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SOX enforcement unchanged after HealthSouth CEO's acquittal

by Catherine Hubbard, M.A., Contributing Editor

The acquittal of HealthSouth Corp. former Chief Executive Officer (CEO) Richard Scrushy of all charges related to a $2.7 billion earnings overstatement at the rehabilitation and medical services chain he founded is the first application of Section 906 of the Sarbanes-Oxley Act (SOX) of 2002, which contains criminal penalties for executives who falsely certify the accuracy of their company's periodic financial reports. The corporate governance law was spurred by Enron-type scandals and intended to make it more difficult for top executives to argue they were ignorant of fraud within their companies.

Centered on knowledge. United States Attorney Alice Martin stated during an AHLA teleconference held on July 15, 2005 that Scrushy was charged not only with falsely certifying the accuracy of reports, but with causing and attempting to cause top executives to falsely certify the accuracy of financial forms. The Department of Justice's (DOJ's) prosecution of Scrushy under Section 906 turned on whether and to what extent he had knowledge that the company's financial reports did not comply with certain sections of the Securities Exchange Act of 1934.

"This acquittal not only has to be a shocking disappointment to the prosecution, but a sobering alarm to the members of Congress who enacted SOX," said Charna Sherman, a partner with Squire, Sanders & Dempsey in Ohio. "The SOX signature requirement was intended as the certain fix to ensure accurate financial reporting," she added.

Had Scrushy fulfilled the fiduciary responsibilities Congress intended when it passed SOX and pressed his financial team, Sherman said, it would seem inconceivable that he would not have discovered this multibillion dollar fraud. "The acquittal by this jury exonerates him from any criminal failings in overseeing what indisputably was one of the largest reporting frauds in the nation's history," she said.

Indicted on 36 counts. The SOX charge, however, was only one of three dozen charges, noted John Coffee, a securities law professor at Columbia University. "I do not think this case says much about SOX," said Coffee. "The indictment, as it went to the jury, contained only one SOX count out of 36 counts," he said. "The jury acquitted on all of those counts, suggesting that it was not any special weakness in SOX that affected them," he added.

To Coffee, the case says more about the strong regional culture of the South and the difficulty in convicting a popular figure in his own hometown than about SOX. Coffee noted that Scrushy "had the benefit of a jury that liked and empathized with him."

Martin stated during the teleconference that the jury did not put more credibility into the testimony of five witnesses who testified that Scrushy had knowledge that the information in the financial statements did not fairly represent HealthSouth's financial condition. She stated that in post-verdict interviews the jury stated that the DOJ clearly proved fraud, but the jury believed that HealthSouth employees lied to Scrushy.

Complex prosecution. The government might have succeeded if it had explained the accounting scheme in simpler terms to the jury. According to Stephen Huggard, a former federal prosecutor who now practices white-collar defense at Palmer & Dodge in Boston, a criminal prosecution works best if the jury readily understands that the defendant did something illegal, such as stealing, rather than understands accounting principles and practices, he said. "The more arcane the proofs, the more the jury usually needs to know that the defendant benefited financially in an inappropriate manner," he said

In this case, the government focused on Scrushy's wealth, and that he benefited when the HealthSouth stock rose in value. "They did not allege, to my knowledge, that he stole any money, or used the company as his personal piggy bank," Huggard said.

SOX enforcement. Still, the SOX law will continue to be useful in preventing corporate fraud, Huggard said. "I do not think this spells trouble for SOX," he said, adding that the reporting and certification requirements of SOX are best understood as vehicles for drawing attention to problematic areas and not necessarily as vehicles for prosecution.

"[The Securities and Exchange Commission (SEC)] remains fully capable of prosecuting any violation of SOX it encounters," said Huggard. "The DOJ is staffed by very capable people. They will undoubtedly try to make the next SOX prosecution immune to the defects they may now perceive in the Scrushy trial," he added.

Scrushy still faces charges before the SEC. Over time, criminal provisions of SOX might function as equivalents to the criminal penalties in Title 31 of the United States Code pertaining to structuring currency transactions in order to evade the filing of a currency transaction report, said Huggard. "[Those would be] nice charges to add as evidence of guilty knowledge when you have an otherwise strong case, but not necessarily the centerpiece of a prosecution," he said.

