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Tax-exempt organizations wary of IRS governance concerns

Member groups of the Internal Revenue Service's (IRS's) Advisory Committee on Tax Exempt and Government Entities (ACT) met in open session on June 11, 2008, and made recommendations that would affect the administration of exempt organizations, as well as other topics that fall under the Tax Exempt and Government Entities Division's regulatory umbrella.

Addressing what may have been the most controversial topic at the meeting, the ACT Exempt Organizations group recommended that the IRS proceed cautiously on the issue of corporate governance by Internal Revenue Code §501(c)(3) charities. Bonnie Brier, General Counsel of The Children's Hospital of Philadelphia and co-project leader for ACT's Exempt Organizations group, commented that good governance was more a factor of the organization's individual leadership, not its governance policies. She also said it was unclear whether prescribing specific requirements results in greater tax compliance, noting that studies of for-profit organizations were inconclusive.

IRS involvement. While it was clear that the IRS would be involved in best practices for exempt organizations, Brier said that the agency must strike a balance between forging requirements and supporting a unique, diverse, vibrant, and flexible charitable sector. Brier recommended that the IRS support the actions of an organization's board of directors and provide a framework for action in the governance area.

Steve Miller, Commissioner of the Tax Exempt and Government Entities Division, said it was not the IRS's intent to mandate governance standards, and it certainly was not its intent to crush vibrancy or innovation in the tax-exempt sector. The IRS's goal is to provoke discussion by the sector and boards of directors. "The ball is in the sector's court," Miller stated.

Form 990. Discussing the revised Exempt Organizations Form 990 annual return, Brier said that the questions on governance are "attenuated" to the tax law, but on balance the form's questions are neutral and appropriate. She pointed out that Part VI of the Form says that a particular response to governance questions is "not required." Other Form 990 questions, however, lack this disclaimer, she noted. The IRS's merely asking about governance creates pressure on the organization, has the potential to usurp the governing board's own ideas, and may discourage board membership. This can lead to bad policies and divert the exempt organization from good governance practices to mere form or process.

Lois Lerner, Director of the IRS's Exempt Organizations Division, responded that she has an open mind on what the IRS will do. A starting point will be the information collected from the new Form 990, she indicated. Lerner said that in scrutinizing an organization, the IRS would only look at good governance in conjunction with other information about the organization's activities, and would not focus on governance alone. ■

CCH Washington Bureau, June 11, 2008.

Trends

Medicare providers had significant tax debt in CY 2006

Over 27,000 health care providers that received Medicare payments during calendar year (CY) 2006 had payroll and other federal tax debts totaling over $2 billion, according to the Government Accountability Office (GAO). The GAO's analysis of data provided by CMS and the Internal Revenue Service (IRS) revealed abusive and potentially criminal activity.

Abusive activity. The GAO selected 25 Medicare providers with significant tax debt for more in-depth investigation and found that: (1) some providers diverted payroll taxes withheld from employees for other purposes; (2) individuals associated with some of these providers used payroll taxes withheld from employees for personal gain, while failing to pay their federal taxes; and (3) some providers received Medicare payments despite having quality of care issues.

Examples of abuse and potentially criminal activity discovered during the GAO's investigation included:

- a hospital that received $21 million in Medicare payments, had $15 million in unpaid federal tax debt, and its owner was found liable for submitting false claims to Medicare from another medical business; and
- a nursing home that received $15 million in Medicare payments, had $7 million in unpaid federal tax debt, and its owner had purchased luxury cars and other personal items with money funneled through a charitable foundation.

GAO recommendations. The IRS can continuously levy up to 15 percent of each Medicare payment made to a provider until the provider's tax debt is paid. CMS, however, has not incorporated most of its Medicare payments into the continuous levy program. As a result, the GAO reported, for CY 2006, the government lost opportunities to potentially collect over $140 million in unpaid taxes.

The GAO recommended that CMS (1) consider issuing guidance to require Medicare contractors to screen prospective Medicare providers for unpaid taxes and (2) incorporate all Medicare payments into the continuous levy program. ■

GAO Report, No. GAO-08-618, June 13, 2008.

