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New Form 990 promotes transparency but may increase burden on hospitals

by Brant Goldwyn, Contributing Editor

With changes in the exempt organization community in the last 25 years, Form 990 no longer provides useful information, IRS Exempt Organizations (EO) Director Lois Lerner stated at a July 16, 2007, program sponsored by the American Society of Association Executives. In response to concerns about the existing form, IRS staff developed the idea of a core form with additional schedules to be used as needed. The use of schedules promotes the filing of information in the same format, rather than in varying attachments developed by each taxpayer, Lerner noted. She added that if the form needs to be updated in 5 or 10 years, it will be easier to change or add a schedule than to redesign the whole form. The redesigned form also will assist private vendors who provide the forms in print or electronic format. According to Lerner, the new Form 990 will reduce taxpayer burden, promote transparency, and assist the IRS in performing its compliance activities.

Hospital schedule. Speaking at a July 17, 2007, teleconference sponsored by the American Health Lawyers Association, Theresa Pattara, IRS project manager for the Form 990 redesign, warned that large tax-exempt organizations such as hospitals may have to fill out as many as 10 out of the 15 schedules that may be required by the redesign. The teleconference moderator, James King of Jones Day, estimated that health care organizations will have to fill out at least eight schedules. King said that Schedule H is "where the rubber hits the road for hospitals." The hospital schedule requires information on community benefit, debt collection, joint ventures, and facilities and "covers a lot of ground." The schedule demands greatly expanded self-reporting and will enhance the transparency of hospital operations. However, the schedule also will increase the administrative burden on hospitals, King noted after being told that the new form would consist of 300 pages.

Transparency and accountability. The summary page of the new form provides a snapshot of an organization's operations. It facilitates comparisons between organizations, an idea Lerner says she borrowed from the Federal Elections Commission. According to Pattara, one of the principles guiding the Form 990 redesign was greater transparency of an exempt organization, and one of its goals was to allow comparisons between organizations.

John Colombo of the University of Illinois Law School, who also spoke at the teleconference, commended the IRS for providing greater transparency,

Wolters Kluwer Law & Business

but questioned how effectively the form would enhance comparability. He noted that similar information is not required of for-profit or government-owned hospitals. Colombo also pointed out that nonprofits are given choices for certain calculations that reduce comparability, such as determining internal costs and allocating indirect costs.

Ronald Schultz, an IRS senior technical advisor who participated in the teleconference, admitted that the IRS struggled with the question of mandating a uniform report or providing some choices. Ultimately, the IRS decided to allow charities to use their own methods because, although it would be at odds with the goal of comparability, providing choices would reduce the burden on taxpayers.

Community benefit. In regards to Schedule H's community benefit requirement, Colombo asserted, "[I]t's a lousy concept," and suggested that hospitals should be evaluated on the basis of access to health care. He commended the schedule for narrowing the activities that are treated as providing a community benefit. The form focuses on health services and eliminates the inclusion of buildings and facilities. Colombo recommended that training expenses and costs of assessing community needs also be eliminated from this calculation. In response, Schultz noted that the form would not treat bad debt expense as a measure of community benefit and that everything on the schedule is relevant, but that all factors may be taken into account.

Board review. Participants in the AHLA conference expressed concern about a question on the form that asks whether the organization's board of directors reviewed the Form 990 before it was filed. King said that the IRS may need to explain what it considers a review, noting one organization that spent two meetings briefing the board on the Form 990. The IRS has gotten some push back about these questions, Lerner acknowledged, but the agency continues to believe that good governance promotes compliance. Lerner conceded that the tax law does not ask about governance. She said the IRS does not have a view of what an organization should do, but organizations should be thinking about governance. Each one needs to decide for itself, she said. ■

CCH Washington Bureau, July 17, 2007.

Hospital's tax-exempt status restored

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

An Illinois acute care hospital, Provena Covenant Medical Center (Covenant), has regained its tax-exempt status following a successful appeal of the state revenue department director's decision to strip the hospital of its property tax exemption. Illinois Seventh Circuit Court Judge Patrick Londrigan issued his ruling reversing the director's decision on July 20, 2007.

