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THE NATION'S ESSENTIAL ALERT FOR HEALTHCARE COMPLIANCE OFFICERS

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Compliance officer role expands to accreditation

Health care experts see inevitable merging of compliance and quality assurance responsibilities

As the role of compliance has grown within hospitals, compliance officers are taking on new and wide-ranging responsibilities in areas such as accreditation and quality assurance. Compliance officers and others say that how these new responsibilities are managed and how organizations are structured will determine their success.

Bret Bissey, chief compliance officer at Deborah Heart and Lung Association in Browns Mills, NJ, says he sees this as a growing trend. "If you have an effective compliance program, regardless of the type of organization you have, you have to step beyond the fraud and abuse issues." According to Bissey, even if compliance officers are not intimately involved in the day-to-day operations of accreditation, they should at least have an oversight role to make sure that what is happening is appropriate.

"I see this as a trend, and I think it makes sense as the compliance field grows," says Bissey. He adds that as compliance programs evolve, compliance officers will want to make sure that issues central to accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), based in Oakbrook Terrace, IL, also become part of their oversight process, even if they are not part of their direct purview.

Lisa Murtha, JD, chief compliance officer at Children's Hospital in Philadelphia, takes a similar view: "Many of those [accreditation] people have

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Feds use CIAs to enforce 'quality' long-term care

Last week's decision by Vencor, one of the nation's largest operators of nursing homes and hospital services, to enter a five-year corporate integrity agreement (CIA) with the Department of Health and Human Services (HHS) Office of Inspector General (OIG) marks a new chapter in the government's war against alleged substandard care in the long-term care industry.

The agreement, which was required as part of Louisville, KY-based Vencor's Chapter 11 bankruptcy protection, puts an unprecedented focus on

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HCA compliance chief: Keys to successful compliance

One of the greatest challenges of compliance officers is keeping the ethics and compliance message fresh, says **Alan Yuspeh**, who oversees ethics and compliance efforts at HCA's 200 hospitals and 85 ambulatory surgery centers. However, Yuspeh argues this can be achieved by changing communication tools, adding new training materials, and addressing new issues.

He says that's why HCA's (formerly Columbia/HCA) recent revision to its code of conduct makes relatively minor substantive changes but alters the look and feel of the document completely compared to the first edition that Yuspeh prepared in late 1997. For example, the revised code includes a series of quotes from well-known individuals, which are intended to reinforce the mission and values statement for HCA hospitals.

Yuspeh adds that HCA views its overall effort as a "comprehensive compliance program" rather than just a "Medicare compliance program."

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recently been appointed as the compliance officers for their institution, which means they are inevitably going to have the quality assurance focus that goes along with what they do concerning JCAHO," she explains.

"That does not mean that regulatory requirements take a back seat," she adds. "It just means that it is incorporated into operations, as opposed to being seen as an afterthought or as merely an oversight function." In fact, she says, the most successful programs she has seen are those that incorporate compliance monitoring and training into the day-to-day operations of the organization.

Murtha also points out that both the Joint Commission and the Washington, DC-based National Commission on Quality Assurance (NCQA) have warned that failure to comply with the looming privacy requirements included in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) would be considered a violation of NCQA and Joint Commission standards. "While we [view] the privacy and security aspects of HIPAA as more of a compliance-related issue, they are now being actively incorporated into the accreditation process and the quality initiative," she asserts.

Al Josephs, chief compliance officer at Hillcrest Health System in Waco, TX, says that while many organizations already have quality assurance departments, their efforts increasingly will merge with compliance efforts. Like Murtha, he says that the more he becomes involved in quality assurance, the more compliance-related activities he discovers. He also agrees that HIPAA is the "800-pound gorilla" just around the corner.

Joe Murphy, president of Compliance Systems Legal Group in Haddonfield, NJ, sees a distinct trend in health care compliance moving from a very narrow focus on areas such as coding and billing to a broader focus including values and ethics. "Fundamentally, I don't have a problem with the compliance office dealing with issues of accreditation because that is very similar to compliance," he asserts. "My concern is whether there are sufficient resources focused on compliance."