Health Information Technology

House committee approves bill promoting HIT use

A bill entitled "Protecting Records, Optimizing Treatment, and Easing Communication through Healthcare Technology Act of 2008" that promotes the nationwide adoption of a health information technology (HIT) infrastructure has been approved in a voice vote by the House Committee on Energy and Commerce.

Provisions of the bill include: (1) incentives for the widespread adoption and use of electronic health records through the creation of three separate competitive grant programs; (2) creation of a demonstration program to integrate HIT into the clinical education of health care professionals, providing $10 million from 2009 through 2011 to fund the project; and (3) additional privacy and security provisions related to protected health information. In addition, the bill promotes the use of electronic health records for each person in the United States by 2014. The bill was introduced by Committee Chairman John Dingell (D-Mich.) and Reps. Joe Barton (R-Texas), Frank Pallone, Jr. (D-N.J.), and Nathan Deal (R-Ga.).

Earlier in June, the American Medical Association (AMA) testified before the subcommittee on ways to move the nation toward an interoperable HIT system. The AMA offered two solutions to help shape legislation that addresses the technology and privacy concerns surrounding adoption of HIT: (1) strengthen the Health Insurance Portability and Accountability Act Privacy Rule by holding all parties that have access to patient health information directly accountable for compliance with privacy standards; and (2) increase physician representation and involvement in the advisory committee process that will develop technical standards, specifications for connectivity, implementation and operability, and criteria for certification. ■

Statement of Congressman John D. Dingell, Chairman, Committee on Energy and Commerce, June 25, 2008; AMA Press Release, June 4, 2008.

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OIG expects $2.2 billion in recoveries in first half of FY 2008

The HHS Office of Inspector General (OIG) Semi-Annual Report to Congress announced expected recoveries of $2.2 billion for the first half of fiscal year (FY) 2008 as a result of efforts to combat fraud, waste, and abuse in Medicare and other HHS programs. Approximately half of that amount represented audit-related recoveries; the other half consisted of investigation-related recoveries.

Enforcement activities. Also during the reporting period, from October 1, 2007, through March 31, 2008, the OIG reported:

(1) exclusions of 1,291 individuals and entities for fraud and abuse involving federal health care programs;

(2) 293 criminal prosecutions for crimes against HHS programs; and

(3) 142 civil actions, including False Claims Act cases, unjust enrichment suits, civil money penalties law settlements, and administrative recoveries related to provider self disclosure matters.

Areas of focus, accomplishment. Areas of recent focus for the OIG have included: oversight of Medicare Part D; public health emergency preparedness and response; oversight of food, drug and medical device safety; integrity of information technology and systems; and ethics program oversight and enforcement.

Among the OIG's most notable accomplishments for the first half of FY 2008 were:

- analysis of Medicare Part D preliminary reconciliation data to estimate that Part D sponsors owed Medicare a net total of $4.4 billion for program year 2006;
- review of Medicare Part D plans' tracking of true out-of-pocket costs for the prescription drug benefit, resulting in a finding that in 2006, 29 percent of Part D plans did not submit their enrollees' additional prescription drug coverage information to coordination of benefits contractors, as required;
- resolution of illegal drug marketing and pricing allegations against Bristol-Myers Squibb Co. for more than $499 million;
- review of financial conflicts of interest reported by grantee institutions to the National Institutes of Health (NIH) resulting in a finding that the NIH needs to improve its oversight of such conflicts;
- a settlement of $310 million for claims against several artificial joint manufacturers alleging violations of the anti-kickback statute and False Claims Act;
- review of Medicare Part D payments to local community pharmacies, resulting in a finding that in September 2006, pharmacies acquired drugs for less than the reimbursement amounts 97 percent of the time;
- a sentence including over 10 years imprisonment, $1.3 million in restitution, and a $175,000 fine for a dermatologist convicted of upcoding surgical procedures;
- resolution of a California laboratory's liability for an alleged violation of the transfer requirements of the select agent regulations;
- pilot review of Temporary Assistance for Needy Families basic assistance payments during a six-month period in 2005, resulting in a finding that three states collectively claimed an estimated $95 million in improper payments; and
- a finding that Medicare Part B made a total of $106.9 million in potential overpayments to suppliers of outpatient services on behalf of beneficiaries in Part A-covered skilled nursing facilities during calendar years 2001 and 2002.

