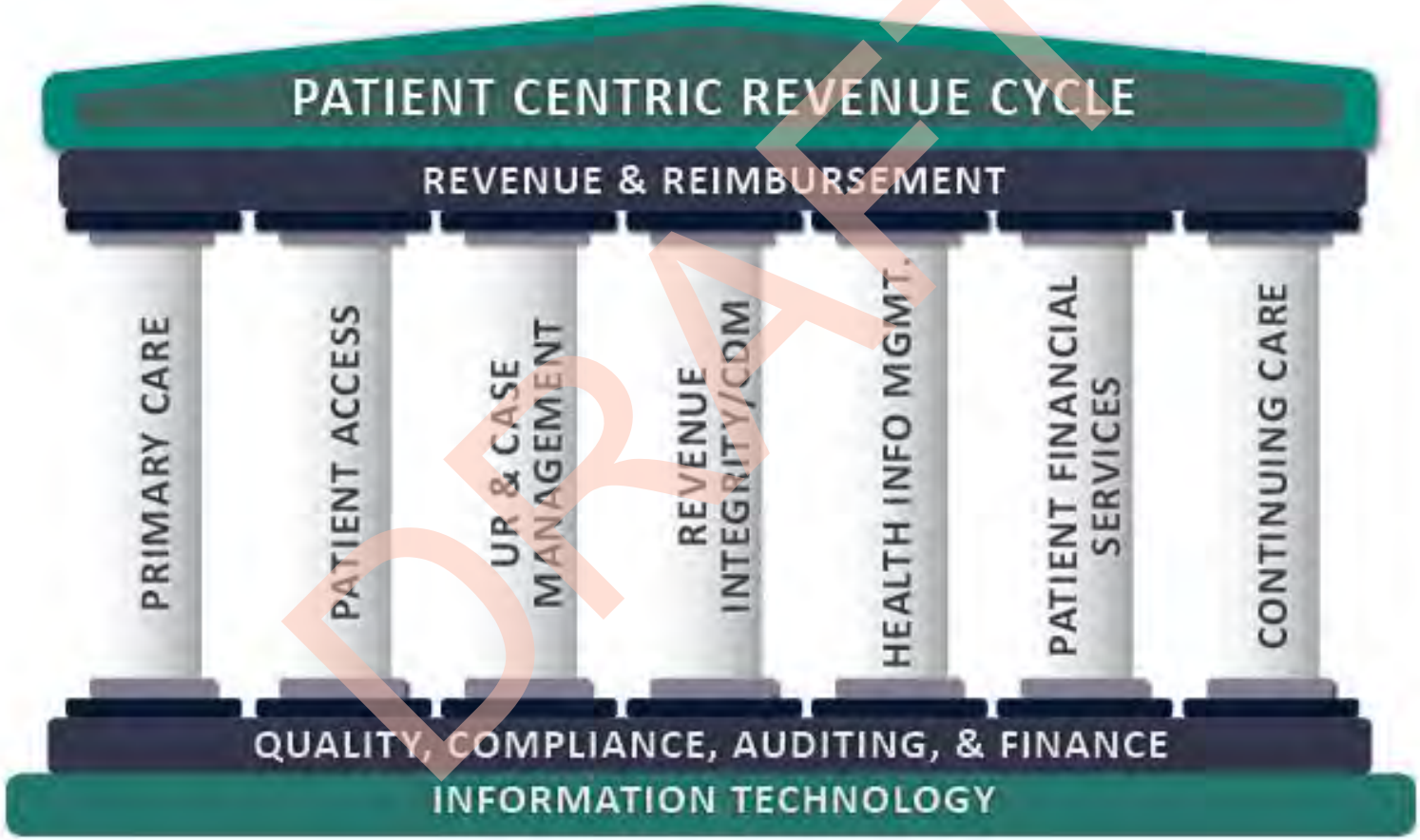
THE JACOBUS SERVICE & STRATEGY

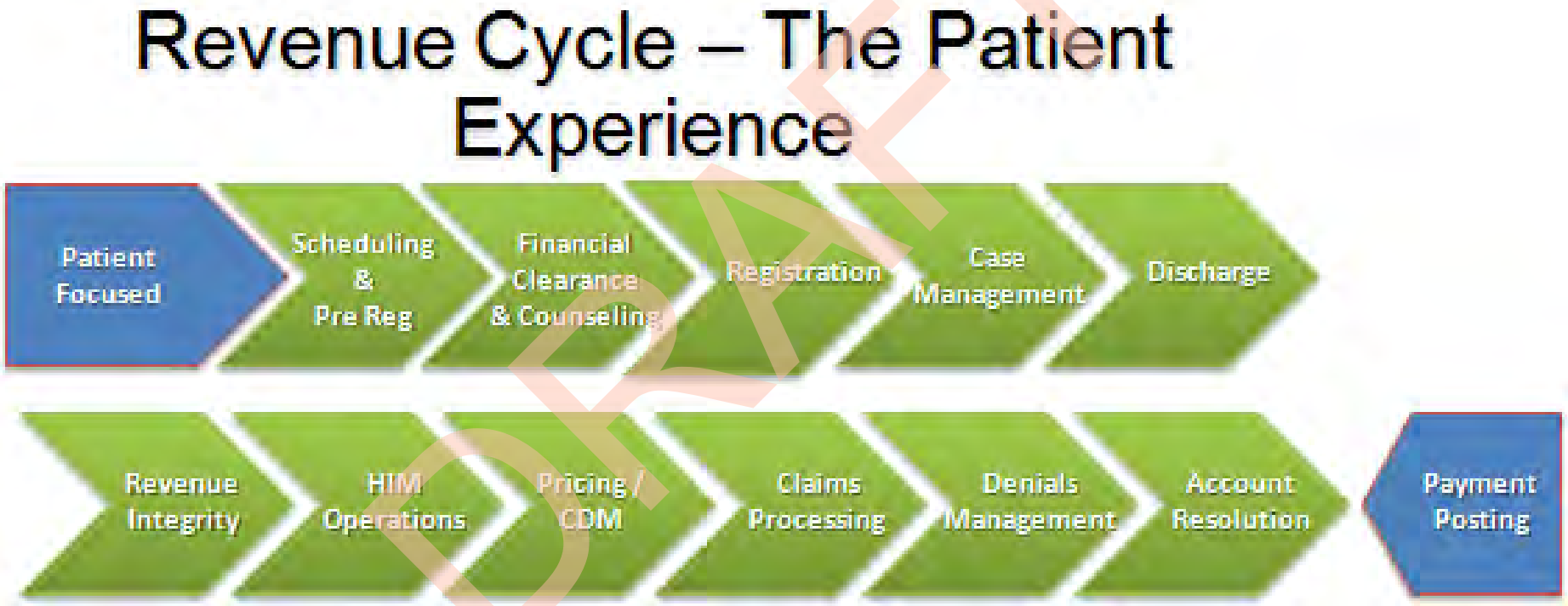
THE JACOBUS SERVICE



THE REVENUE CYCLE PILLARS:



THE PATIENT CENTRIC REVENUE CYCLE



TOP 10 CRITICAL SUCCESS FACTORS

1. Governance
2. Structure
3. Education, Accountability, Communication, & Cohesiveness
4. Key Performance Indicators
5. Job Descriptions
6. Policies, & Procedures
7. Productivity and Goal Setting
8. Optimized Insurance Dictionary
9. Optimized CDM & Revenue Integrity
10. Optimized Technologies

Value Connection to Execution

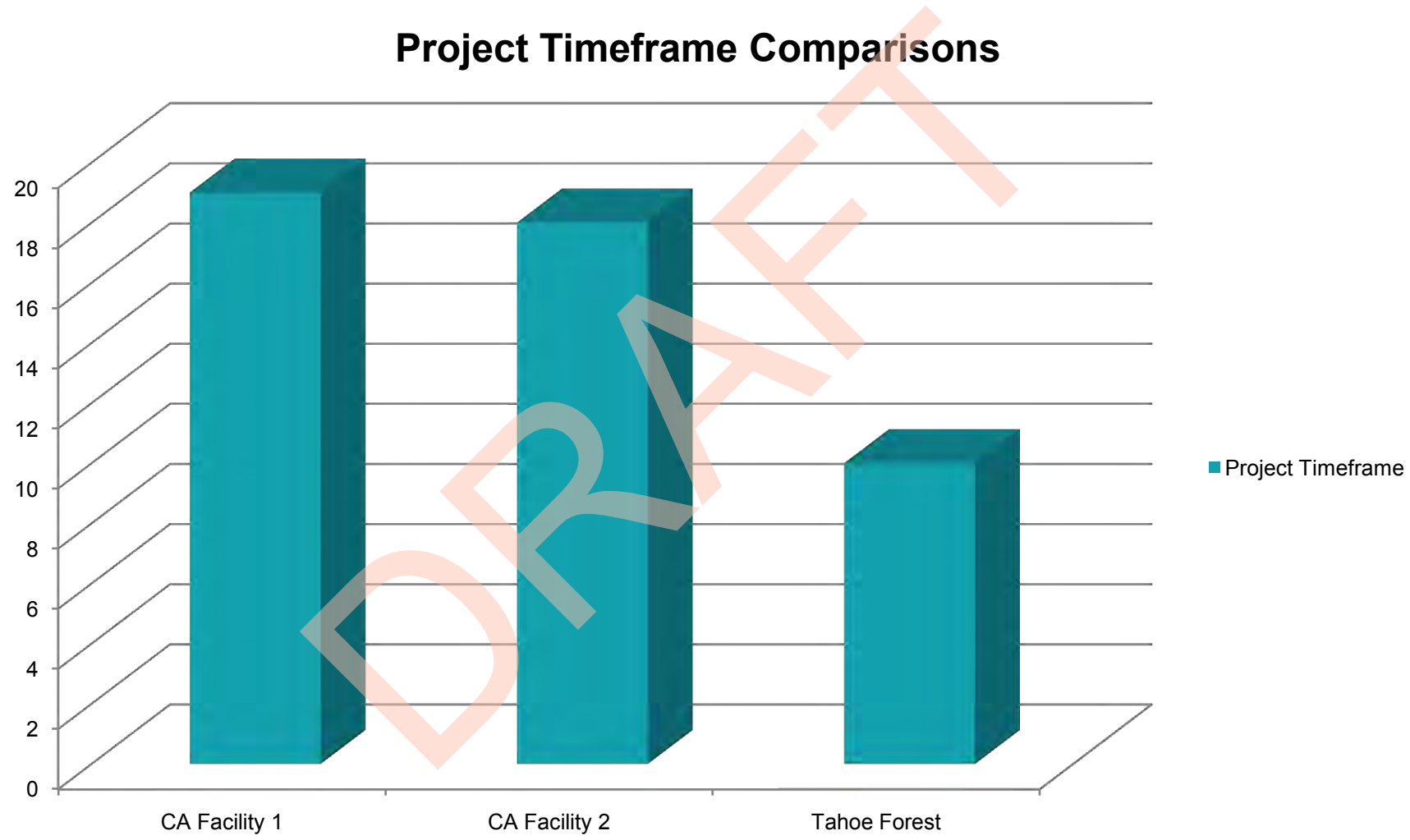
- ✓ Assess RC for Variance to Best Practice & Improvement Opportunities
- ✓ Set Performance Improvement Strategy
- ✓ Project Management / Action Planning
- ✓ Include all Care Areas

- ✓ Revenue Cycle Governance
- ✓ Branding & Exec Commitment
- ✓ Optimized Organization Structures
- ✓ Optimized Cross Pillar Collaboration
- ✓ Role Definition
- ✓ Performance Incentives
- ✓ Equip Workforce Through Training
- ✓ Monitor Productivity
- ✓ Continual Communication
- ✓ Culture of Accountability
- ✓ Excellence in Customer Service

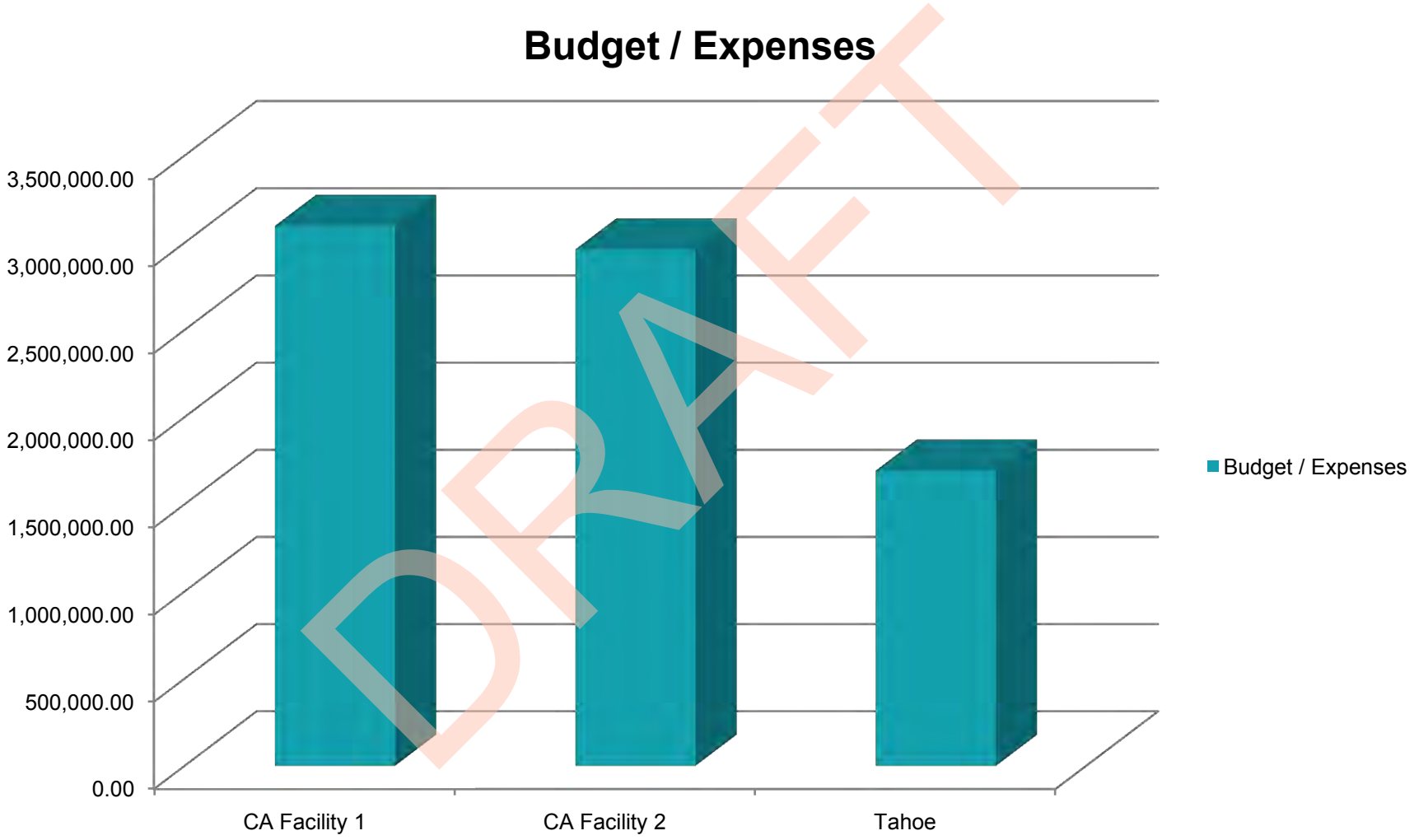
- ✓ Streamlined Workflows
- ✓ Drive Standardization
- ✓ Automate & Improve Efficiency
- ✓ Shorten Time Cycles
- ✓ Establish Control & Standardization of Outsource Partners

- ✓ Establish Visibility & Control – KPI Dashboards
- ✓ Optimize CPSI - Automate & Streamline
- ✓ Implement New Enabling Technologies

PROJECT COMPARISONS



PROJECT COMPARISONS



PROJECT OVERVIEW AND COMPARISONS

Project Comparisons:

- Typical Project: 18 months to 2 years
- Tahoe on track for 12 month Completion

Project Goals : Overview

- Cash Acceleration Focus
  - SWAT Cash Collections $10.8 m
- People, Process, Systems (By Pillar)
- Gap Analysis
- How to Sustain the Gain

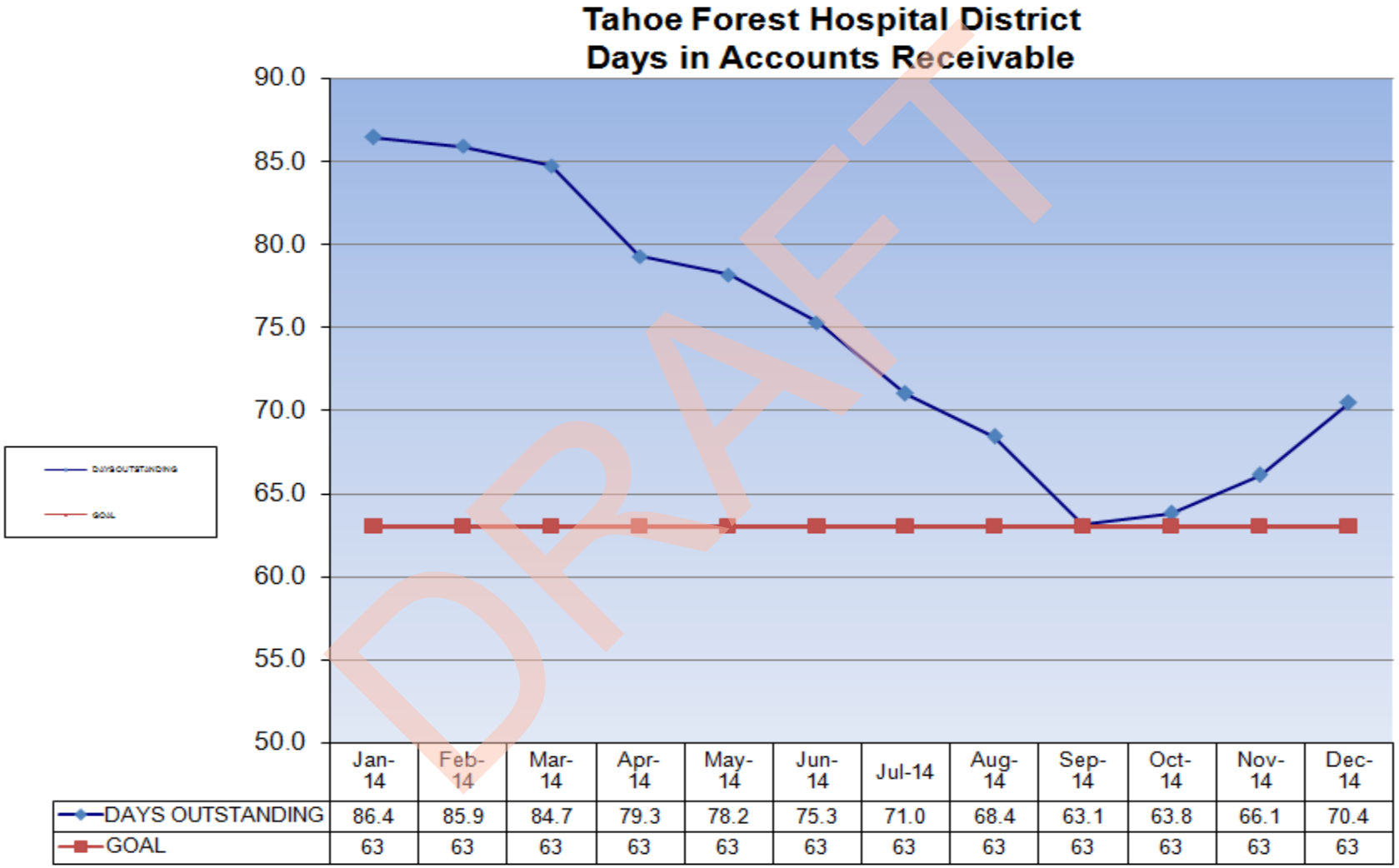
REV CYCLE OVERVIEW: 4 ~~"~~CRUCIAL" KPIS

- Days in accounts receivable
- Cash Collections
- Discharged Not Final Billed (DNFB)
- Aged AR <120 Days

KEY FINANCIAL PERFORMANCE INDICATORS

Before Optimization Project	Current Status
Days in AR: **85.9** Days	**70** Days
Cash Collections: **86%** of Goal	**115%** of Goal
Discharged Not Final Billed: **2,575** accounts Estimated Days: **14.25**	**1,464** accounts **8.1** AR days
Aged AR >120 Days: **34.33%**	**29.5%**
Clean Claim Validation Rate: **30%**	**71%**

ACCOUNTS RECEIVABLE KPI

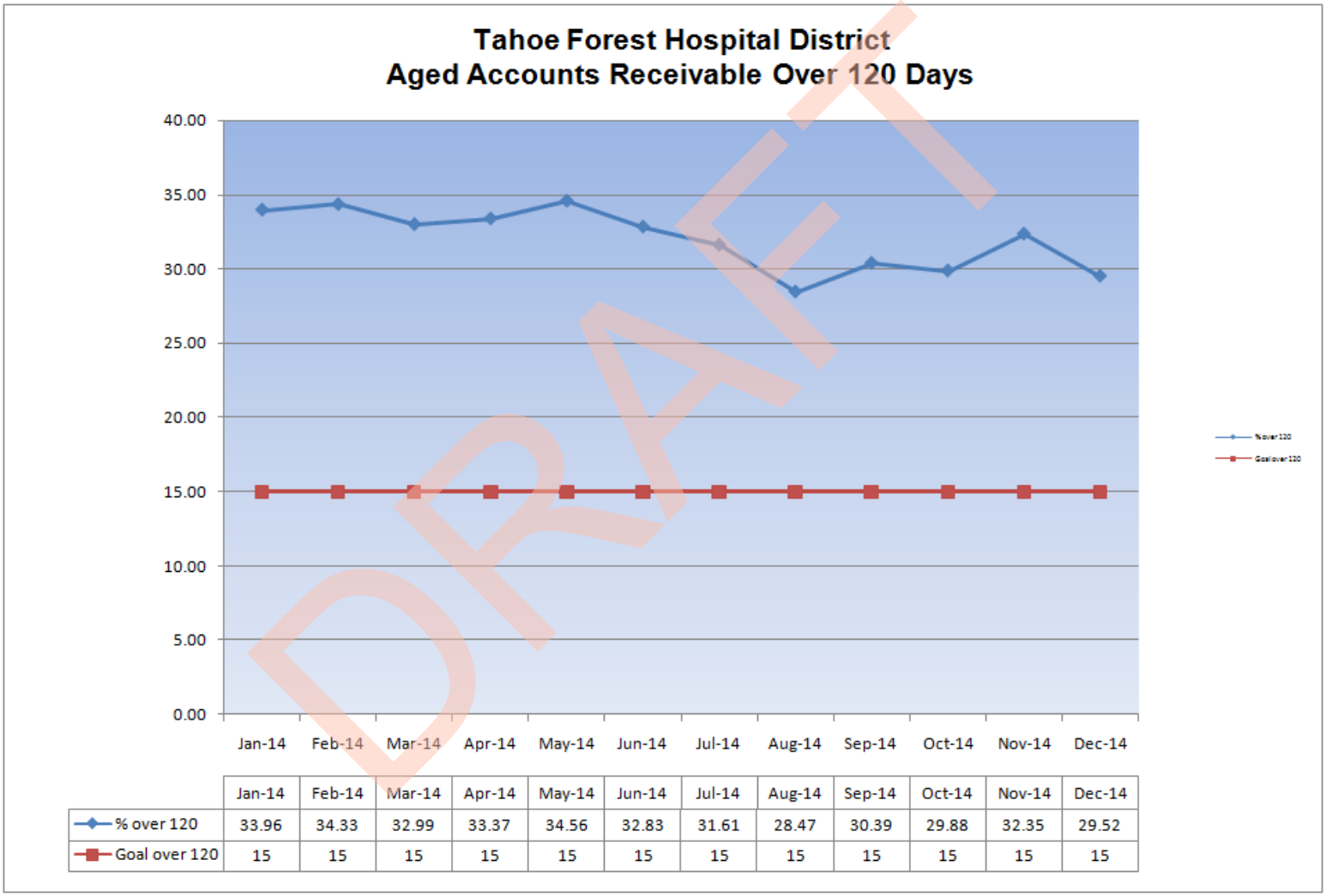


	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
DAYS OUTSTANDING	86.4	85.9	84.7	79.3	78.2	75.3	71.0	68.4	63.1	63.8	66.1	70.4
GOAL	63	63	63	63	63	63	63	63	63	63	63	63

CASH COLLECTIONS KPI

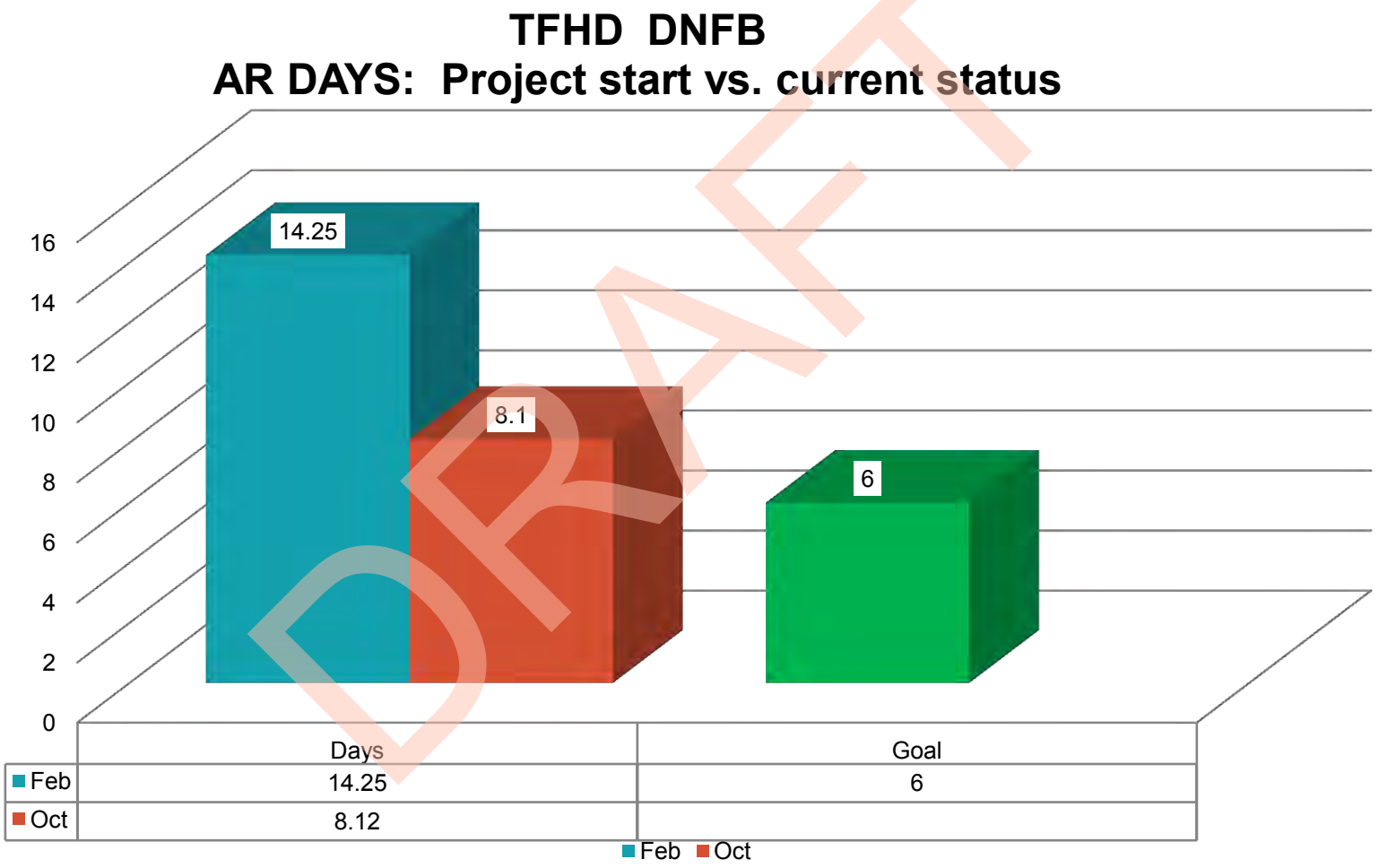
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
CASH RCVD	9,796,931	8,277,672	9,371,472	9,127,456	8,467,806	8,548,782	9,192,765	9,279,102	10,441,520	8,885,055	7,414,016	7,433,641
GOAL	8,071,816	9,647,620	8,481,216	8,265,211	8,741,577	7,960,029	7,961,306	9,002,183	10,748,010	11,598,629	8,809,159	8,982,546
OVER/UNDER	1,725,114	(1,369,948)	890,256	862,245	(273,771)	588,753	1,231,459	276,919	(306,490)	(2,713,574)	(1,395,143)	(1,548,905)
% COLLECTED	121%	86%	110%	110%	97%	107%	115%	103%	97%	77%	84%	83%

AGED AR > 120 DAYS



	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
% over 120	33.96	34.33	32.99	33.37	34.56	32.83	31.61	28.47	30.39	29.88	32.35	29.52
Goal over 120	15	15	15	15	15	15	15	15	15	15	15	15

TFH DISCHARGED NOT FINAL BILLED (ESTIMATED AR DAYS)



PROJECT STATUS UPDATE AND GAP ANALYSIS BY PILLAR

PATIENT ACCESS PILLAR

PILLAR PROJECT STATUS: Estimated Completion Date 2/13/12

- **PEOPLE: TEAM ARCHITECTURE**
  - –Governance/Structure
  - –Pillar Coordination Efforts
  - –Centralized APS Team
  - –Formalized Education/Training Program (New Hires / Existing Employees)

- **PROCESS / TECHNOLOGY: Registration Standardization**
  - —Advance Beneficiary Notice (CPSI, EPIC)
  - —Insurance Selection (Claim Edit Build)
  - —Eligibility Verification (CPSI, PayNav)
  - —Data Integrity / Accuracy (Q-Aid Audit Tool)
  - —Authorization, Pre-Registration, Scheduling Policies/Procedures
  - —Medical Record Identification (Reduction of Duplicates, Improved Percentage to Industry Standard)
  - —Point of Service Collections

CASE MANAGEMENT PILLAR

PILLAR PROJECT STATUS: 25%

- **Technology**
  - —CPSI Utilization Review Module
  - —Interqual Interface with CPSI
  - —Denials Management Functionality
  - —Medi-Cal Electronic Treatment Authorization Request (E-TAR)
- **People**
  - —Team Structure / Organization
  - —Performance Standards and Accountability
  - —Quality Review, Training and Education
- **Process**
  - —Resource Management/Assignment
  - —PreAccess Case Management
  - —Follow The Data: length of Stay, Denials/Appeals, Swing Patients
  - —Readmission Review
  - —Clinical Documentation Improvement Program (CDI)

REVENUE INTEGRITY PILLAR

PILLAR PROJECT STATUS: 65%

- **TECHNOLOGY: CDM ANALYSIS AND CLEAN UP**
  - –Initial Item Master Clean Up
  - –PICIS/CPSI Bi-Directional Interface / Surgery Supply Charge Capture
  - –Automated Modifier Application
  - –ER Procedure Charge Capture
- **PEOPLE: CDM POLICIES AND PROCEDURES**
  - –CDM Book of Knowledge
  - –Charge Capture Policies, Process, CDM Oversight Accountability
  - –Organization Structure: Revenue Integrity Manager
- **PROCESS: PRICING ANALYSIS – Reno Comparisons**
  - –Diagnostic Imaging (excluding PET Scans)
  - –MSC
  - –OB Delivery (Average charge per admission)
  - –Top 25 CPT's
  - –GI Services: Colonoscopy / Endoscopy

HEALTH INFORMATION MGMT PILLAR

PILLAR PROJECT STATUS: 65%

- Technology
  - –Scanning Solution
  - –Computer Assisted Coding Solution (CAC)
- Process
  - –Legal Medical Record Matrix
  - –CAH Split Charge Review Process
  - –ED Procedure Level Charging
  - –Oncology PreBill Charge Review
  - –OBS Hours Charge Capture
- People
  - –Productivity Expectations
  - –Resource Management (including Vendor Management)
  - –Improvement Initiative Tracking
  - –ICD-10 Training and Education

PFS PILLAR ACCOMPLISHMENTS

PILLAR PROJECT STATUS: 45%

- **Technology**
  - —Electronic Remittance Advice (Accupost)
  - —Lockbox/Automated Cash Posting
  - —Denials Management Functionality
  - —Billing Follow Up Workqueues (Gaffey)
  - —NTT Billing System Implementation
  - —CPSI/EPIC Registration Claim Edits
- **People**
  - —Team Structure / Organization
  - —Performance Standards and Accountability
  - —Quality Review, Training and Education (by Payor)
- **Process**
  - —DNFB Management / Cash Acceleration / ATB Analysis
  - —Resource Management/Assignment
  - —Clear Balance Patient Payment Plan Process

QUESTIONS OR COMMENTS

TAHOE FOREST HOSPITAL DISTRICT

Board Executive Summary

By: Crystal Betts
Chief Financial Officer

DATE: January 22, 2015

ISSUE:
On September 28, 2014 the Governor of the State of California approved SB1276: Hospital Fair Billing Policies (Charity Care and Discount Payment Plans). Notification to Hospitals was provided by the California Department of Public Health on December 4, 2014. SB1276 was effective January 1, 2015 and requires modifications to Hospitals existing Charity Care and Financial Assistance Policies.

BACKGROUND:
The District is required to modify its Policy #ABD-9 Financial Assistance Program Full Charity Care and Discount Partial Charity Care Policies to comply with the changes required by the approval/passage of SB1276. Attached is the notification from the California Department of Public Health, as well as a summary of the changes required by SB1276. We have updated the policy appropriately and have highlighted those required changes in yellow for your review.

ACTION REQUESTED:
Approval of the revised ABD-9 Financial Assistance Program Full Charity Care and Discount Partial Charity Care Policy incorporating the required changes from SB1276.

Alternatives:

Summary of SB1276
Required Updates to Financial Assistance Program

- **Policy must include insured patients with high out of pocket expenses:**
  SB1276 Requires expansion of financial assistance discounts to insured patients with high out of pocket expenses. The current Financial Assistance program/policy for Tahoe Forest includes consideration of insured patients with high out of pocket expenses. Page 3, under "Full and Discount Charity Care Eligibility" states in part, "if not covered by third party insurance, or if covered by third party insurance and unable to pay the patient liability amount". No changes required.

- **Payment plans cannot exceed 10% of monthly income after deduction of living expenses:**
  SB1276 requires the hospital to negotiate monthly payment plans, and stipulates that the patient's required payments may not exceed 10% of patient's family income AFTER deduction of essential living expenses. The current Financial Assistance program/policy for Tahoe Forest does not include this stipulation. Suggestion is to add a sentence to section 5.0, "Payment Plans", on page 10 of the policy. See recommendation in attached draft revision.

- **Notification Requirement Changes:**
  SB1276 requires the hospital to notify uninsured patients that they may be eligible for health coverage through Covered California, and requires that the hospital provide the patient with a list of local consumer assistance centers that are housed at legal services offices. It is recommended that the current Tahoe Forest Financial Assistance program/policy be updated to insert language in section 12.0, "Public Notice", to assert that our notices will include this required information. See recommendation in attached draft revision.

State of California—Health and Human Services Agency
California Department of Public Health

RON CHAPMAN, MD, MPH
Director & State Health Officer

EDMUND G. BROWN, JR.
Governor

December 4, 2014 AFL 14-25.1

TO: Acute Psychiatric Hospitals
General Acute Care Hospitals
Special Hospitals

SUBJECT: SB 1276: Hospital Fair Billing Policies (Charity Care and Discount Payment Plans)

AUTHORITY: Health and Safety Code Sections 127400, 127405, 127420, and 127425

This All Facilities Letter (AFL) is being re-issued to clarify the meaning of "patients with high medical costs" for purposes of Hospital Fair Pricing statutes. Health and Safety Code section 127400(g) defines a patient with high medical costs as "a person whose family income does not exceed 350 percent of the federal poverty level."

Effective January 1, 2015, SB 1276 (Chapter 758, Statutes of 2014) expands the availability of charity care and discount payment plans to all "patients with high medical costs," as defined in HSC section 127400(g), including patients with third-party insurance coverage. SB 1276 also clarifies that a patient's application, or pending application, for another health coverage program does not preclude the patient from being eligible for a hospital's charity care or discount payment program.

SB 1276 requires hospitals to negotiate the terms of discount payment plans with the patient, and take into consideration the patient's family income and essential living expenses. If an agreement cannot be reached with the patient, the hospital must institute a reasonable payment plan, with monthly payments of less than 10 percent of a patient's family income for a month after deductions for essential living expenses. Any affiliate, subsidiary, or external collection agency must comply with the hospital's definition and application of a reasonable payment plan.

SB 1276 also requires hospitals to make a reasonable effort to obtain a patient's third-party health coverage information, including coverage through Covered California. If a hospital bills a patient who has not provided proof of coverage by a third party at the time the care is provided or upon discharge, the hospital must notify the patient that they may be eligible for health coverage through Covered California, or other state or

county-funded health coverage.
The hospital must also provide the patient with a referral or list of local consumer assistance centers that are housed at legal services offices.

The information in this AFL is a brief summary of the changes that SB 1276 makes to the HSC. Facilities are responsible for following all applicable laws. The California Department of Public Health's failure to expressly notify facilities of statutory or regulatory requirements does not relieve facilities of their responsibility for following all laws and regulations. Facilities should refer to the full text of all applicable sections of the HSC and Title 22 of the California Code of Regulations.

If you have any questions, please contact your respective Licensing & Certification District Office.

Sincerely,

Original signed by Jean Iacino

Jean Iacino
Interim Deputy Director

	Tahoe Forest Health System				
	Title: Financial Assistance Program Full Charity Care and Discount Partial Charity Care Policies		**Policy/Procedure #:** ABD-9		
	Responsible Department: Administration				
Type of policy		Original Date:	Reviewed Dates:	Revision Dates:	
☒	Board	10/24/07	2/10; 1/12; 1/14	1/09; 5/11; 2/14	
☐	Medical Staff				
☐	Departmental				
Applies to: ☒ System ☐ Tahoe Forest Hospital ☐ Incline Village Community Hospital					

PURPOSE

Tahoe Forest Hospital District (hereinafter referred to as "TFHD") provides hospital and related medical services to residents and visitors within district boundaries and the surrounding region. As a regional hospital provider, TFHD is dedicated to providing high quality, customer oriented and financially strong healthcare services that meet the needs of its patients. Providing patients with opportunities for financial assistance coverage for healthcare services is also an essential element of fulfilling the TFHD mission. This policy defines the TFHD Financial Assistance Program; its criteria, systems, and methods.

California acute care hospitals must comply with the "Hospital Fair Pricing Policies" law at Health & Safety Code Section 127400 et seq. (the "Fair Pricing Law"), including requirements for written policies providing discounts and charity care to financially qualified patients. Under the Fair Pricing Law, uninsured patients or patients with high medical costs who are at or below 350 percent of the federal poverty level shall be eligible to apply for participation under a hospital's charity care policy or discount payment policy. This policy is intended to fully comply with all such legal obligations by providing for both charity care and discounts to patients who qualify under the terms and conditions of the TFHD Financial Assistance Program. Additionally, although the Fair Pricing Law requires hospitals to provide financial assistance to certain qualifying patients for services they have received, it does not require hospitals to provide future services. Nevertheless, TFHD has allowed individuals to apply for financial assistance for future services under this policy. However, any individuals who qualify for such assistance will still be subject to admission and other criteria for receiving services and becoming patients, and will have to demonstrate their ability to meet any applicable financial obligation which is not covered by any discount or other financial assistance granted.

The finance department has responsibility for general accounting policy and procedure. Included within this purpose is a duty to ensure the consistent timing, recording and accounting treatment of transactions at TFHD. This includes the handling of patient accounting transactions in a manner that supports the mission and operational goals of TFHD.

Patients are hereby notified that a physician employed or contracted to provide services in the emergency department of TFHD's hospital in Truckee, California is also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 350 percent of the federal poverty level.

DEFINITIONS

1.0 "Discount Partial Charity Care" means an amount charged for services to a patient who qualifies for financial assistance under the TFHD Financial Assistance Program which is discounted to the amount Medicare would pay for the same services or less. Discount Partial Charity Care, when granted to a patent, will in no case excuse a third party, or the patient, from their respective obligations to pay for services provided to such patient.

2.0 "Elective Services" means any services which are not medically necessary services.

3.0 "Emergency Services" means services required to stabilize a patient's medical condition initially provided in the TFHD emergency department or otherwise classified as "emergency services" under the federal EMTALA Law or Section 1317.1 et.seq. of the California Health & Safety Code, and continuing until the patient is medically stable and discharged, transferred, or otherwise released from treatment.

4.0 "Federal Poverty Level" or "FPL" means the current poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code.

5.0 "Financial Assistance Program" means the TFHD Financial Assistance Program established by this policy for providing Full Charity Care or Partial Discount Charity Care (each, as defined below) to qualified patients.

6.0 "Full Charity Care" means medically necessary services provided by TFHD to a patient who qualifies under the TFHD Financial Assistance Program which are not covered by a third party, and for which the patient is otherwise responsible for paying, for which the patient will not be charged. Full Charity Care, when granted to a patient, in no case will excuse a third party from its obligation to pay for services provided to such patient.

7.0 "Medically Necessary Services" means hospital-based medical services determined, based upon a medical evaluation, to be necessary to preserve a patient's life or health.

8.0 "Monetary Assets" means all monetary assets of the patient's family excluding retirement or deferred compensation plans (both qualified and non-qualified under the Internal Revenue Code), not counting the first $10,000 of such assets, nor fifty percent (50%) of the amount of such assets over the first $10,000.

9.0 "Non-emergency Services" means medically necessary services that are not Emergency Services.

10.0 "Patient" means an individual who has received Emergency Services or Non-emergency Services at a facility operated by TFHD who is requesting financial assistance with respect to such services.

11.0 "The amount Medicare would have paid" means the amount Medicare would pay for the services provided, or, in the event there is no specific amount that can be determined that Medicare would pay for such services, the highest amount payable for such services by any other state-funded program designed to provide health coverage.

12.0 "Third Party Insurance" means health benefits coverage by a public or private program, insurer, health plan, employer, multiple employer trust, or any other third party obligated to provide health benefits coverage to a patient.

SCOPE

This policy applies to all TFHD patients. This policy does not require TFHD to accept as a patient and provide services to any person who does not qualify for treatment or admission under any of TFHD's applicable policies, practices, and procedures, and does not prohibit TFHD from discharging, or otherwise limiting the scope of services provided to, any person in accordance with its normal policies, practices and procedures. This policy does not require TFHD to provide patients with any services that are not medically necessary or to provide access to non-emergency services or to elective services.

The acute care hospital operated by TFHD provides many specialized inpatient and outpatient services. In addition to services provided at the main hospital location, Tahoe Forest Hospital operates primary care and multi-specialty clinics, and therapy service programs at sites in the same community but not located on the main hospital campus. Tahoe Forest Hospital also operates a distinct part skilled nursing facility. Only medically necessary services provided at facilities listed on the Tahoe Forest Hospital acute care license are included within the scope of this Financial Assistance Policy.

This policy pertains to financial assistance provided by TFHD. All requests for financial assistance from patients shall be addressed in accordance with this policy.

Hospital Inpatient, Outpatient and Emergency Service Programs

Introduction

This policy sets forth a program to assist patients who are uninsured or underinsured in obtaining financial assistance in paying their hospital bill. Such financial assistance may include government sponsored coverage programs, Full Charity Care, and Discount Partial Charity Care.

Full Charity Care and Discount Partial Charity Care Reporting

TFHD will report actual Charity Care (including both Full Charity Care and Discount Partial Charity Care) provided in accordance with regulatory requirements of the Office of Statewide Health Planning and Development (OSHPD) as contained in the Accounting and Reporting Manual for Hospitals, Second Edition. The hospital will maintain written documentation regarding its Charity Care criteria and, for individual patients, written documentation regarding all Charity Care determinations. As required by OSHPD, Charity Care provided to patients will be recorded on the basis of actual charges for services rendered.

TFHD will provide OSHPD with a copy of this Financial Assistance Policy which includes the Full Charity Care and Discount Partial Charity Care policies within a single document. The Financial Assistance Policy also contains: 1) all eligibility and patient qualification procedures; 2) the unified application for full charity care and discount partial charity care; and 3) the review process for both full charity care and discount partial charity care. Forms of these documents shall be supplied to OSHPD every two years or whenever a substantial change is made.

Full and Discount Charity Care Eligibility: General Process and Responsibilities

Any patient whose family[1] income is less than 350% of the FPL, if not covered by third party insurance or if covered by third party insurance and unable to pay the patient liability amount

[1] A patient's family is defined as: 1) For persons 18 years of age and older, spouse, domestic partner and dependent children under 21 years of age, whether living at home or not; and 2) For persons under 18 years of age, parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative.

owed after insurance has paid its portion of the account, is eligible to apply for financial assistance under the TFHD Financial Assistance Program.

The TFHD Financial Assistance Program utilizes a single, unified patient application for both Full Charity Care and Discount Partial Charity Care. The process is designed to give each applicant an opportunity to apply for the maximum financial assistance benefit for which he or she may qualify. The financial assistance application provides patient information necessary for determining patient qualification by the hospital and such information will be used to determine the maximum coverage under the TFHD Financial Assistance Program for which the patient or patient's family may qualify.

