HAWAII HEALTH SYSTEMS
C O R P O R A T I O N

"Touching Lives Every Day"

COMPLIANCE ALERT 11-05

Letters of Understanding or Agreement for Physician Volunteers or for Reimbursing Physician Expenses

All physician arrangements must be documented in writing. It is also required that facilities have a letter of understanding or agreement for physicians that are serving on our regional boards and/or those physicians that serve in voluntary capacities or are being reimbursed for expenses for helping on a hospital project. These letters are important documentation that we're meeting all obligations of Stark and Anti-Kickback laws.

For your information, two examples of letters that have been used in the past are included below in this Compliance Alert: 1) for physician Board members in a general volunteer capacity, and; 2) for travel expense reimbursement to an otherwise contracted physician who will be volunteering administrative service in connection with a special hospital project (like some regions are doing for the EMR implementation).

For HHSC employed physicians, the issue is easier as generally these types of outside activities can be construed to fall within most of our employment agreements. However, all situations are specific so legal counsel should be consulted anytime we want to pay a physician for doing something for us.

Please consult your Regional Compliance Officer and/or Chief Compliance and Privacy Officer if you have questions or need further guidance.

March 7, 2011

NAME, M.D.
ADDRESS
ADDRESS, HI 96XXX

Dear Dr. NAME:

Re: NAME Regional System Board Expenses

Thank you, again, for agreeing to serve as a Board Member on the NAME Regional System Board ("Board") from DATE to DATE. We appreciate your willingness to serve in this important role. This letter sets evidences an Agreement between you and the Kauai Region of Hawaii Health Systems Corporation in order to satisfy federal regulatory requirements imposed on hospitals and physicians who are a potential referral sources for patients to the hospital.

As a board member, you will be a volunteer and will be entitled to receive reimbursement for reasonable expenses you incur as a result of your services. There may be planning sessions, educational programs, meetings, and other events which you will be asked to attend. The West Kauai Medical Center and Samuel Mahelona Medical Center ("Hospitals"), agree to reimburse you for the reasonable expenses you incur while fulfilling your duties as a board member, consistent with Hospital policies, including but not limited to the costs of meals, travel, tuition, and lodging. A request for reimbursement must be supported by receipts or other documentation of expenditures satisfactory to the Hospital and must be expended on your behalf, not for another person.

As part of this Agreement, you represent and warrant to the Hospitals that you are not currently excluded, suspended, debarred or otherwise ineligible to participate in Federal health care programs.

The Hospitals and you agree that this payment is fair market value for the service/expense only and nothing contained herein shall require you to refer or admit patients to, or order any goods or services from the Hospitals. Notwithstanding any unanticipated effect of any provision of this Agreement, neither the Hospitals nor you will knowingly or intentionally conduct himself/herself/itself in a manner as to violate the prohibition against fraud and abuse in connection with the Medicare and Medicaid programs (42 USC Sec. 1320a-7b).

The following list constitutes all agreements (including space leases, equipment leases, professional service agreements, medical directorships or any other agreement), existing as of the date of this Agreement between the Hospital and you or any of your immediate family members.

Name of Contracting Party	Relation to Physician	Description of Contract	Start Date	End Date
COMPLETE AS NECESSARY				

To the extent applicable to this Agreement, you agree to comply with the Health Insurance Portability and Accountability Act of 1996, as codified at 42 USC Sec 1320d ("HIPAA") and implementing regulations.. The Physician further agrees not to use or disclose any Protected Health Information (as defined in 45 CFR Sec. 164.501) or Individually Identifiable Health Information (as defined in 42 USC Sec 1320d), other than as permitted by HIPAA Requirements and the terms of this Agreement.

Please note that any and all agreements between you and the Hospital, including this letter agreement, will be included in the master list of all contracts between the Hawaii Health Systems Corporation and all physicians providing services for the Hawaii Health Systems Corporation facilities, maintained and updated centrally and available for review upon request by any governmental authority to the extent such review is required by law.

This Agreement will be effective when you sign and return this letter to the Hospital. Please indicate your agreement to the terms described above by signing where indicated below & fax back to 808-FAX NUMBER ATTN: REGIONAL CONTACT. Thank you, again, for volunteering for this important post!

