Drive Defensively: How Hospice Officers and Directors Can Avoid Liability

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Defensive Driving

- Defensive driving is defined as “driving to save lives, time, and money, in spite of the conditions around you and the actions of others.”
  
  National Safety Council’s Defensive Driving Course
  
  - Stay focused with your eyes on the road
  - Anticipate dangerous situations
  - Be aware of your surroundings
  - Take a refresher course
  - Adapt to road conditions
  - Overcome overconfidence; examine your own behavior

Are you “Driving” in Reckless Disregard or Deliberate Ignorance?

- Government audited us last year and didn’t notify us of any problems
- We weren’t aware of this “new” requirement (“New to You Defense”)
- Our Board doesn’t like to get long (i.e. informative) reports
- Our Board trusts its executives to make operational decisions
- Our organization has a robust compliance plan – I think I saw it a couple of years ago
- The corporation may be responsible but I can’t be personally liable
- My role as a Board member is focused on fundraising
- Our organization provides excellent, needed health care services – that should count for something
- We are a unique provider - the community can’t afford to lose us
- We are a public agency, a non-profit, a small provider, etc. – the Government won’t “go after us”
Introduction

- The Legal Environment
- Organization, Officer and Director Theories of Liability
- Case Study – Review of Current Enforcement Trends
- Lessons Learned
- “Driving Test”
- Questions

The Legal Environment

Federal Laws
- Hospice Medicare Conditions of Participation (42 C.F.R. Part 418)
- Anti-Kickback Statute (42 U.S.C. § 1320a-7(b))
- False Claims Act (31 U.S.C. § 3729)
- Civil Monetary Penalty Law (42 U.S.C. § 1320a-7k(d))
- HIPAA/HITECH (42 U.S.C. § 17921 et seq.) and regulations
- Mandatory & Permissive Exclusion Authority (42 U.S.C. § 1320a-7)

State Laws
- Anti-Kickback Law (Business & Professions Code § 650)
- California False Claims Act (Government Code §§ 12650 et seq.)
- Medi-Cal Anti-Kickback Law (Welfare & Institutions Code § 14107.2)
- State Privacy Laws (e.g. Civil Code § 56 et seq. and § 1230.15)
Federal Anti-Kickback Statute Prohibition

- Criminal offense to knowingly and willfully offer, pay, solicit or receive any remuneration (including kickbacks, bribes or rebates), directly or indirectly, overtly or covertly, in cash or kind in return for:
  - Referring (or inducing referral of) any individual to a provider for any item or service paid by any Federal health care program (Medicare, Medicaid, etc.); or
  - Purchasing, leasing or ordering (or arranging for or recommending the purchase, lease, order of) any good, facility, service or item paid for by such programs.

Federal Anti-Kickback Statute Liability

- Criminal, intent-based statute; can enforce through administrative process where the evidentiary burden is less (preponderance of evidence versus evidence beyond a reasonable doubt)
- Scope of activities covered is very broad
- Imposes liability on both sides of transaction
- Implicated even if no remuneration is actually paid or received – an offer is sufficient to invoke
- Applies even if only one purpose is to obtain money, etc. for referral business
- Penalties include fine, prison or both; CMPs and potential FCA liability and exclusion

Federal Anti-Kickback Statute Safe Harbors

- Conduct and arrangements that are deemed not to violate Anti-Kickback Statute
- Voluntary compliance by individuals and entities
- Must meet every element of safe harbor to come within them
- However, failure to completely meet a safe harbor does not mean that conduct is automatically illegal – intent based statute such that analysis of safeguards and risks may be necessary
- Examples: personal services and management contracts, office space/equipment leases, discounts, group purchasing organizations
Federal False Claims Act Liability

- Civil (also a criminal version; many states also have similar or even more expansive requirements)
- Civil intent: actual, deliberate ignorance, or reckless disregard
- Available against those who submit false claims, or those who cause false claims to be submitted
- Reverse false claims: retention of known overpayments
- Penalties: $5,500 to $11,000/claim; treble damages
- Includes: whistleblower and anti-retaliation provisions

Federal Privacy Law - HIPAA

- Health Insurance Portability & Accountability Act of 1996 (HIPAA)
  Public Law 104-191
- Privacy and Security Regulations
  45 CFR Part 160 and Part 164, Subparts A, C and E
- Breach Notification Regulations
  45 CFR Part 164, Subpart D
- Amended by American Recovery and Reinvestment Act of 2009, Title XIII entitled Health Information Technology for Economic and Clinical Health Act (“HITECH Act”), 42 USC § 17921 et seq. and implementing regulations

