CCH Health Care Compliance LETTER

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IG testifies on ensuring Medicare, Medicaid integrity

Testimony regarding the Office of Inspector General's (OIG) experience in fighting fraud, waste, and abuse in the Medicare and Medicaid programs and OIG recommendations for ensuring the integrity of these programs was given before the Senate Special Committee on Aging on May 6, 2009, by Daniel Levinson, Inspector General of HHS.

According to Levinson, from fiscal year (FY) 2006 through FY 2008, OIG averaged $2.04 billion in investigative receivables and Medicare and Medicaid audit disallowances of $1.22 billion per year. The OIG also excluded 3,129 individuals and entities for fraud or abuse that affected federal health care programs and beneficiaries in FY 2008. In FY 2008, OIG recommendations resulted in $16.72 billion in savings and funds put to better use.

Collaborative legal actions. In FY 2008, the OIG's collaboration with the Department of Justice (DOJ) and state law enforcement as well as with CMS and the Food and Drug Administration resulted in 455 criminal actions against individuals or entities and 337 civil and administrative actions, including False Claims Act and unjust enrichment lawsuits, civil monetary penalties settlements, and administrative recoveries related to provider self-disclosure matters.

HHS and the DOJ have been engaged in joint anti-fraud efforts through the Health Care Fraud and Abuse Control (HCFAC) Program since its inception in 1997. During this period, the HCFAC Program activities have returned over $11.2 billion to the Medicare Trust Fund.

DME and infusion fraud. In an effort to describe areas of vulnerability and the benefits of a collaborative enforcement approach, Levinson's focused his testimony on examples of durable medical equipment (DME) and infusion fraud. In particular, the OIG identified problems related to the obligation of DME suppliers to provide Medicare with the identifier number of the ordering physician. OIG studies uncovered:

(1) the use of invalid or inactive unique physician identification numbers (UPIN),
(2) the use of UPINs that belonged to deceased physicians,
(3) the improper use of surrogate UPINs, and
(4) the use of legitimate UPINs that were associated with an unusually large number of claims.

Levinson also identified certain types of DME that are particularly vulnerable to abuse. For 2004, he estimated that Medicare paid $96 million for claims that did not meet coverage criteria for any type of wheelchair or scooter and that the program overspent an additional $82 million for claims that could have been billed using a code for a less expensive mobility device.

Wolters Kluwer Law & Business

Other areas of vulnerability. According to Levinson, OIG reviews have identified Medicare payments for unallowable services, improper coding, and other types of improper payments for inpatient and outpatient services, including:

- **Hospitals and inpatient facilities.** Problems with: (1) taking advantage of enhanced payments by manipulating billing; (2) reporting inaccurate wage data, which affects future Medicare payments; and (3) gaming prospective payment reimbursement systems by discharging or transferring patients to other facilities for solely financial reasons.
- **Advanced imaging.** From 1995 to 2005, expenditures for advanced imaging paid under the Medicare physician fee schedule grew from $1.4 million to $6.2 million. Independent diagnostic testing facilities (IDTF) accounted for nearly 30 percent of this growth. Problems with IDTFs have included noncompliance with Medicare requirements and billing for services that were not reasonable and necessary.
- **School-based health services.** In a series of reviews, OIG found that schools had not adequately supported their Medicaid claims for school-based health services and identified almost a billion dollars in improper Medicaid payments.
- **Oxygen concentrators.** In 2006, OIG reported that Medicare had allowed, on average, $7,215 for the rental of an oxygen concentrator that costs about $600 to purchase new. Beneficiaries averaged $1,443 in co-insurance charges. OIG determined that if home oxygen payments were limited to 13 months, rather than the current 36 months, Medicare and its beneficiaries would save $3.2 billion over five years.
- **Negative pressure wound therapy pumps.** In March 2009, OIG reported that Medicare reimbursed suppliers for negative pressure wound therapy pumps based on a purchase price of more than $17,000, but that suppliers paid, on average, approximately $3,600 for new models of these pumps.

