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MONDAY
JULY 26, 1999

HCFA on track to beef up oversight of hospitals

Agency eager to correct 'major deficiencies' cited in four-part Inspector General report

The Health Care Financing Administration (HCFA) isn't wasting any time addressing the "major deficiencies" and "significant weaknesses" detailed in the Department of Health and Human Services' Office of Inspector General's (OIG) four-volume report on the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and state agencies. That report was released last week following an exhaustive two-year examination by the OIG **(see Special Alert, "HHS IG blasts JCAHO's oversight of hospitals; reforms coming," July 20, 1999)**.

Congressional sources say the OIG's report is also likely to breathe new life into recent legislation introduced by Rep. Pete Stark (D-CA), the ranking Democrat on the House Ways and Means Health Subcommittee, that would make major changes in the accreditation process **(see related story, below)**.

Eager to counter the litany of shortcomings outlined in the report, HCFA has already completed a not-yet-public "detailed action plan" to follow the four-point action plan included in the report. HCFA spokeswoman **Michelle Robinson** confirms that HCFA's new Conditions of Participation (COP) will be released this fall but added that it is "still very much in draft form." She also says there is "no timetable for the development of performance measures because that is still very much in a preliminary phase." According to Robinson, many of the performance measures will be

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OIG's report on JCAHO likely to stir Congress

The Department of Health and Human Services' (HHS) Office of Inspector General's (OIG) damning assessment of the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and state agencies may not send shock waves across Capitol Hill. But tremors are likely, say congressional sources.

Leading the charge will be Rep. Pete Stark (D-CA), the ranking Democrat on the House Ways and Means Health Subcommittee. Last month, Stark introduced legislation aimed at reducing conflicts of interest in accrediting agencies that review quality standards for Medicare-participating hospitals.

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Congress blasts HCFA's oversight of private carriers

House Commerce Committee Chairman Tom Bliley (R-VA) charged the Health Care Financing Administration (HCFA) with vastly underestimating the level of fraud in the Medicare program and vowed to initiate major changes in the agency's oversight function. Bliley's assault came on July 14 as General Accounting Office (GAO) investigators told his committee that HCFA's lackluster oversight of its 64 carriers is wasting billions of dollars and jeopardizing the integrity of the $217 billion Medicare program.

Bliley's latest attack on HCFA is part of a wide-ranging inquisition into HCFA's oversight of its Medicare, Medicaid, and private carriers. "HCFA is still failing to provide effective oversight of its contractors," asserted Bliley.

He said the new evidence uncovered by the Health and Human Services' (HHS) Office of Inspector General (OIG) proves that "the real figure is probable far higher" than the $12 billion in Medicare fraud the agency consistently touts. In reality, he said HCFA has made little effort to

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Hospital oversight

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derived from the Peer Review Organization (PRO) quality improvement projects currently underway.

HCFA's Hospital Quality Oversight Plan or action plan lays out four broad objectives:

One is "improving oversight of the JCAHO's activities." Specifically, the agency says it will consider supplementing or replacing current validation surveys with observation surveys that would be conducted concurrently with the accreditation survey. These surveys, Robinson adds, should look at both the JCAHO onsite performance and the ability of the hospital to meet COPs.

Addressing yet another OIG criticism, HCFA says it will "work with the JCAHO to set its annual survey priorities" for the Commission's surveys. "If HCFA were to work with the JCAHO today," Robinson says, "HCFA's priorities would be to focus on medication errors, complications from medical errors and patient falls."

Also included in HCFA's preliminary blueprint for JCAHO are these items:

- More unannounced surveys.
- More random selection of records.
- More "contextual information" about hospitals provided to surveyors.
- More rigorous assessments of hospitals' internal continuous quality improvement efforts.
- Greater capacity of surveyors to respond to complaints within the survey process.

A second objective is to "strike a balance between both the quality improvement approach and the regulatory approach to hospital oversight." The agency says the preamble to the final COP will make it clear the agency does not plan to abandon its regulatory role. While founded in a "collegial approach," says HCFA, "JCAHO performs onsite surveys, which may serve as the basis for regulatory actions."

