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Pros and cons of a captive: Should you do it yourself?

You can save money, if you have an appetite for risk

Healthcare providers have been subject to the volatility of the insurance market for years, which has led some to look to the idea of establishing a captive as a way to cut costs, particularly with workers' compensation coverage. A captive can be a great solution in some circumstances, but don't jump without looking first.

A captive insurance company is a property and casualty insurance company established to provide coverage only, or primarily, for its parent company. A captive can be a valuable risk management tool that allows a hospital to more effectively manage corporate risks of all kinds, says **Timothy E.J. Folk**, vice president with The Graham Co., a healthcare consulting company in Philadelphia.

Captives often are set up to insure risks for which commercial insurance is not available or is too expensive, Folk says. The owner of the parent company is also the owner of the captive, but the captive can be structured so that it is owned directly by the operating company, another person, entity, or a trust, Folk explains.

This structure does not mean, however, that the captive is just a puppet for the hospital or health system. The captive insurance company must act as a legitimate business entity, complying with all insurance regulatory provisions and Internal Revenue Service requirements, Folk says. *(See the story on p. 39 for more background on captives.)*

The interest in captives is driven by the fact that there is a very limited marketplace to insure a health provider's risks, which leads to insureds being

EXECUTIVE SUMMARY

A captive can reduce long-term costs for a healthcare employer, but it comes with significant risks. A provider must weigh the potential benefits against the costs of covering a large claim.

- Captives might be best for larger, more established organizations.
- Workers' compensation often is the first focus for a captive.
- Losses can be substantial, but are limited.

beholden to the whims of the marketplace and subjected to class underwriting regardless of their own claims history, says **Christopher M. Keith**, a producer with The Graham Co. This situation has necessitated that insureds and their brokers become more entrepreneurial and creative when it comes to insuring their professional liability and workers compensation exposures. *(See the story on p. 39 for more on determining if a captive is right for you.)*

"Savvy insureds are either considering or actively utilizing risk retention groups or captives in an effort to take control of their coverage terms, conditions, price, and availability rather than let the standard insurance marketplace dictate it to them," Keith says. "Professional liability is certainly more of a severity-driven exposure, so the stakes are much higher in a captive structure. This leads many insured's to graduate to this type of a captive arrangement."

However, relatively speaking, other exposures faced by healthcare or social service providers, such as workers compensation, are not as volatile and can be controlled with the right safety and claims policies and procedures in place, Keith notes.

For any large employer, a captive can create an opportunity to reduce the long-term cost of workers' compensation insurance, Keith says. Workers comp is a more frequent, predictable exposure, and loss control and safety measures can be implemented that have a direct impact. Dividends generated from the underwriting profit and investment income of a captive can be utilized to reinvest back into the operation of the business and increase their operating efficiency.

"This savings is all contingent upon their losses. For example, if you have traditionally had good loss experience then the savings in the form of underwriting profit could be significant," Keith says. "If you were an employer spending $1 million a year on insurance, the carrier puts aside $600,000 of it to pay losses. In the event you only had say $300,000 in losses for your captive, then your savings would be $300,000. This is just one scenario, but as you can see, the savings can be significant."

Premium should be similar to traditional

Starting a captive is not an easy task, but one can be created proactively to take advantage of the opportunity created with worker's comp so that claims and losses are managed properly rather than being forced by the lack of a viable option in the insurance market, Folk says.

Furthermore, once the captive is established, a healthcare provider has the captive as a mechanism to take on part of other exposures, such as professional liability, when the market swings. *(See the stories on p. 39 and p. 40 for more on how captives work.)*

Size matters. Providers considering a captive should have about $400,000 in premiums or more for the option to make financial sense. Also note that a captive will not serve all of your insurance needs. The only lines that will be

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insured by the captive are general liability, professional liability, workers' comp, and automobile liability, Keith explains.

Captives are most popular with for-profit entities because they can take advantage of tax benefits, Keith says. The premiums you pay to your captive become tax deductible, so non-profits have traditionally not been drawn to the captive option. Other benefits, such as being able to direct savings to underfunded programs and projects, and the tightening insurance market are making more non-profits consider forming a captive, Keith says.

With the right claims control processes in place, the captive premium you pay should be similar to what you would pay with a traditional insurer, yet you are able to keep the underwriting profit, Folk adds.

"In addition, while you are waiting for that period of time it takes for losses to be realized, evaluated, and paid, you're realizing investment income," Folk says. "At a time like this when providers are being squeezed in so many ways while expenses stay the same or get higher, the more you can explore creative solutions like this, the better off you will be in the long run. A captive truly has the potential to put dollars back in the pocket of the sponsoring organization."

A captive also takes the organization out of the notoriously volatile insurance market, Folk notes. In the past, insurers with billions of dollars of premiums suddenly have announced that they were not making enough money in that particular market and would not renew any policies.

"That leaves a lot of people without a home, and with so few insurers to choose from in this market, the only option is to take a policy at a very high rate," Folk says. "In a captive you are subject to a lot less volatility and you are assuring yourself that you have a home through which to procure insurance. It changes the whole negotiation of the insurance procurement process every year because you are no longer at the whim of the carrier. You're now a business partner with them."

SOURCES

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When is a captive right for you?

Captive insurance companies aren't for everyone, says **Timothy E.J. Folk**, vice president with The Graham Co., a healthcare consulting company in Philadelphia.

Risk tolerance is necessary, and you have to be willing to enter into a new line of business, he says. Some people are more content to simply write a premium check and know that another company is handling the claims.

"But if captive is a right fit, it can be a very strong business model that is supportive of the rest of your business strategy," Folk says.

If a captive looks like a good option, one of the first decisions is what kind of captive is right for you. These are the different varieties of captives:

• **Single-owner captives:** A provider establishes a single owner captive to insure its own risks and the risks of its subsidiaries and affiliates.

Some single-owner captives also provide coverage for other, non-affiliated organizations, but this is the simplest form of a captive.

• **Group captives:** These captives are owned by multiple, non-related organizations that serve as the policyholders.