Covenant's tax exemption was revoked in September 2006 based on the "insufficient" amount of charity care it had provided, according to a written decision by Brian Hamer, director of the Illinois Department of Revenue. The determination that Covenant did not meet the state definition of a charitable organization was based primarily on a comparison of the value of the tax exemption and the value of Covenant's charitable activities. Specifically, Covenant admitted that its 2002 charitable activities cost only $831,724, 0.7 percent of its total revenue, while the tax exemption it requested was worth over $1.1 million. In addition, 97.7 percent of Covenant's total revenue for 2002 was composed of patient service revenue, indicating that the hospital was not used exclusively for charitable purposes as required by state law.

Covenant argued that it provided over $10 million in additional charity care in 2002 by accepting Medicare and Medicaid patients and included unreimbursed costs from those programs in its list of charitable contributions for the year. However, according to Hamer, those unreimbursed costs do not represent charity care.

Provena, Covenant's parent company, appealed Hamer's ruling and maintained its position that Covenant meets all applcable standards to justify the property tax exemption. Judge Londrigan agreed and, in his summary ruling, restored Covenant's exemption for charitable and religious use. ■

CCH Chicago Bureau, July 26, 2007; Provena Covenant Med. Ctr. v. Ill. Dep't of Revenue, 2006 MR 000597, July 20, 2007.

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Hospitals cannot sustain RICO claim

by Susan L. Smith, J.D., M.A., Contributing Editor

A New Jersey federal court dismissed two hospitals' claims under the Racketeer Influenced and Corrupt Organizations Act (RICO) arising from allegations of artificially inflated Medicare outlier charges. The court found that the hospitals failed to establish two key elements necessary to sustain a RICO claim: (1) proximate cause; and (2) a distinctive enterprise. The court also ruled that the hospitals had not proven a claim of wrongful competition under state law.

The hospitals alleged that the parent corporation of a tax-exempt system and its subsidiary hospitals (the "enterprise") violated RICO by (1) transporting and receiving money stolen from the government; and (2) submitting claims to the government containing artificially inflated Medicare outlier charges. The hospitals further alleged that the enterprise's fraud upon the government ultimately resulted in reduced Medicare payments to the hospitals.

In addition to the RICO claims, the two hospitals alleged that the submission of artificially inflated charges to Medicare allowed the corporation to receive excessive outlier payments, providing it an economic advantage over the hospitals. The hospitals further alleged that the corporation's noncompliance with Medicare regulations provided it an unfair competitive advantage over the hospitals.

RICO claims. To sustain their RICO claim, the hospitals were required to show that the alleged injury — reduced Medicare reimbursement — was a direct result of the alleged RICO violation. This proximate cause analysis involves consideration of three factors: (1) the directness of the injury; (2) the difficulty of apportioning damages among potential victims, and (3) whether there are direct victims of the alleged violation that could better vindicate the policies underlying RICO.

The court determined that the hospitals' claims did not satisfy the requirement of proximate cause because the direct victim of the enterprise's fraudulent conduct was CMS, the government entity that paid the allegedly inflated outlier charges. The hospitals' injuries were derivative of the injuries sustained by the government, and the hospitals' connection to the fraud scheme was too attenuated to support RICO standing. In addition, the court found, the task of calculating damages would be unduly complex and uncertain. The potential for speculation militated against a finding of proximate cause. Moreover, the government already had pursued its remedies against the enterprise and had negotiated a settlement involving repayment of the allegedly excessive outlier charges.

To sustain their civil RICO claim, the hospitals also had to show that the parent corporation acted through an "enterprise" distinct from itself. The hospitals had to allege and prove the existence of two distinct entities: a "person " and an "enterprise." The hospitals named the parent corporation as the person and asserted the existence of an association-in-fact enterprise consisting of the corporation's constituent hospitals and their officers, directors, employees, and agents. The court ruled, however, that the hospitals could not evade the distinctiveness requirement by pleading a corporate enterprise consisting solely of a combination of the corporation and its subsidiaries, employees, and agents.