The agency says it will also make it clear that it views Peer Review Organizations that operate "in a largely penalty-free environment" —and not JCAHO — as its agent to advance the quality of care in the hospital environment, "even though the JCAHO considers itself as having a similar role."

According to HCFA, future data-driven systems of hospital quality oversight will foster both "quality improvement activities" and "the enforcement of minimum quality standards." The agency adds that it is committed to publishing data on hospital performance. But Robinson says there is no anticipated timetable for posting information on the Internet or elsewhere.

HCFA says it will also redesign the survey data system — OSCAR — either by linking it to JCAHO's accreditation survey data system or expanding it to include data on JCAHO data survey results, complaints, sentinel events and performance measures.

The agency's final objectives are to re-evaluate its oversight of state agencies and develop clear criteria for their performance and also to establish a more frequent survey cycle for non-accredited hospitals.

JCAHO responds

How quickly the Joint Commission will move to implement each of these measures is still open to question. "I know the Joint Commission is working very hard to change some of the accreditation process," says the New Jersey Hospital Association's **Judy Finlin**. She points specifically to the continuous survey readiness process, which has now been tested in several states. "That is another way to determine whether the process works or doesn't work," she says. "Instead of coming in once every three years,

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they come in and look at part of it every quarter."

"One of the complaints everybody has about periodic survey processes is that everybody ramps up when they know they are going to be looked at, and then things slack off in the interim," adds Finlin.

On that point, JCAHO is likely to provide little resistance, according to JCAHO spokeswoman **Janet MacIntyre**. The Joint Commission currently performs an on-site evaluation at a minimum every three years. "Most often there is some sort of follow-up in between," she adds. "But it isn't enough that when the Joint Commission comes on-site for that three-year evaluation that everything is in compliance. We want to see some documentation and some evidence to back it up."

Likewise, MacIntyre says JCHAO plans to introduce randomized selection of medical records, credentials files and personnel files for review.

According to MacIntyre, JCAHO also supports standardized performance measures. But like her counterparts in the hospital community, she says this area is extremely complex. The Joint Commission started introducing performance measures "with the idea of getting everyone on the same track," she explains. But she adds that JCAHO's overly broad measures have weakened that system. "We have allowed a lot of flexibility, and let hospitals choose from a very large pool of measures which things they want to measure and collect data on," she concedes.

That is going to change, she warns, so that the Commission can make meaningful comparisons. "Right now you can't," she flatly says. "You may have 300 hospitals that have all decided they are going to measure C-sections but they may measure them in different ways."

MacIntyre says there is no current timetable for implementation of these measures, but adds it will likely takes place "over the next few years." The Joint Commission recently announced some of the initial areas that will be examined but specific measures have not yet been selected.

She says the Joint Commission is also "taking a hard look" at adverse events. "The IG actually cites the way the Joint Commission is handling this in their report," she notes. According to MacIntyre, JCAHO is encouraging accredited facilities to notify the Commission when adverse events occur in order to share that information with other facilities and reduce risk.

Other measures already under way include a new toll-free consumer complaint hotline and the establishment of a Public Advisory Group. MacIntyre says the Commission is looking for up to 20 people from a variety of organizations. ■

Carrier oversight

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measure the full scope of waste, fraud, and abuse in the Medicare program.

Bliley was not alone in his condemnation of HCFA. HHS OIG Deputy Director George Grob revealed to Bliley's committee that in addition to the nine civil settlements and two criminal convictions his office already has under its belt, that office is now actively investigating no fewer than 21 former or current contractors.

Grob told the committee his office has found significant weaknesses and vulnerabilities throughout these operations. "Of all the problems we have observed," Grob asserted, "perhaps the most troubling has to do with contractor's own integrity, [including] misusing government funds and actively trying to conceal their actions, altering documents, and falsifying statements that specific work has been performed."