According to HHS Inspector General Daniel R. Levinson, "[The] OIG's accomplishments reflect a robust oversight agenda implemented through audits, evaluations, and compliance and enforcement activities." He added, "It is through a combination of vigilant oversight, outreach to the health care community, and partnership with government agencies at all levels that we are able to fulfill our mission to protect the integrity of HHS programs and beneficiaries." ■

OIG Semi-Annual Report, June 12, 2008, Health Care Compliance Reporter, ¶540,051.

On The Front Lines

What providers must know when appealing RAC audit findings*

by Paul W. Kim, J.D., MPH, Contributing Editor

Section 306 of the Medicare Modernization Act of 2003 (MMA) instructed CMS to identify both Medicare overpayments and underpayments through the use of new agents called recovery audit contractors (RACs). Launched in March of 2005, the three-year RAC pilot project focused only on California, Florida, New York, Massachusetts, and South Carolina health care providers and suppliers. Because of the enormous success experienced by the RACs in these states, §302 of the Tax Relief and Health Care Act of 2006 directed CMS to expand the RAC audits into all states by 2010. CMS is implementing the RAC program nationwide beginning this summer.

Despite complaints and concerns raised by the medical community in the states affected by the RAC reviews through the conclusion of the demonstration in March of 2008, CMS remains very supportive of the results of the RAC audits. According to CMS, the RACs overall have identified almost $440 million in overpayments. What CMS does not state, because CMS does not know yet, is how much of the $440 million will withstand administrative and judicial review. RACs have been overly aggressive in identifying overpayments largely because, as mandated by Congress, the RACs are paid on a contingency-fee basis. This means that the RACs will receive their compensation for each overpayment amount identified and upheld at the first level of the appeal process. In other words, the RACs will keep their fees even if their decisions are overturned at subsequent levels of the appeal process.

Appeal Process after a RAC Finding

The Medicare claims appeal process, as revised in March of 2005, requires providers and suppliers to pursue a four-step administrative review process prior to appealing to a federal court. Specifically, the first level of appeal is called a Redetermination, which is requested from the local contractor (*e.g.*, carrier, fiscal intermediary, or Medicare Administrative Contractor) and is due within 120 days from the date that the initial denial notice is received. The local contractor is required to render a decision within 60 days. The next level of appeal is called a Reconsideration, which is requested from a qualified independent contractor (QIC) and is due within 180 days from the date the Redetermination is received. The QIC must issue a decision within 60 days.

If the decision from the QIC is unfavorable, then a request for a hearing before an administrative law judge (ALJ) of the Office of Medicare Hearings and Appeals (OMHA) can be made within 60 days from the date the Reconsideration is received. The ALJ will not consider any new evidence unless good cause is demonstrated. The ALJ must issue a decision within 90 days. If the ALJ's decision is unfavorable, then an appeal can be filed with the Medicare Appeals Council (MAC) of the Departmental Appeals Board (DAB) within 60 days from the date the ALJ's decision is received. The MAC generally has 90 days to render a decision. Finally, an unfavorable MAC decision can be appealed to a federal court within 60 days from the date that the unfavorable MAC decision is received.

In particular, five points should be noted about the RAC appeals:

- First, although a provider or supplier may request that the RAC re-review its decision before filing the first-level appeal (the Request for Redetermination), such re-reviews by the RACs have not been very fruitful.
- Second, the local contractors surprisingly and consistently have agreed with the decisions of the RACs to essentially revise their prior initial determinations.
- Third, the second-level appeal (the Request for Reconsideration) is especially significant because, at this stage, the Medicare claims appeal regulations require a full and early presentation of all of the evidence that the provider or supplier plans to utilize for the remainder of the appeal process. Therefore, providers and suppliers must ensure that a complete record is filed with the QIC, including any new evidence that was not submitted or available at the lower appeal levels.

