



Effecting Positive Change in the Next Era of Healthcare Compliance

How clear, accurate and objective data drive a positive and proactive approach to compliance

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Executive Summary

Today's compliance landscape is changing rapidly. In the past, compliance was limited to developing policies and procedures, conducting education and becoming familiar with industry rules and regulations. Yet with healthcare reform and increased governmental scrutiny, compliance has entered a new era.

Regulatory pressures on healthcare organizations are dynamic and pose increasing financial and legal risks. Compliance officers are tasked with safeguarding their organizations, identifying the activities, trends and data that represent risk. However, the human resources required to search and analyze areas of risk are expensive and limited. Add the longstanding negative perception of compliance that pervades the healthcare system, and the complexity of the compliance officer's job reveals itself.

To overcome their many changes and challenges—including driving a positive and proactive approach to compliance—compliance officers must implement tools that give them a clear, accurate and objective picture of their data. This paper examines data analytics solutions that help compliance officers address healthcare reform and regulatory pressures with confidence. Best practices help healthcare organizations discover how the overworked, undervalued compliance organization can benefit greatly from data analytics.

Market Drivers: The changing landscape of compliance

There are two key trends that shape today's compliance department. Developed over the course of several decades is the pervasive, longstanding negative perception of compliance that exists today. Typically undervalued, compliance is seen as a necessary evil. For some, there is a sense of dread by upper management who fear negative news and who don't want compliance officers to examine risk areas too closely. Also, since it's not a revenue-generating department, compliance is typically overworked and resource-poor.

Given these factors, it's all the more critical that compliance officers take a positive, proactive approach to their work while emphasizing to senior leadership that it costs more to respond to an audit than to avoid one altogether. And despite the preference of some to bury their heads in the sand, regulatory pressures are only increasing, with sweeping changes affecting every area of the healthcare organization.

This brings us to the second trend that shapes compliance today: increased government scrutiny and regulation. There's no denying that compliance has entered a new era. With more government initiatives to find abuse and fraud than ever before, healthcare organizations everywhere are subject to extensive data mining now being performed by the government. The penalties include significant financial losses as well as negative press that influences public perception of the organization.

The following are representative of these changes:

- » The Office of Management and Budget reported \$98 billion in improper payments in 2009, with more than half coming from Medicare and Medicaid.¹
- » The Medicare fee-for-service program had \$24 billion in improper payments in fiscal year 2009.²
- » A California hospital was ordered to pay \$5.25 million for overcharging to obtain outlier payments.³
- » A Texas hospital group paid \$27.5 million in false claim settlements.⁴

In response to such news, compliance officers need to be even more determined to protect their healthcare organizations from such stiff penalties, which have reputational consequences as well.

Challenges: Increased government scrutiny drives negative perception

In years past, regulatory agencies were at a disadvantage because of a lack of visibility. Investigations into fraud and abuse could only go so far when done on paper and when the healthcare organization housed much of the data. Today, regulators have access to vast amounts of data, and with the increased use of data analytics solutions, they can uncover fraud, abuse and overpayments faster and more accurately than ever before.

Understanding the government's increased scrutiny

The government has passed several healthcare bills that allow for increased scrutiny and visibility over healthcare.

HITECH Act

The Health Information Technology for Economic and Clinical Health (HITECH) Act was signed into law on Feb. 17, 2009. It significantly

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increases the penalty amounts imposed for violations of HIPAA rules and encourages prompt corrective action. Previously, a healthcare organization could not be imposed a penalty of more than \$100 for each violation or \$25,000 for all identical violations of the same provision. The HITECH Act establishes tiered ranges of increasing minimum penalty amounts, with a maximum penalty of \$1.5 million for all violations of an identical provision.⁵

Patient Protection and Affordable Care Act

Signed into law in March 2010, the Patient Protection and Affordable Care Act (the ACA) represents the most sweeping healthcare legislation in four decades. Its implications for compliance are many and include the 60-day payback rule, mandatory compliance programs, stiff penalties, and conflict of interest specifications.

While providers have always had an obligation to report and return discovered overpayments, the ACA specifies that providers have only 60 days to report identified overpayments. Failure to meet the 60-day repayment requirement may result in hefty penalties.

And while many large healthcare organizations already have some form of compliance program, the ACA requires that a broad range of providers, suppliers and physicians adopt a compliance and ethics program.