The group captive is usually sponsored by a trade group, group medical practices or hospitals, or other professional groups. Group captives can be homogenous, meaning all the members are similar organizations in the same industry, or heterogeneous, meaning the members vary in type. Group captives help spread the risk from any single claim.

• **Agency captives:** These captives are owned by insurance brokers or agents and insure some portion of the insurance sold by its agency or broker shareholders

Group captives help spread the risk from any single claim, similar to the way a standard insurer spreads the risk by having all insureds pay premiums that will be used to pay the claim of one client. But the group captive is not the same as a standard insurer because you, the policyholder, have a say in who can join the captive, explains **Christopher M. Keith**, a producer with The Graham Co. in Philadelphia.

"This is very much a club-like mentality. The barriers to entry are tougher than a traditional insurance market," Keith says. "It's all about their five-year historical loss rate, and you're not going to let a poorly performing organization into the

group."

The flip side of those high standards is that an organization performing above the average can get the better deal it deserves, Keith says. A hospital or health group that has focused on patient safety and can show low loss rates still might be subject to class underwriting, which yields a rate increase that is higher than if the insurer judged the organization on its own.

"A captive decreases the pool that your underwriter is looking at," he says. "You get more favorable rates and more control of the underwriting process." ■

Retention levels, aggregate levels key

Captive insurance bring risk, but there is limit

Captive insurance agencies require the insured to take on more claims risk, but that risk is not unlimited. Even with a captive, you don't risk paying entirely out of pocket for a major claim or repeated claims in one year, says **Christopher M. Keith**, a producer with The Graham Co. in Philadelphia.

The owner of the captive puts a re-insurance carrier on top of it to minimize exposure, and it sets a limit on the retentions it will pay per year, Keith explains. Retention levels can be set depending on your appetite for risk, but it is typical for a captive to set retention levels at about $300,000 per claim, he says. So if a claim is worth $500,000, the captive would pay $300,000, and the re-insurer would pay the remaining $200,000.

A captive also puts a cap on aggregate losses. An example would be a cap set so that if there are five $250,000 losses in the same year, the re-insurer attaches and starts paying first dollar on subsequent claims.

"This is a plan that is appealing to people that have an appetite for risk, have really well-run organizations, and have fairly robust safety and loss control prevention claims procedures in place," Keith says. "They have their arms around their claims situations or at least have partnered with a broker that does that for them. Their skin is squarely in the game."

The potential savings can be substantial. When dealing with a traditional insurer, 50 cents of every dollar you spend on insurance is set aside to pay losses, Keith explains. In a year where you paid out only 20 cents per insurance dollar in claims, the insurer keeps the rest as profit.

"Our feeling is that for well-run organizations, you should keep that 30 cents," Keith says. "You're going to have to put some risk up to do that, but that's why it is right for mature organizations. You wouldn't want to do this with an organization that has been incurring a million dollars-plus a year in losses. It would not be financially viable for them." ■

Most captives formed offshore

There are about 5,000 captive insurance companies in the world, with most being sponsored by U.S. entities, according to information provided by Capstone Associated Services in Houston, TX, which assists organizations with setting up captives.

Although sponsored by U.S.-based companies, most captives are incorporated outside of the United States, according to Capstone. A captive insurance company may be formed only with the permission of regulatory authorities in the insurer's home territory (known as its domicile), and it is monitored by an insurance commissioner.

Capstone notes that many conventional insurance companies began their corporate existence as captive insurers and grew into large-scale insurance companies, including USAA, Highlands, and American General.

Captives can be domiciled and licensed in a wide number of domiciles in the United States and offshore. Captive insurance companies formed outside the United States or offshore can make an IRC section 953(d) election to be taxed as a domestic U.S. corporation. That designation allows a foreign-based captive to receive the same U.S. tax benefits and treatment as a captive formed in any of the 24 U.S. states with captive insurance legislation.

A foreign-based captive generally has a much lower cost of ownership and a far higher degree of flexibility for its U.S. owners, compared to a captive that is formed in the United States, Capstone says. For this reason, most small captive insurance companies with annual premiums below $1.2 million are formed offshore, according to Capstone.

SOURCE

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Monitor webhost to avoid problems in the cloud

With the push toward electronic health records (EHRs) and meaningful use, more healthcare providers are involved with cloud computing through a webhost. The technology offers great advantages, but it also can come with potential problems that must be managed proactively.

Cloud computing means using the Internet to run software applications and to store information through a hosting company, as opposed to maintaining all data internally. Use of the cloud has grown since the Department of Health & Human Services (HHS) imposed a Medicare and Medicaid EHR Incentive Program to provide incentive payments to eligible professionals, eligible hospitals and critical access hospitals as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology.

Medicare reimbursement will decrease to providers who do not demonstrate "meaningful use" of technology by 2015, notes **Bernard Rosof**, MD, MACP, CEO of the Quality in Healthcare Advisory Group, a consulting firm in Huntington, NY. He also is chairman of the board of directors at Huntington (NY) Hospital (North Shore LIJ Health System).

"The deployment of onsite technology comes at considerable expense to smaller medical practices and large hospitals alike," Rosof says. "As a result, cloud computing has been gaining favor as a way to avoid the expense of new computing and communications hardware and software. Computing in the cloud through a webhosting company can also minimize the need to hire additional personnel, by outsourcing computing tasks to third party providers in the cloud."

There are significant issues of concern for patient privacy, timely access to patient records, and webhost selection, says **Paul Rubell**, JD, partner in the Corporate Law Group at the law firm of Meltzer Lippe Goldstein & Breitstone in Mineola, NY. "These are issues that I don't think healthcare providers are focused on," Rubell says. "Maybe their techs are, but not the doctors and administrators."

For starters, state law provides that a patient owns her own health care records. However, it becomes difficult for a patient to obtain her records upon request when those records are stored "in the cloud" by an unknown third party storage company, and not a phone call away at the healthcare provider's possession, Rubell says.

