What Your Board Should Know about Quality and Compliance
Session 108

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WellCare Health Plans case

• What you don’t want to happen during your compliance report to the board!

  – In October 2007, Federal agents raid WellCare’s headquarters during board meeting
  – Likely part of whistle-blower claim
  – WellCare provides Medicare & Medicaid managed care plans to 2.3 million members nationwide
  – WellCare had nearly $4 billion in revenues last year, all from government sources
Disney case

- Well-known 2005 case affirming the business judgment rule and importance of “process” and “good faith” in decision-making
- Important implications for healthcare directors’ oversight functions
- Court ultimately ruled in favor of Disney, finding that although the board made bad decisions, its conduct had been in “good faith” and its actions constituted, at most, negligence so it is protected under the business judgment rule.
Disney case

• Board allegedly breached duties in:
  – entering into an employment agreement with Chief Operating Officer, Michael Ovitz, and
  – causing Disney to fulfill the severance terms of the agreements without minimizing Disney’s exposure

• Court criticism included:
  – Limited information provided to the board
  – Board’s relationship with the CEO
  – Board’s passivity and limited involvement and scrutiny
  – Failure to obtain opinions from outside counsel
Disney case

- “Market remedy” is not available for redress in the nonprofit context

- Attorneys general unlikely to protect board actions that do not constitute “reasonable inquiries”

- Possible “rebuttable presumption of reasonableness” requirement with regard to nonprofit compensation decisions

- Compliance with “best practices”
WELL, BOB... IT'S COME TO MY ATTENTION THAT YOU'RE REGARDED AS THE BOARD MEMBER MOST LIKELY TO HAVE SCRUPLES, SO YOU'LL HAVE TO LEAVE THE ROOM NOW.

HOW BOB GOT DEMOTED TO A NEED-TO-KNOW STATUS.
Disney case

- Confirm the applicability of the business judgment rule
- Adopt and maintain “best practices”
- Exercise active involvement in board discussions & emphasize “process” protections
- Maintain awareness of financials and strategy
- Ensure board access to information necessary to make an informed decision
- Monitor board agenda and review committee minutes
- Assure conflicts of interest disclosure & review process
- Have a coherent understanding of business transactions & their relationship to the organization’s mission
OIG & AHLA Board Resource


• Third in a series of co-sponsored documents designed to assist directors of health care organizations in carrying out their oversight responsibilities.

  – http://oig.hhs.gov/fraud/complianceguidance.html#2
OIG & AHLA Board Resource

• Focuses on the increasing emphasis on quality of care and patient safety as fiduciary obligations of directors. Identifies quality of care and patient safety as emerging enforcement areas for OIG and other regulators.

• Directors are responsible for "keep[ing] a finger on the pulse" with regard to issues of patient safety, levels of care, cost reduction, reimbursement, and collaborations between providers and practitioners.

• Executive staff may be assigned to report on and educate directors regarding these matters, but the responsibility for recognizing and addressing deficiencies lies with the board.
OIG & AHLA Board Resource

• Substantial deficiencies exist within the current U.S. medical community, emphasizing inefficiency, mortality due to medical error, and costs as key improvement areas.

• Endorses a six-part definition of quality health care quality issued by the Institute of Medicine: quality health care is "safe, effective, patient-centered, timely, efficient, and equitable" care.

• Calls for substantial realignment of incentives to create a safer, more integrated, more efficient system in the years to come in light of a projected doubling of healthcare spending over the next decade.
OIG & AHLA Board Resource

• Emphasizes two primary theories of liability, predominantly triggered under the False Claims Act by claims for reimbursement:
  – Provision of medically unnecessary services
  – Provision of care so deficient that it amounts to no care at all, such that the claims are essentially for services not rendered

• Institutions have been penalized under both theories for conduct such as chronic understaffing and the reckless imposition of budgetary constraints that impaired patient care.
OIG & AHLA Board Resource

• In addition to permissive exclusion, OIG is statutorily required to exclude anyone convicted of patient neglect or abuse.

• OIG has also begun using corporate integrity agreements with board-level obligations as an enforcement tool.
OIG & AHLA Board Resource

- Calls on directors to elevate quality to the same level of fiduciary obligation that financial and regulatory compliance currently occupy, in light of these substantial legal consequences, as well as opportunities for positive financial and charitable results.

- Essential that a board develop the requisite understanding of the relevant patient safety and quality issues, and then put into place a system of performance goals and monitoring elements to ensure compliance.
OIG & AHLA Board Resource

• Recommends that board membership include a person or persons knowledgeable in these matters, much like the expectation that boards include financial experts.

• Sets forth ten groups of annotated questions as a resource for directors to educate themselves, design a compliance program, evaluate and monitor its effectiveness, and correct deficiencies.
1. What are the goals of the organization’s quality improvement program? What metrics and benchmarks are used to measure progress towards each of these performance goals? How is each goal specifically linked to management accountability?

2. How does the organization measure and improve the quality of patient/resident care? Who are the key management and clinical leaders responsible for these quality and safety programs?
3. How are the organization’s quality assessment and improvement processes integrated into overall corporate policies and operations? Are clinical quality standards supported by operational policies? How does management implement and enforce these policies? What internal controls exist to monitor and report on quality metrics?

4. Does the board have a formal orientation and continuing education process that helps members appreciate external quality and patient safety requirements? Does the board include members with expertise in patient safety and quality improvement issues?
5. What information is essential to the board’s ability to understand and evaluate the organization’s quality assessment and performance improvement programs? Once these performance metrics and benchmarks are established, how frequently does the board receive reports about the quality improvement efforts?

