CCH Health Care Compliance LETTER

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### Letters to the Editor

The CCH Health Care Compliance team welcomes comments or questions regarding articles published in the CCH Health Care Compliance Letter. Send comments to Sharon Sofinski, Coordinating Editor, at sofinsks@cch.com. For more information about the CCH Health Care Compliance Portfolio visit our online store at http://health.cch.com.

# HIPAA Privacy Rule may interfere with powers of attorney, experts say

## by Catherine Hubbard, MA, Contributing Editor

You've set up a health care power of attorney (POA) and a trust, so you'll be able to make medical and financial decisions for your spouse if he or she becomes incapacitated, right? Not if it's a springing power of attorney. In that case, your power is dormant until the physician determines your spouse is incapacitated. And unless the patient has signed a HIPAA privacy document, the physician may be unable to disclose the protected health information (PHI) necessary for the agent to act on behalf of the incapacitated spouse. The health care POA and trust intended to keep you out of the courts may never take effect.

**Privacy concerns.** A doctor's certification that the patient is unable to make or communicate health care decisions may be considered a disclosure of PHI, said Christy Reid, of Robinson Bradshaw & Hinson PA, Charlotte, North Carolina. during a December 6 interview. "A physician may be reluctant to make that certification without an authorization."

"Doctors have issues with HIPAA and privacy that may have them feel they are precluded from giving personal health information," said certified elder law specialist, Joseph Karp, of The Karp Law Firm, Palm Beach Gardens, Florida.

Karp noted that not every doctor will be as meticulous in analyzing his or her interpretation of the law. But when dealing with a gray area of law and a reasonable concern about how the federal government is going to enforce it, he said, "It is much better to be prudent."

**Springing vs. immediate POA.** Deborah Cohn of Paley, Rothman, Goldstein, Rosenberg, Eig & Cooper in Bethesda, said that if the principal, the person who writes the POA and designates an agent, writes the document and says the agent is authorized to act immediately, then there's no HIPAA issue, because the triggering of authority is not dependent upon the principal's medical condition.

However, Cohn noted, if the POA is springing, meaning the agent's authority arises only if the principal has become unable to manage his or her own affairs as determined by a physician, then a HIPAA issue arises.

"If there is a springing POA, then you have to have language in there that will allow your agent to get letters from your doctors that you're incapacitated," said Karp. "If it's not springing, don't worry."

**Be prepared.** In addition, the HIPAA document must be signed while the person still has their wits about them. If the person already is incapacitated or

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incapable to manage their own affairs, it's probably too late. "In certain states that have a springing health care power of attorney, it may be necessary for the patient to execute in advance an authorization for use and disclosure of PHI that would allow a designated health care agent to receive the certification from the doctor necessary to trigger the health care agent's power," Reid said.

In a typical scenario, the issue is whether the physician can discuss the parent's medical condition with the child, disclose any information regarding the parent's medical condition to the child, and provide a letter to the child stating the physician's medical opinion as to whether or not the parent is capable, said Cohn.

But HIPAA does allow a person to name a "personal representative," authorizing the physician to discuss the patient's PHI with the person who will become the agent once the physician certifies the parent is unable to manage his or her own affairs. Cohn noted that without the parent's having previously named the child as the parent's personal representative under HIPAA, the physician appears to be proscribed from providing the child that letter or, more broadly, discussing the parent's medical condition and situation with the child.

**Double agents.** The principal can even write the POA as nonspringing with regard to the first agent, for instance a spouse, and as springing with regard to a successor, such as a child. In that case, the spouse could act immediately, but the child could act only if both spouses can't handle their own affairs, as certified by their physicians, said Cohn.

**Trusts.** Revocable trust agreements give rise to the same HIPAA issues if the successor trustee can act only if the physician finds and discloses that the patient can't manage his or her own affairs. "The successor has no authority until he or she gets the physician statement and the successor has no ability to get that physician statement unless there's a piece of paper outside the trust agreement," Cohn said.

