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THE NATION'S ESSENTIAL ALERT FOR HEALTHCARE COMPLIANCE OFFICERS

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GAO denies compliance programs cut fraud

Hospitals struggle to get a handle on the direct and indirect costs of compliance, study finds

Based on a survey of 25 hospitals, researchers at the General Accounting Office (GAO) have concluded there's no evidence to suggest that compliance programs have helped to cut the incidence of Medicare fraud.

In its report, the agency did qualify its conclusion by pointing out that Medicare providers generally aren't required to report on these programs and even if they were there is no generally-accepted definition of what constitutes such a program. Even so, the Health and Human Services Office of the Inspector General (OIG) responded critically to the GAO's findings, claiming that compliance plans have "significantly advanced" corporate compliance with federal health care requirements.

As evidence, OIG cited a drop in improper Medicare payments from $23.2 billion in 1996 to $12.6 billion in 1998. The agency conceded that there is no "empirical evidence" that ties this decline to the growing number of compliance programs but argued it is "a significant contributing factor."

"We do believe that compliance plans are an appropriate tool to use," says OIG spokeswoman **Judy Holtz**. "That's why we're devoting so much time and energy into developing them for all of the various health care entities."

Congress recently asked the agency to answer three questions about these programs: How prevalent are they? How much do they cost? And how effective are they?

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HCFA delays OASIS — but operational issues persist

Last week, the Health Care Financing Administration backed off its requirement that home health agencies (HHAs) collect data using the controversial Outcome and Assessment Information Set (OASIS). A Special Alert, released April 27, effectively ended debate on the matter by announcing that HCFA has delayed the implementation of all OASIS collection and reporting requirements.

But at least one major operational question still looms: Should HHAs continue collecting these

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Measure effectiveness with internal audits

At a recent industry roundtable, government and private sector compliance experts were divided on how best to measure the effectiveness of hospital-based compliance plans.

"I don't think there is anything more difficult than assessing the effectiveness of compliance programs," says **Chris Idecker**, a partner with Ernst & Young in Atlanta, and a participant in the Government-Industry Roundtable in Washington, DC, sponsored by the Health and Human Services Office of the Inspector General and the Health Care Financing Administration. Idecker says that while it is relatively easy to assess the "inputs" to a compliance program it is extraordinarily difficult to measure the "output" of those resources. "I think it is almost nonsensical," he argues.

For example, while most experts acknowledge the value of conducting audits as a way to gauge effectiveness, there's sharp disagreement about

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There's no question that compliance plans are becoming standard in the industry. Indeed, a recent survey by the Chicago-based American Hospital Association shows 96% of all hospitals either have a plan in place or one in the works. And roughly 2,000 hospitals have agreed to implement certain compliance procedures to settle billing disputes under the False Claims Act, according to the GAO.

Only five of the 25 hospitals examined by the GAO had fully implemented their compliance program. But most of the hospitals also reported that they felt compelled to implement "more extensive compliance procedures" than those that are required by the Federal government.

In the study, the ability of hospitals to gauge the costs of these programs varied dramatically. In fact, 60% of the hospitals surveyed do not yet budget for compliance activities and most reported some difficulty distinguishing between direct and indirect costs. One direct cost many hospitals pointed to was annual salaries. But that figure ranged from $15,000 (10% of an executive's annual salary at a mid-sized hospital) to $2.5 million (four attorneys and staff at a large hospital system). The direct cost most frequently cited was audits. And that figure ranged from $17,000 to $3.8 million a year.

Evidence about the effectiveness of compliance programs was equally tough to come by, according to the GAO. The most direct measure of success is the prevention of improper Medicare payments. But lack of baseline data makes this difficult. Instead, the agency says the OIG will continue to rely on a variety of indirect measures such as refunds of provider-identified overpayments and self-disclosures as measures of success.