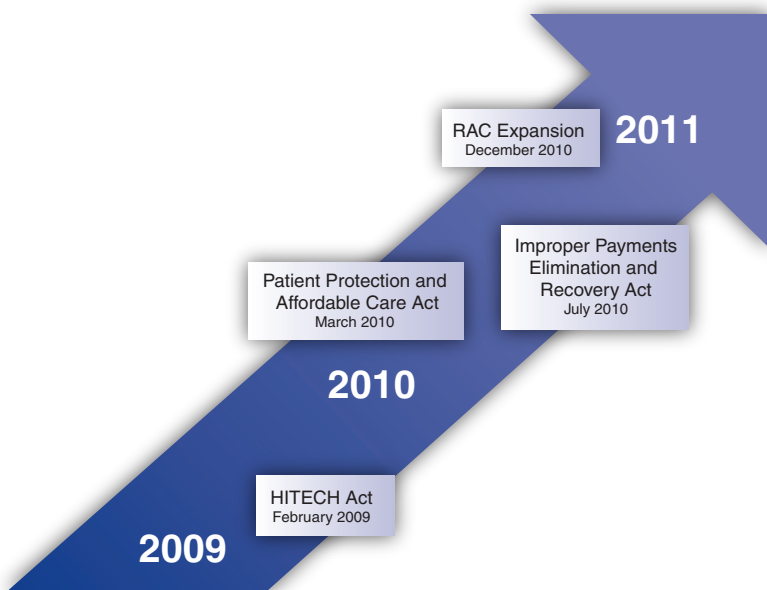


Figure A

Figure A: Healthcare Legislation Timeline

In addition to mandating compliance, the reform legislation requires that physicians openly disclose conflicts of interest. More important than simply having conflict of interest policies is proactively tracking and acting on all potential conflicts of interest.

Perhaps most crucial of the ACA's provisions are the high costs and stiff penalties that it allows. The legislation allows the government to cease all payments to a facility in which the government believes there is credible fraud. Also included are specifications for enhanced financial penalties. Organizations that fail to grant timely access to documents for the purpose of audits and investigations can be subject to strict fines.

More specifically, a report by the Senate Finance Committee projects that the ACA will cost taxpayers twice what the Congressional Budget Office originally estimated. This amounts to at least \$118 billion through 2023, effectively forcing states to make cuts to public education, law enforcement and other local priorities.⁶

Improper Payments Elimination and Recovery Act

In July 2010, President Obama signed the Improper Payments Elimination and Recovery Act in an effort to cut waste, fraud and abuse due to improper payments by federal government agencies. In fiscal year 2009, \$98 billion was spent on improper payments, with more than half that amount (\$54 billion) coming from Medicare and Medicaid programs. A report from the OMB shows that the Medicare fee-for-service program had \$24 billion in improper payments in 2009, an improper payment rate of 7.8 percent (compared with a 2008 rate of 3.6 percent).⁷

Recovery Audit Contractors

Established by the Medicare Modernization Act of 2003 to identify Medicare improper payments, the RAC program utilizes contractors who receive a percentage of the improper payments they collect. Particularly important now is the expansion of the RAC program to Medicare Part C, Medicare Part D and Medicaid as of Dec. 31, 2010. The implications to compliance are many, given the following:

- » The error rate on Medicare fee-for-service claims was 7.8 percent for fiscal year 2009.⁸
- » During fiscal year 2006, RACs collected \$69 million in overpayments.⁹
- » 42% of payments identified by RACs are attributed to improper coding.¹⁰

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(\$75-125 per claim¹¹), compliance plays a key role in protecting the healthcare organization from improper payments. The new legislation undoubtedly raises the bar and makes compliance a more critical component of operations.

Recognizing the pervasive negative perception of compliance

With the increased focus on improper payments and all that the government is doing to identify and recover them, healthcare organizations have had their fair share of negative attention. Recent headlines include:

- » “Developing Story: OIG Outlines Strategy to Combat Medicare Fraud and Abuse; 24 Billion in Medicare Fee for Service Did Not Meet Requirements”¹²
- » “73 Members and Associates of Organized Crime Enterprise, Others Indicted for Health Care Fraud Crimes Involving More than \$163 Million”¹³
- » “Hospital to Pay \$2.2 Million in Settlement”¹⁴

In addition to public perception, the negative view of compliance spreads throughout the typical healthcare organization. As a result, compliance officers must demonstrate the positive worth of an effective compliance program. They must ensure the compliance program fosters a culture in which employees across all disciplines in the hospital are heard and respected.

The promising news is that compliance now has a seat at the table. Given the strong financial implications, the voice of compliance is now being heard by senior management.

Having a voice, however, is just one small step toward generating a favorable opinion of compliance. Effecting a new perception that says compliance is an integral and positive part of the organization requires a proactive approach made possible by powerful data analytics.