Whether a medical POA or a trust, it's important to include that extra document. "In both cases, it is wise in this day and age to have that ounce of prevention," said Karp.

Karp recommended that people check their POA documents to ensure their agents are authorized to act. "Make sure you have the ability to get that information," he said. The principal of a trust can avoid another trip to the lawyer by arranging for a freestanding legal instrument stating that he or she authorizes a financial institution to obtain any medical information necessary to document a disability, he said. In any case, he emphasized, "It's got to be looked at."

**"More than 99 percent of trusts and virtually every springing POA never address issue of authority to release PHI."**

More than 99 percent of trusts and virtually every springing POA never address issue of authority to release PHI, said Karp. "It is absolutely imperative that the instrument authorize the release of information," he said. He recommends to his clients a freestanding document allowing disclosure of PHI.

"Until the courts decide what may be disclosed without a valid authorization, you might need this additional piece of paper," said Reid.

Karp predicted that, eventually, Congress and the courts will probably interpret the law to simplify the issue. ■

*CCH Washington Bureau, December 30, 2004*




CCH Health Care Compliance Letter

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## Anesthesiology clinic could have monopolized by refusing to deal

**by CCH Editorial Staff**

A medical clinic and its owner/operators could have engaged in monopolization or attempted monopolization of the market for anesthesia services in Defiance, Ohio, and its immediate environs by refusing to deal with a local hospital, the federal district court in Toledo has ruled.

The clinic had monopoly power and had engaged in predatory or anticompetitive conduct violative of both the Sherman Act and the Ohio Valentine Act, the court determined. Summary judgment was granted in favor of the complaining hospital and its affiliated health care system on those elements of the monopolization claims, as well as on the issue of whether the clinic had a dangerous probability of achieving monopoly power for purposes of the attempted monopolization claim. However, their motion for summary judgment on the issues of general intent to exclude and specific intent to monopolize was denied on the basis that the clinic's professed business justifications for its conduct could have been legitimate.

The clinic's market share was sufficient to show that it possessed monopoly power in the relevant market. Until the hospital hired a staff anesthesiologist, the clinic provided the only anesthesia services in the market and administered all anesthesia to the hospital's patients. Even after the clinic ceded 35 percent of the market by refusing to serve the patients of independent physicians who would not sign "primary source" agreements effectively requiring them to use the clinic's certified registered nurse anesthetists (CRNAs), the clinic's CNRAs still performed 63 percent of all surgical procedures in the relevant market. The portion of the market not controlled by the defendants was insufficient to support the financial burden to the hospital of maintaining its own comprehensive anesthesia service, which the hospital was forced to develop and implement as a result of the clinic's refusal to work with the hospital's anesthesiologist or the independent physicians.

While the clinic and its principals could have intended to exclude competition—and thereby unlawfully acquire or maintain their monopoly power—through their conduct, business justifications they presented gave rise to a question of fact as to whether they possessed that general intent, the court held. The hospital and its affiliated entity set forth sufficient facts for a jury to conclude that the defendants' conduct was intentionally designed to drive the hospital and health care provider out of the market. The clinic and its principals knew that their failure to provide anesthesia services to independent physicians who did not enter primary source agreements would force the hospital to establish a comprehensive anesthesia service doomed to lose money for the hospital. However, the defendants' claims: (1) that the primary source agreements were terminable, (2) that they ensured proper supervision of the clinic's CRNAs and physicians' maintenance of adequate medical malpractice insurance coverage, and (3) that they were uncomfortable with placing their CRNAs under the supervision of the hospital's anesthesiologist because he had no relationship with the clinic could be deemed legitimate justifications by a reasonable juror.