But even data for those two measures are anecdotal at best, according to the GAO. And if compliance programs are truly effective in preventing misconduct, the use of these measures will decrease over time rather than increase. In addition, the GAO reported that most of the hospitals surveyed do not view formal disclosure as a viable option.

According to the GAO, the "major intangible indicator" cited by hospitals is "an increased corporate awareness" of compliance. This awareness is reflected by frequent calls to compliance staff and hotlines for guidance. Likewise, almost all of the hospitals surveyed told the GAO they believe these programs will reduce their liability under fraud and abuse statutes. ■

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precisely what type of audit is best suited to the task.

Typically, providers use three types of audits: baseline or initial audits; proactive audits, which are usually based on risk areas identified by the OIG; and issue-based audits, which are triggered when providers discover a problem and attempt to determine its magnitude.

Idecker, for one, doesn't believe baseline audits always establish "a basis for demonstrating improvement and effectiveness. Baseline audits suggest that you can identify several major problems and correct them. But my experience is the exact opposite," asserts Idecker, who until recently was chief compliance officer for Medaphis Corporation in Atlanta. "When your compliance program is effective, you start finding more problems and more issues to deal with. That is the hallmark of an effective plan."

Idecker says it's possible for providers to educate staff about certain key aspects of compliance such as coding and then test those skills to measure improvement. "But the problem is that you are dealing with something that you don't know about," he explains. "Non-compliance can be the result of fraud or abuse or systematic errors but you don't know about them; otherwise you would

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Measure effectiveness

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stop them. Can you imagine demonstrating effectiveness by saying, 'We used to have 10% fraud and now it is only 5%'?"

Joe Murphy, Executive Vice President of Compliance Systems Legal Group in Haddonfield, NJ, says certain measures of effectiveness, like billing errors, can be used as a baseline. But he concurs with Idecker that this approach does not address fraud or many types of willful misconduct.

Several compliance officers also point out that when providers perform retrospective audits, they must decide how far back to extend the review. Because that's a difficult decision, many opt instead to focus their resources on establishing new programs and performing audits once those programs have been implemented.

According to Murphy, one of the techniques that can measure the overall impact of a program's effectiveness is what he calls "true compliance audits."

"These are not bean counting exercises," says Murphy. Instead, those with an understanding of compliance and the institution are given responsibility to review files and conduct direct interviews with staff, much as a government investigator would. "In my experience, there is no substitute for that approach," says Murphy. "There is no type of broad-based system that will match the return that you get from a true compliance audit." ■

(In the next issue of Compliance Hotline*, we'll explore the use of surveys to assess the effectiveness of compliance programs.)*

OASIS requirements

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data while HCFA completes the regulation even though the rule itself is on hold?

Some HHAs that have already incorporated the OASIS questions into their comprehensive assessment say they plan to continue doing so, says **Mary St. Pierre**, director of regulatory affairs at the National Association for Home Care, in Washington, DC.

These HHAs claim that if they don't use this opportunity to incorporate the OASIS questions into their comprehensive assessment, they'll have less time to become proficient once the rule does go into effect.

When that might be, HCFA is not yet saying. But most observers believe the agency will take at least several months to address the farther-reaching concerns that Congress and others have about the dimensions of OASIS.

Others argue, however, that there's little point in using OASIS now, since HCFA may be forced by Congress to eliminate many of the questions included in the current OASIS instrument.

"We are advising our members to continue collecting it," reports **Scott Lara**, Director of Government Affairs for the Home Care Association of America in Jacksonville, FL. But Lara adds that he believes the chances are good that HCFA will be forced to limit the scope of questions included in the data set. "I honestly don't expect anything in the next couple of months," he said. "But when they do come back to it, they are going to scale it down."

What is HCFA's advice? "Given that the instrument was designed to be useful to HHAs to assess and improve the care they furnish, they may wish to use the OASIS instrument for their own purposes," according to the Special Alert.