- Fourth, the ALJ hearing may be held live in one of the four field offices of OMHA (Arlington, Virginia; Cleveland, Ohio; Irvine, California; and Miami, Florida), by videoteleconference (VTC), or via telephone.
- Fifth, because of the backlog of appeals, some ALJs may request a waiver of the 90-day decision requirement. Not surprisingly, it can be quite difficult for OMHA to coordinate all of the participants in scheduling the hearing, hold the hearing, and then render a decision, all within 90 days from the date the appeal is received by OMHA.

ALJ Reviews of RAC Appeals

The earliest of the RAC audits recently reached the ALJ level of the appeal process and, despite the lack of success at the lower appeal levels, providers and suppliers have begun to see some relief from the ALJs. In addition, the RACs no longer will participate in ALJ hearings. It remains to be seen if CMS will continue to limit the RAC's participation. Furthermore, many of the RAC appeals that have reached the ALJ hearing level have been reversed based on the RAC's failure to demonstrate good cause to reopen claims that have been paid more than one-year ago. Some ALJs rule favorably on the record based on this issue without even scheduling a hearing. Some ALJs schedule a preliminary hearing to solely address this issue.

In a decision dated February 29, 2008, the MAC ruled that the ALJ erred by requiring the local carrier to demonstrate good cause for reopening old claims pursuant to a post-payment probe audit (*In re: Critical Care of North Jacksonville*, http://www.hhs.gov/dab/macdecision/Reopening022908.pdf). This case raises three interesting questions:

- First, will the MAC, on its own motion as it did in this case, open and review some of the favorable ALJ decisions that were based on the RAC's lack of good cause to reopen old claims?
- Second, how will the MAC rule when some of the RAC cases finally reach the MAC appeal level?
- Third, how will the ALJs rule now, given this new and recent MAC decision?

Despite this daunting decision from the MAC, there are several ways to address and counter arguments questioning the ALJ's authority or jurisdiction to consider evidence regarding good cause. What remains clear is that other MAC decisions have reached different conclusions with respect to the issue of reopening old claims, some of which directly contradict the Critical Care decision. Also, the RACs have begun to articulate different and lengthier reasons for reopening old claims. Hence, providers and suppliers should continue to raise the issue of good cause to the local contractors, the QICs and the ALJs, even though the ALJ hearing most likely will be the first forum at which this argument will be addressed.

Recently, some of the ALJs have begun to retain the services of independent experts to assist in determining whether or not the service denied by a RAC was reasonable and necessary. Fortunately, these expert witnesses generally have been favorable to the providers and suppliers to date. Thus, in addition to successful preliminary legal challenges, the use by the ALJs of their own experts may offer further relief through the appeal process.

Despite the availability of some relief pursuant to the appeal process, providers and suppliers should be proactive and attempt to prevent claims from being subject to the RACs through careful medical documentation and correct coding practices.

RAC Statement of Work

It should be helpful that CMS has promulgated an amended Statement of Work (SOW) in November 2007, which will define what RACs are expected to do under their contracts with CMS. More importantly, the amended SOW imposes some specific limitations and restrictions on RACs that should help reign in these auditors this summer.

RAC responsibilities

CMS has announced that the country will be divided into four regions and that there will be one RAC per region. Each RAC will be required to submit a project plan to CMS in which it identifies the issues the RAC will be focusing on that year. As new issues are identified, the RAC must update the project plan to describe the vulnerability issue to CMS. Conference calls between the RAC's key project staff and CMS must occur twice per month, indicating close CMS oversight of RACs. As part of these monthly meetings, each RAC must submit both administrative and financial progress reports to CMS. In its administrative reports, RACs will be expected to identify problems experienced and recommend corrective actions to CMS, such as changes to local coverage determinations, system edits, or provider education. Financial progress reports will keep CMS apprised of the amount of improper payments identified on a continuing basis and track the timeliness of medical reviews.

Review limited to Medicare fee-for-service program

Under the new SOW, RACs may attempt to identify improper payments that result from:

(1) incorrect payment amounts;
(2) noncovered services, such as a lack of medical necessity;
(3) incorrectly coded services; or
(4) duplicate services.

