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Letters to the Editor

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Bush promotes plan for electronic medical records

by Catherine Hubbard, MA, Contributing Editor

President Bush on May 27 visited medical professionals in Nashville, Tennessee to discuss his plan to promote health information technology, saying it would assure better delivery of health care while protecting patients' privacy. His fiscal 2005 budget would double funding to $100 million for demonstration projects to test health IT and allow for widespread adoption in the health care industry.

Bush said he wants Americans to have access to electronic health records within the next 10 years. He also urged providers to develop a system for sharing information privately and securely. "Privacy is really an important part of an American system that works well," he said during a May 27 visit to Vanderbilt University Medical Center. Bush noted that patients must provide consent before providers share their medical information. "These are your records, it's your health, and you can decide whether or not people can use your records," he said.

In the last several years, the Health and Human Services Department has collaborated with the private sector and other federal agencies to develop voluntary standards to ensure that health providers can share information over the Internet safely and securely, according to a White House release.

During a recent public forum, Richard Russell, associate director of the White House Office of Science and Technology, said transmitting medical information over the Internet will not lead to privacy breaches. "It's possible to secure records for transmission online," he said. Technologies such as encryption allow for transmission of information over the Internet while protecting it from unauthorized disclosure, he noted.

Moving to an electronic system would improve health care, according to the White House. Failure to use health IT has resulted in high costs, uncertain value, medical errors, variable quality, administrative inefficiencies, and poor coordination, it said in a fact sheet. The electronic standards would enable doctors to see X-rays and lab results immediately, which would assure a prompt response and help eliminate errors and duplicative testing due to lost laboratory reports, it said. The Institute of Medicine estimates that between 44,000 and 98,000 Americans die each year from medical errors. Bush originally announced his ten-year goal for electronic medical records on April 26. ■

CCH Washington Bureau, May 28, 2004

OIG's semi-annual self-report lauds healthcare fraud recoveries

by Suzanne Szymonik, JD, Contributing Editor

Highlighting its landmark $631 million settlement with Columbia/HCA Healthcare Corporation resolving remaining civil claims for fraudulent cost reports and its studies on prescription drug costs that influenced congressional passage of new legislation lowering government payments for inhalational drugs, the Office of Inspector General (OIG) concluded in its "Semi-Annual Report to Congress (October 1, 2003—March 31, 2004)" that it had a very busy and successful six months. It intends to remain busy this year by studying drug costs and monitoring drug marketing, two duties mandated by the new legislation, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

Continuing oversight by the OIG, the U.S. Department of Health and Human Services' investigative arm, is critical to the government's ability to evaluate, audit, and investigate fraud, waste, and abuse in federal healthcare programs. For the first half of Fiscal Year (FY) 2004, the OIG reported savings of over $16.8 billion, mostly from implemented recommendations, in addition to: exclusions of 1,544 individuals from participation in government healthcare programs for fraudulent activities, 234 convictions, 107 civil actions for False Claims Act and unjust enrichment offenses resulting in $995 million in settlements, and a number of administrative recoveries.

A number of hospitals, organizations, and agencies were cited in the report for not accurately claiming Medicare/Medicaid reimbursement. The OIG report highlighted these allegedly inappropriate claims:

- Managed care organizations are incorrectly claiming beneficiaries as being institutionalized, thus reaping $12.8 million during the report period in unallowable payments.
- Home health agencies are not properly identifying beneficiaries who have just been discharged from hospitals and whose services are reimbursed by Medicare at lower rates. These overpayments totaled $21 million. Other home health agencies do not properly assess and report patients' homebound status.
- States such as New Jersey are making disproportionate share payments to hospitals for Medicaid services provided to prison inmates, even though CMS guidance prohibits this practice. New Jersey paid $22.2 million in such prisoner health costs.

During this six-month period, in addition to participating in the Columbia/HCA prosecution and in a $615 million settlement with Abbott Laboratories' Ross Products Division concerning alleged kickbacks to enteral nutrition product purchasers, the OIG studied a number of costly government healthcare expenditures and recommended cost containment strategies. The OIG report, which did not suggest that the high costs paid by the government were illegal, highlighted these studies and recommendations:

"A number of hospitals, organizations, and agencies were cited in the report for not accurately claiming Medicare/Medicaid reimbursement."

