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Medicaid fraud referral process lacks standards

by Stacey Fahrner, J.D., M.P.H., Contributing Editor

CMS lacks adequate criteria to measure state Medicaid agency performance in controlling Medicaid fraud, according to a recent study by the Office of Inspector General (OIG). OIG reviewed suspected fraud referrals received by Medicaid Fraud Control Units (MFCUs) over a three year period and concluded that only 29 percent of referrals came from state agencies. These results are surprising given the increased expenditures on the Medicaid program and the increased focus on Medicaid program integrity following the passage of the Deficit Reduction Act in 2005.

Medicaid program integrity is monitored and controlled primarily through the coordination of two state agencies: the state MFCU and the state Medicaid agency. The state agency is responsible for ensuring proper payment, recovering misspent funds, identifying suspected fraud, conducting a preliminary review to determine the extent of the suspected fraud, and referring suspected fraud to the MFCU. The MFCU is responsible for reviewing the referrals to determine whether an investigation is warranted.

Since 1989, OIG has issued three reports regarding the referral of suspected fraud cases from state Medicaid agencies. Each study identified deficiencies in the referral process, such as lack of communication and lack of understanding of roles and responsibilities. In 1996, OIG issued a report entitled "Surveillance and Utilization Review Subsystems Case Referrals to Medicaid Fraud Control Units," in which it recommended that CMS establish fraud referral performance standards for state Medicaid agencies. While CMS concurred with this recommendation, it has not yet established these standards.

Between 2002 and 2005, state MFCUs reported receiving a total of 13,733 suspected fraud referrals. Less than 4,000 of those referrals came from state Medicaid agencies. Eighty-four percent of the MFCUs reported receiving less than half of their referrals from state agencies. Twenty-six MFCUs reported accepting, on average, no more than one referral from their state agency.

Recommendations. In this report, OIG reiterated is 1996 recommendation that CMS establish fraud referral performance standards for state Medicaid agencies. According to OIG, such criteria would aid in determining the adequacy of state Medicaid agency performance by providing specifics concerning development and referral of suspected fraud issues.

CMS concurred with OIG's recommendations and stated that it plans to conduct a state program integrity assessment project. Information from the project will be used to develop state performance standards.

OIG Report, OEI-07-04-00181, Jan. 1, 2007, Health Care Compliance Reporter, ¶530,505.

OIG approves cost sharing, free dialysis services proposals

by Valerie L. Witmer, J.D., Contributing Editor

In recent advisory opinions, the Office of Inspector General (OIG) determined that a hospital's proposed gain-sharing arrangement with a group of cardiac surgeons and a proposed arrangement to provide free acute dialysis services to chronic patients pose minimal risk of abuse to the federal health care programs. OIG explained its position on each of these proposals in two advisory opinions issued on November 9, 2006, and January 18, 2007.

Proposed gain-sharing arrangement. A proposed arrangement in which a hospital would share with a group of cardiac surgeons a percentage of the cost savings arising from the implementation of cost reduction measures contained safeguards sufficient to protect the federal health care programs from fraud and abuse. Under the arrangement, the program administrator would identify cost savings opportunities with respect to certain procedures based on a study of the historic practices of the hospital's cardiac surgery department. The hospital and the surgical group would then adopt the recommendations after reviewing for medical appropriateness.

OIG would not seek civil money penalties for fraud and abuse because:

(1) the recommendations and resulting savings would be clearly and separately identified, allowing for public scrutiny and individual physician accountability;
(2) credible medical support suggests that implementation of the recommendations would not adversely affect patient care;
(3) payments under the proposed arrangement would be based on all surgeries, regardless of patients' insurance coverage;
(4) the arrangement protects against inappropriate reductions in service by utilizing objective clinical and historical measures to establish baselines beyond which no savings can accrue to the surgical group, and ensures that physicians would have the same selection of cardiac devices;
(5) written disclosures of the program would be provided to patients;
(6) financial incentives would be limited in amount and duration; and
(7) cost savings would be distributed to physicians on a per capita basis, eliminating individual physicians' potential to generate disproportionate savings.

