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NY Attorney General investigates health insurers' fraud scheme

New York Attorney General (AG) Andrew M. Cuomo is conducting an industry-wide investigation into a scheme by health insurers to defraud consumers by manipulating reimbursement rates. Central to the scheme is Ingenix, Inc., the nation's largest provider of health care billing information.

The investigation has revealed that Ingenix operates a defective and manipulated database that most major health insurance companies use to set reimbursement rates for out-of-network medical expenses. The investigation also found that two subsidiaries of UnitedHealth Group—Ingenix's parent company—underreimbursed their members for out-of-network medical expenses by using data provided by Ingenix.

Under the United insurers' health plans, members pay a higher premium for the right to use out-of-network physicians. In exchange, the insurers cover up to 80 percent of the lower of the physician's actual charge or the reasonable and customary rate. The AG discovered that, by distorting the reasonable and customary rate, the United insurers were able to keep their reimbursements artificially low and force patients to absorb a larger percentage of the costs.

For example, United insurers knew most simple doctor visits cost $200, but claimed to their members that the reasonable and customary rate was only $77. The insurers then applied the 80 percent reimbursement rate, covering only $62 for a $200 bill, and leaving the patient to cover the $138 remaining balance.

The Ingenix database calculated a reasonable and customary rate for individual claims by assessing how much a similar type of medical service would typically cost, taking into account the physician and the geographical location. The AG's investigation showed, however, that the reasonable and customary rates generated by the Ingenix database were significantly lower than the actual cost of typical medical expenses.

In addition, when members complained that their medical costs were unfairly high, the United insurers hid their connection to Ingenix by claiming the rates were established by independent research. The AG expressed concern that United's ownership of Ingenix created a conflict of interest because their relationship gave Ingenix an incentive to set rates that benefited United and its subsidiaries.

The AG issued a notice of intent to sue United and several of its subsidiaries. He also served subpoenas on 16 of the nation's largest health insurance companies, including Aetna, CIGNA, and Empire Blue Cross Blue Shield. The subpoenas request documents showing how each insurer computes reasonable and customary rates, copies of member complaints and appeals, and communications between the insurer and its members and between the insurer and Ingenix.■

New York Attorney General Press Release, Feb. 13, 2008.

Wolters Kluwer Law & Business

Prepare now for EHR implementation, expert advises

Health information managers should prepare for the day electronic health records (EHRs) become mandatory by making sure their computer and software programs will work to protect the security, quality, and authenticity of patient data, according to Shelley Safian, Chair of the Allied Health Department at Herzing College, Winter Park, Florida. Speaking at a February 7, 2008, audio seminar presented by the American Health Information Management Association, Safian urged that, although there are many challenges, moving to EHR is "incredibly beneficial for patient care."

In 2004, President Bush outlined a plan to ensure that most Americans have EHRs by 2014. In July 2004, HHS unveiled a 10-year plan to create a new national health information infrastructure, including an EHR for every American and a new network to link health records nationwide.

Accuracy. EHRs provide increased accuracy compared to paper documentation, Safian said. "Although EHR will not eliminate errors altogether, it will dramatically reduce errors." For instance, EHR software can be programmed to flag misspelled names, Safian noted. Once a name is entered into the EHR correctly it never has to be entered again. It is that much more important, however, to enter the correct information. "Otherwise, it's going to be wrong a million times," she said.

The software programs also can remind health information managers and physicians to be more thorough in their documentation, Safian said, noting that templates can remind providers to input information that they otherwise may not complete, such as family medical history.

Safian warned against programs that allow certain short cuts that could lead to inaccuracy. "You need to make sure that your EHR program does not allow the physician to copy and paste," she urged. A copy and paste feature can enable a provider to copy text from a case that does not quite apply to the current situation, she warned. While EHR makes documentation easier, "[w]e still need the physicians to do the documentation on their own."

Safian also cautioned against pre-completed templates. "Limit auto-fill coding." More often than not, she said, "[i]t is the cause of…rejected and denied claims and underpayment because of undercoding." Programs that use an auto fill feature can lead to mistakes. Some clinical terms are very similar, such as diverticulitis and diverticulosis, yet are coded differently. It is easy to mistake one for the other if a perso is in a hurry, Safian explained.

