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OIG signals increased flexibility on integrity agreements

American Hospital Association continues to take a hard line on the proliferation of CIAs

Amid growing concerns about the costs imposed by corporate integrity agreements (CIAs) on hospitals and other health care providers, the U.S. Department of Health and Human Services' Office of Inspector General (OIG) got high marks for its July 30 roundtable aimed at coming up with solutions for the most onerous aspects of these agreements.

"It was a very positive interaction with a lot of dialogue and open discussion on a range of relevant issues," says **Bret Bissey**, chief compliance officer at Deborah Heart and Lung in Browns Mill, NJ, who attended the daylong roundtable in Washington, DC.

While the CIA process itself now is a few years old, Bissey says it still is very new to the industry. "It is such a new area that it has its own life cycle," he explains. "It is something that providers must adhere to culturally throughout their system."

According to Bissey, that includes educational and training requirements as well as coping with many expensive independent review organization (IRO) functions that often are difficult to measure. Complicating matters is the fact that reporting requirements and definitions included in CIAs are not well defined by the government.

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How to avoid home health survey deficiencies

If the Medicare home health prospective payment system (PPS) operates as intended, the Centers for Medicare and Medicaid Services (CMS, formerly HCFA) should have no reason to be concerned about patient dumping and patient abandonment, according to home health experts. Nevertheless, CMS has put out the word to state surveyors across the country to crack down on precisely those areas.

CMS wants to avoid overutilization as well as underutilization in home health services. However, veteran home health attorney **Elizabeth Hogue** in Burtonsville, MD, says finding that middle ground

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HHS dispels 'myths' about privacy guidance

Health care providers will be well-served to disregard many of the "myths" surrounding the U.S. Department of Health and Human Services (HHS) final regulation on patient privacy, according to **Linda Sanchez** of HHS' Office of Civil Rights and author of the agency's recent privacy guidance.

The first myth is that "extraordinary" activities will be required for heath care providers to be in compliance with the new rule, which now is scheduled to go into effect in April 2003, Sanchez told listeners to the Philadelphia-based Health Care Compliance Association's Aug. 8 audio conference on the privacy guidance.

Another myth is that health care providers still have a lot of time to come into compliance. Longtime privacy expert and health care attorney **Jim Pyles** says that while dispelling rumors about the final privacy rule is important, so is understanding that the new target dates for compliance are not

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Integrity agreements

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All of those issues were on the table, says **Gil Stone**, chief compliance officer at The Medical Center at Princeton (NJ), who was among the roughly 80 health care professionals who met with OIG officials. He says major topics of conversation included the role of IROs, statistical sampling, adopting other acceptable sampling techniques in addition to the OIG's software package known as RAT-STATS, and changing the sample selection size used by the OIG.

Also at issue was the cost imposed by those agreements, says Stone. One idea that was floated would allow some of the cost of a compliance program for a provider who is under a CIA to be included in the cost report. "Many of the costs that are not directly related to the CIA but are important to the effectiveness of a compliance program could be allowed," he explains. The hope is that the OIG will recommend that step in its final report, which OIG spokeswoman **Judy Holtz** expects to be completed in a matter of weeks.

Another point debated was the increasingly widespread use of CIAs, says **Anthony Boswell**, chief compliance officer for Laidlaw in Arlington, TX. Boswell says he warned the OIG that using CIAs for too many settlements actually undermines the process. "I would like to see CIAs implemented for companies that settle with the government for significant fraudulent issues, as opposed to mistakes or the acquisition of companies that have billing problems the parent company had little or nothing to do with," he asserts.

The Chicago-based American Hospital Association (AHA) takes a similar view. "For a provider that hasn't violated the law itself to learn that a later violation of the CIA may be grounds for termination from Medicare is extraordinary," AHA special counsel **Joseph deGenova** told the Senate Special Committee on Aging late last month. He says many member hospitals believe the OIG's increasing insistence on CIAs now is impeding voluntary disclosures as well as the resolution of billing disputes.

"We feel our CIA was unjustified," says **Mary Barrowman** of Montgomery General in Olney, MD, who attended the roundtable. She says the hospital mistakenly hired a physical therapist who was uncredentialed. However, when the hospital uncovered and self-reported the problem, it received the same penalties as several other home health agencies that never identified the problem on their own. The hospital was working with its fiscal intermediary to correct its cost report when the OIG moved in, reports Barrowman.

CIA training requirements are another costly issue, according to AHA. Typical agreements usually impose a mandatory minimum number of training hours per employee. "The emphasis on hours does not ensure that the training is productive or meaningful," argues deGenova. Instead, hospitals should have the discretion to conduct training in ways that they consider optimal, which might include a web-based tool as opposed to a two-hour lecture, he says.

AHA also objects to the requirement that the first wave of training must take place within 120 days after the agreement is forged, regardless of whether the actions investigated took place before the provider had a compliance plan in place.

Roundtable attendees say all these areas now are on the table. "Time will tell," says **Robert Pierce**, chief financial officer at Guardian Postacute Services in Corte Madera, CA.

CIAs have become a hot issue as they have proliferated over the last two years and increasingly have become an essential ingredient for

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providers under investigation to avoid exclusion from the Medicare program. Roughly 700 CIAs have been imposed, with about 400 of them still active. More than half of those 400 are with hospitals.

"CIAs are a day-in and day-out concern for some number of providers who are under them," says Pierce. But he says it is an area to which all providers should pay close attention. "Even if you are in the most compliant organization of all time, CIAs indicate what areas the government is concerned about and where they want focus, as well as the preferred methodologies for attacking some compliance issues," he says. ■

Privacy 'myths'

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likely to change. "You need to pay attention to it, and you need to pay attention to it now," warns Pyles of Powers Pyles in Washington, DC.

