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by Fay Rozovsky, JD, MPH

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OIG: Rural physician, podiatrist investment group permissible

A proposed arrangement between 23 investor physicians and podiatrists in a rural health professional shortage area to offer various medical care, consultation, diagnosis, and treatment services by sharing office space, facilities, equipment, and personnel, would not generate prohibited remuneration under the anti-kickback statute, according to an Office of Inspector General (OIG) advisory opinion.

Arrangement. The physician practice group would be organized as a limited liability company with a central governing board of managers, comprised of managing practice members. Individual members of the practice group would not work at the practice full-time; they would see patients separately at different office locations not affiliated with the practice. The revenues generated by the practice group would be classified as "in-office ancillary services." Additionally, each member would own a fixed percentage investment stake in the entire practice with shares distributed in direct proportion to each individual member's investment stake. The board of directors would meet regularly and have sole authority on all decisions made for the practice, including management of assets and liabilities, development of drafts and budgets, and compensation rates. A single consolidated accounting system for managing billing and finances would be maintained; expenses and revenues would be pooled across the practice group and not separated in relation to individual members. A one percent interest in the entire practice would be held by a licensed practitioner whose duties at the practice would be administrative in nature.

Safe harbor. A safe harbor provision for investments in group practices under 42 C.F.R. §1001.952(p) would only be applicable if the equity interests were (1) held by licensed health care professionals who practiced in the group; (2) in the group and not a subdivision of the group; (3) in a group that met the definition of a group practice; and (4) based on revenues derived from in-office ancillary services. The proposed arrangement cannot fit in this safe harbor provision because an individual member who would hold a one percent equity would not treat patients at the practice group. The individual, whose duties would be solely administrative, however, would not pose any appreciable additional risks to federal programs or beneficiaries and he would provide substantial services to the practice group's operation and administration. In addition, his returns would be directly proportional to his investment interest. Central decision-making authority would reside with the board; expenses and revenues would be pooled across the enterprise and would not be separated in relation to satellite offices maintained by individual practice group members. Therefore, administrative sanctions would not be imposed. ■

OIG Advisory Opinion, No. 08-24, Dec. 29, 2008, Health Care Compliance Reporter, ¶500,204

IRS: Community benefit test for tax-exempt hospitals may need tweaking

The community benefit standard that governs whether a hospital receives tax-exempt status at the federal level may be outdated in light of the current health care delivery system and may need to be adjusted, or scrapped entirely, according to an Internal Revenue Service (IRS) commissioner. In the meantime, however, the IRS is working to improve community benefit reporting through the new Form 990 Schedule H for nonprofit hospitals.

“To the extent we have had any community benefit reporting in the area in the past, it has been inadequate, at best, and more fairly could be characterized as uneven and haphazard,” said Stephen T. Miller, IRS Commissioner, Tax Exempt and Government Entities. Speaking at a meeting sponsored by the Office of the Attorney General of Texas on January 12, 2009, Miller said the data reported on the Schedule H will allow the IRS as well as the public to assess how much and in what ways hospitals are benefitting their communities.

Community benefit test. Neither the Internal Revenue Code nor the underlying regulations explicitly provide for the exemption of nonprofit hospitals from federal income tax, let alone outline a standard for which hospitals should receive tax-exempt status. The community benefit test was first articulated in a 1969 revenue ruling. The test requires a tax-exempt hospital to demonstrate that (1) it provides benefits to a class of persons broad enough to benefit the community and (2) it is operated to serve a public, rather than private, interest.

The ruling also laid out five factors to consider, though the list is not exclusive or exhaustive. The factors are:

- a community board;
- an open medical staff;
- a full-time emergency room open to all regardless of ability to pay;
- the admission of all types of patients, including those able to pay for care

themselves or through third-party payers; and

- how excess funds are used, such as for expansion and replacement of existing facilities and equipment, medical training, education, and research.

