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Your Problem Is Now My Problem—The New Era of Fraud and Compliance for Health Insurers



BY KIRK J. NAHRA

In an industry full of ongoing change, enormous financial pressure and an extraordinarily complex regulatory environment, where the government has enormous resources, substantial law enforcement tools and proprietary financial concerns, the need in the health care industry for strong, effective compliance programs is extraordinary. For health care providers, the challenge has been to try to follow the rules, and stay out of the way as much as possible when the government came looking.

For health insurers, the compliance challenge has always been something different. First, until recent years, the health insurance industry largely avoided involvement with government health care programs, other than in the limited role as claims processors for the Medicare program. With the advent of Medicare Part C and Part D, and the wide range of government contract-

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ing opportunities for health insurers, however, this situation has now changed substantially.

By blending and blurring the lines between anti-fraud programs and compliance programs, the government has now assigned to health insurers a core responsibility for engaging in anti-fraud investigations across these government health care programs.

In addition, on the commercial side, health insurers can be victims of health care fraud in the same way that the government is—subject to fraud schemes perpetrated by health care providers and others. Health insurers maintain special investigation units, share information with law enforcement, assist law enforcement in investigations, and share training and best practices through organizations like the National Health Care Anti-Fraud Association. For many years, the health insurer anti-fraud units have been partners to government fraud investigators in pursuing health care fraud across all health care programs.

Now, through two recent significant developments, the federal government has changed the landscape for the anti-fraud and compliance environment for the health insurance industry. In particular, these developments will result in more information sharing between the government and private health insurers, but will also shift to health insurers some of the responsibility for policing the behavior of health care providers in connection with government programs.

The government is now expecting health insurers to do the government's work in some fraud investigations as part of a new compliance mandate; and, if health insurers do not do a good job of fighting fraud committed by others, the insurers may face their own government investigations, under the False Claims Act or otherwise.

Health insurers need to pay close attention to these developments, to ensure an appropriate strategy for both anti-fraud operations and appropriate compliance

activities. In addition, these developments mean that this is now a critical time for health insurers to evaluate their overall compliance programs across the board.

■ *The Information Sharing Developments*

The Department of Health and Human Services and the Department of Justice recently announced a “ground-breaking partnership” to prevent health care fraud, involving a variety of private sector entities along with public agencies in the fight. The program (according to the government’s press releases) is designed to “share information and best practices to improve detection and prevention of fraudulent health care billings.”

The laudable goal is to “reveal and halt scams” and enable those “on the front lines” to “share their insights.” In addition, one “innovative objective” is to “share information on specific schemes, utilized billing codes and geographical fraud hotspots so that action can be taken to prevent losses . . . before they occur.”

For those of us experienced enough (or simply old enough) to remember the early era of the HIPAA statute, this all may sound familiar. In HIPAA (which originally meant health care fraud more than it did privacy and security), Congress required the establishment of a

program (A) to coordinate Federal, State, and local law enforcement programs to control fraud and abuse with respect to health plans, (B) to conduct investigations, audits, evaluations, and inspections relating to the delivery of and payment for health care in the United States, (C) to facilitate the enforcement of the provisions [certain statutes] applicable to health care fraud and abuse, (D) to provide for the modification and establishment of safe harbors and to issue advisory opinions and special fraud alerts . . . and (E) to provide for the reporting and disclosure of certain final adverse actions against health care providers, suppliers, or practitioners. . . . In carrying out the program . . . the Secretary and the Attorney General shall consult with, and arrange for the sharing of data with representatives of health plans.

See generally Nahra, *New Anti-Fraud Challenges for Health Care Payers: Creating a Broader Business Role for Fraud Fighting* (1998), available at <http://www.wileyrein.com/publications.cfm?sp=articles&id=261>.

HIPAA therefore *required by statute* a formalized overall program to fight health care fraud, featuring effective information sharing program and partnership between the government and the private health insurance industry.

So, while there has been some history in this area (including both some limited success along with a general lack of progress), this new program represents (a) a renewed effort to improve the sharing of information between the public and private sectors, both of which are affected by health care fraud and (b) a more visible, higher level effort endorsed by the White House, DOJ and HHS.

Through this effort, it is clear that:

- The government is willing to make a significant, visible public effort to bring the private sector into their anti-fraud approach;

- The government appears willing to share some new information about health care fraud investigations with health insurers; and

- The government is paying some attention to private sector cases.