Authenticity. Additionally, she advised that physicians, not coders, should input the data. "There's no reason for coders to have input access into EHR," she said. To increase authenticity, users should have to sign off on their work and they should be tracked with regard to who has permission to enter data versus permission to read only. Safian also suggested implementing e-signatures. A provider identifier or even fingerprints can be used to authenticate the user, she added.

Efficiency. To ensure increased efficiency, EHR software needs to be compatible internally and with systems at other facilities, Safian said. Because there is no national standard, compatibility "is definitely a concern" of EHR. For example, she said, e-mail attachments from other facilities may not open, or outside laboratories and imaging centers may fax documents that need to be scanned into the system. "You're going to have to have an internal process to deal with that," she said.

Efficiencies inherent in EHR systems include: (1) there is no delay waiting for dictation or transcription; (2) electronic queries can provide written responses more quickly; and (3) documents do not need to be copied when a patient is transferred, Safian noted. In addition, more than one nurse or clinician can access the information at one time.

Safian acknowledged that while productivity may suffer 25 or 30 percent while the staff is getting used to the computer programs, the slowdown will last for only weeks or months. "Without question you will be able to exceed your pre-EHR levels with regard to effectiveness and efficiency," she predicted. She added that increased efficiency will lead to faster billing, better collections, and better cash flow. "Accurate, complete, and fast clinical documentation is key to patient care, as well as reimbursement processes." ■

CCH Washington Bureau, Feb. 20, 2008.

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Pay for performance demonstration shows limited benefit

A physicians' group practice (PGP) demonstration testing pay-for-performance (P4P) incentive payments led to some savings, but the feedback and incentive payments came too late for participating groups to respond in a timely manner, and most physician groups would have difficulty achieving similar results, according to a report issued by the Government Accountability Office (GAO).

PGP demonstration. The PGP demonstration combined Medicare fee-for-service payments with a bonus payment that participating physician groups can earn by demonstrating savings through better management of patient care and meeting quality of care performance targets. The demonstration initially was set for three years; in December 2007, it was extended for a fourth year. The first program year began April 1, 2005, and ended March 31, 2006. The final program year will end March 31, 2009.

The project tested ten group practices with 200 or more physicians in multiple specialties. Each implemented a care coordination program targeted to a specific patient population, such as patients with congestive heart failure. If the practice achieved savings of 2 percent or more, it was eligible for bonus payments based on the savings and could receive additional payments for implementation of seven of ten specified quality measures. CMS defined the savings and quality-of-care outcome measures but allowed each practice to decide how to achieve them.

The GAO examined the progress of the demonstration as mandated by §412(b) of the Benefits Improvement and Protection Act (BIPA) (PubLNo 106-554). In program year one (PY1), two of the practice groups were eligible for bonus payments. The other eight practice groups met the quality-of-care measures but did not produce the minimum savings to quality for any incentive payment. The full impact of the physicians' efforts will not be apparent at least until the data from program year two (PY2) are available because many of the programs were not implemented during part or all of PY1.

Data valid but untimely. To be sure that any savings or quality measures were attributable to the demonstration, CMS used comparison groups of patients with characteristics similar to those in the study. Because of other aspects of the study design, reports of the results—and the first incentive payments—from the participants' first year were not available until 15 months from the end of the program year. By then, the demonstration was well into its third year. According to the GAO, the participants stated that they were unable to use the feedback or payments to make changes based on the demonstration because of the delay.

Application to other physician groups. The study is likely to have little impact on the habits of the vast majority of physician practices for several reasons. First, the demonstration was limited to multi-specialty groups with 200 or more physicians. In 2005, less than one percent of physician groups included 150 or more physicians, while more than 80 percent consisted of one or two physicians.

Second, multiple-specialty groups are atypical. While all ten participating physician group practices were multi-specialty practices, 68 percent of all practices in the United States were single-specialty practices, which generally are smaller organizations.

Finally, most of the participant groups had developed electronic health record (EHR) systems; one used the demonstration to begin implementing an EHR system. Only 24 percent of physician groups, however, had either partial or fully implemented EHR systems in 2005.

The large size of the physician practices studied gave them other advantages unavailable to most physicians. Because of their affiliations with institutions or integrated health systems, the ten groups were much more likely to have EHR systems in place and had more support staff, greater access to capital, and much larger annual revenues. The ten participating groups averaged $413 million in annual revenues in 2005, while only about one percent of single specialty groups generated revenues greater than $50 million. Expansion of the demonstration appears limited. ■

GAO Report, No. GAO-08-65, Feb. 15, 2008.