Many of the risks with cloud computing are related to the fact that data is in the hands of the webhost, so Rubell says the solution is to have some control over the webhost's actions. In particular, the healthcare provider should insist on minimal downtime for the cloud so that data is available virtually all the time, Rubell says. Financial penalties are a way to maintain a degree of control over the webhost, he suggests. To that end, a hosting agreement should contain a service level agreement (SLA) which consists of a litmus test of uptime and downtime.

The current industry standard is "the four nine's." "That means the host should contractually commit to being up and running at least 99.99% of the time," Rubell explains. "Downtime, other than for real emergencies, should be specified in the agreement, such as Sunday mornings from 2 to 4 a.m. Scheduled downtime is not included in the SLA computation, but unscheduled downtime would count against the 99.99% requirement."

A good SLA provides for significant discounts in payment obligations if the uptime requirement is not met, Rubell says. *(See the story on p. 42 for more advice on controlling webhost risks.)*

"Contracts manage parties' expectations, and if push comes to shove, you want to assert your rights," he says. "It's annoying enough when your computer goes down, but when your online access to patient data is down, you don't want to hear excuses. An SLA will make sure the cloud computing system is up because the host will have a financial reason to make it so."

EXECUTIVE SUMMARY

More providers are using cloud computing for the storage and management of data, and risk managers should consider the potential problems from this new technology.

- Web hosting companies should be closely monitored.
- Internet downtime is a factor that should be controlled.
- Providers should insist on monthly reports and audits.
- Contracts must be written to account for possible risks.

SOURCES

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Monthly reports, audits improve security of cloud

Security is a major concern for healthcare providers using the cloud, says **Paul Rubell**, JD, partner in the Corporate Law Group at the law firm of Meltzer Lippe Goldstein & Breitstone in Mineola, NY.

Through the use of the cloud, vital patient records can be viewed and updated by different healthcare providers, and shared by all. But because a patient's private information is available to so many important players in the healthcare arena, its integrity and security is at risk, Rubell notes.

"Can patient privacy truly be upheld? The risk of unauthorized access to personally identifiable information is great," Rubell says. "No longer will access to a patient's EHR [electronic health record] be restricted only to the employees of a medical practice. That same patient's EHR will be accessible to the employees of insurance companies, pharmacies, billing companies, and now, industry computer firms."

Rubell offers this advice on improving security in the cloud:

• Insisting on monthly written reports from the webhost to ensure the integrity and security of your data.

A well-written hosting agreement should require the webhost to furnish monthly written reports to the healthcare organization, by providing customized and specific information about the maintenance of patient information. The agreement should specify exactly what information is to be furnished. One size does not fit all; the format and contents of the reports need to be tailored to the circumstances.

• Audit rights are another way to ensure that their patients' confidential information is being maintained appropriately and in accordance with HIPAA and best practices. A cloud hosting agreement should permit the provider's representatives to have access to the host's facility. More importantly, the provider should use this right of access and direct its trained personnel to inspect the host's place of business. Too frequently, although a lawyer may draft a useful contract provision such as this, it is up to the health care provider to take advantage of this contractual power; otherwise it becomes meaningless.

• A cloud computing agreement should call for the host to furnish frequent updates to the client about changes to the location of the client's data.

Again, a contract right such as this becomes meaningless if the client fails to enforce its legal rights and insist upon compliance.

• If the Internet provider goes out of business, it might be difficult or impossible to locate or access a patient's EMR.

Instead of making healthcare records more easily accessed, instead the specter of business failure (especially in today's economy) might have the opposite result. Will patients' data be released to unauthorized people? Will the data be subject to the jurisdiction of bankruptcy courts or available to creditors of the bankrupt Internet provider?

• A source code escrow arrangement is one way for a healthcare provider to maintain a degree of control over the specter of a software host's bankruptcy or cessation of business.

Via an escrow agreement model, the hosting company would deposit, with a third party, the important computer programming and data in a secure place. The arrangement would authorize the third party to release the programs and data to the provider if the host company goes out of business. ■

Many provider benefits are in the cloud

Why should a patient's electronic health record (EHR) be stored on-site, when the records can be cost effectively stored on the Internet at a remote location? This question is posed by **Bernard Rosof**, MD, MACP, CEO of the Quality in Healthcare Advisory Group, a consulting firm in Huntington, NY.

Using the cloud can circumvent the need to license numerous and expensive software programs, which can be accessed on a relatively inexpensive basis via industry providers in the cloud, he says.

The medical community's growing familiarity with computers and computer records, the Internet, smart phones, tablets, and wireless devices makes the transition to the cloud a logical next step, Rosof says. The demands for electronic transmission of records also have increased as hospitals consolidate, which makes it necessary to exchange patient information between numerous physical locations.

"Computer networks, wired and wire-

less, have obscured the distinction between local networks and Internet-based networks. At one moment we might be using our computer workstation, then we seamlessly access information on our company's network, and at other times we access information via the Internet; so, too, for healthcare providers," Rosof says. "Medical practices may access their own patients' records locally, using their own in-house computer servers, and they may store other confidential data on servers that are located remotely and operated by third parties."

Storage is not the only benefit offered by the cloud. Actual computing functions — the input and output of information, and the execution of analysis and databases — can be handled on network computers elsewhere in the cloud, Rosof notes. New technology can protect patient records from natural and terrorist disasters. Industry providers can ensure disaster recovery and data protection in ways that an individual practice could never afford on its own. In urban areas and rural settings, patients and their doctors can have access to information instantaneously and seamlessly, Rosof says. ■

Whistleblower lawsuits are a growing risk

Healthcare leaders have to worry about complying with plenty of industry-specific requirements and the potential cost when a whistleblower reports malfeasance. Another risk, however, comes from the broader world of corporate fraud.

To fight corporate fraud, the federal government recently has focused on providing incentives to employee whistleblowers who identify and report allegations of fraud and other wrongdoing. The Securities and Exchange Commission (SEC) Whistleblower Program, which launched in August 2011, offers payouts of at least $100,000 to anyone that provides original information that leads to SEC financial sanctions. *(See the story on p. 44 for more information on the program.)*

Hospitals and health systems can fall prey to this incentive program, says **Barbara E. Hoey**, JD, a shareholder with the law firm of Littler Mendelson in New York City. Fraudulent billing and many other compliance issues can lead to false portrayals of a company's financial standing, which can in turn lead to SEC violations, she says.

