Strafford

Presenting a live 90-minute webinar with interactive Q&A

Home Health Agencies: Regulatory and Enforcement Trends

Identifying Compliance Pitfalls and Minimizing Risk of Fraud and Abuse Investigations

TUESDAY, NOVEMBER 6, 2012

1pm Eastern | 12pm Central | 11am Mountain | 10am Pacific

Today's faculty features:

Laura F. Laemmle-Weidenfeld, Partner, **Patton Boggs**, Washington, D.C.

Robert W. Markette, Jr., Of Counsel, **Benesch Friedlander Coplan & Aronoff**, Indianapolis

The audio portion of the conference may be accessed via the telephone or by using your computer's speakers. Please refer to the instructions emailed to registrants for additional information. If you have any questions, please contact **Customer Service at 1-800-926-7926 ext. 10**.

Tips for Optimal Quality

Sound Quality

If you are listening via your computer speakers, please note that the quality of your sound will vary depending on the speed and quality of your internet connection.

If the sound quality is not satisfactory and you are listening via your computer speakers, you may listen via the phone: dial **1-866-370-2805** and enter your PIN when prompted. Otherwise, please **send us a chat** or e-mail **sound@straffordpub.com** immediately so we can address the problem.

If you dialed in and have any difficulties during the call, press *0 for assistance.

Viewing Quality

To maximize your screen, press the F11 key on your keyboard. To exit full screen, press the F11 key again.

Continuing Education Credits

FOR LIVE EVENT ONLY

For CLE purposes, please let us know how many people are listening at your location by completing each of the following steps:

- In the chat box, type (1) your **company name** and (2) the **number of attendees at your location**
- Click the word balloon button to send

Home Health Agencies: Regulatory and Enforcement Trends

November 6, 2012

Laura Laemmle-Weidenfeld
Partner, Patton Boggs LLP
lweidenfeld@pattonboggs.com
(202) 457-6542

Billing/Coding/Documentation Enforcement

- Significant documentation requirements for HHA combined with difficulty overseeing compliance => perfect compliance storm
- Enforcement focus
- Particular areas of risk
- How to minimize risks

Billing/Coding/Documentation Enforcement

- Significant enforcement focus
  - Criminal
  - Civil (False Claims Act)
  - Administrative (OIG)

Criminal Enforcement Focus

- Applicable laws:
  - Wire fraud
  - Mail fraud
  - Health care fraud
  - Conspiracy
  - Other
- Increasing activity
  - DOJ-HHS Health Care Fraud Prevention and Enforcement Action Team (HEAT) created in May 2009
    - Operates nationwide
    - Medicare Fraud Strike Force
  - Focus on both corporate entities and individuals

Recent Enforcement Actions

- Federal jury in Detroit convicted physician, HHA owner and patient recruiter for participating in $14.5 million Medicare fraud scheme (October 2012)
  - Patient recruiters allegedly paid beneficiaries to sign blank documents for PT services not provided and/or medically unnecessary
  - HHA allegedly paid physicians to sign referrals and other therapy documents necessary to bill Medicare
  - PTs and PTAs would allegedly create fake medical records to make it appear services actually were rendered
- October 2012 take-down by Strike Force
  - 7 cities
  - charges against 91 individuals
  - Indictments charged more than $230 million in Medicare home health fraud
- Owner of Miami HHA sentenced to 120 months in prison for $42M health care fraud scheme involving paying patient recruiters and physicians for false plans of care and medical certification and falsifying patient files (Oct. 2012)

Civil False Claims Act

- Civil False Claims Act (FCA), 31 U.S.C. §3729 *et seq.*
- Revised in 2009 (Fraud and Enforcement Recovery Act), 2010 (Patient Protection and Affordable Care Act)
- Cases typically filed by private whistleblowers (*qui tam* provisions) before
- Department of Justice has responsibility for investigating, enforcing (Civil Frauds, USAOs)

Conduct Prohibited Under FCA

- Submitting a claim for payment OR causing claim to be submitted for payment, by Government funds. 31 U.S.C. § 3729(a)(1)(A).
- Making or using, or causing to be made or used, false records or statements material to a false claim. 31 U.S.C. §3729(a)(1)(B).
- Making or using, or causing to be made or used, false records or statements material to an obligation to pay money or property to the Government, or knowingly concealing or improperly avoiding or decreasing an obligation to pay money to the Government. 31 U.S.C. §3729(a)(1)(G).
- Conspiring to commit a violation of the FCA. 31 U.S.C. §3729(a)(1)(C).
- All require "knowledge" and link to Government funding.