CCH Washington Bureau, July 13, 2005

Finance panel addresses prescription drug pricing, False Claims Act

by Catherine Hubbard, M.A., Contributing Editor

Senate Finance Committee Senator Charles Grassley, R-Iowa, said he held a hearing on June 28 and June 29 to "kick start some necessary and healthy changes to the Medicaid program." Senator Grassley is focusing on reducing fraud and abuse.

Likewise, Leslie Aronovitz, of the General Accountability Office (GAO), said the Centers for Medicare and Medicaid Services (CMS) need to "make a bigger commitment" to help states control Medicaid fraud and abuse.

Despite the millions of dollars CMS receives each year for fraud and abuse control, CMS does not fund initiatives sufficiently to help states increase the effectiveness of their Medicaid fraud and abuse control efforts, said Aronovitz.

"Developing a strategic plan for Medicaid fraud and abuse control activities would give CMS a basis for providing resources that reflect the financial risk to the federal government," she said in testimony entitled, "Medicaid Fraud and Abuse: CMS's Commitment to Helping States Safeguard Program Dollars is Limited" (GAO-05-855T).

States have modified their programs as a result of CMS compliance reviews, yet the reviews are rare, said Aronovitz. At its current pace, the agency is reviewing state programs about once in seven or eight years, she said. Because of this infrequency, CMS's knowledge of states' fraud and abuse activities is often out-of-date, she added.

Ranking Democrat Max Baucus, of Montana, cautioned against assuming that all growth in Medicaid spending is the result of fraud. Medicaid spending, he noted, is growing due to increased enrollment, rising costs of long-term care and health care inflation. Congress should not expect to reach its goal of reducing Medicaid's growth by $10 billion over the next five years by reducing fraud alone, he stated.

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Prescription drug pricing. Several witnesses testified that Medicaid is overpaying for prescription drugs. Federal Medicaid director Dennis Smith, said the current system invites fraud by allowing manufacturers to artificially raise the average wholesale price (AWP), thus increasing the difference between the pharmacy acquisition cost and the reimbursed amount. The larger this spread, the more a pharmacy profits on the reimbursement from Medicaid, he said. "This system has created an incentive for manufacturers to artificially raise the AWP to make their products more attractive to pharmacies," he added.

Most states use the AWP to calculate their payments, yet this method of reimbursement bears little resemblance to prices incurred by retail pharmacies, said Robert Vito, Department of Health and Human Services regional inspector general for evaluations and inspections, Philadelphia (*See OIG Testimony*, June 29, 2005, p530,259).

Vito said that states could have saved $1.5 billion in 1999 by basing payments on pharmacy acquisition costs. He noted that CMS estimates Medicaid paid more than $30 billion in 2004 for prescription drug reimbursements, compared to $9 billion in 1994.

"There is an urgent need for the Medicaid policymaking community to assist states in strengthening their ability to make reasonable for Medicaid-covered drugs," he concluded.

Timothy Coleman, associate deputy attorney general at the Department of Justice (DOJ), said the federal False Claims Act (FCA) has been key to reigning in this type of fraud.

State False Claim statutes. Several witnesses called for increased use of whistleblower laws, especially in states. Nicholas Messuri, president of the National Association of Medicaid Fraud Control Units, suggested that all states should adopt their own FCA laws, noting that only about 15 states have such statutes.

James Moorman, CEO of Taxpayers Against Fraud, said some states have enacted their own FCAs with qui tam provisions, which reward whistleblowers with a share of the state portion of recoveries in cases of Medicaid Fraud. Currently, 13 states and the District of Columbia have enacted such laws. "Some states have made tremendous use of the FCA," including Texas where the Attorney General has publicized state FCA settlements, he noted.

States should be required to adopt their own FCAs with whistleblower provisions as a condition of receiving federal Medicaid matching funds, said Moorman, adding that if all states adopt FCA laws, whistleblowers would have more incentive to bring cases. Such a requirement "would be a significant reform," he said in response to a question from Grassley about the usefulness of state statutes. He estimated that state laws would reach between 65 percent and 70 percent of payments that are not covered by the federal act.

State FCAs provide whistleblowers additional incentives to file actions and increase the procedural options for filing and prosecuting Medicaid fraud cases, Moorman explained. For example, he said, if the federal government lacks resources to investigate a case, a state attorney general could investigate. Also, state FCA cases can encourage the federal government to pursue leads that it might otherwise neglect, he said.

