

# 'Quality Fraud' Means What?



**Alice G. Gosfield**

**Alice G. Gosfield** is a Principal at Alice G. Gosfield and Associates, P.C. Ms. Gosfield's areas of expertise include reimbursement, clinical integration, fraud and abuse compliance and avoidance, and medical staff issues.

**M**uch has been made in the compliance literature of the implications of the advent of value-based payment models. Value-based payment entails measurement of performance which can affect the amount of payment. Another aspect of this shift is the need for transparent data regarding provider performance to facilitate payment decisions as well as choice of providers. With value-based payment has come increased quality reporting which may be linked to payment or not. Since the Supreme Court decision in *Escobar*,<sup>1</sup> an additional quandary arises regarding to what extent quality performance is implied in submitting claims for Medicare payment, and whether such implications can form the basis for false claims liability. At a more fundamental level, there are compliance issues which arise from a failure to do the right thing clinically or providing the wrong clinical service. Absence of medical necessity is always a problem since it is an express statement in all claims for Medicare payment.<sup>2</sup>

This article examines the bases for risk in this developing context including some long-standing requirements viewed in a new light; looks at the types of quality failures that could lead to problems; discusses some exemplary caselaw; looks at other penalties for failed performance; presents what the government has said on point; and offers some practical guidance. These issues are relevant to virtually every type of Medicare provider. This article does not describe the payment models themselves, but looks at what failure to perform well within them can mean.

## **RISK BASES**

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### **Conditions of Participation**

Conditions of participation are minimum conditions for entry of a provider into Medicare payment eligibility. Virtually every type of facility in Medicare is subject to them, including hospitals, skilled nursing facilities, home health agencies, and more.<sup>3</sup> The basic operational requirements include such matters as medical and nursing staff, governing bodies, medical records, patient safety programs, and utilization review programs with

some variation depending on the type of provider. In the traditional world of quality assurance, these are input requirements. In order to play, you have to comply. The participation agreement may be terminated for failure to maintain the conditions of participation, failure to disclose information requested by the Secretary or failure to provide access to regulators.

Physicians and other practitioners who can bill on their own numbers do not formally have conditions of participation, but they do have conditions for their enrollment which they must maintain.<sup>4</sup> They also can be terminated from participation for not maintaining those standards, but they are not as intrusive to basic structure and operations as the conditions of participation are for facilities.

### **Quality Reporting**

Over the last years, Medicare has imposed quality reporting programs on ambulatory surgery centers, home health agencies, hospices, hospital inpatient and outpatient programs, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term hospitals, prospective payment system-exempt cancer hospitals, and skilled nursing facilities.<sup>5</sup> These programs differ from the Merit Incentive Payment System (MIPS) which applies to physicians, practitioners, and ACOs. That program adjusts payment up or down depending on performance two years earlier. The participants must report their own performance.<sup>6</sup>

### **Value-Based Purchasing Programs**

While a range of initiatives in the changing context -- away from fee-for-service and prospective payment models -- have been characterized as value-based purchasing, the Medicare program has instituted some formal value-based purchasing programs. These apply to hospitals, end-stage renal disease providers, home health agencies, skilled nursing facilities, and nursing homes.<sup>7</sup> The predominant model is to shift money from poor performers to those who

perform better, and therefore get enhanced payment.

### **VBA-VBE Rules**

Distinct from the formal value-based programs just cited, both under Stark and the anti-kickback rules, the regulators have created safety for value-based arrangements (VBA) and value-based enterprises (VBE) which meet certain conditions. The rules allow multiple providers who are otherwise independent of each other to come together and share financially in the rewards for producing better value. Because the Stark statute and regulations are relevant only to physicians, those rules focus on financial reward to physicians.<sup>8</sup> The OIG's antikickback regulations (AKS) are far broader and address other types of participants in these programs including physicians.<sup>9</sup> Both sets of regulations address definitions of value-based activities, value-based arrangements, value-based enterprises, value-based purposes, value-based participants and target patient populations. They confront varying levels of financial risk from no risk at all to full risk, although, strangely, they address them in reverse order, Stark rules compared to AKS rules. Both suffer from a relatively theoretical tone, which makes sense, since without these regulations, the activities they address would have been illegal. So to design what would be protected, the regulators simply made up what seemed to make sense.