With the ongoing efforts by the Department of Health and Human Services (HHS) to root out healthcare fraud, the addition of the SEC program means that healthcare providers are at more risk than ever from whistleblowers, she says.

"We keep hearing that there is a lot of fraud in the system, and they're going to go after the fraud. That's one way they're going to finance universal healthcare, by making the system more efficient," Hoey says. "One very popular way to go after fraud is to encourage whistleblowing, because if you get someone from inside the organization to blow the whistle, that is probably your best source of information."

In one of the largest whistleblower settlements in U.S. history, pharmaceutical giant GlaxoSmithKline PLC agreed in December 2011 to pay the U.S. government $3 billion to settle charges that the company defrauded Medicaid and illegally marketed the diabetes drug Avandia, as well as the anti-depressants Paxil and Wellbutrin. The settlement is largest yet in federal cases against pharmaceutical companies. The previous record was $2.3 billion, paid by Pfizer in 2009.

The number of whistleblowers involved in the case is not yet known, but if the case follows the pattern of previous whistleblower payouts, the GlaxoSmithKline insiders who reported the problem might split about 16% of the $3 billion fine — $500 million — as their reward. The Justice Department reports that whistleblowers were paid $2.39 billion from 1987 to 2009, or 16% of the $15.19 billion collected.

In a separate case, a single whistleblower who exposed serious contamination problems at one of GlaxoSmithKline's pharmaceutical manufacturing operations was awarded $96 million in November 2011, which is thought to be the largest amount ever handed to a U.S. whistleblower. It was awarded when the company agreed to pay the

EXECUTIVE SUMMARY

A new whistleblower program is adding to the risk that employees will report healthcare fraud to collect rewards. The program from the Securities and Exchange Commission (SEC) can ensnare healthcare providers.

- The SEC program offers payouts of at least $100,000.
- Whistleblowers often sue for being fired.
- Risk managers must be approachable to discourage whistleblowing.

U.S. government $750 million to settle the claims, after an eight-year court fight.

Whistleblowers might not stop once they get their share of the government recovery. In many cases, the next step for the whistleblower is to sue the employer for retaliation. "Once you become a whistleblower, the employer cannot take action against you for what you have reported," Hoey says. "That means you have to be extremely careful about disciplining them. All of this together makes whistleblowers very attractive to plaintiffs' attorneys, potentially lucrative, and highly disruptive to a hospital."

To make things even worse, the provider's stockholders could sue, as was the case with Health Management Associates in Naples, FL, recently. Shareholders filed a class action in federal court claiming stock prices plummeted after it was revealed the hospital group had used Medicare fraud to inflate prices and hidden a wrongful-termination whistleblower suit by an employee who uncovered the alleged fraud. *(For more on that case, see the story on p. 45.)*

Even the risk manager is not immune to the siren song of whistleblower rewards. Hoey says one of the most challenging cases of her career was defending a hospital that was sued by its risk manager after she blew the whistle on alleged fraud. *(For more on that case, see the story on p. 45.)*

In light of the whistleblower risk, Hoey says is important for risk managers to position themselves as approachable and trustworthy. The goal is to get employees to come to you with their concerns rather than reporting them to an outside agency, she says. They must trust that if they bring a problem to you, you will understand it and act on their concerns, she says.

Hoey cautions that the negative publicity from a whistleblower case can be more damaging than the monetary costs, especially if the allegations involve poor patient care.

"If you don't have the trust of your doctors and nurses as the head of risk management, you're not going to be effective in your role," Hoey says. "You have to find a balance so that you're not attacking anyone involved in a bad outcome, yet you are known as someone who will act appropriately when concerns are raised."

SOURCE

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SEC encouraging more whistleblowing

The Securities and Exchange Commission (SEC) Whistleblower Program was created in Section 922 of the Dodd-Frank Wall Street Reform and Consumer Protection Act of 2011.

The Dodd-Frank Act authorizes the SEC to make monetary awards to eligible individuals who "voluntarily provide original information that leads to successful Commission enforcement actions resulting in the imposition of monetary sanctions over $1 million, and certain related successful actions." Awards are required to be made in the amount of 10% to 30% of the monetary sanctions collected.

In addition, the Dodd-Frank Act directs the commission to establish a separate office within the commission to administer the whistleblower program. Because the final rules became effective Aug. 12, 2011, only seven weeks of whistleblower tip data is available for 2011.

The most common complaint categories were market manipulation (16.2%), corporate disclosures and financial statements (15.3%), and offering fraud (15.6%). The commission received whistleblower submissions from individuals in 37 states, as well as from several foreign countries, including China (10) and the United Kingdom (9).

The Dodd-Frank Act also sets out the procedures for applying for a whistleblower award. The award process begins following the entry of a final judgment or order for monetary sanctions that, alone or jointly with judgments or orders previously entered in the same action or an action based on the same nucleus of operative facts, exceeds $1 million.

Following the entry of such a judgment or order, the Office of the Whistleblower publishes a "Notice of Covered Action" on the commission's website at www.sec.gov. Once a Notice of Covered Action is posted, individuals have 90 calendar days to apply for an award by submitting a completed whistleblower award application, which is known as Form WBAPP, to the Office of the Whistleblower.

On Aug. 12, 2011, the Office of the Whistleblower posted "Notices of Covered Actions" for the 170 applicable enforcement judgments and orders issued from July 21, 2010, through July 31, 2011, that included the imposition of sanctions exceeding the statutory threshold of $1 million. Because the 90-day application period had not passed with respect to any Notices of Covered Actions as of the end of the fiscal year, applications for awards had not yet been pro-

cessed. Accordingly, the commission did not pay any whistleblower awards during fiscal year 2011. ■

Trouble: Risk manager becomes whistleblower

A hospital being sued by its own risk manager is deep trouble, says **Barbara E. Hoey**, JD, a shareholder with the law firm of Littler Mendelson in New York City.

