# Compliance: A Critical Yet Costly Commitment

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*by Daniel R. Roach, JD*

In the 1970s, the defense budget consumed the largest share of the federal budget. Concerns about both the size and efficiency of the defense bureaucracy triggered a massive crackdown on federal contractors who had either intentionally or inadvertently failed to follow the Department of Defense procurement and reporting requirements. Following some high-profile legal action against numerous contractors, the industry responded with programs designed to set standards, reduce noncompliance, and mitigate the risks when mistakes were made.

By the 1990s, the healthcare industry found itself in the same spot. Healthcare was now the biggest single component of the federal budget. There was increasing concern that costs were spiraling out of control and that fraud was rampant. A few successful-and sizeable-prosecutions of healthcare providers led to an intense focus on federal healthcare programs and the controls (or lack thereof) that permeated the program. Tighter program controls were implemented. The Office of Inspector General of the Department of Health and Human Services (OIG), the internal watchdog for HHS, was greatly expanded, and US attorneys in virtually every state established investigative units focused on healthcare.

This attention, coupled with the effect of amendments to the False Claims Act and additional incentives for whistleblowers, created a climate which has led to a veritable explosion of enforcement actions. This has been followed by a subsequent explosion of compliance programs designed to protect healthcare organizations from the jaws of an aggressive enforcement community.

But what has been the effect of these initiatives on healthcare? Are we better off now than we were 10 years ago? Frequently, your conclusion depends on your point of view.

**Government and Industry Footprints**

There is no question that the combination of enforcement efforts and compliance programs has had some significant and positive impacts on certain aspects of the healthcare delivery system. We have witnessed the purging of unquestionably unscrupulous providers who misused the complexity of the system to rob the public treasury or deprive patients of appropriate and reasonably efficient healthcare services.

We have been successful in restraining the growth in Medicare spending and in dramatically reducing the number of erroneous claims made to federal, state, and other payers. This reduction has contributed to improving the solvency of the Medicare program and helped both the government and private financiers of healthcare control costs.

The drive to eliminate fraud and promote compliance efforts has also led to the development of increased industry/government collaboration to address these issues. Conferences sponsored by numerous organizations reflect a high level of government and industry cooperation in developing, sponsoring, and delivering education programs designed to assist providers.

Government representatives now sit on boards of organizations such as the American Health Lawyers Association and the Health Care Compliance Association, providing important input and working with industry representatives to address the complex challenges faced by healthcare providers. With substantial input and cooperation from the industry, the OIG has developed and published guidance for numerous segments of the healthcare industry designed to promote industry compliance efforts, establish much-needed standards, and improve the efficiency and effectiveness of compliance efforts by providers.

While government resources remain overwhelmingly devoted to enforcement efforts rather than preventive education and simplification, the issuance of fraud alerts, the publication of work plans, and the implementation of programs such as the Payment Error Prevention Program have helped providers understand and address issues of concern to enforcement authorities.

The existence of enforcement and compliance efforts has required many providers to take a hard look at how they do business, the adequacy of internal controls, and the processes used during the claim development and submission process. This focus has at times allowed providers to become more efficient and accurate, which may give them a reimbursement or payment advantage.

**Unearthing the Roots of Noncompliance**

One of the most significant effects of compliance efforts has been the radical change in our understanding of the origin of most compliance problems. I was involved with an investigation and subsequent settlement in the early 1990s. The settlement agreement focused auditing and education efforts on the billing and coding functions within the organization. It didn't take long, however, to figure out that the majority of our problems did not arise in the coding or billing context, but could be directly traced to inadequate or missing documentation.

While it has taken both the industry and the government some time to figure this out, it has become clear to just about everyone that compliance is not merely a billing or coding activity, but one that must permeate every aspect of the claim development and submission process. The best and most conscientious coders and billers in the world simply cannot produce accurate claims if:

- the admitting and registration staff fail to gather necessary and correct information
- physicians fail to dictate complete histories and physicals or discharge summaries and document complications and comorbidities
- patient care providers don't properly or completely document the services and supplies provided
- ancillary services staff fail to insist on an authenticated order and a proper diagnosis for lab, radiology, or other tests

Understanding operations' impact on compliance has led to an emphasis on improving communication and the importance of documentation, documentation, and more documentation.