FCA cases have been instrumental in prosecuting Medicaid fraud. In one noteworthy whistleblower case, the DOJ recovered $345 million from Schering-Plough, a pharmaceutical company. Coleman said that in the past six years, the DOJ has obtained recoveries exceeding $2 billion in pharmaceutical fraud matters, mostly with the help of whistleblowers and state attorneys general. "It is vitally important that Congress maintains the strength and integrity the federal FCA," he said. "We would not be able to obtain the successes that we have enjoyed without the participation of relators," he added.

Recent recoveries include Schering-Plough, Pfizer ($430 million) and TAP Pharmaceuticals ($875 million).

Whistleblower suit. Beatrice Manning, who worked at Schering-Plough for more than five years, said the company cheated Medicaid out of hundreds of millions, if not billions, of dollars, by failing to charge the government and its beneficiaries the lowest price for Claritin.

The scheme, which centered on Schering's blockbuster drug, used kickbacks that resulted in Claritin costing many insurers and HMOs an equal

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Is a ChargeMaster tool in your future?

by Leonard Womack

Managing a chargemaster is an increasingly difficult process. The sheer volume of charges that must be maintained in a manner consistent with laws and regulations can be daunting. The chargemaster must be in compliance with CMS one time notices, CMS Manual changes, new and revised national coverage decisions, new and revised local coverage decisions, changes in online claims editors, changes in the national correct coding initiative edits, new and revised codes, changes in fee schedules, and changes in payment status. Given the importance of the chargemaster to your financial and compliance well-being it is no wonder that an increasing segment of the nation's hospitals are turning to electronic solutions to assist in the management of the chargemaster.

Chargemaster tools provide insights needed to effectively manage a facility's chargemaster. Generally, electronic tools provide coding support and some have the ability to automatically query a facility's chargemaster and arrive at a conclusion (e.g. deleted HCPCS code) and may in some cases even make recommendations for corrections. Some tools interpret changes into actions for specific charge codes in your chargemaster. Electronic tools must be used by persons with a least a basic understanding of coding, billing compliance, finance, contract compliance, and reimbursement as it impacts a facility.

In order to use a tool fully the facility must have a basic understanding of the services, supplies and pharmaceuticals that it provides, the chargemaster and the regulations that guide the billing process.

A facility chargemaster is a listing of billable services, supplies, and pharmaceuticals. In theory, this electronic document should represent everything that the facility has decided to charge its patients. There are several key components to every chargemaster: (1) the charge code or item number, (2) the charge description, (3) revenue codes, (4) HCPCS codes, (5) modifiers, (6) billable versus non-billable charges, and (7) pricing.

1. Charge code or item number. The charge code or item number is a facility unique identifier used to communicate with the facility's patient financial system.

Most facility charge codes are comprised of 7–10 digits. Generally, the first three or four digits represent the primary department using the charge. The remaining numbers usually have no specific meaning, although some facilities attempt to use the CPT© code as part of the charge code or item number, but due to the changes in coding, and the resulting changes in code assignment, these attempts generally are abandoned in favor of the random assignment of numbers.

A good practice is to require that the last digit be a "check digit." A check digit is a calculated value based upon the other digits in the charge code. For any given combination of numbers in a charge code there is a single check digit. The value of a check digit is that if a data entry error occurs, only one number in 10 (0-9) will validate the preceding numbers. This reduces the likelihood of an erroneous charge keying entries by 90%. Due to the reduction in error, every charge should be assigned a check digit. Check digit calculators can be located by searching the term "check digit calculator" online or by simply adding the preceding digits together and using the last digit of the sum. For example, to find the check digit for charge code 4501276: (1) add the individual digits; 4+5+0+1+2+7+6=25, (2) identify the last digit in the sum, which is 5 in the example, and (3) add the last digit to the charge code. In the example, the complete charge code becomes 45012765.