Solution: Clear, accurate and objective data drives a positive view of compliance

To begin to tackle these challenges, compliance officers must take a 360-degree view of their organizations, asking themselves three key questions:

- » What kind of changes do I need to make to prepare myself for the next generation of oversight?

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- » How can I create a compliance program that can stand up to government scrutiny?
- » How do I begin to create a positive perception of compliance?

The answers to these questions and the key to an effective compliance organization lie in data analytics. A review of healthcare legislation shows that regulatory agencies are armed with strong data analytics solutions. It stands to reason that healthcare compliance professionals would be well served by the same analytical expertise when overseeing their own organizations.

Using data analytics to adopt a proactive approach to compliance

Data analytics provides the visibility compliance officers need to proactively mitigate risk and safeguard the financial and operational health of their organizations. Unfortunately, many healthcare organizations today are only able to track and monitor audit appeal activity retroactively. Data analytics allows compliance to prevent and avoid audits rather than merely respond to them. This not only costs the organization less; it also protects revenue.

By the same token, overseeing data and avoiding audits is more effective at maintaining the positive public perception of the organization. It is much more difficult, if not impossible, to correct public perception once the negative news has affected the collective mindset.

More specifically, data analytics contributes to a proactive approach by allowing compliance officers to perform trending and analysis to uncover risk areas. Compliance can drill from top levels downward and across any dimension found in the data (e.g., facility, patient type and discharge disposition). In the same way, data analytics allows compliance officers to set and monitor goals using clear and measurable metrics. Such metrics allow compliance to focus limited resources where they are needed, bringing greater efficiency to the compliance department while achieving maximum results.

Improving compliance workflow with data analytics

In addition to driving a proactive approach to compliance, data analytics helps compliance professionals promote workflow and process improvements. With data analytics, compliance officers can focus on actual risk aversion, rather than manually reviewing mountains of data or relying on a sample of data extrapolated to represent the whole. Data analytics complements an organization's work processes rather than serving merely as a reporting vehicle.

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There are several areas where an improved compliance workflow drives positive change. First, the 60-day payback rule, as set forth by the ACA, requires compliance officers to have quick and easy access to their data. Waiting two weeks for IT to produce a report in response to an improper payment allegation is no longer acceptable. With only 60 days to pay back a known overpayment, the clock starts ticking very quickly. Data analytics solutions allow compliance professionals to make iterative inquiries into the data in real time, without extensive computer language skills or programming expertise.

Just as important as the 60-day rule in driving process improvements is the need for compliance officers to monitor all risk areas, large and small. Many organizations neglect smaller risk areas because the dollars associated are less. The problem, however, is that government agencies have easy access to these data. Unit count, for example, is one potential risk area that gets overlooked. RACs and other governmental agencies can easily determine that the quantity billed is not the appropriate dosage of a particular drug. This seemingly less important factor can affect thousands of claims, costing hundreds of resource hours and significant reimbursement amounts.

On a more positive note, monitoring the areas often deemed less important can reveal under-billing rather than overpayments. A data analytics solution that generates alerts when potential dollars are missed goes a long way toward driving positive change within the organization.

Ensuring revenue integrity with data analytics

Whether the data reveal overpayments or under-billing, the fundamental consideration is ensuring the integrity of the organization's revenue. Revenue integrity is founded on the basic idea of billing correctly and getting paid correctly.

Consistently monitoring revenue integrity earns an organization tremendous respect from government agencies. And with accurate, reliable data in hand, compliance can stand as the voice of reason within the organization and save the hospital from rebills and potentially millions of dollars.

Furthermore, protecting the organization's revenue integrity builds upon itself. When an organization maintains revenue integrity, it can afford the systems that continue to produce the efficiencies that drive revenue integrity.

Finally, government officials have indicated that an organization that never does a self-disclosure is at risk of being labeled as lacking an effective compliance program. Jim Sheehan, New York State Medicaid Inspector General, commented, “If you are a compliance officer and your organization never made a disclosure of an overpayment, know that your compliance program is not working as effectively as it should be.”¹⁵

Using data analytics to prepare for the future

While ensuring revenue integrity and driving compliance efficiencies are important for today, planning for the future is what will ultimately allow compliance to establish a positive reputation.

Excessive payments and outliers is an area of particular focus. Data analytics makes it easy for compliance to monitor those claims that result in large payments, a specific target of RACs. By creating a report of claims with payments over a certain dollar amount, typically \$200,000, compliance can quickly and easily verify that the claims are billed and paid correctly.

Another risk area easily monitored by data analytics is the replacement of medical devices. Medicare should not pay for any medical device if the hospital itself is not paying for the device (due to recalls, warranties, etc.). Validating device data against purchasing department data ensures that the hospital is only billing for devices it actually purchased.

