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Investigators set to target poor quality of care

State and federal health care investigators find allies in private payers and peer review organizations

The Department of Health and Human Services' (HHS) Office of Inspector General (OIG) last week released its 46-page Workplan for FY 2001. But while providers would be well-served to scan the federal government's latest blueprint for combating health care fraud, it would be a mistake to limit compliance efforts to the areas included in the report.

OIG spokeswoman **Judy Holtz** warns providers not to read the document too literally. "The Workplan is only a road map of the things that are on our plate for the coming year," she explains. "It can change weekly or monthly, and many parts of it have not even been assigned."

Even so, one likely focus of state and federal prosecutors will be poor quality care, according to experts at the Philadelphia-based Health Care Compliance Association's (HCCA) recent meeting in New Orleans. "It is a big issue and it is going to get bigger," warns **Jim Sheehan**, Assistant U.S. Attorney in Philadelphia. As many hospitals reduce their staffing in areas such as nursing, Sheehan predicts the crackdown on poor quality already under way will intensify significantly.

In fact, Sheehan says, providers should brace for a convergence of compliance activity and the issue of quality in the coming years. He says investigations will encompass every area of the health care continuum, from managed care to nursing homes. "If you are looking to see where

*See **Quality of care**, page 2*

Compliance efforts still surging, HCCA reports

The rapid growth of health care compliance programs has not abated, according to the third annual survey of health care compliance officers released last week by the Philadelphia-based Health Care Compliance Association (HCCA). In fact, an estimated 71% of health care organizations now have an active compliance program in place, compared to 55% who reported an active program last year.

"I think we are seeing a virtual saturation in terms of programs being established, and that

*See **Compliance survey,** page 4*

Final physician guidance answers key concerns

The final compliance plan for individual and small group practices released by the Department of Health and Human Services' Office of Inspector General (OIG) Oct. 2 answers most but not all of the concerns raised by providers when the draft plan was published last June. The Englewood, CO-based Medical Group Management Association (MGMA) says the guidance is now "more realistic and doable," especially for practices that lack the extensive resources required to establish formal compliance programs.

"The final [version] is more flexible than the draft in that a lot of the 'should' language has been replaced with 'may' language," says health care attorney **William Saraille** of Washington, DC-based Arent Fox.

But not every concern has been answered, Saraille adds. For example, he says the OIG did not respond to concerns regarding the definition of small practice. However, MGMA spokesman

*See **Physician model plan**, page 3*

Quality of care

Continued from page 1

compliance is going to go, the issue of quality is on the radar screen for our office, the U.S. attorney system, the U.S. Department of Justice, and the OIG."

Sara Grim, CEO of the Missouri Peer Review Organization (PRO), says compliance officers would be well served to take note of the new role of PROs. "We are sort of the light side of the regulatory environment," she says. "But now that we have endeavored to go into the payment error prevention program, we also have a dark side."

Grim says compliance officers must begin looking for patient care compliance issues in unusual places. She cites a recent survey that found hospitals often fail to review same-day readmissions for premature discharge or billing errors. "[Hospitals] assumed that a same-day readmission review looked solely at utilization," she explains. "They did not look at premature discharge, and they did not look at billing."

Worse yet, fiscal intermediaries lacked the edits to catch same-day readmissions, much less something as simple as two hospitals billing the same-day readmission using a shared provider number. "That had been going on for 15 years, but nobody caught it," she asserts.

Grim contends that most quality-of-care issues aren't terribly complex, however. In fact, the most commonly identified problems relate to defects of process and defects of knowledge, such as poor quality assurance controls over established policies and procedures and inappropriate or inadequate written policies and procedures. She also cites poor communications processes between physicians and hospitals or health plans and an overall lack of accountability and responsibility within the health care system.

Vicki McCormick, corporate compliance officer for United Health Group in Minnesota, cautions providers that while payers do not typically make findings of fraud, they are increasingly targeting improper billing as well as quality of care.