2. Charge description. Clinicians communicate what a given charge represents internally with charge descriptions. Charge descriptions are limited to 26–38 characters and so the person responsible for the chargemaster also has to be a master of abbreviations. Unfortunately, most facilities invest considerable time and effort in coding and very little time in the descriptions of their charges.

a. Clarity. The charge description is the principle way a facility's clinical personnel relate to a given charge. As such, the description should be clearly related to the service, supply or pharmaceutical and clearly differentiated from similar charges. The ChargeMaster Institute often performs reviews for facilities and finds four or five charges for eye sutures or coronary stents with different prices, but no identifiable means of differentiating one charge from another. Sometimes the description for the procedure cannot be differentiated from the description for the supplies used in the procedure. While the person that established the charge may be able to differentiate the charges, that person may have left the

facility years ago. Yet, their charge description continues to create confusion.

One suggestion is to always start a description of supplies with the noun, such as cath, needle, or stent, and then use any adjectives necessary to differentiate between products. As much as possible, procedures should be labeled with a verb, such as insert, remove, and placement. The charge description should clearly relate to the CPT© code or HCPCS Level II code. This does not necessarily require an exact match, but there should be no mistaking one procedure for another, and the end user should not be misled to think the code can be used in ways that are inconsistent with the published descriptor for CPT©/HCPCS codes.

For example, the act of defibrillating a heart arrhythmia can be reported with CPT© code 92960. However, the CPT© code describes an "elective" procedure and the use of this code for cardioversion during CPR (a non-elective application) would not be appropriate. Including the term "elective" in the descriptor will prevent the use of an incorrect code. In addition, the CPT© code(s) for a CT scan of the lower extremities (73700–73702) each describe a CT scan of a lower extremity. For order entry purposes the codes are often established based upon the anatomical area of interest, such as CT Tibia, CT Fibula, CT Femur, and CT Foot. However, should an unfortunate patient have multiple trauma to the lower extremities, and a physician would like to evaluate several of these areas, it would not be appropriate to charge for each area of interest. It is important to remember that the published description is "lower extremity," which is all-inclusive. The end user, who may have no understanding of the underlying CPT© code definition, may base the charge practice upon the charge description, which may cause a facility to over-charge for this service.

b. Create a dictionary of abbreviations. A dictionary of abbreviations should be compiled. A good place to begin this dictonary is the Health Information Department of a facility. Every Health Information Department maintains a listing of approved abbreviations that all clinicians are required to use. What better way to communicate with clinicians than with their own language. Of course, a facility will still need to add a number of abbreviations in the working dictionary. The ChargeMaster Institute recommends that a facility obtain a download of the chargemaster, parse the description based upon the space, and eliminate the duplicates and then use the resulting listing to create your abbreviation listing.

The same abbreviations should always be used, even when there is enough room for the full description. Consistent use of abbreviations will result in their consistent application. Space is limited on bills and the ChargeMaster Institute recommends that the facility instruct its billing analysts to omit periods, commas, and apostrophes.

3. Revenue codes. Revenue codes are used by different payers in different ways. Medicare generally requires that the revenue code represent the department of cost. However, non-Medicare payers frequently edit the reported HCPCS code for a charge against the revenue code. If the revenue code is inconsistent with the type of service provided, a charge rejection will result. A good example of this can be found in the cardiac cath lab. Many cardiac cath labs also perform peripheral interventional procedures such as a stent placement into the peripheral vascular system. The CPT© codes to report this procedure in the initial vessel are 37205 and 75960. The revenue code to report to Medicare for each of these two procedures is 481 (cardiac cath lab), whereas a bill to a non-Medicare payer would list CPT© code 37206 paired with revenue code 360 and revenue code 75960 paired with revenue code 320.

4. HCPCS Codes. There are two basic levels of HCPCS Codes. Level I codes, which are also known as CPT© codes are issued by the American Medical Association (AMA). HCPCS Level II codes are issued by the Centers for Medicare and Medicaid Services (CMS). The two code sets can overlap. Knowing when to report the CPT© codes instead of the HCPCS Level II code or vice-versa can be a difficult process. Additionally, the process is further complicated because the facility may not use some CPT© and/or HCPCS codes, instead the facility must simply report the item or pharmaceutical without a CPT© or HCPCS code.

5. Modifiers. There are also two levels of modifiers: Level I modifiers issued by the AMA and Level II modifiers issued by CMS. As with HCPCS codes you may only use a limited subset of these modifiers in a hospital setting and some modifiers may only be used with certain types of services.

