



# Healthcare Financial Management Association Southern California Chapter

Quality of Care as an Emerging Legal Risk –  
What Healthcare Providers Need to Know

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# Today's Presenter

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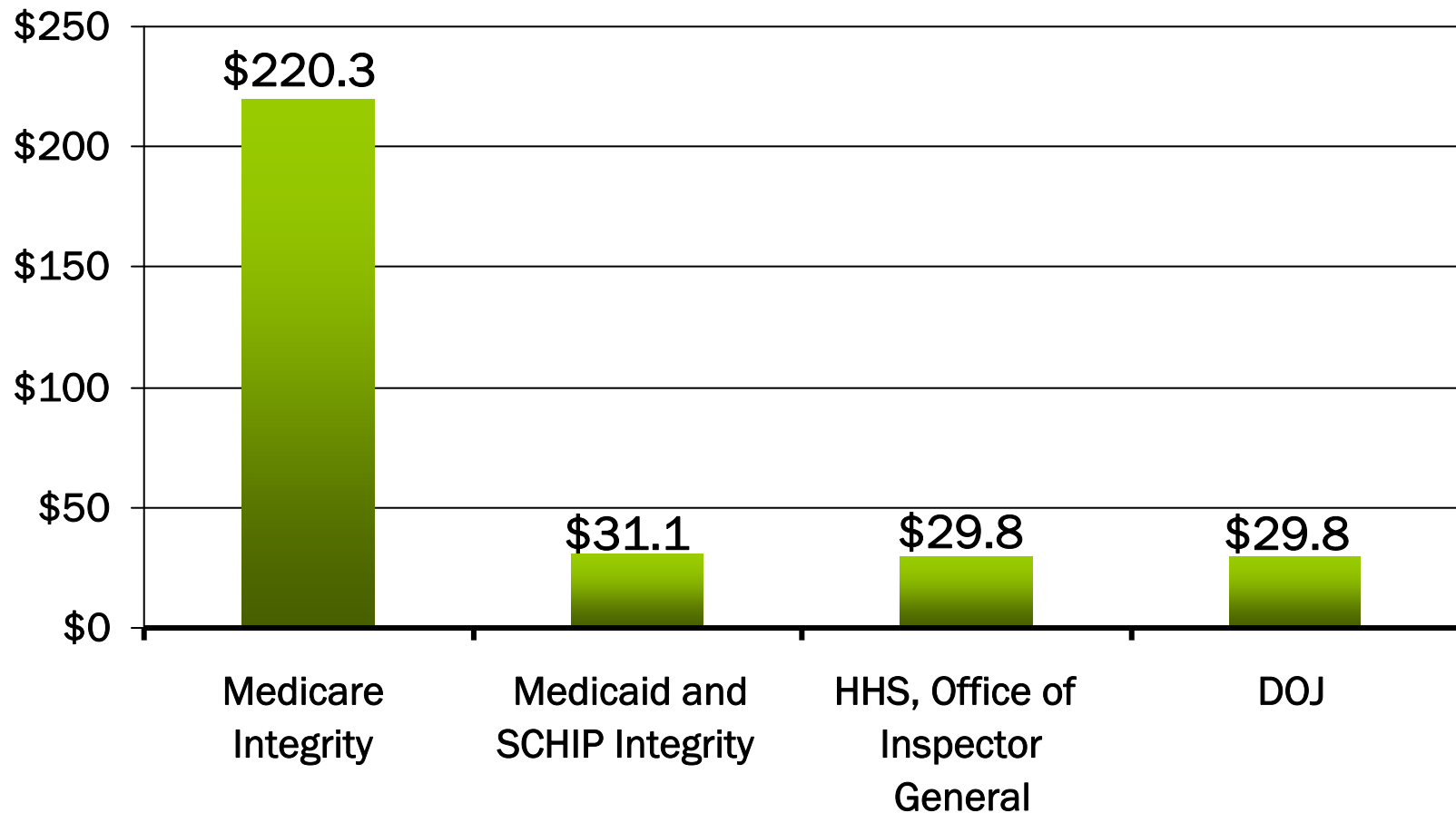
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# Overview

- Current Initiatives and Impact of Reform Movement
- Quality of Care as an Emerging Legal Risk
- Steps Healthcare Providers Should Take Now!