Medicare fraud in South Florida. Levinson reported that OIG and its enforcement partners are focusing their antifraud efforts in areas at high risk, especially South Florida. In 2007, a Medicare Fraud Strike Force made up of staff from OIG, the U.S. Attorney's Office, the Federal Bureau of Investigation, and DOJ launched an effort to identify, investigate, and prosecute DME suppliers and infusion clinics suspected of fraud. As of April 17, 2009, the Strike Force has convicted 146 of its targets and recovered $186 million.

In 2006, OIG conducted unannounced site visits to 1,581 DME suppliers in South Florida and found that 31 percent did not maintain physical facilities or were not open and staffed during business hours.

OIG's analysis of Medicare billing patterns in South Florida for inhalation drugs used with DME has found that Medicare paid almost $143 million for inhalation drugs in Miami-Dade County alone — an amount 20 times greater than the amount paid in Cook County, Illinois, the county with the next highest total payments and twice as many Medicare beneficiaries as Miami-Dade County.

OIG also found that CMS has had limited success controlling aberrant billing by infusion clinics. In the second half of 2006, claims originating in three South Florida counties accounted for 79 percent of the amount submitted to Medicare nationally for drug claims involving HIV/AIDS patients, even though only 10 percent of Medicare beneficiaries with HIV/AIDS lived in these three counties.

OIG's five strategic principles Levinson offered five principles for an effective health care integrity strategy:

(1) scrutinize individuals and entities that want to participate as providers and suppliers prior to their enrollment;
(2) establish payment methodologies that are reasonable and responsive to marketplace changes;
(3) assist providers and suppliers in adopting practices that promote compliance with program requirements;
(4) vigilantly monitor for evidence of fraud, waste, and abuse; and
(5) respond swiftly to detected frauds, impose sufficient punishment and promptly remedy program vulnerabilities.

OIG believes that these principles will provide a useful basis for designing and implementing health care program benefits and safeguarding their integrity. ■

Inspector General Testimony to the Senate Special Committee on Aging, May 6, 2009

CCH Health Care Compliance Letter

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Anti-Kickback/Physician Self-Referral

OIG: Cost-sharing waiver for backup EMS OK

An agreement among three villages to waive cost-sharing obligations for backup emergency medical services (EMS) transportation would not result in civil money penalties or administrative sanctions under the anti-kickback statute, according to the Office of Inspector General (OIG).

Each of the municipalities, which are located adjacent to one another, owns an ambulance service that is operated by its fire department. Each village charges a fee for each use of its emergency ambulance. If a Medicare beneficiary uses the ambulance, Medicare pays a portion of the fee and the beneficiary is obligated to make a copayment. In each of these three municipalities, however, the village has elected to treat local tax revenues as payment-in-full for any copayments owed by insured residents, including residents who are Medicare beneficiaries.

The three municipalities operate under a mutual aid agreement that requires them to provide backup EMS transportation within each other's borders when vehicles and crews of the home village are unable to adequately respond to 911 calls. Under the proposed arrangement, when a village would provide backup EMS transportation to one of the other municipalities participating in the arrangement, it would adopt the billing practice of the village in which the transportation was provided. Thus, the village would bill the patient's insurer but waive the individual's otherwise applicable cost-sharing obligations.

Lack of intent. Although the arrangement could generate prohibited remuneration if the requisite intent to induce or reward referrals of federal health care program business were present, the totality of circumstances present a low risk of abuse, according to the OIG. Because the arrangement involves the waiver of cost-sharing obligations for backup EMS transportation, such waivers will occur only occasionally. Therefore, it does not increase the risk of overutilization and is unlikely to lead to increased costs to federal health care programs.

The existence of the arrangement has no effect on the number of Medicare beneficiaries requiring EMS transportation or on the treatment those beneficiaries receive. Because each village waives cost-sharing obligations when it provides EMS transportation to its own residents, most patients who receive backup EMS transportation would have no expectation that they would be required to make a copayment. ■

OIG Advisory Opinion, No. 09-03, April 23, 2009, Health Care Compliance Reporter, ¶500,207

Quality of Care

Recovery Act funds to be used for improving patient care

Improving the quality of patient care and reducing the number of health care-associated infections should be critical pieces of any effort to reform the American health care system, according to HHS Secretary Kathleen Sebelius. "The status quo is unsustainable and we cannot allow millions of Americans to continue to go without the care they need and deserve," Sebelius said during a speech before the United Nurses of America's 12th National Nurses Congress.