In some cases, Grob said contractors used "bogus documents to falsely demonstrate superior performance for which Medicare rewarded them with bonuses and additional contracts." In other instances, carriers simply turned off system edits designed to prevent inappropriate payments. He highlighted several examples that he added, "are not isolated cases." For example:

- Between 1985 and 1997, Health Care Service Corporation altered documents and manipulated data in order to improve its performance review. Last year, the carrier agreed to pay $140 million — the largest civil fraud settlement to date — to resolve its liability under the Civil False Claims Act and the Civil Monetaries Penalty Law, as well as a $4 million criminal fine for obstructing a criminal audit and related charges.
- XACT Medicare Services of Pennsylvania agreed to pay $38 million last year after a joint investigation by the OIG and other federal agencies discovered that the carrier was rigging samples for

HCFA audits, failing to recover overpayments and other fraudulent activities.

The GAO followed Grob's testimony with the release of two separate reports that shred HCFA's glowing self-assessment about its war on Medicare fraud.

"HCFA's oversight of Medicare claims administration contractors has significant weaknesses that leave the agency without assurance that contractors are paying providers appropriately," concludes the June 14 report. "HCFA still does not regularly check contractors' internal management controls, management and financial data, and key program safeguards to prevent payment errors."

In fact, HCFA's headquarters does not even set oversight priorities, says the GAO, but instead cedes that responsibility almost entirely to regional office reviewers.

HCFA has begun to take steps to improve its oversight, but the GAO concludes it is too early to tell whether those measures will address the fundamental problems.

In a separate report, the GAO points out that every major investigation by the OIG, FBI and U.S. Department of Justice that it reviewed were triggered by the filing of a qui tam action by a current or former employee. In none of these cases had HCFA detected the contractors' fraudulent activity. GAO says the reasons for this are manifold:

- HCFA gave contractors advance notice of performance evaluation reviews as well as specific or probable records that would be reviewed.
- HCFA relied on copies of documents that were altered and recopied without detection.
- HCFA representatives are often "too close" with contractors and "lose their objectivity and ability to conduct meaningful reviews."

Penny Thompson, Director of HCFA's Program Integrity Group, was quick to point out that the agency has been proposing sweeping reforms that would increase competition among contractors for six years.

In short, Thompson says the agency wants explicit authority from Congress that would let it choose its intermediaries, contract separately for specific functions and use payment methods that would allow contractors to earn profits on their Medicare business.

In the meantime, Thompson says HCFA is taking several immediate steps including contracting with an independent public accounting firm to develop standard review procedures, implementing a new management reporting system, and developing a business strategy for Medicare fee-for-service contractor operations.

A spokesperson for the Commerce Committee says no legislative remedy to the problems uncovered by the OIG and GAO is imminent, but signaled that scrutiny of HCFA's oversight is likely to intensify in the months ahead. ■

Stark bill

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There is often "a serious conflict of interest" between the mission of accrediting agencies and their internal governance because the majority of members on governing boards are often "representatives of the very industries that the agency accredits," argues Stark.

Stark's bill — the Improvement of Medicare Accrediting Entity Act of 1999 — would require that a simple majority of the accrediting agency's governing board consist of persons approved by the Secretary of Health and Human Services (HHS) and without a financial interest in the agency or the facilities that it accredits. The bill also stipulates that meetings of the governing board be open to the public.

"Stark is going to agitate on this given the OIG reports because there are some very troubling aspects in there," says a senior aide to Stark. "Not only do the surveyors tell hospitals they are coming ahead of time, but they tell them what files they are going to ask for."

The aide predicts that if Congress passes substantive Medicare legislation this year, the chances are strong that some of the OIG's concerns will be addressed in that bill.

It will be an uphill fight, the aide adds, but the OIG's report improves its chances. "It is a very strong set of reports and whether it is administrative action or hearings to 'jawbone' the issue or an amendment in a bill is not clear; but I think there will be some congressional action," concludes the aide. ■