- Updated studies on two prescription inhalation drugs, albeterol and ipratropium bromide, concluded that had the government purchased the drugs at Medicaid Federal Upper Payment Limit amounts, instead of paying far more for them than other payers, savings would have reached $650 million in FY 2002.
- A recommendation that all Medicare carriers apply a "least costly alternative" policy regarding TAP's Lupron® prostate cancer drug, possibly switching to other less costly drugs if there is no medical necessity for the more expensive product, would save Medicare $40 million per year.
- CMS should consider exercising its "inherent reasonableness authority" to curb costs for enteral nutrition formula products such as Boost®, Ensure®, and Isosource®, since the government is now paying 70 to 115 percent more for these products than other payers.

The report found a number of successes. In particular, the OIG Provider Self-Disclosure Protocol program, which assists providers and suppliers in detecting and preventing fraud, was featured.

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To date, the OIG has received 212 submissions under the program. Self-disclosure cases have resulted in 42 recoveries and 30 settlements, totaling over $74 million. Notably, St. Francis Hospital, Inc., operating in South Carolina, agreed to pay $9.5 million to resolve Medicare billing improprieties in its home health, hospice, and durable medical equipment programs.

The OIG's semiannual report is available on the HHS Web site, at http://oig.hhs.gov. ■

CCH Chicago Bureau, June 7, 2004

OIG permits free infant vision screening tests

by Gené Stephens Connolly, JD, Contributing Editor

The Office of Inspector General (OIG) determined that a proposed program that would provide free vision screening tests for infants between the ages of six and twelve months would not result in civil monetary sanctions under section 1128A(a)(5) of the Social Security Act (prohibiting inducements to beneficiaries).

The proposed program provided for the free vision screening services of infants without conditioning the free screening on any other services, including those services covered by any federal health care program. The free screening program implicated Soc. Sec. Act §1128A(a)(5) because it constituted a waiver of payment for services from a particular provider and provided an inducement to beneficiaries under the Act.

The OIG concluded that the proposed program would not violate the anti-kickback provisions prohibiting remuneration or inducements to beneficiaries under the Social Security Act because the program contained a combination of safeguards to ensure the absence of an impermissible tying of services. The safeguards included the following:

- Optometrists participating in the program would agree not to condition the free tests on receipt of any other services.
- The proposed program was structured so that the infant's parent or guardian would select an optometrist from a list from a list of participating optometrists, and the program would not recommend particular optometrists for tests or follow-up services.
- Very few infants would require follow-up care; the next recommended screening test for the majority of infants would be more than a year after the free screening.

The proposed program also satisfied the definition of preventative care under the Act, as preventative care services are excluded from the definition of a remuneration or incentive. ■

OIG Advisory Opinion 04-04, May 26, 2004, ¶150,215

Pharmaceutical marketing, promotional activities allowed

by Gené Stephens Connolly, JD, Contributing Editor

The Office of Inspector General (OIG) determined that a proposed program, which would market, design, develop, and implement physician surveys on behalf of pharmaceutical firms, would not constitute an impermissible activity under section 1128(b)(7) of the Social Security Act (fraud, kickbacks, and other prohibited activities).

Under the proposed program, the marketing firm would utilize a one-dollar check for communication of the physician survey responses over a twelve-month period. Physicians would receive only a maximum of twelve dollars for completed corresponding surveys and could elect to donate the money to a nonprofit organization.

The OIG determined that while similar marketing arrangements could pose a significant risk of fraud or abuse, the proposed marketing arrangement was permissible because of the firm's limited financial physician relationship and its inability to influence the referral of business to its pharmaceutical clients. The OIG further determined that the proposed marketing arrangement's limited scope provided a sufficiently low risk for fraud and abuse. The OIG concluded that the marketing arrangement would not be subject to administrative sanctions in connection with the anti-kickback statute because of the proposal's mitigating safeguards. ■

OIG Advisory Opinion 04-03, May 21, 2004, ¶150,216

Offshore outsourcing: It's not a three-hour cruise

by Paris Cavic, Esq.

With the introduction of the phenomenon known as offshore outsourcing, compliance professionals, attorneys, risk managers, and business leaders have been forced to address an additional matrix in their quest for improved customer satisfaction and search for financial viability. Compounding the issue is the slew of state (23 at last count) and federal legislation that has been introduced which seeks to limit government-funded work to U.S. locations. Additionally, there are the various state and federal mandated performance and benefit levels that need to be maintained which could affect your decision.