Current climate. Changes in the health care delivery system have made it more difficult to determine which hospitals pass muster under the community benefit test, according to Miller. “An open medical staff, participation in Medicare and Medicaid, and treating all emergency patients without regard to ability to pay are characteristics now shared by tax-exempt and for-profit hospitals,” Miller explained. “So, although they remain factors in assessing whether a nonprofit hospital is entitled to tax-exemption, they no longer meaningfully distinguish one type of hospital from another.”

Because of its lack of precision — and the growing trend of states outlining their own tax-exempt hospital standards — the community benefit test has come under review by the IRS and Congress, Miller said. Proposals requiring hospitals to provide a minimum level of charity care to receive tax-exempt status have been discussed in the Senate and the House.

IRS activity. “We did not design the Schedule H to alter the existing community benefit standard, and it does not do so,” Miller noted. “Rather, it was built with the current standard in mind. We believe the Schedule H and its instructions will result in a more consistent measurement and reporting of hospital community benefit expenditures.”

The IRS is also planning to release a final report based on the study of nonprofit hospitals it initiated in May 2006. After sending questionnaires to more than 500 nonprofit hospitals, the IRS has collected data on community benefit efforts, revenues, profits, and executive compensation.

Miller is hopeful that the data collected through the Schedule H as well as discussion generated by the upcoming IRS final report will allow the IRS to

consider possible refinement of the community benefit standard. “We will have more accurate information, presented uniformly,” he said. “We, the states and others will have a rich vein of data that will help us see nonprofit hospitals more clearly and allow us to make better informed decisions about them.” ■

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HIPAA guidances offer policies for PHI

Three guidances that address the impact of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule on health information organizations (HIOs), the electronic exchange of health information, and personal health records (PHRs) have been issued by the HHS Office of Civil Rights. The HIPAA Privacy Rule guidances assist HIPAA covered entities establish privacy protections and individuals' rights when addressing the use of individually identifiable health information.

Privacy and security framework. The first guidance, "Privacy and Security Framework: An Introduction," describes key principles, such as correction, openness and transparency, individual choice, collection and use, disclosure limitation, and accountability as those principles relate to HIOs. With respect to these guidances, an HIO is defined as a "an organization that oversees and governs the exchange of health-related information among organizations according to nationally recognized standards." Although HIOs generally are not covered by HIPAA, if an HIO performs certain functions or activities on behalf of a covered entity that require access to protected health information (PHI), it is considered a business associate under the Privacy Rule. Because of the necessity of safeguarding PHI in a networked environment, the business associate agreement may be used to define the scope of an HIO's services and functions, the uses and disclosures of PHI, and the safeguarding of PHI.

In those instances that an HIO is considered a business associate, the guidance describes what the HIO must do to be in compliance with the Privacy Rule. For instance, in keeping with the openness and transparency principle related to PHI, HIOs need to provide clear notice of their policies and procedures to explain how they use they use, disclose, and will protect the identifiable health information belonging to individuals. Policies to safeguard PHI may be established through business

associate or data sharing agreements. An HIO also may control the exchange network of information to provide a single set of safeguards.

Electronic exchange of HI. The transition of PHI from paper to electronic records necessitates that entities address an individual's right to request access to PHI electronically, according to the second guidance, "The HIPAA Privacy Rule's Right of Access and Health Information Technology." The Privacy Rule allows an individual to access his or her PHI to the extent it is maintained in a designated record by a covered entity; a personal representative of an individual with PHI on a covered entity's site may have a right to access the information on behalf of the individual. Covered entities may distinguish themselves from other entities in the marketplace by providing faster or instantaneous responses to PHI requests. Covered entities also must develop and implement reasonable policies and procedures to verify the identity of people who request PHI.

The Privacy Rule also allows entities to make alternative agreements as to the form of access to the provided information. If access to information is denied, covered entities must provide denials that are timely, written, provided to individuals in plain language,

a description of the basis for denial, and statements regarding the right to review if applicable.

Personal health records. The third guidance, "Personal Health Records (PHRs) and the HIPAA Privacy Rule," provides information on how to safeguard PHRs, while allowing individuals access to their PHRs to improve the efficiency and quality of their care. A covered entity, health care providers, and health plans that transmit any PHI in electronic form, may use a business associate to perform functions on its behalf. The business associate, however, also must appropriately safeguard the information as required under 45 C.F.R. § 160.103.