# FY 2010 Healthcare Fraud and Abuse Budget (in millions)



Source: White House, Office of Management and Budget. <http://www.whitehouse.gov/omb/budget/fy2010/assets/ohs.pdf>

# Healthcare Reform – Funded by Reducing Waste and Abuse?

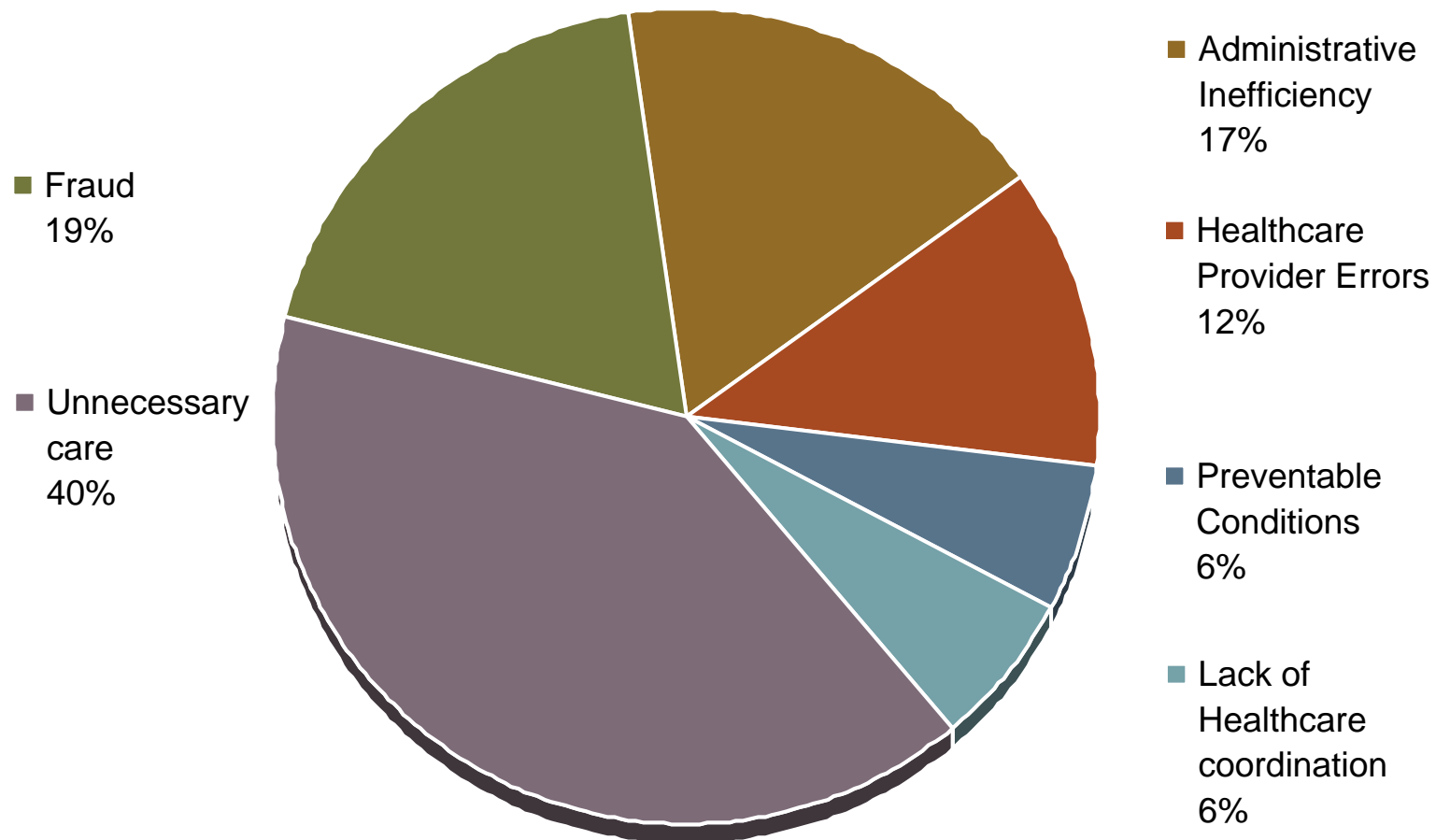
- "[W]e've estimated that most of this [healthcare reform] plan can be paid for by finding savings within the existing health care system, a system that is currently full of waste and abuse." Remarks by President Obama to a Joint Session of Congress, Sept. 9, 2009 (available at [www.whitehouse.gov](http://www.whitehouse.gov)).
- Article: John K. Inglehart, "Finding Money for Health Care Reform -- Rooting Out Waste, Fraud and Abuse," New England Journal of Medicine, 361 NEJM 229 (2009)