### **TYPES OF QUALITY FAILURES**

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#### **Waste**

In an Institute of Medicine study in 2010, "clinical waste" was defined as low-value spending for undesirable health care services. The study found six drivers of waste, but the following three are most relevant here: (1) failures of care delivery. That is, poor execution or lack of widespread adoption of known best care processes; "doing the wrong thing" (errors and adverse events); not doing the right thing; (2)

failure of care coordination, where patients fall through the cracks of the fragmented care system; and (3) overtreatment,<sup>10</sup> which accounts for 2-8.4% of total health spending.

### **EMTALA Violations**

The Emergency Medical Treatment and Active Labor Act<sup>11</sup> (EMTALA) punishes those physicians who transfer patients who might be in labor. Very often the transfers made before the act were based on the patient's insurance and whether that insurance was considered desirable. That is no longer permitted. Civil money penalties of up to \$50,000 apply.<sup>12</sup> Penalties can be imposed on physicians making false certifications regarding the patient's condition; physicians certifying transfer when the risk outweighs the benefits; and on hospitals which have separate obligations to assure physicians comply and patients are stabilized before transfer.

### **Underutilization, Overutilization, and Medical Necessity**

Extended length of stay was the earliest focus on utilization in 1972 with then HR 1, the first major amendment to Medicare which had been enacted in 1966. Although a hospital could obtain Medicare participation based on its Joint Commission survey ("deemed status") the one aspect of the survey that could not be deemed was utilization review which hospitals were required to provide. During the same time period, bases for exclusion were added to include providing services substantially in excess of a patient's needs or of a quality that was substandard.<sup>13</sup> With the advent of the hospital Prospective Payment System (PPS) the financial incentives for hospitals to maximize revenues shifted from overuse (longer lengths of stay because they were paid per diem) to underuse to maximize the monies received for payment based on diagnosis-related groups (DRGs). Medical necessity is an explicit condition for all claims submitted to Medicare, so

submitting claims for inappropriate services not relevant to the patient's condition or for too many services not necessary to treat the condition are additional forms of quality failures. In a recent case decided by the Ninth Circuit,<sup>14</sup> the role of a physician's judgment as to medical necessity of the services was the central issue. The Court overturned the lower court opinion that had taken the position that physician judgment could not be the basis for a false claim because by its nature it is an opinion and therefore could not be objectively false. The Court held that claims for medically unnecessary treatment are false. Period.

### **False Quality Reporting**

False claims may be found when any inaccurate statement is made to secure payment. Some examples of how this plays out in the context of data relevant to quality performance in caselaw include the following.

In *US ex rel. Janssen v. Lawrence Memorial Hospital*,<sup>15</sup> a hospital allegedly falsified patients' arrival times in order to increase its Medicare reimbursement under a pay-for-reporting and pay-for-performance program. The hospital also separately submitted Data Accuracy and Completeness Acknowledgments on an annual basis, certifying that the data submitted was accurate and complete. The district court granted the hospital's motion for summary judgment. On appeal, the circuit court cited the three factors under *Escobar*<sup>16</sup> to be taken into account where allegations of False Claims Act liability turn on noncompliance with regulatory or contractual provisions and whether they are 'material'. The factors are: (1) whether the government consistently refuses to pay similar claims in similar circumstances or continues to pay; (2) whether the non-compliance goes to "the very essence of the bargain" or is only minor or insubstantial; and (3) whether the government has expressly identified a provision as a

condition of payment. Still, none of these factors alone would be dispositive. The relator had complained to the government about the hospital's actions and the government continued to pay, so the falsified times were, the Court found, not material. Amazingly, the Court dismissed the Data Accuracy documents as boilerplate compliance forms and not dispositive of the issue of falsification. The hospital won.

By contrast, another case turned on the timing of physician signatures and whether they were obtained in face-to-face encounters. The Sixth Circuit overturned dismissal in *United States ex rel. Prather v. Brookdale Senior Living Communities, Inc.*,<sup>17</sup> finding that the government's continued payment was not dispositive since the signatures were specifically required to prevent fraud.