> **"These undisputed facts compelled the conclusion that the defendants refused to deal with a competitor, according to the court."**

**Attempted monopolization.** For purposes of the hospital's attempted monopolization claims, the defendants' refusal to work with the hospital's anesthesiologist, their seeking of "primary source" agreements with independent physicians, and their refusal to provide services for physicians who did not enter into those agreements constituted predatory or anticompetitive conduct that was designed to destroy competition in the market for anesthesia services. These undisputed facts compelled the conclusion that the defendants refused to deal with a competitor, according to the court. A question of fact still existed, however, as to whether the medical clinic and its owner/operators acted with the specific intent to monopolize the market for anesthesia services in the Defiance area, the court determined. ■

*Defiance Hospital, Inc., ND Ohio*

# OIG's enforcement priorities for 2005

**by Catherine Hubbard, MA**

*The Health and Human Services Department Office of Inspector General (OIG) Workplan for 2005 contains far-reaching goals to reign in upcoding, fraudulent billing, and compliance problems, said two experts during a recent Healthcare Financial Management Association audio conference on the OIG's 2005 Workplan.*

John Wester, a member of Sidley Austin Brown and Wood's health care group in Washington, D.C., said the OIG, spurred by problems at some acute care hospitals, will look at DRGs that have been used in an aberrant way, particularly with respect to upcoding pneumonia. "Coding remains an issue as far as the OIG is concerned," he said.

In addition, the office is interested in sequential stays as they relate to the avoidance of DRG payment limits, Wester said. "They are looking at whether sequential stays involving the discharge and readmission of patients at different hospitals is being used to avoid payment limits," he said. However, he noted, OIG will be looking at inpatient admissions and long-term care facilities. "It's not limited in any sense to acute care hospitals," he said.

The OIG also is looking at postacute care transfers, according to Wester. "They are trying to determine if this system is in fact working and if the limitation for these DRGs is being enforced," he said.

The OIG will also focus on Medicare and Medicaid inpatient and outpatient outliers to find out whether hospitals are presenting financial vulnerabilities to the Medicare or Medicaid system, Wester previewed. OIG is concerned that computations for outlier thresholds are not being done properly, he said, adding that the office will attempt to look at the computations, regardless of the facility involved. "Anyone that has an outlier computation can expect that ...the OIG will be looking at those in 2005," Wester advised.

## DRG Reimbursement

Jim Dechene, partner with Sidley Austin Brown and Wood, Chicago, said the OIG is going to audit the Medicaid programs that rely on DRG reimbursement, specifically Medicaid DRG payment window compliance and whether hospitals are billing for diagnostic tests performed three days prior to the DRG admission. OIG will identify the extent to which the issue may still occur under Medicaid reimbursement programs, he said.

OIG plans to review administrative and other costs on critical access hospital cost reports both before and after conversion, Dechene said. "OIG wants to see how administrative and other costs that are incurred by critical access hospitals may have changed prior to their conversion," he explained. OIG would be looking at cost reports before and after conversion to find out which administrative and other costs might have changed as a result of a conversion and see if the hospitals are taking advantage of their status, he added.

## Rebates

OIG will also examine rebates paid to hospitals. "OIG is concerned these rebates are not being properly accounted for," said Wester. The office is concerned about rebates paid at a separate time from the initial purchase and whether purchase credits are being properly identified as a separate line item on Medicare cost reports, he said.

There's also a concern about purchase credits, Wester said. Sometimes rebates are paid in the form of a check to the hospital, as a coupon, or directly on the invoice. "The trick here is not only that the credit is made apparent, but that it gets properly allocated to the purchases that generated it," he said. The OIG wants to make sure, for instance, that if a purchase credit is provided based on the purchase of radiology equipment and the credit is used to purchase something in the pathology department, the accounting would not be proper. Hospitals in this case should make sure the credit is allocated to the radiology purchases that generated the credit, he said. "That can be a bit difficult for some hospitals to catch, and the OIG is going to be looking at that," he added.