# Thompson Reuters White Paper (October 26, 2009)

- Estimates \$700 billion wasted in US Healthcare system
  - Unnecessary care (40 %)
  - Fraud (19 %)
  - Administrative inefficiency (17 %)
  - Healthcare provider errors (12 %)
  - Preventable conditions (6 %)
  - Lack of healthcare coordination (6 %)

Source: Thompson Reuters Press Release: Waste in the U.S. Healthcare System Pegged at \$700 Billion in Report from Thompson Reuters (October 26, 2009)

# Waste in the U.S. Healthcare System\*



\* Source: Thompson Reuters Press Release: Waste in the U.S. Healthcare System Pegged at \$700 Billion in Report from Thompson Reuters (October 26, 2009).

# Waste in the U.S. Healthcare System (*cont'd*)

- Fraud and Abuse – 19%
  - Intentional provision of unnecessary or inappropriate services
  - Billing for services never provided (deceased patients)
  - Misrepresentation of the cost of care by insurers to group plan sponsors
  - Kickbacks for referrals for unnecessary services
  - Misbranding of a drug by a pharmaceutical company
  - Abuse of the healthcare system by patients to receive harmful services, such as Medicaid recipients with drug addictions enrolling in multiple states

# Waste in the U.S. Healthcare System (*cont'd*)

- Everything else – 81%
  - Preventable conditions and avoidable care 6%
  - Unwarranted use (unnecessary procedures) 40%
  - Administrative system inefficiencies 17%
  - Lack of care coordination 6%
  - Provider inefficiency and errors 12%

# HEAT Initiative Announced

## May 20, 2009

- Attorney General Eric Holder and Health and Human Services (HHS) Secretary Kathleen Sebelius announced the creation of a new interagency effort, the Health Care Fraud Prevention and Enforcement Action Team (HEAT)
- Reflects improving data sharing between CMS and law enforcement
- Not just to address low hanging fruit

# HEAT – Geographic Focus

- As of December 15, 2009, HEAT strike forces are focused on 7 locations:
  - Tampa
  - Baton Rouge
  - Brooklyn
  - Detroit
  - Houston
  - Los Angeles (2007)
  - Miami (2007)
- Each strike force is led by a federal prosecutor from the respective U.S. Attorneys' Office or the Criminal Division's Fraud Section — Each team has an agent from the FBI and HHS-OIG

# OIG's Five-Principle Strategy to Combat Health Care Fraud, Waste, and Abuse

1. Enrollment
2. Payment
3. Compliance
4. Oversight
5. Response

# OIG 2010 Work Plan

- Significant focus on quality of care and reporting
- Commitment to investigate health care fraud related to quality of care, *i.e.* billing for unnecessary services or for substandard care ("failure of care")
- See pages 67 & 68 of 2010 Work Plan

# Enforcement of Quality of Care Through the False Claims Act

- The government uses a variety of legal theories under the FCA to attack quality failures, but all follow the same principle: **the government will not pay for medically unnecessary or substandard care**
- Physicians, executives, and board members face real risks for poor quality of care

# Enforcement of Quality of Care Through the False Claims Act (*cont'd*)

- OIG will examine quality of care issues to detect and prevent fraud and abuse perpetrated against beneficiaries and the Medicare and Medicaid programs
- Medically unnecessary services
- Services either not rendered, not rendered as prescribed, or for substandard care that is so deficient that it constitutes a "failure of care"
- Serious medical errors – never events
- Reliability of hospital – reported quality measure data
- Medicaid statistical information system data reporting

# Focus on Datamining

- "We are actively analyzing Medicare data in unprecedented coordination between our two agencies [DOJ and HHS], and in as real-time as possible, to identify fraud "hot spots" and expand strike force operations to those areas where there is the most need."
  - Statement of Assistant Attorney General Tony West before the Senate Judiciary Committee Entitled "Effective Strategies for Preventing Health Care Fraud"  
(Wednesday, October 28, 2009)

