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EXECUTIVE SUMMARY

**BUSINESS LAW AND GOVERNANCE
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New OIG Guidance on Governing Board Compliance Plan Oversight Obligations

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Health lawyers should note the thoughtful discussion of a governing board's compliance plan oversight role, authored by U.S. Department of Health and Human Services Inspector General (HHS IG) Daniel Levinson and published in the July/August issues of *Trustee*.¹ The article, *Trustee Engagement and Hospital Success*, generally serves to encourage the board to be more assertive in the exercise of oversight. It also suggests several steps the IG promotes as supportive of board oversight—some of which may have important but controversial implications. Among these are recognizing quality as a compliance issue; assuring the compliance officer's role as a corporate "ombudsman"; clarifying the compliance officer's reporting relationships; and separating (in different persons) the positions of compliance officer and general counsel. The IG's perspective should be regarded as significant and worthy of substantive discussion at a governance-level forum. This is particularly the case given that the article's primary intended audience is the hospital board.

In guiding the related discussion with hospital leadership, health lawyers should review each of Levinson's substantive points, how they relate to the hospital's existing compliance plan structure, and whether they raise implementation issues for which additional OIG clarification would be welcomed.

¹ See www.trusteemag.com/trusteemag_app/jsp/articledisplay.jsp?dcrpath=TRUSTEEMAG/Article/data/07JUL2010/1007TRU_viewpoint&domain=TRUSTEEMAG.

Assertive Oversight

Levinson describes the “best boards” as those that are active, questioning, and exercise (constructive) skepticism in their oversight. This perspective is consistent with the series of Delaware court decisions articulating the director’s fiduciary compliance plan oversight duties.²

The IG’s view also tracks with the 2004 amendments to Chapter Eight of the U.S. Sentencing Guidelines (Effective Compliance and Ethics Program).³ These amendments obligate the board to be knowledgeable about the compliance plan and to exercise reasonable plan oversight as a precondition to favorable treatment under the Guidelines. These core fiduciary oversight obligations are also discussed in the series of three compliance program resources jointly published by the Office of Inspector General and AHLA.⁴

So, nothing new here? Not quite. The *Trustee* article suggests a subtle push from the IG toward more board engagement—particularly but not solely with respect to compliance. While “OIG wants trustees to succeed,” it may be time for the board to re-evaluate the vigor with which it exercises compliance-related oversight. Are the board and the IG of like mind as to what constitutes “assertive oversight”? A worthy topic of boardroom introspection, perhaps.

Quality and Compliance

Here again, the IG seeks to remind boards that quality of care is a compliance concern; that there is material linkage between Medicare/Medicaid billing to the quality of patient care, both in terms of the right to reimbursement *and* the imposition of penalties. This is an increasingly familiar refrain to health lawyers, but perhaps not to their clients’ boards. Indeed, the most recent OIG/AHLA compliance plan resource was devoted entirely to

² See, e.g., *In re Citigroup Inc. Shareholder Derivative Litigation*, 964 A.2d 106; 2009 Del. Ch. LEXIS 25; *Stone v. Ritter*, 911 A.2d 362 (De. 2006); *In re Caremark Int’l Inc. Derivative Litigation*, 698 A.2d 959 (Del. Ch. 1996).

³ See www.ussc.gov/2004guid/RFMay04.pdf.

⁴ See <http://oig.hhs.gov/fraud/complianceresources.asp>.

the relationship between corporate compliance and quality of care.⁵ What is new here is the IG's unwillingness to accept "lack of a medical background" as an excuse for board members to defer to physicians' scrutiny of quality-of-care indicators. The IG also appropriately links the billing issue to broader board concerns about financial stewardship. In that regard, it is a perfect opening to revisit with the board how corporate compliance relates to important quality issues such as mortality rates, hospital infections, medical errors, etc.

The CCO's Role

The article also serves to underscore the organizational importance that the IG attributes to the role of the compliance officer. It has been the IG's long-held view that the chief compliance officer is to serve as an "ombudsman," monitoring both the hospital's legal *and* ethical response to compliance issues as they arise.

Thus, part of the board's oversight obligation is to assure that the compliance officer is appropriately positioned within the organizational hierarchy to effectively serve in the "ombudsman" role. This is fundamentally a "black and white" issue, as the IG and other regulators can read an organizational chart and a job description, and see exactly where the compliance officer fits in. The OIG/AHLA compliance plan resource, *Corporate Responsibility and Corporate Compliance*, provides a series of criteria from which the board can measure the organizational prominence and influence of the compliance officer.⁶

Separate Positions

The OIG also reminds *Trustee* readers of its traditional preference that the positions of chief compliance officer and general counsel be kept separate and staffed by different persons. Over the years, the OIG has expressed its view that the roles of the compliance officer and the general counsel serve the hospital in fundamentally different ways. While the roles have natural areas of overlap, in the OIG's view, "the lawyers tell you whether you can do something, and compliance tells you whether you should. We

⁵ *Corporate Responsibility and Health Care Quality*. See <http://oig.hhs.gov/fraud/docs/complianceguidance/CorporateResponsibilityFinal%209-4-07.pdf>.

think upper management should hear both arguments.”⁷ This reflects a perspective of the compliance officer as a neutral finder of fact, expected to perform duties that transcend the practice of law, with specific responsibility for uncovering legal or ethical misconduct within the organization.⁸ In that regard, it is reminiscent of Senator Charles Grassley’s (R-IA) famous “pig farmer from Iowa” observation about the conflicts of interest he perceived as inherent when the compliance and general counsel responsibilities are held by the same person.⁹ This view does not, however, necessarily acknowledge the general counsel’s ethical obligation under state rules of professional responsibility to serve the interests of the organization at all times.

Nevertheless, the IG’s decision to emphasize this particular viewpoint in *Trustee* should prompt organizations that maintain a unified compliance officer/general counsel position to re-evaluate its continued utility.

No Buffer

The IG sends a related and important message that the compliance officer’s reporting relationships to the board should be unrestricted and without buffer. The expectation is that the board should receive unfiltered advice from the compliance officer, without interference or interpretation by superior officers. (Needless to say, the same can be said for the general counsel’s reporting relationship).

Here, the IG’s view is consistent with the 2010 amendments to the Sentencing Guidelines, which similarly call for the board to assure a “direct reporting relationship” between the compliance officer and the board.¹⁰ The Guidelines define this as providing the compliance officer the “express authority to communicate personally to the

⁶ See <http://oig.hhs.gov/fraud/docs/complianceguidance/040203CorpRespRsceGuide.pdf>.

⁷ Amy Miller, “42.3bn Pfizer settlement strips legal team of compliance brief,” legalweek.com, September 11, 2009.

⁸ Erica Salmon-Byrne and Jodie Frederickson, “The Business Case for Creating a Standalone Chief Compliance Officer Position,” May 25, 2010, *Ethisphere*, available at <http://ethisphere.com/the-business-case-for-creating-a-standalone-chief-compliance-officer-position/>.

⁹ See <http://grassley.senate.gov/releases/2003/p03r09-08.htm>.

¹⁰ See www.ussc.gov/2010guid/20100503_Reader_Friendly_Proposed_Amendments.pdf.

governing authority promptly” on compliance issues including but not limited to the ability to report at least annually on the state of the compliance program.¹¹

This “no buffer” perspective also argues strongly against the compliance officer reporting to or through the general counsel, forcing hospitals and their boards to implement other means of properly coordinating the two roles. In this regard, consider the related discussion contained in the OIG/AHCA resource, *An Integrated Approach to Corporate Compliance*.¹² The board should play a meaningful role in assuring proper coordination of activities between the two positions while protecting against the creation of barriers to the compliance officer’s reporting relationships.

Briefing the Board

The informality of the *Trustee* article notwithstanding, it presents significant compliance plan oversight issues that should be raised for board consideration. Matters relating to assertive oversight; the relationship of quality of care to compliance; the compliance officer as an ombudsman; separating the positions of compliance officer and general counsel; and direct reporting relationships, are all properly the focus of board attention.

This is particularly the case given the significant anti-fraud and abuse provisions contained in the recent healthcare reform law, and recent Congressional testimony and other public comments of the IG¹³ and his colleagues on increased fraud and abuse enforcement. The timing is right for a thoughtful discussion of these compliance issues, involving the full board.

In guiding the board-level discussion, counsel may properly distinguish between legal requirements, Sentencing Guidelines and other guidance, and IG preferences. The board dialogue should also include review of issues left open by the *Trustee* article, e.g.

¹¹ See, Peregrine, Buchman and Shapiro, *Changes to Compliance Plan Guidance Focus on Reporting Relationships*, 19 HLR 728, 5/20/10.

¹² See <http://oig.hhs.gov/fraud/docs/complianceguidance/Tab%20E%20Appendx-Final.pdf>.

¹³ See, e.g., "Highlights of the Keynote Address Delivered by Daniel R. Levinson, Inspector General of the Department of Health & Human Services, at the Health Care Compliance Association Annual Compliance Institute, April 19, 2010." See <http://oig.hhs.gov/testimony/docs/2010/HCCAIGKeynoteSummary.pdf>.

- Is “assertive oversight” capable of being defined?
- Are there organizational ramifications of not separating the compliance officer and general counsel positions (e.g., is there a presumption of impropriety)?
- Can some “work around” be created to reduce the potential conflict between the compliance officer and the general counsel, while retaining necessary coordination between the positions?
- Should the audit or compliance committee exercise greater involvement in the hiring, compensation, and termination of both the compliance officer and the general counsel?
- What is the application of the attorney-client and other privileges where the compliance officer and general counsel roles are separated? (A tougher question is how the privilege applies when both positions are held by the *same person*).
- Does the compliance plan acknowledge the general counsel’s professional responsibility to report “up the ladder” evidence of actual or potential legal violations by the corporation or its agents?

Levinson’s article is a well-intentioned, important new statement on the governing board’s compliance plan oversight obligations. It offers the IG’s perspective on a number of key issues that deserve full board attention, if not understanding or agreement. Corporate counsel can play a vital role in leading the board through a meaningful dialogue on these issues.

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