According to Murphy, all of these issues point directly back to the debate over the appropriate role of the compliance officer. He says one facet of that debate is whether the compliance officer position should be a stand-alone position or a position combined with other functions. "HHS [Health and Human Services] has taken the position that it is better to make it a stand-alone position, but my analysis is a little different," he says. "I would rather have a compliance officer with some clout, and any time you take a compliance officer and give him a narrow compliance/ethics function, you run the risk of marginalizing that person." ■

Successful compliance

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Coding and billing pose some of the toughest challenges, he says. But getting them right won't excuse problems that could arise in other areas of legal compliance.

Here are 10 key requirements that Yuspeh says hospitals should focus on to ensure effective compliance:

I. Formulate an easy-to-understand code of conduct. According to Yuspeh, hospitals are making a mistake if they fail to engage large numbers of their employees in the formulation of a code of conduct. When HCA created its original code and later revised it, the draft was distributed to various functional experts and management groups for comment and then placed on the company intranet so that staff at every level could comment.

Yuspeh explains that a legal compliance document, which had been prepared before he joined

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the company in October 1997, was a fair summary of some legal requirements but was difficult to understand. It was essentially a compilation of laws and regulations. The code of conduct now used at HCA reads at about a 10th-grade level.

II. Develop policies, procedures, and compliance aids for complex areas. According to Yuspeh, the second key requirement is detailed policies and procedures for technical areas that can't be covered in the code of conduct, including comprehensive instructions in areas such as physician relationships, laboratory billing, and cost reports.

HCA's inpatient coding manual is more than 400 pages, and its outpatient coding manual is about 200 pages. Yuspeh says both are intended to set a basic direction and establish internal standards. In addition, a set of overall coding policies includes an expectation that all inpatient coders have at least 30 hours of continuing education each year. Similarly, the cost report policies deal with the method of interaction between the department that prepares cost reports and the individual hospitals with financial management responsibilities.

III. Develop broad-based training. Yuspeh says a third critical requirement is some form of effective broad-based training. In fact, he says it should be standard practice to put core material in front of employees at least once a year. HCA's videotapes are predominantly case studies on issues such as confidentiality that are designed to focus attention and teach people how to reach decisions.

Yuspeh reports that HCA is also expanding its use of the intranet to deliver training modules in specific areas. He points to a refresher course HCA is developing for hospital managers in the area of antitrust that will be placed on the intranet and delivered with an automated tracking mechanism in order to ensure that certain individuals receive the training. Numerous other additional modules will be developed or purchased for Intranet presentation.

IV. Utilize other communications tools on a regular basis. HCA also has employed other communication mechanisms, such as posters, that are designed to consistently reinforce compliance messages. There are also regular conference calls with various managers and e-mails with tailored messages. These are analogous to the OIG's special fraud alerts. "These are used not necessarily because we've found a problem but more where we see an area of complexity," explains Yuspeh.

V. Establish internal reporting mechanisms that reflect proven elements. In order to establish intake coverage 24 hours a day, 365 days a year, Yuspeh says the only practical option is the use of an outside agency. But to make that effective, he says hospitals must provide the agency with detailed scripts explaining how to deal with people who might report a problem.

Yuspeh says that HCA has a team of people who triage cases and perform a case management function. Most matters are sent back to the hospital for investigation. If, however, a matter received by the ethics line were to involve senior management of the hospital, another means of investigation would be used. Eventually, a report is generated that determines whether or not the call was substantiated.

VI. Ensure effective employee discipline. One often overlooked area that Yuspeh highlights is employee discipline. He argues that employees will doubt the seriousness of compliance programs if questionable activity gets only a slap on the wrist. "That doesn't mean that every time you find an error in performance that employment is terminated," he adds. When the cause of the error was negligence and not intentional, something short of termination may suffice.