Likewise, OIG would not impose sanctions under the anti-kickback statute because:

(1) program safeguards reduce the likelihood that the program would be used to increase referrals;
(2) the structure of the program makes it unlikely that it could be used to reward referring physicians; and
(3) the arrangement sets out with specificity the actions that will generate cost savings. ■

OIG Advisory Opinion, No. 06-22, Nov. 9, 2006, Health Care Compliance Reporter, ¶500,157.

Free acute dialysis services. Although a hospital's proposed arrangement to provide free acute dialysis services to chronic dialysis patients could potentially violate the anti-kickback statute and the civil money penalties law, OIG would not impose administrative sanctions because the proposed arrangement poses minimal risk of abuse to the federal health care programs. It is unlikely that the arrangement would influence patients to select the hospital for routine dialysis services, because the hospital does not provide those services on an outpatient basis. In addition, the proposed arrangement would not be advertised. Consequently, patients likely would be influenced more by their need for emergent care.

Furthermore, because the hospital would absorb the costs of the free services, no federal health care programs would be billed. The program also is designed to discourage chronic dialysis patients from self-referring back to the hospital by providing assistance to those patients in locating other outpatient dialysis centers. Moreover, the hospital has a legitimate business purpose in funding the proposed arrangement because the program would free up inpatient beds currently occupied by the dialysis patients, allowing the hospital to fill those beds with patients who can be charged for services. Finally, the proposed arrangement is consistent with the hospital's mission to serve underprivileged populations. ■

OIG Advisory Opinion, No. 07-01, Jan. 18, 2007, Health Care Compliance Reporter, ¶500,158.

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HHS lacks comprehensive privacy approach

by Stacey Fahrner, J.D., M.P.H., Contributing Editor

Although the Department of Health and Human Services (HHS) and its Office of the National Coordinator of Health Information Technology have initiated actions to identify solutions for protecting personal health information (PHI), HHS has not yet defined an overall approach for addressing privacy. According to a report by the General Accountability Office (GAO), HHS lacks milestones for integrating its policy-related initiatives, which the GAO believes are important for setting implementation targets and informing stakeholders of HHS plans for protecting health information as nationwide implementation of health information technology moves forward.

The Office of the National Coordinator of Health Information Technology was established pursuant to a 2004 executive order as the government official responsible for developing and implementing a strategic plan for health information technology. That order also called for the development of a strategic plan for the nationwide implementation of interoperable health care information technology in both the public and private sectors.

Key challenges to protecting PHI. Through discussions with officials from several government agencies, the GAO was able to identify several key challenges to meeting requirements for protecting PHI within a nationwide health information network. Those challenges include: (1) understanding and resolving legal and policy issues such as variations in state privacy laws; (2) ensuring that only the minimum amount of information necessary is disclosed to only those entities authorized to receive such information; (3) ensuring individuals' rights to access and amend their own health information; and (4) implementing adequate security measures to protect PHI.

Recent HHS initiatives. Since the 2004 executive order, HHS has initiated several projects to study the protection of PHI:

- In 2005, several health information technology contracts were awarded that included requirements for addressing privacy of PHI exchanged within a nationwide health information network.
- In 2006, HHS's contractor for privacy and security solutions selected 33 states in which it will perform assessments of organization-level privacy and security-related policies, practices, laws, and regulations that affect interoperable health information exchange. The contractor also proposed privacy and security protections that permit interoperability.
- In 2006, the National Committee on Vital Health Statistics provided a report that made recommendations on protecting the privacy of PHI within a nationwide health information network.
- In 2006, the American Health Information Community convened a work group to address privacy and security policy issues for nationwide health information exchange.

While the results of these activities are intended to be used to identify technology and policy solutions for protecting PHI, HHS is still in the early stages of these efforts and has not yet identified an overall approach for integrating its various policy-related initiatives.