RACs, however, may not attempt to identify improper payments arising from services provided under any program other than a Medicare fee-for-service program. For example, RACs may not investigate a Medicare managed care program or a Medicare drug card program or drug benefit program. RACs also are prohibited from looking into the cost report settlement process and, therefore, may not attempt to identify improper payments that result from indirect medical education or graduate medical education payments.

Review of older claims

CMS also has limited the ability of RACs to review older claims. Under the amended SOW, RACs may not attempt to identify improper payments relating to any claims paid more than three years before the date the RAC issues its written request for medical records. Significantly, this three-year look back period is further curtailed in that all claims with paid dates prior to October 1, 2007, will be considered time-barred. So, for example, a request for medical records made by a RAC in December 2008 will only be permitted to request records for claims paid between October 1, 2007, and December 31, 2008.

Limitation on number of medical records

In addition to limiting the time period during which a RAC may investigate claims, CMS also will place restrictions on the number of medical records a RAC may request. They will vary depending on the provider involved and the time period covered by the request. As an example of what the limits will look like, the SOW states that a RAC would be prohibited from requesting more than 50 medical records from a 150-249 bed hospital within the same 45-day period.

Obtaining medical records

RACs may obtain medical records either by going onsite to a provider's location or by requesting the provider to copy and transmit the records. If a RAC representative shows up onsite, however, the provider should not permit that individual to have access to medical records. There are several reasons to defend the perimeter from a RAC audit in this manner.

First, the new SOW expressly states that: "If the RAC attempts an onsite visit and the provider refuses to allow access to the facility, the RAC may not make an overpayment determination based upon the lack of access." Instead, the RAC will be required to request specific records in a letter. This will permit the provider to have a record for purposes of barring older claims under the three-year look back provision, keep a record of what claims have been reviewed by the RAC, and may be the only way to make sure the RAC limits its review to the quantity of records directed by CMS.

Second, RACs are required under the new SOW to pay most providers for copying medical records. Allowing them to access medical records onsite may not permit the provider to capture these charges.

Finally, requiring RACs to request medical records without seeing them first ensures the records requested are not "hand picked" for review. RACs generally have 60 days from receipt of medical records to complete their reviews. Extensions of time will require the RAC to obtain a waiver from CMS.

Conclusion

Unfortunately, until Congress or CMS reacts to the outrage of the medical community, providers and suppliers need to brace themselves for allocating and expending sufficient resources to address these RAC audits. Specifically, providers and suppliers should identify and task at least one individual to centrally coordinate and track the record request from the RAC. Likewise, the appeal process should be diligently documented so that untimely Redetermination and Reconsideration decisions may be followed up. Given the volume of claims appeals, including those not stemming from RAC audits, some correspondences from the Medicare contractor and QIC inevitably may become lost or misdirected, forcing the provider or supplier to demonstrate good cause to pursue an unfavorable decision to the next appeal level. Finally, providers should take advantage of the right to submit all evidence, including new information, to the QIC. A consultant's analysis and report of the medical records (if not the beneficiary), albeit recent, may be just what is needed to help establish medical necessity.

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Report analyzes prevalence, causes, effects of physician self-referral

Recent growth in the number of physician self-referrals, physician-owned specialty hospitals and ambulatory surgical centers (ASCs), and imaging services performed in physician offices and independent diagnostic testing facilities (IDTFs) has resulted in higher utilization of services, increased costs, and treatment of more profitable patients in specialty hospitals and ASCs than in general hospitals, according to a report released by the Robert Wood Johnson Foundation on June 24, 2008.

The report addresses: (1) the prevalence and growth of self-referral to physician-owned specialty facilities; (2) factors leading to physician self-referral and the creation of physician-owned specialty facilities; and (3) the effects of physician self-referral and physician-owned specialty facilities on the quality, cost, access and organization of health care.

Prevalence. According to the report, the number of specialty hospitals owned partly or wholly by physicians more than doubled between 2002 and 2007, and growth is expected to continue. The prevalence of physician-owned specialty hospitals may be attributed to several factors: (1) they are relatively inexpensive to create; (2) they receive higher per case payments than ASCs for the same types of cases; and (3) they are permitted by Medicare, to a greater extent than ASCs, to bill for imaging services in addition to the per case payment. Generally, the report found, the greater a physician's ownership interest in a specialty hospital, the more likely he or she is to refer patients to the specialty hospital than the general hospital.