The PHR's fundamental purpose is to give individuals more control over, and access to, their health information. Covered entities are encouraged to reassess what uses and disclosures of individuals' information in the PHR may be appropriate. PHRs not offered by HIPAA covered entities are not bound by the Privacy Rule. Although the information in these PHRs is not covered, the rule does govern the flow of health information from a covered entity into a PHR held by a noncovered entity. ■

HHS' Office of Civil Rights Guidances, Dec. 17, 2008, Health Care Compliance Reporter, ¶370,027, ¶370,028, and ¶370,029

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What Compliance Officers Should Know About Recession Risk Management

by Fay Rozovsky, JD, MPH

Read a newspaper, listen to commentators on radio or television, or surf the Internet and the message is quite similar. The economy is in need of a fix. It is not just a matter of people not purchasing cars or new homes. The troubled economy is pervasive, leaving no sector unscathed. Health care is no exception.

If history is any lesson, the first to feel the pinch will be nonrevenue generating sectors of the health care field. In practical terms this has meant those involved in staff training or education. Historically, it has meant slimming down other departments, including quality, health information, and risk management. When funding has been tight in past economic downturns, capital projects have been put on hold. Purchases and leases of new high priced equipment have been deferred as well.

While some experts are loathe using the word “recession,” claiming that the precise economic definition has not been met, others disagree. Health care has seen elective procedures put off by patients. Fearful that they might lose their jobs, some have decided to postpone operations so that they have money to help weather the economic storm rather than fund a large co-pay. The reaction in the health care field has been to consider several cost-cutting measures. As a result, some clinical units will be closing and clinical personnel will receive notice that their jobs have been eliminated.

History has lessons to offer about shortsighted economic decisions. Recessions, like other types of economic downturns, come and go. Rebounds do occur. Pent-up demand for goods and services will be manifest once the current economic condition improves and stability returns. Those who put off expensive diagnostic tests or elective procedures will appear seeking such services. The question is whether health care will be ready to kick into high gear.

There is no doubt that a sour health care economy demands good risk management. Indeed, if ever a time has been ripe for enterprise risk management (ERM), the time is now. Such an approach requires a careful analysis of projected revenue in the short term as well as after the economic downturn is over. An ERM perspective contemplates clinical needs in the midst of what many see as an emerging recession impacting people around the world and in the brick and mortar called the health care facility.

As discussed here, an ERM approach requires a review of economic projections. A good market scan and a forecast for short to mid-term recession service requirements also

are required. The influence of the inpatient prospective payment system (IPPS) for hospitals and private sector “never events” policies should be evaluated by acute care facilities. Clinical needs are no exception in this regard as what might have been the pattern of illness and treatment may change during tense economic times. The prospect of increased health professional liability claims may become apparent. At the same time, long range planning is important to be prepared for the aftermath of an economic recovery. A good ERM approach draws data from all quarters to help design appropriate responses.

Looking at the Projections

Health care chief financial officers (CFOs) will have a pivotal role in forecasting revenue projections. Much can be determined about what to expect in terms of revenue in the short term and long term by monitoring coding and billing as well as self-pay individuals. Charitable care projections also are of importance.

Looking at the aging of outstanding accounts, CFOs can help provide good information for senior leadership and the board on cash flow projections.

The Market Scan

A good analytic approach takes into consideration a variety of factors that could positively or negatively impact a health care organization. For example, if a competitor facility lays off highly skilled infection control nurses, the opportunity may be present to offer employment to such qualified professionals, particularly, if the health care entity has been challenged in recruiting such individuals.

What is happening nationally or globally may not be a true indicator of market conditions at the local level. For example, news reports of major cutbacks or plant closings may be newsworthy but irrelevant to an area that is highly diversified with manufacturing, information technology (IT), food processing, and schools of higher learning. A diversified economic base may see some contraction, but

it may not be as dire as that experienced in communities dominated by one or two large employers impacted adversely by the economic slowdown.