Eligible patients may apply for financial assistance under the TFHD Financial Assistance Program by completing an application consistent with application instructions, together with documentation and health benefits coverage information sufficient to determine the patient's eligibility for coverage under the program. Eligibility alone is not an entitlement to financial assistance under the TFHD Financial Assistance Program. TFHD must complete a process of applicant evaluation and determine, in accordance with this policy, whether financial assistance will be granted.

The TFHD Financial Assistance Program relies upon the cooperation of individual patients to determine who may be eligible for full or partial assistance. To facilitate receipt of accurate and timely patient financial information, TFHD will use a financial assistance application. All patients without adequate financial coverage by Third Party Insurance will be offered an opportunity to complete the financial assistance application. Uninsured patients will also be offered information, assistance and referral to government sponsored programs for which they may be eligible. Insured patients who are unable to pay patient liabilities after their insurance has paid, or those who experience high medical costs may also be eligible for financial assistance. Any patient who requests financial assistance will be asked to complete a financial assistance application.

The financial assistance application should be made as soon as there is an indication by the patient or the patient's representative that he/she may be in need of and requests financial assistance. The application form may be completed at any time prior to or within one year after discharge, or within one year after the patient became eligible, whichever comes first.

To the extent it deems necessary, in its sole and reasonable discretion, TFHD may require an applicant for financial assistance to provide supplemental information in addition to a complete financial assistance application to provide:

- Confirmation of the patient's income and health benefits coverage;
- Complete documentation of the patient's monetary assets;
- Other documentation as needed to confirm the applicant's qualification for financial assistance; and
- Documentation confirming the hospital's decision to provide financial assistance, if financial assistance is provided.

However, a completed financial assistance application may not be required if TFHD determines, in its sole discretion, that it has sufficient patient information from which to make a financial assistance qualification decision.

PROCEDURES

1.0 **Qualification: Full Charity Care and Discount Partial Charity Care**

1.1 Eligibility for financial assistance shall be determined based on the patient's and/or patient's family's ability to pay and on the other factors set forth in this policy. Eligibility for financial assistance shall not be based in any way on age, gender, sexual orientation, ethnicity, national origin, veteran status, disability or religion.

1.2 The patient and/or the patient's family representative who requests assistance in meeting their financial obligation to the hospital shall make every reasonable effort to provide information necessary for the hospital to make a financial assistance qualification determination. The hospital will provide guidance and assistance to patients or their family representative as reasonably needed to facilitate completion of program applications. Completion of the financial assistance application and submission of any or all required supplemental information may be required for establishing qualification for the Financial Assistance Program.

1.3 Whether financial assistance will be granted is determined after the patient and/or patient family representative establishes eligibility according to criteria contained in this policy, as it may be amended from time to time. While financial assistance shall not be provided on a discriminatory or arbitrary basis, the hospital retains full discretion, consistent with this policy, laws and regulations, to determine when a patient has provided sufficient evidence to establish eligibility for financial assistance, and what level of financial assistance an eligible patient is will receive.

1.4 Except as otherwise approved by TFHD, patients or their family representative must complete an application for the Financial Assistance Program in order to qualify for eligibility. The application and required supplemental documents are submitted to the Patient Financial Services department at TFHD. This office shall be clearly identified on the application instructions.

1.5 TFHD will provide personnel who have been trained to review financial assistance applications for completeness and accuracy. Application reviews will be completed as quickly as possible considering the patient's need for a timely response.

1.6 Approval of an application for financial assistance to eligible patients will be made only by approved hospital personnel according to the following levels of authority:

1.6.1 Clinic Manager: Accounts less than $500

1.6.2 Financial Counselor: Accounts less than $2,500

1.6.3 Director of Patient Financial Services: Accounts less than $10,000

1.6.4 Chief Financial Officer: Accounts less than $50,000

1.6.5 Chief Executive Officer: Accounts greater than $50,000

1.7 Factors considered when determining whether to grant an individual financial assistance pursuant to this policy may include (but are not limited to):

- Extent of Third Party Insurance;
- Family income based upon tax returns or recent pay stubs;
- Monetary assets, if the patient requests any level of financial assistance greater than the Basic Discount (as defined below);
- The nature and scope of services for which the patient seeks financial assistance;
- Family size and circumstances;
- Hospital budget for financial assistance;
- Other criteria set forth in this policy.

1.8 Financial assistance will be granted based upon consideration of each individual application for financial assistance in accordance with the Financial Assistance Program set forth in this policy.

1.9 Financial assistance may be granted for Full Charity Care or Discount Partial Charity Care, based upon this Financial Assistance Program policy.

1.10 Once granted, financial assistance will apply only to the specific services and service dates for which the application has been approved by TFHD. In cases of care relating to a patient diagnosis which requires continuous, on-going related services, the hospital, at its sole discretion, may treat such continuing care as a single case for which qualification applies to all related on-going services provided by the hospital. Other pre-existing patient account balances outstanding at the time of qualification determination by the hospital will not be included unless applied for and approved by TFHD pursuant to this policy.

1.11 Patient obligations for Medi-Cal/Medicaid share of cost payments will not be waived under any circumstance. However, after collection of the patient share of cost portion, any other unpaid balance relating to a Medi-Cal/ patient (such as a provided service where coverage is denied) may be considered for financial assistance.

2.0 Full and Discount Partial Charity Care Qualification Criteria

2.1 Cap On Patient Liability For Services Rendered to Patients Eligible for Financial Assistance:

Following completion of the application process for financial assistance, if it is established that the patient's family income is at or below 350% of the current FPL, and the patient meets all other Financial Assistance Program qualification requirements, the entire patient liability portion of the bill for services rendered will be no greater than the amount Medicare would have paid for the services, net of any Third Party Insurance ("the Basic Discount"). This shall apply to all medically necessary hospital inpatient, outpatient and emergency services provided by TFHD.

2.2 Financial Assistance For Emergency Services

If an individual receives Emergency Services and applies for financial assistance under the Financial Assistance Program, the following will apply:

2.2.1 If the patient's family income is at or below 200% or less of the current FPL, and the patient meets all other Financial Assistance Program qualification requirements, the patient will be granted Full Charity Care for Emergency Services provided.

2.2.2 If the patient's family income is between 201% and 350% of the current FPL, and the patient meets all other Financial Assistance Program qualification requirements, the patient will be granted Partial Discount Charity Care for Emergency Services provided in accordance with the following:

2.2.2.1 Patient's care is not covered by Third Party Insurance. If the services are not covered by Third Party Insurance, the patient's payment obligation will be a percentage of the gross amount the Medicare program would have paid for the service if the patient were a Medicare beneficiary. The actual percentage paid by any individual patient shall be based on the sliding scale shown in Table 1 below:

TABLE 1
Sliding Scale Payment Schedule

Family Percentage of FPL	**Percentage of Medicare Amount Payable** (subject to an additional discount if TFHD determines, in its sole discretion, that unusual circumstances warrant an additional discount).
201 – 215%	10%
216 – 230%	20%
231 – 245%	30%
246 – 260%	40%
261 – 275%	50%
276 – 290%	60%
291 - 305%	70%
306 - 320%	80%
321 – 335%	90%
336 – 350%	100

2.2.2.2 Patient's care is covered by Third Party Insurance. If the services are covered by Third Party Insurance, but such coverage or liability is insufficient to pay TFHD's billed charges, leaving the patient responsible for a portion of the billed charges (including, without limitation, any applicable deductible or co-payment), the patient's payment obligation will be an amount equal to the difference between the gross amount paid by Third Party Insurance and the gross amount that Medicare would have paid for the service if the patient were a Medicare beneficiary. If the amount paid by Third Party Insurance exceeds what Medicare would have paid, the patient will have no further payment obligation. In no event shall the patient's obligation to pay a percentage of the unpaid amount be greater than the percentages of the amounts

Medicare would pay for the same services set forth in Table 1, above.

2.2.3 If a patient who meets all other Financial Assistance Program requirements whose family income is either greater than 350% the current FPL, or has family income of less than 350% of the FPL and the seeks a discount for emergency services greater than the discount set forth above, then TFHD may decide, in its sole discretion, whether to provide such financial assistance, and the extent to which it will be provided, if at all. In making its decision, TFHD may consider the following factors, without limitation:

2.2.3.1 The patient's need for financial assistance.

2.2.3.2 The extent of TFHD's limited charitable resources, and whether they are best spent providing these services at an additional discount or whether there are other patients with greater immediate need for TFHD's charitable assistance.

2.2.3.3 Any other facts (such as the patient's monetary assets) that, in TFHD's sole discretion, are appropriate to take into account in considering the patient's request for charity care.

2.3 **Financial Assistance For Non-Emergency Services:**

If a patient requests financial assistance for Non-emergency Services (with the exception of primary care clinic, multi-specialty care clinic, or skilled nursing services, which are covered as described below), the following will apply:

If the patient's family income is 350% or less of FPL and meets all other Financial Assistance Program qualification requirements, the patient will be granted the Basic Discount. TFHD may decide, in its sole discretion, whether and to what extent additional financial assistance will be provided, such as whether to provide the level of assistance the patient would receive if he/she had received Emergency Services.

2.3.1 In addition to the information required by the financial assistance application, TFHD may require the individual to provide additional information regarding the individual's family monetary assets, as it deems appropriate in its sole discretion.

2.3.2 TFHD will decide, in its sole discretion, whether and to what extent to grant financial assistance in addition to the Basic Discount. Only medically necessary services will be considered. In making its determination, TFHD may, in addition to any other criteria set forth in this policy and without limitation, consider the following factors :

2.3.2.1 The degree of urgency that the services be performed promptly.

2.3.2.2 Whether the services must be performed at TFHD, or whether there are other providers in the patient's geographic area that could provide the services in question.

2.3.2.3 Whether the services can most efficiently be performed at TFHD, or whether there are other providers that could perform the services more efficiently.

2.3.2.4 The extent, if any, that TFHD's limited charitable resources are best spent providing the requested service and whether there are others with greater immediate need for TFHD's charitable assistance.

2.3.2.5 The patient's need for financial assistance.

2.3.2.6 Any other facts that, in TFHD's sole discretion, are appropriate to take into account in considering the patient's request for financial assistance.

3.0 Refunds

In the event that a patient is determined to be eligible for financial assistance for services for which he/she or his/her guarantor has made a deposit or partial payment, and it is determined that the patient is due a refund because the payments already made exceed the patient's liability under this policy, any refund due shall be processed under TFHD's Credit and Collection Policy, which provides, in pertinent part, as follows:

> "In the event that a patient or patient's guarantor has made a deposit payment, or other partial payment for services for which the patient has requested financial assistance, and subsequently is granted financial assistance through the Financial Assistance Program, any amounts paid at a time when the patient was eligible for financial assistance which exceed the patient's payment obligation, if any, shall be refunded to the patient, with interest. Any refund due to the patient under this paragraph may not be applied to other open balance accounts or debt owed to the hospital by the patient or his/her family, representative, or guarantor. Any refunds due shall be reimbursed to the patient or his/her representative within a reasonable time. Such interest shall accrue from the first day that TFHD received payment of the amount to be refunded, at the rate set forth in Section 685.010 of the California Code of Civil Procedure."

4.0 Flow Chart

Following is a flow chart describing the process for determining financial assistance for applicants for Emergency Services, Non-emergency Services, and Prior Services:

4.1 Hospital-Based Primary Care and Multi-Specialty Clinics

TFHD operates certain outpatient services of the hospital as clinics which are located apart from the main campus of the hospital. These include a multi-specialty clinic, and a primary care clinic, both of which provide mainly primary care services. Because of the lower cost of primary care procedures performed on an outpatient basis, the following shall apply to hospital services rendered in these outpatient clinics:

4.1.1 Clinic patients are patients of the hospital, and will complete the same basic financial assistance application form

4.1.2 The patient's family income will primarily be determined using pay stubs

4.1.3 Tax returns will not be required as proof of income unless clinic personnel determine it is reasonable and necessary due to unusual circumstances

4.1.4 A patient attestation letter may be used on a limited basis when appropriate to an individual patient's circumstance

4.1.5 Subject to consideration of the factors set forth in paragraph 3 above for non-emergency services, to be determined by TFHD in its sole discretion, patients will pay a reduced fee based on the sliding scale below. If the Patient is covered by a third party obligation, the Patient's obligation will be to pay the difference between the amount paid by the third party and the amounts of the sliding scale, if any.

Clinic Sliding Scale

Patient/Family FPL Qualification	*Amount of Payment Due for Clinic Visit*
Incomes less than or equal to 200%	$25 flat fee, not to exceed what Medicare would pay for the clinic visit
Incomes between 201% and 350%	Actual Medicare Fee Schedule

4.2 **Distinct Part Skilled Nursing Services**

4.2.1 Skilled nursing services are also quite different in nature than acute care inpatient, outpatient and emergency services. Patients at the distinct part skilled nursing facility are often residents at the hospital and require special programs designed to meet their long-term care needs.

4.2.2 Given the unique nature of providing care to skilled nursing facility patients, the following financial assistance requirements shall apply:

4.2.2.1 All skilled nursing patients and/or their family representatives shall complete the TFHD financial assistance application and provide supporting documents as required by the standard application

4.2.2.2 Patients will pay a reduced fee based on the following sliding scale

Distinct Part Skilled Nursing Sliding Scale

Patient/Family FPL Qualification	*Amount of Payment Due for Distinct Part Skilled Nursing Facility Services*
Incomes less than or equal to 200%	50% of the Medi-Cal Payment Rate
Incomes between 201% and 350%	100% of the Medi-Cal Payment Rate

5.0 **Payment Plans**

5.1 When a determination to grant Discount Partial Charity Care has been made by the hospital, the patient may be given the option to pay any or all outstanding amount due through a scheduled term payment plan, as an alternative to a single lump sum payment.

5.2 The hospital will discuss payment plan options with each patient that requests to make arrangements for term payments. Individual payment plans will be arranged based upon the patient's ability to effectively meet the payment terms. As a general guideline, payment plans will be structured to last no longer than 12 months. However, monthly payments will be negotiated so as not to exceed 10%

of family income after deductions for essential living expenses. The hospital shall negotiate in good faith with the patient; however there is no obligation to accept the payment terms offered by the patient if outside the scope of policy. No interest will be charged to qualified patient accounts for the duration of any payment plan arranged under the provisions of the Financial Assistance Policy.

6.0 **Special Circumstances**

6.1 Any application for financial assistance by or on behalf of patients covered by the Medicare Program must be made prior to service completion by TFHD.

6.2 If a patient is determined to be homeless he/she may be deemed eligible for charity care, in the sole discretion of TFHD.

6.3 Deceased patients who do not have any third party coverage, an identifiable estate, or for whom no probate hearing is to occur, may be deemed eligible for charity care, in the sole discretion of TFHD.

6.4 Charges for patients who receive Emergency Services for whom the hospital is unable to issue a billing statement may be written off as Full Charity Care. All such circumstances shall be identified on the patient's account notes as an essential part of the documentation process.

7.0 **Other Eligible Circumstances**

7.1 TFHD deems those patients that are eligible for government sponsored low-income assistance program (e.g. Medi-Cal/Medicaid, Healthy Families, California Children's Services and any other applicable state or local low-income program) to be eligible under the Financial Assistance Policy when services are provided which are not covered by the governmental program. For example, services to patients who qualify for Medi-Cal/Medicaid as well as other programs serving the needs of low-income patients (e.g. CHDP, Healthy Families, and CCS) which the government program does not cover, are eligible for Financial Assistance Program coverage. Under the hospital's Financial Assistance Policy, these resulting non-reimbursed patient account balances are eligible for full write-off as Full Charity Care. Specifically included as Charity Care are charges related to denied stays, denied days of care, and non-covered services. All Treatment Authorization Request (TAR) denials and any lack of payment for non-covered services provided to Medi-Cal/Medicaid and other patients covered by qualifying low-income programs, and other denials (e.g. restricted coverage) are to be classified as Charity Care if, at the time that the services were provided TFHD believed that the services rendered were medically necessary.

7.2 The portion of Medicare patient accounts (a) for which the patient is financially responsible (coinsurance and deductible amounts), (b) which is not covered by insurance or any other payor including Medi-Cal/Medicaid, and (c) which is not reimbursed by Medicare as a bad debt, may be classified as charity care if:

7.2.1 The patient is a beneficiary under Medi-Cal/Medicaid or another program serving the health care needs of low-income patients; or

7.2.2 The patient otherwise qualifies for financial assistance under this policy and then only to the extent of the write-off provided for under this policy.

8.0 **Catastrophic Care Consideration**

Patients who do not qualify for charity care or discount partial charity care may nevertheless be eligible for financial assistance in the event of an illness or condition qualifying as a catastrophic event. Determination of a catastrophic event shall be made on a case-by-case basis. The determination of a catastrophic event shall be based upon the amount of the patient's liability at billed charges, and consideration of the individual's family income and assets as reported at the time of occurrence. Management may use its reasonable discretion on a case-by-case basis to determine whether and to what extent an individual or family is eligible for financial assistance based upon a catastrophic event. Financial assistance will be in the form of a percentage discount of some or all of the applicable monthly charges. The Catastrophic Event Eligibility Table will be used as a guideline by management to determine eligibility and the level of any financial assistance. The Catastrophic Event Eligibility Table does not guarantee that any individual will receive financial assistance, or the level of any assistance given.

9.0 **Criteria for Re-Assignment from Bad Debt to Charity Care**

9.1 Any account returned to the hospital from a collection agency that has determined the patient or family representative does not have the resources to pay his or her bill, may be deemed eligible for Charity Care. Documentation of the patient or family representative's inability to pay for services will be maintained in the Charity Care documentation file.

9.2 All outside collection agencies contracted with TFHD to perform account follow-up and/or bad debt collection will utilize the following criteria to identify a status change from bad debt to charity care:.

9.2.1 Patient accounts must have no applicable insurance (including governmental coverage programs or other third party payers); and

9.2.2 The patient or family representative must have a credit score rating within the lowest 25th percentile of credit scores for any credit evaluation method used; and

9.2.3 The patient or family representative has not made a payment within 150 days of assignment to the collection agency;

9.2.4 The collection agency has determined that the patient/family representative is unable to pay; and/or

9.2.5 The patient or family representative does not have a valid Social Security Number and/or an accurately stated residence address in order to determine a credit score

9.3 All accounts returned from a collection agency for re-assignment from Bad Debt to Charity Care will be evaluated by hospital personnel prior to any re-classification within the hospital accounting system and records.

10.0 **Notification**

Once a determination of eligibility is made, a letter indicating the determination status will be sent to the patient or family representative. The determination status letter will indicate one of the following:

10.1 Approval: The letter will indicate that financial assistance has been approved, the level of assistance, and any outstanding or prospective liability by the patient.

10.2 Denial: If the patient is not eligible for financial assistance due to his/her income and/or monetary assets, the reasons for denial of eligibility will be explained to the patient. Any outstanding amount owed by the patient will also be identified.

10.3 Pending: The applicant will be informed as to why the financial assistance application is incomplete. All outstanding information will be identified and requested to be supplied to the Hospital by the patient or family representative.

11.0 Reconsideration of Eligibility Denial

11.1 In the event that a patient disputes the hospital's determination of eligibility, the patient may file a written request for reconsideration with the Hospital within 60 days of receiving notification of eligibility. The written request should contain a complete explanation of the patient's dispute and rationale for reconsideration. Any additional relevant documentation to support the patient's claim should be attached to the written appeal.

11.2 Any or all appeals will be reviewed by the hospital chief financial officer. The chief financial officer or his/her designee shall consider all written statements of dispute and any attached documentation. After completing a review of the patient's claims, the chief financial officer shall provide the patient with a written explanation of the results of the reconsideration of the patient's eligibility. All determinations by the chief financial officer shall be final. There are no further appeals.

11.3 All discretionary decisions by the hospital shall not be subject to further review or reconsideration.

12.0 Public Notice

12.1 TFHD shall post notices informing the public of the Financial Assistance Program. Such notices shall be posted in high volume inpatient, and outpatient service areas of the hospital, including but not limited to the emergency department, billing office, inpatient admission and outpatient registration areas or other common patient waiting areas of the hospital. Notices shall also be posted at any location where a patient may pay his/her bill. Notices will include contact information on how a patient may obtain more information on financial assistance as well as where to apply for such assistance. Notices will also include information about obtaining applications for potential coverage through the California Health Benefit Exchange and other contact information related to consumer advocacy resources.

12.2 These notices shall be posted in English and Spanish and any other languages that are representative of the primary language of 5% or greater of residents in the hospital's service area.

12.3 A copy of this Financial Assistance Policy will be made available to the public on a reasonable basis.

13.0 Confidentiality

It is recognized that the need for financial assistance is a sensitive and deeply personal issue for recipients. Confidentiality of requests, information and funding will be maintained for all that seek or receive financial assistance. The orientation of staff and selection of personnel who will implement this policy should be guided by these values.

14.0 Good Faith Requirements

14.1 TFHD makes arrangements for financial assistance for qualified patients in good faith and relies on the fact that information presented by the patient or family representative is complete and accurate.

14.2 Provision of financial assistance does not eliminate the right to bill, either retrospectively or at the time of service, for all Full Charity Care or Partial Discount Charity Care services when information has been intentionally withheld or inaccurate information has been intentionally provided by the patient or family representative to the extent such inaccurate or withheld information affects the eligibility of the patient for financial assistance, or any financial assistance provided at the hospital's discretion. In addition, TFHD reserves the right to seek all remedies, including but not limited to civil and criminal remedies from those patients or family representatives who have intentionally withheld or provided inaccurate information in order qualify for the TFHD Financial Assistance Program.

Related Policies/Forms:
References: *See* TFHD BOD Meeting Minutes, May 24, 2011 The Patient Protection and Affordable Care Act, Public Law 111–148 (124 Stat. 119) (2010) Section 9007; Health and Safety Code Sections 127360-127360; Health and Safety Code Sections 127400-127440
Policy Owner: Michelle Cook, Clerk of the Board
Approved by: Robert Schapper, Chief Executive Officer

FINANCE COMMITTEE

RECOMMENDED AGENDA ITEMS FOR NEXT FINANCE COMMITTEE MEETING

1. Financial Report – January 2015
2. Six Month Review Multi-Specialty Clinics
3. Calendar Year Review Truckee Surgery Center, LLC
4. Discussion/outline budget process and timeline
5. Kaufman Hall Projects (Possible)
6. Pricing Comparisons (Possible)

RECOMMENDED DATE(s) AND TIME(s) FOR NEXT FINANCE COMMITTEE MEETING

1. Monday, February 23rd — 3 hrs – Available between 1:00-6:00pm
2. Tuesday, February 24th — 3 hrs – Available between 12:00-3:00pm

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Tahoe Forest Hospital District
Board of Directors Compliance Program Training
Special Meeting of the Board of Directors
January 26, 2015

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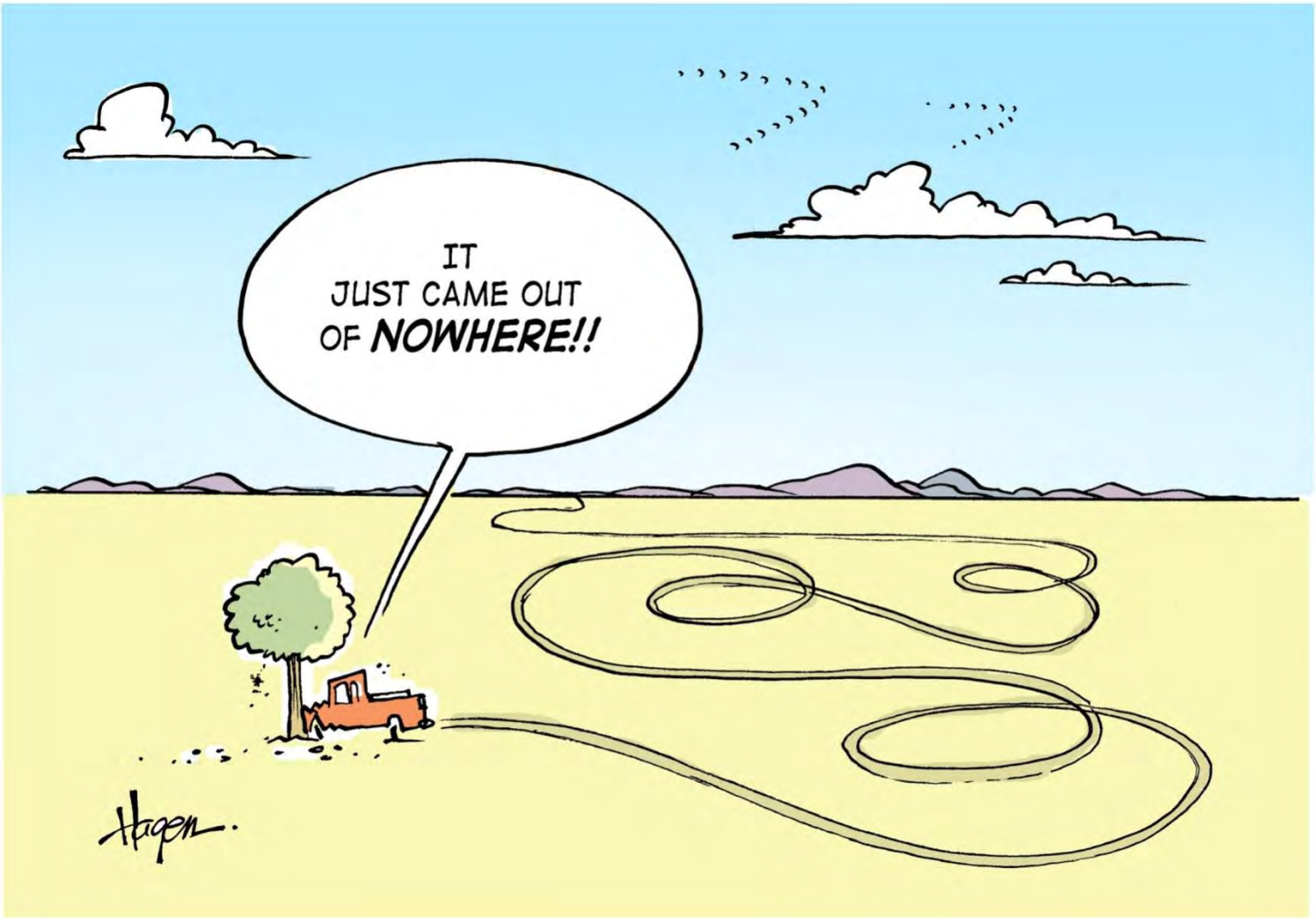
TRAINING OBJECTIVES

- Review the framework for an **effective** compliance program including the role of the Board of Directors
- Discuss recent laws impacting compliance programs in health care organizations
- Identify evolving governance considerations
- Summarize fraud and abuse and other relevant health care laws

FRAMEWORK FOR AN EFFECTIVE COMPLIANCE PROGRAM


IT
JUST CAME OUT
OF NOWHERE!!
Hagen

COMPLIANCE TOP TEN

- Ignorance is no excuse but it is a mistake - know the agency's business and the laws that apply to it
- Complying with the law is not a business decision
- The Government doesn't care that . . . ?
- Don't expect miracles: compliance officers are not magicians
- Hold people accountable
- Don't put off corrective actions - delay will come back to bite you
- Poor communication is often the root of compliance issues
- Actions speak louder than words but the words matter
- You must have an effective reporting system
- Yes, anyone can be personally liable

COMPLIANCE PROGRAM FUNDAMENTALS

- U.S. Sentencing Commission, Guidelines for Healthcare Organizations
- OIG Compliance Program Guidance for Hospitals (1998 and 2005)
- *Corporate Responsibility and Corporate Compliance: A Resource for Health Care Boards of Directors*, OIG/AHLA (2003)
- *An Integrated Approach to Corporate Compliance: A Resource for Health Care Boards of Directors*, OIG/AHLA (2004)
- *Corporate Responsibility and Health Care Quality – A Resource for Health Care Boards of Directors*, OIG/AHLA (2007)
- FCA Settlements - Corporate Integrity Agreements (CIAs)
- OIG Education Handouts – "A Toolkit for Health Care Boards"

SEVEN ELEMENTS OF AN EFFECTIVE COMPLIANCE PROGRAM

- Implement written policies, procedures and standards of conduct
- Designate a compliance officer and compliance committee
- Conduct meaningful compliance training and education
- Develop effective lines of communication; no retaliation policy
- Conduct internal monitoring and auditing
- Enforce standards through well-documented disciplinary guidelines
- Respond promptly to detected offenses and undertake corrective actions

BENEFITS OF AN EFFECTIVE COMPLIANCE PROGRAM

- Demonstrates to employees and the community, the agency's commitment to honest and responsible conduct
- Fosters compliance with ethical conduct and applicable laws and reduces risk of unlawful or improper conduct
- Gives employees a mechanism to report potential or actual non-compliance without fear of retaliation and deters whistleblowers
- Creates a centralized place to disseminate relevant information and guidance on applicable laws and other requirements which facilitates successful operations

BENEFITS OF AN EFFECTIVE COMPLIANCE PROGRAM (CONT'D)

- Minimizes the agency's potential exposure to overpayments, civil damages and penalties, criminal sanctions and/or exclusion
- Reduces risk of developing systemic errors that may become very costly if they are not addressed early
- May be considered as a mitigating factor by the government when addressing refunds, assessments and penalties in self-disclosures, FCA settlements, etc.
- Certifications of an effective compliance program and/or corrective actions may be necessary to support settlements with the Government

BOARD OF DIRECTORS' ROLE

- Formally adopt the agency's compliance program
- Be familiar with health care and other applicable laws that impact the agency's business operations
- Support the Compliance Officer's independence and direct reporting line to the Board
- Require an effective reporting system that allows the Board to properly exercise its oversight role

BOARD OF DIRECTORS' ROLE (CONT'D)

- Exercise reasonable inquiry of management to obtain information necessary to satisfy Board's obligations
- Establish a Board level quality committee and make quality of care a standing Board agenda item
- Perform regular assessments of the Board and its committees
- Actively review results of compliance program (internal and/or external) performance evaluations

“I am a Compliance Officer. I don’t believe in miracles – I rely on them.”

COMPLIANCE OFFICER'S RESPONSIBILITIES

- Member of senior management with direct access to the CEO and Board
- Chairs the Compliance Committee which supports the Compliance Officer in fulfilling his/her responsibilities
- Assignment of duties not related to compliance function are generally limited but this may depend on size and complexity of the organization
- Makes regular reports to the Board; authorized to report at any time
- Not subordinate to General Counsel or the Chief Financial Officer

COMPLIANCE OFFICER'S RESPONSIBILITIES (CONT'D)

- Develops and implements policies, procedures and practices designed to achieve compliance with agency establish standards and applicable laws
- Creates programs that facilitate effective lines of communication between the Compliance Officer and agency personnel
- Conducts independent investigations related to suspected non-compliance and works with outside counsel, auditors, and other health care experts, as necessary and appropriate
- Oversees disciplinary and corrective actions consistent with agency's written standards and coordinates with other relevant parties as necessary and appropriate (Human Resources, management, Board, etc.)

THE COMMUNICATION FUNCTION

- Agency has and supports open lines communication
  - Agency personnel and other parties use the various channels of communication to report suspected non-compliance
  - Agency can encourage a hierarchy of reporting channels i.e. first to immediate supervisor, then to Human Resources, then to Compliance Officer, etc., employees have the right to report directly to Compliance Officer or via anonymous hotline
  - Agency should strive to maintain confidentiality of reporter's identify but anonymity cannot be guaranteed as there may be a point where his/her identity needs to be revealed such as to the Government
- Agency adopts a no retaliation policy that promotes a culture of compliance
  - Environment supports open and candid discussion of concerns
  - Encourages questions about compliance policies and applicable laws
  - Employees may not report concerns if they believe they are subject to retaliation or harassment leading to systemic issues, whistleblowers, etc.

THE REPORTING FUNCTION

- Reports on a regular basis to the agency's governing body, CEO and compliance committee on day-to-day compliance activities
- Presents updates/revisions of the compliance program documents and compliance program performance evaluations to the Board
- Advises on the day-to-day activities of the compliance program
- Informs the Board of investigations, findings and corrective actions
- Develops and presents annual risk assessments and/or work plans
- Identifies ways to improve the agency's quality of services, reduce vulnerability to fraud, waste and abuse and avoid systemic non-compliance

THE INVESTIGATION FUNCTION

- Power to independently investigate instances of non-compliance and implement corrective actions
- Flexibility to design, coordinate and lead internal investigations
- **Given access to sufficient resources (internal and external) necessary to conduct a proper investigation, including authority to engage legal counsel or external consultants**
- Authority to review all documents and other information relevant to compliance activities e.g. patient records, claims and billing records, etc.
- Coordinates any personnel issues with Human Resources and relevant agency policies and procedures

BEST PRACTICES FOR AN EFFECTIVE COMPLIANCE PROGRAM

- The compliance program is established by formal commitment of the governing body e.g. resolution
- The Board and management promote compliance as a culture not merely a collection of documents
- High level agency personnel oversee the implementation of the compliance program and ongoing operations
- The Board has a presence in the compliance program (e.g. ad hoc committee that focuses on compliance, Board member is designated as a member of the agency's compliance committee)

BEST PRACTICES FOR AN EFFECTIVE COMPLIANCE PROGRAM (CONT'D)

- The compliance program functions in a proactive, not reactive, manner
- The compliance program is dynamic and reviewed and/or updated, as necessary and appropriate, on a ongoing basis
- The agency dedicates adequate resources to compliance efforts
- Ethical standards, legal requirements, and disciplinary guidelines are communicated in a meaningful manner to members of the workforce
- Compliance is a condition of continued employment and adherence to legal and ethical standards is considered during employee evaluations
- The agency measures the effectiveness of its program on a regular basis

WHAT MAKES A COMPLIANCE PROGRAM INEFFECTIVE?

- Adopted compliance program "sits on the shelf"
- Governing body, management and/or employees lack knowledge or understanding of the adopted compliance program
- Governing body lacks subject matter knowledge relevant to the organization's lines of business
- Compliance Officer is not a high-level employee of the organization or is someone without relevant experience/expertise

WHAT MAKES A COMPLIANCE PROGRAM INEFFECTIVE? (CONT'D)

- Agency supports a compliance program that is merely reactive to crisis and not proactively engaged in training, monitoring and auditing
- Compliance Officer's efforts are not supported by allocation of adequate staffing, financial and other resources to address seven elements
- Organization's compliance committee is too large to be effective
- Poor communication between business units, operational areas, etc.
- Content of compliance reports to Board is limited, filtered or manipulated

RECENT LAWS AFFECTING HEALTH CARE ORGANIZATION COMPLIANCE PROGRAMS

IMPACT OF HEALTH CARE REFORM

- Mandatory compliance programs
  - Mandates that a broad range of providers and suppliers adopt a compliance and ethics program
  - Many providers, suppliers, and pharmaceutical/device entities and health care plans have historically had mandated (involuntary) compliance programs based on CIAs or applicable laws

- Overpayment statute
  - Duty to report and refund overpayments within sixty (60) days of "identifying" the overpayment
  - Proposed regulation included a ten (10) year "look back" period
  - Whistleblower cases test the duty to refund within 60 days and the look-back period
  - Definition of "obligation" under FCA was previously amended to include retention of overpayments

IMPACT OF HEALTH CARE REFORM (CONT'D)

- Anti-Kickback Statute amendments
  - AKS violations are false or fraudulent claims under FCA
  - AKS violation may be established without showing an individual knew of the AKS' proscriptions and intended to violate it

- Stark Law self-disclosure protocol
  - Method for provider to self-disclose and resolve Stark Law violations that do not implicate AKS
  - Agency discretion to resolve Stark Law violations including reduction of the amount due
  - Particularly important for technical violations

EVOLVING GOVERNANCE CONSIDERATIONS

EVOLVING GOVERNANCE CONSIDERATIONS

- Increased Government interest in holding individuals accountable
- Future trend of using deferred prosecution agreements (DPAs) in lieu of pursuing civil settlements?
- Government's use of derivative permissive exclusion authority
- OIG includes new board and officer contractual accountability obligations in Corporate Integrity Agreements
- New focus on governance best practices
- *Caremark* claims

CORPORATE INTEGRITY AGREEMENTS AS COMPLIANCE TOOL

- Contain mandatory compliance obligations that must be accomplished in specific timeframes
- Indicative of what OIG wants to require of health care organizations but OIG would have to go through rulemaking to include it in regulations
- Imposed in lieu of OIG's permissive authority to exclude a party from participation in the federal healthcare programs (note: mandatory exclusions for some crimes)
- Prospective in nature and designed to assure that the organization will be a good participant in Federal healthcare programs going forward
- Evolved to include specific board and executive accountability provisions, attestations and even "claw-backs" of executive salaries

BOARD DUTY OF CARE – OVERSIGHT FUNCTION

- Directors' **duty of care** is the obligation to act with appropriate level of care that an ordinarily prudent person would exercise in like circumstances and in a manner that they reasonably believe is in best interest of the [corporation]

- Directors are not required to know everything; standard is not perfection

- Directors are entitled to rely on advice of management and outside advisors

- Directors' duty of care arises in two situations: (i) decision making function and (ii) oversight function

- *Caremark* and subsequent legal cases considered the board's oversight function and found that it includes a duty to implement an adequate information and reporting system (also referred to as the duty to monitor)

THE "CAREMARK CLAIM"

- Failure to reasonably oversee the implementation of the [corporate] reporting system may put the organization at risk and expose directors to personal liability
- When presented with red flags, the duty to make reasonable inquiry increases (*e.g.* government investigations, indications of fraud)
- Once presented with information that raises (or should raise) concerns, directors are obligated to make further inquiry until concerns are favorably resolved
- Subsequent courts (and the Government) interpret the case to state that the board has an affirmative duty to assure an effective information reporting system is in place that will allow the board to properly exercise is oversight role

FRAUD AND ABUSE AND OTHER RELEVANT HEALTH CARE LAWS

INTRODUCTION

- General overview of federal fraud and abuse and other health care laws
- These laws are complex and often confusing such that determinations of whether health care arrangements are compliant with them typically requires a detailed analysis of relevant facts and circumstances
- Similar state physician anti-referral and anti-kickback may be implicated depending on the particular facts and circumstances

DEFINITION OF WASTE

- "Waste" means the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs
- Generally not considered to be caused by criminally negligent actions or violation of law but rather the misuse of resources
- Relates primarily to mismanagement, inappropriate actions and inadequate oversight

DEFINITION OF FRAUD

- "Fraud" means an intentional misrepresentation or deception made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or other person (includes fraud under applicable federal or state law) including:
  - Misrepresenting the diagnosis code
  - Unbundling charges
  - Up-coding
  - Billing for services not furnished
  - Falsifying certifications of medical necessity, plans of treatment

DEFINITION OF ABUSE

- "Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost or reimbursement of services:
  - Billing for a non-covered service
  - Inappropriately allocating costs on a cost report
  - Medically unnecessary services that do not meet professionally recognized standards
  - Breaches in the assignment agreement
  - Billing Medicare when another insurer is responsible for payment under Medicare secondary payer regulation

HEALTH CARE FRAUD AND ABUSE AND OTHER LAWS

Federal Laws

- Criminal Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b))
- Civil False Claims Act (31 U.S.C. § 3729)
- Civil Monetary Penalties Law (42 U.S.C. § 1320a-7a)
- Overpayment Statute (42 U.S.C. § 1320a-7k(d))
- Mandatory & Permissive Exclusion Authority (42 U.S.C. § 1320a-7)
- HIPAA/HITECH (42 U.S.C. § 17921 *et seq.*) and implementing regulations

State Laws

- Anti-Kickback Law (Business & Professions Code § 650)
- California False Claims Act (Government Code §§ 12650 *et seq.*)
- Medi-Cal Anti-Kickback Law (Welfare & Institutions Code § 14107.2)
- State Privacy Laws (*e.g.* California Confidentiality of Medical Information Act (CMIA) Civil Code § 56 *et seq.*, Health & Safety Code § 1280.15)
- Local Health Care District Laws, Health & Safety Code § 32000 et seq.

FEDERAL STARK LAW

- Civil statute that prohibits certain physician referrals unless an exception applies
- Covers Medicare (and Medicaid?)
- Purpose is to prevent inappropriate financial incentives from influencing medical decision-making
- Strict liability - no criminal intent is required to prove a Stark Law violation; a violation will exist whether it is intentional or inadvertent
- No materiality threshold such that even minor violations can result in significant penalties
- Even if arrangement is allowed under Stark Law, it may constitute a violation of AKS if there is an intent to induce referrals
- Potential for Civil Monetary Penalties (CMPs) – require intent

STARK LAW PROHIBITION

- Unless an exception applies, **a physician or his or her immediate family** member may not refer a patient for **designated health services** to any **entity** with which the physician (or immediate family member) has a **financial relationship**

- Neither the entity or the physician may bill Medicare (or any other person or entity) for services provided pursuant to a prohibited referral

Definitions Are Critical to Analysis: The application of these laws to any given arrangement is driven by a analysis of the numerous terms defined in the Stark law and regulations.

STARK LAW ANALYSIS

- Is there a **referral** from a **physician** for a **designated health service (DHS)** (covered and paid by Medicare)?
- If yes, does the physician (or an immediate family member) have a **direct** or **indirect financial relationship** with the **entity** providing the DHS?
- If yes, does the financial relationship satisfy an **exception**?
  - If yes to first two questions, must meet an exception and follow it exactly to be compliant
- If the arrangement must meet an exception and doesn't, then there is a potential Stark Law issue.

ARRANGEMENTS IMPLICATING THE STARK LAW

- Physician provides administrative services (e.g. medical director, consultant) to a hospital
- Physician on-call emergency department agreements with hospitals
- Hospital leases MOB space to physician group or individual physicians
- Hospital provides medical staff with gifts e.g. sporting event tickets, golf outings, and free meals
- Hospital funds advertisement that promotes an individual physician or a physician practice
- Hospital pays for physicians to attend clinical conference outside the hospital's service area which provides CLE

DESIGNATED HEALTH SERVICES

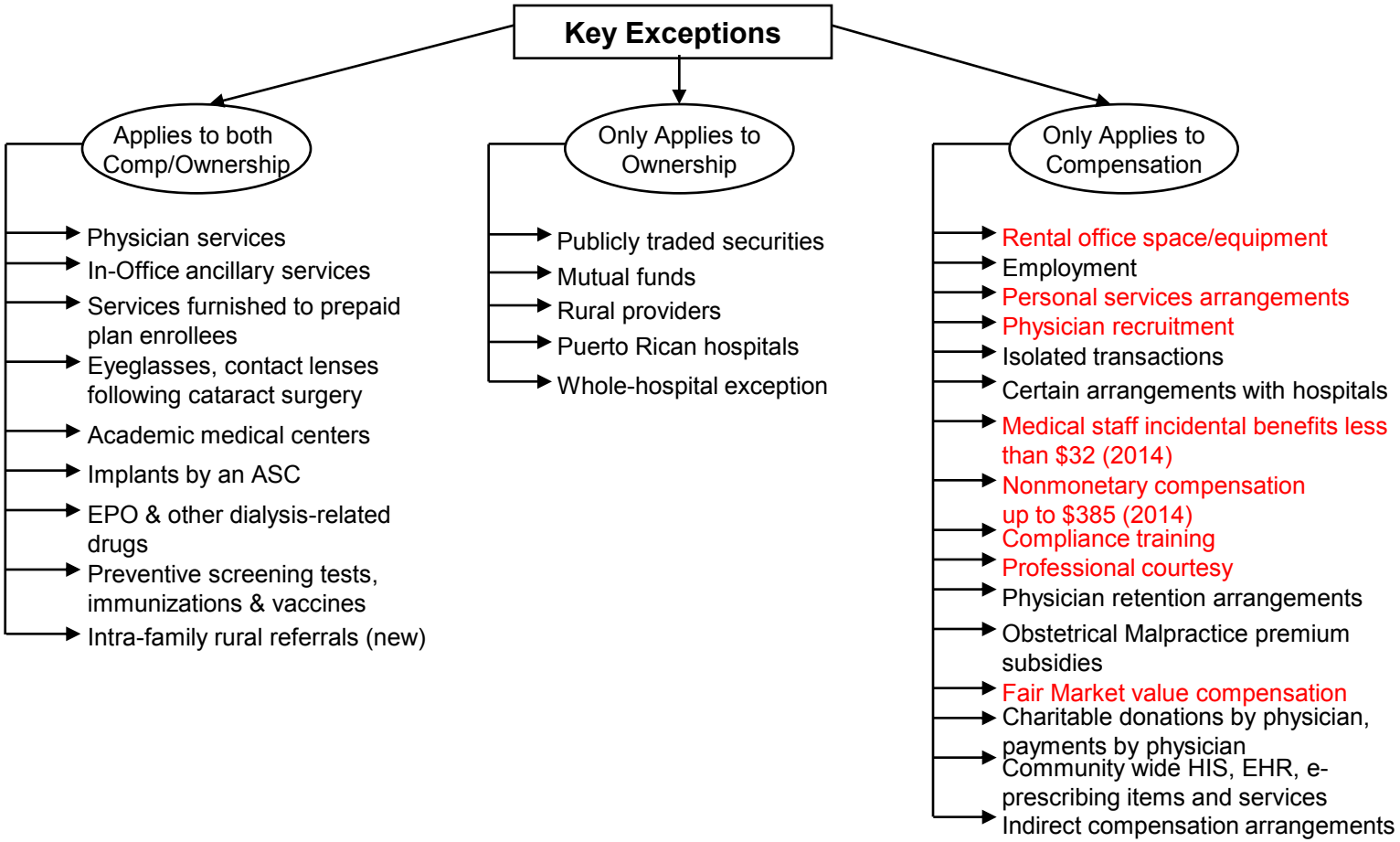
- Clinical laboratory services*
- Physical and occupational therapy and outpatient speech-language pathology services*
- Radiology and certain other imaging services*
- Radiation therapy services and supplies*
- Durable medical equipment and supplies
- Parenteral and enteral nutrients, equipment and supplies
- Prosthetics, orthotics and prosthetic devices and supplies
- Home health services
- Outpatient prescription drugs
- Inpatient and outpatient hospital services

Note: The above services are defined separately in Stark regulations. Those shown with an *include references to the "List of CPT/HCPCS Codes"

STARK LAW EXCEPTIONS

- Arrangement must fall under an exception in order to be compliant with the Stark Law
- Which exception applies will depend on whether the **financial relationship** at issue is (a) an **ownership or investment interest or** (b) a **compensation arrangement** - some exceptions apply to both
- There are restrictions on the use of some exceptions e.g. government (Centers for Medicare and Medicaid Services (CMS)) has indicated that the "fair market exception" can't be used for space leases; recruitments have to rely on recruitment exception
- Must meet every requirement of the applicable exception in order to be compliant with the Stark Law
- Technical violations matter

KEY STARK LAW EXCEPTIONS



POTENTIAL STARK LAW SANCTIONS

- Medicare denies payment or recoups based on prohibited referral – burden of proof on entity furnishing DHS to show exception
- Entity has duty to refund
- Civil monetary penalties: $15,000 for knowingly presenting or causing to present improper claim and $100,000 for circumvention schemes
- Potential False Claims Act liability
- Exclusion from participation in federal and state health care programs

ANTI-KICKBACK PROHIBITIONS

- Criminal offense to knowingly and willfully offer, pay, solicit or receive any remuneration (including kickbacks, bribes or rebates), directly or indirectly, overtly or covertly, in cash or kind in return for:
  - Referring (or inducing referral of) any individual to a provider for any item or service paid by any Federal health care program; or
  - Purchasing, leasing or ordering (or arranging for or recommending the purchase, lease, order of) any good, facility, service or item paid for by such programs.

