# Hard-line Approach to Compliance Pays Off



*by Lewis Morris, Esq.*

While the landscape will continue to change, most observers agree that the healthcare industry finds itself in a very different environment from a decade ago. The reasons for the evolution are numerous, but a significant factor has been the growing influence of compliance initiatives on the business of healthcare. The effect of these efforts can be seen in everything from how reimbursement claims are prepared and transactions are structured to the attention given by third parties to a provider's compliance systems. To appreciate the scope of the healthcare compliance movement, it is helpful to look both at its impetus and some measures of its success in strengthening the integrity of the healthcare system.

**Focus on Fraud**

The early 1990s brought an increasing presence of law enforcement in the healthcare industry. At the beginning of the Clinton administration, Attorney General Janet Reno declared that healthcare fraud prevention would be one of the top priorities at the Department of Justice. Congress passed major antifraud measures that expanded the Office of Inspector General's (OIG) administrative authorities, created new healthcare antifraud statutes, and most significantly, provided substantial funding for anti-fraud enforcement.

In addition to the government's initiatives, the rights afforded under the 1986 amendments to the False Claims Act were increasingly used by private citizens to file private enforcement suits, or qui tams, against any person or entity that filed false or fraudulent claims with the government. The combination of a guaranteed share of 15 to 30 percent of the funds recovered, in addition to attorneys' fees, and a reimbursement system that generates an enormous number of claims made inevitable an explosion of healthcare qui tam lawsuits. By 1996, the majority of qui tam suits were, and continue to be, filed against healthcare providers.

A third source of pressure on the healthcare industry comes from lawyers representing plaintiffs in private lawsuits. These lawsuits, targeting everything from a nursing home resident's wrongful death to management's failure to protect shareholders' equity, have produced multimillion dollar judgments against healthcare providers. In some parts of the country, the risk of these lawsuits has made it difficult for long-term care providers to obtain tort liability insurance.

It is not surprising that the healthcare industry came to recognize that it could reduce its exposure to these threats by improving its compliance with the rules governing the delivery and reimbursement of healthcare. Coincidentally, the government began a campaign to promote regulatory compliance in partnership with the industry. The OIG issued a series of provider-specific guides that offered concrete suggestions on how to construct a comprehensive, voluntary compliance program. In cases where the healthcare entity was subject to False Claims Act liability as a result of the submission of fraudulent claims, the OIG used the framework of these guides to negotiate integrity agreements with the provider. The OIG also established its self-disclosure protocol, recognizing that providers with effective compliance infrastructures needed a procedure for disclosing to the government self-detected violations of program rules.

To further assist providers committed to compliance, the government issued advisory opinions and fraud alert bulletins identifying practices that posed risk to a provider's integrity. Collectively, these government efforts represented an alternative to the traditional law enforcement approach of waiting to respond until a violation of law occurred.

**Compliance: A Booming Industry**

In light of a growing law enforcement presence and the government's efforts to foster industry compliance, has the healthcare community embraced compliance as an integral part of an effective healthcare organization? If measured by the growing number of consultants, newsletters, Web sites, and conferences dedicated to healthcare compliance, the answer is an unqualified "yes."

The increasing number of compliance officers is another indication of the growing presence of healthcare compliance. According to the Healthcare Compliance Association's (HCCA) annual survey of healthcare compliance professionals, the percentage of healthcare organizations with active compliance programs in place increased from 55 to 71 percent in 2000. Of those organizations responding positively, 98 percent have a compliance officer and 100 percent have conducted formal compliance training for employees.

Similarly, the American Hospital Association's 1999 survey of its members found 96 percent of the reporting hospitals either had a compliance program in place or were planning to initiate one in the coming year. In light of the growing number of compliance officers, the HCCA created a Healthcare Compliance Certification Board to establish professional standards of requisite knowledge and to certify those individuals who pass an examination. The growth of the healthcare compliance community is all the more remarkable considering that HCCA, with a current membership of almost 2,500, was formed in 1996.

**Corporations, Providers Under Fire**

Another measure of the compliance movement's effect on healthcare is the changing standard by which the integrity of corporations is judged. For instance, after Caremark, Inc., agreed to pay $161 million to settle its criminal and civil liabilities for paying kickbacks to physicians, the company's shareholders filed a derivative suit against the corporate directors. The court found that the directors had a fiduciary duty to ensure that the company complied with the law and that establishing a compliance program had satisfied that obligation. In light of this decision, it is hard to imagine that a prudent board of directors would close its compliance department or disband internal control structures. In fact, to do so in the current enforcement climate might well be viewed as demonstrating a level of reckless disregard that could contribute to liability under the False Claims Act.