McCormick points out that 38 states now have insurance fraud bureaus, 14 states require health care payers to have an anti-fraud plan, and eight states require special investigative units (SIU). There is overlap between the latter two groups, and some states also require an SIU if there is no anti-fraud plan, she adds.

On top of that, another 11 states now require annual reports on anti-fraud activity, and that number is growing, McCormick reports. "Even more importantly, 33 states require an insurer to report suspected fraud," she says. Meanwhile, another seven states now demand training to increase awareness, and that number is growing as well, says McCormick.

The potential trouble spots for providers are not limited to quality of care, however. High on Sheehan's list of growing compliance issues are the relationships of drug and device manufacturers with hospitals and other organizations. This is no longer a threat facing only research institutions such as the recent cases against Beth Israel in Boston and Thomas Jefferson in Philadelphia, he says.

Instead, Sheehan reports that across the country these relationships are receiving close scrutiny. If Congress passes a Medicare prescription drug benefit, the use of drugs in hospitals and physicians' offices is almost certain to become a "much hotter issue," he says. That includes financial relationships within these organizations and how they handle patients as well as how they approach quality issues in the research context, he adds.

Sheehan says that coding and billing systems, not only of providers but also insurers, represent another area that should not be overlooked. He says one of the most difficult issues right now is what he calls "electronic due process."

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Historically, claims submitted to insurance companies were systematically evaluated. But today many of those systems do not work well in part because they reject valid claims, he argues.

In fact, Sheehan argues that not paying for services rendered is just as fraudulent as billing for services not rendered. "I predict that in the next couple years we are going to see a significant growth in those kinds of cases," he asserts. The good news for hospitals is that will include not only how claims are adjudicated for payers but for providers. ■

Physician model plan

Continued from page 1

Aaron Krupp says that determining whether to make that assessment on the basis of employees, revenues or specialty would be no easy task.

Saraille also credits the OIG for trying to "operationalize" the guidance and offer practical advice about what steps should be taken and in what order, even though he says it is somewhat inflexible about what those steps should be.

For example, he notes the OIG suggests an internal audit as the first step. However, small practices and solo practitioners might benefit more from training that helped show where some of their associations may not be accurate.

Kimberly Brandt, senior counsel for OIG, emphasizes many of the same points regarding the final guidance. "It is voluntary," Brandt emphasizes. "It is not mandatory. It is optional, and it is at your discretion."

She contends that there was a "misperception" among physicians that the guidance was mandatory and there was a specific time frame under which they had to implement the various components.

Brandt zeroes in on three key features of the guidance. First, it is "very flexible," she says. It includes numerous options not only for how you implement the various components but whether they are implemented at all. "There is also an emphasis on the difference between errors vs. fraud," she asserts. "Lastly, there is an emphasis on the active application of compliance principles as opposed to having the formal process of compliance in place." ■

Eight rules for physicians in compliance programs

As hospitals work to implement the Department of Health and Human Services' Office of Inspector General (OIG) final compliance plan for individual and small group practices, **Mark Pfeifer**, vice dean for clinical affairs at the University of Louisville, says hospitals should anticipate considerable resistance on the part of physicians.

After several years of uncertainty, Pfeifer says the rules and expectations are now more evident. But there is still the challenge of changing physician behavior. "There is a real danger in this area if you are responsible for dealing with physicians, and we should not ignore that," he cautions.

According to Pfeifer, that danger stems from a difference in the perspectives regarding the OIG's physician guidance. On its face, the plan may amount to a formal set of policies, procedures, and regulations to prevent, discover, and correct fraudulent billing. But Pfeifer cautions that some physicians take a far more sinister view. To combat that impression and improve physician compliance, Pfeifer suggests that hospitals consider the following steps:

♦ **Leave the pulpit at home.** Pfeifer warns that teaching physicians compliance can get "very preachy very quickly," and instructing doctors to "do the right thing" is not enough. To be effective, he says, hospitals must appeal to physician's self-interest. At 6 p.m., when medical staff are sitting in a nurse's station documenting a Medicare encounter, messages that address the fate of the Medicare trust fund are likely to carry little weight.