"Here's the person who kind of knows where all the bodies are buried, and they're taking you to court," she says. "You're afraid of what's going to come out of her mouth next."

Hoey defended the hospital in that case a few years ago. The director of risk management had first blown the whistle by alleging to outside authorities that the hospital had committed billing fraud and that patient safety was compromised, and then she sued the hospital after she was fired.

The hospital fired the risk manager because she did not have the trust of the physicians and nurses, Hoey says. If the clinicians had concerns, the risk manager was the last person they would approach because she was seen as disconnected and punitive. The clinical staff also thought the risk manager, even though she had a nursing background, did not have sufficient clinical knowledge to understand their concerns, Hoey says.

Over two years, every senior executive including the CEO was deposed, and the risk manager took her story to the media multiple times.

"The hospital ended up on the front page of the New York Post, which called it the hospital from hell and quoted the risk manager saying it was killing mothers and babies in the neonatal intensive care unit," Hoey says. *(See the* New York Post *story at http://tinyurl.com/7ujojp6.)* "It was very disruptive, even though we went to trial and won. Both her whistleblower claims and her firing claim were dismissed, but we still had to suffer through all of that." ■

Investors: Hospital group hid whistleblower suit

Health Management Associates (HMA) shareholders filed a class action in Florida federal court recently and claimed stock prices dropped after it was revealed the hospital group had used Medicare fraud to inflate prices and hidden a wrongful-termination whistleblower suit by an employee who uncovered the alleged fraud.

The shareholders claim that between July 27, 2009, and Jan. 9, 2012, the company and its most senior officers touted the company's solid financial performance and growth in hospital admissions rates, but that seemingly strong performance was based on the group's fraudulently billing Medicare, explains **Barbara E. Hoey**, JD, a shareholder with the law firm of Littler Mendelson in New York City. The fraud allegedly consisted of admitting elderly and disabled Medicare recipients who did not, in fact, meet Medicare standards for inpatient treatment, later revealed by an employee who was subsequently fired.

"Rather than being based on sound business practices and efficiencies, HMA's financial performance was due, in substantial part, to fraudulently generated hospital admissions and treatment statistics, as well as fraudulent Medicare billing," the complaint says.

Shareholders claim that they realized something was wrong on Aug. 3, 2011. The Naples, FL-based company, which operates 59 hospitals and other health facilities, disclosed that the Department of Health and Human Services had issued subpoenas requesting information on physician referrals and the company's management. Stock prices dropped more than 9% the next day, according to the lawsuit.

The August disclosure also was incomplete, the shareholders say. In October 2011, HMA leaders disclosed more details and said that the subpoenas related to the Anti-Kickback Statute and the False Claims Act.

On Jan. 9, 2012, an analyst from CRT Capital Group issued a report saying that HMA's former director of compliance, Paul Meyer, was suing the company for violation of Florida's Private Sector Whistleblower Act. He claimed that he had been fired illegally after he uncovered evidence of the Medicare fraud. Hoey notes that prior to his HMA position, Meyer worked for the Federal Bureau of Investigation for 30 years, most recently as supervisor of the healthcare fraud unit based in Miami.

After news of Meyer's lawsuit surfaced, stock dropped more than 8%. The following day, the company announced that its general counsel had resigned, and stock prices again tumbled, dropping almost 13% in a single day.

The shareholders are suing the company and individual executives for violations of the Securities and Exchange Act of 1934. They are seeking compensatory damages for the money they claim to have lost as a result of HMA and its executives' alleged fraud. ■

Nearly $4.1 billion recovered in health fraud

The government's health care fraud prevention and enforcement efforts recovered nearly $4.1 billion in taxpayer dollars in 2011, the highest annual amount ever recovered.

Attorney General Eric Holder and Department of Health and Human Services (HHS) Secretary Kathleen Sebelius recently released the annual Health Care Fraud and Abuse Control Program (HCFAC) report, which noted that the total number of cities with "strike force" prosecution teams was increased to nine. All nine teams have investigators and prosecutors from the Justice Department, the FBI, and the HHS Office of Inspector General dedicated to fighting fraud.

The strike force teams use advanced data analysis techniques to identify high-billing levels in healthcare fraud hotspots so that interagency teams can target emerging or migrating schemes along with chronic fraud by criminals masquerading as healthcare providers or suppliers. In 2011, strike force operations charged a record number of 323 defendants, who allegedly collectively billed the Medicare program more than $1 billion.

Strike force teams secured 172 guilty pleas, convicted 26 defendants at trial, and sentenced 175 defendants to prison. The average prison sentence in strike force cases in 2011 was more than 47 months.

Including strike force matters, federal prosecutors filed criminal charges against 1,430 defendants for healthcare fraud-related crimes. This amount is the highest number of healthcare fraud defendants charged in a single year in the department's history. Including strike force matters, 743 defendants were convicted for healthcare fraud-related crimes during the year.

In criminal matters involving the pharmaceutical and device manufacturing industry, the department obtained 21 criminal convictions and $1.3 billion in criminal fines, forfeitures, restitution. and disgorgement under the Food, Drug and Cosmetic Act. These matters included the illegal marketing of medical devices and pharmaceutical products for uses not approved by the Food and Drug Administration (FDA) or the distribution of products that failed to conform to the strength, purity, or quality required by the FDA.

The departments also continued their successes in civil healthcare fraud enforcement during FY 2011. About $2.4 billion was recovered through civil healthcare fraud cases brought under the False Claims Act (FCA). These matters included unlawful pricing by pharmaceutical manufacturers, illegal marketing of medical devices and pharmaceutical products for uses not approved by the FDA, Medicare fraud by hospitals and other institutional providers, and violations of laws against self-referrals and kickbacks. FY 2011 marked the second year in a row that more than $2 billion has been recovered in FCA healthcare matters. Since January 2009, the department has used the False Claims Act to recover more than $6.6 billion in federal healthcare dollars.