# Use of Data Mining in Enforcement Actions

## Data Mining

- Defined:
  - Data mining is a **technology** that facilitates the ability to **sort** through masses of information through database exploration, extract specific information in accordance with defined criteria, and then **identify patterns of interest** to its user.
- Goals
  - Correct inappropriate behavior
  - Identify overpayments
  - Deny payment

# Data Mining

- ***"We are reviewing assorted sources of quality information on your facility to see what it says and if it is consistent. You should be doing the same."***

James G. Sheehan

Medicaid Inspector General, New York

February 6, 2007

# Quality of Care Enforcement Actions & Settlements

- Tenet Healthcare Corporation
  - Multiple Settlements with DOJ & OIG
  - Forced Divestment of Redding Hospital
  - 5-year Corporate Integrity Agreement
    - Board Committee Reports to OIG on quality
    - IRO review of clinical quality management
    - Quality-of-Care Failure Reporting Requirement to OIG
- Quest Diagnostic Inc.
  - \$302M global settlement
  - 5 year CIA

# Recent Quality of Care Enforcement Actions & Settlements *(cont'd)*

- Emmanuel Bernabe
  - Owner & President, Nursing Home Corporation
  - Permanent Exclusion from participation in Federal Health Care Programs
  
- Grant Park Nursing Home
  - \$2 million settlement
  - 5-year Corporate Integrity Agreement with Quality Monitor

# Whistleblower Recoveries

- FCA relators are given a significant financial incentive to "blow the whistle"
- With some exceptions, *if the government intervenes*, the relator is entitled to not less than 15% and not more than 25% of the recovery, plus reasonable expenses and reasonable attorneys' fees and costs
- *If the government does not intervene*, the court will decide what is reasonable. This can range from 25% to 30%, plus reasonable expenses, as well as reasonable attorneys' fees and costs, which are paid by the defendant

# Medicaid Integrity Program

- Deficit Reduction Act of 2005 (DRA) created new federal Medicaid Integrity Program (MIP)
- DRA dramatically increased Resources of CMS & HHS-OIG to Fight Medicaid Fraud
- Funding - \$560M over 5 years
  - \$255m For Medicaid Integrity Program
  - \$180m for National Medi-Medi Expansion
  - \$125m for OIG Medicaid Fraud
- Staffing – 100 FTEs for CMS
- As of Fall 2009, audit activity now underway in at least 25 states

# Medicaid Integrity Program (*cont'd*)

- DRA also required policies and procedures which advised employees of false claims acts and whistleblower protections
- MIG (Medicaid Integrity Group) is developing algorithms to streamline audits
  - Algorithms allow for "data mining" by using "structured queries" to elicit specific information (e.g., potential billing errors for one-day hospital stays)
    - This allows investigators to quickly identify potential billing errors
    - Allows MIP to check all Medicaid claims in a state for a particular error in 30 to 60 minutes (i.e., can check all claims in the U.S. for the error in 25 to 50 hours)

# New York Office of Medicaid Inspector General – 2008 Results

- OMIG succeeded in saving the state **\$1.66 billion** through cost-savings activities (including nearly **\$134 million** in recipient restrictions) during 2008.
- During federal fiscal year 2008-09 (October 1, 2007-September 30, 2008), the OMIG met and exceeded federal identification and recovery requirements under the Federal-State Healthcare Reform Partnership (F-SHRP). The goal was \$215 million, and, in collaboration with OMIG's state agency partners particularly the New York State Office of the Attorney General, New York reached **\$551 million**.
- OMIG began 3,281 investigations in 2008; and completed 2,366.