Key Provisions

- Knowledge:
  - Defined by the statute as
    - Actual knowledge that the claim or statement was false, OR
    - Deliberate ignorance of truth or falsity of the claim or statement, OR
    - Reckless disregard of the truth or falsity of the claim or statement
  - Proof of specific intent to defraud is NOT required
- Materiality: having a tendency to influence or be capable of influencing payment or receipt of money or property
- Obligation: established duty, including that arising out of retention of any overpayment

Damages and Penalties under the FCA

The FCA imposes:

- Treble the "amount of damages which the government sustains because of the act" giving rise to liability.

- A civil penalty of $5,500 to $11,000 for each false claim.

HHS-OIG's Exclusion Authority

- Exclusion: Medicare, Medicaid and other Federal health programs won't reimburse services provided, ordered or prescribed by individual or entity
- HHS-OIG has exclusive authority
- Issue arises in FCA cases and criminal cases, as well as administrative exclusion matters
- Mandatory and permissive, 42 U.S.C. §1320a-7
  - Criminal convictions for health care fraud offenses => mandatory exclusion
  - Submission of false claims => permissive exclusion

Home Health Services and OIG Work Plan for 2013

- 2013 OIG Work Plan released October 13, 2012
- Home Health Face-to-Face Requirement
- Employment of Home Health Aides with Criminal Convictions
- Missing or Incorrect Patient Outcome and Assessment Data

Home Health Services and OIG Work Plan for 2013

- Medicare Administrative Contractors' Oversight of Claims
- Home Health Prospective Payment System Requirements
- Duplicate Payments by Medicare and Medicaid
- Screening of Health Care Workers

Home Health Services and OIG Work Plan for 2013

- Provider Compliance and Beneficiary Eligibility
- Homebound Requirements
- Personal Care Services – Compliance with Payment Requirements

HHS-OIG Studies/Reports

- Inappropriate and Questionable Billing by Medicare Home Health Agencies (OEI-04-11-00240 August 2012)

High-Risk Billing/Coding/Documentation Issues

- Issues at administrative level involving clinical and/or personnel issues
- Issues in field at caregiver level or supervisor level
- Issues in billing office

Clinical and Personnel-Related Administrative Issues

- OASIS data
- Physician signatures/dates on plans of care, 485 forms
- Prior authorization signatures
- Background checks
- Qualifications of caregiver
- Exclusion checks
  - Required by CIAs
  - If employee is excluded but HHA bills anyway, repayment is required regardless of knowledge
- Documentation of homebound status
- (Documentation of improvement standard)

Caregiver Documentation Issues

- Inaccurately recording dates and times worked
  - Padding times
  - Dates patient was in hospital, SNF, or deceased
- Pre-filling notes
- Inaccurately recording care given, vitals taken
- Forging patients/families' signatures
- Homebound requirement (where applicable)
- Billing time concurrent with another HHA
- Potential for collusion with patients and/or families

Supervisory Issues

- Inaccurate documentation regarding date of supervisory visit
- Inaccurate documentation regarding whether supervisory visit occurred
- Accurately documenting training and qualifications of individual caregivers, assigning appropriately

Billing Issues

- Billings all impacted by issues identified on prior slides
- Failure to verify timesheet documentation prior to billing
- Billing for higher level of service than provided
- Dual eligibles

Mitigating Risks of Documentation/Coding/Billing Issues

- Recognize risks are real despite good intentions of management
- Create culture that values compliance, from CEO down to lowest-skill caregiver
- Task everyone in organization with responsibility for identifying and stopping errors and fraud
- Create and maintain an effective compliance program

Elements of an Effective Compliance Program

- Written standards of conduct
- Designated compliance officer and related governing bodies
- Regular, effective education and training programs for all employees
- Process to receive complaints, maintain anonymity of complainants, and protect them from retaliation
- Disciplinary system
- Auditing
- Investigation and remediation

How Not To Market: Common Ways to Market Yourself Into Prison

MY BENESCH MY TEAM

Robert W. Markette, Jr. CHC
Of Counsel
Benesch, Friedlander, Coplan & Aronoff LLP
One American Square, Suite 2300
Indianapolis, IN 46282
E-mail: rmarkette@beneschlaw.com

NOTE:

The materials and opinions presented by the speaker at this session represent the speaker's views, are for educational and informational purposes only, are not intended to be legal advice and should not be used for legal guidance or to resolve specific legal problems. The speaker expressly reserves the right to advocate other positions on behalf of clients. In all cases, legal advice applicable to your organization's own specific circumstances should be sought.