Unfair competition charges. The hospitals alleged that the corporation violated the state law of unfair competition because it obtained an undeserved economic advantage through its charging practices. The hospitals claimed that the corporation represented to CMS that it would abide by Medicare rules and then breached that representation by submitting Medicare claims with artificially inflated outlier charges. The court rejected that claim, however, reasoning that state law does not compensate private parties for unfair competition through acts that primarily involve fraud on the government. ■

Longmont United Hosp. v. Saint Barnabas Corp., D. N.J., June 26, 2007, Health Care Compliance Reporter ¶800,344.

PSC fraud detection efforts vary widely, OIG reports

by Matthew E. Mann, J.D., Contributing Editor

Medicare's Program Safeguard Contractors (PSCs) had wide-ranging differences in the number of cases investigated and referred to law enforce-

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Compliance training: Answering the four questions

by Daniel J. Weissburg, Esq., Contributing Editor

Over the range of responsibilities that fall to a compliance officer, none is more daunting than training. Training is the part of a compliance program with which every employee interacts – it is a big part of the "public face" of a compliance program. The act of rolling out compliance training poses a significant professional risk to a compliance officer.

To build a framework for addressing the challenges that run with the multi-faceted training issue, compliance training specialist Dan Weissburg poses the four key questions:

- To train or not to train?
- Do we look like crooks?
- What is the goal of training?
- How best to deliver the training?

The answers to these questions will help compliance officers avoid coming training traps and offer pragmatic tips to make compliance training effective.

To train or not to train?

Posing this question to an audience of health care compliance professionals may seem a bit like asking the choir members if one should go to church this week. Indeed, for most health care organizations, the business case for compliance training has long been compelling.

In each of its many compliance guidances, the Office of Inspector General (OIG) lists "conducting effective education and training" as one of the seven elements "widely recognized as fundamental" to an effective compliance program. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) (PubLNo 104-191) requires that workers be trained on the privacy rules.

Section 6032 of the Deficit Reduction Act of 2005 (DRA) (PubLNo 109-171) requires entities that receive annual payments of $5 million or more under the state Medicaid program to provide employees and vendors with a "specific discussion" about the federal False Claims Act, relevant state false claims act(s), the federal Program Fraud Civil Remedies Acts of 1986, and whistleblower protections provided by these laws, as well as the entity's compliance policies and procedures.

The current terrain can best be summarized as containing pockets of compulsory training surrounded by an expanse of governmentally-suggested training. While compliance training is not yet an explicit condition of Medicare participation, when viewed as a whole, legal and regulatory evolution of the last dozen years seems to be moving in that direction.

Even putting these important governmental dictates aside, as any good employer knows, training the workforce, from cafeteria staff to neurosurgeons, to do their job correctly is good business. It is a component of making an employee feel empowered, and empowerment is a moral booster.

In this context, one should think of compliance training not as an add-on to "real" or "core" job training. Rather, fulfilling compliance training requirements must be just another integral part of employees' job duties. Compliance training is prudently viewed by health care organizations as merely one component among many in a position-specific training regimen.

Part of building that all-important culture of compliance is to inculcate among the work force the understanding that compliance is a component of their job. To work in the cafeteria, one must stay current on sanitation practices, how to work the oven, and compliance. To continue on the hospital's medical staff, one must stay current clinically via continuing medical education and cognizant of compliance via compliance training.

Do we look like crooks?

This question is deliberately provocative — a great one for a compliance officer to ask a board of directors. No one is day dreaming after the word "crook" is tossed on the board room table like the proverbial dead fish.

Not only does compliance training empower a workforce to detect and avoid compliance violations, a training program also demonstrates a health care organization's commitment to compliance if and when such commitment needs to be defended. It seems clear that federal compliance enforcers, when confronted with potential compliance violations, make a sort of front-end classification. Is the health care organization at issue a crook, deliberately violating the law? Or is it an otherwise upright entity that may have made a mistake? During the progress of an investigation, the presumed "crooks" may get very different treatment than the presumed noncrooks.

