



Health Services
LOS ANGELES COUNTY

December 14, 2010

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TO: Each Supervisor

FROM: John F. Schunhoff, Ph.D.
Interim Director

Sharon Ryzak
Chief Compliance Officer

SUBJECT: **DEPARTMENT OF HEALTH SERVICES
COMPLIANCE PROGRAM: STATUS REPORT**

John F. Schunhoff, Ph.D.
Interim Director

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Interim Chief Medical Director

This is to provide your Board with a status report on the Department of Health Services (DHS) Compliance Program. The overall goal of the DHS Compliance Program is to ensure that DHS and its workforce members comply with applicable laws, regulations, policies and other standards of conduct. The primary focus of the Compliance Program is on adherence to government and private health plan requirements and on laws that govern health care business practices, such as the False Claims Act, fraud and abuse laws, and privacy laws.

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through leadership,
service and education*

Following is a summary of the significant Compliance Program activities and other compliance-related events since our last status report of December 21, 2009.

Recovery Audit Contractors (RAC) Program

As reported previously, the Centers for Medicare and Medicaid Services (CMS) began implementation of the permanent RAC Program in 2009. The purpose of the RAC Program is to identify improper Medicare payments. The RACs are paid on a contingency fee basis on the amount of improper payments that they identify. In California, CMS has contracted with Health Data Insights, Inc. (HDI) to perform RAC audits.

In January 2010, DHS received its first RAC requests for medical record documentation to support selected claims. In addition to reviews of medical record documentation to identify improper payments (referred to as complex reviews), the RACs also perform automated reviews, which rely on computer based data mining and analysis to identify improper payments, rather than a review of the medical record. As of October 2010, the HDI has identified \$72,660 in overpayments and \$6,525 in underpayments through both complex and automated reviews of DHS facilities.

While the RAC activity and take-backs to date have been minimal, we expect this activity to increase with the recently added RAC reviews to validate the medical necessity of admissions. Medicare only pays for inpatient hospital services that are medically necessary for the setting billed (e.g., inpatient). Until recently, the



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complex audits have been limited to validating that the diagnostic and procedural information matches the information in the medical records (referred to as DRG validation reviews).

Each DHS Hospital has established a RAC Team to manage the RAC process. The DHS-wide RAC Coordinator and the Audit and Compliance Division are working with DHS Revenue Management and the facilities' RAC Teams to monitor the RAC activity and identify issues and corrective actions needed to minimize the potential for improper payments.

Compliance Update Training

DHS requires its workforce to receive compliance awareness training at the start of service and compliance update training every two years. As reported previously, the Compliance Program rolled out its Compliance Update Training on October 15, 2009. We monitored for completion of this training and 99% of employees, and 96% of the total workforce, including non-County staff, have completed this training.

Compliance Program Survey

The Compliance Program conducted a survey to gauge our workforce members' understanding of the Compliance Program and to identify where improvements could be made to strengthen the Program and help ensure honest, responsible and legal conduct. Approximately 1,700 surveys were completed from August 30, 2010 through October 13, 2010. We are in the process of evaluating the survey results.

Compliance Audits and Investigations

The Compliance Program developed the FY 2009-2010 Compliance Audit Plan based on an evaluation of potential risk areas, available resources and other relevant factors. During FY 2009-2010, the Audit and Compliance Division completed 22 compliance-related investigations and 3 compliance-related audits. These reviews included areas related to patient privacy, falsification of documents, drug diversion and conflicts of interest. Thirteen (59%) of the 22 completed investigations identified non-compliance with policies, procedures, regulations or other standards and resulted in recommendations for corrective actions, including discipline, additional training, improved policies and procedures, revised billings and strengthened internal controls.

Patient Privacy

Significant changes occurred at both the state and federal levels over the past two years regarding the reporting of alleged privacy breaches. In addition to reporting all suspected privacy breaches to State Licensing, privacy breaches that meet specific criteria must also be reported to the U.S. Department of Health and Human Services (HHS) under interim federal regulations issued this year to enhance the protection of patient information. The state and federal governments are authorized to investigate and impose penalties against facilities for privacy breaches, which range from \$2,500 to \$250,000 depending on the severity of the breach and State Licensing may also levy penalties against individuals who participated in a privacy breach. For the period of December 2009 through November 2010, DHS facilities reported 22 alleged privacy breaches to the State, of which six were investigated. Five are pending the results of the State's investigation and one resulted in a deficiency citation but the facility was not fined. Additionally, one breach that affected over 500 individuals was reported to HHS as required.