Highlighting two recent HHS reports that revealed poor performance in patient safety measures, Sebelius announced the availability of $50 million in grants funded by the American Recovery and Reinvestment Act of 2009 (ARRA) to help prevent health care-associated infections (HAIs) and enhance patient safety. Approximately $40 million will be available through competitive grants to eligible states to create or expand HAIs prevention efforts. An additional $10 million in grants will be available for states to improve and increase the frequency of inspections for ambulatory surgical centers.

HAIs are acquired by patients in the course of their stay at a health care facility. They are among the top 10 leading causes of death in the United States and result in an additional $20 billion in health care costs annually. "Health care-associated infections can make illnesses worse, further debilitate patients who are already struggling and sometimes lead to death," Sebelius said.

Troubling reports. Sebelius expressed alarms over two reports published by the Agency for Healthcare Research and Quality. The 2008 National Healthcare Quality

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On The Front Lines

Title VI of the Civil Rights Act of 1964: A Compliance Primer for Health Care Providers

by Bruce L. Adelson, Esq.

Title VI of the Civil Rights Act of 1964 requires that all health care providers receiving federal financial aid offer oral and written language assistance to limited English proficient (LEP) individuals. With the growth in the number of individuals in the United States who do not speak English will come an increased need for language services and greater awareness by LEP individuals of their rights. Providers will confront this reality in clinics, emergency rooms, and hospitals. The health care industry needs to come to grips with our multi-lingual populace by adopting necessary policies to obey the Title VI language requirements. As a result, health care providers must look to regulatory guidance to ensure that such individuals receive "meaningful access" to provider programs and activities.

An Introduction to Title VI

President Lyndon Johnson's enactment into law of the Civil Rights Act of 1964 represented the federal government's response to a series of tumultuous and tragic events spanning more than a decade - the landmark 1954 *Brown v. Board of Education* U.S. Supreme Court school integration decision, massive and bloody resistance throughout the South to the Court's mandate, and President John F. Kennedy's 1963 assassination.

Today, although the United States is much different than it was in 1964, this seminal civil rights law continues to have far reaching implications for the health care industry, particularly the Civil Rights Act's Title VI. This Title requires that all health care providers receiving virtually any kind of federal financial generosity offer oral and written language assistance to limited English proficient, or "LEP," individuals. The U.S. Census Bureau defines limited English proficiency as the ability to speak English "less than very well" or "not at all." The mandated language assistance includes using trained, proficient interpreters, the translation of "vital" documents into various languages, using bilingual staff for specific tasks, retaining a telephone interpretation service, instituting Title VI training for all personnel, and developing and implementing Title VI plans.

Title VI's language mandates are especially relevant today, as the non-English speaking population in the United States continues growing. A quick glance at census data reveals the size of America's non-English speaking population while also demonstrating the daunting challenge of providing the language assistance required by federal law.

In 2007, according to the U.S. Census Bureau, more than 54 million people living in the U.S., nearly 20 percent of the country's total population, spoke a language other than English at home while 24 million of these same people also spoke little or no English. The most widely spoken non-English language in the United States is Spanish, according to the Census Bureau. Of the country's non English speaking population, more than 16 million Spanish-speaking people have virtually no English-speaking ability.

The Law by the Numbers

By its own words, Title VI specifically prohibits discrimination based on race, color or national origin by federal financial assistance recipients. This part of the Civil Rights Act was intended to ensure "that the funds of the United States are not used to support racial discrimination."[1]

Section 601 of Title VI states that no person shall "on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance." This section prohibits intentional discrimination by recipients of federal financial assistance.

Section 602 directs federal agencies that give federal financial assistance "to effectuate the provisions of [Section 601]... by issuing rules, regulations, or orders of general applicability."[2] For example, U.S. Department of Justice (DOJ) regulations promulgated pursuant to Section 602 forbid federal aid recipients from discriminatory conduct that disproportionately impacts individuals because of their race, color, or national origin.[3] Section 602 also empowers federal agencies to terminate federal funding to a program, or otherwise sanction such a program, that is found to have violated Title VI.[4]

In 2000, President Clinton took Title VI a step further. He signed Executive Order 13166, which requires all federal agencies to adopt regulations and guidance for their financial assistance recipients regarding the provision of language services to LEP individuals. In 2002, the DOJ issued its LEP regulations – Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons ("DOJ's Guidance").[5]

Other federal agencies have modeled their regulations on the DOJ's and most issued their own regulatory guidance subsequently.

