COMPLIANCE HOTLINE™

THE NATION'S ESSENTIAL ALERT FOR HEALTHCARE COMPLIANCE OFFICERS

MONDAY
AUGUST 24, 1998

GAO dashes hopes for PATH lawsuit relief

A new GAO report has dashed hopes that teaching hospitals will see an end to PATH investigations any time soon. Despite criticism that hospitals were blindsided by shifting and unclear rules on teaching physicians, Congress' investigative arm has found that OIG is justified in its crackdown.

"HHS' OIG, in our opinion, does have a legal basis for applying the specific criteria used in the PATH [Physicians at Teaching Hospitals] initiative," concludes the report. "The fact that a physical presence requirement has not always been consistently communicated or enforced does not obviate the need for teaching physicians to document their personal involvement in services to legitimately bill Medicare."

And while GAO acknowledges that clear guidance for documenting evaluation and management (E&M) coding was not effective until 1996, the codes have been defined and instructions on their use have been available since 1992, the agency says.

Yet if PATH's legal basis is sound, its scope may not be. OIG's audit of Dartmouth-Hitchcock Medical Center "raises questions about the OIG's original intent to audit all major teaching hospitals," says the study. **(See related story on the DHMC audit in the Feb. 9, 1998 issue of *CH*.)**

The audit, which took 10 months and cost the hospital $1.7 million in direct and indirect costs, "was initiated with little indication that the institution was improperly billing Medicare." Auditors found a total of $778 in billing errors. Ironically, OIG had

*See **PATH report**, page 2*

OIG fires first shot at risk-based Medicare HMOs

After years of targeting fee-for-service providers, OIG has looked at managed care — and found that risk-based HMOs are overcharging Medicare for administrative costs. HCFA could save $1 billion per year if administrative costs were paid according to the "longstanding principle that Medicare will only pay its applicable or fair share of needed health care costs," says a recent OIG report.

*See **Medicare HMOs**, page 4*

New salary survey: Are you worth $82,000 per year?

That's the median salary of compliance officers, according to a new survey of providers by the Health Care Compliance Association and health care executive search firm Tyler & Company, Atlanta. But for many officers, compensation is even more handsome. A full 47% of compliance officers get bonuses of 10% to 19% of their salaries. Another 23% are eligible for bonuses of 20% to 29%. A lucky 6% earn more than $200,000 per year.

Eighty-six percent of respondents say they have an active compliance program, and 91% have a compliance officer. Only 3% of the providers outsource their compliance programs, according to the survey, which was sent to 200 hospitals and health care systems, of which about 20 responded.

Although the survey represents only a handful of providers, it offers a first look at this emerging

*See **Salary survey**, page 3*

PATH report

Continued from page 1

been warned by DOJ that Dartmouth had an excellent billing system, but OIG decided "that since they intended to audit every major teaching institution in their region, it made little difference to them which ones were done first," according to GAO.

Although OIG has backed away from its initial pledge to audit all 125 major teaching hospitals in the country, GAO argues that a "risk-based approach focusing on the most problem-prone institutions would be a more efficient use of these resources."

GAO also questions the severity of what the government saw as violations of teaching regulations. Though concluding that violations had occurred at the Philadelphia-based University of Pennsylvania and Thomas Jefferson, whose combined settlements totaled $42 million, GAO found that audit records did not support the OIG's assertion that teaching doctors had billed for days when they didn't work.

Audit work papers indicate that doctors may have been present when residents performed services, even if they didn't always document their presence. Similarly, GAO disputes the widespread and multi-level upcoding that OIG found at the two Philadelphia schools. "At one of these institutions, not only were few multi-level errors found by the OIG, but one physician accounted for about 70% of these multi-level errors," says the report. Though a multi-level discrepancy in E&M coding, say from a Level Three to a Level Five, might indicate abuse, a one-level difference might just be a legitimate difference in medical judgement.

GAO didn't directly criticize the Justice Department's extrapolation of one year's audit sample over five or six years. But the agency does conclude that if the investigations of Thomas Jefferson and the University of Pennsylvania had gone to court, "the extrapolations could have been challenged on the basis that they were not statistically sound."

Yet in the end, all these problems may be moot. GAO points out that it's the settlement that counts. Because every teaching hospital so far has settled with the government rather than fight it out in court, DOJ is free to negotiate whatever settlement conditions it chooses regardless "of the rules of evidence or methodological constraints."