VII. Carefully plan and execute extensive internal audit and monitoring programs. According to Yuspeh, the HCA information systems staff is increasingly developing data management tools that permit HCA to perform real-time monitoring in areas such as DRG coding. To the extent that hospitals can move toward automated monitoring, they should, Yuspeh argues.

However, Yuspeh notes that monitoring may only identify an area of concern but not confirm any type of error. For example, coding for DRG 79 and 89 might not be consistent with national averages. "In and of itself, that does not mean that you are coding incorrectly," he warns. "It just means that for some reason there is a differential from that national norm." Nevertheless, the monitoring tool points you toward where there may be issues of coding concern, and then you can devote further resources to investigate those possible problems.

VIII. Establish an effective organizational

approach. According to Yuspeh, there is no single appropriate way to organize staff responsible for compliance. However, an effective organizational approach should always include an oversight committee, as well as some direction for the board of directors or trustees.

That structure should always include the concept of "responsible executives," he says, which basically means that responsibility for compliance should lie with those who are true functional experts. As an example, he says the head of health information management at HCA is responsible for coding compliance.

IX. Secure senior management support and involvement. Yuspeh says it goes without saying that hospital CEOs must understand that compliance reflects on their own stewardship. "If the CEO regards compliance as window dressing, that feeling will filter down through the organization and it will be difficult to get people to give it the necessary energy," he cautions.

X. Evaluate and assess failures, and correct problems. Finally, when problems are uncovered, Yuspeh says hospitals sometimes fail to do the two things required — return overpayments and fix the underlying problem. He says that he has heard of cases where an institution may only fix a problem for the future, and then notes: "I am sure that the government doesn't regard that as sufficient." Alternatively, hospitals may repay the overpayment but fail to uncover the underlying problem. For example, there may be a chargemaster error that generated similar mischarges that must be corrected. "You obviously need to evaluate those problems and correct them both in terms of past mistakes and future correctness," he concludes. ■

CIA agreements

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"quality" in the delivery of long-term care by requiring the company to adopt a comprehensive internal quality improvement program at the corporate, regional, and facility levels. The tentative deal resolves part of the government's $2 billion claim against the company alleging poor quality of care and billing abuses.

In addition to creating a quality assurance "infrastructure," Vencor must engage a team of independent monitors selected by the OIG, create a comprehensive internal quality improvement program to review quality-related data, direct quality improvement activities, implement and monitor corrective action plans, and retain an independent review organization to evaluate the integrity and effectiveness of the company's internal systems.

Health care attorney **Joe Bianculli** of Bianculli & Impink in Arlington, VA, says this agreement will not be the last of its kind. He points out that many long-term care companies are in bankruptcy and says the government has asserted a variety of financial claims against them. In order to resolve those claims, many of the companies must have their largest unsecured creditor, the federal government, at least acquiesce in the plan of discharge, he explains. But the government is not shy about its ability to use that leverage, warns Bianculli, who has represented several of these companies.

"There is no question that the OIG is making quality a significant part of corporate integrity agreements in long-term care and devoting a great deal of resources and attention to that issue," he asserts. "Nobody disputes that quality is a significant part of compliance in long-term care," he adds. "But the devil is in the details." ■

OIG advisory opinion rule sunsets in one week

Health care attorney **Sandy Teplitzky** of the Baltimore-based firm Ober Kaler, who was influential in bringing about the initial authorization for the advisory opinion process, says he is optimistic that the process will be re-authorized, perhaps as part of an appropriations bill.

However, he argues the process could be improved if the Office of Inspector General had 90 days, instead of 60, to issue its opinions. Likewise, he contends that it would be better to exempt requests from the Freedom of Information Act process.

Teplitzky argues that trade associations should be allowed to request advisory opinions on behalf of their members, which is currently prohibited. He also maintains that everyone, as opposed to just requestors, should be able to rely on the opinions that are issued and that a process should be created to address requests that are rejected. ■