Myriads of events, both internal and external, have the potential to affect implementation of an offshore strategy. Offshore outsourcing, when properly evaluated, can offer reassurances to senior management and board members that the organization has considered all the appropriate factors, and exercised the required degree of diligence, to make an informed decision and to increase either shareholder or community value. In this article, I hope to present concepts and items to be considered when dealing with a potential offshore outsourcing decision.

Alignment with Strategic Objectives

As a precondition to identifying, assessing, and mitigating your risk, there should be a clearly established strategy by management determining the basis for considering the offshore outsourcing option. This strategic objective should be the basis for determining whether the offshore outsourcing will further those strategic objectives.

Identifying Risks

How does an organization go about identifying the various risks associated with developing an offshore outsourcing strategy? A variety of tools are available, either commercial or through professional services firms. Some potential tools to help you define potential areas of risk are:

- *Event inventories.* These are detailed listings of potential events common to companies within the healthcare industry, or to a particular process or activity common across the healthcare industry. For example, undertaking outsourcing a debt collection process may draw on an inventory detailing generic events related to debt collections processes.
- *Internal analysis.* This may be done as part of a routine business planning cycle process, typically via staff meetings. Internal analysis sometimes utilizes information from other stakeholders, or subject matter expertise outside the unit. For example, a company considering outsourcing maintenance of claims records files may utilize its own historical experience, along with external market research, identifying events that have impacted the success or failures of the organization's attempts at maintaining claims records.
- *Facilitated workshops and interviews.* These serve to identify events by drawing on accumulated knowledge and experience of management, staff and other stakeholders through structured discussions.
- *Process flow analysis.* I consider this one of the most effective techniques because it focuses on the actual process being considered for outsourcing. It considers the input and output points of the process and takes into consideration the combination of tasks and responsibilities that combine to form a process. By considering the internal and external factors that affect the tasks and responsibilities, or activities within a process, you can attach events that could affect achievement of a successful process shipped offshore. For example, a medical imaging company maps its processes for receipt and storage of diagnostic images. Using process maps, the organization considers the range of factors that could affect inputs, tasks and responsibilities, identifying exposures related to image storage, handoffs within the process and shifting personnel responsibilities.

Categories of risk to consider in identifying the risk include:

Operational Risks

- *Personnel and employee capability.* Will the offshore outsourcer be able to offer sufficiently trained *and* motivated staff to meet your, and your customer's, expectations?
- *Health and safety.* Will there be issues with the working conditions of the offshore operation that could result in significant adverse publicity?
- *Security practices.* Is the location stable and free from geopolitical turmoil?
- *Process.* Will it be possible to recreate the outsourced process to adequately replicate your expectations regarding quality?
- *Capacity.* Does the outsourcer have sufficient capacity to deal with your volume of business?
- *Suppliers.* Will the outsourcer be able to get any required supplies including non-technology supplies as needed?

Technology Risks

With high-speed connections and virtual customer service, and the advent of HIPAA and various state regulations relating to protection of data, the following are some technology issues to consider if the outsourced process is technology intensive.

- *Data acquisition.* Is there an adequate mechanism to ensure that the appropriate data is being captured?
- *Data maintenance.* Will the data be current and archived to maintain service levels?
- *Data confidentiality and integrity.* Are the protections no less than that which you would have in place?
- *Data and system availability.* Will the system and data have enough "up time" to achieve required performance levels?
- *Emerging technology.* What effect will emerging technologies and the availability of those technologies to offshore companies have on your risk analysis as well as your ROI?
- *System capacity.* Is there sufficient capacity to handle your organization's anticipated growth?
- *Energy.* Is the energy supply dependable and adequate to prevent service disruptions?

Economic Risks

- *Capital availability and liquidity.* Is the proposed vendor sufficiently established to prevent insolvency?
- *Interest rate and currency exchange rates.* Although domestic wages can be fairly easily controlled, what impact would changes in interest and currency exchange rates have on your cost basis and ROI? Will it impact statutory reserve requirements?
- *Real estate issues.* Is the proposed facility adequately constructed for the purposes intended?