IPPS and Never Events

Recession or not, most IPPS hospitals have embarked on systemic changes to comply with billing and coding for conditions “present on admission” (POA) and hospital associated conditions (HAC) requirements. Whether through voluntary adoption or state law-mandated programs, acute care facilities also face reimbursement challenges for so-called “never events.”

What might have been contemplated as nonbillable or reduced revenue for inaccurate documentation or inadequate care may take on greater importance as revenue decreases due to fewer elective admissions. POA and HAC issues are not going to be put by the wayside by CMS. The same is true for the private sector plans that have embraced “never events” policies for members seeking services at health care facilities.

Changes in Clinical Care Patterns

People affected by a bad economy have to make difficult choices. They may delay seeking care until their situations are quite acute. For acute care facilities, the result may be an increase in emergency department or urgent care utilization.

Some may elect to forgo high-priced medications needed to control chronic conditions. Others may manipulate their medication regimens, splitting pills or stretching their prescriptions by taking a tablet every other day rather than on a daily basis.

Some who would otherwise be attentive to care plans may not do so. Thus, patients who should attend appointments for prenatal care at a medical practice or hospital clinic may miss appointments. Inability to pay may be at the core of such decision-making. The result may be unanticipated health issues that emerge late in term or during labor and delivery.

Nutritional requirements also may be impacted by an economic downturn. Those who have been diligent about maintaining diets to control diabetes may resort to consuming foods that are contraindicated with resulting health consequences.

The Potential for Increased Professional Liability Exposure

Those who have practiced risk management for some period of time know that in bad economic periods, health care organizations may be perceived as having “deep pockets.” Unmatched patient expectations, untoward outcomes, and

poor customer service orientation can serve as the impetus for a spate of health professional liability (HPL) claims in a sour economy.

Others may argue that tort reform in many states will help temper an up tick in such HPL claims. The term “health professional liability,” however, may extend beyond traditional medical malpractice theories. Irate individuals may resort to new theories of litigation; they also may seek redress through alternate channels, including filing formal complaints with state licensing boards for healthcare facilities and professionals.

Being Ready for the Future

Once the economy turns the corner and the situation improves, health care organizations that chose to hunker down may be ill equipped to reverse course and meet pent-up demand. Being behind the curve could leave such entities in a “catch up” mode or at a loss for market share. Not preparing for new service lines to go operational or reversing a hiring freeze in a timely manner could have an adverse impact for such facilities and patients in the community.

Rising Above the Economic Storm with ERM

There are many issues to consider in managing risk exposure stemming from an economic downturn. Using an enterprise risk management (ERM) approach, informed choices can be made about a number of options, from staffing to service lines and from capital expenditures to leasing new equipment. At the same time, an ERM approach can help leadership identify important human factors issues that involve patients and staff. Good governance requires a holistic approach, one that is conducive to ERM.

ERM Strategies for Recession Risk Management

There are a number of considerations in designing an enterprise risk management approach to handling recession issues in the health care field. Good communication with staff is important, as is having the input of management personnel.

Setting realistic expectations can help avoid misunderstanding about holding fast against expansion plans or salary increases. Offering creative educational opportunities also may be a useful approach to dealing with budgetary constraints. The actions taken should be well considered and contemplate needs throughout the organization and the community.

Using the framework of enterprise risk management, some strategies to consider include the following:

1. Complete a comprehensive economic scan.

Prior to making any decisions about curtailing staffing or service lines, conduct a thorough economic scan of the community to ascertain if regional, state, or national economic conditions will have a substantial impact on the health care organization. Recognize that dire news presented by the media may not reflect what is happening or will occur locally. Obtain economic data from reputable resources.

2. Complete a comprehensive utilization scan.

Consider reliable patient care and utilization data when forecasting projected needs in terms of services, staffing, and equipment. Look at demographic data, too. Recognize that if the health care facility serviced a low census of charitable care in the past, economic circumstances may increase the need for such services for the length of time of the anticipated recessionary period. Try to tease out of the data the “types” of services that may be utilized, including emergency and urgent care. Think about access to ancillary support services in the community.