Recommendations. Based on the results of the study, the GAO recommended that HHS define and implement an overall approach for protecting health information as part of the strategic plan called for by the President in the 2004 executive order. The approach should (1) identify milestones for integrating the outcomes of privacy-related initiatives; (2) ensure that key privacy principles are fully addressed; and (3) address key challenges associated with the nationwide exchange of health information.

HHS disagreed with the report and recommendations. Specifically, HHS disagreed with the need to identify milestones and stated that tightly scripted milestones would impede HHS processes and preclude stakeholder dialogue in the direction of important policy matters. ■

GAO Report, No. GAO-07-238, Jan. 2007.

Compliance risks arising from the safe harbor and Stark II exceptions allowing donations supporting e-prescribing and electronic health record systems, Part III

by Timothy P. Blanchard, J.D., Contributing Editor

This article is Part III of a three-part series that identifies compliance issues and risks resulting from significant limitations that remain in the new regulations, and proposes potential approaches for use by compliance professionals in assisting their organizations to navigate around those compliance traps.

Part I of this article provided background on the fraud and abuse laws and the safe harbor and Stark exception regulations for e-prescribing and electronic health records (EHR), and focused on the scope of protected technology and the "necessary" and "used predominantly" criteria under the new regulations. Part II discussed the range of protected donors and recipients of e-prescribing and EHR technology, as well as the interoperability requirement. Part III addresses cost-sharing requirements, recipient selection considerations, and other implications of the new regulations, including tax exemption and state law issues.

Recipient selection considerations

Nonsolicitation standard

The e-prescribing and EHR Rules do not protect the donor or the recipient if the recipient, the recipient's practice, or any affiliated individual or entity makes the donation (or the amount or nature of the donation) **a condition of doing business** with the donor.[35] This bright-line standard makes sense from a fraud and abuse prevention perspective, but could prove very problematic in practice with regard to both individual potential donations and the effectiveness of EHR system development in a community. For example, any statement by anyone associated with a referral source that could reasonably be construed as a demand for donation as a condition of obtaining or retaining business would, at least theoretically, permanently preclude any donation to that entity because it is unclear whether such a statement of intent can be withdrawn, clarified, or corrected for purposes of the Rules.

It appears that this restriction on protection under the Rules reaches not only explicit verbal statements but also implicit expressions of intent (*e.g.*, changes in ordering patterns). While it might be possible to cure some situations involving questionable statements or potentially adverse inferences regarding requests for EHR technology donations, the best course of action is education designed to avoid such communications in the first place. Compliance officers should work with their organizations to develop training for donor personnel regarding the handling and reporting of potentially disqualifying requests from potential recipients and an early communication to potential recipients that includes education regarding the prohibition against such requests and a statement that the organization is considering the donation program in the interest of promoting the use of EHR technology in the community to generate better patient care, improved safety, more efficient services and coordination of care, and reduced administrative costs — not to induce patient referrals. When suspect requests are identified they should be investigated on a case-by-case basis to determine appropriate corrective action, which might range from clarification of ambiguous messages to banning donations to particular individuals and entities. Such prohibitions would be unfortunate and, if applicable to a large practice or provider or to a significant number of physicians or providers, could adversely affect the efficacy of the EHR system in a community by limiting the effective exchange of information among all parties involved in the care of patients in the community. The old saws that you cannot unring a bell and that forewarned is forearmed certainly apply regarding this requirement.

Volume or value standard

The e-prescribing Rules are more restrictive than the EHR Rules with respect to the volume or value standard; the former prohibiting selection of recipients based on the volume or value of prescriptions or other business between donor and recipient.[36] The volume or value standard under the e-prescribing Rules permits donors to select recipients based on the total number of prescriptions written by the recipient, but not on the total value of prescriptions written or the volume or value of the prescriptions reimbursable by a federal health care program.