Marketing and the Medicare/Medicaid Provider: Here comes the law!

Many marketing practices that are considered good business in other industries are considered **illegal** for Medicare/Medicaid Providers (including Waiver).

This is due to federal fraud and abuse laws.

No remedy for fraud and abuse problems will be as good as avoiding them in the first place.

Basic Federal Fraud and Abuse Laws

Brief overview of the following laws:

The Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b);

Physician Self-Referral Law (Stark), 42 U.S.C. § 1395nn;

The Civil Monetary Penalties Statute, 42 U.S.C. § 1320a-7a; and,

The False Claims Act 31 U.S.C. §§ 3729, *et. seq.*

Outside "marketing" companies

There are many options to contract with outside PR companies for marketing.

OIG has repeatedly stated such arrangements should NOT involve commissions.

Outside "marketing" companies

Recently, providers are being approached by "marketers" who are not really marketers.

They are individuals with "access" to a pool of referrals.

Outside "marketing" companies

This may be through relationships or job. Marketer proposes to become the agency's marketing staff.

Requests a fee per referral. Usually a flat $250 - $500. May request a "subscription fee" with bonuses.

Outside "marketing" companies

This type of arrangement is extremely risky. It is one to be avoided.

Yes, someone else may pay the fee, but you are seriously at risk for going to jail if you do.

Inappropriate Marketing: Prizes, Gifts, and Other "Perks"

Many non-healthcare businesses provide gifts to customers who refer clients to the business.

Since the purpose of giving a gift or having a prize giveaway is to generate goodwill with referral sources and/or patients, it meets the one purpose test.

Prizes, Gifts and other “Perks”

Other Examples:

- Meals
- Happy Hour
- Spa Day

Prizes, Gifts and other “Perks”

Recent Face to Face example:

Physician requesting agency pay “administrative fee” before physician will prepare face to face documentation.

Prizes, Gifts and other "Perks"

Providing items of value to patients as an inducement to select the provider for reimbursable services violates the CMP statute.

Prizes, Gifts and other “Perks”

Examples:

- Free Services
- Free Equipment
- Free Chair

Prizes, Gifts and other “Perks”

Examples:

- Movie Tickets
- Transportation – OIG opinion letters
- Other Gifts

Prizes, Gifts and other "Perks"

OIG will not prosecute violations that involve "nominal value."

Nominal Value means less than $10 per person and totaling no more than $50 per year to each person.

Think small gifts.

Free Services

OIG has issued a number of advisory opinions regarding the provision of free items or services to beneficiaries and in almost every instance, the free items or services to beneficiaries were found to be a violation of the fraud and abuse laws.

Free Services

Two Examples:

Advisory Opinion on Free Home Safety Assessments

Advisory Opinion of Free Home Oxygen

Free Services

In both of these cases, OIG looked at the "perceived value" of the services. As a result, the minimal value exception did not apply.

This means if you provide free items or services, even if it does not cost you a lot, it is probably not minimal value.

Special Cases

Health Fairs

Health fairs are one of the most common forms of home health marketing. Many agencies participate in health fairs as a way to generate new business.

Recent Opinion on Free Blood Pressure Screening.

Free Staffing to Referral Source

This situation can come up in a number of ways. A home health agency might send a nurse to a referring physician's office to help them complete their paperwork to obtain reimbursement. A hospice may provide staff to a nursing facility to perform duties that would otherwise be performed by nursing facility staff.

Free Staffing to Referral Source

If you provide staff for free or below fair market value to a referral source to perform the duties normally performed by the referral source's staff, you are providing them with something of value – staff.

Free Staffing to Referral Source

If the free staffing is being provided to increase referrals, it is a violation.

Hard to explain why staff being provided for free.

Free Staffing to Referral Source

A provider may provide staffing to a referral source if the arrangement is structured to meet what is known as the personal services safe harbor to the Anti-Kickback law.

This safe harbor requires, amongst other things, fair market value.

Free Staffing to Referral Source

Home health agencies have provided referring physicians with smart phones, and other communications devices in order to “ensure care coordination.”

This is also a violation. While you may argue it is provided for a legitimate reason, it can be used by the physician for any number of other purposes.

