Healthcare Reform:
The Trustees’ Perspective
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David J. Edquist, Esq.
414.287.1372 or dedquist@vonbriesen.com

Agenda

• The Reform Landscape
• Review of Trustee Obligations
• Oversight of Healthcare Quality
• ACOs and Other Payment Models/Reforms
• New Requirements for 501(c)(3) Hospitals
• The Engaged Board
The Reform Landscape

- **The Positives for Rural Providers**
  - Expansion of coverage/access to care
  - Enhanced reimbursement

- **Rural Provider Concerns**
  - Uncertainty!
  - Delivery system changes/ACOs
  - Medicaid Expansion/DSH Phase-out
  - PCP/Workforce shortages
  - Infrastructure costs
Increased Enforcement Activity

Healthcare Providers Can be Found Liable for:

- **False Claims Act**
  - Knew or should have known
  - Failing to meet service quality standards
- **Fraud & Abuse**
  - Material false statement
  - Inducements for referrals
- **Stark**
  - Improper financial relationship
  - No bad intent required
Penalties for Violations May Include

- Treble damages + $$/claim
- Bad actors - jail time
- Criminal fines
- Medicare exclusion - death sentence
- Corporate Integrity Agreements
  - Implementation of a comprehensive compliance program
  - Independent audits
  - Increased communication with OIG
  - Annual reporting requirements
  - Internal monitoring

Review of Trustee Obligations

- Feds, State AGs, other enforcement officials increasingly look to the board of directors as part of the solution
Nonprofit Boards in Wisconsin: Basic Elements

- Duty of good faith
- Best interests of the organization
- Care exercised by ordinarily prudent person under similar circumstances

Duty of Care

- Corporate directors must exercise the proper amount of care when making decisions. Decisions should be made:
  - in “good faith”
  - with the level of care that an ordinarily prudent person would exercise in a similar situation
  - with the best interest of the corporation in mind
Fiduciary Responsibilities

- Must make reasonable inquiries to obtain the information necessary to perform director’s duties
- Reasonable inquiry does not require proactive vigilance unless there is reason to suspect a problem

What is Reasonable Inquiry?

- Unless there is reason to believe otherwise, directors are entitled to rely on information obtained from the senior leadership team
- If presented with information causing concern, must investigate until concerns are satisfactorily addressed
Duty of Care

- Active participation
- Committees
- Board actions
- Minutes of meetings
- Books and records

Officer Liability: Traditional View

- Piercing the “corporate veil”
  - Alter ego doctrine
- Consumer protection
  - e.g. Wis. Stats. § 425.310
- Personal Misconduct
Officer Liability: Nonprofits

- Limited Liability: Wis. Stats. § 181.0855
  - Relating solely to status as officer/director
- Exceptions
  - Willful failure to deal fairly (conflict of interest)
  - Violation of criminal law
  - Improper personal benefit
  - Governmental action

Officer Liability: Other Contexts

  - Fiduciary duty to creditors
- *State v. Kuhn* (Ct. App. 1993)
  - Officer liability: Criminal acts
Trustee Obligations: Healthcare

- Joint Commission standards
- Medicare Conditions of Participation
- Quality Oversight
  - Performance activities
  - Measures
  - Reports

Was This In My Job Description?

- OIG taking aim at execs
- Individual accountability
- Expansion of exclusions
Responsible Corporate Officer Doctrine (a/k/a “Park Doctrine”)

- Allows for individual exclusion, even if not convicted of fraud
- Not based solely on place in corporate hierarchy
- Had responsibility and authority to either (a) prevent the fraud, or (b) promptly correct certain conduct resulting in fraud
- “Culpable omission” counts

2010 OIG (b)(15) Guidance: Rebuttable Presumption of Exclusion

Factors to be considered in exercising permissive exclusion authority
- Circumstances and seriousness of conduct
- Individual’s role in entity
- Individual’s actions in response
- Information about the entity

“Guidance for Implementing Permissive Exclusion Authority Under Section 1128(b)(15) of the Social Security Act”
Oversight of Healthcare Quality

- New quality measures, transparency of quality reporting, pay for performance
- Importance to mission
- Impact on financial performance
- New tools mean raised expectations

Quality and Transparency

- Public reporting of quality data
  - From voluntary reporting to financial penalties for failure to report
  - More domains of quality measures
    - Patient satisfaction
  - Data mining and analysis
Pay for Performance

- Never events
- Hospital-acquired/preventable conditions
- Hospital readmissions
- Value-based purchasing