*__Federal health care program__ is defined to include any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the US Government or any state health care program as defined in the exclusion statute e.g. Medicare, TRICARE, Medicaid, etc.

PURPOSE OF THE ANTI-KICKBACK STATUTE

- Avoid over-utilization
- Ensure objective medical advice
- Eliminate additional costs resulting from unduly favorable deals for referral business
- Ensure that providers are chosen are merits rather than financial self-interest
- Maintain a level playing field for all competitors

ARRANGEMENTS IMPLICATING THE ANTI-KICKBACK STATUTE

- Pharmaceutical company pays physicians for clinical trial activities
- Durable medical equipment company places employee at hospital to assist patients who may need DME
- Lab employee assists with hospital clerical tasks
- Hospital makes a loan to a physician
- Hospital leases its employees to physician's office
- Hospital reimburses physician for the cost of professional liability insurance
- Hospital recruits a physician or pays a physician to retain practice in the community served by the hospital

SCOPE OF THE ANTI-KICKBACK STATUTE

- Criminal, intent-based statute; however, government can enforce through administrative process where the evidentiary burden is less (preponderance of evidence versus evidence beyond a reasonable doubt)
- Scope of activities covered is very broad - not limited to physician referrals of DHS to entities
- Imposes liability on both sides of impermissible transaction
- Implicated even if no remuneration is actually paid or received – an offer is sufficient to invoke
- Applies even if only ***one*** purpose is to obtain money, etc. for referral business

HOW ANTI-KICKBACK STATUTE SAFE HARBORS WORK

- Conduct and arrangements that are deemed not to violate Anti-Kickback Statute
- Voluntary compliance by providers
- Must meet every element of safe harbor to come within them
- Failure to completely meet a safe harbor does not mean that conduct is automatically illegal
- AKS is an intent based statute such that analysis of safeguards and risks may be necessary but CMPs may be based on violation of AKS

ANTI-KICKBACK STATUTE SAFE HARBORS

- Investments in large publicly-held health care companies
- Investments in small health care companies
- **Space rental**
- **Equipment rental**
- **Personal services and management contracts**
- Sales of retiring physician's practice
- Referral services
- Warranties
- **Discount arrangements**
- Employee compensation
- **Group Purchasing Organizations**
- Beneficiary waivers
- Certain coverage increases or cost reductions by HMOs
- Certain price reductions by providers to HMOs
- **Physician recruitment in underserved areas**

ANTI-KICKBACK STATUTE SAFE HARBORS (CONT'D)

- OB malpractice insurance subsidies
- Group practice investments
- Cooperative hospital services organizations
- Ambulatory Surgery Centers
- Referral agreements for specialty services
- Joint venture investments in underserved areas
- Sales of physician practices to hospitals in underserved areas
- Shared risk arrangements
- Ambulance replenishing
- Payments or loans or donations to health centers (FQHCs)
- Electronic prescribing programs
- **Electronic health records programs**
- FQHCs

ANTI-KICKBACK STATUTE PENALTIES

- Criminal Penalties
  - Felony - fine up to $25,000 per violation, prison term up to 5 years (per violation) or both

- Civil/Administrative Penalties
  - False Claims Act liability – CMPs, civil assessment up to 3 times amount of kickback, federal and state health care program exclusion
  - $50,000 CMP per violation

- Exclusion from federal and state health care programs

FEDERAL (CIVIL) FALSE CLAIMS ACT

- Civil liability for **knowingly** presenting or causing another to present a false or fraudulent claim to the government for payment, making a false record or statement that is material to the false claim; failure to return overpayments
- "Knowingly" includes: actual knowledge; deliberate ignorance; and reckless disregard for truth or falsity of information
- Protects persons from retaliation for reporting false claims or bring legal actions to recover money paid on false claims
- Contains "whistleblower" provisions that extend to employees, contractors
- Penalties up to $11,000 for each false claim, treble amount of damages government sustains by reason of each claim; and potential exclusion from Federal health care programs

REVERSE FALSE CLAIMS

- Fraud Enforcement & Recovery Act of 2009 covers "knowing" retention of overpayments
- FCA imposes liability for knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to the government
- "Obligation" means any "established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the **retention of any overpayment**"

DEFICIT REDUCTION ACT FCA EDUCATION

- Section 6032 of DRA entitled "Employee Education About False Claims Recovery" enacted in 2007
- Applies to most health care organizations that operate under the Medicaid program –receive or make annual Medicaid payments of at least $5 million
- Required to establish and implement an education plan for employees, managers, contractors and agents, which includes written policies and detailed guidance on the federal False Claims Act (FCA) state false claims laws, and the rights and protections afforded whistleblowers under the FCA and its state counterparts
- Condition for participating in Medicaid program and receiving payments
- Penalties for non-compliance

CIVIL MONETARY PENALTIES LAW

- Civil monetary penalties (CMPs) may be imposed for presentation of claim for medical item or service that:
  - person knows or should have known was not provided as claimed
  - is for a medical or other item or service and person knows or should know the claim is false or fraudulent
  - is for a medical or other item or service furnished during a period that the person was excluded from participation in Federal health care programs
  - Commits a violation of the federal Anti-Kickback Statute
  - knows of an overpayment and does not report and return the overpayment in accordance with federal overpayment law
- For improper claim, CMPs up to $10,000 for each item or service improperly claimed, plus no more than 3 times amount as assessment in lieu of damages
- For Anti-Kickback Statute violations, penalty of up to $50,000 for each act, plus damages of no more than up to 3 times the remuneration
- Exclusion from participation in Federal health care programs

OIG EXCLUSION AUTHORITY

- Office of Inspector General (OIG) has authority to exclude individuals and entities from participation in Federal health care programs
- Mandatory exclusions
  - Based on convictions for Medicare/Medicaid fraud, patient abuse/neglect, felony health care fraud, felony relating to controlled substances
  - Conviction is broadly defined
  - Minimum 5-year exclusion term
- Permissive exclusions – derivative and affirmative
  - Include misdemeanor healthcare fraud conviction (unrelated to Medicare/Medicaid), obstruction of investigation/audit, misdemeanor controlled substances, license revocation or suspension, knowing false statements or misrepresentations on enrollment applications, Health Education Assistance loan default
  - Exclusion term varies depending on grounds

EFFECT OF EXCLUSION

- No **Federal health care program payment** may be made for items or services an excluded individual/entity furnishes or orders or prescribes
- Civil monetary penalties (CMPs), assessments and program exclusions may be imposed against excluded persons for items or services furnished during the period of exclusion
- CMPs, assessments and program exclusions may be imposed against individuals or entities that employ/enter into contracts with excluded persons to provide items or services
- CMPs may be imposed when a provider (or other person/entity) submits or causes to be submitted a claim for items/services furnished by an excluded individual entity where knows or should have known of the exclusion
- Exclusion violations can lead to criminal prosecutions or civil actions

PERMISSIVE EXCLUSION AUTHORITY

- Section 1320a-7(b)(15) authorizes exclusion of individual owners and officers and managing employees of a "sanctioned" entity

- Exclusion of individuals with ownership or control interest if they knew or should have known of the conduct that led to the exclusion

- OIG issued guidance in 2010 on implementation of permissive exclusion authority of officers based on role or interest in an entity that has been convicted of or pleads to certain health care offenses or excluded regardless of whether that person was convicted or charged
  - Apply presumption in favor of exclusion if OIG determines there is evidence that officer knew or should have known of the conduct
  - If no evidence that the officer knew or should have known, exclude based on consideration of four categories of factors: information about the entity; individual's role in entity; circumstances of misconduct/seriousness of offense; and individual's actions in response to misconduct

EXCLUSION - PRACTICAL CONSIDERATIONS

- Hospital must screen employees, contractors (including vendors) and members of medical staff against applicable government lists (OIG LEIE, GSA SAM and Medi-Cal) to avoid employing or contracting with excluded persons or entities
- Screening needs to conducted before employed or contracted and on regular basis thereafter (e.g. monthly)
- Need to develop a policy/process to conduct screening and document results
- Need to incorporate warranties and representations in Hospital contracts that persons/entities are not excluded, debarred or suspended from participation in Federal health care programs (and that parties will provide notice of events that may lead to exclusion)
- Need to take appropriate corrective actions based on adverse results (no hiring, termination, no submission of claims for payment, disclosure/refunds, etc.)

FEDERAL OVERPAYMENT LAW

- Overpayment means any funds that a "person" receives or retains under Medicare/Medicaid programs to which the person, after applicable reconciliation, is not entitled

- A "person" is defined as a provider of services, supplier, Medicaid managed care or Medicare Advantage organization or PDP sponsor but not a beneficiary

- If an overpayment is received, the person shall report and return the overpayment to the Secretary, the State, an intermediary, carrier or contractor, as appropriate and identify reason for the overpayment

- Report and return by the later of the date which is 60 days after the date on which the overpayment was identified or, if applicable, date cost report is due

- Overpayments retained after the deadline are "obligations" under FCA

- Look-back period for purposes of refunds is an open issue

OVERPAYMENT LAW - PRACTICAL CONSIDERATIONS

- Providers need to develop processes to timely respond to potential refund situations (e.g. internal and external audits)
- Need to consider what is the most appropriate method to make a disclosure and refund based on particular overpayment situation
- Need to consider legal and financial risks associated with failure to implement an "appropriate look-back period"

PUBLIC AGENCY CONSIDERATIONS

- Conflicts of interest
- Gift of public funds
- Procurement and bidding
- Gifts and honoraria
- Transparency

QUESTIONS?

A Toolkit for Health Care Boards

Promote Quality of Care

- Create a comprehensive policy and objectives to define your quality improvement and patient safety program. Ensure your stakeholders share a common vision of quality. To give your program real impact, incorporate its objectives into employee performance evaluations and incentive compensation.
- Establish a board quality committee and make quality of care a standing board agenda item.
- Ensure you have sufficient clinical expertise on the board. To address potential conflicts, some hospital boards recruit physicians who are not medical staff members, or who are retired.
- Understand how management assesses the credentials of the medical staff and stay current on best practices.
- Implement conflict-of-interest policies to identify and manage financial interests that may affect clinical judgment.
- Use dashboards and benchmarks to measure the success of your organization as it improves outcomes and patient satisfaction. You should track how your organization compares to its peers on these quality indicators. After all, "What gets measured is what gets done."

Evaluate the Compliance Program

- Ask questions that assess your compliance program. If a business unit is lagging, invite the managers to discuss their strategy for improvement. Our website offers resources that can help at http://www.oig.hhs.gov/compliance/compliance-guidance/compliance-resource-material.asp.
- Protect the compliance officer's independence by separating this role from your legal counsel and senior management. All decisions affecting the compliance officer's employment or limiting the scope of the compliance program should require prior board approval. If your compliance officer leaves, the audit committee should conduct an exit interview.
- Learn how quality, patient safety and compliance information flows to the board. Educate the board on the structure of the compliance program, and the organization's fraud and abuse risk areas. Publicize training so employees know the board considers compliance a priority.
- Ensure that your organization can validate the accuracy of its quality data. Federal program reimbursement is tied to quality of care. Accurate data is critical. Concealing unfavorable information or failing to investigate significant inconsistencies not only undercuts your quality improvement program; it can lead to criminal and civil liability.
- Talk to employees to learn how they see the organization's values and culture of compliance. Personal appearances by board members at staff meetings demonstrate a top-down commitment to quality and compliance.
- Perform regular self-assessments of your board and its committees. Evaluate the composition of your compliance, quality committees. Review the board's responses to systemic failures and lapses in patient care.

CORPORATE RESPONSIBILITY AND CORPORATE COMPLIANCE:

A Resource for Health Care Boards of Directors

THE OFFICE OF INSPECTOR GENERAL OF THE
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

AND

THE AMERICAN HEALTH LAWYERS ASSOCIATION

ACKNOWLEDGEMENT

This educational resource represents a unique collaboration between the American Health Lawyers Association and the Office of the Inspector General of the United States Department of Health and Human Services. This publication would have not been possible without the dedicated effort of numerous individuals at both organizations. It is intended to be a useful resource for those serving on the Boards of Directors of our nation's health care institutions.

I. INTRODUCTION

As corporate responsibility issues fill the headlines, corporate directors are coming under greater scrutiny. The Sarbanes-Oxley Act, state legislation, agency pronouncements, court cases and scholarly writings offer a myriad of rules, regulations, prohibitions, and interpretations in this area. While all Boards of Directors must address these issues, directors of health care organizations also have important responsibilities that need to be met relating to corporate compliance requirements unique to the health care industry. The expansion of health care regulatory enforcement and compliance activities and the heightened attention being given to the responsibilities of corporate directors are critically important to all health care organizations. In this context, enhanced oversight of corporate compliance programs is widely viewed as consistent with and essential to ongoing federal and state corporate responsibility initiatives.

Our complex health care system needs dedicated and knowledgeable directors at the helm of both for-profit and non-profit corporations. This educational resource, co-sponsored by the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services and the American Health Lawyers Association, the leading health law educational organization, seeks to assist directors of health care organizations in carrying out their important oversight responsibilities in the current challenging health care environment. Improving the knowledge base and effectiveness of those serving on health care organization boards will help to achieve the important goal of continuously improving the U.S. health care system.

Fiduciary Responsibilites

The fiduciary duties of directors reflect the expectation of corporate stakeholders regarding oversight of corporate affairs. The basic fiduciary duty of care principle, which requires a director to act in good faith with the care an ordinarily prudent person would exercise under similar circumstances, is being tested in the current corporate climate. Personal liability for directors, including removal, civil damages, and tax liability, as well as damage to reputation, appears not so far from reality as once widely believed. Accordingly, a basic understanding of the director's fiduciary obligations and how the duty of care may be exercised in overseeing the company's compliance systems has become essential.

Embedded within the duty of care is the concept of reasonable inquiry. In other words, directors should make inquiries to management to obtain information necessary to satisfy their duty of care. Although in the *Caremark* case, also discussed later in this educational resource, the court found that the Caremark board did not breach its fiduciary duty, the court's opinion also stated the following: "[A] director's obligation includes a duty to attempt in good faith to assure that a corporate information and reporting system, which the Board concludes is adequate, exists, and that failure to do so under some circumstances, may, in theory at least, render a director liable for losses caused by non-compliance with applicable legal standards." Clearly, the organization may be at risk and directors, under extreme circumstances, also may be at risk if they fail to reasonably oversee the organization's compliance program or act as mere passive recipients of information.

On the other hand, courts traditionally have been loath to second-guess Boards of Directors that have followed a careful and thoughtful process in their deliberations, even where ultimate outcomes for the corporation have been negative. Similarly, courts have consistently upheld the distinction between the duties of Boards of Directors and the duties of management. The responsibility of directors is to provide oversight, not manage day-to-day affairs. It is the process the Board follows in establishing that it had access to sufficient information and that it has asked appropriate questions that is most critical to meeting its duty of care.

Purpose of this Document

This educational resource is designed to help health care organization directors ask knowledgeable and appropriate questions related to health care corporate compliance. These questions are not intended to set forth any specific standard of care. Rather, this resource will help corporate directors to establish, and affirmatively demonstrate, that they have followed a reasonable compliance oversight process.

Of course, the circumstances of each organization differ and application of the duty of care and consequent reasonable inquiry will need to be tailored to each specific set of facts and circumstances. However, compliance with the fraud and abuse laws and other federal and state regulatory laws applicable to health care organizations is essential for the lawful behavior and corporate success of such organizations. While these laws can be complex, effective compliance is an asset for both the organization and the health care delivery system. It is hoped that this educational resource is useful to health care organization directors in exercising their oversight responsibilities and supports their ongoing efforts to promote effective corporate compliance.

II. Duty of Care

Of the principal fiduciary obligations/duties owed by directors to their corporations, the one duty specifically implicated by corporate compliance programs is the *duty of care.*[1]

As the name implies, the *duty of care* refers to the obligation of corporate directors to exercise the proper amount of care in their decision-making process. State statutes that create the duty of care and court cases that interpret it usually are identical for both for-profit and non-profit corporations.

In most states, duty of care involves determining whether the directors acted (1) in "good faith," (2) with that level of care that an ordinarily prudent person would exercise in like circumstances, and (3) in a manner that they reasonably believe is in the best interest of the corporation. In analyzing whether directors have complied with this duty, it is necessary to address each of these elements separately.

The "good faith" analysis usually focuses upon whether the matter or transaction at hand involves any improper financial benefit to an individual, and/or whether any intent exists to take advantage of the corporation (a corollary to the duty of loyalty). The "reasonable inquiry" test asks whether the directors conducted the appropriate level of due diligence to allow them to make an informed decision. In other words, directors must be aware of what is going on about them in the corporate business and must in appropriate circumstances make such reasonable inquiry, as would an ordinarily prudent person under similar circumstances. And, finally, directors are obligated to act in a manner that they reasonably believe to be in the best interests of the corporation. This normally relates to the directors' state of mind with respect to the issues at hand.

In considering directors' fiduciary obligations, it is important to recognize that the appropriate standard of care is not "perfection." Directors are *not* required to know everything about a topic they are asked to consider. They may, where justified, rely on the advice of management and of outside advisors.

Furthermore, many courts apply the "business judgment rule" to determine whether a director's duty of care has been met with respect to corporate decisions. The rule provides, in essence, that a director will not be held liable for a decision made in good faith, where the director is disinterested, reasonably informed under the circumstances, and rationally believes the decision to be in the best interest of the corporation.

Director obligations with respect to the duty of care arise in two distinct contexts:

- The *decision-making function*: The application of duty of care principles to a specific decision or a particular board action; and
- The *oversight function*: The application of duty of care principles with respect to the general activity of the board in overseeing the day-to-day business operations of the corporation; *i.e.*, the exercise of reasonable care to assure that corporate executives carry out their management responsibilities and comply with the law.

Directors' obligations with respect to corporate compliance programs arise within the context of that oversight function. The leading case in this area, viewed as applicable to all health care organizations, provides that a director has two principal obligations with respect to the oversight function. A director has a duty to attempt in good faith to assure that (1) a corporate information and reporting system exists, and (2) this reporting system is adequate to assure the board that appropriate information as to compliance with applicable laws will come to its attention in a timely manner as a matter of ordinary operations.[2] In *Caremark,* the court addressed the circumstances in which corporate directors may be held liable for breach of the duty of care by failing to adequately supervise corporate employees whose misconduct caused the corporation to violate the law.

In its opinion, the *Caremark* court observed that the level of detail that is appropriate for such an information system is a matter of business judgment. The court also acknowledged that no rationally designed information and reporting system will remove the possibility that the corporation will violate applicable laws or otherwise fail to identify corporate acts potentially inconsistent with relevant law.

Under these circumstances, a director's failure to reasonably oversee the implementation of a compliance program may put the organization at risk and, under extraordinary circumstances, expose individual directors to personal liability for losses caused by the corporate non-

1 The other two core fiduciary duty principals are the duty of loyalty and the duty of obedience to purpose.

2 *In re Caremark International Inc. Derivative Litigation,* 698 A.2d 959 (Del. Ch. 1996). A shareholder sued the Board of Directors of Caremark for breach of the fiduciary duty of care. The lawsuit followed a multi-million dollar civil settlement and criminal plea relating to the payment of kickbacks to physicians and improper billing to federal health care programs.

compliance.[3] Of course, crucial to the oversight function is the fundamental principle that a director is entitled to rely, in good faith, on officers and employees as well as corporate professional experts/advisors in whom the director believes such confidence is merited. A director, however, may be viewed as not acting in good faith if he/she is aware of facts suggesting that such reliance is unwarranted.

In addition, the duty of care test involving reasonable inquiry has not been interpreted to require the director to exercise "proactive vigilance" or to "ferret out" corporate wrongdoing absent a particular warning or a "red flag." Rather, the duty to make reasonable inquiry increases when "suspicions are aroused or *should be aroused;"* that is, when the director is presented with extraordinary facts or circumstances of a material nature (*e.g.,* indications of financial improprieties, self-dealing, or fraud) or a major governmental investigation. Absent the presence of suspicious conduct or events, directors are entitled to rely on the senior leadership team in the performance of its duties. Directors are not otherwise obligated to anticipate future problems of the corporation.

Thus, in exercising his/her duty of care, the director is obligated to exercise general supervision and control with respect to corporate officers. However, once presented (through the compliance program or otherwise) with information that causes (or should cause) concerns to be aroused, the director is then obligated to make further inquiry until such time as his/her concerns are satisfactorily addressed and favorably resolved. Thus, while the corporate director is not expected to serve as a compliance officer, he/she is expected to oversee senior management's operation of the compliance program.

III. The Unique Challenges of Health Care Organization Directors

The health care industry operates in a heavily regulated environment with a variety of identifiable risk areas. An effective compliance program helps mitigate those risks. In addition to the challenges associated with patient care, health care providers are subject to voluminous and sometimes complex sets of rules governing the coverage and reimbursement of medical services. Because federal and state-sponsored health care programs play such a significant role in paying for health care, material non-compliance with these rules can present substantial risks to the health care provider. In addition to recoupment of improper payments, the Medicare, Medicaid and other government health care programs can impose a range of sanctions against health care businesses that engage in fraudulent practices.

Particularly given the current "corporate responsibility" environment, health care organization directors should be concerned with the manner in which they carry out their duty to oversee corporate compliance programs. Depending upon the nature of the corporation, there are a variety of parties that might in extreme circumstances seek to hold corporate directors personally liable for allegedly breaching the duty of oversight with respect to corporate compliance. With respect to for-profit corporations, the most likely individuals to bring a case against the directors are corporate shareholders in a derivative suit, or to a limited degree, a regulatory agency such as the Securities and Exchange Commission. With respect to non-profit corporations, the most likely person to initiate such action is the state attorney general, who may seek equitable relief against the director (*e.g.,* removal) or damages. It is also possible (depending upon state law) that a dissenting director, or the corporate member, could assert a derivative-type action against the directors allegedly responsible for the "inattention," seeking removal or damages.

Over the last decade, the risks associated with non-compliance have grown dramatically. The government has dedicated substantial resources, including the addition of criminal investigators and prosecutors, to respond to health care fraud and abuse. In addition to government investigators and auditors, private whistleblowers play an important role in identifying allegedly fraudulent billing schemes and other abusive practices. Health care providers can be found liable for submitting claims for reimbursement in reckless disregard or deliberate ignorance of the truth, as well as for intentional fraud. Because the False Claims Act authorizes the imposition of damages of up to three times the amount of the fraud and civil monetary penalties of $11,000 per false claim, record level fines and penalties have been imposed against individuals and health care organizations that have violated the law.

In addition to criminal and civil monetary penalties, health care providers that are found to have defrauded the federal health care programs may be excluded from participation in these programs. The effect of an exclusion can be profound because those excluded will not

3 Law is not static, and different states will have different legal developments and standards. Standards may also vary depending on whether an entity is for profit or non-profit. Boards of public health care entities may have additional statutory obligations and should be aware of state and federal statutory requirements applicable to them.

receive payment under Medicare, Medicaid or other federal health care programs for items or services provided to program beneficiaries. The authorities of the OIG provide for mandatory exclusion for a minimum of five years for a conviction with respect to the delivery of a health care item or service. The presence of aggravating circumstances in a case can lead to a lengthier period of exclusion. Of perhaps equal concern to board members, the OIG also has the discretion to exclude providers for certain conduct even absent a criminal conviction. Such conduct includes participation in a fraud scheme, the payment or receipt of kickbacks, and failing to provide services of a quality that meets professionally recognized standards. In lieu of imposing exclusion in these instances, the OIG may require an organization to implement a comprehensive compliance program, requiring independent audits, OIG oversight and annual reporting requirements, commonly referred to as a Corporate Integrity Agreement.

IV. The Development of Compliance Programs

In light of the substantial adverse consequences that may befall an organization that has been found to have committed health care fraud, the health care industry has embraced efforts to improve compliance with federal and state health care program requirements. As a result, many health care providers have developed active compliance programs tailored to their particular circumstances. A recent survey by the Health Care Compliance Association, for example, has found that in just three years, health care organizations with active compliance programs have grown from 55 percent in 1999 to 87 percent in 2002. In support of these efforts, the OIG has developed a series of provider-specific compliance guidances. These voluntary guidelines identify risk areas and offer concrete suggestions to improve and enhance an organization's internal controls so that its billing practices and other business arrangements are in compliance with Medicare's rules and regulations.

As compliance programs have matured and new challenges have been identified, health care organization boards of directors have sought ways to help their organization's compliance program accomplish its objectives. Although health care organization directors may come from diverse backgrounds and business experiences, an individual director can make a valuable contribution toward the compliance objective by asking practical questions of management and contributing his/her experiences from other industries. While the opinion in *Caremark* established a Board's duty to oversee a compliance program, it did not enumerate a specific methodology for doing so. It is therefore important that directors participate in the development of this process. This educational resource is designed to assist health care organization directors in exercising that responsibility.

V. Suggested Questions for Directors

Periodic consideration of the following questions and commentary may be helpful to a health care organization's Board of Directors. The structural questions explore the Board's understanding of the scope of the organization's compliance program. The remaining questions, addressing operational issues, are directed to the operations of the compliance program and may facilitate the Board's understanding of the vitality of its compliance program.

STRUCTURAL QUESTIONS

1. **How is the compliance program structured and who are the key employees responsible for its implementation and operation? How is the Board structured to oversee compliance issues?**

The success of a compliance program relies upon assigning high-level personnel to oversee its implementation and operations. The Board may wish as well to establish a committee or other subset of the Board to monitor compliance program operations and regularly report to the Board.

2. **How does the organization's compliance reporting system work? How frequently does the Board receive reports about compliance issues?**

Although the frequency of reports on the status of the compliance program will depend on many circumstances, health care organization Boards should receive reports on a regular basis. Issues that are frequently addressed include (1) what the organization has done in the past with respect to the program and (2) what steps are planned for the future and why those steps are being taken.

3. **What are the goals of the organization's compliance program? What are the inherent limitations in the compliance program? How does the organization address these limitations?**

The adoption of a corporate compliance program by an organization creates standards and processes that it should be able to rely upon and against which it may be held accountable. A solid understanding of the rationale and objectives of the compliance program, as well as its goals and inherent limitations, is essential if the Board is to evaluate the reasonableness of its design and the effectiveness of its operation. If the Board has unrealistic expectations of its compliance program, it may place undue reliance

on its ability to detect vulnerabilities. Furthermore, compliance programs will not prevent all wrongful conduct and the Board should be satisfied that there are mechanisms to ensure timely reporting of suspected violations and to evaluate and implement remedial measures.

4. **Does the compliance program address the significant risks of the organization? How were those risks determined and how are new compliance risks identified and incorporated into the program?**

Health care organizations operate in a highly regulated industry and must address various standards, government program conditions of participation and reimbursement, and other standards applicable to corporate citizens irrespective of industry. A comprehensive ongoing process of compliance risk assessment is important to the Board's awareness of new challenges to the organization and its evaluation of management's priorities and program resource allocation.

5. **What will be the level of resources necessary to implement the compliance program as envisioned by the Board? How has management determined the adequacy of the resources dedicated to implementing and sustaining the compliance program?**

From the outset, it is important to have a realistic understanding of the resources necessary to implement and sustain the compliance program as adopted by the Board. The initial investment in establishing a compliance infrastructure and training the organization's employees can be significant. With the adoption of a compliance program, the organization is making a long term commitment of resources because effective compliance systems are not static programs but instead embrace continuous improvement. Quantifying the organization's investment in compliance efforts gives the Board the ability to consider the feasibility of implementation plans against compliance program goals. Such investment may include annual budgetary commitments as well as direct and indirect human resources dedicated to compliance. To help ensure that the organization is realizing a return on its compliance investment, the Board also should consider how management intends to measure the effectiveness of its compliance program. One measure of effectiveness may be the Board's heightened sensitivity to compliance risk areas.

OPERATIONAL QUESTIONS

The following questions are suggested to assist the Board in its periodic evaluation of the effectiveness of the organization's compliance program and the sufficiency of its reporting systems.

A. Code of Conduct

How has the Code of Conduct or its equivalent been incorporated into corporate policies across the organization? How do we know that the Code is understood and accepted across the organization? Has management taken affirmative steps to publicize the importance of the Code to all of its employees?

Regardless of its title, a Code of Conduct is fundamental to a successful compliance program because it articulates the organization's commitment to ethical behavior. The Code should function in the same way as a constitution, *i.e.*, as a document that details the fundamental principles, values, and framework for action within the organization. The Code of Conduct helps define the organization's culture; all relevant operating policies are derivative of its principles. As such, codes are of real benefit only if meaningfully communicated and accepted throughout the organization.

B. Policies and Procedures

Has the organization implemented policies and procedures that address compliance risk areas and established internal controls to counter those vulnerabilities?

If the Code of Conduct reflects the organization's ethical philosophy, then its policies and procedures represent the organization's response to the day-to-day risks that it confronts while operating in the current health care system. These policies and procedures help reduce the prospect of erroneous claims, as well as fraudulent activity by identifying and responding to risk areas. Because compliance risk areas evolve with the changing reimbursement rules and enforcement climate, the organization's policies and procedures also need periodic review and, where appropriate, revision.[4] Regular consultation with counsel, including reports to the Board, can assist the Board in its oversight responsibilities in this changing environment.

4 There are a variety of materials available to assist health care organizations in this regard. For example, both sponsoring organizations of this educational resource offer various materials and guidance, accessible through their web sites.

C. Compliance Infrastructure

1. **Does the Compliance Officer have sufficient authority to implement the compliance program? Has management provided the Compliance Officer with the autonomy and sufficient resources necessary to perform assessments and respond appropriately to misconduct?**

Designating and delegating appropriate authority to a compliance officer is essential to the success of the organization's compliance program. For example, the Compliance Officer must have the authority to review all documents and other information that are relevant to compliance activities. Boards should ensure that lines of reporting within management and to the Board, and from the Compliance Officer and consultants, are sufficient to ensure timely and candid reports for those responsible for the compliance program. In addition, the Compliance Officer must have sufficient personnel and financial resources to implement fully all aspects of the compliance program.

2. **Have compliance-related responsibilities been assigned across the appropriate levels of the organization? Are employees held accountable for meeting these compliance-related objectives during performance reviews?**

The successful implementation of a compliance program requires the distribution throughout the organization of compliance-related responsibilities. The Board should satisfy itself that management has developed a system that establishes accountability for proper implementation of the compliance program. The experience of many organizations is that program implementation lags where there is poor distribution of responsibility, authority and accountability beyond the Compliance Officer.

D. Measures to Prevent Violations

1. **What is the scope of compliance-related education and training across the organization? Has the effectiveness of such training been assessed? What policies/measures have been developed to enforce training requirements and to provide remedial training as warranted?**

A critical element of an effective compliance program is a system of effective organization-wide training on compliance standards and procedures. In addition, there should be specific training on identified risk areas, such as claims development and submission, and marketing practices. Because it can represent a significant commitment of resources, the Board should understand the scope and effectiveness of the educational program to assess the return on that investment.

2. **How is the Board kept apprised of significant regulatory and industry developments affecting the organization's risk? How is the compliance program structured to address such risks?**

The Board's oversight of its compliance program occurs in the context of significant regulatory and industry developments that impact the organization not only as a health care organization but more broadly as a corporate entity. Without such information, it cannot reasonably assess the steps being taken by management to mitigate such risks and reasonably rely on management's judgment.

3. **How are "at risk" operations assessed from a compliance perspective? Is conformance with the organization's compliance program periodically evaluated? Does the organization periodically evaluate the effectiveness of the compliance program?**

Compliance risk is further mitigated through internal review processes. Monitoring and auditing provide early identification of program or operational weaknesses and may substantially reduce exposure to government or whistleblower claims. Although many assessment techniques are available, one effective tool is the performance of regular, periodic compliance audits by internal or external auditors. In addition to evaluating the organization's conformance with reimbursement or other regulatory rules, or the legality of its business arrangements, an effective compliance program periodically reviews whether the compliance program's elements have been satisfied.

4. **What processes are in place to ensure that appropriate remedial measures are taken in response to identified weaknesses?**

Responding appropriately to deficiencies or suspected non-compliance is essential. Failure to comply with the organization's compliance program, or violation of applicable laws and other types of misconduct, can threaten the organization's status as a reliable and trustworthy provider of health care. Moreover, failure to respond to a known deficiency may be considered an aggravating circumstance in evaluating the organization's potential liability for the underlying problem.

E. Measures to Respond to Violations

1. What is the process by which the organization evaluates and responds to suspected compliance violations? How are reporting systems, such as the compliance hotline, monitored to verify appropriate resolution of reported matters?

Compliance issues may range from simple overpayments to be returned to the payor to possible criminal violations. The Board's duty of care requires that it explore whether procedures are in place to respond to credible allegations of misconduct and whether management promptly initiates corrective measures. Many organizations take disciplinary actions when a responsible employee's conduct violates the organization's Code of Conduct and policies. Disciplinary measures should be enforced consistently.

2. Does the organization have policies that address the appropriate protection of "whistleblowers" and those accused of misconduct?

For a compliance program to work, employees must be able to ask questions and report problems. In its fulfillment of its duty of care, the Board should determine that the organization has a process in place to encourage such constructive communication.

3. What is the process by which the organization evaluates and responds to suspected compliance violations? What policies address the protection of employees and the preservation of relevant documents and information?

Legal risk may exist based not only on the conduct under scrutiny, but also on the actions taken by the organization in response to the investigation. In addition to a potential obstruction of a government investigation, the organization may face charges by employees that it has unlawfully retaliated or otherwise violated employee rights. It is important, therefore, that organizations respond appropriately to a suspected compliance violation and, more critically, to a government investigation without damaging the corporation or the individuals involved. The Board should confirm that processes and policies for such responses have been developed in consultation with legal counsel and are well communicated and understood across the organization.

4. What guidelines have been established for reporting compliance violations to the Board?

As discussed, the Board should fully understand management's process for evaluating and responding to identified violations of the organization's policies, as well as applicable federal and state laws. In addition, the Board should receive sufficient information to evaluate the appropriateness of the organization's response.

5. What policies govern the reporting to government authorities of probable violations of law?

Different organizations will have various policies for investigating probable violations of law. Federal law encourages organizations to self-disclose wrongdoing to the federal government. Health care organizations and their counsel have taken varied approaches to making such disclosures. Boards may want to inquire as to whether the organization has developed a policy on when to consider such disclosures.

VI. Conclusion

The corporate director, whether voluntary or compensated, is a bedrock of the health care delivery system. The oversight activities provided by the director help form the corporate vision, and at the same time promote an environment of corporate responsibility that protects the mission of the corporation and the health care consumers it serves.

Even in this "corporate responsibility" environment, the health care corporate director who is mindful of his/her fundamental duties and obligations, and sensitive to the premises of corporate responsibility, should be confident in the knowledge that he/she can pursue governance service without needless concern about personal liability for breach of fiduciary duty and without creating an adversarial relationship with management.

The perspectives shared in this educational resource are intended to assist the health care director in performing the important and necessary service of oversight of the corporate compliance program. In so doing, it is hoped that fiduciary service will appear less daunting, and provide a greater opportunity to "make a difference" in the delivery of health care.

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Corporate Responsibility and Health Care Quality:

A Resource for Health Care Boards of Directors

United States Department of Health and Human Services
Office of Inspector General

American Health Lawyers Association

Corporate Responsibility and Health Care Quality:

A Resource for Health Care Boards of Directors

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I. Introduction

This educational resource is the third in a series of co-sponsored documents by the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services and the American Health Lawyers Association (AHLA), the leading health law educational organization.[1] It seeks to assist directors of health care organizations in carrying out their important oversight responsibilities in the current challenging health care environment. Improving the knowledge base and effectiveness of those serving on health care organization boards will help to achieve the important goal of continuously improving the U.S. health care system.

The prior publications in this series addressed the unique fiduciary responsibilities of directors of health care organizations in the corporate compliance context. With a new era of focus on quality and patient safety rapidly emerging, oversight of quality also is becoming more clearly recognized as a core fiduciary responsibility of health care organization directors. Health care organization boards have distinct responsibilities in this area because promoting quality of care and preserving patient safety are at the core of the health care industry and the reputation of each health care organization. The heightened attention being given to health care quality measurement and reporting obligations also increasingly impacts the responsibilities of corporate directors. Indeed, quality is also emerging as an enforcement priority for health care regulators.

The fiduciary duties of directors reflect the expectations of corporate stakeholders regarding oversight of corporate affairs. The basic fiduciary duty of care principle, which requires a director to act in good faith with the care an ordinarily prudent person would exercise under similar circumstances, is being tested in the current corporate climate. Embedded within the duty of care is the concept of reasonable inquiry. In other words, directors are expected to make inquiries to management to obtain the information necessary to satisfy their duty of care.

This educational resource is designed to help health care organization directors ask knowledgeable and appropriate questions related to health care quality requirements, measurement tools, and reporting requirements. The questions raised in this document are not intended to set forth any specific standard of care, nor to foreclose arguments for a change in judicial interpretation of the law or resolution of any conflicts in interpretation among various courts. Rather, this resource will help corporate directors establish, and affirmatively demonstrate, that they have followed a reasonable quality oversight process.

Of course, the circumstances of each organization differ and application of the duty of care and consequent

1 The other two co-sponsored documents in the series are *Corporate Responsibility and Corporate Compliance: A Resource for Health Care Boards of Directors,* The Office of Inspector General of the U.S. Department of Health and Human Services and The American Health Lawyers Association, 2003; and *An Integrated Approach to Corporate Compliance: A Resource for Health Care Organization Boards of Directors,* The Office of Inspector General of the U.S. Department of Health and Human Services and The American Health Lawyers Association, 2004.

reasonable inquiry by boards will need to be tailored to each specific set of facts and circumstances. However, compliance with standards and regulations applicable to the quality of services delivered by health care organizations is essential for the lawful behavior and corporate success of such organizations. While these evolving requirements can be complex, effective compliance in the quality arena is an asset for both the organization and the health care delivery system. It is hoped that this educational resource is useful to health care organization directors in exercising their oversight responsibilities and supports their ongoing efforts to promote effective corporate compliance as it relates to health care quality.

II. Board Fiduciary Duty and Quality in the Health Care Setting

Governing boards of health care organizations increasingly are called to respond to important new developments—clinical, operational and regulatory—associated with quality of care. Important new policy issues are arising with respect to how quality of care affects matters of reimbursement and payment, efficiency, cost controls, collaboration between organizational providers and individual and group practitioners. These new issues are so critical to the operation of health care organizations that they require attention and oversight, as a matter of fiduciary obligation, by the governing board.

This oversight obligation is based upon the application of the fiduciary duty of care board members owe the organization and, for non-profit organizations, the duty of obedience to charitable mission. It is additive to the traditional duty of board members in the hospital setting to be responsible for granting, restricting and revoking privileges of membership in the organized medical staff.

Duty of Care

The traditional and well-recognized duty of care refers to the obligation of corporate directors to exercise the proper amount of care in their decision-making process. State corporation laws, as well as the common law, typically interpret the duty of care in an almost identical manner, whether the organization is non-profit or for-profit.

In most jurisdictions, the duty of care requires directors to act (1) in "good faith," (2) with the care an ordinarily prudent person would exercise in like circumstances, and (3) in a manner that they reasonably believe to be in the best interests of the corporation.[2] In analyzing compliance with the duty of care, courts typically address each of these elements individually. In addition, in recent years, the duty of care has taken on a richer meaning, requiring directors to actively inquire into aspects of corporate operations where appropriate – the "reasonable inquiry" standard.

Thus, the "good faith" analysis normally focuses upon whether the matter or transaction at hand involves any improper financial benefit to an individual and/or whether any intent exists to take advantage of the corporation. The "prudent person" analysis focuses upon whether directors conducted the appropriate level of due diligence to allow them to render an informed decision. In other words, directors are expected to be aware of what is going on around them in the corporate business and must in appropriate circumstances make such reasonable inquiry as would an ordinarily prudent person under similar circumstances. The final criterion focuses on whether directors act in a manner that they reasonably believe to be in the best interests of the corporation. In this regard, courts typically evaluate the board member's state of mind with respect to the issues at hand.

When evaluating the fiduciary obligations of board members, it is important to recognize that "perfection" is not the required standard of care. Directors are not required to know everything about a topic they are asked to consider. They may, where justified, rely on the advice of executive leadership and outside advisors.

In addition, many courts apply the "business judgment rule" to determine whether a director's duty of care has been met with respect to corporate decisions. The rule provides, in essence, that a director will not be held liable for a decision made in good faith, where the director is disinterested, reasonably informed under the circumstances, and rationally believes the decision to be in the best interests of the corporation. In other words, courts will not "second guess" the board members' decision when these criteria are met.

Director obligations with respect to quality of care may arise in two distinct contexts:

- *The Decision-Making Function:* The application of duty of care principles as to a specific decision or a particular board action, and
- *The Oversight Function:* The application of duty of care principles with respect to the general activity of the board in overseeing the operations of the corporation (i.e., acting in good faith to assure that a reasonable information and reporting system exists).[3]

Board members' obligations with respect to supervising medical staff credentialing decisions arise within the context of the decision-making

2 American Bar Association, Section of Business Law, Revised Model Nonprofit Corporation Act, Section 8.30 (1987).
3 *In re* Caremark International Inc. Derivative Litigation, 698 A.2d 959 (Del. Ch. 1996).

function. These are discrete decisions periodically made by the board and relate to specific recommendations and a particular process.

The emerging quality of care issues discussed in this resource arise in the context of the oversight function—the obligation of the director to "keep a finger on the pulse" of the activities of the organization.

The basic governance obligation to guide and support executive leadership in the maintenance of quality of care and patient safety is an ongoing task. Board members are increasingly expected to assess organizational performance on emerging quality of care concepts and arrangements as they implicate issues of patient safety, appropriate levels of care, cost reduction, reimbursement, and collaboration among providers and practitioners. These are all components of the oversight function.

This duty of care with respect to quality of care also is implicated by the related duty to oversee the compliance program.[4] Many new financial relationships address quality of care issues, including pay-for-performance programs, gainsharing, and outcomes management arrangements, among others. State and federal law closely regulate many of these arrangements. Given that directors have an obligation to assure that the organization has an "effective" compliance program in place to detect and deter legal violations, they may fairly be regarded as having a concomitant duty to make reasonable inquiry regarding the emerging legal and compliance issues associated with quality of care initiatives, and to direct executive leadership to address those issues. The board may direct executive staff to provide periodic briefings to the board with respect to quality of care developments so that the directors may establish a proper "tone at the top" in terms of related legal compliance. In other words, it is the role of the executive staff to brief the board concerning new developments in the law and related legal implications, and it should be the ongoing obligation of the board to reasonably inquire whether the organization's compliance program and other legal control mechanisms are in place to monitor the associated legal risks.

Duty of Obedience to Corporate Purpose and Mission

Oversight obligations with respect to quality of care initiatives also arise—for non-profit boards—in the context of what is generally referred to as the fiduciary duty of obedience to the corporate purpose and mission[5] of health care organizations. Non-profit corporations are formed to achieve a specific goal or objective (e.g., the promotion of health), as recognized under state non-profit corporation laws. This is in contrast to the typical business corporation, which often is formed to pursue a general corporate purpose. It is often said of non-profits that "the means and the mission are inseparable."[6]

The fundamental nature of the duty of obedience to corporate purpose is that the non-profit director is charged with the obligation to further the purposes of the organization as set forth in its articles of incorporation or bylaws.[7] For example, the articles of incorporation of a non-profit health care provider might describe its principal purpose as "the promotion of health through the provision of inpatient and outpatient hospital and health care services to residents in the community." Given that the board is responsible for reasonably inquiring whether there are practices in place to address the quality of patient care, it is fair to state that the concept of quality of care is inseparable from, and is essentially subsumed by, the mission of the organization.