Finally, organizations that hope to have an effective compliance program have recognized the need to recommit to serious and continuous education efforts. This has led to improved educational opportunities for coders and billers and increasing collaboration with physicians and other professionals who may order or document healthcare services. While these activities are frequently costly, they have positive benefits for the organization, particularly if they are coordinated with those working in the quality and care management functions so that multiple objectives can be achieved simultaneously.

**Avalanche of Regulations**

Compliance efforts have had unquestionable success from the government's perspective and many industry representatives can demonstrate positive results from these programs. However, there remains a strong undercurrent that compliance is an unwelcome but necessary response to an enforcement scheme that is at times misguided and unfair. This position seems rooted in two basic problems: complexity of the law and the secrecy surrounding the enforcement process.

Providers are buried by the avalanche of regulations that govern the provision and financing of healthcare. While individual regulations typically include some kind of regulatory impact analysis designed to satisfy Congress that the regulations are not unduly burdensome, the estimated impact is frequently grossly understated and there appears to be little effort to look at the effect of these regulations in the aggregate.

For example, during the last 12 months of the Clinton administration alone, the healthcare industry was saddled with more than 10,000 pages of new and proposed regulations. When coupled with the complex, confusing, and counterintuitive nature of these regulations, it becomes an impossible burden for already financially strapped providers to efficiently bear.

In addition, the government's unwillingness to make commitments about how it will approach provider mistakes and the lack of complete and accurate information about settlements prevents both providers and the government from taking an objective look at the fairness of enforcement efforts. There are numerous instances, at least anecdotally, where providers with lower than average error rates paid large settlement amounts and high multipliers while providers with very high error rates paid substantially less.

Further, there is a belief that the enforcement community has, in at least some instances, applied current positions about how things should be done to conduct that occurred five or 10 years ago. As a result, conduct which no one reasonably believed to be improper is being punished. Few providers believe that the government can or should completely abandon its compliance and enforcement efforts, but without more complete data and openness in the process, many will continue to be skeptical about the fairness of the process.

**Obviously, all of this activity has created a huge demand for individuals who focus on guiding an organization's compliance efforts. Thousands of providers have hired compliance staff and are devoting millions of dollars to compliance programs. The cost of compliance professionals, education, auditing, and other program elements has been substantial. Further, there is a tremendous shortage of coding personnel, and hospitals in particular are scrambling to figure out how to address this need. With increased demand, and no relief in sight, coders will continue to reap the benefits of having a unique and important skill that is in very short supply.[1]**

**Many providers are also spending millions of dollars investigating and defending allegations by qui tam relators. While a few of these cases have merit, it appears that many cases consume incredible resources without ultimately uncovering any evidence that the provider willfully, recklessly, or even ignorantly failed to follow the law.**

**Providers are having a difficult time absorbing those costs in an era of declining and frequently negative margins. While there is clear evidence that compliance has resulted in significant savings to Medicare, it is not at all clear that compliance efforts have resulted in a larger percentage of our healthcare dollars being spent on patient care as opposed to administrative or regulatory matters. We need to move in that direction.**

**Where will healthcare be in another five or 10 years? One thing is clear: fraud enforcement is not likely to subside in the near future, and compliance programs will continue to be an essential response. The industry recognizes that compliance is a fundamental obligation of providers and most organizations are making the necessary commitments. We have opportunities to improve the efficiency of compliance efforts and enforcement processes if the industry and government continue our collaborative efforts. Fortunately, it appears that both provider and the enforcement community are committed to making this happen.**

**1. The value of qualified, committed coders has not been missed by the government. A recent corporate integrity agreement includes a scoring mechanism where the provider loses points for certain types of staff turnover. Losing a coder costs five points while losing the CEO or the CFO costs only two points.**

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