On The Front Lines

What the OIG has in store for the health care industry in 2008, Part I

by Corrine P. Parver, Esq., Editorial Advisory Board Member

Each year, the HHS Office of Inspector General (OIG) unveils its plans for research, investigations, audits, and other activities regarding HHS programs and operations in its annual "Work Plan." Notably, all players in the health care industry, including CMS, treat the ongoing and projected activities of the OIG as described in its Work Plan with considerable attention and, at times, concern.

Predictably, findings derived from the OIG's audits, studies, and research projects often elicit harsh reactions from both CMS and providers alike, for very different reasons. Nonetheless, Congress views with respect and listens closely to the OIG's observations and, invariably, the OIG's recommendations result in congressional action and legislative provisions designed to help curb fraud, waste, and abuse.

For that reason, and as a guide to the health care industry into the OIG's planning, this article highlights the oversight targets noted in the OIG's Work Plan for fiscal year (FY) 2008. Part I of this article focuses on both ongoing and new activities related to the following entities reimbursed by CMS under the Medicare program: hospitals, home health agencies, nursing homes, hospices, physicians, other health professionals, and durable medical equipment suppliers. Part II will review the OIG Work Plan initiatives for Medicare Part B drug reimbursement, Part D administration, other Medicare services, Medicare Advantage, and Medicaid.

Hospitals

For FY 2008, the OIG's top priorities generally lie in the accuracy of payment outlays, especially given the most recent assessment that the Hospital Trust Fund will be in serious jeopardy by 2019. Hospital providers, especially long-term care and physician-owned specialty hospitals, must manage their cost reporting functions prudently, ensuring that they comply with the regulatory requirements affecting reimbursement, compliance, and accreditation.

The following initiatives are ongoing OIG works-in-progress and are expected to be completed in FY 2008.

Medicare-dependent hospital (MDH) program. The OIG will review the appropriateness of FY 2002 base-year costs for a select number of MDHs, and determine whether payments made to MDHs are correct and supported based on allowable costs from the FY 2002 cost reports.

Education payments. The OIG will analyze audit adjustments for direct and indirect graduate medical education made by fiscal intermediaries while settling Medicare cost reports, and determine whether the adjustments were appropriately reflected in the revised Medicare reimbursement.

The OIG also will assess payments for provider-operated nursing and allied health education programs to determine whether payments to providers for these costs were appropriate.

Inpatient prospective payment system (IPPS) wage indices. The OIG will review hospital and Medicare controls over the accuracy of the hospital wage data used to calculate wage indices for the IPPS and determine whether hospitals have complied with Medicare requirements for reporting wage data. This study also will determine the effect of incorrect diagnosis-related group (DRG) reimbursement caused by inaccurate wage data and examine the appropriateness of using hospital wage indices for other provider types.

Organ procurement organizations (OPOs). The OIG will analyze Medicare payments made to OPOs and determine whether such payments are correct and supported.

Long-term care. The OIG will evaluate certain payments made to LTCHs to determine whether payments for interrupted stays were correct.

The OIG also will review payments for patients discharged from LTCHs with lengths of stay well below the average for their DRGs, which are referred to as short stay outliers (SSO). The review will focus on the distribution of and payment amounts for SSO cases and address cases that only marginally exceed the SSO threshold.

Critical access hospitals (CAHs). The OIG will analyze payments made to CAHs to determine whether they have met the CAH classification criteria and conditions of participation set forth in the Medicare statute.

Medicare transfer policy. The OIG will review coding of claims submitted by hospitals for erroneously coded discharges that should have been coded as transfers to determine whether claims were appropriately coded.

Physician-owned specialty hospitals. The OIG will evaluate indicators of patient care and safety in physician-owned specialty hospitals and examine policies related to staffing requirements at these hospitals.

The following initiatives are new OIG studies, the results of which are expected in FY 2008.

Payments for new technologies. The OIG will review payments made to hospitals for new services and technologies to determine whether hospitals submitted claims in accordance with Medicare criteria and were appropriately reimbursed for costs associated with the new devices and technologies.

