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Top Ten Upcoming Compliance Challenges: Putting Your Money Where Your Risks Are

Compliance is not for the faint of heart, with the deluge of program-integrity contractors, transformation of payment systems and crackdowns on nonprofits. It may feel less daunting if compliance officers prioritize their risk areas and take the long view when addressing them.

Boston attorney Larry Vernaglia described the top 10 compliance challenges that hospitals will tackle during the coming decade. "It sounds like a long time, but it's not really in the life of a health care organization," says Vernaglia, with Foley & Lardner LLP. "It may take 10 years to get value-based purchasing [institutionalized] or for accountable care organizations to be more than a pipe dream. And liability under the False Claims Act accrues over 10 years."

Here are Vernaglia's top 10 challenges for the next 10 years, which he says are interrelated:

(1) Quality-based payment liabilities: The health reform law is helping speed "transformation" of a payment system that's based on quality instead of volume through value-based purchasing, ACOs and Inpatient Quality Reporting, which are dependent on interoperable electronic health records, Vernaglia says. "There is a recipe for compliance disaster here. The rules are changing rapidly before regulators and providers know how to deal with them. They are building the car as they are driving it down the street," he says. Despite the "massive financial consequences, there's little compliance apparatus and expertise." For example, CMS bases payments partly on patient outcome and satisfaction measures. "If people make innocent mistakes or individuals figure out how to game the system before it's implemented, that could have great impact," Vernaglia notes. "No one will have safeguards and auditing protocols for a while." *Recommendation:* When hospitals address quality-based payment initiatives, they should include compliance officers with care managers, clinicians and the others. "Get compliance people to think about how to test systems on the front end. There is a lag time between the creation of problems and the discovery of problems and you can shorten it," Vernaglia says. Compliance officers can be the experts in testing for errors in the quality data that are used for Medicare payments, even if they're not experts in generating the data.

(2) Individual liability: Enforcers are increasingly focused on people involved in alleged fraud, not just on the organizations. "The government sees it as an effective way to deter bad behavior," Vernaglia says. If organizations pay millions in damages but violations persist, Medicare watchdogs assume excluding the puppet masters from Medicare or putting them in jail will get the message across, he says. So far, the focus has been on "the real bad guys"; the Department of Justice-HHS "HEAT" initiative has lead to prosecutions against dozens of alleged fraudsters. "But over the next 10 years, the feds will start excluding or putting away not-real-bad guys in greater numbers," he says. Also expect to see executives and board members face the music under the "responsible corporate officer's doctrine," which holds that a director, officer, or employee can be held personally liable for a corporation's civil liability under certain circumstances. *Recommendation:* When trouble is brewing, senior leaders may be inclined in this environment to look out for themselves at the expense of the organization, so the board may need independent counsel.

(3) Overpayments, the 60-day repayment mandate and the False Claims Act: The 60-day rule — which requires providers to return and explain Medicare and Medicaid overpayments within 60 days of identifying them — "is the most dramatic change in the enforcement regime in the past five years" and is already affecting compliance programs *(RMC 7/4/11, p. 1),* Vernaglia says. Compliance departments are focused on this mandate almost to the exclusion of other responsibilities, such as training. "They are obsessed with refunding overpayments before they do the research," he says. CMS could ease the burden in future regulations spelling out the 60-day rule, Vernaglia says. *Recommendation:* Beat this beast into submission. "The best organizations are squarely confronting this law now. They are having

teams of folks actively thinking about how to interpret this law," he says. For example, how can you turn on alarms so problems don't sit too long? You want to set a process in motion when a problem is identified so it can be quantified, understood and explained — not shoved to the bottom of a pile on someone's desk.

(4) Recovery audit contractors (RACs) and other contingency-fee auditors: If they recover enough money for CMS (see box, p. 4), then Medicare and Medicaid RACs will loom over the program-integrity landscape for the next decade. But it won't be the same old, same old. More reviews may be performed remotely. "It's Revenge of the Nerds," Vernaglia says. "In the future, we will find a lot of [audits] won't be based on medical records. There are plenty of databases that Medicare is pulling from and more information is generated electronically, so RACs sit at their desks and send overpayment determinations. It's less labor intensive. If they want money, they will do it the easy way." Imagine RACs using databases to identify certain errors, such as quality-reporting inaccuracies or improperly enrolled providers and the services they referred. Meanwhile, RAC activity will spur more activity from Medicare administrative contractors (MACs). "MACs will get more aggressive because they don't want to look bad when RACs find errors, especially when [MAC] contracts come up for renewal," he says. Commercial payers have also adopted the contingency-fee model. "This is a dangerous and inherently error-prone business method, but it is here until legislators shut it down or providers deliver a few serious blows against the auditors in litigation," he says. *Recommendation:* Beware MAC adjustments stemming from RAC overpayment identifications because you might get hit twice. Vernaglia says hospitals have voluntarily returned money pursuant to the 60-day rule, only to have the RAC ask for the money back for the same error. The hospitals have to prove they already made Medicare whole.