HIPAA/Privacy Law Liability

- Statutory Penalties – OCR settlement and CMPs
  - Civil penalty statute, 42 USC § 1320d-5
    - Wrongful disclosure of individually identifiable health information
    - Civil penalties increased under HITECH to reflect 4 levels of culpability effective for violations on or after 02/18/09
    - Changed provisions that prohibit CMPs in certain circumstances
  - Criminal penalty statute, 42 USC § 1320d-6
    - Criminal fines up to $50,000; imprisonment up to 1 year or both
    - Significantly increased penalties for false pretenses or intent to sell, transfer or use for commercial advantage
- State Attorney General enforcement actions
- Private civil actions for damages – class actions
Civil Monetary Penalty Law

- Civil monetary penalties (CMPs) may be imposed for presentation of claim for medical item or service that:
  - person knows or should have known was not provided as claimed
  - is for a medical or other item or service and person knows or should know the claim is false or fraudulent
  - is for a medical or other item or service furnished during a period that the person was excluded from participation in Federal health care programs
  - Commits a violation of the Federal Anti-Kickback Statute
  - knows of an overpayment and does not report and return the overpayment in accordance with Federal overpayment law
- For improper claim, CMPs up to $10,000 for each item or service improperly claimed, plus no more than 3 times amount as assessment in lieu of damages
- For Anti-Kickback Statute violations, penalty of up to $50,000 for each act, plus damages of no more than up to 3 times the remuneration
- Exclusion from participation in Federal health care programs

Federal Overpayment Law

- Overpayment means any funds that a “person” receives or retains under Medicare and Medicaid programs to which the person, after applicable reconciliation, is not entitled
- A “person” is defined as a provider of services, supplier, Medicaid managed care or Medicare Advantage organization or PDP sponsor but not a beneficiary
- If an overpayment is received the person shall report and return the overpayment to the Secretary, the State, an intermediary, carrier or contractor, as appropriate and notify of the reason for the overpayment
- Report and return by the later of the date which is 60 days after the date on which the overpayment was identified; or the date any corresponding cost report is due, if applicable
- Look-back period – how long?
- Overpayments retained after the deadline are “obligations” under FCA

OIG Exclusion Authority

- Office of Inspector General (OIG) has authority to exclude individuals and entities from participation in federal health care programs
- Mandatory exclusions
  - Based on convictions for Medicare/Medicaid fraud, patient abuse/neglect, felony health care fraud, felony relating to controlled substances
  - Conviction is broadly defined
  - Minimum 5-year exclusion term
- Permissive exclusions – derivative and affirmative
  - Include misdemeanor healthcare fraud conviction (unrelated to Medicare/Medicaid), obstruction of investigation/audit, misdemeanor controlled substances, license revocation or suspension, knowing false statements or misrepresentations on enrollment applications, Health Education Assistance loan default
  - Exclusion term varies depending on grounds
Permissive Exclusion Authority and Owners/Officers

- Section 1320a-7(b)(15) authorizes exclusion of individual owners and officers and managing employees of a “sanctioned” entity
- Exclusion of individuals with ownership or control interest if they knew or should have known of the conduct that led to the exclusion
- OIG issued guidance in 2010 on implementation of permissive exclusion authority of officers based on role or interest in an entity that has been convicted of or pleads to certain health care offenses or excluded regardless of whether that person was convicted or charged
  - Apply presumption in favor of exclusion if OIG determines there is evidence that officer knew or should have known of the conduct
  - If no evidence that the officer knew or should have known, exclude based on consideration of four categories of factors: information about the entity, individual’s role in entity, circumstances of misconduct/seriousness of offense, and individual’s actions in response to misconduct

Effect of Exclusion

- No federal health care program payment may be made for items or services an excluded individual/entity furnishes or orders or prescribes
- Civil monetary penalties (CMPs), assessments and program exclusions may be imposed against excluded persons for items or services furnished during the period of exclusion
- CMPs, assessments and program exclusions may be imposed against individuals or entities that employ or enter into contracts with excluded persons to provide items or services for which payment may be made by Federal health care programs
- CMPs may be imposed when a provider or other person submits or causes to be submitted a claim for Federal health care program payment for items/services furnished by an excluded individual/entity where the person knew or should have known of the exclusion
- Exclusion violations can lead to criminal prosecutions or civil actions (e.g. FCA liability)

Corporate Integrity Agreements (CIAs)