# CMS RAC Review Phase-in Strategy as of 06/24/09

## Earliest possible dates for reviews in yellow/green states

- Automated Review-Black & White Issues (June 2009)
- DRG Validation-complex review (Aug/Sept 2009)
- Complex Review for coding errors (Aug/Sept 2009)
- DME Medical Necessity Reviews – complex review (Fiscal year 2010)
- Medical Necessity Reviews-complex review (calendar year 2010)

## Earliest possible dates for reviews in blue states

- Automated Review-Black & White Issues (August 2009)
- DRG Validation-complex review (Oct/Nov 2009)
- Complex Review for coding errors (Oct/Nov 2009)
- DME Medical Necessity Reviews – complex review (Fiscal year 2010)
- Medical Necessity Reviews-complex review (calendar year 2010)

Source: Recovery Audit Contractors (RACs) and Medicare  
Connie Leonard, Director, Division of Recovery Audit Operations  
Cmdr Marie Casey, Deputy Director, Division of Recovery Audit Operations Centers  
for Medicare & Medicaid Services, available on CMS website, [www.cms.gov](http://www.cms.gov)



# ADVERSE EVENTS/NEVER EVENTS

- Medicare and Medicaid effort to encourage greater patient safety and reduce never events
- Unnecessary costs result from need to treat consequences of errors

# 2010 OIG Work Plan

- OIG includes item on its Work Plan:  
Serious Medical Errors ("Never Events")
  - The OIG is required by the Tax Relief and Health Care Act of 2006 (TRHCA) to "conduct a study of 'never events,' examining types of events and payments by any party; the extent to which the Medicare program paid, denied payment, or recouped payment for services furnished in connection with such events; and the extent to which beneficiaries paid for such services."

## 2010 OIG Work Plan *(cont'd)*

- In addition, they will review CMS' administrative processes regarding the detection and payment for never events.
- Lastly, they will review hospitals' compliance with CMS requirements by identifying several HACs using POA indicators.



# Five Key Steps That Health Care Entities Can Take Now in Order to Reduce Risks

# Step One – Get Your Board and Management Team on Board

- Critical for health care providers to involve board of directors in order to:
  - Set tone at the top
  - Provide guidance and leadership
  - Keep management in check
  - Keep physician leadership in check

# Step One – Get Your Board and Management Team on Board *(cont'd)*

- Resources for Boards
  - "Corporate Responsibility and Corporate Compliance: A Resource for Health Care Boards of Directors" (OIG/AHLA)
  - "Driving For Quality in Long-Term Care: A Board of Directors Dashboard" Government-Industry Roundtable (OIG/HCCA)
  - "Driving for Quality in Acute Care: A Board of Directors Dashboard" Government-Industry Roundtable (OIG/HCCA)

# Step One – Get Your Board and Management Team on Board *(cont'd)*

- Better nail it down with management first
- Presenting "live" issues to the board
- Don't ignore operational impact – pay for performance, etc.

## Step Two – Assess Your Compliance Program and Develop an Action Plan

- Is your current program stale?
- Is your current program structured in a way to address today's risks?
- Look at your resources, dollars spent on program commitment, tone at the time, liaison support
- Don't just focus on seven elements!!!
- Develop a Plan – short term and long term

## Step Three – Implement Action Plan by Engaging in Proactive Information Dissemination and Training Efforts

- Management and employees need to understand environment and impact
- Consider revisions to practical policies and procedures
- Consider new ways of disseminating information in your organization
- Training must zero in on how to spot and issue which could trigger enforcement scrutiny

# Step Four – Implement Action Plan by Engaging in Proactive Auditing and Monitoring Efforts

- Mine your own data before the government does it for you!!! This is an obvious point – essential!
- Understand where your state Medicaid office is in its enforcement efforts and use of data
- Use of Hospital Compare