Hospital-acquired conditions continue to receive attention from the general public and media. Any hospital that has a higher-than-normal rate of hospital-acquired conditions will likely be subject to negative press and will receive lower reimbursement rates. Data and benchmarking activities can help compliance determine the issues and take rectifying action.

These are just three areas that illustrate the significance of data analytics. Proactively planning for the future and thoughtfully applying data analytics solutions helps an organization avoid audits, reimbursements and penalties while overcoming the pervasive negative opinion of compliance that exists today.

Case Study: New York State uses data to set a standard for compliance

Due to its response to recent healthcare legislation, New York State serves as an example to other states and compliance departments of how to effectively eliminate errors. With extensive data analytics tools, New York conducted an unprecedented number of audits. The state's 1,800 audits resulted in \$550 million in repayments in one fiscal year. In addition, the data determined that one New York hospital owed \$76.5 million to Medicaid because of overbilling.¹⁶ The volume of audits and results achieved by New York would not have been possible without the state's new and innovative use of data.

And while recouping improper payments is important, the state's ultimate goal was to fix the Medicaid payment system so errors don't happen in the first place. Its data analytics solutions enabled New York to:

- » Focus on the effectiveness of provider compliance programs
- » Gain visibility into the Medicaid payment process
- » Implement an interactive audit process
- » Conduct a high volume of audits, resulting in significant amounts of corrections

Viewing the state's activities from the perspective of the healthcare organization shows that the same types of system improvements and financial gains can be realized with powerful data analytics solutions.

Best practices in effecting positive change in compliance with data analytics

To achieve the powerful results that data analytics affords, compliance officers must start by defining the optimal characteristics of the ideal compliance program. They include the ability to:

- » Assess risk based on quality data
- » Investigate and remedy systemic problems
- » Reveal appropriate disclosures and reimbursements
- » Document incident reporting and response
- » Monitor corrective actions
- » Test the audit response process
- » Develop a system that responds to allegations of improper or illegal activities, including discipline for violations

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The next step after defining ideal compliance characteristics is choosing a data analytics solution that will accomplish these objectives. There are several qualities to look for in data analytics solutions. The effective data analytics solution provides daily insight into compliance risk areas, coding trends and audit appeal workflow. Leveraging audit rules as well as third-party benchmarks, data analytics minimizes risk by establishing real-time compliance dashboards and proactive alerts.

In addition to minimizing risk, robust data analytics solutions improve compliance workflow processes by effectively managing multiple deadlines and documents of the complex audit appeal process. Delivered on a web analytics platform and supported by revenue cycle and compliance professionals, data analytics solutions help compliance professionals ensure rapid and sustainable results. Characteristics of a powerful data analytics solution include the ability to:

- » Provide visibility into Medicare payment variances to minimize the impact of RAC and other external audits
- » Identify potential coding variances of hospital claims based on CMS and state benchmarks
- » Drill down to understand the root causes of coding outliers at the facility, physician and coder levels
- » Provide a multi-departmental approach to compliance
- » Improve the efficiency of internal and external audit initiatives by proactively pushing meaningful reports to audit staff
- » Integrate CMS benchmarking data and facilitate analysis of coding outliers and physician performance

With data analytics solutions like this, healthcare organizations consistently achieve measurable improvements in reimbursement, coding and quality metrics in key risk areas frequently targeted by regulatory agencies. This leads to a proactive, efficient approach to compliance, ultimately creating a positive perception of compliance with the public and within the four walls of the hospital.

Conclusion

As this paper has shown, today's healthcare system is experiencing the most sweeping changes in the industry since the inception of Medicare and Medicaid in the 1960s. Like it or not, compliance has entered a new era with a new set of tasks and challenges. While important in their own right, setting policies and conducting education are no longer effective in protecting the healthcare

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organization from the stiff penalties specified by the latest healthcare legislation. At the same time, the responsibility of protecting the healthcare organization from negative press now falls squarely on the shoulders of compliance professionals.

Given all that is now required of compliance, effecting positive change must take priority. Having the right tools in place is more important than ever. Data analytics solutions give compliance officers a clear, accurate and objective picture of their data, allowing them to not only prevent and respond to audits, but also improve workflow, protect the integrity of the organization's revenue and plan for the future. In so doing, compliance effectively keeps the healthcare organization out of the news and builds a trustworthy reputation with regulatory agencies.

Faced with such monumental change, compliance professionals have some choices. They can fight the change, let the change happen or lead the charge and prosper. With powerful data analytics solutions in hand, the third option is not only possible but also can give compliance professionals the credit and positive attention they deserve.

Learn More

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