In the hospital setting, various provisions of the law dealing with the relationship to the medical staff also provide a link to the duty of obedience to corporate purpose. These include, for example, traditional provisions that confirm the responsibility of the board for (a) the conduct of the hospital as an institution, (b) ensuring that the medical staff is accountable to the governing board for the quality of care provided to patients, and (c) the maintenance of standards of professional care within the facility and requiring that the medical staff function competently. The "duty of obedience" concept with respect to assuring compliance with law also might be considered to incorporate a duty to assure compliance with those state laws (and perhaps accreditation principles as well) that require the governing board to assume ultimate responsibility for organizational performance, which includes the quality of the provider's medical care.

Summary

In exercising his/her duty of care (and, as appropriate, duty of obedience to corporate purpose and mission), the governing board member may be expected to exercise general supervision and oversight of quality of care and patient safety issues. This is likely to include (a) being sensitive to the emergence of quality of care issues, challenges and opportunities, (b) being attentive to the development of

4 *Id.*
5 In some states, this duty is subsumed within the definition of the broader duty of loyalty.
6 Daniel L. Kurtz, Board Liability: Guide for Nonprofit Directors 84 (Moyer Bell Limited, New York, 1988), citing Commonwealth of Pennsylvania v. The Barnes Foundation, 398 Pa. 458, 159 A.2d 500, 505 (1960); *In re* Manhattan Eye, Ear & Throat Hosp., 715 N.Y.S.2d 575 (1999).
7 Kurtz, supra.

specific quality of care measurement and reporting requirements (including asking the executive staff for periodic education), and (c) requesting periodic updates from the executive staff on organizational quality of care initiatives and how the organization intends to address legal issues associated with those initiatives. Board members are expected to make reasonable further inquiry when concerns are aroused or should be aroused. These expectations increasingly are becoming more significant with the increased attention to quality of care issues from policy makers, providers and practitioners, payors and regulators. Board members must be, and must be perceived as, responsive to this changing environment.

III. Defining Quality of Care and the Critical Need to Implement Quality Initiatives

> "The American health care delivery system is in need of fundamental change. Many patients, doctors, nurses and health care leaders are concerned that the care delivered is not, essentially, the care we should receive … Quality problems are everywhere affecting many patients. Between the healthcare we have and the care we could have lies not just a gap, but a chasm."[8]

In *Crossing the Quality Chasm*, the Institute of Medicine (IOM) provided a six-part definition of health care quality that some view as the emerging standard. According to the IOM, health care should be: *safe* – avoiding injuries to patients from the care that is intended to help them; *effective* – providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively); *patient-centered* – providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions; *timely* – reducing waits and sometimes harmful delays for both those who receive and those who give care; *efficient* – avoiding waste, including waste of equipment, supplies, ideas, and energy; and *equitable* – providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socio-economic status.[9] Because this definition of quality increasingly is being adopted by payors, providers and regulators, health care organizations and their boards will need to be mindful of its implications.

The U.S. health care system is at a challenging point in its history. It is, for many important historical reasons, a mixed public-private system, and there is no foreseeable dynamic on the horizon suggesting a major change to this reality. The health care system also arguably is driving the U.S. economy. A recent federal forecast predicts that over the next decade, U.S. health care spending will double from today's level to $4.1 trillion and will represent 20% of the gross domestic product.[10] We have a health care system that is extraordinarily advanced, yet is inefficient, uneven and too often unsafe. A consensus is forming that improvement in the system will require better collaboration and cooperation among independent providers, payors and purchasers, more integrated care and better aligned incentives. Such collaboration and cooperation inevitably will raise legal compliance issues that health care organization boards of directors will need to understand in exercising their oversight function.

A scorecard on the U.S. health care system developed by the Commonwealth Fund in 2006 showed the following results, among others:[11]

- For 37 key indicators for five health care system dimensions (quality, access, equity, outcomes and efficiencies), the overall U.S. score was 66 out of a possible 100.
- Efficiency was the single worst score among the five dimensions. For example, in 2000/2001, the U.S. ranked 16th out of 20 countries in use of electronic health records.
- The U.S. is the worldwide leader in costs.
- The U.S. scored 15th out of 19 countries in mortality attributable to health care services.
- Basic tools (*i.e.*, Health IT) are missing to track patients through their lives.
- We do poorly at transition stages —hospital readmission rates from nursing homes are high; our reimbursement system encourages "churning."
- Improving performance in key areas would save 100,000 to 150,000 lives and $50 billion to $100 billion annually.

The report makes several key recommendations. The U.S. should expand health insurance coverage; implement major quality and safety improvements; work toward a more organized delivery system that emphasizes primary and preventive care that is patient-centered; increase transparency and reporting on quality and costs; reward performance

8 *Crossing the Quality Chasm*, Institute of Medicine, 2001, p.1
9 *Id.* at 6.
10 "Health Care Spending Projected to Pass $4 Trillion Mark by 2016," *Health Affairs*, February 21, 2007.
11 The Commonwealth Fund Commission on a High Performance Health System, "Why Not the Best? Results from a National Scorecard on U.S. Health System Performance," The Commonwealth Fund, September 2006.

for quality and efficiency; expand the use of interoperable information technology; and encourage collaboration among stakeholders.

In a similar vein, the IOM recently stated in one of several follow-up reports to *Crossing the Quality Chasm* that the Medicare payment system does not reward efficiency and provides few disincentives for overuse, underuse or misuse of care.[12] Furthermore, the IOM proposed that incentives should encourage delivery of high-quality care efficiently, require providers to assume shared accountability for transitions between care settings and require coordination of care for patients with chronic disease.

We are entering a new era of thinking about health care quality and collaboration among health care providers. Numerous new measures of health care quality are becoming public every day. Purchasers, payors, state governments, the Joint Commission and others are requiring reporting, particularly by hospitals, of outcomes pursuant to such measures. Pay-for-performance programs are becoming common among both public and private payors. A new generation of "gainsharing" proposals and demonstrations are emerging.[13] In late February 2007, HHS Secretary Leavitt unveiled a new quality-improvement plan, called "Value Exchanges," that would establish local quality-improvement collaborations with an eye toward a national link-up in a few years.[14] All of this puts increasing focus and scrutiny on health care organizations, and their boards of directors, in connection with the quality issue.

Indeed, the National Quality Forum, perhaps the most well known source of nationally approved quality measures, has issued a paper entitled "Hospital Governing Boards and Quality of Care: A Call to Responsibility."[15]

Perhaps one of the most critical—and often misunderstood—components of health care quality is the relationship between overall quality and cost efficiency. Increasingly, it is becoming more widely understood that quality and efficiency are complementary, not contradictory, elements of an effective health care system. Efficiency, by definition, means avoidance of unnecessary, and often harmful, care. As Don Berwick, a recognized national quality expert, stated in *Health Affairs* in 2005: "Right from the start it has been one of the great illusions in the reign of quality that quality and cost go in opposite directions. There remains very little evidence of that."[16]

Because it is coming from the federal government, state government and private purchasers and payors, the emphasis on collaborative arrangements and cooperation in care giving across independent providers, aggregate payment pools and aligned incentives will require providers to look for legal ways to collaborate and, indeed, align incentives through new financial relationships. In particular, innovative hospital-physician financial relationships, including a variety of formal and informal partnering arrangements, are critical to the achievement of all six of the aims set forth in *Crossing the Quality Chasm*. Examples include pay-for-performance demonstrations, gainsharing initiatives, electronic health record implementation efforts, outpatient care centers, service line joint ventures and management and leasing arrangements.

Evidence-based medicine reasonably can define proper use and increasingly is relied upon to do so. It is expected that the public sector will continue to seek to balance its role as both purchaser and regulator in the search for quality improvement in health care. The private sector at times may have to initiate change before the payment system and regulations catch up, but the rewards are potentially very high—in terms of organizational success as well as social benefit. At the same time, however, legal compliance issues likely will arise in connection with efforts to implement these changes. Health care organizations, with oversight by their boards of directors, will be required in this regard to be mindful of the anti-kickback statute, the physician self-referral (Stark) law, civil money penalty statutes, the Health Insurance Portability and Accountability Act (HIPAA), federal tax-exemption standards and antitrust law, among other legal areas.

There is an opportunity for the best performers in the industry to create profound change—and then open up these best practices through transparency of data and the promotion of collaboration to spread change. Health care boards of directors have the unique opportunity to take leadership in implementing quality systems that will advance their organizations' respective missions and the nation's health. They also have the responsibility to do so in a legally compliant manner.

12 *Rewarding Provider Performance: Aligning Incentives in Medicine*, Institute of Medicine, 2007.
13 OIG reviews gainsharing and pay-for-performance programs on a case-by-case basis, and CMS' position on applicability of the Stark Law to such programs is still evolving.
14 Press Release, U.S. Department of Health & Human Services, HHS Secretary Leavitt Unveils Plan for "Value Exchanges" to Report on Health Care Quality and Cost at Local Level (February 28, 2007).
15 "Hospital Governing Boards and Quality of Care: A Call to Responsibility," The National Quality Forum, December 2, 2004.
16 Robert Galvin, "'A Deficiency of Will and Ambition': A Conversation with Donald Berwick," *Health Affairs Web Exclusive*, January 12, 2005.

IV. The Government's Role in Enforcing Health Care Quality

An extensive federal and state regulatory scheme governs the care delivered by health care providers. Designed to promote quality of care, these standards provide a baseline for assessing the level of care provided to the patient and, as discussed previously, increasingly determine the health care provider's reimbursement. For example, Medicare and Medicaid conditions of participation require hospitals to monitor quality through credentialing of medical staff and maintaining effective quality assessment and performance improvement programs. These conditions of participation specify that the medical staff is accountable to a hospital's governing body for the quality of care provided to patients. Long-term care providers must meet specific quality of care standards, undergo state surveys, and pass state certifications to participate in government programs. The regulatory framework includes a range of progressive administrative sanctions, including heightened oversight and monetary penalties that may be imposed against providers that fail to comply with the regulatory requirements.

In addition to these administrative remedies, the government enforcement authorities are increasingly focusing on the quality of care provided to beneficiaries of the federal health care programs. The OIG, the U.S. Department of Justice, and state Attorneys General are working collaboratively with the health care regulatory agencies to address the provision of substandard care by individuals and institutions. Sanctions may range from monetary penalties to exclusion from federal and state health care programs and even incarceration for the most serious offenses. For example, a health care provider can be subject to exclusion from the federal health care programs if it provides medically unnecessary services or services that fail to meet professionally recognized standards of care. Even individuals who are not direct care providers, such as hospital administrators and nursing home owners, may be subject to exclusion if they cause others to provide substandard care. Consequently, all levels of a health care organization, from the direct caregiver to the governing body of an institutional provider, could face liability for failing to meet the quality of care obligations applicable to government program providers.

As part of these enforcement efforts, authorities are closely evaluating quality-reporting data. For example, government authorities are increasingly scrutinizing quality data submitted by health care providers to identify inconsistencies and evidence of ongoing quality problems that providers fail to address. Sources of quality-reporting data include, for example, the hospital quality data for the annual payment updates, physician quality-reporting data reported to CMS, medical error and "sentinel event" data reported to the Joint Commission, and quality reporting required under state law. The accuracy of the data submitted to government agencies and third party payors is vital. In addition to relying on such information for monitoring quality and patient safety issues, the federal health care programs increasingly use this data for determining reimbursement, as in the case of the Minimum Data Set in the nursing home setting. Consequently, inaccurate reporting of quality data could result in the misrepresentation of the status of patients and residents, the submission of false claims, and potential enforcement action. As authorities continue to scrutinize quality-reporting data, boards will benefit from ensuring that structures and processes exist within their institution to carefully review this data for accuracy and address potential quality of care issues.

To evaluate the potential risk to the organization, it is important that board members understand the theories of liability relied upon by the government. The predominant criminal and civil fraud theories—medically unnecessary services and "failure of care"—rely on the submission of a claim for reimbursement to the government to establish jurisdiction over the provider. Medicare and Medicaid only cover costs that are reasonable and necessary for the diagnosis or treatment of illness or injury. When medically unnecessary services are provided, the patient is unnecessarily exposed to risks of a medical procedure and the federal health care programs incur needless costs. Hospitals have been subject to prosecution under this theory. For example, a grand jury indicted a Michigan hospital based on its failure properly to investigate medically unnecessary pain management procedures performed by a physician on its medical staff. In another case, a California hospital recently paid $59.5 million to settle civil False Claims Act allegations that the hospital inadequately performed credentialing and peer review of cardiologists on its staff who performed medically unnecessary invasive cardiac procedures.

The second theory of liability involves the provision of care that is so deficient that it amounts to no care at all. This theory derives from the concept commonly applied in the financial fraud context, which subjects providers to liability for billing government programs for services that were not actually rendered. These cases frequently involve providers, such as nursing homes, that receive "per diem" payments for providing all necessary treatment to patients. For example, a Colorado rehabilitation center entered into a $1.9 million civil False Claims Act settlement to resolve allegations that it provided worthless services to patients, resulting from systemic understaffing at the facility, where deficient services and abuse caused six patient deaths. Federal prosecutors in Missouri charged a long-term care facility management company, its CEO, and

three nursing homes with conspiracy and health care fraud based on the contention that the defendants imposed budgetary constraints that they knew or should have known would prevent facilities from providing adequate care to residents. The CEO was sentenced to pay $29,000 in criminal fines and to serve an 18-month period of incarceration. The management company and nursing homes were each sentenced to pay $182,250 in criminal fines. In a related civil case, the defendants paid $1.25 million to resolve False Claims Act allegations, and agreed to be excluded from federal health care programs.

This fraud theory also is applied in cases involving violations of regulatory requirements related to quality of care. For example, a Pennsylvania hospital entered into a $200,000 civil False Claims Act settlement to resolve substandard care allegations related to the improper use of restraints.

In addition to substantial civil penalties and criminal fines, health care providers that systematically fail to provide care of an acceptable quality can be excluded from federal health care programs, meaning Medicare and Medicaid will not pay for items or services furnished by the provider. The provision of care that fails to meet accepted standards of care is an enforcement priority for OIG, which is actively pursuing these cases under administrative sanction authorities that explicitly address quality of care. OIG can impose exclusion from the federal health care programs against anyone who furnishes or causes to be furnished medically unnecessary services or services that fail to meet professionally recognized standards of health care.[17] Additionally, OIG is required by law to exclude anyone convicted of patient neglect or abuse.[18]

As part of global settlements of civil health care fraud matters, OIG may negotiate a waiver of the permissive exclusion in exchange for a provider's agreement to enter into a corporate integrity agreement (CIA). In cases involving substandard care, these agreements can involve comprehensive monitoring provisions designed to assess the provider's internal quality improvement infrastructure. Currently, thirteen nursing homes and psychiatric facilities, including eight regional and national chains, are under quality of care CIAs. A list of the health care providers currently subject to CIAs is found at OIG's website, http://hhs.gov/fraud/cias.html.

A CIA also might entail board-level obligations to help ensure that the organization embraces a commitment to the delivery of quality care. For example, the Tenet Healthcare Corporation board of directors has specific obligations under the organization's current CIA. OIG has required the board to (1) review and oversee the performance of the compliance staff, (2) annually review the effectiveness of the compliance program, (3) engage an independent compliance consultant to assist the board in its review and oversight of Tenet's compliance activities, and (4) submit to OIG a resolution summarizing its review of Tenet's compliance with the CIA and federal health care program requirements. These obligations reflect a growing recognition of the critical role that boards of directors play in ensuring that their organizations promote quality, ensure patient safety, and are in compliance with the obligations of government health care programs.

V. Health Care Board Fiduciary Duty and Quality

Health care is unique in representing both a social good and an economic commodity. Boards of directors of many health care organizations have been called upon to see that their organizations approach those realities in concert, not in competition, with each other. These boards understand that the quality of the products and services their organizations provide can have life or death implications. Health care organizations generally view themselves as mission-driven and health care quality is a key component of that mission.

Yet, the Institute of Medicine's recognition in 1999 that medical errors lead to as many as 100,000 deaths per year served as a wake-up call. Evolving evidence and research into best practices and outcomes measures have provided the impetus to today's rapidly growing "quality movement," which is triggering a whole variety of mandatory and voluntary activities by health care organizations to improve quality and reduce costs.

These new programs and requirements raise the stakes for health care organizations, both financially and legally. Poor quality and value—or the failure to demonstrate good quality and value—increasingly may affect the viability of health care providers, products manufacturers and others. Law enforcement agencies are increasing their scrutiny of providers that deliver substandard care to federal health care beneficiaries. On the other hand, demonstrated quality and value likely will have a positive mission as well as financial effect. Accurate measurement and reporting—indeed, effective compliance with an evolving set of obligations—will be required.

17 42 U.S.C. § 1320a-7(b)(6)(B).
18 42 U.S.C. § 1320a-7(a)(2).

Directors will need to understand this evolving reality and, if they have not already done so, elevate quality—as newly defined—to the same level of focus that financial viability and regulatory compliance currently command. The next section of this resource provides directors with certain questions that may assist them in exercising their oversight responsibilities in this increasingly important area.

VI. Suggested Questions for Directors

Boards of Directors can play a critical role in advancing the clinical improvement initiatives in their organizations. To realize its full potential, a board needs to develop an understanding of the relevant quality and patient safety issues and then focus on performance goals that drive the organization to provide the best quality and most efficient care. The following series of suggested questions may be helpful as the board examines the scope and operation of the organization's quality and safety initiatives.

1. *What are the goals of the organization's quality improvement program? What metrics and benchmarks are used to measure progress towards each of these performance goals? How is each goal specifically linked to management accountability?*

There are a growing number of national public and private initiatives directed at promoting quality of care, patient safety and the corresponding reduction in medical errors. These initiatives rely on clinical care benchmarks to facilitate oversight and promote improved quality outcomes. Such benchmarks, used in conjunction with industry-wide reported data, can provide a context for creating quality of care goals, aligning organizational incentives and providing a framework for management's reports to the board. Once these parameters are defined, the board can more readily hold management accountable for meeting the organization's quality performance goals.

2. *How does the organization measure and improve the quality of patient/resident care? Who are the key management and clinical leaders responsible for these quality and safety programs?*

As a threshold matter, the board may wish to confirm its understanding of the structures and processes the organization relies upon to oversee and improve clinical quality and patient safety. Only after it has a complete understanding of how the organization's quality assurance functions operate can the board evaluate the breadth and effectiveness of a quality improvement program. The organizational assessment also can provide a common basis from which management and the board can evaluate these processes against current and emerging regulatory requirements.

3. *How are the organization's quality assessment and improvement processes integrated into overall corporate policies and operations? Are clinical quality standards supported by operational policies? How does management implement and enforce these policies? What internal controls exist to monitor and report on quality metrics?*

Consistent with the fundamental fiduciary responsibility of oversight, the board has responsibility for institutional policies and procedures relative to quality of care. Increasingly, common law recognizes among a board's nondelegable duties the duty to formulate, adopt and enforce adequate rules and policies to ensure quality care for all of the organization's patients and residents. Although boards appropriately may utilize the expertise of the medical staff and other professionals to address professional competency and quality issues, these professionals should work actively with the board to advance the institution's quality agenda, to identify systemic deficiencies and to make appropriate recommendations for action. Periodic reviews with management of the quality of care provided to patients and evaluations of the adequacy of these policies in light of evolving standards, clinical practices and claims experience or trends are consistent with board responsibilities.

4. *Does the board have a formal orientation and continuing education process that helps members appreciate external quality and patient safety requirements? Does the board include members with expertise in patient safety and quality improvement issues?*

In an era of increasing governance accountability, the boards of health care organizations are expected to understand and be involved in the assessment of performance on quality and patient safety initiatives of their organizations. An understanding of clinical quality measurements, the ability to read quality scorecards and spot red flags, and an appreciation of quality of care as a corporate governance issue may be critical to an effective board. Equally important, board members need a general understanding of national trends in health care quality. Collectively, these skills will enable the board to appreciate the interrelationship of patient safety, health care quality and performance measurement, as well as the business case for quality. For the same reasons a board has financial experts on its audit committee, health care organizations that provide or arrange for goods or services need members with competencies in quality and patient safety issues. With such resources, the board is better positioned to call for and evaluate meaningful quality information using recognized performance metrics from which to evaluate the organization's clinical quality performance.

5. *What information is essential to the board's ability to understand and evaluate the organization's quality assessment and performance improvement programs? Once these performance metrics and benchmarks are established, how frequently does the board receive reports about the quality improvement efforts?*

The board should consider the nature and level of information it needs to oversee the quality of care in the organization. If there are too many quality indicators, the data may become overwhelming and the critical measures of success may be overlooked. The board may want to work with management and the organization's medical leadership to identify a focused number of vital indicators that are probative of quality or indicative of changes in quality of patient care. In determining which performance measures to include in its "dashboard," the board may want to consider the quality data reviewed by government agencies, the information subject to mandatory reporting requirements and relevant industry benchmarks.

As part of its oversight of the quality of care delivered by subsidiaries, parent or system boards may have different information needs. While a grounding in quality and patient safety initiatives remains important, the parent board appropriately may rely on local boards to oversee clinical quality of the local facilities under its purview. In large health care systems, the parent board may exercise its governance responsibilities by focusing on the effectiveness of the local boards.

6. *How are the organization's quality assessment and improvement processes coordinated with its corporate compliance program? How are quality of care and patient safety issues addressed in the organization's risk assessment and corrective action plans?*

As discussed in "Corporate Responsibility and Corporate Compliance: A Resource for Health Care Boards of Directors," an effective corporate compliance program can be instrumental in the board's exercise of its fiduciary duty of care. Increasingly, monitoring quality and patient safety issues is recognized as integral to promoting corporate compliance, as well as to risk management and organizational reputation. Use of regulatory compliance processes to continually assess the organization's quality performance can assist in exposing deficiency patterns, which if not recognized and addressed in a timely and effective manner, may expose the organization to enforcement action. Accordingly, as quality improvement takes on increased significance in the organization's compliance program, the board may want to assure itself that the compliance officer is collaborating with the organization's clinical leadership.

7. *What processes are in place to promote the reporting of quality concerns and medical errors and to protect those who ask questions and report problems? What guidelines exist for reporting quality and patient safety concerns to the board?*

A lack of transparency in the organization's response to concerns about quality and patient safety can contribute to a culture where problems are not addressed and are therefore likely to reoccur. Improving the effectiveness and safety of services and quality of care requires participation by clinical staff at all levels. In fulfilling its duty of care, the board should consider verifying that the organization has a mechanism to encourage constructive criticism and reporting of errors. Effective compliance programs are structured to address "whistleblower" reporting and protections and the organization should consider incorporating the reporting of quality and patient safety concerns into both existing compliance procedures and general operating practices.

8. *Are human and other resources adequate to support patient safety and clinical quality? How are proposed changes in resource allocation evaluated from the perspective of clinical quality and patient care? Are systems in place to provide adequate resources to account for differences in patient acuity and care needs?*

Participation in the federal health care programs requires that the health care organization deliver care of a quality that meets professionally recognized standards of care. When investigating allegations of substandard quality of care, the government will scrutinize whether the health care provider devoted sufficient resources to ensure that the care provided to patients or residents met basic quality requirements. Inadequate levels of professional and support staff, for example, may result in a pattern of substandard care. As part of its annual review of the organization's operating plans and budget, the board should consider the impact of these resource allocation decisions on the quality of care and patient safety. For the same reason, the board should ensure that management has assessed the impact of staff reductions or other budget constraints on quality of care.

A companion area for oversight relates to approvals of new services and significant technology acquisitions. Inquiry regarding the scientific bases supporting the efficacy and safety of new services and the identification of supportive processes to ensure quality and safety of new technology and services may serve to protect financial resources as well as patient safety.

9. *Do the organization's competency assessment and training, credentialing, and peer review processes adequately recognize the necessary focus on clinical quality and patient safety issues?*

Boards rely heavily on the expertise of their medical staff and the integrity and comprehensiveness of its competency assessment and training, credentialing,

and peer review processes to ensure the competency of clinical staff. Alignment of professional staff credentialing standards with quality data can advance a quality-driven model for the professional staff and allows the organization to take appropriate action when significant quality deficiencies are identified.

10. *How are "adverse patient events" and other medical errors identified, analyzed, reported, and incorporated into the organization's performance improvement activities? How do management and the board address quality deficiencies without unnecessarily increasing the organization's liability exposure?*

Providers operate under significant federal and state requirements relating to quality reporting and improvement. Hospitals, for example, are required to maintain an effective, data-driven quality assessment and improvement program as a condition of participation in the Medicare program. These programs must track quality indicators, including adverse patient events, and set performance improvement priorities that focus on high-risk or problem-prone areas. A growing number of states have mandatory reporting systems for at least some forms of adverse events occurring in acute care hospitals. For example, some states are mandating the reporting of "never events," those errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients. Examples of "never events" include surgery on the wrong body part, a mismatched blood transfusion, and severe "pressure ulcers" acquired in the hospital. In addition, there are other reporting requirements, including the peer review reporting provisions of the Health Care Quality Improvement Act, state peer review statutes, and the privilege and confidentiality provisions of the Patient Safety and Quality Improvement Act of 2005. Although the application of these statutes to medical staff credentialing, peer review and broader quality reporting and improvement activities may be challenging, greater organizational risks may lie in the failure to address known or foreseeable quality deficiencies.

Obviously, corporate boards and managers need to evaluate and address quality and patient safety issues but without unnecessarily increasing organizational exposure to liability resulting from the provision of deficient care. It is therefore important for the board to understand the scope of federal and state statutory protections given certain quality-related activities and to make reasonable inquiry to assure that management and the medical staff effectively manage this issue. A discussion with legal counsel on this topic may be helpful.

VII. Conclusion

Contemporary health care quality, patient safety and cost efficiency initiatives provide an opportunity for health care organizations to make a positive difference to society while promoting their missions and enhancing their financial success. However, health care boards of directors will need to exercise their oversight responsibilities in this area diligently and assure that their organizations are pursuing these opportunities in compliance with evolving legal requirements. The comments and perspectives shared in this educational resource will, it is hoped, assist health care organization boards in exercising their duty of care as it relates to health care quality effectively and efficiently and in a manner that will help improve the nation's health care system.

741–8138 (301–443–0572 in the Washington, DC area), code 12536. Please call the Information Line for up-to-date information on this meeting.

Agenda: On March 12, 1998, the committee will discuss a proposed draft of a guidance document for the development of drugs for the treatment of diabetes mellitis. On March 13, 1998, the committee will discuss New Drug Application 20–766, Xenical™, (orlistat tetrahydrolipstatin, Hoffman-LaRoche) for long term treatment of obesity.

Procedure: Interested persons may present data, information, or views, orally or in writing, on issues pending before the committee. Written submissions may be made to the contact person by March 6, 1998. Oral presentations from the public will be scheduled between approximately 8 a.m. and 8:30 a.m. on March 12 and 13, 1998. Time allotted for each presentation may be limited. Those desiring to make formal oral presentations should notify the contact person before March 6, 1998, and submit a brief statement of the general nature of the evidence or arguments they wish to present, the names and addresses of proposed participants, and an indication of the approximate time requested to make their presentation.

Notice of this meeting is given under the Federal Advisory Committee Act (5 U.S.C. app. 2).

Dated: February 18, 1998.

Michael A. Friedman,

Deputy Commissioner for Operations.

[FR Doc. 98–4529 Filed 2–20–98; 8:45 am]

BILLING CODE 4160–01–F

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. 97N–0260]

Agency Information Collection Activities; Announcement of OMB Approval

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing that a collection of information entitled ''Customer/Partner Satisfaction Surveys'' has been approved by the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (the PRA).

FOR FURTHER INFORMATION CONTACT: Mark L. Pincus, Office of Information Resources Management (HFA–250), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301–827–1471.

SUPPLEMENTARY INFORMATION: In the **Federal Register** of December 2, 1997 (62 FR 63721), the agency announced that the proposed information collection had been submitted to OMB for review and clearance under section 3507 of the PRA (44 U.S.C. 3507). An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. OMB has now approved the information collection and has assigned OMB control number 0910–0360. The approval expires on January 31, 1999.

Dated: February 13, 1998.

William K. Hubbard,

Associate Commissioner for Policy Coordination.

[FR Doc. 98–4374 Filed 2–20–98; 8:45 am]

BILLING CODE 4160–01–F

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General

Publication of the OIG Compliance Program Guidance for Hospitals

AGENCY: Office of Inspector General (OIG), HHS.

ACTION: Notice.

SUMMARY: This **Federal Register** notice sets forth the recently issued compliance program guidance for hospitals developed by the Office of Inspector General (OIG) in cooperation with, and with input from, several provider groups and industry representatives. Many providers and provider organizations have expressed an interest in better protecting their operations from fraud and abuse through the adoption of voluntary compliance programs. The first compliance guidance, addressing clinical laboratories, was prepared by the OIG and published in the **Federal Register** on March 3, 1997. We believe the development of this second program guidance, for hospitals, will continue as a positive step towards promoting a higher level of ethical and lawful conduct throughout the health care industry.

FOR FURTHER INFORMATION CONTACT: Stephen Davis, Office of Counsel to the Inspector General, (202) 619–0070.

SUPPLEMENTARY INFORMATION: The creation of compliance program guidances has become a major initiative of the OIG in its efforts to engage the private health care community in combating fraud and abuse. In developing these compliance guidances, the OIG has agreed to work closely with the Health Care Financing Administration, the Department of Justice and various sectors of the health care industry. The first of these compliance guidances focused on clinical laboratories, and was intended to provide clear guidance to those segments of the health care industry that were interested in reducing fraud and abuse within their organizations. The compliance guidance was reprinted in an OIG **Federal Register** notice published on March 3, 1997 (62 FR 9435). This second compliance program guidance developed by the OIG continues to build upon the basic elements contained in our initial compliance guidance, and encompasses principles that are applicable to hospitals as well as a wider variety of organizations that provide health care services to beneficiaries of Medicare, Medicaid and all other Federal health care programs.

Like the previously-issued compliance program guidance for clinical laboratories and future compliance program guidances, adoption of the hospital compliance program guidance set forth below will be voluntary. Future compliance program guidances to be developed will be similarly structured and based on substantive policy recommendations, the elements of the Federal Sentencing Guidelines, and applicable statutes, regulations and Federal health care program requirements.

A reprint of the OIG compliance program guidance follows.

Compliance Program Guidance for Hospitals

I. Introduction

The Office of Inspector General (OIG) of the Department of Health and Human Services (HHS) continues in its efforts to promote voluntarily developed and implemented compliance programs for the health care industry. The following compliance program guidance is intended to assist hospitals and their agents and subproviders (referred to collectively in this document as ''hospitals'') develop effective internal controls that promote adherence to applicable Federal and State law, and the program requirements of Federal, State and private health plans. The adoption and implementation of voluntary compliance programs significantly advance the prevention of fraud, abuse and waste in these health care plans while at the same time furthering the fundamental mission of

all hospitals, which is to provide quality care to patients.

Within this document, the OIG intends to provide first, its general views on the value and fundamental principles of hospital compliance programs, and, second, specific elements that each hospital should consider when developing and implementing an effective compliance program. While this document presents basic procedural and structural guidance for designing a compliance program, it is not in itself a compliance program. Rather, it is a set of guidelines for a hospital interested in implementing a compliance program to consider. The recommendations and guidelines provided in this document must be considered depending upon their applicability to each particular hospital.

Fundamentally, compliance efforts are designed to establish a culture within a hospital that promotes prevention, detection and resolution of instances of conduct that do not conform to Federal and State law, and Federal, State and private payor health care program requirements, as well as the hospital's ethical and business policies. In practice, the compliance program should effectively articulate and demonstrate the organization's commitment to the compliance process. The existence of benchmarks that demonstrate implementation and achievements are essential to any effective compliance program. Eventually, a compliance program should become part of the fabric of routine hospital operations.

Specifically, compliance programs guide a hospital's governing body (e.g., Boards of Directors or Trustees), Chief Executive Officer (CEO), managers, other employees and physicians and other health care professionals in the efficient management and operation of a hospital. They are especially critical as an internal control in the reimbursement and payment areas, where claims and billing operations are often the source of fraud and abuse and, therefore, historically have been the focus of government regulation, scrutiny and sanctions.

It is incumbent upon a hospital's corporate officers and managers to provide ethical leadership to the organization and to assure that adequate systems are in place to facilitate ethical and legal conduct. Indeed, many hospitals and hospital organizations have adopted mission statements articulating their commitment to high ethical standards. A formal compliance program, as an additional element in this process, offers a hospital a further concrete method that may improve quality of care and reduce waste. Compliance programs also provide a central coordinating mechanism for furnishing and disseminating information and guidance on applicable Federal and State statutes, regulations and other requirements.

Adopting and implementing an effective compliance program requires a substantial commitment of time, energy and resources by senior management and the hospital's governing body.[1] Programs hastily constructed and implemented without appropriate ongoing monitoring will likely be ineffective and could result in greater harm or liability to the hospital than no program at all. While it may require significant additional resources or reallocation of existing resources to implement an effective compliance program, the OIG believes that the long term benefits of implementing the program outweigh the costs.

A. Benefits of a Compliance Program

In addition to fulfilling its legal duty to ensure that it is not submitting false or inaccurate claims to government and private payors, a hospital may gain numerous additional benefits by implementing an effective compliance program. Such programs make good business sense in that they help a hospital fulfill its fundamental care-giving mission to patients and the community, and assist hospitals in identifying weaknesses in internal systems and management.

Other important potential benefits include the ability to:

- Concretely demonstrate to employees and the community at large the hospital's strong commitment to honest and responsible provider and corporate conduct;
- Provide a more accurate view of employee and contractor behavior relating to fraud and abuse;
- Identify and prevent criminal and unethical conduct;
- Tailor a compliance program to a hospital's specific needs;
- Improve the quality of patient care;
- Create a centralized source for distributing information on health care statutes, regulations and other program directives related to fraud and abuse and related issues;
- Develop a methodology that encourages employees to report potential problems;
- Develop procedures that allow the prompt, thorough investigation of alleged misconduct by corporate officers, managers, employees, independent contractors, physicians, other health care professionals and consultants;
- Initiate immediate and appropriate corrective action; and
- Through early detection and reporting, minimize the loss to the Government from false claims, and thereby reduce the hospital's exposure to civil damages and penalties, criminal sanctions, and administrative remedies, such as program exclusion.[2]

Overall, the OIG believes that an effective compliance program is a sound investment on the part of a hospital.

The OIG recognizes that the implementation of a compliance program may not entirely eliminate fraud, abuse and waste from the hospital system. However, a sincere effort by hospitals to comply with applicable Federal and State standards, as well as the requirements of private health care programs, through the establishment of an effective compliance program, significantly reduces the risk of unlawful or improper conduct.

B. Application of Compliance Program Guidance

There is no single ''best'' hospital compliance program, given the diversity within the industry. The OIG understands the variances and complexities within the hospital industry and is sensitive to the differences among large urban medical centers, community hospitals, small, rural hospitals, specialty hospitals, and other types of hospital organizations and systems. However, elements of this guidance can be used by all hospitals, regardless of size, location or corporate structure, to establish an effective compliance program. We recognize that some hospitals may not be able to adopt certain elements to the same comprehensive degree that others with more extensive resources may achieve. This guidance represents the OIG's suggestions on how a hospital can best establish internal controls and monitoring to correct and prevent fraudulent activities. By no means should the contents of this guidance be viewed as an exclusive discussion of the

[1] Indeed, recent case law suggests that the failure of a corporate Director to attempt in good faith to institute a compliance program in certain situations may be a breach of a Director's fiduciary obligations. See, e.g., *In re Caremark International Inc. Derivative Litigation*, 698 A.2d 959 (Ct. Chanc. Del. 1996).

[2] The OIG, for example, will consider the existence of an *effective* compliance program that pre-dated any Governmental investigation when addressing the appropriateness of administrative penalties. Further, the False Claims Act, 31 U.S.C. 3729–3733, provides that a person who has violated the Act, but who voluntarily discloses the violation to the Government, in certain circumstances will be subject to not less than double, as opposed to treble, damages. See 31 U.S.C. 3729(a).

advisable elements of a compliance program.

The OIG believes that input and support by representatives of the major hospital trade associations is critical to the development and success of this compliance program guidance. Therefore, in drafting this guidance, the OIG received and considered input from various hospital and medical associations, as well as professional practice organizations. Further, we took into consideration previous OIG publications, such as Special Fraud Alerts and Management Advisory Reports, the recent findings and recommendations in reports issued by OIG's Office of Audit Services and Office of Evaluation and Inspections, as well as the experience of past and recent fraud investigations related to hospitals conducted by OIG's Office of Investigations and the Department of Justice.

As appropriate, this guidance may be modified and expanded as more information and knowledge is obtained by the OIG, and as changes in the law, and in the rules, policies and procedures of the Federal, State and private health plans occur. The OIG understands that hospitals will need adequate time to react to these modifications and expansions to make any necessary changes to their voluntary compliance programs. We recognize that hospitals are already accountable for complying with an extensive set of statutory and other legal requirements, far more specific and complex than what we have referenced in this document. We also recognize that the development and implementation of compliance programs in hospitals often raise sensitive and complex legal and managerial issues.[3] However, the OIG wishes to offer what it believes is critical guidance for providers who are sincerely attempting to comply with the relevant health care statutes and regulations.

II. Compliance Program Elements

The elements proposed by these guidelines are similar to those of the clinical laboratory model compliance program published by the OIG in February 1997[4] and our corporate integrity agreements.[5] The elements represent a guide—a process that can be used by hospitals, large or small, urban or rural, for-profit or not for-profit. Moreover, the elements can be incorporated into the managerial structure of multi-hospital and integrated delivery systems. As we stated in our clinical laboratory plan, these suggested guidelines can be tailored to fit the needs and financial realities of a particular hospital. The OIG is cognizant that with regard to compliance programs, one model is not suitable to every hospital. Nonetheless, the OIG believes that every hospital, regardless of size or structure, can benefit from the principles espoused in this guidance.

The OIG believes that every effective compliance program must begin with a formal commitment by the hospital's governing body to include *all* of the applicable elements listed below. These elements are based on the seven steps of the Federal Sentencing Guidelines.[6] Further, we believe that every hospital can implement most of our recommended elements that expand upon the seven steps of the Federal Sentencing Guidelines.[7] We recognize that full implementation of all elements may not be immediately feasible for all hospitals. However, as a first step, a good faith and meaningful commitment on the part of the hospital administration, especially the governing body and the CEO, will substantially contribute to a program's successful implementation.

At a minimum, comprehensive compliance programs should include the following seven elements:

(1) The development and distribution of written standards of conduct, as well as written policies and procedures that promote the hospital's commitment to compliance (e.g., by including adherence to compliance as an element in evaluating managers and employees) and that address specific areas of potential fraud, such as claims development and submission processes, code gaming, and financial relationships with physicians and other health care professionals;

(2) The designation of a chief compliance officer and other appropriate bodies, e.g., a corporate compliance committee, charged with the responsibility of operating and monitoring the compliance program, and who report directly to the CEO and the governing body;

(3) The development and implementation of regular, effective education and training programs for all affected employees;

(4) The maintenance of a process, such as a hotline, to receive complaints, and the adoption of procedures to protect the anonymity of complainants and to protect whistleblowers from retaliation;

(5) The development of a system to respond to allegations of improper/illegal activities and the enforcement of appropriate disciplinary action against employees who have violated internal compliance policies, applicable statutes, regulations or Federal health care program requirements;

(6) The use of audits and/or other evaluation techniques to monitor compliance and assist in the reduction of identified problem area; and

(7) The investigation and remediation of identified systemic problems and the development of policies addressing the non-employment or retention of sanctioned individuals.

A. Written Polices and Procedures

Every compliance program should require the development and distribution of written compliance policies that identify specific areas of risk to the hospital. These policies should be developed under the direction and supervision of the chief compliance officer and compliance committee, and, at a minimum, should be provided to all individuals who are affected by the particular policy at issue, including the hospital's agents and independent contractors.

1. *Standards of Conduct.* Hospitals should develop standards of conduct for all affected employees that include a clearly delineated commitment to compliance by the hospital's senior management[8] and its divisions,

[3] Nothing stated herein should be substituted for, or used in lieu of, competent legal advice from counsel.

[4] See 62 FR 9435, March 3, 1997.

[5] Corporate integrity agreements are executed as part of a civil settlement between the health care provider and the Government to resolve a case arising under the False Claims Act (FCA), including the *qui tam* provisions of the FCA, based on allegations of health care fraud or abuse. These OIG-imposed programs are in effect for a period of three to five years and require many of the elements included in this compliance guidance.

[6] See United States Sentencing Commission Guidelines, *Guidelines Manual*, 8A1.2, comment. (n.3(k)).

[7] Current HCFA reimbursement principles provide that certain of the costs associated with the creation of a voluntarily established compliance program may be allowable costs on certain types of hospitals' cost reports. These allowable costs, of course, must at a minimum be *reasonable* and related to patient care. See generally 42 U.S.C. 1395x(v)(1)(A) (definition of reasonable cost); 42 CFR 413.9(a) and (b)(2) (costs related to patient care). In contrast, however, costs specifically associated with the implementation of a corporate integrity agreement in response to a Government investigation resulting in a civil or criminal judgment or settlement are unallowable, and are also made specifically and expressly unallowable in corporate integrity agreements and civil fraud settlements.

[8] The OIG strongly encourages high-level involvement by the hospital's governing body, chief executive officer, chief operating officer, general counsel, and chief financial officer, as well as other medical personnel, as appropriate, in the development of standards of conduct. Such

Continued

including affiliated providers operating under the hospital's control,[9] hospital-based physicians and other health care professionals (e.g., utilization review managers, nurse anesthetists, physician assistants and physical therapists). Standards should articulate the hospital's commitment to comply with all Federal and State standards, with an emphasis on preventing fraud and abuse. They should state the organization's mission, goals, and ethical requirements of compliance and reflect a carefully crafted, clear expression of expectations for all hospital governing body members, officers, managers, employees, physicians, and, where appropriate, contractors and other agents. Standards should be distributed to, and comprehensible by, all employees (e.g., translated into other languages and written at appropriate reading levels, where appropriate). Further, to assist in ensuring that employees continuously meet the expected high standards set forth in the code of conduct, any employee handbook delineating or expanding upon these standards of conduct should be regularly updated as applicable statutes, regulations and Federal health care program requirements are modified.[10]

2. *Risk Areas.* The OIG believes that a hospital's written policies and procedures should take into consideration the regulatory exposure for each function or department of the hospital. Consequently, we recommend that the individual policies and procedures be coordinated with the appropriate training and educational programs with an emphasis on areas of special concern that have been identified by the OIG through its investigative and audit functions.[11] Some of the special areas of OIG concern include.[12]

- Billing for items or services not actually rendered; [13]
- Providing medically unnecessary services;[14]
- Upcoding;[15]
- ''DRG creep;''[16]
- Outpatient services rendered in connection with inpatient stays;[17]
- Teaching physician and resident requirements for teaching hospitals;
- Duplicate billing;[18]
- False cost reports;[19]
- Unbundling;[20]
- Billing for discharge in lieu of transfer;[21]
- Patients' freedom of choice;[22]
- Credit balances—failure to refund;
- Hospital incentives that violate the anti-kickback statute or other similar Federal or State statute or regulation;[23]
- Joint ventures;[24]
- Financial arrangements between hospitals and hospital-based physicians;[25]
- Stark physician self-referral law;
- Knowing failure to provide covered services or necessary care to members of a health maintenance organization; and
- Patient dumping.[26]

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involvement should help communicate a strong and explicit statement of compliance goals and standards.

[9] E.g., skilled nursing facilities, home health agencies, psychiatric units, rehabilitation units, outpatient clinics, clinical laboratories, dialysis facilities.

[10] The OIG recognizes that not all standards, policies and procedures need to be communicated to all employees. However, the OIG believes that the bulk of the standards that relate to complying with fraud and abuse laws and other ethical areas should be addressed and made part of all affected employees' training. The hospital must appropriately decide which additional educational programs should be limited to the different levels of employees, based on job functions and areas of responsibility.

[11] The OIG periodically issues Special Fraud Alters setting forth activities believed to raise legal and enforcement issues. Hospital compliance programs should require that the legal staff, chief compliance officer, or other appropriate personnel, carefully consider any and all Special Fraud Alerts issued by the OIG that relate to hospitals. Moreover, the compliance programs should address the ramifications of failing to cease and correct any conduct criticized in such a Special Fraud Alert, if applicable to hospitals, or to take reasonable action to prevent such conduct from reoccurring in the future. If appropriate, a hospital should take the steps described in Section G regarding investigations, reporting and correction of identified problems.

[12] The OIG's work plan is currently available on the Internet at http://www.dhhs.gov/progorg/oig.

[13] Billing for services not actually rendered involves submitting a claim that represents that the provider performed a service all or part of which was simply not performed. This form of billing fraud occurs in many health care entities, including hospitals and nursing homes, and represents a significant part of the OIG's investigative caseload.