3. Stress the need for good documentation, coding and billing.

Reinforce the importance of quality charting to substantiate coding, billing and the delivery of medically necessary care. Remind those in coding and billing as well as health professionals of the importance of good documentation practices to avoid allegations of substandard care. Take note that for tax-exempt organizations it is important to record how charitable care is being accomplished for purposes of maintaining the hospital’s tax status and for substantiating IRS 990 Schedule H requirements.

4. Recognize the needs of staff.

Be sensitive to pressure on staff who themselves may be facing considerable pressures as a consequence of economic challenges from a recession. Consider “care for the caregiver” or employee assistance programs (EAPs). Assist staff to cope with greater demands with fewer resources at the health care organization.

5. Provide for innovative staff education.

Recognizing that funding may not be available for personnel to attend educational conferences, consider practical but useful programming to allow them to maintain clinical competencies or to attend continuing education credits. Give thought to webinars, audio conferences, recognized distance learning opportunities, and local collaborative education. Think about obtaining continuing education certification for such programs. Consider too, the use of podcast materials and group learning initiatives.

6. Improve patient communication.

Focus on ways in which staff can improve patient communication about compliance with medication or dietary regimens that may be price-sensitive during challenging economic times. Give them verbal strategies to identify “at risk” situations that may require resorting to ancillary resources in the community.

For example, instead of saying, “Now that you are unemployed, can you afford to pay for this medicine?” consider rephrasing the discussion to say, “A lot of friends and neighbors in the community are finding it difficult to pay for some of their medications. If you think you might benefit from a medication assistance program, please let me know and I will link you up with the right resources. The key point is that you need the medication.” Documenting the discussion is important should there be any question about patient understanding about using expensive medications.

7. Take the pulse for change.

Using a comprehensive approach, look for factors that may signal the need for change, from decreasing elective surgical services, increasing programs, or reopening closed units as the community emerges from the throes of a serious recession. Act on related needs for change, including staff recruiting, training, and equipment requirements.

8. Keep the community in the loop.

Establish a good conduit for communication with the community. Be candid about resources and establish reasonable expectations. Make a two-way channel of communication, learning from community leaders and patients what services need to be increased or improved. Ask practical questions about what the health care organization can do in terms of community outreach through low-cost health fairs, wellness programs, and clinics. Look upon this outreach initiative as part of the health care organization’s good will and commitment to the community. Make the community “loop” part of the ongoing economic and utilization scan so that as the economy improves changes can be initiated in a timely manner to assure continuity of care.

Conclusion

Fears of an economic recession can be overwhelming. Health care entities, however, must steer a steady course to meet the needs of the community and fulfill the mission and vision of care-giving organizations. Using a comprehensive response like that found in enterprise risk management, prudent choices could be made that enable health care entities to provide quality, cost-effective care while looking to the future and delivery of services when prosperity replaces the gloom of foreboding economic travail.

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CMS, Congress to ramp up quality enforcement in 2009

CMS and Congress will be focusing more on regulatory compliance matters in 2009 than they have in years, according to Brian Flood, managing director at KPMG. “You have a lot of activity going on in the next six months,” he said during a recent American Bar Association teleconference. One area CMS has focused its quality measures and enforcement efforts on is improper claims for Medicare payment, where regulators are belatedly ramping up scrutiny of the managed care industry, which has grown to cover more than 37 million state and federal beneficiaries.

CMS recovery audit contractor program pilot identified \$371.5 million in improper Medicare payments in three states. CMS plans to expand the number of states beginning in early 2009 and expand the program nationwide by January 1, 2010. Moreover, Congressional lawmakers on both sides of the aisle are promising to focus on Medicare fraud in 2009, Flood noted. Both comparative effectiveness and pay-for-performance models are under discussion, which could result in “negative consequences for [companies that do not have] high quality programs or cost effective programs,” he said. Flood added that underperformers could be penalized with lower Medicare reimbursement rates of between two and five percent.