Business Risks

- *Brand/trademark/patent impact.* Are sufficient protections in place to prevent theft of any trademark, copyright, or patent protections?
- *Consumer behavior.* Once publicized, will this influence your customers' preferences?
- *Industry standards.* What is the rest of the industry doing? Are you acting within the benchmarks or are you the bellwether?
- *Ownership structure.* If this a joint venture, are there state corporate law issues, or federal ownership and tax issues?

Governmental/Legal Risks

- *Political.* Is outsourcing an issue that could trigger governmental approval or oversight?
- *Governmental changes.* Elections? Violent revolution? What would be the impact on your operations?
- *Legislation.* Be aware of your state and the federal legislative agenda and any contemplated impact on government funding.
- *Regulation.* What is the regulatory environment of the offshore outsourcer?
- *Legal.* Choice of venue issues? Enforceability of contracts? Collections of judgments? Availability of equitable relief? Enforcement of IP rights?

Assessing Risk

In assessing risk, you should consider the impact of expected and unexpected potential events. Many events are routine and recurring, and they are already addressed in strategic programs and budget forecasts. Others are unexpected, with a low likelihood of occurrence, but may have a significant potential impact. Unexpected events usually are responded to separately.

"In assessing risk, you should consider the impact of expected and unexpected potential events."

The uncertainty of potential events is evaluated from two perspectives—likelihood and impact. Likelihood represents the possibility that a given event will occur, while impact represents its effect. Likelihood and impact are commonly used terms, although some entities use terms such as probability, and severity or consequence.

Estimates of risk likelihood and impact often are determined using data from past observable events, much like underwriting criteria. Internally generated data based on your own experience may reflect subjective personal bias, but may

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CMS partners with hospitals to determine best practices in compliance

by Catherine Hubbard, MA, Contributing Editor

The Centers for Medicare and Medicaid Services (CMS) hopes its compliance effectiveness pilot will help all hospitals, both large and small, urban and rural, to improve their compliance programs, according to Lisa Eggleston, health insurance specialist at CMS Program Integrity Group. The agency wants to learn from hospitals that have had effective compliance programs in place for at least one year, said Eggleston, adding that the agency plans to produce new guidance based on the information it gleans and to encourage other provider types to adopt compliance programs. "We want to be able to learn from you," she said at a May 21 Health Care Compliance Association conference in Arlington, Virginia.

The pilot will focus on 13 states and Washington, D.C. in CMS's Boston, Philadelphia and New York regions, Eggleston said, noting that some hospitals from other states have been in contact with the agency as well. Already, CMS has received inquiries from about 40 hospitals that have expressed interest in participating, she said, noting that the program will include about a dozen participants. "We are starting small," she said. She noted that the program might eventually be expanded.

Ninety-eight percent of hospitals already have compliance programs, but some providers, such as mom-and-pop suppliers and home health agencies, have had less success in implementing them, Eggleston said. Smaller companies will be able to tailor the participants' best practices to fit their needs, she noted..

In response to questions, Eggleston said the intent of the 18-month project is not to punish companies with compliance gaps. "The intent is not punitive," she assured the audience, noting that participation in the project is voluntary. Nevertheless, she said, the agency will deal with any problems it finds the same way it would under any other audit. "If we happen to find something, we would deal with that normally," she said.

Participation will bring several advantages to hospitals, Eggleston said. For instance, she said, providers would have direct access to a CMS person to answer their questions about compliance. "For a lot of people that's a plus," she said. Also, as a staff liaison to the Office of Inspector General, Eggleston said she can help providers get in touch with the right people if they need to contact the office. Also, in the event CMS does discover a problem, it would take into consideration the fact that the hospital signed up for the pilot. "We would be able to work with you," she said.

On or around June 25, CMS will begin selecting which hospitals it wants to work with and will start sending out applications, Eggleston said. The pilot will include two site visits—an initial one to check baselines and one at the end of the project. Between two and four inspectors will visit each site, she said.

Participating in the project will not require much time, money or additional staff, Eggleston promised. Although CMS will be asking for lots of documents, it will not impose harsh deadlines for submitting them. "You'll have plenty of time to produce those," she said. Costs for participating should be minimal, and should include only the cost of copying and shipping files, she predicted.