Linda Watts, Director of Quality Management and Health Information at Allacare in Birmingham, AL, says her company has already integrated the OASIS data into its comprehensive assessment and plans to continue using it. "We were using OASIS to do more than just collect information for the federal government," says Watts. "We were trying to improve our information on the functional health status of our patients over time."

On top of all that, legal questions persist, says **Tim Pyles**, JD, a partner with the law firm of Powers, Pyles, Sutter & Verville, PC in Washington, DC. For example, if HHAs do collect and submit sensitive mental health information to state agencies while the rule is suspended, are they violating state and federal laws that prohibit the disclosure of this confidential information?

"Just doing this to practice is not a very wise approach unless you really do need it for the patient's diagnosis and treatment because patients do have rights in this area," warns Pyles.

OASIS requirements

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"This is particularly true if the federal government is not requiring you to collect the information and you go ahead and collect it anyway."

Mandatory collection of OASIS data by all Medicare-certified HHAs became effective earlier this year. But last week HCFA conceded that in order for this mandate to be "valid" it must first clear a several more regulatory hurdles including the Paperwork Reduction Act.

In the meantime, HCFA said it is not requiring HHAs to encode and transmit OASIS data and added that HHAs that have not met these requirements to date will not be considered out of compliance.

Confusion over the status of OASIS data collection bubbled to the surface after HCFA announced on April 7 that it had postponed the April 26 date that HHAs were supposed to start transmitting OASIS data to state agencies.

But that confusion reached fever pitch in recent days as various HCFA officials began signaling that the agency realized it had not met all regulatory requirements.

The home care industry has been protesting the size and scope of the OASIS data set for months. It argued that collection of these data should be limited strictly to Medicare patients and that HHAs should be adequately reimbursed for doing so.

Meanwhile, HCFA maintained that it developed OASIS, a hefty 19-page question set that Medicare-certified HHAs were supposed to administer to all patients, because it needed these data to improve the quality of care and ensure consistent payments rates across the country.

However, after the extent of the OASIS collection requirements were splashed across the front-page of *The Washington Post* in March and Congress began to weigh in against it, the pressure on HCFA started to become unbearable. That story outlined the sensitive nature of the questions patients would be asked such as suicidal tendencies and the status of their personal finances.

The timing could not have been worse for HCFA, as patient privacy legislation continues to gather speed on Capitol Hill. ■

National task force makes nursing homes first target

At a closed-door meeting last week, the National Health Care Fraud and Abuse Task Force convened for the first time, and the first item on its agenda was nursing home fraud. According to **Chris Watney**, a spokeswoman for the Department of Justice, quality of care issues at nursing homes will be a particular focus of the new task force, which is composed of top officials from federal, state and local law enforcement agencies. Federal agencies represented at the meeting included the Department of Justice, the Office of the Inspector General and FBI as well as the National Association of Attorneys General and the National District Attorneys Association.

The task force will focus on a full range of issues including procedures for the coordination of enforcement efforts that impact multiple jurisdictions and the use of information technology to detect and combat fraud, reports National Association of Attorneys General spokeswoman **Maureen Thompson**.

But coming on the heels of a range of administration anti-fraud efforts targeted at nursing homes, that industry can only wonder what lies around the next corner. "These are areas that have been the focus of heightened regulatory attention for some time," says **Howard Sollins**, JD, with the law firm Ober, Kaler in Baltimore. "One of the most important things facilities must realize is that regulatory agencies may seek to cooperate with each other but the basic route to demonstrating compliance is still through the HCFA survey process."

While other agencies are often looking at broader issues, Sollins adds, it's still the survey and certification process that is the trigger for heightened scrutiny on quality of care issues. "The best thing facilities can do is have strong quality improvement process in place that identify and fix problems," advises Sollins. But Sollins also notes that facilities sometimes rush to allege compliance as early as possible because they are fearful of civil monetary penalties and other remedies such as a ban on payment for new admissions. "It is also important for facilities to put permanent measures in place and allege compliance when they know that the compliance can be maintained," adds Sollins. ■