Medical Directors

If the physician who acts as your medical director is a source of referrals, the relationship can violate not only the Anti-Kickback statute, but also the Stark law.

Medical Directors

The AKS and the Stark Law have a safe harbor/exception into which a medical director relationship can fit.

Medical Directors

Medical director relationships must be provided pursuant to a contract that meets all of the requirements of the Exception/Safe Harbors.

Both the Safe Harbor and the Exception require the compensation be fair market value.

Medical Directors

Some providers “hire” medical directors simply as a way to secure referrals. Risks:

- Multiple medical directors
- Paying more than FMV
- Paying for services not rendered

Medical Directors

Having the contract in place is not enough.
Relationship must operate in compliance with contract.
You must be prepared to prove compliance.

Document. Document. Document.

Q: Can you prove what physician is doing, other than referring patients, to justify payments?

Fraud and Abuse In LTC Relationships

OIG has issued a number of bulletins outlining its concerns about the risks in home health and hospice relationships with facilities. Concerns focus on risk agencies will offer inducements to "gain access."

Fraud and Abuse In LTC Relationships

Example: A nursing home requests a hospice provide items or services to a hospice beneficiary that is covered by the nursing home per diem.

Fraud and Abuse In LTC Relationships

Because the services are covered by the nursing home per diem, if the hospice provides them instead, the nursing home reduces its costs. This increases the nursing homes profits and is remuneration to the home.

Fraud and Abuse In LTC Relationships

A facility may request the agency provide staff generally or staff the agency's patients at a level that is not indicated. Again, if the hospice staff is providing care the facility would otherwise provide as part of the nursing home per diem, the nursing home is receiving remuneration.

Fraud and Abuse In LTC Relationships

Other examples:

Facility requests hospice to provide "continuous care" to all hospice patients in facility.

Facility requests provider use related therapy company and then "suggests" excessive services to patients.

Fraud and Abuse In LTC Relationships

Other examples:

Facility requests agency provide supplies that are covered by per diem or excessive amounts of supplies for hospice patients.

Facility requests agency take on “marginal cases.”

Fraud and Abuse In LTC Relationships

Last summer, OIG issue report outlining concerns about certain “long term” hospice patients being cared for in facilities.

RISK: Taking on marginal patients to please referring facility.

Fraud and Abuse In LTC Relationships

These types of issues can come up in relationships with other facilities as well. Assisted living facilities for example.

Fraud and Abuse In LTC Relationships

Assisted Living Facilities may “offer” an agency office space.

May request a provider perform certain services.

Fraud and Abuse In LTC Relationships

Example: ALF requests agency keep an RN on-site at all times, because agency's patients may "need to talk to someone." ALF then advertises "RN available 24/7."

Fraud and Abuse In LTC Relationships

May “request” agency use facility or related therapy staff to serve home health agency patients in the facility.

They may also “advocate” for more services on POC.

Avoiding problems

In your practice as a Medicare or Medicaid provider, you must be sensitive to the fact that many arrangements that are acceptable business practices in other fields are fraud and abuse violations.

Avoiding problems

You also must be sensitive to the fact that both federal and state governments are becoming more aggressive in their attempt to eliminate perceived over-utilization and to cut costs.

Avoiding problems

1. Train, train, and retrain your marketing personnel. The pressure to go compete in home health and to "successfully" market, can lead marketing personnel to try to keep up with competitors. This can lead you into violations of federal laws.

   Training is key to compliance.

Avoiding problems

For marketing compliance, your marketers, and certain clinical staff, are most likely to see or to be approached about suspect arrangements.

They need to know where the lines are at to avoid crossing them.

Avoiding problems

2. Make sure you have compliance oversight of new marketing categories and efforts.

3. Ensure arrangements meet applicable safe harbors on paper and in practice. Requires auditing of relationships.

Avoiding problems

4. When in doubt about a potential marketing practice or joint venture, seek the advice of counsel.

Avoiding problems

If you rely upon a safe harbor that relates to values per individual or totals in a year – TRACK AMOUNTS GIVEN.

This applies to “minimal value” and non-monetary compensation.