## **PENALTIES**

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### **Termination of Participation Agreement**

There are 18 separate bases for termination of a hospital's or other provider's or supplier's participation agreement.<sup>18</sup> Many are about failing to disclose information or failing to provide access to information. Two of them entail breaches of the conditions of participation in the first place.

### **Exclusions**

There are two types of exclusions from Medicare: mandatory and permissive. Mandatory exclusions typically are required when another agency has taken action against a provider. They must last for five years and for the purpose of this consideration are relevant if a person has a conviction of a crime relating to neglect or abuse of patients in connection with the delivery of health care;<sup>19</sup> not limited to federal healthcare programs. The vast majority of individuals excluded under this provision are home care or skilled nursing aides.<sup>20</sup> Aggravating circumstances may extend the exclusion beyond five years;<sup>21</sup>

while mitigating circumstances may diminish the timeframe.

As mentioned briefly above, one of the principal bases for a permissive exclusion is available where a provider or individual

*Has furnished or caused to be furnished items of services to patients (whether or not eligible for benefits under title XVIII or under a State health care program) substantially in excess of the needs of such patients or of a quality which fails to meet professionally recognized standards of health care.*<sup>22</sup>

Note that this is not limited to Medicare or Medicaid. Permissive exclusions must extend at least a year. "Professional standards of care" are defined as "Statewide or national standards of care, whether in writing or not, that professional peers of the individual or entity whose provision of care is an issue, recognize as applying to those peers practicing or providing care within a state."<sup>23</sup> Of the more than 60 individuals excluded under the quality of care provision, one third are physicians, podiatrists, and dentists. A permissive exclusion is available for quality reporting which entails making false statements or misrepresentation of material facts in any application, agreement, bid, or contract to participate or enroll as a provider under a Federal health care program.<sup>24</sup>

### **Civil Money Penalties**

As the Medicare program shifted to the PPS system, the focus of incentives shifted from the over-use that predominated in a cost-based reimbursement system to one in which under-service would maximize reimbursement. Two civil money penalties (CMPs) were designed to address that risk.<sup>25</sup> A \$20,000 CMP may be imposed on anyone who "knowingly gives or causes to be given to any person, with respect to coverage under subchapter XVIII (Medicare) of inpatient hospital services subject to the

provisions of section 1395ww of this title [the inpatient prospective payment system], information that he knows or should know is false or misleading, and that could reasonably be expected to influence the decision when to discharge such person or another individual from the hospital.”<sup>26</sup> Note that the penalty applies if a person “should know,” not did know. The second related CMP is \$5000 per hospital patient to apply to anyone who “knowingly makes a payment, directly or indirectly, to a physician as an inducement to reduce or limit medically necessary services provided with respect to individuals”<sup>27</sup> who are eligible for Medicare or Medicaid plus another \$5000 CMP per patient for any physician who accepts such inducement.

Following on the concern regarding medical necessity, there is a CMP of up to \$20,000 for “a pattern of medical or other items or services that a person knows or should know are not medically necessary.”<sup>28</sup> This standard is *should* know, again, not *did* know. It imputes a standard of knowledge to the target. It could be applied to rendering a wrong service or too many services. With respect to the quality reporting programs linked to payment, there is a whopping \$100,000 CMP per false statement for anyone who “knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim for payment for items and services furnished under a Federal health care program.”<sup>29</sup> Of course, to apply that CMP to the issue of materiality will be the critical touchstone.

### **Quality of Care-based Corporate Integrity Agreements (CIAs)**

CIAs are used as part of the settlement of some False Claims Act cases. Providers consent to the obligations in them to avoid exclusion from the federal programs. They are monitored and must report to the OIG over time, typically five years. There are eight common elements to most CIAs.<sup>30</sup>

But in the context of quality-of-care CIAs, the rules are somewhat different.

Under this type of CIA, OIG requires that the provider retain an entity with clinical expertise to perform quality-related reviews. For example, some CIAs require the provider to retain an independent quality monitor that will look at the entity's delivery of care and evaluate the provider's ability to prevent, detect, and respond to patient care problems. Other quality-of-care CIAs require the provider to retain a peer review consultant to evaluate the provider's peer review and medical credentialing systems. Agreements may also require the provider to retain a clinical expert to review the medical necessity and appropriateness of certain admissions and medical procedures.