LTCH special payment provisions. The OIG will examine the application of special payment provisions for patients who were transferred to onsite providers and then readmitted to LTCHs, to determine whether the special payment provisions were appropriately applied. The OIG also will review the application of special payment provisions for LTCHs discharging beneficiaries to co-located hospital or satellite providers to determine whether these provisions were appropriately applied.

Inpatient psychiatric facility emergency department (ED) adjustments. The OIG will assess payments made to inpatient psychiatric facilities to determine whether appropriate rate adjustments were made for facilities that operate EDs.

Provider bad debts. The OIG will review Medicare bad debts claimed by acute care inpatient hospitals, LTCHs, inpatient rehabilitation facilities, and skilled nursing facilities (SNFs) to determine whether the bad debt payments were appropriate and if recoveries of prior year write-offs were properly used to reduce the cost of beneficiary services for the period in which the recoveries were made.

The following initiatives are new OIG studies, the results of which are expected in FY 2009.

Capital payments. The OIG will determine whether capital payments to hospitals are appropriate by examining the methodology used to update capital rates and analyzing the appropriateness of the payment levels.

Disproportionate share (DSH) payments. The OIG will analyze Medicare DSH payments to hospitals to determine whether these payments were made in accordance with Medicare criteria and if the hospitals' classifications were appropriate. The OIG also will examine the total amounts of uncompensated care costs that hospitals incur.

Diagnostic x-rays in hospital EDs. The OIG will determine the appropriateness of payments for diagnostic x-rays and interpretations by reviewing a sample of Medicare Part B paid claims and medical records for diagnostic x-rays performed in hospital EDs.

Joint Commission accreditation. The OIG will evaluate CMS' policies and procedures regarding the Joint Commission hospital accreditation process, to assess the extent and adequacy of these policies and procedures.

Medicare secondary payer. The OIG will review Medicare payments for beneficiaries who have other insurance to assess the effectiveness of current procedures in preventing inappropriate Medicare payments for beneficiaries with other insurance coverage.

Home health agencies

Long a target for increased OIG scrutiny, home health agencies (HHAs) must pay particular attention this year to the accuracy of submitted claims information and certification standard compliance, especially as the cost of home care continues to rise at an extremely rapid rate, and providers engaging in fraudulent activities continue to avoid detection.

Cyclical noncompliance. The OIG will analyze national data on HHAs' survey and certification deficiencies to identify whether there are trends and patterns of cyclical noncompliance with certification standards. The study will evaluate how cyclically noncompliant HHAs compare to HHAs without such histories and determine whether CMS applies appropriate sanctions to noncompliant HHAs. This study is an ongoing OIG work in progress, and is expected to be completed by FY 2008.

The following two studies are new OIG research projects, the results of which are expected in FY 2009.

Home Health Compare web site data. The OIG will assess the extent to which the Home Health Compare Web site includes accurate and complete information on Medicare-certified HHAs.

Home health resource groups (HHRGs). The OIG will review Medicare claims submitted by HHAs to determine the extent to which the HHRGs that are used in determining payments to HHAs are accurate and supported by documentation in the medical record. The OIG also will assess the accuracy of HHRG assignment and identify potential patterns of upcoding by HHAs.

Skilled nursing facilities (SNFs) and hospice care

As with hospitals, the OIG's focus on the nursing home industry continues to revolve around payment and coding issues, especially for services that ordinarily are reimbursed under Medicare Part B. As this area has been a frequent target for attention and abuse, SNFs must guard against the possibility of double billing for services that should fall under the Part A benefit.

The following initiatives are ongoing OIG works-in-progress and are expected to be completed by FY 2008.

Consolidated billing. The OIG will review Part B claims submitted by suppliers for items, supplies, or services provided to beneficiaries during Part A-covered SNF stays to identify possible overpayments and determine whether edits in CMS' main claims processing system, the Common Working File, are effective in detecting and preventing improper payments.

Hospice care for nursing home residents. The Medicare hospice regulations specify when and where beneficiaries become entitled to receive hospice services as a covered benefit. The OIG's FY 2008 Work Plan initiative focuses specifically on this issue. The OIG will review the nature and

extent of hospice services that are provided to Medicare beneficiaries who reside in SNFs, and assess the appropriateness of payments for hospice care for these services. The review will assess beneficiaries' plans of care to determine whether the services received were consistent with the plans of care and whether payments were appropriate.