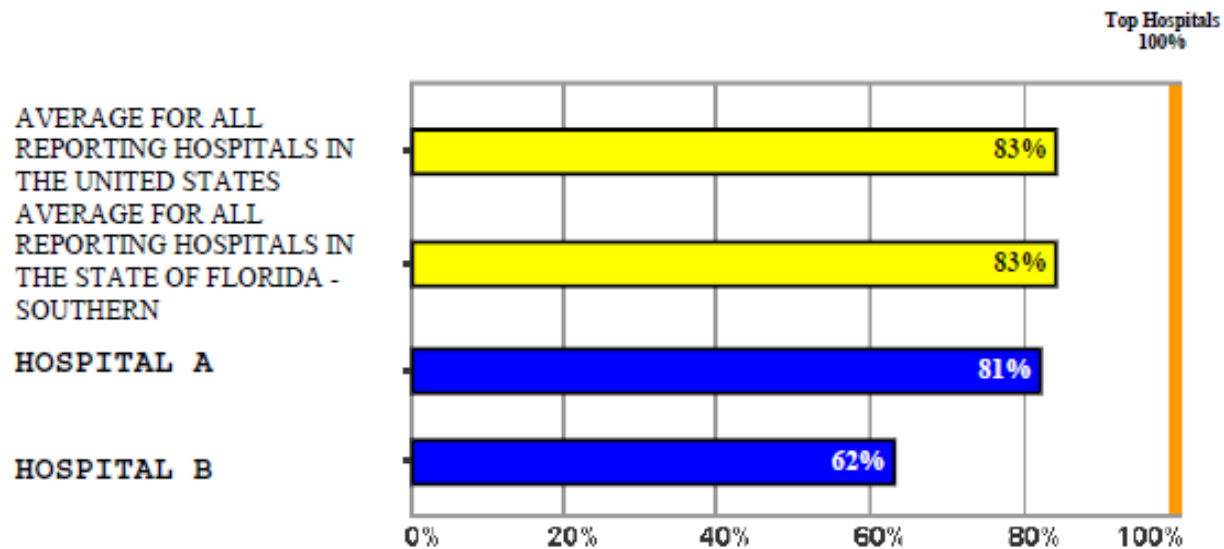
# Hospital Compare

HHS - Hospital Compare - Process of Care Measure Graphs

Graph 1 of 4

Percent of Heart Failure Patients Given ACE Inhibitor or ARB for Left Ventricular Systolic Dysfunction (LVSD)

The rates displayed in this graph are from data reported for discharges April 2006 through March 2007.