OVERPAYMENTS

Overpayments

- Potential liability under the civil False Claims Act (FCA) for failure to return overpayments

- Obligation to return “overpayments” created under 2009 Fraud Enforcement and Recovery Act (FERA) and 2010 Patient Protection and Affordable Care Act (ACA)

FCA and Overpayments

- Relevant FCA provision for "reverse false claims" includes knowingly concealing or *improperly avoiding* or decreasing an *obligation* to pay money to the Government, §3729(a)(1)(G) (emphasis added)
- Added by FERA in 2009
- "Obligation" in the FCA redefined under FERA to include "retention of any overpayment"
- 60-day repayment requirement imposed by ACA

Overpayments and 60-Day Rule

- Statutory 60-day rule (Social Security Act § 6402)
  - Requires specifically that all providers report and return overpayments within the later of sixty (60) days of identifying the overpayment or the date the corresponding cost report is due, "if applicable." 42 U.S.C. § 1320a-7k(d).
  - Defines "overpayment" to mean "any funds that a person receives or retains under [a FHCP] to which the person, after applicable reconciliation, is not entitled under such title." 42 U.S.C. § 1320a-7k(d)(2).
  - Defines an overpayment retained after such deadline as an "obligation" under the FCA. 42 U.S.C. § 1320a-7k(d)(3).
  - Defines terms "knowing" and "knowingly" as having the same meaning given under the FCA, but the statute otherwise does not employ those terms, leaving definitions for terms that otherwise are not used. 42 U.S.C. § 1320a-7k(4)(A).

Overpayments and 60-day Rule (continued)

- Proposed 60-day regulations (issued by CMS on February 16, 2012)
  - Proposed rule applies only to Medicare Part A and Part B providers and suppliers
  - Proposes to adopt the statutory definition of "overpayment" which applies broadly to almost any time a provider/supplier receives more reimbursement that it should have
  - Proposes that a provider/supplier has "identified" an overpayment once it has "actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment"
  - CMS references self-audits and compliance checks as being generally required to avoid deliberate ignorance and reckless disregard

Overpayments and 60-day Rule (continued)

- Proposed 60-day regulations (continued)
  - Proposed timeline for reporting and returning overpayments:
    - If an overpayment is claims-related, the provider must report and return the overpayment within sixty (60) days of identifying the overpayment. If the overpayment is the type that ordinarily would be reconciled through the cost reports, then the provider can report and return the overpayment either within sixty (60) days after identifying the overpayment or on the date that the cost report is due.
    - Receipt of information by a provider or supplier regarding a potential overpayment "creates an obligation to make a reasonable inquiry" to determine whether an overpayment has, in fact, occurred. Then, "[i]f the reasonable inquiry reveals an overpayment, the provider then has 60 days to report and return the overpayment."
    - If the provider or supplier fails to make a reasonable inquiry, or fails to conduct such an inquiry "with reasonable speed," then the provider or supplier could be viewed as having knowingly retained the overpayment on the grounds that it had "acted in reckless disregard or deliberate ignorance" of an overpayment.

Overpayments and 60-day Rule (continued)

- Proposed 60-day regulations (continued)
  - Fails to specify whether quantifying the overpayment is inherent in the definition of "identifying" the overpayment.
  - Proposed 10-year look-back period (through extension of time to re-open claims)
    - Effectively adopting FCA statute of limitations
    - Could create significant issues for providers
  - Self-reporting under CMS's Medicare Self-Referral Disclosure Protocol (SRDP) and HHS-OIG's Self-Disclosure Protocol (SDP) tolls repayment obligation

Overpayments and Exclusion

- The Civil Monetary Penalties (CMP) statute was amended by PPACA to impose CMPs for knowing about an overpayment and failing to report or return it. 42 U.S.C. § 1320a-7a(a)(10).

- Permissive exclusion provisions permit HHS-OIG to exclude any provider/supplier that violates the CMP statute. 42 U.S.C. § 1320a-7(b)(7).

Open Questions Regarding Overpayments

- When is an overpayment “identified”?
- At what point does the PPACA 60-day rule begin to run and what triggers it?
- What level of legal and regulatory certainty is required for there to be an “overpayment”?
- How far back must a provider look for overpayments?
- What level of review for overpayments is necessary for a provider to have made a reasonable inquiry?

PREFERRED PROVIDER AGREEMENTS AND OTHER ARRANGEMENTS

- Health care reform is leading to more collaboration across the continuum of care. ACO's, bundling and similar pilot projects, as well as reimbursement pressures are resulting in providers looking to partner.

Preferred Provider Agreements

Preferred provider agreements have been an accepted arrangement in the hospital and physician realm for many years.

These arrangements are coming to long term care as agencies and facilities look to “partner” with each.

Preferred Provider Agreements

In a preferred provider agreement, one party or both parties designate the other one as preferred.