## DSH Payments

In the Medicaid arena, the OIG will be looking at disproportionate share payments, Wester said. The concern is not that hospitals are engaging in inappropriate conduct, but that some states have put in place computations or thresholds that are inappropriate, he said. CMS believes some states aren't calculating these amounts in accordance with their own plans, he noted. There's also concern states are too generous in establishing and enforcing the eligibility criteria, possibly making DSH payments to nonqualifying hospitals, he said. "If you live in a state that is drawn to CMS' scrutiny, you

may indeed be called upon to provide information to assist in that effort," he forecast.

## Medical Necessity

The OIG is increasingly focusing on the issue of medical necessity, said Dechene. The office is expected to look at inpatient and outpatient coronary stents, considering whether the medical record supports the necessity of them and whether stents could have been implanted at some time as another procedure, rather than in a separate admission or procedure.

Dechene noted that OIG has learned of abusive circumstances at one hospital and is looking at whether there are other examples where hospitals are billing for stents that were not necessary. "If you happen to get subpoenaed for some medical records, it may not necessarily mean you've done anything wrong," he said. However, he noted, "It does make sense to make sure your medical records and charts are in order to support you."

Dechene said the OIG will look at reimbursement for outpatient cardiac rehabilitation services and whether a physician is providing direct supervision. Under Medicare, to get reimbursement, the services need to be directly supervised by a physician that has consulted with the patient. "To the extent your hospital offers these services," Dechene advised, "you should make sure you're operating it in a manner that corresponds with the requirement."

Another area flagged by the OIG is the medical necessity of inpatient psychiatric stays, said Dechene. The OIG is drawing on its experience on the outpatient side, where it has found that hospitals have a 52 percent error rate with respect to medical necessity and that specialty hospitals had a 42 percent error rate. OIG will focus on the PPS exempt hospital and psychiatric specialty hospitals that collectively received $2.8 billion in fiscal 2000, he said, noting that the office has indicated that it wants to study the inpatient side.

Wester said the OIG is concerned the explosive growth in the long-term care hospital provider group is caused not by an expanding elderly population, but an increase in inappropriate care being provided. It will examine whether some settings are inappropriate. "It's a fundamental question of whether they're in the right place and whether Medicare is paying the appropriate amount for providing care to those individuals," Wester said.

Dechene said OIG is concerned about the increasing length of time between state surveys of end stage renal disease dialysis facilities. "Dialysis facilities should expect greater oversight," he said. Specifically, OIG will look at the length of time it takes for state agencies to respond to complaints and the states' oversight focus, particularly with respect to quality-of-care-related issues.

## DME

Wester said that in response to the power wheelchair scam, the OIG is going to attempt to engage in a thorough analysis of the issue. They will look at documentation to make sure it supports that durable medical equipment (DME) and medical supplies, including power wheelchairs and therapeutic footwear, were medically necessary and were actually received.

The OIG will be comparing the prices commercial payers paid for certain DME items relative to the price federal and state programs paid. "The MMA has dramatically changed the way DME will be reimbursed going forward," said Wester. The OIG will help supply more pricing information so that the government can build a database that will permit CMS to set more advantageous rates consistent with what other payers, such as Veterans Affairs and the FEHPB, are paying for these items, he said.

## Prescription Drugs

As part of its health care fraud work, the OIG will increase its focus on prescription drugs—in particular, marketing of pharmaceuticals. Its primary concern is to stop the inflating of drug prices, Wester noted. "The significance of these issues will only be increasing with the new benefit and payment methodologies enacted under MMA," he said, noting that payer programs will increase dramatically in 2006, when the new benefit begins.

Even though the average wholesale pricing method (AWP) is being phased out, the OIG will continue to look at the accuracy of AWP for those drugs still reimbursed on that basis, Wester said. It also will review the forthcoming pricing mechanism, ASP, or average sale price, specifically, the collection and maintenance of ASP and the adequacy of ASP-based rates, he said.