At the same time, however, until some specific information sharing activities develop, it is not clear what kinds of information will be shared and whether this information will be of material benefit to the private sector in its effort to detect and investigate health care fraud. There also have been important developments under health care reform and in the health care debate overall that have provided new opportunities and incentives for the government to focus even more on government program fraud cases, rather than private sector cases.

Concurrently, the health insurance industry faces increasing risks of being a target of government health care fraud investigations, based on this expanded involvement in government health care activities.

Moreover, as part of the information sharing program, the health insurance industry does not know what kinds of information the government will want from the private sector and whether the government will seek information that can be used against health plans in the government’s investigations of the government program activities of health insurers.

While this anti-fraud program may help health insurers in their own investigations—and it is *important for health insurers to fully embrace this program in order to demonstrate a commitment to cooperation with law enforcement authorities in fighting health care fraud*—the program also presents the realistic possibility that the government will now have new ammunition to use against health insurers as part of the government’s own investigative efforts.

■ *The Compliance Guidance*

This information sharing partnership leads directly to the next big development. On July 27, the Centers for Medicare & Medicaid Services (through Gerard Mulcahy, acting director of the Program Compliance and Oversight Group) released the Final Compliance Program Guidelines to replace the current Chapter 9 of the *Prescription Drug Benefit Manual* (for Medicare Part D) and Chapter 21 of the *Medicare Managed Care Manual* (for Medicare Part C) (with identical provisions for both programs).

This document (available at <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter9.pdf>) sets forth the guiding principles for compliance programs to be operated by sponsors of Medicare Part C and Part D plans.

This final guidance focuses primarily on the (now familiar) core elements of an effective compliance program. It spells out, in the context of these government health care programs, the obligations of health insurers participating in those programs to ensure that the companies are complying with applicable law, through the development and maintenance of an effective compliance program.

Health insurers need to pay close attention to the details of this guidance and should evaluate needed improvements to their existing compliance programs across the board.

While most of these new provisions should be neither surprising nor problematic for health insurers (most of whom already have implemented appropriate compliance programs), the guidance creates significant confusion and perhaps a new set of compliance obligations for health insurers by broadening the insurers' responsibilities to include not only their own activities and the activities of their agents, but also the activities of the health care providers that provide services to beneficiaries under this program. *In that way, the government has now used this guidance to turn anti-fraud investigations against health care providers into a compliance program requirement for health insurers. By blending and blurring the lines between anti-fraud programs and compliance programs, the government has now assigned to health insurers a core responsibility for engaging in anti-fraud investigations across these government health care programs.*

So, what's the issue? The real concern stems from the linkage in the guidance of the compliance function for a health plan with the overall activities of the Special Investigation Units for these plans.

Because the guidance requires anti-fraud activity, and obligates the health insurers to oversee the activities of their downstream contractors—including (apparently) most or all health care providers that provide services to beneficiaries—this guidance turns a plan's anti-fraud activities into a compliance requirement with the plan responsible for the providers if they engage in health care fraud. This means that a failure to conduct an effective anti-fraud program (measured by some as yet undetermined standards) may create compliance exposure—including under the False Claims Act—for health insurers resulting from their traditional anti-fraud activities.

The problems start when the guidance incorporates into an effective compliance program “measures to prevent, detect and correct Part C or D program noncompliance as well as FWA [fraud, waste and abuse].” Because of these definitions—and the responsibility of plan sponsors to ensure that downstream contractors are not engaged in inappropriate activity—this overall guidance reflects a mixture of responsibilities of a compliance office and a traditional Special Investigations Unit.

It also links the idea of an inward facing compliance program to the external activities of the SIU. According to CMS, “Sponsors must ensure that the SIU and compliance department communicate and coordinate closely to ensure that the Medicare Parts C and D benefits are protected from fraudulent, abusive and wasteful schemes throughout the administration and delivery of benefits, both at the sponsor and FDR [First Tier, Downstream or Related Entity] levels.”

The guidance also makes clear (as the original guidance did, as well) that the “sponsor maintains the ultimate responsibility for fulfilling the terms and conditions of its contract with CMS, and for meeting the Medicare program requirements. Therefore, CMS may hold the sponsor accountable for the failure of its FDRs to comply with Medicare program requirements.” It is this “ultimate responsibility” that has created much of the confusion between “compliance” activities and traditional “anti-fraud” activities.

In most situations involving health care providers, there is both a sponsor's responsibility for the activities of the providers if they are contracted entities in any

way, and the provider's own responsibilities for its activities if it is participating in the Medicare program themselves. The new focus of this guidance, however, is on turning the responsibility to the health insurers to police the activities of the downstream health care providers.

This means that an “effective compliance program” now includes not only ensuring appropriate steps to police a company's internal activities, but also programs that investigate and detect fraud in the full range of downstream health care providers who provides services to beneficiaries of the health insurer.

■ *Implications for Health Insurers*

So, with these two developments, the government effectively has said:

- We want your data to use with our fraud investigations;
- We'll provide you with some information, but it's not clear what;
- We might use this data to evaluate and investigate your activities;
- We have now made effective anti-fraud activity into a compliance obligation for your plan;
- This obligation extends to the obligation to ensure that health care providers serving your beneficiaries are not committing fraud; and
- We can go after you for a compliance program failure if you don't do a good job detecting fraud by health care providers.

That's a pretty tough set of challenges.

So, what should health insurers be doing to manage this situation?

- The Guidance requires a re-evaluation and upgrade to existing compliance programs.

The core of the guidance provides details on the operation of an effective compliance program. Between the new details about these programs and the increasing usage of the False Claims Act and other fraud enforcement tools against health insurers, it is critical for health insurers to use this new guidance as a baseline for a re-evaluation of existing compliance programs. While this re-evaluation should be an ongoing process at any health care business, this new guidance should force health insurers to properly examine their practices and redefine, expand and improve the compliance program under these new standards.

- The Guidance places a high premium on developing an effective anti-fraud plan for downstream health care providers.

Most health insurers have Special Investigation Units that handle health care fraud investigations. This new guidance means that insurers must have these anti-fraud units, that the fraud units must meet specific legal standards (which previously have not been subject to meaningful regulation) and that a failure to engage in appropriate anti-fraud activities can constitute a compliance violation. Health insurers will need to ensure that these SIUs have appropriate resources and a critical role in development of an overall plan for fighting fraud.

- There is a need for clear and well defined coordination between a compliance officer and the SIU.

At the same time, this guidance links the roles of the compliance officer and the head of the SIU in ways that typically and historically have not been connected. This guidance makes the Compliance Officer responsible for development of the overall anti-fraud program, including the activities typically undertaken by the SIU head. Companies will need to develop an appropriate management response for these overlapping obligations. While there is no mandated organizational structure, the compliance officer will now need to be linked formally to the SIU, and the specific oversight role must be clearly described and implemented.

- Management will have to pay attention to anti-fraud activities.

Anti-fraud programs often have received little oversight or attention from management. While there always have been good reasons to develop a strong anti-fraud program, management now must pay attention to these units to ensure that health insurers are acting appropriately in policing the behavior of others. This may require a significant change in mind set from management towards the SIU, and will require more focused oversight of all anti-fraud activities.

- Management will need to decide whether the Medicare structure will be applied to all SIU activities.

This government program guidance is just that—guidance and requirements for compliance programs and anti-fraud activity in connection with government health care programs. Companies will be faced with an important strategic challenge. The guidance clearly forces some changes to typical anti-fraud activities, in integration with a compliance program for government programs. Will companies apply this integrated structure to all anti-fraud activities, for commercial and government programs alike? While there is not a mandate for anything outside of government programs, companies may choose to adopt an overall corporate strategy

to deal effectively with fraud issues. A decision needs to be made on this overall approach.

- Companies will need to pay close attention to the effectiveness of the anti-fraud program, to ensure appropriate compliance steps.

Companies also will be required to develop appropriate measuring tools to evaluate the effectiveness of anti-fraud programs. These programs typically have been unregulated in the past (outside of some limited requirements from state insurance departments), and each plan made its own assessment of whether the anti-fraud program was working well. Among other items, the CMS guidance includes specific mandates related to the timing of investigations and the “resolution” of investigations (essentially assuming that resolving an investigation of a health care provider is the same as closing an internal investigation). Now, it will be critical to formalize this evaluation, to ensure that anti-fraud programs are being measured and assessed in the same way that applies to other aspects of the compliance program.

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These developments are new, and the CMS guidance clearly reflects some ongoing confusion as to appropriate roles. Nonetheless, it is clear that health insurers will need to implement a new structure for integrating anti-fraud investigations of health care providers with an overall approach to an effective compliance program.

At the same time, aside from these management challenges, health insurers need to be aware that a failure to engage in effective anti-fraud efforts may subject companies to potential exposure (under the False Claims Act or otherwise) in connection with what will now be deemed compliance failures.

Companies need to move quickly to conduct these internal evaluations, and must ensure that all aspects of this compliance guidance are delineated and implemented on an effective basis.