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Bush administration: Kinder and gentler to providers?

Health care leaders see chance for major restructuring at the Health Care Financing Administration

Health care executives harried by the previous administration's unprecedented crackdown on Medicare fraud and abuse issues already are sensing a sea change in the government's attitude toward and relationships with hospitals and other health care organizations. Many in the industry are pinning hopes on newly appointed Department of Health and Human Services (HHS) Secretary Tommy Thompson, who used his recent confirmation hearing to blast Medicare's "excessively complex paperwork" that he says "criminalizes honest mistakes" and drives providers from the program.

"Hospitals are drowning in a sea of government rules and regulations," **Gary Mecklenberg**, president & CEO of Northwestern Memorial Healthcare in Chicago, told the House Ways and Means Health Subcommittee this month. But like many others in the health care community, Mecklenberg now sees light at the end of the tunnel.

"There is definitely a new tone in Washington, and I think a lot of positive change is possible," says **Mary Grealy**, president of the Healthcare Leadership Council in Washington, DC. According to Grealy, that new tone already is reflected in the new administration's recent decision to revisit

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Feds outline attack on research abuse

Hospitals attempting to gauge the threats emerging from the government's increased scrutiny in the field of research are facing uncharted territory, warns **Stephen Hanlon**, who manages Holland & Knight's community services team in Tallahassee, FL. "I don't envy those who are charged with compliance in this area," he asserts. "Neither the time, resources, or mechanisms currently exist to get a good idea about what is really [happening] on the hospital floor."

Despite much talk about whistle-blowers and potential liability, the paramount concern for hospitals should be basic protections for human subjects

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How to use data mining to identify trouble spots

The increasing use of computer software by public and private payers to analyze data and uncover problematic trends in billing and reimbursement is fundamentally changing the fraud and abuse enforcement landscape. The good news is that providers can use these same "data mining" techniques technically to uncover problems on their own.

"The OIG and HCFA's [Health Care Financing Administration's] fiscal intermediaries are becoming more and more sophisticated in technology, just as we are," asserts **Bret Bissey**, chief compliance officer at Deborah Heart and Lung in Browns Mill, NJ. "I think this is a natural progression in the life cycle compliance."

The old way of looking for fraud and billing errors by examining samples and waiting for the hotline to ring is increasingly giving way to this technique, which lets payers and providers alike look at the breadth of claims rather than just a sample, says

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Bush administration

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HHS' final privacy regulation as well as recent Congressional efforts toward finding ways to ease the current regulatory burden and high costs of compliance confronting hospitals and other providers.

Grealy points out that hospitals now have a friendly face heading up the Health Care Financing Administration (HCFA) as well. Last week, Washington lobbyist Tom Scully was appointed the new HCFA Administrator, after a six-year stint at the Federation of American Hospitals in Washington, DC.

American Hospital Association (AHA) executive vice president **Rick Pollack** says Scully has the perfect mix of "real-world experience" and public service to bring about fundamental change at HCFA. Scully has worked at the Office of Management and Budget and on Capitol Hill, experience that gives him a Washington road map for executing real change, says Grealy.

That may be a good thing, because Pollack and his colleagues are pushing for fundamental reform. Testifying before the Ways and Means Health Subcommittee on behalf of the AHA March 15, Mecklenberg argued that HCFA must do a better job coordinating regulations issued by many different departments and providers should be engaged early to help make regulations more practical.

Mecklenberg said hospitals also should have the right to challenge "questionable" HHS policies that skirt established rule-making procedures. Currently, hospitals seeking judicial review of a regulation must knowingly violate Medicare law and risk exclusion, he explained.

But it doesn't stop there. The association also wants to see compliance costs factored into payment rates to account for complex regulations such as the Health Insurance Portability and Accountability Act of 1996, which alone will cost hospitals more than $22 billion to implement over the next five years, according to the AHA.

The Republican Congress may yet have something to say about that issue as well. At a third hearing on the subject last week, Rep. Billy Tauzin (R-LA), chairman of the Committee on Energy and Commerce, said that while drafting the privacy regulation was an arduous task, Congress still must find a way to make the final regulation more workable.

Gail Wilensky, who heads up the Medicare Payment Advisory Commission, appeared to bolster the AHA's arguments when she told the Ways and Means health panel that discrepancies in the program integrity portion of Medicare are now the greatest single source of provider frustration.

While local discretion in payment and coverage is one source of confusion, Wilensky said the larger problem is discrepancies in the policies and behavior among HCFA's central office, 10 regional offices, and more than 50 private contractors that carry out the actual payment, claims processing, and audit operations for Medicare, she asserted.

According to the former HCFA Administrator, the current environment presumes that billing may be incorrect or inappropriate. As a result, contractors develop a series of automated strategies that deny claims. But while this practice has limited the need to "pay and chase," Wilensky says it has also led to "an explosion of medical review policies" and a heavy reliance on documentation.

Worse yet, Wilensky contends that confusion over how to bill Medicare and fears of false claims allegations by HCFA and the OIG may be creating a pattern of "down-coding" among doctors and hospitals.

Wilensky says a more effective strategy would

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be to pay properly submitted bills and search for patterns of abuse based on statistical analysis. This shift in focus would mirror a change that began taking place among professional review organizations in the 1990s, when those organizations moved from a case-by-case retrospective review of medical records to a focus on "patterns of care" and "patterns of outcomes."

OIG Deputy Inspector General **Paul Grob** sharply disputed provider complaints, but added HCFA should have more flexibility in the ways it selects and works with contractors. He also suggested providers can expect an increase in the agency's use of contractors for specific program safeguard functions in areas such as medical review, fraud detection, and cost report audits.