Of the five quality-of-care CIAs listed in place as of February 2025, Universal Health Services, a behavioral health hospital company, entered into its agreement regarding medically unnecessary services (among other misbehaviors) in 2020. Four additional quality-of-care CIAs involved long-term care facilities and their requirements to assure appropriate staffing and quality of care delivered to their residents. Several had expired. In 2019, Vanguard Health Services and its eight related companies entered into an agreement. SpringGate Rehabilitation, another nursing facility, entered into a similar CIA in 2018. Health Services Management, a Texas long-term care company, entered into its quality of care CIA in 2017. While the number of quality-of-care CIAs is not large, it is startling to note that today there are more than forty enforcement actions the OIG has posted regarding the failure of organizations to adhere to their CIAs.

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## **GOVERNMENT ADVICE**

### **Compliance Guidance**

In the 1990s, the government began publishing compliance guidance directed to specific sectors of the health care industry.

These were both advocacy documents as well as predicates to draft a personalized compliance plan for any participant in that sector of the industry. The government cited many advantages to having a compliance plan besides false claims avoidance, among which was the improvement of the quality of patient care, although they didn't really identify how that would happen. All of the published guidance set forth seven common elements of a good compliance plan, which all compliance professionals know and will not be repeated here.

In November 2023, the OIG published its General Compliance Program Guidance (GCPG) and noted that it would later focus on industry segment-specific compliance program guidance (ICPG) once again. As of this writing, OIG has only published one ICPG, addressing skilled nursing facilities (SNFs). More than twenty pages of the GCPG are devoted to issues related to quality of care and quality of life. The SNF sector's guidance had always focused more on quality than the other sector-specific guidance, going back to the original SNF guidance published in 2000 and supplemented in 2008. By contrast, the hospital guidance in 1998 mentioned "quality" only four times. However, the 2005 supplemental guidance on hospitals included a new section devoted specifically to "substandard care." In the small group practices and individual physician guidance from 2000, there was a direct and explicit link to quality of care as noted below.

The OIG acknowledges that patient care is, and should be, the first priority of a physician practice. However, a practice's focus on patient care can be enhanced by the adoption of a voluntary compliance program. For example, the increased accuracy of documentation that may result from a compliance program will actually assist in enhancing patient care. . . . Physicians should

view compliance programs as analogous to practicing preventive medicine for their practice.

More ICPGs are expected to be published later in 2025. Given the shift in emphasis, both in the GCPG as well as the one published so far for nursing facilities, it can be expected that quality of care will have much more emphasis in future guidance than it has in the past -- thereby requiring the industry to adapt in the evolution of their own compliance programs and plans.

### **OIG Guidance to Health Care Governing Boards**

In the early 2000s, the OIG published a number of documents directed at health care facility governing boards to heighten their consciousness regarding compliance obligations and expectations. OIG joined with the American Health Lawyers Association (AHLA) in these early publications. These publications, which can be found on OIG's website, are: OIG and AHLA, "Corporate Responsibility and Corporate Compliance: A Resource for Health Care Boards of Directors" (2003); OIG and AHLA, "An Integrated Approach to Corporate Compliance: A Resource for Health Care Organization Boards of Directors" (2004); and three years later with a clear focus on quality of care, OIG and AHLA, "Corporate Responsibility and Health Care Quality: A Resource for Health Care Boards of Directors" (2007).

In 2015 the OIG joined with AHLA, the Association of Healthcare Internal Auditors (AHIA), and the Health Care Compliance Association (HCCA) to offer "Practical Guidance for Health Care Governing Boards on Compliance Oversight."<sup>31</sup> That document cites a range of resources from the Federal Sentencing Guidelines to the OIG's own CIAs as well as its compliance guidance, including an emphasis on making the scale and scope of programs appropriate to the size and

complexity of the organization, quoting its own position on flexibility for physician practices in their model compliance guidance and at the same time calling out quality-related events for specific attention. The document cites as implied direction enforcement settlements, CIAs as noted above, and the VBA-VBE regulations. These pronouncements make clear the enforcers' views, along with those who operate and audit health care facilities, that quality is an essential aspect of health care compliance.