New Medicare Part D issues already are beginning to form, said Dechene. The OIG will be monitoring prescription drug card sponsors, abuse of transitional assistance and beneficiary understanding of the program. "OIG wants to take a look to make sure that only the patients that in fact are Medicare beneficiaries that qualify for transitional assistance, receive that transitional assistance," said Dechene, adding that it also wants to make sure beneficiaries understand the Medicare drug card and how it works.

The full text of the OIG 2005 Workplan is available at http://www.oig.hhs.gov/publications/docs/workplan/2005/2005%20Work%20Plan.pdf. ■

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## Pharmacist's five-year exclusion reversed

**by Anuradha Gupta, JD, Contributing Editor**

The five-year exclusion from participation in all federal health care programs against a pharmacist was reversed by the Departmental Appeals Board (DAB) because the Inspector General (IG) failed to prove that the pharmacist was convicted of a criminal offense related to the delivery of an item or service under the Medicaid program.

**Alleged pharmaceutical mislabeling.** The pharmacist, who was employed by a pharmacy company that participates in Medicare and Medicaid programs, was accused of "tacitly participating" in a scheme where pharmaceuticals dispensed to long-term care facilities were returned to the pharmacy company, removed from blister packs, and put into pharmacy stock bottles. According to the IG, the pharmaceuticals were then removed from the stock bottle, resealed in blister packs, and re-dispensed to other long-term care facilities, in violation of state law. The IG alleged that the pharmacist's involvement resulted in the submission of fraudulent claims to the state Medicaid program and the receipt of payments to which the pharmacy company was not entitled.

**Conviction not Medicaid-related.** The pharmacist pled no contest to a charge of recklessly exposing for sale mislabeled commodities while in the course of engaging in a business, occupation, or profession thereby committing the offense of Deceptive Business Practices in violation of state law. Although the conviction was valid, the offense was not related to the delivery of an item or service under the Social Security Act or any other state health program because there was not sufficient evidence to find a nexus between the convicted offense and the item or service in the Medicaid program. Even though the pharmacist was determined to have participated in a scheme to repackage "some" pharmaceuticals, there was no proof that those pharmaceuticals were subsequently sold to an entity affiliated with any government health program. ■

*Lyle Kai v. Inspector General, HHS Departmental Appeals Board, Dec. No. CR1262, Dec. 17, 2004, ¶300,100*

## Proposed pathology services joint venture may violate anti-kickback statute

**by Anuradha Gupta, JD, Contributing Editor**

A proposed arrangement for a pathology services joint venture could potentially generate prohibited remuneration under the anti-kickback statute and face administrative sanctions by the Office of Inspector General (OIG), according to an advisory opinion issued by the OIG. Under the proposed arrangement, a company in the business of arranging for the provision of pathology services would enter into a series of contracts with physician group practices to operate pathology laboratories for each group in an off-site location. The company proposes to furnish all necessary management and administrative services, equipment leasing, premises subleasing, technical, professional, and supervisory pathology services, and, if requested, billing services for each physician group to operate its own pathology lab.

**"...the OIG report explains that a party need not be a provider or supplier to fall under the anti-kickback statute."**

Although the company itself is not a provider or supplier of health care services and does not participate in any federal halth care programs, it is part of a group of affiliated entities that include a licensed Medicare-certified anatomic pathology laboratory and a laboratory staffing company. Additionally, despite the company's assertion that as a management company it is not in a position to solicit or receive federal health care program business, the OIG report explains that a party need not be a provider or supplier to fall under the anti-kickback statute. Furthermore, given the close relationship between the company and the affiliated entities, including: (1) the overlapping officers and directors; (2) common control by a parent company; and (3) ability to assign the proposed arrangement contracts to other affiliated entities, the OIG considers the company and affiliated entities sufficiently related to be treated as a single entity for purposes of anti-kickback statute analysis.