The Department has revised the Privacy and Confidentiality workforce training materials to incorporate the new laws and expects to initiate the Privacy and Confidentiality Update Training for our existing workforce by the fourth quarter of FY 2010 – 2011. We will also incorporate the training into our new workforce orientation.

DHS management continues to provide patient privacy compliance education on various topics such as how to prevent privacy or security violations, reporting requirements, privacy concerns when using social networking sites, photographing patients, and also reissued the Department's Information Technology Resources policy, which reminds staff of their responsibility to protect patients' electronic information. The Department has also worked with County Counsel to revise the Business Associate Agreement language to comply with the changes in federal law.

Compliance Implications of Health Care Reform

On March 23, 2010, President Obama signed comprehensive health reform, the Patient Protection and Affordable Care Act, into law. Among the complex mix of payment and coverage provisions, the law creates several new compliance obligations and increases the County's risks in the event that it fails, even unintentionally, to follow all of Medicare and Medicaid's payment rules. This law makes it clear that the federal government intends to aggressively pursue and prevent fraudulent, wasteful, and abusive practices and to maximize recovery. Some of the significant compliance provisions of health care reform are:

Mandatory Compliance Programs

As a condition of enrollment in Medicare and Medicaid, providers and suppliers will be required to maintain a compliance program. The legislation requires CMS to issue regulations regarding the required elements of the compliance program and implementation details. To date, CMS has not proposed those regulations.

The DHS Compliance Program has tailored its program after the seven elements of an effective compliance program included in the Department of Health and Human Services Office of Inspector General's compliance guidance. We expect that the new regulations will contain similar requirements and do not anticipate that we will need to make significant changes to the structure of our existing program. However, we anticipate the emphasis on compliance programs will continue to grow and the Department will need to continue to strengthen its efforts to maintain an effective compliance program.

Return of Overpayments

Prior law did not expressly require providers to return Medicare and Medicaid over-payments, although they were required to be disclosed. Under the new law, overpayments must be reported and returned by 60 days after the date on which the overpayment was identified, or the date any corresponding cost report is due, whichever is later. Providers reporting overpayments also must provide the reason for the overpayment in writing. Failure to do so is considered a false claim and can subject the County to penalties.

DHS practice is to promptly return any known overpayments. However, this is often done without submitting an explanation. The Department may need to establish policy to ensure that all identified overpayments are reported and returned within the required time frame.

Enhanced Enforcement

The legislation substantially increases funding for fraud and abuse enforcement activities. One of the increased activities is the expansion of the RAC Program (discussed above) from Medicare Parts A and B to also cover Medicaid, as well as Medicare Parts C and D. This expansion must be fully implemented by April 2011. While the County provides a substantial amount of Medicaid services, it bills and is paid under several unusual payment mechanisms, such as per visit cost-based reimbursement for outpatient care, and TAR-based per diems for inpatient care. Accordingly, it is difficult to assess whether the expansion of the RAC program will, as a pragmatic matter, have a substantial effect on the Department.

Ongoing Compliance Activities

In addition to the above, following are some of the ongoing compliance activities:

The DHS Compliance Committee continues to meet approximately monthly to discuss and determine actions needed related to potential risk areas, new compliance initiatives/regulations, compliance goals and priorities, policy changes, the status of compliance audits and investigations, and other compliance issues.

The Audit and Compliance Division continues to manage the DHS Compliance Hotline which provides a mechanism for employees and the public to report concerns and suspected violations, and to make inquiries related to ethical and compliance issues. During FY 2009-2010, A&CD received 137 calls through the Compliance Hotline.

The Compliance Program distributed compliance tips/reminders to the workforce to help promote honest and responsible conduct.

Conclusion

The Compliance Program continues to promote a culture of compliance and take steps to prevent, detect and correct instances of non-compliance. However, given budget constraints, the Department has not been able to dedicate additional resources to increase compliance audits and investigations or support additional preventive activities at the local facility level.

We will continue to provide periodic status reports to your Board to keep you informed of the compliance activities. Significant compliance issues will be brought to your immediate attention, as appropriate.

If you have any questions or need additional information, please let us know.

JFS:SR:km

c: Chief Executive Officer
County Counsel
Executive Officer, Board of Supervisors