### WHAT TO DO

Most actors in the health care arena will have to revisit their compliance plans if they want to take into account the implications set forth here in a meaningful way. The point of a compliance plan is to facilitate doing the right thing and take action if mistakes are made. As an ongoing matter, following government enforcement developments, including the substantive issues in quality of care CIAs, settlements, and the coming OIG guidance updates, will be important. But in almost any health care enterprise, to assure a better chance of doing the right thing clinically a significant step would be to standardize operations to the science as much as possible. This means adopting clinical practice guidelines and other evidence-based statements of proper care delivery to drive standardized documentation, among all clinicians, along with standardized use of ancillary personnel and use of expensive equipment and services.

A more formalized way to do this is to adopt the techniques of clinical integration within the health care enterprise.<sup>32</sup> As we have seen, with increasing government attention over the last ten years, the need now to focus on quality as part of compliance has become far more urgent. There are resources to help.<sup>33</sup> Because physicians drive most of what gets ordered and delivered in health care, along with

non-physician practitioners, they are a critical element in successful quality management, including avoiding trouble. This article is intended to stimulate invigorated approaches to these critical issues. We assist our clients in doing that very thing.

### Endnotes

1. *Universal Health Servs., Inc. v. United States ex rel. Escobar*, 579 U.S. 176 (2016).
2. For a deeper look at the issues addressed here, see Gosfield, "Quality Fraud: Gathering The Threads," *Health Law Handbook* (2023 ed.) WestGroup (now Thomson Reuters), available at <https://www.gosfield.com/images/PDF/QualFrd.%20w.cover.pdf>.
3. CMS lists the following as having conditions of participation and conditions of coverage:
  - Ambulatory Surgical Centers (ASCs);
  - Community Mental Health Centers (CMHCs);
  - Comprehensive Outpatient Rehabilitation Facilities (CORFs);
  - Critical Access Hospitals (CAHs);
  - End-Stage Renal Disease Facilities;
  - Federally Qualified Health Centers;
  - Home Health Agencies;
  - Hospices;
  - Hospitals; Hospital Swing Beds;
  - Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID);
  - Organ Procurement Organizations (OPOs);
  - Portable X-Ray Suppliers;
  - Programs for All-Inclusive Care for the Elderly Organizations (PACE);
  - Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services;
  - Psychiatric Hospitals;
  - Religious Nonmedical Health Care Institutions;
  - Rural Health Clinics;
  - Long Term Care Facilities; and
  - Transplant Centers.Available at <https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs>.
4. See Shay, "Maintaining Medicare Enrollment Data: Managing the Ongoing High-Hurdles Race" *Compliance Today*, January-February, 2020.
5. See <https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/asc-quality-reporting>; <https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/homehealthqualityinits>; <https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/hospice-quality-reporting>; <https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/hospitalqualityinits/hospitalrhqdapu>; <https://www.cms.gov/Medicare/>

- Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/hospitalOutpatientQualityReportingProgram*; <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/IPFOR>; <https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/irf-quality-reporting>; <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index>; [https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information](https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-instruments/HospitalQualityInits/PCHQR#:~:text=PPS%2DExempt%20Cancer%20Hospital%20Quality%20Reporting%20(PCHQR)%20Program,-what's%20the%20PCHQR&text=It%20is%20also%20intended%20to,facilities%20and%20type%20of%20care).
6. See <https://app.cms.gov/about/app-overview>; and AMA, "Understanding Medicare's Merit-Based Incentive System (MIPS)," (Sept. 18, 2023), available at <https://www.ama-assn.org/practice-management/payment-delivery-models/understanding-medicare-s-merit-based-incentive-payment>.
  7. See <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HVBP/Hospital-Value-Based-Purchasing>; <https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/esrdqip>; <https://innovation.cms.gov/innovation-models/home-health-value-based-purchasing-model>; <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/SNF-VBP/SNF-VBP-Page>; and <https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/nursinghomequalityinits>.
  8. 85 Fed. Reg. 77684 (Dec. 2, 2020); 42 CFR § 411.357(aa).
  9. 85 Fed. Reg. 77492 (Dec. 2, 2020); 42 CFR § 1001.952(ee)-(hh).
  10. The other three were pricing failures, administrative complexity and fraud and abuse. Institute of Medicine 2010. "The Healthcare Imperative: Lowering Costs and Improving Outcomes": Workshop Series Summary. Washington, DC: The National Academies Press. Available at <https://doi.org/10.17226/1275>.
  11. 42 U.S.C. § 1395dd.
  12. See Zibulewsky, "The Emergency Medical Treatment and Active Labor Act (EMTALA): what it is and what it means for physicians," *Proc (Bayl Univ Med Cent)*. 2001 Oct;14(4):339-346. Available at <https://pubmed.ncbi.nlm.nih.gov/articles/PMC1305897/>.
  13. 42 U.S.C. § 1320a-7(b)(6)(B); 42 CFR 1001.701(a)(2).
  14. Winter ex rel. United States v. Gardens Regional Hospital and Medical Center, Inc., 953 F.3d 1108 (9th Cir. 2020), cert. denied, 141 S. Ct. 1380, 209 L. Ed. 2d 124 (2021).
  15. 949 F.3d 533 (10th Cir. 2020).
  16. See n. 1.
  17. 892 F.3d 822 (6th Cir. 2018), cert. denied, 2019 WL 1231774 (U.S. 2019).
  18. 42 C.F.R. § 489.53(a).
  19. 42 U.S.C. § 1320a-7(a)(2); 42 C.F.R. § 1001.101(b).
  20. Available at [https://www.oig.hhs.gov/exclusions/exclusions\\_list.asp](https://www.oig.hhs.gov/exclusions/exclusions_list.asp).
  21. 42 C.F.R. § 1001.102.
  22. 42 U.S.C. § 1320a-7(b)(6)(B).
  23. 42 C.F.R. § 1001.2.
  24. 42 U.S.C. § 1320a-7(b)(16).
  25. CMPs are adjusted annually for inflation so by 2024, a \$20,000 CMP was \$36,246. See 89 Fed. Reg. 64815 (Aug. 8, 2024).
  26. 42 U.S.C. § 1320a-7a(a)(3).
  27. 42 U.S.C. § 1320a-7a(b)(1), (2).
  28. 42 U.S.C. § 1320a-7a(a)(1)(E).
  29. 42 U.S.C. § 1320-7a(a)(8).
  30. Hire a compliance officer/appoint a compliance committee; develop written standards and policies; implement a comprehensive employee training program; retain an independent review organization to conduct annual reviews; establish a confidential disclosure program; restrict employment of ineligible persons; report overpayments, reportable events, and ongoing investigations/legal proceedings; and provide an implementation report and annual reports to OIG on the status of the entity's compliance activities. Available at <https://oig.hhs.gov/compliance/corporate-integrity-agreements/index.asp>.
  31. Available at <https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/2006053221-hi-practicalguidanceforhealthcareboardsoncomplianceoversight.pdf>.
  32. Gosfield, "How Clinical Integration Lowers Fraud and Abuse Risks," *Compliance Today*, Sept. 2014, pp 47-50, available at [https://www.gosfield.com/images/PDF/Compliance\\_Today.Clinical\\_Integration\\_Lowers\\_FA\\_Risks.Sept\\_2014.pdf](https://www.gosfield.com/images/PDF/Compliance_Today.Clinical_Integration_Lowers_FA_Risks.Sept_2014.pdf).
  33. Gosfield, "Clinical Integration Self-Assessment Tool" v.2.1 (Network/IPA Version), January 2012. Available at [https://www.gosfield.com/images/PDF/CISAT\\_IPA\\_V.2.1.pdf](https://www.gosfield.com/images/PDF/CISAT_IPA_V.2.1.pdf); Gosfield and Reinertsen, "Clinical Integration Self-Assessment Tool v 2.0" (2011), available at [https://www.gosfield.com/images/PDF/CISAT\\_v2.050211.pdf](https://www.gosfield.com/images/PDF/CISAT_v2.050211.pdf); Gosfield and Reinertsen, "Achieving Clinical Integration with Highly Engaged Physicians" (November 2010), p. 31. Available at <https://www.gosfield.com/images/PDF/ACI-fnl-11-29.pdf>.

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