Accordingly, the OIG is unable to exclude the possibility that the parties' contractual relationship is designed to permit the company to indirectly pay the physician groups a share of the profits from their laboratory referrals. The company is in the position to offer the physician groups impermissible remuneration by giving them the opportunity to obtain the difference between the reimbursement received by the physician groups from the federal health care programs and the fees paid by the physician groups to the company. The OIG report notes that even if the individual agreements in the proposed arrangement could satisfy the applicable safe harbor conditions for space and equipment rental and personal services and management contracts, the safe harbors would only protect the remuneration paid for actual services rendered or space or equipment rented, and not protect the physician group's retained profit from the pathology services. ■

*OIG Advisory Opinion 04-17,¶500,120*

## $325 million HealthSouth settlement announced

**by Sharon Sofinski, Coordinating Editor**

The Department of Justice (DOJ) announced that HealthSouth Corpora-

tion will pay $325 million to resolve allegations of fraud involving outpatient physical therapy services and inpatient rehabilitation admissions.

Some of the civil issues resolved by the settlement stem from whistleblower lawsuits filed in Texas and New Mexico. The three whistleblowers will receive over $12 million as their share of the settlement amount.

According to Assistant Attorney General Peter Keisler, head of the DOJ Civil Division, "HealthSouth's fraud on Medicare was driven both by longstanding business practices in its outpatient physical therapy business and improprieties in its inpatient rehabilitation business." The settlement breakdown is as follows:

- $169 million to resolve allegations that HealthSouth submitted claims for outpatient physical therapy services that lacked a properly certified plan of care, that were submitted by individuals who were not licensed physical therapists, or that were billed as one-on-one services when such services were not provided.
- $89 million to resolve claims that HealthSouth submitted claims involving unallowable costs on its hospital cost reports and home office cost statements, and that it submitted improper claims for individual inpatient discharges. The latter included false claims for Medicare outlier payments for 11 of HealthSouth's inpatient facilities and claims for medically unnecessary admissions to Doctor's Hospital Arthritis Unit.
- $65 million to settle charges that HealthSouth submitted claims to Medicare for a variety of unallowable costs on its hospital cost reports and home office cost statements.
- $1 million to resolve allegations that several of HealthSouth's skilled nursing facilities (SNFs) unlawfully billed Medicare for the costs of skilled labor for infusion therapy services as "ancillary services" to avoid Medicare payment limits for skilled labor at the SNFs.
- More than $700,000 to settle claims that HealthSouth and its subsidiary, HealthSouth Rehabilitation Hospital, billed for a range of unallowable costs on the Hospital's 1991 and 1992 cost reports.

Some of the unallowable costs on HealthSouth's hospital cost reports and home office cost statements were travel and entertainment costs for HealthSouth's annual administrators' meeting at Disney World in Orlando, Florida.

**"HealthSouth's fraud on Medicare was driven both by longstanding business practices in its outpatient physical therapy business and improprieties in it inpatient rehabilitation business."**

In addition to the $325 million settlement, HealthSouth has also entered into a Corporate Integrity Agreement with the Office of Inspector General of the Department of Health and Human Services. The agreement requires that HealthSouth make significant compliance efforts over the next five years, including utilizing independent review organizations to review the accuracy of its inpatient and outpatient rehabilitation therapy claims. To view the DOJ press release announcing the settlement, visit http://www.usdoj.gov/opa/pr/2004/December/04_civ_807.htm. ■

*CCH Chicago Bureau, January 3, 2005*

## Gambro Healthcare to pay over $350 million to settle fraud allegations

**by Sharon Sofinski, Coordinating Editor**

In one of the largest healthcare fraud settlements ever reached by the Department of Justice, Gambro Healthcare, the third largest owner and operator of renal dialysis clinics in the United States, will pay in excess of $350 million to settle allegations of health care fraud.

Assistant Attorney General Peter Keisler, head of the Civil Division, remarked, "This case is significant not only because of the size of the recovery but also because it demonstrates the Justice Department commitment to health care fraud enforcement."