And no teaching hospital is likely to risk incurring the full weight of the False Claims Act by fighting the government in court, says **Bob Dickler**, senior vice-president of the Washington, DC-based American Association of Medical Colleges.

In a response to the GAO report, HHS Inspector General June Gibbs Brown admitted that the OIG had overstated multi-level coding at the Pennsylvania schools, but said it had not made a difference in the PATH audits. She also endorsed risk-based targeting of schools, but said the OIG had no way of picking out the most problem-prone institutions. However, GAO believes the OIG can find enough information, such as carrier records that show a history of billing problems, to narrow the scope of the PATH program. ■

GAO slams Justice over its use of the False Claims Act

Another new GAO study cautions the Justice Department to move carefully before filing False Claims Act suits. The report, commissioned by congressional critics of DOJ's investigative tactics, acknowledges the health care industry's concerns regarding the use of the FCA.

"Hospital groups have raised legitimate concerns about how the Justice Department used computer data from various sources as the sole basis for alleging liability under the False Claims

Compliance Hotline® is published every two weeks by American Health Consultants®, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Opinions expressed are not necessarily those of this publication. Mention of Products or services does not constitute endorsement. *Compliance Hotline*® is a trademark of American Health Consultants®, a Medical Economics Company.

Editor: **Michael Peck** (703) 834-0910 (mpeck@erols.com)
Assoc. Managing Editor: **Russ Underwood** (404) 262-5536 (russ.underwood@medec.com)
Consulting Editor: **F. Lisa Murtha, JD**
Director, Control and Compliance Practice, Deloitte & Touche, Philadelphia

Publisher: **Brenda L. Mooney** (404) 262-5403 (brenda.mooney@medec.com)
General Manager: **Thomas J. Kelly** (404) 262-5430 (tom.kelly@medec.com)

Act," GAO concludes. It also recommends that providers be given time to analyze the data underlying a demand letter before the Justice Department threatens legal action. DOJ is already responding to those concerns through its new guidance to U.S. Attorneys as well as the formation of special working groups.

The GAO report can help hospitals in settlement negotiations with the government, says **Mary Greeley**, JD, senior Washington, DC counsel for the Chicago-based American Hospital Association (AHA). The AHA emphasizes the DOJ's obligation to back up its demand letters with clear data, as well as the obligation of fiscal intermediaries to give clear instructions. The AHA isn't yet sure whether the GAO study, coupled with the DOJ's guidance, offers hospitals legal grounds for challenging prior settlements.

The report includes the following topics:

♦ **The tiers of the 72-hour investigation.**

DOJ is using a multi-tiered system in its campaign against violations of the 72-hour rule, which bars hospitals from billing for outpatient services that were already paid for through inpatient payments. In New Jersey, for example, hospitals were divided into four tiers. Tier Zero included those with overpayments of $1,000 or less. They only repaid the overpayment plus interest. Tier One included those with fewer than .0676 errors per bed. They also avoided penalties. Tier Two hospitals had between .0725 and .1385 errors per bed. They paid a penalty of 75% of actual overpayments. Tier Three hospitals had between .1425 and .4592 errors per bed, and they paid a hefty penalty of 200% of potential overpayments and 100% of actual overpayments. As of April, 3,000 hospitals had received DOJ demand letters, of which 2,400 have settled for about $58 million. Of those who settled, 1,700 fell into Tiers Zero and One.

♦ **Possible problems with DOJ data in lab unbundling investigations.**

In Ohio, notes GAO, "some tests that in fact were identified on different days may have been identified as duplicates." However, Ohio settlements were usually based on hospitals' self-audits rather than data from U.S. Attorney's offices, says GAO.

In Texas, DOJ and the U.S. Attorney in Texas both told GAO demand letters should have been less aggressive, and more advance research was needed before auditing providers. Yet they also maintain that hospitals were always given additional time for an internal investigation if they requested it.

♦ **Questionable timing of OIG audits.** OIG says hospitals ignored several of its reports on abuse of the 72-hour rule, which prompted the agency to turn the issue over to the DOJ. But GAO found that hospitals weren't given much time to correct the problems in the audit reports. For example, the third report covered December 1987 to October 1990. The results of the second audit weren't released until August 1990. And the fourth audit prior to the DOJ investigation did find a substantial decrease in improper claims, though OIG claims that reflected better edits rather than any change in hospital billing practices. ■

Salary survey

Continued from page 1

profession. How new are compliance positions? Only 49% of compliance officers have held their positions for more than a year, with another 22% there for one to two years. But even as newbies, compliance officers are getting some respect. More than two-thirds of respondents are considered senior-level managers.