6. Billable versus non-billable charges. Many services are billable based upon the type of caregiver who provides the service. For example a service provided by a bedside nursing staff is known as a "routine service." According to CMS, routine service costs are captured by the facility's room and board charge and so no other charge is indicated.

Some services are covered by Medicare only in an inpatient setting, which is not usually an issue with non-Medicare payers. But provide one of the services to a Medicare patient in an outpatient setting and the facility will not receive any payment.

Some services are not covered by Medicare in any setting. A careful review of your chargemaster to insure these types of services are not being provided to Medicare patients is an essential part of your chargemaster maintenance.

7. Pricing. Providers have considerable discretion in establishing prices in a hospital setting. However, providers are required to maintain the statutory and regulatory requirements. These requirements include:

- to maintain a consistent relationship between cost and charges;

- to bill like charges for like services;
- to assess the same gross charge for inpatient, outpatients and if you have subprovider status the facility must have the same pricing for these patients as well;
- to maintain a billing system that charges Medicare and non-Medicare patients the same.

Note that there are exceptions to these requirements. But most facilities do not know that there are any pricing requirements, let alone that exceptions exist to those requirements. Beware of multiple charges for the same services or items in the facility's chargemaster with varying prices. It could indicate that these regulations are not being followed.

Conclusion. Given all of the variables, numbers and frequency of ongoing changes to a facility's chargemaster, a chargemaster tool can be a useful revenue management, coding and compliance guide. As with any tool, proper use assumes that the user has some basic understanding of the tool's function. As a facility evaluates new or existing tools the facility should not forget to evaluate the employees who will use the tools. A user that blindly follows any and all findings or recommendations can be a recipe for a financial or compliance disaster. A chargemaster tool is a supplement and does not replace a knowledgeable chargemaster manager or analyst.

Leonard Womack has been performing hospital chargemaster reviews since 1988. He founded ChargeMaster Institute, Inc. in July 2001, available at www.chargemasterinstitute.com. Since that time his company has performed over 130 chargemaster reviews and provides ongoing support to over 40 hospitals. Known for their ability to defend company findings with supportive documentation, the company's primary goal is to provide educational programs designed to result in defensible internal chargemaster management controls.

Technology

CMS to streamline NPI process

by Catherine Hubbard, M.A., Contributing Editor

The Centers for Medicare and Medicaid Services (CMS) are working toward instituting a one-step process that would allow providers to obtain national provider identifiers and enroll in Medicare at the same time, according to officials who spoke during a recent conference call.

By May 23, 2007, providers engaging in electronic transactions, healthcare clearinghouses, and large health plans must use a national provider identifier (NPI) in standard transactions. Small plans, those with $5 million or less in revenues, have an additional year to implement the requirement.

Allen Gillespie, who works in the provider enrollment area of the Office of Financial Management, said the NPI will serve as the billing number once the health care provider or supplier is approved by Medicare."CMS will no longer issue billing numbers," he added.

Currently, the process to apply for an NPI is separate from Medicare enrollment, said Gillespie, noting that CMS wants to let providers use the Medicare enrollment application to obtain an NPI. "That is a long-range plan," he said. "Our goal is that by May 23, 2007, you will either already have an NPI and we will validate it, or you can request Medicare enrollment and an NPI at the same time."

CMS already has begun issuing HIPAA's NPIs and providers may apply for their number on the CMS web site, according to Stanley Nachimson, senior technical advisor of the Office of E-Health Standards and Services, during a June 22 National HIPAA Roundtable conference call. "It behooves providers to obtain their NPIs by May of 2007," he said.

Liza Zone, Deputy Director of CMS' Office of Financial Management Program Integrity Group, said CMS' enumeration system has been a success since it started on May 23 of this year. "We have been successful in making sure that this system is running efficiently and effectively to address all of our provider needs," she said. So far, nearly 32,000 NPIs have been issued to various types of healthcare providers, she noted.

In addition, the system has processed 2260 updates or changes from enumerator providers, said Patricia Peyton, who works on the NPI team of CMS' Office of Financial Management Program Integrity Group. CMS has also assigned 1747 numbers to healthcare providers that have submitted paper application forms, she added.

