PLDW
HEALTH CARE

CLIENT ADVISORY:

COMPLIANCE IN HEALTH CARE IS *NOT* AN ELECTIVE

The occurrence of health care fraud reached epidemic proportions in the United States during the late 1990s. As expected, the reaction by Congress was to pass legislation that significantly altered legal standards to make it easier for the federal government to prove violations of federally funded health care programs. At the same time, Congress provided additional funding to the Federal Bureau of Investigation and Department of Justice in order to investigate providers and enforce compliance with health care laws and regulations.

In 1996, the Health Insurance Portability and Accountability Act (HIPAA) established a national Health Care Fraud and Abuse Control Program (HCFAC) empowering the Attorney General and the Secretary of the Department of Health and Human Services (Department), through the Office of Inspector General (OIG) to enforce increased regulation of providers. The HCFAC coordinated law enforcement activities on the federal, state and local levels dealing with health care fraud and abuse. The identification and prosecution of health care fraud by the OIG has been stepped up in an effort to deter this type of activity now and in the future.

The OIG has declared a zero tolerance policy relating to health care fraud and has outlined steps to establish and implement a meaningful compliance programs by the providers. Identifying and preventing conduct that could be deemed fraudulent is the primary benefit in establishing a health care compliance program. If a viable program exists and a violation is determined to have occurred, the provider may receive a reduction in the level of sanctions, penalties or exclusions from federal health care programs because it has taken proactive measures.

In 2013, the federal government obtained in excess of $2.6 billion in judgments and fines resulting from health care fraud and as a harbinger of things to come, the Department of Justice opened more than 1,000 criminal health care fraud investigations and continued to pursue thousands of pending matters. It is important to note that the majority of investigations conducted by OIG fall into three primary categories: (i) billing; (ii) anti-kickback/ self-referral; and (iii) antitrust matters. Notwithstanding the increased cost of doing business, it is imperative that health care providers adopt, implement and maintain a compliance program in order to avoid technical violations, which may result in fines and judgments.

The formation of the Accountable Care Organization (ACO) has permanently changed the health care landscape. The ACO is responsible for providing a set population with health care that meets quality targets, and compliance is at the core of their existence. A significant result of this trend is the development of new payment incentives by Medicare, Medicaid and employer groups that reward higher quality and more efficient care, which also require a high level of expertise to avoid becoming a target of the OIG and other federal agencies.

The basic elements of an effective compliance program include the following: (1) written standards of conduct, (2) employment of a compliance officer who is tasked with enforcing the compliance program, (3) effective employee education and training, (4) regular evaluations and audits, (5) effective internal reporting processes, (6) disciplinary mechanisms, and (7) effective remediation.

Appointing a compliance officer, educating staff, conducting compliance audits, and establishing a hot line to correct issues of compliance are essential to an effective program with all steps designed to establish guidelines for preventing fraud and abuse.

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