The following initiatives are new OIG research projects, the results of which are expected in FY 2009.

Cost reports. The OIG will review a sample of SNF cost reports and evaluate CMS' oversight of Medicare expenditures contained in these reports to determine the extent to which CMS is monitoring SNF cost reports to ensure compliance with established requirements.

Resource utilization group (RUG) claims. The OIG will analyze a national sample of Medicare claims submitted by SNFs to determine the extent to which RUGs included on SNF claims for Medicare reimbursement are accurate and supported by the residents' medical records. The OIG also will identify areas to improve the accuracy of payments to SNFs.

Physicians and other health professionals

Physicians, now more than ever, are facing increased OIG scrutiny not only because of rising costs of medical care, but also because of continuing violations of Medicare fraud and abuse laws, especially the anti-kickback statute and the physician self-referral prohibition (Stark law). The studies described below focus on areas relating to these laws, as well as reimbursement issues.

The following initiatives are ongoing OIG works-in-progress and are expected to be completed by FY 2008.

Place of service errors. The OIG will review physician coding of place of service on claims for services performed in ambulatory surgical centers (ASCs) and hospital outpatient departments to determine whether physicians properly coded the place of service.

"Incident to" services. The OIG also will analyze Medicare claims for services furnished incident to the professional services of selected physicians to determine the qualifications and appropriateness of the staff who perform the services. This study will review medical necessity, documentation, and quality of care for incident to services.

Evaluation and management (E&M) services. The OIG will assess industry practices related to the number of E&M services provided by physicians and reimbursed as part of the global surgery fee to determine whether industry practices related to the number of E&M services provided during the global surgery period have changed since that fee concept was developed in 1992.

Magnetic resonance imaging (MRI) services. The OIG will evaluate the arrangements under which MRI is provided under the Medicare Physician Fee Schedule and describe financial relationships among physicians, billing providers, and others who work together to provide these services to determine whether those relationships affect levels of utilization.

Interventional pain management procedures. The OIG will review Medicare payments for interventional pain management procedures to determine the appropriateness of these payments and assess the oversight of the procedures.

Chiropractic treatments. The OIG will analyze chiropractor billings for high frequency treatments to determine whether they comply with Medicare coverage criteria and documentation requirements.

The following initiatives are new OIG research projects, the results of which are expected in FY 2008.

Assignment rules. The OIG will assess whether Medicare providers are adhering to assignment rules in billing Medicare beneficiaries, to determine the extent to which providers may be billing beneficiaries in excess of amounts allowed by Medicare requirements and assess beneficiary awareness of the potential violations.

The OIG also will evaluate the extent to which Medicare physicians reassign their benefits to other entities and the extent to which the physicians are aware of reassignments requested on their behalf.

Independent diagnostic testing facilities (IDTFs). The OIG will analyze services and billing patterns in geographic areas with high concentrations of IDTFs to examine service, provider, and beneficiary profiles and billing patterns.

The following initiatives are new OIG research studies, the results of which are expected in FY 2009.

Psychiatric services. The OIG will review Medicare payment for psychiatric services to determine whether claims for these services were supported and billed in accordance with Medicare requirements.

Clinical social worker (CSW) services. The OIG will review services furnished by CSWs to inpatients of Medicare participating hospitals or SNFs to determine if the services were separately billed to Medicare Part B.

Physician services. The OIG will assess the appropriateness of Medicare Part B payments for selected physician services to determine whether these services were paid in accordance with Medicare requirements.

Additionally, the OIG will assess the appropriateness of payments for physician services under Medicare Part B for beneficiaries receiving care from Medicare HHAs or residing in SNFs while living significant distances from the physicians billing for services to determine whether these services have been appropriately claimed.

Medicare payments for polysomnography. The OIG will determine the appropriateness of payments for polysomnography services and examine the factors contributing to the rise in Medicare payments for this service.

Ultrasound services. The OIG will examine services and billing patterns in geographic areas with high utilization of ultrasound services paid under the Medicare Physician Fee Schedule, to examine service, provider, and beneficiary profiles.

Durable medical equipment

Another favorite target of OIG attention over the last 15 years has been the durable medical equipment (DME) industry. Although payments for DME constitute a relatively minor portion of the overall Medicare budget (approximately 2-3 percent), suspicious activities by unscrupulous DME suppliers have accounted for a significant amount of both congressional and OIG scrutiny. The FY 2008 Work Plan describes numerous audits, studies, and research projects analyzing various payment issues relating to DME suppliers.