Poor Quality: A Compliance Risk

- False Claims Act Liability
  - Medically unnecessary treatment
  - Care not delivered, or deemed worthless
  - Violation of quality standards
- OIG Work Plan
Poorest Quality: A Compliance Risk

- Transparency, public availability of data
- Affirmative duty to investigate once board is on notice of a quality concern

Poor Quality: A Financial Risk

- Financial incentives and penalties related to quality
- Financial investment in infrastructure for measuring quality
- Ability to participate in strategic affiliations based on quality measures and performance
ACOs and Other Payment Models

- Medicare Shared Savings Program (ACOs)
- Bundled Care models
- Medical homes
- Center for Medicare/Medicaid Innovation

ACOs: An Overview

Accountable Care Organization (ACO) is a group of doctors, hospital(s), and other health care providers (i.e. DMEs) who voluntarily come together to give coordinated high quality care to their Medicare patients.

Medicare ACO Models:
1. Pioneer ACO Model
2. Advance Payment ACO Model
3. Medicare Shared Savings Program
Where do savings come from?

• Pre-hospitalization interventions and alternative practice settings that improve patient health while avoiding acute events and expensive hospitalizations where appropriate

• Improved coordination in the discharge and rehabilitation of patients so as to minimize readmissions and lengths of stay at skilled nursing facilities and ensuring that the patients comply with their post-discharge instructions

• Leverage access to inter-operative EHR so as to minimize duplicate testing and length of stay

• Negotiation for discounts on medical devices

Medicare Shared Savings Program

Quality Metrics: Four Domains

• Patient/Caregiver experience

• Care coordination/Patient safety

• Preventive Health

• At-risk population/frail elderly
ACO Challenges

• Infrastructure Costs - Categories
  - Network Development
  - Care coordination
  - Clinical Information Systems
  - Data Analytics

ACO Challenges

• Legal/Compliance
  - Benefits to referring physicians
  - Benefits to patients
  - Issues under Stark, anti-kickback, gainsharing, beneficiary inducement CMP laws
  - IRS/Antitrust
  - ACO/MSSP waivers
Questions to ask

- Responsibilities
- Independence
- Impact on existing operational norms
- Financial incentives/quality metrics
- Availability of data
- Other support

Questions to ask

- Assessment of performance
- Your ability to control costs
- Outliers
- Attribution of patients
- Access to care
Bundled Payment Arrangements

- Bundled Payment Initiative
- CMS Pilot Program
- Gainsharing

Medical Homes

- Care coordination for patients with multiple chronic conditions
- Federal funding to states
  - Policies and processes to manage care
  - Use IT to improve quality and deliver patient-centered care
New 501(c)(3) Requirements

• Four new requirements for 501(c)(3) hospitals
  - Adoption of written financial assistance policy, and policy on emergency medical care
  - Limitation on what hospitals may charge individuals eligible for financial assistance
  - Limiting extraordinary collection activities prior to making reasonable efforts to determine eligibility for financial assistance
  - Requiring hospitals to conduct a community health needs assessment at least once every three years.

Financial Assistance Policy

• Eligibility Criteria
• Basis for calculating amounts charged
• Method for applying for assistance
• Billing and collection procedures
• Policy on emergency medical treatment
Limitation on Charges

- Patients eligible for financial assistance
- Emergency or other medically necessary care
  - Based on amounts generally billed (“AGB”) to persons who have insurance covering such care
- May not use gross charges (“chargemaster”)

Billing and Collection Requirements

- Restricts “extraordinary” collection efforts
- Reasonable efforts to determine eligibility for assistance
  - Notification upon admission
  - Other communications relating to bill (e.g. invoices and phone calls)
CHNAs

- Community Health Needs Assessment
  - Every three years
  - Sources of input
  - Use of public data
  - Implementation strategy
  - Widely available to the public

CHNAs

- Authorized body of the hospital facility approves
  - CHNA Report
  - Implementation Strategy
- Annual Progress Reports in Form 990
- Public Comment/Feedback Loop
The Engaged Board

- Oversight vs. Management
- Boards becoming more informed, active, and accountable
- Board composition/recruiting
- Board training and education
- Knowledge and oversight/Reporting and response

How is the board kept apprised of significant regulatory and industry developments affecting it? How is the compliance program structured to address such risks?

- Regular quarterly reports
- Education sessions
Board/Officer Accountability and Corporate Compliance

- No Magic Formula
  - Periodic review and education
  - Independence and committee structure
  - Access to information including new quality metrics
  - Active role in charting the course

Questions?