The liability insurers and investors also have begun to expect healthcare providers to have efficient, effective, and compliant control structures in their organizations. Liability insurers are becoming increasingly apprehensive about underwriting policies for providers that do not have acceptable internal controls. Inadequate training, disregard of procedures, and a failure of systems that monitor resident care are in part responsible for the multimillion dollar verdicts against nursing homes that failed to provide adequate care. Some insurance underwriters are refusing even to issues liability policies to many long-term care providers.

For similar reasons, healthcare lawyers have grown cautious in their review of business transactions. The "due diligence" review of a potential acquisition or a contemplated merger requires a rapid but comprehensive assessment of potential liabilities. The most attractive candidates can produce a series of internal audit reports and other objective evidence of compliance with the government's regulations. Conversely, a company that does not have systems that monitor compliance with this highly regulated and scrutinized industry presents significant uncertainty and financial risk. As several national hospital chains have learned, the acquisition of providers that do not have compliance programs can be extremely expensive. If the government subsequently uncovers misconduct by that provider, the new owner can be civilly liable for damages, even if the fraud occurred before the acquisition.

In structuring new deals, lawyers also are paying greater attention to fraud and abuse concerns and steering their clients away from legally questionable deals. The criminal indictment of two healthcare lawyers for their advice in the recent prosecution of Kansas City healthcare executives (United States v. McClatchey) was a stark reminder of the risks of testing the limits of the law. Although the lawyers were acquitted, the legal community received a strong message about the need to scrutinize transactions for compliance with the anti-kickback and physician self-referral laws. As one commentator put it, "It's harder to get an aggressive opinion from an attorney in a world where healthcare attorneys are getting indicted."

**A Measure of Success**

By far the most dramatic evidence of the effect of compliance on the industry, however, is the heightened care with which healthcare providers submit claims to the federal healthcare programs. For example, the rate of improper Medicare payments has dropped significantly since 1996, when the OIG began annual audits of the fee-for-service part of the Medicare program. In that year, the estimated improper payments were about $23 billion, or about 14 percent of program expenditures. Most of the improper payments consisted of improperly documented or coded claims and claims for medically unnecessary services. Fraudulent claims are more difficult to identify and were not the objective of the audits.

In 1997, the figure for improper payments dropped to $20 billion, or 12 percent of expenditures. The error rate dropped to $12.6 billion, or 7 percent of program expenditures in 1998, representing almost a 50 percent drop in the rate of improper payments in just three years. In 1999, the results were about the same as for 1998: just over $13 billion in improper payments. Commentators have correctly noted that the decreasing payment error rate does not purport to reflect shifts in the amount of healthcare fraud. Nonetheless, the numbers strongly suggest that providers are being much more careful in coding and documenting their services.

The impact of compliance is also visible through the "case complexity index." Since the prospective payment system was put in place for hospital inpatient services in 1983, the average complexity (directly related to cost) of the average inpatient service increased every year. This statistic could suggest that Medicare patients became sicker as a group or, more likely, hospitals developed more sophisticated coding strategies. When the OIG and Department of Justice started national projects to scrutinize some of the more questionable coding practices, the consultants who had encouraged these practices began to lose credibility and clients. In 1998, the case complexity index actually decreased for the first time.

The continued solvency of the Medicare program and its present low rate of inflation also have been credited to the effort to ensure compliance with payment rules. The program's outlays increased by an average of almost 11 percent a year during the first half of the 1990s. But between 1997 and 1999, the rate of growth fell from a high of 9 percent in 1997 to a 1 percent decline in spending in 1999.

In 1996, the trustees of the Medicare Part A trust fund projected the trust fund would be insolvent by 1999. However, they have since extended their estimate of the financial life of the trust fund by 26 years to the year 2025. One of the primary contributing factors cited by the trustees was the increased effort to control fraud and abuse. The Congressional Budget Office specifically attributes this drop in Medicare spending to the industry's compliance efforts, but adds a cautionary note: "Most of the decline can be explained by a strong effort to ensure compliance with payment rules. The savings from this effort more than offset the additional spending caused by increases in payment rates and higher enrollment in the late 1990s. However, the bulk of the savings from that effort has been realized, and as a result the increases in spending are now greater that the reduction caused by stricter compliance with payment rules."[1]

While there may be disagreement about the merits of the government's anti-fraud initiatives, it is clear that increasing compliance with program rules is paying off. As pressure to contain costs and reduce erroneous payments intensifies, the importance of compliance programs to the healthcare industry will continue to grow.

**Note**

1. "The Budget and Economic Outlook: Fiscal Years 2002-2011." Congressional Budget Office, January 2001. Available at http://www.cbo.gov/.

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