According to the allegations, Gambro Healthcare:

- Provided home dialysis patients with equipment and supplies through Gambro Supply, a sham durable medical equipment company (and a wholly owned subsidiary of Gambro Healthcare), in violation of Medicare billing regulations,
- Engaged in "hard coding" of diagnostic codes on its claims, resulting in false statements and bills being submitted for unnecessary services and medications,
- Hired physicians as medical directors for the dialysis clinics and paid them based on the number of anticipated patient referrals they would make to Gambro clinics, in violation of the anti-kickback statute, and
- Entered into joint ventures with physician partners, under which contracts were premised on the number of anticipated referrals, in violation of the anti-kickback statute.

Gambro Healthcare will pay more than $310 million to resolve civil liabilities resulting from the allegations. Gambro Supply Corporation admitted that it executed a healthcare fraud scheme and will pay a $25 million fine. Gambro Supply will also be permanently excluded from the Medicare program.

Under the settlement, Gambro also must pay an additional $15 million to resolve potential liability under a preliminary understanding reached with various state Medicaid programs.

The suit against Gambro was originally filed in 2001 by its former Chief Medical Officer, who oversaw medical

and nursing services at Gambro Healthcare's outpatient dialysis centers. The whistleblower will receive a portion of the settlement amount under the provisions of the False Claims Act.

The Office of the U.S. Attorney for the Eastern District of Missouri, the Department of Health and Human Services Office of Inspector General, and the Federal Bureau of Investigation participated in the investigation. The DOJ press release on the settlement is at http://www.usdoj.gov/opa/pr/2004/December/04_civ_774.htm. ■

*CCH Chicago Bureau, December 30, 2004*

## DOJ announces settlement with Polymedica Corp.

**by Sharon Sofinski, Coordinating Editor**

The Department of Justice announced that Polymedica Corporation and two of its subsidiaries have agreed to pay a $35 million settlement to resolve false claims allegations.

Polymedica and its subsidiaries, Liberty Medical Supply and Liberty Home Pharmacy, allegedly submitted false claims for various diabetic and nebulizer products. The allegations state that the subsidiaries failed to obtain a prescription or signed doctor's orders for the products and to obtain documentation verifying the necessity of treatment volumes in excess of administrative guidelines. They also failed to document the actual use of the products.

The companies also allegedly:

- Did not maintain documentary proof of physicians' oral orders prior to shipping the product,
- Failed to get written doctor's orders or prescriptions prior to shipping the product,
- Did not obtain the Medicare beneficiary's written authority to bill Medicare on his or her behalf prior to submitting a bill to Medicare.

The settlement resolves claims in two whistleblower suits brought by private citizens in 2001. Under the settlement, Polymedica has also entered into a corporate integrity agreement negotiated by the Office of Inspector General of the U.S. Department of Health and Human Services. To view the DOJ's press release on the settlement, visit http://www.usdoj.gov/opa/pr/2004/December/04_civ_776.htm. ■

*CCH Chicago Bureau, December 30, 2004*

### Health care is a top concern of Americans, poll finds

As Congress prepares to reconvene in January, health care remains a concern of most Americans, making it likely members will continue to focus on major health issues including costs, access and affordable prescriptions.

In a recent poll, the Kaiser Family Foundation discovered that consumers ranked health care as the third most important problem the government needs to address. This ranked above terrorism, tax and budget issues, education, social security and crime.

When asked about the most important health problem for the government to address, health care costs were mentioned by almost half of respondents (46%). Other responses include access to care and insurance (25%) and senior citizens' issues (16%).

When asked to choose the most important issue for President Bush and Congress to address among several specific health care issues, 29 percent said increasing the number of insured Americans is most important, followed by lowering the cost of health care and insurance (25%), lowering the cost of prescription drugs (14%), reducing medical errors (13%) and lowering the cost of medical malpractice insurance for physicians (8%).

Source: Kaiser Family Foundation Health Pool Report, December 2004, http://www.kff.org/healthpollreport/Dec_2004/care/index.cfm.