The EHR Rules provide greater latitude in recipient selection, allowing donors to select recipients in any reasonable and verifiable manner that does not **directly** take into account the volume or value of referrals or other business generated between the parties. While not as restrictive as the e-prescribing Rules, this standard is unclear and could subject donors to challenge based on subsequent interpretations and application of the standard to particular situations. Consequently, to encourage arrangements for the donation of EHR technology, the EHR Rules establish six criteria[37] that, when applied by a donor, would be deemed not to directly take into account the volume or value of business generated by a potential recipient:

- the total number of prescriptions written by the physicians (but not the volume or value of prescriptions dispensed or paid by the donor or billed to a federal health care program);
- the size of the physician's medical practice, *e.g.*, total patients, total patient encounters, or total relative value units;
- the total number of hours that the physician practices medicine;
- the physician's overall use of automated technology in his or her medical practice (without reference to the use of technology in connection with referrals made to the donor);
- membership on the donor's medical staff; and
- the level of uncompensated care provided by the physician or other permitted recipient.

These deeming provisions create some additional ambiguity and uncertainty for donors. With the exception of medical staff membership,[38] which can be readily determined by a hospital without reliance on data from other sources, the other deeming provisions are subject to questions related to definitions and data integrity. In particular:

- Because a physician's prescriptions can be filled by a number of different pharmacies for payment by a number of different drug plans — or no plan at all — no one potential donor would have access to complete information regarding the number of prescriptions written by a potential recipient.
- However a donor chooses to define the size of a physician's practice, the donor would have to rely upon the potential recipient for data. Further, this type of data would be considered highly confidential by many physicians.
- It is not clear how the number of hours a physician practices medicine should be defined and what data would be acceptable evidence thereof.
- Again, use of automated technology is not further defined in the EHR Rules and would have to be defined and measured in some standardized manner.
- There is no general reporting system for uncompensated care furnished by physicians; this concept also is subject to various definitions that could affect the outcome of comparisons among physician practices and other potential recipients within a community.

To take advantage of these deemed-permissible criteria, a donor will need to clearly define the criterion selected as well as the data that will be accepted in the evaluation of the potential recipients in the community. Donors should attempt to structure the selected criterion to allow for fair comparisons among potential recipients based on standard data sets collected from the potential recipients. Because these criteria will determine which potential recipients will be offered EHR technology, it is important for the donor to have a reasonable basis for believing that the data are accurate and not misrepresentations by potential recipients to qualify for the donation and the opportunity to participate in a community EHR system.

Recipient cost-sharing and prohibited cost-shifting

Required cost-sharing

The EHR Rules require recipients of donated technology to pay 15 percent of the donor's cost prior to receipt of the technology. The Rules further prohibit the donor or any related organization from providing financing or lending money to the physician or other recipient to pay this cost-sharing requirement. The cost-sharing requirement applies to initial and subsequent items or services, such as software updates or additional training, provided to the recipient, unless such items and services were included in the donor's initial purchase price.

In some cases it may be difficult to place a proper value on the EHR technology. In some cases determining the donor's cost will be relatively straightforward, but in others, such as "homegrown" products developed by the donor itself, it is unclear whether donors must fully allocate significant capital investments in technology to recipients. If such allocations are required it is not clear how such calculations are to be made across the population of recipients. This would be complicated further if the donor elects to roll out the donation program on a phased basis. Compliance officers for such organizations must be sure that their organizations have adopted reasonable and verifiable methods for allocating costs incurred by the donor in developing the technology so the cost-sharing requirement can be satisfied and an excess benefit is not provided to the recipients. Documentation of these calculations must be maintained by the organization.

Another compliance complication arises in connection with technology that is purchased by the donor as a package that includes certain items or functionalities that are not permissible donations under the EHR Rules or that the donor does not wish to donate. In such situations the donor must structure its information technology acquisition contracts to explicitly list incremental charges for licenses to allow an accurate breakdown of expenses, including any discounts received by the donor, so the recipient's cost-sharing requirement can be calculated accurately.