[14] A claim requesting payment for medically unnecessary services intentionally seeks reimbursement for a service that is not warranted by the patient's current and documented medical condition. See 42 U.S.C. 1395y(a)(1)(A) (''no payment may be made under part A or part B for any expenses incurred for items or services which . . . are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of the malformed body member''). On every HCFA claim form, a physician must certify that the services were medically necessary for the health of the beneficiary.

[15] ''Upcoding'' reflects the practice of using a billing code that provides a higher payment rate than the billing code that actually reflects the service furnished to the patient. Upcoding has been a major focus of the OIG's enforcement efforts. In fact, the Health Insurance Portability and Accountability Act of 1996 added another civil monetary penalty to the OIG's sanction authorities for upcoding violations. See 42 U.S.C. 1320a–7a(a)(1)(A).

[16] Like upcoding, ''DRG creep'' is the practice of billing using a Diagnosis Related Group (DRG) code that provides a higher payment rate than the DRG code that accurately reflects the service furnished to the patient.

[17] Hospitals that submit claims for non-physician outpatient services that were already included in the hospital's inpatient payment under the Prospective Payment System (PPS) are in effect submitting duplicate claims.

[18] Duplicate billing occurs when the hospital submits more than one claim for the same service or the bill is submitted to more than one primary payor at the same time. Although duplicate billing can occur due to simple error, systematic or repeated double billing may be viewed as a false claim, particularly if any overpayment is not promptly refunded.

[19] As another example of health care fraud, the submission of false costs reports is usually limited to certain Part A providers, such as hospitals, skilled nursing facilities and home health agencies, which are reimbursed in part on the basis of their self-reported operating costs. An OIG audit report on the misuse of fringe benefits and general and administrative costs identified millions of dollars in unallowable costs that resulted from providers' lack of internal controls over costs included in their Medicare cost reports. In addition, the OIG is aware of practices in which hospitals inappropriately shift certain costs to cost centers that are below their reimbursement cap and shift non-Medicare related costs to Medicare cost centers.

[20] ''Unbundling'' is the practice of submitting bills piecemeal or in fragmented fashion to maximize the reimbursement for various tests or procedures that are required to be billed together and therefore at a reduced cost.

[21] Under the Medicare regulations, when a prospective payment system (PPS) hospital transfers a patient to another PPS hospital, only the hospital to which the patient was transferred may charge the full DRG; the transferring hospital should charge Medicare only a per diem amount.

[22] This area of concern is particularly important for hospital discharge planners referring patients to home health agencies, DME suppliers or long term care and rehabilitation providers.

[23] Excessive payment for medical directorships, free or below market rents or fees for administrative services, interest-free loans and excessive payment for intangible assets in physician practice acquisitions are examples of arrangements that may run afoul of the anti-kickback statute. See 42 U.S.C. 1320a–7b(b) and 59 FR 65372 (12/19/94).

[24] Equally troubling to the OIG is the proliferation of business arrangements that may violate the anti-kickback statute. Such arrangements are generally established between those in a position to refer business, such as physicians, and those providing items or services for which a Federal health care program pays. Sometimes established as ''joint ventures,'' these arrangements may take a variety of forms. The OIG currently has a number of investigations and audits underway that focus on such areas of concern.

[25] Another OIG concern with respect to the anti-kickback statute is hospital financial arrangements with hospital-based physicians that compensate physicians for less than the fair market value of services they provide to hospitals or require physicians to pay more than market value for services provided by the hospital. See OIG Management Advisory Report: ''Financial Arrangements Between Hospitals and Hospital-Based Physicians.'' OEI–09–89–0030, October 1991. Examples of such arrangements that may violate the anti-kickback statute are token or no payment for Part A supervision and management services; requirements to donate equipment to hospitals; and excessive charges for billing services.

[26] The patient anti-dumping statute, 42 U.S.C. 1395dd, requires that all Medicare participating hospitals with an emergency department: (1) Provide for an appropriate medical screening examination to determine whether or not an individual requesting such examination has an emergency medical condition; and (2) if the person

Additional risk areas should be assessed as well by hospitals and incorporated into the written policies and procedures and training elements developed as part of their compliance programs.

3. *Claim Development and Submission Process.* A number of the risk areas identified above, pertaining to the claim development and submission process, have been the subject of administrative proceedings, as well as investigations and prosecutions under the civil False Claims Act and criminal statutes. Settlement of these cases often has required the defendants to execute corporate integrity agreements, in addition to paying significant civil damages and/or criminal fines and penalties. These corporate integrity agreements have provided the OIG with a mechanism to advise hospitals concerning what it feels are acceptable practices to ensure compliance with applicable Federal and State statutes, regulations, and program requirements. The following recommendations include a number of provisions from various corporate integrity agreements. While these recommendations include examples of effective policies, each hospital should develop its own specific policies tailored to fit its individual needs.

With respect to reimbursement claims, a hospital's written policies and procedures should reflect and reinforce current Federal and State statutes and regulations regarding the submission of claims and Medicare cost reports. The policies must create a mechanism for the billing or reimbursement staff to communicate effectively and accurately with the clinical staff. Policies and procedures should:

- Provide for proper and timely documentation of all physician and other professional services prior to billing to ensure that only accurate and properly documented services are billed;
- Emphasize that claims should be submitted only when appropriate documentation supports the claims and only when such documentation is maintained and available for audit and review. The documentation, which may include patient records, should record the length of time spent in conducting the activity leading to the record entry, and the identity of the individual providing the service. The hospital should consult with its medical staff to establish other appropriate documentation guidelines;
- State that, consistent with appropriate guidance from medical staff, physician and hospital records and medical notes used as a basis for a claim submission should be appropriately organized in a legible form so they can be audited and reviewed;
- Indicate that the diagnosis and procedures reported on the reimbursement claim should be based on the medical record and other documentation, and that the documentation necessary for accurate code assignment should be available to coding staff; and
- Provide that the compensation for billing department coders and billing consultants should not provide any financial incentive to improperly upcode claims.

The written policies and procedures concerning proper coding should reflect the current reimbursement principles set forth in applicable regulations [27] and should be developed in tandem with private payor and organizational standards. Particular attention should be paid to issues of medical necessity, appropriate diagnosis codes, DRG coding, individual Medicare Part B claims (including evaluation and management coding) and the use of patient discharge codes.[28]

a. Outpatient services rendered in connection with an inpatient stay. Hospitals should implement measures designed to demonstrate their good faith efforts to comply with the Medicare billing rules for outpatient services rendered in connection with an inpatient stay. Although not a guard against intentional wrongdoing, the adoption of the following measures are advisable:

- Installing and maintaining computer software that will identify those outpatient services that may not be billed separately from an inpatient stay; or
- Implementing a periodic manual review to determine the appropriateness of billing each outpatient service claim, to be conducted by one or more appropriately trained individuals familiar with applicable billing rules; or
- With regard to each inpatient stay, scrutinizing the propriety of any potential bills for outpatient services rendered to that patient at the hospital, within the applicable time period.

In addition to the pre-submission undertakings described above, the hospital may implement a post-submission testing process, as follows:

- Implement and maintain a periodic post-submission random testing process that examines or re-examines previously submitted claims for accuracy;
- Inform the fiscal intermediary and any other appropriate government fiscal agents of the hospital's testing process; and
- Advise the fiscal intermediary and any other appropriate government fiscal agents in accordance with current regulations or program instructions with respect to return of overpayments of any incorrectly submitted or paid claims and, if the claim has already been paid, promptly reimburse the fiscal intermediary and the beneficiary for the amount of the claim paid by the government payor and any applicable deductibles or copayments, as appropriate.

b. Submission of claims for laboratory services. A hospital's policies should take reasonable steps to ensure that all claims for clinical and diagnostic laboratory testing services are accurate and correctly identify the services ordered by the physician (or other authorized requestor) and performed by the laboratory. The hospital's written policies and procedures should require, at a minimum,[29] that:

- The hospital bills for laboratory services only after they are performed;
- The hospital bills only for medically necessary services;
- The hospital bills only for those tests actually ordered by a physician and provided by the hospital laboratory;
- The CPT or HCPCS code used by the billing staff accurately describes the service that was ordered by the

has such a condition, (a) stabilize that condition; or (b) appropriately transfer the patient to another hospital.

[27] The official coding guidelines are promulgated by HCFA, the National Center for Health Statistics, the American Medical Association and the American Health Information Management Association. See International Classification of Diseases, 9th Revision, Clinical Modification (ICD9–CM); 1998 Health Care Financing Administration Common Procedure Coding System (HCPCS); and Physicians' Current Procedural Terminology (CPT).

[28] The failure of hospital staff to: (i) document items and services rendered; and (ii) properly submit them for reimbursement is a major area of potential fraud and abuse in Federal health care programs. The OIG has undertaken numerous audits, investigations, inspections and national enforcement initiatives aimed at reducing potential and actual fraud, abuse and waste. Recent OIG audit reports, which have focused on issues such as hospital patient transfers incorrectly paid as discharges, and hospitals' general and administrative costs, continue to reveal abusive, wasteful or fraudulent behavior by some hospitals. Our inspection report entitled ''Financial Arrangements between Hospitals and Hospital-Based Physicians,'' see fn. 25, *supra*, and our Special Fraud Alerts on Hospital Incentives to Physicians and Joint Venture Arrangements, further illustrate how certain business practices may result in fraudulent and abusive behavior.

[29] The OIG's February 1997 Model Compliance Plan for Clinical Laboratories provides more specific and detailed information than is contained in this section, and hospitals that have clinical laboratories should extract the relevant guidance from both documents.

physician and performed by the hospital laboratory;

- The coding staff: (1) Only submit diagnostic information obtained from qualified personnel; and (2) contact the appropriate personnel to obtain diagnostic information in the event that the individual who ordered the test has failed to provide such information; and
- Where diagnostic information is obtained from a physician or the physician's staff after receipt of the specimen and request for services, the receipt of such information is documented and maintained.

c. Physicians at teaching hospitals. Hospitals should ensure the following with respect to all claims submitted on behalf of teaching physicians:

- Only services actually provided may be billed;
- Every physician who provides or supervises the provision of services to a patient should be responsible for the correct documentation of the services that were rendered;
- The appropriate documentation must be placed in the patient record and signed by the physician who provided or supervised the provision of services to the patient;
- Every physician is responsible for assuring that in cases where that physician provides evaluation and management (E&M) services, a patient's medical record includes appropriate documentation of the applicable key components of the E&M service provided or supervised by the physician (e.g., patient history, physician examination, and medical decision making), as well as documentation to adequately reflect the procedure or portion of the service performed by the physician; and
- Every physician should document his or her presence during the key portion of any service or procedure for which payment is sought.

d. Cost reports. With regard to cost report issues, the written policies should include procedures that seek to ensure full compliance with applicable statutes, regulations and program requirements and private payor plans. Among other things, the hospital's procedures should ensure that:

- Costs are not claimed unless based on appropriate and accurate documentation;
- Allocations of costs to various cost centers are accurately made and supportable by verifiable and auditable data;
- Unallowable costs are not claimed for reimbursement;
- Accounts containing both allowable and unallowable costs are analyzed to determine the unallowable amount that should not be claimed for reimbursement;
- Costs are properly classified;
- Fiscal intermediary prior year audit adjustments are implemented and are either not claimed for reimbursement or claimed for reimbursement and clearly identified as protested amounts on the cost report;
- All related parties are identified on Form 339 submitted with the cost report and all related party charges are reduced to cost;
- Requests for exceptions to TEFRA (Tax Equity and Fiscal Responsibility Act of 1982) limits and the Routine Cost Limits are properly documented and supported by verifiable and auditable data;
- The hospital's procedures for reporting of bad debts on the cost report are in accordance with Federal statutes, regulations, guidelines and policies;
- Allocations from a hospital chain's home office cost statement to individual hospital cost reports are accurately made and supportable by verifiable and auditable data; and
- Procedures are in place and documented for notifying promptly the Medicare fiscal intermediary (or any other applicable payor, e.g., TRICARE (formerly CHAMPUS) and Medicaid) of errors discovered after the submission of the hospital cost report, and where applicable, after the submission of a hospital chain's home office cost statement.

With regard to bad debts claimed on the Medicare cost report, see also section six, below, on Bad Debts.

4. Medical Necessity—Reasonable and Necessary Services. A hospital's compliance program should provide that claims should only be submitted for services that the hospital has reason to believe are medically necessary and that were ordered by a physician [30] or other appropriately licensed individual.

As a preliminary matter, the OIG recognizes that licensed health care professionals must be able to order any services that are appropriate for the treatment of their patients. However, Medicare and other government and private health care plans will only pay for those services that meet appropriate medical necessity standards (in the case of Medicare, i.e., ''reasonable and necessary'' services). Providers may not bill for services that do not meet the applicable standards. The hospital is in a unique position to deliver this information to the health care professionals on its staff. Upon request, a hospital should be able to provide documentation, such as patients' medical records and physicians' orders, to support the medical necessity of a service that the hospital has provided. The compliance officer should ensure that a clear, comprehensive summary of the ''medical necessity'' definitions and rules of the various government and private plans is prepared and disseminated appropriately.

5. Anti-Kickback and Self-Referral Concerns. The hospital should have policies and procedures in place with respect to compliance with Federal and State anti-kickback statutes, as well as the Stark physician self-referral law.[31] Such policies should provide that:

- All of the hospital's contracts and arrangements with referral sources comply with all applicable statutes and regulations;
- The hospital does not submit or cause to be submitted to the Federal health care programs claims for patients who were referred to the hospital pursuant to contracts and financial arrangements that were designed to induce such referrals in violation of the anti-kickback statute, Stark physician self-referral law or similar Federal or State statute or regulation; and
- The hospital does not enter into financial arrangements with hospital-based physicians that are designed to provide inappropriate remuneration to the hospital in return for the physician's ability to provide services to Federal health care program beneficiaries at that hospital.[32]

Further, the policies and procedures should reference the OIG's safe harbor regulations, clarifying those payment practices that would be immune from prosecution under the anti-kickback statute. See 42 CFR 1001.952.

6. Bad Debts. A hospital should develop a mechanism [33] to review, at least annually: (1) whether it is properly reporting bad debts to Medicare; and (2) all Medicare bad debt expenses claimed, to ensure that the hospital's procedures are in accordance with applicable

[30] For Medicare reimbursement purposes, a physician is defined as: (1) a doctor of medicine or osteopathy; (2) a doctor of dental surgery or of dental medicine; (3) a podiatrist; (4) an optometrist; and (5) a chiropractor, all of whom must be appropriately licensed by the state. 42 U.S.C. 1395x(r).

[31] Towards this end, the hospital's in-house counsel or compliance officer should, inter alia, obtain copies of all OIG regulations, special fraud alerts and advisory opinions concerning the anti-kickback statute, Civil Monetary Penalties Law (CMPL) and Stark physician self-referral law (the fraud alerts and anti-kickback or CMPL advisory opinions are published on HHS OIG's home page on the Internet), and ensure that the hospital's policies reflect the guidance provided by the OIG.

[32] See fn. 25, *supra.*

[33] E.g., assigning in-house counsel or contracting with an independent professional organization, such as an accounting, law or consulting firm.

Federal and State statutes, regulations, guidelines and policies. In addition, such a review should ensure that the hospital has appropriate and reasonable mechanisms in place regarding beneficiary deductible or copayment collection efforts and has not claimed as bad debts any routinely waived Medicare copayments and deductibles, which waiver also constitutes a violation of the anti-kickback statute. Further, the hospital may consult with the appropriate fiscal intermediary as to bad debt reporting requirements, if questions arise.

7. Credit Balances. The hospital should institute procedures to provide for the timely and accurate reporting of Medicare and other Federal health care program credit balances. For example, a hospital may redesignate segments of its information system to allow for the segregation of patient accounts reflecting credit balances. The hospital could remove these accounts from the active accounts and place them in a holding account pending the processing of a reimbursement claim to the appropriate program. A hospital's information system should have the ability to print out the individual patient accounts that reflect a credit balance in order to permit simplified tracking of credit balances.

In addition, a hospital should designate at least one person (e.g., in the Patient Accounts Department or reasonable equivalent thereof) as having the responsibility for the tracking, recording and reporting of credit balances. Further, a comptroller or an accountant in the hospital's Accounting Department (or reasonable equivalent thereof) may review reports of credit balances and reimbursements or adjustments on a monthly basis as an additional safeguard.

8. *Retention of Records.* Hospital compliance programs should provide for the implementation of a records system. This system should establish policies and procedures regarding the creation, distribution, retention, storage, retrieval and destruction of documents. The two types of documents developed under this system should include: (1) all records and documentation, e.g., clinical and medical records and claims documentation, required either by Federal or State law for participation in Federal health care programs (e.g., Medicare's conditions of participation requirement that hospital records regarding Medicare claims be retained for a minimum of five years, see 42 CFR 482.24(b)(1) and HCFA Hospital Manual section 413(C)(12–91)); and (2) all records necessary to protect the integrity of the hospital's compliance process and confirm the effectiveness of the program, e.g., documentation that employees were adequately trained; reports from the hospital's hotline, including the nature and results of any investigation that was conducted; modifications to the compliance program; self-disclosure; and the results of the hospital's auditing and monitoring efforts.[34]

9. *Compliance as an Element of a Performance Plan.* Compliance programs should require that the promotion of, and adherence to, the elements of the compliance program be a factor in evaluating the performance of managers and supervisors. They, along with other employees, should be periodically trained in new compliance policies and procedures. In addition, all managers and supervisors involved in the coding, claims and cost report development and submission processes should:

- Discuss with all supervised employees the compliance policies and legal requirements applicable to their function;
- Inform all supervised personnel that strict compliance with these policies and requirements is a condition of employment; and
- Disclose to all supervised personnel that the hospital will take disciplinary action up to and including termination or revocation of privileges for violation of these policies or requirements.

In addition to making performance of these duties an element in evaluations, the compliance officer or hospital management should include in the hospital's compliance program a policy that managers and supervisors will be sanctioned for failure to instruct adequately their subordinates or for failing to detect noncompliance with applicable policies and legal requirements, where reasonable diligence on the part of the manager or supervisor would have led to the discovery of any problems or violations and given the hospital the opportunity to correct them earlier.

B. Designation of a Compliance Officer and a Compliance Committee

1. *Compliance Officer.* Every hospital should designate a compliance officer to serve as the focal point for compliance activities. This responsibility may be the individual's sole duty or added to other management responsibilities, depending upon the size and resources of the hospital and the complexity of the task. Designating a compliance officer with the appropriate authority is critical to the success of the program, necessitating the appointment of a high-level official in the hospital with direct access to the hospital's governing body and the CEO.[35] The officer should have sufficient funding and staff to perform his or her responsibilities fully. Coordination and communication are the key functions of the compliance officer with regard to planning, implementing, and monitoring the compliance program.

The compliance officer's primary responsibilities should include:

- Overseeing and monitoring the implementation of the compliance program; [36]
- Reporting on a regular basis to the hospital's governing body, CEO and compliance committee on the progress of implementation, and assisting these components in establishing methods to improve the hospital's efficiency and quality of services, and to reduce the hospital's vulnerability to fraud, abuse and waste;
- Periodically revising the program in light of changes in the needs of the organization, and in the law and policies and procedures of government and private payor health plans;
- Developing, coordinating, and participating in a multifaceted educational and training program that focuses on the elements of the compliance program, and seeks to ensure that all appropriate employees and management are knowledgeable of, and comply with, pertinent Federal and State standards;
- Ensuring that independent contractors and agents who furnish medical services to the hospital are aware of the requirements of the hospital's compliance program with respect to coding, billing, and marketing, among other things;
- Coordinating personnel issues with the hospital's Human Resources office

[34] The creation and retention of such documents and reports may raise a variety of legal issues, such as patient privacy and confidentiality. These issues are best discussed with legal counsel.

[35] The OIG believes that there is some risk to establishing an independent compliance function if that function is subordinance to the hospital's general counsel, or comptroller or similar hospital financial officer. Free standing compliance functions help to ensure independent and objective legal reviews and financial analyses of the institution's compliance efforts and activities. By separating the compliance function from the key management positions of general counsel or chief hospital financial officer (where the size and structure of the hospital make this a feasible option), a system of checks and balances is established to more effectively achieve the goals of the compliance program.

[36] For multi-hospital organizations, the OIG encourages coordination with each hospital owned by the corporation or foundation through the use of a headquarter's compliance officer, communicating with parallel positions in each facility, or regional office, as appropriate.

(or its equivalent) to ensure that the National Practitioner Data Bank and Cumulative Sanction Report[37] have been checked with respect to all employees, medical staff and independent contractors;

- Assisting the hospital's financial management in coordinating internal compliance review and monitoring activities, including annual or periodic reviews of departments;

- Independently investigating and acting on matters related to compliance, including the flexibility to design and coordinate internal investigations (e.g., responding to reports of problems or suspected violations) and any resulting corrective action with all hospital departments, providers and sub-providers,[38] agents and, if appropriate, independent contractors; and

- Developing policies and programs that encourage managers and employees to report suspected fraud and other improprieties without fear of retaliation.

The compliance officer must have the authority to review all documents and other information that are relevant to compliance activities, including, but not limited to, patient records, billing records, and records concerning the marketing efforts of the facility and the hospital's arrangements with other parties, including employees, professionals on staff, independent contractors, suppliers, agents, and hospital-based physicians, etc. This policy enables the compliance officer to review contracts and obligations (seeking the advice of legal counsel, where appropriate) that may contain referral and payment issues that could violate the anti-kickback statute, as well as the physician self-referral prohibition and other legal or regulatory requirements.

2. *Compliance Committee.* The OIG recommends that a compliance committee be established to advise the compliance officer and assist in the implementation of the compliance program.[39] The committee's functions should include:

- Analyzing the organization's industry environment, the legal requirements with which it must comply, and specific risk areas;
- Assessing existing policies and procedures that address these areas for possible incorporation into the compliance program;
- Working with appropriate hospital departments to develop standards of conduct and policies and procedures to promote compliance with the institution's program;
- Recommending and monitoring, in conjunction with the relevant departments, the development of internal systems and controls to carry out the organization's standards, policies and procedures as part of its daily operations;
- Determining the appropriate strategy/approach to promote compliance with the program and detection of any potential violations, such as through hotlines and other fraud reporting mechanisms; and
- Developing a system to solicit, evaluate and respond to complaints and problems.

The committee may also address other functions as the compliance concept becomes part of the overall hospital operating structure and daily routine.

C. Conducting Effective Training and Education

The proper education and training of corporate officers, managers, employees, physicians and other health care professionals, and the continual retraining of current personnel at all levels, are significant elements of an effective compliance program. As part of their compliance programs, hospitals should require personnel to attend specific training on a periodic basis, including appropriate training in Federal and State statutes, regulations and guidelines, and the policies of private payors, and training in corporate ethics, which emphasizes the organization's commitment to compliance with these legal requirements and policies.

These training programs should include sessions highlighting the organization's compliance program, summarizing fraud and abuse laws, coding requirements, claim development and submission processes and marketing practices that reflect current legal and program standards. The organization must take steps to communicate effectively its standards and procedures to all affected employees, physicians, independent contractors and other significant agents, e.g., by requiring participation in training programs and disseminating publications that explain in a practical manner specific requirements.[40] Managers of specific departments or groups can assist in identifying areas that require training and in carrying out such training. Training instructors may come from outside or inside the organization. New employees should be targeted for training early in their employment.[41] Any formal training undertaken by the hospital as part of the compliance program should be documented by the compliance officer.

A variety of teaching methods, such as interactive training, and training in several different languages, particularly where a hospital has a culturally diverse staff, should be implemented so that all affected employees are knowledgeable of the institution's standards of conduct and procedures for alerting senior management to problems and concerns. Targeted training should be provided to corporate officers, managers and other employees whose actions affect the accuracy of the claims submitted to the Government, such as employees involved in the coding, billing, cost reporting and marketing processes. Given the complexity and interdependent relationships of many departments, proper coordination and supervision of this process by the compliance officer is important. In addition to specific training in the risk areas identified in section II.A.2, above, primary training to appropriate corporate officers, managers and other hospital staff should include such topics as:

- Government and private payor reimbursement principles;
- General prohibitions on paying or receiving remuneration to induce referrals;
- Proper confirmation of diagnoses;

[37] The Cumulative Sanction Report is an OIG-produced report available on the Internet at http://www.dhhs.gov/progorg/oig. It is updated on a regular basis to reflect the status of health care providers who have been excluded from participation in the Medicare and Medicaid programs. In addition, the General Services Administration maintains a monthly listing of debarred contractors on the Internet at http://www.arnet.gov/epls. Also, once the data base established by the Health Care Fraud and Abuse Data Collection Act of 1996 is fully operational, the hospital should regularly request information from this data bank as part of its employee screening process.

[38] E.g., skilled nursing facilities and home health agencies.

[39] The compliance committee benefits from having the perspectives of individuals with varying responsibilities in the organization, such as operations, finance, audit, human resources, utilization review, social work, discharge planning, medicine, coding and legal, as well as employees and managers of key operating units.

[40] Some publications, such as OIG's Management Advisory Report entitled ''Financial Arrangements between Hospitals and Hospital-Based Physicians,'' Special Fraud Alerts, audit and inspection reports, and advisory opinions, as well as the annual OIG work plan, are readily available from the OIG and could be the basis for standards, educational courses and programs for appropriate hospital employees.

[41] Certain positions, such as those involving the coding of medical services, create a greater organizational legal exposure, and therefore require specialized training. One recommendation would be for a hospital to attempt to fill such positions with individuals who have the appropriate educational background and training.

- Submitting a claim for physician services when rendered by a non-physician (i.e., the ''incident to'' rule and the physician physical presence requirement);
- Signing a form for a physician without the physician's authorization;
- Alterations to medical records;
- Prescribing medications and procedures without proper authorization;
- Proper documentation of services rendered; and
- Duty to report misconduct.

Clarifying and emphasizing these areas of concern through training and educational programs are particularly relevant to a hospital's marketing and financial personnel, in that the pressure to meet business goals may render these employees vulnerable to engaging in prohibited practices.

The OIG suggests that all relevant levels of personnel be made part of various educational and training programs of the hospital. Employees should be required to have a minimum number of educational hours per year, as appropriate, as part of their employment responsibilities.[42] For example, for certain employees involved in the billing and coding functions, periodic training in proper DRG coding and documentation of medical records should be required.[43] In hospitals with high employee turnover, periodic training updates are critical.

The OIG recommends that attendance and participation in training programs be made a condition of continued employment and that failure to comply with training requirements should result in disciplinary action, including possible termination, when such failure is serious. Adherence to the provisions of the compliance program, such as training requirements, should be a factor in the annual evaluation of each employee.[44] The hospital should retain adequate records of its training of employees, including attendance logs and material distributed at training sessions.

Finally, the OIG recommends that hospital compliance programs address the need for periodic professional education courses that may be required by statute and regulation for certain hospital personnel.

D. Developing Effective Lines of Communication

1. *Access to the Compliance Officer.* An open line of communication between the compliance officer and hospital personnel is equally important to the successful implementation of a compliance program and the reduction of any potential for fraud, abuse and waste. Written confidentiality and non-retaliation policies should be developed and distributed to all employees to encourage communication and the reporting of incidents of potential fraud.[45] The compliance committee should also develop several independent reporting paths for an employee to report fraud, waste or abuse so that such reports cannot be diverted by supervisors or other personnel.

The OIG encourages the establishment of a procedure so that hospital personnel may seek clarification from the compliance officer or members of the compliance committee in the event of any confusion or question with regard to a hospital policy or procedure. Questions and responses should be documented and dated and, if appropriate, shared with other staff so that standards, policies and procedures can be updated and improved to reflect any necessary changes or clarifications. The compliance officer may want to solicit employee input in developing these communication and reporting systems.

2. *Hotlines and Other Forms of Communication.* The OIG encourages the use of hotlines (including anonymous hotlines), e-mails, written memoranda, newsletters, and other forms of information exchange to maintain these open lines of communication. If the hospital establishes a hotline, the telephone number should be made readily available to all employees and independent contractors, possibly by conspicuously posting the telephone number in common work areas.[46] Employees should be permitted to report matters on an anonymous basis. Matters reported through the hotline or other communication sources that suggest substantial violations of compliance policies, regulations or statutes should be documented and investigated promptly to determine their veracity. A log should be maintained by the compliance officer that records such calls, including the nature of any investigation and its results. Such information should be included in reports to the governing body, the CEO and compliance committee. Further, while the hospital should always strive to maintain the confidentiality of an employee's identity, it should also explicitly communicate that there may be a point where the individual's identity may become known or may have to be revealed in certain instances when governmental authorities become involved.

The OIG recognizes that assertions of fraud and abuse by employees who may have participated in illegal conduct or committed other malfeasance raise numerous complex legal and management issues that should be examined on a case-by-case basis. The compliance officer should work closely with legal counsel, who can provide guidance regarding such issues.

E. Enforcing Standards Through Well-Publicized Disciplinary Guidelines

1. *Discipline Policy and Actions.* An effective compliance program should include guidance regarding disciplinary action for corporate officers, managers, employees, physicians and other health care professionals who have failed to comply with the hospital's standards of conduct, policies and procedures, or Federal and State laws, or those who have otherwise engaged in wrongdoing, which have the potential to impair the hospital's status as a reliable, honest and trustworthy health care provider.

The OIG believes that the compliance program should include a written policy statement setting forth the degrees of disciplinary actions that may be imposed upon corporate officers, managers, employees, physicians and other health care professionals for failing to comply with the hospital's standards and policies and applicable statutes and regulations. Intentional or reckless noncompliance should subject transgressors to significant sanctions. Such sanctions could range from oral

[42] Currently, the OIG is monitoring approximately 165 corporate integrity agreements that require many of these training elements. The OIG usually requires a minimum of one to three hours annually for basic training in compliance areas. More is required for speciality fields such as billing and coding.

[43] Accurate coding depends upon the quality and completeness of the physician's documentation. Therefore, the OIG believes that active staff physician participation in educational programs focusing on coding and documentation should be emphasized by the hospital.

[44] In addition, where feasible, the OIG believes that a hospital's outside contractors, including physician corporations, should be afforded the opportunity to participate in, or develop their own, compliance training and educational programs, which complement the hospital's standards of conduct, compliance requirements, and other rules and regulations.

[45] The OIG believes that whistleblowers should be protected against retaliation, a concept embodied in the provisions of the False Claims Act. In many cases, employees sue their employers under the False Claims Act's *qui tam* provisions out of frustration because of the company's failure to take action when a questionable, fraudulent or abusive situation was brought to the attention of senior corporate officials.

[46] Hospitals should also post in a prominent, available area the HHS OIG Hotline telephone number, 1–800–HHS–TIPS (447–8477), in addition to any company hotline number that may be posted.

warnings to suspension, privilege revocation (subject to any applicable peer review procedures), termination or financial penalties, as appropriate. The written standards of conduct should elaborate on the procedures for handling disciplinary problems and those who will be responsible for taking appropriate action. Some disciplinary actions can be handled by department managers, while others may have to be resolved by a senior hospital administrator. Disciplinary action may be appropriate where a responsible employee's failure to detect a violation is attributable to his or her negligence or reckless conduct. Personnel should be advised by the hospital that disciplinary action will be taken on a fair and equitable basis. Managers and supervisors should be made aware that they have a responsibility to discipline employees in an appropriate and consistent manner.

It is vital to publish and disseminate the range of disciplinary standards for improper conduct and to educate officers and other hospital staff regarding these standards. The consequences of noncompliance should be consistently applied and enforced, in order for the disciplinary policy to have the required deterrent effect. All levels of employees should be subject to the same disciplinary action for the commission of similar offenses. The commitment to compliance applies to all personnel levels within a hospital. The OIG believes that corporate officers, managers, supervisors, medical staff and other health care professionals should be held accountable for failing to comply with, or for the foreseeable failure of their subordinates to adhere to, the applicable standards, laws, and procedures.

2. *New Employee Policy.* For all new employees who have discretionary authority to make decisions that may involve compliance with the law or compliance oversight, hospitals should conduct a reasonable and prudent background investigation, including a reference check, as part of every such employment application.[47] The application should specifically require the applicant to disclose any criminal conviction, as defined by 42 U.S.C. 1320a–7(i), or exclusion action. Pursuant to the compliance program, hospital policies should prohibit the employment of individuals who have been recently convicted of a criminal offense related to health care or who are listed as debarred, excluded or otherwise ineligible for participation in Federal health care programs (as defined in 42 U.S.C. 1320a–7b(f)).[48] In addition, pending the resolution of any criminal charges or proposed debarment or exclusion, the OIG recommends that such individuals should be removed from direct responsibility for or involvement in any Federal health care program.[49] With regard to current employees or independent contractors, if resolution of the matter results in conviction, debarment or exclusion, the hospital should terminate its employment or other contract arrangement with the individual or contractor.

F. Auditing and Monitoring

An ongoing evaluation process is critical to a successful compliance program. The OIG believes that an effective program should incorporate thorough monitoring of its implementation and regular reporting to senior hospital or corporate officers.[50] Compliance reports created by this ongoing monitoring, including reports of suspected noncompliance, should be maintained by the compliance officer and shared with the hospital's senior management and the compliance committee.

Although many monitoring techniques are available, one effective tool to promote and ensure compliance is the performance of regular, periodic compliance audits by internal or external auditors who have expertise in Federal and State health care statutes, regulations and Federal health care program requirements. The audits should focus on the hospital's programs or divisions, including external relationships with third-party contractors, specifically those with substantive exposure to government enforcement actions. At a minimum, these audits should be designed to address the hospital's compliance with laws governing kickback arrangements, the physician self-referral prohibition, CPT/HCPSC ICD–9 coding, claim development and submission, reimbursement, cost reporting and marketing. In addition, the audits and reviews should inquire into the hospital's compliance with specific rules and polices that have been the focus of particular attention on the part of the Medicare fiscal intermediaries or carriers, and law enforcement, as evidenced by OIG Special Fraud Alerts, OIG audits and evaluations, and law enforcement's initiatives. See section II.A.2, *supra*. In addition, the hospital should focus on any areas of concern that have been identified by any entity, i.e., Federal, State, or internally, specific to the individual hospital.

Monitoring techniques may include sampling protocols that permit the compliance officer to identify and review variations from an established baseline.[51] Significant variations from the baseline should trigger a reasonable inquiry to determine the cause of the deviation. If the inquiry determines that the deviation occurred for legitimate, explainable reasons, the compliance officer, hospital administrator or manager may want to limit any corrective action or take no action. If it is determined that the deviation was caused by improper procedures, misunderstanding of rules, including fraud and systemic problems, the hospital should take prompt steps to correct the problem. Any overpayments discovered as a result of such deviations should be returned promptly to the affected payor, with appropriate documentation and a thorough explanation of the reason for the refund.[52]

Monitoring techniques may also include a review of any reserves the hospital has established for payments that it may owe to Medicare, Medicaid, TRICARE or other Federal health care programs. Any reserves discovered that include funds that should have been paid to Medicare or another government program should be paid promptly,

[47] See fn. 37, *supra*.

[48] Likewise, hospital compliance programs should establish standards prohibiting the execution of contracts with companies that have been recently convicted of a criminal offense related to health care or that are listed by a Federal agency as debarred, excluded, or otherwise ineligible for participation in Federal health care programs.

[49] Prospective employees who have been officially reinstated into the Medicare and Medicaid programs by the OIG may be considered for employment upon proof of such reinstatement.

[50] Even when a hospital is owned by a larger corporate entity, the regular auditing and monitoring of the compliance activities of an individual hospital must be a key feature in any annual review. Appropriate reports on audit findings should be periodically provided and explained to a parent-organization's senior staff and officers.

[51] The OIG recommends that when a compliance program is established in a hospital, the compliance officer, with the assistance of department managers, should take a ''snapshot'' of their operations from a compliance perspective. This assessment can be undertaken by outside consultants, law or accounting firms, or internal staff, with authoritative knowledge of health care compliance requirements. This ''snapshot,'' often used as part of benchmarking analyses, becomes a baseline for the compliance officer and other managers to judge the hospital's progress in reducing or eliminating potential areas of vulnerability. For example, it has been suggested that a baseline level include the frequency and percentile levels of various diagnosis codes and the increased billing of complications and co-morbidities.

[52] In addition, when appropriate, as referenced in section G.2 reports of fraud or systemic problems should also be made to the appropriate governmental authority.

regardless of whether demand has been made for such payment.

An effective compliance program should also incorporate periodic (at least annual) reviews of whether the program's compliance elements have been satisfied, e.g., whether there has been appropriate dissemination of the program's standards, training, ongoing educational programs and disciplinary actions, among others. This process will verify actual conformance by all departments with the compliance program. Such reviews could support a determination that appropriate records have been created and maintained to document the implementation of an effective program. However, when monitoring discloses that deviations were not detected in a timely manner due to program deficiencies, appropriate modifications must be implemented. Such evaluations, when developed with the support of management, can help ensure compliance with the hospital's policies and procedures.

As part of the review process, the compliance officer or reviewers should consider techniques such as:

- On-site visits;
- Interviews with personnel involved in management, operations, coding, claim development and submission, patient care, and other related activities;
- Questionnaires developed to solicit impressions of a broad cross-section of the hospital's employees and staff;
- Reviews of medical and financial records and other source documents that support claims for reimbursement and Medicare cost reports;
- Reviews of written materials and documentation prepared by the different divisions of a hospital; and
- Trend analysis, or longitudinal studies, that seek deviations, positive or negative, in specific areas over a given period.

The reviewers should:

- Be independent of physicians and line management;
- Have access to existing audit and health care resources, relevant personnel and all relevant areas of operation;
- Present written evaluative reports on compliance activities to the CEO, governing body and members of the compliance committee on a regular basis, but no less than annually; and
- Specifically identify areas where corrective actions are needed.

With these reports, hospital management can take whatever steps are necessary to correct past problems and prevent them from reoccurring. In certain cases, subsequent reviews or studies would be advisable to ensure that the recommended corrective actions have been implemented successfully.

The hospital should document its efforts to comply with applicable statutes, regulations and Federal health care program requirements. For example, where a hospital, in its efforts to comply with a particular statute, regulation or program requirement, requests advice from a government agency (including a Medicare fiscal intermediary or carrier) charged with administering a Federal health care program, the hospital should document and retain a record of the request and any written or oral response. This step is extremely important if the hospital intends to rely on that response to guide it in future decisions, actions or claim reimbursement requests or appeals. Maintaining a log of oral inquiries between the hospital and third parties represents an additional basis for establishing documentation on which the organization may rely to demonstrate attempts at compliance. Records should be maintained demonstrating reasonable reliance and due diligence in developing procedures that implement such advice.

G. Responding to Detected Offenses and Developing Corrective Action Initiatives

1. *Violations and Investigations.* Violations of a hospital's compliance program, failures to comply with applicable Federal or State law, and other types of misconduct threaten a hospital's status as a reliable, honest and trustworthy provider capable of participating in Federal health care programs. Detected but uncorrected misconduct can seriously endanger the mission, reputation, and legal status of the hospital. Consequently, upon reports or reasonable indications of suspected noncompliance, it is important that the chief compliance officer or other management officials initiate prompt steps to investigate the conduct in question to determine whether a material violation of applicable law or the requirements of the compliance program has occurred, and if so, take steps to correct the problem.[53] As appropriate, such steps may include an immediate referral to criminal and/or civil law enforcement authorities, a corrective action plan,[54] a report to the Government,[55] and the submission of any overpayments, if applicable.

Where potential fraud or False Claims Act liability is not involved, the OIG recognizes that HCFA regulations and contractor guidelines already include procedures for returning overpayments to the Government as they are discovered. However, even if the overpayment detection and return process is working and is being monitored by the hospital's audit or coding divisions, the OIG still believes that the compliance officer needs to be made aware of these overpayments, violations or deviations and look for trends or patterns that may demonstrate a systemic problem.

Depending upon the nature of the alleged violations, an internal investigation will probably include interviews and a review of relevant documents. Some hospitals should consider engaging outside counsel, auditors, or health care experts to assist in an investigation. Records of the investigation should contain documentation of the alleged violation, a description of the investigative process, copies of interview notes and key documents, a log of the witnesses interviewed and the documents reviewed, the results of the investigation, e.g., any disciplinary action taken, and the corrective action implemented. While any action taken as the result of an investigation will necessarily vary depending upon the hospital and the situation, hospitals should strive for some consistency by utilizing sound practices and disciplinary protocols. Further, after a reasonable period, the compliance officer should review the circumstances that formed the basis for the investigation to determine whether similar problems have been uncovered.

[53] Instances of non-compliance must be determined on a case-by-case basis. The existence, or amount, of a *monetary* loss to a health care program is not solely determinative of whether or not the conduct should be investigated and reported to governmental authorities. In fact, there may be instances where there is no monetary loss at all, but corrective action and reporting are still necessary to protect the integrity of the applicable program and its beneficiaries.

[54] Advice from the hospital's in-house counsel or an outside law firm may be sought to determine the extent of the hospital's liability and to plan the appropriate course of action.

[55] The OIG currently maintains a voluntary disclosure program that encourages providers to report suspected fraud. The concept of voluntary self-disclosure is premised on a recognition that the Government alone cannot protect the integrity of the Medicare and other Federal health care programs. Health care providers must be willing to police themselves, correct underlying problems and work with the Government to resolve these matters. The OIG's voluntary self-disclosure program has four prerequisites: (1) the disclosure must be on behalf of an entity and not an individual; (2) the disclosure must be truly voluntary (i.e., no pending proceeding or investigation); (3) the entity must disclose the nature of the wrongdoing and the harm to the Federal programs; and (4) the entity must not be the subject of a bankruptcy proceeding before or after the self-disclosure.

If an investigation of an alleged violation is undertaken and the compliance officer believes the integrity of the investigation may be at stake because of the presence of employees under investigation, those subjects should be removed from their current work activity until the investigation is completed (unless an internal or Government-led undercover operation is in effect). In addition, the compliance officer should take appropriate steps to secure or prevent the destruction of documents or other evidence relevant to the investigation. If the hospital determines that disciplinary action is warranted, if should be prompt and imposed in accordance with the hospital's written standards of disciplinary action.

2. Reporting. If the compliance officer, compliance committee or management official discovers credible evidence of misconduct from any source and, after a reasonable inquiry, has reason to believe that the misconduct may violate criminal, civil or administrative law, then the hospital promptly should report the existence of misconduct to the appropriate governmental authority [56] within a reasonable period, but not more than sixty (60) days [57] after determining that there is credible evidence of a violation.[58] Prompt reporting will demonstrate the hospital's good faith and willingness to work with governmental authorities to correct and remedy the problem. In addition, reporting such conduct will be considered a mitigating factor by the OIG in determining administrative sanctions (e.g., penalties, assessments, and exclusion), if the reporting provider becomes the target of an OIG investigation.[59]

When reporting misconduct to the Government, a hospital should provide all evidence relevant to the alleged violation of applicable Federal or State law(s) and potential cost impact. The compliance officer, under advice of counsel, and with guidance from the governmental authorities, could be requested to continue to investigate the reported violation. Once the investigation is completed, the compliance officer should be required to notify the appropriate governmental authority of the outcome of the investigation, including a description of the impact of the alleged violation on the operation of the applicable health care programs or their beneficiaries. If the investigation ultimately reveals that criminal or civil violations have occurred, the appropriate Federal and State officials [60] should be notified immediately.

As previously stated, the hospital should take appropriate corrective action, including prompt identification and restitution of any overpayment to the affected payor and the imposition of proper disciplinary action. Failure to repay overpayments within a reasonable period of time could be interpreted as an intentional attempt to conceal the overpayment from the Government, thereby establishing an independent basis for a criminal violation with respect to the hospital, as well as any individuals who may have been involved.[61] For this reason, hospital compliance programs should emphasize that overpayment obtained from Medicare or other Federal health care programs should be promptly returned to the payor that made the erroneous payment.[62]

III. Conclusion

Through this document, the OIG has attempted to provide a foundation to the process necessary to develop an effective and cost-efficient hospital compliance program. As previously stated, however, each program must be tailored to fit the needs and resources of an individual hospital, depending upon its particular corporate structure, mission, and employee composition. The statutes, regulations and guidelines of the Federal and State health insurance programs, as well as the policies and procedures of the private health plans, should be integrated into every hospital's compliance program.

The OIG recognizes that the health care industry in this country, which reaches millions of beneficiaries and expends about a trillion dollars, is constantly evolving. However, the time is right for hospitals to implement a strong voluntary compliance program concept in health care. As stated throughout this guidance, compliance is a dynamic process that helps to ensure that hospitals and other health care providers are better able to fulfill their commitment to ethical behavior, as well as meet the changes and challenges being imposed upon them by Congress and private insurers. Ultimately, it is the OIG's hope that a voluntarily created compliance program will enable hospitals to meet their goals, improve the quality of patient care, and substantially reduce fraud, waste and abuse, as well as the cost of health care to Federal, State and private health insurers.

Dated: February 11, 1998.

June Gibbs Brown,

Inspector General.

[FR Doc. 98–4399 Filed 2–20–98; 8:45 am]

BILLING CODE 4150–04–M

[56] I.e., Federal and/or State law enforcement having jurisdiction over such matter. Such governmental authority would include DOJ and OIG with respect to Medicare and Medicaid violations giving rise to causes of actions under various criminal, civil and administrative false claims statutes.

[57] To qualify for the ''not less than double damages'' provision of the False Claims Act, the report must be provided to the Government within thirty (30) days after the date when the hospital first obtained the information. 31 U.S.C. 3729(a).