The fraud prevention and enforcement report coincided with the announcement of a proposed rule from the Centers for Medicare and Medicaid Services aimed at recollecting overpayments in the Medicare program. Before the Affordable Care Act, providers and suppliers did not face a deadline for returning taxpayers' money.

The HCFAC annual report can be found at oig.hhs.gov/publications/hcfac.asp. For more information on the joint Department of Justice (DOJ)-HHS Strike Force activities, visit www.StopMedicareFraud.gov. ■

TJC: Worker fatigue can threaten safety

With the link between healthcare worker fatigue and adverse events s well documented, The Joint Commission (TJC) issued a new Sentinel Event Alert: Healthcare worker fatigue and patient safety.

The alert urges greater attention to preventing fatigue among healthcare workers and suggests specific actions for health care organizations to mitigate the risks. *(The alert is available online at http://www.jointcommission.org/sea_issue_48.)*

Research has shown that nurses who work more than 12-hour shifts and residents working recurrent 24-hour shifts were involved in three times more fatigue-related preventable adverse events, TJC reports. In addition, healthcare professionals who work long hours are at greater risk of injuring themselves on the job.

The alert addresses the effects and risks of an extended work day and of cumulative days of extended work hours. It recommends that healthcare organizations take these steps:

- Assess fatigue-related risks such as off-shift hours, consecutive shift work, and staffing levels.
- Examine processes when patients are handed off or transitioned from one caregiver to another, a time

of risk that is compounded by fatigue.

• Seek staff input on how to design work schedules that minimize the potential for fatigue and provide opportunities for staff to express concerns about fatigue.

• Create and implement a fatigue management plan that includes scientific strategies for fighting fatigue such as engaging in conversation, physical activity, strategic caffeine consumption, and short naps.

• Educate staff about good sleep habits and the effects of fatigue on patient safety.

The Joint Commission also suggests that healthcare organizations encourage teamwork as a strategy to support staff who work extended work shifts or hours. For example, use a system of independent second checks for critical tasks or complex patients. Also, organizations should consider fatigue as a potentially contributing factor when reviewing all adverse events, and you should educate employees on the importance of good sleep habits, including ensuring their rest environment is conducive to sleeping. ■

Alcohol abuse called problem for surgeons

Alcohol abuse is a "significant problem" for surgeons in the United States, with more than 15% of respondents in a nationwide survey signaling that they might have dependency issues, the American College of Surgeons reports.

The survey found that the rate of alcohol use disorders among the 7,197 responding surgeons is slightly higher than that of the general U.S. population.

For surgeons reporting dependency issues, the survey found there was a "strong association" with problems in personal and professional relationships that included burnout, depression, and medical errors, the authors report. In fact, the study found that nearly 78% of surgeons reporting a medical error in the previous three months also had issues with alcohol abuse or dependence.

The study recommends that healthcare organizations and professional associations, including the American College of Surgeons, develop early warning and intervention programs that identify problem drinkers and provide treatment and therapy options. "These findings should also decrease the shame and stigma associated with alcohol abuse or dependence and encourage surgeons to pursue treatment and rehabilitation to promote patient safety and personal well-being," the authors write.

Alcohol disorders target female surgeons particularly hard. The survey found that 25.6% of female surgeons indicated that they have alcohol use issues, compared with 13.9% of their male colleagues. By contrast, in the general population, 9.4% meet the criteria for alcohol and substance abuse, including 10.5% of men and 5.1% of women.

REFERENCE

1. Oreskovich MR, Kaups KL, Balch CM, et al. Prevalence of alcohol use disorders among American surgeons. *Arch Surg* 2012; 147:168-174. ■

CNE INSTRUCTIONS

Nurses participate in this CNE/ CME program and earn credit for this activity by following these instructions.

1. Read and study the activity, using the provided references for further research.
2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.*
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly.

CNE OBJECTIVES

Upon completion of this educational activity, participants should be able to:

- describe the legal, clinical, financial and managerial issues pertinent to risk management;
- explain the impact of risk management issues on patients, physicians, nurses, legal counsel and management;
- identify solutions to risk management problems in healthcare for hospital personnel to use in overcoming the challenges they encounter in daily practice.

COMING IN FUTURE MONTHS

- Telehealth exposures and solutions
- Family secretly records doc's confession
- Sex scandals looming in healthcare?
- Get rid of verbally abusive physicians

CNE QUESTIONS

1. What is a captive insurance company?
   A. A property and casualty insurance company established to provide coverage only, or primarily, for its parent company.
   B. A property and casualty insurance company that is required to provide coverage in a prescribed geographical area.
   C. An insurance company that has agreed to provide coverage to an organization for a specified time, during which the policy must be renewed.
   D. An insurance company that will not renew insurance policies in a particular industry.

2. According to Christopher M. Keith, a producer with The Graham Co., what is the typical retention level in a captive?
   A. $100,000
   B. $300,000
   C. $500,000
   D. $700,000

3. With regard to a webhost, how does a source code escrow arrangement work?
   A. The hosting company deposits important computer programming and data with a third party, which will release it to the provider if the host company goes out of business.
   B. The hosting company agrees that a portion of all monthly fees will be held in escrow until the client is satisfied with the host's performance.
   C. The healthcare provider deposits a portion of all required fees in an escrow account, which the host can obtain only after returning all data at the conclusion of the contract.
   D. The healthcare provider holds back key programming data so that the hosting company cannot have complete access to the provider's system.

4. The Securities and Exchange Commission (SEC) Whistleblower Program offers rewards to whistleblowers in what amount?
   A. 30% to 60% of the monetary sanctions collected, but only when the sanctions total $1 million or more.
   B. 10% to 30% of the monetary sanctions collected, but only when the sanctions total $1 million or more.
   C. 10% to 30% of the monetary sanctions collected, with no minimum amount of sanctions required.
   D. No awards are issued by the SEC Whistleblower Program.