6. How are the organization’s quality assessment and improvement processes coordinated with its corporate compliance program? How are quality of care and patient safety issues addressed in the organization’s risk assessment and corrective action plans?
7. What processes are in place to promote the reporting of quality concerns and medical errors and to protect those who ask questions and report problems? What guidelines exist for reporting quality and patient safety concerns to the board?

8. Are human and other resources adequate to support patient safety and clinical quality? How are proposed changes in resource allocation evaluated from the perspective of clinical quality and patient care? Are systems in place to provide adequate resources to account for differences in patient acuity and care needs?
9. Do the organization’s competency assessment and training, credentialing, and peer review processes adequately recognize the necessary focus on clinical quality and patient safety issues?

10. How are “adverse patient events” and other medical errors identified, analyzed, reported, and incorporated into the organization’s performance improvement activities? How do management and the board address quality deficiencies without unnecessarily increasing the organization’s liability exposure?
OIG & HCCA Roundtable

- **Driving for Quality in Long-Term Care: A Board of Directors Dashboard** – Report published by OIG and HCCA regarding co-sponsored a government-industry roundtable in January 2008.

- **Goals:**
  - Industry representatives shared experiences and informed OIG and HCCA of issues surrounding boards of directors’ oversight of quality of care.
  - Create a tool for organizations that specifies items that could be included on a “Quality of Care Dashboard”.

- **http://oig.hhs.gov/fraud/complianceguidance.html#2**
OIG & HCCA Roundtable

- Boards can communicate a **commitment** to quality in the following ways:
  - Provide a Forum for Quality Issues
  - Demonstrate Board Engagement
  - Craft a Board Mission Statement or Resolution
  - Demonstrate Commitment through Structures and Processes
  - Effectively Allocate Resources
OIG & HCCA Roundtable

• **Processes** that can be used to involve a board in quality improvement and to help boards understand the tracking and measuring of quality:

  – Provide Quality Data Reports for the Board
  – Validate Quality Reports
  – Develop Board Expertise and Understanding of Quality Information
  – Promote the Free Flow of Information
  – Coordinate a Response to Quality Issues
OIG & HCCA Roundtable

• Valuable outcome measures to consider when designing a Quality of Care Dashboard:
  
  – Survey Results
  
  – Resident Outcomes and Care Delivery
  
  – Events Reporting
  
  – Complaints
  
  – Resident, Family, and Staff Satisfaction Surveys
  
  – Financial Indicators
OIG & HCCA Roundtable

• Challenges to the Implementation of a Quality of Care Dashboard:
  – “One Size Does Not Fit All”
  – Beware of Information Overload
  – Consider Legal Liability Concerns
  – Scrutinize Available Quality Measures

• Opportunities for the Implementation of a Quality of Care Dashboard:
  – Board Sets Quality as a Priority
  – Financial Indicators are Intertwined with Quality
  – Quality Impacts the Success of the Organization
The Development of Corporate Compliance Programs

- US Sentencing Guidelines
- OIG Compliance Guidance
- Medicare Health Plan requirement
- HCA, Enron, HealthSouth
- Public Outrage
- Sarbanes-Oxley
- By 2002, substantial utilization of compliance programs across the industry
- Board compliance program oversight responsibility is an ongoing element of the duty of care
The Duty of Care

- Duty of care involves determining whether the directors acted:
  - In good faith
  - With the level of care that an ordinarily prudent person would in like circumstances
  - In a manner that they reasonably believe is in the best interest of the corporation

- Applies to decision making functions

- Applies to oversight functions
The Business Judgment Rule

- Governs the level of detail appropriate for such information systems
- Directors are entitled to rely in good faith on officers and employees, as well as consultants in whom such confidence is merited
- Duty to make reasonable inquiry where facts warrant
Board Education Slides

Practical Implications of the Duty of Care

- Board members do not need to know every detail of compliance program activities, or individually ferret out allegations of fraud
- Board members can rely on the advice of management and outside consultants
- Board members should ask questions if suspicious about particular conduct or events
- Periodically inquire about status of compliance program per the OIG Board Guidance
- Follow proper procedure for conflicts of interest
The Tone at the Top

- Board commitment to compliance program essential for its effectiveness
- Sends message throughout the organization that compliant practices are how we conduct business
- Includes all 7 elements of an effective compliance program: compliance officer; compliance policies; communication; auditing and monitoring; discipline; corrective action; and education
Primary Compliance Risks

- False claim statute: Prohibition against submitting false information to the gov’t for payment
- Anti-kickback statute: Prohibition against making or receiving payments in exchange for referrals
- Stark: Prohibition against physicians against referring patients to providers with which they have a financial relationship, except under certain conditions
- IRS: Tax-exempt organizations penalized for private inurement and excess benefit transactions
Common Compliance Problems: False Claims

- Billing for services that were not delivered, or not in the manner documented
- Upcoding
- Unbundling
- Submitting claims for services of an excluded person
- Services provided under an arrangement prohibited under Stark and/or Anti-kickback Statute
- Deficient quality
- Medically unnecessary care
Common Compliance Problems: Anti-Kickback, Stark & Private Inurement

- Lack of fair market value compensation for physician contracts
- Provision of free or discounted services to referring physicians
- Joint ventures disguising kick-back arrangements
- Contractual relationships that improperly benefit others
Sample Board Report
Questions