[58] The OIG believes that some violations may be so serious that they warrant immediate notification to governmental authorities, prior to, or simultaneous with, commencing an internal investigation, e.g., if the conduct: (1) is a clear violation of criminal law; (2) has a significant adverse effect on the quality of care provided to program beneficiaries (in addition to any other legal obligations regarding quality of care); or (3) indicates evidence of a systemic failure to comply with applicable laws, an existing corporate integrity agreement, or other standards of conduct, regardless of the financial impact on Federal health care programs.

[59] The OIG has published criteria setting forth those factors that the OIG takes into consideration in determining whether it is appropriate to exclude a health care provider from program participation pursuant to 42 U.S.C. 1320a–7(b)(7) for violations of various fraud and abuse laws. See 62 FR 67392, December 24, 1997.

[60] Appropriate Federal and State authorities include the Criminal and Civil Divisions of the Department of Justice, the U.S. Attorney in the hospital's district, and the investigative arms for the agencies administering the affected Federal or State health care programs, such as the State Medicaid Fraud Control Unit, the Defense Criminal Investigative Service, and the Offices of Inspector General of the Department of Health and Human Services, the Department of Veterans Affairs and the Office of Personnel Management (which administers the Federal Employee Health Benefits Program).

[61] See 42 U.S.C. 1320a–7b(a)(3).

[62] Normal repayment channels as described in HCFA's manuals and guidances are the appropriate vehicle for repaying identified overpayments. Hospitals should consult with its fiscal intermediary or HCFA for any further guidance regarding these repayment channels. Interest will be assessed, when appropriate. See 42 CFR 405.376.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General

Program Exclusions: January 1998

AGENCY: Office of Inspector General, HHS.

ACTION: Notice of program exclusions.

During the month of January 1998, the HHS Office of Inspector General imposed exclusions in the cases set forth below. When an exclusion is imposed, no program payment is made to anyone for any items or services (other than an emergency item or service not provided in a hospital emergency room) furnished, ordered or prescribed by an excluded party under

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General

OIG Supplemental Compliance Program Guidance for Hospitals

AGENCY: Office of Inspector General (OIG), HHS.

ACTION: Notice.

SUMMARY: This **Federal Register** notice sets forth the Supplemental Compliance Program Guidance (CPG) for Hospitals developed by the Office of Inspector General (OIG). Through this notice, the OIG is supplementing its prior compliance program guidance for hospitals issued in 1998. The supplemental CPG contains new compliance recommendations and an expanded discussion of risk areas, taking into account recent changes to hospital payment systems and regulations, evolving industry practices, current enforcement priorities, and lessons learned in the area of corporate compliance. The supplemental CPG provides voluntary guidelines to assist hospitals and hospital systems in identifying significant risk areas and in evaluating and, as necessary, refining ongoing compliance efforts.

FOR FURTHER INFORMATION CONTACT: Darlene M. Hampton, Office of Counsel to the Inspector General, (202) 619–0335.

SUPPLEMENTARY INFORMATION:

Background

Several years ago, the OIG embarked on a major initiative to engage the private health care community in preventing the submission of erroneous claims and in combating fraud and abuse in the Federal health care programs through voluntary compliance efforts. In the last several years, the OIG has developed a series of compliance program guidances (CPGs) directed at the following segments of the health care industry: hospitals; clinical laboratories; home health agencies; third-party billing companies; the durable medical equipment, prosthetics, orthotics, and supply industry; hospices; Medicare+Choice organizations; nursing facilities; physicians; ambulance suppliers; and pharmaceutical manufacturers. CPGs are intended to encourage the development and use of internal controls to monitor adherence to applicable statutes, regulations, and program requirements. The suggestions made in these CPGs are not mandatory, and the CPGs should not be viewed as exhaustive discussions of beneficial compliance practices or relevant risk areas. Copies of these CPGs can be found on the OIG Web page at *http://oig.hhs.gov.*

Supplementing the Compliance Program Guidance for Hospitals

The OIG originally published a CPG for the hospital industry on February 23, 1998. (*See* 63 FR 8987 (February 23, 1998), available on our Web page at *http://oig.hhs.gov/authorities/docs/cpghosp.pdf.*) Since that time, there have been significant changes in the way hospitals deliver, and are reimbursed for, health care services. In response to these developments, on June 18, 2002, the OIG published a notice in the **Federal Register,** soliciting public suggestions for revising the hospital CPG. (*See* 67 FR 41433 (June 18, 2002), available on our Web page at *http://oig.hhs.gov/authorities/docs/cpghospitalsolicitationnotice.pdf.*) After consideration of the public comments and the issues raised, the OIG published a draft supplemental compliance program guidance for hospitals in the **Federal Register** on June 8, 2004, to ensure that all parties had a reasonable and meaningful opportunity to provide input into the final product. (*See* 69 FR 32012 (June 8, 2004), available on our Web page at *http://oig.hhs.gov/authorities/docs/04/060804hospitaldraftsuppCPGFR.pdf.*) The OIG received comments from a variety of parties with interests in the hospital industry and diverse points of view. These comments were carefully considered during the development of this final supplemental CPG. While some commenters preferred a replacement CPG, for efficiency and to create a concise product of particular use to hospitals with existing compliance programs, we have decided to supplement, rather than replace, the 1998 guidance.

Many public commenters sought guidance on the application of specific Medicare rules and regulations related to payment and coverage, an area beyond the scope of this OIG guidance. Hospitals with questions about the interpretation or application of payment and coverage rules or regulations should contact their Fiscal Intermediaries (FIs) or the Centers for Medicare & Medicaid Services, as appropriate.

Supplemental Compliance Program Guidance for Hospitals

I. Introduction

Continuing its efforts to promote voluntary compliance programs for the health care industry, the Office of Inspector General (OIG) of the Department of Health and Human Services (the Department) publishes this Supplemental Compliance Program Guidance (CPG) for Hospitals.[1] This document supplements, rather than replaces, the OIG's 1998 CPG for the hospital industry (63 FR 8987; February 23, 1998), which addressed the fundamentals of establishing an effective compliance program.[2] Neither this supplemental CPG, nor the original 1998 CPG, is a model compliance program. Rather, collectively the two documents offer a set of guidelines that hospitals should consider when developing and implementing a new compliance program or evaluating an existing one.

We are mindful that many hospitals have already devoted substantial time and resources to compliance efforts. We believe that those efforts demonstrate the industry's good faith commitment to ensuring and promoting integrity. For those hospitals with existing compliance programs, this document may serve as a benchmark or comparison against which to measure ongoing efforts and as a roadmap for updating or refining their compliance plans.

In crafting this supplemental CPG, we considered, among other things, the public comments received in response to the solicitation notice published in the **Federal Register** [3] and the draft supplemental CPG,[4] as well as relevant OIG and Centers for Medicare & Medicaid Services (CMS) statutory and regulatory authorities (including the Federal anti-kickback statute, together with the safe harbor regulations and

[1] For purposes of convenience in this guidance, we use the term ''hospitals'' to refer to individual hospitals, multi-hospital systems, health systems that own or operate hospitals, academic medical centers, and any other organization that owns or operates one or more hospitals. Where applicable, the term ''hospitals'' is also intended to include, without limitation, hospital owners, officers, managers, staff, agents, and sub-providers. This guidance primarily focuses on hospitals reimbursed under the inpatient and outpatient prospective payment systems. While other hospitals should find this CPG useful, we recognize that they may be subject to different laws, rules, and regulations and, accordingly, may have different or additional risk areas and may need to adopt different compliance strategies. We encourage all hospitals to establish and maintain ongoing compliance programs.

[2] The 1998 OIG Compliance Program Guidance for Hospitals is available on our Web page at *http://oig.hhs.gov/authorities/docs/cpghosp.pdf.*

[3] *See* 67 FR 41433 (June 18, 2002), ''Solicitation of Information and Recommendations for Revising a Compliance Program Guidance for the Hospital Industry,'' available on our Web page at *http://oig.hhs.gov/authorities/docs/cpghospitalsolicitationnotice.pdf.*

[4] *See* 69 FR 32012 (June 8, 2004), ''OIG Draft Supplemental Compliance Program Guidance for Hospitals,'' available on our Web page at *http://oig.hhs.gov/authorities/docs/04/060804hospitaldraftsuppCPGFR.pdf.*

preambles,[5] and CMS transmittals and program memoranda); other OIG guidance (such as OIG advisory opinions, special fraud alerts, bulletins, and other guidance); experience gained from investigations conducted by the OIG's Office of Investigations, the Department of Justice (DoJ), and the State Medicaid Fraud Units; and relevant reports issued by the OIG's Office of Audit Services and Office of Evaluation and Inspections.[6] We also consulted generally with CMS, the Department's Office for Civil Rights, and DoJ.

A. Benefits of a Compliance Program

A successful compliance program addresses the public and private sectors' mutual goals of reducing fraud and abuse; enhancing health care providers' operations; improving the quality of health care services; and reducing the overall cost of health care services. Attaining these goals benefits the hospital industry, the government, and patients alike. Compliance programs help hospitals fulfill their legal duty to refrain from submitting false or inaccurate claims or cost information to the Federal health care programs[7] or engaging in other illegal practices. A hospital may gain important additional benefits by voluntarily implementing a compliance program, including:

- Demonstrating the hospital's commitment to honest and responsible corporate conduct;
- Increasing the likelihood of preventing, identifying, and correcting unlawful and unethical behavior at an early stage;
- Encouraging employees to report potential problems to allow for appropriate internal inquiry and corrective action; and
- Through early detection and reporting, minimizing any financial loss to government and taxpayers, as well as any corresponding financial loss to the hospital.

The OIG recognizes that implementation of a compliance program may not entirely eliminate improper or unethical conduct from the operations of health care providers. However, an effective compliance program demonstrates a hospital's good faith effort to comply with applicable statutes, regulations, and other Federal health care program requirements, and may significantly reduce the risk of unlawful conduct and corresponding sanctions.

B. Application of Compliance Program Guidance

Given the diversity of the hospital industry, there is no single ''best'' hospital compliance program. The OIG recognizes the complexities of the hospital industry and the differences among hospitals and hospital systems. Some hospital entities are small and may have limited resources to devote to compliance measures; others are affiliated with well-established, large, multi-facility organizations with a widely dispersed work force and significant resources to devote to compliance.

Accordingly, this supplemental CPG is not intended to be one-size-fits-all guidance. Rather, the OIG strongly encourages hospitals to identify and focus their compliance efforts on those areas of potential concern or risk that are most relevant to their individual organizations. Compliance measures adopted by a hospital to address identified risk areas should be tailored to fit the unique environment of the organization (including its structure, operations, resources, and prior enforcement experience). In short, the OIG recommends that each hospital adapt the objectives and principles underlying this guidance to its own particular circumstances.

In section II below, titled ''Fraud and Abuse Risk Areas,'' we present several fraud and abuse risk areas that are particularly relevant to the hospital industry. Each hospital should carefully examine these risk areas and identify those that potentially impact the hospital. Next, in section III, ''Hospital Compliance Program Effectiveness,'' we offer recommendations for assessing and improving an existing compliance program to better address identified risk areas. Finally, in section IV, ''Self-Reporting,'' we set forth the actions hospitals should take if they discover credible evidence of misconduct.

II. Fraud and Abuse Risk Areas

This section is intended to help hospitals identify areas of their operations that present a potential risk of liability under several key Federal fraud and abuse statutes and regulations. This section focuses on areas that are currently of concern to the enforcement community and is not intended to address all potential risk areas for hospitals. Importantly, the identification of a particular practice or activity in this section is not intended to imply that the practice or activity is necessarily illegal in all circumstances or that it may not have a valid or lawful purpose underlying it.

This section addresses the following areas of significant concern for hospitals: (A) Submission of accurate claims and information; (B) the referral statutes; (C) payments to reduce or limit services; (D) the Emergency Medical Treatment and Labor Act (EMTALA); (E) substandard care; (F) relationships with Federal health care beneficiaries; (G) HIPAA Privacy and Security Rules; and (H) billing Medicare or Medicaid substantially in excess of usual charges. In addition, a final section (I) addresses several areas of general interest that, while not necessarily matters of significant risk, have been of continuing interest to the hospital community. This guidance does not create any new law or legal obligations, and the discussions in this guidance are not intended to present detailed or comprehensive summaries of lawful and unlawful activity. Nor is this guidance intended as a substitute for consultation with CMS or a hospital's Fiscal Intermediary (FI) with respect to the application and interpretation of Medicare payment and coverage provisions, which are subject to change. Rather, this guidance should be used as a starting point for a hospital's legal review of its particular practices and for development or refinement of policies and procedures to reduce or eliminate potential risk.

A. Submission of Accurate Claims and Information

Perhaps the single biggest risk area for hospitals is the preparation and submission of claims or other requests for payment from the Federal health care programs. It is axiomatic that all claims and requests for reimbursement from the Federal health care programs—and all documentation supporting such claims or requests—must be complete and accurate and must reflect reasonable and necessary services ordered by an appropriately licensed medical professional who is a participating provider in the health care program from which the individual or entity is seeking reimbursement. Hospitals must disclose and return any overpayments that result from mistaken

[5] *See* 42 U.S.C. 1320a–7b(b). *See also* 42 CFR 1001.952. The safe harbor regulations and preambles are available on our Web page at *http://oig.hhs.gov/fraud/safeharborregulations.html#1.*

[6] The OIG's materials are available on our Web page at *http://oig.hhs.gov.*

[7] The term ''Federal health care programs,'' as defined in 42 U.S.C. 1320a–7b(f), includes any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the Federal Employees Health Benefit Plan described at 5 U.S.C. 8901–8914) or any State health plan (*e.g.,* Medicaid or a program receiving funds from block grants for social services or child health services). In this document, the term ''Federal health care program requirements'' refers to the statutes, regulations, and other rules governing Medicare, Medicaid, and all other Federal health care programs.

or erroneous claims.[8] Moreover, the knowing submission of a false, fraudulent, or misleading statement or claim is actionable. A hospital may be liable under the False Claims Act[9] or other statutes imposing sanctions for the submission of false claims or statements, including liability for civil money penalties (CMPs) or exclusion.[10] Underlying assumptions used in connection with claims submission should be reasoned, consistent, and appropriately documented, and hospitals should retain all relevant records reflecting their efforts to comply with Federal health care program requirements.

Common and longstanding risks associated with claims preparation and submission include inaccurate or incorrect coding, upcoding, unbundling of services, billing for medically unnecessary services or other services not covered by the relevant health care program, billing for services not provided, duplicate billing, insufficient documentation, and false or fraudulent cost reports. While hospitals should continue to be vigilant with respect to these important risk areas, we believe these risk areas are relatively well-understood in the industry and, therefore, they are not generally addressed in this section.[11] Rather, the following discussion highlights evolving risks or risks that appear to the OIG to be under-appreciated by the industry. The risks are grouped under the following topics: Outpatient procedure coding; admissions and discharges; supplemental payment considerations; and use of information technology. By necessity, this discussion is illustrative, not exhaustive, of risks associated with the submission of claims or other information. In all cases, hospitals should consult the applicable laws, rules, and regulations.

1. Outpatient Procedure Coding

The implementation of Medicare's Hospital Outpatient Prospective Payment System (OPPS)[12] increased the importance of accurate procedure coding for hospital outpatient services. Previously, hospital coding concerns mainly consisted of ensuring accurate ICD–9–CM diagnosis and procedure coding for reimbursement under the inpatient prospective payment system (PPS). Hospitals reported procedure codes for outpatient services, but were reimbursed for outpatient services based on their charges for services. With the OPPS, procedure codes effectively became the basis for Medicare reimbursement. Under the OPPS, each reported procedure code is assigned to a corresponding Ambulatory Payment Classification (APC) code. Hospitals are then reimbursed a predetermined amount for each APC, irrespective of the specific level of resources used to furnish the individual service. In implementing the OPPS, CMS developed new rules governing the use of procedure code modifiers for outpatient coding.[13] Because incorrect procedure coding may lead to overpayments and subject a hospital to liability for the submission of false claims, hospitals need to pay close attention to coder training and qualifications.

Hospitals should also review their outpatient documentation practices to ensure that claims are based on complete medical records and that the medical records support the levels of service claimed. Under the OPPS, hospitals must generally include on a single claim all services provided to the same patient on the same day. Coding from incomplete medical records may create problems in complying with this claim submission requirement. Moreover, submitting claims for services that are not supported by the medical record may also result in the submission of improper claims.

In addition to the coding risk areas noted above and in the 1998 hospital CPG, other specific risk areas associated with incorrect outpatient procedure coding include the following:

• *Billing on an outpatient basis for ''inpatient-only'' procedures*—CMS has identified procedures for which reimbursement is typically allowed only if the service is performed in an inpatient setting.[14]

• *Submitting claims for medically unnecessary services by failing to follow the FI's local policies*—Each FI publishes local policies, including local medical review polices (LMRPs) and local coverage determinations (LCDs), that identify certain procedures that are only reimbursable when specific conditions are present.[15] In addition to relying on a physician's sound clinical judgment with respect to the appropriateness of a proposed course of treatment, hospitals should regularly review and become familiar with their individual FI's LMRPs and LCDs. LMRPs and LCDs should be incorporated into a hospital's regular coding and billing operations.[16]

• *Submitting duplicate claims or otherwise not following the National Correct Coding Initiative guidelines*—CMS developed the National Correct Coding Initiative (NCCI) to promote correct coding methodologies. The NCCI identifies certain codes that should not be used together because they are either mutually exclusive or one is a component of another. If a hospital uses code pairs that are listed in the NCCI and those codes are not detected by the editing routines in the hospital's billing system, the hospital may submit duplicate or unbundled claims. Intentional manipulation of code assignments to maximize payments and avoid NCCI edits constitutes fraud. Unintentional misapplication of NCCI coding and billing guidelines may also give rise to overpayments or civil liability for hospitals that have developed a pattern of inappropriate billing. To minimize risk, hospitals

[8] *See* 42 U.S.C. 1320a–7b(a)(3).

[9] The False Claims Act (31 U.S.C. 3729–33), among other things, prohibits knowingly presenting or causing to be presented to the Federal government a false or fraudulent claim for payment or approval, knowingly making or using or causing to be made or used a false record or statement to have a false or fraudulent claim paid or approved by the government, and knowingly making or using or causing to be made or used a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the government. The False Claims Act defines ''knowing'' and ''knowingly'' to mean that ''a person, with respect to the information—(1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.'' 31 U.S.C. 3729(b).

[10] In some circumstances, inaccurate or incomplete reporting may lead to liability under the Federal anti-kickback statute. In addition, hospitals should be mindful that many States have fraud and abuse statutes—including false claims, anti-kickback, and other statutes—that are not addressed in this guidance.

[11] To review the risk areas discussed in the original hospital CPG, *see* 63 FR 8987, 8990 (February 23, 1998), available on our Web page at *http://oig.hhs.gov/authorities/docs/cpghosp.pdf.*

[12] Congress enacted the OPPS in section 4523 of the Balanced Budget Act of 1997. The OPPS became effective on August 1, 2001. CMS promulgated regulations implementing the OPPS at 42 CFR part 419. For more information regarding the OPPS, *see http://www.cms.gov/providers/hopps/.*

[13] The list of current modifiers is listed in the Current Procedural Terminology (CPT) coding manual. However, hospitals should pay particular attention to CMS transmittals and program memoranda that may introduce new or altered application of modifiers for claims submission and reimbursement purposes. *See* chapter 4, section 20.6 of the Medicare Claims Processing Manual at *http://www.cms.gov/manuals/104_claims/clm104c04.pdf.*

[14] The list of ''inpatient-only'' procedures appears in the annual update to the OPPS rule. For the 2004 final rule, the ''inpatient-only'' list is found in Addendum E. *See http://www.cms.gov/regulations/hopps/2004f.*

[15] Effective December 7, 2003, FI's began issuing LCDs instead of LMRPs, and FI's will convert all existing LMRPs into LCDs by December 31, 2005.

[16] A hospital may contact its FI to request a copy of the pertinent LMRPs and LCDs, or visit CMS's Web page at *http://www.cms.gov/mcd* to search existing local and national policies.

should ensure that their coding software includes up-to-date NCCI edit files.[17]

• *Submitting incorrect claims for ancillary services because of outdated Charge Description Masters*—Charge Description Masters (CDMs) list all of a hospital's charges for items and services and include the underlying procedure codes necessary to bill for those items and services. Outdated CDMs create significant compliance risk for hospitals. Because the Healthcare Common Procedure Coding System (HCPCS) codes and APCs are updated regularly, hospitals should pay particular attention to the task of updating the CDM to ensure the assignment of correct codes to outpatient claims. This should include timely updates, proper use of modifiers, and correct associations between procedure codes and revenue codes.[18]

• *Circumventing the multiple procedure discounting rules*—A surgical procedure performed in connection with another surgical procedure may be discounted. However, certain surgical procedures are designated as non-discounted, even when performed with another surgical procedure. Hospitals should ensure that the procedure codes selected represent the actual services provided, irrespective of the discounting status. They should also review the annual OPPS rule update to understand more fully CMS's multiple procedure discounting rule.[19]

• *Improper evaluation and management code selection*—Hospitals should use proper codes to describe the evaluation and management (E/M) services they provide. A hospital's E/M coding guidelines should ensure that services are medically necessary and sufficiently documented and that the codes accurately reflect the intensity of hospital resources required to deliver the services.

• *Improperly billing for observation services*—In certain circumstances, Medicare provides a separate APC payment for observation services for patients with diagnoses of chest pain, asthma, or congestive heart failure. Claims for these observation services must correctly reflect the diagnosis and meet certain other requirements. Seeking a separate payment for observation services in situations that do not satisfy the requirements is inappropriate and may result in hospital liability. Hospitals should become familiar with CMS's detailed policies for the submission of claims for observation services.[20]

2. Admissions and Discharges

Often, the status of patients at the time of admission or discharge significantly influences the amount and method of reimbursement hospitals receive. Therefore, hospitals have a duty to ensure that admission and discharge policies are updated and reflect current CMS rules. Risk areas with respect to the admission and discharge processes include the following:

• *Failure to follow the ''same-day rule''*—The OPPS rules require hospitals to include on the same claim all OPPS services provided at the same hospital, to the same patient, on the same day, unless certain conditions are met. Hospitals should review internal billing systems and procedures to ensure that they are not submitting multiple claims for OPPS services delivered to the same patient on the same day.[21]

• *Abuse of partial hospitalization payments*—Under the OPPS, Medicare provides a *per diem* payment for specific hospital services rendered to behavioral and mental health patients on a partial hospitalization basis. Examples of improper billing under the partial hospitalization program include, without limitation: reducing the range of services offered; withholding services that are medically appropriate; billing for services not covered; and billing for services without a certificate of medical necessity.[22]

• *Same-day discharges and readmissions*—Same-day discharges and readmissions may indicate premature discharges, medically unnecessary readmissions, or incorrect discharge coding. Hospitals should have procedures in place to review discharges and admissions carefully to ensure that they reflect prudent clinical decision-making and are properly coded.[23]

• *Violation of Medicare's post-acute care transfer policy*—The post-acute care transfer policy provides that, for certain designated Diagnosis Related Groups (DRGs), a hospital will receive a per diem transfer payment, rather than the full DRG payment, if the patient is discharged to certain post-acute care settings.[24] CMS may periodically revise the list of designated DRGs that are subject to its post-acute care transfer policy.[25] To avoid improperly billing for discharges, hospitals should pay particular attention to CMS's post-acute care transfer policy and keep an accurate list of all designated DRGs subject to that policy.

• *Improper churning of patients by long-term care hospitals co-located in acute care hospitals*—Long term care hospitals that are co-located within acute care hospitals may qualify for PPS-exempt status if certain regulatory requirements are satisfied.[26] Hospitals should not engage in the practice of churning, or inappropriately transferring, patients between the host hospital and the hospital-within-a-hospital.

3. Supplemental Payment Considerations

Under the Medicare program, in certain limited situations, hospitals may claim payments in addition to, or in some cases in lieu of, the normal reimbursement available to hospitals under the regular payment systems. Eligibility for these payments depends on compliance with specific criteria. Hospitals that claim supplemental payments improperly are liable for fines and penalties under Federal law. Examples of specific risks that hospitals should address include the following:

• *Improper reporting of the costs of ''pass-through'' items*—''Pass-through'' items are certain items of new technology and drugs for which Medicare will reimburse the hospital

[17] More information regarding the NCCI can be obtained from CMS's Web page at *http://www.cms.gov/medlearn/ncci.asp.*

[18] For information relating to HCPCS code updates, *see http://www.cms.gov/medicare/hcpcs/.* For information relating to annual APC updates, *see http://www.cms.gov/providers/hopps/.*

[19] *See http://www.cms.gov/medlearn/refopps.asp.*

[20] *See* CMS Program Transmittal A–02–026, available on CMS's Web page at *http://www.ems.gov/manuals/pm_trans/A02026.pdf.*

[21] *See, e.g.,* chapter 1, section 50.2 of the Medicare Claims Processing Manual, available on CMS's Web page at *http://www.cms.gov/manuals/104_claims/clm104c01.pdf.*

[22] *See* chapter 4, section 260 of the Medicare Claims Processing Manual, available on CMS's Web page at *http://www.cms.gov/manuals/104_claims/clm104c04.pdf.*

[23] *See, e.g.,* OIG Audit Report A–03–01–00011, ''Review of Medicare Same-Day, Same-Provider Acute Care Readmissions in Pennsylvania During Calendar year 1998,'' August 2002, available on our Web page at *http://oig.hhs.gov/oas/reports/region 3/30100011.pdf.*

[24] *See* 42 CFR 412.4(c). *See, e.g.,* OIG Audit Report A–04–00–01220 ''Implementation of Medicare's Postacute Care Transfer Policy,'' October 2001, available on our Web page at *http://oig.hhs.gov/oas/reports/region4/40001220.pdf.*

[25] The initial 10 designated DRGs were selected by the Secretary, pursuant to section 1886(d)(5)(J) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(J)). With the 2004 fiscal year PPS rule, CMS revised the list of DRGs paid under CMS's post-acute care transfer policy, bringing the total number of designated DRGs to 29. *See* 68 FR 45346 (August 1, 2003). Then, with the 2005 fiscal year PPS rule, CMS revised the list again, bringing the current total number of designated DRGs to 30. *See* 69 FR 48916 (August 11, 2004). *See also* chapter 3, section 402.4 of the Medicare Claims Processing Manual, available on CMS's Web page at *http://www.cms.gov/manuals/104_claims/clm104c03.pdf.*

[26] *See* 42 CFR 412.22(e).

based on costs during a limited transitional period.[27]

• *Abuse of DRG outlier payments*—Recent investigations revealed substantial abuse of outlier payments by hospitals with Medicare patients. Hospital management, compliance staff, and counsel should familiarize themselves with CMS's new outlier rules and requirements intended to curb abuses.[28]

• *Improper claims for incorrectly designated ''provider-based'' entities*—Certain hospital-affiliated entities and clinics can be designated as ''provider-based,'' which allows for a higher level of reimbursement for certain services.[29] Hospitals should take steps to ensure that facilities or organizations are only designated as provider-based if they satisfy the criteria set forth in the regulations.

• *Improper claims for clinical trials*—Since September 2000, Medicare has covered items and services furnished during certain clinical trials, as long as those items and services would typically be covered for Medicare beneficiaries, but for the fact that they are provided in an experimental or clinical trial setting. Hospitals that participate in clinical trials should review the requirements for submitting claims for patients participating in clinical trials.[30]

• *Improper claims for organ acquisition costs*—Hospitals that are approved transplantation centers may receive reimbursement on a reasonable cost basis to cover the costs of acquisition of certain organs.[31] Organ acquisition costs are only reimbursable if a hospital satisfies several requirements, such as having adequate cost information, supporting documentation, and supporting medical records.[32] Hospitals must also ensure that expenses not related to organ acquisition, such as transplant and post-transplant activities and costs from other cost centers, are not included in the hospital's organ acquisition costs.[33]

• *Improper claims for cardiac rehabilitation services*—Medicare covers reasonable and necessary cardiac rehabilitation services under the hospital ''incident-to'' benefit, which requires that the services of nonphysician personnel be furnished under a physician's direct supervision. In addition to satisfying the supervision requirement, hospitals must ensure that cardiac rehabilitation services are reasonable and necessary.[34]

• *Failure to follow Medicare rules regarding payment for costs related to educational activities*[35]—Hospitals should pay particular attention to these rules when implementing dental or other education programs, particularly those not historically operated at the hospital.

4. Use of Information Technology

The implementation of the OPPS increased the need for hospitals to pay particular attention to their computerized billing, coding, and information systems. Billing and coding under the OPPS is more data intensive than billing and coding under the inpatient PPS. When the OPPS began, many hospitals' existing systems were unable to accommodate the new requirements and required adjustments.

As the health care industry moves forward, hospitals will increasingly rely on information technology. For example, HIPAA Privacy and Security Rules (discussed below in section II.G), electronic claims submission,[36] electronic prescribing, networked information sharing among providers, and systems for the tracking and reduction of medical errors, among others, will require hospitals to depend more on information technologies. Information technology presents new opportunities to advance health care efficiency, but also new challenges to ensuring the accuracy of claims and the information used to generate claims. It may be difficult for purchasers of computer systems and software to know exactly how the system operates and generates information. Prudent hospitals will take steps to ensure that they thoroughly assess all new computer systems and software that impact coding, billing, or the generation or transmission of information related to the Federal health care programs or their beneficiaries.

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

1. The Physician Self-Referral Law

From a hospital compliance perspective, the physician self-referral law (section 1877 of the Social Security Act (Act), commonly known as the ''Stark'' law) should be viewed as a threshold statute. The statute prohibits hospitals from submitting—and Medicare from paying—any claim for a ''designated health service'' (DHS) if the referral of the DHS comes from a physician with whom the hospital has a prohibited financial relationship.[37] This is true even if the prohibited financial relationship is the result of inadvertence or error. In addition, hospitals and physicians that *knowingly* violate the statute may be subject to CMPs and exclusion from the Federal health care programs. Furthermore, under certain circumstances, a knowing violation of the Stark law may also give rise to liability under the False Claims Act. Because all inpatient and outpatient hospital services furnished to Medicare or Medicaid patients

[27] For more information regarding CMS's APC ''pass-through'' payments, *See http://www.cms.gov/providers/hopps/apc.asp.*

[28] *See* 42 CFR 412.84; 68 FR 34493 (June 9, 2003).

[29] The criteria for determining whether a facility or organization is provider-based can be found at 42 CFR 413.65. In April 2003, CMS published Transmittal A–03–030, outlining changes to the criteria for provider-based designation. *See http://www.cms.gov/manuals/pm_trans/A03030.pdf.*

[30] To view Medicare's National Coverage Decision regarding clinical trials, *see http://www.cms.gov/coverage/8d2.asp.* Specific requirements for submitting claims for reimbursement for clinical trials can be accessed on CMS's Web page at *http://www.cms.gov/coverage/8d4.asp.*

[31] *See* 42 CFR 412.2(e)(4), 42 CFR 412.113(d), and 42 CFR 413.203. *See generally* 42 CFR part 413 (setting forth the principles of reasonable cost reimbursement).

[32] *See* Medicare's Provider Reimbursement Manual (PRM), Part I, section 2304 and Part II, section 3610, available on CMS's Web page at *http://www.cms.gov/manuals/cmsfoc.asp.*

[33] *See* 42 CFR 412.100. *See also,* chapter 3, section 90 of the Medicare Claims Processing Manual, available on CMS's Web page at *http://www.cms.gov/manuals/104_claims/clm104c03.pdf.See, e.g.,* OIG Audit Report A–04–02–02017, ''Audit of Medicare Costs for Organ Acquisitions at Tampa General Hospital,'' April 2003, available on our Web page at *http://oig.hhs.gov/oas/reports/region4/40202017.pdf.*

[34] *See* section 35–25 of the Medicare Coverage Issues Manual. *See, e.g.,* OIG Audit Report A–01–03–00516, ''Review of Outpatient Cardiac Rehabilitation Services at the Cooley Dickinson Hospital,'' December 2003, available on our Web page at *http://oig.hhs.gov/oas/reports/region 1/10300516.pdf.*

[35] Payments for direct graduage medical education (GME) and indirect graduate medical education (IME) costs are, in part, based upon the number of full-time equivalent (FTE) residents at each hospital and the proportion of time residents spend in training. Hospitals that inappropriately calculate the number of FTE residents risk receiving inappropriate medical education payments. Hospitals should have in place procedures regarding: (i) Resident rotation monitoring; (ii) resident credentialing; (iii) written agreements with non-hospital providers; and (iv) the approval process for research activities. For more information regarding medical education reimbursement, *see* 42 CFR 413.75 *et. seq.* (GME requirements) and 42 CFR 412.105 (IME requirements). *See, e.g.,* OIG Audit Report A–01–01–00547 ''Review of Graduate Medical Education Costs Claimed by the Hartford Hospital for Fiscal Year Ending September 30, 1999,'' October 2003, available on our Web page at *http://oig.hhs.gov/oas/reports/region 1/10100547.pdf.*

[36] For more information regarding Medicare's Electronic Data Interchange programs, *see http://www.cms.gov/providers/edi/.*

[37] The statute also prohibits physicians from referring DHS to entities, including hospitals, with which they have prohibited financial relationships. However, the billing prohibition and nonpayment sanction apply only to the DHS entity (*e.g.*, the hospital). *See* section 1877(a) of the Act. Section 1903(s) of the Act extends the statutory prohibition to Medicaid-covered services.

(including services furnished directly by a hospital or by others ''under arrangements'' with a hospital) are DHS under the statute,[38] hospitals must diligently review all financial relationships with referring physicians for compliance with the Stark law. Simply put, hospitals face significant financial exposure unless their financial relationships with referring physicians fit squarely in statutory or regulatory exceptions to the Stark law.

For purposes of analyzing a financial relationship under the Stark law, the following three-part inquiry is useful:

- Is there a *referral* from a *physician* for a *designated health service*? If not, then there is no Stark law issue (although other fraud and abuse authorities, such as the anti-kickback statute, may be implicated). If the answer is ''yes,'' the next inquiry is:
- Does the physician (or an immediate family member) have a *financial relationship* with the entity furnishing the DHS (*e.g.*, the hospital)? Again, if the answer is no, the Stark law is not implicated. However, if the answer is ''yes,'' the third inquiry is:
- Does the financial relationship fit in an *exception*? If not, the statute has been violated.

Detailed definitions of the highlighted terms are set forth in regulations at 42 CFR 411.351 through 411.361 (substantial additional explanatory material appears in the regulatory preambles to the final regulations: 66 FR 856 (January 4, 2001); 69 FR 16054 (March 26, 2004); and 69 FR 17933 (April 6, 2004)). Importantly, a financial relationship can be almost any kind of direct or indirect ownership or investment relationship (*e.g.*, stock ownership, a partnership interest, or secured debt) or direct or indirect compensation arrangement, whether in cash or in-kind (*e.g.*, a rental contract, personal services contract, salary, gift, or gratuity), between a referring physician (or immediate family member) and a hospital. Moreover, the financial relationship need not relate to the provision of DHS (*e.g.*, a joint venture between a hospital and a physician to operate a hospice would create an indirect compensation relationship between the hospital and the physician for Stark law purposes).

[38] The statute lists ten additional categories of DHS, including, among others, clinical laboratory services, radiology services, and durable medical equipment. See section 1877(h)(6) of the Act. Hospitals and health systems that own or operate free-standing DHS entities should be mindful of the ten additional DHS categories. CMS has clarified that lithotripsy services furnished to hospital inpatients are not DHS. See 69 FR 16054, 16106 (March 26, 2004).

The statutory and regulatory exceptions are the key to compliance with the Stark law. Any financial relationship between the hospital and a physician who refers to the hospital must fit in an exception. Exceptions exist in the statute and regulations for many common types of business arrangements. To fit in an exception, an arrangement must squarely meet all of the conditions set forth in the exception. Importantly, it is the actual relationship between the parties, and not merely the paperwork, that must fit in an exception. Unlike the anti-kickback safe harbors, which are voluntary, fitting in an exception is mandatory under the Stark law.

Compliance with a Stark law exception does not immunize an arrangement under the anti-kickback statute. Rather, the Stark law sets a minimum standard for arrangements between physicians and hospitals. Even if a hospital-physician relationship qualifies for a Stark law exception, it should still be reviewed for compliance with the anti-kickback statute. The anti-kickback statute is discussed in greater detail in the next subsection.

Because of the significant exposure for hospitals under the Stark law, we recommend that hospitals implement systems to ensure that all conditions in the exceptions upon which they rely are fully satisfied. For example, many of the exceptions, such as the rental and personal services exceptions, require signed, written agreements with physicians. We are aware of numerous instances in which hospitals failed to maintain these signed written agreements, often inadvertently (*e.g.*, a holdover lease without a written lease amendment; a physician hired as an independent contractor for a short-term project without a signed agreement). To avoid a large overpayment, hospitals should ensure frequent and thorough review of their contracting and leasing processes. The final regulations contain a new limited exception for certain inadvertent, temporary instances of noncompliance with another exception. This exception may only be used on an occasional basis. Hospitals should be mindful that this exception is not a substitute for vigilant contracting and leasing oversight. In addition, hospitals should review the new reporting requirements at 42 CFR 411.361, which generally require hospitals to retain records that the hospitals know or should know about in the course of prudently conducting business. Hospitals should ensure that they have policies and procedures in place to address these reporting requirements.

In addition, because many exceptions to the Stark law require fair market value compensation for items or services actually needed and rendered, hospitals should have appropriate processes for making and documenting reasonable, consistent, and objective determinations of fair market value and for ensuring that needed items and services are furnished or rendered. Other areas that may require careful monitoring include, without limitation, the total value of nonmonetary compensation provided annually to each referring physician, the value of medical staff incidental benefits, and the provision of professional courtesy.[39] As discussed further in the anti-kickback section below, hospitals should exercise care when recruiting physicians. Importantly, while the final regulations contain a limited exception for certain joint recruiting by hospitals and existing group practices, the exception strictly forbids the use of income guarantees that shift group practice overhead or expenses to the hospital or any payment structure that otherwise transfers remuneration to the group practice.

Further information about the Stark law and applicable regulations can be found on CMS's Web page at *http://cms.gov/medlearn/refphys.asp.* Information regarding CMS's Stark advisory opinion process can be found at *http://cms.gov/physicians/aop/default.asp*.

2. The Federal Anti-Kickback Statute

Hospitals should also be aware of the Federal anti-kickback statute, section 1128B(b) of the Act, and the constraints it places on business arrangements related directly or indirectly to items or services reimbursable by any Federal health care program, including, but not limited to, Medicare and Medicaid. The anti-kickback statute prohibits in the health care industry some practices that are common in other business sectors, such as offering gifts to reward past or potential new referrals.

The anti-kickback statute is a criminal prohibition against payments (in any form, whether the payments are direct

[39] Hospitals affiliated with academic medical centers should be aware that the regulations contain a special exception for certain academic medical center arrangements. *See* 42 CFR 411.355(e). Specialty hospitals should be mindful of certain limitations on new physician-owned specialty hospitals contained in section 507 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003. *See* CMS's One-Time Notification regarding the 18-month moratorium on physician investment in specialty hospitals, CMS Manual System Pub. 100–20 One-Time Notification, Transmittal 26 (March 19, 2004), available on CMS's Web page at *http://www.cms.gov/manuals/pm_trans/R62OTN.pdf*.

or indirect) made purposefully to induce or reward the referral or generation of Federal health care program business. The anti-kickback statute addresses not only the offer or payment of anything of value for patient referrals, but also the offer or payment of anything of value in return for purchasing, leasing, ordering, or arranging for or recommending the purchase, lease, or ordering of any item or service reimbursable in whole or in part by a Federal health care program. The statute extends equally to the solicitation or acceptance of remuneration for referrals or the generation of other business payable by a Federal health care program. Liability under the anti-kickback statute is determined separately for each party involved. In addition to criminal penalties, violators may be subject to CMPs and exclusion from the Federal health care programs. Hospitals should also be mindful that compliance with the anti-kickback statute is a condition of payment under Medicare and other Federal health care programs. *See, e.g.*, Medicare Federal Health Care Provider/Supplier Application, CMS Form 855A, Certification Statement at section 15, paragraph A.3, available on CMS's Web page at *http://www.cms.gov/providers/enrollment/forms/*. As such, liability may arise under the False Claims Act where the anti-kickback statute violation results in the submission of a claim for payment under a Federal health care program.

Although liability under the anti-kickback statute ultimately turns on a party's intent, it is possible to identify arrangements or practices that may present a significant potential for abuse. For purposes of analyzing an arrangement or practice under the anti-kickback statute, the following two inquiries are useful:

- Does the hospital have any remunerative relationship between itself (or its affiliates or representatives) and persons or entities in a position to generate Federal health care program business for the hospital (or its affiliates) directly or indirectly? Persons or entities in a position to generate Federal health care program business for a hospital include, for example, physicians and other health care professionals, ambulance companies, clinics, hospices, home health agencies, nursing facilities, and other hospitals.
- With respect to any remunerative relationship so identified, could *one* purpose of the remuneration be to induce or reward the referral or recommendation of business payable in whole or in part by a Federal health care program? Importantly, under the anti-kickback statute, neither a legitimate business purpose for the arrangement, nor a fair market value payment, will legitimize a payment if there is also an illegal purpose (*i.e.*, inducing Federal health care program business).

Although any arrangement satisfying both tests implicates the anti-kickback statute and requires careful scrutiny by a hospital, the courts have identified several potentially aggravating considerations that can be useful in identifying arrangements at greatest risk of prosecution. In particular, hospitals should ask the following questions, among others, about any potentially problematic arrangements or practices they identify:

- Does the arrangement or practice have a potential to interfere with, or skew, clinical decision-making?
- Does the arrangement or practice have a potential to increase costs to Federal health care programs, beneficiaries, or enrollees?
- Does the arrangement or practice have a potential to increase the risk of overutilization or inappropriate utilization?
- Does the arrangement or practice raise patient safety or quality of care concerns?

Hospitals that have identified potentially problematic arrangements or practices can take a number of steps to reduce or eliminate the risk of an anti-kickback violation. Detailed guidance relating to a number of specific practices is available from several sources. Most importantly, the anti-kickback statute and the corresponding regulations establish a number of ''safe harbors'' for common business arrangements. The following safe harbors are of most relevance to hospitals:

- Investment interests safe harbor (42 CFR 1001.952(a)),
- Space rental safe harbor (42 CFR 1001.952(b)),
- Equipment rental safe harbor (42 CFR 1001.952(c)),
- Personal services and management contracts safe harbor (42 CFR 1001.952(d)),
- Sale of practice safe harbor (42 CFR 1001.952(e)),
- Referral services safe harbor (42 CFR 1001.952(f)),
- Discount safe harbor (42 CFR 1001.952(h)),
- Employee safe harbor (42 CFR 1001.952(i)),
- Group purchasing organizations safe harbor (42 CFR 1001.952(j)),
- Waiver of beneficiary coinsurance and deductible amounts safe harbor (42 CFR 1001.952(k)),
- Practitioner recruitment safe harbor (42 CFR 1001.952(n)),
- Obstetrical malpractice insurance subsidies safe harbor (42 CFR 1001.952(o)),
- Cooperative hospital service organizations safe harbor (42 CFR 1001.952(q)),
- Ambulatory surgical centers safe harbor (42 CFR 1001.952(r)),
- Ambulance replenishing safe harbor (42 CFR 1001.952(v)), and
- Safe harbors for certain managed care and risk sharing arrangements (42 CFR 1001.952(m), (t), and (u)).[40]

Safe harbor protection requires strict compliance with all applicable conditions set out in the relevant safe harbor.[41] Although compliance with a safe harbor is *voluntary* and failure to comply with a safe harbor does *not* mean an arrangement is illegal per se, we recommend that hospitals structure arrangements to fit in a safe harbor whenever possible. Arrangements that do not fit in a safe harbor must be evaluated on a case-by-case basis.

Other available guidance includes special fraud alerts and advisory bulletins issued by the OIG identifying and discussing particular practices or issues of concern and OIG advisory opinions issued to specific parties about their particular business arrangements.[42] A hospital concerned about an existing or proposed arrangement may request a binding OIG advisory opinion regarding whether the arrangement violates the Federal anti-kickback statute or other OIG fraud and abuse authorities, using the procedures set out at 42 CFR part 1008. The safe harbor regulations (and accompanying **Federal Register** preambles), fraud alerts and bulletins, advisory opinions (and instructions for obtaining them, including a list of frequently asked questions), and other guidance are

[40] Importantly, the anti-kickback statute safe harbors are not the same as the Stark law exceptions described above at section II.B.1 of this guidance. An arrangement's compliance with the anti-kickback statute and the Stark law must be evaluated separately.

[41] Parties to an arrangement cannot obtain safe harbor protection by entering into a sham contract that complies with the written agreement requirement of a safe harbor and appears, on paper, to meet all of the other safe harbor requirements, but does not reflect the actual arrangement between the parties. In other words, in assessing compliance with a safe harbor, the OIG examines not only whether the written contract satisfies all of the safe harbor requirements, but also whether the actual arrangement satisfies the requirements.