Medicare costs for imaging services more than doubled between 1999 and 2004 and have continued to increase rapidly since 2004, the report stated. Physician self-referral for imaging services within a physician's own office or medical group practice is permitted by the Stark regulations. Self-referral to IDTFs with which a physicians has a financial relationship, however, is prohibited by the Stark regulations and the anti-kickback statute. Nevertheless, according to the report, physicians are using lease, time-share, and "per-click" (payment of a leasing fee each time a physician uses equipment) arrangements with IDTFs to profit by referring patients to these facilities while trying to remain compliant with these laws.

Surgeries are increasingly being performed in ASCs and physician offices rather than hospital outpatient departments. According to the report, between 1999 and 2005, the volume of services performed in ASCs grew at seven times the rate of services performed in hospital outpatient departments.

Causes. The report cited several factors contributing to the growth in physician self-referral and the creation of physician-owned specialty facilities, including:

- the opportunity to be paid a professional fee and a facility fee;
- fee-for-service payment and the opportunity to increase the volume of services provided;
- the ability to profit from services that use little of the physician's time;
- cost containment policies and efficieny;
- higher reimbursement for certain services;
- payment policies that make some patients more profitable than others;
- elective procedures not covered by health insurance; and
- anti-self-referral legislation.

Effects. The report summariz.ed data on the effects of specialty hospital, imaging, and ASC and office-based surgery self-referral and found that it impacted four areas: (1) access and patient selection; (2) quality; (3) cost; and (4) organization of health care.

Access and patient selection. Patients in physician-owned specialty hospitals on average were healthier than patients in general hospitals. Physician-owned facilities, however, had few Medicaid patients, more higher-income patients, and fewer minority patients. Patients treated in ASCs were healthier than those treated in hospital outpatient departments. Like physician-owned specialty hospitals, ASCs treated a lower percentage of Medicaid patients than hospital outpatient departments. Patients' cost-sharing amounts were lower in ASCs than hospital outpatient departments for most procedures.

Quality. Quality concerns with physician-owned specialty hospitals included higher readmission rates compared to general hospitals and a smaller likelihood of having an emergency department or a physician in the hospital at all times. Physician-owned facilities had similar transfer rates and slightly lower risk-adjusted mortality rates than general hospitals. Data indicated that the quality of imaging services in IDTFs and physician offices varies greatly and is poor in some cases. Increased use of CT scanning is of concern because two percent of all cancers in the U.S. are estimated to be caused by CT scanning. Quality data for ASCs and office-based surgery show that mortality and serious complication rates are similar and very low in ASCs and hospital outpatient departments, but higher for office-based surgery.

Cost. Cost data for physician-owned specialty hospitals showed shorter length of stay for cardiac hospitals; similar cost per case for cardiac hospitals; higher cost per case for orthopedic and surgical hospitals; higher rates of cardiac and spinal surgery in markets with specialty hospitals; and self-referral rates that increased with ownership share. Rates of diagnostic imaging, especially advanced imaging, are increasing rapidly, and the rate of increase is much higher for physicians who self-refer than for radiologists. With respect to ASC and office-based surgery, per case costs to the facility were lower for ASCs than for hospital outpatient departments, and probably lower for physician offices than for ASCs.

Organization of health care. According to the report, physician-owned specialty hospital self-referral has no demonstrable effect on general hospitals' profits or operations, but general hospitals lose profitable admissions to specialty hospitals. Imaging self-referral has impacted the organization of health care insofar as some physicians are creating large single-specialty groups in part to enable them to purchase advanced imaging equipment. ASCs adversely affect hospitals' outpatient volume, but there are no studies addressing the effect of ASCs on general hospital profit margins. ■

Robert Wood Johnson Foundation Report, Research Synthesis Report No. 15, "Physician self-referral and physician-owned facilities," June 2008.

Medicare

Hospice conditions of participation finalized

Effective December 2, 2008, hospices participating in the Medicare and Medicaid programs must meet new requirements for infection control, quality assessment and performance improvement programs, and qualifications of hospice aides, homemakers, social workers and therapists, according to a CMS Final rule.