Prohibited cost-shifting

The EHR Rules state that donors may not "shift" the costs of donated EHR items or services to any federal health care program.[39] OIG believes that such cost shifting could occur "in many ways, including, without limitation, shifting the costs of staff, office space, or equipment ..., by way of example, ongoing maintenance and help desk support for previously purchased electronic health records systems."[40] This concern highlights the difficulty of complying with the cost-sharing requirement with respect to help desk and maintenance services unless the cost of such services is incorporated in the cost of the initial technology donation or a separately qualifying supplemental donation. Compliance professionals should develop policies and procedures to facilitate proper allocation, tracking, and reporting of EHR costs to comply with this provision and the cost-sharing obligations and to avoid challenges based on cost-shifting with respect to e-prescribing technology. Donors must be careful at the outset in defining and costing the donated technology because failure to comply with these requirements not only would forfeit the protections of the Rules, but also could result in false claims exposure for a donor based on misrepresentation of costs (*i.e.*, claiming recipient costs covered by the donor as costs of donor services) on donor cost reports.

Additional implications

Tax exemption issues

Donors that are tax-exempt organizations must consider whether providing EHR technology at the 85 percent discount allowed under the Rules is consistent with their obligations under the Internal Revenue Code private inurement and private benefit prohibitions. Although the Rules provide a strong public policy argument that EHR donations with 15 percent cost sharing serve a community rather than a private purpose, the Internal Revenue Service (IRS) has yet to issue guidance regarding its interpretation in this area, and it is not clear how the IRS will treat the donation programs or whether it will impose additional tests or requirements. Compliance professionals should ensure that an appropriate strategy to address these tax exemption risks is included in the planning of any EHR technology donation program.

State law issues

Many states have enacted their own versions of anti-kickback and self-referral prohibitions. While it would have been simpler for all concerned if Congress had provided that the new federal physician self-referral exception and anti-kickback safe harbors preempted any conflicting provisions of state law, Congress declined to preempt state anti-kickback[41] or physician self-referral laws that could be implicated by donations of e-prescribing or EHR technology. Accordingly, compliance officers of donor and recipient organizations must carefully review applicable state laws before offering or accepting donations under the Rules.

Heightened risk of scrutiny

There is every reason to expect that e-prescribing and EHR donation programs will receive heightened scrutiny by regulators, who expect these programs to yield the promoted benefits of e-prescribing and EHRs without comprising the integrity of the federal health care programs. Certainly, absent qualification for a safe harbor, the anti-kickback risk under the "one-purpose" test is very high. Moreover, the risk of "whistleblowers" instigating *qui tam* suits under the False Claims Act is increased because donors may not be able to accommodate every entity interested in participating in a particular donation program. This could create tension among the "haves" and "have-nots," potentially generating complaints and triggering governmental investigations regarding compliance with the Rules, the anti-kickback statute, and the Stark law.

Conclusion

The public policy arguments in favor of e-prescribing and EHR systems are very strong and the potential operational benefits great. The protection offered in the regulations, however, is limited. Compliance professionals need to be prepared to delineate the critical issues and risks resulting from significant limitations that remain in the new regulations to temper the current enthusiasm for e-prescribing and EHR donation programs with practical safeguards to bolster the protection actually provided by the Rules.

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35 42 C.F.R. §§411.357(w)(5), 1001.952(y)(4).

36 See 42 C.F.R. §§411.357(v)(6), 1001.952(x)(6).

37 See 42 C.F.R. §§411.357(w)(6)(i)-(vii), 1001.952(y)(5)(i)-(vii).

38 With regard to this criterion, notwithstanding sound business, operational, and clinical reasons for a hospital to stage the roll-out of EHR technology to its medical staff beginning with the medical specialty or department that accounts for the greatest hospital utilization, it is not clear under current guidance whether this approach would be sufficiently indirect to qualify for an EHR under the Rules.

39 42 C.F.R. §1001.952(y)(12).