Electronic file submission. Organizations interested in being Electronic File Interchange organizations must complete and send a form to the enumerator in order to be considered, said Peyton. Approved organizations will send files containing NPI application data to the CMS system. After the numbers are assigned, the organizations will download the files containing the NPIs and will notify the providers of their number. The agency expects to use the interchange for updates and deactivations as well, she added. "Our goal is to have EFI in operation by fall of this year," she said.

In addition, CMS is developing a small batch process to allow providers to submit application data as to approximately 20 providers, perhaps in an Excel file, said Peyton. She added that she doesn't know when that process will be operational.

Subparts. The regulations, published in January of 2004, require covered healthcare providers to obtain NPIs and allows covered organization healthcare providers to obtain NPIs for themselves as well as any related components that are not legal entities, but that need to be identified in standard transactions, Peyton explained.

The Final Rule also requires covered organization providers to designate as subparts any departments that conduct their own standard transactions and to

obtain NPIs for those subparts or instruct them to obtain their own, said Peyton. "Subparts cannot be individuals such as physicians because individuals are considered legal entities," she clarified.

Peyton reminded the callers that the NPI was mandated to identify each healthcare provider, not simply each service address at which healthcare is furnished. Moreover, she said, the standard claims transactions can accommodate the address at which healthcare was furnished, even if that address is different from that of the billing or the pay-to provider and is not the patient's home.

Moreover, Peyton noted, the Final Rule notes that other federal regulations or statutes may require healthcare providers to have unique billing numbers in order to be identified in claims sent to federal health programs such as Medicare. In many cases, those healthcare providers are actually components of covered organization healthcare providers, even though they may be located at the same address as the covered organization provider. In situations where such federal regulations or statutes are applicable, she said, the covered organization providers would designate the components as subparts and ensure that they obtain NPIs, she said.

When providers receive their number, they should contact those health plans with whom they do business to find out how the health plans intend to implement the NPI in standard transactions and should contact their practice management system company to find out their plans for implementing the NPI, said Helen Dietrick, who works with the national provider identifier team from CMS' Office of Financial Management. "When providers contact their vendors, they need to make sure that the NPI will be implemented in time to meet the compliance date and any health plan requirement," she said.

In an attempt to strike a balance between the need for NPI information for covered entities with the need to ensure the privacy and security of individual information and identifiers, CMS plans to publish a data dissemination notice in the Federal Register in the fall of 2005, Dietrick said.

Transition to NPIs. Deborah Auerbach, from the Office of Information Services (OIS), outlined CMS' plans for implementing NPI in the fee-for-service arena. The OIS is developing a crosswalk between the NPI and all necessary legacy identifiers. Auerbach outlined the many different types of identifiers CMS uses, such as provider identification numbers for Medicare billing, national supplier clearinghouse numbers, online survey certification and retrieval system numbers, unique physician identification numbers and National Council for Prescription Drug Program numbers.

In June, CMS announced its strategy for getting ready for NPI. For instance, CMS cannot accept a claim in a fee-for-service transaction if it only has the NPI. "We are not ready for it," Auerbach said. But as of January 2006, CMS will be able to accept both the legacy identifier and the NPI as long as providers send both in, she said. In October 2006, CMS will be able to accept either the legacy identifier and the NPI, or just the NPI. By May 23, 2007, CMS will finish implementing the system and will only accept NPIs, she said.

Tax-Exempt

Uninsured patients of Tax-Exempt hospital not third-party beneficiaries

by CCH Editorial Staff

Uninsured and indigent patients who received treatment at a tax-exempt hospital were not third-party beneficiaries of a contract that purportedly arose from that exemption. The Internal Revenue Service (IRS) granted tax-exempt status, either by a determination or by an administrative ruling, not by contract. Therefore, because there was no contract between the hospital and the federal government, the hospital was not required to provide free or reduced-cost case as a condition of its tax-exemption. Further, there was no legal basis for analogizing Code Sec. 501 with the Hill-Burton Act (42 U.S.C. Section 291), under which funds are awarded to hospitals that provide care to uninsured or indigent patients.

The uninsured patients lacked standing to enforce rights allegedly created by the hospital's tax exemption under Code Sec. 501, either in suits against the federal government or in suits against the hospital.