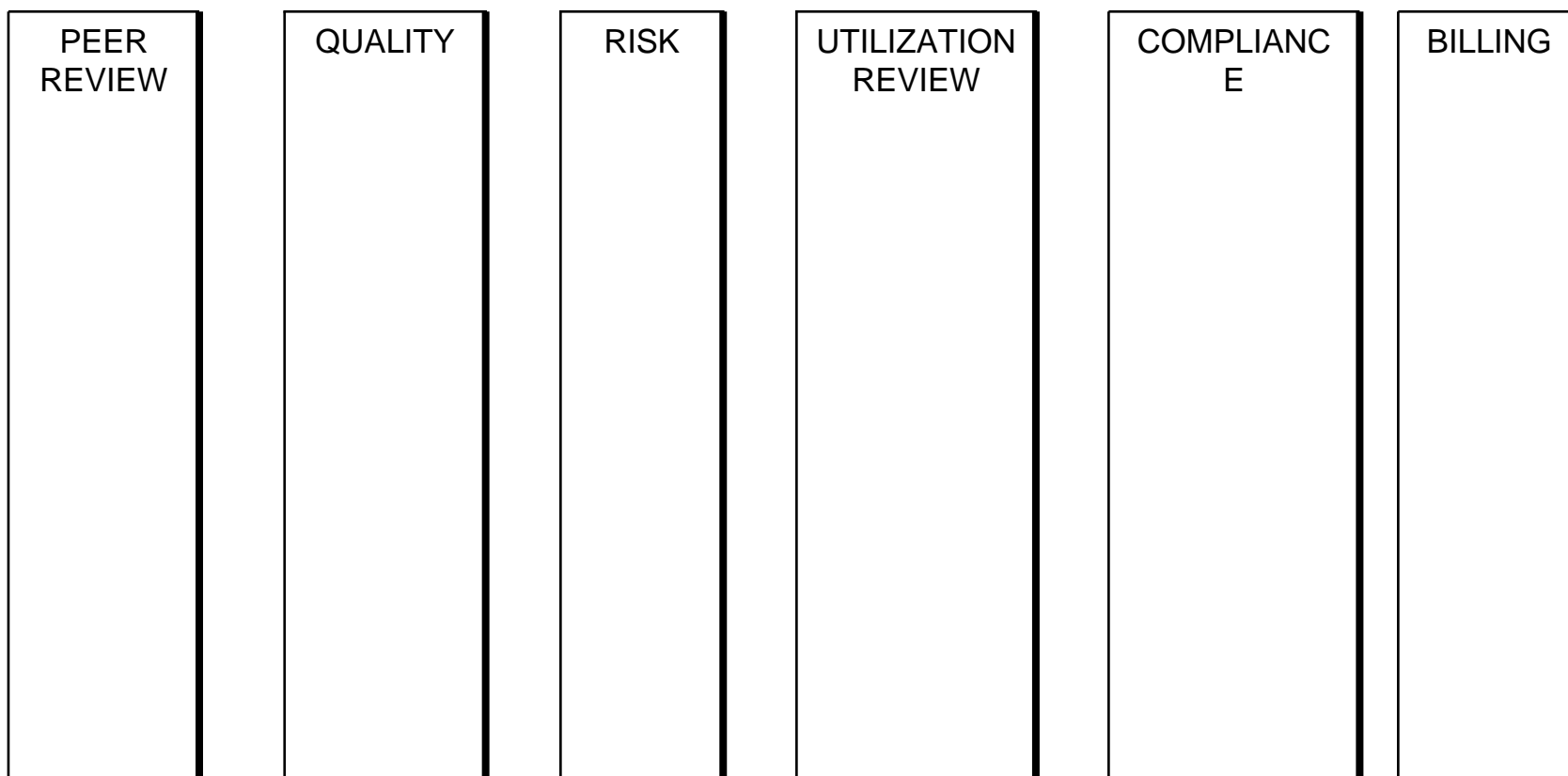


Top Hospitals represents the top 10% of hospitals nationwide. Top hospitals achieved a 100% rate or better.

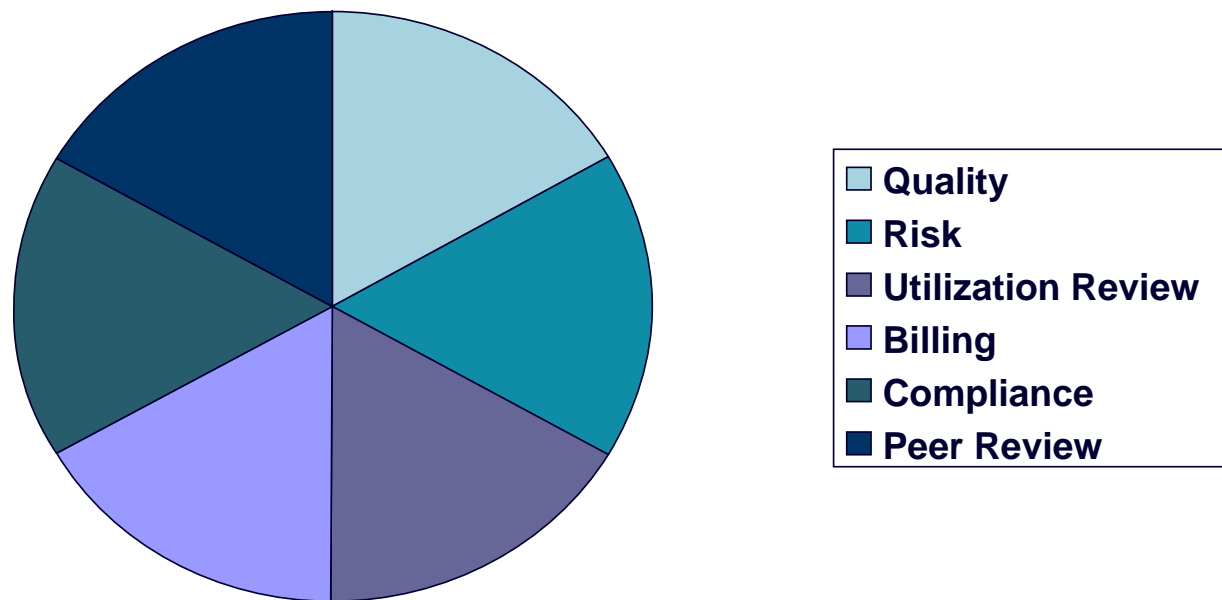
# Step Five – Integrate Quality of Care into Your Compliance Program

- No time for continued turf wars
- Quality of Care must be recognized as a compliance risk
- Break down the silos

# Old Structures – SILO Approach



# New Structure Needed



# Wrap Up Summation

- In today's enforcement environment, everyone is the low hanging fruit
- Assess where you are in addressing these new risks
- Get your organization's support and develop and implement a plan

# QUESTIONS