There are a number of devices that health care organizations may use proactively to show that they are "not a crook," and training is an important one. An organiza-

tion's leadership should ask themselves the following: "*If the OIG walked in the door tomorrow alleging compliance violations, are we prepared to demonstrate that we have been taking the steps – like training the work force – to try to prevent such violations?*" If the answer is "no," the organization may be perceived — rightly or wrongly — as one that deliberately kept its workforce ignorant, so as to facilitate noncompliant activities. Such presumed "crooks" tread a difficult road.

If the organization can credibly assert that it has been working proactively to prevent compliance violations — including through providing training — it then can legitimately argue that the alleged noncompliance activity is an outlier, the result of an internal misunderstanding, or due to a rogue worker. Such compliance violations must be reconciled with commensurate repayments and penalties, but such reconciliations are far less disruptive than defending the charges brought by enforcers against deliberately noncompliant crooks.

"While compliance training is not yet an explicit condition of Medicare participation, when viewed as a whole, legal and regulatory evolution of the last dozen years seems to be moving in that direction."

Given this reality, documenting the delivery of training becomes critical. For purposes of looking "not like a crook," training that is not documented is effectively training that is not delivered at all. The process of documenting the delivery of training is often tied to the media in which the training is delivered. As examined below, documentation can range from fully automated to totally manual. Different out-of-pocket and labor costs run with each option.

Comprehensive documentation of compliance training is not just useful in response to an investigation. The compliance function is viewed as an expense to most health care organizations. The powers that be — like the chief financial officer (CFO) or the board of directors — may rightly ask, "What did the compliance department do for us this quarter?" An answer of "well ... no one was indicted" would seem to be pretty sound, but adding a fact-laden report of the number of workers trained and on what topics is a bit more tangible.

Note, however, that the mere existence and documentation of compliance training does not, in itself, excuse any misconduct, nor should it. Rather, being able to demonstrate, via the evidence of rigorous training, that a health care organization is at least trying to stay in compliance can have an impact on the approach and attitude of compliance enforcers.

What is the goal of training?

One might think that this is an easy question, but the answer reveals a trap into which many compliance officers fall. A good compliance officer lives and breaths the nuanced and fluid substance of the many facets of health care compliance. Indeed, some of us revel in this. A realistic compliance officer, however, must accept that nearly the rest of the world wishes the whole topic would simply go away.

Given that most of the workers in a health care organization will greet the compliance component of their education with less than bubbling enthusiasm, the goal of training must be realistic: "compliance sensitivity." While compliance must be "core" to a health care worker's job function, save the compliance officer and his staff, most folks are not in the "business of compliance" *per se*. They are in the "business of nursing" or the "business of surgery" or the "business of coding." When formulating the wish list for compliance training, be clear — the goal for a compliance training program should not be to produce an army of compliance experts. Rather, the goal should be to leave most trainees with sensitivity to, and a reasonable understanding of, key compliance topics. Don't bowl them over; it is too expensive, will intimidate and confuse, and, in most cases, is not necessary.

Anti-kickback really can be covered in five minutes for most workers. "*We do not and can not pay folks for sending us patients. This is sometimes called a kickback, and the law on this is complex. Here are three examples of a kickback ... If you see something that looks like it could be a kickback, tell your manager, call the compliance officer, or call the hot line.*" If the trainee walks away with a basic understanding of what a kickback is, and maybe has a trinket with the hot line number on it, for 90 percent of the training audience, one has achieved 90 percent of the goal. Not perfect, but pretty good.

While for most of the training audience, extensive, complex training is not necessary, most health care organizations include some workers in high risk compliance areas, such as the business development/marketing staff for an imaging center. These staffers are motivated to be creative and generate revenue. Accordingly, they may confront complex anti-kickback issues almost every day. These folks would need a more comprehensive understanding of compliance.