Integrity contractors. Under the Medicare Improvements for Patients and Providers Act of 2008 (PubLNo 110-275), there are new risk areas within the organization, especially with a provision that ties safety and quality measures to the financial statement of the institution. “Under the pay-for-performance models, if those measures are not up to standard (that is, 80 percent accurate) and if you’re in a top tier provider category, you won’t get paid the same as your competition,” Flood said. The law provides \$10 million a year from fiscal years 2009 through 2012 from the Medicare trust funds to fund the process.

Program safeguard contractors were replaced with “zone program integrity contractors” (ZPICs) that will have a more

aggressive mandate to fight fraud. ZPICs will tackle all benefit-integrity activities across the country and form “rapid response teams.” Five of the seven ZPICs will be assigned to “hot spot” areas of California, Florida, New York, Illinois, and Texas to resolve fraud-and-abuse and overpayment matters administratively more often via tools including sanctions and education.

Medicaid review. Medicaid services also will experience heightened scrutiny under the CMS Medicaid Integrity Program Initiative to identify potential overpayments made as a result of fraud, waste, or abuse. Integrity contractors will use data-mining and analysis techniques to develop models that combine health care quality indicators, billing practices and Medicaid specific business rules to predict aberrant provider patterns to identify and rank by risk providers to be audited. This initial analysis will provide the necessary level of detail to commence the auditing process. The individual audits of providers will include, but are not limited to, fee for service providers, managed care entities, and individual providers and institutional providers of Medicaid services within the region.

Special Review Initiatives (SRIs) also will be used to implement new legislation and policy and respond to issues raised by agencies such as the Government Accountability Office, the Office of Inspector General, and CMS, Flood said. Additionally, the SRIs may include reviews of managed care organizations. ■

CCH Washington Bureau, Dec. 31, 2008

AG closes Ingenix's out-of-network rate setting database

Under an agreement with New York Attorney General Andrew Cuomo, UnitedHealth Group Inc. (United), the nation's second largest health insurer, will pay \$50 million to establish an independent database that will allow consumers across the country to find out in advance how much they may be reimbursed for out-of-network medical expenses. The

database will be owned and operated by a nonprofit organization and the database operated by Ingenix, Inc., a wholly-owned subsidiary of United, will close.

Medical and consumer advocates praised the agreement as a positive first step toward improving transparency for out-of-network charges and creating a more fair rate-setting system for consumers.

The scheme. In February 2008, following a six-month investigation into rate-setting practices for out-of-network services, Cuomo announced that his office had uncovered a “scheme to defraud consumers” by Ingenix, the nation's largest provider of health care billing information, and United.

Cuomo's investigation revealed that health insurers unfairly overburden consumers with too much of the cost of out-of-network health care. Ingenix operated a database that was used by more than 1,500 health plans and insurers to determine the “usual, customary and reasonable” rates for services rendered to members by nonparticipating providers. According to Cuomo's investigation, the database skewed rates downward through faulty data collection, poor pooling procedures, and a lack of audits. The inaccurate rates forced consumers to pay more than they should have, with underpayments by insurers ranging from 10 to 28 percent for various services across the state of New York.

The agreement. Cuomo explained that he intended to remove the conflict of interest that had been present under the Ingenix system by placing the database under the control of an independent nonprofit organization. Under the agreement, the nonprofit will be the sole arbiter and decision-maker with respect to data contribution protocol and methodologies used for assembling data. The nonprofit, which will be selected at a later date, will also develop a Web site where consumers can access rate data.

Cuomo's investigation is ongoing. He has called on insurers to follow United's lead by supporting the establishment of an independent rate-setting database. ■

CCH Chicago Bureau, Jan 16, 2009

DOJ investigations lead to false claims settlement, convictions

Investigations of health care fraud by the Department of Justice (DOJ) resulted in a settlement with a hospice company for allegedly submitting false claims to Medicare and the convictions of a physician and nurse for health care fraud.

False claims settlement. SouthernCare Inc., an Alabama-based hospice company, agreed to pay \$24.7 million to settle allegations that it submitted false claims to the government for payment. The company allegedly submitted fraudulent claims for Medicare reimbursement for patients who were not eligible for such care because the patients did not have a terminal prognosis of six months or less to live. The DOJ began its investigation of SouthernCare after *qui tam* lawsuits were filed by two former employees, who will receive \$4.9 million as their share of the government's recovery.