(5) Medicaid compliance: This area will pick up as state governments and the feds look for revenue and state and federal False Claims Act enforcement hits Medicaid. Not only are CMS's Medicaid integrity contractors doing their thing (slowly), but Medicaid RACs will get to work this year. "As soon as you give bounty hunters incentives to find problems, they will find them," he says. *Recommendation:* Shake things up to change the fact that "organizations with equal numbers of Medicare and Medicaid patients have vastly more information about Medicare compliance than Medicaid compliance."

(6) Health information privacy and security: While the HIPAA rules are old news, leakage of sensitive information will get worse in the future as it's shared across and outside health systems (e.g., among ACO players). Lewis Morris, chief counsel to HHS Inspector General Dan Levinson, emphasized this point during a July 12 hearing in the Senate, where he testified on harnessing technology to fight health waste and fraud. Although it's an exciting frontier, he also cited the risks to electronic health and financial data. "CMS and state government data centers process hundreds of terabytes of data each month. To put this in perspective, a terabyte is equal to 220 million pages of text. This vast amount of data is transmitted with varying degrees of control and oversight. Trends show that health care data, including beneficiary and provider information, are stolen and sold by organized crime rings or individuals. Provider and/or beneficiary information is being compromised by social engineering schemes such as phishing emails. Data breaches of public and private entities have been occurring worldwide at an alarming rate. And the attacks are becoming increasingly sophisticated and stealthy," Morris told a subcommittee of the Senate Committee on Homeland Security & Governmental Affairs. *Recommendation:* Compliance officers, who are well-versed in HIPAA, must think more broadly about the risks of EHRs and other HIT.

(7) Provider enrollment: There's a disconnect between the government's fixation on enrollment as a fraud prevention and enforcement tool and providers' cavalier attitude about it. Vernaglia says the completion and updating of Medicare enrollment forms tends to be assigned to lower-level workers. "It does not have the attention of higher-level people," he says. It should, he notes, because the stakes are high. CMS can yank Medicare provider numbers for failure to inform Medicare contractors of certain information, such as changes in board members or addresses. "This will be a source of risk in the future." The health reform law empowered enforcers to use enrollment and payment suspension to protect Medicare and CMS regulations making the most of this *(RMC 9/27/10, p. 1). Recommendation:* Develop new policies and procedures for enrollment form completion and oversight and implement protocols that enable your organization to identify errors on the front end, especially as health systems shape-shift, Vernaglia says.

(8) Conflict-of-interest law enforcement: "There will be continued interest in the overall notion of conflicts influencing referrals," he says. Stark and kickback enforcement is one arena, and landmark cases are still pending against Tuomey Healthcare System in South Carolina and Bradford Regional Medical Center in Pennsylvania *(RMC 3/21/11, p. 1).* Another intriguing area involves potential board member conflicts at

nonprofit organizations. A dramatic case just unfolded in Massachusetts, where Attorney General Martha Coakley investigated nonprofit Blue Cross Blue Shield of Massachusetts after it gave the outgoing CEO $4.6 million in severance pay. "The investigation found that, under the terms of his contract, [CEO Cleve] Killingsworth was entitled to a significant payment upon his termination or non-renewal unless his removal was a result of intentional misconduct. Factors such as unsatisfactory performance and poor management or negligence still did not relieve BCBS of the legal obligation to make such a significant payment. The investigation found that contracts with similar provisions are held by the chief executive officers of other major health care organizations in Massachusetts," according to the state AG's office. After the investigation, Blue Cross Blue Shield board members refunded the same amount to its ratepayers. Vernaglia says the suspicion is that board members aren't fully independent when management makes decisions about their compensation. To address these problems, Coakley filed legislation to allow the AG's office to prevent a charity from paying its board members "without justification," according to a press release. Already, two health plans have voluntarily stopped compensating their board members. *Recommendation:* Nonprofits that pay their board members better think this through, Vernaglia says.

(9) Board involvement in compliance: "The government says boards need to be more on top of compliance failures. When they let management run amok, they are failing at their duties," Vernaglia says. "This issue has been brewing for some time." For example, OIG has made it clear that it will use its permissive exclusion authority to throw owners, officers and managing employees out of Medicare if their entity is excluded or convicted of certain offenses *(RMC 11/1/11, p. 1). Recommendation:* Board training is essential. Compliance officers must teach board members what questions to ask about the compliance program and risk areas.

(10) Nonprofit tax issues: Tax exemptions for nonprofit hospitals face increasing scrutiny. As more hospitals (e.g., Detroit Medical Center) are bought by for-profit companies, questions are raised about whether there are meaningful differences between hospitals that pay taxes and hospitals that don't. At the same time, nonprofits may jeopardize their exemptions when they turn to for-profits for joint ventures or to raise capital, he says. And the health reform law "has several provisions that turn up the heat on nonprofit hospitals," Vernaglia says (see Sec. 9007(a), which affects Internal Revenue Code 501(r)). For example, starting in March next year, tax-exempt hospitals must conduct a community health needs assessment at least every three years and set forth a financial assistance policy. *Recommendation:* "Nonprofit hospitals must distinguish themselves from for-profit hospitals," he says. Provide additional services and "be really smart when doing it." Also, keep an eye on the new health reform restrictions for nonprofits.

Contact Vernaglia at lvernaglia@foley.com. ✧