In training initiatives, perfection can be the enemy. Good is the goal. This is not to assert that one aim for mediocrity. From a clinical perspective, excellence or perfection is always the goal. "The text book suture" is what the patient wants and what the professional aspires to provide. But compliance training is not surgery. Get a high percentage of the audience to reach a reasonable level of comprehen-

sion. Make them feel good about it. Leave them sensitive to the issues, but not scared. Let them exit training empowered to take next steps when warranted, but never overwhelmed with confusing complexity.

How best to deliver the training?

There really is no right answer to this final question. Each health care organization is unique, with its own culture, history, strengths, and vulnerabilities. The different delivery options have a range of price tags, and there is no one right per-worker budget for training.

Small-group live training

At least theoretically, this is the best of the best. Think of a college seminar with ten students and a really good professor. An expert trainer can take a small group through case studies and role-playing. It is easy make live training 100 percent custom tailored to the health care organization. The teaching style can vary with the group's expertise and experience. It is live, so it can always be hyper-current. It is fully interactive. Documentation of participation is usually manual, via a sign-in sheet.

What is not to like about small-group live training? The cost is typically very high, the physical logistics can be daunting, and the needed human resource — a top quality trainer — often can be rare. If there is room in the budget, use small-group live training for the board, the compliance committee, and the marketing and sales departments.

Large-group live training

This is the most popular training delivery method among smaller health care organizations (those with less than 1000 workers). The cost of delivering training in this manner is typically low. All one really needs is a room, a microphone, and a decent PowerPoint presentation. Large-group live training can be marginally interactive, if it includes quizzes and a question and answer session. Importantly, large-group live training can be a community builder among workers. Like with small group training, documentation of participation is usually manual, via a sign-in sheet. With audiences over one hundred, this can be cumbersome.

A real trap with large-group live training is the boredom factor. Too often, health care organizations present training that is too dense. After all, the substance of health care compliance is, by its nature, complex. The trainer has to be very sure that the audience is not tuning out.

Large-group live training is a great opportunity to have a bit of fun. Maybe a training session can open with the chief executive officer or other senior executive briefly commenting on the importance of compliance and introducing the compliance officer or other trainer. Let the main presentation open with an ostensibly serious but in reality silly "pre-test" question. Allude to prizes and have a big, flashy box of "treasures" on the stage. Ask an easy question about the local sports team, celebrity gossip, or vapid pop-culture icon. "Who are the three stooges?" Hands will shoot up all over the room. Pick a person from the crowd, and when they get the answer right, hand them $20. Now the room is paying attention and, importantly, having fun. One can launch into the true substance of the training.

"Not only does compliance training empower a workforce to detect and avoid compliance violations, a training program also demonstrates a health care organization's commitment to compliance if and when such commitment needs to be defended."

Showing a video

Custom videos are expensive to produce, and generic, off-the-shelf videos generally are worth about the low price one typically pays for them. Of course, videos can be shown any time, any where, over and over, but the static, noninteractive nature of a video makes this among the least effective way to deliver effective training. Paper pamphlets fall into this same category. Again, documentation of participation is manual.

Internet-based training

Also called "e-learning," internet-based training has grown in popularity among larger health care organizations, especially large hospital systems. Practically speaking, there simply are not many efficient ways to train all the workers in a large, geographically disperse organization. It would take a squad of trainers to deliver live training, so asynchronous electronic delivery has a lot of appeal.

When a compliance officer rolls out a new training initiative, he or she takes a personal and professional risk. In the context of a large health care organization, with tens of thousands of workers to the be trained, the cost of implementing internet-based training will exceed $100,000 — a bargain for the amount of the training one can deliver, but not the kind of dollars a shrewd executive squanders.

What happens if the CFO logs on and it does not work? What if all 40,000 workers try to log on during the first eight hours and the server crashes? For each type of training examined here, one can conceptually segregate the substance of the training and the medium of delivery, and that segregation is critical for internet-based training. Internet-based training is accessed from a "learning delivery system" (LDS) usually housed outside of the health care organization's own computer systems. There are big traps with an outsourced LDS. How does the LDS add and delete workers over time? How are passwords

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On The Front Lines (cont.)

and IDs disseminated and by whom? Who else, outside the health care organization, even in other industries, is using the same LDS and taxing the same servers? The technical issues involved in selecting and using an LDS are myriad and typically well outside the expertise of a compliance officer.