[42] While informative for guidance purposes, an OIG advisory opinion is binding only with respect to the particular party or parties that requested the opinion. The analyses and conclusions set forth in OIG advisory opinions are very fact-specific. Accordingly, hospitals should be aware that different facts may lead to different results.

available on the OIG Web page at *http://oig.hhs.gov.*

The following discussion highlights several known areas of potential risk under the anti-kickback statute. The propriety of any particular arrangement can only be determined after a detailed examination of the attendant facts and circumstances. The identification of a given practice or activity as ''suspect'' or as an area of ''risk'' does not mean it is necessarily illegal or unlawful, or that it cannot be properly structured to fit in a safe harbor; nor does it mean that the practice or activity is not beneficial from a clinical, cost, or other perspective. Rather, the areas identified below are areas of activity that have a potential for abuse and that should receive close scrutiny from hospitals. The discussion highlights potential risks under the anti-kickback statute arising from hospitals' relationships in the following seven categories: (a) Joint ventures; (b) compensation arrangements with physicians; (c) relationships with other health care entities; (d) recruitment arrangements; (e) discounts; (f) medical staff credentialing; and (g) malpractice insurance subsidies. (In addition, the kickback risks associated with gainsharing arrangements are discussed below in section II.C of this guidance.)

Physicians are the primary referral source for hospitals, and, therefore, most of the discussion below focuses on hospitals' relationships with physicians. Notwithstanding, hospitals also receive referrals from other health care professionals, including physician assistants and nurse practitioners, and from other providers and suppliers (such as ambulance companies, clinics, hospices, home health agencies, nursing facilities, and other hospitals). Therefore, in addition to reviewing their relationships with physicians, hospitals should also review their relationships with nonphysician referral sources to ensure that the relationships do not violate the anti-kickback statute. The principles described in the following discussions can be used to assess the risk associated with relationships with both physician and nonphysician referral sources.

a. Joint Ventures

The OIG has a long-standing concern about joint venture arrangements between those in a position to refer or generate Federal health care program business and those providing items or services reimbursable by Federal health care programs.[43] In the context of joint ventures, our chief concern is that remuneration from a joint venture might be a disguised payment for past or future referrals to the venture or to one or more of its participants. Such remuneration may take a variety of forms, including dividends, profit distributions, or, with respect to contractual joint ventures, the economic benefit received under the terms of the operative contracts.

When scrutinizing joint ventures under the anti-kickback statute, hospitals should examine the following factors, among others:

• *The manner in which joint venture participants are selected and retained.* If participants are selected or retained in a manner that takes into account, directly or indirectly, the value or volume of referrals, the joint venture is suspect. The existence of one or more of the following indicators suggests that there might be an improper nexus between the selection or retention of participants and the value or volume of their referrals:

—A substantial number of participants are in a position to make or influence referrals to the venture, other participants, or both;
—Participants that are expected to make a large number of referrals are offered a greater or more favorable investment or business opportunity in the joint venture than those anticipated to make fewer referrals;
—Participants are actively encouraged or required to make referrals to the joint venture;
—Participants are encouraged or required to divest their ownership interest if they fail to sustain an ''acceptable'' level of referrals;
—The venture (or its participants) tracks its sources of referrals and distributes this information to the participants; or
—The investment interests are nontransferable or subject to transfer restrictions related to referrals.

• *The manner in which the joint venture is structured.* The structure of the joint venture is suspect if a participant is already engaged in the line of business to be conducted by the joint venture, and that participant will own all or most of the equipment, provide or perform all or most of the items or services, or take responsibility for all or most of the day-to-day operations. With this kind of structure, the co-participant's primary contribution is typically as a captive referral base.

• *The manner in which the investments are financed and profits are distributed.* The existence of one or more of the following indicators suggests that the joint venture may be a vehicle to disguise referrals:

—Participants are offered investment shares for a nominal or no capital contribution;
—The amount of capital that participants invest is disproportionately small, and the returns on the investment are disproportionately large, when compared to a typical investment in a new business enterprise;
—Participants are permitted to borrow their capital investments from another participant or from the joint venture, and to pay back the loan through deductions from profit distributions, thus eliminating even the need to contribute cash;
—Participants are paid extraordinary returns on the investment in comparison with the risk involved; or
—A substantial portion of the gross revenues of the venture are derived from participant-driven referrals.

In light of the obvious risk inherent in joint ventures, whenever possible, hospitals should structure joint ventures to fit squarely in one of the following safe harbors for investment interests:

• The ''small entity'' investment safe harbor (42 CFR 1001.952(a)(2)), which applies to returns on investments as long as no more than 40 percent of the investment interests are held by investors who are in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the venture (interested investors), no more than 40 percent of revenues come from referrals or business otherwise generated from investors, and all other conditions are satisfied;[44]

• The safe harbor for investment interests in an entity located in an underserved area (42 CFR 1001.952(a)(3)), which applies to ventures located in medically underserved areas (as defined in regulations issued by the Department and set forth at 42 CFR part 51c), as long as no more than 50 percent of the investment interests are held by interested investors and all other conditions are satisfied; or

• The hospital-physician ambulatory surgical center (ASC) safe harbor (42 CFR 1001.952(r)(4)). This safe harbor only protects investments in Medicare-certified ASCs owned by hospitals and certain qualifying physicians. Importantly, it does *not* protect

[43] *See* 1989 Special Fraud Alert on Joint Venture Arrangements, reprinted in the **Federal Register** (59 FR 65372; December 19,1994) and available on our Web page at *http://oig.hhs.gov/fraud/docs/alertsandbulletins/121994.html.*

[44] There is also a safe harbor for investment interests in large entities (*i.e.,* entities with over fifty million dollars in assets) (42 CFR 1001.952(a)(1)).

investments by hospitals and physicians in non-ASC clinical joint ventures, including, for example, cardiac catheterization or vascular laboratories, oncology centers, and dialysis facilities. Investors in such clinical ventures should look to other safe harbors and to the factors noted above.

These safe harbors protect remuneration in the form of returns on investment interests (*i.e.*, money paid by an entity to its owners or investors as dividends, profit distributions, or the like). However, they do not protect payments made by participating investors to a venture or payments made by the venture to other parties, such as vendors, contractors, or employees (although in some cases these arrangements may fit in other safe harbors).

As we originally observed in our 1989 Special Fraud Alert on Joint Venture Arrangements,[45] joint ventures may take a variety of forms, including a contractual arrangement between two or more parties to cooperate in a common and distinct enterprise providing items or services, thereby creating a ''contractual joint venture.'' We elaborated more fully on contractual joint ventures in our 2003 Special Advisory Bulletin on Contractual Joint Ventures.[46] Contractual joint ventures pose the same kinds of risks as equity joint ventures and should be analyzed similarly. Factors to consider include, for example, whether the hospital is expanding into a new line of business created predominately or exclusively to serve the hospital's existing patient base, whether a would-be competitor of the new line of business is providing all or most of the key services, and whether the hospital assumes little or no *bona fide* business risk. An example of a potentially problematic contractual joint venture would be a hospital contracting with an existing durable medical equipment (DME) supplier to operate the hospital's newly formed DME subsidiary (with its own DME supplier number) on essentially a turnkey basis, with the hospital primarily furnishing referrals and assuming little or no business risk.[47]

Hospitals should be aware that, for reasons described in our 2003 Special Advisory Bulletin on Contractual Joint Ventures,[48] safe harbor protection may not be available for contractual joint ventures, and attempts to carve out separate contracts and qualify each separately for safe harbor protection may be ineffectual and leave the parties at risk under the statute.[49]

If a hospital is planning to participate, directly or indirectly, in a joint venture involving referring physicians and the venture does not qualify for safe harbor protection, the hospital should scrutinize the venture with care, taking into account the factors noted above, and consider obtaining advice from an experienced attorney. At a minimum, to reduce (but not necessarily eliminate) the risk of abuse, hospitals should consider (i) barring physicians employed by the hospital or its affiliates from referring to the joint venture; (ii) taking steps to ensure that medical staff and other affiliated physicians are not encouraged in any manner to refer to the joint venture; (iii) notifying physicians annually in writing of the preceding policy; (iv) refraining from tracking in any manner the volume of referrals attributable to particular referrals sources; (v) ensuring that no physician compensation is tied in any manner to the volume or value of referrals to, or other business generated for, the venture; (vi) disclosing all financial interests to patients; [50] and (vii) requiring that other participants in the joint venture adopt similar steps.

b. Compensation Arrangements With Physicians

Hospitals enter into a variety of compensation arrangements with physicians whereby physicians provide items or services to, or on behalf of, the hospital. Conversely, in some arrangements, hospitals provide items or services to physicians. Examples of these compensation arrangements include, without limitation, medical director agreements, personal or management services agreements, space or equipment leases, and agreements for the provision of billing, nursing, or other staff services. Although many compensation arrangements are legitimate business arrangements, compensation arrangements *may* violate the anti-kickback statute if *one* purpose of the arrangement is to compensate physicians for past or future referrals.[51]

The general rule of thumb is that any remuneration flowing between hospitals and physicians should be at fair market value for actual and necessary items furnished or services rendered based upon an arm's-length transaction and should not take into account, directly or indirectly, the value or volume of any past or future referrals or other business generated between the parties. Arrangements under which hospitals (i) provide physicians with items or services for free or less than fair market value, (ii) relieve physicians of financial obligations they would otherwise incur, or (iii) inflate compensation paid to physicians for items or services pose significant risk. In such circumstances, an inference arises that the remuneration may be in exchange for generating business.

In particular, hospitals should review their physician compensation arrangements and carefully assess the risk of fraud and abuse using the following factors, among others:

- Are the items and services obtained from a physician legitimate, commercially reasonable, and necessary to achieve a legitimate business purpose of the hospital (apart from obtaining referrals)? Assuming that the hospital needs the items and services, does the hospital have multiple arrangements with different physicians, so that in the aggregate the items or services provided by all physicians exceed the hospital's actual needs (apart from generating business)?
- Does the compensation represent fair market value in an arm's-length transaction for the items and services? Could the hospital obtain the services from a non-referral source at a cheaper rate or under more favorable terms? Does the remuneration take into

[45] *See* 1989 Special Fraud Alert on Joint Venture Arrangements, *supra* note 43.

[46] This Special Advisory Bulletin is available on our Web page at *http://oig.hhs.gov/fraud/docs/alertsandbulletins/042303SABJointVentures.pdf.*

[47] Contractual ventures with existing clinical laboratories and outpatient therapy providers, among others, are also potentially problematic, particularly if the venture is functionally a turnkey operation that enables a hospital to use its captive referrals to expand into a new line of business with little or no contribution of resources or assumption of real risk.

[48] *See* 2003 Special Advisory Bulletin on Contractual Joint Ventures, *supra* note 46.

[49] The Medicare program permits hospitals to furnish services ''under arrangements'' with other providers or suppliers. Hospitals frequently furnish services ''under arrangements'' with an entity owned, in whole or in part, by referring physicians. Standing alone, these ''under arrangements'' relationships do not fall within the scope of problematic contractual joint ventures described in the Special Fraud Alert; however, these relationships will violate the anti-kickback statute if remuneration is purposefully offered or paid to induce referrals (*e.g.*, paying above-market rates for the services to influence referrals or otherwise tying the arrangements to referrals in any manner). These ''under arrangements'' relationships should be structured, when possible, to fit within an anti-kickback safe harbor. They *must* fit within a Stark exception, even if the service furnished ''under arrangements'' is not itself a DHS. *See* 66 FR 856, 941–2 (January 4, 2001); 69 FR 16054, 16106 (March 26, 2004).

[50] While disclosure to patients does not offer sufficient protection against Federal health care program abuse, effective and meaningful disclosure offers some protection against possible abuses of patient trust.

[51] As previously noted, a hospital should ensure that each compensation arrangement with a referring physician fits squarely in a statutory or regulatory exception to the Stark law.

account, directly or indirectly, the value or volume of any past or future referrals or other business generated between the parties? Is the compensation tied, directly or indirectly, to Federal health care program reimbursement?

- Is the determination of fair market value based upon a reasonable methodology that is uniformly applied and properly documented? If fair market value is based on comparables, the hospital should ensure that the market rate for the comparable services is not distorted (*e.g.,* the market for ancillary services may be distorted if all providers of the service are controlled by physicians).
- Is the compensation commensurate with the fair market value of a physician with the skill level and experience reasonably necessary to perform the contracted services?
- Were the physicians selected to participate in the arrangement in whole or in part because of their past or anticipated referrals?
- Is the arrangement properly and fully documented in writing? Are the physicians documenting the services they provide? Is the hospital monitoring the services?
- In the case of physicians staffing hospital outpatient departments, are safeguards in place to ensure that the physicians do not use hospital outpatient space, equipment, or personnel to conduct their private practices? In addition, physicians working in outpatient departments must bill the appropriate site-of-service modifier. The hospital should take reasonable steps to ensure that physicians are aware of this requirement and should take appropriate action if it identifies physicians engaging in improper site-of-service billing.

Whenever possible, hospitals should structure their compensation arrangements with physicians to fit in a safe harbor. Potentially applicable are the space rental safe harbor (42 CFR 1001.952(b)), the equipment rental safe harbor (42 CFR 1001.952(c)), the personal services and management contracts safe harbor (42 CFR 1001.952(d)), the sale of practice safe harbor (42 CFR 1001.952(e)), the referral services safe harbor (42 CFR 1001.952(f)), the employee safe harbor (42 CFR 1001.952(i)), the practitioner recruitment safe harbor (42 CFR 1001.952(n)), and the obstetrical malpractice insurance subsidies safe harbor (42 CFR 1001.952(o)). *An arrangement must fit squarely in a safe harbor to be protected.* Arrangements that do not fit in a safe harbor should be reviewed in light of the totality of all facts and circumstances. At minimum, hospitals should develop policies and procedures requiring physicians to document, and the hospital to monitor, the services or items provided under compensation arrangements (including, for example, by using written time reports). In some cases, particularly rentals, hospitals should consider obtaining an independent fair market valuation using appropriate health care valuation standards.

Arrangements between hospitals and traditional hospital-based physicians (*e.g.,* anesthesiologists, radiologists, and pathologists) raise some different concerns.[52] In these arrangements, it is typically the hospitals that are in a position to influence the flow of business to the physicians, rather than the physicians making referrals to the hospitals.[53] Such arrangements may violate the anti-kickback statute if the hospital solicits or receives something of value—or the physicians offer or pay something of value—in exchange for access to the hospital's Federal health care program business. Illegal kickbacks between hospitals and hospital-based physicians may take a variety of forms, including, without limitation:

- A hospital requiring physicians to pay more than the fair market value for services provided to the hospital-based physicians by the hospital; or
- A hospital compensating physicians less than the fair market value for goods or services provided to the hospital by the physicians.

Accordingly, arrangements that require physicians to provide Medicare Part A supervision and management services for token or no payment in exchange for the ability to provide physician-billable Medicare Part B services at the hospital potentially violate the anti-kickback statute and should be closely scrutinized.

We are aware that hospitals have long provided for the delivery of certain hospital-based physician services through the grant of an *exclusive* contract to a physician or physician group, which includes management, staffing, and other administrative functions, and in some cases limited clinical duties. These exclusive arrangements affect the cash and non-cash value of the overall arrangement to the respective parties.

Depending on the circumstances, an exclusive contract can have substantial value to the hospital-based physician or group, as well as to the hospital, that may well have nothing to do with the value or volume of business flowing between the hospital and the physicians. By way of example only, an exclusive arrangement may reduce the costs a physician or group would otherwise incur for business development and may eliminate administrative costs otherwise incurred by the hospital. In an appropriate context, an exclusive arrangement that requires a hospital-based physician or physician group to perform *reasonable* administrative or *limited* clinical duties *directly related* to the hospital-based professional services at no or a reduced charge would not violate the anti-kickback statute, provided that the overall arrangement is consistent with fair market value in an arm's-length transaction, taking into account the value attributable to the exclusivity. Depending on the circumstances, examples of directly-related administrative or clinical duties include, without limitation: participation on hospital committees, tumor boards, or similar hospital entities; participation in on-call rotation; and performance of quality assurance and oversight activities. Notwithstanding, whether the scope and volume of the required services in a particular arrangement reasonably reflect the value of the exclusivity will depend on the facts and circumstances of the arrangement.

Nothing in this supplemental CPG should be construed as requiring hospital-based physicians to perform administrative or clinical services at no or a reduced charge. Uncompensated or below-market arrangements for goods or services will be subject to close scrutiny for compliance with the statute.

c. Relationships With Other Health Care Entities

As addressed in the preceding subsection, hospitals may obtain referrals of Federal health care program business from a variety of health care professionals and entities. In addition, when furnishing inpatient, outpatient, and related services, hospitals often direct or influence referrals for items

[52] Arrangements between hospitals and hospital-based physicians were the topic of a Management Advisory Report (MAR) titled ''Financial Arrangements Between Hospitals and Hospital-Based Physicians,'' OEI–09–89–00330, available on our Web page at *http://oig.hhs.gov/oei/reports/oei-09-89-00330.pdf.*

[53] In this regard, arrangements between hospitals and traditional hospital-based physicians generally do not pose the same potential to cause the harms typically associated with kickback schemes. Moreover, a hospital's attending medical staff's quality expectations and a hospital's liability exposure for the malpractice of hospital-based physicians constrain the hospital's choice of a hospital-based physician or group. Finally, to the extent that any qualified group can bid for hospital-based business and the request for proposals clearly includes the entire arrangement, the competition is not unfair. (Of course, an open, competitive bidding process does not protect an otherwise illegal kickback arrangement.)

and services reimbursable by Federal health care programs. For example, hospitals may refer patients to, or order items or services from, home health agencies,[54] skilled nursing facilities, durable medical equipment companies, laboratories, pharmaceutical companies, and other hospitals. In cases where a hospital is the referral source for other providers or suppliers, it would be prudent for the hospital to scrutinize carefully any remuneration flowing to the hospital from the provider or supplier to ensure compliance with the anti-kickback statute, using the principles outlined above. Remuneration may include, for example, free or below-market-value items and services or the relief of a financial obligation.

Hospitals should also review their managed care arrangements to ensure compliance with the anti-kickback statute. Managed care arrangements that do not fit within one of the managed care and risk sharing safe harbors at 42 CFR 1001.952(m), (t), or (u) must be evaluated on a case-by-case basis.

d. Recruitment Arrangements

Many hospitals provide incentives to recruit a physician or other health care professional to join the hospital's medical staff and provide medical services to the surrounding community. When used to bring needed physicians to an underserved community, these arrangements can benefit patients. However, recruitment arrangements pose substantial fraud and abuse risk.

In most cases, the recruited physician establishes a private practice in the community instead of becoming a hospital employee.[55] Such arrangements potentially implicate the anti-kickback statute if one purpose of the recruitment arrangement is to induce referrals to the recruiting hospital. Safe harbor protection is available for certain recruitment arrangements offered by hospitals to attract primary care physicians and practitioners to health professional shortage areas (HPSAs), as defined in regulations issued by the Department.[56] The scope of this safe harbor is very limited. In particular, the safe harbor does not protect (a) recruitment arrangements in areas that are not designated as HPSAs, (b) recruitment of specialists, or (c) joint recruitment with existing physician practices in the area.

Because of the significant risk of fraud and abuse posed by improper recruitment arrangements, hospitals should scrutinize these arrangements with care. When assessing the degree of risk associated with recruitment arrangements, hospitals should examine the following factors, among others:

- *The size and value of the recruitment benefit.* Does the benefit exceed what is reasonably necessary to attract a qualified physician to the particular community? Has the hospital previously tried and failed to recruit or retain physicians?
- *The duration of payout of the recruitment benefit.* Total benefit payout periods extending longer than three years from the initial recruitment agreement should trigger heightened scrutiny.
- *The practice of the existing physician.* Is the physician a new physician with few or no patients or an established practitioner with a ready stream of referrals? Is the physician relocating from a substantial distance so that referrals are unlikely to follow or is it possible for the physician to bring an established patient base?
- *The need for the recruitment.* Is the recruited physician's specialty necessary to provide adequate access to medically necessary care for patients in the community? Do patients already have reasonable access to comparable services from other providers or practitioners in or near the community? An assessment of community need based wholly or partially on the competitive interests of the recruiting hospital or existing physician practices would subject the recruitment payments to heightened scrutiny under the statute.

Significantly, hospitals should be aware that the practitioner recruitment safe harbor excludes any arrangement that directly or indirectly benefits any existing or potential referral source other than the recruited physician. Accordingly, the safe harbor does *not* protect ''joint recruitment'' arrangements between hospitals and other entities or individuals, such as solo practitioners, group practices, or managed care organizations, pursuant to which the hospital makes payments directly or indirectly to the other entity or individual. These joint recruitment arrangements present a high risk of fraud and abuse and have been the subject of recent government investigations and prosecutions. These arrangements can easily be used as vehicles to disguise payments from the hospital to an existing referral source—typically an existing physician practice—in exchange for the existing practice's referrals to the hospital. Suspect payments to existing referral sources may include, among other things, income guarantees that shift costs from the existing referral source to the recruited physician and overhead and build-out costs funded for the benefit of the existing referral source. Hospitals should review all ''joint recruiting'' arrangements to ensure that remuneration does not inure in whole or in part to the benefit of any party other than the recruited physician.

e. Discounts

Public policy favors open and legitimate price competition in health care. Thus, the anti-kickback statute contains an exception for discounts offered to customers that submit claims to the Federal health care programs, if the discounts are properly disclosed and accurately reported.[57] However, to qualify for the exception, the discount must be in the form of a reduction in the price of the good or service based on an arm's-length transaction. In other words, the exception covers only reductions in the product's price. Moreover, the regulation provides that the discount must be given at the time of sale or, in certain cases, set at the time of sale, even if finally determined subsequent to the time of sale (*i.e.,* a rebate).

In conducting business, hospitals sell and purchase items and services reimbursable by Federal health care programs. Therefore, hospitals should thoroughly familiarize themselves with the discount safe harbor at 42 CFR 1001.952(h). In particular, depending on their role in the arrangement, hospitals should pay attention to the discount safe harbor requirements applicable to ''buyers,'' ''sellers,'' or ''offerors.'' Compliance with the safe harbor is determined separately for each party. In general, hospitals should ensure that all discounts—including rebates—are properly disclosed and accurately reflected on hospital cost reports. If a hospital offers a discount on an item or service to a buyer, it should ensure that the discount is properly disclosed on the invoice or other documentation for the item or service.

[54] When referring to home health agencies and skilled nursing facilities, hospitals must comply with section 1861(ee)(2)(D) and (H) of the Act, requiring that Medicare participating hospitals, as part of the discharge planning process, (i) share with each beneficiary a list of Medicare-certified home health agencies or skilled nursing facilities, as applicable, that serve the beneficiary's geographic area, and (ii) identify any home health agency or skilled nursing facility in which the hospital has a disclosable financial interest or that has a financial interest in the hospital. *See also* 42 CFR 482.43.

[55] When paid pursuant to a properly structured employment arrangement, payments to physicians who become hospital employees may be protected by the employee safe harbor at 42 CFR 1001.952(i).

[56] *See* 42 CFR 1001.952(n).

[57] *See* 42 U.S.C. 1320a–7b(b)(3)(A); 42 CFR 1001.952(h).

The discount safe harbor does not protect a discount offered to one payor but not to the Federal health care programs. Accordingly, in negotiating discounts for items and services paid from a hospital's pocket (such as those reimbursed under the Medicare Part A prospective payment system), the hospital should ensure that there is no link or connection, explicit or implicit, between discounts offered or solicited for that business and the hospital's referral of business billable by the seller directly to Medicare or another Federal health care program. For example, a hospital should not engage in ''swapping'' by accepting from a supplier an unreasonably low price on Part A services that the hospital pays for out of its own pocket in exchange for hospital referrals that are billable by the supplier directly to Part B (*e.g.,* ambulance services). Suspect arrangements include below-cost arrangements or arrangements at prices lower than the prices offered by the supplier to other customers with similar volumes of business, but without Federal health care program referrals.

Hospitals may also receive discounts on items and services purchased through group purchasing organizations (GPOs). Discounts received from a vendor in connection with a GPO to which a hospital belongs should be properly disclosed and accurately reported on the hospital cost reports. Although there is a safe harbor for payments made by a vendor to a GPO as part of an agreement to furnish items or services to a group of individuals or entities (42 CFR 1001.952(j)), the safe harbor does not protect the discount received by the individual or entity.[58]

f. Medical Staff Credentialing

Certain medical staff credentialing practices may implicate the anti-kickback statute.[59] For example, conditioning privileges on a particular number of referrals or requiring the performance of a particular number of procedures, beyond volumes necessary to ensure clinical proficiency, potentially raise substantial risks under the statute. On the other hand, a credentialing policy that *categorically* refuses privileges to physicians with significant conflicts of interest would not appear to implicate the statute in most situations. Whether a particular credentialing policy runs afoul of the anti-kickback statute would depend on the specific facts and circumstances, including the intent of the parties. Hospitals are advised to examine their credentialing practices to ensure that they do not run afoul of the anti-kickback statute. The OIG has solicited comments about, and is considering, whether further guidance in this area is appropriate.[60]

g. Malpractice Insurance Subsidies

The OIG historically has been concerned that a hospital's subsidy of malpractice insurance premiums for potential referral sources, including hospital medical staff, may be suspect under the anti-kickback statute, because the payments may be used to influence referrals. The OIG has established a safe harbor for medical malpractice premium subsidies provided to obstetrical care practitioners in health professional shortage areas.[61] Depending on the circumstances, premium support may also be structured to fit in other safe harbors.

We are aware of the current disruption (*i.e.,* dramatic premium increases, insurers' withdrawals from certain markets, and/or sudden termination of coverage based upon factors other than the physicians' claims history) in the medical malpractice liability insurance markets in some geographic areas.[62] Notwithstanding, hospitals should review malpractice insurance subsidy arrangements closely to ensure that there is no improper inducement to referral sources. Relevant factors include, without limitation:

- Whether the subsidy is being provided on an interim basis (*e.g.,* until an unrelated insurer is commercially available) for a reasonable fixed period in a geographic area experiencing severe access or affordability problems;
- Whether the subsidy is being offered only to current active medical staff (or physicians new to the locality or in practice less than a year, *i.e.*, physicians with no or few established patients);
- Whether the criteria for receiving a subsidy is unrelated to the volume or value of referrals or other business generated by the subsidized physician or his practice;
- Whether physicians receiving subsidies are paying at least as much as they currently pay for malpractice insurance (*i.e.,* are windfalls to physicians avoided);
- Whether physicians are required to perform services or relinquish rights, which have a value equal to the fair market value of the insurance assistance; and
- Whether the insurance is available regardless of the location at which the physician provides services, including, but not limited to, other hospitals.

No one of these factors is determinative, and this list is illustrative, not exhaustive, of potential considerations in connection with the provision of malpractice insurance subsidies. Parties contemplating malpractice subsidy programs that do not fit into one of the safe harbors may want to consider obtaining an advisory opinion. Parties should also be mindful that these subsidy arrangements also implicate the Stark law.

C. Payments To Reduce or Limit Services: Gainsharing Arrangements

The CMP set forth in section 1128A(b)(1) of the Act prohibits a hospital from knowingly making a payment directly or indirectly to a physician as an inducement to reduce or limit items or services furnished to Medicare or Medicaid beneficiaries under the physician's direct care.[63] Hospitals that make (and physicians that receive) such payments are liable for CMPs of up to $2,000 per patient covered by the payments.[64] The statutory proscription is very broad. The payment need not be tied to an actual diminution in care, so long as the hospital knows that the payment may influence the physician to reduce or limit services to his or her patients. There is no requirement that the prohibited payment be tied to a specific patient or to a reduction in medically necessary care. In short, any hospital incentive plan that encourages physicians through payments to reduce

[58] To preclude improper shifting of discounts, the safe harbor excludes GPOs that wholly own their members or have members that are subsidiaries of the parent company that wholly owns the GPO. Hospitals with affiliated GPOs should be mindful of these limitations.

[59] In addition to the anti-kickback statute, hospitals should make sure that their credentialing policies comply with all other applicable Federal and State laws and regulations, some of which may prohibit or limit economic credentialing.

[60] *See* our ''Solicitation of New Safe Harbors and Special Fraud Alerts'' (67 FR 72894; December 9, 2002), available on our Web page at *http://oig.hhs.gov/authorities/docs/solicitationannsafeharbor.pdf.*

[61] *See* 42 CFR 1001.952(o).

[62] *See* the OIG's letter on a hospital corporaiton's medical malpractice insurance assistance program, available on our Web page at *http://oig.hhs.gov/fraud/docs/alertsandbulletins/MalpracticeProgram.pdf*

[63] The prohibition applies only to reductions or limitations of items or services provided to Medicare and Medicaid fee-for-service beneficiaries. *See* section 1128A(b)(1)(A) of the Act. *See also* our August 19, 1999 letter regarding ''Social Security Act sections 1128A(b)(1) and (2) and hospital-physician incentive plans for Medicare or Medicaid beneficiaries enrolled in managed care plans,'' available on our Web page at *http://oig.hhs.gov/fraud/docs/alertsandbulletins/gsletter.htm.*

[64] *See* sections 1128A(b)(1)(B) and (b)(2) of the Act.

or limit clinical services directly or indirectly violates the statute.

We are aware that a number of hospitals are engaged in, or considering entering into, incentive arrangements commonly called ''gainsharing.'' While there is no fixed definition of a ''gainsharing'' arrangement, the term typically refers to an arrangement in which a hospital gives physicians a percentage share of any reduction in the hospital's costs for patient care attributable in part to the physicians' efforts. We recognize that, properly structured, gainsharing arrangements can serve legitimate business and medical purposes, such as increasing efficiency, reducing waste, and, thereby, potentially increasing a hospital's profitability. However, the plain language of section 1128A(b)(1) of the Act prohibits tying the physicians' compensation for services to reductions or limitations in items or services provided to patients under the physicians' clinical care.[65]

In addition to the CMP risks described above, gainsharing arrangements can also implicate the anti-kickback statute if the cost-savings payments are used to influence referrals. For example, the statute is potentially implicated if a gainsharing arrangement is intended to influence physicians to ''cherry pick'' healthy patients for the hospital offering gainsharing payments and steer sicker (and more costly) patients to hospitals that do not offer gainsharing payments. Similarly, the statute may be implicated if a hospital offers a cost-sharing program with the intent to foster physician loyalty and attract more referrals. In addition, we have serious concerns about overly broad arrangements under which a physician continues for an extended time to reap the benefits of previously-achieved savings or receives cost-savings payments unrelated to anything done by the physician, whether work, services, or other undertaking (*e.g.,* a change in the way the physician practices).

Wherever possible, hospitals should consider structuring cost-saving arrangements to fit in the personal services safe harbor. However, in many cases, protection under the personal services safe harbor is not available because gainsharing arrangements typically involve a percentage payment (*i.e.,* the aggregate fee will not be set in advance, as required by the safe harbor). Finally, gainsharing arrangements may also implicate the Stark law.

[65] A detailed discussion of gainsharing can be found in our July 1999 Special Advisory Bulletin titled ''Gainsharing Arrangements and CMPs for Hospital Payments to Physicians to Reduce or Limit Services to Beneficiaries,'' available on our Web page at *http://oig.hhs.gov/fraud/docs/altersandbulletins/gainsh.htm.*

D. Emergency Medical Treatment and Labor Act (EMTALA)

Hospitals should review their obligations under EMTALA (section 1867 of the Act) to evaluate and treat individuals who come to their emergency departments and, in some circumstances, other facilities. Hospitals should pay particular attention to when an individual must receive a medical screening exam to determine whether that individual is suffering from an emergency medical condition. When such a screening or treatment of an emergency medical condition is required, it cannot be delayed to inquire about an individual's method of payment or insurance status. If the hospital's emergency department (ED) is ''on diversion'' and an individual comes to the ED for evaluation or treatment of a medical condition, the hospital is required to provide such services despite its diversionary status.

Generally, hospital emergency departments may not transfer an individual with an unstable emergency medical condition unless a physician certifies that the benefits outweigh the risks. In such circumstances, the hospital must provide stabilizing treatment to minimize the risks of transfer. Further, the hospital must ensure that the receiving facility has available space and qualified personnel to treat the individual and has agreed to accept transfer of that individual. Moreover, certain medical records must accompany the individual and a hospital that has specialized capabilities or facilities must accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.

A hospital must provide appropriate screening and treatment services within the full capabilities of its staff and facilities. This includes access to specialists who are on call. Thus, hospital policies and procedures should be clear on how to access the full services of the hospital, and all staff should understand the hospital's obligations to individuals under EMTALA. In particular, on-call physicians need to be educated as to their responsibilities under EMTALA, including the responsibility to accept appropriately transferred individuals from other facilities. In addition, all persons working in emergency departments should be periodically trained and reminded of the hospital's EMTALA obligations and hospital policies and procedures designed to ensure that such obligations are met.

For further information about EMTALA, hospitals are directed to: (i) The EMTALA statute at section 1867 of the Act; (ii) the EMTALA statute's implementing regulations at 42 CFR part 489; (iii) our 1999 Special Advisory Bulletin on the Patient Anti-Dumping Statute (64 FR 61353; November 10, 1999), available on our Web page at *http://oig.hhs.gov/fraud/docs/alertsandbulletins/frdump.pdf;* and (iv) CMS's EMTALA resource Web page located at *http://www.cms.gov/providers/emtala/emtala.asp.*

E. Substandard Care

The OIG has authority to exclude any individual or entity from participation in Federal health care programs if the individual or entity provides unnecessary items or services (*i.e.,* items or services in excess of the needs of a patient) or substandard items or services (*i.e.,* items or services of a quality which fails to meet professionally recognized standards of health care).[66] Significantly, neither knowledge nor intent is required for exclusion under this provision. The exclusion can be based upon unnecessary or substandard items or services provided to any patient, even if that patient is not a Medicare or Medicaid beneficiary.

We are mindful that the vast majority of hospitals are fully committed to providing quality care to their patients. To achieve their quality-related goals, hospitals should continually measure their performance against comprehensive standards. Medicare participating hospitals must meet all of the Medicare hospital conditions of participation (COPs), including without limitation, the COP pertaining to a quality assessment and performance improvement program at 42 CFR 482.21 and the hospital COP pertaining to the medical staff at 42 CFR 482.22. Compliance with the COPs is determined by State survey agencies or accreditation organizations, such as the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association. In addition, hospitals should develop their own quality of care protocols and implement mechanisms for evaluating compliance with those protocols.

In reviewing the quality of care provided, hospitals must not limit their review to the quality of their nursing and other ancillary services. Hospitals must monitor the quality of medical

[66] *See* section 1128(b)(6)(B) of the Act, which is available through the Internet at *http://www4.law.cornell.edu/uscode/42/1320a-7.html.*

services provided at the hospital by appropriately overseeing the credentialing and peer review of their medical staffs.

F. Relationships With Federal Health Care Beneficiaries

Hospitals' relationships with Federal health care beneficiaries may also implicate the fraud and abuse laws. In particular, hospitals should be aware that section 1128A(a)(5) of the Act authorizes the OIG to impose CMPs on hospitals (and others) that offer or transfer remuneration to a Medicare or Medicaid beneficiary that the offeror knows or should know is likely to influence the beneficiary to order or receive items or services from a particular provider, practitioner, or supplier for which payment may be made under the Medicare or Medicaid programs. The definition of ''remuneration'' expressly includes the offer or transfer of items or services for free or other than fair market value, including the waiver of all or part of a Medicare or Medicaid cost-sharing amount.[67] In other words, hospitals may not offer valuable items or services to Medicare or Medicaid beneficiaries to attract their business. In this regard, hospitals should familiarize themselves with the OIG's August 2002 Special Advisory Bulletin on Offering Gifts and Other Inducements to Beneficiaries.[68]

1. Gifts and Gratuities

Hospitals should scrutinize any offers of gifts or gratuities to beneficiaries for compliance with the CMP provision prohibiting inducements to Medicare and Medicaid beneficiaries. The key inquiry under the CMP is whether the remuneration is something that the hospital knows or should know is likely to influence the beneficiary's selection of a particular provider, practitioner, or supplier for Medicare or Medicaid payable services. As interpreted by the OIG, section 1128A(a)(5) of the Act does not apply to the provision of items or services valued at less than $10 per item and $50 per patient in the aggregate on an annual basis.[69] A special exception for incentives to promote the delivery of preventive care services is discussed below at section II.I.2.

2. Cost-Sharing Waivers

In general, hospitals are obligated to collect cost-sharing amounts owed by Federal health care program beneficiaries. Waiving owed amounts may constitute prohibited remuneration to beneficiaries under section 1128A(a)(5) of the Act or the anti-kickback statute. Certain waivers of Part A inpatient cost-sharing amounts may be protected by structuring them to fit in the safe harbor for waivers of beneficiary inpatient coinsurance and deductible amounts at 42 CFR 1001.952(k). In particular, under the safe harbor, waived amounts may not be claimed as bad debt; the waivers must be offered uniformly across the board without regard to the reason for admission, length of stay, or DRG; and waivers may not be made as part of any agreement with a third party payer, unless the third party payer is a Medicare SELECT plan under section 1882(t)(1) of the Act.[70]

In addition, hospitals (and others) may waive cost-sharing amounts on the basis of a beneficiary's financial need, so long as the waiver is not routine, not advertised, and made pursuant to a good faith, individualized assessment of the beneficiary's financial need or after reasonable collection efforts have failed.[71] The OIG recognizes that what constitutes a good faith determination of ''financial need'' may vary depending on the individual patient's circumstances and that hospitals should have flexibility to take into account relevant variables. These factors may include, for example:

- The local cost of living;
- A patient's income, assets, and expenses;
- A patient's family size; and
- The scope and extent of a patient's medical bills.

Hospitals should use a reasonable set of financial need guidelines that are based on objective criteria and appropriate for the applicable locality. The guidelines should be applied uniformly in all cases. While hospitals have flexibility in making the determination of financial need, we do not believe it is appropriate to apply inflated income guidelines that result in waivers for beneficiaries who are not in genuine financial need. Hospitals should consider that the financial status of a patient may change over time and should recheck a patient's eligibility at reasonable intervals sufficient to ensure that the patient remains in financial need. For example, a patient who obtains outpatient hospital services several times a week would not need to be rechecked every visit. Hospitals should take reasonable measures to document their determinations of Medicare beneficiaries' financial need. We are aware that in some situations patients may be reluctant or unable to provide documentation of their financial status. In those cases, hospitals may be able to use other reasonable methods for determining financial need, including, for example, documented patient interviews or questionnaires.

In sum, hospitals should review their waiver policies to ensure that the policies and the manner in which they are implemented comply with all applicable laws. For more information about cost-sharing waivers, hospitals should review our February 2, 2004 paper on ''Hospital Discounts Offered To Patients Who Cannot Afford To Pay Their Hospital Bills,'' containing a section titled ''Reductions or Waivers of Cost-Sharing Amounts for Medicare Beneficiaries Experiencing Financial Hardship'' and available on our Web page at *http://oig.hhs.gov/fraud/docs/alertsandbulletins/2004/FA021904hospitaldiscounts.pdf.*[72]

3. Free Transportation

The plain language of the CMP prohibits offering free transportation to Medicare or Medicaid beneficiaries to influence their selection of a particular provider, practitioner, or supplier. Notwithstanding, hospitals can offer free local transportation of *low* value (*i.e.*, within the $10 per item and $50 annual limits).[73] Luxury and specialized transportation, such as limousines or ambulances, would exceed the low value threshold and are problematic, as are arrangements tied in any manner to the volume or value of referrals and arrangements tied to particularly lucrative treatments or medical conditions. However, we have indicated that we are considering developing a regulatory exception for some complimentary local transportation provided to beneficiaries residing in a

[67] *See* section 1128A(i)(6) of the Act.

[68] The Special Advisory Bulletin on Offering Gifts and Other Inducements to Beneficiaries (67 FR 55855; August 30, 2002) is available on our Web page at *http://oig.hhs.gov/fraud/docs/alertsandbulletins/SABGiftsandInducements.pdf.*

[69] *See id.*

[70] The OIG has proposed a rule to extend this safe harbor to protect waivers of Part B cost-sharing amounts pursuant to agreements with Medicare SELECT plans. *See* 67 FR 60202 (September 25, 2002), available on our Web page at *http://oig.hhs.gov/fraud/docs/safeharborregulations/MedicareSELECTNPRMFederalRegister.pdf.* However, the OIG is still considering comments on this rule, and it has not been finalized.

[71] *See* section 1128A(i)(6)(A) of the Act.

[72] *See also* the OIG's Special Fraud Alert on Routine Waiver of Copayments or Deductibles Under Medicare Part B, issued May 1991, republished in the **Federal Register** at 59 FR 65372, 65374 (December 19, 1994), and available on our Web page at *http://oig.hhs.gov/fraud/docs/alertsandbulletins/121994.html.*

[73] Our position on local transportation of nominal value is more fully set forth in the preamble to the final rule enacting 42 CFR 1003.102(b)(13). *See* 65 FR 24400, 24411 (April 26, 2000).

hospital's primary service area.[74] Accordingly, until such time as we promulgate a final rule on complimentary local transportation under section 1128A(a)(5) of the Act or indicate our intention not to proceed with such rule, we have indicated that we will not impose administrative sanctions for violations of section 1128A(a)(5) of the Act in connection with hospital-based complimentary transportation programs that meet the following conditions:

- The program was in existence prior to August 30, 2002, the date of publication of the Special Advisory Bulletin on Offering Gifts and Other Inducements to Beneficiaries.
- Transportation is offered uniformly and without charge or at reduced charge to all patients of the hospital or hospital-owned ambulatory surgical center (and may also be made available to their families).
- The transportation is only provided to and from the hospital or a hospital-owned ambulatory surgical center and is for the purpose of receiving hospital or ambulatory surgical center services (or, in the case of family members, accompanying or visiting hospital or ambulatory surgical center patients).
- The transportation is provided only within the hospital's or ambulatory surgical center's primary service area.
- The costs of the transportation are not claimed directly or indirectly by any Federal health care program cost report or claim and are not otherwise shifted to any Federal health care program.
- The transportation does not include ambulance transportation.

Other arrangements are subject to a case-by-case review under the statute to ensure that no improper inducement exists.

G. HIPAA Privacy and Security Rules

As of April 14, 2003, all hospitals that conduct electronic transactions for which standards have been adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) were required to comply with the Privacy Rule promulgated pursuant to HIPAA. Generally, the HIPAA Privacy Rule addresses the use and disclosure of individuals' identifiable health information (protected health information or PHI) by covered hospitals and other covered entities, as well as standards for individuals' privacy rights to understand and control how their health information is used. The Privacy Rule (45 CFR parts 160 and 164, subparts A and E) and other helpful information about how it applies, including frequently asked questions, can be found on the Web page of the Department's Office for Civil Rights (OCR) at *http://www.hhs.gov/ocr/hipaa/.* Questions about the privacy rule should be submitted to OCR. Hospitals can contact OCR by following the instructions on its Web page, *http://www.hhs.gov/ocr/contact.html,* or by calling the HIPAA toll-free number, (866) 627–7748.

To ease the burden of complying with the new requirements, the Privacy Rule gives covered hospitals and other covered entities some flexibility to create their own privacy procedures. Each hospital should make sure that it is compliant with all applicable provisions of the Privacy Rule, including provisions pertaining to required disclosures (such as required disclosures to the Department when it is undertaking a Privacy Rule investigation or compliance review) in developing its privacy procedures that are tailored to fit its particular size and needs.

The final HIPAA Security Rule (45 CFR parts 160 and 164, subparts A and C) was published in the **Federal Register** on February 20, 2003. It is available on CMS's Web page at *http://www.cms.gov/hipaa/hipaa2.* The Security Rule specifies a series of administrative, technical, and physical security safeguards for hospitals that are covered entities and other covered entities to use to assure, among other provisions, the confidentiality of electronic PHI. Hospitals that are covered entities must be compliant with the Security Rule by April 20, 2005. The Security Rule requirements are flexible and scalable, which allows each covered entity to tailor its approach to compliance based on its own unique circumstances. Covered entities can consider their organization and capabilities, as well as costs, in designing their security plans and procedures. Questions about the HIPAA Security Rule should be submitted to CMS. Hospitals can contact CMS by following the instructions on its Web page, *http://www.cms.gov/hipaa/hipaa2/contact,* or by calling the HIPAA toll-free number, (866) 627–7748.

H. Billing Medicare or Medicaid Substantially in Excess of Usual Charges

Section 1128(b)(6)(A) of the Act provides for the permissive exclusion from Federal health care programs of any provider or supplier that submits a claim *based on costs or charges* to the Medicare or Medicaid programs that is ''substantially in excess'' of its usual charge or cost, unless the Secretary finds there is ''good cause'' for the higher charge or cost. The exclusion provision does not require a provider to charge everyone the same price; nor does it require a provider to offer Medicare or Medicaid its ''best price.'' However, providers cannot routinely charge Medicare or Medicaid substantially more than they usually charge others. Hospitals have raised concerns regarding the impact of the exclusion authority on hospital services, and the OIG is considering those concerns in the context of the rulemaking process.[75] The OIG's policy regarding application of the exclusion authority to discounts offered to uninsured and underinsured patients is discussed below.

I. Areas of General Interest

Although in most cases the following areas do not pose significant fraud and abuse risk, the OIG has received numerous inquiries from hospitals and others on these topics. Therefore, we offer the following guidance to assist hospitals in their review of these arrangements.

1. Discounts to Uninsured Patients

No OIG authority, including the Federal anti-kickback statute, prohibits or restricts hospitals from offering discounts to uninsured patients who are unable to pay their hospital bills.[76] In addition, the OIG has never excluded or attempted to exclude any provider or supplier for offering discounts to uninsured or underinsured patients under the permissive exclusion authority at section 1128(b)(6)(A) of the Act. However, to provide additional assurance to the industry, the OIG recently proposed regulations that would define key terms in the statute.[77] Among other things, the proposed regulations would make clear that free or substantially reduced charges to

[74] *See supra* note 68.