Health care providers who are banking on a further reprieve from Congress are making a risky gamble, he says. Pyles notes that one bill already introduced in Congress would delay the compliance date for the standards under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 until 24 months after they are issued. But even if that bill passes, it will not alter the effective date for privacy requirements.

Meanwhile, litigation has surfaced in several states challenging the scope of the final rule. But those legal challenges face an uphill battle because they are taking on the constitutionality of the act itself, he adds.

Sanchez further clarified several key areas:

♦ **Minimum necessary.** According to Sanchez, there was a great deal of angst among providers regarding the minimum necessary requirements. Many people did not understand this was a "'reasonable' standard," she explains. "Many people seemed to think this was an 'absolute' standard."

Sanchez says the general idea is that providers should be making uses and disclosures of information that are consistent with good practices that a "prudent professional" might exercise. She says that information can come from a variety of sources, and it is then up to providers to make sure it makes sense within their own facility.

♦ **Oral communications.** Another myth concerns the restrictions on oral communications, which are viewed by many as an entirely new policy. Sanchez says that's not the case and that HHS plans to provide further clarification regarding information that third parties might overhear.

"It was certainly not the intent that people be in violation of the rule if adequate safeguards have been put in place and minimum necessary [requirements] were followed," she says. If providers take "reasonable steps," they should be in compliance, she says. That means that entirely new configurations are not required, she adds.

♦ **Business associates.** "There is a lot of confusion regarding business associates," warns Sanchez. One myth that surfaces almost everywhere, she says, is that the entire privacy rule applies to business associates. "That is not the case," she counters.

The rule requires covered entities to use contracts to get assurance from business associates that they will properly safeguard information, says Sanchez. However, the safeguards required by that contract are much more restricted than what is required of covered entities themselves.

Sanchez says the other major question in this area is whether covered entities are liable for all the actions of business associates. She says a covered entity is not required to monitor the activities of a business associate, even though that might be a good business practice. What is required is for covered entities to take "reasonable steps" to cure any material breach of the contract, she explains. ■

HHA surveys

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can be difficult. "It is difficult, if not impossible, to articulate what is reasonable, necessary, and appropriate care in terms of national standards of care," she explains.

While surveyors may report allegations of patient dumping to fraud enforcers, Hogue says there are steps that home health agencies (HHAs) can take to avoid or address any deficiencies that

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may result in the survey process. She says the first step is to understand that surveyors now are more likely than ever to accept the word of patients and their families, especially in surveys based on specific complaints, without first verifying the facts with agency personnel.

For protection, she says agencies should assign at least one staff member to assist surveyors in finding information during the survey. "To the extent possible, these staff members should encourage surveyors to ask for what they need before they reach any conclusions about the agencies' compliance," she maintains.

When HHAs receive deficiencies based upon erroneous facts, Hogue says they must dispute those deficiencies and request that they be withdrawn. When agencies dispute survey findings but fail to provide corrective action anyway, their plans of correction will be rejected, she cautions.

Under PPS, Hogue points out that providers have fewer resources to provide uncompensated care, and HHAs are more likely to encounter instances when they must terminate services to patients. They also are increasingly exposed to professional liability when they continue to care for patients who are chronically noncompliant.

"Documentation is the key," says **Cynthia Hohmann** of Health Care Management Consulting, Inc. in Jacksonville, FL. She says it is imperative that HHAs properly inform the patient and family to avoid charges of abandonment. "For the most part, agencies are not abandoning patients," she explains. "In most cases, they are failing to properly document."

According to Hogue, providers who give patients reasonable notice prior to termination will not be liable for abandonment. She says staff members involved in the patient's care should hold a case conference that addresses the clinical condition of patients, their mental status, and the availability of alternative sources of care, among other factors.

"A reasonable notice period, unless a specified period of notice is mandated by state statute or regulation, is probably a maximum of three to five days for most patients," says Hogue.

After staff members agree on a reasonable notice period, patients and their physicians must be notified verbally and in writing, Hogue says. Given the relatively short notice period, written notice should be hand-delivered to patients and faxed to the attending physicians. "It is unnecessary to put alternative sources of care in place prior to discontinuation of services," she adds.

Another potential problem is care planning that is directed by reimbursement rates, according to **Bill Dombi**, vice president for law at the National Association for Home Care in Washington, DC. He cites concerns that some HHAs might be devising care plans based on a goal of achieving a certain profit margin on a per-patient basis. Using this approach, an HHA determines the projected PPS payment for a patient following the OASIS assessment.

For example, if the payment expected is $2,000 for the episode and the HHA wants a 10% profit, the care plan is structured to provide only the number of visits that involve a total cost no greater than $1,800.

"While this is not patient dumping, it is another illustration of the quality-of-care risks under the PPS incentives," says Dombi. He says this type of care planning is a recipe for malpractice litigation and survey deficiencies that could lead to termination of the Medicare provider agreement. ■

DRG overpayments decline

The U.S. Department of Health and Human Services' Office of Inspector General (OIG) reported last week that duplicate payments associated with the diagnosis-related group payment window have fallen dramatically. From November 1990 through December 1996, the national initiative recovered roughly $73 million from 2,800 hospitals. By contrast, the OIG identified only about $5 million of potential duplicate payments for calendar years 1997 and 1998.

The OIG also reported that Medicare allowed approximately $48.5 million for medically unnecessary, undocumented, and inadequately documented physical, occupational, and speech therapy for Medicare nursing home patients during the first six months of 1999, representing an overall error rate of 24.7%. The Centers for Medicare and Medicaid Services concurred with the OIG's recommendation to improve provider education and medical review. ■