Also revealing is that 43% of providers say they don't have a job description for the compliance officer slot. That's a situation that should be rectified, says **Roy Snell**, president of the Health Care Compliance Association, a trade group for compliance officers based in Philadelphia. Compliance officers should write up a job description and present it to their organization, adds Snell, who is also a consultant at Deloitte and Touche. "It's a small protection. But it means that your entire team — including those you report to — will understand what your job is." That could prevent tensions rising during, say, an internal investigation.

The HCAA/Tyler survey also reveals that:

♦ **Compliance is a mixed profession.** Women account for 55% of compliance officers, compared to 45% for men.

♦ **Titles vary.** Only 55% of compliance officers actually have that title. The next most common title is executive or senior vice-president at 18%, followed by internal auditor at 9%.

♦ **Lawyers rule.** Experience as an attorney is the most valuable skill for a compliance officer, respondents said. The next most valued is CPA

experience, followed by health care consulting and human resources.

♦ **Staffs are small.** Two-thirds of compliance officers have a staff of two or less. Another 17% have three to five staffers. Administrative employees are the most common staff members, closely followed by CPAs, internal auditors, and coders.

♦ **It's an educated group.** Thirty-two percent of compliance officers have bachelor's degrees, while 33% have a master's degree. Lawyers are well-represented, with 14% of officers having a JD, while 11% have a CPA.

♦ **Compliance is a lonely job.** Though OIG encourages providers to have a compliance committee as well as a compliance officer, 55% of providers say the compliance officer's slot is a stand-alone position. The majority of the remainder have their officers report to a compliance committee. Meanwhile, 33% of respondents also say their compliance officers also report to the CEO, while another 22% report to the board of trustees. ■

Medicare HMOs

Continued from page 1

The problem lies in the Adjusted Community Rate (ACR) process, in which HMOs present HCFA with their estimated administrative and other costs of covering Medicare beneficiaries. If estimated costs are less than estimated Medicare revenue, HMOs are supposed to return the excess, cut premiums or offer more services. Yet the current system allows risk-based HMOs to pass on virtually unlimited administrative costs and vastly inflate Medicare reimbursement because there are no restrictions on using medical utilization factors to multiply costs, OIG concludes.

In one case, an HMO's ACR administration cost was "almost three times ($102.04 versus $35.11) what would be charged on the commercial side," OIG found. In another case, HCFA in 1994 paid 127% of a plan's administrative expenses.

Yet another HMO had 31% of its administrative expenses covered — even though only 8.9% of its enrollees were Medicare beneficiaries. After adjusting for the value of the extra benefits, OIG calculates the value of the excess administration payments at $446 million for 1994, $691 million for 1995 and $785 million for 1996. That's equivalent to 4.6% of the risk payments made to the health plans.

Most significant, however, is OIG's belief that HMOs know they're overcharging the government. In particular, the report notes that managed care plans are waiving the premiums they would normally charge for "extra" benefits. "One can only conclude that the plans are funding the extra benefits out of the excessive administration component," the report says. "If this is true, it indicates that plans are aware that the amounts that they submit for administration are inaccurate."

The Washington, DC-based American Association of Health Plans disputes that conclusion. AAHP spokesman **Don White** says the managed care industry billed in accordance with HCFA regulations and formulas, though he won't comment on the behavior of individual HMOs. In any event, the Balanced Budget Act cuts Medicare payments to HMOs by nearly $3 billion through 1999, adds White. "That far outweighs any alleged overpayments."

OIG does not recommend that HCFA merely cap payments, for fear that HMOs would try to garner extra payments by inflating the cost of providing benefits or offering benefits that beneficiaries would rarely use. Instead, OIG recommends capping both administrative payments and benefits.

Other recommendations include:

♦ **Forcing HMOs to justify administrative expenses in the same fashion as justifying medical expenses, which have more rigorous reporting requirements.** HCFA believes its current plan to revamp ACR reporting, as well as ACR audits mandated by the Balanced Budget Act, will help solve the problem.

♦ **Enacting legislation that would allow HCFA to recover excess payments.** That's an idea HCFA opposes. "HCFA believed the congressional intent with the changes brought about by the BBA of 1997 was that all savings should be passed on to the beneficiaries," says the report. "In addition, HCFA stated some HMOs are reducing the amount of benefits because of reduced Medicare capitation payments."

OIG counters that it's easier to ask for overpayments to be returned than to force HMOs to provide benefits that should have been offered. ■