For a home health or hospice agency, this will lead to an increase in referrals.

Preferred Provider Agreements

These agreements generally focus on quality, communications, and speed of admissions.

IMPORTANT: They do not usually call for any value to be exchanged.

IMPORTANT: They also recognize and protect patient choice.

Preferred Provider Agreements

Problems arise when there are related agreements or “understandings”.

Example: Preferred provider rents space from referring hospital. The rental agreement can become the remuneration that led to the preferred provider agreement.

Preferred Provider Agreements

Problems also arise when value is involved.

Example: Home health agency agrees, as preferred provider, to provide CEUs to hospital staff.

Joint Ventures

The term joint venture can describe many business relationships. They can be a great way for two or more entities to pool resources in order to start a new business.

However, OIG suspects that they are an effort to disguise remuneration being paid for referrals.

Joint Ventures

Although providers have long shied away from joint ventures as the marketplace becomes more competitive, they are starting to return.

Joint Ventures

OIG has repeatedly stated that it will carefully scrutinize joint ventures involving investors who are in a position to refer federal health care program business to the venture or to co-investors.

Joint Ventures

Two types of Joint Ventures

- Ownership Joint Ventures
- Contractual Joint Ventures

Joint Ventures

There is a safe harbor that might be used to structure ownership joint ventures. It is called the small investment interest safe harbor. As we will see, most JVs do not fit into it. It has eight elements.

Small Investment Safe Harbor

1. No more than forty percent of the entity may be owned by individuals or entities who have the power to make or influence referrals to the entity, furnish items or services to the entity, or otherwise generate business for the entity.

Small Investment Safe Harbor

2. Investment interests must be offered on the same terms to interested investors as they are offered to other investors.

Small Investment Safe Harbor

The terms on which an investment interest is offered to an interest investor must not be related to the previous or expected volume of referrals, items or services furnished, or the amount of business otherwise generated from that investor to the entity.

Small Investment Safe Harbor

3. There is no requirement that a passive investor, makes referrals to, be in a position to make or influence referrals to, furnish items or services to, otherwise generate business for the entity as a condition for remaining as an investor.

Small Investment Safe Harbor

4. The entity or any investor must not market or furnish the entity's items or services to passive investors differently than to non-investors.

Small Investment Safe Harbor

5. No more than forty percent of the entity's gross revenue related to the furnished of health care items and services in the previous fiscal year or previous 12 month period may come from referrals or business otherwise generated from the investors.

Small Investment Safe Harbor

6. The entity or any investor must not loan funds to or guarantee a loan for a potential referring investor if that loan is used to purchase an interest in the company.

Small Investment Safe Harbor

7. The amount of payment to an investor in return for the investment interest must be directly proportional to the amount of the capital investment of that investor.

Small Investment Safe Harbor

Most JVs will not have 60% disinterested investors. However, it can be a defense to be close, even if you do not fit into it.

Important to structure ownership ventures with this in mind.

Contractual Joint Venture

The other form of joint venture is known as a contractual joint venture. In this situation, the provider looking to branch out into a new area contracts with another provider to “manage” the new entities.

Contractual Joint Venture

As with ownership ventures, OIG is concerned that the contract may simply be a tool to disguise payments for referrals.

Contractual Joint Venture

Problematic contractual joint ventures involve the owner not investing in the new venture and basically contracting with the “manager” to provide substantially all of the aspects of the new business.

Contractual Joint Venture

OIG has issued bulletins that list “red flags.” Important to structure relationship to avoid those flags.

Joint Venture Operational Issues

Important. Forming the joint venture correctly in the first place is only the first step.

The venture must operate in compliance with the agreements, corporate structure, etc.

Joint Venture Operational Issues

Any JV or preferred provider agreement should be regularly monitored to ensure compliant operations. Failing to do so can lead to a compliant venture becoming a source of significant liability.

Joint Venture Operational Issues

Problems can arise in how profits are distributed, how management fees are calculated and paid, how investors with other contractual relationships to JV are treated, etc.

Many aspects of a JV can become a vehicle for illegal referrals.

Joint Venture

Whenever you are approached about a potential joint venture, you should not take any action without seeking the advice of counsel that is thoroughly familiar with fraud and abuse laws.

You may find your well intentioned business venture has become a source of immense liability.

Avoiding problems

Preferred provider arrangements and joint venture agreements may seem like an excellent way to develop new referrals.

If you do not both form and operate them correctly, the liability you incur will far outstrip the profits you gain.