The substance of training delivered over the internet can be quite different from that delivered in live training or even via a video. Text on a screen includes no body language and no inflection. Humor seldom works. Conversely, a wide range of interactive tools can be employed to make the worker's training experience engaging. A wide range of generic content is available and it is easy to customize content as desired.

The biggest advantage of internet-based training is in the documentation of participation. Real-time current, multi-field spread sheets can show all levels of supervisors who took which lesson when. Workers who score low on a post-test can "fail" and start over. Best of all, with push-button ease, the compliance officer can easily show other organization leaders and interested investigators how much training has been delivered.

Conclusion

What type of compliance training is best? There can be no right answer. Internet-based training technology has improved in recent years and likely will continue to do so. As the substance of compliance is dynamic, so is the terrain of each health care organization. The "right" training solution this year may be the "wrong" solution next year.

Variety adds spice to life. Correspondingly, altering and mixing both the form and substance of compliance training from year to year can spice up a compliance training initiative.

When confronting the multifaceted challenge of designing and implementing compliance training, a compliance officer is well served to know the limits of his or her skill set. The technical nuances of internet-based training are many and can be complex. Even the most substantively expert compliance professional may lack the creativity to craft content that is clear, concise, and, at its best, fun to learn for the employee. ■

Fraud & Abuse (cont.)

ment in 2005 and had only minimal results from proactive data analysis, according to the Office of Inspector General (OIG). CMS must determine if low-volume PSCs are taking all necessary steps to detect and deter fraud and abuse, provide more guidance if needed, and consider all contractual remedies. CMS also should require more detailed monthly status reports from PSCs so that best practices and efficient techniques can be shared.

Background. The Health Insurance Portability and Accountability Act of 1996, §202, established the Medicare Integrity Program and gave CMS the authority to transfer the work of detecting and deterring fraud and abuse from carrier and fiscal intermediary fraud units to PSCs under competitive contracts called "benefit integrity task orders,"which may be terminated or renewed at the end of a performance period. A PSC performance period typically lasts one year. PSCs are expected to have detection and deterrence capabilities that go above and beyond those of carrier and intermediary fraud units. PSCs also are expected to cooperate with the OIG and other law enforcement agencies in their deterrence and detection activities. To gain an understanding of PSC accomplishments, the OIG examined PSC workload statistics and monthly status reports for 2005, as well as budget allocation and level of oversight responsibility data.

Findings. The number of new investigations and case referrals to law enforcement differed substantially across PSCs in 2005, and did not correlate strongly to either the size of the PSC's budget or its oversight responsibility. Between five and 479 new Part A investigations, with a median of 60, were initiated. The four lowest PSCs in terms of volume had between five and 19 new investigations for the entire year. PSCs produced between zero and 10 Part A law enforcement referrals for the same year, with a median of 3. For Part B, PSCs produced between 18 and 3,707 new investigations, with a median of 196. Three of the PSCs had 80 or fewer new part B investigations. PSCs referred between 2 and 39 cases to law enforcement, with a median of 13. Three PSCs had four or fewer Part B case referrals for the year.

Recommendations. For especially low-volume PSCs, the OIG recommended that CMS determine if they are taking all the necessary steps to detect and deter fraud and abuse and, if not, provide additional guidance or consider all contractual remedies available, including termination. The OIG also recommended that CMS demand more detailed information about PSC activities in monthly status reports, both to get a better indication of how PSCs are performing and to allow the sharing of effective techniques. CMS has already begun implementing changes by aligning PSC jurisdictions to jurisdictions of claims processing contractors to better compare PSCs. In addition, CMS has begun to allocate funds based on performance, workload and Medicare program vulnerabilities, and revised its monthly reporting system to collect more information and improve reporting consistency from PSCs. ■

OIG Report, OEI-03-06-00010, July 1, 2007, Health Care Compliance Reporter ¶530,607.