[75] *See* Notice of Proposed Rulemaking regarding ''Clarification of Terms and Application of Program Exclusion Authority for Submitting Claims Containing Excessive Charges'' (68 FR 53939; September 15, 2003), available on our Web page at *http://oig.hhs.gov/authorities/docs/FRSIENPRM.pdf.*

[76] Discounts offered to *underinsured* patients potentially raise a more significant concern under the anti-kickback statute, and hospitals should exercise care to ensure that such discounts are not tied directly or indirectly to the furnishing of items or services payable by a Federal health care program. For more information, *see* our February 2, 2004 paper on ''Hospital Discounts Offered To Patients Who Cannot Afford To Pay Their Hospital Bills,'' available on our Web page at *http://oig.hhs.gov/fraud/docs/alertsandbulletins/2004/FA021904hospitaldiscounts.pdf,* and CMS's paper titled ''Questions On Charges For The Uninsured,'' dated February 17, 2004, and available on CMS's Web page at *http://www.cms.gov/FAQ_Uninsured.pdf.*

[77] *See* 68 FR 53939 (September 15, 2003), available on our Web page at *http://oig.hhs.gov/authorities/docs/FRSIENPRM.pdf.*

uninsured persons would not affect the calculation of a provider's or supplier's ''usual'' charges, as the term ''usual charges'' is used in the exclusion provision. The OIG is currently reviewing the public comments to the proposed regulations. Until such time as a final regulation is promulgated or the OIG indicates its intention not to promulgate a final rule, it will continue to be the OIG's enforcement policy that when calculating their ''usual charges'' for purposes of section 1128(b)(6)(A) of the Act, individuals and entities do not need to consider free or substantially reduced charges to (i) uninsured patients or (ii) underinsured patients who are self-paying patients for the items or services furnished. In offering such discounts, a hospital should report full uniform charges, rather than the discounted amounts, on its Medicare cost report and make the FI aware that it has reported its full charges.[78]

Under CMS rules, Medicare generally reimburses a hospital for a percentage of its ''bad debt'' (*i.e.*, uncollectible Medicare deductible or coinsurance amounts), but only if the hospital bills the Medicare patient for unpaid amounts first, and engages in reasonable, good faith collection efforts that are consistent with the degree of effort applied to collecting similar debts from non-Medicare patients.[79] However, as explained in CMS's paper titled ''Questions On Charges For The Uninsured,'' a hospital can forgo collection efforts aimed at a Medicare patient, if the hospital, using its customary methods, documents that the patient is indigent or medically indigent[80] and that no source other than the patient is legally responsible for the unpaid deductibles and coinsurance.

CMS Medicare bad debt reimbursement guidelines provide that a hospital should apply its customary indigency criteria to Medicare patients; however, the hospital must document such determination for such patients. To claim Medicare bad debt reimbursement, the hospital must follow the guidance laid out in sections 310, 312, and 322 of the Provider Reimbursement Manual.[81] A hospital should examine a patient's total resources, which could include, but are not limited to, an analysis of assets, liabilities, income, expenses, and any extenuating circumstances that would affect the determination. The hospital should document the method by which it determined the indigency and include all backup information used to substantiate the determination. If, instead of making such a determination, a hospital attempts to collect the outstanding amounts from the Medicare beneficiary, such efforts must be documented in the patient's file with copies of the bill(s), follow-up letters, and reports of telephone and personal contacts. In the case of a dually-eligible patient (*i.e.*, a patient entitled to both Medicare and Medicaid), the hospital should document the bad debt claim by including a denial of payment from the State.

2. Preventive Care Services

Hospitals frequently participate in community-based efforts to deliver preventive care services. The Medicare and Medicaid programs encourage patients to access preventive care services. The prohibition against beneficiary inducements at section 1128A(a)(5) of the Act does not apply to incentives offered to promote the delivery of certain preventive care services, if the programs are structured in accordance with the regulatory requirements at 42 CFR 1003.101. Generally, to fit within the preventive care exception, a service must be a prenatal service or post-natal well-baby visit or a specific clinical service described in the current U.S. Preventive Services Task Force's *Guide to Clinical Preventive Services*[82] that is reimbursed by Medicare or Medicaid. Obtaining the service may not be tied directly or indirectly to the provision of other Medicare or Medicaid services. In addition, the incentives may not be in the form of cash or cash equivalents and may not be disproportionate to the value of the preventive care provided. From an anti-kickback perspective, the chief concern is whether an arrangement to induce patients to obtain preventive care services is intended to induce other business payable by a Federal health care program. Relevant factors in making this evaluation would include, but not be limited to: the nature and scope of the preventive care services; whether the preventive care services are tied directly or indirectly to the provision of other items or services and, if so, the nature and scope of the other services; the basis on which patients are selected to receive the free or discounted services; and whether the patient is able to afford the services.

3. Professional Courtesy

Although historically ''professional courtesy'' referred to the practice of physicians waiving the entire professional fee for other physicians, the term is variously used in the industry now to describe a range of practices involving free or discounted services (including ''insurance only'' billing) furnished to physicians and their families and staff. Some hospitals have used the term ''professional courtesy'' to describe various programs that offer free or discounted hospital services to medical staff, employees, community physicians, and their families and staff. Although many professional courtesy programs are unlikely to pose a significant risk of abuse (and many may be legitimate employee benefits programs eligible for the employee safe harbor), some hospital-sponsored ''professional courtesy'' programs may implicate the fraud and abuse statutes.

In general, whether a professional courtesy program runs afoul of the anti-kickback statute turns on whether the recipients of the professional courtesy are selected in a manner that takes into account, directly or indirectly, any recipient's ability to refer to, or otherwise generate business for, the hospital. Also relevant is whether the physicians have solicited the professional courtesy in return for referrals. With respect to the Stark law, the key inquiry is whether the arrangement fits in the exception for professional courtesy at 42 CFR 411.357(s). Finally, hospitals should evaluate the method by which the courtesy is granted. For example, ''insurance only'' billing offered to a Federal program beneficiary potentially implicates the anti-kickback statute, the False Claims Act, and the CMP

[78] For more information, *see* CMS's paper titled ''Questions On Charges For The Uninsured,'' dated February 17, 2004, and available on CMS's Web page at *http://www.cms.gov/FAQ_Uninsured.pdf*.

[79] *See* 42 CFR 413.89 and Medicare's Provider Reimbursement Manual, Part I, Chapter 3, Section 310, available on CMS's Web page at *http://www.cms.hhs.gov/manuals/pub151/PUB_15_1.asp; see also* Provider Reimbursement Manual, Part II, chapter 11, section 1102.3.L, available on CMS's Web page at *http://www.cms.gov/manuals/pub152/PUB_15_2.asp*.

[80] *See* ''Questions On Charges For The Uninsured,'' dated February 17, 2004 and available on CMS's Web page at *http://www.cms.gov/FAQ_Uninsured.pdf*. In the paper, CMS further explains that hospitals may, but are not required to, determine a patient's indigency using a sliding scale. In this type of arrangement, the provider would agree to deem the patient indigent with respect to a portion of the patient's account (*e.g.*, a flat percentage of the debt based on the patient's income, assets, or the size of the patient's liability relative to income). In the case of a Medicare patient who is determined to be indigent using this method, the amount the hospital decides, pursuant to its policy, not to collect from the patient can be claimed by the provider as Medicare bad debt. The hospital must, however, engage in a reasonable collection effort to collect the remaining balance before claiming such balance as reimbursable bad debt. *Id.*

[81] See Medicare's Provider Reimbursement Manual, Part I, chapter 3, available on CMS's Web page at *http://www.cms.hhs.gov/manuals/pub151/PUB_15_1.asp*.

[82] Available on the Internet at *http://www.ahrq.gov/clinic/cps3dix.htm*.

provision prohibiting inducements to Medicare and Medicaid beneficiaries (discussed in section II.F above). Notably, the Stark law exception for professional courtesy requires that insurers be notified if ''professional courtesy'' includes ''insurance only'' billing.

III. Hospital Compliance Program Effectiveness

Hospitals with an organizational culture that values compliance are more likely to have effective compliance programs and, thus, are better able to prevent, detect, and correct problems. Building and sustaining a successful compliance program rarely follows the same formula from organization to organization. However, such programs generally include: The commitment of the hospital's governance and management at the highest levels; structures and processes that create effective internal controls; and regular self-assessment and enhancement of the existing compliance program. The 1998 CPG provided guidance for hospitals on establishing sound internal controls.[83] This section discusses the important roles of corporate leadership and self-assessment of compliance programs.

A. Code of Conduct

Every effective compliance program necessarily begins with a formal commitment to compliance by the hospital's governing body and senior management. Evidence of that commitment should include active involvement of the organizational leadership, allocation of adequate resources, a reasonable timetable for implementation of the compliance measures, and the identification of a compliance officer and compliance committee vested with sufficient autonomy, authority, and accountability to implement and enforce appropriate compliance measures. A hospital's leadership should foster an organizational culture that values, and even rewards, the prevention, detection, and resolution of problems. Moreover, hospitals' leadership and management should ensure that policies and procedures, including, for example, compensation structures, do not create undue pressure to pursue profit over compliance. In short, the hospital should endeavor to develop a culture that values compliance from the top down and fosters compliance from the bottom up. Such an organizational culture is the foundation of an effective compliance program.

Although a clear statement of detailed and substantive policies and procedures—and the periodic evaluation of their effectiveness—is at the core of a compliance program, the OIG recommends that hospitals also develop a general organizational statement of ethical and compliance principles that will guide the entity's operations. One common expression of this statement of principles is a code of conduct. The code should function in the same fashion as a constitution, *i.e.*, as a document that details the fundamental principles, values, and framework for action within an organization. The code of conduct for a hospital should articulate a commitment to compliance by management, employees, and contractors, and should summarize the broad ethical and legal principles under which the hospital must operate. The Code of Conduct should also include a requirement that professionals follow the ethical standards dictated by their respective professional organizations. Unlike the more detailed policies and procedures, the code of conduct should be brief, easily readable, and cover general principles applicable to all members of the organization.

As appropriate, the OIG strongly encourages the participation and involvement of the hospital's board of directors, officers (including the chief executive officer (CEO)), members of senior management, representatives from the medical and clinical staffs, and other personnel from various levels of the organizational structure in the development of all aspects of the compliance program, especially the code of conduct. Management and employee involvement in this process communicates a strong and explicit commitment by management to foster compliance with applicable Federal health care program requirements. It also communicates the need for all directors, officers, managers, employees, contractors, and medical and clinical staff members to comply with the organization's code of conduct and policies and procedures.

B. Regular Review of Compliance Program Effectiveness

Hospitals should regularly review the implementation and execution of their compliance program elements. This review should be conducted at least annually and should include an assessment of each of the basic elements individually, as well as the overall success of the program. This review should help the hospital identify any weaknesses in its compliance program and implement appropriate changes.

A common method of assessing compliance program effectiveness is measurement of various outcomes indicators (*e.g.*, billing and coding error rates, identified overpayments, and audit results). However, we have observed that exclusive reliance on these indicators may cause an organization to miss crucial underlying weaknesses. We recommend that hospitals examine program outcomes and assess the underlying structure and process of each compliance program element. We have identified a number of factors that may be useful when evaluating the effectiveness of basic compliance program elements. Hospitals should consider these factors, as well as others, when developing a strategy for assessing their compliance programs. While no one factor is determinative of program effectiveness, the following factors are often observed in effective compliance programs.

1. Designation of a Compliance Officer and Compliance Committee

The compliance department is the backbone of the hospital's compliance program. The compliance department should be led by a well-qualified compliance officer, who is a member of senior management, and should be supported by a compliance committee. The purpose of the compliance department is to implement the hospital's compliance program and to ensure that the hospital complies with all applicable Federal health care program requirements. To ensure that the compliance department is meeting this objective, each hospital should conduct an annual review of its compliance department. Some factors that the organization may wish to consider in its evaluation include the following:

- Does the compliance department have a clear, well-crafted mission?
- Is the compliance department properly organized?
- Does the compliance department have sufficient resources (staff and budget), training, authority, and autonomy to carry out its mission?
- Is the relationship between the compliance function and the general counsel function appropriate to achieve the purpose of each?
- Is there an active compliance committee, comprised of trained

[83] Among other things, the 1998 hospital CPG includes a detailed discussion of the structure and processes that make up the recommended seven elements of a compliance program. The seven basic elements of a compliance program are: Designation of a compliance officer and compliance committee; development of compliance policies and procedures, including standards of conduct; development of open lines of communication; appropriate training and education; response to detected offenses; internal monitoring and auditing; and enforcement of disciplinary standards.

representatives of each of the relevant functional departments, as well as senior management?

• Are *ad hoc* groups or task forces assigned to carry out any special missions, such as conducting an investigation or evaluating a proposed enhancement to the compliance program?

• Does the compliance officer have direct access to the governing body, the president or CEO, all senior management, and legal counsel?

• Does the compliance officer have independent authority to retain outside legal counsel?

• Does the compliance officer have a good working relationship with other key operational areas, such as internal audit, coding, billing, and clinical departments?

• Does the compliance officer make regular reports to the board of directors and other hospital management concerning different aspects of the hospital's compliance program?

2. Development of Compliance Policies and Procedures, Including Standards of Conduct

The purpose of compliance policies and procedures is to establish bright-line rules that help employees carry out their job functions in a manner that ensures compliance with Federal health care program requirements and furthers the mission and objective of the hospital itself. Typically, policies and procedures are written to address identified risk areas for the organization. As hospitals conduct a review of their written policies and procedures, some of the following factors may be considered:

• Are policies and procedures clearly written, relevant to day-to-day responsibilities, readily available to those who need them, and re-evaluated on a regular basis?

• Does the hospital monitor staff compliance with internal policies and procedures?

• Have the standards of conduct been distributed to all directors, officers, managers, employees, contractors, and medical and clinical staff members?

• Has the hospital developed a risk assessment tool, which is re-evaluated on a regular basis, to assess and identify weaknesses and risks in operations?

• Does the risk assessment tool include an evaluation of Federal health care program requirements, as well as other publications, such as the OIG's CPGs, work plans, special advisory bulletins, and special fraud alerts?

3. Developing Open Lines of Communication

Open communication is essential to maintaining an effective compliance program. The purpose of developing open communication is to increase the hospital's ability to identify and respond to compliance problems. Generally, open communication is a product of organizational culture and internal mechanisms for reporting instances of potential fraud and abuse. When assessing a hospital's ability to communicate potential compliance issues effectively, a hospital may wish to consider the following factors:

• Has the hospital fostered an organizational culture that encourages open communication, without fear of retaliation?

• Has the hospital established an anonymous hotline or other similar mechanism so that staff, contractors, patients, visitors, and medical and clinical staff members can report potential compliance issues?

• How well is the hotline publicized; how many and what types of calls are received; are calls logged and tracked (to establish possible patterns); and is the caller informed of the hospital's actions?

• Are all instances of potential fraud and abuse investigated?

• Are the results of internal investigations shared with the hospital governing body and relevant departments on a regular basis?

• Is the governing body actively engaged in pursuing appropriate remedies to institutional or recurring problems?

• Does the hospital utilize alternative communication methods, such as a periodic newsletter or compliance intranet website?

4. Appropriate Training and Education

Hospitals that fail to train and educate their staff adequately risk liability for the violation of health care fraud and abuse laws. The purpose of conducting a training and education program is to ensure that each employee, contractor, or any other individual that functions on behalf of the hospital is fully capable of executing his or her role in compliance with rules, regulations, and other standards. In reviewing their training and education programs, hospitals may consider the following factors:

• Does the hospital provide qualified trainers to conduct annual compliance training for its staff, including both general and specific training pertinent to the staff's responsibilities?

• Has the hospital evaluated the content of its training and education program on an annual basis and determined that the subject content is appropriate and sufficient to cover the range of issues confronting its employees?

• Has the hospital kept up-to-date with any changes in Federal health care program requirements and adapted its education and training program accordingly?

• Has the hospital formulated the content of its education and training program to consider results from its audits and investigations; results from previous training and education programs; trends in hotline reports; and OIG, CMS, or other agency guidance or advisories?

• Has the hospital evaluated the appropriateness of its training format by reviewing the length of the training sessions; whether training is delivered via live instructors or via computer-based training programs; the frequency of training sessions; and the need for general and specific training sessions?

• Does the hospital seek feedback after each session to identify shortcomings in the training program, and does it administer post-training testing to ensure attendees understand and retain the subject matter delivered?

• Has the hospital's governing body been provided with appropriate training on fraud and abuse laws?

• Has the hospital documented who has completed the required training?

• Has the hospital assessed whether to impose sanctions for failing to attend training or to offer appropriate incentives for attending training?

5. Internal Monitoring and Auditing

Effective auditing and monitoring plans will help hospitals avoid the submission of incorrect claims to Federal health care program payors. Hospitals should develop detailed annual audit plans designed to minimize the risks associated with improper claims and billing practices. Some factors hospitals may wish to consider include the following:

• Is the audit plan re-evaluated annually, and does it address the proper areas of concern, considering, for example, findings from previous years' audits, risk areas identified as part of the annual risk assessment, and high volume services?

• Does the audit plan include an assessment of billing systems, in addition to claims accuracy, in an effort to identify the root cause of billing errors?

• Is the role of the auditors clearly established and are coding and audit personnel independent and qualified, with the requisite certifications?

• Is the audit department available to conduct unscheduled reviews and does a mechanism exist that allows the compliance department to request additional audits or monitoring should the need arise?

• Has the hospital evaluated the error rates identified in the annual audits?

• If the error rates are not decreasing, has the hospital conducted a further investigation into other aspects of the hospital compliance program in an effort to determine hidden weaknesses and deficiencies?

• Does the audit include a review of all billing documentation, including clinical documentation, in support of the claim?

6. Response to Detected Deficiencies

By consistently responding to detected deficiencies, hospitals can develop effective corrective action plans and prevent further losses to Federal health care programs. Some factors a hospital may wish to consider when evaluating the manner in which it responds to detected deficiencies include the following:

• Has the hospital created a response team, consisting of representatives from the compliance, audit, and any other relevant functional areas, which may be able to evaluate any detected deficiencies quickly?

• Are all matters thoroughly and promptly investigated?

• Are corrective action plans developed that take into account the root causes of each potential violation?

• Are periodic reviews of problem areas conducted to verify that the corrective action that was implemented successfully eliminated existing deficiencies?

• When a detected deficiency results in an identified overpayment to the hospital, are overpayments promptly reported and repaid to the FI?

• If a matter results in a probable violation of law, does the hospital promptly disclose the matter to the appropriate law enforcement agency? [84]

7. Enforcement of Disciplinary Standards

By enforcing disciplinary standards, hospitals help create an organizational culture that emphasizes ethical behavior. Hospitals may consider the following factors when assessing the effectiveness of internal disciplinary efforts:

• Are disciplinary standards well-publicized and readily available to all hospital personnel?

• Are disciplinary standards enforced consistently across the organization?

• Is each instance involving the enforcement of disciplinary standards thoroughly documented?

• Are employees, contractors and medical and clinical staff members checked routinely (*e.g.*, at least annually) against government sanctions lists, including the OIG's List of Excluded Individuals/Entities (LEIE) [85] and the General Services Administration's Excluded Parties Listing System.

In sum, while no single factor is conclusive of an effective compliance program, the preceding seven areas form a useful starting point for developing and maintaining an effective compliance program.

IV. Self-Reporting

Where the compliance officer, compliance committee, or a member of senior management discovers credible evidence of misconduct from any source and, after a reasonable inquiry, believes that the misconduct may violate criminal, civil, or administrative law, the hospital should promptly report the existence of misconduct to the appropriate Federal and State authorities [86] within a reasonable period, but not more than 60 days,[87] after determining that there is credible evidence of a violation.[88] Prompt voluntary reporting will demonstrate the hospital's good faith and willingness to work with governmental authorities to correct and remedy the problem. In addition, reporting such conduct will be considered a mitigating factor by the OIG in determining administrative sanctions (*e.g.,* penalties, assessments, and exclusion), if the reporting hospital becomes the subject of an OIG investigation.[89] To encourage providers to make voluntary disclosures, the OIG published the Provider Self-Disclosure Protocol.[90]

When reporting to the government, a hospital should provide all information relevant to the alleged violation of applicable Federal or State law(s)and the potential financial or other impact of the alleged violation. The compliance officer, under advice of counsel and with guidance from the governmental authorities, could be requested to continue to investigate the reported violation. Once the investigation is completed, and especially if the investigation ultimately reveals that criminal, civil, or administrative violations have occurred, the compliance officer should notify the appropriate governmental authority of the outcome of the investigation, including a description of the impact of the alleged violation on the applicable Federal health care programs or their beneficiaries.

V. Conclusion

In today's environment of increased scrutiny of corporate conduct and increasingly large expenditures for health care, it is imperative for hospitals to establish and maintain effective compliance programs. These programs should foster a culture of compliance that begins at the highest levels and extends throughout the organization. This supplemental CPG is intended as a resource for hospitals to help them operate effective compliance programs that decrease errors, fraud, and abuse and increase compliance with Federal health care program requirements for the benefit of the hospitals and public alike.

[FR Doc. 05–1620 Filed 1–27–05; 8:45 am]

BILLING CODE 4150–01–P

[84] For more information on when to self-report, *see* section IV, below.

[85] *See http://oig.hhs.gov/fraud/exclusions.html.* The OIG also makes available Monthly Supplements for Standard LEIE, which can be compared to existing hospital personnel lists.

[86] Appropriate Federal and State authorities include the OIG, CMS, the Criminal and Civil Divisions of the Department of Justice, the U.S. Attorney in relevant districts, the Food and Drug Administration, the Department's Office for Civil Rights, the Federal Trade Commission, the Drug Enforcement Administration, the Federal Bureau of Investigation, and the other investigative arms for the agencies administering the affected Federal or State health care programs, such as the State Medicaid Fraud Control Unit, the Defense Criminal Investigative Service, the Department of Veterans Affairs, the Health Resources and Services Administration, and the Office of Personnel Management (which administers the Federal Employee Health Benefits Program).

[87] In contrast, to qualify for the ''not less than double damages'' provision of the False Claims Act, the provider must provide the report to the government within 30 days after the date when the provider first obtained the information. *See* 31 U.S.C. 3729(a).

[88] Some violations may be so serious that they warrant immediate notification to governmental authorities prior to, or simultaneous with, commencing an internal investigation. By way of example, the OIG believes a provider should immediately report misconduct that: (i) Is a clear violation of administrative, civil, or criminal laws; (ii) has a significant adverse effect on the quality of care provided to Federal health care program beneficiaries; or (iii) indicates evidence of a systemic failure to comply with applicable laws or an existing corporate integrity agreement, regardless of the financial impact on Federal health care programs.

[89] The OIG has published criteria setting forth those factors that the OIG takes into consideration in determining whether it is appropriate to exclude an individual or entity from program participation pursuant to 42 U.S.C. 1320a–7(b)(7) for violations of various fraud and abuse laws. *See* 62 FR 67392 (December 24, 1997).

[90] *See* 63 FR 58399 (October 30, 1998), available on our Web page at *http://oig.hhs.gov/authorities/docs/selfdisclosure.pdf.*

	Tahoe Forest Health System				
	Title: Corporate Compliance Program TFHD			**Policy/Procedure #:** AGOV-31	
	Responsible Department: Administration				
Type of policy		Original Date:	Reviewed Dates:	Revision Dates:	
☒	Administrative	3/2/98	1/10; 3/11; 11/13	7/09; 04/12	
☐	Medical Staff				
☐	Departmental				
Applies to: ☒ System ☐ Tahoe Forest Hospital ☐ Incline Village Community Hospital					

POLICY*:*

The Tahoe Forest Hospital District (TFHD) Administration is committed to full compliance with all applicable federal, state, and local laws, rules and regulations, and to conduct itself in accordance with the highest level of business and community ethics and standards. To meet this goal, TFHD has implemented the development and continued advancement of a corporate compliance program throughout the Tahoe Forest Health System (Health System). The Health System includes, but is not limited to, two hospitals, a skilled nursing facility, home health services, hospice services, and various inpatient and outpatient services.

The Compliance Program exhibits the Health System's commitment to ethical and legal standards of conduct and sets forth guidelines to prevent and detect any violation of the law. While the Compliance Program places a strong emphasis on the prevention of fraud, abuse and waste in federal, state and private health care plans, the scope of the Program is not limited to these issues and covers other areas of compliance to which the Health System is subject.

Compliance Program Components

Tahoe Forest Hospital District's comprehensive Compliance Program includes the following seven elements:

I. Written policies and procedures
II. Designation of a compliance officer and a compliance committee
III. Conducting effective training and education
IV. Developing effective lines of communication
V. Enforcing standards through well-publicized disciplinary guidelines
VI. Auditing and monitoring
VII. Responding to detected offenses and developing corrective action initiatives

PROCEDURE:

I. Written Policies and Procedures

Tahoe Forest Hospital District (TFHD) has developed and distributed a written Standard for Business Conduct, the Health System Code of Conduct, as well as written policies and procedures that promote the Health System's commitment to compliance (e.g., by including

adherence to compliance as an element of evaluating managers). This policy addresses specific areas of potential fraud, such as claims development and submission processes, code gaming, and financial relationships with physicians and other health care professionals.

This compliance program required the development and distribution of written compliance policies that identify specific areas of risk to the Health System. Policies have been developed under the direction and supervision of the Compliance Officer and compliance committee, and are provided to all individuals who are affected by the particular policy at issue, including the Health System's agents and independent contractors. The attached table of hyperlinked policies and procedures (**Appendix A**) is a crosswalk of the leading administrative policies and procedures arising out of or directly related to the TFHD Compliance Program and which incorporate principles of compliance as established by this Compliance Program. (The list is not exclusive and is subject to addition or revision.)

1.0 **Standards for Business Conduct**

- 1.1 Developed Standards for Business conduct for all employees
- 1.2 Standards state TFHD's requirements of compliance reflecting a carefully crafted, clear expression of expectations for all Health System governing body members, directors, employees, physicians, and where appropriate, contractors and other agents.
- 1.3 Standards are distributed to all employees

2.0 **Risk Areas**

- 2.1 Billing for items or services not actually rendered
- 2.2 Providing medically unnecessary services
- 2.3 Upcoding
- 2.4 DRG creep
- 2.5 Outpatient services rendered in connection with inpatient stays
- 2.6 Duplicate billing
- 2.7 False cost reports
- 2.8 Unbundling
- 2.9 Billing for discharge in lieu of transfer
- 2.10 Patients' freedom of choice
- 2.11 Credit balances - failure to refund
- 2.12 Incentives that violate the anti-kickback statute or other similar federal or state statute or regulation
- 2.13 Joint ventures
- 2.14 Financial arrangements between Health System and Health System-based physicians
- 2.15 Stark physician self-referral law
- 2.16 Knowing failure to provide covered services or necessary care to members of a health maintenance organization
- 2.17 Patient dumping

3.0 **Claim Development and Submission Process**

Claim development and submission process policies and procedures include the following:

3.1 Provide for proper and timely documentation of all physician and other professional services prior to billing to ensure that only accurate and properly documented services are billed.

3.2 Emphasize that claims will be submitted only when appropriate documentation supports the claims, and only when such documentation is maintained and available for audit and review.

3.3 Be consistent with appropriate guidance from medical staff, physician and Health System records and medical notes used as a basis for a claim submission. This information is appropriately organized in a legible form so they can be audited and reviewed.

3.4 Indicates that the diagnosis and procedures reported on the reimbursement claim is based on the medical record and other documentation, and that the documentation necessary for accurate code assignment is available to coding staff.

3.5 Provide that the compensation for billing department coders, physicians and billing consultants should not provide any financial incentive to improperly up code claims.

4.0 **Medical Necessity - Reasonable and Necessary Services**

Medical necessity service policies and procedures:

4.1 Provide that claims are only submitted for services when TFHD has reason to believe they are medically necessary and that they were ordered by a physician or other appropriately licensed individuals.

4.2 Assure that documentation such as patients' medical records and physicians orders should be available to support the medical necessity of a service that TFHD has provided.

4.3 Ensure that a clear, comprehensive summary of the medical necessity definitions and rules of the various government and private plans is prepared and disseminated appropriately by the compliance officer.

5.0 **Anti-Kickback and Self-Referral Concerns**

5.1 All of TFHD's contracts and arrangements with referral sources must comply with applicable statutes and regulations.

5.2 TFHD should insure that it does not submit to the federal health care programs claims for patients who were referred to the Health System pursuant to contracts and financial arrangements that were designed to induce such referrals in violation of the anti-kickback statue, Stark physician self-referral law or similar federal or state statute or regulation.

5.3 TFHD will not enter into financial arrangements with Health System-based physicians that are designed to provide inappropriate remuneration to the Health System in return for the physician's ability to provide services to federal health care program beneficiaries at that Health System.

6.0 **Bad Debts**

TFHD developed a mechanism to review, at least annually:

6.1 Whether it is properly reporting bad debts to Medicare

6.2 All Medicare bad debt expenses claimed to ensure that the Health System's procedures are in accordance with applicable federal and state statutes, regulations guidelines and policies. Such a review should ensure that the Health System has appropriate and reasonable mechanisms in place regarding patient deductible or co-payment collection efforts and has not claimed as bad debts any routinely waived Medicare co-payment and deductibles, which waiver also constitutes a violation of the anti-kickback statute.

7.0 **Credit Balance**

7.1 TFHD instituted procedures to provide for the timely and accurate reporting of Medicare and other federal health care program credit balances.

7.2 TFHD's Health System information system has the ability to print out the individual patient accounts that reflect a credit balance in order to permit simplified tracking of credit balances.

7.3 TFHD designated at least one person as having responsibility for the tracking, recording and reporting of credit balances.

7.4 An accountant in the Health System's accounting department may review reports of credit balances and reimbursements or adjustments on a monthly basis as an additional safeguard.

8.0 **Retention of Records**

8.1 TFHD has provided for the implementation of a records system.

8.2 This system establishes policies and procedures regarding the creation, distribution, retention, storage, retrieval and destruction of documents.

8.3 This system includes such documentation as clinical and medical records, claim documentation, all records necessary to protect TFHD's integrity of its compliance process and confirm the effectiveness of the program.

8.4 Documentation is maintained to indicate employees were adequately trained. Reports from the Health System's hotline, including the nature and results of any investigation that was conducted, modifications to the compliance program, self-disclosures, and the results of the Health System's auditing and monitoring efforts.

9.0 **Compliance as an Element of a Performance Plan**

9.1 TFHD's compliance program requires that the promotion of, and adherence to, the elements of the compliance program be a factor in evaluating the performance of managers. They, along with other employees, will be periodically trained in new compliance policies and procedures. In addition, all managers and supervisors involved in the coding, claims and cost report development and submission processes will:

9.2 Discuss with all supervised employees the compliance policies and legal requirements applicable to their function.

9.3 Inform all supervised personnel that strict compliance with the policies and requirements is a condition of employment.

9.4 Disclose to all supervised personnel that TFHD will take disciplinary action up to and including termination or revocation of privileges for violation of these policies or requirements.

II. Designation of a Compliance Officer and Compliance Committee

TFHD has designated a compliance officer to serve as the focal point for compliance activities. This responsibility may be the individual's sole duty or added to other management responsibilities, depending upon the size and resources of the Health System and the complexity of the task. Designating a compliance officer with the appropriate authority is critical to the success of the program, necessitating the appointment of a high-level official in TFHD with direct access to TFHD's governing body and the CEO.

1.0 **Compliance Officer**

The compliance officer's primary responsibilities include:

1.1 Overseeing and monitoring the implementation of the compliance program.

1.2 Reporting on a regular basis to TFHD's governing body, CEO, and compliance committee on the progress of implementation, and assisting these components in establishing methods to improve the Health System's efficiency and quality of service and to reduce the Health System's vulnerability to fraud and abuse.

1.3 Periodically revising the program in light of changes in the needs of TFHD, and in the law and policies and procedures of government and private payor health plans.

1.4 Developing, coordinating, and participating in a multifaceted educational and training program that focuses on the elements of the compliance program, and seeks to ensure that all appropriate employees and management are knowledgeable of, and comply with, pertinent federal and state standards.

1.5 Ensuring that independent contractors and agents who furnish medical services to the Health System are aware of the requirements of the TFHD compliance program with respect to coding, billing, and marketing, among other things.

1.6 Coordinating personnel issues with TFHD Human Resources office to ensure that the National Practitioner Data Bank, Cumulative Sanction Reports, and applicable government exclusion sites have been checked with respect to all employees, medical staff and independent contractors.

1.7 Assisting the TFHD financial management in coordinating internal compliance review and monitoring activities, including annual or periodic reviews of departments.

1.8 Independently investigating and acting on matters related to compliance, including the flexibility to design and coordinate internal investigations and any resulting corrective action with all Health System departments, providers and sub-providers, agents and, if appropriate, independent contractors.

1.9 Developing policies and programs that encourage managers and employees to report suspected fraud and other improprieties without fear of retaliation.

2.0 **Compliance Committee**

A compliance committee has been established to advise the compliance officer and assist in the implementation of the compliance program. The committee's functions include:

2.1 Analyzing the TFHD industry environment, the legal requirements with which it must comply, and specific risk areas.

2.2 Assessing existing policies and procedures that address these areas for possible incorporation into the compliance program.

2.3 Working with appropriate TFHD departments to develop standards of conduct and policies and procedures to promote compliance with the TFHD program.

2.4 Recommending and monitoring, in conjunction with the relevant departments, the development of internal systems and controls to carry out TFHD's standards, policies and procedures as part of its daily operations.

2.5 Determining the appropriate strategy/approach to promote compliance with the program and detection of any potential violations, such as through hotlines and other fraud reporting mechanisms.

2.6 Developing a system to solicit, evaluate and respond to complaints and problems.

III. Conducting Effective Training and Education

The proper education and training of corporate officers, managers, employees, physicians and other health care professionals, and the continual retraining of current personnel at all levels, are significant elements of an effective compliance program. As part of a compliance program, TFHD requires personnel to attend specific training on a periodic basis, including appropriate training in federal and state statutes, regulations and guidelines, and the policies of private payors, and training in corporate ethics, which emphasizes TFHD's commitment to compliance with these legal requirements and policies.

Training and education includes:

1.0 Government and private payor reimbursement principles

2.0 General prohibitions on paying or receiving remuneration to induce referrals

3.0 Proper confirmation of diagnoses

4.0 Submitting a claim for physician services when rendered by a non-physician

5.0 Signing a form for a physician without the physician's authorization

6.0 Alterations to medical records

7.0 Prescribing medications and procedures without proper authorization

8.0 Proper documentation of services rendered

9.0 Duty to report misconduct

IV. Developing Effective Lines of Communication

An open line of communication between the compliance officer and TFHD personnel is equally important to the successful implementation of the compliance program and the reduction of any potential for fraud and abuse. Written confidentiality and non-retaliation policies are developed and distributed to all employees to encourage communication and the reporting of incidents of

potential fraud. TFHD has also developed a reporting path for an employee to report fraud and abuse so that supervisors or other personnel cannot divert such reports.

1.0 **Access to the Compliance Officer**

1.1 Encouraged the establishment of a procedure so that Health System personnel may seek clarification from the compliance officer or members of the compliance committee.

1.2 Questions and responses are documented and dated and, if appropriate, shared with other staff so that standards, policies and procedures can be updated and improved to reflect any necessary changes or clarifications.

1.3 The compliance officer may want to solicit employee input in developing these communications and reporting systems.

2.0 **Hotlines and Other Forms of Communication**

2.1 Encourages the use of hotlines, e-mails, written memoranda, newsletters, and other forms of information exchange to maintain an open line of communication.

2.2 The telephone number is made readily available to all employees and independent contractors in the form of a written communication.

2.3 Employees are permitted to report matters on an anonymous basis.

2.4 Documentation is required for all matters reported through the hotline, which pertain to substantial violations of compliance policies, regulations or statutes.

2.5 All investigations are promptly handled to determine their veracity.

2.6 The compliance officer, who records such calls, including the nature of any investigation and its results, maintains a log.

2.7 While TFHD strives to maintain the confidentiality of an employee's identity, it should also explicitly communicate that there may be a point where the individual's identity may become known or may have to be revealed in certain instances when governmental authorities become involved.

V. Enforcing Standards through Well-publicized Disciplinary Guidelines

TFHD policies include guidance regarding disciplinary action for directors, employees, physicians and other health care professionals who have failed to comply with TFHD's Standard for Business Conduct, policies and procedures, or federal and state laws, or those who have otherwise engaged in wrongdoing, which have the potential to impair TFHD's status as a reliable, honest and trustworthy health care provider.

1.0 **Discipline Policy and Actions**

1.1 TFHD has a written policy setting forth the degrees of disciplinary actions that may be imposed upon directors, employees, physicians and other health care professionals for failing to comply with TFHD's standards and policies and applicable statutes and regulations.

1.2 Intentional or reckless non-compliance will subject transgressors to significant sanctions. Such sanctions could range from oral warnings to suspension, privilege revocation, termination or financial penalties, as appropriate.

1.3 TFHD advises personnel that disciplinary action will be taken on a fair and equitable basis.

1.4 TFHD publishes and disseminates the range of disciplinary standards for improper conduct and to educate managers and other Health System staff regarding these standards.

1.5 Consequences of noncompliance will be consistently applied and enforced, in order for the disciplinary policy to have the required deterrent effect.

2.0 **New Employee Policy**

2.1 All new employees who have discretionary authority to make decisions that may involve compliance with the law or compliance oversight will have a reasonable and prudent background investigation, including a reference check, as part of every such employment application.

2.2 Applications require the applicant to disclose any criminal conviction or exclusion action.

VI. Auditing and Monitoring

An ongoing evaluation process is critical to a successful compliance program. TFHD incorporates thorough monitoring of its implementation and regular reporting to senior Health System staff. Compliance reports, including reports of suspected noncompliance, are maintained by the compliance officer and shared with the Health Systems' senior management and the compliance committee

1.0 **Auditing and Monitoring Requirements**

1.1 One effective tool to promote and ensure compliance is the performance of regular, periodic compliance audits by internal or external auditors who have expertise in federal and state health care statutes, regulations and federal health care program requirements.

1.2 Audits should focus on TFHD programs or divisions, including external relationships with third-party contractors, specifically those with substantive exposure to government enforcement actions.

1.3 Audits should be designed to address the Health System's compliance with laws governing kickback arrangements, the physician self-referral prohibition, coding, claim development and submission, reimbursement, cost reporting and marketing.

1.4 Audits and reviews should inquire into the Health System's compliance with specific rules and policies that have been the focus of particular attention on the part of Medicare fiscal intermediaries or carriers, and law enforcement.

1.5 Monitoring techniques may include sampling protocols that permit the compliance officer to identify and review variations from an established baseline.

1.6 If it is determined that a deviation was caused by improper procedures, misunderstanding of rules, including fraud and systemic problems, TFHD should take prompt steps to correct the problem.

2.0 **Auditing and Monitoring Techniques**

As part of the review process, the compliance officer or reviewers consider techniques such as:

2.1 On-site visits

2.2 Interviews with personnel involved in management, operations, coding, claim development and submission, patient care, and other related activities

2.3 Reviews of medical and financial records and other source documents that support claims for reimbursement and Medicare cost reports.

2.4 Reviews of written materials and documentation prepared by the different departments of TFHD.

2.5 The reviewers are:

2.5.1 Independent of physicians and line management.

2.5.2 Have access to existing audit and health care resources, relevant personnel and all relevant areas of operations.

2.5.3 Present written evaluative reports on compliance activities to the members of the compliance committee on a regular basis, but no less than annually.

2.5.4 Specifically identify areas where corrective actions are needed

VII. Responding to Detected Offenses and Developing Corrective Action Initiatives

1.0 Violations and Investigations

1.1 Violations of TFHD's compliance program, failures to comply with applicable federal or state law, and other types of misconduct threaten TFHD's status as a reliable, honest and trustworthy provider capable of participating in federal health care programs. Detected by uncorrected misconduct can seriously endanger the mission, reputation, and legal status of TFHD. Consequently, upon reports or reasonable indications of suspected noncompliance, it is important that the Compliance Officer or other management officials initiate prompt steps to investigate the conduct in question to determine whether a material violation of applicable law or the requirements of the compliance program has occurred, and if so, take steps to correct the problem.

1.2 Depending on the nature of the alleged violations, an internal investigation will probably include interviews and a review of relevant documents.

1.3 TFHD should consider engaging outside counsel, auditors, or health care experts to assist in an investigation.

1.4 Records of investigations will contain:

1.4.1 Documentation of the alleged violation

1.4.2 A description of the investigative process

1.4.3 Copies of interview notes and key documents

1.4.4 A log of the witnesses interviewed and the documents reviewed

1.4.5 The results of the investigation

1.4.6 Any disciplinary action taken

1.4.7 The corrective action implemented

1.5 TFHD strives for some consistency by utilizing sound practices and disciplinary protocols.

1.6 The compliance officer will review the circumstances that formed the basis for the investigation to determine whether similar problems have been uncovered.

2.0 **Reporting**

2.1 If the compliance officer, compliance committee or administrator discovers there is credible evidence of fraud or abuse from any source and, after a reasonable inquiry, has reason to believe that the misconduct may violate criminal, civil or administrative law, then TFHD must promptly report the existence of misconduct to the Office of the Internal General (OIG) or the appropriate reporting government agency within a reasonable period, but no more than 60 days after determining that there is credible evidence of a violation. Prompt reporting will demonstrate TFHD's good faith and willingness to work with governmental authorities to correct and remedy the problem. In addition, reporting such conduct will be considered a mitigating factor by the OIG in determining administrative sanctions.

Related Policies/Forms: Standard for Business Conduct: Health System Code of Conduct AGOV-39; Standards of Business Conduct AHR-103
References: (42 CFR 1001.952)
Policy Owner: Janet S. Van Gelder, RN, DNP, NEA-BC, Director of Quality & Regulations
Approved by: Bob Schapper, CEO

Appendix A
Crosswalk of Compliance Program Related Policies & Procedures

	Policy #	Policy & Procedure
1.	ABD-06	Conflict Of Interest Code
2.	ABD-06-A	Conflict Of Interest Code.doc
3.	ABD-07	Conflict of Interest Policy
4.	ABD-17	Manner Of Governance For TFHD Board of Directors
5.	ABD-18	New Programs And Services
6.	ABD-21	Physicians and Professional Service Agreements
7.	AGOV-03	Americans With Disabilities Act
8.	AGOV-04	Antitrust Trade Laws
9.	AGOV-06	Available CAH Services
10.	AGOV-08	Civil Rights Grievance Procedure
11.	AGOV-10	Contract Review Policy
12.	AGOV-11	Red Flags Identify Theft Program
13.	AGOV-12	Corporate Compliance Violation Reporting
14.	AGOV-13	Corporate Compliance Violations Suspected
15.	AGOV-20	False Claims Act
16.	AGOV-21	Nondiscrimination
17.	AGOV-24	Patient Family Complaints Grievance
18.	AGOV-25	Patient Rights Responsibilities
19.	AGOV-27	Consent Informed
20.	AGOV-30	Records Retention and Destruction
21.	AGOV-30a	Record Retention Guidelines From CHA
22.	AGOV-31	Corporate Compliance Program TFHD
23.	AGOV-36	Subpoenas
24.	AGOV-39	Standards For Business Conduct
25.	AGOV-40	Business Associate Agreements
26.	AGOV-41	Procedure for Communication Information to Persons With Sensory Impairments
27.	AGOV-43	HIPAA Breach Investigation, Response, and Corrective Action

Appendix A
Crosswalk of Compliance Program Related Policies & Procedures

	Policy #	Policy & Procedure
28.	AHR-103	Standards for Business Conduct
29.	AHR-13	Confidentiality
30.	AHR-18	Disciplinary Due Process
31.	AHR-19	Discipline and Discharge
32.	AHR-31	Equal Employment Opportunity
33.	AHR-36	Harassment in the Workplace
34.	AHR-5	California Pregnancy Disability Leave
35.	AIT - 100	Network Usage Policy NUP
36.	AIT-102	Network Usage Policy for Providers NUPP
37.	AIT-105	Computer Security Incident
38.	AIT-112	Network Security Policy
39.	DHIM-13	Confidentiality of Patient Information
40.	DHIM-21	Confidentiality Release of Information
41.	DHIM-32	HIPAA Confidentiality Security
42.	DHIM-37	Coding Compliance
43.	DHIM-45	Standards of Ethical Coding
44.	DHIM-47	HIM Department Ethics

Tahoe Forest Hospital District

Board of Directors Meeting Evaluation Form

Date: _____

		Exceed Expectations		Meets Expectations		Below Expectations
1	Overall, the meeting agenda is clear and includes appropriate topics for Board consideration	5	4	3	2	1
2	The consent agenda includes appropriate topics and worked well	5	4	3	2	1
3	The Board packet & handout materials were sufficiently clear and at a 'governance level'	5	4	3	2	1
4	Discussions were on target	5	4	3	2	1
5	Board members were prepared and involved	5	4	3	2	1
6	The education was relevant and helpful	5	4	3	2	1
7	Board focused on issues of strategy and policy	5	4	3	2	1
8	Objectives for meeting were accomplished	5	4	3	2	1
9	Meeting ran on time	5	4	3	2	1

Please provide further feedback here: