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The increasingly enforcement tone of the debate on comprehensive immigration reform (CIR) has spawned a host of compliance concerns that many healthcare employers may not appreciate. Many healthcare organizations face immigration-related risks, and in this article, we will provide tips on how best to manage them.

The Form I-9 process
Most healthcare employers are familiar with the Form I-9 process. Under US immigration laws, all employers must complete a new Form I-9 for every employee hired since November 7, 1986. On March 8, 2013, the U.S. Citizenship and Immigration Services (USCIS) issued a new Form I-9.1 This new form must be used for all new employees who complete the Form I-9 process on or after May 8, 2013. Immigration and Customs Enforcement (ICE) is the federal agency that audits the Form I-9s maintained by employers and issues fines where violations of the process have occurred. Under the Obama administration, ICE has conducted a record number of Form I-9 audits and levied a record amount of fines. For this reason, all healthcare organizations need to include the Form I-9 process within their risk management policies.

One helpful approach to this process is to use the 12 best employment practices that ICE issued as part of its IMAGE program as a guide.2 We are not recommending that healthcare employers enroll in IMAGE under most circumstances. However, the best practices that ICE has identified in that program provide a useful checklist of procedures that employers may want to include in their Form I-9 compliance programs.

IRCA’s anti-discrimination provisions
In their efforts to comply with Form I-9 requirements, many employers in the healthcare industry appear to have ignored the anti-discrimination provisions that the immigration

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laws contain. When Congress inserted the Form I-9 requirement in the Immigration Reform and Control Act of 1986 (IRCA), it was concerned that employers would use the process to improperly reject applications by “foreign looking” workers. For this reason, it incorporated separate anti-discrimination provisions into IRCA that define unfair immigration-related employment practices in the Form I-9 completion process. IRCA also established the Office of Special Counsel (OSC) within the Department of Justice to enforce these anti-discrimination provisions. In recent years, the OSC has brought enforcement actions against a disproportionate number of healthcare employers who acted too vigorously in discharging their Form I-9 obligations.

Liability under IRCA’s employment discrimination provisions can arise in a variety of different contexts, such as when an employer asks a “foreign looking” applicant for more or different documents than it seeks from an “American looking” worker, or instructs applicants on the specific documents they must provide to satisfy the Form I-9 requirements. Several recent settlements illustrate how the OSC enforces IRCA’s requirements. The University of California, San Diego Medical Center, paid a penalty of $115,000 to settle OSC allegations that it required foreign nationals to supply excess documentation. Onward Healthcare paid $100,000 to settle OSC allegations regarding discriminatory job postings that impermissibly limited applicants to just American citizens when there was no legal basis for the limitation. Avant Healthcare Professionals LLC paid $27,750 to settle OSC claims that its job postings were discriminatory because they impermissibly preferred foreign nationals seeking permanent residence or H-1B visa holders. The OSC has published a pamphlet entitled, *Immigration Status and National Origin Discrimination in Employment*, which is designed to assist employers in navigating between these IRCA requirements.3

Impact of the ACA

The implementation of the Patient Protection and Affordable Care Act (ACA) on January 1, 2014 has forced U.S. healthcare organizations to think about how best to position themselves with such massive changes coming up the pike. ACA will expand coverage to approximately 32 million individuals lawfully present in the United States. Non-citizens lawfully present in the U.S. are eligible for insurance coverage.4 At the same time, the U.S.’s rapidly increasing aging population will account for an additional 15 million more seniors covered by Medicare.5 This incredible influx of elderly and newly insured patients is forcing an already overly burdened U.S. healthcare system to develop and implement policies to adequately handle this expanded patient population.

The million dollar question is: Where will these organizations get the healthcare talent required to meet this new demand? The answer is: Not from within the United States.

According to the Association of American Medical Colleges, the United States will face a physician shortage of close to 63,000 in 2015 that will increase to 91,500 by 2020. The U.S. also currently has a shortage of registered nurses (RNs).6 Like the physician shortage, the RN shortage issue will be magnified with the onset of ACA. The shortage projections for physical therapists and occupational therapists are similar, although the Bureau of Labor Statistics’ data indicates that these are two of the fastest growing occupations in America.7

The fact is that the ACA will force America to look beyond its borders to locate the healthcare talent required to properly address this anticipated worker shortage. The proposed CIR lacks the sensible immigration options for healthcare workers, so employers necessarily must continue to look to current U.S. non-immigrant (temporary) work visa and green card options for foreign medical graduates, nurses, physical therapists, and other
professional healthcare workers. Many of these options, however, are subject to severe quota restrictions, potential bureaucratic delays at the visa issuance level, and extensive and often complicated credentialing requirements. Moreover, under current U.S. immigration law, certain foreign healthcare workers are required to secure a healthcare certificate (HCC) to be eligible to obtain the visa required to work in the United State.8 Also, they are required to secure any license required by the state where they intend to work, in order to practice the profession and be eligible for the visa.

Securing both the HCC and state license is often a lengthy, expensive, and at times arduous task. In addition, employers are often mandated to shoulder the costs associated with securing the relevant works visas, which can be significant. The onset of ACA should function as a strong incentive and push for healthcare organizations to better understand the immigration laws, so they have adequate compliance measures and policies in place. Otherwise they risk running afoul of such requirements and inadvertently open themselves up to liability if they fail to satisfy these requirements.

Healthcare organizations need to recognize where exactly the healthcare worker gaps are within their respective organizations in order to implement realistic plans to address potential professional personnel shortages. Those that develop a strong understanding of how the immigration laws operate and can leverage these provisions will have a healthy step up on their competition. Employers who truly understand the shortage issues and learn how U.S. immigration laws can play a part in the solution will be best positioned to handle the influx of patients and rise above their competition.

H-1B temporary worker issues
The H-1B non-immigrant classification is one frequently used by healthcare and other organizations to employ eligible foreign nationals. The H-1B classification applies to professionals who will perform professional work. To the government, a professional position is one that requires at least a specialized Bachelor’s degree, and an eligible H-1B employee is a foreign national who has the requisite degree. To protect the domestic workforce, employers seeking H-1B status for a potential foreign nationals hire must secure an approved Labor Condition Application (LCA) in which they agree, among other things, to pay at least the prevailing wage for the position in the geographic area where the job is located.

In recent years, the Department of Labor (DOL) has developed rules regarding what constitutes a “prevailing” wage for the offered position. Many healthcare employers may not appreciate that these rules constitute an increasing risk for those forced to rely more extensively on foreign national medical professionals under the ACA. Under the DOL regulations, for example, employers are required to pay all expenses, including legal expenses and filing fees, associated with an H-1B petition. In one case, an employer who relied extensively on H-1B employees and required them to pay their own legal fees was required by the DOL to reimburse the foreign nationals more than $4 million, to pay a $100,000 fine, and to stop filing H-1B petitions for two years.9 In another case, a medical practice operating five clinics in Tennessee was charged by the DOL with violating federal law by failing to cover the expenses that H-1B employees incurred in securing the J-1 waivers they needed to remain and work in the United States.10 Under US immigration laws, foreign nationals who participate in medical residency programs here in J-1 status are subject to a two-year foreign residence requirement. They can avoid this requirement by seeking a waiver that involves, among other things, practicing in a medically
underserved area. If they find a qualifying position, the employer can sponsor them for H-1B status while the J-1 waiver process continues. The DOL has taken the position that the costs of the J-1 waiver process are part of the expenses required to secure H-1B status and thus must be paid by the employer as part of its obligations to pay the H-1B prevailing wage.

Finally, healthcare employers must be careful in how they terminate H-1B employees. In recent years, the DOL has adopted the concept of a “bona fide” termination. This requires an employer to terminate the H-1B worker properly under state law, offer to pay reasonable transportation costs home, and notify the USCIS of the termination. Until all these steps occur, a bona fide termination has not taken place and the employer remains liable for the salary required under the controlling LCA for the position. This is true even if there has been acceptance of severance and execution of a release, because it will not cover this statutory obligation.

Immigration policies
All healthcare employers that employ or plan to employ foreign nationals should adopt and implement comprehensive immigration policies. These should address the organization’s Form I-9 requirements and instruct employees how to discharge the employer’s legal obligations in this process. They also should define the organization’s responsibilities when it elects to sponsor a foreign national for either a non-immigrant visa or for permanent residence. In recent years, foreign nationals unable to secure permanent residence while working for an employer have asserted increasingly aggressive claims, trying to hold the employer responsible for the failure. In many cases, the hardships associated with the failure are extensive, because the employee must leave the United States. In one case, DerKevorkian v. Lionbridge Technologies, Inc., a foreign national recovered a $1.3 million jury verdict. The Tenth Circuit reduced the verdict to $300,000, but it affirmed the employer’s liability on the ground that its immigration policy created a fiduciary duty that was breached. This and other cases strongly counsel healthcare employers to develop and implement immigration policies designed to thwart the type of claim that succeeded in Lionbridge.

Professional recordkeeping
Most healthcare employers know that they must retain Form I-9s for at least three years, or one year following the employee’s separation from the employer, whichever is longer. These employers may not realize, however, that they have other documentary requirements when employing foreign nationals as healthcare professionals. Those sponsoring H-1B employees must retain the LCA for one year after separation of the last foreign national employee who relied on the LCA or, if no foreign national employee did, then one year from LCA approval. If they support the foreign nationals for a green card based on labor certification, they must retain the Program Electronic Review Management (PERM) audit file for five years from the approval date of the PERM application.

Healthcare employers also need to track the expiration dates not only of foreign national employees, but also of the licenses and credentials they need to maintain or extend status. Many of the licenses and various levels of necessary credentials have different, and often unpredictable, expiration dates. On occasion, it can take months to renew the necessary credential and the USCIS usually requires current credentials before it will approve a status extension. Unless these expiration dates are tracked, the employer may be forced to lay off a critical healthcare worker if it cannot obtain the underlying credential in time to secure an extension of the foreign national’s status.
Export control requirements
The export control laws of the United States are enforced by various branches of the Department of Commerce. Those relating to foreign nationals appear primarily in the Export Control regulations (EAR) and the International Traffic in Arms (ITAR) regulations. These regulations prohibit giving certain foreign nationals access to controlled technology or technical data unless an export license is secured. Under the EAR and ITAR, the release of “controlled technology” to a foreign national is considered a “deemed” export of that technology to the foreign national’s home country. If an export license would be required to send the technology to the foreign national’s home country, an export license is required simply to allow the foreign national to see that technology. An example of controlled technology is encryption software.

The emphasis in the ACA and other healthcare initiatives on the electronic storage of medical data and the privacy concerns that surround that transformation should remind all healthcare organizations to audit their operations for potential export control violations. Recognizing the growing role that foreign nationals play in the IT and MIS departments of many employers, the USCIS amended the I-129 application for non-immigrant workers in 2011 to include specific questions designed to measure export control compliance. Thus, any healthcare organization that employs foreign nationals in this manner must be cognizant of these important legal obligations.

1. The new Form I-9 is available at http://1.usa.gov/l6J1c76
3. Immigration Status and National Origin Discrimination in Employment pamphlet http://1.usa.gov/l6j1z0
8. See 8 C.F.R. Section 212.15(c).
11. 316 Fed. Appendix. 727 (10th Cir. 2008)

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