Title VI applies to all recipients of federal funds or assistance, such as states, counties, municipalities, their myriad agencies and departments, and health care providers. Title VI only applies during the time these organizations receive their federal assistance. After this time expires and the assistance ends, so does the prospective application of Title VI. Federal financial assistance for purposes of Title VI encompasses more than cash or direct grants. Such assistance includes:

- use or rent of federal land or property at below market rates,
- Medicare and Medicaid reimbursements,
- equipment,
- grants,
- economic stimulus money from the recently enacted American Recovery and Reinvestment Act of 2009,
- federal training, and
- loan of federal employees.

Consequences of Noncompliance

Under Title VI, private plaintiffs have standing to sue in federal court for money damages and an injunction prohibiting certain conduct by an organization that is found to have violated Title VI.[6] Federal agencies also may terminate funding upon finding a violation of this law.

Burden of proof. To win a Title VI case in court, plaintiffs must prove they are the victims of intentional discrimination. While such proof may at first blush appear difficult to show, federal law says otherwise. Sometimes, intent is very clear cut and plainly apparent. Racist statements by decision makers and actions that remove minority groups from the decision-making process are model examples of intentional discrimination. Such blatant statements and acts, however, are more unusual today than in the past. Today, public officials are often more conscious about what they say publicly and, for example, are likelier than in the 1960s to monitor their speech and behavior.

Intent to discriminate. Evidence of discriminatory intent may consist of an organization applying the same criteria differently for racial or language minorities.[7] Discriminatory intent also can be shown by a change in established procedures. Indeed, a deviation from customary policy is a well-accepted example of discriminatory intent.[8]

Discriminatory intent also can be inferred from an organization's failure to act. Doing nothing or not doing enough to provide non-English language assistance can be evidence of intentional discrimination against LEP individuals and, therefore, violate Title VI.

For example, in *Almendares v. Palmer*,[9] government agencies knew that many of their customers needed Spanish-language assistance. Indeed, in a prior related state court case, the director of one of the *Almendares* defendants testified that her department had a legal obligation to provide such assistance.

Plaintiffs alleged that defendants' continued failure to provide Spanish-language assistance to LEP individuals who needed such assistance to access the desired, federally subsidized government service (food stamps) was intentional discrimination on the basis of national origin or language.[10]

The *Almendares* court found that the plaintiffs' allegations about this continuing failure were sufficient to show intentional discrimination and defeat defendants' attempt to dismiss the case.[11]

The court also awarded plaintiffs $72,000 in attorneys' fees and ordered defendants to implement a comprehensive language assistance plan, the same plan they could have adopted themselves if they had not ignored plaintiffs' language assistance requirements. Defendants could have avoided significant time and expenses as well as unwanted attention from their federal funder, the U.S. Department of Health and Human Services (HHS), if they had complied with Title VI from the beginning.

Filing Complaints with the Federal Government

Individuals claiming that a federal aid recipient has violated Title VI also can file an administrative complaint with the federal agency that funded the recipient or with DOJ, the federal agency that by law interprets and enforces Title VI.[12]

DOJ has jurisdiction over any Title VI complaint, not just those complaints concerning the recipients of DOJ funding. For example, if a person has a Title VI complaint against a federally assisted health clinic, that complaint can be filed with DOJ, instead of the likely funding agency, the HHS. Like any complaint, DOJ can decide to investigate the allegations or not pursue them. DOJ also can refer the matter to HHS completely, or retain some measure of jurisdiction and monitor how HHS handles the complaint.

The federal government can choose to investigate the Title VI complaint and sanction recipients if the recipients are found to be in violation or the government can ignore the complaint. This decision is completely up to the agency. People who file such complaints with the government have virtually no recourse against the federal funder if that agency decides not to pursue these grievances.

For a federal agency to find that an administrative Title VI complaint concerns a federally funded activity and federally prohibited discrimination, the alleged discrimination must be

in a program or activity that receives federal assistance. Notably, if a health clinic receives federal funding for only one of its many departments and locations, the entire organization is covered by Title VI. The law's application cannot be confined to the small corner of the organization that receives the federal assistance.