40 *Final rule*, 71 FR 45110, 45124, Aug. 8, 2006. Notwithstanding the concern expressed by the OIG, the Rules specifically permit the inclusion of helpdesk services in an EHR donation program. 71 FR at 45112.

41 71 FR at 45114; *Final rule*, 71 FR 45140, 45143, Aug. 8, 2006.

Rulemaking process change draws criticism

by Paula Cruikshank, Contributing Editor

An amended White House executive order on the federal government's regulatory process and an accompanying Office of Management and Budget (OMB) bulletin require federal agencies to make several "process improvements" for the development, issuance and use of significant guidance documents by Executive Branch departments and agencies. On January 18, 2007, the White House issued "Executive Order: Further Amendments to Executive Order 12866 on Regulatory Planning and Review." The same day, OMB issued "Final Bulletin for Agency Good Guidance Practices (M-07-07)."These amendments include a requirement that agencies identify the "market failures" or other "significant problems" that warrant regulation, according to an administration official.

Critics contend that the revised executive order will delay the proposed rulemaking process and chill the development of guidance documents explaining federal regulations. An analysis of the executive order by OMB Watch, a nonprofit government watchdog organization, warned that "[b]y requiring agency guidance documents to come under [White House Office of Information and Regulatory Affairs] review, and to treat 'significant' guidance in the same way as 'significant' regulations, the [executive order] amendments will lead to further delay in providing information to the public about compliance with regulations, as well as with general guidance on agency policies."

Value of guidance documents. In a written statement, OMB Deputy Press Secretary Andrea Wuebker noted, "Both the executive order and bulletin will lead to improvements in the way the federal government does business — by increasing the quality, consistency, accountability, coordination, and transparency of agency guidance documents."

In regards to guidance documents, Wuebker said, "OMB recognizes the enormous value and benefit of agency guidance, and when used properly, guidance documents can further consistency and fairness in an agency's enforcement of its regulations."

Wuebker stressed that the Bush administration supports government transparency and welcomes public comments on agency guidance documents. According to the OMB bulletin, the administration will publish drafts of "significant documents" in the *Federal Register*, invite public comments on them, and prepare responses to the comments before finalizing the guidance. In addition, agency websites will contain current lists of significant guidance documents and instructions on how to submit comments electronically about the guidance documents. The OMB bulletin provides examples of "guidance documents," and explains that they "often come in a variety of formats and names, including interpretive memoranda, policy statements, guidances, manuals, and circulars."

According to the OMB bulletin, "Guidance documents, used properly, can channel the discretion of agency employees, increase efficiency, and enhance fairness by providing the public clear notice of the line between permissible and impermissible conduct while ensuring equal treatment of similarly situated parties." OMB recognized the need for good guidance practices, however, including a review process and public comment period for certain guidance documents that "may be poorly designed or improperly implemented" and can take on a life of their own inconsistent with the intent of the underlying regulations.

Wuebker told CCH that agencies' regulatory policy officers will be designated presidential appointees and noted that, in most instances, designated officials have been approved by the Senate. Wuebker noted that for many agencies, the current regulatory policy officers are presidential appointees and have "the appropriate level of responsibility to make regulatory policy."

Spokespeople at both HHS and CMS said that they are putting plans in place to comply with the revised rulemaking process.

The final bulletin detailing the review process changes can be found at http://www.whitehouse.gov/omb/memoranda/fy2007/m07-07.pdf. ■

CCH Washington Bureau, Feb. 2, 2007.

Fraud & Abuse

U.S. joins false claims suit against drug company

by Valerie L. Witmer, J.D., Contributing Editor

The U.S. has intervened in a whistleblower suit originally filed almost ten years ago by a Florida home infusion company against an Ohio-based pharmaceutical manufacturer, alleging violations of the False Claims Act (FCA), the Department of Justice announced on January 29, 2007. The government's complaint alleges that Boehringer Ingelheim Roxane, Inc. (Roxane) engaged in a scheme to report fraudulent and inflated prices for several pharmaceutical products, knowing that federal health care programs established reimbursement rates based on those reported prices.