Healthcare Risk Management's
Legal Review & Commentary™
A Monthly Supplement

Jury awards patient $7.6 million in case of permanent spinal cord injury

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News: In 2003, a 14-year-old girl went to the emergency department (ED) with complaints of weakness in her legs. The radiology department performed an MRI, but it failed to diagnose an abnormal mass on her spine. When the mass bled four years later, the patient suffered permanent spinal damage. At age 18, the woman was a paraplegic. The jury awarded the woman a total of $7.6 million dollars in damages.

Background: In mid-December 2003, a young woman woke up one morning and immediately had weakness and numbness in her legs. After first visiting her pediatrician, the woman's parents sought care for her in the ED of a local medical center. The woman was admitted to the hospital, and physicians ordered a magnetic resonance imaging scan (MRI). The radiology department read the scan as normal; however, the MRI showed an abnormal mass in her thoracic spine. She was diagnosed with and treated for Guillain Barre Syndrome, an autoimmune disorder that can cause ascending paralysis. Exactly what triggers Guillain Barre Syndrome is unknown. The syndrome may occur at any age, but it is most common in people of both sexes between ages 30 and 50. The woman was discharged from the hospital on Christmas Day.

The young woman returned to high school and eventually graduated. The summer after graduation, she became pregnant. In February 2008, four years after the initial incident, the patient began to experience the same symptoms. The woman was taken to another hospital. Another MRI was performed, while taking into account the Guillain Barre Syndrome. This time, treating physicians discovered an arteriovenous malformation in her thoracic spine. The patient underwent surgery to remove the mass; however, it already had bled into her spinal cavity. The bleeding resulted in a permanent spinal cord injury. At 18 years old, the woman was a T4 paraplegic, so she was unable to move her body from the chest down. At the time of the verdict, the woman had a 3-year-old son, and she requires special medical care and an attendant for the rest of her life.

The woman filed a complaint against the medical center and claimed the hospital's failure to diagnose the mass resulted in her paralysis. In court, the woman's expert testified that the mass was visible on the MRI from 2003 and should have been diagnosed by the radiologist at that

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time. The expert claimed that if the radiologist had detected the tumor, further studies would have led to proper treatment and the removal of the mass. Additional testimony was offered regarding the fact that the radiology department at the hospital had varied from its standard protocol for performing this kind of study, which would have included views in two planes: sagittal and axial.

The medical center denied any negligence in the case and claimed the medical care provided was appropriate. Furthermore, the hospital testified that both views had not been obtained because the patient was uncomfortable in the machine. The evidence showed, however, that she was seated and had no difficulty with the study. The hospital's expert testified that because the mass was subtle, the hospital's failure to diagnose was within the standard of care owed to the patient at that time. The hospital also claimed that the woman's parents were at fault since they followed up with the girl's pediatrician instead of a trained neurologist.

After three days of deliberation, the jury found that the medical center was negligent in their care for the woman in 2003. The jury awarded the woman $6.4 million for lost wages and ongoing medical care, including a medical attendant to care for her. Additionally, the jury awarded the woman $1.2 million for pain and suffering; however, due to state medical injury laws, her non-economic damages will be reduced to $250,000. The total verdict of $7.6 million is believed to be one of the largest medical malpractice verdicts in the county's history.

What this means to you: This situation involves an unfortunate, preventable missed diagnosis and, therefore, a misdiagnosis that resulted in a devastating untoward outcome. There are a myriad of risk management, patient safety, standard of care, and patient care issues raised by this situation.

In such events, the first notice is often the notice of intent to sue or service of the actual Summons and Complaint, depending on the laws where the event occurred. In this case, it was four years; this lapse of time means personnel, physicians, standards of care, and electronic aspects might have changed, and memories might not be as sharp. These circumstances create challenges for the risk manager in terms of fact-finding and in regard to loss control activities. Therefore, when events such as this one occur, facilities should take measures to document the events and involved personnel.

The risk management activities or actions that should be taken to investigate the events that lead to an untoward outcome and the determination and implementation of loss control action are not linear, or one after another. One of the skills of a risk manager is multi-tasking and the ability to prioritize. An event such as this one can be particularly challenging.

Another challenge is that the evolution of electronic equipment and support is growing by leaps and bounds every year. MRIs are a revolutionary diagnostic technique that requires the assistance of a human to review and interpret the results. When the technical equipment works but the human aspect does not, it is the patient that is made to suffer, such as in this situation.

The plaintiff's expert testified that the mass was visible, although subtle, on the MRI when done in 2003. If the radiologist who served as the expert could see the mass, why was the hospital-based radiologist who interpreted the MRI in 2003 unable to do so? Is there information regarding who initially read the MRI in 2003? What is the process to request a re-read from a colleague when there are "subtleties" on a film? What was the training of the radiologist to read MRIs? Were there quality control activities in place to provide for re-reads of sample MRIs by the various radiologists credentialed to read MRIs to verify results? What was the rate of mis-reads or missed-reads? What are the medical staff rules regarding the visual acuity of physicians and surgeons? Was impaired vision a factor in missing the mass? Employee job descriptions require 20/20 or 20/30 corrected vision (or they should), but facilities often do not address vision acuity standards for physicians and surgeons.

This 14-year-old came in to the ED with a chief complaint of leg weakness for which she was hospitalized. This scenario does not indicate whether the weakness was an acute onset or had been in evidence for a time and whether she had been being followed by her pediatrician before going to the ED. The defendant hospital blamed the untoward outcome on the failure of the parents to follow-up with a neurologist rather than their pediatrician. This allegation raises the issue of communication and discharge education.

Was the patient referred to a neurologist for follow up or back to the pediatrician? Guillain Barre Syndrome is not a disease/condition usu-

ally followed up by a pediatrician without periodic consultation with a neurologist. The discussion by the physician with the patient and her parents regarding the diagnosis and the importance of following up with a neurologist would have been an important aspect of the continuing care of the patient and the discharge preparation and teaching.