When a conference participant asked whether there is an out clause, Eggleston said she will look into it. But she added: "I don't know why you'd want to drop out." She assured the audience that providers and the CMS alike will learn and benefit from the pilot. "Try to focus on the positive," she said. "The glass is half full." ■

CCH Washington Bureau, May 28, 2004

Tips for ensuring your providers are credentialed

by Catherine Hubbard, MA, Contributing Editor

Even the most diligent health care organizations could find out they've let a fraudulent doctor join their ranks. In a recent case, a fake psychotherapist was operating for years until the patient finally caught on and turned him in. However, these breaches can be prevented if organizations take proper precautions.

Suzie Draper, corporate compliance and privacy officer at Intermountain Health Care (IHC), Salt Lake City, Utah, said her organization has adopted strict mechanisms to ensure staff members have the right credentials. "We have to take this credentialing process very, very seriously," Draper said during a June 1 audio conference sponsored by the Health Care Compliance Association. "Providers have a great responsibility that when we put a professional out there as someone to provide quality health care, we take that responsibility seriously," she added.

Update the process. It's important to keep up-to-date with the latest Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and National Commission for Quality Assurance (NCQA) standards, Draper emphasized. "You need to look at the policies and procedures that your facility or your clients have developed and ensure that they are compliant with the current standards," she advised.

"You have to check, check and check again," said Margaret Hutchinson, assistant U.S. attorney at the U.S. Attorney's Office for Eastern Pennsylvania. She recommended health care organizations review their credentialing processes at least every two years. But she added that "monthly and quarterly checking is important."

Getting the facts. Under new JCAHO standards, IHC is required to gather comparative data on initial appointment, Draper said. "We need to make sure we're doing our due diligence in collecting that information and that we're getting the relevant professional references of specific clinical activities performed in prior settings by the applicant," she said.

Verifying information applicants provide with prior settings is particularly challenging, but also is crucial, Draper said. "The prior practice things are some-

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times difficult to get," she said. Even if the applicant provides what looks like adequate information, it is the duty of the facility to double-check the facts. "Sometimes you can get the applicant to dog that through, but you still have to go back and verify that information," she said.

Using the applicant as a source of information about prior practice should be a last choice, Draper said. "We're very careful using the applicant as the primary source of information. You never want to rely solely on what the applicant is giving you," she cautioned.

Another challenge is figuring out which health professionals need to be credentialed and recredentialed, Draper said. "You need to be very specific in your policies and procedures about what types of professionals need to be credentialed," she said. Providers need to consider factors such as whether the person will have advanced administrative duties or serve on a panel. At IHC, she noted, "Those policies are very clearly delineated."

Follow up. In addition, the association regularly updates information on physicians, Draper said. "We are continually working on the process using software and technology to ensure we have the most accurate data possible," she said. The organization has developed an internal flow chart so that providers who have submitted an application can find out the status of their application. The flow chart will also help establish due diligence whenever there is a challenge, she said.

Hiring a physician or other care provider is never the last step in the credentialing process, Draper said. "When we place them on medical staff or on our panel, that's not the last time we look at them," she shared. IHC constantly reviews the physician's records to find out whether there are any Office of Inspector General sanctions or other problems. "You'd hate to wait for a two-year cycle to find out that something had occurred," she warned.

Draper also recommended providers establish a central credentialing process or a credentialing process within each facility. IHC has a central credentialing committee, she said. The association relies on professionals on the committee to help uphold the standards. "They want to make sure fellow practitioners have credentialing that will maximize the quality of the care," she said. ■

CCH Washington Bureau, June 3, 2004

Creating a culture that encourages ethical conduct

by Catherine Hubbard, MA, Contributing Editor

Compliance officers need to reach beyond the basic elements of compliance and create a culture that fosters ethical conduct, according to Diane Meyer, vice president and interim corporate compliance officer at MedStar Health. "Integrate compliance into the fabric of your culture in such a way that ethical enhancers become a part of your day-to-day operations," she recommended at a Health Care Compliance Association conference on May 21 in Arlington, Virginia.

In 1998, the Health and Human Services Department's Office of Inspector General issued its first compliance guide for hospitals. The guide outlined seven elements of compliance, including: designation of a compliance officer; written policies and procedures; training and education; communication; disciplinary guidelines; monitoring and review and responding to violations and taking corrective action.

"Constant communication is absolutely imperative."

While paramount to a successful compliance program, these elements should be expanded upon, Meyer said. She noted that in this post-Enron era, the public has increased its awareness and expectations regarding ethical corporate conduct.