The deadlines and requirements for initial and comprehensive patient assessments have changed. A registered nurse must complete the initial assessment within 48 hours of the patient's election of hospice care and develop a plan of care that addresses the immediate needs of patient and family. The initial assessment must address the patient's functional status, the ability of the patient and family to participate in care, the severity of symptoms, the imminence of death, and the needs for counseling. The comprehensive assessment must be completed within five calendar days of the patient's election of hospice services.

Hospices must conduct criminal background checks on all workers who have direct contact with patients or access to patient records. The check must include every state in which the worker has lived or worked for the preceding three years.

Patient records must include all versions of the assessments and plans of care, physician orders, clinical notes, advance directives, physician's certification and recertification of terminal illness, the patient's election of hospice care, data related to goals and outcome measures, responses to medication, and discharge summary. In addition, the receipt of the notice of patient rights must be documented with the patient's signature.

All patient information must be protected from loss or unauthorized use, and all providers must comply with Health Insurance Portability and Accountability Act regulations. Hospices must retain patient records for six years after the death or discharge of the patient unless state law requires a longer period.■

Final rule, 73 FR 32087, June 5, 2008, Health Care Compliance Letter ¶700,069.

In the News

Senate leaves physician pay cuts in place for now

After the House overwhelmingly approved legislation to block a 10.6 percent physician pay cut scheduled to take effect on July 1, 2008, the Senate narrowly rejected it. The Medicare Improvements for Patients and Providers Act of 2008 (HR 6331) would have "avert[ed] an unfair cut in the reimbursement rate for doctors who treat Medicare beneficiaries," Senate Finance Committee ranking member Charles Grassley (R-Iowa) said. The 355-to-59 vote in the House was veto-proof, but the Senate fell one vote shy of the 60 needed to pass the bill under expedited rules. The final vote was 58-to-40 after Senate Majority Leader Harry Reid (D-Nev.) changed his vote so that he could bring up the bill again after the Senate returns on July 7 from a one-week recess during which the cuts are scheduled to take place.

CCH Washington Bureau, June 27, 2008.

Quality ratings added to nursing home Web site

CMS has announced plans to launch a ranking system of nursing homes, giving each nursing home a "star" rating. The system is designed to provide patients and their families an easy to understand assessment of nursing home quality. The ratings will be posted on CMS's Nursing Home Compare Web site by the end of 2008. A sample screen shot of the proposed star ratings is available on the CMS Web site at http://www.cms.hhs.gov/PressContacts/10_PR_fivestar.asp. Descriptive information about the quality rating system and its progress also may be obtained on the CMS Web site at http://www.cms.hhs.gov/SurveyCertification/GenInfo/02_HotTopics.asp. According to CMS Acting Administrator Kerry Weems, "The new 'five-star' rating system will provide a composite view of the quality and safety information currently on Nursing Home Compare to help beneficiaries, their families, and care givers compare nursing homes more easily." It also will "provide an incentive for nursing homes to strive toward earning a five-star rating by providing an environment of better quality care," he said.

CMS Press Release, June 18, 2008.

HQID shows improved inpatient care

Recent results of the Hospital Quality Incentive Demonstration (HQID) show substantial improvement in hospital inpatient care, according to CMS. The demonstration, which was launched in October 2003 by CMS and the Premier Inc. Healthcare Alliance, involves about 250 hospitals in 36 states. HQID was designed to test new payment systems under Medicare that would improve the safety, quality, and efficiency of care delivered in hospitals. The average composite quality scores (CQS), an aggregate of all quality measures within five high-volume inpatient clinical areas, improved significantly between the inception of the program and the end of its third year. The total increment in average CQS over HQID's first three years was 15.8 percent. The CQS increase between the demonstration's second and third years was 4.4 percent. The top-performing 112 hospitals earned a total of $7 million in incentive payments for substantial and continual advancement in quality of care. CMS has awarded more than $24.5 million over the first three years of the HQID project and extended the project for an additional three years, through September 2009.

CMS Press Release, June 17, 2008.