DOJ's Four Factor Analysis - The Basics of Compliance

Faced with the Title VI mandate, what should health care providers do? The first place to look for answers is the regulatory framework behind Executive Order 13166.

The DOJ's Title VI Regulatory Guidance provides the benchmark for Title VI compliance by all federal agencies and their financial assistance recipients. The Guidance outlines a four-factor analysis that informs federal agencies and their financial assistance recipients how to ensure that LEP individuals have "meaningful access" to their programs and activities as required by federal law.

The four factors are the:

(1) number or proportion of LEP individuals eligible to be served or likely to be encountered by the grantee;
(2) frequency with which LEP individuals come into contact with the program;
(3) nature and importance of the program, activity or service provided by the program to people's lives; and
(4) resources available to the grantee/recipient and costs.[13]

Implementation plan. After completing the four-factor analysis assessment, federal assistance recipients "... should develop an implementation plan [an LEP plan] to address the identified needs of the LEP populations they serve."[14]

The development of an LEP plan is essential because the plan's existence and effective implementation can show compliance with Title VI, both to a court, in case of suit, and to the federal funder, in case of complaint against the recipient

An effective and legally compliant LEP plan should inform an organization's entire language services program. Once developed and implemented, such a plan will provide the framework for Title VI compliance and insulate the organization from liability. With an effective and legally compliant plan in operation, plus effective Title VI training for all personnel, it would be difficult for a private plaintiff to prove intentional discrimination in court. Rhetorically speaking, how can an organization be guilty of intentional discrimination if it is abiding by a legally compliant plan to provide language assistance? Simply put, the answer is likely to be that such an organization cannot be guilty of intentional discrimination.

"Meaningful access." Federal agencies and recipients use the four-factor analysis to determine how to comply with Title VI. As the analysis suggests, federal agencies treat each recipient, and its federally assisted program, differently. The extent that a recipient must provide "meaningful access" to its programs for LEP individuals will depend upon the "nature and importance" of the services provided. For example, federal regulations regard the provision of health care services as important and essential to the community. Thus, health care providers have a high legal threshold to reach concerning Title VI compliance and ensuring "meaningful access" to their services by the LEP population.

Providing Language Assistance

Title VI requires all recipients of federal aid to provide LEP individuals with "meaningful access" to their federally subsidized services by using, for example, competent, trained, proficient interpreters for communications between LEP patients and medical professionals and "vital documents" accurately translated into the relevant languages. Failure to do so would likely violate federal law.

"Vital" documents. By law, each federal aid recipient should decide which of its documents are "vital." For example, the law considers an informed consent form used by a hospital to be "vital." Therefore, it must be translated into other languages. The languages this document and others should be translated into will vary depending upon the community served by the provider, the languages spoken in the community, and the size of each non-English speaking population.

Examples of vital documents needing translation:

- consent forms,
- complaint forms,
- explanations of language assistance rights,
- Medicare and Medicaid benefit information,
- eligibility criteria, and
- patient discharge instructions.

Examples of non vital documents not needing translation:

- hospital menus,
- written materials provided by outside groups, and
- benefit handbooks.

Waiver of rights. Each LEP individual has the federal right to language assistance. An individual, however, may choose to use a friend or relative to interpret for him or her instead of the interpreter offered by the provider. In this case, the LEP individual can use his or her own interpreter ONLY after the provider has one of its trained interpreters explain Title VI and the federal right to language assistance in the patient's own language.

Then, the provider should ask the patient to sign a waiver of rights. This waiver should indicate that the patient understands his or her right to language assistance, as explained by the provider, but voluntarily chooses to use his or her own interpreter. This waiver form would be considered a "vital" document by law and should be translated into the patient's language. The waiver should also be orally explained to the patient by the provider's trained interpreter

Telephone services. The provider should have a telephone language line and in-person interpreters available for language assistance. A telephone language service is most helpful in situations in which the patient speaks a rare language that is not spoken by anyone on the provider's staff. While telephone services are helpful, however, providers should not rely on them to provide all kinds of language assistance in all cases. The DOJ recommends that using an in-person interpreter remains preferable in most situations. Providers are required by law to determine the types of services and personnel they need to offer legally required language assistance. Such determinations should be in the provider's Title VI/LEP plan.