♦ **Use data, not dictum.** Hospitals must learn how to use data to convince physicians about the values of compliance. Pfeifer says power comes from using data fragments to alter perceptions and generate appropriate responses.

Most physicians respond well to data, he argues, especially when it is may reduce their own risks, lead to value-added services, or save them money.

♦ **Promote enlightened self-interest.** In one sense, Pfeifer says "enlightened self-interest" is simply a nice name for selfishness. But he argues that the key to success is convincing doctors that

the program as well as the consequences are theirs and not anybody else's.

♦ **When dealing with physicians, be a hospice worker and not a surgeon.** Physicians will progress through compliance education at different stages and at different speeds, warns Pfeifer. "I suggest that we try to meet them where they are in those stages and try to teach them at that level," he says. "I see our role as helping physicians get through this and not trying to fix it."

♦ **Park it in neutral.** "[Physicians] will vote you off the island if you in fact sound too excited about all of this." He also warns against trying to be popular with physicians by trivializing the issue or joining "the fraternity of cynicism" that can develop. "Stay neutral," he urges. "That has been the secret of success in our institution."

♦ **"Don't just do something, stand there."** Pfeifer says hospitals should be slow to respond to the "inevitable absurd responses" from some physicians about certain facets of the compliance program. "You will hear longings for yesteryear," he says. But if hospitals become defensive about their compliance programs, it will be difficult to develop a culture of "organizational self-education," he warns.

♦ **"Spot your 800-pound gorillas early.** You do live in a world with high-powered players," says Pfeifer. "Spot them early and identify them." He says that means leaders in this area must be respected and have tenure. However, you should also seek to involve other physicians, ideally of the same specialty. "Some opponents we defeat, but there are others we work around, and some we simply try to outlive," he explains.

♦ **They have got to eat sometime.** Pfeifer says hospitals should not overlook practical steps either. Physicians spend most of their time speaking and giving opinions, he notes. "If you finish a meeting with physicians about compliance and they have not had a chance to speak, I would suggest that your meeting is a failure," he says.

Finally, Pfeifer says hospitals should use these suggestions to improve communications with doctors: 1) prepare to listen; 2) defer impossible one-on-ones; 3) run short, organized meetings; 4) keep it pragmatic; 5) use multiple small hints; 6) use humor and avoid sarcasm; and 7) schedule training during lunch or existing meetings. ■

Compliance survey

Continued from page 1

movement is still afoot," observes **Jeff Marr** of Walker Information in Indianapolis, who designed and implemented the survey. On the other hand, he says, the survey shows that having a plan in place and operating it effectively are often two different things.

HCCA's immediate past president, **Brent Saunders**, points out that even though 71% of respondents report an active program in place, 66% also report that program development and implementation is the biggest issue facing their organization. According to Saunders, that shows that while many compliance officers have been able to develop significant infrastructure, it is still a challenge to turn that infrastructure into a proactive system that mitigates problems before they pose major risk.

Saunders also points out that one of the top three goals among compliance officers this year is monitoring and auditing. In fact, the number of respondents citing that as a top goal has more than doubled from last year — 88% compared to 41%. The other top goals for this year included education and training (82%) and conducting effectiveness evaluations (72%).

Saunders adds that last year's survey reflected a shift away from "enforcement-driven" compliance to "process-improvement" compliance. "Now we see people trying to make the program effective," he says. "Hopefully, next year we will be increasingly benchmarking and assessing the effectiveness of what we have done this year."

Other key findings included in the HCCA survey include the following:

♦ 82% have developed a compliance officer job description (compared to 71% in 1999).

♦ 57% have stand-alone departments with budget responsibilities and staff.

♦ 39% of compliance officers qualify for incentive compensation (identical to last year) and 60% project a salary increase of 3% to 5%.

♦ 17% of the organizations responding are under a corporate integrity agreement.

You can obtain a copy of HCCA's 2nd Annual Profile of Health Care Compliance Officers on HCCA's Web site at www.hcca-info.org. ■