Medicaid

CMS targets growth in Medicaid drug costs

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

In an effort to rein in inflated drug payments, CMS has announced a new method for setting limits on the amount the federal government will reimburse state Medicaid agencies for prescription drug payments. The new payment formula, mandated by the Deficit Reduction Act of 2005 (DRA) (PubLNo 109-171), was issued by CMS on July 6, 2007, and published in a final rule in the *Federal Register* on July 17, 2007.

The Office of Inspector General (OIG) and the Government Accountability Office (GAO) found that states were overpaying for drugs because they were using commercial drug pricing compendia as the basis for setting reimbursement amounts. Investigation of these pricing guides revealed that the prices were artificially inflated, especially for generic drugs. According to the OIG and the GAO, Medicaid payments to pharmacies for generic drugs were much higher than the pharmacies' acquisition costs for those drugs.

Under the pre-DRA methodology, the prices listed in the compendia bore little relationship to the drugs' actual costs. Moreover, actual drug costs were considered proprietary information and CMS was prohibited from disclosing the Average Manufacturers Price (AMP). The DRA introduced transparency in Medicaid drug pricing by requiring that AMPs be publicly reported so states would be able to use actual AMP data to set reimbursement amounts.

Norwalk predicted that the "new calculation method will allow Medicaid to pay more accurately for the medicines enrollees need ... and will yield a payment level that will be sufficient to assure widespread availability of drugs for Medicaid patients." ■

CMS Press Release July 6, 2007; Final Rule, 72 FR 39142, July 17, 2007.

In the News

OIG reviews MFCU enforcement

In fiscal year 2006, state Medicaid Fraud Control Units (MFCUs) recovered more than $1.1 billion in court-ordered restitution, fines, civil settlements, and penalties, according to an annual report by the Office of Inspector General (OIG). MFCUs reported a total of 676 instances in which civil actions resulted in successful outcomes. They also obtained 1,226 convictions. Of the 3,425 exclusions from participation in Medicare, Medicaid, and other federal health care programs, 731 were based on referrals made to the OIG by the MFCUs. In addition to these enforcement activities, the MFCUs have taken steps to improve Medicaid policies and regulations and participated in joint investigations and prosecutions involving both federal and state law enforcement agencies.

OIG Report, July 20, 2007, Health Care Compliance Reporter ¶530,608.

Pharmacy owner convicted for Medicare fraud

The owner of a Florida pharmacy was convicted of Medicare fraud after a jury found him guilty of conspiracy to defraud the U.S. government, submit false claims to Medicare, and receive kickbacks; conspiracy to commit health care fraud; and receiving kickbacks in exchange for referring patients to co-conspirator pharmacies. The pharmacy owner referred patients to co-conspirator pharmacies in exchange for half of what Medicare paid for compounded aerosols. CMS recently announced that it will no longer pay for compounded aerosols because such drugs are medically unnecessary. Trial testimony established that compounding was done for the sole purpose of defrauding Medicare, and the prescriptions were predetermined before any of the beneficiaries saw a physician or received a legitimate prescription. The Florida pharmacy owner faces a maximum sentence of 30 years in prison.

DOJ Press Release, July 18, 2007.

OPPS rule proposes quality incentives

A CMS proposal to update the hospital outpatient prospective payment system (OPPS) focuses on value-based purchasing, proposing incentives to improve quality and promote efficiency. The proposed rule contains 10 specific hospital outpatient quality measures, the reporting of which would be directly tied to payment incentives for hospitals in calendar year (CY) 2009. Hospitals that fail to report data for these quality measures in 2008 would face a reduction in their annual OPPS payment update factor of 2 percentage points in CY 2009. The proposed rule also would extend the current packaging approach to additional services so the additional services would be paid through larger payment bundles to further efficiencies within the OPPS payment structure. Seven categories of supportive ancillary services have been identified by CMS to be packaged for payment along with the primary diagnostic or treatment procedure with which they are performed. Finally, the proposed rule aims to increase efficiencies through one bundled payment for several major services through composite ambulatory payment classification groups.

CMS Press Release, July 16, 2007.