- Arising from the settlement of Federal health care program investigations (e.g. Federal False Claims Act violations)
- Between Office of Inspector General and entities (e.g. hospices, hospitals, pharmaceutical companies) and/or individuals
- Settling entity/individual agrees to (mandatory) compliance program obligations and stipulated penalties for noncompliance
- OIG agrees not to seek exclusion from participation in Federal health care programs pursuant to its statutory permissive exclusion authority
- Comprehensive CIAs typically contain a five-year term
- New obligations for officers and directors; certifications
Organization, Officer and Director Liability

Transparency, Oversight & Accountability Realities
- Sarbanes Oxley Act
- IRS tax exempt status
- Federal health care program audits: State MICs, Medicare MAC, ZPIC, etc.
- Commercial payer audits; new partnerships with government
- Federal and State FCA Whistleblowers
- Health Care Reform compliance obligations including, overpayment disclosure and repayment obligations

Organization, Officer and Director Liability
- Statutory Liability
- Caremark and Breach of the Duty of Care
- Responsible Corporate Officer Doctrine
- Piercing the Corporate Veil
- Corporate Integrity Agreement Obligations
- Exclusion Authority
Board Responsibility

“Even in this ‘corporate responsibility’ environment, the health care corporate director who is mindful of his/her fundamental duties and obligations, and sensitive to the premises of corporate responsibility, should be confident in the knowledge that he/she can pursue governance service without needless concern about personal liability for breach of fiduciary duty and without creating an adversarial relationship with management.”


Board of Directors Breach of Fiduciary Duties

- **General Rule**: to hold directors personally liable, shareholders must prove that directors violated fiduciary duty owed to the corporation

- **Fiduciary Duties Owed to the Corporation**
  - Duty of loyalty: avoid self-dealing
  - Duty to exercise due care: Business Judgment Rule (BJR)

- *In re Caremark International Inc. Derivative Litigation (1996) and progeny*: Duty of corporate compliance program oversight

Corporate Director Liability for Corporate Compliance

- **Oversight Function**:  
  - Duty to attempt in good faith to assure that a corporate information and reporting system exists, and that the reporting system is adequate to assure the board that appropriate information as to compliance with applicable laws will come to its attention in a timely manner as matter of ordinary operations

- **Information System**:  
  - Level of detail of information system is a business decision
  - Directors are entitled to rely, in good faith, on officers and employees and professional experts and advisors if warranted
  - Not generally interpreted to require proactive vigilance or rooting out corporate wrongdoing about red flags
  - Duty to make reasonable inquiry increases when suspicions aroused (or should) (e.g., financial irregularities, self-dealing, fraud, government investigation)
Lessons Learned from Caremark, etc.

- Adopting a compliance program is not enough
- Directors are not expected to know every detail of the corporation’s operations
- But, have affirmative duty assure an effective information system that will allow the Board to properly exercise its oversight role
- If “red flags” come to attention of directors, they need to respond appropriately

Federal Sentencing Guidelines

- Duty to be knowledgeable about content and operation of compliance and ethics program
- Exercise reasonable oversight over implementation and effectiveness of compliance and ethics program
- Direct reporting obligation of corporate compliance officer to Board

Piercing the Corporate Veil

- General rule is that owners of a corporation will not be liable for debts of corporation
- “Corporate Veil” doesn’t protect individuals from liability in certain circumstances e.g. criminal liability for own conduct, civil liability under False Claims Act
- “Piercing the corporate veil” is an equitable doctrine which imposes liability on individuals (officer, shareholder, director), parent corporation or subsidiary where there is a disregard for the general protections associated with the corporate structure
Piercing the Corporate Veil - Factors

• Courts look to a list of factors to determine whether corporate veil should be pierced in particular factual circumstances including:
  – failure to observe corporate formalities
  – absence of corporate records
  – use of corporate funds to pay non-corporate expenses
  – commingling of corporate/non-corporate assets
  – inadequate capitalization
  – closely held corporation
  – unpaid corporate debts
  – insolvency of debtor corporation at the time
  – allegations of corporation’s fraud upon unpaid creditor(s)
  – element of injustice or fundamental unfairness

Responsible Corporate Officer or “Park” Doctrine

• Doctrine that permits corporate officers to be held personally responsible for certain corporate criminal violations (historically, strict liability misdemeanors)

• Corporate officer can be convicted even if he or she knew nothing about the alleged wrongdoing or did not participate in it

• Hold corporate officers responsible for corporation’s violation of strict liability statutes (government public health, welfare or safety, where the corporate officer is in a position of authority as to the violation at issue i.e. in a position to prevent it)