Price inflation. According to the government's complaint, Roxane artificially inflated spreads to market, promote, and sell generic drugs that are reimbursed by Medicare and Medicaid. The "spread" is the difference between the government reimbursement rate and the actual price paid by health care providers for a drug. Accordingly, the larger the spread on a drug, the larger the profit for the provider.

The government's complaint alleges that from at least on or before January 1, 1996, Roxane reported prices that, in some instances, exceeded 1,000 percent of the actual sales prices on some of the drugs it manufactures. The U.S. alleges that Medicare and Medicaid have reimbursed Roxane's customers more than $500 million for the drugs that are the subject of the complaint.

Possible money judgment. Under the FCA, if it is determined that Roxane submitted or caused others to submit false or fraudulent claims to the federal health care programs, the government can recover treble damages plus statutory penalties of $5,500 to $11,000 for each false or fraudulent claim filed. In addition, if the government is successful in litigating its claims, the whistleblower who initiated the action can receive between 15 and 25 percent of the amount recovered.■

DOJ Press Release, Jan. 29, 2007.

In the News

SCCI settles Stark, FCA allegations

SCCI Health Services Corporation (SCCI) and its subsidiary, SCCI Hospital Ventures, Inc., have paid $7.5 million to settle allegations that they violated the Stark self-referral statute and the False Claims Act (FCA), the Department of Justice announced on January 5, 2007. The government's complaint alleged that from November 1996 through at least 1999, SCCI, a Texas-based corporation that operates long term acute care facilities across the U.S., entered into prohibited financial relationships with physicians and submitted or caused false claims to be submitted to Medicare as a result of these prohibited financial relationships. The settlement resolves a civil FCA case filed on behalf of the government on April 1, 1999, by former employees and an independent contractor who worked for SCCI Houston. As a result of the settlement, the five whistleblowers shared $1.7 million.

DOJ Press Release, Jan. 5, 2007.

Senate confirms Astrue for SSA post

Michael J. Astrue will serve as commissioner of the Social Security Administration (SSA) through January 2013. Astrue received Senate approval on February 1, 2007. He replaces Jo Anne B. Barnhart, whose term expired on January 19. Astrue previously served as chief executive officer of Transkaryotic Therapies, a pharmaceutical company. He has held positions in the Department of Health and Human Services, including general counsel and counselor to the commissioner of Social Security. During his confirmation hearings, Astrue pledged to be politically neutral on the issue of establishing private investment accounts in the Social Security program, saying his role would be to serve as an "honest broker and supplier of information."

CCH Washington Bureau, Feb. 5, 2007.

Health care reform planned in Illinois

Illinois Governor Rod Blagojevich has a plan to offer health care coverage for all 1.7 million uninsured state residents, according to a report by Crain's Chicago Business. Blagojevich outlined his plan to lawmakers, advocacy groups, and health care providers, and will unveil the plan next month. The proposal, still in draft form, would increase corporate tax rates to cover the costs of the plan. The proposal also includes an expansion of the state's Medicaid program to cover approximately 500,000 residents who are poor and currently do not qualify for aid, as well as state subsidies to help low-income workers afford health insurance from employers or from a state fund.

United Press International, Feb. 4, 2007.

Medicare payment project improves quality of care

Second-year results from the Hospital Quality Improvement Demonstration (HQID) show substantial improvement in quality of care, leading to incentive payments totaling $8,690,447 to 115 top-performing hospitals, CMS announced. HQID is a value-based purchasing project launched in 2003 as part of an overall shift in Medicare to pay based on value, not volume of services. Project participants reported significant improvement in quality of care across five clinical focus areas measured by more than 30 nationally standardized and widely accepted quality indicators. The average improvement in the project's second year was 6.7 percent, for total gains of 11.8 percent over the project's first two years.

CMS Press Release, Jan. 26, 2007.