Children and third-party interpreters. Providers should not ask minor children to act as interpreters. It is thought that minors are not capable of providing accurate language assistance, especially if their parents or relatives are patients. Federal law

permits providers to use children as interpreters in emergency situations, such as when a parent or guardian is unconscious and the child is the only person available to give needed information to medical professionals. Federal law states that other third persons, such as friends or relatives, also should not be asked to act as interpreters. The only exceptions would be in emergencies and if the LEP patient voluntarily and knowingly chooses to use a particular person instead of the provider's interpreter.

Bilingual staff. Providers can use bilingual staff to offer certain information to LEP patients in non English languages. Interpreters and bilingual staff both fulfill important Title VI functions *but they are not interchangeable*. While bilingual staff should not provide interpretation between doctor and patient, they can fulfill other key roles as part of a federally subsidized entity's Title VI compliance. For example, they can staff a facility's information desk and provide important information to LEP people about how to access various services.

An employee who is not fluent in a given language, who is unfamiliar with medical terminology, and not trained as an interpreter should not interpret a doctor's instructions for an LEP patient. Using untrained and unqualified people to provide language assistance could be illegal by not giving LEP individuals the "meaningful access" that the law mandates and also could raise standard of care an malpractice concerns.

Conclusion

The number of individuals in the United States who do not speak English continues to grow. The release of the 2010 Census should confirm the past decade's population trend while also continuing to illustrate the enormous challenges of providing language assistance by those organizations accepting federal funds. With this growth will come an increased need for language services as well as greater awareness by LEP individuals of their rights.

The prominence of non English languages in American life will likely remain and increase for the indefinite future. Health care providers will continue to confront this reality on a daily basis, in clinics, emergency rooms, and hospitals across the country. The health care industry's need to come to grips with our multi-lingual populace by adopting necessary policies to obey the language requirements of Title VI of the Civil Rights Act of 1964 is preventive medicine that will leave everyone healthy.

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1 Comments of Sen. Hubert H. Humphrey, 110 Congressional Record 6544.
2 42 U.S.C. §2000d-1.
3 28 C.F.R. §42.104(b)(2).
4 42 U.S.C. §2000d-1.
5 Department of Justice policy guidance document, 67 FR 41455, June 18, 2002.
6 *Cannon v. University of Chicago*, 441 U.S. 677 (1979).
7 *U.S. v. Yonkers Board of Education*, 837 F.2d 1181 (2nd Cir., 1987), cert. denied 510 U.S. 1055 (1994).
8 *Arlington Heights v. Metropolitan Housing Development Co.*, 429 U.S. 252, 267 (1977).
9 *Almendares v. Palmer*, 284 F.Supp. 799 (W.D. Ohio, 2003).
10 *Id.* at 807.
11 *Id.* at 808.
12 For an example of one agency's Title VI complaint procedures, access this link, http://www.usdoj.gov/ert/cor/complaint.htm, for the U.S. Department of Justice's Coordination and Review Section, the lead DOJ entity charges with Title VI enforcement.
13 Policy guidance document, *supra* n. 5 at 41459.
14 *Id.* at 41464.

Quality of Care (cont.)

Report (NHQR) found that health care quality is suboptimal and continues to improve at a slow pace. Receipt of needed health care varies widely, according to the report. While patients hospitalized with a heart attack receive 95 percent of recommended services, only 15 percent of patients on dialysis are registered on a kidney transplant waiting list. Across the core report measures tracked in the NHQR, the median level of receipt of needed care was 59 percent.

Other troubling statistics included the finding that only 40 percent of diabetic patients received the recommended preventative exams in the past year, a rate that has not shown improvement over time. The report found that seven out of 10 adults with mood, anxiety, or impulse disorders received inadequate treatment or no treatment at all.

The NHQR also concluded that patient safety is lagging and that quality measures need improvement. The report recommends improved training for health care providers, increased use of health information technology and electronic medical records, and broader dissemination of information on quality of care.

