

Unavoidable Truths Of Health Care Reform

Law360, New York (July 21, 2010) -- There are times in history when one realizes that today is different than yesterday and yesterday will never be again. So it goes for the health care system in America.

The sweeping change embedded within the Patient Protection and Accountable Care Act (PPACA) and the Fraud Enforcement and Recovery Act (FERA) has or will touch virtually every segment of the industry, and many core business processes as we know them today. While some of the health care reform provisions have already begun to be enacted, much of the “devil in the details” CMS has yet to develop and will be rolled out over the coming three years.



Kevin Cornish

Fraud, waste, abuse and compliance are all words that saturate a significant portion of the health care reform laws and within which the federal government is placing a significant amount of expectation for fiscal recovery in part to fund the costs of the sweeping reform changes. The cost of implementing PPACA (estimated by the Congressional Budget Office to total \$940 million during the first 10 years) as described within the act will be paid for, in part, by eliminating fraudulent, wasteful, or abusive practices.

- The National Health Care Anti-Fraud Association estimates that fraud amounts to at least three percent of total health care spending, or more than \$60 billion per year.
- The Congressional Budget Office estimates that every \$1 invested to fight fraud results in approximately \$1.75 in savings.
- Attorney General Holder highlighted in the U.S. Department of Justice’s 2009 accomplishments, a record number of health care fraud defendants charged (more than 800), more than 580 convictions, and civil health care fraud recoveries under the False Claims Act of \$2.2 billion.

The health care industry is facing a dramatically increased level of scrutiny designed to assess compliance with ever-changing state and federal regulations and to detect fraud or incorrect payment. After analyzing the state of the health care industry, Navigant Consulting sees four unavoidable truths about health care compliance, fraud and abuse, which health care entities must consider:

- 1) Every health care entity in the U.S. will be under the microscope and scrutinized more than ever by government agencies or federal contractors on their level of compliance, often without their knowledge.
- 2) All health care organizations are at risk for potential false claim act violations due to billing and documentation process complexity and a constantly shifting regulatory environment.
- 3) Whether proactive or reactive, the ability to definitively demonstrate compliance effectiveness is the best way to mitigate risk and exposure associated with fraud investigations and lawsuits.
- 4) If faced with an investigation or lawsuit, the only way to mitigate the potential damage is to know your data and processes better than anyone else and be able to understand and clearly articulate your risk areas, patterns, systems, processes and compliance activities better than the government.

What Should Companies Focus On Now?

Of the many new changes within PPACA, there is one area in particular that represents significant organizational risk, which requires company planning and preparation now, before it's too late. The May 2009 Fraud Enforcement and Recovery Act (FERA) expanded the definition of the False Claims Act to include retention of overpayments. This may appear to be a subtle distinction but it is a major shift in risk to health care companies.

The PPACA requires that once an overpayment is identified, it must be returned within 60 days (or by the date that the corresponding cost report is due) and the entity must notify the Secretary of the Department of Health and Human Services, the state, the contractor, intermediary or carrier in writing, regarding the reason for the overpayment.

For a health care company that processes thousands of claims weekly or monthly, it will be a major challenge to implement effective processes to define, let alone identify, overpayments on claims. Such "violations" will be a primary entrée that a state or federal enforcement agency may use to initiate an investigative proceeding and/or financial recoupment.

In addition to the black and white overpayments, there is a tremendous amount of grey areas that are often part of health care reimbursements, which can, and will, translate to an overpayment, but not be readily known or understood by the provider.

These include: inappropriate payer identification (Medicare paying as primary when other payer should have been primary); inappropriate line level payment for a service/item that should have been paid as part of a global or prospective payment; credit balances; payment for services in violation of the Stark law (which is now a False Claims Act violation too); payments for services where the order for the service was alleged to be induced by a kickback; and services that are provided by excluded persons or by excluded ordering providers to name a few.

Health care companies must have a well designed, tested and monitored process system that will provide reasonable assurance to the entity, its board of directors and any outside regulatory agency that overpayments can, and are, detected and processed in a timely manner, consistent with the act.

If a provider does not have such a comprehensive system, or cannot demonstrate effectiveness of such a system, the risk for multiple investigations and False Claims Act triggers by regulatory enforcement agencies, private party plaintiffs and whistleblowers alike, is very high.

The deck is stacked in the favor of the government and private plaintiffs under the new laws. Health care companies have a short window of time while the momentum of the new laws and resources ramp up to get their

claim overpayment systems and processes developed and implemented, and be the primary sentinel to manage compliance and False Claims Act risks.

--By Kevin Cornish, Navigant Consulting Inc.

Kevin Cornish is a managing director with Navigant Consulting in the firm's Phoenix office and the national leader of the firm's health care dispute and investigations practice.

The opinions expressed are those of the author and do not necessarily reflect the views of the firm, its clients, or Portfolio Media, publisher of Law360.