• HHS OIG expects to make referrals to DOJ for criminal prosecution of individuals for healthcare fraud under Responsible Corporate Officer Doctrine

Current Enforcement Trends
A Case Study
A Case Study Part 1

• Non-profit Hospice Program has a nine member Board of Directors, mostly including Board members who have served five years or more
• Board members are respected community leaders and philanthropists; except for one retired physician, members do not have health care experience
• The Chief Operating Officer is also the Quality Improvement Officer and the Compliance Officer
• New employees receive Hospice Program’s “Vision Statement” and new hire orientation which consists of training on computer system programs, human resources and administrative policies, and clinical policies and procedures, if applicable; but no compliance program training
• Hospice Program has been surveyed a couple of times and has responded to State investigations but has never had a Medicare or Medicaid claims audit

Case Study Part 2

• A Hospice Program Board member has relationship with a couple of private practice physicians specializing in geriatrics and asked CEO consider using physicians to fill area medical directors needs
• Hospice Program contracted with Drs. A and B to provide medical director services to it for $150/hour (minimum payment of $5,000/month regardless of hours of service)
• Drs. A and B also received annual productivity bonuses based on patient census and admissions
• Drs. A and B provided 10 - 20 hours of service a month but didn’t document their hours/services

Case Study Part 3

• Hospice Program’s Chief Operating Officer developed a new “Admissions Staff Performance Program”:
  – Admissions staff are told they need to meet admissions quotas
  – Admissions to hospice program are tracked and included in reports to management
  – No commission or bonuses are paid based on admissions
  – Supervisors take into account performance results as part of employee annual performance reviews
• The Admissions Staff Performance Program was never discussed with or brought to the attention of the Board
Case Study Part 4

- Marketing Director initiated a strategic initiative to expand Hospice Program’s network of nursing facility contracts.
- Hospice Program would “partner” exclusively with key nursing facilities to enhance cross referrals by (1) offering training courses on palliative care; (2) using Hospice staff to fill in some of the duties typically undertaken by the nursing facility staff under Medicare skilled nursing benefits; (3) paying the nursing facility 120% of the Medicaid room and board rate.
- Drs. A and B assisted the Marketing Director with introductions at nursing facilities because they had good relationships with the nursing facilities based on making rounds at facilities and Dr. A is the Medical Director of one of the nursing facilities.

Case Study Part 5

- Hospice Program received a ZPIC audit request for 60 Medicare hospice patient records with dates of services between 2012 and 2013.
- Hospice Program’s Compliance Officer reviewed the demographic data and found that 55 of the 60 patients had been on service over 180 days, some for several years. 25 patients were nursing home residents with admitting diagnosis of dementia or debility unspecified.
- CFO had HIM Director respond to the ZPIC record request but told the Compliance Officer not to do anything else with the records pending results of ZPIC audit.
- The Board of Directors first learned about the ZPIC audit when the Hospice received the audit findings and the demand for repayment of (an extrapolated) overpayment of $2 million dollars based on findings that the patients were ineligible for the hospice benefit and “technical” documentation deficiencies.
- When the Board questioned the CFO about the audit findings, it learned that the certifying physicians on most of the denied cases were Drs. A and B.

Case Study Part 6

- CFO also engaged a consultant to conduct an assessment of the Hospice Program for “operational improvements” and “revenue enhancement opportunities.”
- Consultant reviewed sample claims, billing records, and medical records, examined internal policies, interviewed key employees.
- Consultant learned during operations assessment:
  - Medical record documentation failed to meet “technical” Medicare certification, plan of care and other documentation requirements.
  - Hospice Program’s nursing home team had an unwritten “policy” to use dementia and debility unspecified as default admitting diagnoses.
  - CFO’s budget included a “minimum” level of crisis care.
  - The Admissions Supervisor said that some employees felt that the Admissions Staff Performance Program “violated the law.”
- CFO ended the consultant’s engagement early, never reviewed the consultant’s findings with the Board, never reviewed the 60 ZPIC audit cases.
Lessons Learned

• Knowledge is power: understand the business and the current laws and rules that apply to it
• Form over substance is a mistake: implement real, robust systems
• Set up and use effective information reporting systems: communicate relevant information to the governing body in a timely manner
• Make it real: ensure adequate funding and support of corporate compliance officers and compliance programs
• Demand accountability from everyone: from the top on down
• Don’t put off what you need to do today: proactive efforts are better than reactive responses
• Don’t operate on assumptions: validate compliance
• Act swiftly and effectively to resolve non-compliance: listen and react appropriately to “red flags”

Questions?