The 2008 National Healthcare Disparities Report (NHDR) found that large disparities exist in the quality of patient care received among Americans. Access to care, provider biases, poor provider-patient communication, poor health literacy, and other factors contribute to such disparities, according to the report. Minority patients receive disproportionately poor care compared to white patients. At least 60 percent of quality measures have not improved for minorities compared to white patients over the past six years.

The full NHQR can be found at http://www.ahrq.gov/qual/qrdr. The full NHDR can be found at http://www.ahrq.gov/qual/nhdr08/nhdr08.pdf. ■

HHS Press Release, May 6, 2009

Trends

Technology contributes to successes in compliance field, HCCA CEO reports

At a time when the nation's recession is forcing cutbacks in most industries, health care compliance remains a growing field, according to Roy Snell, chief executive officer of the Health Care Compliance Association (HCCA). Addressing HCCA's annual Compliance Institute April 26-29, Snell said that there have been bright spots, in spite of the overall economic climate.

"Despite the economy, this has been the most exciting year since I've been involved," Snell said at the conference's opening session. In particular, Snell said the increased use of technology has made it easier for compliance professionals to network and share ideas. It is not uncommon, he said, for a piece of compliance-related news to spread from a list serve to a blog to a social networking web site.

"The days of simply meeting people through an annual meeting and a newsletter are gone," he added.

HCCA successes. While other professional associations reported losing revenue in 2008, HCCA reported a small net gain. Snell credits the association's success with a practical, rather than academic, approach that emphasizes serving the needs of its members.

"We don't overly concern ourselves with committees and white papers and sitting around thinking," he said. "We want to be out there doing."

Discretionary spending cuts. To better withstand the economic downturn, Snell said HCCA has attempted to make small cuts here and there — reducing expenditures on luxury or discretionary items — rather than deep, across-the-board cuts.

The result, Snell explained, is a quicker and leaner organization, better able to buoy itself during economic turbulence. ■

CCH Chicago Bureau, May 7, 2009

In the News

New York's fraud control unit named nation's best

New York's Medicaid fraud control unit has been recognized as the best in the country by the Office of Inspector General, (OIG). The unit, which operates under the leadership of New York Attorney General Andrew Cuomo, "clearly demonstrated its outstanding ability to effectively and efficiently detect, investigate, and prosecute Medicaid provider fraud and patient abuse and neglect," according to OIG. In 2008, the office won nearly 150 convictions in cases involving Medicaid provider fraud and patient abuse and recovered more than $263 million. Under the federal legislation that created the Medicaid fraud control unit program in 1978, the federal government funds 75 percent of Medicaid fraud control units' budgets and states fund 25 percent. The OIG administers the federal grant funds and oversees the nation's 50 Medicaid fraud control units.

New York Attorney General's Office News Release, May 6, 2009

WellCare pays $80 million to settle fraud charges

WellCare Health Plans Inc., Florida's largest Medicaid managed care provider, will pay $80 million to settle a Medicaid fraud investigation under an agreement with the U.S. Attorney's Office. The company has been accused of defrauding the state's Medicaid program and the Florida Healthy Kids Corporation of about $40 million. Under the agreement, WellCare will be able to avoid prosecution if, in addition to paying civil forfeiture of $40 million and restitution of $40 million, it retains an independent monitor, selected by the U.S. Attorney's Office, to review its business operations and report on its compliance with federal and state law. The government's investigation of WellCare is ongoing. The company must cooperate with the probe and implement internal controls to prevent future fraud and abuse.

U.S. Attorney's Office News Release, May 5, 2009

Medical students prefer surgery and specialization

Medical students prefer surgical and procedural specialties, and physician subspecialization is increasing, according to a Government Accountability Office (GAO) report. As a result, surgical and procedural specialties have been more competitive than primary care specialties. The percentage of physicians pursuing subspecialty training grew from 2002 to 2007. While there is no consensus on the most influential factors affecting specialty choice, students consider various factors, including their intellectual interest, their exposure to the specialty, the prestige of the specialty, the desire for a controllable life style — a predictable schedule and fewer on-call hours, and higher salary. Married students are more likely to select primary care specialties and women are more likely to select obstetrics and gynecology and less likely to choose surgery. The median amount of educational debt for indebted medical students graduating in 2008 was $155,000 — a 53 percent increase since 1998.

GAO Report, GAO-09-438R, May 4, 2009