In addition to paying \$24.7 million to the government, SouthernCare and its shareholders agreed to enter into a corporate integrity agreement (CIA) with HHS. The CIA includes provisions designed to ensure future compliance with the requirements for federal reimbursement.

Infusion treatment fraud. As a result of a separate DOJ investigation, a Miami physician and nurse were sentenced to 30 and seven years in prison, respectively, for their roles in an \$11 million HIV infusion fraud scheme. A jury found Ana Alvarez-Jacinto and Sandra Mateos guilty of conspiracy to defraud the United States, submit false claims, and pay health care kickbacks, and conspiracy to commit health care fraud. In addition to their prison sentences, the two were ordered to pay more than \$8 million in restitution to the Medicare program.

According to evidence presented at trial, Alvarez-Jacinto, with assistance from Mateos, ordered hundreds of medically unnecessary HIV infusion treatments at Saint Jude Rehab Center. Medicare paid more than \$8 million in reimbursements for those treatments. ■

CCH Chicago Bureau, Jan. 19, 2009

In the News

Reported data breaches surge in 2008

The personal records of more than 35.7 million Americans were exposed in data breaches at businesses, governments, and educational institutions in 2008, according to the Identity Theft Resource Center. The San Diego-based nonprofit group announced that the number of reported data breaches rose by nearly 50 percent from 2007 levels. The center also found that the percentage of breaches attributed to data theft by current and former employees more than doubled from 7 percent in 2007 to nearly 16 percent. The largest single cause of reported data breaches, however, was human error, according to the study. Lost or stolen electronic devices, such as laptops, or the inadvertent posting of personal data online were blamed for more than 35 percent of reported incidents. Computer hacking and software that steals data were responsible for more than 14 percent of breaches.

Identity Theft Resource Center Press Release, Jan. 5, 2009

Five new MACs receive CMS nod

CMS awarded contracts to five Medicare administrative contractors (MACs) worth \$1.4 billion over five years for the combined administration of Part A and Part B Medicare fee-for-service claims, representing an area covering 14 states and 36 percent of the fee-for-service claims processed in 2008. The MACs will administer and pay claims, tasks currently fulfilled by fiscal intermediaries and carriers; the MACs serve as the first point of contact for the processing and payment of Medicare fee-for-service claims from hospitals, skilled nursing facilities, physicians and other health care practitioners. The contracts also fulfill the requirements of the Medicare Modernization Act's (MMA) contracting reform provisions. The five MACs are: Noridian Administrative Services, National Government Services, Cahaba Government Benefit Administrators, Palmetto Government Benefits Administrator, and Highmark Medicare Services. The award of contracts to the MACs, represents another step toward improved service to providers, physicians, and practitioners as well as greater administrative efficiency and effectiveness for fee-for-service Medicare. CMS selected the MACs using competitive procedures in accordance with federal procurement rules.

CMS Press Release, Jan. 7, 2009

Health care-associated infections targeted

The U.S. Department of Health and Human Services (HHS) unveiled a plan that established a set of five-year national prevention targets to reduce and possibly eliminate the approximately 1.7 million health care-associated infections (HAIs) that patients acquire while undergoing medical treatment or surgical procedures. The "Action Plan to Prevent Health Care-Associated Infections" lists a number of areas, such as surgical site infections, in which HAIs can be prevented. The plan also outlined cross-agency efforts to save lives and reduce health care costs through expanded HAI prevention efforts, including (1) development of national benchmarks prioritizing recommended clinical practices; (2) a coordinated research agenda; (3) an integrated information systems strategy; and (4) a national messaging plan. In addition to the tremendous toll on human life, the financial burden attributed to these infections is staggering. It was estimated that HAIs are the cause of 99,000 deaths and add as much as \$20 billion to health care costs each year. HHS' plan can be found at <http://www.hhs.gov/ophs>.

HHS Press Release, Jan. 6, 2009