S. Kolari v. New York Presbyterian Hospital, S.D.N.Y., March 29, 2005

Quality of Care

CMS outlines health care quality initiatives

by Catherine Hubbard, M.A., Contributing Editor

House Ways and Means Committee Chairman William Thomas, R-Calif., and Health Subcommittee Chairman Nancy Johnson, R-Conn., wrote to Centers for Medicare and Medicaid Services (CMS) Administrator Mark McClellan on June 16 asking for information on how CMS is moving Medicare toward value-based purchasing.

Specifically, Thomas and Johnson asked whether CMS uses quality indicators for providers besides hospitals, whether it has worked with the physician community to develop measures and whether the measures apply to specialties and sub-specialties. They also wanted to know how CMS is implementing the hospital reporting of quality indica-

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amount or less compared to Allegra, its major competitor. But it didn't reflect the lower amount in its calculation of best price, which it is required to give to Medicaid and other government programs, she said.

Manning recommended that whistleblower laws be modified to result in higher settlements and to hold executives personally responsible for fraud. While the settlement was one of the largest Medicaid settlements ever, $350 million dollars plus legal expenses was to some extent the cost of doing business for Schering, she said. While Claritin was still on patent, there were several years where Schering collected revenue exceeding $2 billion per year from Claritin sales, she added.

Grassley thanked Manning for stepping forward. "We could not do our congressional job of oversight without patriotic people like you," he told her.

CCH Washington Bureau, July 13, 2005

Reward offered for Medi-Cal fraud information

by Sheila Lynch-Afryl, J.D., Contributing Editor

An offer of an reward of up to $1,000 for information leading to the conviction of health care providers who defraud the Medi-Cal program has been announced by California Attorney General Bill Lockyer. Medi-Cal is a $34 billion program that underwrites the health care expenses of approximately 6 million low- income people in California.

This plan is a response to a 2004 study of Medi-Cal's fee-for-service and dental programs that found that 3.57 percent of the total paid by the state involved some kind of fraud or payment error. Medi-Cal fraud is committed by providers who bill for services or supplies that are unnecessary or not actually performed. These include:

- medical doctors who order unnecessary lab tests and allow untrained, uncertified assistants to provide medical treatment to patients;
- dentists performing unnecessary teeth extractions;
- medical supply companies billing for equipment and products that were neither ordered nor delivered;

For example, some fraudulent providers entice poor and non-English speaking providers to undergo unnecessary procedures in exchange for clothing and other items that the patient cannot afford.

More than 6 million Medi-Cal recipients will be contacted and asked to look for and report Medi-Cal fraud. These alerts will be in English, Spanish, Russian, and Vietnamese. Health care providers also will receive flyers and posters. Those wishing to report fraud can call the Attorney General's Bureau of Medi-Cal Fraud & Elder Abuse Hotline or file them online at www.stopmedicalfraud.ca.gov.

California Department of Justice Press Release, June 16, 2005

tors, the size of incentives needed to encourage reporting. Currently, almost all hospitals report quality indicators to receive a .4 percent point increase in their annual update.

On June 24, 2005, McClellan responded, saying that CMS is collaborating with a wide range of health care providers, other public agencies and private organizations that want to improve quality and avoid unnecessary health care costs. "We will continue to work with health care providers and Medicare beneficiaries to make further progress on these efforts," he said. He added that CMS has been working closely with consumer groups and nursing home leaders to improve quality of care in nursing homes and has been collaborating with providers who care for patients with end stage renal disease.

In addition, McClellan said, CMS has made "substantial progress" with physician groups and other stakeholders on developing and using quality measures for physician-related services, including ambulatory care. While collaborations such as these have resulted in quality measures for many physician specialties, some specialty societies are still developing processes and a few are not reporting any activity, he said. CMS wants to work with any medical specialty to support their quality measurement and improvement efforts, he added.

Regarding the size of incentives needed to encourage reporting, McClellan said limited adjustments in payment rates "may be sufficient incentive to encourage providers to perform well." Nearly every eligible hospital has been willing and able to submit the required data to qualify for a full payment update, he said, adding that is "a clear indication that well-defined incentives can bring about appropriate system change."

Under a demonstration project, hospitals scoring in the top 20 percent for quality measures receive an additional increase above the normal DRG payment of between one and two percent. In the third and final year of the demonstration, CMS will lower payments to hospitals that do not improve. Preliminary results "show that these modest payment adjustments are sufficient to drive quality improvement," McClellan said.

CCH Washington Bureau, July 13, 2005