The following initiatives are ongoing OIG works-in-progress and are expected to be completed by FY 2008.

Beneficiaries receiving home health services. The OIG will analyze Medicare claims for DME, prosthetics, orthotics, and supplies furnished to beneficiaries receiving HHA services to determine whether DME claims paid by Medicare on behalf of beneficiaries receiving home health services were allowable.

DME payments in South Florida. The OIG will review Medicare claims submitted by South Florida providers for DME items and supplies to determine whether the DME claims were allowable.

Negative pressure wound therapy pumps. The OIG will compare suppliers' acquisition costs and prices of certain negative pressure wound therapy pumps to Medicare reimbursement to see how Medicare reimbursement compares to the median supplier purchase price.

Payment suspensions for DME suppliers. The OIG will assess whether CMS has inappropriately made payments to suspended or excluded DME suppliers to assess the adequacy of CMS' safeguards to prevent payment to those entities.

Power wheelchairs. The OIG will evaluate documentation supporting claims for power wheelchairs paid for by Medicare to determine whether Medicare beneficiaries received the required face-to-face examinations from the referring practitioners prior to receipt of power wheelchairs. The OIG also will review invoice prices for power wheelchairs and compare those prices to the Medicare fee schedule to assess pricing variations.

Part B services in nursing homes and SNFs. The OIG will conduct three separate reviews in this area:

- the extent of Part B services provided to nursing home residents whose stays are not paid for under Medicare's Part A SNF benefit;
- the appropriateness of Medicare Part B DME services allowed for beneficiaries during nursing home stays not covered by Medicare Part A; and
- the appropriateness of payments for services associated with claims for Part B enteral nutrition therapy (ENT).

Enteral nutrition therapy (ENT). The OIG will examine Part B pricing of ENT and compare Medicare's fee schedule for ENT to prices available to nursing homes, individuals, and other purchasers.

The following study is an ongoing OIG work-in-progress and is expected to be completed by FY 2009.

Pressure-reducing support surfaces. The OIG will assess the appropriateness of payments for pressure-reducing support surfaces by conducting a medical review of claims.

The study below is a new OIG research project, the result of which is expected in FY 2008.

Comprehensive error rate testing. The OIG will review Medicare payments for DME to determine the adequacy of medical records and other supporting documentation used by the Comprehensive Error Rate Testing Program to support CMS' FY 2006 DME error rate. The items to be reviewed include power wheelchairs, orthotics, and other medical supplies. The OIG will assess suppliers' and physicians' documentation to support the claims and evaluate whether the items were medically necessary and whether the beneficiaries received the items.

The following initiatives are new OIG research projects, the results of which are expected in FY 2009.

Claims with modifiers. The OIG will assess the appropriateness of Medicare payments to DME suppliers that submitted claims with modifiers to determine whether payments to DME suppliers were made in accordance with Medicare rules.

Home blood glucose testing supplies. The OIG will analyze Medicare Part B payments made for home blood glucose test strips and lancet supplies to determine the appropriateness of these payments.

Conclusion

Part I of this article addressed the OIG's oversight targets for various provider types. The OIG's review of hospitals will focus largely on the accuracy of payments, particularly to critical access hospitals, long-term care facilities, and physician-owned specialty hospitals. Top OIG priorities for HHAs include compliance with survey and certification standards and the accuracy of HHRGs used to determine payments to HHAs. SNFs likewise will be evaluated for accuracy of payments, as well as compliance with cost report requirements. Physicians and other health care professionals will face scrutiny because of continuing violations of the fraud and abuse, anti-kickback, and Stark laws. Fraudulent conduct also will account for a significant amount of OIG scrutiny of DME suppliers.

Part II of this article, which will appear in an upcoming issue of the *Health Care Compliance Letter*, will address the remaining sections of the OIG's FY 2008 Work Plan, including initiatives related to Medicare Part B drug reimbursement, Part D administration, other Medicare services, Medicare Advantage, and Medicaid. ■

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Anti-Kickback

OIG approves cost-sharing arrangements

In two recent advisory opinions, the Office of Inspector General (OIG) weighed in on two existing arrangements under which a hospital shares a percentage of its cost savings with a particular group of physicians.