Grob argued that more resources are needed for quality assurance reviews not only for the 20% of all hospitals that are not accredited by the Joint Commission, but for nursing homes, which are only surveyed once a year, and home health agencies, where surveys have slipped to once every three years. ■

Data mining

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Mark Rucci, vice president of the consulting group of NiiS/APEX Group Holdings Inc. in Princeton, NJ.

"Not only do providers make mistakes in billing, Medicare makes mistakes in paying claims," he warns. "Hospitals should not only be concerned with billing correctly, but getting paid correctly."

But while data mining takes a proactive posture by looking for patterns that might reveal underlying problems by itself, it rarely leads to proof of fraud or even a mistake in billing, Rucci adds. A second-level manual review is almost always required.

Rucci reports that private payers as well as Medicare and Medicaid increasingly are employing these techniques prior to releasing a check. For example, he says Medicare code edits are now looking for mutually exclusive procedures billed simultaneously as well as comorbidities and other requirements.

According to Rucci, most data mining occurs post-payment. That is when issues such as same-day stays surface because data mining looks at claims historically. Previously, a random sample of claims would be reviewed manually and followed by a more thorough review of targeted claims. "You get a thorough review that way, but only on a sample of claims," he says.

Increasingly, electronic audits review all transactions. But Rucci says that even the most sophisticated commercial software packages available handle only certain issues. "Even though it may include a long list such as upcoding and unbundling, they can't catch every possible thing that could be wrong with a Medicare claim," he explains.

"There is a definite movement and training program in this area that is well under way in the FBI [Federal Bureau of Investigation]," warns **Edward Peloquin**, director of the health care services department at Withum & Smith in Princeton, NJ. He says the FBI now is linking several commercial insurance companies with other databases and electronically mining those data to look for information on a national or regional basis, as well as sometimes between individual hospitals.

Peloquin says the FBI is employing this technique with the cooperation of special investigation units and others to review large volumes of data and then relate it back to individual providers.

According to Rucci, data mining now is being used to uncover a range of problems in addition to upcoding and unbundling. For example:

- **Duplicate claims.** Duplicate billing can take a variety of forms; sometimes bills are inadvertently submitted a second time, or interim billing for a long hospital stay results in overlapping bills. Data mining now is being used to run through a database of claims to examine the entire history of a patient to determine whether any services overlap.
- **Eligibility data.** Eligibility is a major issue for hospitals. Rucci says data mining can spot things such as over-age dependents as well as newborns, which sometimes are treated as a separate person on a claim. "You could actually have the same services billed once under the mother's name and once under the child's name and some unsophisticated systems won't catch that," he says.

Data mining also can run all claims paid and the service dates against the dates of actual eligibility. The search looks for claims for people not on the

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eligibility file, claims outside the period of eligibility, and claims for dependents.

♦ **Actuarial analysis.** According to Rucci, one of the purest forms of data mining is looking at data from an actuarial point of view. That involves separating claims into very fine service categories from intensive care to skilled nursing and looking for patterns of unusual activity.

"That is data mining at its purest," he asserts. "There may be too many of something or not enough of something given certain norms, and that may warrant looking into how those kinds of claims are being billed," he explains. "That can uncover billing or reimbursement issues or highlight problems in how services are bundled."

♦ **Utilization analysis.** Related to actuarial analysis is utilization analysis, which looks at data against historical patterns of the data themselves. For example, hospital data over a three-year period can be aggregated to uncover inappropriate payments.

"Payers and providers using this technique as an investigative tool alsoare getting smarter and realizing that when they get a data dump, they are not getting everything that they think they are getting," adds Peloquin. "That is one reason that we are seeing probe audits, and one of the reasons why there will be more data requests and less on-site confiscation of records and documents." ■

Research abuse

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who are part of clinical research, argues **David Hoffman**, Assistant U.S. Attorney for the Eastern District of Pennsylvania and one of the federal attorneys spearheading the government's effort in this area.

Richard Stern, senior counsel at the Department of Health and Human Services (HHS) Office of Inspector General (OIG), warns hospitals that while his office primarily devotes its attention to Medicare and Medicaid, it also has responsibility for the Food and Drug Administration (FDA), the National Institutes of Health, and other agencies.

"Unlike the FDA, we are not a regulatory agency," Stern explains. "But we certainly respond when allegations come to us regarding the expenditure of federal funds." Under a recent arrangement with HHS, the OIG also will be conducting the initial investigations of research misconduct that had previously been performed by the Office of Research Integrity.

Hoffman says the primary concern in almost all cases is potential harm to individuals as the result of fraudulent conduct. "However, the intent standard is very different for a criminal case and a civil case," he adds.

By and large, grant fraud cases usually are difficult to prosecute, especially if investigators are attacking scientific research itself, Hoffman says. That is because explaining specific scientific research to juries usually is no easy task, he explains. "You are not going to see a lot of those cases brought," he predicts. On the other hand, he says, jurors will clearly understand schemes that lie about results in order to gain notoriety or financial benefits.

Hoffman cautions anybody who signs a certification that he or she is at risk for potential liability. "You are certifying to the government that what you are saying to them is true and correct," he asserts. "So if you have no mechanism by which you check the accuracy of what is being said, than you are putting yourself on the hook." ■

HCCA agenda takes shape under new CEO

In order to keep pace with today's rapidly changing compliance environment, the Health Care Compliance Association (HCCA) named **Roy Snell** its first full-time CEO. HCCA president **Greg Warner** says the association's rapid growth and plans for the future made a full-time executive officer critical.

Formerly a senior manager at PriceWaterhouse Coopers in Minneapolis, Snell says he wants to improve member benefits and maintain HCCA's financial viability in part through expanded cost-effective local education and increased member involvement at the local level.

Another key issue the association is working on is measuring the effectiveness of compliance officers. In addition, HCCA plans to build on its certification program by providing a more advanced certification. ■