NAME OF FACILITY
OR FACILITIES

by _____
Signature of
its Regional Chief Executive Officer

_____
RCEO TYPED NAME

Date: _____

Physician Board Member

_____
Signature OF PHYSICIAN

_____
TYPED NAME, M.D.

Date: _____

March 7, 2011

DOCTOR NAME, M.D.
ADDRESS
ADDRESS

Dear Dr. NAME:

Re: NAME Regional System Expenses

This letter memorializes an agreement between you and the FACILITY NAME of the NAME Regional Health Care System of the Hawaii Health Systems Corporation (hereinafter, the "Hospital"), relative to your acceptance of our request for you to participate as a physician volunteer in the Hospital's initiative to NAME OF SERVICE OR INITIATIVE. The initiative is a part of the Hospital's continuing efforts to better serve the health care needs of the community of ISLAND COMMUNITY.

The request for your participation in this initiative was made pursuant to an agreement between you and the Hospital, HHSC Log No. FY XX-XXX, in which you have agreed to "make best efforts to perform such other duties as may from time to time be requested by [the Hospital]." We thank you for accepting our request for you to serve as a volunteer participant in this significant Hospital initiative.

As a volunteer physician participant in this initiative, who will head the development of the new line of services at the Hospital, you will be asked to participate in various meetings, planning sessions, educational programs, and other events, both locally and nationally, including DETAILS OF EFFORT or INITIATIVE HERE. While as a volunteer participant, you will not be entitled to any additional compensation for your time and efforts, the Hospital will reimburse you for all the out-of-pocket expenses of meals, travel, tuition, and lodging that you incur to participate in the Events at the request of the Hospital. Reimbursements of expenses for participation in any events not requested by the Hospital shall be subject to prior written approval of the Hospital. Reimbursements will be made in accordance with applicable Hospital policies then in effect. A request for reimbursement must be supported by receipts or other documentation of expenditures satisfactory to the Hospital. Reimbursable expenses do not include expenses incurred by you for another person.

Subject to appropriations and allotments, the total sum of money the Hospital is administratively authorized to expend for reimbursement with respect to your participation in this Hospital initiative, including all applicable taxes and expenses incurred, is $XXXX.XX

The amount of reimbursement that you seek will be consistent with the fair market value of the item for which reimbursement is sought; and reimbursements shall be made only for those expenses that are reasonable and necessary for the purposes of your participation in the Hospital

initiative. Nothing contained herein shall require you to refer or admit patients to, or order any goods or services from the Hospital for you to be reimbursed by the Hospital. Notwithstanding any unanticipated effect of any provision of this Agreement, neither the Hospital nor you will knowingly or intentionally conduct himself/herself/itself in a manner as to violate the prohibition against fraud and abuse in connection with the Medicare and Medicaid programs (42 USC Sec. 1320a-7b).

As part of this letter agreement, you represent and warrant to the Hospital that you are not currently excluded, suspended, debarred or otherwise ineligible to participate in Federal health care programs.

The following list constitutes all agreements (including space leases, equipment leases, professional service agreements, medical directorships or any other agreement), existing as of the date of this letter agreement between the Hospital and you or any of your immediate family members.

Name of Contracting Party	Relation to Physician	Description of Contract	Start Date	End Date
COMPLETE AS APPROPRIATE				

To the extent applicable, you agree to comply with the Health Insurance Portability and Accountability Act of 1996, as codified at 42 USC Sec 1320d ("HIPAA") and implementing regulations.. You further agree not to use or disclose any Protected Health Information (as defined in 45 CFR Sec. 164.501) or Individually Identifiable Health Information (as defined in 42 USC Sec 1320d), other than as permitted by HIPAA Requirements.

Please note that any and all agreements between you and the Hospital, including this letter agreement, will be included in the master list of all contracts between the Hawaii Health Systems Corporation and all physicians providing services for the Hawaii Health Systems Corporation facilities, maintained and updated regionally and available for review upon request by any governmental authority to the extent such review is required by law.

This letter agreement will be effective for a period of one year commencing on the later of the date you sign and return this letter to Hospital or the date Hospital signs this letter. Please indicate your agreement to the terms described above by signing where indicated below & fax back to 808-xxx-xxxx. ATTN: NAME OF REGIONAL CONTACT.

Thank you, again, for agreeing to be a volunteer participant in this important Hospital initiative!

NAME OF FACILILTY Physician

by _____ _____

Signature of
its Regional Chief Executive Officer

_____
NAME OF RCEO

Date: _____

Signature OF PHYSICIAN

_____
NAME of PHYSICIAN, M.D.

Date: _____