Under the first arrangement, a hospital shares with a group of cardiac surgeons a percentage of its cost savings arising from the cardiac group's implementation of 25 cost reduction measures in its operating room procedures. Similarly, under the second arrangement, a hospital agreed to pay an anesthesiology group a percentage of the cost savings achieved by implementing five specific cost reduction measures related to anesthesiology services provided during cardiac surgery. In both arrangements, 50 percent of the cost savings are distributed to individual group members on a *per capita* basis.

Both arrangements were approved by the OIG because: (1) the cost saving actions and resulting savings are clearly and separately identified; (2) credible medical support shows that implementation of the recommendations will not adversely affect patient care; (3) the amount to be paid has been calculated based on all procedures regardless of patients' insurance coverage, subject to the cap on payment for federal health care program procedures; (4) the arrangements protect against reductions in services by utilizing objective historical and clinical measures; (5) written disclosures are provided to patients prior to any procedures; (6) financial incentives in the arrangements are reasonably limited in duration and amount; and (7) any incentive generate disproportionate cost savings is mitigated by *per capita* distribution of profits.

The OIG would not seek sanctions under the anti-kickback statute because: (1) the circumstances and safeguards of the arrangements reduce the likelihood that they will be used to attract referring physicians or increase referrals from existing physicians; and (2) the arrangements are structured to eliminate the risk that they will be used to reward physicians who refer patients to each group. ■

OIG Advisory Opinion, No. 07-21, Dec. 28, 2007, Health Care Compliance Reporter ¶500,178; OIG Advisory Opinion, No. 07-22, Dec. 28, 2007, Health Care Compliance Reporter ¶500,179.

In the News

Several states promote e-health initiatives

Motivated to improve health system performance, assure quality, and maximize value from health care, states are promoting a wide variety of e-health initiatives that exploit the capabilities of health information technology (HIT) and electronic health information exchanges, according to a February 15, 2008, Commonwealth Fund report, entitled "State E-Health Activities in 2007." The report describes the range of state e-health activities, the challenges states are facing, and emerging best practices. The report finds that: (1) all states place a high priority on e-health and nearly 70 percent report "very significant" e-health activities; (2) states' highest e-health priorities over the next two years are development of electronic health information exchanges and interconnectivity among health care providers; (3) e-health applications are enabling states to promote quality improvement and greater transparency, and public-private consortia are aiding the creation of standardized utilization and performance measures; and (4) privacy and security concerns and limited funding are among the most significant barriers to the widespread adoption of interoperable HIT and a nationwide network of electronic information exchange.

CCH Washington Bureau, Feb. 20, 2008.

Senate passes fraud penalty amendment

The Senate has passed a measure that would double the penalties currently allowed to redress Medicare fraud. The amendment would: (1) increase the current maximum sentence for Medicare fraud from five years to ten years; (2) double all civil fines to $20,000 per claim; and (3) quadruple the criminal fine to $100,000. Senator Mel Martinez (R-Fla.), who led the effort pass the amendment, called it a "first step" toward ensuring taxpayer dollars have better oversight. "Medicare fraud is running rampant...across the country....The current penalties aren't deterring people and organizations from taking advantage of the system, so until we can reform the larger oversight issue, this will give the judicial system greater discretion in helping to put offenders behind bars," Martinez said. Current estimates put Medicare fraud as high as $60 billion per year.

U.S. Senator Mel Martinez Press Release, Feb. 15, 2008.

AHA lauds patient safety organization proposal

HHS' proposed rule to create patient safety organizations (PSOs) has garnered support from hospitals, which view the creation of PSOs as "one of the most important tools to spur safer patient care," according to the American Hospital Association (AHA). The proposed regulations would implement the Patient Safety and Quality Improvement Act of 2005 (PubLNo 109-41), which would establish a framework for hospitals, physicians, and other health care providers to voluntarily report information to PSOs, on a privileged and confidential basis, for analysis of patient safety events. "PSOs provide a better way for all hospitals that participate to learn from each other. Hospitals will be able to look to their PSO to help identify the underlying causes of errors so that all health care providers can implement strategies to prevent harm to patients," the AHA said.

AHA Press Release, Feb. 12, 2008; Proposed rule, 73 FR 8111, Feb. 12, 2008, Health Care Compliance Reporter ¶730,034.