Aside from the clinical aspects of this unfortunate case is the insurance, contractual, relationship side. Was the radiologist who interpreted the MRI an employee of the hospital, contracted or independent? What was the relationship with the hospital, and what were the insurance requirements and coverage in place? Was the MRI read by a radiologist off site to whom the MRI was sent electronically?

Even though this incident occurred four years earlier, a root cause analysis is called for to identify the root cause and what interventions and loss control actions can be implemented to prevent a recurrence. Those questions itemized above should be addressed as a part of the hospital's root cause process.

REFERENCE

• Sacramento County Superior Court, Case No. 34-2009-00032610. ■

$1 million awarded to paralyzed dentist

News: A 68-year-old paraplegic male was undergoing occupational therapy to increase his level of independence following a spinal cord injury. The patient's primary goal was to complete toilet transfers independently to avoid the need for a colostomy. During a therapy session in February 2007, the patient sustained a femur fracture when pressure was applied to his leg during therapy. The patient claimed that the femur fracture was a result of negligence, and a jury agreed. The jury awarded him more than $1 million in damages.

Background: In 2006, a 68-year-old man fell while trimming his trees, which rendered him a paraplegic. The patient underwent therapy and medical treatment in the hospital and in the hospital's rehabilitation facility.

Six months after the initial injury, the patient continued treatment at the hospital's rehabilitation center for bowel control issues and toilet and transfer training in an effort to avoid the need for a colostomy. The patient had a history of heterotopic ossification, or bone growth in the muscle adjacent to the femur, which his therapists were aware of.

In February 2007, the patient was being treated by an occupational therapist, who was an employee of the hospital. During therapy, pressure was applied to the patient's femur, and a fracture resulted. The patient underwent surgery to repair the fracture; however, the patient was unable to continue or later resume therapy due to the new injury. Subsequently, the patient was never able to perform his own wheelchair transfers or continue other toilet training. The patient was required to have a permanent colostomy placed after the femur injury.

In court, the patient and his experts claimed that the therapist was negligent. Experts testified that because the therapist knew of that the patient suffered from heterotopic ossification, it was negligent for him to apply pressure to the patient's leg in such a way that would result in a fracture that required surgery to repair. The plaintiff's expert claimed that the injury was avoidable and there were no previous femur fractures. The hospital and therapist argued that they did not violate the standard of care and the injury was unavoidable.

The jury sided with the paraplegic patient and awarded him $1 million in damages.

What this means to you: Gaining and maintaining independence is an ongoing goal of those with a disability. In this situation, a patient was undergoing rehab to meet that goal when the event occurred that would prevent the patient being able to attain that goal forever. While many people have permanent colostomies and live a quality life, this man was undergoing rehab to avoid that eventuality. The jury awarded this patient a considerable amount of money to compensate for the injury after hearing the facts of this incident. However, the money will never be able to replace this patient's lost independence.

Lack of exercise and weight bearing, along with wasting of muscle mass, are factors that can influence bone strength. These potential factors and the other co-morbidities mentioned should have been flags that this patient was at

risk for fracture. Occupational and physical therapists undergo education and training to understand this concept as it relates to therapy and patient care. We have no further information as to the type of and reason for the pressure applied to the femur.

Therapists, in private practice and in the hospital setting, participate in research and play a key role in optimizing wellness, fitness, and quality of life by enhancing movement, strength, and physical health. Physical therapists often are called upon to assist patients in regaining the mobility and strength they need to return to work or school, as well as normal life activities, after surgery, debilitating illness, or traumatic injury. However, when a patient is injured while engaging in therapy, the therapists (and their employers) become vulnerable to professional liability claims. To prevent patient injury and adverse outcomes, and to minimize risk and liability, therapists must incorporate effective quality improvement, risk management, infection control, and patient safety strategies into their clinical practice.

Competency evaluations by the facility of all clinical staff members, including those assigned to the physical therapy department, should be undertaken annually. Some physical therapy departments employ physical and occupational therapy techs to assist the therapists. In this case we do not know if that employment situation was in place. In any department where therapy assistants are utilized, parameters of function and supervision of their therapy work with patients should be a policy and practice. Likewise, therapists should be educated on the importance of reading through patient charts and related documentation to gain a full understanding of the patient's issues before making clinical determinations about course of treatment.

Conditions of Participation for physical therapists are found in the Code of Federal Regulations; "Title 42: Public Health — Part 485 Conditions of Participation: Specialized Providers; Subpart H — Conditions of Participation for Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services." Contained therein are certain requirements governing a physical therapy patient's plan of care and physician involvement. Specifically, a plan of care is required to be established by a physician or by the physical therapist who furnishes the services. The plan of care anticipates goals and specifies type, amount, frequency, and duration of services. This plan and the results of treatment are reviewed by the physician or the individual who established the plan at least as often as the patient's condition requires. If there is an attending physician, the physical therapist must promptly notify the physician of any change in the patient's condition or in the plan of care.

The therapist's specified scope of practice is critical to determine whether liability may attach or potential allegations may result in malpractice litigation. It also forms the context within which a court can determine whether negligent conduct occurred. Facilities that employ or contract with therapists should be familiar with these requirements and ensure that personnel receive training regarding any limitations. Likewise, scopes of practice for each therapist should be maintained in the personnel files of the therapist and reviewed and revised as necessary. Ultimately, the conditions and the facility's documentation regarding the therapist's scope of practice give juries the information they need. They must decide whether the therapist adhered to or breached the standard of a reasonable and prudent therapist in the same or similar circumstances in a specific liability claim. There is no information given regarding whether a physician was involved in the treatment plan of this particular patient and whether any limitations were placed on the extent of the therapy services to be provided. The ability of the hospital to prove that the therapist acted outside his or her scope can sometimes mitigate a portion of the liability faced by the facility-employer.

Not only should a root cause analysis be undertaken to identify why and how this incident happened, but a Failure Mode and Effects Analysis (FMEA) also should be undertaken to identify proactively the steps of the process that are risk-prone. Loss control measures should be the focus of the risk management interventions to prevent such incidents from recurring.

REFERENCE

• Circuit Court of Michigan, Oakland County, Docket Number 2009102704NH. ■