Also at the conference, Laura Ellis, senior Counsel to HHS OIG Administrative and Civil Remedies Branch, said the office hopes to update the 1998 hospital compliance guidance very soon. "If you're wondering how to keep your program fresh and effective, this will be useful," she said.

Joining Meyer, de Raye Walker, interim compliance director at MedStar Health, said compliance officers should incorporate the following five core functions into the OIG's seven elements:

- hospital compliance oversight;
- billing integrity;
- occurrence reporting and resolution;
- training and education; and
- operating unit support.

However, she stressed that the OIG's elements should remain at the heart of a program. "We definitely need to hold onto the seven elements and use them as a foundation as we build and renovate our compliance programs," she said.

Successful compliance programs and officers will integrate ethics into every department, including legal services and human resources, Walker said. "We include everyone in our hospital, so it's everyone's responsibility," she said, urging hospitals to "let go of the silo mentality." Compliance officers should also work with information systems, risk management and billing and finance departments, she said. "Be proactive. Work with these groups so that you can address what needs to be done up front," she said.

"Constant communication is absolutely imperative," said Meyer, adding that good communication will minimize system-wide redundant compliance efforts, maximize sharing of best practices and emphasize strategic planning. She recommended compliance directors explore ways to make their compliance programs preventative rather than reactive. "Ask: Is my compliance program making a difference?" she suggested.

Moreover, officers should look for opportunities to insert internal controls into business practices and build them into daily activities, Meyer said. "Look for opportunities to insert measurable benchmarks so that you know whether it's making a difference to the ethical environment," she said. ■

CCH Washington Bureau, May 28, 2004

also provide better results than data from external sources. However, even where internally generated data is a primary input, external data can be useful as a "reality check" or to enhance your analysis. Exercise caution when using past events to make predictions about the future, as factors influencing events may change over time.

There are certain quantitative assessment techniques that you may find useful. Among them are:

- *Benchmarking.* A collaborative process among a group of similar organizations, benchmarking focuses on specific events or processes, compares measures and results using common metrics, and identifies commonalities and improvement opportunities. Some organizations use benchmarking to assess the impact and likelihood of potential events across an industry.
- *Probabilistic models.* Probabilistic models associate a range of events and the resulting impact with the likelihood of those events based on assumptions. Likelihood and impact are assessed based on historical data or simulated outcomes reflecting assumptions of future behavior. Examples of probabilistic models include value at risk, cash flow at risk, earnings at risk and the development of loss distributions. Probabilistic models may be used with different time horizons to estimate outcomes. Probabilistic models may be used to assess expected or average impacts versus best or worst case scenarios.
- *Non-probabilistic models.* Non-probabilistic models use subjective assumptions in estimating the impact of events without quantifying an associated likelihood. Assessing the impact of events is based on historical or simulated data and assumptions of future behavior. Examples of non-probabilistic models include sensitivity measures and scenario analyses.

Correlation of Events

Care should be taken to assess how the proposed outsourced processes correlate, where sequences of events combine and interact to create significantly different probabilities or impacts. While the impact of a single event might be slight, a sequence of events might have more significant impact. For example, a delay in payment results in delayed delivery, which results in further delay of delivery until service levels are no longer being met or other extreme action is being taken by a vendor.

Mitigating Risks

Examples of manners of mitigating your risks associated with outsourcing might include:

- *Avoidance.* Action is taken to exit the activities giving rise to risk. Risk avoidance may involve exiting a service line, declining expansion to a new geographical market, or selling a division.
- *Reduction.* Action is taken to reduce the risk likelihood or impact, or both. This may involve any of a myriad of everyday business decisions, including the implementation of stronger controls, greater oversight, or tighter safeguards.
- *Sharing.* Action is taken to reduce risk likelihood or impact by transferring or otherwise sharing a portion of the risk. Common risk-sharing techniques include purchasing insurance products, engaging in hedging financial transactions, or limitations of liability tied with indemnification provisions of contracts.
- *Acceptance.* No action is taken to affect likelihood or impact.

Conclusion

By developing and addressing potential risk factors that are relevant to your own organization, then following up with appropriate risk assessment and mitigation steps, you can help your organization reach the decision that would be right for it in deciding whether or not to outsource certain business processes.

Paris Cavic, Esq. is a member of the CCH Healthcare Compliance Editorial Advisory Board.